NOTICE OF A SPECIAL MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE

MONDAY, MAY 22, 2017
4:00 P.M.

CALOPTIMA
505 CITY PARKWAY WEST, SUITE 109-N
ORANGE, CALIFORNIA 92868

Board of Directors' Quality Assurance Committee
Paul Yost, M.D., Chair
Ria Berger
Dr. Nikan Khatibi
Alexander Nguyen, M.D.

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Michael Schrader	Gary Crockett	Suzanne Turf

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form(s) identifying the item(s) and submit to Clerk of the Board. To speak on a matter not appearing on the agenda, but under the jurisdiction of the Board of Directors' Quality Assurance Committee, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Consent Calendar, the reading of the individual agenda items, and/or the beginning of Public Comments. When addressing the Committee, it is requested that you state your name for the record. Address the Committee as a whole through the Chair. Comments to individual Committee Members or staff are not permitted. Speakers are limited to three (3) minutes per item.

In compliance with the Americans with Disabilities Act, those requiring accommodations for this meeting should notify the Clerk of the Board's Office at least 72 hours prior to the meeting at (714) 246-8806

The Board of Directors' Quality Assurance Committee Meeting Agenda and supporting documentation is available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, 8 a.m. – 5:00 p.m., Monday-Friday, and online at www.caloptima.org

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PUBLIC COMMENTS
At this time, members of the public may address the Committee on matters not appearing on the agenda, but under the jurisdiction of the Board of Directors' Quality Assurance Committee. Speakers will be limited to three (3) minutes.

CONSENT CALENDAR
1. Approve Minutes of the February 15, 2017 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS
2. Consider Recommending the Board of Directors' Approval of the 2017 CalOptima Utilization Management (UM) Program and 2017 UM Work Plan

3. Receive and File 2016 Utilization Management Program Evaluation

4. Receive and File 2016 Quality Improvement Program Evaluation

5. Consider Recommending Board of Directors' Approval of the 2017 Delegation Grid, Appendix B to 2017 Quality Improvement Program Description and Work Plan

INFORMATION ITEMS
6. CalOptima Care Network Performance: Quality and Financial Analysis

7. Behavioral Health Integration Update

8. 2016 Group Needs Assessment Final Results

9. PACE Member Advisory Committee Update

10. Quarterly Reports to the Quality Assurance Committee
    a. Quality Improvement Report
    b. Member Trend Report

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS'
QUALITY ASSURANCE COMMITTEE

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 15, 2017

CALL TO ORDER
Chair Paul Yost called the meeting to order at 3:00 p.m., and led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Ria Berger; Dr. Nikan Khatibi (at 3:09 p.m.); Alexander Nguyen M.D.

Members Absent: All members present

Others Present: Michael Schrader, Chief Executive Officer; Richard Helmer, M.D., Chief Medical Officer; Richard Bock, Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Ladan Khamseh, Chief Operating Officer; Suzanne Turf, Clerk of the Board

Chair Yost announced the following change to the agenda: Agenda Item 3, Consider Recommending Board of Directors' Approval of the CalOptima 2017 Quality Improvement Program and 2017 Quality Improvement Work Plan to be considered before hearing Agenda Item 2, Consider Opioid Reduction Program and Next Steps.

PUBLIC COMMENTS
Pamela Pimentel, RN, MOMS Orange County – Oral re: Agenda Item 7, Consider Recommending Issuance of Request for Proposal for Medi-Cal Perinatal Support Services.

CONSENT CALENDAR

1. Approve the Minutes of the November 16, 2016 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Director Nguyen, seconded and carried, the Committee approved the Minutes of the November 16, 2016 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Director Khatibi absent)***

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REPORTS

Chair Yost left the proceedings and passed the gavel to Director Khatibi.

3. Consider Recommending Board of Directors' Approval of the CalOptima 2017 Quality Improvement Program and 2017 Quality Improvement Work Plan

Caryn Ireland, Quality Analytics Executive Director, presented the action to recommend Board of Directors' approval of the 2017 Quality Improvement (QI) Program and 2017 QI Work Plan. A review of the proposed revisions to the QI Program for 2017 was presented, which included the following: updates to health network and behavioral health delegate information; adoption of the annual Utilization Management (UM) Program and UM Work Plan; updates to advisory committees, quality committees, and subcommittees that support the QI Program; updates the scope of the Credentialing program; and additional details on the Interdisciplinary Care Teams and risk stratification processes.

Enhancements to the 2017 QI Work Plan include continuous quality improvement projects for the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), behavioral health access and coordination of services, long-term support services initiatives, pharmacy and initial health assessments. The Work Plan continues to focus on Member Experience including access and availability, and improvement initiatives related to Healthcare Effectiveness Data and Information Set (HEDIS), CMS star ratings, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. It was noted that the proposed changes are necessary to meet the requirements specified by CMS, DHCS, and NCQA accreditation standards.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors approval of the CalOptima 2017 Quality Improvement Program and 2017 Quality Improvement Work Plan as presented. (Motion carried 3-0-0; Chair Yost absent)***

2. Consider CalOptima Opioid Reduction Program and Next Steps

Richard Bock, M.D., Deputy Chief Medical Officer, presented an overview of the opioid epidemic, the impact on the Medi-Cal program, and opioid use disorder treatment. The Orange County Health Care Agency Behavioral Health Services (HCA BHS) provides mental health and substance use disorder services to eligible youth and adults. It was reported that California received a waiver from the federal government to develop a five-year pilot project to serve people with substance abuse disorder (SUD), and who are eligible for Drug Medi-Cal; HCA BHS provides the majority of the waiver-required services. A Memorandum of Understanding (MOU) between CalOptima and HCA delineates the responsibilities to ensure members receive the appropriate level of care to address mental health issues. An addendum to this MOU is in development to ensure the coordination of SUD screening and the provision of services between CalOptima and HCA.

Dr. Bock reviewed the following CalOptima interventions: formulary restrictions beginning January 1, 2017; member restriction programs including Pharmacy Home Policy, Prescriber Restriction Program Policy, Part D opioid overutilization monitoring and case management, and referring fraud and abuse to Compliance; prescriber outreach programs; quality measures; ongoing continuing medical education (CME) series for physicians; and coalition participation including the Association for Community Health Plans (ACAP), Safe Rx OC, and DHCS Health Homes Program in 2018.

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The CalOptima Opioid Reduction Program will be presented to the Board at the March 2, 2017 meeting for additional discussion.

4. Consider Recommending Board of Directors' Approval of the 2017 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement (QAPI) Plan

Miles Masatsugu, M.D., Medical Director, presented the action to recommend Board of Directors' approval of the 2017 PACE QAPI Plan. Proposed updates to the 2017 CalOptima PACE QAPI Plan are based on the first three (3) years of data collection, and review and analysis with specific data driven goals and objectives. Revisions to the QAPI Work Plan elements for 2017 include: Physician's Orders for Life-Sustaining Treatment (POLST); 30-day all-cause readmissions; transportation issues regarding one-hour violations, on-time performance and incident resolution; and access and availability to specialty care. Proposed new QAPI Work Plan elements include quality of care for older adults, potentially harmful drug-disease interactions in the elderly, utilization management related to long term placement, and patient satisfaction.

After discussion of the matter, the Committee took the following action.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of the 2017 CalOptima PACE Quality Assessment and Performance Improvement Plan. (Motion carried 3-0-0; Chair Yost absent)***

Chair Yost rejoined the proceedings at 3:50 p.m.

5. Consider Recommending Board of Directors' Approval of the Fiscal Year (FY) 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect

Dr. Bock presented the action to recommend Board of Directors approval of the FY 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect. For Measurement Year 2017 programs, it was recommended to maintain elements from the prior year with the following proposed modifications. Medi-Cal modifications include revising the minimum denominator from 100 to 30 eligible members for each specified quality measure to be eligible for incentive payment, and revise CAHPS minimum performance threshold to reflect California benchmarks. In addition to the four clinical incentive measures in the OneCare Connect Pay for Value program, a member experience survey will be added to the program beginning in calendar year 2017. It was noted that clinical measures are weighted at 60 percent; member experience at 40 percent.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of the FY 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect, as described in Attachments 1 and 2, subject to regulatory approval, as applicable. (Motion carried 4-0-0)***

6. Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 2016-17 for Member and Provider Incentives

Caryn Ireland, Executive Director, Quality Analytics, presented the action to recommend that the Board of Directors authorize staff to develop and implement Member and Provider incentive programs in the amounts listed on Attachment 1, subject to applicable regulatory approval and guidelines. Proposed member incentives are related to postpartum visits, cervical and breast cancer screenings. Provider

incentives include providing office staff incentives related to documentation of postpartum visits, assisting CalOptima members in scheduling pap tests, and extended provider office hours for cervical and breast cancer screenings. It was noted that staff has incorporated DHCS guidance on best practices for member incentives and in accordance with CalOptima policy. Provider offices and clinics identified for the incentive programs will be high volume providers in good standing with CalOptima. Staff will present an analysis of the incentive results to the Committee at a future meeting.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended that the Board of Directors authorize staff to develop and implement Member and Provider incentive programs in the amounts listed on Attachment 1, subject to applicable regulatory approval and guidelines. (Motion carried 4-0-0)***

7. Consider Recommending Issuance of Request for Proposal for Medi-Cal Perinatal Support Services

Richard Helmer, M.D., Chief Medical Officer, presented the action to recommend the Board of Directors authorize the issuance of a Request for Proposal (RFP) to identify community partner(s) experienced with providing Medi-Cal covered Perinatal Support Services, and authorize the Chief Executive Officer, with the assistance of legal counsel, to contract with qualifying RFP responders and in compliance with Medi-Cal Perinatal Support program requirements established by DHCS.

Pshyra Jones, Health Education and Disease Management Director, presented an overview of the DHCS Perinatal Service requirements, CalOptima's contract for Comprehensive Perinatal Services Program with MOMS Orange County, and CalOptima HEDIS rates for prenatal and postpartum services. The new proposed program is designed to provide a more comprehensive approach, and strategically increase utilization, coordination of services and member engagement. As proposed, staff will conduct an RFP process to identify partner(s) to meet the requirements of the new program design for Perinatal Care for CalOptima members.

Action: ***On motion of Director Khatibi, seconded and carried, the Committee recommended that the Board of Directors authorize the issuance of an RFP to identify community partner(s) experienced with providing Medi-Cal covered Perinatal Support Services, and authorize the Chief Executive Officer, with the assistance of legal counsel, to contract with qualifying RFP responders and in compliance with Medi-Cal Perinatal Support program requirements established by DHCS. (Motion carried 4-0-0)***

INFORMATION ITEMS

8. PACE Member Advisory Committee (PMAC) Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, reported on PMAC activities at the December 12, 2016 PMAC meeting, including an update on the Participant Satisfaction Survey indicating an increase in overall satisfaction, new PACE Participant Orientations that began in January, and an update on transportation services. PMAC participants requested additional information prior to attending appointments to specialists, and shared their appreciation for the PACE program.

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The following Information Items were accepted as presented:

9. Quarterly Reports to the Quality Assurance Committee
    a. Quality Improvement Report
    b. Member Trend Report

COMMITTEE MEMBER COMMENTS

Director Khatibi requested an update on behavioral health integration at a future Committee meeting. Committee members commented on the opioid epidemic, including the importance of an aggressive communication campaign, and the need to address post operative medications.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:30 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: May 22, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 22, 2017
Special Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

2. Consider Recommending the Board of Directors' Approval of the 2017 CalOptima Utilization Management (UM) Program and 2017 UM Work Plan

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Action

Recommend Board of Directors' approval of recommended revisions to the 2017 Utilization Management (UM) Program and 2017 UM Work Plan.

Background

Utilization Management activities are conducted to ensure that members' needs are always at the forefront of any determination regarding care and services. The program is established and conducted as part of CalOptima's purpose and mission to ensure the consistent delivery of medically necessary, quality health care services. It provides for the delivery of care in a coordinated, comprehensive and culturally competent manner. It also ensures that medical decision making is not influenced by financial considerations, does not reward practitioners or other individuals for issuing denials of coverage, nor does the program encourage decisions that result in underutilization. Additionally, the Utilization Management Program is conducted to ensure compliance with CalOptima's obligations to meet contractual, regulatory and accreditation requirements.

CalOptima's Utilization Management Program ("the UM Program") must be reviewed and evaluated annually by the Board of Directors. The UM Program defines the structure within which utilization management activities are conducted, and establishes processes and metrics for systematically coordinating, managing and monitoring these processes to achieve positive member outcomes.

CalOptima staff has updated the 2017 UM Program Description and related UM Work Plan with revisions to ensure that it is aligned to reflect the health network and strategic organizational changes. This will ensure that all regulatory and NCQA accreditation standards are met in a consistent manner across the Medi-Cal, OneCare and OneCare Connect programs.

Discussion

The 2017 Utilization Management Program is based on the Board-approved 2016 Utilization Management Program and describes: (i) the scope of the program; (ii) the progam structure and services provided; (iii) the populations served; (iv) key business processes; (v) integration across CalOptima; and (vi) important aspects of care and service for all lines of business. It is consistent with regulatory requirements, NCQA standards and CalOptima's own Success Factors.

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The revisions are summarized as follows:

1. Aligned program descriptions and committee references with the Quality Management Program
2. Removed references to the payment arrangements of the delegated Health Networks
3. Updated program to reflect the new Managed Behavioral Health Organization, Magellan
4. Updated Committee Structure Organization Chart, reflecting new structure and operational unit support
5. Assumed responsibility for the Benefit Management Sub-Committee to ensure timely incorporation of regulatory benefit changes
6. Detailed description for measuring UM effectiveness, including fourteen (14) over/under utilization metrics monitored, tracked and evaluated
7. Included Conflict of Interest statement
8. Expanded description of responsibilities for various key positions to align with NCQA elements

The recommended changes are designed to better review, analyze, implement and evaluate the components of the UM Program and Work Plan. The recommended changes are necessary to meet the requirements specified by the Centers for Medicare & Medicaid Services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact
There is no fiscal impact.

Concurrence
CalOptima Utilization Management Subcommittee
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation – 2017 Utilization Management Program Description
2. 2017 Utilization Management Program – Executive Summary of Revisions
3. Proposed 2017 Utilization Management Program
4. Proposed 2017 Utilization Management Work Plan

/s/ Michael Schrader — **Authorized Signature**

5/18/2017 — **Date**

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2017 Utilization Management
Program Description and Work Plan

Special Board of Directors' Quality Assurance Committee Meeting
May 22, 2017

Richard Bock, MD, Deputy Chief Medical Officer
Tracy Hitzeman, RN, Executive Director Clinical Operations

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2017 UM Program Description Revisions

Summary of Changes

- Aligned with the Quality Management Program
  - Program descriptions
  - Committee references
- Updated Committee Structure Organization Chart
  - Reflects new structure and operational unit support
- Detailed description for measuring UM effectiveness
  - Fourteen (14) over/under utilization metrics monitored, tracked and evaluated
- Included Conflict of Interest statement

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2017 Utilization Management Workplan
Projects and Initiatives

- Over/Under Utilization tracking, trending and reporting
  - Enhanced and centralized to highlight over arching trends and facilitate analysis
- Enriched clinical decision making resources
  - Support appropriate evaluation of complex/highly specialized testing or treatment requests
- Medical management systems enhancements
- Improve coordination of services between CalOptima and County Mental Health Plan

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2017 Utilization Management Workplan
Projects and Initiatives

- Oversight and internal auditing
  - Consistent with CMS, DHCS and NCQA approach
  - Designation of staff with Medicare expertise for processing of OneCare and OCC authorization referrals
- Improve member notices
  - Task force established to focus on standardization of denial letter - lay language use
- Continued development of Long Term Support Services (LTSS) metrics

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Utilization Management (UM) Program 2017

Executive Summary of Revisions

1. Aligned program descriptions and committee references with the Quality Management Program
2. Removed references to the payment arrangements of the delegated Health Networks
3. Updated program to reflect the new Managed Behavioral Health Organization, Magellan
4. Updated Committee Structure Organization Chart, reflecting new structure and operational unit support
5. Assumed responsibility for the Benefit Management Sub-Committee to ensure timely incorporation of regulatory benefit changes
6. Detailed description for measuring UM effectiveness, including fourteen (14) over/under utilization metrics monitored, tracked and evaluated
7. Included Conflict of Interest statement
8. Expanded description of responsibilities for various key positions to align with NCQA elements

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20~~16~~17 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

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UTILIZATON MANAGEMENT PROGRAM
SIGNATURE PAGE

Utilization Management Committee Chairperson:

_____ ~~1/~~_____~~28/2016~~

Francesco Federico, MD **Date**
~~**UM Medical Director**~~

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

_____ ~~1/28/2016~~

~~Viet Van Dang~~Paul Yost, MD ___Date

Board of Directors Chairperson:

_____

~~Mark Refowitz~~Paul Yost, MD ~~1/28/2016~~ ___Date

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PROGRAM DESCRIPTION

~~Purpose~~About CalOptima

The mission of CalOptima is to provide members with access to quality health care services delivered in a cost effective and compassionate manner.

Caring for the people of Orange County has been CalOptima's privilege since 1995. CalOptima's Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum.

CalOptima's Programs:

CalOptima has four programs that it administers:

1. CalOptima Medi-Cal — California's Medicaid program is known as Medi-Cal.
2. OneCare (HMO SNP) — A program for persons who qualify for both Medicare and Medi-Cal, but do not qualify for OneCare Connect~~. — Combined Medicare and Medi-Cal benefits for low-income seniors and people with disabilities~~.
3. OneCare Connect — OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) a demonstration program for low-income people who qualify for Medicare and Medi-Cal.
4. CalOptima PACE — Program of All-Inclusive Care for the Elderly (PACE) that provides coordinated and integrated health care services to frail elders who live independently.

For more details about CalOptima, as well as the scope of services for the above programs, please see the 2017 Quality Improvement Program pages 1–8.

Utilization Management Purpose

The purpose of the Utilization Management (UM) Program Description is to define the structures and processes within the ~~Utilization Management~~UM ~~D~~department, including assignment of responsibility to appropriate individuals, in order to deliver quality, coordinated health care services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, timely manner by delegated and non-delegated providers.

UM Scope

The scope of the ~~Utilization Management~~UM Program ~~(UM Program)~~ is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, home and community based services, as well as acute, short term, long-~~-~~term facility and ancillary care services.

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UM Program Goals

The goals of the UM Program are is to optimize members' health status., We achieve this by pProvideing members with a sense of well-being and , productivity, through and access to quality and , cost effective efficient health care., while Occurring cConcurrently, there is activeAactiveat the same time actively managegement of ging the appropriate utilization of health plan services in order to ensure that appropriate processes are used to review and approve the provision of medically necessary covered services. The clinical goals include but are not limited to:

- Assist in the coordination of medically necessary medical and behavioral health care services as indicated by evidence based clinical criteria.
- Assure that care provided conforms to acceptable clinical quality standards.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address access, availability, and timeliness of care.
- Clearly define staff responsibility for clinical activities specifically regarding decisions on f medical necessity.
- Establish the process used to review and approve the provision of medical and behavioral health care services, including timely notification to members and/or providers of an appeal process for adverse determinations.
- Identify high-risk, high cost members for referral to the Case Management and Care Coordination Programs, including Complex Case Management, Long--Term Services and Supports (LTSS), and/or the Disease Management/Health Education & Disease Management Programs —- when indicated and provided by CalOptima.
- Promote a high level of satisfaction across members, practitioners, stakeholders, and client organizations.
- —Comply with all applicable regulatory and accrediting agency rules, regulations and standards, and applicable state and federal laws that govern the utilization managementUM process.

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-
- Protect the confidentiality of member protected health information and other personal/provider information.
- Provide a mechanism and process for identifying potential quality of care issues and reporting them to the Quality Improvement ~~D~~department for further action when necessary.
- Identify and resolve problems and issues that result in over or under utilization and the inefficient or inappropriate delivery of health care services.
- Identify opportunities to optimize the health of members through quality initiatives for ~~disease/~~health education/disease management programs, focused population interventions, and preventive care services, and coordinating the implementation of these initiatives with the activities delegated to contract Health Maintenance Organizations (HMOs), Physician-Hospital Consortias (PHCs), Shared Risk Medical Groups (SRGs) and Provider Medical Groups (PMGs).
- Optimize the member's health benefits by linking and coordinating services with the appropriate county/state sponsored programs such as Community Based Adult Services, (CBAS), In-Home Supportive Services (IHSS), and Multipurpose Senior Services Program, (MSSP).
- Educate practitioners, providers, HMOs, PHCS, SRGs and PMGs on CalOptima's U~~tilization~~ M~~anagement~~ policies~~-~~, procedures and program requirements to ensure compliance with the goals and objectives of the UM Program.
- Monitor utilization practice patterns of practitioners to identify variations and implement best practice guidelines.

Providers

Contracted Health Networks/Network Providers/Hospitals

In 2014, CalOptima contracted with a variety of Health Networks to provide care to Orange County's beneficiaries. Since 2008 CalOptima has also included ~~Health Maintenance Organizations (~~HMOs~~)~~, ~~Physician/Hospital Consortias (~~PHCs~~)~~, and ~~Shared Risk Medical Groups (~~SRGs~~)~~. CalOptima's HMOs, PHCs, and SRGs include over 3,500 ~~P~~primary ~~C~~care ~~P~~providers (PCPs) and 30 hospitals and clinics. New networks that demonstrate the ability to comply with CalOptima's delegated requirements will be added as needed.

~~**Payment Arrangements**~~

~~Each PHC is composed of a Primary Medical Group (PMO) and one hospital. The SRGs are composed of~~
~~a physician group which assumes risk for professional services, while the hospital risk resides at the CalOptima level. The Pphysician group is capitated, and responsible for all primary and specialty physician services. The Hhospitals are reimbursed by CalOptima on a fee-for-service basis. Members must access in-network physicians and CalOptima-contracted hospitals. Select physician groups are delegated for the following clinical and administrative function. See next section.~~

~~Under Shared Risk in Medi-Cal, CalOptima maintains greater financial risk than under the current PHC model, but the provider medical group (PMG) participates in risk sharing through a risk pool agreement and/or incentive pool with CalOptima. OneCare (HMO SNP) a (dual eligible program is comprised of a variety of provider groups in a delegated model with a variety of payor arrangements for administrative services (medical and behavioral health).~~

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Delegation

CalOptima ~~P~~physician groups are delegated for the following clinical and administrative functions:

- UM~~tilization~~ and Case Management
- Claims
- Contracting
- Credentialing of practitioners
- Member Services
- Cultural and Linguistic Services

CalOptima delegates various UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM P~~p~~lan and policies and procedures. CalOptima conducts ongoing oversight on a regular basis and performs an annual review of each delegate's UM P~~p~~rogram. Delegation is dependent upon the following factors:

- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
-
- Conformation to CalOptima's UM standards; including timeframes outlined in CalOptima's policy and procedure. (GG.1508: Authorization and Processing of Referrals; Attachment A, Timeliness of UM Decisions and Notifications.)
- Delegate~~s''s~~ written UM ~~P~~program ~~D~~description/~~P~~plan are reviewed annually and approval by CalOptima's Quality Improvement Committee (QIC).
- Submission of required monthly reports which include but are not limited to~~;~~ : UM data, denial information and quality assurance/improvement issues and activities.

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CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:

- Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.
- Routine reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight ~~D~~department, UM Committee (UMC) and/or QIC.
- Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to CalOptima ~~Plan~~ standards and state program requirements.

In the event that the delegated provider does not perform contractually specified delegated duties, CalOptima may take action up to and including selected reviews, corrective actions, sanctions, capitation adjustments, probation, suspension or de-delegation.

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At the time of pre-delegation, CalOptima evaluates the compatibility of the delegate's UM ~~P~~program with CalOptima's UM Program. Once delegation is approved, CalOptima requires that the delegate provide the appropriate reports as determined by CalOptima to monitor the delegate's continued compliance with the needs of CalOptima. CalOptima annually review ~~s~~

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ongoing accreditation status and compliance. Oversight for all delegated activities is performed by CalOptima's Audit and Oversight ~~D~~department.

Member Focused Program

CalOptima is committed to "Member Centric" care that recognizes the beliefs, traditions, customs and individual differences of the diverse population served. Beginning with the identification of needs, through a Group Needs Assessment, programs are developed to address the specific education, treatment, and cultural norms of the population while impacting the overall wellness of a specific community. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation.
Please refer to CalOptima's Cultural and Linguistic Services Policies DD 2002 (Medi-Cal) and MA 4002 (OneCare) for a detailed description of the program.

~~**CalOptima Products**~~

~~**1.**~~

~~**Medi-Cal Program**~~

~~**Healthcare services provided include, but are not limited to, the following:**~~

- ~~**Preventive Services**~~
- ~~**Inpatient and Ambulatory Behavioral Health Services**~~
- ~~**Dental Services**~~
- ~~**Long Term Supportive Services**~~
- ~~**Primary Care**~~
- ~~**Specialty Care**~~
- ~~**Complex Case Management**~~
- ~~**Emergency Services**~~
- ~~**Urgent Care**~~
- ~~**Inpatient and Ambulatory Medical Services**~~
- ~~**Ancillary Services**~~

Medi-Cal Managed Long-Term Services and Supports

Beginning July 1, 2015, Long-Term Services and Supports, (LTSS) became a CalOptima benefit for all Medi-Cal enrollees. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program has two primary components with four programs.

Nursing Facility:

- Nursing Facility Services for Long-Term Care Services: CalOptima utilizes the Department of Health Care Services (DHCS) Medi-Cal Criteria Chapter, Criteria for Long-Term Care Services and Title 22, CCR, Sections: 51003, 51303, 51511(b), 51334, 51335, and 51343. CalOptima is responsible for the clinical review, medical determination and performs authorization functions for Long-Term Care services for the following levels of care:
  - Nursing Facility Level B, (Long-Term Care)
  - Nursing Facility Level A
  - Subacute Adult and Pediatric

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- Intermediate Care Facility / Developmentally Disabled, (ICF/DD)
- Intermediate Care Facility / Developmentally Disabled~~s~~ Habilitative, (ICF/DD-H)
- Intermediate Care Facility / Developmentally Disabled Nursing, (ICF/DD-N)

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Home and Community Based Services:

- ~~Community Based Adult Services (~~CBAS~~);~~ ~~–~~CalOptima provides CBAS as a health plan benefit.~~-~~ CalOptima utilizes the ~~Department of Health Services, (~~DHCS~~),~~ approved CBAS Eligibility Determination Tool~~,~~ (CEDT)~~,~~ criteria to assess a member's health condition and make a medical determination for the program. ~~The Community Based Adult Services~~CBAS is an outpatient, facility-based program that offers health and social services to seniors and persons with disabilities.

- ~~Multipurpose Senior Services Program, (~~MSSP~~):~~ ~~–~~CalOptima is responsible for identification referral and coordination of integrated services within the MSSP ~~S~~site. The CalOptima MSSP ~~S~~site adheres to the California Department of Aging contract and eligibility determination criteria.

- ~~In-Home Supportive Services, (~~IHSS~~),:~~ ~~–~~CalOptima and the health networks are responsible for identification, referral and ~~provide~~ care coordination. CalOptima collaborates with Orange County Social Services Agency~~,~~ (SSA), ~~In-Home Supportive Services~~IHSS, Orange County Public Authority and health networks to ensure members receive appropriate level of care services.

Behavioral Health Services

Medi-Cal Ambulatory Behavioral Health Services

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental ~~H~~health services include but are not limited to: individual and group psychotherapy, psychology, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition.

~~CalOptima delegates to Magellan Health Inc. College Health Independent Practice Association CHIPA for utilization~~
~~M~~management of the ~~P~~provider ~~N~~network~~,~~. ~~CHIPA sub-contracts and delegates to Beacon Health Strategies, LLC (Beacon) other functions that include credentialing the provider network, managing the CalOptima Behavioral Health Phone the Access Line, and several other quality improvement functions.~~

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD).

Behavioral health services ~~are also~~ within the scope of practice for PCPs, may include ~~including~~ offering ~~CalOptima offers~~ screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

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CalOptima delegates to Magellan Health Inc. for utilization management of the provider network, credentialing the provider network, managing the CalOptima Behavioral Health Phone Line, and several other quality improvement functions.

~~CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental Health services include but are not limited to: individual and group psychotherapy, psychology, psychiatric consultation medication management, and psychological testing when clinically indicated to evaluate a mental health condition.~~

CalOptima members access Behavioral Health Services by calling the CalOptima Behavioral Health Phone Line toll-free at~~:~~ ~~1~~-855-877-3885. ~~A CHIPA / Beacon clinician assesses the level of care needed.~~ If office based services are appropriate, the member is registered in the ~~CHIPA / Beacon~~Magellan system and referrals to an appropriate provider are given to the member. If the member meets criteria for Specialty Mental Health Services, ~~more complex needs are identified,~~ the member is referred to the County ~~for Specialty~~ Mental Health Plan. Specialty Mental Health Services are not the responsibility of CalOptima.

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~~CalOptima covers behavioral health treatment (BHT) for members 20 and younger with a diagnosis of Autism Spectrum Disorder (ASD). BHT services are managed by CHIPA / Beacon. Members can access BHT services by calling the 24/7 CalOptima Behavioral Health Line at 1-855-877-3885.~~

~~CalOptima offers screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.~~

CalOptima ensures members with coexisting medical and behavioral health care needs have adequate coordination and continuity of their care. Communication with both the medical and behavioral health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and behavioral health practitioners involved.

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Services Not Provided by CalOptima

Under its Medi-Cal ~~P~~program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible populations. Certain health care services are not provided by CalOptima, as determined by law and contract.

Other services may be provided by different agencies including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (HCA) County Mental Health Plan.

- Dental services are provided through California's Denti-Cal program.

- California Children's Services (CCS) is a statewide program managed by ~~the Department of Health Care Services (~~DHCS~~)~~ and authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for children with certain physical limitations and chronic health conditions or diseases.

- Regional Center of Orange County ~~as~~ is a local agency contracted ~~by the State~~ by the State of California to coordinate lifelong services and supports for people with developmental disabilities, Regional Center of Orange County, (RCOC), provides services and supports that are as diverse as the people served. Each person serviced by RCOC has an individual Family Service Plan~~,~~ (IFSP)~~, –~~that addresses his or her individual needs. ~~-~~The following are types of services and supports available through RCOC, or that RCOC can assist clients and families access through other sources:
    - Prenatal Diagnostic Evaluation
    - Early Intervention Services, (Birth to 36 months)
    - Therapy Services
    - Respite Care Services
    - Child Care Services
    - Adult Day Program Services, (Employment and Community-Based Activities)
    - ~~o~~ Transportation Services
    - o

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- Residential Services
- Psychological, Counseling and Behavioral Services
- Medical and Dental Services
- Equipment and Supplies
- Social and Recreational Services
-

In addition, CalOptima provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap around services that enhance their medical benefits. These linkages are established through special programs, such as the CalOptima Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the Orange County Heath Care Agency's California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate state agencies and specialist care when the benefit coverage of the member dictates. The UM department coordinates activities with the Case Management and/or Disease Management departments to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

OneCare and OneCare Connect Behavioral Health Services

CalOptima has contracted with Windstone Magellan Behavioral Health Inc. for the behavioral health services portion of care for the OneCare and OneCare Connect line of business. Functions delegated to Magellan include CalOptima is responsible for credentialing the provider network and for grievances and appeals. CalOptima delegates utilization management, credentialing, and customer service to MagellanWindstone. Evidence based MCG guidelines are utilized in the UM decision making process.

CalOptima OneCare and OneCare Connect members access Behavioral Health Services by calling Magellan Windstone at 1-800-55-577877-47013885. If office based services are appropriate, the member is registered and referrals to the appropriate provider are given to the member. If ambulatory Specialty Mental Health needs are identified, services may be rendered at the County Mental Health Plan.

CalOptima offers screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima Direct (COD)

CalOptima Direct (COD) is comprised of the following component:

CalOptima Direct Administrative (COD-A) is a fee-for-service program administered by CalOptima. Some members are enrolled in COD-A on a permanent basis, and may not be eligible

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to join a health network because they meet certain COD – A eligibility criteria. Permanent members of COD – A include share of cost members, that are not enrolled in either OneCare or OneCare Connect ~~dually eligible beneficiaries~~ (members eligible with both Medicare and Medi-Cal), retro-assigned, and out of Orange

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County residents. COD– –A also provides benefits to new members transitioning to a health network that are enrolled in CalOptima Direct on a temporary basis.

CalOptima Community Network (CCN)

~~CalOptima Community Network (CN) was open to new members beginning in March of 2015.~~ CalOptima Community Network ~~This~~ (CCN) is a managed care program administered by CalOptima to serve Medi-Cal members, and dual eligibles (those with both Medicare and Medi-Cal)~~,~~ who elect to participate in the Cal MediConnect program detailed below. CCN~~This network~~ is open to participation of any willing and qualified provider. CalOptima already contracts with a variety of providers: PHCs, ~~one~~ HMOs, and ~~many~~ SRGs. With ~~the new launch of Community Network~~CCN, individual providers ~~will now~~ have the option of contracting directly with CalOptima.

Dual Eligible Programs

OneCare

For a complete description of the OneCare program and scope of services, please see the 2017 Quality Improvement Program, pages 5–6.

OneCare members qualify for Medicare by age (turning 65) or by disability (24 months of Social Security Disability Insurance [SSDI], End-Stage Renal Disease [ESRD], or Amyotrophic Lateral Sclerosis [ALS]~~.~~). Nearly one third of OneCare members are under 65. OneCare members qualify for Medicaid by standards established by the State of California and administered at the county social services agency level. The standards for qualifying for ~~S~~state Medicaid include a review of income, assets, and in some cases, medical condition.

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The threshold languages spoken by the majority of OneCare members are English, Spanish, Farsi and Vietnamese. OneCare members represent over twenty ethnic groups including White, Asian/Pacific Islander, Alaskan native, American Indian, African-American~~Black,~~ and Hispanic.

The management of OneCare's Medicare covered benefits is delegated to the PMGs. CalOptima manages the Medi-Cal wrap around and taxi transportation determinations. Cal-Optima performs concurrent review for members who are admitted to out of area hospitals.

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CalOptima works with community programs to ensure that individual needs are met for members with special health care needs and/or chronic or high risk complex medical conditions. This, includesing, but is not limited to, Meals on Wheels, Dayle MacIntosh Developmental Center, Orange County Social Service Agency, and Orange County Goodwill. It also includes and Orange County Community Centers with direct links to the Long--Term Support Services and Supports (LTSS) and the Orange County Aging and Disability Resource Center (ADRC).

To ensure that coordinated community and clinical services are accessible and available to these Seniors and Persons with Disabilities (SPD) members, CalOptima has developed a robust Model of Care that defines case management activities that includes nurses, social workers, behavioral health specialists, and personal care coordinators (PCCs). –These case management services are designed to ensure coordination and continuity of care for every member, and are described in the Case Management Program Description.

Certain covered services are not provided by CalOptima, or may be provided by a different agency including those indicated below:

- Dental Sservices
- Vision
- Non-Mmedical Ttransportation (benefit decreased for 2015)

Cal MediConnect (OneCare Connect)

Cal Optima's OneCare Connect (Cal MediConnect) program, is a three (3) year demonstration project in an effort by California and the federal government to begin the process, — through a single organized health care delivery system, — of integrating the delivery of medical, behavioral health, long term care services and supportLTSS and community based servicesCBAS for dual eligible beneficiaries. The program's goal is to help members stay in their homes for as long as possible and shift services out of institutional settings and into the home and community.
A key feature of CalOptima OneCare Connect is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individualized care plan.

For a complete description of the OneCare Connect program and scope of services, please see the 2017 Quality Improvement Program, pages 6–7.

CalOptima Board of Directors

Authority, Responsibility and Accountability

The CalOptima Board of Directors has ultimate authority, accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the Utilization ManagementUM Pprogram is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC). The Board holds the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. The responsibility for the direction and management of the UM Program has been delegated to the Chief Medical Officer (CMO). Before coming to the Board of Directors for

approval, the UM Program is reviewed and approved by the ~~Utilization Management~~UM Sub~~-~~c~~-~~C~~ommittee (UMC), the Quality Improvement Committee (QIC) and the Quality Assurance Committee (QAC) on an annual basis.

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CalOptima Officers and Directors

Chief Medical Officer

The Chief Medical Officer (CMO) has operational responsibility for and provides support to CalOptima's UM Program. CalOptima's CMO, Deputy CMO, and Executive ~~Vice Presiden~~Director~~t~~ of

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Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Pprogram including appropriate use of health care resources, medical and behavioral quality improvement, medical and behavioral utilization review and authorization, case management, disease management and health education program implementations, with successful operation of the QIC, QAC and UMC.

The CMO's responsibilities include, but are not limited to coordination and oversight of the following activities:

- Assists in the development/revision of UM policies and procedures as necessary to meet state and federal statutes, regulations and accrediting agency requirements;
- Monitors compliance with the UM Program;
- Appoints the Chairperson of the UMC;
- Chairs the ~~Utilization Management~~UM Workgroup (UMG);
- Provides clinical support to the UM staff in the performance of their UM responsibilities;
- Assures that the medical necessity criteria used in the UM process are appropriate and reviewed by physicians and other practitioners according to policy but not less than annually;
- Assures that the medical necessity criteria are applied in a consistent manner;
- Ensures that there are no financial incentives for practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care;
- Assures that reviews of cases that do not meet medical necessity criteria are conducted by appropriate physicians or other appropriate health care professionals in a manner that meets all pertinent statutes and regulations and takes into consideration the individual needs of the involved members;
- Assures that appropriate health care professionals review, approve, and sign denial letters for cases that do not meet medical necessity criteria after appropriate review has occurred in accordance with UM Policy and Procedure GG.1508: Authorization and Processing of Referrals;
- Assures the medical necessity appeal process is carried out in a manner that meets all applicable contractual requirements, as well as all federal and state statutes and regulations, is consistent with all applicable accreditation standards, and is done in a consistent and efficient manner;
- Provides a point of contact for practitioners calling with questions about the UM process;
- Communicates/consults with practitioners in the field as necessary to discuss UM issues;
- Coordinates and oversees the delegation of UM activity as appropriate and monitors that delegated arrangement to ensure that all applicable contractual requirements and accreditation standards are met;
- Assures there is appropriate integration of physical and behavioral health services for all p~~P~~lan members;
- Participates in and provides oversight to the UMC and all other physician committees or s~~S~~ubcommittees;
- Recommends and assists in monitoring corrective actions, as appropriate, for practitioners with identified deficiencies related to UM;
- Serves as a liaison between UM and other ~~P~~plan departments;
- Educates practitioners regarding UM issues, activities, reports, requirements, etc.;
- Reports UM activities to the QIC as needed.

~~Deputy Chief Medical Officer fulfills all of the roles and responsibilities of the office of the CMS in conjunction with and/or in the absence of the CMO, (as outlined above).~~

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Executive Director of Clinical Operations (ED) is responsible for oversight of all operational aspects of key Medical Affairs functions including: ~~Utilization Management~~UM, Case Management, ~~Behavioral Health,~~ Managed Long-Term Services and Support (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED of Clinical Operations serves as a member of the executive team and, with the CMO, ensures that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals, and objectives. The ~~Executive Director~~ ED of Clinical Operations is expected to anticipate, continuously improve, communicate and leverage resources, as well as balance achieving set accountabilities with constraints of limited resources.

Medical Director of Utilization Management assists in the development and implementation of the ~~Utilization Management~~UM Program, policies, and procedures. Ensures that an appropriate licensed professional conducts reviews on cases that do not meet medical necessity, and utilizes evidence based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO, the Medical Director of ~~Utilization Management~~UM also provides supervisory oversight and administration of the ~~Utilization Management~~UM Program. ~~,~~ ~~O~~oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, provides clinical education and in-services to staff weekly and on an as needed basis. Presents key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. ~~,~~ Provides feedback to UM staff on trends identified for over/under utilization, readmissions, one-day stays, and observation initiatives. Ensures availability to staff either onsite or telephonically during normal business hours and on call after hours. ~~S~~serves on the Utilization and Quality Improvement Committees, serves as the Chair of the ~~Utilization Management Committee~~UMC and the Benefit Management Subcommittee, and may participate in the CalOptima Medical Directors Forum. Other related duties may also be performed at the discretion of the Chief Medical Officer.

Utilization Management Medical Director ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in ~~utilization management~~UM. In this role, the Medical Director oversees the ~~utilization management~~UM activities of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support~~s~~ the ~~utilization management~~UM process. Ensures availability to staff either onsite or telephonically during normal business hours and on call after hours. The Medical Director works closely with the nursing leadership of these departments, and also works in collaboration with the Chief Medical Officer and all clinical staff within CalOptima.

Medical Director, Behavioral Health provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and behavioral health care services for CalOptima members. Provides clinical and operational oversight for behavioral health benefits and services provided to members. Works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality behavioral health

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outcomes. The Behavioral Health Medical Director is involved in the implementation, monitoring and directing of the behavioral health aspects of the UM Program.

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Medical Director, Senior Programs is a key member of the medical management team and is responsible for the Medi-Medi programs (OneCare and OneCare ~~Medi~~Connect ~~(OneCare))~~, Managed ~~Long Term Support and Services~~LTSS (MLTSS) programs, and Case Management and Transitions of Care programs. Provides physician leadership

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~~ii~~n the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The Medical Director is also expected to work in collaboration with the other Medical Directors and the clinical staff within Disease Management, Grievance and Appeals, and Provider Relations. The Medical Director works closely with the nursing and non-clinical leadership of these departments.

Medical Director Disease Management/Health Education/Program for All Inclusive Care for the Elderly (PACE) Programs is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of disease management and health education programs while also providing clinical quality oversight of the PACE Program.

Director of Utilization Management assists in the development and implementation of the ~~Utilization Management~~UM Program, policies, and procedures. Ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The Director of ~~Utilization Management~~UM also provides supervisory oversight and administration of the ~~Utilization Management~~UM Program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and Quality Improvement Committees, participates in the ~~Utilization Management Committee~~UMC and the Benefit Management Subcommittee.

Director of Clinical Pharmacy Management leads the development and implementation of the Pharmacy Management Program, develops and implements Pharmacy Management ~~D~~department policies and procedures; ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of Pharmacy related clinical affairs, and serves on the Pharmacy and Therapeutics Subcommittee and Quality Improvement Committees. A Pharmacist oversees the implementation, monitoring and directing of pharmacy services.

~~Executive~~ Director of Behavioral Health ~~Integration~~ Services provides leadership and program development expertise in the creation, expansion and improvement of services and systems that leads to the integration of physical and behavioral health care services for CalOptima members. ~~S/he leads and assists the organization in developing and successfully implementing short and long term strategic goals and objectives toward integrated care. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors and executive staff, members, providers, health network management, legal counsel, State and Federal officials, and representatives of other agencies. S/he~~The Director of Behavioral Health ~~Serivces~~Services is responsible for monitoring, analyzing, and reporting to senior staff on changes in the health care delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services. ~~-~~This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors and executive staff, members, providers, health network management, legal counsel, ~~S~~state and f~~F~~ederal officials, and representatives of other agencies.

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Executive Director of Quality and Analytics provides oversight of key medical affairs functions including: Quality Management, Quality Analytics and Disease Management, which includes health education programs. The ED of Quality and Analytics serves as a member of the executive team and, with the CMO, ensures that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals, and objectives for CalOptima. Position will anticipate, continuously improve,

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ecommunicate and leverage resources. The ED of Quality and Analytics will balance achieving set accountabilities with constraints of limited resources.

Director of Quality is responsible for ensuring that CalOptima and its HMOs PHCs, SRGs and PMGs meet the requirements set forth by Department of Health Care Services (DHCS), Centers for Medicare/Medicaid Services (CMS), and Department of Managed Health Care (DMHC). The Compliance staff works in collaboration with the CalOptima Quality Improvement Ddepartment to refer any potential sustained noncompliance issues or trends encountered during audits of health networks, provider medical groups, and other functional areas, such as Utilization ManagementUM, and Credentialing, and Grievance & Appeals Resolution Services (GARS), as appropriate. The staff evaluates the results of performance audits to determine the appropriate course of action to achieve desired results. Functions relating to fraud and abuse investigations, referrals, and prevention are handled by the Office of Compliance.

Director, Audit and Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and Physician Medical Group (PMG) delegated functions with an emphasis on efficiency and effectiveness and in accordance with Sstate/Ffederal requirements, CalOptima policies, and industry best practices. Theis Director role is to ensures that CalOptima and its subcontracted health networks perform consistently with both CMS and sState requirements for all programs. Specifically, theis position Director leads the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the Director is Rresponsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. This position interacts with the Board of Directors, CalOptima executives, departmental management, health network management and Legal Counsel.

Director of Case Management is responsible for Case Management, Transitions of Care and the clinical operations for the Medi-Cal, OneCare, and MediConnect OneCare Connect programs. S/The Director supports improving quality and access through seamless care coordination for targeted member populations. Develops and implements policies, procedures and processes related to program operations.

Director of Disease Management/Health Education & Disease Management is responsible for the development and implementation of Disease Management/Health Education and Disease Management programs and determines priorities for health education and member self-care management. The position Director also oversees the group needs assessments to identify health education, and cultural and linguistic opportunities that improve the well-being of specific member populations. The position Director is also responsible for provider clinical office education for the promotion of quality initiatives.

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~~Director of Long Term Services and Supports is responsible for LTSS programs which include Community Based Adult Services, (CBAS), In-Home Support Services, (IHSS), Long Term Care Services, (LTC, and Multipurpose Senior Services Program, (MSSP). The position supports a "Member-Centric" approach to help to keep members in the least restrictive living environment. Collaborates with stakeholders including community partners and ensures LTSS services provided are procedures and processes related to the LTSS program operations.~~

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~~Utilization Management~~UM Resources

The following staff positions provide support for organizational/operational UM ~~D~~department's functions and activities:

Manager, Utilization Manager (Concurrent Review Manager ~~(~~[CCR])~~RN Managers (Referral/Prior Authorization/Retrospective Review and Concurrent Review)~~ manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The Manager~~s~~ develops, implements, and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Experience & Education

- ~~A c~~Current and unrestricted Registered Nurse (RN) or Licensed Vocational Nurse (LVN) ~~–~~ license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3~~5 -~~ 7 years managed care experience ~~preferred~~.
- 2-3 years supervisory/management experience in ~~utilization management~~UM activities.

~~Concurrent Review -~~Supervisor, Utilization Management (Concurrent Review)~~RN Supervisor (Concurrent Review)~~ p~~P~~rovides day-to-day supervision of assigned staff, monitors and oversees ~~the~~ daily ~~departmental~~ work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload., ~~and~~The Manager is a resource to the CCR ~~Concurrent Review~~ staff regarding CalOptima policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff~~.~~ through training and in-servicing activities. Monitor for documentation adequacy including appropriateness of clinical documentation to make a clinical determination, ~~also,~~and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted Registered Nurse (RN) or Licensed Vocational Nurse (LVN) license in the State of California.
- A Bachelor's ~~D~~degree or relevant experience in a health care field.
- ~~Current and unrestricted Registered Nurse (RN) or Licensed Vocational Nurse (LVN) license in the State of California.~~
- 3 ~~5 – 7~~ years of managed care experience preferred~~.~~
- Supervisor experience in Managed Care/~~Utilization Management~~UM preferred.

~~Prior Authorization -~~Manager, Utilization Management (Prior Authorization [~~(~~PA]), manages the day-to-day operational activities of the department to ensure staff compliance with company policies

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and procedures, and regulatory and accreditation agency requirements. The Manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

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Experience & Education

- Current and unrestricted Registered Nurse (RN) or Licensed Vocational Nurse (LVN) license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2 3 years supervisory/management experience in Utilization Management activities.

Prior Authorization Supervisor, Utilization Management RN Supervisor (Referral/Prior/Retrospective Authorization) (PA) Pprovides day-to-day supervision of assigned staff, monitors and oversees theassigned daily departmental work activities to ensure that service standards are met. The Supervisor makes recommendations regarding assignments based on assessment of workload, and is a resource to the Prior Authorization staff regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing while providing ongoing monitoring and development of staff through training and in-servicing activities. Monitors for documentation adequacy including clinical documentation to make a clinical determination also, audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted Registered Nurse (RN) license or Licensed Vocational Nurse (LVN) license in the State of California.
-
- A Bachelor's Ddegree or relevant experience in a health care field preferred.
- Current and unrestricted Registered Nurse (RN) license.
- 3 3 5 years of managed care experience.
- Supervisor and/or Lead experience in Managed Care/Utilization ManagementUM preferred.

Notice of Action RN drafts and evaluates denial letters for adequate documentation and utilization of appropriate criteria. Audits clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, assures denial reason is written in plain language that a lay person understands, and is specific to the clinical information presented and criteria referenced. Works with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Experience & Education

- Current and unrestricted Registered Nurse License (RN) in the State of California
- A Bachelor's dDegree or relevant experience in a health care field preferred.
- 3 years managed care experience
- Excellent analytical and communication skills required

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Medical Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. The Case Manager is responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence based criteria. This activity is conducted prospectively, concurrently, or retrospectively. The Case Manager also provides concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs, SRGs and PMGs, and acts as a liaison to Orange County based community agencies in the delivery of health care services. All potential denial, and/or modifications of pProvider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- Current and unrestricted California Board Licensed Vocational Nurse (LVN) or Registered Nurse (RN) license.
- Minimum of ~~three (~~3~~)~~ years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Authorization Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager. The Medical Assistant performs medical, administrative, routine medical administrative tasks specific to the assigned unit and office support functions. The Medical Assistant also authorizes requested services according to departmental guidelines. All potential denial, and/or modifications of pProvider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- High school graduate or equivalent; a minimum of 2 years of college preferred.
- 2 years of related experience that would provide the knowledge and abilities listed.

Program Specialist provides high-~~-~~level administrative support to the Director of ~~Utilization Management~~UM, the UM~~RN~~ Managers, Supervisors and the UM Medical Directors.

Experience & Education

- High school diploma or equivalent; a minimum of 2 years of college preferred.
- ~~2~~2–3 years previous administrative experience preferred.
- Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.
- ~~2–3 years previous administrative experience preferred.~~

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Pharmacy Department Resources

Director, Clinical Pharmacy ~~Director~~ develops, implements, and administers all aspects of the CalOptima

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pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, contracts with and manages the pharmacy network and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The Pharmacy Director is also responsible for administration of pharmacy services delivery, including, but not limited to, the contract with the third party auditor, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies, and pharmacy organizations.

Experience & Education

- A current, valid, unrestricted California ~~S~~state Pharmacy License and Pharm.D required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.

~~Pharmacy~~ Manager, Clinical Pharmacists assists the Pharmacy Director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to m~~M~~embers enrolled in the CalOptima Delegated Health Plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy Manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national- practice guidelines and on an ongoing basis, researches, develops, and updates drug ~~utilization management~~UM strategies and intervention techniques. The Pharmacy Manager develops and implements methods to measure the results of these programs, assists the Pharmacy Director in preparing drug monographs and reports for the Pharmacy & Therapeutics Committee, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- At least 3 years experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for Pharmacy & Therapeutics Committees.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ~~A current, valid, unrestricted California Sstate Pharmacy License and Pharm.D required.~~
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Clinical Pharmacists assist the Pharmacy Director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to m~~M~~embers enrolled in the CalOptima Health Networks and CalOptima Direct. Through various modalities (e.g., provider/plan

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profiling, member drug profile reviews, development and updating

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of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug ~~utilization management~~UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs. They assist the Pharmacy Director in preparing drug monographs and reports for the Pharmacy & Therapeutics Committee, interact s ~~s~~ frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- ~~Three~~ 3 ~~(3)~~ years experience in clinical pharmacy practice including performing drug use evaluations and preparing drug monographs and other types of drug information for Pharmacy & Therapeutics Committees.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- ~~A current, valid, unrestricted California S~~state Pharmacy License and Pharm.D required.~~.~~
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

Experience & Education

- Pharm.D degree from an accredited college of pharmacy.
- Eligibility for licensure in California.

PBM (Pharmacy Benefits Manager) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and ~~Title 22, California Code of Regulations~~appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's Pharmacy ~~and~~ & Therapeutics Committee. CalOptima pharmacists~~,~~ with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria. CalOptima pharmacists with a current license to practice without restriction perform all denials.

~~Long Term Services and Supports~~LTSS Resources

The following staff positions provide support for LTSS operations:

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~~LTSS Director, (CBAS/IHSS/LTC/MSSP) The~~ Director, ~~of~~ Long-~~-~~Term ~~Services and~~ Support ~~s~~Services (CBAS/IHSS/LTC/MSSP)~~, (LTSS),~~ will develop, manage and implement LTSS,~~the Long-Term Care Services and Support~~ including Long-~~-~~Term Care (LTC) facilities, ~~In-Home Supportive Services~~IHSS, ~~Community Based Adult Services~~CBAS and ~~the Multipurpose Senior Services~~MSSP ~~Program~~ and staff associated with those programs. ~~S/~~The Director will be responsible for ensuring high quality and responsive service for CalOptima members residing in ~~Long Term Care~~LTC facilities~~,~~ (all levels of care)~~,~~ and to those members enrolled in other LTSS programs. D~~D~~evelops and~~,~~ evaluates programs and policy initiatives affecting seniors and (SNF/Suba~~A~~cute/ICF/ICF-DD/N/H) and other LTSS services.

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Experience & Education

- Bachelor's degree in Nursing or in a related field required.
- ~~_____~~Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social ~~_____~~ Worker is desirable
- 5~~_~~~~_~~7 years varied related experience, including five~~5~~ years of supervisory experience with experience in supervising groups of staff in a similar environment.
- ~~Bachelor's degree in Nursing or in a related field required.~~
- ~~Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.~~
- Some experience in government or public environment preferred.
- Experience in the development and implementation of new programs.

~~LTSS~~ Manager, Long-Term Support Services, RN~~,~~ (CBAS/IHSS/LTC) The Manager is expected to develop and manage the L~~ong Term Services and Supports~~TSS d~~D~~epartment's work activities and personnel. ~~S/~~The Manager will ensure that services standards are met and operations are consistent with the health plan's policies and regulatory and accrediting agency requirements to ensure high quality and responsive service for CalOptima's members who are receiving ~~long term care services and supports~~LTSS. The Manager mus~~teh~~ have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, health networks, and other internal and external customers in a professional and competent manager. The Manager~~is position~~ will work in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTC~~long term care~~ services

Experience and Education

- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5~~_~~~~_~~7 years varied clinical experience required.
- 3~~_~~~~_~~5 years supervisory/management experience in a managed care setting and~~-~~/or nursing facility.
- Experience in government or public environment preferred.
- Experience in health with geriatrics and persons with disabilities.

~~LTSS~~ Supervisor, Long-Term Support Services, RN,(CBAS, IHSS, LTC) The Supervisor is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of ~~long term care services and supports~~LTSS to members in the community and institutionalized setting. The Supervisor is responsible for the management of the day-to-day operational activities for LTSS programs: ~~Long Term Care, (~~LTC~~)~~, ~~Community Based Adult Services, (~~CBAS~~)~~, and ~~In- Home Support Services, (~~IHSS~~)~~, and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers

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~~i~~in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the S~~s~~upervisor will be resolving members and providers issues and barriers ensuring excellent customer service. Additional responsibilities include: m~~M~~anaging staff coverage in all areas of LTSS to complete assignments, orienting, and training of new employees to ensure contractual and regulatory requirements are met.

Experience and Education

- A current unrestricted RN license in the State of California.
- A B~~b~~achelor's degree or relevant experience in a health care field preferred.
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required.
- Experience in interacting/managing with geriatrics and persons with disabilities.
- Supervisory/management experience in ~~utilization management~~UM activities.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

Medical Case Managers, ~~The~~ Long-Term Support Services ~~LTSS Medical Case Manager,~~ (MCM LTSS) (RN/LVN), ~~is~~ are part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, provides coordination of care, and provides ongoing case management services for CalOptima members in ~~Long term Care, (~~LTC~~),~~ facilities and members receiving ~~Community Bases Adult Services, (~~CBAS~~)~~. They r~~ R~~eviews and determine~~s~~ medical eligibility based on approved criteria/guidelines, National Committee for Quality Assurance (NCQA) standards, Medicare and Medi-Cal guidelines, and facilitate ~~s~~ communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality~~,~~ and cost-effective outcomes. The ~~LTSS~~ MCM LTSS provides case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. The ~~LTSS~~ MCM LTSS is the subject matter expert and acts as a liaison to Orange County base~~ds~~ community agencies, CBAS center~~s~~, skilled nursing facilities, ~~and to~~ members and providers.

Experience and Education

- ~~A~~ current and unrestricted RN license in the State of California~~,~~ or a ~~;~~
- ~~A~~ current unrestricted LVN license in the State of California.
- Minimum of 3 years managed care or nursing facility experience.
- Excellent interpersonal skills.
- Computer literacy required.
- Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time.

~~CBAS~~ Program Manager, CBAS (MSW/MS) ~~The CBAS Program Manager~~ is responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. The CBAS Program Manager is responsible for the annual CBAS Provider Workshop, CBAS

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process

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improvement, reporting requirements, reviewings monthly files audit, developpings inter-rater reliability questions, performings psychosocial and functional assessments, and servesing as a liaison and a key contact person for California Department of Health Care Services (DHCS), California Department Office of Aging (CDA), CBAS Coalition and CBAS centers. The CBAS Program Manager is responsible responsible for developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.

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Experience & Education

- Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required. Masters preferred.
- Minimum of ~~three (3) years~~ 3 ~~-5~~ years CBAS and program development experience.
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Excellent interpersonal skills.
- Computer literacy required~~-~~.
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 5% of the time or more will involve ~~while~~ traveling to CBAS centers and community events.

Qualifications and Training

CalOptima seeks to recruit highly-qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

- CalOptima New Employee Orientation
- HIPA~~P~~A and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM Program, policies/procedures, etc.
- MIS data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- Seniors and Persons with Disabilities Awareness Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima.~~-~~ Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are~~is~~ monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations, and inter-rater reliability. Training ~~-~~

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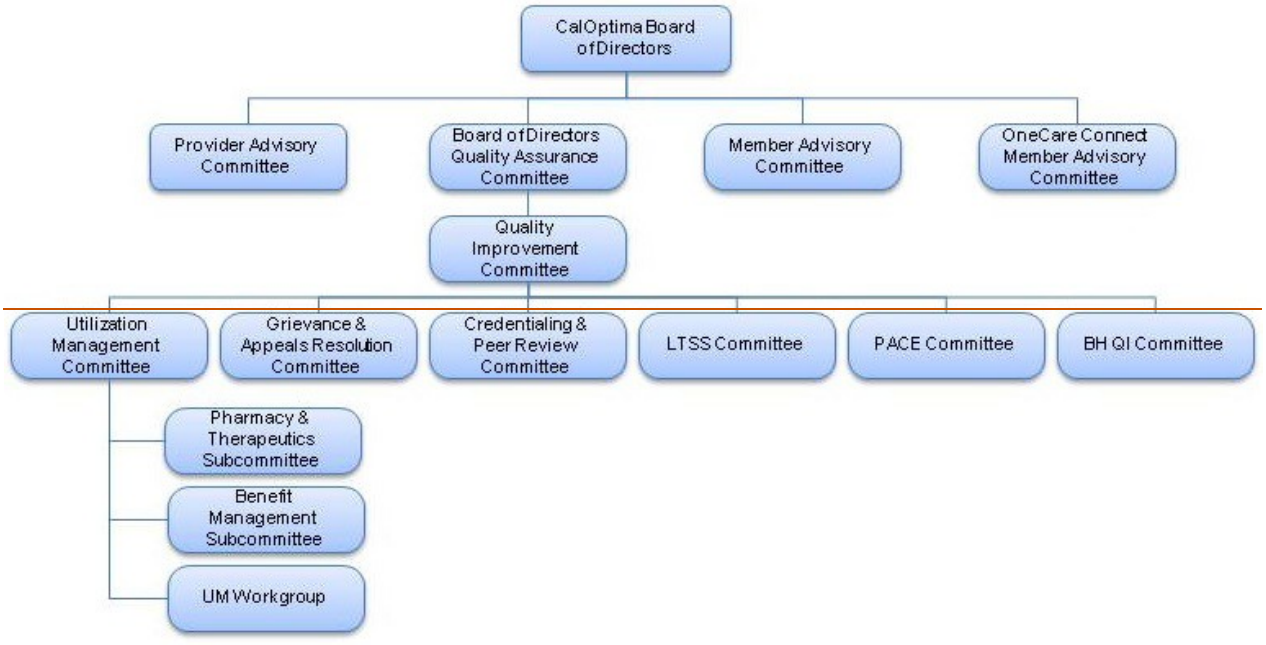
opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health professionals supervise the ~~utilization management~~UM process and all medical necessity decisions. -A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and behavioral health benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure. This licensure is specific to the ~~s~~State of California. UM employee compensation includes hourly and salaried positions. All medical management staff is required to sign an Affirmative Statement regarding compensation annually. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is prohibited.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

- The percentage of the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or
- Any other method that encourages the rendering of an adverse determination.

Committee Structure



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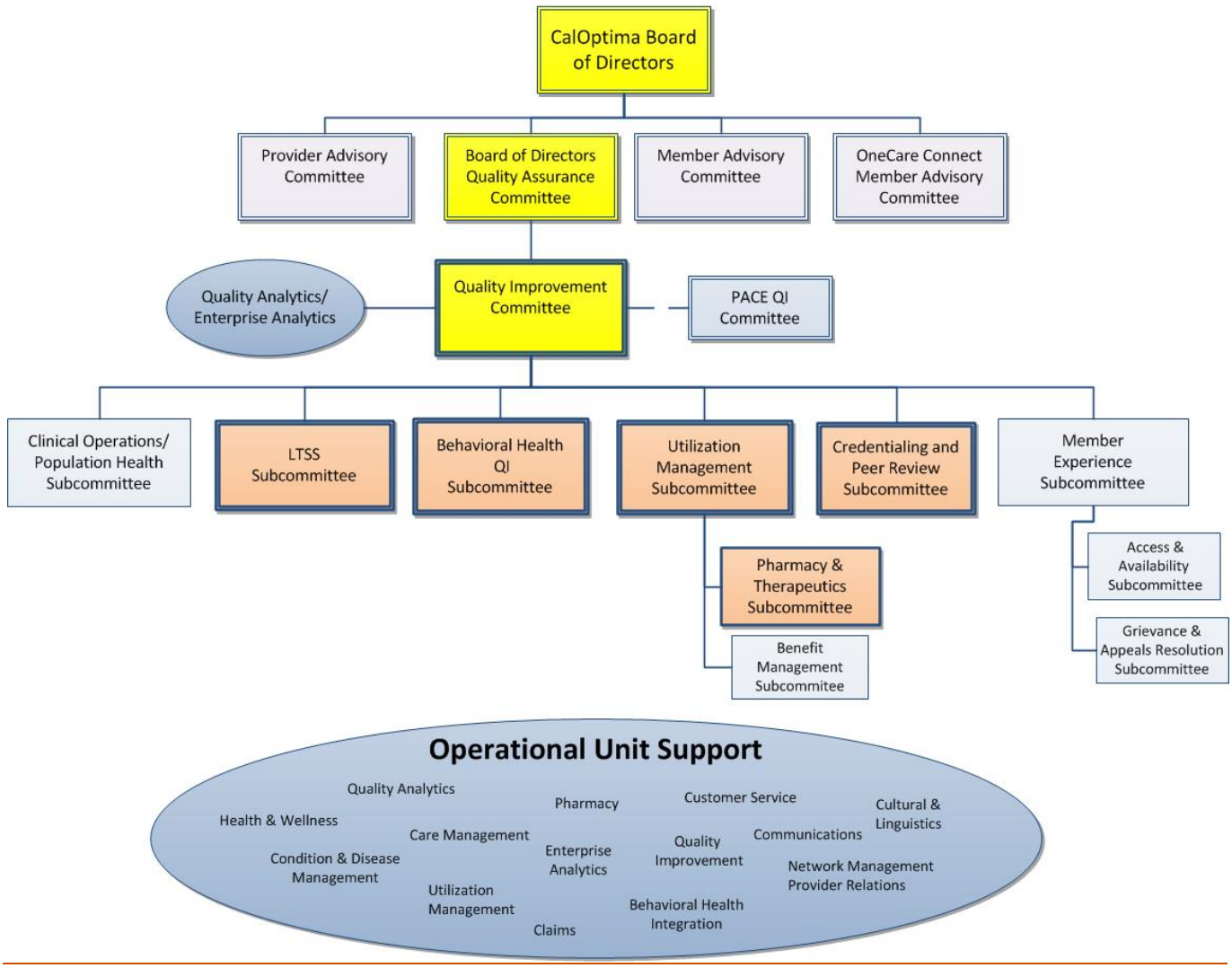

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Utilization Management Committee (UMC)

The ~~Utilization Management Committee (~~ UMC~~)~~ is responsible for the review and approval of medical necessity criteria and protocols and ~~utilization management~~UM policies, procedures and programs. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, coordination of care, appropriate use of services and resources, and member and practitioner satisfaction with the UM process.

The UMC meets quarterly and coordinates an annual review and revision of the ~~Utilization Management~~UM Program Description, Work Plan and Annual UM Program Evaluation. Before ~~eg~~o~~m~~ing to the Board of Directors for approval, the documents are reviewed and approved by the ~~Quality Improvement Committee (~~QIC~~)~~ and ~~Quality Assurance Committee (~~QAC~~)~~. The Director of U~~tilization M~~anagement~~ maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analysis of the above tracking and monitoring processes and status of corrective action plans to the QIC. Daily oversight and operating authority of UM~~utilization management~~ activities is delegated to the UMC which reports up through CalOptima's QIC and ultimately to CalOptima's QAC and the Board of Directors.

~~Utilization Management Committee~~UMC Scope

- Oversees the UM activities of CalOptima in regard to compliance with contractual requirements, f~~F~~ederal and ~~S~~state statutes and regulations, and ~~National Committee for Quality Assurance (~~NCQA~~)~~ requirements;
- Develops and annually reviews/approves the UM Program Description, Work Plan, criteria, policies and procedures;
- Reviews practitioner specific UM reports to identify trends and/or utilization patterns and makes recommendations to the QIC for further review;
- Reviews reports specific to facility and/or geographic areas for trends and/or patterns of under or over utilization;
- Examines appropriateness of care reports to identify trends and/or patterns of under or over utilization and refers identified practitioners to the QIC for performance improvement and/or corrective action;
- Examines results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM ~~p~~Program, ~~and~~ identify areas for performance improvement, and evaluate performance improvement initiatives;
- Provides a feedback mechanism to the QIC for communicating findings, recommendations, and a plan for implementing corrective actions related to UM issues;
- Identifies~~-~~ opportunities where UM data can be utilized in the development of quality improvement activities and submitted to the QIC for recommendations;
- Provides feedback to the QIC regarding effectiveness of CalOptima's P4P programs;
- Report's findings of UM studies and activities to the QIC;
- Liaisons with the QIC for ongoing review of quality indicators.

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~~Utilization Management Committee~~UMC Members

The UMC actively involves a number of actively participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. CalOptima's UMC is chaired by the UM Medical Director and is comprised of the:

- CMO;
- Deputy CMO;
- Executive Director, Clinical Operations;
- CalOptima Medical Directors of Behavioral Health, Senior Programs, Quality and Analytics, ~~and~~ network Medical Directors and practitioners;
- The UMC is supported by the Medical Directors of Referral/Prior Authorization and Concurrent Review, and the Director and Managers of Utilization, and any additional staff may also attend the U~~tilization~~ M~~anagement~~ C~~ommittee~~ as appropriate.

Benefit Management Subcommittee (BMSC)

The Benefit Management Subcommittee is a subcommittee of the U~~tilization~~ M~~anagement~~ C~~ommittee~~. The BMSC was chartered by the UMC and, ~~directed~~ to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Operational Instruction Letters (OILs), Medi-C~~e~~al Managed Care Division (MMCD) All Plan Letters (APLs), and the Medi-Cal Manual.

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The BMSC is responsible for the following:

- Recommending how to implement new or modified benefits;
- Clarifying the financial responsibility of benefit coverage;
- Recommending benefit decisions to the UMC;
- Updating and maintaining the Benefit Matrix, and
- Communicating benefit changes to staff, providers, and health networks for implementation.

The Subcommittee membership consists of the following:

- Medical Director, Utilization Management
- Executive Director, Clinical Operations
- Director, ~~of~~ Utilization Management
- Director, Case Management
- Director, Healthy Education & Disease Management~~/Health Education~~
- Director, Regulatory Affairs
- Director, Clinical Pharmacy Management
- Director, Quality and Analytics
- Director, Managed Long Term Support and Services (MLTSS)
- Director, Claims Management
- Director, Grievance and Appeals Resolution
- Director, Coding Initiatives

The BMSC meets ten times per year, and recommendations from the BMSC are reported to the UMC on a Quarterly basis.

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Behavioral Health Quality Improvement Committee (BHQIC)

The Behavioral Health Quality Improvement Committee was established in 2011 with the intended purpose of:

- Ensuring members receive timely and satisfactory behavioral health care services;
- Enhancing the ~~continuity~~ integration and coordination between physical health and behavioral health care providers;~~,~~ ~~and~~
- ~~Guiding CalOptima towards the vision of bi-directional behavioral health care integration.~~
- Monitoring key areas of service utilization by members and providers;~~,~~
- ~~and~~ I~~i~~dentifying areas of improvement; and~~.~~
- Guiding CalOptima towards the vision of bi-directional behavioral health care integration.

The BHQIC responsibilities are to:

- Ensure adequate provider availability and accessibility to effectively serve the membership
- Oversee the functions of delegated activities
- Monitor that care rendered is based on established clinical criteria, and clinical practice guidelines, and complies with regulatory and accrediting agency standards
- Ensure that m~~M~~ember benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize m~~M~~ember and Network Provider satisfaction study results when implementing quality activities
- Maintain compliance with evolving ~~National Committee for Quality Assurance (~~NCQA~~)~~ accreditation standards
- Communicate results of clinical and service measures to Network Providers
- Document and report all monitoring activities to appropriate committees

The designated Chairman of the BHQIC is the Medical Director, ~~of the~~ Behavioral Health, ~~Integration~~ who is responsible for chairing the Committee, as well as reporting findings and recommendations to the QIC. The composition of the BHQI Committee is defined in the BHQIC Charter.

The BHQIC meets quarterly at a minimum or more frequently as needed.

~~Long Term Services and Supports~~LTSS Quality Improvement Subcommittee (LTSS QISC)

In 2014, the ~~Long Term Services and Supports~~LTSS Q~~I~~~~mprovement~~ S~~C~~~~ubCommittee~~ replaced the Long~~-~~
Term Care ~~Quality Improvement Subcommittee~~QIS. The LTSS QISC was created to provide a forum for LTSS programs to share best practices, identify challenges and barriers, and together find solutions that are member person-centered, maximize available resources and reducing duplicate services while providing quality of care and ability for members to safely reside in the least restrictive living environment.

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The purpose of the LTSS QISC:

- Engage stakeholders input on ways to best integrate the LTSS programs with managed care delivery system and improved quality of care.
- Improving and providing coordinated care for CalOptima ~~M~~members who resides in long-- term care facilities and those who receive Home- and Community Based Services (HCBS).

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The LTSS QISC Responsibilities:

- Identify barriers to keeping mMembers safe in their own homes or in the community, develop solutions, make appropriate recommendations to improve discharge planning process and prevent ing inappropriate admissions.
- Evaluate the performance, success, and challenges of LTSS program providers of the following services: CBAS, IHSS, MSSP and other Home and Community Based Services (HCBS).
- Monitor the important aspects of quality of care, qualitfy of services, and patient safety by collecting and organizing data for all selected indicators.
- Provide input on enhancing the capacity and coordination among LTSS providers, community-based organizations, housing providers, and managed care plans to care for individuals discharged from institutions.
- Identify and recommend topics for LTSS providers workshops, educations and trainings.

The LTSS QISC Structure:

- The designated Chairman of the LTSS QISC is the Medical Director, Senior Programs, who is responsible for chairing the Ccommittee.
- The LTSS Activity Summary is reported to QIC, and includes, but is not limited to the following:
    - Nursing Facility Administrators
    - Community Based Adult Services (CBAS) Administrators
    - Orange County Social Services AgencyOC SSA, Deputy Director or Designee
    - Multipurpose Senior Services ProgramMSSP, Site Director or Designee
    - Chief Medical Officer/Deputy Medical Officer
    - Medical Director, QI and Analytics
    - Medical Director, UM
    - Executive Director, Clinical Operations
    - Executive Director, Quality Analytics
    - LTSS Manager(s), LTSS
    - LTSS Director, LTSS
- The LTSS QISC meets quarterly at a minimum or more frequently as needed.
- The LTSS Activity Summary will be reported to QIC and includes, but is not limited to,: will be reported to QIC.
    - Member review of Hospital Admission for each LTSS program;
    - Member review of Emergency Department visit for each LTSS program;
    - Members review for Hospital Readmissions for each LTSS program;
    - Health Risk Assessment results for LTC OCC members;
    - LTC Provider Annual Workshop;
    - CBAS Provider Workshop;
    - CBAS Centers Profile
    - LTC Profile
    - Care Coordination and Interdisciplinary Care Team Participation by LTSS staff;
    - Total number of participants by LTSS program

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- In addition, LTSS utilization activities'' summary is reported to UMC, and includes, but is not limited to, the following;
    - ~~Community Based Adult Services (~~CBAS~~)~~ statistics such as to number of participants, assessment type, turn-around time, and denials rates;
    - ~~Long Term Care (~~LTC~~)~~ ~~S~~statistics include, but is not limited to, bed type, turn-around time, and denials rate;
    - ~~Multipurpose Senior Services Program (~~MSSP~~)~~ statistics such as total number of participants, total number of termination, number of ER visits, average length of stay (ALOS), and skilled nursing facility (SNF) admissions.
    - LTSS Inter-Rater Reliability study result;
    - Rate Adjustments for LTC facilities

Integration with the Quality Improvement Program

The UM Program and Work ~~p~~Plan are evaluated and submitted for review and approval annually by both the CalOptima ~~Utilization Management Committee~~ UMC and the ~~Quality Improvement Committee (~~QIC~~)~~, with final review and approval by the Board of Director's ~~Quality Assurance Committee (~~QAC~~)~~.

- Utilization data is collected, and aggregate UM data, member grievances, denials, and appeals are reviewed at the ~~CalOptima Utilization Management Committee~~UMC and recommendations are presented to the ~~CalOptima~~ QIC, and are presented to the participating HMOs, PHCs, SRGs and PMGs on a quarterly basis.
- The UM staff may identify actual or potential quality issues during utilization review activities. These issues are referred to the QI staff for follow-up.
- The ~~CalOptima Quality Improvement Committee~~QIC reports to the Board ~~Quality Assurance Committee~~QAC.
- The ~~Utilization Management Committee~~UMC is a sub-committee of the ~~Quality Improvement Committee (~~QI~~C~~) and routinely reports activities to the QIC.

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

Fiscal and clinical interests are separated. CalOptima and its delegates do not provide any financial rewards or incentives to practitioners or other individuals conducting utilization review for issuing denials of coverage, services or care.

~~CalOptima maintains a Conflict of Interest policy to ensure that conflicts of interest are avoided by staff and members of Committees. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial~~

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~~interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict.~~

~~As stated in CalOptima's Human Resource Manual, a Conflict of Interest policy is provided to all employees when hired, and all Committee members, regardless of employment status (i.e., CalOptima or entity), sign a Conflict of Interest statement on an annual basis.~~

~~Fiscal and clinical interests are separated. CalOptima and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services or care. There are no financial incentives for UM decision makers that could encourage decisions that result in under-utilization.~~

Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QI ~~C~~committee and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is ~~is~~ ~~are~~ maintained in confidential files. The HMOs, PHCs, SRGs, Managed Behavioral Health Organizations (MBHOs) and PMGs hold all information in the strictest confidence. Members of the QI ~~C~~committee and the subcommittees sign a Confidentiality Agreement. This Agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the State Contract.

Integration with Other Processes

The UM Program, Case Management Program, Behavioral Health Program, Managed ~~Long Term Support and Services~~LTSS Programs, Pharmacy ~~and~~ & Therapeutics (P&T) Program, ~~Quality Improvement (~~QI~~)~~, Credentialing, ~~and the~~ Compliance, and Audit and Oversight Programs are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to CalOptima's QI department. ~~-~~As case managers perform the functions of ~~utilization management~~UM, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. ~~-~~As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI d~~D~~epartment in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the

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information warrants additional review by CalOptima's Peer Review or Credentialing Committee. If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The U~~tilization~~ M~~anagement~~ ~~D~~department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified.

In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention;
- State protective and regulatory services;
- Women, Infant and Children Services (WIC);
- EPSDT Health Check;
- Services provided by local public health departments.

~~Utilization Management~~UM Process

The ~~utilization management~~UM process encompasses the following program components: 24-hour seven day week nurse triage, second opinions, referral/prior authorization, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination. All approved services must be medically necessary. The clinical decision process begins when a request for authorization of service is received at CalOptima level. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the D~~epartment of~~ H~~ealth~~ C~~are~~ S~~ervices~~ (Medi-Cal), a variety of programs, regulations, policy letters and all the Center for Medicare and Medicaid Services benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place, and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the CalOptima Audit and Oversight ~~D~~department via its delegation oversight team for compliance.

~~Utilization Management~~UM Program Structure

The UM Program is designed to work collaboratively with delegated entities, including but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality-based health care.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of the ~~Department of Health Care Services (~~DHCS~~)~~, ~~Department of Managed Healthcare (~~DMHC~~)~~, ~~Centers for Medicare and Medicaid Services (~~CMS~~)~~, ~~California Department of Aging (~~CDA~~)~~ and ~~National Committee on Quality Assurance (~~NCQA~~)~~ at least annually. Recommendations for

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revisions and improvements are made, as appropriate, and subsequently annually. The ~~Utilization Management~~ UM Work Plan is based on the findings of the annual program Work ~~p~~Plan evaluation. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.

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The ~~O~~organization ~~C~~chart and the program Committee's reporting structure accurately reflect CalOptima's Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. ~~-~~The composition and functions of the ~~Utilization Management~~UM Workgroup (UMG), ~~and~~ the UMC and QIC, which serve as the oversight committees for CalOptima UM functions, are contained and delineated in the Committees Charters.

The CalOptima UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer, Medical Directors of UM, the Executive Director of Clinical Operations, ~~and~~ the UMC and QIC. CalOptima-contracted delegates are delegated UM responsibilities, including the ~~Utilization Management~~UM Program and W~~w~~ork ~~p~~Plans, which are presented annually to the QIC as part of CalOptima's Delegation Oversight Program. The QIC then reviews and approves or does not approve the delegate's UM Program and ~~w~~Work ~~p~~Plans.

Methods of Review and Authorization

Prior Authorization

Prior authorization requires the provider or practitioner to submit a formal medical necessity determination request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior authorization is required for select services such as ~~non-emergent~~non-emergency inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization List. This list is accessible on the CalOptima website at www.caloptima.org.

Clinical Information

Prior Authorization is required for selected services appearing on ~~a~~ the ~~p~~Prior ~~a~~Authorization ~~l~~List in the
provider section on the CalOptima website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima~~'~~'s ~~A new~~ medical management system, Altruista/GuidingCare is a~~was implemented in the first quarter of 2015. This~~ member-~~-~~centric system utilizes evidence-~~-~~based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The~~In April 2012,~~ CalOptima Link ~~launched. The~~ system~~s~~ allows for on-line authorizations to be submitted by the health networks and processed electronically. The referrals are auto-adjudicated

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through referral intelligence rules (RIR). ~~45% of the on-line referrals met the RIR guidelines for auto-approval in the 4th quarter of 2015.~~ Practitioners also send referrals and requests to the

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~~Utilization Management~~UM ~~D~~department by mail, fax and/or telephone based on the urgency of the request.

Referrals

A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. ~~Primary Care Providers (~~PCP~~)~~s are not required to issue paper referrals, but are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians and all ~~non-emergent~~non-emergency out-of- network practitioners as noted on the Prior Authorization List.

Second Opinions

A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of- network practitioner, if there is no in- network practitioner available.

Extended Specialist Services

Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "Standing Referral" policy and procedure Standing Referral: GG.1112 includes guidance on how members with life-threatening conditions or diseases which require specialized medical care over a prolonged period of time can request and obtain access to specialty care centers.

Out-of-Network Providers

If a member or provider requires or requests a provider out-of-network for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise, and complexity of the case.

~~Network providers are prohibited from making referrals for designated health services to health care entities with which the practitioner or a member of the practitioner's family has a financial relationship.~~

Pharmaceutical Management

The Pharmacy Management Program is overseen by the CMO, and CalOptima Director, ~~of~~ Pharmacy. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by the Pharmacy ~~and~~ & Therapeutics Committee (P&T) and updated as new pharmaceutical information becomes available.

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Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals, and are made available to practitioners via the pProvider newsletter and/or CalOptima website.

The CalOptima ~~Pharmacy and Therapeutics~~ P&T Committee is responsible for development of the CalOptima Formulary, which is based on sound clinical evidence, and is reviewed at least annually by actively practicing practitioners and pharmacists. Updates to the CalOptima Approved Drug List are communicated to both members and providers.

If the following situations exist, CalOptima evaluates the appropriateness of prior authorization of non-formulary drugs:

- No formulary alternative is appropriate and the drug is medically necessary.
- The member has failed treatment or experienced adverse effects on the formulary drug.
- The member's treatment has been stable on a non-formulary drug, and change to a formulary drug is medically inappropriate.

To request prior authorization for outpatient medications not on the CalOptima Formulary, the physician or physician's agent must provide documentation to support the request for coverage. Documentation is provided via the CalOptima Pharmacy Prior Authorization (PA) form, which is faxed to CalOptima's ~~Pharmacy Benefits Manager (~~PBM~~)~~ for review. All potential authorization denials are reviewed by a Pharmacist at CalOptima, as per DHCS and DMHC regulations. The Pharmacy Management ~~D~~department profiles drug utilization by members to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for members receiving multiple medication fills per month are reviewed by a Clinical Pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over-utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

Pharmacy Determinations

Medi-Cal

CalOptima's Pharmacy Management ~~D~~department delegates initial prior authorization review to the ~~Pharmacy Benefits Manager (~~PBM~~)~~ based on clinical prior authorization criteria developed by the CalOptima Pharmacy Management staff and approved by the CalOptima ~~Pharmacy and Therapeutics (~~P&T~~)~~ Committee. The PBM may approve or defer for additional information, but final denial and appeal determinations may only be made by a CalOptima Pharmacist or CalOptima Medical Director. Final decisions for requests that are outside of the available criteria must be made by a CalOptima Pharmacist or CalOptima Medical Director.

CalOptima's written notification of pharmacy denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments,

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documents or other information relevant to the appeal.

- An explanation of the appeal process, including the appeal time frames and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.

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- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions.

OneCare/OneCare Connect

CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow the appropriate UMrequired CMS timeliness guidelines for and medical necessity review criteria.

The following edit checks are completed on-line, real-time, as a prescription is being dispensed:

- Duplicate Drug Therapy
- Too-Early Refill
- Low-Dose/High-Dose Alert
- Incorrect Daily Dosage
- Excessive or Questionable Days' Supply
- Drug to Drug Interaction
- Drug/Age Interaction
- Drug/Gender Interaction
- Drug/Pregnancy Interaction

Formulary

The CalOptima drug Formularies was were created to offer a core list of preferred medications to all practitioners. Occasionally it is necessary to address requests from localLocal providers may make requests to review specific drugs for addition to the Formulary. The Formulary is developed and maintained by the CalOptima Pharmacy and Therapeutics (P&T) Committee. Final approval from the P&T must be received to add drugs to the Formulary. The CalOptima Formularies are available on the CalOptima website or in hard copy upon request.

Pharmacy Benefit Manager

The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, customer service, pharmacy help desk, prior authorization, clinical services and quality improvement functions. The PBM makes denial decisions based on lack of medical necessity, drugs not included in the Formulary, prior authorization not obtained, etc. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity the PBMs is monitored according to the Audit and Oversight department's policies and procedures.

The following edit checks are completed in the PBM claims system on-line, real-time, as a prescription is being dispensed:

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- ~~Duplicate Drug Therapy~~
- ~~Too-Early Refill~~
- ~~Low-Dose/High-Dose Alert~~
- ~~Incorrect Daily Dosage~~
- ~~Excessive or Questionable Days' Supply~~
- ~~Drug to Drug Interaction~~
- ~~Drug/Age Interaction~~
- ~~Drug/Gender Interaction~~
- ~~Drug/Pregnancy Interaction~~

~~**Specialty Injectables**~~

~~**CalOptima contracts with community pharmacies for the provision of specialty injectables not available through the delegated Pharmacy Benefit Manager's network.**~~

~~**CalOptima is responsible for medically necessary determinations related to specialty injectables. The pharmacies are not a subcontracted vendor and do not make medical necessity decisions. In the first Quarter of 2015 the responsibility for authorizing specialty injectables will transition from the UM Department to the Pharmacy Management Department to align the authorization process with the most appropriate health care professionals organizationally.**~~

Medical Necessity Review

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with the State of California for Medi-Cal, as well as OneCare and OneCare Connect. Medically necessary means services or supplies that: are appropriate and needed for the diagnosis or treatment of a member's medical condition; are provided for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local area; and are not mainly for the convenience of the member or the doctor.

The CalOptima UM process uses an active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost efficient manner, without compromising quality. Physicians, or other appropriate health care professionals, review and determine all final denial decisions for requested medical and behavioral health care services. The review of the denial of a pharmacy prior authorization, however, may be carried out by a qualified Physician or Pharmacist.

The Medical Directors are responsible for providing clinical expertise to the ~~Utilization Management~~UM staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, with the support of the UMC, have the authority, accountability and responsibility for denial determinations. For those contracted delegated PMGs that are delegated UM responsibilities, that entity's Medical Director, or designee,

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has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

CalOptima's ~~Utilization Management~~UM ~~D~~department is responsible for the review and authorization of health care services for CalOptima Direct members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services;
- Admission Review;
- Concurrent/Continued Stay Review for selected conditions;
- Discharge Planning Review;
- Retrospective Review;
- Emergency Service Authorization is not required but may be reviewed;
- Identification of Opportunities for Case Management, Disease Management or Health Education of CalOptima members;
- Evaluation for potential transplant services for health network members;

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The following standards are applied to all prior authorization, concurrent review, and retrospective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications, or termination of services;
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated;
- Member characteristics are considered when applying criteria in order to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological situation
    - Home environment, when applicable;

- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. In the event that member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the ~~Utilization Management~~UM Medical Director to determine an appropriate course of action, GG.1508, Authorization and Processing of Referrals;
- Reasons for decisions are clearly documented in the medical management system;
- Notification to ~~M~~members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, and members and providers are notified of appeals and grievance procedures;
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's ~~Grievance and Appeals Resolution~~GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services;
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing;
- Records, including an oral or written Notice of Action, are retained for a minimum of ~~ten (~~10)~~five~~ ~~(~~10~~5)~~~~ years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law;
- Requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested;
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a determination. ~~-~~Contact can be made directly to the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. ~~-~~A provider may request a discussion with the Medical Director, or a copy of the specific criteria utilized.

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The following is appropriate clinical information used to make medical necessity determinations and includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

CalOptima's ~~Utilization Management Committee~~UMC reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director of Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management departments are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima' program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the ~~Utilization Management~~UM Nurse Case Managers and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial, or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima distributes a statement to all members in the Member Handbook, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage of service or care, and CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

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Authorization Review Roles				
Authorization Type*	**Criteria Utilized**	**Medical Assistant**	**Nurse**	**Medical Director / Physician Reviewer**
Chemotherapy	MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines		X	X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals		X	X
Dialysis	MCG / Medi-Cal and Medicare Manuals	X	X	X
Hearing Aids	Medi-Cal and Medicare Manuals	X	X	X
Home Health	InterQual / MCG / Medi-Cal and Medicare Manuals		X	X
Imaging	MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals	X	X	X
Injectables	MCG / Medi-Cal and Medicare Manuals		X	X
Medical Supplies (DME Related)	Medi-Cal and Medicare Manuals	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	MCG / Medi-Cal and Medicare Manuals		X	X
Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG / Medi-Cal and Medicare Manuals		X	X
Prosthetics	MCG / Medi-Cal and Medicare Manuals		X	X
Radiation Oncology	MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals	RCOC Referrals	X	X
Transplants	DHCS Guidelines	Referral	X	X
Administrative Denial	CalOptima Policy	X	X	
Medical Necessity Denial	MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines			X

*If Medical Necessity is not met, the request is referred to the Medical Director / Physician

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Reviewer for review and determination.

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Long-Term Services and Supports

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer
Community Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		**X**	**X**
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51335		**X**	**X**
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51334		**X**	**X**
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Sections 51003 and 51303		**X**	**X**
Long-Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Sections 51343 and 51164	X DDS or DMH Certified	**X**	**X**
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	**X**	**X**	**X**

*If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board certified physician from the appropriate specialty for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on a UM decision made the original request for authorization or determination or is in, or is affiliated with the same practice group as the practitioner who made the original request or determination.

For the purposes of Behavioral Health review and oversight as a delegated vendor, ~~College Health IPA (CHIPA)~~Magellan ~~Health Inc.~~ ensures there are p~~P~~eer r~~R~~eviewers/c~~C~~linical c~~C~~onsultants. Peer ~~R~~reviewers are behavioral health professionals who are qualified, as determined by Magellan~~CHIPA~~'s Medical Director, to render a clinical opinion about the behavioral health condition, procedure, and/or treatment

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under review. Peer reviewers must hold a current unrestricted California license to practice medicine in the appropriate specialty to render an opinion about whether a requested service meets established medical necessity criteria.

New Technology Review

Medi-Cal, OneCare, OneCare Connect

CalOptima's ~~Pharmacy and Therapeutics~~P&T Committee and Benefit Management Subcommittee shall

study the medical, social, ethical, and economic implications of new technologies in order to evaluate the safety and efficacy of use for ~~M~~members in accordance with policy GG.1534.

Preventive and Clinical Practice Guidelines (CPG)

Clinical Guidelines are developed and implemented via the QIC, and assist in making health care decisions and improving the quality of care provided to members. Medication use guidelines have been developed that are reviewed by the ~~Pharmacy & Therapeutics~~P&T Committee, which includes outside physician and pharmaceutical participants, whose recommendations are forwarded to the QIC for review and approval. These guidelines are posted on the CalOptima website. Additional condition specific guidelines are in development, and are based on a compilation of current medical practices researched from current literature and professional expert consensus documents. Guidelines are reviewed and updated at least annually by the respective committees. These standards for patient care are to be used as guidelines, and are not intended to replace the clinical medical judgment of the individual physician. CPGs are shared with the delegated HMOs, PHCs, SRGs and PMGs as they are approved.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD Guidelines for both adults and children.

UM criteria are nationally recognized, evidence based standards of care and include input from recognized experts in the development, adaption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate.

CalOptima uses the following criteria sets for all medical necessity determinations:

- Medi-Cal and Medicare Manual of Criteria;
- MCG —– Evidence-based nationally recognized criteria;
- National Comprehensive Cancer Network (NCCN) Guidelines;
- Centers of Excellence ~~g~~Guidelines;
- Specialty Guidelines such as the American Academy of Pediatric Guidelines (AAP) and American Heart Association;
- ~~Evidence- based nationally recognized criteria such as MCG and InterQual;~~
- CalOptima ~~Level of Care~~ Criteria for outpatient behavioral health services;
- CalOptima Medical Policy and Medi-Cal Benefits Guidelines;
- National (CMS) and l~~L~~ocal (s~~S~~tate) Determination Guidelines.

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- National Guideline Clearinghouse
- Medicare Part D: CMS-approved Compendia

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Delegated HMOs, PHCs, SRGs and PMGs must utilize the same or similar nationally recognized criteria.

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting CalOptima's ~~Utilization Management~~UM ~~D~~department or may discuss the UM decision with CalOptima Medical Director. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the ~~Utilization Management~~UM ~~D~~department. The manual also outlines CalOptima's ~~Utilization Management~~UM policies and procedures. Similar information is found in the Member Handbook and on the CalOptima website at ~~www.caloptima.org.~~www.caloptima.org.

Inter-Rater Reliability

At least annually, the CMO and Executive Director of Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions, apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director of Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, CalOptima's ~~Utilization Management~~UM leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight.

Provider/Member Communication

Members and practitioners can access UM staff through a toll free telephone number **~~(1-~~888-587-8088~~)~~** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TDD/TTY services for deaf, hard of hearing or speech impaired members are available toll free at **~~1-~~800-735-2929**. The phone numbers for these are included in the ~~m~~Member ~~h~~Handbook, on the web, and in all member letters. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services.

Inbound and outbound communications may include directly speaking with practitioners and members, or faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM ~~D~~department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore does not make authorization

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decisions. The vendor staff takes authorization information for the next business day

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response by CalOptima or notifies CalOptima on-call nurse in cases requiring immediate response. A log is forwarded to the UM ~~D~~department daily identifying those issues that need follow-up by the UM staff the following day.

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Access to Physician Reviewer

The CalOptima Medical Director or appropriate practitioner reviewer (behavioral health and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation, and the ~~P~~provider ~~N~~newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling CalOptima's main toll-free phone number and asking for the CalOptima Medical Director. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner.

Requesting Copies of Medical Records

~~Utilization Management~~UM staff does not routinely request copies of medical records on all patients reviewed. During prospective and concurrent telephonic review, copies of medical records are only required when difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay during a verbal review. In those cases, only the necessary or pertinent sections of the record are required. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times. Members requesting a copy of CalOptima's designated record set are not charged for the copy.

Sharing Information

CalOptima's ~~Utilization Management~~UM staff share all clinical and demographic information on individual patients among various divisions (e.g. discharge planning, case management, disease management, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider/Member Communication

CalOptima's UM program in no way prohibits or otherwise restricts a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or absence of treatment;
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

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Timeliness of UM Decisions

~~Utilization management~~UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

UM Decision and Notification Timelines

~~Medi-Cal and OneCare Connect~~ ~~OneCare (Medicare)~~

Medi-Cal and OneCare Connect (Medi-Cal)	OneCare (Medicare) and OneCare Connect (Medicare)
Medical ~~and Pharmaceutical~~ - Decision Making	Medical ~~and Pharmaceutical~~ - Decision Making
• Processed by CalOptima ~~Utilization Management~~UM ~~D~~department for members in direct or non-delegated network • Processed by ~~Utilization Management~~UM ~~D~~department at the ~~Physician Medical Groups~~PMGs • Qualified physician review for any modifications or denials • Qualified pharmacist review for any modifications or~~f~~ denials	• Processed by ~~Utilization Management~~UM ~~D~~department at the Physician Medical Groups • Processed by Case Management ~~D~~department at CalOptima for out of area and Medi-Cal wrap authorizations • ~~Processed by Pharmacy Management Department at CalOptima or Pharmacy Benefits Manager for pharmaceutical prior authorizations~~ • Qualified physician review for any modifications or denials • Qualified pharmacists or physician review for any pharmaceutical partial approvals or denials

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Timeframes for Determinations: • Routine 5 business days • Urgent 72 hours • Retrospective 30 days Timeframes for Notification: Authorization Request Type: Routine (Non-Urgent) Pre- Service: (Oral or Electronic) Provider: Initial within 24 hours of the decision Member: None specified Provider: Within 2 working days of making the decision Member: Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request. Routine (Non-Urgent): Pre-Service Extension Needed: Provider: Within 24 hours of making the	Timeframes for Determinations (non-Part B): Routine 14 calendar days • Urgent 72 hours • Retrospective 30 days ~~Timeframes for Determinations (Part D):~~ ~~• Routine: 72 hours~~ ~~• Urgent: 24 hours~~ ~~• Retrospective: 14 days~~ Timeframes for Notification (non-Part D) Authorization Request Type: For Expedited requests, oral notification to the member must be made within 72 hours from the receipt of the request and must include expedited appeal rights. Written notification must be sent to the member and provider within three days of oral notification. For standard determinations the member must be notified of the decision no later than 14 days after receipt of the request.

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decision. Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision Member: Within 14 calendar of making the decision, not to exceed 28 calendar days from receipt of the request Expedited Authorization (Pre-Service): (Oral or Electronic) Provider: Within 24 hours of making the decision Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision. Member: Within 2 working days of making the decision. Expedited Authorization (Pre-Service) – Extension Needed: (Oral or Electronic) Provider: Within 24 hours of making the decision Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision Member: Within 2~~w~~ working days of making the decision. Concurrent: (Oral or Electronic) Practitioner: Within 24 hours of making the decision (for approvals and denials). Member: None Specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision. Member: Within 2 working days of making the	If an extension is requested the member must be notified no later than the expiration of the request (28 days maximum.) Notification includes the reason for the delay and their right to file an expedited grievance if they disagree with the extension request.

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~~Pharmaceutical - Timeframes for Notification (Part D)~~
~~Authorization Request Type:~~
~~For expedited requests, written notification must be provided to the member within 24 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.~~
~~For standard requests, written notification must be provided to the member within 72 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.~~
~~For retrospective requests, written notification must be provided to the member within 14 calendar days from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.~~

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decision. NOTE: For Provider and Member: If oral notification is given within 24 hours of request, written notification must be given no later than 3 working days after the oral notification. Post Service – Retrospective Review: (Oral or Electronic) Member and Provider: None specified Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of request. Post- Service – Extension Needed: (Oral or Electronic) Provider and Member: None specified Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of the information necessary to make the determination	
Denial Letter/Member Notification State mandated "Notice of Action"	Denial Letter/Member Notification CMS mandated "Medicare Notice of Non-Coverage" including specific language for expedited appeal for expedited initial organization determination

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Medi-Cal and OneCare Connect (Medi-Cal)	OneCare (Medicare) and OneCare Connect (Medicare)
Pharmaceutical - Decision Making	Pharmaceutical - Decision Making
• Processed by CalOptima Pharmacy Management ~~D~~department or Pharmacy Benefits Manager • Qualified physician review for any modifications or denials • Qualified pharmacist review for any modifications or denials • Qualified physician review for any appeal denials	• Processed by Pharmacy Management ~~D~~department at CalOptima • Qualified physician review for any appeals
Timeframes for Determinations: • Response (approval, Deferral, Denial) within 24 hours or next business day of receiving the request. • Approvals or Denials • Routine 5 business days • Urgent 72 hours • Retrospective 30 days Timeframes for Notification: Authorization Request Type: Routine (Non-Urgent) Pre-Service: (Oral or Electronic) Provider: Initial within 24 hours of the decision Member: None specified Provider: Within 2 working days of making the decision Member: Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request. Routine (Non-Urgent): Pre-Service Extension Needed: Provider: Within 24 hours of making the	Timeframes for Determinations (Part D): • Routine: 72 hours • Urgent: 24 hours • Retrospective: 14 days Pharmaceutical - Timeframes for Notification (Part D) Authorization Request Type: For expedited requests, written notification must be provided to the member within 24 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification. For standard requests, written notification must be provided to the member within 72 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification. For retrospective requests, written notification must be provided to the member within 14 calendar days from the receipt of the request. If initial notification is made orally, then written

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decision. Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision Member: Within 14 calendar of making the decision, not to exceed 28 calendar days from receipt of the request Expedited Authorization (Pre-Service): (Oral or Electronic) Provider: Within 24 hours of making the decision Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision. Member: Within 2 working days of making the decision. NOTE: For Provider and Member: If oral notification is given within 24 hours of request, written notification must be given no later than 3 working days after the oral notification. Post Service – Retrospective Review: (Oral or Electronic) Member and Provider: None specified Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of request. Post- Service – Extension Needed: (Oral or Electronic) Provider and Member: None specified Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of the information necessary to make the determination	notification must be provided within 3 calendar days of the oral notification.

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Denial Letter/Member Notification State mandated “Notice of Action”	Denial Letter/Member Notification CMS mandated “Medicare Notice of Non-Coverage” including specific language for expedited appeal for expedited initial organization determination

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UM Urgent/Expedited Prior Authorization Services

For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima within five (5) days prior to the requested service date. Prior authorization is never required for emergent or urgent care services. Facilities are required to notify CalOptima of all inpatient admissions and long-term care facility admissions within one (1) business day following the admission. Post-stabilization services ~~(at out of network facilities)~~ require authorization. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required.

UM Routine/Standard Prior Authorization Services

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within five (5) business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. CalOptima makes a determination for urgent concurrent, expedited continued stay, post stabilization review or in cases for ongoing ambulatory care or if the lack of treatment may result in an emergency visit or emergency admission within 24 hours of receipt of the request for services. A request made

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~~w~~while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service and post-service). Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Nurse Advice Phone Line

CalOptima has a twenty-four hour, seven days per week NCQA accredited Nurse Advice Phone Line
accessible to all lines of business. The health line is designed to reduce unwarranted ER visits and associated costs; elevate member knowledge, engagement, health and satisfaction; and boost clinical, financial and operational outcomes. Multiple communication options allow the member access by web, email~~,~~ and phone.

A b~~B~~ilingual staff~~s~~ of ~~Registered Nurses (~~RNs~~)~~ assess and triage symptoms, make urgent and non urgent care recommendations using evidence based guidelines and resources, give provider and facility referrals and educate members on diagnoses, conditions and medications. The Nurse Advi~~s~~ce Phone Line also helps support CalOptima member's comprehensive needs by cross referring members to existing programs such as case or disease management, Pe~~r~~einatal ~~Natal~~ Support Services, ~~In Home Support Services~~IHSS, ~~Multipurpose Senior Services~~MSSP, Health Education, and local resources available in the community.

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Emergency Services

Emergency room services are available 24 hours/day, 7 days/week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered inpatient and outpatient services when furnished by a qualified provider ~~that~~ and are needed to evaluate or stabilize an emergency medical condition. CalOptima covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a Plan network practitioner, or Plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the

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member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as previously stated.

Although CalOptima may establish guidelines and timelines for submittal of notification regarding the provision of emergency services, including emergent admissions, CalOptima does not refuse to cover an emergency service based on the practitioner's or the facility's failure to notify CalOptima of the screening and treatment within the required time frames, except as related to any claim filing time frames. Members who have an emergency medical condition are not required to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

Admission/Concurrent Review Process

The admission/concurrent review process assesses the clinical status of the member and verifies the need for continued hospitalization and facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed,
- Validating the diagnosis;
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care;
- Additional days/service/procedures proposed, and
- Reasons for extension of the treatment or service.

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonic. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the ~~Utilization Management~~UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight ~~C~~certified ~~M~~mail to the attending physician, hospital and the member.

The need for case management, disease management, or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima ~~Quality Improvement~~QI ~~D~~department for investigation and resolution.

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Hospitalist/SNFist Program

The goal of the Hospitalist/SNFist Program is for early identification and management of members, either in the Emergency Room or ~~I~~inpatient setting, with prompt linkage to an identified hospitalist/SNFist to ensure that the member receives the appropriate care in the most appropriate setting. Appropriate setting is determined by medical providers using established evidence based clinical and administrative criteria. Other program objectives include:

Initiate appropriate care plan consistent with:

- Established estimated length of stay criteria
- Medical necessity criteria to establish appropriate level of care
- Member psychosocial needs impacting ongoing care
- Communication of current and ongoing needs impacting discharge planning and after-care requirements to PCP and others involved in the members care
- Facilitation of transfer of members from non-contracted facilities to facilities with a contracted hospitalist team

Contracted hospitalist groups, facilities case management staff, and Emergency Room personnel receive training from CalOptima staff on:

- Early identification of CalOptima Direct (COD) members
- Process for notification of ~~H~~hospitalists
- Face sheet and/or telephonic notification to CalOptima
- Care Plan development and implementation
- Discharge Planning

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The role of the hospitalist is to work together with the Emergency Department team to determine the optimal location and level of care for the member's treatment needs. -If, based on clinical information and medical necessity criteria, the member requires admission to the facility; the hospitalist assumes primary responsibility for the member's care as the admitting physician and will coordinate the member's care together with CalOptima medical management staff. -If at any time the member is appropriate for transfer to a lower level of care, whether directly from the emergency room or after admission, the hospitalist will facilitate the transfer to the appropriate setting, in concert with the accepting facility and with CalOptima staff.

Discharge Planning Review

Discharge planning begins within 48 hours of an inpatient admission, and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention;
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- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the members care;
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources;
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization;
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge Planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM~~tilization~~ Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial or termination of any service based on medical necessity or benefit limitations. Upon any adverse determination for medical or behavioral health services made by a CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the time frames as noted in the Referral/Authorization Processing Policy and Procedure. The written notification is easily understandable and includes the member specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and time frames for appeal of the decision. All templates for written notifications of decision making are DHCS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Medical Director or appropriate practitioner reviewer (behavioral health practitioner, pharmacist, etc.) serves as the point of contact for the peer to peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

~~Utilization Management~~UM Appeals Process

CalOptima has a comprehensive review system to address matters when Medi-Cal, ~~or~~ OneCare or OneCare Connect members wish to exercise their right to review of a ~~utilization management~~UM decision to deny, delay, terminate or modify a request for services. This process is initiated by contact from a member, a member's representative, or practitioner to CalOptima. Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs, SRGs and PMGs, are submitted to CalOptima's ~~Grievance and~~

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~~Appeals Resolution Services (~~GARS~~)~~. The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution. The appeals process is in accordance with CalOptima Policy and Procedure HH.1102: Grievance and Appeals Resolution Services. This process includes:

- Collection of data
- Communication to the member and provider
- Thorough evaluation of the substance of the appeal
- Resolution of operational or systems issues
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case

The UM appeal process for COD, HMOs, PHCs and SRGs is handled by ~~the~~ CalOptima ~~Grievance and Appeals Resolution Services (~~GARS~~)~~. CalOptima works collaboratively with the delegated entity in the gathering of information and supporting documentation. If a member is not satisfied with the initial decision, he/she may file for a State Hearing with the California Department of Social Services.

UM ~~A~~appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination; however, the initial reviewer may participate in the appeal process if new or additional information is submitted.

The UM or CM Medical Director or designee evaluates appeals regarding the denial, delay, termination, or modification of care or service. The UM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the required timelines. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Customer Service ~~D~~department.

Expedited Appeals

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A member or member's representative may request the appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited appeal requests shall be reviewed and resolved in as expeditious a manner as the matter requires, but no later than 72 hours after receipt.

At the time of the request, the information is reviewed and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature, and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member, or could jeopardize the member's ability to regain maximum functionality.

Provider Preventable Conditions (PPCs)

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. ~~h~~Health care acquired conditions (HCAC~~),)1). Those~~ occurring in inpatient acute care hospitals, and ~~2)~~
2. ~~1.~~Other ~~P~~provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's ~~Quality Improvement~~QI ~~Division~~department for further research and reporting to government and/or regulatory agencies.

~~Long Term Support Services (~~LTSS~~)~~

Long-~~-~~Term Care

The Long-~~-~~Term Care case management program includes authorizations for the following facilities: skilled nursing, intermediate care, sub-acute care, intermediate care–developmentally disabled, intermediate care–developmentally disabled—habilitative, and intermediate care–developmentally disabled—nursing. ~~-~~It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, and assisted living facilities. ~~-~~Facilities are required to notify CalOptima of admissions within 21 days. ~~-~~An on-site visit is scheduled to assess patient's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system. Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to ~~the Multipurpose Senior Services Program (~~MSSP~~)~~, ~~In-Home Supportive Services (~~IHSS~~)~~ ~~program~~ or to a ~~Community Based Adult Services (~~CBAS~~)~~ facility. ~~-~~In addition, the LTC staff provides education to facilities and staff through monthly onsite visits, quarterly and annual workshops, or in response to individual facility requests, and when new

programs are implemented.

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~~Community Based Adult Services (~~CBAS~~)~~
An outpatient, facility based program offering day time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of a nursing facility.
Services may include: health care coordination~~,~~; meal service (at least one per day at center)~~;~~ medication management~~,~~; mental health services~~;~~ nursing services~~;~~ personal care and social services~~,~~; physical, occupational, and speech therapy~~;~~ recreational activities~~;~~ training and support for family and caregivers~~;~~ and transportation to and from the center.

~~Multipurpose Senior Services Program (~~MSSP~~)~~
CalOptima has responsibility for the payment of the MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help persons 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to: senior center programs, case management, money management and counseling, respite, housing assistance, assistive devices, legal services, transportation, nutrition services, home health care, meals, personal care assistance with hygiene, personal safety and activities of daily living.

~~In Home Supportive Services (~~IHSS~~)~~
CalOptima is responsible for payment of services for CalOptima members who receive services from the IHSS program (which is operated by the County of Orange). The program provides services to those members who are disabled, blind, or 65 years of age or older and are unable to live safely at home without help who meet the financial need requirement. Services are provided by a caretaker that the member hires. The County ~~will still make the determin~~determines~~ation of~~ eligibility under the program. It ~~as well as~~also determines the number of hours that an individual can ~~will be~~ receive~~ing~~ services. Under an MOU with the county, CalOptima ~~will be~~ work~~sing~~ collaboratively to ensure that referrals are being made and to involve members and their caregivers, when agreed to, in the care planning process.

Retrospective Review
Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director, ~~of Utilization Management~~UM~~,~~ or designee, reviews the request for retrospective authorization. If supporting documentation satisfies the administrative waiver of notification the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director, UM~~of Utilization Management~~ or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. The decision, to authorize or deny, is made within thirty (30) calendar days of receipt.

Transitions of Care (TOC)
TOC is a 4-week patient-centered intervention, managed by the Case Management ~~D~~department, which employs a coaching, rather than doing, approach. It provides patients or caregivers with tools and support to encourage and sustain self-management skills in an effort to minimize a possible readmission and optimize the member's quality of life.

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TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- Knowledge of Red Flags: Patient is knowledgeable about indications that their condition is worsening and how to respond;
- Medication Self-Management: Patient is knowledgeable about medications and has a medication management system;
- Patient-Centered Health Record: Patient understands and uses a Personal Health Record (PHR) to facilitate communication with their health care team and ensure continuity of care across providers and settings;
- Physician Follow-Up: Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Complex Case Management

The Case Management Program is an ongoing outpatient collaborative process that strives to assure the delivery of health care services in a responsible, optimally cost-efficient manner. Case Management is a distinct and unique program that identifies eligible persons, with specific health care needs, in order to facilitate the development and implementation of a care plan to efficiently use health care resources to achieve optimum member outcomes. Case Management activities are complimentary, not duplicative, of ~~Utilization Management~~UM activities.

Case Managers are licensed ~~N~~nurses with caseloads that are variable, depending on the complexity of the cases managed.

The case management program includes:

- Standardized mechanisms for member identification through use of data;
- Multiple avenues for referrals to case management;
- Following members across the continuum of health care from outpatient or ambulatory to inpatient settings;
- Use of evidence-based clinical practice guidelines or algorithms;
- Initial assessment and ongoing management process;
- Developing, implementing and modifying an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the member and/or his or her family and/or care giver(s);
- Developing comprehensive long and short term goals;
- Analyzing all data for formulating appropriate recommendations;
- Coordinating services for members for appropriate levels of care and resources;
- Documenting all findings;
- Monitoring, reassessing, and modifying ~~CalOptima of~~ care to ensure quality, timeliness, and effectiveness of services;
- Mechanism for identification and referral of quality of care issues to QI ~~D~~department;
- Assessing the outcomes of case management and presenting findings to the Medical Director

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of Case Management.

Case Management Process

- Referral/Case Identification
- Intake
- Assessment
- Risk Stratification
- Care Plan development, with long and short term goals

For further details of the structure, process, staffing, and overall program management please refer to the 2016 7 Case Management Program document.

Transplant Program

The CalOptima tTransplant pProgram is coordinated by CalOptima's mMedical dDirector and managed by the Case Management Ddepartment's collaboration. Transplants are not delegated to the HMOs, PHCs, SRGs and PMGs, other than Kaiser Foundation Health Plan. It provides the resources and education needed to proactively manage members identified as potential transplant candidates. The CalOptima Case Management Ddepartment works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence, or CMS Center(s) of Excellence for OneCare, as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the tTransplant pProgram benefits the member, the community of transplant staff, and the facilities. CalOptima monitors and maintains oversight of the tTransplant pProgram, and reports to the UM Committee to oversee the accessibility, timeliness and quality of the transplant process across networks.

Coordination of Care

Coordination of services and benefits is a key function of Cease mManagement both during inpatient acute episodes of care as well as for complex or special needs cases which are referred to the Case Management and/or Disease Management Ddepartment for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medicaid is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider under certain situations. CalOptima also coordinates continuity of care with other

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Medicaid health plans when a new member comes onto CalOptima or a member terminates from CalOptima to a new health plan.

Disease Management (DM)

~~Disease Management~~DM is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. CalOptima's ~~Disease Management~~DM Program is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. The diagnosis based programs are offered telephonically, involving interaction with a trained health care professional, and require an extended series of interactions, including a strong educational element. CalOptima's DM~~disease management~~ ~~p~~Programs emphasize prevention and members are expected to play an active role in managing their diseases.

~~Disease Management~~DM Process

CalOptima's DM ~~p~~Programs are disease specific and evaluated for relevance to CalOptima's membership demographics and utilization patterns. DM ~~p~~Programs may include, but are not limited to: Asthma, Chronic Kidney Disease, COPD, Diabetes, Pregnancy Management, and Depression. The major components of each disease management program include:

- Identification of members with specified diagnosis;
- Stratification or classification of these members according to the severity of their disease, the appropriateness of their treatment, and the risk for complications and high resource utilization;
- Provision of proven interventions that will improve the clinical status of the member and reduce the risk for complications and long-term problems;
- Involvement of the member, family/caregiver(s), and physician to promote appropriate use of resources;
- Education of patient and family/caregiver(s) to promote increased understanding of the disease and increase self-management of the disease in an effort to decrease exacerbations;
- Ongoing measurement of the process and its outcomes in order to document successes and/or identify necessary revisions of the program.

Members with a potential diagnosis applicable to the specific DM ~~p~~Program are identified through various sources, including, but not limited to: inpatient census reports, medical claims data (office, emergency department, outpatient, and inpatient levels of care), pharmaceutical claims data, health risk assessments (HRA) results, laboratory reports, data from UM/CM processes, new member welcome calls, member self-referral, and physician referral.

Based on the data received during the identification phase, members are stratified into risk groups that guide the care coordination interventions provided. Members are stratified into Low, Moderate, or High Risk categories. Definitions for each risk category are program specific and are outlined in the program's description document. Members may change between risk groups based on data retrieved during each reporting period, as well as through collaboration/interaction with the member or PCP.

Members enrolled into a disease management program receive some level of intervention, which may include, but is not limited to: identification, assessment, disease specific education, reminders

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about preventive/monitoring services, assistance with making needed appointments and transportation arrangements, referral to specialists as needed, authorization for services and/or medical equipment, coordination of benefits, and coordination with community based resources. Education is a crucial component of the disease management program. Education is presented to members and their treating physician(s) and may be provided through mailings, telephone calls, or home visits.

High-risk members are referred to CalOptima's cComplex cCase Mmanagement pProgram for development of an individualized care plan. Both the member/family/caregiver(s) and the physician will be included in the development of the care plan. Including the member/family/caregiver(s) in the development of the individualized goals and interventions promotes ownership of the program and stimulates a desire for success. Care plan goals and interventions are reviewed routinely and CalOptima of care is adjusted as necessary by the care coordinator to assure an optimal outcome for the member.

Measuring Effectiveness

Effectiveness of both the Ceomplex cCase mManagement and disease managementDM pPrograms are
measured on, at a minimum, an annual basis. Methods of evaluation include condition specific indicators (e.g. Healthcare Effectiveness Data and Information Set [HEDIS] measures for Comprehensive Diabetes Care), utilization data, such as frequency of ER visits or inpatient admissions, and self-reported member information such as satisfaction with the program, level of understanding of the disease, or improvement in life impact, such as days of school or work missed. This measurement and analysis is documented as part of the annual UM pProgram evaluation.

Over-/ Uunder Uutilization monitoring is tracked by UM and reported to UMC. Measures are monitored and reviewed for over and under utilization changes in trends. Actions are determined based on trends identified and evaluated for effectiveness.

The following are measures tracked and monitored for over/under utilization trends:

- Emergency RoomER admissions (ER)
- Bed Days
- Admits per 1000
- Average Length of Stay (ALOS)
- Readmission Rates
- Used/Unused Authorizations
- Inter-rater Reliability- for all licensed staff utilizing clinical review criteria
- Grievances — Member per 1000 per Year
- Appeals — Member per 1000 per Year
- Overturn Rates — Provider per 1000 per Year
- Satisfaction with Primary Care Access
- Provider Satisfaction
- Member Satisfaction
- HEDIS/Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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State Fair Hearing (Medi-Cal Line of Business Only)

CalOptima Medi-Cal members have the right to request a State Fair Hearing from the California Department of Social Services at any time during the appeals process, or within 90 days of an adverse decision. A member may file a request for a State Fair Hearing and a request for an appeal at the same time. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Fair Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each resolution letter sent to the member or the member's representative.

Independent Medical Review

OneCare and OneCare Connect members have a right to request an independent review if they disagree with the termination of services from a ~~skilled nursing facility (~~SNF~~)~~, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). T~~he Center for Medicare and Medicaid Services (~~CMS~~)~~ contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. OneCare is notified when a requests is made by a member or member representative. OneCare supports the process with providing the medical records for the QIC's review. The QIO notifies the member or member representative and OneCare of the outcome of their review. ~~-~~If the decision is overturned, OneCare complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Program Evaluation

The UM Program is evaluated at least annually, and modifications made as necessary. The CMO and Executive Director of Clinical Operations evaluate the impact of the UM ~~p~~Program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- Drug Utilization Review (DUR) profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. ~~-~~The evaluation and recommendations are submitted to the UMC for review, action and follow-up. ~~-~~The final document is then submitted to the Board of Directors through the QIC for approval.

Satisfaction with the UM Process

CalOptima provides an explanation of the ~~grievance and appeal~~GARS process, Administrative Hearing, Independent Review, and DHCS Board of Appeals review processes to newly enrolled members upon enrollment and annually thereafter. ~~-~~The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima ~~Quality Improvement~~QI ~~D~~department for investigation and

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resolution.

Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include, but are not limited to: member satisfaction survey results (CAHPS), member/provider complaints and appeals that relate specifically to UM, provider satisfaction surveys with specific questions about the UM process, and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on the areas of concern which may include staff retraining and member/provider education.

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2017
UTILIZATION MANAGEMENT WORKPLAN & EVALUATION

Medi-Cal

OneCare

OneCare Connect

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2017
UTILIZATION MANAGEMENT WORKPLAN & EVALUATION
Medi-Cal, OneCare & OneCare Connect

SIGNATURE PAGE

INITIAL WORKPLAN AND APPROVAL:

Submitted and approved by UMC **Date:** _____

Submitted and approved by Board of Directors'

Quality Assurance Committee (QAC) **Date:** _____

Submitted and approved by Board of Directors **Date:** _____

_____ _____

Francesco Federico, MD **Date**

Utilization Management Committee Chairperson

_____ _____

Paul Yost, MD **Date**

Board of Directors' Quality Assurance Committee Chairperson

_____ _____

Paul Yost, MD **Date**

Board of Directors' Chair

2017
UTILIZATION MANAGEMENT
WORKPLAN & EVALUATION
Medi-Cal, OneCare & OneCare Connect

SIGNATURE PAGE

FINAL EVALUATION APPROVAL:

Submitted and approved by UMC **Date:** _____

Submitted and approved by Board **Date:** _____

Submitted and approved by Board of Directors **Date:** _____

Quality Assurance Committee (QAC)

Utilization Management Committee Chairperson:

_____ _____

Francesco Federico, MD **Date**

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Paul Yost, MD **Date**

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3. **Metrics Defined**
    a. Outpatient behavioral health services encounter data for BH Medi-Cal, Medi-Cal ABA, and OneCare Connect
    b. Inpatient encounter data BH OneCare Connect

C. UM Data Management — Owner: Francesco Federico

1. **Goals**
    a. Medical Management UM Data Management will develop standardized dynamic / static UM reports utilizing Enterprise Analytics resources
    b. UM patterns - understanding patterns / trends using analytics resource tools
    c. Strategies (Strategic) to affect UM outcomes
    d. Monitoring of UM metrics

2. **Strategic**
    a. Continued refinement of analytic tools (Data Mart)
    b. Continued collaboration development of select, standard, periodic reporting
    c. Assistance in development of critical metrics and benchmarks
    d. Maintenance of UM Dashboard

3. **Metrics Defined**
    a. Standard reporting (Quarterly)
    b. Data Mart continued use
    c. Technology Integration (Altruista)

II. Operation Performance

A. Authorization (PA) for Expedited/Urgent/Routine/Retro — Owner: Debra Armas

1. **Goals**
    a. Efficient prior authorization process
    b. Maintain compliance (contractual, regulatory, quality)

2. **Strategic**
    a. Prior authorization oversight
    b. Inter-Rater Reliability

3. **Metrics Defined**
    a. Regulatory requirements
        - Timeliness
        - Classification
        - Member language preference
        - Member notice
        - Provider notice
    b. Clinical decision-making assessments
    c. Medical necessity criteria compliance
    d. Inter-Rater Reliability test scores

B. Denial Letter Process (LTC TAT in development) — Owner: Debra Armas

1. **Goals**
    a. Regulatory compliance.

2. **Strategic**
    a. Denial process oversight.

3. **Metrics Defined**
    a. Regulatory compliance

C. Inter-Rater Reliability (IRR), for Physicians, Nurses, Pharmacy Evaluation for Applying MCG Medical Necessity Review Criteria – UM, Pharmacy and LTSS — Owner: Debra Armas

1. **Goals**
    a. Licensed staff who perform medical necessity review utilizing MCG criteria will demonstrate a 90% pass rate for the IRR

2. **Strategic**
    a. MCG case review
    b. Annual internal evaluation

3. **Metrics Defined**
    a. Evaluate and determine an action plan for outliers with LTC turnaround times
    b. Evaluate and determine an action plan for outliers with CBAS turnaround times

III. Utilization Performance - Ambulatory

A. Delegated Provider Group (PMG) Oversight – Over/Under Utilization and Utilization Trends — Owner: Debra Armas

1. **Goals**
    a. Report over/under utilization trends identified through PMG oversight monitoring
    b. Regulatory, PMG and CalOptima compliance

2. **Strategic**
    a. Data collection, monitoring, analysis and reporting of PMGs utilization trends
    b. Data collection, monitoring, analysis and reporting of PMG organizational determinations, (OD)/Denial trends

3. **Metrics Defined**
    a. Plan of action to be taken for outliers identified
    b. Outcomes for action plan placed

B. CCN – Over/Under Utilization and Utilization Trends — Owner: Francesco Federico

1. **Goals**
    a. Report over/under utilization trends identified by the prior authorization process
    b. Report over/under utilization trends identified by the inpatient authorization process
    c. Regulatory and CalOptima compliance

2. **Strategic**
    a. Data collection, monitoring, analysis and reporting of utilization trends identified
    b. Data collection, monitoring, analysis and reporting of OD/Denial trends

3. **Metrics Defined**
    a. Turnaround time tracking and trending

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- Expedited
- Routine 4-5 days
- Urgent 36 – 48 hrs
- Retro

b. Plan of action to be taken for outliers identified
c. Outcomes for action plan placed

C. Pharmacy Utilization Trends — Owner: Kris Gericke

1. **Goals**
   a. Efficient pharmacy department prior authorization process
   b. Maintain compliance (contractual, regulatory, quality)

2. **Strategic**
   a. Prior authorization process oversight
      - Regulatory compliance
      - PBM delegation
      - Inter-rater reliability

3. **Metrics Defined**
   a. Regulatory requirements
      - Timeliness
      - Classification
      - Member language preference
      - Member notice
      - Provider notice
   b. Clinical decision making assessments
   c. PBM criteria compliance
   d. Inter-rater test scores

D. LTSS (CBAS, LTC) applies to CBAS only (LTC TAT in development) — Owner: Marsha Petersen

1. **Goals**
   a. Regulatory/CalOptima compliance

2. **Strategic**
   a. Data collection, monitoring, analysis and reporting of LTC turnaround time report
   b. Data collection, monitoring, analysis and reporting of Community Based Adult Services (CBAS) turnaround time report

3. **Metrics Defined**
   a. Evaluate and determine an action plan for outliers with LTC turnaround times
   b. Evaluate and determine an action plan for outliers with CBAS turnaround times

IV. Utilization Performance Facility / Inpatient

A. Facility Utilization — Owner: Francesco Federico

i. Facility (Acute, Post Acute)

1. **Goals**
    a. To improve facility utilization
    b. To promote healthcare value ((Q + S)/C)
    c. To improve quality (provider satisfaction, member experience)

2. **Strategic**
    a. Data Generation (quarterly, yearly) by CalOptima, by Comparative (CA state, CalOptima Networks, CCN)
    b. Utilization of concurrent review process (CCR)
        - Evidence based authorization decision making using MCG guidelines
        - Collaboration with case management at facilities, and with CalOptima for complex care patients
        - Hospitalist program promotion including collaboration with / use of contracted hospitalists,, monitoring the acceptance of hospitalist use in our hospital network
        - Enhance data collection from hospitals by fax, by e-mail, by access to hospital electronic records (select facilities) both onsite by CalOptima nurses (select facilities) and offsite by CalOptima nurses
        - Promotion of appropriate medical director to physician, peer to peer communication
        - Promotion of concurrent review medical management collaboration, communication, education
    c. Utilization of care management (CM) resources
    d. Focused UM attention - 1 day admits, readmissions, etc.

3. **Metrics Defined**
    a. Standard facility UM metrics such as admits/1000, bed days/1000, ALOS, ER visits, re-admissions
    b. DATA by LOB, by Comparative: Health Networks vs CCN
    c. CalOptima contracted hospitalist use by facility providers

ii. LTSS Facility UM — Owner: Marsha Petersen

1. **Goals**
    a. To develop a Long Term Care (LTC) strategy that will:
        - Improve utilization of ER visits, readmissions
        - Increase member satisfaction
        - Increase HEDIS scores

2. **Strategic**
    a. Utilize LTSS department resources

3. **Metrics Defined**
    a. Facility UM metrics (admits/1000, bed days/1000, ALOS, ED visits)
    b. Other metrics (hospitalization, nursing home admissions, hospital re-admissions)

B. Emergency Department (ED) Utilization — Owner: Himmet Dajee

1. **Goals**
    a. To achieve appropriate ER utilization by members by providers

2. **Strategic**
    a. 24 hr on call health line (nurse)
    b. Education of members and providers regarding appropriate ER use
    c. Model of care designed to proactively deal with complex care patients
    d. High utilizer tracking, referral to CM
    e. Provider access assurance by monitoring office times, communication, on call
    f. Urgent care promotion: location, services, differences in wait times, differences in services
    g. UM data tracking by network (delegated vs. CCN), by provider

h. Focus on excess use by providers (corrected for acuity, insurance class, co-morbidities)
i. Education of provider/ members on the CalOptima pharmacy limited emergency prescription (outpatient) 2 days(maximum) by pharmacy
j. Mental health issues identification, coordination, complex care management (ICT)
k. Member communication: newsletter (re screenings, medication management, nurse advice line), wellness events (free flu shots, health screening), new member orientation (re ER/UC, NEMT, Taxi, etc.)
l. Provider communication: hours of operation (UC), access availability standards, screening standards, etc.
m. Follow up care post ER visits
n. Improve HEDIS gaps in diabetic care

3. Metrics Defined

a. ER visits/1000
b. Urgent care visits/1000

C. Community Network (CN) Development — Owner: Francesco Federico

1. Goals

a. Promote better quality healthcare value through appropriate utilization, improved services
b. Delineate types of complex care populations served
c. Promote an effective network comparable to existing CalOptima Network
d. Promote better patient experience through expanded member and provider choice through the CN network

2. Strategic

a. UM Data Management (generation, analysis, metrics, action)
b. Multidisciplinary team based management approach
c. Utilization performance enhancement utilizing comparisons to historical, other network, regional, material trends

3. Metrics Defined

a. Facility utilization metrics
b. ED utilization metrics
c. Pharmacy UM performance (TBD)
d. Outpatient utilization performance (TBD)

I. Projects and Initiatives

A. Utilization Management (UM) Medical Management

Owner: Debra Armas

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

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B. Behavioral Health (BH) Integration

Owner: Edwin Poon

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

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C. UM Data Management

Owner: Francesco Federico

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

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II. Operation Performance

A. Authorization (PA) for Expedited/Urgent/Routine/Retro

Owner: Debra Armas

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

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B. Denial Letter Process

Owner: Debra Armas

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

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C. Inter-Rater Reliability (IRR), for Physicians, Nurses, Pharmacy Evaluation for Applying MCG Medical Necessity Review Criteria – UM, Pharmacy and LTSS

Owner: Debra Armas

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

	CBAS	MSSP	LTC	IHSS
Q1				
Q2				
Q3				
Q4				

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III. Utilization Performance - Ambulatory

A. Delegated Provider Group (PMG) Oversight – Over/Under Utilization and Utilization Trends Owner: Debra Armas

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

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B. CCN – Over/Under Utilization and Utilization Trends

Owner: Francesco Federico

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

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C. Pharmacy Utilization Trends

Owner: Kris Gericke

Monitoring	Narrative	Next Steps

Q1	$PMPM CY17
	• Medi-Cal:
	  • Goal: $49.86
	  • Actual: $49.15
	• OneCare
	  • Goal: $385.00
	  • Actual: $360.05
	• OneCare Connect
	  • Goal: $360.50
	  • Actual: $342.57
	
	The 1Q17 average $PMPM costs are below the goal for all lines of business.
		Next P&T Committee meeting is scheduled for May 18, 2017.

Q2		
Q3		
Q4		
Year End		

Outcomes	Results / Metrics	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		

D. LTSS (CBAS, LTC) applies to CBAS only (LTC TAT in development) Owner: Marsha Petersen

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

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IV. Utilization Performance – Facility/Inpatient

A. Facility Utilization

Owner: Francesco Federico

i. Facility (Acute, Post Acute)

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

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A. Facility Utilization

Owner: Marsha Petersen

ii. LTSS Facility UM

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

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B. Emergency Department (ED) Utilization

Owner: Himmet Dajee

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

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C. Community Network (CN) Development

Owner: Francesco Federico

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

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2016 Utilization Management Program Evaluation

Special Board of Directors' Quality Assurance Committee Meeting
May 22, 2017

Tracy Hitzeman, RN CCM
Executive Director, Medical Management

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2016 UM Program Evaluation

- Represents the analysis of clinical and service indicators to determine if the Utilization Management (UM) Program has achieved its performance goals during the year
- Based upon the 2016 UM Work Plan
- Provided guidance for the 2017 UM Program

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Accomplishments

Utilization Management:

- Developed audit tools to monitor and improve UM processing quality and timeliness
- Instituted the Notice of Action (NOA) Team to improve quality and ensure timeliness when adverse determinations are made
- Reduced prior authorization requirements for services with low to no denial activity
- Established a Hospitalist Program serving CalOptima's four (4), highest volume facilities
- Assembled a Health Network Denial Task Force to share best practices and challenges faced when drafting denial letters

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Accomplishments (cont.)

- UM Delegated Provider Oversight
  - Member letter audits performed by Audit and Oversight assuring letters are written in clear language members can understand
- Prior Authorization Operational Performance
  - Turnaround times met targets throughout the year for UM, Pharmacy, LTSS and CBAS
  - Inter-Rater Reliability scores were 100% for UM, Pharmacy, LTSS and Physicians for applying medical necessity criteria
- Pharmacy Operational Performance
  - Retail pharmacy per member per month (PMPM), costs for all lines of business were below targets
  - Ongoing monitoring of drug costs

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Opportunities 2017

- Focus on Over/Under Utilization tracking, trending, analysis and reporting
- Technology enhancements for CalOptima's medical management system, Guiding Care; and MCG integration
- Continue efforts with health networks to better align denial letter initiatives with regulatory standards
- Reevaluate inpatient facility goals
- Continue to focus on UM internal auditing to align with regulatory standards

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2016 Utilization Management Workplan Evaluation

OneCare Connect, OneCare and Medi-Cal

I Projects and Initiatives:

A. Utilization Management

2016 was a year of enlightenment for the UM process. The CMS mock audit brought to the forefront new areas to focus on while older areas require more focus. Departmental audit tools have been developed to measure UM's compliancy. Additional tools are needed to accurately monitor denial activity. Some CORE reports currently in production require modification and/or merger to capture complete UM data. Also, for 2016 many new teams were organized to facilitate an expert approach to all lines of businesses and a new team to process Notice of Action letters. UM also made an attempt to secure an RFP for transplant facility contracts however, per a financial impact analysis demonstrated an RFP to not be as cost effective as current LOAs in place. UM has assumed accountability for managing the functions of the Benefit Management Subcommittee (BMSC). Implemented a RightFax configuration by which faxes are sent to email boxes. This increases transparency and facilitates better incoming referral activity.

B. Behavioral Health

MCP MH utilization has increased throughout the year and is up from .8-1% from 2015. ABA hourly utilization PMPW has leveled in 2016 and has slightly decreased. Bed days for 2016 continue to trend down in 2016.

C. UM Data Management

Hospitalist program launched following data collection establishing the need for a hospitalist program. Communication was initiated with 3 hospitalist groups with the hospitalist program was launched mid-year.

Analysis of UM patterns for all health networks shows targets were not met. For 2017, CalOptima will re-evaluate benchmarks established for hospital bed day targets.

D. UM Delegated Provider Oversight

Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests – As expected with the change in auditing methodology, monitoring results showed that a decrease occurred in the majority of the audit areas with the exception of Urgent Letter scores and Timeliness for Deferrals, which remained consistent. The following are areas that contributed to the lower scores and where networks have been issued a corrective action plan request:

The lower scores for timeliness were due to the following reasons:

- Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days);
- Failure to meet timeframe for member notification (Routine – 2 business days);
- Failure to meet timeframe for provider initial notification (24 hours); and
- Failure to provide proof of successful initial written notification to requesting provider (24 hours).

The lower scores for clinical decision making (CDM) were due to the following reasons:

- Failure to cite the criteria utilized to make the decision;
- No indication of adequate clinical information obtained to make the decision to deny; and
- No indication that the medical reviewer was involved in the denial determination.

The lower letter scores were due to the following reasons:

- Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document;
- Failure to provide letter with description of services in lay language;
- Failure to provide letter in member's primary language;
- Failure to include name and contact information for health care professional responsible for decision to deny;
- Failure to provide information on how to file a grievance;
- Failure to outline reason for not meeting the criteria in lay language;
- Failure to provide referral back to Primary Care Provider (PCP) on denial letter; and
- Failure to notify provider of delayed decision and anticipated decision date.

• OneCare Utilization Management (UM): Prior Authorization (PA) Requests –Monitoring results showed an increase in the majority of the audit areas with the exception of Timeliness for EIOD, Clinical Decision Making for EIOD, and Letter Sore for SOD. The following are areas that contributed to the lower scores and where networks have been issued a corrective action plan request:

The lower letter scores were due to the following reasons:

- Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days);
- Failure to meet timeframe for member notification (Routine – 2 business days);
- Failure to meet timeframe for provider initial notification (24 hours); and
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- No indication of adequate clinical information obtained to make the decision to deny; and

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− Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document;
− Failure to provide letter with description of services in lay language;
− Failure to provide letter in member's primary language;
− Failure to include name and contact information for health care professional responsible for decision to deny;
− Failure to provide information on how to file a grievance;
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− Failure to provide referral back to Primary Care Provider (PCP) on denial letter; and
− Failure to notify provider of delayed decision and anticipated decision date.

• OneCare Utilization Management (UM): Prior Authorization (PA) Requests –Monitoring results showed an increase occurred in the majority of the audit areas with the exception of Timeliness for EIOD, Clinical Decision Making for EIOD, and Letter Sore for SOD. The following are areas that contributed to the lower scores and where networks have been issued a corrective action plan request:

The lower letter scores were due to the following reasons:

− Failure to use approved CMS letter template;
− Failure to provide letter with description of services in lay language;
− Failure to offer to discuss decision with a reviewer;
−Failure to outline reason for not meeting the criteria in lay language; and
− Failure to use the CalOptima logo on letter template.

The lower scores for timeliness were due to the following reasons:

− Failure to meet time frame for member oral notification (Expedited – 72 hours);
− Failure to meet time frame for member written notification (Expedited – 72 hours); and
− Failure to meet time frame for provider notification (Expedited – 24 hours).

The lower scores for clinical decision making (CDM) were due to the following reasons:

− Failure to cite the criteria utilized to make the decision;
− No indication of adequate clinical information obtained to make the decision to deny; and
− Failure to have evidence of appropriate professional making decision.

• OneCare Connect Utilization Management (UM): Prior Authorization (PA) Requests –Monitoring results showed an increase occurred in the majority of the audit areas with the exception of Timeliness for Urgent, Timeliness for Routine, and Timeliness for Denials. The following are areas that contributed to the lower scores and where networks have been issued a corrective action plan request:

The lower scores for timeliness were due to the following reasons:

− Failure to meet timeframe for member notification (Routine - 2 business days);
− Failure to meet timeframe for provider initial notification (24 hours); and
− Failure to provide proof of successful initial written notification to requesting provider (24 hours).

The lower letter scores were due to the following reasons:

− Failure to provide letter in member's primary language; and
− Failure to provide letter with description of services in lay language.

E. Utilization Outlier Trends

- The Medi-Cal line of business exceeded goals for all Networks.
- For 2017 UM metrics will be revaluated.

Shared Risk - MC	Q1	Q2	Q3	Q4
SPD				
ALOS	5.6	5	4.5	4.7
Bed Days/PTMPY	1065	1147	946	921
Readmissions	28%	28%	21%	23%
ED Visits/PTMPY		785	748	728
TANF >18				
ALOS	4	3.9	3.9	3.7
Bed Days/PMPY	309	314	333	324
Readmissions	17%	16%	15%	14%
ED Visits/PTMPY		438	456	444
TANF<18				
ALOS	3.1	2	2.8	2.6
Bed Days/PTMPY	51	20	20	38
Readmissions	3.8%	5.9%	2.5%	5.1%
ED Visits/PTMPY		309	307	335

- The OCC line of business hasn't had goals set due to time needed to gather and trend data.

Shared Risk - OCC	Q1	Q2	Q3	Q4
SPD				
ALOS	6.4	6.4	6.6	9.7
Bed Days/PTMPY	3428	2305	2828	5539
Readmissions	19%	32%	25%	22%
ED Visits/PTMPY	788	877	697	1073
TANF>18				
ALOS	7.6	4.4	2.7	2.2
Bed Days/PTMPY	5768	2598	1964	1928
Readmissions	6.3	11.7	1.78	3.4
ED Visits/PTMPY	1559	900	1262	955

- Goals have not been set for the OC line of business.

OC	Q1	Q2	Q3	Q4
ALOS	6	7.8	8.2	4.1
Bed Days/PTMPY	1236	1807	1661	843
Readmissions	10.4%	10.3%	14.2%	14.6%
ED Visits/PTMPY	420	593	668	403

- On average goals are met for CCN-COD

CCN-COD	Q1	Q2	Q3	Q4
SPD				
ED Visits/PTMPY	1022	934	1049	1016
TANF>18				
ED Visits/PTMPY	802	801	954	891
TANF<18				
ED Visits/PTMPY	603	549	299	328

Toward the later part of 2016, over and under utilization management became the focus. Through the regulatory mock audits, it was observed, metrics that were being tracked and trended, however, reporting was not consistent. As a result, a UM/QI dashboard was drafted to capture data in once location to be reported at UMC for 2017.

II Operational Performance

A. Prior Authorization for Expedited / Urgent / Routine / Retro Requests - UM - Non Pharmacy

Annual summary of referral volume, 4 quarter average - includes online referral submission:

Authorization Processed (TAT)	Referrals Processed	Turnaround Time Compliancy
Routine: 30,184 9.48%	Faxed: 29,095	Routine TAT: 4.09 days /
Urgent: 4,508 97.37%	COLAS: 25,013	Urgent TAT: 2.06 days /
Retro: 2,167 98.11%	Total: 52,869	Retro TAT: 16.34 days /
Total: 36,871	Online: 49.31%	

Prior Authorization activity has remained relatively stable and within compliant turnaround times with expected fluctuations in volume depending on the time of the year. To maintain compliant turnaround times, overtime and temporary staff were needed.

B. Prior Authorization for Expedited / Urgent / Routine / Retro Requests - Pharmacy

Annual summary of referral volume, 4 quarter average:

One Care: 100%
OnCare Connect: 99.98%
Medi-Cal: 99.45%

Pharmacy Prior Authorization turnaround time processing time are above goal of 99% for all lines of business.

C. Authorization for Expedited / Urgent / Routine / Retro Requests - LTSS (CBAS, LTC) Applies to CBAS Only (LTAC TAT in development)

- LTSS consistently met or exceeded required turnaround times throughout the year; goal met with 100% compliance.
- CBAS CEDT TAT: Average of 14.60 days
- CBAS Routine TAT: Average of 2.11 days
- CBAS Expedited TAT: 1 processed throughout the year with a TAT of 2
- LTC Routine TAT: Average of 1.39 days
- LTC Urgent TAT: Zero (0) processed throughout the year.

D. Online Referral Rate Submission Increase in Non-Network Providers (COD and CCN)

Online referrals submissions over 4 quarters was 46.31% Addition options being reviewed to enhance the Cerecons portal to facilitate better utilization.

E. Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review in UM, CBAS, MSSP, LTC by annual review of scheduled auths

The IRR was administered in compliance with the UM Program. All staff who apply medical necessity review successfully exceeded the annual goal of 90%.

UM - 100%
Physicians - 100%
Pharmacy - 100%
LTSS - 100%

F. Denial Letter Process

Performance has been steady throughout 2016. Timeliness has been compliant with regulatory standards.
UM and A&O will continue to review audit findings prior to being posted. New processes have been implemented in 2016 to facilitate the audit process: a Member Material Approval Committee has been established for all member-facing materials to be vetted and approved. The audit template

utilized by A&O has been revised to reflect correct fields to be audited. Ongoing application for lay language and criteria continue to be an issue and will be an ongoing effort for 2017.

- Turnaround times were compliant for 2016.

III Utilization Performance

A. Facility Utilization - Facility Acute Care

Monitoring 1 day admissions and LTAC stays. Started Hospitalist program. Reported general bed day improvement, however, need to relook at bed day goals for 2017.

B. Facility Utilization - LTSS Facility UM

- CBAS achieved the goal of 2% for LTC admissions; average admission percentage of 0.6%.
- CBAS did not meet the goal of 2.5% for Hospital readmissions; average readmission percentage of 22%.
- CBAS did not meet the goal of 9% for Emergency Department Visits; average percentage of 11.5%.

C. Pharmacy Utilization

- Retail Pharmacy - $PMPM costs for all LOB are below goal
- Diabetes drug utilization is the highest drug class for OCC and second highest for MCAL. .
- Hepatitis C drug utilization has leveled off in CY16 but remains the highest cost drug class for MCAL
- Hydrocodone/APAP is the 5th highest drug for Medi-Cal by # Rxs, down from 4th highest in 1Q16.
- Physician-Administered Drug Claims
- Antineoplastics remain the highest cost class.

  Medi-Cal: Goal $ PMPM $47.50, actual CY16 $46.67
  OC: Goal $ PMPM $397.80, actual CY16 $365.43
  OCC: Goal $ PMPM $397.80, actual CY16 $343.43

IV Summary

Overall, during 2016, enrollment started to level off. Programs have been in place for a full year cycle. This provides an opportunity to take a look at program effectiveness during 2017.

For 2017:

- Staff oversight and internal auditing for UM to better align with NCQA, DHCS and CMS elements.
- Focus on over/under utilization tracking, trending and reporting has been enhanced and centralized to provide a global view of how initiatives have a relationship and what actions are needed based on trends identified.
- UM inpatient facility goals will be re-evaluated and set as identified through evaluation.

- Align denial language to be member friendly and regulatory compliant across the networks.
- Ongoing evaluation of the Prior Auth List to further streamline the authorization requirements for facilitate member/provider satisfaction.
- Enhancements to the Medical Management authorization module in Guiding Care to facilitate quicker turnaround times during the prior authorization process.
- MCG integration with Guiding Care to facilitate better flow with the prior authorization process.

2016 Quality Improvement Evaluation

Special Board of Directors' Quality Assurance Committee Meeting
May 22, 2017

Caryn Ireland
Executive Director, Quality and Analytics

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2016 QI Program Evaluation

- Represents the analysis of the core clinical and service indicators to determine if the Quality Improvement (QI) Program has achieved its key performance goals during the year
- Is based on the 2016 QI Work Plan
- Provided guidance for the 2017 QI Program

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Accomplishments

- Behavioral Health Integration:
  - Participation in Integrated Care Teams (ICTs) for coordination of care
  - Continued monitoring and implementation of initiatives to improve behavioral health Healthcare Effectiveness Data and Information Set (HEDIS) measures
  - Assured implementation of the new managed behavioral health care organization (MBHO) Magellan Healthcare, Inc. by January 1, 2017

- Case Management:
  - Continued efforts to improve outreach and collection of health risk assessments for OneCare, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) and SPD members
  - Continued work with health networks on identification of complex cases
  - Achieved high member satisfaction with case management programs

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Accomplishments (cont.)

- Long-Term Support Services (LTSS)
  - Monitored Community-Based Adult Services (CBAS), developed baselines for In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP) and Long-Term Care (LTC) in the areas of Acute Admits, Emergency Department Utilization and All-Cause Readmission rates
  - Continued program development around safety, quality and clinical initiatives

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Accomplishments (cont.)

- Safety Program:
  - Implemented pharmacy management programs, including:
    - Monitoring underutilization of asthma, diabetes, cardiovascular and osteoporosis medications
    - Monitoring overutilization of opioid medications
    - Ongoing review of specialty drug utilization (Hepatitis C)
  - Implemented initiatives for:
    - Appropriate Testing for Children with Pharyngitis (CWP)
    - Appropriate Testing for Children with Upper Respiratory Infection (URI)
  - Continued monitoring implementation of the pharmacy benefit manager (PBM)
  - Assured timely completion of facility site reviews and physical accessibility review surveys
  - Improved turnaround time (TAT) for resolving potential quality of care issues (PQI); 1451 PQI cases were closed in 2016
  - Provided quality and safety monitoring for CBAS and skilled nursing facilities

Accomplishments (cont.)

- Continued enhancement of population health/disease management (DM) programs
  - Completed targeted incentive program for members with diabetes either missing an HbA1c test or a HBA1c test >9
  - Continued the Chronic Care Improvement Project (CCIP) on controlling blood pressure
  - Ongoing member engagement and interventions for members with asthma, diabetes and heart failure
  - Completed the Group Needs Assessment and submitted timely to Department of Health Care Services (DHCS)
  - Implemented reporting tools and educational sessions for the health networks to improve completion of the DHCS Initial Health Assessment

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Accomplishments (cont.)

- Customer Service
  - Met Average Speed to Answer (ASA) and abandonment rate goals every quarter for Medi-Cal and OneCare;
- Cultural & Linguistics
  - Fielded the cultural needs and preferences study and implemented a plan of action:
    - Promoted interpreter services to the membership
    - Included findings in quarterly awareness educational seminars
    - Refined goals and objectives based on findings from the study
  - Standards and ratios (member/practitioner ratios) monitored
- Grievance and Appeals (GARS)
  - Continued to evaluate GARS by issue type and provider specialty
    - Top issues include: Delay in services/follow-up and rudeness of staff
    - Top Specialty remains primary care providers
  - Evaluated highest frequency of complaints by provider for trends

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Accomplishments (cont.)

- Participated in three performance improvement projects (PIP) for DHCS and one quality improvement project (QIP) for Centers for Medicare & Medicaid Services (CMS):
  - Two projects on improving diabetes care
  - One project on reducing the 30-day readmission rates for OneCare Connect members

- Member Experience
  - Continued actions to improve Consumer Assessment of Healthcare Provider (CAHPS) results:
    - Getting needed care, getting care quickly, how well doctors communicate, customer service
  - Implemented Clinical Group-CAHPS to identify patient-specific/provider-specific issues and opportunities
  - Completed detailed review of and subsequently updated prior authorization list to eliminate unnecessary processes

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Accomplishments (cont.)

- Access and Availability Monitoring
  - Completed evaluation of network adequacy
  - Processed 816 initial and recredentialing applications for the CalOptima Community Network, monitored health network credentialing processes through audit & oversight
  - Assured members were notified within 30 days when a primary care provider was terminated
  - Completed Timely Access study to determine appointment wait times and access to practitioners

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Accomplishments (cont.)

- Implemented activities designed to improve the clinical quality measures (HEDIS and Stars measures)
  - Analyzed HEDIS and Stars performance based on 2015 results (HEDIS 2016)
  - Launched updated Pay-for-Value Program
  - Implemented various initiatives for chronic care and preventive care improvement

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Opportunities 2017

- Support CalOptima's care management model and population health management approach, stratifying the population based on health needs, conditions and issues
- Address ongoing quality of care, quality of service and safely of clinical care
- Continue improvement and trending of HEDIS, Stars and CAHPS measures to assess performance in quality and safety of clinical care and service

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Opportunities 2017 (cont.)

- Implement focused projects on improving continuity and coordination of care between medical and behavioral health;
- Partner with our health networks on quality improvement activities, including:
  - Continue implementation and further development of Pay-for-Value programs
- Partner with our new MBHO and PBM on shared responsibility for patient safety and clinical quality improvement initiatives

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2016

QUALITY IMPROVEMENT EVALUATION

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2016 QUALITY IMPROVEMENT EVALUATION

SIGNATURE PAGE

Quality Improvement Committee Chair:

Richard Bock, M.D.
Deputy Chief Medical Officer

Date

Board of Directors' Quality Assurance Committee Chair:

Paul Yost, M.D.

Date

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2016 Quality Improvement Evaluation

Executive Summary

The 2016 Annual Quality Improvement (QI) Program Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved its key performance goals during the year. This evaluation focuses on quality activities undertaken during calendar year 2016 to improve the health care and service available to members of CalOptima. The 2016 QI Evaluation also identifies key areas that offer opportunities for improvement to be implemented or continued as part of the 2017 QI Program and its work plan

Program Structure

In 2016, CalOptima sustained the development of its QI Program and infrastructure that included:

- A written evaluation of the 2015 QI Program reviewed and approved by the QI Committee (QIC) on February 9, 2016, and the Board of Director's Quality Assurance Committee (QAC) on March 23, 2016.

- A written QI Program Description for 2016 included structure, scope, and process which was reviewed and approved by the QIC on February 9, 2016 and the Board of Director's QAC on March 23, 2016.

- A written work plan that included clinical, patient safety and service monitors to evaluate quality activities, and that were reviewed and approved by the QIC on February 9, 2016 and the Board of Director's QAC on March 23, 2016. The CalOptima QI Medical Director provided direction and supervision of QI activities at the direction of the Chief Medical Officer (CMO). Overall oversight of the QI Program was provided by the Board of Directors.

2016 QI Program Goals Accomplishments:

In 2016, CalOptima sustained the considerable and major steps in the development of its QI infrastructure, which included the achievement of National Committee for Quality Assurance (NCQA) Commendable Status. The QI Program incorporates continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies):

- It was organized to identify and analyze significant opportunities for improvement in care and service.
    - Accomplished as evidenced by the following summaries and the completed QI Work Plan.

- It fostered the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress toward established benchmarks or goals.
    - Accomplished as evidenced by multidisciplinary committees, participation by practicing network providers, company-wide subcommittees and collaboration with delegated entities.
- It focused on QI activities carried out on an ongoing basis to promote efforts that support the identification and correction of quality of care issues.
    - Accomplished as evidenced by the following summaries and the completed QI Work Plan.
- Maintained a functional and viable combined QIC to oversee all lines of business.
- Developed a new format for the 2016 QI Work Plan.
    - This format allowed the organization to evaluate and track the effectiveness of the QI Program throughout the year.
    - Quarterly status updates, evaluations, and goals for the next quarter were documented and tracked.
- Continued activities in preparation for the 2018 NCQA accreditation survey.

QI goals and objectives are to monitor, evaluate and improve:

- The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
    - Accomplished as evidenced by QI reviews of Facility Site Reviews, follow up with potential quality issues with practitioners and facilities, monitoring of member grievances and complaints, and review of delegated entities review processes.
    - Collaboration with the Compliance department for identification of potential quality issues that may involved fraud, waste, abuse, confidentiality, security, etc.
    - Accomplished as evidenced by the Measures Worksheet progress on various HEDIS, CAHPS and STARS metrics.
- The important clinical and service issues facing the Medi-Cal population relevant to its demographics, high-risks, disease profiles for both acute and chronic illnesses, and preventive care.
    - Accomplished as evidenced by member group needs assessment.
    - Aligned with Clinical Practice Guidelines.
    - Includes Medical and Behavioral Health population management activities.
- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually acting on at least three identified opportunities.
    - Accomplished as evidenced by the strong increase in interdisciplinary care team meetings, which include primary care, specialty and behavioral health practitioners.
- The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
    - Accomplished as evidenced by the access and availability studies and summary of activities from the Access and Availability QI Work Team

- The qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
    - Accomplished as evidenced by a solid credentialing and peer review process.
- Member and provider satisfaction, including the timely resolution of complaints and grievances.
    - Accomplished as evidenced by Member Experience Surveys and Reports, the Primary Care Provider (PCP) Satisfaction Survey and the summary of the Grievance & Appeals Resolution Services (GARS) activities.
- Risk prevention and risk management processes.
    - Accomplished as evidenced by sound Potential Quality Issue (PQI) process to identify and address high-risk practitioners.
- Compliance with regulatory agencies and accreditation standards.
    - Accomplished through participation in mock and regulatory audits.
- Annual review and acceptance of the UM Program Description and Work Plan.
    - Accomplished as evidenced by the acceptance of the UM Program Description and Work Plan at QIC on February 9, 2016, and the QAC on March 23, 2016.
- The effectiveness and efficiency of internal operations and operations associated with functions delegated to the contracted medical groups.
    - Accomplished as evidenced by progress reports by individual departments and quarterly delegation reports.
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values.
    - Accomplished as evidenced by achievements in cross-departmental activities to improve member experience, expansion of the pay-for-value program, further focus on opioid epidemic.
- Compliance with Clinical Practice Guidelines (CPGs) and evidence-based medicine
    - Accomplished as evidenced by the annual review and acceptance of updated CPGs for medical and behavioral guidelines.
- Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.
    - Accomplished as evidenced by Audit & Oversight department quarterly reports of functions delegated to the Health Networks or conducted by internal departments.
- Promote patient safety and minimize risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and work with appropriate committees, departments, staff, practitioners, provider medical groups, and other related health care delivery organizations (HDOs) to assure that steps are taken to resolve and prevent recurrences.
    - Accomplished as evidenced by summary of the Quality Improvement Work Teams' activities and the QIPs, PIPs and CCIP.
    - Accomplished by ongoing monitoring and implementation of pharmacy initiatives including over/under utilization and specialty drug utilization.
    - Accomplished by CBAS, SNF/LTC, MSSP and IHSS ongoing monitoring and reporting of Critical Incidents.

QUALITY AND CHRONIC CARE IMPROVEMENT

CalOptima has built a healthy community for our members through our QI Projects (QIP) and Chronic Care Improvement Programs (CCIP). In 2016, these programs revolved around improving diabetes care, controlling blood pressure, reducing readmissions, increasing the rate of initial health assessments, increasing adherence to evidence based guidelines in the treatment of heart failure and improving transitions of care. In addition to these projects, eight QI work teams were designated to focus and target specific areas for improvement.

Those areas are the following:

- Access and Availability Team
- Adult Care Team
- Appropriate Medication Management Team
- Behavioral Health Team
- Child and Adolescent Team
- Chronic Care Team
- Member Experience Team
- Prenatal/ Postpartum Team

CalOptima is committed to playing a major role in the continuous improvement of quality health care to our members. The program evaluation outlined in the subsequent pages is comprehensive and robust. Although individual measures may vary in their level of success, our overall effort has been a considerable success. As we continuously monitor our performance and refine our methodologies, we are confident that our QI efforts will continue to develop and make a positive impact on the quality of health care for our members.

QI Work Plan
The QI Work Plan was developed to implement and evaluate actions to achieve the above goals and objectives. See Attachment A for details and results of the 2016 QI Work Plan.

SUMMARY OF ACCOMPLISHMENTS, BARRIERS AND ACTIONS

CalOptima has developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care management, disease management and complex care management. Ongoing data analysis across multiple areas provides the basis for identifying over/under utilization of services. Our approach also uses support systems for our members with vulnerabilities, disabilities and chronic illnesses.

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's QAC. Table 1 shows the frequency of the QIC and QAC meetings during 2016.

Table 1:

Committee Meeting Dates				
QAC (Quarterly)	3/23/2016	5/18/2016	9/21/2016	11/16/2016
QIC (Monthly, at least 8 times/year)	01/13/2016 02/09/2016 03/08/2016	04/13/2016 05/10/2016 06/18/2016	08/09/2016 09/13/2016	10/04/2016 11/08/2016 12/13/2016

Committee and Subcommittee Reports:
Six committees and subcommittees support CalOptima's Quality Improvement Program and report to QIC at least quarterly. These committees are:

1. **Credentialing Peer Review Committee (CPRC):**
   - The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to ensure that all practitioners and providers that serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC reviews, investigates, and evaluates the credentials of all internal CalOptima medical staff for membership, and maintains a continuing review of the qualifications and performance of all external medical staff. In 2016, CPRC met nine times, approved 400 initial applications and re-credentialed 417 providers.

2. **Behavioral Health Quality Improvement (BHQI) Committee:**
   - The BHQI reviews data and information to ensure members receive timely and satisfactory behavioral health care services, enhancing continuity and coordination between physical health and behavioral health care providers, monitoring key areas of services to members and providers, and identifying areas of improvement towards the vision of bi-directional behavioral health care integration. In 2016, BHQI met quarterly and addressed key areas of concern, as well as provided oversight to the selection and implementation of the new MBHO on 1/1/17.

3. **Utilization Management Committee (UMC):**
   - The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC monitors the utilization of health care services by CalOptima Direct and Medi-Cal overall through the delegated Health Maintenance Organizations (HMO), Physician/Hospital Consortia (PHC), Shared Risk Medical Groups (SRG), Managed Behavioral Healthcare Organization (MBHO), and Physician Medical Groups (PMG) to identify areas of under or over utilization that may adversely impact member care. In 2016, the UMC met quarterly; it monitored medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. The UMC also reviewed and approved the 2016 Utilization Management annual evaluation on 02/23/17.

4. **Pharmacy & Therapeutics (P&T) Subcommittee:**
    - The P&T is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost effective pharmaceutical care for all CalOptima members and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. In 2016, the P&T met quarterly and addressed key pharmacy issues facing our providers and members.

5. **Grievances & Appeals Resolution Services (GARS) Subcommittee:**
    - GARS serves to protect the rights of our members, and to promote the provision of quality health care services and enforces that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. Quarterly, the GARS Subcommittee reviews the member trend report, which includes rate of complaints (appeals/grievances), a breakdown of complaint by type and interventions based on trends. In 2016, GARS met quarterly and addressed complaints & appeals issues.

6. **Long-Term Services and Supports (LTSS) Subcommittee:**
    - The LTSS assists CalOptima in the development, implementation, and evaluation of establishing criteria and methodologies to measure and report quality standards with Home and Community Based Services (HCBS) and in Long-Term Care (LTC) facilities where CalOptima members reside. In 2016, LTSS met quarterly and addressed the OCC enrollment project, progress on the LTSS Performance Improvement Project (PIP), IHSS and CBAS staffing and utilization measures, and nursing facility (NF) quality measures.

Each Committee reported quarterly to QIC; minutes were submitted and approved. Presentations from each committee focused on the QI or UM Work Plans and included reports on progress-to-date, issues and/or barriers identified collaboration across functional areas, and any operational concerns.

BEHAVIORAL HEALTH INTEGRATION

The Behavioral Health Integration (BHI) department manages the BHQI subcommittee, which reports up to the QIC. The BHQI meets quarterly to: monitor and identify improvement areas of member and provider services, ensure access to quality BH care, and enhance continuity and coordination between behavioral health and physical health care providers.

The BHQI is chaired by the Medical Director of BHI and comprised of members internal and external to CalOptima including delegated networks, community partners, behavioral health practitioners, and the Orange County Mental Health Plan (MHP) administered by the Orange County Health Care Agency (OC HCA). The Chair is responsible for leading and presenting

subcommittee recommendations to the QIC. In addition, a BHQI workgroup met regularly throughout 2016 for additional work and analysis on the Quality initiatives. This group served to address suggestions from the BHQI that assisted with strengthening interventions, data review and key areas for improving the member experience.

QUALITY OF CLINICAL CARE: INTEGRATION OF BEHAVIORAL HEALTH SERVICES

Key Findings:

Coordination of Care

- ***Goal: To monitor and identify opportunities to improve continuity and coordination of care between mental and physical health needs through the Interdisciplinary Care Team (ICT)/Interdisciplinary Care Plan (ICP) or other processes***
- BH vendors (CHIPA and Windstone) reported ICT participation data quarterly
- MHP reported ICT participation metrics during monthly collaboration meetings
- Goal of 10% improvement in ICT participation over 2015 (previous year)
  - Windstone reported 100% participation in ICTs
  - CHIPA reported low participation rates due to lack of understanding of the requirements
  - MHP reported low participation rates due to the parameters imposed for information sharing
  - BHI clinicians attended all CCN ICTs

HEDIS

- ***Goal: To design and implement activities to improve BH HEDIS measures and meet the organizational goal of at least the 50% percentile by year end***

Medi-Cal (M/C)					
HEDIS Measure	**Q1 2016**	**Q2 2016**	**Q3 2016**	**Q4 2016**	**NCQA 50th Percentile**
AMM Acute phase	49.46%	54.90%	55.10%	54.90%	50.51%
AMM continuation phase	23.97%	31.10%	39.49%	39.85%	34.02%
ADD	16.22%	17.00%	38.47%	38.84%	40.79%
ADD continuation phase	2.65%	10.90%	38.94%	40.07%	50.61%

OneCare (OC) / OneCare Connect (OCC)					
HEDIS Measure	**Q1 2016**	**Q2 2016**	**Q3 2016**	**Q4 2016**	**NCQA 50th Percentile**
AMM Acute phase	55.66%	60.70%	63.50%	63.34%	68.66%
AMM continuation phase	37.74%	41.90%	47.30%	46.97%	54.76%
FUH 7 day	11.59%	48.40%	30.30%	26.92%	31.58%
FUH 30 day	7.25%	54.70%	34.80%	31.20%	52.08%

Interventions:

Coordination of Care

- ICT participation was included as a topic in all BHQI, Health Care Appraisals (HCA)/CalOptima collaboration, and Joint Operation Meetings (JOM)
- Presented at the Health Network (HN) forums to increase the opportunity for participation by the primary care providers (PCP) in collaboration with BH providers
- Modified the ICT/ICP invitation process in collaboration with MHP to help increase the county BH providers participation
- Developed ICT/ICP information form to allow for ease of completion by participating parties
- Collaborated with MHP to modify their specific Information Sharing Form to increase level of participation
- Developed new work flows with Magellan, CalOptima's new MBHO, to mitigate the frequency of missed opportunities for provider and member participation

HEDIS

- Reviewed specifications for each measure to ensure they were accounted for in interventions and data results
- Evaluated current interventions for effectiveness based on rate trends
- Addressed technical issues with current interventions and identified opportunities for additional interventions
- Utilized BHQI meetings to obtain feedback from community partners and identify best practice ideas
- Met with HEDIS and Pharmacy subject matter experts to dissect areas where the measures were presenting challenges to address

	• Continued to distribute educational brochures and send prescriber letters to the top 10 Medi-Cal providers • Continued to send letters to members and providers reminding them about the importance of follow-up care for Medi-Cal children prescribed attention-deficit/hyperactivity disorder (ADHD) medications • Monitored MHBO performance on follow up appointments for OC and OCC members after hospitalization and provided support in mitigating barriers faced
Analysis:	**Continuity & Coordination of Care** • Active coordination with MBHO and MHP helped improve participation of BH providers in Medi-Cal ICT/ICP planning. • MBHO continued to participate in all OC/OCC ICT requests • CalOptima partnered with Magellan to identify services that encompass Medi-Cal, OC and OCC. • Workflows were developed collaboratively to mitigate the frequency of missed opportunities for provider and member participation. **HEDIS** • Medi-Cal antidepressant medication management (AMM): Data compiled through November 2016 shows this measure met the 50th percentile. • Medi-Cal ADD: Data compiled through November 2016 showed highest rates since 2014 but not quite at 50th percentile mark. • OC/OCC AMM: Data compiled through November 2016 showed the highest rates in the past 2 years; just shy of the 50th percentile. • OC/OCC Follow-up after Hospitalization (FUH): Data compiled through November 2016 showed the lowest rates in 2016, fell below the 50th percentile. • Shared Q3 and Q4 data with Magellan (new MBHO for 2017), and identified opportunities on methods to work through these measures and collaborate on opportunities to improve rates for 2017.
Barriers:	**Coordination of Care** • Lack of commitment from CHIPA to support ICT participation • MHP requires member to sign a release of information form before County BH providers can participate in ICTs • Title 42 Code of Federal Regulations (CFR), Confidentiality of Substance Use Disorder Patient Records, limits the ability for agencies to share information regarding substance use disorder treatment • The invitation process does not provide enough time for providers to plan for attending the ICTs • Extra steps needed to determine who are the member BH providers **HEDIS** • Several barriers to the interventions were discussed during BHQI meetings and brought to BHQI workgroup for further investigation

	• Ability to impact how members respond to treatment was discussed along with how to engage providers with national and CalOptima suggested best practices • Data issues throughout the year impacted the scores for some measures • Windstone stopped providing bridge appointments in 2016 for members discharged from hospital, which resulted in drop of performance for FUH (a bridge appointment is where a clinician meets with the member at the hospital on day of discharge to discuss follow-up care needs.). • Providers may not be documenting treatment appropriately • Member perception of treatment goals may lead to non-compliance • Population treated and variety of types of service locations for access to care has been considered as barriers

QUALITY OF CLINICAL CARE: CLINICAL BH PRACTICE GUIDELINES ADOPTION FOR MEDI-CAL LINE OF BUSINESS

Key Findings:	• ***Goal: Adoption of CPGs; at least two (2) behavioral health will be reviewed and adopted.*** • BH Clinical Practice Guidelines (CPGs) were reviewed and adopted
Interventions:	• Reviewed ADHD and Depression CPGs to ensure they were up-to-date • Updated guidelines were presented at BHQI for additional review and comment • Considered feedback from committee members, including challenges or submissions of alternate guidelines • Allowed for consensus and adoption of selected guidelines • Posted CPGs on CalOptima's website under "practitioner / provider tools" for provider use
Analysis:	• ***Goal met. CPGs adopted at May 3, 2016 meeting.***
Barriers:	• Consideration should have been given for managed care populations and services when choosing CPGs.

QUALITY OF SERVICE AND QUALITY OF CLINICAL CARE: REVIEW OF BH PROVIDERS COMMUNICATIONS WITH PCPS

Key Findings:	• ***Goal: 85% of chart audit shows communication between primary care providers and behavioral health providers*** • Continuity and Coordination of Care between medical care and behavioral health care was accomplished by assessment of medical records for annotation of communication between primary care providers and BH providers. • 15 charts were chosen from 3 high volume BH providers at 3 group practices for coordination of care. • ***Goal was not met with only 60% of the chart records indicating record of Release of Information form to be able to speak with the PCP*** o Additionally only 22% of the charts contained documentation that communication had actually occurred

Interventions:	• CHIPA reviewed 15 charts from 3 high volume providers at 3 group practices for coordination of care with 6 practitioners reviewed: 2 MDs, 2NPs, 1 LMFT, 1 LCSW • CHIPA continued to educate BH providers on the importance of communication with PCPs. • Distributed "Quality Packets" to inpatient, outpatient and PCP providers • Sent email blasts, newsletters to providers; included a "coordination" slide into new provider training • CHIPA continued to educate BH providers about ROI forms and expectations of collaborative work with PCPs and other providers at new provider orientations, in monthly bulletins, and in articles to providers (May/Jun) and members (Jun/Oct) • CalOptima's PCP Satisfaction Survey included questions regarding communication with BH providers
Analysis:	• Chart audit frequency should be increased to provide opportunity of intervention prior to end of measurement year (should have positive results) • Provide information on the level of detail and frequency engagement of providers should occur to ensure communication is occurring across treatment lines • Utilize findings in 2017 provider engagement and education opportunities • Provide a cover letter for BH questions in the PCP Satisfaction Survey to increase response rate
Barriers:	• Annual chart audit limits the ability of interventions prior to the next measurement year • Staff at the PCP office, who complete the CalOptima PCP Satisfaction Survey might not understand the nature of the BH questions • Changing the current questions will make it difficult to trend previous years' results • It is possible that some PCPs completing the survey do not have members receiving BH services thus limiting the response rate

Lastly, in 2016 the CalOptima Board of Directors requested staff to conduct a Request for Proposal (RFP) process to ensure the best behavioral health services were delivered in the most cost effective manner. The BHI department was intricately involved in the RFP process, which resulted in the implementation of the selected vendor —Magellan Healthcare, Inc. — on January 1, 2017.

Implementation of new MBHO vendor/partner
CalOptima successfully implemented Magellan Healthcare as its new MBHO partner, January 1, 2017. BHI worked closely with multiple CalOptima business units to ensure the following areas were functional by the go-live date:

1. Implementation of the Provider Network, Behavioral Health & ABA services
2. Oversight of the BH call center, including appropriate call transfers to clinicians
3. Approval of member materials (meeting all regulatory requirements)
4. Development of process flows to ensure continuity of care
5. Coordination with UM, CM, GARS, and Claims
6. Coordination with Finance, Accounting and Regulatory
7. Interface with County Specialty Mental Health services

SAFETY PROGRAM

Member (patient) safety is a very important part of CalOptima's quality program, and aligns with CalOptima's mission statement to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

As monitored in the 2016 QI Work Plan, the success of the patient safety program was measured by ensuring the following:

1. Timely completion of facility site reviews
2. Review and Follow-up of Quality of Care complaints
3. Review of Pharmacy Management
4. Review of Specialty Drug Utilization
5. Review and Assessment of CBAS and SNF quality monitoring
6. Review of antibiotic usage
7. Implementation of new PBM

SAFETY OF CLINICAL CARE — TIMELY COMPLETION OF FACILITY SITE REVIEWS (FSR)

Key Findings:

In 2016 CalOptima continued to provide safety to its members by conducting Facility Site Reviews at all PCP offices, within CCN and including Health Networks. CalOptima's team of three nurses, and two PARS reviewers conducted:

- 57 Educational sessions
- 115 Initial Full Scope reviews
- 395 Periodic Full Scope visits
- 405 Physical Accessibility Review (PAR) surveys

Comparing 2016 and 2015 site visits, there was a minor decrease in the number of reviews by 9%.

	2015	2016
FSR/MRR Site Reviews (Initials/ Periodic)	561	510
PARS	440	405

The goal for this measure is to ensure that all sites pass their review with at least 80% total score on their FSR & Medical Record Review (MRR). The table below shows that the majority of the sites met the 80% goal for FSR and MRR with the exception of Adult Preventative Medical Record Review which achieved at only 76.8% overall.

AVERAGE SCORE: FSR		<80%	>80%
ACCESS & SAFETY	97.3%	0	56
PERSONNEL	97.0%	3	53
OFFICE MANAGEMENT	99.4%	0	56
CLINICAL SERVICES	95.7%	2	54
PREVENTIVE SERVICES	98.5%	0	56
INFECTION CONTROL	95.0%	4	52

AVERAGE SCORE: MRR		<80%	>80%
FORMAT	**97.9%**	**0**	**91**
DOCUMENTATION	**91.0%**	**5**	**86**
CONTINUITY & COORDINATION	**94.9%**	**1**	**91**
PEDIATRIC PREVENTIVE	**80.6%**	**25**	**31**
ADULT PREVENTIVE	**76.8%**	**41**	**36**
OB/CPSP PREVENTIVE	**0.0%**	**0**	**0**

In addition, for physical accessibility and ADA compliance of the 405 sites surveyed in 2016, 51% achieved Basic Access, meeting the required 29 elements. The remaining 49% did not meet at least 1 of the 29 PARS elements, resulting in Limited Access.

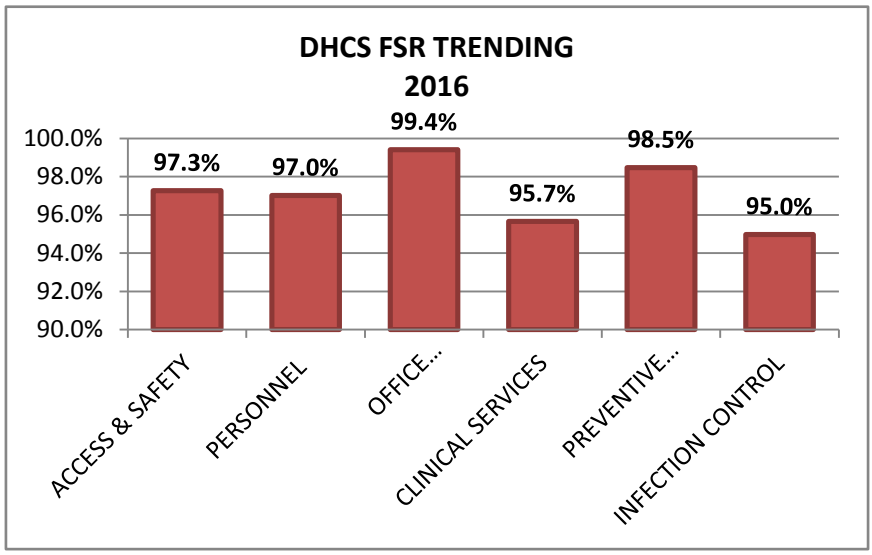
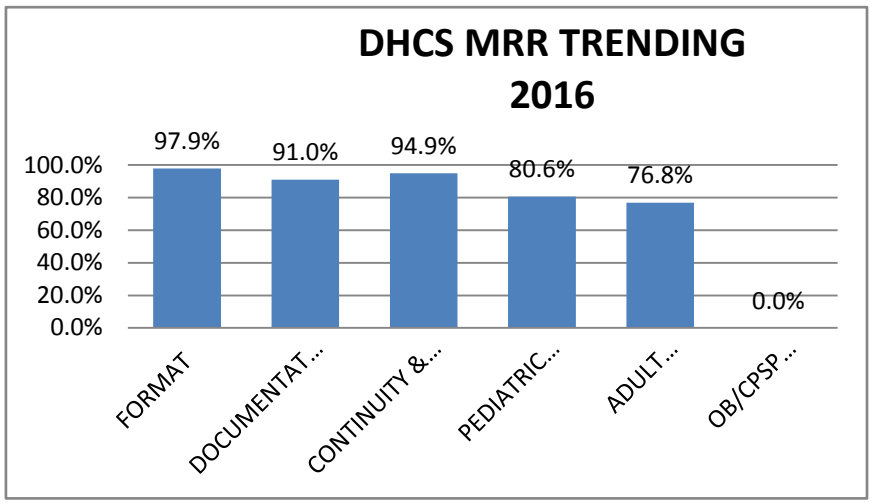
Interventions:

57 Educational sessions completed to prepare sites for Initial FSR
117 Follow-ups completed for corrective action plans (CAPS)
44 Critical element on-site visits
50 Un-announced visits completed as a results of PQI

Conducted training with health networks to improve process for requesting FSR to ensure timely completion of Initial FSR for credentialing

Analysis:

CAPS were issued to sites that scored below 80%, and the nurses worked with the sites until the CAPS were resolved. If a critical element CAP was issued, a site had 10 days to respond with their action plan. For a regular CAP the site had 45 days to respond. There appears to be growing trend identified in 2016 of provider offices not closing CAPS in the required timeframes. Only 11% responded in the required amount of time. There are many reasons

	for the delays; however, the delay results in extra staff time and follow-up to ensure the CAPS are completed.   For PARS, 49% received Limited Access. Deficiencies were provided to the sites; however, many sites were reluctant to make changes mainly due to cost constraints.
Barriers:	Some of the causes for such low adult preventative medical record review scores are due to lack of training in the provider offices. Although the nurses take the time to educate office staff prior to a site visit, the reality is, most offices are extremely busy, and do not take the time to follow-up on what they have learned. Additionally, there is a sense that there is an unrealistic expectation for small provider offices to meet all of CalOptima's requirements, which can be extremely burdensome in some cases. Hence, they are not able to pass a particular section/requirement.

SAFETY OF CLINICAL CARE — REVIEW AND FOLLOW-UP ON POTENTIAL QUALITY OF CARE ISSUES

Key Findings:	***Goals:*** ***To achieve a turnaround time of 90 day on 90% of case received.*** ***Assure patient safety and enhance patient experience by timeliness of Clinical care reviews*** • Received an average of 84 new cases per month during 2016. • In Q3, 82% of the time we achieved a TAT in 90 days or less. • In Q4, 100% of the time we achieved a TAT in 90 days or less. • A total of 1451 cases were closed. • A total of 23 cases were leveled with a Severity rating of 3 or 4 (potential for significant to serious effect or adverse outcome).
Interventions:	• Completed the review and determination of older cases, and, by the end of the year, were able to meet our TAT goal of completing cases within 90 days. • Developed a weekly report of caseload and TAT by staff member and shared the report with the nurses to keep them apprised of their individual data as compared to their colleagues.
Analysis:	• In Q1 2016, it was identified that several files had been opened for > 90 days. • By the end of 2016, 100% were closed in 90 days or less. • The department has made a concerted effort to identify, track and close the cases to our TAT goal.
Barriers:	• There was a change in electronic systems for tracking cases in July 2016. This created challenges in training/use of the system as well as crossing between systems as open cases were still managed within the old system. • There was a change in management in July 2016, which led to a change in reporting structure. • There was a reduction in nurses through attrition, which increased the number of cases for review per nurse.

SAFETY OF CLINICAL CARE AND QUALITY OF CLINICAL CARE — REVIEWED THROUGH PHARMACY MANAGEMENT

Key Findings:	***Goals:*** • ***Reduce under- and overutilization year over year*** • ***At or above CMS benchmark for statin use in persons with diabetes (SUPD)*** Underutilization measures • Asthmatics not receiving long term controllers

	• Bisphosphonates without calcium • Diabetics with hypertension not receiving ACE/ARB • Statin use in persons with diabetes (SUPD) Overutilization measures • Opioid utilization • Pharmacy Home
Interventions:	• Member-specific monthly provider faxes for under- and overutilization measures • Prescriber Restriction policy approved by DHCS and implementation to start February 2017
Analysis:	• For CY16 compared with 4Q15, there were no significant changes in potential under-utilization of pharmaceuticals for diabetics with hypertension without an ACE/ARB (3.0/K vs 2.9/K), and bisphosphonates without calcium (1.8/K to 1.9/K). • There was a decrease in potential under-utilization for prednisone without a bisphosphonate (CY16:1.6/K vs 4Q15: 1.9/K). • Statin use in persons with diabetes year-end results show that both OneCare and OneCare Connect are below the average value for MA-PDs overall. • As of January 1, 2017, there are 1,022 members in the Pharmacy Home program (average of 85/month).

Barriers	• In January 2016 with the new PBM implementation there were many process changes and changes in data reporting
	• Limited resources
	  ○ Focus on maintaining regulatory compliance with prior authorizations
	  ○ Multiple audits
	• Staff maternity leave

SAFETY OF CLINICAL CARE AND QUALITY OF CLINICAL CARE — REVIEW OF SPECIALTY DRUG UTILIZATION

Key Findings:	• Favorable DHCS kick payments for Hepatitis C medications • Compliance with following DHCS guidelines
Interventions:	• Maintain updated Hepatitis C prior authorization guidelines as per the AASLD guidelines • Monthly Hepatitis C drug utilization monitoring • Regular updates to the Hepatitis C prior authorization criteria • Outreach (fax and phone) to prescribers to promote the most cost-effective Hepatitis C drug regimens

Analysis:	Hepatitis C drug utilization monitoring CY15 vs. CY16 • The number of utilizing members increased from 411 to 439, 0.5% increase in /K members. • The average cost per Rx decreased 8% due to increased utilization of Epclusa and Zepatier. • Complexities associated with developing and maintaining updated Hepatitis C guidelines

Barriers:	• Complexities associated with developing and maintaining updated Hepatitis C guidelines (also a barrier)
	• Limited resources
	  o Focus on maintaining regulatory compliance with prior authorizations
	  o Multiple audits
	• Staff maternity leave

PATIENT SAFETY — REVIEW AND ASSESSMENT OF CBAS QUALITY MONITORING

Key Findings:	Twenty-nine of thirty CBAS centers had a Corrective Action Plan (CAP) from the State.
Interventions:	At least annually, CalOptima staff monitors all CBAS centers with a CAP, and offers recommendations/best practices.
Analysis:	All CAPs were completed and closed by the end of the year.
Barriers:	The greatest barrier is regarding staff turnover, making consistent implementation of the CAP requirements a challenge for the CBAS centers.

PATIENT SAFETY — REVIEW AND ASSESSMENT OF SNF QUALITY MONITORING

Key Findings:	Every SNF/LTC facility has received a Plan of Correction (POC) from the State.
Interventions:	CalOptima staff provides monitoring every 3-6 months of each facility to ensure POC compliance. CalOptima staff offered recommendations for improvement and shared best practices.
Analysis:	Most facilities have been able to demonstrate compliance with the POC prior to next audit by the State.
Barriers:	• Some facilities do not welcome the monitoring activities. CalOptima staff is perceived as auditors, not supporters. • There is significant turnover of Administrators and Directors of Nursing in the facilities leading to inconsistent or incomplete POC compliance.

SAFETY OF CLINICAL CARE — REVIEW OF ANTIBIOTIC USAGE (HEDIS MEASURES)

Key Findings:	Pharyngitis Testing (CWP): November 2016 PR = 49.08%, Goal: 62.98% Appropriate Treatment for URI: November 2016 PR = 93.18%; Goal: 92.51%
Interventions:	CWP • Distribution of pharyngitis kits to Providers: Approximately 1,000 kits were distributed to high volume/high performing and high volume/low performing Providers since September 2016 URI • Distribution of AWARE Tool kits to high prescribing providers • Articles in Provider Fax Updates; Pharmacy Faxes
Analysis:	CWP: **Goal not met;** [13.9% to meet goal] URI: **Goal met:** 92.51%; Rate = 93.18% (Note: data is based on prospective rates; final HEDIS rates will be available in June, 2017)
Barriers:	CWP: lack of documentation of pharyngitis testing, lack of appropriate coding for test, lack of compliance for testing among providers/urgent care/emergency rooms URI: No barriers identified

PATIENT SAFETY — IMPLEMENTATION OF THE NEW PHARMACY BENEFIT MANAGER (PBM)

Key Findings:	• Review and report on Performance Guarantees for the PBM
Interventions:	• PBM Performance Guarantees reported met goals through 3Q16 except for one measure • Performance Guarantees for 4Q16 met • Revised performance Guarantees in progress
Analysis:	• PBM Performance Guarantees reported met goals through 3Q16
Barriers:	Some Performance Guarantees need updating due to new requirements • NCQA • Regulatory changes • New prior • Authorization system

CASE MANAGEMENT

QUALITY OF CLINICAL CARE — REVIEW OF HEALTH RISK ASSESSMENTS TO OCC

Key Findings:	OCC: Total HRA collection rate for 2016 of all remaining eligible members = 64% Total HRA collection rate for 2016 of all remaining high risk eligible members = 71% Total HRA collection rate for 2016 of all remaining low risk eligible member = 59% Total HRA collection rate for 2016 of all outreached high risk members = 53% Total HRA collection rate for 2016 of all outreached low risk members = 40% Total number OCC HRAs collected in 2016=11,001 100% compliance with target outreach for the year except for 14 members during transition period from OC to OCC.
Interventions:	Utilized temporary staff to accommodate large volume of newly transitioned members. Developed full CORE annual call list to capture effect of telephonic outreach efforts to increase annual HRA collection rate. Report in development to determine effect of outreach. Full implementation of annual outreach for OCC HRAs will continue. Reorganized PCC outreach teams to optimize and centralize HRA collection for maximum collection. Planned new goals for 2017 will continue focus on completion of outreach process, and add focus on collection of HRA. Goals for 2017: Complete OCC outreach timely: 100% for high and low risk Collect 56% of high risk OCC HRAs Collect 43% of low risk OCC HRAs
Analysis:	Target outreach for year was successfully achieved.
Barriers:	High volume of members transitioned from OC to OCC on 1/1/16. This taxed our staffing as we transitioned over 10,000 members on one date. Outreach strategy for OCC did not include a call for annual members. This has been modified in 2017.

QUALITY OF CLINICAL CARE — REVIEW OF HEALTH RISK ASSESSMENTS TO OC

Key Findings:	OneCare: 100% compliance with target outreach for the year with the exception of 5 members who were due on 1/1/16. 74% (189) HRA collection rate for initial OC members for the year. 32% (618) collection rate for annual OC members. Overall HRA collection rate for OC LOB is 36.4% Total number of HRAs collected was 807.
Interventions:	Worked with IS to stabilize reporting Reorganized PCC outreach teams to optimize collection Develop targets for next year based on 2016 rates. Include collection rates as well as completion. Goals for 2017: Complete 100% of outreach timely Collect 78% of initial OC HRAs Collect 34% of annual OC HRAs Monitor and analyze strategies monthly
Analysis:	Outreach was completed timely throughout the year. Significant reduction in volume of members contributed to outreach success.
Barriers:	Reports needed to be stabilized as our new MMS went live 3/31/15 and reports were still under development in beginning of year.

QUALITY OF CLINICAL CARE — REVIEW OF HEALTH RISK ASSESSMENTS TO SPD

Key Findings:	SPD Overall collection rate from Mid March until end of Q4 is 58 %* HRA collection for SPD initial including pediatrics from Mid March 2016 to end of Q4 is 60%. HRA collection for SPD does not include annual HRAs which are mailed with no outreach. Based on CORE Report CC0123 SPD Universe current population as 1/6/17 is 39,301. Total annual HRAs collected in 2016 including pediatrics are 6424. Annual mailings to entire SPD population began May 2016. Overall collection rate for 2016 is 16.3%

Interventions:	Reorganized PCC outreach teams to optimize and centralize HRA collection for maximum collection. Develop targets for next year based on 2016 rates. Include collection rates as well as completion. Goals for 2017: Complete 100% of initial outreach timely Collect 63% of initial SPD HRAs Establish baseline percent for collection of annual HRAs.
Analysis:	Outreach was completed timely throughout the year.
Barriers:	Annual outreach method does not include a call.

QUALITY OF CLINICAL CARE — CONTINUITY & COORDINATION OF MEDICAL/BH

Key Findings:	Increases shown in participation with MBHO and some county participation noted. Opportunity exists to improve quality of participation by individual BH providers in ICT.
Interventions:	BHI department provided outreach weekly to collaborate and extend invitations to participate to MBHO and county of Orange. Cohorting of members with MBHO participation at similar meeting times to increase convenience of participation for MBHO. BHI department worked with County of Orange and MBHO on care coordination. Goals for 2017: Refine reporting process to include participation by individual providers and county providers. Goal for 2017=100% for BHI, 85% for MBHO, 10% for individual providers
Analysis:	Strong gains were made in participation of MBHO and County of Orange participation.
Barriers:	County of Orange concerns about participation. Coordination with MBHO participants.

QUALITY OF CLINICAL CARE — REVIEW OF EMERGENCY ROOM (ER) COMMUNICATIONS WITH PCP

Key Findings:	Assessment of medical records was not feasible for this goal. Data mining underway to identify members for case management with the aim of reducing unnecessary ER visits. Limitations in ECEDA reports.
Interventions:	Recommend continuing current notification process into 2017. Plan: Remove goal from 2017 QI work plan due to lack of method for collecting data and impacting goal.
Analysis:	This goal was placed on hold and was removed from plan for 2017.
Barriers:	Access to medical records and availability of data.

PATIENT SAFETY, QUALITY OF CARE CASE MANAGEMENT — HIGH ER UTILIZATION

Key Findings:	Microstrategies data mining for members with high ER visits and referral to case management as appropriate. Interdepartmental work group is on hold. Plan is to transition to CCN focused case management strategy.
Interventions:	2017 New Goal: Data mine for top ER high utilizers quarterly, establish baseline visits for those members, and collect data to determine change in ER visits. Dedicated staff will manage cohort.
Analysis:	Goal was placed on hold throughout the year as it was dependent on interdepartmental work group.
Barriers:	Completeness of ECEDA data.

QUALITY OF CLINICAL CARE — REVIEW OF MEMBER SATISFACTION WITH CM PROGRAMS

Key Findings:	Overall Satisfaction with CM: 88% Case Management was beneficial: 96% Educational materials were helpful: 88% CM was helpful with medical questions: 100% Community resources were helpful: 100% Questions were answered to satisfaction: 100%
Interventions:	• Hosted two Community Resource Fairs for networks and internal case management to increase familiarity with community resources.

	• Provided customer service workshop to increase skill set in engaging members. • Provided in-services on intimate partner violence and housing resources
Analysis:	Results for year met or exceeded benchmark and demonstrated improvement over previous year.
Barriers:	Volume of members who are eligible to participate in survey is low. Will be changing methodology of collection to include collection after three months of case management to increase sample size.

QUALITY OF IDENTIFICATION OF COMPLEX CASE MANAGEMENT

Key Findings:	Identification and file review scores have stabilized and improved across most networks with one outlier. Training on 2017 NCQA standards commenced. Anticipated completion Q2 2017. 78% increase noted in identification of cases from January to September. Interventions of individual outreach to networks, review of policies, and inclusion in JOM has been effective.
Interventions:	Inclusion of monthly results in JOMs Individual trainings onsite at health networks Refined reporting documents for health networks.
Analysis:	Most scores for health networks increased with the exception of one outlier
Barriers:	Staffing changes in health networks requiring additional training; inaccuracies in health network use of reporting log (auto-validation of monthly logs under development)

HEALTH EDUCATION & DISEASE MANAGEMENT

Key Findings:	Health Education (HE) and Disease Management (DM) had several significant accomplishments in 2016. HE/DM provided program oversight for the DHCS Initial Health Assessment (IHA) which included development of monthly reporting tools to track IHA completion rates. As a result of our efforts, the organization was able to report a 20% increase in completion rate over the 2015 rate, which exceeded our internal goal of a 10% increase. HE/DM accomplished another milestone with the submission of the DHCS Group Needs Assessment (GNA). The GNA is scheduled every 5 years to help health plans identify the health risks, beliefs, practices, and cultural & linguistic needs of their members. CalOptima oversampled and added questions addressing Social Determinants of Health to inform program planning in the next fiscal year.

Interventions:	A targeted incentive offer was sent to members with diabetes either missing an A1C test and/or having an A1C>9. The offer was mailed to over 19,000 members and yielded a 7% rate of participation, where members sent in proof of completing their A1C test within the recommended time period. Asthma Aware, Heart Health and Diabetes Talk newsletters were successfully mailed to all DM members with helpful and relevant information on how members can best manage their conditions. Chronic care improvement projects (CCIP) continued. For OC Controlling Blood Pressure, members who opted-in were provided a home blood pressure monitor and received phone follow-up from health coaches to track blood pressure control. There were strides made to streamline the transitions of care process in regards to reducing unplanned readmission due to heart failure for the OCC Heart Failure CCIP. The 2016 DM Member Experience Survey mailed to 40,259 English and Spanish speaking DM members showed 82% (N=3,256) overall satisfaction with CalOptima's DM programs. This included satisfaction with helpfulness of program staff, usefulness of information received and member experience in adhering to treatment plans. The department continues with the program redesign of disease management. The new criteria for diabetes was finalized in 2016 and is pending implementation in the Guiding Care system
Analysis:	While HE/DM accomplished many objectives and performance goals, there are still areas of opportunity in 2017. The department is still working to increase active member participation in disease management programs through the redesign. Redesign efforts will focus on obtaining assessment information from the lower risk population, so that we can have a better snapshot of the entire population and its needs. For higher risk members with diabetes, the goal is to engage them more in telephonic self-management sessions. The redesign for the asthma program will include expanding interventions and services to adults with asthma. For heart failure, redesign will incorporate inclusion of Medi-Cal members with more events and classes to link members with community resources, including CalOptima health coaches. In addition, a provider notification report is being developed to communicate with physicians about key health indicators for their patients

	in CalOptima's DM program, which may warrant partnering to bring our member's conditions under better care management. The department is committed to aligning DM efforts to positively impact HEDIS rates, especially the Comprehensive Diabetes Care and Asthma Medication Ratio(AMR) measures. In addition, the Shape Your Life Childhood Obesity, Weight Watchers and Perinatal programs are being designed and planned for RFP, vendor selection and program roll out in 2017.

Please see Attachment B — 2016 Disease Management Programs Annual Evaluation for full details.

QUALITY OF CLINICAL CARE — REVIEW OF DIABETES

Key Findings:	In addition to the CCIP referenced in the Disease Management evaluation section, CalOptima also implemented Performance Improvement Projects (PIPs) during 2016. It is a DHCS regulatory requirement for CalOptima to participate in a minimum of two Performance Improvement Projects (PIPs) at any given time. DHCS requested the MCPs to have a narrowed focus on the target populations. The goal is to assess each intervention on a smaller scale. If the intervention proves to be successful, CalOptima would expand the intervention to the broader population at a later time. In addition to the 2 PIPs, CalOptima is also required by CMS to implement a Quality Improvement Projects (QIP). CMS requires a broader approach to their required improvement projects. In 2016, there were 2 Diabetes improvement projects: 1. PIP: MC Diabetes HbA1c Testing Intervention: Goal: To Target one provider office (Provider A) who has a high volume of members and lower screening rates for HbA1c testing. The intervention focuses on the following: a) develop member education materials on HbA1c testing, b) send Provider A a list of members who need HbA1c testing to conduct outreach, and c) provide members with a resource sheet with a list of local labs, hours of operation and options for transportation. 2. QIP: OC Diabetes HbA1c Testing QIP Plan: Goal: To increase Diabetes HbA1c testing for CalOptima's OneCare population to a HEDIS rate of 92.94% through member outreach and health network involvement.

Interventions:	1. MC Diabetes PIP: Provider Office A received educational materials, a member outreach list of those who need a HbA1c test and list of local labs and other educational resources for members. 2. OC Diabetes QIP: a) Member outreach list compiled. Members who were also enrolled in the hypertension disease management program received additional education and/or resources from the Disease Management Health Coaches; b) Additional outreach provided by Disease Management as needed to targeted members; c) Reminder letter for member outreach sent November 2016; d) Members tracked onto database for additional review and evaluation.
Analysis:	1. The MC Diabetes PIP is currently in Module 4, testing/implementation phase through June 30, 2017. Results for the PIP will be submitted to DHCS by August, 2017. The rate of HbA1c testing will be tracked monthly in Quarter 1, 2017. 2. The OC Diabetes QIP completed Year 1 measurement: Total OC population with diabetes was 1,368. Of those members, 171 (12.5%) were eligible for the intervention. Results indicate that 51 out of 171 members (29.8%) received educational outreach via mail and/or phone. Of the total OC population with diabetes (1,368), 171 members (12.5%) were eligible for the intervention. 144 out of 177 members (84.2%) received their HbA1c testing based on the HEDIS 2016 November Prospective Rate.
Barriers:	1. Going through the PIP process was challenging initially, as there were a number of resubmissions to DHCS/HSAG to clarify the project. The requirements for PIPs are very stringent and require a lot of resources to get the modules approved. 2. In 2016, member enrollment shifted where a large volume of OC members transitioned to OCC. This transition created a data challenge for staff working on this QIP as data pulls were quickly out-dated. Staff had difficulty accurately identifying and sharing information on members and high volume providers with our contracted health networks in a timely manner 3. The number of members receiving HbA1c testing has still not met the goal. The team will reassess other opportunities for improving the interventions necessary to meet goal

QUALITY OF CLINICAL CARE- ALL CAUSE READMISSIONS

Key Findings:	***Goal: To reduce the 30 day readmission rates for eligible OC Connect members with identified chronic conditions to 16.8%, from 1/1/16 to 12/31/16.*** A 30-day readmission is defined as the number of acute inpatient stays followed by an acute readmission for any diagnosis within 30 days.
Interventions:	CalOptima revised the Transitions of Care (TOC) program by expanding the eligible population criteria from 5 targeted diagnoses to include: 1. All diagnoses to increase the volume of enrollees. 2. Quality Analytics staff was granted access to Case Management documentation systems which allowed for increased productivity, improved time management, and reduced miscommunication. 3. Case management (CM) and Information Services (IS) departments were able to backfill positions mid-year. 4. Increased collaboration between CM and IS helped address the reporting challenges. IS updated TOC reports with new criteria, incorporated the MMP population into the reporting systems and identified the need for more real-time data to improve enrollment. 5. Case Management increased member engagement efforts by spending more time to build rapport and trust through active listening skills and sharing benefits of program with members, families, and other clinicians. 6. Member-focused materials were also updated. CalOptima will work with vendor to address interpretation services issues. CalOptima will continue to work with our hospital partners to improve post-discharge processes and obtain timely discharge instructions and patient information.
Analysis:	The overall readmission rate of the MMP program eligible members is 30.6%, which is 13.8 percentage points higher than the goal set at 16.8%. CalOptima did not meet the overall goal for this submission. While enrollee participation in the TOC program is at 50%, the 30-day readmission rate amongst that group who received coaching and participated in the program is 27 percentage points lower compared to the group who did not receive the coaching intervention (17% versus 44%). Data suggests that members who received coaching had a lower readmission rate than those who did not receive coaching. 1. The PCP/specialist follow-up rate amongst the group who received coaching was 56 percentage points higher (100% vs 44%) compared to the group who did not receive coaching. When comparing readmission rates between the group who had a 30-day PCP/specialist follow-up visit (19%) and the group who did not have a follow-up (20%), there was only a 1% point difference between the two groups. Data suggests that there was little impact on readmission rates for the follow-up visits at the time of this

	submission. This could be due to the low eligible population for this submission. While the denominator is low for this study, the results suggest that the coaching intervention increases the likelihood of members having a PCP/specialist follow-up within 30 days and decrease 30 day readmissions.
Barriers:	CalOptima experienced delays in implementing the TOC program on time (1/1/16) due to program revisions and enhancements, infrastructure changes, and staffing resources. The TOC Program for the OCC (MMP) population launched in May 2016 for the coaching intervention and July 2016 for the mailing intervention. As a result, a lower volume of enrollees were eligible during this measurement period. In addition, a late start date and reporting challenges did not allow for a comprehensive analysis of the program. Hence, outcomes results for the mailing intervention (discharge mailing kit) will be included in the second QIP Annual Update. Case management staff indicated that members declined services despite efforts by clinical staff to engage the member. In addition, Case management staff encountered communication barriers and engaged Interpreter Services while talking with the member via speaker phone method. Clinical staff had difficulty contacting members post-discharge despite efforts to gather current contact information during hospital stay, accessing chart notes via medical records (fax request) and developing reports for effective evaluation. In addition, members had difficulty retaining discharge instructions, especially obtaining the medication list

LONG-TERM SUPPORT SERVICES

LTSS participated in various quality and clinical initiatives to support appropriate access and availability for all eligible members for whom the services are medically appropriate. In 2016, efforts were focused on enhancing relationships with LTSS providers and community stakeholders including (but not limited to) Community Based Adult Services (CBAS) providers, Orange County Social Services Agency – In Home Supportive Services (OC SSA IHSS), Orange County Public Authority (PA)/IHSS, Nursing Facilities, (NFs), the Multipurpose Senior Services Program (MSSP) and health networks.

The LTSS Quality Improvement Sub Committee (QISC) met on a quarterly basis in 2016, and addressed key components of regulatory, safety, quality and clinical initiatives. The LTSS/Case Management Medical Director chairs the LTSS QISC meetings, whose members also include administrators and clinical leaders from the following groups: CBAS providers, OC SSA IHSS,

OC PA/IHSS, NFs, MSSP, delegated Health Networks and other CalOptima clinical and operational staff.

- Development of reporting mechanisms and analytic experience to ensure valid cohorting of the LTSS subpopulations.
- Access to a full year of historical claims and encounter data provided a baseline from which future trends can be compared and appropriate goals set.*
- Focus on member satisfaction with LTSS providers.*
- Completed OCC LTC Passive Enrollment-by-facility in June 2016.
- LTSS Performance Improvement Project planned and implemented. The topic selected and approved by DHCS was "Improved IHSS Social Worker participation in OCC Interdisciplinary Care Team meetings."
- Long Term Care Providers Workshop held. The LTSS QISC reviewed and approved agenda items including: Outcomes of the OCC facility "Family Nights" presentations, OCC enrollment trends, Facility Incident reporting trends
- CBAS Provider Workshop. The LTSS QISC reviewed and approved agenda items including: MLTSS overview, accessing Behavioral Health, CBAS QI.
- Launched the LTSS enhanced provider education initiative.

*Only applies to CBAS, MSSP and LTC populations

SAFETY OF CLINICAL CARE AND QUALITY OF CLINICAL REVIEW

Chart Key: ID = In development for 2017 measurement

Key Finding	Members	Q1	Q2	Q3	Q4
	CBAS Members				
	Acute Admits (per thousand member months)	213	322	223	332
	ED Utilization (per thousand member months)	181	714	564	404
	All Cause Readmissions (30 days-percent readmissions)	3%	16%	48%	21%
	IHSS Members				
	Acute Admits (per thousand member months)	260	306	350	289
	ED Utilization (per thousand member months)	332	689	679	646
	All Cause Readmissions (30 days-percent readmissions)	9%	19%	24%	22%
	MSSP Members				
	Acute Admits (per thousand member months)	312	398	620	413

	ED Utilization (per thousand member months)	372	1057	874	874
	All Cause Readmissions (30 days-percent readmissions)	3%	9%	20%	0%
	LTC Members				
	Acute Admits (per thousand member months)	465	637	339	467
	ED Utilization (per thousand member months)	258	448	398	383
	All Cause Readmissions (30 days-percent readmissions)	16%	30%	31%	49%

Interventions:	**CBAS, IHHS, MSSP and LTC:** • Centralized responsibility for aggregation, review and analysis of metrics • Training and consultation with Enterprise Analytics Team to support ongoing development of LTSS data subject matter expert and LTSS management team **CBAS:** • Third Annual CBAS Providers Workshop
Analysis:	**CBAS:** • Goals partially met. Admit rate is baseline year. ER utilization goal for 2016 not expressed in industry standard units of measure. All cause 30-day readmission rate goal not met. Goal set for 2016 was significantly lower than the readmission rate for the non-LTSS population and not reasonably attainable. **IHHS, MSSP and LTC:** • Goals partially met. Admit rate is baseline year. ED utilization and all cause 30-day readmission rate goal not consistently reported. • Focus in 2017 will be on consistent and valid reporting, analysis and review of utilization metrics to support thoughtful interventions to improve performance for.
Barriers:	**CBAS, IHHS, MSSP and LTC:** • Lack of established technical specifications for accurate analysis of utilization data. • Goals set not aligned with industry standard measurement units. • No identified industry standard benchmark specific to this subpopulations' utilization. • Change in departmental leadership/strategic alignment/interpretation of utilization trends.

Critical to the evaluation of our LTSS services is measuring our member's satisfaction with their site of care. Below are the key findings, barriers, interventions and analysis relating to finding from the CBAS & SNF member satisfaction surveys.

CBAS MEMBER SATISFACTION

Key Findings:	• 30 CBAS distributed and returned surveys • ***Goal of 90% Overall Satisfaction*** ▪ 100% of the centers had an overall satisfaction rate > 90% ▪ 43% of the centers had an overall satisfaction rate = 100% • ***Goal 5% improvement over previous year*** ▪ 2015 Results: 30/30 (100%) met the threshold of 90% overall satisfaction. ▪ 2016: 30/30 (100%) met the threshold
Interventions:	• Results of the survey have been shared with the CBAS centers. • Several centers have implemented changes based upon the feedback, including: ➢ Hired a new caterer with menus that are sensitive to religious and cultural preferences ➢ Implemented a monthly communication folder ➢ Added cooking and health classes to activity program ➢ Created a new physical and occupational therapy activity questionnaire to elicit feedback ensuring goals are incorporated into the treatment plan. ➢ Increased the hours for OT, RD, ST, LCSW and pharmacist. ➢ Met with OCTA to review transportation concerns ➢ Nutritionist met with participants quarterly. ➢ Caterer provided more fish options in meals
Analysis:	• With 100% of the CBAS centers achieving an overall satisfaction of 90%, we met our goal. • We were unable to achieve a 5% improvement over the previous year (2015) since, in both 2015 and 2016, 100% of the centers achieved a satisfaction rate of at least 90%. • Greatest areas of repeated concern include: ➢ Dissatisfaction with meals ➢ Transportation issues ➢ Previous concerns not addressed ➢ Physical and/or occupational therapy not meeting their needs.
Barriers:	• The satisfaction survey questions changed from 2015 to 2016. • Four of the CBAS centers choose to use their own surveys and results. • The survey was only provided in English, so those requiring threshold languages may not have been able to complete the survey due to the language barrier.

	• The survey was limited to members without cognitive impairment. • Questions regarding ancillary services such as registered dietician and occupational health may not have been well understood by the members.

SNF MEMBER SATISFACTION

Key Findings:	• Ten skilled nursing facilities received surveys for 20 member each, for a total of 200 surveys. • 124 (62%) of the surveys were returned • ***Goal of 90% Overall Satisfaction*** ➢ 77% of the members had a positive overall satisfaction rating • ***Goal 5% improvement over previous year*** • No previous year measurement
Interventions:	• The results of the survey will be shared in Q2 2017 with the facilities. ➢ Recommendations for changes to address the concerns will be discussed with the facilities. • The survey will be distributed again in 2017. ➢ The survey questions have been modified to provide descriptions of the services provided by ancillary department. The survey will be available in the threshold languages
Analysis:	• With 77% overall satisfaction rating, we did not meet our goal of 90% overall satisfaction. • This was the first year of the member satisfaction survey, so we were unable to compare the overall satisfaction in 2016 to 2015. • The greatest areas of concern include: ➢ Dissatisfaction with meals ➢ Services provided by the dietician ➢ Activities are not meaningful ➢ Concerns are not addressed.
Barriers:	• The survey was only provided in English, so those requiring threshold languages may not have been able to complete the survey due to the language barrier. • The survey was limited to members without cognitive impairment. • Questions regarding ancillary services such as registered dietician and occupational health may not have been well understood by the members.

ACCESS & AVAILABILITY

QUALITY OF SERVICE AND CLINICAL CARE – NOTIFICATION OF TERMINATION TO MEMBERS

Key Findings:	***Goal: To communicate to members when a primary care provider is terminated from the network within 30 days.*** Many times providers do not notify the plan of their termination; hence CalOptima ensures that members are notified within three days from the date of when the provider notified CalOptima.
Interventions:	CalOptima's Provider Relations team works together with the Customer Service department when practitioners are terminated from the Community Network.
Analysis:	CalOptima met the standard for member notification when a provider terminates.
Barriers:	No barriers. The standard was met.

ACCESS TO CARE — CREDENTIALING AND RE-CREDENTIALING OF PROVIDER NETWORK

Key Findings:	In 2016, the Credentialing department supported members' access to care by ensuring the quality of the provider through the credentialing and re-credentialing process. During the year, 816 providers were approved. CalOptima continues to credential provider types including physicians, non-physician medical practitioners (NMP), and health delivery organizations (HDO). Many processes were put in place to improve how applications were processed and the turnaround time required to complete a credentialing file. The Peer Review Committee met 8 times and reviewed those providers with clean files (i.e. no issue) as well as specifically reviewed 12% of the files that were identified with potential issues or concerns. The committee took actions in two cases that resulted in the requirement to file 805s and NPDB reports. In addition, audit functions were implemented within the credentialing department and in conjunction with the Audit & Oversight department to ensure appropriate completion of all critical verification process steps. There was a 7 % decrease in the total number of files processed from 2015, however overall the access to care for the member was sustained, and processes were improved. The goal established for 2016 was to ensure that all initial credentialing files were processed within 180 days, and re-credentialing files did not exceed 36 months. In 2016, initial and re-credentialing files met the timeliness standard 97% of the time.

<table>
<tr><td>Interventions:</td><td>

Updated end-to-end processes for Initial Credentialing, Re-Credentialing and Adverse Activity Monitoring, including elimination of redundant and unnecessary steps to increase productivity and improve turn-around-times.
Updated policies & procedures and desktop procedures to reflect new end-to-end processes and new DHCS APL requirements.
Improved collaboration and communication between Contracting and Provider Relations through monthly cross-functional meetings.
In Q4, upgraded the credentialing software system to a web-based version, and implemented the interface that allowed applications to be loaded automatically into the software.
Improved monitoring of the Provider network with the use of Lexis Nexis to monitor OIG & SAM sanction lists.

</td></tr>
<tr><td>Analysis:</td><td>
In 2016, 816 initial and re-credentialing files were processed compared with 877 in 2015. The number of initial files processes was less than the previous year, however re-credentialing files actually increased over 2015.
<table>
<tr><th>Initials</th><th>2015 Totals</th><th>2016 Totals</th></tr>
<tr><td>Practitioners</td><td>411</td><td>359</td></tr>
<tr><td>HDO</td><td>65</td><td>38</td></tr>
<tr><td>Totals</td><td>476</td><td>397</td></tr>
<tr><th>Recredentialing</th><th>2015 Totals</th><th>2016 Totals</th></tr>
<tr><td>Practitioners</td><td>252</td><td>257</td></tr>
<tr><td>HDO</td><td>149</td><td>162</td></tr>
<tr><td>Totals</td><td>401</td><td>419</td></tr>
<tr><td>Total (I/R)</td><td>877</td><td>816</td></tr>
</table>
Timeliness of processing initial credentialing files was monitored throughout the year. The average turnaround time to process an initial file in 2016 was 101 days. There was an increase in Q3 to 112 days, after the process for submitting the credentialing application changed for the provider. This required new workflows and communication with the providers on how to electronically provide their credentialing application. In Q4 there was an improvement and the turnaround time decreased to 78 days.

For re-credentialing, CalOptima had one provider whose credentialing expired in April 2016. Actions regarding this practitioner were finalized, and the provider was eventually administratively terminated for not completing re-credentialing requirements. Also, there was one HDO whose credentials expired October 2016, but was re-credentialed in November 2016. This was due to a process issue that was resolved in the credentialing system.
</td></tr>
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Barriers:	One factor that may have contributed to the decrease of initial credentialing files was the decline in providers submitting complete credentialing applications. A change in the application process may also have contributed to lower numbers. Previously, Provider Relations department submitted the credentialing application on behalf of the interested provider. In 2016, CalOptima revised this process to require the provider to submit their application directly. This change was designed to streamline credentialing processes, and move the responsibility and ownership to the provider. This change was likely a variable in the decline in initial applications. Regarding turn-around-times, the cause of the increase seen in Q3 was due to staff changes and implementing the new process of receiving applications. Changes were implemented, which eliminated extra steps in the process and helped reduce the amount of time required to process an application. In addition, the credentialing software was updated to remove redundant processing steps and to eliminate manual data entry of the CPPA application.

ACCESSIBILITY: REVIEW OF ACCESS TO CARE

Key Findings:	CalOptima monitors appointment availability through the annual Timely Access Provider survey. CalOptima provider offices are asked for their next available appointment for a specific type of appointment and the wait time for the appointment is calculated based on the date of the survey. The wait time is then measured against the CalOptima standard to determine whether the provider office is compliant with the standard. Results are aggregated by line of business. There were six primary care and specialist appointment availability performance measures and two customer service call performance measures monitored during 2016. For the appointment availability measures, the minimum performance level (MPL) was set at 90%. Two of the six measures met the MPL and four measures did not meet the MPL. Four of the six measures showed an increase from the year before with the exception of *primary care within ten business days* and *routine specialty visit within 15 business days*. For customer service calls, the goals were: 1) a less than 5% abandonment rate and 2) call wait time of less than 30 seconds. These customer service standards were consistently met throughout the year. Data is tracked by Customer Service and reported quarterly.

Appointment Availability Standards

Measure (Minimum performance Level (MPL) = 90%)	2016 Medi-Cal	2016 OC	2016 OCC	2016 Status
1. Urgent care appointments within 48 hours of request:	97.2% (+4.4%)	97.8% (+8.65)	97.2%	Met
2. Non-urgent care within 3 business days:	84.9% (-2.9%)	86.3% (+3.6%)	82.3%	Not Met
3. Primary care appointments within 10 business days:	92.7% (-1.4%)	92.9% (+1.0)	91.1%	Met
4. Urgent appointments with prior authorization with 96 hours of request:	79.0% (+7.2%)	80.7% (+6.3%)	79.2%	Not Met
5. Appointment with specialist within 15 business days:	84.4% (-1.9%)	85.8% (-0.2%)	85.4%	Not Met
6. First pre-natal visit within 10 business days:	88.9% (+1.4%)	92.1% (-6.8%) *	85.7%*	Not Met

Data Source: Annual Timely Access Provider Survey
The value in parentheses indicates change in score from the previous year: (+) = increase in score; (-) = decrease in score
There is no score for OCC in 2015
*Measure not a standard for OC/OCC – result for monitoring only.

Appointment availability by Health Network is analyzed annually. For 2016, the data is currently under evaluation and will be reported in 2017. Any deficiencies will be reviewed with the specific Health Network to determine actions for improvement.

Interventions:

List of completed activities included:

1. Educated member and providers of appointment availability standards via member and provider newsletters,
2. Updated the prior authorization list to remove authorization that are never denied,
3. Promoted the nurse advice line,
4. Issued corrective action plans, and
5. Requested observations plans from the health networks for areas of non-compliance.

Analysis:

Areas of focus for 2017 will be on the following appointment availability measures: non-urgent care within 3 business days, urgent appointments with prior authorization within 96 hours of request, routine specialist appointment within 15 business days and first pre-natal visit within 10 business days as these measures did not meet the 90% MPL. Additional focus will be placed on acute and specialty care as there was a drop in score from the previous year. For the customer service measures, the goals were met throughout the year.

Barriers:	The Access and Availability team conducted a barrier analysis exercise soon after the 2016 results were made available. Barriers to appointment availability measures included lack of contracted specialists, provider not aware of standards and appropriate wait times, lack of timely approvals for referrals and authorizations, lack of timely notification of approvals, office scheduling not streamlined, authorizations not marked as urgent, and OB/GYN scheduling 1st prenatal appointment near end of first trimester.

ACCESSIBILITY: REVIEW OF AVAILABILITY OF PRACTITIONERS

Key Findings:

This area monitors PCPs and specialists, including high volume, high impact and behavioral health providers, availability (practitioner to member ratio) and geographic distribution (distance/time from provider to member). Goals and standards vary by specialist, but a 90% to 95% minimum performance level is set for the geographic distribution standards and 100% MPL for provider–to-member ratio standard. There were 8 measures in the work plan and all measures were met throughout the year.

Network Adequacy: Provider to Member Ratios				
Measure	Medi-Cal	OneCare	OneCare Connect	Status
1. Practitioner to Member	Met	Met	Met	Met All
2. PCP to Member	Met	Met	Met	Met All
3. Specialist to Member	Met	Met	Met	Met All
4. BH Specialist to Member (Psychiatrist, Psychologist, License Social Worker, and Marriage and Family Therapist)	Met	Met	Met	Met All
5. Practitioner to Member (Male, Female, and Threshold Languages)	Met	Met	Met	Met All

Network Adequacy: Distance and Time Standards				
Measure	Medi-Cal	OneCare	OneCare Connect	Status
1. PCP to Member is 1:2,000 or better	Met	Met	Met	Met All
2. Specialist to Member is 1:5,000 or better	Met	Met	Met	Met All
3. BH Specialist to Member (Psychiatrist, Psychologist, License Social Worker, and Marriage and Family Therapist)	Met	Met	Met	Met All

Interventions:

List of completed activities include:

- Recruitment of dermatology and in-demand specialists from the provider relations staff,

	• Health network data reconciliation for provider directory to ensure that provider data is accurately capture in the directory and, • Issued corrective action plans to health networks that were non-compliance with availability standards.
Analysis:	There were 8 measures in the work plan and all measures were met throughout the year. When focusing on specific specialists, dermatology did not meet the standards and was an area of focus for the year.
Barriers:	Barriers for this area include: not enough contracted dermatologists in the network and some dermatologists do not want to contract with Medi-Cal. The Access and Availability Team will monitor the following specialties closely as they may be at risk for not meeting the MPL: nephrologists, endocrinologists and pulmonologists.

ACCESSIBILITY: REVIEW OF AVAILABILITY OF PRACTITIONERS: CULTURAL NEEDS AND PREFERENCES

Key Findings: CalOptima monitored members' ability to obtain health care services by ensuring an adequate network of practitioners and by analyzing the networks' ability to meet the cultural needs and preferences of the membership. Data was collected March through May, and June through August, on gender, race/ethnicity, language, and member needs/preferences. Data was then compared against the practitioner data to determine adequate coverage. The results of both surveys identified the following:

Highest respondents for both surveys by ethnicity were: White, Hispanic/Latino, Vietnamese, Korean, Filipino, and Other.

Members Needs and Preferences: March – May 2016:

Do you prefer to be treated by a doctor:	Count (Yes Answers)	Percentage
Who is from the same ethnic group as you	17	7.20%
Who is from any ethnic group	24	10.17%
Who is not your ethnicity but familiar with your culture	99	41.95%
Member has no ethnic preference	96	38.57%

Members Needs and Preferences: June – August 2016:

Do you prefer to be treated by a doctor:	Count (Yes Answers)	Percentage
Who is from the same ethnic group as you	37	31.90%
Who is from any ethnic group	12	10.34%
Who is not your ethnicity but familiar with your culture	8	6.90%
Member has no ethnic preference	63	54.31%

Interventions: CalOptima implemented the following plans of action:

- Promoted interpreters services by consistently communicating the availability of no-cost interpreter services through a standing article in the Medi-Cal member newsletter, including a section on no cost language services in the new member handbook and on the CalOptima website. It was also promoted in the Annual Notices newsletters for Medi-Cal, OneCare Connect and OneCare, as well as in the Disease Management newsletters.
- Featured as part of the quarterly CalOptima Awareness Education Seminar (AES), topics related to culture or tradition concerns identified as part of the Member Needs and Preferences survey.
- Monitored and abided by the Cultural and Linguistic Services Service Program outline and ensure the C&L Goals and Objectives are met.

MEMBER EXPERIENCE

QUALITY OF SERVICE — REVIEW OF MEMBER SATISFACTION

Key Findings:	CalOptima's Quality Analytics department successfully fielded and/or obtain results for 3 plan level CAHPS and 3 health network level CAHPS. In 2016, CalOptima fielded the first CG-CAHPS (provider level) CAHPS. The results from these member experience surveys along with other member data, including but not limited to, member grievances and appeals data, customer service complaints data, and access and availability data were presented to the Member Experience Steering Committee for review. The committee evaluated the data and identified the following areas as focus areas for member experience: Rating of Health Care/Plan, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Providers Attitude and Service and Quality of Care. A member experience work plan was developed for 2017 and the committee will continue to monitor overall member experience.
Interventions:	List of completed activities include: implementation of all planned CAHPS surveys, review and analysis of results that included data from other sources (i.e. GARS, access, customer service, etc), identification of areas of improvement, sharing of results to committees and health networks, discussion of results with health networks at forums, JOMs and quality meetings and development of initiatives and work plan for 2017.
Analysis:	All planned CAHPS surveys were successfully fielded and deliverables were received on time, with the exception a minor delay of CG-CAHPS. Overall, there was an increase in CAHPS performance from 2015 to 2016. There was an improvement in CAHPS scores related to Personal Doctor and How Well Doctors Communicate. For Getting Needed Care and Getting Care Quickly remained below the 25th percentile and continue to be areas for improvement.
Barriers:	Barriers identified include: delay in the initial implementation of CG-CAHPS and transition of CAHPS sample pull to a new analyst, survey fatigue by our members, health networks do not understand all the different CAHPS surveys that CalOptima fields and gets them confused, and health networks have different levels of interest and engagement in member experience.

QUALITY OF SERVICE — REVIEWED THROUGH CUSTOMER SERVICE FIRST CALL RESOLUTION

What is Monitored	*Required Key Performance Indicators*	*Annual Findings*	*Barriers*	*Interventions*
• The Medi-Cal Call Center monitors the calls to determine the rate of first call resolution.	• First call resolution is 85% of calls are resolved the first time a member calls for assistance	• Q1 – 87% • Q2 – 85% • Q3 - 85% • Q4 – 85%	None identified	None needed as the key performance indicators for First Call Resolution have been achieved.
• The OC Call Center monitors the calls to determine the rate of first call resolution*. *Measure was not implemented until Q3.	• First call resolution is 85% of calls are resolved the first time a member calls for assistance	• Q3 – 88% • Q4 – 88%	None identified	None needed as the key performance indicators for First Call Resolution have been achieved.
• The OCC Call Center monitors the calls to determine the rate of first call resolution. *Measure was not implemented until Q3.	• First call resolution is 85% of calls are resolved the first time a member calls for assistance	• Q3 – 91% • Q4 – 87%	None identified	None needed as the key performance indicators for First Call Resolution have been achieved.

QUALITY OF SERVICE — REVIEWED THROUGH CUSTOMER SERVICE ACCESS

What is Monitored	*Required Key Performance Indicators*	*Annual Findings*	*Barriers*	*Interventions*
• The Medi-Cal Call Center monitors the Customer Service lines hourly for	• ASA goal is all calls are answered in 30 seconds or less. • ABD goal is less than 3% of	• ASA Q1- 23 Seconds Q2 – 26 Seconds Q3 – 26 Seconds Q4 – 26 Seconds	None identified	None needed as the key performance indicators for ASA and ABD have been

Average Speed of Answer/Hold Time (ASA) and total number of calls abandoned (ABD) and service levels. • If any deficiencies are noted, the workforce is immediately adjusted to ensure ASA and ABD key performance indicators are achieved.	all calls received are abandoned before completion.	• ABD Q1- 2.0% Q2 -2.2% Q3 – 2.5% Q4 – 1.8%		achieved.
• The OC Call Center monitors the Customer Service lines hourly for Average Speed of Answer/Hold Time (ASA) and total number of calls abandoned (ABD) and service levels. • If any deficiencies are noted, the workforce is immediately adjusted to ensure ASA and ABD key performance indicators are achieved.	• ASA goal is all calls are answered in 30 seconds or less. • ABD goal is less than 3% of all calls received are abandoned before completion.	• ASA Q1- 16 Seconds Q2 – 11 Seconds Q3 – 6 Seconds Q4 – 6 Seconds • ABD Q1- 2.8% Q2 -3.3% Q3 – 0.8 % Q4 – 1.0%	None identified.	None needed as the key performance indicators for ASA and ABD have been achieved.
• The OCC Call Center monitors the Customer Service lines hourly for	• ASA goal is all calls are answered in 30 seconds or less. • ABD goal is	• ASA Q1- 20 Seconds Q2 – 11 Seconds Q3 – 6 Seconds Q4 – 7 Seconds	None identified.	None needed as the key performance indicators for ASA and ABD

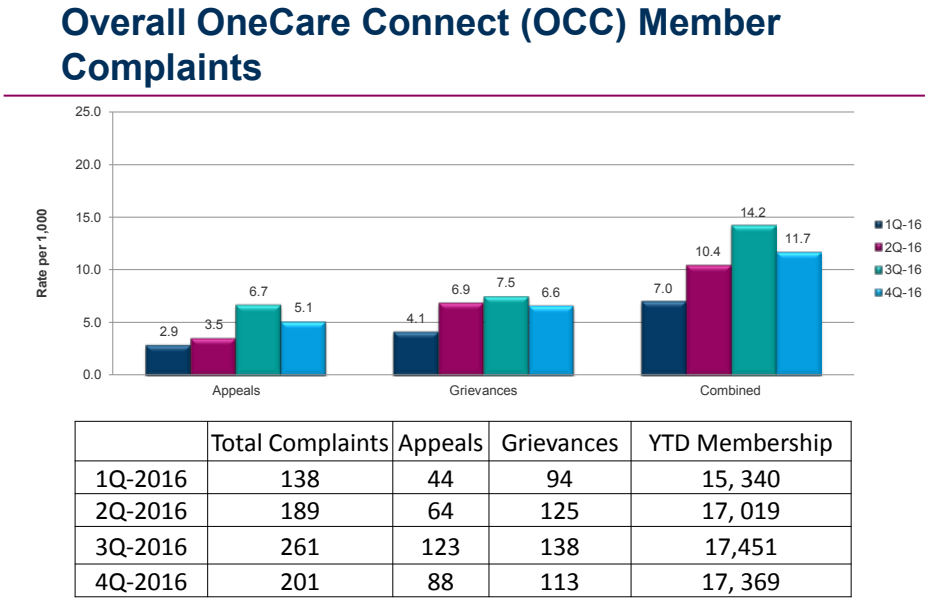
Average Speed of Answer/Hold Time (ASA) and total number of calls abandoned (ABD) and service levels. • If any deficiencies are noted the workforce is immediately adjusted to ensure ASA and ABD key performance indicators are achieved.	less than 3% of all calls received are abandoned before completion.	• ABD Q1- 1.4% Q2 -1.5% Q3 – 0.9% • Q4 – 0.8%		have been achieved.

QUALITY OF SERVICE – REVIEWED THROUGH GRIEVANCES AND APPEAL

CalOptima provided quarterly trend reports on the rate of complaints (appeals/grievances) for all programs during 2016. The tables below show the quarterly data for each population.

Key Findings:

ONECARE CONNECT:



	Total Complaints	Appeals	Grievances	YTD Membership
1Q-2016	138	44	94	15, 340
2Q-2016	189	64	125	17, 019
3Q-2016	261	123	138	17,451
4Q-2016	201	88	113	17, 369

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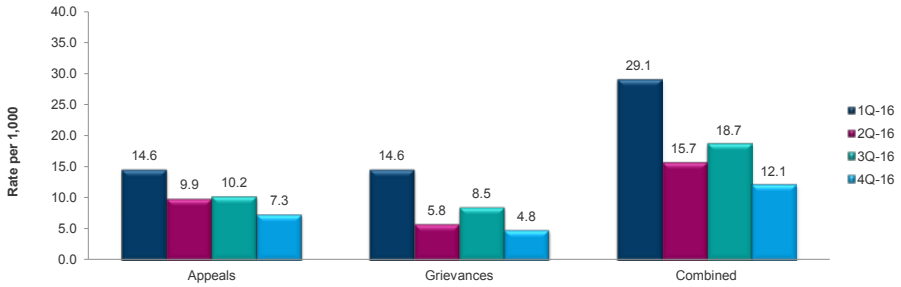
ONECARE:

Overall OneCare (OC) Member Complaints



	Total Complaints	Appeals	Grievances	YTD Membership
1Q-2016	38	19	19	1,305
2Q-2016	18	12	7	1,257
3Q-2016	22	12	10	1,230
4Q-2016	16	10	6	1,232

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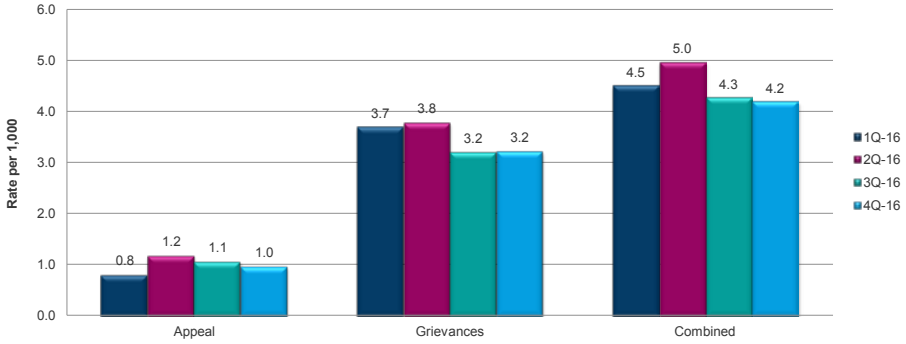
MEDI-CAL:

Overall Medi-Cal Member Complaints



	Total Complaints	Appeals	Grievances	YTD Membership
1Q-2016	856	154	702	769,385
2Q-2016	958	229	729	770,487
3Q-2016	838	210	628	772,927
4Q-2016	826	192	634	774,869

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ANALYSIS:
Overall access issues related to appointment availability for PCP visits increased. There were no specific trends identified. There was a slight increase in grievances regarding delay in referral submission. However, the increase was not significant and there were no specific trends identified. OC Advantage reported a higher quarterly rate/1,000 grievance due to low membership. Two (2) grievances were received out of 892 members. Overall grievances as a rate/1,000 members remained low at 3.2 in Q4 2016.

INTERVENTIONS:
- All quality of care concerns are referred to the Quality Improvement department for investigation.
- CalOptima works with all our networks (by sharing the grievance and appeals data specific to each network) and providers to improve in these areas including QOS and QOC concerns.
- Provided tips and recommendations related to the common complaints at the CCN Lunch & Learn meeting for providers and their office staff.

HEDIS/STARS IMPROVEMENT

IMPROVE HEDIS MEASURES LISTED ON "MEASURES" WORKSHEET

2016 HEDIS/CAHPS/Stars Measures

Data based on prospective rates as of November 30, 2016. Additional claims/encounter to be received through December 31, 2016. Hybrid measures will go through medical chart review.

HEDIS Medi-Cal Measures	MC Rate	MC Goal	Goal Met/ Not Met	Quantitative Analysis	Qualitative Analysis (Barriers)	Completed Activities
Diabetes Care: a. HbA1c Testing b. A1C Poor Control **(lower is better)** c. A1C Adequate Control d. Eye Exams e. Nephropathy Screening f. B/P Control	a. 86.28% b. 35.58% c. 54.42% d. 55.42% e. 90.07% f. 41.40%	a. 85.95% b. 36.87 c. 52.55% d. 61.50% e. 90.51% f. 68.61%	a. Met b. Met c. Met d. Not Met e. Not Met f. Not Met	a. Exceeds goal +.33 b. Exceeds goal +1.29 c. -1.87 to goal d. -6.08 to goal e. -.44 to goal f. -27.21 to goal	• Provider barriers: lack of documentation in medical charts, lack of resources to conduct outreach to members, lack of referrals to specialist • Member barriers: Lack of transportation, lack of understanding of benefits to get annual eye exams for diabetics, lack of adherence to medication	• Implemented Diabetes PIP/QIPs to increase HbA1c testing for the MC and OC populations • Sent PCPs list of patients in the Disease Management program to conduct outreach • Quarterly diabetic eye exam member mailing • Diabetes Talk newsletter

HEDIS Medi-Cal Measures	MC Rate	MC Goal	Goal Met/ Not Met	Quantitative Analysis	Qualitative Analysis (Barriers)	Completed Activities
Plan All-Cause Readmissions (PCR)	16.49%	<14%	Not Met	-2.49 to goal	• Limited real time hospital data to conduct timely interventions • Large population to conduct outreach to • Delay in outreach; program needed to be updated. • Lack of staffing to support	• Implemented the transition of care program that conducts Health coach outreach and discharge mailing kits.
Flu/Pneumonia (CAHPS Survey)	Not yet available	90%	Not Met	TBD	• CAHPS survey does not capture all flu/pneumococcal data. Based on member response • Lack of data collection on measure	• Flu/pneumonia mailing with immunization schedule • Articles in the Medi-Cal Newsletter
Prenatal/Postpartum Care • Prenatal • Postpartum	• 80.75% • 65.96%	• 82.25% • 67.53%	• Not Met • Not Met	• -1.5 to goal • -1.39 to goal	• Member barriers: lack of transportation, child care, compliance due to perception (not necessary because they have had multiple children and are ok, lack of availability to attend appointments • Health Plan: Lack of	• Prenatal and postpartum mailings to members (bi-weekly) • Text 4 baby program; expanding to "personalized messaging" • CME/CE seminars • PNR/MOMs database data review • Developed small

HEDIS Medi-Cal Measures	MC Rate	MC Goal	Goal Met/ Not Met	Quantitative Analysis	Qualitative Analysis (Barriers)	Completed Activities
					timely outreach to members	workgroup to improve Maternal Data Mart; goal to produce timely and accurate reports for PPC • Updated educational insert for prenatal
Attention Deficit Disorder • Initiation • Continuation	• 38.84% • 40.07%	• 42.19% • 52.47%	• Not Met • Not Met	• -3.35 to goal • -12.4 to goal	• Lack of complete data for behavioral health services • County does not share BH data with CalOptima on our members • Mailing data – prescribers/practitioners could be from the County and CalOptima may have outdated provider information	• ADD mailing to both members and providers. Members received reminder to go in for follow up visits. PCP/Prescribers are notified of members on ADHD medication.
Antidepressant Medication Management • Initiation • Continuation	• 54.98% • 39.85%	• 59.52% • 41.46%	• Not Met • Not Met	• -4.54 to goal • --1.61 to goal	• Lack of complete data for behavioral health services • County does not share BH data with CalOptima on our members • Mailing data – prescribers/practitioners could be from the County and CalOptima may have outdated provider information	• Provider educational faxes; pharmacy and provider update • ICT medication reconciliation tool
Appropriate Use of Antibiotics	22.52%	26.3%	Not met	-3.78 to goal	• Provider barriers: Members request antibiotics and makes it	• PDSA project for this measure: Outreaching to 5 high prescribing/low

HEDIS Medi-Cal Measures	MC Rate	MC Goal	Goal Met/ Not Met	Quantitative Analysis	Qualitative Analysis (Barriers)	Completed Activities
					difficult for providers to refuse, lack of coding appropriately, not excluding members with certain co-morbid conditions.	performing providers for this measure by Medical Director
Adolescent Immunizations • Meningococcal • Tdap • Combo 1	• 80.42% • 83.86% • 78.24%	• 83.7% • 90% • 82.09%	• Not Met • Not Met • Not Met	• -3.28 to goal • -6.64 to goal • -3.85 to goal	• Difficult population to outreach. Adolescents are less inclined to go in for a visit unless sick • Parent's perception of immunizations impact rates	• Healthy You newsletters • Child Health Guide mailings
Low Back Pain	73.35%	73.71%	Not met	-.36 to goal		
Adults Access to Preventive Care	65.17%	82.15%	Not Met	-16.98 to goal		
Children's Access to Preventive Care • 12-24 months • 25mo-6 years • 7-11 years • 12-19 years	• 93.61% • 84.89% • 89.38% • 85.62%	• 95.74% • 90.98% • 93.25% • 89.37%	• Not met • Not met • Not met • Not met	• -2.13 to goal • -6.09 to goal • -3.87 to goal • -3.75 to goal	Provider barriers: Lack of outreach to members, lack of resources to conduct outreach Member barriers: may not go into visit unless they are sick, lack of transportation, time, resources to get to appt.	• Healthy You newsletters for babies (0-2 years) and children (3-12 years) • Child Health Guide mailings to children who were recently admitted to the hospital • CME/CE trainings; 3 educational seminars
Childhood Immunizations (Combo 10)	31.71%	40.91%	Not met	-9.2 to goal	Provider barriers: Lack of outreach to members, lack of resources to conduct outreach Member barriers: may not go into visit unless they are sick, lack of transportation, time, resources to get to appt.	• CAIR outreach; outreach to Providers and members • Healthy You newsletters for babies (0-2 years) and children (3-12 years) • Child Health Guide mailings to children who were recently admitted to

HEDIS Medi-Cal Measures	MC Rate	MC Goal	Goal Met/ Not Met	Quantitative Analysis	Qualitative Analysis (Barriers)	Completed Activities
						the hospital • CME/CE trainings; 3 educational seminars • Interactive voice recordings (IVR) calls; promoting immunizations for children from 0-before 2nd birthday
Well Child Visits in the First 15 months of Life	36.73%	59.57	Not Met	--22.84 to goal	• Provider barriers: Lack of outreach to members, lack of resources to conduct outreach • Member barriers: may not go into visit unless they are sick, lack of transportation, time, resources to get to appt.	• Healthy You newsletters for babies (0-2 years) and children (3-12 years) • Child Health Guide mailings to children who were recently admitted to the hospital • CME/CE trainings; 3 educational seminars
Cervical Cancer Screening	48.96%	55.94%	Not Met –but has achieved DHCS MPL	-6.98 to goal	• Health Plan: Lack of data on members who were part of MC expansion. Measure goes back 3 years to assess compliance. Large population >140K members to outreach to • Provider Barriers: Lack of time, resources to conduct outreach to members. Not incentives to put out staffing time	• CCS workgroup barrier analysis • CCS PDSA: Provider Office Staff incentive • CCS IVR calls outreach to members who have not received screening • CCS Mailing dropped in December, 2016. Updated the cervical cancer screening brochure • Preconception insert in Prenatal mailings (Promoting cervical

HEDIS Medi-Cal Measures	MC Rate	MC Goal	Goal Met/ Not Met	Quantitative Analysis	Qualitative Analysis (Barriers)	Completed Activities
					• Member barriers: Cultural stigma for member, Invasive tests that women are less likely to complete, lack of transportation, child care, resources	health before getting pregnant)
Breast Cancer Screening	62.5%	71.52%	Not Met	-9.02 to goal	• Health Plan: Lack of data on members who were part of MC expansion. Measure goes back 3 years to assess compliance. Large population to outreach to • Provider Barriers: Lack of time, resources to conduct outreach to members. Not incentives to put out staffing time • Member barriers: Cultural stigma for member, Invasive tests that women are less likely to complete, lack of transportation, child care, resources	• BCS member mailing • Updated breast cancer brochure

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IMPROVE IDENTIFIED STARS MEASURES LISTED ON "MEASURE" WORKSHEET

2016 HEDIS/CAHPS/Stars Measures

Data based on prospective rates as of November 30, 2016. Additional claims/encounter to be received through December 31, 2016. Hybrid measures will go through medical chart review.

STARS Measures	OC Rate	OC Goal	Goal Met/ Not Met	Quantitative Analysis	Qualitative Analysis (Barriers)	Completed Activities
Diabetes Care (OneCare) a. HbA1c Testing **b. A1C Poor Control (lower is better)** c. A1C Adequate Control d. Eye Exams e. Nephropathy Screening f. Blood Pressure Control	a. 91.26% b. 25.68% c. 68.31% d. 72.13% e. 89.07% f. 61.75%	a. 91.39% b. 18.8% c. 72.75% d. 81.00% e. 96.00% f. 73.92%	a. Not Met b. Not Met c. Not Met d. Not Met e. Not Met f. Not Met	a. -.13 to goal b. -6.88 to goal c. -4.44 to goal d. -8.87 to goal e. -6.93 to goal f. -12.17 to goal	• Provider barriers: Lack of documentation in medical charts, lack of resources to conduct outreach, lack of referrals to specialists. • Member Barriers: Lack of transportation, lack of understanding of benefits to get annual eye exams for diabetics, lack of adherence to medication	• Implemented Diabetes PIP/QIPs to increase HbA1c testing for the MC and OC populations • Sent PCPs list of patients in the Disease Management program to conduct outreach • Quarterly diabetic eye exam member mailing • Diabetes Talk newsletter
Plan All-Cause Readmissions (PCR)	Not yet available	<14%	TBD		• Limited real time hospital data to conduct timely interventions • Most of the population has transitioned to OCC • Delay in outreach; program needed to be updated.	• Implemented the transition of care program that conducts Health coach outreach and discharge mailing kits.

STARS Measures	OC Rate	OC Goal	Goal Met/ Not Met	Quantitative Analysis	Qualitative Analysis (Barriers)	Completed Activities
Flu/Pneumonia (CAHPS Survey)	Not yet available	90%	TBD		• CAHPS survey does not capture all flu/pneumococcal data. Based on member response • Lack of data collection on measure	• Flu/pneumonia mailing • Articles in the Medi-Cal Newsletter
Antidepressant Medication Management • Initiation • Continuation	• 73.58%% • 50.94%	• 68.66% • 54.76%	• Met • Not Met	Met goal for the initiation phase.--3.82 to goal for continuation	• Lack of complete data for behavioral health services	• Provider educational faxes; pharmacy and provider update • ICT medication reconciliation tool
Osteoporosis Management in Women	100%	47.6%	Met	Only 1 member in the denominator	• Most members have transitioned to OCC program	• OMW provider faxes, notifying providers of members to conduct outreach to. • ICT medication reconciliation tool
Breast Cancer Screening	70.2%	71.36%	Not met	-1.16 to goal	• Provider Barriers: Lack of time, resources to conduct outreach to members. Not incentives to put out staffing time • Member barriers: Cultural stigma for member, Invasive tests that women are less likely to complete, lack of transportation, resources	• BCS member mailing
Colorectal Cancer Screening	56.14%	71.00%	Not met	-14.86 to goal	• Provider Barriers: Lack of time, resources to	• Updating colorectal brochures/fact sheets

STARS Measures	OC Rate	OC Goal	Goal Met/ Not Met	Quantitative Analysis	Qualitative Analysis (Barriers)	Completed Activities
					conduct outreach to members. No incentives for staffing time • Member barriers: Cultural stigma for member, Invasive procedure, lack of transportation, discomfort	

IMPROVE CAHPS MEASURES LISTED ON "MEASURES" WORKSHEET

Key Findings:	Areas of focus for CY 2016 are the following: • Rating of Health Plan • Getting Needed Care • Getting Care Quickly • How Well Doctors Communicate and • Customer Service Goals for plan level Medi-Cal CAHPS are set at the 50th percentile (NCQA benchmark). For OC, the goal is maintaining or exceeding 4.0 CMS STAR rating. For the Medi-Cal Child Survey, CalOptima met 1 of the 5 areas: Rating of All Health Care. For Medi-Cal Adult, CalOptima met 1 of the 5 areas: How Well Doctors Communicate. For OC, CalOptima did not meet a 4 STAR rating for any CAHPS measures.
Interventions:	List of completed activities include: • Implementation of CG-CAHPS, sharing member experience results with members, providers and health networks • Quality Meetings with HNs to discuss results and share best practices increase weight of member experience in Pay4Value • Issued corrective action plans on access and availability • Updated the prior authorization list • Promoted the nurse advice line • Continued ongoing customer service training
Analysis:	Overall, there was an increase in CAHPS performance from 2015 to 2016. • There was an improvement in CAHPS scores related to Personal Doctor and How Well Doctors Communicate. • Getting Needed Care and Getting Care Quickly remain below the 25th percentile and are areas of focus.
Barriers:	Barriers for member experience include: 1) members, providers and health networks are not aware of member experience performance; 2) members may not feel engaged in their own health care; 3) members and providers are unaware of the referral and authorization processes; 4) providers may not have the skills or tools to provider better customer service; 5) challenges in recruiting in-demand specialists; and 6) high turnover of customer service staff.

HEDIS: Launch Pediatric Wellness Clinic

The pediatric wellness clinic was not launched in 2016; this program required additional funds and approvals from the CalOptima Board of Directors in order to implement. However, the Quality Analytics department is planning a pediatric health and wellness event in collaboration with participating health networks in 2017.

However, there were other quality initiatives surrounding pediatric HEDIS measures implemented in 2016, including:

- CAIR outreach to providers and members
- "Healthy You" newsletters about babies (0-2 years) and children (3-12 years)
- Updated immunization inserts for newsletters
- Child Health Guide mailings for parents of children who were recently admitted to the hospital
- Four educational seminars/CME/CE trainings about: Weight Management for Children & Adults; Infections in Pregnant Women & Neonates and How to Avoid Them; Asthma Update; Healthy Birth Spacing.
- "Text 4 Baby" promotion; included messages for well-care visits and immunizations
- Interactive voice recordings (IVR) calls; promoting immunizations for children from 0- before 2nd birthday
- Medi-Cal newsletter articles

STARS Improvement — Medication Adherence

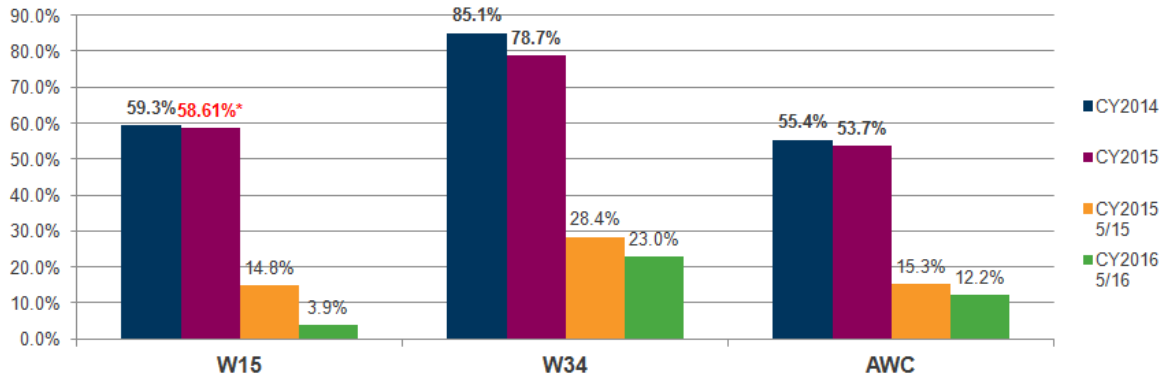
Key Findings:	***Goal:*** ***Achieve CMS 4-Star Performance in the three Medication Adherence Measures***
Interventions:	• Member outreach • Mailings-Letter with member's action plan, Healthy You, medication log • Follow up calls • Provider P4P
Analysis:	• OC adherence % are above the MA-PD average for 2 of the 3 measures • OCC adherence % are below the MA-PD average for all 3 measures • For 2017, OC results were 3 stars for two measures and 4 stars for one measure • For 2017, OCC was too new for measurement • 2018 Star results will be available in September 2017

Barriers:	• Interventions are resource-intensive; resources are limited
	  ○ Focus on maintaining regulatory compliance with prior authorizations
	  ○ Multiple audits
	  ○ Staff maternity leave
	• Low income subsidy (LIS) population tends to have lower adherence rates

HEDIS 2016 RESULTS

MEDI-CAL RESULTS FOR CHILDREN AND WOMEN'S HEALTH

MEDI-CAL WELL CHILD VISITS

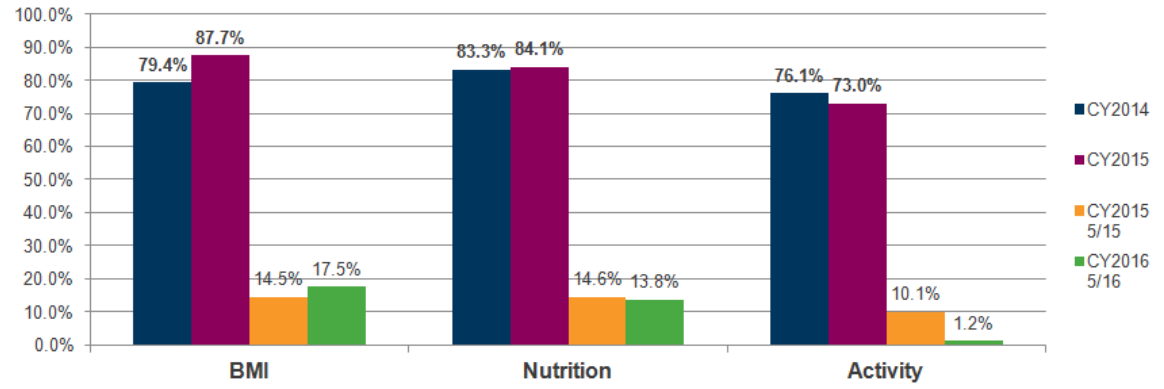


HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements**
Well-Child Visits in the First 15 Months of Life - Six Well Child Visits (W15)	**62.86%**	69.75%	76.92%	**RS**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	72.02%	78.46%	**83.75%**	**MPL, P4V, RS**
Adolescent Well-Care Visits (AWC)	**49.15%**	59.98%	66.58%	**P4V, RS**

*Red = less than 50th percentile

**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

MEDI-CAL WEIGHT ASSESSMENT AND COUNSELING

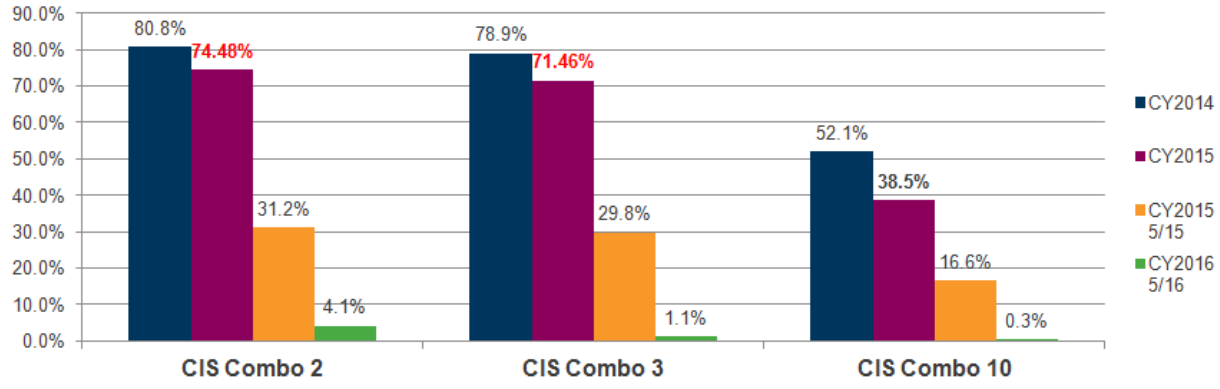


HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements**
Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)				
1. BMI Percentile	67.23%	77.98%	**85.61%**	**ACC, MPL, RS**
2. Counseling for Nutrition	61.44%	72.87%	**79.56%**	**MPL, RS**
3. Counseling for Physical Activity	53.89%	64.43%	**71.53%**	**MPL, RS**

*Red = less than 50th percentile

**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

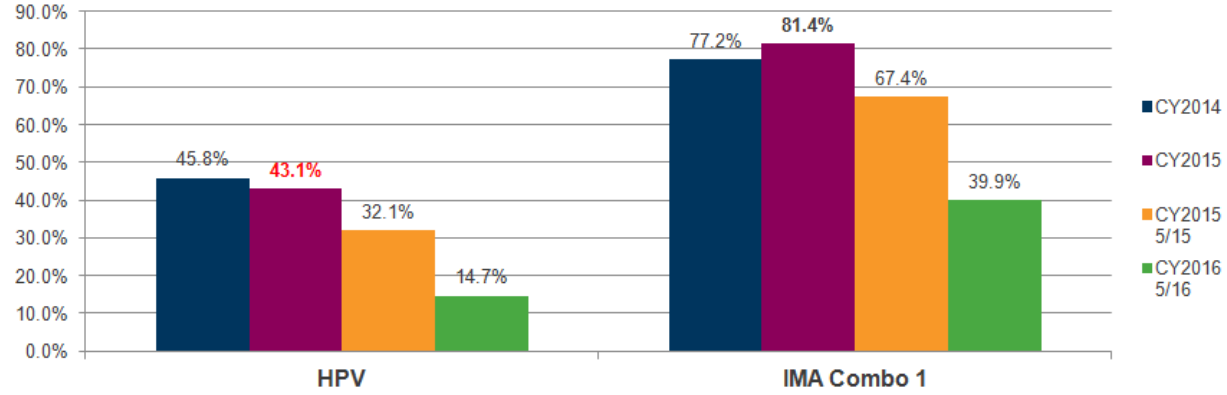
MEDI-CAL IMMUNIZATIONS — CIS



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements**
Childhood Immunization Status (CIS)				
CIS - combo 2	75.47%	79.40%	82.78%	ACC
CIS - combo 3	71.53%	76.50%	81.25%	MPL
CIS - combo10 ++	35.88%	42.13%	49.63%	ACC, P4V, RS

*Red = less than 50th percentile; ++ measure triple weighted for Health Plan Ratings
**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

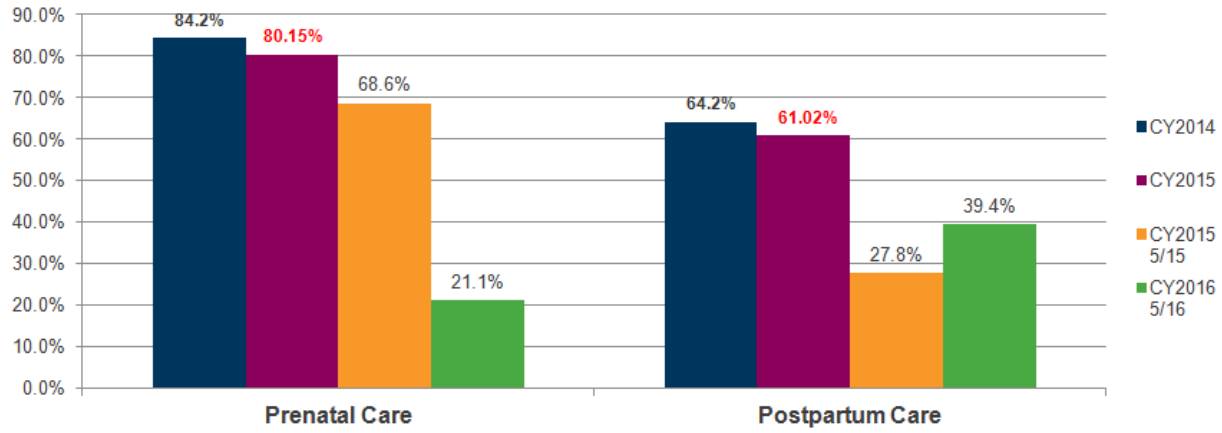
MEDI-CAL IMMUNIZATIONS — HPV, IMA



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements**
Human Papillomavirus Vaccine for Female Adolescents (HPV) ++	21.90%	25.61%	31.43%	ACC, RS
Immunizations for Adolescents (IMA)				
IMA - Combo 1 ++	73.15%	81.51%	87.71%	ACC, MPL, RS

*Red = less than 50th percentile; ++ measure triple weighted for Health Plan Ratings
**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

MEDI-CAL WOMEN'S HEALTH — PPC

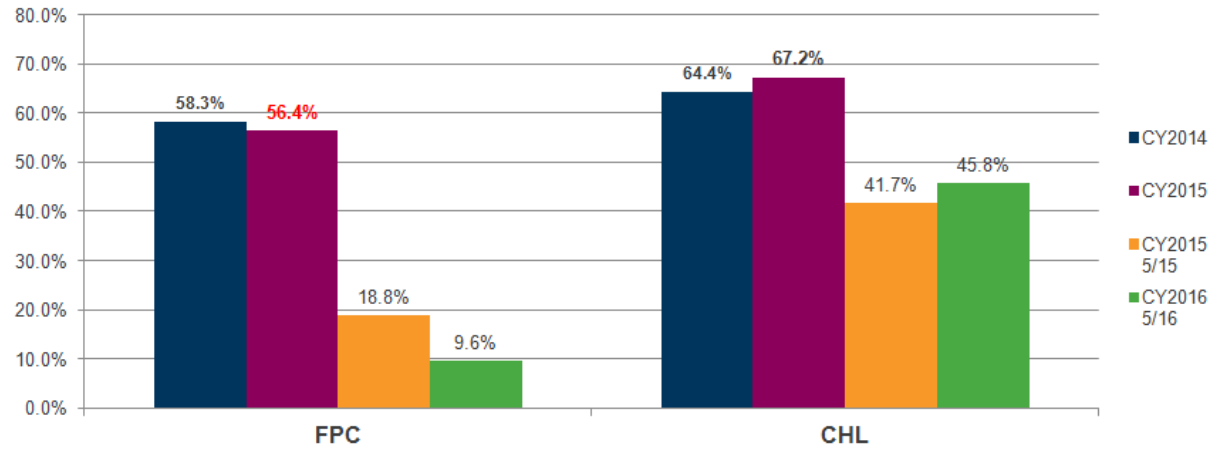


HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements**
Prenatal Care and Postpartum Care (PPC)				
Prenatal Care	85.19%	88.66%	91.73%	ACC, MPL, RS
Postpartum Care	62.77%	68.85%	72.43%	ACC, MPL, RS

*Red = less than 50th percentile

**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

MEDI-CAL WOMEN'S HEALTH — FPC, CHL

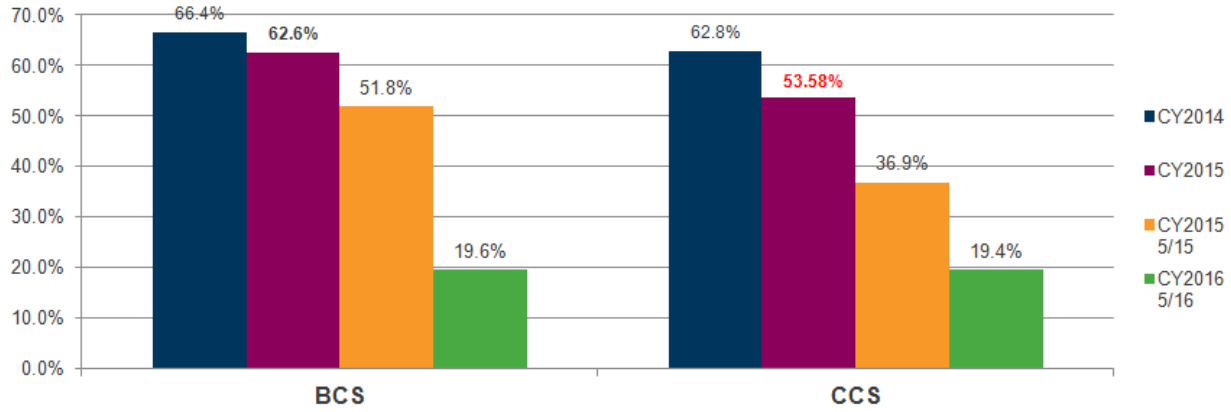


HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements**
Frequency of Prenatal Care (FPC) >=81%	59.49%	69.78%	75.35%	ACC, RS
Chlamydia Screening (CHL)	54.40%	61.98%	68.60%	ACC, RS

*Red = less than 50th percentile

**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

MEDI-CAL WOMEN'S HEALTH — BCS, CCS

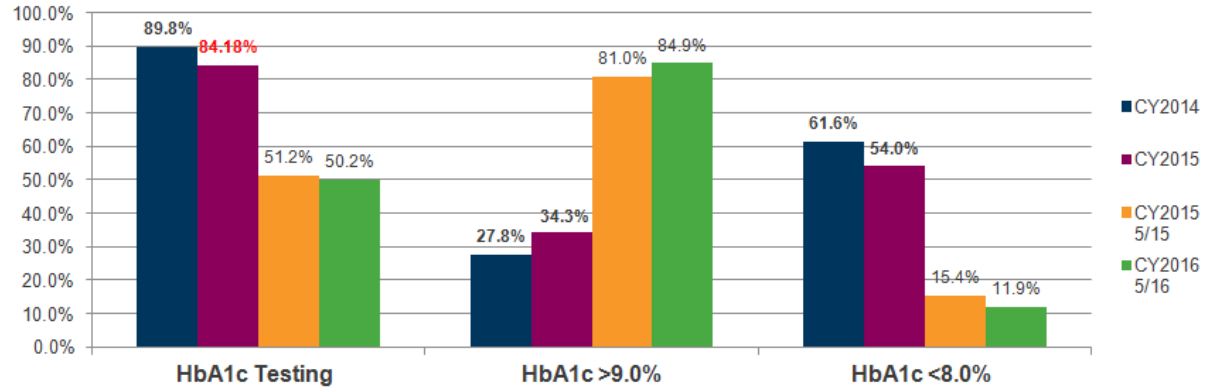


HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Breast Cancer Screening (BCS)	58.34%	66.02%	71.41%	ACC, P4V, RS
Cervical Cancer Screening (CCS)	61.05%	67.88%	73.08%	ACC,MPL, P4V, RS

*Red = less than 50th percentile
**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

CARE FOR CHRONIC CONDITIONS

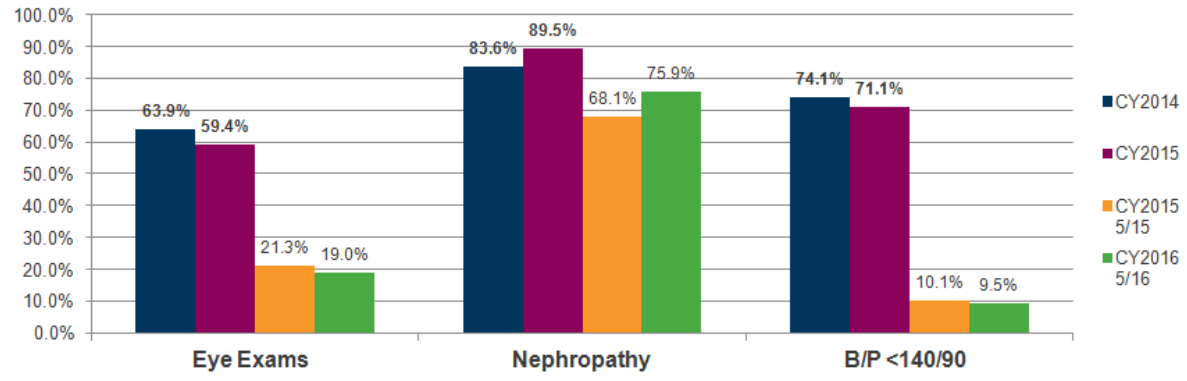
MEDI-CAL COMPREHENSIVE DIABETES CARE — HBA1C



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Comprehensive Diabetes Care (CDC)				
1. HbA1c Testing	86.20%	89.55%	91.94%	ACC, MPL, P4V
2. HbA1c Poor Control (>9.0%) (Lower is better)	42.22%	34.66%	29.68%	ACC, MPL
3. HbA1c Adequate Control (<8.0%)	47.91%	54.01%	58.58%	ACC, MPL, RS

*Red = less than 50th percentile, ++ measure triple weighted for Health Plan Ratings
**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

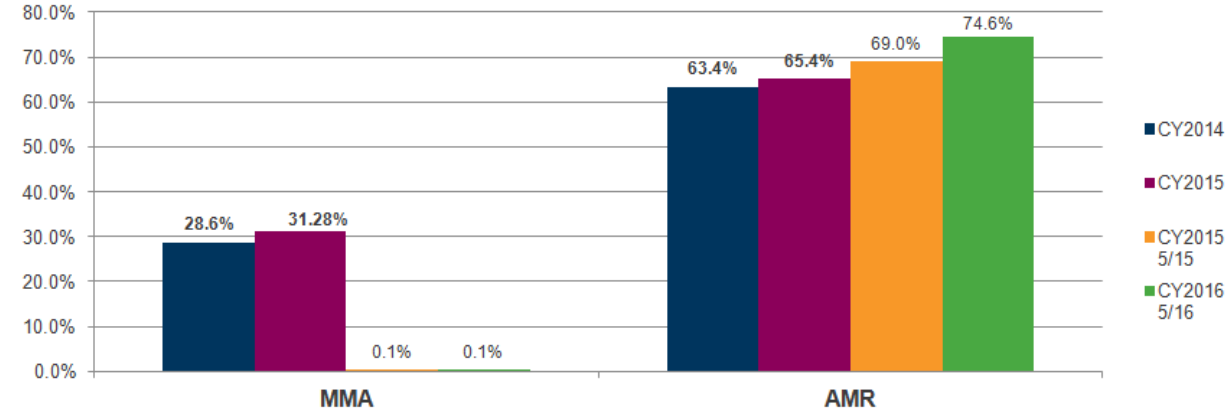
MEDI-CAL COMPREHENSIVE DIABETES CARE — EYE EXAM, NEPHROPATHY, BP



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Comprehensive Diabetes Care (CDC)				
4. Eye Exams	**54.74%**	63.23%	67.74%	ACC, MPL, P4V, RS
5. Nephropathy Monitoring	81.75%	84.88%	**87.70%**	ACC, MPL, RS
6. B/P <140/90	62.23%	**69.16%**	76.64%	ACC, MPL, RS

*Red = less than 50th percentile, ++ measure triple weighted for Health Plan Ratings
**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

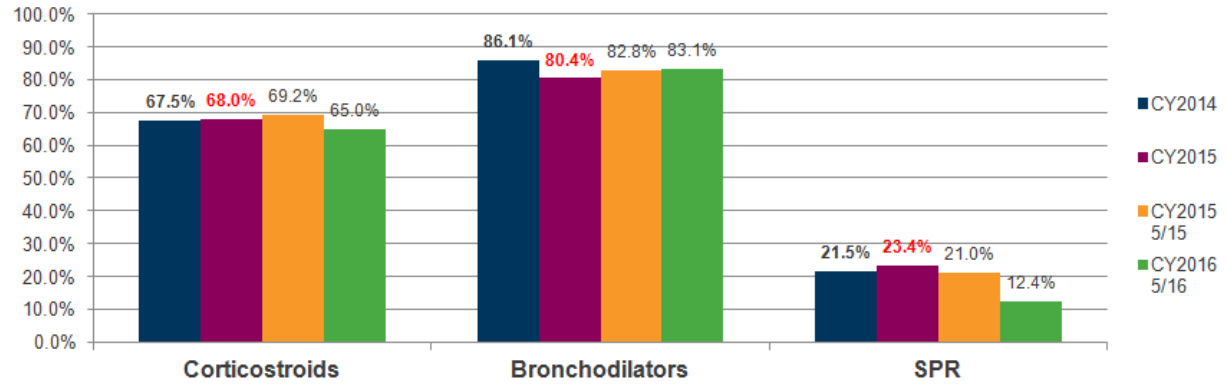
MEDI-CAL ASTHMA



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Medication Management for People with Asthma (MMA) - 75% Compliance	**29.60%**	34.84%	43.38%	ACC, MPL, P4V, RS
Asthma Medication Ratio (AMR) > 50%	60.76%	**65.01%**	70.43%	ACC, RS

*Red = less than 50th percentile
**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

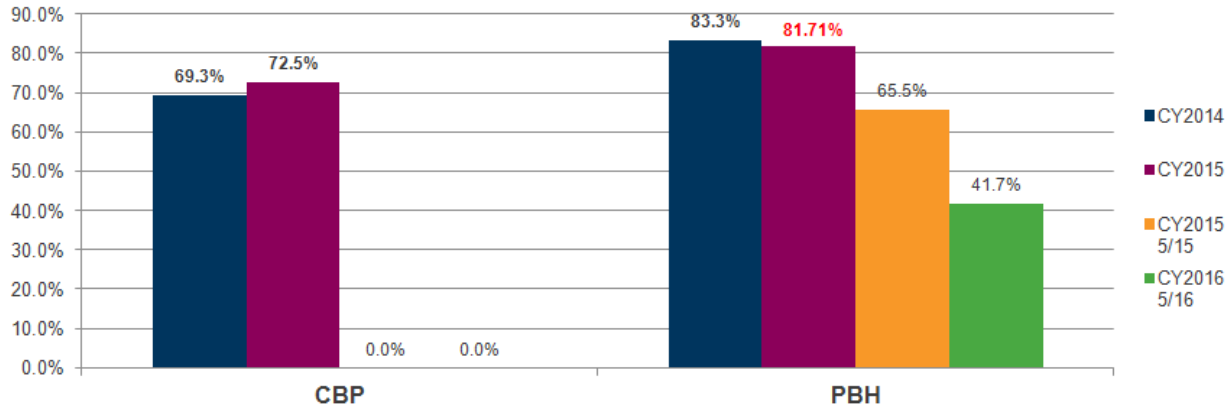
MEDI-CAL COPD



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Pharmacotherapy Management of COPD Exacerbation (PCE)				
1. Systemic Corticosteroids	69.01%	74.76%	78.21%	ACC, RS
2. Bronchodilators	83.43%	87.07%	89.04%	ACC, RS
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	30.77%	35.77%	40.54%	ACC

*Red = less than 50th percentile
**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

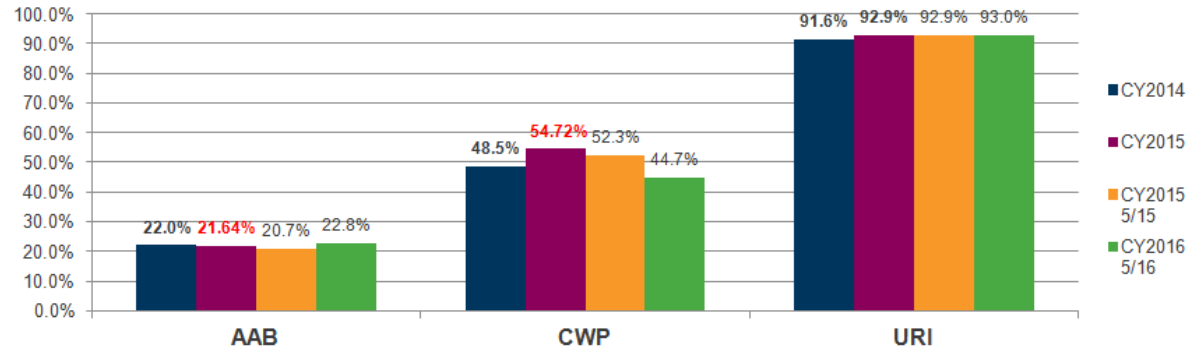
MEDI-CAL CARDIOVASCULAR CONDITIONS



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Controlling High-Blood Pressure (CBP)	57.53%	65.49%	70.32%	ACC, MPL, P4V, RS
Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	84.15%	89.33%	92.31%	RS

*Red =less than 50th percentile, ++ measure triple weighted for Health Plan Ratings
**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

MEDI-CAL RESPIRATORY CONDITIONS

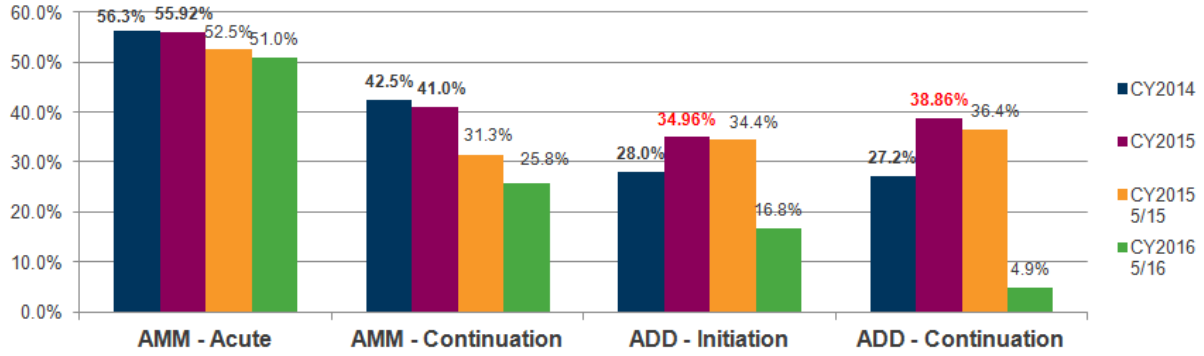


HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) (Below DHCS MPL)	26.30%	32.80%	40.38%	ACC, MPL, RS
Appropriate Testing for Children with Pharyngitis	71.48%	79.83%	85.25%	ACC, P4V, RS
Appropriate Treatment for Children with Upper Respiratory Infection	88.09%	92.51%	95.17%	ACC, P4V, RS

*Red = less than 50th percentile
**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

BEHAVIORAL HEALTH

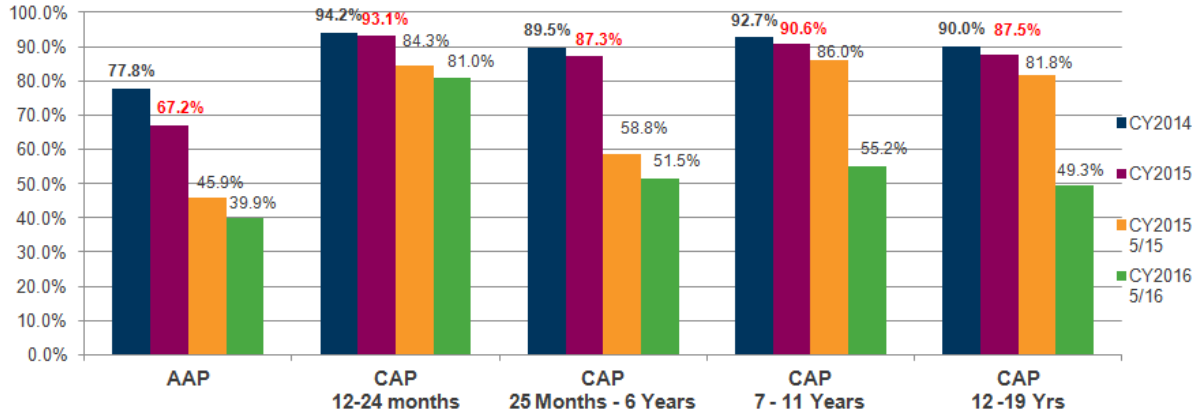
MEDI-CAL BEHAVIORAL HEALTH



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Antidepressant Medications Management (AMM) - Acute Phase Treatment	50.51%	56.15%	62.56%	ACC, P4V, RS
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	34.02%	40.48%	48.39%	ACC, P4V
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Phase	40.79%	49.07%	53.99%	ACC, RS
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Continuation Phase	50.61%	58.36%	65.20%	ACC

*Red = less than 50th percentile
**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

MEDI-CAL ACCESS/AVAILABILITY OF CARE



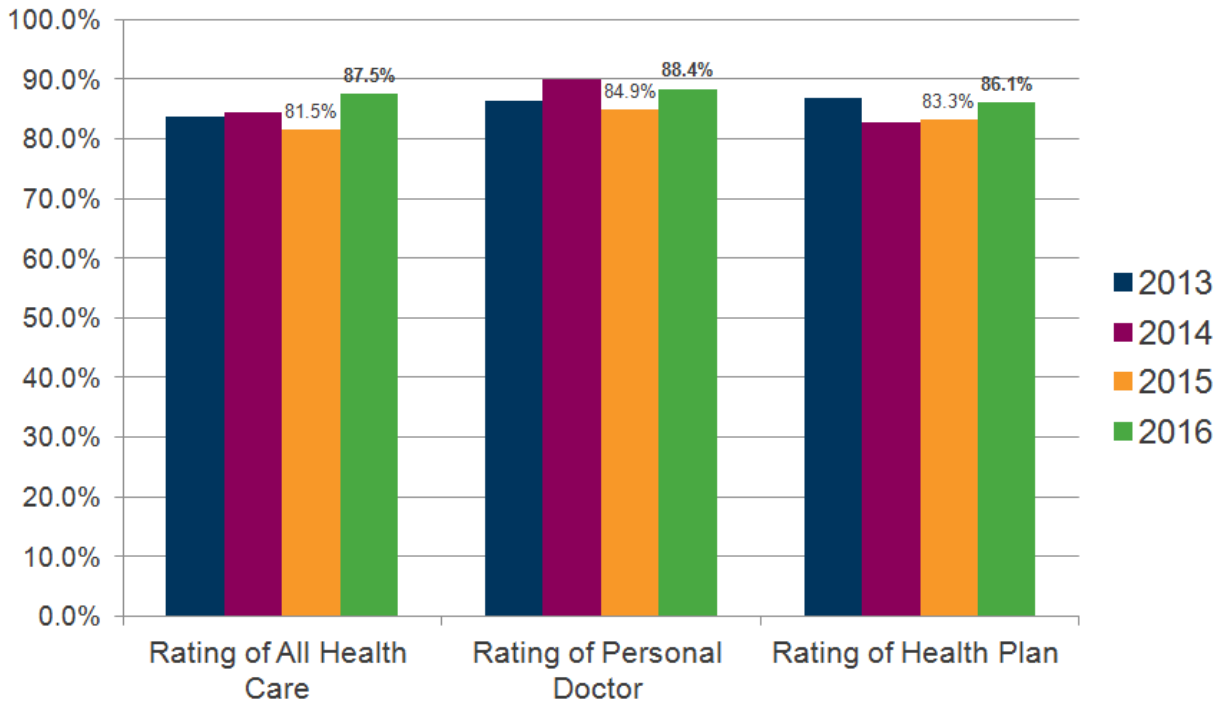
HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Adult's Access to Preventive/Ambulatory Health Services (AAP)	83.84%	86.91%	88.75%	P4V
Children's Access to Primary Care Practitioners (CAP)				
12 - 24 Months	96.28%	97.43%	98.17%	P4V
25 Months - 6 Years	88.46%	91.22%	92.93%	P4V
7 - 11 Years	91.42%	93.90%	95.88%	P4V
12 -19 Years	90.06%	92.46%	94.91%	P4V

*Red = less than 50th percentile

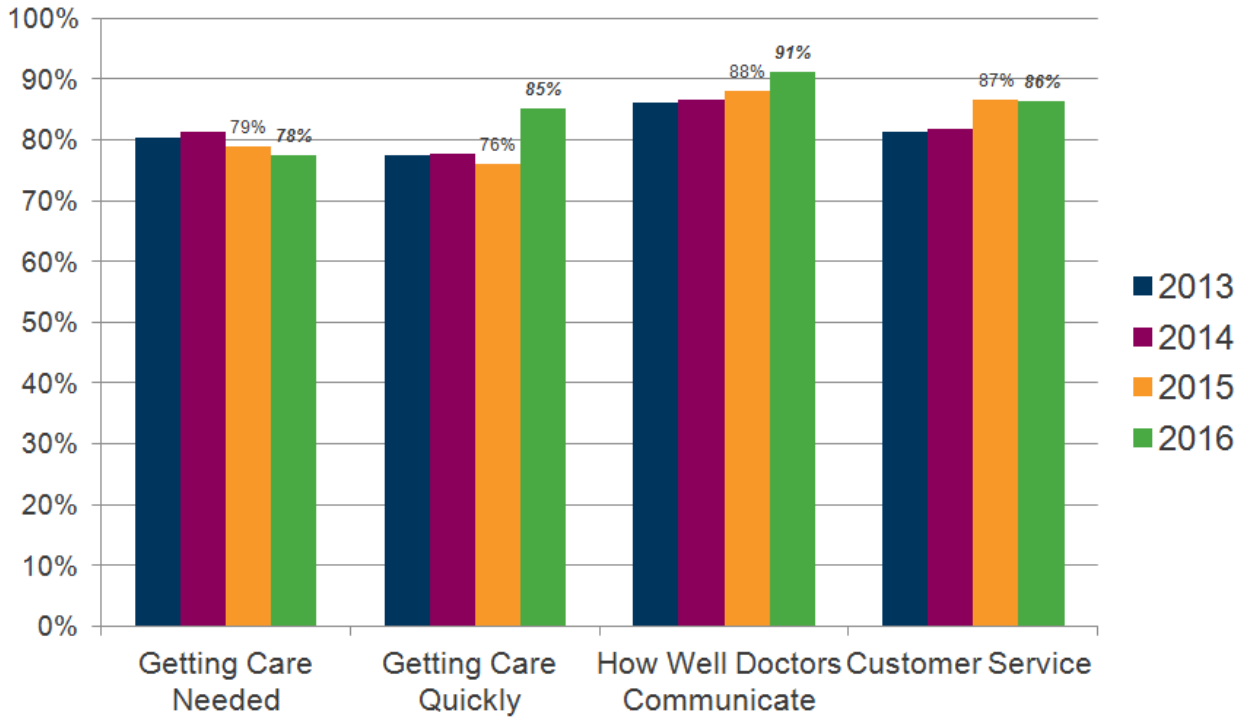
**RS=Health plan ratings, MPL=DHCS Minimal Performance Level, ACC=NCQA Accreditation P4V=Pay for Value

CAHPS

CAHPS® 5.0H CHILD MEMBER SURVEY RESULTS (PARENT'S SATISFACTION WITH THEIR CHILD'S CARE

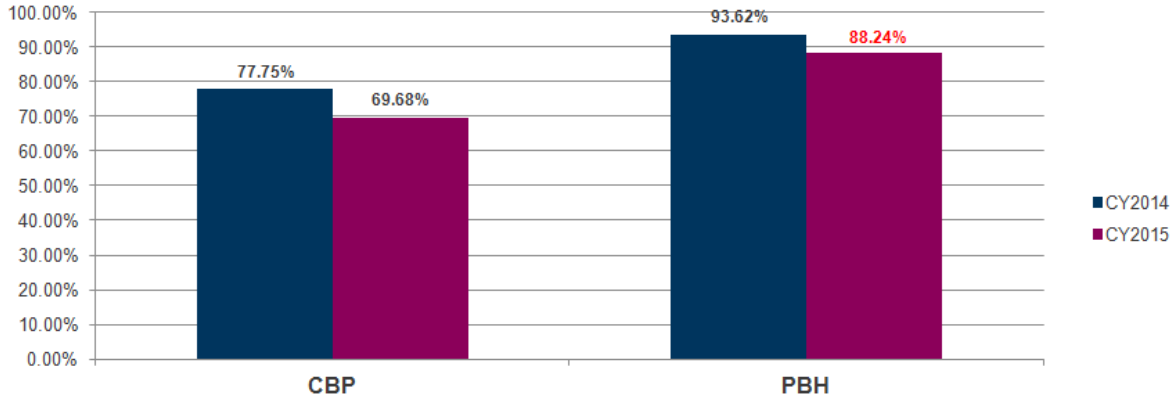


CAHPS® 5.0H Child Member Survey Results (Parent's Satisfaction With Their Child's Care



OneCare Results

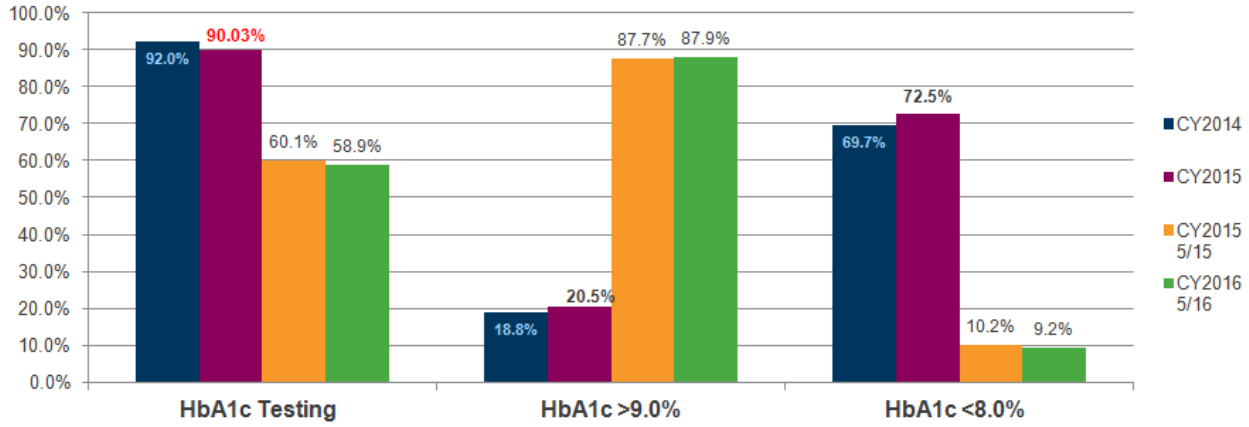
OneCare Cardiovascular Conditions



HEDIS Measure	3-Star/ 50th percentile	4-Star/ 75th percentile	5-Star/ 90th percentile	Reporting Requirements*
Controlling High-Blood Pressure	62%	75%	82%	Star, P4V
Persistence of Beta Blocker Treatment after a Heart Attack	91.20%	94.12%	96.31%	

*Red = less than 3-Star or 50th percentile
** Triple weighted for STARS

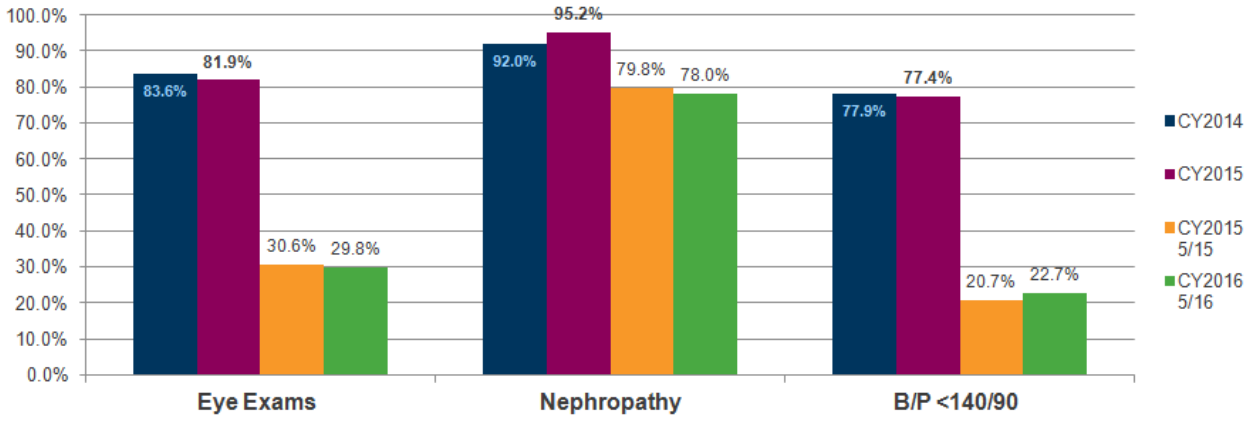
ONECARE COMPREHENSIVE DIABETES CARE — HBA1C



HEDIS Measure	3-Star/ 50th percentile	4-Star/ 75th percentile	5-Star/ 90th percentile	Reporting Requirements*
Comprehensive Diabetes Care (CDC)				
1. HbA1c Testing	93.50%	95.62%	97.16%	
2. HbA1c Poor Control (>9.0%) ** (lower is better)	40%	29%	16%	Star
3. HbA1c Adequate Control (<8.0%)	67.42%	73.08%	77.74%	

*Red = less than 3-Star or 50th percentile
**Triple weighted for STARS

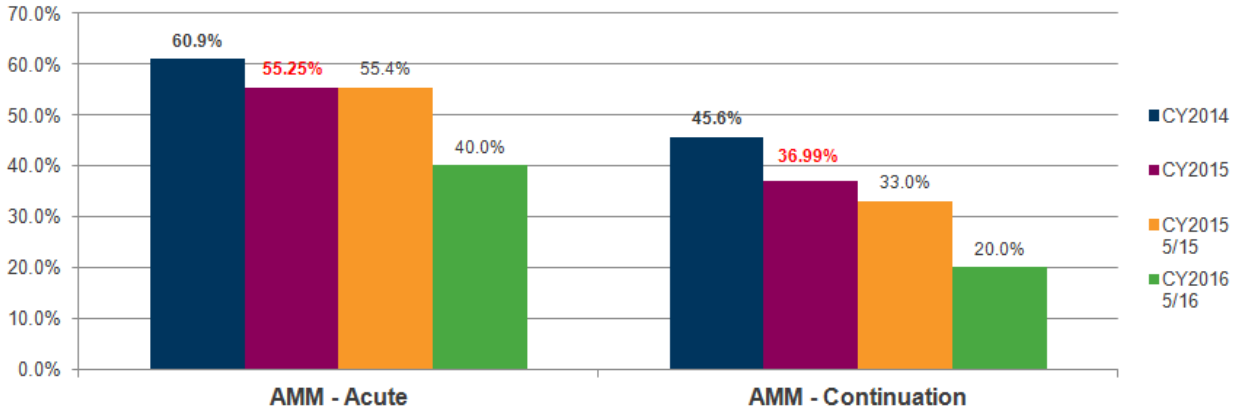
ONECARE COMPREHENSIVE DIABETES CARE — EYE EXAM, NEPHROPATHY, BP



HEDIS Measure	3-Star/ 50th percentile	4-Star/ 75th percentile	5-Star/ 90th percentile	Reporting Requirements*
Comprehensive Diabetes Care (CDC)				
4. Eye Exams	65%	75%	82%	Star
5. Nephropathy Monitoring	89%	93%	97%	Star
6. B/P <140/90	60%	71%	84%	Star

*Red = less than 3-Star or 50th percentile
**Triple weighted for STARS

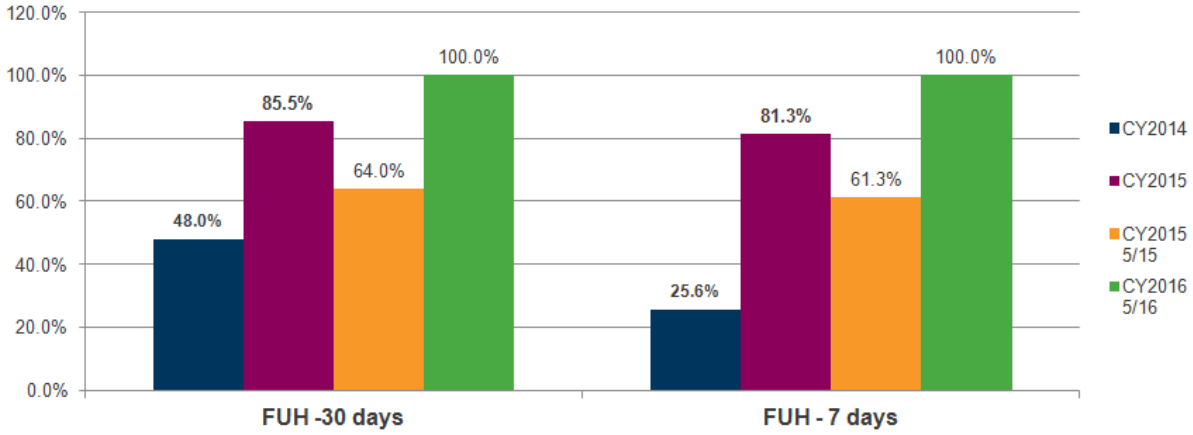
ONECARE BEHAVIORAL HEALTH — AMM



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Antidepressant Medications Management (AMM) - Acute Phase Treatment	68.66%	74.64%	79.43%	P4V
Antidepressant Medications Management (AMM) -Continuation Phase Treatment	54.76%	61.47%	69.62%	P4V

*Red =less than 3-Star or 50th percentile

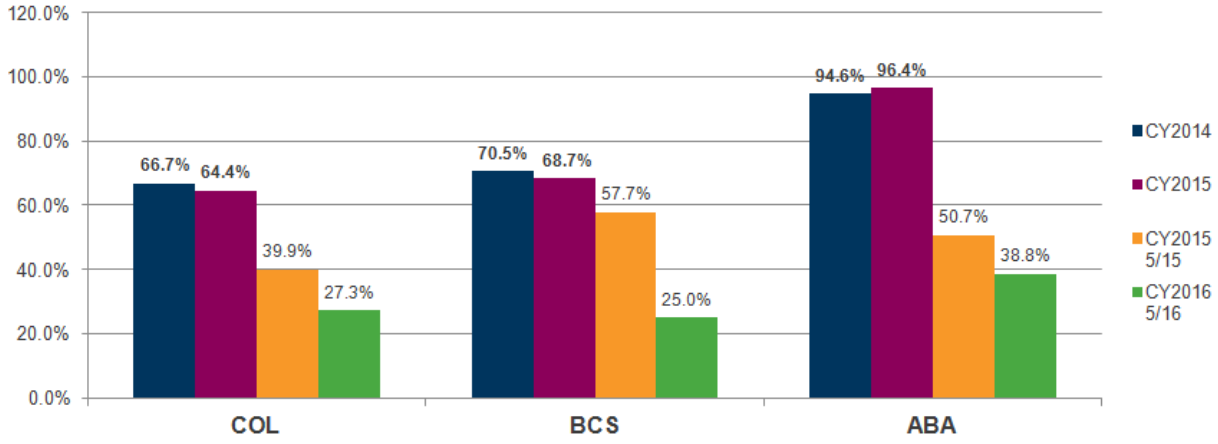
ONECARE BEHAVIORAL HEALTH — FUH



HEDIS Measure	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days	52.08%	67.74%	77.78%	
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days	31.58%	44.64%	62.15%	

*Red =less than 3-Star or 50th percentile

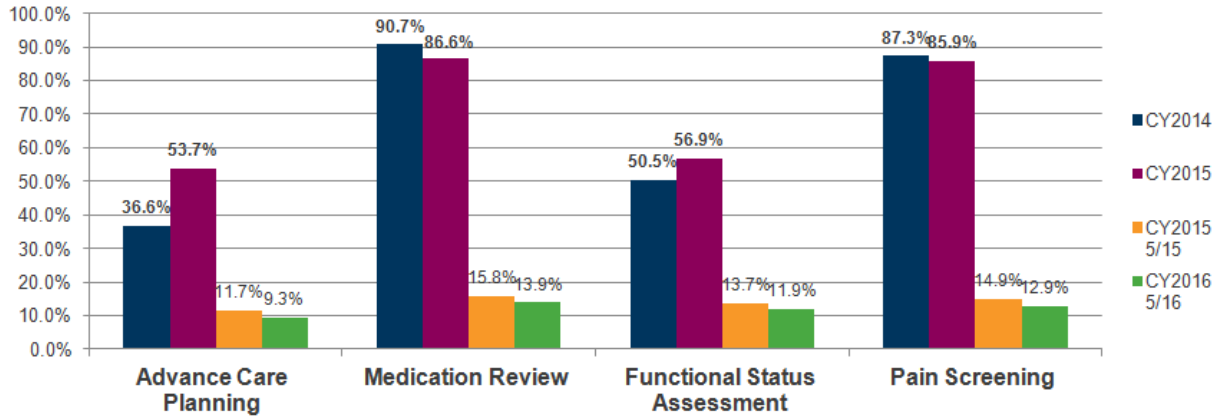
ONECARE PREVENTION AND SCREENING



HEDIS Measure	3-Star	4-Star	5-Star	Reporting Requirements*
Colorectal Cancer Screening (COL)	63%	71%	78%	Star
Breast Cancer Screening (BCS)	63%	74%	80%	Star, P4V
Adult BMI Assessment (ABA)	81%	90%	96%	Star

*Red = less than 3-Star or 50th percentile

ONECARE CARE FOR OLDER ADULTS



HEDIS Measure	3-Star	4-Star	5-Star	Reporting Requirements*
Care for Older Adults (COA)				
1. Advance Care Planning				
2. Medication Review	60%	77%	87%	Star
3. Functional Status Assessment	54%	67%	86%	Star
4. Pain Screening	62%	78%	95%	Star

*Red = less than 3-Star or 50th percentile

PATIENT SAFETY

Many activities in 2016 have patient safety aspects and were integrated throughout the QI Work Plan:

- Investigations of adverse clinical safety occurrences "Sentinel Events," with subsequent review through the peer review process with actions taken when indicated and depending on the severity of findings may have been referred to the Credentialing and Peer Review Committee;
- Ongoing investigation of Quality of Care issues or trends identified by staff, practitioners, or as the result of a member complaint, with subsequent action by Provider Relations and/or the Credentialing and Peer Review Committee to initiate actions when appropriate;
- Site visits of potential high-volume providers for facility and record review, a portion of which focuses on patient safety;
- Pharmacy medication management;
- CBAS monitoring for compliance to California Department of Aging Survey CAPs.

OPPORTUNITIES FOR IMPROVEMENT IN 2017

- Continue to support CalOptima's Care Management model and population health management approach, stratifying our population based on their health needs, conditions, and issues and align the appropriate resources to meet those needs.
- Continue to address ongoing Quality of Care, Quality of Service and Safety of Clinical Care in all areas of QI.
- Further analyze HEDIS, CAHPS and Stars scores and related interventions to identify meaningful improvement activities.
- Continue to improve Continuity and Coordination of Care between Medical and Behavioral Health.
- Continue to trend measures to assess performance in the quality and safety of clinical care and service.
- Analyze and evaluate the overall effectiveness of the QI Program and its progress toward influencing network-wide clinical practices.
- Enhance knowledge and understanding of quality improvement efforts with network providers through provider newsletters and participation in the Health Network Forums to include, but not limited to, the following topics:
    - Key information about the scope, structure, and purpose of the QI program
    - Availability of Preferred Practice Guidelines
    - How practitioners are monitored against practice guidelines
    - Efforts to improve the continuity and coordination of care with PCPs
    - Shared responsibility for patient safety
    - Collaborative efforts between CalOptima and our new MBHO regarding diagnosis and treatment of depression
- Further evolve the Pay-for-Value program to support clinical & service improvement
- Utilize the Quality Improvement Committee Organization Structure to evaluate, enhance and achieve our goals for clinical and service quality for our members.

ATTACHMENT A — 2016 QUALITY IMPROVEMENT WORK PLAN
ATTACHMENT B — 2016 DISEASE MANAGEMENT PROGRAMS ANNUAL EVALUATION

"Attachment A"

CalOptima
2016 Quality Improvement Work Plan
OneCare Connect/OneCare and Medi-Cal
April 2016

I. Program Oversight
- **A. Program scope- QI Annual oversight of programs and work plans**
- **B. Program Scope- 2016 QI Program Annual Evaluation**
- **C. Program Scope- UM Program and UM Work Plan annual oversight**
- **D. Program Scope- 2016 UM Program Annual Evaluation**
- **E. Quality of Care- Case Management Program annual oversight**
- **F. Quality of care- 2016 Case Management Program Evaluation**
- **G. Quality of Care- Disease Management Program annual oversight**
- **H. Quality of Care- 2016 Disease Management Program Evaluation**
- **I. Quality of Care- Credentialing Peer Review Committee (CPRC) Oversight**
- **J. NCQA Monitoring & Compliance**

II. Case Management
- **A. Quality of Clinical Care- Review of health risk assessments to OCC, OC, SPD members**
- **B. Quality of Clinical Care- Continuity & Coordination of Medical/BH**
- **C. Quality of Clinical Care- Review of emergency department communications With PCPs**
- **D. Patient Safety, Quality of Care Case Management- High ER utilization**
- **E. Quality of Clinical Care-Review of member satisfaction with CM programs**
- **F. Quality of Identification of Complex Case Management**

III. Behavioral Health
- **A. Quality of Clinical Care: Integration of BH services**
- **B. Quality of Care- Clinical BH Practice Guidelines adoption for Medi-Cal line of business**
- **C. Quality of Service and Quality of Clinical Care- Review of behavioral health provider's communications with PCPs**

IV. LTSS
- **A. Safety of Clinical Care and Quality of Clinical Care- Review and assess LTSS placement for members participating with each organization/program**
- **B. Safety of Clinical Care and Quality of Clinical Care- Review and assess emergency department visits for LTSS members participating with each organization/program**
- **C. Safety of Clinical Care and Quality of Clinical Care- Review and assess readmissions for LTSS members participating with each organization/program: Hospital Readmissions**
- **D. Safety of Clinical Care and Quality of Clinical Care-Review and assess readmissions for LTSS members participating with each organization/program: Long Term Care Admissions**
- **E. Quality of Clinical Care- Review of health risk assessment (HRA) for OneCare Connect (OCC) Long Term Care (LTC) members**
- **F. CBAS Member Satisfaction**
- **G. SNF Member Satisfaction**

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC Date: **2/9/16**
Submitted and approved by Board Date: **4/1/16**

Submitted and approved by Board of Director's Quality Assurance Committee (QAC) **Date: 3/23/16**

Quality Improvement Committee Chairperson:

_____
Richard Bock, M.D. , Medical Director Date:

Board of Directors' Quality Assurance Committee Chairperson:

_____
Paul Yost, MD Date:

V. Health Education & Disease Management

- **A. Quality of Care- All new members will complete the Initial Health Assessment and related IHEBA/SHAs**
- **B. Quality of Clinical Care, review of Disease Management Program (Asthma)**
- **C. Quality of Clinical Care, review of Disease Management Program (Diabetes)**
- **D. Quality of Clinical Care, review of Disease Management Program (CHF)**
- **E. Quality of Care- Clinical Practice Guidelines adoption for Medi-Cal line of business**
- **F. Quality of Clinical Care, review of member satisfaction with DM programs**
- **G. Quality of Clinical Care- Review of cardiovascular Disease**
- **H. Quality of clinical Care- Review of Diabetes and All Cause Readmissions**
- **I. Implementation of the Childhood Obesity (Shape Your Life) Program**
- **J. Implement Weight Watchers (WW) for Medi-Cal Members**
- **K. Implement Home Assessments for member participating in Care Management Programs**
- **L. Conduct 2016 Group Needs Assessment (GNA)**

VI. Access & Availability

- **A. Quality of Service and Quality of Clinical Care- Review of notification to members**
- **B. Access to Care- Credentialing of provider network is monitored**
- **C. Access to Care- Recredentialing of provider network is monitored**
- **D. Accessibility: Review of access to care**
- **E. Availability: Review of availability of practitioners**

VII. Patient Safety

- **A. Safety of Clinical Care- Providers shall have timely and complete facility site reviews**
- **B. Safety of Clinical Care- Review and follow-up on member's potential Quality of Care Complaints**
- **C. Safety of Clinical Care and Quality of Clinical Care- reviewed through Pharmacy Management**
- **D. Safety of Clinical care and Quality of Clinical Care- review of Specialty Drug Utilization**
- **E. Patient Safety- Review and assessment of CBAS Quality Monitoring**
- **F. Patient Safety- Review and assessment of SNF Quality Monitoring**
- **G. Safety of Clinical Care- Review of antibiotic usage**
- **H. Implementation of the new PBM**

VIII. Member Experience

- **A. Quality of Service- Review of Member Satisfaction**
- **B. Quality of Service- Reviewed through customer service first call resolution**
- **C. Quality of Service- Reviewed through customer service access**
- **D. Quality of Care & Service reviewed through GARS & PQI (MOC)**

IX. HEDIS/STARS Improvement

- **A. Improve identified HEDIS Measures listed on "Measures" worksheet**
- **B. Improve identified STARS measures listed on "Measure" worksheet**
- **C. Improve CAHPS measures listed on "Measures" worksheet**
- **D. HEDIS: Launch pediatric wellness clinic**
- **E. STARS improvement- Medication Adherence Measures**
- **F. HEDIS: Health Network support of HEDIS & CAHPS Improvement**

X. Delegation Oversight

- **A. Delegation Oversight of CM**
- **B. Quality of Care & service of UM through delegation oversight reviews**
- **C. Delegation Oversight of BH Services**

XI. Organizational Projects

- **A. Implementation of the 2016 Value Based P4P program**
- **B. Value Based P4P 2016-2019**

Previously identified issues to be monitored

I. Program Oversight

A. Program Scope- QI Annual oversight of programs and work plans

Owner: Medical Director, Quality & Analytics

1. **Activity**
   - QI Program and QI Work Plan will be adopted on an annual basis
   - QI Program Description- QIC-BOD
   - QI Work Plan- QIC-QAC

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Adoption

B. Program Scope- 2016 QI Program Annual Evaluation

Owner: Medical Director, Quality & Analytics

1. **Activity**
   - QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis

2. **Goals**
   - Annual Evaluation

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

C. Program Scope- UM Program and UM Work Plan annual oversight

Owner: Terrie Stanley, ED Clinical Operations

1. **Activity**
   - UM Program and UM Work Plan will be adopted on an annual basis
   - Delegate UM annual oversight reports-from DOC

Approved by UMC: 2/9/16
Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Adoption

D. Program Scope- 2016 UM Program Annual Evaluation

Owner: Tracy Hitzeman, ED Clinical Operations

1. **Activity**
   - UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis
   - Delegate oversight from DOC

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Evaluation

E. Quality of Care- 2016 Case Management Program Annual Oversight

Owner: Tracy Hitzeman, Director, CM

1. **Activity**
   - CM Program will be adopted on an annual basis
   - Delegation oversight reported by DOC

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Adoption

F. Quality of Care 2016 Case Management Program Evaluation

Owner: Tracy Hitzeman, Director, CM

1. **Activity**
   - CM Program will be evaluated by members including member feedback and complaints and to measure effectiveness of the overall CM Program, including interventions and actions for re-measurements
   - Delegation oversight reported by DOC

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Evaluation

G. Quality of Care- 2016 Disease Management Program Annual Oversight

Owner: Pshyra Jones, Dir of Health Ed & DM

1. **Activity**
   - DM Program will be adopted on an annual basis

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Adoption

H. Quality of Care- 2016 Disease Management Program Evaluation

Owner: Pshyra Jones, Dir. Health Ed & DM

1. **Activity**
   - DM Program will be evaluated by members including member feedback and complaints and to measure effectiveness of the overall DM Program, including interventions and actions for re-measurement

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Evaluation

I. Quality of Care- Credentialing Peer Review Committee (CPRC) Oversight

Owner: Medical Director, Quality

1. **Activity**
   - Review of initial and recredentialing applications, related quality of care issues, approvals, denials, and reported to QIC
   - Delegation oversight reported by DOC

Approved by QIC:
Q1 4/13/16
Q2 8/09/16
Q3 11/08/16
Q4 02/01/17

2. **Goals**
   - Quarterly Adoption of Report

J. NCQA Monitoring & Compliance

Owner: Kelly Rex-Kimmet, Director, QA

1. **Activity**
   - Evaluate NCQA standards, HEDIS & CAHPS for improvement opportunities to achieve Commendable status

2. **Goals**
   - Annual HIP Ranking

Approved by QIC
Q1
Q2
Q3 09/13/16
Q4 10/04/16 & 12/13/16

II. Case Management

A. *Quality Of Clinical Care-Review of health risk assessments to OCC, OC, SPD members Owner: Sloane Petrillo, Director, CM

The Approach

1. **Objective**

- **OCC-** Health Risk Assessment Outreach Appraisals for members in the OneCare Connect Program monitored for completeness
- **OC-** Health Risk Assessment Outreach for members in the OneCare Program monitored for completion
- **SPD-** Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion

2. **Activity**

- **OCC-** Administer the initial HRA to the high risk beneficiary within:
  1. 90 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **OCC-** Administer the initial HRA to the low risk beneficiary within:
  1. 45 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **OC-** Administer the annual HRA to the beneficiary
  1. 90 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **SPD-** Administer the initial HRA to the high risk beneficiary within:
  1. 45 days of a beneficiary's eligibility
  2. Administer the annual HRA to the beneficiary
- **SPD-** Administer the initial HRA to the low risk beneficiary within:
  1. 90 days of a beneficiary's eligibility
  2. Administer the annual HRA to the beneficiary

3. **Goals**

- **OCC** 100% of eligible population improvement over 2016
- **OC** 100% of eligible population
- **SPD** 100% of eligible population

Case Management: Quality of Clinical Care-Review of health risk assessments to OCC Members
Owner: Sloane Petrillo, Director, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	**OCC**- Improved percentage of HRA completed *with* HRA collection in January 2016, likely due to the transitioning OneCare to OneCare Connect members and the informed HRA process. Low 61.6% (11.4% declined, 26.3% UTC) High 83.8% (15.3% declined, 0% UTC)	Continue current outreach processes. Review and focus on % of HRA completion *with* an HRA collected. Identify strategies to improve the HRA collected rate.	Q2
Q2	**OCC**-Completed outreach consistently high, however, HRA collection decreased (Low 46.1% (17% declined, 35.2% UTC), High 29.8% (17.9% declined, 21.2% UTC) Annual OCC HRA mailing process initiated for members with Target HRA month of July, August and September. 100% annual HRA completion for July (1 member).	Continue current outreach processes for newly enrolled members. Monitor HRA collection rate for annual members.	Q3
Q3	OCC-Completed outreach at 100%, however collection rates vary. Low: July 21%, Aug 71%, Sept 63%. High: July 22%, Aug 90%, Sep 78%)	Continue close monitoring of process by supervisor to maintain 100% outreach rate. Transitioned HRA collection for directly managed population to established PCCs. Transitioned all other HRA collection to single outreach team. Annual outreach call process planned for Q4.	Q4
Q4	OCC- Completed outreach at 100% for High Risk members. December still has 45 day call scheduled for mid January for High risk members. Completed outreach at 99% for Low Risk members with 1 member missed in November. 90th day call due the end of January for November eligible members and 90th day call due the end of February for December eligible members. HRA Collection: Low: Oct 64%, Nov 42%, Dec 47%. High: Oct 67%, Nov 66%, Dec 51% Annual outreach for OCC began in July 2016 with HRAs mailed to members with no additional outreach. Annual outreach call process started in December for January reassessments.	Continue current outreach processes for newly enrolled members. Develop full CORE annual call list to capture effect of telephonic outreach efforts to increase annual HRA collection rate. Report in development to determine effect of outreach.	

Year End	Total HRA collection rate for 2016 of all remaining eligible members= 64% Total HRA collection rate for 2016 of all remaining high risk eligible members = 71% Total HRA collection rate for 2016 of all remaining low risk eligible member = 59% Total HRA collection rate for 2016 of all outreached high risk members = 53% Total HRA collection rate for 2016 of all outreached low risk members = 40% Total number OCC HRAs collected in 2016=11,001	Continue current outreach processes for newly enrolled members. Develop full CORE annual call list to capture effect of telephonic outreach efforts to increase annual HRA collection rate. Report in development to determine effect of outreach. Full implementation of annual outreach for OCC HRAs will continue.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	Completed HRA Outreach: **OCC High**- Jan: 99.9.%, Feb: 100%, Mar 96.3% **OCC Low**-Jan: 99.5%, Feb 98.3%, Mar 100%	Implement annual OCC HRA mailing for Target July.	May 2016
Q2	Completed HRA Outreach: **OCC High**- Apr 98% May100% Jun 100% **OCC Low**- Apr 100% May 100% Jun 100%	Complete outreach processes for newly enrolled members.	August 2016
Q3	Completed HRA Outreach: **OCC High**- Jul 100% Aug 100% Sep 100% **OCC Low**- Jul 100% Aug 100% Sep 73% (in process)	Continue outreach process for newly enrolled members. Implementation of annual outreach calls planned for Q4.	November 2016
Q4	Completed HRA Outreach:* OCC High- Oct 100%, Nov 100%, Dec 100% OCC Low - Oct 100% Nov 99% , Dec 100% *Members are on target for compliance with regulatory time frames.	Continue outreach process for newly enrolled members	2017
Year End	100% compliance with target outreach for the year except for 14 members during transition period from OC to OCC.	Planned new goals for 2017 will continue focus on completion of outreach process, and add focus on collection of HRA. Goals for 2017: Complete OCC outreach timely: 100% for high and low risk Collect 56% of high risk OCC HRAs Collect 43% of low risk OCC HRAs	2017

Case Management: Quality of Clinical Care-Review of health risk assessment to OC Members
Owner: Sloane Petrillo, Director, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	**OneCare**- On target	Continue current outreach processes. Review and focus on % of HRA completion *with* an HRA collected. Identify strategies to improve the HRA collected rate.	Q2
Q2	**OneCare**-Initial HRA outreach is on target. Annual HRA outreach has failed to meet goal.	Identify resource/process barriers to completing goal of 100% annual HRA outreach. Remediate identified issues.	August 2016
Q3	**OneCare**-Both Q2 and Q3 met 100% goal for annual process. OneCare Initial for September eligibles is on target but still in process.	Continue current outreach processes. Review and focus on increasing percent of HRA completions with HRA collection.	December 2016
Q4	OneCare-100% compliance based on annual and initial assessments due in October, November, and December.	Continue current outreach process	
Year End	100% compliance with target outreach for the year with the exception of 5 members who were due on 1/1/16. The reports were not accurate during the transition of OC to OCC members effective 1/1/16. Audit also reveals members reported as incomplete on report are 1. No longer eligible, 2. Have HRA on file, 3. Currently eligible with OCC. Reports have been made to IS for correction.	Develop targets for next year based on 2016 rates. Include collection rates as well as completion.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	Completed HRA Outreach: **OneCare Initial**- Jan: 100%, Feb:100% Mar 100% **OneCare Annual**- Jan: 98.5%, Feb 93.6%, Mar 100%		May 2016
Q2	Completed HRA Outreach: **OneCare Initial**- Apr 100% May 100% Jun 100% (in process) **OneCare Annual**- Apr 100% May 100% Jun 100%	Identify resource/process barriers to completing goal of 100% annual HRA outreach. Remediate identified issues. Customer service engagement in-service for PCCs targeted at HRA collection.	August 2016

Q3	Completed HRA Outreach: **OneCare Initial**- Jul 100% Aug 100% Sep 100% **OneCare Annual**- Jul 100% Aug 100% Sep 100%	Continue monitoring HRA Outreach	December 2016
Q4	Completed HRA Outreach: OneCare Initial- Oct, Nov, Dec 100% OneCare Annual Oct, Nov. Dec 100%	Monitor, report, and analyze collection and completion for both initial and annually members.	
Year End	74% (189) HRA collection rate for initial OC members for the year. 32% (618) collection rate for annual OC members. Overall HRA collection rate for OC LOB is 36.4% Total number of HRAs collected was 807.	Goals for 2017: Complete 100% of outreach timely Collect 78% of initial OC HRAs Collect 34% of annual OC HRAs Monitor and analyze strategies monthly	

Case Management: Quality of Clinical Care-Review of health risk assessments to SPD Members
Owner: Sloane Petrillo, Director, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	**SPD**- Consistently attaining 100% completion	Continue current outreach processes. Review and focus on % of HRA completion *with* an HRA collected. Identify strategies to improve the HRA collected rate.	Q2
Q2	**SPD**- Consistently attaining 100% completion of outreach attempts. High average HRA collected rates (67-76%) Initiated annual HRA mailings for all members according to Target month- effective with the July Target HRA month members- Mailed in May 2016.	Continue current outreach processes. Customer service engagement in-service for PCCs targeted at HRA collection.	Q 3
Q3	**SPD**- Consistently attaining 100% completion of outreach attempts. Some reduction in HRA collection rate for Low for July and both High and Low for August, but increased again in September.	Consolidated the HRA collection process for all lines of business under one team to allow for consistency of process. Hired one Korean speaking PCC to reach additional members in their preferred language.	Q 4
Q4	SPD-Consistently attaining 100% completion of outreach attempts. HRA Collection rate for Q4 is 55%	Continue outreach attempts. Review annual performance and develop new goals for next year.	
Year End	Overall collection rate from Mid March until end of Q4 is 58 %*	Develop targets for next year based on 2016 rates. Include collection rates as well as completion.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	Completed HRA Outreach: **SPD High**- Jan:100%, Feb:100%, Mar 100% **SPD Low**-Jan:100% , Feb: 100%, Mar: 100%	Implement full annual SPD HRA mailings for all members according to Target month.	May 2016
Q2	Completed initial HRA Outreach: **SPD High**- Apr 100% May 100% Jun 100% **HRA collected**- Apr 72% May 76% Jun 73% **SPD Low**-Apr 100% May 100% Jun 100%	Implement full annual SPD HRA mailings for all members according to Target month. Customer service engagement in service for PCCs targeted	May 2016

	HRA collected-Apr 67% May 70% Jun 65%	at HRA collection.	
Q3	Completed initial HRA Outreach: **SPD High**- Jul 100% Aug 100% Sep 100% **HRA collected**- Jul 70 % Aug 47% Sep 76% **SPD Low**-Jul 100% Aug 100% Sep 100% **HRA collected**-Jul 58% Aug 58% Sep 64%	Consolidated the HRA collection process for all lines of business under one team to allow for consistency of process.	December 2016
Q4	Completed initial HRA Outreach: **SPD High**- Oct 100% Nov 100% Dec 100% **HRA collected**- Oct 63%, Nov 58%, Dec 49% **SPD Low** - Oct 100% Nov 100% Dec 100% **HRA collected**- Oct 62%, Nov 63%, Dec 60%	Continue outreach attempts to increase collection rates	Q1 2017
Year End	HRA collection for SPD initial including pediatrics from Mid March 2016 to end of Q4 is 60% HRA collection for SPD does not include annual HRAs which are mailed with no outreach. Based on CORE Report CC0123 SPD Universe current population as 1/6/17 is 39,301. Total annual HRAs collected in 2016 including pediatrics is 6424. Annual mailings to entire SPD population began May 2016. Overall collection rate for 2016 is 16.3%	Goals for 2017: Complete 100% of initial outreach timely Collect 63% of initial SPD HRAs Establish baseline percent for collection of annual HRAs.	

II. Case Management

B. *Quality of Clinical Care-Continuity & Coordination of Medical/BH

Owner: Sloane Petrillo, Director, CM

The Approach

1. **Objective**
   - Continuity and Coordination between Medical & Behavioral Health

2. **Activity**
   - Monitor and identify opportunities to improve continuity & coordination of care across settings and/or transitions of care through ICT/ICP or other processes

3. **Goals**
   - 85%

Case Management
Owner: Sloane Petrillo, Director, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	Regular attendance of Behavioral Health Integration at Interdisciplinary Care Team meetings and increased referrals to BHI by case management team noted for members who have behavioral health concerns. Focused intervention by BHI has decreased member resistance to treatment. Current practice includes interdisciplinary team meeting invitations are issued to Managed Behavioral Health Care partners for 100% of members engaged in treatment.	Collaborate with Behavioral Health Integration to deliver staff training/in-service on strategies to increase acceptance of behavioral health interventions for members with an elevated PHQ-9 score. Develop processes to measure rate of involvement of MBHO participants in ICTs.	October July 2016
Q2	**1 Qtr 2016 OCC**: 100% Behavioral Health Integration participation 100% MBHO participation 0% County participation **1 Qtr 2016 SPD**: 100% Behavioral Health Integration participation 0% MBHO participation 0% County participation	Continue BHI meetings with County to facilitate County participation in ICT meetings. Collaborate with BHI to facilitate MBHO participation in ICT meetings for SPD members.	October 2016
Q3	**2 Qtr 2016 OCC**: 100% Behavioral Health Integration participation 100% MBHO participation 0% County participation **2 Qtr 2016 SPD**: 100% Behavioral Health Integration participation 20% MBHO participation 50% FSP participation	Continue BHI meetings with County to facilitate County participation in ICT meetings. Collaborate with BHI to facilitate MBHO participation in ICT meetings for SPD members. Transition of MBHO planned for Q1 2017. Work with BHI to establish workflows for new MBHO to provide smooth transition for members.	December 2016
Q4	**3 Qtr 2016 OCC**: 100% Behavioral Health Integration participation 87.5% MBHO participation 0% County	Collaborate with BHI to ensure smooth transition of ICT participation in ICTs for new MBHO.	

	0% FSP participation **3 Qtr 2016 SPD**: 100% Behavioral Health Integration participation 47% MBHO participation (Behavioral Health and ABA) (Beacon was going to attend 6 additional ICTs but 5 calls were missed during the ICTs and 1 CM was out sick-counted in the denominator) 18 % County participation (County was going to attend 2 additional ICTs but calls were missed during the ICTs-counted in the denominator) 0 ASO participation 0 FSP participation		
Year End	Increases shown in participation with MBHO and some county participation noted. Opportunity exists to improve quality of participation by individual BH providers in ICT.	Collaborate closely with BHI to ensure smooth transition of ICT participation in ICTs for new MBHO.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2	**1 Qtr 2016 OCC**: 206 ICTs held 7 members with MBHO- 3 members with County Specialty Mental Health- 0 % County participation- no response to invite **1 Qtr 2016 SPD**: 80 ICTs held 1 member with County Specialty Mental Health- psychiatrist did not participate in ICT but spoke with Dr. Dajee prior to ICT	Close collaboration with BHI clinicians.	October 2016
Q3	**2 Qtr 2016 OCC**: 101 ICTs held 4 members with MBHO- 0 members with	Close collaboration with BHI clinicians. Establishment of standard participation time for ICTs for OCC. Creation of	December

	County Specialty Mental Health **2 Qtr 2016 SPD**: 130 ICTs held 5 members with MBHO-1 provider Participated. 0 members with OCBH. 2 members with FSP-1 provider participated.	standard participation time for SPD MHBO for ICTs begun in Q3 for SPD.	2016
Q4	**3 Qtr 2016 SPD**: 279 ICTs held 19 members with MBHO- 9 participation 15 members with ASO – 0 participation FSP 4 invites, 0 participation 11 members with County Specialty Mental Health, 2 participation **3 Qtr 2016 OCC**: 115 ICTs held 8 members with MBHO- 0 members with County Specialty Mental Health		
Year End	Increases shown in participation with MBHO and some county participation noted. Opportunity exists to improve quality of participation by individual BH providers in ICT.	Goals for 2017: Refine reporting process to include participation by individual providers and county providers. Goal for 2017=100% for BHI, 85% for MBHO, 10% for individual providers	2017

II. Case Management

C. *Quality of Clinical Care-Review of emergency department communications with PCPs Owner: Sloane Petrillo, Director, CM

The Approach

1. **Objective**
   - Continuity and Coordination of Care reviewed and assessed

2. **Activity**
   - Assessment of medical records for communication from emergency department to primary care providers

3. **Goals**
   - 85%

Case Management
Owner: Sloane Petrillo, Director, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	Current process includes notification of CCN PCPs by CalOptima CM Department following ED visits. Additionally, post ED visit calls are made to members to encourage f/u appt with PCP, to identify those with care coordination needs and address those needs. Additional CN intervention performed is requesting PCP to provide f/u appointment details back to CalOptima.	Measure percent of PCPs notified of ED visit for CN network within a stated period of time.	June 2016
Q2	Report in development to measure current interventions/outcomes.	Await report to obtain data.	October 2016
Q3	Report remains in development to quantify current efforts and number of PCPs who return notification form confirming post ER PCP visit. IS resources are an issue with report development. Report review scheduled by IS for 10/31/16 for update on delivery date. Began process to data mine frequent ER utilizers for potential case management cases.	Obtain report; pursue data mining process to identify members for case management. Assessment of medical records is not feasible for case management; therefore case management will utilize our Post ER discharge process to promote notification of PCPs of ER visits.	December 2016
Q4	Report remains in development to quantify current efforts and number of PCPs who return notification form confirming post ER PCP visit. IS resources are an issue with report development. Report is under development with delivery date anticipated for Q1 2017.	Obtain report. Assessment of medical records is not feasible for case management; therefore case management will utilize our Post ER discharge process to promote notification of PCPs of ER visits.	December 2016
Year End	Assessment of medical records was not feasible for this goal. Data mining underway to identify members for case management with the aim of reducing unnecessary ER visits. Limitations in ECEDA reports.	Recommend continuing current notification process into 2017. Plan: Remove goal from 2017 QI work plan due to lack of method for collecting data and impacting goal.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**

Q1			
Q2			
Q3			
Q4			
Year End			

II. Case Management

D. Patient Safety, Quality of Care Case Management- High ER utilization

Owner: Sloane Petrillo, Director, CM

The Approach

1. **Objective**
   - Evaluation and intervention for ongoing review of high ER utilizers

2. **Activity**
   - Ongoing monitoring of ER utilization; findings reported to Case Management for follow-up and/or further interventions

3. **Goals**
   - 35%

Case Management
Owner: Sloane Petrillo, Director, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	14 CCN Members referred to CM. Members previously identified continue to be monitored. **High ER Utilization:** Regular interdepartmental meetings on high ER utilizers and interventions at the HN level (including CCN). Decreased utilization threshold for referral trigger to CM resulted in an increase in members referred for CM for intervention.	Identify HN high ER utilizers. Provide HNs with tools to manage high ER utilizers Tracking and trending of future ER use among those high utilizing members referred to CM to assess impact and identify strategies to support appropriate utilization of resources.	5/30/2016 Q2
Q2	No new members referred for case management from ER high utilizer workgroup. Opportunity exists for regular data mining to identify members with patterns of frequent ER usage as part of the case management identification process.	Survey of available CORE reports/Microstrategies Process development for ID of frequent ED utilizers	October 2016
Q3	ER High Utilizer workgroup is on hold. Data mining process has commenced for case management outreach to high utilizers.	Microstrategies data mining under way in early Q4 to identify members with 10 or more ER visits and examine prior case management outreach attempts and find opportunities for case management.	December 2016
Q4	Microstrategies data mining for members with high ER visits and referral to case management as appropriate.	2017 New Goal: Data mine for top ER high utilizers quarterly, establish baseline visits for those members, and collect data to determine change in ER visits. Dedicated staff will manage cohort.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	CM has assigned all 14 members to a Case Management Nurse. ***100% of cases identified referred to CM.***	Continue to monitor ER utilization. Coordinate PCP and SCP appointments as applicable.	Ongoing
Q2	ER High utilizer workgroup on hold	Continue to monitor ER utilization.	Ongoing

Q3	ER High utilizer workgroup on hold	Development of case management data mining strategy to identify high utilizing members for case management.	Ongoing
Q4	ER High utilize workgroup on hold	Development of case management data mining strategy to identify high utilizing members for case management.	Ongoing
Year End	Interdepartmental work group is on hold. Plan is to transition to CCN focused case management strategy.	2017 New Goal: Data mine for top ER high utilizers quarterly, establish baseline visits for those members, and collect data to determine change in ER visits. Dedicated staff will manage cohort.	

E. Quality of Clinical Care-Review of member satisfaction with CM programs Owner: Sloane Petrillo, Director, CM

The Approach

1. **Objective**
   - Annual review of member feedback on the case management programs to assure high satisfaction and improved health status

2. **Activity**
   - Review annual satisfaction survey results, define areas for improvement and implement interventions to monitor and improve the member experience in CM programs

3. **Goals**
   - Satisfaction with Case Management - 85%

Case Management: Review of member satisfaction with CM programs
Owner: Sloane, Petrillo, Director, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	14 CCN Members referred to CM. Members previously identified continue to be monitored. **High ER Utilization:** Regular interdepartmental meetings on high ER utilizers and interventions at the HN level (including CCN). Decreased utilization threshold for referral trigger to CM resulted in an increase in members referred for CM for intervention.	Identify HN high ER utilizers. Provide HNs with tools to manage high ER utilizers Tracking and trending of future ER use among those high utilizing members referred to CM to assess impact and identify strategies to support appropriate utilization of resources.	5/30/2016 Q2
Q2	No new members referred for case management from ER high utilizer workgroup. Opportunity exists for regular data mining to identify members with patterns of frequent ER usage as part of the case management identification process.	Survey of available CORE reports/Microstrategies Process development for ID of frequent ED utilizers	October 2016
Q3	ER High Utilizer workgroup is on hold. Data mining process has commenced for case management outreach to high utilizers.	Microstrategies data mining under way in early Q4 to identify members with 10 or more ER visits and examine prior case management outreach attempts and find opportunities for case management.	December 2016
Q4	Microstrategies data mining for members with high ER visits and referral to case management as appropriate.	2017 New Goal: Data mine for top ER high utilizers quarterly, establish baseline visits for those members, and collect data to determine change in ER visits. Dedicated staff will manage cohort.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	CM has assigned all 14 members to a Case Management Nurse. ***100% of cases identified referred to CM.***	Continue to monitor ER utilization. Coordinate PCP and SCP appointments as applicable.	Ongoing
Q2	ER High utilizer workgroup on hold	Continue to monitor ER utilization.	Ongoing

Q3	ER High utilizer workgroup on hold	Development of case management data mining strategy to identify high utilizing members for case management.	Ongoing
Q4	ER High utilize workgroup on hold	Development of case management data mining strategy to identify high utilizing members for case management.	Ongoing
Year End	Interdepartmental work group is on hold. Plan is to transition to CCN focused case management strategy.	2017 New Goal: Data mine for top ER high utilizers quarterly, establish baseline visits for those members, and collect data to determine change in ER visits. Dedicated staff will manage cohort.	

II. Case Management

F. Quality of Identification Of Complex Case Management — Owner: Sloane Petrillo, Director, CM

The Approach

1. **Objective**
   - Identify all members eligible for Complex Case Management
2. **Activity**
   - Health Networks are required to report members identified for Complex Case Management
3. **Goals**
   - Health Networks are identifying members eligible for Complex Case Management

Complex Case Management
Owner: Sloane Petrillo, Interim Director, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	Significant opportunity exists for increased identification of members for Complex Case Management.	Development and implementation of CalOptima oversight procedure to monitor Health Network's active processes for proactive identification of members eligible for complex case management. Health Network education completed for identification of complex cases.	September 2016
Q2	Significant opportunity exists for increased identification of members for Complex Case Management. Slight decrease in identification of cases for Complex Case Management, possibly because of an outlier February result.	Began inclusion of complex case management review results and number of cases referred for complex case management as a standing item in JOMs for each health network. Provides consistency of feedback across management team.	Ongoing
Q3	Reviewed results and reporting format with consultant. Provided individual feedback to Health Networks. Met with two Health Networks individually regarding results and provided education.	Increase feedback in cover letter to health networks. Continue monitoring.	Ongoing
Q4	Began on site Health Network training for new 2017 NCQA standards. Two groups completed in December 2016. Redesigned reporting form.	Continue inclusion of complex case management review results and number of cases referred for complex case management as a standing item in JOMs for each health network. Provides consistency of feedback across management team.	Ongoing
Year End	Identification and file review scores have stabilized and improved across most networks with one outlier. Training on 2017 NCQA standards commenced. Anticipated completion Q2 2017.	Continue outreach and training to Health Networks through Q2 2017.	Ongoing

<table>
<tr><th>Outcomes</th><th>Results / Metrics</th><th>Next Steps</th><th>Target Completion</th></tr>
<tr><td>Q1</td><td>Members referred to Complex Case Management:

<table><tr><td></td><td>Jan</td><td>Feb</td><td>Mar</td></tr><tr><td>AltaMed</td><td>1</td><td>26</td><td>7</td></tr><tr><td>AMVI</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Arta</td><td>1</td><td>2</td><td>0</td></tr><tr><td>CCN</td><td>114</td><td>113</td><td>96</td></tr><tr><td>CHOC</td><td>7</td><td>6</td><td>2</td></tr><tr><td>FCMG</td><td>5</td><td>7</td><td>7</td></tr><tr><td>Heritage-ADOC</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Heritage-Regal</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Kaiser</td><td>9</td><td>5</td><td>6</td></tr><tr><td>Monarch</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Noble</td><td>5</td><td>4</td><td>3</td></tr><tr><td>OCA</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Prospect</td><td>0</td><td>7</td><td>3</td></tr><tr><td>Talbert</td><td>2</td><td>5</td><td>2</td></tr><tr><td>UCMG</td><td>3</td><td>1</td><td>3</td></tr><tr><td>Total</td><td>147</td><td>176</td><td>129</td></tr></table></td><td>Review of each Health Networks':

1. Complex Case Management Policies and Procedures
2. Desk Top Procedures/Job Aids describing identification of members for Complex Case Management
3. Samples of reports used for identification of members for Complex Case Management</td><td>August 2016</td></tr>
<tr><td>Q2</td><td><table><tr><td></td><td>Apr</td><td>May</td><td>Jun</td></tr><tr><td>AltaMed</td><td>9</td><td>8</td><td>7</td></tr><tr><td>AMVI</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Arta</td><td>1</td><td>3</td><td>6</td></tr><tr><td>CCN</td><td>85</td><td>84</td><td>100</td></tr><tr><td>CHOC</td><td>1</td><td>5</td><td>9</td></tr><tr><td>FCMG</td><td>8</td><td>6</td><td>5</td></tr><tr><td>Heritage-ADOC</td><td>0</td><td>0</td><td>0</td></tr></table></td><td>Requested documents from health networks for review of processes for identification of cases for complex case management.

Documents requested:

1. Complex Case Management Policies and Procedures
2. Desk Top Procedures/Job Aids describing identification of members for Complex Case Management
3. Samples of reports used for identification of members for Complex Case Management</td><td>Q3</td></tr>
</table>

	Heritage-Regal	0	0	2		Began inclusion of complex case management review results and number of cases referred for complex case management as a standing item in JOMs for each health network. Targeted outreach to one health network.	
	Kaiser	5	7	7			
	Monarch	13	9	9			
	Noble	3	5	6			
	OCA	0	0	0			
	Prospect	5	8	8			
	Talbert	2	2	2			
	UCMG	1	5	7			
	Total	**133**	**142**	**168**			
Q3		Jul	Aug	Sep		Received documents from all health networks. Review of documented processes will occur in Q4.	Q4
	AltaMed	7	11	10			
	AMVI	1	1	45			
	Arta	5	5	6			
	CCN	116	118	103			
	CHOC	9	8	8			
	FCMG	4	4	4			
	Heritage-ADOC	0	1	4			
	Heritage-Regal	2	0	3			
	Kaiser	6	6	7			
	Monarch	5	4	5			
	Noble	4	6	7			
	OCA	0	0	0			
	Prospect	8	6	50			
	Talbert	2	3	3			
	UCMG	8	7	6			
	Total	**177**	**180**	**261**			
Q4		Oct	Nov	Dec			
	AltaMed	11	8	8			
	AMVI	86	0	103			

	Arta	4	3	1			
	CCN	97	97	94			
	CHOC	7	8	10			
	FCMG	6	6	6			
	Heritage-ADOC	0	2	0			
	Heritage-Regal	5	0	0			
	Kaiser	7	5	6			
	Monarch	12	20	17			
	Noble	5	5	8			
	OCA	0	0	3			
	Prospect	168	4	207			
	Talbert	5	4	5			
	UCMG	11	2	2			
	Total	**424**	**164**	**470**			
Year End	78% increase noted in identification of cases from January to September. Interventions of individual outreach to networks, review of policies, and inclusion in JOM has been effective.					2017 New Goal: Continued reporting of complex CM files to include file review results. All network scores to be >85%.	

III. Behavioral Health

A. *Quality of Clinical Care: Integration of BH Services

Owner: Dr. Donald Sharps, Medical Director, BHI

The Approach

1. **Objective**
   - Behavioral Health services, continuity & coordination of care and BH HEDIS measures will be monitored and measured

2. **Activity**
   - Monitor and identify opportunities to improve continuity & coordination of care across settings and/or transitions of care through ICT/ICP or other processes
   - Design and implement activities to improve HEDIS/ STARS measures relating to Behavioral Health

3. **Goals**
   - 10% improvement over 2015
   - Meet Organizational NCQA goals of 50th percentile or more

Behavioral Health
Owner: Dr. Donald Sharps, Medical Director, BHI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	1) M/C low participation due to variables related to whether members in service at time of invitation; OCC Substantial participation in ICTs. CCN full participation BHI Clinical. 2) M/C: ADD and AMM – in process; OC/OCC: FUH 7 & 30 day – in process	1) Participation process reviewed and updated; BH inbox incorporated as a primary resource; BH Clinical team attends all CCN ICT meetings. 2) interventions evaluation stage	Q2 Q4
Q2	1) Beacon participation gradually increasing; OCC continues to report full participation in ICTs.CCN full participation by BHI Clinical team. (2) Beacon(M/C): ADD and AMM – in process; Windstone(OC/OCC): FUH 7 & 30 day – in process	1) Monitor requests to BH inbox for ICT BH provider participation and coordinate for Beacon specific invites; continue to monitor OCC provider participation; BH Clinical team to attend all CCN ICT meetings. (2) current interventions evaluated to determine opportunity to increase efforts and awareness	Q4 Q3
Q3	1) Beacon participation continues to gradually increase; OCC continues to report full participation in ICTs.CCN full participation by BHI Clinical team. (2) Beacon(M/C): ADD and AMM Windstone(OC/OCC): FUH 7 & 30 day – results presented to BHQIC at Nov. 2016 meeting	1) Assist with coordination of ICT BH provider participation or ICP completion for Beacon specific invites; Monitor requests to BH inbox; continue to monitor OCC provider participation; BH Clinical team attend all CCN ICT meetings. (2) Assessment feedback will be used to tailor efforts of improving importance of measures with HNs and BH providers	Q4 Q4

Q4	1) Beacon participation in ICTs has increased, however, still face challenges with identifying of members in treatment at time of ICT invite. OCC continues to report full participation in ICTs.CCN full participation by BHI Clinical team.(2) Beacon (M/C): ADD and AMM & Windstone (OC/OCC): FUH 7 & 30 day Q4 results presented to BHQIC at Feb 2017 meeting however, Beacon and Windstone were not present due to expiration of their contracts. Higher rates for this same time last year were achieved for the Medi-Cal measures. OC/OCC rates were higher than all years combined for AMM measures, yet FUH held the lowest rates since 2014.	1) Continue to assist with coordination of ICT BH provider participation or ICP completion for new MBHO invites which incorporates both M/C and OC/OCC requests going forward; Monitor requests to BH inbox; BH Clinical team attend all CCN ICT meetings. (2) Discussion at BHQI yielded additional suggestions to take to BHQI workgroup for advisement on next steps.	N/A
Year End	(1) Coordination with MBHOs and County Providers to engage participation in ICT/ICP planning improved the rates throughout the year for M/C. OC/OCC continued to engage in full participation of ICT/ICP requests. (2) M/C AMM – Dec data unavailable. With data through November meets 50th percentile. M/C ADD - Without Dec. data showing highest rates since 2014 but not quite at 50th percentile mark. OC/OCC AMM – highest of all years just shy of 50th percentile. OC/OCC FUH – lowest rates seen during 2016 falling below 50th percentile.	(1) CalOptima has partnered with a new MBHO with services that encompass M/C, OC and OCC. Work flows have been developed collaboratively to mitigate the frequency of missed opportunities for provider and member participation. (2) New MBHO has reviewed Q3 and Q4 data with questions on how best to work through these measures and collaborate on opportunities to improve.	Q1

Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	1) Participation: Beacon: 4/133 ICTs Windstone: 334 ICTs	1) Increase participation by correcting system; continue to monitor participation and process.	Q3

<table>
<tr>
<td></td>
<td>2a) HEDIS – M/C: AMM and ADD

<table><tr><th>M/C</th><th>2015</th><th>2016</th></tr><tr><td>AMM Acute phase</td><td>55.92%</td><td>49.46%</td></tr><tr><td>AMM cont. phase</td><td>41.02%</td><td>23.97%</td></tr><tr><td>ADHD</td><td>34.96%</td><td>16.22%</td></tr><tr><td>ADHD cont. phase</td><td>38.86%</td><td>2.65%</td></tr></table>
2b) HEDIS – Medicare : AMM and FUH

<table><tr><th>Medicare</th><th>2015</th><th>2016</th></tr><tr><td>AMM Acute phase</td><td>55.25%</td><td>55.66%</td></tr><tr><td>AMM cont. phase</td><td>36.99%</td><td>37.74%</td></tr><tr><td>FUH 7 day</td><td>85.49%</td><td>11.59%</td></tr><tr><td>FUH 30 day</td><td>81.35%</td><td>7.25%</td></tr></table></td>
<td>2a) HEDIS – M/C: AMM - educational brochure and top 10 Prescriber letters sent to providers. ADHD – weekly member and provider mailings.

2b) HEDIS – Medicare, looking at ways to ensure avoidance of placement issues; coordinating with hospital and provider contracts to increase results.</td>
<td>Q4

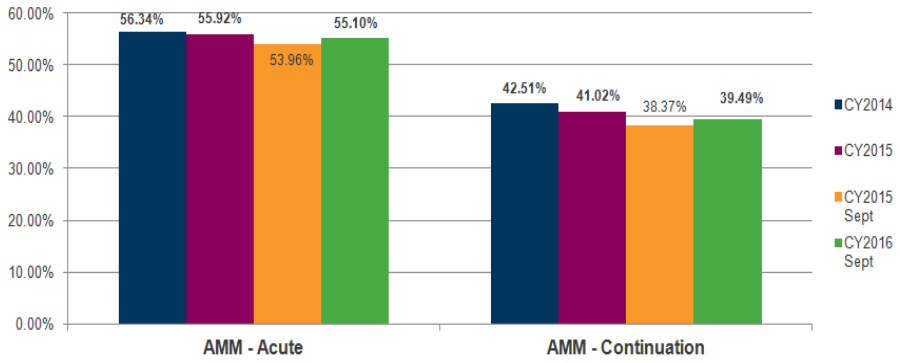
Q4</td>
</tr>
<tr>
<td>Q2</td>
<td>1) M/C: Beacon is demonstrating a gradual increase in participation post system corrections with goal to show improvement by Q4;</td>
<td>1) M/C: Increase participation by correcting system;

OC/OCC: continue to monitor performance</td>
<td>Q4</td>
</tr>
</table>

	OC/OCC: Windstone demonstrates 100% participation 2a) HEDIS – M/C: AMM and ADD M/C / CY 2015 / CY2016, Q2 AMM Acute phase: 55.92% / 54.9% AMM cont. phase: 41.02% / 31.1% ADHD: 34.96% / 17.0% ADHD cont.phase: 38.86% / 10.9% 2b) HEDIS – Medicare(OC/OCC): AMM and FUH Medicare / 2015 / 2016 AMM Acute phase: 55.25% / 60.7% AMM cont. phase: 36.99% / 41.9% FUH 7 day: 81.3% / 48.4% FUH 30 day: 85.5% / 54.7% **Red denotes measures not met	2a) HEDIS – M/C: AMM - Analysis of monthly rates to determine trends in data. Continue educational brochure distribution and top 10 Prescriber letters sent to providers. Continue with ADHD – weekly member and provider mailings 2b) HEDIS – Medicare(OC/OCC),Analysis of data to determine trends by month and locate any patterns that will help improve rates	Q3 Q3
Q3	**1) M/C**: Beacon participation continues to show progress with 6 ICTs participated in during Q3. Additional 3 ICPs were completed by Provider who was unable to participate during ICT for a total of 9 completed Q3. **OC/OCC:** Windstone ICT participation for Q3 reported at 64 ICTS without member and 1 with	1) **M/C:** Continue to Participate in ICTs as invited and attempt 100% participation. BH continues to monitor performance. **OC/OCC**: Continue to Participate in ICTs as invited with 100% participation; BH	Q4

member. Windstone reports 100% participation in ICT requests received.

2) **HEDIS M/C AMM**



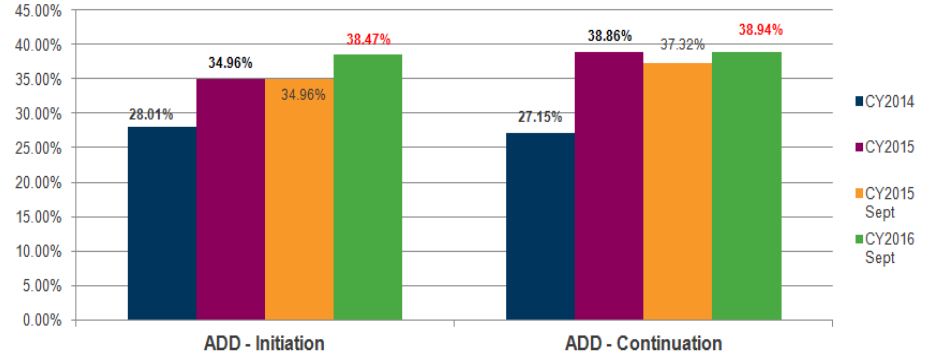
HEDIS Measure	Sep 16 Denominator	NCQA 50th Percentile	NCQA 75th Percentile	CY 2016 SEP
AMM Acute Phase Treatment	5746	50.51%	56.15%	**55.10%**
AMM Continuation Phase Treatment	5746	34.02%	40.48%	**39.49%**

continues to monitor performance.

2) **HEDIS M/C AMM and ADHD**

- Q3 AMM Acute & Continuation rates Meets NCQA 50th percentile. BHI continues to detail high prescribing providers and supply with information / brochures on importance of intervention, including posting articles in Wkly/Monthly/Qtrly provider communications.
- New Look: breakdown and target low performing prescribers; additional research on how many members prescribed do not require antidepressant post 6 months, consider call campaign for measures at risk of not meeting the 50th percentile..

2) **HEDIS M/C ADD**



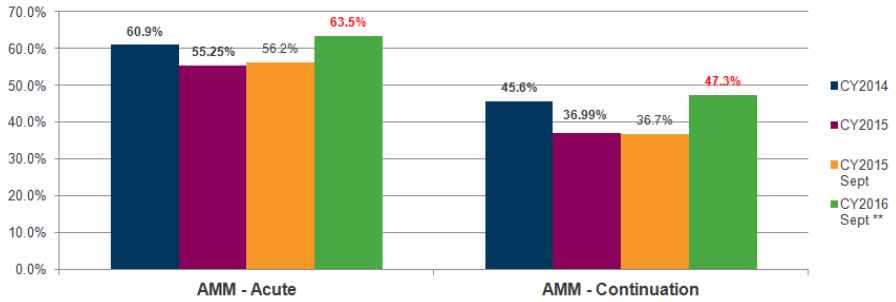
HEDIS Measure	Sep 16 Denominator	NCQA 50th Percentile	CY 2016 Sep
Follow-up Care for Children Prescribed ADHD	1349	40.79%	**38.47%**

- ADD, Initiation and Continuation rates for Q3 fall below NCQA 50th percentile by 2% and 12% respectively. BHI Continues to send letters to newly prescribed members (268) on importance of keeping appointments and continuing treatment. Additional reminders to Providers (247) on keeping appointments and monitoring member progress and Rx.
  New look: review of Provider types prescribing medication and look at worst performing prescriber offices to offer training to office staff on coding. Letter mailing timing for initiation phase members – should current timing be modified. Consider call campaign for measures at risk of not meeting the 50th

ADHD Medication (ADD) - Continuation Phase	303	50.61%	**38.94%**

percentile.

2) **HEDIS OC/OCC AMM**



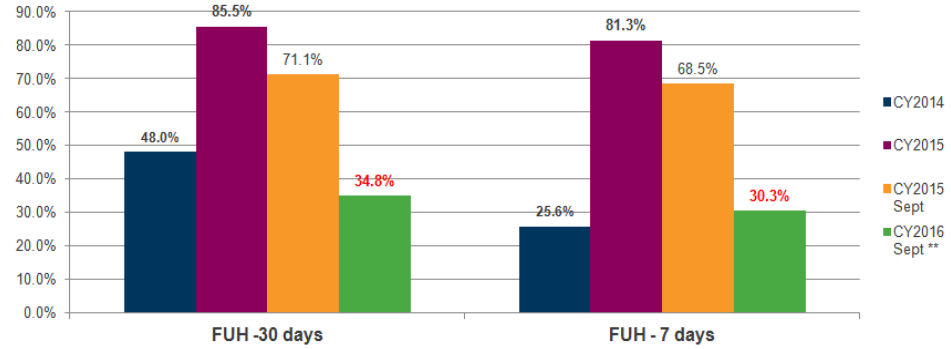
HEDIS Measure	Sep 16 Denominator	NCQA 50th Percentile	CY 2016 Sep
AMM) - Acute Phase	260	68.66%	**63.5%**
AMM) -Continuation Phase	303	54.76%	**47.3%**

HEDIS

OC/OCC AMM

- Q3 AMM Acute & Continuation rates below NCQA 50th percentile. AMM rates have increased from 2015. BHI Goals are to meet at least 50th percentile. **New Look:** breakdown and target low performing prescribers; additional research on how many members prescribed do not require antidepressant post 6 mos.

2) **HEDIS OC/OCC FUH**



HEDIS Measure	Sep 16 Denominator	NCQA 50th Percentile	CY 2016 Sep

HEDIS

OC/OCC FUH –

- FUH 7-day and 30-day rates for Q3 fall below NCQA 50th. Rates were at 90th percentile last year.
- Identified & trained in-home practitioner's for post-hospitalization bridge appointments
- Agreement with a group practice to secure post-hospitalization appointments within 24-72 hours of discharge when bridge program unavailable

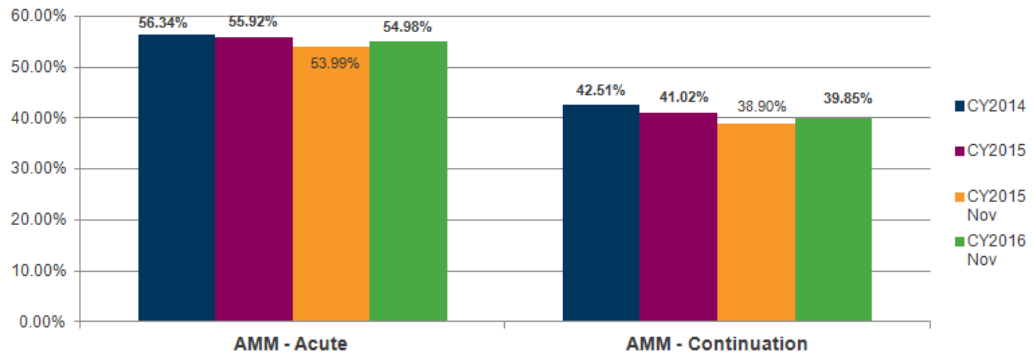
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days	178	52.08%	**34.8%**
AMM) -Continuation Phase Treatment	178	31.58%	**30.3%**

Q4

1) **M/C**: Beacon participated in 7/11 ICTs Q4, including a provider participant in 1 instance.
OC/OCC: Windstone participated in 89 ICTs Q4. Member services were lower overall in Q4.

2) **HEDIS M/C and OC/OCC**

M/C - AMM

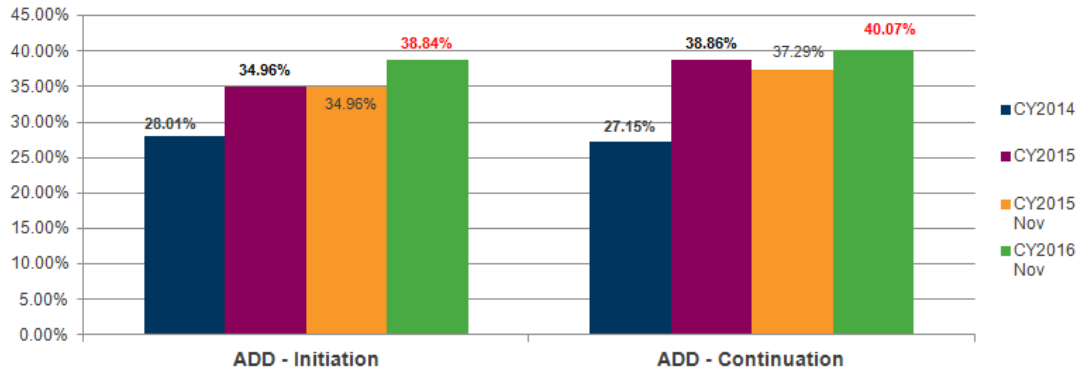


1) **M/C & OC/OCC:** data will be used as baseline for 2017 metrics and monitoring. New MBHO expected to participate in 10% more ICTs per quarter than last year.

2) **HEDIS**
M/C AMM
- Q4 AMM Acute & Continuation rates Meet NCQA 50th percentile.
- BHQI workgroup to determine next steps on options for campaigns to consider including targeting low performing prescribers. * December rates were not available at this time.

HEDIS Measure	Nov 16 Denomin-ator	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Antidepressant Medications Management (AMM) - Acute Phase Treatment	**5809**	**50.51%**	56.15%	62.56%	**ACC, RS, P4V***
Antidepressant Medications Management (AMM) -Continuation Phase Treatment	**5809**	**34.02%**	**40.48%**	48.39%	**ACC, P4V***

HEDIS M/C ADHD

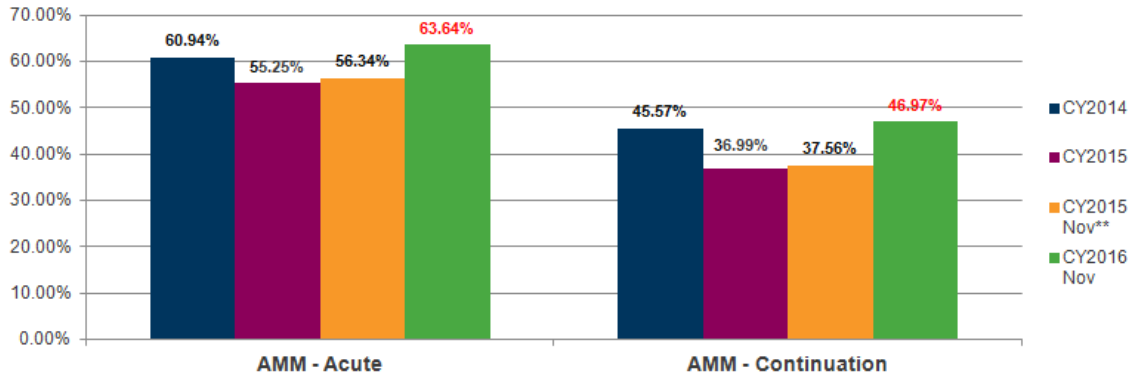


HEDIS Measure	Nov 16 Denominator	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Phase	1349	40.79%	49.07%	53.99%	ACC, RS
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Continuation Phase	307	50.61%	58.36%	65.20%	ACC

M/C ADHD

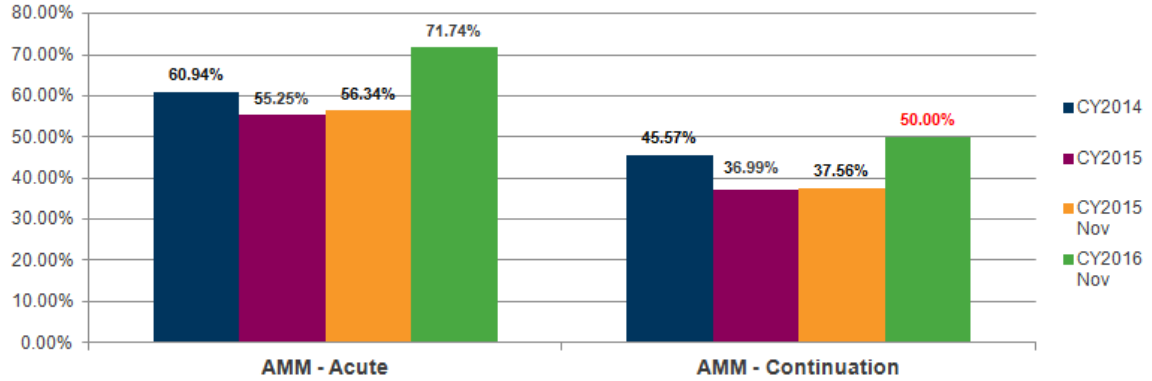
- Q4 ADD Initiation and continuation phases both demonstrate increase in rates overall. While we do not yet meet the 50th percentile, it has been determined in BHI Workgroup through HEDIS evaluation that the efforts have been successful in increasing awareness but are taking some time to inch up to the 50th percentile mark. *Dec. rates were not available at this time.
- BHI workgroup considering call campaign for measures at risk of not meeting the 50th percentile. Extensive work is ongoing in review of the current letter campaign & data.

HEDIS OCC AMM



HEDIS Measure	Nov 2016 Denominator	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Antidepressant Medications Management (AMM) - Acute Phase Treatment	264	68.66%	74.64%	79.43%	P4V
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	264	54.76%	61.47%	69.62%	P4V

HEDIS OC AMM

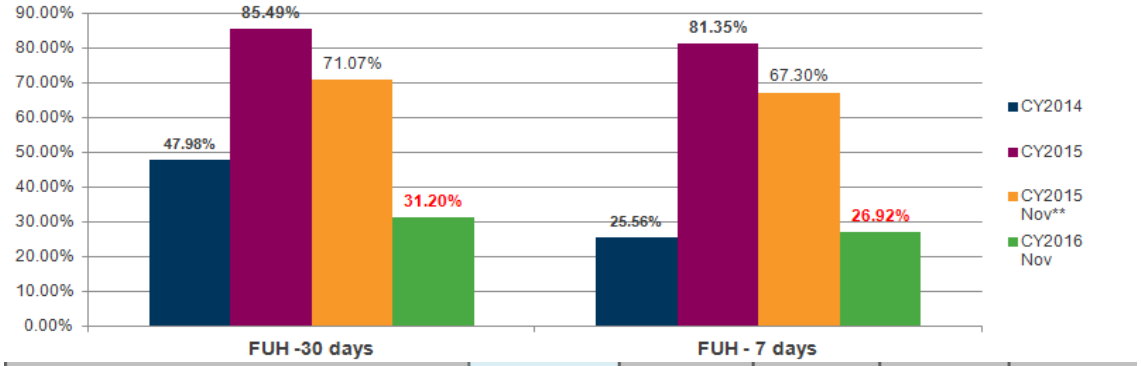


HEDIS Measure	Nov 2016 Denominator	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Antidepressant Medications Management (AMM) - Acute Phase Treatment	46	68.66%	74.64%	79.43%	P4V
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	46	54.76%	61.47%	69.62%	P4V

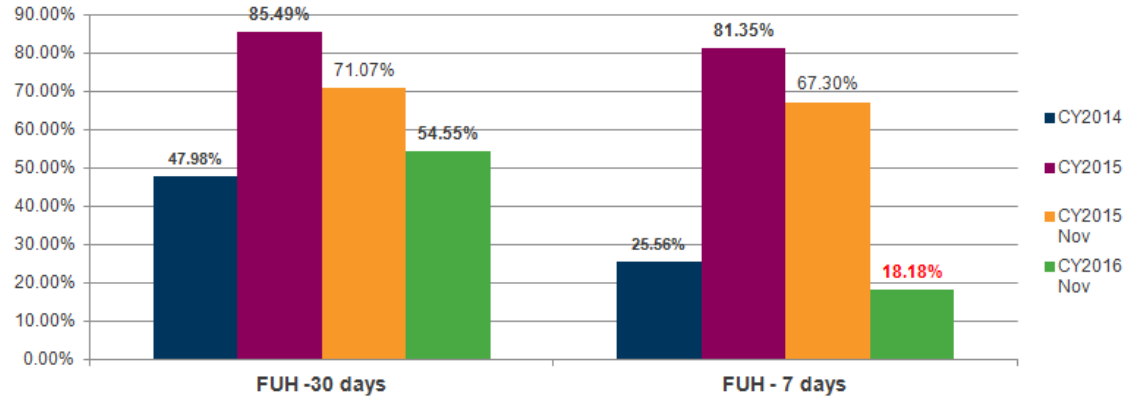
OC/OCC AMM

- Q4 both demonstrate improvement over last year same time data and overall 3 year rates. OCC does not yet meet 50th percentile. OC AMM acute phase meets 50th percentile but on continuation phase falls below the mark. *Dec. rates were not available at this time.
- BHI workgroup considering whether members can taper off medication post 6 months time and this would account for the lower rates in continuation phase.

HEDIS OCC FUH



HEDIS Measure	Nov 2016 Denominator	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days	234	52.08%	67.74%	77.78%	P4V
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days	234	31.58%	44.64%	62.15%	P4V



HEDIS Measure	Nov 2016 Denominator	NCQA 50th Percentile	NCQA 75th Percentile	NCQA 90th Percentile	Reporting Requirements*
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days	11	52.08%	67.74%	77.78%	P4V
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days	11	31.58%	44.64%	62.15%	P4V

OC/OCC FUH

- Q4 rates for OCC /OC fell below all previous rates and did not meet 50th percentile for either membership group. OC denominator was very low due to migration of most members into the OCC line. *Dec. rates were not available at this time.
- BHI workgroup took into consideration this measure was very successful in previous years due to a program that the MBHO ran which addressed this population. This program ended sometime during Q3 according to the MBHO.

Year End	Met 50th percentile for M/C AMM acute and continuation phases and OC/OCC AMM continuation for 2016; shy of 50th percentile for OC/OCC AMM acute phase. 50th percentile Goal not met for ADD initiation and continuation phases but highest rates seen overall since 2014. OC/OCC FUH 2014-2015 doubled rates for 30 day and tripled rates for 7 day phase. 2016 FUH both phases fell below 50th percentile where this year's goal should have been 90th percentile based on 2015 rates.	Collaborating with new MBHO to present workgroup findings for HEDIS measures and determine best practices and campaigns to help improve quality for members.	

III. Behavioral Health

B. *Quality of Care-Clinical BH Practice Guidelines adoption for Medi-Cal Line of business

Owner: Dr. Donald Sharps, Medical Director, BH

The Approach

1. **Objective**
   - BH Clinical Practice Guidelines will be reviewed and adopted

2. **Activity**
   - Adoption of Clinical Practice Guidelines, at least two (2) behavioral health will be reviewed and adopted
   - Depression & Autism CPGs reviewed annually

3. **Goals**
   - 100%

Behavioral Health
Owner: DR. Donald Sharps, Medical Director, BH

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	Updates to AMM and ADHD measures reported at 2.2.16 BHQI meeting. Clinical guidelines under review.	Present clinical guidelines and ask for adoption at next BHQI committee meeting.	5/3/16
Q2	Clinical guidelines presented and adopted at BHQI on 5/3/16.	Clinical guidelines adoption at 5/3/16 – no further steps 2016.	completed
Q3	Completed for 2016	Review any CPGs due to expire	
Q4	N/A Completed for 2016	Reviewing expiring CPGs for update	
Year End	Completed review and update to CPGs online/provider access	Review entire list of BH CPGs for expiration	March 30
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	Pharmacy data used; in process	If new guidelines are published, they will be reviewed and presented for discussion and adoption consideration at the BHQI meeting most appropriate to annual timeline. Guidelines will be available and reviewed on annual basis posted on the CalOptima website. https://www.caloptima.org/EN/Providers/ManualsPoliciesAndResources/ClinicalPracticeGuidelines.aspx	5/3/16
Q2	2016 Clinical Guidelines review complete.	Review new/current CPGs prior to Q1 2017 for updates and present to committee, if changes.	Q3
Q3	Completed for 2016	Review any CPGs due to expire	Q4
Q4	N/A Completed for 2016	Reviewing expiring CPGs for update	N/A
Year End	Current CPGs assisted Providers for reference.	Present any CPGs updates for BHQI review; replace online.	Q1

III. Behavioral Health

C. *Quality of Service and Quality of Clinical Care-Review of Behavioral Health Providers communications with PCPs

Owner: Dr. Donald Sharps, Medical Director, BH

The Approach

1. **Objective**
   - Continuity and Coordination of Care reviewed and assessed for medical care with behavioral health care

2. **Activity**
   - Assessment of medical records for communication between primary care providers and behavioral health providers

3. **Goals**
   - 85%

Behavioral Health
Owner: Dr. Donald Sharps, Medical Director, BH

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	Chart audits in Process	Annual – reported once per year; Looking at option of conducting survey to add frequency of reviews performed	Q2
Q2	**Medi-Cal:** Beacon reviewed 15 Charts from 3 High Volume Providers at 3 group practices for Coordination of Care with 6 practitioners reviewed: 2 MDs, 2NPs, 1 LMFT, 1 LCSW. **Access & Availability:** CalOptima Primary Care Physician Satisfaction Survey – Results presented to BHI, Provider Network Ops and Provider Relations departments. There was no trending as data from 2015 was not available for Continuity of Care.	**Medi-Cal:** Beacon will continue to educate providers on importance of communication. Distribution of "Quality Packets" to Inpatient, Outpatient and PCP providers. Email blasts, newsletters, & coordination slide added to new provider training. **Access & Availability:** This information will be presented in the BH Continuity of Care report for NCQA QI 9.	Q3
Q3	Completed (Annual measure)	Completed (Annual measure)	
Q4	Completed (Annual measure)	Completed (Annual measure)	
Year End	Provides valuable information on the level of detail and frequency engagement of providers should occur to ensure communication is occurring across treatment lines.	Utilize findings in 2017 provider engagement and education	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	Report in process	Provider education and enhanced frequency of review (propose quarterly vs. annual reporting)	Q2
Q2	**Medi-Cal:** 60% (9/15) chart records provide evidence of Release of Information to speak to PCP. Only 22% (2/9) show actual communication occurred. Providers report barriers include lack of time, failure to document, and that members don't share PCP information.	**Medi-Cal:** Beacon will continue Provider education; include PCP and ROI forms in packet for newly contracted providers; continue to collaborate with CalOptima; Beacon will emphasize expectations of collaborative work with PCPs and other providers at new provider orientations, in monthly bulletins,	Q4

	Medi-Cal: Four (4) Behavioral Health Services questions included in 2016 PCP Satisfaction Survey. Results: Are you aware of the behavioral health services that your members are receiving? **59.6%** Was the behavioral health services information sufficient and clear? **54.1%** Were you provided with information about the behavioral health services your members are receiving? **51.6%** Did you receive behavioral health services information in a timely manner? **46.9%**	and in articles to providers (May/Jun) & members (Jun/Oct). **Medi-Cal:** Results will be shared with the Health Networks; Supports will be put in place to address Provider Experience Initiatives; Pursuit of educational "team" approach to working with PCPS on barriers to care at their site of service Proposing to further clarify BH questions so that responses can direct next steps and provide more education to providers on accessing BH services and the ease of referrals and coordination of care.	
Q3	Completed (Annual measure)	Completed (Annual measure)	
Q4	Completed (Annual measure)	Completed (Annual measure)	
Year End	Survey information will be used to increase the communication opportunities in the 2017 Access measure.	This Quality measure has been changed for 2017.	N/A

IV. LTSS

A. Safety of Clinical Care and Quality of Clinical Care- Review and assess LTSS placement for members participating with each organization/program

Owner: Marie Earvolino, Director, Clinical Outcomes

The Approach

1. **Objective**
   - Member review of **Hospital Admissions** (for each organization/program)

2. **Activity**
   - Measure those members participating in each program for hospital admissions:
     1. CBAS
     2. IHSS
     3. LTC
     4. MSSP

3. **Goals**
   - 2% CBAS; Establishing goals in 2016 for IHSS, LTC & MSSP

LTSS
Owner: Marie Earvolino, Director, Clinical Outcomes

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	Community-Based Adult Services (CBAS): Establishing goals In-Home Supportive Services (IHSS): Establishing goals Long Term Care (LTC): Establishing goals Multipurpose Senior Services Program (MSSP): Establishing goals	Will monitor, track and trend to establish goals	
Q2	Community-Based Adult Services (CBAS): Establishing goals In-Home Supportive Services (IHSS): Establishing goals Long Term Care (LTC): Establishing goals Multipurpose Senior Services Program (MSSP): Establishing goals	Will monitor, track and trend to establish goals	
Q3	Community-Based Adult Services (CBAS): Establishing goals In-Home Supportive Services (IHSS): Establishing goals Long Term Care (LTC): Establishing goals Multipurpose Senior Services Program (MSSP): Establishing goals	Will monitor, track and trend to establish goals	
Q4	Community-Based Adult Services (CBAS): Establishing goals In-Home Supportive Services (IHSS): Establishing goals Long Term Care (LTC): Establishing goals Multipurpose Senior Services Program (MSSP): Establishing goals	Will monitor, track and trend to establish goals	
Year End	Community-Based Adult Services (CBAS): Establishing goals Home Supportive Services (IHSS): Establishing goals Long Term Care (LTC): Establishing goals Multipurpose Senior Services Program (MSSP): Establishing goals	Will monitor, track and trend to establish goals	

Outcomes	Results / Metrics	Next Steps	Target Completion
Q1	Community-Based Adult Services (CBAS): 2,008 Members Hospital Admissions: 213/1000 of CBAS Participants were admitted to the Hospital during the reporting period (data based on all LOBs excluding CODMED A, B, & C). Utilization remained the same as Q4 2015 at 5%. Top five diagnoses at the time of admission were: Influenza and pneumonia (6), ischemic heart disease (5), diseases of esophagus, stomach and duodenum (4), other diseases of urinary system (4), and infections of the skin and subcutaneous tissue (3). ALOS: CBAS ALOS is 4.6 compared to 3.7 non-CBAS; CBAS cost per day $1,015 compared to $2,673. Actual Bed Days: 983/1000 of CBAS Members were admitted during the quarter. In-Home Supportive Services (IHSS): 21,003 Members Hospital Admissions: 260/1000 IHSS Members were admitted to the hospital during the reporting period (data based on all LOBs excluding CODMED A, B & C). Utilization decreased by 3% from Q4 2015 (7% to 4%). Top five diagnoses for admission: Other bacterial diseases (25), arthrosis (21), other diseases of the intestines (16), complications of surgical and medical care not elsewhere classified (13), and Ischemic heart disease (12). ALOS: IHSS ALOS is 4.5 compared to non-IHSS 3.6; IHSS cost per day $1,059 compared to $2,532. Actual Bed Days: 1174/1000 of IHSS Members were admitted during the quarter.	This is the first quarter reporting hospital admissions for all LTSS services by program. During year one reporting report, will monitor, track, trend, and establish goals.	
Q1	Long Term Care (LTC): 4,757 Members		

	Hospital Admissions: 465/1000 LTC Members were admitted to the hospital during the reporting period (data based on all LOBs excluding CODMEDA, B, & C); utilization decreased by 3% from Q4 2015 (15% to 12%). Top five diagnoses for admissions: Other bacterial diseases (12), influenza and pneumonia (9), other diseases of the respiratory system (7), other diseases of urinary system (6), and lung diseases due to external agents (5). Will continue to monitor. ALOS: LTC ALOS is 5.9 compared to non-LTC 3.6; LTC cost per day is $1,232 compared to non-LTC $2,522. Actual Bed Days: 2726/1000 of LTC Members were admitted during the quarter. Multipurpose Senior Services Program (MSSP): 478 Members Hospital Admissions: 312/1000 MSSP Members were admitted to the hospital during the reporting period (data based on all LOBs excluding CODMED A, B & C). Utilization decreased 7% from Q4 2015 (15% to 8%). Diagnoses for admissions: Influenza and pneumonia (3), chronic lower respiratory diseases (1), other diseases of intestines (1), diabetes mellitus (1), and other forms of heart disease (1). ALOS: ALOS is 4.7 compared to non-MSSP 4.3; MSSP cost per day is $951 compared to $2,840. Actual Bed Days: 1470/1000 of MSSP Members were admitted during the quarter.		
Q2	Community-Based Adult Services (CBAS): 2,045 Members Hospital Admissions: 322/1000 of CBAS Participants were admitted to the Hospital during the reporting period (data based on all LOBs excluding CODMED A, B, & C). Utilization decreased 1% from Q1 2016 (7% to 6%). Top five diagnoses at the time of admission were: Other bacterial diseases (4),	1st Year Reporting for Admit/1000. Track, trend, monitor and will establish a benchmark for 2017. Will comply with DHCS CBAS eligibility criteria. Collaborate and coordinate members' care with HNs/CCNs. Will comply with CalOptima and OC SSA MOU agreement and workflow protocols. Collaborate and coordinate	

Q2	Cerebrovascular diseases (4), influenza and pneumonia (3), diseases of esophagus, stomach and other duodenum (3), and other diseases of intestines (2). Two of five diagnoses remain the same compared to Q1 2016: Other bacterial diseases and influenza and pneumonia. CBAS ALOS: 5.1 ALOS for CBAS members compared to 3.9 non-CBAS members; CBAS cost per day was $3,177 compared to $2,337 for non-CBAS members. Actual Bed Days: 1642/1000 of CBAS members admitted during the quarter. In-Home Supportive Services (IHSS): 21,077 Members Hospital Admissions: 306/1000 IHSS Members were admitted to the hospital during the reporting period (data based on all LOBs excluding CODMED A, B & C). Utilization decreased by 2% from Q1 2016 (7% to 6%). Top five diagnoses for admission: Other bacterial diseases (51), other forms of heart disease (44), metabolic disorders (28), cerebrovascular diseases (21), and other diseases of the intestines (21). Two of the five diagnoses remain the same as Q1 2016: Other bacterial diseases and other diseases of the intestines. IHSS ALOS: 4.1 ALOS for IHSS members compared to 3.8 non-IHSS members; IHSS cost per day was $2,727 compared to $2,283 for non-IHSS members. Actual Bed Days: 1270/1000 of IHSS members were admitted during the quarter. Long Term Care (LTC): 4,715 Members Hospital Admissions: 637/1000 LTC Members were admitted to the hospital during the reporting period (data based on all LOBs excluding CODMEDA, B, & C). Utilization decreased by 6% from Q1 2016 (16% to 10%). Top five diagnoses for admissions: Other bacterial diseases (71), complications of surgical and medical care, not elsewhere specified (20), other diseases of the digestive	members' care with HNs/CCNs. OC SSA IHSS Social Worker to continue to participate in IHSS Member ICT meetings. LTC Care Managers will continue to comply with Title 22 and DHCS LTC Provider Manual, and CalOptima policy. For OCC LTC residents, CalOptima clinical staff will participate in Member ICT meetings. Continue to share completed health risk assessments and assist with coordination of care as appropriate. Will share OC and SPD member's SNF plan of care with HNs/CCN Will assist HNs/CCN with difficult SNF placement. MSSP Care Managers will continue to comply with CDA MSSP Site Manual guidelines. Will share CBAS, IHSS, LTC, and MSSP plan of care with health networks and CCN.	

	system (16), influenza and pneumonia (9), and other diseases of urinary system (7). Three out of five diagnoses remain the same as Q2 2016: Other bacterial diseases, influenza and pneumonia, and other diseases of urinary system. LTC ALOS: 6.4 ALOS for LTC members compared to 3.8 non-LTC members; LTC cost per day was $2,258 compared to $2,306 for non-LTC members. Actual Bed Days: 4075/1000 of LTC members was admitted during the quarter Multipurpose Senior Services Program: 466 Members Hospital Admissions: 398/1000 MSSP members were admitted to the hospital during the reporting period (data based on all LOBs excluding CODMED A, B & C). Utilization decreased 3% from Q1 2016 (12% to 9%). Diagnoses for admissions: Cerebrovascular diseases (2), Other disorders of the nervous system (2), ischemic heart disease (1), infections of the skin and subcutaneous tissue (1), and injuries to the thorax (1). Five of five diagnoses are new compared to Q1 2016.		
Q2	ALOS: 3.5 ALOS for MSSP members compared to 4.6 non-MSSP; MSSP cost per day was $4,385 compared to $2,873 for non-MSSP members. Actual Bed Days: 1404/1000 of MSSP members were admitted during the quarter.		
Q3	Community-Based Adult Services (CBAS): 2,048 Members 450 Members after Excluding CODMED A, B, & C Hospital Admissions: 223/1000 of CBAS Participants were admitted to the Hospital during the reporting period (data based on all LOBs excluding CODMED A, B, & C). Utilization decreased 2% from Q2 2016 (6% to 4%). Top five diagnoses at the time of admission were: Other bacterial diseases (3), other diseases of the respiratory system (2), disorders of gallbladder, biliary tract and pancreas (2), other diseases of urinary system	Will monitor, track and trend to established goals. Note: All populations are being reviewed based on all LOBs excluding CODMED A, B, & C. Changes were made to generate a truer comparison across groups. Based on this data, CBAS established goals may need to be re-evaluated and updated for 2017.	

	(2), and other diseases of digestive system (2). One of five diagnoses remains the same compared to Q2 2016: Other bacterial diseases. CBAS ALOS: 4.2 ALOS for CBAS members compared to 2.9 non-CBAS members; CBAS cost per day was $2,599 compared to $1,598 for non-CBAS members. Actual Bed Days: 929/1000 bed days during this reporting period.		
Q3	In-Home Supportive Services (IHSS): 20,526 Members 6,752 Members after Excluding CODMED A, B, & C Hospital Admissions: 350/1000 IHSS Members were admitted to the hospital during the reporting period (data based on all LOBs excluding CODMED A, B & C). Utilization remained the same as Q2 2016 (6% to 6%). Top five diagnoses for admission: Other bacterial diseases (70), complications of surgical and medical care, not elsewhere classified (36), other forms of heart disease (34), metabolic disorders (27), and diabetes mellitus (22).Two of the five diagnoses remain the same as Q1 2016: Other bacterial diseases and other forms of heart disease. IHSS ALOS: 4.3 ALOS for IHSS members compared to 3.6 non-IHSS members; IHSS cost per day was $2,711 compared to $2,168 for non-IHSS members. Actual Bed Days: 1495/1000 bed days during this reporting period. Long Term Care (LTC): 3,977 Members 1,115 Members after Excluding CODMED A, B, & C Hospital Admissions: 339/1000 LTC Members were admitted to the hospital during the reporting period (data based on all LOBs excluding CODMEDA, B, & C). Utilization decreased by 4% from Q2 2016 (10% to 6%). Top five diagnoses for admissions: Other bacterial diseases (27), complications of surgical and medical		

	care, not elsewhere specified (9), other diseases of the digestive system (7), lung diseases due to external agents (6), and other diseases of the respiratory system (4). Three out of five diagnoses remain the same as Q2 2016: Other bacterial diseases, complications of surgical and medical care, not elsewhere specified, and other diseases of the digestive system. LTC ALOS: 6.8 ALOS for LTC members compared to 3.6 non-LTC members; LTC cost per day was $2,365 compared to $2,197 for non-LTC members. Actual Bed Days: 2297/1000 bed days during reporting period.		
Q3	Multipurpose Senior Service Program: 456 Members 110 Members after Excluding CODMED A, B, & C Hospital Admissions: 620/1000 MSSP members were admitted to the hospital during the reporting period (data based on all LOBs excluding CODMED A, B & C). Utilization increased 2% from Q2 2016 (9% to 11%). Top five primary diagnosis at time of admission: Other bacterial diseases (6), complications of surgical and medical care, not elsewhere classified (1), Cerebrovascular diseases (1), episodic and paroxysmal disorders (1), and other diseases of intestines (1). One of five diagnoses remains the same compared to Q2 2016: Other bacterial diseases. ALOS: 3.7 ALOS for MSSP members compared to 4.7 non-MSSP; MSSP cost per day was $3,135 compared to $2,672 for non-MSSP members. Actual Bed Days: 2323/1000 bed days during reporting period. Members Enrolled in Multiple LTSS Home and Community Based Services (HCBS) Programs: 1) CBAS, IHSS & MSSP: 58 Members, 11 after excluding CODMED A, B, & C	Per request: Comparisons were added for Members enrolled in multiple Home and Community Based Services (HCBS) programs. Will continue to monitor, track and trend going forward.	

Q3	Hospital Admissions: 836/1000 LTSS members admitted to the hospital during the reporting period. Utilization increased 19% compared to Q2 2016 (0% to 19%). ALOS: 1.0 ALOS for LTSS members compared to 4.6 non-LTSS; LTSS cost per day was $8,564 compared to $2,351 for non-LTSS members. Actual Bed Days: 855/1000 bed days per reporting period. 2) CBAS & IHSS: 1,196 Members Hospital Admissions: 219/1000 LTSS members admitted to the hospital during the reporting period. Utilization remained the same compared to Q2 2016 (5%). ALOS: 4.0 ALOS for LTSS members compared to 2.7 non-LTSS; LTSS cost per day was $2,836 compared to $1,416 for non-LTSS members. Actual Bed Days: 876/1000 bed days per reporting period. 3) CBAS & MSSP: 67 Members, 13 after excluding CODMED A, B, & C Hospital Admissions: 690/1000 LTSS members were admitted to the hospital during the reporting period. Utilization increased 9% compared to Q2 2016 (7% to 16%). ALOS: 1.0 ALOS for LTSS members compared to 4.8 non-LTSS; LTSS cost per day was $8,564 compared to $2,385 for non-LTSS members. Actual Bed Days: 754/1000 bed days per reporting period. 4) IHSS & MSSP: 390 Members, 88 after excluding CODMED A, B, & C Hospital Admissions: 497/1000 LTSS members admitted to		

Q3	hospital during reporting period. Utilization increased 3% compared to Q2 2016 (6% to 9%). ALOS: 3.6 ALOS for LTSS members compared to 4.6 non-LTSS; LTSS cost per day was $2,388 compared to $2,351 for non-LTSS members. Actual Bed Days: 1794/1000 bed days per reporting period. Decreased 2% from Q2 2016 (23% to 21%).		
Q4	Community-Based Adult Services (CBAS): 2,038 Members; 439 Members after Excluding CODMED A, B, & C Hospital Admissions: 332/1000 (5%) of CBAS Participants were admitted to the Hospital during the reporting period (data based on all LOBs excluding CODMED A, B, & C). Utilization increased 1% from Q3 2016 (4% to 5%). Top five diagnoses at the time of admission were: Other bacterial diseases (6), general symptoms and signs (3), chronic lower respiratory diseases (2), arthrosclerosis (2), and non-infective enteritis and colitis (2). One of five diagnoses remains the same compared to Q3 2016: Other bacterial diseases. CBAS ALOS: 3.7 ALOS for CBAS members compared to 3.9 non-CBAS members; CBAS cost per day was $2,644 compared to $2,662 for non-CBAS members. Actual Bed Days: 1320/1000 bed days during this reporting period. In-Home Supportive Services (IHSS): 20,105 Members 6,287 Members after Excluding CODMED A, B, & C Hospital Admissions: 289/1000 (5%) IHSS Members were admitted to the hospital during the reporting period (data based on all LOBs excluding CODMED A, B & C). Utilization decreased 1% from Q3 2016 (6% to 5%). Top five diagnoses for admission: Other bacterial diseases (62), hypertensive diseases (24), influenza and pneumonia (21), other forms of heart disease (20),	Will monitor, track and trend and establish goals. Note: LTSS populations are being reviewed based on all LOBs excluding CODMED A, B and C. Changes were made to generate a truer comparison across groups. Based on this data, CBAS established goals need to be re-evaluated and updated for 2017.	

	and renal failure (19).Two of the five diagnoses remain the same as Q3 2016: Other bacterial diseases and other forms of heart disease. IHSS ALOS: 4.5 ALOS for IHSS members compared to 3.8 non-IHSS members; IHSS cost per day was $2,997 compared to $2,512 for non-IHSS members. Actual Bed Days: 1261/1000 bed days during this reporting period.		
Q4	Long Term Care (LTC): 3,979 Members 1,106 Members after Excluding CODMED A, B, & C Hospital Admissions: 467/1000 (8%) LTC Members were admitted to the hospital during the reporting period (data based on all LOBs excluding CODMEDA, B, & C). Utilization increased by 2% from Q3 2016 (6% to 8%). Top five diagnoses for admissions: Other bacterial diseases (35), complications of surgical and medical care, not elsewhere specified (11), lung diseases due to external agents (6), infections of the skin and subcutaneous tissue (5), and renal failure (5). Three out of five diagnoses remain the same as Q3 2016: Other bacterial diseases, complications of surgical and medical care, not elsewhere specified, and lung diseases due to external agents. LTC ALOS: 6.1 ALOS for LTC members compared to 3.8 non-LTC members; LTC cost per day was $2,602 compared to $2,541 for non-LTC members. Actual Bed Days: 2694/1000 bed days during reporting period. Multipurpose Senior Service Program: 568 Members 130 Members after Excluding CODMED A, B, & C Hospital Admissions: 413/1000 (7%) MSSP members were admitted to the hospital during the reporting period (data based on all LOBs excluding CODMED A, B & C). Utilization decreased 4% from Q3 2016 (11% to 7%). Top five primary diagnosis at time of		

Q4	admission: Other bacterial diseases (5), renal failure (3), injuries to the head (unspecified subdural trauma) (2), arthrosis (1) and infections to the skin and subcutaneous tissue (1). One of five diagnoses remains the same compared to Q3 2016: Other bacterial diseases. ALOS: 5.0 ALOS for MSSP members compared to 3.9 non-MSSP; MSSP cost per day was $3,412 compared to $3,264 for non-MSSP members. Actual Bed Days: 2323/1000 bed days during reporting period. Members Enrolled in Multiple LTSS Home and Community Based Services (HCBS) Programs: 1) CBAS, IHSS & MSSP: 61 Members, 9 Members after excluding CODMED A, B, & C Hospital Admissions: 645/1000 (10%) LTSS members admitted to the hospital during the reporting period. Utilization decreased 9% compared to Q3 2016 (19% to 10%). ALOS: 1.0ALOS for LTSS members compared to 3.8 non-LTSS; LTSS cost per day not reported; LTSS cost per admit was $9,164 compared to $13,429 for non-LTSS members. Actual Bed Days:0/1000 bed days reported during reporting period. 2) CBAS & IHSS: 1,143 Members, 193 Members after excluding CODMED A, B, & C Hospitalizations:173/1000 (2%) LTSS members admitted to the hospital during the reporting period. Utilization decreased 3% compared to Q3 2016 (5% to 2%). ALOS:3.2 ALOS for LTSS members compared to 3.8 non-LTSS; LTSS cost per day was $2,072 compared to $2,637 for non-LTSS members. Actual Bed Days:616/1000 bed days per reporting period.		

Q4	3) CBAS & MSSP: 75 Members, 14 Members after excluding CODMED A, B, & C Hospitalizations:746/1000 (13%) LTSS members were admitted to the hospital during the reporting period. Utilization decreased 3% compared to Q3 2016 (16% to 13%). ALOS:1.6 ALOS for LTSS members compared to 3.9 non-LTSS; LTSS cost per day was $8,805 compared to $3,267 for non-LTSS members. Actual Bed Days:983/1000 bed days per reporting period. 4) IHSS & MSSP: 443 Members, 91 Members after excluding CODMED A, B, & C Hospitalization:356/1000 (6%) LTSS members admitted to hospital during reporting period. Utilization decreased 3% compared to Q2 2016 (9% to 6%). ALOS:5.2 ALOS for LTSS members compared to 3.8 non-LTSS; LTSS cost per day was $3,223 compared to $3,264 for non-LTSS members. Actual Bed Days:1841/1000 bed days per reporting period.		
Year End	Establishing goals	LTSS Program goals for 2017: CBAS: Hospital Admissions: 4.5% IHSS: Hospital Admissions: 5% LTC: Hospital Admissions: 7% MSSP: Hospital Admissions: 9% Recommend establishing new goals to include: Evaluate utilization of members enrolled in multiple Home	

		and Community Based Programs: CBAS, IHSS & MSSP: Hospital Admissions: 15% CBAS & IHSS: Hospital Admissions: 3% CBAS & MSSP: Hospital Admissions: 15% MSSP & IHSS: Hospital Admissions: 7.5%	

IV. LTSS

B. *Safety of Clinical Care and Quality of Clinical Care- Review and assess emergency department visits for LTSS members participating with each organization/program **Owner: Marie Earvolino, Director, Clinical Outcomes**

The Approach

1. **Objective**
   - Member review of Emergency Department Visits (for each organization/program)

2. **Activity**
   - Measure those members participating in each program for hospital admissions:
     1. CBAS
     2. IHSS
     3. LTC
     4. MSSP

3. **Goals**
   - 9% CBAS; Establishing goals in 2016 for IHSS, LTC, MSSP

LTSS
Owner: Marie Earvolino, Director, Clinical Outcomes

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	CBAS: Goal is 9% IHSS: Establishing goal LTC: Establishing goal MSSP: Establishing goal	Will monitor, track and trend to establish goals.	
Q2	CBAS: Goal is 9% IHSS: Establishing goal LTC: Establishing goal MSSP: Establishing goal	Will monitor, track and trend to establish goals.	
Q3	CBAS: Goal is 9% IHSS: Establishing goal LTC: Establishing goal MSSP: Establishing goal	Will monitor, track and trend to establish goals.	
Q4	CBAS: Goal is 9% IHSS: Establishing goal LTC: Establishing goal MSSP: Establishing goal	Will monitor, track and trend to establish goals.	
Year End	CBAS: Goal is 9% IHSS: Establishing goal LTC: Establishing goal MSSP: Establishing goal	Will monitor, track and trend to establish goals.	

Outcomes	Results / Metrics	Next Steps	Target Completion
Q1	**Community-Based Adult Services (CBAS):** **2,008 Members** **ED Visits:** Four percent (4%) or 181/1000 CBAS members had ED visits during the reporting period compared to 6% of non-CBAS members. Cost per visit: CBAS $456 compared to $195 non-CBAS. Utilization increase by 1% from Q4 2015 (16% to 17%). Top five primary diagnoses: Symptoms and signs involving the circulatory and respiratory systems (8), Other	This is the first quarter reporting ED visits for IHSS, LTC and MSSP. During year one reporting report, will monitor, track, trend, and establish goals. CBAS ED visits were 4% which was below established goal (9%). Goal met. Continue to monitor, track, and trend.	

Q1	diseases of intestines (8), Injuries to the head (including lower back pain and head abrasion due to fall) (8), symptoms and signs involving the digestive system and abdomen (7), and symptoms and signs involving cognition, perception, emotional state and behavior (5). Goal met. **In-Home Supportive Services (IHSS):** **21,003 Members** **ED Visits:** Five percent (5%) or 332/1000 of IHSS Members had ED visits during the reporting period compared to 7% of non-IHSS Members. Cost per visit for IHSS is $435 compared to $187 for non-IHSS. Utilization remained the same as Q4 2015 at 17%. Top five primary diagnoses for ED visits: General symptoms and signs (141), symptoms and signs involving the digestive system and abdomen (123), symptoms and signs involving the circulatory and respiratory systems (116), chronic lower respiratory diseases (79), injuries to the head (including: Syncope, fall, head pain, dizziness, seizure, eyebrow laceration) (76). **Long Term Care (LTC):** **4,757 Members** **ED Visits:** Six percent (6%) or 258/1000 LTC members went to ED during the reporting period compared to 6% of non-LTC members. Cost per visit: LTC $438 compared to non-LTC $194. Utilization decreased 4% from Q4 2015 (23% to 19%). Top five primary diagnoses: General symptoms and signs (45), symptoms and signs involving the circulatory and respiratory systems (38), persons encountering health services for specific procedures and health care (including G tube problems and replacement) (20), injuries to the head (including contusion of head, suicidal ideation, laceration, fall, and confused dizziness) (18), symptoms and signs involving the digestive system and abdomen (18). Most frequently used EDs: Fountain Valley Regional (29); St Joseph (19); and, UCI (19). LTC facilities most frequently sending members to ED: Fountain Care Center (11); and, Carehouse Healthcare Center (9).		

	Multipurpose Senior Services Program (MSSP): **478 Members** **ED Visits:** Six percent (6%) or 372/1000 MSSP Members went to ED during the reporting period compared to those who are non-MSSP members. Cost per visit: MSSP $566 compared to $781. Utilization decreased 6% from Q4 2015 (28% to 22%). Top five primary diagnoses: Other soft tissue disorders (14), Injuries to the knee and lower leg (7), general symptoms and signs (2), acute upper respiratory infections (2), and other diseases of the intestines (2).		
Q2 **Q2**	**Community-Based Adult Services (CBAS):** **2,045 Members** **ED Visits:** 714/1000 of CBAS members had ED visits during the reporting period compared to 438/K of non-CBAS members. Cost per visit: CBAS $825 compared to $282 non-CBAS. Overall ED utilization decreased by 1% from Q1 2016 (17% to 16%). Top five primary diagnoses: Injuries to head, including contusion (8), other diseases of urinary system (7), symptoms and signs involving the digestive system and abdomen (7), general symptoms and signs (6), and injuries to the shoulder and upper arm (6). Two of the five diagnoses remain the same as Q1 2016: Injuries to the head symptoms and signs involving the digestive system and abdomen. Goal met. **In-Home Supportive Services (IHSS):** **21,077 Members** **ED Visits:** 689/1000 of IHSS Members had ED visits during the reporting period compared to 334/K of non-IHSS Members. Cost per visit for IHSS is $626 compared to $212 for non-IHSS. Overall, utilization remained the same compared to Q1 2016 (17%). Top five primary diagnoses for ED visits: symptoms and signs involving the circulatory and respiratory systems (122), symptoms and signs involving the digestive system and abdomen (119), general symptom and signs (99), other	1st Year Reporting for Admit/1000. Track, trend, monitor and will establish a benchmark for 2017. Will comply with DHCS CBAS eligibility criteria. Collaborate and coordinate members' care with HNs/CCNs. Will comply with CalOptima and OC SSA MOU agreement and workflows protocols. Collaborate and coordinate members' care with HNs/CCNs. OC SSA IHSS Social Worker continues to participate in IHSS Member's ICT meetings. LTC Care Managers will continue to comply with Title 22 and DHCS LTC Provider Manual, and CalOptima policy. For OCC LTC residents, CalOptima clinical staff will participate in Member's ICT meetings. Continue to share completed health risk assessments and assist with coordination of care as appropriate. Will share OC and SPD member's SNF plan of care with HNs/CCN Will assist HNs/CCN with difficult SNF placement. MSSP Care Managers will continue to comply with CDA	

	diseases of urinary system (74), and other dorsopathies (60). Three of the five diagnoses remained the same as Q1 2016: symptoms and signs involving the digestive system and abdomen, general symptoms and signs and symptoms and signs involving the circulatory and respiratory systems.	MSSP Site Manual guidelines. Will track, trend, and continue to monitor to establish goals.	
Q2	**Long Term Care (LTC):** **4,715 Members** **ED Visits:** 448/1000 of LTC members went to ED during the reporting period compared to 338/K of non-LTC members. Cost per visit: LTC $660 compared to non-LTC $219. Utilization decreased by 5% from Q1 2016 (21% to 16%). Top five primary diagnoses: Diabetes Mellitus (51), Persons encountering health services for specific procedure and health care (21), other diseases of the urinary system (20), injuries to the head (including laceration) (19), and other dorsopathies (12). Two of the five diagnoses remain the same as Q1 2016: Persons encountering health services for specific procedure and health care and injuries to the head. Most frequently used EDs: Fountain Valley Regional Hospital and Medical Center (22); Hoag Memorial Hospital Presbyterian (13); and St Joseph Hospital (12). LTC facilities most frequently sending members to ED: Fountain Care Center (9); Flagship Healthcare Center (6); and, Carehouse Healthcare Center (5). Fountain Care continues to be the most ED utilizing LTC facilities; with an increase of use form 11 in Q1 to 22 in Q2. **Multipurpose Senior Services Program (MSSP):** **466 Members** **ED Visits:** 1057/1000 MSSP members admitted to ED during the reporting period compared to of 297/K non-MSSP members. Cost per visit: MSSP $1,232 compared to $815. Utilization decreased 2% from Q1 2016 (26% to 24%). Top five primary diagnoses: Injuries to the knee and lower leg (4), general symptoms and signs (3), symptoms and signs involving the digestive system and abdomen (3), metabolic disorders (2), and other disorders of the nervous system (2). Two of five diagnoses		

	remained the same as Q1 2016: Injuries to the knee and lower leg and general symptoms and signs.		
Q3 **Q3**	**Community-Based Adult Services (CBAS):** **2,048 Members** **450 Members after Excluding CODMED A, B and C** **ED Visits**: 564/1000 of CBAS members had ED visits during the reporting period compared to 435/K of non-CBAS members. Cost per visit: CBAS $576 compared to $281 non-CBAS. Overall, ED utilization decreased by 2% from Q2 2016 (16% to 14%). Top five primary diagnoses: Injuries to head, including contusion (10), symptoms and signs involving the urinary system (8), symptoms and signs involving the digestive system and abdomen (5), general symptoms and signs (4), and symptoms and signs involving the circulatory and respiratory systems (4). Three of the five diagnoses remain the same as Q2 2016: Injuries to the head symptoms, signs involving the digestive system and abdomen, and general symptoms and signs. **In-Home Supportive Services (IHSS):** **20,526 Members** **6,752 Members after Excluding CODMED A, B and C** **ED Visits:** 679/1000 of IHSS Members had ED visits during the reporting period compared to 351/K of non-IHSS Members. Cost per visit for IHSS is $649 compared to $204 for non-IHSS. Overall, utilization decreased 2% from Q2 2016 (17% to 15%). Top five primary diagnoses for ED visits: Symptoms and signs involving the digestive system and abdomen (124), symptoms and signs involving the circulatory and respiratory systems (116), general symptom and signs (86), other diseases of urinary system (76), and other diseases of intestines (63). Four of the five diagnoses remained the same as Q2 2016: symptoms and signs involving the digestive system and abdomen, general symptoms and signs, symptoms and signs involving the circulatory and respiratory systems, general symptom and signs, and other diseases of urinary system.		

Q3	**Long Term Care (LTC):** **3,977 Members** **1,115 Members after Excluding CODMED A, B and C** **ED Visits:** 398/1000 of LTC members went to ED during the reporting period compared to 354/K of non-LTC members. Cost per visit: LTC $338 compared to non-LTC $212. Utilization decreased by 3% from Q2 2016 (16% to 13%). Top five primary diagnoses: Metabolic Disorders (20), Persons encountering health services for specific procedure and health care (16), complications of surgical and medical care, not elsewhere classified (12), injuries to the head (including laceration) (11), and other diseases of the digestive system (9). One of the five diagnoses remains the same as Q2 2016: Persons encountering health services for specific procedure and health care. Most frequently used EDs: Fountain Valley Regional Hospital and Medical Center (30); St Joseph Hospital (17), and West Anaheim Medical Center (7). LTC facilities most frequently sending members to ED: Fountain Care Center (17); Carehouse Healthcare Center (12); Flagship Healthcare Center (7); Anaheim Terrace Care Center (7); and The Pavilion at Sunny Hills (7). Fountain Care continues to be the most ED utilizing LTC facilities; with an increase of use form 22 in Q2 to 30 in Q3.		
Q3	**Multipurpose Senior Services Program (MSSP):** **456 Members** **110 Members after Excluding CODMED A, B and C** **ED Visits:** 874/1000 MSSP members admitted to ED during the reporting period compared to 317/K non-MSSP members. Cost per visit: MSSP $1,269 compared to $796. Utilization decreased 3% from Q2 2016 (24% to 21%). Top five primary diagnoses: Symptoms and signs involving the digestive system and abdomen (5), injuries to the head (3), injuries to the shoulder and upper arm (1), other diseases of intestines (1), and other diseases of the urinary system (1). One of five diagnoses remained the same as Q2 2016: Symptoms and signs involving the digestive system and abdomen.		

	Members Enrolled in Multiple LTSS Home and Community Based Services (HCBS) Programs: **1) CBAS, IHSS & MSSP:** **58 Members** **11 Members after Excluding CODMED A, B and C** **ED Visits:** 1,314/K members visited ED during the reporting period compared to 154/1000 non-LTSS members. Cost per visit: LTSS $707 compared to $299. Utilization decreased 4% from Q2 2016 (25% to 21%). **2) CBAS & IHSS:** **1,196 Members** **ED Visits:** 573/K members visited ED during the reporting period compared to 351 non-LTSS members. Cost per visit: LTSS $567 compared to $204. Utilization increased 2% from Q2 2016 (13% to 15%). **3. CBAS & MSSP**: **67 Members** **13 Members after Excluding CODMED A, B and C** **ED Visits:** 1,093/K members visited ED during the reporting period compared to 147/1000 non-LTSS members. Cost per visit: LTSS $707 compared to $234. Utilization decreased 10% from Q2 2016 (28% to 18%). **4) IHSS & MSSP:** **390 Members** **88 Members after Excluding CODMED A, B and C** **ED Visits:** 1,052/K members visited ED during the reporting period compared to 153/1000 non-LTSS members. Cost per visit: LTSS $777 compared to $230. Utilization decreased 2% from Q2 2016 (23% to 21%).		
Q4	**Community-Based Adult Services (CBAS):** **2,038 Members** **439 Members after Excluding CODMED A, B and C** **ED Visits**:404/1000 (12%) of CBAS members had ED visits	For the current methodology: CBAS ED utilization is at 12%, goal not met.	

Q4	during the reporting period compared to 418/K of non-CBAS members. Cost per visit: CBAS $856 compared to $279 non-CBAS. Overall, ED utilization decreased by 2% from Q3 2016 (14% to 12%). Top five primary diagnoses: Injuries to head, including contusion (14), general symptoms and signs (9), other diseases of the urinary system (6), symptoms and signs involving the urinary system (8), symptoms and signs involving the circulatory and respiratory systems (4), injuries to the thorax (3), and chronic lower respiratory diseases (2). Three of the five diagnoses remain the same as Q3 2016: Injuries to the head symptoms, symptoms and signs involving the urinary system, symptoms, and signs involving the circulatory and respiratory systems. **In-Home Supportive Services (IHSS):** **20,105 Members** **6,287 Members after Excluding CODMED A, B and C** **ED Visits:** 646/1000 (13%) of IHSS Members had ED visits during the reporting period compared to 360/K (7%) of non-IHSS Members. Cost per visit for IHSS is $684 compared to $190 for non-IHSS. Overall, utilization decreased 2% from Q3 2016 (15% to 13%). Top five primary diagnoses for ED visits: Symptoms and signs involving the circulatory and respiratory systems (128), symptoms and signs involving the digestive system and abdomen (114), general symptom and signs (78), other diseases of urinary system (65), and injuries to the head (60). Four of the five diagnoses remained the same as Q3 2016: symptoms and signs involving the digestive system and abdomen, general symptoms and signs, symptoms and signs involving the circulatory and respiratory systems, general symptom and signs, and other diseases of urinary system. **Long Term Care (LTC):** **3,979 Members** **1,106 Members after Excluding CODMED A, B and C** **ED Visits:** 383/1000 (13%) of LTC members went to ED during the reporting period compared to 362/K (7%) of non-LTC members. Cost per visit: LTC $531 compared to non-LTC $198. Utilization remained the same when compared to Q3 2016 (13% to 13%). Top five primary diagnoses: Other diseases of the digestive system (20), persons encountering health services for		

Q4	specific procedure and health care (13), complications of surgical and medical care, not elsewhere classified (11), injuries to the head (including laceration) (10), and other bacterial diseases (7).Four of the five diagnosis remain the same as Q3 2016: Other diseases of the digestive system, persons encountering health services for specific procedure and health care, complications of surgical and medical care, not elsewhere classified, and injuries to the head (including laceration). LTC facilities most frequently sending members to ED: Anaheim Terrace Care Center (11), Carehouse Healthcare Center (8), Chapman Care Center (6), Flagship Healthcare Center (6), Fountain Care Center (6), and St Edna Subacute and Rehabilitation Center (6). **Multipurpose Senior Service Program:** **568 Members** **130 Members after Excluding CODMED A, B and C** **ED Visits:** 874/1000 (21%) MSSP members admitted to ED during the reporting period compared to 286/K (7%) non-MSSP members. Cost per visit: MSSP $1,757 compared to $862. Utilization remained the same when compared to Q3 2016 (21% to 21%). Top five primary diagnoses: Injuries to the head (7), symptoms and signs involving the circulatory and respiratory systems (5), metabolic disorders (5), influenza and pneumonia (2), and symptoms and signs involving the digestive system and abdomen (2). Two of the five diagnoses remained the same as Q3 2016: Injuries to the head and symptoms and signs involving the digestive system and abdomen. **Members Enrolled in Multiple LTSS Home and Community Based Services (HCBS) Programs:** **1) CBAS, IHSS & MSSP:** **61Members,** **9 after excluding CODMED A, B, & C** **ED Visits:** 1,385/K (39%) members visited ED during the reporting period compared to 259/1000 (6%) non-LTSS		

	members. Cost per visit: LTSS $1,424 compared to $782. Utilization increased 18% from Q3 2016 (21% to 39%). **2) CBAS & IHSS:** **1,143 Members,** **193 after excluding CODMED A, B, & C** **ED Visits:**448/K (12%) members visited ED during the reporting period compared to 414/K (7%) non-LTSS members. Cost per visit: LTSS $744 compared to $268. Utilization decreased 3% from Q3 2016 (15% to 12%). **3) CBAS & MSSP:** **75 Members,** **14 after excluding CODMED A, B, & C** **ED Visits:**933/K (26%) members visited ED during the reporting period compared to 286/1000 (7%) non-LTSS members. Cost per visit: LTSS $1,424 compared to $858. Utilization increased 8% from Q3 2016 (18% to 26%). 4. **IHSS & MSSP**: **443 Members,** **91 after excluding CODMED A, B, & C** **ED Visits:**938/K (22%) members visited ED during the reporting period compared to 259/1000 (6%) non-LTSS members. Cost per visit: LTSS $1,997 compared to $788. Utilization increased 1% from Q3 2016 (21% to 22%).		
Year End	CBAS did not meet the goal of 9% for Emergency Department Visits; average percentage of 11.5%.	LTSS Program goals for 2017: **CBAS:** Emergency Dept Visits: 13% **IHSS:** Emergency Dept Visits: 14% **LTC:** Emergency Dept Visits: 14% **MSSP:** Emergency Dept Visits: 21% Recommend establishing new goals to include: **Evaluate utilization of members enrolled in multiple**	

		Home and Community Based Programs: **CBAS, IHSS & MSSP:** Emergency Dept Visits: 20% **CBAS & IHSS:** Emergency Dept Visits: 13% **CBAS & MSSP:** Emergency Dept Visits: 22% **MSSP & IHSS:** Emergency Dept Visits: 21%	

IV. LTSS

C. *Safety of Clinical Care and Quality of Clinical Care-Review and assess readmissions for LTSS members participating with each organization/program Owner: Marie Earvolino, Director, Clinical Outcomes

The Approach

1. **Objective**
   - Members reviewed for Hospital Readmissions (for each organization/program)

2. **Activity**
   - Measure and assess readmissions within 30 days for members in each program to drive interventions to minimize hospital readmissions:
     1. CBAS
     2. IHSS
     3. LTC
     4. MSSP

3. **Goals**
   - 2.5% CBAS; Establishing goals in 2016 for IHSS, LTC, MSSP

LTSS
Owner: Marie Earvolino, Director, Clinical Outcomes

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	CBAS: Goal is 2.5% IHSS: Establishing goal LTC: Establishing goal MSSP: Establishing goal	Will monitor, track and trend to establish goals	
Q2	CBAS: Goal is 2.5% IHSS: Establishing goal LTC: Establishing goal MSSP: Establishing goal	Will monitor, track and trend to establish goals	
Q3	CBAS: Goal is 2.5% IHSS: Establishing goal LTC: Establishing goal MSSP: Establishing goal	Will monitor, track and trend to establish goals	
Q4	CBAS: Goal is 2.5% IHSS: Establishing goal LTC: Establishing goal MSSP: Establishing goal		
Year End	CBAS: Goal is 2.5% IHSS: Establishing goal LTC: Establishing goal MSSP: Establishing goal		
Outcomes	Results / Metrics	Next Steps	Target Completion
Q1 **Q1**	Community-Based Adult Services (CBAS): 2,008 Members Readmissions: 3% of CBAS members were re-admitted to the hospital within 30 days of discharge during the reporting period. Utilization decreased 4% from Q4 2015 (14% to 10%). Primary diagnoses: Other bacterial diseases (1). Goal not met. In-Home Supportive Services (IHSS): 21,003 Members	This is the first quarter reporting hospital readmissions for IHSS, LTC and MSSP. During year one reporting report, will monitor, track, trend, and establish goals. CBAS Readmits rate of 3% which was slightly higher than the established goal (2.5%). Goal not met. Continue to provide care coordination, monitor, track, and trend.	

	Readmissions: Nine percent (9%) of IHSS Members were readmitted to the hospital within 30 days of discharge. Utilization decrease 2% from Q4 2015 (22% to 20%). Primary diagnoses for re-admissions: Schizophrenia, Schizotypal, and delusional disorders (2), diseases of liver (2), episodic and paroxysmal disorders (2), inflammatory diseases of the central nervous system (2), and influenza and pneumonia (2). Long Term Care (LTC): 4,757 Members Readmissions: Sixteen percent (16%) of LTC Members were readmitted within 30 days of discharge. Utilization decreased by 8% from Q4 2015 (35% to 27%). Top five primary diagnoses for re-admissions: Lung diseases due to external agents (2), episodic and paroxysmal disorders (2), other disorders of the nervous system (1), other bacterial diseases (1), and influenza and pneumonia (1). Multipurpose Supportive Services Program (MSSP): 478 Members Readmissions: Three percent (3%) of MSSP Members were readmitted to the hospital within 30 days of discharge. Utilization decreased 3% from Q4 2015 (11% to 8%). Diagnoses not available for readmissions.		
Q2	Community-Based Adult Services (CBAS): 2,045 Members Readmissions: Overall,16% of CBAS members were re-admitted to the hospital; four members within 30 days of discharge during the reporting period. Utilization increased 6% from Q1 2016 (10% to 16%). Primary diagnosis: Diseases of the esophagus, stomach and duodenum (1), complications of surgical and medical care, not elsewhere classified (1), other diseases of intestines (1), and injuries to the hip and thigh (1). In-Home Supportive Services (IHSS): 21,077 Members	1st Year Reporting for Admit/1000. Track, trend, monitor and will establish a benchmark for 2017. Will comply with DHCS CBAS eligibility criteria. Collaborate and coordinate members' care with HNs/CCNs. Will comply with CalOptima and OC SSA MOU agreement and workflows protocols. Collaborate and coordinate members' care with HNs/CCNs. OC SSA IHSS Social Worker continues to participate in IHSS Member's ICT meetings LTC Care Managers will continue to comply with Title 22 and DHCS LTC Provider Manual, and CalOptima policy. For OCC LTC residents, CalOptima clinical staff will participate in Member ICT meetings. Continue to share completed health risk assessments and assist with	

Q2	Readmissions: Overall, 19% of IHSS Members were readmitted to the hospital within 90 days; Eighty-two members within 30 days of discharge. Overall, utilization decreased 1% from Q1 2016 (20% to 19%). Primary diagnoses for re-admissions: Metabolic disorders (7), other forms of heart disease (5), other diseases of intestines (4), other bacterial diseases (4), and episodic and paroxysmal disorders (3). One of five diagnoses remains the same as Q1: Episodic and paroxysmal disorders. Long Term Care (LTC): 4,715 Members Readmissions: Overall, 30% of LTC Members were readmitted within 90 days of discharge; 57 members within 30 days of discharge. Utilization increased by 2% from Q1 2016 (28% to 30%). Top five primary diagnoses for re-admissions: Other bacterial diseases (16), complications of surgical and medical care, not elsewhere specified (9), injuries to the hip and thigh (3), influenza and pneumonia (3), diseases of liver (2), and diseases of the liver (2). Two of the five diagnoses remain the same as Q1 2016: Other bacterial diseases and influenza and pneumonia. Multipurpose Senior Services Program (MSSP): 466 Members Readmissions: Overall, 9% of MSSP Members were readmitted to the hospital within 90 days; 1 member was re-admitted within 30 days of discharge. Utilization increased 3% from Q1 2016 (6% to 9%). Diagnosis for readmission: Viral hepatitis (1).	coordination of care as appropriate. Will share OC and SPD member's SNF plan of care with HNs/CCN Will assist HNs/CCN with difficult SNF placement. MSSP Care Managers will continue to comply with CDA MSSP Site Manual guidelines. Will share CBAS, IHSS, LTC, and MSSP plan of care with health networks and CCN.	
Q3	Community-Based Adult Services (CBAS): 2,048 Members 450 Members after Excluding CODMED A, B and C Readmissions: Ten or 48% of CBAS members that were hospitalized were re-admitted to the hospital within 30 days of discharge. Overall, utilization increased 28% from Q2 2016 (16% to 44%). Primary diagnosis: Other diseases of the digestive system (2); other diseases of the respiratory system (2); disorders of the gallbladder, biliary tract and pancreas (1); metabolic disorders (1); and other bacterial diseases (1). All five diagnoses are new compared to Q2 2016.		

Q3	In-Home Supportive Services (IHSS): 20,526 Members 6,752 Members after Excluding CODMED A, B and C Readmissions: One hundred nineteen (119) or 24% of IHSS Members that were hospitalized were readmitted to the hospital within 30 days of discharge. Overall, utilization increased 4% from Q2 2016 (20% to 24%). Primary diagnoses for re-admissions: Other bacterial diseases (6); other forms of heart disease (5); other diseased of the respiratory system (3); Metabolic disorders (3); and complications of surgical and medical care, not elsewhere classified (3).Three of five diagnosis remains the same as Q2: Other bacterial diseases, other forms of heart disease, and Metabolic disorders. Long Term Care (LTC): 3,977 Members 1,115 Members after Excluding CODMED A, B and C Readmissions: Twenty five (25) or 31% of LTC Members that were hospitalized were readmitted within 30 days of discharge. Overall, utilization increased by 1% from Q2 2016 (30% to 31%). Top five primary diagnoses for re-admissions: Other bacterial diseases (11), respiratory and intrathoracic organs (2), aplastic and other anemia's (2), and hemolytic anemia's (2), diseases of liver (2), and infections of the skin and subcutaneous tissue (1). One of the five diagnoses remains the same as Q2 2016: Other bacterial diseases. Multipurpose Senior Services Program (MSSP): 456 Members 110 Members after Excluding CODMED A, B and C Readmissions: Three or 20% of MSSP Members that were hospitalized were readmitted to the hospital within 30 days of discharge. Overall, utilization increased 10% from Q2 2016 (9% to 19%). Top diagnosis for readmission: other Bacterial diseases (2); Renal failure (1); and lung diseases due to external agents (1). All	Per request: Comparisons were added for Members enrolled in multiple Home and Community Based Services (HCBS) programs. Will continue to monitor, track and trend going forward.	

Q3	readmission diagnoses are the same compared to Q2 2016. Members Enrolled in Multiple LTSS Home and Community Based Services (HCBS) Programs: 1) CBAS, IHSS & MSSP: 58 Members 11 Members after Excluding CODMED A, B and C Readmissions: Zero (0) or 0% of LTSS Members was readmitted to the hospital within 30 days of discharge. 2) CBAS & IHSS: 1,196 Members Readmissions: Two (2) or 20% of LTSS Members were readmitted to the hospital within 30 days of discharge. 3) CBAS & MSSP: 67 Members 13 Members after Excluding CODMED A, B and C Readmissions: Zero (0) or 0% of LTSS Members was readmitted to the hospital within 30 days of discharge. 4) IHSS & MSSP: 390 Members 88 Members after Excluding CODMED A, B and C Readmissions: Two (2) or 20% of LTSS Members were readmitted to the hospital within 30 days of discharge.		
Q4	Community-Based Adult Services (CBAS): 2,038 Members 438 Members after Excluding CODMED A, B and C Readmissions: Five (5) or 21% of CBAS members that were hospitalized were re-admitted to the hospital within 30 days of discharge. Overall, utilization decreased 23% from Q32016 (44% to 21%). Primary diagnosis: General symptoms and signs (1), other viral diseases (1), non-infective enteritis and colitis (1), and	For the current methodology: CBAS readmission utilization is at 21%, goal not met.	

Q4	other diseases of the intestines (1). All five diagnoses are new compared to Q3 2016. In-Home Supportive Services (IHSS): 20,105 Members 6,287 Members after Excluding CODMED A, B, & C Readmissions: Seventy Eight (78) or 22% of IHSS Members that were hospitalized were readmitted to the hospital within 30 days of discharge. Overall, utilization decreased 2% from Q3 2016 (24% to 22%). Primary diagnoses for re-admissions: Other bacterial diseases (6); hypertensive diseases (3), diabetes mellitus (2), episodic and paroxysmal disorders (epilepsy) (2) and influenza and pneumonia (2).One of the five diagnoses remains the same as Q3: Other bacterial diseases. Long Term Care (LTC): 3,979 Members 1,106 Members after Excluding CODMED A, B, & C Readmissions: Forty Seven (47) or 49% of LTC Members that were hospitalized were readmitted within 30 days of discharge. Overall, utilization increased by 18% from Q3 2016 (31% to 49%). Top five primary diagnoses for re-admissions: Other bacterial diseases (8), complications of surgical and medical care, not otherwise classified (4), cerebrovascular diseases (2), disorders of gallbladder, biliary tract and pancreas (2), and other diseases of intestines (1). One of the five diagnoses remains the same as Q3 2016: Other bacterial diseases. Multipurpose Senior Service Program: 568 Members 130 Members after Excluding CODMED A, B, & C Readmissions: Zero (0) or 0% of MSSP Members that were hospitalized was readmitted to the hospital within 30 days of discharge. Overall, utilization decreased 19% from Q3 2016 (19% to 0%).		

Q4	Members Enrolled in Multiple LTSS Home and Community Based Services (HCBS) Programs: 1) CBAS, IHSS & MSSP: 61 Members 9 Members after excluding CODMED A, B, & C Readmissions: Zero (0) or 0% of LTSS Members was readmitted to the hospital within 30 days of discharge. 2) CBAS & IHSS: 1,143 Members 193 Members after excluding CODMED A, B, & C Readmissions: One (1) or 29% of LTSS Members were readmitted to the hospital within 30 days of discharge. 3) CBAS & MSSP: 75 Members 14 Members after excluding CODMED A, B, & C Readmissions: Zero (0) or 0% of LTSS Members was readmitted to the hospital within 30 days of discharge. 4) IHSS & MSSP: 443 Members 91 Members after excluding CODMED A, B, & C Readmissions: Zero (0) or 0% of LTSS Members was readmitted to the hospital within 30 days of discharge.		
Year End	CBAS did not meet the goal of 2.5% for Hospital readmissions; average readmission percentage of 22%.	LTSS Program Goals CBAS: Hospital Re-Admissions: 20% IHSS:	

		Hospital Re-Admissions: 22% LTC: Hospital Readmissions: 40% MSSP: Hospital Re-Admissions: 10% Recommend establishing new goals to include: Evaluate utilization of members enrolled in multiple Home and Community Based Programs: CBAS, IHSS & MSSP: Hospital Re-Admissions: 10% CBAS & IHSS: Hospital Re-Admissions: 24% CBAS & MSSP: Hospital Re-Admissions: 10% MSSP & IHSS: Hospital Re-Admissions: 20%	

IV. LTSS

D. *Safety of Clinical Care and Quality of Clinical Care-Review and assess readmissions for LTSS members participating with each organization/program

Owner: Marie Earvolino, Director, Clinical Outcomes

The Approach

1. **Objective**
   - Members reviewed for Long Term Care Admissions (LTC) (for each organization/program)

2. **Activity**
   - Measure and assess admissions to Long Term Care for members in each program to drive interventions to minimize hospital readmissions:
     1. CBAS
     2. IHSS
     3. MSSP

3. **Goals**
   - 2% CBAS; Establishing goals in 2016 for IHSS, LTC, MSSP

LTSS
Owner: Marie Earvolino, Director, Clinical Outcomes

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	CBAS: Goal is 2% IHSS: Establishing goal MSSP: Establishing goal	Will monitor, track and trend and establish goals	
Q2	CBAS: Goal is 2% IHSS: Establishing goal MSSP: Establishing goal	Will monitor, track and trend and establish goals	
Q3	CBAS: Goal is 2% IHSS: Establishing goal MSSP: Establishing goal	Will monitor, track and trend and establish goals	
Q4	CBAS: Goal is 2% IHSS: Establishing goal MSSP: Establishing goal		
Year End	CBAS: Goal is 2% IHSS: Establishing goal MSSP: Establishing goal		
Outcomes	Results / Metrics	Next Steps	Target Completion
Q1	Community-Based Adult Services (CBAS): 2,008 Members LTC Admission: A total of 15 or 0.75% of CBAS Members was newly admitted to LTC during the reporting period: SNF/Subacute Level B (13); Nursing Facility/ICF Level A (1). Goal met. In-Home Supportive Services (IHSS): 21,003 Members LTC Admission: Total of 271 or 1.29% of IHSS members newly admitted to LTC during reporting period: Level B SNF (220); SNF Subacute Level B (45); NF-ICF Level A (5); ICF-DD-N (1).	This is the first quarter reporting LTC admissions for IHSS and MSSP. During year one reporting period, will monitor, track, trend, continue to monitor and establish goals. CBAS LTC Admission rate of 0.75% which was below the established goal of 2%. Goal met. Continue to provide care coordination, monitor, track, and trend.	

	Multipurpose Senior Services Program (MSSP): 478 Members LTC Admission: A total of 11 or 2.3% of MSSP Members were admitted to LTC during the reporting period; Level B SNF (11).		
Q2	Community-Based Adult Services (CBAS): 2,045 Members Long Term Care Admissions: 23 or 1.12% of CBAS Members were newly enrolled in LTC during the reporting period: Level B SNF (19); SNF/Subacute Level B (3), and ICF-DD-N (1). 1.12% is an increase from Q1 2016 (0.75%), however it is less than the establish goal of 2%. Goal met. In-Home Supportive Services: (IHSS): 21,077 Members Long Term Care Admissions: 380 or 1.80% of IHSS members newly enrolled in LTC during reporting period: Level B SNF (299); Level B Subacute (71); ICF-A (8); and ICF-DD-H (1) Level B Adult Subacute (1). This is an increase compared to Q1 2016 (1.29%). Multipurpose Senior Services Program (MSSP): 466 Members Long Term Care Admissions: A total of 7 or 1.5% of MSSP Members were admitted to LTC during the reporting period; Level B SNF (7). This is a decrease compared to Q1 2016 (0.8%).	1st Year Reporting for Admit/1000. Track, trend, monitor and will establish a benchmark for 2017. Will comply with DHCS CBAS eligibility criteria. Collaborate and coordinate members' care with HNs/CCNs. Will comply with CalOptima and OC SSA MOU agreement and workflows protocols. Collaborate and coordinate members' care with HNs/CCNs. OC SSA IHSS Social Worker continues to participate in IHSS Member's ICT meetings Will assist HNs/CCN with difficult SNF placement. MSSP Care Managers will continue to comply with CDA MSSP Site Manual guidelines. Will share CBAS, IHSS, LTC, and MSSP plan of care with health networks and CCN.	
Q3	Community-Based Adult Services (CBAS): 2,048 Members 450 Members after Excluding CODMED A, B and C Long Term Care Admissions: 4 or 0.19% of CBAS Members were newly enrolled in LTC during the reporting period: Nursing Facilities-ICF Level A (2) and SNF/Subacute Level B (2). This is a decrease from Q2 2016 (1.12%). This is less than the established goal of 2%. Goal met.	CBAS LTC Admission rate of 0.19% which was below the established goal of 2%. Goal met.	

	IHSS 20,526 Members 6,752 Members after Excluding CODMED A, B and C Long Term Care Admissions: 134 or 0.65% of IHSS members newly enrolled in LTC during reporting period: Level B SNF (112); Level B Subacute (17); LTC (2); ICF-A (2); and ICF-DD-N(1). This is a decrease compared to Q2 2016 (1.80%). MSSP 456 Members 110 Members after Excluding CODMED A, B and C Long Term Care Admissions: A total of 7 or 1.53% of MSSP Members were admitted to LTC during the reporting period; Level B SNF (7). No change from Q2.		
Q4	Community-Based Adult Services (CBAS): 2,038 Members 439 Members after Excluding CODMED A, B and C Long Term Care Admissions: 7 or 0.34% of CBAS Members were newly enrolled in LTC during the reporting period: Level B SNF (5), SNF/Subacute Level B (1), and ICF-DD-Nursing (1). This is a increase of 0.15% from Q3 2016 (0.19% to 0.34%). This is less than the established goal of 2%. Goal met. In-Home Supportive Services (IHSS): 20,105 Members 6,287 Members after Excluding CODMED A, B, & C Long Term Care Admissions: 124 or 0.62% of IHSS members newly enrolled in LTC during reporting period: Level B SNF (99); SNF/subacute Level B (123); Nursing Facilities - ICF-A (1); and ICF-DD-H(1). This is a decrease of 0.03% compared to Q3 2016 (0.65% to 0.62%).		

	Multipurpose Senior Service Program: 568 Members 130 Members after Excluding CODMED A, B, & C Long Term Care Admissions: A total of 11 or 1.93% of MSSP Members were admitted to LTC during the reporting period; Level B SNF (7). This is an increase of 0.40% when compared to Q3 2016. (1.53% to 1.93%)		
Year End	CBAS achieved the goal of 2% for LTC admissions; average admission percentage of 0.6%.	LTSS Program Goals CBAS: LTC Admissions: 0.27% IHSS: LTC Admissions: 0.62% MSSP: LTC Admissions: 1.5%	

IV. LTSS

E. Quality of Clinical Care-review of Health Risk Assessment (HRA) for OneCare Connect (OCC) Long Term Care (LTC) members

Owner: Marie Earvolino, Director, Clinical Outcomes

The Approach

1. **Objective**
   - Health risk assessment for members in the OCC line of business monitored for completeness

2. **Activity**
   - HRA to comprehensively assess each newly enrolled OCC LTC member's current health risk.
   - Completion of an HRA process must be performed within 90 calendar days of enrollment for those identified by the risk stratification mechanism as lower risk who is residing in LTC facilities

3. **Goals**
   - 100%

LTSS
Owner: Marie Earvolino, Director, Clinical Outcomes

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	Health Risk Assessment (HRA) goal 100% completed	Will monitor and continue to ensure 100% completed	
Q2	Health Risk Assessment (HRA) goal 100% completed	Will monitor and continue to ensure 100% completed	
Q3	Initial Health Risk Assessment (HRA) goal 100% completed Annual Health Risk Assessment (HRA) goal 100% completed	As of October 1, 2016, Initial HRAs will be monitored by Case Management.	
Q4	N/A - HRA is currently managed by Case Management		
Year End	N/A		
Outcomes	Results / Metrics	Next Steps	Target Completion
Q1 **Q1**	A total of 318 OCC LTC Members during quarter one 2016. HRA Process completed = 318 HRA Completed via Face to Face = 55 HRA Completed via Telephone = 166 HRA Declined/Cognitively Impaired = 97	Will monitor and continue to ensure 100% completed	
Q2	Q2 2016: Initial OCC Members Count = 693 Q2 2016: Active OCC Members Count = 158 Health Risk Assessment Process = 158 (or 100%): ➢ HRA Survey Declined/Cognitive Impaired = 88 (56%) ➢ HRA Survey completed = 70 (44%) o Face to Face = 20 (29%) o Telephone = 50 (71%)	Will monitor and continue to ensure 100% completed Goal met	
Q3	Q3 2016: Initial OCC Members Count = 86 Q2 2016: Active OCC Members Count = 63 Health Risk Assessment Process = 63 (or 100%): ➢ HRA Survey Declined/Cognitive Impaired = 33 (52%)	Goal Met As of October 1, 2016, HRAs will be completed and monitored by Case Management.	

Q3	➢ HRA Survey completed = 30 (48%) o Face to Face = 14 (47%) o Telephone = 16 (53%) Q3 2016: Annual OCC Members Count = 6 ➢ HRA Survey Declined/Cognitive Impaired = 0 ➢ HRA Survey completed = 6 (100%) o Face to Face = 0 (0%) o Telephone = 6 (100%)		
Q4	N/A - HRA is currently managed by Case Management		
Year End	N/A		

IV. LTSS

F. CBAS Member Satisfaction

Owner: Esther Okajima, Director, QI

The Approach

1. **Objective**
   - Monitor and/or improve member satisfaction in CBAS/LTSS

2. **Activity**
   - Measure, assess and identify areas for improvement and implement interventions to assure high member satisfaction

3. **Goals**
   - -5% Improvement over previous year

LTSS
Owner: Esther Okajima, Director, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	2014 and 2015 Baseline Data Measurements were reported at the LTSS QI Committee	Member Satisfaction Survey is being developed for deployment, August 2016	08/15/16
Q2	Data pending for Quarter 2. Continue to monitor facilities for potential quality of care issues.	Create and send out survey, collect aggregate data, and report when completed.	12/31/2016
Q3	Collecting 2016 Satisfaction Surveys	Continue Collecting satisfaction surveys from CBAS centers	Dec 2016
Q4	Collecting 2016 Satisfaction Surveys New 2017 Satisfaction Survey in development	Continue collecting satisfaction surveys from CBAS Centers Communications working on edits of 2017 Satisfaction Survey, implementation TBD	Dec 2016
Year End	The analysis of the satisfaction surveys will be reported as part of Annual Evaluation.	The analysis of the satisfaction surveys will be reported as part of Annual Evaluation.	Q1 2017
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	**Benchmark**: 90% Passing ■ 2014 – a) The Average passing score was 93%; b) 10% (3 of the 30) CBAS centers scored below 90% ■ 2015 – a) The Average passing score was 95%; b) All met the benchmark **2014/2015 results revealed the following**: ■ CBAS not clean and neat ■ Not satisfied with meals ■ Transportation issues	Continue to monitor Opportunities for improvement identified; complete data analysis will commence after year-end 2016	12/31/2016 12/31/16

Q2	Deferred to Q3.	Continue to monitor. Opportunities for improvement identified; complete data analysis will commence after year-end 2016.	12/31/16
Q3	12 out of 30 CBAS Centers have submitted their 2016 satisfaction surveys and/or results	1. Continue Collecting satisfaction surveys from remaining centers 2. Aggregate data and report when completed	Dec 2016
Q4	29 out of 30 contracted CBAS Centers have submitted their 2016 satisfaction surveys and/or results.	Collect remaining satisfaction surveys/results from Happy CBAS, issue CAP as needed Aggregate data and report when completed; complete data analysis will commence after year-end 2016	Feb 2017
Year End	The results of the satisfaction surveys will be reported as part of the annual evaluation.	The results of the satisfaction surveys will be reported as part of the annual evaluation.	Q1 2017

IV. LTSS

G. SNF Member Satisfaction

Owner: Esther Okajima, Director, QI

The Approach

1. **Objective**
   - Monitor and/or improve member satisfaction in SNF

2. **Activity**
   - Measures, assess and identify areas for improvement and implement interventions to assure high member satisfaction

3. **Goals**
   - 5% Improvement over previous year

LTSS
Owner: Esther Okajima, Director, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	Data pending for Quarter 1; The 2016 Member Satisfaction Survey is in development.	Survey will be deployed in August; data to be reported when available. Continue to monitor for potential quality of care issues	12/31/2016
Q2	Data pending for Quarter 1; The 2016 Member Satisfaction Survey is in development. Continue to monitor facilities for potential quality of care issues.	Create and send out survey, collect aggregate data, and report when completed.	12/31/2016
Q3	Completed 2015 POC (plan of correction) Reviews which included 3 previous years of Recertification surveys for each facility. **Common findings:** 1. Incomplete/inadequate documentation of Quality Improvement Committee meeting minutes to validate compliance with their plan of correction 2. Failure to conduct all staff in-services as stated in their plan of correction 3. In-service sign-in sheets inconsistent in identifying staff title/dept 4. Lack of organization of facility audit/monitoring forms/logs	1. Download 2016 Surveys from CMS website 2. Review 2016 Survey Results and Plan of Correction to identify recurrent deficiencies from 2-3 previous surveys. 3. Schedule onsite visits beginning in the 4th Qtr to validate implementation of SNF/LTC 2016 Plan of Correction 4. Distribution of satisfaction surveys	Ongoing
Q4	Performance of member satisfaction survey was completed for the first time in 2016. Determination of audit results and improvement will be not be known as this will be the baseline year.	Analysis and reporting will be completed by the end of Q1 2017. QI and LTSS to analyze results and determine opportunities for improvement.	March 2017 \
Year End	The results of the satisfaction surveys will be reported as part of the annual evaluation.	The results of the satisfaction surveys will be reported as part of the annual evaluation.	Q1 2017

Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	N/A	N/A	N/A
Q2	N/A	N/A	12/31/2016
Q3	**Recommendations given:** ▪ Create Plan of Correction binders to house all audit/monitoring logs/forms and in-services related to deficiencies, include each specific deficiency and status of audits/monitoring (e.g. threshold met, continue monitoring/ discontinue monitoring) In Quality Improvement Committee meeting minutes, complete all staff In-services as stated in their plan of correction and include staff title/dept on sign-in sheets.	Continue monitoring to evidence compliance with Plan of Correction	Ongoing
Q4	There were 20 Member Satisfaction surveys distributed to the 10 facilities with highest CalOptima census, for a total of 200 individual surveys. ▪ 124 (62.0%) survey were completed.	Analyze the results of the survey. Determine opportunities for improvement.	Expected completion by the end of Q1 2017
Year End	Summary of SNF Satisfaction Surveys will be reported in the Annual Evaluation		March 2017

V. Health Education & Disease Management

A. *Quality of Care-All new members will complete the Initial Health Assessment and related IHEBA/SHAs

Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. **Objective**
   - To assure all new members are connected with a PCP and their health risks are assessed

2. **Activity**
   - IHA/IHEBA [Staying Healthy Assessment(SHA)] will be completed with 120 days of enrollment
   - Reports will be available for Health Networks on IHA/SHA completion
   - Facility Site Reviews will review sample of medical records for compliance with completing appropriate age level IHA/SHA
   - If use of alcohol or drugs, the member will have an SBIRT documented (Screening, Brief intervention, and Referral to Treatment)

3. **Goals**
   - Improve plan performance over 2015 by 10%

Health Education & Disease Management
Owner: Pshyra Jones, Director, Health ED & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	1. IHA completion rate identified as a finding with DHCS audit. CalOptima must demonstrate a way to monitor IHA performance for new enrollees. 2. Finalize methodology for the "IHA Days Aged' report. 3. Revise IVR campaign to new CalOptima Members. 4. Develop welcome call scripts for CalOptima Community Network members. 5. Identify a health network partner for the IHA performance improvement project.	1. Document and submit Corrective Action Plan to DHCS for low IHA completion rate. 2. Evaluate version one of "IHA Days Aged" report. Create P4P display measure using this data source. 3. Create a member alert for the first 120 days in FACETS to support Customer Service IHA reminders. 4. Submit updated scripts to Carenet supporting the IVR and Community Network welcome calls. 5. Submit project intake request for adding the IHA flag to the monthly eligibility file 6. Pilot IHA Member Incentive opportunity for Community Network members 7. Add IHA flag to the monthly eligibility file.	Q2
Q2	1. Data analytical resources are limited in support of the IHA task force and PIP initiatives. 2. Need to identify a less manual process to deliver weekly files to Carenet for IVR and welcome calls. 3. Determine if member alerts in FACETS or on eligibility files are still feasible with CalOptima resources and other initiatives.	1. Revise version one of the Days Aged Report to include a csv. file format. 2. Schedule regular HN/CO task force meetings	Q3
Q3	1. IHA rate included to the Audit and Oversight dashboard process 2. Secured provide office participation for IHA PIP. Submitted PIP Modules Plan and Study. 3. Chaired a series of meetings IHA Task Force meetings with Health Network involvement.	4. Work on PIP Module - Intervention for IHA with selected provider offices. Create Provider toolkit to support provider office visits. 5. Identify analytical resources to support IHA PIP and other IHA Initiatives.	Q4
Q4	1. Continue implementation, monitoring and evaluation of IHA performance improvement project (PIP) initiatives. The Provider offices impacted need a way to submit monthly updates to CalOptima.	1. Design a process for chart validation of Days Aged Report with FQHCs and Community Clinics 2. Re-start IHA Task Force 3. Develop IHA Aggregate reports and scorecard by HN.	Q1

Year End	The department developed and successfully implemented several initiatives to improve IHA completion rates. The IHA completion rate was increased by 24.6% over 2015. The efforts identified to support the increase in the rate include- 1) IVR outreach campaigns to new members 2) Welcome Calls to CCN members 3) IHA Days Aged Report to monitor IHA completion by Health Network and physician 4) Included IHA rates as a P4V display measure and on the Delegation Oversight Grids 5) Implemented a IHA Task Force inclusive of Health Network participation 6) IHA Corrective Action Plan closed by DHCS	Continue efforts with IHA monitoring and reporting. 1) Include Health Plan Effective date to the eligibility files submitted to the Health Networks. This will help them identify the correct time frame to complete the IHA for new members. 2) Implement chart validation for FQHCs and Community Clinics based on the IHA Days Aged report.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	IVR Call Outcome Results - 40.92% reach rate	Report IHA completion rate for 1st Q Report IVR and Welcome Call Results	Q2
Q2	IVR Call Outcome Results - 52.2% (represents newly identified members in April 2016) CCN Welcome Call Member Outreach - 37.6% (represents January - May 2016 members) IHA Fully Met Results - 0.81% (end of June 2016) IHA Fully and Partially Met Results - 29.40% (end of June 2016)	Resume monthly IVR calls in 3rd Q Report IVR Call Outcome Results for 3rd Q Report CCN Welcome Call Member Outreach for 3rd Q Report IHA Fully Met Results for 3rd Q Report IHA Fully and Partially Met Results for 3rd Q	Q3

		Report activities from the CO/HN IHA Task Force Report activities from the IHA performance improvement project w/Talbert.	
Q3	IVR Call Outcome Results - 31% Listened to message (includes all threshold languages) 69% Message left on Voicemail Box Total Mbrs (excludes bad #s) - 9066 CCN Welcome Call Member Outreach - 95.7% Successful Total Mbrs (excludes bad #s) - 1167	Implement IHA on A&O dashboard	Q4
Q4	**IVR Outreach Results:** *includes voice messages and played messages Successful Attempts* 12,995 Total # of Attempts 28,752 Avg % of Successful Attempts 45.2% **CCN Welcome Call Outreach:** *includes complete delivery of the scripted message, and delivery of the purpose of scripted message Successful Attempts* 2,633 Total # of Attempts 19,583 Avg % of Successful Attempts 48.1%	Implement chart validation for FQHCs and Community Clinics by end of 2nd Q, 2017.	
Year End	2016 Results for IHA Performance is 24.62%. This exceeds the goal of 10% increase by 6 points over 2015performance (7.8%). Results include Fully Met and Partially Met IHAs.	Continue goal to increase IHA rates annually until the organization reaches 90 percent completion or greater.	

V. Health Education & Disease Management

B. Quality of Clinical Care, review of Disease Management Program (Asthma)

Owner: Pshyra Jones, Director, Health Ed & DM

The Approach

1. **Objective**
   - Disease Management activity reviewed to assess clinical care delivered to members with Asthma

2. **Activity**
   - Increase Asthma Medication Ratio (AMR) rates for members with persistent asthma in our Asthma DM program
   - Incorporate HEDIS improvement for Asthma into DM program interventions
   - Evaluate more technology-based interventions into DM programs
   - Assure DM programs are implemented across all populations
   - Conduct annual member satisfaction of DM programs
   - Evaluate the overall effectiveness of the Asthma Program-Participation Member Rates, ED, IP and RX related utilization

3. **Goals**
   - Increase to 50th percentile for members between 5-18 yrs old

Health Education & Disease Management
Owner: Pshyra Jones, Director, Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	1. Medi-Cal Pediatric Asthma DM program expanded to manual inclusion of identified adult members across all LOBs. 2. Project intake submitted to revise the identification methodology supporting all DM programs (Asthma, Diabetes, and Heart Failure) including refinement of member risk levels and appropriation for health coach care management. 3. Health coach prioritization of members with persistent asthma and no evidence of controller medication. 4. Review of current DM materials being sent to low and high risk DM members with Asthma. 5. Asthma Aware DM newsletter written with asthma medication and action plan articles for May distribution.	1. Create targeted intervention for members identified with persistent asthma without evidence of controller medication. 2. Resolution of issues with IS/Guiding Care uploads. Resume monthly identification loads to Guiding Care. 3. Increase opportunities for member feedback -2016 DM Member Experience paper survey scheduled for insertion in Issue 2 of Heart Health, Asthma Alert and Diabetes Talk DM newsletters.	Q2
Q2	1. Identified new materials for Asthma DM program high and low kits. 2. The department needs analytical support to routinely prioritize members with persistent asthma and not evidence of controller medication 3. Guiding Care uploads resumed July, 2016.	1. Implement NCQA MEM asthma intervention for no controller and persistent asthma. 2. Implement a companion physician intervention for members without evidence of controller medications.	Q3
Q3	1. Guiding Care loads of monthly identification resumed July, 2016. Multiple errors were identified with program start dates. This impacts NCQA reporting for DM programs. 2. Provider notification delayed due to unavailable department resources	1. Continue working on the correction of Program Identification start dates in Guiding Care. 2. Re-initiate the process to revise the DM methodology. 3. Include Asthma survey in low member mailing.	Q1
Q4	1. Asthma Aware DM newsletter completed with asthma articles for January distribution to 17,164 asthma DM members. 2. DM Experience survey was mailed to 40,259 members (English and Spanish only) in all DM programs (Asthma, Diabetes and CHF) and 3,256 responses were received.		
Year End	The department continues to meet the NCQA requirements for the CalOptima DM programs. During the Mock Review, consultants identified areas where the	Update the DM program descriptions based on the feedback during the NCQA Mock Audit.	

	department could strengthen existing program design. The areas are as follows- 1) Improve evidence for Element B- Factor 7- Identifying members from EHRs 2) Add evidence for Element H - Factor 1 Integrating Member Information (Health Information Line/Nurse Advice Line) is not mentioned in our program description and should be included if the organization has one.	Expand program outreach to adults and Medicare population.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	Asthma Medication Ratio (AMR) as of 4/2016 Age 5 to 11 Ratio >50%: 1437/1982 = 72.5% Medi-Cal Age 12 to18 Ratio >50% 757/1172 = 64.59% Medi-Cal	Continued monitoring of HEDIS rates for AMR.	Ongoing
Q2	Asthma Medication Ratio (AMR) Compared to HEDIS 2015 Final Admin Rate Age 5 to 11 Ratio >50%: 72.50% Medi-Cal 50th percentile Age 12 to18 Ratio >50% 64.59% Medi-Cal 75th percentile Compared to 2016 June Prospective Rates as of 6/2016 Age 5 to 11 Ratio >50%: 87.44% Medi-Cal 90th percentile Age 12 to18 Ratio >50% 74.10% Medi-Cal 90th percentile	Continued monitoring and development of programs to maintain or increase performance of HEDIS rates for AMR	Ongoing
Q3	Asthma Medication Ratio (AMR) Compared to HEDIS 2015 Final Admin Rate Age 5 to 11 Ratio >50%: 72.50% Medi-Cal 50th percentile Age 12 to18 Ratio >50% 64.59% Medi-Cal 75th percentile	Continued monitoring and development of programs to maintain or increase performance of HEDIS for AMR. Continue work with IS to make corrections in Guiding Care as appropriate.	

	Compared to 2016 August Prospective Rates Age 5 to 11 Ratio >50%: 81.15% Medi-Cal 75th percentile Age 12 to18 Ratio >50% 71.51% Medi-Cal 90th percentile		
Q4	Asthma Medication Ratio (AMR) Compared to HEDIS 2015 Final Admin Rate Age 5 to 11 Ratio >50%: 72.50% Medi-Cal 50th percentile Age 12 to18 Ratio >50% 64.59% Medi-Cal 75th percentile Compared to 2016 November Prospective Rates as of 11/2016 Age 5 to 11 Ratio >50%: 77.12% Medi-Cal 75th percentile Age 12 to18 Ratio >50% 68.02% Medi-Cal 75th percentile Dropped from last quarter, but still above last year's final rate	Continued monitoring and development of programs to maintain or increase performance of HEDIS for AMR. Continue work with IS to make corrections in Guiding Care as appropriate.	
Year End	Goal -increase AMR to 50th percentile for members between 5-18 yrs old- Goal Status - Met	Identify applicable programmatic and HEDIS goals for the management of members with Asthma in 2017.	

V. Health Education & Disease Management

C. Quality of Clinical Care-Review of Disease Management Program (Diabetes)

Owner: Pshyra Jones, Director, Health Ed & DM

The Approach

1. **Objective**
   - Disease Management activity reviewed to assess clinical care delivered to members with Diabetes

2. **Activity**
   - A1C Control for members with existing A1C>9 and receiving Health Coach interventions in 2016
   - Incorporate HEDIS improvement for CDC into DM program interventions
   - Evaluate more technology-based interventions into DM programs
   - Assure DM programs are implemented across all populations
   - Conduct annual member satisfaction of DM programs
   - Evaluate the overall effectiveness of the Diabetes Program-Member Participation rates, ED, IP, and RX related utilization

3. **Goals**
   - Maintain 90th percentile for Medi-Cal; increase to 75th percentile for Medicare

Health Education & Disease Management
Owner: Pshyra Jones, Director, Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	1. HSAG Diabetes A1C testing PIP submissions of modules 1 and 2 approved. 2. Prioritize A1C>9 members to receive Health Coaching. 3. Project intake submitted to revise the identification methodology supporting all DM programs (Asthma, Diabetes, and Heart Failure) including refinement of member risk levels and appropriation for health coach care management. 4. Review of current DM materials being sent to low and high risk DM members with Diabetes.	1. Identify provider-focused interventions to increase A1C testing in pilot provider office. 2. Assess which members with A1C>9 should be considered for recommendation of insulin-use as an alternative to current medication therapies. 3. Drafting content of Diabetes Talk Newsletter scheduled for distribution in June 2016, to include A1C control article. 4. Standardize Diabetes educational packet for all identified Diabetes DM members. 5. Resolution of issues with IS/Guiding Care uploads. Resume monthly identification loads to Guiding Care. 6. Increase opportunities for member feedback -2016 DM Member Experience paper survey scheduled for insertion in Issue 2 of Heart Health, Asthma Alert and Diabetes Talk DM newsletters.	Q2
Q2	1. Need to evaluate a member educational piece to encourage testing with incentive.	1. Continue to work with the Quality team in support of member and provider initiatives linked to PIPs and QIPs.	Q3
Q3	1. Guiding Care loads of monthly identification resumed July, 2016. Multiple errors were identified with program start dates. This impacts NCQA reporting for DM programs. 2. Provider notification delayed due to unavailable department resources 3. Mailed member communication supporting the Diabetes A1C MEM 7 activity	1. Continue working on the correction of Program Identification start dates in Guiding Care 2. Re-initiate the process to revise the DM methodology 3. Work on 4th Q Diabetes newsletter 4. Continue work on Diabetes QIP 5. Continue to participate in the QI work team supporting the Diabetes PIP. 6. Include Diabetes assessment in low mailing.	Q4
Q4	1. The work to correct false start dates in Guiding Care for Diabetes grew into redesigning the methodology for Diabetes identification. New program requirements finalized by 11/7/2016. User Acceptance Testing in the QA environment scheduled for January 9, 2016 with deployment to production tentatively scheduled the week of January 23rd. 2. A1C Mem 7 incentive offer mailed to 20,077 Medi-Cal	1. Continue working on the deployment of new program methodology. 2. Rerun NCQA reports for entire look back period. 3. Collaborate with the Chronic Care QI work team on combined initiatives for improved CDC rates, particularly member compliance with annual eye-exam, for 2017.	

	members with A1C>9 AND/OR NO A1C test on record by June 2016. Respondents to the incentive offer with proof of completed A1C test = 1458 [1104 gift cards mailed, 93 unable to fulfill (incomplete, not invited, out of date range), 261 remaining to be processed with responses still being received.] 3. Diabetes Talk DM newsletter mailed to 33,840 DM members with diabetes in November with key articles regarding blood sugar monitoring and A1C testing distribution. 4. DM Experience survey was mailed to 40,259 members (English and Spanish only) in all DM programs (Asthma, Diabetes and CHF) and 3,256 responses were received.		
Year End	The department continues to meet the NCQA requirements for the CalOptima DM programs. During the Mock Review, consultants identified areas where the department could strengthen existing program design. The areas are as follows- 1) Improve evidence for Element B- Factor 7- Identifying members from EHRs 2) Add evidence for Element H - Factor 1 Integrating Member Information (Health Information Line/Nurse Advice Line) is not mentioned in our program description and should be included if the organization has one.	Update the DM program descriptions based on the feedback during the NCQA Mock Audit. Implement new Diabetes methodology in Guiding Care for 1st Q of 2017.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	1. HbA1c Poor Control (9.0%); (Lower is better) **Medi-Cal Hybrid Rate: 62.14% <P50 as of 4/4/16** **Medi-Cal Admin Rate: 94.85% <P25 March 2016** **OneCare Hybrid Rate: 36.02% <P50 as of 4/4/16** **OneCare Admin Rate: 95.68% <P25 March 2016** **OneCare Connect Hybrid Rate: Not Available** **OneCare Connect Admin Rate: 96.55% <P25 March 2016**	Continue monitoring HEDIS Comprehensive Diabetes Control measure for A1C Control sub-measure.	Ongoing
Q2	1. HbA1c Poor Control (9.0%) Lower is better **Medi-Cal Hybrid Rate: 34.31% P75** as of 6/2016	Continue monitoring HEDIS Comprehensive Diabetes Control measure for A1C Control sub-measure.	Ongoing

	Medi-Cal Admin Rate: 80.24% <P25 June 2016 **OneCare Hybrid Rate: 36.02% <P25** as of 6/2016 **OneCare Admin Rate: 85.61% <P25 June 2016** **OneCare Connect Hybrid Rate: Not Available** **OneCare Connect Admin Rate: 85.09% <P25 June 2016**	Evaluate the impact of the member incentive	
Q3	1. HbA1c Poor Control (9.0%) Lower is better **Medi-Cal Admin Rate: 75.16% <P25 September 2016** **OneCare Admin Rate: 81.71% <P25 September 2016** **OneCare Connect Admin Rate: 81.28% <P25 September 2016** Hybrid Rates not available	Continue monitoring HEDIS Comprehensive Diabetes Control measure for A1C Control sum-measure. Special emphasis to the OC/OCC populations.	Ongoing
Q4	1. HbA1c Poor Control (9.0%) Lower is better **Medi-Cal Admin Rate: 51.82% <P25 November 2016** **OneCare Admin Rate: 79.53% <P25 November 2016** **OneCare Connect Admin Rate: 59.70% <P25 November 2016** Hybrid Rates not available		
Year End	Goal - Maintain 90th percentile for Medi-Cal; increase to 75th percentile for Medicare Goal status - Not Met	The DM identification criteria did not always help the department identify the members in most need of Diabetes disease management. In the next year, the department will have improved identification methodology in addition to increased collaboration with Quality Analytics to identify population subsets requiring targeted intervention.	

V. Health Education & Disease Management

D. Quality of Clinical Care-Review of Disease Management Program (CHF)

Owner: Pshyra Jones, Director, Health ED & DM

The Approach

1. **Objective**
   - Disease Management activity reviewed to assess clinical care delivered to members with CHF

2. **Activity**
   - Establish baseline for unplanned readmissions with an admitting diagnosis of heart failure for members in the Heart Failure DM program
   - Incorporate HEDIS improvement for CHF into DM program interventions
   - Evaluate more technology-based interventions into DM programs
   - Assure DM programs are implemented across all populations
   - Evaluate the overall effectiveness of the CHF Program-Member Participation Rates, ED, IP and RX related utilization

3. **Goals**
   - CHF - Establish baseline for unplanned readmissions with an admitting diagnosis of heart failure for members in the Heart Failure DM Program
   - Satisfactions with DM - 90%

Health Education & Disease Management
Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	1. Heart Health DM newsletter completed and contains information about symptoms, self-management and how to avoid unnecessary hospitalizations. 2. Identify appropriate data sources to calculate Heart Failure readmission baseline rate. 3. Project intake submitted to revise the identification methodology supporting all DM programs (Asthma, Diabetes, and Heart Failure) including refinement of member risk levels and appropriation for health coach care management. 4. OneCare/OneCare Connect DM program expanded to manual inclusion of identified CHF members in Medi-Cal LOB without restriction of age.	1. Heart Health DM newsletter completed for April distribution/publication. 2. Develop report from claims, data marts and daily census to identify unplanned readmissions in a timely fashion for immediate outreach. 3. Seeking resolution of issues with IS/Guiding Care uploads and coding for identification solution. 4. 2016 DM Member Experience survey scheduled for insertion in Issue 2 of Heart Health, Asthma Alert and Diabetes Talk DM newsletters.	Q2
Q2	1. Implemented a workgroup with case management, pharmacy, and disease management to identify opportunities for increased coordination for members in the TOC program. 2. When should members with HF admissions receive contact from DM or Rx?	1. TOC program is targeted for OC/OCC members. Continue to coordinate DM and Rx interventions with Case Mgmt for these members. 2. Collaborate with pharmacy on other readmission opportunities with Medi-Cal population	Q3/Q4
Q3	1. Guiding Care loads of monthly identification resumed July, 2016. Multiple errors were identified with program start dates. This impacts NCQA reporting for DM programs. 2. Provider notification delayed due to unavailable department resources	1. Continue working on the correction of Program Identification start dates in Guiding Care 2. Re-initiate the process to revise the DM methodology	Q2, 2017
Q4	1. Ongoing collaboration with CM, QA and Pharmacy departments to identify CHF members with unplanned readmissions and to determine interventions to fill in current gaps in member outreach post-discharge, to prevent unplanned readmissions. 2. Heart Health DM newsletter mailed to 884 DM members with heart failure in December with key articles regarding cholesterol and blood pressure control, smoking cessation and exercise.	1. Target program changes for Health Failure program in Guiding Care by May, 2017. 2. Rerun reporting to support NCQA. 3. Evaluate Heart Failure program objectives and future coordination with Transitions of Care Program	Q2, 2017

	3. DM Experience survey was mailed to 40,259 members (English and Spanish only) in all DM programs (Asthma, Diabetes and CHF) and 3,256 responses were received.		
Year End	The Heart Failure program is not an NCQA submitted program; however, the program design will be updated to reflect the findings from the NCQA Mock Audit (see Asthma and Diabetes Year End above).	The department still has work to expand DM Heart Failure interventions with CalOptima Medicaid members. The department needs to also identify 2 to 3 opportunities to align program initiatives with the Transitions of Care program.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End	Goal - CHF - Establish baseline for unplanned readmissions with an admitting diagnosis of heart failure for members in the Heart Failure DM Program Satisfactions with DM - 90% Goal Status - Not Met Overall satisfaction with DM programs is 80%; and the department is still reviewing data to tease out the readmission rate for CHF.	Identify goals for unplanned readmissions aligned with the Heart Failure program and Transitions of Care program	

V. Health Education & Disease Management

E. *Quality of Care-Clinical Practice Guidelines adoption for Medi-Cal line of business

Owner: Pshyra Jones, Director Health Ed & DM

The Approach

1. **Objective**
   - Clinical Practice Guidelines will be reviewed and adopted

2. **Activity**
   - Adoption of Clinical Practice Guidelines, at least three (3) will be reviewed and adopted (linked to DM: Diabetes, Asthma, CHF)

3. **Goals**
   - 100%

Health Education & Disease Management
Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			Q3
Q3			
Q4			
Year End	Continue the practice of aligning program development with approved clinical practice guidelines.	Prepare for annual review in 2017	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	Clinical Practice Guidelines **QIC Approval Date -2/9/2016** Institute for Clinical Systems Improvement Heart Failure in Adults 13th Edition - July 2013	Annual approval	1Q,2017
Q2	Clinical Practice Guidelines **QIC Approval Date - 4/13/2016** Institute for Clinical Systems Improvement *Diagnosis and Management of Asthma 10th Edition- July 2012* Institute for Clinical Systems Improvement *Diagnosis and Management of Type-2 Diabetes in Adults 16th Edition -July 2014*	Annual approval	1Q, 2017
Q3	N/A	N/A	
Q4	N/A	N/A	

Year End	Goal Met. Continue the practice of aligning program development with approved clinical practice guidelines. See evaluation.	Prepare for annual review in 2017	

V. Health Education & Disease Management

F. Quality of Clinical Care-Review of member satisfaction with DM programs

Owner: Pshyra Jones, Director, Health ED & DM

The Approach

1. **Objective**
   - Annual review of member feedback on the disease management programs to assure high satisfaction and improved health status

2. **Activity**
   - Review annual satisfaction survey results, define areas for improvement and implement interventions to monitor and improve the member experience in DM programs
   - Transition manual satisfaction survey to alternate process to gather ongoing feedback

3. **Goals**
   - 90% satisfaction with the DM program

Health Education & Disease Management
Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	1. Revise existing methodology to include feedback on mailed materials and health coach experience. 2. Explore technology to support automation of member satisfaction surveys with Budget and Vendor Management. 3. 2016 DM Member Experience survey scheduled for insertion in two cycles of DM Newsletters	1. 2016 DM Member Experience survey scheduled for insertion in Issue 2 of Heart Health, Asthma Alert and Diabetes Talk DM newsletters. 2. Explore Interactive Voice Response (IVR) capabilities to support member satisfaction	Q2
Q2	1. Q2 DM Newsletter efforts were not mailed with satisfaction surveys.	1. Explore Autodata Solutions software to support scanned survey capabilities. 2. Insert satisfaction survey with the upcoming DM newsletters. 3. Evaluate additional workflows to measure program satisfaction (other than DM newsletters) to measure Health Coach Satisfaction in 4th Q.	Q3
Q3	1. Completed 30 day pilot of Autodata ExpertScan. Determined product would support the department needs. 2. Designed upcoming satisfaction survey for DM newsletters using Autodata ExpertScan software. 3. Satisfaction survey included in DM newsletters; however, they will drop too late for analysis by 1st Q, 2017. Need to identify alternate plan to disseminate satisfaction tool.	1. Participating in efforts to use a standardized tool to measure member satisfaction for DM and CM programs.	Q4
Q4	1. DM Experience survey conducted via direct mailing in early November, separate from previously proposed DM Newsletter insertion process. Mailed to DM Members in Asthma, Diabetes and Heart Failure High and Low risk programs [English (22,358) and Spanish (17,901) = Total 40,259. The DM Newsletters production schedule delayed distribution causing it to be too late to send our DM experience surveys. Surveys mailed to members in 1 or more DM programs during 2016. One survey tool to measure satisfaction for all programs. 3,256 responses were received as of 12/31/16.	1. Evaluate responses for DM Satisfaction mailed survey tool. 2. Develop a process to measure satisfaction quarterly for members actively working with a health coach and assessed in the previous 90 days.	Q1
Year End	The department successfully met the NCQQ requirement for measuring satisfaction; however, survey measurement was conducted late in the year.	In 2017, the department would like to improve on the measurement of member feedback by the following- Implement a quarterly satisfaction for members	

		participating with DM Health Coaches. Twice annually evaluate satisfaction for members only receiving mailed interventions (low risk members) in 2nd and 3rd quarters.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	N/A	Evaluate member satisfaction with DM newsletters.	Q2
Q2	N/A	Evaluate member satisfaction with DM newsletters	Q3
Q3	N/A	Implement member satisfaction tool with DM newsletters	Q4
Q4	Preliminary results for subset of questions evaluating our DM programs are as follows-(strongly agree and somewhat agree percentages included below) CalOptima staff was helpful in getting the information I needed. 82% CalOptima staff responded to my request or concerns in a timely manner. 80% I learned useful information from this program. 79% The information I got has helped me manage my health better. 76.8% I would tell others about CalOptima's Disease Management programs. 82.4%		
Year End	Goal - 90% Satisfaction with DM programs Goal Status - Not Met	Evaluate member responses and identify opportunities for improvement, including the survey tool and timeliness of measurement. Final report will be available with the other NCQA reporting items in February, 2017.	

V. Health Education & Disease Management

G. Quality of Clinical Care-Review of Cardiovascular Disease

Owner: Pshyra Jones, Director, Health Ed & DM

The Approach

1. **Objective**
   - CCIP Chronic Care Improvement Projects

2. **Activity**
   - CCIP-CMS Mandatory topic New Goal
   - Achieve high BP control or improvement among 50% of the members actively opting into health coaching OneCare
   - Achieve high BP control or improvement among 50% of OC members and receiving health coaching interventions
   - Achieve high BP medication adherence or improvement for 50% of OC members as identified through PBM date and receiving health coaching interventions OneCare Connect
   - Reduced unplanned readmissions by 1% below the national readmission rates for OCC members with admitting diagnosis specific to heart failure
   - Achieve high BP medication adherence for 50% of members opt-ing into health coaching identified through PBM data

3. **Goals**
   - As determined by CMS; currently CMS is tracking activity and interventions.

Health Education & Disease Management
Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1		OCC CHF Unplanned Readmissions: Identification and workflow being planned for logistics and execution of phone outreach by health coaches and tracking outcomes. OneCare uncontrolled high BP monitor offer letter being drafted; workflow being planned for logistics and execution of phone outreach and self-reported blood pressure value tracking by health coaches	Q2 2016
Q2	1. Implemented a workgroup with case management, pharmacy, and disease management to identify opportunities for increased coordination for members with unplanned HF readmissions in the Transitions of Care program. 2. Members are already receiving interventions from Case Mgmt and Transitions of Care coaches. When should they be triaged to DM? 3. Offer letter for OC uncontrolled blood pressure finalized and pending translation for Spanish and Vietnamese populations.	1. Continue coordination discussions and leverage Guiding Care to support seamless transition between TOC and DM for HF members. 2. DM Health Coaches to make biweekly outreach with OC members identified with uncontrolled blood pressure. Members will be given a blood pressure monitor to log their readings in support of these efforts. 3. Current model is an opt in program. May need to consider opt out design if only a small number take advantage of our program offering.	
Q3	1. Postponed distribution of Member letter for uncontrolled blood pressure intervention due to department resources expended on Diabetes PIP initiative. Department will evaluate distribution the end of October.		
Q4	1. 197 OneCare members identified with hypertension were mailed an offer to opt-in to receive a No Cost home blood pressure monitor upon agreement to commit to bi-weekly health coaching sessions with education on medication adherence, dietary and lifestyle changes. 22 members requested to opt-in, while only 12 members were eligible, and 11 members are currently receiving biweekly health coaching with progress being tracked by blood pressure control.		
Year End	The department met the goals of the CCIP program requirements; however, interventions to support program	Identify ways to integrate CCIP activities in the	

	objectives were often delayed due to department resources and/or other health plan initiatives.	maintenance of business for DM programs.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	Rate as of 4/4/16 OneCare Blood Pressure Control: **Rate 27.33%**	Continue monitoring CBP Rate against member and provider interventions	Q2
Q2	Rate as of 6/2016 OneCare Blood Pressure Control: **Rate 27.33%**	Distribute program letter to OC members identified with uncontrolled blood pressure. Continue to monitor % reduction in population opting in to BP program for Q3.	Q1, 2017
Q3		Distribute program letter to OC members identified with uncontrolled blood pressure. Continue to monitor % reduction in population opting in to BP program for Q4.	Q1, 2017
Q4			
Year End	OneCare Blood Pressure Control: **Rate 69.68% as of June, 2016**. 2016 was considered as baseline year; goal will be established for 2017	It has been challenging to evaluate program effectiveness using the OneCare Blood Pressure Control Rates. Blood Pressure Control for members receiving health coach interventions are not available based on delays with program implementation. These and other findings will be included in the CCIP report for CMS.	

V. Health Education & Disease Management

H. Quality of Clinical Care-Review of Diabetes and All Cause Readmissions

Owner: Kelly Rex-Kimmet, Director, QA PIPS

The Approach

1. **Objective**
   - PIP Performance Improvement Projects

2. **Activity**
   - PIP-DHCS Mandatory Projects-Readmission & Diabetes

3. **Goals**
   - Readmission: 2016 was baseline year; goal to be established after review of results (2nd quarter 2017)
     Diabetes: HbA1C rate of 92.94% or higher

Health Education & Disease Management
Owner: Kelly Rex-Kimmet, Director, QA PIPS

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion

Q1	• PIP: MC Diabetes HbA1c Testing: Modules 1-3 were submitted and approved. Submitted Module 4 (Plan).
	  ○ Identified a high volume low performing provider office for the PIP – Provider Office A
	  ○ Plan section includes the following interventions: Enhanced member outreach from the provider office, monthly distribution of gap analysis with list of non-compliant patients to provider office; patient distribution of local labs and their hours.
	• PIP: MC Access IHA: Modules 1-2 submitted to DHCS.
	  ○ Identified two high volume low performing provider office for the PIP – Provider Office A and B
	• QIP: OC Diabetes HbA1c Testing: QIP submitted to CMS in October 2015
	  ○ Plan: Member telephone outreach to members with HbA1c >9 from our HE/DM department; Provider outreach from provider relations staff for providers to outreach to their patients; identify top and low performing provider offices to learn about best practices and challenges; diabetic measure in the Pay for Value Program
	• QIP: OCC Readmissions: QIP submitted to CMS in October 2015
	  ○ Plan: Expand the Transitions of Care program to include OCC members
	  ▪ Notified HNs and Providers of the expansion of the program
	  ▪ Updated the member materials with OCC branding
	  ▪ OCC clinical criteria: All diagnoses
	  ▪ Go-Live: May 2, 2015
	• PIP: OCC LTSS: Improving In-Home Supportive Services Care Coordination (OCC)
	  ○ Modules 1-2 submitted to DHCS.
	  ○ Aim: to increase IHSS staff participation in ICTs
	
	*Module 1: PIP Initiation; Module 2: SMART Aim Data Collection;
		• For the following PIPs, improvement projects, interventions will be implemented and assessed upon approval from DHCS.
		  ○ MC Diabetes HbA1c Testing
		  ○ MC Access IHA
		  ○ OCC LTSS
		• OC Diabetes HbA1c Testing:
		  ○ Implementation of interventions listed in the plan.
		• OCC Readmissions:
		  ○ Phase 1: Go-live on May 2, 2016 for coaching.
		  ○ Phase 2: Mailing of discharge kits to OCC population.
		  ○ Evaluate the effectiveness of the program.
			• June 30, 2017
			
			• October 31, 2018
			
			• October 31, 2018

	Module 3: Intervention Determination; Module 4: PDSA; Module 5: PIP Conclusions		
Q2	• **PIP: MC Diabetes HbA1c Testing:** Modules 1-2 approved on 3/2/16; Module 3 approved 5/2/16; Module 4 pre-validation review completed 6/28/16 to continue with interventions. ○ Identified a high volume low performing provider office for the PIP – Provider Office A. ○ Plan section includes the following interventions: Enhanced member education outreach from the provider office, monthly distribution of gap analysis with list of non-compliant patients to provider office; patient distribution of local labs and their hours. • **QIP: OC Diabetes HbA1c Testing:** QIP submitted to CMS in October 2015, approved November 18, 2015. Plan: Member telephone outreach to members with HbA1c >9 from our HE/DM department; Provider outreach from provider relations staff for providers to outreach to their patients; identify top and low performing provider offices to learn about best practices and challenges; diabetic measure in the Pay for Value Program. • **QIP: OCC Readmissions: QIP submitted to CMS in October 2015** ▪ Go live in May, 2016 with new expansion ▪ Identified discharged mailing issue.	**MC Diabetes HbA1c Testing Interventions** **Module 4 (Plan Section):** • MC Diabetes HbA1c Testing Next Steps: ○ Work with Provider Office A to provide information on labs and transportation ○ Learn what Provider Office A barriers are currently ○ October 7, 2016 intervention testing summary to HSAG. **QIP: OC Diabetes HbA1c Testing QIP Plan:** 1. Letter to members needing HbA1c testing. (to be sent 10/2016). 2. Additional script re: HbA1c testing to Health Coaches outreaching to members who have uncontrolled HTN. (Completed 8/4/2016). **QIP: OCC Readmissions: QIP submitted to CMS in October 2015** • Working with CM, IS to update desktops and address	June 30, 2017 Implement Q4 Follow-up to be submitted January 2017 *tentative.* • Quarter 3

		mailing issue.	
	• **PIP: MC Access IHA: Modules 1-2 submitted to DHCS** o Identified two high volume low performing provider office for the PIP – Provider Office A and B o For Module 3, Intervention Determination, a process map, failure modes and causes, and analysis of the intervention effectiveness was assessed and prioritized. Received DHCS final approval on Module 3 September 13, 2016 o Module 4: The potential interventions selected include: (1) Provide in-service to staff at Providers A&B; (2) CalOptima to provide health plans member effective data for new members assigned to Providers A&B; (3) Increase member awareness and understanding of the IHA; (4) Identify administrative resources to help reschedule appointments for missed IHA appointments.	**PIP: MC Access IHA: Modules 1-2 submitted to DHCS.** In preparation for Module 4, Plan-Do-Study-Act (PDSA), the "Plan" portion will be completed and includes justifying the interventions chosen, planning the implementation for each intervention and evaluation methodologies.	Quarter 4 Submission due date October 20, 2016
	• **PIP: OCC LTSS: Improving In-Home Supportive Services Care Coordination (OCC)** o Modules 1-2 submitted to DHCS. o Aim: to increase IHSS staff participation in ICTs o Module 3: Received DHCS final approval on August 12, 2016	**PIP: OCC LTSS: Improving In-Home Supportive Services Care Coordination (OCC)** In preparation for Module 4, Plan-Do-Study-Act (PDSA), the "Plan" portion will be completed and includes justifying the interventions chosen, planning the implementation for each intervention and evaluation methodologies.	Submission due date September 15, 2016

Q3	• **PIP: MC Diabetes HbA1c Testing:** Modules 1-2 approved on 3/2/16; Module 3 approved 5/2/16; Module 4 pre-validation review completed 6/28/16 to continue with interventions. o Identified a high volume low performing provider office for the PIP – Provider Office A. o Plan section includes the following interventions: Enhanced member education outreach from the provider office, monthly distribution of gap analysis with list of non-compliant patients to provider office; patient distribution of local labs and their hours. • **QIP: OC Diabetes HbA1c Testing:** QIP submitted to CMS in October 2015, approved November 18, 2015. Plan: Member telephone outreach to members with HbA1c >9 from our HE/DM department; Provider outreach from provider relations staff for providers to outreach to their patients; identify top and low performing provider offices to learn about best practices and challenges; diabetic measure in the Pay for Value Program. • **QIP: OCC Readmissions: QIP submitted to CMS in October 2015** ▪ Go live in May, 2016 with new expansion ▪ Update all materials sent to members (PHR) • **PIP: MC Access IHA: Modules 1-2 submitted to DHCS**	• **PIP: MC Diabetes HbA1c Testing Interventions per Module 4 (Plan Section):** 1. Initial conference call mtg with Provider Office A for collaboration and participation on PIP held on 8/25/16. a. Member outreach compiled and shared with provider office. b. Discussion on current barriers of Provider Office A. c. Reminder letter for member outreach to be created. i. Letters to be sent early 4Q 2016. d. Tracking of members to be outreached to will be entered into a database for review and evaluation. 2. HSAG/DHCS pre-evaluation due November 14, 2016. • **QIP: OC Diabetes HbA1c Testing QIP Plan:** 1. Member outreach list compiled and compared to CBP members in OneCare for Disease Management Health Coaches to provide additional education and outreach to members. 2. Reminder letter for member outreach to be created. a. Tracking of members to be outreached to will be entered into a database for review and evaluation. b. Reminder letter for member outreach to be created. c. Letters to be sent early 4Q 2016. • **QIP: OCC Readmissions: QIP submitted to CMS in October 2015** **1.** QIP Annual Update due 1/13/17 **2.** Update Personal Health Record (PHR) • **PIP: Access Initial Health Assessment (IHA) (MC)**	Q2, 2017 Annual Update due 1/13/17 Annual update due 1/13/17

	○ Identified two high volume low performing provider office for the PIP – Provider Office A and B ○ For Module 3, Intervention Determination, a process map, failure modes and causes, and analysis of the intervention effectiveness was assessed and prioritized. Received DHCS final approval on Module 3 September 13, 2016 ○ Module 4: The potential interventions selected include: (1) Provide in-service to staff at Providers A&B; (2) CalOptima to provide health plans member effective data for new members assigned to Providers A&B; (3) Increase member awareness and understanding of the IHA; (4) Identify administrative resources to help reschedule appointments for missed IHA appointments. • **PIP: OCC LTSS: Improving In-Home Supportive Services Care Coordination (OCC)** ○ Modules 1-2 submitted to DHCS. ○ Aim: to increase IHSS staff participation in ICTs ○ Module 3: Received DHCS final approval on August 12, 2016	• Module 4 –Plan-Do-Study-Act (PDSA) was completed and included the intervention to be tested, "Provider in-service to staff at Providers A&B". The test cycle objective is hypothesized "To increase the number of IHAs completed among Provider offices A & B by improving IHA appointment scheduling and encounter data submissions by March 2017." • Testing the in-service training with Providers A&B will include assessing knowledge and awareness levels of providers and office staff. Training materials and in-service trainings will be scheduled during Q4. • The Intervention Justification portion of the module included justification for the intervention testing and key drivers the intervention is expected to impact. The intervention is hypothesized to impact one identified key driver. • Module 4 completed and submitted October 20, 2016. **PIP: OCC LTSS: Improving In-Home Supportive Services Care Coordination (OCC)** • Module 4 –Plan-Do-Study-Act (PDSA) was completed and included the intervention to be tested, "Education for Health Networks and CalOptima Community Network". The test cycle objective is hypothesized "To increase the number of timely ICT (Interdisciplinary Care Team) invitations the IHSS (In-Home Support Services) Social Worker liaison receives from Health Network D and E by December 31, 2016." • Testing the education of the Health Networks and CalOptima Community Network will include the development and distribution of material and information designed to improve the participation rate of social worker liaisons for ICTs at two selected Health Networks. • The Intervention Justification portion of the module included justification for the intervention testing and	PIP Completion: Q3, 2017

		key drivers the intervention is expected to impact. The intervention is hypothesized to impact five identified key drivers. • Module 4 completed and submitted September 15, 2016.	
Q4	• **PIP: MC Diabetes HbA1c Testing:** 1. Pre-validation of interventions submitted to DHCS on 10/7/16. o Identified a high volume low performing provider office for the PIP – Provider Office A. o Plan section includes the following interventions: Enhanced member education outreach from the provider office, monthly distribution of gap analysis with list of non-compliant patients to provider office; patient distribution of local labs and their hours. • **QIP: OC Diabetes HbA1c Testing:** QIP submitted to CMS in October 2015, approved November 18, 2015. Plan: Member telephone outreach to members with HbA1c >9 from our HE/DM department; Provider outreach from provider relations staff for providers to outreach to their patients; identify top and low performing provider offices to learn about best practices and challenges; diabetic measure in the Pay for Value Program.	• **PIP: MC Diabetes HbA1c Testing Interventions per Module 4 (Plan Section):** 1. Pre-validation of interventions submitted to DHCS on 10/7/16. a. Response received by DHCS on11/14/16 with no questions or feedback re: interventions. To continue interventions as planned. b. Provider Office A reached out to member list provided 1/2016 and shared feedback with CalOptima for additional outreach. c. Reminder letters sent to targeted members November 2016. • Members tracked onto database for additional review and evaluation. 2. HSAG/DHCS PIP Module 4s to complete testing by 6/30/2017. 3. To begin PIP Module 5s (Conclusion) after 6/30/17 completion of PIP Module 4s. • **QIP: OC Diabetes HbA1c Testing QIP Plan:** 1. Member outreach list compiled and compared to CBP members in OneCare for Disease Management Health Coaches to provide additional education and outreach to members. a. Additional outreach provided by Disease Management as needed to targeted members. 2. Reminder letter for member outreach sent November 2016. a. Members tracked onto database for additional review and evaluation. 3. Annual Update due to CMS 1/13/17, submitted to CMS on 1/11/17.	**PIP: MC Diabetes HbA1c Testing Module 4s and 5s due to HSAG by 8/15/17.** **QIP: OC Diabetes HbA1c Testing QIP Plan Submission to CMS completed 1/11/17.**

	• **QIP: OCC Readmissions: Year 1 Annual Update submitted to CMS in January 2017** Plan • Outreach to members by Health Coach RN to all OCC members admitted to Fountain Valley or Anaheim Hospital. • Outreach from CM Coordinator to schedule in-home follow-up visit between discharged member and Health Coach RN. • Track readmission data for OCC members receiving coaching and those that did not receive coaching. Track readmission data for OCC members that completed a follow-up visit with physician post-discharge and those that did not complete a post-discharge follow-up. • Provide soft skills training to staff on resources and correct barriers related to technology • Increase member engagement efforts and promote benefits of program with members, families, and other clinicians. **PIP: MC Access IHA: Modules 4 submitted to DHCS** • Module 4 completed and submitted October 20, 2016. o Module 4: The potential interventions selected include: (1) Provide in-service to staff at Providers A&B; (2) CalOptima to provide health plans member effective data for new members assigned to Providers A&B; (3) Increase member awareness and understanding of the IHA; (4) Identify administrative resources to help reschedule appointments for missed IHA	a. Awaiting feedback from CMS for next steps. *** QIP: OCC Readmissions: Year 1 Annual Update submitted to CMS in January 2017** • Update Personal Health Record (PHR) and discharge kit material • Evaluate program expansion beyond 2 hospitals • Strengthen internal and external partnerships to streamline data collection methods and identify additional opportunities, including post-discharge instructions and patient information. • **PIP: Access Initial Health Assessment (IHA) (MC)** • Module 4 –Plan-Do-Study-Act (PDSA) was completed and included the intervention to be tested, "Provider in-service to staff at Providers A&B". The test cycle objective is hypothesized "To increase the number of IHAs completed among Provider offices A & B by improving IHA appointment scheduling and encounter data submissions by March 2017." • Testing the in-service training with Providers A&B will include assessing knowledge and awareness levels of providers and office staff. Training materials and in-service trainings completed in November, 2016 **PIP: OCC LTSS: Improving In-Home Supportive**	**QIP OCC Readmissions:** Year 1 Annual update due 01/17 **PIP: (IHA) (MC):** Module 4 submitted 10/2016. Currently in PDSA testing cycle. **PIP OCC LTSS**

	appointments. • **PIP: OCC LTSS: Improving In-Home Supportive Services Care Coordination (OCC)** o Module 4: Submitted to DHCS on 9/15/16; Resubmitted with feedback from DHCS on 11/23/16. Currently implementing the PDSA testing phase.	**Services Care Coordination (OCC)** • Module 4 –Plan-Do-Study-Act (PDSA) was completed and included the intervention to be tested, "Education for Health Networks and CalOptima Community Network". The test cycle objective is hypothesized "To increase the number of timely ICT (Interdisciplinary Care Team) invitations the IHSS (In-Home Support Services) Social Worker liaison receives from Health Network D and E by December 31, 2016." • Testing the education of the Health Networks and CalOptima Community Network will include the development and distribution of material and information designed to improve the participation rate of social worker liaisons for ICTs at two selected Health Networks. The Intervention Justification portion of the module included justification for the intervention testing and key drivers the intervention is expected to impact. The intervention is hypothesized to impact five identified key drivers.	**IHSS** Module 4 submitted 11/2016. Currently in PDSA testing cycle.
Year End	All PIPs successfully submitted Modules 1-4 to DHCS and are in the PDSA testing phase. The PIPs have been a challenging process due to the resubmissions earlier in the process for Modules 1-3. However, the teams have successfully developed a plan that received DHCS approval and all PIP are currently in the PDSA implementation/testing phase. Data collection is in progress for each PIP project. Expected completion of Module 5 is Quarter 3, 2017. QIP annual submission for Year 1 results was due in January, 2017.	Continue with the all interventions set forth for the PIP/QIPs in 2017. All PIPs will complete Module 5 by Quarter 3, 2017. Year 1 QIP submission is due January, 2017.	PIP timelines are dependent on DHCS approval have varying completion date. All PIPs will start Module 5 by Q3, 2017. QIPs: Year 1 Annual update due 1/2017
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**

Q1	• PIP: MC Diabetes HbA1c Testing Rate:
	  ○ 2015 HbA1c Testing rate for Provider A: 70.15%
	  ○ Goal for Provider A: 80.00%
	• PIP: MC Access IHA Rate:
	  ○ 2015 IHA rate for Provider A: 0%
	  ○ 2015 IHA rate for Provider B: 6.4%
	  ○ Goal for Provider A and B: 25.0%
	• QIP: OC Diabetes HbA1c Testing Rate:
	  ○ 2015 HbA1c Testing rate: 92.02%
	  ○ Goal for QIP: 92.94% (50th percentile 2015)
	• QIP: OCC Readmissions Rate:
	  ○ TOC Program:
	  ▪ 2015 OC TOC Eligible Readmission Rate: 25.1% (OCC no rate – OC rate as proxy)
	  ▪ Goal for QIP: 16.8%
	• PIP: OCC LTSS rate:
	  ○ July to Dec 2015 Rate of IHSS Staff Participation in ICT: 21.84%
	  ○ Goal: 35.0%
		• For all PIPs, interventions will be tracked, at minimum, on a monthly basis.
		• For all QIPs, evaluation will occur prior to annual resubmission.
			PIP timelines are dependent on DHCS approval.

Q2	• **PIP: MC Diabetes HbA1c Testing Rate:**
	  ○ 2015 HbA1c Testing rate for Provider A: 70.15%
	  ○ Goal for Provider A: 80.00%
	  ○ March 2016 showed 31 out of 91 members needing their HbA1c testing.
	• **QIP: OC Diabetes HbA1c Testing Rate:**
	  ○ 2015 HbA1c Testing rate: 92.02%
	  ○ Goal for QIP: 92.94% (50th percentile 2015)
	  ○ Of the OC population for 2016, there was a total of 51 members need HbA1c testing.
	• PI**P: MC Access IHA Rate:**
	  ○ 2015 IHA rate for Provider A: 0%
	  ○ 2015 IHA rate for Provider B: 6.4%
	  ○ Goal for Provider A and B: 25.0%
	• PIP: OCC LTSS rate:
	  ○ July to Dec 2015 Rate of IHSS Staff Participation in ICT: 21.84%
	  ○ Goal: 35.0%
		• Module 4 Plan Section intervention testing summary due to HSAG on October 7, 2016.
		• QI Team will be sending reminder letters to targeted members of Provider Office A upon completion of internal letter review.
		• QI Team will be sending reminder letters to targeted members upon completion of internal letter review.
		• Team to outreach to Providers A&B and start intervention.
		• Submit measurement year 1
			Quarter 4
			Quarter 4
			Quarter 4
			Tentative: January 2017

Q3	• **PIP: MC Diabetes HbA1c Testing Rate:** o 2015 HbA1c Testing rate for Provider A: 70.15% o Goal for Provider A: 80.00% o March 2016 showed 31 out of 91 members needing their HbA1c testing. • **QIP: OC Diabetes HbA1c Testing Rate:** o 2015 HbA1c Testing rate: 92.02% o Goal for QIP: 92.94% (50th percentile 2015) o Of the OC population for 2016, there was a total of 51 members need HbA1c testing. • **QIP: OCC Readmissions: QIP submitted to CMS in October 2015** ▪ Go live in May, 2016 with new expansion ▪ Update all materials sent to members (PHR) • PI**P: MC Access IHA Rate:** o 2015 IHA rate for Provider A: 0% o 2015 IHA rate for Provider B: 6.4% o Goal for Provider A and B: 25.0% • **PIP: OCC LTSS rate:** o July to Dec 2015 Rate of IHSS Staff Participation in ICT: 21.84% o Goal: 35.0%	• **PIP: MC Diabetes HbA1c Testing Interventions per Module 4 (Plan Section):** 3. Initial conference call mtg with Provider Office A for collaboration and participation on PIP held on 8/25/16. a. Member outreach compiled and shared with provider office. b. Discussion on current barriers of Provider Office A. c. Reminder letter for member outreach to be created. i. Letters to be sent early 4Q 2016. d. Tracking of members to be outreached to will be entered into a database for review and evaluation. 4. HSAG/DHCS pre-evaluation due November 14, 2016. **QIP: OC Diabetes HbA1c Testing Rate:** • Intervention implemented: Discharge kit mailings send twice a week **PIP: MC Access IHA:** • Q4 is the testing cycle for the IHA intervention. **PIP: OCC LTSS:** • Q4 is the testing cycle for the LTSS intervention.	June 30, 2017
Q4	• **PIP: MC Diabetes HbA1c Testing Rate:** o 2015 HbA1c Testing rate for Provider A: 70.15% o Goal for Provider A: 80.00% o March 2016 showed 31 out of 91 members needing their HbA1c testing.	• **PIP: MC Diabetes HbA1c Testing Interventions per Module 4 (Plan Section):** 1. Data pull for September 2016 showed 30 members needing outreach. b. Provider Office A reviewed and outreached to members October 2016. • 2 members no longer had Provider Office A as their PCP. • 7 members were no longer affiliated with their HN with Provider A. • 1 member hospitalized.	**PIP: MC Diabetes HbA1c Testing Module 4s and 5s due to HSAG by 8/15/17.**

	• **QIP: OC Diabetes HbA1c Testing Rate:** o 2015 HbA1c Testing rate: 92.02% o Goal for QIP: 92.94% (50th percentile 2015) o Of the OC population for 2016, there was a total of 51 members need HbA1c testing. • **QIP: OCC Readmissions Rate:** o TOC Program: ▪ 2015 OC TOC Eligible Readmission Rate: 25.1% (OCC no rate – OC rate as proxy) ▪ Goal for QIP: 16.8% - Results: **36** OCC members were eligible for the TOC program. - Of the 36 eligible members for the TOC program, 50% (18 of 36) received the coaching intervention and 50% (18 of 36) did not receive the coaching intervention. - When looking at the total MMP eligible population, 30.6% (11 of the 36) of the MMP eligible members were readmitted within 30 days of discharge. All 100% of members who received coaching completed a follow-up visit with a PCP/specialist within 30 days of discharge and those who completed the follow-up visit had a 62% percentage points lower readmission rate. • PI**P: MC Access IHA Rate:** o 2015 IHA rate for Provider A: 0% o 2015 IHA rate for Provider B: 6.4% o Goal for Provider A and B: 25.0% • **PIP: OCC LTSS rate:** o July to Dec 2015 Rate of IHSS Staff Participation in ICT: 21.84%	• 9 members already received their testing. • 6 members were given HbA1c testing orders. c. Next data pull 2/2017. **QIP: OC Diabetes HbA1c Testing Interventions** • Total population for this measure: 1,368 o 171 members eligible for the outreach. o 51 members received the outreach • November 2016 Prospective Rate: 84.2% **QIP: OCC Readmissions:** • Update Personal Health Record (PHR) and discharge kit material • Evaluate program expansion beyond 2 hospitals • Strengthen internal and external partnerships to streamline data collection methods and identify additional opportunities, including post-discharge instructions and patient information. • Additional evaluation of the discharge kits will be assessed in the next annual update. Evaluate the rates for members who received the discharge kits. **PIP: MC Access IHA:** • Currently in Module 4; PDSA testing cycle for the IHA intervention. **PIP: OCC LTSS:** • Currently in Module 4; PDSA testing cycle for the	**QIP: OC Diabetes HbA1c Testing QIP Plan Submission to CMS completed 1/11/17.**

	Goal: 35.0%	LTSS intervention.	
Year End	○ **PIP: MC Diabetes HbA1c Testing Interventions per Module 4 (Plan Section):** a. Goal, to increase screening to 80% for Provider Office A by June 30, 2017. Currently, Provider Office A has an HbA1c testing rate of 30% for the targeted population as of October, 2016. More outreach is to be conducted to reach the goal of 80% for this targeted provider. Numbers are based on data collected so far for Provider Office A as of Oct, 2016. Goals status – not met for this quarter/ ○ **QIP: OC Diabetes HbA1c Testing Intervention:** a. Goal for QIP: To achieve a rate of 92.94% (50th percentile 2015) for HbA1c testing among OC Diabetic members. The total population for this measure: 1,368. Of this population, 171 members eligible for the outreach. 51 members (29.8%) received the intervention as of November, 2016. The Nov 2016 Prospective Rate: 84.2%. Goal status is not met. ○ **QIP: OCC Readmissions:** a. Goal was 16.8%. The readmissions rate is 30.6% (11 of the 36) for the MMP eligible members were readmitted within 30 days of discharge. All 100% of members who received coaching completed a follow-up visit with a PCP/specialist within 30 days of discharge and those who completed the follow-up visit had a 62% percentage points lower readmission rate. ○ **PIP: MC Access IHA:** ▪ Goal for Provider A and B: 25.0%. Currently implementing the PDSA testing phase. Team will be pulling data in Q1, 2017 ○ **PIP: OCC LTSS:** ▪ Goal for IHSS Staff participation in ICT: 35.0%. Jan – Dec, 2016, there were 1216 ICTs held. Of those ICTs held, IHSS staff were invited to 707 meetings. Of those IHSS staff invited to the meetings, 63.2% attended the ICT meetings.	QI work teams to continue with implementing the PDSA testing cycles and the interventions for the PIPs and QIPs.	

	▪ **Goal Status:** 36.8% IHSS staff participated in the ICT meetings. Goal Met		

V. Health Education & Disease Management

I. Implementation of the Childhood Obesity (Shape your Life) Program

Owner: Pshyra Jones, Director, Health ED & DM

The Approach

1. **Objective**
   - Evaluate, identify and develop clinical and operational content for revisions to existing Childhood Obesity Prevention and Treatment Program (COPTP), and develop network of providers to support program for 2016 and beyond

2. **Activity**
   - Evaluate existing COPTP program goals, objectives and interventions
   - Develop clinical and operational components to revise existing program design to expand the reach and capability
   - Identify program resources and vendor support (Provider, Health ED/RD linkages)
   - Implementation of revised program design

3. **Goals**
   - Implement revised program design-2017
   - Evaluate progress semi-annually

Health Education & Disease Management
Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	1. Request For Information submitted in 4thQ 2. Board request to allocate funds for RFP was not approved by the Quality Assurance Committee	Create short list of programmatic requirements that can be implemented internally with support from Network Management.	Q2/Q3
Q2	1. Developed high level draft of program design, inclusive of department resources, community classes, and external vendor programs (Dr. Riba, LHA).	Finalize RFI efforts to meet the programmatic, geographic and linguistic needs of our population.	Q3
Q3	1. Present SYL expansion efforts proposal and COBAR request to September QAC.	Create Scope of Work document for RFP based on QAC approval and support of SYL expansion efforts. Hire Program Manager to support RFP responses and program implementation.	Q4
Q4	1. QAC approval of SYL expansion and COBAR. 2. Shape Your Life RFP loaded to BidSync on 12/21/16 3. Program Manager job description created 4. Request To Fill submitted for Program Manager on 12/20/16	Evaluate RFP responses by 1/27/16. Interview candidates for Program Manager Present status update at next January QIC and February QAC.	Q1
Year End	As of 12/30, 2016- no questions submitted against the RFP for Shape Your Life program expansion. RFP responses are expected the middle to end of January.	Evaluate RFP responses by 1/27/16. Interview candidates for Program Manager Present status update at next January QIC and February QAC.	

Outcomes	Results / Metrics	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4	Request for Proposal for Shape Your Life on BidSync - 12/21/16 Program Manager position posted	Present status update at QAC Identify vendor(s) to support expansion efforts	
Year End	N/A	Present program status updates, including recommendation to provide Weight Watchers for adult members at the next February, 2017 QAC meeting.	

V. Health Education & Disease Management

J. Implement Weight Watchers (WW) for Medi-Cal members

Owner: Pshyra Jones, Director, Health ED & DM

The Approach

1. **Objective**
   - Design weight Watchers benefit for CalOptima Medi-Cal members age 15yrs or greater

2. **Activity**
   - Obtain MOU and finalize contract between WW and CalOptima organization
   - Establish criteria and program goals for participating CalOptima members
   - Identify appropriate regulatory approvals for member materials and program incentives

3. **Goals**
   - Implement revised program design-2017
   - Evaluate progress semi-annually

Health Education & Disease Management
Owner: Pshyra Jones. Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	1. Completed information gathering on Weight Watcher program design and implementation requirements. 2. Included in approved 2016 QI work plan 3. Pending board approval of WW line item in the 2017 department budget.		Q2
Q2		Continue contractual discussion with Weight Watchers. Draft COBAR for Sept/Nov QAC.	3rd/4th Q
Q3	1. Request authority to use funds for Weight Watchers implementation at September QAC.	Hold off on Weight Watchers until the November QAC meeting. Prep by submitting a RFI to Weight Watchers and other similar entities in preparation for November QAC.	Q4
Q4	1. Develop Request for Information (RFI) to identify adult weight management programs. 2. Develop a COBAR for Weight Watchers- most appropriate vendor based on RFI responses.	1. Include Weight Watchers request with SYL update at the next QAC meeting. 2. Presentation to include: a. Marketing strategy b. Program criteria & exclusions c. Member and Provider evaluations d. Program evaluation	Q1
Year End		1. Include Weight Watchers request with SYL update at the next QAC meeting. 2. Presentation to include: a. Marketing strategy b. Program criteria & exclusions c. Member and Provider evaluations d. Program evaluation	

Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	N/A	N/A	
Q2	N/A	N/A	
Q3	N/A	N/A	
Q4	N/A	N/A	
Year End	N/A	N/A	

V. Health Education & Disease Management

K. Implement Home Assessments for member participating in Care Management Programs

Owner: Pshyra Jones, Director, Health ED & DM

The Approach

1. **Objective**
   - Design a face to face assessment and coaching option for high risk members with chronic conditions participating in CalOptima Care management programs

2. **Activity**
   - Obtain MOU and contracts with appropriate vendors (TBD)
   - Establish criteria and program goals for participating CalOptima members
   - Identify appropriate regulatory approvals for member materials and program incentives

3. **Goals**
   - Implement revised program design-2016
   - Evaluate progress semi-annually

Health Education & Disease Management
Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	1. Scope of work created with contracting in support of RFI/RFP	1. Work with Contracting to finalize fee schedule 2. Draft RFI/RFP with Budget and Vendor Management	Q2
Q2		1. Continue to work with contracting on fee schedule 2. RFI efforts to include possible requirements for Alana - vendor supporting in home support for COPD & CHF.	Q3
Q3	No activity in Q3. Department was responding to other initiatives.	1. Identify department resources to managing the RFI process for this initiative.	Q4
Q4		Consider deferring this activity until 2018.	Q1, 2018
Year End	Department resources and other health plan initiatives did not allow efforts to continue in this area.	Evaluate this objection against staff resources and priorities for 2017.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	N/A	N/A	
Q2	N/A	N/A	
Q3	N/A	N/A	
Q4	N/A	N/A	
Year End	N/A	N/A	

V. Health Education & Disease Management

L. Conduct 2016 Group Needs assessment (GNA)

Owner: Pshyra Jones, Director, Health ED & DM

The Approach

1. **Objective**
   - The GNA supports identification of health risks, beliefs, practices, and cultural and linguistic needs for CalOptima's Medi-Cal membership

2. **Activity**
   - Complete Request for Proposal
   - Identify eligible CalOptima survey participants based on methodology required by Department of Healthcare Services (DHCS)
   - Mail assessment tool available in all 7 threshold languages
   - Submit Executive Summary and supporting reports to DHCS by October, 2016

3. **Goals**
   - Complete GNA requirement for 2016

Health Education & Disease Management
Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	1. Completed Request For Quote and Request For Response.	1. Interview RFP responses 2. Evaluate the work burden if internal staff resources are required to complete the GNA activities by Oct, 2016.	Q2
Q2	1. Selected Gary Bess and Associates to support GNA efforts 2. Expanded DHCS denominator requirement (411) to 2500 completed responses. 3. Included custom questions to address social determinants of health. 4. Presented GNA methodology at Board of Directors' Provider/Member Advisory Committees	1. Continue to support the vendor with project implementation. 2. Initial results will be shared in September QIC.	Q3
Q3		1. Continue to support the vendor with project implementation. 2. Presentation of data to support DHCS work plan scheduled for 10/7/2016. 3. GNA Executive Summary and report due 10/15. 4. Future presentations of findings will be scheduled for QIC, and CalOptima Board of Directors' PAC, MAC, and QAC.	Q4
Q4			
Year End	The department successfully met the October, 15th DHCS submission date for the GNA Executive Summary.	The department is continuing to work on the CalOptima enhanced GNA in support of the new Member Needs Assessment initiative.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**

Q1			
Q2			
Q3	Submission of GNA to DHCS on 10/15th.		
Q4			
Year End	Submission of GNA to DHCS on 10/15th.	Presentation on the CalOptima enhanced GNA for January, 2017.	

VI. Access & Availability

A. *Quality of Service and Quality of Clinical Care- Review of notification to members

Owner: Laura Grigoruk
Dir. Provider Relations

The Approach

1. **Objective**
   - Continuity and coordination of Care reviewed and assessed

2. **Activity**
   - Communication to members when a primary care provider is terminated from the network will be assessed. Standard is 30 days notice. (CCN & HN/Delegation reports)
   - Exception: CalOptima is notified in less than 30 days of termination, then notification would be within three business days.

3. **Goals**
   - 85%

Access & Availability
Owner: Laura Grigoruk, Director, Provider Relations

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	15 primary care physicians were terminated from the CalOptima Community Network in the first quarter of 2016. Three of the physicians had members assigned to them.	Continue to monitor	Ongoing
Q2	20 primary care physicians were terminated from the CalOptima Community Network in the second quarter of 2016. Four of the physicians had members assigned to them.	Continue to monitor	Ongoing
Q3	29 primary care physicians were terminated from the CalOptima Community Network in the third quarter of 2016. Only one of the physicians had members assigned to them.	Continue to monitor	Ongoing
Q4	Nine primary care physicians were terminated from the CalOptima Community Network in the fourth quarter of 2016. Seven of the physicians had members assigned	Continue to monitor	Ongoing
Year End	73 primary care physicians were terminated from the Community Network in 2016. All members were notified within 30 days.	CalOptima's Provider Relations team will continue to work together with the Customer Service Department when practitioners are terminated from the Community Network. Continue to monitor	Ongoing
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	CalOptima met the standard for member notification.	Continue to monitor	Ongoing
Q2	CalOptima met the standard for member notification.	Continue to monitor	Ongoing
Q3	CalOptima met the standard for member notification.	Continue to monitor	Ongoing
Q4	CalOptima met the standard for member notification.	Continue to monitor	Ongoing

Year End	CalOptima met the 85% standard for member notification when primary care physicians are terminated.	CalOptima's Provider Relations team will continue to work together with the Customer Service Department when practitioners are terminated from the Community Network. Continue to monitor	Ongoing

VI. Access & Availability

B. *Access to Care: Credentialing of provider network is monitored

Owner: Esther Okajima, Director, QI

The Approach

1. **Objective**
   - Credentialing program activities monitored for timeliness

2. **Activity**
   - New applicants processed within 180 calendar days of receipt of application
   - **Report from CPRC

3. **Goals**
   - 100%

C. Access to Care-Recredentialing of provider network is monitored

Owner: Esther Okajima, Director, QI

The Approach

1. **Objective**
   - Recredentialing of practitioners is completed timely

2. **Activity**
   - Recredentialing is processed with 36 month report of Admin term due to missed recredentialing cycle
   - Report of # of providers termed due to move, retired, etc
   - Quarterly Access & Availability report
   - **Report from CPRC

3. **Goals**
   - 100%

Access & Availability
Owner: Esther Okajima, Director, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	Credentialing, PR, and Contracting clean up continue Files closed in CACTUS closed by one Cred Coordinator. File cannot be closed until approved by QI manager and has documentation supporting closure.	Continue to work collaboratively with Process excellence to identify gaps. Continue to accept closure with supporting documentation.	4/30/2016 On-going
Q2	In Q2, all initial credentialing activities were monitored for timeliness to ensure that applications were processed within 180 days from the attestation date. In addition, re-credentialing applications are being monitored to ensure that they are completed in less than 36 months from their last credentialed date.	Continue monitoring timeliness for all credentialing and recredentialing files.	9/30/2016
Q3	In Q3, credentialing activities continue to be monitored for timeliness. Changes were made to the initial credentialing process where practitioners can access the CPPA application from the CalOptima website, directly into the credentialing software. This change was to streamline the process for completing applications, and will be monitored closely in Q4. The TAT in Q3 averaged about 112 days, which is higher than Q2 where the average was 99 days. Also, we had 1 provider whose credentialing expired in April 2016. Actions regarding this practitioner are pending CPRC decision. Notices have been issued and action for termination due to non-compliance is in process.	Final action by CPRC regarding the practitioner will be taken. Will continue to monitor changes to the initial application processing to determine if change was effective.	12/30/16
Q4	In Q4 credentialing activities continue to monitor timeliness and productivity. In mid-November, the department experienced turnover staff, and implemented an upgrade to its credentialing system. The results was a decrease in number of completed files for Q4, however there was an improvement in TAT which was 78 days, compared to 112 days in Q3. The practitioner identified in Q3 with an expired credential is in the process of termination due to non-compliance. Also, there was a HDO whose credential expired October 2016, but was re-credentialed, November. This was due to a process issue that was resolved in our credentialing system.	Final action to terminate provider with expired credentials will be completed. New staff was hired, new system was implemented. Will be monitoring productivity and timeliness in 2017.	1/31/17
Year End	97% of the initial and recredentialing files met the timeliness standard for 2016	Continue to monitor timeliness in 2017, and add TAT goals for initial and re-credentialing completion times	1/31/17

Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	**TAT** **Initial** – 238 completed 31 – R2I 1 – HDO non-compliant with re-cred request changed to initial after 36 months passed ***77% completed within 36 months*** **Re-cred** – 93 **Files Closed in CACTUS** 58 files closed in CACTUS all with either a termination letter or ACT form from PR.	Continue to complete R2I project.	5/31/2016
Q2	113 Initial Credentialing Applications completed in <180 days 104 Re-Credentialing Applications completed <36 months 64 Closed Files in CACTUS	Continue to ensure timelines standards are met	9/30/2016
Q3	80 Initial Credentialing Applications completed in <180 days, with average TAT 112 days. 162 Re-Credentialing Applications completed within 36 months with average TAT 97 days.	Look at processes to determine what is causing the long TAT times, and work towards improving TAT days to less than 100.	12/31/2016
Q4	43 Initial Credentialing Applications completed in <180 days, with average TAT 78 days. 91 of 92 Re-credentialing Applications completed within 36 months with average TAT of 83 days. 1 file was >36 month	Additional efforts to streamline and reduce TAT have resulted in decrease TAT from Q3. However, with the staffing changes, system change, and # of work days in Q4, the # of credentialing files completed in Q4 decreased. In Q4 of 2017, the goal would be to keep TAT under 90 days and increase number of completed files to address the backlog of files.	1/31/17
Year End	There was an overall 7% decrease in the number of initial credentialing and re-credentialing files (Practitioners & HDO's) completed from 2015 to 2016. Many changes to staff and processes resulted in the decrease primarily in the initial files completed for both Practitioners & HDO's. The number of re-credentialing files actually increased year over year.	Continue to work on improving processes to reduce TAT to less than 90 days. Meet the timeliness criteria for initials and recreds.	1/31/17

VI. Access and Availability

D. *Accessibility: Review of access to care

Owner: Marsha Choo, Manager, QA

The Approach

1. **Objective**
   - Practitioner accessibility (medical services in a timely manner) is measured, assessed and adjusted as necessary to standard

2. **Activity**
   - Data against goals will be measured and analyzed for the following through the implementation of our annual Timely Access study and Customer Service monitoring of wait time
     1. Non-urgent primary care appointments within 10 business days
     2. Urgent appointments with prior authorization with 96 hours of request
     3. Non-urgent primary care appointments within 10 business days
     4. Appointment with specialist within 15 business days
     5. First pre-natal visit within 10 business days
     6. Member services, by telephone ASA 30 seconds with abandonment rate <5%

   - Health Networks will be issued Corrective Action Plans for their areas of non-compliance
     1. Urgent Care appointments with 48 hours of request
     2. Appointments with specialist within 15 business days
     3. Member services, by telephone ASA 30 seconds with abandonment rate <5%
     4. Non-urgent acute care within 3 days of request

3. **Goals**
   - Appt.: 90%
   - Phone: <5%

Access & Availability
Owner: Marsha Choo, Manager, QA

Monitoring	Assessments, Findings, Monitoring of Previous Issues		Next Steps	Target Completion
Q1	**Standards**	MC OC	• Plan level results were presented at the HN Quality Forum and the HN Forum • HNs were sent their HN specific reports • GG.1600 Access and Availability Policy Updated for June PRC • MA.7007 Access and Availability Policy to be updated for July PRC • Access and Availability will report up to the Member Experience Steering Committee • Corrective Action Plans will be issued to HN for their areas of non-compliance Continue to monitor and ensure Access and Availability standards are being adhered to.	• May 2016 • May 2016 • June 2016 • July 2016 • June 2016 • TBD
	1. Urgent care appointments within 48 hours of request:	1. Met Not Met		
	2. Non-urgent care within 3 business days:	2. Not Met Not Met		
	3. Primary care appointments within 10 business days:	3. Met Met		
	4. Urgent appointments with prior authorization with 96 hours of request:	4. Not Met Not Met		
	5. Appointment with specialist within 15 business days:	5. Not Met Not Met		
	6. First pre-natal visit within 10 business days:	6. Not Met Not Met		
	*Data as of October 2015 (annual data collection)			
	7. Member services, by telephone ASA 30 seconds	7. Met Met		
	8. Member Service: Abandonment rate <5%:	8. Met Met		
	*Data as of March 2016			
Q2	Appointment Availability remains the same as data is collected annually. Current year results will be available Quarter 4 2016.	MC OC OCC	• Update MA.7007: OneCare/OneCare Connect Access and Availability Policy for August 2016 PRC • Workgroup to improve the referral and authorization process to address timeliness in obtain specialty appointments	• August 2016 • Sept 2016

	1. Member services, by telephone ASA 30 seconds 2. Member Service: Abandonment rate <5%: Data as of June 2016 (met standard if they met all 3 months in the quarter)	1. Met Met Met 2. Met Met Met *Month of May 2016 did not meet standard.	• Expand the scope of the Access and Availability Work Team to include access to other services that may include but are not limited to LTSS, transportation, VSP, etc. • Review and trend grievances and appeals for access • Continue to identify barriers and interventions to improve access • Corrective Action Plans will be issued to HN for their areas of non-compliance Continue to monitor and ensure Access and Availability standards are being adhered to.	• Sept 2016 • Oct 2016 • On-going • TBD
Q3	Appointment Availability remains the same as data is collected annually. 2016 results will be available Quarter 4 2016. 1. Member services, by telephone ASA 30 seconds 2. Member Service: Abandonment rate <5%: Data as of September 2016 (met standard if they met all 3 months in the quarter)	MC OC OCC 1. Met Met Met 2. Met Met Met	• Updated prior authorization list • Expanding the scope of access and availability monitoring to include: LTSS, transportation, VSP, and more. • Additional license for GeoAccess software to expand availability capabilities in Quality Analytics • 2015 Access and Availability Corrective Action Plans to be issued to the health networks in December 2016 • 2017 Work Plan for 2017 • 2016 Timely Access Study Results to be presented at January QIC	Quarter 3 Quarter 4 Quarter 1 2017
Q4	**<u>Standards</u>** 1. Urgent care appointments within 48 hours of request: 2. Non-urgent care within 3 business days: 3. Primary care appointments within 10 business days: 4. Urgent appointments with prior authorization with 96 hours of request:	MC OC OCC 1. Met Met Met 2. Not Met Not Met Not Met 3. Met Met Met 4. Not Met Not Met Not Met	• Update access and availability policy on the following areas: corrective action plans, high volume specialists, high impact specialists, data collection methodology for health delivery organizations	• Quarter 1 2017

	5. Appointment with specialist within 15 business days: 6. First pre-natal visit within 10 business days: *Data as of December 2016 (annual data collection) 7. Member services, by telephone ASA 30 seconds 8. Member Service: Abandonment rate <5%: *Data as of December 2016	5. Not Met Not Met Not Met 6. Not Met Not Met Not Met MC OC OCC 7. Met Met Met 8. Met Met Met		
Year End	CalOptima has developed and implemented several initiatives to improve appointment availability. The efforts identified to support the improvement include: 1. Member education through the Medi-Cal Newsletter 2. Provider education through the Provider Manual, Provider Update, and CCN Lunch and Learn 3. Health Network education through the HN Forum, HN Quality Forum, JOMs 4. Request for Observations Plans from Health Networks that were out of compliance with accessibility standards. 5. Update the prior authorization list.		Continue efforts to better monitor and improve appointment availability. 1. Issue corrective action plans or equivalent to health networks who are not compliance with accessibility standards in 2016 2. Continued efforts in health network, member and provider education of standards. 3. Development of workgroups to focus on specific areas of appointment availability	
Outcomes	**Results / Metrics**		**Next Steps**	**Target Completion**

Q1	**Standards – Goal 90%**
	
	1. Urgent care appointments within 48 hours of request:
	
	2. Non-urgent care within 3 business days
		MC OC
		
		1. 92.8% 89.2%
		
		2. 87.8% 82.7%
			• Fielding for the 2016 Timely Access Study began on May 20, 2016.
			• Data run and the following were included/updated
			  ○ Included OCC providers
			  ○ High Volume Specialties are included in the 2016 Timely Access Study:
			  ▪ MC: OB/GYN, Orthopedic Surgery, Gastroenterology, Cardiology,
				• Fielding: 5/20/2016
				• June and July PRC
				
				Deliverables: November

	3. Primary care appointments within 10 business days 4. Urgent appointments with prior authorization with 96 hours of request 5. Appointment with specialist within 15 business days 6. First pre-natal visit within 10 business days *Data as of October 2015 (annual data collection) 7. Member services, by telephone ASA 30 seconds 8. Abandonment Rate < 5%: Avg. abandonment rate: 2% *Data as of March 2016	3. 94.1% 91.9% 4. 71.8% 74.4% 5. 86.3% 86.0% 6. 87.5% 88.9% 7. 24 sec 12 sec 8. 2% 3%	Ophthalmology, Dermatology ▪ OC: Orthopedic Surgery, Neurology, Podiatry, Cardiology, Ophthalmology ○ Timely Access Study now includes the following high impact specialties: Oncology, Nephrology and Endocrinology 2016 Timely Access Study results to be available in November 2016.	2016
Q2	Appointment Availability remains the same as data is collected annually. 1. Member services, by telephone ASA 30 seconds 2. Member Service: Abandonment rate <5% Data as of June 2016	MC OC OCC 1. 0:27 0:07 0:07 2. 2% 0.0% 2.4%	• CalOptima fielded the 2016 Timely Access survey beginning in June 2016. (2016 Timely Access Report will be available quarter 4 2016.)	• June-August 2016
Q3	Appointment Availability remains the same as data is collected annually. 1. Member services, by	MC OC OCC 1. 0:23 0:07 0:07	• New reporting template for availability • Timely Access Results available for analysis. Data will be presented to committees.	• Quarter 3 • Quarter 4 2016 and Quarter 1

	telephone ASA 30 seconds 2. Member Service: Abandonment rate <5% Data as of Sept 2016	 2. 2% 0.0% 1.0%		2017
Q4	**<u>Standards – Goal 90%</u>** 1. Urgent care appointments within 48 hours of request: 2. Non-urgent care within 3 business days 3. Primary care appointments within 10 business days 4. Urgent appointments with prior authorization with 96 hours of request 5. Appointment with specialist within 15 business days 6. First pre-natal visit within 10 business days *Data as of December 2016 (annual data collection) 7. Member services, by telephone ASA 30 seconds (Data presented is the highest rate of the quarter) 8. Abandonment Rate < 5%: Avg. abandonment rate: 2% *Data as of December 2016	MC OC OCC 1. 97.2% 97.8% 97.2% 2. 84.9% 86.3% 82.3% 3. 92.7% 92.9% 91.1% 4. 79.0% 80.7% 79.2% 5. 84.4% 85.8% 85.4% 6. 88.9% 92.1% 85.7% MC OC OCC 7. 0:27 0:06 0:07 8. 2% 0% 1.4%	• Timely Access Results were reports were delivered from the vendor. • Data analysis occurred to monitor trends in performance. • Data to be shared with the Access and Availability QI Work Team, Member Experience Subcommittee and QIC. • Explore mystery shopper methodology for accessibility data collection and monitoring. •	• Quarter 4 2016 • Quarter 1 2017

Year End	For 2016, CalOptima met 2 of the 6 appointment availability standards in the QI Work Plan. Scores were consistent across all lines of business. Improvements can be seen from 2015 to 2016, with the exception of specialty appointments for all lines of business and non-urgent and primary care appointments in Medi-Cal. The following areas are areas of focus for 2017: 1. Non-urgent care within 3 business days 2. Urgent appointments with prior authorization with 96 hours of request 3. Appointment with specialist within 15 business days 4. First pre-natal visit within 10 business days For Member Service access monitoring, CalOptima met the call standards for all quarters across all lines of business.	Continue to explore better ways to collect data to monitor appointment availability, focusing on "mystery shopper" methodology as a viable option for 2017. Continue to monitor performance for customer service calls.	On-going

VI. Access and Availability

E. *Availability: Review of Availability of Practitioners

Owner: Marsha Choo, Manager, QA;
Dr. Donald Sharps, Medical Director, BH

The Approach

1. **Objective**
   - Practitioner availability (geographic distribution) in measured assessed and adjusted to meet standard
   - Practitioner availability (cultural, ethnic, racial and linguistic member needs) is measured, assessed and adjusted as necessary to standard
   - Availability of practitioners is measured and assessed to Behavioral Health services
   - Availability of practitioners is measured and assessed by geographic distribution specific to Behavioral health
   - Practitioner availability (practitioner to member ratio) is measured, assessed and adjusted to meet standard

2. **Activity**
   - Practitioner network to determine how the network is meeting the needs and preferences of the plans membership will be measured and analyzed and adjusted as necessary. Each type of PCP and high volume specialist' geographic distribution performance will be measured against set standards
     1. Members within ten (10) miles or thirty (30) minutes of a practitioner
     2. Member within thirty (30) miles or forty0five (45) minutes of a high volume specialist

   - Practitioner network on the cultural, ethnic, racial and linguistic needs of membership will be measured and analyzed
   - Analyses performance against established quantifiable standards for the number of each type of high volume BH practitioners
   - Measure and analyze BH practitioner network to determine how the network is meeting the needs and preferences of the plans membership and adjusts as necessary.
   - Measured through quantifiable and measurable standards for each type of BH practitioner by geographic distribution performance against standards
   - Member within thirty (30) miles or forty-five (45) minutes of a high volume specialist

   - Availability of practitioners against goals will be measured and analyzed and adjusted as necessary
     1. Practitioner to Member
     2. Ratio of PCP to Members
     3. Ratio Specialists to Members (Neurology 1:10,000)

3. **Goals**
   - 1:2,000
   - 1:2,000
   - 1:5,000
   - 95%
   - 90%
   - 1:100
   - 100%

Access & Availability
Owners: Marsha Choo, Manager, Quality Analytics; Dr. Donald Sharps, Medical Director, BHI

Monitoring	Assessments, Findings, Monitoring of Previous Issues		Next Steps	Target Completion
Q1	Standards 1. Practitioner to Member 2. Ratio of PCP to Members: 3. Ratio Specialists to Members (Neurology 1:10,000): 4. Ratio of BH Specialist to Members: 5. Distance of PCP to Member 6. Distance of Specialist to Member 7. Distance of BH Specialist to Member 8. Ratio of PCP to Members (C&L) *Data pulled as of 10/1/2015 (trending four quarters)	MC OC OCC 1. Met Met Met 2. Met Met Met 3. Met Met Met 4. Met Met Met 5. Met Met Met 6. Met Met Met 7. Met Met Met 8. Met for all areas	• Plan level results were presented at the HN Quality Forum and the HN Forum • HNs were sent their HN specific reports • GG.1600 Access and Availability Policy Updated for June PRC • MA.7007 Access and Availability Policy to be updated for July PRC • Educate CCN providers of the Access Standards at the CCN Lunch and Learn • Access and Availability will report up to the Member Experience Steering Committee • Corrective Action Plans will be issued to HN for their areas of non-compliance Continue to monitor and ensure Access and Availability standards are being adhered to.	• May 2016 • May 2016 • June 2016 • June 2016 • June 2016 • July 2016 • TBD
Q2	Standards 1. Practitioner to Member 2. Ratio of PCP to Members: 3. Ratio Specialists to Members (Neurology 1:10,000): 4. Ratio of BH Specialist to Members: 5. Distance of PCP to Member 6. Distance of Specialist to Member	MC OC OCC 1. Met Met Met 2. Met Met Met 3. Met Met Met 4. Met Met Met 5. Met Met Met 6. Met Met Met	• Update OneCare/OneCare Connect Access and Availability Policy for August 2016 PRC • Expand the scope of the Access and Availability Work Team to include access to other services that may include but are not limited to LTSS, transportation, VSP, etc. • Review and trend grievances and appeals for access • Continue to identify barriers and interventions to improve access • Corrective Action Plans will be issued to HN for their areas of non-compliance Continue to monitor and ensure Access and Availability	• August 2016 • Sept 2016 • Oct 2016 • On-going • TBD

	7. Distance of BH Specialist to Member 8. Ratio of PCP to Members (C&L) *Data pulled as of 7/1/2016	7. Met Met Met Met for all areas	standards are being adhered to.	
Q3	Standards 1. Practitioner to Member 2. Ratio of PCP to Members: 3. Ratio Specialists to Members (Neurology 1:10,000): 4. Ratio of BH Specialist to Members: 5. Distance of PCP to Member 6. Distance of Specialist to Member 7. Distance of BH Specialist to Member 8. Ratio of PCP to Members (C&L) *Data pulled as of 10/1/2016	MC OC OCC 1. Met Met Met 2. Met Met Met 3. Met Met Met 4. Met Met Met 5. Met Met Met 6. Met Met Met 7. Met Met Met 8. Met Met Met Met for all areas	• Update all access and availability policies to clearly indicate a minimum performance level and develop a more strategic method to CAP our HNs on access. • Expand the scope of the Access and Availability Work Team to include access to other services that may include but are not limited to LTSS, transportation, VSP, etc. • Review and trend grievances and appeals for access • Continue to identify barriers and interventions to improve access • Corrective Action Plans will be issued to HN for their areas of non-compliance • Updated the prior authorization list to improve administrative burden to providers and improve authorization timeliness (authorization that were not denied were removed from the list) Continue to monitor and ensure Access and Availability standards are being adhered to.	• December 2016 • On-going • On-going • On-going • December 2016 • October 2016
Q4	Standards 1. Practitioner to Member 2. Ratio of PCP to Members: 3. Ratio Specialists to Members (Neurology 1:10,000): 4. Ratio of BH Specialist to Members: 5. Distance of PCP to Member	MC OC OCC 1. Met Met Met 2. Met Met Met 3. Met Met Met 4. Met Met Met 5. Met Met Met	• Update access and availability policy on the following areas: corrective action plans, high volume specialists, high impact specialists, data collection methodology for health delivery organizations	• Quarter 1 2017

	6. Distance of Specialist to Member 7. Distance of BH Specialist to Member 8. Ratio of PCP to Members (C&L) *Data pulled as of 1/1/2017	6. Met Met Met 7. Met Met Met 8. Met Met Met Met for all areas		
Year End	CalOptima has developed and implemented several initiatives to improve appointment availability. The efforts identified to support the improvement include: 1. Provider Relations staff continue to recruit high volume and high impact specialists 2. Issue Corrective Action Plans to health networks who are not in compliance with availability standards		Continue efforts to better monitor and improve appointment availability. 1. Issue corrective action plans or equivalent to health networks who are not compliance with accessibility standards in 2016 2. Continued efforts in health network, member and provider education of standards. 3. Development of workgroups to focus on specific areas of appointment availability 4. Continue efforts from Provider Relations staff to recruit in-demand specialists.	
Outcomes	**Results / Metrics**		**Next Steps**	**Target Completion**
Q1	Standards 1. Practitioner to Member 2. Ratio of PCP to Members 3. Ratio Specialists to Members 4. Ratio of BH Specialist to Members: Data for Q1 2016 a. Non-prescribers to Member Ratio b. Prescribers to Member Ratio c. Doctoral to Member Ratio	MC OC OCC 1. 1:108 2:1 1:3 2. 1:298 1:1 1:10 3. 1:166 1:1 1:5 4. BH Ratio (Beacon) a. 1:982 b. 1:4847 c. 1:2813	• Data run and the following were include/updated ○ Included OCC Providers ○ High Volume Specialties are included for monitoring: ▪ MC: OB/GYN, Orthopedic Surgery, Gastroenterology, Cardiology, Ophthalmology, Dermatology ▪ OC: Orthopedic Surgery, Neurology, Podiatry, Cardiology, Ophthalmology Timely Access Study now includes the following high impact specialties: Oncology, Nephrology and Endocrinology	• Data run quarterly

	5. Distance of PCP to Member 6. Distance of Specialist to Member 7. Distance of BH Specialist to Member a. Non-prescribers to Member Ratio: b. Prescribers to Member Ratio: c. Doctoral to Member Ratio: *Data for Q1 2016 8. Ratio of PCP to Members (C&L): a. Male PCP to Male Member Ratio: b. Female PCP to Female Member Ratio: c. Spanish PCP to Spanish Member Ratio: d. Vietnamese PCP to Vietnamese Member Ratio: e. Farsi PCP to Farsi Member Ratio: f. Korean PCP to Korean Member Ratio: *Data pulled 4/1/2016 Data pulled as of 4/1/2016 unless otherwise identified	5. 100.0% 100% 100% 6. 100.0% 100% 100% 7. BH Distance (Beacon) a. 100.0% b. 100.0% c. 99.9% 8. C&L Ratio a. 1:75 3:1 1:2 b. 1:183 1:1 1:6 c. 1:108 6:1 1:3 d. 1:119 5:1 1:6 e. 1:17 23:1 1:1 f. 1:38 35:1 1:1		
Q2	Standards 1. Practitioner to Member 2. Ratio of PCP to Members	MC OC OCC 1. 1:110 2:1 1:3 2. 1:300 1:1 1:10	• Update format for Access and Availability reporting	• Sept 2016

	3. Ratio Specialists to Members 4. Ratio of BH Specialist to Members: Data for Q1 2016 a. Psychiatrist b. Psychologist c. LCSW d. MFT e. Non-prescriber (Beacon) 5. Distance of PCP to Member 6. Distance of Specialist to Member 7. Distance of BH Specialist to Member a. Psychiatrist b. Psychologist c. LCSW d. MFT e. Non-prescriber *Data for Q1 2016 8. Ratio of PCP to Members (C&L): a. Male PCP to Male Member Ratio: b. Female PCP to Female Member Ratio: c. Spanish PCP to	3. 1:170 1:1 1:5 4. BH Ratio a. 1:2878 1:62 1:996 b. 1:2548 1:107 1:1,721 c. N/A 1:65 1:1,052 d. N/A 1:90 1:1456 e. 1:846 N/A N/A 5. 100.0% 100% 100% 6. 100.0% 100% 100% 7. BH Distance a. 100.0% 100% 100% b. 100.0% 100% 100% c. 100.0% 100% 100% d. 100.0% 100% 100% e. 100.0% N/A N/A 8. C&L Ratio a. 1:77 1:2 1:2 b. 1:188 1:7 1:7 c. 1:112 1:3 1:3		

	Spanish Member Ratio: d. Vietnamese PCP to Vietnamese Member Ratio: e. Farsi PCP to Farsi Member Ratio: f. Korean PCP to Korean Member Ratio: *Data pulled 7/1/2016 Data pulled as of 7/1/2016 unless otherwise identified	d. 1:119 1:6 1:6 e. 1:18 1:2 1:2 f. 1:40 1:1 1:1		
Q3	Standards 1. Practitioner to Member 2. Ratio of PCP to Members/Min # of PCP 3. Ratio Specialists to Members//Min # of Specialist 4. Ratio of BH Specialist to Members: Data for Q1 2016 a. Psychiatrist b. Psychologist c. LCSW d. MFT 5. Distance of PCP to Member 6. Distance of Specialist to Member 7. Distance of BH Specialist to Member	MC OC OCC 1. 6,170 2,652 5,468 2. 1,437 1,029 1,144 3. 4,942 1,708 4,559 4. BH Ratio a. 123 43 54 b. 202 25 25 c. 117 26 26 d. 278 19 19 5. 100% 100% 100% 6. 100% 100% 100.0% 7. BH Distance	• Update format for Access and Availability reporting (convert the ratio standards to min number of providers to be aligned with HSD summary tables). • Purchase an additional license for GeoAccess to cross train a data analyst in Quality Analytics to run the availability reports.	• October 2016 • December 2016

	a. Psychiatrist b. Psychologist c. LCSW d. MFT 8. Ratio of PCP to Members (C&L): a. Male Provider to Male Member Ratio: b. Female Provider to Female Member Ratio: c. Spanish Provider to Spanish Member Ratio: d. Vietnamese Provider to Vietnamese Member Ratio: e. Farsi Provider to Farsi Member Ratio: f. Korean Provider to Korean Member Ratio: g. Chinese Provider to Chinese Member Ratio: h. Arabic Provider to Arabic Member Ratio: *Data pulled 10/1/2016 Data pulled as of 10/1/2016 unless otherwise identified	a. 100% 100% 98.9% b. 100% 100% 100% c. 100% 100% 100% d. 100% 100% 100% 8. C&L Ratio a. 4,203 1,844 3,777 b. 1,948 778 1,619 c. 1,840 1,006 1,662 d. 496 329 460 e. 281 180 261 f. 195 98 187 g. 155 N/A N/A h. 188 N/A N/A		
Q4	Standards (in number of providers) 1. Practitioner to Member 2. Ratio of PCP to Members/Min # of PCP	MC OC OCC 1. 4977 2612 4418 2. 1423 1018 1134	• Initiated efforts to purchase GeoAccess Software • Purchase an additional license for GeoAccess to cross train a data analyst in Quality Analytics to run the availability reports.	• December 2016 • Quarter 1 2017

	3. Ratio Specialists to Members//Min # of Specialist 4. Ratio of BH Specialist to Members: Data for Q1 2016 a. Psychiatrist b. Psychologist c. LCSW d. MFT 5. Distance of PCP to Member 6. Distance of Specialist to Member 7. Distance of BH Specialist to Member a. Psychiatrist b. Psychologist c. LCSW d. MFT 8. Ratio of PCP to Members (C&L): a. Male Provider to Male Member Ratio: b. Female Provider to Female Member Ratio: c. Spanish Provider to Spanish Member Ratio: d. Vietnamese Provider to Vietnamese Member Ratio:	3. 5050 1696 4614 4. BH Ratio a. 148 140 182 b. 172 304 327 c. 107 139 146 d. 223 8 10 5. 100% 100% 100% 6. 100% 100% 100% 7. BH Distance a. 100% 100% 100% b. 100% 100% 100% c. 100% 100% 100% d. 100% 100% 100% 8. C&L Ratio a. 6923 3658 6319 b. 3186 1584 2639 c. 2002 930 1668 d. 537 321 461	• Cross training of QA data analyst to run the availability data. • Efforts to better coordinate availability data.	

	e. Farsi Provider to Farsi Member Ratio: f. Korean Provider to Korean Member Ratio: g. Chinese Provider to Chinese Member Ratio: h. Arabic Provider to Arabic Member Ratio: *Data pulled 1/1/2017 Data pulled as of 1/1/2017 unless otherwise identified	e. 303 181 268 f. 221 100 192 g. 199 N/A N/A h. 162 N/A N/A		
Year End	For 2016, CalOptima met all of the availability standards in the QI Work Plan. Scores were consistent across all lines of business. The following areas are areas of focus for 2017: high volume and high impact specialists		Continue to explore better ways to collect data to monitor to availability, focusing on high volume and high impact specialists. Pull annual data to update high volume and high impact specialists. Train Quality Analytics Analyst on GeoAccess Software to enhance monitoring and analysis of availability data.	On-going

VII. Patient Safety

A. *Safety of Clinical Care-Providers shall have timely and complete facility site reviews

Owner: Esther Okajima, Director, QI

The Approach

1. **Objective**
   - To assure all new and recredentialed providers are compliant with FSR/MRR/PAR requirements
2. **Activity**
   - Facility Site Reviews (FSR), Medical Record reviews (MRR) and Physical Accessibility Reviews (PARs) are completed as part of initial & recredentialing cycles
3. **Goals**
   - 80%

Patient Safety
Owner: Esther Okajima, Director, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	Conducted Initial and Tri-annual FSR/MRR Conducted PARS with identified deficiencies.	PARS identified with deficiencies. Providing deficiencies to offices. Minor fixes are being pushed back because offices do not want to put out the funds to fix items costing anywhere from $50- $200.	
Q2	Continue to conduct Initial and Tri-Annual FSR/MRR for PCP's. Continue to conduct PARS for PCP's, and High Volume Specialist. Also identified that we need to include PARS information for anyone published in web directory.	Need to start collecting PARS data for ancillary service providers including hospitals for OCC providers published on web-directory. In the process of identifying complete list and developing a plan to collect the PARS data.	Ongoing
Q3	Continue conducting Initial and Tri-Annual FSR/MRR for PCP's. Also, continue to conduct PARS for PCP's and High Volume Specialist. Working on including PARS information for ancillary providers in the web directory per CMS requirement.	Working on improving data collection process for all FSR/MRR/PARS survey. Need to find ways to sync data in database with main enterprise system for accuracy of data source. Also, conducting training with health networks to describe CalOptima's process for completing FSR/MRR/PARS	Training by 10/31 Systems in 2017
Q4	Conduct Initial and Tri-Annual FSR/MRR and PARS per requirements. Less activity in Q4 due to number of work days which resulted in less site reviews as well as CAPS issued.	Continue to track productivity and completion rates. Work on follow-up with CAPS process to improve TAT when responses are low	3/31/17
Year End	Continue to conduct Initial and Tri-Annual reviews per requirements. Still looking at how to incorporate PARS information for ancillary providers in web directory.	Meet requirement for collecting PARS data for ancillary providers SPD/OCC, and publishing in web directory. Obtaining training for PARS reviewers for ancillary providers. Look at systems improvement for FSR/MRR/PARS to streamline processes.	3/31/17
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	***All CAPs completed – 100%*** FSRs – 60 ■ CAPS – 26 issued. 7 not due until April and May MRRs – 64 ■ CAPs – 83 issued*. 22 CAPs due in April and May PARS – 96 (PCPs and high volume SPD SCPs)	Continue to monitor CAPs and educate offices to stay compliant in between Surveys. Continue to work with offices and HNs to assist with OCC requirement to comply with OSHA and ADA requirements.	On-going

Q2	83 FSR/MRR Completed 70 PARS Completed for PCP's and High Volume Specialists 25 Critical Element CAPS issued, 96% closed within 10 day TAT 41 FSR CAPS issued, 95% closed within 45 Day TAT 39 MRR CAPS issued, 97% closed within 45 Day TAT	Continue to gather data to establish baseline and targets for completing FSR/MRR/PARS. Begin monitoring PARS for ancillary service providers.	Ongoing
Q3	86 FSR/MRRs Completed 132 PARS Completed for PCP's and High Volume Specialists 21 Critical Element CAPS issued, 85% closed within 10 day TAT 36 FSR CAPS issued, 89% closed within 45 day TAT 50 MRR CAPS issued, 72% closed within 45 day TAT	Need to follow-up with the TAT, especially MRR TAT at 72%. Conduct training with Health Network Relation and Provider Relation staff to improve TAT of CAPS issued.	12/31/2016
Q4	35 FSR/MRRs Completed 107 PARS completed for PCP's and High Volume Specialists 15 Critical Element CAPS issued, 87% closed within 10 day TAT 21 FSR CAPS issued, 90% closed within 45 day TAT 28 MRR CAPS issued, 93% closed within 45 day TAT	Working with staff on workflows and P&P regarding CAPS follow-up. Some of the issue is consistent follow-up with the office staff by each nurse. Will be reviewing process with staff in Q1	3/31/17
Year End	9% decrease in number of sites reviewed from 2015 to 2016. Highest activity quarter was Q3 in 2016. 99% of Initial and Periodic reviews achieved score above 80%, however CAPS were issued, and TAT responses from the offices were low	Continue to track and monitor number of sites completed with passing scores above 80%. Add tracking of the number of FSR/MRR/PARS due and number completed, on time. Also include number of panel closures affected by overdue CAPS	3/31/17

VII. Patient Safety

B. Timeliness of Clinical care-review and follow-up on Potential Quality of Care Issues Owner: Esther Okajima, Director, QI

The Approach

1. **Objective**
   - To assure all PQI's are evaluated for severity and investigated within a 90 day turn around time 90% of the time.

2. **Activity**
   - QI Nurse Specialists and Med Directors review cases and provide determination.
   - Report to CPRC for discussion, any cases that exceed the threshold level of 2.
   - Follow through on Medical Director determination, when applicable to ensure closure and compliance of all cases.

3. **Goals**
   - To achieve a turnaround time of 90 day on 90% of case received.
   - Assure patient safety and enhance patient experience by timeliness of Clinical care reviews

Patient Safety
Owner: Esther Okajima, Director, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	Average of 95 cases reported to QI Averaging 154 cases closed by 6 nurses which average out to 42 cases closed per nurse. In January set initial goal to 20 files per month. Upped the goal to 30 in March. This was met by all but one nurse in March. PQI nurses were assigned case loads according to aging. The more experienced nurses are tackling the 2015 and older cases. Three nurses were assigned a month starting with January. Severity 3 & 4 – Identified.	Continue to assess all cases received for QOC issues. Cases to be reported at May CPRC	On-going
Q2	Average of 87 cases reported to QI Due to the backlog of aging PQI cases, metrics for each nurse increased from 20 files (closure of case) per month to 30 files per month in March of 2016. The more experienced nurses continued to work the 2014 and 2015 cases). Three nurses were assigned a month starting with January. Plan: Decrease Backlog, increase TAT and improve monitoring of member's outcome. Training provided for staff development.	Continue to assess all cases received for QOC issues. Continue to assess all cases for TAT_ goal: close cases within 90 days.	On-going On-going
Q3	▪ Average of 75 cases reported to QI Department (monthly). ▪ Slight decreased in cases compared to the Q2 related to transition to GC July 1, 2016. Average number of case reviewed/closed per month/ 100	Continue to assess all cases received for QOC issues. Monthly meeting us GARS to ensure proper transition of Clone cases. Continue to training Nursing Staff /provide support in GC process Continue to closely monitor cases for 90 days TAT for	Ongoing

	82% of cases met 90-day TAT (Q2 31%) ▪ At present time – 8 cases >90 days (TAT) ▪ Average of 75 cases reported to QI Department (monthly) ▪ Average number of cases reviewed/closed per month (3nd quarter) 100 ▪ 82% of cases met 90-day TAT (increase from Q2_31%) ▪ At present time – 8 cases >90 days (TAT) ▪ No backlog -8 aging PQI cases. Total of 8 old cases (old cases are pending CAP, CPRC). ▪ 3 cases 2015 ▪ 5 cases 2016 All cases have been reviewed by MD_ pending CAP and or CPRC	closure. Continue to monitor all cases for TAT_goal: close cases within 90 days. Close remaining 8 cases Continue to assess all cases received for QOC issues Continue to monitor all cases for TAT_goal: close cases within 90 days. Continue to training Nursing Staff/ provide support Continue to monitoring TAT to meet the 90 days. TAT is at 82% in the 3rd Q. Plan: 90% for Q4 Closure of all 2015 cases	Ongoing Dec 2016 Ongoing Dec 2016 and Ongoing Ongoing
Q4	Average of 78 cases reported to QI Department per month (4th quarter). This is a slight increase over Q3 from 75. At present time – 6 cases >90 days (TAT) Average of 67 of cases reviewed/closed per month (4th quarter) This is a reduction from the Q3 (100). The reduction is related to an open nurse reviewer position. 100% of cases met 90-day TAT (improvement from Q3 at 82%) No backlog -8 aging PQI cases. Total of 8 old cases (old cases are pending CAP, CPRC).	Continue to assess all cases received for QOC issues. Monthly meeting with GARS to ensure proper transition of Clone cases. Continue to train Nursing Staff /provide support in GC process Continue to closely monitor cases for 90 days TAT for closure. Continue to monitor all cases for TAT goal: close cases Continue to assess all cases received for QOC issues within	Ongoing

	All cases have been reviewed by MD, pending CAP and or CPRC	90 days. Close remaining 8 cases	 Q1 2017
Year End	Average of 66 cases reported to QI Department per month. At present time – 6 open cases >90 days (TAT) Average of 105 of cases reviewed/closed per month 48% of cases met 90-day TAT. Many of the cases closed in 2016 were a layover from 2015. No backlog -8 aging PQI cases. Total of 8 old cases (old cases are pending CAP, CPRC). All cases have been reviewed by MD, pending CAP and or CPRC	Continue to assess all cases received for QOC issues. Monthly meeting with GARS to ensure proper transition of Clone cases. Continue to train Nursing Staff /provide support in GC process Continue to closely monitor cases for 90 days TAT for closure. Continue to monitor all cases for TAT goal: close cases within 90 days. Continue to assess all cases received for QOC issues Closure of all 2016 cases	Q1 2017
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	**<u>462 cases closed -</u> 19% met 90 day TAT.** **<u>Number closed as of 3/31/2016</u>** **January – 28%** **February – 25%** **March – 16%** **<u>Nurse Productivity per nurse</u>** EI – 48 GP – 92 CL – 78 WY – 64 MB – 80 NN – 76	It has been discovered the system is counting holidays and weekends. Will work with Data Analyst to adjust. Continue to support staff with meeting goal Counsel nurse not meeting goal	 On-going 4/30/2016

	Leveling Severity 3 – 6 (1.3%) Severity 4 - 0	Report at May CPRC	May 19, 2016
Q2	**Cases closed in Qtr 2: 496** **Average Cases reviewed/closed per month: 165** **90-day TAT met: 31%** **TAT Increase from Qtr 1: 12%** ➢ **At the present time 19 cases >90 days** **QI Department is transitioning from their Master Profiling Database to Guiding Care Database. This will allow the QI Department to be on the same system as the GARS Dept, Case Management and Disease Management; enabling better access to needed clinical records.** **Leveling** Severity 3 – 6 (1.2%) Severity 4 – 2 (0.4%)	Continue to improve overall TAT Guiding Care Database should correct the above issue/problem with the system counting holidays and weekends	On-going August 31
Q3	**PQI Cases** 227-Cases Opened 302-Cases Closed 82% met 90 day TAT (Q2_31%) Goal 90% **Critical Incidents** CBAS- 1 Nursing Facilities- 1 IHSS- 0 MSSP- 0 **Total Cases opened per month** • July: 69 cases • August: 84 cases • September: 74 cases **Total Cases Closed per month** • July: 92 cases • August: 115 cases • September: 95 cases **Total of 302 cases closed Q3** • 248 (82%) cases closed at 90 days or less • 31 (10%) cases closed between 91-120 days • 12 (4%) cases closed between 121-170 days • 11 (306%) cases closed over 180 days **Leveling**	**Reported to CPRC – July and September 2016**	Ongoing

	Severity 3 – 4 (1.3%) Severity 4 – 4 (1.3%)		
Q4	**PQI Cases** 236 Cases Opened 129-Cases Closed 100% met 90 day TAT; Goal 90% **Critical Incidents** CBAS- 2 IHSS – 0 – Reported to the State. Nursing Facilities- 0 MSSP- 2 **Total Cases Closed per month** • October: 71 cases • November: 63 cases • December: 57 cases **Total of 191 cases closed Q4** • 191 (100%) cases closed at 90 days or less • 0 (0%) cases closed between 91-120 days • 0 (0%) cases closed between 121-180 days • 0 (0%) cases closed over 180 days **Leveling** Severity 3 – 0 (0.0%) Severity 4 – 1 (0.8%)	Reported to CPRC in November and December 2016	On-going
Year End	**PQI Cases** 789 Cases Opened 1256-Cases Closed 100% met 90 day TAT; Goal 90% **Critical Incidents** CBAS- 3 IHSS – 0 – Reported to the State Nursing Facilities- 1 MSSP- 11 **Total of 1256 cases closed** • 587 (47%) cases closed at 90 days or less	To be reported as part of the Annual Evaluation	Q1 2017

	• 122 (10%) cases closed between 91-120 days • 98 (8%) cases closed between 121-180 days • 449 (36%) cases closed over 180 days **Leveling** Severity 3 – 11 (8.8%) Severity 4 – 2 (0.2%)		

VII. Patient Safety

C. *Safety of Clinical Care and Quality of Clinical Care reviewed through Pharmacy Management

Owner: Kris Gericke, PharmD, Director, Pharmacy Management

The Approach

1. **Objective**
   - To promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima Members.

2. **Activity**
   - Review and update the CalOptima Plan Formularies on an ongoing basis in order to ensure access to quality pharmaceutical care which is consistent with the program's scope of benefits
   - Review anticipated and actual utilization trends including specialty medications
   - Review and evaluate pharmacy-related issues related to delivery of health care to CalOptima's members
   - Report on medication recalls and process for informing members and providers
   - Report on Underutilization of Asthmatics not receiving long term controllers, Diabetics not receiving statins, Diabetics with Hypertension not receiving ACE/ARB
   - Overutilization/PolyPharmacy-Report on interventions for preventing opioid overuse to include Pharmacy home, Monthly RX limit, Opioid overutilization (MED over 120mg.)

3. **Goals**
   - Four stars or better for adherence measures, reductions in underutilization and overutilization measures

Patient Safety
Owner: Kris Gericke, PharmD, Director, Pharmacy Management

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	Underutilization • Asthmatics not receiving long term controllers • Bisphosphonates without calcium • Diabetics with hypertension not receiving ACE/ARB Overutilization • Pharmacy Home • Rx limit	Report on diabetics not receiving statins	June
Q2	Underutilization • Asthmatics not receiving long term controllers • Bisphosphonates without calcium • Diabetics with hypertension not receiving ACE/ARB • Statin use in persons with diabetes (SUPD) Overutilization • Pharmacy Home • Rx limit		September
Q3	Underutilization • Asthmatics not receiving long term controllers • Bisphosphonates without calcium • Diabetics with hypertension not receiving ACE/ARB • Statin use in persons with diabetes (SUPD) Overutilization • Opioid formulary changes • Prescriber Restriction Policy	Report on opioid utilization	October
Q4	Underutilization • Asthmatics not receiving long term controllers • Bisphosphonates without calcium • Diabetics with hypertension not receiving ACE/ARB • Statin use in persons with diabetes (SUPD) Overutilization • Opioid utilization • Pharmacy Home	Continue over/underutilization interventions	December

Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	Underutilization • Asthmatics not receiving long term controllers decreased 21.7% from 3Q15 to 4Q15 • Bisphosphonates without calcium decreased 48.0% from 3Q15 to 4Q15 • Diabetics with hypertension not receiving ACE/ARB decreased 15.4% from 3Q15 to 4Q15 Overutilization • Pharmacy Home members increased 6.7% from 3Q15 to 4Q15 • Rx limit exemption 32/39 requests in 4Q15	Report on diabetics not receiving statins. Underutilization of Bisphosphonates without calcium is being monitored and will be reported in 3Q	June
Q2	Underutilization For 1Q16, there was a slight increase of ~8.5% in potential under-utilization of pharmaceuticals for diabetics with hypertension without an ACE/ARB, and bisphosphonate without calcium, as compared to 4Q15. In the other two categories, there was a slight decrease of potential under-utilization by 8.5% for prednisone without a bisphosphonate and a decrease by 12.8% for asthmatics not receiving a long-term controller. Statin use in persons with diabetes (Jan-Jun 2016): OneCare: 65% OneCare Connect: 71% MA-PD Average: 73% Overutilization • Pharmacy Home members decreased 22.6% from 4Q15 to 1Q16 • Rx limit exemption 13/13 requests in 1Q16	Opioid utilization reviewed at August P&T Committee	September
Q3	Underutilization For 3Q16, there was a slight decrease in potential under-utilization of pharmaceuticals for diabetics with hypertension without an ACE/ARB (3.1/K to 2.9/K), and no change in	Continue over/underutilization interventions	February

	bisphosphonates without calcium (2.0/K), as compared to 2Q16. In the other two categories, there was a slight decrease in potential under-utilization for prednisone without a bisphosphonate (1.7/K to 1.6/K) and no change for asthmatics not receiving a long-term controller (0.1/K), as compared to 2Q16. Statin use in persons with diabetes (Jan-Sep 2016): OneCare: 69.8% OneCare Connect: 73.2% MA-PD Average: 75.6% Overutilization P&T Committee Opioid Overutilization Interventions Formulary changes 1. Cumulative morphine equivalent dose (MED) point-of-sale (POS) pharmacy edits 2. Restrictions for drugs with the highest risk of overdose a. Methadone: Add PA new starts for methadone doses above 30mg/day b. High-potency and extended-release opioids: Add PA new starts for MS Contin 100mg, 200mg 3. Concurrent use of opioids and buprenorphine edits: Initiate soft edit to reject opioid claims when there are recent fills (within 30 days) of buprenorphine products. Medi-Cal Prescriber Restriction Program Policy Resident Projects • Top opioid prescribers report cards • Prescriber detailing to decrease the use of narcotic-containing cough medications		
Q4	Underutilization For 4Q16, there were slight increases in potential under-utilization of pharmaceuticals for diabetics with hypertension without an ACE/ARB (2.9/K to 3.0/K), and bisphosphonates without calcium (1.9/K to 2.0/K), as compared to 3Q16. There was no change in potential under-utilization for prednisone without a bisphosphonate (1.6/K). Statin use in persons with diabetes (Jan-Nov 2016):	Continue over/underutilization interventions	

	OneCare: 70.6% OneCare Connect: 74.5% MA-PD Average: 76.4% Overutilization Medi-Cal Prescriber Restriction Program Policy to start in February 2017. Resident Projects • Top MED opioid prescribers report cards: o 15 prescribers identified o 757 opioid RX's o 17/30 questionnaires received as of 1-12-17 • Prescriber detailing to decrease the use of narcotic-containing cough medications: o Medication reviews were performed for 177 members o As of 1-12-17, 101/177 members had not received additional Rx fills		
Year End	For CY16 compared with 4Q15, there were no significant changes in potential under-utilization of pharmaceuticals for diabetics with hypertension without an ACE/ARB (3.0/K vs. 2.9/K), and bisphosphonates without calcium (1.8/K to 1.9/K). There was a decrease in potential under-utilization for prednisone without a bisphosphonate (CY16:1.6/K vs. 4Q15: 1.9/K). Asthma medication adherence will be reported with HEDIS results in 2017. Statin use in persons with diabetes year-end results is not yet available. As of January 1, 2017, there are 1,022 members in the Pharmacy Home program (average of 85/month). Prescriber Restriction policy starts February 2017. .		

VII. Patient Safety

D. *Safety of Clinical Care and Quality of Clinical Care- Review of Specialty Drug Utilization

Owner: Kris Gericke, PharmD, Director, Pharmacy Services

The Approach

1. **Objective**
   - Provide ongoing monitoring of specialty drug trends

2. **Activity**
   - Review and reporting of Specialty Drug trends, identify any actions necessary with the member or provider/HN

3. **Goals**
   - Favorable kick payments for Medi-Cal

Patient Safety
Owner: Kris Gericke, Director, Pharmacy Services

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	• Updated Hepatitis C prior authorization guidelines for new medications (Daklinza, Zepatier) • Hepatitis C drug utilization monitoring • Physician-administered drug utilization	DHCS updated kick payment file reporting June 2016	June
Q2	• Updated Hepatitis C prior authorization guidelines for new medication (Epclusa) • Hepatitis C drug utilization monitoring • Physician-administered drug utilization	Opioid guidelines/formulary changes	August
Q3	• Hepatitis C drug utilization monitoring	Updated Hepatitis C prior authorization guidelines for new medication (Epclusa) to be reviewed at November P&T Committee	November
Q4	• Hepatitis C drug utilization monitoring	Continue promoting cost-effective agents first-line	December
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	• Hepatitis C drug kick payments from DHCS favorable • Physician-administered drug utilization pending UM Committee review	UM Committee May 2016 P&T Committee May 2016	June
Q2	• Hepatitis C drug kick payments from DHCS favorable • Hepatitis C specialty drug utilization decreased 23% from January to June 2016	P&T Committee August 2016	August

Q3	• Hepatitis C drug utilization monitoring
	  ○ Utilization increased 81% from 2Q to 3Q.
	  ○ The cost per utilizing member decreased 22% due to increased utilization of Epclusa and Zepatier.
		P&T Committee November 2016	

Q4	• Hepatitis C drug utilization monitoring ○ Utilization remained unchanged from 3Q to 4Q.	Continue promoting cost-effective agents first-line	December
Year End	• Hepatitis C drug utilization monitoring CY15 vs. CY16 ○ The number of utilizing members increased from 411 to 439, 0.5% increase/K members. ○ The average cost per Rx decreased 8% due to increased utilization of Epclusa and Zepatier.		

VII. Patient Safety

E. *Patient Safety-Review and assessment of CBAS Quality Monitoring

Owner: Esther Okajima, Director, QI

The Approach

1. **Objective**
   - Review of CBAS Quality monitoring of services provided

2. **Activity**
   - CBAS Quality Assurance-continue to assess compliance of contracted CBAS centers.
   - Report to LTSS QIC
   - Report Member Satisfaction Survey Results
   - Report CDA audit results in comparison to past results

3. **Goals**
   - 100% CDA Audit Results

F. Patient Safety-Review and assessment of SNF Quality Monitoring

Owner: Esther Okajima, Director, QI

The Approach

1. **Objective**
   - Review of SNF Quality monitoring of services provided

2. **Activity**
   - SNF Quality Assurance-continue to assess compliance of contracted SNF centers.
   - Report to LTSS QIC
   - Report on progress of on-site visits and CAPs issued
   - Report on Member Satisfaction Survey Results

3. **Goals**
   - 100% DHCS Audit results

Patient Safety-Review and Assessment of CBAS Quality Monitoring
Owner: Esther Okajima, Director, QI

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	CBAS Member Satisfaction Survey results reported at 3/21/2016 LTSS QIC.		
Q2	CBAS Satisfaction Survey results: revealed the need for improvement in areas of: 1. Cleanliness 2. Meals 3. Transportation 4. Voicing complaints **2015 CBAS** most frequent cited findings: Failure to provide evidence related to services provided as specified in care plan/failure to communication with PCP related to participant's status as noted in the care plan.	In-service CBAS staff regarding satisfaction survey results. Reach out to separate transportation company, change caterer, offer alternate meal options, review cleaning schedule with staff and janitorial company, and implement complaint box and reminder to participants of open door policy. 1. Issue Corrective Action Plans, 2. In-service and staff training 3. Regrouping of MDT meetings	Dec. 2016
Q3	2016 CBAS most frequent cited findings: Multi Disciplinary Team needs to assess participant needs and ensure these needs are included in plan of care; fail to provide evidence of services provided as specified in care plan; fail to provide liaison with PCP related to participant status; time documentation needed for as needed medications administered at CBAS CBAS # of Corrective Action Plans issued and date responses received back: Alzheimer's: 3 – 5/10/16 Anaheim VIP: 6 – 8/19/16 Commonwealth: 2 – 7/11/16 Cypress: 2 – 10/7/16 Evergreen: 2 – 9/6/16 Get Together: 6 – 8/19/16 Happy: 3 – 8/19/16 Home Avenue: 1 – 6/9/16	Issue Corrective Action Plans, In-service and staff training, regrouping of MDT meetings	Dec 2016

	Irvine: 4 – 6/24/16 Joy: 1 – 8/24/16 La Puente: 1 – 8/26/16 RIO Fullerton: 3 – 4/7/16 RIO Orange: 2 – 5/17/16 RIO San Clemente: 4 – 7/14/16 Santa Ana/Tustin: 3 – 6/10/16 Sarang: 1 – 8/22/16 South County: 2 – 10/20/16 Southern Ca Cares: 3 – 9/30/16 Spring: 3 – 5/25/16 Sultan: 3 – 6/29/16 Well & Fit: 3 – 5/20/16 Pending/Due date: ABC: 2 – 12/5/16 Acacia: 4 – 11/28/16 HMS: 4 – 11/28/16 Joyful: 1 – 12/1/16 New Life: 3 – 11/21/16 St Christopher: 1 – 11/21/16 Regent: 6 – 11/4/16 Whittier: 4 – 11/21/16		
Q4	2016 CBAS most frequent cited findings: Multi Disciplinary Team needs to assess participant needs and ensure these needs are included in plan of care; fail to provide evidence of services provided as specified in care plan; fail to provide liaison with PCP related to participant status; time documentation needed for as needed medications administered at CBAS CBAS, # of Corrective Action Plans issued, and date responses received back: ABC: 2 – 11/18/16 Acacia: 4 – 11/28/16 HMS: 4 – 11/16/16 Joyful: 1 – 11/16/16 New Life: 3 – 11/21/16 St Christopher: 1 – 11/17/16 Regent: 6 – 11/4/16 Whittier: 4 – 11/21/16	CBAS to conduct internal in-service/staff trainings and regroup their MDT meetings CBAS providers' participation encouraged for workshop held on-site at CalOptima 10/5/16 Forward 'closed' Corrective Action plans to Department of Aging Continue monitoring of CBAS Centers	Dec 2016

	Helping Hands No Deficiencies – visit on 12/14/16		
Year End	29 CAPs were issued to CBAS Centers in CY2016. All CBAS Centers have provided responses to the CAPs.	Continue to monitor the open CAPs.	Ongoing
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	Not reported		
Q2	CBAS: 2014 _Satisfaction Survey Average _95.88% 2015_ Satisfaction Survey Average _98% (increase 2.12%) 1. Better developed care plans 2. Improved flow sheets /progress notes 3. Items posted per regulatory requirements 4. Compliance with Federal Regulations and CalOptima-CBAS contract.	Collect Satisfaction Surveys for 2016 Continue annual & PRN monitoring of CBAS Centers	Dec. 2016
Q3	-Better developed care plans, improved flow sheets/progress notes, improved communication & care coordination with staff and Doctors, Compliance with Federal Regulations and CalOptima-CBAS contract	Continue Collecting from CBAS : Responses for Corrective Action Plans issued -Continue annual & as needed monitoring of CBAS Centers	Dec 2016
Q4	9 CBAS Centers responded to their CAP. One center was revisited and found to have no deficiencies.	Continue Collecting from CBAS : Responses for Corrective Action Plans issued -Continue annual & as needed monitoring of CBAS Centers	Dec. 2016

Year End	A total of 30 onsite visits of CBAS centers were conducted. 17 centers failed to provide evidence of services as specified in care plan; 19 centers failed to liaison with PCP related to participant status; - 7 centers failed to provide documentation needed for medications administration. The visits have resulted in better developed care plans, improved flow sheets/progress notes, improved communication & care coordination with staff and Doctors, Compliance with Federal Regulations and CalOptima-CBAS contract.	Continue monitoring CBAS Centers Continue to encourage multi-disciplinary team needs assessment of participant needs, and ensure their needs are included in plan of care Participation in trainings for New CBAS Individual Plan of Care - State regulated implementation TBD in 2017	2016 CAPs Completed and Closed.

Patient Safety- Review and Assessment of SNF Quality Monitoring
Owner: Esther Okajima, Director, QI

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	SNF		
Q2	SNF/LTC: 26 onsite visits conducted to validate facilities implementation of 2015 Plan of Corrections that were approved by California Department of Public Health Common findings: 1. Incomplete/inadequate documentation of Quality Improvement Committee meeting minutes to validate compliance with their plan of correction. 2. Failure to conduct all staff in-services as stated in their plan of correction, in-service sign-in sheets inconsistent in identifying staff title/dept. 3. Lack of organization of facility audit/monitoring forms/logs. SNF/LTC Member Satisfaction Survey	1. Issue Corrective Action Plans 2. Offer recommendations to: create Plan of Correction binders to house all audit/ monitoring logs/forms and in-services related to deficiencies, include each specific deficiency and status of audits/ monitoring (e.g. threshold met, continue monitoring, discontinue monitoring) in Quality Improvement Committee meeting minutes. 3. Complete all staff In-services as stated in their plan of correction and include staff title/dept on sign-in sheets. Admin Satisfaction Survey	Ongoing Dec 2016
Q3	Completed 2015 POC Reviews which included 3 previous years of Recertification surveys for each facility. Common findings: Incomplete/inadequate documentation of Quality Improvement Committee meeting minutes to validate compliance with their plan of correction, failure to conduct all staff in-services as stated in their plan of correction, in-service sign-in sheets inconsistent in identifying staff title/dept, lack of organization of facility audit/monitoring forms/logs.	Download 2016 Surveys from CMS website Review 2016 Survey Results and Plan of Correction to identify recurrent deficiencies from 2-3 previous surveys. Schedule onsite visits beginning in the 4th Qtr to validate implementation of SNF/LTC 2016 Plan of Correction. Distribution of Satisfaction Surveys	Ongoing
Q4	2016 POC (Plan of Correction) Reviews are in process which included 3 previous years of Recertification surveys for each	Download 2016 Surveys from CMS website Review 2016 Survey Results and Plan of Correction to	Ongoing

	facility. Common findings continue to include: 1. Incomplete/inadequate documentation of Quality Improvement Committee meeting minutes to validate compliance with their plan of correction 2. Failure to conduct all staff in-services as stated in their plan of correction 3. In-service sign-in sheets inconsistent in identifying staff title/dept 4. Lack of organization of facility audit/monitoring forms/logs Continue to monitor facilities for potential quality of care issues.	identify recurrent deficiencies from 2-3 previous surveys. Schedule onsite visits beginning in the 4th Qtr to validate implementation of SNF/LTC 2016 Plan of Correction	Ongoing Ongoing Completed 11/2016 Q1 2017
Year End	The results of the SNF monitoring activities will be reported as part of the annual evaluation.	The results of the SNF monitoring activities will be reported as part of the annual evaluation.	Q1 2017
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2	One (1) Correction Action Plan issued. Facility has corrected identified issue and provided evidence of completion. SNF/LTC: Member Satisfaction Surveys still in process of being developed/revised/updated.	Continue annual & PRN monitoring of contracted SNF/LTC's implementation of their Plan of Correction Issue Satisfaction Surveys Oct / Nov 2016	Ongoing Dec 2016
Q3	Recommendations given: Create Plan of Correction binders to house all audit/monitoring logs/forms and in-services related to deficiencies, include each specific deficiency and status of audits/monitoring (e.g. threshold met, continue monitoring, discontinue monitoring) in Quality Improvement Committee meeting minutes, complete all staff In-services as stated in their	Continue monitoring to evidence compliance with Plan of Correction	

	plan of correction and include staff title/dept on sign-in sheets.		
Q4	**Recommendations given:** ▪ Create Plan of Correction binders to house all audit/monitoring logs/forms and in-services related to deficiencies, include each specific deficiency and status of audits/monitoring (e.g. threshold met, continue monitoring/ discontinue monitoring) ▪ In Quality Improvement Committee meeting minutes, complete all staff In-services as stated in their plan of correction and include staff title/dept on sign-in **Common Findings**	Continue monitoring to evidence compliance with Plan of Correction	Ongoing
Year End	The year-end summary of SNF monitoring will be reported as part of the annual evaluation		March 2017

VII. Patient Safety

G. *Safety of Clinical Care-Review of antibiotic usage

Owner: Kelly Rex-Kimmet Dir of Quality Analytics

The Approach

1. **Objective**
   - Increase the appropriate testing for children with Pharyngitis rate
   - Appropriate treatment for children with upper respiratory infection (URI) to meet goals

2. **Goals**
   - 68.53%
   - 91.21%

Patient Safety
Owner: Kelly Rex-Kimmet, Director, QA

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion

Q1	• Pharyngitis Testing:
	  ○ HEDIS 2016 (MY 2015) final rate of 54.72% is 6.19% point higher than the HEDIS 2015 (MY 2014) HEDIS rate of 48.53%
	  ○ CWP did not meet the goal of 71.48% by 16.76% points
	• Appropriate Treatment for URI:
	  ○ HEDIS 2016 (MY 2015) final rate is 1.3% points higher than the 2015 HEDIS (MY 2014) rate of 91.55%
	  ○ URI did meet the goal of 92.50% by 0.35% points
		• To purchase Strep A Test Kits and distribute kits to provider who are high prescribers of antibiotics and have a high volume of patients (including urgent care facilitates)
		• Kits to be distributed with provider education on appropriate treatment of URI and dispensing of antibiotics
			Q3

Q2	**Pharyngitis Testing (CWP):** • Purchased 1600 Rapid Strep A Test kits (40,000 tests) • Implement kit distribution to providers **Appropriate Treatment for URI:** **URI Prospective Rates (Aug, 2016):** PR Rate= 93.21%; Goal: 92.51% On Track	• Outreach goal to high volume high performing and high volume and low volume Providers. Outreach to being in September and continue through flu season (Fall 2016-Winter 2017) • Send Provider Fax Blast promoting strep test usage during cold/flu season • Working with CMA on distributing the AWARE toolkit.	Q2 Q3 Q4 Q4
Q3	**Pharyngitis Testing (CWP):** • Purchased 1600 Rapid Strep A Test kits (40,000 tests) • Implement kit distribution to providers **Appropriate Treatment for URI:** • AWARE toolkit to be distributed to high volume providers	• Continue with distributing pharyngitis kits to provider offices • Work with CMA foundation to distribute AWARE toolkit to providers	Ongoing Q4, 2016
Q4	**Pharyngitis Testing (CWP):** • Distribute 1600 Rapid Strep A Test kits (40,000 tests)	• Continue with distributing pharyngitis kits to provider offices • Work with CMA foundation to distribute AWARE toolkit to	Ongoing

	• Implement kit distribution to providers **Appropriate Treatment for URI:** AWARE toolkit to be distributed to high volume providers	providers	Q4, 2016
Year End	The QI work teams continue efforts to implement interventions for the CWP and URI measures. Pharyngitis kits were distributed to Provider offices. The remaining kits will be distributed through Q1-2, 2017. The top high prescribing providers were sent an AWARE toolkit that addressed URIs.	• Continue with distributing pharyngitis kits to provider offices through Q1, 2017. • Evaluate the impact of the pharyngitis kits by Quarter 4, 2017.	
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	• Pharyngitis Testing Rate: 54.72%. Below 25th percentile • Appropriate Treatment for URI: 92.85%, 75th percentile. *Final HEDIS 2016 (MY 2015)	Conduct further data analysis on these measures to develop specific and targeted interventions.	Q3
Q2	**Pharyngitis Testing (CWP):** August 2016 PR = 48.87%, Goal: 62.98% **Appropriate Treatment for URI:** **URI Prospective Rates (Aug, 2016):** August 2016 PR = 93.21%; Goal: 92.51% **Goal Met**	• Outreach goal to high volume high performing and high volume and low volume Providers. Outreach to being in September and continue through flu season (Fall 2016-Winter 2017) • Send Provider Fax Blast promoting strep test usage during cold/flu season	Q3 Q4
Q3	**Pharyngitis Testing (CWP):** **October 2016 PR** = 49.07%, Goal: 62.98% **Appropriate Treatment for URI:** **October 2016 PR** = 93.18%; Goal: 92.51% **Goal Met**	• To date 960 kits (24,000) tests have been distributed to high volume high performing and high volume and low performing Provider since September 2017. • Distribute AWARE Toolkit to providers	Ongoing Q4 '16/Q1'17

Q4	**Pharyngitis Testing (CWP):** **November 2016 PR** = 49.08%, Goal: 62.98% **Appropriate Treatment for URI:** **November 2016 PR** = 93.18%; Goal: 92.51% **Goal Met**	• Distribute AWARE Toolkit to providers through Q1, 2017	Ongoing
Year End	• CWP Goal Status: Goal Not Met • URI Goal Status: Goal Met The CWP Prospective Rates (PR) are gradually increasing but have not met goal as of Nov, 2016. However, the URI Prospective Rates show that we have met the goal for this year.	• Continue with distributing pharyngitis kits to provider offices through Q1, 2017. • Evaluate the impact of the pharyngitis kits by Quarter 4, 2017. • Evaluate the URI measure and assess all	

VII. Patient Safety

H. Implementation of the new PBM

Owner: Kris Gericke, Dir of Pharmacy

The Approach

1. **Objective**
   - Provide ongoing monitoring of the implementation of the new PBM: quality of care, service, clinical metrics

2. **Activity**
   - Review and report on clinical and service metrics for Med Impact, as it relates to STARS, HEDIS, Quality of care, Quality of Service

3. **Goals**
   - Performance guarantees per the contract

Patient Safety
Owner: Kris Gericke, Director, Pharmacy

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	PBM Pharmacy/Provider call center monitoring	Will receive additional oversight reports next month	June
Q2	PBM Performance Guarantees reported	June reports pending	August
Q3	PBM Performance Guarantees reported	3Q16 reports pending	November
Q4	PBM Performance Guarantees reported	4Q16 reports pending	March
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	PBM Pharmacy/Provider call center monitoring: Met goals for 1Q16	Will receive additional oversight reports next month	June
Q2	PBM Performance Guarantees reported met goals for April/May 2016	June reports pending	August
Q3	PBM Performance Guarantees reported met goals for 2Q16	3Q16 reports pending	November
Q4	PBM Performance Guarantees reported met goals for 3Q16 except for resolution of eligibility file errors within 24 hours	4Q16 reports pending	March
Year End	PBM Performance Guarantees reported met goals for 4Q16		

VIII. Member Experience

A. Quality of Service-Review of Member Satisfaction

Owner: Kelly Rex-Kimmet, Director, Quality Analytics

The Approach

1. **Objective**
   - Annual review of member feedback (CAHPS, complaints & grievances); identification of areas for improvement

2. **Activity**
   - Identify key areas of concern and implement related activities to improve Member Experience (CAHPS)
   - Work in conjunction with the Health Networks and other Delegates to monitor and improve the Member Experience

3. **Goals**
   - Annual CAHPS results

Member Experience
Owner: Kelly Rex-Kimmet, Director, QA

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion

Q1	**MC Child Plan Level CAHPS MY 2014**
	
	• 0 areas are above the 90th percentile
	• 4 areas are below the 25th percentile
	  ○ Getting Needed Care: 82.4% (below the 25th percentile)
	  ○ Getting Care Quickly: 73.5% (below the 25th percentile)
	  ○ How Well Doctors Communicate: 88.2% (below the 25th percentile)
	  ○ Customer Service: 86.0% (below the 25th percentile)
	• 4 areas had a score increase from the previous year (four area had a decrease)
	  ○ Rating of health plan
	  ○ Getting needed care
	  ○ How well doctors communicate
	  ○ Customer service
	• 0 areas moved up in benchmark percentiles from the previous year (one had a decrease – Rating of personal doctor)
	
	MC Adult Plan Level CAHPS MY 2014
	
	• 0 areas are above the 90th percentile
	• 5 areas are below the 25th percentile
	  ○ Rating of All Health Care: 69.8% (below the 25th percentile)
	  ○ Specialist Seen Most Often: 76.2% (below the 25th percentile)
	  ○ Getting Needed Care:72.3% (below the 25th percentile)
	  ○ Getting Care Quickly: 65.3% (below the 25th percentile)
	  ○ Customer Service: 75.5% (below the 25th percentile)
	
	OC Adult Plan Level CAHPS MY 2014
	
	• 1 measures has 4 stars
		• Gather action plans on improving members experience from the health networks
		• Member experience scores were given greater weight (up from 25% to 40%) in our new proposed P4V program for the calendar year 2016
		• Evaluate member pain points
		• Customer service post call survey (addressing first call resolution)
		• Implement member education on referral and authorizations
		• Engage the PAC Ad Hoc Subcommittee on Member Experience
			Q2

	○ Annual flu vaccine • 6 measures has 2 stars ○ Getting needed care ○ Getting appointments and care quickly ○ Customer service ○ Getting needed prescription drugs ○ Rating of health plan ○ Rating of drug plan • 2 measures has 1 stars ○ Care coordination ○ Rating of health care quality		
Q2	**MC Child Plan Level CAHPS MY 2015** • 2 areas are at or above the 90th percentile • 4 areas are below the 25th percentile • 6 areas had an increase in score from the previous measurement year (one area had a decrease) • 3 areas moved up in benchmark percentiles **MC Adult Plan Level CAHPS MY 2015** • 0 areas are above the 90th percentile • 3 areas are below the 25th percentile • 6 areas had an increase in score from the previous measurement year (only one area had a decrease) • 4 areas moved up in benchmark percentiles (one area had a decrease) **OC Adult Plan Level CAHPS MY 2015** • 3 areas had an increase in rate from the previous MY year • 8 areas had an decrease in rate from the previous MY year	• Request for Information on Provider Coaching • Development of a member experience provider scorecard • Workgroup to address member experience on referral and authorization – update the prior authorization list • Explore ways to collaborate with the health networks on data collection on CG-CAHPS • Provide our health networks with a list of their contracted providers with low performance on the supplemental survey	Q3 Q4
Q3	Same as Q2 as the survey is fielded annually.	• Updated prior authorization list • Plan level results were presented to forums and committees • HN level survey summaries and reports shared with HNs at JOM or HN Quality Meetings • CAHPS results shared with providers in Provider Update (fax blast) with tips to improve member experience • CAHPS CCN results shared at the CCN Lunch and Learn	Quarter 3 and 4

		• Customer service post call survey • Customer service huddles and trainings	
Q4	CG-CAHPS Results available. No benchmarks available. Medi-Cal providers have lower scores than One Care Connect providers. Areas of focus: Getting Timely Appt., Care and Information and Coordination of Care	• Supplemental survey provider level results shared with individual providers • Explore how to share the CG-CAHPS results.	Quarter 1. 2017
Year End	For 2016, plan level CAHPS scores showed a general improvement from 2015 to 2016. Improvement was most evident in areas concerning performance from a personal doctor. Little improvement and lower performance can be seen in Getting Needed Need and Getting Care Quickly. **<u>Focus:</u>** 2017 Areas of Focus: Rating of Health Plan, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service. Areas of focus for CG-CAHPS: Getting Timely Appt., Care and Information and Coordination of Care	For 2017, CalOptima will focus on sharing practitioner level results to our health networks as well as to the practitioners. Results will come from the CalOptima Supplemental Survey and the CG-CAHPS survey. In addition, focus will be placed on supporting health networks and their physicians on coaching providers on how to better communicate with patients and improve overall member experience. Continue efforts on identifying member pain points through the analysis and trending of data and on developing initiatives to increase satisfaction.	On-going
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	**<u>MC Child Plan Level CAHPS MY 2014</u>** Rating of Health Care: 81.5% (50th percentile) Rating of Personal Doctor: 84.9% (25th percentile) Specialist Seen Most Often:86.8% Rating of Health Plan: 83.3% (25th percentile) Getting Needed Care: 82.4% (below the 25th percentile) Getting Care Quickly: 73.5% (below the 25th percentile) How Well Doctors Communicate: 88.2% (below the 25th percentile)	• Further analysis of the supplemental survey • Prepare for CG-CAHPS implementation	Q2

	Customer Service: 86.0% (below the 25th percentile) **MC Adult Plan Level CAHPS MY 2014** Rating of All Health Care: 69.8% (below the 25th percentile) Rating of Personal Doctor: 76.3% (25th percentile) Specialist Seen Most Often: 76.2% (below the 25th percentile) Rating of Program: 70.2% (25th percentile) Getting Needed Care:72.3% (below the 25th percentile) Getting Care Quickly: 65.3% (below the 25th percentile) How Well Doctors Communicate: 87.5% (25th percentile) Customer Service: 75.5% (below the 25th percentile) **OC Adult Plan Level CAHPS MY 2014** Rating of Health Care:70.4% Rating of Personal Doctor: 83.7% Specialist Seen Most Often: 74.0% Rating of Health Plan: 75.6% Rating of Drug Plan: 79.2% Getting Needed Care: 82.8% Getting Care Quickly: 67.8% How Well Doctors Communicate: 90.5% Customer Service: 73.8% Getting Needed Prescription Drugs: 89.1% Getting Information from Drug Plan: 75.8% Care Coordination: 79.8%		
Q2	**MC Child Plan Level CAHPS MY 2015** Rating of Health Care: 87.5% (90th percentile) Rating of Personal Doctor: 88.4% (90th percentile) Specialist Seen Most Often: N/A Rating of Program: 86.1% (75th percentile) Getting Needed Care: 77.6% (below the 25th percentile) Getting Care Quickly: 85.3% (below the 25th percentile) How Well Doctors Communicate: 91.2% (below the 25th percentile) Customer Service: 86.5% (below the 25th percentile) **MC Adult Plan Level CAHPS MY 2015**	• Plan level CAHPS results will be presented to the Member Experience Steering Committee Meeting • Implementation of CG-CAHPS and results will be available in Q4 2016. • Further analysis of the supplemental survey at the provider and clinical level • Explore how we can collaborate with the health networks on CG-CAHPS. • Plan level CAHPS results will be presented at the following groups/committees: Health Network Quality Forum, Health Network Forum, MAC and PAC, etc. • Group level CAHPS results will be presented to the Member Experience Steering Committee.	Q3 Q4

	Rating of Health Care: 71.7% (25th percentile) Rating of Personal Doctor: 77.9% (50th percentile) Specialist Seen Most Often: 78.5% (25th percentile) Rating of Program: 68.1% (below 25th percentile) Getting Needed Care: 75.9% (below the 25th percentile) Getting Care Quickly: 68.0% (below the 25th percentile) How Well Doctors Communicate: 91.1% (75th percentile) Customer Service: N/A **<u>OC Adult Plan Level CAHPS MY 2015</u>** Rating of Health Care: 61.7% Rating of Personal Doctor: 78.5% Specialist Seen Most Often: 73.9% Rating of Health Plan: 68.1% Rating of Drug Plan: 74.8% Getting Needed Care: 77.9% Getting Care Quickly: 66.4% How Well Doctors Communicate: 91.7% Customer Service: 77.6% Getting Needed Prescription Drugs: 86.4% Getting Information from Drug Plan: 66.4% Care Coordination: 81.5%	• Health network specific results will be presented to each health network either at the HN JOM or at the Quality Meetings.	
Q3	Same as Q2 as the survey is fielded annually.	• CG-CAHPS implementation • CG-CAHPS data analysis • CG-CAHPS presentation to committees and share with HNs	Quarter 3 Quarter 4 2016 and Quarter 1 2017
Q4	CG-CAHPS MC OCC Overall provider rating 62.7% 77.0% Getting Timely Appt, Care, Info 80.9% 86.8% How Well Drs. Communicate 87.9% 93.3% Providers' Use of Info to Coordinate Care 74.8% 81.0%	• CG-CAHPS results received • CG-CAHPS data analysis • CG-CAHPS presentation to the Member Experience Sub-Committee	Quarter 4 Quarter 1

	Helpful, Courteous and Respectful Staff 86.2% 92.7% • CG-CAHPS presentation to committees and external groups.		2017
Year End	**MC Child Plan Level CAHPS MY 2015** • 3 of 7 areas met the 50th percentile benchmark **MC Adult Plan Level CAHPS MY 2015** • 2 of the 7 areas met the 50th percentile benchmark **OC Adult Plan Level CAHPS MY 2015** • 3 areas had an increase in rate from the previous MY year • 8 areas had an decrease in rate from the previous MY year **CG-CAHPS MY 2016** First year of fielding CG-CAHPS. No benchmarks available. Medi-Cal providers have lower scores than One Care Connect providers.	Continued efforts to monitor member experience through our plan level, health network level and provider level member experience surveys. For 2017, we will not be fielding the Adults with Disability CAHPS survey at the health network level and will begin fielding the Adults CAHPS survey at the health network level.	On-going

VIII. Member Experience

B. *Quality of Service-Reviewed through customer service first call resolution

Owner: Belinda Abeyta, Director, Customer Service

The Approach

1. **Objective**
   - Gather data and information from members after interface with Customer Service to assure expectations/reason for call was resolved

2. **Activity**
   - Monitor port call information and determine key strategies to assure first call resolution/member satisfaction with customer service

3. **Goals**
   - 85% of calls resolved at first call

Member Experience
Owner: Belinda Abeyta, Director, Customer Service

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	1. Monitor of call center data to determine reason for call. 2. Determine if member previously call for the same reason/concern. 3. Determine top two reasons for repeat calls. 4. Determine the percentage of calls that are repeat calls for the same reason	1. Develop actionable items from assessment of data by implementing new call center category codes. 2. Training CS staff on call center category codes. 3. Update Member Satisfaction survey to indentify whom the member previously reached out to for assistance. 4. Implement First Call Resolution KPI for Medi-Cal	July 31, 2016 July 31, 2016 August 31,2016 Jan 1, 2016
Q2	1. Monitor First Call Resolution KPI. 2. Determine top two reasons for repeat calls	1. Indentify call categories that required additional calls to resolve. 2. Updated and Implemented Member Satisfaction survey to indentify whom the member previously reached out to for assistance 3. Implement First Call Resolution KPI for OC/OCC.	Ongoing July 31, 2016 July 1, 2016
Q3	1. Monitor First Call Resolution KPI. 2. Monitor top two reasons for repeat calls for OC/OCC.	1. Implement Member Satisfaction Survey for OC/OCC.	Nov 1, 2016
Q4	1. Monitor First Call Resolution KPI. 2. Monitor top two reason for repeat calls for LOB's	1. Soft skill training for all CS call center staff. 2. Implemented a voice mail option within the member survey	Ongoing September 1, 2016
Year End	1. Monitor of call center data to determine reason for call. 2. Determine if member previously call for the same reason/concern. 3. Determine top two reasons for repeat calls. 4. Determine the percentage of calls that are repeat calls for the same reason 5. Monitor First Call Resolution KPI for Medi-Cal 6. Determine top two reasons for repeat calls for Medi-Cal 7. Monitor First Call Resolution KPI for OC/OCC 8. Determine top two reasons for repeat calls for OC/OCC	1. Developed actionable items from assessment of data by implementing new call center category codes. 2. Trained CS staff on call center category codes. 3. Updated Member Satisfaction survey to indentify whom the member previously reached out to for assistance. 4. Implemented First Call Resolution KPI for Medi-Cal 5. Indentified call categories that required additional calls to resolve. 6. Implemented First Call Resolution KPI of OC/OCC. 7. Implemented Member Satisfaction Survey for OC/OCC 8. Soft Skills training of all CS call center staff members	July 31, 2016 August 31,2016 Jan 1, 2016 Ongoing July 31, 2016 November 1, 2016

		9. Implemented a voice mail option within the member survey for members to leave comments.	Ongoing September 1, 2016
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	First Call Resolution Required Metrics – 85% Q1 Average - 87% 1. January - 88% 2. February - 87% 3. March - 86%	Monthly review outcome call center data to determine opportunities for continuous improvement of First Call Resolution Rates.	Ongoing
Q2	First Call Resolution Required Metrics – 85% Q2 Average - 85% 4. April - 86% 5. May - 85% 6. June - 85%	Monthly review outcome call center data to determine opportunities for continuous improvement of First Call Resolution Rates.	Ongoing
Q3	First Call Resolution Required Metrics – 85% Q3Average - 85% Medi-Cal 1. July - 85% 2. August- 84% 3. September - 85% OC 1. July - 91% 2. August- 88% 3. September - 86% OCC 1. July - 92% 2. August- 91% 3. September - 89%	Continued monthly review of call center data to determine opportunities for improvement of the First Call Resolution Rates with Medi-Cal, OCC and OCC.	Ongoing
Q4	Med- Call Required Metrics – 85% Q4Average - 85%	Continued monthly review of call center data to determine opportunities for improvement of the First Call Resolution	Ongoing

	Medi-Cal 1. October – 85% 2. November – 86% 3. December – 85% OC Required Metrics – 85% Q4Average - 88% OC 1. October – 88% 2. November – 89% 3. December – 88% OC Required Metrics – 85% Q4Average - 89% OCC 1. October – 88% 2. November – 90% 3. December – 88%	Rates with Medi-Cal, OCC and OCC.	
Year End	Medi-Cal First Call Resolution KPI - 86% OC First Call Resolution KPI – 88% OCC First Call Resolution KPI – 90%		

VIII. Member Experience

C. *Quality of Service-Reviewed through Customer Service access

Owner: Belinda Abeyta, Director, Customer Service

The Approach

1. **Objective**
   - Customer Service call lines evaluated for average speed to answer
   - Customer Service call line evaluated for call abandonment rate
   - Customer Service call lines evaluated for hold times

2. **Activity**
   - Customer Service lines monitored for average speed to answer
   - Customer service lines monitored for abandonment rate
   - Customer service lines monitored for hold time

3. **Goals**
   - ASA 30 seconds
   - <3%
   - Hold time under 30 seconds
   - First Call Resolution 85%

Member Experience
Owner: Belinda Abeyta, Director, Customer Service

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	1. Monitoring of Call Center KPI's: a. ASA 30 Seconds b. Abandonment Rate <3% c. Hold time under 30 seconds d. First Call Resolution 85%	1. Daily, weekly and monthly monitor of Call Center KPI's. 2. Monthly review of First Call Resolution Rate.	Ongoing Ongoing
Q2	1. Monitoring of Call Center KPI's: a. ASA 30 Seconds b. Abandonment Rate <3% c. Hold time under 30 seconds d. First Call Resolution 85%	1. Daily, weekly and monthly monitor of Call Center KPI's. 2. Monthly review of First Call Resolution Rate.	Ongoing Ongoing
Q3	1. Monitoring of Call Center KPI's: a. ASA 30 Seconds b. Abandonment Rate <3% c. Hold time under 30 seconds d. First Call Resolution 85%	1. Daily, weekly and monthly monitor of Call Center KPI's. 2. Monthly review of First Call Resolution Rate.	Ongoing Ongoing
Q4	1. Monitoring of Call Center KPI's: a. ASA 30 Seconds b. Abandonment Rate <3%	1. Daily, weekly and monthly monitor of Call Center KPI's. 2. Monthly review of First Call Resolution Rate.	Ongoing Ongoing

	c. Hold time under 30 seconds d. First Call Resolution 85%		
Year End	1. Monitoring of Call Center KPI's: a. ASA 30 Seconds b. Abandonment Rate <3% c. Hold time under 30 seconds d. First Call Resolution 85%	1. Daily, weekly and monthly monitor of Call Center KPI's. 3. Monthly review of First Call Resolution Rate.	Ongoing Ongoing
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	All service required goals met for Q1..	1. Adjust staffing resources if needed to ensure KPI's are achieved. 2. Monthly review outcome call center data to determine opportunities for continuous improvement of First Call Resolution Rates.	Ongoing Ongoing
Q2	All service required goals met for Q2..	1. Adjust staffing resources if needed to ensure KPI's are achieved. 2. Monthly review outcome call center data to determine opportunities for continuous improvement of First Call Resolution Rates.	Ongoing Ongoing
Q3	All service required goals met for Q2 with the exception of Medi-Cal First Call Resolution for August 2016..	3. Adjust staffing resources if needed to ensure KPI's are achieved. 4. Monthly review outcome call center data to determine opportunities for continuous improvement of First Call Resolution Rates.	Ongoing Ongoing
Q4	All service required goals met for Q2..	1. Adjust staffing resources if needed to ensure KPI's are achieved. 2. Monthly review outcome call center data to determine opportunities for continuous improvement of First Call Resolution Rates.	Ongoing Ongoing

Year End	All service required goals met for all LOBs with the exception of Medi-Cal First Call Resolution for August 2016.	1. Adjusted staffing resources if needed to ensure KPI's were achieved. 2. Reviewed outcome call center data to determine opportunities for continuous improvement of First Call Resolution Rates.	Ongoing Ongoing

VIII. Member Experience

D. Quality of Care & Service Reviewed through GARS & PQI (MOC)

Owner: Janine Kodama, Director, GARS
Esther Okajima, Director, QI

The Approach

1. **Objective**
   - Global review of member "pain points" (Grievances, Complaints and Quality of Care); assure appropriate actions are taken to assist the member experience

2. **Activity**
   - Quarterly review of all GARS and PQI data to identify issues and trends; implement any necessary corrections
   - Report QIC
   - HN quarterly totals by PMPM of grievance and PQI and steps taken to address with HN

3. **Goals**
   - Employ data-based Quality Improvement measures to upgrade performance

Member Experience
Owners: Janine Kodama, Director, GARS; Esther Okajima, Director, QI

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	Quality of Service for all lines of business is the highest grievance category.	Trend the Quality of Service by provider regardless of line of business or member's health network. Identify trends at provider level. Break down by staff vs. provider.	August 2016
Q2	Quality of Service for all lines of business is the highest grievance category.	Trend the Quality of Service by provider regardless of line of business or member's health network. Identify trends at provider level. Break down by staff vs. provider.	December 2016
Q3	Quality of Service for all lines of business is the highest grievance category.	Trend the Quality of Service by provider regardless of line of business or member's health network. Identify trends at provider level. Break down by staff vs. provider.	March 2017
Q4	Quality of Service for all lines of business is the highest grievance category.	Trend the Quality of Service by provider regardless of line of business or member's health network. Identify trends at provider level. Break down by staff vs. provider.	March 2017
Year End	Will be reported in Annual Evaluation	Will be reported in Annual Evaluation	March 2017
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	In 2015, the Quality of Service grievance category average percentage is: Medi-Cal: 63% OneCare: 79%	Find opportunities to improve member experience	August 2016
Q2	Nurses reviewed 16 cases Quality of Services Issues- No service issues Identified In 2016, the Quality of Service grievance category average percentage is: Medi-Cal: 62%	Continue to track and trend providers/ office staff issues. Find opportunities to improve member experience Find opportunities to improve member experience if we identify these issues by provider	On-going December 2016

	OneCare: 78%		
Q3	QI Department/nurses have completely transition from Master Profiling Database to Guiding Care. The QI Department and GARS continue to have meeting to ensure cases are not being misplaced during the cloning process and or other issue. GC has allowed a better access to clinical records/documentation from GARS Dept, Case Management and Disease Management.	Nurses are receiving cases round robin (3 cases at a time) Continue support /training for nurses with update related to GC	Dec. 2016 and On-going
Q4	Nurses reviewed 236 and closed 191 cases Q4 2016. Of the cases closed: Severity Level 0 – 164 cases, 85.59% Severity Level 1 – 26 cases 13.14% Severity Level 2 – 1 case, 0.04% Severity Level 3 – 0 cases, 0.00% Severity Level 4 – 0 cases 0.00%	Continue to determine the severity of the cases and find opportunities to improve the member experience.	Dec 2016
Year End	Nurses reviewed and closed 1256 cases in CY2016. Of the cases closed: Severity Level 0 – 1103 cases, 87.82% Severity Level 1 – 69 cases, 5.49% Severity Level 2 – 25 cases, 1.99% Severity Level 3 – 0.00% Severity Level 4 – 1 case, 0.07% Severity Level SO – 34 cases, 2.71%	Continue to determine the severity of the cases and find opportunities to improve the member experience.	Ongoing

IX. HEDIS/STARS Improvement

A. Improve identified HEDIS Measures listed on "Measure" worksheet

Owner: Kelly Rex-Kimmet Director, Quality Analytics

The Approach

1. **Objective**
   - Regain "Commendable" NCQA accreditation rating
   - Maintain or exceed NCQA 4.0 health plan rating
2. **Activity**
   - See measures worksheet for specific activities
3. **Goals**
   - See measures worksheet

B. Improve identified STARS measures listed on "Measures" worksheet

The Approach

1. **Objective**
   - Maintain or exceed 4.0 CMS STAR rating
2. **Activity**
   - See measures worksheet for specific activities
3. **Goals**
   - See measures worksheet

IX. HEDIS/STARS Improvement

C. Improve CAHPS measures listed on "Measures" worksheet

Owner: Kelly Rex-Kimmet Director, Quality Analytics

The Approach

1. **Objective**
   - Achieve 3.0 CAHPS score
2. **Activity**
   - See Measures worksheet for specific activities
3. **Goals**
   - See Measures worksheet

D. HEDIS: Launch pediatric wellness clinic

The Approach

1. **Objective**
   - Improve child and adolescent HEDIS measures (i.e. adolescent immunizations, childhood immunizations, adolescent well care)
2. **Activity**
   - Evaluate options to deliver pediatric preventive care, including immunizations in unique settings to achieve higher adherence
   - Work in conjunction with the HN and CCN providers on this initiative
3. **Goals**
   - Improve HEDIS rates per measure worksheet

IX. HEDIS/STARS Improvement

E. STARS Improvement-Medication Adherence Measures

Owner: Kris Gericke, Director, Pharmacy

The Approach

1. **Objective**
   - Continue to achieve 4 Star Performance in the three Medication Adherence Measures in each measure

2. **Activity**
   - Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)
   - Interventions include:
     - Outreach
     - Pre-Assessment: Modified Morisky Scale (MMS) for knowledge/motivation and confidence
     - Mailings-Letter with member's action plan, Healthy You, medication log
     - Follow up calls at:
       - 2 weeks: to see if they received the mailing and engage in a conversation with member
       - 1 month: to check on member's progress and address any questions/ concerns
       - 3 months: Post-assessment
     - At the 6 month mark: Compare pre and post PDC rates
       - Call member for another follow up.
       - If member's rate(s) improve to .80 or higher, send an "Acknowledgement" letter
       - If member's rate does not improve to .80 or higher, re-evaluate and work with member to revise their action plan. Will also send another health education piece on medication adherence if needed.
       - Member satisfaction surveys will be sent to members.
     - Evaluate the program by looking at how many cases where successful
       - Pre and Post PDC rates
       - If there was improvement in knowledge, motivation (MMS) and confidence
       - Evaluate surveys

3. **Goals**
   - Maintain 4 Stars

F. HEDIS: Health Network support of HEDIS & CAHPS improvement

Owner: Kelly Rex-Kimmet, Director, Quality Analytics

The Approach

1. **Objective**
   - Provider regular reporting to the Health Networks to ensure HEDIS improvement for expected measures

2. **Activity**
   - Provide ongoing reports to Health Networks on their specific HEDIS & CAHPS performance, including patient lists for intervention
   - Gather feedback from Health Networks on tools to assist in HEDIS & CAHPS improvement activities

3. **Goals**
   - 24.33%

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Reporting Months
****HEDIS/STARS**: Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures MC and OC members - in conjunction with Diabetes Disease Management Program	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	90th percentile for all sub-measures	2016 April, July, October
****HEDIS/STARS** Improvement: Review and assessment Controlling Blood Pressure*	Increase the BP control for MC and OC members to meet goal	Blood pressure control will increase through member outreach and education with member diagnosed with hypertension.	MC: 70.32% (90th percentile) OC 79.15% (75th percentile)	2016 April, July, October
****HEDIS/STARS** Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medi-Cal <15% Readmission rate Medicare <14% Readmission rate	2016 April, July, October
****HEDIS/STARS** Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and 2. OC members 65 years	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	2016 April, July, October

Scope	Objective	Activity	Goals or Baseline	Reporting Months
	old and older to meet goal			
HEDIS: Review of prenatal & postpartum care services (PPC)	Increase the prenatal and postpartum care rate for all Medi-Cal deliveries to meet goal	The number of prenatal and postpartum care visits will increase through provider education to submit Prenatal Notification Reports, member and provider education and sharing of provider data. Utilize Text-For-Baby custom messages to encourage member compliance.	MC Prenatal: 85.19% (50th percentile) MC Postpartum: 68.85% (75th percentile)	2016 April, July, October
HEDIS: Review and assessment prescribed ADHD medication (ADHD)	Increase the follow-up care for children prescribed ADHD medication rate in MC children who were newly prescribed an ADHD medication to meet goal	Follow-up care for children with newly prescribed ADHD medication will increase through member and provider education and reminder letter to members.	Initiation Phase: 40.79% (50th percentile) Maintenance Phase: 50.61% (50th percentile)	2016 April, July, October
HEDIS: Review and assessment of antidepressant medication management (AMM)	Increase the antidepressant medication management rate in MC and OC members with a diagnosis of major depression to meet goal	Antidepressant medication management rates will increase with the distribution of member health education material.	MC: Acute Phase Treatment: 62.56% (90th percentile) MC: Continuation Phase Treatment: 48.39% (90th percentile) OC: Effective Phase Treatment 68.66% (50th percentile) OC: Continuation Phase Treatment 54.76% (50th percentile)	2016 Mar Jun Sep Dec
****HEDIS/STARS**: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	OC: 49.48% (75th percentile)	2016 April, July, October

Scope	Objective	Activity	Goals or Baseline	Reporting Months
HEDIS: Review and assessment avoidance of treatment of bronchitis (AAB)	Increase the avoidance of antibiotic treatment in adults with acute bronchitis rate in MC members with a diagnosis of acute bronchitis to meet goal	Avoidance of antibiotic treatment in adults with a diagnosis of acute bronchitis rate in MC members 18-64 years old will increase through member and provider education.	MC: 26.30% (50th percentile)	2016 April, July, October
HEDIS: Review and assessment of childhood immunization rates	Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal	Immunization in children by their 2nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 52.08% (90th percentile)	2016 April, July, October
HEDIS: Review and assessment of adolescent Immunization rates	Increase the adolescent immunization rate to meet goal	Adolescent immunizations will improve through an adolescent focused event that will provide immunization opportunities, member education and member resources.	MC: 81.51% (75th percentile)	2016 April, July, October
HEDIS: Review and assessment of appropriate testing for pharyngitis rates	Increase the appropriate testing of pharyngitis in children 2-18 years of age to meet goal	Appropriate testing for pharyngitis will improve through the distribution of strep A tests and provider education.	MC: 71.48% (50th percentile)	2016 April, July, October
HEDIS: Review and assessment of use of imaging studies for low back pain	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain)	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education	MC: 78.06% (75th percentile)	2016 April, July, October

Scope	Objective	Activity	Goals or Baseline	Reporting Months
HEDIS: Review and assessment of adult's access to preventive/ambulatory health (AAP)	Increase MC and OC adult's access to preventive/ambulatory health to meet goal	Comprehensive member and provider outreach with reminders to increase access for adults	MC: 83.84% (50th percentile) OC: 95.56% (50th percentile)	2016 April, July, October
HEDIS: Review and assessment of children's access to primary care practitioners (CAP)	Increase children's access to primary care practitioners to meet goal	Comprehensive member and provider outreach with reminders to increase access for children	MC: 1) 12-24 months 96.28% (50th percentile) 2) 25 months -6 years 91.22% (75th percentile) 3) 7-11 years 93.90% (75th percentile) 4) 12-19 years 90.06% (50th percentile)	2016 April, July, October
HEDIS: Review and assessment of cervical cancer screening (CCS)	Increase the cervical cancer screening in our MC female members 21-64 to meet goal	Increase cervical cancer screening through member and provider outreach and education with reminders.	MC: 67.88% (75th percentile)	2016 April, July, October
HEDIS: Review and assessment of well child visits in the first 15 months of life (W15)	Increase the well care visits for MC children in their first 15 months of life to meet goal	Increase of well care visit for children in their first 15 months of life through member and provider outreach and education with reminders	MC: 59.76% (50th percentile)	2016 April, July, October
HEDIS: Review and assessment of breast cancer screening (BCS)	Increase the breast cancer screening for MC and OC female members to meet goal	Increase the breast cancer screening through member and provider education and outreach with reminders as ways to decrease barriers to screening	MC: 71.41% (90th percentile) OC: 71.36% (50th percentile)	2016 April, July, October
HEDIS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile)	2016 April, July, October
***STARS Improvement** - Medication Adherence Measures	Improve the 3 Medication Adherence Measures to achieve 4 Star performance in each measure	Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)	4 Stars	No Change
CAHPS: Rating of Health Plan	Increase CAHPS score on	Utilize results from CalOptima's	50th Percentile or higher	Monitor Only: Met goal

Scope	Objective	Activity	Goals or Baseline	Reporting Months
	Rating of Health Plan	supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.		at the 75th percentile
CAHPS: Getting Needed Care	Increase CAHPS score on Getting Needed Care	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Needed Care.	50th Percentile or higher (2.52)	No Change
CAHPS: Getting Care Quickly	Increase CAHPS score on Getting Care Quickly	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Care Quickly.	50th Percentile or higher	No Change
CAHPS: How Well Doctors Communicate	Increase CAHPS score on How Well Doctors Communicate	Tips on "Preparing for your Dr. Visit," toolkits/decision tools for PCPs, and provider and office staff in-service on customer service will improve rating on How Well Doctors Communicate.	50th percentile or higher	No Change
CAHPS: Customer Service	Increase CAHPS score on Customer Service	Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service.	50th percentile or higher	No Change
HOS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: 1)Reducing Risk of Falls 2)Improving Physical Health Status 3)Improving Mental Health Status	50th percentile or higher	No Change

HEDIS Measures
Owner: Marsha Choo, Manager, QA

	Results / Metric	Next Steps	Target Completion
Q1 **Diabetes care** **Review and assessment Comprehensive Diabetes (CDC)** **Goal is 90th percentile for all submeasures**	Hybrid Rate: As of 4/4/16 ***Medi-Cal*** 2. HbA1c Testing– **Rate: 79.61% Goal: 91.94%** 3. HbA1c Poor Control (.9.0%); (Lower is better) **Rate: 62.14% Goal: 27.78%** 4. HbA1c Adequate Control (<8.0%); **Rate: 30.58% Goal: 61.57%** 5. Eye Exams; **Rate: 48.3% Goal:67.74%** 6. Nephropathy Monitoring; **Rate: 87.86% Goal: 84.88%; Goal Met** 7. B/P <140/90; **Rate: 31.07% Goal: 76.64%** ***OneCare*** 1. HbA1c Testing– **Rate: 87.9% Goal: 93.50%** 2. HbA1c Poor Control (.9.0%); (Lower is better) **Rate: 36.02% Goal: 15.87%** 3. HbA1c Adequate Control (<8.0%); **Rate: 58.6% Goal: 73.08%** 4. Eye Exams; **Rate: 69.89% Goal: 83.57%** 5. Nephropathy Monitoring; **Rate: 93.82% Goal: 92.66% Goal Met** 6. B/P <140/90; **Rate: 52.96% Goal: 80.29%**	Medi-Cal: 1. DHCS PIP on Diabetes A1c Testing a. Target low performing HbA1c testing Provider office to test pilot intervention. b. Implement with targeted office, better member educational outreach for HbA1c testing c. Obtain monthly lab data on members needing HbA1c testing for targeted Provider office and share with office for outreach. d. With targeted Provider office, identify a list of labs and their hours to provide to members who may not be aware of these options. 2. Quarterly diabetic eye exam member reminder mailing 3. Send PCPs list of their patients in the Diabetes DM Program along with their profile 4. Article on A1c in Diabetes Talk Newsletter OneCare: 5. CMS QIP: Diabetes A1c Testing a. Outreach to members who need their HbA1c testing b. Gather from top performing provider offices and their share best practices with other providers 6. Conduct Diabetes CE Workshop	1. June 30, 2017 2. Quarter 2 and Quarterly 3. Quarter 3 4. Quarter 2 5. Quarter 2 6. Quarter 3

Q2 **Diabetes care** **Review and assessment Comprehensive Diabetes (CDC)** **Goal is 90th percentile for all submeasures**	**HEDIS 2016 Final Rate:** ***Medi-Cal*** 1. HbA1c Testing– **Rate: 84.18% Goal: 91.94%** 2. HbA1c Poor Control (.9.0%); (Lower is better) **Rate: 34.31% Goal: 27.78%** 3. HbA1c Adequate Control (<8.0%); **Rate: 54.01% Goal: 61.57%** 4. Eye Exams; **Rate: 59.37% Goal:67.74%** 5. Nephropathy Monitoring; **Rate: 89.54% Goal: 84.88%;** 6. B/P <140/90; **Rate: 71.05% Goal: 76.64%** **Prospective Rates (June 2016):** **NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** ***Medi-Cal*** 1. HbA1c Testing– **Rate: 59.59% Goal: 91.94%** 2. HbA1c Poor Control (.9.0%); (Lower is better) **Rate: 80.24% Goal: 27.78%** 3. HbA1c Adequate Control (<8.0%); **Rate: 15.86% Goal: 61.57%** 4. Eye Exams; **Rate: 23.80%**	Medi-Cal: 1. DHCS PIP on Diabetes A1c Testing a. Target low performing HbA1c testing Provider office to test pilot intervention. b. Implement with targeted office, better member educational outreach for HbA1c testing c. Obtain monthly lab data on members needing HbA1c testing for targeted Provider office and share with office for outreach. d. With targeted Provider office, identify a list of labs and their hours to provide to members who may not be aware of these options. 2. Quarterly diabetic eye exam member reminder mailing 3. Send PCPs list of their patients in the Diabetes DM Program along with their profile 4. Article on A1c in Diabetes Talk Newsletter OneCare: 5. CMS QIP: Diabetes A1c Testing a. Outreach to members who need their HbA1c testing b. Diabetes member telephonic outreach for High Risk Members c. Gather from top performing provider offices and their share best practices with other providers 6. Conduct Diabetes CE Workshop	1. June 30, 2017 2. Quarter 2 and Quarterly 3. Quarter 3 4. Quarter 2 5. Quarter 2 6. Quarter 3

	Goal:67.74% 5. Nephropathy Monitoring; **Rate: 79.90% Goal: 84.88%** 6. B/P <140/90; **Rate: 11.09% Goal: 76.64%** **HEDIS 2016 Final Rate:** ***OneCare*** 1. HbA1c Testing– **Rate: 90.03% Goal: 93.50%** 2. HbA1c Poor Control (.9.0%); (Lower is better) **Rate: 20.49% Goal: 15.87%** 3. HbA1c Adequate Control (<8.0%); **Rate: 72.51% Goal: 73.08%** 4. Eye Exams; **Rate: 81.94% Goal: 83.57%** 5. Nephropathy Monitoring; **Rate: 95.15% Goal: 92.66% Goal Met** 6. B/P <140/90; **Rate: 77.36% Goal: 80.29%** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** ***OneCare*** 1. HbA1c Testing– **Rate: 68.18% Goal:**		

	93.50% 2. HbA1c Poor Control (.9.0%); (Lower is better) 3. **Rate: 85.61% Goal: 15.87%** 4. HbA1c Adequate Control (<8.0%); **Rate: 12.12% Goal: 73.08%** 5. Eye Exams; **Rate: 41.67% Goal: 83.57%** 6. Nephropathy Monitoring; **Rate: 80.30% Goal: 92.66%** 7. B/P <140/90; **Rate: 27.27% Goal: 80.29%**		
Q3 **Diabetes care** **Review and assessment Comprehensive Diabetes (CDC)** **Goal is 90th percentile for all submeasures**	**Prospective Rates (October 2016):** **NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** ***Medi-Cal*** 1. HbA1c Testing– **Rate: 74.74% Goal: 91.94%** 2. HbA1c Poor Control (.9.0%); ***(Lower is better)*** **Rate: 70.71% Goal: 27.78%** 3. HbA1c Adequate Control (<8.0%); **Rate: 24.39% Goal: 61.57%** 4. Eye Exams; **Rate: 34.36% Goal:67.74%**	**Medi-Cal** Continue with HSAG/DHCS PIP on HbA1c testing.	June 30, 2017

	5. Nephropathy Monitoring; **Rate: 86.48% Goal: 84.88%; On Track** 6. B/P <140/90; **Rate: 22.26% Goal: 76.64%** **Prospective Rates (October 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** ***OneCare*** 1. HbA1c Testing– **Rate: 82.25% Goal: 93.50%** 2. HbA1c Poor Control (.9.0%); (Lower is better) **Rate: 79.88% Goal: 15.87%** 3. HbA1c Adequate Control (<8.0%); **Rate: 17.75% Goal: 73.08%** 4. Eye Exams; **Rate: 61.54 % Goal: 83.57%** 5. Nephropathy Monitoring; **Rate: 85.80% Goal: 92.66%** B/P <140/90; **Rate: 32.54% Goal: 80.29%**	**OneCare** Continue with CMS QIP on HbA1c testing.	January 13, 2017
Q4 **Diabetes care** **Review and assessment Comprehensive**	**Prospective Rates (November 2016):** **NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.**	**Medi-Cal** Continue with HSAG/DHCS PIP on HbA1c testing.	On-going

Diabetes (CDC) **Goal is 90th percentile for all submeasures**	***Medi-Cal*** 7. HbA1c Testing– **Rate: 78.07% Goal: 91.94%** 8. HbA1c Poor Control (.9.0%); ***(Lower is better)*** **Rate: 51.82% Goal: 27.78%** 9. HbA1c Adequate Control (<8.0%); **Rate: 40.78% Goal: 61.57%** 10. Eye Exams; **Rate: 37.04% Goal:67.74%** 11. Nephropathy Monitoring; **Rate: 87.57% Goal: 84.88%; Goal Met** 12. B/P <140/90; **Rate: 16.48% Goal: 76.64%** **Prospective Rates (November 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** ***OneCare*** 6. HbA1c Testing– **Rate: 84.21% Goal: 93.50%** 7. HbA1c Poor Control (.9.0%); (Lower is better) **Rate: 79.53% Goal: 15.87%** 8. HbA1c Adequate Control (<8.0%); **Rate: 17.54% Goal: 73.08%**	**OneCare** Continue with CMS QIP on HbA1c testing.	

	9. Eye Exams; **Rate: 60.82% Goal: 83.57%** 10. Nephropathy Monitoring; **Rate: 86.55% Goal: 92.66%; On track** B/P <140/90; **Rate: 32.16% Goal: 80.29%**		
Year End	The CDC rates have gradually improved. There are still areas in which rates are still below the goal for both MC and OC. The only submeasure that has reached goal as of Nov, 2016 PR rates is Nephropathy. We anticipate improvement in the rates with medical chart review.	The department continues to implement the interventions for the Diabetes PIP and QIPs. In addition, DM members are sent diabetic newsletters and reminder mailings. Chronic care team to assess opportunities for improving this measure in 2017.	
Q1 **Controlling Blood Pressure**	Hybrid Rate: As of 4/4/16 Med-Cal: Rate: **23.92% Goal: 70.32%** OneCare: Rate**: 27.33% Goal: 79.15%**	1. Educate Provider offices. DHCS provided Health Plans with a Hypertension Algorithm to share with Providers as helpful diagnosis tool. 2. Provide education and offer blood pressure cuffs to members who qualify	1. Quarter 4 2. On-going
Q2 **Controlling Blood Pressure**	**HEDIS 2016 Final Rate:** Med-Cal: Rate: **72.51% Goal: 70.32%; Goal Met** OneCare: Rate**: 69.68% Goal: 79.15%** **NOTE: No Prospective Rates**	1. Provide education and offer blood pressure cuffs to members who qualify. 2. Educate Provider offices. DHCS provided Health Plans with a Hypertension Algorithm to share with Providers as helpful diagnosis tool; QI team will be including CPT codes to help offices.	1. On-going 2. Quarter 3
Q3 **Controlling Blood Pressure**	**HEDIS 2016 Final Rate:** Med-Cal: Rate: **72.51% Goal: 70.32%; Goal Met**	1. Provide education and offer blood pressure cuffs to members who qualify. 2. Educate Provider offices. DHCS provided Health Plans with a Hypertension Algorithm to share with Providers as helpful diagnosis tool; QI team will be including CPT codes to help	1. On-going 2. Quarter 3

	OneCare: Rate**: 69.68% Goal: 79.15%** **NOTE: No Prospective Rates**	offices.	
Q4 **Controlling Blood Pressure**	**HEDIS 2016 Final Rate:** Med-Cal: Rate: **72.51% Goal: 70.32%; Goal Met** OneCare: Rate**: 69.68% Goal: 79.15%** **NOTE: No Prospective Rates**	1. Provide education and offer blood pressure cuffs to members who qualify.	1. On-going
Year end	The QI work team continues to conduct outreach and distribute blood pressure cuffs through DM program. This measure requires medical chart review therefore there are not PR rates to be reported until HEDIS 2017.	Completed evaluation of the educational outreach and distribution of the blood pressure cuffs to be completed by Q3, 2017.	
Q1 **30 Day Readmissions**	HEDIS Rate (admin refresh) **<u>Medi-Cal</u>** MC: Readmission (Total 21+): **Rates: 17.4%** **Goals**: Medi-Cal <15% Readmission rate **<u>OneCare:</u>** OC: Readmission (Total 18+): **Rates: 17.3%** **Goals:** Medicare <14% Readmission rate **<u>OneCare Connect*:</u>** OC: Readmission (Total 18+): **Rates:**	1. Expand the Transitions of Care (TOC) Program to include the OneCare Connect Population 2. Reviewing and updating the TOC member and provider outreach materials including scripts 3. Continue to implement the TOC program for all lines of business	1. 4/18/2016 2. Quarter 2 3. On-going

	25% **Goals:** Medicare <14% Readmission rate **NOTE: OCC membership is low; only 4 in denominator*		
Q2 **30 Day Readmissions**	**HEDIS 2016 Final Rate:** MC: Readmission (Total 21+): **Rate: 17.45%** **Goals**: Medi-Cal <15% Readmission rate **<u>OneCare:</u>** OC: Readmission (Total 18+): **Rates: 17.33%** **Goals:** Medicare <14% Readmission rate **Prospective Rates (June 2016):** **<u>Medi-Cal</u>** MC: Readmission (Total 21+): **Rates: 15.29%** **Goals**: Medi-Cal <15% Readmission rate **<u>OneCare:</u>** OC: Readmission (Total 18+): **Rates:**	1. Reviewing and updating the TOC member and provider outreach materials including scripts 2. Send OCC TOC eligible program members a discharge kit 3. Continue to implement the TOC program for all lines of business	1. May 2016 2. Quarter 3 3. On-going

	4.34%; on track **Goals:** Medicare <14% Readmission rate **<u>OneCare Connect*:</u>** OC: Readmission (Total 18+): **Rates: 12.27%; on track** **Goals:** Medicare <14% Readmission rate		
Q3 **30 Day Readmissions**	**Prospective Rates (Oct 2016):** **<u>Medi-Cal</u>** MC: Readmission (Total 21+): **Rates: 16.24%** **Goals**: Medi-Cal <15% Readmission rate **<u>OneCare:</u>** OC: Readmission (Total 18+): **Rates: 4.65%** **Goals:** Medicare <14% Readmission rate **<u>OneCare Connect*:</u>** OC: Readmission (Total 18+): **Rates: 15.03%** **Goals:** Medicare <14% Readmission rate	1. Reviewing and updating the TOC member and provider outreach materials including scripts 2. Send OCC TOC eligible program members a discharge kit 3. Continue to implement the TOC program for all lines of business	1. November 2016 2. Quarter 4 3. On-going
Q4 **30 Day Readmissions**	**Prospective Rates (Nov 2016):** **<u>Medi-Cal</u>** MC: Readmission (Total 21+): **Rates:**	1. Reviewing and updating the TOC member and provider outreach materials including scripts 2. Continue to implement the TOC program for all lines of business	1. November 2016 2. On-going

	16.49% **Goals**: Medi-Cal <15% Readmission rate **<u>OneCare:</u>** OC: Readmission (Total 18+): **Rates: 4.65%** **Goals:** Medicare <14% Readmission rate **<u>OneCare Connect*:</u>** OC: Readmission (Total 18+): **Rates: 15.63%** **Goals:** Medicare <14% Readmission rate		
Year End	Medi-Cal and the OCC populations have not met the goal of <15%. However, the OC population has met goal for the PCR measure	Evaluate the TOC program for all lines of business.	
Q1 Flu & Pneumococcal Rates	Data from CAHPS surveys: MC: Prior Year Flu Immunization Rate: **46.2%** **Goal: 90%** OC Prior Year Flu Immunizations Rate : **76.2%** **Goal: 90%** OC Prior Year Pneumococcal Immunizations **Rate: 63.3%** **Goal: 90%** **CAHPS survey is currently fielding**	1. Review and update materials for member flu reminder mailings 2. Send out immunization schedule 3. Send out flu reminder mailing (one to each household) 2016 CAHPS results will be available Q3	1. Quarter 2 2. Quarter 2 3. Quarter 3

Q2 Flu & Pneumococcal Rates	MC: 2014 MY Flu Immunization Rate: **40.45% Goal: 90% Not Met** OC 2014 MY Flu Immunizations Rate : **69.0% Goal: 90% Not met** OC 2014 MY Pneumococcal Immunizations **Rate: 42.5% Goal: 90% Not Met**	• Flu/Pneumonia activities are in progress and expected to launch in January 2017 for all LOB.	Q1, 2017
Q3 Flu & Pneumococcal Rates	MC: 2015 MY Flu Immunization Rate: 38.2 **% Goal: 90% Not Met** OC 2015 MY Flu Immunizations Rate : **69.0% Goal: 90% Not met** OC 2015 MY Pneumococcal Immunizations **Rate: 42.5% Goal: 90% Not Met**	• Flu/Pneumonia activities are in progress and expected to launch in January 2017 for all LOB.	Q1, 2017
Q4 Flu & Pneumococcal Rates	MC: 2015 MY Flu Immunization Rate: 38.2 **% Goal: 90% Not Met** OC 2015 MY Flu Immunizations Rate : **69.0% Goal: 90% Not met** OC 2015 MY Pneumococcal Immunizations **Rate: 42.5% Goal: 90% Not Met**	• For Medi-Cal, a flu member mailing will be sent to all households • For OCC, the Healthy You Healthy Year mailing sent to all OCC household with flu and pneumonia reminder information	Quarter 1 2017

Year End	There was a decrease in flu and pneumonia rates from 2015 to 2016. Flu and pneumonia rates did not meet the goal of 90%. Goal may be too high. Goal will be set using the star rating for the next year.	Continued efforts to remind members to get their flu and pneumonia shots during the flu season. Consider redesigning the reminder member materials (i.e. postcards).	
Q1 **Prenatal Care (PPC)**	Hybrid Rate: 4/4/16 **Rate: 72.45% Goal:85.19%**	1. Weekly mailing for pregnant member to encourage ongoing prenatal care, provide helpful resources and information for a healthy pregnancy. 2. Text4Baby Program and promotion 3. CME on Prenatal and Postpartum Care	1. On-going 2. On-going 3. Quarter 4
Q2 **Prenatal Care (PPC)**	**HEDIS 2016 Final Rate:** **Rate: 80.15% Goal:85.19%** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **Rate: 30.48% Goal:85.19%**	1. Weekly mailing for pregnant member to encourage ongoing prenatal care, provide helpful resources and information for a healthy pregnancy. 2. Text4baby program and promotion, for example the HN Forum presentation 4/2016 3. Text4baby "personalized messaging" to CalOptima members to promote preventive health. 4. CME confirmation 9/28/16: Infections in Pregnant Women and Neonates and How to Avoid Them. 5. PNRs and MOMS database completion and review 6. Update Preconception Insert for Cervical Cancer Mailing.	1. On-going 2. On-going 3.Quarter 4 4. Quarter 3 5. June 2016 6. June 2016
Q3 **Prenatal Care (PPC)**	**Prospective Rates (October 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **Rate: 72.87% Goal:85.19%**	• Bi-weekly mailing targeting recent members who have just delivered to encourage returning for their postpartum visit in recommended timeframe. • Text4baby program and promotion, to include enhancement to current outreach via "broadcast" texts. • Text4baby "personalized messaging" to CalOptima members to	• On-going • On-going • Quarter 4 • Quarter 4

		promote preventive health. • CME completed 9/28/16: Infections in Pregnant Women and Neonates and How to Avoid Them.	
Q4 **Prenatal Care (PPC)**	**Prospective Rates (November 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **Rate: 73.17% Goal:85.19%**	• Bi-weekly mailing targeting recent members who have just delivered to encourage returning for their postpartum visit in recommended timeframe. • Text4baby program and promotion, to include enhancement to current outreach via "broadcast" texts. • Text4baby "personalized messaging" to CalOptima members to promote preventive health. • CME completed 9/28/16: Infections in Pregnant Women and Neonates and How to Avoid Them.	• On-going • On-going • Quarter 4 • Quarter 4
Year End	Goals Status: the PPC measure has not met goal but we anticipate the rates to improve through medical chart review.	• Improving the Maternal Data Mart reports to produce more accurate and timely data. • Expand the Text4baby to create "personalized messaging" to CalOptima members to promote preventive health.	
Q1 **Post Partum (PPC)**	Hybrid Rate: 4/4/16 **Rate: 51.07% Goal: 68.85%**	1. Bi-weekly mailing targeting recent members who have just delivered to encourage returning for their postpartum visit in recommended timeframe. 2. Text4Baby Program 3. Text4Baby promotion 4. CME on Prenatal and Postpartum Care 5. Member Incentive for Postpartum Visit	1. On-going 2. On-going 3. On-going 4. Quarter 4 5. Quarter 3
Q2 **Post Partum (PPC)**	**HEDIS 2016 Final Rate:** **Rate: 61.02% Goal: 68.85%** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles**	1. Bi-weekly mailing targeting recent members who have just delivered to encourage returning for their postpartum visit in recommended timeframe. 2. Text4baby program and promotion. 3. Text4baby "personalized messaging" to CalOptima members to	1. On-going 2. On-going 3. Quarter 4 4. Quarter 4

	are out in October. Hybrid Rate: 4/4/16 **Rate: 39.83% Goal: 68.85%**	promote preventive health. 4. CME confirmation 9/28/16: Infections in Pregnant Women and Neonates and How to Avoid Them. 5. Postpartum YE push (Q4 2015) Evaluation completed.	5. May 2016
Q3 **Post Partum (PPC)**	**Prospective Rates (October 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **Rate: 44.81% Goal: 68.85%**	• Bi-weekly mailing targeting recent members who have just delivered to encourage returning for their postpartum visit in recommended timeframe. • Text4baby program and promotion, to include enhancement to current outreach via "broadcast" texts. • Text4baby "personalized messaging" to CalOptima members to promote preventive health. • CME completed 9/28/16: Infections in Pregnant Women and Neonates and How to Avoid Them.	• On-going • On-going • Quarter 4 • Quarter 4
Q4 **Post Partum (PPC)**	**Prospective Rates (November 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **Rate: 47.24% Goal: 68.85%**	• Bi-weekly mailing targeting recent members who have just delivered to encourage returning for their postpartum visit in recommended timeframe. • Text4baby program and promotion, to include enhancement to current outreach via "broadcast" texts. • Text4baby "personalized messaging" to CalOptima members to promote preventive health. • CME completed 9/28/16: Infections in Pregnant Women and Neonates and How to Avoid Them.	• On-going • On-going • Quarter 4 • Quarter 4
Year End	Goals Status: the PPC measure has not met goal but we anticipate the rates to improve through medical chart review.	• Improving the Maternal Data Mart reports to produce more accurate and timely data. • Expand the Text4baby to create "personalized messaging" to CalOptima members to promote preventive health.	

Q1 **ADHD Medication (ADD)**	HEDIS Rate (admin refresh) Initiation: **Rate: 34.96%** **Goal: 40.79%** Maintenance: **Rate: 38.86%** **Goal: 50.61%**	1. Member reminder mailings for members to go for their follow-up visit 2. Provider reminder mailings with clinical practice guidelines, member chart, etc	1.On-going 2. On-going
Q2 **ADHD Medication (ADD)**	**HEDIS 2016 Final Rate:** Initiation: **Rate: 34.96%** **Goal: 40.79%** Maintenance: **Rate: 38.86%** **Goal: 50.61%** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** Initiation: **Rate: 16.96%** **Goal: 40.79%** Maintenance: **Rate: 10.89%** **Goal: 50.61%**	1. Member reminder mailings for members to go for their follow-up visit 2. Provider reminder mailings with clinical practice guidelines, member chart, etc	1. On-going 2. On-going
Q3 **ADHD Medication (ADD)**	**Prospective Rates (Oct 2016): NOTE:** Initiation: **Rate: 38.77%** **Goal: 40.79%** Maintenance: **Rate: 39.74%** **Goal: 50.61%** • Rate is currently above 2016 HEDIS rate	1. Member reminder mailings for members to go for their follow-up visit 2. Provider reminder mailings with clinical practice guidelines, member chart, etc	1. On-going 2. On-going

Q4 **ADHD Medication (ADD)**	**Prospective Rates (Nov 2016): NOTE:** Initiation: **Rate: 38.84% Goal: 40.79%** Maintenance: **Rate: 40.07% Goal: 50.61%** • Rate is currently above 2016 HEDIS rate	3. Member reminder mailings for members to go for their follow-up visit 4. Provider reminder mailings with clinical practice guidelines, member chart, etc	1. On-going 2. On-going
Year End	Rates have gradually improved throughout the years for the ADD measure however the initiation phase is less than 2% short of the goal. The Continuation/Maintenance submeasure did not meet goal as of November, 2016. Additional claims/encounter through December, 2016 may change the rate.	• Assess barriers to the ADD measure • Evaluate the mailing interventions for the ADD measure. • Update materials and review criteria for the current intervention.	
Q1 **Antidepressant Medication Mgmt (AMM)**	HEDIS Rate (admin refresh) ***Medi-Cal:*** Acute Phase: **Rate: 55.92% Goal: 62.56%** Continuation Phase: **Rate: 41.02% Goal: 33.93%-Goal Met** ***OneCare:*** Acute Phase: Rate: **55.25% Goal: 66.67%** Continuation Phase: **36.99% Goal: 52.87%**	Conduct provider education. Send the top 10 antidepressant medication prescribers a informational provider letter and brochures to give to members	Quarter 2

Q2 **Antidepressant Medication Mgmt (AMM)**	**HEDIS 2016 Final Rate:** ***Medi-Cal:*** Acute Phase: **Rate: 55.92% Goal: 62.56%** Continuation Phase: **Rate: 41.02% Goal: 48.39%** ***OneCare:*** Acute Phase: Rate: **55.25% Goal: 68.66%** Continuation Phase: **36.99% Goal: 54.76%** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** ***Medi-Cal:*** Acute Phase: **Rate: 54.89% Goal: 62.56%** Continuation Phase: **Rate: 31.06% Goal: 48.39%** ***OneCare:*** Acute Phase: Rate: **45.45% Goal: 68.66%** Continuation Phase: **18.18% Goal: 54.76%**	Conduct provider education. Send the top 10 antidepressant medication prescribers a informational provider letter and brochures to give to members	Quarter 2

	OneCare Connect: Acute Phase: Rate: **60.68%** **Goal: 68.66%** Continuation Phase: **41.88%** **Goal: 54.76%**		
Q3 **Antidepressant Medication Mgmt (AMM)**	**Prospective Rates (Oct 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated.** ***Medi-Cal:*** Acute Phase: **Rate: 55.09% Goal: 62.56%** Continuation Phase: **Rate: 39.96% Goal: 48.39%** ***OneCare:*** Acute Phase: Rate: **71.74%** **Goal: 68.66%; Goal Met** Continuation Phase: **50.0%** **Goal: 54.76%** ***OneCare Connect:*** Acute Phase: Rate: **63.46%** **Goal: 68.66%** Continuation Phase: **47.31%** **Goal: 54.76%**	Conduct provider education. Send the top 10 antidepressant medication prescribers a informational provider letter and brochures to give to members	Quarter 2

Q4 **Antidepressant Medication Mgmt (AMM)**	**Prospective Rates (NOV 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated.** ***Medi-Cal:*** Acute Phase: **Rate: 54.98% Goal: 62.56%** Continuation Phase: **Rate: 39.85% Goal: 48.39%** ***OneCare:*** Acute Phase: Rate: **71.74% Goal: 68.66%; Goal Met** Continuation Phase: **50.0% Goal: 54.76%** ***OneCare Connect:*** Acute Phase: Rate: **63.64% Goal: 68.66%** Continuation Phase: **46.97% Goal: 54.76%**	Conduct provider education. Send the top 10 antidepressant medication prescribers a informational provider letter and brochures to give to members	Quarter 2
Year End	Goal Status: The Medi-Cal and OneCare Connect population did not meet goal as of November, 2016. The OneCare population met goal for the initiation phase and was shy of the goal by less than 5% for the continuation phase for this measure. Additional claims/encounter through December, 2016 may change the rate.	Continue with the interventions for this measure and assess opportunities for improving this measure.	
Q1	HEDIS Rate (admin refresh)	Send provider fax notifications on appropriate treatment	Quarter 3

Osteoporosis Mgmt (OMW)	**Rate:** 44.87% **Goal:** OC: 49.48%		
Q2 **Osteoporosis Mgmt (OMW)**	**HEDIS 2016 Final Rate:** **OC Rate:** 44.87% **Goal:** OC: 49.48% **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **OC: Rate:** 100% **Goal:** OC: 49.48%; on track **OCC: Rate:** 26.67% **Goal:** OC: 49.48%; on track	Send provider fax notifications on appropriate treatment	Quarter 4
Q3 **Osteoporosis Mgmt (OMW)**	**Prospective Rates (Oct. 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **OC: Rate:** 46.15% **Goal:** OC: 49.48% **OCC: Rate:** 32.35% **Goal:** OC: 49.48%	Provider communication in (Aug Sept and Nov, 2016)	Quarter 3-4
Q4 **Osteoporosis Mgmt (OMW)**	**Prospective Rates (Nov. 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **OC: Rate:** 0% **Goal:** OC: 49.48%; No Data to report for November, 2016. **OCC: Rate:** 31.43% **Goal:** OC: 49.48%	Provider communication in (Aug Sept and Nov, 2016)	Quarterly
Year End	The OneCare population has declined due to the transition of membership to the OneCare Connect line of business. There was no data to report in November, 2016 as the some of the members may have fallen out of the HEDIS denominator.	Continue with the interventions for this measure and assess opportunities for improving this measure. Sending a member education piece in Q2, 2017.	

	The OneCare Connect population did not meet goal as of November, 2016. Additional claims/encounter through December, 2016 may change the rate.		
Q1 **Antibiotics Use/ Bronchitis (AAB);** **Inverted rate**	HEDIS Rate (admin refresh) **MC: Rate: 21.64% Goal: 26.30%**	Educate providers on the appropriate antibiotic use	Quarter 2
Q2 **Antibiotics Use/ Bronchitis (AAB);** **Inverted rate**	**HEDIS 2016 Final Rate:** **MC: Rate: 21.64% Goal: 26.30%** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **MC: Rate: 22.89% Goal: 26.30%**	Educate providers on the appropriate antibiotic use	Quarter 2-3
Q3 **Antibiotics Use/ Bronchitis (AAB);** **Inverted rate**	**Prospective Rates (Oct 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated** **MC: Rate: 22.76% Goal: 26.30%**	• Working PIP interventions; Medical Director outreach to targeted providers • Educate providers on the appropriate antibiotic use • Send AWARE Toolkit • Data Dive on measures	Quarter 4
Q4 **Antibiotics Use/ Bronchitis (AAB);** **Inverted rate**	**Prospective Rates (Nov 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated** **MC: Rate: 22.96 Goal: 26.30%**	• Working PIP interventions; Medical Director outreached to targeted providers • Educate providers on the appropriate antibiotic use • Send AWARE Toolkit • Data Dive on measures	Quarter 4

Year End	Goal Status: CalOptima did not meet goal for the AAB measure by 3.34% as of November, 2016 PR data. The QI work team has been working on the PDSA project for this measure. We hope to see improvements from outreach conducted by the Medical Director. Additional claims/encounter through December, 2016 may change the rate.	CalOptima will continue with the AAB PDSA project. Medical Director targeted 15 offices and successfully outreached to 8 providers for the PDSA project. Follow ups with these providers are expected to be completed by Q1-2, 2017. Providers received telephonic training on the AAB measure, HEDIS rate, clinical practice guidelines and codes.	
Q1 **Childhood Immunizations. Combo 10**	Hybrid Rate: 4/4/16 MC: Combo 10: **Rate: 29.0% Goal: 52.08%**	1. Healthy You Newsletters mailings with immunization schedules 2. CME on Personal Belief Exemption planning 3. Educate parents on the importance of allowing vaccination information to be entered into CAIR	1. On-going 2. Quarter 2-3 3. Quarter 3
Q2 **Childhood Immunizations. Combo 10**	**HEDIS 2016 Final Rate:** MC: Combo 10: **Rate: 38.52% Goal: 52.08%** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** MC: Combo 10: **Rate: 0.24% Goal: 52.08%**	1. Healthy You Newsletters mailings with immunization schedules 2. CME Prenatal and Childhood Immunizations 3. Text4Baby messaging of childhood immunization reminders specific to vaccination scheduling provided to members up to one year of age 4. Text4Baby messaging of childhood immunization reminders generalized to members ages 1-3 years of age 5. Development of a fact sheet educating providers on the importance of utilizing the CAIR site and promoting CAIR to parents. Collaborating with CHOC in the development and distribution of the fact sheet 6. Development of CIS fact sheet educating parents of the importance of childhood immunizations 7. Development and implementation of automated call (IVR) messages to members (2,523 English, Spanish and Vietnamese) in need of immunizations	1. On-going 2. Quarter 3 3. Continuous since July 2015 4. Continuous since July 2015 5. Quarter 2-3 6. Quarter 2-3 7. Quarter 2-3

		8. CHOC presentation opportunities highlighting CAIR and CIS tentatively scheduled for 4th quarter. 9. Assessing CAIR data	8. Quarter 2-3; Aug-Dec., 2016 9. Quarter 3
Q3 **Childhood Immunizations. Combo 10**	**Prospective Rates (Oct 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated** **MC: Combo 10** Rate: 24.04% Goal: 52.08%	1. Healthy You Newsletters mailings with immunization schedules 2. Text4Baby messaging of childhood immunization reminders specific to vaccination scheduling provided to members up to one year of age 3. Text4Baby messaging of childhood immunization reminders generalized to members ages 1-3 years of age 4. Developed a fact sheet educating providers on the importance of utilizing the CAIR site. Collaborating with CHOC in the development and distribution of the fact sheet 5. Developed of CIS fact sheet educating parents of the importance of childhood immunizations 6. Developed and implemented automated call (IVR) messages to a total of members (7,913 English, Spanish and Vietnamese) in need of immunizations 7. CHOC presentation opportunities highlighting CAIR and CIS tentatively scheduled for 4th quarter. 8. Assessing CAIR data for possible rate adjustment 9. Review and revise Healthy You newsletters content	On-going Q3-Q4 Q3-Q4 Q3 Q4 Q3-Q4 2017 Q4

			Q4-16/Q1-17
Q4 **Childhood Immunizations. Combo 10**	**Prospective Rates (Nov, 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated** **MC: Combo 10** Rate: 23.09% Goal: 52.08%	1. Healthy You Newsletters mailings with immunization schedules 2. Text4Baby messaging of childhood immunization reminders specific to vaccination scheduling provided to members up to one year of age 3. Text4Baby messaging of childhood immunization reminders generalized to members ages 1-3 years of age 4. Developed a fact sheet educating providers on the importance of utilizing the CAIR site. Collaborating with CHOC in the development and distribution of the fact sheet 5. Developed of CIS fact sheet educating parents of the importance of childhood immunizations 6. Developed and implemented automated call (IVR) messages to a total of members (7,913 English, Spanish and Vietnamese) in need of immunizations 7. CHOC presentation opportunities highlighting CAIR and CIS tentatively scheduled for 4th quarter. 8. Assessing CAIR data for possible rate adjustment 9. Review and revise Healthy You newsletters content	On-going Q3-Q4 Q3-Q4 Q3 Q4 Q3-Q4 2017 Q4 Q4-16/Q1-17
Year End	CalOptima continues to conduct outreach and implement interventions for this measure. However, there seems to be a slight declined in rates when compared to	• Continue with interventions. Increase IVR calls and immunization outreach for 2017 via health and wellness events and activities. • Collaborate with the health networks and leverage on initiatives	

	last year's data. Goal Status – Not met as of November, 2016 PR rates. We anticipate more information will be captured through medical chart review and the monthly CAIR data upload. Additional claims/encounter to be submitted through December, 2016 may change the rate.	that each HN is planning on implementing for CY 2017.	
Q1 **Adolescent Immunizations**	Hybrid Rate: 4/4/16 1. Meningococcal: **Rate: 74.92% Goal: 83.7%** 2. Tdap/Td: **Rate: 78.14% Goal: 90.0%** 3. Combo 1: **Rate: 71.06% Goal: 81.51%**	1. Healthy You Teen Newsletter sent to teens with information on immunizations 2. Member incentive; movie tickets to members who receive immunization 3. Adolescent Wellness Campaign to promote immunizations in collaboration with the health networks. Event to focus on teen wellness.	1. On-going 2. Quarter 3 3. Quarter 3
Q2 **Adolescent Immunizations**	**HEDIS 2016 Final Rate:** 1. Meningococcal: **Rate: 84.89% Goal: 83.7%; Goal Met** 2. Tdap/Td: **Rate: 91.0% Goal: 90.0%; Goal Met** 3. Combo 1: **Rate: 81.35% Goal: 81.51%** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** 1. Meningococcal: **Rate: 45.35% Goal: 83.7%;** 2. Tdap/Td: **Rate: 48.10%**	1. Healthy You Teen Newsletter sent to teens with information on immunizations 2. Member incentive; movie tickets to members who receive immunization 3. Adolescent Wellness Campaign to promote immunizations in collaboration with the health networks. Event to focus on teen wellness.	1. On-going 2. Q4-16/Q1-17 3. Q4-16/Q1-17

	Goal: 90.0%; Combo 1: **Rate: 40.88% Goal: 81.51%**		
Q3 **Adolescent Immunizations**	**Prospective Rates (Oct 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated** 1. Meningococcal: **Rate: 80.54% Goal: 83.7%;** 2. Tdap/Td: **Rate: 83.89% Goal: 90.0%;** **3.** Combo 1: **Rate: 75.83% Goal: 81.51%**	1. Healthy You Teen Newsletter sent to teens with information on immunizations 2. Member incentive project budget approved for 2017 implementation 3. Adolescent Wellness Campaign budget approved for 2017 implementation 4. Review and revise Healthy You newsletters content	1. On-going 2. Q1-Q2, 2017 3. Q1-Q2, 2017 4. Q1-Q2, 2017
Q4 **Adolescent Immunizations**	**Prospective Rates (Nov 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated** 1. Meningococcal: **Rate: 80.42% Goal: 83.7%;** 2. Tdap/Td: **Rate: 83.86% Goal: 90.0%;** **3.** Combo 1: **Rate: 75.73% Goal: 81.51%**	5. Healthy You Teen Newsletter sent to teens with information on immunizations 6. Member incentive project budget approved for 2017 implementation 7. Adolescent Wellness Campaign budget approved for 2017 implementation 8. Review and revise Healthy You newsletters content	5. On-going 6. Q1-Q2, 2017 7. Q1-Q2, 2017 8. Q1-Q2, 2017
Year End	CalOptima continues to conduct outreach and implement interventions for this measure. **Goal Status for the IMA measures as of Nov, 2016:** • Meningococcal: Goal not met by 3.28% • Tdap: Goal not met by 6.14%	• Continue with interventions and increase immunization outreach for 2017 • Update all Healthy You newsletters and promoting well-care and immunizations through health and wellness events.	

	• Combo 1: Goal not met by 5.78% The IMA measure seems to be improving when compared to last year's Nov 2015 rate. We anticipate more information will be captured through medical chart review and the monthly CAIR data upload. Additional claims/encounter to be submitted through December, 2016 may change the rate.		
Q1 **Appropriate testing for pharyngitis (CWP)**	HEDIS Rate (admin refresh) **Rate: 54.72% Goal: 71.48%**	1. Order Pharyngitis kits 2. Distribute pharyngitis kits to high prescribing providers. Educate on appropriate testing methods	1. Quarter 2 2. Quarter 3-4
Q2 **Appropriate testing for pharyngitis (CWP)**	**HEDIS 2016 Final Rate:** **Rate: 54.72% Goal: 71.48%** ***Improvement from the prior year** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **Rate: 46.11% Goal: 71.48%**	1. Distribute pharyngitis kits to high prescribing providers. Educate on appropriate testing methods 2. Data review of networks and providers eligible for kits based on HEDIS rates and member volume. Supplemental provider educational material being reviewed and finalized that will accompany the kits. 3. Review and approval of AWARE (Alliance Working on Antibiotic Resistance Education) toolkit materials. Toolkits will be distributed to providers in an effort to increase proper testing before antibiotic prescription. 4. Pharmacy Dept developed article targeting Providers entitled "Appropriate Antibiotic Use for Respiratory Tract Infections (RTIs) in Adults. Scheduled to circulate on August.	1. Quarter 3-4 2. Quarter 2-3 3. Quarter 3 4. Quarter 3

Q3 **Appropriate testing for pharyngitis (CWP)**	**Prospective Rates (Oct 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated** **Rate: 49.07% Goal: 62.98% (25th percentile)**	1. Review and approved of AWARE (Alliance Working on Antibiotic Resistance Education) toolkit materials. Toolkits will be distributed to 1,344 providers in an effort to increase proper testing before antibiotic prescription. 2. Pharmacy Dept developed article targeting Providers entitled "Appropriate Antibiotic Use for Respiratory Tract Infections (RTIs) in Adults. Scheduled to circulate on August.	Q4, 2016 Q3, 2016
Q4 **Appropriate testing for pharyngitis (CWP)**	**Prospective Rates (Nov 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated** **Rate: 49.08% Goal: 62.98% (25th percentile)**	• Continue with distributing pharyngitis kits to provider offices • Work with CMA foundation to distribute AWARE toolkit to providers	Ongoing Q4, 2016
Year End	CWP Goal Status: Goal Not Met The CWP Prospective Rates (PR) are gradually increasing but have not met goal as of Nov, 2016. AWARE Provider Toolkits were distributed Q4, 2017.	• Continue with distributing pharyngitis kits to provider offices through Q1, 2017. • Evaluate the impact of the pharyngitis kits by Quarter 4, 2017. • Evaluate the URI measure and assess all	
Q1 **Low Back Pain; Inverted rate**	HEDIS Rate (admin refresh) **MC: Rate: 76.1% Goal: 78.06%**	1. Outreach to top 3 low performing providers 2. Provider performance report card	1. Quarter 3 2. Quarter 3
Q2 **Low Back Pain; Inverted rate**	**HEDIS 2016 Final Rate:** **MC: Rate: 76.1% Goal: 78.06%** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles**	1. Outreach to top 3 low performing providers by a Medical Director 2. Provider performance report card 3. LBP mailing to providers encouraging correct TX of LBP within first 28 days of TX to 461 providers	1. Quarter 4 2. June 2016 3. June, 2016

	are out in October. **MC: Rate**: **73.53% Goal: 78.06%**		
Q3 **Low Back Pain; Inverted rate**	**Prospective Rates (October 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **MC: Rate**: **72.57% Goal: 78.06%**	1. Provider performance report card 2. LBP mailing to providers encouraging correct TX of LBP within first 28 days of TX to 461 providers 3. No longer conducting outreach by Medical Director	1. June, 2016 2. June, 2016
Q4 **Low Back Pain; Inverted rate**	**Prospective Rates (November 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **MC: Rate**: **72.30% Goal: 78.06%**	1. Provider performance report card 2. LBP mailing to providers encouraging correct TX of LBP within first 28 days of TX to 461 providers 3. No longer conducting outreach by Medical Director	1. June, 2016 2. June, 2016
Year End	CalOptima continue to conduct outreach for the LBP measure in 2016. However, rates appear to be declining. Measure is just shy of goal (50th percentile) by less than 5 % as of November, 2016. Additional claims/encounter to be submitted through December, 2016 may change the rate.	• Assess barriers to the LBP measure. • QI work team to assess opportunities to improve LBP measure and implement new initiatives	
Q1 **Adult's Access to Preventive/ Ambulatory Health (AAP)**	**HEDIS 2016 Final Rate:** **ALL MEMBERS: Rate**: **67.16% Goal: 79.59%**	1. Send all **OC** and **OCC** birthday card on their birthday month. Card includes message for member to go in for a well-care visit (No MC)	1. On-going
Q2 **Adult's Access to Preventive/ Ambulatory**	**HEDIS 2016 Final Rate:** **ALL MEMBERS: Rate**: **67.16% Goal: 79.59%**	1. Send all **OC** and **OCC** birthday card on their birthday month. Card includes message for member to go in for a well-care visit	1. On-going

Health (AAP)	**Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **ALL MEMBERS: Rate: 46.20% Goal: 79.59%**		
Q3 **Adult's Access to Preventive/ Ambulatory Health (AAP)**	**HEDIS 2016 Final Rate:** **ALL MEMBERS: Rate: 67.16% Goal: 79.59%** **Prospective Rates (October 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated.** **ALL MEMBERS: Rate: 58.47% Goal: 79.59%**	1. Send all **OC** and **OCC** birthday card on their birthday month. Card includes message for member to go in for a well-care visit (No MC)	1. On-going
Q4 **Adult's Access to Preventive/ Ambulatory Health (AAP)**	**HEDIS 2016 Final Rate:** **MC ALL MEMBERS: Rate: 67.16% Goal: 79.59%** **Prospective Rates (November 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated.** **MC ALL MEMBERS (Nov): Rate: 58.67% Goal: 79.59%**	2. Send all **OC** and **OCC** birthday card on their birthday month. Card includes message for member to go in for a well-care visit (No MC)	1. On-going
Year End	CalOptima did not meet goal of 79.59% for this measure. The AAP measure appears to be declining when comparing with last year's (Nov, 2015) rate.	Team to review opportunities for improving this measure. Look at all data sources, access and availability information to evaluate barriers. Continue with sending all **OC** and **OCC** birthday card on their birthday month. Card includes message for member to go in for a well-care visit (No MC)	

Q3 (New) Children's Access to Primary Care Practitioners (CAP)	**1) 12-24 mo: 96.28%** **2) 25 mo-6 years: 91.22%** **3) 7-11 years 93.90%** **4) 12-19 years 90.06%**	1. Healthy You mailings 2. Child Health Guide	1. Ongoing 2. Ongoing
Q4(New) Children's Access to Primary Care Practitioners (CAP)	**1) 12-24 mo: 92.14%** **2) 25 mo-6 years: 81.27%** **3) 7-11 years 88.19%** **4) 12-19 years 84.22%** **MC Goals:** MC: 1) 12-24 months 96.28% (50th percentile) 2) 25 months -6 years 91.22% (75th percentile) 3) 7-11 years 93.90% (75th percentile) 4) 12-19 years 90.06% (50th percentile)	1. Healthy You mailings 2. Child Health Guide	1. Ongoing 2. Ongoing
Year End	Goal Status as of Nov, 2016: **1) 12-24 mo: 92.14%; Goal not met** **2) 25 mo-6 years: 81.27%; Goal not met** **3) 7-11 years 88.19%; Goal not met** **4) 12-19 years 84.22%; Goal not met** The CAP measure has been declining for the past two years.	Team to review opportunities for improving this measure. Look at all data sources, access and availability information to evaluate barriers.	
Q3 (New) Well-Child Visits in the first 15 months (W15)	**Rate: 24.41%** **MC: 59.76%** **Goal: 59.76%**	1. Healthy You mailings 2. Child Health Guide	1. Ongoing 2. Ongoing

Q4 (New) Well-Child Visits in the first 15 months (W15)	**Nov, 2016 PR MC: 24.86%** **Goal: 59.76%**	1. Healthy You mailings 2. Child Health Guide	1. Ongoing 2. Ongoing
Year End	Goal status as if Nov, 2016: Goal not met. There has been a slight decline in the W15 measure when compared to last Nov, 2015's data. This is a hybrid measure. We anticipate the rates to improve through medical chart review.	Team to assess barriers and opportunities for improving this measure.	
Q1 **Cervical Cancer Screening (CCS)**	**HEDIS 2016 Final Rate:** **MC: Rate: 48.04% Goal: 54.33%**	1. Update member education material	Q2
Q2 **Cervical Cancer Screening (CCS)**	**HEDIS 2016 Final Rate:** **MC: Rate: 48.04% Goal: 54.33%** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **MC: Rate: 21.89% Goal: 54.33%**	1. Update member education material	2. June 2016
Q3 **Cervical Cancer Screening (CCS)**	**HEDIS 2016 Final Rate:** **MC: Rate: 48.04% Goal: 54.33%** **Prospective Rates (October 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated.**	1. Finalize member education material 2. Develop automated, outbound calls to women due for screening 3. Launch Adult Health workgroup 4. Develop pilot to partner with front office staff of offices w/ high volume of members due for a	1. September 2016 2. October 2016 3. September 2016 4. Q4 2016 5. Q4 2016

	MC: Rate: **46.66% Goal: 54.33%**	screening 5. Mail Cervical Cancer screening brochure	
Q4 **Cervical Cancer Screening (CCS)**	**HEDIS 2016 Final Rate:** **MC: Rate**: **48.04% Goal: 54.33%** **Prospective Rates (October 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated.** **MC: Rate**: **46.66% Goal: 54.33%**	1. Finalize member education material. Mail Cervical Cancer screening brochure 2. Develop automated, outbound calls to women due for screening 3. Develop pilot to partner with front office staff of offices w/ high volume of members due for a screening	1. Q4, 2016 2. Q4, 2016 3. Q1, 2017
Year End	**PR rates as of November, 2016:** **MC: Rate**: **46.79% Goal: 54.33%; Goal not met** CalOptima has conducted an extensive barrier analysis for the CCS measure. Several new QI initiatives were planned and preparing to implement in Q1, 2017. Additional claims/encounter to be submitted through December, 2016 may change the rate. We anticipate the rates to improve through medical chart review.	• Implement new initiatives for the 2017 calendar year to improve the CCS measure. (Women's health campaign, member incentives, community outreach) • Continue with the CCS PDSA project – Provider office staff incentive (Q1, 2017) Newly adjusted 2017 quality compass rate = 48%	
Q1 **Breast Cancer Screening (BCS)**	**HEDIS 2016 Final Rate:** **MC: Rate**: **62.55% Goal: 66.02%** **OC: Rate: 68.64% Goal: 71.36%**		
Q2 **Breast Cancer Screening**	**HEDIS 2016 Final Rate:** **MC: Rate**: **62.55% Goal: 66.02%**	1. Update member education material	2. June 2016

(BCS)	**OC: Rate: 68.64% Goal: 71.36%** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **MC: Rate: 23.82% Goal: 66.02%** **OC: Rate: 33.16% Goal: 71.36%**		
Q3 **Breast Cancer Screening (BCS)**	**HEDIS 2016 Final Rate:** **MC: Rate: 62.55% Goal: 66.02%** **OC: Rate: 68.64% Goal: 71.36%** **Prospective Rates (October 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **MC: Rate: 59.12% Goal: 66.02%** **OC: Rate: 70.68% Goal: 71.36%**	1. Finalize member education material 2. Launch Adult Health workgroup Mail Breast Cancer screening brochure 3. Mail Breast Cancer Screening brochure	1. September 2016 2. September 2016 3. Q4 2016
Q4 **Breast Cancer Screening (BCS)**	**HEDIS 2016 Final Rate:** **MC: Rate: 62.55% Goal: 66.02%** **OC: Rate: 68.64% Goal: 71.36%** **Prospective Rates (November 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **MC: Rate: 59.51% Goal: 66.02%** **OC: Rate: 71.2% Goal: 71.36%** **OCC: Rate: 54.92% Goal: 71.36%**	• BCS member mailing dropped for all LOBs in December, 2016 • IVR call outreach to all LOBs in December, 2016	4. Q4, 2016 5. Q4, 2016

Year End	**Goal Status as of Nov, 2016:** • MC: Goal not met • OC: Goal not met • OCC: Goal not met CalOptima continues to implement activities to improve the BCS measure. Additional claims/encounter to be submitted through December, 2016 may change the rate. We anticipate the rates to improve through medical chart review.	• Implement new initiatives for the 2017 calendar year to improve the CCS measure. (Women's health campaign, member incentives, community outreach) • QI work team to assess barriers and opportunities for improving measure.	
Q1 **Colorectal Cancer Screening (COL)**	**HEDIS 2016 Final Rate:** **OC: Rate**: **56.75% Goal: 67.27%**	N/A	N/A
Q2 **Colorectal Cancer Screening (COL)**	**HEDIS 2016 Final Rate:** **OC: Rate**: **56.75% Goal: 67.27%** **Prospective Rates (June 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are out in October.** **OC: Rate**: **31.91% Goal: 67.27%**	N/A	N/A
Q3 **Colorectal Cancer Screening (COL)**	**HEDIS 2016 Final Rate:** **OC: Rate**: **56.75% Goal: 59.85%** **Prospective Rates (October 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated**	Added to QI Work Plan 1. Develop Project Plan for Member Outreach	1. Q1 2017

	OC: Rate: **51.07% Goal: 67.27%** **OCC: Rate**: **37.96% Goal: 67.27%**		
Q4 **Colorectal Cancer Screening (COL)**	**HEDIS 2016 Final Rate:** **OC: Rate**: **56.75% Goal: 59.85%** **Prospective Rates (October 2016): NOTE: Using HEDIS 2016 Goals for now until the new quality compass percentiles are calculated** **OC: Rate**: **54.72% Goal: 67.27%** **OCC: Rate**: **41.59% Goal: 67.27%**	Added to QI Work Plan 1. Develop Project Plan for Member Outreach	1. Q1 2017
Year End	Goal Status: **OC: Rate**: **54.72% Goal: 67.27%; not met** **OCC: Rate**: **41.59% Goal: 67.27%; not met** This is a hybrid measure. We anticipate more information will be captured through medical chart review. Additional claims/encounter to be submitted through December, 2016 may change the rate. We anticipate the rates to improve through medical chart review.	• Conduct member mailing for colorectal outreach in March, 2017 to promote Colorectal Cancer Awareness month. • Update the Colorectal brochure for members • Conduct IVR calls and member mailing to drop in Q1, 2017 (March)	

CAHPS Measures
Owner: Member Experience Team

	Results / Metric	Next Steps	Target Completion
Q1 **Rating of Health Plan**	Medi-Cal CAHPS Child Plan Level Survey 2014 MY CalOptima's Score: 83.3% (NCQA Rating=2.56) Goal: At or above the NCQA 50thth Percentile (NCQA Rating = 2.57)	• Conduct further analysis on Supplemental Survey data in regards to provider specific results and qualitative analysis and share results. • Educate the HNs on the new CAHPS measure "Care Coordination" at the HN Forum • Outreach to the top CAHPS scoring Health Plans to learn of their best practices • CMO Medical Director's Forum • Outreach to physicians with low member satisfaction scores (data from the supplemental survey) • Implement CG-CAHPS to obtain provider level detail on member experience.	Quarter 2 Quarter 3
Q2 **Rating of Health Plan**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 86.1% (NCQA Rating=2.64) Goal: At or above the NCQA 50thth Percentile (NCQA Rating = 2.57) – Goal Met	• Conduct further analysis on Supplemental Survey data in regards to provider specific results and qualitative analysis and share results – clinic level data • Outreach to the top CAHPS scoring Health Plans to learn of their best practices • CMO Medical Director's Forum – P4P • Educate HNs on their provider who had low CAHPS scores on the supplemental survey and the CG-CAHPS • Distribute HN specific CAHPS reports and supplemental survey results to HNs. • Subgroup to review the referral and authorization process • RFI on Physician and Office Staff Coaching	Quarter 3
Q3 **Rating of Health Plan**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 86.1% (NCQA Rating=2.64) Goal: At or above the NCQA 50thth Percentile (NCQA Rating = 2.57) – Goal Met	• Conduct further analysis on Supplemental Survey data in regards to provider specific results and qualitative analysis and share results – clinic level data • Presented all member and provider survey plan level results to the following committees: Member Experience Steering Committee, QIC, PAC, HN Forum, HN Quality Forum, etc.	Quarter 3

		• Developed HN Survey Summaries and presented this survey results to the HNs at the HN JOM or Quality Meeting • Distribute HN specific CAHPS results to HNs via email • Updated the prior authorization list to improve administrative burden to providers and improve authorization timeliness (authorization that were not denied were removed from the list) • Implemented CG-CAHPS survey • Continue to work with the PAC Ad Hoc Subcommittee on member experience • Member communication to inform members of CalOptima's members surveys and to encourage them to complete the surveys (OCC New Years Letter, MC Flu Mailing) • Article in the Provider Update (fax blast) to share of our CAHPS results and provide tips on how to improve overall member experience • Hired a project manager for member experience. • Presented CAHPS results with CCN specific results to the CCN Lunch and Learn • Work with HN to explore CG-CAHPS data collection collaboration	Quarter 4
Q4 **Rating of Health Plan**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 86.1% (NCQA Rating=2.64) Goal: At or above the NCQA 50thth Percentile (NCQA Rating = 2.57) – Goal Met	• Article in the Provider Update (fax blast) to share of our CAHPS results and provide tips on how to improve overall member experience • Hired a project manager for member experience. • Presented CAHPS results with CCN specific results to the CCN Lunch and Learn • Presented CAHPS results to the HNs at forums and JOMs. • Work with HN to explore CG-CAHPS data collection collaboration • Provided HNs with their CAHPS results along with a one page summary of their performance • Member communication to inform members of CalOptima's members surveys and to encourage them to complete the surveys (OCC New Years Letter, MC Flu Mailing) • Article in the provider fax blast to inform the providers of the up-and-coming CAHPS fielding so they can encourage their patients to complete the survey	Quarter 4 Quarter 1 2017

		• Present member experience results to MAC • Share 2017 survey schedule with HNs • Article on CAHPS and member experience in the OCC Health You Healthy Year mailing • Promote health education services •	
Year End	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 86.1% (NCQA Rating=2.64) Goal: At or above the NCQA 50thth Percentile (NCQA Rating = 2.57) – Goal Met	Continued efforts in the following: 1. Share health network and practitioner level member experience results timely. 2. Provider coaching 3. Promote CalOptima benefits (i.e. health education, disease management, nurse advice line). 4. Better coordinate member communications.	
Q1 **Getting Needed Care**	Medi-Cal CAHPS Child Plan Level Survey 2014 MY CalOptima's Score: 82.4% (NCQA Rating=2.24) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.47)	• Issue corrective action plans to HNs who did not meet CalOptima's Access Standards as part of the 2015 Timely Access Survey • Field the 2016 Timely Access Study • Educate members on how to get better care at an appointment and better communicate with the provider (materials handed to members at the provider office). • Add an FTE (Member Connections 8) to close the gap on missed opportunities and initiate reminders for preventive services and immunizations. • Annually update standards and protocols on access • Continue to monitor geographical distance and distribution of our provider network • Trend and evaluate members' complaints (GARS) files on getting care and access. Pull provider capacity data (provider to member ratio) to better monitor member access to services.	Quarter 2 On-going
Q2 **Getting Needed**	Medi-Cal CAHPS Child Plan Level Survey	• Subgroup to review the referral and authorization process • Review and update annual Access and Availability Policy MA. 7007	Quarter 3

Care	2015 MY CalOptima's Score: 77.6% (NCQA Rating=2.25) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.47) – Goal Not Met	• Provider education on Prior Authorization Guidelines, Urgent Prior Authorization Requests, and Services that do not require prior authorizations. • Educate members on how to get better care at an appointment and better communicate with the provider • Work with HNs on identifying best practices related to getting care, tests or treatment needed.	
Q3 **Getting Needed Care**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 77.6% (NCQA Rating=2.25) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.47) – Goal Not Met	• Updated the prior authorization list to improve administrative burden to providers and improve authorization timeliness (authorization that were not denied were removed from the list) • Updated MA.7007 OC and OCC Access and Availability Policy • Updated the reporting format for the availability report • Presented Access and Availability standards and changes to the policy at the HN Forum •	Quarter 3 Quarter 4
Q4 **Getting Needed Care**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 77.6% (NCQA Rating=2.25) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.47) – Goal Not Met	• Trend and evaluate members' complaints (GARS) files on getting care and access. • Monitor geographical distance and distribution of our provider network • Educate HNs on their areas of non-compliance on access standards and issue Corrective Action Plans. • Trend and evaluate members' complaints (GARS) files on getting care and access. • Monitor geographical distance and distribution of our provider network • Provider phone and after hours script to physicians	Quarter 4 Quarter 1 2017
Year End	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 77.6% (NCQA Rating=2.25) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.47) – Goal Not Met	Continue efforts to improve member experience include the following: 1. Communication with health networks and practitioners on their performance 2. Member and provider education on standards 3. Small workgroups to identify barriers and developing initiatives 4. Recruitment of high volume and high impact specialists	

		5. Better communication with members on how best to access services.	
Q1 **Getting Care Quickly**	Medi-Cal CAHPS Child Plan Level Survey 2014 MY CalOptima's Score: 73.5% (NCQA Rating=2.28) Goal: At or above the NCQA 50thth Percentile (NCQA Rating = 2.47)	• Provider education on Prior Authorization Guidelines, Urgent Prior Authorization Requests, and Services that do not require prior authorizations • Educate members on prior auth and referral process via member newsletter, etc • Promote the use of the nurse advice line via member newsletter, etc • Internet access for health information and advice (CalOptima's Member Portal).	Quarter 2 TBD
Q2 **Getting Care Quickly**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 85.3% (NCQA Rating=2.45) Goal: At or above the NCQA 50thth Percentile (NCQA Rating = 2.47) – Goal Not Met	• Distribute HN-specific reports on access and availability to HNs • Educate HNs on their areas of non-compliance on access standards and issue Corrective Action Plans. • Implement frequent education to members regarding routine and emergency appointment expectations and best practices to prepare for an office visit. • Promote the use of the nurse advice line • Promote the use of the Health Education Portal • Development of the Member On-line Portal	Quarter 3 Quarter 4
Q3 **Getting Care Quickly**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 85.3% (NCQA Rating=2.45) Goal: At or above the NCQA 50thth Percentile (NCQA Rating = 2.47) – Goal Not Met	• Distribute HN-specific reports on access and availability to HNs • Educate HNs on their areas of non-compliance on access standards and issue Corrective Action Plans. • Implement frequent education to members regarding routine and emergency appointment expectations and best practices to prepare for an office visit. • Promote the use of the nurse advice line • Promote the use of the Health Education Portal	Quarter 3

		• Development of the Member On-line Portal	Quarter 4
Q4 **Getting Care Quickly**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 85.3% (NCQA Rating=2.45) Goal: At or above the NCQA 50thth Percentile (NCQA Rating = 2.47) – Goal Not Met	• Educate the HNs of the Access Standards at the HN Forum • Educate HNs on their areas of non-compliance on access standards and issue Corrective Action Plans. • Access to Care standards placed in the MC Newsletter (Dec) • Updated the Access to Care Standards in the Provider Manual • Educate the providers and HNs on areas of non-compliance • Engage the UM Workgroup to identify opportunities for improvement related to referrals and authorizations	Quarter 4 Quarter 1 2017
Year End	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 85.3% (NCQA Rating=2.45) Goal: At or above the NCQA 50thth Percentile (NCQA Rating = 2.47) – Goal Not Met	Continue efforts to improve member experience include the following: 1. Communication with health networks and practitioners on their performance 2. Member and provider education on standards 3. Small workgroups to identify barriers and developing initiatives 4. Recruitment of high volume and high impact specialists 5. Better communication with members on how best to access services. 6. Tools and scripts to providers 7. Promoting best practices in the offices	
Q1 **How well Doctors Communicate**	Medi-Cal CAHPS Child Plan Level Survey 2014 MY CalOptima's Score: 88.2% (NCQA Rating=2.52) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.68)	• Provide decision tool for providers to better communicate with members • Develop and distribute Provider Toolkit for providers with recommendations on how to improve member experience • In-service training to providers offices identified as having	Quarter 2 Quarter 3

		poor customer service	
Q2 **How well Doctors Communicate**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 91.2% (NCQA Rating=2.61) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.68) – Goal Not Met	• RFI on Physician and Office Staff Coaching • Decision Tools for Providers • Provider Toolkits for providers on how to improve member experience • Education "team" and education for PCPs and office staff to help improve service and reduce barriers to care within clinical settings • Identify best practices and interventions implemented through the HNs at the PCP/clinic office • Exploring working with the HNs on how PCPs can help utilize the care team to help communicate with their patients.	Quarter 3
Q3 **How well Doctors Communicate**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 91.2% (NCQA Rating=2.61) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.68) – Goal Not Met	• RFI on Physician and Office Staff Coaching • Implement CG-CAHPS • RFP For Provider Coaching • Decision Tools for Providers • Provider Toolkits for providers on how to improve member experience • Education "team" and education for PCPs and office staff to help improve service and reduce barriers to care within clinical settings • Identify best practices and interventions implemented through the HNs at the PCP/clinic office Exploring working with the HNs on how PCPs can help utilize the care team to help communicate with their patients.	Quarter 3 Quarter 4
Q4 **How well Doctors Communicate**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 91.2% (NCQA Rating=2.61) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.68) – Goal Not Met	• Article in the Provider Update (faxblast) on CalOptima's overall CAHPS results and performance. Article included tips on how to better communicate with patient. • Issued a Provider Coaching RFI • Develop provider coaching RFP	Quarter 4 Quarter 1

			2017
Year End	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 91.2% (NCQA Rating=2.61) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.68) – Goal Not Met	Continue efforts to improve member experience include the following: 1. Better communication with members on how best to access services. 2. Provider training on cultural and linguistic needs 3. Provider coaching 4. Promoting best practices in the offices 5. Celebrate/highlight top performers	
Q1 **Customer Service**	Medi-Cal CAHPS Child Plan Level Survey 2014 MY CalOptima's Score: 86.0% (NCQA Rating=2.49) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.53)	• "Mystery Shopper" calls to HN Customer Service or ensure access to threshold languages with findings to be reported out to Provider Network and Audit and Oversight. • Trend and evaluate members complaints filed with Grievance and Appeals against Customer Service staff and provided coaching and training to the staff member identified. • Review and update CalOptima's Customer Service training program based on findings from the telephonic survey, complaints files against Customer Service staff, in-line auditing and Audit and Oversight. • Add an option for member to leave a voicemail and contact information if members answers "no" or "somewhat" as part of the CS telephonic survey • Add an option for member to identify if they called their assigned network for assistance prior to calling CalOptima for assistance • Expanding the telephonic post-service survey to all lines of business (currently MC Only) • Continue "Quarterly training for customer service staff • Continue audits of customer service calls • Continue "Weekly huddles" to CS staff to review	Quarter 2 Quarter 4 On-going

		new/updated benefits or member communications that may impact the member to ensure the staff are trained to answer questions and handle the call appropriately. • Staff training on soft skills and what CS staff can do vs. what they can't do. Continue "CS Training Workshops "	
Q2 **Customer Service**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 86.5% (NCQA Rating=2.48) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.53) – Goal Not Met	• Educate HNs on their customer service performance, particularly on whether they are about to provide members with assistance in their language. • Conduct and share "mystery shopper" of HNs and share results with HNs and work with them to improve after hours customer service • Conduct and share "mystery shopper" of CalOptima's after hours vendor and share results with HNs and work with them to improve after hours customer service • Weekly huddles to review the information for the week. Staff is given training on soft skills and what they can do and what they can't do • CS Training Workshops • Quarterly training for customer service staff • Identify Customer Service agents who need training and/or coaching and provide specific education • Review and updates CalOptima's Customers Service training program • Audit customer service staff calls	Quarter 3 On-going
Q3 **Customer Service**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 86.5% (NCQA Rating=2.48) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.53) – Goal Not Met	• Weekly huddles to review the information for the week. Staff is given training on soft skills and what they can do and what they can't do • CS Training Workshops • Quarterly training for customer service staff • Identify Customer Service agents who need training and/or coaching and provide specific education • Review and updates CalOptima's Customers Service training program • Customer Service Post Call Survey • Conduct and share "mystery shopper" of HNs and share	On-going

		results with HNs and work with them to improve after hours customer service • Conduct and share "mystery shopper" of CalOptima's after hours vendor and share results with HNs and work with them to improve after hours customer service	Quarter 4
Q4 **Customer Service**	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 86.5% (NCQA Rating=2.48) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.53) – Goal Not Met	• Weekly huddles to review new/updated benefits or member communications that may impact the member to ensure the staff are trained to answer questions and handle the call appropriately. Staff is given training on soft skills and what they can do vs. what they can't do. • Quarterly training for customer service staff include but are not limited to: a) New or changing benefits b) Updates on Health Networks and PCPs c) How to Use the Drug Formulary and Changes to CalOptima Approved Drug List d) Soft Skills e) New vendors such as, Nurse Advice Line • Audit of staff calls by management. Audit of calls by A&O. • Add an option for member to leave a voicemail and contact information if members answers "no" or "somewhat" as part of the CS telephonic survey • Expanding the telephonic post-service survey to all lines of business (currently MC Only) • Weekly huddles to review new/updated benefits or member communications that may impact the member to ensure the staff are trained to answer questions and handle the call appropriately. Staff is given training on soft skills and what they can do vs. what they can't do. • Quarterly training for customer service staff • "Mystery Shopper" calls to HN Customer Service or ensure access to threshold languages with findings to be reported out to Provider Network and Audit and Oversight.	Quarter 4 Quarter 1 2017

Year End	Medi-Cal CAHPS Child Plan Level Survey 2015 MY CalOptima's Score: 86.5% (NCQA Rating=2.48) Goal: At or above the NCQA 50th Percentile (NCQA Rating = 2.53) – Goal Not Met	Continue efforts to improve member experience include the following: 1. Continuous customer service staff trainings (trainings updated from feedback from post call survey) 2. Weekly huddles for customer service staff 3. 'Mystery Shopper' calls to HN customer service to ensure access to threshold services	

STARS
Owner: Kris Gericke, PharmD, Director, Pharmacy

Q1	Results / Metric	Next Steps	Target Completion
Cholesterol Medication Adherence	OneCare CY16 Report Card: 4 Stars (75%) OneCare CY17 Report Card: ? Stars (76%)	Data will be provided for 2016 YTD soon. Preliminary star ratings will be provided in September, 2016 for 2015 data (CY17 Report Card).	June
Antihypertensive Medication (RAS Antagonist) Adherence	OneCare CY16 Report Card: 4 Stars (77%) OneCare CY17 Report Card: ? Stars (78%)		June
Diabetes Medication Adherence	OneCare CY16 Report Card: 4 Stars (78%) OneCare CY17 Report Card: ? Stars (79%)		June

Q2	Results / Metric	Next Steps	Target Completion
Cholesterol Medication Adherence	OneCare CY16 Report Card (2014 data): 4 Stars (75%) OneCare CY17 Report Card (2015 data): 4 Stars (76%) OneCare CY18 Report Card (2016 data): ? Stars (95%) OneCare Connect CY17 Report Card (2015 data): 5 Stars (82%) OneCare Connect CY18 Report Card (2016 data): ? Stars (86%)	Preliminary star ratings will be provided in September 2016 for 2015 data (CY17 Report Card).	September
Antihypertensive Medication (RAS Antagonist) Adherence	OneCare CY16 Report Card (2014 data): 4 Stars (77%) OneCare CY17 Report Card (2015 data): 4 Stars (78%) OneCare CY18 Report Card (2016 data): ? Stars (90%) OneCare Connect CY17 Report Card (2015 data): 5 Stars (86%) OneCare Connect CY18 Report Card (2016 data): ? Stars (87%)	Star threshold values for 2016 based on 2015 thresholds (may change when star ratings are released in September 2016).	September
Diabetes Medication Adherence	OneCare CY16 Report Card (2014 data): 4 Stars (78%) OneCare CY17 Report Card (2015 data): 4 Stars (79%) OneCare CY18 Report Card (2016 data): ? Stars (88%) OneCare Connect CY17 Report Card (2015 data): 4 Stars (82%) OneCare Connect CY18 Report Card (2016 data): ? Stars (86%)	Data for PDEs through June 2016.	September

Q3	Results / Metric	Next Steps	Target Completion
Cholesterol Medication Adherence	OneCare CY16 Report Card (2014 data): 4 Stars (75%) OneCare CY17 Report Card (2015 data): 3 Stars (76%) OneCare CY18 Report Card (9-16 data): 5 Stars (92%) OneCare Connect CY17 Report Card (2015 data): 5 Stars (82%) OneCare Connect CY18 Report Card (9-16 data): 4 Stars (80%) MA-PD average through 9-16: 82.3%	Preliminary star ratings will be provided in September 2016 for 2015 data (CY17 Report Card).	September
Antihypertensive Medication (RAS Antagonist) Adherence	OneCare CY16 Report Card (2014 data): 4 Stars (77%) OneCare CY17 Report Card (2015 data): 3 Stars (78%) OneCare CY18 Report Card (9-16 data): 5 Stars (86%) OneCare Connect CY17 Report Card (2015 data): 5 Stars (86%) OneCare Connect CY18 Report Card (2016 data): 5 Stars (87%) MA-PD average through 9-16: 85.6%	Star threshold values for 2016 based on 2015 thresholds (may change when star ratings are released in September 2016).	September
Diabetes Medication Adherence	OneCare CY16 Report Card (2014 data): 4 Stars (78%) OneCare CY17 Report Card (2015 data): 4 Stars (79%) OneCare CY18 Report Card (9-16 data): 5 Stars (86%) OneCare Connect CY17 Report Card (2015 data): 4 Stars (82%) OneCare Connect CY18 Report Card (9-16 data): 5 Stars (83%) MA-PD average through 9-16: 83.4%	Final star ratings provided in September 2016 for 2015 data (CY17 Report Card). OneCare Connect did not receive star measure scores since it started in July 2015. Star threshold values for 2018 based on 2017 thresholds (may change when star ratings are released in September 2017). Continue interventions to improve member adherence.	December

Q4	Results / Metric	Next Steps	Target Completion
Cholesterol Medication Adherence	OneCare CY16 Report Card (2014 data): 4 Stars (75%) OneCare CY17 Report Card (2015 data): 3 Stars (76%) OneCare CY18 Report Card (11-16 data): ? Stars (89%) OneCare Connect CY17 Report Card (2015 data): 5 Stars (82%) OneCare Connect CY18 Report Card (11-16 data): ? Stars (77%) MA-PD average through 11-16: 79.0%	Continue interventions to improve member adherence.	
Antihypertensive Medication (RAS Antagonist) Adherence	OneCare CY16 Report Card (2014 data): 4 Stars (77%) OneCare CY17 Report Card (2015 data): 3 Stars (78%) OneCare CY18 Report Card (11-16 data): ? Stars (84%) OneCare Connect CY17 Report Card (2015 data): 5 Stars (86%) OneCare Connect CY18 Report Card (11-16 data): ? Stars (80%) MA-PD average through 11-16: 83.5%		
Diabetes Medication Adherence	OneCare CY16 Report Card (2014 data): 4 Stars (78%) OneCare CY17 Report Card (2015 data): 4 Stars (79%) OneCare CY18 Report Card (11-16 data): ? Stars (83%) OneCare Connect CY17 Report Card (2015 data): 4 Stars (82%) OneCare Connect CY18 Report Card (11-16 data): ? Stars (79%) MA-PD average through 11-16: 80.9%		
Year End	**Cholesterol Medication Adherence** OneCare CY16 Report Card (2014 data): 4 Stars (75%) OneCare CY17 Report Card (2015 data): 3 Stars (76%) OneCare CY18 Report Card (12-16 data): ? Stars (87%) OneCare Connect CY17 Report Card (2015 data): 5 Stars (82%) OneCare Connect CY18 Report Card (12-16 data): ? Stars (75%) MA-PD average through 12-16: 78% **Antihypertensive Medication (RAS Antagonist) Adherence** OneCare CY16 Report Card (2014 data): 4 Stars (77%) OneCare CY17 Report Card (2015 data): 3 Stars (78%) OneCare CY18 Report Card (12-16 data): ? Stars (80%)		

	OneCare Connect CY17 Report Card (2015 data): 5 Stars (86%) OneCare Connect CY18 Report Card (12-16 data): ? Stars (79%) MA-PD average through 12-16: 83% **Diabetes Medication Adherence** OneCare CY16 Report Card (2014 data): 4 Stars (78%) OneCare CY17 Report Card (2015 data): 4 Stars (79%) OneCare CY18 Report Card (12-16 data): ? Stars (83%) OneCare Connect CY17 Report Card (2015 data): 4 Stars (82%) OneCare Connect CY18 Report Card (12-16 data): ? Stars (78%) MA-PD average through 12-16: 80%		

Health Outcomes Survey
Owner: Marsha Choo, Manager, QA

	Results / Metric	Next Steps	Target Completion
Q1 **Reducing Risk of Falls**	Cohort 17 Baseline: Discussing Fall Risk: 37.15% Managing Fall Risk: 72.35%	HOS results have been received and data analysis is in progress.	Q2
Q2 **Reducing Risk of Falls**	Results are received annual and there were no new results available. (Scores remain the same as in Q1).	• Provider education via the provider update fax blast • Member education via the member newsletter	Q3
Q3 **Reducing Risk of Falls**	Results are received annual and there were no new results available. (Scores remain the same as in Q2).	• Provider education via the provider update fax blast on osteoporosis treatment • Member education via the member newsletter	Quarter 3 and 4 Quarter 4
Q4 **Reducing Risk of Falls**	Cohort 18 Baseline: Discussing Fall Risk: 32.76% Managing Fall Risk: 63.30%	• Provider education fax on osteoporosis treatment	Quarter 1, 2017
Year End	Cohort 18 Baseline: Discussing Fall Risk: 32.76% Managing Fall Risk: 63.30% In 2016, both the scores for these measures decreased from the year before.	• Continued efforts to improve the score through provider education on osteoporosis management. • Member mailing on Osteoporosis	1. Quarterly Faxes, Ongoing 2. Q2, 2017
Q1 **Improving**	Cohort: 15 Follow-up: 70.27% performed as expected (the same as the national average)	HOS results have been received and data analysis is in progress.	Q2

Physical Health Status			
Q2 **Improving Physical Health Status**	Results are received annual and there were no new results available. (Scores remain the same as in Q1).	• Mail out the self-care guide to the OC population • Telephonic outreach to diabetic members with A1c >9	Q3
Q3 **Improving Physical Health Status**	Results are received annual and there were no new results available. (Scores remain the same as in Q2).	• Telephonic outreach to diabetic members with A1c >9 • Mail out the self-care guide to the OC population	Quarter 3 Quarter 4
Q4 **Improving Physical Health Status**	Cohort: 16 Follow-up: 67%	• Telephonic outreach to diabetic members with A1c >9 • Outreach to DM members to manage high blood pressure and distribute blood pressure cuffs when appropriate • Outreach to population to obtain preventive screenings [breast cancer and colorectal cancer]	Ongoing Ongoing Ongoing
Year End	Cohort: 16 Follow-up: 67% In 2016, there was a 3 percentage point decrease and a 1 star decrease from the previous year.	Continue efforts to increase the score include outreach to members with chronic conditions on how to better care for their condition and overall outreach to members on obtaining screenings.	2017
Q1 **Improving Mental Health Status**	Cohort: 15 Follow-up: 77.32%performed as expected (the same as the national average)	HOS results have been received and data analysis is in progress.	Q2
Q2 **Improving Mental Health Status**	Results are received annual and there were no new results available. (Scores remain the same as in Q1).	• Educate providers on depression screenings. • Explore the ability to provider PCPs with a depression screening	Q3

Q3 **Improving Mental Health Status**	Results are received annual and there were no new results available. (Scores remain the same as in Q2).	• CalOptima contract with new BH partner • Strategize with BH Partner on how to ensure continuity of care for our members • Educate providers on depression screenings. • Explore the ability to provider PCPs with a depression screening •	Quarter 3 Quarter 4
Q4 **Improving Mental Health Status**	Cohort: 16 Follow-up: 87%	• Strategize with BH Partner on how to ensure continuity of care for our members • Educate providers on depression screenings. • Explore the ability to provider PCPs with a depression screening	Quarter 1 2017
Year End	Cohort: 16 Follow-up: 87% In 2016, there was a 10 percentage point increase and a 2 star increase from the previous year.	Continue efforts to increase the score include working with Magellan to better coordinate care for CalOptima members.	2017

X. Delegation Oversight

A. Delegation Oversight of CM

Owner: Sloane Petrillo, Director, CM

The Approach

1. **Objective**
   - Regular review of the Health Network's performance of CM functions

2. **Activity**
   - Assure compliance to all regulatory and accreditation delegation oversight requirements
   - **Report from DOC

3. **Goals**
   - 100%

Delegation Oversight
Owner: Sloane Petrillo, Director, CM

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	**OCC:** Aggregate scores: Jan: 80%, Feb 78.8%, Mar 85.6%	AMVI/Prospect under CAP for MOC quality scores	Q 2 2016
Q2	OCC: Aggregate scores: Apr 87% May 83.6% Jun 81.6%	AMVI/Prospect under CAP for MOC quality scores/timeliness	Q4 2016
Q3	OCC: Aggregate scores: Jul: 81% Aug: 86% Sept: 91%	AMVI/Prospect under CAP for MOC quality scores/timeliness FCMG under CAP for OCC quality scores as of 8/2016	Q1 2017
Q4	OCC: Aggregate scores: Oct:91% Nov: 93% Dec: 90%	AMVI/Prospect under CAP for MOC quality scores/timeliness FCMG under CAP for OCC quality scores as of 8/2016	Q1 2017
Year End	OCC Aggregate scores have improved as 2016 progressed and have stabilized.		
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	**OCC:** **Jan** / **Feb** / **Mar** **AltaMed** 80% / 86.2% / 76.9% **AMVI** 65.7% / 69.6% / 61.0% **Arta** 85% / 88.5% / 92.42%	AMVI/Prospect under CAP for MOC quality scores and timeliness.	Q 2 2016

	Heritage ADOC	100%	100%	100%			
	Heritage Regal	100%	100%	75.5%			
	FCMG	64.8%	72.5%	80.3%			
	OCA	95%	100%	91%			
	Talbert	100%	94.79%	95.63%			
	Monarch	81.9%	79.9%	88.3%			
	Prospect	70.3%	69.2%	63.5%			
	Noble	100%	80.2%	96.7%			
	UCMG	88.6%	91%	92.1%			
	CCN	71.7%	79.7%	72.6%			

<table>
<tr>
<td>Q2</td>
<td>
<table>
<tr><th></th><th><u>Apr</u></th><th><u>May</u></th><th><u>Jun</u></th></tr>
<tr><td>AltaMed</td><td>71.4%</td><td>83.7%</td><td>95.2%</td></tr>
<tr><td>AMVI</td><td>64.6%</td><td>61.4%</td><td>58.8%</td></tr>
<tr><td>Arta</td><td>94.89%</td><td>98.45%</td><td>94.75%</td></tr>
<tr><td>Heritage ADOC</td><td>75%</td><td>85%</td><td>-</td></tr>
<tr><td>Heritage Regal</td><td>91.3%</td><td>91.3%</td><td>93%</td></tr>
<tr><td>FCMG</td><td>69.9%</td><td>74.1%</td><td>53.1%</td></tr>
<tr><td>OCA</td><td>99.2%</td><td>90%</td><td>95%</td></tr>
<tr><td>Talbert</td><td>95.35%</td><td>97.31%</td><td>95.66%</td></tr>
<tr><td>Monarch</td><td>81.8%</td><td>77.9%</td><td>74.7%</td></tr>
<tr><td>Prospect</td><td>67.2%</td><td>62.2%</td><td>56.2%</td></tr>
<tr><td>Noble</td><td>96.1%</td><td>93.3%</td><td>96%</td></tr>
<tr><td>UCMG</td><td>81.7%</td><td>79.6%</td><td>76.8%</td></tr>
<tr><td>CCN</td><td>87%</td><td>92.5%</td><td>90.5%</td></tr>
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</td>
<td>AMVI/Prospect under CAP for MOC quality scores and timeliness.</td>
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</tr>
</table>

<table>
<tr>
<td>Q3</td>
<td>
<table>
<tr><th></th><th><u>Jul</u></th><th><u>Aug</u></th><th><u>Sep</u></th></tr>
<tr><td>AltaMed</td><td>93.60%</td><td>94.30%</td><td>93.20%</td></tr>
<tr><td>AMVI</td><td>55.00%</td><td>61.80%</td><td>84.60%</td></tr>
<tr><td>Arta</td><td>91.43%</td><td>97.50%</td><td>95.60%</td></tr>
<tr><td>Heritage ADOC</td><td>75.00%</td><td>75.00%</td><td>100%</td></tr>
<tr><td>Heritage Regal</td><td>0%*</td><td>87.10%</td><td>95.00%</td></tr>
<tr><td>FCMG</td><td>94.88%</td><td>96.00%</td><td>96.86%</td></tr>
<tr><td>OCA</td><td>100.00%</td><td>86.70%</td><td>100.00%</td></tr>
<tr><td>Talbert</td><td>95.88%</td><td>96.00%</td><td>97.94%</td></tr>
<tr><td>Monarch</td><td>86.80%</td><td>90.20%</td><td>91.40%</td></tr>
<tr><td>Prospect</td><td>58.30%</td><td>69.40%</td><td>81.40%</td></tr>
<tr><td>Noble</td><td>95.00%</td><td>87.50%</td><td>94.20%</td></tr>
<tr><td>UCMG</td><td>75.80%</td><td>76.50%</td><td>80.60%</td></tr>
<tr><td>CCN</td><td>88.70%</td><td>89.50%</td><td>88.40%</td></tr>
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</td>
<td>AMVI/Prospect under CAP for MOC quality scores and timeliness.

FCMG under CAP for MOC quality scores.</td>
<td>Q1 2017</td>
</tr>
</table>

<table>
<tr>
<td>Q4</td>
<td>
<table>
<tr><th></th><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>AltaMed</td><td>80%</td><td>87.7%</td><td>95%</td></tr>
<tr><td>AMVI</td><td>94.2%</td><td>93%</td><td>87.5%</td></tr>
<tr><td>Arta</td><td>98.3%</td><td>98.3%</td><td>95%</td></tr>
<tr><td>Heritage ADOC</td><td>90%</td><td>-</td><td>95%</td></tr>
<tr><td>Heritage Regal</td><td>91.2%</td><td>95%</td><td>80%</td></tr>
<tr><td>FCMG</td><td>83.7%</td><td>86.1%</td><td>90.8%</td></tr>
<tr><td>OCA</td><td>100%</td><td>100%</td><td>96.7%</td></tr>
<tr><td>Talbert</td><td>95.7%</td><td>98.3%</td><td>96.3%</td></tr>
<tr><td>Monarch</td><td>89%</td><td>89.6%</td><td>91.2%</td></tr>
<tr><td>Prospect</td><td>83.1%</td><td>92.1%</td><td>88.1%</td></tr>
<tr><td>Noble</td><td>97.5%</td><td>96.7%</td><td>90%</td></tr>
<tr><td>UCMG</td><td>88.5%</td><td>88.3%</td><td>82.5%</td></tr>
<tr><td>CCN</td><td>88.6%</td><td>91.9%</td><td>86.8%</td></tr>
</table>
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<td></td>
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</tr>
<tr>
<td>Year End</td>
<td>Health Network performance for 2016 has improved as the year progressed with all Networks performing above the 80% threshold for quality during the 4th Quarter. Two Health Networks under CAP have shown good improvement and should not require intensive monitoring in 2017.</td>
<td></td>
<td></td>
</tr>
</table>

Delegation Oversight
Owner: Sloane Petrillo, Director, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	**SPD**: Aggregate scores: Jan 95.7%, Feb 94.6%, Mar 96.9%	AMVI/Prospect under CAP for MOC quality scores and timeliness	Q 2 2016
Q2	**SPD**: Aggregate scores: Apr 95.95% May 95.72% Jun 96.23%	AMVI/Prospect under CAP for MOC quality scores and timeliness	Q3 2016
Q3	**SPD**: Aggregate scores: Jul 96.76% Aug 95.97% Sep 95.52%	AMVI/Prospect under CAP for MOC quality scores and timeliness	Q4 2016
Q4	**SPD**: Aggregate scores: Oct: 96% Nov: 97% Dec: 97%	AMVI/Prospect under CAP for MOC quality scores and timeliness	
Year End	SPD Aggregate scores have remained stable through 2016.		
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**

<table>
<tr>
<td>Q1</td>
<td><u>SPD:</u>
<table>
<tr><td></td><td>Jan</td><td>Feb</td><td>Mar</td></tr>
<tr><td>AltaMed</td><td>97.1%</td><td>95.7%</td><td>92.8%</td></tr>
<tr><td>Arta</td><td>99%</td><td>98.8%</td><td>96.9%</td></tr>
<tr><td>AMVI</td><td>92.8%</td><td>72.8%</td><td>87.8%</td></tr>
<tr><td>CHOC</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>CN</td><td>95.5%</td><td>96.6%</td><td>97.6%</td></tr>
<tr><td>FCMG</td><td>88%</td><td>94.4%</td><td>96.7%</td></tr>
<tr><td>Heritage-ADOC</td><td>100%</td><td>100%</td><td>80%</td></tr>
<tr><td>Heritage-Regal</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Monarch</td><td>97.4%</td><td>93.2%</td><td>97.6%</td></tr>
<tr><td>Noble</td><td>96.4%</td><td>92.1%</td><td>100%</td></tr>
<tr><td>OCA</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Prospect</td><td>73.9%</td><td>76.9%</td><td>84.2%</td></tr>
<tr><td>Talbert</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>UCMG</td><td>100%</td><td>98.2%</td><td>100%</td></tr>
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</td>
<td>AMVI/Prospect under CAP for MOC quality scores</td>
<td>Q 2 2016</td>
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</table>

<table>
<tr>
<td>Q2</td>
<td>
<table>
<tr><td></td><td>Apr</td><td>May</td><td>Jun</td></tr>
<tr><td>AltaMed</td><td>89.71%</td><td>96.33%</td><td>100%</td></tr>
<tr><td>Arta</td><td>99%</td><td>98.50%</td><td>100%</td></tr>
<tr><td>AMVI</td><td>82%</td><td>88%</td><td>88%</td></tr>
<tr><td>CHOC</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>CN</td><td>95.72%</td><td>94.43%</td><td>97.8%</td></tr>
<tr><td>FCMG</td><td>92.67%</td><td>91.20%</td><td>100%</td></tr>
<tr><td>Heritage-ADOC</td><td>100%</td><td>-</td><td>-</td></tr>
<tr><td>Heritage-Regal</td><td>94%</td><td>92%</td><td>-</td></tr>
<tr><td>Monarch</td><td>98.29%</td><td>97.82%</td><td>98.1%</td></tr>
<tr><td>Noble</td><td>94%</td><td>100%</td><td>96.4%</td></tr>
<tr><td>OCA</td><td>100%</td><td>88%</td><td>-</td></tr>
<tr><td>Prospect</td><td>88%</td><td>88%</td><td>72.8%</td></tr>
<tr><td>Talbert</td><td>98%</td><td>100%</td><td>100%</td></tr>
<tr><td>UCMG</td><td>100%</td><td>100%</td><td>94%</td></tr>
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<td>AMVI/Prospect under CAP for MOC quality scores</td>
<td>Q3 2016</td>
</tr>
</table>

Q3		AMVI/Prospect under CAP for MOC quality scores	Q4 2016

	Jul	Aug	Sep
AltaMed	94.00%	95.43%	93.68%
Arta	98.40%	98.78%	98.02%
AMVI	94.00%	90.67%	90.45%
CHOC	97.57%	98.78%	97.85%
CN	95.33%	94.88%	93.64%
FCMG	95.17%	95.19%	93.97%
Heritage-ADOC	-	-	88%
Heritage-Regal	88.00%	97.33%	94.00%
Monarch	98.67%	98.17%	97.71%
Noble	94.00%	95.80%	93.72%
OCA	-	100.00%	100.00%
Prospect	88.00%	88.66%	93.82%
Talbert	100.00%	100.00%	98.91%
UCMG	93.71%	95.24%	95.56%

Q4		AMVI/Prospect under CAP for MOC quality scores and timeliness	

	Oct	Nov	Dec
AltaMed	98.15$	97.87%	96%
Arta	99.21%	99.08%	97.79%
AMVI	96%	98%	91.29%
CHOC	99.4%	99.33%	100%
CN	93.48%	95.01%	95.68%
FCMG	93.78%	95.59%	97%
Heritage-ADOC	-	-	-
Heritage-Regal	94.67%	96%	93.6%
Monarch	97.67%	97.48%	99.11%
Noble	95.38%	96.5%	96.4%
OCA	100%	100%	-
Prospect	95.13%	95.54%	95.8%
Talbert	100%	99.65%	97.33%
UCMG	96.04%	95.35%	95.88%

Delegation Oversight
Owner: Sloane Petrillo, Director, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1	**OneCare:** Aggregate scores: Jan 95.44%, Feb 95.17%, Mar 93.95%	AMVI/Prospect under CAP for MOC quality scores/timelines	Q 2 2016
Q2	**OneCare:** Aggregate scores: Apr 98.19% May 98.77% Jun 96.56%	AMVI/Prospect under CAP for MOC quality scores/timeliness	Q 3 2016
Q3	**OneCare:** Aggregate scores: Jul 97.87 % Aug 97.36% Sep 97.47%	AMVI/Prospect under CAP for MOC quality scores/timeliness	Q 4 2016
Q4	**OneCare:** Aggregate scores: Oct: 98.9% Nov:99.35% Dec: 98.46%	AMVI/Prospect under CAP for MOC quality scores/timeliness	
Year End	OneCare Aggregate scores have remained stable through 2016 despite the sharp downturn in membership secondary to the OneCare Connect transition in 1/2016.		
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**

<table>
<tr>
<td>Q1</td>
<td><u>OneCare</u>
<table>
<tr><th></th><th><u>Jan</u></th><th><u>Feb</u></th><th><u>Mar</u></th></tr>
<tr><td>AltaMed</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Arta</td><td>100%</td><td>92.50%</td><td>92.17%</td></tr>
<tr><td>AMVI/Prospect</td><td>95.10%</td><td>94.31%</td><td>89.19%</td></tr>
<tr><td>FCMG</td><td>98.36%</td><td>97.78%</td><td>97.68%</td></tr>
<tr><td>Monarch</td><td>95.55%</td><td>95.19%</td><td>95.17%</td></tr>
<tr><td>Noble</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Talbert</td><td>91.40%</td><td>94.72%</td><td>96.20%</td></tr>
<tr><td>UCMG</td><td>97.43%</td><td>100%</td><td>96.84%</td></tr>
</table></td>
<td>AMVI/Prospect under CAP for MOC quality scores/timeliness</td>
<td>Q 2 2016</td>
</tr>
<tr>
<td>Q2</td>
<td>
<table>
<tr><th></th><th><u>Apr</u></th><th><u>May</u></th><th><u>Jun</u></th></tr>
<tr><td>AltaMed</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Arta</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>AMVI/Prospect</td><td>87.79%</td><td>91.94%</td><td>90.13%</td></tr>
<tr><td>FCMG</td><td>100%</td><td>98.86%</td><td>96%</td></tr>
<tr><td>Monarch</td><td>99.56%</td><td>97.88%</td><td>98.68%</td></tr>
<tr><td>Noble</td><td>-</td><td>100%</td><td>-</td></tr>
<tr><td>Talbert</td><td>100%</td><td>100%</td><td>99.11%</td></tr>
<tr><td>UCMG</td><td>100%</td><td>100%</td><td>100%</td></tr>
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<td>AMVI/Prospect under CAP for MOC quality scores/timeliness</td>
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<table>
<tr>
<td>Q3</td>
<td>
<table>
<tr><th></th><th>Jul</th><th>Aug</th><th>Sep</th></tr>
<tr><td>AltaMed</td><td>100.00%</td><td>100.00%</td><td>100.00%</td></tr>
<tr><td>Arta</td><td>100.00%</td><td>100.00%</td><td>100.00%</td></tr>
<tr><td>AMVI/Prospect</td><td>90.77%</td><td>94.45%</td><td>89.51%</td></tr>
<tr><td>FCMG</td><td>94.88%</td><td>96.00%</td><td>96.86%</td></tr>
<tr><td>Monarch</td><td>99.41%</td><td>99.41%</td><td>98.82%</td></tr>
<tr><td>Noble</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>Talbert</td><td>100.00%</td><td>98.50%</td><td>97.12%</td></tr>
<tr><td>UCMG</td><td>100.00%</td><td>100.00%</td><td>100.00%</td></tr>
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<td>AMVI/Prospect under CAP for MOC quality scores/timeliness</td>
<td>Q4 2016</td>
</tr>
<tr>
<td>Q4</td>
<td>
<table>
<tr><th></th><th>Oct</th><th>Nov</th><th>Dec</th></tr>
<tr><td>AltaMed</td><td>100%</td><td>100%</td><td>-</td></tr>
<tr><td>Arta</td><td>-</td><td>100%</td><td>100%</td></tr>
<tr><td>AMVI/Prospect</td><td>95.29%</td><td>93.58%</td><td>93.13</td></tr>
<tr><td>FCMG</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Monarch</td><td>98.1%</td><td>97.3%</td><td>96.05%</td></tr>
<tr><td>Noble</td><td>100%</td><td>-</td><td>100%</td></tr>
<tr><td>Talbert</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>UCMG</td><td>-</td><td>-</td><td>100%</td></tr>
</table>
</td>
<td>AMVI/Prospect under CAP for MOC quality scores and timeliness</td>
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</tr>
</table>

Year End	OneCare PMGs have demonstrated consistent performance throughout 2016.	2017 New Goal: Continue current goal of 100%	

X. Delegation Oversight

B. Quality of Care & Service of UM through delegation oversight reviews

Owner: Solange Marvin Director, Audit & Oversight

The Approach

1. **Objective**
   - Delegation Oversight of Health Networks to assess compliance
2. **Activity**
   - Delegated entity oversight supports how UM delegated activities are performed to expectations and compliance with standards, such as Prior Authorizations
   - **Report from DOC
3. **Goals**
   - 98%

Delegation Oversight
Owner: Solange Marvin, Director, Audit & Oversight

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	**Medi-Cal** Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (January 2016 -March 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. **OneCare** Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (January 2016 -March 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. **OneCare Connect** Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (January 2016 -March 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe		
Q2	**Medi-Cal** Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (April 2016 – June 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. **OneCare** Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (April 2016 – June 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe.		

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
	OneCare Connect Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (April 2016 – June 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe		
Q3	**Medi-Cal** Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (July 2016 – September 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. **OneCare** Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (July 2016 – September 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. **OneCare Connect** Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (July 2016 – September 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe		
Q4	**Medi-Cal** Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (October 2016 – November 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. **OneCare**		

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
	Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (October 2016 – November 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. **OneCare Connect** Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (October 2016 – November 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe **For the month of December 2016, monthly file reviews were suspended. As an alternative, Audit & Oversight conducted webinars for each Health Network.*		
Year End	See above		

Outcomes	Results / Metrics	Next Steps	Target Completion
Q1	**Medi-Cal**	Corrective Action Plans issued and Continued Monitoring for Performance Improvement.	Ongoing

Month	Timeliness for Urgents	CDM for Urgents	Letter Score for Urgents	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
January 2016	95%	NA	NA	86%	92%	95%	96%	91%	100%	93%	90%	100%	87%
February 2016	88%	95%	87%	90%	89%	96%	89%	78%	98%	97%	100%	100%	100%
March 2016	93%	97%	93%	91%	92%	99%	97%	88%	100%	100%	17%	100%	83%

The lower scores for timeliness, clinical decision making (CDM), and letter scores were due to the following reasons:

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion

Timeliness:
-Failure to meet timeframe for decision
-Failure to meet timeframe for provider initial notification
-Failure to meet timeframe for provider written notification

CDM:
-Failure to cite the criteria utilized to make the decision

Letter Scores:
-Failure to provide letter with description of services in lay language

OneCare

Month	Timeliness for EIOD [a\]	CDM for EIOD [c\]	Letter Score for EIOD	Timeliness for SOD [b\]	Letter Score for SOD	Timelines for Denials	CDM for Denials [c\]	Letter Score for Denials
January 2016	97%	NTR	90%	100%	98%	100%	97%	100%
February 2016	100%	NTR	95%	100%	92%	100%	100%	100%
March 2016	83%	NTR	79%	89%	83%	67%	67%	67%

[a\] *EIOD = expedited* initial *organization determination*
[b\] *SOD = standard organization determination*
[c\] *CDM = clinical decision making*

The lower scores for timeliness, clinical decision making (CDM), and letter scores were due to failure to submit files for review by Talbert.

OneCare Connect

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion

Month	Timeliness for Urgents	CDM for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
January 2016	100%	100%	81%	91%	77%	72%	100%	91%	100%	100%	89%	NA	NA	NA
February 2016	88%	NTR	58%	98%	71%	80%	96%	88%	100%	100%	67%	NA	NA	NA
March 2016	70%	33%	59%	78%	67%	61%	67%	65%	0%	33%	33%	44%	50%	50%

The lower scores for timeliness, clinical decision making (CDM), and letter scores were due to the following reasons:

Timeliness:
-Failure to submit files
-Failure to meet timeframe for decision
-Failure to meet timeframe for member oral notification
-Failure to meet timeframe for member written notification
-Failure to meet timeframe for provider initial notification
-Failure to meet timeframe for provider written notification

Clinical Decision Making (CDM):
-Failure to provide adequate clinical information
-Failure to make decision by appropriate professional
-Failure to cite the criteria utilized to make the decision

Letter Score:
-Failure to provide CMS approved letter template
-Failure to provide letter with CalOptima logo
-Failure to provide letter with description of services in lay language

<table>
<tr><th>Monitoring</th><th>Assessments, Findings, Monitoring of Previously Identified Issues</th><th>Next Steps</th><th>Target Completion</th></tr>
<tr><td></td><td>-Failure to provide language assistance program (LAP) insert with approved threshold languages
-Failure to provide information on how to file a grievance
-Failure to provide referral back to PCP regarding any denial</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Q2</td><td>• Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

<table>
<tr><th>Month</th><th>Timeliness for Urgents</th><th>Clinical Decision Making (CDM) for Urgents</th><th>Letter Score for Urgents</th><th>Timeliness for Routine</th><th>Timeliness for Denials</th><th>CDM for Denials</th><th>Letter Score for Denials</th><th>Timeliness for Modifieds</th><th>CDM for Modifieds</th><th>Letter Score for Modifieds</th><th>Timeliness for Deferrals</th><th>CDM for Deferrals</th><th>Letter Score for Deferrals</th></tr>
<tr><td>April 2016</td><td>95%</td><td>100%</td><td>100%</td><td>98%</td><td>89%</td><td>97%</td><td>95%</td><td>85%</td><td>95%</td><td>98%</td><td>39%</td><td>100%</td><td>85%</td></tr>
<tr><td>May 2016</td><td>80%</td><td>100%</td><td>100%</td><td>77%</td><td>76%</td><td>89%</td><td>95%</td><td>91%</td><td>93%</td><td>97%</td><td>50%</td><td>67%</td><td>77%</td></tr>
<tr><td>June 2016</td><td>86%</td><td>83%</td><td>100%</td><td>89%</td><td>80%</td><td>92%</td><td>94%</td><td>92%</td><td>95%</td><td>99%</td><td>50%</td><td>87%</td><td>78%</td></tr>
</table>
➢ The lower scores for timeliness were due to the following reasons:
– Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days);
– Failure to meet timeframe for member notification (Routine – 2 business days);
– Failure to meet timeframe for provider initial notification (24 hours);
– Failure to provide proof of successful initial written notification to requesting provider (24 hours); and
– Failure to meet time for extended decision (14 calendar days).
➢ The lower scores for clinical decision making (CDM) were due to the following reasons:
– Failure to cite the criteria utilized to make the decision;
– No indication that the medical reviewer was involved in the denial determination; and</td><td>Corrective Action Plans issued and Continued Monitoring for Performance Improvement.</td><td>Ongoing</td></tr>
</table>

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
	– No indication of adequate clinical information obtained to make the decision to deny. ➢ The lower letter scores were due to the following reasons: – Provider notification did not include name and contact information for the medical director responsible for the decision to delay; – Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document; – Failure to provide letter with description of services in lay language; – Failure to provide letter in member's primary language; – Failure to provide lay language explaining why the request did not meet criteria; – Failure to include name and contact information for health care professional responsible for decision to deny; – Failure to notify member of delayed decision and anticipated decision date; – Failure to provide peer -to peer discussion of the decision with medical reviewer; – Failure to notify provider of delayed decision and anticipated decision date; and – Failure to provide referral back to PCP on denial letter. • <u>OneCare Utilization Management (UM):</u> Prior Authorization (PA) Requests		

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timelines for Denials	Clinical Decision Making for Denials	Letter Score for Denials
April 2016	100%	Nothing to Report	91%	100%	96%	100%	100%	100%
May 2016	100%	Nothing to Report	100%	100%	81%	100%	89%	100%
June 2016	100%	Nothing to Report	98%	100%	97%	100%	89%	95%

- The lower letter scores were due to the following reasons:
  - Failure to use approved CMS letter template; and
  - Failure to provide letter with description of services in lay language.
- The lower scores for clinical decision making (CDM) were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision.

- <u>OneCare Connect Utilization Management (UM):</u> Prior Authorization (PA) Requests

Month	Timeliness for Urgents	*Clinical Decision Making for*	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	*Clinical Decision Making for*	Letter Score for Denials	Timeliness for Modifieds	*Clinical Decision Making for*	Letter Score for Modifieds	Timeliness for Deferrals	*Clinical Decision Making for*	Letter Score for Deferrals

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion

		Urgents					Denials			Modifieds			Deferrals	
April 2016	86%	89%	86%	94%	77%	66%	100%	98%	43%	83%	89%	100%	100%	100%
May 2016	92%	100%	78%	87%	83%	51%	92%	85%	33%	100%	90%	100%	100%	100%
June 2016	84%	99%	82%	76%	80%	66%	100%	87%	75%	100%	97%	Nothing to Report	Nothing to Report	Nothing to Report

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days);
  - Failure to meet timeframe for provider initial notification (24 hours); and
  - Failure to provide proof of successful initial written notification to requesting provider (24 hours).

- The lower scores for clinical decision making were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision.

- The lower letter scores were due to the following reasons:
  - Failure to provide letter in member's primary language;
  - Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document;
  - Failure to outline reason for not meeting the criteria (lay language) in denial letter;
  - Failure to include name and contact information for health care professional responsible for decision to deny;
  - Failure to provide letter with description of services in lay language; and
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer.

Q3	• Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests is no CDM score for the review of September 2016 deferrals due to the review of approval files only.	Corrective Action Plans issued and Continued Monitoring	Ongoing

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
July 2016	89%	100%	98%	93%	70%	91%	94%	94%	98%	97%	50%	67%	73%
Aug 2016	87%	79%	86%	87%	72%	92%	89%	71%	94%	98%	100%	100%	93%
Sept 2016	57%	69%	93%	66%	60%	91%	86%	60%	87%	88%	100%	*N/A	100%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days);
  - Failure to meet timeframe for member written notification of denials, modifications, and deferrals (Routine – 2 business days from decision);
  - Failure to meet timeframe for provider initial notification (24 hours); and
  - Failure to provide proof of successful written notification to requesting provider (2 business days).

- The lower scores for clinical decision making (CDM) were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision;
  - No indication of adequate clinical information obtained to make the decision to deny; and
  - No indication that the medical reviewer was involved in the denial determination.
- The lower letter scores were due to the following reasons:
  - Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document;
  - Failure to provide letter with description of services in lay language;
  - Failure to provide letter in member's primary language;
  - Failure to include name and contact information for health care professional responsible for decision to deny;
  - Failure to provide information on how to file a grievance;

for Performance Improvement.

<table>
<tr><th>Monitoring</th><th>Assessments, Findings, Monitoring of Previously Identified Issues</th><th>Next Steps</th><th>Target Completion</th></tr>
<tr><td></td><td>
– Failure to outline reason for not meeting the criteria in lay language;
– Failure to provide referral back to Primary Care Provider (PCP) on denial letter; and
– Failure to provide peer -to peer discussion of the decision with medical reviewer.

• <u>OneCare Utilization Management (UM):</u> Prior Authorization (PA) Requests

<table>
<tr><th>Month</th><th>Timeliness for Expedited Initial Organization Determination (EIOD)</th><th>Clinical Decision Making for EIOD</th><th>Letter Score for EIOD</th><th>Timeliness for Standard Organization Determination (SOD)</th><th>Letter Score for SOD</th><th>Timelines for Denials</th><th>Clinical Decision Making for Denials</th><th>Letter Score for Denials</th></tr>
<tr><td>July 2016</td><td>83%</td><td>Nothing to Report</td><td>95%</td><td>97%</td><td>93%</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Aug 2016</td><td>69%</td><td>Nothing to Report</td><td>88%</td><td>80%</td><td>87%</td><td>100%</td><td>83%</td><td>89%</td></tr>
<tr><td>Sept 2016</td><td>50%</td><td>Nothing to Report</td><td>93%</td><td>90%</td><td>90%</td><td>100%</td><td>65%</td><td>92%</td></tr>
</table>

➢ The lower letter scores were due to the following reasons:
– Failure to use approved CMS letter template;
– Failure to provide letter with description of services in lay language;
– Failure to offer to discuss decision with a reviewer; and
– Failure to provide letter with description of services in lay language.
</td><td></td><td></td></tr>
</table>

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion

➢ The lower scores for timeliness were due to the following reasons:
- Failure to meet time frame for member oral notification (Expedited – 72 hours);
- Failure to meet time frame for member written notification (Expedited – 72 hours); and
- Failure to meet time frame for provider notification (24 hours).

➢ The lower scores for clinical decision making (CDM) were due to the following reasons:
- Failure to cite the criteria utilized to make the decision;
- No indication of adequate clinical information obtained to make the decision to deny; and
- Failure to have evidence of appropriate professional making decision.

- <u>OneCare Connect Utilization Management (UM):</u> Prior Authorization (PA) Requests

Month	Timeliness for Urgents	*Clinical Decision Making* for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	*Clinical Decision Making* for Denials	Letter Score for Denials	Timeliness for Modifieds	*Clinical Decision Making* for Modifieds	Letter Score for Modifieds	Timeliness for Deferrals	*Clinical Decision Making* for Deferrals	Letter Score for Deferrals
July 2016	75%	100%	72%	79%	72%	51%	81%	80%	60%	89%	75%	Nothing to Report	Nothing to Report	Nothing to Report
Aug 2016	59%	50%	65%	76%	72%	59%	87%	73%	93%	100%	94%	Nothing to Report	Nothing to Report	Nothing to Report
Sept 2016	50%	100%	69%	58%	75%	42%	66%	66%	0%	67%	100%	Nothing to Report	Nothing to Report	Nothing to Report

➢ The lower scores for timeliness were due to the following reasons:
- Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days);
- Failure to meet timeframe for member written notification of denials, modifications, and deferrals (Routine – 2 business days from decision);
- Failure to meet timeframe for provider initial notification (24 hours); and
- Failure to provide proof of successful written notification to requesting provider (2 business days).

<table>
<tr><th>Monitoring</th><th>Assessments, Findings, Monitoring of Previously Identified Issues</th><th>Next Steps</th><th>Target Completion</th></tr>
<tr><td></td><td>

The lower scores for clinical decision making were due to the following reasons:

Failure to cite the criteria utilized to make the decision;
No indication of adequate clinical information obtained to make the decision to deny; and
Failure to have evidence of appropriate professional making decision.

The lower letter scores were due to the following reasons:

Failure to provide letter in member's primary language;
Failure to outline reason for not meeting the criteria in lay language;
Failure to provide letter with description of services in lay language;
Failure to provide peer-to-peer discussion of the decision with medical reviewer;
Failure to provide information on how to file a grievance; and
Failure to provide referral back to Primary Care Provider (PCP) on denial letter.

</td><td></td><td></td></tr>
<tr><td>Q4</td><td>

<u>Medi-Cal Utilization Management (UM):</u> Prior Authorization (PA) Requests

<table>
<tr><th>Month</th><th>Timeliness for Urgents</th><th>Clinical Decision Making for Urgents</th><th>Letter Score for Urgents</th><th>Timeliness for Routine</th><th>Timeliness for Denials</th><th>Clinical Decision Making for Denials</th><th>Letter Score for Denials</th><th>Timeliness for Modifieds</th><th>Clinical Decision Making for Modifieds</th><th>Letter Score for Modifieds</th><th>Timeliness for Deferrals</th><th>Clinical Decision Making for Deferrals</th><th>Letter Score for Deferrals</th></tr>
<tr><td>October 2016</td><td>58%</td><td>Nothing to Report</td><td>Nothing to Report</td><td>68%</td><td>53%</td><td>89%</td><td>90%</td><td>47%</td><td>87%</td><td>88%</td><td>50%</td><td>83%</td><td>75%</td></tr>
<tr><td>November 2016</td><td>63%</td><td>92%</td><td>89%</td><td>71%</td><td>65%</td><td>88%</td><td>87%</td><td>58%</td><td>94%</td><td>91%</td><td>83%</td><td>100%</td><td>63%</td></tr>
</table>
No CDM score for EIODs due to the review of approval decisions only
For the month of December 2016, monthly file reviews were suspended. As an alternative, Audit & Oversight conducted webinars for each Health Network.

The lower scores for timeliness were due to the following:

Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days);
Failure to meet timeframe for member notification (Routine – 2 business days);
Failure to meet timeframe for provider initial notification (24 hours); and

</td><td>Corrective Action Plans issued and Continued Monitoring for Performance Improvement.</td><td>Ongoing</td></tr>
</table>

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion

- Failure to provide proof of successful initial notification to requesting provider (24 hours).

➢ The lower scores for clinical decision making were due to the following**:**
- Failure to cite the criteria utilized to make the decision;
- No indication of adequate clinical information obtained to make the decision to deny; and
- No indication that the medical reviewer was involved in the denial determination.

➢ The lower letter scores were due to the following:
- Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document;
- Failure to provide letter with description of services in lay language;
- Failure to provide letter in member's primary language;
- Failure to include name and contact information for health care professional responsible for decision to deny in the initial notification;
- Failure to provide information on how to file a grievance;
- Failure to outline reason for not meeting the criteria in lay language;
- Failure to provide referral back to Primary Care Provider (PCP) on denial letter; and
- Failure to notify provider of delayed decision and anticipated decision date.

- OneCare Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timelines for Denials	Clinical Decision Making for Denials	Letter Score for Denials

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion

October 2016	40%	0%	83%	90%	82%	100%	73%	94%
November 2016	77%	Nothing to Report	84%	97%	79%	100%	78%	95%

No CDM score for EIODs due to the review of approval decisions only

**For the month of December 2016, monthly file reviews were suspended. As an alternative, Audit & Oversight conducted webinars for each Health Network.*

- The lower scores for timeliness were due to the following:
  - Failure to meet timeframe for member oral notification (Expedited – 72 hours);
  - Failure to meet timeframe for favorable member written notification (Expedited – 72 hours); and
  - Failure to meet timeframe for provider notification (Expedited – 24 hours).

- The lower scores for clinical decision making were due to the following:
  - Failure to cite the criteria utilized to make the decision;
  - No indication of adequate clinical information obtained to make the decision to deny; and
  - Failure to have evidence of appropriate professional making decision.

- The lower letter scores were due to the following:
  - Failure to use approved CMS letter template;
  - Failure to provide letter with description of services in lay language; and
  - Failure to use the CalOptima logo on letter template.

- OneCare Connect Utilization Management (UM): Prior Authorization (PA) Requests

<table>
<tr><th>Monitoring</th><th>Assessments, Findings, Monitoring of Previously Identified Issues</th><th>Next Steps</th><th>Target Completion</th></tr>
<tr><td></td><td>
<table>
<tr><th>Month</th><th>Timeliness for Urgents</th><th>Clinical Decision Making for Urgents</th><th>Letter Score for Urgents</th><th>Timeliness For Routine</th><th>Letter Score for Routine</th><th>Timeliness for Denials</th><th>Clinical Decision Making for Denials</th><th>Letter Score for Denials</th><th>Timeliness for Modifieds</th><th>Clinical Decision Making for Modifieds</th><th>Letter Score for Modifieds</th><th>Timeliness for Deferrals</th><th>Clinical Decision Making for Deferrals</th><th>Letter Score for Deferrals</th></tr>
<tr><td>October 2016</td><td>48%</td><td>100%</td><td>72%</td><td>65%</td><td>73%</td><td>48%</td><td>82%</td><td>73%</td><td>52%</td><td>92%</td><td>99%</td><td>Nothing to Report</td><td>Nothing to Report</td><td>Nothing to Report</td></tr>
<tr><td>November 2016</td><td>58%</td><td>84%</td><td>68%</td><td>77%</td><td>69%</td><td>90%</td><td>83%</td><td>82%</td><td>44%</td><td>89%</td><td>99%</td><td>Nothing to Report</td><td>Nothing to Report</td><td>Nothing to Report</td></tr>
</table>
*For the month of December 2016, monthly file reviews were suspended. As an alternative, Audit & Oversight conducted webinars for each Health Network.

➢ The lower scores for timeliness were due to the following:
– Failure to meet timeframe for member notification (Routine - 2 business days); and
– Failure to provide proof of successful initial written notification to requesting provider (24 hours).

➢ The lower scores for clinical decision making were due to the following:
– Failure to cite the criteria utilized to make the decision;
– No indication of adequate clinical information obtained to make the decision to deny; and
– No indication that the medical reviewer was involved in the denial determination.

➢ The lower letter scores were due to the following:
– Failure to provide letter in member's primary language; and
– Failure to provide letter with description of services in lay language.
</td><td></td><td></td></tr>
<tr><td>Year End</td><td>See above</td><td></td><td></td></tr>
</table>

X. Delegation Oversight

C. Delegation oversight of BH Services

Owner: Dr. Edwin Poon, Director, BHI

The Approach

1. **Objective**
   - Regular review of the MBHO's performance of BH functions

2. **Activity**
   - Assure compliance to all regulatory and accreditation delegation oversight requirements
   - **Report from DOC

3. **Goals**
   - 98%

Delegation Oversight
Owner: Dr. Edwin Poon, Director, BHI

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	**CHIPA/Beacon (Medi-Cal)** Delegation Oversight Dashboard: Customer Service (March 2016) - Customer Service metrics are reviewed to assure calls to the Behavioral Health Line are answered within the appropriate timeframe. **Windstone (OneCare Connect)** Delegation Oversight Dashboard: Utilization Management (March 2016) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe.	Will continue to monitor MBHOs' performance of delegation functions on a monthly basis	Will report Q2 results at the next QIC in Sept 2016
Q2	**CHIPA/Beacon (Medi-Cal)** Delegation Oversight Dashboard: Customer Service - Customer Service metrics are reviewed to assure calls to the Behavioral Health Line are answered within the appropriate timeframe. **Windstone (OneCare Connect)** Delegation Oversight Dashboard: Utilization Management – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe.	Will continue to monitor MBHOs' performance of delegation functions on a monthly basis	Will report Q3 results at the next QIC in Dec 2016
Q3	**CHIPA/Beacon (Medi-Cal)** Delegation Oversight Dashboard: Customer Service - Customer Service metrics are reviewed to assure calls to the Behavioral Health Line are answered within the appropriate timeframe. **Windstone (OneCare Connect)** Delegation Oversight Dashboard: Utilization Management – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe.	Will continue to monitor MBHOs' performance of delegation functions on a monthly basis	Will report Q4 results at the next QIC in Mar 2017

Q4	**CHIPA/Beacon (Medi-Cal)** Delegation Oversight Dashboard: Customer Service - Customer Service metrics are reviewed to assure calls to the Behavioral Health Line are answered within the appropriate timeframe. **Windstone (OneCare Connect)** Delegation Oversight Dashboard: Utilization Management – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe.	Will continue to monitor MBHOs' performance of delegation functions on a monthly basis	Will report Q4 results at the next QIC in Mar 2017
Year End	BHI has contracted with new MBHO to provide services to Medi-Cal and Medi-Medi members for MCE, OC, OCC and Autism services. No further monitoring will be conducted for CHIPA/Beacon or Windstone. Monitoring and oversight will begin with Magellan for Q1 of 2017.		

Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	**CHIPA/Beacon (Medi-Cal)** See table below. Scores for January and February 2016 were below standard. Reasons for poor performance include: - High employee turnover - Insufficient number of employees - Lack of ability to properly monitor and respond to incoming call flow and volume	Corrective Action Plans issued to Beacon on call center metrics. Additional measure to be added to the DOC dashboard pending AOC approval.	Ongoing

Month	Average Speed of Answer (ASA)	% of Incoming Calls Answered within 30 sec	Abandonment Rate
Jan 2016	70 sec	59%	5.9%
Feb 2016	80 sec	56%	6.5%
Mar 2016	23 sec	85%	2.1%

Windstone (OCC)

Month	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Expedited	CDM for Expedited
Jan 2016	100%	100%	NF	NF	NF	NF	NF
Feb 2016	100%	100%	NF	NF	NF	NF	NF
Mar 2016	99%	100%	NF	NF	NF	NF	NF

NF = no file to review

Q2

CHIPA/Beacon (Medi-Cal)

Month	Average Speed of Answer (ASA)	% of Incoming Calls Answered within 30 sec	Abandonment Rate
April 2016	33 sec	80%	2.6%
May 2016	16 sec	93%	1.5%

Scores for April and May 2016 have improved since Q1. ASA in April 2016 is the only measure that is below performance standard.

Corrective Action Plans issued to Beacon on call center metrics. The CAP is currently in the monitoring phase. Additional measure has been added to the DOC dashboard to monitor frequency of disconnected calls (i.e. clinicians are unavailable).

Ongoing

Windstone (OCC)

Month	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Expedited	CDM for Expedited
April 2016	100%	100%	NF	NF	NF	NF	NF
May 2016	NA	NA	NF	NF	NF	NF	NF

<table>
<tr><td></td><td>NA = Delegate has been moved to Quarterly File Review
NF = no file to review</td><td></td><td></td></tr>
<tr><td>Q3

Reporting updated for Q2 due to data lag</td><td>
CHIPA/Beacon (Medi-Cal)
<table>
<tr><th>Month</th><th>Average Speed of Answer (ASA)</th><th>% of Incoming Calls Answered within 30 sec</th><th>Abandonment Rate</th></tr>
<tr><td>April 2016</td><td>33 sec</td><td>80%</td><td>2.6%</td></tr>
<tr><td>May 2016</td><td>16 sec</td><td>93%</td><td>1.5%</td></tr>
<tr><td>Jun 2016</td><td>19 sec</td><td>93%</td><td>1.3%</td></tr>
</table>

ASA standard is <30 seconds. Red Indicates standards not met.
% of Incoming Calls Answered within 30 sec standard is >=80%
Abandonment Rate standard is <5%

Scores have improved since April in all areas and continue to improve and meet the standard.

Windstone (OCC)
<table>
<tr><th>Month</th><th>Timeliness For Routine</th><th>Letter Score for Routine</th><th>Timeliness for Denials</th><th>CDM for Denials</th><th>Letter Score for Denials</th><th>Timeliness for Expedited</th><th>CDM for Expedited</th></tr>
<tr><td>April 2016</td><td>100%</td><td>100%</td><td>NF</td><td>NF</td><td>NF</td><td>NF</td><td>NF</td></tr>
<tr><td>May 2016</td><td>NA</td><td>NA</td><td>NF</td><td>NF</td><td>NF</td><td>NF</td><td>NF</td></tr>
<tr><td>Jun 2016</td><td>38%</td><td>100%</td><td>NF</td><td>NF</td><td>NF</td><td>NF</td><td>NF</td></tr>
</table>

Timeliness for Routine standards are >=98%, Red indicates standard not met
NA = Delegate has been moved to Quarterly File Review
NF = no file to review

</td><td>Corrective Action Plans issued to Beacon on call center metrics. The CAP is currently in the monitoring phase. Additional measure has been added to the DOC dashboard to monitor frequency of disconnected calls (i.e. clinicians are unavailable).

CAP for Beacon will be closed during Q4 providing performances continues to meet current standards.</td><td>Q2 Complete</td></tr>
</table>

Q4

CHIPA/Beacon (Medi-Cal)

Month	Average Speed of Answer (ASA)	% of Incoming Calls Answered within 30 sec	Abandonment Rate
July 2016	21 sec	93%	1.1%
Aug 2016	15 sec	93%	1.3%
Sep 2016	17 sec	90%	1.3%

- ASA standard is <30 seconds. Standard met this report quarter.
- % of Incoming Calls Answered within 30 sec standard is >=80% - Standard Met
- Abandonment Rate standard is <5% - Standard Met

Scores have improved over the last 2 reporting quarters and therefore CAP was lifted as the plan successfully met the standard for 6 months consecutively.

CAP for Beacon was closed during Q4 as plan continues to meet current standards.

Windstone (OCC)

Month	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Expedited	CDM for Expedited
Jul 2016	100%	100%	NF	NF	NF	NF	NF
Aug 2016	100%	100%	NF	NF	NF	NF	NF
Sep 2016	100%	100%	NF	NF	NF	NF	NF

- Standards Met Quarter 3; final files to be received 2017
- Timeliness for Routine standards are >=98%, Red indicates standard not met
- NA = Delegate has been moved to Quarterly File Review

NF = no file to review

Year End	BHI has contracted with new MBHO to provide services to Medi-Cal and Medi-Medi members for MCE, OC, OCC and Autism services. No further monitoring will be conducted for CHIPA/Beacon or Windstone. Monitoring and oversight will begin with Magellan for Q1 of 2017.		

XI. Organizational Projects

A. Implementation of the 2016 Value Based P4P Program

Owner: Medical Director, Quality & Analytics

The Approach

1. **Objective**
   - Confirm and implement the 2016 Value Based P4P Program (Medi-Cal & OCC)

2. **Activity**
   - Complete review of 2014 & 2015; confirm measures, align with auto-assignment quality measures and define weighting for 2016
   - Incentivize Health Networks via a P4P to achieve high quality scores on targeted accreditation, health plan rating and STARS measures

3. **Goals**
   - Improve performance over 2015

Organizational Projects
Owner: Medical Director, QA

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	MY 2016 P4P program approved by Board of Directors 5/5/16	Implementation of MY 2016 P4P program in process. Development of monthly P4V measure results by HN complete. Update P4V programs to calculate 2016 payments. Hire P4V manager.	10/1/16
Q2	MY2016 P4V program scoring methodology approved by QAC 9/21. Final MY2016 P4V program for Medi-Cal will be presented to Board of Directors 10/6/16 for approval. .P4V Manager and P4V senior analyst hired.	Develop proposal (COBAR) for payment of CCN and OCC 2016 P4V results for presentation to QAC on 11/16/16. Onboard new P4V team starting 10/17/16. Recommend proposed changes to quality measures utilized for auto-assignment to align measures with quality strategic goals (accreditation and health plan ratings).	11/15/16
Q3	P4V Steering committee reviewed display measures and considered moving IHA measure from display to 2017 P4V program. P4V Steering Committee also reviewed and recommended updating current auto assignment logic for HN and community clinics. Ongoing discussions about P4P payment to CCN providers. P4V Manager and second Senior Analyst on board; actively recruiting additional analysts. (2)	IHA to remain a display measure for 2017 P4V program due to concerns about provider data completeness and possible changes needed to codes utilized in measure programming. Finalize proposal (COBAR) for payment to CCN providers. Finalize proposed changes to quality measures utilized for auto-assignment to align measures with quality strategic goals (accreditation and health plan ratings).	01/15/2017
Q4	P4V Steering Committee discussed aligning auto assignment measures for health networks and community clinics to be similar with the other P4V measures.	Finalize auto assignment measures; develop a COBAR for auto assignment changes, present to the Board for review and discussion; and start implementing policy changes after Board approval.	06/30/2017
Year End	MY 2016 COBAR was approved by the Board; significant discussions and progress has been attained in updating the auto assignment process and trying to align the logic with the P4V measures.	Finalize COBAR for new auto assignment process, present to the various Committees for review and approval before taking it up to the Board for their approval.	06/30/2017
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**

Q1	MY 2015 P4P scores	Calculate final scores and payment; report to QIC	10/1/16
Q2	Calculation of MY 2015 P4P payments in progress.	Awaiting OneCare HN Specific CAHPS results before calculations and payments can be finalized. Assess whether scores improved compared to prior year.	11/15/16
Q3	MY 2015 P4P payment calculations completed. 73% of available Medi-Cal funds left on the table. 76% of available OneCare funds left on the table.	. P4P checks for MY 2015 performance to be mailed to Health Networks and Providers.	12/31/16
Q4	MY 2015 P4V incentive checks mailed to health networks	Develop a COBAR for P4P measures for MY 2017 and present to QAC, MAC, and PAC and get their approvals before taking it up to the Board.	03/31/2017
Year End	MY 2015 incentive dollars paid out to participating health networks.	Finalize COBAR for MY 2017 P4V incentives	03/31/2017

XI. Organizational Projects

B. Value Based P4P 2016-2019

Owner: Kelly Rex-Kimmet, Director, QA

The Approach

1. **Objective**
   - Design longer term Value Based P4P Program and gain board approval by 7/1/16

2. **Activity**
   - Design new program in conjunction with provider/ Health Network Stakeholders, PAC & MAC input; develop COBAR for presentation to board
   - Define analytics and matching resources to support new P4Value Program

3. **Goals**
   - National & State Benchmarks

Organizational Projects
Owner: Kelly Rex-Kimmet, Director, QA

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1	Implement P4P measures for MY 2016 per the BOD P4P program approval; calculate the P4P incentive payments to participating health networks.	Implementation of MY 2016 P4P program in process. Update P4V programs to calculate 2016 payments.	10/1/16
Q2	Final MY2016 P4V program for Medi-Cal will be presented to Board of Directors 10/6/16 for approval. .	Recommend proposed changes to quality measures utilized for auto-assignment to align measures with quality strategic goals (accreditation and health plan ratings).	11/15/16
Q3	P4V Steering Committee also reviewed and recommended updating current auto assignment logic for HN and community clinics. Ongoing discussions about P4P payment to CCN providers.	Finalize proposal (COBAR) for payment to CCN providers. Finalize proposed changes to quality measures utilized for auto-assignment to align measures with quality strategic goals (accreditation and health plan ratings).	01/15/2017
Q4	P4V Steering Committee continued discussions about P4V payment methodology for CCN providers to be at par with the health networks.	Finalize payment methodology and budget for CCN providers, and present to the Board for review and approval.	03/31/2017
Year End	Significant discussions and progress has been attained in trying to align CCN providers incentive dollars with the other health networks; and to	Finalize COBAR for new P4V measures for CCN providers; present to the various Committees for review and approval before taking it up to the Board for their approval.	03/31/2017
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1	Develop a plan for P4V measures for CCN providers which includes how many provides will be included; minimum eligibility criteria; how many performance measures to include	Initiate discussion about CCN providers and payment methodology with the Network Management staff and Finance Dept and P4V Steering Committee	10/1/16
Q2	Finalize CCN provider eligibility and P4V performance measures.	Ongoing discussions between the stakeholders about CCN provider inclusion and P4V measures	11/15/16
Q3	Develop a plan for updating current auto assignment measures	Initiate discussion with all concerned parties about reviewing auto assignment measures, as well as creating a	12/31/16

		list of new measures that we would to adapt	
Q4	Finalize auto assignment measures	Ongoing discussions between stakeholders about new and current auto assignment measure inclusion	03/31/2017
Year End	Developing CCN provider P4V methodology and revisiting the auto assignment allocations	Finalizing CCN provider P4V methodology and auto assignment allocations	03/31/2017

2016 Disease Management Programs

Annual Evaluation

4/10/2017
CalOptima
Pshyra Jones

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Health Education and Disease Management had several significant accomplishments in 2016. The department provided program oversight for the DHCS Initial Health Assessment (IHA) which included development of monthly reporting tools to track IHA completion rates. As a result of our efforts, the organization was able to report a 20% increase in completion rate over the 2015 rate, which exceeded our internal goal of a 10% increase. The department accomplished another milestone with the submission of the DHCS Group Needs Assessment (GNA). The GNA is scheduled every 5 years to help health plans identify the health risks, beliefs, practices, and cultural & linguistic needs of their members.

CalOptima oversampled and added questions addressing Social Determinants of Health to inform program planning in the next fiscal year. A targeted incentive offer was sent to members with diabetes either missing an A1C test and/or having an A1C>9. The offer was mailed to over 19,000 members and yielded a 7% rate of participation, where members sent in proof of completing their A1C test within the recommended time period. Asthma Aware, Heart Health and Diabetes Talk newsletters were successfully mailed to all DM members with helpful and relevant information on how members can best manage their conditions. Chronic care improvement projects (CCIP) continued. For OneCare Controlling Blood Pressure, members who opted-in were provided a home blood pressure monitor and received phone follow-up from health coaches to track blood pressure control. There were strides made to streamline the transitions of care process in regards to reducing unplanned readmission due to heart failure for the OneCare Connect Heart Failure CCIP. The 2016 DM Member Experience Survey mailed to 40,259 English and Spanish speaking DM members showed 82% (N=3,256) overall satisfaction with CalOptima's DM programs. This included satisfaction with helpfulness of program staff, usefulness of information received and member experience in adhering to treatment plans. The department continues with the program redesign of disease management. The new criteria for diabetes was finalized in 2016 and is pending implementation in the Guiding Care system.

While the department accomplished many objectives and performance goals, there are still areas of opportunity in 2017. The department is still working to increase active member participation in disease management programs through the redesign. Redesign efforts will focus on obtaining assessment information from the lower risk population, so that we can have a better snapshot of the entire population and its needs. For higher risk members with diabetes, the goal is to engage them more in telephonic self-management sessions. The redesign for the asthma program will include expanding interventions and services to adults with asthma. For heart failure, redesign will incorporate inclusion of Medi-Cal members with more events and classes to link members with community resources, including CalOptima health coaches. In addition, a provider notification report is being developed to communicate with physicians about key health indicators for their patients in CalOptima's DM program, which may warrant partnering to bring our member's conditions under better care management. The department is committed to aligning DM efforts to positively impact HEDIS rates, especially the Comprehensive Diabetes Care and Asthma Medication Ratio(AMR) measures. In addition, the Shape Your Life Childhood Obesity, Weight Watchers and Perinatal programs are being designed and planned for RFP, vendor selection and program roll out in 2017.

2016 Disease Management Program Evaluation			
2016 Disease Management Work Plan		2016 Disease Management Evaluation	
Methodology/Action Plan	Results	Barriers	Recommendations for Future
Activity: Disease Management (DM)			
Description: The organization, which possesses data about the health status of its members and has a responsibility for meeting their health needs, actively intervenes to help members and practitioners manage chronic conditions.			
Goal: Improve the quality of life, quality of care and health outcomes for members in disease management programs. Improve member knowledge of their condition and promote effective self-management.			
Identify and implement Disease Management Programs for CalOptima members: • Asthma (ages 3-18) • Diabetes (age 18+) • Congestive Heart Failure (age 18+)	2016 ***Asthma*** Program Population: 20,205 Member Active Participation Rate: 1.77% ***Diabetes*** Program Population: 30,122 Member Active Participation Rate: 3.74% ***OC /OCC Diabetes*** Total Population: 5,242 ***OC/OCC CHF*** Total Population: 792	The department is still working with CalOptima IS and Altruista to successfully implement monthly identification and triage of new members for DM programs. NCQA defines Member Active Participation as- Number of identified eligible members with at least one interactive contact/Number of identified eligible members. Interactive contact can be challenging for opt out program designs. The department included additional data sources which helped to increase our percentages slightly from 2015. The department is still not able to leverage other technological advances like IVR or texting, which meets NCQAs definition of interactive contact.	Increase participation rates by including mailed assessment tools in welcome mailing to low risk members. Use AutoData ExpertScan data to support scanning responses back and incorporating feedback into Guiding Care.

2016 Disease Management Program Evaluation			
2016 Disease Management Work Plan		2016 Disease Management Evaluation	
Methodology/Action Plan	Results	Barriers	Recommendations for Future
Project : Experience with Disease Management (QI7, Element I)			
Description: The organization track annual review of member feedback on the disease management programs to assure high satisfaction and improved health status.			
Goal: 90% satisfaction with DM programs			
Preliminary results for subset of questions evaluating our DM programs are as follows: (strongly agree and somewhat agree percentages included below) CalOptima staff was helpful in getting the information I needed. 82% CalOptima staff responded to my request or concerns in a timely manner. 80% I learned useful information from this program. 79% The information I got has helped me manage my health better. 76.8% I would tell others about CalOptima's Disease Management programs. 82.4%	Goal Not Met	The methodology used to administer the satisfaction survey was old and required updating. It required members to recall their experiences with the DM program or health coach for 6 months or greater. The survey instrument also does not clearly identify which CalOptima staff they should be evaluating.	The department worked collaboratively with Quality Analytics and Case management to revise the survey tool. The department is also going to administer the survey monthly to members currently working with health coaches---to help with experience recall. Survey is still being administered using paper and by mail. Future recommendations are to administer survey after a health coach call using IVR or other available technologies.
Project: Measuring Effectiveness (QI7, Element J)			
Description: The organization employs and tracks one performance measure for each DM program. Each measure addresses a relevant process or outcome, produces a quantitative result, is population based, uses data and methodology that are valid for the process or outcome being measured, and has been analyzed in comparison with a benchmark or goal.			
Goal: Increase Asthma Medication Ratio (AMR) for members with persistent asthma in our Asthma DM program. Increase to 50th percentile for members between 5-18 years old. *Goal: A1C control for member with existing A1C>9 and receiving health coach interventions in 2016. Maintain 90th percentile for Medi-Cal, increase to 75th percentile for Medicare.*			

2016 Disease Management Program Evaluation			
2016 Disease Management Work Plan		2016 Disease Management Evaluation	
Methodology/Action Plan	Results	Barriers	Recommendations for Future
	AMR Prospective Rates as of 11/2016: Age 5 to 11 77.12% Medi-Cal 75th percentile Age 12 to18 68.02% Medi-Cal 75th percentile **Goal Met** HbA1c Poor Control (9.0%) as of 11/2016 : Medi-Cal Admin Rate: 34.31 % 75th percentile OneCare Admin Rate: 20.49% 50th percentile **Goal Not Met**	The diabetes program identification criteria did not support finding members who could benefit most from a health coach intervention.	Revised methodology (includes lab score or absence of lab test over 12 months) should help identify members in poor control for health coach intervention. Evaluate the effectiveness of the targeted A1C initiative against staff resources and if similar activities should continue in 2017. Include additional outcome metrics to evaluate program effectiveness- ED visit rate, IP visit rate, and Rx utilization.
Project: Cholesterol Management (OneCare CCIP)			
Description: Implement interventions for the OneCare Heart Health Program population with a focus on cholesterol management, an aspect of the Million Hearts Initiative.			
Goal: Achieve high blood pressure control on 50% of OC/OCC members receiving health coach interventions			
Program intervention- 197 OneCare members identified with hypertension were mailed an offer to opt-in to receive a No Cost home blood pressure monitor upon agreement to commit to bi-weekly health coaching sessions with education on medication adherence, dietary and lifestyle changes. 22 members responded to the program invitation.	Results will be evaluated throughout 2017, as interventions were implemented during 4th quarter, 2016.	The CCIP member intervention was delayed until 4th quarter. Staff resources were limited and managing the huge response to the A1C targeted mailing initiative from 2nd Q. Program design uses invitational model. Participation from CalOptima members is very low.	Consider making this intervention an opt out design. Evaluate the cost of blood pressure monitors to support opt out vs. opt in model.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken May 22, 2017
Special Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item
5. Consider Recommending Board of Directors' Approval of the 2017 Delegation Grid, Appendix B to 2017 Quality Improvement Program Description and Work Plan.

Contact
Richard Bock, Deputy Chief Medical Officer (714) 246-8400

Recommended Action
Recommend Board of Directors' approval of the 2017 Delegation Grid, Appendix B, to the 2017 Quality Improvement Program Description and Work Plan.

Background
Annually, CalOptima reviews and updates its delegation agreement to meet accreditation and regulatory requirements. For 2017, this also included updating the agreement with elements now delegated to Magellan Healthcare. This document serves as Attachment B to the 2017 Quality Improvement Program Description and Workplan, previously approved by the Board of Directors on March 2, 2017.

Fiscal Impact
There is no fiscal impact for the recommended action to approve the 2017 Delegation Grid, Appendix B, to the 2017 Quality Improvement Program Description and Work Plan.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Proposed 2017 Delegation Grid, Appendix B
2. March 2, 2017 Board Action, Consider Approval of the 2017 CalOptima Quality Improvement Program and 2017 Quality Improvement Work Plan

/s/ Michael Schrader — *5/18/2017*
Authorized Signature — **Date**

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2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
QI1A: QI Program Structure	X		X				CO responsibility P&P, even if delegated
QI1B: Annual Evaluation	X		X				CO responsibility P&P, even if delegated
QI2A: QI Committee Responsibilities	X		X				CO responsibility P&P, even if delegated
QI2B: Informing Members and Practitioners	X		X				CO responsibility P&P, even if delegated
QI3A: Practitioner Contracts	X		X				CO responsibility P&P, even if delegated
QI3B: Affirmative Statement- Must pass element	X		X				CO responsibility P&P, even if delegated
QI3C: Provider Contracts	X		X				CO responsibility P&P, even if delegated
QI4A: Member Services Telephone Access	X	X	X				
QI4B: BH Telephone Access Standards	X		X	X			CO responsibility P&P, even if delegated
QI4C: Annual Assessment-Member Experience	X						CO fields CAHPS, Kaiser complaint data included
QI4D: Opportunities for Improvement-Member Experience	X						
QI4E: Annual Assessment of BH and Services-Member Experience	X		X	X			Kaiser:Factor1 & Factor2 ; Magellan Factor2 only
QI4F: BH Opportunities for Improvement-Member Experience	X						

NCQA Standards Abbreviations: QI = Quality Improvement; NET – Network Management; UM – Utilization Management; CR – Credentialing; RR – Member Rights & Responsibilities; MEM – Member Connections; MED – Medicaid Benefits and Services. Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

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"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
QI4G: Assessing Experience With the UM Process	X			X			Magellan: Factor1 & Factor2; Factor3 & Factor4 activities may not be delegated; CO utilizes Kaiser data
QI5A: Population Assessment	X						
QI5B: Program Description-Complex Case Management (CCM)	X	X	X				
QI5C: Identifying Members for CCM	X	X	X				
QI5D: Access to Case Management-CCM	X	X	X				
QI5E: Case Management Systems-CCM	X	X	X				
QI5F: Case Management Process-CCM	X	X	X				CO responsibility P&P, even if delegated
QI5G: Initial Assessment-CCM	X	X	X				
QI5H: Case Management- Ongoing Management-CCM	X	X	X				
QI5I: Experience With Case Management-CCM	X		X				
QI5J: Measuring Effectiveness-CCM	X		X				
QI5K : Action and Re-measurement-CCM	X		X				
QI6A: Program Content-Disease Management (DM)	X		X				

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QI6B: Identifying Members for DM Programs	X		X				
QI6C : Frequency of Member Identification-DM	X		X				
QI6D: Providing Members With Information-DM	X		X				
QI6E: Interventions Based on Assessment-DM	X		X				
QI6F: Eligible Member Active Participation-DM	X		X				
QI6G: Informing and Educating Practitioners-DM	X		X				
QI6H: Integrating Member Information-DM	X		X				
QI6I: Experience With DM	X		X				
QI6J: Measuring Effectiveness-DM	X		X				
QI7A: Adoption of Guidelines	X		X				
QI7C: Relation to DM Programs	X		X				
QI8A: Identifying Opportunities-Continuity & Coordination of Care (C&C)	X		X				
QI8B: Acting on Opportunities-C&C	X		X				

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QI8C: Measuring Effectiveness-C&C	X		X				
QI8D: Transition to Other Care-C&C	X	X	X	X			
QI9A: Data Collection- C&C Behavioral Health	X						
QI9B: Collaborative Activities- C&C Behavioral Health	X						
QI9C: Measuring Effectiveness- C&C Behavioral Health	X						
QI10A: Delegation Agreement	X						
QI10B: Provision of Member Data to the Delegate	X						
QI10D: Pre-delegation Evaluation-NA	X						
QI10E: Review of QI Program	X						
QI10F: Opportunities for Improvement	X						
NET1A: Cultural Needs and Preferences	X		X				CO responsibility P&P, even if delegated
NET1B: Practitioners Providing Primary Care	X						CO responsibility Factor1-2 P&P, even if delegated
NET1C: Practitioners Providing Specialty Care	X						CO responsibility Factor1-3 P&P, even if delegated

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Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
NET1D: Practitioners Providing Behavioral Health (BH)-Auto Credit	X		X	X			CO responsibility Factor1-3 P&P, even if delegated, Magellan/Kaiser Factor4
NET2A: Access to Primary Care	X		X				CO responsibility P&P, even if delegated
NET2B: Access to BH	X		X	X			CO responsibility P&P, even if delegated
NET2C: Access to Specialty Care	X		X				
NET3A: Assessment of Member Experience Accessing the Network	X		X	X			For BH See QI4E: Kaiser Factor 1&2; CO Factor1, Magellan Factor2 only
NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X				
NET3C: Opportunities to Improve Access to BH Services	X		X	X			For BH See QI4E: Kaiser Factor1&2; CO Factor1, Magellan Factor2 only
NET5A: Notification of Termination	X	X	X	X			
NET5B: Continued Access to Practitioners	X	X	X	X			
NET6A: Physician Directory Data	X		X				
NET6B: Physician Directory Updates	X		X				

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Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
NET6C: Assessment of Physician Directory Accuracy	X		X				
NET6D: Identifying and Acting on Opportunities	X		X				
NET6E: Physician Information Transparency	X		X				
NET6F: Searchable Physician Web-Based Directory	X		X				
NET6G: Hospital Directory Data	X		X				
NET6H: Hospital Directory Updates	X		X				
NET6I: Hospital Information Transparency	X		X				
NET6J: Searchable Hospital Web-Based Directory	X		X				
NET6K: Usability Testing	X		X				
NET6L: Availability of Directories	X		X				
NET7A: Delegation Agreement	X		X				

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NET7B: Provisions of Member Data to the Delegate	X		X				
NET7D: Pre-delegation Evaluation	X		X				
NET7E: Review of Delegated Activities	X		X				
NET7F: Opportunities for Improvement	X		X				
UM1A: Written Program Description	X		X				CO responsibility P&P, even if delegated
UM1B: Physician Involvement	X		X				CO responsibility P&P, even if delegated
UM1C: BH Practitioner Involvement	X		X				CO responsibility P&P, even if delegated
UM1D: Annual Evaluation	X		X				CO responsibility P&P, even if delegated
UM2A: UM Criteria	X	X	X	X			CO responsibility P&P, even if delegated
UM2B: Availability of Criteria	X	X	X	X			CO responsibility P&P, even if delegated
UM2C: Consistency in Applying Criteria	X	X	X	X	X		CO responsibility P&P, even if delegated
UM3A: Access to Staff	X	X	X	X			CO responsibility P&P, even if delegated
UM4A: Licensed Health Professionals	X	X	X	X	X		CO responsibility P&P, even if delegated

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Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
UM4B: Use of Practitioners for UM Decisions	X	X	X	X	X		CO responsibility P&P, even if delegated
UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X				
UM4D: Practitioner Review of BH Denials- Auto Credit	X		X	X			
UM4E: Practitioner Review of Pharmacy Denials	X		X				
UM4F: Use of Board-Certified Consultants	X	X	X	X			
UM4G: Affirmative Statement About Incentives	X	X	X	X			
UM4H: Appropriate Classification of Denials	X	X	X	X			
UM5A: Timeliness of Non-Behavioral UM Decision Making	X	X	X				
UM5B: Notification of Non-Behavioral Decisions	X	X	X				
UM5C: Timeliness of Behavioral Healthcare UM Decision Making- Auto Credit	X		X	X			
UM5D: Notification of Behavioral Healthcare Decisions- Auto Credit	X		X	X			
UM5E: Timeliness of Pharmacy UM Decision Making	X		X		X		
UM5F: Notification of Pharmacy Decisions	X		X		X		

NCQA Standards Abbreviations: QI = Quality Improvement; NET – Network Management; UM – Utilization Management; CR – Credentialing; RR – Member Rights & Responsibilities; MEM – Member Connections; MED – Medicaid Benefits and Services. Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

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Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
UM5G: UM Timeliness Report	X	X	X	X			Magellan delegated for Factor3&4 only; HN Factor1 & Factor2. Factor5; CO Factor6
UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X				
UM6B: Relevant Information for BH Decisions- Auto Credit	X		X	X			
UM6C: Relevant Information for Pharmacy Decisions	X		X				
UM7A: Discussing a Denial With a Reviewer	X	X	X				
UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X				
UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X				
UM7D: Discussing a BH Denial with a Reviewer- Auto Credit	X		X	X			
UM7E: Written Notification of BH Denials- Auto Credit	X		X	X			
UM7F: BH Notice of Appeal Rights/Process- Auto Credit	X		X	X			
UM7G: Discussing a Pharmacy Denial With a Reviewer	X		X				
UM7H: Written Notification of Pharmacy Denials	X		X		X		
UM7I: Pharmacy Notice of Appeal Rights/Process	X		X		X		

NCQA Standards Abbreviations: QI = Quality Improvement; NET – Network Management; UM – Utilization Management; CR – Credentialing; RR – Member Rights & Responsibilities; MEM – Member Connections; MED – Medicaid Benefits and Services. Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

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2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
UM8A: Internal Appeals (Policies and Procedures)	X		X				CO responsibility P&P, even if delegated
UM9A: Pre-service and Post-service Appeals	X		X				CO responsibility P&P, even if delegated
UM9B: Timeliness of the Appeal Process	X		X				
UM9C: Appeal Reviewers	X		X				
UM9D: Notification of Appeal Decision/Rights	X		X				
UM11A: Pharmaceutical Management Procedures(Policies and Procedures)	X		X				
UM11B: Pharmaceutical Restrictions/Preferences	X		X				
UM11C: Pharmaceutical Patient Safety Issues	X		X				
UM11D: Reviewing and Updating Procedures	X		X				
UM11E: Considering Exceptions	X		X				
UM12A: Triage and Referral Protocols- Auto Credit	X		X	X			
UM12B: Supervision and Oversight- Auto Credit	X		X	X			
UM13A: Delegation Agreement	X						

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Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
UM13B: Provision of Member Data to the Delegate	X						
UM13D: Pre-delegation Evaluation	X						
UM13E: Review of the UM Program	X						
UM13F: Opportunities for Improvement	X						
CR1A: Practitioner Credentialing Guidelines	X	X	X	X			CO responsibility P&P, even if delegated
CR1B: Practitioner Rights	X	X	X	X			CO responsibility P&P, even if delegated
CR2A: Credentialing Committee	X	X	X	X			
CR3A: Verification of Credentials	X	X	X	X			
CR3B: Sanction Information	X	X	X	X			
CR3C: Credentialing Application	X	X	X	X			
CR4A: Recredentialing Cycle Length	X	X	X	X			
CR5A: Ongoing Monitoring and Interventions	X	X	X	X			
CR6A: Actions Against Practitioners	X	X	X	X			CO responsibility P&P, even if delegated

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Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
CR7A: Review and Approval of Provider	X	X	X				
CR7B: Medical Providers	X	X	X				
CR7D: Assessing Medical Providers	X	X	X				
CR8A: Delegation Agreement	X						
CR8C: Pre-delegation Evaluation-NA	X						
CR8D: Review of Delegate's Credentialing Activities	X						
CR8E: Opportunities for Improvement	X						
CR1C: Performance Monitoring for Re-Credentialing (CMS/DHCS)	X	X	X	X			CMS/DHCS Requirement
CR1D: Contracts Opt-Out Provisions (CMS)	X	X	X	X			CMS Requirement
CR1E: Medicare-Exclusions/Sanctions (CMS)	X	X	X	X			CMS Requirement
CR3D: Hospital Admitting Privileges (CMS/DHCS)	X	X	X	X			CMS/DHCS Requirement
CR6B: Monitoring Medicare Opt Out (CMS)	X	X	X	X			CMS Requirement
CR6C: Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)	X	X	X	X			DHCS Requirement

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Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
CR7F: Appeals Process for Termination/Suspension (CMS)	X	X	X	X			CMS Requirement
CR10A: ID of HIV/AIDS Specialists: Written Process	X	X	X				DHCS Requirement
CR10B: ID of HIV/AIDS Specialists: Evidence of Implementation	X	X	X				DHCS Requirement
CR10C: ID of HIV/AIDS Specialists: Distribution of Findings	X	X	X				DHCS Requirement
RR1A: Rights and Responsibility Statement	X						
RR1B: Distribution of Rights Statement	X						
RR2A: Policies and Procedures for Complaints	X		X				CO responsibility P&P, even if delegated
RR2B: Policies and Procedures for Appeals	X		X				CO responsibility P&P, even if delegated
RR3A: Subscriber Information	X						
RR3B: Interpreter Services	X	X	X	X			
MEM1A: Health Appraisal (HA) Components	X		X			X	Auto Credit available with Health Information Products (HIP) Certified
MEM1B: HA Disclosure	X		X			X	Auto Credit available with HIP Certified
MEM1C: HA Scope	X		X			X	Auto Credit available when HIP Certified

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Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
MEM1D: HA Results	X		X			X	Auto Credit available when HIP Certified
MEM1E: Formats	X		X			X	Auto Credit available when HIP Certified
MEM1F: Frequency of HA Completion	X		X			X	Auto Credit available when HIP Certified
MEM1G: Review and Update Process	X		X			X	Auto Credit available when HIP Certified
MEM2A: Topics of Tools	X		X			X	Auto Credit available when HIP Certified
MEM2B: Usability Testing	X		X			X	Auto Credit available when HIP Certified
MEM2C: Review and Update Process	X		X			X	Auto Credit available when HIP Certified
MEM2D: Formats	X		X			X	Auto Credit available when HIP Certified
MEM3B: Functionality: Telephone Requests	X	X	X	X			
MEM4A: Pharmacy Benefit Information: Website	X		X		X		PBM delegate possibility for Factors 6-8
MEM4B: Pharmacy Benefit Information: Telephone	X		X				
MEM4C: QI Process on Accuracy of Information	X		X				
MEM4D: Pharmacy Benefit Updates	X		X				

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Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
MEM5A: Functionality: Web Site	X		X				CO: Factors 1-3; Kaiser Factors 1,2,3; Factor4 NA
MEM5B: Functionality: Telephone	X	X	X	X			
MEM5C: Quality and Accuracy of Information	X	X	X	X			HN and Magellan For telephone only
MEM5D: E-Mail Response Evaluation	X		X				
MEM6A: Supportive Technology	X		X				
MEM7A: Identifying Members	X		X				
MEM7B: Targeted Follow-Up With Members	X		X				
MEM8A: Delegation Agreement	X						
MEM8B: Provision Of Member Data to the Delegate	X						
MEM8D: Pre-delegation Evaluation	X						
MEM8E: Review of Performance	X						
MEM8F: Opportunities for Improvement	X						
MED1A: Direct Access to Women's Health Services	X						

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Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
MED1B: Second Opinion	X	X	X	X			
MED1C: Out-of-Network Services	X	X					
MED1D: Out-of Network Cost to Member	X	X					
MED1E: Hours of Operation Parity	X	X					
MED2A: Distribution of Practice Guidelines	X						
MED3A: Coverage of Emergency Services	X	X					
MED4A: Performance Standards and Thresholds	X						
MED4B: Site Visits and Ongoing Monitoring	X						
MED5A: Privacy and Confidentiality	X						
MED5B: Authorization	X						
MED5C: Communication of PHI	X						

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 2, 2017
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Approval of the 2017 CalOptima Quality Improvement Program and 2017 Quality Improvement Work Plan

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Action

Approve recommended revisions to the 2017 Quality Improvement Program and 2017 Quality Improvement Work Plan.

Background

As part of existing regulatory and accreditation mandated oversight processes, CalOptima's Quality Improvement Program (" QI Program") and Quality Improvement Work Plan ("QI Work Plan") must be reviewed, evaluated, and approved annually by the Board of Directors.

The QI Program defines the structure within which quality improvement activities are conducted, and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima Members. It is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks. The QI Program guides the development and implementation of the annual QI Work Plan.

The QI Work Plan is the operational and functional component of the QI Program and outlines the key activities for the upcoming year. The QI Work Plan provides the detail objectives, scope, timeline, monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year.

CalOptima staff has updated the 2017 QI Program Description and related QI Work Plan with revisions to ensure that it is aligned to reflect the changes regarding the health networks and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner across the Medi-Cal and OneCare programs.

Discussion

The 2017 Quality Improvement Program is based on the Board-approved 2016 Quality Improvement Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all programs to ensure they are consistent with regulatory requirements, NCQA standards, and CalOptima's own Success Factors.

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The revisions are summarized as follows:

1. Updates the introductory pages to align with CalOptima's Vision, Mission & new Strategic Plan for 2017-19;
2. Updates the plans we offer, scope of services and who we work with – including an updated list of our Health Networks;
3. Updates the Behavioral Health Services delegate to Magellan Health, Inc.for Medi-Cal, OneCare and OneCare Connect ;
4. Updates the list of CalOptima Officers and staff; and included a broader representation of the key areas supporting the QI Program;
5. Incorporates the description of CalOptima's approach to population health management in the design and delivery of care;
6. Reflects the adoption of the annual UM Work Plan which complements the QI Program and Work Plan;
7. Updates the Advisory Committees and Quality Committees/Subcommittees that support the QI Program;
8. Updates the scope of the Credentialing program with the revised list of included practitioners;
9. Updates the Care of Members with Complex Needs to include further details on the Interdisciplinary Care Teams and risk stratification processes
10. Updates the QI Committee structure.

The recommended changes are designed to better review, analyze, implement and evaluate the components of the QI Program and Work Plan. In addition, the changes are necessary to meet the requirements specified by the Centers for Medicare and Medicaid Services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact

There is no fiscal impact for the recommended action to approve the CalOptima QI Program and Work Plan.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments

1. Proposed 2017 Quality Improvement Program – Executive Summary of Revisions
2. Proposed 2017 Quality Improvement Program and 2017 Quality Improvement Work Plan

/s/ Michael Schrader — *2/23/2017*
Authorized Signature — **Date**

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Quality Improvement (QI) Program 2017

Executive Summary of Revisions

1. Updates the introductory pages to align with CalOptima's Vision, Mission & Strategic Plan for 2017-19;
2. Updates the plans we offer, scope of services and who we work with – including an updated list of our Health Networks;
3. Updates the Behavioral Health Services delegate to Magellan Health, Inc. for Medi-Cal, OneCare and OneCare Connect;
4. Updates the list of CalOptima Officers and staff and included a broader representation of the key areas supporting the QI Program;
5. Incorporates the description of CalOptima's approach to population health management in the design and delivery of care;
6. Reflects the adoption of the annual UM Work Plan which complements the QI Work Plan;
7. Updates the Advisory Committees and Quality Committees/Subcommittees that support the QI Program;
8. Updates the scope of the Credentialing program with the revised list of included practitioners;
9. Updates the Care of Members with Complex Needs to include further details on the Interdisciplinary Care Teams and risk stratification processes;
10. Updates the QI Committee structure
11. Updates the 2017 QI Work Plan;
12. Assures NCQA & DHCS requirements are included in the program description and related work plans.

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2016~~6~~7

QUALITY IMPROVEMENT PROGRAM

~~REVISED 10/6/2016~~

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2016~~6~~7 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

Richard ~~Helmer~~Bock, M.D. **____Date**
Deputy Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

Paul Yost, M.D. **Date**

Board of Directors Chair:

_____ _____

Mark Refowitz **Date**

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

To provide members with access to quality health care services delivered in a cost effective and compassionate manner.

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all of our members.

Our Values — CalOptima CARES

Collaboration: We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability: We were created by the community, for the community, and are accountable to the community. Our Board of Directors, Member Advisory Committee, OneCare Connect Member Advisory Committee, and Provider Advisory Committee meetings are open to the public.

Respect: We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members

We respect and care about our partners. We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence: We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship: We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."
We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan
CalOptima's 2017–19 Strategic Plan honors our longstanding mission focused on members while recognizing that the future holds some unknowns given possible changes for Medicaid plans serving low-income people through the Affordable Care Act. Still, any future environment will demand attention to the priorities of more innovation and increased value, as well as enhanced partnerships and engagement. Additionally, CalOptima must focus on workforce performance and financial strength as building blocks so we can achieve our strategic goals. Below are the key elements in our Strategic Plan framework.

Strategic Priorities:

- **Innovation:** Pursue innovative programs and services to optimize member access to care.
- **Value:** Maximize the value of care for members by ensuring quality in a cost-effective way.
- **Partnerships and Engagement:** Engage providers and community partners in improving the health status and experience of members.

Building Blocks:

- **Workforce Performance:** Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes.
- **Financial Strength:** Provide effective financial management and planning to ensure long-term financial strength.

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is unique in that we must ~~exhibit~~ be~~ing~~ the best of both a public agency upholding public trust, and a health plan seeking quality health care, efficiency and member satisfaction.

As both, CalOptima must:

- Make the best use of our resources, funding and expertise
- Solicit stakeholder input
- Ensure transparency in our governance procedures
- Be accountable for the decisions we make

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How We Became CalOptima

Orange County is unique in that it does not have county-run hospitals or clinics. By the mid-1990s, there was a coalescing crisis since not enough providers accepted Medi-Cal. This resulted in overcrowding in emergency rooms and delayed care, due to Medi-Cal recipients using emergency rooms across the county not only for acute care, but for primary care as well.

A dedicated coalition of local elected officials, hospitals, physicians and community advocates rallied and created a solution. The answer was to create CalOptima as a county organized health system (COHS) authorized by State and Federal law to administer Medi-Cal benefits in Orange County.

~~**CalOptima was created as a public agency, operates like a private sector health plan and is accountable to stakeholders to build public trust.**~~

CalOptima began serving members in 1995. Today, CalOptima is the largest of six COHS in the United States.

CalOptima ~~is~~ as a public agency and ~~has, as~~ a COHS has:

- Single-plan ~~responsibil~~responsible~~ity~~ for providing ~~services to~~Medi-Cal coverage in the county
- Mandatory enrollment of all full-scope Medi-Cal beneficiaries, including dual eligibles
- ~~Responsibil~~Responsible~~ity~~ for almost all medical acute services and Long-Term Services and Supports (LTSS), including custodial long-term care.

In 2005, CalOptima became licensed to furnish a Medicare Advantage Special Needs Plan (MA SNP) and MA Prescription Drug plan through a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS). This plan, called OneCare (HMO SNP), allows CalOptima to offer Medicare and Medi-Cal benefits under one umbrella to dual eligible individuals.

OneCare (OC) ~~is also a Medicare Advantage Prescription Drug plan. OneCare~~ operates exclusively as a "Zero Cost Share, Medicaid Subset Dual Special Needs Plan." ~~OneCare~~OC only enrolls beneficiaries who qualify as a zero cost sharing Medicaid subset. To identify dual eligible members, ~~OneCare~~OC imports daily member eligibility files from the State and Federal government with Medicaid and Medicare eligibility segments.

In July 2015, CalOptima launched OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan). ~~This~~ OneCare Connect (OCC) is a demonstration project in an effort by California and the Federal government to begin the process — through a single organized health care delivery system — of integrating medical, behavioral health, long-term care services and supports, and community-based services for dual eligible beneficiaries. One of t~~T~~he program's goal is to help members stay in their homes for as long as possible and shift services out of institutional settings and into the home and community. A key feature of CalOptima is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individual care plan. Members eligible for OCC cannot enroll in OC.

~~CalOptima was created as a public agency, operates like a private sector health plan and is accountable to stakeholders to build public trust.~~

WHAT ~~W~~WE OFFER:

Medi-Cal

In California, Medicaid is known as Medi-Cal. For more than 20 years, CalOptima has been serving Orange County's Medi-Cal population. Due to the implementation of the Affordable Care Act~~,~~ — as more low-income children and adults qualified for Medi-Cal — membership in CalOptima ~~from 2014–16~~ grew by an unprecedented 49 percent between 2014 and 2016~~.~~ ! ~~More low-income children and adults qualified for Medi-Cal.~~

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must ~~live~~ reside in Orange County ~~and~~ to be enrolled in CalOptima Medi-Cal.

Scope of Services~~:~~

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population.

These services include but are not limited to the following:

Acupuncture	Hospice care	Outpatient mental health services – limited
Adult preventive services	Hospital/inpatient care	Pediatric preventive services
Community-based adult services	Immunizations	Child health and disability prevention (CHDP)
Doctor visits	Laboratory services	Physical therapy
Durable medical equipment	Limited allied health services	Prenatal care
Emergency care	Medical supplies	Specialty care services
Emergency transportation	Medications	Speech therapy
Non-emergency medical transportation (NEMT)	Newborn care	Substance use disorder preventive services – limited
Hearing aid(s)	Nursing facility services	Vision care
Home health care	Occupational therapy	

Certain services are not covered by CalOptima, or may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.

- Dental services are provided through California's Denti-Cal program.
- Eligible conditions under California Children's Services (CCS).

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care, and are described in the Utilization Management (UM) Program.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established through special programs, such as the CalOptima Member Liaison program, and specific Memoranda of Understanding (MOU) with certain community agencies, including HCA, CCS and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Beginning July 1, 2015, Long-Term Services and Supports (LTSS) became a benefit for all Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

LTSS includes four programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)
- In-Home Supportive Services (IHSS)

~~Prior to July 1, 2015, CalOptima was responsible for all of the LTSS programs with the exception of In-Home Supportive Services (IHSS). In **XXX** 201**X**, IHHS will move back to county responsibility throughout the state.~~

OneCare (HMO SNP)

OneCare (HMO SNP) means total care. Our members with Medicare and Medi-Cal benefits are covered in one single plan, making it easier for our members to get the health care they need. ~~For more than a decade~~Since 2005, CalOptima has been offering ~~OneCare~~OC to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal**.** ~~We have~~OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County.

To be a member of ~~OneCare~~OC, a person must live in Orange County and be enrolled in Medi-Cal and Medicare Parts A and B, and not be eligible for ~~OneCare Connect~~OCC.

Scope of Services~~:~~

OC provides a comprehensive scope of services for the dual eligible members who are not eligible for OCC, and who voluntarily enroll in OC.

These services include but are not limited to the following:

Acupuncture and other alternative therapies	Gym membership	Prescription drugs
Ambulance	Hearing services	Preventative care
Chiropractic care	Home health care	Prosthetic devices
Dental services – limited	Hospice	Renal dialysis
Diabetes supplies and services	Inpatient hospital care	Skilled nursing facility
Diagnostic tests, lab and radiology services, and X-rays	Inpatient mental health care	Taxi rides for medical and pharmacy visits
Doctor visits	Mental health care	Urgently needed services
Durable medical equipment	Outpatient rehabilitation	Vision services
Emergency care	Outpatient substance abuse	
Foot care	Outpatient surgery	

OneCare Connect

~~OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a new plan that launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect also integrates the Multipurpose Senior Services Program (MSSP), In-Home Supportive Services (IHSS) and Long-Term Care (LTC).~~

~~At no extra cost, our members also get vision care, taxi rides to medical appointments and enhanced dental benefits. Plus, our members get support so they can receive the services they need, when they need them. A Personal Care Coordinator works with our members and their doctors to create an individualized health care plan that fits our members' needs.~~

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal.

These members often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost, OCC adds supplemental benefits such as vision care, taxi rides to medical appointments, gym benefits and enhanced dental benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results is a better, more efficient and higher quality health care experience for the member.

To join ~~OneCare Connect~~OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions apply.

Scope of Services:

OCC simplifies and improves health care for low-income seniors and people with disabilities.

These services include but are not limited to the following:

Acupuncture (pregnant women)	Hearing aids – limited	Rehabilitation services
Ambulance services	Hearing screenings	Renal dialysis
Case management	Incontinence supplies – limited	Screening tests
Chiropractic services	Inpatient hospital care	Skilled nursing care
Community-based adult services (CBAS)	Inpatient mental health care	Specialist care
Diabetes supplies and services	Institutional care	Substance abuse services
Disease self-management	Lab tests	Supplemental dental services
Doctor visits	Medical equipment for home care	Taxi rides for medical and pharmacy visits
Durable medical equipment	Mental or behavioral health services	Transgender services
Emergency care	Multipurpose Senior Services Program (MSSP)	Occupational, physical or speech therapy
Eye exams	Over-the-counter drugs – limited Prescription drugs	Urgent care
Foot care	Outpatient care	"Welcome to Medicare" preventive visit
Glasses or contacts – limited	Preventive care	
Gym membership	Prosthetic devices	
Health education	Radiology	

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the ~~first~~ only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

~~PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dieticians, physical therapists, occupational therapists, home care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participates.~~

To be a PACE participant, members must be eligible for both Medicare Parts A & B, be at least 55 years old, live in our Orange County service area, be determined as eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

~~PACE participants must receive all needed services, other than emergency care, from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.~~

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dieticians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participates.

~~Launched August 1, 2013, CalOptima PACE is the only PACE center in Orange County. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.~~

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged for ~~our~~ participants, based on their needs as indicated by ~~our~~the Interdisciplinary Team.

PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

NEW PROGRAM INITIATIVES O~~O~~N O~~O~~UR H~~H~~ORIZON:

Palliative Care

CalOptima expects to implement palliative care standards for its Medi-Cal members no sooner than ~~April 1, 2017~~July 1, 201~~7~~8.

Whole-Person Care

Whole-Person Care is a five-year pilot led by the Orange County Health Care Agency to focus on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. Whole-Person Care will be launched in stages, with full implementation by January 1, 2018.

Long-Term Connect

CalOptima plans to realign its internal operations to better support members who reside in a long-term care facility. Referred to as "Long-Term Connect" its focus will be on increasing member/provider visits, preventing avoidable inpatient hospitalizations, and improving health outcomes. Long-Term Connect is expected to launch in July 2017.

WHOM WWE WWORK WWITH:

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can contract with a CalOptima health network, and/or participate through CalOptima Direct, and/or the CalOptima Community Network.

CalOptima members can choose one of 14 health networks (HNs), representing more than 7,500 practitioners.

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. Currently, CalOptima contracts with 13 private ~~health networks~~HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 14th network available for members to select, supplementing the existing health network delivery model and creating additional capacity for growth.

CalOptima Direct (COD)
CalOptima Direct is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including ~~foster children,~~ dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's MA SNP), ~~members in skilled nursing facilities, and~~ share of cost members, and members residing outside of Orange County. ~~COD also currently includes the following categories of vulnerable and complex/catastrophic care members: transplant, hemophilia, HIV, end-stage renal disease (ESRD), and seniors and persons with disabilities.~~ Members enrolled in CalOptima Direct are not health network eligible.

~~Not all CalOptima members are health network eligible. Members who are not eligible for enrollment in a health network may be assigned to CalOptima Direct based on the below criteria:~~

- ~~Transitional members waiting to be assigned to a delegated health network~~
- ~~Medi-Cal/Medicare members (Medi-Medi)~~
- ~~Members who reside outside of Orange County~~
- ~~Medi-Cal share of cost members~~
- ~~Members residing in Fairview Developmental Center~~

Health Networks
CalOptima contracts with a variety of health network models to provide care to members. Since 2008, CalOptima's HNs consist of ~~has also included~~ Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), Physician Medical Groups (PMGs) and Shared Risk Medical Groups (SRGs). Through these HNs, CalOptima members have access to ~~CalOptima's HMOs, PHCs, PMGs and SRGs include~~ more than ~~3,5~~1,500 Primary Care Providers (PCPs), nearly 6,000 specialists and 30 hospitals and clinics. New networks that demonstrate the ability to comply with CalOptima's delegated requirements are added as needed with CalOptima Board approval.

The following are CalOptima's contracted Health Networks:

Health Network/Delegate ~~No.~~	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	PMG	SRG
AMVI Care Health Network	PHC	PMG	PHC
Arta Western Health Network	SRG	PMG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	SRG	PMG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	~~SRG~~HMO	PMG	~~SRG~~HMO
Noble Mid-Orange County	SRG	PMG	SRG
OC Advantage Medical Group	PHC		PHC
Prospect Medical Group	SRG		SRG
Talbert Medical Group	SRG	PMG	SRG
United Care Medical Group	SRG	PMG	SRG

Upon successful completion of readiness reviews and audits, the ~~health networks~~HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management (UM)
- Case and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

BEHAVIORAL HEALTH SERVICES

Medi-Cal Ambulatory Behavioral Health Services

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional or behavioral functioning, resulting from a mental health disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders. Mental health services include but are not limited to: individual and group psychotherapy, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition.

CalOptima delegates to ~~College Health Independent Practice Association (CHIPA)~~Magellan Health, Inc. [a managed behavioral healthcare organization (MBHO)] for ~~utilization management~~ UM of the provider network~~,~~. ~~CHIPA subcontracts and delegates to Beacon Health Strategies LLC (Beacon) other functions that include~~ network adequacy and credentialing the provider network, ~~the Access Line~~ customer service/managing the CalOptima Behavioral Health phone line, and several quality improvement functions.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD).

~~B~~Some behavioral health services are also within the scope of practice for PCPs, including offering screening, brief intervention and referral to treatment (SBIRT) services to members 18 years of age and older who misuse alcohol. Providers in primary care settings also screen for alcohol misuse and provide people engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

OneCare and OneCare Connect Behavioral Health Services

CalOptima is also contracted with ~~has contracted with Windstone Behavioral Health~~Magellan Health, Inc. for the behavioral health services portion of ~~OneCare~~OC and ~~OneCare Connect~~OCC. ~~CalOptima~~ The ~~F~~delegated functions are identical to those listed above. ~~delegatesd to Magellan include utilization management (UM), credentialing and customer service. to Windstone. Evidence-based MCG guidelines are used in the UM decision-making process.~~

~~Our Lines Of Business:~~

~~Medi-Cal~~

~~Scope of Services~~

~~Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population.~~

~~These services include but are not limited to the following:~~

~~Adult preventive services~~	~~Hospital/inpatient care~~	~~Pediatric preventive services~~
~~Community-based adult services~~	~~Immunizations~~	~~Child health and disability prevention (CHDP)~~
~~Doctor visits~~	~~Laboratory services~~	~~Physical therapy~~
~~Durable medical equipment~~	~~Limited allied health services~~	~~Prenatal care~~
~~Emergency care~~	~~Medical supplies~~	~~Specialty care services~~
~~Emergency transportation~~	~~Medications~~	~~Speech therapy~~
~~Non-emergency medical~~	~~Newborn care~~	~~Substance use disorder~~

transportation (NEMT)		preventive services – limited
Hearing aid(s)	Nursing facility services	Vision care
Home health care	Occupational therapy	
Hospice care	Outpatient mental health services – limited	

Certain services are not covered by CalOptima, or may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California's Denti-Cal program. (CCS).

California Children's Services

Services for children with certain physical limitations, chronic health conditions or diseases are provided through California Children's Services (CCS), which is a statewide program. Currently, CCS authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for CCS-eligible conditions. DHCS manages the CCS program and the Orange County Health Care Agency operates the program. CalOptima is responsible for coordinating care and services for all non-CCS related conditions. There is work underway to integrate CCS services as a benefit of CalOptima. This transition is planned for 2017.

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care, and are described in the Utilization Management Program.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established through special programs, such as the CalOptima Member Liaison program, and specific Memoranda of Understanding (MOU) with certain community agencies, including HCA, CCS and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Beginning July 1, 2015, Long-Term Services and Supports (LTSS) became a CalOptima benefit for all Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

LTSS includes four programs:

- Community-Based Adult Services (CBAS)

- Nursing Facility Services for Long-Term Care
- Multipurpose Senior Services Program (MPSS)
- In-Home Supportive Services (IHSS)

OneCare (HMO SNP)

Scope of Services

OneCare (HMO SNP) provides a comprehensive scope of services for the dual eligible members who are not eligible for OneCare Connect.

These services include but are not limited to the following:

Acupuncture and other alternative therapies	Foot care	Outpatient surgery
Ambulance	Hearing services	Prescription drugs
Chiropractic care	Home health care	Preventative care
Dental services – limited	Hospice	Prosthetic devices
Diabetes supplies and services	Inpatient hospital care	Renal dialysis
Diagnostic tests, lab and radiology services, and X-rays	Inpatient mental health care	Skilled nursing facility
Doctor visits	Mental health care	Transportation – limited
Durable medical equipment	Outpatient rehabilitation	Urgently needed services
Emergency care	Outpatient substance abuse	Vision services

OneCare Connect

Scope of Services

Launched July 1, 2015, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan offered by CalOptima to simplify and improve health care for low-income seniors and people with disabilities. OneCare Connect combines our members' Medicare and Medi-Cal benefits, adds supplemental benefits, and offers personalized support – all to ensure each member receives the right care in the right setting.

OneCare Connect is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal. These people often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OneCare Connect delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

OneCare Connect achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Addressing individual needs results isn a better, more efficient and higher quality health care experience for the member.

These services include but are not limited to the following:

Acupuncture (pregnant women)	Hearing screenings	Over-the-counter drugs – limited
Ambulance services	Incontinence supplies – limited	Radiology
Case management	In-Home Supportive Services (IHSS)	Rehabilitation services
Chiropractic services	Inpatient hospital care	Renal dialysis
Diabetes supplies and services	Inpatient mental health care	Screening tests
Disease self-management	Institutional care	Skilled nursing care
Doctor visits	Lab tests	Specialist care
Durable medical equipment	Medical equipment for home care	Substance abuse services
Emergency care	Mental or behavioral health services	Supplemental dental services
Eye exams	Multipurpose Senior Services Program (MSSP)	Transgender services
Foot care	Prescription drugs	Transportation to a doctor's office
Glasses or contacts – limited	Preventive care	Occupational, physical or speech therapy
Health education	Prosthetic devices	Urgent care
Hearing aids – limited	Outpatient care	"Welcome to Medicare" preventive visit

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

~~Scope of Services~~

~~Launched August 1, 2013, CalOptima PACE is the only PACE center in Orange County. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.~~

~~PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged for our participants, based on their needs as indicated by our Interdisciplinary Team.~~

Membership Demographics

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2017

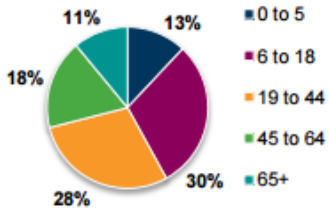
Mission: To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Membership Data as of December 31, 2016

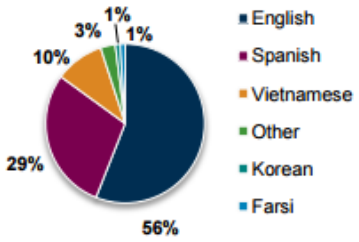
Total CalOptima Membership
800,001

Program	Members
Medi-Cal	781,733
OneCare Connect	16,810
OneCare (HMO SNP)	1,275
Program of All-Inclusive Care for the Elderly (PACE)	183

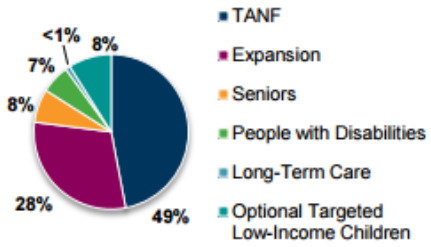
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



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CalOptima
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Fast Facts: February 2016

Mission: To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

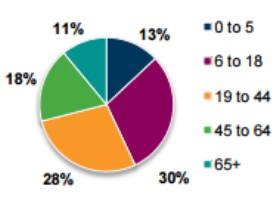
Membership Data as of December 31, 2015

Total CalOptima Membership
779,410

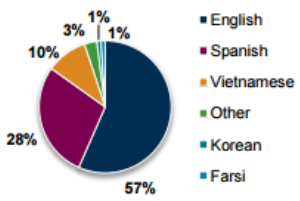
Program	Members
Medi-Cal	779,410
OneCare (HMO SNP)*	11,891
OneCare Connect*	4,437
Multipurpose Senior Services Program*	464
Program of All-Inclusive Care for the Elderly (PACE)*	129

*Membership already accounted for in total Medi-Cal membership

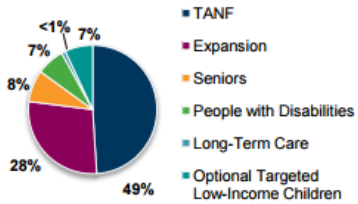
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



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QUALITY IMPROVEMENT PROGRAM

~~CalOptima's~~ CalOptima's ~~Quality~~ Quality Improvement (QI) Program encompasses all clinical care, clinical services and organizational services provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all of our members.

CalOptima has developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care management, disease management and complex care management. Our approach uses support systems for our members with vulnerabilities, disabilities and chronic illnesses.

CalOptima's ~~Quality Improvement~~QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

AUTHORITY, ~~A~~ACCOUNTABILITY AND RESPONSIBILITY

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the ~~Quality Improvement~~QI Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board of Directors promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the QI Program annually.

The QI Program is based on ongoing data analysis to identify the clinical needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of members. The CMO is charged with identifying appropriate interventions and resources necessary to implement the QI Program. Such recommendations shall be aligned with Federal and State regulations, contractual obligations and fiscal parameters.

Quality Improvement Program, Role of CalOptima Officers

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the ~~Quality Improvement~~QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the State and Federal Contracts.

Chief Medical Officer (CMO) — or physician designee — chairs the QIC, which oversees and provides direction to CalOptima's QI activities, and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO) along with the ~~CMO,~~CMO oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics, Quality Management, ~~Utilization Management~~UM, Care Coordination, Case Management, H~~ealth E~~~~ducation &~~ D~~isease~~ M~~anagement~~, Pharmacy Management, Behavioral Health Integration and Long-Term Services and Supports.

~~**Chief Network Officer (CNO)** is responsible for developing and expanding CalOptima's programs by implementing strategies that achieve the established program objectives; leveraging the core competencies of CalOptima's existing administrative infrastructure to build an effective and efficient operational unit to serve CalOptima's networks; and making sure the delivery of accessible, cost-effective, quality health care services throughout the service delivery network. The CNO leads and directs the integrated operations of the networks, and must coordinate organizational efforts internally, as well as externally, with members, providers and community stakeholders.~~

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, ~~and~~ Electronic Business and Human Resources.

Executive Director, Quality & Analytics (ED of QA) is responsible for facilitating the company-wide QI Program, driving improvements with Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS S~~s~~tar measures and ratings, and facilitating compliance with National Committee for Quality Assurance (NCQA) standards. The ED of QA serves as a member of the executive team and with the CMO/DCMO supports efforts to promote adherence to established quality improvement strategies and programs throughout the company. Reporting to the ED of QA is the Director of Quality Analytics, the Director of Health Education & Disease Management, ~~and the Manager~~the Director of ~~for~~ Quality Improvement and the Director of Behavioral Health Services.

Executive Director of Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including: ~~Utilization Management~~UM, Care Coordination, ~~Case Management, Long,~~ Complex Case Management, Long-Term Services and Supports~~,~~ and MSSP Services, along with new program implementation related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO/DCMO, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director of Public Affairs (ED of PA) serves as the State Liaison; ~~oversees the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements;~~ and the management, development and implementation of CalOptima's Communication plan, Issues Management and Legislative Advocacy. This position also oversees Strategic Development and the integration of activities for the Community Relations Program. The QI department collaborates with Public Affairs to address specific developments or changes to policies and procedures that impact areas within the purview of QI.

Executive Director of Compliance (ED of C) is responsible to monitor and drive interventions so that CalOptima and its HMOs, PHCs, SRGs, MBHO and PMGs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight department to refer any potential sustained noncompliance issues or trends encountered during audits of ~~health networks~~HNs, ~~provider medical group~~PMGs, and other functional areas. The ED of C also oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements.

Executive Director of Network Operations (ED of NO) ~~is responsible for leading and directing~~leads and directs the integrated operations of the health networks, and must coordinate organizational efforts internally, as well as externally, with members, providers and community stakeholders. The ED of NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective, quality health care services throughout the service delivery network.

Executive Director of Operations (ED of O) is responsible for overseeing and guiding Claims Administration, Customer Service, Grievance & Appeals Resolution Services, Coding Initiatives, and Electronic Business

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD, as well as our contracted provider networks. Through the QI Program, and in collaboration with its providers, CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The CalOptima QI Program incorporates continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies):

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress toward established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to promote efforts that support the identification and correction of quality of care issues.
- It maintains agencywide practices that support accreditation by the ~~National Commission for Quality Assurance (~~NCQA~~)~~, and meets Department of Health Care Services (DHCS) ~~&~~and Centers for Medicare & Medicaid Services (CMS) quality requirements and measures.

~~Quality Improvement, Quality Analytics, Health Education & Disease Management~~The Quality ~~&~~and Clinical Operations departments, ~~-~~and Medical Directors~~,~~ in conjunction with multiple CalOptima departments ~~Medical Directors~~ support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

QUALITY IMPROVEMENT DEPARTMENT

The ~~Quality Improvement~~QI department is responsible for the execution and coordination of the quality assurance and improvement activities. ~~The QI Department~~It also supports the specific focus of monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and that care and services are rendered appropriately and safely to all CalOptima members.

~~Quality Improvement~~QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both division and department-specific as well as agencywide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care and all lines of business
- Monitor and maintain ~~Maintain~~ agencywide practices that support accreditation and meeting regulatory requirements.~~by the National Commission for Quality Assurance (NCQA)~~

QUALITY ANALYTICS DEPARTMENT

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics ~~and~~, programs~~,~~ and ~~and~~ processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The ~~Quality Analytics~~QA department activities include design, implementation and evaluation of initiatives to:

- Report, m~~M~~onitor and trend outcomes
- Drive solutions and interventions to improve quality of care, access to preventive care, and management of chronic conditions to clinical guidelines
- Support efforts to improve internal and external customer satisfaction

- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze problems and measure improvement
- Coordinate and communicate organizational information, both division and department specific, and agencywide
- Participate in various reviews through the QI Program such as the All Cause Readmission monitoring, access to care, availability of practitioners and other reviews
- Facilitate satisfaction surveys for members and practitioners
- ~~Evaluate and monitor provider credentials~~
- Provide agencywide oversight of monitoring activities that are:

  Balanced: Measures clinical quality of care and customer service
  Comprehensive: Monitors all aspects of the delivery system
  Positive: Provides incentive to continuously improve

In addition to working directly with the contracted ~~health networks~~HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case Management reports
- Pharmacy data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores ~~STARS and HOCC~~ data
- Group Needs Assessments
- Results of Risk Stratification
- HEDIS Performance
- Member and Provider satisfaction surveys
- ~~Quality Improvement~~QI Projects (QIPs, PIPs and CCIPs)
- Health Risk Assessment (HRA) data

HEALTH EDUCATION & DISEASE MANAGEMENT DEPARTMENT

The Health Education & Disease Management (HE & DM) department is the third area in Quality that provides program development and implementation for ~~the~~ agencywide ~~chronic condition~~population health ~~improvement~~ programs. ~~Health Education & Disease Management (~~HE & DM~~)~~ Programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members and designed to achieve behavioral change for improved health and are reviewed on an annual basis.~~-~~ Program topics covered include Asthma, Congestive Heart Failure, Diabetes, Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, ~~Pediatric~~ Shape Your Life/Weight Management and Tobacco Cessation.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the sixth grade reading level and are culturally and linguistically appropriate for our members.

~~Health Education & Disease Management~~ HE & DM supports CalOptima members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- Execute and coordinate programs with Case Management, ~~Utilization Management, Quality Analytics~~QA and our Health Network Providers.

RESOURCES TO DIRECTLY SUPPORT THE QUALITY IMPROVEMENT PROGRAM AND QUALITY IMPROVEMENT COMMITTEE

CalOptima's budgeting process includes personnel, IT resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

The following staff positions provide direct support for organizational and operational QI Program functions and activities:

Medical Director, Quality
Appointed by the CMO, the Medical Director of Quality is responsible for the direction of the QI Program objectives to drive the organization's mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services delivered to members.

~~Manager~~Director, Quality Improvement
Responsibilities include assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Facility Physical Access Compliance and working with the ED of Quality. This position is also responsible for implementation of the QI Program and Work Plan implementation.

- The following positions report to the Quality Improvement ~~Manager~~Director:
  - Manager, Quality Improvement
  - Supervisor, Quality Improvement (PQI)
  - Supervisor, Quality Improvement (Credentialing)
  - QI Program Specialists

- QI Nurse Specialists~~,~~
- Data Analyst
- Credentialing Coordinators~~,~~
- Program Specialists
- ~~Credentialing~~ Program Assistants
- ~~Facility~~ Site Review Master Trainer
-
- Facility Site Review Nurse Reviewers

Director, Quality Analytics
Provides administrative and analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory, and accreditation agencies.

- The following positions report to the Director of Quality Analytics:
  - Quality Analytics HEDIS Manager
  - Quality Analytics ~~Medical Data~~Pay for Value Manager
  - Quality Analytics QI Initiatives Manager
  - Quality Analytics Analysts
  - Quality Analytics Project Managers
  - Quality Analytics Program Coordinators
  - Quality Analytics Program Specialists

Director, Health Education & Disease Management
Provides direction for program development and implementation for the agencywide ~~health education and disease management~~population health initiatives. ~~e~~Ensures linkages supporting a whole-person perspective to health and health care with Case Management, Care Management ~~and~~, ~~Utilization Management~~UM, Pharmacy ~~&~~and Behavioral Health Integration. Also, supports the Model of Care implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation ~~agencies~~agency requirements.

- The following positions report to the Director, Health Education & Disease Management:
  - Disease Management Manager (Program Design)
  - Disease Management Manager (Operations)
  - Disease Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Disease Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dieticians
  - Data Analyst
  - Program Manager
  - Program Specialists
  - Program Assistant

In addition, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our member's health status.

~~UM~~
Executive Director of Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including: UM, Care Coordination, Complex Case Management, Long-Term Services and Supports, MSSP Services, along with new program implementation related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO/DCMO, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Director of Utilization Management assists in the development and implementation of the ~~Utilization Management~~ UM ~~P~~program, policies, and procedures. This ~~D~~director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. -The ~~D~~director of U~~tilization~~ M~~anagement~~ also provides supervisory oversight and administration of the U~~tilization~~ M ~~anagement P~~program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and ~~Quality Improvement~~QI Committees, participates in the ~~Utilization Management~~UM Committee and the Benefit Management Subcommittee.

Director of Clinical Pharmacy Management leads the development and implementation of the Pharmacy Management (PM) ~~P~~program, develops and implements ~~Pharmacy Management~~PM ~~D~~department policies and procedures; ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of Pharmacy related clinical affairs, and serves on the Pharmacy ~~and~~& Therapeutics Subcommittee and ~~Quality Improvement~~QI Committees. The ~~D~~director of ~~Pharmacy Management~~PM also guides the identification and interventions on key pharmacy quality and utilization measures.

Director of Care Management is responsible for Care Management, Transitions of Care, Complex Case Management and the clinical operations of OCC and OC~~the OneCare and MediConnect programs~~. The~~is~~ ~~D~~director supports improving quality and access through seamless care coordination for targeted member populations. Develops and implements policies, procedures and processes related to program operations and quality measures.

Director of Long Term Services and Supports is responsible for LTSS programs which include ~~Community Based Adult Services (~~CBAS~~)~~, In-Home Supportive Services (IHSS), ~~Long Term Care Services (~~LTC~~)~~, and ~~Multipurpose Senior Services Program (~~MSSP~~)~~. The position supports "Member-Centric" approach and helps keep~~ing~~ members ~~at~~in the least restrictive living environment, collaborate with stakeholders including community partners, and ensure LTSS services are available to the appropriate population. The ~~D~~director also develops and implements policies, procedures, and processes related to the LTSS program operations and quality measures.

Director of Behavioral Health Services provides leadership and program development expertise in the creation, expansion and improvement of services and systems that leads to the integration of physical and behavioral health care services for CalOptima members. Thes ~~Dd~~director leads and assists the organization in developing and successfully implementing short and long--term strategic goals and objectives toward integrated care. The ~~Dd~~irector ~~BHI~~ plays a key leadership role in coordinating with all levels of CalOptima staff, is responsible for monitoring, analyzing, and reporting on changes in the health care delivery environment and identifying program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services.

Director of Clinical Outcomes supports medical management with program development, data analysis, evaluation, and ~~and~~ specialized education related to the Model of Care and other Medical Affairs initiatives. The ~~Dd~~irector contributes expertise in care management innovation, evaluation methods, data definitions and specifications, and predictive risk models to guide the stratification of members and allocation of appropriate resources. The ~~Dd~~irector assumes leadership role as designated for new program development and/or implementation.

Director of Enterprise Analytics provides leadership across CalOptima in the development and distribution of analytical capabilities. The Director drives the development of the strategy and roadmap for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the roadmap. Working with departments that supply data, the team will be responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the enterprise analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

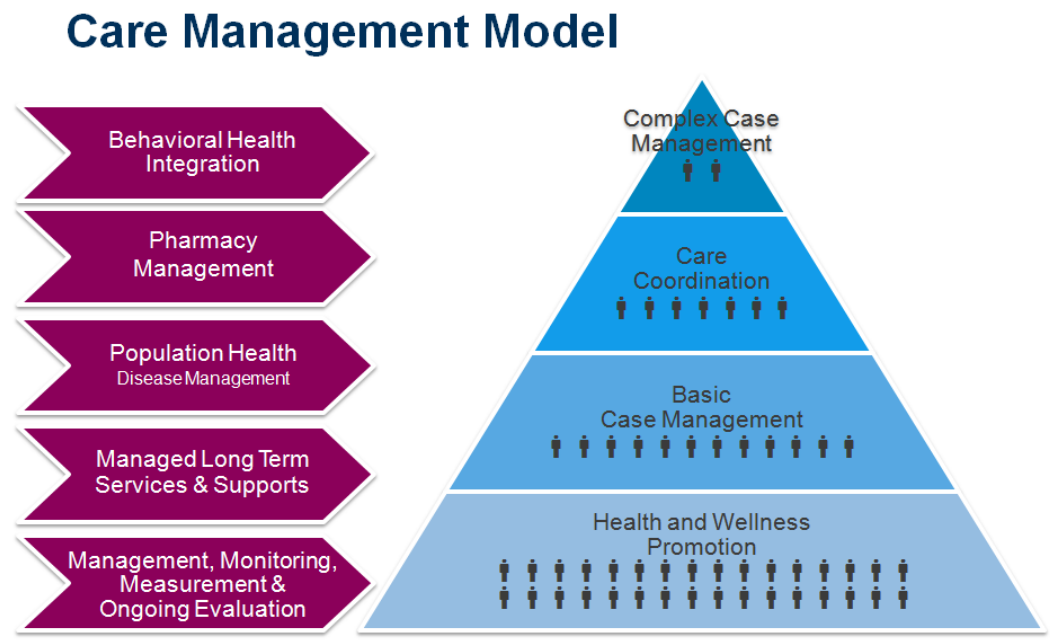
QUALITY IMPROVEMENT ~~(QI)~~ STRATEGIC GOALS

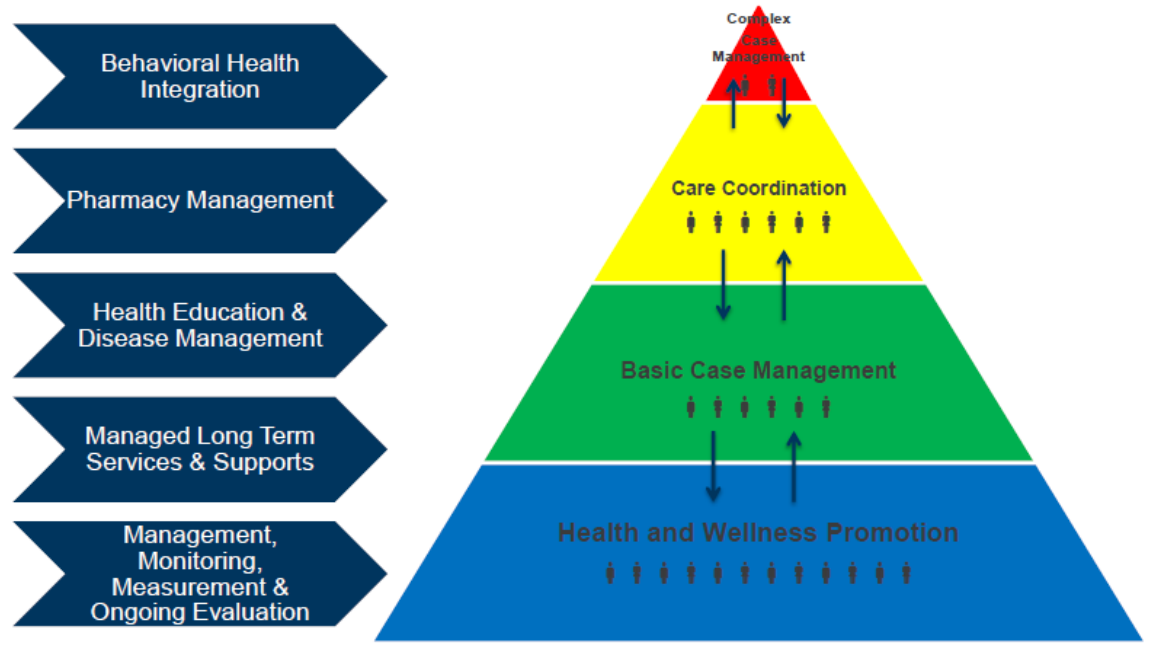
The purpose of the QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members. Through the QI Program, CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The QI Program incorporates continuous QI methodology that focuses on the specific needs of multiple stakeholders (members, health care providers and community and government agencies):

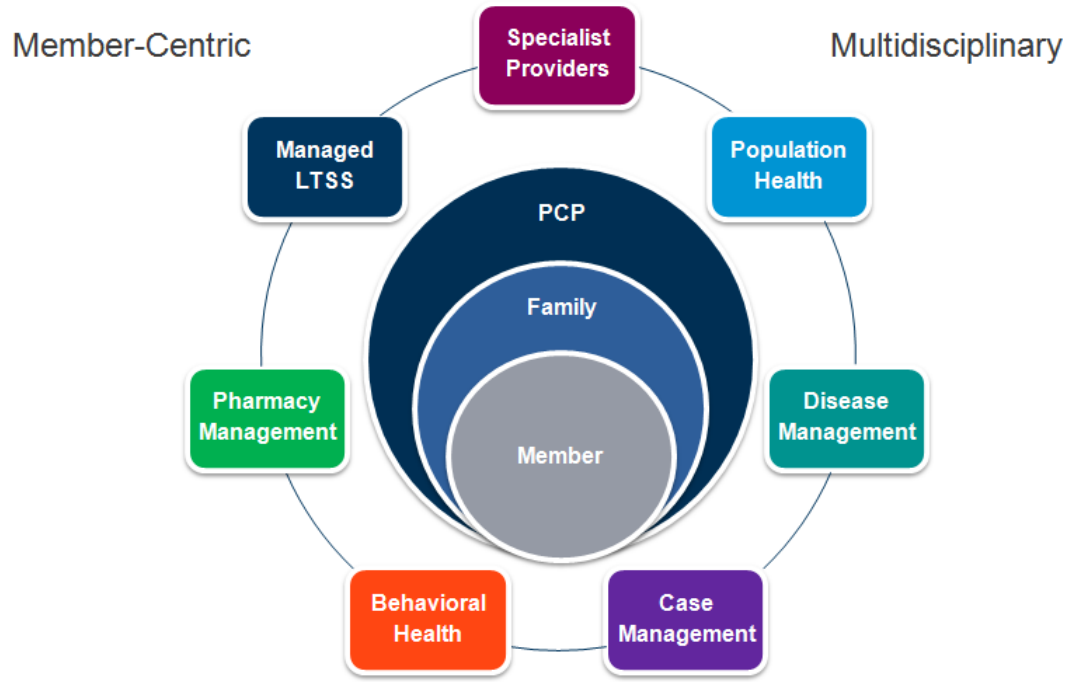
- It is organized to identify and analyze significant opportunities for improvement in care and service
- It fosters the development of quality improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals
- It is focused on QI activities and projects carried out on an ongoing basis to monitor that quality of care issues are identified and corrected as needed

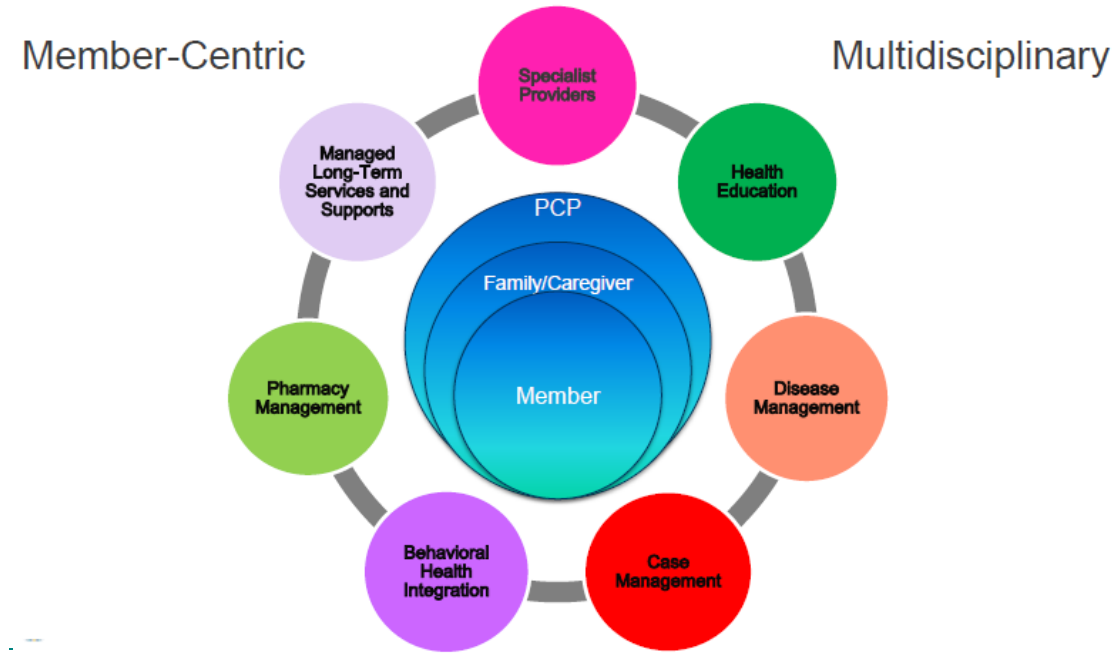
The QI Program supports a population health management approach, stratifying our population based on their health needs, conditions, and issues and aligning the appropriate resources to meet these needs. Our model follows an intervention hierarchy, as shown below:





In addition, our model recognizes the importance of multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, care settings —– plus our internal experts support a member-centric approach to care/care coordination.





QI Goals and Objectives

QI goals and objectives are to monitor, evaluate and improve:

- The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
- The important clinical and service issues facing the Medi-Cal, ~~OneCare~~OC ~~&~~and ~~OneCare Connect~~OCC populations relevant to its demographics, high-risks, disease profiles for both acute and chronic illnesses, and preventive care

- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually acting on at least three identified opportunities
- The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
- The qualifications and practice patterns of all individual providers in the network to deliver quality care and service
- Member and provider satisfaction, including the timely resolution of complaints and grievances
- Risk prevention and risk management processes
- Compliance with regulatory agencies and accreditation standards
- Annual review and acceptance of the UM Program Description and Work Plan
- The effectiveness and efficiency of internal operations
- The effectiveness and efficiency of operations associated with functions delegated to the contracted medical groups
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values
- Compliance with Clinical Practice Guidelines and evidence-based medicine
- Compliance with regulatory agencies and accreditation standards (NCQA)
- Support of the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently

- In addition, the QI Program:
  - Set expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes
  - Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers
  - Provide oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals
  - Makes certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — Orange County Health Care Agency — which may include but are not limited to ~~M~~methicillin ~~R~~resistant ~~s~~*Staphylococcus aureus* (MRSA), ~~staphylococcus aureus infections,~~ scabies, ~~T~~tuberculosis, etc.~~,~~ as reported by the ~~health networks~~HNs.
  - Promote patient safety and minimize risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and work with appropriate committees, departments, staff, practitioners, provider medical groups, and other related health care delivery organizations (HDOs) to assure that steps are taken to resolve and prevent recurrences
    -

QI Measureable Goals from the Model of Care

The Model of Care (MOC) is member-centric by design, and monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care. The MOC meets the needs of the special member populations through strategic activities and goals. Measureable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving integration of medical and, behavioral health servicesand pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. These are reported to the QI Committee. Please see the Model of Care Quality Matrix in the 2017 QI Work Plan.

QUALITY IMPROVEMENT WORK PLAN

(SEE ATTACHMENT A — 20162017 QI WORK PLAN)

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and the CalOptima's Board of Directors' Quality Assurance Committee of the Board. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. QI Work Plan addendums may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on the most recent and trended HEDIS, Consumer Assessment of Healthcare Providers & Systems (CAHPS), Stars and HOS scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the State or accreditation standards where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores are received.

The QI Program guides the development and implementation of an annual QI Work Plan and a separate Utilization Management (UM) Work Plan that includes:

- Case ManagementCare Coordination/Complex Case Management
- Client Revisions
- LTSS
- Health Education &Population Health & Disease Management, Health Assessments and related CCIP, QIP, PIPs

- Access and Availability to Care
- Member Experience and Service (CAHPS)
- Patient Safety and Pharmacy Initiatives
- HEDIS~~/~~, STARS and~~/ Health Outcomes Survey (~~HOS~~)~~)~~ Improvement
- Delegation Oversight
- Organizational Quality Projects
- QI Program scope
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program
- Priorities for QI activities based on the specific needs of Cal-Optima's organizational needs and specific needs of Cal Optima's populations for key areas or issues identified as opportunities for improvement
- Priorities for QI activities based on the specific needs of Cal-Optima's populations, and on areas identified as key opportunities for improvement
- Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

(SEE ~~ATTACHMENT~~APPENDIX A — 2017 QI WORK PLAN)

UTILIZATION MANAGEMENT

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those which are established as safe and effective, consistent with symptoms and diagnosis and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the ~~2016~~2017 ~~Utilization Management (~~UM~~)~~ Program all review staff are trained and audited in these principles. Clinical staff makes all medical necessity decisions and any denial based on medical necessity is made only by a physician reviewer, including those decisions made by delegated ~~health networks~~HNs. Medical Directors actively engage subspecialty physicians as peer review consultants to assist in medical necessity determinations. Adherence to standards and evidence-based clinical criteria is obtained by cooperative educational efforts, personal contact with providers and monitoring through clinical studies.

Further details of the UM Program, activities and ~~can~~measurements can be found in the 2017 UM Program Description and related Work Plan.

~~UM WORK PLAN~~
~~(SEE ATTACHMENT B — 2017 UM WORK PLAN)~~

BEHAVIORAL HEALTH

CalOptima focuses on the continuum of care for both medical and behavioral health services. Focusing on continuity and coordination of care, CalOptima monitors and works to improve the quality of behavioral health care and services provided to our members. The QI Program includes services for behavioral health and review of the quality and outcomes of those services delivered to the members within our network of practitioners and providers.

The quality of Behavioral Health services may be determined through, but not limited to the following:

- Access to care
- Availability of practitioners
- Coordination of care
- Medical record and treatment record documentation
- Complaints and grievances
- Appeals
- Compliance with evidence-based clinical guidelines

- Language assistance
- HEDIS and STAR measurements

The Medical Director responsible for Behavioral Health services is involved in the behavioral aspects of the QI Program. The BH Medical Director is available for assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, providinge behavioral health QI statistical data and follow-up on identified issues. The BH Medical Director shall serve as the chairperson of the BH QI Committee which is a subcommittee of the CalOptima QI Committee. The BH Medical Director also serves as a voting member of CalOptima's QI Committee.

CONFIDENTIALITY

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QI Committee and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The HMOs, PHCs, SRGs, MBHOs and PMGs hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a Confidentiality Agreement. This Agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any ~~Quality Improvement~~QI reports required by law or by the State Contract.

CONFLICT OF INTEREST

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. ~~CalOptima maintains a Conflict of Interest policy to make certain potential conflicts area Conflict of Interest policy to make certain potential conflicts is avoided by staff and members of Committees.~~ This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees ~~sign a Conflict of Interest statement~~ who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

Fiscal and clinical interests are separated. CalOptima and its delegates do not provide any financial rewards or incentives to practitioners or other individuals ~~reward practitioners or other individuals~~ conducting utilization review for issuing denials of coverage, services or care. ~~There are no financial incentives for UM decision-makers that could encourage decisions that result in under-utilization.~~

STAFF ORIENTATION, TRAINING A~~A~~ND EDUCATION

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in health services for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective positions.

Each new employee is provided an intensive, hands-on training and orientation program with a staff preceptor. The following topics are covered during the ~~program~~introductory period, with specific training, as applicable to ~~specific~~ individual job descriptions:

- CalOptima New Employee Orientation and B~~b~~oot Camp (CalOptima programs)
- HIPAA and Privacy~~/Corporate Compliance~~
- Fraud, Waste and Abuse, Compliance and Code of Conduct Training
- Workplace Harassment Prevention Training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable ~~D~~department ~~P~~program, ~~P~~policies & ~~P~~procedures, etc.
- Appeals ~~P~~process
- Seniors and Persons with Disabilities Awareness Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed employee.

MOC-related employees and contracted providers and practitioners networks are trained at least annually on the ~~Model of Care (~~MOC~~)~~. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

SAFETY PROGRAM

Member (~~P~~patient) safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced.~~-~~ Active, involved and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery organization continuum oversight and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally, and include strategic efforts specific to member safety.

This plan is based on a needs assessment and includes the following areas:

- Identification and prioritization of patient safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Plans to conduct appropriate patient safety training and education are available to members, families and health care personnel/physicians
- Patient safety program and its outcomes~~,~~ to be reviewed annually
- Health education and promotion
- Group Needs Assessment
- Over/Under ~~u~~Utilization monitoring
- Medication Management
- Case Management/Disease Management
- Operational Aspects of Care and Service

To ensure m~~M~~ember ~~S~~safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, cultural and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care; (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with ~~Health Networks~~HNs and practitioners in performing the following activities:

- ~~i~~Improving medical record documentation and legibility, establishing timely follow-up for lab results; addressing and distributing data on adverse outcomes or polypharmacy issues by the Pharmacy & Therapeutics (P&T) Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to correct the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ~~ADA (~~Americans with Disabilities Act (ADA) and ~~SPD (~~Seniors and Persons with Disabilities (SPD) site review audits into the general facility site review process

- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote that equipment is kept in good working order
  - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings including ~~Long-Term Care (LTC),~~ CBAS, SNF, ~~and~~ MSSP settings and Long-Term Services and Supports (LTSS) settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address post-operative complications
  - Sentinel events, ~~&~~ critical incident identification ~~and~~, appropriate investigation and remedial action
  - Administration of flu and ~~/~~pneumonia vaccine
- Administrative offices
  - ~~o~~ Fire, disaster, and evacuation plan, testing and annual training
  -

COMMITTEES AND KEY GROUP STRUCTURES

~~(SEE PAGE 52 — 2017 QUALITY IMPROVEMENT COMMITTEE ORGANIZATION STRUCTURE DIAGRAM)~~

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to review and accept the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC shall also make recommendations for annual modifications of the QI program and actions to be taken when objectives are not met. CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's QAC meetings are open to the public.

Member Advisory Committee

The Member Advisory Committee (MAC) is ~~composed~~ comprised of 15 voting members, each seat represent~~satives of the population~~a constituency served by CalOptima ~~serves~~. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice

and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, preventative services and contracting. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumer
- Family Support
- Foster Children
- Long-Term Care
- Medi-Cal beneficiaries
- Medically indigent persons
- Orange County Health Care Agency
- Orange County Social Services Agency
- Persons with disabilities
- Persons with mental illnesses
- Persons with Special Needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by the Health Care Agency and the Social Services Agency — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) is comprised of 10 voting members, each seat representing a constituency served by OCC and four non-voting liaisons representing county agencies, collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - Orange County Social Services Agency
    - Orange County Community Resources Agency, Office on Aging

- Orange County Health Care Agency, Behavioral Health
- Orange County IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits.

Provider Advisory Committee

The Provider Advisory Committee (PAC) is comprised of 15 voting members, each seat representing a constituency that works with CalOptima and our members. These include:

- ~~composed of representatives from the following constituencies:~~ ~~Health Networks~~
- HNs
- Hospitals
- Physicians
- Nurses
- Allied Health Services
- Community Clinics
- ~~The~~ Orange County Health Care Agency (HCA)
- ~~Long-Term Services and Supports~~LTSS including (LTC ~~F~~facilities and CBAS)
- Mid-~~L~~level ~~P~~practitioners
- Behavioral/mental health

Quality Improvement Committee (QIC)

The QIC is the foundation of the QI program. The QIC assists the CMO in overseeing, maintaining, and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted HMOs, PHCs, SRGs, MBHO, and PMGs to achieve the end result of improved care and services for members. The QIC oversees the performance of delegated functions by its HMOs, PHCs, SRGs, MBHO, and PMGs and contracted provider and practitioner partners. The composition of the QIC includes a participating Behavioral Health ~~P~~practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to ~~Quality Improvement~~QI Projects (QIP), activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored and reported through the QIC.

Responsibilities of the QI Committee include the following:

- Recommends policy decisions
- Analyzes and evaluates policy decisions
- Makes certain that there is practitioner participation in the QI Program through planning, design, implementation and review
- Identifies needed actions and interventions
- Makes certain that there is follow-up as necessary

Practice patterns of providers, practitioners, HMOs, PHCs, SRGs, MBHO, and PMGs are evaluated, and recommendations are made to promote practices that all members receive medical care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, HMOs, PHCs, SRGs, MBHO, and PMGs.

The QI Projects themselves consist of four (4) cycles:

- **Plan** — ~~d~~Detailed description and goals
- **Do** — ~~I~~Implementation of the plan
- **Study** — D~~d~~ata and collection
- **Act** — A~~a~~nalyze data and develop conclusions

The goal of the QI Program is to improve the health outcomes of members through systematic and ongoing monitoring of specific focus areas and development and implementation of QI Projects and interventions designed to improve provider and practitioner and system performance.

The QIC provides overall direction for the continuous improvement process and monitors that process to ensure that activities are consistent with CalOptima's strategic goals and priorities. It promotes efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program and drives actions when opportunities for improvement are identified.

The composition of the QIC is defined in the QIC Charter and includes, but may not be limited to the following:

Voting Members~~:~~

- Four (4) participating physicians or practitioners, with no more than two (2) administrative medical directors
- CalOptima CMO/DCMO
- CalOptima Medical Director, Quality (Chair)
- CalOptima Medical Director also representing the UM Committee
- CalOptima Medical Director, Behavioral Health also representing the Behavioral Health Quality Improvement Committee ~~BH QI Committee~~(BHQIC)
- Executive Director, Clinical Operations
- Director, ~~of~~ Network Management
- Director, Business Integration

The QIC is supported by:

Executive Director, Quality Improvement

~~Manager~~Director, Quality Improvement
Director, Quality Analytics
Director, Health Education & Disease Management
Committee Recording Secretary as assigned

Quorum
A quorum consists of a majority of the voting members (at least six) of which at least four are physicians or practitioners. ~~–~~Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by phone.

The QIC meets no less than eight times per year, and reports to the Board QAC no less than quarterly.

QIC and all ~~quality improvement~~QI subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the Quality Improvement Committee (QIC)
Contemporaneous minutes reflect all Committee decisions and actions. These minutes are dated and signed by the Committee Chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- ~~g~~Goals and objectives outlined in the QI Charter ~~and which include but are not limited to:~~
- Active discussion and analysis of quality issues analysis
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of work plan activities

All agendas, minutes, reports, and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and not reproduced (except for Quality Profile documentation) in order to maintain confidentiality, privilege and protection.

~~THE FOLLOWING ARE~~ QUALITY IMPROVEMENT C~~C~~OMMITTEES A~~A~~ND S~~S~~UBCOMMITTEES ~~OF THE QIC:~~

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to ~~support~~ ensure that all practitioners and providers that serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC reviews, investigates, and evaluates the credentials of all internal CalOptima medical staff for membership, and maintains a continuing review of the qualifications and performance of all external medical staff. The CPRC's review and findings are reported to the QIC at least quarterly.~~, with recommendations for approval/denial of credentialing. All approved providers and practitioners are presented to QAC on a quarterly basis as part of the CMO's report.~~

The goals of the CPRC include:

1. Maintain a peer review and credentialing program that aligns with regulatory (DHCS, DMHCS, CMS) and accreditation (NCQA) standards.
2. Promote continuous improvement of the quality of health care provided by providers in CalOptima Direct/CalOptima Community Network and its delegated ~~health networks~~HNs.
3. Conduct peer-level review and evaluation of provider performance and credentialing information against CalOptima requirements and appropriate clinical standards.
4. Investigate patient care outcomes that raise quality and safety concerns for corrective actions, as appropriate.

CPRC primary responsibilities include:

1. Provide peer review and credentialing functions for CalOptima.
2. Review reports submitted by internal departments including but not limited to Audit & Oversight, ~~Quality Improvement~~QI (PQI issues), and GARS (complaints) and take action on credentialing or quality issues, as appropriate.
3. Provide guidance and peer participation in the CalOptima credentialing and re-credentialing processes to ensure that all providers that serve CalOptima members meet generally accepted standards for their profession or industry.
4. Make final determinations regarding the eligibility of providers to participate in the CalOptima program based on CalOptima policies and applicable standards.
5. Review, investigate, and evaluate the credentials of CalOptima Direct/CalOptima Community Network practitioners and internal CalOptima medical staff.
6. Review facility site review results and oversee all related actions.
7. Investigate, review and evaluate quality of care matters referred by CalOptima's functional departments (including, without limitation, Customer Service, ~~Grievance and Appeals Resolution Services~~GARS, ~~Utilization Management~~UM, Case Management, ~~and~~ Pharmacy and LTSS) and/or the CMO or his/her physician designee related to CalOptima Direct/CalOptima Care Network or its delegated ~~Health Networks~~HNs.
8. Initiate and monitor imposed provider corrective actions and make adverse action recommendations, as necessary and appropriate.

In addition, as a part of CalOptima's Patient Safety Program, and utilizing the full range of methods and tools of that program, CalOptima conducts Sentinel Event monitoring. A Sentinel Event is defined as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof." The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Sentinel Event monitoring includes patient safety monitoring across the entire continuum of CalOptima's contracted providers: HMOs, PHCs, SRGs, MBHO, PMGs, and health care delivery organizations. The presence of a Sentinel Event is an indication of possible quality issues, and the monitoring of such events will increase the likelihood of early detection of developing quality issues so that they can be addressed as early as possible. Sentinel Event monitoring serves as an independent source of information on possible quality problems, supplementing the existing Patient Safety Program's consumer-complaint-oriented system.

All medically related cases are reviewed by the CPRC to determine the appropriate course of action and/or evaluate the actions recommended by an HMO, PHC, SRG, MBHO, or PMG delegate. Board certified peer-matched specialists are available to review complex cases as needed. Results of peer review are used at the reappointment cycle, or upon need, to review the results of peer review and determine the competency of the provider. This is accomplished through routine reporting of peer review activity to HMOs, PHCs, SRGs, MBHO and PMGs for incorporation in their re-credentialing process.

The CPRC shall consist of a minimum of five physicians selected on a basis that will provide representation of active physicians from the CalOptima Direct network and/or the ~~Health Networks~~HNs. Physician participants shall represent various specialties including but not limited to general surgery, OB/ GYN and primary care. In addition, the c~~C~~hairperson and CalOptima's CMO or DCMO are considered part of the Committee and, as such, are voting members. The CPRC provides reports to CalOptima QI Committee at least quarterly.

Grievance and Appeals Resolution Services Subcommittee (GARS)

The ~~Grievance and Appeals Resolution Services~~GARS subcommittee serves to protect the rights of our members, and to promote the provision of quality health care services and enforces that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS subcommittee serves to provide a mechanism to resolve provider ~~and practitioner~~ complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS subcommittee meets at least quarterly and reports to the QIC.

Pharmacy & Therapeutics Subcommittee (P&T)

The ~~Pharmacy & Therapeutics (~~P&T~~)~~ s~~S~~ubcommittee is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost effective pharmaceutical care for all CalOptima members and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T includes practicing physicians and the contracted provider networks. A majority of the members of the P&T are physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The

P&T provides written decisions regarding all formulary development and revisions. The P&T meets at least quarterly, and reports to the UM subcommittee.

Utilization Management Subcommittee (UM)

The ~~Utilization Management~~ UM subcommittee promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM subcommittee is multidisciplinary, and provides a comprehensive approach to support the ~~Utilization Management~~UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UM subcommittee monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, SRGs, MBHO, and PMGs to identify areas of under or over utilization that may adversely impact member care. The UM subcommittee oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, as well as development of Evidence Based Clinical Practice Guidelines and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. The UM subcommittee meets quarterly and reports to the QIC.

The UM subcommittee includes a minimum of four ~~(4)~~ practicing physician representatives, reflecting CalOptima's HMO, PHC, SRG, MBHO, and PMG composition, and is appointed by the CMO. The composition includes a participating Behavioral Health practitioner* to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed. Additionally, the UMC also includes and is supported by the following staff positions:

~~The UM subcommittee is supported by:~~
CMO/DCMO
Medical Director, Concurrent Review
Director, Utilization Management
Director, Pharmacy
Director, Enterprise Analytics
Manager, Referral/Prior Authorization
Manager, Concurrent Review

Quorum:
A quorum consists of fifty percent (50%) plus one of voting member participation and of the eleven, the minimum quorum must include three committee participants from the community. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

** Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.*

Benefit Management Subcommittee (BMSC)

The purpose of the ~~Benefit Management subcommittee~~ BMSC is to oversee, coordinate, and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its program lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. The subcommittee shall also see to it that benefit updates are implemented, and communicated accordingly, to internal CalOptima staff, and that updates are provided to contracted HMOs, PHCs, SRGs, MBHO, and PMGs. The Government Affairs department provides ~~the~~ technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules.

Long-Term Services and Supports Subcommittee (LTSS)

The LTSS subcommittee is composed of representatives from the ~~Long-Term Care (~~LTC~~)~~, ~~Community-Based Adult Services (~~CBAS~~)~~, IHSS and ~~Multipurpose Senior Services Program (~~MSSP~~)~~ communities, which may include administrators, directors of nursing, facility Medical Directors, and pharmacy consultants, along with appropriate CalOptima staff. ~~Previously, the CBAS Quality Advisory sSubcommittee was integrated into the LTSS Quality Ssubcommittee. The~~ LTSS subcommittee members serve as specialists to assist CalOptima in the development, implementation, and evaluation of establishing criteria and methodologies to measure and report quality and access standards with ~~Home and Community Based Services (~~HCBS~~)~~ and in LTC facilities where CalOptima members reside. The LTSS subcommittee also serves to identify ~~"~~best practices,~~"~~ monitor over and underutilization patterns and partner with facilities to share the information as it is identified. The LTSS subcommittee meets quarterly and reports through Clinical Operations ~~S~~subcommittee to the QIC.

~~**Benefit Management Subcommittee (BMSC)**~~

~~The purpose of the Benefit Management Ssubcommittee is to oversee, coordinate, and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its program lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. The subcommittee shall also see to it that benefit updates are implemented, and communicated accordingly, to internal CalOptima staff, and that updates are provided to contracted HMOs, PHCs, SRGs, MBHO, and PMGs. The Government Affairs department provides the technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules.~~

Behavioral Health Quality Improvement Committee (BHQIC)

The ~~Behavioral Health Quality Improvement Committee~~BHQIC ~~was established in 2011 to~~ ensures members receive timely and satisfactory behavioral health care services, through enhancing ~~continuity~~ integration and coordination between physical health and behavioral health care providers, monitoring key areas of services to members and providers, identifying areas of improvement and guiding CalOptima towards the vision of bi-directional behavioral health care integration.

The BHQIC responsibilities are to:

- Ensure adequate provider availability and accessibility to effectively serve the membership
- Oversee the functions of delegated activities
- Monitor that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards
- Ensure that ~~M~~member benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize ~~M~~member and ~~N~~network ~~P~~provider satisfaction study results when implementing quality activities
- Maintain compliance with evolving ~~National Committee for Quality Assurance (~~NCQA~~)~~ accreditation standards
- Communicate results of clinical and service measures to ~~N~~network ~~P~~providers

- Document and report all monitoring activities to appropriate committees

The designated ~~C~~chairman of the BHQI subcommittee is the Medical Director, Behavioral Health, who is responsible for chairing the subcommittee as well as reporting findings and recommendations to QIC.

The composition of the BHQIC ~~Committee~~ is defined in the BHQIC Charter and includes, but may not be limited to the following:

- Medical Director, Behavioral Health Integration (Chair)
- Chief Medical Officer/Deputy Chief Medical Officer
- Medical Director, Quality and Analytics
- Executive Director, Clinical Operations
- Executive Director, Quality Analytics
- Medical Director, Utilization Management
- Director, Behavioral Health Integration
- Clinical Pharmacist
- Medical Director, Orange County Health Care Agency
- Medical Director, ~~Medi-Cal~~ MBHO
- Chief Clinical Officer, ~~Medi-Medi~~ MBHO
- Medical Director, Health Network
- Medical Director, Regional Center of Orange County
- Contracting Behavioral Health Care Practitioners

The BHQIC shall meet, at a minimum, on a quarterly basis, or more often as needed.

Additionally, CalOptima is formalizing two additional subcommittees to QIC, focusing on Clinical Operations and Member Experience.

Clinical Operations/Population Health ~~-~~Subcommittee ~~:~~(COPHS)

The purpose of the ~~Clinical Operations Subcommittee~~COPHS is to oversee, guide and ensure the integration and coordination of functions across the continuum of care, including but not limited to population health, disease management, care management, complex case management, ~~utilization management~~UM, LTC~~long term care~~, pharmacy & behavioral health services.~~-~~ This subcommittee monitors the progress of the established program goals and metrics defined for CalOptima's disease management, complex case management programs and Model of Care. ~~This subcommittee~~COPHS reviews these programs at least quarterly, and includes the following key individuals:

- Chief Medical Officer/Deputy Chief Medical Officer
- Executive Director, Clinical Operations
- Executive Director, Quality & Analytics
- Director, Care Management
- Director, Utilization Management
- Director, Health Education & Disease Management

- Director, Enterprises Analytics
- Director, Quality Analytics
- Director, Long--Term Services & Supports
- Director, Quality Improvement
- Director, Clinical Outcomes
- Director, Clinical Pharmacy Management
- Director, Behavioral Health Services.

Member Experience Subcommittee :(MES)

The final subcommittee in the quality committees structure is MES and focuses on the issues and factors that influence the member's experience with the health care system for Medi-Cal, ~~OneCare~~OC, O~~ne~~Care ~~Connect~~ ~~&~~and LTSS. NCQA Medicaid Plan Ratings measure three dimensions – Prevention, Treatment and Customer Satisfaction.- CalOptima's ~~Quality Improvement~~QI program focuses on the performance in each of these areas. -The ~~Member Experience Subcommittee~~MES is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the ~~Health Networks~~HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in ~~healthcare~~health care that impact our members.

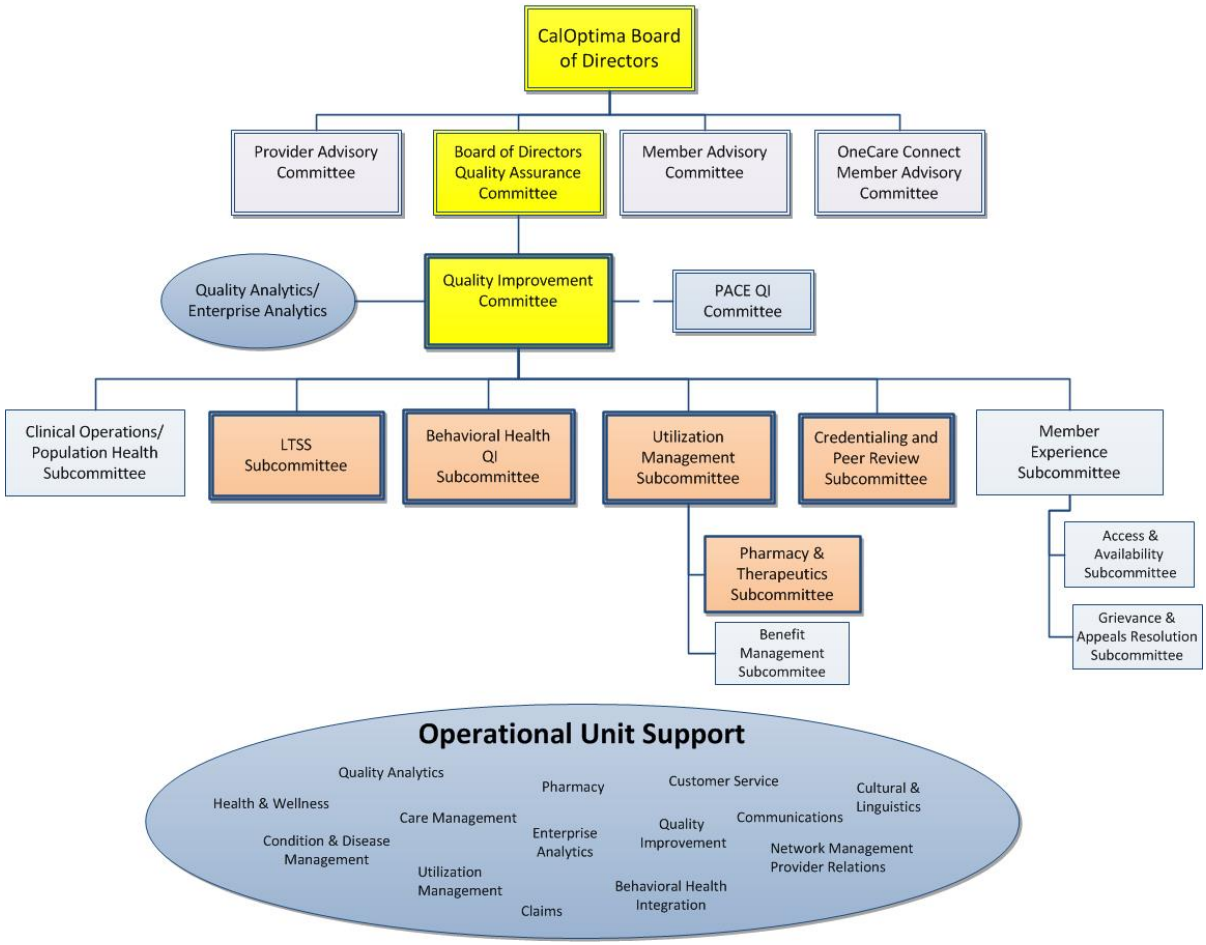
-This subcommittee meets at least bi-monthly and includes the following key individuals:

- Chief Medical Officer/Deputy Chief Medical Officer or designee
- Executive Director, Quality & Analytics
- Director, Customer Service
- Director, Grievances & Appeals
- Director, Network Management
- Director, Provider Services
- Manager, Access & Availability
- Director, Quality Analytics
- Director, Utilization Management~~.~~

The ~~Member Experience Subcommittee~~MES focuses on improving the following key areas of satisfaction:

- Getting needed care & getting care quickly
- How well doctors communicate
- Customer service
- Rating of health care, providers ~~&~~and health plan
- Other areas as defined by specific metrics, focus groups or survey results.

2017 Committee Organization Structure — Diagram



METHODOLOGY

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous HMO, PHC, SRG, PMG, and internal monitoring activities, including, but not limited to, (a) potential quality concern (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) satisfaction surveys, (f) HEDIS results, and (g) other subcommittee unfavorable outcomes
- Measures required by regulators such as DHCS and CMS

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, long-term ~~care~~services and supports, and ancillary care services

- Access to and availability of services, including appointment availability, as described in the ~~Utilization Management~~UM Program and in policy and procedure
- Coordination and continuity of care for ~~seniors and persons with disabilities~~SPD
- Provisions of chronic, complex care management and case management services

- Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization.

- Staff, administration, and physicians provide vital information necessary to support continuous performance is occurring at all levels of the organization
- Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
- Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes
- Project coordination occurs through the various leadership structures: Board of Directors, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort
- These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

QI Project Quality Indicators

Each QI Project will have at least one (and frequently more) quality indicator(s). While at least one quality indicator must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Quality indicators will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, MBHO, PMG, or system performance. Quality indicators will be clearly defined and objectively measurable. Standard indicators from HEDIS & STARS measures are acceptable.

Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized. See explanation of Clinical Data Warehouse below.

For studies /measuresor measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5 to 10% over sampling), so asin order to allow performance of conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Measures that rely exclusively on administrative data utilize the entire target population as a denominator.

CalOptima also uses a variety of QI methodologies dependent on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change/plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

CARE OF MEMBERS WITH COMPLEX NEEDS

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs or
- ~~M~~management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt-out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education and member incentive programs
- Use of evidenced- based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)
- Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
- Coordinating services for members for appropriate levels of care and resources
- Documenting all findings

- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. ~~All~~ SPD, OCC and OC members are stratified using a plan-developed ~~stratification~~ tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. ~~The members are stratified into complex, care coordination and basic care management levels.~~ This s~~S~~tratification results in the ~~categories~~categorizing members as ~~of~~ "high" ~~and~~or "low" ~~risk, for those members who are stratified. The~~risk. The case management levels (CML) of complex, care coordination and basic are specific to SPD, OCC and OC members who have either completed a HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. -The ICT may occur at the PCP (basic), the Health Network/Group ~~&~~and system (primary), or system/transition (complex) level, dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status.

~~The Interdisciplinary Care Team (ICT) for low risk members — is basic — and occurs at the PCP level. Moderate and high risk members are managed by an ICT at the Medical Group level for delegated groups or at the plan level in the instance of the Community Network.~~
~~The Interdisciplinary Care Team (ICT) for members in basic case management occurs at the primary care provider level. (This is ***not*** the same as saying that low risk members have a ICT at the PCP level. For instance, a member may stratify low risk, have an HRA completed, and as a result of information gathered through the HRA process, be placed in care coordination or complex case management.) Conversely, a member who stratifies as high risk and completes an HRA may ultimately be found to be more appropriate for basic case management.~~

The ~~members of the~~ ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, but not limited to a Medical Director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietician, and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — ~~Basic Team~~occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic case management, including advanced care planning
      - Medication reconciliation

        - Identification of member at risk of planned and unplanned transitions
        - Referral and coordination with specialists
        - Development and implementation of an ICP
        - Communication with members or their representatives, vendors, and medical group
        - Review and update the ICP at least annually, and when there is a change in the member's health status
        - Referral to the primary ICT, as needed

- Primary ICT for Moderate to High-Risk Members — ICT occurs at the Physician Medical Group (PMG) level or the Health Plan for Community Network
    - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, ~~PMG~~ health network (HN) Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, ~~PMG~~ HN ~~Utilization Management~~UM staff, behavioral health specialist and social worker
        - Roles and responsibilities of this team:
            - Identification and management of planned transitions
            - Case management of high risk members
            - Coordination of ICPs for high risk members
            - Facilitating member, PCP and specialists, and vendor communication
            - Meets as frequent as is necessary to coordinate and care and stabilize member's medical condition

- Complex ICT for High-Risk Members — ICT at the Physician Medical Group (PMG) level or Health Plan for Community Network
    - Team Composition (a~~A~~s appropriate for identified needs): member, caregiver, or authorized representative, ~~PMG~~ HN Medical Director, CalOptima clinical/~~PMG~~ HN case manager, PCP and/or specialist, social worker, and behavioral health specialist
        - Roles and responsibilities of this team:
            - Consultative for the PCP and ~~PMG~~ HN teams
            - Encourages member engagement and participation in the IC~~D~~T process
            - Coordinating the management of members with complex transition needs and development of ICP
            - Providing support for implementation of the ICP by the ~~PMG~~HN
            - Tracks and trends the activities of the ~~IDTs~~ICTs
            - Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the ~~IDTs~~ ICTs to identify areas for improvement
            - Oversight of the activities of all transition activities at all levels of the delivery system
            - Meets as often as needed until member's condition is stabilized

Dual Eligible Special Needs Plan (SNP)/~~OneCare~~ OC and ~~OneCare Connect~~OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help patients regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow-up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of re-hospitalization
- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at high-risk individuals (e.g., patients dually eligible for Medicare and Medicaid or patients who are institutionalized)
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning
- Care management program focused on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life

CalOptima's goals for ~~2016~~2017 are:

- Continue with the comprehensive assessment strategy
- Measure and assess the quality of care CalOptima provides
- Evaluate how CalOptima addresses the special needs of our beneficiaries
- Drive interventions and actions when opportunities for improvement are identified

Please reference the ~~2016~~2017 Case Management Program Description for further details and program plans.

DISEASE MANAGEMENT PROGRAM

The Disease Management (DM) program is a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner and CalOptima. The DM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinatinges care for members across time, localtes and providinges services, and resources, and support tos the members as they learn to care for themselves and their condition. The Disease Management (DM) Pprogram also is a targeted programidentifies those members in need of closer for the management, coordination, and intervention. for a highly vulnerable patient population. CalOptima assumes responsibility for the Disease ManagemenDMt program for all of its lines of business, therefore the management for Disease ManagementDM is non-not delegated to the PHCs, SRGs, HMOs and PMGs. -The contracted PHCs, SRGs, HMOs and PMGs must participate collaboratively with interventions necessary to produce compliant identified quality outcomes. The DM Program is evaluated on an annual basis.

~~The DM program is a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the healthcare practitioner and CalOptima. The DM program coordinates care for members across time, locates and provides services and resources, and supports the members as they learn to care for themselves.~~

Further details of the Disease ManagementDM Pprograms, activities and measurements can be found in the 2017 Disease ManagementDM Program Description.

~~A detailed description of the Disease Management Program is contained in the Disease Management Program Description document. The DM Program is evaluated on an annual basis.~~

CLINICAL DATA WAREHOUSEQUALITYQUALITY ANALYTICSNALYTICS

Core to the QI Program is the statistical analysis of various data sources to support continuous quality improvement of our programs, projects, activities, and initiatives. The CalOptima's Clinical Data Warehouse is a dynamic environment which aggregates data from CalOptima's various core business systems and processes, such as member eligibility, provider, encounters, claims, and pharmacy and care management systems to support the QI program. The clinical data warehouse allows staff to apply logic, population definitions and/or evidence-based clinical practice guidelinesbased guidelines to analyze data for quality purposes, such as disease management population identification, risk stratification, process measures and outcomes measures. CalOptima staff creates and maintains the data-base with quarterly data updates.

Based upon evidence-based practice guidelines built into the system, the clinical data warehouse can assess the following:

- Identify and stratify members with certain disease states
- Identify over/under utilization of services
- Identify missing preventive care services
- Identify members for targeted interventions

Identification/Stratification of Members

Using clinical business rules, the database identifies members with a specific ~~chronic~~ diseases or conditions, such as Asthma, Diabetes, or Congestive Heart Failure. It then categorizes the degree of certainty the member has the condition as being probable or definitive. Once the member has been identified with a specific disease or condition, the database is designed to detect treatment failure, complications and co-morbidities, noncompliance, or exacerbation of illness to determine if the member requires medical care, and recommends an appropriate level of intervention.

Identify Over/Under Utilization of Services

Using clinical business rules, the database can identify if a member or provider is over or under utilizing medical services. In analyzing claims and pharmacy data, the data warehouse can identify if a member did not refill their prescription for maintenance medication, such as high blood pressure medicines. The database can also identify over utilization or poor management by providers. For example, the system can list all members who have exceeded the specified timeframe for using a certain medication, such as persistent use of antibiotics greater than 61 days.

Identify Missing Preventive Care Services

The data warehouse can identify members who are missing preventative care services, such as an annual exam, an influenza vaccination for members over 65, a mammogram for women for over 50 or a retinal eye exam for a diabetic.

Identify Members for Targeted Interventions

The rules for identifying members and initiating the intervention are customizable to CalOptima to fit our unique needs. By using the standard clinical rules and customizing CalOptima specific rules, the database is the primary conduit for targeting and prioritizing heath education, disease management and HEDIS or Stars related interventions.

By analyzing data that CalOptima currently receives (i.e. claims data, pharmacy data, and encounter data) the data warehouse can identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS, STARS~~tars~~ and HOS measures. This information will guide CalOptima in not only targeting the members, but also the HMOs, PHCs, SRGs, MBHO, PMGs, and providers who need additional assistance.

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality indicators. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality indicator) is accompanied by clear guidelines for interpretation. Validation will be done through a minimum 10% sampling of abstracted data for rate to standard reliability, and will be conducted by the Director, Quality Analytics or designee. If validation is not achieved on all records samples, a

further 25% sample will be reviewed. If validation is not achieved, all records completed by the individual will be re-abstracted by another staff member.

Where medical record review is utilized, the abstractor will obtain copies of the relevant section of the record. Medical record copies, as well as completed data abstraction tools, are maintained for a minimum period, in accordance with applicable law and contractual requirements.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements, evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project; there ~~is~~ are no other regulatory reporting requirements related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source and overall project goal.
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data

- List of data elements (quality indicators). Where data elements are process indicators, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality indicator
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection, and analysis timelines
- Evaluation of re-measurement performance on each quality indicator

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical "home" for each member. The primary care practitioner is this medical "home" for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the CalOptima model:

- Primary Care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.

- Community Oriented Primary Care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

Clinical Care and Service:

- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care and treatment of acute and chronic conditions
- Complex Case Management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and

Case Management departments, which details this process in its UM/CM Program and other related policies and procedures.

- Drug utilization
- Health education and promotion
- Over/under utilization
- Disease management

Administrative Oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

* CalOptima has a zero tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to HMO, PHC, SRG, MBHO, and PMG contractors who are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. Predelegation review is conducted through the Audit and Oversight department and overseen by the Delegation Oversight Committee reporting to the Compliance Committee. ~~(See Attachment B for the 20162017 Delegation Grid.)~~

Non-Delegated Activities

The following activities are not delegated, and remain the responsibility of CalOptima:

- ~~Quality Improvement~~QI, as delineated in the Contract for Health Care Services
- QI ~~P~~program for all lines of business, HMOs, PHCs, SRGs, MBHO, and PMGs must comply with all quality related operational, regulatory and accreditation standards
- ~~Disease Management~~ DM ~~P~~program, may otherwise be referred to as Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, peer review process on specific, referred cases
- Development of system-wide indicators, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and ~~healthcare~~health care delivery organizations (HDOs)
- Credentialing and re-credentialing of HDOs
- Development of ~~Utilization Management~~UM and Case Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with State and Federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

Further details of the delegated and non-delegated activities can be found in the 2017 Delegation Grid.

SEE APPENDIX BC — 2017 DELEGATION GRID

~~PEER REVIEW PROCESS~~

~~Peer Review is coordinated through the QI Ddepartment. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases are presented to CPRC to assess if documentation is complete, and no further action is required. The QI department also tracks, monitors, and trends, service and access issues to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews and tracking and trending of service and access issues are reported to the CPRC at time of re-credentialing. Quality of care case referral to the QI department are based on referrals to the QI department originated from multiple areas, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or grievances and appeals resolution.~~

CULTURAL & LINGUISTIC SERVICES

CalOptima serves a large and culturally diverse population. The five most common languages spoken for all CalOptima programs are: English at 57 percent, Spanish at 28 percent, Vietnamese at 10 percent, Farsi at one percent, Korean at one percent, Chinese at one percent, Arabic at one percent and all others at three percent, combined. CalOptima provides member materials in:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic
- ~~OneCare~~ OC member materials are provided in three languages: English, Spanish and Vietnamese
- ~~OneCare Connect~~OCC member materials are provided in five languages: English, Spanish, Vietnamese, Korean and Farsi.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to Member Centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation. See CalOptima Policy DD. 2002 — Cultural and Linguistic Services for a detailed description of the program.

Objectives for serving a culturally and linguistically diverse membership include:

- Analyze significant health care disparities in clinical areas

- Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Consider outcomes of member grievances and complaints
- Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/~~language~~ language or gender specific risks
- Identify and reduce a specific health care disparity affecting a ~~with~~particular cultur~~e~~al, race or~~,~~ gender group
- Provide information, training and tools to staff and practitioners to support culturally competent communication

PEER REVIEW PROCESS

Peer Review is coordinated through the QI Department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors, and trends PQI cases, in order to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, tracking and trending of service and access issues are reported to the CPRC, and are also reviewed at time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or grievances and appeals resolution.

COMPREHENSIVE CREDENTIALING PROGRAM STANDARDS

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS and NCQA). The scope of the credentialing program includes all licensed M.D.s, D.O.s, DPMs (doctor of podiatric medicine), DC (doctor of chiropractic medicine), DDS (doctor of dental surgery), allied health and midlevel practitioners, which include, but are not limited to: behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrist, physician assistants, optometrists, registered physician therapists, occupational therapists, speech therapists and audiologists, ~~etc.,~~ both in the delegated and CalOptima direct environments. Credentialing and recredentialing activities are delegated to the ~~Health Networks~~HNs and performed by CalOptima for CCN.

Health Care Delivery Organizations

CalOptima performs credentialing and re-credentialing of ancillary providers and HDOs (these include, but are not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc.) upon initial contracting, and every three years thereafter. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies.

Use of Quality Improvement Activities in the Re-credentialing Process
Findings from quality improvement activities are included in the re-credentialing process.

Monitoring for Sanctions and Complaints
CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, State or Federal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns and member complaints between re-credentialing periods.

FACILITY SITE REVIEW, MEDICAL RECORD AND PHYSICAL ACCESSIBILITY REVIEW SURVEY

CalOptima does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted HMOs, PHCs, SRGs, MBHO, and PMGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by MMCD -Policy Letter ~~02-02~~ 14-004. CalOptima assumes responsibility and conducts and coordinates Facility Site Review (FSR), Medical Record Review (~~/~~MRR) for the non-delegated SRGs and PMGs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs and PMGs to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs.

Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter ~~02-02~~14-004 and CalOptima policies. Medical records of new providers shall be reviewed within ninety calendar days of the date on which members are first assigned to the provider. An additional extension of ninety calendar days may be allowed only if the provider does not have sufficient assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)
CalOptima conducts an additional DHCS-required facility audit for American with Disabilities Act compliance for ~~seniors and persons with disabilities (~~SPD~~)~~ members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Exterior ramps
- Exterior stairways
- Entrances

- Interior circulation
- Interior doors
- Interior ramps
- Interior stairways
- Elevators
- Controls
- Sanitary facilities
- Reception and waiting areas
- Diagnostic and treatment areas

Medical Record Documentation Standards

CalOptima requires that its contracted HMOs, PHCs, SRGs, MBHO, and PMGs make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, ~~x~~X-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.

The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by State and Federal laws and regulations, and the requirements of CalOptima's contracts with CMS, DHCS, and MRMIB.

The medical record should be protected in that medical information is released only in accordance with applicable Federal and/or State law.

CORRECTIVE ACTION PLAN(S) TO IMPROVE CARE, SERVICE

When monitoring by either CalOptima's Q~~uality I~~~~mprovement~~ ~~D~~department or Audit & Oversight ~~D~~department identifies an opportunity for improvement, the delegated or functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the QI department or Audit and Oversight ~~D~~department as overseen by the ~~Delegation~~ Audit & Oversight Committee, reporting to the Compliance Committee. ~~–~~Those activities specific to CalOptima's functional areas will be overseen by the Q~~uality I~~~~mprovement~~ d~~D~~epartment as overseen by and reported to QIC. ~~-~~Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation of performance via the appropriate clinical monitor. (This process shall determine if ~~follow~~ follow-up action has resolved the original problem.)

- Discussion of the results of clinical monitoring. (The committee/functional area may refer an unresolved matter to the appropriate committee/functional area for evaluation and, if necessary, action.)
- Intensified evaluation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- Prescribed continuing education
- Intensive monitoring and oversight
- De-delegation
- Contract termination

Performance Improvement Evaluation Criteria for Effectiveness

The effectiveness of actions taken and documentation of improvements made are reviewed through the monitoring and evaluation process. Additional analysis and action will be required when the desired state of performance is not achieved. Analysis will include use of the statistical control process, use of comparative data, and benchmarking when appropriate.

COMMUNICATION OF QUALITY IMPROVEMENT ACTIVITIES

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups, and be reflected on the work plan or calendar. The QI Ssubcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Board of Directors, and/or the QAC, through the CMO or designee, on a quarterly basis. QIC participants are responsible for communicating pertinent, non-confidential QI issues to all members of CalOptima staff. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
- Annual synopsized QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on CalOptima's website, in addition to the annual article in both practitioner and member newsletter. The information includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service. Notification

on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
- Annual PCP pamphlet
- Member Advisory Committee (MAC), OCC Member Advisory Committee (OCC MAC) and Provider Advisory Committee (PAC).

ANNUAL PROGRAM EVALUATION

The objectives, scope, organization and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC, QAC, and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and incorporated into the QI Work Plan and reported to DHCS ~~&~~ and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization,
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions
- An evaluation of each QI Activity, including Q~~uality I~~~~mprovement~~ Projects (QIPs), with any area showing improvements in care or service as a result of QI activities receiving continued interventions to sustain improvement
- An evaluation of member satisfaction surveys and initiatives
- A report to the QIC and QAC of a summary of all quality indicators and identification of significant trends
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process
- The recommended changes, included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors for review and approval

IN SUMMARY

As stated earlier, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better. Together."

APPENDIX A — 2017 QI WORK PLAN

APPENDIX B — 2017 DELEGATION GRID

"Attachment A"

CalOptima
20176 Quality Improvement Work Plan
OneCare Connect/OneCare and Medi-Cal
February, 2016 7

I. Program Oversight

- **A. Program Sscope- 2017 QI Annual oversight of programs and work plans 2/9/16**
- **B. Program Scope- 20156 QI Program Annual Evaluation**
- **C. Program Scope- 2017 UM Program and UM Work Plan annual oversight**
- **D. Program Scope- 20176 5 UM Program Annual Evaluation**
- **E. Quality of Care- 2017 Case Management Program annual oversight**
- **F. Quality of Ccare- 20156 Case Management Program Evaluation**
- **G. Quality of Care- 2017 Disease Management Program annual oversight**
- **H. Quality of Care- 20156 Disease Management Program Evaluation**
- **I. Quality of Care- Credentialing Peer Review Committee (CPRC) Oversight**
- **J. NCQA Monitoring & Compliance**

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC _____ Date: _____

Submitted and approved by Board _____ Date: **4/1/16**

Submitted and approved by Board of Director's _____ Date: **3/23/16**

Quality Assurance Committee (QAC)

Quality Improvement Committee Chairperson:

_____

Medical Director _____ Date: _____

II. Case Management

- **A. Quality of Clinical Care- Review of health risk assessments to OCC, OC, SPD members**
- **B. Quality of Clinical Care- Continuity & Coordination of Medicceal/BH**
- **C. Quality of Clinical Care- Review of emergency department communications with PCPs**
- **D.C. Patient Safety, Quality of Care Case Management- High ER utilization**
- **E.D. Quality of Clinical Care-Review of member satisfaction with CM programs**
- **F.E. Quality of Adherence to Complex Case Management NCQA StandardsIdentification of Complex Case Management**

Board of Directors' Quality Assurance Committee Chairperson:

Board of Directors' Quality Assurance Committee Chairperson:

_____

Paul Yost, Viet Van Dang, MD _____ _____

III. Behavioral Health

Date:

- **A. Quality of Clinical Care: HEDIS Measure for M/C & OCCIntegration of BH services**
- **B. Quality of Clinical Care: Interdisciplinary Care Treatment Team Participationare- Clinical BH Practice Guidelines adoption for Medi-Cal line of business**
- **C. Quality of Clinical Care: Behavioral Health Practice Guidelines**
- **C. Access and Coordination of Care Service and Quality of Clinical Care- Review of behavioral health providers communications with PCPs**

IV. LTSS

- **A. Safety of Clinical Care and Quality of Clinical Care- Review and assess LTSS placement for members participating with each organization/program**
- **B. Safety of Clinical Care and Quality of Clinical Care- Review and assess emergency department visits for LTSS members participating with each organization/program**
- **C. Safety of Clinical Care and Quality of Clinical Care- Review and assess readmissions for LTSS members participating with each organization/program: Hospital Readmissions**
- **D. Safety of Clinical Care and Quality of Clinical Care-Review and Assess Readmissions for LTSS members participating with each organization/program: Long Term Care Admissions**

~~D.~~E. **Quality of Clinical Care- Review of health risk assessment (HRA) for OneCare Connect (OCC) Long Term Care (LTC) members**
~~E.~~F. **CBAS Member Satisfaction**
G. **SNF Member Satisfaction**

~~F.~~

V. Health Education & Disease Management
- ~~A.~~ Quality of Care-~~-~~All new members will complete the
- A. Initial Health Assessment and related IHEBA/SHAs
- ~~B.~~ Quality of Clinical Care-R~~, r~~eview of Disease Management Programs ~~(Asthma)~~
- ~~C. Quality of Clinical Care, review of Disease Management Program (Diabetes)~~
- ~~D.~~B. ~~Quality of Clinical Care, review of Disease Management Program (CHF)~~
- ~~E.~~ Quality of Care-~~-~~Clinical Practice Guidelines ~~-~~adoption ~~-~~for Medi-Cal line of business
- ~~F.~~C. ~~Quality of Clinical Care, review of member satisfaction with DM programs~~
- ~~G.~~D. Quality of Clinical Care-~~-~~Review of C~~c~~ardiovascular Disease
- ~~H. Quality of clinical Care- Review of Diabetes and All Cause Readmissions~~
- ~~I. Implementation of the Childhood Obesity (Shape Your Life) Program~~
- ~~J. Implement Weight Watchers (WW) for Medi-Cal Members~~
- ~~K. Implement Home Assessments for member participating in Care Management Programs~~
- ~~L. Conduct 2016 Group Needs Assessment (GNA)~~
- E. Implementation of Population Health & Wellness Programs
- F. Quality of Clinical Care-Quality and Performance Improvement Projects

VI. Access & Availability
- A. Quality of Service and Quality of Clinical Care-~~-~~Review of notification to members
- B. Access to Care-~~-~~Credentialing of provider network is monitored
- C. Access to Care-~~-~~Recredentialing of provider network is monitored
- D. Accessibility: Review of access to care
- E. Availability: Review of availability of practitioners

VII. Patient Safety
- A. Safety of Clinical Care-~~-~~Providers shall have timely and complete facility site reviews
- B. Safety of Clinical Care-~~-~~Review and follow-up on member's potential Quality of Care Complaints
- C. Safety of Clinical Care and Quality of Clinical Care-~~-r~~Reviewed through Pharmacy Management
- D. Safety of Clinical care and Quality of Clinical Care-~~-~~R~~r~~eview of Specialty Drug Utilization
- E. Patient Safety-~~-~~Review and assessment of CBAS Quality Monitoring
- F. Patient Safety-~~-~~Review and assessment of SNF Quality Monitoring
- G. Safety of Clinical Care-~~-~~Review of antibiotic usage
- H. Pharmacy Benefit~~r~~ Manager (PBM) Oversight Management ~~Implementation of the new PBM~~

VIII. Member Experience
- A. Quality of Service-~~-~~Review of Member Satisfaction
- B. Quality of Service-~~-~~Reviewed through customer service first call resolution
- C. Quality of Service-~~-~~Reviewed through customer service access
- D. Quality of Care & Service reviewed through GARS & PQI (MOC)

IX. HEDIS/STARS Improvement
- A. Improve identified HEDIS Measures listed on "Measures" worksheet
- B. Improve identified STARS ~~m~~Measures listed on "Measures" worksheet
- ~~C.~~ Improve CAHPS ~~m~~Measures listed on "Measures" worksheet
- ~~D.~~C. ~~HEDIS: Launch pediatric wellness clinic~~
- ~~E.~~D. STARS Medication Related Measures~~improvement- Medication Adherence Measures~~

~~F.~~ HEDIS: Health Network support of HEDIS & CAHPS Improvement

X. Delegation Oversight
- **A. Delegation Oversight of CM**
- **B. Quality of Care & Ss~~s~~ervice of UM through d~~D~~Delegation o~~O~~versight r~~R~~eviews**
- **C. Delegation Oversight of BH Services**

XI. Organizational Projects
- ~~**A. Implementation of the 2016 Value Based P4P program**~~
- **A. Value Based P4P 2017**
- **B. MOC Dashboard 2016-2019**

Previously identified issues to be monitored

I. Program Oversight

A. Program Scope- QI Annual oversight of programs and work plans

Owner: Medical Director, Quality & Analytics

1. Activity

- QI Program and QI Work Plan will be adopted on an annual basis
- QI Program Description- QIC-BOD
- QI Work Plan- QIC-QAC

Approved by QIC: ~~2/9/16~~
Approved by QAC: ~~3/23/16~~
Approved by Board: ~~4/1/16~~

2. Goals

- Annual Adoption

B. Program Scope- 201~~6~~6 QI Program Annual Evaluation

Owner: Medical Director, Quality & Analytics

1. Activity

- QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis

2. Goals

- Annual Evaluation

Approved by QIC: ~~2/9/~~ ~~16~~
Approved by QAC: ~~3/23/16~~
Approved by Board: ~~4/1/~~ ~~16~~

C. Program Scope- UM Program and UM Work Plan annual oversight

Owner: ~~Terrie Stanley~~Tracy Hitzeman, Interim ED Clinical Operations

1. Activity

- UM Program and UM Work Plan will be adopted on an annual basis
- Delegate UM annual oversight reports-from DOC

Approved by UMC: ~~2/9/16~~
Approved by QIC: ~~2/9/16~~
Approved by QAC: ~~3/23/16~~
Approved by Board: ~~4/1/16~~

2. Goals

- Annual Adoption

D. Program Scope- 201~~6~~6 UM Program Annual Evaluation

Owner: ~~Terrie Stanley~~Tracy Hitzeman, Interim~~interim~~ ED ~~Clinical Operations~~CO

1. Activity

- UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis
- Delegate oversight from DOC

Approved by QIC: ~~2/9/16~~
Approved by QAC: ~~3/23/16~~
Approved by Board: ~~4/1/16~~

2. Goals

- Annual Evaluation

E. Quality of Care – 2016 Case Management Program Annual Oversight

Owner: Tracy Hitzeman Sloane Petrillo, Interim Director, Case Management

1. **Activity**
   - CM Program will be adopted on an annual basis
   - Delegation oversight reported by DOC

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Adoption

F. Quality of Care – 2016 Case Management Program Evaluation

Owner: Sloane Tracy Hitzeman Petrillo, Interim Director Dtr, CM

1. **Activity**
   - CM Program will be evaluated by members including member feedback and complaints, and to measure effectiveness of the overall CM Program, including interventions and actions for re-measurements
   - Delegation oversight reported by DOC
   -

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Evaluation

G. Quality of Care – 2016 Disease Management Program Annual Oversight

Owner: Pshyra Jones, Dir Director, of Health Education & Disease Management

1. **Activity**
   - DM Program will be adopted on an annual basis

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Adoption

H. Quality of Care – 2016 Disease Management Program Evaluation

Owner: Pshyra Jones, Dtr. Health Ed HE and & DM

1. **Activity**
   - DM Program will be evaluated by members including member feedback and complaints and to measure effectiveness of the overall
   - DM Program, including interventions and actions for re-measurement

Approved by QIC:
Approved by QAC:
Approved by Board:
Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Evaluation

I. Quality of Care- Credentialing Peer Review Committee (CPRC) Oversight

Owner: Medical Director, Quality

1. **Activity**
   - Review of initial and recredentialing applications, related quality of care issues, approvals, denials, and reported to QIC
   - Delegation oversight reported by DOC

Approved by QIC:
Q1
Q2
Q3
QI 4/13/16
Q4Q2
Q3
Q4

2. **Goals**
   - **Quarterly Adoption of Report**

J. NCQA Monitoring & Compliance

Owner: ~~Kelly Rex-Kimmet~~Esther Okajima, Director, Quality ImprovementA

1. **Activity**
   - Evaluate NCQA standards, HEDIS & CAHPS for improvement opportunities to achieve Commendable status

Approved by QIC:
Q1
Q2
Q3
Q4

~~Approved by QIC~~

2. **Goals**

Q1
Q2
Q3
Q4

2. **Annual HIP ~~Ranking~~Rating**

II. Case Management

A. *Quality Of Clinical Care-Review of Hhealth rRisk aAssessments to OCC, OC, SPD members

A. Owner: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

The Approach

1. Objective

- **OCC-** Health Risk Assessment Outreach for members in the OneCare
- Connect Program monitored for completion and collection
  - Initial HRA
  - Annual HRA
- **OC-** Health Risk Assessment Outreach for members in the OneCare Program monitored for completion
  - Initial HRA
  - Annual HRA
- **SPD-** Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion
  - Initial HRA
  - Annual HRA

2. Activity

- **OCC-** Administer the initial HRA to the high risk beneficiary within:
  1. 90 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **OCC-** Administer the initial HRA to the low risk beneficiary within:
  1. 45 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **OC-** Administer the annual HRA to the beneficiary
  1. 90 days of a beneficiary's enrollment

2. Administer the annual HRA to the beneficiary

- **SPD-** Administer the initial HRA to the high risk beneficiary within:
  1. 45 days of a beneficiary's eligibility
  2. Administer the annual HRA to the beneficiary

- **SPD-** Administer the initial HRA to the low risk beneficiary within:
  1. 90 days of a beneficiary's eligibility
  2. Administer the annual HRA to the beneficiary

3. Goals

- **Completion of Outreach**

~~**Completion of outreach**~~

~~OCC-100% of eligible population~~

- ~~**OCCC-**-100% of eligible population~~
- **OC~~SPD~~**-1~~-~~100% of eligible population
- **SPD**-100% of eligible population

- **Collection**

- **OCC**-Collect 56% of high risk OCC HRAs
- **OCC**-Collect 43% of low risk OCC HRAs
- **OC**-Collect 78% of initial OC HRAs
- **OC**-Collect 34% of annual OC HRAs
- **SPD**-Collect 63% of initial SPD HRAs

~~**Collectio n**~~

~~OCC-Collect 56% of high risk OCC HRAs~~

- **OCC** Collect 43% of low risk OCC HRAs
- **OC** Collect 78% of initial OC HRAs
- **OC** Collect 34% of annual OC HRAs
- **SPD** Collect 63% of initial SPD HRAs

The Approach

1. Objective

- **OCC** Health Risk Assessment Outreach Appraisals for members in the OneCare Connect Program monitored for completeness
- **OC** Health Risk Assessment Outreach for members in the OneCare Program monitored for completion
- **SPD** Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion

2. Activity

- **OCC** Administer the initial HRA to the high risk beneficiary within:
  1. 90 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **OCC** Administer the initial HRA to the low risk beneficiary within:
  1. 45 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **OC** Administer the annual HRA to the beneficiary
  1. 90 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **SPD** Administer the initial HRA to the high risk beneficiary within:
  1. 45 days of a beneficiary's eligibility
  2. Administer the annual HRA to the beneficiary

- **SPD**- Administer the initial HRA to the low risk beneficiary within:
    1. 90 days of a beneficiary's eligibility
    2. Administer the annual HRA to the beneficiary

3. Goals

- **OCC**-100% of eligible population improvement over 2016
- **OC**- 100% of eligible population
- **SPD**- 100% of eligible population

2201~~6~~7 Quality Improvement Work Plan- Case Management Owner: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			

Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

II. Case Management

B. *Quality of Clinical Care-Continuity & Coordination of Medical/BH

Owners: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM; ~~Edwin Poon, Director, Behavioral Health Services (BHS)~~

Edwin Poon, Director, Behavioral Health Services (BHS)

The Approach

~~1. Objective~~

~~• Continuity and Coordination between Medical & Behavioral Health~~

~~2. Activity~~

~~• Monitor and identify opportunities to improve continuity & coordination of care across settings and/or transitions of care through ICT/ICP or other processes~~

~~3. Goals~~

~~• 85%~~

1. Objective

- Continuity and Coordination between Medical & Behavioral Health

2. Activity

- Monitor and identify opportunities to improve continuity & coordination of care across settings and/or transitions of care through ICT/ICP or other processes

3. Goals

- 100% participation in ICT for BHI
- 85% participation in ICT for MBHO
- 10% participation in ICT for individual providers
- 20% participation in ICT for county mental health

"Attachment A"

2016~~6~~7 Quality Improvement Work Plan- Case Management **Owners: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM; ~~,~~Edwin Poon, D~~irector~~tr, BHS**

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

II. Case Management

C. Patient Safety, Quality of Care Case Management- High ER utilization

Owner: Sloane Petrillo, Interim ~~Director~~Dtr, CM~~;~~

The Approach

1. Objective

- Evaluation and intervention for ongoing review of high ER utilizers

2. Activity

- Identify top 10 high ER utilizers for CCN per quarter (all lines of business)
- Open to case management with focused group of case managers
- Regular meetings to identify causes of high utilization and effective strategies
- for reduction in inappropriate ER utilization

3. Goals

- 5% reduction in ER visits among intervention cohort

~~C. *Quality of Clinical Care-Review of emergency department communications with PCPs~~

~~Owner: Tracy Hitzeman Director, CM~~

~~The Approach~~

~~1. Objective~~

- ~~Continuity and Coordination of Care reviewed and assessed~~

~~2. Activity~~

- ~~Assessment of medical records for communication from emergency department to primary care providers~~

~~3. Goals~~

- ~~85%~~

2016~~6~~7 Quality Improvement Work Plan- Case Management Owner: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

II. Case Management

D. Quality of Clinical Care-Review of member satisfaction with CM programs **Owner: Sloane Petrillo, Interim ~~Director~~Dtr, CM**

The Approach

1. Objective

- Annual review of member feedback on the case management programs to assure high satisfaction and improved health status

2. Activity

- Review annual satisfaction survey results, define areas for improvement and implement interventions to improve member experience with CM programs
- Revise methodology to increase sample size of responses

3. Goals

- Satisfaction with Case Management - 88%

~~**D. Patient Safety, Quality of Care Case Management- High ER utilization** **Owner: Tracy Hitzeman Director, CM; Novella Quesada, Manager, QI**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Evaluation and intervention for ongoing review of high ER utilizers~~

~~**2. Activity**~~

- ~~Ongoing monitoring of ER utilization; findings reported to Case Management for follow-up and/or further interventions~~

~~**3. Goals**~~

- ~~35%~~

~~E. Quality of Clinical Care-Review of member satisfaction with CM programs~~ ~~Owner: Tracy Hitzeman Director, CM~~

~~The Approach~~

~~1. Objective~~

- ~~Annual review of member feedback on the case management programs to assure high satisfaction and improved health status~~

~~2. Activity~~

- ~~Review annual satisfaction survey results, define areas for improvement and implement interventions to monitor and improve the member experience in CM programs~~

~~3. Goals~~

- ~~Satisfaction with Case Management - 85%~~

2016~~6~~7 Quality Improvement Work Plan- Case Management Owner: ~~Tracy Hitzeman, Director, CM; Novella Quesada, Manger QI~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

~~2016 Quality Improvement Work Plan- Case Management: Review of member satisfaction with CM programs~~
~~Owner: Tracy Hitzeman, Director, CM~~

~~Monitoring~~	~~Assessments, Findings, Monitoring of Previous Issues~~	~~Next Steps~~	~~Target Completion~~
~~Q1~~			
~~Q2~~			
~~Q3~~			
~~Q4~~			
~~Year End~~			
~~Outcomes~~	~~Results / Metrics~~	~~Next Steps~~	~~Target Completion~~
~~Q1~~			
~~Q2~~			
~~Q3~~			
~~Q4~~			
~~Year End~~			

II. Case Management

E. Quality of Adeherence to Complex Case Management NCQA Standards Owner: Sloane Petrillo, Interim ~~Director~~Dtr, CM

The Approach

1. Objective

- Improve adherence to NCQA standards for all Health Networks

2. Activity

- Monthly review of complex case files (5 or 5%)
- Monthly feedback provided to health networks

3. Goals

- All Health Networks will achieve an average score of 85% or greater on their monthly file reviews

~~F. Quality of Identification Of Complex Case Management Owner: Tracy Hitzeman, Director, CM~~

~~The Approach~~

~~1. Objective~~

- ~~Identify all members eligible for Complex Case Management~~

~~2. Activity~~

- ~~Health Networks are required to report members identified for Complex Case Management~~

~~3. Goals~~

- ~~Health Networks are identifying members eligible for Complex Case Management~~

201~~6~~7 Quality Improvement Work Plan- Case ~~Management~~ Management Owner: ~~Tracy Hitzemen~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			

Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

III. Behavioral Health

~~**A. *Quality of Clinical Care: Integration of BH Services** **Owner: Dr. Donald Sharps, Medical Director, BHI**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Behavioral Health services, continuity & coordination of care and BH HEDIS measures will be monitored and measured~~

~~**2. Activity**~~

- ~~Monitor and identify opportunities to improve continuity & coordination of care across settings and/or transitions of care through ICT/ICP or other processes~~
- ~~Design and implement activities to improve HEDIS/ STARS measures relating to Behavioral Health~~

~~**3. Goals**~~

- ~~10% improvement over 2015~~

A. *Quality of Clinical Care: HEDIS Measures for M/C & OCC **Owner: Dr. Donald Sharps, Medical Director, BHI**

The Approach

1. Objective

- Behavioral Health HEDIS measures will be monitored and measured

2. Activity

- Design and implement activities to improve HEDIS measures relating to Behavioral Health

3. Goals

- At or above the 50th Percentile
-

20172~~2~~[01]~~6~~7 Quality Improvement Work Plan- Behavioral Health Owner: ~~Terrie Stanley, ED Clinical Operations~~Dr. Donald Sharps, Medical ~~Director~~Dtr, BHI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

III. Behavioral Health

B. *Quality of Clinical Care: Interdisciplinary Care Treatment Team Participation ~~——~~**Owner: Dr. Donald Sharps, Medical ~~Director~~Dtr, BH~~I~~**

~~— Medical Director, BH~~

~~T~~The Approach

1. **Objective**
   - BH Services, integration & coordination of care will be monitored and measured
2. **Activity**
   - Monitor and ~~i~~identify opportunities to improve integration and coordination of care across settings and~~-~~/or transitions of care through ICT/ICP
3. **Goals**
   - 10% Improvement over 2016

~~**B. *Quality of Care-Clinical BH Practice Guidelines adoption for Medi-Cal Line of business —— Owner: Dr. Donald Sharps, Medical Director, BH**~~

~~**The Approach**~~

1. ~~**Objective**~~
   - ~~BH Clinical Practice Guidelines will be reviewed and adopted~~
2. ~~**Activity**~~
   - ~~Adoption of Clinical Practice Guidelines, at least two (2) behavioral health will be reviewed and adopted~~
   - ~~Depression & Autism CPGs reviewed annually~~
3. ~~**Goals**~~
   - ~~100%~~

20167 Quality Improvement Work Plan- Behavioral Health Owner: DRr. Donald Sharps, Medical DirectorDtr, BHI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

III. Behavioral Health

~~C. *Quality of Service and Quality of Clinical Care-Review of Behavioral Health Providers communications with PCPs~~ ~~Owner: Dr. Donald Sharps, Medical Director, BH~~

~~The Approach~~

~~1. Objective~~
- ~~Continuity and Coordination of Care reviewed and assessed for medical care with behavioral health care~~

~~2. Activity~~
- ~~Assessment of medical records for communication between primary care providers and behavioral health providers~~

~~3. Goals~~
- ~~85%~~

C. *Quality of Care- Clinical Behavioral Health Practice Guidelines Owner: Dr. Donald Sharps, Medical D~~irec~~tor, BHI

The Approach

1. Objective
- BH Clinical Practice Guidelines will be reviewed and adopted

2. Activity
- Adoption of Clinical Practice Guidelines, at least two (2) behavioral health guidelines will be reviewed and adopted

3. Goals
- 100%

2016~~6~~7 Quality Improvement Work Plan- Behavioral Health Owner: Dr. Donald Sharps, Medical D~~irect~~or, BH~~I~~

Monitoring	~~N~~ Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			

Q4			
Year End			

III. Behavioral Health

D. *Access and Coordination of Care ~~(NEW)~~ Owner: Dr. Donald Sharps, Medical D~~irec~~tor, BHI

The Approach

1. Objective

- Appropriate, timely, and effective access for BB~~B~~ehavioral ~~H~~HHealth services in LTC/SNF facilities
- Explore opportunities for coordination of care with PCPs

2. Activity

- Identify and survey existing LTC/SNF facilities,
- conduct analysis~~; and~~
- P~~p~~ropose interventions to address barriers to access Behavioral Health services

3. Goals

- Maintain amount of encounters from previous MBHO
- Establish gap analysis and needs for Behavioral Health support to PCPs
- Establish gap analysis and needs for Behavioral Health in LTC
- Develop uniform process for accessing Behavioral Health in LTC

2017 Quality Improvement Work Plan–Behavioral Health Owner: Dr. Donald Sharps, Medical Director, BHI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			

Q4			
Year End			

IV. LTSS

A. Safety of Clinical Care and Quality of Clinical Care- Review and assess LTSS placement for members participating with each organization/program

Owner: ~~Suzanne Harvey~~Marie ~~Earvoline~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, ~~Clinical~~ CO~~Operations~~

~~Clinical Operations~~

The Approach

1. **Objective**
   - Member review of Hospital Admissions (for each organization/program)

2. **Activity**
   - Measure those members participating in each program for hospital admissions~~:~~
     1. CBAS
     2. IHSS
     3. LTC
     4. MSSP

3. **Goals**
   - ~~2% CBAS;~~ Establishing goals in 2016 for IHSS, LTC & MSSP

2016~~7~~ Quality Improvement Work Plan- LTSS Owner: ~~Suzanne Harvey~~Marie ~~Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical O~~perations

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

B. *Safety of Clinical Care and Quality of Clinical Care- Review and assess emergency department visits for LTSS members participating with each organization/program

Owner: ~~Suzanne Harvey~~Marie Earvolino Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical~~O ~~Operations~~ ~~Operations~~

The Approach

1. **Objective**
   - Member review of Emergency Department Visits (for each organization/program)

2. **Activity**
   - Measure those members participating in each program for hospital admissions~~:~~
     1. CBAS
     2. IHSS
     3. LTC
     4. MSSP

3. **Goals**
   - 9% CBAS~~;~~
   - R~~Establishing goals in~~Review 2016 data to establish goals for IHSS, LTC, MSSP
   - Monitor progress towards goals quarterly

2016~~7~~ Quality Improvement Work Plan- LTSS Owner: ~~Suzanne Harvey~~~~Marie Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical~~ Operations

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

C. *Safety of Clinical Care and Quality of Clinical Care-Review and assess readmissions for LTSS members participating with each organization/program

Owner: ~~Suzanne Harvey~~Marie ~~Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, CO ~~Clinical Operations~~ ~~Operations~~

The Approach

1. **Objective**
   - Members reviewed for Hospital Readmissions (for each organization/program)

2. **Activity**
   - ~~Measure and assess readmissions within 30 days for members in each~~
   - ~~program to drive~~
     interventions to minimize hospital readmissions~~:~~
     1. CBAS
     2. IHSS
     3. LTC
     4. MSSP

3. **Goals**
   - 2.5% CBAS~~;~~
   - Review 2016 data to establish goals for IHSS, LTC, MSSP
   - ~~Establishing goals in 2016 for IHSS, LTC, MSSP~~

2016~~6~~7 Quality Improvement Work Plan- LTSS **Owner: ~~Suzanne Harvey~~Marie ~~Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical O~~perations**

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

D. *Safety of Clinical Care and Quality of Clinical Care-Review and assess readmissions for LTSS members participating with each organization/program

Owner: ~~Marie Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSSED~~, CO~~Clinical Operations~~

~~Clinical Operations~~

The Approach

1. Objective

- Members reviewed for Long Term Care Admissions (LTC) (for each organization/program)

2. Activity

- Measure and assess admissions to LTC ~~ong Term Care~~ for members in each program to drive interventions to minimize hospital readmissions~~:~~
  1. CBAS
  2. IHSS
  3. MSSP

3. Goals

- 2% CBAS
- ~~; Establishing goals in~~Review data from 2016 and establish goals for ~~for~~ IHSS, LTC, MSSP

2017 Quality Improvement Work Plan- LTSS Owner: ~~Marie Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical O~~perations~~

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

D. Quality of Clinical Care-review of Health Risk Assessment (HRA) for OneCare Connect (OCC) Long Term Care (LTC) members

Owner: Suzanne HarveyMarie Earvolino, Interim Director, LTSS

The Approach

1. **Objective**
   - Health risk assessment for members in the OCC line of business monitored for completeness

2. **Activity**
   - HRA to comprehensively assess each newly enrolled OCC LTC member's current health risk.
   - Completion of an HRA process must be performed within 90 calendar days of enrollment for those identified by the risk stratification mechanism as lower risk who are residing in LTC facilities

3. **Goals**
   - 100%

~~2016~~7 Quality Improvement Work Plan- LTSS ~~Owner: Suzanne Harvey~~Marie Earvolino, ~~Interim~~ ~~Director, LTSS~~

	~~Assessments, Findings, Monitoring of Previous Issues~~	~~Next Steps~~	
	~~Results / Metrics~~	~~Next Steps~~	

IV. LTSS

~~E.~~ CBAS Member Satisfaction

Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director, QI~~I~~

~~E.~~

The Approach

1. **Objective**
   - **Monitor and/or improve member satisfaction in CBAS/LTSS**
2. **Activity**
   - **Measur**e, assess and identify areas for improvement and implement
   - interventions to assure high member satisfaction
3. **Goals**
   - ~~-~~5% Improvement over previous year

2016~~6~~7 Quality Improvement Work Plan- LTSS Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Di~~rec~~tor, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

A. SNF Member Satisfaction

Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director~~or~~, QI

The Approach

1. **Objective**
   - Monitor and/or improve member satisfaction in SNF
2. **Activity**
   - Measure~~s~~, assess and identify areas for improvement and implement interventions
   - to assure high member satisfaction
3. **Goals**
   - 5% Improvement over previous year

2016~~6~~7 Quality Improvement Work Plan- LTS S Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~D~~irect~~or, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

~~A. *Quality of Care-All new members will complete the Initial Health Assessment and related IHEBA/SHAs~~ ~~Owner: Pshyra Jones, Director, Health ED and DM~~

~~The Approach~~

~~1. Objective~~
- ~~To assure all new members are connected with a PCP and their health risks are assessed~~

~~2. Activity~~
- ~~IHA/IHEBA [Staying Healthy Assessment(SHA)] will be completed with 120 days of enrollment~~
- ~~Reports will be available for Health Networks on IHA/SHA completion~~
- ~~Facility Site Reviews will review sample of medical records for compliance with completing appropriate age level IHA/SHA~~
- ~~If use of alcohol or drugs, the member will have an SBIRT documented (Screening, Brief intervention, and Referral to Treatment)~~

~~3. Goals~~
- ~~Improve plan performance over 2015 by 10%~~

A. *Quality of Care-All new members will complete the Initial Health Assessment and related IHEBA/SHAs

Owner: Pshyra Jones, Director, Health ~~E~~Education & ~~and~~ Disease Management

The Approach

1. Objective
- To assure all new members are connected with a PCP and their health risks are assessed

2. Activity
- IHA/IHEBA [Staying Healthy Assessment(SHA)] will be completed

- within 120 days of enrollment
- Reports will be available for Health Networks on IHA/SHA completion
- Facility Site Reviews will review a sample of medical records for compliance with completing appropriate age level IHA/SHA
- If use of alcohol or drugs, the member will have an SBIRT documented (Screening, Brief Intervention, and Referral to Treatment)

3. Goals

- Improve plan performance over 2016 by 10%

2016~~6~~7 Quality Improvement Work Plan- ~~Health Education & Disease Management~~HE & DM _Owner: Pshyra Jones, D~~irect~~or, H~~ealth~~ Ed~~d~~D & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

~~**B. Quality of Clinical Care, review of Disease Management Program (Asthma) Owner: Pshyra, Jones, Director, Health Ed and DM**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Disease Management activity reviewed to assess clinical care delivered to members with Asthma~~

~~**2. Activity**~~

- ~~Increase Asthma Medication Ratio (AMR) rates for members with persistent asthma in our Asthma DM program~~
- ~~Incorporate HEDIS improvement for Asthma into DM program interventions~~
- ~~Evaluate more technology based interventions into DM programs~~
- ~~Assure DM programs are implemented across all populations~~
- ~~Conduct annual member satisfaction of DM programs~~
- ~~Evaluate the overall effectiveness of the Asthma Program Participation Member Rates, ED, IP and RX related utilization~~

~~**3. Goals**~~

- ~~Increase to 50th percentile for members between 5-18 yrs old~~

B. Quality of Clinical Care, Rreview of Disease Management Programs Owner: Pshyra, Jones, ~~Director, Health Ed & and DM~~Dtr, HE & DM

The Approach

1. Objective

- Disease Management activity reviewed to assess clinical care delivered to members with Asthma, ~~Diabetes,~~Diabetes and Heart Failure

2. Activity

- Incorporate HEDIS improvement into DM program interventions
- Assure DM programs are implemented across all populations

- Conduct annual member satisfaction of DM programs
- Evaluate the overall effectiveness of the Program-Participation Member Rates, ED, IP and RX related utilization

3. Goals

Medi-Cal

- Increase to 75th percentile for Asthma Medication Ratio (AMR) Ages 5-11
- Increase to 75th percentile for Medication Management for People with Asthma (MMA), ages 5-85
- Increase to 50th percentile for HbA1c Testing
- Increase to 90th percentile for HbA1c Poor Control
- Increase to 75th percentile for Eye Exams
- Increase to 50th percentile for Annual Monitoring for Patients on Persistent Medications (MPM) Ace Inhibitors or ARBSs - Increase to 50th percentile for HbA1c Testing - Medicare
- Increase to 50th percentile for Controlling High Blood Pressure (CBPC) - Medicare
- 85% satisfaction with DM Programs

2016~~7~~ Quality Improvement Work Plan- ~~Health Education & Disease Management~~HE & DM _____-Owner: Pshyra Jones, ~~Dir~~Dtr~~.ector~~ H~~ealth~~ E~~d~~ & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

~~**C. Quality of Clinical Care-Review of Disease Management Program (Diabetes)** **Owner: Pshyra Jones, Director, Health Ed and DM**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Disease Management activity reviewed to assess clinical care delivered to members with Diabetes~~

~~**2. Activity**~~

- ~~A1C Control for members with existing A1C>9 and receiving Health Coach interventions in 2016~~
- ~~Incorporate HEDIS improvement for CDC into DM program interventions~~
- ~~Evaluate more technology-based interventions into DM programs~~
- ~~Assure DM programs are implemented across all populations~~
- ~~Conduct annual member satisfaction of DM programs~~
- ~~Evaluate the overall effectiveness of the Diabetes Program-Member Participation rates, ED, IP, and RX related utilization~~

~~**3. Goals**~~

- ~~Maintain 90th percentile for Medi-Cal; increase to 75th percentile for Medicare~~

C. *Quality of Care-Clinical Practice Guidelines adoption for Medi-Cal line of business **Owner: Pshyra Jones, D~~irector~~tr, HE & DM**

~~**Health Ed & DM**~~

The Approach

1. Objective

- Clinical Practice Guidelines will be reviewed and adopted

2. Activity

- Adoption of Clinical Practice Guidelines, as least three (3) will be

- reviewed and adopted (linked to DM: Diabetes, Asthma, CHF)

3. Goals

- 100%

"Attachment A"

2016~~6~~7 Quality Improvement Work Plan- ~~Health Education & Disease Management~~ HE & DM ~~—~~Owner: Pshyra Jones, D~~irect~~or H~~ealth E~~d & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

~~**D. Quality of Clinical Care-Review of Disease Management Program (CHF)** **Owner: Pshyra Jones, Director, Health ED and DM**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Disease Management activity reviewed to assess clinical care delivered to members with CHF~~

~~**2. Activity**~~

- ~~Establish baseline for unplanned readmissions with an admitting diagnosis of heart failure for members in the Heart Failure DM program~~
- ~~Incorporate HEDIS improvement for CHF into DM program interventions~~
- ~~Evaluate more technology based interventions into DM programs~~
- ~~Assure DM programs are implemented across all populations~~
- ~~Evaluate the overall effectiveness of the CHF Program Member Participation Rates, ED, IP and RX related utilization~~

~~**3. Goals**~~

- ~~CHF - Establish baseline for unplanned readmissions with an admitting diagnosis of heart failure for members in the Heart Failure DM Program~~
- ~~Satisfactions with DM - 90%~~

D. Quality of Clinical Care-Review of Cardiovascular Disease **Owner: Pshyra Jones, D~~irect~~or, H~~ealth Ed~~ &~~and~~ DM**

The Approach

1. Objective

- CCIP Chronic Care Improvement Projects

2. Activity

- CCIP-CMS m~~M~~andatory topic New Goal

Achieve high BP control or improvement among 50% of the members

actively opting into health coaching OneCare
- Achieve high BP control or improvement among 50% of OC members and receiving health coaching interventions
- Achieve high BP medication adherence or improvement for 50% of OC members as identified through PBM date and receiving health coaching interventions through OneCare Connect.
- Reduced unplanned readmissions by 1% below the national readmission rates for OCC members with admitting diagnosis specific to heart failure
- Achieve high BP medication adherence for 50% of members opt-ing into health coaching identified through PBM data

3. Goals

- As determined by CMS

2016~~6~~7 Quality Improvement Work Plan- ~~Health Education & Disease Management~~ ManagementHE & DM
Owner: Pshyra Jones, D~~irec~~tor H~~ealth~~ E~~d~~ & ~~____~~ DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			

Q4			
Year End			

V. Health Education & Disease Management

E. Implementation of Population Health & Wellness Programs **Owner: Pshyra Jones, Director, Health EdD &and DM**

The Approach

1. Objective

- Expand child and adolescent components for the Shape Your Life/Weight Management Program
- Implement Weight Watchers benefit for Shape Your Life CalOptima Medi-Cal members age 15 years or greater
- Design and implement a comprehensive Perinatal Health Program

2. Activity

- Establish program goals, objectives and interventions
- Develop clinical and operational components to expand the reach and capability
- Identify program resources and vendor support (Provider, Health EdD/RD linkages, Community Based Organizations)
- Implementation of revised program design

3. Goals

- Implement revised program design-2017
- Evaluate progress semi-annually

~~**E. *Quality of Care-Clinical Practice Guidelines adoption for Medi-Cal line of business** **Owner: Pshyra Jones, Director Health Ed & DM**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Clinical Practice Guidelines will be reviewed and adopted~~

~~**2. Activity**~~

- ~~Adoption of Clinical Practice Guidelines, as least three (3) will be reviewed and adopted (linked to DM: Diabetes, Asthma, CHF)~~

~~**3. Goals**~~

- ~~100%~~

2016~~7~~ Quality Improvement Work Plan- ~~HE & DM~~~~Health Education & Disease Management~~ Owner: Pshyra Jones, D~~irect~~~~o~~r H~~ealth~~ E~~d~~ & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

F. Quality of Clinical Care-Review of member satisfaction with DM programs Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Annual review of member feedback on the disease management programs to assure high satisfaction and improved health status

2. Activity

- Review annual satisfaction survey results, define areas for improvement and implement interventions to monitor and improve the member experience in DM programs
- Transition manual satisfaction survey to alternate process to gather ongoing feedback

3. Goals

- 90% satisfaction with the DM program

2016 Quality Improvement Work Plan- Health Education & Disease Management Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

~~V. Health Education & Disease Management~~

~~G. Quality of Clinical Care-Review of Cardiovascular Disease~~ ~~Owner: Pshyra Jones, Director, Health Ed and DM~~

~~The Approach~~

~~1. Objective~~

- ~~CCIP Chronic Care Improvement Projects~~

~~2. Activity~~

- ~~CCIP-CMS Mandatory topic New Goal~~
- ~~Achieve high BP control or improvement among 50% of the members actively opting into health coaching OneCare~~
- ~~Achieve high BP control or improvement among 50% of OC members and receiving health coaching interventions~~
- ~~Achieve high BP medication adherence or improvement for 50% of OC members as identified through PBM date and receiving health coaching interventions OneCare Connect~~
- ~~Reduced unplanned readmissions by 1% below the national readmission rates for OCC members with admitting diagnosis specific to heart failure~~
- ~~Achieve high BP medication adherence for 50% of members opt ing into health coaching identified through PBM data~~

~~3. Goals~~

- ~~As determined by CMS~~

2016 Quality Improvement Work Plan- Health Education & Disease Management Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

~~**H. Quality of Clinical Care-Review of Diabetes and All Cause Readmissions** **Owner: Kelly Rex-Kimmet, Director, QA PIPS**~~

~~**The Approach**~~

~~**1. Objective**~~
- ~~PIP Performance Improvement Projects~~

~~**2. Activity**~~
- ~~PIP-DHCS Mandatory Projects-Readmission & Diabetes~~

~~**3. Goals**~~
- ~~As determined by CMS& DHCS~~

H. Quality of Clinical Care – Quality and Performance Improvement Projects **Owner: Kelly Rex-Kimmet, Director, Quality Analytics, ~~PIPS~~Pshyra Jones, Dtr, HE & DM**

The Approach

1. Objective
- Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs)

2. Activity
- QIPs
  - OneCare Diabetes QIP to Improve HbA1c Testing
  - OneCare Connect QIP to Improve 30-day Readmission Rate
- PIPs
  - Medi-Cal Diabetes PIP to Improve HbA1c Testing
  - Medi-Cal PIP to Improve Initial Health Assessments
  - OneCare Connect LTSS PIP to Improve In-Home Support Services Care Coordination

3. Goals

- HbA1c Testing rate at the 50th percentile based on the 2016~~5~~ NCQA Quality Compass
- 16.8% readmissions rate
- 80% HbA1c Testing
- 25% IHA rate
- 35% IHSS Participation rate

2016~~7~~ Quality Improvement Work Plan- ~~Health Education & Disease Management~~HE & DM Owner~~s~~: Kelly Rex-Kimmet, D~~irect~~t~~o~~r, QA~~;~~

Pshyra Jones, Dtr, HE & DM ~~PIPS~~

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

I. Implementation of the Childhood Obesity (Shape your Life) Program — Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Evaluate, identify and develop clinical and operational content for revisions to existing Childhood Obesity Prevention and Treatment Program (COPTP), and develop network of providers to support program for 2016 and beyond

2. Activity

- Evaluate existing COPTP program goals, objectives and interventions
- Develop clinical and operational components to revise existing program design to expand the reach and capability
- Identify program resources and vendor support (Provider, Health ED/RD linkages)
- Implementation of revised program design

3. Goals

- Implement revised program design-2017
- Evaluate progress semi-annually

2016 Quality Improvement Work Plan- Health Education & Disease Management Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

J. Implement Weight Watchers (WW) for Medi-Cal members — Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Design weight Watchers benefit for CalOptima Medi-Cal members age 15yrs or greater

2. Activity

- Obtain MOU and finalize contract between WW and CalOptima organization
- Establish criteria and program goals for participating CalOptima members
- Identify appropriate regulatory approvals for member materials and program incentives

3. Goals

- Implement revised program design 2017
- Evaluate progress semi-annually

2016 Quality Improvement Work Plan- Health Education & Disease Management Owner: Pshyra Jones. Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

K. Implement Home Assessments for member participating in Care Management Programs

Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Design a face to face assessment and coaching option for high risk members with chronic conditions participating in CalOptima Care management programs

2. Activity

- Obtain MOU and contracts with appropriate vendors (TBD)
- Establish criteria and program goals for participating CalOptima members
- Identify appropriate regulatory approvals for member materials and program incentives

3. Goals

- Implement revised program design-2016
- Evaluate progress semi-annually

2016 Quality Improvement Work Plan- Health Education & Disease Management Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

L. Conduct 2016 Group Needs assessment (GNA) — Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- The GNA supports identification of health risks, beliefs, practices, and cultural and linguistic needs for CalOptima's Medi-Cal membership

2. Activity

- Complete Request for Proposal
- Identify eligible CalOptima survey participants based on methodology required by Department of Healthcare Services (DHCS)
- Mail assessment tool available in all 7 threshold languages
- Submit Executive Summary and supporting reports to DHCS by October, 2016

3. Goals

- Complete GNA requirement for 2016

2016 Quality Improvement Work Plan- Health Education & Disease Management Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VI. Access & Availability

A. *Quality of Service and Quality of Clinical Care- Review of Nnotification to mMembers Owners: Laura Grigoruk, Director Provider Relations; Belinda Abeyta

~~A.~~ The Approach Director, Customer Service ~~Dir. Provider Relations~~

~~Belinda Abeyta, Director, Customer Service~~

~~The Approach~~

1. **Objective**
   - Continuity and Ccoordination of Care reviewed and assessed

2. **Activity**
   - Communication to members when a primary care provider is terminated from the network will be assessed. Standard is 30 d days notice. (CCN & HN /Delegation reports)
   - Exception: CalOptima is notified in less than 30 days of termination n, then notification would be within three business days.

3. **Goals**
   - 85%

2016~~6~~7 Quality Improvement Work Plan- Access & Availability
Owner~~s~~: Laura Grigoruk, D~~irect~~o~~r~~, P~~rovider R~~elations~~;~~
~~s &~~ Belinda Abeyta, D~~irect~~o~~r~~, C~~ustomer S~~ervice~~

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VI. Access & Availability

B. *Access to Care: Credentialing of Pprovider ~~n~~Network is ~~m~~Monitored — Owner: Esther Okajima, Di~~rect~~or, QI

The Approach

1. **Objective**
   - Credentialing program activities monitored for volume and timeliness
2. **Activity**
   - New applicants processed within 180 calendar days of receipt of application
   - Report of initial credentialing file activity to CPRC
3. **Goals**
   - 90~~% of~~% of initial credentialing applications are processed within 120 days of receipt of application~~.~~

~~**B. *Access to Care: Credentialing of provider network is monitored — Owner: Novella Quesada, Manager, QI**~~

~~**The Approach**~~

~~1. **Objective**~~
   - ~~Credentialing program activities monitored for timeliness~~

~~2. **Activity**~~
   - ~~New applicants processed within 180 calendar days of receipt of application~~
   - ~~**Report from CPRC~~

~~3. **Goals**~~
   - ~~100%~~

C. Access to Care-Recredentialing of Pprovider N~~n~~etwork is M~~m~~onitored — Owner: Esther Okajima, Di~~rect~~or, QI

The Approach

1. **Objective**
   - Recredentialing of practitioners is completed timely

2. **Activity**
   - Recredentialing is processed everywith 36 months
   - Report of Admin term due to missed recredentialing cycle
   -
   - Report of re-credentialing activity to CPRC

3. **Goals**
   - 100% of all recredentialing files are processed within 36 months of last credentialing date.

~~**C. Access to Care-Recredentialing of provider network is monitored**~~

~~**The Approach**~~

1. ~~**Objective**~~
   - ~~Recredentialing of practitioners is completed timely~~

2. ~~**Activity**~~
   - ~~Recredentialing is processed with 36 month report of Admin term due to missed recredentialing cycle~~
   - ~~Report of # of providers termed due to move, retired, etc~~
   - ~~Quarterly Access & Availability report~~
   - ~~**Report from CPRC~~

3. ~~**Goals**~~
   - ~~100%~~

2016~~6~~7 Quality Improvement Work Plan- Access & Availability Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VI. Access and Availability

~~**D. *Accessibility: Review of access to care** **Owner: Esther Okajima, Manager, QA**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Practitioner accessibility (medical services in a timely manner) is measured, assessed and adjusted as necessary to standard~~

~~**2. Activity**~~

- ~~Data against goals will be measured and analyzed for the following through the implementation of our annual Timely Access study and Customer Service monitoring of wait time~~
  ~~1. Non-urgent primary care appointments within 10 business days~~
  ~~2. Urgent appointments with prior authorization with 96 hours of request~~
  ~~3. Non-urgent primary care appointments within 10 business days~~
  ~~4. Appointment with specialist within 15 business days~~
  ~~5. First pre-natal visit within 10 business days~~
  ~~6. Member services, by telephone ASA 30 seconds with abandonment rate <5%~~

- ~~Health Networks will be issued Corrective Action Plans for their areas of non-compliance~~
  ~~1. Urgent Care appointments with 48 hours of request~~
  ~~2. Appointments with specialist within 15 business days~~
  ~~3. Member services, by telephone ASA 30 seconds with abandonment rate <5%~~
  ~~4. Non-urgent acute care within 3 days of request~~

~~**3. Goals**~~

- ~~Appt.: 90%~~
- ~~Phone: <5%~~

D. *Accessibility: Review of access to care **Owner: Marsha Choo, Manager, QA**

The Approach

1. Objective

- Practitioner accessibility (medical services in a timely manner) is measured, assessed and adjusted as necessary to standard

2. Activity

- Data against goals will be measured and analyzed for the following through the implementation of our annual Timely Access study and Customer Service monitoring of wait time
  1. Urgent care appointments without prior authorization within 48 hours of request
  2. Urgent appointments with prior authorization with 96 hours of request
  3. Non-urgent primary care appointments within 10 business days of request
  4. Appointment with specialist within 15 business days of request
  5. Non-urgent mental health appointment within 10 business days of request
  6. Non-urgent appointment for ancillary services within 15 business days of request
  7. First pre-natal visit within 10 business days
  8. Member services, by telephone ASA 30 seconds with abandonment rate <5%

- Health Networks will be issued Corrective Action Plans in accordance with CalOptima's Access and Availability Policies: GG.1600 and MA.7007

3. Goals

- Appointment: 90% minimum performance level
- Phone: ASA 30 seconds; Abandonment rate <5%

2016~~6~~7 Quality Improvement Work Plan- Access & Availability Owner: ~~Esther Okajima~~Marsha Choo, M~~ana~~g~~e~~r, QA

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VI. Access and Availability

E. *Availability: Review of Availability of Practitioners

Owner: Esther Okajima, Manager, QA; Dr. Donald Sharps, Medical Director, BH

The Approach

1. Objective

- Practitioner availability (geographic distribution) in measured assessed and adjusted to meet standard
- Practitioner availability (cultural, ethnic, racial and linguistic member needs) is measured, assessed and adjusted as necessary to standard
- Availability of practitioners is measured and assessed to Behavioral Health services
- Availability of practitioners is measured and assessed by geographic distribution specific to Behavioral health
- Practitioner availability (practitioner to member ratio) is measured, assessed and adjusted to meet standard

2. Activity

- Practitioner network to determine how the network is meeting the needs and preferences of he plans membership will be measured and analyzed and adjusted as necessary. Each type of PCP and high volume specialist' geographic distribution performance will be measured against set standards
  1. Members within ten (10) miles or thirty (30) minutes of a practitioner
  2. Member within thirty (30) miles or forty0five (45) minutes of a high volume specialist

- Practitioner network on the cultural, ethnic, racial and linguistic needs of membership will be measured and analyzed
- Analyses performance against established quantifiable standards for the number of each type of high volume BH practitioners
- Measure and analyze BH practitioner network to determine how the network is meeting the needs and preferences of the plans membership and adjusts as necessary.
- Measured through quantifiable and measurable standards for each type of BH practitioner by geographic distribution performance against standards
- Member within thirty (30) miles or forty five (45) minutes of a high volume specialist

- Availability of practitioners against goals will be measured and analyzed and adjusted as necessary
  1. Practitioner to Member
  2. Ratio of PCP to Members
  3. Ratio Specialists to Members (Neurology 1:10,000)

~~3. Goals~~

- ~~1:2,000~~
- ~~1:2,000~~
- ~~1:5,000~~
- ~~95%~~
- ~~90%~~
- ~~1:100~~
- ~~100%~~

E. *Availability: Review of Availability of Practitioners

Owners: Marsha Choo, Manager, QA; Dr. Donald Sharps, Medical Director, BHI

The Approach

1. Objective

- Practitioner availability (practitioner to member ratio) is measured, assessed and adjusted to meet standard
- Practitioner availability (cultural, ethnic, racial and linguistic member needs) is measured, assessed and adjusted as necessary to standard
- Practitioner availability (geographic distribution) isn measured, assessed and adjusted to meet standard
- Availability of practitioners is measured and assessed to Behavioral Health services
- Availability of practitioners is measured and assessed by geographic distribution specific to Behavioral health

2. Activity

- Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software
  1. Practitioner network by practitioner type (i.e., PCP, high volume specialists, high impact specialists, ancillary providers, health delivery organizations, ~~etc~~etc.)~~.~~ will be measured for minimum number of providers against goals, assessed and adjusted as necessary
  2. Practitioner network on the cultural, ethnic, racial and linguistic needs of membership minimum number of providers will be measured against goals, assessed and adjusted as necessary~~.~~
  3. Practitioner network by practitioner type (i.e., PCP, high volume specialists, high impact specialists, ancillary providers, health delivery organizations, ~~etc~~etc.)~~.~~ will be measured for geographic distribution performance against set standards

4. Practitioner network by BH practitioner type (i.e., psychiatrist, psychologist, marriage and family therapist and licensed clinical social worker, ~~etc~~etc.)~~.~~ will be measured for minimum number of providers against goals, assessed and adjusted as necessary
5. Practitioner network by BH practitioner type (i.e., psychiatrist, psychologist, marriage and family therapist and licensed clinical social worker, ~~etc~~etc.)~~.~~ will be measured for geographic distribution performance against set standards

3. Activity (cont.)

- Health Networks will be issued Corrective Action Plans in accordance with CalOptima's Access and Availability Policies: GG.1600 and MA.7007

4. Goals

- Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007

2016~~6~~7 Quality Improvement Work Plan- Access & Availability Owners: ~~Esther Okajima~~Marsha Choo, Manager, QA;

Donald Sharps, MD, Medical Di~~rec~~tor, BHI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

A. *Safety of Clinical Care-Providers shall have timely and complete facility site reviews — **Owner: Esther Okajima, Director, QI**

The Approach

1. Objective

- To assure all new and re-credentialed providers are compliant with FSR/MRR/PAR requirements

2. Activity

- Facility Site Reviews (FSR), Medical Record Reviews (MRR) and Physical Accessibility Review Surveys (PARS) are completed as part of initial and re-credentialing cycles
- Report of FSR/MRR/PARS activity to CPRC

3. Goals

- 100% of FSR/MRR/PARS Initial or Full Scope Surveys are completed within initial and re-credentialing timeframes.

~~**A. *Safety of Clinical Care-Providers shall have timely and complete facility site reviews** — **Owner: Novella Quesada, Manager, QI**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~To assure all new and recredentialed providers are compliant with FSR/MRR/PAR requirements~~

~~**2. Activity**~~

- ~~Facility Site Reviews (FSR), Medical Record reviews (MRR) and Physical Accessibility Reviews (PARs) are completed as part of initial & recredentialing cycles~~

~~**3. Goals**~~

- ~~80%~~

2016~~6~~7 Quality Improvement Work Plan- Patient Safety Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~D~~irect~~or, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

~~**B. Safety of Clinical care-review and follow-up on member's potential Quality of Care complaints Owner: Novella Quesada Manager, QI**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~To assure all PQI's are evaluated for severity and investigated in a timely fashion (90 days)~~

~~**2. Activity**~~

- ~~QI Nurse Specialists and Med Directors review cases….reported to CPRC~~
- ~~Report to CPRC~~
- ~~Report PQI Productivity activity Report~~
- ~~Discuss PQIs with a severity code of 3 and 4~~

~~**3. Goals**~~

- ~~80%~~

B. Timeliness of Clinical Care R~~care r~~eview and F~~f~~ollow-up on Potential Quality of Care Issues Owner: Esther Okajima, D~~irec~~t~~o~~r, QI

The Approach

1. Objective

To assure patient safety and enhance patient experience by timeliness of clinical care reviews~~.~~

2. Activity

- QI Nurse Specialists and Medical Directors review cases and provide determination~~.~~
- Report all case results to CPRC for discussion~~,~~
- ~~any~~Present cases that have a severity rating of ~~-~~ 1 ~~exceed the threshold level of 1~~ (one) or higher will be presented to CPRC for action~~.~~

Follow through on Medical Director determination, when applicable, to ensure

- closure and compliance of all cases
- Conduct a PQI trend analysis at least two times a year ~~of all cases.~~

~~Conduct a PQI trend analysis at least two times/year~~

3. Goals

- ~~To achieve~~Achieve a turnaround time of 90 days on 90% of cases received
- Review data for trends and~~&~~ patterns for potential further actions~~.~~

2016~~6~~7 Quality Improvement Work Plan- Patient Safety_____ Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~D~~irect~~or, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

~~C. *Safety of Clinical Care and Quality of Clinical Care reviewed through Pharmacy Management~~ ~~Owner: Kris Gericke,PharmD, Director, Pharmacy Management~~

~~The Approach~~

~~1. Objective~~
- ~~To promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima Members.~~

~~2. Activity~~
- ~~Review and update the CalOptima Plan Formularies on an ongoing basis in order to ensure access to quality pharmaceutical care which is consistent with the program's scope of benefits~~
- ~~Review anticipated and actual utilization trends including specialty medications~~
- ~~Review and evaluate pharmacy related issues related to delivery of health care to CalOptima's members~~
- ~~Report on medication recalls and process for informing members and providers~~
- ~~Report on Underutilization of Asthmatics not receiving long term controllers, Diabetics not receiving statins, Diabetics with Hypertension not receiving ACE/ARB~~
- ~~Overutilization/PolyPharmacy-Report on interventions for preventing opiod overuse to include Pharmacy home, Monthly RX limit, Opiod overutilization (MED over 120mg.)~~

~~3. Goals~~
- ~~100%~~

C. *Safety of Clinical Care and Quality of Clinical Care reviewed through Pharmacy Management **Owner: Kris Gericke, Pharm.D., Director, Pharmacy Management**

The Approach

1. Objective
- To promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima Members~~.~~

2. Activity

Monitor for underutilization of pharmaceuticals and provide education to providers.
- Underutilization of long-term controllers for members diagnosed with asthma.
- Underutilization of osteoporosis therapies for members receiving corticosteroids.
- Underutilization of calcium for members with a diagnosis of osteoporosis.
- Underutilization of statins for members with diabetes.

- Programs to prevent overutilization include:
  - Monthly prescription limit.
  - Pharmacy Home Pprogram.
  - Prescriber Restriction Pprogram.
  - Opioid overutilization monitoring.

3. Goals

- Reductions in underutilization and overutilization measures

2016~~6~~7 Quality Improvement Work Plan- Patient Safety_____ _____Owner: Kris Gericke, Pharm.D., D~~irect~~ir, Pharm~~ana~~acy M~~anag~~anag~~emen~~emnt

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

D. *Safety of Clinical Care and Quality of Clinical Care- Review of Specialty Drug Utilization — **Owner: Kris Gericke,PharmD, Director, Pharmacy Services**

The Approach

1. Objective

- Provide ongoing monitoring of specialty drug trends

2. Activity

- Review and reporting of Specialty Drug trends, identify any actions necessary with the member or provider/HN

3. Goals

- TBD

~~2016 Quality Improvement Work Plan- Patient Safety Owner: Kris Gericke, Director, Pharmacy Services~~

~~Monitoring~~	~~Assessments, Findings, Monitoring of Previously Identified Issues~~	~~Next Steps~~	~~Target Completion~~
~~Q1~~			
~~Q2~~			
~~Q3~~			
~~Q4~~			
~~Year End~~			
~~Outcomes~~	~~Results / Metrics~~	~~Next Steps~~	~~Target Completion~~
~~Q1~~			
~~Q2~~			
~~Q3~~			
~~Q4~~			
~~Year End~~			

VII. Patient Safety

D. *Patient Safety-Review and assessment of CBAS Quality Monitoring

Owner: Esther Okajima, Director, QI

The Approach

1. Objective

- Review of CBAS Quality monitoring of services provided

2. Activity

- CBAS Quality Assurance - continue to assess compliance of contracted CBAS centers.
- Report to LTSS QI SubcommitteeC
- Report Member Satisfaction Survey Results
- Report CDA audit results in comparison to past results

3. Goals

- 100% CDA Audit Results

E. Patient Safety-Review and Aassessment of SNF Quality Monitoring

Owner: Esther Okajima, Director, QI

The Approach

1. Objective

- Review of SNF Quality monitoring of services provided

2. Activity

- SNF Quality Assurance - continue to assess compliance of contracted SNF centers.
- Report to LTSS QIC
- Report on progress of on-siresite visits and CAPs issued
- Report on Member Satisfaction Survey Results

3. Goals

- 100% DHCS Audit results

~~E. *Patient Safety-Review and assessment of CBAS Quality Monitoring Owner: Novella Quesada, Manager, QI~~

~~The Approach~~

~~1. Objective~~

- ~~Review of CBAS Quality monitoring of services provided~~

~~2. Activity~~

- ~~CBAS Quality Assurance-continue to assess compliance of contracted CBAS centers.~~
- ~~Report to LTSS QIC~~
- ~~Report Member Satisfaction Survey Results~~
- ~~Report CDA audit results in comparison to past results~~

~~3. Goals~~

- ~~100% CDA Audit Results~~

~~F. Patient Safety-Review and assessment of SNF Quality Monitoring~~

~~The Approach~~

~~1. Objective~~

- ~~Review of SNF Quality monitoring of services provided~~

~~2. Activity~~

- ~~SNF Quality Assurance-continue to assess compliance of contracted SNF centers.~~
- ~~Report to LTSS QIC~~
- ~~Report on progress of on-sire visits and CAPs issued~~
- ~~Report on Member Satisfaction Survey Results~~

~~3. Goals~~

- ~~100% DHCS Audit results~~

2016~~6~~7 Quality Improvement Work Plan- Patient Safety Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director, QI

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

~~G.~~**F. *Safety of Clinical Care-Review of antibiotic usage** **Owner: Kelly Rex-Kimmet ~~Dir~~Dir.tr, ~~of Quality Analytics~~QA**

The Approach

1. **Objective**
   - Increase the appropriate testing for children with Pharyngitis rate (CWP)
   - Appropriate treatment for children with upper respiratory infection (URI) to meet goals
   - Improve appropriate use of antibiotics in Adults with Acute Bronchitis (AAB)

2. **Goals**
   - Appropriate Testing for Children with Pharyngitis~~-~~: 63.24% (25th percentile)~~68.53%~~
   - Appropriate treatment for Children with URI:~~L~~ 93.~~2~~38% (75th percentile)
   - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) 22.25% (25th percentile)~~91.21%~~

20167 Quality Improvement Work Plan- Patient Safety Owner: Kelly Rex-Kimmet, Director, QA

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

~~**H. Implementation of the new PBM** **Owner: Kris Gericke, Dir of Pharmacy**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Provide ongoing monitoring of the implementation of the new PBM: quality of care, service, clinical metrics~~

~~**2. Activity**~~

- ~~Review and report on clinical and service metrics for Med Impact, as it relates to STARS, HEDIS, Quality of care, Quality of Service~~

~~**3. Goals**~~

- ~~TBD~~

G. Pharmacy Benefit Manager (PBM) Oversight Management **Owner: Kris Gericke, Pharm.D., D~~irect~~or, Pharm~~acy Manag~~e~~m~~ent~~**

The Approach

1. Objective

- Provide ongoing monitoring of the PBM: quality of care, service, timeliness

2. Activity

- Review and report on clinical and service metrics for MedImpact~~,~~ as it relates to performance guarantees

3. Goals

- Meet performance guarantees per the contract

20167 Quality Improvement Work Plan- Patient Safety Owner: Kris Gericke, Director, Pharmacy

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VIII. Member Experience

~~A. Quality of Service-Review of Member Satisfaction~~ ~~Owner: Kelly Rex-Kimmet, Director, Quality Analytics~~

~~The Approach~~

~~1. Objective~~
- ~~Annual review of member feedback (CAHPS, complaints & grievances); identification of areas for improvement~~

~~2. Activity~~
- ~~Identify key areas of concern and implement related activities to improve Member Experience (CAHPS)~~
- ~~Work in conjunction with the Health Networks and other Delegates to monitor and improve the Member Experience~~

~~3. Goals~~
- ~~Annual CAHPS results~~

A. Quality of Service-Review of Member Satisfaction Owner: Kelly Rex-Kimmet, ~~Director~~, ~~Quality Analytics~~

The Approach

1. Objective
- Annual review of member feedback (CAHPS, complaints & grievances); identification of areas for improvement

2. Activity
- Identify key areas of concern and implement related activities to improve Member Experience (CAHPS)
- Work in conjunction with the Health Networks and other Delegates to monitor and improve the Member Experience

3. Goals
- Annual CAHPS results

20167 Quality Improvement Work Plan- Member Experience Owner: Kelly Rex-Kimmet, Director, QA

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VIII. Member Experience

B. *Quality of Service-Reviewed through customer service first call resolution **Owner: Belinda Abeyta, Director, Customer Service**

The Approach

1. **Objective**
   - Gather data and information from members after interface with Customer Service
   - to assure expectations/reason for call was resolved

2. **Activity**
   - Monitor port call information and determine key strategies to assure first call
   - resolution/member satisfaction with customer service

3. **Goals**
   - 85% of calls resolved at first call

20167 Quality Improvement Work Plan- Member Experience Owner: Belinda Abeyta, Director, Customer Service

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VIII. Member Experience

C. *Quality of Service - -Reviewed through Customer Service access

Owner: Belinda Abeyta, Director, Customer Service

The Approach

1. **Objective**
   - Customer Service call lines evaluated for average speed to answer
   - Customer Service call line evaluated for call abandonment rate
   - ~~Customer Service call lines evaluated for hold times~~

2. **Activity**
   - Customer Service lines monitored for average speed to answer
   - Customer service lines monitored for abandonment rate
   - ~~Customer service lines monitored for hold time~~

3. **Goals**
   - ASA 30 seconds
   - <3%
   - ~~Hold time under 30 seconds~~
   - First Call Resolution 85%

20167 Quality Improvement Work Plan- Member Experience Owner: Belinda Abeyta, Director, Customer Service

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VIII. Member Experience

D. Quality of Care and ~~&~~ Service Reviewed through GARS & PQI (MOC)

Owners: Janine Kodama, Director, ~~D.~~ & Appeals; ; ~~Novella Quesada, Manager~~Laura Guest, Supervisor, QI

The Approach

1. **Objective**
   - Global review of member "pain points" (Grievances, Complaints and Quality of Care);
   - assure appropriate actions are taken to assist the member experience

2. **Activity**
   - Quarterly review of all GARS and PQI data to identify issues and trends; implement any necessary corrections
   - Report QIC
   - HN quarterly totals ~~by PMPM oo~~f grievance and PQI ~~and steps taken to address with HN~~
   - Conduct a GARS trend analysis at least two times per y~~y~~ear

3. **Goals**
   - Improve over 2015 performance

2016~~6~~7 Quality Improvement Work Plan- Member Experience ~~__~~ ~~—~~Owners: Janine Kodama, Director, GARS; ~~Novella Quesada, Manager~~Laura Guest, Super~~vis~~or, QI

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

IX. HEDIS/STARS Improvement

A. Improve identified HEDIS Measures listed on "Measure" worksheet — Owner: Kelly Rex-Kimmet Director, Quality Analytics

The Approach

1. **Objective**
   - Regain "Commendable" NCQA accreditation rating
   - Maintain or exceed NCQA 4.0 health plan rating
2. **Activity**
   - See measures worksheet for specific activities
3. **Goals**
   - See measures worksheet

B. Improve identified STARS measures listed on "Measures" worksheet

The Approach

1. **Objective**
   - Maintain or exceed 4.0 CMS STAR rating
2. **Activity**
   - See measures worksheet for specific activities
3. **Goals**
   - See measures worksheet

~~IX. HEDIS/STARS Improvement~~

~~C. Improve CAHPS measures listed on “Measures” worksheet~~

~~The Approach~~

~~1. Objective~~
- ~~Achieve 3.0 CAHPS score~~

~~2. Activity~~
- ~~See Measures worksheet for specific activities~~

~~3. Goals~~
- ~~See Measures worksheet~~

~~D. HEDIS: Launch pediatric wellness clinic~~

~~The Approach~~

~~1. Objective~~
- ~~Improve child and adolescent HEDIS measures (i.e. adolescent immunizations, childhood immunizations, adolescent well care)~~

~~2. Activity~~
- ~~Evaluate options to deliver pediatric preventive care, including immunizations in unique settings to achieve higher adherence~~
- ~~Work in conjunction with the HN and CCN providers on this initiative~~

~~3. Goals~~
- ~~Improve HEDIS rates per measure worksheet~~

~~IX. HEDIS/STARS Improvement~~

~~E. STARS Improvement-Medication Adherence Measures~~ ~~Owner: Kris Gericke, Director, Pharmacy~~

~~The Approach~~

~~1. Objective~~
- ~~Improve the 3 Medication Adherence Measures to achieve 4 Star Performance in each measure~~

~~2. Activity~~
- ~~Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)~~

~~3. Goals~~
- ~~See measures worksheet~~

~~F. HEDIS: Health Network support of HEDIS & CAHPS improvement~~ ~~Owner: Kelly Rex-Kimmet, Director, Quality Analytics~~

~~The Approach~~

~~1. Objective~~
- ~~Provider regular reporting to the Health Networks to ensure HEDIS improvement for expected measures~~

~~2. Activity~~
- ~~Provide ongoing reports to Health Networks on their specific HEDIS & CAHPS performance, including patient lists for intervention~~
- ~~Gather feedback from Health Networks on tools to assist in HEDIS & CAHPS improvement activities~~

~~3. Goals~~
- ~~24.33%~~

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion
**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures MC and OC members - in conjunction with Diabetes Disease Management Program	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	90th percentile for all subsmeasures	2016 April, July, October
**HEDIS/STARS Improvement: Review and assessment Controlling Blood Pressure*	Increase the BP control for MC and OC members to meet goal	Blood pressure control will increase through member outreach and education with member diagnosed with hypertension.	MC: 70.32% (90th percentile) OC 79.15% (75th percentile)	2016 April, July, October
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medi-Cal <15% Readmission rate Medicare <14% Readmission rate	2016 April, July, October
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and 2. OC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	2016 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
HEDIS: Review of prenatal & postpartum care services (PPC)	Increase the prenatal and postpartum care rate for all Medi-Cal deliveries to meet goal	The number of prenatal and postpartum care visits will increase through provider education to submit Prenatal Notification Reports, member and provider education and sharing of provider data. Utilize Text For Baby custom messages to encourage member compliance.	MC Prenatal: 85.19% (50th percentile) MC Postpartum: 68.85% (75th percentile)	2016 April, July, October
HEDIS: Review and assessment prescribed ADHD medication (ADHD)	Increase the follow-up care for children prescribed ADHD medication rate in MC children who were newly prescribed an ADHD medication to meet goal	Follow-up care for children with newly prescribed ADHD medication will increase through member and provider education and reminder letter to members.	Initiation Phase: 40.79% (50th percentile) Maintenance Phase: 50.61% (50th percentile)	2016 April, July, October
HEDIS: Review and assessment of antidepressant medication management (AMM)	Increase the antidepressant medication management rate in MC and OC members with a diagnosis of major depression to meet goal	Antidepressant medication management rates will increase with the distribution of member health education material.	Acute Phase Treatment: MCAL 62.56% (90th percentile) Continuation Phase Treatment: 33.93% OneCare: Effective Phase Treatment 66.67% Continuation Phase Treatment 52.87%	2016 Mar Jun Sep Dec
****HEDIS/STARS**: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	OC: 49.48% (75th percentile)	2016 April, July, October
HEDIS: Review and assessment of treatment of bronchitis (AAB)	Increase the avoidance of antibiotic treatment in adults with acute bronchitis rate in MC members with a diagnosis of acute bronchitis to meet goal	Avoidance of antibiotic treatment in adults with a diagnosis of acute bronchitis rate in MC members 18-64 years old will increase through member and provider education.	MC: 26.30% (50th percentile)	2016 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
HEDIS: Review and assessment of childhood immunization rates	Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal	Immunization in children by their 2nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 49.63% (90th percentile)	2016 April, July, October
HEDIS: Review and assessment of adolescent Immunization rates	Increase the adolescent immunization rate to meet goal	Adolescent immunizations will improve through a adolescent focused event that will provide immunization opportunities, member education and member resources.	75th percentile (or above) 59.98%	2016 April, July, October
HEDIS: Review and assessment of appropriate testing for pharyngitis rates - - -	Increase the appropriate testing of pharyngitis in children 2-18 years of age to meet goal - - -	Appropriate testing for pharyngitis will improve through the distribution of strep A tests and provider education.	MC: 71.48% (50th percentile)	2016 April, July, October - - -
HEDIS: Review and assessment of use of imaging studies for low back pain - - -	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain) - - -	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education	MC: 74.95% (50th percentile) - - -	2016 April, July, October - - -
***STARS Improvement** Medication Adherence Measures	Improve the 3 Medication Adherence Measures to achieve 4 Star performance in each measure	Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)	4 Stars	2016 Mar Jun Sep Dec
CAHPS: Rating of Health Plan	Increase CAHPS score on Rating of Health Plan	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	50th Percentile or higher	2016 Mar Jun Sep Dec

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion~~
~~CAHPS: Getting Needed Care~~	~~Increase CAHPS score on Getting Needed Care~~	~~Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Needed Care.~~	~~50th Percentile or higher (2.52)~~	~~2016 Mar Jun Sep Dec~~
~~CAHPS: Getting Care Quickly~~	~~Increase CAHPS score on Getting Care Quickly~~	~~Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Care Quickly.~~	~~50th Percentile or higher~~	~~2016 Mar Jun Sep Dec~~
~~CAHPS: How Well Doctors Communicate~~	~~Increase CAHPS score on How Well Doctors Communicate~~	~~Tips on "Preparing for your Dr. Visit," toolkits/decision tools for PCPs, and provider and office staff in-service on customer service will improve rating on How Well Doctors Communicate.~~	~~50th percentile or higher~~	~~2016 Mar Jun Sep Dec~~
~~CAHPS: Customer Service~~	~~Increase CAHPS score on Customer Service~~	~~Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service.~~	~~50th percentile or higher~~	~~2016 Mar Jun Sep Dec~~
~~HOS: Health Outcome Survey Measures~~	~~Improve HOS measures for Star Rating~~	~~Develop and implement activities around: 1)Reducing Risk of Falls 2)Improving Physical Health Status 3)Improving Mental Health Status~~	~~50th percentile or higher~~	~~2016 Mar Jun Sep Dec~~

A. Improve identified HEDIS ~~HEDIS~~ Measures listed on "Measures" worksheet **Owners: Kelly Rex-Kimmet ~~Director~~, Quality ~~Analytics~~**

The Approach

1. Objective

- Maintain "Commendable" NCQA accreditation rating

- Maintain or exceed NCQA 4.0 health plan rating
- Earn Quality Withhold Dollars back for OneCare Connect for all HEDIS measures in OCC QW program~~Maintain "Commendable" NCQA accreditation rating~~
- ~~Maintain or exceed NCQA 4.0 health plan rating~~

2. Activity

- See M~~m~~easures worksheet for specific activities

3. Goals

- See M~~m~~easures worksheet

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures MC and OC members - in conjunction with Diabetes Disease Management Program	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	Medicaid: • A1C Screening: ~~86.0%~~85.95% (50th percentile) • A1C Control <8.0%: ~~55.47%~~52.55% (~~Between~~ 75th ~~and 90th~~ percentile) • A1C Control >9.0%: ~~33.05%~~36.87% (lower score is better) ~~Between~~ (75th ~~and 90th~~ percentile) • Eye Exams: ~~65.1%~~61.5 (75th percentile) • Nephropathy Screening: 90.51% (50th percentile) • BP Control: ~~72.17%~~68.61% (~~between~~ 75th ~~and 90th~~ percentile) Medicare: • A1C Screening: 91.4% • A1C Control <8.0%: 72.8% • A1C Control >9.0 18.8% (lower score is better) • Eye Exams: 82% Nephropathy Screening: 95.8% • BP Control: 79.3%	2017 April, July, October
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program.	Medi-Cal <145% Readmission rate Medicare <14% Readmission rate OCC <11% readmission Rate (Quality Withhold goal)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
members (PCR)		A reporting mechanism will be established followed by analysis of data.		
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and 2. OC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	2017 April, July, October
HEDIS: Review of prenatal & postpartum care services (PPC)	Increase the prenatal and postpartum care rate for all Medi-Cal deliveries to meet goal	The number of prenatal and postpartum care visits will increase through provider education to submit Prenatal Notification Reports, member and provider education and sharing of provider data. Utilize Text-For-Baby custom messages to encourage member compliance.	MC Prenatal: 82.25% (50th percentile) MC Postpartum: ~~65.96~~67.53% (~~66th~~75th -percentile)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
~~**Cervical Cancer Screening**~~**Lead Screening (Monitoring Measure)**	Increase lead screening rate~~Increase the cervical cancer screening rate for Medi-Cal to meet DHCS MPL of 25th percentile~~	~~Cervical cancer screening rate will increase through office staff, provider and member incentives as well as planned campaigns for women's health preventive screenings.~~Analyze data to determine low performing HN. Implement initiatives to address identified barriers to better performance (data strategy as well as provider outreach)	MC: 75.7% (66th percentile)~~MC:~~	
HEDIS: Review and assessment prescribed ADHD medication (ADHD)	Increase the follow-up care for children prescribed ADHD medication rate in MC children who were newly prescribed an ADHD medication to meet goal	Follow-up care for children with newly prescribed ADHD medication will increase through member and provider education and reminder letter to members.	Initiation Phase: 42.19% (50th percentile) Maintenance Phase: ~~40.91~~52.47% (~~25~~50th percentile)	2017 April, July, October
HEDIS: Review and assessment of antidepressant medication management (AMM)	Increase the antidepressant medication management rate in MC and OC members with a diagnosis of major depression to meet goal	Antidepressant medication management rates will increase with the distribution of member health education material.	MC: Acute Phase Treatment: ~~56.65%~~59.52 (~~66~~75th percentile) MC: Continuation Phase Treatment: 41.46% (66th percentile) OC: Effective Phase Treatment 68.66% (50th percentile) OC: Continuation Phase Treatment 54.76% (50th percentile)	2017 Mar Jun Sep Dec
HEDIS/STARS: Review and assessment of	Increase the osteoporosis management in women	Osteoporosis management in women who had a	OC: 47.6% (66th percentile)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
osteoporosis management (OMW)	who had a fracture rate in OC women who suffered a fracture to meet goal	fracture will increase through improved member identification using claims and pharmacy data and provider education.		- -
~~**HEDIS**: Review and assessment of treatment of bronchitis (AAB)~~	~~Increase the avoidance of antibiotic treatment in adults with acute bronchitis rate in MC members with a diagnosis of acute bronchitis to meet goal~~	~~Avoidance of antibiotic treatment in adults with a diagnosis of acute bronchitis rate in MC members 18-64 years old will increase through member and provider education.~~	~~MC: 22.25% (25th percentile)~~	~~2017 April, July, October~~
HEDIS: Review and assessment of childhood immunization rates	Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal	Immunization in children by their 2nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 40.9% (75th percentile)	2017 April, July, October
-	-			-
HEDIS: Review and assessment of use of imaging studies for low back pain ~~**HEDIS:** Review and assessment of adult's access to preventive/ambulatory health (AAP)~~	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain) ~~Increase MC and OC adult's access to preventive/ambulatory health to meet goal~~	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education ~~Comprehensive member and provider outreach with reminders to increase access for adults~~	MC: ~~77.09~~73.71% (~~75~~50th percentile) ~~MC: 83.84% (50th percentile)~~ ~~OC: 95.56% (50th percentile)~~	2017 April, July, October ~~2017 April, July, October~~
HEDIS: Review and	Increase MC and OC	Comprehensive member	MC: 82.15% (50th percentile)	2017 April,

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
assessment of adult's access to preventive/ambulatory health (AAP)	adult's access to preventive/ambulatory health to meet goal	and provider outreach with reminders to increase access for adults	OC: 95.56% (50th percentile)	July, October
HEDIS: Review and assessment of children's access to primary care practitioners (CAP)	Increase children's access to primary care practitioners to meet goal	Comprehensive member and provider outreach with reminders to increase access for children	MC: 1) 12-24 months ~~96.28%~~95.74% (50th percentile) 2) 25 months -6 years ~~91.22%~~90.98% (75th percentile) 3) 7-11 years 93.~~90~~25% (75th percentile) 4) 12-19 years ~~90.06%~~89.37% (50th percentile)	2017 April, July, October
HEDIS: Review and assessment of cervical cancer screening (CCS)	Increase the cervical cancer screening in our MC female members 21-64 to meet goal	Increase cervical cancer screening through member and provider outreach and education with reminders.	MC: ~~67.88~~55.94% (~~75~~50th percentile)	2017 April, July, October
HEDIS: Review and assessment of well child visits in the first 15 months of life (W15)	Increase the well care visits for MC children in their first 15 months of life to meet goal	Increase of well care visit for children in their first 15 months of life through member and provider outreach and education with reminders	MC: 59.~~76~~57% (6 or more visits) (50th percentile)	2017 April, July, October
HEDIS: Review and assessment of breast cancer screening (BCS)	Increase the breast cancer screening for MC and OC female members to meet goal	Increase the breast cancer screening through member and provider education and outreach with reminders as ways to decrease barriers to screening	MC: 71.~~41~~52% (90th percentile) OC: 71.36% (50th percentile)	2017 April, July, October
HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile) Monitor for Medicaid population. Develop internal benchmark as National Medicaid Benchmark does not exist.	2017 April, July, October
HOS/STARS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: ~~1~~)Reducing Risk of Falls 2)Improving Physical Health Status		2017 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion (Proposed reporting months to QIC)~~
~~**HEDIS/STARS: Review and assessment Comprehensive Diabetes~~	~~Increase the comprehensive diabetes care measures MC and OC~~	~~Comprehensive diabetes care will increase through member education to~~	~~Medicaid: A1C Screening: 86.0% (50th percentile) A1C Control <8.0%: 55.47% (Between 75th and 90th percentile)~~	~~20167 April, July, October~~

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
Care (CDC)	members - in conjunction with Diabetes Disease Management Program	identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	A1C Control >9.0%: 33.05% (lower score is better) Between 75th and 90th percentile Eye Exams: 65.1% (75th percentile) Nephropathy Screening: 90.51% (50th percentile) BP Control: 72.17% (between 75th and 90th) Medicare: A1C Screening: 91.4% A1C Control <8.0%: 72.8% A1C Control >9.0 18.8% (lower score is better) Eye Exams: 82% Nephropathy Screening: 95.8% BP Control: 79.3%	
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medi-Cal <15% Readmission rate Medicare <14% Readmission rate OCC <11% readmission Rate (Quality Withhold goal)	20167 April, July, October
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	20167 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
	2. OC members 65 years old and older to meet goal			
HEDIS: Review of prenatal & postpartum care services (PPC)	Increase the prenatal and postpartum care rate for all Medi-Cal deliveries to meet goal	The number of prenatal and postpartum care visits will increase through provider education to submit Prenatal Notification Reports, member and provider education and sharing of provider data. Utilize Text For Baby custom messages to encourage member compliance.	MC Prenatal: 82.25% (50th percentile) MC Postpartum: 65.96% (66th percentile)	20167 April, July, October
Cervical Cancer Screening	Increase the cervical cancer screening rate for Medi-Cal to meet DHCS MPL of 25th percentile	Cervical cancer screening rate will increase through office staff, provider and member incentives as well as planned campaigns for women's health preventive screenings.	MC:	
HEDIS: Review and assessment prescribed ADHD medication (ADHD)	Increase the follow-up care for children prescribed ADHD medication rate in MC children who were newly prescribed an ADHD medication to meet goal	Follow-up care for children with newly prescribed ADHD medication will increase through member and provider education and reminder letter to members.	Initiation Phase: 42.19% (50th percentile) Maintenance Phase: 40.91% (25th percentile)	20167 April, July, October
HEDIS: Review and assessment of antidepressant	Increase the antidepressant medication management rate in MC	Antidepressant medication management rates will increase with the	MC: Acute Phase Treatment: 56.65% (66th percentile) MC: Continuation Phase Treatment: 41.46% (66th percentile) OC: Effective Phase Treatment 68.66% (50th percentile)	20167 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
medication management (AMM)	and OC members with a diagnosis of major depression to meet goal	distribution of member health education material.	OC: Continuation Phase Treatment 54.76% (50th percentile)	
**HEDIS/STARS: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	OC: 47.6% (66th percentile)	20167 April, July, October - -
HEDIS: Review and assessment of treatment of bronchitis (AAB)	Increase the avoidance of antibiotic treatment in adults with acute bronchitis rate in MC members with a diagnosis of acute bronchitis to meet goal	Avoidance of antibiotic treatment in adults with a diagnosis of acute bronchitis rate in MC members 18-64 years old will increase through member and provider education.	MC: 22.25% (25th percentile)	20167 April, July, October
HEDIS: Review and assessment of childhood immunization rates	Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal	Immunization in children by their 2nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 40.9% (75th percentile)	20167 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
HEDIS: Review and assessment of appropriate testing for pharyngitis rates	Increase the appropriate testing of pharyngitis in children 2-18 years of age to meet goal	Appropriate testing for pharyngitis will improve through the distribution of strep A tests and provider education.	MC: 63.24% (25th percentile)	20167 April, July, October
HEDIS: Review and assessment of use of imaging studies for low back pain	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain)	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education	MC: 77.09% (75th percentile)	20167 April, July, October
HEDIS: Review and assessment of adult's access to preventive/ambulatory health (AAP)	Increase MC and OC adult's access to preventive/ambulatory health to meet goal	Comprehensive member and provider outreach with reminders to increase access for adults	MC: 83.84% (50th percentile) OC: 95.56% (50th percentile)	20167 April, July, October
HEDIS: Review and assessment of children's access to primary care practitioners (CAP)	Increase children's access to primary care practitioners to meet goal	Comprehensive member and provider outreach with reminders to increase access for children	MC: 1) 12-24 months 96.28% (50th percentile) 2) 25 months -6 years 91.22% (75th percentile) 3) 7-11 years 93.90% (75th percentile) 4) 12-19 years 90.06% (50th percentile)	20167 April, July, October
HEDIS: Review and assessment of cervical cancer screening (CCS)	Increase the cervical cancer screening in our MC female members 21-64 to meet goal	Increase cervical cancer screening through member and provider outreach and education with reminders.	MC: 67.88% (75th percentile)	20167 April, July, October
HEDIS: Review and assessment of well child visits in the first 15 months of life (W15)	Increase the well care visits for MC children in their first 15 months of life to meet goal	Increase of well care visit for children in their first 15 months of life through member and provider outreach and education with reminders	MC: 59.76% (50th percentile)	20167 April, July, October
HEDIS: Review and assessment of breast	Increase the breast cancer screening for MC and OC	Increase the breast cancer screening through member	MC: 71.41% (90th percentile) OC: 71.36% (50th percentile)	20167 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
cancer screening (BCS)	female members to meet goal	and provider education and outreach with reminders as ways to decrease barriers to screening		
HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile)	20167 April, July, October
HOS/STARS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: 1)Reducing Risk of Falls 2)Improving Physical Health Status		20167 Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

B. Improve identified STARS midentified STARS measures listed on "Measures" worksheet **Owners: Kelly Rex-Kimmet Director, Quality Analytics; Kris Gericke, Pharm.D., Director, Pharmacy Management; Tracy Hitzeman, Interim Executive Director, Clinical Operations ; Kris Gericke, Pharm.D., Director, Pharmacy**

~~Management, Tracy Hitzemen, Executive Director,~~

~~Clinical Operations~~

The Approach

1. Objective

- Attain 4.0 CMS STAR rating~~ttain 4.0 CMS STAR rating~~

2. Activity

- See Mmeasures worksheet for specific activities

3. Goals

- See Mmeasures worksheet

~~STARS~~~~HEDIS~~ Measures Worksheet

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion~~
~~**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)~~	~~Increase the comprehensive diabetes care measures- MC and OC members - in conjunction with~~	~~Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to~~	~~90th percentile for all subsmeasures~~	~~20167 April, July, October~~

Scope	Objective	Activity	Goals or Baseline	Target Completion
	Diabetes Disease Management Program	better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)		!
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30-day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medicare <14% Readmission rate	20167 April, July, October - - !
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and 2. OC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	20167 April, July, October
**HEDIS/STARS: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	OC: 49.48% (75th percentile)	20176 April, July, October
HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile)	20167 April, July, October
HOS/STARS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: 1)Reducing Risk of Falls 2)Improving Physical Health Status		20167 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion
**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures OC and OCC members - in conjunction with	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with	Medicare: 1) A1C Control >9:.0 16% (lower score is better;	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
	Diabetes Disease Management Program	targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	CMS 5 star goal) 2) Eye Exams: 82% (maintain 2016 above CMS 5-star goal) 3) Nephropathy Screening: 96% (CMS 4 star goal)	
**HEDIS/STARS Review Adult BMI Assessment	Increase the BMI assessment in adults	Assessment of BMI will increase through provider education and dissemination of BMI assessment tools.	Medicare: 96% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS Improvement: Review Care of Older Adult	Increase the Care of Older Adult Rate in: 1) Medication Review 2) Pain Screening 3) Functional Status Assessment	Care of Older Adult measures to increase through provider education and dissemination of provider tools.	OneCare Only: 1) Medication Review: 87% (CMS 5 star goal) 2) Pain Screening: 88% (CMS 5 star goal) 3) Functional Status Assessment: 74% (CMS 4 star goal)	2017 April, July, October
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with OneCare & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medicare: <10% Readmission rate (CMS 4 star goal)	2017 April, July, October
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in OC and OCC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	Medicare: 74% (CMS 4 star goal)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
**HEDIS/STARS: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC and OCC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	Medicare: 51% (CMS 4 start goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC and OCC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	Medicare: 71% (CMS 4 star goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of breast cancer screening (BCS)	Increase the breast cancer screening for OC and OCC members to meet goal	Increase breast cancer screening through member and provider outreach as well as ways to decrease barriers to screening	Medicare: 76% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of monitoring physical activity	Increase the monitoring of physical activity for OC and OCC members to meet goal	Increase of monitoring of physical activity through provider outreach and education and dissemination of provider tools	Medicare: 57% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of controlling blood pressure (CBP)	Increase of controlling blood pressure rate	Increase of controlling blood pressure rate through provider and member outreach and education	Medicare: 75% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS: Improvement: Rheumatoid Arthritis Management	Increase of rheumatoid arthritis management rate	Increase of rheumatoid arthritis management through provider education	Medicare: 72% (CMS 3 star goal)	2017 April, July, October
**HEDIS: Follow-up after Hospitalization for Mental Illness (7 days / 30 days)	Increase follow-up after hospitalization for mental illness	Increase follow-up after hospitalization through collaboration with our behavioral health partner to conduct provider education and member outreach through reminders.	Medicare: 56% (Quality Withhold Goal)	2017 April, July, October
**HOS/STARS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: 1) Reducing Risk of Falls 2) Improving Physical Health Status 3) Improving Mental Health Status	Medicare: 1) Reducing Risk of Falls: 73% (CMS 5 star goal) 2) Improving Physical Health Status: 72% (CMS 4 star goal) 3) Improving Mental Health Status: 87% (CMS 5 star goal	2017 Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

C. Improve CAHPS measures listed on "Measures" worksheet

Owner: Kelly Rex-Kimmet Director, Quality Analytics

The Approach

1. Objective

- Achieve 3.0 CAHPS score
- Attain 4.0 CMS STAR rating
- Meet CMS STAR Goals

2. Activity

- See Measures worksheet for specific activities

3. Goals

- See Measures worksheet

CAHPS MHEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion
CAHPS: Rating of Health Plan	Increase CAHPS score on Rating of Health Plan	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	50th Percentile or higher	20167 Mar Jun Sep Dec
CAHPS: Getting Needed Care	Increase CAHPS score on Getting Needed Care	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating	50th Percentile or higher (2.52)	20167 Mar Jun Sep Dec

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion~~
		~~of Getting Needed Care.~~		
~~CAHPS: Getting Care Quickly~~	~~Increase CAHPS score on Getting Care Quickly~~	~~Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Care Quickly.~~	~~50th Percentile or higher~~	~~20167 Mar Jun Sep Dec~~
~~CAHPS: How Well Doctors Communicate~~	~~Increase CAHPS score on How Well Doctors Communicate~~	~~Tips on "Preparing for your Dr. Visit," toolkits/decision tools for PCPs, and provider and office staff in-service on customer service will improve rating on How Well Doctors Communicate.~~	~~50th percentile or higher~~	~~20167 Mar Jun Sep Dec~~
~~CAHPS: Customer Service~~	~~Increase CAHPS score on Customer Service~~	~~Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service.~~	~~50th percentile or higher~~	~~20167 Mar Jun Sep Dec~~

Scope	Objective	Activity	Goals or Baseline	Target Completion
STARS: CAHPS: Rating of Health Plan	Increase CAHPS score on Rating of Health Plan	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	Medicaid: 50th Percentile or higher Medicare: 82% (CMS 3 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Getting Needed Care	Increase CAHPS score on Getting Needed Care	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Needed Care.	Medicaid: 50th Percentile or higher (2.52) Medicare: 79% (CMS 2 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Getting Care Quickly	Increase CAHPS score on Getting Care Quickly	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider	Medicaid: 50th Percentile or higher	2017 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion
		capacity and geoaccess standards will improve rating of Getting Care Quickly.	Medicare: 72% (CMS 2 star goal)	
CAHPS: How Well Doctors Communicate	Increase CAHPS score on How Well Doctors Communicate	Tips on "Preparing for your Dr. Visit," toolkits/decision tools for PCPs, and provider and office staff in-service on customer service will improve rating on How Well Doctors Communicate.	Medicaid: 50th percentile or higher	2017 Mar Jun Sep Dec
STARS:CAHPS: Customer Service	Increase CAHPS score on Customer Service	Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service.	Medicaid: 50th percentile or higher Medicare: 86% (CMS 3 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Getting Needed Prescription Drugs	Increase CAHPS score on Getting Needed Prescription Drugs		Medicare: 89% (CMS 3 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Care Coordination	Increase CAHPS score on Care Coordination	Provider and office staff in-service on best practices to better coordinate care for members will improve rating on Care Coordination.	Medicare: 82% (CMS 2 star goal)	2017 Mar Jun Sep Dec
STARS: CAHPS: Overall Rating of Health Care Quality	Increase CAHPS score on Overall Rating of Health Care Quality	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	Medicare: 82% (CMS 2 star goal)	2017 Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

D. STARS-Medication Related Measures

Owner: Kris Gericke, Pharm.D., Director, Pharmacy Management

The Approach

1. Objective

- Optimal Performance in the CMS Pharmacy Star and Display Measures.

2. Activity

- Decrease utilization of high-risk medications
  - Formulary controls
  - Prior authorization criteria
  - Prescriber education
- Antipsychotic use in members with dementia in nursing homes

- Prescriber education
- LTC quality incentive program

- Appropriate dosing of oral diabetes medications
  - Formulary controls
  - Prior authorization criteria
  - Prescriber education
- Medication Adherence
  - Comprehensive member and & provider outreach to identified members who appear non-adherent with medication management (interventions based on unique member characteristics)
  - Interventions include:
    - Outreach
    - Pre-Assessment: Modified Morisky Scale (MMS) for knowledge, /motivation and confidence
    - Mailings - lL etter with member's action plan, Healthy You, medication log;
    - Ffollow--up calls as needed
  - Outcomes include:
    - Pre –and Post--PDC rates to measure program success
    - Evaluate member's improvement in knowledge, motivation (MMS) and confidence
    - Evaluate member survey results

3. Goals

- Scores above the national MA-PD average as reported by CMS

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion
***STARS Improvement -** Medication Adherence Measures	Improve the 3 Medication Adherence Measures to achieve 4 Star performance in each measure	Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)	4 Stars	2016~~7~~ Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

E. HEDIS: Health Network support of HEDIS & CAHPS improvement

Owner: Kelly Rex-Kimmet, Director, Quality Analytics

The Approach

1. Objective

- Provider regular reporting to the Health Networks to ensure HEDIS improvement for expected measures

2. Activity

- Provide ongoing reports to Health Networks on their specific HEDIS & CAHPS performance, including patient lists for intervention
- Gather feedback from Health Networks on tools to assist in HEDIS & CAHPS improvement activities

3. Goals

- 24.33%

HEDIS Measures **Owner: Marsha Choo, Manager, QA**

	Results / Metric	Next Steps	Target Completion
Diabetes Ccare			
Controlling Blood Pressure			
30-Day ReadmmsionsReadmissions			
Flu & PheumoccalPneumococcal Rates			
Prenatal Care			
Post PartumPost-Partum			
ADMHD			
Antidepressant Medication MgmtManagement			
Osteoporosis MgmtManagement			

Antibiotics Use/ Bronchitis			
Childhood Immunizations. Combo 10			
Adolescent Immunizations	Not on HEDIS Measures worksheet		
Low Back Pain			
Adult Access to Preventive Care (AAP)			

CAHPS Measures Team — **Owner: Member Experience**

	Results / Metric	Next Steps	Target Completion
Rating of Health			
Getting Needed Care			
Getting Care Quickly			
How ~~W~~well Doctors Communicate			
Customer Service			

STARS **Owner: Kris Gericke, PharmDPharm.D, Director, Pharmacy**

	Results / Metric	Next Steps	Target Completion
Cholesterol			
Hypertension			
Diabetes			

Health Outcomes Survey **Owner: Marsha Choo, Manager, QA**

	Results / Metric	Next Steps	Target Completion
Reducing Risk of Falls			
Improving Physical Health Status			
Improving Mental Health Status			

X. Delegation Oversight

~~**A. Delegation Oversight of CM** **Owner: Tracy Hitzeman, Director, CM**~~

~~**The Approach**~~

~~**1. Objective**~~
- ~~Regular review of the Health Network's performance of CM functions~~

~~**2. Activity**~~
- ~~Assure compliance to all regulatory and accreditation delegation oversight requirements~~
- ~~**Report from DOC~~

~~**3. Goals**~~
- ~~100%~~

A. Delegation Oversight of CM **Owner: Sloane Petrillo, Interim D~~irec~~tor, CM**

The Approach

1. Objective
- Regular review of the Health Network's performance of CM functions

2. Activity
- Review of 100% of MOC files with monthly feedback provided to Health Networks
- Assure compliance to all regulatory and accreditation delegation oversight requirements
- **Report from DOC

3. Goals
- 90%

201~~6~~7 Quality Improvement Work Plan--Delegation Oversight Owner: ~~Tracy Hitzeman~~Sloane Petrillo, Interim Di~~rec~~t~~o~~r, CM

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

X. Delegation Oversight

B. Quality of Care and & Service of UM through Ddelegation oOversight rReviews ——— Owner: Solange Marvin Directo r, Audit & Oversight

The Approach

1. **Objective**
   - Delegation Oversight of Health Networks to assess compliance
2. **Activity**
   - Delegated entity oversight supports how UM delegated activities are performed
   - to expectations and compliance with standards, such as Prior Authorizations
   - **Report from DAOC
3. **Goals**
   - 98%

20167 Quality Improvement Work Plan- Delegation Oversight Owner: Solange Marvin, Director, Audit & Oversight

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

X. Delegation Oversight

C. Delegation oversight of BH Services

Owner: ~~Solange Marvin~~Dr. Edwin Poon, D~~irec~~tor, ~~Audit & Oversight~~BH~~I~~SI

The Approach

1. **Objective**
   - Regular review of the MBHO's performance of BH functions

2. **Activity**
   - Assure compliance to all regulatory and accreditation delegation oversight requirements
   - **Report from ~~D~~AOC

3. **Goals**
   - 98%

2016~~7~~ Quality Improvement Work Plan- Delegation Oversight ——— Owner: ~~Solange Marvin~~Dr. Edwin Poon, D~~irec~~t~~o~~r, ~~Audit & Oversight~~BH~~I~~SI

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

XI. Organizational Projects

A. Implementation of the 2016 Value Based P4P Program — Owner: Medical Director, Quality & Analytics

The Approach

1. Objective

- Confirm and implement the 2016 Value Based P4P Program (Medi-Cal & OCC)

2. Activity

- Complete review of 2014 & 2015; confirm measures, align with auto-assignment quality measures and define weighting for 2016
- Incentivize Health Networks via a P4P to achieve high quality scores on targeted accreditation, health plan rating and STARS measures

3. Goals

- Improve performance over 2015

~~2016~~7 Quality Improvement Work Plan- Organizational Projects ~~Owner: Medical Director, QA~~

~~Monitoring~~	~~Assessments, Findings, Monitoring of Previously Identified Issues~~	~~Next Steps~~	~~Target Completion~~
~~Q1~~			
~~Q2~~			
~~Q3~~			
~~Q4~~			
~~Year End~~			
~~Outcomes~~	~~Results / Metrics~~	~~Next Steps~~	~~Target Completion~~
~~Q1~~			
~~Q2~~			
~~Q3~~			
~~Q4~~			
~~Year End~~			

XI. Organizational Projects

~~B. Value Based P4P 2016-2019~~ ~~Owner: Kelly Rex-Kimmet, Director, QA~~

~~The Approach~~

~~1. Objective~~

- ~~Design longer term Value Based P4P Program and gain board approval by 7/1/16~~

~~2. Activity~~

- ~~Design new program in conjunction with provider/ Health Network Stakeholders, PAC & MAC input; develop COBAR for presentation to board~~
- ~~Define analytics and matching resources to support new P4Value Program~~

~~3. Goals~~

- ~~National & State Benchmarks~~

A. Value Based P4P 2017- Owner: Sandeep Mital, Manager, Quality P4V

The Approach

1. Objective

- Present MY~~MY~~2017 P4V program to QAC and Board of Directors by 3/1/17
- Re-Evaluate Auto Assignment Quality Measures and Recommend Changes to measures and algorithm
- Design 2018 P4Value program based on interim measures

2. Activity

- Design new program in conjunction with provider/ Health Network s~~S~~takeholders,
- PAC & MAC input
- ~~;~~ D~~d~~evelop COBAR for presentation to board
- Define analytics and matching resources to ~~support~~define ~~new~~2018 P4Value Program

3. Goals

- Implement 2017 prospective rates by 3/1/17
- Design 2018 P4V by 4th Quarter, 2017

2016~~6~~7 Quality Improvement Work Plan- Organizational Projects Owner: ~~Kelly Rex-Kimmet~~Sandeep Mital, ~~Director~~Manager, Quality ~~QA~~P4V

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

XII. Organizational Projects

B. MOC Dashboard

Owner: Esther~~.~~ Okajima, D~~irec~~tor, Q~~uality I~~mprovement

The Approach

~~Objective~~
~~Activity~~

1. ~~Goal~~Objective
   - Present OC/OCC & SPD MOC Quality Matrix to QAC and Board of Directors by 2nd Quarter, 2017
   - Re-e~~E~~valuate measurements through data analysis

2. Activity
   - Define analytics and resources to support the Model of Care for OC/OCC & SPD members
   - Implement activities to meet or exceed measures

3. Goals
   - Meet or exceed defined MOC metrics

G:\Model of Care\CalOptima Model of Care\MOC Dashboard\Latest version\MOC Dashboard_12.12.16.xlsx

- (right click and select "open hyperlink)

"Attachment A"

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
2	**Program Structure:**									
3	QI Program Description (submission date)	Date	Esther	Annual	Apr-15	Met	Apr-16	Met		
4	QI Work Plan (submission date)	Date	Esther	Annual	Apr-15	Met	Apr-16	Met		
5	QI Evaluation (submission date)	Date	Esther	Annual	Apr-16	Met				
6										
7	**Network Management**									
8	Strong Network (Access)-Survey	See report	Marsha C.	Annual	See access report	N/A				
9	Strong Network (Availability)-Quarterly Report	See report	Marsha C.	Quarterly	See availability report	N/A				
10	Behavioral Health Access (BH Access & Availability)	See report	Dr. Poon	Quarterly	See Member Satisfaction Survey Report	N/A				
11	LTSS Access & Availability	TBD	Marie E.	Quarterly						
12	Complaints associated with Network Access	%/1000	Janine	Quarterly	0%	Y				
13	Use of Dental Benefit	41.50%	Lizeth	Monthly						
14	Complaints associated with use of Dental Benefit	1.80%	Janine	Quarterly	15%	N				
15	Utilization of Taxi Benefit (Transportation Services)	29.80%	Belinda	Annual	19.43%	Y				
16	Complaints associated with Taxi Benefit (Transportation Services)	2.70%	Janine	Quarterly	8%	N				
17										

"Attachment A"

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
18	**Coordination of Care**									
19	% of calls resolved at first call	85%	Belinda	Quarterly	NA					
20	Member voluntary disenrollment rate	3.00%	Belinda	Quarterly	14.25%	N				
21	Transitions of Care									
22	Sending Member's Care Plan to Next Care Setting	% sent	Denise	Quarterly						
23	Notification to PCP of Transition	% notified	Denise	Quarterly						
24	HRA Outreach Completion Rate	90%	Cecelia	Quarterly	99%	Met				
25	HRA completion rate	TBD	Cecelia	Quarterly	22.90%					
26	ICP/ICT									
27	ICP (% of members with ICP)	90%	Denise	Quarterly						
28	ICT (% of members with ICT)	TBD	Denise	Quarterly						
29	DM inclusion in ICP (CCN)	30%	Pshyra	Quarterly						
30	Over/Under-Utilization of Services (Unused Auths?)			Quarterly	See HN rpt tab					
31	In-Patient Admits/1000	Admits/1000	Debra/Solange	Semi-Annual	See HN rpt tab					
32	Readmission Rate	<9.9%	Debra/Solange	Semi-Annual	See HN rpt tab					
33	Reduction in ER Visits (visit/1000 members)	585/1000	Debra/Solange	Quarterly	See HN rpt tab					
34	ALOS	4	Debra/Solange	Monthly	See HN rpt tab					
35	Response to Key Events (Need definition)	TBD	Denise	Quarterly						
36	F/Up after MH hospitalization (7 & 30 day)	50th %tile	Paul J	Annual	7 day = 81.35% 30 day = 85.49% (One Care)					
37	LTSS:									
38	Access to LTSS (utilization of LTSS services)	TBD	Marie E.	Quarterly						
39	Inpatient Days/1000 LTSS	Days/1000	Marie E.	Quarterly	Process not finalized in 2015					

"Attachment A"

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
40	ER Visits (visits/1000)	Visits/1000	Marie E.	Quarterly	Process not finalized in 2015					
41	Annual Analysis of Risk Level Classification (% Low/% High)	TBD	Cecelia	Quarterly	74%/26%					
42	Disease Mgmt penetration for Basic CM members	30%	Pshyra	Quarterly						
43	Other									
44										
45	**QIP/CCIP**									
46	Topic : Improving In-Home Supportive Services Care Coordination	% improvement	Marie E./Marsha C	Quarterly	PIP not in place for 2015; 2016 only					
47	Topic: Readmission within 30 days	baseline year	Tracy/ Marsha C	Quarterly	QIP not in place for 2015; 2016 only					
48										

"Attachment A"

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
49	**Health Outcomes**									
50	HEDIS performance (Stars Measure)				One Care Results for 2015					
51	Improvement in Adult Preventive Service	94.8% (50th %tile)	Paul J	Annual	93.61%	N				
52	Measure 1 (Controlling Blood Pressure)	4 Star Goal	Paul J	Annual	69.68%					
53	Measure 2 (Diabetes Care - A1C Control)	4 Star Goal	Paul J	Annual	72.51%					
54	Measure 3 (Diabetes Care - Nephropathy Monitoring)	4 Star Goal	Paul J	Annual	95.15%					
55	Measure 4 (Breast Cancer Screening)	69.80%	Paul J	Annual	68.69%	N				
56	Measure 5 (Colorectal Cancer Screening)	54.70%	Paul J	Annual	64.36%	Y				
57	Measure 6 (Acute Phase Depression Tx)	63.40%	Paul J	Annual	55.25%	N				
58	Measure 7 (Rheumatoid Arthritis)	4 Star Goal	Paul J	Annual	66.00%					
59	Measure 8 (Osteoporosis)	4 Star Goal	Paul J	Annual	44.87%					
60	Pharmacy Measures									
61	Medication Adherence - Hypertension	4 Star Goal	Nicki	Annual	5 stars (86%)	Y				
62	Medication Adherence - Diabetes	4 Star Goal	Nicki	Annual	4 stars (82%)	Y				
63	Medication Adherence - Cholesterol	4 Star Goal	Nicki	Annual	5 stars (82%)	Y				
64	HOS performance									

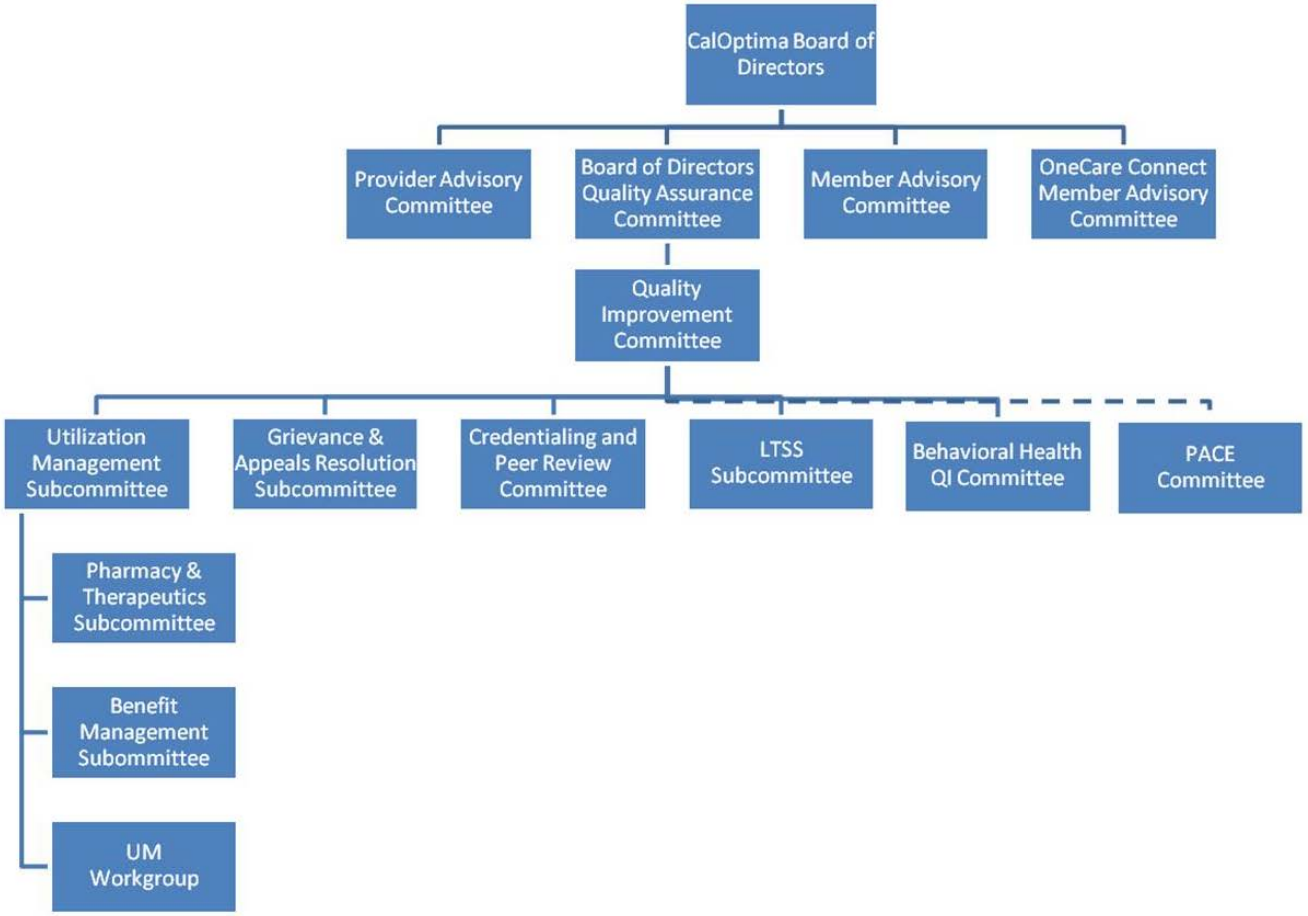
"Attachment A"

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
65	Maintaining or improving physical health status	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016					
66	Maintaining or improving mental health status	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016					
67	Reducing the risk of falling	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016					
68										
69	**Member Experience**									
70	CAHPS Performance (Stars Measures)				One Care Results for 2015					
71	Getting Needed Care	4 Star Goal	Marsha C	Annual	77%	Not Met				
72	Rating of Drug Plan	4 Star Goal	Marsha C	Annual	82%	Not Met				
73	Customer Service	4 Star Goal	Marsha C	Annual	85%	Not Met				
74	Getting Appointments & Care Quickly	4 Star Goal	Marsha C	Annual	70%	Not Met				
75	Getting Needed Prescription Drugs	4 Star Goal	Marsha C	Annual	88%	Not Met				
76	Care Coordination	4 Star Goal	Marsha C	Annual	80%	Not Met				
77	Overall Rating of Plan	4 Star Goal	Marsha C	Annual	82%	Not Met				
78	Overall Rating of Health Care Quality	4 Star Goal	Marsha C	Annual	81%	Not Met				

"Attachment A"

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
79	**Medical Record Review (HN compliance to policies)**									
80	MRR results - CalOptima	Clinical Ops	Esther	Annual						
81										
82	**IRR for UM activities**									
83	Annual IRR for Staff	90%	Debra	Annual	96-100%	Y				
84	Annual IRR for RX	TBD	Solange	Annual	Completed?					
85	**Delegated functions oversight**									
86	Health Network performance	A/O Report	Solange	Quarterly						
87	MRR results - HN	A/O Report	Esther	Quarterly						
88	IRR for Delegates	A/O Report	Solange	Annual	Completed?					
89	**Clinical Practice Guidelines**									
90	Reviewed annually (linked with DM)	QIC minutes	Pshyra	Annual						

~~Quality Improvement Committee Structure~~ – 2016



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CCN Performance:
Quality and Financial Analysis

Special Board of Directors' Quality Assurance Committee Meeting
May 22, 2017

Richard Helmer, M.D.
Chief Medical Officer

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CalOptima Community Network (CCN) Analysis

- Background of CalOptima Direct (COD) and CCN
- Membership Growth in CCN
- Performance on Quality Measures
  - Clinical Measures
  - CAHPS (Satisfaction) Measures

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CalOptima Community Network (CCN) Analysis (Cont.)

- Financial Performance
  - Revenue/Risk Adjustment Factor
  - Comparable Utilization Metrics
  - Medical Loss Ratio
- The Challenge With a Medi-Cal Comparison
- Considerations for the Future of CCN

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Background of CCN

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Background of CCN

- Original CalOptima Direct (COD) network for members:
  - Could not be assigned a primary care physician (PCP)
    - New to CalOptima and transitioning to network
    - Out of area
    - Dual coverage (fee-for-service Medicare)
  - Complicated, vulnerable and high risk ("Complex")
    - In Long-Term Care (LTC) facilities
    - Transplants, end-stage renal disease, HIV/AIDS, hemophilia, etc.
- Additional members and PCPs added for networks that had terminated ("General")
  - Members linked to PCP
  - Rebranded as "CalOptima Care Network" or CCN

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Background of CCN (Cont.)

- Common feature of COD and earlier CCN
  - Members could not select the network except with a family linkage
  - No auto assignment — relatively flat growth
  - Higher acuity of member needs
  - Limited to Medi-Cal line of business (OneCare still excluded)
- 2014 — needed to reconsider COD/CCN network
  - Small- to medium-size physician practices not included in recent network expansion RFP desired to participate more fully
  - Need to have the broadest possible network for duals demonstration/OneCare Connect
    - Large number of FFS Medicare beneficiaries served by COD/CCN practitioners
    - These physicians may only participate in CCN and not delegated networks

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Background of CCN (Cont.)

- CalOptima Community Network (CCN) implemented Q2 2015
  - Members could select CCN
  - CCN received auto-assignment
  - Membership limited to 10% of total membership as opposed to 33% for delegated networks

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Background of CCN (Cont.)

- Premise of CCN
  - Held accountable to the same standards as delegated networks
    - Financially viable — not “subsidized” by CalOptima
    - Assessed by Audit and Oversight for regulatory, operational and accreditation compliance
    - Comparable quality scores
  - Funded based on member risk
  - Reward physicians for appropriate performance
    - Pay for value
    - Appropriate utilization
- CalOptima management would update Board and other stakeholders with key quality and financial performance when information is available

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Membership Growth in CCN

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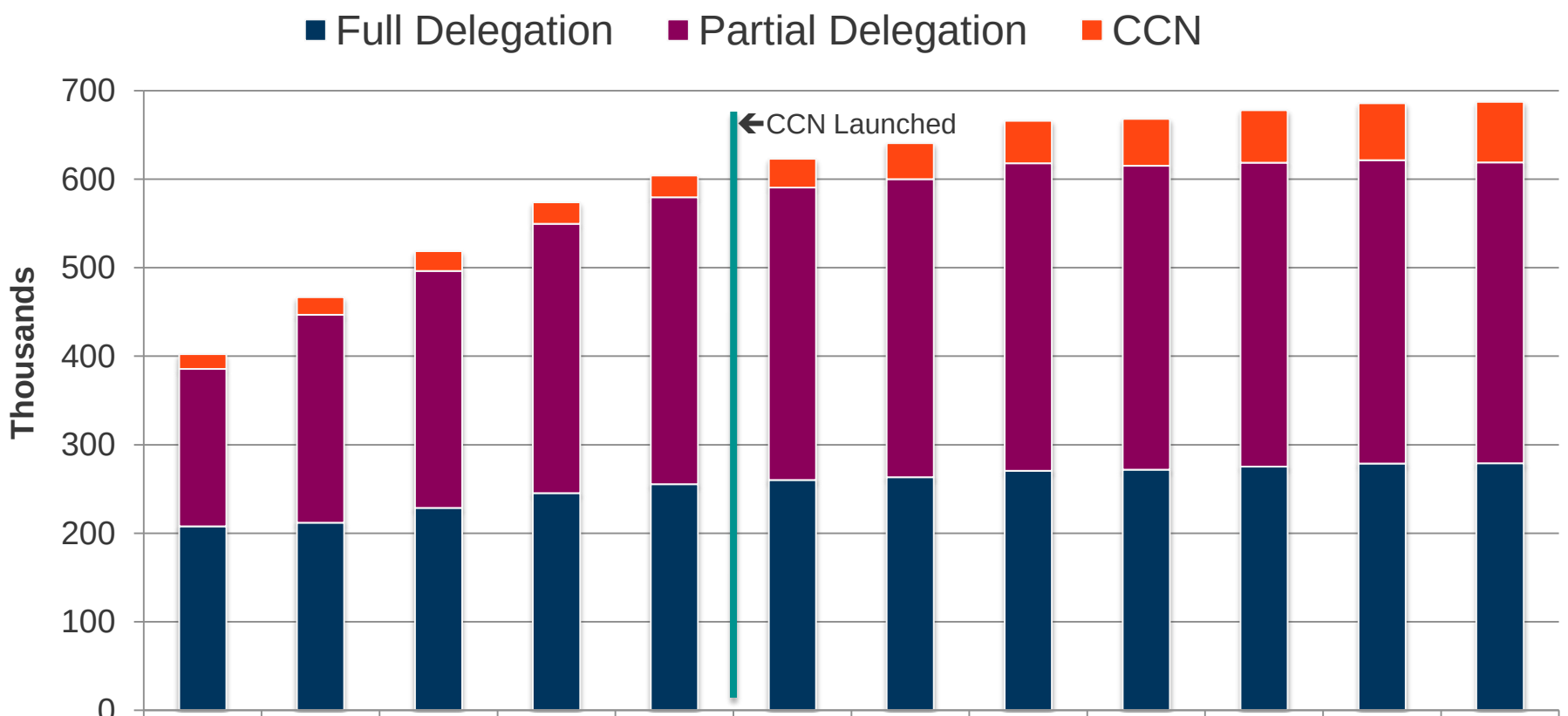
Medi-Cal Members by Network Type



	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016
CCN	16,839	20,089	22,376	24,376	24,583	32,382	40,700	47,974	53,211	59,438	64,365	68,422
Partial Delegation	177,773	234,556	267,604	304,169	324,119	330,334	336,565	347,458	343,177	343,173	342,557	339,609
Full Delegation	207,708	212,070	228,582	245,317	255,404	260,199	263,419	270,550	271,818	275,281	278,701	279,188

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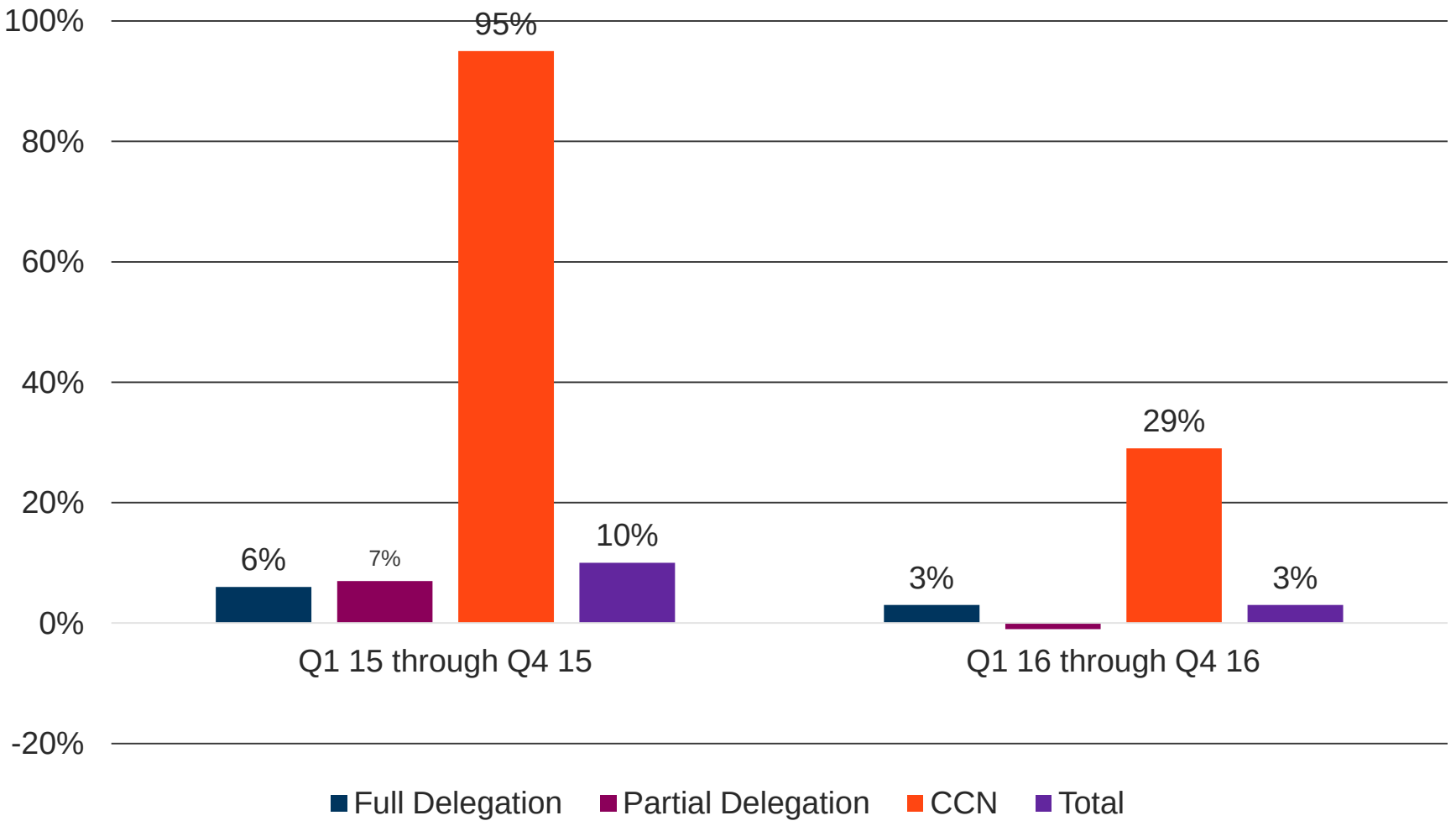
Medi-Cal Membership Q1 to Q4 2015 and 2016 Growth by Network Type



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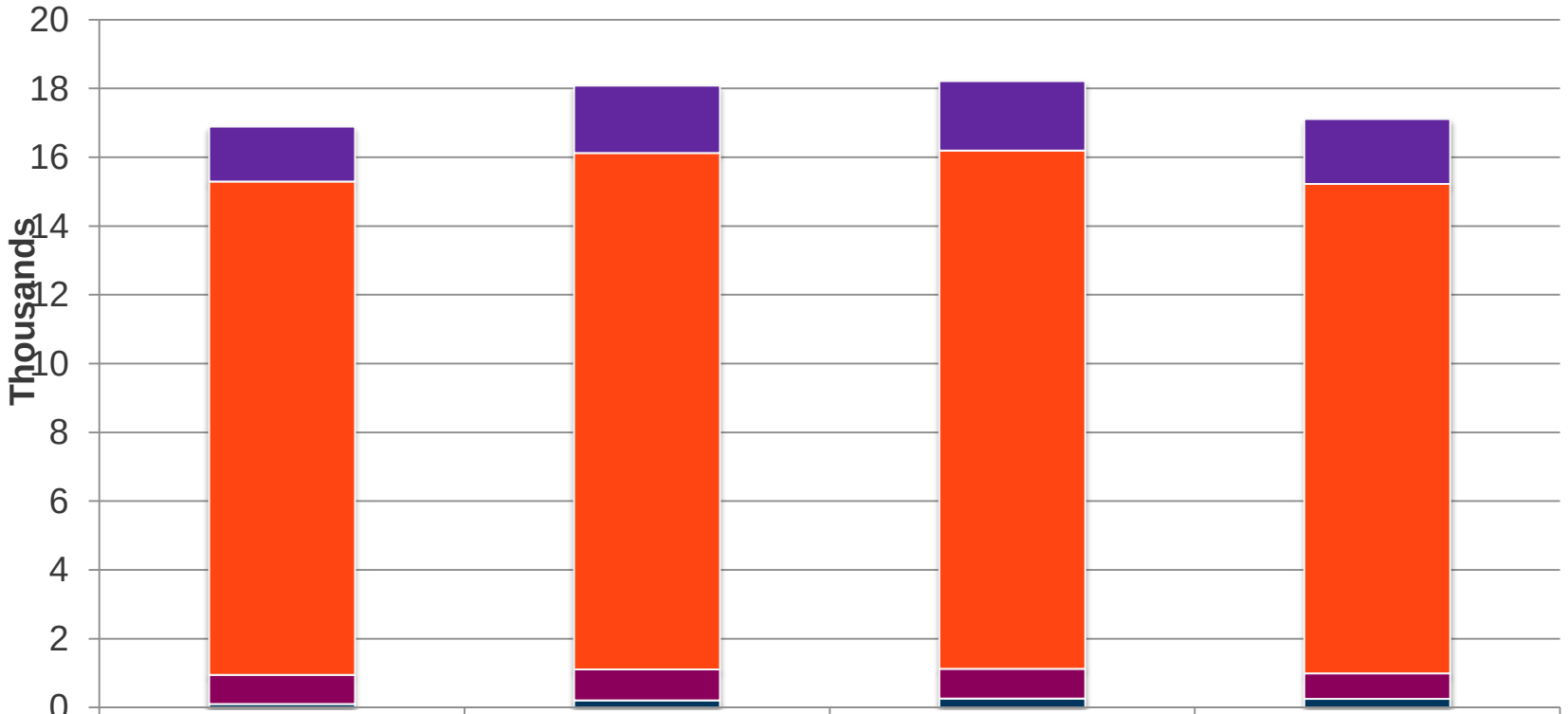
OCC Membership by Network Type



	Q1 2016	Q2 2016	Q3 2016	Q4 2016
CCN	1,596	1,960	2,014	1,893
SRG	14,347	15,014	15,071	14,230
PHC	848	901	867	745
HMO	97	207	260	247

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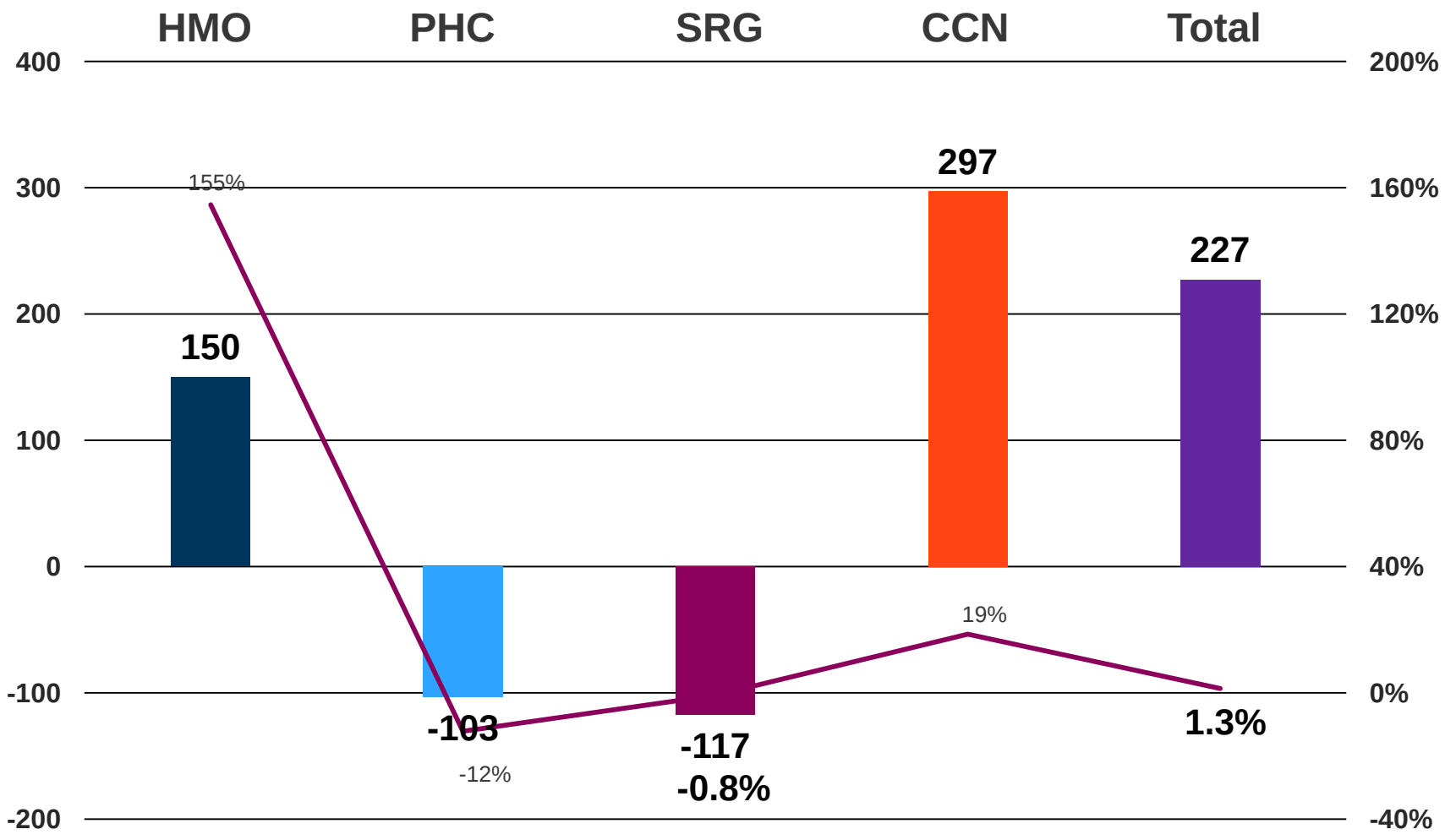
OCC Membership Change Q1 to Q4 2016



Conclusion: Membership Growth

- Members have chosen CCN for both the Medi-Cal and OCC programs in significant numbers

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Performance on Quality Measures

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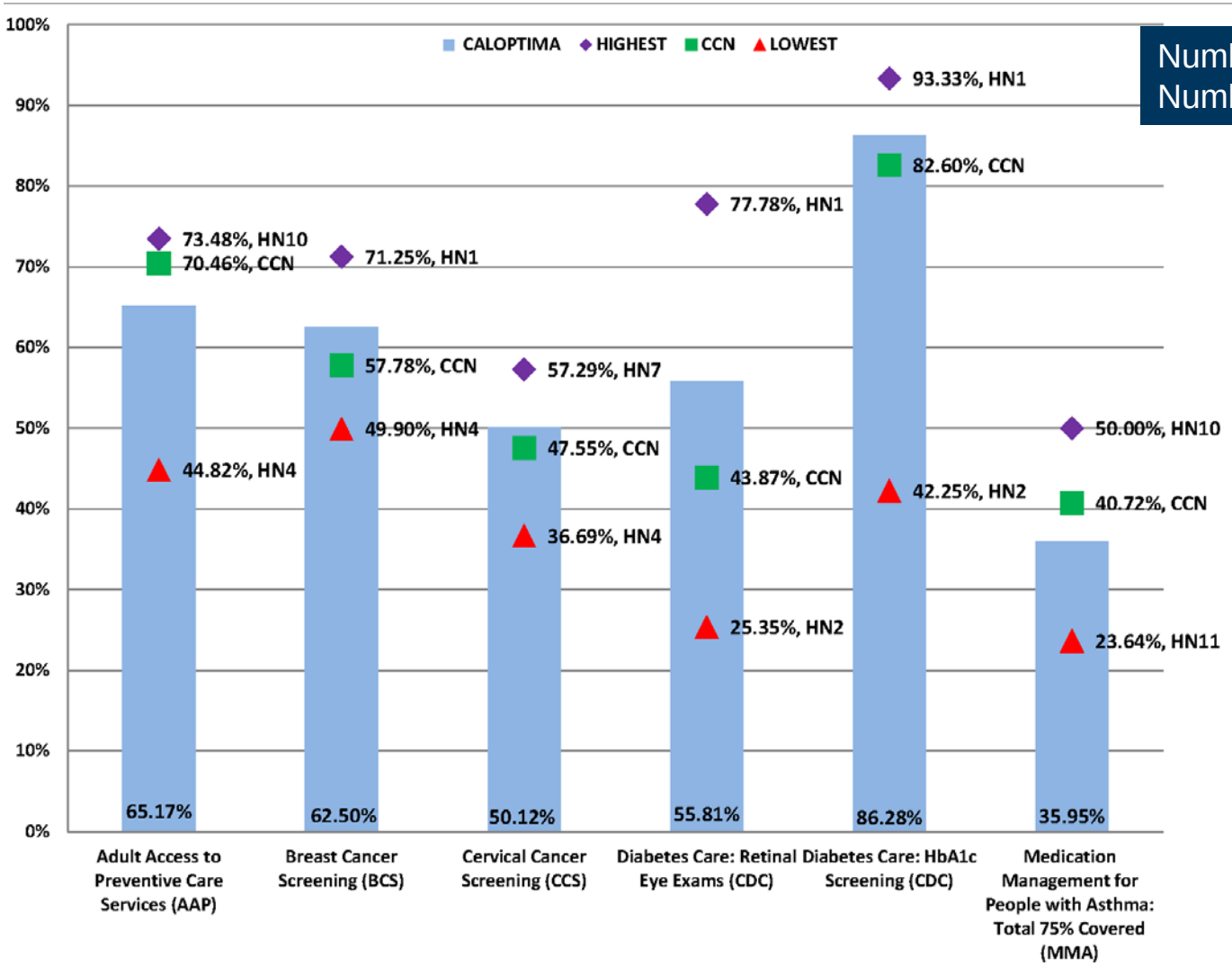
Adult Medi-Cal Clinical Measures



Number Above: 2
Number Below: 4

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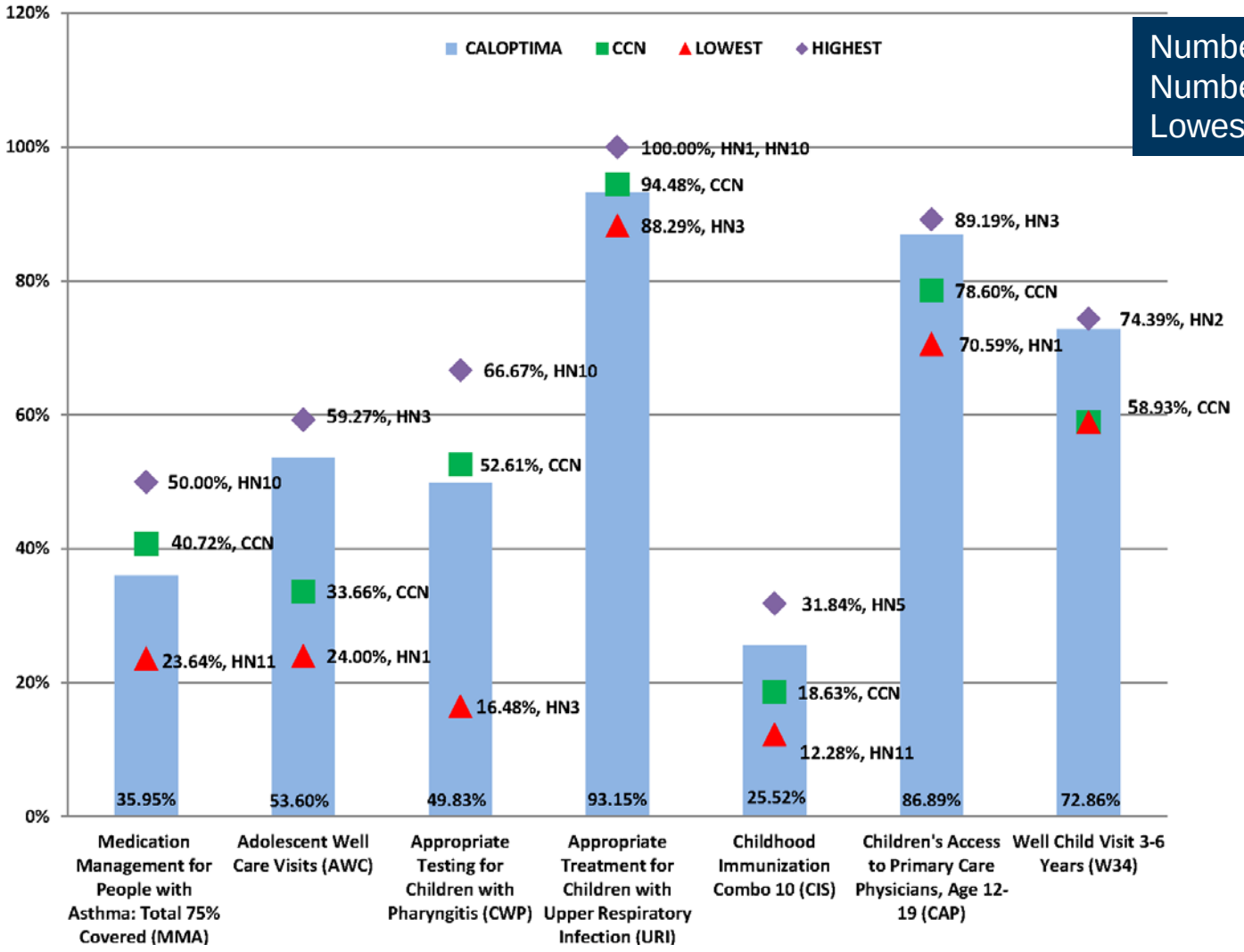
Child Medi-Cal Clinical Measures



Number Above: 3
Number Below: 4
Lowest: 1

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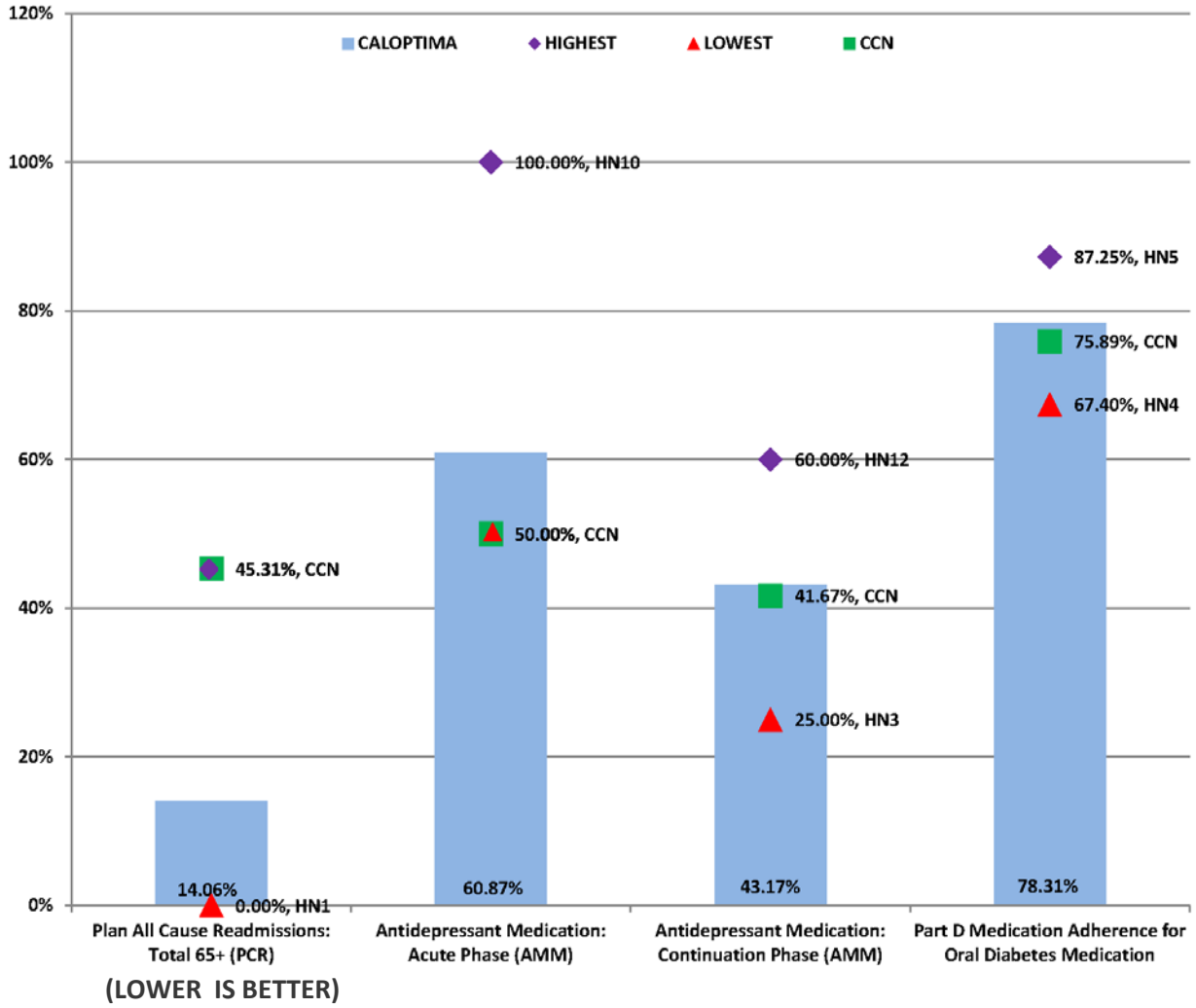
Adult OCC Clinical Measures



Number Above: 0
Number Below: 4
Lowest: 2

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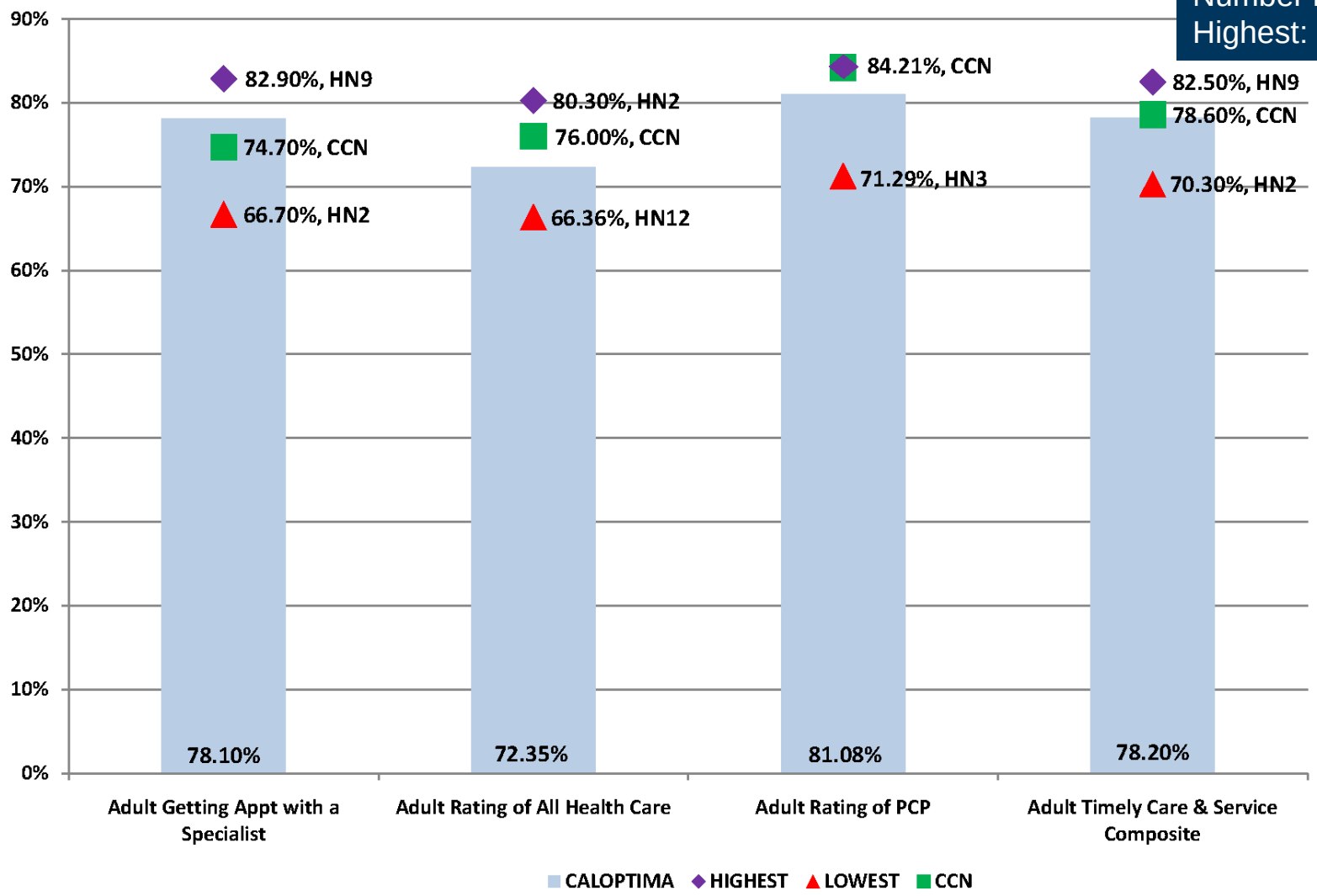
Adult Medi-Cal CAHPS

Number Above: 3
Number Below: 1
Highest: 1



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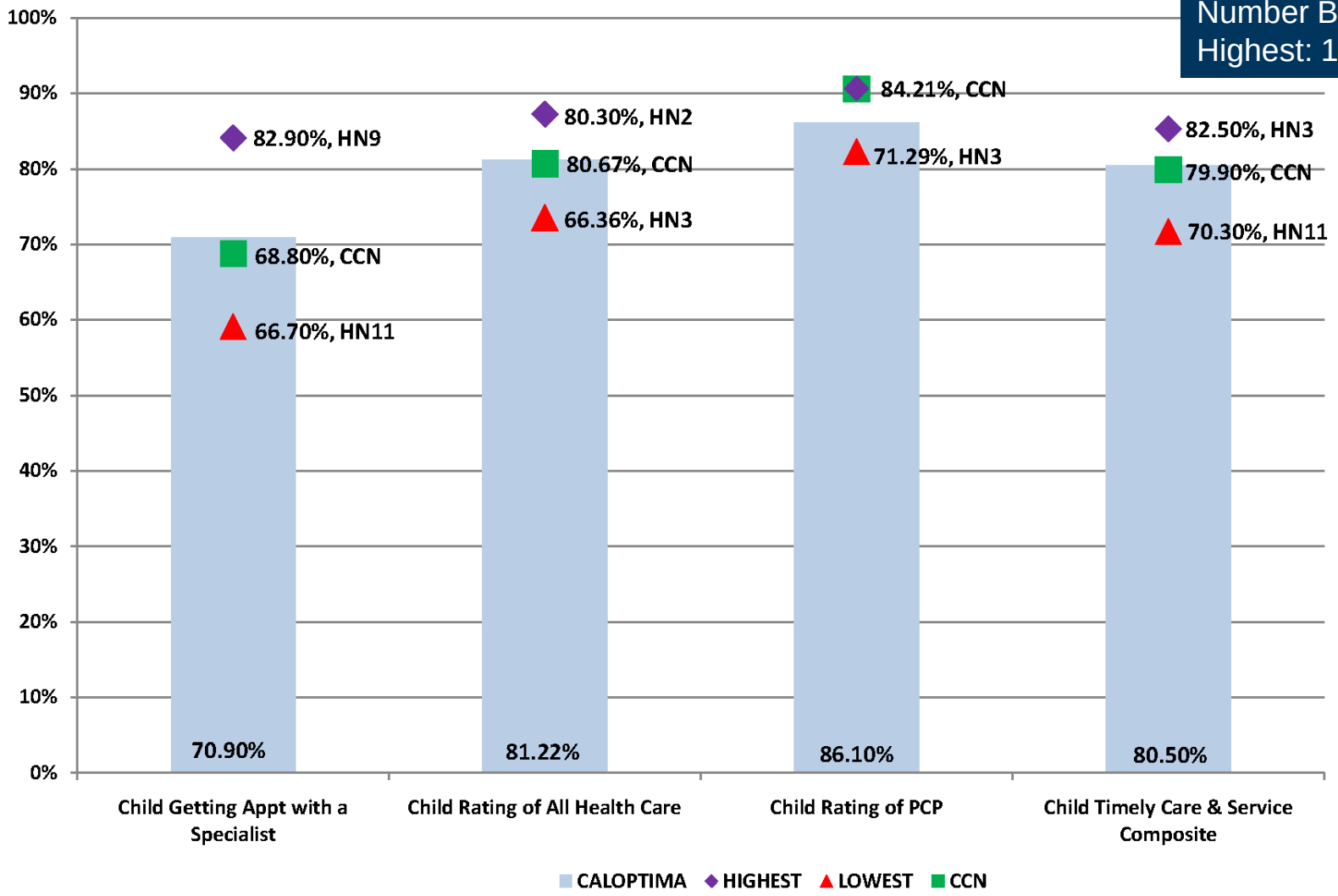
Child Medi-Cal CAHPS

Number Above: 1
Number Below: 3
Highest: 1



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Conclusion: Quality Metrics

- Medi-Cal
  - Clinical Quality
    - CCN performed better than CalOptima overall in five out of 13 Medi-Cal measures
  - Satisfaction
    - Adult and Child CAHPS: CCN performed better than CalOptima overall for four of the eight measures
    - Highest in PCP satisfaction for both Adult and Child
- OCC
  - Clinical Quality
    - CCN was below CalOptima overall in all four OCC measures
    - Readmission score has both quality and utilization implications

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Financial Performance

Back to Agenda

Financial/Utilization Measures

- Use OneCare Connect (OCC)
  - Revenue follows member
  - Comparable membership (no special populations)
- Calculate for Calendar Year 2016
- Include Medicare revenue and costs only
- Exclude Medi-Cal revenue and costs
  - Long-Term Services and Supports (LTSS) are major components and managed by CalOptima

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Financial/Utilization Measures (Cont.)

- Include claims and capitation payment but not encounter data

- Define performance as medical loss ratio (MLR)
  - Exclude administrative loss ratio (ALR)
  - Add CalOptima medical management based on resources required by network type
  - Exclude shared risk group (SRG) pool funding or settlements

- Align with Finance reports — with some exceptions

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OCC Summary of Performance

	CCN	SRG	PHC	HMO	All
Average Member Months	1,888	14,664	840	203	**17,595**
Revenue PMPM	$1,584	$1,445	$1,153	$1,559	**$1,448**
Risk Adjustment Factor (RAF)	1.30	1.17	0.91	1.34	**1.17**
Emergency Dept. Visits (Visits/1,000 mbrs/Y)	682	502	N/A	N/A	**N/A**
Non-Psych Inpatient (Bed Days/1,000 mbrs /Y)	1,911	1,224	N/A	N/A	**N/A**
Pharmacy PMPM	$385	$339	$314	$282	**$342**
Medical Cost PMPM	$1,323	$1,256	$1,111	$1,424	**$1,258**
MLR	**83.5%**	**86.9%**	**96.4%**	**91.3%**	**86.9%**

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Medical Management Allocation

Medical Management Accounts	CCN	SRG	PHC	HMO
Behavioral Health	25%	25%	25%	25%
Case Management	40%	20%	20%	20%
Health Education/ Disease Management	25%	25%	25%	25%
Long-Term Services and Supports	25%	25%	25%	25%
Pharmacy Management	25%	25%	25%	25%
Quality Improvement/ Analytics	25%	25%	25%	25%
Utilization Management	60%	20%	10%	10%
Amount	**$87.74**	**$52.76**	**$49.06**	**$49.06**

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Conclusion: Financial Performance

- CCN financial performance as measured by the MLR is comparable with delegated health networks

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The Challenge With a Medi-Cal Comparison

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The Challenge With a Medi-Cal Comparison

- For Medicare: Every member has an actual revenue amount
- For Medi-Cal: The state pays CalOptima a fixed amount for every member based on aid code
- CalOptima adjusts payments to networks based on actuarial analysis and Medicaid specific risk-adjustment factor “Chronic Illness and Disability Payment System” (CDPS)

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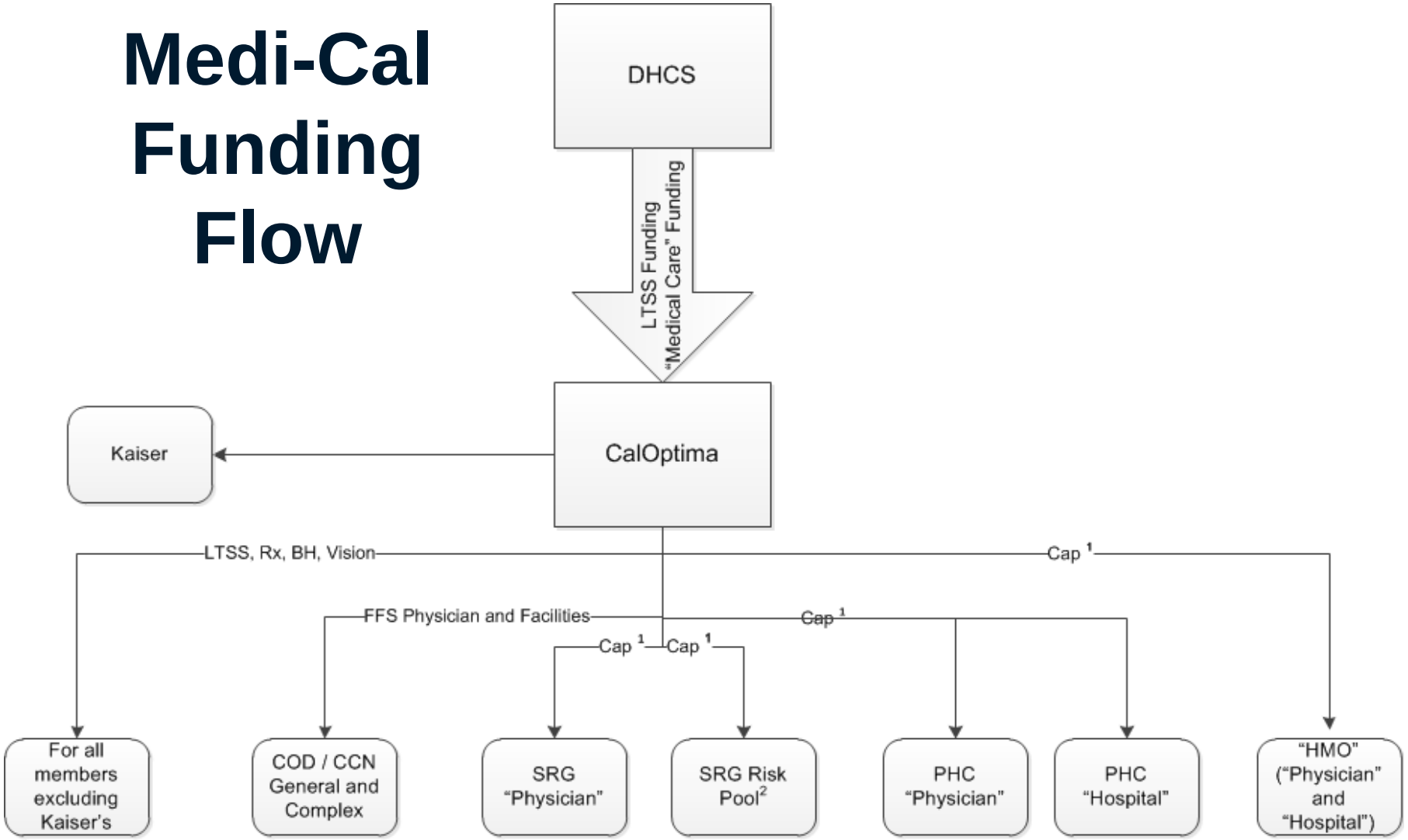
Medi-Cal Funding Flow



1 = Capitation is based on aid category, age, sex. CDPS risk adjustment

2 = Surplus funds from SRG pool are distributed between SRG Physician and CalOptima

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The Challenge With a Medi-Cal Comparison (Cont.)

- CCN has not been included in past calculation
- Use of CDPS in previous utilization management comparison has shown significant increased risk for CCN:
  - Complex = 6.1
  - General = 1.2
  - SRG = .9
- Meaningful comparison of financial performance by MLR requires calculation of CCN funding using standard network methodology

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Considerations for the Future of CCN

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Considerations for CCN

- Need evaluation and plan to address high readmission rate for OCC

- Complete incentive programs for CCN PCPs
  - Pay for value program
  - Appropriate utilization

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Considerations for CCN (Cont.)

- Evaluate network management and resources of CCN "IPA"
  - Ensure capabilities are in place and efficient
  - Consider appropriate "admin" percentage for managing the network to ensure:
    - High quality
    - Appropriate utilization

- Implement "Long Term Connect" program to meet the unique needs of CalOptima's institutionalized members

Considerations for CCN (Cont.)

- Establish appropriate funding for CCN for Medi-Cal membership
  - Ensures resources are aligned with member needs
  - Provides meaningful MLR comparison
  - Minimize potential negative financial impact on CalOptima

- In light of member preference for CCN, should membership cap be aligned with other networks?

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Behavioral Health Integration Update

Special Board of Directors' Quality Assurance Committee Meeting
May 22, 2017

Richard Bock, Deputy Chief Medical Officer
Donald Sharps, MD, Behavioral Health Integration

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Topics of Discussion

- Customer Service
  - Center Results
  - Call Center Staffing
  - CalOptima Audit
  - New Site – Open House
- Audit and Oversight
  - Claims, Credentialing, Utilization Management
- Utilization Management/Quality Improvement
- Collaboration with the County Mental Health Plan (MHP) and Drug Medi-Cal (DMC)
- Interdisciplinary Care Teams (ICTs)
- Performance Guarantees

Back to Agenda

First Quarter Call Center: Medi-Cal

	Goal	Beacon 2016 Monthly Average	January 2017	February 2017	March 2017
Total Incoming Calls Average		3,956	3,176	2,816	3,169
Average Speed of Answer	**<30 seconds**	28	25	23	16
Percentage of Calls Abandoned	**<5%**	2%	3.1%	2.4%	1.9%
Percent Answered Within 30 Seconds	**>= 80%**	85%	85.3%	85.2%	89.4%

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First Quarter Call Center: OC/OCC

	Goal	Windstone 2016 Monthly Average	January 2017	February 2017	March 2017
Total Incoming Calls Average		307	2,629	2,029	2,143
Average Speed of Answer	**<30 sec**	17	22	18	13
Percentage of Calls Abandoned	**<5%**	2%	3.3%	3.1%	2.1%
Percent Answered Within 30 Seconds	**>= 80%**	87%	86.2%	87.9%	90%

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Magellan Customer Service Monitoring

- CalOptima Customer Service department has conducted two rounds of mystery caller test calls

Test Dates	Topic	# of Test Calls Passed	# of Test Calls Failed
3/20–3/24	Provider assistance	5	5
4/3–4/7	Provider assistance	6	4
4/3–4/7	Safety and welfare check	3	7

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Magellan Customer Service Monitoring

- CalOptima Customer Service
  - Reconciled results of its mystery caller audit in March & April
  - Discussed at weekly Operations meeting with action plans developed on recent findings
  - Is conducting another mystery caller audit in May
- Magellan
  - Implemented Customer Service quality assurance protocol
    - Minimum of three audits per customer service agent per month
    - Audit tool (50 items covering 17 topics) including safety and welfare
    - Incorporate results into the Magellan agent's scorecard
- CalOptima and Magellan will review audit findings against expected performance standards and guarantees
  - Findings will be reported to A/O

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Call Center Staffing

- Senior Director, Service Operations
- Medical Directors (1 FTE and two .5 FTEs)
- Customer Service
  - Manager (1)
  - Supervisor (1)
  - Leads (2)
  - Customer Service Agents (12)
- Clinical Team
  - Manager (1)
  - Supervisor (1)
  - Care Managers (6 with 2 vacancies)
  - ABA Care Manager (2)
  - Care Coordinators (5)
  - Care Workers (6)

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Permanent Site

- As of April 1, 2017
- 500 N. State College Blvd., Suite 1300, Orange, CA 92868

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Audit & Oversight: Claims, Credentialing, Utilization Management

- Monthly audits
- Claims — Review 40 files from XML universe
  - First CAPs returned 4/21/17
- Credentialing — Review eight initial and eight recredential
  - First CAPs returned 4/4/17
- Utilization Management — Review XML universe
  - First submission in progress

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Utilization Management and Quality Improvement

- Utilization Management
  - No decrease in service due to transition
  - Over- and underutilization
    - Medi-Cal: psychiatrists, psychotherapy, psych testing and ABA
    - OneCare Connect: psychiatrist visits, psychotherapy, psychological testing and inpatient hospitalization
- Quality Improvement
  - Call Center/First Call Resolution
  - LTC/SNF access to BH services
  - HEDIS measures including:
    - Follow-Up after Hospitalization, AMM and ADD
- BH provider information available at the ICT/ICP

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Increase Collaboration With MHP and DMC

- County Mental Health Plan (MHP)
  - Long-standing MOU delineates the responsibilities of CalOptima and HCA to ensure appropriate level of care
- Drug Medi-Cal (DMC)
  - An addendum to the MOU is in development to ensure the coordination of Substance Use Disorder (SUD) screening and the provision of member services between CalOptima and HCA
  - Supports the use of Medication-Assisted Treatment (MAT) for opioid and alcohol disorders
  - Changes SUD services from social model to medical model
  - Supports integrated services with BH and physical health

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Performance Guarantee: Interdisciplinary Care Team

2017 First Quarter Behavioral Health Interdisciplinary Care Team Invitations		
	Number of meetings where behavioral health information is available	Participation Rate
January	35/39	89.75%
February	53/54	98.15%
March	56/57	98.25%

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Performance Guarantee: Other

Customer Service: Five Performance Guarantees	Systems & Compliance: Two Performance Guarantees
5% or less call abandonment rate	Systems and reporting tools operational 99% of the time 24/7
80% or more of calls will be answered within 30 seconds or less	98% of eligibility files will be processed and loaded accurately
Average speed of answer will be 30 seconds or less	**Reporting: One Performance Guarantee**
100% of registration calls result in completed screening without disconnecting	Compliance with encounter files (837)
95% of members will be successfully linked to services within 30 days	**Care Coordination: One Performance Guarantee**
Claims: Two Performance Guarantees	>80% Interdisciplinary Care Team participation
90% or more of clean claims will be paid or denied within 30 days of receipt	**NCQA Status: One Performance Guarantee**
99% of clean claims will be paid or denied within 45 days of receipt	Full accreditation confirmed by NCQA by September 1, 2017

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2016 Group Needs Assessment Final Results

Special Board of Directors' Quality Assurance Committee Meeting
May 22, 2017

Pshyra Jones
Director, Health Education & Disease Management

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Background

Health plans are required to conduct Group Needs Assessments (GNAs) to identify the needs of members, available health education and cultural and linguistic (C&L) programs and resources, and gaps in services.

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Goal

The goal of the GNA is to improve health outcomes for members enrolled in Medi-Cal managed care by evaluating member health risks, identifying health needs, and prioritizing health education, C&L services, and preventative health and quality improvement programs to improve member health outcomes.

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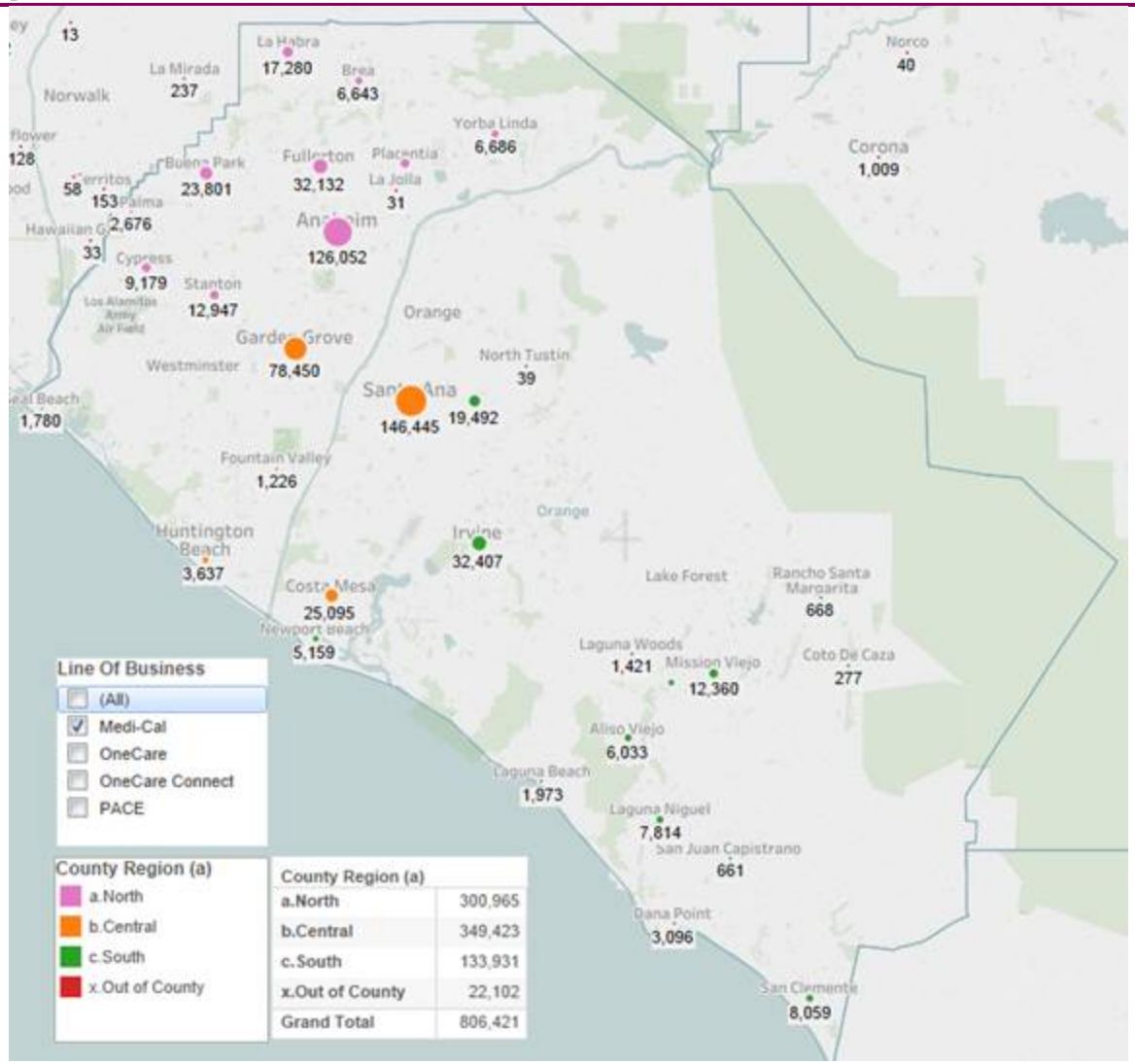
CalOptima Medicaid Membership by Region



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CalOptima Required Sample Size (English/Spanish)

Health Network	Target # Surveys	Health Network Proportion	Sample Size (4X)
1	200	9%	800
2	200	9%	800
3	200	9%	800
4	200	9%	800
5	200	9%	800
6	200	9%	800
7	200	9%	800
8	200	9%	800
9	200	9%	800
10	200	9%	800
11	200	9%	800
Total	**2200**	**100%**	**8800**

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CalOptima Required Sample Size (Other Languages)

Language	Target # Surveys	Membership Proportion	Sample Size (4X)
Vietnamese	180	10%	722
Korean	336	3%	1344
Farsi	368	2%	1472
Arabic	378	1%	1514
Chinese	384	1%	1536
Total	**1646**	**16%**	**6586**

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Sample Size Goals

- Mailed 17,030 surveys
- Expect a minimum of 200 responses
  - Double-check we have Health Network coverage across regions
- With that we can compare
  - Language difference within or between regions
  - Health Network difference between regions
  - Health Network difference between languages
  - All within +/- 7% confidence interval

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GNA Areas of Focus

- People Who Provide Health Care (Primary Care Provider)
- Medical Interpreters
- Member Health Perception and Health Plan Benefits
- Forms and Health Plan Materials
- Social Determinants of Health (Custom Questions)

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Social Determinants of Health

- Included custom questions to address categories representing social determinants of health.

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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GNA Results

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GNA Results: Survey Response Rate

Language	North OC Responses	Central OC Responses	South OC Responses	Region Unknown	Total Response
Vietnamese	224	186	109	2	521
Korean	208	128	207	7	550
Farsi	35	13	132	2	182
Arabic	91	34	58	5	188
Chinese	167	62	184	4	417
English	209	200	178	6	593
Spanish	198	206	208	8	620
Total*	**1,132**	**829**	**1,076**	**34**	**3,071**

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GNA Results: Profiling Respondents

- 64% (1,979) of the completed surveys were from CalOptima adult Medi-Cal members.
- 36% (1092) were completed by adults for CalOptima children with Medi-Cal.
- 13% (400) of completed surveys respondents were received from our Seniors and Persons with Disabilities (SPD) population.

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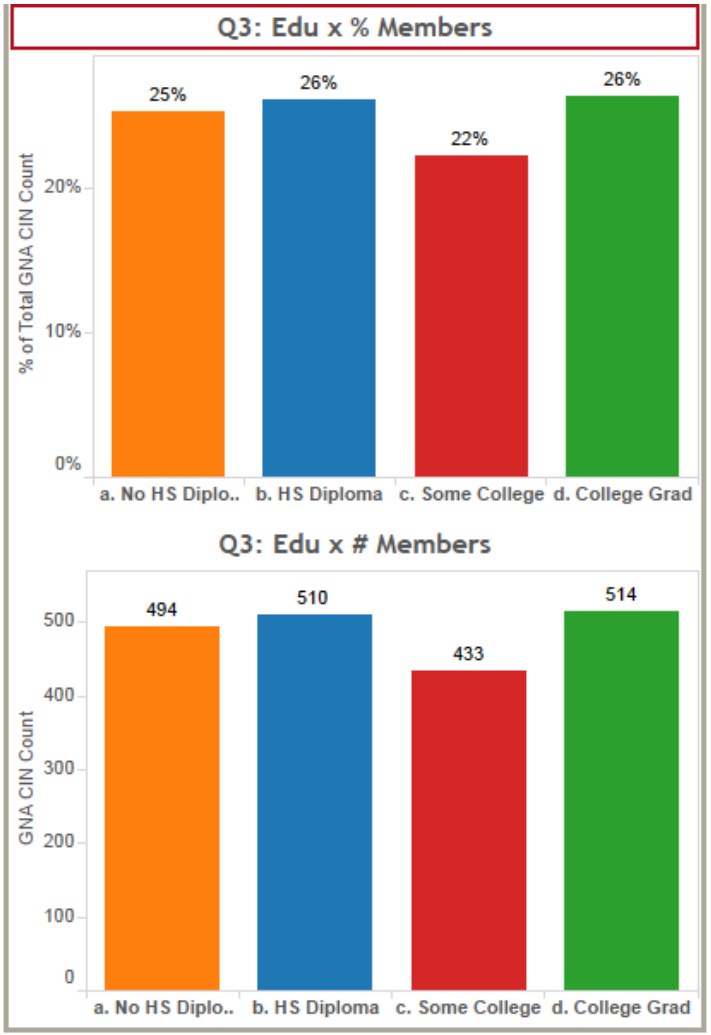
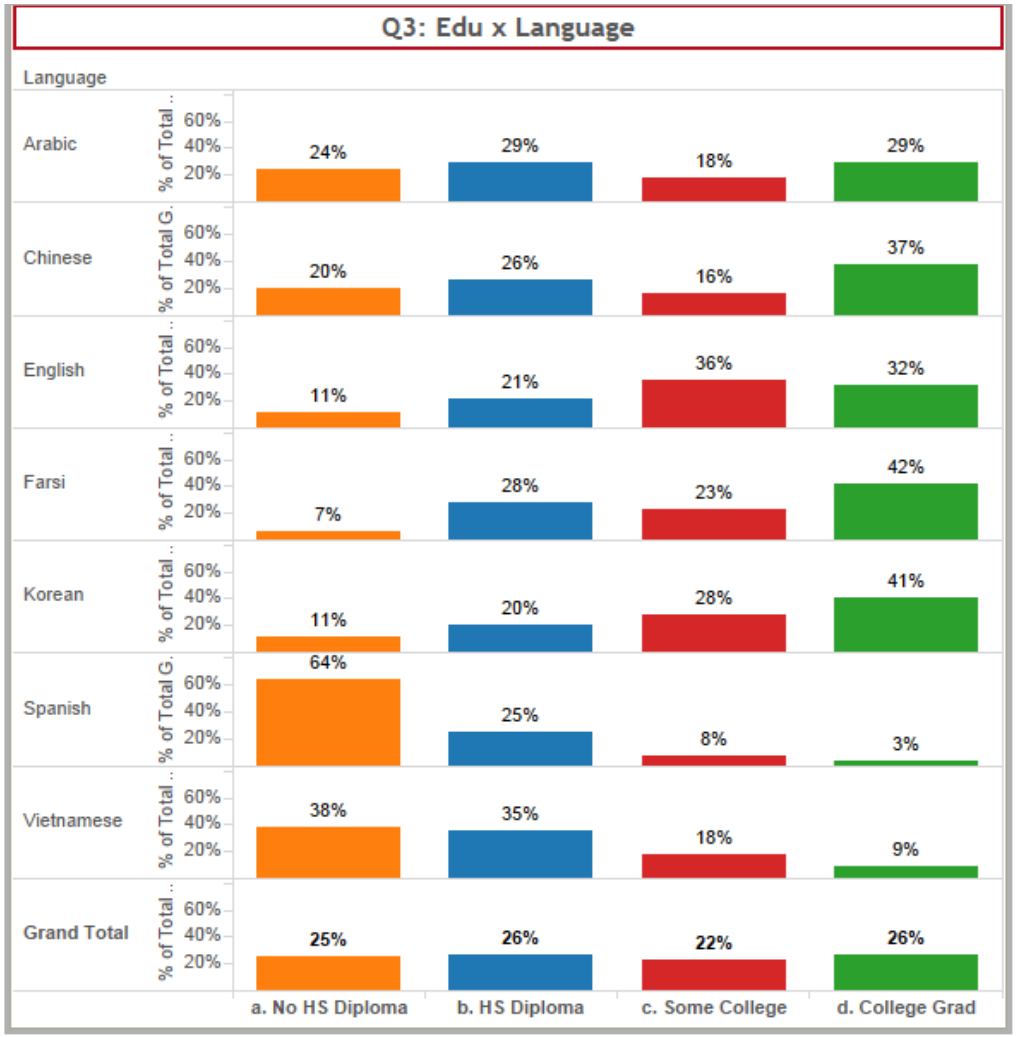
GNA Results: Education





Total adult responses: 1,952

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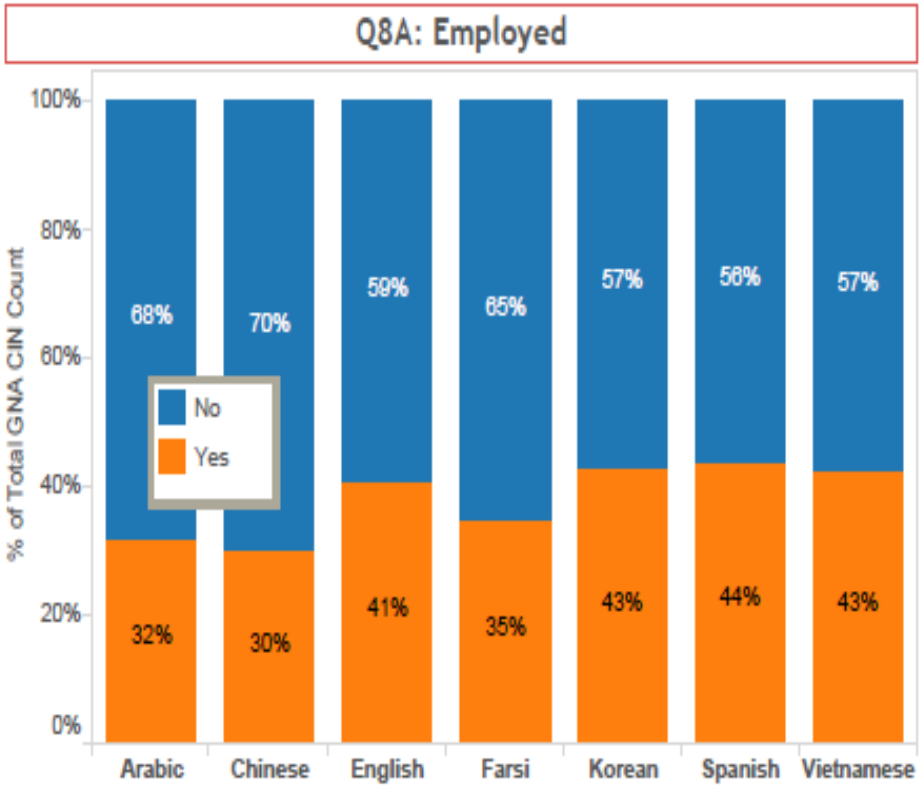
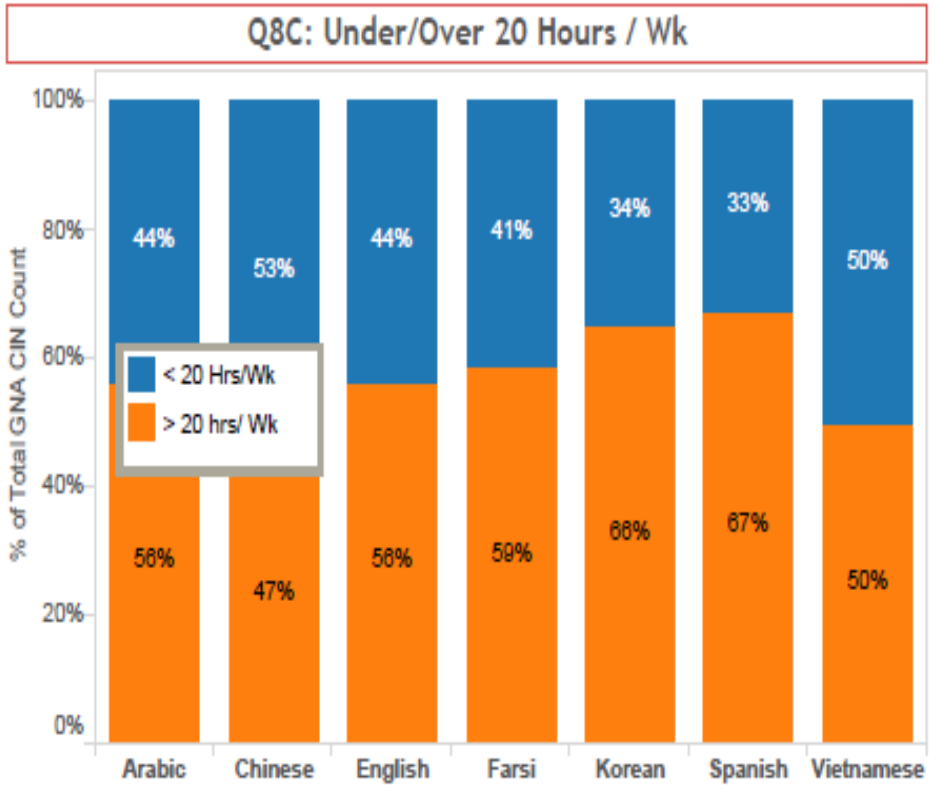
GNA Results: Employment





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GNA Results: Number of Jobs

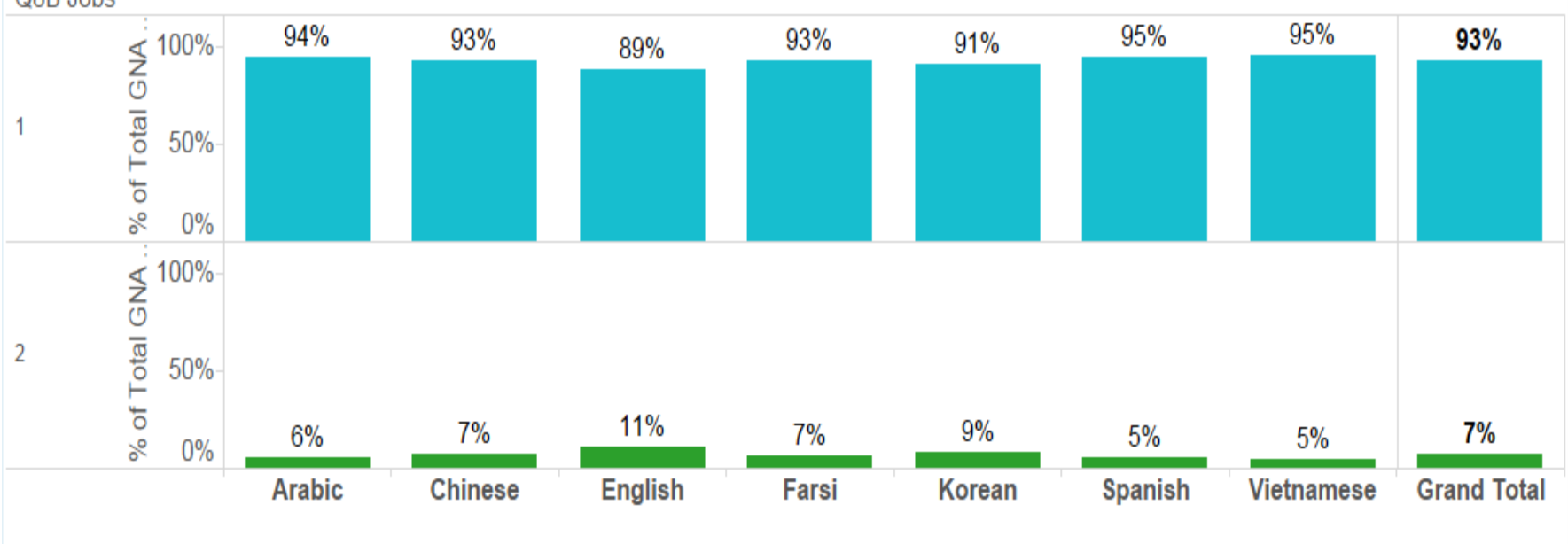
Q8B: Number of Jobs (ws)

Overall, 8% of our working members have more than 1 job

Volume-wise: 773K members x 40% (working) x 8% (> 1 job)

This comes to ~25K members

for whom 8-5 PCP office hours are unlikely to be considered as 'readily accessible'



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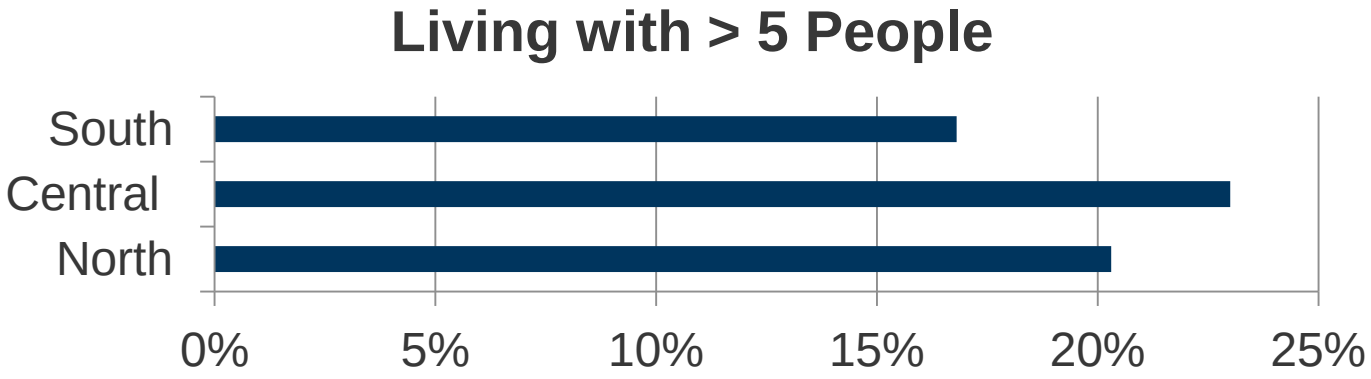
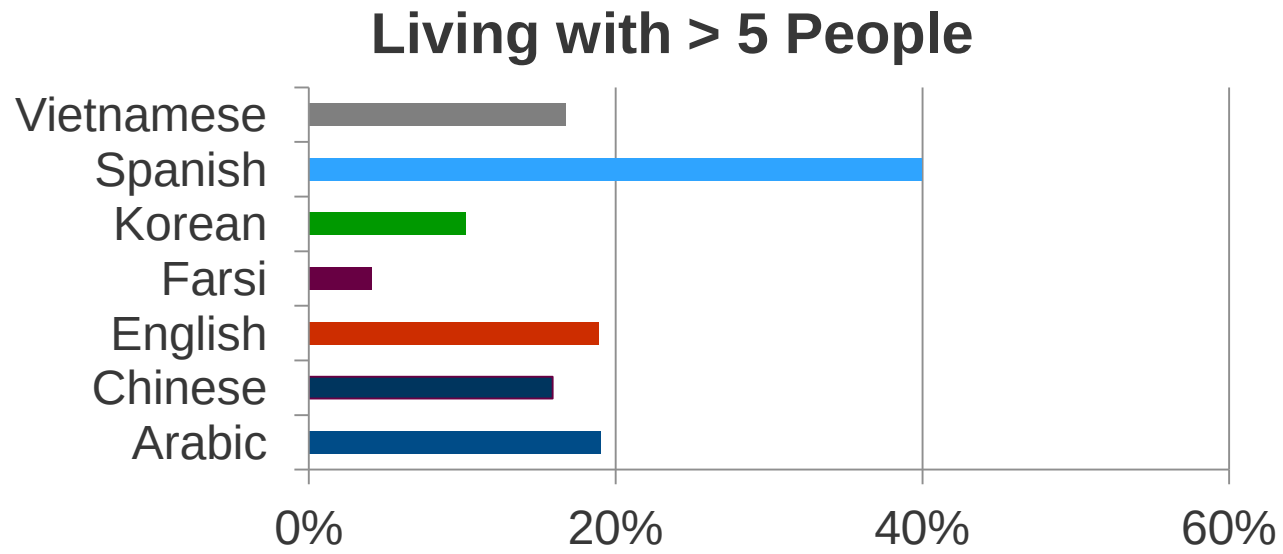
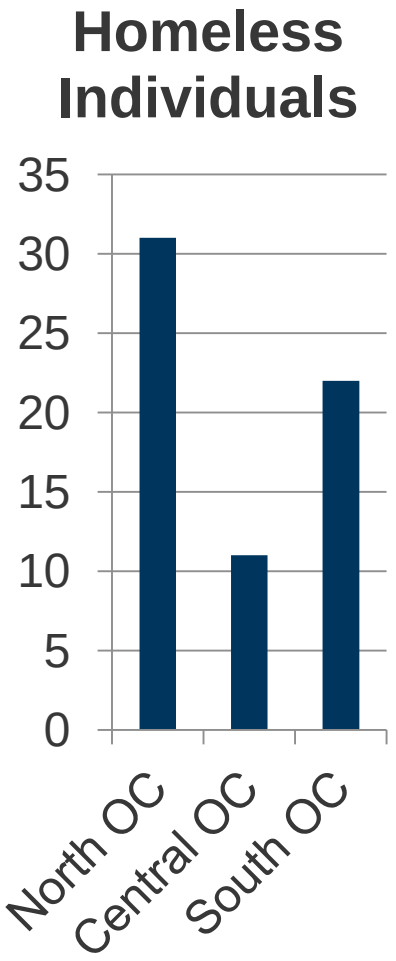
GNA Results: Living Situation







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GNA Results: Health Concerns in Area

What do you think are important health concerns or issues for people living in your area? Check all that apply.

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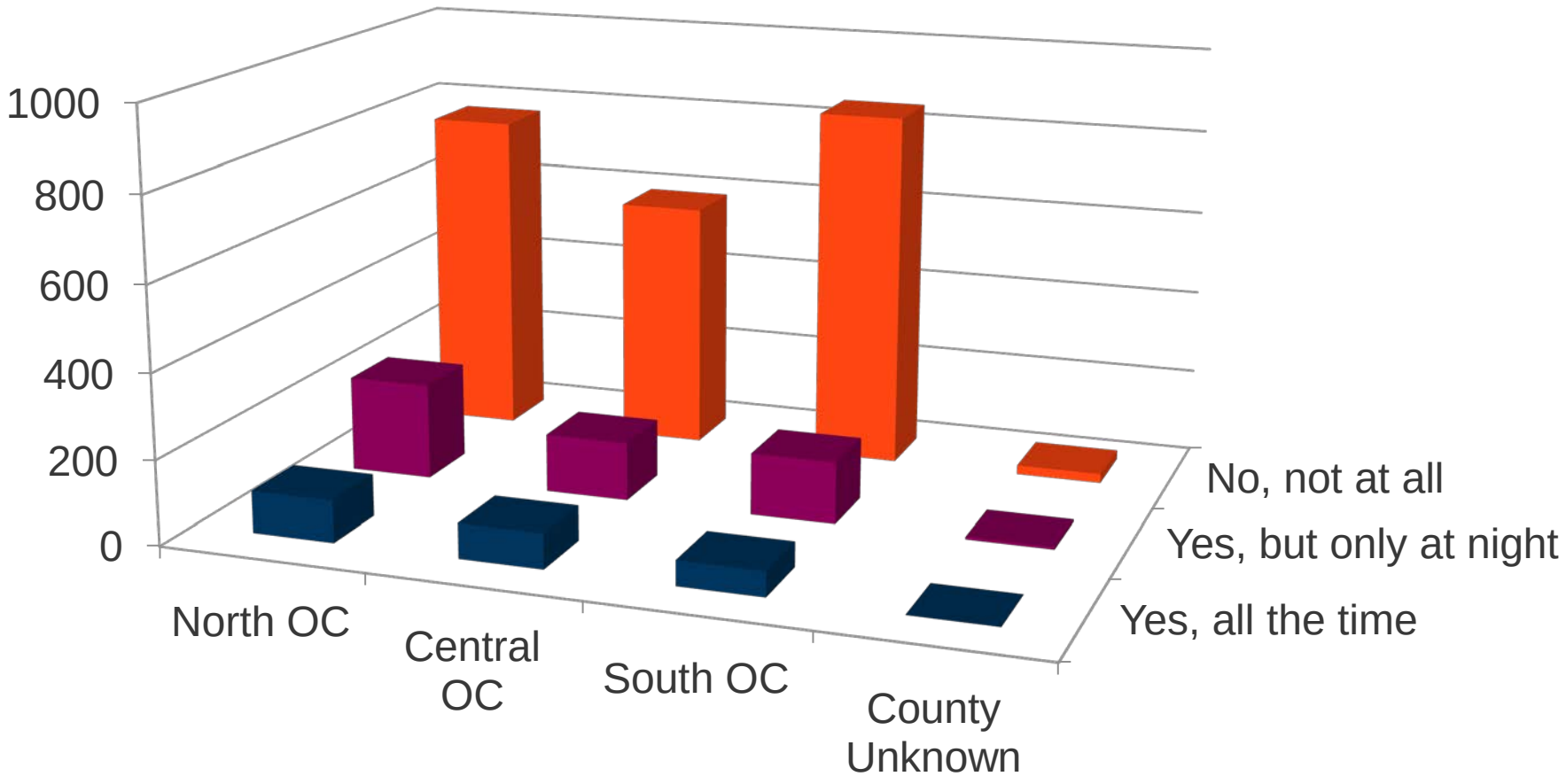
GNA Results: Worried About Being a Victim of Crime in Neighborhood



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GNA Results: Time to Primary Care Provider

		a. <= 15 min	b. 15 - 30 min	c. > 30 min
Arabic	a.North	37%	51%	12%
	b.Central	19%	69%	11%
	c.South	26%	44%	30%
Chinese	a.North	26%	62%	12%
	b.Central	34%	52%	14%
	c.South	21%	60%	18%
English	a.North	45%	45%	9%
	b.Central	48%	44%	8%
	c.South	43%	46%	11%
Farsi	a.North	21%	35%	44%
	b.Central	8%	75%	17%
	c.South	22%	60%	17%
Korean	a.North	41%	48%	12%
	b.Central	46%	49%	5%
	c.South	37%	55%	8%
Spanish	a.North	36%	46%	18%
	b.Central	42%	46%	12%
	c.South	40%	45%	15%
Vietnamese	a.North	40%	50%	9%
	b.Central	38%	56%	7%
	c.South	20%	63%	17%

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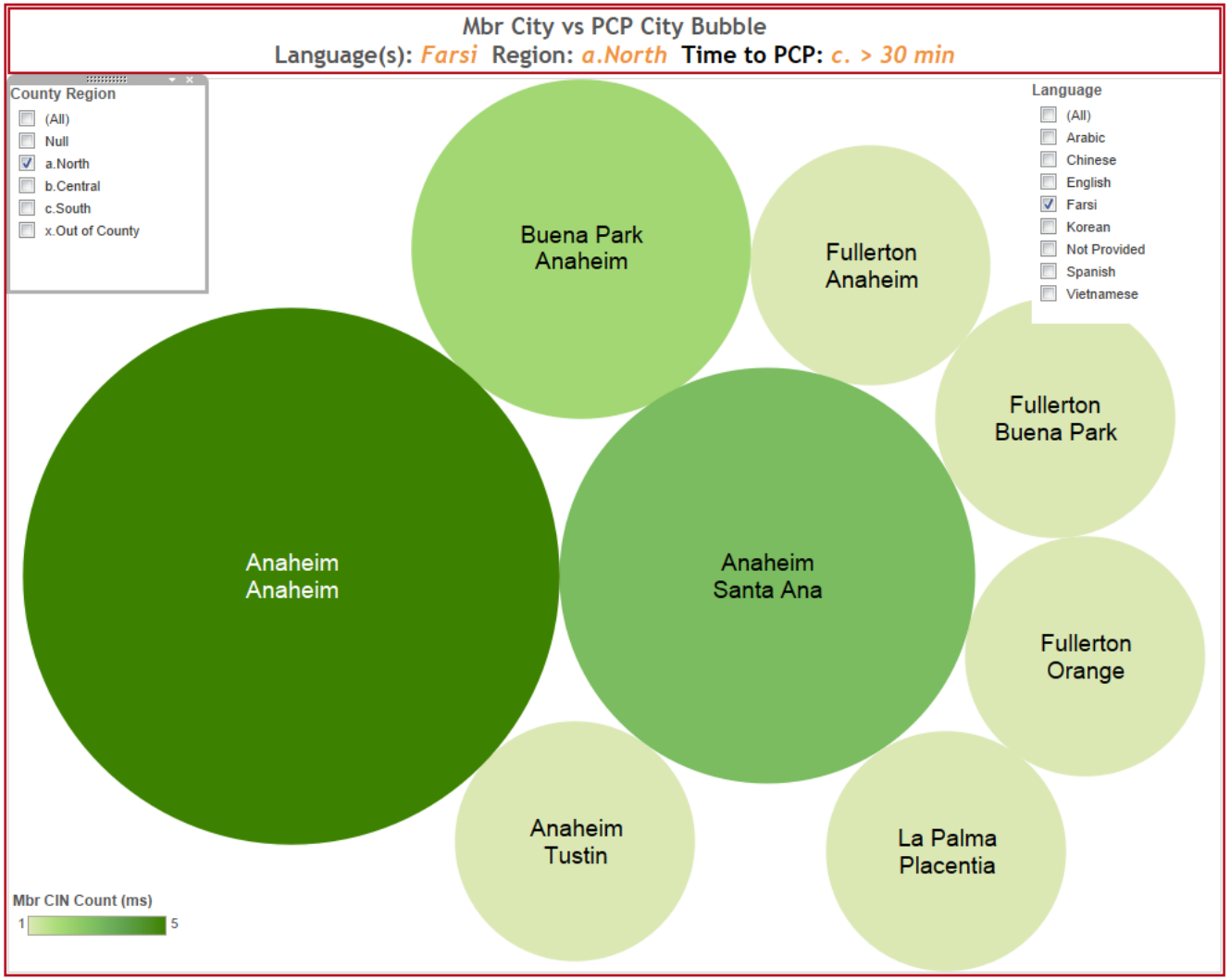
GNA Results:
Member City vs. PCP: Farsi Population

Legend

Member City
PCP City

Color & Size
Represent #
Of Members



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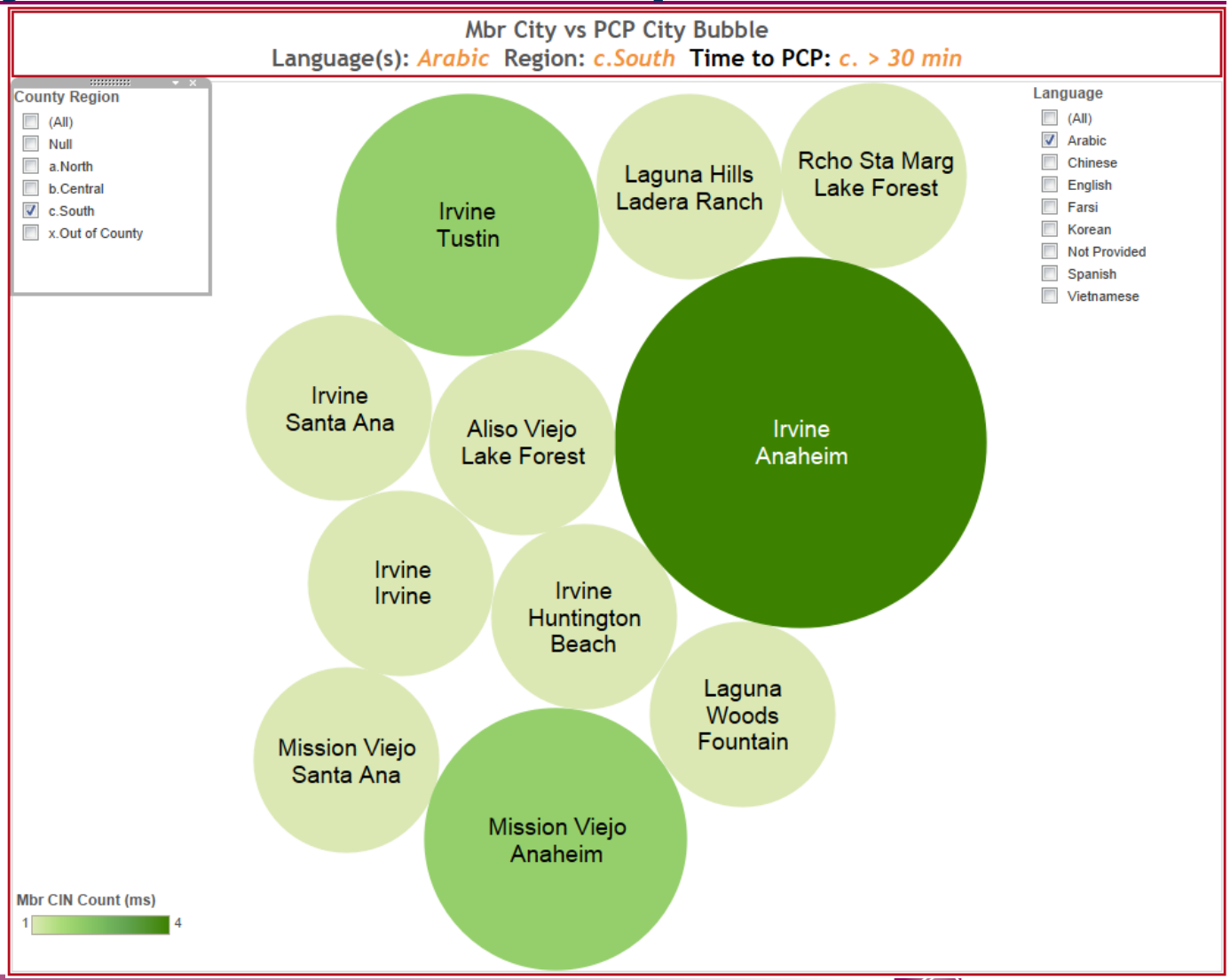
GNA Results:
Member City vs. PCP: Arabic Population

Legend

Member City
PCP City

Color & Size
Represent #
Of Members



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GNA Results:
Appt Times x ER Visits and PCP Visits

Q25b Appt Times x ER Visits

In the aggregate, those who thought there were NOT enough appointment times have a higher ER visit rate

Language	Appt Times Ok				Agreed, Not Enough			
	ER Visits / GNA Mbr	Er Visit Count	GNA CIN Count	% of Language	ER Visits / GNA Mbr	Er Visit Count	GNA CIN Count	% of Language
Arabic	0.3	36	111	63%	0.4	25	65	37%
Chinese	0.1	39	317	82%	0.1	4	68	18%
English	0.3	120	394	72%	0.5	72	155	28%
Farsi	0.3	38	112	67%	0.3	16	55	33%
Korean	0.2	44	247	49%	0.1	19	257	51%
Spanish	0.3	107	351	61%	0.4	97	228	39%
Vietnamese	0.1	35	359	76%	0.1	10	116	24%
Grand Total	0.2	419	1,891	67%	0.3	243	944	33%

Q25b Appt Times x PCP Visits

In the aggregate, those who thought there were NOT enough appointment times have a lower PCP visit rate

Language	Appt Times Ok				Agreed, Not Enough			
	Visits / GNA Mbr	Visit Count	GNA CIN Count	% of Language	Visits / GNA Mbr	Visit Count	GNA CIN Count	% of Language
Arabic	1.9	54	28	68%	2.6	34	13	32%
Chinese	2.2	195	87	87%	1.7	22	13	13%
English	2.4	286	120	79%	2.3	70	31	21%
Farsi	2.2	35	16	53%	2.5	35	14	47%
Korean	2.3	147	64	54%	1.9	102	54	46%
Spanish	2.4	288	122	65%	2.5	165	67	35%
Vietnamese	2.6	142	55	82%	1.9	23	12	18%
Grand Total	2.3	1,147	492	71%	2.2	451	204	29%

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GNA Results:
Support x ER Visits and PCP Visits

Q13 Support Friends / Relatives x ER Visits

In the aggregate, those who said they have support from relatives & friends have a lower ER visit rate

	Don't have support				Have support			
Language	ER Visits / GNA Mbr	Er Visit Count	GNA CIN Count	% of Language	ER Visits / GNA Mbr	Er Visit Count	GNA CIN Count	% of Language
Arabic	0.6	16	25	22%	0.3	24	90	78%
Chinese	0.0	0	20	8%	0.1	16	222	92%
English	0.6	33	56	15%	0.3	108	310	85%
Farsi	0.2	5	29	20%	0.3	34	113	80%
Korean	0.2	20	109	30%	0.1	20	255	70%
Spanish	0.6	37	57	24%	0.3	52	184	76%
Vietnamese	0.1	18	192	48%	0.1	30	207	52%
Grand Total	0.3	129	488	26%	0.2	284	1,381	74%

Q13 Support Friends / Relatives x PCP Visits

In the aggregate, those who said they have support from relatives & friends have a higher PCP visit rate

	Don't have support				Have support			
Language	Visits / GNA Mbr	Visit Count	GNA CIN Count	% of Language	Visits / GNA Mbr	Visit Count	GNA CIN Count	% of Language
Arabic	3.0	6	2	18%	3.3	30	9	82%
Chinese	4.0	12	3	10%	3.6	101	28	90%
English	2.2	20	9	14%	3.3	186	56	86%
Farsi	2.0	6	3	25%	3.4	31	9	75%
Korean	3.4	27	8	28%	3.0	62	21	72%
Spanish	3.6	50	14	29%	5.1	172	34	71%
Vietnamese	1.8	21	12	48%	3.8	50	13	52%
Grand Total	2.8	142	51	23%	3.7	632	170	77%

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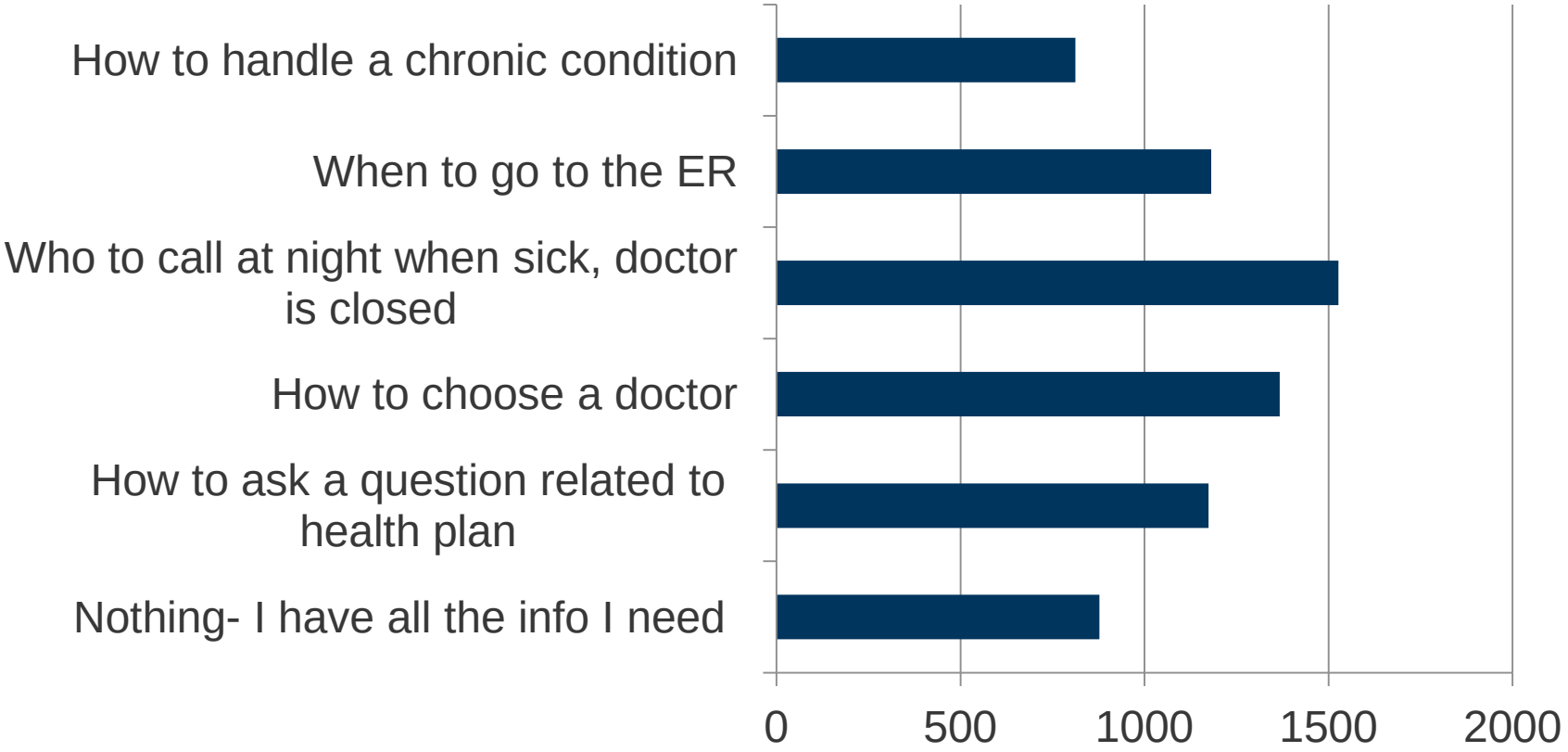
GNA Results: Helpful information

What information would be helpful to you on how to use CalOptima? Check all that apply.



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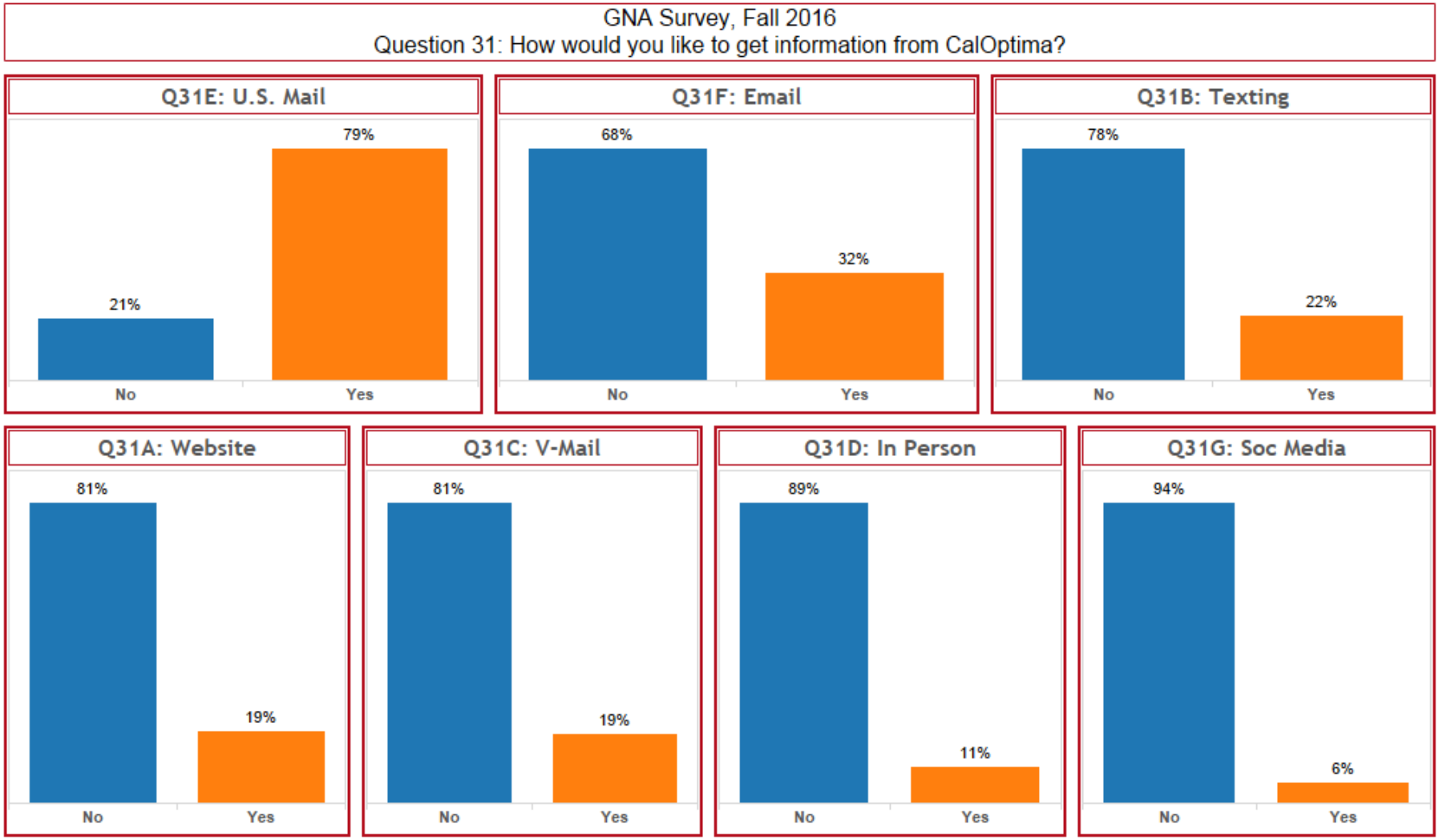
GNA Results: How members like to get information from CalOptima



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CalOptima
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After the survey…

- Collaboration with:
  - Member Health Needs Assessment
  - Access & Availability
  - Member Experience
  - Providers
  - Community Agencies
  - Members

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Special Board of Director's Quality Assurance Committee Meeting
May 22, 2017

PACE Member Advisory Committee (PMAC) Update

PMAC Meeting March 6, 2017

- Updates from the Director
  - Staffing Update: New team members at PACE include a new social worker, dietician, and a kitchen assistant.
  - Specialty appointment scheduling: Social workers will provide calendars to the participant with their specialty care appointments.

- New Items Discussed
  - Participant Newsletter: A committee composed of PACE staff and participants are currently working on a newsletter that will be published on a quarterly basis beginning in June. The newsletter will consist of clinic updates, health issues, and a segment featuring each department. Each issue will also include a 'Guess Who' featuring a staff that is interviewed by a participant.

- The following suggestions and comments were provided by PACE Participants:
  - Request for advance notice of appointments.
  - Access to specialty appointments and transportation services has improved. An 'Employee of the Month' feature was suggested.
  - Activity calendars available on tables in the social day area.
  - Suggested additional religious and spiritual services at PACE.

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Executive Summary

Quality Improvement Committee (QIC) 1st Quarter 2017

- Reviewed and approved:
  - 2017 QI Program Description & Work Plan
  - 2017 UM Program Description & Work Plan
  - 2017 PACE Quality Assurance Performance Improvement (QAPI) Description and Work Plan
- Quarterly reports provided by all key areas
- Provided an update on PACE quality improvement activities
- Completed 100% outreach for Health Risk Assessments for OCC, OC, SPD members
- Presented updates on Initial Health Assessment progress, disease management clinical and satisfaction measures
- Reported on initial and re-credentialing of the provider network and related facility site review/medical record review/physical accessibility review results
- Provided an update on Pharmacy Management activities to improve patient safety
- Reported the Quality Measurement & Performance Improvement monitoring, including progress on regulatory QIPs, PIPs, & CCIPs
- Identified priority quality initiatives to improve HEDIS & CAHPS measures, including new initiatives approved in December, 2016
- Provided an update on the Customer Services metrics and Timely Access/Appointment Availability
- Presented an update on Behavioral Health services, BH initiatives and an update on the new MBHO implementation
- Provided the quarterly Audit & Oversight and delegation monitoring reports
- Reported Member Grievances by type and provider

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Quality Improvement Committee (QIC) 1st Quarter 2017 Update

Special Board of Directors' Quality Assurance Committee Meeting
May 22, 2017

Caryn Ireland
Executive Director, Quality and Analytics

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QIC Reporting By Department

- The following departments report to the QIC quarterly meeting at a minimum:
  - Case Management and Complex Case Management
  - Behavioral Health Integration (BHI)
  - Customer Service
  - Health Education & Disease Management (HE & DM)
  - Grievance & Appeals Resolution Services (GARS)
  - Long-Term Services and Support (LTSS)
  - Provider/Network Management
  - OneCare (OC) and OneCare Connect (OCC)
  - PACE
  - Pharmacy
  - Utilization Management (UM)

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Committee Updates and Dashboard

- Reviewed and Approved:
  - UM Committee Report and Minutes
    February 23, 2017
  - GARS Subcommittee Report
    February 28, 2017
  - LTSS Subcommittee Report
    March 20, 2017
  - BHI Subcommittee Report
    February 7, 2017
- QI Dashboard 4th Quarter
  - See Attachment A
- QIC Charter reviewed and approved for 2017

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QI Program Update

- Reviewed and approved the 2017 QI Program Description and Work Plan
  - New committee and subcommittee reporting structures
- Reviewed and approved the 2017 UM Program Description and Work Plan
- Reviewed and approved the 2017 PACE Quality Assurance Performance Improvement (QAPI) Description and Work Plan
  - Reviewed PACE 4th Quarter Quality Update
    - Successful audits for the third year with both the Centers for Medicare and Medicaid Services (CMS) and Department of Health Care Services (DHCS)
    - Successful implementation of the new Electronic Medical Record system
    - Continued monitoring of transportation service and issues

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UMC 4th Quarter Update

- All reporting areas represented at 4th quarter meeting
- Areas of opportunity identified:
  - CalOptima Community Network's (CCN) facility bed day goals to be revaluated for 2017
  - Recent audit findings consistently identified Notice of Action letter language is deficient:
    - Criteria and denial reasons written at 6th grade level
    - A task force will be assembled consisting of UM representation from all health networks to address this element
    - Dr. Matthew Collins from Monarch has offered to serve as physician support for the task force

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QIC Highlights

Credentialing Activity	4th Quarter 2016	Year End Summary
Total number of Initial and Re-credential files completed and approved by CPRC*	135	816
Percentage of Clean Files approved	89%	90%
Percentage of Files with Issues presented to CPRC	11%	10%
Timeliness for Initials (percentage of files completed within 180 days)	100%	97%
Timeliness for Recreds (percentage of files completed within 36 Months)	97.8%	97%
Number of Provider Files Requiring CPRC Action	3	4

* Credentialing and Peer Review Subcommittee (CPRC)

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QIC Highlights

Facility Site Review (FSR), Medical Record Review (MRR), Physical Accessibility Review (PAR)

- Conducted Initial and Full Scope FSR/MRR surveys for primary care providers (PCP)
  - 35 FSR/MRR completed
- Conducted initial and tri-annual Physical Accessibility Review Surveys (PARS) for all PCPs and high volume specialists
  - 107 PARs completed
- Hosted webinar with Health Network Relations, Provider Relations, Credentialing Coordinators on CalOptima's Site Review Process

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QIC Highlights

Potential Quality Issue (PQI): Oct – Dec 2016

Description	Count
Number of PQI Cases Opened	**236**
Number of PQI Cases Closed	**191**
Severity Level: Level 0 – 164 cases/85.59% Level 1 – 26 cases/13.14% Level 2 – 1 case/0.04% Level 3 – 0 cases/0.00% Level 4 – 0 cases/0.00%	

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QIC Highlights

Patient Safety: CBAS & SNF

- Continued assessment of CBAS facilities for patient safety issues
  - Most frequent cited findings: Multi-Disciplinary Team assess participant needs more thoroughly; include needs in Plan of Care
- Member Satisfaction
  - Implemented CBASF satisfaction survey; 29 of 30 surveys returned; results under review
  - Implemented LTSS-SNF satisfaction survey; 20 surveys distributed to10 facilities with 62% response rate; results under review
- Completed Plan of Correction reviews for each SNF facility
  - Reviews completed, included 3 years of re-certification surveys for each facility.
- Critical Incidents:
  - 4 critical incidents were reported (2 CBAS, 2 SNF)

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QIC Highlights

Case Management

- Health Risk Assessments OC, OneCare Connect (OCC) and Seniors and Persons with Disabilities (SPD) members
  - Outreach across all Lines of Business = 100%
- Continuity and coordination of Medical/BHI
  - BHI participation in Individual Care Team (ICT) = 100%
- Review of Emergency Department (ED) communications with PCPs
  - ED post discharge process produces 100% notification of PCPs of member's ED visits
  - Receiving some confirmations of post ED PCP visits from physicians
- Member Satisfaction with CM programs
  - Satisfaction above threshold for all measures
- Identification of Complex Cases (Health Networks)
  - 77% increase in cases identified over the first 9 months of the year
  - Most improvement in two networks

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QIC Highlights

HE& DM

- Initial Health Assessment (IHA) improvement plan update
  - Achieved 10% increase over 2015 in IHA completeness
- Diabetes Program: HbA1c Control
  - Medi-Cal = 54.01% (75th percentile)
  - OC = 72.51% (50th percentile)
- Asthma Program: Asthma Medication Ratio (AMR)
  - Age 5 to 11 Rate 72.50% (50th percentile)
  - Age 12 to 18 Rate 64.59% (70th percentile)
- Member Satisfaction with the DM program
  - CalOptima staff was helpful in getting the information I needed: 82%
  - CalOptima staff responded to my request or concerns in a timely manner: 80%
  - I learned useful information from this program: 79%
  - The information I got has helped me manage my health better: 76.8%
  - I would tell others about CalOptima's Disease Management programs: 82.4%

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QIC Highlights

QIPs, PIPs & CCIP Update — on track

- Medi-Cal:
  - Diabetes HbA1c testing
  - Initial Health Assessment
- OC:
  - Diabetes HbA1c testing
- OCC:
  - Readmissions
- LTSS:
  - IHSS staff participation in ICTs
- OC/OCC
  - Blood Pressure Control (including medication adherence)

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QIC Highlights

2016 CAHPS Survey Results:

- Medi-Cal Child: 4 Measures below 25th percentile
  - Getting Needed Care
  - Getting Care Quickly
  - How Well Doctors Communicate
  - Customer Service
- Medi-Cal Adult: 3 Measures below 25th percentile
  - Rating of Health Plan
  - Getting Needed Care
  - Getting Care Quickly
- Activities to Improve Member Experience:
  - Evaluate member pain points
  - Develop member experience provider scorecard
  - Explore provider coaching options

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QIC Highlights

Pharmacy Management

- Underutilization:
  - No significant change in potential under-utilization for diabetics with hypertension without an ACE/ARB
- Continued opioid overutilization interventions
- Provided ongoing monitoring of specialty drug trends: Hepatitis C
- Continued monitoring of Specialty Drug Utilization
  - Specialty Hepatitis C medications
  - Physician-administered drugs
- Medication Adherence Measures – Progress Towards Goals
  - Cholesterol medications
  - Antihypertensive medications
  - Diabetes medications

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QIC Highlights

Audit & Oversight

- Delegation of Utilization Management, Customer Service, Credentialing/Recredentialing
- Monthly File Audit Results Presented for each Health Network and CalOptima internal
- Delegation Oversight Committee continues to monitor and recommend corrective action plans for any deficiencies

Provider Relations

- Continuity and Coordination of Care
  - Achieved standard of 30-day notice when a primary care provider is terminated (goal is 85%)
  - Reasons for termination include PCP leaving group; not interested in participating in CCN (most are members with another Health Network)

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QIC Highlights

Access and Availability

- Timely Access/Appointment Availability and Member Services
  - For all lines of business: 4 of the 8 standards were MET
  - Non-compliance areas
    - Non-urgent care within 3 business days
    - Urgent appointment with prior authorization in 96 hrs
    - Specialty appointment within 15 business days
    - 1st prenatal appt within 10 business days
- Availability Standards (Ratio and Distance)
  - All LOB: 8 of the 8 standards were MET

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QIC Highlights

- Customer Service
  - ➢ Reviewed 4th Quarter 2016 call center results
    - Met all call center targets for 2016
      - Abandonment Rate
      - Average Speed of Answer
      - First Call Resolution
  - ➢ Top Callback Categories:
    - OneCare: Member Eligibility and Dental Services
    - Medi-Cal: Provider Information and Pharmacy services

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QIC Highlights

Quality Initiatives Healthcare Effectiveness Data (HEDIS) update

- Closely monitoring measures; comparing to 2015 progress
- Identifying measures for hybrid chart review and pursuit strategy in process
- Project plans in place for new initiatives (approved CalOptima Board Action Agenda Referral [COBAR])
  - Women's Wellness Campaign (cervical and breast cancer)
  - Member and provider office staff Incentives
    - Extended office hours pilot project
  - Member and provider Incentives:
    - Prenatal/postpartum
    - Cervical and breast cancer screening
    - PCP office incentives for well woman visits/screenings
  - Health and wellness campaign
    - Culturally-specific radio public service announcements (PSA)

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QIC Highlights

Behavioral Health Integration (BHI)

- Presented progress on quality of clinical care and service
  - Maintained 100% ICT participation
  - Completed annual assessment of medical records for communication between PCPs and BH providers
  - Antidepressant medication management and attention-deficit/hyperactivity disorder (ADHD) interventions
  - Struggled with interventions for follow up after hospitalization measure
  - Clinical Practice Guidelines (CPGs): adoption of 2 BH CPGs completed
- Delegation oversight of BHI services
  - Monitored through Delegation Oversight Committee

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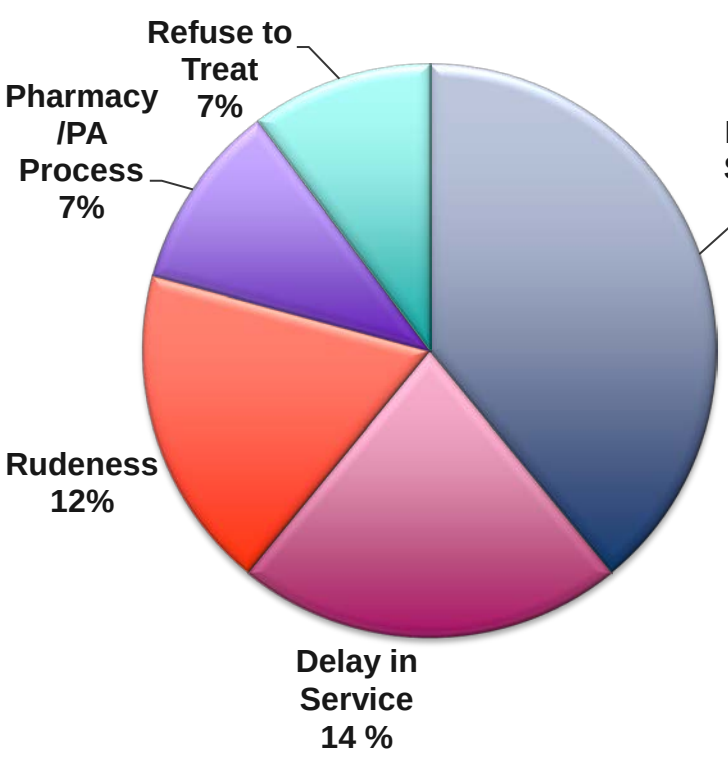
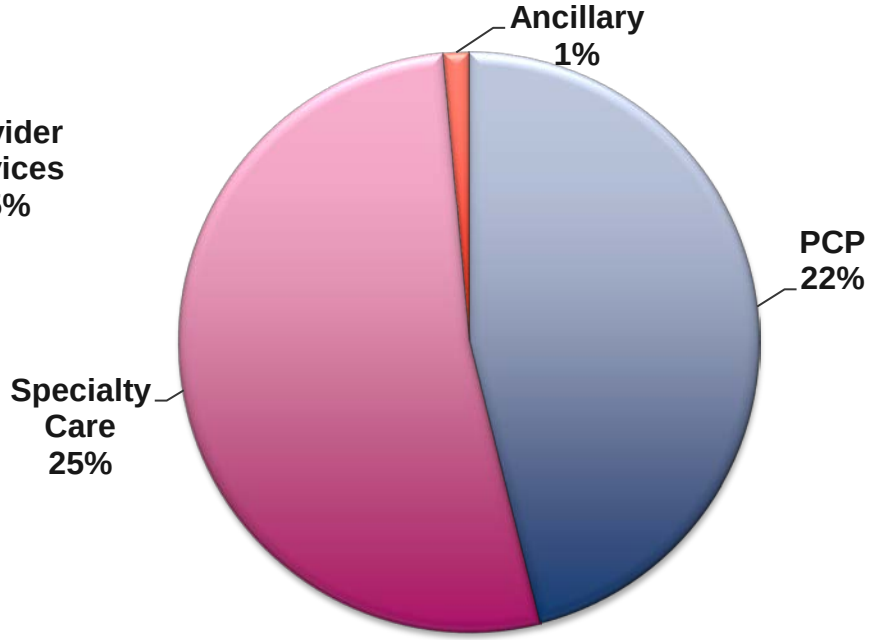
QIC Highlights

- Member complaints and grievances
  - Presented member grievances by type and provider and analysis of providers with higher volume of complaints/grievances





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QIC Highlights

- GARS: Highest frequency of complaints by provider type
  - Pain medicine specialist (8 grievances)
    - Refuse to treat (change of medication dosage)
    - Delay in service
    - Provider services (request of records)
  - General practice provider (8 grievances)
    - Rudeness
    - Provider services
    - Refuse to treat
    - Delay in service
    - Office wait time
  - Family medicine provider (6 grievances)
    - Rudeness
    - Delay in service
    - Provider services (no call back, unprofessional)
    - Wrong information given (incorrect prescription)

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2016 QI Dashboard - Year End

2016 QI Work Plan Title	Goal	Owner	Red-50% Yellow 75 % Green 90%+
			Completion
Case Management			
II. A. Quality of Clinical Care- Review of health risk assessments to OCC, OC, SPD members	OCC, OC, SPD:100% of eligible population improvement over 2016	Sloane Petrillo	OCC OneCare SPD
II. B. Quality of Clinical Care- Continuity & Coordination of Medical/BH	85%	Sloane Petrillo	
II. C. Quality of Clinical Care- Review of emergency department communications with PCPs	85%	Sloane Petrillo	
II. D. Patient Safety, Quality of Care Case Management- High ER utilization	35%	Sloane Petrillo	
II. E. Quality of Clinical Care-Review of member satisfaction with CM programs	Satisfaction with Case Management:85%	Sloane Petrillo	
II. F. Quality of Identification of Complex Case Management (added)	Health Networks are identifying members eligible for Complex Case Management	Sloane Petrillo	
Behavioral Health			
III. A. Quality of Clinical Care: Integration of BH services	10% improvement over 2015 ICT Participation	Dr. Donald Sharps	
III. A. Quality of Clinical Care: Integration of BH services	50th percentile or more on BH HEDIS Measures	Dr. Donald Sharps	
III. B. Quality of Care- Clinical BH Practice Guidelines adoption for Medi-Cal line of business	100%	Dr. Donald Sharps	
III. C. Quality of Service and Quality of Clinical Care- Review of behavioral health providers communications with PCPs	85%	Dr. Donald Sharps	
LTSS			
IV. A. Safety of Clinical Care and Quality of Clinical Care- Review and assess LTSS placement for members participating with each organization/program	2% CBAS; Establishing goals in 2016 for IHSS, LTC, & MSSP	Tracy Hitzeman	CBAS
IV. B. Safety of Clinical Care and Quality of Clinical Care- Review and assess emergency department visits for LTSS members participating with each organization/program	9% CBAS; Establishing goals in 2016 for IHSS, LTC, & MSSP	Tracy Hitzeman	CBAS
IV. C. Safety of Clinical Care and Quality of Clinical Care- Review and assess readmissions for LTSS Members participating with each organization/program: **Hospital Readmission**	2.5% CBAS; Establishing goals in 2016 for IHSS, LTC, & MSSP	Tracy Hitzeman	CBAS
IV. C. Safety of Clinical Care and Quality of Clinical Care-Review and Assess Readmissions for LTSS members participating with each organization/program: **Long Term Care Admissions**	2% CBAS; Establishing goals in 2016 for IHSS, LTC, & MSSP	Tracy Hitzeman	CBAS
IV. D. Quality of Clinical Care- Review of health risk assessment (HRA) for OneCare Connect (OCC), Long Term Care (LTC) Members. This Goal was measured in CM	100%	Tracy Hitzeman	See CM
IV. E. CBAS Member Satisfaction	5% improvement over previous year	Laura Guest	
IV. F. SNF Member Satisfaction	5% Improvement over Previous Year	Laura Guest	
Health Education & Disease Management			
V. A. Quality of Care- All new members will complete the Initial Health Assessment and related IHEBA/SHAs	Improve plan performance over 2015 by 10%	Pshyra Jones	
V. B. Quality of Clinical Care, review of Disease Management Program (Asthma)	Increase to 50th percentile for members between 5-18 yrs old	Pshyra Jones	
V. C. Quality of Clinical Care, review of Disease Management Program (Diabetes)	Maintain 90th percentile for Medi-Cal; increase to 75th percentile for Medicare	Pshyra Jones	OneCare Medi-Cal

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2016 QI Dashboard - Year End

Attachment A

2016 QI Work Plan Title	Goal	Owner	Red-50% Yellow 75 % Green 90%+
V. D. Quality of Clinical Care, review of Disease Management Program (CHF)	1. CHF-Establish baseline for unplanned readmissions with an admitting diagnosis of heart failure for members in the Heart Failure DM Program 2. Satisfactions with DM-90%	Pshyra Jones	
V. E. Quality of Care- Clinical Practice Guidelines adoption for Medi-Cal line of business	100%	Pshyra Jones	
V. F. Quality of Clinical Care, review of member satisfaction with DM programs	90% satidfaction with the DM program	Pshyra Jones	
V. G. Quality of Clinical Care- Review of cardiovascular Disease	As determined by CMS	Pshyra Jones	
V. H. Quality of Clinical Care - Review of Diabetes and All Cause Readmissions	As determined by CMS	Marsha Choo	
V. I. Implementation of the Childhood Obesity (Shape Your Life) Program	Implement revised program design-2017; Evaluate progress semi-annually	Pshyra Jones	
V. J. Implement Weight Watchers (WW) for Medi-Cal Members	Implement revised program design-2017; Evaluate progress semi-annually	Pshyra Jones	
V. K. Implement Home Assessments for member participating in Care Management Programs	Implement revised program design-2016; Evaluate progress semi-annually	Pshyra Jones	
V. L. Conduct 2016 Group Needs Assessment (GNA)	Complete GNA requirement for 2016	Pshyra Jones	
Access & Availability			
VI. A. Quality of Service and Quality of Clinical Care- Review of notification to members	85%	Belinda Abeyta	
VI. B. Access to Care- Credentialing of provider network is monitored	100%	Esther Okajima	
VI. C. Access to Care- Recredentialing of provider network is monitored	100%	Esther Okajima	
VI. D. Accessibility: Review of access to care	Appt.: 90% Phone: <5%	Marsha Choo	
VI. E. Availability: Review of availability of practitioners	1:2,00; 1:2,000; 1:5,000; 95%; 90%; 1:100; 100%	Marsha Choo & Dr. Donald Sharps	
Patient Safety			
VII. A. Safety of Clinical Care- Providers shall have timely and complete facility site reviews	80%	Esther Okajima	
VII. B. Safety of Clinical Care- Review and follow-up on member's potential Quality of Care Complaints	To achieve a turnaround time of 90 day of case received; Assure patient safety and enhance patient experience by timeliness of clinical care reviews	Esther Okajima	
VII. C. Safety of Clinical Care and Quality of Clinical Care- reviewed through Pharmacy Management	100%	Kris Gericke, PharmD	
VII. D. Safety of Clinical care and Quality of Clinical Care- review of Specialty Drug Utilization	TBD	Kris Gericke, PharmD	
VII. E. Patient Safety- Review and assessment of CBAS Quality Monitoring	100% CDA Audit Results	Esther Okajima	
VII. F. Patient Safety- Review and assessment of SNF Quality Monitoring	100% DHCS Audit Results	Esther Okajima	
VII. G. Safety of Clinical Care- Review of antibiotic usage	68.53%; 91.21%	Kelly Rex-Kimmet	
VII. H.Implementation of the new PBM	Meet Performance Guarantee Per Contract	Kris Gericke, PharmD	

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2016 QI Dashboard - Year End

Attachment A

2016 QI Work Plan Title	Goal	Owner	Red-50% Yellow 75 % Green 90%+
Member Experience			
VIII. A. Quality of Service- Review of Member Satisfaction	Annual CAHPS Results	Kelly Rex-Kimmet	
VIII.B. Quality of Service- Reviewed through customer service first call resolution	85% of calls resolved at first call	Belinda Abeyta	**OneCare OCC Medi-Cal**
VIII. C. Quality of Service- Reviewed through customer service access	ASA 30 Seconds <3% Hold time under 30 Seconds First Call Resolution 85%	Belinda Abeyta	**OneCare OCC Medi-Cal**
VIII. D. Quality of Care & Service reviewed through GARS & PQI (MOC)	Employ data-based Quality Improvement Measures to upgrade performance	Janine Kodama & Quality Of Care	
HEDIS/STARS Improvement			
iX. A. Improve identified HEDIS Measures listed on "Measures" worksheet	See Measures Worksheet	Kelly Rex-Kimmet	
IX. B. Improve identified STARS measures listed on "Measure" worksheet	See Measures Worksheet	Kelly Rex-Kimmet	**Yellow→Green**
IX. C. Improve CAHPS measures listed on "Measures" worksheet	See Measures Worksheet	Kelly Rex-Kimmet	
IX. D. HEDIS: Launch pediatric wellness clinic	See Measures Worksheet	Kelly Rex-Kimmet	
IX. E. STARS improvement- Medication Adherence Measures	4 Stars	Kris Gericke	
IX. F. HEDIS: Health Network support of HEDIS & CAHPS Improvement (added)	24.33%	Kelly Rex-Kimmet	
Delegation Oversight			
X. A. Delegation Oversight of CM	100%	Sloane Petrillo	
X. B. Quality of Care & service of UM through delegation oversight reviews	98%	Solange Marvin	
X. C. Delegation Oversight of BH Services	98%	Dr. Edwin Poon	
Organizational Projects			
XI. A. Implementation of the 2016 Value Based P4P program	Improve Performance over 2015	Kelly Rex-Kimmet	
XI. B. Value Based P4P 2016-2019	National & State Benchmarks	Kelly Rex-Kimmet	

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Member Trend Report
4th Quarter 2016

Special Board of Directors' Quality Assurance Committee Meeting
May 22, 2017

Janine Kodama
Director, Grievance and Appeals

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Overview

- Trend of the rate of complaints (appeals/grievances) per thousand members for all CalOptima programs for the fourth quarter in 2016.
  - Appeal — A request by the member for review of any decision to deny, modify or discontinue a covered service
  - Grievance — An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program
- Breakdown of the complaints by type
- Interventions based on trends, as appropriate

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Quality of Service and Quality of Care

- Quality of Service (QOS) are issues resulting in inconvenience or dissatisfaction to the member.
- Quality of Care (QOC) concerns occur if the member feels there was a problem with the care they received or that they did not receive enough care.

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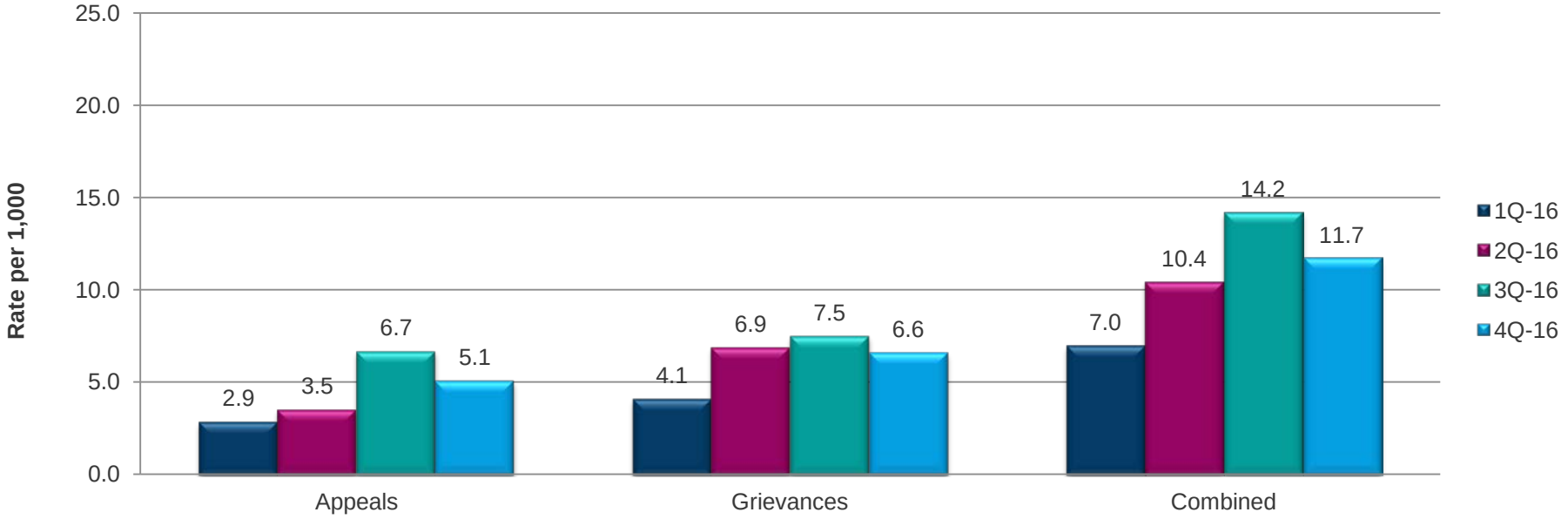
Overall OneCare Connect (OCC) Member Complaints



	Total Complaints	Appeals	Grievances	YTD Membership
1Q-2016	138	44	94	15, 340
2Q-2016	189	64	125	17, 019
3Q-2016	261	123	138	17,451
4Q-2016	201	88	113	17, 369

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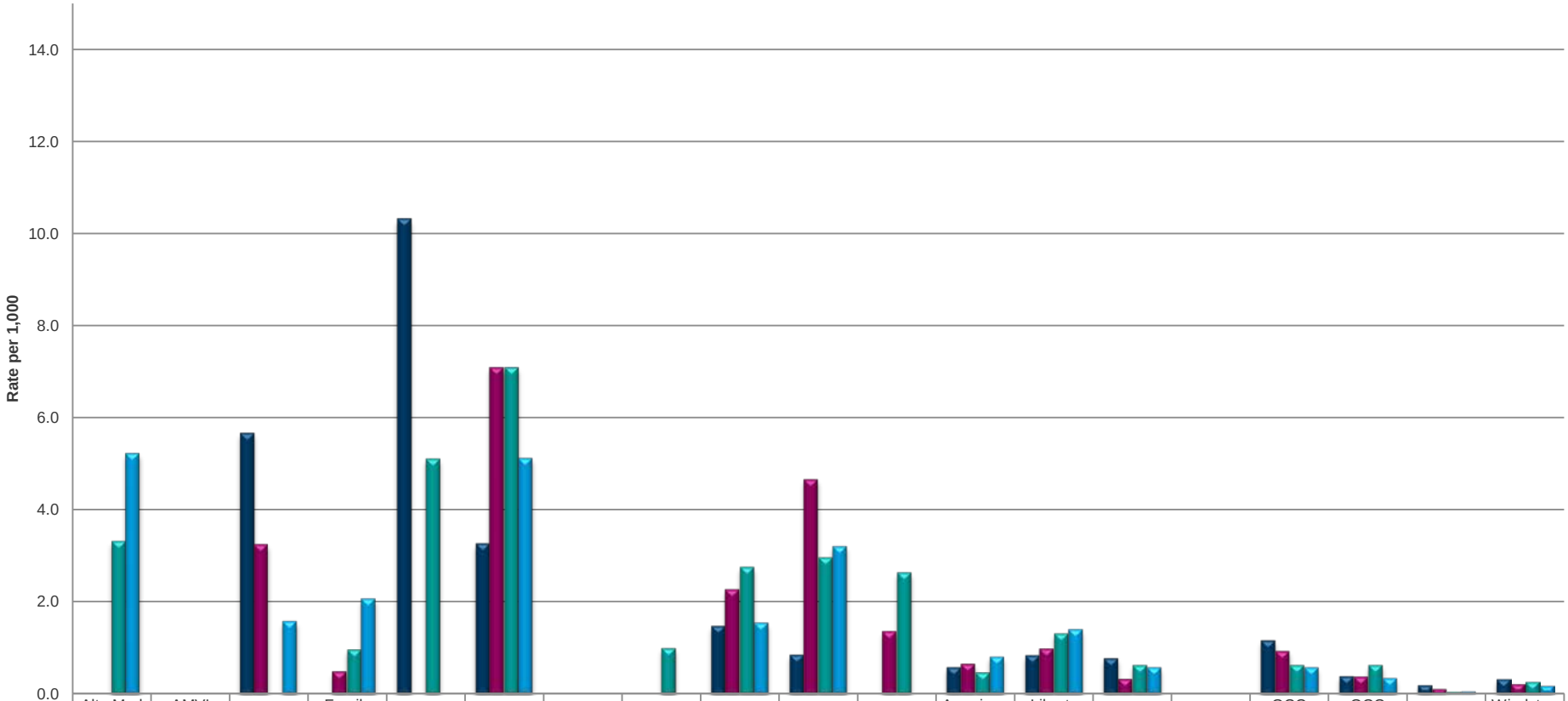
OCC Member Grievances Quarterly Rate/1,000



	Alta Med Health (575)	AMVI Care (626)	Arta (633)	Family Choice (1,929)	Heritage (247)	Monarch (5,475)	Noble (464)	OC Adv (119)	Prospect (3,242)	Talbert (1,248)	UCMG (669)	American Logistics (17,122)	Liberty Dental (17,122)	CCN (17,122)	MLTSS (17,122)	OCC Prog (17,122)	OCC Pharm (17,122)	VSP (17,122)	Windstone (17,122)
1Q-16 (15,340)	0.0	0.0	5.7	0.0	10.3	3.3	0.0	0.0	1.5	0.9	0.0	0.6	0.8	0.8	0.0	1.2	0.4	0.2	0.3
2Q-16 (18,123)	0.0	0.0	3.3	0.5	0.0	7.1	0.0	0.0	2.3	4.7	1.4	0.7	1.0	0.3	0.0	0.9	0.4	0.1	0.2
3Q-16 (18,317)	3.3	0.0	0.0	1.0	5.1	7.1	0.0	1.0	2.8	3.0	2.6	0.5	1.3	0.6	0.0	0.6	0.6	0.1	0.3
4Q-16 (17,122)	5.2	0.0	1.6	2.1	0.0	5.1	0.0	0.0	1.5	3.2	0.0	0.8	1.4	0.6	0.0	0.6	0.4	0.1	0.2

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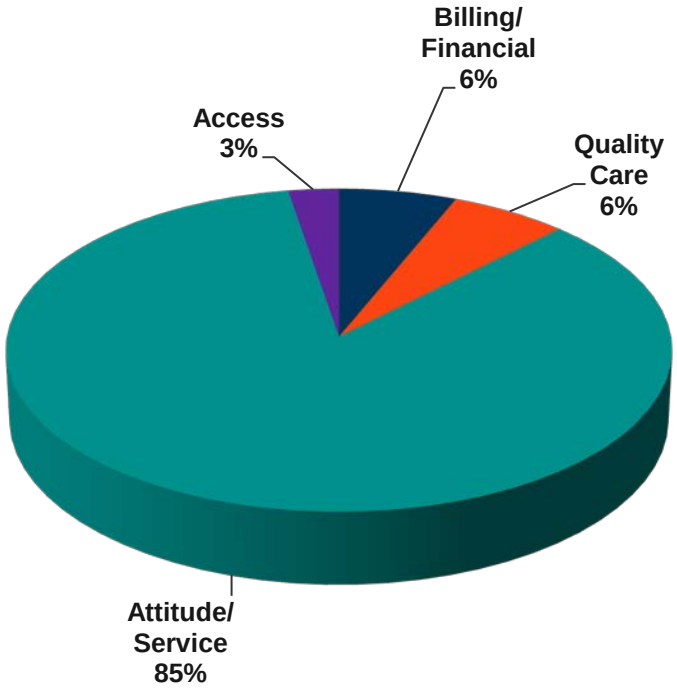
OCC Grievances by Category

- Total of 113 grievances filed by 97 unique members in Q4 2016.
  - Of these, 96 grievances (85%) were related to QOS, and 7 grievances (6%) were related to QOC concerns.
  - Note: The percentage by categories represents the historic trend.
- The QI department continues to review for QOC issues and potential trending.



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Common QOS and QOC Concerns

- Delay in service (QOS)
- Dental (QOS)
  - Rudeness
  - Authorizations
- Transportation vendor (QOS)
  - Late/no show
  - Cancelled without notice
- Question diagnosis/treatment (QOC)

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Summary

- Although Alta Med and Arta seem to report a higher quarterly rate/1,000 grievances from the prior quarter, it's mainly due to their low membership.
  - Alta Med — Three (3) grievances received out of 543 members
  - Arta — One (1) grievance received out of 581 members.
- American Logistics grievances increased from 9 in Q3 to 14 in Q4. The complaints were related to no show, late pickups and cancellations without notice.
- All quality of care concerns are referred to Quality Improvement department for investigation.

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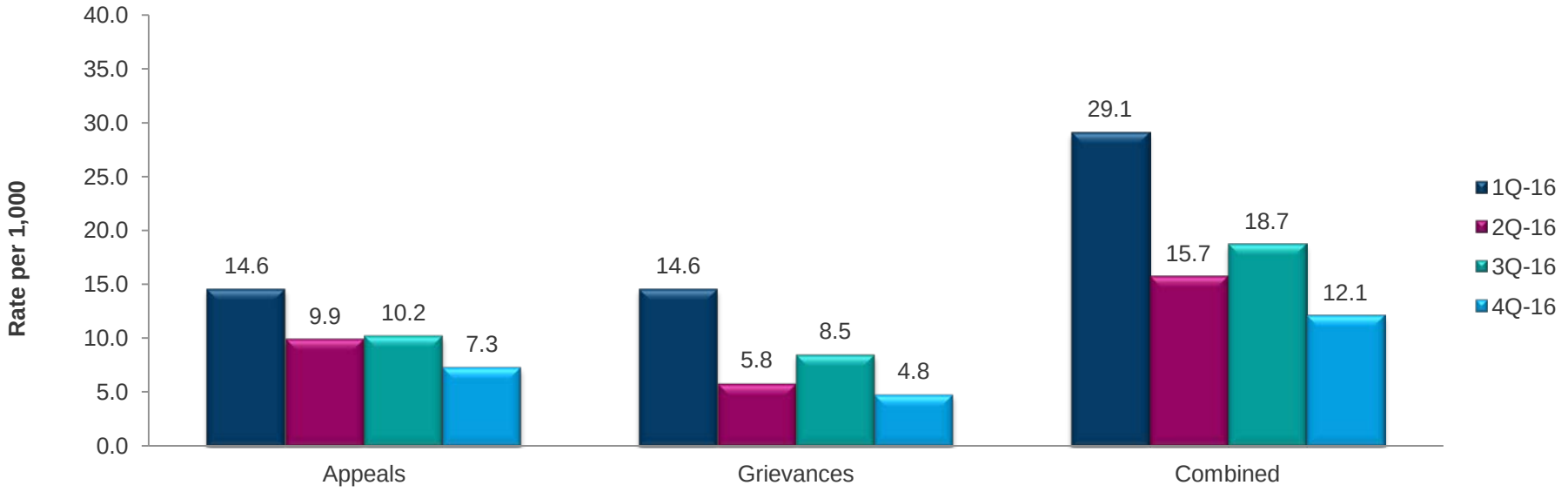
Overall OneCare (OC) Member Complaints



	Total Complaints	Appeals	Grievances	YTD Membership
1Q-2016	38	19	19	1,305
2Q-2016	18	12	7	1,257
3Q-2016	22	12	10	1,230
4Q-2016	16	10	6	1,232

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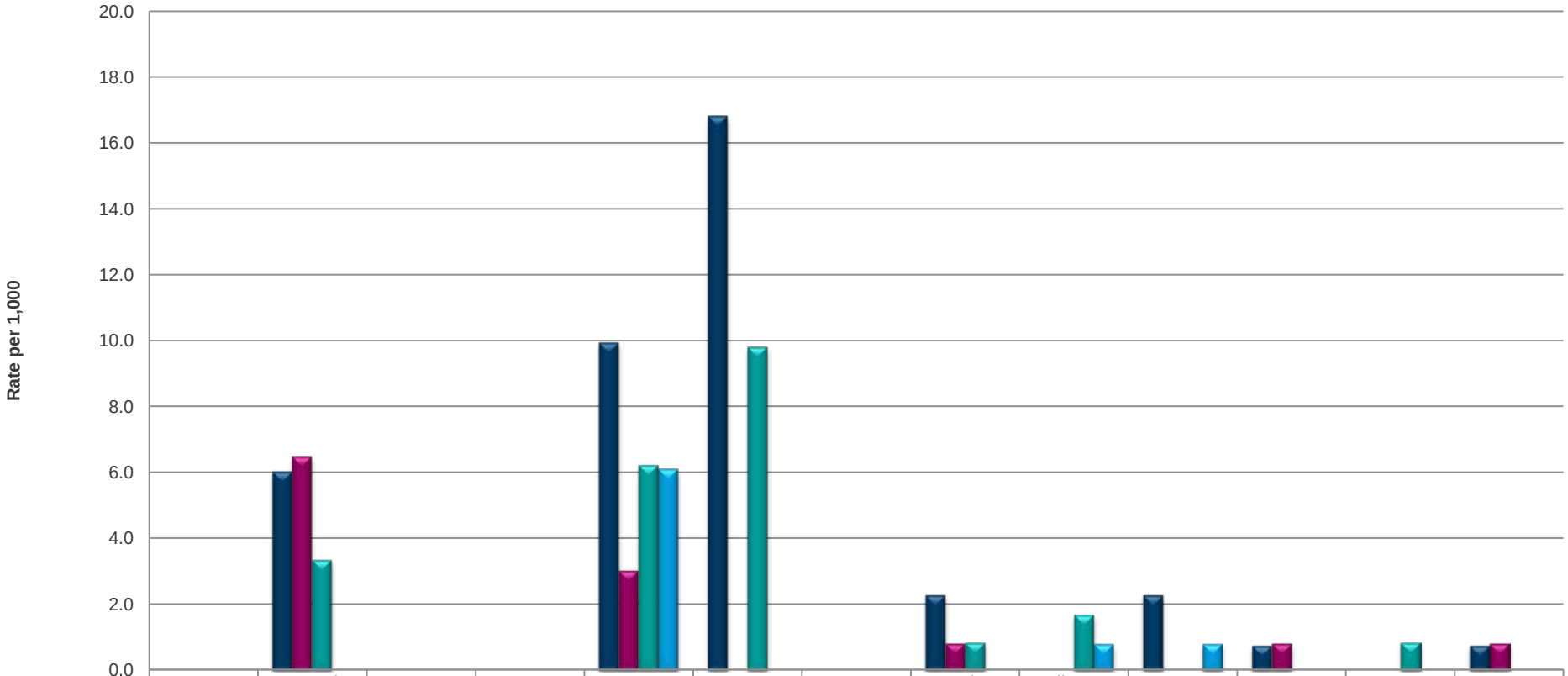
OC Member Grievances Quarterly Rate/1,000



	Alta Med Health (30)	AMVI/ Prospect (311)	Arta Western (39)	Family Choice (66)	Monarch (658)	Talbert (108)	UCMG (21)	American Logistics (1,238)	Liberty Dental (1,238)	OC Ops (1,238)	OC Pharm (1,238)	VSP (1,238)	Windstone (1,238)
1Q-16 (1,305)	0.00	6.04	0.00	0.00	9.94	16.81	0.00	2.3	0.0	2.3	0.8	0.0	0.8
2Q-16 (1,208)	0.00	6.48	0.00	0.00	3.03	0.00	0.00	0.8	0.0	0.0	0.8	0.0	0.8
3Q-16 (1,177)	0.00	3.36	0.00	0.00	6.22	9.80	0.00	0.8	1.7	0.0	0.0	0.8	0.0
4Q-16 (1,238)	0.00	0.00	0.00	0.00	6.08	0.00	0.00	0.00	0.81	0.81	0.00	0.00	0.00

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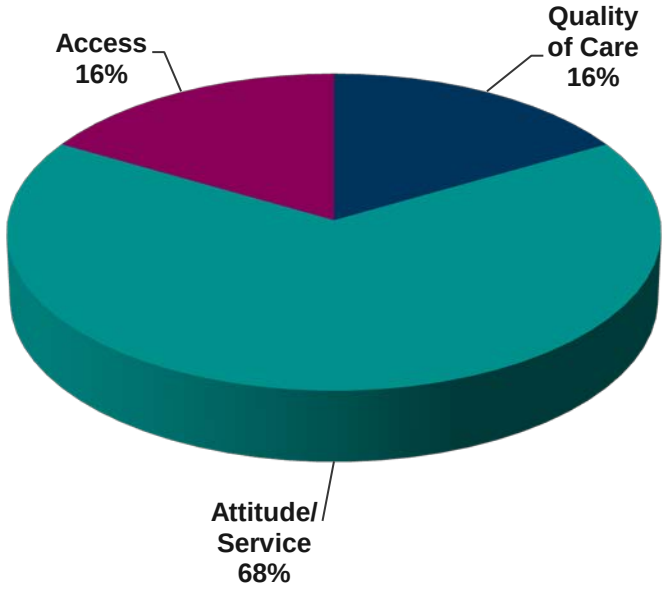
OC Grievances by Category

- Total of 6 grievances filed by 6 unique members in Q4 2016.
  - Of these, 4 grievances (67%) were related to QOS, and 1 grievance (16%) was related to QOC concerns.
  - Note: The percentage by categories represents the historic trend.
- The QI department continues to review for QOC issues and potential trending.



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Common QOS and QOC Concerns

- Provider services (QOS)
- Dental/delay in treatment (QOC)

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Summary

- Although Monarch seem to report a higher quarterly rate/1,000 grievances compared to the other networks, it's mainly due to the overall low membership for OneCare and that Monarch has the most members for that program.
  - Monarch – Four (4) grievances received out of 658 members.
- No specific trending of issues or providers identified.

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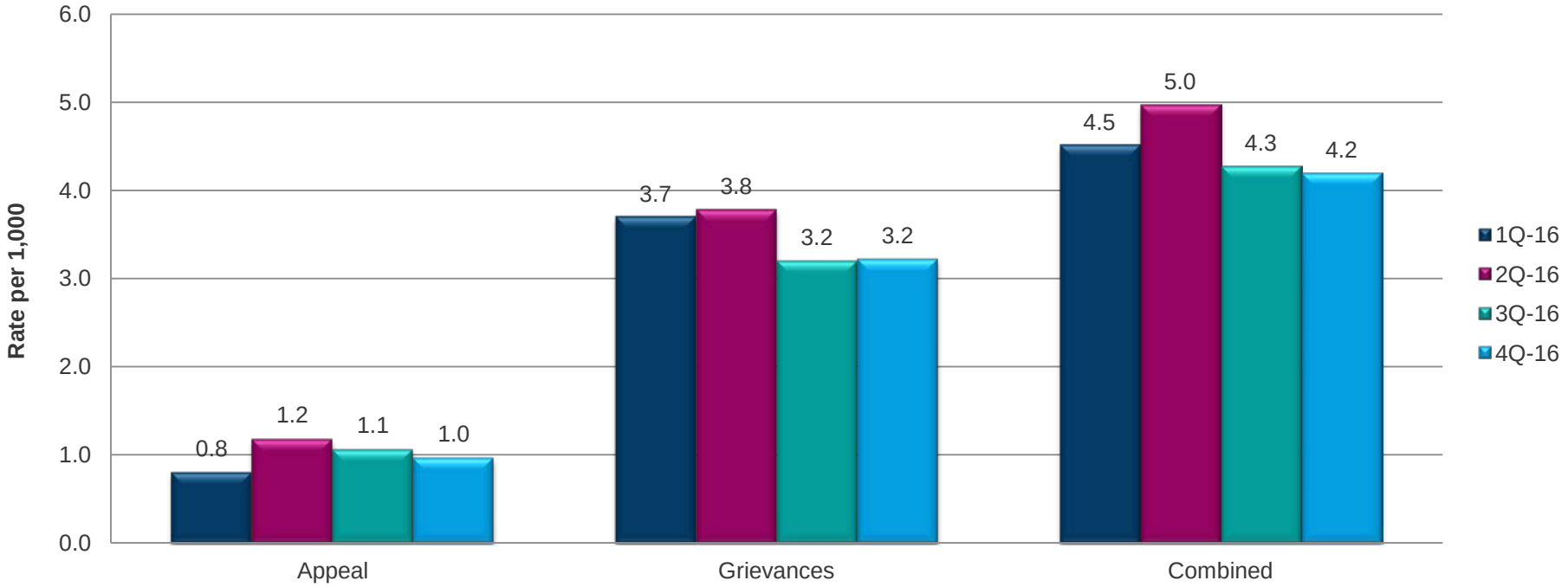
Overall Medi-Cal Member Complaints



	Total Complaints	Appeals	Grievances	YTD Membership
1Q-2016	856	154	702	769,385
2Q-2016	958	229	729	770,487
3Q-2016	838	210	628	772,927
4Q-2016	826	192	634	774,869

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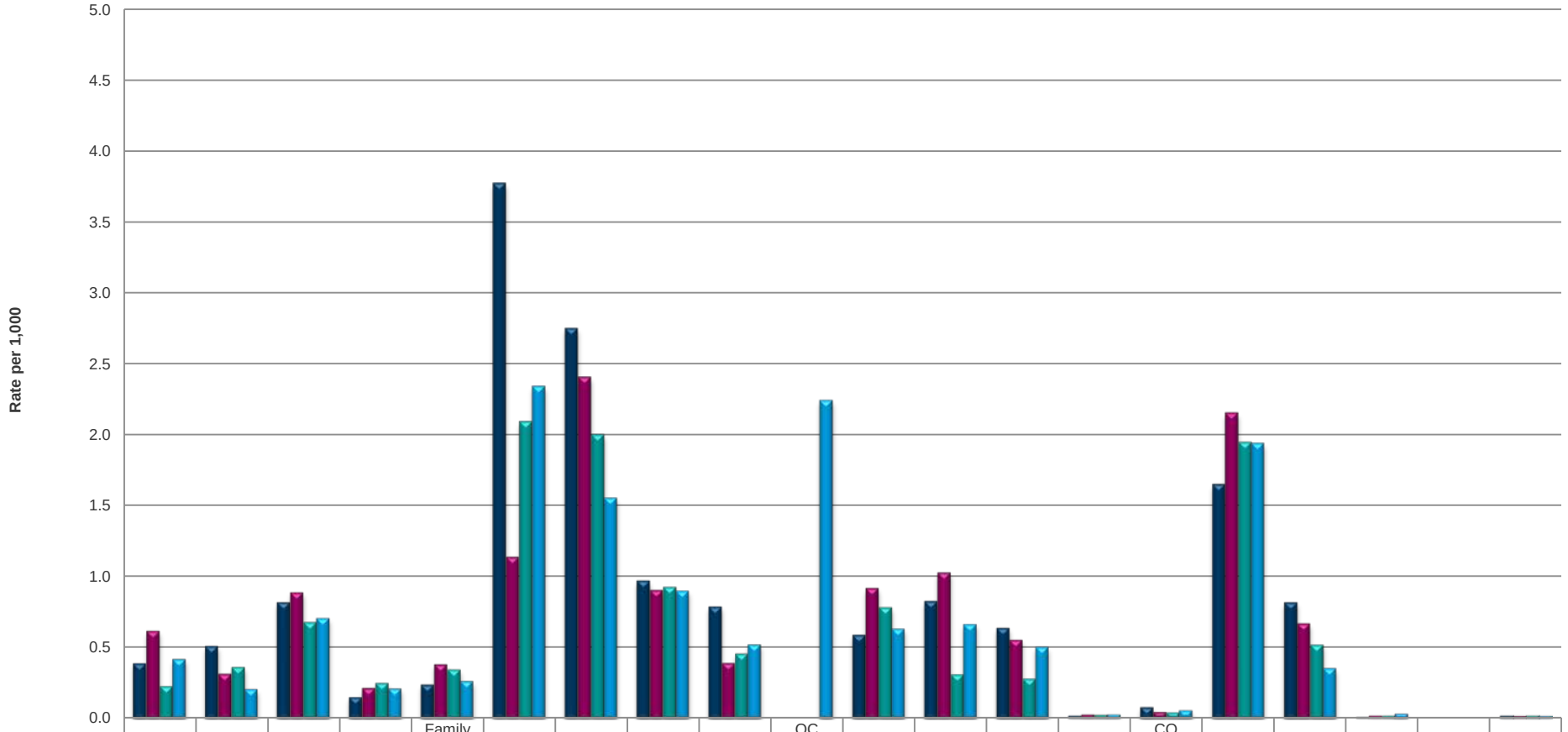
Medi-Cal Member Grievances
Quarterly Rate/1,000



	AltaMed (40,529)	AMVI (24,067)	Arta (77,766)	CHA (156,000)	Family Choice (49,123)	Heritage (3,416)	Kaiser (45,717)	Monarch (89,767)	Noble (34,416)	OC Advantage (892)	Prospect (36,253)	Talbert (25,493)	UCMG (35,651)	CO Prog (780,695)	CO Pharm (780,695)	CCN (68,522)	COD (93,086)	Beacon (780,695)	MLTSS (734,979)	VSP (734,979)
1Q-16 (769,385)	0.39	0.51	0.82	0.15	0.24	3.77	2.75	0.97	0.79	0.00	0.59	0.83	0.64	0.02	0.08	1.65	0.82	0.01	0.00	0.02
2Q-16 (772,164)	0.62	0.32	0.89	0.22	0.38	1.14	2.40	0.91	0.39	0.00	0.92	1.03	0.55	0.03	0.05	2.15	0.67	0.02	0.00	0.02
3Q-16 (778,808)	0.23	0.36	0.68	0.25	0.35	2.09	2.00	0.93	0.46	0.00	0.78	0.31	0.28	0.03	0.04	1.95	0.52	0.02	0.00	0.02
4Q-16 (780,695)	0.42	0.21	0.71	0.21	0.26	2.34	1.55	0.90	0.52	2.24	0.63	0.67	0.50	0.03	0.06	1.94	0.35	0.03	0.00	0.02

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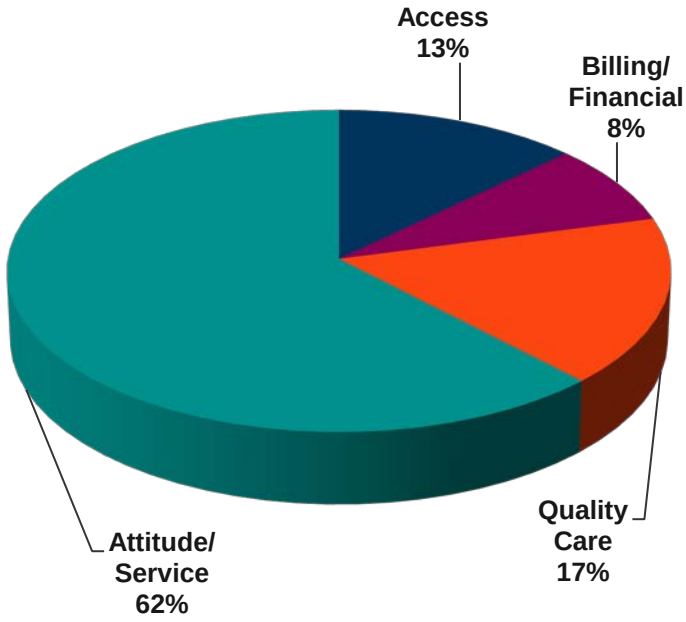
Medi-Cal Grievances by Category

- Total of 634 grievances filed by 575 unique members in Q4 2016.
  - Of these, 393 grievances (62%) were related to QOS and 107 grievances (17%) were related to QOC concerns.
  - The percentage by categories represents the historic trend.
- The Quality Improvement (QI) department continues to review for QOC issues and potential trending.



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Common QOS Concerns

- Delay in service
  - Referrals
  - Prescriptions
  - General response from doctor
- Provider services
  - Dissatisfied with staff, doctor or program
- Rudeness
- Refusal to treat
  - Pain management/Rx refills
  - Lack of walk-in appointment availability

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Common QOC Concerns

- Question diagnosis
- Question treatment
- Delay in treatment impacting member's care
- Lack of follow up

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Summary

- Overall access issues related to appointment availability for PCP visits increased. There were no specific trends identified.
- There was a slight increase in grievances regarding delay in referral submission. However, the increase was not significant and there were no specific trends identified.
- OC Advantage reported a higher quarterly rate/1,000 grievances due to low membership. Two (2) grievances were received out of 892 members.
- Overall grievances as a rate/1,000 members remained low at 3.2 in Q4 2016.

Interventions

- All quality of care concerns are referred to the Quality Improvement department for investigation.
- CalOptima works with all our networks (by sharing the grievance and appeals data specific to each network) and providers to improve in these areas including QOS and QOC concerns.
- Provided tips and recommendations related to the common complaints at the CCN Lunch & Learn meeting for providers and their office staff.

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CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

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