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

**WEDNESDAY, NOVEMBER 15, 2017
3:00 P.M.**

**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 within the subject matter 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 (714) 246-8806, at least 72 hours prior to the meeting.

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 September 20, 2017 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS

2. Consider Recommending Board of Directors Ratification and Amendment of Existing OneCare Contract with Housecall Doctors Medical Group for the Provision of Home Assessments to OneCare Connect Members

INFORMATION ITEMS

3. PACE Member Advisory Committee Update

4. Behavioral Health Integration Update

5. Palliative Care Update

6. Over/Under Utilization Report

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

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

September 20, 2017

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CALL TO ORDER

Chair Paul Yost called the meeting to order at 3:03 p.m. Director Nguyen led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Ria Berger; Alexander Nguyen M.D.

Members Absent: Dr. Nikan Khatibi

Others Present: Michael Schrader, Chief Executive Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Caryn Ireland, Executive Director Quality Analytics; Gary Crockett, Chief Counsel; Suzanne Turf, Clerk of the Board

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the May 22, 2017 Special Meeting of the CalOptima Board of Directors Quality Assurance Committee

> *Action:* ***On motion of Director Berger, seconded and carried, the Committee approved the Minutes of the May 22, 2017 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Dr. Khatibi absent)***

REPORTS

2. Consider Recommending Board of Directors' Approval of the Proposed Pay for Value (P4V) Payment Methodology for CalOptima Community Network (CCN) Providers for Medi-Cal and OneCare Connect, and Distribution of Payments to Providers

Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend Board of Directors' approval of the Measurement Years 2016 and 2017 payment methodology for the P4V Program for CCN providers for Medi-Cal and OneCare Connect (OCC), subject to regulatory

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approval, as applicable; and authorize distribution of P4V payments based on this methodology in an amount not to exceed $2 per member per month (PMPM) for CCN Medi-Cal and $20 PMPM for CCN OneCare Connect membership.

A review of the recommended scoring methodology for CCN providers was provided to the Committee. Performance allocations are distributed based upon final calculation and validation of each measurement rate. To quality for payment for each of the clinical measures, the provider must meet the noted minimum denominator and distribution. Medi-Cal CCN provider payments for clinical measures will be based on the provider's measurement rate for each clinical performance measure and member months. As CalOptima did not obtain individual provider satisfaction data, it was recommended that CAHPS payments be distributed based on the provider's percent of total CCN Medi-Cal membership. OneCare Connect (OCC) CCN provider payments will be based on the provider's percent of total CCN OCC membership. In order to qualify for payments, a physician or clinic must be contracted with CalOptima during the entire measurement period and the period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

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 Measurement Years 2016 and 2017 payment methodology for the P4V Program for CalOptima CCN providers for Medi-Cal and OCC, subject to regulatory approval, as applicable (Attachment 1); and authorize distribution of P4V payments based on this methodology in an amount not to exceed $2 pmpm for CCN Medi-Cal and $20 pmpm for CCN OCC membership. (Motion carried 3-0-0; Dr. Khatibi absent)***

3. Consider Recommending Board of Directors Approval of Revised Medi-Cal Quality Improvement and Accreditation Activities during CalOptima Fiscal Year (FY) 2017-18 for Member and Provider Incentives
Dr. Bock presented the action to recommend Board of Directors' approval of proposed revisions to Member and Provider incentive program start and end dates, subject to regulatory approval, as applicable. The following program extensions were requested: Cervical Cancer Provider - Provider Extended Hours and Provider Office Staff initiatives extended to December 31, 2017; member incentives related to Breast Cancer Screening extended to December 31, 2017; and Postpartum Care member incentive program extended to November 5, 2017.

> *Action:* ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of proposed revisions to Member and Provider incentive program start and end dates, subject to regulatory approval, as applicable. (Motion carried 3-0-0; Dr. Khatibi absent)***

4. Consider Recommending Board of Directors Approval of 2018 Pay for Value (P4V) Measure Changes
Caryn Ireland, Executive Director Quality Analytics, presented the action to recommend Board of Directors' approval of proposed Fiscal Year 2019 (Measurement Year 2018) Pay for Value Programs

for Medi-Cal and OneCare Connect, which defines measures and allocations for performance and improvement, as described in Attachment 1, subject to regulatory approval, as applicable.

The recommended changes to MY 2018 Medi-Cal P4V program are as follows: replace Medication Management for People with Asthma (MMA) - Total 75% compliance, with MMA 5-11 years (child), and MMA 19-50 years (adult); retire Comprehensive Diabetes Care - HbA1c testing, and CAHPS Getting Appointment with a Specialist, Timely Care and Service Composite, and Rating of all Healthcare; add three new clinical measures - Well Child visits in the first 15 months of Life (W15) - six well child visits, Comprehensive Diabetes Care (CDC) - HbA1c <8 (adequate control), and Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB); and add three new Member Experience measures (CAHPS Surveys - Medi-Cal Adult and Child) - Getting Needed Care, Getting Care Quickly, and How well Doctors Communicate.

Recommended changes to the Measurement Year 2018 OneCare Connect P4V Measure include: retire Antidepressant Medication Management (AMM) – Continuation and Acute Phase Treatment, and Controlling Blood Pressure (CBP; and add two new measures – Breast Cancer Screening, and Comprehensive Diabetes Care (CDC) – HbA1c. Ms. Ireland corrected the CDC HbA1c measure to read ">9 (poor control)".

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

> *Action:* ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the proposed Fiscal Year 2019 (Measurement Year 2018) Pay for Value Programs for Medi-Cal and OneCare Connect, which defines measures and allocations for performance and improvement, as described in Attachment 1, subject to regulatory approval, as applicable, with the noted correction. (Motion carried 3-0-0; Dr. Khatibi absent)***

5. Receive and File the Updated 2016 Utilization Management Program Evaluation
Tracy Hitzeman RN CCM, Executive Director, Clinical Operations, presented the recommended action to receive and file the updated 2016 Utilization Management (UM) Program Evaluation. Ms. Hitzeman noted that CalOptima's NCQA re-accreditation preparation leverages consultant reviews of the 2016 UM Program Plan, Work Plan, and Program Evaluation. A review of the Program Evaluation indicated that additional narrative detail was needed to improve the readability and ease of understanding. Revisions included enhancement of Utilization Outlier Trend tables, additional detail added to acute and long-term support services facility utilization evaluation, and expanded narrative regarding member and provider satisfaction.

> *Action:* ***On motion of Director Nguyen, seconded and carried, the Committee received and filed the updated 2016 Utilization Management Program Evaluation as presented. (Motion carried 3-0-0; Dr. Khatibi absent)***

6. Receive and File the 2016 Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment Performance Improvement Plan Evaluation
Miles Masatsugu, M.D., Medical Director, PACE, presented the action to receive and file the 2016 PACE Quality Assessment Performance Improvement (QAPI) Plan Evaluation. It was reported that

PACE reached its goal on 10 of the QAPI elements, a successful Year 3 CMS/DHCS audit was completed, membership grew to 182 participants, and all utilization goals were met. Opportunities for improvement in 2017 include patient satisfaction, membership, utilization management, and increasing the quality of care elements.

> ***Action:*** ***On motion of Director Berger, seconded and carried, the Committee received and filed the 2016 Program of PACE Quality Assessment Performance Improvement Plan Evaluation as presented. (Motion carried 3-0-0; Dr. Khatibi absent)***

INFORMATION ITEMS

7. PACE Member Advisory Committee Update
This Information Item was accepted as presented.

8. 2017 HEDIS Results
Ms. Ireland provided a brief update on the 2017 HEDIS results. It was noted that the HEDIS results compared to CalOptima goals were all met. HEDIS regulatory reporting included patient level detail files for Medicare and Medicaid submitted to the Centers for Medicare & Medicaid Services (CMS) and NCQA respectively, and 49 measures required medical record review. A medical record retrieval rate of 98% was noted. A review of the HEDIS results was provided to the Committee.

9. Behavioral Health Update
Donald Sharps, M.D., Medical Director, Behavioral Health Integration, provided an overview of the Customer Service Call Center Metrics and CalOptima's audit of the call center. The monthly average of incoming calls was 4,567 during the second quarter. Dr. Sharps also provided an update on utilization trends, and the Drug Medi-Cal Memorandum of Understanding between CalOptima and the Orange County Health Care Agency.

10. Program Updates: Shape-Your-Life and CalOptima Perinatal Health Program
Pshyra Jones, Health Education and Disease Management Director, provided a brief overview of the Shape-Your-Life (SYL) program, a childhood obesity program. In July 2017, Request for Proposals were issued and the responses are currently under review. It is anticipated that a contract will be awarded in October 2017. Newsletters have been redesigned, and CalOptima has sponsored several community classes that are 4 to 6 weeks in length and offered in English and Spanish.

With regard to the Comprehensive Perinatal Services Program (CPSP), a Request for Information was released in August 2017 for CPSP-like services, and a CPSP provider survey is in progress. Additionally, the County of Orange has several no-cost prenatal/postnatal resources for at-risk women.

11. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Report
This Information Item was accepted as presented.

b.   Member Trend Report
Ana Aranda, Interim Director, Grievance and Appeals, provided an update on OneCare Connect transportation and improvements made during the second quarter.

COMMITTEE MEMBER COMMENTS
Dr. Bock announced that CalOptima was rated California's top Medi-Cal plan, according to the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings 2017-2018. It is the fourth year in a row that NCQA has named CalOptima best overall in the state.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 4:55 p.m.

  /s/   Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: November 15, 2017

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 15, 2017
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item
2.   Consider Recommending Board of Directors Ratification and Amendment of Contract with Housecall Doctors Medical Group

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

Recommended Actions
Recommend that the Board of Directors:
1. Ratify contract with Housecall Doctors Medical Group; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to Amend existing OneCare contract with Housecall Doctors Medical Group to include OneCare Connect Line of Business for Members in the CalOptima Community Network.

Background
Historically, home assessments have been administered to CalOptima members through various initiatives. In 2008, CalOptima's Board of Directors approved a pilot project to conduct home assessments of 150 institutionalized and homebound OneCare members and authorized contracting with a selected vendor to perform the assessments. Following the pilot, CalOptima staff contracted with Housecall Doctors Medical Group in September 2013 to provide home assessments to OneCare members as assigned. Assignments typically follow unsuccessful attempts by both CalOptima and the member's primary care provider (PCP) to contact the member, and a full year passing since the member's last provider visit. Staff has subsequently extended the contract on an annual basis, relying on the annual Board approval of all specialty provider contracts. Since 2013, the arrangement with Housecall Doctors has produced favorable results including robust patient assessments, positive reception by CalOptima members, and approximately 20 member health assessments completed per month.

In the intervening years, CalOptima's delivery system has changed significantly with the addition of the Coordinated Care Initiative, OneCare Connect (OCC), CalOptima Community Network (CCN), and an enhanced model of care. As a result, CalOptima has continued to increase the focus on improved health outcomes, quality of care, and clinical care in members' home and community settings. Frequent member contact and care coordination are key objectives of the current delivery model.

Additionally, the Centers for Medicare & Medicaid Services (CMS) now recognize home care visits as covered services under Medicare in support of care coordination. There have also been updates by creating procedural codes for home assessments. CMS has also developed related quality withhold measures such as encounters, documentation of care goals, and case management which are supported by completion of home assessments.

CalOptima Board Action Agenda Referral
Consider Recommending Board of Directors Ratification and
Amendment of Contract with Housecall Doctors Medical Group
Page 2

In alignment with these changes and to continue best practices for appropriate assessment and access to care, staff is recommending amendment of the contract with Housecall Doctors to include the OneCare Connect line of business to cover similar situations when an extended period of time passes during which neither the PCP nor CalOptima staff are successful in contacting the member.

Discussion
Recent provider chart audits, claims data and encounters indicate there are approximately 160 OCC CCN members who have not seen a provider recently or who have incomplete medical documentation to support their conditions. This is a fragile population due to age, chronic health conditions and disabilities. These members may have barriers in accessing care or limitations in mobility. They may reside at their personal residence, in a long-term care facility or be homeless. Given difficulties in engaging these members, home assessments provide an essential alternative option for these members to obtain health care services.

Home assessments are intended to supplement and not replace the responsibilities of the member's PCP. The goal is to engage with members and support the PCP's care plan through complete health information and increased member visits. Home assessment providers provide a needed solution by delivering clinical care to vulnerable members in their preferred setting or circumstance who would otherwise not be receiving care. These Housecall Doctors providers are qualified providers who must meet credentialing requirements, are well known within the community, and have experience in providing care to CalOptima members. Given these providers' experience, they have processes for obtaining member consent and providing instructions for seamless delivery. They also produce comprehensive history and physicals, document HEDIS related findings, and may serve as a source of information for members who may otherwise run the risk of falling through the cracks.

As a contracted provider Housecall Doctors receives payment for each completed home assessment via submitted and processed claims. Reimbursement is based on Medicare fee-for-service (FFS) guidelines, care coordination codes, appropriate billing procedures.

In summary, frequent member contact and assessments are key to CalOptima's current delivery model which strives to serve and provide quality care to our members. Home assessments of members who would otherwise not receive care support the core objectives of CalOptima's model of care program and overall quality performance. Two of CalOptima's delegated health networks have established similar home assessment programs with positive outcomes. It would be beneficial to produce similar outcomes for CalOptima's Community Network

Fiscal Impact
The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017, included expenses related to home assessments for OneCare Connect members. Assuming the rates and terms of the existing and new contracts remain unchanged, the recommended action through June 30, 2018, is a budgeted item with a FY 2017-18 fiscal impact of $60,000 based on the projected utilization for the targeted OCC CCN population.

Rationale for Recommendation
Amending the Housecall Doctors' contract to provide in-home physicals and plans of care to members who might otherwise not receive care are essential to ensuring quality care for CalOptima's OneCare

CalOptima Board Action Agenda Referral
Consider Recommending Board of Directors Ratification and
Amendment of Contract with Housecall Doctors Medical Group
Page 3

and OneCare Connect members. The proposed actions may also support appropriate clinical documentation and improvements in quality measures. The proposed actions pertain to covered Medicare services and do not provide any greater extent of service or reimbursement than is currently allowed.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated September 4, 2008, Approve Pilot Project to Conduct Assessments of 150 Institutionalized and Homebound OneCare Members and Authorize the Chief Executive Officer to Enter into a Contract with a Selected Vendor to Implement the Project
2. Board Action dated December 4, 2008, Approve Project to Conduct Health Assessments on Certain Institutionalized OneCare Members and Authorize the Chief Executive Officer to Enter into a Contract with a Selected Vendor to Complete the Health Assessments

  /s/   Michael Schrader   *11/8/2017*
Authorized Signature   **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 4, 2008
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. D. Approve Pilot Project to Conduct Assessments of 150 Institutionalized and Homebound
OneCare Members and Authorize the Chief Executive Officer to Enter into a Contract
with a Selected Vendor to Implement the Project

Contact
Gertrude Carter, Chief Medical Officer, 714-246-8400

Recommended Actions
1. Approve a pilot project to conduct assessments on a subgroup of 150 institutionalized and
homebound OneCare members; and,
2. Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into a
contract with a selected vendor to implement the pilot project.

Background
CalOptima has tracked performance measures for its OneCare program since its inception.
Performance has been based on industry standard measures such as Health Employer Data &
Information Set (HEDIS), Hierarchical Condition Categories (HCCs), and encounter data
analysis. Recent data analysis has demonstrated that a significant portion of the OneCare
population has not accessed preventive services. Among members who may not consistently
access the full range of covered preventive services are members who are institutionalized in
skilled nursing facilities and those members who are homebound.

This pilot project aims to provide a health risk assessment to institutionalized and homebound
members. A comprehensive risk assessment will appropriately identify HCC codes and enable
the appropriate provision of preventive services, diagnostic testing and evidence-based care.

Discussion
The provision of timely health assessments is essential to provide coordinated care to special
needs members such as the dual eligible members in OneCare. Since the members who are
included in this pilot are institutionalized or homebound in addition to being special needs, the
ability to bring the assessments to where the members reside is critical.

During the course of the pilot project, physicians trained to use the selected vendor's analytics
will assess the member's medical and social service needs. As proposed, the pilot will include
assessments of the approximately 100 institutionalized OneCare members, along with
approximately 50 OneCare members identified as homebound. Based on this assessment, a
comprehensive care plan will be developed. Components of the assessment will include a
history and physical, mental status exam, functional status review, review of systems, personal
and social history, and chart review. Information gathered from the assessment will be developed
into a comprehensive care plan which will be coordinated with the member's primary care

CalOptima Board Action Agenda Referral
Approve Pilot Project to Conduct Assessments of 150
Institutionalized and Homebound OneCare Members and
Authorize the Chief Executive Officer to Enter into a Contract
With a Selected Vendor to Implement the Project
Page 2

physician for implementation. This assessment does not replace the contracted physician groups' history and physical/assessment obligations. It is intended to ensure that all appropriate ICD-9s are identified for appropriate HCC coding. As contemplated, Leprechaun LLC, the proposed vendor, provides the analysis and will subcontract with Matrix and At Home Doctors to implement the pilot program.

Fiscal Impact
The vendor will receive payment of $350 for each assessment it completes. In addition, to the extent that additional HCCs are identified and included in the final CMS sweeps, the vendor will be paid an additional amount of up to $750 per member participating in the pilot. OneCare's FY08-09 budget includes funds of $165,000 for member assessment which, as proposed, will be used to fund the pilot program.

Rationale for Recommendation
The recommended actions will enable OneCare to provide health assessments to a vulnerable subset of OneCare's membership and to provide comprehensive information to implement an appropriate care plan.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

 _/s/_ _Richard Chambers_   _8/28/2008_
Authorized Signature   **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2008
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

V. E.   Approve Project to Conduct Health Assessments on Certain Institutionalized OneCare Members and Authorize the Chief Executive Officer to Enter into a Contract with a Selected Vendor to Complete the Health Assessments

Contact

Kurt Hubler, Executive Director of OneCare, 714-246-8400

Recommended Actions

1. Approve modification to a project to conduct health assessments on certain institutionalized OneCare members; and,
2. Authorize the Chief Executive Officer to enter into a contract with a selected vendor to implement the project.

Background

At its September 4, 2008 meeting, the CalOptima Board of Directors approved a pilot project to conduct health assessments on a subgroup of 150 institutionalized and home bound OneCare members. The Board also authorized the CEO to enter into a contract with Leprechaun LLC to implement the pilot project. However, subsequent to the Board approval of this pilot project, Leprechaun LLC informed CalOptima that it will not be able to complete the pilot project in 2008. Completion of the health assessments in 2008 is essential to the success of the project to ensure that the Hierarchical Condition Codes (HCC's) and Health Employer Data & Information Set (HEDIS) performance results are accurate for the 2008 calendar year.

Discussion

The provision of timely health assessments is essential to provide coordinated care to special needs members such as the dual eligible members in OneCare. OneCare has reviewed the encounter profiles of the current institutional members and have identified approximately 100 members that have insufficient medical encounters during the calendar year. To assure these members receive the appropriate assessment, OneCare has identified a provider—Housecall Doctors Medical Group—that can complete 50 – 100 health assessments in 2008. Based on these assessments, comprehensive care plans will be developed for assessed members.

Fiscal Impact

The selected vendors will receive payment of $210 for each assessment it completes. If assessments for 100 members are completed, that would total $21,000. OneCare's FY08-09 budget includes funding for this amount for member assessments.

CalOptima Board Action Agenda Referral
Approve Project to Conduct Health Assessments on Certain
Institutional OneCare Members and Authorize the Chief Executive
Officer to Enter into a Contract with a Selected Vendor to Complete the
Health Assessments
Page 2

Rationale for Recommendation

The recommended actions will enable OneCare to provide health assessments to a vulnerable subset of OneCare's membership and to provide comprehensive information to implement appropriate, member-specific care plans.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

Attachments

None

  /s/   Richard Chambers   _11/26/2008_
Authorized Signature   **Date**

Board of Director's Quality Assurance Committee Meeting
November 15, 2017

PACE Member Advisory Committee (PMAC) Update

PMAC Meeting September 11, 2017

- PMAC participated in a focus group for the CalOptima Member Health Needs Assessment (MHNA). The focus group was organized by CalOptima Strategic Development team, in coordination with PACE staff.
- Nine (9) PMAC members participated. Members were asked questions about the needs and factors affecting their health. The purpose of the MHNA is to identify the highest needs of members, most importantly the barriers to access, gaps in services and disparities in the health among members. PMAC is one of many groups the MHNA is including in the process.

Behavioral Health Integration Update

Board of Directors' Quality Assurance Committee Meeting
November 15, 2017

Richard Helmer, M.D., Chief Medical Officer
Donald Sharps, M.D., Behavioral Health Integration

Topics of Discussion

- Network status

- Applied Behavioral Analysis (ABA) status

- Drug Medi-Cal (DMC) update

- SBIRT

Network Status

- CalOptima has met adequate network goal to cover 75% of members receiving services over the past year
  - Includes ABA and Mental Health Providers
- Recruitment of approximately 60 staff members (Clinical staff, claims, GARS, Customer Services)
  - 20 new clinical staff members ranging from licensed professionals to member liaison specialists
- Significant progress in developing internal workflows and procedures for handling this service in house
  - 12 new BH Service workflows ranging from member and provider general inquires, appointment requests, authorizations for ABA and psychological testing, and crisis intervention
  - Testing and adjusting workflows into mid December

Network Status (cont'd)

- Finalized the BH Toll Free phone cutover plan from Magellan back to CalOptima
- Phone system call trees are setup and will be tested along with the workflows over the next month
- Magellan has been extremely cooperative with the transitions and is providing key information such as access to their systems to ensure our members are not impacted by the change
- Approval from DHCS for our member correspondence in the event their provider isn't willing to contract with us and they need to switch
  - ➢ However we anticipate very little impact as mentioned in our contracting status

Network Status as of 11/3/17

MH Providers

Contract Status	Contract Count	Contract Overlap	Percent	Member Count	Percent
Contract Sent	129	55	13.3%	914	6.8%
In Negotiation	7	7	1.7%	2,326	17.4%
Canceled	26	17	4.1%	336	2.5%
Contract Signed/Returned	88	60	14.5%	2,404	18.0%
Contract Fully Executed	304	275	66.4%	7,371	55.2%
Network Status	392	335	80.9%	9,775	**73.2%**

ABA Providers

Contract Status	Contract Count	Contract overlap	Percent	Member Count	Percent
Contract Sent	9	7	11.1%	120	5.9%
In Negotiation	8	8	12.7%	203	10.0%
Canceled	12	9	14.3%	150	7.4%
Contract Signed/Returned	25	22	34.9%	1,078	53.3%
Contract Fully Executed	18	17	27.0%	470	23.3%
Network Status	43	39	61.9%	1,548	**76.6%**

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Drug Medi-Cal update

- The County reported 10/30/17 they just resubmitted revised rates and utilization figures to DHCS, and are expecting a relatively prompt reply to the resubmission

- The County is targeting go live of March 1, 2018

- As soon as the rates are approved, County will provide information regarding how to notify providers and members that DMC services will be available

- Screening Brief Intervention and Referral for Treatment (SBIRT) will continue to be an entry to DMC services from CalOptima Network physicians

Palliative Care Update

Board of Directors' Quality Assurance Committee Meeting
November 15, 2017

Tracy Hitzeman, RN, CCM
Executive Director, Clinical Operations

Legislative Background

- Senate Bill 1004 (2014) requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance to ensure delivery of palliative care services by Managed Care Plans

- Implementation **no later than 1/1/18**

- DHCS policy document (9/1/16) and final APL (10/19/17) provide guidance for Medi-Cal only members
  - Additional final guidance anticipated before implementation
    - Reporting requirements
    - Quality measures
  - Rate Adjustment not expected

Palliative Care Defined

"Patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice." – www.CMS.gov
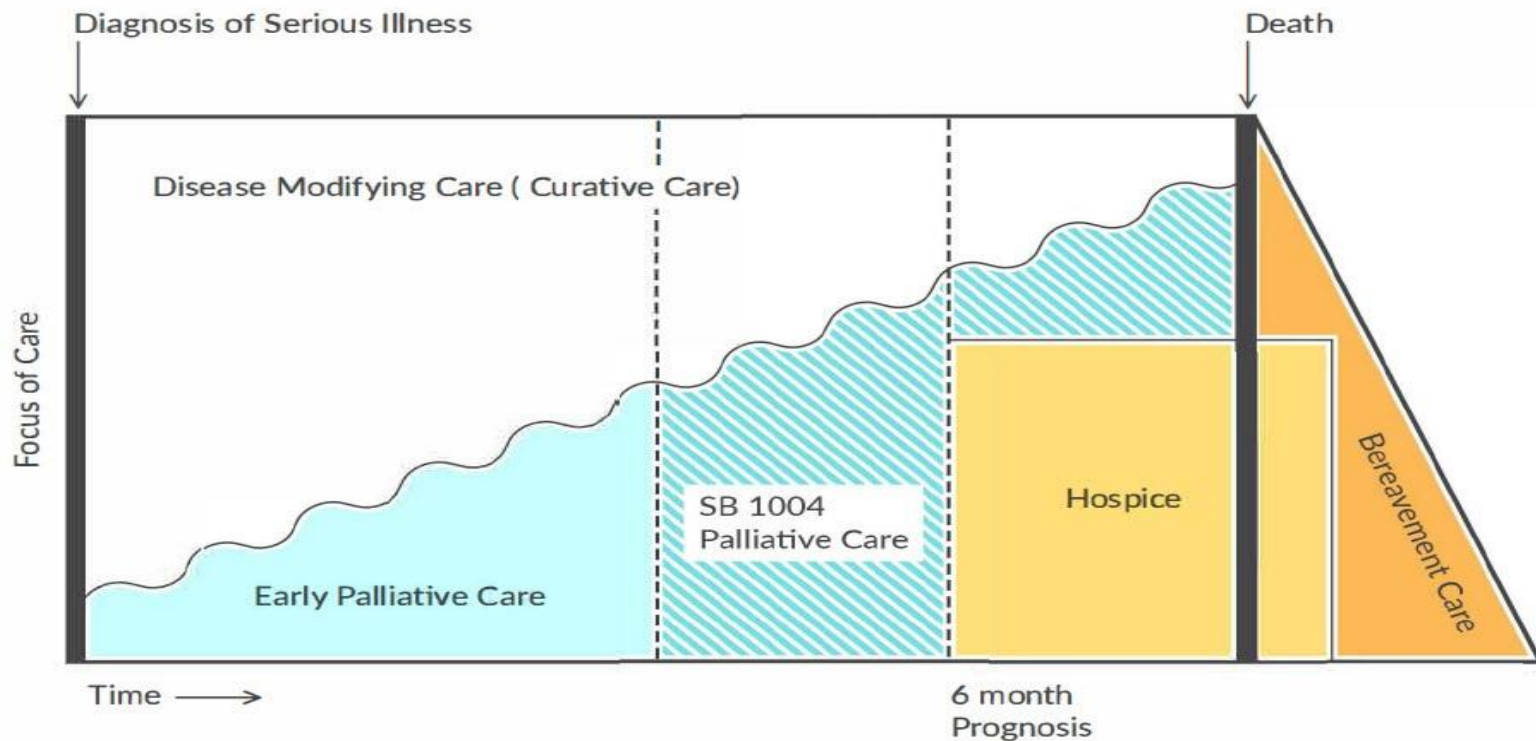
DHCS Palliative Care Goals

- Optimize member quality of life by anticipating, preventing and treating suffering

- Address physical, intellectual, emotional, social and spiritual needs

- Facilitate patient autonomy, access to information and choice

Target Population

General Eligibility Criteria

- Using/likely to use hospital or ED to manage disease
- Advance stage of illness
- Death within 1 year would not be unexpected
- Willing to participate in advanced care planning discussions
- Not eligible for or declines hospice
- Received appropriate desired medical therapy or therapy is not longer effective
- Willing to receive disease management

Has One of Four Diagnoses

- Advanced Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Liver Disease

Notes:

- *Each diagnosis has specific criteria, which may require file review*
- *Plans/HNs may choose to offer Palliative Care based on broader clinical criteria*

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CalOptima Direct (COD) Members

- COD Includes CalOptima Community Network (CCN)

  - ➢ SB 1004 target population and services at implementation
  - ➢ Will contract with providers for service delivery and care coordination
    - ▪ Service, reporting and other requirements detailed in P&P being finalized
  - ➢ Consider use of Medi-Cal FFS rates
    - ▪ Use existing billing codes
    - ▪ Potential addition of informational modifiers to distinguish Palliative Care from Hospice
  - ➢ Standard provider credentialing criteria based on contracting provider type

Health Network (HN) Members

- HNs will be responsible for all SB 1004 Palliative Care services for their assigned members effective 1/1/18

  ➢ CalOptima does not plan to prescribe delivery requirements other than as required in legislation, APL and outlined in CalOptima's policies and procedures
    - Final APL has been provided to HNs for planning purposes
    - CalOptima policy and procedure pending approval from DHCS

  ➢ Reporting will be based on DHCS and plan requirements

Next Steps

- Anticipate receipt of DHCS guidance mid-November
  - Reporting requirements
- Receive DHCS approval for CalOptima policies and procedures
- Provide updated guidance and finalized CalOptima policies and procedures to Health Networks
- CalOptima to contract with palliative care providers for CCN/COD members
- Develop reporting metrics per DHCS requirements

Resources

- DHCS' Palliative Care website
  - ➢ http://www.dhcs.ca.gov/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx

Over/Under Utilization Report

Board of Directors' Quality Assurance Committee Meeting
November 15, 2017

Tracy Hitzeman, RN, CCM
Executive Director, Clinical Operations

Over/Under Utilization Reporting & Monitoring
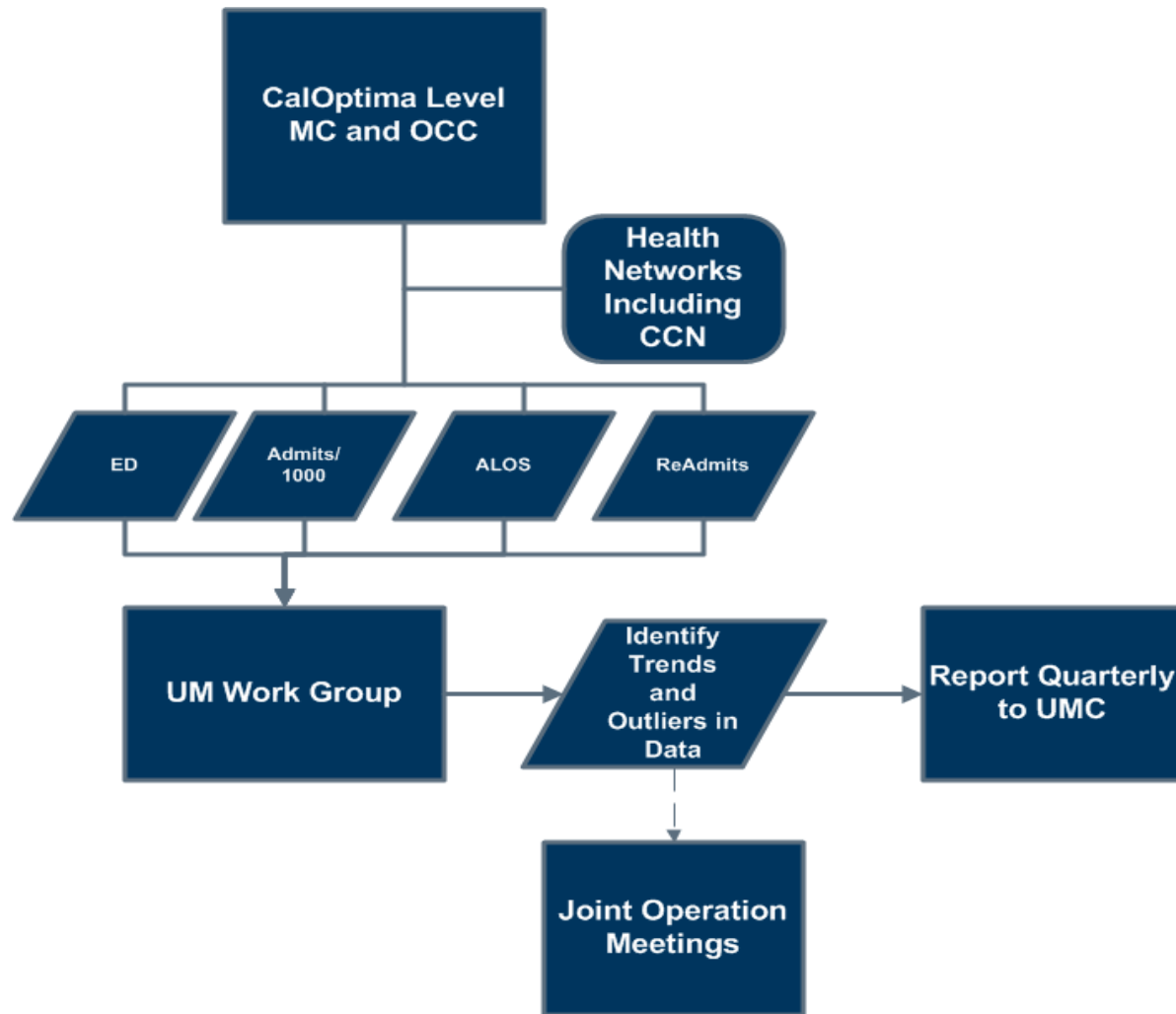
Additional Over/Utilization Metrics Proposed (Physician Specific)

- Unused Authorizations
  - Modified
  - Denied
  - Reported to Member Experience Committee
    - Member Experience Committee reports to QIC
- Pharmacy Utilization
- Frequency of Selected Procedures Utilization
  - Angioplasties/CABG (reported separately)
  - Hysterectomies
  - Back Surgeries
  - Hip and Knee Replacements (reported separately)
  - Bariatric Weight Loss
  - Lumpectomy/Mastectomy (reported separately)
  - Cholecystectomies

Executive Summary

Quality Improvement Committee (QIC) 3 nd Quarter 2017

- Quarterly reports provided by all key areas
  - UM Report
    - New UM initiative launched focusing on the 10 highest ED utilizers each quarter
    - 2017 Inpatient and ED Utilization goals approved
    - Accepted the revisions to the 2016 UM Program Evaluation
  - Reported on initial and re-credentialing of the provider network and related facility site review/medical record review/physical accessibility review results
  - Reported on Potential Quality of Care (PQI) cases
    - Case loads have been increasing since the change in process with Customer Service/GARS to review service-related cases for potential underlying quality of care issues
  - Reviewed the Long Term Services and Supports (LTSS) update; highlights included:
    - Case turn-around-time standards were met;
    - Reviewed member denials and reasons (did not meet criteria);
    - Multiple utilization goals (utilization, admissions and readmissions, emergency department visits) were not met for LTC, IHSS and MSSP
  - Provided an update on PACE operations and the 2nd quarter PACE Quality Improvement Committee update
  - Approved the 2017 Clinical Practice Guidelines
  - Approved the HEDIS 2017 (MY 2016) Final Results
    - All Minimum Performance Levels (MPLs) were met;
    - Clinical and Satisfaction Survey results were presented for Medi-Cal, OneCare and OneCare Connect

- Reviewed progress on the 2017 Quality Initiatives; recommendation was approved to extend the Post Partum initiative and Breast Cancer screening incentive programs to November and December prospectively
- Presented the 2018 Model of Care (MOC) and the 2017-2018 MOC Dashboards
    - MOC effectiveness measures have been defined for each of the key components: population assessment, care management/ICT, network management and quality initiatives
- Presented the new 2017 Provider Notification Report – a provider-specific report on member-specific diabetes metrics
- Provided an update from the Member Experience Sub-committee, including:
    - 2017 CAHPS results
    - Customer Service Q2 Key Performance Indicators
    - Q2 Grievance, Appeals and PQIs
    - Network Adequacy

- Reported progress on the following Work Plans through the updated Dashboards:
    - Provided the quarterly Audit & Oversight, Pharmacy Management and Performance Improvement Projects
    - 2017 QI Work Plan Dashboard Q2 – Attachment 1a
    - 2017 HEDIS Dashboard Q2 – Attachment 1b
    - 2017 Case Management Dashboard Q2 – Attachment 1c

Accepted minutes from the following committees:
- Medical Affairs: 04/10/17, 04/25/17, 06/19/17
    - MOC OC/OCC Performance Monitoring Dashboard: 9/12/17
- Behavioral Health Quality Improvement: 8/1/17
- Long Term Services and Supports: 6/26/17
- PACE Quality Improvement Committee: 04/11/17, 05/09/17
- Members Experience:
    - 09/13/17 (Member & Provider Trend Report), GARS,
- Utilization Management Committee: 08/24/17

Quality Improvement Committee Third Quarter 2017 Update

Board of Directors' Quality Assurance Committee Meeting
November 15, 2017

Richard Bock, M.D., MBA
Deputy Chief Medical Officer

Quality Improvement Committee (QIC) Reporting

- The following departments report to the QIC quarterly through various subcommittees:
  - ➤ Case Management and Complex Case Management
  - ➤ Behavioral Health Integration (BHI)
  - ➤ Customer Service
  - ➤ Grievance & Appeals (GARS)
  - ➤ Health Education & Disease Management (HE & DM)
  - ➤ Long Term Services and Supports (LTSS)
  - ➤ Program of All-Inclusive Care for the Elderly (PACE)
  - ➤ Pharmacy
  - ➤ Utilization Management (UM)

2017 QI Reporting Structure
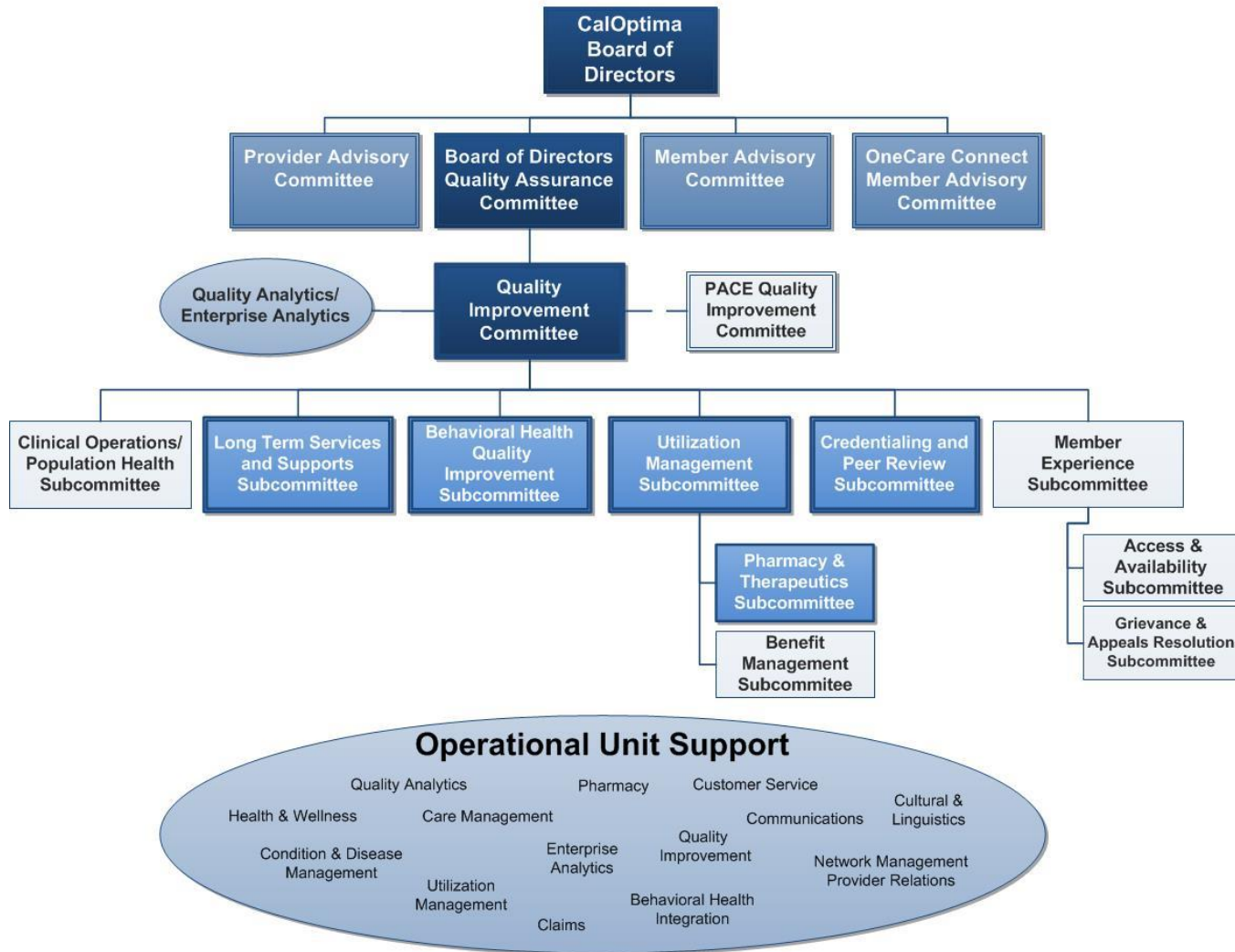
3rd Quarter QIC Highlights
(Based on 2nd Quarter Data and Activities)

- Quarterly reports provided by all key areas
  - UM Report
    - New UM initiative launched focusing on the 10 highest ED utilizers each quarter
    - 2017 Inpatient and ED Utilization goals approved
    - Accepted the revisions to the 2016 UM Program Evaluation
  - Credentialing Peer Review Report
    - Initial and re-credentialing of the provider network and related facility site review/medical record review/physical accessibility review results
    - Potential Quality of Care (PQI) cases increasing since the change in process with Customer Service/GARS to review service-related cases for potential underlying quality of care issues

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3rd Quarter QIC Highlights (cont.)

- Long-Term Services and Supports Report
  - Case turnaround time standards were met.
  - Reviewed member denials and reasons (did not meet criteria).
  - Multiple utilization goals (utilization, admissions and readmissions, emergency department visits) were not met for LTC, IHSS and MSSP.
- PACE Report
  - Update on PACE Operations and 2nd quarter PACE Quality Improvement Committee update
- Quality Analytics Report
  - Reviewed progress on the 2017 Quality Initiatives
  - Recommendation was approved to extend the postpartum initiative and breast cancer screening incentive programs to November and December respectively.

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3rd Quarter QIC Highlights (cont.)

- ➢ Member Experience Report
  - 2017 CAHPS results
  - Customer Service Q2 key performance indicators
  - Q2 grievance, appeals and PQIs
  - Network adequacy
- Additional Reports reviewed and approved by QIC
  - ➢ Approved the HEDIS 2017 (MY 2016) Final Results
    - All Minimum Performance Levels (MPLs) were met.
    - Clinical and satisfaction survey results were presented for Medi-Cal, OneCare and OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

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3rd Quarter QIC Highlights (cont.)

➢ Approved 2017 Clinical Practice Guidelines

➢ Presented 2018 Model of Care (MOC) and the 2017–2018 MOC dashboards

  ▪ MOC effectiveness measures have been defined for each of the key components: population assessment, care management/ICT, network management and quality initiatives

➢ QI Work Plans:

  ▪ Provided the quarterly Audit & Oversight, Pharmacy Management and Performance Improvement Projects

    • 2017 QI Work Plan Dashboard Q2 — Attachment 1a

    • 2017 HEDIS Dashboard Q2 — Attachment 1b

    • 2017 Case Management Dashboard Q2 — Attachment 1c

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Committee Updates

- Accepted minutes from the following committees:
  - ➢ UM Committee Report and Minutes — August 24, 2017
  - ➢ BHI Subcommittee Report — August 1, 2017
  - ➢ LTSS Subcommittee Report — June 26, 2017
  - ➢ Medical Affairs — April 10, 2017, April 25, 2017, June 19, 2017 and MOC OC/OCC Performance Monitoring Dashboard on September 12, 2017
  - ➢ PACE Quality Improvement Committee — April 11, 2017, May 9, 2017
  - ➢ Member Experience — September 13, 2017 (Member and Provider Trend Report), GARS

UM Committee Report Highlights

- 2016 UM Program Evaluation (Revised)
  - ➢ Added evaluation statements of program performance in 2016 with recommendations for improving existing programs
  - ➢ Distributed to UMC voting members for approval of revisions
- ED high utilizers — Complex CM program focuses on 10 highest ED utilizers each quarter
- Behavioral Health UM goals are being developed; metrics to follow.
- Over/under utilization analytics process being developed in collaboration with Quality (see separate presentation for details)

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LTSS — QI Subcommittee Report Highlights

- LTSS metrics reporting
  - ➢ Turnaround times (TAT) meeting standards
  - ➢ Denials
    - ▪ CBAS denials: 16 members (9.2 percent) — did not meet CBAS criteria
    - ▪ LTC denials
      - Medical necessity: 1 member (0.03 percent)
      - Administrative: 229 members (6.82 percent)

- LTSS Utilization Metrics for Q1 2017
  - ➢ Admissions, readmissions, emergency room visits — goal not met*
  - ➢ Reviewing appropriateness of goals and implementing actions

Goals are based on 2016 data, which was based on a slightly different population.

Credentialing and Peer Review Subcommittee (CPRC) Q2 Highlights: Credentialing

Credentialing Activity	1st Quarter 2017	2nd Quarter 2017
Total initial files completed	32	35
Total re-credentialed files completed	108	101
Total initial and re-cred files (clean list and CPRC approved)	140	136
Files with issues — presented to CPRC and NOT approved for administrative cause	3	0
Timeliness for initials — goal met (within 180 days from attestation date)	100%	100%
Timeliness for re-creds — goal met (within 36 months)	100%	100%

CPRC Q2 Highlights: FSR/MRR/PARS*

FSR/MRR/PARS Activity	1st Quarter 2017	2nd Quarter 2017
Full Scope FSR/MRR completed (PCP)	65	72
% of FSR/MRR completed score >80%	100%	100%
Critical Element CAPS issued and % closed within 10-day goal	12 issued 100%	11 issued 75%
Number of FSR CAPs issued and % closed within 45-day goal	30 issued 89%	30 issued 82%
Number of MRR CAPS issued and % closed within 45-day goal	24 issued 85%	23 issued 82%
PARS completed (PCP and HVS)	132	119
% of PARS with BASIC Access	57%	48%

*Facility Site Review/Medical Record Review/Physical Accessibility Review Survey

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CPRC Q2 Highlights — PQI

- Potential Quality Issue Activity:
  - 120 new cases opened
  - 267 closed cases
  - 60 percent closed within 90-day goal

Type of Action	# of Closed Cases
No further action required	216
Office Letter/Best Practices/Recommend Training (QOS)	11
Provider Letter/Best Practices/Recommend Training (QOC)	3
Present to CPRC	8
Review file in 6 months to ensure no trend emerges	28
Close PQI and open new PQI with another Provider	1

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CPRC Q2 Highlights — PQI Closed Cases

Severity Code	Definition	Closed Cases
0	No quality of care issue	204
1	Clinical judgment issue without adverse outcome	8
2	Clinical judgment issue with a mild to moderate adverse outcome	0
3	Severe clinical judgment issue with or without severe adverse outcome	1
HDS	Health care delivery system issue with or without adverse outcome	5
H1	Potential clinical care issue with or without adverse outcome in hospital	0
S0	Service-related issue, unable to verify	19
S1	Service-related issue, verified	30

Behavioral Health QIC Report Highlights

- Addressed need to modify process for inviting BH providers to participate in Interdisciplinary Care Team (ICT)

- HEDIS Behavioral Health (BH) Measures:
  - Reviewed YTD rates on the following measures and discussed planned provider outreach :
    - Follow up after hospitalization(FUH)
      - Magellan to continue phone call reminders to members
      - Outreach to providers to confirm member seen by provider
    - Antidepressant Medication Management (AMM)
      - Follow up with top prescribers selected from data for intervention
    - Attention Deficit Disorder (ADD)
      - Need more timely intervention

Member Experience Report Highlights

- 2017 CAHPS results reviewed and approved — presented to QAC in September

- Customer service key performance indicators (KPI)
  - First call resolution — KPI met for all programs
  - Call-backs — Slight decrease from previous quarter
  - Speed of answer — KPI met for all programs

- Grievance and Appeals and Potential Quality Issues (PQIs) — Medi-Cal, OneCare and OneCare Connect
  - Volume of grievances, appeals and PQI's increased due to process change for handling member complaints.

Member Experience GARS Report — Medi-Cal

	Appeal	Grievances	Combined
■1Q-17	1.2	3.6	4.8
■2Q-17	1.2	4.5	5.7
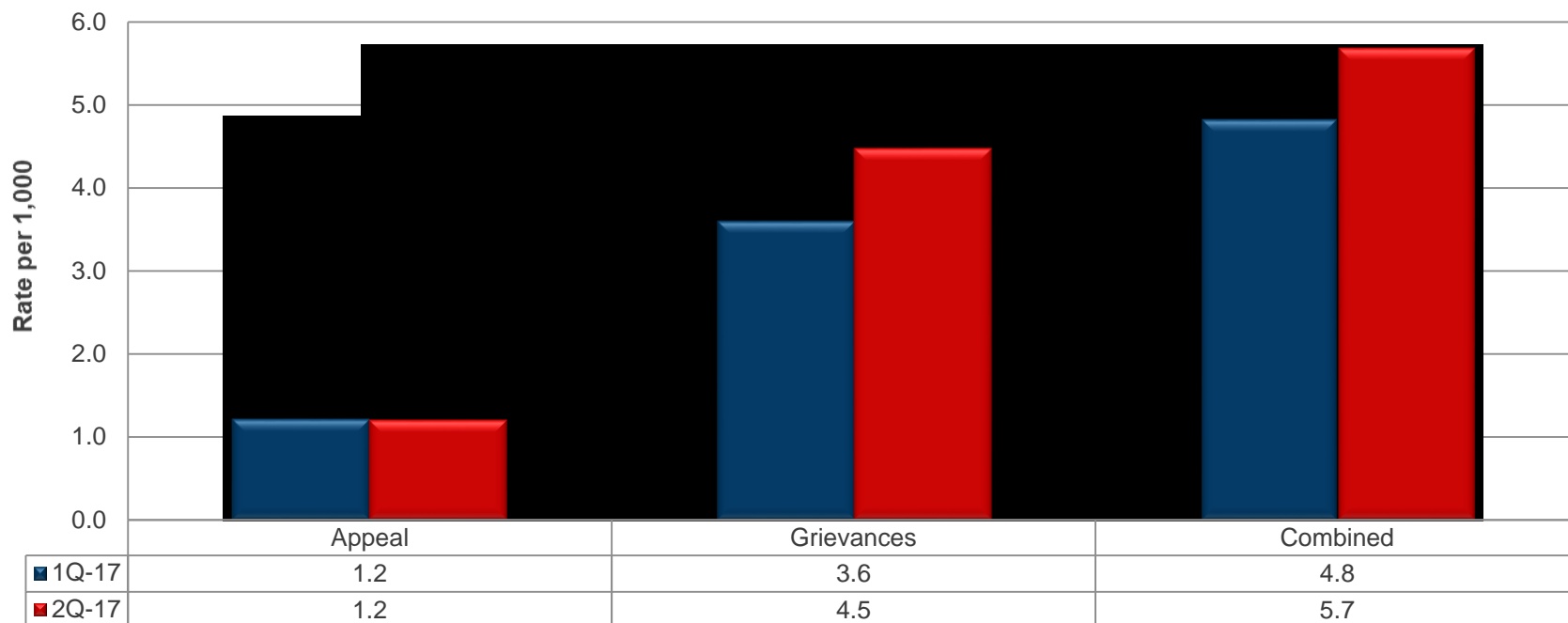
	Total Complaints*	Appeals	Grievances	Membership
1st Q 2017	921	233	688	774, 750
2nd Q 2017	1,094	232	862	773, 412

Definition of complaint changed per audit finding

Member Experience GARS Report — OneCare

		Appeals	Grievances	Combined
■	1Q-17	9.3	8.6	17.9
■	2Q-17	6.1	4.5	10.6

Y-axis: Rate per 1,000
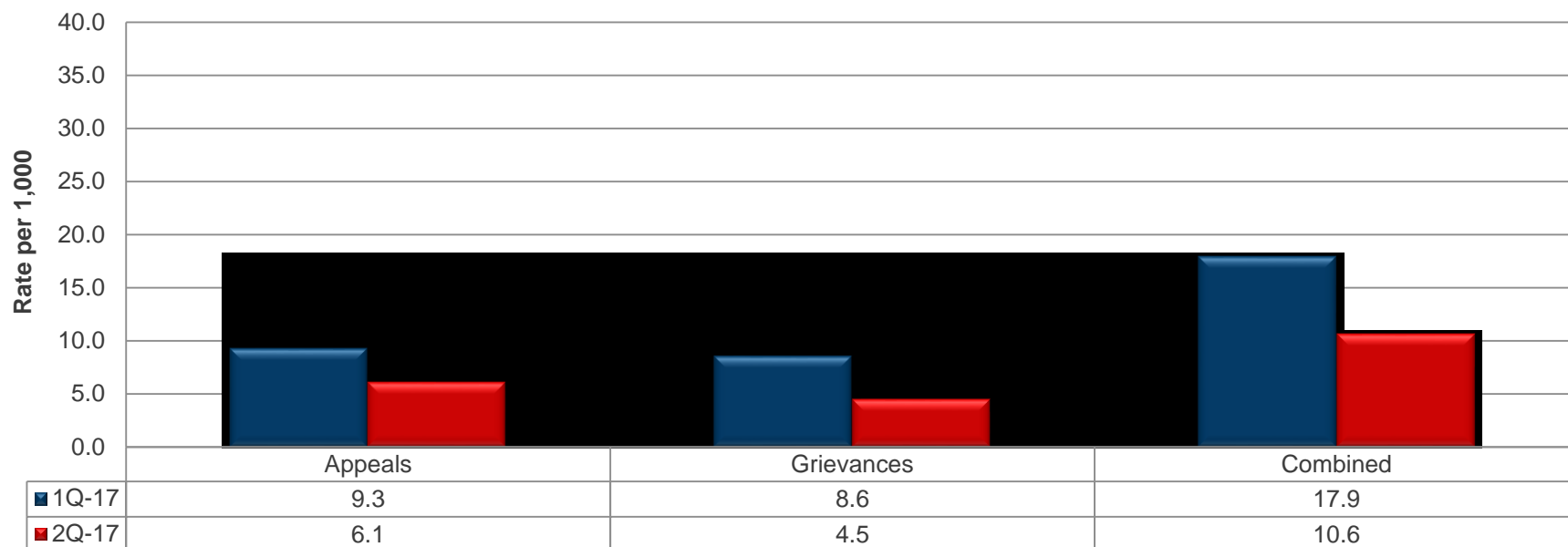
	Total Complaints	Appeals	Grievances	Membership
1st Q 2017	18	12	11	1,285
2nd Q 2017	14	8	6	1,302

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Member Experience GARS Report — OneCare Connect

	Appeals	Grievances	Combined
1Q-17	5.8	8.3	14.1
2Q-17	7.0	13.8	20.8
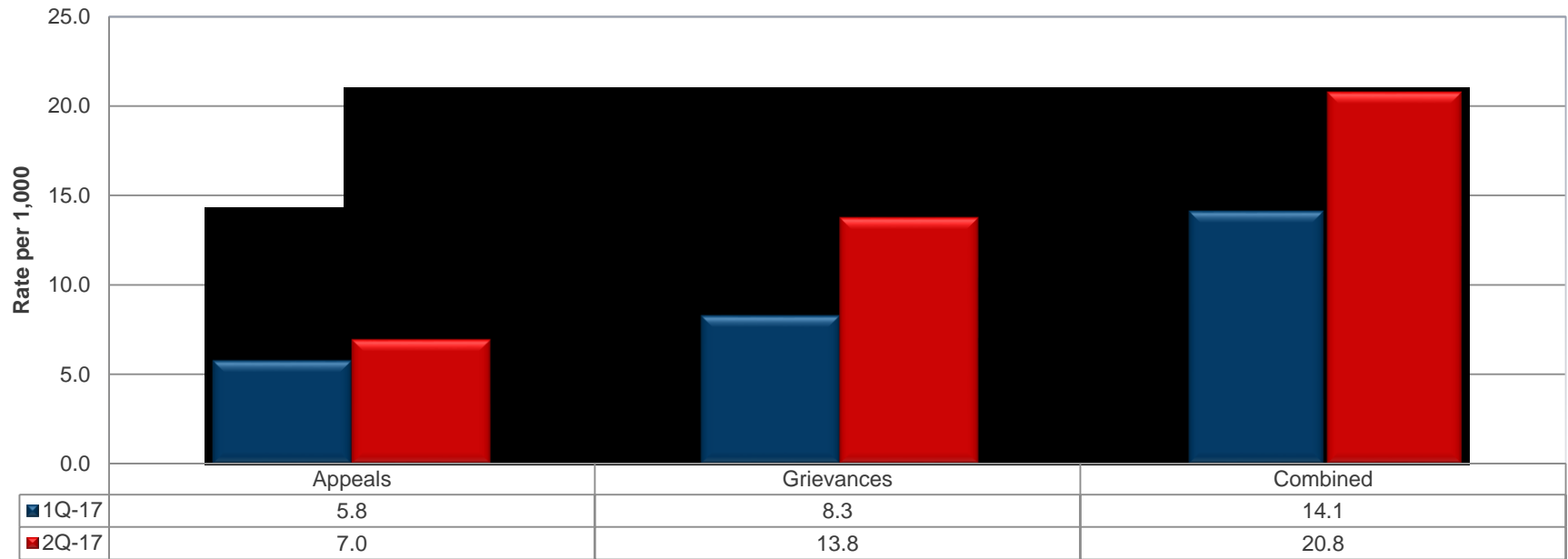
	Total Complaints	Appeals	Grievances	Membership
1st Q 2017	230	95	135	16,297
2nd Q 2017	328	110	218	16,054

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Member Experience PQI Report

- **Number of Cases:**
  - ➤ 345 cases referred
  - ➤ 275 of the cases referred by GARS

- **Cases by Specialty:**
  - ➤ 117 = Primary Care
  - ➤ 92 = Specialists
  - ➤ 24 = Hospitals
  - ➤ 18 = Health Networks
  - ➤ 94 = Other

- **Top 5 Quality of Service Issues:**
  - ➤ 78 = Treatment: delay, failure, inappropriate or complications
  - ➤ 38 = Delay of service
  - ➤ 29 = Medication: fail to order appropriate medication, medication reaction, medication error, medication allergy, wrong medication ordered, failure to respond to pharmacy
  - ➤ 24 = Inappropriate provider, office or patient behavior
  - ➤ 18 = Access to Care

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Access and Availability Report

- Areas that met all plan level standards (ratio, distance and time)
  - ➤ Primary care providers
  - ➤ OB/GYN
  - ➤ Behavioral health providers

Access and Availability Report (cont.)

- Areas of concern forwarded to Health Networks and Provider Relations
  - ➢ Specialists
    - ▪ Dermatology (Medi-Cal)
    - ▪ Endocrinology (Medi-Cal)
    - ▪ Nephrology (Medi-Cal)
  - ➢ Facilities
    - ▪ Nursing Facilities (Medi-Cal)
    - ▪ Heart/Lung/Liver Transplant (OneCare)
    - ▪ Cardiac Catheterization Services (OneCare and OneCare Connect)

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2nd Quarter Work Plan Update (Attachment 1a)

- Updates were also made to the QI Work Plan for the following areas:
  - ➤ Audit & Oversight/Delegation Oversight
    - ▪ UM, CM and Behavioral Health
  - ➤ Review of Pharmacy Management
    - ▪ No significant change in potential underutilization for diabetics with hypertension without an ACE/ARB medication
    - ▪ 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 toward goals
  - ➤ Performance Improvement Projects (PIP)
    - ▪ PIPs, QIPS and Chronic Care Improvement Program — All on track according to plan

2nd Quarter Work Plan Update (cont.)

- HEDIS Work Plan Updates (Attachment 1b)
  - Progress year-to-date on MY 2017 HEDIS measures
  - Includes intervention strategies
- Case Management Work Plan Updates (Attachment 1c)
  - Health Risk Assessments
  - Continuity and coordination of medical/BHI
  - Review of emergency department communication with PCPs
  - Member satisfaction with CM programs
  - Identification of complex cases (health networks)
- Model of Care 2017–2018 Dashboard (attachment)

2017 QI Work Plan	Owner	Goal	Previous Rpt/Last Update 1Q	Red - At Risk Yellow - Concern Green - On Target- 2Q	Monitoring and Next Steps	Target Completion
Program Oversight						
I. A. Program Scope-2017 QI Annual oversight of programs and work plans	Caryn Ireland	Annual Adoption	[green]		Adopted and approved.	3/22/2017
I. B. Program Scope-2016 QI Program Annual Evaluation	Caryn Ireland	Annual Evaluation	[green]		Adopted and approved.	5/22/2017
I. C. Program Scope-2017 UM Program and UM Work Plan annual oversight	Debra Armas	Annual Adoption	[green]		Adopted and approved.	5/22/2017
I. D. Program Scope-2016 UM Program Annual Evaluation	Debra Armas	Annual Evaluation	[green]		Adopted and approved.	5/22/2017
I. E. Quality of Care-2017 Case Management Program annual oversight	Sloane Petrillo	Annual Adoption	[green]		CM program reviewed and approved at QIC	4/11/2017
I. F. Quality of Care-2016 Case Management Program Evaluation	Sloane Petrillo	Annual Evaluation of CCM Program Effectiveness	[green]		CCM Effectivness approved at QIC	5/1/2017
I. G. Quality of Care-2017 Disease Management Program annual oversight	Pshyra Jones	Annual Adoption	[green]		DM program reviewed and approved at QIC	4/11/2017
I. H. Quality of Care-2016 Disease Management Program Evaluation	Pshyra Jones	Annual Evaluation of DM Program Effectiveness	[green]		DM Effectiveness approved at QIC	5/1/2017
I. I. Quality of Care-Credentialing Peer Review Committee (CPRC) Oversight	Medical Director	Quarterly Adoption of Report	[green]		Q1 Activity Reviewed and Approved	4/11/2017
I. J. NCQA Monitoring & Compliance	Kelly Rex-Kimmet	Annual HIP Rating , Maintain Commendable Status	[yellow]		Currently monitoring activity, as with previous year, on the border between commendable and accredited. Will report final results in August of 2017	Q3
Case Management						
II. A. Quality of Clinical Care- Review of health risk assessments to OCC, OC, SPD members	Sloane Petrillo	Initials OCC,OC, SPD (Collection Rate) 56% Of high risk; 43% low risk; 78% initial; 34% of annual; 63% initial Annual OCC, OC, SPD Collection Rate	Initials OCC [green]	Initials OCC [yellow]	OCC initial HRA's are approaching goals. Staffing needs have been addressed and additional oversight implemented.	Q3
			Initials OC [yellow]	Initials OC [yellow]	Q2 met goal for outreach, but fell slightly short of goal for collection. Monitor in Q3.	Q3
			Initials SPD [green]	Initials SPD [green]	QI met goal: 63% initial	Q3
			Annual OCC [yellow]	Annual OCC [yellow]	Did not meet Q2 goal--Q2 rate was 9.7%. New process instituted for annual calls during Q1 expected to increase annual collection rate.	Q3
			Annual OC [green]	Annual OC [green]	Met goal.	Q3
			Annual SPD [green]	Annual SPD [green]	No goal for this measure.	Q3
II. B. Quality of Clinical Care- Continuity & Coordination of Medical/BH	Sloane Petrillo	ICT Particiation; 100% for BHI,85% MBHO, 10% Individual providers, 20% County mental health	BHI Integration [green]	BHI Integration [green]	BHI participation for ICT remains at 100%. The rates for county participation remain above goal at 58.33%. Individual provider participation does not meet goal, however providers were represented at ICT and provided feedback via MBHO.	Q3
II. C. Patient Safety, Quality of Care Case Management-High ER utilization	Sloane Petrillo	5% reduction in ER visits among intervention cohort Process Measure: Enroll 10 High ED utilizers quarterly .	ER Utilization [green]	ER Utilization [green]	ER visits among the intervention cohort decreased by 45% over the Q1 baseline reported data.	Q3
II. D. Quality of Clinical Care-Review of member satisfaction with CM programs	Sloane Petrillo	Satisfaction with Case Management - 88%	Satisfaction with Case Management [green]	Satisfaction with Case Management [green]	Q2 Member Satisfaction results exceeded benchmark goal, achieving 100% staisfaction.	Q3
II. E. Quality of Adherence to Complex Case Management NCQA Standards	Sloane Petrillo	All HN will achieve an average score of 85% or greater on their monthly file reviews	CCM [yellow]	CCM [yellow]	UCMG and Prospect did not meet the overall goal of 85%. Any HN that does not meet goal for 2 consecutive months will be subject to a CAP.	Q3

2017 QI Work Plan	Owner	Goal	Previous Rpt/Last Update 1Q	Red - At Risk Yellow - Concern Green - On Target- 2Q	Monitoring and Next Steps	Target Completion
Behavioral Health						
III. A. Quality of Clinical Care: HEDIS Measure for M/C & OCC	Dr. Donald Sharps	At or above the 50th Percentile	*(green)*	*(green)*	Q2 results presented to BHQI. 1 Committee rep would like to partner on supporting measures. Medi-cal AMM: Acute phase is at 50th percentile. Meeting to look at provider level detail and implement targeted interventions to maintain or increase. Continuation phase just below 50th percentile. Efforts on Acute intervention should result in increase here as well. Medi-cal ADD: Intiation phase is at 50th percentile. Continuous intervention targets new prescriptions (reminders to parents and providers about keeping appts/refill medications). Other strategies being considered include call campaign and partnering for CME event with HN. OCC AMM: Acute phase just below 50th percentile. AMM intervention and next steps same as MC effort for both initiation and Continuation Phase interventions. OCC FUH: BHQI report suggested low denominator and possibly missing coding opportunities on Magellan part given historical trend. Next steps: BHI working wiht HEDIS team and Magellan to ensure coding is being captured by QSI. Address errors if any.	Q4
III. B. Quality of Clinical Care: Interdisciplinary Care Treatment Team Participation	Dr. Donald Sharps	10% Improvement over 2016	*(green)*	*(green)*	SPD CCN 2016 participation rate: 34% (35/102) in comparison to Q1 Report - SPD CCN 2017 participation rate: 96% participation (28/29) - continue to monitor for annual total participation rate with a 10% improvement. Meeting standard to date.	Q4
III. C. Quality of Clinical Care: Behavioral Health Practice Guidelines	Dr. Donald Sharps	100%	*(green)*	*(green)*	Completed Q2. Continuous monitoring for updates or new CPGs for review and implementation quarterly. Must occur each 2 years at minimum.	Q2
III. D. Access and Coordination of Care	Dr. Donald Sharps	Maintain amount of services from previous MBHO; Establish gap analysis and needs for BH support to PCPs and in LTC; Develop unifrom process for accessing BH in LTC	*(green)*	*(green)*	Completed Survey outreach in Q2: 28 of 70 surveys completed by LTC providers for a 40% response rate. Tabulated responses for analysis to be presented to BHQI in Q3.	Q4
LTSS						
IV. A. Safety of Clinical Care and Quality of Clinical Care-Review and assess LTSS placement for members participating with each organization/program	Tracy Hitzeman	CBAS - 277/PTMPY IHSS- 319/PTMPY LTC - 403/PTMPY MSSP - 516/PTMPY	*(yellow)*	*(green)*	CBAS, IHSS and MSSP met the goal. LTC did not meet goal (520/PTMPY) but is significantly reduced from Q1. Planned interventions include regular educational outreach to LTC Facilities and development of Treatment in Place (TIP) program. In the process of monitoring, evaluating and re-establishing the goals.	On-Going
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	Tracy Hitzeman	CBAS - 484/PTMPY IHSS - 662/PTMPY LTC - 390/PTMPY MSSP - 874/PTMPY	*(yellow)*	*(green)*	CBAS, IHSS, LTC and MSSP met the goal. In the process of monitoring, evaluating and re-establishing the goals.	Q3
IV. C. Safety of Clinical Care and Quality of Clinical Care-Review and assess readmissions for LTSS members participating with each organization/program: **Hospital Readmissions**	Tracy Hitzeman	CBAS - 20% IHSS - 23% LTC - 40% MSSP - 20%	*(green)*	*(green)*	IHSS, LTC and MSSP met the goal. CBAS did not meet goal (24%). Met with CBAS center staff to discuss barriers in preventing readmissions, established workgroup to address barriers. In the process of monitoring, evaluating and re-establishing the goals.	On-Going
IV. 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**	Tracy Hitzeman	CBAS - Establishing Goals IHSS - Establishing Goals MSSP - Establishing Goals	*(yellow)*	*(yellow)*	CBAS - 16 members were admitted to LTC during reporting period; IHSS - 168 members admitted to LTC; MSSP - 22 members admitted to LTC.	Q3
IV. E. Quality of Clinical Care-Review of health risk assessment (HRA) for OneCare Connect (OCC) Long Term Care (LTC) members	Tracy Hitzeman	Goal is measured as part of CM, need to make sure it is captured in CM	N/A	N/A	See CM Reporting Lines 14-19	

2017 QI Work Plan	Owner	Goal	Previous Rpt/Last Update 1Q	Red - At Risk Yellow - Concern Green - On Target- 2Q	Monitoring and Next Steps	Target Completion
IV. F. CBAS Member Satisfaction	Laura Guest	Achieve an overall satisfaction rating of 90%.			Survey tool has been approved by Communications. Tool has been sent for translation in threshold languages.	8/31/2017
IV. G. SNF Member Satisfaction	Laura Guest	Achieve an overall satisfaction rating of 90%.			Survey tool has been approved by Communications. Tool has been sent for translation in threshold languages.	8/31/2017
Health Education & Disease Management						
V. A. Quality of Care- All new members will complete the Initial Health Assessment and related IHEBA/SHAs	Pshyra Jones	Improve plan performance over 2016 by 10%			Data collection for IHA PIP ended 6/30/17 Incorporating IHA messaging with DHCS HIF/MET requirement	9/30/2017
V. B. Quality of Clinical Care-Review of Disease Management Programs	Pshyra Jones	Medical: Increase: 75th percentile for Asthma Medication Ratio (AMR) Ages 5-11; 75th percentile for Medication Management for People with Asthma (MMA), ages 5-85; 50th percentile for HbA1c Testing; 90th percentile for HbA1c Poor Control; 75th percentile for Eye Exams; 50th percentile for Annual Monitoring for Patients on Persistent Medications (MPM) Ace Inhibitors or ARBs - Increase to 50th percentile for HbA1c Testing - Medicare; 50th percentile for Controlling High Blood Pressure (CBP); 85% satisfaction with DM Programs			Department recently received QI Reserves funding to support the following targeted initiatives- - Member incentive campaign for HbA1cPoor Control - Member incentive campaign for HbA1c Testing - Member incentive campaign for Eye Exam Diabetes related member incentive campaign target for September, 2017. Member campaign for Asthma Medication Ratio (AMR) and Medication Management for People with Asthma (MMA) deferred until 4th Q.	9/30/2017
V. C. Quality of Care-Clinical Practice Guidelines adoption for Medi-Cal line of business	Pshyra Jones	100%			CPGs Approved at QIC	7/18/2017
V.D. Quality of Clinical Care-Review of Cardiovascular Disease	Pshyra Jones	As determined by CMS			The department is continuing to provide Health Coach outreach and blood pressure cuffs for OC/OCC members identified with high blood pressure.	Q3
V. E. Implementation of Population Health & Wellness Programs	Pshyra Jones	Implement revised program design-2017; Evaluate progress semi-annually			Completed revised program methodology for Diabetes. Currently programming revisions for Asthma.	Q3
V. F. Quality of Clinical Care-Quality and Performance Improvement Projects	Pshyra Jones /Kelly Rex-Kimmet	HbA1c Testing rate at the 50th percentile based on the 2016 NCQA Quality Compass; 16.8% readmissions rate; 80% HbA1c Testing; 25% IHA rate; 35% IHSS Participation rate	Diabetes QIP	Diabetes QIP	On track. Data Collection for OC Diabetes QIP will continue through 12/31/17. Submission for the QIP update is due 1/2018.	Q3
			Readmission QIP	Readmission QIP	Data Collection for Readmissions OCC QIP is due 1/2018. Currently, the Transition of Care (TOC) program is being updated by work group (CM, IS, QA staff) to address the changes with eCeda data. In addition, team will be making revisions to the TOC program description and member educational materials.	Q3
			MC Diabetes PIP	MC Diabetes PIP	On track. Data Collection for Diabetes PIP ended 6/30/17. Final submission to DHCS is due 8/15/17.	Q3
			MC IHA PIP	MC IHA PIP	On track. Data Collection for IHA PIP ended 6/30/17. Final submission to DHCS is due 8/15/17.	Q3
			OCC LTSS PIP	OCC LTSS PIP	On track. Data Collection for OCC LTSS PIP ended 6/30/17. Final submission to DHCS is due 8/15/17.	Q3

2017 QI Work Plan	Owner	Goal	Previous Rpt/Last Update 1Q	Red - At Risk Yellow - Concern Green - On Target- 2Q	Monitoring and Next Steps	Target Completion
Access & Availability						
VI. A. Quality of Service and Quality of Clinical Care-Review of notification to members	Belinda Abeyta & Laura Grigoruk	85%	YELLOW	YELLOW	Enrollment received late 7 PCP provider termination and 6 of those were received late from PR impacting the member notification process. 7/24/17 email sent to Director of Network Management requesting the CalOptima add, change, termination form be updated to include the date CalOptima was notified. Implementation date of new form TBD.	Q3
VI. B. Access to Care-Credentialing of provider network is monitored	Esther Okajima	90% of initial credentialing applications are processed within 120 days of receipt of application	YELLOW	YELLOW	Completed 35 initial cred files and 101 recredentialing files for Practitioners and HDO's. Average TAT frin attestation to approval is 153 days for Practitioners and 57 days for HDO's Working with team to look at process improvements to reduce the TAT of the cred process for all initial files.	Q3
VI.C. Access to Care-Recredentialing of provider network is monitored	Esther Okajima	100% of all recredentialing files are processed within 36 months of last credentialing date	GREEN	GREEN	All recred files were completed within 36 months of the last credentialing date. The TAT to process a recred file is 130 days for practitioners, and 87 days for HDO's. Continue to work with team to improve TAT of the re-cred process.	Q3
VI.D. Accessibility: Review of access to care	Marsha Choo	Appointment: 90% minimum performance level; Phone: ASA 30 seconds; Abandonment rate <5%	GREEN	GREEN	1) Continuous monitoring of Customer Service measures 2) Field 2017 Timely Access Study 3) Share 2016 Access and Availability Results (i.e. HN Quality Forum, HN Forum, CCN Lunch and Learn) 4) Issue CAPS for 2016 Access Results 5) Update Access and Availability Policies	Q3
VI. E. Availability: Review of availability of practitioners	Marsha Choo & Dr. Donald Sharps	Minimum performance levels in CalOptima s Access and Availability Policies: GG.1600 and MA.7007	GREEN	GREEN	1) Continuous quarterly monitoring of availability against standards. 2) Continuous recruitment efforts by our Provider Relations Staff and collaboration with HNs to improve their network capacity. 3) Issue CAPS for 2016 Access Results 4) Update Access and Availability Policies

BH: Meeting MPGs. Continue to monitor. | Q4 |
Patient Safety						
VII. A. Safety of Clinical Care-Providers shall have timely and complete facility site reviews	Esther Okajima	100% of FSR/MRR/PARS Initial or Full Scope Surveys are completed within initial and re-credentialing timeframes	GREEN	GREEN	The FSR team completed a total of 73 FSR/MRR Initial and Full Scope Reviews. All reviews passed with overall score of 80% or greater. However 64 total CE/FSR/MRR CAPS were issued to sites that received section scores less than 80%. CE CAPS were closed timely 75% of the time. FSR/MRR CAPS were closed timely 82% of the time. There were 119 PARS completed of which 61 % achieved BASIC accessibility. Continue to work with provider sites to improve TAT for CAP submission and documenting PARS deficiencies encountered.	Q3
VII. B. Safety of Clinical Care-Review and follow-up on member s potential Quality of Care Complaints	Laura Guest	Achieve a turnaround time of 90 days on 90% of cases received; Review data for trends and patterns for potential further actions	YELLOW	RED	The % of cases closed in 90 days has dropped from 83% in Q1 to 60% in Q2. We have had an increase in case referrals by GARS from an average of 66 cases/month to 91 cases/month. Most of these cases are QOS, not QOC. We are making the following changes to improve the rate: 1)Review of cases by RN before assigning to a nurse to determine if the case is QOS or QOC. 2)Meeting with CS and GARS to review case examples of QOS to improve referrals of only QOC cases.	9/30/2017
VII. C. Safety of Clinical Care and Quality of Clinical Care-Reviewed through Pharmacy Management	Kris Gericke, PharmD	Reductions in underutilization and overutilization measures	GREEN	GREEN	On target, and monitoring progress.	Q3
VII. D. Safety of Clinical care and Quality of Clinical Care-Review of Specialty Drug Utilization	Kris Gericke, PharmD	Review and reporting of Specialty Drug trends, identify any actions necessary with the member or provider/HN	GREEN	GREEN	On target, and monitoring progress.	Q3
VII. E. Patient Safety-Review and assessment of CBAS Quality Monitoring	Laura Guest	Complete on-site audit review of all CBAS centers receiving a CAP from CDA.	GREEN	GREEN	Continue monitoring of the CBAS centers. Those centers receiving CAPS will have increased monitoring to ensure CAP compliance.	9/30/2017
VII. F. Patient Safety-Review and assessment of SNF Quality Monitoring	Laura Guest	Complete the on-site assessment of all contracted SNFs in Orange County, and attain a goal that 90% of the facilities will be in compliance with the Plan of Correction provided by DHCS.	GREEN	GREEN	Continue monitoring of the SNFs.	9/30/2017

2017 QI Work Plan	Owner	Goal	Previous Rpt/Last Update 1Q	Red - At Risk Yellow - Concern Green - On Target- 2Q	Monitoring and Next Steps	Target Completion
VII. G. Safety of Clinical Care-Review of antibiotic usage	Kelly Rex-Kimmet/Marsha Choo	Appropriate Testing for Children with Pharyngitis: 63.24% (25th percentile);	(Yellow)	(Yellow)	CWP: This measure tends to score low. Interventions are progress. Will continue to monitor until final rates are published.	Q3
		Appropriate treatment for Children with URI: 93.38% (75th percentile)	(Green)	(Green)	URI: June PR Rates: 93.56% Interventions are in progress and aligned with the correlating measures (CWP and AAB)	Q3
		Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) 22.25% (25th percentile)	(Green)	(Green)	AAB: June PR Rates: 25.51%. (On Track) PDSA project for this measure outreached to eight (8) high prescribing/low performing providers for this measure by Medical Director. Completed PDSA cycles in June, 2017.	Q2
VII. H. Pharmacy Benefit Manager (PBM) Oversight Management	Kris Gericke, PharmD	PBM Performance Guarantees met Per Contract	(Yellow)	(Green)	1Q17 PBM Performance Guarantees met.	Q3
Member Experience						
VIII. A. Quality of Service- Review of Member Satisfaction	Kelly Rex-Kimmet/Marsha Choo	Annual CAHPS Results			Continuous review of CAHPS and other member experience data at the Member Experience Sub-Committee. Data includes, but is not limited to the following: CAHPS, Access and Availability, GARS, and Customer Service.	Q3 2017
VIII.B. Quality of Service- Reviewed through customer service first call resolution	Belinda Abeyta	85% of calls resolved at first call			Continue monthly review of call center data to determine opportunities for improvement of the First Call Resolution Rates with Medi-Cal, OCC and OCC.	Monthly Monitoring
VIII. C. Quality of Service- Reviewed through customer service access	Belinda Abeyta	ASA 30 Seconds <3% First Call Resolution 85%			Continue monthly review of call center data to determine opportunities for improvement of the First Call Resolution Rates with Medi-Cal, OCC and OCC.	Monthly Monitoring
VIII. D. Quality of Care & Service reviewed through GARS & PQI (MOC)	Janine Kodama & Laura Guest	Identify through the bi-annual review of GARS and PQI cases with high severity and/or high quantity of cases by provider, and complete the plan of action for follow-up of these providers.	(Yellow)	(Yellow)	GARS and QI are developing a reporting process to review high severity/high quantity of cases by provider.	9/30/2017
HEDIS/STARS Improvement						
IX. A. Improve identified HEDIS Measures listed on "Measures" worksheet	Kelly Rex-Kimmet/ Marsha Choo	See Measures Worksheet	(Yellow)	(Yellow)	All QI work team to continue with initiatives and interventions. Majority of the initiatives are on track with a few initiatives in process.	Q4
IX. B. Improve identified STARS measures listed on "Measure" worksheet	Kelly Rex-Kimmet & Kris Gericke & Tracy Hitzeman	See Measures Worksheet	(Yellow)	(Yellow)	All QI work team to continue with initiatives and interventions. Majority of the initiatives are on track with a few initiatives in process.	Q4
IX. C. Improve CAHPS measures listed on "Measures" worksheet	Kelly Rex-Kimmet/Marsha Choo	See Measures Worksheet	(Green)	(Green)	1) Distribute CG-CAHPS provider scorecards to the PCPs and HNs 2) Continuous training for Customer Service Representatives 3) Issue RFP for provider coaching 4) Share CAHPS performance with health networks 5) Further analysis of CAHPS result along with other member experience data	Q3
IX. D. STARS Medication Related Measures	Kris Gericke	Star measure scores above the national MA-PD average as reported by CMS	(Yellow)	(Yellow)	Adherence rates through May 2017 reporting: OneCare Above MAPD average for 2/3 measures. OneCare Connect below MPAD average for all 3 measures. Will continue interventions. Additional member mailings to be sent. Working with pharmacies to implement refill reminder program.	Q3
IX. E. HEDIS: Health Network support of HEDIS & CAHPS Improvement	Kelly Rex-Kimmet/Marsha Choo	24.33%	(Green)	(Green)	1) Continue to share the annual Survey Schedule with the HNs 2) Continue to share CAHPS data will the HNs 3) Continue to share 2017 HEDIS prospective rates with patient list for interventions with the HNs 4) Continue HN Quality Forum 5) Continue HN individual Quality Meetings	Q3

2017 QI Work Plan	Owner	Goal	Previous Rpt/Last Update 1Q	Red - At Risk Yellow - Concern Green - On Target- 2Q	Monitoring and Next Steps	Target Completion
Delegation Oversight						
X. A. Delegation Oversight of CM	Sloane Petrillo	OCC, OC, SPD Goal 90%	OCC	OCC	Goal met. Continue to monitor.	Q3
			OC	OC	See results above, line 23	
			SPD	SPD	See results above, line 23	
X. B. Quality of Care & service of UM through delegation oversight reviews	Solange Marvin	98%			Medi-Cal Utilization Management (UM): Summary of Findings of file Review for Utilization Management decisions (April 2017 - June 2017) – 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 2017 - June 2017) – 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 April 2017 - June 2017) – The Utilization Management Requests are reviewed to assure that they are approved or denied appropriately to the requirements and are processed within appropriate timeframe. Next Step: Corrective Action Plan issued and continued monitoring from performance Improvement.	Ongoing
X. C. Delegation Oversight of BH Services	Dr. Edwin Poon	98%			Magellan continues to meet the respective goals. Continue to monitor.	Q4
Organizational Projects						
XI. A. Value Based P4P 2017	Sandeep Mital	Collect final HEDIS 2017 data to assess health network performance towards Pay for Value measures; Present revised payment methodology for MY2016 to Senior Management at CalOptima and upon their approval, present methodology and scoring to health networks.			Final HEDIS 2017 data collection is ongoing; payment methodology has been approved and shared with participating health networks.	Ongoing
XI. B. MOC Dashboard 2016-2019	Tracy Hitzeman	Meet or exceed defined MOC Metrics			This measure is in process. Will present full MOC dashboard at next QIC	Sep-17

Quarter 2, 2017 QI Work Plan Update

HEDIS MEASURES

HEDIS Medi-Cal Measures	Objective	Planned Activity	Goal	Results/ Metrics Medi-Cal Prospective Rates: (June, 2017)	Red: At Risk Yellow: Concern Green: On Track (Based on PR Rates and Progress)	Monitoring and Next Steps	Target Completion
Comprehensive Diabetes Care (CDC) Medicaid: a) A1C Screening: 85.95% (50th percentile) b) A1C Control <8.0%: 52.55% (75th percentile) c) A1C Control >9.0%: 36.87% (lower score is better) (75th percentile) d) Eye Exams: 61.5 (75th percentile) e) Nephropathy Screening: 90.51% (50th percentile) f) BP Control: 68.61% (75th percentile)	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. - 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)	a. 85.95% b. 52.55% c. 36.87% d. 61.5% e. 90.51% f. 68.61%	a. 68.51% b. 59.50% c. 33.62% d. 39.03% e. 80.92% f. 15.05%	Green	• 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 • Diabetes Talk newsletter • Diabetes workgroup (Lead by Dr. Dajee) to address uncontrolled HbA1c levels	On-going

HEDIS Medi-Cal Measures	Objective	Planned Activity	Goal	Results/ Metrics **Medi-Cal Prospective Rates: (June, 2017)**	Red: At Risk Yellow: Concern Green: On Track (Based on PR Rates and Progress)	Monitoring and Next Steps	Target Completion
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 <14% Readmission rate	11.94%	Green	• Currently implementing the transition of care (TOC) program which has two interventions; 1) Health Coach outreach directly to members and 2) Discharge mail kits to members who did not participate in the health coaching • Update (TOC) program requirements; reassess intervention strategies, update educational materials	On-going
Flu/Pneumonia (CAHPS Survey)	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	Medi-Cal: Adult: 45.9%	Yellow	• Preparing materials for flu mailing beginning of Q4, 2017. • Reminder flu/pneumonia mailing sent end of March, 2017	Annual
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,	MC Prenatal: 82.25% (50th percentile) MC Postpartum: 67.53% (75th percentile)	**Prenatal:** 74.83% **Postpartum:** 47.39%	Green	• Launched the Postpartum Member incentive program in June, 2017. Incentive offered members a $25 gift card and an entry into an opportunity drawing for a $100 gift card. • Launched the Provider Office	• On-going

HEDIS Medi-Cal Measures	Objective	Planned Activity	Goal	Results/ Metrics Medi-Cal Prospective Rates: (June, 2017)	Red: At Risk Yellow: Concern Green: On Track (Based on PR Rates and Progress)	Monitoring and Next Steps	Target Completion
		member and provider education and sharing of provider data. Utilize Text-For-Baby custom messages to encourage member compliance.				Incentive pilot in June, 2017. Medical chart review trainings were conducted at three (3) participating offices. Follow up medical record reviews were conducted to assess improvements. • Prenatal and postpartum mailings to members (bi-weekly) • Text 4 baby program; expanding to "personalized messaging" • CE Healthy Birth Spacing (2/9/17) • PNR/MOMs database data review • Developed small workgroup to improve Maternal Data Mart; goal to produce timely and accurate reports for PPC • Updated educational insert for prenatal • Health Education Dept – Maternal Health program	
Lead Screening (Monitoring Measure)	Increase lead screening rate	Analyze data to determine low performing HN. Implement initiatives to address identified barriers to better performance (data strategy as well as	MC: 75.7% (66th percentile)	72.11%	Green	• Healthy You Mailing (About Your Baby) – Ended as of 6/30/17. • Currently reassessing opportunities to collaborate with internal departments on targeted member mailings	

HEDIS Medi-Cal Measures	Objective	Planned Activity	Goal	Results/ Metrics **Medi-Cal Prospective Rates: (June, 2017)**	Red: At Risk Yellow: Concern Green: On Track (Based on PR Rates and Progress)	Monitoring and Next Steps	Target Completion
		provider outreach)					
HEDIS: Review and assessment prescribed ADHD medication (ADD)	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: 52.47% (50th percentile)	Initiation: 40.96% Maintenance: 42.49%	<mark>Yellow</mark>	• Behavioral team to reassess the current intervention - ADD mailing to both members and providers for the initiation phase. Members received reminder to go in for follow up visits. PCP/Prescribers are notified of members on ADHD medication. • ADD mailing evaluation was conducted and proves effective at improving rates. Alternative interventions being considered.	• On-going
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: 59.52 (75th percentile) **MC:** Continuation Phase Treatment: 41.46% (66th percentile)	**MC:** Acute: 54.28% Continuation: 32.31%	<mark>Green</mark>	• Provider educational faxes (monthly) • ICT medication reconciliation tool in guiding care • Provider incentive for screening pre-adolescents (12-year olds) is active and will continue through 2018.	• On-going
HEDIS: Review and assessment of childhood	Increase the childhood immunization	Immunization in children by their 2nd birthday will increase through member	MC: Combo 10: 40.9% (75th percentile)	Combo 10: 24.45%	<mark>Green</mark>	• CE Workshop (july, 2017): Preventable adolescent infections – discussed	• On-going

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HEDIS Medi-Cal Measures	Objective	Planned Activity	Goal	Results/ Metrics **Medi-Cal Prospective Rates: (June, 2017)**	Red: At Risk Yellow: Concern Green: On Track **(Based on PR Rates and Progress)**	Monitoring and Next Steps	Target Completion
immunization rates (CIS)	status rate in children 2 years old (combo 10) to meet goal	reminders and education (Combo 10) This measure is also incentivized in our P4V program.				immunizations for children. • Health and Wellness Event (CalOptima Day) to promote well-care visits and immunizations will be conducted in August, 2017. Four participating Health networks and their selected providers have engaged in initiative. • Promotion of immunizations as part of the Text-4 Baby program. • Healthy You Mailings (About Your Baby (0-2 years) and children (3-12 years) and Child); Child Health Guide and IVR calls – Ended as of 6/30/17. • Currently reassessing opportunities to collaborate with internal departments on targeted member mailings	
HEDIS: Review and assessment of use of imaging studies for low back pain(LBP)	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education	MC: 73.71% (50th percentile)	72.88%	Green	• Continue to monitor	

HEDIS Medi-Cal Measures	Objective	Planned Activity	Goal	Results/ Metrics Medi-Cal Prospective Rates: (June, 2017)	Red: At Risk Yellow: Concern Green: On Track (Based on PR Rates and Progress)	Monitoring and Next Steps	Target Completion
	back pain)						
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: 82.15% (50th percentile)	**MC:** 49.62%	<mark>Yellow</mark>	• Adult team to discuss possible interventions	• On-going
Review and assessment of children's access to primary care practitioners (CAP) • 12-24 months • 25mo-6 years • 7-11 years • 12-19 years	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 95.74% (50th percentile) 2) 25 months -6 years 90.98% (75th percentile) 3) 7-11 years 93.25% (75th percentile) 4) 12-19 years 89.37% (50th percentile)	1. 88.10% 2. 64.86% 3. 85.92% 4. 81.43%	<mark>Yellow</mark>	• Health and Wellness Event (CalOptima Day) to promote well-care visits and immunizations will be conducted in August, 2017. Four participating Health networks and their selected providers have engaged in initiative. • Healthy You Mailings (About Your Baby (0-2 years) and children (3-12 years) and Child); Child Health Guide and IVR calls – Ended as of 6/30/17. • Currently reassessing opportunities to collaborate with internal departments on targeted member mailings. • Child/Adolescent team to discuss interventions.	• On-going
HEDIS: Review and	Increase the	Increase cervical cancer	MC: 55.94% (50th	47.18%	<mark>Green</mark>	• Radio Ad launched in June, 2017	• On-

HEDIS Medi-Cal Measures	Objective	Planned Activity	Goal	Results/ Metrics Medi-Cal Prospective Rates: (June, 2017)	Red: At Risk Yellow: Concern Green: On Track (Based on PR Rates and Progress)	Monitoring and Next Steps	Target Completion
assessment of cervical cancer screening (CCS)	cervical cancer screening in our MC female members 21-64 to meet goal	screening through member and provider outreach and education with reminders.	percentile)			in 4 threshold languages to promote cervical cancer screening • Print Ads launched in June, 2017. Ads were printed in local OC newspapers in E,S,V,&K. (Promoted breast and cervical cancer screenings) • Launch of the "Good Health" landing page on the CalOptima web site. • CCS member incentive – launch in Q2, 2017 – Extended through December, 2017. • CCS PDSA: Provider Office Staff incentive – Extended through September, 2017. • <mark>CCS Extended Office Hours:</mark> Expected launch in Q3, 2017 • Preconception insert in Prenatal mailings (Promoting cervical health before getting pregnant • Q1-2: CCS IVR calls outreach to members who have not received screening (program ended)	going
HEDIS: Review and assessment of well child visits in the first	Increase the well care visits for MC children in	Increase of well care visit for children in their first 15 months of life through	MC: 59.57% (6 or more visits) (50th percentile)	16.21%	Green	• Health and Wellness Event (CalOptima Day) to promote well-care visits and immunizations will be conducted in August, 2017.	• On-going

HEDIS Medi-Cal Measures	Objective	Planned Activity	Goal	Results/ Metrics Medi-Cal Prospective Rates: (June, 2017)	Red: At Risk Yellow: Concern Green: On Track (Based on PR Rates and Progress)	Monitoring and Next Steps	Target Completion
15 months of life (W15)	their first 15 months of life to meet goal	member and provider outreach and education with reminders				Four participating Health networks and their selected providers have engaged in initiative. • Healthy You Mailings (About Your Baby (0-2 years) and children (3-12 years) and Child); Child Health Guide and IVR calls – Ended as of 6/30/17. • Currently reassessing opportunities to collaborate with internal departments on targeted member mailings. • Child team to discuss possible interventions.	
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: 71.52% (90th percentile) OC: 71.36% (50th percentile)	**MC:**53.31% **OC**: 58.40% **OCC:** 57.30%	Green	• Medi-Cal member incentive Breast Cancer Screening launched in June, 2017. Targeted mailings were sent to members to promote initiative. • Print Ads launched in June, 2017. Ads were printed in local OC newspapers in E,S,V,&K. (Promoted breast and cervical cancer screenings) • Breast cancer screening promotion (mail/outreach) in October, 2017.	3/1/17-8/31/17

HEDIS Medi-Cal Measures	Objective	Planned Activity	Goal	Results/ Metrics Medi-Cal Prospective Rates: (June, 2017)	Red: At Risk Yellow: Concern Green: On Track (Based on PR Rates and Progress)	Monitoring and Next Steps	Target Completion
HEDIS: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	Increase the AAB measure for MC members above the minimum performance level (MPL)	PDSA project for this measure: Outreaching to 5 high prescribing/low performing providers for this measure by Medical Director	MC: 26.17% (50th percentile)	PR: 25.51%	Green	• AAB PDSA cycle completed - Cycle 1 submission: 2/21/17 - Cycle 2 submission: 6/23/17 • Provider Fax Blast sent out Q1 2017 • Potential HSAG information-sharing collaboration through 2018	• On-going
HEDIS: Appropriate treatment for Children with URI	Increase URI measure	AWARE Toolkit distribution and continue education of appropriate treatment with antibiotics	MC: 93.38% (75th percentile)	93.58%	Green	• Potential HSAG information-sharing collaboration through 2018 • Discuss interventions with Child/Adolescent work team.	• On-going

MEDICARE/STAR MEASURES

MEDICARE/STARS Measures	Objective	Planned Activity	OC Goal	Results/ Metrics	Red – At Risk Yellow – Concern Green – On Target	Monitoring/Next Steps	Target Completion
**MEDICARE/STARS: Review and assessment Comprehensive	Increase the comprehensive diabetes care measures OC	Comprehensive diabetes care will increase through member education to identified members with	Medicare: 1) A1C Control >9:.0 16% (lower score	**OC**: a) 68.10% b) 70.48% c) 22.86%	Green	• Implemented Diabetes PIP/QIPs to increase HbA1c testing for the MC and OC populations • Sent PCPs list of patients in the	On-going

MEDICARE/STARS Measures	Objective	Planned Activity	OC Goal	Results/ Metrics	Red – At Risk Yellow – Concern Green – On Target	Monitoring/Next Steps	Target Completion
Diabetes Care (CDC) **OneCare/OneCare Connect** *HEDIS Medicare:* a) A1C Screening: 91.4% b) A1C Control <8.0%: 72.8% c) A1C Control >9.0 18.8% (lower score is better) d) Eye Exams: 82% e) Nephropathy Screening: 95.8% f) BP Control: 79.3%	and OCC members - in conjunction with Diabetes Disease Management Program	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)	is better; CMS 5 star goal) 2) Eye Exams: 82% (maintain 2016 above CMS 5-star goal) 3) Nephropathy Screening: 96% (CMS 4 star goal)	d) 49.52% e) 83.33% f) 21.43% **OCC:** a) 69.74% b) 71.63% c) 24.51% d) 49.23% e) 88.38% f) 17.90%		Disease Management program to conduct outreach • Quarterly diabetic eye exam member mailing • Diabetes Talk newsletter • Diabetes workgroup (Lead by Dr. Dajee) to address uncontrolled HbA1c levels	
**MEDICARE/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)	**OC:** 42.17% **OCC:** 58.78%	Yellow	• Adult Team to discuss interventions	
**MEDICARE/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	**OC:** 1) 12.92% 2) 17.92% 3) 12.36% 4) 12.17% **OCC:** 1) 9.54% 2) 14.37% 3) 11.76%	Green	• Continue with Health Risk Assessments for members • Conduct ICT meetings • Adult Team to discuss interventions	

MEDICARE/STARS Measures	Objective	Planned Activity	OC Goal	Results/ Metrics	Red – At Risk Yellow – Concern Green – On Target	Monitoring/Next Steps	Target Completion
			Status Assessment: 74% (CMS 4 star goal)	4) 13.66%			
MEDICARE/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)	**OC**: 0.00% **OCC**:14.23%	Yellow	• Currently implementing the transition of care (TOC) program which has two interventions; 1) Health Coach outreach directly to members and 2) Discharge mail kits to members who did not participate in the health coaching • Update (TOC) program requirements; reassess intervention strategies, update educational materials	On-going
MEDICARE: Review and assessment of adult's access to preventive/ ambulatory health (AAP)	Increase MC and OC adult's access to preventive/amb ulatory health to meet goal	Comprehensive member and provider outreach with reminders to increase access for adults	OC: 95.56% (50th percentile)	**OC**: 83.48% **OCC**: 74.78%	Yellow	• Adult team to discuss possible interventions	• On-going
MEDICARE/STARS: Improvement: Review of flu and pneumococcal immunization rates* (CAHPS Survey)	1. Increase the flu and pneumococcal screening rate in OC and OCC 2. OC members 65 years old and older to meet	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	Medicare: 74% (CMS 4 star goal)	Not available yet	Yellow	• Preparing materials for flu mailing beginning of Q4, 2017. • Flu mailing was sent to OC/OCC members at the end of February, 2017	

MEDICARE/STARS Measures	Objective	Planned Activity	OC Goal	Results/ Metrics	Red – At Risk Yellow – Concern Green – On Target	Monitoring/Next Steps	Target Completion
	goal members 65 years old and older to meet goal						
MEDICARE/STARS: 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.	OC: Effective Phase Treatment 68.66% (50th percentile) OC: Continuation Phase Treatment 54.76% (50th percentile)	**OC:** Acute: 50.00% Continuation: 55.56% **OCC:** Acute: 64.56% Continuation: 41.21%	Green	• Provider educational faxes; pharmacy and provider update • ICT medication reconciliation tool	•
MEDICARE/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)	**OC:** Not Available **OCC:** 20.97%	Green	• Pharmacy Provider faxes sent with other measure faxes, on alternating schedule • ICT medication reconciliation tool • QA developing database to streamline provider faxes for pharmacy • Member education mailer sent June 2017	•
MEDICARE/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	**OC**: 48.96% **OCC**: 41.46%	Green	• March, 2017: Colorectal cancer mailing sent to targeted OC/OCC members who have not had a colorectal screenings based on our records	

MEDICARE/STARS Measures	Objective	Planned Activity	OC Goal	Results/ Metrics	Red – At Risk Yellow – Concern Green – On Target	Monitoring/Next Steps	Target Completion
			benchmark as National Medicaid Benchmark does not exist.				
**MEDICARE/STARS: 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: 71.52% (90th percentile) OC: 71.36% (50th percentile)	MC: 53.31% OC: 58.40% OCC: 57.30%	Green	• Print Ads launched in June, 2017. Ads were printed in local OC newspapers in E,S,V,&K. (Promoted breast and cervical cancer screenings) • Breast cancer screening promotion (mail/outreach) in October, 2017.	
**MEDICARE/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)	Not available yet	Yellow	• Provider education	
**MEDICARE/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)	Not available yet (Medical chart review measure)	Green	• Disease Management health coaches –distribute blood pressure cuffs for eligible members	
**MEDICARE/STARS: Improvement: Rheumatoid Arthritis Management (ART)	Increase of rheumatoid arthritis management rate	Increase of rheumatoid arthritis management through provider education	Medicare: 72% (CMS 3 star goal)	OC: 80.00% OCC: 81.90%	Green	• Pharmacy Provider faxes sent with other measure faxes, on alternating schedule • QA developing database to streamline provider faxes for pharmacy	On-going

MEDICARE/STARS Measures	Objective	Planned Activity	OC Goal	Results/ Metrics	Red – At Risk Yellow – Concern Green – On Target	Monitoring/Next Steps	Target Completion
MEDICARE/STARS: Follow-up after Hospitalization for Mental Illness (7 days / 30 days) (FUH)	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)	**OC**: 7-day: 0.00% 30-day:0.00% **OCC**: 7-day: 8.00% 30-day:12.0%	<mark>Yellow</mark>	• Behavioral health team to discuss possible interventions with Magellan.	
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	Not available yet	<mark>Green</mark>	• Continue with Health Risk Assessments for members • Conduct ICT meetings • Adult Team to discuss intervention	

CAHPS MEASURES

STARS Measures	Objective	Planned Activity	Goal	Results/ Metrics (based on 2016 MY)	Red – At Risk Yellow – Concern Green – On Target (based on projects)	Monitoring/Next Steps	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.	Medicaid: 50th Percentile or higher Medicare: 82% (CMS 3 star goal)	MC Child: 25th percentile – Not met MC Adult: 25th percentile – Not met OC/OCC: data not yet available	Green	• Share CAHPS results with the HNs • Continue to monitor and analyze data to improve this area. Initiatives to be developed through the Member Experience Sub-Committee	
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)	MC Child: below 25th percentile – Not met MC Adult: below 25th percentile – Not met OC/OCC: data not yet available	Yellow	• Share CAHPS results with the HNs • Share Timely Access Study results with HNs • Issue corrective action plans on access and availability to the HNs	
CAHPS: Getting Care	Increase CAHPS	Sharing of HN specific	Medicaid: 50th	MC Child:	Yellow	• Share CAHPS results with the HNs	

STARS Measures	Objective	Planned Activity	Goal	Results/ Metrics (based on 2016 MY)	Red – At Risk Yellow – Concern Green – On Target (based on projects)	Monitoring/Next Steps	Target Completion
Quickly	score on Getting Care Quickly	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.	Percentile or higher Medicare: 72% (CMS 2 star goal)	below 25th percentile – Not met MC Adult: below 25th percentile – Not met OC/OCC: data not yet available		• Share Timely Access Study results with HNs • Issue corrective action plans on access and availability to the HNs	
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	MC Child: below 25th percentile – Not met MC Adult: 50th percentile – Not met OC/OCC: data not yet available	Green	• Share CAHPS results with the HNs • Issue RFP for provider coaching	Q3
CAHPS: Customer Service Increase CAHPS score on 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	Medicaid: 50th percentile or higher Medicare: 86% (CMS 3 star	MC Child: below 25th percentile – Not met	Green	• Share CAHPS results with the HNs • Continuous monitoring of customer service metrics • Continuous training of customer service staff	

STARS Measures	Objective	Planned Activity	Goal	Results/ Metrics (based on 2016 MY)	Red – At Risk Yellow – Concern Green – On Target (based on projects)	Monitoring/Next Steps	Target Completion
		Service.	goal)	MC Adult: 25th percentile – Not met OC/OCC: data not yet available			
CAHPS: Getting Needed Prescription Drugs	Increase CAHPS score on Getting Needed Prescription Drugs		Medicare: 89% (CMS 3 star goal)	OC/OCC: data not yet available	Green	• Continue to monitor and analyze data to improve this area. Initiatives to be developed through the Member Experience Sub-Committee	
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)	OC/OCC: data not yet available	Green	• Continue to monitor and analyze data to improve this area. Initiatives to be developed through the Member Experience Sub-Committee	
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	Medicare: 82% (CMS 2 star goal)	OC/OCC: data not yet available	Green	• Continue to monitor and analyze data to improve this area. Initiatives to be developed through the Member Experience Sub-Committee	

STARS Measures	Objective	Planned Activity	Goal	Results/ Metrics (based on 2016 MY)	Red – At Risk Yellow – Concern Green – On Target (based on projects)	Monitoring/Next Steps	Target Completion
		improve Rating of Health Plan.					

HRA Collection

Newly Eligible OCC	April	%	Overall %		May	%	Overall %		June	%	Overall %		Quarter 2 Collected/non responder Average
OCC Collection High	78	32.1%	72.0%		45	26.8%	79.2%		107	45.9%	78.1%		76.4%
OCC Collection Low	97	39.9%			88	52.4%			75	32.2%			
OCC (non responders) High	27	11.1%	28.0%		13	7.7%	20.8%		26	11.2%	15.5%		21.4%
OCC (non responders) Low	41	16.9%			22	13.1%			10	4.3%			
HRA Incomplete High	0	Att. 1 / 0	Att. 2 / 0	0.0%	0	Att. 1 / 0	Att. 2 / 0	0.0%	0	Att.1 / 0	Att. 2 / 0	0.0%	0%
HRA Incomplete Low*	0	Att. 1 / 0	Att. 2 / 0	0.0%	0	Att. 1 / 0	Att. 2 / 13	0.0%	15	Att.1 / 0	Att. 2 / 15	6.4%	2.1%
OCC Totals	243	100.0%			168	100.0%			233	93.6%			100.0%

*Please note: June (LOW): There are 15 members requiring 3rd attempts between 8/26/17-8/30/17.

Annual OCC Members	April	%	May	%	June	%	Quarter 2 Average
HRAs collected	38	11.7%	35	9.7%	24	7.7%	10%
HRAs (non responders)	286	88.3%	327	90.3%	287	92.3%	90%
HRA Incomplete	0	Att. 1 / 0 — Att. 2 / 0 — 0.0%	0	Att.1 / 0 — Att. 2 / 0 — 0.0%	0	Att.1 / 0 — Att. 2 / 0 — 0.0%	0%
Total	324	100%	362	100%	311	100%	100%

Newly Eligible SPD	April	%	Overall %		May	%	Overall %		June	%	Overall %		Quarter 2 Collected/non responder Average
SPD Collection High	117	14.6%	64.8%		115	14.2%	63.3%		105	13.4%	60.9%		63%
SPD Collection Low	401	50.1%			398	49.1%			373	47.5%			
SPD (non responders) High	49	6.1%	35.3%		50	6.2%	36.7%		53	6.8%	39.1%		37%
SPD (non responders) Low	233	29.1%			247	30.5%			254	32.4%			
HRA Incomplete High	0	Att. 1 / 0	Att. 2 / 0	0.0%	0	Att. 1 / 0	Att. 2 / 0	0.0%	0	Att.1 / 0	Att. 2 / 0	0.0%	0%
HRA Incomplete Low	0	Att. 1 / 0	Att. 2 / 0	0.0%	0	Att. 1 / 0	Att. 2 / 0	0.0%	0	Att.1 / 0	Att. 2 / 0	0.0%	0%
SPD Totals*	800	100%			810	100%			785	100%			100%

*Please Note: Total count excluded members with other primary insurance, member moved out of area, member not eligible.

Newly Eligible OC	April	%			May	%			June	%			Quarter 2 Average
HRA's Collected	48	75.0%			70	77.8%			44	53.0%			69%
HRA (non responders)	16	25.0%			20	22.2%			9	10.8%			19%
HRA Incomplete*	0	Att. 1 / 0	Att. 2 / 0	0.0%	0	Att. 1 / 0	Att. 2 / 0	0.0%	30	Att. 1 / 29	Att. 2 / 1	36.1%	12%
OC Totals	64	100.0%			90	100%			83	64%			88%

* Please Note: June HRAs due 08/30/2017

OC Annual HRA	April	%			May	%			June	%			Quarter 2 Average
HRA's Collected	55	57.9%			48	52.7%			50	56.8%			56%
HRA (non responders)	40	42.1%			43	47.3%			38	43.2%			44%
HRA Incomplete	0	Att. 1 / 0	Att. 2 / 0	0.0%	0	Att.1 / 0	Att. 2 / 0	0.0%	0	Att.1 / 0	Att. 2 / 0	0.0%	0%
OC Totals	95	100%			91	100%			88	100%			100%

Mailed SPD Annual HRA	
April	884
May	1,310
June	936
Total	3,130

Goals	% Goal	Apr	May	Jun	Average
OCC-Collect Initial High Risk	56%	32.1%	26.8%	45.9%	34.9%
OCC-Collect Initial Low Risk	43%	39.9%	52.4%	32.2%	41.5%
OCC - Annual HRA		11.7%	9.7%	7.7%	9.7%
SPD-Collect Initial	63%	64.8%	63.3%	60.9%	63.0%
OC-Collect Initial OC HRA's	78%	75.0%	77.8%	53.0%	68.6%
OC-Collect Annual OC HRA's	34%	57.9%	52.7%	56.8%	55.8%

BEHAVIORIAL HEALTH

APRIL

OCC

	Participation	Invitation(s) (denom.)	%
Participation in ICT for BHI	31	31	100.00%
Participation in ICT for County MH Adult	0	0	
Participation in ICT for County MH Children and Youth	0	0	
Participation in ICT for FSP	0	0	
Magellan Participation in ICT (CCN)	2	2	100.00%
Magellan Individual Provider Participation in ICT (CCN)	0	0	
Total Participation	2	2	100.00%
Magellan Participation in ICT (HN-OCC)	18	18	100.00%
Magellan Individual Provider Participation in ICT (HN-OCC)	0	0	
Total Participation	18	18	100.00%

OC

	Participation	Invitation(s) (denom.)	%
Participation in ICT for BHI	0	0	
Participation in ICT for County MH Adult	0	0	
Participation in ICT for County MH Children and Youth	0	0	
Participation in ICT for FSP	0	0	
Magellan Participation in ICT (CCN)	0	0	
Magellan Individual Provider Participation in ICT (CCN)	0	0	
Total Participation			
Magellan Participation in ICT (HN-OC)	23	23	100.00%
Magellan Individual Provider Participation in ICT (HN-OC)	0	0	
Total Participation	23	23	100.00%

SPD

	Participation	Invitation(s) (denom.)	%
Participation in ICT for BHI	103	103	100.00%
Participation in ICT for County MH Adult	5	6	83.33%
Participation in ICT for County MH Children and Youth	0	0	
Participation in ICT for FSP	0	1	0.00%
Participation in ICT for ASO	0	4	0.00%
Magellan Participation in ICT (CCN)	5	5	100.00%
Magellan Individual Provider Participation in ICT (CCN)	0	0	
Total Participation	5	5	100.00%
Magellan Participation in ICT (HN-SPD)	8	9	88.89%
Magellan Individual Provider Participation in ICT (HN-SPD)	1	9	11.11%
Total Participation	9	9	100.00%

MAY

OCC

	Participation	Invitation(s) (denom.)	%
Participation in ICT for BHI	37	37	100.00%
Participation in ICT for County MH Adult	0	0	
Participation in ICT for County MH Children and Youth	0	0	
Participation in ICT for FSP	0	0	
Magellan Participation in ICT (CCN)	5	5	100.00%
Magellan Individual Provider Participation in ICT (CCN)	0	0	
Total Partcipation	5	5	100.00%
Magellan Participation in ICT (HN-OCC)	21	22	95.45%
Magellan Individual Provider Participation in ICT (HN-OCC)	1	22	4.55%
Total Partcipation	22	22	100.00%

OC

	Participation	Invitation(s) (denom.)	%
Participation in ICT for BHI	0	0	
Participation in ICT for County MH Adult	0	0	
Participation in ICT for County MH Children and Youth	0	0	
Participation in ICT for FSP	0	0	
Magellan Participation in ICT (CCN)	0	0	
Magellan Individual Provider Participation in ICT (CCN)	0	0	
Total Participation			
Magellan Participation in ICT (HN-OC)	32	32	100.00%
Magellan Individual Provider Participation in ICT (HN-OC)	0	0	
Total Participation	32	32	100.00%

SPD

	Participation	Invitation(s) (denom.)	%
Participation in ICT for BHI	80	80	100.00%
Participation in ICT for County MH Adult	2	3	66.67%
Participation in ICT for County MH Children and Youth	0	0	
Participation in ICT for FSP	1	1	100.00%
Participation in ICT for ASO	0	0	
Magellan Participation in ICT (CCN)	4	4	100.00%
Magellan Individual Provider Participation in ICT (CCN)	0	0	
Total Participation	4	4	100.00%
Magellan Participation in ICT (HN-SPD)	17	19	89.47%
Magellan Individual Provider Participation in ICT (HN-SPD)	0	0	
Total Participation	17	19	89.47%

JUNE

OCC

	Participation	Invitation(s) (denom.)	%
Participation in ICT for BHI	34	34	100.00%
Participation in ICT for County MH Adult	0	0	
Participation in ICT for County MH Children and Youth	0	0	
Participation in ICT for FSP	0	0	
Magellan Participation in ICT (CCN)	2	2	100.00%
Magellan Individual Provider Participation in ICT (CCN)	0	0	
Total Participation	2	2	100.00%
Magellan Participation in ICT (HN-OCC)	18	18	100.00%
Magellan Individual Provider Participation in ICT (HN-OCC)	0	0	
Total Participation	18	18	100.00%

OC

	Participation	Invitation(s) (denom.)	%
Participation in ICT for BHI	0	0	
Participation in ICT for County MH Adult	0	0	
Participation in ICT for County MH Children and Youth	0	0	
Participation in ICT for FSP	0	0	
Magellan Participation in ICT (CCN)	0	0	
Magellan Individual Provider Participation in ICT (CCN)	0	0	
Total Participation			
Magellan Participation in ICT (HN-OC)	39	39	100.00%
Magellan Individual Provider Participation in ICT (HN-OC)	0	0	
Total Participation	39	39	100.00%

SPD

	Participation	Invitation(s) (denom.)	%
Participation in ICT for BHI	111	111	100.00%
Participation in ICT for County MH Adult	3	3	100.00%
Participation in ICT for County MH Children and Youth	0	0	
Participation in ICT for FSP	2	3	66.67%
Participation in ICT for ASO	0	2	0.00%
Magellan Participation in ICT (CCN)	8	11	72.73%
Magellan Individual Provider Participation in ICT (CCN)	1	11	9.09%
Total Participation	9	11	81.82%
Magellan Participation in ICT (HN-SPD)	23	31	74.19%
Magellan Individual Provider Participation in ICT (HN-SPD)	6	31	19.35%
Total Participation	29	31	93.55%

Top ED Utilizers 1/1/2017-6/26/2017

	Ranking									
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
CIN	92618125C	92440927E	90103929A	96280687E	91108367A	94323073C	95487435C	91184547F	91283043D	93614815C
NAME	Melanie R Denny	Joanna Y Ortiz	Mark Cypra	Garrett S Morgan	Reggie Silverstone	Augustine Collins	Martin B Nunez	Erin Byrne	April Simmons	Gregory Patterson
LOB	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-Cal	Medi-cal	Medi-Cal	Medi-Cal
ER VISIT Count	30	29	25	22	21	20	19	17	17	17
Aid Code	**M1**	**M3**	**M1**	**24**	**26**	**60**	**60**	**M1**	**M3**	**M1**
Program	CC	CC	CC	CC		CC		CC	CC	CC
Case Manager	*Karen H*	*Roseann W*	*Noushin D*	*Roseann W*		*Karen H*		*Noushin D*	*RoseannW*	*Cierra C*
BH										
Substance use										
Homeless										
Eligibility Issues										
Engaged w/PCP										
Out of Area										
Valid Phone #										
Notes										

Total visits   **217**

Member Satisfaction Q2 2017

Results	
Member Satisfaction	
	Score
Overall Satisfaction with CM	100%
Case Management was beneficial	100%
Educational materials were helpful	100%
CM was helpful with medical questions	100%
Community resources were helpful	100%
Questions were answered to Satsifaction	100%

24 Completed
24 of 24 positive scores = 100%

Complex case management Q2 2017

	Mbrs referred to CCM Complex Cases								
	April			May			June		
Health Network	# of cases reported	# of Cases reviewed	Score %	# of cases reported	# of Cases reviewed	Score %	# of cases reported	# of Cases reviewed	Score %
AltaMed	1	0		1	1	100%			
AMVI	1	1	100%	0	0				
Arta Western	2	1	100%	1	1	100%			
CCN	91	5	100%	88	5	98%			
CHOC	4	4	100%	2	2	100%			
FCMG	5	5	100%	3	3	100%			
Hertiage Regal	6	2	78%	6	3	91%			
Kaiser	10	5	90%	6	5	96%			
Monarch	16	5	100%	11	5	100%			
Noble	7	5	100%	5	5	100%			
OCA	0	0		0	0				
Prospect	9	5	94%	7	4	90%			
Talbert	2	2	97%	3	2	100%			
UCMG	3	0		5	1	83%			
Totals:	157	40		138	37		0	0	
* Pending completion									

HN Performance Q2 2017

HN	April	May	June
Results			
OneCare Connect (OCC)			
AltaMed	100.00%	100.00%	80.00%
AMVI	*0%	100.00%	*0%
Arta	96.30%	94.40%	93.00%
Heritage Regal	100.00%	100.00%	100.00%
FCMG	90.60%	89.00%	85.80%
OCA	100.00%	*0%	100.00%
Talbert	98.50%	95.70%	95.00%
Monarch	91.40%	94.70%	92.00%
Prospect	97.70%	96.10%	100.00%
Noble	100.00%	100.00%	100.00%
UCMG	*0%	100.00%	70.00%
CCN	94.50%	96.10%	97.90%
* No bundles due or returned			
Indicates payment Modifier <80%			

HN Performance Q2 2017

Results			
SPD			
HN	**April**	**May**	**June**
AltaMed	97.41%	97.47%	98.32%
AMVI	88.29%	91.00%	98.50%
Arta	98.85%	98.62%	99.73%
CHOC	95.44%	97.81%	99.59%
Heritage Regal	96.00%	91.00%	93.33%
FCMG	97.23%	97.39%	97.17%
OCA	100.00%	100.00%	100.00%
Talbert	100.00%	99.60%	98.52%
Monarch	98.99%	98.80%	98.23%
Prospect	95.17%	96.33%	97.78%
Noble	95.20%	97.75%	95.38%
UCMG	96.10%	94.00%	93.79%
CCN	94.19%	95.98%	97.12%
* No bundles due or returned			
Indicates payment Modifier <80%			

HN Performance Q2 2017

Results			
OneCare (OC)			
HN	**April**	**May**	**June**
FCMG	100.00%	98.67%	95.21%
AltaMed	100.00%	100.00%	95.00%
AMVI/Prospect	97.15%	98.86%	100.00%
Arta Western	98.67%	100.00%	98.00%
Monarch	97.80%	98.68%	97.48%
Noble	*0%	100.00%	*0%
Talbert	84.29%	97.14%	100.00%
UCMG	100.00%	98.40%	100.00%
* No bundles due or returned			
Indicates payment Modifier <80%			

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	Data Source/Owner Notes
Program Structure:										
QI Program Description (submission date)	Date	Esther	Annual	Apr-15	Met	Apr-16	Met			
QI Work Plan (submission date)	Date	Esther	Annual	Apr-15	Met	Apr-16	Met			
QI Evaluation (submission date)	Date	Esther	Annual	Apr-16	Met					
Network Management										
Strong Network (Access)-Survey	See report	Marsha C.	Annual	See access report	N/A					2016 Timely Access Results available Nov 2016.
Strong Network (Availability)-Quarterly Report	See report	Marsha C.	Quarterly	See availability report	N/A					Availability reports are ran quarterly.
Behavioral Health Access (BH Access & Availability)	See report	Dr. Poon	Quarterly							
LTSS Access & Availability	TBD	Marie E.	Quarterly							
Complaints associated with Network Access	%/1000	Janine	Quarterly	0%	Y					
Use of Dental Benefit	41.50%	Lizeth	Monthly							
Complaints associated with use of Dental Benefit	1.80%	Janine	Quarterly	15%	N					
Utilization of Taxi Benefit (Transportation Services)	29.80%	Belinda	Annual	19.43%	Y					
Complaints associated with Taxi Benefit (Transportation Services)	2.70%	Janine	Quarterly	8%	N					

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	Data Source/Owner Notes
Coordination of Care										
% of calls resolved at first call	85%	Belinda	Quarterly	NA						11/8/16: this internal CalO measurement began Oct. 2016; included in QIC work plan; no 2015 results available; are there interventions in place for this measure? 12/5/16: First call resolution for Q3 is 91% and is monitored monthly.
Member voluntary disenrollment rate	3.00%	Belinda	Quarterly	14.25%	N					11/8/16: 3% goal is for 2016; 2015 rate reflects passive enrollment and 3% is not reasonable goal; retention plan proposal for OCC set to be presented by Candice at exec this week 12/5/16: November 2016 Voluntary Disenrollment Rate is 1.06%/182 members.
Transitions of Care										
Sending Member's Care Plan to Next Care Setting	% sent	Denise	Quarterly							
Notification to PCP of Transition	% notified	Denise	Quarterly							
HRA Outreach Completion Rate	90%	Cecelia	Quarterly	99%	Met					
HRA completion rate	TBD	Cecelia	Quarterly	22.90%						
ICP/ICT										
ICP (% of members with ICP)	90%	Denise	Quarterly							
ICT (% of members with ICT)	TBD	Denise	Quarterly							
DM inclusion in ICP (CCN)	30%	Pshyra	Quarterly							
Over/Under-Utilization of Services (Unused Auths?)			Quarterly	See HN rpt tab						
In-Patient Admits/1000	Admits/1000	Debra/Solange	Semi-Annual	See HN rpt tab						
Readmission Rate	<9.9%	Debra/Solange	Semi-Annual	See HN rpt tab						
Reduction in ER Visits (visit/1000 members)	585/1000	Debra/Solange	Quarterly	See HN rpt tab						
ALOS	4	Debra/Solange	Monthly	See HN rpt tab						

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	Data Source/Owner Notes
Response to Key Events (Need definition)	TBD	Denise	Quarterly							
F/Up after MH hospitalization (7 & 30 day)	50th %tile	Paul J	Annual	7 day = 81.35% 30 day = 85.49% (One Care)						
LTSS:										
Access to LTSS (utilization of LTSS services)	TBD	Marie E.	Quarterly							
Inpatient Days/1000 LTSS	Days/1000	Marie E.	Quarterly	Process not finalized in 2015						
ER Visits (visits/1000)	Visits/1000	Marie E.	Quarterly	Process not finalized in 2015						
Annual Analysis of Risk Level Classification (% Low/% High)	TBD	Cecelia	Quarterly	74%/26%						
Disease Mgmt penetration for Basic CM members	30%	Pshyra	Quarterly							
Other										
QIP/CCIP										
Topic : Improving In-Home Supportive Services Care Coordination	% improvement	Marie E./Marsha C	Quarterly	PIP not in place for 2015; 2016 only						Annual submission in January 2017
Topic: Readmission within 30 days	baseline year	Tracy/ Marsha C	Quarterly	QIP not in place for 2015; 2016 only						Annual submission in January 2017

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	Data Source/Owner Notes
Health Outcomes										
HEDIS performance (Stars Measure)				One Care Results for 2015						
Improvement in Adult Preventive Service	94.8% (50th %tile)	Paul J	Annual	93.61%	N					
Measure 1 (Controlling Blood Pressure)	4 Star Goal	Paul J	Annual	69.68%						
Measure 2 (Diabetes Care - A1C Control)	4 Star Goal	Paul J	Annual	72.51%						
Measure 3 (Diabetes Care - Nephropathy Monitoring)	4 Star Goal	Paul J	Annual	95.15%						
Measure 4 (Breast Cancer Screening)	69.80%	Paul J	Annual	68.69%	N					
Measure 5 (Colorectal Cancer Screening)	54.70%	Paul J	Annual	64.36%	Y					
Measure 6 (Acute Phase Depression Tx)	63.40%	Paul J	Annual	55.25%	N					
Measure 7 (Rheumatoid Arthritis)	4 Star Goal	Paul J	Annual	66.00%						
Measure 8 (Osteoporosis)	4 Star Goal	Paul J	Annual	44.87%						
Pharmacy Measures										
Medication Adherence - Hypertension	4 Star Goal	Nicki	Annual	5 stars (86%)	Y					
Medication Adherence - Diabetes	4 Star Goal	Nicki	Annual	4 stars (82%)	Y					
Medication Adherence - Cholesterol	4 Star Goal	Nicki	Annual	5 stars (82%)	Y					
HOS performance										
Maintaining or improving physical health status	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016						
Maintaining or improving mental health status	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016						

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	Data Source/Owner Notes
Reducing the risk of falling	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016						
Member Experience										
CAHPS Performance (Stars Measures)				One Care Results for 2015						
Getting Needed Care	4 Star Goal	Marsha C	Annual	77%	Not Met					
Rating of Drug Plan	4 Star Goal	Marsha C	Annual	82%	Not Met					
Customer Service	4 Star Goal	Marsha C	Annual	85%	Not Met					
Getting Appointments & Care Quickly	4 Star Goal	Marsha C	Annual	70%	Not Met					
Getting Needed Prescription Drugs	4 Star Goal	Marsha C	Annual	88%	Not Met					
Care Coordination	4 Star Goal	Marsha C	Annual	80%	Not Met					
Overall Rating of Plan	4 Star Goal	Marsha C	Annual	82%	Not Met					
Overall Rating of Health Care Quality	4 Star Goal	Marsha C	Annual	81%	Not Met					
Medical Record Review (HN compliance to policies)										
MRR results - CalOptima	Clinical Ops	Esther	Annual							
IRR for UM activities										
Annual IRR for Staff	90%	Debra	Annual	96-100%	Y					
Annual IRR for RX	TBD	Solange	Annual	Completed?						
Delegated functions oversight										
Health Network performance	A/O Report	Solange	Quarterly							
MRR results - HN	A/O Report	Esther	Quarterly							
IRR for Delegates	A/O Report	Solange	Annual	Completed?						
Clinical Practice Guidelines										
Reviewed annually (linked with DM)	QIC minutes	Pshyra	Annual							

Member Trend Report 2nd Quarter 2017

Board of Directors' Quality Assurance Committee Meeting

November 15, 2017

Ana Aranda

Interim Director, Grievance and Appeals Resolution Services

Overview

- Trend of the rate of complaints (appeals/grievances) per thousand members for all CalOptima programs for the second quarter in 2017.

  ➤ 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

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 Cal MediConnect Plan (Medicare-Medicaid Plan) (OCC) Member Complaints
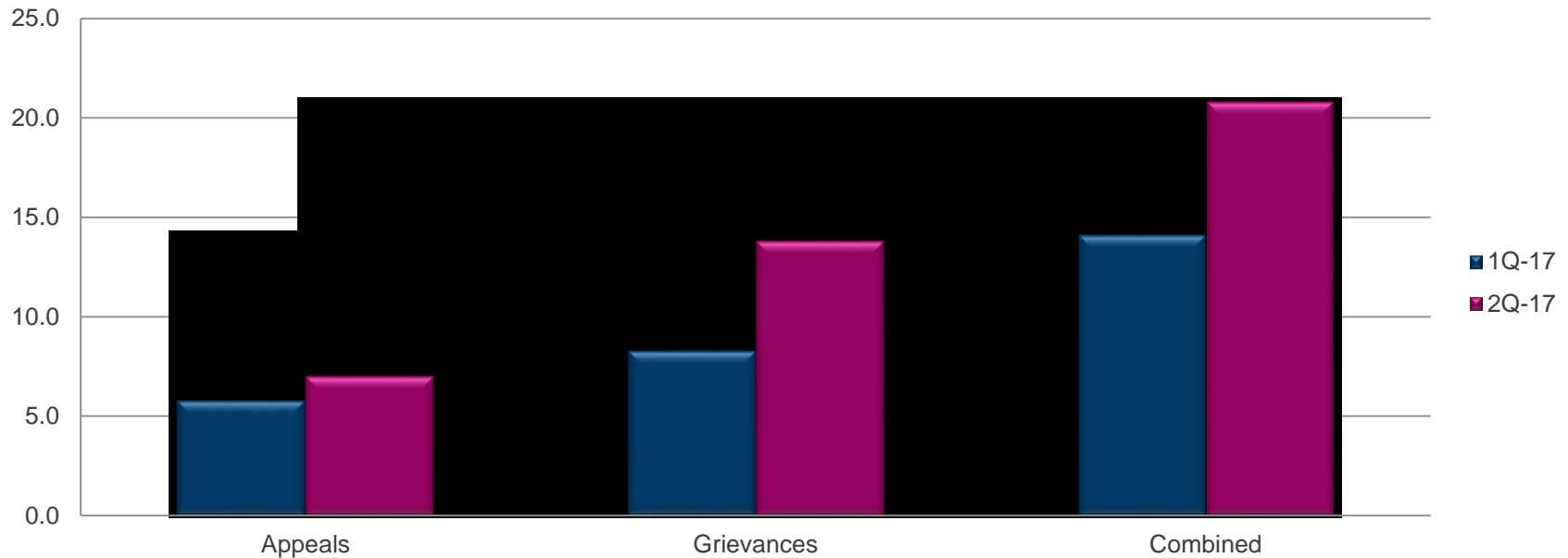
	Total Complaints	Appeals	Grievances	Membership
1Q-2017	230	95	135	16,297
2Q-2017	328	110	218	16,054

OCC Member Grievances Quarterly Rate/1,000

	Alta Med Health (538)	AMVI Care (524)	Arta (550)	Family Choice (1,877)	Heritage (242)	Monarch (4,980)	Noble (454)	OC Adv (117)	Prospect (3,053)	Talbert (1,155)	UCMG (565)	American Logistics (15,810)	CCN (1,756)	Liberty Dental (15,810)	MLTSS (15,810)	Magellan (15,810)	OCC Prog (15,810)	OCC Pharm (15,810)	VSP (15,810)
1Q-17 (135)	1.8	0.0	1.7	0.0	0.0	4.1	0.0	0.0	4.8	5.0	0.0	2.2	6.2	1.2	0.0	0.1	0.6	0.5	0.2
2Q-17 (218)	9.3	1.9	21.8	0.5	0.0	7.4	2.2	0.0	5.6	2.6	1.8	4.0	10.3	2.2	0.0	0.2	0.6	0.4	0.3
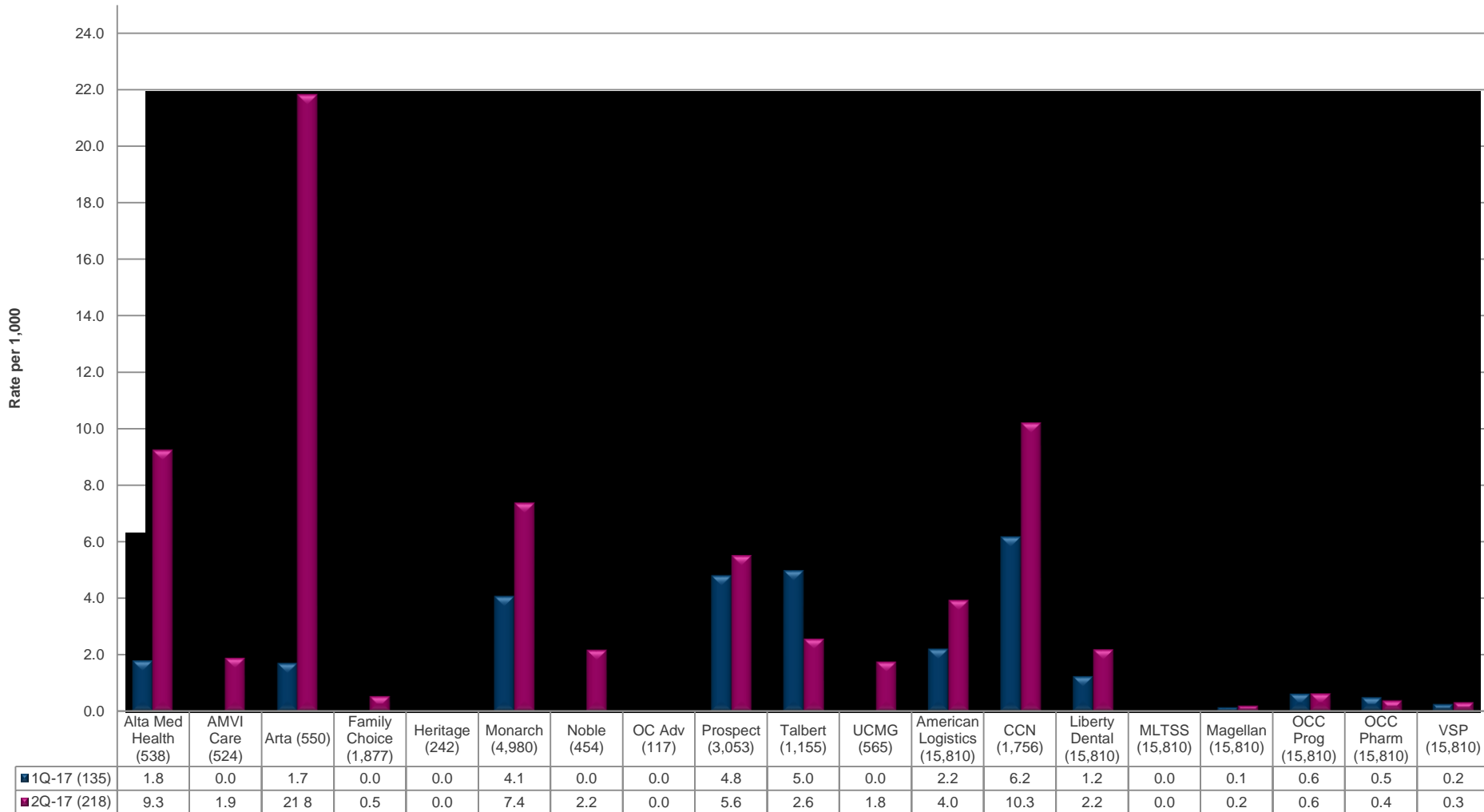
OCC Grievances by Category

- Total of 218 grievances filed by 173 unique members in Q2 2017.
  - ➢ Of these, 187 grievances (86 percent) were related to QOS, and 18 grievances (8 percent) were related to QOC concerns.
  - ➢ Note: The percentage by categories represents the historic trend.

Attitude/Service 86% **Access 2%** **Billing/Financial 4%** **QualityCare 8%**

- The Quality Improvement (QI) department continues to review for QOC issues and potential trending.

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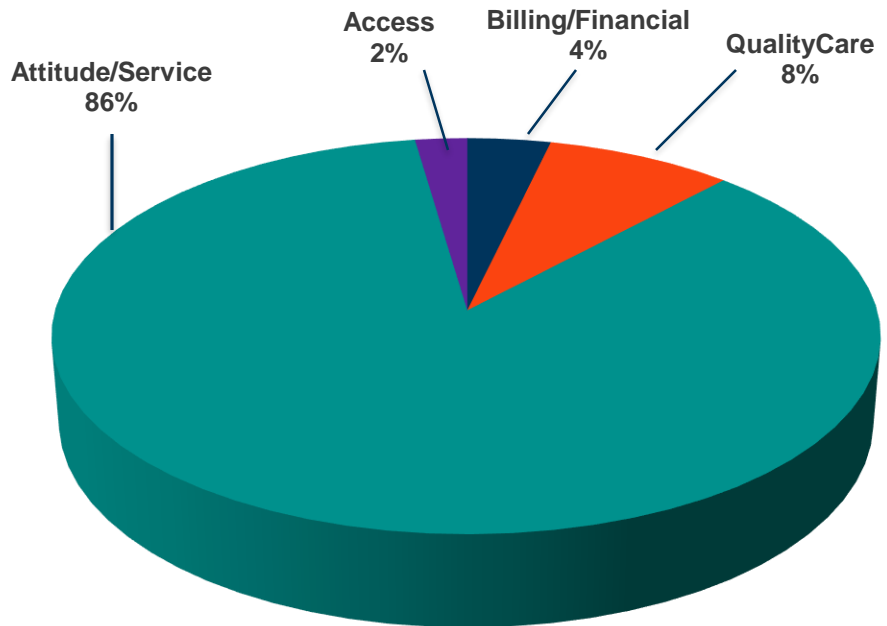
Common QOS and QOC Concerns

- Delay in service (QOS)
  - Referral/test results delay
  - Appointments
- Dental (QOS)
  - Dissatisfied with dental services
  - Charged for services not done/unwanted
- Transportation vendor (QOS)
  - Late/no show
  - Poor customer service
- Question diagnosis/treatment (QOC)
  - Inadequate care provided
  - Medication issues

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Summary

- Overall increase in grievances filed from 135 in Q1 to 218 in Q2 2017.

- Increase in volume is generally in the area of Quality of Service grievances related to the following providers/health networks:

  ➤ American Logistics (63)

  ➤ LIBERTY Dental (35)

  ➤ Monarch (37)

  ➤ Prospect (17)

  ➤ CCN (18)

 ➤ Arta (12)

Summary (cont.)

- American Logistics made up 29 percent of all grievances filed in Q2

- CalOptima escalated issues with American Logistics

- Working with Provider Network Relations and Quality Improvement departments to address issues

- All quality of care concerns are referred to CalOptima's Quality Improvement department for investigation

- American Logistics

  - Taxi vendor continues to add drivers to avoid late rides or no shows. At times, the dispatcher has made errors in booking the rides. Additional training by American Logistics has been provided to their dispatchers.

  - Monthly meetings scheduled to track performance and update action plan with vendor
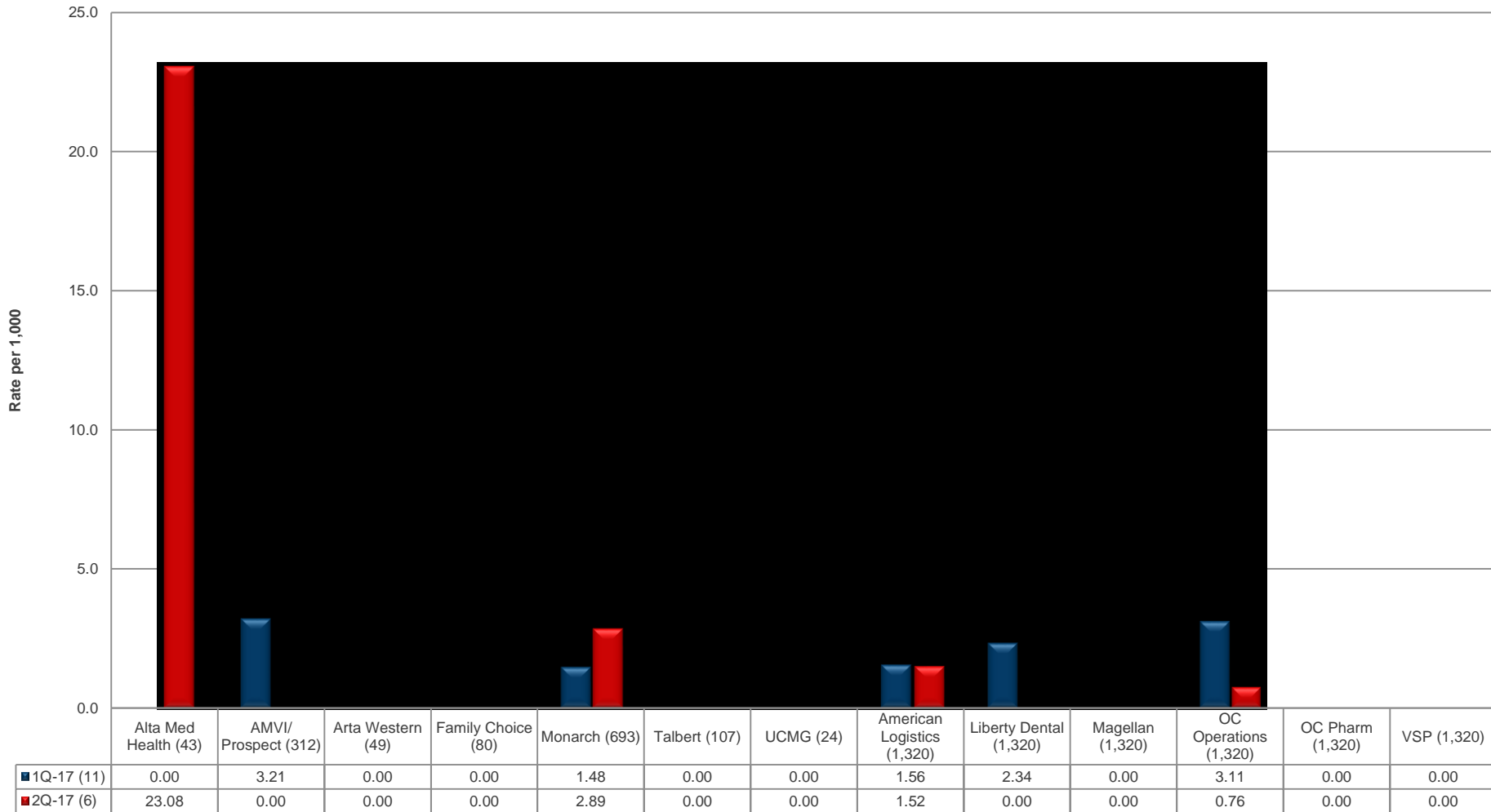
Summary (cont.)

- Liberty Dental
  - Providers offering/providing add-on services to members that are Denti-Cal covered benefits, causing confusion to Members on their financial responsibility. Liberty Dental has tasked their Provider Relations department to educate the dental providers about benefit limitations.
- Arta and Monarch
  - Most of the Grievances were related to services provided by S&G Homecare Medical Supply (e.g. timely delivery of supplies)
- CCN
  - Member's lack of awareness of the referral and the triage processes is the root cause for a substantial number of CCN grievances. Better education and targeted communication with providers are being used to address this issue

Overall OneCare (OC) Member Complaints
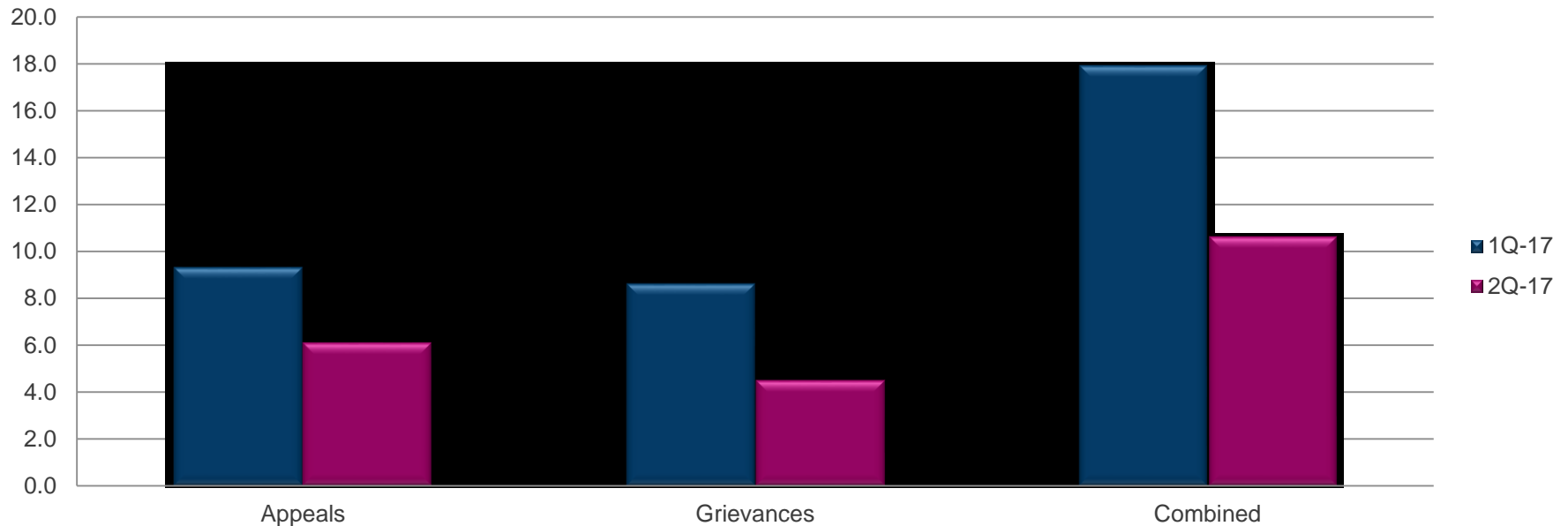
	Total Complaints	Appeals	Grievances	Membership
1Q-2017	18	12	11	1,285
2Q-2017	14	8	6	1,302

OC Member Grievances Quarterly Rate/1,000

	Alta Med Health (43)	AMVI/ Prospect (312)	Arta Western (49)	Family Choice (80)	Monarch (693)	Talbert (107)	UCMG (24)	American Logistics (1,320)	Liberty Dental (1,320)	Magellan (1,320)	OC Operations (1,320)	OC Pharm (1,320)	VSP (1,320)
1Q-17 (11)	0.00	3.21	0.00	0.00	1.48	0.00	0.00	1.56	2.34	0.00	3.11	0.00	0.00
2Q-17 (6)	23.08	0.00	0.00	0.00	2.89	0.00	0.00	1.52	0.00	0.00	0.76	0.00	0.00

OC Grievances by Category

- Total of six grievances filed by six unique members in Q2 2017.
  - ➤ Of these, four grievances (67 percent) were related to QOS, and two grievances (33 percent) were related to QOC concerns.
- The QI department continues to review for QOC issues and potential trending.

Attitude/Service
67%

Billing/Financial
33%
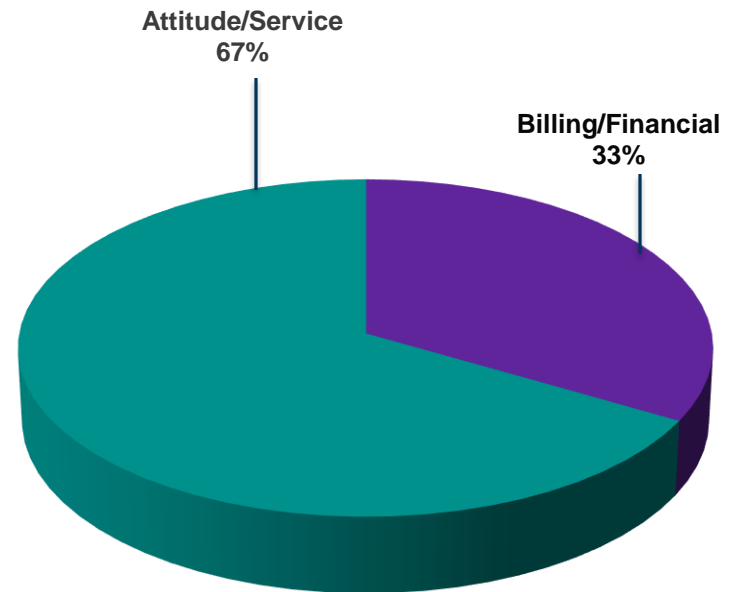
Common QOS and QOC Concerns

- Operational process (QOS)
- Transportation vendor (QOS)
- Member billing

Summary

- Overall decrease in grievances filed from 11 in Q1 to 6 in Q2 2017.

- Decrease is attributed to members no longer filing a grievance related to an incentive program (movie tickets) that was previously available for completing the health risk assessment.

Overall Medi-Cal (MC) Member Complaints

	Appeal	Grievances	Combined
■ 1Q-17	1.2	3.6	4.8
■ 2Q-17	1.2	4.5	5.7
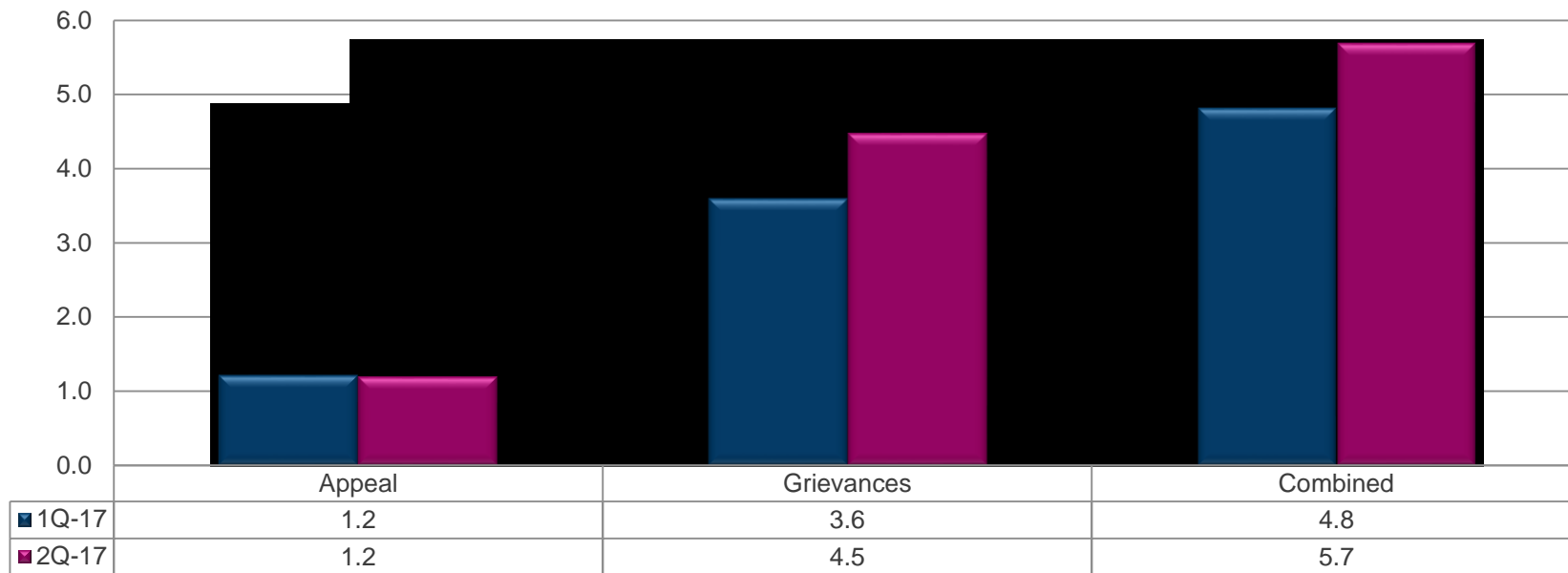
	Total Complaints	Appeals	Grievances	Membership
1Q-2017	921	233	688	774, 750
2Q-2017	1094	232	862	773, 412

MC Member Grievances Quarterly Rate/1,000

|	AltaMed (44,256)	AMVI (22,155)	Arta (70,349)	CHA (151,072)	Family Choice (47,573)	Heritage (4,622)	Kaiser (45,698)	Monarch (86,118)	Noble (31,122)	OC Advantage (1,316)	Prospect (33,627)	Talbert (24,016)	UCMG (34,999)	CO Prog (772,074)	CO Pharm (772,074)	CCN (72,140)	COD (103,010)	MLTSS (726,376)	Magellan /Beacon (772,074)	VSP (726,376)
1Q-17 (688)	0.43	0.22	0.85	0.19	0.25	2.70	2.44	1.11	0.46	2.85	0.61	0.77	0.43	0.02	0.09	1.87	0.38	0.00	0.02	0.01
2Q-17 (862)	0.66	0.27	0.77	0.32	0.44	3.46	2.47	1.22	0.58	0.76	0.51	0.58	0.63	0.03	0.10	2.59	0.60	0.00	0.05	0.02

Medi-Cal Grievances by Category

- Total of 862 grievances filed by 773 unique members in Q2 2017.
  - Of these, 575 grievances (67 percent) were related to QOS and 114 grievances (13 percent) 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.

Billing & Financial 14%

Access 6%

Practitioner office <1%

Quality Care 13%

Attitude/Service 67%
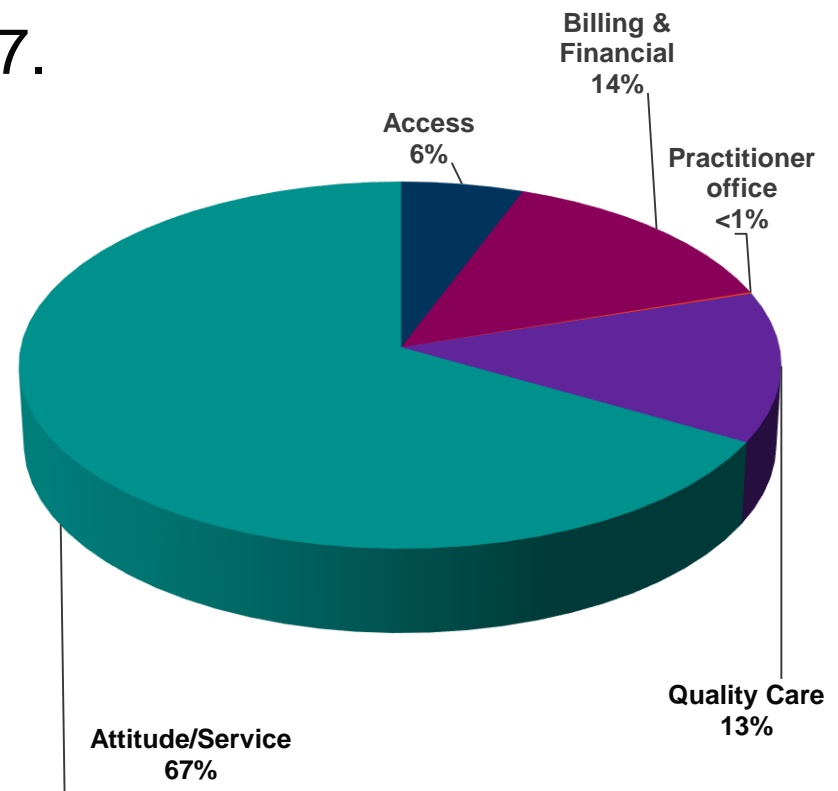
Common QOS Concerns

- Delay in service
  - ➢ Referrals
  - ➢ Prescriptions
  - ➢ Test results
- Provider services
  - ➢ Dissatisfied with staff, doctor or program
- Rudeness
- Pharmacy
  - ➢ Vendor issues (i.e., Walgreens, CVS, Rite Aid)
  - ➢ Prior Authorizations process

Common QOC Concerns

- Question diagnosis
- Question treatment
- Delay in treatment impacting member's care
- Refuse to treat

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Summary

- Overall grievances at a rate/1,000 members increased from 3.6 in Q1 2017 to 4.5 in Q2 2017.

- Increase is attributed to member billing and quality of service grievances.

  ➤ Billing issues were previously resolved by Customer Service staff. Due to a change in the handling of these types of grievances, the Grievance and Appeals Resolution Services department is now responsible to resolve billing concerns under the grievance process. Billing grievances include reimbursement requests, urgent care visits, out of state ER services and non-authorized services.

  ➤ QOS issues include poor provider services, delay in service and health network or CalOptima staff.

    ▪ Recurring providers were identified and reported to the Quality Improvement department for further review.

Interventions

- Providers are tracked and trended and escalation is done to Provider Relations, Compliance or Quality Improvement departments for further review.

- 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 during the Joint Operations Meeting (JOM) and Health Network Forum to improve in these areas including QOS and QOC concerns.

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner