



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

**THURSDAY, JANUARY 17, 2019
4:00 P.M.**

**505 CITY PARKWAY WEST, SUITE 108-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
Michael Schrader

CHIEF COUNSEL
Gary Crockett

CLERK OF THE BOARD
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 12, 2018 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS

2. Consider Recommending Board of Directors' Approval of CalOptima Population Health Management Strategy for 2019
3. Consider Recommending Board of Directors' Approval of an Amendment to the Board-Approved Action for Fiscal Year 2019 (Measurement Year 2018) Pay for Value Programs for Medi-Cal and OneCare Connect Lines of Business
4. Consider Recommending Board of Directors' Approval of the Proposed Pay for Value Program for Fiscal Year 2020 (Measurement Year 2019) for Medi-Cal and OneCare Connect Lines of Business

INFORMATION ITEMS

5. Program of All-Inclusive Care for the Elderly (PACE) Member Advisory Committee Update
6. Longitudinal Retrospective Quality Improvement Program Evaluation Tool
7. Provider Coaching Pilot Update
8. Whole-Child Model Clinical Advisory Committee Update
9. Improve Access to Annual Eye Exam for Medi-Cal Members with Diabetes
10. Quarterly Reports to the Board of Directors' Quality Assurance Committee
 - a. Quality Improvement Committee Update
 - b. Member Trend Report Update

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

September 12, 2018

CALL TO ORDER

Chair Paul Yost called the meeting to order at 3:30 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 Helmer M.D., Chief Medical Officer; Betsy Ha, Executive Director, Quality Analytics; Gary Crockett, Chief Counsel; Sessa Mudunuri, Executive Director, Operations; Suzanne Turf, Clerk of the Board

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the May 16, 2018 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: On motion of Director Nguyen, seconded and carried, the Committee approved the Minutes of the May 16, 2018 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Director Khatibi absent)

REPORTS

2. Consider Recommending Board of Directors' Approval of the Updated Strategy for the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to CalOptima Community Network (CCN)

Action: On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the updated strategy for the disbursement of OneCare Connect demonstration years 2-5 (calendar years

2016-19) quality withhold payment to CalOptima's Community Network as presented. (Motion carried 3-0-0; Director Khatibi absent)

INFORMATION ITEMS

3. PACE Member Advisory Committee Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, reported on the activities of the June 18, 2018 PMAC meeting, including participation in a survey regarding experience, satisfaction with meals, and preferences. The Dietary Services Focus Group had a discussion on dietary services at the PACE regarding members food choices and the alternatives that are available and offered during meal service.

4. CalOptima Personal Care Coordinator Evaluation

Tracy Hitzeman, Executive Director, Clinical Operations, provided an overview of CalOptima Personal Care Coordinator (PCC) Evaluation. The PCC role was designed to support the implementation of the Health Risk Assessment (HRA), Individualized Care Plan (ICP), and the care planning process. CalOptima engaged an independent consultant group to conduct an evaluation of the PCC's impact using quantitative and qualitative data sources from 2012 through 2017. The evaluation data included both process and outcome measures and focused on metrics that the PCC directly or indirectly influences in their role. A review of the findings was presented to the Committee for discussion. It was reported that the PCC position has had a significant impact on achieving compliance with the Centers for Medicare & Medicaid Services and the Department of Health Care Services (DHCS) requirements for the HRA, ICP, and the Interdisciplinary Care Team (ICT) process. Continued refinement of the PCC duties will support ongoing improvement on quality measures.

Director Berger requested that staff provide the following to the Committee at a future meeting: additional information on the OneCare Connect Core Measures related to the percentage of members with documented discussion of care goals, and the percentage of members who have a care coordinator and at least one care team contact during the reporting period, including actual numbers for each measure and the action plan to improve the scores.

5. 2018 National Committee for Quality Assurance (NCQA) Update

Betsy Ha, Executive Director, Quality Analytics, reported that CalOptima completed the tri-annual renewal survey for NCQA Health Plan Accreditation in July 2018 and received commendable status based on scores from the 2018 Renewal Survey, 2017 Healthcare Effectiveness Data and Information Set (HEDIS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS).

6. Healthcare Effectiveness Data and Information Set (HEDIS) 2018 Results

Ms. Ha and Kelly Rex-Kimmet, Quality Analytics Director, presented a review of the HEDIS 2018 results for the Medi-Cal, OneCare and OneCare Connect lines of business compared to CalOptima goals. It was reported that the Medi-Cal program met all DHCS minimum performance levels. For the OneCare program, 56% of the measures met the goal, 74% of the measures were better than last year, and opportunities for improvement are in the areas of diabetes nephropathy and breast cancer screening. OneCare Connect measures were reported as follows: 33% of measures met the goal, 74% of measures were better than last year, and opportunities for improvement are in the areas of diabetes and behavioral health measures. Next steps include: implementing strategies in low

performing areas related to strategic initiatives; presenting results to stakeholder groups and committees; awaiting NCQA Health Plan rating; and calculating Pay for Value scores and payments.

7. Member Experience Initiatives Update

Ms. Ha reported that an enterprise-wide Member Experience Subcommittee was formed to improve member experience and to ensure members have access to quality health care. The areas of focus are getting needed care and care quickly, how well doctors communicate, and customer service. Next steps include continuing with planned interventions, evaluating effectiveness of interventions, implementing strategies on low performing areas, and continued collaboration with health networks and providers to improve member experience.

Director Nguyen requested that staff provide an update on provider coaching at a future Committee meeting.

8. Whole-Child Model Update

Ms. Ha provided an update on the Whole-Child Model (WCM) Clinical Advisory Committee. In addition to the WCM Family Advisory Committee, the WCM Clinical Advisory Committee (CAC) was formed to ensure that clinical and behavioral health services for children with California Children's Services (CCS) eligible conditions are integrated into the design, implementation, operation and evaluation of the CalOptima WCM program in collaboration with County CCS, WCM Family Advisory Committee, and Health Network CCS providers. CalOptima is in the process of accepting recommendations to fill the designated Committee seats with CCS-paneled physicians. The first WCM-CAC meeting will be held on September 25, 2018.

Sesha Mudunuri, Operations Executive Director, presented an overview of the claims payment process as it relates to the transition of CCS to CalOptima's Whole-Child Model. Mr. Mudunuri reported that in order to promote a smooth transition to WCM and to ensure continued access to services for members, staff proposes implementing a transition period that permits claims payments in certain situations when there is no CalOptima or health network authorization. For dates of service of January 1, 2019 through June 30, 2019, staff proposes that CalOptima and the health networks pay for CCS services provided by contracted or non-contracted providers for eligible children who were enrolled in CCS program prior to January 1, 2019, as long as there is an active CCS Service Authorization Request and other claims payment requirements are met. All inpatient services are excluded from this proposed exception, and depending on member's eligibility, will require a CalOptima or a health network authorization. This proposal will be presented for discussion to the Board of Directors' Finance and Audit Committee on September 18, 2018, and to the Board of Directors for consideration at the October 4, 2018 meeting.

9. Bright Steps Perinatal Support Program

Pshyra Jones, Health Education and Disease Management Director, provided an overview of the Bright Steps Perinatal Support Program. CalOptima contracts with certified Comprehensive Perinatal Services Program (CPSP) providers to deliver evidenced-based prenatal and postpartum care to members. Certified providers are required to have current Medi-Cal enrollment with the California Department of Health Care Services (DHCS), be CalOptima credentialed, and be recognized by the Orange County Health Care Agency. Certified providers shall provide the opportunity for members to have enhanced support services, including: health education, psychosocial, and nutrition assessments each trimester, in accordance with The American College of Obstetricians and Gynecologists (ACOG) and CPSP protocols. Contracted providers shall not provide enhanced

support services to members already receiving these services from another contracted Provider. Comprehensive care shall exclusively be provided to a member by one contracted Provider during any given time period.

The goals of the Bright Steps Perinatal Support Program include: comprehensive support for CalOptima pregnant members; early identification, assessment, and intervention; improved coordination between CalOptima, Bright Steps contracted providers, OB/GYNs, and health network case management staff; recognition in the community; improved outcomes for mothers and babies; and improved member satisfaction. Program performance measures include the prenatal and postpartum care HEDIS measure, NICU days, birth weights, preterm births under 37 weeks, and program satisfaction. A review of the components of the Bright Steps Perinatal Support Program was provided to the Committee.

10. Depression Screening Initiative Update

Donald Sharps, M.D., Medical Management, provided an update on the activities related to depression screenings. As of today, 5,400 members have received depression screenings. CalOptima has conducted in-person visits to provider offices to support office staff and provide guidance on billing procedures, and a quick reference billing guide was created for staff, which led to a decrease in claim denials. A provider survey was developed that will be used to measure the effectiveness and success of the program.

11. Health Homes Program Update

Medical Director Emily Fonda, M.D., provided a brief update on the Health Homes Program (HHP). The California Department of Health Care Services (DHCS) selected CalOptima for implementation of the HHP in two stages: July 1, 2019 for members with chronic conditions; and January 1, 2020 for members with Serious Mental Illness or Serious Emotional Disturbance. Dr. Fonda provided an overview of the HHP eligibility criteria and program exclusions as specified by DHCS, as well as the program demographics, service requirements, health network distribution, and staffing.

12. The following Quarterly Reports were accepted as presented:

- a. Quality Improvement Committee – First and Second Quarter 2018 Update
- b. Member Trend Report – First Quarter 2017

COMMITTEE MEMBER COMMENTS

Chair Yost requested that staff provide the following at a future Committee meeting: information on programs for providers who may be at risk for depression, and strategies to improve CCN quality scores.

Committee members thanked staff for their work.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 5:20 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: January 17, 2019

[Back to Agenda](#)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 17, 2019 Special Meeting of the CalOptima Board of Directors’ Quality Assurance Committee

Report Item

2. Consider Recommending Board of Directors’ Approval of CalOptima Population Health Management Strategy for 2019

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Betsy Ha, Executive Director, Quality and Analytics, (714) 246-8400

Recommended Action

Consider recommending Board of Directors’ approval of the CalOptima Population Health Management Strategy for 2019.

Background

The National Committee for Quality Assurance (NCQA) continuously assesses the health care landscape, as well as pending regulations, to enhance accreditation standards annually. Effective July 1, 2018, NCQA implemented a significant change by creating a new Population Health Management (PHM) Standards section (see Attachment 2). Concurrently, NCQA eliminated the Disease Management standards, moved Complex Case Management (CCM) Standards from the Quality Management & Improvement Standards (QI) section, and Wellness and Prevention Standards from the Member Connections Standards (MEM) section to the PHM section. The PHM section also included new standards requiring health plans to provide Delivery System Supports, such as providing transformation support to the primary care practitioners. The comprehensive PHM Strategy is the first structural requirement of the new standard set. In preparation for the next NCQA re-accreditation and onsite audit scheduled for July 11-12, 2021, CalOptima must start implementing the PHM Strategy with appropriate resource alignment starting on May 24, 2019 upon Board approval.

Discussion

The intent of the CalOptima PHM Strategy for 2019 is to develop a comprehensive plan of action for addressing our culturally diverse member needs across the continuum of care. The community driven plan of action is based on numerous efforts to assess the health and well-being of CalOptima members. The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The year one approach of the CalOptima PHM Strategy is to align current and new programs (e.g., Bright Steps, Behavioral Health Integration, Whole-Child Model, Complex Case Management, and Health Management Programs, etc.) to the new PHM framework leveraging internal and external population health needs assessment findings to date. The PHM plan of action as part of the Quality Improvement (QI) Work Plan is updated annually through the comprehensive annual QI Program and

Evaluation process. In addition to the cost and quality performance data sets, CalOptima's PHM strategy is adjusted annually based on the analysis of other data sources that reflect the changing demographics and local population needs of the Orange County community.

The PHM Strategy addresses four focus areas:

1. Keeping members healthy
2. Managing members with emerging risk
3. Patient safety or outcomes across all settings
4. Managing multiple chronic conditions.

Building upon the current high touch Model of Care and expanding its relevant care components to provide access to quality health care services to a broader member population, the CalOptima PHM Strategy proposed innovative ways to provide members with access to quality health care services leveraging secured virtual technology. CalOptima will be testing the feasibility of various telehealth use cases, ranging from the traditional e-consult, remote patient monitoring, and texting applications, to non-medical virtual visits in member's home.

Additionally, the PHM Strategy proposed new strategies to support providers in the delivery system transformation.

1. Practice Site Transformation - Develop CalOptima Quality Improvement nursing expertise to serve as Quality Advisors or Practices Facilitators to provide individualized technical assistance to improve member experience and patient safety at the practices starting with high volume safety net community centers.
2. Expand Provider Coaching and Leadership Development - Offer individual provider coaching sessions and office staff workshops to improve quality of services and patient experience, especially targeting high volume practices with high incidences of Quality of Services (QOS) grievances.

Fiscal Impact

There is no additional fiscal impact for the recommended action to approve the CalOptima PHM Strategy for Calendar Year 2019. The Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018, included funding to start implement the PHM Strategy by May 2019.

Rationale for Recommendation

These recommendations reflect alignment between CalOptima Population Health Strategy with the NCQA's new standards to provide integrated quality healthcare services to CalOptima's population at large, including those members who are currently healthy and low emerging risk. The timely implementation of the PHM Strategy by May 2019, will position CalOptima well to achieve NCQA re-accreditation aiming for Excellence accreditation status in 2021.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Population Health Management (PHM) Strategy for 2019
 - a. 2018 NCQA PHM Standards
2. 2019 NCQA PHM Standards and Guidelines
3. PowerPoint Presentation: CalOptima PHM Strategy - 2019 Overview

/s/ Michael Schrader
Authorized Signature

1/10/2019
Date

CalOptima Population Health Management (PHM) Strategy

PHM Strategy Description [PHM1 A]

BACKGROUND

Who We Are

Orange County is unique in that it does not have county-run hospitals or clinics. CalOptima was created in 1993 by a unique and dedicated coalition of local elected officials, hospitals, physicians, and community advocates. It is a county organized health system (COHS) authorized by State and Federal law to administer Medi-Cal (Medicaid) benefits in Orange County, and is the largest COHS nationwide. As a public agency, CalOptima is governed by a Board of Directors with voting members from the medical community, business, county government and a CalOptima member. CalOptima's mission is to provide members with access to high quality health services delivered in a cost-effective and compassionate manner.

CalOptima contracts with the State of California Department of Health Care Services (DHCS) to arrange and pay for covered services to Medi-Cal members, and also contracts with the Centers for Medicare & Medicaid Services (CMS) for Medicare-reletad programs. As of October 2018, CalOptima's total membership is more than 775,000, which includes members in Medi-Cal; a Medicare Advantage SNP; a Cal MediConnect Plan (Medicare-Medicaid); and the Program for All-Inclusive Care for the Elderly (PACE).

Medical services are delivered to CalOptima's Medi-Cal members through a variety of contractual arrangements. As of May 2018, CalOptima contracts with 13 health networks, including four Health Maintenance Organizations (HMOs), three Physician/Hospital Consortia (PHCs) composed of a primary medical group and hospital, and five Shared Risk Medical Groups (SRGs). CalOptima is able to fulfill its mission in Orange County because of its successful partnership with its outstanding providers.

Intent

CalOptima has a comprehensive plan of action for addressing our culturally diverse member needs across the continuum of care. The community driven plan of action is based on numerous efforts to assess the health and well-being of CalOptima members. The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe,

effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

❖ **CalOptima's Target Population**

➤ **Population Identification [PHM2]**

- CalOptima identifies and assesses its population through a variety of efforts and uses the findings for appropriate interventions. One of many sources that the PHM Strategy is based upon is the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. The PHM plan of action addresses the unique needs and challenges of specific ethnic communities, including economic, social, spiritual, and environmental stressors, to improve health outcomes. The PHM plan of action, as part of the Quality Improvement (QI) Work Plan, is updated annually through the comprehensive annual QI Program Evaluation process. In addition to the cost and quality performance data sets, CalOptima's PHM strategy is adjusted annually based on the analysis of other data sources that reflects the changing demographics and local population needs of the Orange County community. Since CalOptima members represent 25% of Orange County residents, other examples of external reports used to help identify trends that may impact CalOptima population are identified below.
 - The 2016 Orange County Community Indicators Report
 - The 2017 Conditions of Children in Orange County Report
 - Children eligible for California Children's Services (CCS) Report from the county CCS Program
 - Prenatal Notification Report (PNR)

➤ **Data Integration [PHM2 A]**

- CalOptima integrates multiple internal and external data sources in its data warehouse to support population identification and various PHM functions. Some examples of internal and external data sources are:
 - Member data from the Department of Health Care Services (DHCS)
 - Medical and Behavioral claims from DHCS and Orange County Health Care Agency (OC HCA) Mental Health inpatient claims
 - Encounters data from contracted health networks
 - Pharmacy claims
 - Laboratory claims and results from Quest and LabCorp
 - Other advanced data sources (e.g., member data of homeless status from Illumination Foundation, Regional Center of Orange County, Utilization Management (UM) authorization data, and qualitative data from health appraisals)

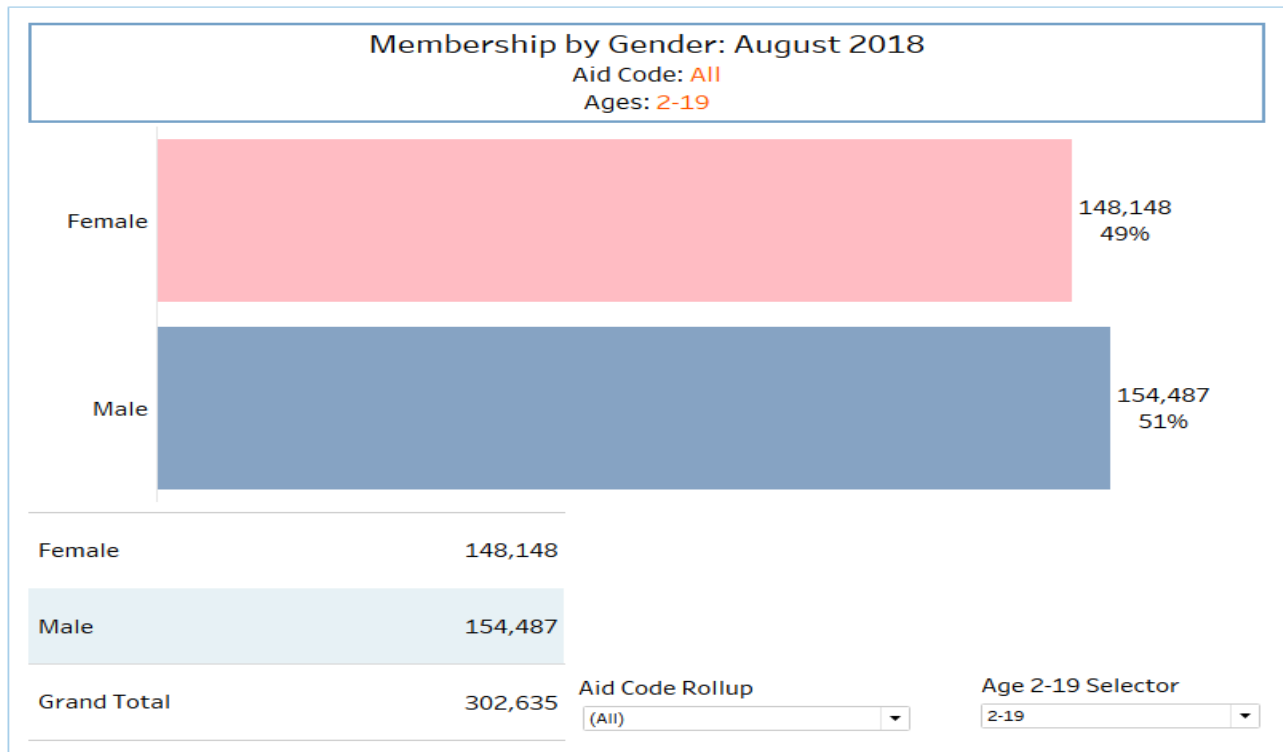
➤ **CalOptima Population and Sub-Population Segments [PHM2 B]**

- In addition to external data sources, CalOptima leverages Tableau, an enterprise analytic platform, for segmenting and stratifying our membership, including the subsets to which members are assigned (e.g. high-risk pregnancy, multiple inpatient admissions, co-morbid conditions, disabilities, polypharmacy, high risk and high cost cases, transgender population etc.). The Enterprise and Quality Analytics departments provide standard and ad hoc reports specifying the numbers of members in each category and the programs or services for which they are eligible.

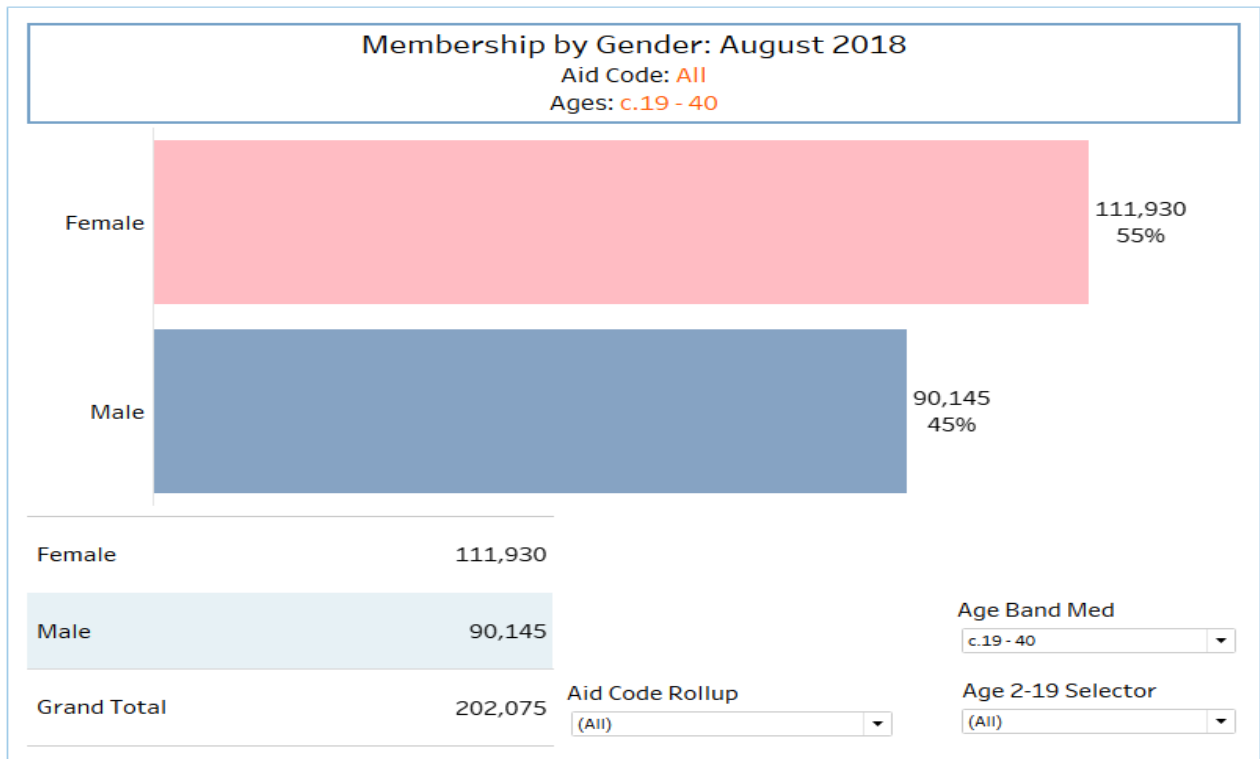
Example of Member Segmentation – Source: Tableau_f_dx_v33_m95_08.24.18

- *By Age and Gender*

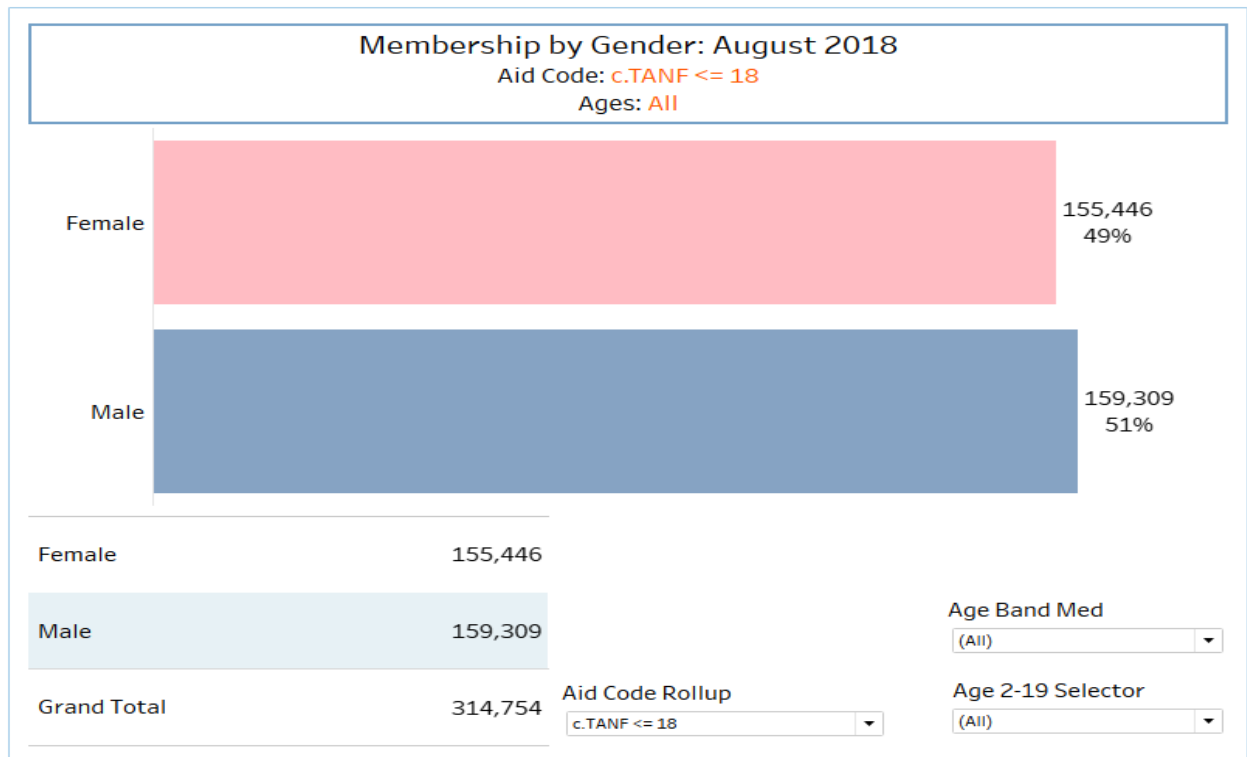
- *Ages 2–19*



- *Adults 19–40*



- *TANF (<18 Non-SPD)*



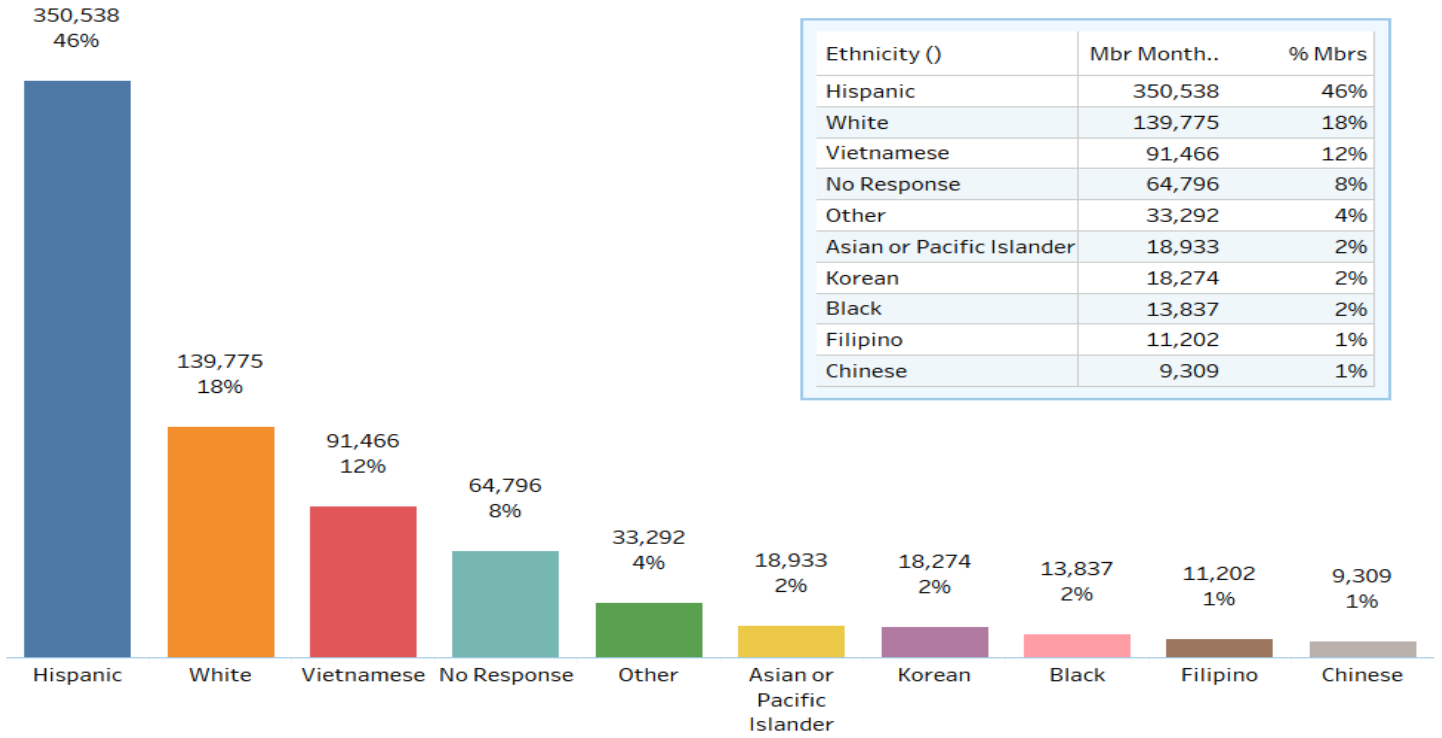
- *Ethnicity*

CalOptima Top Ten Member Ethnicities

Aid Code: **All**

Ages: **All**

Total Members: **764,774**



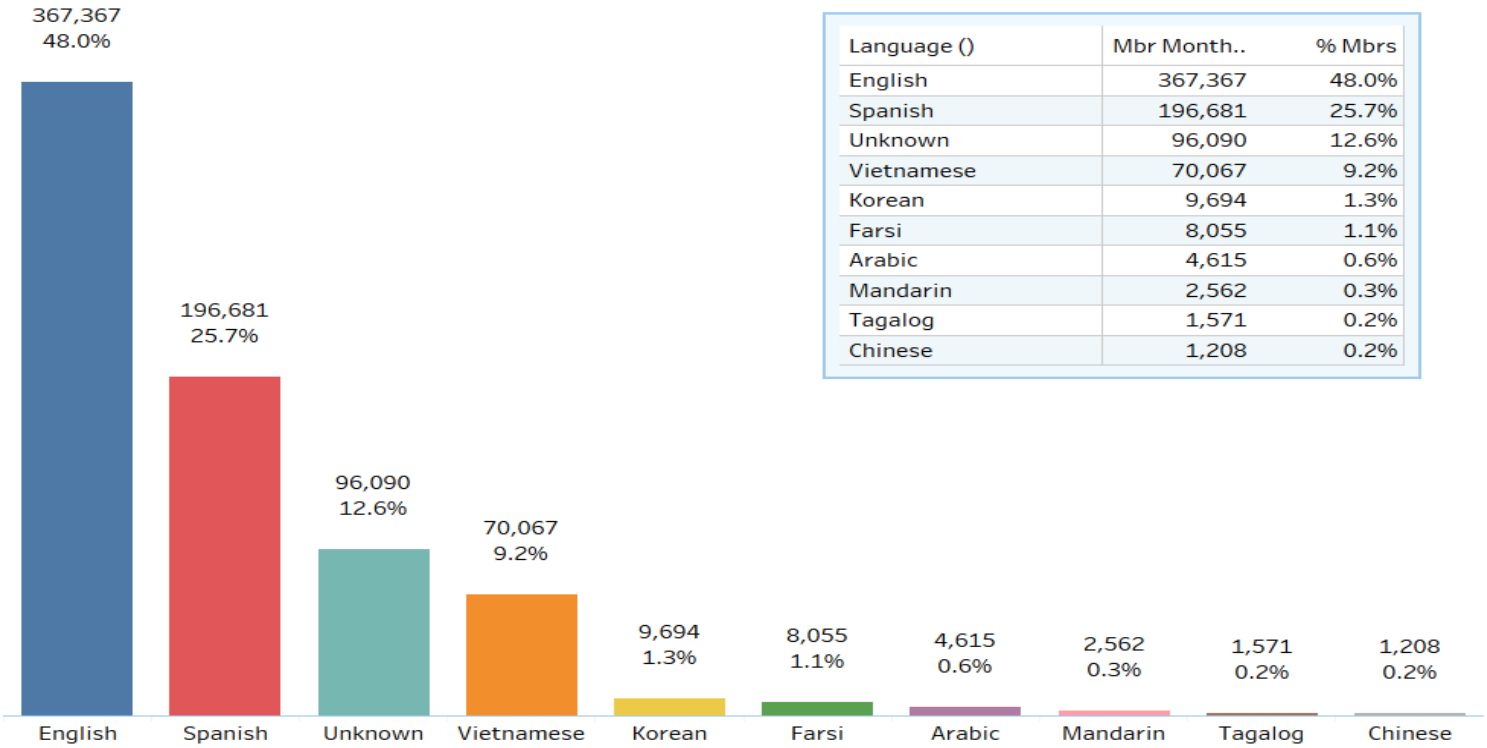
- Language

CalOptima Top Ten Member Languages

Aid Code: All

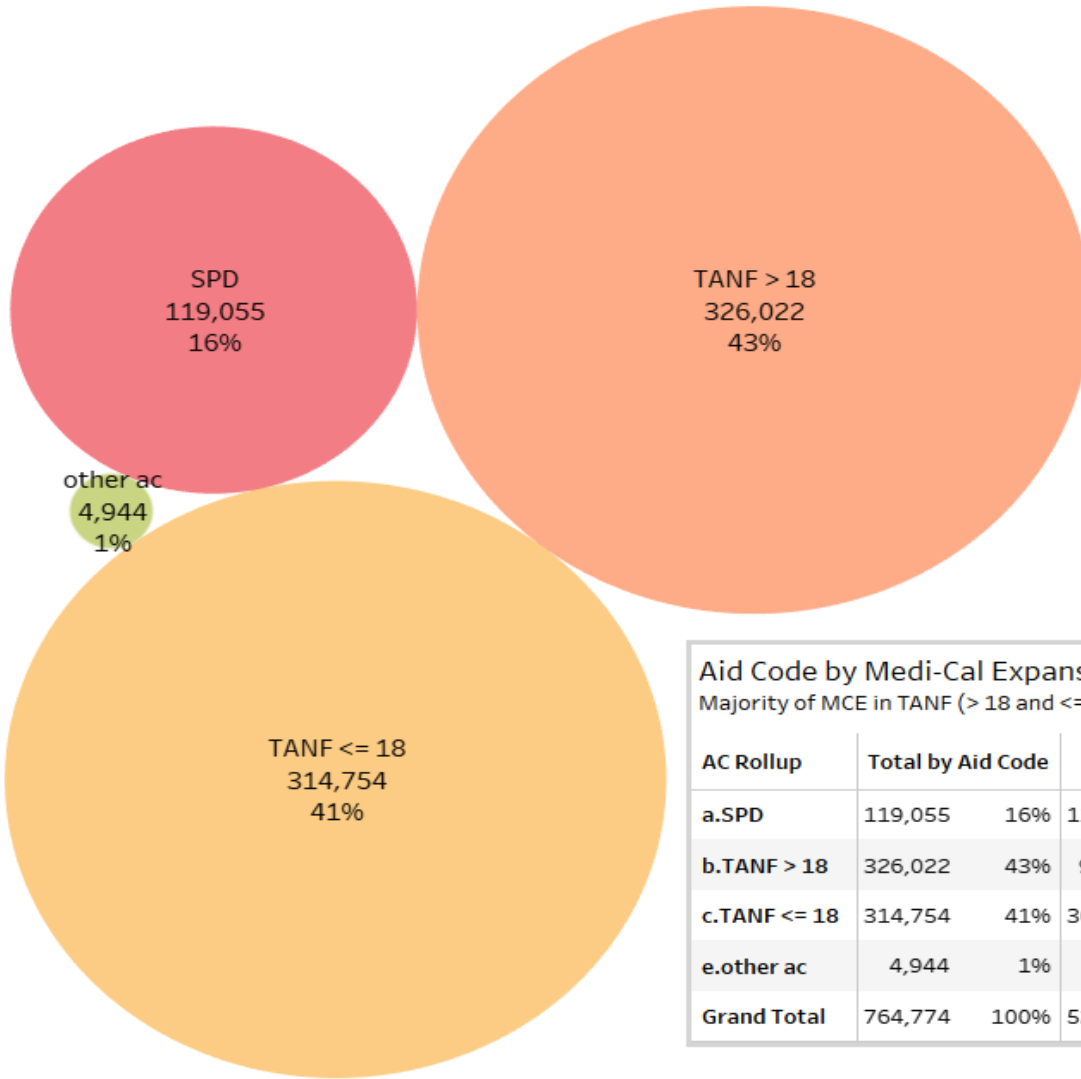
Ages: All

Total Members: 764,774



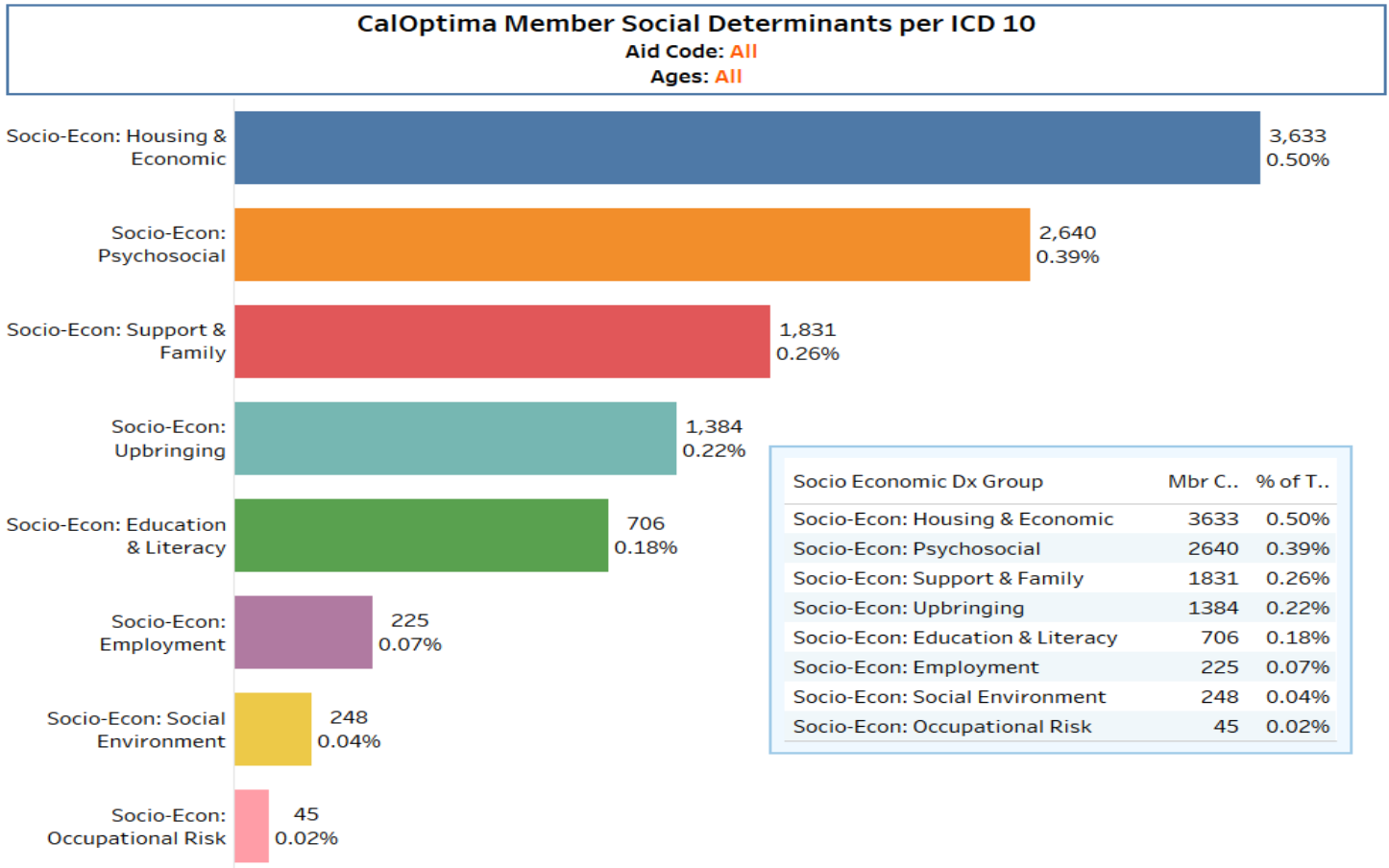
- *By Aid Code*

Membership by Aid Code: August 2018



Aid Code by Medi-Cal Expansion (MCE)						
Majority of MCE in TANF (> 18 and <= 18) aid codes						
AC Rollup	Total by Aid Code		Not MCE		MCE	
a.SP	119,055	16%	118,657	22%	398	0%
b.TANF > 18	326,022	43%	96,110	18%	229,912	98%
c.TANF <= 18	314,754	41%	309,583	58%	5,171	2%
e.other ac	4,944	1%	4,944	1%		
Grand Total	764,774	100%	529,294	100%	235,481	100%

- **Social Determinants**



- **Other Sub-Populations**

- Women during pregnancy
- Children with obesity
- Children with California Children’s Services (CCS) eligible condition
- Children and adults with autism
- Adult with disability and chronic conditions
- Persons with substance abuse disorder
- Persons requiring organ transplants
- Person with multiple chronic conditions and homelessness
- Frail elderly adults at risk for institutional care
- Transgender population
- Persons at end of life

- ❖ **Population Assessment [PHM2 B]**

- CalOptima conducts an annual population health risk assessment through analysis of quality performance trends, including Healthcare Effectiveness Data and Information Set (HEDIS) results, member experience surveys in all threshold languages by Health Networks, members complaints and grievances trends, and

inpatient utilization trends. To date, CalOptima serves eligible Medi-Cal beneficiaries from birth to 111 years of age! CalOptima serves a broad spectrum of population with health care needs from the cradle to the grave. Our population segments include well infants, children, adolescents, young adults, pregnant mothers, children with disabilities, children with CCS conditions, well adults, adults with chronic conditions and disabilities, members with serious and persistent mental illness (SPMI), well seniors, frail elderly with deteriorating functional status, and members residing in long-term care (LTC) facilities. The sub-populations include, but are not limited to, populations with health disparities due to race and ethnicity, transgender identity, food insecurity, and homelessness. As the Orange County demographic assessment changes every five years, CalOptima conducts a comprehensive Member Health Needs Assessment of Orange County residents to assess the characteristics and needs of the member population in the community we serve.

2019 PHM STRATEGY

❖ Strategies to Keep Members Healthy [PHM1 A Factor 1, 2]

➤ Bright Steps — Improve Prenatal and Postpartum Care

- **Goal:** Demonstrate significant improvement in prenatal and postpartum care rates to achieve 90th percentile by December 2020
 - Improve 2018 HEDIS Prenatal Care rates (83.6%) from the 50th percentile to 75th percentile over a 24-month period.
 - Improve 2018 HEDIS Postpartum Care rates (69.44%) from 75th percentile to 90th percentile over a 24-month period
- **Target Population:** Members in the first trimester of pregnancy newly identified through the pregnancy notification form.
- **Description of Programs or Services:** CalOptima contracts with certified Comprehensive Perinatal Service Program (CPSP) providers to deliver evidenced-based prenatal and postpartum care to members. Bright Steps is designed to support CalOptima Medi-Cal moms through a healthy pregnancy and postpartum care. Annually the program will be evaluated for increased Prenatal and Postpartum Care (PPC) HEDIS rate, reduced rates for neonatal intensive care unit usage, reduced number of low birth weights and preterm births, and member satisfaction with the program.
- **Activities:** CalOptima staff provide member outreach and coordination with CPSP providers. In areas with limited CPSP providers, CalOptima staff will provide direct health education and support program interventions aligned with the CPSP guidelines.

- **Shape Your Life — Prevent Childhood Obesity**
 - **Goal:** Maintain 2018 HEDIS Rates of 90th percentile or greater for Weight Assessment and Counseling for Nutrition and Physical Activity for following Children/Adolescents (WCC) measures year-over-year:
 - BMI Percentile (WCC)
 - Counseling for Nutrition (WCC)
 - Counseling for Physical Activity (WCC)
 - **Target Population:** Members age 5-18 with a Body Mass Index (BMI) equal to or above the 85th percentile.
 - **Description of Programs or Services:** CalOptima's Shape Your Life health education and physical fitness activity program aims to increase youth member access to weight management program(s), increase doctor/patient communication regarding healthy weight and nutrition and physical activity counseling, and increase member nutrition and physical activity knowledge and improve behaviors. Annually the program will be evaluated for program effectiveness. Measurement goals include pre/post BMI, knowledge gains (pre/post validated survey) and member satisfaction with program.
 - **Activities:** The program uses the licensed Kids-N Fitness curriculum which is evidenced-based and validated through Children's Hospital Los Angeles. Interventions includes up to 12 group classes, which include nutrition education and physical activity, and an incentive for a follow up visit with provider after 6 consecutive classes. All classes are conducted in members' community using appropriate threshold language of the participants.

❖ **Strategies to Manage Members with Emerging Risk [PHM1 A Factor 1,2]**

➤ **Health Management Programs — Improving Chronic Illness Care Prevention and Self-Management**

- **Goals:** Develop chronic illness program interventions to support improvements in HEDIS and Member Experience scores
 - Demonstrate significant improvement in 2018 HEDIS measures related to chronic illness management for Asthma Medication Ratio (AMR), Medication Management for People with Asthma (MMA), Monitoring for Patients on Persistent Medications (MPM), Controlling Blood Pressure (CBP), and Comprehensive Diabetes Care (CDC)
 - Increase overall Member Satisfaction by improving Rating of All Health Care to 90th Percentile by 2021
 - Reduce ED and IP rates by 3% for program participants in 2018
- **Target population:** Members discovered to be at risk for Asthma, Diabetes and/or Heart Failure based on primary care physician referral, new diagnosis codes, or pharmacy claims. Specific criteria detailed below.

- Members > 3 (Asthma); Members > 18 (Diabetes, Heart Failure) for Medi-Cal, OneCare, and OneCare Connect line of business
 - Two year look back period for Asthma, Diabetes, or Heart Failure Related Utilization
 - Exclusion Criteria:
 - ◆ Ineligible CalOptima Members
 - ◆ Members Identified for LTC or diagnosed with Dementia
 - ◆ Members Delegated to Kaiser
 - **Description of Programs or Services:** CalOptima’s Health Management Programs focus on disease prevention and health promotion for members with Asthma, Diabetes and Heart Failure. Health Management Programs are designed to improve the health of our members with low acuity to moderate-risk chronic illness requiring ongoing intervention. To assess the effectiveness of each Health Management Program, measures are set annually against organization or national benchmark standards. The evaluation takes into consideration program design, methodology, implementation and barriers to provide an analysis with quantitative and qualitative results for CalOptima’s population with chronic illness. Measurement goals for each program include improvement in HEDIS measures related to the chronic conditions managed, reduced IP/ED for members with chronic illness, and member satisfaction with health management program.
 - **Activities:** Health education using evidence-based clinical practice guidelines and self-management tools, relevant to members for the provision of preventive, acute, or chronic, medical services and behavioral health care services standards and requirements. *(Refer activities list in Policies and Procedures GG.1211.)*
- **Opioid Misuse Reduction Initiative — Prevent and Decrease Opioid Addiction**
- **Goal:** Decrease the prevalence of opioid use disorder by implementing a comprehensive pharmacy program by December 2019
 - **Target Population:** Members with diagnosis of opioid substance abuse disorder
 - **Description of Programs or Services:** A multi-departmental and health collaborative aim at reducing opioid misuse and related death.
 - **Activities:** Includes, but is not limited to, pharmacy lock-in program, physician academic detailing for safer prescribing, increased access to Medication Assisted Treatment (MAT), and case management outreach.

❖ **Strategies to Ensure Patient Safety [PHM1 A Factor 1,2]**

➤ **Behavioral Health Treatment (BHT) Services**

- **Goal:** Establishing appropriate program baseline in 2019
- **Target Population:** Children with Autism Spectrum Disorder (ASD) who are eligible Medi-Cal members under 21 years of age, as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.
- **Description of Programs or Services:** Provide medically necessary BHT services to children with Autism Spectrum Disorder through early identification and early intervention in collaboration with the parents to promote optimal functional independence before aging out of the Regional Center system. BHT is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior.
- **Activities:** Treatments include direct observation, measurement, and functional analysis of the relations between environment and behavior of children with ASD.

➤ **Practice Facilitation Team — Improve Practice Health & Safety Leveraging the QI Practice Facilitators Team**

- **Goals:** Achieve and sustain 100% compliance in all Facility Site Review (FSR) audits year-over-year for primary care practices.
- **Target Population:** Medi-Cal adults and children accessing primary care.
- **Description of Programs or Services:** Enhancing the existing FSR nursing function by training nurses in QI facilitation skills to address any gaps from FSR audits to improve compliance with practice health and safety standards at the practice sites of the CalOptima Community Networks (CCN).
- **Activities:** CalOptima will develop Practice Facilitator functions for the FSR nurses to identify opportunities to improve practice site health and safety and provide QI technical assistance to these practices to achieve zero defect patient safety at the primary care practices. CalOptima will coordinate with the community clinics, Federally Qualified Health Centers (FQHC), and eventually expand to other potential settings such as PACE to promote patient safety practices.

❖ **Strategies to Manage Members with Multiple Chronic Illnesses [PHM1 A Factor 1,2]**

➤ **Whole-Child Model — Ensure Whole-Child-Centric Quality and Continuity Care for Children with CCS Eligible Conditions**

- **Goal:** Improve Children and Adolescent Immunization HEDIS measures by 10% from the 2018 baseline by December 2020 (excluding children and adolescent under cancer treatment)
 - Improve Childhood Immunization Status Combo10 for Children with CCS eligible conditions to $\geq 37.0\%$ (2018 Baseline = 33.3 %)
 - Improve Immunization for Adolescents with CCS eligible conditions to $\geq 50.0\%$ (2018 Baseline = 45.33%)
- **Targeted Population:** Children with CCS Eligible Conditions
- **Description of Programs or Services:** The WCM program is designed to help children receiving CCS services and their families get better care coordination, access to care, and to promote improved health results. Currently, children who have CCS-eligible diagnoses are enrolled in and get care from both the county CCS program for their CCS condition and CalOptima for their non-CCS conditions, routine care and preventive health. Beginning July 1, 2019, Orange County Medi-Cal CCS eligible children will receive services for both CCS and non-CCS conditions from CalOptima. Children whose CCS care will be transitioning under WCM to CalOptima on July 1, 2019, are referred to as Transitioning WCM members.

Activities: CalOptima identifies children with potentially eligible CCS conditions. Upon confirmation of CCS Program eligibility, CalOptima assigns a Personal Care Coordinator (PCC) to each Member. The PCC assists the members and family to navigate the health care system, accessing high quality primary care providers, CCS-paneled specialists, care centers and Medical Therapy Units. The primary goal is facilitation of timely, appropriate health care and coordination among the health care team, especially including the member and family.

➤ **Health Home Program (HHP) — Improve clinical outcomes of members with multiple chronic conditions and experiencing homelessness**

- **Goal:** Establishing baseline measures in 2019
 - Member Engagement Rate
 - Inpatient Readmissions
 - Emergency Department (ED) Visits
- **Target Population:** DHCS identified list of *highest risk 3-5 % of the Medi-Cal members with multiple chronic conditions meeting the following eligible criteria:*
 - Specific combination of physical chronic conditions and/or substance use disorder (SUD) or specific serious mental illness (SMI) condition;
 - Meet specified acuity/complex criteria

- Eligible members consent to participate and receive Health Home Program services.
 - **Description of Programs or Services:** A pilot program of enhanced comprehensive care management program with wrap-around non-clinical social services for members with multiple chronic conditions and homelessness.
 - **Activities:** Core services as defined by DHCS are detailed below.
 - Comprehensive care management
 - Health promotion
 - Care coordination
 - Individual and family support services
 - Comprehensive transitional care
 - Referral to community and social support services
 - Other new services
 - Accompany participants to critical appointments
 - Provider housing navigation services for members experiencing homelessness
 - Manage transition from non-hospital or nursing facility settings, such as residential treatment programs
 - Trauma informed care
- ❖ **PHM Activities and Resources [PHM 1A Factor 3]**
- CalOptima will use our annual population assessment to review and update our PHM structure, activities and resources. The annual population assessment helps CalOptima to set new program priorities, re-calibrate existing programs, re-distribute resources to ensure health equity, and proactively mitigate emerging risk, such as partnering with Orange County Health Care Agency to address social determinants that adversely impacting the health and wellness of the CalOptima member population and relevant sub-populations.
 - As the various health care sectors adopt technology to address the changing demographic of the population and bring needed care to members in non-traditional ways, CalOptima will be exploring the feasibility of advancing our mission to provide members with access to quality health care services leveraging advanced virtual technology. In order to bring timely care and services to a broader population, CalOptima will explore the feasibility of leveraging telehealth usage in cases ranging from the traditional e-consult, remote patient monitoring, and texting applications, to non-medical virtual visits in members' homes.
- ❖ **Expanding Strategies to Inform Members Leveraging Technology [PHM1 A5, PHM B]**
- CalOptima deploys multiple methods for informing members about PHM programs and services. Based on the members' language preferences, members

are informed of various health promotion programs, and how to contact Care Management, via the initial Member Packet in the mail, CalOptima website, personal telephone outreach or Robo calls, in person, and by email. One of the PHM strategies to support members age 19–40 is to develop telehealth technology enhanced methods of informing members, such as text or other mobile applications.

- CalOptima PHM programs are accessible to eligible Orange County Medi-Cal beneficiaries who meet the PHM program criteria.
- CalOptima provides instruction on how to use these services in multiple languages and at appropriate health literacy levels.
- CalOptima honors member choice; hence, all the PHM programs are voluntary. The members can decline the program or opt out any time.

❖ **Delivery System for Practitioner/Provider Support [PHM3 A]**

➤ **Information Sharing**

- CalOptima Provider Relations and QI departments provide ongoing support to practitioners and providers in our health networks, such as sharing patient-specific data, offering evidenced-based or certified decision-making aids and continuing education sessions, and providing comparative quality and cost information. CalOptima will continue to improve information sharing with Health Network providers using integrated and actionable data.

➤ **Practice Transformation Technical Assistance (New Idea)**

- One of the PHM strategies is to offer practice transformation support through Lean QI training, practice site facilitations and/or individualized technical assistance to improve member experience.

➤ **Provider Coaching and Leadership Development (New Idea)**

- Offer individual provider coaching sessions and office staff workshops to improve quality of services and patient experience, especially targeting high volume practices and the top 30 providers with high volume grievances and potential quality of services issues.
- Allocate one scholarship to sponsor community clinic physician leadership development through the California Health Care Foundation (CHCF) Health Care Leaders Fellowship.

➤ **Pay for Value [PHM3 B]**

- CalOptima already incentivizes providers based on quality performance in its directly contracted CalOptima Community Network (CCN) and the contracted Health Networks.

❖ **Population Health Management Impact [PMH 6]**

➤ **Measuring Effectiveness**

- CalOptima annually conducts a comprehensive analysis of the PHM strategy's impact and effectiveness as part of the annual QI Program evaluation. The comprehensive analysis includes quantitative results for relevant clinical, cost, utilization, and qualitative member experience.

CalOptima regularly compares its performance results with external benchmarks and internal goals. The results are reviewed and interpreted by the interdisciplinary team through various QI Committees. Given the capability of Tableau, an enterprise analytic platform, CalOptima has the capability to conduct longitudinal QI Program Evaluation to ensure sustained effectiveness year over year.

➤ **Improvement and Action**

- ❖ Based on the annual PHM program evaluation using internal and external data, CalOptima annually updates its QI Work Plan to improve CalOptima's PHM program and act on at least one opportunity for improvement within each of the quality domains as define in the CalOptima Quality Improvement Program.

APPENDICES:

2018 NCQA PHM Standards

Overview

Notable Changes for 2018

Changes to the Policies and Procedures

- **Section 1**
 - Clarified that a Medicaid-only organization that manages CHIP members included those members in its Medicaid product line.
 - Described how to navigate NCQA's web-based application process.
 - Clarified, under "Organization Obligations," that a Discretionary Survey is based on the standards in effect during the discretionary survey.
- **Section 2**
 - Added reference to government requirements under "State and Federal Agency Surveys."
 - Added URL for NCQA Guidelines for Advertising and Marketing (<http://www.ncqa.org/marketing.aspx>) under "Marketing accreditation results"
 - Added PHM 1, Element A to the list of elements with critical factors.
- **Section 3:**
 - Added "Web-based survey platform" subhead and text.
 - Replaced QI 5 with PHM 4 under "File review results."
- **Section 4**
 - Added a note about Federal Medicaid Rule: §438.332 regarding state deeming survey results.
- **Section 5**
 - Updated English-speaking USA and Canada fraud hotline number to 844-440-0077.
 - Updated language under "Notifying NCQA of Reportable Events" subhead and added "Annual Attestation of Compliance With Reportable Events" and "NCQA Investigation" subheads and text.
 - Updated language under "Mergers and Acquisitions and Changes to Operations" subhead.
- **Section 6**
 - Described how to navigate NCQA's Web-based application process.

Changes to the standards and guidelines

- New category, Population Health Management (PHM):
 - *PHM 1: PHM Strategy.*
 - *PHM 2: Population Identification.*
 - *PHM 3: Delivery System Supports.*
 - *PHM 4: Wellness and Prevention.*
 - *PHM 5: Complex Case Management.*
 - *PHM 6: Population Health Management Impact.*
- Moved the following standards to the PHM category:
 - *QI 5: Complex Case Management (PHM 5).*
 - *MEM 1: Health Appraisals (PHM 4, Elements A–G).*
 - *MEM 2: Self-Management Tools (PHM 4, Elements H–K).*

- Eliminated the following standards and elements:
 - QI 5:
 - Element B: Complex Case Management Program Description.
 - Element C: Identifying Members for Case Management.
 - Element J: Measuring Effectiveness.
 - QI 6: *Disease Management*.
 - QI 7: *Practice Guidelines*.
 - MEM 7: *Support for Healthy Living*.
 - UM 4, Element H: Appropriate Classification of Denials.
- Added a factor to NET 3, Element A: Assessment of Member Experience Accessing the Network.
- Renumbered the QI and MEM standards to account for standards and elements that were incorporated into the PHM category or eliminated.

Changes to the appendices

• **Appendix 1**

- Updated points for all evaluation options to account for new PHM category and eliminated QI standards, UM 4, Element H and MEM standards.

• **Appendix 2**

- Added new measures for the commercial, Medicare and Medicaid product lines. Refer to the table below.

Measure		Commercial	Medicare	Medicaid
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA	NA	✓
IET	Initiation and Engagement of Alcohol & Other Drug Dependence Treatment— <i>Initiation of AOD Treatment rate</i>	✓	✓	✓
PSA	Non-Recommended PSA-Based Screening in Older Men	NA	✓	NA
EDU	Emergency Department Utilization	✓	✓	NA
SPC	Statin Therapy for Patients With Cardiovascular Disease— <i>Both rates</i>	✓	✓	✓
SPD	Statin Therapy for Patients With Diabetes— <i>Both rates</i>	✓	✓	✓
IMA	Immunizations for Adolescents (Combination 2)	✓	NA	✓

- Retired the measures listed in the table below.

Measure		Commercial	Medicare	Medicaid
ABA	Adult BMI Assessment	Retain	✓	Retain
CDC	Comprehensive Diabetes Care— <i>Medical Attention for Nephropathy rate</i>	✓	✓	✓
	Comprehensive Diabetes Care— <i>HbA1c Poor Control (>9%) rate</i>	✓	✓	✓
MSC	Medical Assistance With Smoking and Tobacco Use Cessation — <i>Advising Smokers to Quit rate</i>	✓	Retain	Retain
IMA	Immunizations for Adolescents (Combination 1)	✓	NA	✓

• **Appendix 3**

- Updated points reporting category based on changes in appendix 1.

- **Appendix 4**
 - Updated calculation of HEDIS score based on changes in appendix 2
- **Appendix 5**
 - Updated standards and elements eligible for automatic credit based on the new PHM category and eliminated QI requirements. (Refer to *Appendix 5* for the list of changes.)

Accreditation: A Symbol of Quality and Improvement

Why NCQA?

Health plans accredited by NCQA demonstrate their commitment to delivering high-quality care through one of the most comprehensive evaluations in the industry, and the only assessment that bases results on clinical performance (i.e., HEDIS measures) and consumer experience (i.e., CAHPS measures). NCQA publicly reports quality results, allowing “apples-to-apples” comparison among plans. NCQA’s Health Plan Accreditation program helps organizations demonstrate their commitment to quality and accountability.

Health plans choose NCQA Health Plan Accreditation because:

- **Employers want it.** Many employers—especially the Fortune 500 employers—do business only with NCQA-Accredited plans. They and other purchasers want to keep employees healthy and productive and maximize the value of their health investment by focusing on quality care. The National Business Coalition on Health’s widely used eValue8 tool captures NCQA Accreditation status and HEDIS/CAHPS scores as an important indicator of a plan’s ability to improve health, and health care.
- **It meets regulatory requirements.** NCQA Accreditation contains many of the key elements that federal law and regulations require for State Health Insurance and Marketplace plans. Forty-two states recognize NCQA Accreditation as meeting their requirements for Medicaid or commercial plans; 17 states mandate it for Medicaid. The Federal Employees Health Benefit Program accepts NCQA Accreditation.
- **Consumers are looking for quality.** As consumers become more responsible for managing their health care, consumer interest in choosing high-quality plans will grow. The standards focus on key patient protections that consumers, regulators, public purchasers and employers value.
- **It’s flexible and comprehensive.** NCQA builds flexible, yet rigorous standards that apply to all types of health plans. Annual updates to accreditation standards support the fast-changing needs of regulators and the health care marketplace. NCQA’s Health Plan Accreditation is the most widely recognized accreditation program in the United States.

The rigor and competitive pricing of NCQA’s program represent an excellent value for health plans. NCQA supports the accreditation process through its publications, users’ groups and educational programs, making the path to performance-based accreditation accessible and feasible.

Changes and Updates: *What’s New in 2018?*

NCQA continuously assesses the health care landscape, as well as new and pending regulations, to enhance accreditation standards on an annual basis. The HPA 2018 focuses on a new category: Population Health Management (PHM).

New PHM Category: NCQA combined existing population health management related requirements from Health Plan Accreditation categories (Quality Management and Improvement [QI] and Member Connections [MEM]) and new requirements that reflect a broader, population-wide focus on care management. The update removes elements that no longer add value.

- **Reasons for the update:** NCQA's goal is to streamline evaluation of an organization's population health management strategy by consolidating PHM-related elements into one category. The new category provides flexibility in how plans manage their members and encourages health plans to work with the delivery system to deliver quality care.

Tracking Out-of-Network Requests: A new factor (3) in NET 3A: Assessment of Member Experience Accessing the Network expands tracking of out-of-network requests for services to all product lines.

- **Reasons for the update:** Network adequacy is an important area of concern for consumers and purchasers alike because it affects timely access to care and out-of-pocket costs among other areas. The intent of this requirement is that organizations monitor and identify issues of access to primary care services, behavioral healthcare services and other specialty services. Analysis of out-of-network data helps organizations understand why members seek out-of-network services. Finding ways to address these occurrences can lead to better member experience.

Marketplace Readiness

NCQA's Health Plan Accreditation is the superior choice for insurers offering Marketplace products. It provides a "glide path" to accreditation; plans with varied goals and capabilities can earn the NCQA seal. The glide path involves three options or steps:

1. **Interim Evaluation** is for organizations that need accreditation before or soon after they open for business. It focuses on insurers' policies and procedures, does not include HEDIS/CAHPS reporting.
2. **First Evaluation** is for organizations new to NCQA. HEDIS/CAHPS reporting is required only in the final year, helping plans prepare for their Renewal Evaluation.
3. **Renewal Evaluation** is available to NCQA-Accredited organizations seeking to extend their accreditation. HEDIS/CAHPS reporting is mandatory, and performance results count in the scoring.

Accreditation Scoring System

NCQA uses the standards and audited HEDIS/CAHPS results to evaluate an organization. Depending on the Evaluation Option selected, a total of 50 or 100 points is possible (i.e., performance against the standards accounts for 50 possible points; HEDIS results account for 50 possible points).

Organizations submit audited results for designated HEDIS measures for each product line/product brought forward for accreditation as required for the Evaluation Option selected. To ensure validity, accuracy and comparability, an NCQA-Certified HEDIS Compliance Auditor must audit the results. NCQA evaluates the organization's audited HEDIS results against established benchmarks and thresholds to determine the score.

Accreditation Status Levels

Because most organizations offer several product lines (i.e., commercial, Marketplace, Medicare, Medicaid), NCQA determines accreditation status by product line for HMO, POS PPO and EPO products. Each product line/product reviewed by NCQA earns one of the following accreditation status levels, based on evaluation of the organization's performance against the standards and HEDIS results (if applicable) and the Evaluation Option.

- Excellent.
- Accredited.
- Interim.
- Commendable.
- Provisional.
- Denied.

New: PHM Category of Standards

Health care expenditures account for 17 percent of the gross domestic product (\$17 trillion) in the United States, estimated to be 20 percent by 2020.³ Although health spending is the highest in the world, our life expectancy is significantly shorter than that of other industrialized nations. Guided by the Institute for Healthcare Improvement's (IHI) Triple Aim framework,⁴ the federal government, states, health plans and other stakeholders are tackling these challenges through various initiatives. The Triple Aim framework has three main objectives: improve patient experience of care, improve the health of populations and reduce the per capita cost of health care.

NCQA emphasizes the Triple Aim throughout Health Plan Accreditation through its new standard category, Population Health Management (PHM). PHM addresses health at all points on the continuum of care, including the community setting, through participation, engagement and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions.⁵

This category's scope facilitates population health management, not public health—an important distinction. "Public health" is a broad term for the coordinated efforts of local, state and national health departments to improve the quality of health for insured and uninsured community members. "Population health management" supports care activities for a defined population.

The PHM standards establish basic expectations:

1. Organizations have a population health management strategy that focuses on the "whole person" and the member's entire care journey.
2. Organizations can provide wellness services (e.g., health appraisal administration, self-management tools) and intervene with highest-risk members (i.e., requiring complex case management).
3. Organizations have the flexibility to choose members/populations with which to intervene (including the specific population under complex case management).
4. Organizations are committed to supporting their delivery system to facilitate better health outcomes and encourage value-based decisions.

The PHM requirements were developed through literature reviews, Stakeholder Advisory Committee discussions, feedback from our public comment period and enhanced feedback from additional stakeholder advisory councils and groups.

Delivery System Support and Value-Based Payment Arrangements

NCQA recognizes the need to align organizations with the delivery system, including hospitals, accountable care entities, practitioners and PCMHs, and other vendors delivering care. Toward that end, NCQA recommends standards for delivery system supports, with elements that allow flexibility in how organizations support delivery system. The elements provide many methods to support providers and allow the health plans to determine which best fit their network arrangement and current delivery system capabilities. Through these requirements, NCQA intends to increase data sharing and transparency between plans and providers. Also, NCQA requires a report describing the organization's value-based payment arrangements to better understand the changing landscape of the healthcare market (*PHM 3: Delivery System Supports*).

³CMS Strategy: The Road Forward 2013-2017. <https://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/Downloads/CMS-Strategy.pdf>

⁴IMI Triple Aim Initiative. <http://www.ihl.org/engage/initiatives/tripleaim/pages/default.aspx>

⁵Population Health Alliance. <http://www.populationhealthalliance.org/research/understanding-population-health.html>

Eliminated Elements

NCQA eliminated the following standards and elements. With these changes, the HPA focus shifts from single-condition evaluation to population health-based evaluation. Retired elements include:

- **QI 5:**
 - Element B: Complex Case Management Program Description.
 - Element C: Identifying Members for Case Management.
 - Element J: Measuring Effectiveness.
 - Element K: Action and Remeasurement.
- **QI 6:**
 - Element A: Program Content.
 - Element B: Identifying Members for DM Programs.
 - Element C: Frequency of Member Identification.
 - Element E: Interventions Based on Assessment.
 - Element F: Eligible Member Active Participation.
 - Element G: Informing and Educating Practitioners.
 - Element H: Integrating Member Information.
 - Element I: Experience With Disease Management.
 - Element J: Measuring Effectiveness.
- **QI 7:**
 - Element A: Adoption of Guidelines.
 - Element B: Adoption of Preventive Health Guidelines.
 - Element C: Relation to DM Programs.
 - Element D: Performance Measurement.
- **MEM 7:**
 - Element A: Identifying Members.
 - Element B: Targeted Follow-Up With Members.

Where to Find Specific Information

The *Standards and Guidelines* include policies and procedures, standards and elements, scoring guidelines and appendices.

Policies and Procedures

- Information on organizations eligible for accreditation.
- Responsibilities of organizations seeking accreditation.
- Information on applying for accreditation.
- Information on the survey tool and readiness evaluation.
- Information on reporting accreditation results.
- Information on annual reevaluation.
- Information on the Accreditation Survey process.
- Information on evaluating HEDIS results and calculating HEDIS scores.
- Information on the Reconsideration process.

Accreditation Standards, Organized by Category

- The standards, elements and factors.
- A summary of changes from the previous standards year.
- Scoring guidelines describing requirements for each standard, element and factor.
- Information about how an organization can demonstrate performance against the element's requirements.
- Data sources for demonstrating compliance with requirements.
- The scope of review.
- The look-back period.

Appendices

- Appendix 1: Standard and Element Points for 2018.
- Appendix 2: HEDIS and CAHPS Points for HEDIS Reporting Year 2018.
- Appendix 3: Points by Reporting Category for 2018.
- Appendix 4: Calculating the Total HEDIS Score.
- Appendix 5: Delegation and Automatic Credit Guidelines.
- Appendix 6: CMS Regions.
- Appendix 7: Merger, Acquisition and Consolidation Policy for Health Plan Accreditation and LTSS Distinction.
- Appendix 8: Answers to Commonly Asked Questions.
- Appendix 9: Glossary.
- Appendix 10: Summary of Changes for 2018.

Other Important NCQA Information

NCQA publications, user groups and educational programs facilitate the evaluation process. They help plans succeed by making the path to performance-based accreditation accessible and feasible. In addition to the web-based survey platform, NCQA provides a variety of information to help organizations prepare for Accreditation Surveys.

- NCQA produces many publications relevant to organizations. Call NCQA Customer Support at 888-275-7585 or go to the NCQA website (www.ncqa.org).
- Access policy clarifications from the NCQA Policy Clarification Support (PCS) system on the NCQA Web page (<http://my.ncqa.org>). General questions are usually answered within 2 business days; complex questions are usually answered within 30 days.
- Find corrections, clarifications and policy changes to this publication at <http://www.ncqa.org/tabid/119/Default.aspx>
- Find frequently asked questions (FAQ) at <http://ncqa.force.com/faq/FAQSearch> FAQs are updated on the 15th of the month or on the first business day following the 15th of the month.
- Organizations that are involved in NCQA Accreditation and Certification activities are encouraged to join the Accreditation and Certification Users Group (ACUG). The ACUG provides a learning and development platform for members to discuss updates applicable to their organization's procedures. Membership benefits include a monthly newsletter; WebEx discussions; and vouchers for publications, educational conferences and Quality Compass. For more information, e-mail acug@ncqa.org or go to <http://www.ncqa.org/programs/accreditation/accreditation-certification-users-group-acug> for a full description of the program.

- Organizations collecting HEDIS data are encouraged to join the NCQA HEDIS Users Group (HUG) for technical assistance and guidance on interpreting measure specifications. Membership benefits include NCQA HEDIS and accreditation publications, newsletters, Internet seminars, discount vouchers for HEDIS conferences and publications and up-to-date technical information. For more information, e-mail hug@ncqa.org.
- NCQA educational seminars provide valuable information on NCQA standards, the survey process and HEDIS. Course offerings range from a basic introduction to NCQA standards and HEDIS measures to advanced techniques for quality improvement. Visit the NCQA website or call NCQA Customer Support at 888-275-7585.
- NCQA staff are available to help organizations determine the Evaluation Option for which they are eligible. Staff provide step-by-step guidance on the application process, which includes an overview of policies and procedures, the fee structure, timelines and survey preparation. Contact ApplicationsandScheduling@ncqa.org.

Other NCQA Programs

NCQA offers the following accreditation programs:

- Accountable Care Organization (ACO).
- Case Management (CM).
- Case Management for Long-Term Services and Supports Programs (CM-LTSS).
- Disease Management (DM).
- Managed Behavioral Healthcare Organization (MBHO).
- Wellness and Health Promotion (WHP).

NCQA offers the following certification programs:

- Accreditation in Utilization Management, Credentialing and Provider Network UM/CR/PN).
- Credentials Verification Organization (CVO).
- Disease Management (DM).
- Health Information Products (HIP).
- Physician and Hospital Quality (PHQ).
- Wellness and Health Promotion (WHP).

NCQA offers the following recognition programs:

- Diabetes Recognition (DRP).
- Heart/Stroke Recognition (HSRP).
- Patient-Centered Connected Care™
- Patient-Centered Medical Home (PCMH).
- Patient-Centered Specialty Practice (PCSP).
- Oncology Medical Home (PCMH-O).
- School-Based Medical Home (SBMH).

NCQA offers the following evaluation program:

- New York Ratings Examiner Reviews (NYRx).

NCQA offers the following distinction programs:

- Multicultural Health Care (MHC).
- Long-Term Services and Supports (LTSS).

NCQA offers the following distinction programs for recognized PCMHs:

- Patient Experience Reporting.
- Behavioral Health Integration.
- Electronic Quality Measures (eCQM) Reporting.

Note: Organizations that contract with NCQA-Accredited or NCQA-Certified organizations can reduce their delegation oversight. Refer to Appendix 5: Delegation and Automatic Credit Guidelines.

11/20/17: Add the following as the last bullet under "NCQA offers the following accreditation programs":

- Utilization Management, Credentialing and Provider Network (UM-CR-PN).
- Delete the first bullet under "NCQA offers the following certification programs" that reads:
- Accreditation in Utilization Management, Credentialing and Provider Network (UM-CR-PN).

Population Health Management

Standards for Population Health Management

<i>PHM 1: PHM Strategy</i>	
Element A: Strategy Description.....	111
Element B: Informing Members	114
<i>PHM 2: Population Identification</i>	
Element A: Data Integration	116
Element B: Population Assessment	118
Element C: Activities and Resources	120
Element D: Segmentation.....	121
<i>PHM 3: Delivery System Supports</i>	
Element A: Practitioner or Provider Support	123
Element B: Value-Based Payment Arrangements	127
<i>PHM 4: Wellness and Prevention</i>	
Element A: Health Appraisal Components	129
Element B: Health Appraisal Disclosure.....	131
Element C: Health Appraisal Scope	133
Element D: Health Appraisal Results	134
Element E: Health Appraisal Format	136
Element F: Frequency of Health Appraisal Completion	137
Element G: Health Appraisal Review and Update Process	138
Element H: Topics of Self-Management Tools.....	139
Element I: Usability Testing of Self-Management Tools	140
Element J: Review and Update Process for Self-Management Tools	142
Element K: Self-Management Tool Formats	143
<i>PHM 5: Complex Case Management</i>	
Element A: Access to Case Management.....	145
Element B: Case Management Systems.....	146
Element C: Case Management Process	147
Element D: Initial Assessment.....	153
Element E: Case Management—Ongoing Management	157
Element F: Experience With Case Management	160
<i>PHM 6: Population Health Management Impact</i>	
Element A: Measuring Effectiveness	163
Element B: Improvement and Action	166
<i>PHM 7: Delegation of PHM</i>	
Element A: Delegation Agreement	167
Element B: Provision of Member Data to the Delegate.....	169
Element C: Provisions for PHI	170
Element D: Predelegation Evaluation.....	171
Element E: Review of PHM Program	172
Element F: Opportunities for Improvement	174

PHM 1: PHM Strategy—Refer to Appendix 1 for points

The organization outlines its population health management (PHM) strategy for meeting the care needs of its member population.

Intent

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

Summary of Changes

Additions

- Added PHM 1, Element A: Strategy Description as a new element.

Clarifications

- Added “interactive contact” to the element stem (Element B).
- Updated the scope of review to state that NCQA reviews up to 4 randomly selected programs (Element B).
- Added language to address how the element will be reviewed for the 2019 Standards Year (Element B).

Element A: Strategy Description—Refer to Appendix 1 for points

The strategy describes:

- Goals and populations targeted for each of the four areas of focus.*
- Programs or services offered to members.
- Activities that are not direct member interventions.
- How member programs are coordinated.
- How members are informed about available PHM programs.

**Critical factors: Score cannot exceed 20% if critical factors are not met.*

Scoring	100%	80%	50%	20%	0%
	The organization meets all 5 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

NCQA reviews a description of the organization’s comprehensive PHM strategy. The strategy may be fully described in one document or the organization may provide a summary document with references or links to supporting documents provided in other PHM elements.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period	<p><i>For Interim Surveys:</i> Prior to the survey date.</p> <p><i>For First and Renewal Surveys:</i> 6 months.</p>
Explanation	<p>This element is a structural requirement. The organization must present its own materials.</p> <p>Factor 1 is a critical factor that the organization must meet to score higher than 20% on this element.</p> <p>The organization has a comprehensive strategy for population health management that <i>at minimum</i> addresses member needs in the following four areas of focus:</p> <ul style="list-style-type: none"> • Keeping members healthy. • Managing members with emerging risk. • Patient safety or outcomes across settings. • Managing multiple chronic illnesses. <p>Factors 1, 2: Four areas of focus</p> <p>At a minimum, the description includes for each of the four areas of focus:</p> <ul style="list-style-type: none"> • Goals (factor 1). • Populations targeted (factor 1). • Program or services for each area of focus (factor 2). <p>Goals are measurable and connected to a targeted population. NCQA does not prescribe a definition of “program or services.” Programs and services may be provided to members by the organization or by other entities.</p> <p>Factor 3: Activities that are not direct member interventions</p> <p>The organization describes all activities conducted by the organization that support PHM programs or services not directed at individual members. An activity may apply to more than one areas of focus. The organization has at least one activity in place.</p> <p>Factor 4: Coordination of member programs</p> <p>The organization coordinates programs or services it directs and those facilitated by providers, external management programs and other entities. The PHM strategy describes how the organization coordinates programs across potential settings, providers and levels of care to minimize the confusion for members being contacted from multiple sources. Coordination activities are not required to be exclusive to one area of focus and may apply across the continuum of care and to other organization initiatives.</p> <p>Factor 5: Informing members</p> <p>The organization describes its methods for informing members about all available PHM programs and services. Programs and services include any level of contact. The organization may make the information available on its website; by mail, e-mail, text or other mobile application; by telephone; or in person.</p> <p>Exceptions</p> <p>None.</p>
Examples	<p>Factors 1, 2: Goals, target populations, opportunities, programs or services</p> <p><i>Keeping members healthy</i></p> <ul style="list-style-type: none"> • <u>Goal</u>: 55 percent of members in the targeted population report receiving annual influenza vaccinations. <ul style="list-style-type: none"> – Targeted populations: <ul style="list-style-type: none"> ▪ Members with no risk factors. ▪ Members enrolled in wellness programs.

- Programs or services: Community flu clinics, e-mail and mail reminders, radio and TV advertisement reminding public to receive vaccine.
- Goal: 10 percent of targeted population reports meeting self-determined weight-loss goal.
 - Targeted population: Members with BMI 27 or above enrolled in wellness program.
 - Programs or services: Wellness program focusing on weight management.

Managing members with emerging risk

- Goal: Lower or maintain HbA1c control <8.0% rate by 2 percent compared to baseline.
 - Targeted population:
 - Members discovered at risk for diabetes during predictive analysis.
 - Members with controlled diabetes.
 - Programs or services: Diabetes management program.
- Goal: Improve asthma medication ratio (total rate) by 3 percent compared to baseline.
 - Targeted population: Diagnosed asthmatic members 18–64 years of age with at least one outpatient visit in the prior year.
 - Programs or services: Condition management program.

Patient safety

- Goal: Improve the safety of high-alert medications.
 - Targeted population: Members who are prescribed high-alert medications and receive home health care.
 - Activity: Collaborate with community-based organizations to complete medication reconciliation during home visits.

Outcomes across settings

- Goal: Reduce 30-day readmission rate after hospital stay (all causes) of three days or more by 2 percentage points compared to baseline.
 - Targeted population: Members admitted through the emergency department who remain in the hospital for three days or more.
 - Program or services: Organization-based case manager conducts follow-up interview post-stay to coordinate needed care.
 - Activity: Collaborate with network hospitals to develop and implement a discharge planning process.

Managing multiple chronic illnesses

- Goal: Reduce ED visits in target population by 3 percentage points in 12 months.
 - Targeted population: Members with uncontrolled diabetes and cardiac episodes that led to hospital stay of two days or more.
 - Programs or services: Complex case management.
- Goal: Improve antidepressant medication adherence rate.
 - Targeted population: Members with multiple behavioral health diagnoses, including severe depression, who lack access to behavioral health specialists.
 - Programs or services: Complex case management with behavioral health telehealth counseling component.

Factor 3: Activities that are not direct member interventions

- Data and information sharing with practitioners.
- Interactions and integration with delivery systems (e.g., contracting with accountable care organizations).
- Providing technology support to or integrating with patient-centered medical homes.

- Integrating with community resources.
- Value-based payment arrangements.
- Collaborating with community-based organizations and hospitals to improve transitions of care from the post-acute setting to the home.
- Collaborating with hospitals to improve patient safety.

Element B: Informing Members—Refer to Appendix 1 for points

The organization informs members eligible for programs that include interactive contact:

1. How members become eligible to participate.
2. How to use program services.
3. How to opt in or opt out of the program.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 3 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
For All Surveys: NCQA reviews the organization’s policies and procedures in effect during the look-back period from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.
For First Surveys and Renewal Surveys: For surveys beginning on or after July 1, 2019, NCQA also reviews materials sent to members from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.
 The score for the element is the average of the scores for all programs or services.

Look-back period *For Interim Surveys:* Prior to the survey date.
For First Surveys and Renewal Surveys: 6 months for documented process.

Explanation This element applies to PHM programs or services in the PHM strategy require interactive contact with members, including those offered directly by the organization.

Interactive contact

Programs with interactive contact have two-way interaction between the organization and the member, during which the member receives self-management support, health education or care coordination through one of the following methods:

- Telephone.
- In-person contact (i.e., individual or group).
- Online contact:
 - Interactive web-based module.
 - Live chat.
 - Secure e-mail.
 - Video conference.

Interactive contact does not include:

- Completion of a health appraisal.
- Contacts made only to make an appointment, leave a message or verify receipt of materials.

Distribution of materials

The organization distributes information to members by mail, fax or e-mail, or through messages to members' mobile devices, through real-time conversation or on its website, if it informs members that the information is available online. If the organization posts the information on its website, it notifies members that the information is available through another method listed above. The organization mails the information to members who do not have fax, e-mail, telephone, mobile device or Internet access. If the organization uses telephone or other verbal conversations, it provides a transcript of the conversation or script used to guide the conversation.

Factors 1–3: Member information

The organization provides eligible members with information on specific programs with interactive contact.

Exceptions

None.

Examples

Dear Member,

Because you had a recent hospital stay, you have been selected to participate in our Transitions Case Management Program. Sometime in the next three days, a nurse will call you to make sure you understand the instructions you were given when you left the hospital, and to make sure you have an appropriate provider to see for follow-up care. To contact the nurse directly, call 555-555-1234.

If you do not want to participate in the Transitions Case Management Program, let us know by calling 555-123-4567.

PHM 2: Population Identification—Refer to Appendix 1 for points

The organization systematically collects, integrates and assesses member data to inform its population health management programs.

Intent

The organization assesses the needs of its population and determines actionable categories for appropriate intervention.

Summary of Changes

Additions

- Added PHM 2, Element A: Data Integration as a new element.
- Added PHM 2, Element D: Segmentation as a new element.
- Split factor 1 into two factors, factors 1 and 2, updated scoring and added social determinants of health to factor 1 language (Element B).
- Added a new factor 3: “Review community resources for integration into program offerings to address member needs” (Element C).

Clarifications

- Updated the scope of review for First Surveys and Renewal Surveys to state “at least once during the prior year” (Element B).
- Updated the explanation to reflect population health management (Elements B, C).
- Updated the look-back period for all surveys to state “prior to the survey date” (Element C).

Element A: Data Integration—Refer to Appendix 1 for points

The organization integrates the following data to use for population health management functions:

1. Medical and behavioral claims or encounters.
2. Pharmacy claims.
3. Laboratory results.
4. Health appraisal results.
5. Electronic health records.
6. Health services programs within the organization.
7. Advanced data sources.

Scoring

100%	80%	50%	20%	0%
The organization meets 5-7 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

For Interim Surveys: NCQA reviews the organization’s policies and procedures for the types and sources of integrated data.

For First and Renewal Surveys: NCQA reviews reports or materials (e.g., screenshots) for evidence that the organization integrated data types and data from sources listed in the factors. The organization may submit multiple examples that collectively demonstrate integration from all data types and sources, or may submit one example that demonstrates integration of all data types and sources.

Look-back period

For Interim, First and Renewal Surveys: Prior to the survey date.

Explanation

Data integration is combining data from multiple sources databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy), across care sites (e.g., inpatient, ambulatory, home) and across domains (e.g., clinical, business, operational). The organization may limit data integration to the minimum necessary to identify eligible members and determine and support their care needs.

Factor 1: Claims or encounter data

Requires both medical and behavioral claims or encounters. Behavioral claim data are not required if all purchasers of the organization's services carve out behavioral healthcare services (i.e., contract for a service or function to be performed by an entity other than the organization).

Factors 2, 3

No additional explanation required.

Factor 4: Health appraisals

The organization demonstrates the capability to integrate data from health appraisals and health appraisals should be integrated if elected by plan sponsor.

Factor 5: Electronic health records

Integrating EHR data from one practice or provider meets the intent of this requirement.

Factor 6: Health service programs within the organization.

Relevant organization programs may include utilization management, care management or wellness coaching programs. The organization has a process for integrating relevant or necessary data from other programs to support identification of eligible members and determining care needs. Health appraisal results would not meet this factor.

Factor 7: Advanced data sources

Advanced data sources are those that aggregate data from multiple entities such as all-payer claims systems, regional health information exchanges or other community collaboratives. The organization must have access to use data from the source to meet the intent.

Examples

EHR integration

- Direct link from EHRs to data warehouse.
- Normalized data transfer or other method of transferring data from practitioner or provider EHRs.

Health services programs within the organization

- Case management.
- UM programs.
 - Daily hospital census data captured through UM.
 - Diagnosis and treatment options based on prior authorization data.
 - Health information line.

Advanced data sources may require two-way data transfer: The organization and other entities can submit data to the source and can use data from the same source. These include but are not limited to:

- Regional, community or health system Health Information Exchanges (HIE).
- All-payer databases.
- Integrated data warehouses between providers, practitioners, and the organization with all parties contributing to and using data from the warehouse.
- State or regionwide immunization registries.

Element B: Population Assessment—Refer to Appendix 1 for points

The organization annually:

1. Assesses the characteristics and needs, including social determinants of health, of its member population.
2. Identifies and assesses the needs of relevant member subpopulations.
3. Assesses the needs of child and adolescent members.
4. Assesses the needs of members with disabilities.
5. Assesses the needs of members with serious and persistent mental illness (SPMI).

Scoring	100%	80%	50%	20%	0%
	The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
For Interim Surveys, NCQA reviews the organization's policies and procedures
For First and Renewal Surveys, NCQA reviews the organization's most recent annual assessment reports.

Look-back period *For Interim Surveys: Prior to the survey date.*
For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation The organization uses data at its disposal (e.g., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population.

Factor 1: Characteristics and needs

The organization assesses the characteristics and needs of the member population. The assessment includes the characteristics of the population and associated needs identified.

At a minimum, social determinants of health must be assessed. **Social determinants of health**¹ are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. The organization defines the determinants assessed.

¹<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

Characteristics that define a relevant population may also include, but are not limited to:

- Federal or state program eligibility (e.g., Medicare or Medicaid, SSI, dual-eligible).
- Multiple chronic conditions or severe injuries.
- At-risk ethnic, language or racial group.

Factor 2: Identifying and assessing characteristics and needs of subpopulations

The organization uses the assessment of the member population to identify and assess relevant subpopulations.

Factor 3: Needs of children and adolescents

The organization assesses the needs of members 2–19 years of age (children and adolescents). If the organization’s regulatory agency’s definition of children and adolescents is different from NCQA’s, the organization uses the regulatory agency’s definition. The organization provides the definition to NCQA, which determines whether the organization’s needs assessment is consistent with the definition.

Factors 4, 5: Individuals with disabilities and SPMI

Members with disabilities and with serious and persistent mental illness (SPMI) have particularly acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases).

Exception

Factor 3 is NA for Medicare.

Examples

Factors 1, 2: Relevant characteristics

Social determinants of health include:

- Resources to meet daily needs.
- Safe housing.
- Local food markets.
- Access to educational, economic and job opportunities.
- Access to health care services.
- Quality of education and job training.
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
- Transportation options.
- Public safety.
- Social support.
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
- Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community).
- Socioeconomic conditions.
- Residential segregation.
- Language/literacy.
- Access to mass media and emerging technologies.
- Culture.

Physical determinants include:

- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change).
- Built environment, such as buildings, sidewalks, bike lanes and roads.
- Worksites, schools and recreational settings.
- Housing and community design.
- Exposure to toxic substances and other physical hazards.
- Physical barriers, especially for people with disabilities.
- Aesthetic elements (e.g., good lighting, trees, and benches).
- Eligibility categories included in Medicaid managed care (e.g., TANF, low-income, SSI, other disabled).
- Nature and extent of carved out benefits.
- Type of Special Needs Plan (SNP) (e.g., dual eligible, institutional, chronic).
- Race/ethnicity and language preference.

Element C: Activities and Resources—Refer to Appendix 1 for points

The organization annually uses the population assessment to:

1. Review and update its PHM activities to address member needs.
2. Review and update its PHM resources to address member needs.
3. Review community resources for integration into program offerings to address member needs.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
For Interim Surveys: NCQA reviews the organization's policies and procedures.
For First and Renewal Surveys: NCQA reviews committee minutes or similar documents showing process and resource review and updates.

Look-back period *For Interim Surveys, First Surveys, and Renewal Surveys:* Prior to the survey date.

Explanation **Factors 1, 2: PHM activities and resources**

The organization uses assessment results to review and update its PHM structure, strategy (including programs, services, activities) and resources (e.g., staffing ratios, clinical qualifications, job training, external resource needs and contacts, cultural competency) to meet member needs.

Factor 3: Community resources

The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment.

Actively responding to member needs is more than posting a list of resources on the organization’s website; active response includes referral services and helping members access community resources.

Examples

Community resources and programs

- Population assessment determines a high population of elderly members without social supports. The organization partners with the Area Agency on Aging to help with transportation and meal delivery.
- Connect at-risk members with shelters.
- Connect food-insecure members with food security programs or sponsor community gardens.
- Sponsor or set up fresh food markets in communities lacking access to fresh produce.
- Participate as a community partner in healthy community planning.
- Partner with community organizations promoting healthy behavior learning opportunities (e.g., nutritional classes at local supermarkets, free fitness classes).
- Support community improvement activities by attending planning meetings or sponsoring improvement activities and efforts.
- Social workers or other community health workers that contact members to connect them with appropriate community resources.
- Referrals to community resources based on member need.
- Discounts to health clubs or fitness classes.

Element D: Segmentation—Refer to Appendix 1 for points

At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.

Scoring	100%	80%	50%	20%	0%
	The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
For All Surveys: NCQA reviews a description of the method used.
For First Surveys and Renewal Surveys: NCQA also reviews the organization’s reports demonstrating implementation.

Look-back period *For Interim Surveys:* Prior to the survey date.
For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation **Population segmentation** divides the population into meaningful subset using information collected through population assessment and other data sources.
Risk stratification uses the potential risk or risk status of individuals to assign them to tiers or subsets. Members in specific subsets may be eligible for programs or receive specific services.
 Segmentation and risk stratification result in the categorization of individuals with care needs at all levels and intensities. Segmentation and risk stratification is a means of

targeting resources and interventions to individuals who can most benefit from them. Either process may be used to meet this element.

Methodology

The organization describes its method for segmenting or stratifying its membership, including the subsets to which members are assigned (e.g., high risk pregnancy, multiple inpatient admissions). Organizations may use various risk stratification methods or approaches to determine actionable subsets.

Segmentation and stratification methods use population assessment and data integration findings (e.g., clinical and behavioral data, population and social needs) to determine subsets and programs/services members are eligible for. Methods may also include utilization/resource use or cost information, but methods that use only cost information to determine categories do not meet the intent of this element.

Reports

The organization provides reports specifying the number of members in each category and the programs or services for which they are eligible. Reports may be a “point-in-time” snapshot during the look back period.

Reports reflect the number of members eligible for each PHM program. They display data in raw numbers and as a percentage of the total enrolled member population, and may not add to 100% if members fall into more than one category.

PHM programs or services provided to members include, but are not limited to, complex case management. Reports must reflect the number of members eligible for each PHM program.

Examples

Health Plan A: Commercial HMO/PPO

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Pregnancy: Over 35 years, multiple gestation	High-risk pregnancy care management	55	0.5%
Type I Diabetes: Moderate risk	Diabetes management	660	6%
Tobacco use	Smoking cessation	110	1%
Behavioral health diagnosis in ages 15-19, rural	Telephone or video behavioral health counseling sessions	330	3%
Women of child-bearing age	Targeted women’s health newsletter	3,850	35%
No risk factors	Routine member newsletters	2,750	25%
No associated data	None	3,850	35%

Health Plan A: Medicare

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Multiple chronic conditions	Complex case management: Over 65	2,000	5%
Over 65, needs assistance with 2 or more ADLs	Long-term services and supports	2,800	7%
COPD: High risk	Complex case management: Over 65	1,600	4%
Osteoporosis: High-risk women	Targeted member newsletter	8,800	22%
No risk factors	Routine member newsletters	6,000	15%
No associated data	None	4,800	12%

PHM 3: Delivery System Supports—Refer to Appendix 1 for points

The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements.

Intent

The organization works with practitioners or providers to achieve population health management goals.

Summary of Changes

Additions

- Added *PHM 3: Delivery System Supports* as a new standard.

Element A: Practitioner or Provider Support—Refer to Appendix 1 for points

The organization supports practitioners or providers in its network to achieve population health management goals by:

1. Sharing data.
2. Offering certified shared-decision making aids.
3. Providing practice transformation support to primary care practitioners.
4. Providing comparative quality information on selected specialties.
5. Providing comparative pricing information for selected services.
6. One additional activity to support practitioners or providers in achieving PHM goals.

Scoring	100%	80%	50%	20%	0%
	The organization meets 3-6 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

For *Interim Surveys*, NCQA reviews the organization's description of how it supports practitioners or providers.

For *First Surveys* and *Renewal Surveys*, NCQA reviews the organization's description of how it supports practitioners or providers and materials demonstrating implementation.

Look-back period *For Interim Surveys:* Prior to the survey date.

For First Surveys and Renewal Surveys: 6 months.

Explanation The organization identifies and implements activities that support practitioners and providers in meeting population health goals. Practitioners and providers may include accountable care entities, primary or specialty practitioners, PCMHs, or other providers included in the organization's network. Organizations may determine the practitioners or providers with which they support.

Factor 1: Data sharing

Data sharing is transmission of member data from the health plan to the provider or practitioner that assists in delivering services, programs, or care to the member. The organization determines the frequency for sharing data.

Factor 2: Certified shared-decision making aids.

Shared decision-making (SDM) aids provide information about treatment options and outcomes. SDM aids are designed to complement practitioner counselling, not replace it. SDM aids facilitate member and practitioner discussion on treatment decisions.

SDM aids may focus on preference-sensitive conditions, chronic care management or lifestyle changes, to encourage patient commitment to self-care and treatment regimens.

The organization provides information (e.g., through the organization, practitioner, provider) about how, when, what conditions, and to whom certified SDM aids are offered. SDM aids must be certified by a third-party entity that evaluates quality. At least one SDM aid must be certified to meet the intent.

Factor 3: Practice transformation support

Transformation includes movement to becoming a more-integrated or advanced practice (e.g., ACO, PCMH) and toward value-based care delivery.

The organization provides documentation that it supports practice transformation.

Factor 4: Comparative quality and cost information on selected specialties

The organization provides comparative quality information about selected specialties to practitioners or providers and reports cost information if it is available. Comparative cost information may be cost or efficiency information and may be represented as relative rates or as a relative range.

Comparative quality information may be reported without cost information if cost information is not available.

To meet this requirement, the organization must provide quality information (with or without cost information) for at least one specialty and show that it has provided the information to at least one provider that refers members to the specialty.

Factor 5: Comparative pricing information for selected services

Comparative pricing information may contain actual unit prices per service or relative prices per service, compared across practitioners or providers.

To meet this requirement, the organization must provide comparative pricing information on at least one service and show that it has provided the information to at least one provider that prescribes the service to members.

Factor 6: Another activity

Other activities include those that cannot be categorized in factors 1–5. The organization describes the activity, how it supports providers or practitioners and how it contributes to achieving PHM goals.

Data sharing activities that use a different method of data sharing from that in factor 1 may be used to meet this factor. The method indicates how data are shared.

Exceptions

None.

Related information

Partners in Quality. The organization can receive automatic credit for factors 3 and 6 if the organization is an NCQA-designated Partner in Quality.

The organization must provide documentation of its status.

Examples**Factor 1**

- Sharing patient-specific data listed below that the practitioner or provider does not have access to:
 - Pharmacy data.
 - ED reports.
 - Enrollment data.
 - Eligibility in the organization’s intervention programs (e.g., enrollment in a wellness or complex case management program).
 - Reports on gaps in preventive services (e.g., a missed mammogram, need for a colonoscopy).
 - Claims data indicate if these services were not done; practitioners or staff can remind members to receive services.
 - Claims data.
 - Data generated by specialists, urgent clinics or other care providers.
- Methods of data sharing:
 - Transmitted through electronic channels as “raw” data to practitioners who conduct data analysis to drive improved patient outcomes.
 - Practitioner or provider portals that have accessible patient-specific data.
 - Submit data to a regional HIE.
- Reports created for practitioners or providers about patients or the attributed population.
 - A direct link to EHRs, to automatically populate recent claims for relevant information and alert practitioners or providers to changes in a patient’s health status.

Factor 2

- Certification bodies:
 - National Quality Forum.
 - Washington State Health Care Authority.

Factor 3

- Incentive payments for PCMH arrangement.
- Technology support.
- Best practices.
- Supportive educational information, including webinars or other education sessions.
- Help with application fees for NCQA PCMH Recognition (beyond the NCQA program’s sponsor discount).
- Help practices transform into a medical home.
- Provide incentives for NCQA PCMH Recognition, such as pay-for-performance.
- Use NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network.

Factor 4

- Selected specialties:
 - Specialties that a primary care practitioner refers members to most frequently.
- Quality information:
 - Organization-developed performance measures based on evidence-based guidelines.
 - AHRQ patient safety indicators associated with a provider.
 - In-patient quality indicators.
 - Risk-adjusted measures of mortality, complications and readmission.
 - Physician Quality Reporting System (PQRS) measures.
 - Non-PQRS Qualified Clinical Data Registry (QCDR) measures.
 - CAHPS measures.
 - The American Medical Association’s Physician Consortium for Performance Improvement (PCPI) measures.
 - Cost information:
 - Relative cost of episode of care.
 - Relative cost of practitioner services.
 - In-office procedures.
 - Care pattern reports that include quality and cost information.

Factor 5

- Selected services:
 - Services for which the organization has unit price information.
 - Services commonly requested by primary care practitioners that are not conducted in-office.
 - Radiology services.
 - Outpatient procedures.
 - Pharmaceutical costs.

Factor 6

- Health plan staff located full-time at the provider facility to assist with member issues.
- The ability to view evidence-based practice guidelines on demand (e.g., practitioner portal).
- Incentives for two-way data sharing.

Element B: Value-Based Payment Arrangements—Refer to Appendix 1 for points

The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Scoring	100%	80%	50%	20%	0%
	The organization demonstrates it has VBP arrangement(s) by reporting the percentage of payment tied to VBP	No scoring option	No scoring option	No scoring option	The organization does not demonstrate that it has VBP arrangement(s)

Data source Reports

Scope of review *This element applies to First Surveys and Renewal Surveys.*
 For *First Surveys* and *Renewal Surveys*, NCQA reviews the VBP worksheet to demonstrate that it has VBP arrangements in each product line.
 The score for the element is the average of the scores for all product lines.

Look-back period *For First Surveys and Renewal Surveys: Prior to the survey date.*

Explanation **This element may not be delegated.**

There is broad consensus that payment models need to evolve from payment based on volume of services provided to models that consider value or outcomes. The FFS model does not adequately address the importance of non-visit-based care, care coordination and other functions that are proven to support achievement of population health goals.

The organization demonstrates that it has at least one VBP arrangement and reports the percentage of total payments made to providers and practitioners associated with each type of VBP arrangement.

The organization uses the following VBP types, sourced from *CMS Reports to Congress: Alternative Payment Models and Medicare Advantage* to report arrangements to NCQA. The organization is not required to use them for internal purposes. If the organization uses different labels for its VBP arrangements, it categorizes them using the NCQA provided definitions.

- **Pay-for-performance (P4P):** Payments are for individual units of service and triggered by care delivery, as under the FFS approach, but providers or practitioners can qualify for bonuses or be subject to penalties for cost and/or quality related performance. Foundational payments or payments for supplemental services also fall under this payment approach.
- **Shared savings:** Payments are FFS, but provider/practitioners who keep medical costs below the organization’s established expectations retain a portion (up to 100 percent) of the savings generated. Providers/practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the portion of total savings the provider or practitioner retains.
- **Shared risk:** Payments are FFS, but providers/practitioners whose medical costs are above expectations, as predetermined by the organization, are liable for a portion (up to 100 percent) of cost overruns.

- **Two-sided risk sharing:** Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.
- **Capitation/population-based payment:** Payments are not tied to delivery of services, but take the form of a fixed per patient, per unit of time sum paid in advance to the provider/practitioner for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/ population-based payment amount and retains all (or most) savings if costs fall below the capitation/population-based payment amount. Payments, penalties and awards depend on quality of care.

Calculating VBP reach

Percentage of payments is calculated by:

- (Numerator:) Total payments made to network practitioners/providers in contracts tied to VBP arrangement(s), divided by,
- (Denominator:) Total payments made to all network providers/practitioners in all contracts, including traditional FFS.

The percentage of payments can reflect the current year to date or the previous year's payments, and can be based on allowed amounts, actual payments or forecasted payments.

Types of providers/practitioners

For each type of VBP arrangement, the organization reports a percentage of total payments and indicates the provider/practitioner types included in the arrangement.

Exceptions

None.

Examples

None.

PHM 4: Wellness and Prevention—Refer to Appendix 1 for points

The organization offers wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk.

Intent

The organization helps members identify and manage health risks through evidence-based tools that maintain member privacy and explain how the organization uses collected information.

Summary of Changes

Additions

- Added factor 14 (Safety behaviors), added explanation text and updated the 100% scoring to reflect the new factor (Element C).

Clarifications

- Revised standard stem and intent statement.
- Added an exception for the Medicaid product line (Elements A–G).
- Clarified the explanation under the subhead for *Factor 5: Special needs assessment* to state that questions include specific demographics to meet the requirement (Element A).
- Clarified the explanation under the subhead for factor 2 to include requirements for the HA disclosure (Element B).

Element A: Health Appraisal Components—Refer to Appendix 1 for points

The organization's HA includes the following information:

1. Questions on demographics.
2. Questions on health history, including chronic illness and current treatment.
3. Questions on self-perceived health status.
4. Questions to identify effective behavioral change strategies.
5. Questions to identify members with special hearing and vision needs and language preference.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's HA that is available throughout the look-back period. If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site.

Look-back period	<p><i>For First Surveys:</i> 6 months.</p> <p><i>For Renewal Surveys:</i> 24 months.</p>
Explanation	<p>The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.</p> <p>HAs help identify at-risk and high-risk members, determine focus areas for timely intervention and prevention efforts and monitor risk change over time. They are an educational tool that can engage members in making healthy behavior changes.</p> <p>The questions required by the factors gather information to determine members' overall risk or wellness, allowing the organization to tailor services and activities.</p> <p>Factor 1: Demographics</p> <p>Member demographics include age, gender and ethnicity.</p> <p>Factor 2: Personal health history</p> <p>No additional explanation required.</p> <p>Factor 3: Self-perceived health status</p> <p>Self-perceived health status is a members' assessment of current health status and well-being.</p> <p>Factor 4: Behavioral change strategies</p> <p>The HA includes questions to help guide changes in behavior and reduce risk.</p> <p>Factor 5: Special needs assessment</p> <p>The HA includes questions that assess hearing and vision impairment and language preferences to help the organization provide special services, materials or equipment to members as needed. To meet this factor, questions must include all three special needs: hearing, vision impairment and language preferences.</p> <p>Exception</p> <p>This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.</p> <p>Related information</p> <p><i>Use of vendors for HA services.</i> If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.</p>
Examples	<p>Factor 1: Demographics</p> <ul style="list-style-type: none">• Age.• Gender.• Race or ethnicity.• Level of education.• Level of income.• Marital status.• Number of children.

Factor 2: Personal health history

- Do you have any of the following conditions?
- Have you had any of the following conditions?
- Do you smoke or use tobacco? How long has it been since you smoked or used tobacco?
- When did you last receive the following preventive services or screenings?

Factor 3: Self-perceived health status

- SF 20® questions or other questions where participants rate their health status on a relative scale.

Factor 4: Behavioral change theories and models

- Prochaska's Stages of Change.
- Patient Activation Measure.
- Knowledge-Attitude Behavior Model.
- Health Belief Model.
- Theory of Reasoned Action.
- Bandura's Social Cognitive Theory.

Factor 5: Special needs assessment

- Do you have a vision impairment that requires special reading materials?
- Do you have a hearing impairment that requires special equipment?
- Is English your primary language? If not, what language do you prefer to speak?

Element B: Health Appraisal Disclosure—Refer to Appendix 1 for points

The organization's HA includes the following information in easy-to-understand language:

1. How the information obtained from the HA will be used.
2. A list of organizations and individuals who might receive the information, and why.
3. A statement that participants may consent or decline to have information used and disclosed.
4. How the organization assesses member understanding of the language used to meet factors 1–3.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's HA for factors 1–3 and reviews policies and procedures for factor 4. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen

shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

Factor 1: Use of HA information

No additional explanation required.

Factor 2: Information recipients

A list of the organizations and individuals who will receive the information, and why, is required. Organizations and individuals are identified by role and are not required to be identified by name.

Factor 3: Right to consent or decline

The HA may include a statement that the member accepts or declines participation or a notice that completion and submission implies consent to the HA's stated use. If the opportunity to consent or decline is associated with HA completion, members have access to the organization's definition of "HA completion." For online consent forms, disclosure information is available in printed form.

Factor 4: Assessing member understanding

The HA is not expected to have language regarding how the organization assesses member understanding of HA disclosure requirements. NCQA reviews the organization's documented process for assessing member understanding.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples**Factor 2: Information recipients**

- An organization that contracts directly with an employer or plan sponsor may disclose information to the participant's health plan. Because the employer or plan sponsor could change health plans, the organization may identify that it "disclose[s] information to the participant's health plan," instead of identifying the plan by name.
- An organization that has a direct relationship with practitioners may disclose information to a participant's primary care practitioner. Because the participant might change practitioners, the organization may identify that it "disclose[s] information to the member's primary care physician," instead of identifying the practitioner by name.

Element C: Health Appraisal Scope—Refer to Appendix 1 for points

HAs provided by the organization assess at least the following personal health characteristics and behaviors:

1. Weight.
2. Height.
3. Smoking and tobacco use.
4. Physical activity.
5. Healthy eating.
6. Stress.
7. Productivity or absenteeism.
8. Breast cancer screening.
9. Colorectal cancer screening.
10. Cervical cancer screening.
11. Influenza vaccination.
12. At-risk drinking.
13. Depressive symptoms.
14. Safety behaviors.

Scoring	100%	80%	50%	20%	0%
	The organization meets 13-14 factors	The organization meets 11-12 factors	The organization meets 7-10 factors	The organization meets 3-6 factors	The organization meets 0-2 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's HA that is available throughout the look-back period. If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site.

Look-back period *For First Surveys: 6 months.*
For Renewal Surveys: 24 months.

Explanation The organization offers an HA with questions that address the scope of areas evaluated by this element, even if no employers or plan sponsors purchase an HA that addresses the full scope listed in the factors.

Factors 1–13

No additional explanation required.

Factor 14: Safety behaviors

Safety behaviors include, but are not limited to, wearing protective gear when recommended or wearing seat belts in motor vehicles. Evidence may not reveal a consistent set of validated questions, but safety behavior is closely associated with other modifiable risk areas, where validated questions exist.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Validated survey items. Evidence shows that certain HA items produce valid and reliable results for key health characteristics and behaviors listed in the factors. NCQA recommends that organizations use validated survey items on their HAs. Refer to the *Technical Specifications for Wellness & Health Promotion* publication for suggested validated survey items. The specifications are available through the *Publications and Products* section of the NCQA website.

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples**Factor 7: Productivity or absenteeism**

- Work days missed due to personal or family health issues.
- Time spent on personal or family health issues during the work day.

Element D: Health Appraisal Results—Refer to Appendix 1 for points

Participants receive their HA results, which include the following information in language that is easy to understand:

1. An overall summary of the participant's risk or wellness profile.
2. A clinical summary report describing individual risk factors.
3. Information on how to reduce risk by changing specific health behaviors.
4. Reference information that can help the participant understand the HA results.
5. A comparison to the individual's previous results, if applicable.

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating the understandability of HA results and reviews HA results.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot

provide a test or demo log-on, NCQA reviews the organization's website or screen shots of web functionality, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

For factors 2–5, NCQA also reviews HA results for evidence that they contain all the health characteristics and behaviors listed in Element C.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meanings, to the extent practical.

Factor 1: Overall summary of risk and wellness profile

HA results include:

- An evidenced-based summary or profile of the participant's overall level of risk or wellness.
- The core health areas (healthy weight [BMI] maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, clinical preventive services).

Factor 2: Clinical summary report

A clinical summary report describes the risk factors that the HA identifies and is in a format that can be shared with a participant's practitioner.

Factor 3: Reducing risk and changing behavior

HA results identify specific behaviors that can lower each risk factor and include recommended targets for improvement and information on how to reduce risk.

Factor 4: Reference information

HA results include additional resources or information external to the organization that participants can use to learn more about their specific health risks and behaviors to improve their health and well-being.

Factor 5: Comparing HA results

If a participant previously completed an HA administered by the organization, the organization includes comparison information to the previous HA results in the current report.

Exceptions

Factor 5 is NA if the organization has not previously administered an HA.

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples None.

Element E: Health Appraisal Format—Refer to Appendix 1 for points

The organization makes HAs available in language that is easy to understand, in the following formats:

1. Digital services.
2. In print or by telephone.

Scoring	100%	80%	50%	20%	0%
	The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's policies and procedures for evaluating understandability, digital HA, and printed or telephonic HA. Each format must be in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period *For First Surveys: 6 months.*
For Renewal Surveys: 24 months.

Explanation The organization is capable of making HAs available through digital media, printed copies or telephone, even if no employers or plan sponsors purchase HAs in multiple formats.

Easy to understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

Factor 1: Digital services

Digital services include online, Internet-based access and downloadable applications for smartphones and other devices.

Factor 2: In print or by telephone

The printed version of the HA contains the same content as the web version of the HA.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples None.

Element F: Frequency of Health Appraisal Completion—Refer to Appendix 1 for points

The organization has the capability to administer the HA annually.

Scoring	100%	80%	50%	20%	0%
	The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's policies and procedures for administering annual HAs, or documentation that the organization administered an annual HA.

Look-back period *For First Surveys:* At least once during the prior year.
For Renewal Surveys: 24 months.

Explanation The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples **Evidence of capability to administer**

- Contracts that specify at least annual administration of the HA.
- Reports that demonstrate at least annual administration of the HA.

Element G: Health Appraisal Review and Update Process**—Refer to Appendix 1 for points**

The organization reviews and updates the HA every two years, and more frequently if new evidence is available.

Scoring	100%	80%	50%	20%	0%
	The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's policies and procedures for reviewing and updating its HA. The policies and procedures must be in place throughout the look-back period.

For Renewal Surveys, NCQA also reviews evidence that the organization reviewed and updated the HA every two years or more frequently if new evidence is available that warrants an update.

Look-back period *For First Surveys: 6 months.*

For Renewal Surveys: 24 months.

Explanation No explanation required.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples **Evidence of review**

- Analysis of HA against current or new evidence.
- Documentation in meeting minutes or reports demonstrating review and update of the HA occurred.

Element H: Topics of Self-Management Tools—Refer to Appendix 1 for points

The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas:

1. Healthy weight (BMI) maintenance.
2. Smoking and tobacco use cessation.
3. Encouraging physical activity.
4. Healthy eating.
5. Managing stress.
6. Avoiding at-risk drinking.
7. Identifying depressive symptoms.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's policies and procedures for developing evidence based self-management tools, and reviews the organization's self-management tools. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site.

Look-back period *For First Surveys: 6 months.*
For Renewal Surveys: 24 months.

Explanation The organization provides evidence that it can perform all activities required by this element, even if it does not provide services to any employer or plan sponsor.

Self-management tools

Self-management tools help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information. This element addresses self-management tools that members can access directly from the organization's website or through other methods (e.g., printed materials, health coaches).

Evidence-based information

The organization meets the requirement of “evidenced-based” information if recognized sources are cited prominently in the self-management tools.

If the organization’s materials do not cite recognized sources, NCQA also reviews the organization’s documented process detailing the sources used, and how they were used in developing the self-management tools.

Factors 1–7

No additional explanation required.

Exceptions

None.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor’s self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor’s self-management tools against the requirements.

Examples

Self-management tools

- Interactive quizzes.
- Worksheets that can be personalized.
- Online logs of physical activity.
- Caloric intake diary.
- Mood log.

Element I: Usability Testing of Self-Management Tools—Refer to Appendix 1 for points

For each of the required seven health areas in Element H, the organization evaluates its self-management tools for usefulness to members at least every 36 months, with consideration of the following:

1. Language is easy to understand.
2. Members’ special needs, including vision and hearing, are addressed.

	100%	80%	50%	20%	0%
Scoring	The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source Documented process, Reports

Scope of review *This element applies to First Surveys and Renewal Surveys.*
 NCQA reviews the organization’s policies and procedures, and reviews evidence of usability testing for each of the seven health areas. The score for the element is the average of the scores for all health areas.

Look-back period *For First Surveys and Renewal Surveys: At least once during the prior 36 months.*

Explanation Usability

The organization is not required to conduct usability testing with an external audience. Testing with internal staff who were not involved in development of the self-management tool meets the requirements of this element, if staff are representative of the population that will use the tool.

Factor 1: Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

Factor 2: Members with special needs

The organization's documented process explains the methods used to identify usability issues for members with special needs and the organization assesses its tools for members who have vision or hearing limitations. All must be addressed in order to receive credit for this factor.

Exception

Factors marked "No" in Element A are scored NA in this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples**Guidelines on usability testing for online tools**

- www.usability.gov.

Evaluation methods

- Focus groups.
- Cognitive testing and surveys that focus on specific tools.

Element J: Review and Update Process for Self-Management Tools**—Refer to Appendix 1 for points**

The organization demonstrates that it reviews its self-management tools on the following seven health areas and updates them every two years, or more frequently if new evidence is available:

1. Healthy weight (BMI) maintenance.
2. Smoking and tobacco use cessation.
3. Encouraging physical activity.
4. Healthy eating.
5. Managing stress.
6. Avoiding at-risk drinking.
7. Identifying depressive symptoms.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's policies and procedures.

For Renewal Surveys, NCQA also reviews documentation that shows review and update of the self-management tools.

Look-back period *For First Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation **Factors 1–7**

No explanation required.

Exception

Factors marked "No" in Element A are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples None.

Element K: Self-Management Tool Formats—Refer to Appendix 1 for points

The organization’s self-management tools are offered in the following formats for each required seven health areas:

1. Digital services.
2. In print or by telephone.

Scoring	100%	80%	50%	20%	0%
	The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*
 NCQA scores this element for each of seven required health areas in Element H. The score for the element is the average of the scores for all health areas.
 NCQA reviews the organization’s digital and printed or telephonic self-management tools in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period *For First Surveys: 6 months.*
For Renewal Surveys: 24 months.

Explanation The content of self-management tools is the same in all formats.

Factor 1: Digital services

Digital services include online, Internet-based access and downloadable applications for smartphones and other devices.

Factor 2: In print or by telephone

Materials must be available in printed format or by telephone. An option to print an online document does not meet the requirement.

Exception

Factors marked “No” in Element H are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor’s self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor’s self-management tools against the requirements.

Examples None.

PHM 5: Complex Case Management—Refer to Appendix 1 for points

The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources.

Intent

The organization helps members with multiple or complex conditions to obtain access to care and services, and coordinates their care.

Summary of Changes

Additions

- Combined former factor 1 (Health information line referral), factor 2 (DM program referral), factor 4 (UM referral) to the new factor 1 (Medical management program referral), updated scoring and added Explanation text for that factor (Element A).

Clarifications

- Clarified the standard statement to specify that highest-risk members are included in the CCM program.
- Replaced “psychosocial issues” with “social determinants of health” in factor 5 and revised the explanation text for that factor (Element C).
- Clarified the scope of review to state “files are selected from active or closed cases that were open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management” (Elements D, E).
- Updated the factor 5 language to state “initial assessment of social determinants of health” and revised the explanation text (Element D).
- Updated timeliness of assessment to state that the organization's initial assessment begins within 30 calendar days of identification and is completed within 60 days of identification (Element D).
- Added a fourth bullet under the subhead *Timeliness of assessment*: “The member is dead” (Element D).
- Added an example: *Factors 1–5: Case Management—Ongoing Management* (Element E).
- Added a bullet under the subhead for *Factor 1: Analyzing member feedback* in the explanation (Element F).

Element A: Access to Case Management—Refer to Appendix 1 for points

The organization has multiple avenues for members to be considered for complex case management services, including:

1. Medical management program referral.
2. Discharge planner referral.
3. Member or caregiver referral.
4. Practitioner referral.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews evidence that the organization has multiple referral avenues in place throughout the look-back period and that it communicates the referral options to members and practitioners at least once during the look-back period.

Look-back period *For Interim Surveys:* Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation The overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

NCQA considers complex case management to be an opt-out program: All eligible members have the right to participate or to decline to participate.

The organization offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in the organization's DM program.

In addition to the process described in PHM 2, Element D: Segmentation, multiple referral avenues can minimize the time between identification of a need and delivery of complex case management services.

The organization has a process for facilitating referrals listed in the factors, even if it does not currently have access to the source.

Factor 1

Medical management program referrals include referrals that come from other organization programs or through a vendor or delegate. These may include disease management programs, UM programs, health information lines or similar programs that can identify needs for complex case management and are managed by organization or vendor staff.

Factor 2

No additional explanation required.

Factors 3, 4

The organization communicates referral options to members (factor 3) and practitioners (factor 4).

Exceptions

None.

Examples

Facilitating referrals

- Correspondence from members, caregivers or practitioners about potential eligibility.
- Monthly or quarterly reports, from various sources, of the number of members identified for complex case management.
- Brochures or mailings to referral sources about the complex case management program and instructions for making referrals.
- Web-based materials with information about the case management program and instructions for making referrals.

Element B: Case Management Systems—Refer to Appendix 1 for points

The organization uses case management systems that support:

1. Evidence-based clinical guidelines or algorithms to conduct assessment and management.
2. Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred.
3. Automated prompts for follow-up, as required by the case management plan.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
For Interim Surveys: NCQA reviews the organization’s policies and procedures.
For First Surveys and Renewal Surveys: NCQA also reviews the organization’s complex case management system or annotated screenshots of system functionality. The system must be in place throughout the look-back period.

Look-back period *For Interim Surveys:* Prior to the survey date.
For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation	<p>Factor 1: Evidence-based clinical guidelines or algorithms</p> <p>The organization develops its complex case management system through one of the following sources:</p> <ul style="list-style-type: none"> • Clinical guidelines, <i>or</i> • Algorithms, <i>or</i> • Other evidence-based materials. <p>NCQA does not require the entire evidence-based guideline or algorithm to be imbedded in the automated system, but the components used to conduct assessment and management of patients must be imbedded in the system.</p> <p>Factor 2: Automated documentation</p> <p>The complex case management system includes automated features that provide accurate documentation for each entry (record of actions or interaction with members, practitioners or providers) and use automatic date, time and user (user ID or name) stamps.</p> <p>Factor 3: Automated prompts</p> <p>The complex case management system includes prompts and reminders for next steps or follow-up care.</p> <p>Exceptions</p> <p>None.</p>
Examples	None.

Element C: Case Management Process—Refer to Appendix 1 for points

The organization's complex case management procedures address the following:

1. Initial assessment of members' health status, including condition-specific issues.
2. Documentation of clinical history, including medications.
3. Initial assessment of the activities of daily living.
4. Initial assessment of behavioral health status, including cognitive functions.
5. Initial assessment of social determinants of health.
6. Initial assessment of life-planning activities.
7. Evaluation of cultural and linguistic needs, preferences or limitations.
8. Evaluation of visual and hearing needs, preferences or limitations.
9. Evaluation of caregiver resources and involvement.
10. Evaluation of available benefits.
11. Evaluation of community resources.
12. Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.
13. Identification of barriers to member meeting goals or complying with the case management plan.
14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals.

15. Development of a schedule for follow-up and communication with members.
16. Development and communication of a member self-management plan.
17. A process to assess member progress against the case management plan.

Scoring	100%	80%	50%	20%	0%
	The organization meets 16-17 factors	The organization meets 12-15 factors	The organization meets 8-11 factors	The organization meets 3-7 factors	The organization meets 0-2 factors

Data source Documented process

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
NCQA reviews the organization's policies and procedures.

Look-back period *For Interim Surveys:* Prior to the survey date.
For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation This is a **structural requirement**. The organization must present its own documentation.

Complex case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases). The organization records the specific factor and the reason in the case management system and file.

Assessment and evaluation

Assessment and evaluation each require the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Factor 1: Initial assessment of members' health status

Complex case management policies and procedures specify the process for initial assessment of health status, specific to an identified condition and likely comorbidities (e.g., high-risk pregnancy and heart disease, for members with diabetes). The assessment should include:

- Screening for presence or absence of comorbidities and their current status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the member's identification for complex case management.

Factor 2: Documentation of clinical history

Complex case management policies and procedures specify the process for documenting clinical history (e.g., disease onset; acute phases; inpatient stays; treatment history; current and past medications, including schedules and dosages).

Factor 3: Initial assessment of activities of daily living

Complex case management policies and procedures specify the process for assessing functional status related to activities of daily living, such as eating, bathing and mobility.

Factor 4: Initial assessment of behavioral health status

Complex case management policies and procedures specify the process for assessing behavioral health status, including:

- Cognitive functions:
 - The member's ability to communicate and understand instructions.
 - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

Factor 5: Initial assessment of social determinants of health

Complex case management policies and procedures specify the process for assessing social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.

Factor 6: Initial assessment of life-planning activities

Complex case management policies and procedures specify the process for assessing whether members have completed life-planning activities such as wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms.

If a member does not have expressed life-planning instructions on record, during the first contact the case manager determines if life-planning instructions are appropriate. If they are not, the case manager records the reason in the member's file.

Providing life-planning information (e.g., brochure, pamphlet) to all members in case management meets the intent of this factor.

Factor 7: Evaluation of cultural and linguistic needs

Complex case management policies and procedures specify a process for assessing culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. It should include consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Factor 8: Evaluation of visual and hearing needs

Complex case management policies and procedures specify a process for assessing vision and hearing to identify potential barriers to effective communication or care.

Factor 9: Evaluation of caregiver resources

Complex case management policies and procedures specify a process for assessing the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation.

Factor 10: Evaluation of available benefits

Complex case management policies and procedures specify a process for assessing the adequacy of health benefits regarding the ability to fulfill a treatment plan. Assessment includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 11: Evaluation of community resources

Complex case management policies and procedures specify a process for assessing eligibility for community resources that supplement those for which the organization has been contracted to provide, at a minimum:

- Community mental health.
- Transportation.
- Wellness organizations.
- Palliative care programs.

Factor 12: Individual case management plan and goals

Complex case management policies and procedures specify a process for creating a personalized case management plan that meets member needs and includes:

- Prioritized goals.
 - Prioritized goals consider member and caregiver needs and preferences; they may be documented in any order, as long as the level of priority is clear.
- Time frame for reevaluation of goals.
- Resources to be utilized, including appropriate level of care.
- Planning for continuity of care, including transition of care and transfers between settings.
- Collaborative approaches to be used, including level of family participation.
 - Time frames for reevaluation are specified in the case management plan.

Factor 13: Identification of barriers

Complex case management policies and procedures to a member receiving or participating in a case management plan. A barrier analysis can assess:

- Language or literacy level.
- Access to reliable transportation.
- Understanding of a condition.
- Motivation.
- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

The organization documents that it assessed barriers, even if none were identified.

Factor 14: Referrals to available resources

Complex case management policies and procedures specify a process for facilitating referral to other health organizations, when appropriate.

Factor 15: Follow-up schedule

Case management policies and procedures have a follow-up process that includes determining if follow-up is appropriate or necessary (for example, after a member is referred to a disease management program or health resource). The case management plan contains a schedule for follow-up that includes, but is not limited to:

- Counseling.
- Follow-up after referral to a DM program.
- Follow-up after referral to a health resource.
- Member education.

- Self-management support.
- Determining when follow-up is not appropriate.

Factor 16: Development and communication of self-management plans

Complex case management policies and procedures specify a process for communicating the self-management plan to the member or caregiver (i.e., verbally, in writing). **Self-management plans** are activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers.

Factor 17: Assessing progress

Complex case management policies and procedures specify a process for assessing progress toward overcoming barriers to care and to meeting treatment goals, and for assessing and adjusting the care plan and its goals, as needed.

Exceptions

None.

Examples

Factor 3: Activities of daily living

- Grooming.
- Dressing.
- Bathing.
- Toileting.
- Eating.
- Transferring (e.g., getting in and out of chairs).
- Walking.

Factor 4: Cognitive functioning assessment

- Alert/oriented, able to focus and shift attention, comprehends and recalls direction independently.
- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g. on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

Factor 5: Social determinants of health

- Current housing and housing security.
- Access to local food markets.
- Exposure to crime, violence and social disorder.
- Residential segregation and other forms of discrimination.
- Access to mass media and emerging technologies.
- Social support, norms and attitudes.
- Access, transportation and financial barriers to obtaining treatment.

Factor 7: Cultural needs, preferences or limitations

- Health care treatments or procedures that are discouraged or not allowed for religious or spiritual reasons.
- Family traditions related to illness, death and dying.
- Health literacy assessment.

Factor 9: Caregiver assessment

- Member is independent and does not need caregiver assistance.
- Caregiver currently provides assistance.
- Caregiver needs training, supportive services.
- Caregiver is not likely to provide assistance.
- Unclear if caregiver will provide assistance.
- Assistance needed but no caregiver available.

Factor 10: Assessment of available benefits

- Benefits covered by the organization and by providers.
- Services carved out by the purchaser.
- Services that supplement those the organization has been contracted to provide, such as:
 - Community mental health.
 - Medicaid.
 - Medicare.
 - Long-term care and support.
 - Disease management organizations.
 - Palliative care programs.

Factor 14: Assessment of barriers²

- Does the member understand the condition and treatment?
- Does the member want to participate in the case management plan?
- Does the member believe that participation will improve health?
- Are there financial or transportation limitations that may hinder the member from participating in care?
- Does the member have the mental and physical capacity to participate in care?

Factor 16: Self-management

- Self-management includes ensuring that the member can:
 - Perform activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding).
 - Perform instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances).
 - Self-administer medication (e.g., oral, inhaled or injectable).
 - Self-administer medical procedures/treatments (e.g., change wound dressing).
 - Manage equipment (e.g., oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies).
 - Maintain a prescribed diet.
 - Chart daily weight, blood sugar.

²Lorig, K. 2001. *Patient Education, A Practical Approach*. Sage Publications, Thousand Oaks, CA. 186–92.

Element D: Initial Assessment—Refer to Appendix 1 for points

An NCQA review of a sample of the organization’s complex case management files demonstrates that the organization follows its documented processes for:

1. Initial assessment of member health status, including condition-specific issues.
2. Documentation of clinical history, including medications.
3. Initial assessment of the activities of daily living (ADL).
4. Initial assessment of behavioral health status, including cognitive functions.
5. Initial assessment of social determinants of health.
6. Evaluation of cultural and linguistic needs, preferences or limitations.
7. Evaluation of visual and hearing needs, preferences or limitations.
8. Evaluation of caregiver resources and involvement.
9. Evaluation of available benefits.
10. Evaluation of available community resources.
11. Assessment of life-planning activities.

Scoring	100%	80%	50%	20%	0%
	High (90-100%) on file review for 10-11 factors and medium (60-89%) on no more than 1 factor	High (90-100%) on file review for at least 7 factors and medium (60-89%) on file review for the remainder	At least medium (60-89%) on file review for 11 factors	Low (0-59%) on file review for 1-6 factors	7 or more factors in the low range (0-59%)

Data source Records or files

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period *For First Surveys: 6 months.*

For Renewal Surveys: 12 months.

Explanation Documentation to meet the factors includes evidence that the assessments were completed and documented results of each assessment. A checklist of assessments without documentation of results does not meet the requirement.

Assessment components may be completed by other members of the care team and with the assistance of the member’s family or caregiver. Assessment results for each factor must be clearly documented in case management notes, even if a factor does not apply.

If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the patient’s family or caregiver.

If case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment must be performed after discharge if the member is identified for case management.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Assessment and evaluation

Assessment and evaluation each require that the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Timeliness of assessment

The organization begins the initial assessment within 30 calendar days of identifying a member for complex case management and completes it within 60 calendar days of identification. NCQA scores each factor "No" for files of initial assessments completed 60 calendar days or more from member identification, unless the delay was due to circumstances beyond the organization's control:

- The member is hospitalized during the initial assessment period.
- The member cannot be contacted or reached through telephone, letter, e-mail or fax.
- Natural disaster.
- The member is dead.

The organization documents the reasons for the delay and actions it has taken to complete the assessment.

The assessment may be derived from care or encounters occurring up to 30 calendar days prior to determining identification, if the information is related to the current episode of care (e.g., health history taken as part of disease management or during a hospitalization).

Files excluded from review

The organization excludes files from review that meet the following criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
 - Telephone.
 - Regular mail.
 - E-mail.
 - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
 - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA confirms that the files met the criteria for an NA score.

Factor 1: Initial assessment of members' health status

The file or case record documents a case manager's assessment of the member's current health status, including:

- Information on presence or absence of comorbidities and their current status.
- Self-reported health status.
- Information on the event or diagnosis that led to identification for complex case management.
- Current medications, including dosages and schedule.

Factor 2: Documentation of clinical history

The file or case record contains information on the member's clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Past medications, including schedules and dosages.

Factor 3: Initial assessment of activities of daily living

The file or case record documents a case manager's assessment of the member's functional status relative to at least the six basic ADLs. Bathing, hygiene, dressing, toileting, transferring or functional mobility and eating.

Factor 4: Initial assessment of behavioral health status

The file or case record documents a case manager's assessment of:

- Cognitive functions.
 - The member's ability to communicate and understand instructions.
 - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

Factor 5: Initial assessment of social determinants of health

The case manager assesses social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet goals.

Factor 6: Evaluation of cultural and linguistic needs

The file or case record documents a case manager's evaluation of the member's culture and language needs and their impact on communication, care or acceptability of specific treatments. At a minimum, the case manager evaluates:

- Cultural health beliefs and practices.
- Preferred languages.
- Health literacy.

Factor 7: Evaluation of visual and hearing needs

The file or case record documents a case manager's evaluation of the member's vision and hearing. The document describes specific needs to consider in the case management plan and barriers to effective communication or care.

Factor 8: Evaluation of caregiver resources

The file or case record documents a case manager's evaluation of the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation. The documentation describes what resources are in place, whether these are sufficient for the members needs and notes specific gaps that should be addressed.

Factor 9: Evaluation of available benefits

The file or case record documents a case manager's evaluation of the adequacy of member's specific health insurance benefits in relation to the needs of the treatment plan. The evaluation goes beyond checking insurance coverage; it includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 10: Evaluation of community resources

The file or case record documents a case manager's evaluation of the member's eligibility for community resources and the availability of those resources. At a minimum, the evaluation includes:

- Community mental health.
- Transportation.
- Wellness programs.
- Nutritional support.
- Palliative care programs.

If a specific resource is not applicable to the member's situation, the case record or file documents why.

Factor 11: Initial assessment of life planning activities

The file or case record documents a case manager's assessment of whether the member has in place or has considered the need for wills, living wills or advance directives, Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms and health care powers of attorney.

During the first contact, the case manager assesses and documents whether it is appropriate to discuss these activities and documents with the member. If determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place.

If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Documentation that the organization provided life-planning information (e.g., brochure, pamphlet) to all members in complex case management meets the intent of this requirement.

Exceptions

None.

Examples

None.

Element E: Case Management—Ongoing Management—Refer to Appendix 1 for points

The NCQA review of a sample of the organization’s complex case management files that demonstrates that the organization follows its documented processes for:

1. Development of case management plans that include prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program.
2. Identification of barriers to meeting goals and complying with the case management plan.
3. Development of schedules for follow-up and communication with members.
4. Development and communication of member self-management plans.
5. Assessment of progress against case management plans and goals, and modification as needed.

Scoring	100%	80%	50%	20%	0%
	High (90%-100%) on file review for all 5 factors	High (90%-100%) on file review for at least 3 factors and low (0-59%) on 0 factors	At least medium (60-89%) on file review for 5 factors	Low (0-59%) on file review for no more than 2 factors	3 or more factors in the low range (0-59%)

Data source Records or files

Scope of review *This element applies to First Surveys and Renewal Surveys.*
 NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.
 The organization must provide the identification date for each case in the file universe.

Look-back period *For First Surveys: 6 months.*
For Renewal Surveys: 12 months.

Explanation Each case file contains evidence that the organization completed the five factors listed, according to its complex case management procedures specified in Element C.

Dispute of file review results

Onsite file review is conducted in the presence of the organization’s staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Files excluded from review

The organization excludes files from review that meet these criteria:

- Identified members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
 - Telephone.
 - Regular mail.
 - E-mail.
 - Fax.

- Members in complex case management for less than 60 calendar days during the look-back period.
 - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA reserves the right to confirm that the files met the criteria for an NA score.

Factor 1: Case management plans and goals

The organization documents a plan for case management that is specific to the member's situation and needs, and includes goals that reflect issues identified in the member assessment and the supporting rationale for goal selection. Goals are specific, measurable and timebound. To be timebound, each goal must have a target completion date. The organization prioritizes goals using high/low, numeric rank or other similar designation. Priorities reflect input from the member or a caregiver, demonstrating the member or caregiver's preferences and priorities.

Factor 2: Identification of barriers

Barriers are related to the member or to the member's circumstances, not to the CCM process. The organization documents barriers to the member meeting the goals specified in the CCM plan.

Factor 3: Follow-up and communication with members

The organization documents the next scheduled contact with the member, including the scheduled time or time frame and method, which may be an exact date or relative (e.g., "in two weeks").

Factor 4: Self-management plan

A self-management plan includes actions the member agrees to take to manage a condition or circumstances. The organization documents that the plan has been communicated to the member. Communication may be verbal or written. Documentation includes the member's acknowledgment of and agreement to expected actions.

Factor 5: Assessment of progress

The organization documents the member's progress toward goals. If the member does not demonstrate progress over time, the organization reassesses the applicability of the goals to the member's circumstances and modifies the goals, as appropriate.

Exceptions

None.

Examples Factors 1–5: Case Management—Ongoing Management

Member Diagnosis: Severe mental illness (depression); chronic homelessness (unstable housing for 8 months)	
Identification date: 1/5/2017	Initial Assessment Completed: 1/30/2017
Goal 1:	Secure stable housing for member by 2/11/2017. (Factor 1)
<p><i>Goal case notes:</i> Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager’s help to manage other conditions, once in stable housing. (Factor 1)</p> <p><i>Strategies to achieve goal:</i> Referral to community housing resources; secure temporary safe housing, pending a more permanent solution; accompany member to housing services.</p> <p><i>Barriers to goal:</i> Member was previously evicted from temporary shelter due to unwillingness to comply with shelter staff rules. (Factor 2)</p> <p><i>Progress assessment:</i> Member moved out of initial temporary shelter because he felt his belongings were unsafe. Asked for help getting into a home where he can lock up his belongings. CM adjusted completion date to 2/21/2017 and investigated group housing. (Factor 5)</p>	
Goal 1 completed:	2/16/2017. Note: Member was accepted into adult male group housing, once he understood and accepted house rules, is comfortable with secure locker for belongings. (Factor 5)
Goal 2:	<ul style="list-style-type: none"> • Improve member’s Patient Health Questionnaire-9 (PHQ-9) score from baseline (23 at initial assessment 1/30/2017) over 3–6 months. • Improve 5 points from baseline by 4/30/2017. • Improve 11 points from baseline by 7/30/2017. (Factor 1)
<p><i>Goal case notes:</i> Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager’s help to manage other conditions, once in stable housing. Member feels that stable housing will help depression and is willing to attend therapy sessions. (Factor 1)</p> <p><i>Strategies to achieve goal:</i> Implement a reminder system for taking medications; arrange transportation for therapist visits; check in weekly to discuss progress.</p> <p><i>Barriers to goal:</i> Member uncertain about how to get to therapy sessions and states that he feels overwhelmed by having to change buses and remember schedules. Member said his medication has been stolen in shelters before. (Factor 2)</p> <p><i>Progress assessment:</i> Member feels his medications are safe in group home lockers. CM helped the member set up a calendar pill case and clock alarm as medication reminders. CM arranged van transportation to twice weekly therapy sessions.</p> <p>CM assessed PHQ score at weekly call on 4/28/2017. Score was 16 (9 less than baseline). Member stated that housing greatly improved depression. Therapy sessions adjusted to weekly.</p> <p>CM assessed PHQ score at weekly call on 7/28/2017. Score was 12 (11 less than baseline). (Factor 5)</p>	
Goal 2 completed:	7/28/2017. Note: Member attends therapy. Member can navigate bus lines without anxiety; assisted transportation to sessions discontinued. (Factor 5)
Follow-up and communication plan:	CM scheduled weekly follow-up calls at 5pm on Fridays via the group home’s phone line. CM gave member direct emergency line and is working to secure cell phone for member. (Factor 3)

Self-management plan:	<ul style="list-style-type: none"> • Member will attend weekly follow-up calls on Fridays at 5pm via [number]. • Member will continue to follow rules of group home. • Member will alert CM if changes to housing occur. • Member will use alarm clock reminders to take medication on schedule. Member and CM will discuss monthly refills to medications box. • CM arranges medication to be mailed to group home; member agrees to verify medication with CM during weekly calls. • Member attends therapy sessions and alerts group home staff to dramatic changes in mood (e.g., suicidal ideation). • Member will work with group home staff and other residents to learn bus routes and how to change buses on route. (Factor 4) <p>Note: Member signed and has copies of the agreed-on self-management and case management plans. Signed copies attached. (Factor 4)</p>
------------------------------	--

Element F: Experience With Case Management—Refer to Appendix 1 for points

At least annually, the organization evaluates experience with its complex case management program by:

1. Obtaining feedback from members.
2. Analyzing member complaints.

Scoring	100%	80%	50%	20%	0%
	The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source Reports

Scope of review *This element applies to First Surveys and Renewal Surveys.*
 For *First Surveys*, NCQA reviews the organization's most recent annual data collection and evaluation report.
 For *Renewal Surveys*, NCQA reviews the last two annual data collections and evaluation reports.

Look-back period *For First Surveys:* At least once during the prior year.
For Renewal Surveys: 24 months.

Explanation **Factor 1: Analyzing member feedback**
 The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may assess the entire population or draw statistically valid samples.

If the organization uses a sample, it describes the sample universe and the sampling methodology.

If satisfaction surveys are conducted at the corporate or regional level, results are stratified at the accreditable entity level for analysis and to determine actions. CAHPS and other general survey questions do not meet the intent of this element.

The organization conducts a quantitative data analysis to identify patterns in member feedback, and conducts a causal analysis if it did not meet stated goals.

Factor 2: Analyzing member complaints

The organization analyzes complaints to identify opportunities to improve satisfaction with its complex case management program.

Exceptions

None.

Examples Member feedback questions

1. Did the case manager help you understand the treatment plan?
2. Did the case manager help you get the care you needed?
3. Did the case manager pay attention to you and help you with problems?
4. Did the case manager treat you with courtesy and respect?
5. How satisfied are you with the case management program?

Table 1: Annual complex case management member satisfaction survey results (N = Number of respondents)

How Satisfied Are You...	Very Satisfied		Satisfied		Combined		Sample Size	Percentage of Goal Met?
	N	%	N	%	N	%		
With how the case manager helped you understand the doctor's treatment plan?	75	60	25	20	100	80	125	No
With how the case manager helped you get the care you needed?	80	64	35	28	115	92	125	Yes
With the case manager's attention and help with problems?	70	56	45	36	115	92	125	Yes
With how the case manager treated you?	85	68	35	28	120	96	125	Yes

The Complex Case Management Team and the QI staff conducted a root cause analysis of the areas where goals were not met.

Table 2: Member feedback qualitative analysis

Root Cause/Barrier	Opportunity for Improvement	Prioritized for Action (Y/N)
Members do not understand the treatment plan	Case managers identify health literacy issues and member preferences for information early in the case management process	Y

Complaints

- Limited access to case manager.
- Dissatisfaction with case manager.
- Timeliness of case management services.

Table 3: Complaint volume

Complex Case Management Complaints	Q1	Q2	Q3	Q4	Total 2017	Total 2016
Access to case manager	2	0	0	1	3	4
Dissatisfaction with case manager	1	2	0	1	4	5
Timeliness of case management services	1	0	2	2	5	5
Inquiries	3	1	2	4	10	12
Total case management	7	3	4	8	22	26

Findings

There were 22 complex case management complaints in 2018; there were 26 in 2017. Totals by category were also lower in 2018 than in 2017. Given the volume of cases over the past year, the numbers and types of complaints do not present opportunities for improvement.

The organization will continue to track and trend complaints and grievances annually, and compare results with the previous year's performance.

PHM 6: Population Health Management Impact

—Refer to Appendix 1 for points

The organization measures the effectiveness of its PHM strategy.

Intent

The organization has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement.

Summary of Changes

Additions

- Added *PHM 6: Population Health Management Impact* as a new standard.

Element A: Measuring Effectiveness—Refer to Appendix 1 for points

At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:

1. Quantitative results for relevant clinical, cost/utilization and experience measures.
2. Comparison of results with a benchmark or goal.
3. Interpretation of results.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process

Scope of review *This element applies to First Surveys and Renewal Surveys.*

For First and Renewal Surveys, NCQA reviews the organization's plan for its annual comprehensive analysis of PHM strategy impact. Beginning on or after July 1, 2019, NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period *For First Surveys and Renewal Surveys: 6 months.*

Explanation This element is a **structural requirement**. The organization must present its own materials.

The organization conducts an annual quantitative analysis of findings.

Factor 1: Quantitative results

Relevant measures align with the areas of focus, activities or programs as described in PHM 1, Element A. The organization describes why measures are relevant. Measures may focus on one segment of the population or on populations across the organization.

Clinical measures

Measures can be activities, events, occurrences or outcomes for which data can be collected for comparison with a threshold, benchmark or prior performance. There are two types of clinical measures:

1. *Outcome measures*: Incidence or prevalence rates for desirable or undesirable health status outcomes (e.g., infant mortality).
2. *Process measures*: Measures of clinical performance based on objective clinical criteria defined from practice guidelines or other clinical specifications (e.g., immunization rates).

Cost/Utilization measures

Utilization is an unweighted count of services (e.g., inpatient discharges, inpatient days, office visits, prescriptions). Utilization measures capture the frequency of services provided by the organization. Cost-related measures can be used to demonstrate utilization. The organization measures cost, resource use or utilization.

Cost of care considers the mix and frequency of services, and is determined using actual unit price per service or unit prices found on a standardized fee schedule.

Examples of cost of care measurement include:

- Dollars per episode, overall or by type of service.
- Dollars per member, per month (PMPM), overall or by type of service.
- Dollars per procedure.

Resource use considers the cost of services in addition to the count of services across the spectrum of care, such as the difference between a major surgery and a 15-minute office visit.

Experience

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may also analyze complaints to identify opportunities to improve satisfaction.

The organization uses complex case management member experience results and member experience results from one other program or service.

CAHPS and other general survey questions do not meet the intent of this element.

Factor 2: Comparison of results

The organization performs a first-level, quantitative data analysis that compares results with an established, explicit and quantifiable goal or benchmark. Analysis includes past performance, if a previous measurement was performed.

Tests of statistical significance are not required, but may be useful when analyzing trends.

Factor 3: Interpretation of results

Interpretation of results gives the organization insight into its PHM programs and strategy, and helps it understand the programs' effectiveness and impact on areas of focus. The measures must be analyzed and assessed together to provide a comprehensive analysis of the effectiveness of the PHM strategy. The interpretation of the results should include interpretation of the measures and should go beyond just a presentation of the quantitative results of the measures. The organization conducts a qualitative analysis if stated goals are not met.

Note:

- *Participation rates do not qualify for this element.*
- *If the organization uses SF-8®, SF-12® or SF-36y to measure health status, results may count for two measures of effectiveness: one each for physical and mental health functioning.*

Exceptions

None.

Examples**Factor 1**

Utilization includes measures of waste, overutilization, access, cost or underutilization.

Experience

- Patient Health Questionnaire (PHQ-9).
- Patient-Reported Outcomes Measurement Information System (PROMIS) tools.
- Program-specific surveys.

Element B: Improvement and Action—Refer to Appendix 1 for points

The organization uses results from the PHM impact analysis to annually:

1. Identify opportunities for improvement.
2. Act on one opportunity for improvement.

Scoring	100%	80%	50%	20%	0%
	The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source Reports

Scope of review *This element applies to First Surveys and Renewal Surveys.*
For First and Renewal Surveys, for surveys beginning on or after July 1, 2019, NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.
 NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period *For First Surveys and Renewal Surveys: Prior to the survey date.*

Explanation This element is a **structural requirement**. The organization must present its own materials.

Factor 1: Opportunities for improvement

The organization uses the results of its analysis to identify opportunities for improvement, which may be different each time data are measured and analyzed. NCQA does not prescribe a specific number of improvement opportunities.

Factor 2: Act on opportunity for improvement

The organization develops a plan to act on at least one identified opportunity for improvement.

Exceptions

This element is NA for 2018.

Examples None.

PHM 7: Delegation of PHM—Refer to Appendix 1 for points

If the organization delegates NCQA-required PHM activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated PHM activities.

Summary of Changes

Additions

- Added *PHM 7: Delegation of PHM* as a new standard.

Element A: Delegation Agreement—Refer to Appendix 1 for points

The written delegation agreement:

1. Is mutually agreed upon.
2. Describes the delegated activities and the responsibilities of the organization and the delegated entity.
3. Requires at least semiannual reporting by the delegated entity to the organization.
4. Describes the process by which the organization evaluates the delegated entity's performance.
5. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
 NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.
 The score for the element is the average of the scores for all delegates.

Look-back period *For Interim Surveys and First Surveys: 6 months.*
For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation **This element may not be delegated.**
 This element applies to agreements that are in effect during the look-back period.
 The delegation agreement describes all delegated PHM activities. A generic policy statement about the content of delegated arrangements does not meet this element.

Factor 1: Mutual agreement

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

Factor 2: Assigning responsibilities

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the PHM activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
- The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other PHM functions not specified in this agreement as the delegate’s responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

Factor 3: Reporting

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about PHM delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited/Certified delegates.

Factor 4: Performance monitoring

The delegation agreement specifies how the organization evaluates the delegate’s performance.

Factor 5: Consequences for failure to perform

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples

None.

Element B: Provision of Member Data to the Delegate—Refer to Appendix 1 for points

The organization provides the following information to its delegates when requested:

1. Member experience data, if applicable.
2. Clinical performance data.

Scoring	100%	80%	50%	20%	0%
	The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

NCQA reviews a sample of up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. NCQA reviews the organization's process for sharing information with its delegates.

For First Surveys and Renewal Surveys, NCQA also reviews evidence that the organization provides the delegate with direct access to or shared the information with its delegates when requested throughout the look-back period.

The score for the element is the average of the scores for all delegates.

Look-back period *For Interim and First Surveys:* 6 months.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 12 months for all other PHM activities.

Explanation **This element may not be delegated.**

If the organization delegates PHM activities, it allows the delegate to collect performance data necessary to assess member experience and clinical performance, as applicable. If the organization does not allow the delegate to collect data from members or practitioners directly, it provides data to the delegate to assess its performance.

NCQA scores this element "Yes" if the organization allows the delegate to collect performance data directly or provides data to the delegate.

Factor 1: Member experience data

The organization provides data from complaints, CAHPS 5.0H survey results and other data collected on members' experience with the delegate's services.

Factor 2: Clinical performance data

The organization provides data to the delegate on HEDIS measures, claims and other clinical data collected by the organization. The organization may provide data feeds for relevant claims data or provide results of relevant clinical performance measures.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples None.

Element C: Provisions for PHI—Refer to Appendix 1 for points

If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions:

1. A list of the allowed uses of PHI.
2. A description of delegate safeguards to protect the information from inappropriate use or further disclosure.
3. A stipulation that the delegate ensures that subdelegates have similar safeguards.
4. A stipulation that the delegate provides individuals with access to their PHI.
5. A stipulation that the delegate informs the organization if inappropriate use of the information occurs.
6. A stipulation that the delegate ensures that PHI is returned, destroyed or protected if the delegation agreement ends.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 6 factors	The organization meets 4-5 factors	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
 NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.
 The score for the element is the average of the scores for all delegates.

Look-back period *For Interim Surveys and First Surveys: 6 months.*
For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation **This element may not be delegated.**
 This element applies to agreements that are in effect within the look-back period.

Factor 1: Allowed uses of PHI

The delegation agreement specifies PHI the delegate may use and disclose, and to whom PHI may be disclosed.

Factors 2, 3: Delegate and subdelegate safeguards

The organization provides reasonable administrative, technical and physical safeguards to ensure PHI confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI.

Factor 4: Access to PHI

No additional explanation required.

Factor 5: Inappropriate use of PHI

The agreement specifies procedures for delegates to identify and report unauthorized access, use, disclosure, modification or destruction of PHI and the systems used to access or store PHI.

Factor 6: Disposal of PHI

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements do not involve the use, creation or disclosure of PHI in any form.
- The agreement states that the delegation arrangement does not involve PHI.
- Delegation arrangements are with covered entities.

Examples None.

Element D: Predelegation Evaluation—Refer to Appendix 1 for points

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Scoring	100%	80%	50%	20%	0%
	The organization evaluated delegate capacity before delegation began	No scoring option	The organization evaluated delegate capacity after delegation began	No scoring option	The organization did not evaluate delegate capacity

Data source Reports

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
 NCQA reviews the organization’s predelegation evaluation for up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.
 The score for the element is the average of the scores for all delegates.

Look-back period *For Interim and First Surveys: 6 months.*
For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 12 months for all other PHM activities.

Explanation **This element may not be delegated.**

NCQA-Accredited/Certified delegates
 NCQA scores this element 100% if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Predelegation evaluation
 The organization evaluated the delegate’s capacity to meet NCQA requirements within the prescribed look-back periods prior to implementing delegation.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the prescribed look-back period, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional PHM activities less than 6 months or 12 months, as prescribed by the look-back period, prior to the survey date, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaborative. An organization may collaborate in a statewide, predelegation evaluation with other organizations that have overlapping practitioner and provider networks. The organizations in the collaborative use the same audit tool and share data.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element E: Review of PHM Program—Refer to Appendix 1 for points

For arrangements in effect for 12 months or longer, the organization:

1. Annually reviews its delegate’s PHM program.
2. Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.
3. Annually evaluates delegate performance against NCQA standards for delegated activities.
4. Semiannually evaluates regular reports, as specified in Element A.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Reports

Scope of review *Factor 1 applies to Interim Surveys, First Surveys and Renewal Surveys.
All factors in this element apply to First Surveys and Renewal Surveys.*

NCQA reviews a sample from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For *Interim Surveys*, NCQA reviews the organization's review of the delegate's PHM program.

For *First Surveys*, NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation.

For *Renewal Surveys*, NCQA reviews the organization's most recent and previous year's annual reviews, audits, performance evaluations and four semiannual evaluations

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 6 months for all other PHM activities.

For Renewal Surveys: Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA scores factor 2 and 3 “yes” if all delegates are NCQA NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Factor 1: Review of the PHM program

Appropriate organization staff or committee reviews the delegate's PHM program. At a minimum, the organization reviews parts of the PHM program that apply to the delegated functions.

Factor 2: Annual file audit

If the organization delegates complex case management , it audits the delegate's complex case management files against NCQA standards. The organization uses either of the following to audit the files:

- 5 percent or 50 of its files, whichever is less.
- The NCQA “8/30 methodology” available at <http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx>

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

Factor 3: Annual evaluation

No additional explanation required.

Factor 4: Evaluation of reports

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if the organization does not delegate complex case management activities.

Factors 2–4 are NA for Interim Surveys.

Examples

None.

Element F: Opportunities for Improvement—Refer to Appendix 1 for points

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Scoring	100%	80%	50%	20%	0%
	At least once in each of the past 2 years that the delegation arrangement has been in effect, the organization has acted on identified problems, if any	No scoring option	The organization has taken inappropriate or weak action, or has taken action only in the past year	No scoring option	The organization has taken no action on identified problems

Data source Documented process, Reports, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews reports for opportunities for improvement if applicable from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For *First Surveys*, NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For *Renewal Surveys*, NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period *For First Surveys:* At least once during the prior year.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation **This element may not be delegated.**

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
 - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.

Population Health Management

Standards for Population Health Management

<i>PHM 1: PHM Strategy</i>	
Element A: Strategy Description.....	125
Element B: Informing Members.....	129
<i>PHM 2: Population Identification</i>	
Element A: Data Integration.....	131
Element B: Population Assessment.....	133
Element C: Activities and Resources.....	136
Element D: Segmentation.....	137
<i>PHM 3: Delivery System Supports</i>	
Element A: Practitioner or Provider Support.....	140
Element B: Value-Based Payment Arrangements.....	144
<i>PHM 4: Wellness and Prevention</i>	
Element A: Health Appraisal Components.....	146
Element B: Health Appraisal Disclosure.....	148
Element C: Health Appraisal Scope.....	150
Element D: Health Appraisal Results.....	152
Element E: Health Appraisal Format.....	154
Element F: Frequency of Health Appraisal Completion.....	155
Element G: Health Appraisal Review and Update Process.....	156
Element H: Topics of Self-Management Tools.....	157
Element I: Usability Testing of Self-Management Tools.....	158
Element J: Review and Update Process for Self-Management Tools.....	160
Element K: Self-Management Tool Formats.....	161
<i>PHM 5: Complex Case Management</i>	
Element A: Access to Case Management.....	162
Element B: Case Management Systems.....	164
Element C: Case Management Process.....	165
Element D: Initial Assessment.....	171
Element E: Case Management—Ongoing Management.....	175
Element F: Experience With Case Management.....	179
<i>PHM 6: Population Health Management Impact</i>	
Element A: Measuring Effectiveness.....	182
Element B: Improvement and Action.....	185
<i>PHM 7: Delegation of PHM</i>	
Element A: Delegation Agreement.....	186
Element B: Predelegation Evaluation.....	188
Element C: Review of PHM Program.....	190
Element D: Opportunities for Improvement.....	192

PHM 1: PHM Strategy—Refer to Appendix 1 for points

The organization outlines its population health management (PHM) strategy for meeting the care needs of its member population.

Intent

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

Summary of Changes

Clarifications

- Added “in place throughout the look-back period” to the scope of review for documented process (Element A).
- Revised the look-back period for Renewal Surveys from 6 months to 12 months (Element A).
- Moved the Explanation text regarding the four areas of focus to the subsection *Factors 1, 2: Four areas of focus* to clarify that the language applies to factors 1 and 2 (Element A).
- Added an example regarding clinical safety to the subhead *Patient safety* in the examples for factors 1,2 (Element A).
- Added “materials” as a data source and revised the scope of review to remove the reference to July 1, 2019 (Element B).
- Revised the look-back period for Renewal Surveys to 6 months for materials and 12 months for documented process (Element B).

Element A: Strategy Description—Refer to Appendix 1 for points

The strategy describes:

1. Goals and populations targeted for each of the four areas of focus.*
2. Programs or services offered to members.
3. Activities that are not direct member interventions.
4. How member programs are coordinated.
5. How members are informed about available PHM programs.

*Critical factors: Score cannot exceed 20% if critical factors are not met.

	100%	80%	50%	20%	0%
Scoring	The organization meets all 5 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

NCQA reviews a description of the organization’s comprehensive PHM strategy that is in place throughout the look-back period. The strategy may be fully described in one document or the organization may provide a summary document with references or links to supporting documents provided in other PHM elements.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

This element is a structural requirement. The organization must present its own materials.

Factor 1 is a critical factor that the organization must meet to score higher than 20% on this element.

Factors 1, 2: Four areas of focus

The organization has a comprehensive strategy for population health management that, *at a minimum*, addresses member needs in the following four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

At a minimum, the description includes the following for each of the four areas of focus:

- A goal (factor 1).
- A target population (factor 1).
- A program or service (factor 2).

Goals are measurable and specific to a target population. A program is a collection of services or activities to manage member health. A service is an activity or intervention in which individuals can participate to help reach a specified health goal.

Factor 3: Activities that are not direct member interventions

The organization describes all activities it conducts in support of PHM programs or services not directed at individual members. An activity may apply to more than one areas of focus. The organization has at least one activity in place.

Factor 4: Coordination of member programs

The organization coordinates programs or services it directs and those facilitated by providers, external management programs and other entities. The PHM strategy describes how the organization coordinates programs across settings, providers and levels of care to minimize the confusion for members being contacted from multiple sources. Coordination activities are not required to be exclusive to one area of focus and may apply across the continuum of care and to other organization initiatives.

Factor 5: Informing members

The organization describes its process for informing members about all available PHM programs and services, regardless of level of contact. The organization may make the information available on its website; by mail, email, text or other mobile application; by telephone; or in person.

Exceptions

None.

Examples**Factors 1, 2: Goals, target populations, opportunities, programs or services***Keeping members healthy*

- Goal: 55 percent of members in the target population report receiving annual influenza vaccinations.
 - Target populations:
 - Members with no risk factors.
 - Members enrolled in wellness programs.
 - *Programs or services*: Community flu clinics, email and mail reminders, radio and TV advertisement reminding the public to get vaccinated.
- Goal: 10 percent of the target population reports meeting a self-determined weight-loss goal.
 - *Target population*: Members with BMI 27 or above enrolled in wellness program.
 - *Programs or services*: Wellness program focusing on weight management.

Managing members with emerging risk

- Goal: Lower or maintain HbA1c control <8.0% rate by 2 percent compared to baseline.
 - Target population:
 - Members discovered to be at risk for diabetes during predictive analysis.
 - Members with controlled diabetes.
 - *Programs or services*: Diabetes management program.
- Goal: Improve asthma medication ratio (total rate) by 3 percent compared to baseline.
 - *Target population*: Diagnosed asthmatic members 18–64 years of age with at least one outpatient visit in the prior year.
 - *Programs or services*: Condition management program.

Patient safety

- Goal: Improve the safety of high-alert medications.
 - *Target population*: Members who are prescribed high-alert medications and receive home health care.
 - *Activity*: Collaborate with community-based organizations to complete medication reconciliation during home visits.
- Goal: Improve clinical safety.
 - *Target population*: Members receiving in-patient surgical procedures.
 - *Activity*: Distribute information to members that facilitates informed decisions regarding care such as:
 - Questions to ask surgeons before surgery.
 - Questions to ask the practitioner about medication interactions.
 - Resources needed at discharge such as appropriate nutrition or transportation assistance.
 - *Activity*: Implement follow-up system to contact members after discharge to confirm receipt of care and post-surgical care instructions.

Outcomes across settings

- Goal: Reduce 30-day readmission rate after hospital stay (all causes) of 3 days or more by 2 percentage points compared to baseline.
 - *Target population*: Members admitted through the emergency department who remain in the hospital for three days or more.
 - *Program or services*: Organization-based case manager conducts a follow-up interview post-stay to coordinate needed care.
 - *Activity*: Collaborate with network hospitals to develop and implement a discharge planning process.

Managing multiple chronic illnesses

- Goal: Reduce ED visits in target population by 3 percentage points in 12 months.
 - *Target population*: Members with uncontrolled diabetes and cardiac episodes that led to hospital stay of two days or more.
 - *Programs or services*: Complex case management.
- Goal: Improve antidepressant medication adherence rate.
 - *Target population*: Members with multiple behavioral health diagnoses, including severe depression, who lack access to behavioral health specialists.
 - *Programs or services*: Complex case management with behavioral health telehealth counseling component.

Factor 3: Activities that are not direct member interventions

- Share data and information with practitioners.
- Interactions and integration with delivery systems (e.g., contract with accountable care organizations).
- Provide technology support to or integrate with patient-centered medical homes.
- Integrate with community resources.
- Value-based payment arrangements.
- Collaborate with community-based organizations and hospitals to improve transitions of care from the post-acute setting to the home.
- Collaborate with hospitals to improve patient safety.

Element B: Informing Members—Refer to Appendix 1 for points

The organization informs members eligible for programs that include interactive contact:

1. How members become eligible to participate.
2. How to use program services.
3. How to opt in or opt out of the program.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 3 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
For All Surveys: NCQA reviews the organization's policies and procedures in effect during the look-back period from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

For First Surveys and Renewal Surveys: NCQA also reviews materials sent to members from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

The score for the element is the average of the scores for all programs or services.

Look-back period *For Interim Surveys:* Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 6 months for materials; 12 months for documented process.

Explanation This element applies to PHM programs or services in the PHM strategy that require interactive contact with members, including those offered directly by the organization.

Interactive contact

Programs with interactive contact have two-way interaction between the organization and the member, during which the member receives self-management support, health education or care coordination through one of the following methods:

- Telephone.
- In-person contact (i.e., individual or group).
- Online contact:
 - Interactive web-based module.
 - Live chat.
 - Secure email.
 - Video conference.

Interactive contact does not include:

- Completion of a health appraisal.
- Contacts made only to make an appointment, leave a message or verify receipt of materials.

Distribution of materials

The organization distributes information to members by mail, fax or email, or through messages to members' mobile devices, through real-time conversation or on its website, if it informs members that the information is available online. If the organization posts the information on its website, it notifies members that the information is available through another method listed above. The organization mails the information to members who do not have fax, email, telephone, mobile device or internet access. If the organization uses telephone or other verbal conversations, it provides a transcript of the conversation or script used to guide the conversation.

Factors 1–3: Member information

The organization provides eligible members with information on specific programs with interactive contact.

Exceptions

None.

Examples

Dear Member,

Because you had a recent hospital stay, you have been selected to participate in our Transitions Case Management Program. Sometime in the next three days, a nurse will call you to make sure you understand the instructions you were given when you left the hospital, and to make sure you have an appropriate provider to see for follow-up care.

To contact the nurse directly, call 555-555-1234. If you do not want to participate in the Transitions Case Management Program, let us know by calling 555-123-4567.

PHM 2: Population Identification—Refer to Appendix 1 for points

The organization systematically collects, integrates and assesses member data to inform its population health management programs.

Intent

The organization assesses the needs of its population and determines actionable categories for appropriate intervention.

Summary of Changes

Clarifications

- Revised the look-back period for First Surveys to 6 months and for Renewal Surveys to 12 months (Element A).
- Revised the first sentence of the Explanation for *Factor 1: Characteristics and needs* to state, “To determine the necessary structure and resources for its PHM program, the organization assesses the characteristics and needs of the member population” (Element B).
- Revised the look-back period for First and Renewal Surveys to state “at least once during the prior year” (Element C).
- Clarified the scope of review to state that NCQA reviews the most recent report for First Surveys and Renewal Surveys (Element D).
- Clarified the Explanation text under the subhead *Reports* to state that data may total more than 100 percent (Element D).

Element A: Data Integration—Refer to Appendix 1 for points

The organization integrates the following data to use for population health management functions:

1. Medical and behavioral claims or encounters.
2. Pharmacy claims.
3. Laboratory results.
4. Health appraisal results.
5. Electronic health records.
6. Health services programs within the organization.
7. Advanced data sources.

Scoring

100%	80%	50%	20%	0%
The organization meets 5-7 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review	<p><i>This element applies to Interim Surveys, First Surveys and Renewal Surveys.</i></p> <p><i>For Interim Surveys:</i> NCQA reviews the organization's policies and procedures for the types and sources of integrated data.</p> <p><i>For First and Renewal Surveys:</i> NCQA reviews reports or materials (e.g., screenshots) for evidence that the organization integrated data types and data from sources listed in the factors. The organization may submit multiple examples that collectively demonstrate integration from all data types and sources, or may submit one example that demonstrates integration of all data types and sources.</p>
Look-back period	<p><i>For Interim Surveys:</i> Prior to the survey date.</p> <p><i>For First Surveys:</i> 6 months.</p> <p><i>For Renewal Surveys:</i> 12 months.</p>
Explanation	<p>Data integration is combining data from multiple sources databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy), across care sites (e.g., inpatient, ambulatory, home) and across domains (e.g., clinical, business, operational). The organization may limit data integration to the minimum necessary to identify eligible members and determine and support their care needs.</p> <p>Factor 1: Claims or encounter data</p> <p>Requires both medical and behavioral claims or encounters. Behavioral claim data are not required if all purchasers of the organization's services carve out behavioral healthcare services (i.e., contract for a service or function to be performed by an entity other than the organization).</p> <p>Factors 2, 3</p> <p>No additional explanation required.</p> <p>Factor 4: Health appraisals</p> <p>The organization demonstrates the capability to integrate data from health appraisals and health appraisals should be integrated if elected by plan sponsor.</p> <p>Factor 5: Electronic health records</p> <p>Integrating EHR data from one practice or provider meets the intent of this requirement.</p> <p>Factor 6: Health service programs within the organization.</p> <p>Relevant organization programs may include utilization management, care management or wellness coaching programs. The organization has a process for integrating relevant or necessary data from other programs to support identification of eligible members and determining care needs. Health appraisal results do not meet this factor.</p> <p>Factor 7: Advanced data sources</p> <p>Advanced data sources aggregate data from multiple entities such as all-payer claims systems, regional health information exchanges and other community collaboratives. The organization must have access to the data to meet the intent of this factor.</p> <p>Exceptions</p> <p>None.</p>

Examples**EHR integration**

- Direct link from EHRs to data warehouse.
- Normalized data transfer or other method of transferring data from practitioner or provider EHRs.

Health services programs within the organization

- Case management.
- UM programs.
 - Daily hospital census data captured through UM.
 - Diagnosis and treatment options based on prior authorization data.
- Health information line.

Advanced data sources may require two-way data transfer. The organization and other entities can submit data to the source and can use data from the same source. These include but are not limited to:

- Regional, community or health system Health Information Exchanges (HIE).
- All-payer databases.
- Integrated data warehouses between providers, practitioners, and the organization with all parties contributing to and using data from the warehouse.
- State or regionwide immunization registries.

Element B: Population Assessment—Refer to Appendix 1 for points

The organization annually:

1. Assesses the characteristics and needs, including social determinants of health, of its member population.
2. Identifies and assesses the needs of relevant member subpopulations.
3. Assesses the needs of child and adolescent members.
4. Assesses the needs of members with disabilities.
5. Assesses the needs of members with serious and persistent mental illness (SPMI).

Scoring

100%	80%	50%	20%	0%
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys, NCQA reviews the organization's policies and procedures

For First and Renewal Surveys, NCQA reviews the organization's most recent annual assessment reports.

Look-back period *For Interim Surveys:* Prior to the survey date.
For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation The organization uses data at its disposal (e.g., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population.

Factor 1: Characteristics and needs

To determine the necessary structure and resources for its PHM program, the organization assesses the characteristics and needs of the member population. The assessment includes the characteristics of the population and associated needs identified.

At a minimum, the organization assesses social determinants of health. Social determinants of health¹ are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. The organization defines the determinants assessed.

Characteristics that define a relevant population may also include, but are not limited to:

- Federal or state program eligibility (e.g., Medicare or Medicaid, SSI, dual-eligible).
- Multiple chronic conditions or severe injuries.
- At-risk ethnic, language or racial group.

Factor 2: Identifying and assessing characteristics and needs of subpopulations

The organization uses the assessment of the member population to identify and assess relevant subpopulations.

Factor 3: Needs of children and adolescents

The organization assesses the needs of members 2–19 years of age (children and adolescents). If the organization's regulatory agency's definition of children and adolescents is different from NCQA's, the organization uses the regulatory agency's definition. The organization provides the definition to NCQA, which determines whether the organization's needs assessment is consistent with the definition.

Factors 4, 5: Individuals with disabilities and SPMI

Members with disabilities and with serious and persistent mental illness (SPMI) have particularly acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases).

Exception

Factor 3 is NA for the Medicare product line.

¹<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

Examples**Factors 1, 2: Relevant characteristics**

- Social determinants of health include:
 - Resources to meet daily needs.
 - Safe housing.
 - Local food markets.
 - Access to educational, economic and job opportunities.
 - Access to health care services.
 - Quality of education and job training.
 - Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
 - Transportation options.
 - Public safety.
 - Social support.
 - Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
 - Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community).
 - Socioeconomic conditions.
 - Residential segregation.
 - Language/literacy.
 - Access to mass media and emerging technologies.
 - Culture.
- Physical determinants include:
 - Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change).
 - Built environment, such as buildings, sidewalks, bike lanes and roads.
 - Worksites, schools and recreational settings.
 - Housing and community design.
 - Exposure to toxic substances and other physical hazards.
 - Physical barriers, especially for people with disabilities.
 - Aesthetic elements (e.g., good lighting, trees, benches).
 - Eligibility categories included in Medicaid managed care (e.g., TANF, low-income, SSI, other disabled).
 - Nature and extent of carved out benefits.
 - Type of Special Needs Plan (SNP) (e.g., dual eligible, institutional, chronic).
 - Race/ethnicity and language preference.

Element C: Activities and Resources—Refer to Appendix 1 for points

The organization annually uses the population assessment to:

1. Review and update its PHM activities to address member needs.
2. Review and update its PHM resources to address member needs.
3. Review community resources for integration into program offerings to address member needs.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
For Interim Surveys: NCQA reviews the organization's policies and procedures.
For First and Renewal Surveys: NCQA reviews committee minutes or similar documents showing process and resource review and updates.

Look-back period *For Interim Surveys:* Prior to the survey date.
For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation **Factors 1, 2: PHM activities and resources**

The organization uses assessment results to review and update its PHM structure, strategy (including programs, services, activities) and resources (e.g., staffing ratios, clinical qualifications, job training, external resource needs and contacts, cultural competency) to meet member needs.

Factor 3: Community resources

The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment.

Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources.

Exceptions

None.

Examples **Community resources and programs**

- Population assessment determines a high population of elderly members without social supports. The organization partners with the Area Agency on Aging to help with transportation and meal delivery.
- Connect at-risk members with shelters.
- Connect food-insecure members with food security programs or sponsor community gardens.

- Sponsor or set up fresh food markets in communities lacking access to fresh produce.
- Participate as a community partner in healthy community planning.
- Partner with community organizations promoting healthy behavior learning opportunities (e.g., nutritional classes at local supermarkets, free fitness classes).
- Support community improvement activities by attending planning meetings or sponsoring improvement activities and efforts.
- Social workers or other community health workers that contact members to connect them with appropriate community resources.
- Referrals to community resources based on member need.
- Discounts to health clubs or fitness classes.

Element D: Segmentation—Refer to Appendix 1 for points

At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.

Scoring	100%	80%	50%	20%	0%
	The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

For All Surveys: NCQA reviews a description of the method used.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's most recent report demonstrating implementation.

Look-back period *For Interim Surveys:* Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation Population segmentation divides the population into meaningful subset using information collected through population assessment and other data sources.

Risk stratification uses the potential risk or risk status of individuals to assign them to tiers or subsets. Members in specific subsets may be eligible for programs or receive specific services.

Segmentation and risk stratification result in the categorization of individuals with care needs at all levels and intensities. Segmentation and risk stratification is a means of targeting resources and interventions to individuals who can most benefit from them. Either process may be used to meet this element.

Methodology

The organization describes its method for segmenting or stratifying its membership, including the subsets to which members are assigned (e.g., high-risk pregnancy, multiple inpatient admissions). The organization may use more than one risk stratification methods to determine actionable subsets.

Segmentation and stratification use population assessment and data integration findings (e.g., clinical and behavioral data, population and social needs) to determine subsets and programs or services for which members are eligible. Although these methods may include utilization/resource use or cost information. Methods that use only cost information for segmentation and stratification do not meet the intent of this element.

Reports

The organization provides reports specifying the number of members in each category and the programs or services for which they are eligible. Reports may be a “point-in-time” snapshot during the look-back period.

Reports reflect the number of members eligible for each PHM program. They display data in raw numbers and as a percentage of the total enrolled member population, and may total more than 100% if members fall into more than one category.

PHM programs or services provided to members include, but are not limited to, complex case management.

Exceptions

None.

Examples

Health Plan A: Commercial HMO/PPO

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Pregnancy: Over 35 years, multiple gestation	High-risk pregnancy care management	55	0.5%
Type I Diabetes: Moderate risk	Diabetes management	660	6%
Tobacco use	Smoking cessation	110	1%
Behavioral health diagnosis in ages 15-19, rural	Telephone or video behavioral health counseling sessions	330	3%
Women of child-bearing age	Targeted women’s health newsletter	3,850	35%
No risk factors	Routine member newsletters	2,750	25%
No associated data	None	3,850	35%

Health Plan A: Medicare

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Multiple chronic conditions	Complex case management: Over 65	2,000	5%
Over 65, needs assistance with 2 or more ADLs	Long-term services and supports	2,800	7%
COPD: High risk	Complex case management: Over 65	1,600	4%
Osteoporosis: High-risk women	Targeted member newsletter	8,800	22%
BMI over 30	Weight management program	4,800	12%
No risk factors	Routine member newsletters	12,000	30%
No associated data	None	8,000	20%

PHM 3: Delivery System Supports—Refer to Appendix 1 for points

The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements.

Intent

The organization works with practitioners or providers to achieve population health management goals.

Summary of Changes

Clarifications

- Added “in place throughout the look-back period” to the scope of review for documented process (Element A).
- Revised the look-back period for Renewal Surveys from 6 months to 12 months (Element A).
- Moved the examples for *Factor 3: Providing practice transformation support to primary care practitioners* as the third paragraph under *Related information* (Element A).
- Revised the scoring language for 100% and 0% (Element B).
- Revised the look-back period for First Surveys to 6 months and Renewal Surveys to 12 months (Element B).

Element A: Practitioner or Provider Support—Refer to Appendix 1 for points

The organization supports practitioners or providers in its network to achieve population health management goals by:

1. Sharing data.
2. Offering evidence-based or certified decision-making aids.
3. Providing practice transformation support to primary care practitioners.
4. Providing comparative quality information on selected specialties.
5. Providing comparative pricing information on selected services.
6. One additional activity to support practitioners or providers in achieving PHM goals.

	100%	80%	50%	20%	0%
Scoring	The organization meets 3-6 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
For Interim Surveys: NCQA reviews the organization’s description of how it supports practitioners or providers.
For First Surveys and Renewal Surveys: NCQA reviews the organization’s description that is in place throughout the look-back period of how it supports practitioners or providers and materials demonstrating implementation.

Look-back period	<p><i>For Interim Surveys:</i> Prior to the survey date.</p> <p><i>For First Surveys:</i> 6 months.</p> <p><i>For Renewal Surveys:</i> 12 months.</p>
Explanation	<p>The organization identifies and implements activities that support practitioners and providers in meeting population health goals. Practitioners and providers may include accountable care entities, primary or specialty practitioners, PCMHs, or other providers included in the organization's network. Organizations may determine the practitioners or providers they support.</p> <p>Factor 1: Data sharing</p> <p>Data sharing is transmission of member data from the health plan to the provider or practitioner that assists in delivering services, programs, or care to the member. The organization determines the frequency for sharing data.</p> <p>Factor 2: Evidence-based or certified decision-making aids</p> <p>Shared decision-making (SDM) aids provide information about treatment options and outcomes. SDM aids are designed to complement practitioner counselling, not replace it. SDM aids facilitate member and practitioner discussion on treatment decisions.</p> <p>SDM aids may focus on preference-sensitive conditions, chronic care management or lifestyle changes, to encourage patient commitment to self-care and treatment regimens.</p> <p>SDM aids are certified by a third party that evaluates quality, or are created using evidence-based criteria. If certified, the organization provides information about how, when, under what conditions and to whom certified SDM aids are offered. If created using evidence-based criteria, criteria must be cited. At least one certified or evidence-based SDM aid must be offered to meet the intent.</p> <p>Factor 3: Practice transformation support</p> <p>Transformation includes movement to becoming a more-integrated or advanced practice (e.g., ACO, PCMH) and toward value-based care delivery.</p> <p>The organization provides documentation that it supports practice transformation.</p> <p>Factor 4: Comparative quality and cost information on selected specialties</p> <p>The organization provides comparative quality information about selected specialties to practitioners or providers and reports cost information if it is available. Comparative cost information may be cost or efficiency information and may be represented as relative rates or as a relative range.</p> <p>Comparative quality information may be reported without cost information if cost information is not available.</p> <p>To meet this requirement, the organization must provide quality information (with or without cost information) for at least one specialty and show that it has provided the information to at least one provider that refers members to the specialty.</p> <p>Factor 5: Comparative pricing information for selected services</p> <p>Comparative pricing information may contain actual unit prices per service or relative prices per service, compared across practitioners or providers.</p>

To meet this requirement, the organization must provide comparative pricing information on at least one service and show that it has provided the information to at least one provider that prescribes the service to members.

Factor 6: Another activity

Other activities include those that cannot be categorized in factors 1–5. The organization describes the activity, how it supports providers or practitioners and how it contributes to achieving PHM goals.

Data sharing activities that use a different method of data sharing from that in factor 1 may be used to meet this factor. The method indicates how data are shared.

Exceptions

None.

Related information

Partners in Quality. The organization receives automatic credit for factors 3 and 6 if it is an NCQA-designated Partner in Quality.

The organization must provide documentation of its status.

Practice transformation support. The organization can support its practitioners/providers in meeting their population health management goals by any of the following methods:

- Incentive payments for PCMH arrangement.
- Technology support.
- Best practices.
- Supportive educational information, including webinars or other education sessions.
- Help with application fees for NCQA PCMH Recognition (beyond the NCQA program's sponsor discount).
- Help practices transform into a medical home.
- Provide incentives for NCQA PCMH Recognition, such as pay-for-performance.
- Use NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network.

Examples**Factor 1**

- Sharing patient-specific data listed below that the practitioner or provider does not have access to:
 - Pharmacy data.
 - ED reports.
 - Enrollment data.
 - Eligibility in the organization's intervention programs (e.g., enrollment in a wellness or complex case management program).
 - Reports on gaps in preventive services (e.g., a missed mammogram, need for a colonoscopy).
 - Claims data indicate if these services were not done; practitioners or staff can remind members to receive services.
 - Claims data.
 - Data generated by specialists, urgent care clinics or other care providers.

- Methods of data sharing:
 - Transmitted through electronic channels as “raw” data to practitioners who conduct data analysis to drive improved patient outcomes.
 - Practitioner or provider portals that have accessible patient-specific data.
 - Submit data to a regional HIE.
 - Reports created for practitioners or providers about patients or the attributed population.
 - A direct link to EHRs, to automatically populate recent claims for relevant information and alert practitioners or providers to changes in a patient’s health status.

Factor 2

- Certification bodies:
 - National Quality Forum.
 - Washington State Health Care Authority.

Factor 4

- Selected specialties:
 - Specialties that a primary care practitioner refers members to most frequently.
- Quality information:
 - Organization-developed performance measures based on evidence-based guidelines.
 - AHRQ patient safety indicators associated with a provider.
 - In-patient quality indicators.
 - Risk-adjusted measures of mortality, complications and readmission.
 - Physician Quality Reporting System (PQRS) measures.
 - Non-PQRS Qualified Clinical Data Registry (QCDR) measures.
 - CAHPS measures.
 - The American Medical Association’s Physician Consortium for Performance Improvement (PCPI) measures.
 - Cost information:
 - Relative cost of episode of care.
 - Relative cost of practitioner services.
 - In-office procedures.
 - Care pattern reports that include quality and cost information.

Factor 5

- Selected services:
 - Services for which the organization has unit price information.
 - Services commonly requested by primary care practitioners that are not conducted in-office.
 - Radiology services.
 - Outpatient procedures.
 - Pharmaceutical costs.

Factor 6

- Health plan staff located full-time at the provider facility to assist with member issues.
- The ability to view evidence-based practice guidelines on demand (e.g., practitioner portal).
- Incentives for two-way data sharing.

Element B: Value-Based Payment Arrangements—Refer to Appendix 1 for points

The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Scoring	100%	80%	50%	20%	0%
	The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Reports

Scope of review *This element applies to First Surveys and Renewal Surveys.*
For First Surveys and Renewal Surveys: NCQA reviews the VBP worksheet to demonstrate that it has VBP arrangements in each product line.
 The score for the element is the average of the scores for all product lines.

Look-back period *For First Surveys:* 6 months.
For Renewal Surveys: 12 months.

Explanation This element may not be delegated.

There is broad consensus that payment models need to evolve from payment based on volume of services provided to models that consider value or outcomes. The fee-for-service (FFS) model does not adequately address the importance of non-visit-based care, care coordination and other functions that are proven to support achievement of population health goals.

The organization demonstrates that it has at least one VBP arrangement and reports the percentage of total payments made to providers and practitioners associated with each type of VBP arrangement.

The organization uses the following VBP types, sourced from *CMS Report to Congress: Alternative Payment Models and Medicare Advantage* to report arrangements to NCQA. The organization is not required to use them for internal purposes. If the organization uses different labels for its VBP arrangements, it categorizes them using the NCQA provided definitions.

- *Pay-for-performance (P4P):* Payments are for individual units of service and triggered by care delivery, as under the FFS approach, but providers or practitioners can qualify for bonuses or be subject to penalties for cost and/or quality related performance. Foundational payments or payments for supplemental services also fall under this payment approach.
- *Shared savings:* Payments are FFS, but provider/practitioners who keep medical costs below the organization's established expectations retain a portion (up to 100 percent) of the savings generated. Providers/practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the portion of total savings the provider or practitioner retains.
- *Shared risk:* Payments are FFS, but providers/practitioners whose medical costs are above expectations, as predetermined by the organization, are liable for a portion (up to 100 percent) of cost overruns.

- *Two-sided risk sharing*: Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.
- *Capitation/population-based payment*: Payments are not tied to delivery of services, but take the form of a fixed per patient, per unit of time sum paid in advance to the provider/practitioner for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/ population-based payment amount and retains all (or most) savings if costs fall below the capitation/population-based payment amount. Payments, penalties and awards depend on quality of care.

Calculating VBP reach

Percentage of payments is calculated by:

- *Numerator*: Total payments made to network practitioners/providers in contracts tied to VBP arrangement(s), divided by,
- *Denominator*: Total payments made to all network providers/practitioners in all contracts, including traditional FFS.

The percentage of payments can reflect the current year to date or the previous year's payments, and can be based on allowed amounts, actual payments or forecasted payments.

Types of providers/practitioners

For each type of VBP arrangement, the organization reports a percentage of total payments and indicates the provider/practitioner types included in the arrangement.

Exceptions

None.

Examples

None.

PHM 4: Wellness and Prevention—Refer to Appendix 1 for points

The organization offers wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk.

Intent

The organization helps adult members identify and manage health risks through evidence-based tools that maintain member privacy and explain how the organization uses collected information.

Summary of Changes

Clarifications

- Revised the look-back period from 6 months to 12 months for Renewal Surveys, for factor 14 (Element C).
- Added “throughout the look-back period” to the scope of review for documented process (Elements I, J).
- Clarified in the Explanation for *Factor 2: Members with special needs* that vision and hearing must be addressed to receive credit for the factor (Element I).

Element A: Health Appraisal Components—Refer to Appendix 1 for points

The organization’s HA includes the following information:

1. Questions on demographics.
2. Questions on health history, including chronic illness and current treatment.
3. Questions on self-perceived health status.
4. Questions to identify effective behavioral change strategies.
5. Questions to identify members with special hearing and vision needs and language preference.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization’s HA that is available throughout the look-back period.

If the organization can provide a “test” or “demo” log-on ID, NCQA reviews the organization’s performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization’s website or screen shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period	<p><i>For First Surveys:</i> 6 months. <i>For Renewal Surveys:</i> 24 months.</p>
Explanation	<p>The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.</p> <p>HAs help identify at-risk and high-risk members, determine focus areas for timely intervention and prevention efforts and monitor risk change over time. They are an educational tool that can engage members in making healthy behavior changes.</p> <p>The questions required by the factors gather information to determine members' overall risk or wellness, allowing the organization to tailor services and activities.</p> <p>Factor 1: Demographics</p> <p>Member demographics include age, gender and ethnicity.</p> <p>Factor 2: Personal health history</p> <p>No additional explanation required.</p> <p>Factor 3: Self-perceived health status</p> <p>Self-perceived health status is a members' assessment of current health status and well-being.</p> <p>Factor 4: Behavioral change strategies</p> <p>The HA includes questions to help guide changes in behavior and reduce risk.</p> <p>Factor 5: Special needs assessment</p> <p>The HA includes questions that assess hearing and vision impairment and language preferences to help the organization provide special services, materials or equipment to members as needed. To meet this factor, questions must include all three special needs: hearing, vision impairment and language preferences.</p> <p>Exception</p> <p>This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.</p> <p>Related information</p> <p><i>Use of vendors for HA services.</i> If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to <i>Vendor Relationships</i> in Appendix 5.</p>
Examples	<p>Factor 1: Demographics</p> <ul style="list-style-type: none"> • Age. • Gender. • Race or ethnicity. • Level of education. • Level of income. • Marital status. • Number of children.

Factor 2: Personal health history

- Do you have any of the following conditions?
- Have you had any of the following conditions?
- Do you smoke or use tobacco? How long has it been since you smoked or used tobacco?
- When did you last receive the following preventive services or screenings?

Factor 3: Self-perceived health status

- SF 20[®] questions or other questions where participants rate their health status on a relative scale.

Factor 4: Behavioral change theories and models

- Prochaska's Stages of Change.
- Patient Activation Measure.
- Knowledge-Attitude Behavior Model.
- Health Belief Model.
- Theory of Reasoned Action.
- Bandura's Social Cognitive Theory.

Factor 5: Special needs assessment

- Do you have a vision impairment that requires special reading materials?
- Do you have a hearing impairment that requires special equipment?
- Is English your primary language? If not, what language do you prefer to speak?

Element B: Health Appraisal Disclosure—Refer to Appendix 1 for points

The organization's HA includes the following information in easy-to-understand language:

1. How the information obtained from the HA will be used.
2. A list of organizations and individuals who might receive the information, and why.
3. A statement that participants may consent or decline to have information used and disclosed.
4. How the organization assesses member understanding of the language used to meet factors 1–3.

	100%	80%	50%	20%	0%
Scoring	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's HA for factors 1–3 and reviews policies and procedures for factor 4. Both must be available throughout the look-back period.

If the organization can provide a “test” or “demo” log-on ID, NCQA reviews the organization’s performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization’s website or screen shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

Factor 1: Use of HA information

No additional explanation required.

Factor 2: Information recipients

A list of the organizations and individuals who will receive the information, and why, is required. Organizations and individuals are identified by role and are not required to be identified by name.

Factor 3: Right to consent or decline

The HA may include a statement that the member accepts or declines participation or a notice that completion and submission implies consent to the HA’s stated use. If the opportunity to consent or decline is associated with HA completion, members have access to the organization’s definition of “HA completion.” For online consent forms, disclosure information is available in printed form.

Factor 4: Assessing member understanding

The HA is not expected to have language regarding how the organization assesses member understanding of HA disclosure requirements. NCQA reviews the organization’s documented process for assessing member understanding.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor’s HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor’s HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples**Factor 2: Information recipients**

- An organization that contracts directly with an employer or plan sponsor may disclose information to the participant's health plan. Because the employer or plan sponsor could change health plans, the organization may identify that it "disclose[s] information to the participant's health plan," instead of identifying the plan by name.
- An organization that has a direct relationship with practitioners may disclose information to a participant's primary care practitioner. Because the participant might change practitioners, the organization may identify that it "disclose[s] information to the member's primary care physician," instead of identifying the practitioner by name.

Element C: Health Appraisal Scope—Refer to Appendix 1 for points

HAs provided by the organization assess at least the following personal health characteristics and behaviors:

1. Weight.
2. Height.
3. Smoking and tobacco use.
4. Physical activity.
5. Healthy eating.
6. Stress.
7. Productivity or absenteeism.
8. Breast cancer screening.
9. Colorectal cancer screening.
10. Cervical cancer screening.
11. Influenza vaccination.
12. At-risk drinking.
13. Depressive symptoms.
14. Safety behaviors.

Scoring

100%	80%	50%	20%	0%
The organization meets 13-14 factors	The organization meets 11-12 factors	The organization meets 7-10 factors	The organization meets 3-6 factors	The organization meets 0-2 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen

shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months; 12 months for factor 14.

Explanation

The organization offers an HA with questions that address the scope of areas evaluated by this element, even if no employers or plan sponsors purchase an HA that addresses the full scope listed in the factors.

Factors 1–13

No additional explanation required.

Factor 14: Safety behaviors

Safety behaviors include, but are not limited to, wearing protective gear when recommended or wearing seat belts in motor vehicles. Evidence may not reveal a consistent set of validated questions, but safety behavior is closely associated with other modifiable risk areas, where validated questions exist.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Validated survey items. Evidence shows that certain HA items produce valid and reliable results for key health characteristics and behaviors listed in the factors. NCQA recommends that organizations use validated survey items on their HAs. Refer to the *Technical Specifications for Wellness & Health Promotion* publication for suggested validated survey items. The specifications are available through the *Publications and Products* section of the NCQA website.

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Factor 7: Productivity or absenteeism

- Work days missed due to personal or family health issues.
- Time spent on personal or family health issues during the work day.

Element D: Health Appraisal Results—Refer to Appendix 1 for points

Participants receive their HA results, which include the following information in language that is easy to understand:

1. An overall summary of the participant’s risk or wellness profile.
2. A clinical summary report describing individual risk factors.
3. Information on how to reduce risk by changing specific health behaviors.
4. Reference information that can help the participant understand the HA results.
5. A comparison to the individual’s previous results, if applicable.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization’s policies and procedures for evaluating the understandability of HA results and reviews HA results.

If the organization can provide a “test” or “demo” log-on ID, NCQA reviews the organization’s performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization’s website or screen shots of web functionality, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

For factors 2–5, NCQA also reviews HA results for evidence that they contain all the health characteristics and behaviors listed in Element C.

Look-back period *For First Surveys: 6 months.*
For Renewal Surveys: 24 months.

Explanation The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meanings, to the extent practical.

Factor 1: Overall summary of risk and wellness profile

HA results include:

- An evidenced-based summary or profile of the participant’s overall level of risk or wellness.
- The core health areas (healthy weight [BMI] maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, clinical preventive services).

Factor 2: Clinical summary report

A clinical summary report describes the risk factors that the HA identifies and is in a format that can be shared with a participant's practitioner.

Factor 3: Reducing risk and changing behavior

HA results identify specific behaviors that can lower each risk factor and include recommended targets for improvement and information on how to reduce risk.

Factor 4: Reference information

HA results include additional resources or information external to the organization that participants can use to learn more about their specific health risks and behaviors to improve their health and well-being.

Factor 5: Comparing HA results

If a participant previously completed an HA administered by the organization, the organization includes comparison information to the previous HA results in the current report.

Exceptions

Factor 5 is NA if the organization has not previously administered an HA.

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples None.

Element E: Health Appraisal Format—Refer to Appendix 1 for points

The organization makes HAs available in language that is easy to understand, in the following formats:

1. Digital services.
2. In print or by telephone.

Scoring	100%	80%	50%	20%	0%
	The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's policies and procedures for evaluating understandability, digital HA and printed or telephonic HA. Each format must be in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period *For First Surveys: 6 months.*
For Renewal Surveys: 24 months.

Explanation The organization is capable of making HAs available through digital media, printed copies or telephone, even if no employers or plan sponsors purchase HAs in multiple formats.

Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

Factor 1: Digital services

Digital services include online, internet-based access and downloadable applications for smartphones and other devices.

Factor 2: In print or by telephone

The printed version of the HA contains the same content as the web version of the HA.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples None.

Element F: Frequency of Health Appraisal Completion—Refer to Appendix 1 for points

The organization has the capability to administer the HA annually.

Scoring	100%	80%	50%	20%	0%
	The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's policies and procedures for administering annual HAs, or documentation that the organization administered an annual HA.

Look-back period *For First Surveys: At least once during the prior year.
For Renewal Surveys: 24 months.*

Explanation The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples **Evidence of capability to administer**

- Contracts that specify at least annual administration of the HA.
- Reports that demonstrate at least annual administration of the HA.

Element G: Health Appraisal Review and Update Process*—Refer to Appendix 1 for points*

The organization reviews and updates the HA every two years, and more frequently if new evidence is available.

Scoring	100%	80%	50%	20%	0%
	The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's policies and procedures for reviewing and updating its HA. The policies and procedures must be in place throughout the look-back period.

For Renewal Surveys: NCQA also reviews evidence that the organization reviewed and updated the HA every two years or more frequently if new evidence is available that warrants an update.

Look-back period *For First Surveys:* 6 months.
For Renewal Surveys: 24 months.

Explanation No explanation required.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples **Evidence of review**

- Analysis of HA against current or new evidence.
- Documentation in meeting minutes or reports demonstrating review and update of the HA occurred.

Element H: Topics of Self-Management Tools—Refer to Appendix 1 for points

The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas:

1. Healthy weight (BMI) maintenance.
2. Smoking and tobacco use cessation.
3. Encouraging physical activity.
4. Healthy eating.
5. Managing stress.
6. Avoiding at-risk drinking.
7. Identifying depressive symptoms.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's policies and procedures for developing evidence based self-management tools, and reviews the organization's self-management tools. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period *For First Surveys: 6 months.*
For Renewal Surveys: 24 months.

Explanation The organization provides evidence that it can perform all activities required by this element, even if it does not provide services to any employer or plan sponsor.

Self-management tools

Self-management tools help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information. This element addresses self-management tools that members can access directly from the organization's website or through other methods (e.g., printed materials, health coaches).

Evidence-based information

The organization meets the requirement of "evidenced-based" information if recognized sources are cited prominently in the self-management tools.

If the organization's materials do not cite recognized sources, NCQA also reviews the organization's documented process detailing the sources used, and how they were used in developing the self-management tools.

Factors 1–7

No additional explanation required.

Exceptions

None.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Self-management tools

- Interactive quizzes.
- Worksheets that can be personalized.
- Online logs of physical activity.
- Caloric intake diary.
- Mood log.

Element I: Usability Testing of Self-Management Tools—Refer to Appendix 1 for points

For each of the required seven health areas in Element H, the organization evaluates its self-management tools for usefulness to members at least every 36 months, with consideration of the following:

1. Language is easy to understand.
2. Members' special needs, including vision and hearing, are addressed.

	100%	80%	50%	20%	0%
Scoring	The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source Documented process, Reports

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's policies and procedures in place throughout the look-back period, and reviews evidence of usability testing for each of the seven health areas. The score for the element is the average of the scores for all health areas.

Look-back period *For First Surveys and Renewal Surveys: At least once during the prior 36 months.*

Explanation	<p>Usability</p> <p>The organization is not required to conduct usability testing with an external audience. Testing with internal staff who were not involved in development of the self-management tool meets the requirements of this element, if staff are representative of the population that will use the tool.</p> <p>Factor 1: Easy-to-understand language</p> <p>The organization presents information clearly and uses words with common meaning, to the extent practical.</p> <p>Factor 2: Members with special needs</p> <p>The organization’s documented process explains the methods used to identify usability issues for members with special needs. Vision and hearing must be addressed to receive credit for this factor.</p> <p>Exception</p> <p>Factors marked “No” in Element H are scored NA in this element.</p> <p>Related information</p> <p><i>Use of vendors for self-management tool services.</i> If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor’s self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor’s self-management tools against the requirements. Refer to <i>Vendor Relationships</i> in Appendix 5.</p>
Examples	<p>Guidelines on usability testing for online tools</p> <ul style="list-style-type: none"> • www.usability.gov. <p>Evaluation methods</p> <ul style="list-style-type: none"> • Focus groups. • Cognitive testing and surveys that focus on specific tools.

Element J: Review and Update Process for Self-Management Tools**—Refer to Appendix 1 for points**

The organization demonstrates that it reviews its self-management tools on the following seven health areas and updates them every two years, or more frequently if new evidence is available:

1. Healthy weight (BMI) maintenance.
2. Smoking and tobacco use cessation.
3. Encouraging physical activity.
4. Healthy eating.
5. Managing stress.
6. Avoiding at-risk drinking.
7. Identifying depressive symptoms.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's policies and procedures in place throughout the look-back period.

For Renewal Surveys: NCQA also reviews documentation that shows review and update of the self-management tools.

Look-back period *For First Surveys:* 6 months.

For Renewal Surveys: 24 months.

Explanation **Factors 1–7**

No explanation required.

Exception

Factors marked “No” in Element H are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples None.

Element K: Self-Management Tool Formats—Refer to Appendix 1 for points

The organization's self-management tools are offered in the following formats for each of the required seven health areas:

1. Digital services.
2. In print or by telephone.

Scoring	100%	80%	50%	20%	0%
	The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA scores this element for each of seven required health areas in Element H. The score for the element is the average of the scores for all health areas.

NCQA reviews the organization's digital and printed or telephonic self-management tools in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period *For First Surveys: 6 months.*
For Renewal Surveys: 24 months.

Explanation The content of self-management tools is the same in all formats.

Factor 1: Digital services

Digital services include online, internet-based access and downloadable applications for smartphones and other devices.

Factor 2: In print or by telephone

Materials must be available in printed format or by telephone. An option to print an online document does not meet the requirement.

Exception

Factors marked "No" in Element H are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples None.

PHM 5: Complex Case Management—Refer to Appendix 1 for points

The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources.

Intent

The organization helps members with multiple or complex conditions to obtain access to care and services, and coordinates their care.

Summary of Changes

Clarifications

- Clarified the scope of review for First and Renewal Surveys to state that policies and procedures are in place throughout the look-back period (Element C).
- Revised the look-back period for Renewal Surveys from 6 months to 12 months for factors 3, 5 and 11 (Element C).
- Moved the second paragraph of the Explanation under the subhead *Assessment and evaluation* (Element C).
- Clarified under the subhead *Assessment and evaluation* that the policies describe the process to collect information and document summary (Element C).
- Clarified the explanation under *factor 5 (social determinants of health)* to state that the organization considers more than one social determinant of health (Elements C, D).
- Moved “Time frames are specified in the case management plan” to be a subbullet under *Time frames for reevaluation* in the Explanation for factor 12 (Element C).
- Revised the look-back period to 12 months for Renewal Surveys, for all factors (Element D).
- Divided the Explanation for *Factor 1: Case management plans and goals* into two paragraphs and added text to clarify that goals must be both timebound and prioritized (Element E).

Element A: Access to Case Management—Refer to Appendix 1 for points

The organization has multiple avenues for members to be considered for complex case management services, including:

1. Medical management program referral.
2. Discharge planner referral.
3. Member or caregiver referral.
4. Practitioner referral.

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review	<p><i>This element applies to Interim Surveys, First Surveys and Renewal Surveys.</i></p> <p>NCQA reviews the organization’s policies and procedures.</p> <p><i>For First Surveys and Renewal Surveys:</i> NCQA also reviews evidence that the organization has multiple referral avenues in place throughout the look-back period and that it communicates the referral options to members and practitioners at least once during the look-back period.</p>
Look-back period	<p><i>For Interim Surveys:</i> Prior to the survey date.</p> <p><i>For First Surveys:</i> 6 months.</p> <p><i>For Renewal Surveys:</i> 24 months.</p>
Explanation	<p>The overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member’s condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.</p> <p>NCQA considers complex case management to be an opt-out program: All eligible members have the right to participate or to decline to participate.</p> <p>The organization offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in the organization’s DM program.</p> <p>In addition to the process described in PHM 2, Element D: Segmentation, multiple referral avenues can minimize the time between identification of a need and delivery of complex case management services.</p> <p>The organization has a process for facilitating referrals listed in the factors, even if it does not currently have access to the source.</p> <p>Factor 1</p> <p>Medical management program referrals include referrals that come from other organization programs or through a vendor or delegate. These may include disease management programs, UM programs, health information lines or similar programs that can identify needs for complex case management and are managed by organization or vendor staff.</p> <p>Factor 2</p> <p>No additional explanation required.</p> <p>Factors 3, 4</p> <p>The organization communicates referral options to members (factor 3) and practitioners (factor 4).</p> <p>Exceptions</p> <p>None.</p>
Examples	<p>Facilitating referrals</p> <ul style="list-style-type: none"> • Correspondence from members, caregivers or practitioners about potential eligibility. • Monthly or quarterly reports, from various sources, of the number of members identified for complex case management.

- Brochures or mailings to referral sources about the complex case management program and instructions for making referrals.
- Web-based materials with information about the case management program and instructions for making referrals.

Element B: Case Management Systems—Refer to Appendix 1 for points

The organization uses case management systems that support:

1. Evidence-based clinical guidelines or algorithms to conduct assessment and management.
2. Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred.
3. Automated prompts for follow-up, as required by the case management plan.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
For Interim Surveys: NCQA reviews the organization's policies and procedures.
For First Surveys and Renewal Surveys: NCQA also reviews the organization's complex case management system or annotated screenshots of system functionality. The system must be in place throughout the look-back period.

Look-back period *For Interim Surveys:* Prior to the survey date.
For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation **Factor 1: Evidence-based clinical guidelines or algorithms**

The organization develops its complex case management system through one of the following sources:

- Clinical guidelines, **or**
- Algorithms, **or**
- Other evidence-based materials.

NCQA does not require the entire evidence-based guideline or algorithm to be imbedded in the automated system, but the components used to conduct assessment and management of patients must be imbedded in the system.

Factor 2: Automated documentation

The complex case management system includes automated features that provide accurate documentation for each entry (record of actions or interaction with members, practitioners or providers) and use automatic date, time and user (user ID or name) stamps.

Factor 3: Automated prompts

The complex case management system includes prompts and reminders for next steps or follow-up care.

Exceptions

None.

Examples None.

Element C: Case Management Process—Refer to Appendix 1 for points

The organization’s complex case management procedures address the following:

1. Initial assessment of member health status, including condition-specific issues.
2. Documentation of clinical history, including medications.
3. Initial assessment of the activities of daily living.
4. Initial assessment of behavioral health status, including cognitive functions.
5. Initial assessment of social determinants of health.
6. Initial assessment of life-planning activities.
7. Evaluation of cultural and linguistic needs, preferences or limitations.
8. Evaluation of visual and hearing needs, preferences or limitations.
9. Evaluation of caregiver resources and involvement.
10. Evaluation of available benefits.
11. Evaluation of community resources.
12. Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.
13. Identification of barriers to the member meeting goals or complying with the case management plan.
14. Facilitation of member referrals to resources and a follow-up process to determine whether members act on referrals.
15. Development of a schedule for follow-up and communication with members.
16. Development and communication of a member self-management plan.
17. A process to assess member progress against the case management plan.

Scoring	100%	80%	50%	20%	0%
	The organization meets 16-17 factors	The organization meets 12-15 factors	The organization meets 8-11 factors	The organization meets 3-7 factors	The organization meets 0-2 factors

Data source Documented process

Scope of review	<p><i>This element applies to Interim Surveys, First Surveys and Renewal Surveys.</i></p> <p>NCQA reviews the organization's policies and procedures.</p> <p><i>For First Surveys and Renewal Surveys:</i> NCQA reviews the organization's policies and procedures in place throughout the look-back period.</p>
Look-back period	<p><i>For Interim Surveys:</i> Prior to the survey date.</p> <p><i>For First Surveys:</i> 6 months.</p> <p><i>For Renewal Surveys:</i> 24 months; 12 months for factors 3, 5 and 11.</p>
Explanation	<p>This is a structural requirement. The organization must present its own documentation.</p>

Assessment and evaluation

Assessment and evaluation each require the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. Policies describe the process to both collect information and document a summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Complex case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases) and specify that the organization documents such assessment in the case management system and file.

Factor 1: Initial assessment of members' health status

Complex case management policies and procedures specify the process for initial assessment of health status, specific to an identified condition and likely comorbidities (e.g., high-risk pregnancy and heart disease, for members with diabetes). The assessment includes:

- Screening for presence or absence of comorbidities and their current status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the member's identification for complex case management.

Factor 2: Documentation of clinical history

Complex case management policies and procedures specify the process for documenting clinical history (e.g., disease onset; acute phases; inpatient stays; treatment history; current and past medications, including schedules and dosages).

Factor 3: Initial assessment of activities of daily living

Complex case management policies and procedures specify the process for assessing functional status related to at least the six basic ADLs: bathing, dressing, going to the toilet, transferring, feeding and continence.

Factor 4: Initial assessment of behavioral health status

Complex case management policies and procedures specify the process for assessing behavioral health status, including:

- Cognitive functions:
 - The member's ability to communicate and understand instructions.
 - The member's ability to process information about an illness.

- Mental health conditions.
- Substance use disorders.

Factor 5: Initial assessment of social determinants of health

Complex case management policies and procedures specify the process for assessing social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.

Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.

Factor 6: Initial assessment of life-planning activities

Complex case management policies and procedures specify the process for assessing whether members have completed life-planning activities such as wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms.

If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Providing life-planning information (e.g., brochure, pamphlet) to all members in case management meets the intent of this factor.

Factor 7: Evaluation of cultural and linguistic needs

Complex case management policies and procedures specify a process for assessing culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. Policies and procedures also include consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Factor 8: Evaluation of visual and hearing needs

Complex case management policies and procedures specify a process for assessing vision and hearing to identify potential barriers to effective communication or care.

Factor 9: Evaluation of caregiver resources

Complex case management policies and procedures specify a process for assessing the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation.

Factor 10: Evaluation of available benefits

Complex case management policies and procedures specify a process for assessing the adequacy of health benefits regarding the ability to fulfill a treatment plan. Assessment includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 11: Evaluation of community resources

Complex case management policies and procedures specify a process for assessing eligibility for community resources that supplement those for which the organization has been contracted to provide, at a minimum:

- Community mental health.
- Transportation.
- Wellness organizations.
- Palliative care programs.
- Nutritional support.

Factor 12: Individual case management plan and goals

Complex case management policies and procedures specify a process for creating a personalized case management plan that meets member needs and includes:

- Prioritized goals.
 - Prioritized goals consider member and caregiver needs and preferences; they may be documented in any order, as long as the level of priority is clear.
- Time frames for reevaluation of goals.
 - Time frames are specified in the case management plan.
- Resources to be utilized, including appropriate level of care.
- Planning for continuity of care, including transition of care and transfers between settings.
- Collaborative approaches to be used, including level of family participation.

Factor 13: Identification of barriers

Complex case management policies and procedures to a member receiving or participating in a case management plan. A barrier analysis can assess:

- Language or literacy level.
- Access to reliable transportation.
- Understanding of a condition.
- Motivation.
- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

The organization documents that it assessed barriers, even if none were identified.

Factor 14: Referrals to available resources

Complex case management policies and procedures specify a process for facilitating referral to other health organizations, when appropriate.

Factor 15: Follow-up schedule

Case management policies and procedures have a follow-up process that includes determining if follow-up is appropriate or necessary (for example, after a member is referred to a disease management program or health resource). The case management plan contains a schedule for follow-up that includes, but is not limited to:

- Counseling.
- Follow-up after referral to a DM program.
- Follow-up after referral to a health resource.
- Member education.
- Self-management support.
- Determining when follow-up is not appropriate.

Factor 16: Development and communication of self-management plans

Complex case management policies and procedures specify a process for communicating the self-management plan to the member or caregiver (i.e., verbally, in writing). Self-management plans are activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers.

Factor 17: Assessing progress

Complex case management policies and procedures specify a process for assessing progress toward overcoming barriers to care and to meeting treatment goals, and for assessing and adjusting the care plan and its goals, as needed.

Exceptions

None.

Examples

Factor 3: Activities of daily living

- Grooming.
- Dressing.
- Bathing.
- Toileting.
- Eating.
- Transferring (e.g., getting in and out of chairs).
- Walking.

Factor 4: Cognitive functioning assessment

- Alert/oriented, able to focus and shift attention, comprehends and recalls direction independently.
- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g. on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

Factor 5: Social determinants of health

- Current housing and housing security.
- Access to local food markets.
- Exposure to crime, violence and social disorder.

- Residential segregation and other forms of discrimination.
- Access to mass media and emerging technologies.
- Social support, norms and attitudes.
- Access, transportation and financial barriers to obtaining treatment.

Factor 7: Cultural needs, preferences or limitations

- Health care treatments or procedures that are discouraged or not allowed for religious or spiritual reasons.
- Family traditions related to illness, death and dying.
- Health literacy assessment.

Factor 9: Caregiver assessment

- Member is independent and does not need caregiver assistance.
- Caregiver currently provides assistance.
- Caregiver needs training, supportive services.
- Caregiver is not likely to provide assistance.
- Unclear if caregiver will provide assistance.
- Assistance needed but no caregiver available.

Factor 10: Assessment of available benefits

- Benefits covered by the organization and by providers.
- Services carved out by the purchaser.
- Services that supplement those the organization has been contracted to provide, such as:
 - Community mental health.
 - Medicaid.
 - Medicare.
 - Long-term care and support.
 - Disease management organizations.
 - Palliative care programs.

Factor 13: Assessment of barriers²

- Does the member understand the condition and treatment?
- Does the member want to participate in the case management plan?
- Does the member believe that participation will improve health?
- Are there financial or transportation limitations that may hinder the member from participating in care?
- Does the member have the mental and physical capacity to participate in care?

Factor 16: Self-management

- Self-management includes ensuring that the member can:
 - Perform activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding).
 - Perform instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances).

²Lorig, K. 2001. *Patient Education, A Practical Approach*. Thousand Oaks, CA: Sage Publications. 186–92.

- Self-administer medication (e.g., oral, inhaled or injectable).
- Self-administer medical procedures/treatments (e.g., change wound dressing).
- Manage equipment (e.g., oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies).
- Maintain a prescribed diet.
- Chart daily weight, blood sugar.

Element D: Initial Assessment—Refer to Appendix 1 for points

An NCQA review of a sample of the organization’s complex case management files demonstrates that the organization follows its documented processes for:

1. Initial assessment of member health status, including condition-specific issues.
2. Documentation of clinical history, including medications.
3. Initial assessment of the activities of daily living (ADL).
4. Initial assessment of behavioral health status, including cognitive functions.
5. Initial assessment of social determinants of health.
6. Evaluation of cultural and linguistic needs, preferences or limitations.
7. Evaluation of visual and hearing needs, preferences or limitations.
8. Evaluation of caregiver resources and involvement.
9. Evaluation of available benefits.
10. Evaluation of available community resources.
11. Assessment of life-planning activities.

	100%	80%	50%	20%	0%
Scoring	High (90-100%) on file review for 10-11 factors and medium (60-89%) on no more than 1 factor	High (90-100%) on file review for at least 7 factors and medium (60-89%) on file review for the remainder	At least medium (60-89%) on file review for 11 factors	Low (0-59%) on file review for 1-6 factors	7 or more factors in the low range (0-59%)

Data source Records or files

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were opened during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period *For First Surveys: 6 months.
For Renewal Surveys: 12 months.*

Explanation

Documentation to meet the factors includes evidence that the assessments were completed and documented results of each assessment. A checklist of assessments without documentation of results does not meet the requirement.

Assessment components may be completed by other members of the care team and with the assistance of the member's family or caregiver. Assessment results for each factor must be clearly documented in case management notes, even if a factor does not apply.

If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the patient's family or caregiver.

If case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment must be performed after discharge if the member is identified for case management.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Assessment and evaluation

Assessment and evaluation each require that the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Timeliness of assessment

The organization begins the initial assessment within 30 calendar days of identifying a member for complex case management and completes it within 60 calendar days of identification. If the initial assessment was started after the first 30 calendar days of member identification, NCQA scores only factor 1 "No"; the remaining factors are not marked down for starting after the first 30 calendar days of identification.

Additionally, NCQA scores any factor for which the initial assessment is completed more than 60 calendar days from member identification "No", unless the delay was due to circumstances beyond the organization's control:

- The member is hospitalized during the initial assessment period.
- The member cannot be contacted or reached through telephone, letter, email or fax.
- Natural disaster.
- The member is deceased.

The organization documents the reasons for the delay and actions it has taken to complete the assessment.

The assessment may be derived from care or encounters occurring up to 30 calendar days prior to determining identification, if the information is related to the current episode of care (e.g., health history taken as part of disease management or during a hospitalization).

Members are considered eligible upon identification unless they subsequently opt out or additional information reveals them to be ineligible.

Excluded files from review

The organization excludes files from review that meet the following criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
 - Telephone.
 - Regular mail.
 - Email.
 - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
 - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA confirms that the files met the criteria for an NA score.

Factor 1: Initial assessment of members' health status

The file or case record documents a case manager's assessment of the member's current health status, including:

- Information on presence or absence of comorbidities and their current status.
- Self-reported health status.
- Information on the event or diagnosis that led to identification for complex case management.
- Current medications, including dosages and schedule.

Factor 2: Documentation of clinical history

The file or case record contains information on the member's clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Past medications, including schedules and dosages.

Factor 3: Initial assessment of activities of daily living

The file or case record documents the results of the ADL assessment.

For ADLs with which the member needs assistance, the type of assistance and reason for need of assistance is recorded. The case manager does not need to describe ADLs the member does not need assistance with.

If the member does not need assistance with any ADLs, the case file or case notes reflect that no assistance is needed (e.g., "Member is fully independent with ADLs").

Factor 4: Initial assessment of behavioral health status

The file or case record documents a case manager's assessment of:

- Cognitive functions.
 - The member's ability to communicate and understand instructions.
 - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

Factor 5: Initial assessment of social determinants of health

The case manager assesses social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet goals.

Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.

Factor 6: Evaluation of cultural and linguistic needs

The file or case record documents a case manager's evaluation of the member's culture and language needs and their impact on communication, care or acceptability of specific treatments. At a minimum, the case manager evaluates:

- Cultural health beliefs and practices.
- Preferred languages.

Factor 7: Evaluation of visual and hearing needs

The file or case record documents a case manager's evaluation of the member's vision and hearing. The document describes specific needs to consider in the case management plan and barriers to effective communication or care.

Factor 8: Evaluation of caregiver resources

The file or case record documents a case manager's evaluation of the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation. Documentation describes the resources in place and whether they are sufficient for the member's needs, and notes specific gaps to address.

Factor 9: Evaluation of available benefits

The file or case record documents a case manager's evaluation of the adequacy of the member's health insurance benefits in relation to the needs of the treatment plan. The evaluation goes beyond checking insurance coverage; it includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 10: Evaluation of community resources

The file or case record documents a case manager's evaluation of the member's eligibility for community resources and the availability of those resources and documents which the member may need.

For the community resources the member needs, the availability and member's eligibility is also recorded in the file. The case manager does not need to address community resources the member does not need.

If no community resources are needed by the member, the case file or case notes reflect that no community resources are needed (e.g., “Member does not need any of the available community resources”).

Factor 11: Initial assessment of life planning activities

The file or case record documents a case manager’s assessment of whether the member has in place or has considered the need for wills, living wills or advance directives, Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms and health care powers of attorney.

If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Documentation that the organization provided life-planning information (e.g., brochure, pamphlet) to all members in complex case management meets the intent of this requirement.

Exceptions

None.

Examples None.

Element E: Case Management: Ongoing Management—Refer to Appendix 1 for points

The NCQA review of a sample of the organization’s complex case management files that demonstrates that the organization follows its documented processes for:

1. Development of case management plans that include prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program.
2. Identification of barriers to meeting goals and complying with the case management plan.
3. Development of schedules for follow-up and communication with members.
4. Development and communication of member self-management plans.
5. Assessment of progress against case management plans and goals, and modification as needed.

Scoring	100%	80%	50%	20%	0%
	High (90%-100%) on file review for all 5 factors	High (90%-100%) on file review for at least 3 factors and low (0-59%) on 0 factors	At least medium (60-89%) on file review for 5 factors	Low (0-59%) on file review for no more than 2 factors	3 or more factors in the low range (0-59%)

Data source Records or files

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were opened during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period *For First Surveys: 6 months.*
For Renewal Surveys: 12 months.

Explanation Each case file contains evidence that the organization completed the five factors listed, according to its complex case management procedures specified in Element C.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Excluded files from review

The organization excludes files from review that meet these criteria:

- Identified members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
 - Telephone.
 - Regular mail.
 - Email.
 - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
 - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA reserves the right to confirm that the files met the criteria for an NA score.

Factor 1: Case management plans and goals

The organization documents a plan for case management that is specific to the member's situation and needs, and includes goals that reflect issues identified in the member assessment and the supporting rationale for goal selection. Goals are specific, measurable and timebound. To be timebound, each goal must have a target completion date.

Case management goals are prioritized. The organization prioritizes goals using high/low, numeric rank or other similar designation. Priorities reflect input from the member or a caregiver, demonstrating the member or caregiver's preferences and priorities. Designating goals as long-term or short-term is not sufficient to meet the requirement. The organization must rank or prioritize goals.

Factor 2: Identification of barriers

Barriers are related to the member or to the member’s circumstances, not to the CCM process. The organization documents barriers to the member meeting the goals specified in the CCM plan.

Factor 3: Follow-up and communication with members

The organization documents the next scheduled contact with the member, including the scheduled time or time frame and method, which may be an exact date or relative (e.g., “in two weeks”).

Factor 4: Self-management plan

A self-management plan includes actions the member agrees to take to manage a condition or circumstances. The organization documents that the plan has been communicated to the member. Communication may be verbal or written. Documentation includes the member’s acknowledgment of and agreement to expected actions.

Factor 5: Assessment of progress

The organization documents the member’s progress toward goals. If the member does not demonstrate progress over time, the organization reassesses the applicability of the goals to the member’s circumstances and modifies the goals, as appropriate.

Exceptions

None.

Examples Factors 1–5: Case Management—Ongoing Management

Member Diagnosis: Severe mental illness (depression); chronic homelessness (unstable housing for 8 months)	
Identification date: 1/5/2018	Initial Assessment Completed: 1/30/2018
Goal 1:	Secure stable housing for member by 2/11/2018. (Factor 1)
<p><i>Goal case notes:</i> Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager’s help to manage other conditions, once in stable housing. (Factor 1)</p> <p><i>Strategies to achieve goal:</i> Referral to community housing resources; secure temporary safe housing, pending a more permanent solution; accompany member to housing services.</p> <p><i>Barriers to goal:</i> Member was previously evicted from temporary shelter due to unwillingness to comply with shelter staff rules. (Factor 2)</p> <p><i>Progress assessment:</i> Member moved out of initial temporary shelter because he felt his belongings were unsafe. Asked for help getting into a home where he can lock up his belongings. CM adjusted completion date to 2/21/2018 and investigated group housing. (Factor 5)</p>	
Goal 1 completed:	2/16/2018. Note: Member was accepted into adult male group housing, once he understood and accepted house rules, is comfortable with secure locker for belongings. (Factor 5)

Goal 2:	<ul style="list-style-type: none"> • Improve member's Patient Health Questionnaire-9 (PHQ-9) score from baseline (23 at initial assessment 1/30/2018) over 3–6 months. • Improve 5 points from baseline by 4/30/2018. • Improve 11 points from baseline by 7/30/2018. (Factor 1)
<p><i>Goal case notes:</i> Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. Member feels that stable housing will help depression and is willing to attend therapy sessions. (Factor 1)</p> <p><i>Strategies to achieve goal:</i> Implement a reminder system for taking medications; arrange transportation for therapist visits; check in weekly to discuss progress.</p> <p><i>Barriers to goal:</i> Member uncertain about how to get to therapy sessions and states that he feels overwhelmed by having to change buses and remember schedules. Member said his medication has been stolen in shelters before. (Factor 2)</p> <p><i>Progress assessment:</i> Member feels his medications are safe in group home lockers. CM helped the member set up a calendar pill case and clock alarm as medication reminders. CM arranged van transportation to twice weekly therapy sessions.</p> <p>CM assessed PHQ score at weekly call on 4/28/2018. Score was 16 (9 less than baseline). Member stated that housing greatly improved depression. Therapy sessions adjusted to weekly.</p> <p>CM assessed PHQ score at weekly call on 7/28/2018. Score was 12 (11 less than baseline). (Factor 5)</p>	
Goal 2 completed:	<p>7/28/2018.</p> <p><i>Note:</i> Member attends therapy. Member can navigate bus lines without anxiety; assisted transportation to sessions discontinued. (Factor 5)</p>
Follow-up and communication plan:	<p>CM scheduled weekly follow-up calls at 5pm on Fridays via the group home's phone line. CM gave member direct emergency line and is working to secure cell phone for member. (Factor 3)</p>
Self-management plan:	<ul style="list-style-type: none"> • Member will attend weekly follow-up calls on Fridays at 5pm via ***_***_****. • Member will continue to follow rules of group home. • Member will alert CM if changes to housing occur. • Member will use alarm clock reminders to take medication on schedule. Member and CM will discuss monthly refills to medications box. • CM arranges medication to be mailed to group home; member agrees to verify medication with CM during weekly calls. • Member attends therapy sessions and alerts group home staff to dramatic changes in mood (e.g., suicidal ideation). • Member will work with group home staff and other residents to learn bus routes and how to change buses on route. (Factor 4) <p><i>Note:</i> Member signed and has copies of the agreed-on self-management and case management plans. Signed copies attached. (Factor 4)</p>

Element F: Experience With Case Management—Refer to Appendix 1 for points

At least annually, the organization evaluates experience with its complex case management program by:

1. Obtaining feedback from members.
2. Analyzing member complaints.

Scoring	100%	80%	50%	20%	0%
	The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors
Data source	Reports				
Scope of review	<p><i>This element applies to First Surveys and Renewal Surveys. For First Surveys:</i> NCQA reviews the organization's most recent annual data collection and evaluation report.</p> <p><i>For Renewal Surveys:</i> During the most recent year, the organization obtains and analyzes member feedback about:</p> <ul style="list-style-type: none"> • Information about the overall program. • The program staff. • Usefulness of the information disseminated. • Members' ability to adhere to recommendations. • Percentage of members indicating that the program helped them achieve health goals. <p>During the previous year, the organization obtains and analyzes member feedback about:</p> <ul style="list-style-type: none"> • Information about the overall program. • The program staff. • Usefulness of the information disseminated. • Members' ability to adhere to recommendations. 				
Look-back period	<p><i>For First Surveys:</i> At least once during the prior year.</p> <p><i>For Renewal Surveys:</i> 24 months; at least once during the prior year for the percentage of members component of factor 1.</p>				
Explanation	<p>Factor 1: Analyzing member feedback</p> <p>The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:</p> <ul style="list-style-type: none"> • Information about the overall program. • The program staff. • Usefulness of the information disseminated. • Members' ability to adhere to recommendations. • Percentage of members indicating that the program helped them achieve health goals. 				

The organization may assess the entire population or draw statistically valid samples.

If the organization uses a sample, it describes the sample universe and the sampling methodology.

If satisfaction surveys are conducted at the corporate or regional level, results are stratified at the accreditable entity level for analysis and to determine actions. CAHPS and other general survey questions do not meet the intent of this element.

The organization conducts a quantitative data analysis to identify patterns in member feedback, and conducts a causal analysis if it did not meet stated goals.

Factor 2: Analyzing member complaints

The organization analyzes complaints to identify opportunities to improve satisfaction with its complex case management program.

Exceptions

None.

Examples

Member feedback questions

1. Did the case manager help you understand the treatment plan?
2. Did the case manager help you get the care you needed?
3. Did the case manager pay attention to you and help you with problems?
4. Did the case manager treat you with courtesy and respect?
5. How satisfied are you with the case management program?

Table 1: Annual complex case management member satisfaction survey results (N = Number of respondents)

How Satisfied Are You...?	Very Satisfied		Satisfied		Combined		Sample Size	90% Goal Met?
	N	%	N	%	N	%		
With how the case manager helped you understand the doctor's treatment plan	75	60%	25	20%	100	80%	125	No
With how the case manager helped you get the care you needed	80	64%	35	28%	115	92%	125	Yes
With the case manager's attention and help with problems	70	56%	45	36%	115	92%	125	Yes
With how the case manager treated you	85	68%	35	28%	120	96%	125	Yes

The Complex Case Management Team and the QI staff conducted a root cause analysis of the areas where goals were not met.

Table 2: Member feedback qualitative analysis

Root Cause/Barrier	Opportunity for Improvement	Prioritized for Action? (Y/N)
Members do not understand the treatment plan	Case managers identify health literacy issues and member preferences for information early in the case management process	Y

Complaints

- Limited access to case manager.
- Dissatisfaction with case manager.
- Timeliness of case management services.

Table 3: Complaint volume

Complex Case Management Complaints	Q1	Q2	Q3	Q4	Total 2019	Total 2018
Access to case manager	2	0	0	1	3	4
Dissatisfaction with case manager	1	2	0	1	4	5
Timeliness of case management services	1	0	2	2	5	5
Inquiries	3	1	2	4	10	12
Total case management	7	3	4	8	22	26

Findings

There were 22 complex case management complaints in 2019; there were 26 in 2018. Totals by category were also lower in 2019 than in 2018. Given the volume of cases over the past year, the numbers and types of complaints do not present opportunities for improvement.

The organization will continue to track and trend complaints and grievances annually, and compare results with the previous year's performance.

PHM 6: Population Health Management Impact

—Refer to Appendix 1 for points

The organization measures the effectiveness of its PHM strategy.

Intent

The organization has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement.

Summary of Changes

Clarifications

- Added “reports” as a data source and revised the look-back period for First and Renewal surveys to at least once during the prior year (Element A).
- Revised the Explanation for *factor 3 (interpretation of results)* (Element A).
- Revised the look-back period for First and Renewal Surveys to at least once during the prior year (Element B).
- Deleted the exception that reads, “This element is NA for 2018” (Element B).

Element A: Measuring Effectiveness—Refer to Appendix 1 for points

At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:

1. Quantitative results for relevant clinical, cost/utilization and experience measures.
2. Comparison of results with a benchmark or goal.
3. Interpretation of results.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports

Scope of review *This element applies to First Surveys and Renewal Surveys.*

For First and Renewal Surveys: NCQA reviews the organization’s plan for its annual comprehensive analysis of PHM strategy impact. NCQA also reviews the organization’s most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period *For First Surveys and Renewal Surveys:* At least once in the prior year.

Explanation **This element is a structural requirement.** The organization must present its own materials.

The organization conducts an annual comprehensive, quantitative, analysis of the impact of the organization's PHM strategy.

Factor 1: Quantitative results

Relevant measures align with the areas of focus, activities or programs as described in PHM 1, Element A. The organization describes why measures are relevant. Measures may focus on one segment of the population or on populations across the organization.

Clinical measures

Measures can be activities, events, occurrences or outcomes for which data can be collected for comparison with a threshold, benchmark or prior performance. Clinical measures may be:

1. *Outcome measures*: Incidence or prevalence rates for desirable or undesirable health status outcomes (e.g., infant mortality), **or**
2. *Process measures*: Measures of clinical performance based on objective clinical criteria defined from practice guidelines or other clinical specifications (e.g., immunization rates).

Cost/Utilization measures

Utilization is an unweighted count of services (e.g., inpatient discharges, inpatient days, office visits, prescriptions). Utilization measures capture the frequency of services provided by the organization. Cost-related measures can be used to demonstrate utilization. The organization measures cost, resource use or utilization.

Cost of care considers the mix and frequency of services, and is determined using actual unit price per service or unit prices found on a standardized fee schedule. Examples of cost of care measurement include:

- Dollars per episode, overall or by type of service.
- Dollars per member, per month (PMPM), overall or by type of service.
- Dollars per procedure.

Resource use considers the cost of services in addition to the count of services across the spectrum of care, such as the difference between a major surgery and a 15-minute office visit.

Experience

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may also analyze complaints to identify opportunities to improve satisfaction.

The organization analyzes feedback from at least two types of programs. The organization may use its complex case management member experience results and member experience results from one other program or service (e.g., disease management program or wellness program).

CAHPS and other general survey questions do not meet the intent of this element.

Factor 2: Comparison of results

The organization performs quantitative data analysis that compares results with an established, explicit and quantifiable goal or benchmark. Analysis includes past performance, if a previous measurement was performed.

Tests of statistical significance are not required, but may be useful when analyzing trends.

Factor 3: Interpretation of results

Measures are assessed together to provide a comprehensive analysis of the effectiveness of the PHM strategy. Interpretation is more than simply a presentation of results; it gives the organization insight into its PHM programs and strategy, and helps it understand the programs' effectiveness and impact on areas of focus. The organization conducts a qualitative analysis if stated goals are not met.

Note:

- *Participation rates do not qualify for this element.*
- *If the organization uses SF-8®, SF-12® or SF-36® to measure health status, results may count for two measures of effectiveness: one each for physical and mental health functioning.*

Exceptions

None.

Examples

Factor 1

Utilization includes measures of waste, overutilization, access, cost or underutilization.

Experience

- Patient Health Questionnaire (PHQ-9).
- Patient-Reported Outcomes Measurement Information System (PROMIS) tools.
- Program-specific surveys.

Element B: Improvement and Action—Refer to Appendix 1 for points

The organization uses results from the PHM impact analysis to annually:

1. Identify opportunities for improvement.
2. Act on one opportunity for improvement.

Scoring	100%	80%	50%	20%	0%
	The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source Reports

Scope of review *This element applies to First Surveys and Renewal Surveys.*
For First and Renewal Surveys: NCQA reviews the organization’s most recent annual comprehensive analysis of PHM strategy impact.
 NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period *For First Surveys and Renewal Surveys:* At least once during the prior year.

Explanation **This element is a structural requirement.** The organization must present its own materials.

Factor 1: Opportunities for improvement

The organization uses the results of its analysis to identify opportunities for improvement, which may be different each time data are measured and analyzed. NCQA does not prescribe a specific number of improvement opportunities.

Factor 2: Act on opportunity for improvement

The organization develops a plan to act on at least one identified opportunity for improvement.

Exceptions

None.

Examples None.

PHM 7: Delegation of PHM—Refer to Appendix 1 for points

If the organization delegates NCQA-required PHM activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated PHM activities.

Summary of Changes

Clarifications

- Element B: Provision of Member Data to the Delegate is now factor 5 in Element A: Delegation Agreement (Elements A).
- Revised the look-back period for new requirements for Renewal Surveys to 12 months from 6 months (Elements A, B, D).
- Revised the look-back period to from 6 months to 12 months for Renewal Surveys (Element B).
- Revised the use of collaborative language in the Related information (Element B).
- Added a *Related information* section and the use of collaborative language (Element C).

Deletions

- Eliminated *Element C: Provisions for PHI* and relettered the remaining elements.

Element A: Delegation Agreement—Refer to Appendix 1 for points

The written delegation agreement:

1. Is mutually agreed upon.
2. Describes the delegated activities and the responsibilities of the organization and the delegated entity.
3. Requires at least semiannual reporting by the delegated entity to the organization.
4. Describes the process by which the organization evaluates the delegated entity's performance.
5. Describes the process for providing member experience and clinical performance data to its delegates when requested.
6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.

Scoring

100%	80%	50%	20%	0%
The organization meets all 6 factors	The organization meets 5 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Materials

Scope of review	<p><i>This element applies to Interim Surveys, First Surveys and Renewal Surveys.</i></p> <p>NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.</p> <p>Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in factor 5.</p> <p>For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process. This documentation of notification is not required to be mutually agreed upon.</p> <p>The score for the element is the average of the scores for all delegates.</p>
Look-back period	<p><i>For Interim Surveys and First Surveys: 6 months.</i></p> <p><i>For Renewal Surveys: 12 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5, 11; Element D, factor 5; Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.</i></p>
Explanation	<p>This element may not be delegated.</p> <p>This element applies to agreements that are in effect during the look-back period.</p> <p>The delegation agreement describes all delegated PHM activities. A generic policy statement about the content of delegated arrangements does not meet this element.</p> <p>Factor 1: Mutual agreement</p> <p>Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.</p> <p>Factor 2: Assigning responsibilities</p> <p>The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the PHM activities:</p> <ul style="list-style-type: none"> • Performed by the delegate, in detailed language. • Not delegated, but retained by the organization. • The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other PHM functions not specified in this agreement as the delegate’s responsibility). <p>If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.</p> <p>Factor 3: Reporting</p> <p>The organization determines the method of reporting and the content of the reports, but the agreement must specify:</p> <ul style="list-style-type: none"> • That reporting is at least semiannual. • What information is reported by the delegate about PHM delegated activities. • How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited/Certified delegates.

Factor 4: Performance monitoring

The delegation agreement specifies how the organization evaluates the delegate's performance.

Factor 5: Providing member and clinical data

The organization provides:

- *Member experience data:* Complaints, CAHPS 5.0H survey results or other data collected on members' experience with the delegate's services.
- *Clinical performance data:* HEDIS measures, claims and other clinical data collected by the organization. The organization may provide data feeds for relevant claims data or clinical performance measure results.

Factor 6: Consequences for failure to perform

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples None.

Element B: Predelegation Evaluation—Refer to Appendix 1 for points

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

	100%	80%	50%	20%	0%
Scoring	The organization evaluated delegate capacity before delegation began	No scoring option	The organization evaluated delegate capacity after delegation began	No scoring option	The organization did not evaluate delegate capacity

Data source Reports

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*
 This element applies if delegation was implemented in the look-back period.
 NCQA reviews the organization's predelegation evaluation for up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.
 The score for the element is the average of the scores for all delegates.

Look-back period *For Interim and First Surveys:* 6 months.
For Renewal Surveys: 12 months.

Explanation This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional PHM activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaboratives. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples **Predelegation evaluation**

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of PHM Program—Refer to Appendix 1 for points

For arrangements in effect for 12 months or longer, the organization:

1. Annually reviews its delegate’s PHM program.
2. Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.
3. Annually evaluates delegate performance against NCQA standards for delegated activities.
4. Semiannually evaluates regular reports, as specified in Element A.

Scoring	100%	80%	50%	20%	0%
	The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Reports

Scope of review *Factor 1 applies to Interim Surveys, First Surveys and Renewal Surveys.*

All factors in this element apply to First Surveys and Renewal Surveys.

NCQA reviews a sample from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For Interim Surveys: NCQA reviews the organization’s review of the delegate’s PHM program.

For First Surveys: NCQA reviews the organization’s most recent annual review, audit, performance evaluation and semiannual evaluation.

For Renewal Surveys: NCQA reviews the organization’s most recent and previous year’s annual reviews, audits, performance evaluations and four semiannual evaluations

The score for the element is the average of the scores for all delegates.

Look-back period *For Interim Surveys and First Surveys:* Once during the prior year.

For Renewal Surveys: Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5, 11; Element D, factor 5; Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.

Explanation This element may not be delegated.

NCQA scores factor 2 and 3 “yes” if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Factor 1: Review of the PHM program

Appropriate organization staff or committee reviews the delegate’s PHM program. At a minimum, the organization reviews parts of the PHM program that apply to the delegated functions.

Factor 2: Annual file audit

If the organization delegates complex case management, it audits the delegate's complex case management files against NCQA standards. The organization uses either of the following to audit the files:

- 5 percent or 50 of its files, whichever is less.
- The NCQA "8/30 methodology" available at <http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx>

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

Factor 3: Annual evaluation

No additional explanation required.

Factor 4: Evaluation of reports

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if the organization does not delegate complex case management activities.

Factors 2–4 are NA for Interim Surveys.

Related information

Use of collaboratives. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples

None.

Element D: Opportunities for Improvement—Refer to Appendix 1 for points

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Scoring	100%	80%	50%	20%	0%
	At least once in each of the past 2 years that the delegation arrangement has been in effect, the organization has acted on identified problems, if any	No scoring option	The organization has taken inappropriate or weak action, or has taken action only in the past year	No scoring option	The organization has taken no action on identified problems

Data source Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews reports for opportunities for improvement if applicable from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For First Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 12 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5, 11; Element D, factor 5; Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
 - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.



CalOptima
Better. Together.

Proposed Population Health Management (PHM) Strategy Overview

**Special Board of Directors' Quality Assurance Committee Meeting
January 17, 2019**

**Betsy Ha, RN, MS, Lean Six Sigma Master Black Belt
Executive Director, Quality & Analytics**

[Back to Agenda](#)

Agenda

- 2018 National Committee for Quality Assurance (NCQA) Standards Change
- Population Health Management Conceptual Framework
- New Standards Overview
- Timeline and Accomplishments To Date
- Proposed PHM Strategy
- Discussion and Feedback

2018 NCQA Standard Changes

OLD

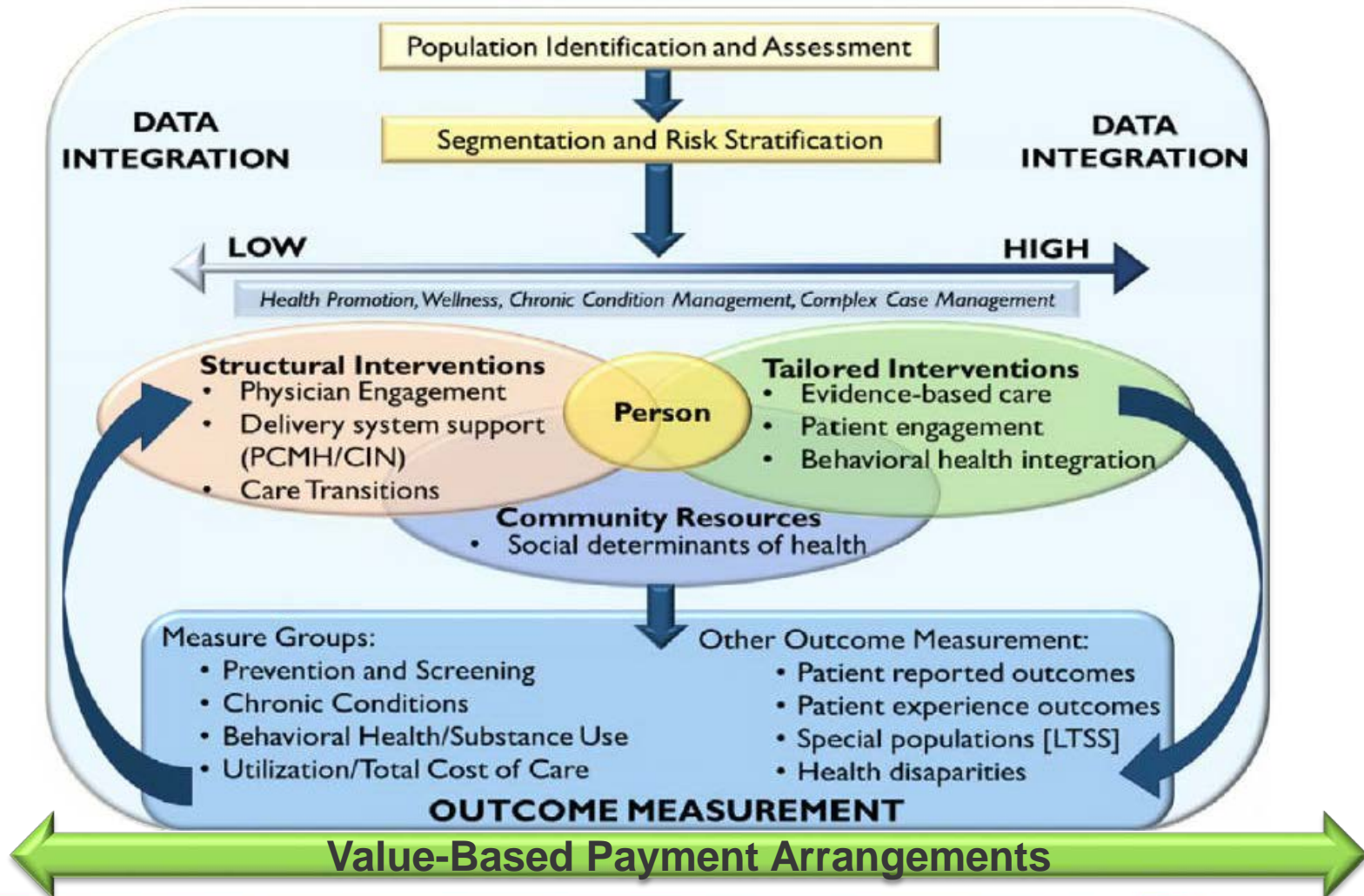
- Quality Improvement (QI) 5 Complex Case Management (CCM)
- QI 6 Disease Management (DM)
- Measuring Effectiveness by Individual Program

NEW

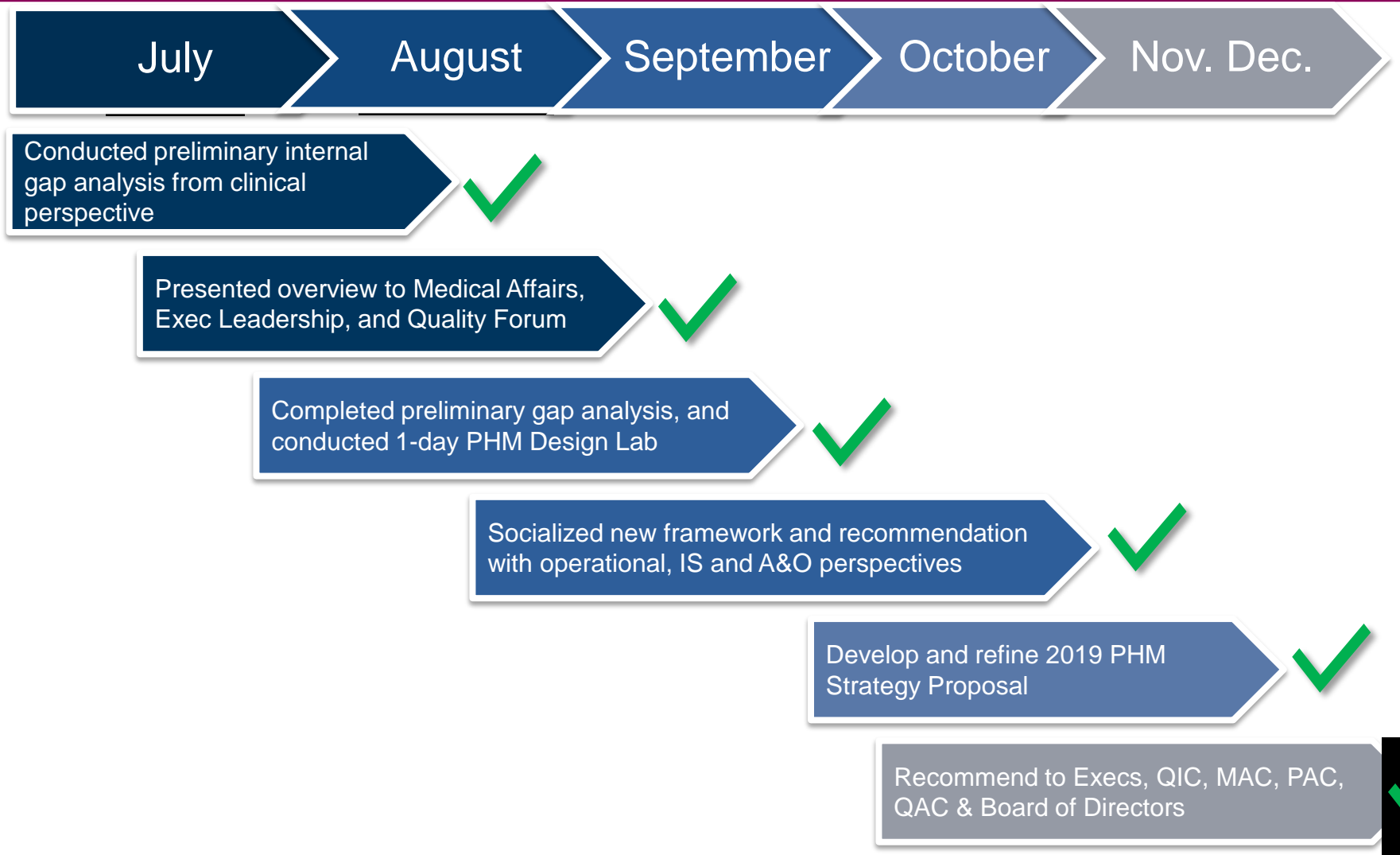
- Created Population Health Management (PHM) Standard Set
- Eliminated DM
- Move CCM under PHM
- Combined Measuring Effectiveness
- Added Standards
 - Data Integration
 - Delivery System Support

PHM Conceptual Framework

Figure 1. PHM Conceptual Model



2018 Accomplishments



PHM1 Element A: Strategy

(Effective July 2018)

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

1. Goals and populations targeted for each of the four areas of focus
 - Keeping members healthy
 - Managing members with emerging risk
 - Patient safety or outcomes across settings
 - Managing multiple chronic illnesses
2. Programs or services offered to members
- 3. Activities that are not direct member interventions**
4. How member programs are coordinated
5. How members are informed about available PHM programs

Data Source: Documented Process

PHM2 Element A: Data Integration

(Effective July 2018)

The organization assesses the needs of its population and determines actionable categories for appropriate interventions using:

1. Medical and behavioral claims or encounters
2. Pharmacy claims
3. Laboratory results
4. Health appraisal results
5. Electronic health records
6. Health services programs within the organization
7. Advanced data sources

Data source: Documented Process, Reports and Materials

PHM3 Element A: Practitioner or Provider Support

(Effective July 2018)

The organization works with practitioners or providers to achieve population health management goals as part of Delivery System Support.

1. Sharing data
2. Offering evidence-based or certified decision-making aids
3. Providing practice transformation support to primary care practitioners
4. Providing comparative quality information on selected specialties
5. Comparative pricing information for selected services
6. One additional activity to support practitioners or providers in achieving PHM goals.

Data source: Documented Process and Materials

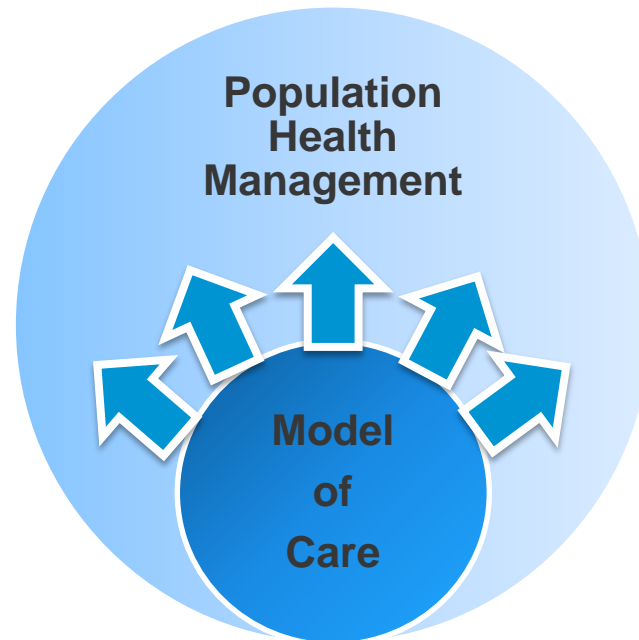
PHM1 Four Areas of Focus



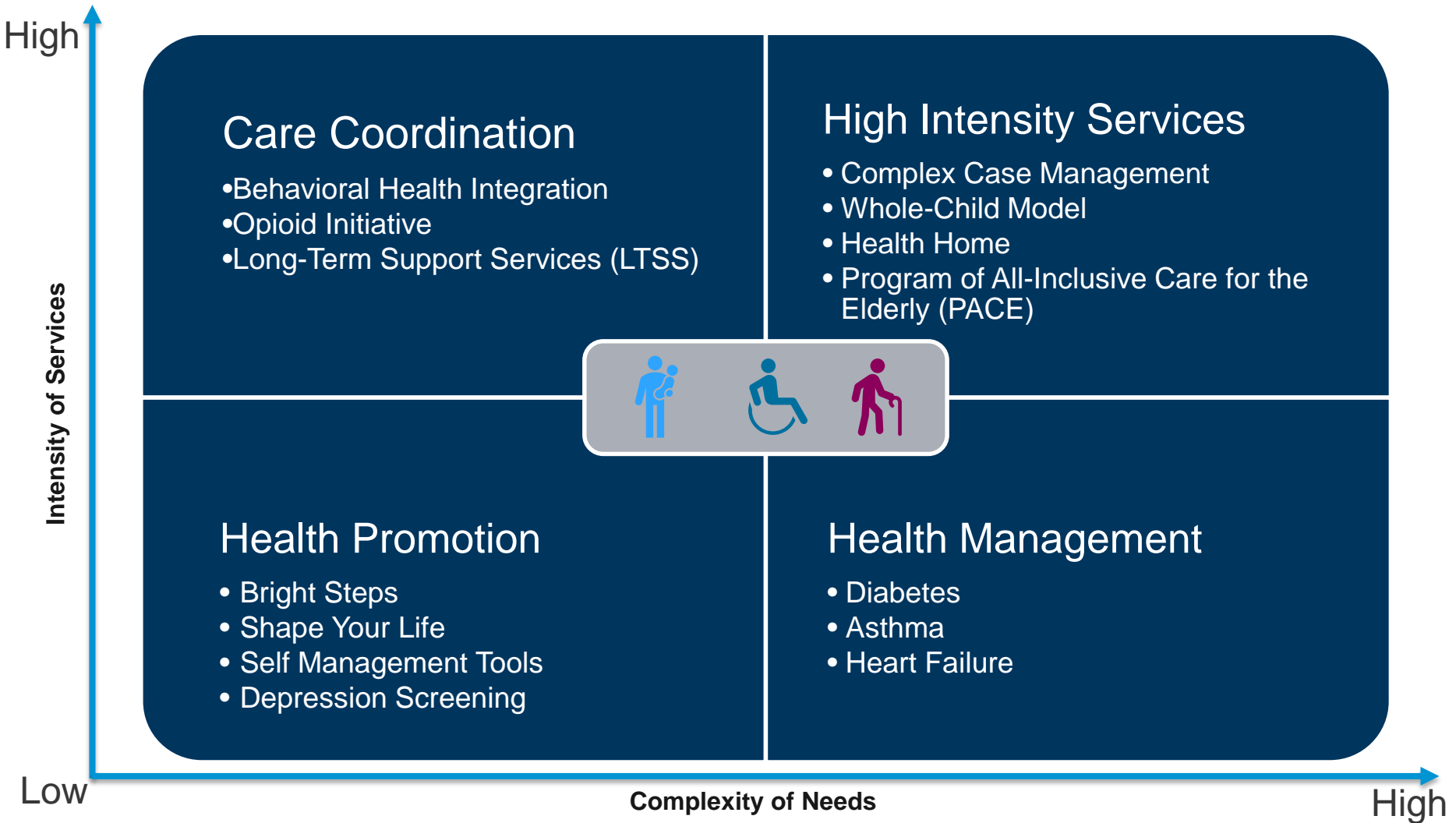
Improving Outcomes Across All Settings

PHM Strategy Intent and Approach

The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.



Current CalOptima Programs



Keeping Members Healthy

Bright Steps — Improve Prenatal and Postpartum Care

➤ Goals:

- Improve 2018 Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal Care rates (83.6%) from the 50th percentile to 75th percentile over a 24-month period.
- Improve 2018 HEDIS Postpartum Care rates (69.44%) from 75th percentile to 90th percentile over a 24-month period
- Reduce NICU Days/K

➤ Target Population:

- Members in the first trimester of pregnancy

➤ Description of Programs or Services:

- Support a healthy pregnancy and postpartum care aligned with the Comprehensive Perinatal Services Program (CPSP) guidelines

➤ Activities:

- Member outreach and coordination with CPSP providers
- Direct health education and support CPSP interventions

Keeping Members Healthy (Cont.)

Shape Your Life — Prevent Childhood Obesity

➤ Goal:

- Maintain HEDIS Rates of 90th percentile or greater for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measures year-over-year for the following:
 - BMI Percentile (WCC)
 - Counseling for Nutrition (WCC)
 - Counseling for Physical Activity (WCC)

➤ Target Population:

- Members age 5-18 with a Body Mass Index (BMI) equal to/or above the 85th percentile.

➤ Description of Programs or Services:

- Health education and physical fitness activity program using evidence-based Kids-N Fitness curriculum conducted in 12 group classes in the community.

➤ Activities:

- Active health education and member incentive for follow up visit with PCP after 6 consecutive classes

Managing Members with Emerging Risk

Health Management Programs — Improving Chronic Illness Care

➤ Goals:

- Demonstrate significant improvement in 2018 HEDIS measures related to chronic illness management for Asthma Medication Ratio (AMR), Medication Management for People with Asthma (MMA), Monitoring for Patients on Persistent Medications (MPM), Controlling Blood Pressure (CBP) and Comprehensive Diabetes Care (CDC)
- Increase member satisfaction with program to 90% in 2018
- Reduce ED and IP rates by 3% for program participants in 2018

➤ Target population:

- Members at risk for Asthma, Diabetes and/or Heart Failure

Managing Members with Emerging Risk (cont.)

Health Management Programs — Improving Chronic Illness Care (cont.)

- Description of Programs or Services:
 - Integrated health management and disease prevention programs to improve the health of our members with low acuity to moderate-risk chronic illness requiring ongoing intervention.
- Activities:
 - Member outreach
 - Health education classes
 - Self-management Tools
 - Telephonic coaching
 - Explore Board approval to expand member engagement leveraging virtual technology such as secured telehealth, texting, and remote patient monitoring ([New Idea](#))

Managing Members with Emerging Risk (Cont.)

Opioid Misuse Reduction Initiative — Prevent and Decrease Opioid Addiction

➤ Goals:

- Decrease the prevalence of opioid use disorder by implementing a comprehensive pharmacy program by December 2019
- Decrease Emergency Department utilization related to substance disorder

➤ Target Population:

- Members with diagnosis of opioid substance abuse disorder

➤ Description of Programs or Services:

- A multi-department and health collaborative aimed at reducing opioid misuse and related death

➤ Activities:

- Pharmacy lock-in program
- Case management outreach
- Physician academic detailing for safer prescribing
- Develop access to Medication Assisted Treatment (MAT)

Patient Safety

Behavioral Health Treatment (BHT) Services

- Goal: Establish baseline in 2018
- Target Population:
 - Children with Autism Spectrum Disorder (ASD) who are eligible Medi-Cal members under 21 years of age Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate
- Description of Programs or Services:
 - Provide medically necessary BHT services to children with ASD. BHT is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior.
- Activities:
 - Treatment planning and implementation
 - Direct observation and measurement
 - Functional analysis

Patient Safety — New Idea

Practice Transformation — Improve Practice Health and Safety Leveraging the QI Practice Facilitators Team

➤ Goal:

- Achieve and sustain 100% compliance of all Facility Site Review (FSR) audits year-over-year for primary care practices.

➤ Target Population:

- Medi-Cal adults and children accessing primary care.

➤ Description of Programs or Services:

- Enhancing the existing FSR nursing function by training nurses QI facilitation skills to address any gaps from FSR audit to improve compliance with practice health and safety standards at the practices sites of the CalOptima Community Network (CCN).

Patient Safety — New Idea

Practice Transformation — Improve Practice Health and Safety Leveraging the QI Practice Facilitators Team (cont.)

➤ Activities:

- Develop Practice Facilitator function of the existing Facility Site Review (FSR) nurses to identify opportunities to improve practice site health and safety, provide QI technical assistance to these practices to achieve zero defect patient safety at the primary care practices.
- Provide QI technical support to the safety net community clinics, Federally Qualified Health Center (FQHC), and PACE to promote patient safety practices.

Managing Members with Multiple Chronic Illnesses

Whole Child Model — Ensure Whole-Child Centric Quality and Continuity Care for Children with California Children's Condition (CCS) Eligible Conditions

➤ Goal:

- Improve Children and Adolescent Immunization HEDIS measures to \geq 75th percentile by December 2020 (excluding children and adolescent under cancer treatment)

➤ Targeted Population:

- Children with CCS eligible conditions

➤ Description of Programs or Services:

- The WCM program is designed to help children receiving CCS services and their families get better care coordination, access to care, and to promote improved health results.

➤ Activities:

- Care Management
- Personal Care Coordinator (PCC)

Managing Members with Multiple Chronic Illnesses (Cont.)

Health Home Program (HHP) Pilot — Improve Clinical Outcomes of Members With Multiple Chronic Conditions and Experiencing Homelessness

- Goal: Establish baseline in 2019
- Target Population:
 - Highest risk 3-5% of the Medi-Cal members with multiple chronic conditions meeting the following eligible criteria as determined by Department of Health Care Services (DHCS).
- Description of Programs or Services:
 - A pilot program of enhanced comprehensive care management program with wrap-around non-clinical social services for members with multiple chronic conditions and homelessness.
- Activities:
 - High touch core services as defined by DHCS

Delivery System Support (PHM3A)

Delivery System for Practitioner/Provider Support

➤ Information Sharing

- Increase actionable data sharing to support academic detailing to improving outcomes across all settings.

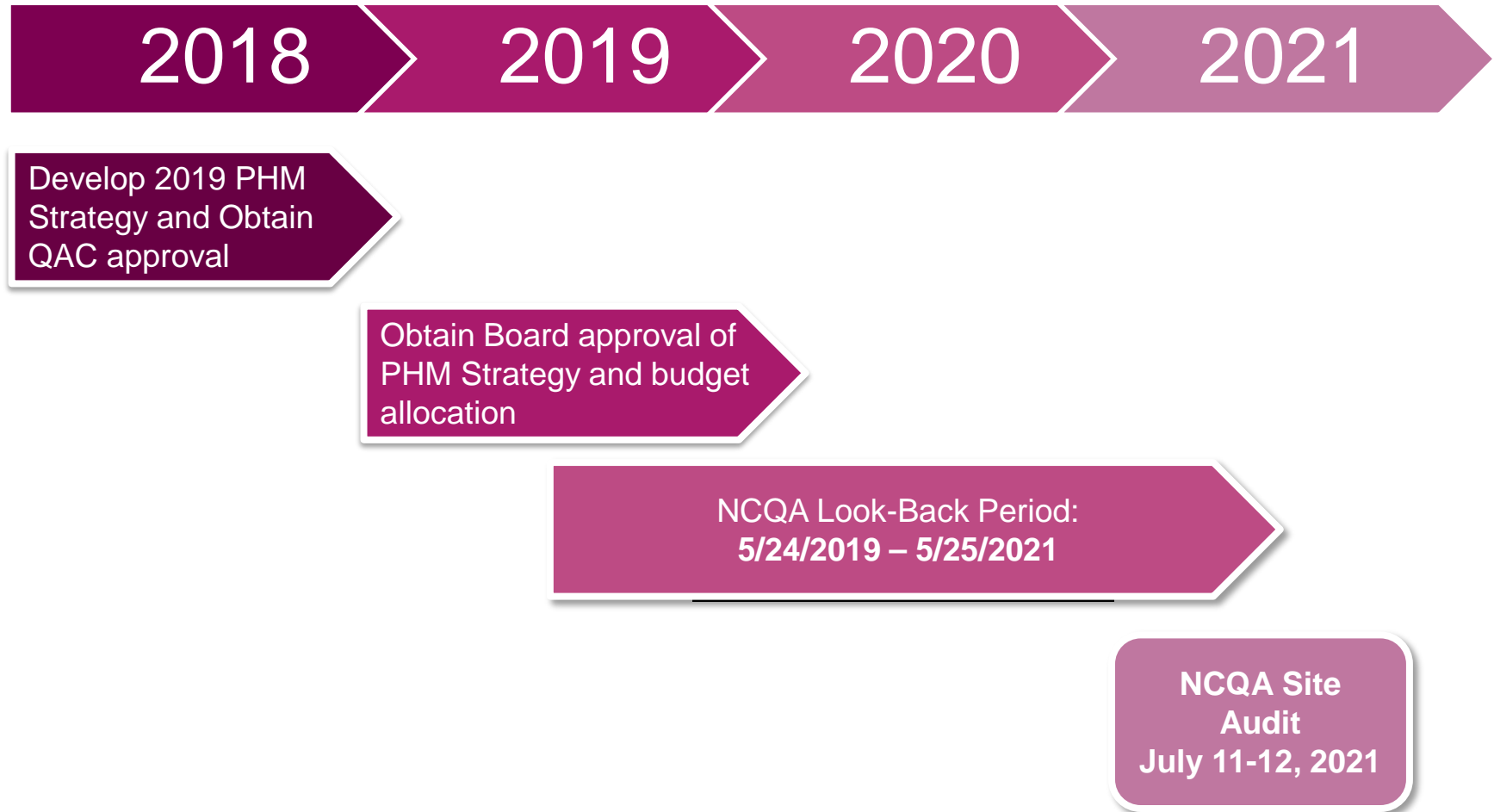
➤ Practice Transformation Technical Assistance (New Idea)

- Build upon internal FSR and QI capability to offer practice transformation support through Lean QI training, practice site facilitations, and/or individualize technical assistance to improve member experience.

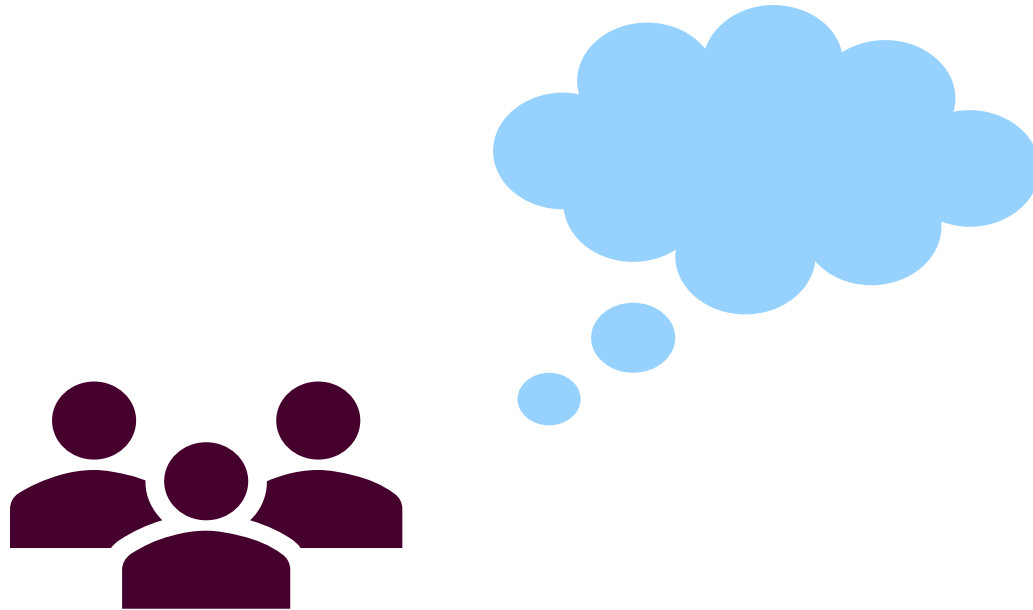
➤ Provider Coaching (New Idea)

- Offer individual provider coaching session and office staff workshops to improve quality of services and patient experience to targeted high volume CCN provider practices.

NCQA Timeline



Discussion and Feedback



CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 17, 2019 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee

Report Item

3. Consider Recommending Board of Directors' Approval of an Amendment to the Board-Approved Action for Fiscal Year 2019 (Measurement Year 2018) Pay for Value Programs for Medi-Cal and OneCare Connect Lines of Business

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Betsy Ha, Executive Director, Quality and Analytics, (714) 246-8400

Recommended Action

Approve amendment to Board-approved Fiscal Year (FY) 2019 (Measurement Year (MY) 2018) "Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect (OCC)," so that "continuous enrollment" is assessed at the health plan level instead of at the health network level.

Background

CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program intended to recognize outstanding performance and support on-going improvement in the provision of quality health care. Annually, the CalOptima staff conducts a review of the current measures and their performance over time. A part of this analysis includes evaluating both the overall performance of the measure over time and the level of improvement left to achieve. Additionally, staff evaluates any changes to the measures that are important to CalOptima's NCQA Accreditation status or overall Health Plan Rating.

The purpose of CalOptima's MY 2018 P4V program for the Health Networks, including CalOptima Community Network (CCN), is consistent with the P4V programs of the prior two years, which remains:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks and physicians on their quality improvement efforts.

Discussion

Per the November 2, 2017 Board-approved Fiscal Year 2019 (Measurement Year (MY) 2018) "Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect (OCC)," each performance measure is calculated per HEDIS methodology except that continuous enrollment is assessed at the health network level instead of at the health plan level. Continuous enrollment refers to the member being enrolled with CalOptima each month for the entire duration of the year. When staff generates the Prospective Rates report for health networks each month, continuous enrollment is assessed at the health plan level. However, for the Pay for Value incentives calculations, continuous enrollment is assessed at the health network level, which leads to discrepancy in the rates being reported throughout the year and the actual incentives being paid out at the end of the year.

This operational parameter has been in place since the original inception of the Pay for Performance program and is considered a legacy program component that no longer makes a meaningful difference in P4V scores or payments. Removal of this operational component will introduce P4V program operational efficiencies.

Staff has reviewed overall performance on the Pay for Value measures with continuous eligibility at the health plan level and health network level and found no statistically significant difference in health network performance between the two methodologies. Continuous enrollment is assessed at the health plan level in the Prospective Rate reports that we generate each month for health network performance and at the health plan level for the final incentive calculations on Pay for Value measures at the end of the year. This imposes an additional and unnecessary administrative burden on the team with no impact on performance and/or payments to health networks. Staff is proposing that continuous enrollment be assessed at the health plan level effective for the MY2018 program payments.

Fiscal Impact

The recommended action to amend the FY 2019/MY 2018 P4V programs for Medi-Cal and OCC has no additional fiscal impact. The fiscal impact of the Medi-Cal P4V program will not exceed \$2.00 per member per month (PMPM) and the OCC P4V program will not exceed \$20.00 PMPM for MY 2018. Since distribution of incentive dollars will be made in FY 2019-20, Management will include expenses related to the MY 2018 P4V programs for Medi-Cal and OCC in next year's operating budget.

CalOptima Board Action Agenda Referral
Consider Recommending Board of Directors' Approval of an
Amendment to the Board-Approved Action for Fiscal Year 2019
(Measurement Year 2018) Pay for Value Programs for Medi-Cal and
OneCare Connect Lines of Business
Page 3

Rationale for Recommendation

This amendment will make the health network reporting and tracking their performance on Pay for Value measures easier and more streamlined for staff and our participating health networks as the Prospective Rate reports generated during the year will match the overall performance report at the end of the year.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Board Action dated November 2, 2017, Consider Approval of the Fiscal Year 2019
(Measurement Year 2018) Pay for Value Programs for Medi-Cal and OneCare Connect

/s/ Michael Schrader
Authorized Signature

1/10/2019
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

5. Consider Approval of Proposed Fiscal Year (FY) 2019 (Measurement Year 2018) Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect

Contact

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

Recommended Action

Approve Fiscal Year 2019 (Measurement Year (MY) 2018) “Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect (OCC),” which defines measures and allocations for performance and improvement, as described in Attachment 1, subject to regulatory approval, as applicable.

Background

CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program intended to recognize outstanding performance and support on-going improvement in the provision of quality health care. Annually, the CalOptima staff conducts a review of the current measures and their performance over time. A part of this analysis includes evaluating both the overall performance of the measure and the level of improvement left to achieve. In addition, staff analyzes the difficulty of improving a measure due to the size of the eligible population (such as Anti-Depressant Medication Management – AMM) or difficulty in data gathering (such as Controlling Blood Pressure). Additionally, staff evaluates any changes to the measures that are important to CalOptima’s NCQA Accreditation status or overall Health Plan Rating.

The purpose of CalOptima's MY 2018 P4V program for the Health Networks, including CalOptima Community Network (CCN), is consistent with the P4V programs of the prior two years, which remains:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima’s performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks and physicians on their quality improvement efforts.

Discussion

For the MY 2018 programs, staff recommends maintaining the tenets from the prior year, with some modifications. As proposed, for the Medi-Cal line of business, both Adult and Child measures remain in the measurement set and weighting by acuity (Seniors and Persons with Disabilities (SPD) vs. non-SPD) will carry forward in the proposed 2018 P4V program.

In order to sustain improvements and leverage resources that the Health Networks have allocated towards improvement in P4V measures, staff recommends the following modifications to the MY 2017 plan for MY 2018:

Measurement Year 2018 Medi-Cal P4V Measures Changes:

Recommend replacing existing P4V measure:

- Medication Management for People with Asthma (MMA) - Total 75% compliance
 - With:
 - MMA 5-11 years (child)
 - MMA 19-50 years (adult)

Recommend retiring:

- Comprehensive Diabetes Care (CDC) - HbA1c testing
- CAHPS
 - Getting Appointment with a Specialist
 - Timely Care and Service Composite
 - Rating of all Healthcare

Recommend adding 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)
- Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)

Recommend adding three new Member Experience measures: (CAHPS Surveys - Medi-Cal Adult and Child)

- Getting Needed Care
- Getting Care Quickly
- How well Doctors Communicate

Measurement Year 2018 OneCare Connect P4V Measures Changes:

Recommend retiring two existing measures

- Antidepressant Medication Management (AMM) – Continuation and Acute Phase Treatment
 - small denominator measure
- Controlling Blood Pressure (CBP)
 - requires chart review, which makes it resource intensive to get a statistically significant sample size of chart review data across all health networks

Recommend adding two new measures:

- Breast Cancer Screening (BCS)
 - Model of Care and STAR measure
- Comprehensive Diabetes Care (CDC) - HbA1c >9 poor control
 - STAR measure

Display measures are not eligible for P4V payments. The intent of including them in the data set is to raise awareness of the measure and provide time for the Health Networks to evaluate, educate, monitor and implement actions to improve the rates. The CalOptima P4V team will also monitor the performance of these display measures throughout the year and offer recommendations to potentially include them as payment measures for MY 2019. As proposed, the display measures for Medi-Cal will remain the same for MY 2018; however, staff is recommending adding one new Display Measure for the OneCare Connect program:

- Colorectal Cancer Screening (COL)
 - Model of Care and STAR measure

Distribution of Incentive Dollars

The following P4V program requirements will remain for MY 2018:

- All health networks will continue to have performance measures for both adult and child care.
- Performance and improvement allocations are distributed upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid in proportion to acuity level, as determined by aid category. Weighting of performance and improvement may be adjusted based on overall CalOptima performance.
- To qualify for payment for each of the Clinical and CAHPS measures, the Health Network must have a minimum denominator size of 30 eligible members for Medi-Cal line of business and 5 eligible members for each specified quality measure for the OneCare Connect line of business.
- In order to qualify for payments, a physician group 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.
- Any separate OCC Quality Withhold incentive dollars earned will be distributed based upon Board of Directors--approved methodology developed by staff and approved by CMS.
- Payment of any reward under the P4V program will occur after CalOptima receives official notice of HEDIS and CAHPS scores for 2018, which is anticipated to be on or around 4th quarter, 2019. The time of payment is subject to change at CalOptima's discretion.
- Distribution methodology to CCN providers for measurement years 2016 and 2017 payout will remain the same as approved by Board of Directors.

Fiscal Impact

The fiscal impact of the Medi-Cal P4V program will not exceed \$2.00 per member per month (PMPM) and the OneCare Connect P4V program will not exceed \$20.00 PMPM for the Measurement Year of January 1, 2018 through December 31, 2018. Since the distribution of incentive dollars for the MY

2018 P4V programs for Medi-Cal and OneCare Connect will be made in FY 2019-20, Management will include expenses related to the MY 2018 P4V program in a future operating budget.

Rationale for Recommendation

This alignment leverages improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments

1. 2018 Medi-Cal and OCC P4V Program Measurement Set
2. PowerPoint Presentation - 2018 Medi-Cal and OneCare Connect Pay for Value Programs
3. Board Action dated March 2, 2017, Consider Approval of the Fiscal Year 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect

/s/ Michael Schrader
Authorized Signature

10/23/2017
Date

**Attachment 1: FY 2018~~9~~ (MY 2017~~8~~) Medi-Cal and OCC
Pay for Value Program Measurement Set**

Adult Measures	<p align="center"><u>2017-2018</u> Measurement Year / HEDIS <u>2018-2019</u> Specifications</p> <p align="center">Anticipated Payment Date: Q3 <u>2018</u><u>2019</u></p>	Measurement Assessment Methodology
<p>Clinical Domain - HEDIS Weight: 60.00%</p> <p>SPD Weight 4.0</p> <p>TANF Weight 1.0</p>	<p><u>Prevention:</u></p> <ul style="list-style-type: none"> • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) <p><u>Diabetes:</u></p> <ul style="list-style-type: none"> • HbA1c <u>Testing <8 (adequate control)</u> • Retinal Eye Exams <p><u>Access to Care:</u></p> <ul style="list-style-type: none"> • Adults Access to Preventive/Ambulatory Care <u>(AAP)</u> <p><u>Respiratory:</u></p> <ul style="list-style-type: none"> • <u>Medication Management for People with Asthma (MMA) – 19-50 years 75% compliance</u> • <u>Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)</u> 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA National HEDIS percentiles • <u>Percentile</u> Improvement

<u>Adult Measures</u>	<u>2018 Measurement Year / HEDIS 2019 Specifications</u> <u>Anticipated Payment Date: Q3 2019</u>	<u>Measurement Assessment Methodology</u>
Patient Experience Domain - CAHPS Weight: 40%	<u>Adult Satisfaction Survey (Adult CAHPS):</u> <ol style="list-style-type: none"> 1. Getting appointment with a Specialist<u>Needed Care</u> 2. Timely Care and Service<u>Getting Care Quickly</u> 3. Rating of PCP 4. Rating of all Healthcare<u>How Well Doctors Communicate</u> 	A relative point system by measure based on: <ul style="list-style-type: none"> • NCQA National HEDIS<u>California CAHPS</u> percentiles • <u>Percentile</u> Improvement
<u>Display Measure</u>	<u>Initial Health Assessment</u>	A relative point system by <u>measure, based on:</u> <ul style="list-style-type: none"> • <u>DHCS percentiles</u> • <u>Percent Improvement</u>

Pediatric Measures	<p style="text-align: center;">2017-2018 Measurement Year / HEDIS 2018-2019 Specifications</p> <p style="text-align: center;">Anticipated Payment Date: Q3 20182019</p>	Measurement Assessment Methodology
<p>Clinical Domain - HEDIS</p> <p>Weight: 60.00%</p> <p>SPD Weight 4.0</p> <p>TANF Weight 1.0</p>	<p><u>Respiratory:</u></p> <ul style="list-style-type: none"> • Medication Management for People with Asthma (MMA) – <u>5-11 years 75% Compliance</u> • Appropriate Testing for Children with Pharyngitis (CWP) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) <p><u>Prevention:</u></p> <ul style="list-style-type: none"> • Childhood Immunization Status Combo 10 (CIS) • Well-Care Visits in the 3-6 Years of Life (W34) • <u>Adolescent Well-Care Visits (AWC)</u> • <u>Well Child Visits in the First 15 months of Life – six well child visits (W15)</u> <p><u>Access to Care:</u></p> <ul style="list-style-type: none"> • <u>Children's Access to Primary Care Physician (CAP)</u> 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA National HEDIS percentiles • <u>Percentile</u> Improvement

<u>Pediatric Measures</u>	<u>2018 Measurement Year / HEDIS 2019 Specifications</u> <u>Anticipated Payment Date: Q3 2019</u>	<u>Measurement Assessment Methodology</u>
Patient Experience Domain - CAHPS Weight: 40%	<u>Child Satisfaction Survey (Child CAHPS)</u> <ul style="list-style-type: none"> • Getting Appointment with a Specialist<u>Needed Care</u> • Timely Care and Service<u>Getting Care Quickly</u> • Rating of PCP • Rating of all Healthcare<u>How Well Doctors Communicate</u> 	A relative point system by measure based on: <ul style="list-style-type: none"> • NCQA National HEDIS<u>California CAHPS</u> percentiles • Percentile Improvement

OneCare Connect Measures	<p align="center">2017-2018 Measurement Year / HEDIS 2018-2019 Specifications</p> <p align="center">Anticipated Payment Date: Q3 20182019</p>	Measurement Assessment Methodology
<p>Clinical Domain - HEDIS</p> <p>Weight: 60.00%</p> <p>Each measure weighted equally</p>	<p><u>Measures:</u></p> <ul style="list-style-type: none"> ● Comprehensive Diabetes Care (CDC) – HbA1c poor control (>9) ● Plan All Cause Readmissions ● Part D Medication Adherence for Diabetes ● Antidepressant Medication Management Outcome Measures ● Blood Pressure Control ● Part D Medication Adherence for Diabetes <p align="center">Back to Agenda</p>	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> ● NCQA National HEDIS CMS STAR thresholds percentiles ● Percent Improvement <p>For the Part D Medication Adherence Measure:</p> <p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> ● CMS Star Rating Percentiles ● Percentile Improvement

<p><u>Patient Experience Domain – CAHPS</u></p> <p><u>Weight: 40%</u></p>	<p><u>Adult Satisfaction Survey (Adult CAHPS):</u></p> <ul style="list-style-type: none"> • <u>Annual Flu Vaccine</u> • <u>Getting Appointments and Care Quickly</u> • <u>Getting Needed Care</u> • <u>Rating of Healthcare Quality</u> 	<p><u>A relative point system by measure, based on:</u></p> <ul style="list-style-type: none"> • <u>NCQA National HEDIS percentiles</u> • <u>Percent Improvement</u>
<p><u>Display Measures</u></p>	<p><u>Colorectal Cancer Screening</u></p>	<p><u>CMS Technical Specifications and Benchmarks for STAR measures</u></p>



CalOptima
Better. Together.

Measurement Year 2018 Pay for Value Program

**Board of Directors' Quality Assurance Committee Meeting
September 20, 2017**

**Richard Bock, M.D., M.B.A.
Deputy Chief Medical Officer**

Introduction

- Annually, staff conduct a review of CalOptima's performance on key quality performance metrics such as:
 - NCQA Accreditation
 - Pay4Value
 - Health Plan Ratings
 - Model of Care
 - CMS STARS
- This analysis includes evaluating the overall performance of the measure, improvement over time and the level of improvement left to achieve.

P4V Measure Set Considerations

- The P4V measure sets include a diverse set of measures including:
 - Preventive screenings for children and adults
 - Chronic Care Measures
 - Outcomes based Measures
 - Member Experience
 - Utilization/Readmissions
- Measures must be actionable by PCPs;
 - Monthly, staff provide industry benchmarks and data-driven feedback to Health Networks, including CCN physicians, on their performance on P4V measures.
- Reporting Administrative Data Only - obtaining chart review data can be challenging (cost- and labor-intensive)

Measures recommended for removal

Medi-Cal:

- Diabetes Care: HbA1c testing
- Medication Management for People with Asthma: Total 75% Compliance
 - Separated the measure by sub measure – Adult & Child

OneCare Connect:

- Antidepressant Medication Management Acute Phase
- Antidepressant Medication Management Continuation Phase
- Controlling Blood Pressure

Medi-Cal P4V Clinical Measures - Adult

2018 Measurement Year Measures

Adult	Quality Strategy
Adult Access to Preventive Care Services	Area of HEDIS auditor focus due to declining rates; at 5 th percentile Nationally
Breast Cancer Screening	Accreditation and Health Plan Rating
Cervical Cancer Screening	Accreditation, DHCS, and Health Plan Rating
NEW: Diabetes Care: HbA1c <8.0% (adequate control)	Accreditation and Health Plan Rating
Diabetes Care: Retinal Eye Exams	Accreditation, DHCS, and Health Plan Rating
NEW : Medication Management for People with Asthma: Age 19 – 50 years 75% Compliance	Accreditation, Health Plan Rating
NEW: Avoidance of Antibiotic Treatment in Adults with Bronchitis	Accreditation

Medi-Cal P4V Clinical Measures - Child

2018 Measurement Year Measures

Child	Quality Strategy
Adolescent Well-Care Visits	Health Plan Rating
Appropriate Testing for Children with Pharyngitis	Accreditation and Health Plan Rating
Appropriate Treatment for Children with URI	Accreditation and Health Plan Rating
Childhood Immunizations: Combo 10	Accreditation and Health Plan Rating
Children's Access to Primary Care Providers	Area of HEDIS Auditor focus; below 50 th percentile Nationally
NEW : Medication Management for People with Asthma: Age 5 – 11 years 75% Compliant	Accreditation, DHCS, and Health Plan Rating
Well-Child Visits 3–6 Years	DHCS and Health Plan Rating
NEW : Well Child Visits in the first 15 Months of Life	Health Plan Rating and HN performance dropped 7.66% from last year

Medi-Cal P4V CAHPS Measures

2018 Measurement Year Measures

Adult and Child Measures

NEW: Getting Needed Care	Accreditation and Health Plan Rating
NEW: Getting Care Quickly	Accreditation and Health Plan Rating
Rating of PCP	Accreditation and Health Plan Rating
NEW: How well Doctors Communicate	Accreditation

Medi-Cal P4V Display Measures

2018 Measurement Year Display Measures

Initial Health Assessment

Medi-Cal Health Network

Payment Methodology - NO CHANGES

Population Included

Total Number of Adult Member Months (MM) and Total Number of Child MM

SPD Members Weighted 4x Non-SPD Members

Payment Calculation

- **Allocated Funds** = Total MM for all health networks x the allocated PMPM.
- Allocated PMPM for 2016 is **\$2.00**

Clinical Funds = 60% of Allocated Funds (\$1.20 PMPM)

- **Clinical Funds** = Performance Funds (\$0.60 PMPM) + Improvement Funds (\$0.60)
- **Performance Payments** = Performance Funds
- **Improvement Payments** = Improvement Funds x CalOptima Overall Improvement Pct.

CAHPS Funds = 40% of Allocated Funds (\$0.80 PMPM)

- **CAHPS Funds** = Performance Funds (\$0.40 PMPM) + Improvement Funds (\$0.40)
- **Performance Payments** = Performance Funds
- **Improvement Payments** = Improvement Funds x CalOptima Overall Improvement Pct.

OneCare Connect P4V Measures

2018 Measurement Year Measures

NEW: Breast Cancer Screening	Model of Care and STAR measure
NEW: Diabetes Care – HbA1c poor control (>9%)	STAR measure
Medication Adherence for Diabetes Medications (Part D measure)	Model of Care, STAR, and Quality Withhold
Plan All-Cause Readmissions	STAR and Quality Withhold measure

OneCare Connect P4V CAHPS Measures

2018 Measurement Year Measures

Annual Flu Vaccine	STAR
Getting Appointments and Care Quickly	Model of Care and STAR
Getting Needed Care	Model of Care and STAR
Rating of Healthcare Quality	Model of Care and STAR

OneCare Connect P4V Display Measure - **NEW**

2018 Measurement Year Display Measure

Colorectal Cancer Screening

Model of Care and STAR

OneCare Connect Health Network Payment Methodology

Population Included

Total Number of Member Months (MM)

Payment Calculation

- **Allocated Funds** = Total MM for all Health Networks x the Allocated PMPM.
- Allocated PMPM for 2018 is **\$20**.

Clinical Funds = 60% of Allocated Funds (\$12.00 PMPM)

- **Clinical Funds** = Performance Funds (\$6 PMPM) + Improvement Funds (\$6)
- **Performance Payments** = Performance Funds
- **Improvement Payments** = Improvement Funds x CalOptima Overall Improvement Pct.

CAHPS Funds = 40% of Allocated Funds (\$8.00 PMPM)

- **CAHPS Funds** = Performance Funds (\$4 PMPM) + Improvement Funds (\$4)
- **Performance Payments** = Performance Funds
- **Improvement Payments** = Improvement Funds x CalOptima Overall Improvement Pct.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 2, 2017 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

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

Contact

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

Recommended Action

Approve the Fiscal Year 2018 (Measurement Year 2017) “Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect” which defines measures and allocations for performance, as described in Attachment 1 and 2, subject to regulatory approval, as applicable.

Background

CalOptima has implemented a comprehensive Health Network Performance Measurement System consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima’s mission of providing quality health care.

The purpose of the Health Network performance measurement system, which includes both delegates and the CalOptima Community Network as previously approved by the Board on March 1, 2014, is three-fold:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima’s performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks on their quality improvement efforts.

Discussion

For the Measurement Year CY 2017 programs, staff recommends maintaining many of the elements from the prior year with some modifications. As described in the 2016 P4V program, measures and scoring methodology address the need to consider the complexity or member acuity (SPD compared to non-SPD members) and the subsequent higher consumption of physician / health network resources to care for SPD members. In addition, the scoring methodology will continue to reward performance and improvement. The program will include both Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, thereby expanding our focus on the member experience. The proposed MY17 Medi-Cal and OneCare Connect Pay for Value programs are one year programs which use HEDIS 2018 specifications and for which payments will be made in 2018.

In order to sustain improvements and leverage resources that the health networks have allocated towards improvement in P4V measures, staff recommends the following modifications:

Medi-Cal Changes:

- Revise minimum denominator size from 100 to 30 eligible members for each specified quality measure to be eligible for incentive payment
- Revise CAHPS minimum performance threshold to reflect CA benchmarks

OneCare Connect Changes:

To incentivize quality care in our new OneCare Connect program and to better align with the CMS Quality Withhold program, the four clinical incentive measures below remain in the OneCare Connect P4V program:

- Plan All Cause Readmissions
- Controlling Blood Pressure
- Medication Adherence for oral anti-diabetic medications (Part D measure)
- Behavioral Health: Antidepressant Medication Management

Starting in CY 2017, a member experience survey (CAHPS) is added to the program.

Clinical measures are weighted at 60%; member experience is weighted at 40%. In the Board approved 2016 P4V program, only clinical measures were included and were weighted at 100%.

Distribution of Incentive Dollars

Performance allocations are distributed to the Health Networks, including CCN, upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid proportional to acuity level, as determined by aid category. To qualify for payment for each of the clinical and CAHPS measures, the Health Network must have a minimum denominator, as noted.

In order to qualify for payments, a physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

Any separate OCC Quality Withhold incentive dollars earned by CalOptima will be distributed based upon a Board-approved methodology to be developed by staff and subject to any needed regulatory approvals.

Fiscal Impact

Since the distribution of incentive dollars for the MY 2017 P4V Programs for Medi-Cal and OneCare Connect will be made in FY 2017-18, there is no fiscal impact to the FY 2016-17 Operating Budget.

Staff estimates that the fiscal impact for the MY 2017 P4V Program will be no more than \$2 per member per month (PMPM) for Medi-Cal, and no more than \$20 PMPM for OneCare Connect. Staff will include expenses for the MY 2017 P4V Program for Medi-Cal and OneCare Connect in the upcoming FY 2017-18 CalOptima Operating Budget.

Time of Payment

Payment of any reward under the P4V program will occur after CalOptima receives official notice of HEDIS and CAHPS scores for 2017, which is anticipated to be on or around 4th quarter, 2018. The time of payment is subject to change at CalOptima's discretion.

Rationale for Recommendation

This alignment will leverage improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments

1. FY 2018 (MY 2017) Medi-Cal Pay for Value Program
2. FY 2018 (MY 2017) OneCare Connect Pay for Value Program

/s/ Michael Schrader
Authorized Signature

2/23/2017
Date

Attachment 1: FY 2018 (MY 2017) Medi-Cal Pay for Value Program Measurement Set

<p>Adult Measures</p>	<p>2017 Measurement Year / HEDIS 2018 Specifications Anticipated Payment Date: Q3 2018</p>	<p>Measurement Assessment Methodology</p>
<p>Clinical Domain - HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0</p>	<p><u>Prevention:</u></p> <ul style="list-style-type: none"> • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) <p><u>Diabetes:</u></p> <ul style="list-style-type: none"> • HbA1c Testing • Retinal Eye Exams <p><u>Access to Care:</u></p> <ul style="list-style-type: none"> • Adults Access to Preventive/Ambulatory Care <p><u>Respiratory:</u></p> <ul style="list-style-type: none"> • Medication Management for People with Asthma (MMA) 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA National HEDIS percentiles • Percentile Improvement
<p>Patient Experience Domain - CAHPS Weight: 40%</p>	<p><u>Adult Satisfaction Survey (Adult CAHPS):</u></p> <ol style="list-style-type: none"> 1. Getting appointment with a Specialist 2. Timely Care and Service 3. Rating of PCP 4. Rating of all Healthcare 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA California CAHPS percentiles • Percentile Improvement

Pediatric Measures	2017 Measurement Year / HEDIS 2018 Specifications Anticipated Payment Date: Q3 2018	Measurement Assessment Methodology
<p>Clinical Domain - HEDIS</p> <p>Weight: 60.00%</p> <p>SPD Weight 4.0</p> <p>TANF Weight 1.0</p>	<p><u>Respiratory:</u></p> <ul style="list-style-type: none"> • Medication Management for People with Asthma (MMA) • Appropriate Testing for Children with Pharyngitis (CWP) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) <p><u>Prevention:</u></p> <ul style="list-style-type: none"> • Childhood Immunization Status Combo 10 (CIS) • Well-Care Visits in the 3-6 Years of Life (W34) • Adolescent Well-Care Visits (AWC) <p><u>Access to Care:</u></p> <ul style="list-style-type: none"> • Children's Access to Primary Care Physician 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA National HEDIS percentiles • Percentile Improvement
<p>Patient Experience Domain - CAHPS</p> <p>Weight: 40%</p>	<p><u>Child Satisfaction Survey (Child CAHPS)</u></p> <ul style="list-style-type: none"> • Getting Appointment with a Specialist • Timely Care and Service • Rating of PCP • Rating of all Healthcare 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA California CAHPS percentiles • Percentile Improvement

Attachment 2: FY 2018 (MY 2017) OneCare Connect Pay for Value Program

<p>OneCare Connect Measures</p>	<p>2017 Measurement Year / HEDIS 2018 Specifications</p> <p>Anticipated Payment Date: Q3 2018</p>	<p>Measurement Assessment Methodology</p>
<p>Clinical Domain - HEDIS</p> <p>Weight: 60.00%</p> <p>Each measure weighted equally</p>	<p><u>Measures:</u></p> <ul style="list-style-type: none"> • Plan All Cause Readmissions • Antidepressant Medication Management Outcome Measures • Blood Pressure Control • Part D Medication Adherence for Diabetes 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA National HEDIS percentiles • Percent Improvement <p>For the Part D Medication Adherence Measure:</p> <p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • CMS Star Rating Percentiles • Percentile Improvement
<p>Patient Experience Domain - CAHPS</p> <p>Weight: 40%</p>	<p><u>Adult Satisfaction Survey (Adult CAHPS):</u></p> <ul style="list-style-type: none"> • Getting appointment with a Specialist • Timely Care and Service • Rating of PCP • Rating of all Healthcare 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA California CAHPS percentiles • Percentile Improvement

Participation in Quality Improvement Initiatives

For each measure in which a Health Network/medical group performs below the 50th percentile, Health Networks/medical groups must submit a Corrective Action Plan (CAP) to CalOptima which outlines, at a minimum, the following items:

- Interim measures and goals
- Measurement cycle
- Member interventions including education and outreach
- Provider interventions including education and training
- Timeline for interventions

Health networks/medical groups must submit quarterly work plans which document implementation of the corrective action plan and progress made towards goals.

In conjunction with the Health Networks, CalOptima will lead quality improvement initiatives for measures that fall below the 50th percentile. Funding for these initiatives will come from forfeited dollars.

MEASUREMENT DETAILS:

1. Clinical Domain (HEDIS measures)

Program Specific Measurement Sets

Performance measures were selected as appropriate per program based on the following criteria:

- Measures are appropriate for membership covered by the program
- Measures are based on regulatory requirements
- Measures are used by the industry for performance measurement and incentive payment

Criteria

The following criteria were considered in selecting these indicators:

- Each of these indicators measures the delivery of services that are critical to the health of the respective segments of CalOptima's membership. In addition, these measures collectively address the range of age appropriate services.
- The measures use administrative data for all except Blood Pressure only reporting since they are single point of service measures.
- CBP will be captured with a specific chart review activity for this P4V program.

Each measure is calculated per HEDIS methodology except that continuous enrollment is assessed at the health network level instead of at the health plan level.

Incentive Measure Definition

Please refer to HEDIS 2018 Technical Specifications Volume 2 for measure definitions. For each HEDIS indicator, members will be identified according to the most recent HEDIS technical specifications updates.

II. Customer Satisfaction

Member Satisfaction

Background

CalOptima conducts annual member satisfaction surveys that are carefully designed to provide network-level satisfaction information to meet precision requirements and to support comparisons between networks and at the CalOptima agency level. The goal is to survey different subsets of the CalOptima membership (e.g. Children, Persons with disabilities, and Adults) on a rotating basis so that we develop:

- trend information over time about individual networks' performance for a specific population, and
- comparable performance information across networks both for a specific time period as well as trended over time.

Survey Methodology

The surveys are administered using the CAHPS protocol, including a mixed-mode methodology of mail and telephone contact to notify members of the study, distribute questionnaires, and encourage participation by non-respondents. Both surveys have been conducted in three threshold languages as defined by our Medi-Cal contract.

CalOptima has worked with outside technical and substantive consultants to refine its survey instruments and sampling and weighting strategies and has employed a nationally known survey research group to conduct both surveys.

The samples consisted of systematically selected Medi-Cal members who met specific requirements for inclusion as specified by the CAHPS and by our interest in targeted subgroups. The sample is a disproportionately stratified random sample with strata defined by health network. CalOptima required sample sizes and allocations across strata be developed to provide estimates of population proportions at the network level that were within 2.5 percentage points of the true value with 95% statistical confidence.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken January 17, 2019 **Special Meeting of the CalOptima Board of Directors’** **Quality Assurance Committee**

Report Item

4. Consider Recommending Board of Directors’ Approval of the Proposed Pay for Value Program for Fiscal Year 2020 (Measurement Year 2019) for Medi-Cal and OneCare Connect Lines of Business

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Betsy Ha, Executive Director, Quality and Analytics, (714) 246-8400

Recommended Action

Recommend the Board of Directors approve Fiscal Year 2020 (Measurement Year 2019) “Pay for Value (P4V) Program” for Medi-Cal and OneCare Connect (OCC),” which defines measures and allocations for performance and improvement, as described in Attachment 1, subject to regulatory approval, as applicable.

Background

CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima’s mission of providing quality health care. Annually, the CalOptima staff conducts a review of the current measures and their performance over time. A part of this analysis included evaluating both the overall performance of the measure and the level of improvement left to achieve. In addition, the staff analyzed the difficulty of improving a measure due to the size of the eligible population or difficulty in data gathering. Finally, the staff evaluated any changes to the measures that are important to CalOptima’s NCQA Accreditation status, CMS Star Rating Status and/or overall NCQA Health Plan Rating.

The purpose of CalOptima's P4V program for the Health Networks, including CalOptima Community Network (CCN) is consistent with the P4V programs of the prior three years, which remains:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima’s performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks and physicians on their quality improvement efforts.

Discussion

For the Measurement Year 2019 programs, staff recommends maintaining the tenets from the prior year, with some modifications.

For the Medi-Cal line of business, staff recommends no changes to the incentivized Adult and Child clinical and member experience performance measures. Both Adult and Child measures remain in the measurement set and weighting by acuity (SPD vs. non-SPD) will carry forward in the proposed MY 2019 P4V program. Staff propose one additional measure to be added to the Medi-Cal measurement set.

Measurement Year 2019 Medi-Cal P4V Display Measure Changes:

Recommendation: Addition of one new Display measure:

- Persistence of Beta Blocker treatment after a Heart attack

Clinical guidelines recommend prescribing a beta-blocker after a heart attack to prevent another heart attack from occurring. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes. Current CalOptima performance based on measurement year 2017 performance is at the National NCQA Medicaid 25th percentile which is well below the National Medicaid average at the 75th percentile.

Display measures are not eligible for P4V payments. The intent of including them in the data set is to raise awareness of the measure and provide time for the Health Networks to evaluate, educate, monitor and implement actions to improve the rates. The CalOptima P4V team will also monitor the performance of these display measures throughout the year and offer recommendations to potentially include them as payment measures for MY2020. For example, Colorectal Screening is now proposed to move from a Display measure to a Pay for Value clinical measure.

Measurement Year 2019 OneCare Connect P4V Measures Changes:

For the OneCare Connect line of business, staff recommends one change to the clinical performance measures and one addition to the clinical display measures.

Recommendation: Addition of one new Clinical measure:

- Colorectal Cancer Screening

Regular screening, beginning at age 50, is the key to preventing colorectal cancer. The U.S. Preventive Services Task Force (USPSTF) recommends that adults age 50 to 75 be screened for colorectal cancer. Current CalOptima performance based on measurement year 2017 performance is at the two-star CMS Rating. Our goal is to achieve three star or higher rating from CMS on all quality metrics in the Star Rating set.

Recommendation: Addition of one new Clinical Display measure:

- Comprehensive Diabetes Care Nephropathy Monitoring

Clinical guidelines recommend annual screening or monitoring test for diabetics for evidence of nephropathy. This includes urine protein tests, evidence of treatment for nephropathy, stage 4 chronic kidney disease, end stage renal disease, kidney transplant, or visit to a nephrologist or prescription for one ACE/ARB medication.

Distribution of Incentive Dollars

There are no proposed changes to the previously-Board-approved distribution strategy for earned pay for value dollars. The following P4V program requirements will remain:

- All health networks will continue to have performance measures for both adult and child care.
- Performance and improvement allocations are distributed upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid proportional to acuity level, as determined by aid category. Weighting of performance and improvement may be adjusted based on overall CalOptima performance.
- To qualify for payment for each of the Clinical and CAHPS measures, the Health Network must have a minimum denominator in accordance with statistical principles.
- To qualify for payments, a health network or physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.
- Any separate OCC Quality Withhold incentive dollars earned will be distributed based upon the methodology previously approved by the Board of Directors.
- Payments can be made annually or more frequently, at CalOptima's discretion.
- Distribution methodology to CCN providers for measurement year 2019 payout will remain the same as previously approved by the Board of Directors.

Fiscal Impact

The fiscal impact of the Medi-Cal P4V program will not exceed \$2.00 per member per month (PMPM) and the OCC P4V program will not exceed \$20.00 PMPM for the MY of January 1, 2019, through December 31, 2019. Since the distribution of incentive dollars for the MY 2019 P4V programs for Medi-Cal and OneCare Connect will be made in Fiscal Year 2020-21, Management will include expenses related to the MY 2019 P4V program in a future operating budget.

Rationale for Recommendation

This alignment leverages improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

Concurrence

Gary Crockett, Chief Counsel

CalOptima Board Action Agenda Referral
Consider Recommending Board of Directors' Approval of the Proposed
Pay for Value Program for Fiscal Year 2020 (Measurement Year 2019)
for Medi-Cal and OneCare Connect Lines of Business
Page 4

Attachments

1. FY 2020 (MY 2019) Medi-Cal and OneCare Connect Pay for Value Program Measurement Set
2. PowerPoint Presentation: Measurement Year 2019 Pay for Value Program Proposed Changes

/s/ Michael Schrader
Authorized Signature

1/10/2019
Date

**Attachment 1: FY 2020 (MY 2019) Medi-Cal and OCC
Pay for Value Program Measurement Set**

Adult Measures	2019 Measurement Year / HEDIS 2020 Specifications Anticipated Payment Date: Q3 2020	Measurement Assessment Methodology
<p>Clinical Domain – HEDIS</p> <p>Weight: 60.00%</p> <p>SPD Weight 4.0</p> <p>TANF Weight 1.0</p>	<p><u>Prevention:</u></p> <ul style="list-style-type: none"> • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) <p><u>Diabetes (CDC):</u></p> <ul style="list-style-type: none"> • HbA1c < 8.0 (adequate control) • Retinal Eye Exams <p><u>Access to Care:</u></p> <ul style="list-style-type: none"> • Adults Access to Preventive/Ambulatory Care (AAP) <p><u>Respiratory:</u></p> <ul style="list-style-type: none"> • Medication Management for People with Asthma (MMA) – 19-50 years 75% compliance • Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB) 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA National HEDIS percentiles • Percentile Improvement
Adult Measures	2019 Measurement Year / HEDIS 2020 Specifications Anticipated Payment Date: Q3 2020	Measurement Assessment Methodology
<p>Patient Experience Domain - CAHPS</p> <p>Weight: 40%</p>	<p><u>Adult Satisfaction Survey (Adult CAHPS):</u></p> <ul style="list-style-type: none"> • Getting Needed Care • Getting Care Quickly • Rating of PCP • How well Doctors Communicate 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA CA CAHPS percentiles • Percentile Improvement
Display Measure	<ul style="list-style-type: none"> • Initial Health Assessment • Persistence of Beta Blocker treatment after a Heart Attack 	<ul style="list-style-type: none"> • DHCS percentiles • NCQA National HEDIS percentiles

Pediatric Measures	2019 Measurement Year / HEDIS 2020 Specifications Anticipated Payment Date: Q3 2020	Measurement Assessment Methodology
Clinical Domain - HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	<u>Respiratory:</u> <ul style="list-style-type: none"> • Medication Management for People with Asthma (MMA) - 5-11 years 75% Compliance • Appropriate Testing for Children with Pharyngitis (CWP) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) <u>Prevention:</u> <ul style="list-style-type: none"> • Childhood Immunization Status Combo 10 (CIS) • Well-Care Visits in the 3-6 Years of Life (W34) • Adolescent Well-Care Visits (AWC) • Well Child Visits in the First 15 months of Life –six well child visits (W15) <u>Access to Care:</u> <ul style="list-style-type: none"> • Children's Access to Primary Care Physician (CAP) 	A relative point system by measure based on: <ul style="list-style-type: none"> • NCQA National HEDIS percentiles • Percentile Improvement
Pediatric Measures	2019 Measurement Year /HEDIS 2020 Specifications Anticipated Payment Date: Q3 2020	Measurement Assessment Methodology
Patient Experience Domain - CAHPS Weight: 40%	<u>Child Satisfaction Survey (Child CAHPS)</u> <ul style="list-style-type: none"> • Getting Needed Care • Getting Care Quickly • Rating of PCP • How well Doctors Communicate 	A relative point system by measure based on: <ul style="list-style-type: none"> • NCQA CA CAHPS percentiles • Percentile Improvement

OneCare Connect Measures	2019 Measurement Year /HEDIS 2020 Specifications Anticipated Payment Date: Q3 2020	Measurement Assessment Methodology
Clinical Domain – HEDIS Weight: 60.00% Each measure weighted equally	<u>Measures:</u> <ul style="list-style-type: none"> • Breast Cancer Screening (BCS) • Comprehensive Diabetes Care (CDC) – HbA1c poor control (> 9.0) • Plan All Cause Readmissions (PCR) • Part D Medication Adherence for Diabetes • Colorectal Cancer Screening 	A relative point system by measure based on: <ul style="list-style-type: none"> • CMS STAR thresholds • Percentile Improvement
Patient Experience Domain - CAHPS Weight: 40%	<u>Adult Satisfaction Survey (Adult CAHPS):</u> <ul style="list-style-type: none"> • Annual Flu Vaccine • Getting Appointments and Care Quickly • Getting Needed Care • Rating of Healthcare Quality 	A relative point system by measure based on: <ul style="list-style-type: none"> • CMS CAHPS Cut Points • Cut Point Level Improvement
Display Measure	Comprehensive Diabetes Care (CDC) Nephropathy Monitoring	CMS Technical Specifications and Benchmarks for STAR measures



CalOptima
Better. Together.

Measurement Year 2019 Pay for Value Program Proposed Changes

**Special Board of Directors' Quality Assurance Committee Meeting
January 17, 2019**

**Betsy Ha, RN, MS, Lean Six Sigma Master Black Belt
Executive Director, Quality & Analytics**

Introduction

- Annually, staff conduct a review of CalOptima's performance on key quality performance metrics such as:
 - NCQA Accreditation
 - Pay4Value
 - Health Plan Ratings
 - Model of Care
 - CMS STARS
- This analysis includes evaluating the overall performance of the measure, improvement over time, and the level of improvement left to achieve.

P4V Measure Set Considerations

- The P4V measure sets include a diverse set of measures including:
 - Preventive screenings for children and adults
 - Chronic Care Measures
 - Outcomes based Measures
 - Member Experience
 - Utilization/Readmissions
- Measures must be actionable by PCP's:
 - Monthly, staff provide industry benchmarks and data-driven feedback to Health Networks on their performance on P4V measures.
- Reporting Administrative Data Only

Medi-Cal P4V Measures

P4V Recommendations:

- No changes to Medi-Cal Adult measures for MY 2019.
- No changes to Medi-Cal Child measures for MY 2019.
- No changes to CAHPS Survey measures but the CAHPS benchmarks were changed to California benchmarks from National benchmarks for MY 2018 and will remain in place for MY 2019.
- Prefer measures to remain in program for at least 2-3 years for health networks to adapt to changes.
- Based on recommendation from Chronic Care conditions team, adding “Persistence for Beta Blocker Treatment after a Heart Attack” as a Display Measure (< 25th percentile currently).

Medi-Cal P4V Clinical Measures - Adult

Measurement Year 2019 – **NO CHANGES**

Adult	Quality Strategy
Adult Access to Preventive Care Services	Area of HEDIS auditor focus due to declining rates; at 10 th percentile Nationally
Breast Cancer Screening	Accreditation and Health Plan Rating
Cervical Cancer Screening	Accreditation, DHCS, and Health Plan Rating
Diabetes Care: HbA1c <8.0% (adequate control)	Accreditation and Health Plan Rating
Diabetes Care: Retinal Eye Exams	Accreditation, DHCS, and Health Plan Rating
Medication Management for People with Asthma: Age 19 – 50 years 75% Compliance	Accreditation, Health Plan Rating
Avoidance of Antibiotic Treatment in Adults with Bronchitis	Accreditation

Medi-Cal P4V Clinical Measures - Child

Measurement Year 2019 – **NO CHANGES**

Child	Quality Strategy
Adolescent Well-Care Visits	Health Plan Rating
Appropriate Testing for Children with Pharyngitis	Accreditation and Health Plan Rating
Appropriate Treatment for Children with URI	Accreditation and Health Plan Rating
Childhood Immunizations: Combo 10	Accreditation and Health Plan Rating
Children's Access to Primary Care Providers	Area of HEDIS Auditor focus; below 50 th percentile
Medication Management for People with Asthma: Age 5 – 11 years 75% Compliant	Accreditation, DHCS, and Health Plan Rating
Well-Child Visits 3–6 Years	DHCS and Health Plan Rating
Well Child Visits in the first 15 Months of Life	Health Plan Rating

Medi-Cal P4V Display Measures

Measurement Year 2019	
Display	Quality Strategy
Initial Health Assessment	DHCS focus measure
NEW: Persistence for Beta Blocker Treatment after a Heart Attack	Health Plan Rating

Medi-Cal P4V CAHPS Measures

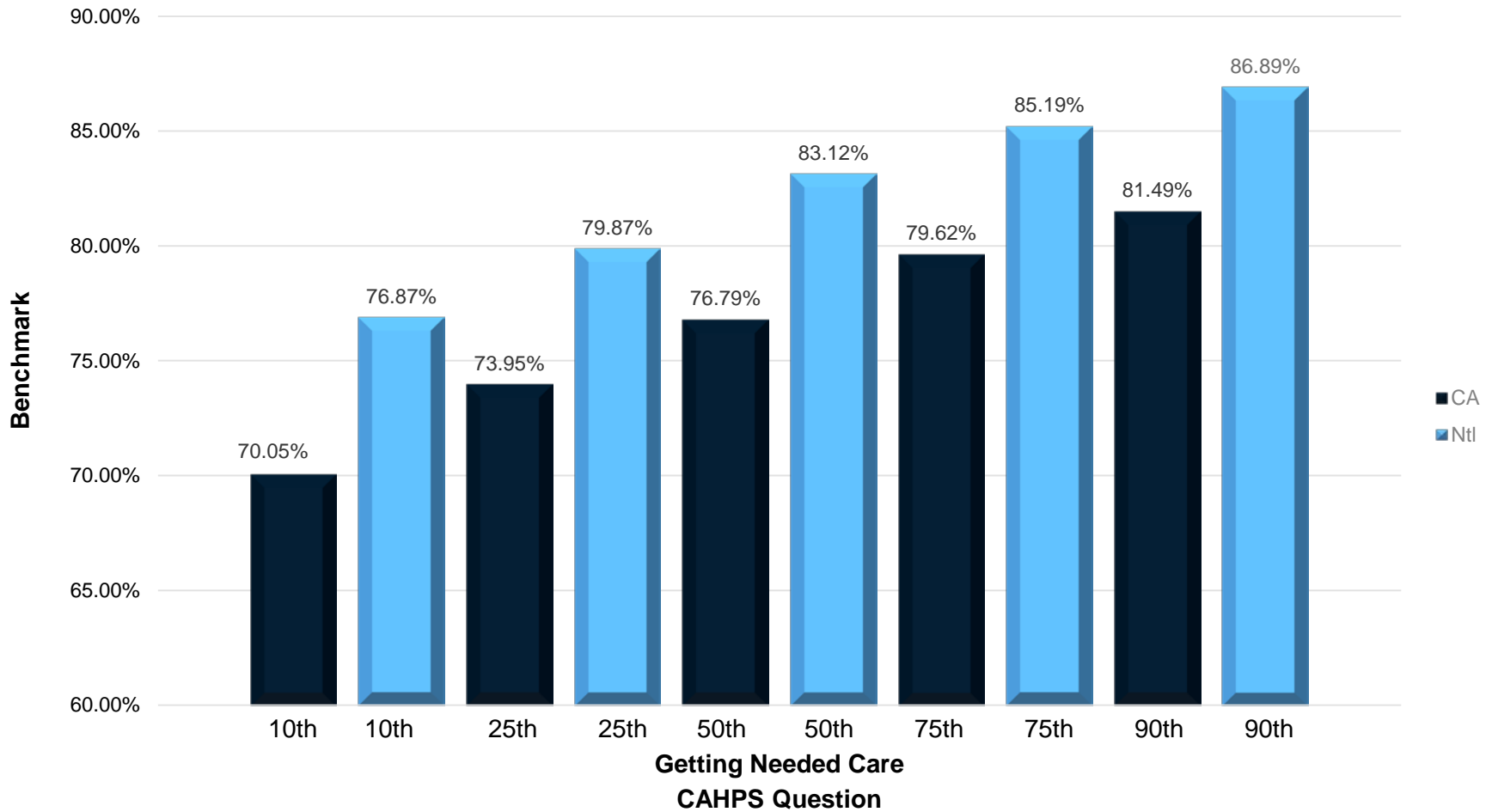
Measurement Year 2019 – **NO CHANGES**

Adult and Child Measures

Getting Needed Care	Accreditation and Health Plan Rating
Getting Care Quickly	Accreditation and Health Plan Rating
Rating of PCP	Accreditation and Health Plan Rating
How well Doctors Communicate	Accreditation

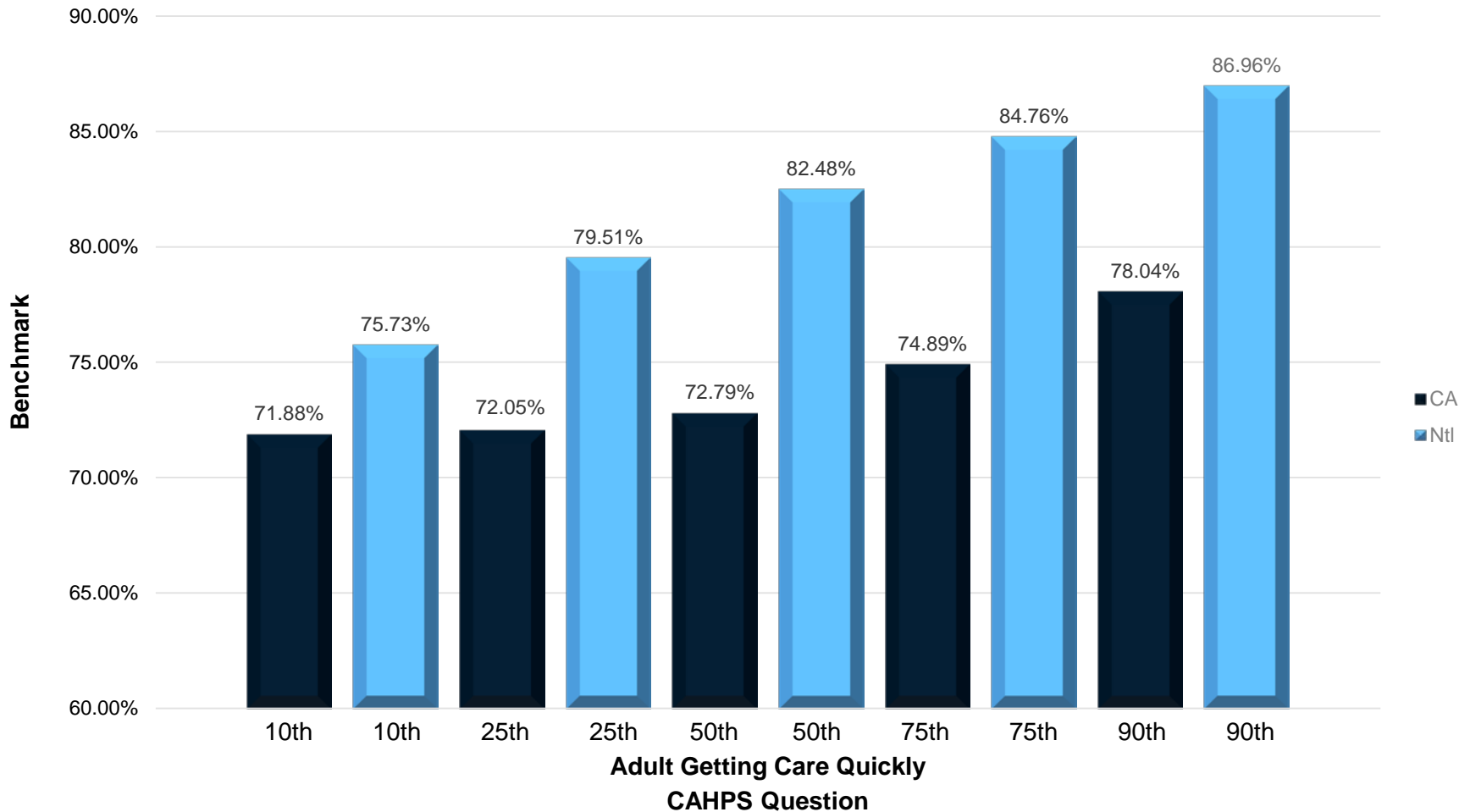
Adult CAHPS Benchmark Comparison

NCQA 2018 CA Benchmark vs National Benchmark



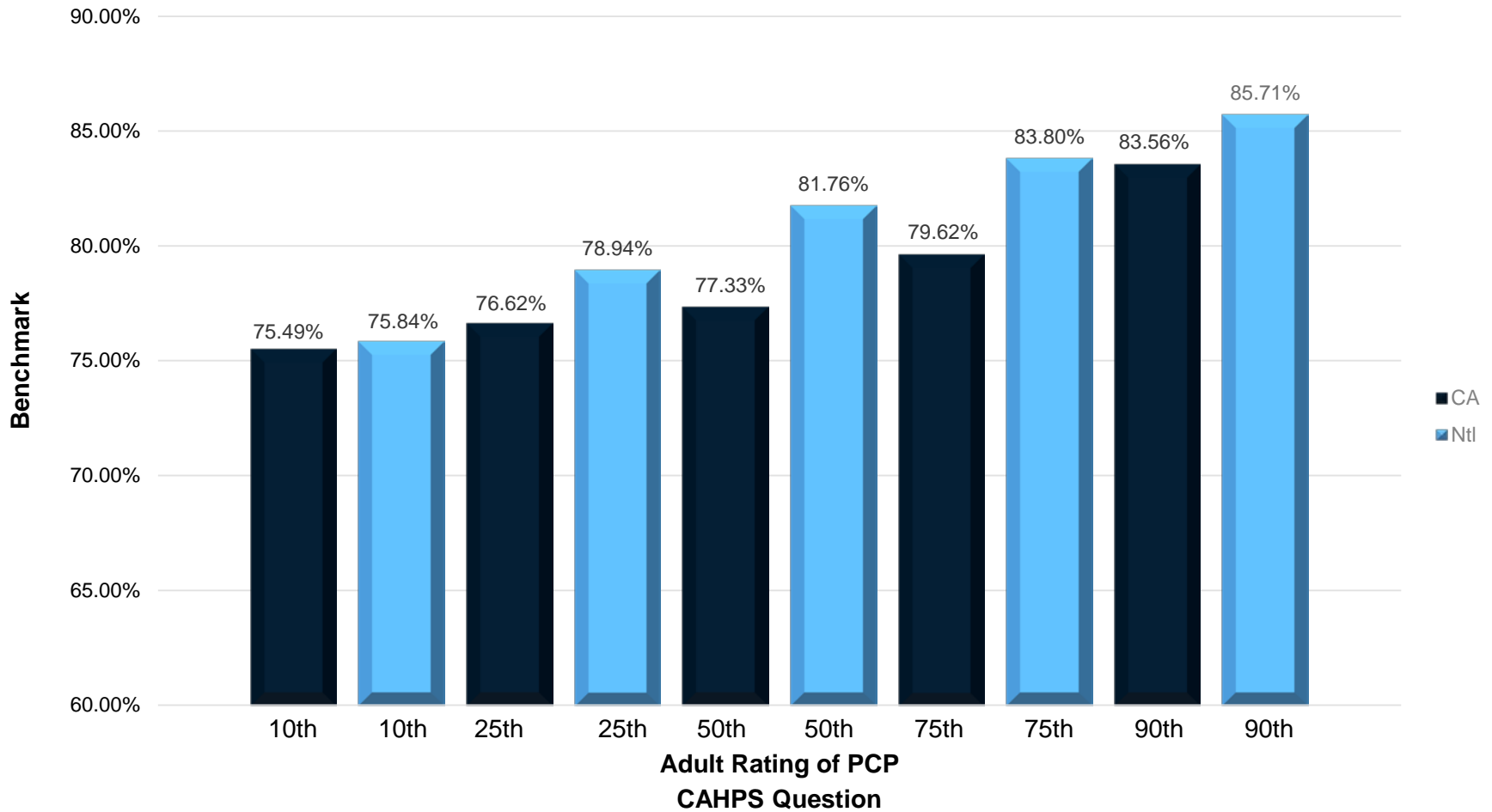
Adult CAHPS Benchmark Comparison

NCQA 2018 CA Benchmark vs National Benchmark



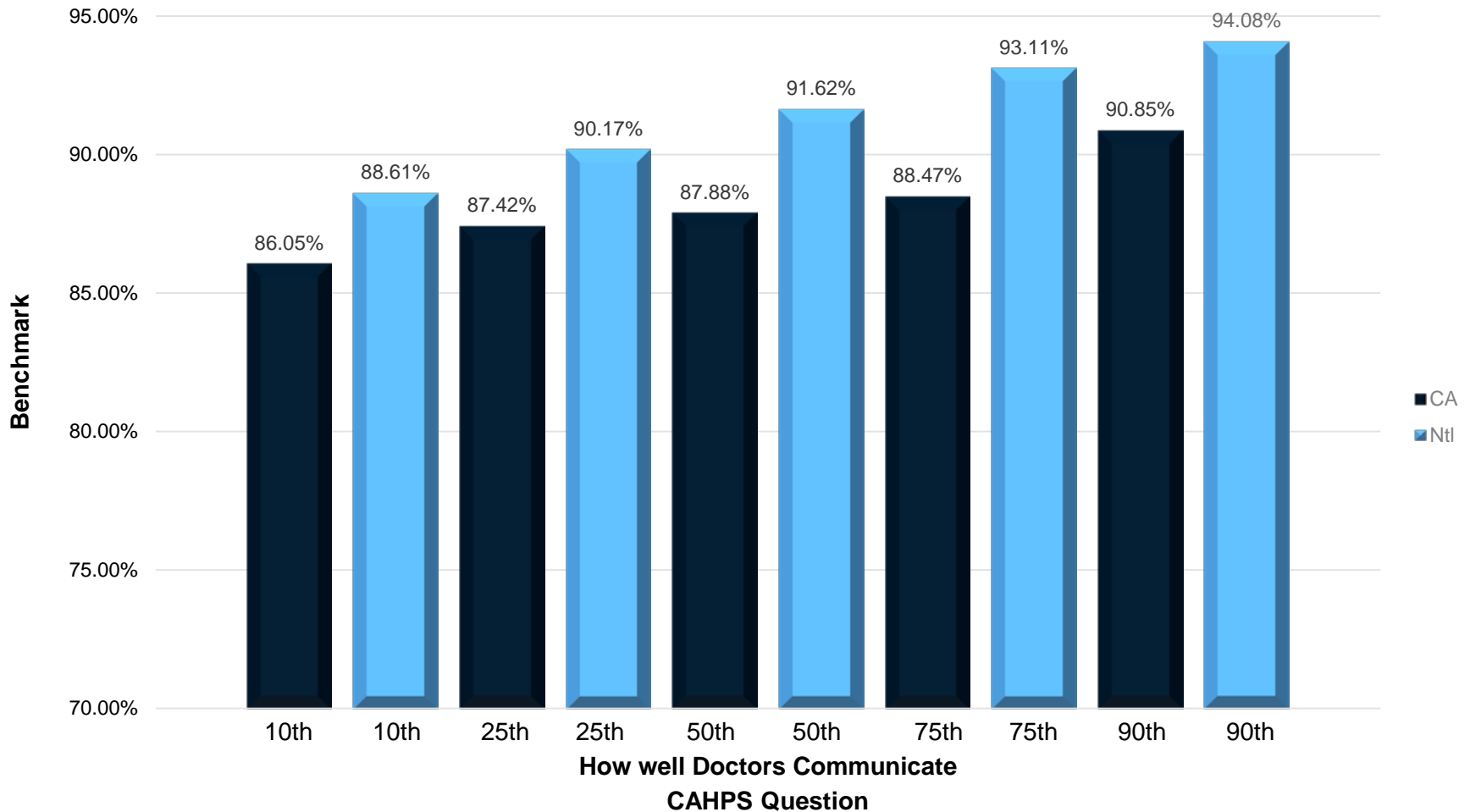
Adult CAHPS Benchmark Comparison

NCQA 2018 CA Benchmark vs National Benchmark



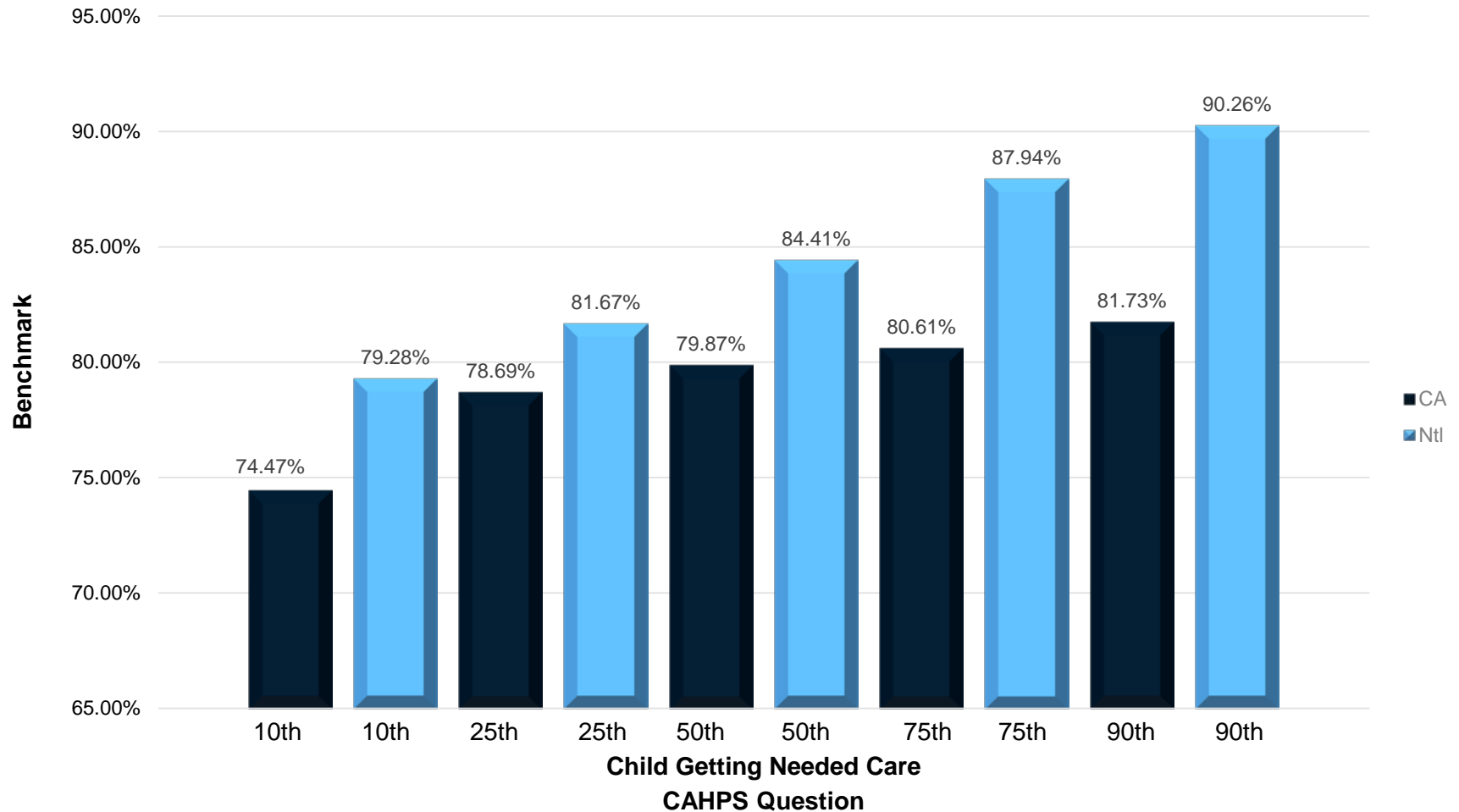
Adult CAHPS Benchmark Comparison

NCQA 2018 CA Benchmark vs National Benchmark



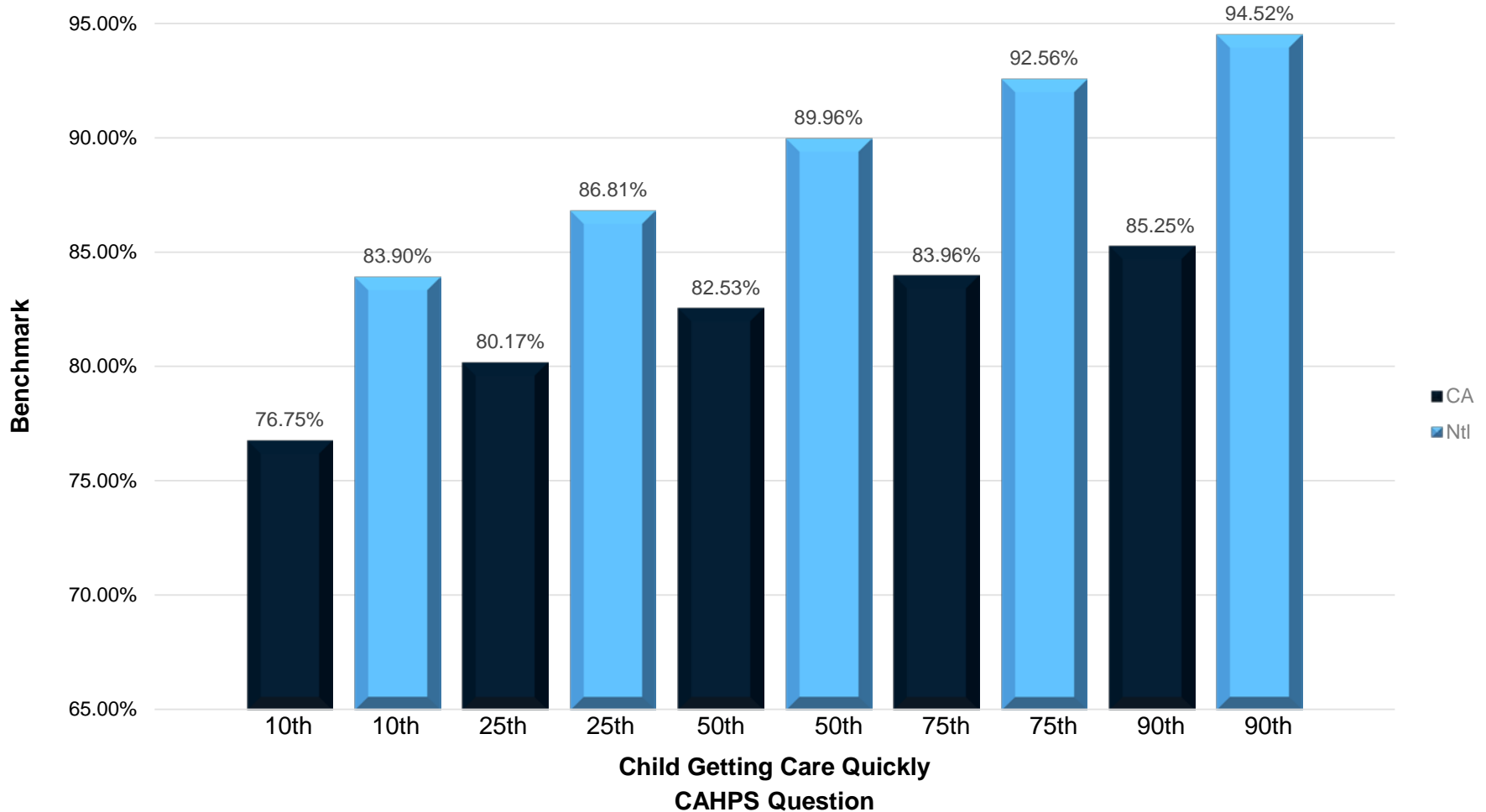
Child CAHPS Benchmark Comparison

NCQA 2018 CA Benchmark vs National Benchmark



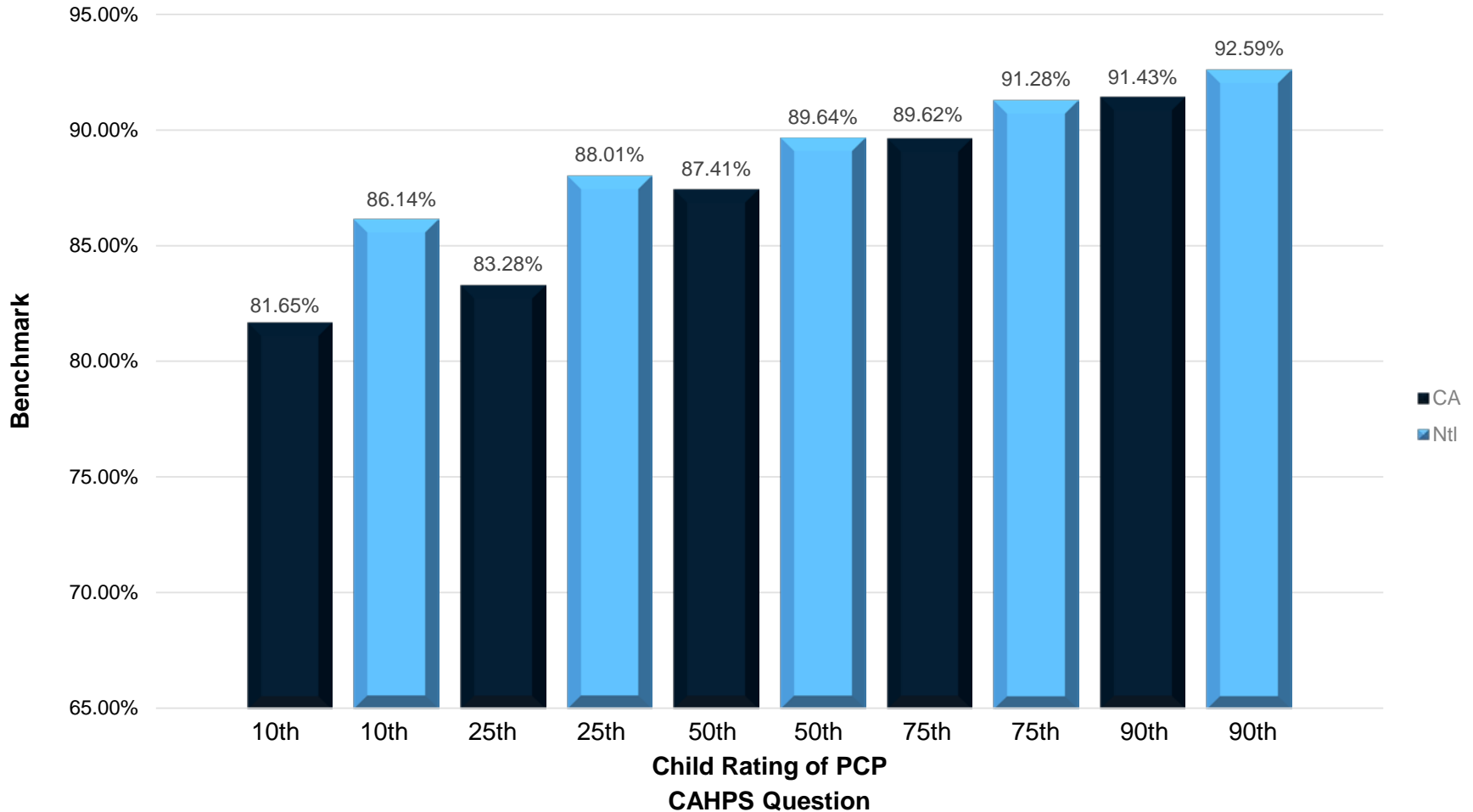
Child CAHPS Benchmark Comparison

NCQA 2018 CA Benchmark vs National Benchmark



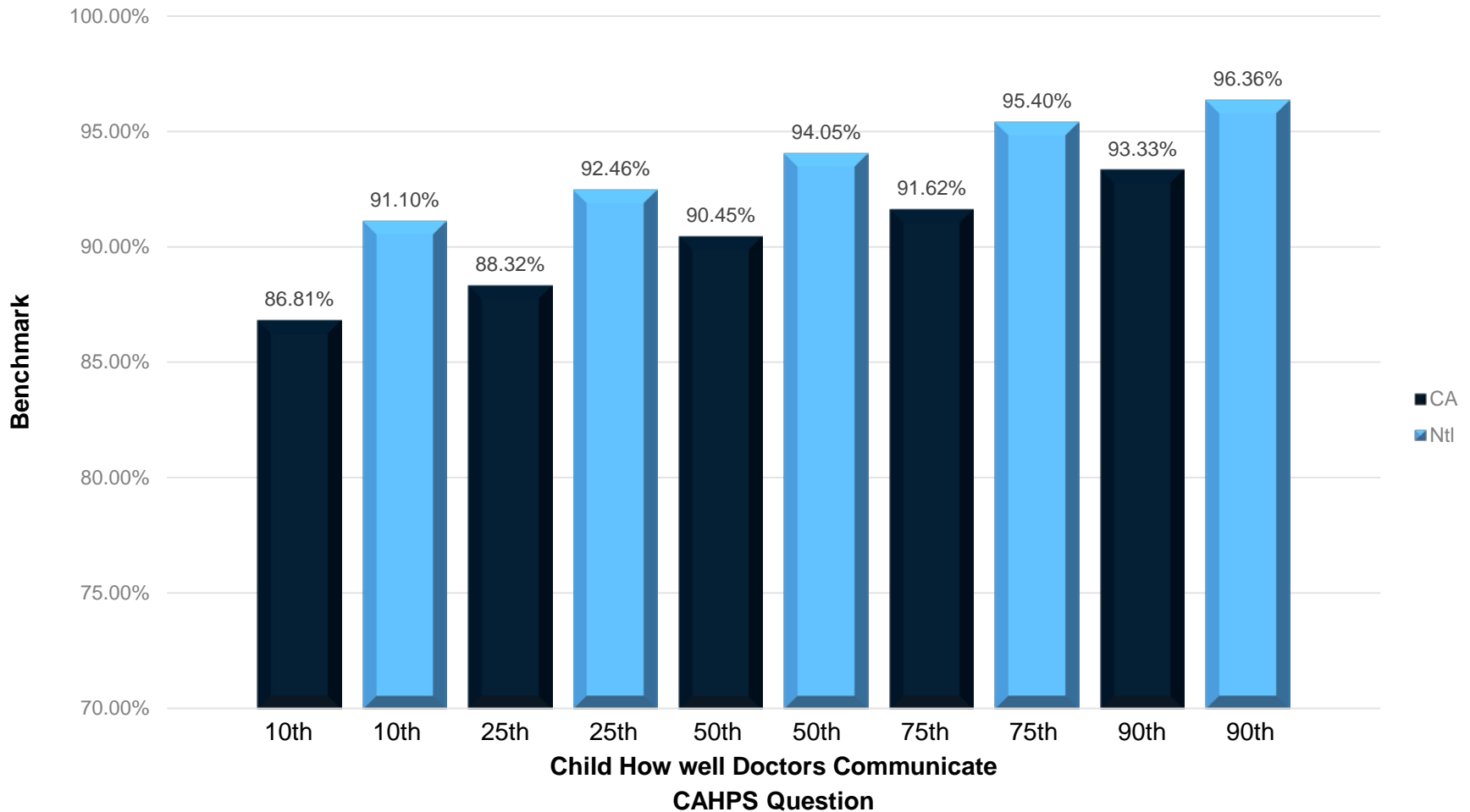
Child CAHPS Benchmark Comparison

NCQA 2018 CA Benchmark vs National Benchmark



Child CAHPS Benchmark Comparison

NCQA 2018 CA Benchmark vs National Benchmark



OneCare Connect P4V Measures – MY 2019

P4V Recommendations:

- One change to OneCare Connect measures for MY 2019.
- Colorectal Screening to be moved from a Display measure to a P4V measure.
- CDC Nephropathy Monitoring to be included as a Display Measure for MY2019.
- No changes to OneCare Connect CAHPS Survey measures.

OneCare Connect P4V Measures

Measurement Year 2019

Breast Cancer Screening	Model of Care and STAR measure
Diabetes Care – HbA1c poor control (>9.0%)	STAR measure
Medication Adherence for Diabetes Medications (Part D measure)	Model of Care, STAR, and Quality Withhold
Plan All-Cause Readmissions	STAR and Quality Withhold measure
NEW: Colorectal Cancer Screening	Model of Care and STAR

OneCare Connect P4V CAHPS Measures

Measurement Year 2019 – **NO CHANGES**

Annual Flu Vaccine	STAR
Getting Appointments and Care Quickly	Model of Care and STAR
Getting Needed Care	Model of Care and STAR
Rating of Healthcare Quality	Model of Care and STAR

OneCare Connect P4V Display Measure

Measurement Year 2019

NEW: Diabetes Care - Nephropathy Monitoring

STAR measure

Special Board of Director's Quality Assurance Committee Meeting January 17, 2019

PACE Member Advisory Committee (PMAC) Update

PMAC Meeting September 17, 2018

- Updates from the Director
 - New staff welcomed to the PACE team include a pharmacist, registered nurse, 2 medical assistants, enrollment coordinator, therapy aide and a part-time physician. Clinic Nurse Samantha Brewers is now assigned as the Intake Nurse to assess eligibility of prospective participants.

- Items Discussed
 - CMS / DHCS 2018 Audit Report
 - Quality Improvement Manager Eva Elser, RN, reviewed the results of the most recent joint CMS / DHCS audit that occurred in May 2018. A participant asked about the changes that will be made as a result of the audit. Ms. Elser described changes to how service delivery requests are processed. A copy of the report has been placed near the lobby for review by participants.
 - Dietary Services Focus Group Updates
 - Dietary Services Supervisor Cyndi Stivers, RD, facilitated a discussion on dietary services at the June 2018 PMAC meeting. Ms. Stivers returned to report on the main discussion points of diet and food preferences.
 - Clinic Services Focus Group
 - Per the request of the PMAC, Clinic Manager Christine Sisil, RN, was asked to facilitate a focus group on clinic services. Ms. Sisil provided an overview of clinic services. A participant wanted to know how often in-house specialists come to PACE. Another participant requested that lab results be shared. Christine educated the committee members on clinic schedule and the process of sharing lab results.
 - General Discussion:
 - One participant asked that PACE change the wall colors in the facility. He indicated there is too much beige.
 - A participant liked the bigger print dictionary PACE purchased.
 - Multiple committee members agreed that there should be more technology-help classes
 - A participant felt the building is too cold and requested that there be an update on center-wide activities at a future PMAC meeting.

PMAC Meeting December 17, 2018

- Updates from the Director
 - Current enrollment is 299 participants. New staff welcomed to the PACE team include a registered nurse, physical therapist, home care coordinator and occupational therapist.

- Items Discussed
 - Old Business
 - Clinic Manager, Christine Sisil, shared feedback from the September 17, 2018 PMAC focus group regarding clinic experience. Respondents felt they were “treated with courtesy and respect” and the physicians and nurses “listen to you”. Respondents replied that they felt that sometimes “things are explained in a clear and understandable language”.
 - Center Manager, Monica Macias responded to requests made at the last PMAC meeting, including increasing the temperature of the thermostat, a notepad was added to the Suggestion Box, dictionary books with larger print are now available, and more Vietnamese speaking staff have been hired for the day center.
 - Activity Focus Group
 - Monica Macias led a focus group on day center activities. A few current activities were highlighted, including English-language and Spanish-language classes, birthday celebrations, low-vision groups, music activities, spiritual group sessions and a session called Delta group, which was developed by a PACE Occupational Therapist focusing on changes through life from a functional standpoint. Monica distributed a questionnaire to the participants to survey activity preferences and solicit suggestions for other activities.
 - Participants suggested that the monthly calendar should be in other languages besides English. One participant wanted more activities in both the morning and afternoon shifts. The same participant also stated that he would like more time at the center and suggested that the center be open at 7:30am so that he could do more exercise activities. Members suggested field trips to the Discovery Science Center, thrift stores, picnics in the park, drives, and aquatic therapy.
 - General Discussion:
 - One participant requested an option where he could go online to check his appointment schedule and lab results.
 - A participant complimented the Transportation Department and wants to celebrate them. The PMAC participants felt that the drivers were courteous, polite and helpful. The group wants to draft a letter to celebrate the drivers.

Special Board of Directors' Quality Assurance Committee Meeting January 17, 2019

A Tableau Demo: Longitudinal Retrospective Quality Improvement Evaluation Executive Summary

CalOptima's Quality Analytics team has developed a unique tool to review longitudinal HEDIS, Access and Availability and Member Experience Results. This tool will be used by the Quality Improvement Committee to establish the HEDIS metrics that will be prioritized to drive the 2019 Quality Improvement Workplan. This tool is unique in that end users will now have several meaningful variables at their fingertips to make informed business decisions about which measures are improving, declining, or remaining flat compared to established goals and benchmarks.

Currently, the tool has the capability to display the past five year's rates for selected measures. Moving forward, new data will be added upon annual completion of our auditor certified HEDIS results. In addition to display of rates however, the tool will also allow the user to better understand the drivers of rate change and performance compared to established benchmarks including:

- Member Incentives offered during the measurement period
- Provider Incentives offered during the measurement period
- Measures incentivized as part of CalOptima's Pay for Value programs
- Change in NCQA measure definition from previous year(s)
- Improvements in data capture
- Changes in NCQA National Medicaid or DHCS minimum performance levels

Today we will demonstrate the tool focusing on two or three (time permitting) HEDIS measures for your review and feedback.



CalOptima
Better. Together.

Provider Coaching Pilot

**Special Board of Directors' Quality Assurance Committee Meeting
January 17, 2019**

**Betsy Ha, RN, MS, LSSMBB, Executive Director, Quality & Analytics
Miles Masatsugu, M.D., Medical Director**

Enhanced Pilot Goals

- Pilot Goals:
 - Reduce grievances
 - Reduce potential quality issues (PQIs)
 - Improve customer service performance
 - Improve member experience and satisfaction

Rapid Cycle Improvement Learnings

- Cycle One: Aim to enroll 25 out of 50 outreached middle performing physicians to Physician Shadow Coaching Sessions by October 2018
 - Measure: 10% or 6/50 CCN PCP completed shadow coaching session
 - Lessons Learned: Middle performing PCP are not motivated to participate in Physician Shadow Coaching for various reasons
- Cycle Two: Expand Provider Coaching and Customer Services Workshop to Health Networks
 - Progress date: 16 of office manager/staff signed up for Customer Service Workshop, and 1 of HN PCP signed up for Coaching
 - Lessons Learned: Continue partnership with HN
 - One physician training — November 9
 - One manager/supervisor training — November 2
 - One staff training — November 2

Expanding Provider Coaching

- Current Improvement Cycle Three:
 - New Outreach Strategy: target physicians with a high volume of grievances and PQIs
 - Provider Selection Criteria (Refer to Table)
 - Notification letter sent to 30 primary care physicians and specialists with the largest number of grievance and potential quality issues (PQIs).
 - Letter highly recommended participation in shadow coaching sessions.

Provider Grievances and PQI Trend Data

CPRC Activity Report: GARS ≥ 25							CPRC Activity Report: PQI ≥ 10					
Specialty	2Y Prac GARS Count**	2Y Spec GARS Count**	Claim Count Prac**	Claim Count Spec**	Prac GARS Rate	Spec GARS Rate	3Y Prac PQI Count**	3Y Spec PQI Count**	Claim Count Prac**	Claim Count Spec**	Prac PQI Rate	Spec PQI Rate
Family Medicine	94	1,916	1,061	568,809	88.60	3.37	18	686	1,719	843,701	10.47	0.81
Family Medicine	74	1,916	6,350	568,809	11.65	3.37	20	686	11,146	843,701	1.79	0.81
Family Medicine	73	1,916	2,387	568,809	30.58	3.37	10	65	3,161	671,589	3.16	0.10
Family Medicine	59	1,916	2,963	568,809	19.91	3.37	12	686	4,613	843,701	2.60	0.81
Family Medicine	54	1,916	5,155	568,809	10.48	3.37	20	686	8,434	843,701	2.37	0.81
General Practice	46	610	991	154,118	46.42	3.96						
Internal Medicine	43	1,092	2,172	539,486	19.80	2.02						
Family Medicine	42	1,916	3,818	568,809	11.00	3.37	10	686	5,327	843,701	1.88	0.81
Pain Management	41	270	5,766	442,652	7.11	0.61	19	65	7,404	671,589	2.57	0.10
Family Medicine	40	1,916	1,553	568,809	25.76	3.37						
Family Medicine	37	1,916	1,773	568,809	20.87	3.37	16	686	2,337	843,701	6.85	0.81
Orthopaedic Surgery	35	255	19,558	97,385	1.79	2.62						
General Practice	35	610	485	154,118	72.16	3.96						
Family Medicine	34	1,916	2,803	568,809	12.13	3.37	11	686	3,899	843,701	2.82	0.81
Internal Medicine	34	1,092	1,407	539,486	24.16	2.02						
Family Medicine	33	1,916	5,838	568,809	5.65	3.37	13	686	8,533	843,701	1.52	0.81
Family Medicine	31	1,916	6,036	568,809	5.14	3.37						
Pain Management	30	296	1,867	79,083	16.07	3.74	18	131	2,554	111,681	7.05	1.17
Family Medicine	29	1,916	4,213	568,809	6.88	3.37	14	686	6,793	843,701	2.06	0.81
Family Medicine	29	1,916	12,163	568,809	2.38	3.37						
Family Medicine	28	1,916	2,396	568,809	11.69	3.37	15	686	3,773	843,701	3.98	0.81
Family Medicine	28	1,916	2,857	568,809	9.80	3.37	10	686	3,244	843,701	3.08	0.81
Neurology	28	161	1,681	46,092	16.66	3.49						
General Practice	27	610	23,381	154,118	1.15	3.96						
Internal Medicine	26	1,092	6,136	539,486	4.24	2.02						
Internal Medicine	25	1,092	4,390	539,486	5.69	2.02						

Provider Response

- Immediate response
- Surprised by the data
- Wanted to give their perspective
- Open to feedback
- Requested additional information
- Interested in provider coaching

Provider Coaching Pilot Next Steps

- Continue with outreach and planned interventions: shadow coaching and training sessions in partnership with HNs
- Pivot Provider Coaching Pilot to decrease grievances and PQIs
- Evaluate effectiveness of interventions
 - Feedback from participants
 - Grievances — trend in six months
 - PQIs — trend in six months
 - Clinician and Group Consumer Assessment of Healthcare Providers and Systems (GG-CAHPS) or member experience survey rates by provider in 2019

Special Board of Directors' Quality Assurance Committee Meeting January 17, 2019

Whole Child Model (WCM) Clinical Advisory Committee (CAC) Update

Whole Child Model (WCM) Clinical Advisory Committee (CAC) Meeting September 25, 2018

Emily Fonda MD, Interim Chief Medical Officer, chaired the first CAC. Dr. Fonda welcomed the participants and emphasized the importance of the committee to CalOptima in our efforts to make the WCM a better and more comfortable experience for patients with CCS conditions and their families. Our previous experience with our Model of Care, utilized with our sickest adults, along with our history of having the number one Medi-Cal Plan ranking in California for the fifth year in a row, will allow us to improve services and improve outcomes. We also let the committee members know that we were happy to impart information about the WCM in order for them to pass it along to their colleagues and patients. This was followed by a request for each new member to give their personal reasons for joining the committee, their main concerns and their expectations.

This was followed by a presentation by Tracy Hitzeman, Executive Director of Clinical Operations which described the Whole Child Model. The last presentation was a review of the WCM Clinical Advisory Committee Charter by Betsy Ha, Director of Quality and Analytics.

The meeting on November 21, 2018 was deferred to January 15, 2019 due to the Thanksgiving holiday. The first WCM CAC in 2019 will be chaired by CalOptima's new Chief Medical Officer, Dr. David Ramirez and joined by the new WCM Medical Director, Dr. Thanh-Tam Nguyen.

Special Board of Directors' Quality Assurance Committee Meeting January 17, 2019

Improve Access to Annual Eye Exam for Medi-Cal Members with Diabetes

CalOptima has contracted with Vision Service Plan (VSP) for the provision of vision services, continuously, since October 1, 1998. New contracts with VSP were executed in 2009 and 2016 through Board-approved competitive procurement processes, most recently, a Request for Proposal (RFP) held in 2015. The current contract covers Medi-Cal, OneCare, OneCare Connect, and PACE members and is effective July 1, 2016, through June 30, 2019, with two additional one-year extension options, at CalOptima's discretion.

The current VSP contract covers one routine eye exam during any 24-month period for CalOptima Medi-Cal members. As an effort to improve access to annual eye exam for Medi-Cal members, clinical staff recommends Contracting to amend the HMO Contract with VSP to modify the covered benefit to 12-month period.

The proposed amendment aligns with the Department of Health Care Services Medi-Cal and American Diabetes Association approved clinical guidelines and National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS)[®] requirements.

CalOptima Contracting Department will be submitting a COBAR for approval at the future Board meeting.



Special Board of Director's Quality Assurance Committee Meeting January 17, 2019

Quality Improvement Committee (QIC) Quarter 3 Update

QIC Meeting Dates: July 17, 2018, August 14, 2018, September 11, 2018

- Summary
 - 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)
 - Clinical Operations Population Health (COPHS)/Medical Affairs
 - Credentialing Peer Review Committee (CPRC)
 - Access and Availability
 - Accepted minutes from the following subcommittees:
 - Utilization Management Committee: May 24, 2018
 - Behavioral Health Integration QI Committee: May 01, 2018
 - Long-Term Services and Supports: March 19, 2018
 - Grievance & Appeals Committee: May 31, 2018
 - Clinical Operations Population Health: July 23, 2018
 - Member Experience: June 26, 2018, July 12, 2018, July 24, 2018, August 21, 2018
 - PACE Quality Improvement Committee: March 13, 2018, June 12, 2018
- QIC Highlights
 - Whole-Child Model Clinical Advisory Committee (WCM CAC) Charter was presented and approved. The committee members were selected and the kickoff meeting was held in September.
 - Personal Care Coordinator Evaluation was presented to the QIC
 - Final results of NCQA Health Plan Accreditation were released. Once again, CalOptima maintains its Commendable rating from NCQA.
 - Diabetic Care pilot program was presented by Dr. Dajee

- Q3 Sub-Committee Highlights

- Behavioral Health (BH) Integration Quality Improvement Committee (BHIQIC)
 - The committee reviewed access, member experience, and coordination of care workplan elements as well as reviewed BH related HEDIS measures. Greatest concern is meeting follow-up after hospitalization HEDIS measures which were below targeted rates.
- Utilization Management Committee (UMC)
 - The UM workplan goals and specific related projects were presented to the committee. Operational performance statistics were shared and are on target across all lines of business. Projects and initiatives that continue to require resources include Whole Child Model Planning, MSSP Transition, and Palliative Care.
- Long Term Services and Supports Quality Improvement Subcommittee (LTSS-QISC)
 - Presented operational performance measures results which are on target for CBAS and LTC. Current projects and initiatives include transition of MSSP members to new benefit mode, and the CMS Plan-Do-Study-Act (PDSA) for LTC.
- Grievance and Appeal Resolution (GARS) Subcommittee
 - GARS presented Q2 member and provider complaints in October QIC. GARS minutes submitted with this quarter.
- Credentialing Peer Review Committee (CPRC)
 - The committee continues to review practitioner specific files with issues. Committee also reviews presentations from Audit & Oversight regarding Health Network credentialing performance, Facility Site Review, regarding non-compliant sites with failed FSR/MRR and open CAPS, and Potential Quality Issues regarding reviewed quality of care issues.
- Member Experience Subcommittee (MEMX)
 - CAHP Survey results, Customer Service statistics, and Access & Availability subcommittee activity were presented to the committee. Updates to Shadow Coaching pilot project were also presented.
- Clinical Operations Population Health Subcommittee (COPHS)
 - Case Management is workplan metrics were presented. Case Management working on measures that are not meeting goals.
- Quality Analytics Update
 - 2018 HEDIS Results (MY 2017) was presented. For Medi-Cal, all DHCS MPLs have been met. 56% of measures met goal, 76% of measures performed better than 2017. Opportunities for improvement include respiratory, cardiovascular and access to care measures. For OneCare 56% measures met goal, 74% of measures are better than last year. Opportunities for improvement include Diabetes Nephropathy and Breast Cancer Screening. For OneCare Connect, 33% of measures met goal 74% of measures are better than last year. Opportunities for improvement include Diabetes and Behavioral Health measures.
 - CAHPS Survey results were presented. Medi-Cal Adult survey results are consistent with previous year at 25th percentile. Factors impacting in low scores include higher Member Experience benchmarks; double waited scoring for Rating of Health Plan, and <25th percentile scores for Coordination of Care, Getting Needed Care, Getting Care Quickly, and Rating of a Specialist.
- PACE QIC - Presented PACE QIC updates from Q2. Minutes included with QIC minutes.

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT											
QIC	Program Oversight	Quality Improvement	Esther Okajima/Kelly Rex-Kimmet	2018 QI Annual Oversight of Program and Work Plan	Approve QI Program and Workplan for 2018	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption	Approved at QIC 1/23/2018; QAC 2/20/2018; BOD 3/1/2018	None	3/1/2018	
QIC	Program Oversight	Quality Improvement	Esther Okajima/Kelly Rex-Kimmet	2017 QI Program Evaluation	Evaluate QI Program for 2017	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation	Approved at QIC 1/23/2018; QAC 2/20/2018; BOD 3/1/2018	None	3/1/2018	
QIC	Program Oversight	Utilization Management	Tracy Hitzeman	2018 UM Program and UM Workplan	Approve UM Program and Workplan for 2018	UM Program and UM Work Plan will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Annual Adoption	Approved at QIC 1/23/2018; QAC 2/20/2018; BOD 3/1/2018 (UM Program Only)	Work Plan will go in 2Q to QIC	3/1/2018	
QIC	Program Oversight	Utilization Management	Tracy Hitzeman	2017 UM Program Evaluation	Evaluate UM Program for 2017	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Annual Evaluation	Approved at UMC 3/22/2018; QIC 4/10/2018; QAC 5/16/18 Will go to BOD 6/7/2018	QIC Approved April 10th meeting.	4/1/2018	
QIC	Program Oversight	Case Management	Sloane Petrillo	2018 Case Management Program	Approve CM Program for 2018	CM Program will be adopted on an annual basis; Delegation oversight reported by DOC	Annual Adoption	CM Program on target to present at QIC.	QIC approved May 8th Meeting.	5/8/2018	
QIC	Program Oversight	HE & DM	Pshyra Jones	2018 Health Management Program	Approve HM program for 2018	HM Program will be adopted on an annual basis	Annual Adoption	Approved at QIC 2/13/2018	None	2/13/2018	
QIC	Program Oversight	Quality Improvement	Esther Okajima	Credentialing Peer Review Committee Oversight	Peer Review of Provider Network	Review of initial and recredentialing applications, related quality of care issues, approvals, denials, and reported to QIC ; Delegation oversight reported by A&O quarterly to CPRC.	Quarterly Adoption of Report	CPRC 1Q was presented to QIC on May 8th	2Q results will be presented to QIC on 9/11/2018.	3Q	
QIC	Program Oversight	Behavioral Health	Donald Sharps MD	BHQIC Oversight	Internal and External oversight of BHI Activities	BHQI meets quarterly to monitor and identify improvement areas of member and provider services, ensure access to quality BH care, and enhance continuity and coordination between behavioral health and physical health care providers.	Quarterly Adoption of Report	BHQIC 1Q was presented to QIC on April 10th.	2Q results will be presented to QIC 7/17/2018.	3Q	
QIC	Program Oversight	Utilization Management	Sharon Fetterman	UMC Oversight	Internal and External oversight of UM Activities	UMC meets quarterly; it monitored medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results	Quarterly Adoption of Report	UMC 1Q was presented to QIC April 10th with an update on the IRR results.	2Q results will be presented to QIC 7/17/2018.	3Q	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
QIC	Program Oversight	Quality & Analytics	Kelly Rex-Kimmet	Member Experience Subcommittee Oversight	Oversight of Member Experience activities to improve member experience	The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNS), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	MEMX 1Q was presented to QIC June 12th.	2Q results will be presented to QIC 9/11/2018.	3Q	
QIC	Program Oversight	LTSS	Steven Chang	LTSS QISC Oversight	LTSS QI Oversight	The LTSS Quality Improvement Sub Committee meets on a quarterly basis and addresses key components of regulatory, safety, quality and clinical initiatives.	Quarterly Adoption of Report	LTSS 1Q. was presented to QIC on July 17th.	2Q will be presented to QIC on 10/09/2018	Q4	
QIC	Program Oversight	Medical Affairs	Tracy Hitzeman/ Betsy Ha	Clinical Operations/Population Health Oversight	Clinical Operations Oversight	This COPHS monitors the progress of the established program goals and metrics defined for CalOptima's disease management, complex case management programs and Model of Care.	Quarterly Adoption of Report	COPHS 1Q results were reported to QIC on May 8th	2Q will be presented to QIC on 8/14/2018	3Q	
QIC	Program Oversight	GARS	Ana Aranda	GARS Committee	GARS Committee Oversight	The GARS Committee oversees the Grievance Appeals and Resolution of complaints by members for CalOptima's network. Results are presented to committee quarterly	Quarterly Adoption of Report	GARS Committee meeting scheduled for 8/30/18 to review Q2, 2018 data. Presented Q1, 2018 to QIC on 6/12/18. No outstanding issues.	2Q will be presented to QIC on 9/11/2018	3Q	
QIC	Program Oversight	PACE	Dr. Miles Masatsugu	PACE QIC	PACE QIC Oversight	The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC	Quarterly Adoption of Report	Pace 1Q results were report to QIC on June 12th.	2Q will be presented to QIC on 9/11/2018	3Q	
QIC	Program Oversight	Quality & Analytics	Esther Okajima/Kelly Rex-Kimmet	Quality Program Oversight - NCQA	Maintain "Commendable" NCQA accreditation rating	Monitor specific HEDIS measures listed below. Conduct NCQA Renewal Survey submission May 2018	Maintain Commendable Status. Accreditation evaluated every three years. HEDIS measures scored annually.	In the final stages submission was on May 22, 2018. On-Site Audit prep in process with a scheduled on-site date of July 9-10.	On target to submit by May 22.	3Q	
QIC	Program Oversight	Quality & Analytics	Kelly Rex-Kimmet/ Esther Okajima	Quality Program Oversight - Health Plan Rating	Maintain or exceed NCQA 4.0 health plan rating	Monitor specific HEDIS measures listed below and Maintain Commendable Status.	Achieve 4.0 Health Plan Rating - Annual Assessment	NCQA renewal survey was submitted on May 22nd. HEDIS and CAHPS were submitted in June.	Awaiting NCQA accreditation results which will be reported in August of 2018. Health Plan Ratings will be released in Sept.	3Q	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
QIC	Program Oversight	Quality & Analytics	Kelly Rex-Kimmet/ Tracy Hitzeman	Quality Program Oversight - Quality Withold	Earn Quality Withold Dollars back for OneCare Connect in OCC QW program.	Quarterly monitoring and reporting to OCC Steering Committee and QIC	Annual Assessment	50% of Withold dollars were earned back for demonstration year 2 (MY 2016). Payments to HN for DY2 were mailed 9/10/18. Reimbursement for DY3 (MY 2017) are expected to be 75%. Follow-up After Hospitalization for Mental Illness (FUH) was failed both years. This has been discussed with BHI team for an action plan.	Develop action plan with Behavioral Health team for improvement of FUH measure for OCC. Consider P4V program for MH vendor?	4Q	Yellow
QIC	Program Oversight	Quality & Analytics	Kelly Rex-Kimmet/ Sandeep Mital	Pay for Value	<ul style="list-style-type: none"> Implement and monitor health network performance on P4V measures during the year; Calculate and distribute the P4V incentive payments to participating health networks for MY 2017; and Calculate and distribute the P4V incentive payments to participating providers in CCN for MY 2017 	<ul style="list-style-type: none"> Generate and share Prospective Rate reports monthly for all health networks on their performance on adult and child clinical measures Complete review of 2017 measures at the end of the year Hold provider education with Provider relations team to educate CCN providers and provider relations team on the new CCN P4V program. Implement CCN P4V Prospective Rate reporting 	National and State benchmarks	<ul style="list-style-type: none"> Calculate and distribute the P4V incentive payments to participating health networks for MY 2017; and Calculate and distribute the P4V incentive payments to participating providers in CCN for MY 2017 	Awaiting CA-specific benchmarks for CAHPS surveys for the Medi-Cal line of business and final CAHPS results for the OneCare Connect line of business.	4Q	Green
QIC	Program Oversight	Medical Affairs	Tracy Hitzeman/ Betsy Ha	MOC Dashboard 2016-2019	Present OC/OCC & SPD MOC Quality Matrix to QAC and Board of Directors by 2nd Quarter, 2018; Re-evaluate measurements through data analysis	Define analytics and resources to support the Model of Care for OC/OCC & SPD members; Implement activities to meet or exceed measures	Meet or exceed defined MOC Metrics	From Q1, MOC metrics are being updated to meet the performance reporting measures outlined in the QIPE_PPME Technical Specifications. The QI Workplan include activities for OC/OCC and will be monitored below. For OCC activities include OCCRA collection and completion, OCC ICP Completion, OCC Discussion of care goals, OCC PDSA. For OC activities include CCIP, QIP and HRA initial and annual.	Evaluate whether all the measures needed for the QIPE_PPME are captured within the QI Workplan	10/31/2018	Yellow
II. QUALITY OF CLINICAL CARE - CARE MANAGEMENT											
COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	Review of Health Risk Assessments for OCC New Beneficiaries	OCC- Health Risk Assessment Outreach for members in the OneCare Connect Program monitored for completion and collection for Initial HRA	OCC- Administer the initial HRA to the high risk beneficiary within 45 days of a beneficiary's enrollment OCC- Administer the initial HRA to the low risk beneficiary within 90 days of a beneficiary's enrollment	OCC High Risk Initial 56% OCC Low Risk Initial 43%	OCC High Risk Initial 70% collected OCC Low Risk Initial 57% collected	Continue to monitor HRA redesign. Monitor results of addition of new question designed to promote engagement.	4Q	Green
COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	Review of Health Risk Assessments for OC New Beneficiaries	OC- Health Risk Assessment Outreach for members in the OneCare Program monitored for completion for Initial HRA	OC - Administer the Initial HRA within 90 days of beneficiary eligibility.	For OC Initial HRA - Achieve Collection Rate of 78%, report quarterly	OC Initial HRA 67% (Quarter 1)	Continue to monitor outreach efforts. Consider addition of new question designed to promote engagement question to HRA.	4Q	Yellow
COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	Review of Health Risk Assessments for SPD New Beneficiary's	SPD- Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion for Initial HRA	SPD- Administer the initial HRA to the high risk beneficiary within 45 days of a beneficiary's eligibility; SPD- Administer the initial HRA to the low risk beneficiary within 105 days of a beneficiary's eligibility	For SPD Initial High Risk HRA - Achieve Collection Rate of 63% report quarterly	SPD High Risk Initial 63% SPD Low Risk Initial 63%	Continue to monitor HRA redesign. Monitor results of addition of new question designed to promote engagement.	4Q	Green

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	Annual Collection and Review of Health Risk Assessments for OCC/OC/SPD existing members	OCC/OC/SPD Administer the annual HRA to the beneficiary to all participants	OCC/OC/SPD Administer the annual HRA to the beneficiary to all participants	OCC Annual 50% OC Annual 34% No goal set for SPD.	OCC Annual 51% collected OC Annual 56% collected	Continue to monitor	4Q	
COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	High ER Utilization	Evaluation and intervention for ongoing review of high ER utilizers	Identify top 10 high ER utilizers for CCN per quarter (all lines of business); Open to case management with focused group of case managers; Regular meetings to identify causes of high utilization and effective strategies for reduction in inappropriate ER utilization	5% reduction in ER visits among intervention cohort	Cohort 6 members identified and assigned. Current pilot enrollment is 56. Exceeded 5% reduction over all cohorts.	Continue adding cohorts. Refine data analysis.	4Q	
COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	Review Of Member Satisfaction With CM Programs	Annual review of member feedback on the case management programs to assure high satisfaction and improved health status	Review annual satisfaction survey results, define areas for improvement and implement interventions to improve member experience with CM programs	Satisfaction with Case Management - 88%	Overall Satisfaction with Case Management 86%	Hire one additional complex case manager. Realigned case management teams and hired one additional supervisor for staff support and training. Added engagement as department overall goal.	4Q	
COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	Coordination of CCS Medical Home and CalOptima PCP	Monitor coordination efforts between CCS Medical Home and CalOptima PCP's	Coordinated quarterly review with CCS. Establishment of pilot to address CCS questions. Root cause analysis completed.	90%	Quarter 2 sample yielded a match of 60% between the medical home and CalOptima PCP.	Continue working through pilot. Planning underway for Whole Child Model which will ensure PCP alignment.	4Q	
COPHS	Quality of Clinical Care	Case Management	Sloane Petrillo	HN MOC Oversight	Regular review of the Health Network's performance of MOC functions	Review of 100% of MOC files with monthly feedback provided to Health Networks	HN to achieve 80% score on file review monthly	OCC - OCA did not meet goal for one month. OC - All HNs met goal. SPD - All HNs met goal.	Continue intensive oversight and reporting.	4Q	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
III. QUALITY OF CLINICAL CARE - BEHAVIORAL HEALTH											
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up Care for Children with Prescribed ADHD Medication (ADD) Initiation Phase	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	<ul style="list-style-type: none"> Continue to hold monthly BH QI work group with representation from the various departments associated with the measures Continue to work on current intervention focus for AMM and ADD HEDIS measures BHI has several measures that are being monitored which may also serve as opportunity for improvements 	Medicaid 48.18%	<p>Measurement year Feb to March Q1 - Q1 following year. 2018 Results for this measure processed Q2.</p> <p>2018 results were 42.07% (50th percentile not met); in comparison, 2017 results were 38.95% (50th percentile not met)</p> <p>Despite not meeting goal, rates have slowly increased each year.</p>	Compare data reports and analyze to find trends in providers or service months where improvement can be made.	1Q2019	
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up Care for Children with Prescribed ADHD Medication (ADD) Continuation Phase	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	<ul style="list-style-type: none"> Continue to hold monthly BH QI work group with representation from the various departments associated with the measures Continue to work on current intervention focus for AMM and ADD HEDIS measures BHI has several measures that are being monitored which may also serve as opportunity for improvements 	Medicaid 44.80%	<p>Measurement year Feb to March Q1 - Q1 following year. 2018 Results for this measure processed Q2.</p> <p>2018 results were 45.89% (Met 50th percentile); in comparison, 2017 results were 43.07% (50th percentile not met)</p> <p>This was the first year of this measure meeting the NCOA 50th percentile goal which was a big deal.</p>	compare data reports and analyze to find trends in providers or service months where improvement can be made.	1Q2019	
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Antidepressant Medication Management (AMM) Acute Phase Treatment	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	<ul style="list-style-type: none"> Continue to hold monthly BH QI work group with representation from the various departments associated with the measures Continue to work on current intervention focus for AMM and ADD HEDIS measures BHI has several measures that are being monitored which may also serve as opportunity for improvements 	Medicaid 56.94% OneCare 75.00% OneCare Connect 63.45%	<p>AMM Acute results processed in Q2 2018. AMM Acute Met 50th percentile/ close to meeting 75th percentile for Medi-Cal.</p> <p>AMM Acute results for OC not reported due to low volume.</p> <p>AMM Acute NOT MET for OCC. This year results 62.59%. Comparison to previous year shows slight increase (60.56%)</p>	encourage resources to be used where members best practices can result in improved quality care.		

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/TimeLine	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Antidepressant Medication Management (AMM) Continuation Phase Treatment	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	<ul style="list-style-type: none"> Continue to hold monthly BH QI work group with representation from the various departments associated with the measures Continue to work on current intervention focus for AMM and ADD HEDIS measures BH has several measures that are being monitored which may also serve as opportunity for improvements 	Medicaid 41.12% OneCare 53.90% OneCare Connect 47.09%	AMM Continuation phase met 50th percentile and close to meeting 75th percentile for Medi-Cal. AMM Continuation results for OC not reported due to low volume. AMM Continuation NOT MET for OCC. This year results 45.41%. Comparison to previous year shows slight increase (43.17%) Between 2016 and 2017 rates BH issued RFP. This resulted in decrease in rates for 2017. New vendor tried to bring the rates back up for 2018. Not quite met yet.	encourage resources to be used where members best practices can result in improved quality care.		Green
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up After Hospitalization within 30 days of discharge (FUH)	FUH measures the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow up visit with a mental health practitioner.	Will monitor and measure -The percentage of discharges for which the patient received follow up within 30 days of discharge	OCC Quality Withhold Goal 60.89%	Goal not met. Decrease from previous years.	Monthly meeting to address MBHO practices and interventions. Provide Monthly HEDIS rates to encourage outreach and see monthly progress towards goals.	4Q	Red
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up After Hospitalization within 7 days of discharge (FUH)	FUH measures the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow up visit with a mental health practitioner.	Will monitor and measure -The percentage of discharges for which the patient received follow up within 7 days of discharge	OCC Quality Withhold Goal 56%	Goal not met. Decrease from previous years.	Monthly meeting to address MBHO practices and interventions. Provide Monthly HEDIS rates to encourage outreach and see monthly progress towards goals.	4Q	Red
BHQIC	Quality of Clinical Care	Behavioral Health	Edwin Poon	Interdisciplinary Care Treatment Team Participation	Behavioral health services, integration and coordination of care will be monitored and measured	Monitor and identify opportunities to improve integration and coordination of care across settings and/or transitions of care through ICT/ICP	Maintain or improve the participation rate of 95% or higher for Medi-Cal, One Care and One Care Connect ICTs or ICPs completed	YTD Rates for CCN ICT participation is at 44%	work through barriers to participation; ensure clear definition of participation observed by all; outreach by clinical staff to reach potential participants for ICT or ICP updates received.	4Q	Yellow
BHQIC	Quality of Clinical Care	Behavioral Health	Edwin Poon	Adopt Behavioral Health Clinical Practice Guidelines	BH Clinical Practice Guidelines will be reviewed and adopted	Adoption of at least two behavioral health Clinical practice guidelines will be reviewed and adopted	Annual Adoption of BH Clinical Practice Guidelines	Requirement met for 2 year period. Next review will be conducted in Q1 2019	completed	2Q	Green

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
IV. QUALITY OF CLINICAL CARE - LONG TERM SERVICES AND SUPPORTS											
UMC	Quality of Clinical Care	LTSS	Steven Chang	Operational Performance CBAS	100 % Compliance	Timeliness of Determination Inquiry to CEDT completion	CBAS CEDT TAT 100% completed within 30 calendar days of request for services.	QTR 2 CBAS CEDT 100%	Continue to monitor.	3Q	Green
UMC	Quality of Clinical Care	LTSS	Steven Chang	Operational Performance	Consistent application of guidelines	Inter-Rater Reliability (IRR) assessment to ensure consistent application of guidelines	Annual IRR assessment will reflect a score \geq 90% Annual Assessment occurs in Quarter 2	LTC Clinical Staff 95% CBAS Clinical Staff 100%	LTSS Clinical staff will complete IRR testing in May 2019.	2Q2019	Green
UMC	Quality of Clinical Care	LTSS	Steven Chang	Operational Performance MSSP	Ensure provision of MSSP to maximal participants (within program constraints).	Monitor New Admissions Discharges (voluntary terminations and involuntary terminations)	Discharges w/ll not exceed New Admissions by more than two members during the quarter.	QTR 2 New Admissions 26 Discharges Voluntary 21 Involuntary 5	Continue to monitor.	3Q	Green
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Number of CBAS members transitioned to LTC.	Promote continued community placement when safe and appropriate.	Track CBAS participants who transition to LTC.	Less than 0.50% of CBAS participants will transition to LTC during the quarter.	QTR 2 Medi-Cal 9 of 2,238 (0.39%) OCC 0 of 127	Continue to monitor.	3Q	Green
UMC	Quality of Clinical Care	LTSS	Steven Chang	Overall Ratio of average CBAS utilization (delivered) to average authorization (approved) for CBAS participation days.	Ensure appropriate level (amount) of CBAS services.	Implement processes to track authorized days versus actual participant days. Evaluate variance reasons (e.g. illness, hospitalized, vacation)	80% of authorized CBAS participation days will be utilized/delivered.	QTR 2 80,518 Days Used of 107,111 Authorized (75.2%)	Continue to monitor.	3Q	Yellow
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Overall ratio of members participating in CBAS versus potentially program-eligible members.	Promote continued community placement with HCBS when safe and appropriate.	Quarterly reporting	Overall CBAS participation ratio does not decrease from previous quarter.	QTR 2 OCC 117/8,818 (1.33%) Decrease Medi-Cal 2,287/109,127 (2.10%) Increase	Continue to monitor.	3Q	Yellow
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang/Laura Guest	Member satisfaction	Evaluate member satisfaction with LTSS programs.	Annual member satisfaction survey CBAS and LTC	Average CBAS Member Satisfaction will exceed 85%. Average LTC Member Satisfaction will exceed 65%.	2017 Results: CBAS: 88% overall satisfaction LTC: 67% overall satisfaction 2017 CBAS Member Satisfaction Survey Results Description	2018 survey in progress.	4Q	Green
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Overall ratio of members residing in LTC versus entire OCC/SPD memberships.	Monitor impact of HCBS in promoting residence in least restrictive environment.	Quarterly reporting	Overall LTC residency ratio does not increase from previous quarter.	QTR 2 OCC 238/8,818 (2.70%) Decrease SPD 4,295/109,127 (3.94%) Decrease	Continue to monitor.	4Q	Green
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	Number of LTC members successfully transitioned out to a lower LOC/community.	Monitor impact of focused transition efforts supporting member transitions to the community.	Quarterly reporting	Percentage of LTC members successfully transitioned to lower LOC/community does not decrease from previous quarter.	QTR 2 38 of 5,155 members (0.74%)	Continue to monitor.	4Q	Green

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/TimeLine	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang	MSSP Transition Planning	Coordinated transition of all MSSP members into new benefit model.	Transition planning involving DHCS, CDA, internal and external stakeholders.	1/1/2020 is scheduled transition date.	Meetings with internal stakeholders held.	Continue communication and coordination with DHCS and CDA.	1Q2020	Green
V. QUALITY OF CLINICAL CARE - HEDIS											
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC) HbA1c Testing	Outreach to members who are due for HbA1c testing. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives.	Medicaid 87.1% OneCare 93.82% OneCare Connect 91.73%	<p>HEDIS 2018 Final Rates: Medicaid: 90.75%; Met Goal OneCare: 90.32%; Goal not met OneCare Connect: 90.05%; Goal not met</p> <p>June 2018 Prospective Rates: Medicaid: 68.95% OneCare: 69.85% OneCare Connect: 72.63% - Rates are higher for all LOBs when compared to same time last year.</p>	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices, 2) DM Member incentive programs to be implemented Q2, 2018, 3) targeted mailings, 4) educational outreach by health coaches/ educators.	4Q	Yellow
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC) HbA1c Poor Control (>9.0%)	Outreach to members who have poor or uncontrolled HbA1c levels. For the CCN population, targeted outreach to high volume providers via medical director outreach. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid 29.07% OneCare 20% OneCare Connect 27%	<p>HEDIS 2018 Final Rates: Medicaid: 22.87%; Met Goal OneCare: 18.95%; Met Goal OneCare Connect: 21.94%; Met Goal A lower rate is better for this measure.</p> <p>June 2018 Prospective Rates: Medicaid: 59.15% OneCare:73.16 % OneCare Connect:71.55 % - MC Rates are performing better when compared to same time last year. OC and OCC is performing lower when compared to last year.</p>	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices, 2) DM Member incentive programs to be implemented Q2, 2018, 3) targeted mailings, 4) educational outreach by health coaches/ educators.	4Q	Green
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC) HbA1c Control (<8.0%)	Interventions may include; targeted mailings with educational materials. Members are identified and enrolled in the disease management program with opt-out option.	Medicaid 59.12% OneCare 69.71% OneCare Connect 64.72%	<p>HEDIS 2018 Final Rates: Medicaid: 63.99%; Met Goal OneCare: 76.61%; Met Goal OneCare Connect: 70.15%; Met Goal</p> <p>June 2018 Prospective Rates: Medicaid: 33.84% OneCare:23.90 % OneCare Connect:24.30 % - MC and OC rates are higher when compared to same time last year. Whereas OCC rates are slightly lower compared to last year.</p>	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices, 2) DM Member incentive programs to be implemented Q2, 2018, 3) targeted mailings, 4) educational outreach by health coaches/educators.	4Q	Green

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC) Eye Exam	Targeted outreach to members who are due for a diabetic eye exam. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid 65.83% OneCare 81% OneCare Connect 81%	HEDIS 2018 Final Rates: Medicaid: 65.94%; Met Goal OneCare: 76.61%; Goal not met OneCare Connect: 77.55%; Goal not met June 2018 Prospective Rates: Medicaid: 41.24% OneCare: 47.06 % OneCare Connect: 53.15% - MC and OCC rates are better when compared to last year. Whereas OC rates are slightly lower than last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices, 2) DM Member incentive programs to be implemented Q2, 2018, 3) targeted mailings, 4) educational outreach by health coaches/educators.	4Q	Yellow
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC) Medical Attention for Nephrology	Targeted outreach to members who are due for a screening. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid 91.24% OneCare 94% OneCare Connect 96%	HEDIS 2018 Final Rates: Medicaid: 91.73%; Met Goal OneCare: 89.52%; Goal not met OneCare Connect: 95.15%; Goal not met June 2018 Prospective Rates: Medicaid: 81.89% OneCare: 81.62 % OneCare Connect: 89.38% - MC and OCC rates are higher when compared to same time last year. OC is performing lower than last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices, 2) targeted mailings, 3) educational outreach by health coaches/educators.	4Q	Yellow
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC) Blood Pressure Control (<140/90 mm Hg	Outreach to diabetic members with high blood pressure. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid 72.24% OneCare 80.12 OneCare Connect 70.83%	HEDIS 2018 Final Rates: Medicaid: 72.26%; Met Goal OneCare: 79.03%; Goal not met by <1% OneCare Connect: 69.90%; Goal not met <1% June 2018 Prospective Rates: Medicaid: 16.64% OneCare: 28.31% OneCare Connect: 21.69% - All LOB rates are higher when compared to same time last year.	Continue with implementing interventions; 1) Targeting high-volume CCN provider offices, 2) DM Member incentive programs to be implemented Q2, 2018, 3) targeted mailings, 4) educational outreach by health coaches/educators.	4Q	Green
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	All-Cause Hospital Readmissions (PRC)	Continue to implement the Transition of Care program; focus on the health coaching intervention.	OneCare 6% OneCare Connect 9%	HEDIS 2018 Final Rates: OneCare: OneCare Connect June 2018 Prospective Rates: OneCare: 20.0% OneCare Connect: 9.56% - OC rates are higher when compared to same time last year however the denominator for this measure is low (n=35). OCC rates are better when compared to last year and close to the goal of 9%.	Continue to implement the Transition of Care program; focus on the health coaching intervention. Working on improving data process and validating results on a monthly basis	4Q	Yellow

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Prenatal and Postpartum Care Services (PPC) Timeliness of Prenatal Care	Targeted outreach to members who are due for prenatal/postpartum visits. Interventions may include; targeted mailings and incentives. The Bright Steps maternal health program is set to launch July, 2018.	Medicaid 86.79%	HEDIS 2018 Final Rate: Medicaid: 86.16%; Goal not met by <1% June 2018 Prospective Rates: Medicaid: 74.79% - Rate is slightly lower when compared to same time last year.	Continue with targeted prenatal and postpartum mailings until the launch of the Bright Steps program. Implement the member incentive program in June, 2018.	4Q	Green
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Prenatal and Postpartum Care Services (PPC) Postpartum Care	Targeted outreach to members who are due for prenatal/postpartum visits. Interventions may include; targeted mailings and incentives. The Bright Steps maternal health program is set to launch July, 2018.	Medicaid 69.44%	HEDIS 2018 Final Rate: Medicaid: 71.75%; Met Goal June 2018 Prospective Rates: Medicaid: 47.48% - Rate is higher when compared to same time last year.	Continue with targeted prenatal and postpartum mailings until the launch of the Bright Steps program. Member incentive program launched in Q2. [Runs from June 1- Dec. 31, 2018]	4Q	Green
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Childhood Immunization Status (CIS) Combo 3	Targeted outreach to members who are due for an immunization. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 74.39%	HEDIS 2018 Final Rate: Medicaid: 74.94%; Met Goal June 2018 Prospective Rates: Medicaid: 46.74% - Rate is higher when compared to same time last year.	Implement the next series of "CalOptima Day" events which includes a member and provider incentive in Q3, 2018. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]	4Q	Green
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Childhood Immunization Status (CIS) Combo 10	Targeted outreach to members who are due for an immunization. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 37.23%	HEDIS 2018 Final Rate: Medicaid: 45.01%; Met Goal June 2018 Prospective Rates: Medicaid: 27.46% - Rate is higher when compared to same time last year.	Implement the next series of "CalOptima Day" events which includes a member and provider incentive in Q3, 2018. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]	4Q	Green
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Lower Back Pain (LBP)	Provider education and outreach	Medicaid 74.40%	HEDIS 2018 Final Rate: Medicaid: 70.50%; Goal not met June 2018 Prospective Rates: Medicaid: 71.49% - Rate is lower when compared to same time last year. Measure currently at the 50th percent ile.	Developing a news article for Provider Update and/or targeted mailings to Providers.	4Q	Yellow

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/TimeLine	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 76.17%	<p>HEDIS 2018 Final Rate: Medicaid: 68.65%; Goal not met</p> <p>June 2018 Prospective Rates: Medicaid: 52.53% - Rate is higher when compared to same time last year</p>	Implement PIP activities focusing on targeted provider offices. Develop/Update educational materials for members to be included in newsletters.	4Q	
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP) 12-24 months	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 95.7%	<p>HEDIS 2018 Final Rate: Medicaid: 93.44%; Goal not met by 2.26%</p> <p>June 2018 Prospective Rates: Medicaid: 88.30% - Rate is higher when compared to same time last year.</p>	<p>Implement the next series of "CalOptima Day" events which includes a member and provider incentive in Q3, 2018. These events will impact the following measures [CIS, IMA, WC15, W34, AWC].</p> <p>Close to reaching goals for all submeasures. Activities are in progress.</p>	4Q	
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP) 25 months - 6 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 87.87%	<p>HEDIS 2018 Final Rate: Medicaid: 87.63%; Goal not met by <1%</p> <p>June 2018 Prospective Rates: Medicaid: 65.14% - Rate is higher when compared to same time last year</p>	<p>Implement the next series of "CalOptima Day" events which includes a member and provider incentive in Q3, 2018. These events will impact the following measures [CIS, IMA, WC15, W34, AWC].</p> <p>Close to reaching goals for all submeasures. Activities are in progress.</p>	4Q	
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP) 7-11 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 90.77%	<p>HEDIS 2018 Final Rate: Medicaid: 90.67%; Goal not met by <1%</p> <p>June 2018 Prospective Rates: Medicaid: 85.93% - Rate is higher when compared to same time last year</p>	<p>Implement the next series of "CalOptima Day" events which includes a member and provider incentive in Q3, 2018. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]. Tdap targets members 10-13 years olds which impact CAP population.</p> <p>Close to reaching goals for all submeasures. Activities are in progress.</p>	4Q	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/TimeLine	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP) 12-19 years	Targeted outreach to members who are due for a preventive visit. Interventions may include: preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 89.52%	<p>HEDIS 2018 Final Rate: Medicaid: 87.32%; Goal not met 2.2%</p> <p>June 2018 Prospective Rates: Medicaid: 82.06% - Rate is higher when compared to same time last year</p>	<p>Implement the next series of "CalOptima Day" events which includes a member and provider incentive in Q3, 2018. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]. Events also impacts the CAP population.</p> <p>Close to reaching goals for all submeasures. Activities are in progress.</p>	4Q	Yellow
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Cervical Cancer Screening (CCS)	Targeted outreach to members who are due for a screening. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid 58.48%	<p>HEDIS 2018 Final Rate: Medicaid: 60.24%; Met Goal</p> <p>June 2018 Prospective Rates: Medicaid: 49.71% - Rate is higher when compared to same time last year</p>	<p>Implement the member incentive program in June, 2018. Plan targeted mailings.</p>	4Q	Green
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)	Targeted outreach to members who are due for a screening. Interventions may include; wellness events at high volume provider sites, target mailings, incentives, and facets pop-ups.	Medicaid 80.64%	<p>HEDIS 2018 Final Rate: Medicaid: 83.15%; Met Goal</p> <p>June 2018 Prospective Rates: Medicaid: 37.39% - Rate is higher when compared to same time last year</p>	<p>Planning the next series of "CalOptima Day" events which includes a member and provider incentive. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]</p>	4Q	Green
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Well-Care Visits in first 15 months of life (W15)	Targeted outreach to members who are due for a screening. Interventions may include; wellness events at high volume provider sites, target mailings, incentives, and facets pop-ups.	Medicaid 56.11%	<p>HEDIS 2018 Final Rate: Medicaid: 48.18%; Goal not met</p> <p>June 2018 Prospective Rates: Medicaid: 21.73% - Rate is higher when compared to same time last year</p>	<p>Planning the next series of "CalOptima Day" events which includes a member and provider incentive. These events will impact the following measures [CIS, IMA, WC15, W34, AWC]</p>	4Q	Yellow
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Appropriate Testing for Children with Pharyngitis (CWP)	Provider outreach at PCP sites. Target urgent care centers	Medicaid 67.15%	<p>HEDIS 2018 Final Rate: Medicaid: 55.37%; Goal not met</p> <p>June 2018 Prospective Rates: Medicaid: 55.46% - Rate is higher when compared to same time last year</p>	<p>Focus is on Urgent Care centers. Purchasing kits to distribute to CCN contracted Urgent Care centers and some targeted high-volume offices.</p>	2Q2019	Yellow

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Colorectal Cancer Screening (COL)	Targeted outreach to members who are due for a screening. Interventions may include; preventive screenings event, target mailings, incentives, and facets pop-ups.	OneCare 63% OneCare Connect 63%	<p>HEDIS 2018 Final Rates: OneCare:63.07%; Met Goal OneCare Connect: 61.99%; Goal not met</p> <p>June 2018 Prospective Rates: OneCare: 46.18% OneCare Connect: 42.52%</p> <p>- OC rates are lower and OCC rates are higher when compared to same time last year.</p>	Add article in OCC newsletter and/or send targeted mailing to OC and OCC members in Q4.	4Q	Green
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA) Medication Review	Targeted outreach to providers; obtain ICP for each members	OneCare 88% OneCare Connect 79%	<p>HEDIS 2018 Final Rates: OneCare: 90.13%; Met Goal OneCare Connect: 79.81%; Met Goal</p> <p>June 2018 Prospective Rates:: OneCare: 20.26% OneCare Connect:18.37 % - OC and OCC rates are better when compared to same time last year.</p>	<p>Case Management to continue outreaching and obtaining ICPs. CM updated the HRA form and collect information at first contact with members.</p> <p>Implement OCC PIP project that focuses on ICP 1.5 and 1.6 (ICP completion for high/low risk members and discussion of care goals).</p>	4Q	Green
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA) Functional Status Assessment	Targeted outreach to providers; obtain ICP for each member	OneCare 67% OneCare Connect 67%	<p>HEDIS 2018 Final Rates: OneCare: 73.68%; Met Goal OneCare Connect: 59.37%; Goal not met</p> <p>June 2018 Prospective Rates: OneCare: 14.66% OneCare Connect: 17.47 % - OC and OCC rates are better when compared to same time last year.</p>	<p>Case Management to continue outreaching and obtaining ICPs. CM updated the HRA form and collect information at first contact with members.</p> <p>Implement OCC PIP project that focuses on ICP 1.5 and 1.6 (ICP completion for high/low risk members and discussion of care goals).</p>	4Q	Yellow
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA) Pain Assessment	Targeted outreach to providers; obtain ICP for each member	OneCare 94% OneCare Connect 80%	<p>HEDIS 2018 Final Rates: OneCare: 88.16%; Goal not met OneCare Connect: 75.67%; Goal not met</p> <p>June 2018 Prospective Rates: OneCare: 18.10% OneCare Connect:18.20 % - OC and OCC rates are better when compared to same time last year.</p>	<p>Case Management to continue outreaching and obtaining ICPs. CM updated the HRA form and collect information at first contact with members.</p> <p>Implement OCC PIP project that focuses on ICP 1.5 and 1.6 (ICP completion for high/low risk members and discussion of care goals).</p>	4Q	Yellow

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Breast Cancer Screening (BCS)	Targeted outreach to members who are due for a screening. Interventions may include: mobile mammography event, target mailings, incentives, and facets pop-ups.	Medicaid 65.52% OneCare 78% OneCare Connect 78%	<p>HEDIS 2018 Final Rates: Medicaid: 63.73%; Goal not met OneCare: 66.13%; Goal not met OneCare Connect: 66.93%; Goal not met</p> <p>June 2018 Prospective Rates: Medicaid: 52.29% OneCare: 58.31% OneCare Connect: 54.27% - All LOB rates are lower when compared to same time last year.</p>	<p>Implement the Medi-Cal member incentive program in June, 2018.</p> <p>Caloptima to collaborate with community clinics to host mobile mammography screening events for CCN members. CalOptima is contracted with Alinea (mobile mammography vendor) to provide direct services to CCN members.</p>	4Q	Yellow
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	Provider education via the AWARE Toolkit.	Medicaid 24.91%	<p>HEDIS 2018 Final Rate: Medicaid: 25.05%, Met Goal</p> <p>June 2018 Prospective Rates: Medicaid: 26.07% - Rates are better when compared to same time last year.</p>	Send AWARE toolkit in Q4, 2018.	4Q	Green
COPHS	Quality of Clinical Care - HEDIS	Pharmacy	Nicki Ghazanfarpour, Pharm.D.	Improve identified HEDIS Measures	Statin Therapy for Patients with Cardiovascular Disease (SPC)	Physician notification faxes	<p>MCAL Statin therapy 75.85% Adherence 73.43% OCC Statin therapy 73.56% Adherence 71.14% OC Denominator too small last year to set goal</p>	<p>MCAL: faxes sent to 204 providers for 317 members OCC: faxes sent to 52 providers for 55 members OC: faxes sent to 4 providers for 4 members Failed faxes: 1 failed fax for 1 prescriber (2 members)</p> <p>Barriers: -HEDIS registry data refreshes in January so intervention data has to be revised to take into account end of the year pharmacy claims for statins -Some members do not have PCPs assigned -True prospective rates for adherence submeasure not read by available—special request to QI to pull it because HEDIS registry report is not a true assessment of current adherence rates</p> <p>Provider responses prompting removal from intervention faxes: -Member can not tolerate a moderate/high potency statin -Member has allergy to statins -Member can not tolerate any statin</p> <p>Upcoming enhancements: -Adherence calculation is being automated to calculate continued adherence rate with a 12 month look back. This real-time rate will be used to flag and target members who are on a statin but remain non-adherent (<80% proportion of days covered)</p> <p>2017 Final HEDIS rates: MCAL: Statin therapy: 73.64%; Adherence: 71.91% OCC: Statin therapy: 70.45%; Adherence: 70.41% OC: Statin therapy: 45.45%; Adherence: 00%</p>	3Q18 faxes	3Q	Green

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
COPHS	Quality of Clinical Care - HEDIS	Pharmacy	Nicki Ghazanfarpour, Pharm.D.	Improve identified HEDIS Measures	Statin Therapy for Patients with Diabetes (SPD)	Physician notification faxes	<p>MCAL Statin therapy 66.31% Adherence 67.76%</p> <p>(5/2/18- OC/OCC was added to goal/Timeline) OCC Statin therapy 73.83% Adherence 74.75% OC Statin therapy 67.37% Adherence 77.13%</p>	<p>MCAL: faxes sent to 827 providers for 6 248 members OCC: faxes sent to 350 providers for 706 members OC: faxes sent to 52 providers for 64 members</p> <p>Failed faxes: 20 failed faxes for 20 unique prescribers 114 members (across all LOBs)</p> <p>Barriers: -HEDIS registry data refreshes in January so intervention data has to be revised to take into account end of the year pharmacy claims for statins -Some members do not have PCPs assigned -Bad fax numbers -Some Providers no longer work at that location -True prospective rates for adherence submeasure not read by available--special request to QI to pull it because HEDIS registry report is not a true assessment of current adherence</p> <p>Provider responses prompting member removal from intervention: -Member does not have diabetes (coding error) -Member refuses to take statin</p> <p>Upcoming enhancements: -Adherence calculation is being automated to calculate continued adherence rate with a 12 month look back. This real-time rate will be used to flag and target members who are on a statin but remain non-adherent (<80% proportion of days covered)</p> <p>2017 Final HEDIS rates: MCAL: Statin therapy: 65.44%; Adherence: 65.28% OCC: Statin therapy: 73.25%; Adherence: 71.98% OC: Statin therapy: 66.18%; Adherence: 76.67%</p>	3Q18 faxes	3Q	
COPHS	Quality of Clinical Care - HEDIS	Pharmacy	Nicki Ghazanfarpour, Pharm.D.	Improve identified HEDIS Measures	Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	Physician notification faxes	<p>MCAL: 80.95%</p> <p>(5/2/18- OC/OCC was added to goal/Timeline) OCC: 95.1% OC: Denominator too small last year to set goal</p>	<p>MCAL: faxes sent to 20 providers for 20 members OCC: none OC: none Failed faxes: none</p> <p>Barriers: -HEDIS registry data refreshes in January so intervention data has to be revised to take into account end of the year pharmacy claims for beta blockers Failed faxes require manual intervention</p> <p>2017 Final HEDIS rates: MCAL: 79.79% (goal 83.06%); below 50th percentile OCC: 96.97% (goal NA); above 75th percentile OC: NA (denominator too small to report)</p>	3Q18 faxes	3Q	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
VI. QUALITY OF CLINICAL CARE - HEALTH EDUCATION & DISEASE MANAGEMENT											
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Initial Health Assessment Completion Rate	To assure all new members are connected with a PCP and their health risks are assessed	IHA/IHEBA [Staying Healthy Assessment(SHA)] will be completed within 120 days of enrollment; Reports will be available for Health Networks on IHA/SHA completion; Facility Site Reviews will review a sample of medical records for compliance with completing appropriate age level IHA/SHA; If use of alcohol or drugs, the member will have an SBIRT documented (Screening, Brief Intervention, and Referral to Treatment)	Improve plan performance over 2017 by 5%	IHA Completion Rates* Q1 2018 - 46.35% Q2 2018 - 40.30% *Data as of 7/19/18; IHA performance calculated as fully met + partially met (Fully Met =Evidence of an IHA visit and SHA within 120 days of member effective date; Partially Met =Evidence of an IHA visit or SHA within 120 days of member effective date)	*Remove urgent care and emergency department visits for methodology *Send desktop for IHA chart audit to Health Networks *Prepare for IHA chart audit with Community Clinics in July 2018	4Q	
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Review of Disease Management Programs	Disease Management activity reviewed to assess clinical care delivered to members with Asthma, Diabetes and Heart Failure	Develop DM Program interventions to help improve HEDIS measures such as AMR, MMA, MPM, CBP; Assure DM programs are implemented across all populations; Conduct annual member satisfaction of DM programs; Evaluate the overall effectiveness of the Program-Participation Member Rates, ED, IP and RX related utilization	Improve program participation rates over 2017 by 3% Reduce ED and IP rates for program participants by 3% Increase member satisfaction with DM Programs to 90%	June 2018 Medi-Cal Prospective Rates: AMR 5-11: 76.30% ↓ 3.65% since March - 50th percentile MMA 5-64: 0.22% ↑ 0.22% since March - below 25th percentile HbA1c Testing: 68.95% ↑ 26.57% since March - below 25th percentile HbA1c Poor Control: 59.15% ↓ 15.19% since March - decrease is better - below 25th percentile Eye Exam: 41.24% ↑ 10.72% since March - below 25th percentile Annual Monitoring for Patients on Persistent Medications (MPM) Ace Inhibitors or ARBs: 70.38% - ↑ 22.01% since March -below 25th percentile 2017 DM Satisfaction -98.4% actively managed DM members are overall satisfied with CalOptima's DM Programs June 2018 OC Prospective Rates: HbA1c Testing 69.85% ↑ 33.99% since March 2018 - below 25th percentile HbA1c Poor Control: 73.16% ↓ 13.71% since March - decrease is better - below 25th percentile Eye Exam: 47.06% ↑ 5.65% since March - below 25th percentile Annual Monitoring for Patients on Persistent Medications (MPM) Ace Inhibitors or ARBs: 72.44% - ↑ 37.96% since March -below 25th percentile June 2018 OCC Prospective Rates: HbA1c Testing: 72.63% ↑ 30.09% since March 2018 - below 25th percentile	*Identification methodology already ready for Go-live in Guiding Care *Continue efforts to improve member triage and referral to staff (Round Robin) *Implement targeted campaigns for AMR through Asthma Action Plan Incentive in June and repeat member incentive for Diabetes eye exam and A1C testing being launched in July.	4Q	
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Implementation of Population Health & Wellness Programs	Expand child and adolescent components for the Shape Your Life/Weight Management Program; Implement Weight Watchers benefit for Shape Your Life CalOptima Medi-Cal members age 15 years or greater; Design and implement a comprehensive Perinatal Health Program	Establish program goals, objectives and interventions; Develop clinical and operational components to expand the reach and capability; Identify program resources and vendor support (Provider, Health Ed/RD linkages, Community Based Organizations); Implementation of revised program design	Implement revised program design-2018; Evaluate progress semi-annually	SYL vendor contracts effective on 4/1/18 to implement a group class model. Perinatal Health program is being branded as <i>Bright Steps</i> . Board approval (July 2018) to cancel RFP (Dec 2017) and allow for contracting with any qualified CPSP or PSS provider for eligible services at 100% MC rate.	Bright Step Program Design	4Q	
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Adopt Medical Clinical Practice Guidelines	Clinical Practice Guidelines will be reviewed and adopted	Adoption of Clinical Practice Guidelines, as least three (3) will be reviewed and adopted (linked to DM Diabetes, Asthma, CHF)	CPG's reviewed and adopted every two years	CPGS approved in July 2017	Next review in 2019	3Q2019	
VII. QUALITY OF CLINICAL CARE - QUALITY IMPROVEMENT PROJECTS											
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Quality And Performance Improvement Projects (QIP, PIPs, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	OneCare CCIP: Diabetes to improve HBA1C Testing, Targeted mailings to members; Outreach to health networks; provide monthly Prospective Rates and member detail information to health networks	Goal TBD/ Starting January 2018	After conversion from OC QIP into OC CCIP, DM is almost ready to execute launch of health coach telephone outreach to identified members needing A1C and self-management skills.	Health Coach calls to initiate in July 2018	4Q	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Quality And Performance Improvement Projects (QIP, PIPs, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	OneCare Connect CCIP: Heart Health	Goal TBD/ Starting January 2018	Pilot transitions of care program developed for OCC CCN Heart Failure members with admission. Collaboration between DM, UM and Pharmacy departments to implement phone intervention within 3 days of hospital discharge to help prevent readmission within 30 days.	*Identification report finalized for pilot CCN CHF TOC program *Program components finalized in July, Program official launch in August	1/4/1900	
COPHS	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPs, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	OneCare Connect QIP: To Improve 30-day Readmission Rate <16.8% ; Transition of Care program; health coach outreach	OneCare Connect QIP: To Improve 30-day Readmission Rate <16.8%; Transition of Care program; health coach outreach	June PR rates: OCC = 9.56%; (lower rate is better). TOC team is continuing efforts to address data discrepancies and improve processes.	Transition of Care program; focus on the health coaching intervention at the two (2) targeted hospitals. Team will also continue efforts to improve data process and validating results on a monthly basis. There has been rate improvements since the last update. QIP is on track.	4Q	
COPHS	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPs, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	OneCare QIP (NEW) Improving hypertension management and caregiver involvement in the OC SNP population	QIP Goals: 1) Obtain 30% PHI forms for OC hypertension members w/ outdated caregiver information. 2) Reach a 10% opt-in participation rate of eligible OC hypertension members or caregivers to provide telephonic coaching. 3) Demonstrate decrease in blood pressure values of 20% of active participants in the coaching program over member's personal baseline.	Obtaining updated/new PHI forms from caregivers is imperative as directly impacts the coaching program. Health coaches cannot share information to caregivers about the OC member unless a PHI form is obtained. DM will be implementing the intervention starting Q3.	Disease Management and Quality Analytics are developing new program. DM will implement interventions in Q3.	4Q	
COPHS	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPs, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	Medi-Cal PIP: Improving Diabetes Care for Medi-Cal Members with Poor Control (HbA1c >9%) residing in Santa Ana, CA. (Focus on health disparities); Targeted provider outreach in the CCN network; Increase referrals and participation in CalOptima' Disease Management program; Educational classes	PIP: Reduce the Poor Control (HbA1c >9) targeted group down from 62.5% to 52.31%	Currently in Module 3 phase	Submitted Module 3 of the PIP on 5/15/18 to DHCS for approval. On Track Proposed Interventions: 1) Conduct targeted outreach by a health coach to provide comprehensive telephonic counseling services. 2) Provide member registry list to targeted provider offices for outreach.	2Q2019	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
COPHS	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPs, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	Medi-Cal PIP: Improving Adult's Access to Preventive/Ambulatory Health Services Ages 45-64 years	Improving Adult's Access to Preventive/Ambulatory Health Services Ages 45-64 years PIP Goal 82.49%	Currently in Module 3 phase	Submitted Module 3 of the PIP on 5/15/18 to DHCS for approval. On Track. Proposed Interventions: 1) Office staff to conduct targeted outreach to schedule preventive/well-care visits 2) Test holding extended office hours beyond normal provider office hours of operations with targeted offices.	2Q2019	
COPHS	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPs, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	OneCare Connect PIP: Improving rate of completed Individualized Care Plan Completed for members and improve rate of Members with Documented Discussions of Care Goals	PIP Member with an Individualized Care Plan Completed/Members with Documented Discussions of Care Goals (OCC) 1) CA 1.5 – Members with an Individualized Care Plan Completed. Year 1 Goal High Risk 79.9%; Low Risk 71% 2) CA 1.6 – Members with Documented Discussions of Care Goals. Year 1 Goal 77.91%	Submitted plan proposal on 4/6/18. Resubmitted proposal on 5/18/18. Received approval from DHCS on 6/23/18.	To submit PDSA intervention plan due on 7/18/18. Intervention 1 was implemented on 1/3/18. Intervention 2 implemented 4/3/18. Data collection in process.	12/31/2019	
COPHS	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPs, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	OneCare Connect PDSA - Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents (LTC - OCC); Treatment in Place training to targeted facility sites and Follow up with targeted facility sites by CalOptima nurses	SMART Objective 1: By 6/30/2018 CalOptima will offer enhanced care coordination to all OCC CCN LTC members with ≥ two (2) acute admissions within the last rolling 12 months. SMART Objective 2: By 9/30/2018 the rolling 12-month average acute admissions represented by OCC CCN LTC members with multiple admissions 2.76 admissions per member per year at 2017 base line will decrease to <2.45 admissions per member per year SMART Objective 3: By 3/31/2019 the overall rolling 12-month average ratio of acute admissions represented by all OCC CCN LTC members 0.88 admissions per member at 2017 baseline will decrease to ≤0.79 admissions per member per year.	Starting Q2, 2018, CalOptima is implementing a new intervention. Title Increasing post-hospitalization coordination and support among OneCare Connect Long Term Care members in the CalOptima Community Network to decrease acute readmission rates. Results pending.	Implement enhanced care management strategies in Q2, 2018, CYCLE 1. On Track	Ongoing; PDSA cycles are determined by CMS	
VIII. SAFETY OF CLINICAL CARE											
UMC	Safety of Clinical Care	Pharmacy	Kris Gericke	Utilization of Opioid Analgesics	Promote optimal utilization of opioid analgesics	Quarterly opioid analgesic monitoring. Formulary limits and prior authorization requirements for opioid analgesics. Prescriber monitoring and education	Reduction in opioid analgesic overutilization as measured by number of prescriptions and quantity per prescription for short-acting opioid analgesics	The average number of Rxs PMPM for opioid analgesics decreased from 0.0245 to 0.0235 from 1Q18 to 2Q18 (4.1% decrease). The average quantity per Rx for short-acting opioid analgesics decreased from 57.6 to 55.0 from 1Q18 to 2Q18 (4.6% decrease).	Implement additional formulary quantity limits per P&T Committee approval. Continue with quarterly prescriber report cards.	4Q	
UMC	Safety of Clinical Care	Pharmacy	Kris Gericke	Pharmacy Benefit Manager (PBM) Oversight	Provide ongoing monitoring of the PBM contract performance guarantees	Review and report on clinical and service metrics for MedImpact as it relates to performance guarantees	PBM Performance Guarantees met per the PBM Services Agreement	1Q18 Performance Guarantees met.	Continue to monitor quarterly reports.	4Q	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
CPRC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Katy Noyes	Providers Shall Have Timely And Complete Facility Site Reviews	To assure all new and re-credentialed providers are compliant with FSR/MRR/PAR requirements	Facility Site Reviews (FSR), Medical Record Reviews (MRR) and Physical Accessibility Review Surveys (PARS) are completed as part of initial and re-credentialing cycles; Report of FSR/MRR/PARS activity to CPRC	100% of FSR/MRR/PARS Initial or Full Scope Surveys are completed within initial and re-credentialing timeframes, measured as 100% Full Scope Periodic Audits completed within three years from the last FSR/MRR and PARS.	The goal is measured as the number of Periodic Full Scope audits completed within three years of previous audit. In Q2, 15 audits were overdue. This is down from 17 in Q1. There have only been 2 FSR nurses since May 2017. This has contributed greatly to the number overdue audits. Other results include 77 Periodic Full Scope audits completed; 12 Initial FSR/MRRs completed; 1 failed MRR, scoring <80% of threshold. An MRR Corrective Action Plan (CAP) was issued and Member panels were closed until CAP was completed. 16 CE CAPs, 45 FSR CAPs, 16 MRR CAPs issued. 77 total CAP issued for Q2. CAPS closed within required time frames (10 days for CE CAPs, 45 days for FSR/MRR CAPs) were 71% of CE CAPs closed within TAT; 80% of FSR CAPs closed within TAT; 83% of MRR CAPs closed within TAT. 154 PARS completed. 51% attaining BASIC access for sites measured.	Currently all FSR nurse positions have been filled. This should significantly reduce the number of overdue audits. Processes have been implemented to increase communication with the sites regarding due dates. This includes but is not limited to closing Member panels when sites are unwilling to complete audit by due date. Additionally FSR nurses are contacting sites 2-3 months before due date in order avoid overdue audits. Continuing to work on assuring all issued CAPs are closed before due dates.	3Q	
CPRC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	Follow-up on Potential Quality Of Care Complaints	To assure patient safety and enhance patient experience by timeliness of clinical care reviews	QI Nurse Specialists and Medical Directors review cases and provide determination; Report all case results to CPRC for discussion; Present cases that have a severity rating of 1 (one) or higher will be presented to CPRC for action; Follow through on Medical Director determination, when applicable, to ensure closure and compliance of all cases; Conduct a PQI trend analysis at least two times a year. Review GARS and PQI's twice annually for trends by practitioner.	a) Achieve a turnaround time of 90 days on 90% of cases received. b) Review data for trends and patterns by practitioner. Take appropriate actions for outliers.	a) In Q2, we closed 390 cases as compared to 432 cases in Q1. Of the closed cases, 56% of the cases were closed in 90 days or less. b) We did not perform case trending in Q2, but are scheduled to do so in Q3. c) The top 10 PQI complaint types in Q2 are as follows Treatment delay, failure, inappropriate, or complications 112 Access to Care 41 Failure to communicate 32 Inadequate work-up/evaluation 29 Authorization denied or delayed 28 Delay of Service 24 Improper management of med regimen 21 Inappropriate patient/provider/office behavior 19 Mismanaged care 18 Diagnosis delay, failure, missed 17	a) Continue to monitor TAT of cases and identify reasons for not being able to meet the goal. b) Perform trending for the Jan - Jun 2018. c) Continue to monitor trends of complaint types	4Q	
LTSS-QISC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	CBAS Quality Monitoring	Review CBAS quality monitoring of services provided	a) Continue to assess compliance of contracted CBAS Centers. Report to LTSS QIS Subcommittee. b) Continue to review Incident and Critical Incident Reports for Potential Quality of Care issues	a) All (100%) contracted CBAS centers will be audited at least annually against the audit performed by CDA. b) All (100%) CAPs generated as a result of the audit will be returned by the due date. c) The number of CBAS centers receiving a CAP will be reduced to 75% in 2018, down from 93% in 2017. d) All (100%) Incident and Critical Incident reports will be reviewed for Potential Quality of Care issues	a) Eleven CBAS centers were reviewed against the CDA audit. b) Ten of the centers received a CAP. Nine of the CAPs have been returned; one is still pending. One center had no deficiencies. c) In Q2, there were 48 Incidents reported. Fifteen of the incidents were fall related; seven additional falls resulted in minor injury. There were nine incidents requiring transportation to the hospital. Twelve of the incidents occurred at Alzheimer CBAS, and 16 at RIO Orange. There were no critical incidents, and none of the incidents resulted in a PQI.	Continue to provide quality oversight monitoring of the CBAS Centers and review critical incident reports for PQI.	4Q	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
LTSS-QISC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	SNF/LTC Quality Monitoring	Review SNF/LTC quality monitoring of services provided	a) Continue to assess compliance of contracted SNF/LTC Facilities. Report to LTSS QIS Subcommittee. b) Continue to review Critical Incident Reports for Potential Quality of Care issues	a) All (100%) contracted SNF/LTC Facilities will be audited at least annually against the audit performed by DHCS. b) All (100%) CAPS generated, as a result of the audit, will be returned by the due date. c) The number of SNF/LTC Facilities receiving a CAP will be below 10%. d) All (100%) Critical Incident reports will be reviewed for Potential Quality of Care issues.	a) Twenty-two facilities were reviewed against the audit performed by DHCS. b) Two of the facilities received CAPS and both returned the CAPS timely. c) There were 2 critical incidents in the NFs in Q2. Both are currently being investigated as PQIs.	Continue to provide quality oversight monitoring of the NFs and review critical incident reports for PQI.	4Q	
IX. QUALITY OF SERVICE											
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Rating of Health Plan	Implement CG-CAHPS to obtain provider level specific member experience data. Utilize results from CalOptima's CG-CAHPS survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan. Contract with vendor to implement Provider Coaching to improve provider satisfaction and overall member experience.	Adult Medicaid 2.43 (50th Percentile) Child Medicaid 2.57 (50th Percentile) OneCare Medicare 86% (CMS 4 star goal) OneCare Connect Medicare 86% (CMS 4 star goal)	CalOptima 2018 Plan Level CAHPS Results Adult Medicaid 2.35 (Below NCOA 25th Percentile) Child Medicaid 2.68 (NCOA 90th Percentile, significant improvement from previous year's 25th percentile) OC Medicare Awaiting 2018 Results OCC Medicare Awaiting 2018 Results Provider Coaching list solidified and outreach for shadow coaching began in Q2. PCPs have been scheduled for coaching and SullivanLuallin has already begun coaching with a few PCPs.	RFP issued for a new vendor to field CG-CAHPS. Awaiting approval from A&O to execute the contract. Fielding to occur in Q1, 2019. Planning and scheduling of patient experience workshops for physicians, medical managers and office staff to take place by 4th Q.	Q1, 2019 Q4, 2018	
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	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.	Adult Medicaid 2.28 (25th Percentile) Child Medicaid 2.37 (25th Percentile) OneCare Medicare 82% (CMS 3 star goal) OneCare Connect Medicare 82% (CMS 3 star goal)	CalOptima 2018 Plan Level CAHPS Results Adult Medicaid 2.25 (Below NCOA 25th Percentile) Child Medicaid 2.27 (Below NCOA 25th Percentile) OC Medicare Awaiting 2018 Results OCC Medicare Awaiting 2018 Results Continuous monitoring of CalOptima members' ability to access care. Shared with each health network their performance on Timely Access. Completed DHCS and CMS submissions for network adequacy. Passed all network adequacy requirements. Continous outreach to contract with in-demand providers. Outreached to Monarch to include additional Occupational Therapists in South County into our FACETS system. Monarch was able to provide us with 7 additional OT providers they contract. which were uploaded to Facets in June and now meet standard.	Share plan and health network level CAHPS at committees and forums. Health network specific CAHPS will be shared with each health network at either the HN Quality Meetings or their JOMS. Access & Availability subcommittee agreed to put a workgroup together to focus on the following three CAHPS areas: -Got Appointments with specialists as soon as needed -Easy to get the care tests or treatment child needed -Got urgent care as soon as needed Member Experience subcommittee area of focus include Care Coordination and Referrals and Authorization.	Q3, 2018 Q4, 2018	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Getting Care Quickly	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of timely access and appointment availability standards will improve rating of Getting Care Quickly.	Adult Medicaid 2.33 (25th Percentile) Child Medicaid 2.54 (25th Percentile) OneCare Medicare 79% (CMS 4 star goal) OneCare Connect Medicare 76% (CMS 3 star goal)	CalOptima 2018 Plan Level CAHPS Results Adult Medicaid 2.24 (Below NCQA 25th Percentile) Child Medicaid 2.37 (Below NCQA 25th Percentile) OC Medicare Awaiting 2018 Results OCC Medicare Awaiting 2018 Results Continuous monitoring of CalOptima members' ability to access care. Shared with each health network their performance on Timely Access. Completed DHCS and CMS submissions for network adequacy. Passed all network adequacy requirements. Continous outreach to contract with in-demand providers. Outreached to Monarch to include additional Occupational Therapists in South County into our FACETS system. Monarch was able to provide us with 7 additional OT providers they contract. which were uploaded to Facets in June and now meet standard.	Share plan and health network level CAHPS at committees and forums. Health network specific CAHPS will be shared with each health network at either the HN Quality Meetings or their JOMS. Access & Availability subcommittee agreed to put a workgroup together to focus on the following three CAHPS areas: -Got Appointments with specialists as soon as needed -Easy to get the care tests or treatment child needed -Got urgent care as soon as needed Member Experience subcommittee area of focus include Care Coordination and Referrals and Authorization.	Q3, 2018 Q4, 2018	
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Customer Service	Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service. Contract with vendor to implement Provider Coaching for Customer Service staff.	Adult Medicaid 2.54 (50th Percentile) Child Medicaid 2.50 (25th Percentile) OneCare Medicare 89% (CMS 3 star goal) OneCare Connect Medicare 89% (CMS 3 star goal)	CalOptima 2018 Plan Level CAHPS Results Adult Medicaid 2.50 (NCQA 25th Percentile) Child Medicaid 2.47 (Below NCQA 25th Percentile) OC Medicare 85.7% OCC Medicare 86.1% Provider Coaching list solidified and outreached for shadow coaching began in Q2.	Planning and scheduling of patient experience workshops that include components on in-office and telephone customer service for physicians, medical managers and office staff to take place by 4th Quarter.		
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	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.	Adult Medicaid 2.34 (25th Percentile) Child Medicaid 2.36 (25th Percentile) OneCare Medicare 85% (CMS 3 star goal) OneCare Connect Medicare 85% (CMS 3 star goal)	CalOptima 2018 Plan Level CAHPS Results Adult Medicaid Plan Level N/A Child Medicaid Plan Level 2.27 (Below NCQA 25th Percentile) OC Medicare Awaiting 2018 Results OCC Medicare Awaiting 2018 Results	Member Experience subcommittee Area of focus include Care Coordination and Referrals and Authorization. Subcommittee to review member pain points and identify interventions to improve this area.	4Q	
MEMX	Quality of Service	Customer Service	Belinda Abeyta/ Albert Cardenas/L. Nguyen	Customer Service Access	Customer Service call lines evaluated for average speed to answer; Customer Service call line evaluated for call abandonment rate	Customer Service lines monitored for average speed to answer; Customer service lines monitored for abandonment rate	ASA 30 Seconds <5% First Call Resolution 85%	Medi-Cal: ASA - 37 Seconds: Target Not Met ABD: 2.6%: Target Met First Call Resolution: 84% Target Not Met OneCare: ASA - 16 Seconds: Target Met ABD: 2.2%: Target Met First Call Resolution: 86.3% Target Not Met OneCare Connect: ASA - 16 Seconds: Target Met ABD: 2.2%: Target Met First Call Resolution: 88.6% Target Not Met	Medi-Cal: Training of staff to increase efficiency and reduce handle time of each call. Actively recruiting to fill all open positions. OneCare: Continue to monitor and report. OneCare Connect: Continue to monitor and report.	3Q	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
MEMX	Quality of Service	GARS	Ana Aranda/Laura Guest	Review and Report GARS for all Lines of Business. Include review of quality issues (QOC, QOS, Access) related to member experience.	Global review of member "pain points"; assure appropriate actions are taken to assist the member experience, and present data to the Member Experience Committee and QJC	a) Quarterly review of all GARS data to identify issues and trends; including Health Network b) Implement any necessary corrections c) Review health network quarterly totals of grievances d) Conduct causal analysis and determine plan of action for "pain points" that affect member experience	Meet GARS Regulatory Turnaround Times 100%. Improve member experience as measured by improved CAHPS scores.	Provided high level overview of Q1 data. Still in discussion with QI on the best way to present GARS data to the Member Experience Committee.	*Review of call center scripting to reduce documentation fields in templates.	3Q	
MEMX	Quality of Service	Pharmacy	Kris Gericke	Member Accessing Pharmacy Benefit Information	Maintain member access to their pharmacy benefit and the operations of network pharmacies through the CalOptima website, or through telephone communication with CalOptima Customer Service staff	Monitor and annually report requirements for NCQA Member Connection 4 Pharmacy Benefit Information Standards	Via the CalOptima website Members are able to -Submit Prior Authorization requests; -Conduct network pharmacy proximity searches based on zip code; -Find information on potential drug-drug interactions, common side effects and significant risks, and availability of generic substitutes; and -Receive responses to pharmacy inquiries within twenty-four (24) hours (or next business day).	2Q18 MEM 4 website access testing passed all elements.	*Actively recruiting to fill all open positions.	4Q	
X. NETWORK ADEQUACY											
MEMX	Network Adequacy	Customer Service/ Network Mangement	Belinda Abeyta/ Jennifer Bamberg	Notification to Member when Practitioners Terminate.	Members are notified when Practitioners Terminate.	Termination of Practitioners is monitored through monthly CT forms that are submitted to PDMS. 1) Members are notified of terminated practitioners with 30 days from when CalOptima is notified 2) Network is monitored to determine if adjustments to network are necessary.	Notification to members are within 30 days of notification to CalOptima 85% of the time.	Medi-Cal: Achieved 100% for member notification within 30 days of provider termination.	Medi-Cal: Continue to monitor and report.	3Q	
MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of access to care non-urgent primary care appointments	1. Non-urgent primary care appointments within 10 business days of request	Data against goals will be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Appointment 90% minimum performance level	2018 Scores not yet available. For 2017 1) Met 92.7% RFP was issued and new vendor has been selected. Awaiting A&O approval to execute contract. Fielding to occur Q1, 2019. HN scores were shared with each health network at the HN Quality Meetings or their JOM.	Execute contract with new vendor and field survey in Q1, 2019.	1Q2019	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
MEMX	Network Adequacy	Quality Analytics	Marshe Choo	Review of availability of primary care practitioners (min. provider ratios)	Primary care practitioner availability (min. provider ratio) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies: GG.1.600 and MA.7007	Met for all lines of business	Continue to monitor. Update reports for network adequacy.	1Q2019	
MEMX	Network Adequacy	Quality Analytics	Marshe Choo	Review of availability of primary care practitioners (geographic distribution)	Primary care practitioner availability (geographic distribution) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies: GG.1.600 and MA.7007	Met for all lines of business. For OC, not reached to Monarch to ensure that all Occupational Therapy providers were in our FACETS system. Added 7 additional Occupational Therapy Providers to ensure that we meet network adequacy for this specialty.	Continue to monitor. Update reports for network adequacy.	Q1 2019	
MEMX	Network Adequacy	Quality Analytics	Marshe Choo	Review of availability of specialty practitioners (min. provider ratios)	High volume and high impact specialty availability (practitioner to member ratio) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies: GG.1.600 and MA.7007	Met for all lines of business	Continue to monitor. Update reports for network adequacy.	1Q2019	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Risk - At Risk Yellow - Concern Green - On Target
MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of availability of specialty practitioners (geographic distribution)	High volume and high impact specialty availability (geographic distribution) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007	Met for all lines of business	Continue to monitor. Update reports for network adequacy.	1Q2019	
MEMX	Network Adequacy	Quality Analytics	Marsha Choo/ Edwin Poon	Review of availability of behavioral health practitioners (min. provider ratios)	Behavioral Health practitioner availability (practitioner to member ratio) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007	Met for all lines of business	Continue to monitor. Update reports for network adequacy.	1Q2019	
MEMX	Network Adequacy	Quality Analytics	Marsha Choo/ Edwin Poon	Review of availability of behavioral health practitioners (geographic distribution)	Behavioral Health practitioner availability (geographic distribution) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007	Met for all lines of business	Continue to monitor. Update reports for network adequacy.	1Q2019	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/TimeLine	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
MEMX	Network Adequacy	Pharmacy	Kris Gericke	Network Pharmacy Access	Network pharmacy availability (geographic distribution) is measured and assessed to meet the standard	Quarterly GeoAccess report	Pharmacy Network Access Requirements -At least ninety percent (90%) of Members, on average, in urban areas live within two (2) miles of a Participating Pharmacy; -At least ninety percent (90%) of Members, on average, in suburban areas live within five (5) miles of a Participating Pharmacy; and -At least seventy percent (70%) of Members, on average, in rural areas live within fifteen (15) miles of a Participating Pharmacy	1Q18 network access requirements met.	Continue to monitor quarterly reports.	4Q	
CPRC	Network Adequacy	Quality Improvement	Esther Okajima/ Melinda Enos	Credentialing Of Provider Network Is Monitored	Credentialing program activities monitored for volume and timeliness	New applicants processed within 180 calendar days of receipt of application; Report of initial credentialing file activity to CPRC	90% of initial credentialing applications are processed within 120 days of receipt of application	In Q2, 79 initial files were completed & approved. 100% HDO initial files were completed within 120 days. Unfortunately, 0% of the practitioner initial files were completed in less than 120 days. Files that take greater than 120 days to complete are often due to difficulty in obtaining information from the provider. There has been an increase in processing time due to the 20% increase in volume of both initial and recred files.	Will continue to work towards reducing TAT when processing files. Adding additional staff to assist with increase in volume.	4Q	
CPRC	Network Adequacy	Quality Improvement	Esther Okajima/ Melinda Enos	Recredentialing Of Provider Network Is Monitored	Reccredentialing of practitioners is completed timely	Reccredentialing is processed every 36 months; Report of Admin term due to missed reccredentialing cycle; Report of re-credentialing activity to CPRC	100% of all reccredentialing files are processed within 36 months of last credentialing date	In Q2, 164 re-credentialing files were approved. 1 practitioner file exceeded the 36 month timeframe for re-credentialing. The file was over the 36 month re-cred cycle, due to the provider sending in their re-credentialing application in late. There is a 30 day termination cure period once contracting terms a provider which can lead to over 36 month non-compliant re-credentialing.	Change process for issuing Termination letters to providers, by sending out 60 days prior to recred date. Thus, if applications are returned, they can be processed prior to 36 months.	4Q	
MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of access to care for urgent appointments	1. Urgent care appointments without prior authorization within 48 hours of request 2. Urgent appointments with prior authorization with 96 hours of request	Data against goals will be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Appointment 90% minimum performance level	2018 Scores not yet available. For 2017 1) Primary Care Met 95.6% Specialty Care Not Met 81.1% 2) Not Met 75.4% On-going efforts to recruit in-demand providers.	Execute contract with new vendor and field timely access survey in Q1, 2019.	1Q2019	

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/TimeLine	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of access to care specialty appointments	1. Appointment with specialist within 15 business days of request 2. Non-urgent, non-physician mental health appointment within 10 business days of request 3. First pre-natal visit within 10 days	Data against goals will be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Appointment 90% minimum performance level	2018 Scores not yet available. For 2017 1) Not Met 89.0% 2) MC Not Met 87.4% OC No respondents OCC Not Met 71.5% 3) Met 91.7% On-going efforts to recruit in-demand providers.	Execute contract with new vendor and field timely access survey in Q1, 2019.	1Q2019	Yellow
xi. COMPLIANCE											
AOC	Compliance	A&O	Solange Marvin/Karla Gutierrez	Delegation Oversight of HN Compliance (UM, CR, Claims)	Delegation Oversight of Health Networks to assess compliance of UM, CR, Claims	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as Prior Authorizations, Credentialing, Claims etc. **Report from AOC	98%	Medi-Cal Utilization Management (UM) Summary of Findings of file Review for Utilization Management decisions (April 2018 - June 2018) – 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 2018 - June 2018) – 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 2018 - June 2018) – 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.	3Q	Yellow
AOC	Compliance	Case Management	Sloane Petrillo	HN Compliance with CCM NCCA Standards	Delegation Oversight of Health Networks to assess compliance of CCM	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as CCM; **Report from AOC	HN to achieve 90% on file review monthly	AltaMed did not meet goal for one month. Kaiser did not meet goal for one month. Prospect did not meet goal for two months. UCMG did not meet goal for one month.	Offer additional training to lower performing networks. Revise and standardize feedback letters.	4Q	Green



**Quality Improvement Committee
MEETING MINUTES
July 17, 2018
Medi-Cal / One Care / OneCare Connect**

Miles Masatsugu, M.D.
Medical Director
Committee Chair

<u>External Voting Members Attending</u>	<u>CalOptima Voting Members Attending</u>	<u>CalOptima Staff Attendees</u>
<input checked="" type="checkbox"/> GORDON, Lowell, M.D., Medical Director FCMG, Pediatrician.	<input checked="" type="checkbox"/> DAJEE, Himmet, M.D., Medical Director, Cardiothoracic Surgeon	<input checked="" type="checkbox"/> CHANG, Steven, Director, Long Term Supports Services
<input checked="" type="checkbox"/> KELLY, John, M.D., * Orthopedic Surgeon, Private Practice	<input checked="" type="checkbox"/> FEDERICO, Frank, M.D., Medical Director, Hem/Onc	<input checked="" type="checkbox"/> FETTERMAN, Shanon, Director, Utilization Management
<input checked="" type="checkbox"/> KO, Edward, MD Medical Director, AltaMed Health Services	<input checked="" type="checkbox"/> FONDA, Emily, MD, Medical Director, Internal Medicine	<input checked="" type="checkbox"/> GARCIA, Gloria, Program Assistant, Quality Improvement
<input checked="" type="checkbox"/> MARCHESE, Sarah, MD Medical Director, CHOC Health Alliance, Pediatrician	<input checked="" type="checkbox"/> HELMER, Richard, M.D., Chief Medical Officer, Family Medicine	<input checked="" type="checkbox"/> GUEST, Laura, Supervisor, Quality Improvement
<input checked="" type="checkbox"/> MASOUEM, Shahryar, MD Medical Director, Ambulatory Surgery Center, HealthCare Partners Medical Group	<input checked="" type="checkbox"/> HITZEMAN, Tracy, Executive Director, Case Management	<input checked="" type="checkbox"/> HA, Betsy, Executive Director, Quality Analytics & Improvement
<input checked="" type="checkbox"/> SINHA, Mohini, M.D. Medical Director, Monarch, Pediatrician	<input type="checkbox"/> LAUGHLIN, Michelle Executive Director Network Operations, CalOptima	<input checked="" type="checkbox"/> OKAJIMA, Esther, Director, Quality Improvement
<input checked="" type="checkbox"/> SWEIDAN, Jacob, M.D. Medical Director, Noble, * Pediatrician	<input checked="" type="checkbox"/> MASATSUGU, Miles, M.D., Medical Director, PACE, Family Medicine	<input checked="" type="checkbox"/> POON, Edwin Director, Behavioral Health
	<input checked="" type="checkbox"/> MUNDUNURI, Sessa, Executive Director, Operations	<input checked="" type="checkbox"/> RAMIREZ, Nicole Manager, Behavioral Health
	<input checked="" type="checkbox"/> SHARPS, Donald, M.D., Medical Director, Behavioral Health, Psychiatrist	<input type="checkbox"/> REX-KIMMET, Kelly, Interim Executive Director Quality and Analytics
		<input checked="" type="checkbox"/> ZAVALA, Natalie, Manager Behavioral Health

*Full time practitioners

QIC

Topic	Discussion	Recommendation/Action
Call to Order	Miles Masatsugu, M.D., Committee Chair, called the meeting to order at 12:06 p.m.	No action necessary
Introductions	Introductions were made around the room. Dr. Masatsugu introduced the new CalOptima Executive Assistant of Quality to the Committee, Betsy Ha and announced that Dr. Richard Bock is no longer with CalOptima. There is currently a search of a Medical Director at CalOptima.	No action necessary
Review and Approval of Minutes	<p>1. <u>Approve the Minutes of the June 12, 2018 CalOptima Quality Improvement Committee (QIC) Meeting</u></p> <p><u>The June 12, 2018 meeting minutes were reviewed and approved as presented.</u></p>	<i>On motion of Dr. Sharps seconded and carried, the Committee approved the June 12, 2018 CalOptima Quality Improvement Committee Meeting as presented.</i>
CMO Update	<p>2. <u>Chief Medical Office (CMO) Update</u></p> <p>Dr. Helmer updated the Committee on CalOptima's PACE centers that recently expended county wide and Whole Child Model expansion. CalOptima just went thru a two-day file review with NCQA and are awaiting for the final results. Dr. Helmer thanked all involved including CalOptima departments and Health Networks. Final scoring will be shared as it becomes available.</p>	No action needed.
Department/Subcommittee Reports Behavioral Health Quality Improvement Committee (BHQIC)	<p>3. <u>Behavioral Health QIC update</u></p> <p>Donald Sharps, MD, Medical Director Behavioral Health Integration presented BHQIC update. A copy of the report is attached to the original set of these minutes. The BHQIC meeting was held 05/01/18. Dr. Sharps also presented a copy of those meeting minutes to the Committee and moved on to share meeting highlights. Access, Member Experience & Coordination of Care: Behavioral Health (BH) Customer Service metrics was provided with barriers and opportunities. Barriers to access include Provider availability, capacity and location issues. Improvement opportunities included appointment assistance</p>	<i>On motion of Dr. Gordon seconded and carried, the Committee approved the BHQIC update as presented.</i>

QIC

<p>Long-Term Services & Supports (LTSS)</p>	<p>linkage and provider education on timely appointment standards for Medi-Cal. BH will be assessing results of provider appointment linkage and providing education where needed. There was no drop in calls or a drop in measures in the call center.</p> <p>HEDIS BH Measures: Attention Deficit Disorder(ADD), Antidepressant Medication Management (AMM), and Follow up after hospitalization (FUH) for OneCare (OC) OneCare Connect (OCC) updates were provided. FUH follow up appointment 7 / 30-day reminders were conducted post discharge. Rates presented at Behavioral Health Quality Improvement (BHQI) committee were not complete for that period; Final data shows lower rates upon analysis post BHQI; There is concern it will not meet annual goal with current rates below 50th. A separate workgroup with Managed Behavioral Health Organization (MBHO) will address approach for risk is being formed. For other Measures more, timely intervention approaches were discussed. New provider tip sheets for HEDIS measures are being developed.</p> <p>PHQ9 – A Depression Screening: Provider guide to claims issues were distributed, an upcoming provider site visits announced. BHQIC 1st year analysis and review with committee will be addressed at BHQIC in Q3 2018 and will report back to the Committee.</p> <p>4. <u>Long-Term Services and Supports</u> Steven Chang, LTSS Director presented highlights of LTSS-QISC Subcommittee Meeting that was held 06/18/18. A copy of the report and meeting minutes are attached to the original set of these minutes. Highlights of LTSS Sub-Committee include the 2017 Member Satisfaction Survey Results for LTC and CBAS will be shared later in today's meeting. CMS recently focused on Adult Day Health Center (ADHC)/CBAS operations for CBAS providers. 20 ADHC facilities in Minnesota failed CMS inspection. CalOptima's Skilled Nursing Facilities have new staffing guidelines for Certified Nursing Assistant ratios that are going into effect 7/1/2018, in addition UCI Infection Control Prevention Program has been extended by grants. IHSS/Orange County Social Services Agency Caregiver Enrollment with Public Authority process has changed. Details will be brought to QIC as they become available. Reporting Operational Performance: CBAS Eligibility Turn Around Time (Completion within 30 calendar days) was reported at 100% compliant. Reporting on Availability and Provision of Multi-Purpose Senior Services Program (MSSP): Of 455 MSSP members there were 33 new enrollments and 32 discharges of which 9 were voluntary and 23 involuntary with</p>	<p><i>On motion of Dr. Gordon seconded and carried, the Committee approved the LTSS Subcommittee update as presented.</i></p>
---	--	---

QIC

<p>LTSS Satisfaction Survey</p>	<p>one member thought to be a carry over.</p> <p>The Level of actual Community Based Adult Services (CBAS) utilization was 89,617 days used of 114,631 authorized (78.2%). This being the 1st quarter of measures being gathered; a goal has not been set. A Goal will be determined at the next LTSS meeting and will then be shared at LTSS's next report to QIC.</p> <p><u>CBAS participants who transitioned to LTC</u></p> <ul style="list-style-type: none"> • Medi-Cal: 9 CBAS members of 2,238 were admitted to LTC. • OCC: Zero (0) CBAS members of 127 were admitted to LTC. <p><u>Ratio of members participating in CBAS versus potentially eligible members</u></p> <ul style="list-style-type: none"> • OCC: 127 CBAS participants of 984 potentially eligible members (12.9%). • Medi-Cal: 2239 CBAS participants of 11,265 potentially eligible members (19.9%). <p><u>Ratio of members residing in LTC</u></p> <ul style="list-style-type: none"> • OCC: 251 LTC members compared to 15,012 OCC members (1.57%). • SPD: 1875 LTC members compared to 122,775 SPD members (1.53%). <p><u>LTC members successfully transitioned to a community setting</u></p> <ul style="list-style-type: none"> • 103 of 5,319 LTC members transitioned to the community <p>Current projects and Initiatives is the coordinate transition of all MSSP members into a new benefit model with a scheduled transition date of January 1, 2020 and the CMS Plan-Do-Study-Act (PDSA) for Long Term Care. Q4 update of current project: Treatment in Place with an introduction of 2nd quarter 2018 proposed project: Care Coordination Support.</p> <p><u>LTSS Satisfaction Survey</u> Laura Guest, R.N., A.N.P., Quality Improvement Supervisor reported CalOptima's 2017 LTSS Member Satisfaction Survey Results. There were 148 surveys completed in 9 facilities. Survey tool had 33 questions with 3 of the questions allowed for an open written response. Response results were then shared with the Committee. Six questions fell below the 60% benchmark for LTC and two from CBAS. Details of those responses were then shared with the Committee. Individual data will be sent to the LTC facilities and CBAS centers to share with their staff. Due to the length of the survey and concern of the members'</p>	<p><i>No action necessary.</i></p>
---------------------------------	--	------------------------------------

QIC

<p>Utilization Management Committee</p>	<p>comprehension of the survey questions, the 2018 LTSS tool has been modified with fewer and shorter questions, with response options similar to patients' pain scale. The 2018 LTSS Satisfaction Survey is expected to launch summer of 2018.</p> <p>5. <u>Utilization Management (UM) Committee</u> Sharon Fetterman, RN, BSN, CCM, Director Utilization Management presented the Utilization Management update. A copy of the report is attached to the original set of these minutes. Utilization Management Committee (UMC) met May 24, 2018 with updates to the pilot for high Emergency Department (ED) user intervention and Ambulatory Dialysis. Quarter 1 2018 results for: Medical, Pharmacy, Behavioral Health & Long Term Services & Support as well as projects and initiatives of Whole Child Model Planning, MSSP Transition Planning, and Palliative Care. Case Management presented Emergency Department (ED) High Utilizers Pilot for CCN and in all CalOptima lines of business. The pilot was divided into 4 cohorts and had 1 cohort per quarter with the top 10 Emergency Room(ER) Utilizers per cohort (based on previous quarter utilization). The methodology was four dedicated Case Management's, intensive outreach, data gathering, and individualized Case Management. On the first quarter after year one results for Cohort 1 showed a 73% reduction in ER visits. Episodic component, Behavioral Health continues to be a consistent theme, connecting to Primary Care Provider is essential. Engagement remains challenging. Case Management is effective in diverting ER visits. The plan is to continue the pilot and are selecting new Coherts each quarter.</p> <p>Ms. Fetterman moved to report on UM's Workplan Q1 results.</p> <p>Operational Performance – Medical on Timeliness of authorization decisions met below the goal with an overall >97%. Contributing Factors include requests for services not requiring prior authorization, request, misclassification, and incomplete medical information submitted. UM will address this with ongoing staff education, provider training on auth process, and involvement of provider relations staff to support communication with provider offices. Ongoing monitoring for improvement in compliance rate for timeliness will be continued.</p> <p>Utilization Performance – Medical was met for measures with exception of ED visits for Medi-Cal TANF < 18 where the goal; OCC Bed Days, and Medi-Ca; SPD Goal Re-admits. Contributing Factors include the extended flu season that</p>	<p><i>On motion of Dr. Gordon seconded and carried, the Committee approved Utilization Management Committee update as presented.</i></p>
---	---	--

QIC

requires trending and ongoing analysis. UM will continue to monitor OC beddays, Medi-Cal TANF ≤ 18 ED visits and Medi-Cal SPD readmissions and will identify regional benchmarks and present to UMC.

Operational Performance – Pharmacy while the Cost Per Member Per Month (\$PMPM) for Q1 results for Medi-Cal, OneCare Connect and Once care were below the goal, they have increased over CY17. Contributing factors: Medi-Cal extended flu season; \$PMPM is high due to cold & flu season / Tamiflu; All time high utilization with over 0.8 prescriptions PMPM; decrease in opportunities to increase generic % due to fewer generics and brand insulin/other diabetes medications; Biologics are increasing in cost; OCC % Generic is flat; no new blockbuster generics on the market; OneCare plan membership is small, any fluctuation with a high cost drug can influence a lot. UM will strive to be below \$PMPM projection for all LOB and continue formulary changes and monitoring. They will also monitor pharmacy utilization, identify cost/quality outliers; Promotion of evidence-based medicine for pharmacy decision making; Prior authorization is placed on most of the high cost drugs.

Utilization Performance - Medi-Cal: Top Drug Classes Rx PMPM - Cardiovascular, Hypertension, Diabetes & Infectious Disease – Bacterial. Top Drug Classes \$ PMPM - Infectious Disease (Viral), Diabetes, Neoplastic Disease; Cost coming down a bit due to less expensive drugs than Harvoni now available.

Utilization Performance - One Care Connect (OCC): Top Drug Classes Rx PMPM – Hypertension, Lipid Reducers, Diabetes & Antipsychotics (are carved out of Medi-Cal plan). Top Drug Classes \$ PMPM – Diabetes by far. Top Drugs by Volume - Hypertension, Lipid Reducers (Statins, Fibrates and others), Diabetes. Top Drugs by Amount Paid - Januvia

Utilization Performance – One Care (OC) Top Drug Classes Rx PMPM - highest utilization class is behavioral health drugs, seizure drugs and lipid reducers. Top Drug Classes \$ PMPM - Behavioral health is the highest cost followed by diabetes and seizure drugs. Top Drugs by Volume - Top drugs by volume are levothyroxine sodium, atorvastatin calcium and risperidone. Top Drugs by Amount Paid - Rexulti & Vraylar (newer antipsychotics) Prior authorization is placed on most of the high cost drugs.

Operational Performance Metrics – Behavioral Health: Timeliness in decision

QIC

	<p>making for Medi-Cal services such as BHT and Psychological Testing. Timeliness for OC and OCC covered services such as: inpatient hospital stays, psychological testing, partial hospitalization and intensive outpatient programs. Additionally, Operational Performance includes consistent application of guidelines when making decisions regarding utilization of services.</p> <p>Operational Performance - Long Term Services and Support - was presented earlier in today's meeting.</p> <p>Utilization Performance - Pharmacy Utilization Performance – Medi-Cal Behavioral Health Inpatient is carved out to the County. Outpatient data for 2018 is pending – ABA services were brought in house January 2018, was previously managed by Magellan. Working on development of benchmarks and goals. Evaluating psychotherapy and psychiatry visits Q1 2018. Psychotherapy - 1,265 unique members had visits > 60 minutes every other week and a significant number also had weekly visits. Psychiatry – some prolonged office visits were noted.</p> <p>Utilization Performance – Behavioral Health OC and OCC Utilization data Q1 is pending. Combined because OC membership is low. Managed by Magellan. Inpatient Census runs 5-15 members / day. Vendor oversight is conducted by Audit & Oversight department who reviews timeliness of decisions; Goal not met for Q1 2018.</p> <p>Projects and Initiatives - Whole Child Model has multiple workgroup meetings focused on clinical topics. Transition plan is under development. CalOptima is working closely with the county CCS office. Health Network meetings to begin in July to help educate and prepare them. MSSP - Coordinate transition of all MSSP members into a new benefit model has a scheduled transition date of January 1, 2020. CalOptima continues planning meetings with internal stakeholders and has ongoing communication and coordination with Department of Health Care Services (DHCS) and California Department of Aging (CDA). Palliative Care (aka "Supportive Care"), a home and clinic-based services was implemented 1/1/18. A total of 89 members (CCN) were offered services as of May 2018. CalOptima is requiring prior authorization for initiation of program to permit reporting to the State.</p>	
<p>Open Discussion</p>	<p>There was no discussion.</p>	<p>No action necessary</p>

QIC

Approval of attachments	<ul style="list-style-type: none"> • QIC Agenda 07 17 2018 • QIC Meeting Minutes_06.12.18 Draft • QIC 07 17 2018 PPT • 5-1-18 BHCIC min Draft, QIC • 3-19-18 LTSS Draft of minutes • UMC MEETING MINUTES_05 24 2018_DRAFT 	<p><i>On motion of Dr. Sharps seconded and carried, the Committee approved the submitted attachments as presented.</i></p>
Next Meeting	<p>August 14, 2018</p> <ul style="list-style-type: none"> • Clinical Operations/Population Health Subcommittee • Credentialing Peer Review Committee • Quality Analytics 	<p>No action necessary</p>
Adjournment and Next Meeting	<p>There being no further business before the Committee, the meeting was adjourned at 1:16 p.m.</p>	<p>Dr. Masatsugu adjourned the meeting.</p>

Respectfully Submitted:


8/14/18

 Miles Masatsugu M.D., Medical Director Date

Recorded by: Gloria Garcia, QI Program Assistant



**Quality Improvement Committee
MEETING MINUTES
August 14, 2018
Medi-Cal / One Care / OneCare Connect**

Miles Masatsugu, M.D.
Medical Director
Committee Chair

<u>External Voting Members Attending</u>	<u>CalOptima Voting Members Attending</u>	<u>CalOptima Staff Attendees</u>
<input checked="" type="checkbox"/> GORDON, Lowell, M.D., Medical Director FCMG, Pediatrician.	<input checked="" type="checkbox"/> DAJEE, Himmet, M.D., Medical Director, Cardiothoracic Surgeon	<input checked="" type="checkbox"/> HA, Betsy, Executive Director, Quality Analytics & Improvement
<input checked="" type="checkbox"/> KELLY, John, M.D., * Orthopedic Surgeon, Private Practice	<input checked="" type="checkbox"/> FEDERICO, Frank, M.D., Medical Director, Hem/Onc	<input checked="" type="checkbox"/> GARCIA, Gloria, Program Assistant, Quality Improvement
<input checked="" type="checkbox"/> KO, Edward, MD Medical Director, AltaMed Health Services	<input checked="" type="checkbox"/> FONDA, Emily, MD, Medical Director, Internal Medicine	<input checked="" type="checkbox"/> GOMEZ, Veronica, Program Specialist, Int. Quality Improvement
<input checked="" type="checkbox"/> MARCHESE, Sarah, MD Medical Director, CHOC Health Alliance, Pediatrician	<input type="checkbox"/> HELMER, Richard, M.D., Chief Medical Officer, Family Medicine	<input checked="" type="checkbox"/> JIANG, Paul, Manager, Quality Analytics
<input checked="" type="checkbox"/> MASOUEM, Shahryar, MD Medical Director, Ambulatory Surgery Center, HealthCare Partners Medical Group	<input checked="" type="checkbox"/> HITZEMAN, Tracy, Executive Director, Case Management	<input checked="" type="checkbox"/> JONES, Pshyra, Director, Health Education and Disease Management
<input checked="" type="checkbox"/> SINHA, Mohini, M.D. Medical Director, Monarch, Pediatrician	<input checked="" type="checkbox"/> LAUGHLIN, Michelle Executive Director Network Operations, CalOptima	<input checked="" type="checkbox"/> OKAJIMA, Esther, Director, Quality Improvement
<input checked="" type="checkbox"/> SWEIDAN, Jacob, M.D. Medical Director, Noble, Pediatrician	<input checked="" type="checkbox"/> MASATSUGU, Miles, M.D., Medical Director, PACE, Family Medicine	<input checked="" type="checkbox"/> POON, Edwin, Director Behavioral Health Services
	<input type="checkbox"/> MUNDUNURI, Sessa, Executive Director, Operations	<input checked="" type="checkbox"/> REX-KIMMET, Kelly, Executive Director Quality and Analytics
	<input checked="" type="checkbox"/> SHARPS, Donald, M.D., Medical Director, Behavioral Health, Psychiatrist	

*Full time practitioners

QIC

Topic	Discussion	Recommendation/Action
Call to Order	Miles Masatsugu, M.D., Committee Chair, called the meeting to order at 12:07 p.m.	No action necessary
Introductions	Introductions were made around the room.	No action necessary
Review and Approval of Minutes	<p>1. <u>Approve the Minutes of the July 17, 2018 CalOptima Quality Improvement Committee (QIC) Meeting</u></p> <p><u>The July 17, 2018 meeting minutes were reviewed and approved as presented.</u></p>	On motion of Dr. Sweidan seconded and carried, the Committee approved the July 17, 2018 CalOptima Quality Improvement Committee Meeting as presented.
CMO Update	<p>2. <u>Chief Medical Office (CMO) Update</u></p> <p>At the absence of CalOptima's CMO, no update was given.</p>	No action needed.
New Business Whole Child Model (WCM) Clinical Advisory Committee Charter	<p>3. <u>Whole Child Model (WCM) Clinical Advisory Committee Charter</u></p> <p>Betsy Ha, Quality Analytics Executive Director presented Whole-Child Model (WCM) overview. WCM Clinical Advisory Committee (CAC) is formed pursuant to All Plan Letter 18-011 to ensure clinical and behavior health services for children with CCS eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers. California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions. The Department of Health Care Services (DHCS) is implementing WCM into designated COHS (21counties/5 Plans) to incorporate CCS services into select Medi-Cal Managed Care for Medi-Cal eligible CCS members. CalOptima will implement WCM effective January 1, 2019. All Plan Letter 18-011 was released June 7, 2018. Ms. Ha moved to share the guiding principles, goals, accountability, voting membership, recommended physicians or practitioners selection criteria, committee's staff, term of membership, and committee responsibilities described</p>	On motion of Dr. Kelly seconded and carried, the Committee approved CalOptima's Whole Child Model Clinical Advisory Committee with the recommended changes.

QIC

	<p>in the Charter. The Committee recommended adding WCM Health Network Medical Director and CCS Panel Pediatrician to the charter.</p> <p>4. <u>Bright Steps Perinatal Support Program</u> Pshyra Jones, Director of Health Education & Disease Management presented an overview of CalOptima’s Bright Steps Program. The program is modeled after the protocol for CPSP as part of CalOptima’s contractual requirements to provide members with access to a comprehensive perinatal support program. She shared components, goals and performance measures associated with the program. The Committee then recommended CalOptima utilize provider incentives to increase the program goals and performance measures.</p>	<p>On motion of Dr. Kelly seconded and carried, the Committee accepted the Bright Steps Perinatal Support Program update as presented.</p>
<p>Old Business</p> <p>Personal Care Coordinator (PCC) Evaluation</p>	<p>5. <u>Personal Care Coordinator (PCC) Evaluation</u> Tracy Hitzeman, RN, Executive Director of Clinical Operations presented a follow up to CalOptima’s Board of Director’s request on CalOptima’s Personal Care Coordination (PCC) Evaluation that are involved in Model of Care OneCare(OC)/OneCare Connect(OCC)/Seniors and Persons with Disabilities(SPD). The Personal Care Coordinator role was designed to support implementation of the Health Risk Assessment (HRA), Individualized Care Plan (ICP), and the care planning process. Beginning in 2014, CalOptima created and implemented the PCC role for the Model of Care. The role was introduced to increase CalOptima and Health Network (HN) compliance with CMS care management requirements and improve care coordination and efficiency. Additional goals included improving the care experience for members and providers and increasing CalOptima oversight of the Health Networks.</p> <p>PCCs directly influenced measure outcomes by developing an ICP for each beneficiary that needs or wants one; Ensuring that the ICP addresses issues identified in the HRA; Documenting implementation of the ICP through care management notes; Including pertinent specialists required by the beneficiary’s health needs on the ICT; and using professional and credentialed personnel to review the HRA. The PCC role has had a significant impact on achieving compliance with CMS and DHCS requirements for the HRA, ICP, and ICT processes. PCCs help patients overcome barriers to accessing care in order to improve health outcomes. Ms. Hitzeman moved to share PCC role and responsibilities, the project scope, data analysis. Health Network Status reports: There was steady improvements are seen across the board for measures</p>	<p>On motion of Dr. Sinha seconded and carried, the Committee approved CalOptima’s Personal Care Coordination (PCC) Evaluation as presented.</p>

QIC

selected for OneCare. In the OneCare Connect Program, measure 5 demonstrates consistent ability to address all issues raised in the HRA for both new members and those receiving annual re-assessments. And Measures selected for the SPD population demonstrate consistent compliance.

Cal MediConnect Core Measures

OneCare Connect exceeded the average for two measures: Percent of members willing to participate and who the MMP was able to locate with an assessment completed within 90 days of enrollment; and the percent of low-risk members with an ICP within 30 working days after the completion of the initial HRA. OneCare Connect was below the average for three measures: Percentage of members with an ICP; Percentage of members with documented discussion of care goals; and percentage of members who had contact with at least one member of the care team within the preceding year.

OneCare Trended HEDIS Rates

Several HEDIS measures demonstrated steady improvement over the evaluation timeframe. There were multiple interventions to address quality improvement; PCC involvement was one part of the strategy.

OneCare Connect Comparative HEDIS Rates

PCC impacts these measures by facilitating preventive care and chronic care management. There were multiple interventions to address quality improvement; PCC involvement was one part of the strategy.

PQA Medication Management

OneCare has achieved the highest ranking of five stars in medication adherence for Diabetes and Cholesterol Medications.

OneCare Model of Care Process

OneCare Program Measures that improved: Documented review of the HRA/ICP; A member or designated representative invited to or attending an ICT meeting; Addressing all issues identified in the HRA; and Evidence that Member received final ICP.

For the OneCare Connect program, the following measures improved: A member or designated representative invited to or attending an ICT meeting; PCP invited to or attending an ICT meeting; Appropriate Specialist or Discipline invited to or

QIC

	<p>attending an ICT meeting; Addressing all issues identified in the HRA; A copy of the ICP provided to the member. Future considerations is to 1) Co-locate PCCs at high volume PCP sites. This would enable the PCC to take a more active role on the care team, initiate the HRA and ICP for new members or members due for a reassessment. 2) For field-based PCCs, consider placing PCCs at CBOs, ancillary service sites, dialysis centers, etc. that serve a high volume of CalOptima members. 3) Home visits, PCCs could conduct home visits for high-risk or complex members to follow up on care plan goals, conduct additional assessments, and assist members with transitions of care. 4) For complex members, non-adherent, or members without caregivers, consider using the PCC to accompany members to physician visits.</p> <p>Additional opportunity for PCCs to assist CalOptima with management of behavioral health services in Orange County. Consider placing PCCs at County Mental Health Outpatient clinics.</p> <p><u>Member Experience Impact</u> Members value the quality of communication with their health care providers and want to feel cared for, and desire to be involved with their care. Recommendation is: 1) Patient Relationship, the PCC plays an important role by establishing relationships with their assigned members and involving members in their care through implementing the ICP. 2) PCC Skills, the PCC is currently trained on techniques for patient activation and motivational interviewing. 3) Patient Satisfaction enhance training to probe for levels of member satisfaction and to set standards for customer service. 4) Opportunity, CalOptima can leverage training used in the Member Services department for PCC training.</p>	
<p>Department/Subcommittee Reports</p> <p>Clinical Operations/Population Health Subcommittee</p>	<p>6. <u>Clinical Operations/Population Health Subcommittee- Quarter 2, 2018</u> Tracy Hitzeman, RN, Executive Director of Clinical Operations presented Clinical Operations/Population Health Subcommittee-Q2 2018 update. A copy of the report is attached to the original set of these minutes.</p> <p><u>Case Management:</u> Collection of OneCare Health Risk Assessment goal is not met. Preliminary result (41% of Qtr 2 members are still in process). Final quarter 1 result- 69 %. Improved result point in time (Qtr 1: 54% vs. Qtr 2: 67%= 14%).</p>	<p>On motion of Dr. Gordon seconded and carried, the Committee approved the Clinical Operations/Population Health Subcommittee-Q2 2018 update as presented.</p>

QIC

<p>2018 Healthcare Effectiveness Data and Information Set (HEDIS®) Results (MY 2017 Performance)</p>	<p>Member Satisfaction with Case Management: Goal not met, however there is 4% improvement from the prior quarter. There has been realignment of CM teams to support the front-line managers who interact with members on a day to day basis. There's been focus on member engagement, staff training and support and have added additional complex case managers.</p> <p><u>Coordination of Medical Home/PCP:</u> Goal not met, root cause analysis reveals system differences in data conformity between State CCS medical management platform and CalOptima core systems. The processes/goals may differ between County CCS and CalOptima. There is limited ability for County CCS to confirm PCP accuracy. There is significance of certain data points.</p> <p>7. <u>2018 Healthcare Effectiveness Data and Information Set (HEDIS®) Results (MY 2017 Performance)</u></p> <p>Paul Jiang, Manager, Quality Analytics (HEDIS). A copy of the report is attached to the original set of these minutes. For HEDIS submission; six reports (IDSS) were submitted to NCQA /CMS/DHCS for regulatory reporting, star rating, accreditation, and national health plan ratings. Three Patient Level Detail (PLD) files were submitted to CMS/DHCS. 10,320 medical record pursuits. Medical record retrieval rate is 98.25%. Mr. Jiang thanked all the offices that collaborated for their support of the medical record review process.</p> <p>Summary results by product line compared to CalOptima Goals was given. Noting that goals were set to the next higher NCQA percentile based on previous performance. Some goals were "stretch goals".</p> <ul style="list-style-type: none"> • Medi-Cal <ul style="list-style-type: none"> ➢ All DHCS MPLs have been met ➢ 35 out of 62 (56%) measures met goal (vs. 44% last year) ➢ 48 out of 62 (76%) measures are better than last year (vs. 72% last year) ➢ Opportunities for Improvement: Respiratory, Cardiovascular, and Access of Care measures • OneCare <ul style="list-style-type: none"> ➢ 15 out of 27 (56%) measures met goal (vs. 62% last year) 	<p>On motion of Dr. Sweidan seconded and carried, the Committee approved 2018 Healthcare Effectiveness Data and Information Set (HEDIS®) Results update as presented.</p>
--	--	---

QIC

- 20 out of 27 (74%) measures are better than last year (vs. 67% last year)
- Opportunities for Improvement: Diabetes Nephropathy and Breast Cancer Screening
- OneCare Connect
 - 13 out of 39 (33%) measures met goal
 - 29 out of 39 (74%) measures are better than last year
 - Opportunities for Improvement: Diabetes and Behavioral Health measures

Mr. Jiang provided details of each measures performance and a summary of all with green color coded to indicate the measure improvement in performance and red color code to indicate a decrease in performance.

LOB	HEDIS	Number of Measures at NCQA National Medicaid/Medicare Percentiles										Total # of measures *	Percent of measures at National 50th percentile or higher
		90 th Percentile		75 th Percentile		50 th Percentile		25 th Percentile		10 th Percentile			
		# of measures	% of total measures	# of measures	% of total measures	# of measures	% of total measures	# of measures	% of total measures	# of measures	% of total measures		
Medi-Cal	2018	13	21%	17	27%	15	24%	9	15%	8	13%	62	73%
	2017	6	10%	12	19%	22	35%	13	21%	9	15%	62	65%
OneCare	2018	1	4%	5	19%	11	41%	5	19%	5	19%	27	63%
	2017	0	0%	5	19%	7	26%	8	30%	7	26%	27	44%
OneCare Connect	2018	2	5%	1	3%	12	31%	16	41%	8	21%	39	38%
	2017	1	3%	1	3%	11	28%	15	38%	11	28%	39	33%

*reported measures in the domains of Effectiveness of Care and Access/Availability of Care only

In addition to the measure goals, details for a few select measures were provided for review.

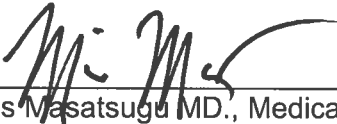
Next steps are to implement strategies on low performing areas. Priority areas will include low areas of performance and areas related to strategic initiatives (DHCS MPL, NCQA Accreditation, NCQA Health Plan Ratings, Medicare Star Rating). Results will be presented to stakeholder groups and committees. Will await NCQA Health Plan Rating and Accreditation Status Results. Calculate P4V scores and payments and begin preparations for HEDIS 2019.

Open Discussion	At the next QIC meeting, Dr. Dajee will bring information on the meetings with CalOptima medical director and providers with high volume of members with poorly controlled A1C. Data is being gathered and analyzed and more information to come on the Uncontrolled Diabetes Pilot Project.	No action necessary
Approval of attachments	<ul style="list-style-type: none"> • QIC Meeting Minutes_07.17.18 Draft 	On motion of Dr.

QIC

	<ul style="list-style-type: none"> • WCM Clinical Advisory Committees Charter_ORIGINAL • QIC 08 14 2018 PPT • CPE_COPHS 7.23.18 meeting minutes 	<i>Marchese seconded and carried, the Committee approved the submitted attachments as presented.</i>
Next Meeting	<p>September,11, 2018</p> <ul style="list-style-type: none"> • Grievance and Resolution Services • Program of All-Inclusive Care for the Elderly (PACE) • Quality Analytics <ul style="list-style-type: none"> ○ Consumer Assessment of Healthcare Providers and Systems (CAHPS) ○ Member Experience Initiatives • Quality Improvement Work Plan Dashboard • Clinical Operations Population Health Subcommittee: Improve Diabetic Care Pilot Program 	No action necessary
Adjournment and Next Meeting	There being no further business before the Committee, the meeting was adjourned at 1:25 p.m.	Dr. Masatsugu adjourned the meeting.

Respectfully Submitted:



Miles Masatsugu MD., Medical Director

9/11/18

Date

Recorded by: Gloria Garcia, QI Program Assistant



Quality Improvement Committee
MEETING MINUTES
 September 11, 2018
 Medi-Cal / One Care / OneCare Connect

Miles Masatsugu, M.D.
 Medical Director
 Committee Chair

<u>External Voting Members Attending</u>	<u>CalOptima Voting Members Attending</u>	<u>CalOptima Staff Attendees</u>
<input checked="" type="checkbox"/> GORDON, Lowell, M.D., Medical Director FCMG, Pediatrician.	<input checked="" type="checkbox"/> DAJEE, Himmet, M.D., Medical Director, Cardiothoracic Surgeon	<input checked="" type="checkbox"/> CHEUNG, Mimi, Supervisor, Quality and Analytics
<input checked="" type="checkbox"/> KELLY, John, M.D., * Orthopedic Surgeon, Private Practice	<input checked="" type="checkbox"/> FEDERICO, Frank, M.D., Medical Director, Hem/Onc	<input checked="" type="checkbox"/> CHOO, Marsha, Manager, Quality and Analytics
<input checked="" type="checkbox"/> KO, Edward, MD Medical Director, AltaMed Health Services	<input checked="" type="checkbox"/> FONDA, Emily, MD, Medical Director, Internal Medicine	<input checked="" type="checkbox"/> FETTERMN, Sharon Director, Utilization Management
<input type="checkbox"/> MARCHESE, Sarah, MD Medical Director, CHOC Health Alliance, Pediatrician	<input type="checkbox"/> HELMER, Richard, M.D., Chief Medical Officer, Family Medicine	<input checked="" type="checkbox"/> HA, Betsy, Executive Director, Quality & Analytics & Improvement
<input checked="" type="checkbox"/> MASOUEM, Shahryar, MD Medical Director, Ambulatory Surgery Center, HealthCare Partners Medical Group	<input checked="" type="checkbox"/> HITZEMAN, Tracy, Executive Director, Case Management	<input checked="" type="checkbox"/> GARCIA, Gloria, Program Assistant, Quality Improvement
<input checked="" type="checkbox"/> SINHA, Mohini, M.D. Medical Director, Monarch, Pediatrician	<input type="checkbox"/> LAUGHLIN, Michelle Executive Director Network Operations, CalOptima	<input checked="" type="checkbox"/> GOMEZ, Veronica, Program Specialist, Int. Quality Improvement
<input type="checkbox"/> SWEIDAN, Jacob, M.D. Medical Director, Noble, Pediatrician	<input checked="" type="checkbox"/> MASATSUGU, Miles, M.D., Medical Director, PACE, Family Medicine	<input type="checkbox"/> JONES, Pshyra, Director, Health Education and Disease Management
	<input type="checkbox"/> MUNDUNURI, Sesha, Executive Director, Operations	<input checked="" type="checkbox"/> OKAJIMA, Esther, Director, Quality Improvement
	<input checked="" type="checkbox"/> SHARPS, Donald, M.D., Medical Director, Behavioral Health, Psychiatrist	<input checked="" type="checkbox"/> POON, Edwin, Director Behavioral Health Services
		<input checked="" type="checkbox"/> REX-KIMMET, Kelly, Director Quality and Analytics

*Full time practitioners

QIC

Topic	Discussion	Recommendation/Action
Call to Order	Miles Masatsugu, M.D., Committee Chair, called the meeting to order at 12:10 p.m.	No action necessary
Introductions	Introductions were made around the room.	No action necessary
Review and Approval of Minutes	<p>1. <u>Approve the Minutes of the August 14, 2018 CalOptima Quality Improvement Committee (QIC) Meeting</u></p> <p><u>The August 14, 2018 meeting minutes were reviewed and approved as presented.</u></p>	On motion of Dr. Kelly seconded and carried, the Committee approved the August 14, 2018 CalOptima Quality Improvement Committee Meeting as presented.
CMO Update Whole Child Model (WCM) Clinical Advisory Committee Charter	<p>2. <u>Whole Child Model CAC update</u></p> <p>Whole Child Model Clinical Advisory Committee (WCM CAC) is formed pursuant to All Plan Letter 18-011 to ensure clinical and behavior health services for children with CCS eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers. California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions. The Department of Health Care Services (DHCS) is implementing WCM into designated COHS (21counties/5 Plans) to incorporate CCS services into select Medi-Cal Managed Care for Medi-Cal eligible CCS members. CalOptima will implement WCM effective January 1, 2019. All Plan Letter 18-011 was released June 7, 2018. Ms. Ha moved to share the guiding principles, goals, accountability, voting membership, recommended physicians or practitioners selection criteria, committee's staff, term of membership, and committee responsibilities described in the Charter. The Committee recommended adding WCM Health Network Medical Director and CCS Panel Pediatrician to the charter.</p>	No action needed.

QIC

<p>New Business</p> <p>NCQA status update</p> <p>Improv Diabetic Care Pilot Program</p>	<p>3. <u>NCQA status update</u> CalOptima went thru renewal survey earlier this year received score of 49.2 and have received NCQA Commendable accreditation.</p> <p>4. <u>Improve Diabetic Care Pilot Program</u> A copy of the report is attached to the original set of these minutes. Efforts to Improve Diabetic Care are to create an interdisciplinary team and develop a multi-pronged approach in addressing the barriers to HbA1c control among diabetic members in the CalOptima Community Network (CCN). Data is based on the Comprehensive Diabetes Care (CDC) HEDIS 2017 sub-measure “HbA1c Poor Control (> 9.0 percent)” with focus on the number of diabetic CCN members who have an HbA1c test result greater than 9.0 percent or are missing a test. CalOptima engaged high-volume offices to help improve the health outcomes and quality of life for our Diabetic CCN population. This is a continued office involvement for Q4 2017 thru Q2 2018.</p> <p>NOTES that poor control measure lower rate is better. The total CCN Poor control data (Caveat: data lag up to 90 days and CalOptima only account for ½ of the year. Still have time to conduct outreach to reduce the poor control numerator.</p> <p>Total CCN Diabetic members: 2017= 4449 in denominator and 2018= 5640. 15 targeted offices: (Aggregate Data):</p> <ul style="list-style-type: none"> • HbA1c>9: <ul style="list-style-type: none"> - 2017 = 57.21% - 2018 data from 1/1-6/30 = 48.15% • CKD (Stages 3-5): <ul style="list-style-type: none"> - 2017 = 20.53% - 2018 = 14.79% <p>2018 Data [15 CCN Targeted Offices]: April 2018 Pie Chart: Measurement Period [1/1/2018 to 4/30/2018] (Q1); n=2,140 July 2018 Pie Chart: Measurement Period [1/1/2018 to 7/31/2018] (Q1 and Q2); n=1,923.</p> <p><u>Findings:</u></p> <ul style="list-style-type: none"> • There was a decrease of 217 members from Q1 to Q2 	<p>No action required.</p> <p>On motion of Dr. Kelly seconded and carried, the Committee accepted the Improve Diabetic Care Pilot Program as presented.</p>
---	--	---

QIC

- The number of “No Test” category reduced from 31% to 19%; [12% improvement]. Which means more Claims received for members who took a HbA1c test. However, there is an increase in No Lab results by 8%. The Data workgroup is looking into this data gap and look for opportunities to improve.
- Reasons for “No lab results” may include:
 - We only receive data from our three (3) contracted lab vendors.
 - Potential data gaps and/or process improvements (Data workgroup looking into this)
- There are slight increases for members in the “Adequate control” groups [HbA1c<7 to<9] from Q1 (48%) to Q2 (52%).
- For the Poor Control group:
 - The percent of those in (HbA1c>9-13+) stayed about the same at (12%) from Q1 to Q2.
 - However, the number of members in the No Test/No Lab results in Q1 (40%) vs. Q2 (36%). Shows slight improvements and that we are moving in the right direction.

No test = No claim, no test

No lab results= There was a claim, but did not receive lab results, no member match

Of the Poor Control Group:

2017:

- Member with HbA1c >9 = 12%
- Members w/ NO Test = 31%
- Members w/ NO lab results = 9%

2018:

- Member with HbA1c >9 = 12%
- Members w/ NO Test = 19%
- Members w/ NO lab results = 17%

Barriers identified in the providers were member hard to reach, noncompliant with medication, member/provider lack of awareness about CalOptima resources and inconvenient lab locations or hour for members. Barriers for CalOptima were challenges with scheduling outreach appointments with providers, data challenges, staffing resources, and competing priorities/projects.

QIC

	<p>Planning is to establish an interdisciplinary team within CalOptima to address the diabetes issues pulling data from various sources (data warehouse, pharmacy, guiding care, etc.) establishing a data workgroup to address any data gaps; reconciling data. Developing databases to share reports with Providers and exchanging information between CalOptima and Providers to obtain accurate/up-to-date information. CalOptima will continue the outreach efforts with the 15 targeted CCN provider offices. Collaborate and share data between CalOptima and targeted CCN providers. Increase members' awareness about CalOptima's resources. Look into potentially offering educational classes at provider offices sites and look for opportunities to improve processes and obtain more accurate data.</p>	
<p>Department/Subcommittee Reports</p> <p>Quality Analytics CAHPS</p>	<p>5. <u>Quality Analytics Medi-Cal Member Experience (Consumer Assessment Healthcare Providers and Systems or CAHPS)</u> Marsha Choo, Manager of Quality Initiatives presented an update. A copy of the report is attached to the original set of these minutes. Medi-Cal Member Experience (Consumer Assessment Healthcare Providers and Systems or CAHPS)</p> <p>Medi-Cal Adult and Child survey are conducted at plan level. Sample size for Adult survey is 1,350 and the response rate was 24%. Sample size for Child survey is 1,650 and the response rate was 28%.</p> <p>Medi-Cal Adult and Child survey at the Health Network level are also conducted. Total Adult survey sample size for all Health Networks is 17,183 and the overall response rate is 30%. Total Child survey sample size for all Health Networks is 15,397 and the overall response rate is 37%.</p> <p>Medicare CAHPS surveys conducted for OneCare at plan level and OneCare Connect at both plan level and health network level. Results for OC/OCC Member Experience Surveys are not yet available.</p> <p>Medi-Cal Adult Survey Results are consistent with last year (25th percentile) pain points which keep us low scoring: Member Experience Benchmarks have risen across the nation (bar continues to be raised); "Rating of Health Plan" is double</p>	<p>On motion of Dr. Gordon seconded and carried, the Committee approved the Quality Analytics CAPHS update as presented.</p>

QIC

<p>Member Experience Initiatives</p>	<p>weighted; our score is at less than 25th percentile; Coordination of Care is statistically significantly lower than last year; Getting Needed Care, Getting Care Quickly, Rating of Specialist all stay at the < 25th percentile; There were three (3) health networks with many areas statistically below the CalOptima average.</p> <p>Medi-Cal Child Survey Results improved from the previous year. "Rating of Health Plan" is statistically significantly higher than the previous year. Pain points which keep us low scoring: Rating of Specialist is lower than the previous year; Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service continue to be areas of focus; There were two (2) health networks with many areas statistically below the CalOptima average</p> <p>6. <u>a. Member Experience Initiatives Update</u> Marsha Choo, Manager of Quality Analytics presented an update. A copy of the report is attached to the original set of these minutes. An enterprise-wide Member Experience Subcommittee was formed to improve member experience at various settings and ensure members have access to quality health care. Senior leadership executive sponsors from operations, medical affairs and provider network participate in this subcommittee. Strategy is to identify focus areas and implement initiatives to improve member experience. Member Pain Points are identified by Member Experience Surveys. Performance at the plan, health network and physician level, by timely access survey as well as monitor and review member complaints/potential quality issues (PQIs) and member needs assessment.</p> <p>Getting Needed Care and Getting Care Quickly strategy is to provide Member and provider education on access to care by providing Member and provider communications on CalOptima access standards. With articles in member communications about how to better access care. Articles about how to get care. Tips on "Preparing for Your Office Visit" and articles about how to obtain referrals and authorizations. CalOptima partners with health networks to increase access for members. Provide specific member experience and access performance shared with health networks (e.g. CAHPS, timely access). Corrective action plans are issued to health networks if timely access standards are not met. Pilot provider incentive for extended office hours and have CalOptima Days that collaborate with health networks and participating provider offices to host a day dedicated for preventive health screenings.</p>	<p>On motion of Dr. Gordon seconded and carried, the Committee approved the Member Experience Initiatives update as presented.</p>
--------------------------------------	---	--

QIC

<p>Member Experience Subcommittee Update</p>	<p>How Well Doctors Communicate and Customer Service the strategy is for CalOptima to educate providers of strategies and techniques to improve member experience (Provider Coaching Pilot) by improving customer service through trainings and workshops for: Physicians (1), managers and supervisors (1) and staff who provide customer service to CalOptima members (3) scheduled for October and November; Physician-Patient Communication Online CME (12 month access) and provide physician shadow coaching sessions.</p> <p>Rating of Health Plan strategy is to enhance coordination and redesign of member materials. Update the Medi-Cal New Member Packet (e.g. member ID cards, health network selection form, health network descriptions pack) for member ease of use. Refresh the covers to member materials (e.g. member handbook, provider directory, annual notice) and Streamline member communication. To Expand methods for members to access services CalOptima has a Member Portal where Members can access their personal health information when needed (24 hours a day) via personal electronic devices They can register for an account and complete self-service requests. There's soft launch (internal use only) in June 2018 with member release at the beginning of 2019. Community grants (Intergovernmental Transfer Program) are also available to provide better services to CalOptima members.</p> <p>Next steps are to continue with the planned interventions. Evaluate effectiveness of interventions. Implement strategies on low performing areas. Priority areas will include: Care Coordination and Referrals and Authorizations. And continue collaboration with health network and providers to improve member experience.</p> <p><u>b. Member Experience Subcommittee Update</u> Marsha Choo, Manager of Quality Analytics presented an update. A copy of the report is attached to the original set of these minutes.</p> <p>Customer Service Results: Q2–2018 result for Medi-Cal: First Call of Resolution - 85% of Member Calls Resolved the First Time the Member Calls was not met. No finding was identified. CalOptima will continue to monitor.</p> <p>Average Speed of Answer (ASA) - Not to Exceed 30 Seconds. ASA did not meet standard of 30 seconds. Average Handle Time increased 1.28% from Q1 2018. Staffing resources was identified as a finding. CalOptima will train staff to</p>	<p>On motion of Dr. Gordon seconded and carried, the Committee approved the Member Experience Subcommittee update as presented.</p>
--	---	---

QIC

increase efficiency and reduce handle time of each call and are actively recruiting to fill all open positions. There is also a redesign of Customer Service InfoNet Resource tools to improve ease of use.

Abandonment Rate: Not to Exceed 5%; Notification to members (CCN) of provider termination from network within 30 days; met KPI goal and will continue to be monitored.

Customer Service Results: Q2–2018 result for OC/OCC:

First Call of Resolution - 85% of Member Calls Resolved the First Time the Member Calls, Average Speed of Answer (ASA) - Not to Exceed 30 Seconds, and Abandonment Rate: Not to Exceed 5% all met goals and will continue to be monitored.

Access and Availability Sub-Committee

CalOptima met all Network Adequacy Standards at the plan level for all lines of business (part of internal monitoring). CalOptima passed the Department of Health Care Services (DHCS) Medi-Cal Network Certification for 2018 (submission in March). 9 of 27 plans did not pass for distance or time standards. Revised All Plan Letter (APL) on Network Certification to be issued in September 2018. The Whole Child Model Network Adequacy Submission as in Mid-August. CalOptima contracts with 87% of the providers on the DHCS California Children Services paneled providers Orange County list (minimum was set at 50%). Providers who are nearing or exceeding capacity will be notified of their status and issued a correction action. Standard: Provider to member ratio is 1:2,000. 1,000 additional members for each additional mid-level (up to 4). Updates on Access and Availability Policy for Medi-Cal, with new requirements including Whole Child Model, approved by the Policy Review Committee and submitted for September Board approval; Health Network Access Quality Improvement Plans (QIPs) for 2016 performance have officially closed out. An area of focus will be on access to specialty care services. Next Steps are to: Update network adequacy reports to reflect new regulatory access standards effective July 1, 2018; Run network adequacy reports based on new guidance and revised APL from DHCS; and issue access-related Corrective Action Plans for 2017 performance.

Member Experience Highlights

Workgroup to streamline the grievance and appeals and potential quality issues

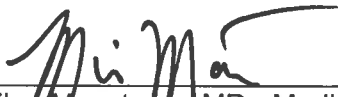
QIC

<p>Program for All-Inclusive Care for the Elderly</p> <p>Credentialing Peer Review Committee Update</p>	<p>(PQIs) data for analysis. Data presented/reviewed: Access and Availability data; quarter 1, 2018 grievances and appeals; 2018 Member Experience CAHPS results; Medi-Cal Plan and HN Level results; customer service quality; and accuracy reports. Identified areas of focus will be on care coordination and referrals and authorizations.</p> <p>7. <u>Program for All-Inclusive Care for the Elderly</u> Due to time allotted the PACE presentation it was pended to the next QIC meeting.</p> <p>8. <u>Credentialing Peer Review Committee (CPRC) Update</u> Esther Okajima, Director Quality Improvement presented CPRC update. A copy of the report is attached to the original set of these minutes. CPRC met on 4/25/16, 5/23/18, June meeting was cancelled. There was 22% increase in the number of credentialing files processed due to an increase in CCN Network with additional Behavioral Health and CCS paneled providers. Facility Site Review (FSR)(s) /Medical Records Review (MRR)(s)/Physical Accessibility Review(s)(PARS) had a 30% increase in number of sites reviewed for FSR/MRR. Potential Quality of Care(PQI)(s) had a 20% decrease in number of potential quality cases, closing more cases with 90 days, 95% have no quality of care issue identified or are service related issues. In Q2 there were a total of 238 Initial and Recred files on the Clean List that were CPRC approved. 78 initial files were completed; 160 re-credentialled files completed of which one was non-compliant on timelines for Recreds >36 months. FSR/MRR completed 77 Full Scopes of which 12 were initial and 1 failed with score <80%. 4-member panels were closed, and 15 Full Scopes were overdue. 154 PAR(s) were completed and 51% with BASIC access. Moving on to PQI activity, there were 302 new cases opened, 390 closed with average of 116turn around time in days. 56% were closed within 90 days. The majority of PQI Cases were issued Severity Code , SO an S1.</p>	<p>Pended</p> <p>On motion of Dr. Gordon seconded and carried, the Committee approved the Credentialing Peer Review Committee Update as presented</p>
<p>Open Discussion</p>	<p>At the next QIC meeting, Dr. Dajee will bring information on the meetings with CalOptima medical director and providers with high volume of members with poorly controlled A1C. Data is being gathered and analyzed and more information to come on the Uncontrolled Diabetes Pilot Project.</p>	<p>No action necessary</p>
<p>Approval of attachments</p>	<ul style="list-style-type: none"> • QIC Meeting Minutes_08.14.18 Draft • QIC 09 11 2018 PPT • Member Experience Team Minutes_09.04.18_Draft • Member Experience Team_Minutes_6.26.18-Approved 	<p>On motion of Dr. Marchese seconded and carried, the Committee approved</p>

QIC

	<ul style="list-style-type: none"> • Member Experience Team_Minutes_7.24.18_Approved • Member Experience Team_Minutes_7.12.18_Approved • Member Experience Team_Minutes_8.21.18_Approved 	the submitted attachments as presented.
Next Meeting	<p>September,11, 2018</p> <ul style="list-style-type: none"> • Grievance and Resolution Services • Program of All-Inclusive Care for the Elderly (PACE) • Quality Analytics <ul style="list-style-type: none"> ○ Consumer Assessment of Healthcare Providers and Systems (CAHPS) ○ Member Experience Initiatives • Quality Improvement Work Plan Dashboard • Clinical Operations Population Health Subcommittee: Improve Diabetic Care Pilot Program 	No action necessary
Adjournment and Next Meeting	There being no further business before the Committee, the meeting was adjourned at 1:25 p.m.	Dr. Masatsugu adjourned the meeting.

Respectfully Submitted:



 Miles Masatsugu MD., Medical Director



 Date

Recorded by: Gloria Garcia, QI Program Assistant



PACE Quality Improvement Committee Meeting Minutes

March 13th, 2018

Time: 10:30am – 12:00pm

Place: PACE Conference Room 109

Meeting Attendees: Dr. Miles Masatsugu, Elizabeth Lee, Christine Sisil, Jenny Nguyen, Rebekkah Bitterman, LCSW, Mardany Escobedo, Franco Estacio, PT, Noe Zuniga, Terri Williams, Dr. Arghami, Dr. Nguyen, Viri Chavez

Meeting Notes Taker: Jenny Nguyen

Topic	Presentation/Discussion	Actions	Owner/Leader	Due Date
Roll Call and Introduction	Meeting called to order by Dr. Masatsugu at 10:33 a.m.	N/A	Miles Masatsugu, MD	
OLD BUSINESS				
Review and Accept Previous PQIC Minutes	Minutes of the PQIC February 13 th , 2018 approved.	First by Viri Chavez second by Franco.	Miles Masatsugu, MD	
Review HPMS submissions for Q4 2017	Membership & Immunizations – Membership and enrollments are continuing at the same rate. The rate of disenrollments are decreasing which is contributing to overall growth. Falls without Injury – Falls without injury has seen a decrease since 2015 with 974 falls/k/year at the end		Miles Masatsugu, MD	

	<p>of 2017 compared to 1327 in 2015. According to Supervisor of Therapy Services, Franco Estacio, PT, this rate of falls is currently stabilizing as this may be the baseline. Current interventions in place consists of the Falls Anonymous Group which meets quarterly and has involvement of families and caregivers. PACE's therapy department also hold classes in collaboration with the Orange County Council on Aging related to falls recovery, Matter of Balance. This class is held twice a year. PACE rehab staff also attended a one-day course on falls recovery. The Falls committee that began in Q3 2017 meets once a month to revisit the effectiveness of interventions in place. Currently, an average of 8 participants attend PACE's Falls Anonymous class.</p> <p>Grievances – In review of the year, grievances have seen a decrease year over year since 2014 with 131 grievances/k/year at the end of 2017. Grievances are crucial to providing oversight. Members of the committee suggested that participants may need more education on their right to file a grievance. PACE Social Work Supervisor suggests reviewing grievance rights with participants every 6 months.</p> <p>Appeals- In Q4 2017, there were no appeals, a decrease from Q3 2017.</p> <p>Level II events – In Q4 2017, there were one reported burn, two pressure injuries, and five falls reported as level II events. It appears that falls and pressure</p>			
--	---	--	--	--

	<p>injuries are seeing a similar amount each quarter. With the falls committee and wound committee in place, trends may see a decrease in Q1 2018.</p>			
<p>Medical Record's Report</p>	<p>PACE QI EMR Specialist Mardany Escobedo provided an update on the findings from the Q4 2017 Medical Record Chart Review Audit. A total of twelve charts were audited out of 237 charts (5% of total). Trends and deficiencies were categorized by 14 elements including: Demographics, Life plan, GARS, healthcare wishes, forms, assessments, contracted services & procurement, medications, vital signs, immunizations, labs, admissions, scanned forms, and service delivery. Committee members suggested using the CMS audit universe for next quarter's medical record review. Deficiencies from the elements are then separated by disciplines with Medical Assistants having the least amount of deficiencies with zero to day center having the most with 27 deficiencies. Overall, deficiencies have decreased since Q2. A finding related to document management shows missing documentation from the following specialties: Dr. Janet Conney (7), UCI Medical Center (6), Providence Speech and Hearing for Audiology (5), and Eye Associates of Orange County (5). UCI started a new Electronic Medical Record system in November, so this may have contributed to the number of deficiencies.</p>		<p>Mardany Escobedo</p>	
<p>Director's Report</p>	<p>PMAC Update – Director Elizabeth Lee gave an overview to the committee on items discussed at the December 11, 2017 PQIC. Suggestions included a request for a make-up session with Santa Clause,</p>		<p>Elizabeth Lee</p>	

	<p>advance notices for when staff members leave, more activities like the 'Sunshine Club', a cell phone usage class, and what staff member's acronyms mean.</p> <p>Transportation -In Q4 2017, there were zero one-hour violations reported with on-time performance averaging at 96% which is within the goal of 90%. A paperless scheduling process started in august to address workflow concerns. Improvements continued with PACE having direct access to Secure Transportation's affiliated ride times.</p>			
Enrollment Report	<p>Manager of Marketing and Enrollment, Noe Zuniga, provided a report on enrollment, withdrawals, and denials. In Q4 2017, there were a total of 12 withdrawals and 0 denials. In addition, Q4 a total net increase of 13. About the conversion rate between home visits and enrollments, Q4 was 59%. A recommendation from the committee is to include this number in Q1 2018 report.</p>		Noe Zuniga	
Center Manager Report	<p>Center Manager Terri Williams provided an update on equipment log findings, disenrollments, and home-care one-hour violations. Average water temperature for October was 108.2, November 108.7, and December 108.3. To be within compliance, water temperature must be within 108 – 140 degrees. No other findings. There were no findings for kitchen sanitizer. Regarding freezer-refrigerator temperatures, there were two instances in which staff did not document. Staff were counseled on this matter. There were 14 disenrollments in Q4 2017 with one being under 90</p>		Center Manager Terri Williams	

	<p>days enrollment. Of all the disenrollments, three were involuntary while seven were voluntary, and four deaths. Recommendations includes monitoring Medi-Cal eligibility, minimizing dissatisfaction of participants through use of suggestion box, center manager availability, and increased staff communication. There were 0 hour violations for participants who are transported by home care.</p>			
<p>Clinical Operations Report</p>	<p>Manager of Clinic Operations, Christine Sisil provided an update on equipment, infection control, weekly restraint monitoring, and the Glucometer Cap. In Q4 2017, there was one instance on 10/25/17 where the medication refrigerator showed a reading of 47 degrees. Temperature was rechecked within an hour and showed it was within normal limits. A review of infection control shows PACE is below the national benchmark, no other significant findings. There are no PACE participants on NRSB in Q4 2017. Although the CAP has been closed, PACE Clinic Manager is still doing unannounced checks to ensure compliance. An audit of five unannounced checks revealed 100% compliance.</p>		<p>Christine Sisil, RN</p>	



PACE Quality Improvement Committee Meeting Minutes

June 12th, 2018

Time: 10:30am – 12:00pm

Place: PACE Conference Room 109

Meeting Attendees: Dr. Miles Masatsugu, Elizabeth Lee, Christine Sisil, Jenny Nguyen, Rebekkah Bitterman, LCSW, Mardany Escobedo, Franco Estacio, PT, Noe Zuniga, Eva Elser, Dr. Arghami, Dr. Nguyen, Viri Chavez

Meeting Notes Taker: Jenny Nguyen

Topic	Presentation/Discussion	Actions	Owner/Leader	Due Date
Roll Call and Introduction	Meeting called to order by Dr. Masatsugu at 10:35 a.m.	N/A	Miles Masatsugu, MD	
OLD BUSINESS				
Review and Accept Previous PQIC Minutes	Minutes of the PQIC May 8 th , 2018 approved.	First by Franco second by Christine.	Miles Masatsugu, MD	
Review HPMS submissions for Q1 2018	Membership & Immunizations – Membership and enrollments are gradually increasing. Marketing and Enrollment Manager Noe Zuniga states that July is looking good, similar to February which is one of the highest enrollment months. The most recent quarter made some ground from the decreased enrollments in the winter months. For June, PACE was below	Continue to track and trend	Marketing and Enrollment Manager Noe Zuniga	

	<p>budget by one, 270 actual versus a 271 budget. PACE will be able to start marketing in South County July 1st, with hopes that the first South County participant can start August 1st. Director Elizabeth Lee stated that within the next few months, PACE leadership will be engaged to discuss how much volume the IDT can establish care on. Elizabeth suggested the IDT to identify participants who are appropriate for and may be interested in attending one of the other ACS sites. Particularly, participants who attend PACE for protective supervision. Social Work Supervisor Rebekah Bitterman mentions the importance of having physician buy-in with regard to having a participant go to an ACS. Elizabeth states during care plans, the question the IDT should be asking is:</p> <ol style="list-style-type: none"> 1. Where should the participant attend? 2. How many days? <p>Falls without Injury – Falls without injury has seen a decrease since the last quarter with 249 falls/k/quarter. Particularly, Q2 2018 is lower than Q2 2017. According to Supervisor of Therapy Services, Franco Estacio, PT, the monthly falls committee has had good outcomes thus far. One of the items that are a focus during the falls committee is polypharmacy spearheaded by PACE PCP Dr. Arghami. PACE Pharmacy has started one on one discussions with participants. Franco also stated that he recommended his team to take CEU courses that are related to falls prevention. In addition, Franco states that it's the same participants with the</p>	<p>PACE Center Manager on behalf of the IDT to identify participants appropriate for ACS attendance.</p> <p>Continue to track and trend</p>	<p>Center Manager Monica Macias</p> <p>Rehab Supervisor Franco Estacio</p>	
--	--	---	--	--

	<p>repeated falls. Franco’s team states that fall prevention education will start at the time of enrollment to attempt to address the issue at the time of enrollment. Franco will also engage the nursing team to give rehab a good baseline of the participant’s fall risk.</p> <p>Grievances – In Q1 2018, there are ten grievances, 1 other, 3 transportation, and 6 related to clinical issues. Regarding clinical issues, trends include dissatisfaction with their dental provider and length of time to receive eye glasses.</p> <p>Appeals- In Q1 2018, there are a total of 6 appeals. Four appeals were upheld by third-party, two appeals were overturned related to home care hours. Five appeals were related to untimely processing of service delivery requests.</p>	<p>Continue to track and trend. Will continue to look for addition dentists who are willing to work with PACE. PACE has recently added a new Optometrist who will be seeing PACE members. Additionally, the funds to purchase optometry equipment has been approved by the Board. We have started looking for the equipment. Once purchased, the optometrists will be coming the PACE to see participants.</p> <p>Continue to track and trend</p>	<p>Quality Improvement Manager Eva Else</p>	
--	--	---	---	--

	<p>Level II events – In Q1 2018, there are a total of 11 events, four falls with injury, three elopements, one pressure injury, three cases of influenza which were identified as part of the infectious disease outbreak related to the flu. Related to tracking level II system recommended changes, all system recommend changes are completed besides one. PACE SW and OT will add hand-offs to the participant's care plan.</p>	<p>The influenza outbreak started in Q4, 2017. The first case of influenza was identified on 12/23/17 with additional cases on 12/27/17 and 12/30/17. In Q1, 2018 we had three cases identified on 1/2/18 1/4/18 and 1/4/18 respectively. The team identified those participants who were found to be high risk and those with any signs of symptoms of influenza and quickly rescheduled them to keep them home. They quickly coordinated transportation, meals (if needed) and care givers (if needed). All participants with any signs/symptoms of influenza were tested and treated if positive. For those participants who were at home, a nurse was sent to their home to</p>		
--	--	---	--	--

		test the participant. IDT decided to prophylactically treat all participants for influenza.		
Medical Record's Report	<p>PACE QI EMR Specialist Mardany Escobedo provided a new medical records desktop reference for PQIC Approval. Notable changes include:</p> <ul style="list-style-type: none"> • Changing the tracking of service recording to service delivery requests. • All interventions will require a timeline. • Semi-annual assessments must be done for active interventions. • Review Lifeplan with the participant and/or authorized representative. <p>New Medical Records Desktop Reference approved.</p> <p>In addition, Mardany provided an update on the findings from the Q1 2018 Medical Record Chart Review Audit. A total of eleven charts were audited out of 259 charts (5% of total). Trends and deficiencies were categorized by 14 elements including: Demographics, Life plan, GARS, healthcare wishes, forms, assessments, contracted services & procurement, medications, vital signs, immunizations, labs, admissions, scanned forms, and service delivery requests. Deficiencies from the elements are then separated by disciplines with Pharmacy having the least amount of deficiencies with one to medical records having the most with 47 deficiencies. A finding related to document</p>	<p>Continue to track and trend</p> <p>First by Rebekah Bitterman, second by Christine Sisil.</p>	Mardany Escobedo	

	<p>management shows missing documentation from the following specialties: UCI Medical Center (8), Lumina Dental (6), Eye Associates of Orange County (5), PEC home health notes (3), and ER/Hospitalization reports (8). UCI started a new Electronic Medical Record system in November, so this may have contributed to the number of deficiencies.</p>			
Director's Report	<p>PMAC Update – Director Elizabeth Lee gave an overview to the committee on items discussed at the March 26, 2018 PQIC. At this meeting, Director Elizabeth Lee updated committee members on new staff, provided an update on the results of the participant satisfaction survey, and participant feedback. Highlights include:</p> <ul style="list-style-type: none"> -One participant mentioned she felt healthier because of the PT services she receives at PACE. -One participant mentioned that homecare did not get her ready in time. -One participant complimented Bertha and Maria on their scheduling abilities. -A discussion on emergency codes. <p>Next PMAC will include PACE Dietitian for a Dietary Service Focus Group.</p> <p>Transportation -In Q1 2018, there were zero one-hour violations reported with on-time performance averaging at 93% which is within the goal of 90%. Discussions have already taken place with Secure Transportation for South County to start in the</p>	Continue to track and trend.	Elizabeth Lee	

	summer. Onsite will be the primary transportation provider until PACE can get an estimate on the volume.			
Enrollment Report	Manager of Marketing and Enrollment, Noe Zuniga, provided a report on enrollment, withdrawals, and denials. In Q1 2018, there were a total of 7 withdrawals and 0 denials. In addition, Q1 a total net increase of 14. About the conversion rate between home visits and enrollments, Q1 was 65.9%. PACE Marketing and Enrollment Manager Noe Zuniga thanks the committees and their respective teams for their support in assessing participants' needs prior to enrolling.	Continue to track and trend.	Noe Zuniga	
Center Manager Report	<p>Social Work Supervisor disenrollments, and home-care one-hour violations. There were 16 disenrollments in Q1 2017 with five being under 90 days enrollment including: one with unstable housing, one death, one moved out of the service area, one dissatisfied with the clinic, and one had loss of Medi-Cal. There were 0-hour violations for participants who are transported by home care.</p> <p>PACE Day Center Supervisor discussed operation logs. Average water temperature for January was 108.2, February 107.8, and March 106.8. To be within compliance, water temperature must be within 108 – 140 degrees. No other findings. For the sanitizer strength, it was discovered that on March 23rd, the sanitizer was not distributing to dishwasher. This was fixed on March 26th and kitchen assistants were instructed to use the three-compartment sink.</p>	<p>Continue to track and trend.</p> <p>Continue to track and trend.</p>	<p>Rebekah Bitterman, LCSW</p> <p>Day Center Supervisor Viri Chavez</p>	

	<p>Regarding freezer-refrigerator temperatures, there were no findings.</p> <p>Director Elizabeth Lee provided an update on a new reporting area on behalf of the center manager concerning service delivery requests as part of the audit remediation. For Q1 2018, there were 118 approvals, 3 denials, 2 modified decisions. Of the 118, 90 were process timely with zero extensions. An analysis states there are 73% of SDRs processed within CMS regulation. Of the 33 SDRs that were out of regulation, 94% were approvals. Director Elizabeth Lee states that this will improve as PACE due to the new SDR workflow and ongoing trainings which have been implemented.</p>	Continue to track and trend.	Director Elizabeth Lee	
Clinical Operations Report	<p>Manager of Clinic Operations, Christine Sisil provided an update on equipment, infection control, weekly restraint monitoring, and the Glucometer Cap. In Q1 2018, there were two instances of the laboratory refrigerator being out of compliance on 3/5/18 and 3/6/18. Temperature was rechecked within an hour and showed it was within normal limits. A review of infection control shows PACE is below the national benchmark, no other significant findings. There are no PACE participants on NRSB in Q1 2018. Although the CAP has been closed, PACE Clinic Manager is still doing unannounced checks to ensure compliance. An audit of seven unannounced checks revealed 100% compliance.</p>	Continue to track and trend.	Christine Sisil, RN	

<p>Summary and Resource Allocation</p>	<p>Dr. Miles Masatsugu shared his experience regarding a recent conference. Most programs do not have Community-based PCP using the PACE EMR. Rather, they are using their own EMR and then fax their visit note to PACE. This does create a lot of additional work for the PACE program as PACE then needs to transcribe the notes into the ER including the care plans and orders. Dr. Miles Masatsugu also shared the importance of finding the right partner who will assist PACE in setting the foundation for future community-based physicians. Currently, 10+ potential PACE community-based PCP's have been identified and Dr. Masatsugu is in the process of meeting with them to gauge interest and fit with PACE.</p> <p>Dr. Miles Masatsugu also shared that the CalOptima Board of Directors authorized a PACE PCP incentive program. There is a quality and a utilization component. Dr. Miles Masatsugu discussed the challenge of managing inappropriate admissions. Because our participants are frail with multiple medical issues and ADL limitations, once they go to the ER, they are often admitted. Many of these are inappropriate admissions and could have been treated at a lower level of care. We would like to ensure that every PACE participant is evaluated and treated at the correct level of care. Currently, UCI is PACE's after-hours line provider. Starting July 1st, 2018, HCMA will be taking over this service for PACE. All 4 of the HCMA's after-hours physicians are very</p>	<p>Identify and implement a community-based physician workflow</p> <p>Provide a presentation regarding PCP Incentive Program to PACE IDT</p>	<p>Dr. Miles Masatsugu</p> <p>Dr. Miles Masatsugu</p>	
--	---	--	---	--

	<p>familiar with our participants as they see them at the PACE center, in SNF's and in the hospitals. Additionally, HCMA will be doing enhanced after-hour evaluations. These include: 1) Home visits by a nurse or physician, 2) Sending and meeting participants at a SNF to begin a workup 3) Sending and meeting the participant in the ER to start a workup and make a determination if they participant needs to be admitted or can just do an observation stay. Additionally, a new after-hours check out system will be implemented on July 1st, 2018. This consists of the PACE RN Case Manager checking out with the HCMA after-hours nurse to pass along any urgent cases. Then in the morning the HCMA after-hours nurse will call and check out with the PACE RN Case Manager to let them know of anything which occurred after-hours.</p>			
Meeting adjourned	11:39 p.m.			



PACE Quality Improvement Committee Meeting Minutes

June 12th, 2018

Time: 10:30am – 12:00pm

Place: PACE Conference Room 109

Meeting Attendees: Dr. Miles Masatsugu, Elizabeth Lee, Christine Sisil, Jenny Nguyen, Rebekkah Bitterman, LCSW, Mardany Escobedo, Franco Estacio, PT, Noe Zuniga, Eva Elser, Dr. Arghami, Dr. Nguyen, Viri Chavez

Meeting Notes Taker: Jenny Nguyen

Topic	Presentation/Discussion	Actions	Owner/Leader	Due Date
Roll Call and Introduction	Meeting called to order by Dr. Masatsugu at 10:35 a.m.	N/A	Miles Masatsugu, MD	
OLD BUSINESS				
Review and Accept Previous PQIC Minutes	Minutes of the PQIC May 8 th , 2018 approved.	First by Franco second by Christine.	Miles Masatsugu, MD	
Review HPMS submissions for Q1 2018	Membership & Immunizations – Membership and enrollments are gradually increasing. Marketing and Enrollment Manager Noe Zuniga states that July is looking good, similar to February which is one of the highest enrollment months. The most recent quarter made some ground from the decreased enrollments in the winter months. For June, PACE was below	Continue to track and trend	Marketing and Enrollment Manager Noe Zuniga	

	<p>budget by one, 270 actual versus a 271 budget. PACE will be able to start marketing in South County July 1st, with hopes that the first South County participant can start August 1st. Director Elizabeth Lee stated that within the next few months, PACE leadership will be engaged to discuss how much volume the IDT can establish care on. Elizabeth suggested the IDT to identify participants who are appropriate for and may be interested in attending one of the other ACS sites. Particularly, participants who attend PACE for protective supervision. Social Work Supervisor Rebekah Bitterman mentions the importance of having physician buy-in with regard to having a participant go to an ACS. Elizabeth states during care plans, the question the IDT should be asking is:</p> <ol style="list-style-type: none"> 1. Where should the participant attend? 2. How many days? <p>Falls without Injury – Falls without injury has seen a decrease since the last quarter with 249 falls/k/quarter. Particularly, Q2 2018 is lower than Q2 2017. According to Supervisor of Therapy Services, Franco Estacio, PT, the monthly falls committee has had good outcomes thus far. One of the items that are a focus during the falls committee is polypharmacy spearheaded by PACE PCP Dr. Arghami. PACE Pharmacy has started one on one discussions with participants. Franco also stated that he recommended his team to take CEU courses that are related to falls prevention. In addition, Franco states that it's the same participants with the</p>	<p>PACE Center Manager on behalf of the IDT to identify participants appropriate for ACS attendance.</p> <p>Continue to track and trend</p>	<p>Center Manager Monica Macias</p> <p>Rehab Supervisor Franco Estacio</p>	
--	--	---	--	--

	<p>repeated falls. Franco’s team states that fall prevention education will start at the time of enrollment to attempt to address the issue at the time of enrollment. Franco will also engage the nursing team to give rehab a good baseline of the participant’s fall risk.</p> <p>Grievances – In Q1 2018, there are ten grievances, 1 other, 3 transportation, and 6 related to clinical issues. Regarding clinical issues, trends include dissatisfaction with their dental provider and length of time to receive eye glasses.</p> <p>Appeals- In Q1 2018, there are a total of 6 appeals. Four appeals were upheld by third-party, two appeals were overturned related to home care hours. Five appeals were related to untimely processing of service delivery requests.</p>	<p>Continue to track and trend. Will continue to look for addition dentists who are willing to work with PACE. PACE has recently added a new Optometrist who will be seeing PACE members. Additionally, the funds to purchase optometry equipment has been approved by the Board. We have started looking for the equipment. Once purchased, the optometrists will be coming the PACE to see participants.</p> <p>Continue to track and trend</p>	<p>Quality Improvement Manager Eva Else</p>	
--	--	---	---	--

	<p>Level II events – In Q1 2018, there are a total of 11 events, four falls with injury, three elopements, one pressure injury, three cases of influenza which were identified as part of the infectious disease outbreak related to the flu. Related to tracking level II system recommended changes, all system recommend changes are completed besides one. PACE SW and OT will add hand-offs to the participant's care plan.</p>	<p>The influenza outbreak started in Q4, 2017. The first case of influenza was identified on 12/23/17 with additional cases on 12/27/17 and 12/30/17. In Q1, 2018 we had three cases identified on 1/2/18 1/4/18 and 1/4/18 respectively. The team identified those participants who were found to be high risk and those with any signs of symptoms of influenza and quickly rescheduled them to keep them home. They quickly coordinated transportation, meals (if needed) and care givers (if needed). All participants with any signs/symptoms of influenza were tested and treated if positive. For those participants who were at home, a nurse was sent to their home to</p>		
--	--	---	--	--

		test the participant. IDT decided to prophylactically treat all participants for influenza.		
Medical Record's Report	<p>PACE QI EMR Specialist Mardany Escobedo provided a new medical records desktop reference for PQIC Approval. Notable changes include:</p> <ul style="list-style-type: none"> • Changing the tracking of service recording to service delivery requests. • All interventions will require a timeline. • Semi-annual assessments must be done for active interventions. • Review Lifeplan with the participant and/or authorized representative. <p>New Medical Records Desktop Reference approved.</p> <p>In addition, Mardany provided an update on the findings from the Q1 2018 Medical Record Chart Review Audit. A total of eleven charts were audited out of 259 charts (5% of total). Trends and deficiencies were categorized by 14 elements including: Demographics, Life plan, GARS, healthcare wishes, forms, assessments, contracted services & procurement, medications, vital signs, immunizations, labs, admissions, scanned forms, and service delivery requests. Deficiencies from the elements are then separated by disciplines with Pharmacy having the least amount of deficiencies with one to medical records having the most with 47 deficiencies. A finding related to document</p>	<p>Continue to track and trend</p> <p>First by Rebekah Bitterman, second by Christine Sisil.</p>	Mardany Escobedo	

	<p>management shows missing documentation from the following specialties: UCI Medical Center (8), Lumina Dental (6), Eye Associates of Orange County (5), PEC home health notes (3), and ER/Hospitalization reports (8). UCI started a new Electronic Medical Record system in November, so this may have contributed to the number of deficiencies.</p>			
Director's Report	<p>PMAC Update – Director Elizabeth Lee gave an overview to the committee on items discussed at the March 26, 2018 PQIC. At this meeting, Director Elizabeth Lee updated committee members on new staff, provided an update on the results of the participant satisfaction survey, and participant feedback. Highlights include:</p> <ul style="list-style-type: none"> -One participant mentioned she felt healthier because of the PT services she receives at PACE. -One participant mentioned that homecare did not get her ready in time. -One participant complimented Bertha and Maria on their scheduling abilities. -A discussion on emergency codes. <p>Next PMAC will include PACE Dietitian for a Dietary Service Focus Group.</p> <p>Transportation -In Q1 2018, there were zero one-hour violations reported with on-time performance averaging at 93% which is within the goal of 90%. Discussions have already taken place with Secure Transportation for South County to start in the</p>	Continue to track and trend.	Elizabeth Lee	

	summer. Onsite will be the primary transportation provider until PACE can get an estimate on the volume.			
Enrollment Report	Manager of Marketing and Enrollment, Noe Zuniga, provided a report on enrollment, withdrawals, and denials. In Q1 2018, there were a total of 7 withdrawals and 0 denials. In addition, Q1 a total net increase of 14. About the conversion rate between home visits and enrollments, Q1 was 65.9%. PACE Marketing and Enrollment Manager Noe Zuniga thanks the committees and their respective teams for their support in assessing participants' needs prior to enrolling.	Continue to track and trend.	Noe Zuniga	
Center Manager Report	<p>Social Work Supervisor disenrollments, and home-care one-hour violations. There were 16 disenrollments in Q1 2017 with five being under 90 days enrollment including: one with unstable housing, one death, one moved out of the service area, one dissatisfied with the clinic, and one had loss of Medi-Cal. There were 0-hour violations for participants who are transported by home care.</p> <p>PACE Day Center Supervisor discussed operation logs. Average water temperature for January was 108.2, February 107.8, and March 106.8. To be within compliance, water temperature must be within 108 – 140 degrees. No other findings. For the sanitizer strength, it was discovered that on March 23rd, the sanitizer was not distributing to dishwasher. This was fixed on March 26th and kitchen assistants were instructed to use the three-compartment sink.</p>	<p>Continue to track and trend.</p> <p>Continue to track and trend.</p>	<p>Rebekah Bitterman, LCSW</p> <p>Day Center Supervisor Viri Chavez</p>	

	<p>Regarding freezer-refrigerator temperatures, there were no findings.</p> <p>Director Elizabeth Lee provided an update on a new reporting area on behalf of the center manager concerning service delivery requests as part of the audit remediation. For Q1 2018, there were 118 approvals, 3 denials, 2 modified decisions. Of the 118, 90 were process timely with zero extensions. An analysis states there are 73% of SDRs processed within CMS regulation. Of the 33 SDRs that were out of regulation, 94% were approvals. Director Elizabeth Lee states that this will improve as PACE due to the new SDR workflow and ongoing trainings which have been implemented.</p>	Continue to track and trend.	Director Elizabeth Lee	
Clinical Operations Report	<p>Manager of Clinic Operations, Christine Sisil provided an update on equipment, infection control, weekly restraint monitoring, and the Glucometer Cap. In Q1 2018, there were two instances of the laboratory refrigerator being out of compliance on 3/5/18 and 3/6/18. Temperature was rechecked within an hour and showed it was within normal limits. A review of infection control shows PACE is below the national benchmark, no other significant findings. There are no PACE participants on NRSB in Q1 2018. Although the CAP has been closed, PACE Clinic Manager is still doing unannounced checks to ensure compliance. An audit of seven unannounced checks revealed 100% compliance.</p>	Continue to track and trend.	Christine Sisil, RN	

<p>Summary and Resource Allocation</p>	<p>Dr. Miles Masatsugu shared his experience regarding a recent conference. Most programs do not have Community-based PCP using the PACE EMR. Rather, they are using their own EMR and then fax their visit note to PACE. This does create a lot of additional work for the PACE program as PACE then needs to transcribe the notes into the ER including the care plans and orders. Dr. Miles Masatsugu also shared the importance of finding the right partner who will assist PACE in setting the foundation for future community-based physicians. Currently, 10+ potential PACE community-based PCP's have been identified and Dr. Masatsugu is in the process of meeting with them to gauge interest and fit with PACE.</p> <p>Dr. Miles Masatsugu also shared that the CalOptima Board of Directors authorized a PACE PCP incentive program. There is a quality and a utilization component. Dr. Miles Masatsugu discussed the challenge of managing inappropriate admissions. Because our participants are frail with multiple medical issues and ADL limitations, once they go to the ER, they are often admitted. Many of these are inappropriate admissions and could have been treated at a lower level of care. We would like to ensure that every PACE participant is evaluated and treated at the correct level of care. Currently, UCI is PACE's after-hours line provider. Starting July 1st, 2018, HCMA will be taking over this service for PACE. All 4 of the HCMA's after-hours physicians are very</p>	<p>Identify and implement a community-based physician workflow</p> <p>Provide a presentation regarding PCP Incentive Program to PACE IDT</p>	<p>Dr. Miles Masatsugu</p> <p>Dr. Miles Masatsugu</p>	
--	---	--	---	--

	<p>familiar with our participants as they see them at the PACE center, in SNF's and in the hospitals. Additionally, HCMA will be doing enhanced after-hour evaluations. These include: 1) Home visits by a nurse or physician, 2) Sending and meeting participants at a SNF to begin a workup 3) Sending and meeting the participant in the ER to start a workup and make a determination if they participant needs to be admitted or can just do an observation stay. Additionally, a new after-hours check out system will be implemented on July 1st, 2018. This consists of the PACE RN Case Manager checking out with the HCMA after-hours nurse to pass along any urgent cases. Then in the morning the HCMA after-hours nurse will call and check out with the PACE RN Case Manager to let them know of anything which occurred after-hours.</p>			
Meeting adjourned	11:39 p.m.			



CalOptima
Better. Together.

Member Trend Report: Second Quarter 2018

**Special Board of Directors' Quality Assurance Committee Meeting
January 17, 2019**

**Ana Aranda
Director, Grievance and Appeals**

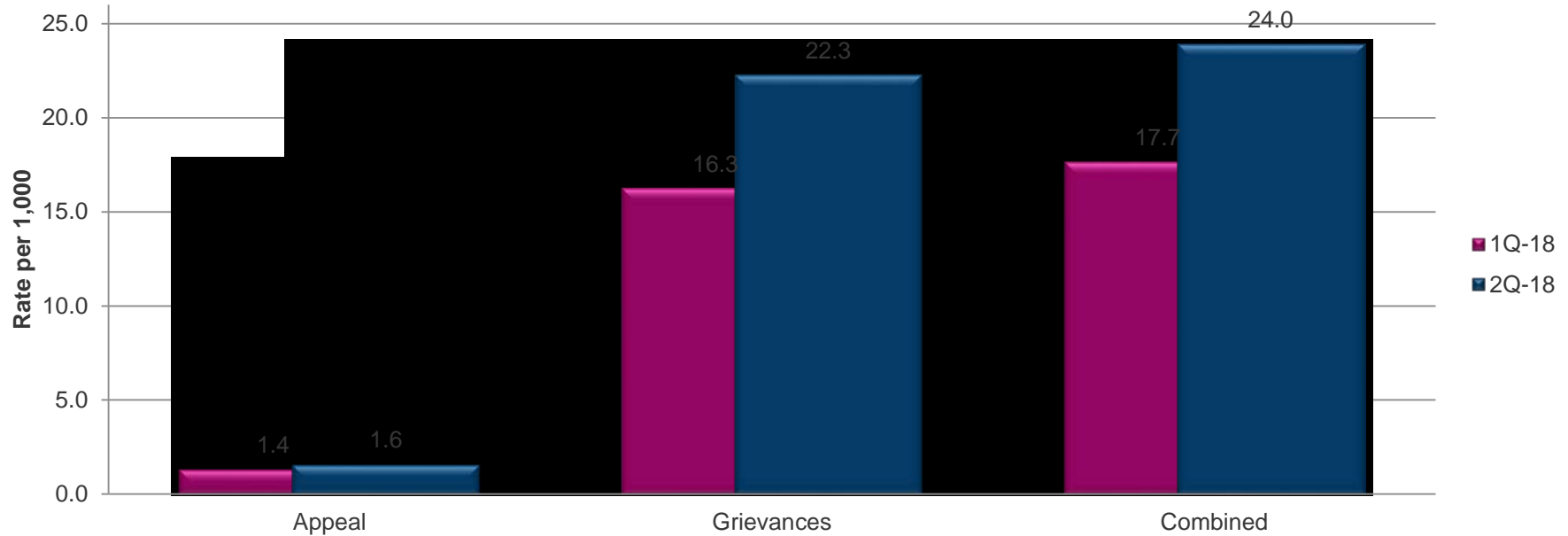
Overview

- Breakdown of complaints by category
- Trends in rate of complaints (appeals/grievances) per thousand members for all CalOptima programs for second quarter 2018
- Interventions based on trends, as appropriate

Definitions

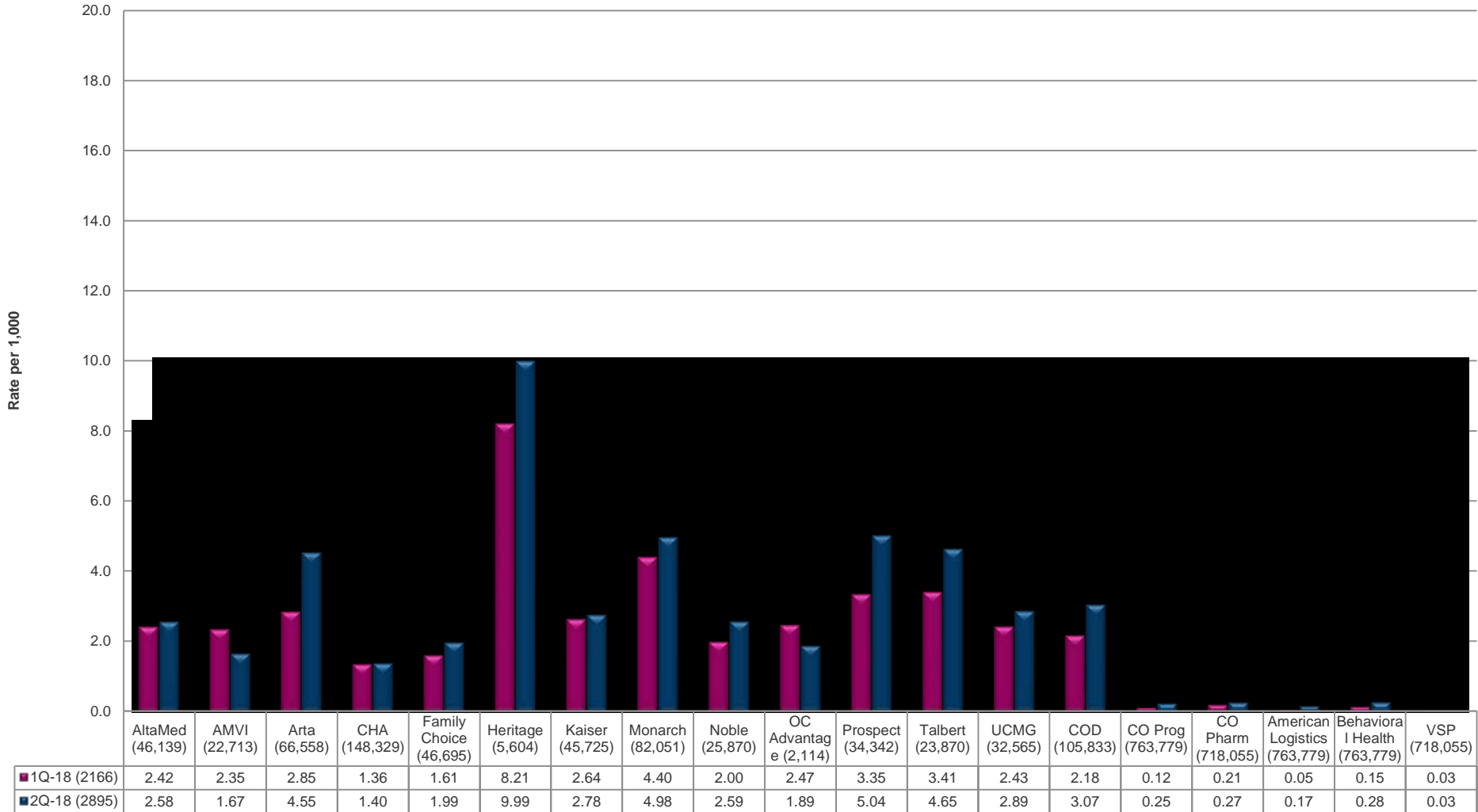
- Appeal: A request by the member for review of any decision to deny, modify or discontinue a covered service
- Grievance: An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program
- Quality of Service (QOS): Issues that result in member inconvenience or dissatisfaction
- Quality of Care (QOC): Concerns regarding the care member received or feels should have been received

Medi-Cal Member Complaints



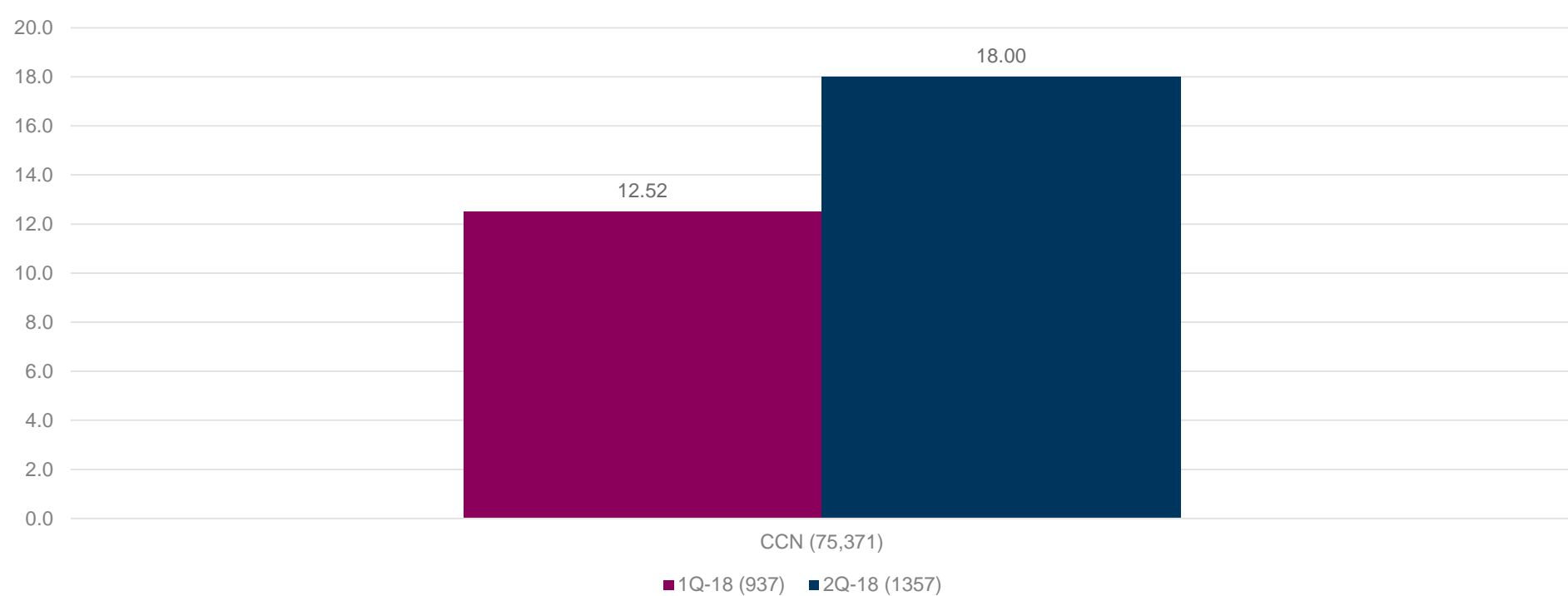
	Total Complaints	Appeals	Grievances	Membership
1Q-2018	3,365	262	3,103	771,453
2Q-2018	4,562	310	4,252	767,616

Medi-Cal Grievances Quarterly Rate/1,000 Members



[Back to Agenda](#)

CCN Medi-Cal Grievances Quarterly Rate/1,000 Members



CCN grievances had an increase in the following areas:

- Misdirected specialty referrals
- *Anonymous/Silent grievances captured at the point of intake
- Billing Issues

*Anonymous Grievance: Complaints where the member does not want their info disclosed.
Silent Grievance: Potential complaints where the member does not want to file a grievance

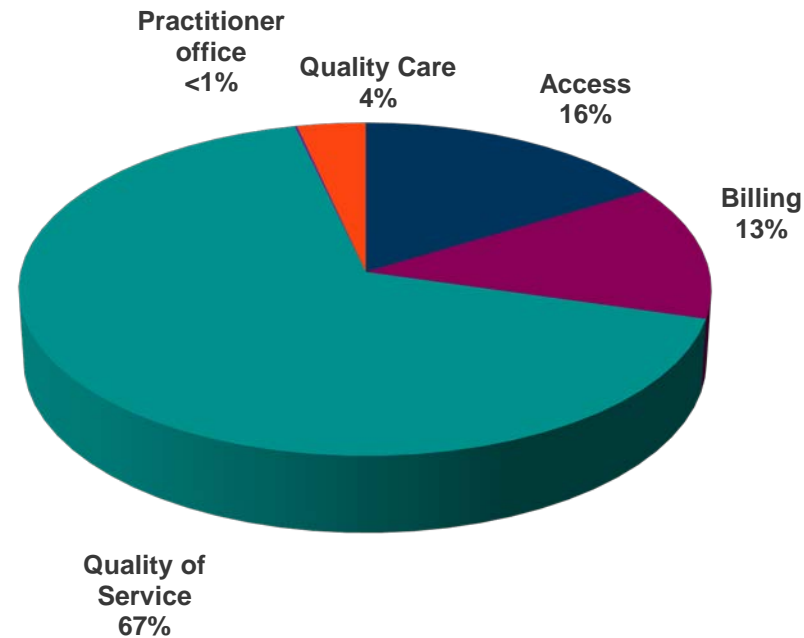
Areas of Improvement Identified

- GARS Management collaborates with other Medi-Cal Health Plans in reviewing and updating the criteria used for the categorization of grievances.
- Grievances related to misdirected specialty referrals are being addressed by internal cross-functional teams to address the root-cause and provide solutions to mitigate the delay in access.
- A triage team setup within Medi-Cal Customer Service department to address the exempt grievances* within the required timeframe.

*Exempt Grievances: Complaints resolved by the next business day which are exempted from an acknowledgement and resolution letter.

Medi-Cal Grievances by Category

- 4,252 grievances filed by 3,458 unique members in Q2 2018
 - 2,844 grievances (67%) were related to QOS
 - 150 grievances (4%) were related to QOC
 - The percentage by categories represents the historic trend
- The Quality Improvement (QI) department continues to review for QOC issues.



Medi-Cal Summary

- Quality of Service grievances account for the majority of the increase with the top complaints in:
 - ✓ Delay in service
 - ✓ Provider/Staff attitude and service
- Other top complaints include:
 - ✓ Appointment availability
 - ✓ Billing issues

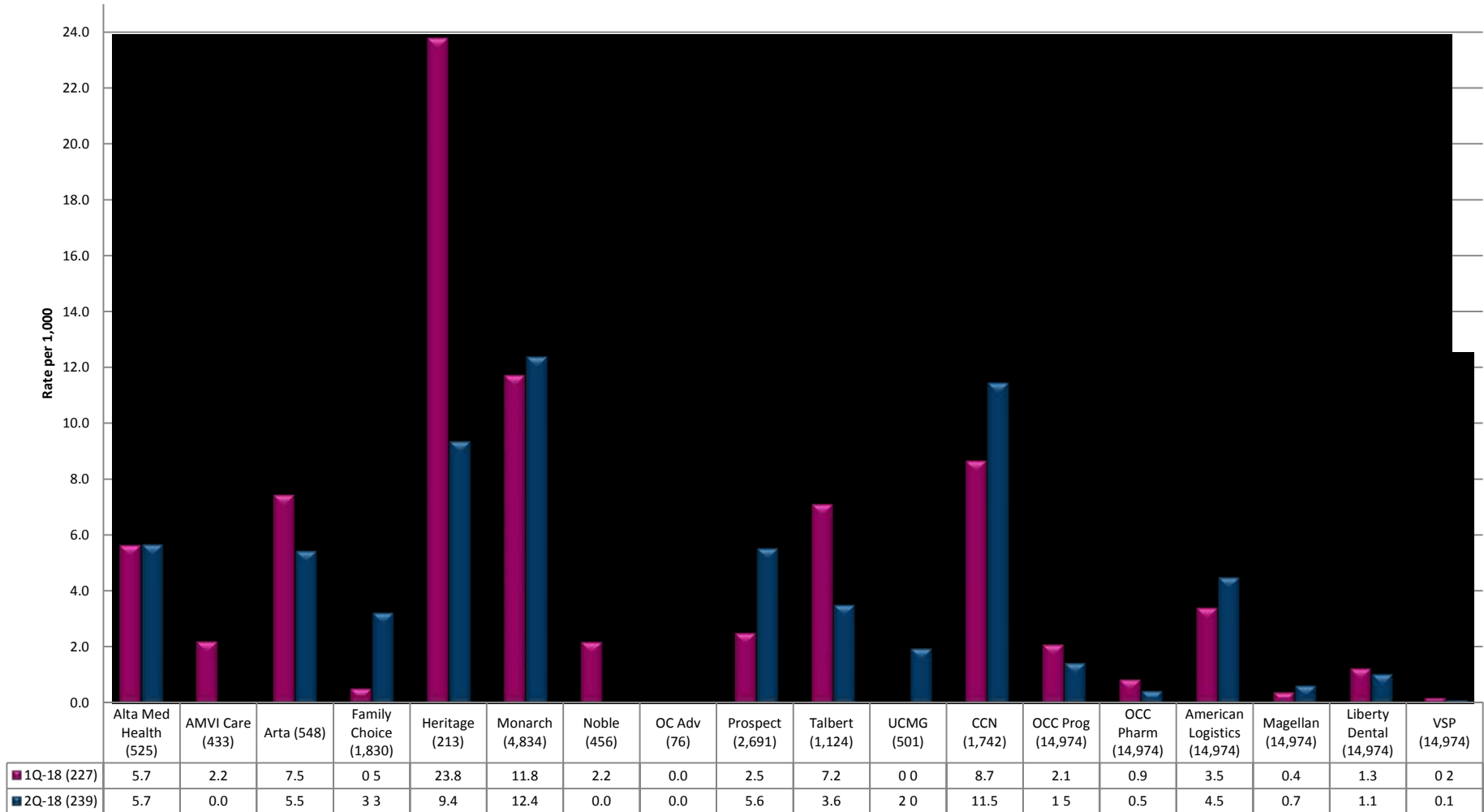
OneCare Connect Member Complaints



	Total Complaints	Appeals	Grievances	Membership
1Q-2018	282	55	227	15,031
2Q-2018	314	75	239	15,003

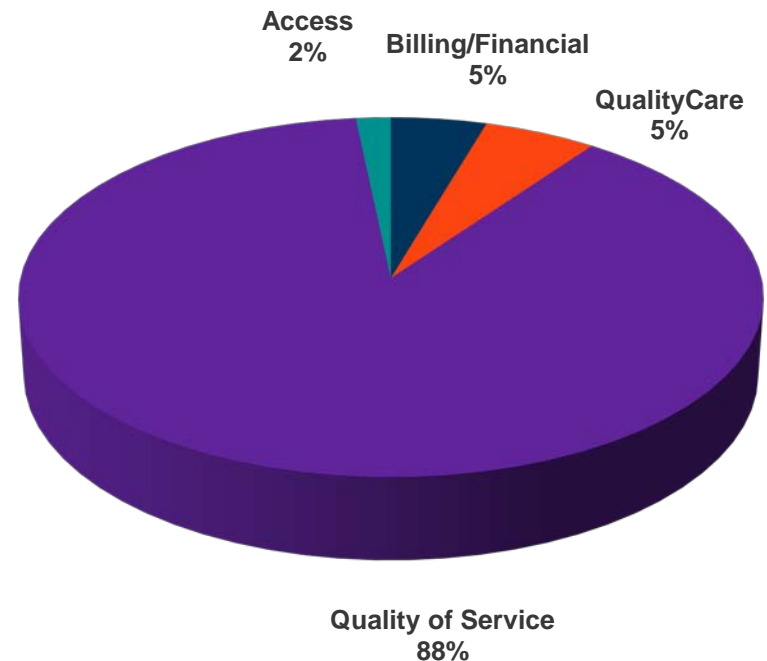
- There was a 36% increase in appeals from Q1, 2018 to Q2, 2018. The increase was found in coverage appeals primarily related to payment denials and out of network services.
- Grievances had a slight increase of 5%.

OneCare Connect Member Grievances Quarterly Rate/1,000



OneCare Connect Grievances by Category

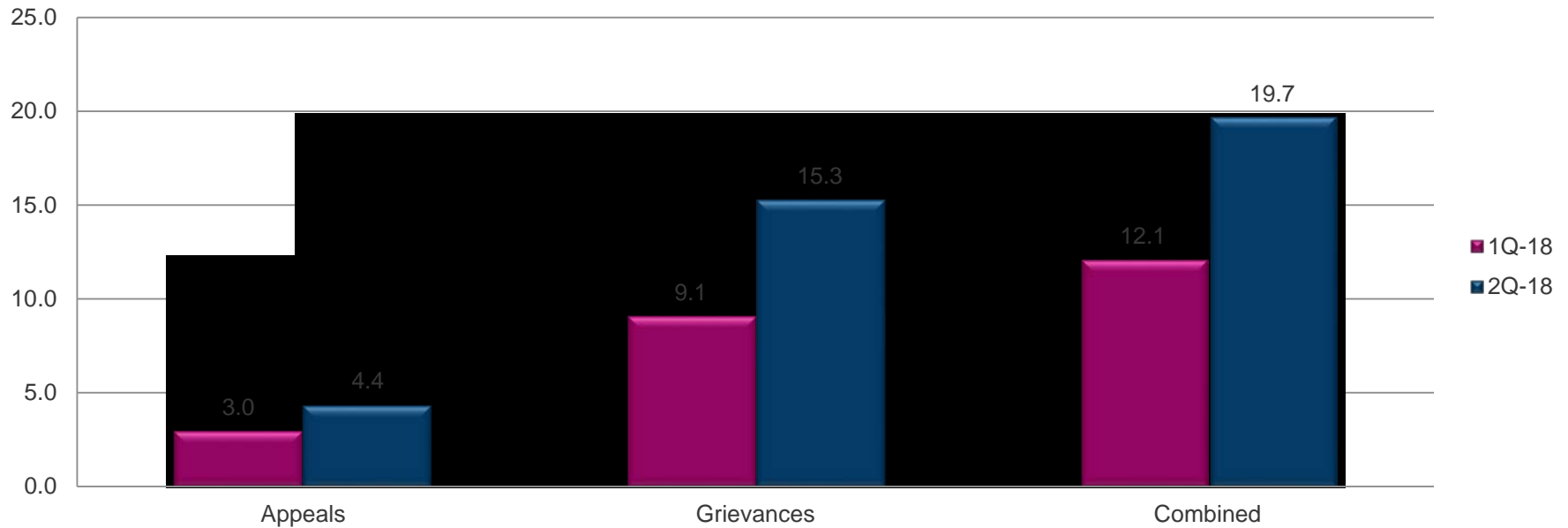
- 239 grievances filed by 167 unique members in Q2 2018
 - 211 grievances (88%) were related to QOS
 - 13 grievances (5%) were related to QOC
 - The percentage by categories represents the historic trend.
- The QI department continues to review for QOC issues.



OneCare Connect Summary

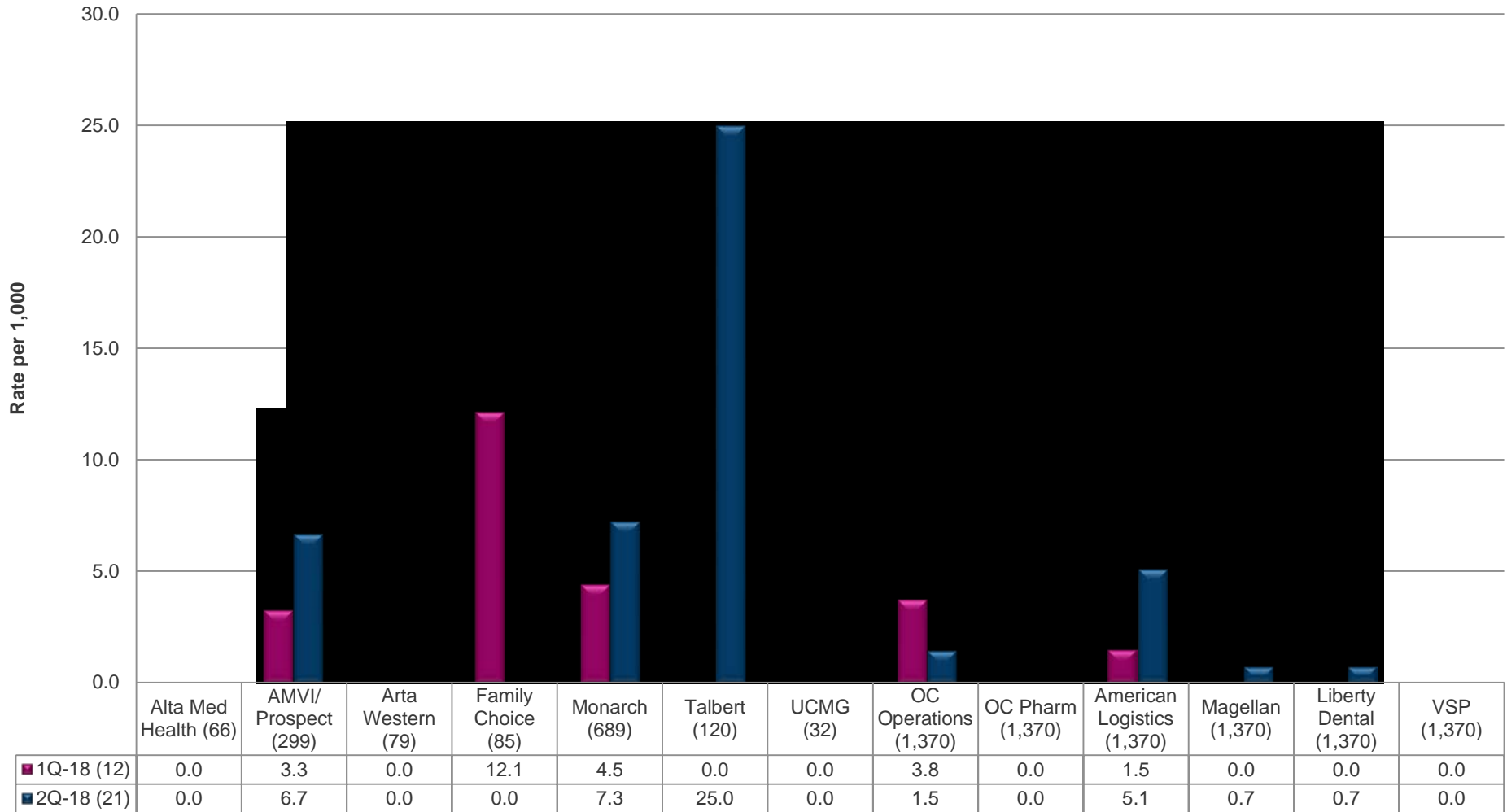
- Quality of Service grievances account for the majority of the increase with the top complaints in:
 - ✓ Delay in service
 - ✓ Provider/Staff attitude and service
 - ✓ Late pick-ups by taxi vendor
- Multiple grievances filed by a handful of members continue to impact the overall volume of grievances

OneCare Member Complaints



	Total Complaints	Appeals	Grievances	Membership
1Q-2018	16	4	12	1,325
2Q-2018	27	6	21	1,341

OneCare Member Grievances Quarterly Rate/1,000



OneCare Summary

- Low membership and multiple grievances filed by same members contributed to the increase in rate/1,000 members
- 19 of the 21 total grievances were related to quality of service with the following three as the top complaints
 - ✓ Delay in service
 - ✓ Provider/Staff attitude and service
 - ✓ Transportation vendor

Overall Interventions

- GARS is working closely with CalOptima's Quality Improvement (QI) department as part of an ongoing effort to improve quality and member satisfaction.
- CalOptima's QI department is offering providers who have a high volume of grievances an opportunity to work with a consultant that provides coaching and shadowing to improve services.
- A Provider Data Initiative was developed to improve provider information in CalOptima's systems in order to refer members appropriately to specialty and ancillary care.

CalOptima's Mission

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



CalOptima

Better. Together.



Medi-Cal

CalOptima

Better. Together.



OneCare (HMO SNP)

CalOptima

Better. Together.



OneCare Connect

CalOptima

Better. Together.



PACE

CalOptima

Better. Together.