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

WEDNESDAY, FEBRUARY 15, 2017
3:00 P.M.

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

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

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

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

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

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

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

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

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

REPORTS
2. Consider CalOptima Opioid Reduction Program and Next Steps

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

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

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

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

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

INFORMATION ITEMS
8. PACE Member Advisory Committee Update

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

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

NEXT REGULAR MEETING: Wednesday, May 10, 2017 at 3:00 p.m.

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

November 16, 2016

CALL TO ORDER

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

Members Present: Paul Yost, M.D., Chair; Ria Berger (at 3:08 p.m.); Dr. Nikan Khatibi; Alexander Nguyen M.D.

Members Absent: All members present

Others Present: Michael Schrader, Chief Executive Officer; Richard Helmer, M.D., Chief Medical Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Ladan Khamseh, Chief Operating Officer; Caryn Ireland, Executive Director, Quality Analytics; Tracy Hitzeman, Interim Executive Director, Clinical Operations; Suzanne Turf, Clerk of the Board

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the September 21, 2016 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Director Khatibi, seconded and carried, the Committee approved the Minutes of the September 21, 2016 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Director Berger absent)***

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REPORTS

2. Consider Recommending Board of Directors' Authorization to Request a Waiver Allowing Nurse Practitioners to Provide Primary Care at the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Center

Rena Smith, PACE Program Director, presented the action to recommend Board of Directors' authorization to request a waiver allowing Nurse Practitioners (NP) to provide primary care at the CalOptima PACE Center.

Ms. Smith provided an overview of Section 903of the Benefits Improvement and Protection Act (BIPA) of 2000, which allows for specific modifications or waivers of certain regulatory provisions to meet the needs of PACE organizations. It was noted that CalOptima PACE has experienced significant difficulty in recruiting and retaining primary care physicians to meet its growth needs. As proposed, a waiver of certain regulatory sections of Title 42: Public Health, Section 460 – PACE: Section 460.012 (c), Interdisciplinary Team, primary care physician, and Section 460.104 (a) and (c) regarding participant assessments, would be submitted to the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), to allow PACE NPs to conduct services that, as set forth in the PACE regulation, are currently assigned to the primary care physician, including assessments and reassessments, care plans, prescribing medications, and to serve on the interdisciplinary team as a primary care provider, in addition to, an in collaboration with, the PACE primary care physicians.

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

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended that the Board of Directors authorize the Chief Executive Officer to file a waiver request for CalOptima's PACE for Section 903 of the Benefits Improvement and Protection Act of 2000, to the Department of Health Care Services and the Centers for Medicare & Medicaid Services in order to allow Nurse Practitioners (NPs) to provide primary care, in addition to and in collaboration with the PACE primary care physicians; and authorize contracts with NPs to provide such services, subject to the requested waiver first being granted. . (Motion carried 4-0-0)***

3. Consider Recommending Board of Directors' Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives and Expenditures of Unbudgeted Funds of up to $1.1 Million

Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to consider recommending Board of Directors' approval of Medi-Cal Quality Improvement and Accreditation activities during CalOptima FY 2016-17, including contracts and contract amendments with consultant(s), member and provider incentives and expenditures of unbudgeted funds of up to $1.1 Million.

Dr. Bock reported that ongoing investment in innovative quality initiatives is required in order to maintain CalOptima's "commendable" accreditation status and rating by the National Committee for Quality Assurance (NCQA) as a top Medicaid plan in California. The following proposed expenditures were presented to the Committee for consideration: budget augmentation totaling $457,740 for current quality initiatives including surveys and NCQA fees, a NCQA consultant, quality initiatives in progress,

and required staff training; and $605,839 in new requests for quality initiatives for member and provider programs, member experience initiatives, provider toolkits, and outreach projects. It was noted that member and provider incentive programs will be established by CalOptima. Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives. All member and provider incentive programs will be presented to the Board for approval prior to implementation, as well as regulatory approval, as applicable.

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

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended that the Board of Directors: 1)Approve the Quality Improvement activities listed on Attachment 1; 2) Authorize the Chief Executive Officer, with the assistance of legal counsel, to contract with new vendors and amend existing vendor contracts, as appropriate, for quality improvement-related services, including NCQA consulting and provider coaching services, incentive distribution and tracking services, PSA development services, survey implementation services, and material and print services selected consistent with CalOptima's Board-approved procurement process; 3) Direct staff to develop Member and Provider incentive programs in the amounts listed on Attachment 1, subject to applicable regulatory approval and guidelines, and final approval by the CalOptima Board prior to implementation; and 4) Authorize unbudgeted expenditures not to exceed $1.1 million to implement these initiatives. (Motion carried 4-0-0)***

4. Consider Recommending Board of Directors' Ratification of the 2016 CalOptima Utilization Management Work Plan

Dr. Bock presented the action to recommend Board of Directors' ratification of the 2016 CalOptima Utilization Management Work Plan. On March 23, 2016, revisions to the 2016 Utilization Management Program were presented to the CalOptima Board of Directors' Quality Assurance Committee for the Committee's recommendation to the CalOptima Board of Directors. On April 7, 2016, the proposed revisions to the 2016 Utilization Management Program were presented to, and approved by, the CalOptima Board of Directors. It was intended that the 2016 Utilization Management Work Plan would accompany the Utilization Management Program for approval, but the Work Plan was not included in the documents reviewed by the Quality Assurance Committee and approved by the Board of Directors. As proposed, approval of the 2016 Utilization Management Work Plan will ensure implementation of the approved 2016 Utilization Management Program.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' ratification of the 2016 CalOptima Utilization Management Work Plan as presented. (Motion carried 3-0-0)***

INFORMATION ITEMS

5. Program of All-Inclusive Care for the Elderly (PACE) Member Advisory Committee Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, reported on activities at the November 16, 2016 PMAC meeting, including: the addition of five new transportation vans and the implementation of an efficient transportation route process beginning on October 12, 2016;

and staff training on the scheduling process, which will result in shorter wait times for specialist appointments. PMAC participant members discussed the upcoming participant satisfaction survey, and new participant orientation groups will begin at the end of the year. PMAC participant member's suggestions and comments included requests for a library with current reading materials, assistance with getting back into the workforce, and distributing a list of all PACE staff and their responsibilities for participants to use as a resource.

6. PACE Program Update

Ms. Smith presented an overview of CalOptima's PACE Program, including services provided and eligibility criteria. As of November 1, 2016, 183 participants are enrolled in the program. Future plans for PACE include the proposed expansion of the PACE service area to include south Orange County. The Board of Directors authorized the submittal of a PACE Service Area Expansion application in February 2016. A brief overview of the Alternative Care Setting (ACS) model was presented, which has been identified as the most advantageous approach to best address the needs of eligible PACE participants in Orange County.

7. Medical Affairs Updates

a. Long-Term Care Update

Tracy Hitzeman, Interim Executive Director of Clinical Operations, provided an update on CalOptima's Long-Term Care (LTC) program, which is designed to encourage more frequent LTC provider visits with the goal of improved coordination of care, increased member and family satisfaction, and enhanced communication with specialty care. CalOptima currently contracts with approximately 100 area LTC facilities in Orange County, and adjacent counties; approximately 4,300 CalOptima members are in LTC. The proposed LTC Provider Incentive Program will be presented to the Board of Directors for approval, subject to regulatory approval as applicable.

b. Update on Perinatal Support Services

Pshyra Jones, Health Education and Disease Management Director, provided an overview of the Perinatal Support Services Program, and the new approach for a comprehensive, coordinated program with more emphasis on member-initiated activity, outreach and program marketing strategy. CalOptima's Perinatal Services Program components include identification of pregnant members, assessment, health education, high-risk case management, improve prenatal and postpartum HEDIS rates, and monitor program effectiveness through evaluation of outcomes.

Director Berger requested a follow-up presentation to the Committee to include steps taken to improve outcomes.

8. Quarterly Reports to the Quality Assurance Committee

The following Quarterly Reports were accepted as presented:

a. Quality Improvement Report
b. Member Trend Report

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COMMITTEE MEMBER COMMENTS
Committee members extended their wishes for a Happy Thanksgiving.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 5:00 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: February 15, 2017

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Opioid Reduction Program

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

Richard Bock, M.D.
Deputy Chief Medical Officer

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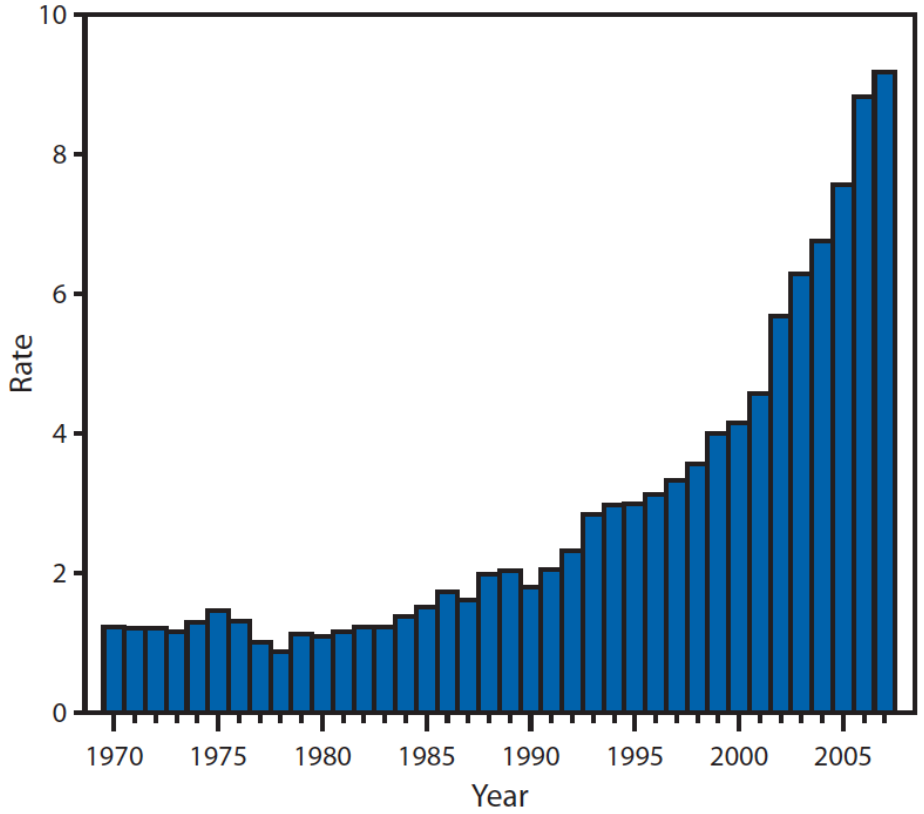
U.S. Drug Overdose Deaths

FIGURE 1. Rate* of unintentional drug overdose deaths — United States, 1970–2007



Source: National Vital Statistics System. Available at http://www.cdc.gov/nchs/nvss.htm.
* Per 100,000 population.

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On an Average Day in the U.S.

- More than **650,000 opioid prescriptions** dispensed
- **3,900 people** initiate nonmedical use of prescription opioids
- **580 people** initiate heroin use
- **78 people** die from an opioid-related overdose
- More people die of overdose than car accidents

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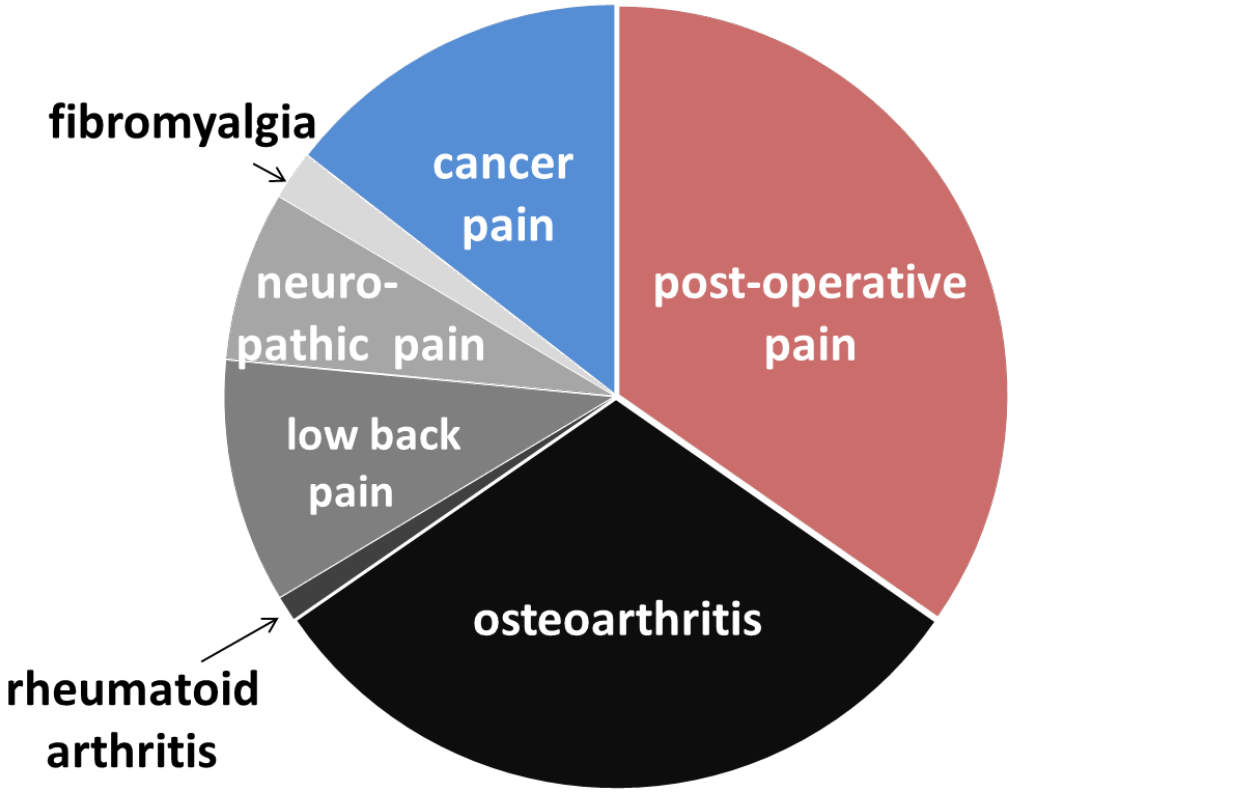
How the Epidemic Began

- Late 1990s — marketing of longer acting opioids
- States passed new laws and regulations moving from near prohibition of opioids to use without dosing guidance
- Laws were based on weak science, good experience with cancer pain and aggressive “pain control” lobby
- Thus, no ceiling on dose and axiom to use more opioid if tolerance develops

U.S. Opioids Market Revenues

U.S. opioids market revenues for 7 leading indications, 2010

Source: GBI Research. Opioids Market to 2017. June 2011



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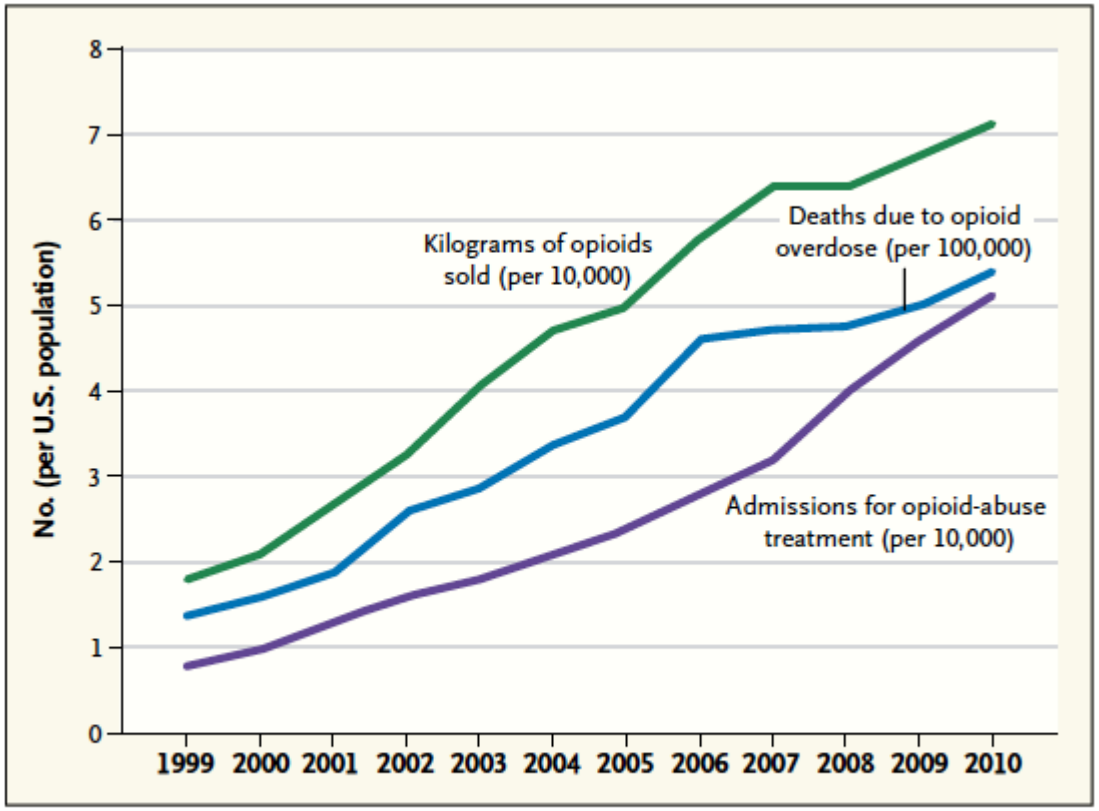
CalOptima A Public Agency Better. Together.

Opioid Deaths Rose With Increased Sales



Opioid Sales, Admissions for Opioid-Abuse Treatment, and Deaths Due to Opioid Overdose in the United States, 1999–2010.

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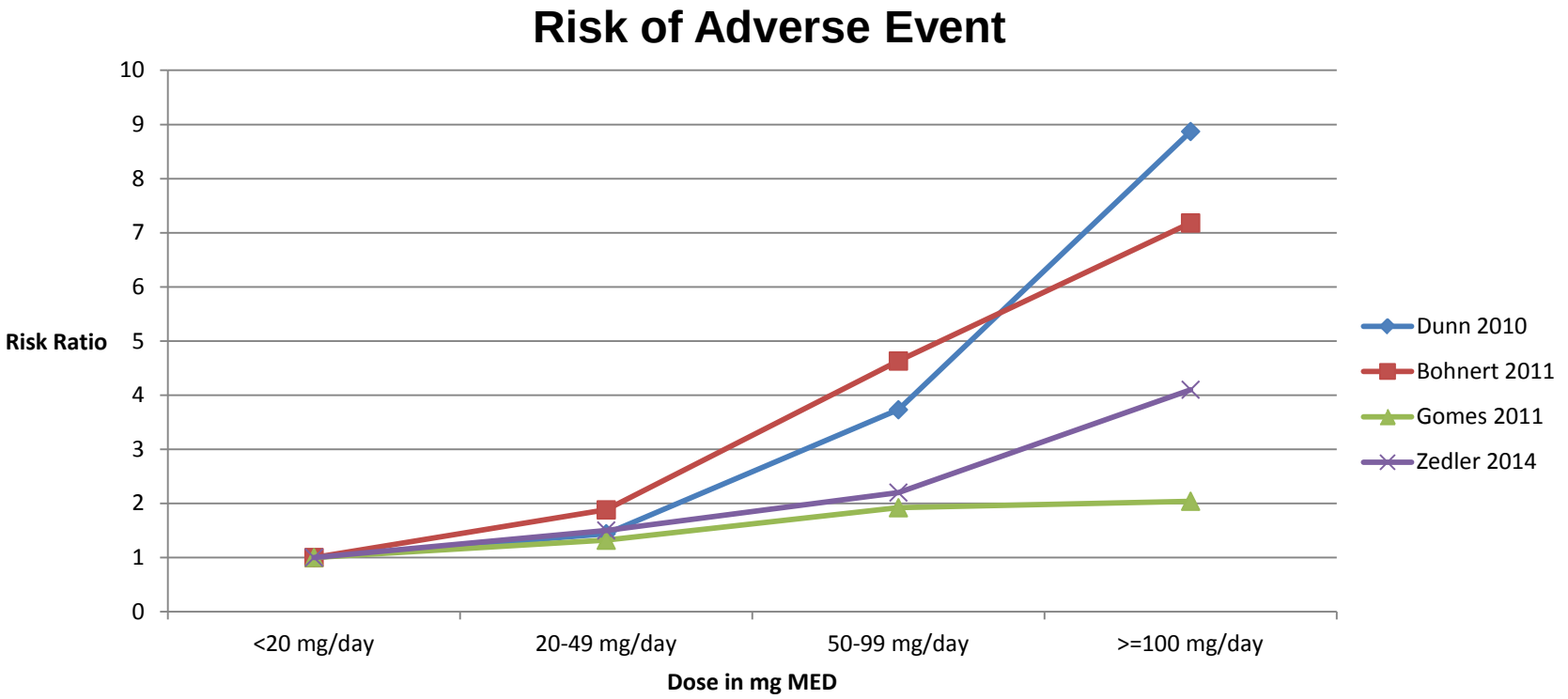
Dose-Related Risk



Two thirds of those using opioid medications for 90 days continue to use them long term (more than 2 years)

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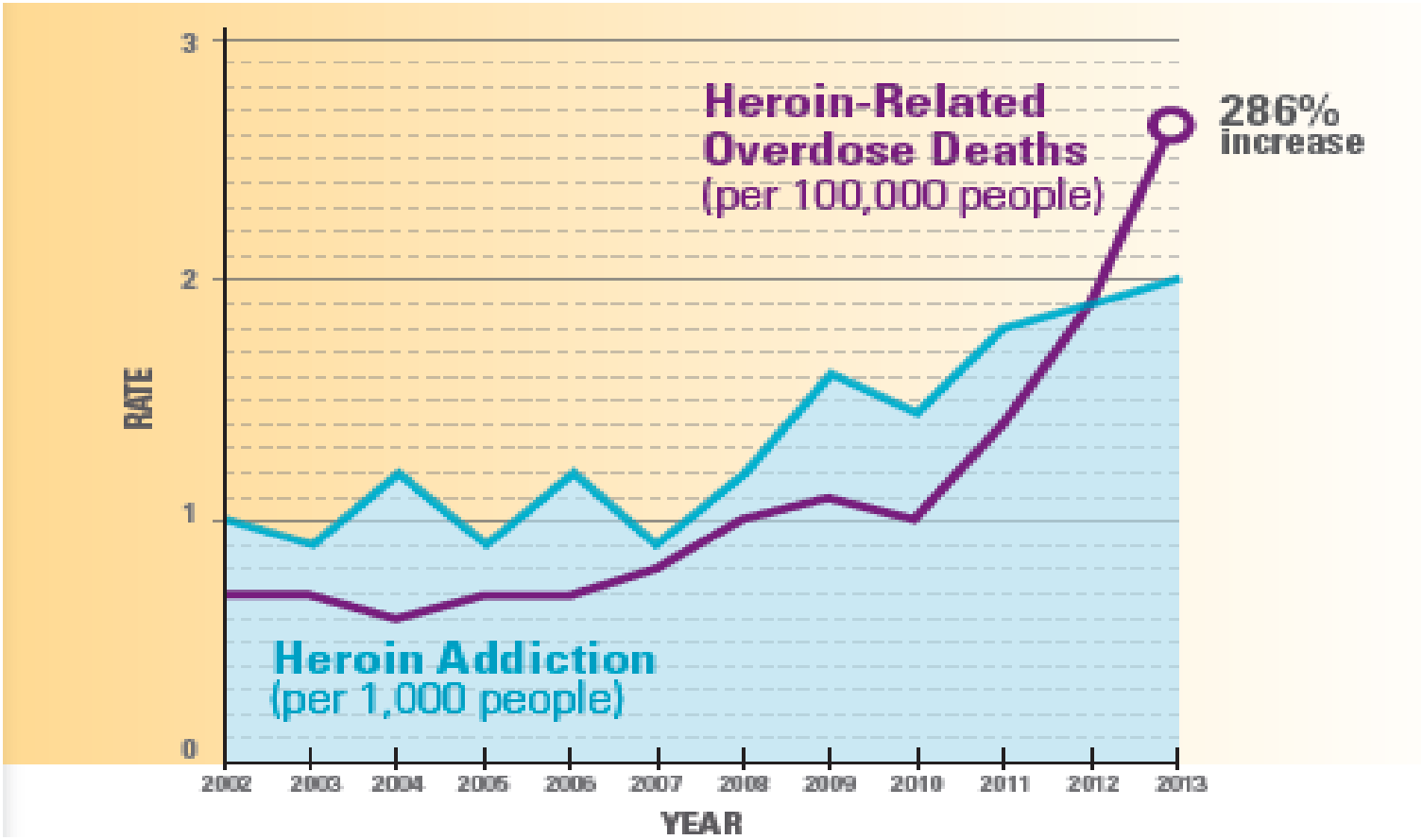
Heroin Addiction and Overdose



Source: National Survey on Drug Use and Health, 2002–13
National Vital Statistics System, 2001–13

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Effect on Orange County

- Drug overdose deaths in Orange County have soared to the highest levels in at least a decade
- Fatal drug overdoses climbed to at least 400 in 2016, a 63 percent jump compared with 2005 when the number stood at 246
- In the past five years, drug overdoses have killed 1,769 people in the county, topping the state
- More than two-thirds of last year's cases – 286 – involved opioids, including heroin and prescription painkillers such as Percocet, OxyContin and Vicodin

Orange County	3-Year Change
Opioid Prescriptions (excluding Buprenorphine)	2.1%
Residents on Opioids/Benzos	6.6%
Residents on >100MME Daily	-19.0%
Buprenorphine Prescriptions	36.4%
Residents w/ 6+ Prescribers or Pharmacies	6.6%

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Impact on Medi-Cal

- >45% of fatal prescription drug overdoses were Medicaid enrollees
- Medicaid beneficiaries
  - 2x the prevalence of opioid Rx
  - 6x the risk of overdose death
- Prescription drug misuse elevated in poverty, rural communities, co-occurring mental illness, and a history of substance abuse
- Between 2000 and 2009, the rate of newborns diagnosed with Neonatal Abstinence Syndrome (NAS) nearly tripled
- Abusers of opioids have been found to have total health care costs 8 times that of non-abusers

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Changing Face of Opioid Epidemic

- Fentanyl related overdoses prompt CDC alert synthetic opioid — 50 times stronger than heroin
- DEA issues nationwide warning on Carfentanil, an animal opioid sedative10,000 times that of morphine
- Fentanyl and Carfentanil have been mixed with powder heroin and substituted for pill ingredients
- Combined Benzodiazepine use was associated with 30.1 percent of opioid overdose deaths
- Opioid use was associated with 77.2 percent of benzodiazepine overdose deaths

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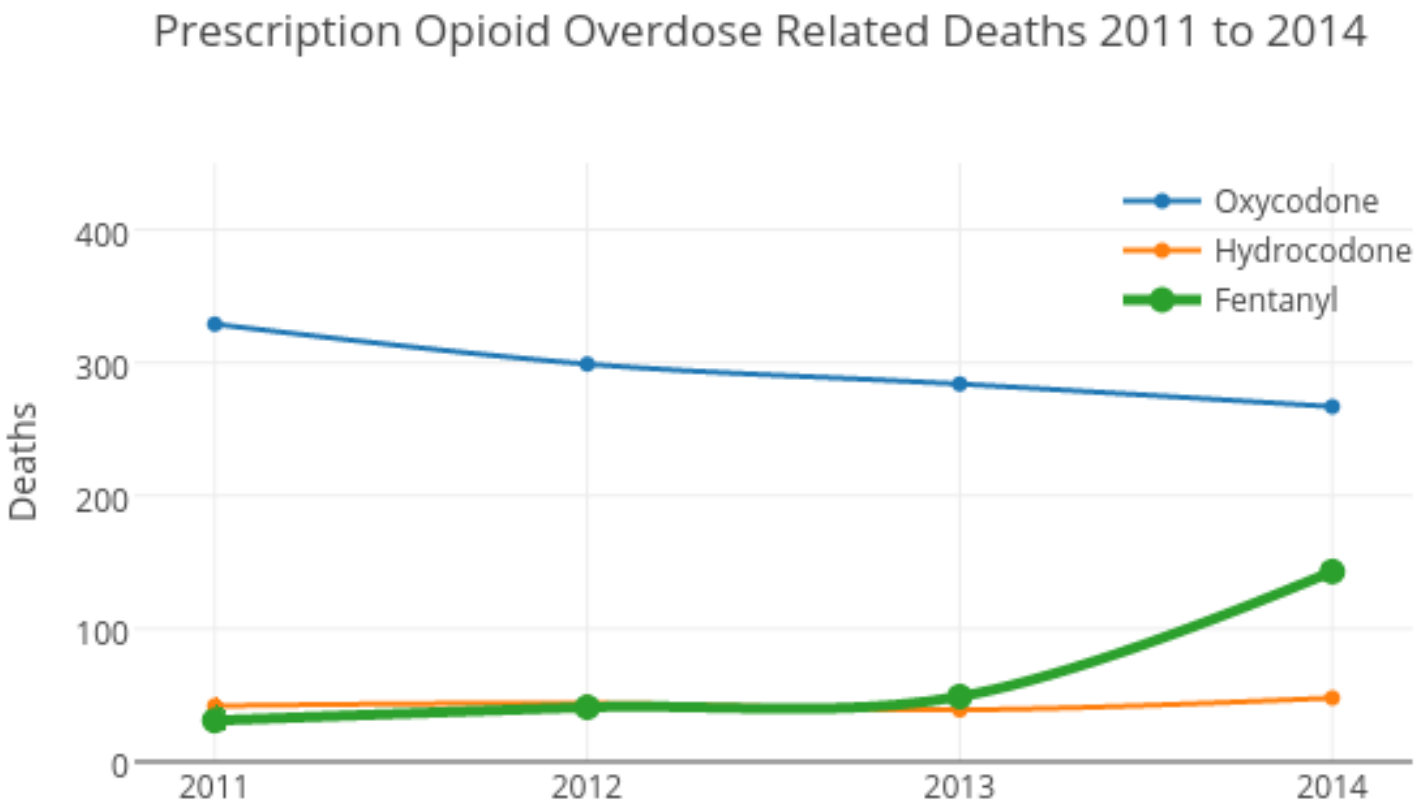
Changing Face of Opioid Epidemic



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Opioid Use Disorder Treatment

- Medication-assisted treatment, e.g., Buprenorphine (Suboxone)
  - Stabilizes neurochemical imbalances
  - Relieves symptoms of abstinence syndromes
  - Prevents intoxication and overdose
  - Reduces benzodiazepines
- Overdose rescue – Naloxone
- No wrong door for starting treatment of opioid agonist
- Wellness model with treatment for stable patients located at medical home
- Behavioral restructuring
- Integrated care for needle-related chronic illness such as HIV and Hepatitis C

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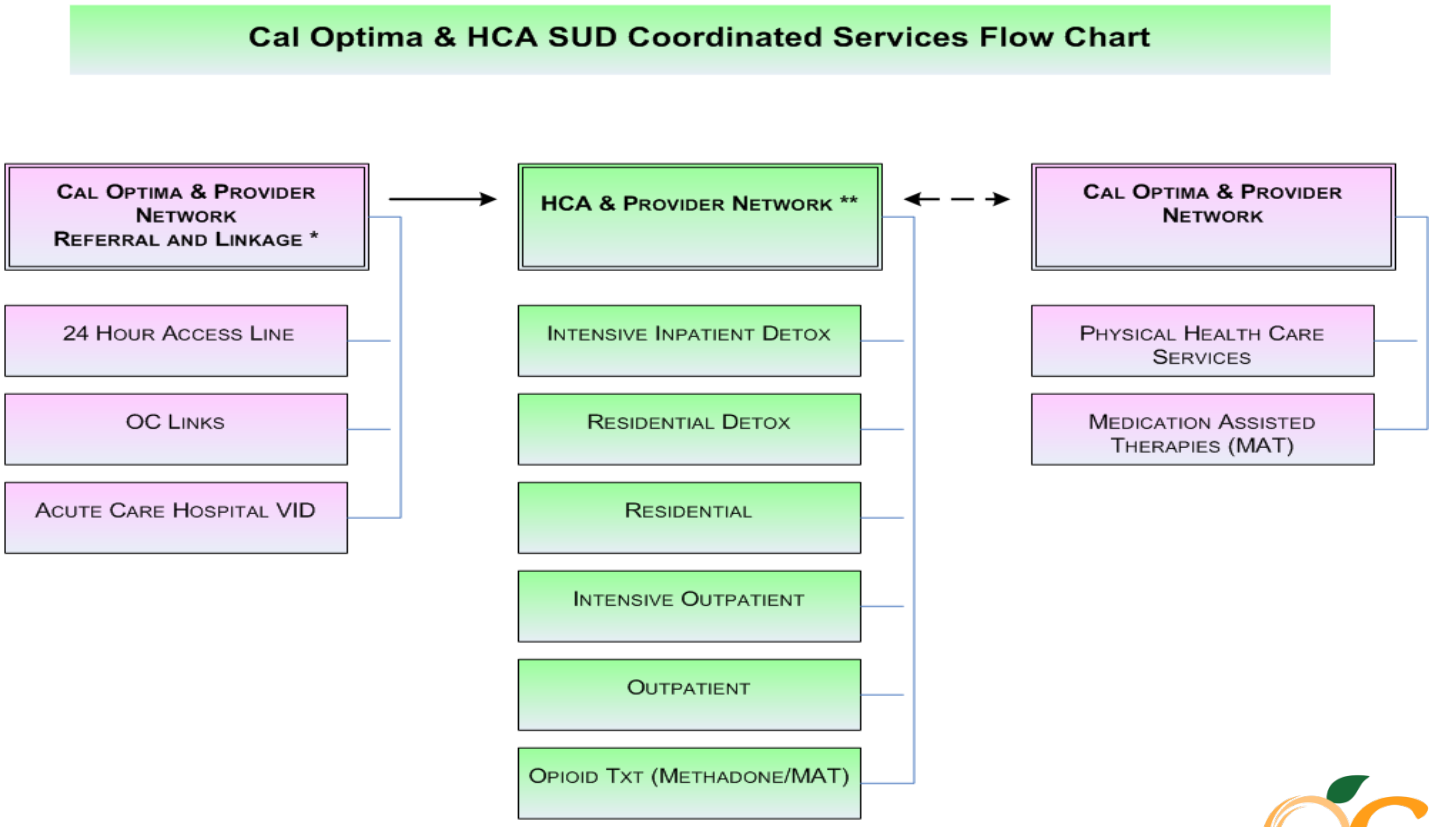
CalOptima and HCA SUD Coordinated Services



** Based Upon Screening, Brief Interventions, Referral to Tx (SBIRT)*

**Case Management, Physician Consultation and Recovery Support Services are available in all program*

OC health CARE AGENCY

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CalOptima A Public Agency Better. Together.

HCA BHS Substance Use Disorder Tx

- Orange County Health Care Agency (HCA) Behavioral Health Services (BHS) provides mental health and substance use disorder (SUD) services to eligible youth and adults

- California received a waiver from the federal government to develop a 5-year pilot project to better serve people with SUD and who are eligible for Drug Medi-Cal (DMC)

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HCA BHS Substance Use Disorder Tx (Cont.)

- BHS currently provides the majority of the waiver required services, using other funding. The additional DMC revenue will enable service expansion and enhancement
  - HCA served more than 7,000 youth and adults with SUD this past Fiscal Year
    - More than 68 percent were Medi-Cal eligible
- DHCS approved Orange County DMC plan in December 2016 and services are anticipated to begin as early as July 2017
- Federal Financial Participation (FFP) will cover up to 95 percent of allowable costs of SUD treatment

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CalOptima–HCA Coordination

- A longstanding MOU delineates the responsibilities of CalOptima and HCA to ensure members receive the appropriate level of care to address mental health issues

- An addendum to the MOU is in development to ensure the coordination of SUD screening and the provision of member services between CalOptima and HCA

- The MOU is currently under review by Orange County and CalOptima and will be submitted to DHCS upon approval

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HCA SUD Service Benefits to CalOptima Members

- Supports the use of Medication-Assisted Treatment (MAT) for opioid and alcohol disorders
- Changes SUD services from a social model to a medical model
- Supports integrated services with both mental health and physical health
- Supports coordinated care and services with other systems

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HCA SUD Continuum of Care for CalOptima Members

- Withdrawal Management Services
  - Social Model Residential and inpatient detox programs (up to 10 days)
- Residential Treatment with BHS authorization
  - Up to 90 days for adults and 30 days for youth
- Intensive Outpatient Treatment
  - 9–19 hours per week for adults and 6–13 hours for youth
  - Individual and group sessions
- Outpatient Drug Free
  - Up to 9 hours per week for adults and 6 hours per week for youth
  - Individual and group sessions

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HCA SUD Continuum of Care for CalOptima Members (Cont.)

- Opioid Treatment
  - Methadone Maintenance and other Medication-Assisted Treatment (MAT)
- All Treatment Programs Include
  - Linkage to MAT services
  - Case management services
    - To ensure appropriate treatment levels, transitions and services
- Physician Consultation
  - MD to MD related to MAT and treatment
- Recovery Support Services
  - Counseling, ancillary services, linkage and peer support

CalOptima Interventions – I

- **Formulary restrictions January 1, 2017**
  - Cumulative Morphine equivalent dose (MED) pharmacy edits (Part D)
  - Restrictions for drugs with the highest risk of overdose
    - Methadone
    - Extended-release opioids
    - Concurrent use of opioids and buprenorphine pharmacy edits

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CalOptima Interventions – II

- **Member restriction programs**
  - Pharmacy Home Program Policy (2,011 members enrolled)
  - Prescriber Restriction Program Policy (364 eligible Medi-Cal members)
  - Part D opioid overutilization monitoring and case management (60 member interventions)
  - Fraud and abuse referrals to Compliance (176 members)

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CalOptima Interventions – III

- **Prescriber outreach programs**
  - Opioid-containing cough medicines
    - 177 resident reviews
    - 101 discontinued
  - Highest MED prescribers
    - 15 prescribers, 177 high-dose Rx
    - 237 concomitant benzodiazepines
  - High volume/high MED prescribers
    - Top 5 percent sent scorecards (December 2016)

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CalOptima Interventions – IV

- **Quality measures**
  - Retrospective review of opioid overutilization by medical director
    - 120 members referred to Compliance and/or Case Management
  - ACAP plan opioid utilization benchmarking study (on legal hold)
  - Pharmacy Quality Alliance (PQA) Part D Star display measures
    - High dosage
    - Multiple providers

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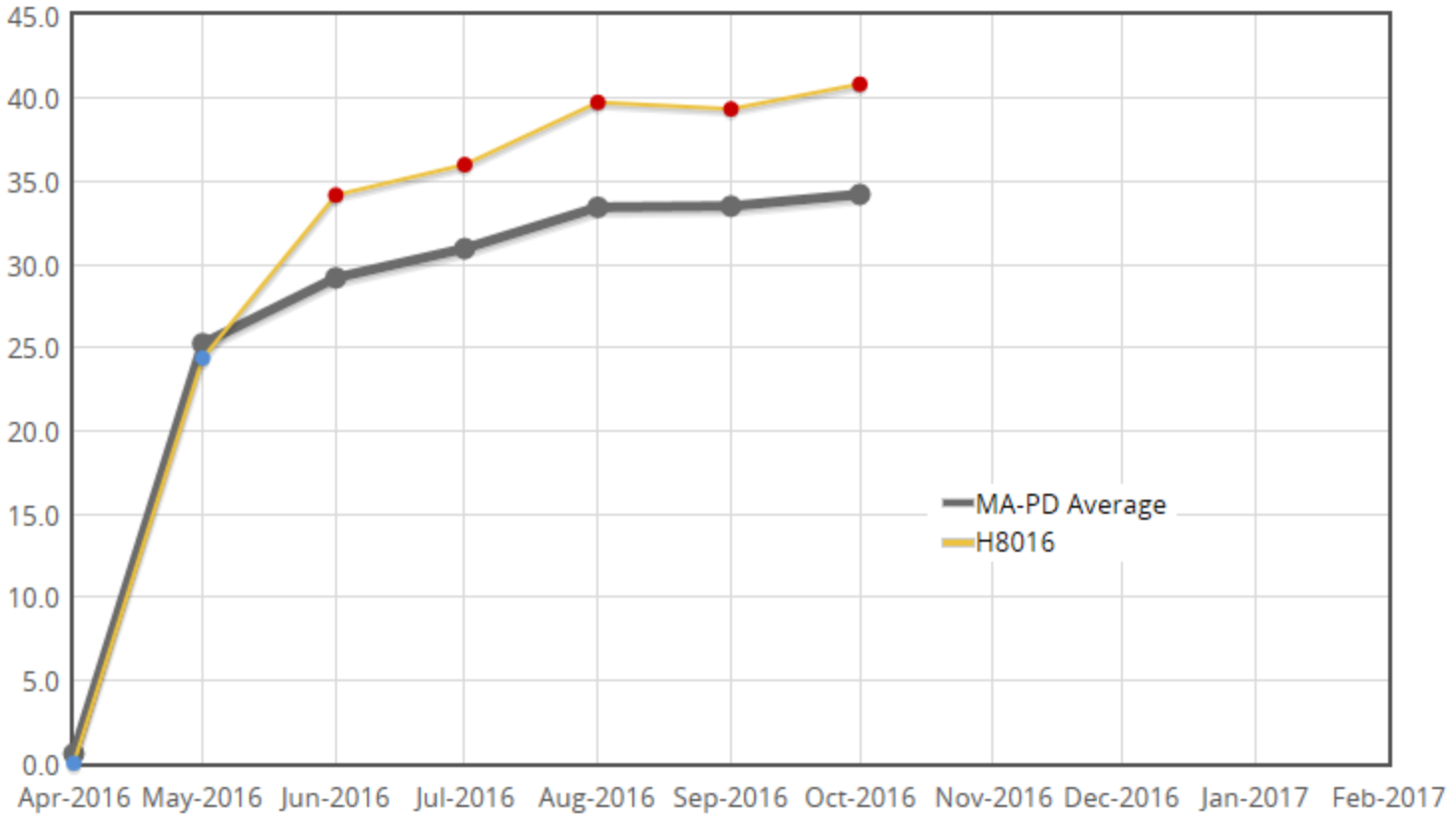
OneCare Connect Part D Report Card – Display

Opioid – High Dosage Measure Performance



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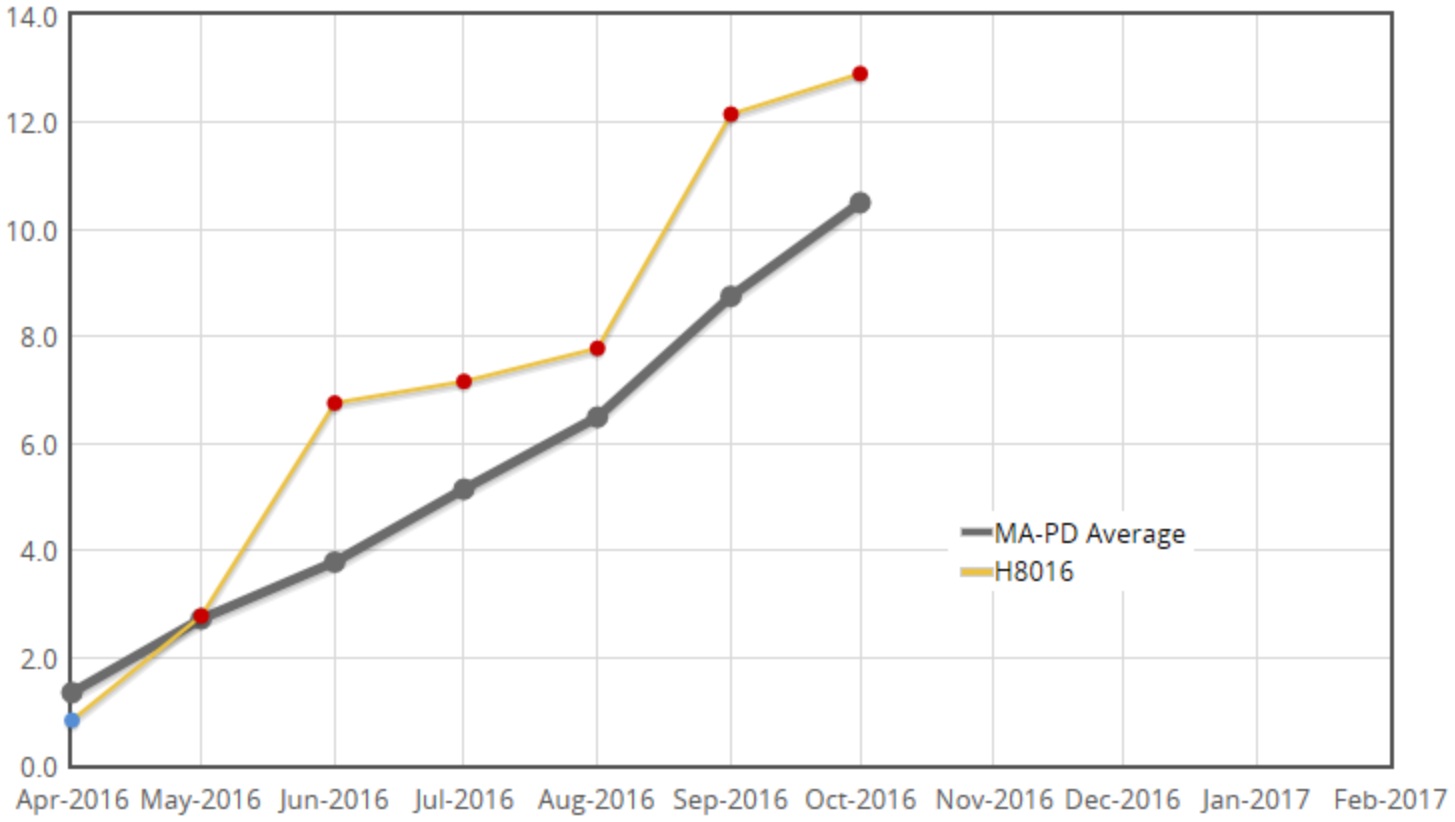
OneCare Connect Part D Report Card – Display

Opioid – Multiple Providers Measure Performance



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CalOptima Interventions – V

- **Ongoing CME series for physicians**
  - January 27, 2016

    The State of Opioid Prescribing in Orange County: Practical Strategies and Update on CURES 2.0

    Total attendees: 63
  - July 28, 2016

    The State of Opioid Prescribing in Orange County: Critical Issues in Over-the-Counter (OTC) Analgesia

    Total attendees: 72
  - March 30, 2017 (tentative)

    The State of Opioid Prescribing in Orange County: PCP Treatment Options and Access to Behavioral Health Services

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CalOptima Interventions – VI

- **Coalition participation**
  - ACAP
    - Opioid Intervention (2015) – CalOptima cited as one of 13 Best Practice Plans for Pharmacy Lock-in Program
  - Safe Rx OC
    - Since 2015, CalOptima participating with public health agencies, hospitals, prescribers, community clinics, emergency rooms, medical associations and law enforcement to curb abuse and save lives
  - DHCS Health Homes Program (2018)
    - Care management for those with SUD and eligible chronic conditions

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Affiliations and Resources

- NIH: National Institute on Drug Abuse
- Drugabuse.gov
- SAMHSA: Substance Abuse and Mental Health Services Administration
- ACAP: SUD Collaborative
- Cures 2.0
- CHCF: Opioid Safety Coalition Network
- Smart Care California (DHCS, CalPERS, Covered CA)
- California Department of Public Health
  - Prescription Opioid Misuse and Overdose Prevention Workgroup
  - Prescription Drug Overdose Prevention Initiative
  - California Opioid Overdose Surveillance Dashboard

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

Recommend Board of Directors' approval of the recommended revisions to the 2017 Quality Improvement Program and 2017 Quality Improvement Work Plan.

Background

As part of existing regulatory and accreditation mandated oversight processes, CalOptima's Quality Improvement Program (" QI Program") and Quality Improvement Work Plan ("QI Work Plan") must be reviewed, evaluated, and approved annually by the Board of Directors.

The QI Program defines the structure within which quality improvement activities are conducted, and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima Members. It is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks. The QI Program guides the development and implementation of the annual QI Work Plan.

The QI Work Plan is the operational and functional component of the QI Program and outlines the key activities for the upcoming year. The QI Work Plan provides the detail objectives, scope, timeline, monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year.

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

Discussion

The 2017 Quality Improvement Program is based on the Board-approved 2016 Quality Improvement Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all programs to ensure they are consistent with regulatory requirements, NCQA standards, and CalOptima's own Success Factors.

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The revisions are summarized as follows:

1. Updates the introductory pages to align with CalOptima's Vision, Mission & new Strategic Plan for 2017-19;
2. Updates the plans we offer, scope of services and who we work with – including an updated list of our Health Networks;
3. Updates the Behavioral Health Services delegate to Magellan Health, Inc.for Medi-Cal, OneCare and OneCare Connect ;
4. Updates the list of CalOptima Officers and staff; and included a broader representation of the key areas supporting the QI Program;
5. Incorporates the description of CalOptima's approach to population health management in the design and delivery of care;
6. Reflects the adoption of the annual UM Work Plan which complements the QI Program and Work Plan;
7. Updates the Advisory Committees and Quality Committees/Subcommittees that support the QI Program;
8. Updates the scope of the Credentialing program with the revised list of included practitioners;
9. Updates the Care of Members with Complex Needs to include further details on the Interdisciplinary Care Teams and risk stratification processes
10. Updates the QI Committee structure.

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

Fiscal Impact

There is no fiscal impact for the recommended action to approve the CalOptima QI Program and Work Plan.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Proposed 2017 Quality Improvement Program – Executive Summary of Revisions
2. Proposed 2017 Quality Improvement Program and 2017 Quality Improvement Work Plan
3. PowerPoint Presentation: 2017 Quality Improvement Program Description and Work Plan

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

02/10/2017 — **Date**

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Quality Improvement (QI) Program 2017

Executive Summary of Revisions

1. Updates the introductory pages to align with CalOptima's Vision, Mission & Strategic Plan for 2017-19;
2. Updates the plans we offer, scope of services and who we work with – including an updated list of our Health Networks;
3. Updates the Behavioral Health Services delegate to Magellan Health, Inc. for Medi-Cal, OneCare and OneCare Connect;
4. Updates the list of CalOptima Officers and staff and included a broader representation of the key areas supporting the QI Program;
5. Incorporates the description of CalOptima's approach to population health management in the design and delivery of care;
6. Reflects the adoption of the annual UM Work Plan which complements the QI Work Plan;
7. Updates the Advisory Committees and Quality Committees/Subcommittees that support the QI Program;
8. Updates the scope of the Credentialing program with the revised list of included practitioners;
9. Updates the Care of Members with Complex Needs to include further details on the Interdisciplinary Care Teams and risk stratification processes;
10. Updates the QI Committee structure
11. Updates the 2017 QI Work Plan;
12. Assures NCQA & DHCS requirements are included in the program description and related work plans.

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2016~~6~~7

QUALITY IMPROVEMENT PROGRAM

~~REVISED 10/6/2016~~

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2016~~6~~7 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

Richard ~~Helmer~~Bock, M.D. **____Date**
Deputy Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

Paul Yost, M.D. **Date**

Board of Directors Chair:

_____ _____

Mark Refowitz **Date**

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all of our members.

Our Values — CalOptima CARES

Collaboration: We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability: We were created by the community, for the community, and are accountable to the community. Our Board of Directors, Member Advisory Committee, OneCare Connect Member Advisory Committee, and Provider Advisory Committee meetings are open to the public.

Respect: We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members

We respect and care about our partners. We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence: We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship: We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."
We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan
CalOptima's 2017–19 Strategic Plan honors our longstanding mission focused on members while recognizing that the future holds some unknowns given possible changes for Medicaid plans serving low-income people through the Affordable Care Act. Still, any future environment will demand attention to the priorities of more innovation and increased value, as well as enhanced partnerships and engagement. Additionally, CalOptima must focus on workforce performance and financial strength as building blocks so we can achieve our strategic goals. Below are the key elements in our Strategic Plan framework.

Strategic Priorities:

- **Innovation:** Pursue innovative programs and services to optimize member access to care.
- **Value:** Maximize the value of care for members by ensuring quality in a cost-effective way.
- **Partnerships and Engagement:** Engage providers and community partners in improving the health status and experience of members.

Building Blocks:

- **Workforce Performance:** Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes.
- **Financial Strength:** Provide effective financial management and planning to ensure long-term financial strength.

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is unique in that we must ~~exhibit~~ be~~ing~~ the best of both a public agency upholding public trust, and a health plan seeking quality health care, efficiency and member satisfaction.

As both, CalOptima must:

- Make the best use of our resources, funding and expertise
- Solicit stakeholder input
- Ensure transparency in our governance procedures
- Be accountable for the decisions we make

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How We Became CalOptima

Orange County is unique in that it does not have county-run hospitals or clinics. By the mid-1990s, there was a coalescing crisis since not enough providers accepted Medi-Cal. This resulted in overcrowding in emergency rooms and delayed care, due to Medi-Cal recipients using emergency rooms across the county not only for acute care, but for primary care as well.

A dedicated coalition of local elected officials, hospitals, physicians and community advocates rallied and created a solution. The answer was to create CalOptima as a county organized health system (COHS) authorized by State and Federal law to administer Medi-Cal benefits in Orange County.

~~**CalOptima was created as a public agency, operates like a private sector health plan and is accountable to stakeholders to build public trust.**~~

CalOptima began serving members in 1995. Today, CalOptima is the largest of six COHS in the United States.

CalOptima ~~is~~ as a public agency and ~~has, as~~ a COHS has:

- Single-plan ~~responsibil~~responsible~~ity~~ for providing ~~services to~~Medi-Cal coverage in the county
- Mandatory enrollment of all full-scope Medi-Cal beneficiaries, including dual eligibles
- ~~Responsibil~~Responsible~~ity~~ for almost all medical acute services and Long-Term Services and Supports (LTSS), including custodial long-term care.

In 2005, CalOptima became licensed to furnish a Medicare Advantage Special Needs Plan (MA SNP) and MA Prescription Drug plan through a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS). This plan, called OneCare (HMO SNP), allows CalOptima to offer Medicare and Medi-Cal benefits under one umbrella to dual eligible individuals.

OneCare (OC) ~~is also a Medicare Advantage Prescription Drug plan. OneCare~~ operates exclusively as a "Zero Cost Share, Medicaid Subset Dual Special Needs Plan." ~~OneCare~~OC only enrolls beneficiaries who qualify as a zero cost sharing Medicaid subset. To identify dual eligible members, ~~OneCare~~OC imports daily member eligibility files from the State and Federal government with Medicaid and Medicare eligibility segments.

In July 2015, CalOptima launched OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan). ~~This~~ OneCare Connect (OCC) is a demonstration project in an effort by California and the Federal government to begin the process — through a single organized health care delivery system — of integrating medical, behavioral health, long-term care services and supports, and community-based services for dual eligible beneficiaries. One of t~~T~~he program's goal is to help members stay in their homes for as long as possible and shift services out of institutional settings and into the home and community. A key feature of CalOptima is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individual care plan. Members eligible for OCC cannot enroll in OC.

~~CalOptima was created as a public agency, operates like a private sector health plan and is accountable to stakeholders to build public trust.~~

WHAT ~~W~~WE OFFER:

Medi-Cal

In California, Medicaid is known as Medi-Cal. For more than 20 years, CalOptima has been serving Orange County's Medi-Cal population. Due to the implementation of the Affordable Care Act~~,~~ — as more low-income children and adults qualified for Medi-Cal — membership in CalOptima ~~from 2014–16~~ grew by an unprecedented 49 percent between 2014 and 2016~~.~~ ! ~~More low-income children and adults qualified for Medi-Cal.~~

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must ~~live~~ reside in Orange County ~~and~~ to be enrolled in CalOptima Medi-Cal.

Scope of Services~~:~~

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population.

These services include but are not limited to the following:

Acupuncture	Hospice care	Outpatient mental health services – limited
Adult preventive services	Hospital/inpatient care	Pediatric preventive services
Community-based adult services	Immunizations	Child health and disability prevention (CHDP)
Doctor visits	Laboratory services	Physical therapy
Durable medical equipment	Limited allied health services	Prenatal care
Emergency care	Medical supplies	Specialty care services
Emergency transportation	Medications	Speech therapy
Non-emergency medical transportation (NEMT)	Newborn care	Substance use disorder preventive services – limited
Hearing aid(s)	Nursing facility services	Vision care
Home health care	Occupational therapy	

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

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.

- Dental services are provided through California's Denti-Cal program.
- Eligible conditions under California Children's Services (CCS).

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care, and are described in the Utilization Management (UM) Program.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established through special programs, such as the CalOptima Member Liaison program, and specific Memoranda of Understanding (MOU) with certain community agencies, including HCA, CCS and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

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

LTSS includes four programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)
- In-Home Supportive Services (IHSS)

~~Prior to July 1, 2015, CalOptima was responsible for all of the LTSS programs with the exception of In-Home Supportive Services (IHSS). In **XXX** 201**X**, IHHS will move back to county responsibility throughout the state.~~

OneCare (HMO SNP)

OneCare (HMO SNP) means total care. Our members with Medicare and Medi-Cal benefits are covered in one single plan, making it easier for our members to get the health care they need. ~~For more than a decade~~Since 2005, CalOptima has been offering ~~OneCare~~OC to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal**.** ~~We have~~OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County.

To be a member of ~~OneCare~~OC, a person must live in Orange County and be enrolled in Medi-Cal and Medicare Parts A and B, and not be eligible for ~~OneCare Connect~~OCC.

Scope of Services~~:~~

OC provides a comprehensive scope of services for the dual eligible members who are not eligible for OCC, and who voluntarily enroll in OC.

These services include but are not limited to the following:

Acupuncture and other alternative therapies	Gym membership	Prescription drugs
Ambulance	Hearing services	Preventative care
Chiropractic care	Home health care	Prosthetic devices
Dental services – limited	Hospice	Renal dialysis
Diabetes supplies and services	Inpatient hospital care	Skilled nursing facility
Diagnostic tests, lab and radiology services, and X-rays	Inpatient mental health care	Taxi rides for medical and pharmacy visits
Doctor visits	Mental health care	Urgently needed services
Durable medical equipment	Outpatient rehabilitation	Vision services
Emergency care	Outpatient substance abuse	
Foot care	Outpatient surgery	

OneCare Connect

~~OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a new plan that launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect also integrates the Multipurpose Senior Services Program (MSSP), In-Home Supportive Services (IHSS) and Long-Term Care (LTC).~~

~~At no extra cost, our members also get vision care, taxi rides to medical appointments and enhanced dental benefits. Plus, our members get support so they can receive the services they need, when they need them. A Personal Care Coordinator works with our members and their doctors to create an individualized health care plan that fits our members' needs.~~

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal.

These members often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost, OCC adds supplemental benefits such as vision care, taxi rides to medical appointments, gym benefits and enhanced dental benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results is a better, more efficient and higher quality health care experience for the member.

To join ~~OneCare Connect~~OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions apply.

Scope of Services:

OCC simplifies and improves health care for low-income seniors and people with disabilities.

These services include but are not limited to the following:

Acupuncture (pregnant women)	Hearing aids – limited	Rehabilitation services
Ambulance services	Hearing screenings	Renal dialysis
Case management	Incontinence supplies – limited	Screening tests
Chiropractic services	Inpatient hospital care	Skilled nursing care
Community-based adult services (CBAS)	Inpatient mental health care	Specialist care
Diabetes supplies and services	Institutional care	Substance abuse services
Disease self-management	Lab tests	Supplemental dental services
Doctor visits	Medical equipment for home care	Taxi rides for medical and pharmacy visits
Durable medical equipment	Mental or behavioral health services	Transgender services
Emergency care	Multipurpose Senior Services Program (MSSP)	Occupational, physical or speech therapy
Eye exams	Over-the-counter drugs – limited Prescription drugs	Urgent care
Foot care	Outpatient care	"Welcome to Medicare" preventive visit
Glasses or contacts – limited	Preventive care	
Gym membership	Prosthetic devices	
Health education	Radiology	

Program of All-Inclusive Care for the Elderly (PACE)

In 2013, CalOptima launched the ~~first~~ only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

~~PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dieticians, physical therapists, occupational therapists, home care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participates.~~

To be a PACE participant, members must be eligible for both Medicare Parts A & B, be at least 55 years old, live in our Orange County service area, be determined as eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

~~PACE participants must receive all needed services, other than emergency care, from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.~~

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dieticians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participates.

~~Launched August 1, 2013, CalOptima PACE is the only PACE center in Orange County. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.~~

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged for ~~our~~ participants, based on their needs as indicated by ~~our~~the Interdisciplinary Team.

PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

NEW PROGRAM INITIATIVES O~~O~~N O~~O~~UR H~~H~~ORIZON:

Palliative Care

CalOptima expects to implement palliative care standards for its Medi-Cal members no sooner than ~~April 1, 2017~~July 1, 201~~7~~8.

Whole-Person Care

Whole-Person Care is a five-year pilot led by the Orange County Health Care Agency to focus on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. Whole-Person Care will be launched in stages, with full implementation by January 1, 2018.

Long-Term Connect

CalOptima plans to realign its internal operations to better support members who reside in a long-term care facility. Referred to as "Long-Term Connect" its focus will be on increasing member/provider visits, preventing avoidable inpatient hospitalizations, and improving health outcomes. Long-Term Connect is expected to launch in July 2017.

WHOM WWE WWORK WWITH:

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can contract with a CalOptima health network, and/or participate through CalOptima Direct, and/or the CalOptima Community Network.

CalOptima members can choose one of 14 health networks (HNs), representing more than 7,500 practitioners.

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. Currently, CalOptima contracts with 13 private ~~health networks~~HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 14th network available for members to select, supplementing the existing health network delivery model and creating additional capacity for growth.

CalOptima Direct (COD)
CalOptima Direct is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including ~~foster children,~~ dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's MA SNP), ~~members in skilled nursing facilities, and~~ share of cost members, and members residing outside of Orange County. ~~COD also currently includes the following categories of vulnerable and complex/catastrophic care members: transplant, hemophilia, HIV, end-stage renal disease (ESRD), and seniors and persons with disabilities.~~ Members enrolled in CalOptima Direct are not health network eligible.

~~Not all CalOptima members are health network eligible. Members who are not eligible for enrollment in a health network may be assigned to CalOptima Direct based on the below criteria:~~

- ~~Transitional members waiting to be assigned to a delegated health network~~
- ~~Medi-Cal/Medicare members (Medi-Medi)~~
- ~~Members who reside outside of Orange County~~
- ~~Medi-Cal share of cost members~~
- ~~Members residing in Fairview Developmental Center~~

Health Networks
CalOptima contracts with a variety of health network models to provide care to members. Since 2008, CalOptima's HNs consist of ~~has also included~~ Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), Physician Medical Groups (PMGs) and Shared Risk Medical Groups (SRGs). Through these HNs, CalOptima members have access to ~~CalOptima's HMOs, PHCs, PMGs and SRGs include~~ more than ~~3,5~~1,500 Primary Care Providers (PCPs), nearly 6,000 specialists and 30 hospitals and clinics. New networks that demonstrate the ability to comply with CalOptima's delegated requirements are added as needed with CalOptima Board approval.

The following are CalOptima's contracted Health Networks:

Health Network/Delegate ~~No.~~	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	PMG	SRG
AMVI Care Health Network	PHC	PMG	PHC
Arta Western Health Network	SRG	PMG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	SRG	PMG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	~~SRG~~HMO	PMG	~~SRG~~HMO
Noble Mid-Orange County	SRG	PMG	SRG
OC Advantage Medical Group	PHC		PHC
Prospect Medical Group	SRG		SRG
Talbert Medical Group	SRG	PMG	SRG
United Care Medical Group	SRG	PMG	SRG

Upon successful completion of readiness reviews and audits, the ~~health networks~~HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management (UM)
- Case and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

BEHAVIORAL HEALTH SERVICES

Medi-Cal Ambulatory Behavioral Health Services

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

CalOptima delegates to ~~College Health Independent Practice Association (CHIPA)~~Magellan Health, Inc. [a managed behavioral healthcare organization (MBHO)] for ~~utilization management~~ UM of the provider network~~,~~. ~~CHIPA subcontracts and delegates to Beacon Health Strategies LLC (Beacon) other functions that include~~ network adequacy and credentialing the provider network, ~~the Access Line~~ customer service/managing the CalOptima Behavioral Health phone line, and several quality improvement functions.

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

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

OneCare and OneCare Connect Behavioral Health Services

CalOptima is also contracted with ~~has contracted with Windstone Behavioral Health~~Magellan Health, Inc. for the behavioral health services portion of ~~OneCare~~OC and ~~OneCare Connect~~OCC. ~~CalOptima~~ The ~~F~~delegated functions are identical to those listed above. ~~delegatesd to Magellan include utilization management (UM), credentialing and customer service. to Windstone. Evidence-based MCG guidelines are used in the UM decision-making process.~~

~~Our Lines Of Business:~~

~~Medi-Cal~~

~~Scope of Services~~

~~Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population.~~

~~These services include but are not limited to the following:~~

~~Adult preventive services~~	~~Hospital/inpatient care~~	~~Pediatric preventive services~~
~~Community-based adult services~~	~~Immunizations~~	~~Child health and disability prevention (CHDP)~~
~~Doctor visits~~	~~Laboratory services~~	~~Physical therapy~~
~~Durable medical equipment~~	~~Limited allied health services~~	~~Prenatal care~~
~~Emergency care~~	~~Medical supplies~~	~~Specialty care services~~
~~Emergency transportation~~	~~Medications~~	~~Speech therapy~~
~~Non-emergency medical~~	~~Newborn care~~	~~Substance use disorder~~

transportation (NEMT)		preventive services – limited
Hearing aid(s)	Nursing facility services	Vision care
Home health care	Occupational therapy	
Hospice care	Outpatient mental health services – limited	

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

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California's Denti-Cal program. (CCS).

California Children's Services

Services for children with certain physical limitations, chronic health conditions or diseases are provided through California Children's Services (CCS), which is a statewide program. Currently, CCS authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for CCS-eligible conditions. DHCS manages the CCS program and the Orange County Health Care Agency operates the program. CalOptima is responsible for coordinating care and services for all non-CCS related conditions. There is work underway to integrate CCS services as a benefit of CalOptima. This transition is planned for 2017.

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care, and are described in the Utilization Management Program.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established through special programs, such as the CalOptima Member Liaison program, and specific Memoranda of Understanding (MOU) with certain community agencies, including HCA, CCS and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

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

LTSS includes four programs:

- Community-Based Adult Services (CBAS)

- Nursing Facility Services for Long-Term Care
- Multipurpose Senior Services Program (MPSS)
- In-Home Supportive Services (IHSS)

OneCare (HMO SNP)

Scope of Services

OneCare (HMO SNP) provides a comprehensive scope of services for the dual eligible members who are not eligible for OneCare Connect.

These services include but are not limited to the following:

Acupuncture and other alternative therapies	Foot care	Outpatient surgery
Ambulance	Hearing services	Prescription drugs
Chiropractic care	Home health care	Preventative care
Dental services – limited	Hospice	Prosthetic devices
Diabetes supplies and services	Inpatient hospital care	Renal dialysis
Diagnostic tests, lab and radiology services, and X-rays	Inpatient mental health care	Skilled nursing facility
Doctor visits	Mental health care	Transportation – limited
Durable medical equipment	Outpatient rehabilitation	Urgently needed services
Emergency care	Outpatient substance abuse	Vision services

OneCare Connect

Scope of Services

Launched July 1, 2015, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan offered by CalOptima to simplify and improve health care for low-income seniors and people with disabilities. OneCare Connect combines our members' Medicare and Medi-Cal benefits, adds supplemental benefits, and offers personalized support – all to ensure each member receives the right care in the right setting.

OneCare Connect is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal. These people often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OneCare Connect delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

OneCare Connect achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Addressing individual needs results isn a better, more efficient and higher quality health care experience for the member.

These services include but are not limited to the following:

Acupuncture (pregnant women)	Hearing screenings	Over-the-counter drugs – limited
Ambulance services	Incontinence supplies – limited	Radiology
Case management	In-Home Supportive Services (IHSS)	Rehabilitation services
Chiropractic services	Inpatient hospital care	Renal dialysis
Diabetes supplies and services	Inpatient mental health care	Screening tests
Disease self-management	Institutional care	Skilled nursing care
Doctor visits	Lab tests	Specialist care
Durable medical equipment	Medical equipment for home care	Substance abuse services
Emergency care	Mental or behavioral health services	Supplemental dental services
Eye exams	Multipurpose Senior Services Program (MSSP)	Transgender services
Foot care	Prescription drugs	Transportation to a doctor's office
Glasses or contacts – limited	Preventive care	Occupational, physical or speech therapy
Health education	Prosthetic devices	Urgent care
Hearing aids – limited	Outpatient care	"Welcome to Medicare" preventive visit

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

~~Scope of Services~~

~~Launched August 1, 2013, CalOptima PACE is the only PACE center in Orange County. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.~~

~~PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged for our participants, based on their needs as indicated by our Interdisciplinary Team.~~

Membership Demographics

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2017

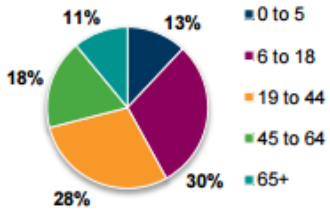
Mission: To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Membership Data as of December 31, 2016

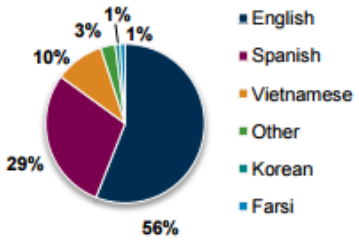
Total CalOptima Membership
800,001

Program	Members
Medi-Cal	781,733
OneCare Connect	16,810
OneCare (HMO SNP)	1,275
Program of All-Inclusive Care for the Elderly (PACE)	183

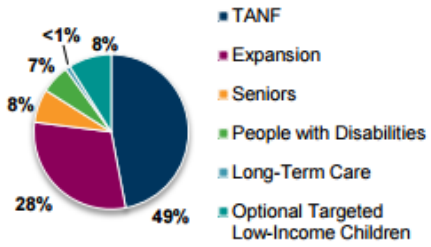
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



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CalOptima
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Fast Facts: February 2016

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

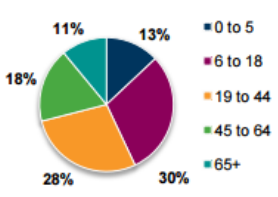
Membership Data as of December 31, 2015

Total CalOptima Membership
779,410

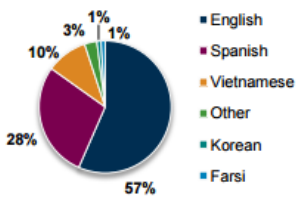
Program	Members
Medi-Cal	779,410
OneCare (HMO SNP)*	11,891
OneCare Connect*	4,437
Multipurpose Senior Services Program*	464
Program of All-Inclusive Care for the Elderly (PACE)*	129

*Membership already accounted for in total Medi-Cal membership

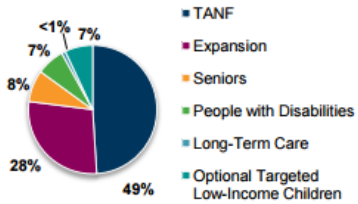
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



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QUALITY IMPROVEMENT PROGRAM

~~CalOptima's~~ CalOptima's ~~Quality~~ Quality Improvement (QI) Program encompasses all clinical care, clinical services and organizational services provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all of our members.

CalOptima has developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care management, disease management and complex care management. Our approach uses support systems for our members with vulnerabilities, disabilities and chronic illnesses.

CalOptima's ~~Quality Improvement~~QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

AUTHORITY, ~~A~~ACCOUNTABILITY AND RESPONSIBILITY

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the ~~Quality Improvement~~QI Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board of Directors promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the QI Program annually.

The QI Program is based on ongoing data analysis to identify the clinical needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of members. The CMO is charged with identifying appropriate interventions and resources necessary to implement the QI Program. Such recommendations shall be aligned with Federal and State regulations, contractual obligations and fiscal parameters.

Quality Improvement Program, Role of CalOptima Officers

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the ~~Quality Improvement~~QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the State and Federal Contracts.

Chief Medical Officer (CMO) — or physician designee — chairs the QIC, which oversees and provides direction to CalOptima's QI activities, and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO) along with the ~~CMO,~~CMO oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics, Quality Management, ~~Utilization Management~~UM, Care Coordination, Case Management, H~~ealth E~~~~ducation &~~ D~~isease~~ M~~anagement~~, Pharmacy Management, Behavioral Health Integration and Long-Term Services and Supports.

~~**Chief Network Officer (CNO)** is responsible for developing and expanding CalOptima's programs by implementing strategies that achieve the established program objectives; leveraging the core competencies of CalOptima's existing administrative infrastructure to build an effective and efficient operational unit to serve CalOptima's networks; and making sure the delivery of accessible, cost-effective, quality health care services throughout the service delivery network. The CNO leads and directs the integrated operations of the networks, and must coordinate organizational efforts internally, as well as externally, with members, providers and community stakeholders.~~

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, ~~and~~ Electronic Business and Human Resources.

Executive Director, Quality & Analytics (ED of QA) is responsible for facilitating the company-wide QI Program, driving improvements with Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS S~~s~~tar measures and ratings, and facilitating compliance with National Committee for Quality Assurance (NCQA) standards. The ED of QA serves as a member of the executive team and with the CMO/DCMO supports efforts to promote adherence to established quality improvement strategies and programs throughout the company. Reporting to the ED of QA is the Director of Quality Analytics, the Director of Health Education & Disease Management, ~~and the Manager~~the Director of ~~for~~ Quality Improvement and the Director of Behavioral Health Services.

Executive Director of Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including: ~~Utilization Management~~UM, Care Coordination, ~~Case Management, Long,~~ Complex Case Management, Long-Term Services and Supports~~,~~ and MSSP Services, along with new program implementation related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO/DCMO, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director of Public Affairs (ED of PA) serves as the State Liaison; ~~oversees the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements;~~ and the management, development and implementation of CalOptima's Communication plan, Issues Management and Legislative Advocacy. This position also oversees Strategic Development and the integration of activities for the Community Relations Program. The QI department collaborates with Public Affairs to address specific developments or changes to policies and procedures that impact areas within the purview of QI.

Executive Director of Compliance (ED of C) is responsible to monitor and drive interventions so that CalOptima and its HMOs, PHCs, SRGs, MBHO and PMGs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight department to refer any potential sustained noncompliance issues or trends encountered during audits of ~~health networks~~HNs, ~~provider medical group~~PMGs, and other functional areas. The ED of C also oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements.

Executive Director of Network Operations (ED of NO) ~~is responsible for leading and directing~~leads and directs the integrated operations of the health networks, and must coordinate organizational efforts internally, as well as externally, with members, providers and community stakeholders. The ED of NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective, quality health care services throughout the service delivery network.

Executive Director of Operations (ED of O) is responsible for overseeing and guiding Claims Administration, Customer Service, Grievance & Appeals Resolution Services, Coding Initiatives, and Electronic Business

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD, as well as our contracted provider networks. Through the QI Program, and in collaboration with its providers, CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The CalOptima QI Program incorporates continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies):

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress toward established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to promote efforts that support the identification and correction of quality of care issues.
- It maintains agencywide practices that support accreditation by the ~~National Commission for Quality Assurance (~~NCQA~~)~~, and meets Department of Health Care Services (DHCS) ~~&~~and Centers for Medicare & Medicaid Services (CMS) quality requirements and measures.

~~Quality Improvement, Quality Analytics, Health Education & Disease Management~~The Quality ~~&~~and Clinical Operations departments, ~~-~~and Medical Directors~~,~~ in conjunction with multiple CalOptima departments ~~Medical Directors~~ support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

QUALITY IMPROVEMENT DEPARTMENT

The ~~Quality Improvement~~QI department is responsible for the execution and coordination of the quality assurance and improvement activities. ~~The QI Department~~It also supports the specific focus of monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and that care and services are rendered appropriately and safely to all CalOptima members.

~~Quality Improvement~~QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both division and department-specific as well as agencywide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care and all lines of business
- Monitor and maintain ~~Maintain~~ agencywide practices that support accreditation and meeting regulatory requirements.~~by the National Commission for Quality Assurance (NCQA)~~

QUALITY ANALYTICS DEPARTMENT

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics ~~and~~, programs~~,~~ and ~~and~~ processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The ~~Quality Analytics~~QA department activities include design, implementation and evaluation of initiatives to:

- Report, m~~M~~onitor and trend outcomes
- Drive solutions and interventions to improve quality of care, access to preventive care, and management of chronic conditions to clinical guidelines
- Support efforts to improve internal and external customer satisfaction

- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze problems and measure improvement
- Coordinate and communicate organizational information, both division and department specific, and agencywide
- Participate in various reviews through the QI Program such as the All Cause Readmission monitoring, access to care, availability of practitioners and other reviews
- Facilitate satisfaction surveys for members and practitioners
- ~~Evaluate and monitor provider credentials~~
- Provide agencywide oversight of monitoring activities that are:

  Balanced: Measures clinical quality of care and customer service
  Comprehensive: Monitors all aspects of the delivery system
  Positive: Provides incentive to continuously improve

In addition to working directly with the contracted ~~health networks~~HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case Management reports
- Pharmacy data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores ~~STARS and HOCC~~ data
- Group Needs Assessments
- Results of Risk Stratification
- HEDIS Performance
- Member and Provider satisfaction surveys
- ~~Quality Improvement~~QI Projects (QIPs, PIPs and CCIPs)
- Health Risk Assessment (HRA) data

HEALTH EDUCATION & DISEASE MANAGEMENT DEPARTMENT

The Health Education & Disease Management (HE & DM) department is the third area in Quality that provides program development and implementation for ~~the~~ agencywide ~~chronic condition~~population health ~~improvement~~ programs. ~~Health Education & Disease Management (~~HE & DM~~)~~ Programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members and designed to achieve behavioral change for improved health and are reviewed on an annual basis.~~-~~ Program topics covered include Asthma, Congestive Heart Failure, Diabetes, Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, ~~Pediatric~~ Shape Your Life/Weight Management and Tobacco Cessation.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the sixth grade reading level and are culturally and linguistically appropriate for our members.

~~Health Education & Disease Management~~ HE & DM supports CalOptima members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- Execute and coordinate programs with Case Management, ~~Utilization Management, Quality Analytics~~QA and our Health Network Providers.

RESOURCES TO DIRECTLY SUPPORT THE QUALITY IMPROVEMENT PROGRAM AND QUALITY IMPROVEMENT COMMITTEE

CalOptima's budgeting process includes personnel, IT resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

The following staff positions provide direct support for organizational and operational QI Program functions and activities:

Medical Director, Quality
Appointed by the CMO, the Medical Director of Quality is responsible for the direction of the QI Program objectives to drive the organization's mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services delivered to members.

~~Manager~~Director, Quality Improvement
Responsibilities include assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Facility Physical Access Compliance and working with the ED of Quality. This position is also responsible for implementation of the QI Program and Work Plan implementation.

- The following positions report to the Quality Improvement ~~Manager~~Director:
  - Manager, Quality Improvement
  - Supervisor, Quality Improvement (PQI)
  - Supervisor, Quality Improvement (Credentialing)
  - QI Program Specialists

- QI Nurse Specialists~~,~~
- Data Analyst
- Credentialing Coordinators~~,~~
- Program Specialists
- ~~Credentialing~~ Program Assistants
- ~~Facility~~ Site Review Master Trainer
-
- Facility Site Review Nurse Reviewers

Director, Quality Analytics
Provides administrative and analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory, and accreditation agencies.

- The following positions report to the Director of Quality Analytics:
  - Quality Analytics HEDIS Manager
  - Quality Analytics ~~Medical Data~~Pay for Value Manager
  - Quality Analytics QI Initiatives Manager
  - Quality Analytics Analysts
  - Quality Analytics Project Managers
  - Quality Analytics Program Coordinators
  - Quality Analytics Program Specialists

Director, Health Education & Disease Management
Provides direction for program development and implementation for the agencywide ~~health education and disease management~~population health initiatives. ~~e~~Ensures linkages supporting a whole-person perspective to health and health care with Case Management, Care Management ~~and~~, ~~Utilization Management~~UM, Pharmacy ~~&~~and Behavioral Health Integration. Also, supports the Model of Care implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation ~~agencies~~agency requirements.

- The following positions report to the Director, Health Education & Disease Management:
  - Disease Management Manager (Program Design)
  - Disease Management Manager (Operations)
  - Disease Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Disease Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dieticians
  - Data Analyst
  - Program Manager
  - Program Specialists
  - Program Assistant

In addition, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our member's health status.

~~UM~~
Executive Director of Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including: UM, Care Coordination, Complex Case Management, Long-Term Services and Supports, MSSP Services, along with new program implementation related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO/DCMO, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

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

Director of Clinical Pharmacy Management leads the development and implementation of the Pharmacy Management (PM) ~~P~~program, develops and implements ~~Pharmacy Management~~PM ~~D~~department policies and procedures; ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of Pharmacy related clinical affairs, and serves on the Pharmacy ~~and~~& Therapeutics Subcommittee and ~~Quality Improvement~~QI Committees. The ~~D~~director of ~~Pharmacy Management~~PM also guides the identification and interventions on key pharmacy quality and utilization measures.

Director of Care Management is responsible for Care Management, Transitions of Care, Complex Case Management and the clinical operations of OCC and OC~~the OneCare and MediConnect programs~~. The~~is~~ ~~D~~director supports improving quality and access through seamless care coordination for targeted member populations. Develops and implements policies, procedures and processes related to program operations and quality measures.

Director of Long Term Services and Supports is responsible for LTSS programs which include ~~Community Based Adult Services (~~CBAS~~)~~, In-Home Supportive Services (IHSS), ~~Long Term Care Services (~~LTC~~)~~, and ~~Multipurpose Senior Services Program (~~MSSP~~)~~. The position supports "Member-Centric" approach and helps keep~~ing~~ members ~~at~~in the least restrictive living environment, collaborate with stakeholders including community partners, and ensure LTSS services are available to the appropriate population. The ~~D~~director also develops and implements policies, procedures, and processes related to the LTSS program operations and quality measures.

Director of Behavioral Health Services provides leadership and program development expertise in the creation, expansion and improvement of services and systems that leads to the integration of physical and behavioral health care services for CalOptima members. Thes ~~Dd~~director leads and assists the organization in developing and successfully implementing short and long--term strategic goals and objectives toward integrated care. The ~~Dd~~irector ~~BHI~~ plays a key leadership role in coordinating with all levels of CalOptima staff, is responsible for monitoring, analyzing, and reporting on changes in the health care delivery environment and identifying program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services.

Director of Clinical Outcomes supports medical management with program development, data analysis, evaluation, and ~~and~~ specialized education related to the Model of Care and other Medical Affairs initiatives. The ~~Dd~~irector contributes expertise in care management innovation, evaluation methods, data definitions and specifications, and predictive risk models to guide the stratification of members and allocation of appropriate resources. The ~~Dd~~irector assumes leadership role as designated for new program development and/or implementation.

Director of Enterprise Analytics provides leadership across CalOptima in the development and distribution of analytical capabilities. The Director drives the development of the strategy and roadmap for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the roadmap. Working with departments that supply data, the team will be responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the enterprise analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

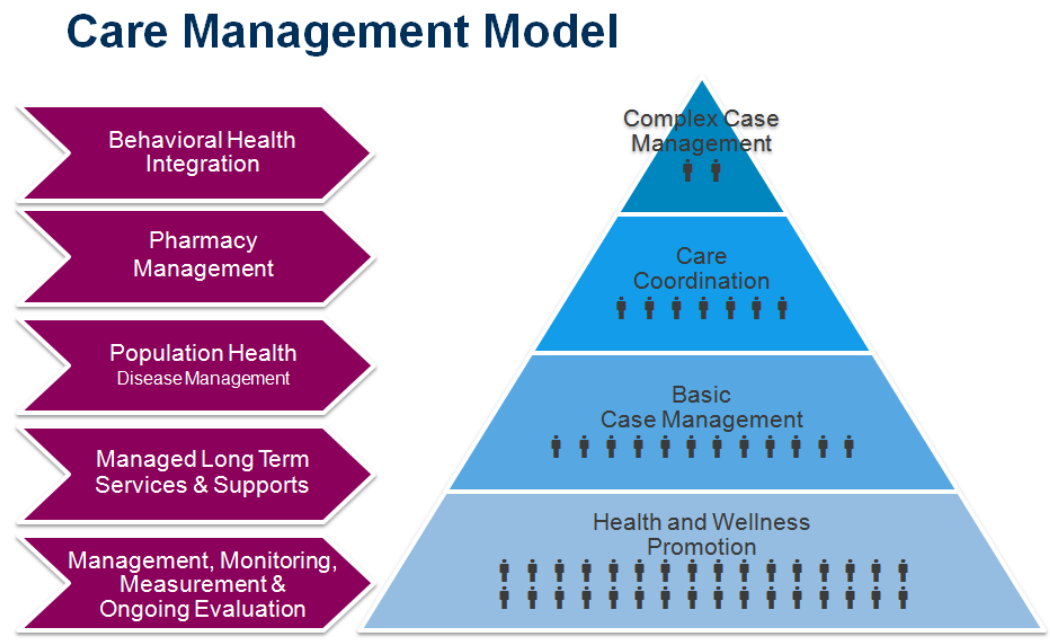
QUALITY IMPROVEMENT ~~(QI)~~ STRATEGIC GOALS

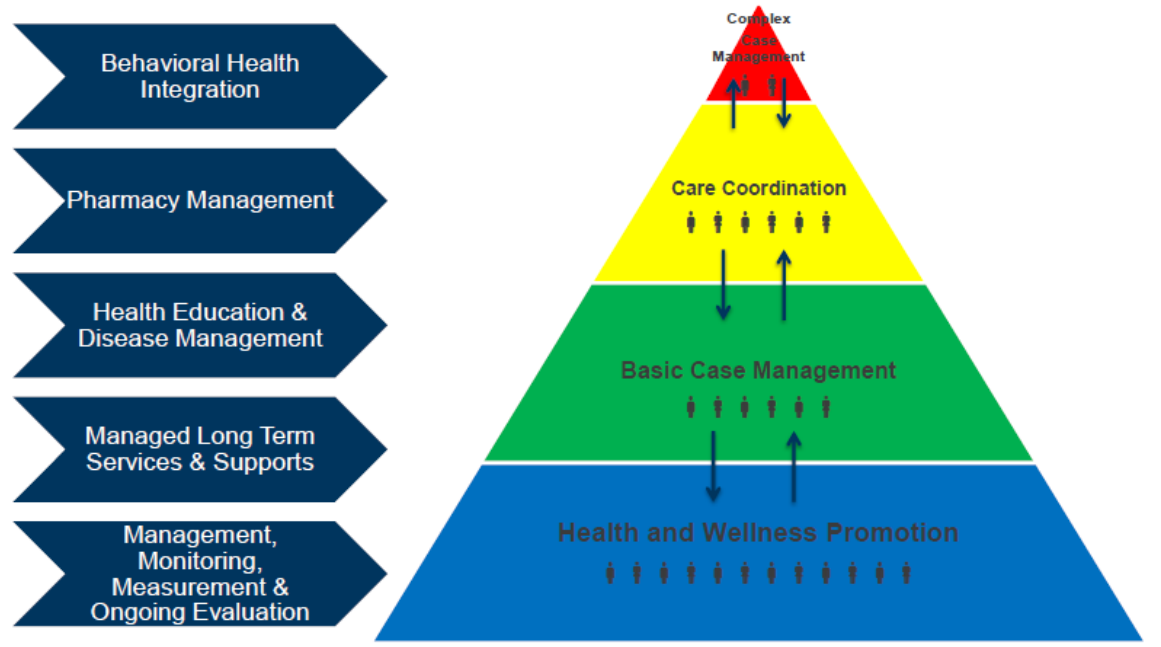
The purpose of the QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members. Through the QI Program, CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The QI Program incorporates continuous QI methodology that focuses on the specific needs of multiple stakeholders (members, health care providers and community and government agencies):

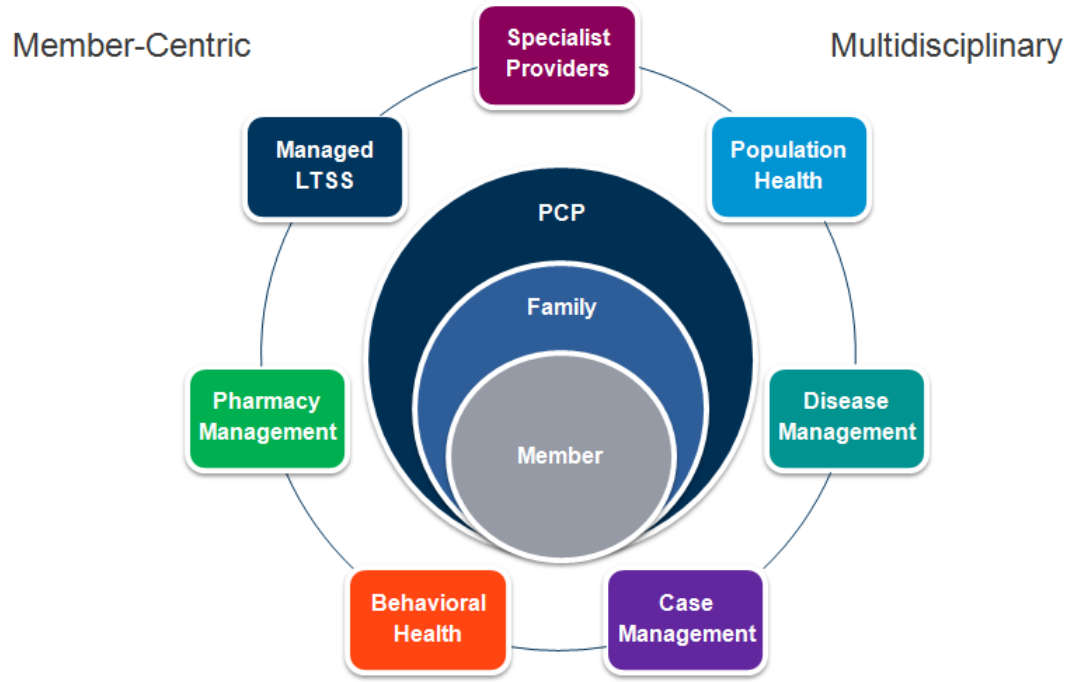
- It is organized to identify and analyze significant opportunities for improvement in care and service
- It fosters the development of quality improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals
- It is focused on QI activities and projects carried out on an ongoing basis to monitor that quality of care issues are identified and corrected as needed

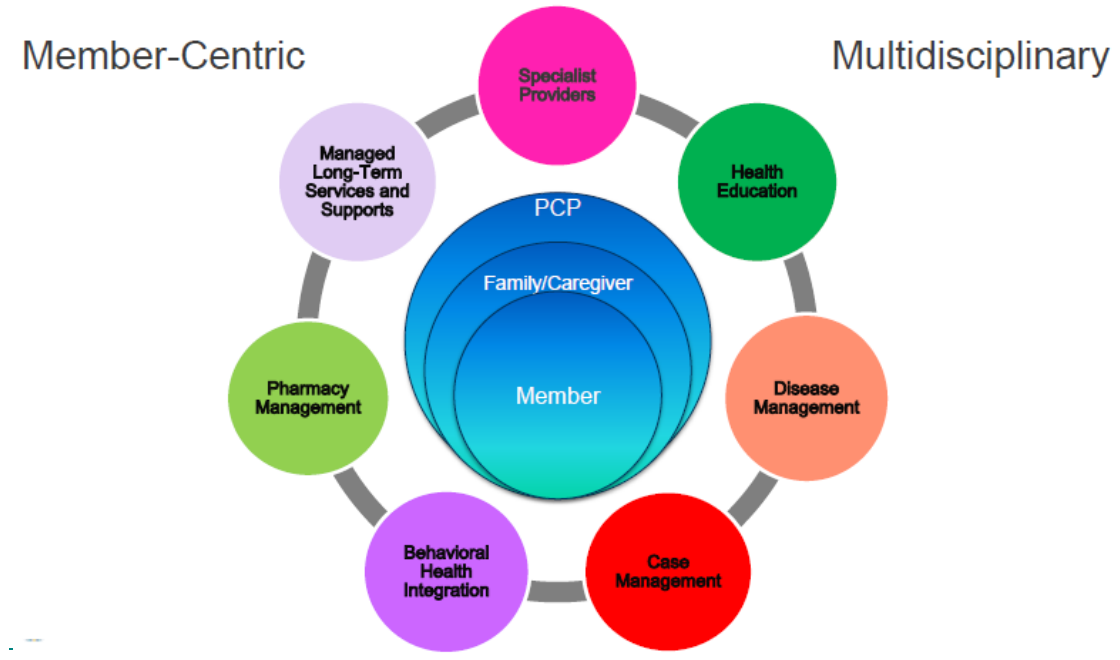
The QI Program supports a population health management approach, stratifying our population based on their health needs, conditions, and issues and aligning the appropriate resources to meet these needs. Our model follows an intervention hierarchy, as shown below:





In addition, our model recognizes the importance of multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, care settings —– plus our internal experts support a member-centric approach to care/care coordination.





QI Goals and Objectives

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

- The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
- The important clinical and service issues facing the Medi-Cal, ~~OneCare~~OC ~~&~~and ~~OneCare Connect~~OCC populations relevant to its demographics, high-risks, disease profiles for both acute and chronic illnesses, and preventive care

- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually acting on at least three identified opportunities
- The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
- The qualifications and practice patterns of all individual providers in the network to deliver quality care and service
- Member and provider satisfaction, including the timely resolution of complaints and grievances
- Risk prevention and risk management processes
- Compliance with regulatory agencies and accreditation standards
- Annual review and acceptance of the UM Program Description and Work Plan
- The effectiveness and efficiency of internal operations
- The effectiveness and efficiency of operations associated with functions delegated to the contracted medical groups
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values
- Compliance with Clinical Practice Guidelines and evidence-based medicine
- Compliance with regulatory agencies and accreditation standards (NCQA)
- Support of the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently

- In addition, the QI Program:
  - Set expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes
  - Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers
  - Provide oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals
  - Makes certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — Orange County Health Care Agency — which may include but are not limited to ~~M~~methicillin ~~R~~resistant ~~s~~*Staphylococcus aureus* (MRSA), ~~staphylococcus aureus infections,~~ scabies, ~~T~~tuberculosis, etc.~~,~~ as reported by the ~~health networks~~HNs.
  - Promote patient safety and minimize risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and work with appropriate committees, departments, staff, practitioners, provider medical groups, and other related health care delivery organizations (HDOs) to assure that steps are taken to resolve and prevent recurrences
    -

QI Measureable Goals from the Model of Care

The Model of Care (MOC) is member-centric by design, and monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care. The MOC meets the needs of the special member populations through strategic activities and goals. Measureable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving integration of medical and, behavioral health servicesand pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. These are reported to the QI Committee. Please see the Model of Care Quality Matrix in the 2017 QI Work Plan.

QUALITY IMPROVEMENT WORK PLAN

(SEE ATTACHMENT A — 20162017 QI WORK PLAN)

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and the CalOptima's Board of Directors' Quality Assurance Committee of the Board. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. QI Work Plan addendums may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on the most recent and trended HEDIS, Consumer Assessment of Healthcare Providers & Systems (CAHPS), Stars and HOS scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the State or accreditation standards where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores are received.

The QI Program guides the development and implementation of an annual QI Work Plan and a separate Utilization Management (UM) Work Plan that includes:

- Case ManagementCare Coordination/Complex Case Management
- Client Revisions
- LTSS
- Health Education &Population Health & Disease Management, Health Assessments and related CCIP, QIP, PIPs

- Access and Availability to Care
- Member Experience and Service (CAHPS)
- Patient Safety and Pharmacy Initiatives
- HEDIS~~/~~, STARS and~~/ Health Outcomes Survey (~~HOS~~)~~)~~ Improvement
- Delegation Oversight
- Organizational Quality Projects
- QI Program scope
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program
- Priorities for QI activities based on the specific needs of Cal-Optima's organizational needs and specific needs of Cal Optima's populations for key areas or issues identified as opportunities for improvement
- Priorities for QI activities based on the specific needs of Cal-Optima's populations, and on areas identified as key opportunities for improvement
- Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

(SEE ~~ATTACHMENT~~APPENDIX A — 2017 QI WORK PLAN)

UTILIZATION MANAGEMENT

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those which are established as safe and effective, consistent with symptoms and diagnosis and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the ~~2016~~2017 ~~Utilization Management (~~UM~~)~~ Program all review staff are trained and audited in these principles. Clinical staff makes all medical necessity decisions and any denial based on medical necessity is made only by a physician reviewer, including those decisions made by delegated ~~health networks~~HNs. Medical Directors actively engage subspecialty physicians as peer review consultants to assist in medical necessity determinations. Adherence to standards and evidence-based clinical criteria is obtained by cooperative educational efforts, personal contact with providers and monitoring through clinical studies.

Further details of the UM Program, activities and ~~can~~measurements can be found in the 2017 UM Program Description and related Work Plan.

~~UM WORK PLAN~~
~~(SEE ATTACHMENT B — 2017 UM WORK PLAN)~~

BEHAVIORAL HEALTH

CalOptima focuses on the continuum of care for both medical and behavioral health services. Focusing on continuity and coordination of care, CalOptima monitors and works to improve the quality of behavioral health care and services provided to our members. The QI Program includes services for behavioral health and review of the quality and outcomes of those services delivered to the members within our network of practitioners and providers.

The quality of Behavioral Health services may be determined through, but not limited to the following:

- Access to care
- Availability of practitioners
- Coordination of care
- Medical record and treatment record documentation
- Complaints and grievances
- Appeals
- Compliance with evidence-based clinical guidelines

- Language assistance
- HEDIS and STAR measurements

The Medical Director responsible for Behavioral Health services is involved in the behavioral aspects of the QI Program. The BH Medical Director is available for assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, providinge behavioral health QI statistical data and follow-up on identified issues. The BH Medical Director shall serve as the chairperson of the BH QI Committee which is a subcommittee of the CalOptima QI Committee. The BH Medical Director also serves as a voting member of CalOptima's QI Committee.

CONFIDENTIALITY

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

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

CONFLICT OF INTEREST

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

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

STAFF ORIENTATION, TRAINING A~~A~~ND EDUCATION

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

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

- CalOptima New Employee Orientation and B~~b~~oot Camp (CalOptima programs)
- HIPAA and Privacy~~/Corporate Compliance~~
- Fraud, Waste and Abuse, Compliance and Code of Conduct Training
- Workplace Harassment Prevention Training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable ~~D~~department ~~P~~program, ~~P~~policies & ~~P~~procedures, etc.
- Appeals ~~P~~process
- Seniors and Persons with Disabilities Awareness Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed employee.

MOC-related employees and contracted providers and practitioners networks are trained at least annually on the ~~Model of Care (~~MOC~~)~~. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

SAFETY PROGRAM

Member (~~P~~patient) safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced.~~-~~ Active, involved and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery organization continuum oversight and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally, and include strategic efforts specific to member safety.

This plan is based on a needs assessment and includes the following areas:

- Identification and prioritization of patient safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Plans to conduct appropriate patient safety training and education are available to members, families and health care personnel/physicians
- Patient safety program and its outcomes~~,~~ to be reviewed annually
- Health education and promotion
- Group Needs Assessment
- Over/Under ~~u~~Utilization monitoring
- Medication Management
- Case Management/Disease Management
- Operational Aspects of Care and Service

To ensure m~~M~~ember ~~S~~safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, cultural and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care; (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with ~~Health Networks~~HNs and practitioners in performing the following activities:

- ~~i~~Improving medical record documentation and legibility, establishing timely follow-up for lab results; addressing and distributing data on adverse outcomes or polypharmacy issues by the Pharmacy & Therapeutics (P&T) Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to correct the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ~~ADA (~~Americans with Disabilities Act (ADA) and ~~SPD (~~Seniors and Persons with Disabilities (SPD) site review audits into the general facility site review process

- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote that equipment is kept in good working order
  - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings including ~~Long-Term Care (LTC),~~ CBAS, SNF, ~~and~~ MSSP settings and Long-Term Services and Supports (LTSS) settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address post-operative complications
  - Sentinel events, ~~&~~ critical incident identification ~~and~~, appropriate investigation and remedial action
  - Administration of flu and ~~/~~pneumonia vaccine
- Administrative offices
  - ~~o~~ Fire, disaster, and evacuation plan, testing and annual training
  -

COMMITTEES AND KEY GROUP STRUCTURES

~~(SEE PAGE 52 — 2017 QUALITY IMPROVEMENT COMMITTEE ORGANIZATION STRUCTURE DIAGRAM)~~

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to review and accept the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC shall also make recommendations for annual modifications of the QI program and actions to be taken when objectives are not met. CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's QAC meetings are open to the public.

Member Advisory Committee

The Member Advisory Committee (MAC) is ~~composed~~ comprised of 15 voting members, each seat represent~~satives of the population~~a constituency served by CalOptima ~~serves~~. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice

and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, preventative services and contracting. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumer
- Family Support
- Foster Children
- Long-Term Care
- Medi-Cal beneficiaries
- Medically indigent persons
- Orange County Health Care Agency
- Orange County Social Services Agency
- Persons with disabilities
- Persons with mental illnesses
- Persons with Special Needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by the Health Care Agency and the Social Services Agency — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) is comprised of 10 voting members, each seat representing a constituency served by OCC and four non-voting liaisons representing county agencies, collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - Orange County Social Services Agency
    - Orange County Community Resources Agency, Office on Aging

- Orange County Health Care Agency, Behavioral Health
- Orange County IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits.

Provider Advisory Committee

The Provider Advisory Committee (PAC) is comprised of 15 voting members, each seat representing a constituency that works with CalOptima and our members. These include:

- ~~composed of representatives from the following constituencies:~~ ~~Health Networks~~
- HNs
- Hospitals
- Physicians
- Nurses
- Allied Health Services
- Community Clinics
- ~~The~~ Orange County Health Care Agency (HCA)
- ~~Long-Term Services and Supports~~LTSS including (LTC ~~F~~facilities and CBAS)
- Mid-~~L~~level ~~P~~practitioners
- Behavioral/mental health

Quality Improvement Committee (QIC)

The QIC is the foundation of the QI program. The QIC assists the CMO in overseeing, maintaining, and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted HMOs, PHCs, SRGs, MBHO, and PMGs to achieve the end result of improved care and services for members. The QIC oversees the performance of delegated functions by its HMOs, PHCs, SRGs, MBHO, and PMGs and contracted provider and practitioner partners. The composition of the QIC includes a participating Behavioral Health ~~P~~practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to ~~Quality Improvement~~QI Projects (QIP), activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored and reported through the QIC.

Responsibilities of the QI Committee include the following:

- Recommends policy decisions
- Analyzes and evaluates policy decisions
- Makes certain that there is practitioner participation in the QI Program through planning, design, implementation and review
- Identifies needed actions and interventions
- Makes certain that there is follow-up as necessary

Practice patterns of providers, practitioners, HMOs, PHCs, SRGs, MBHO, and PMGs are evaluated, and recommendations are made to promote practices that all members receive medical care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, HMOs, PHCs, SRGs, MBHO, and PMGs.

The QI Projects themselves consist of four (4) cycles:

- **Plan** — ~~d~~Detailed description and goals
- **Do** — ~~I~~Implementation of the plan
- **Study** — D~~d~~ata and collection
- **Act** — A~~a~~nalyze data and develop conclusions

The goal of the QI Program is to improve the health outcomes of members through systematic and ongoing monitoring of specific focus areas and development and implementation of QI Projects and interventions designed to improve provider and practitioner and system performance.

The QIC provides overall direction for the continuous improvement process and monitors that process to ensure that activities are consistent with CalOptima's strategic goals and priorities. It promotes efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program and drives actions when opportunities for improvement are identified.

The composition of the QIC is defined in the QIC Charter and includes, but may not be limited to the following:

Voting Members~~:~~

- Four (4) participating physicians or practitioners, with no more than two (2) administrative medical directors
- CalOptima CMO/DCMO
- CalOptima Medical Director, Quality (Chair)
- CalOptima Medical Director also representing the UM Committee
- CalOptima Medical Director, Behavioral Health also representing the Behavioral Health Quality Improvement Committee ~~BH QI Committee~~(BHQIC)
- Executive Director, Clinical Operations
- Director, ~~of~~ Network Management
- Director, Business Integration

The QIC is supported by:

Executive Director, Quality Improvement

~~Manager~~Director, Quality Improvement
Director, Quality Analytics
Director, Health Education & Disease Management
Committee Recording Secretary as assigned

Quorum
A quorum consists of a majority of the voting members (at least six) of which at least four are physicians or practitioners. ~~–~~Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by phone.

The QIC meets no less than eight times per year, and reports to the Board QAC no less than quarterly.

QIC and all ~~quality improvement~~QI subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the Quality Improvement Committee (QIC)
Contemporaneous minutes reflect all Committee decisions and actions. These minutes are dated and signed by the Committee Chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- ~~g~~Goals and objectives outlined in the QI Charter ~~and which include but are not limited to:~~
- Active discussion and analysis of quality issues analysis
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of work plan activities

All agendas, minutes, reports, and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and not reproduced (except for Quality Profile documentation) in order to maintain confidentiality, privilege and protection.

~~THE FOLLOWING ARE~~ QUALITY IMPROVEMENT C~~C~~OMMITTEES A~~A~~ND S~~S~~UBCOMMITTEES ~~OF THE QIC:~~

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to ~~support~~ ensure that all practitioners and providers that serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC reviews, investigates, and evaluates the credentials of all internal CalOptima medical staff for membership, and maintains a continuing review of the qualifications and performance of all external medical staff. The CPRC's review and findings are reported to the QIC at least quarterly.~~, with recommendations for approval/denial of credentialing. All approved providers and practitioners are presented to QAC on a quarterly basis as part of the CMO's report.~~

The goals of the CPRC include:

1. Maintain a peer review and credentialing program that aligns with regulatory (DHCS, DMHCS, CMS) and accreditation (NCQA) standards.
2. Promote continuous improvement of the quality of health care provided by providers in CalOptima Direct/CalOptima Community Network and its delegated ~~health networks~~HNs.
3. Conduct peer-level review and evaluation of provider performance and credentialing information against CalOptima requirements and appropriate clinical standards.
4. Investigate patient care outcomes that raise quality and safety concerns for corrective actions, as appropriate.

CPRC primary responsibilities include:

1. Provide peer review and credentialing functions for CalOptima.
2. Review reports submitted by internal departments including but not limited to Audit & Oversight, ~~Quality Improvement~~QI (PQI issues), and GARS (complaints) and take action on credentialing or quality issues, as appropriate.
3. Provide guidance and peer participation in the CalOptima credentialing and re-credentialing processes to ensure that all providers that serve CalOptima members meet generally accepted standards for their profession or industry.
4. Make final determinations regarding the eligibility of providers to participate in the CalOptima program based on CalOptima policies and applicable standards.
5. Review, investigate, and evaluate the credentials of CalOptima Direct/CalOptima Community Network practitioners and internal CalOptima medical staff.
6. Review facility site review results and oversee all related actions.
7. Investigate, review and evaluate quality of care matters referred by CalOptima's functional departments (including, without limitation, Customer Service, ~~Grievance and Appeals Resolution Services~~GARS, ~~Utilization Management~~UM, Case Management, ~~and~~ Pharmacy and LTSS) and/or the CMO or his/her physician designee related to CalOptima Direct/CalOptima Care Network or its delegated ~~Health Networks~~HNs.
8. Initiate and monitor imposed provider corrective actions and make adverse action recommendations, as necessary and appropriate.

In addition, as a part of CalOptima's Patient Safety Program, and utilizing the full range of methods and tools of that program, CalOptima conducts Sentinel Event monitoring. A Sentinel Event is defined as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof." The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Sentinel Event monitoring includes patient safety monitoring across the entire continuum of CalOptima's contracted providers: HMOs, PHCs, SRGs, MBHO, PMGs, and health care delivery organizations. The presence of a Sentinel Event is an indication of possible quality issues, and the monitoring of such events will increase the likelihood of early detection of developing quality issues so that they can be addressed as early as possible. Sentinel Event monitoring serves as an independent source of information on possible quality problems, supplementing the existing Patient Safety Program's consumer-complaint-oriented system.

All medically related cases are reviewed by the CPRC to determine the appropriate course of action and/or evaluate the actions recommended by an HMO, PHC, SRG, MBHO, or PMG delegate. Board certified peer-matched specialists are available to review complex cases as needed. Results of peer review are used at the reappointment cycle, or upon need, to review the results of peer review and determine the competency of the provider. This is accomplished through routine reporting of peer review activity to HMOs, PHCs, SRGs, MBHO and PMGs for incorporation in their re-credentialing process.

The CPRC shall consist of a minimum of five physicians selected on a basis that will provide representation of active physicians from the CalOptima Direct network and/or the ~~Health Networks~~HNs. Physician participants shall represent various specialties including but not limited to general surgery, OB/ GYN and primary care. In addition, the c~~C~~hairperson and CalOptima's CMO or DCMO are considered part of the Committee and, as such, are voting members. The CPRC provides reports to CalOptima QI Committee at least quarterly.

Grievance and Appeals Resolution Services Subcommittee (GARS)

The ~~Grievance and Appeals Resolution Services~~GARS subcommittee serves to protect the rights of our members, and to promote the provision of quality health care services and enforces that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS subcommittee serves to provide a mechanism to resolve provider ~~and practitioner~~ complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS subcommittee meets at least quarterly and reports to the QIC.

Pharmacy & Therapeutics Subcommittee (P&T)

The ~~Pharmacy & Therapeutics (~~P&T~~)~~ s~~S~~ubcommittee is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost effective pharmaceutical care for all CalOptima members and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T includes practicing physicians and the contracted provider networks. A majority of the members of the P&T are physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The

P&T provides written decisions regarding all formulary development and revisions. The P&T meets at least quarterly, and reports to the UM subcommittee.

Utilization Management Subcommittee (UM)

The ~~Utilization Management~~ UM subcommittee promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM subcommittee is multidisciplinary, and provides a comprehensive approach to support the ~~Utilization Management~~UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UM subcommittee monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, SRGs, MBHO, and PMGs to identify areas of under or over utilization that may adversely impact member care. The UM subcommittee oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, as well as development of Evidence Based Clinical Practice Guidelines and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. The UM subcommittee meets quarterly and reports to the QIC.

The UM subcommittee includes a minimum of four ~~(4)~~ practicing physician representatives, reflecting CalOptima's HMO, PHC, SRG, MBHO, and PMG composition, and is appointed by the CMO. The composition includes a participating Behavioral Health practitioner* to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed. Additionally, the UMC also includes and is supported by the following staff positions:

~~The UM subcommittee is supported by:~~
CMO/DCMO
Medical Director, Concurrent Review
Director, Utilization Management
Director, Pharmacy
Director, Enterprise Analytics
Manager, Referral/Prior Authorization
Manager, Concurrent Review

Quorum:
A quorum consists of fifty percent (50%) plus one of voting member participation and of the eleven, the minimum quorum must include three committee participants from the community. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

** Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.*

Benefit Management Subcommittee (BMSC)

The purpose of the ~~Benefit Management subcommittee~~ BMSC is to oversee, coordinate, and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its program lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. The subcommittee shall also see to it that benefit updates are implemented, and communicated accordingly, to internal CalOptima staff, and that updates are provided to contracted HMOs, PHCs, SRGs, MBHO, and PMGs. The Government Affairs department provides ~~the~~ technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules.

Long-Term Services and Supports Subcommittee (LTSS)

The LTSS subcommittee is composed of representatives from the ~~Long-Term Care (~~LTC~~)~~, ~~Community-Based Adult Services (~~CBAS~~)~~, IHSS and ~~Multipurpose Senior Services Program (~~MSSP~~)~~ communities, which may include administrators, directors of nursing, facility Medical Directors, and pharmacy consultants, along with appropriate CalOptima staff. ~~Previously, the CBAS Quality Advisory sSubcommittee was integrated into the LTSS Quality Ssubcommittee. The~~ LTSS subcommittee members serve as specialists to assist CalOptima in the development, implementation, and evaluation of establishing criteria and methodologies to measure and report quality and access standards with ~~Home and Community Based Services (~~HCBS~~)~~ and in LTC facilities where CalOptima members reside. The LTSS subcommittee also serves to identify ~~"~~best practices,~~"~~ monitor over and underutilization patterns and partner with facilities to share the information as it is identified. The LTSS subcommittee meets quarterly and reports through Clinical Operations ~~S~~subcommittee to the QIC.

~~**Benefit Management Subcommittee (BMSC)**~~

~~The purpose of the Benefit Management Ssubcommittee is to oversee, coordinate, and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its program lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. The subcommittee shall also see to it that benefit updates are implemented, and communicated accordingly, to internal CalOptima staff, and that updates are provided to contracted HMOs, PHCs, SRGs, MBHO, and PMGs. The Government Affairs department provides the technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules.~~

Behavioral Health Quality Improvement Committee (BHQIC)

The ~~Behavioral Health Quality Improvement Committee~~BHQIC ~~was established in 2011 to~~ ensures members receive timely and satisfactory behavioral health care services, through enhancing ~~continuity~~ integration and coordination between physical health and behavioral health care providers, monitoring key areas of services to members and providers, identifying areas of improvement and guiding CalOptima towards the vision of bi-directional behavioral health care integration.

The BHQIC responsibilities are to:

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

- Document and report all monitoring activities to appropriate committees

The designated ~~C~~chairman of the BHQI subcommittee is the Medical Director, Behavioral Health, who is responsible for chairing the subcommittee as well as reporting findings and recommendations to QIC.

The composition of the BHQIC ~~Committee~~ is defined in the BHQIC Charter and includes, but may not be limited to the following:

- Medical Director, Behavioral Health Integration (Chair)
- Chief Medical Officer/Deputy Chief Medical Officer
- Medical Director, Quality and Analytics
- Executive Director, Clinical Operations
- Executive Director, Quality Analytics
- Medical Director, Utilization Management
- Director, Behavioral Health Integration
- Clinical Pharmacist
- Medical Director, Orange County Health Care Agency
- Medical Director, ~~Medi-Cal~~ MBHO
- Chief Clinical Officer, ~~Medi-Medi~~ MBHO
- Medical Director, Health Network
- Medical Director, Regional Center of Orange County
- Contracting Behavioral Health Care Practitioners

The BHQIC shall meet, at a minimum, on a quarterly basis, or more often as needed.

Additionally, CalOptima is formalizing two additional subcommittees to QIC, focusing on Clinical Operations and Member Experience.

Clinical Operations/Population Health ~~-~~Subcommittee ~~:~~(COPHS)

The purpose of the ~~Clinical Operations Subcommittee~~COPHS is to oversee, guide and ensure the integration and coordination of functions across the continuum of care, including but not limited to population health, disease management, care management, complex case management, ~~utilization management~~UM, LTC~~long term care~~, pharmacy & behavioral health services.~~-~~ This subcommittee monitors the progress of the established program goals and metrics defined for CalOptima's disease management, complex case management programs and Model of Care. ~~This subcommittee~~COPHS reviews these programs at least quarterly, and includes the following key individuals:

- Chief Medical Officer/Deputy Chief Medical Officer
- Executive Director, Clinical Operations
- Executive Director, Quality & Analytics
- Director, Care Management
- Director, Utilization Management
- Director, Health Education & Disease Management

- Director, Enterprises Analytics
- Director, Quality Analytics
- Director, Long--Term Services & Supports
- Director, Quality Improvement
- Director, Clinical Outcomes
- Director, Clinical Pharmacy Management
- Director, Behavioral Health Services.

Member Experience Subcommittee :(MES)

The final subcommittee in the quality committees structure is MES and focuses on the issues and factors that influence the member's experience with the health care system for Medi-Cal, ~~OneCare~~OC, O~~ne~~Care ~~Connect~~ ~~&~~and LTSS. NCQA Medicaid Plan Ratings measure three dimensions – Prevention, Treatment and Customer Satisfaction.- CalOptima's ~~Quality Improvement~~QI program focuses on the performance in each of these areas. -The ~~Member Experience Subcommittee~~MES is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the ~~Health Networks~~HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in ~~healthcare~~health care that impact our members.

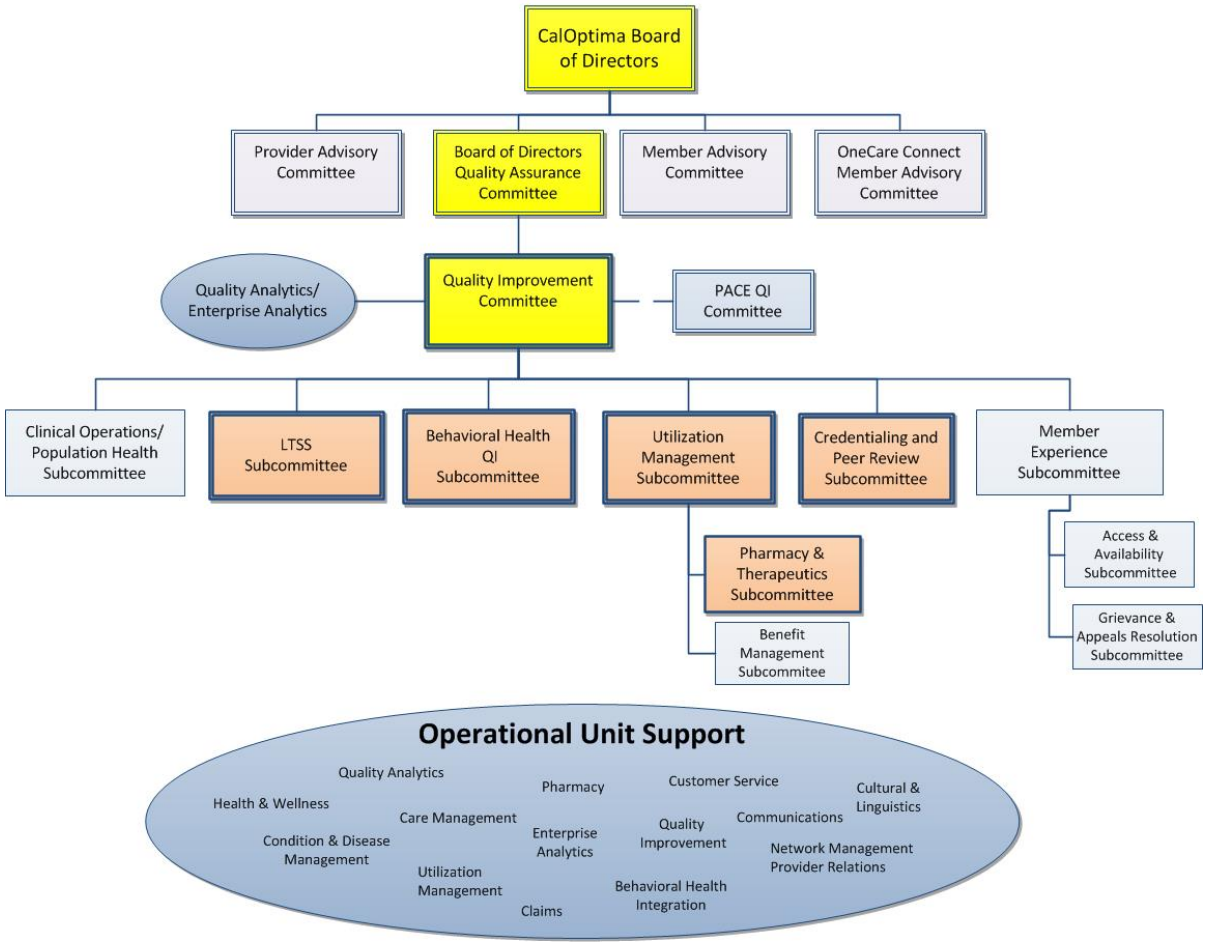
-This subcommittee meets at least bi-monthly and includes the following key individuals:

- Chief Medical Officer/Deputy Chief Medical Officer or designee
- Executive Director, Quality & Analytics
- Director, Customer Service
- Director, Grievances & Appeals
- Director, Network Management
- Director, Provider Services
- Manager, Access & Availability
- Director, Quality Analytics
- Director, Utilization Management~~.~~

The ~~Member Experience Subcommittee~~MES focuses on improving the following key areas of satisfaction:

- Getting needed care & getting care quickly
- How well doctors communicate
- Customer service
- Rating of health care, providers ~~&~~and health plan
- Other areas as defined by specific metrics, focus groups or survey results.

2017 Committee Organization Structure — Diagram



METHODOLOGY

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous HMO, PHC, SRG, PMG, and internal monitoring activities, including, but not limited to, (a) potential quality concern (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) satisfaction surveys, (f) HEDIS results, and (g) other subcommittee unfavorable outcomes
- Measures required by regulators such as DHCS and CMS

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, long-term ~~care~~services and supports, and ancillary care services

- Access to and availability of services, including appointment availability, as described in the ~~Utilization Management~~UM Program and in policy and procedure
- Coordination and continuity of care for ~~seniors and persons with disabilities~~SPD
- Provisions of chronic, complex care management and case management services

- Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization.

- Staff, administration, and physicians provide vital information necessary to support continuous performance is occurring at all levels of the organization
- Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
- Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes
- Project coordination occurs through the various leadership structures: Board of Directors, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort
- These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

QI Project Quality Indicators

Each QI Project will have at least one (and frequently more) quality indicator(s). While at least one quality indicator must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Quality indicators will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, MBHO, PMG, or system performance. Quality indicators will be clearly defined and objectively measurable. Standard indicators from HEDIS & STARS measures are acceptable.

Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized. See explanation of Clinical Data Warehouse below.

For studies /measuresor measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5 to 10% over sampling), so asin order to allow performance of conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Measures that rely exclusively on administrative data utilize the entire target population as a denominator.

CalOptima also uses a variety of QI methodologies dependent on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change/plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

CARE OF MEMBERS WITH COMPLEX NEEDS

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs or
- ~~M~~management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt-out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education and member incentive programs
- Use of evidenced- based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)
- Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
- Coordinating services for members for appropriate levels of care and resources
- Documenting all findings

- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. ~~All~~ SPD, OCC and OC members are stratified using a plan-developed ~~stratification~~ tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. ~~The members are stratified into complex, care coordination and basic care management levels.~~ This s~~S~~tratification results in the ~~categories~~categorizing members as ~~of~~ "high" ~~and~~or "low" ~~risk, for those members who are stratified. The~~risk. The case management levels (CML) of complex, care coordination and basic are specific to SPD, OCC and OC members who have either completed a HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. -The ICT may occur at the PCP (basic), the Health Network/Group ~~&~~and system (primary), or system/transition (complex) level, dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status.

~~The Interdisciplinary Care Team (ICT) for low risk members — is basic — and occurs at the PCP level. Moderate and high risk members are managed by an ICT at the Medical Group level for delegated groups or at the plan level in the instance of the Community Network.~~
~~The Interdisciplinary Care Team (ICT) for members in basic case management occurs at the primary care provider level. (This is ***not*** the same as saying that low risk members have a ICT at the PCP level. For instance, a member may stratify low risk, have an HRA completed, and as a result of information gathered through the HRA process, be placed in care coordination or complex case management.) Conversely, a member who stratifies as high risk and completes an HRA may ultimately be found to be more appropriate for basic case management.~~

The ~~members of the~~ ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, but not limited to a Medical Director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietician, and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — ~~Basic Team~~occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic case management, including advanced care planning
      - Medication reconciliation

        - Identification of member at risk of planned and unplanned transitions
        - Referral and coordination with specialists
        - Development and implementation of an ICP
        - Communication with members or their representatives, vendors, and medical group
        - Review and update the ICP at least annually, and when there is a change in the member's health status
        - Referral to the primary ICT, as needed

- Primary ICT for Moderate to High-Risk Members — ICT occurs at the Physician Medical Group (PMG) level or the Health Plan for Community Network
    - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, ~~PMG~~ health network (HN) Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, ~~PMG~~ HN ~~Utilization Management~~UM staff, behavioral health specialist and social worker
        - Roles and responsibilities of this team:
            - Identification and management of planned transitions
            - Case management of high risk members
            - Coordination of ICPs for high risk members
            - Facilitating member, PCP and specialists, and vendor communication
            - Meets as frequent as is necessary to coordinate and care and stabilize member's medical condition

- Complex ICT for High-Risk Members — ICT at the Physician Medical Group (PMG) level or Health Plan for Community Network
    - Team Composition (a~~A~~s appropriate for identified needs): member, caregiver, or authorized representative, ~~PMG~~ HN Medical Director, CalOptima clinical/~~PMG~~ HN case manager, PCP and/or specialist, social worker, and behavioral health specialist
        - Roles and responsibilities of this team:
            - Consultative for the PCP and ~~PMG~~ HN teams
            - Encourages member engagement and participation in the IC~~D~~T process
            - Coordinating the management of members with complex transition needs and development of ICP
            - Providing support for implementation of the ICP by the ~~PMG~~HN
            - Tracks and trends the activities of the ~~IDTs~~ICTs
            - Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the ~~IDTs~~ ICTs to identify areas for improvement
            - Oversight of the activities of all transition activities at all levels of the delivery system
            - Meets as often as needed until member's condition is stabilized

Dual Eligible Special Needs Plan (SNP)/~~OneCare~~ OC and ~~OneCare Connect~~OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help patients regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow-up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of re-hospitalization
- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at high-risk individuals (e.g., patients dually eligible for Medicare and Medicaid or patients who are institutionalized)
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning
- Care management program focused on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life

CalOptima's goals for ~~2016~~2017 are:

- Continue with the comprehensive assessment strategy
- Measure and assess the quality of care CalOptima provides
- Evaluate how CalOptima addresses the special needs of our beneficiaries
- Drive interventions and actions when opportunities for improvement are identified

Please reference the ~~2016~~2017 Case Management Program Description for further details and program plans.

DISEASE MANAGEMENT PROGRAM

The Disease Management (DM) program is a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner and CalOptima. The DM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinatinges care for members across time, localtes and providinges services, and resources, and support tos the members as they learn to care for themselves and their condition. The Disease Management (DM) Pprogram also is a targeted programidentifies those members in need of closer for the management, coordination, and intervention. for a highly vulnerable patient population. CalOptima assumes responsibility for the Disease ManagemenDMt program for all of its lines of business, therefore the management for Disease ManagementDM is non-not delegated to the PHCs, SRGs, HMOs and PMGs. -The contracted PHCs, SRGs, HMOs and PMGs must participate collaboratively with interventions necessary to produce compliant identified quality outcomes. The DM Program is evaluated on an annual basis.

~~The DM program is a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the healthcare practitioner and CalOptima. The DM program coordinates care for members across time, locates and provides services and resources, and supports the members as they learn to care for themselves.~~

Further details of the Disease ManagementDM Pprograms, activities and measurements can be found in the 2017 Disease ManagementDM Program Description.

~~A detailed description of the Disease Management Program is contained in the Disease Management Program Description document. The DM Program is evaluated on an annual basis.~~

CLINICAL DATA WAREHOUSEQUALITYQUALITY ANALYTICSNALYTICS

Core to the QI Program is the statistical analysis of various data sources to support continuous quality improvement of our programs, projects, activities, and initiatives. The CalOptima's Clinical Data Warehouse is a dynamic environment which aggregates data from CalOptima's various core business systems and processes, such as member eligibility, provider, encounters, claims, and pharmacy and care management systems to support the QI program. The clinical data warehouse allows staff to apply logic, population definitions and/or evidence-based clinical practice guidelinesbased guidelines to analyze data for quality purposes, such as disease management population identification, risk stratification, process measures and outcomes measures. CalOptima staff creates and maintains the data-base with quarterly data updates.

Based upon evidence-based practice guidelines built into the system, the clinical data warehouse can assess the following:

- Identify and stratify members with certain disease states
- Identify over/under utilization of services
- Identify missing preventive care services
- Identify members for targeted interventions

Identification/Stratification of Members

Using clinical business rules, the database identifies members with a specific ~~chronic~~ diseases or conditions, such as Asthma, Diabetes, or Congestive Heart Failure. It then categorizes the degree of certainty the member has the condition as being probable or definitive. Once the member has been identified with a specific disease or condition, the database is designed to detect treatment failure, complications and co-morbidities, noncompliance, or exacerbation of illness to determine if the member requires medical care, and recommends an appropriate level of intervention.

Identify Over/Under Utilization of Services

Using clinical business rules, the database can identify if a member or provider is over or under utilizing medical services. In analyzing claims and pharmacy data, the data warehouse can identify if a member did not refill their prescription for maintenance medication, such as high blood pressure medicines. The database can also identify over utilization or poor management by providers. For example, the system can list all members who have exceeded the specified timeframe for using a certain medication, such as persistent use of antibiotics greater than 61 days.

Identify Missing Preventive Care Services

The data warehouse can identify members who are missing preventative care services, such as an annual exam, an influenza vaccination for members over 65, a mammogram for women for over 50 or a retinal eye exam for a diabetic.

Identify Members for Targeted Interventions

The rules for identifying members and initiating the intervention are customizable to CalOptima to fit our unique needs. By using the standard clinical rules and customizing CalOptima specific rules, the database is the primary conduit for targeting and prioritizing heath education, disease management and HEDIS or Stars related interventions.

By analyzing data that CalOptima currently receives (i.e. claims data, pharmacy data, and encounter data) the data warehouse can identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS, STARS~~tars~~ and HOS measures. This information will guide CalOptima in not only targeting the members, but also the HMOs, PHCs, SRGs, MBHO, PMGs, and providers who need additional assistance.

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality indicators. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality indicator) is accompanied by clear guidelines for interpretation. Validation will be done through a minimum 10% sampling of abstracted data for rate to standard reliability, and will be conducted by the Director, Quality Analytics or designee. If validation is not achieved on all records samples, a

further 25% sample will be reviewed. If validation is not achieved, all records completed by the individual will be re-abstracted by another staff member.

Where medical record review is utilized, the abstractor will obtain copies of the relevant section of the record. Medical record copies, as well as completed data abstraction tools, are maintained for a minimum period, in accordance with applicable law and contractual requirements.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements, evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project; there ~~is~~ are no other regulatory reporting requirements related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source and overall project goal.
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data

- List of data elements (quality indicators). Where data elements are process indicators, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality indicator
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection, and analysis timelines
- Evaluation of re-measurement performance on each quality indicator

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical "home" for each member. The primary care practitioner is this medical "home" for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the CalOptima model:

- Primary Care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.

- Community Oriented Primary Care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

Clinical Care and Service:

- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care and treatment of acute and chronic conditions
- Complex Case Management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and

Case Management departments, which details this process in its UM/CM Program and other related policies and procedures.

- Drug utilization
- Health education and promotion
- Over/under utilization
- Disease management

Administrative Oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

* CalOptima has a zero tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to HMO, PHC, SRG, MBHO, and PMG contractors who are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. Predelegation review is conducted through the Audit and Oversight department and overseen by the Delegation Oversight Committee reporting to the Compliance Committee. ~~(See Attachment B for the 20162017 Delegation Grid.)~~

Non-Delegated Activities

The following activities are not delegated, and remain the responsibility of CalOptima:

- ~~Quality Improvement~~QI, as delineated in the Contract for Health Care Services
- QI ~~P~~program for all lines of business, HMOs, PHCs, SRGs, MBHO, and PMGs must comply with all quality related operational, regulatory and accreditation standards
- ~~Disease Management~~ DM ~~P~~program, may otherwise be referred to as Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, peer review process on specific, referred cases
- Development of system-wide indicators, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and ~~healthcare~~health care delivery organizations (HDOs)
- Credentialing and re-credentialing of HDOs
- Development of ~~Utilization Management~~UM and Case Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with State and Federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

Further details of the delegated and non-delegated activities can be found in the 2017 Delegation Grid.

SEE APPENDIX BC — 2017 DELEGATION GRID

~~PEER REVIEW PROCESS~~

~~Peer Review is coordinated through the QI Ddepartment. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases are presented to CPRC to assess if documentation is complete, and no further action is required. The QI department also tracks, monitors, and trends, service and access issues to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews and tracking and trending of service and access issues are reported to the CPRC at time of re-credentialing. Quality of care case referral to the QI department are based on referrals to the QI department originated from multiple areas, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or grievances and appeals resolution.~~

CULTURAL & LINGUISTIC SERVICES

CalOptima serves a large and culturally diverse population. The five most common languages spoken for all CalOptima programs are: English at 57 percent, Spanish at 28 percent, Vietnamese at 10 percent, Farsi at one percent, Korean at one percent, Chinese at one percent, Arabic at one percent and all others at three percent, combined. CalOptima provides member materials in:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic
- ~~OneCare~~ OC member materials are provided in three languages: English, Spanish and Vietnamese
- ~~OneCare Connect~~OCC member materials are provided in five languages: English, Spanish, Vietnamese, Korean and Farsi.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to Member Centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation. See CalOptima Policy DD. 2002 — Cultural and Linguistic Services for a detailed description of the program.

Objectives for serving a culturally and linguistically diverse membership include:

- Analyze significant health care disparities in clinical areas

- Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Consider outcomes of member grievances and complaints
- Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/~~language~~ language or gender specific risks
- Identify and reduce a specific health care disparity affecting a ~~with~~particular cultur~~e~~al, race or~~,~~ gender group
- Provide information, training and tools to staff and practitioners to support culturally competent communication

PEER REVIEW PROCESS

Peer Review is coordinated through the QI Department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors, and trends PQI cases, in order to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, tracking and trending of service and access issues are reported to the CPRC, and are also reviewed at time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or grievances and appeals resolution.

COMPREHENSIVE CREDENTIALING PROGRAM STANDARDS

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS and NCQA). The scope of the credentialing program includes all licensed M.D.s, D.O.s, DPMs (doctor of podiatric medicine), DC (doctor of chiropractic medicine), DDS (doctor of dental surgery), allied health and midlevel practitioners, which include, but are not limited to: behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrist, physician assistants, optometrists, registered physician therapists, occupational therapists, speech therapists and audiologists, ~~etc.,~~ both in the delegated and CalOptima direct environments. Credentialing and recredentialing activities are delegated to the ~~Health Networks~~HNs and performed by CalOptima for CCN.

Health Care Delivery Organizations

CalOptima performs credentialing and re-credentialing of ancillary providers and HDOs (these include, but are not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc.) upon initial contracting, and every three years thereafter. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies.

Use of Quality Improvement Activities in the Re-credentialing Process
Findings from quality improvement activities are included in the re-credentialing process.

Monitoring for Sanctions and Complaints
CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, State or Federal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns and member complaints between re-credentialing periods.

FACILITY SITE REVIEW, MEDICAL RECORD AND PHYSICAL ACCESSIBILITY REVIEW SURVEY

CalOptima does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted HMOs, PHCs, SRGs, MBHO, and PMGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by MMCD -Policy Letter ~~02-02~~ 14-004. CalOptima assumes responsibility and conducts and coordinates Facility Site Review (FSR), Medical Record Review (~~/~~MRR) for the non-delegated SRGs and PMGs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs and PMGs to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs.

Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter ~~02-02~~14-004 and CalOptima policies. Medical records of new providers shall be reviewed within ninety calendar days of the date on which members are first assigned to the provider. An additional extension of ninety calendar days may be allowed only if the provider does not have sufficient assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)
CalOptima conducts an additional DHCS-required facility audit for American with Disabilities Act compliance for ~~seniors and persons with disabilities (~~SPD~~)~~ members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Exterior ramps
- Exterior stairways
- Entrances

- Interior circulation
- Interior doors
- Interior ramps
- Interior stairways
- Elevators
- Controls
- Sanitary facilities
- Reception and waiting areas
- Diagnostic and treatment areas

Medical Record Documentation Standards

CalOptima requires that its contracted HMOs, PHCs, SRGs, MBHO, and PMGs make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, ~~x~~X-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.

The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by State and Federal laws and regulations, and the requirements of CalOptima's contracts with CMS, DHCS, and MRMIB.

The medical record should be protected in that medical information is released only in accordance with applicable Federal and/or State law.

CORRECTIVE ACTION PLAN(S) TO IMPROVE CARE, SERVICE

When monitoring by either CalOptima's Q~~uality I~~~~mprovement~~ ~~D~~department or Audit & Oversight ~~D~~department identifies an opportunity for improvement, the delegated or functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the QI department or Audit and Oversight ~~D~~department as overseen by the ~~Delegation~~ Audit & Oversight Committee, reporting to the Compliance Committee. ~~–~~Those activities specific to CalOptima's functional areas will be overseen by the Q~~uality I~~~~mprovement~~ d~~D~~epartment as overseen by and reported to QIC. ~~-~~Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation of performance via the appropriate clinical monitor. (This process shall determine if ~~follow~~ follow-up action has resolved the original problem.)

- Discussion of the results of clinical monitoring. (The committee/functional area may refer an unresolved matter to the appropriate committee/functional area for evaluation and, if necessary, action.)
- Intensified evaluation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- Prescribed continuing education
- Intensive monitoring and oversight
- De-delegation
- Contract termination

Performance Improvement Evaluation Criteria for Effectiveness

The effectiveness of actions taken and documentation of improvements made are reviewed through the monitoring and evaluation process. Additional analysis and action will be required when the desired state of performance is not achieved. Analysis will include use of the statistical control process, use of comparative data, and benchmarking when appropriate.

COMMUNICATION OF QUALITY IMPROVEMENT ACTIVITIES

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups, and be reflected on the work plan or calendar. The QI Ssubcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Board of Directors, and/or the QAC, through the CMO or designee, on a quarterly basis. QIC participants are responsible for communicating pertinent, non-confidential QI issues to all members of CalOptima staff. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
- Annual synopsized QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on CalOptima's website, in addition to the annual article in both practitioner and member newsletter. The information includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service. Notification

on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
- Annual PCP pamphlet
- Member Advisory Committee (MAC), OCC Member Advisory Committee (OCC MAC) and Provider Advisory Committee (PAC).

ANNUAL PROGRAM EVALUATION

The objectives, scope, organization and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC, QAC, and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and incorporated into the QI Work Plan and reported to DHCS ~~&~~ and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization,
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions
- An evaluation of each QI Activity, including Q~~uality I~~~~mprovement~~ Projects (QIPs), with any area showing improvements in care or service as a result of QI activities receiving continued interventions to sustain improvement
- An evaluation of member satisfaction surveys and initiatives
- A report to the QIC and QAC of a summary of all quality indicators and identification of significant trends
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process
- The recommended changes, included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors for review and approval

IN SUMMARY

As stated earlier, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better. Together."

APPENDIX A — 2017 QI WORK PLAN

APPENDIX B — 2017 DELEGATION GRID

"Attachment A"

CalOptima
20176 Quality Improvement Work Plan
OneCare Connect/OneCare and Medi-Cal
February, 2016 7

I. Program Oversight

- **A. Program Sscope- 2017 QI Annual oversight of programs and work plans 2/9/16**
- **B. Program Scope- 20156 QI Program Annual Evaluation**
- **C. Program Scope- 2017 UM Program and UM Work Plan annual oversight**
- **D. Program Scope- 20176 5 UM Program Annual Evaluation**
- **E. Quality of Care- 2017 Case Management Program annual oversight**
- **F. Quality of Ccare- 20156 Case Management Program Evaluation**
- **G. Quality of Care- 2017 Disease Management Program annual oversight**
- **H. Quality of Care- 20156 Disease Management Program Evaluation**
- **I. Quality of Care- Credentialing Peer Review Committee (CPRC) Oversight**
- **J. NCQA Monitoring & Compliance**

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC _____ Date: _____

Submitted and approved by Board _____ Date: **4/1/16**

Submitted and approved by Board of Director's _____ Date: **3/23/16**

Quality Assurance Committee (QAC)

Quality Improvement Committee Chairperson:

_____

Medical Director _____ Date: _____

II. Case Management

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

Board of Directors' Quality Assurance Committee Chairperson:

Board of Directors' Quality Assurance Committee Chairperson:

_____

Paul Yost, Viet Van Dang, MD _____ _____

III. Behavioral Health

Date:

- **A. Quality of Clinical Care: HEDIS Measure for M/C & OCCIntegration of BH services**
- **B. Quality of Clinical Care: Interdisciplinary Care Treatment Team Participationare- Clinical BH Practice Guidelines adoption for Medi-Cal line of business**
- **C. Quality of Clinical Care: Behavioral Health Practice Guidelines**
- **C. Access and Coordination of Care Service and Quality of Clinical Care- Review of behavioral health providers communications with PCPs**

IV. LTSS

- **A. Safety of Clinical Care and Quality of Clinical Care- Review and assess LTSS placement for members participating with each organization/program**
- **B. Safety of Clinical Care and Quality of Clinical Care- Review and assess emergency department visits for LTSS members participating with each organization/program**
- **C. Safety of Clinical Care and Quality of Clinical Care- Review and assess readmissions for LTSS members participating with each organization/program: Hospital Readmissions**
- **D. Safety of Clinical Care and Quality of Clinical Care-Review and Assess Readmissions for LTSS members participating with each organization/program: Long Term Care Admissions**

~~D.~~E. **Quality of Clinical Care- Review of health risk assessment (HRA) for OneCare Connect (OCC) Long Term Care (LTC) members**
~~E.~~F. **CBAS Member Satisfaction**
G. **SNF Member Satisfaction**

~~F.~~

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

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

VII. Patient Safety
- A. Safety of Clinical Care-~~-~~Providers shall have timely and complete facility site reviews
- B. Safety of Clinical Care-~~-~~Review and follow-up on member's potential Quality of Care Complaints
- C. Safety of Clinical Care and Quality of Clinical Care-~~-r~~Reviewed through Pharmacy Management
- D. Safety of Clinical care and Quality of Clinical Care-~~-~~R~~r~~eview of Specialty Drug Utilization
- E. Patient Safety-~~-~~Review and assessment of CBAS Quality Monitoring
- F. Patient Safety-~~-~~Review and assessment of SNF Quality Monitoring
- G. Safety of Clinical Care-~~-~~Review of antibiotic usage
- H. Pharmacy Benefit~~r~~ Manager (PBM) Oversight Management ~~Implementation of the new PBM~~

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

IX. HEDIS/STARS Improvement
- A. Improve identified HEDIS Measures listed on "Measures" worksheet
- B. Improve identified STARS ~~m~~Measures listed on "Measures" worksheet
- ~~C.~~ Improve CAHPS ~~m~~Measures listed on "Measures" worksheet
- ~~D.~~C. ~~HEDIS: Launch pediatric wellness clinic~~
- ~~E.~~D. STARS Medication Related Measures~~improvement- Medication Adherence Measures~~

~~F.~~ HEDIS: Health Network support of HEDIS & CAHPS Improvement

X. Delegation Oversight
- **A. Delegation Oversight of CM**
- **B. Quality of Care & Ss~~s~~ervice of UM through d~~D~~Delegation o~~O~~versight r~~R~~eviews**
- **C. Delegation Oversight of BH Services**

XI. Organizational Projects
- ~~**A. Implementation of the 2016 Value Based P4P program**~~
- **A. Value Based P4P 2017**
- **B. MOC Dashboard 2016-2019**

Previously identified issues to be monitored

I. Program Oversight

A. Program Scope- QI Annual oversight of programs and work plans

Owner: Medical Director, Quality & Analytics

1. Activity

- QI Program and QI Work Plan will be adopted on an annual basis
- QI Program Description- QIC-BOD
- QI Work Plan- QIC-QAC

Approved by QIC: ~~2/9/16~~
Approved by QAC: ~~3/23/16~~
Approved by Board: ~~4/1/16~~

2. Goals

- Annual Adoption

B. Program Scope- 201~~6~~6 QI Program Annual Evaluation

Owner: Medical Director, Quality & Analytics

1. Activity

- QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis

2. Goals

- Annual Evaluation

Approved by QIC: ~~2/9/~~ ~~16~~
Approved by QAC: ~~3/23/16~~
Approved by Board: ~~4/1/~~ ~~16~~

C. Program Scope- UM Program and UM Work Plan annual oversight

Owner: ~~Terrie Stanley~~Tracy Hitzeman, Interim ED Clinical Operations

1. Activity

- UM Program and UM Work Plan will be adopted on an annual basis
- Delegate UM annual oversight reports-from DOC

Approved by UMC: ~~2/9/16~~
Approved by QIC: ~~2/9/16~~
Approved by QAC: ~~3/23/16~~
Approved by Board: ~~4/1/16~~

2. Goals

- Annual Adoption

D. Program Scope- 201~~6~~6 UM Program Annual Evaluation

Owner: ~~Terrie Stanley~~Tracy Hitzeman, Interim~~interim~~ ED ~~Clinical Operations~~CO

1. Activity

- UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis
- Delegate oversight from DOC

Approved by QIC: ~~2/9/16~~
Approved by QAC: ~~3/23/16~~
Approved by Board: ~~4/1/16~~

2. Goals

- Annual Evaluation

E. Quality of Care – 2016 Case Management Program Annual Oversight

Owner: Tracy Hitzeman Sloane Petrillo, Interim Director, Case Management

1. **Activity**
   - CM Program will be adopted on an annual basis
   - Delegation oversight reported by DOC

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Adoption

F. Quality of Care – 2016 Case Management Program Evaluation

Owner: Sloane Tracy Hitzeman Petrillo, Interim Director Dtr, CM

1. **Activity**
   - CM Program will be evaluated by members including member feedback and complaints, and to measure effectiveness of the overall CM Program, including interventions and actions for re-measurements
   - Delegation oversight reported by DOC
   -

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Evaluation

G. Quality of Care – 2016 Disease Management Program Annual Oversight

Owner: Pshyra Jones, Dir Director, of Health Education & Disease Management

1. **Activity**
   - DM Program will be adopted on an annual basis

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Adoption

H. Quality of Care – 2016 Disease Management Program Evaluation

Owner: Pshyra Jones, Dtr. Health Ed HE and & DM

1. **Activity**
   - DM Program will be evaluated by members including member feedback and complaints and to measure effectiveness of the overall
   - DM Program, including interventions and actions for re-measurement

Approved by QIC:
Approved by QAC:
Approved by Board:
Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Evaluation

I. Quality of Care- Credentialing Peer Review Committee (CPRC) Oversight

Owner: Medical Director, Quality

1. **Activity**
   - Review of initial and recredentialing applications, related quality of care issues, approvals, denials, and reported to QIC
   - Delegation oversight reported by DOC

Approved by QIC:
Q1
Q2
Q3
QI 4/13/16
Q4Q2
Q3
Q4

2. **Goals**
   - **Quarterly Adoption of Report**

J. NCQA Monitoring & Compliance

Owner: ~~Kelly Rex-Kimmet~~Esther Okajima, Director, Quality ImprovementA

1. **Activity**
   - Evaluate NCQA standards, HEDIS & CAHPS for improvement opportunities to achieve Commendable status

Approved by QIC:
Q1
Q2
Q3
Q4

~~Approved by QIC~~

2. **Goals**

Q1
Q2
Q3
Q4

2. **Annual HIP ~~Ranking~~Rating**

II. Case Management

A. *Quality Of Clinical Care-Review of Hhealth rRisk aAssessments to OCC, OC, SPD members

A. Owner: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

The Approach

1. Objective

- **OCC-** Health Risk Assessment Outreach for members in the OneCare
- Connect Program monitored for completion and collection
  - Initial HRA
  - Annual HRA
- **OC-** Health Risk Assessment Outreach for members in the OneCare Program monitored for completion
  - Initial HRA
  - Annual HRA
- **SPD-** Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion
  - Initial HRA
  - Annual HRA

2. Activity

- **OCC-** Administer the initial HRA to the high risk beneficiary within:
  1. 90 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **OCC-** Administer the initial HRA to the low risk beneficiary within:
  1. 45 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **OC-** Administer the annual HRA to the beneficiary
  1. 90 days of a beneficiary's enrollment

2. Administer the annual HRA to the beneficiary

- **SPD-** Administer the initial HRA to the high risk beneficiary within:
  1. 45 days of a beneficiary's eligibility
  2. Administer the annual HRA to the beneficiary

- **SPD-** Administer the initial HRA to the low risk beneficiary within:
  1. 90 days of a beneficiary's eligibility
  2. Administer the annual HRA to the beneficiary

3. Goals

- **Completion of Outreach**

~~**Completion of outreach**~~

~~OCC-100% of eligible population~~

- ~~**OCCC-**-100% of eligible population~~
- **OC~~SPD~~**-1~~-~~100% of eligible population
- **SPD**-100% of eligible population

- **Collection**

- **OCC**-Collect 56% of high risk OCC HRAs
- **OCC**-Collect 43% of low risk OCC HRAs
- **OC**-Collect 78% of initial OC HRAs
- **OC**-Collect 34% of annual OC HRAs
- **SPD**-Collect 63% of initial SPD HRAs

~~**Collectio n**~~

~~OCC-Collect 56% of high risk OCC HRAs~~

- **OCC** Collect 43% of low risk OCC HRAs
- **OC** Collect 78% of initial OC HRAs
- **OC** Collect 34% of annual OC HRAs
- **SPD** Collect 63% of initial SPD HRAs

The Approach

1. Objective

- **OCC** Health Risk Assessment Outreach Appraisals for members in the OneCare Connect Program monitored for completeness
- **OC** Health Risk Assessment Outreach for members in the OneCare Program monitored for completion
- **SPD** Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion

2. Activity

- **OCC** Administer the initial HRA to the high risk beneficiary within:
  1. 90 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **OCC** Administer the initial HRA to the low risk beneficiary within:
  1. 45 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **OC** Administer the annual HRA to the beneficiary
  1. 90 days of a beneficiary's enrollment
  2. Administer the annual HRA to the beneficiary
- **SPD** Administer the initial HRA to the high risk beneficiary within:
  1. 45 days of a beneficiary's eligibility
  2. Administer the annual HRA to the beneficiary

- **SPD**- Administer the initial HRA to the low risk beneficiary within:
    1. 90 days of a beneficiary's eligibility
    2. Administer the annual HRA to the beneficiary

3. Goals

- **OCC**-100% of eligible population improvement over 2016
- **OC**- 100% of eligible population
- **SPD**- 100% of eligible population

2201~~6~~7 Quality Improvement Work Plan- Case Management Owner: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			

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

II. Case Management

B. *Quality of Clinical Care-Continuity & Coordination of Medical/BH

Owners: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM; ~~Edwin Poon, Director, Behavioral Health Services (BHS)~~

Edwin Poon, Director, Behavioral Health Services (BHS)

The Approach

~~1. Objective~~

~~• Continuity and Coordination between Medical & Behavioral Health~~

~~2. Activity~~

~~• Monitor and identify opportunities to improve continuity & coordination of care across settings and/or transitions of care through ICT/ICP or other processes~~

~~3. Goals~~

~~• 85%~~

1. Objective

- Continuity and Coordination between Medical & Behavioral Health

2. Activity

- Monitor and identify opportunities to improve continuity & coordination of care across settings and/or transitions of care through ICT/ICP or other processes

3. Goals

- 100% participation in ICT for BHI
- 85% participation in ICT for MBHO
- 10% participation in ICT for individual providers
- 20% participation in ICT for county mental health

"Attachment A"

2016~~6~~7 Quality Improvement Work Plan- Case Management **Owners: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM; ~~,~~Edwin Poon, D~~irector~~tr, BHS**

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

II. Case Management

C. Patient Safety, Quality of Care Case Management- High ER utilization

Owner: Sloane Petrillo, Interim ~~Director~~Dtr, CM~~;~~

The Approach

1. Objective

- Evaluation and intervention for ongoing review of high ER utilizers

2. Activity

- Identify top 10 high ER utilizers for CCN per quarter (all lines of business)
- Open to case management with focused group of case managers
- Regular meetings to identify causes of high utilization and effective strategies
- for reduction in inappropriate ER utilization

3. Goals

- 5% reduction in ER visits among intervention cohort

~~C. *Quality of Clinical Care-Review of emergency department communications with PCPs~~

~~Owner: Tracy Hitzeman Director, CM~~

~~The Approach~~

~~1. Objective~~

- ~~Continuity and Coordination of Care reviewed and assessed~~

~~2. Activity~~

- ~~Assessment of medical records for communication from emergency department to primary care providers~~

~~3. Goals~~

- ~~85%~~

2016~~6~~7 Quality Improvement Work Plan- Case Management Owner: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

II. Case Management

D. Quality of Clinical Care-Review of member satisfaction with CM programs **Owner: Sloane Petrillo, Interim ~~Director~~Dtr, CM**

The Approach

1. Objective

- Annual review of member feedback on the case management programs to assure high satisfaction and improved health status

2. Activity

- Review annual satisfaction survey results, define areas for improvement and implement interventions to improve member experience with CM programs
- Revise methodology to increase sample size of responses

3. Goals

- Satisfaction with Case Management - 88%

~~**D. Patient Safety, Quality of Care Case Management- High ER utilization** **Owner: Tracy Hitzeman Director, CM; Novella Quesada, Manager, QI**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Evaluation and intervention for ongoing review of high ER utilizers~~

~~**2. Activity**~~

- ~~Ongoing monitoring of ER utilization; findings reported to Case Management for follow-up and/or further interventions~~

~~**3. Goals**~~

- ~~35%~~

~~E. Quality of Clinical Care-Review of member satisfaction with CM programs~~ ~~Owner: Tracy Hitzeman Director, CM~~

~~The Approach~~

~~1. Objective~~

- ~~Annual review of member feedback on the case management programs to assure high satisfaction and improved health status~~

~~2. Activity~~

- ~~Review annual satisfaction survey results, define areas for improvement and implement interventions to monitor and improve the member experience in CM programs~~

~~3. Goals~~

- ~~Satisfaction with Case Management - 85%~~

2016~~6~~7 Quality Improvement Work Plan- Case Management Owner: ~~Tracy Hitzeman, Director, CM; Novella Quesada, Manger QI~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

~~2016 Quality Improvement Work Plan- Case Management: Review of member satisfaction with CM programs~~
~~Owner: Tracy Hitzeman, Director, CM~~

~~Monitoring~~	~~Assessments, Findings, Monitoring of Previous Issues~~	~~Next Steps~~	~~Target Completion~~
~~Q1~~			
~~Q2~~			
~~Q3~~			
~~Q4~~			
~~Year End~~			
~~Outcomes~~	~~Results / Metrics~~	~~Next Steps~~	~~Target Completion~~
~~Q1~~			
~~Q2~~			
~~Q3~~			
~~Q4~~			
~~Year End~~			

II. Case Management

E. Quality of Adeherence to Complex Case Management NCQA Standards Owner: Sloane Petrillo, Interim ~~Director~~Dtr, CM

The Approach

1. Objective

- Improve adherence to NCQA standards for all Health Networks

2. Activity

- Monthly review of complex case files (5 or 5%)
- Monthly feedback provided to health networks

3. Goals

- All Health Networks will achieve an average score of 85% or greater on their monthly file reviews

~~F. Quality of Identification Of Complex Case Management Owner: Tracy Hitzeman, Director, CM~~

~~The Approach~~

~~1. Objective~~

- ~~Identify all members eligible for Complex Case Management~~

~~2. Activity~~

- ~~Health Networks are required to report members identified for Complex Case Management~~

~~3. Goals~~

- ~~Health Networks are identifying members eligible for Complex Case Management~~

201~~6~~7 Quality Improvement Work Plan- Case ~~Management~~ Management Owner: ~~Tracy Hitzemen~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			

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

III. Behavioral Health

~~**A. *Quality of Clinical Care: Integration of BH Services** **Owner: Dr. Donald Sharps, Medical Director, BHI**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Behavioral Health services, continuity & coordination of care and BH HEDIS measures will be monitored and measured~~

~~**2. Activity**~~

- ~~Monitor and identify opportunities to improve continuity & coordination of care across settings and/or transitions of care through ICT/ICP or other processes~~
- ~~Design and implement activities to improve HEDIS/ STARS measures relating to Behavioral Health~~

~~**3. Goals**~~

- ~~10% improvement over 2015~~

A. *Quality of Clinical Care: HEDIS Measures for M/C & OCC **Owner: Dr. Donald Sharps, Medical Director, BHI**

The Approach

1. Objective

- Behavioral Health HEDIS measures will be monitored and measured

2. Activity

- Design and implement activities to improve HEDIS measures relating to Behavioral Health

3. Goals

- At or above the 50th Percentile
-

20172~~2~~[01]~~6~~7 Quality Improvement Work Plan- Behavioral Health Owner: ~~Terrie Stanley, ED Clinical Operations~~Dr. Donald Sharps, Medical ~~Director~~Dtr, BHI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

III. Behavioral Health

B. *Quality of Clinical Care: Interdisciplinary Care Treatment Team Participation ~~——~~**Owner: Dr. Donald Sharps, Medical ~~Director~~Dtr, BH~~I~~**

~~— Medical Director, BH~~

~~T~~The Approach

1. **Objective**
   - BH Services, integration & coordination of care will be monitored and measured
2. **Activity**
   - Monitor and ~~i~~identify opportunities to improve integration and coordination of care across settings and~~-~~/or transitions of care through ICT/ICP
3. **Goals**
   - 10% Improvement over 2016

~~**B. *Quality of Care-Clinical BH Practice Guidelines adoption for Medi-Cal Line of business —— Owner: Dr. Donald Sharps, Medical Director, BH**~~

~~**The Approach**~~

1. ~~**Objective**~~
   - ~~BH Clinical Practice Guidelines will be reviewed and adopted~~
2. ~~**Activity**~~
   - ~~Adoption of Clinical Practice Guidelines, at least two (2) behavioral health will be reviewed and adopted~~
   - ~~Depression & Autism CPGs reviewed annually~~
3. ~~**Goals**~~
   - ~~100%~~

20167 Quality Improvement Work Plan- Behavioral Health Owner: DRr. Donald Sharps, Medical DirectorDtr, BHI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

III. Behavioral Health

~~C. *Quality of Service and Quality of Clinical Care-Review of Behavioral Health Providers communications with PCPs~~ ~~Owner: Dr. Donald Sharps, Medical Director, BH~~

~~The Approach~~

~~1. Objective~~
- ~~Continuity and Coordination of Care reviewed and assessed for medical care with behavioral health care~~

~~2. Activity~~
- ~~Assessment of medical records for communication between primary care providers and behavioral health providers~~

~~3. Goals~~
- ~~85%~~

C. *Quality of Care- Clinical Behavioral Health Practice Guidelines Owner: Dr. Donald Sharps, Medical D~~irec~~tor, BHI

The Approach

1. Objective
- BH Clinical Practice Guidelines will be reviewed and adopted

2. Activity
- Adoption of Clinical Practice Guidelines, at least two (2) behavioral health guidelines will be reviewed and adopted

3. Goals
- 100%

2016~~6~~7 Quality Improvement Work Plan- Behavioral Health Owner: Dr. Donald Sharps, Medical D~~irect~~or, BH~~I~~

Monitoring	~~N~~ Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			

Q4			
Year End			

III. Behavioral Health

D. *Access and Coordination of Care ~~(NEW)~~ Owner: Dr. Donald Sharps, Medical D~~irec~~tor, BHI

The Approach

1. Objective

- Appropriate, timely, and effective access for BB~~B~~ehavioral ~~H~~HHealth services in LTC/SNF facilities
- Explore opportunities for coordination of care with PCPs

2. Activity

- Identify and survey existing LTC/SNF facilities,
- conduct analysis~~; and~~
- P~~p~~ropose interventions to address barriers to access Behavioral Health services

3. Goals

- Maintain amount of encounters from previous MBHO
- Establish gap analysis and needs for Behavioral Health support to PCPs
- Establish gap analysis and needs for Behavioral Health in LTC
- Develop uniform process for accessing Behavioral Health in LTC

2017 Quality Improvement Work Plan–Behavioral Health Owner: Dr. Donald Sharps, Medical Director, BHI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			

Q4			
Year End			

IV. LTSS

A. Safety of Clinical Care and Quality of Clinical Care- Review and assess LTSS placement for members participating with each organization/program

Owner: ~~Suzanne Harvey~~Marie ~~Earvoline~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, ~~Clinical~~ CO~~Operations~~

~~Clinical Operations~~

The Approach

1. **Objective**
   - Member review of Hospital Admissions (for each organization/program)

2. **Activity**
   - Measure those members participating in each program for hospital admissions~~:~~
     1. CBAS
     2. IHSS
     3. LTC
     4. MSSP

3. **Goals**
   - ~~2% CBAS;~~ Establishing goals in 2016 for IHSS, LTC & MSSP

2016~~7~~ Quality Improvement Work Plan- LTSS Owner: ~~Suzanne Harvey~~Marie ~~Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical O~~perations

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

B. *Safety of Clinical Care and Quality of Clinical Care- Review and assess emergency department visits for LTSS members participating with each organization/program

Owner: ~~Suzanne Harvey~~Marie Earvolino Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical~~O ~~Operations~~ ~~Operations~~

The Approach

1. **Objective**
   - Member review of Emergency Department Visits (for each organization/program)

2. **Activity**
   - Measure those members participating in each program for hospital admissions~~:~~
     1. CBAS
     2. IHSS
     3. LTC
     4. MSSP

3. **Goals**
   - 9% CBAS~~;~~
   - R~~Establishing goals in~~Review 2016 data to establish goals for IHSS, LTC, MSSP
   - Monitor progress towards goals quarterly

2016~~7~~ Quality Improvement Work Plan- LTSS Owner: ~~Suzanne Harvey~~~~Marie Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical~~ Operations

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

C. *Safety of Clinical Care and Quality of Clinical Care-Review and assess readmissions for LTSS members participating with each organization/program

Owner: ~~Suzanne Harvey~~Marie ~~Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, CO ~~Clinical Operations~~ ~~Operations~~

The Approach

1. **Objective**
   - Members reviewed for Hospital Readmissions (for each organization/program)

2. **Activity**
   - ~~-~~Measure and assess readmissions within 30 days for members ~~-~~in each
   - ~~-~~program to drive interventions to minimize hospital readmissions~~:~~
     1. CBAS
     2. IHSS
     3. LTC
     4. MSSP

3. **Goals**
   - 2.5% CBAS~~;~~
   - Review 2016 data to establish goals for IHSS, LTC, MSSP
   - ~~Establishing goals in 2016 for IHSS, LTC, MSSP~~

2016~~6~~7 Quality Improvement Work Plan- LTSS **Owner: ~~Suzanne Harvey~~Marie ~~Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical O~~perations**

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

D. *Safety of Clinical Care and Quality of Clinical Care-Review and assess readmissions for LTSS members participating with each organization/program

Owner: ~~Marie Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSSED~~, CO~~Clinical Operations~~

~~Clinical Operations~~

The Approach

1. Objective

- Members reviewed for Long Term Care Admissions (LTC) (for each organization/program)

2. Activity

- Measure and assess admissions to LTC ~~ong Term Care~~ for members in each program to drive interventions to minimize hospital readmissions~~:~~
  1. CBAS
  2. IHSS
  3. MSSP

3. Goals

- 2% CBAS
- ~~; Establishing goals in~~Review data from 2016 and establish goals for ~~for~~ IHSS, LTC, MSSP

2017 Quality Improvement Work Plan- LTSS Owner: ~~Marie Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical O~~perations~~

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

D. Quality of Clinical Care-review of Health Risk Assessment (HRA) for OneCare Connect (OCC) Long Term Care (LTC) members

Owner: Suzanne HarveyMarie Earvolino, Interim Director, LTSS

The Approach

1. **Objective**
   - Health risk assessment for members in the OCC line of business monitored for completeness

2. **Activity**
   - HRA to comprehensively assess each newly enrolled OCC LTC member's current health risk.
   - Completion of an HRA process must be performed within 90 calendar days of enrollment for those identified by the risk stratification mechanism as lower risk who are residing in LTC facilities

3. **Goals**
   - 100%

~~2016~~7 Quality Improvement Work Plan- LTSS ~~Owner: Suzanne Harvey~~Marie Earvolino, ~~Interim~~ ~~Director, LTSS~~

	~~Assessments, Findings, Monitoring of Previous Issues~~	~~Next Steps~~	
	~~Results / Metrics~~	~~Next Steps~~	

IV. LTSS

~~E.~~ CBAS Member Satisfaction

Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director, QI~~I~~

~~E.~~

The Approach

1. **Objective**
   - **Monitor and/or improve member satisfaction in CBAS/LTSS**
2. **Activity**
   - **Measur**e, assess and identify areas for improvement and implement
   - interventions to assure high member satisfaction
3. **Goals**
   - ~~-~~5% Improvement over previous year

2016~~6~~7 Quality Improvement Work Plan- LTSS Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Di~~rec~~tor, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

A. SNF Member Satisfaction

Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director~~or~~, QI

The Approach

1. **Objective**
   - Monitor and/or improve member satisfaction in SNF
2. **Activity**
   - Measure~~s~~, assess and identify areas for improvement and implement interventions
   - to assure high member satisfaction
3. **Goals**
   - 5% Improvement over previous year

2016~~6~~7 Quality Improvement Work Plan- LTS S Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~D~~irect~~or, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

~~A. *Quality of Care-All new members will complete the Initial Health Assessment and related IHEBA/SHAs~~ ~~Owner: Pshyra Jones, Director, Health ED and DM~~

~~The Approach~~

~~1. Objective~~
- ~~To assure all new members are connected with a PCP and their health risks are assessed~~

~~2. Activity~~
- ~~IHA/IHEBA [Staying Healthy Assessment(SHA)] will be completed with 120 days of enrollment~~
- ~~Reports will be available for Health Networks on IHA/SHA completion~~
- ~~Facility Site Reviews will review sample of medical records for compliance with completing appropriate age level IHA/SHA~~
- ~~If use of alcohol or drugs, the member will have an SBIRT documented (Screening, Brief intervention, and Referral to Treatment)~~

~~3. Goals~~
- ~~Improve plan performance over 2015 by 10%~~

A. *Quality of Care-All new members will complete the Initial Health Assessment and related IHEBA/SHAs

Owner: Pshyra Jones, Director, Health ~~E~~Education & ~~and~~ Disease Management

The Approach

1. Objective
- To assure all new members are connected with a PCP and their health risks are assessed

2. Activity
- IHA/IHEBA [Staying Healthy Assessment(SHA)] will be completed

- within 120 days of enrollment
- Reports will be available for Health Networks on IHA/SHA completion
- Facility Site Reviews will review a sample of medical records for compliance with completing appropriate age level IHA/SHA
- If use of alcohol or drugs, the member will have an SBIRT documented (Screening, Brief Intervention, and Referral to Treatment)

3. Goals

- Improve plan performance over 2016 by 10%

2016~~6~~7 Quality Improvement Work Plan- ~~Health Education & Disease Management~~HE & DM _Owner: Pshyra Jones, D~~irect~~or, H~~ealth~~ Ed~~d~~D & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

~~**B. Quality of Clinical Care, review of Disease Management Program (Asthma) Owner: Pshyra, Jones, Director, Health Ed and DM**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Disease Management activity reviewed to assess clinical care delivered to members with Asthma~~

~~**2. Activity**~~

- ~~Increase Asthma Medication Ratio (AMR) rates for members with persistent asthma in our Asthma DM program~~
- ~~Incorporate HEDIS improvement for Asthma into DM program interventions~~
- ~~Evaluate more technology based interventions into DM programs~~
- ~~Assure DM programs are implemented across all populations~~
- ~~Conduct annual member satisfaction of DM programs~~
- ~~Evaluate the overall effectiveness of the Asthma Program Participation Member Rates, ED, IP and RX related utilization~~

~~**3. Goals**~~

- ~~Increase to 50th percentile for members between 5-18 yrs old~~

B. Quality of Clinical Care, Rreview of Disease Management Programs Owner: Pshyra, Jones, ~~Director, Health Ed & and DM~~Dtr, HE & DM

The Approach

1. Objective

- Disease Management activity reviewed to assess clinical care delivered to members with Asthma, ~~Diabetes,~~Diabetes and Heart Failure

2. Activity

- Incorporate HEDIS improvement into DM program interventions
- Assure DM programs are implemented across all populations

- Conduct annual member satisfaction of DM programs
- Evaluate the overall effectiveness of the Program-Participation Member Rates, ED, IP and RX related utilization

3. Goals

Medi-Cal

- Increase to 75th percentile for Asthma Medication Ratio (AMR) Ages 5-11
- Increase to 75th percentile for Medication Management for People with Asthma (MMA), ages 5-85
- Increase to 50th percentile for HbA1c Testing
- Increase to 90th percentile for HbA1c Poor Control
- Increase to 75th percentile for Eye Exams
- Increase to 50th percentile for Annual Monitoring for Patients on Persistent Medications (MPM) Ace Inhibitors or ARBSs - Increase to 50th percentile for HbA1c Testing - Medicare
- Increase to 50th percentile for Controlling High Blood Pressure (CBPC) - Medicare
- 85% satisfaction with DM Programs

2016~~7~~ Quality Improvement Work Plan- ~~Health Education & Disease Management~~HE & DM _____-Owner: Pshyra Jones, ~~Dir~~Dtr~~.ector~~ H~~ealth~~ E~~d~~ & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

~~**C. Quality of Clinical Care-Review of Disease Management Program (Diabetes)** **Owner: Pshyra Jones, Director, Health Ed and DM**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Disease Management activity reviewed to assess clinical care delivered to members with Diabetes~~

~~**2. Activity**~~

- ~~A1C Control for members with existing A1C>9 and receiving Health Coach interventions in 2016~~
- ~~Incorporate HEDIS improvement for CDC into DM program interventions~~
- ~~Evaluate more technology-based interventions into DM programs~~
- ~~Assure DM programs are implemented across all populations~~
- ~~Conduct annual member satisfaction of DM programs~~
- ~~Evaluate the overall effectiveness of the Diabetes Program-Member Participation rates, ED, IP, and RX related utilization~~

~~**3. Goals**~~

- ~~Maintain 90th percentile for Medi-Cal; increase to 75th percentile for Medicare~~

C. *Quality of Care-Clinical Practice Guidelines adoption for Medi-Cal line of business **Owner: Pshyra Jones, D~~irector~~tr, HE & DM**

~~**Health Ed & DM**~~

The Approach

1. Objective

- Clinical Practice Guidelines will be reviewed and adopted

2. Activity

- Adoption of Clinical Practice Guidelines, as least three (3) will be

- reviewed and adopted (linked to DM: Diabetes, Asthma, CHF)

3. Goals

- 100%

"Attachment A"

2016~~6~~7 Quality Improvement Work Plan- ~~Health Education & Disease Management~~ HE & DM ~~—~~Owner: Pshyra Jones, D~~irect~~or H~~ealth E~~d & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

~~**D. Quality of Clinical Care-Review of Disease Management Program (CHF)** **Owner: Pshyra Jones, Director, Health ED and DM**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Disease Management activity reviewed to assess clinical care delivered to members with CHF~~

~~**2. Activity**~~

- ~~Establish baseline for unplanned readmissions with an admitting diagnosis of heart failure for members in the Heart Failure DM program~~
- ~~Incorporate HEDIS improvement for CHF into DM program interventions~~
- ~~Evaluate more technology based interventions into DM programs~~
- ~~Assure DM programs are implemented across all populations~~
- ~~Evaluate the overall effectiveness of the CHF Program Member Participation Rates, ED, IP and RX related utilization~~

~~**3. Goals**~~

- ~~CHF - Establish baseline for unplanned readmissions with an admitting diagnosis of heart failure for members in the Heart Failure DM Program~~
- ~~Satisfactions with DM - 90%~~

D. Quality of Clinical Care-Review of Cardiovascular Disease **Owner: Pshyra Jones, D~~irect~~or, H~~ealth Ed~~ &~~and~~ DM**

The Approach

1. Objective

- CCIP Chronic Care Improvement Projects

2. Activity

- CCIP-CMS m~~M~~andatory topic New Goal

Achieve high BP control or improvement among 50% of the members

actively opting into health coaching OneCare
- Achieve high BP control or improvement among 50% of OC members and receiving health coaching interventions
- Achieve high BP medication adherence or improvement for 50% of OC members as identified through PBM date and receiving health coaching interventions through OneCare Connect.
- Reduced unplanned readmissions by 1% below the national readmission rates for OCC members with admitting diagnosis specific to heart failure
- Achieve high BP medication adherence for 50% of members opt-ing into health coaching identified through PBM data

3. Goals

- As determined by CMS

2016~~6~~7 Quality Improvement Work Plan- ~~Health Education & Disease Management~~ ManagementHE & DM
Owner: Pshyra Jones, D~~irec~~tor H~~ealth~~ E~~d~~ & ~~____~~ DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			

Q4			
Year End			

V. Health Education & Disease Management

E. Implementation of Population Health & Wellness Programs **Owner: Pshyra Jones, Director, Health EdD &and DM**

The Approach

1. Objective

- Expand child and adolescent components for the Shape Your Life/Weight Management Program
- Implement Weight Watchers benefit for Shape Your Life CalOptima Medi-Cal members age 15 years or greater
- Design and implement a comprehensive Perinatal Health Program

2. Activity

- Establish program goals, objectives and interventions
- Develop clinical and operational components to expand the reach and capability
- Identify program resources and vendor support (Provider, Health EdD/RD linkages, Community Based Organizations)
- Implementation of revised program design

3. Goals

- Implement revised program design-2017
- Evaluate progress semi-annually

~~**E. *Quality of Care-Clinical Practice Guidelines adoption for Medi-Cal line of business** **Owner: Pshyra Jones, Director Health Ed & DM**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Clinical Practice Guidelines will be reviewed and adopted~~

~~**2. Activity**~~

- ~~Adoption of Clinical Practice Guidelines, as least three (3) will be reviewed and adopted (linked to DM: Diabetes, Asthma, CHF)~~

~~**3. Goals**~~

- ~~100%~~

2016~~7~~ Quality Improvement Work Plan- ~~HE & DM~~~~Health Education & Disease Management~~ Owner: Pshyra Jones, D~~irect~~~~o~~r H~~ealth~~ E~~d~~ & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

F. Quality of Clinical Care-Review of member satisfaction with DM programs Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Annual review of member feedback on the disease management programs to assure high satisfaction and improved health status

2. Activity

- Review annual satisfaction survey results, define areas for improvement and implement interventions to monitor and improve the member experience in DM programs
- Transition manual satisfaction survey to alternate process to gather ongoing feedback

3. Goals

- 90% satisfaction with the DM program

2016 Quality Improvement Work Plan- Health Education & Disease Management Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

~~V. Health Education & Disease Management~~

~~G. Quality of Clinical Care-Review of Cardiovascular Disease~~ ~~Owner: Pshyra Jones, Director, Health Ed and DM~~

~~The Approach~~

~~1. Objective~~

- ~~CCIP Chronic Care Improvement Projects~~

~~2. Activity~~

- ~~CCIP-CMS Mandatory topic New Goal~~
- ~~Achieve high BP control or improvement among 50% of the members actively opting into health coaching OneCare~~
- ~~Achieve high BP control or improvement among 50% of OC members and receiving health coaching interventions~~
- ~~Achieve high BP medication adherence or improvement for 50% of OC members as identified through PBM date and receiving health coaching interventions OneCare Connect~~
- ~~Reduced unplanned readmissions by 1% below the national readmission rates for OCC members with admitting diagnosis specific to heart failure~~
- ~~Achieve high BP medication adherence for 50% of members opt ing into health coaching identified through PBM data~~

~~3. Goals~~

- ~~As determined by CMS~~

2016 Quality Improvement Work Plan- Health Education & Disease Management Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

~~**H. Quality of Clinical Care-Review of Diabetes and All Cause Readmissions** **Owner: Kelly Rex-Kimmet, Director, QA PIPS**~~

~~**The Approach**~~

~~**1. Objective**~~
- ~~PIP Performance Improvement Projects~~

~~**2. Activity**~~
- ~~PIP-DHCS Mandatory Projects-Readmission & Diabetes~~

~~**3. Goals**~~
- ~~As determined by CMS& DHCS~~

H. Quality of Clinical Care – Quality and Performance Improvement Projects **Owner: Kelly Rex-Kimmet, Director, Quality Analytics, ~~PIPS~~Pshyra Jones, Dtr, HE & DM**

The Approach

1. Objective
- Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs)

2. Activity
- QIPs
  - OneCare Diabetes QIP to Improve HbA1c Testing
  - OneCare Connect QIP to Improve 30-day Readmission Rate
- PIPs
  - Medi-Cal Diabetes PIP to Improve HbA1c Testing
  - Medi-Cal PIP to Improve Initial Health Assessments
  - OneCare Connect LTSS PIP to Improve In-Home Support Services Care Coordination

3. Goals

- HbA1c Testing rate at the 50th percentile based on the 2016~~5~~ NCQA Quality Compass
- 16.8% readmissions rate
- 80% HbA1c Testing
- 25% IHA rate
- 35% IHSS Participation rate

2016~~7~~ Quality Improvement Work Plan- ~~Health Education & Disease Management~~HE & DM Owner~~s~~: Kelly Rex-Kimmet, D~~irect~~t~~o~~r, QA~~;~~

Pshyra Jones, Dtr, HE & DM ~~PIPS~~

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

I. Implementation of the Childhood Obesity (Shape your Life) Program — Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Evaluate, identify and develop clinical and operational content for revisions to existing Childhood Obesity Prevention and Treatment Program (COPTP), and develop network of providers to support program for 2016 and beyond

2. Activity

- Evaluate existing COPTP program goals, objectives and interventions
- Develop clinical and operational components to revise existing program design to expand the reach and capability
- Identify program resources and vendor support (Provider, Health ED/RD linkages)
- Implementation of revised program design

3. Goals

- Implement revised program design-2017
- Evaluate progress semi-annually

2016 Quality Improvement Work Plan- Health Education & Disease Management Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

J. Implement Weight Watchers (WW) for Medi-Cal members — Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Design weight Watchers benefit for CalOptima Medi-Cal members age 15yrs or greater

2. Activity

- Obtain MOU and finalize contract between WW and CalOptima organization
- Establish criteria and program goals for participating CalOptima members
- Identify appropriate regulatory approvals for member materials and program incentives

3. Goals

- Implement revised program design 2017
- Evaluate progress semi-annually

2016 Quality Improvement Work Plan- Health Education & Disease Management Owner: Pshyra Jones. Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

K. Implement Home Assessments for member participating in Care Management Programs

Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Design a face to face assessment and coaching option for high risk members with chronic conditions participating in CalOptima Care management programs

2. Activity

- Obtain MOU and contracts with appropriate vendors (TBD)
- Establish criteria and program goals for participating CalOptima members
- Identify appropriate regulatory approvals for member materials and program incentives

3. Goals

- Implement revised program design-2016
- Evaluate progress semi-annually

2016 Quality Improvement Work Plan- Health Education & Disease Management Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

L. Conduct 2016 Group Needs assessment (GNA) — Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- The GNA supports identification of health risks, beliefs, practices, and cultural and linguistic needs for CalOptima's Medi-Cal membership

2. Activity

- Complete Request for Proposal
- Identify eligible CalOptima survey participants based on methodology required by Department of Healthcare Services (DHCS)
- Mail assessment tool available in all 7 threshold languages
- Submit Executive Summary and supporting reports to DHCS by October, 2016

3. Goals

- Complete GNA requirement for 2016

2016 Quality Improvement Work Plan- Health Education & Disease Management Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VI. Access & Availability

A. *Quality of Service and Quality of Clinical Care- Review of Nnotification to mMembers Owners: Laura Grigoruk, Director Provider Relations; Belinda Abeyta

~~A.~~ The Approach Director, Customer Service ~~Dir. Provider Relations~~

~~Belinda Abeyta, Director, Customer Service~~

~~The Approach~~

1. **Objective**
   - Continuity and Ccoordination of Care reviewed and assessed

2. **Activity**
   - Communication to members when a primary care provider is terminated from the network will be assessed. Standard is 30 d days notice. (CCN & HN /Delegation reports)
   - Exception: CalOptima is notified in less than 30 days of termination n, then notification would be within three business days.

3. **Goals**
   - 85%

2016~~6~~7 Quality Improvement Work Plan- Access & Availability
Owner~~s~~: Laura Grigoruk, D~~irect~~o~~r~~, P~~rovider R~~elations~~;~~
~~s &~~ Belinda Abeyta, D~~irect~~o~~r~~, C~~ustomer S~~ervice~~

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VI. Access & Availability

B. *Access to Care: Credentialing of Pprovider ~~n~~Network is ~~m~~Monitored — Owner: Esther Okajima, Di~~rect~~or, QI

The Approach

1. **Objective**
   - Credentialing program activities monitored for volume and timeliness
2. **Activity**
   - New applicants processed within 180 calendar days of receipt of application
   - Report of initial credentialing file activity to CPRC
3. **Goals**
   - 90~~% of~~% of initial credentialing applications are processed within 120 days of receipt of application~~.~~

~~**B. *Access to Care: Credentialing of provider network is monitored — Owner: Novella Quesada, Manager, QI**~~

~~**The Approach**~~

~~1. **Objective**~~
   - ~~Credentialing program activities monitored for timeliness~~

~~2. **Activity**~~
   - ~~New applicants processed within 180 calendar days of receipt of application~~
   - ~~**Report from CPRC~~

~~3. **Goals**~~
   - ~~100%~~

C. Access to Care-Recredentialing of Pprovider N~~n~~etwork is M~~m~~onitored — Owner: Esther Okajima, Di~~rect~~or, QI

The Approach

1. **Objective**
   - Recredentialing of practitioners is completed timely

2. **Activity**
   - Recredentialing is processed everywith 36 months
   - Report of Admin term due to missed recredentialing cycle
   -
   - Report of re-credentialing activity to CPRC

3. **Goals**
   - 100% of all recredentialing files are processed within 36 months of last credentialing date.

~~**C. Access to Care-Recredentialing of provider network is monitored**~~

~~**The Approach**~~

1. ~~**Objective**~~
   - ~~Recredentialing of practitioners is completed timely~~

2. ~~**Activity**~~
   - ~~Recredentialing is processed with 36 month report of Admin term due to missed recredentialing cycle~~
   - ~~Report of # of providers termed due to move, retired, etc~~
   - ~~Quarterly Access & Availability report~~
   - ~~**Report from CPRC~~

3. ~~**Goals**~~
   - ~~100%~~

2016~~6~~7 Quality Improvement Work Plan- Access & Availability Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VI. Access and Availability

~~**D. *Accessibility: Review of access to care** **Owner: Esther Okajima, Manager, QA**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Practitioner accessibility (medical services in a timely manner) is measured, assessed and adjusted as necessary to standard~~

~~**2. Activity**~~

- ~~Data against goals will be measured and analyzed for the following through the implementation of our annual Timely Access study and Customer Service monitoring of wait time~~
  ~~1. Non-urgent primary care appointments within 10 business days~~
  ~~2. Urgent appointments with prior authorization with 96 hours of request~~
  ~~3. Non-urgent primary care appointments within 10 business days~~
  ~~4. Appointment with specialist within 15 business days~~
  ~~5. First pre-natal visit within 10 business days~~
  ~~6. Member services, by telephone ASA 30 seconds with abandonment rate <5%~~

- ~~Health Networks will be issued Corrective Action Plans for their areas of non-compliance~~
  ~~1. Urgent Care appointments with 48 hours of request~~
  ~~2. Appointments with specialist within 15 business days~~
  ~~3. Member services, by telephone ASA 30 seconds with abandonment rate <5%~~
  ~~4. Non-urgent acute care within 3 days of request~~

~~**3. Goals**~~

- ~~Appt.: 90%~~
- ~~Phone: <5%~~

D. *Accessibility: Review of access to care **Owner: Marsha Choo, Manager, QA**

The Approach

1. Objective

- Practitioner accessibility (medical services in a timely manner) is measured, assessed and adjusted as necessary to standard

2. Activity

- Data against goals will be measured and analyzed for the following through the implementation of our annual Timely Access study and Customer Service monitoring of wait time
  1. Urgent care appointments without prior authorization within 48 hours of request
  2. Urgent appointments with prior authorization with 96 hours of request
  3. Non-urgent primary care appointments within 10 business days of request
  4. Appointment with specialist within 15 business days of request
  5. Non-urgent mental health appointment within 10 business days of request
  6. Non-urgent appointment for ancillary services within 15 business days of request
  7. First pre-natal visit within 10 business days
  8. Member services, by telephone ASA 30 seconds with abandonment rate <5%

- Health Networks will be issued Corrective Action Plans in accordance with CalOptima's Access and Availability Policies: GG.1600 and MA.7007

3. Goals

- Appointment: 90% minimum performance level
- Phone: ASA 30 seconds; Abandonment rate <5%

2016~~6~~7 Quality Improvement Work Plan- Access & Availability Owner: ~~Esther Okajima~~Marsha Choo, M~~ana~~g~~e~~r, QA

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VI. Access and Availability

E. *Availability: Review of Availability of Practitioners

Owner: Esther Okajima, Manager, QA; Dr. Donald Sharps, Medical Director, BH

The Approach

1. Objective

- Practitioner availability (geographic distribution) in measured assessed and adjusted to meet standard
- Practitioner availability (cultural, ethnic, racial and linguistic member needs) is measured, assessed and adjusted as necessary to standard
- Availability of practitioners is measured and assessed to Behavioral Health services
- Availability of practitioners is measured and assessed by geographic distribution specific to Behavioral health
- Practitioner availability (practitioner to member ratio) is measured, assessed and adjusted to meet standard

2. Activity

- Practitioner network to determine how the network is meeting the needs and preferences of he plans membership will be measured and analyzed and adjusted as necessary. Each type of PCP and high volume specialist' geographic distribution performance will be measured against set standards
  1. Members within ten (10) miles or thirty (30) minutes of a practitioner
  2. Member within thirty (30) miles or forty0five (45) minutes of a high volume specialist

- Practitioner network on the cultural, ethnic, racial and linguistic needs of membership will be measured and analyzed
- Analyses performance against established quantifiable standards for the number of each type of high volume BH practitioners
- Measure and analyze BH practitioner network to determine how the network is meeting the needs and preferences of the plans membership and adjusts as necessary.
- Measured through quantifiable and measurable standards for each type of BH practitioner by geographic distribution performance against standards
- Member within thirty (30) miles or forty five (45) minutes of a high volume specialist

- Availability of practitioners against goals will be measured and analyzed and adjusted as necessary
  1. Practitioner to Member
  2. Ratio of PCP to Members
  3. Ratio Specialists to Members (Neurology 1:10,000)

~~3. Goals~~

- ~~1:2,000~~
- ~~1:2,000~~
- ~~1:5,000~~
- ~~95%~~
- ~~90%~~
- ~~1:100~~
- ~~100%~~

E. *Availability: Review of Availability of Practitioners

Owners: Marsha Choo, Manager, QA; Dr. Donald Sharps, Medical Director, BHI

The Approach

1. Objective

- Practitioner availability (practitioner to member ratio) is measured, assessed and adjusted to meet standard
- Practitioner availability (cultural, ethnic, racial and linguistic member needs) is measured, assessed and adjusted as necessary to standard
- Practitioner availability (geographic distribution) isn measured, assessed and adjusted to meet standard
- Availability of practitioners is measured and assessed to Behavioral Health services
- Availability of practitioners is measured and assessed by geographic distribution specific to Behavioral health

2. Activity

- Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software
  1. Practitioner network by practitioner type (i.e., PCP, high volume specialists, high impact specialists, ancillary providers, health delivery organizations, ~~etc~~etc.)~~.~~ will be measured for minimum number of providers against goals, assessed and adjusted as necessary
  2. Practitioner network on the cultural, ethnic, racial and linguistic needs of membership minimum number of providers will be measured against goals, assessed and adjusted as necessary~~.~~
  3. Practitioner network by practitioner type (i.e., PCP, high volume specialists, high impact specialists, ancillary providers, health delivery organizations, ~~etc~~etc.)~~.~~ will be measured for geographic distribution performance against set standards

4. Practitioner network by BH practitioner type (i.e., psychiatrist, psychologist, marriage and family therapist and licensed clinical social worker, ~~etc~~etc.)~~.~~ will be measured for minimum number of providers against goals, assessed and adjusted as necessary
5. Practitioner network by BH practitioner type (i.e., psychiatrist, psychologist, marriage and family therapist and licensed clinical social worker, ~~etc~~etc.)~~.~~ will be measured for geographic distribution performance against set standards

3. Activity (cont.)

- Health Networks will be issued Corrective Action Plans in accordance with CalOptima's Access and Availability Policies: GG.1600 and MA.7007

4. Goals

- Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007

2016~~6~~7 Quality Improvement Work Plan- Access & Availability Owners: ~~Esther Okajima~~Marsha Choo, Manager, QA;

Donald Sharps, MD, Medical Di~~rec~~tor, BHI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

A. *Safety of Clinical Care-Providers shall have timely and complete facility site reviews — **Owner: Esther Okajima, Director, QI**

The Approach

1. Objective

- To assure all new and re-credentialed providers are compliant with FSR/MRR/PAR requirements

2. Activity

- Facility Site Reviews (FSR), Medical Record Reviews (MRR) and Physical Accessibility Review Surveys (PARS) are completed as part of initial and re-credentialing cycles
- Report of FSR/MRR/PARS activity to CPRC

3. Goals

- 100% of FSR/MRR/PARS Initial or Full Scope Surveys are completed within initial and re-credentialing timeframes.

~~**A. *Safety of Clinical Care-Providers shall have timely and complete facility site reviews** — **Owner: Novella Quesada, Manager, QI**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~To assure all new and recredentialed providers are compliant with FSR/MRR/PAR requirements~~

~~**2. Activity**~~

- ~~Facility Site Reviews (FSR), Medical Record reviews (MRR) and Physical Accessibility Reviews (PARs) are completed as part of initial & recredentialing cycles~~

~~**3. Goals**~~

- ~~80%~~

2016~~6~~7 Quality Improvement Work Plan- Patient Safety Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~D~~irect~~or, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

~~**B. Safety of Clinical care-review and follow-up on member's potential Quality of Care complaints Owner: Novella Quesada Manager, QI**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~To assure all PQI's are evaluated for severity and investigated in a timely fashion (90 days)~~

~~**2. Activity**~~

- ~~QI Nurse Specialists and Med Directors review cases….reported to CPRC~~
- ~~Report to CPRC~~
- ~~Report PQI Productivity activity Report~~
- ~~Discuss PQIs with a severity code of 3 and 4~~

~~**3. Goals**~~

- ~~80%~~

B. Timeliness of Clinical Care R~~care r~~eview and F~~f~~ollow-up on Potential Quality of Care Issues Owner: Esther Okajima, D~~irec~~t~~o~~r, QI

The Approach

1. Objective

To assure patient safety and enhance patient experience by timeliness of clinical care reviews~~.~~

2. Activity

- QI Nurse Specialists and Medical Directors review cases and provide determination~~.~~
- Report all case results to CPRC for discussion~~,~~
- ~~any~~Present cases that have a severity rating of ~~-~~ 1 ~~exceed the threshold level of 1~~ (one) or higher will be presented to CPRC for action~~.~~

Follow through on Medical Director determination, when applicable, to ensure

- closure and compliance of all cases
- Conduct a PQI trend analysis at least two times a year ~~of all cases.~~

~~Conduct a PQI trend analysis at least two times/year~~

3. Goals

- ~~To achieve~~Achieve a turnaround time of 90 days on 90% of cases received
- Review data for trends and~~&~~ patterns for potential further actions~~.~~

2016~~6~~7 Quality Improvement Work Plan- Patient Safety_____ Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~D~~irect~~or, QI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

~~C. *Safety of Clinical Care and Quality of Clinical Care reviewed through Pharmacy Management~~ ~~Owner: Kris Gericke,PharmD, Director, Pharmacy Management~~

~~The Approach~~

~~1. Objective~~
- ~~To promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima Members.~~

~~2. Activity~~
- ~~Review and update the CalOptima Plan Formularies on an ongoing basis in order to ensure access to quality pharmaceutical care which is consistent with the program's scope of benefits~~
- ~~Review anticipated and actual utilization trends including specialty medications~~
- ~~Review and evaluate pharmacy related issues related to delivery of health care to CalOptima's members~~
- ~~Report on medication recalls and process for informing members and providers~~
- ~~Report on Underutilization of Asthmatics not receiving long term controllers, Diabetics not receiving statins, Diabetics with Hypertension not receiving ACE/ARB~~
- ~~Overutilization/PolyPharmacy-Report on interventions for preventing opiod overuse to include Pharmacy home, Monthly RX limit, Opiod overutilization (MED over 120mg.)~~

~~3. Goals~~
- ~~100%~~

C. *Safety of Clinical Care and Quality of Clinical Care reviewed through Pharmacy Management **Owner: Kris Gericke, Pharm.D., Director, Pharmacy Management**

The Approach

1. Objective
- To promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima Members~~.~~

2. Activity

Monitor for underutilization of pharmaceuticals and provide education to providers.
- Underutilization of long-term controllers for members diagnosed with asthma.
- Underutilization of osteoporosis therapies for members receiving corticosteroids.
- Underutilization of calcium for members with a diagnosis of osteoporosis.
- Underutilization of statins for members with diabetes.

- Programs to prevent overutilization include:
  - Monthly prescription limit.
  - Pharmacy Home Pprogram.
  - Prescriber Restriction Pprogram.
  - Opioid overutilization monitoring.

3. Goals

- Reductions in underutilization and overutilization measures

2016~~6~~7 Quality Improvement Work Plan- Patient Safety_____ _____Owner: Kris Gericke, Pharm.D., D~~irect~~ir, Pharm~~ana~~acy M~~anag~~anag~~emen~~emnt

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

D. *Safety of Clinical Care and Quality of Clinical Care- Review of Specialty Drug Utilization — **Owner: Kris Gericke,PharmD, Director, Pharmacy Services**

The Approach

1. Objective

- Provide ongoing monitoring of specialty drug trends

2. Activity

- Review and reporting of Specialty Drug trends, identify any actions necessary with the member or provider/HN

3. Goals

- TBD

~~2016 Quality Improvement Work Plan- Patient Safety Owner: Kris Gericke, Director, Pharmacy Services~~

~~Monitoring~~	~~Assessments, Findings, Monitoring of Previously Identified Issues~~	~~Next Steps~~	~~Target Completion~~
~~Q1~~			
~~Q2~~			
~~Q3~~			
~~Q4~~			
~~Year End~~			
~~Outcomes~~	~~Results / Metrics~~	~~Next Steps~~	~~Target Completion~~
~~Q1~~			
~~Q2~~			
~~Q3~~			
~~Q4~~			
~~Year End~~			

VII. Patient Safety

D. *Patient Safety-Review and assessment of CBAS Quality Monitoring

Owner: Esther Okajima, Director, QI

The Approach

1. Objective

- Review of CBAS Quality monitoring of services provided

2. Activity

- CBAS Quality Assurance - continue to assess compliance of contracted CBAS centers.
- Report to LTSS QI SubcommitteeC
- Report Member Satisfaction Survey Results
- Report CDA audit results in comparison to past results

3. Goals

- 100% CDA Audit Results

E. Patient Safety-Review and Aassessment of SNF Quality Monitoring

Owner: Esther Okajima, Director, QI

The Approach

1. Objective

- Review of SNF Quality monitoring of services provided

2. Activity

- SNF Quality Assurance - continue to assess compliance of contracted SNF centers.
- Report to LTSS QIC
- Report on progress of on-siresite visits and CAPs issued
- Report on Member Satisfaction Survey Results

3. Goals

- 100% DHCS Audit results

~~E. *Patient Safety-Review and assessment of CBAS Quality Monitoring Owner: Novella Quesada, Manager, QI~~

~~The Approach~~

~~1. Objective~~

- ~~Review of CBAS Quality monitoring of services provided~~

~~2. Activity~~

- ~~CBAS Quality Assurance-continue to assess compliance of contracted CBAS centers.~~
- ~~Report to LTSS QIC~~
- ~~Report Member Satisfaction Survey Results~~
- ~~Report CDA audit results in comparison to past results~~

~~3. Goals~~

- ~~100% CDA Audit Results~~

~~F. Patient Safety-Review and assessment of SNF Quality Monitoring~~

~~The Approach~~

~~1. Objective~~

- ~~Review of SNF Quality monitoring of services provided~~

~~2. Activity~~

- ~~SNF Quality Assurance-continue to assess compliance of contracted SNF centers.~~
- ~~Report to LTSS QIC~~
- ~~Report on progress of on-sire visits and CAPs issued~~
- ~~Report on Member Satisfaction Survey Results~~

~~3. Goals~~

- ~~100% DHCS Audit results~~

2016~~6~~7 Quality Improvement Work Plan- Patient Safety Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director, QI

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

~~G.~~**F. *Safety of Clinical Care-Review of antibiotic usage** **Owner: Kelly Rex-Kimmet ~~Dir~~Dir.tr, ~~of Quality Analytics~~QA**

The Approach

1. **Objective**
   - Increase the appropriate testing for children with Pharyngitis rate (CWP)
   - Appropriate treatment for children with upper respiratory infection (URI) to meet goals
   - Improve appropriate use of antibiotics in Adults with Acute Bronchitis (AAB)

2. **Goals**
   - Appropriate Testing for Children with Pharyngitis~~-~~: 63.24% (25th percentile)~~68.53%~~
   - Appropriate treatment for Children with URI~~:L~~ 93.2~~3~~8% (75th percentile)
   - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) 22.25% (25th percentile)~~91.21%~~

20167 Quality Improvement Work Plan- Patient Safety Owner: Kelly Rex-Kimmet, Director, QA

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

~~**H. Implementation of the new PBM** **Owner: Kris Gericke, Dir of Pharmacy**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Provide ongoing monitoring of the implementation of the new PBM: quality of care, service, clinical metrics~~

~~**2. Activity**~~

- ~~Review and report on clinical and service metrics for Med Impact, as it relates to STARS, HEDIS, Quality of care, Quality of Service~~

~~**3. Goals**~~

- ~~TBD~~

G. Pharmacy Benefit Manager (PBM) Oversight Management **Owner: Kris Gericke, Pharm.D., D~~irect~~or, Pharm~~acy Manag~~e~~m~~ent~~**

The Approach

1. Objective

- Provide ongoing monitoring of the PBM: quality of care, service, timeliness

2. Activity

- Review and report on clinical and service metrics for MedImpact~~,~~ as it relates to performance guarantees

3. Goals

- Meet performance guarantees per the contract

20167 Quality Improvement Work Plan- Patient Safety Owner: Kris Gericke, Director, Pharmacy

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VIII. Member Experience

~~A. Quality of Service-Review of Member Satisfaction~~ ~~Owner: Kelly Rex-Kimmet, Director, Quality Analytics~~

~~The Approach~~

~~1. Objective~~
- ~~Annual review of member feedback (CAHPS, complaints & grievances); identification of areas for improvement~~

~~2. Activity~~
- ~~Identify key areas of concern and implement related activities to improve Member Experience (CAHPS)~~
- ~~Work in conjunction with the Health Networks and other Delegates to monitor and improve the Member Experience~~

~~3. Goals~~
- ~~Annual CAHPS results~~

A. Quality of Service-Review of Member Satisfaction Owner: Kelly Rex-Kimmet, ~~Director~~, ~~Quality Analytics~~

The Approach

1. Objective
- Annual review of member feedback (CAHPS, complaints & grievances); identification of areas for improvement

2. Activity
- Identify key areas of concern and implement related activities to improve Member Experience (CAHPS)
- Work in conjunction with the Health Networks and other Delegates to monitor and improve the Member Experience

3. Goals
- Annual CAHPS results

20167 Quality Improvement Work Plan- Member Experience Owner: Kelly Rex-Kimmet, Director, QA

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VIII. Member Experience

B. *Quality of Service-Reviewed through customer service first call resolution **Owner: Belinda Abeyta, Director, Customer Service**

The Approach

1. **Objective**
   - Gather data and information from members after interface with Customer Service
   - to assure expectations/reason for call was resolved

2. **Activity**
   - Monitor port call information and determine key strategies to assure first call
   - resolution/member satisfaction with customer service

3. **Goals**
   - 85% of calls resolved at first call

20167 Quality Improvement Work Plan- Member Experience Owner: Belinda Abeyta, Director, Customer Service

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VIII. Member Experience

C. *Quality of Service - -Reviewed through Customer Service access

Owner: Belinda Abeyta, Director, Customer Service

The Approach

1. **Objective**
   - Customer Service call lines evaluated for average speed to answer
   - Customer Service call line evaluated for call abandonment rate
   - ~~Customer Service call lines evaluated for hold times~~

2. **Activity**
   - Customer Service lines monitored for average speed to answer
   - Customer service lines monitored for abandonment rate
   - ~~Customer service lines monitored for hold time~~

3. **Goals**
   - ASA 30 seconds
   - <3%
   - ~~Hold time under 30 seconds~~
   - First Call Resolution 85%

20167 Quality Improvement Work Plan- Member Experience Owner: Belinda Abeyta, Director, Customer Service

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

VIII. Member Experience

D. Quality of Care and ~~&~~ Service Reviewed through GARS & PQI (MOC)

Owners: Janine Kodama, Director, ~~D.~~ & Appeals; ; ~~Novella Quesada, Manager~~Laura Guest, Supervisor, QI

The Approach

1. **Objective**
   - Global review of member "pain points" (Grievances, Complaints and Quality of Care);
   - assure appropriate actions are taken to assist the member experience

2. **Activity**
   - Quarterly review of all GARS and PQI data to identify issues and trends; implement any necessary corrections
   - Report QIC
   - HN quarterly totals ~~by PMPM oo~~f grievance and PQI ~~and steps taken to address with HN~~
   - Conduct a GARS trend analysis at least two times per y~~y~~ear

3. **Goals**
   - Improve over 2015 performance

2016~~6~~7 Quality Improvement Work Plan- Member Experience ~~__~~ ~~—~~Owners: Janine Kodama, Director, GARS; ~~Novella Quesada, Manager~~Laura Guest, Super~~vis~~or, QI

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

IX. HEDIS/STARS Improvement

A. Improve identified HEDIS Measures listed on "Measure" worksheet — Owner: Kelly Rex-Kimmet Director, Quality Analytics

The Approach

1. **Objective**
   - Regain "Commendable" NCQA accreditation rating
   - Maintain or exceed NCQA 4.0 health plan rating
2. **Activity**
   - See measures worksheet for specific activities
3. **Goals**
   - See measures worksheet

B. Improve identified STARS measures listed on "Measures" worksheet

The Approach

1. **Objective**
   - Maintain or exceed 4.0 CMS STAR rating
2. **Activity**
   - See measures worksheet for specific activities
3. **Goals**
   - See measures worksheet

~~IX. HEDIS/STARS Improvement~~

~~C. Improve CAHPS measures listed on “Measures” worksheet~~

~~The Approach~~

~~1. Objective~~
- ~~Achieve 3.0 CAHPS score~~

~~2. Activity~~
- ~~See Measures worksheet for specific activities~~

~~3. Goals~~
- ~~See Measures worksheet~~

~~D. HEDIS: Launch pediatric wellness clinic~~

~~The Approach~~

~~1. Objective~~
- ~~Improve child and adolescent HEDIS measures (i.e. adolescent immunizations, childhood immunizations, adolescent well care)~~

~~2. Activity~~
- ~~Evaluate options to deliver pediatric preventive care, including immunizations in unique settings to achieve higher adherence~~
- ~~Work in conjunction with the HN and CCN providers on this initiative~~

~~3. Goals~~
- ~~Improve HEDIS rates per measure worksheet~~

~~IX. HEDIS/STARS Improvement~~

~~E. STARS Improvement-Medication Adherence Measures~~ ~~Owner: Kris Gericke, Director, Pharmacy~~

~~The Approach~~

~~1. Objective~~
- ~~Improve the 3 Medication Adherence Measures to achieve 4 Star Performance in each measure~~

~~2. Activity~~
- ~~Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)~~

~~3. Goals~~
- ~~See measures worksheet~~

~~F. HEDIS: Health Network support of HEDIS & CAHPS improvement~~ ~~Owner: Kelly Rex-Kimmet, Director, Quality Analytics~~

~~The Approach~~

~~1. Objective~~
- ~~Provider regular reporting to the Health Networks to ensure HEDIS improvement for expected measures~~

~~2. Activity~~
- ~~Provide ongoing reports to Health Networks on their specific HEDIS & CAHPS performance, including patient lists for intervention~~
- ~~Gather feedback from Health Networks on tools to assist in HEDIS & CAHPS improvement activities~~

~~3. Goals~~
- ~~24.33%~~

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion
**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures MC and OC members - in conjunction with Diabetes Disease Management Program	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	90th percentile for all subsmeasures	2016 April, July, October
**HEDIS/STARS Improvement: Review and assessment Controlling Blood Pressure*	Increase the BP control for MC and OC members to meet goal	Blood pressure control will increase through member outreach and education with member diagnosed with hypertension.	MC: 70.32% (90th percentile) OC 79.15% (75th percentile)	2016 April, July, October
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medi-Cal <15% Readmission rate Medicare <14% Readmission rate	2016 April, July, October
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and 2. OC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	2016 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
HEDIS: Review of prenatal & postpartum care services (PPC)	Increase the prenatal and postpartum care rate for all Medi-Cal deliveries to meet goal	The number of prenatal and postpartum care visits will increase through provider education to submit Prenatal Notification Reports, member and provider education and sharing of provider data. Utilize Text For Baby custom messages to encourage member compliance.	MC Prenatal: 85.19% (50th percentile) MC Postpartum: 68.85% (75th percentile)	2016 April, July, October
HEDIS: Review and assessment prescribed ADHD medication (ADHD)	Increase the follow-up care for children prescribed ADHD medication rate in MC children who were newly prescribed an ADHD medication to meet goal	Follow-up care for children with newly prescribed ADHD medication will increase through member and provider education and reminder letter to members.	Initiation Phase: 40.79% (50th percentile) Maintenance Phase: 50.61% (50th percentile)	2016 April, July, October
HEDIS: Review and assessment of antidepressant medication management (AMM)	Increase the antidepressant medication management rate in MC and OC members with a diagnosis of major depression to meet goal	Antidepressant medication management rates will increase with the distribution of member health education material.	Acute Phase Treatment: MCAL 62.56% (90th percentile) Continuation Phase Treatment: 33.93% OneCare: Effective Phase Treatment 66.67% Continuation Phase Treatment 52.87%	2016 Mar Jun Sep Dec
****HEDIS/STARS**: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	OC: 49.48% (75th percentile)	2016 April, July, October
HEDIS: Review and assessment of treatment of bronchitis (AAB)	Increase the avoidance of antibiotic treatment in adults with acute bronchitis rate in MC members with a diagnosis of acute bronchitis to meet goal	Avoidance of antibiotic treatment in adults with a diagnosis of acute bronchitis rate in MC members 18-64 years old will increase through member and provider education.	MC: 26.30% (50th percentile)	2016 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
HEDIS: Review and assessment of childhood immunization rates	Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal	Immunization in children by their 2nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 49.63% (90th percentile)	2016 April, July, October
HEDIS: Review and assessment of adolescent Immunization rates	Increase the adolescent immunization rate to meet goal	Adolescent immunizations will improve through a adolescent focused event that will provide immunization opportunities, member education and member resources.	75th percentile (or above) 59.98%	2016 April, July, October
HEDIS: Review and assessment of appropriate testing for pharyngitis rates - - -	Increase the appropriate testing of pharyngitis in children 2-18 years of age to meet goal - - -	Appropriate testing for pharyngitis will improve through the distribution of strep A tests and provider education.	MC: 71.48% (50th percentile)	2016 April, July, October - - -
HEDIS: Review and assessment of use of imaging studies for low back pain - - -	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain) - - -	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education	MC: 74.95% (50th percentile) - - -	2016 April, July, October - - -
***STARS Improvement** Medication Adherence Measures	Improve the 3 Medication Adherence Measures to achieve 4 Star performance in each measure	Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)	4 Stars	2016 Mar Jun Sep Dec
CAHPS: Rating of Health Plan	Increase CAHPS score on Rating of Health Plan	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	50th Percentile or higher	2016 Mar Jun Sep Dec

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion~~
~~CAHPS: Getting Needed Care~~	~~Increase CAHPS score on Getting Needed Care~~	~~Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Needed Care.~~	~~50th Percentile or higher (2.52)~~	~~2016 Mar Jun Sep Dec~~
~~CAHPS: Getting Care Quickly~~	~~Increase CAHPS score on Getting Care Quickly~~	~~Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Care Quickly.~~	~~50th Percentile or higher~~	~~2016 Mar Jun Sep Dec~~
~~CAHPS: How Well Doctors Communicate~~	~~Increase CAHPS score on How Well Doctors Communicate~~	~~Tips on "Preparing for your Dr. Visit," toolkits/decision tools for PCPs, and provider and office staff in-service on customer service will improve rating on How Well Doctors Communicate.~~	~~50th percentile or higher~~	~~2016 Mar Jun Sep Dec~~
~~CAHPS: Customer Service~~	~~Increase CAHPS score on Customer Service~~	~~Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service.~~	~~50th percentile or higher~~	~~2016 Mar Jun Sep Dec~~
~~HOS: Health Outcome Survey Measures~~	~~Improve HOS measures for Star Rating~~	~~Develop and implement activities around: 1)Reducing Risk of Falls 2)Improving Physical Health Status 3)Improving Mental Health Status~~	~~50th percentile or higher~~	~~2016 Mar Jun Sep Dec~~

A. Improve identified HEDIS ~~HEDIS~~ Measures listed on "Measures" worksheet **Owners: Kelly Rex-Kimmet ~~Director~~, Quality ~~Analytics~~**

The Approach

1. Objective

- Maintain "Commendable" NCQA accreditation rating

- Maintain or exceed NCQA 4.0 health plan rating
- Earn Quality Withhold Dollars back for OneCare Connect for all HEDIS measures in OCC QW program~~Maintain "Commendable" NCQA accreditation rating~~
- ~~Maintain or exceed NCQA 4.0 health plan rating~~

2. Activity

- See M~~m~~easures worksheet for specific activities

3. Goals

- See M~~m~~easures worksheet

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures MC and OC members - in conjunction with Diabetes Disease Management Program	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	Medicaid: • A1C Screening: ~~86.0%~~85.95% (50th percentile) • A1C Control <8.0%: ~~55.47%~~52.55% (~~Between~~ 75th ~~and 90th~~ percentile) • A1C Control >9.0%: ~~33.05%~~36.87% (lower score is better) ~~Between~~ (75th ~~and 90th~~ percentile) • Eye Exams: ~~65.1%~~61.5 (75th percentile) • Nephropathy Screening: 90.51% (50th percentile) • BP Control: ~~72.17%~~68.61% (~~between~~ 75th ~~and 90th~~ percentile) Medicare: • A1C Screening: 91.4% • A1C Control <8.0%: 72.8% • A1C Control >9.0 18.8% (lower score is better) • Eye Exams: 82% Nephropathy Screening: 95.8% • BP Control: 79.3%	2017 April, July, October
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program.	Medi-Cal <145% Readmission rate Medicare <14% Readmission rate OCC <11% readmission Rate (Quality Withhold goal)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
members (PCR)		A reporting mechanism will be established followed by analysis of data.		
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and 2. OC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	2017 April, July, October
HEDIS: Review of prenatal & postpartum care services (PPC)	Increase the prenatal and postpartum care rate for all Medi-Cal deliveries to meet goal	The number of prenatal and postpartum care visits will increase through provider education to submit Prenatal Notification Reports, member and provider education and sharing of provider data. Utilize Text-For-Baby custom messages to encourage member compliance.	MC Prenatal: 82.25% (50th percentile) MC Postpartum: ~~65.96~~67.53% (~~66th~~75th -percentile)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
~~**Cervical Cancer Screening**~~**Lead Screening (Monitoring Measure)**	Increase lead screening rate~~Increase the cervical cancer screening rate for Medi-Cal to meet DHCS MPL of 25th percentile~~	~~Cervical cancer screening rate will increase through office staff, provider and member incentives as well as planned campaigns for women's health preventive screenings.~~Analyze data to determine low performing HN. Implement initiatives to address identified barriers to better performance (data strategy as well as provider outreach)	MC: 75.7% (66th percentile)~~MC:~~	
HEDIS: Review and assessment prescribed ADHD medication (ADHD)	Increase the follow-up care for children prescribed ADHD medication rate in MC children who were newly prescribed an ADHD medication to meet goal	Follow-up care for children with newly prescribed ADHD medication will increase through member and provider education and reminder letter to members.	Initiation Phase: 42.19% (50th percentile) Maintenance Phase: ~~40.91~~52.47% (~~25~~50th percentile)	2017 April, July, October
HEDIS: Review and assessment of antidepressant medication management (AMM)	Increase the antidepressant medication management rate in MC and OC members with a diagnosis of major depression to meet goal	Antidepressant medication management rates will increase with the distribution of member health education material.	MC: Acute Phase Treatment: ~~56.65%~~59.52 (~~66~~75th percentile) MC: Continuation Phase Treatment: 41.46% (66th percentile) OC: Effective Phase Treatment 68.66% (50th percentile) OC: Continuation Phase Treatment 54.76% (50th percentile)	2017 Mar Jun Sep Dec
HEDIS/STARS: Review and assessment of	Increase the osteoporosis management in women	Osteoporosis management in women who had a	OC: 47.6% (66th percentile)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
osteoporosis management (OMW)	who had a fracture rate in OC women who suffered a fracture to meet goal	fracture will increase through improved member identification using claims and pharmacy data and provider education.		- -
~~**HEDIS**: Review and assessment of treatment of bronchitis (AAB)~~	~~Increase the avoidance of antibiotic treatment in adults with acute bronchitis rate in MC members with a diagnosis of acute bronchitis to meet goal~~	~~Avoidance of antibiotic treatment in adults with a diagnosis of acute bronchitis rate in MC members 18-64 years old will increase through member and provider education.~~	~~MC: 22.25% (25th percentile)~~	~~2017 April, July, October~~
HEDIS: Review and assessment of childhood immunization rates	Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal	Immunization in children by their 2nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 40.9% (75th percentile)	2017 April, July, October
-	-			-
HEDIS: Review and assessment of use of imaging studies for low back pain ~~**HEDIS:** Review and assessment of adult's access to preventive/ambulatory health (AAP)~~	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain) ~~Increase MC and OC adult's access to preventive/ambulatory health to meet goal~~	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education ~~Comprehensive member and provider outreach with reminders to increase access for adults~~	MC: ~~77.09~~73.71% (~~75~~50th percentile) ~~MC: 83.84% (50th percentile)~~ ~~OC: 95.56% (50th percentile)~~	2017 April, July, October ~~2017 April, July, October~~
HEDIS: Review and	Increase MC and OC	Comprehensive member	MC: 82.15% (50th percentile)	2017 April,

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
assessment of adult's access to preventive/ambulatory health (AAP)	adult's access to preventive/ambulatory health to meet goal	and provider outreach with reminders to increase access for adults	OC: 95.56% (50th percentile)	July, October
HEDIS: Review and assessment of children's access to primary care practitioners (CAP)	Increase children's access to primary care practitioners to meet goal	Comprehensive member and provider outreach with reminders to increase access for children	MC: 1) 12-24 months ~~96.28%~~95.74% (50th percentile) 2) 25 months -6 years ~~91.22%~~90.98% (75th percentile) 3) 7-11 years 93.~~90~~25% (75th percentile) 4) 12-19 years ~~90.06%~~89.37% (50th percentile)	2017 April, July, October
HEDIS: Review and assessment of cervical cancer screening (CCS)	Increase the cervical cancer screening in our MC female members 21-64 to meet goal	Increase cervical cancer screening through member and provider outreach and education with reminders.	MC: ~~67.88~~55.94% (~~75~~50th percentile)	2017 April, July, October
HEDIS: Review and assessment of well child visits in the first 15 months of life (W15)	Increase the well care visits for MC children in their first 15 months of life to meet goal	Increase of well care visit for children in their first 15 months of life through member and provider outreach and education with reminders	MC: 59.~~76~~57% (6 or more visits) (50th percentile)	2017 April, July, October
HEDIS: Review and assessment of breast cancer screening (BCS)	Increase the breast cancer screening for MC and OC female members to meet goal	Increase the breast cancer screening through member and provider education and outreach with reminders as ways to decrease barriers to screening	MC: 71.~~41~~52% (90th percentile) OC: 71.36% (50th percentile)	2017 April, July, October
HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile) Monitor for Medicaid population. Develop internal benchmark as National Medicaid Benchmark does not exist.	2017 April, July, October
HOS/STARS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: ~~1~~)Reducing Risk of Falls 2)Improving Physical Health Status		2017 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion (Proposed reporting months to QIC)~~
~~**HEDIS/STARS: Review and assessment Comprehensive Diabetes~~	~~Increase the comprehensive diabetes care measures MC and OC~~	~~Comprehensive diabetes care will increase through member education to~~	~~Medicaid: A1C Screening: 86.0% (50th percentile) A1C Control <8.0%: 55.47% (Between 75th and 90th percentile)~~	~~20167 April, July, October~~

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
Care (CDC)	members - in conjunction with Diabetes Disease Management Program	identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	A1C Control >9.0%: 33.05% (lower score is better) Between 75th and 90th percentile Eye Exams: 65.1% (75th percentile) Nephropathy Screening: 90.51% (50th percentile) BP Control: 72.17% (between 75th and 90th) Medicare: A1C Screening: 91.4% A1C Control <8.0%: 72.8% A1C Control >9.0 18.8% (lower score is better) Eye Exams: 82% Nephropathy Screening: 95.8% BP Control: 79.3%	
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medi-Cal <15% Readmission rate Medicare <14% Readmission rate OCC <11% readmission Rate (Quality Withhold goal)	20167 April, July, October
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	20167 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
	2. OC members 65 years old and older to meet goal			
HEDIS: Review of prenatal & postpartum care services (PPC)	Increase the prenatal and postpartum care rate for all Medi-Cal deliveries to meet goal	The number of prenatal and postpartum care visits will increase through provider education to submit Prenatal Notification Reports, member and provider education and sharing of provider data. Utilize Text For Baby custom messages to encourage member compliance.	MC Prenatal: 82.25% (50th percentile) MC Postpartum: 65.96% (66th percentile)	20167 April, July, October
Cervical Cancer Screening	Increase the cervical cancer screening rate for Medi-Cal to meet DHCS MPL of 25th percentile	Cervical cancer screening rate will increase through office staff, provider and member incentives as well as planned campaigns for women's health preventive screenings.	MC:	
HEDIS: Review and assessment prescribed ADHD medication (ADHD)	Increase the follow-up care for children prescribed ADHD medication rate in MC children who were newly prescribed an ADHD medication to meet goal	Follow-up care for children with newly prescribed ADHD medication will increase through member and provider education and reminder letter to members.	Initiation Phase: 42.19% (50th percentile) Maintenance Phase: 40.91% (25th percentile)	20167 April, July, October
HEDIS: Review and assessment of antidepressant	Increase the antidepressant medication management rate in MC	Antidepressant medication management rates will increase with the	MC: Acute Phase Treatment: 56.65% (66th percentile) MC: Continuation Phase Treatment: 41.46% (66th percentile) OC: Effective Phase Treatment 68.66% (50th percentile)	20167 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
medication management (AMM)	and OC members with a diagnosis of major depression to meet goal	distribution of member health education material.	OC: Continuation Phase Treatment 54.76% (50th percentile)	
**HEDIS/STARS: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	OC: 47.6% (66th percentile)	20167 April, July, October - -
HEDIS: Review and assessment of treatment of bronchitis (AAB)	Increase the avoidance of antibiotic treatment in adults with acute bronchitis rate in MC members with a diagnosis of acute bronchitis to meet goal	Avoidance of antibiotic treatment in adults with a diagnosis of acute bronchitis rate in MC members 18-64 years old will increase through member and provider education.	MC: 22.25% (25th percentile)	20167 April, July, October
HEDIS: Review and assessment of childhood immunization rates	Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal	Immunization in children by their 2nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 40.9% (75th percentile)	20167 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
HEDIS: Review and assessment of appropriate testing for pharyngitis rates	Increase the appropriate testing of pharyngitis in children 2-18 years of age to meet goal	Appropriate testing for pharyngitis will improve through the distribution of strep A tests and provider education.	MC: 63.24% (25th percentile)	20167 April, July, October
HEDIS: Review and assessment of use of imaging studies for low back pain	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain)	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education	MC: 77.09% (75th percentile)	20167 April, July, October
HEDIS: Review and assessment of adult's access to preventive/ambulatory health (AAP)	Increase MC and OC adult's access to preventive/ambulatory health to meet goal	Comprehensive member and provider outreach with reminders to increase access for adults	MC: 83.84% (50th percentile) OC: 95.56% (50th percentile)	20167 April, July, October
HEDIS: Review and assessment of children's access to primary care practitioners (CAP)	Increase children's access to primary care practitioners to meet goal	Comprehensive member and provider outreach with reminders to increase access for children	MC: 1) 12-24 months 96.28% (50th percentile) 2) 25 months -6 years 91.22% (75th percentile) 3) 7-11 years 93.90% (75th percentile) 4) 12-19 years 90.06% (50th percentile)	20167 April, July, October
HEDIS: Review and assessment of cervical cancer screening (CCS)	Increase the cervical cancer screening in our MC female members 21-64 to meet goal	Increase cervical cancer screening through member and provider outreach and education with reminders.	MC: 67.88% (75th percentile)	20167 April, July, October
HEDIS: Review and assessment of well child visits in the first 15 months of life (W15)	Increase the well care visits for MC children in their first 15 months of life to meet goal	Increase of well care visit for children in their first 15 months of life through member and provider outreach and education with reminders	MC: 59.76% (50th percentile)	20167 April, July, October
HEDIS: Review and assessment of breast	Increase the breast cancer screening for MC and OC	Increase the breast cancer screening through member	MC: 71.41% (90th percentile) OC: 71.36% (50th percentile)	20167 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
cancer screening (BCS)	female members to meet goal	and provider education and outreach with reminders as ways to decrease barriers to screening		
HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile)	20167 April, July, October
HOS/STARS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: 1)Reducing Risk of Falls 2)Improving Physical Health Status		20167 Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

B. Improve identified STARS midentified STARS measures listed on "Measures" worksheet **Owners: Kelly Rex-Kimmet Director, Quality Analytics; Kris Gericke, Pharm.D., Director, Pharmacy Management; Tracy Hitzeman, Interim Executive Director, Clinical Operations ; Kris Gericke, Pharm.D., Director, Pharmacy**

~~Management, Tracy Hitzemen, Executive Director,~~

~~Clinical Operations~~

The Approach

1. Objective

- Attain 4.0 CMS STAR rating~~ttain 4.0 CMS STAR rating~~

2. Activity

- See Mmeasures worksheet for specific activities

3. Goals

- See Mmeasures worksheet

~~STARS~~~~HEDIS~~ Measures Worksheet

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion~~
~~**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)~~	~~Increase the comprehensive diabetes care measures- MC and OC members - in conjunction with~~	~~Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to~~	~~90th percentile for all subsmeasures~~	~~20167 April, July, October~~

Scope	Objective	Activity	Goals or Baseline	Target Completion
	Diabetes Disease Management Program	better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)		!
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30-day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medicare <14% Readmission rate	20167 April, July, October - - !
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and 2. OC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	20167 April, July, October
**HEDIS/STARS: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	OC: 49.48% (75th percentile)	20176 April, July, October
HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile)	20167 April, July, October
HOS/STARS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: 1)Reducing Risk of Falls 2)Improving Physical Health Status		20167 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion
**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures OC and OCC members - in conjunction with	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with	Medicare: 1) A1C Control >9:.0 16% (lower score is better;	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
	Diabetes Disease Management Program	targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	CMS 5 star goal) 2) Eye Exams: 82% (maintain 2016 above CMS 5-star goal) 3) Nephropathy Screening: 96% (CMS 4 star goal)	
**HEDIS/STARS Review Adult BMI Assessment	Increase the BMI assessment in adults	Assessment of BMI will increase through provider education and dissemination of BMI assessment tools.	Medicare: 96% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS Improvement: Review Care of Older Adult	Increase the Care of Older Adult Rate in: 1) Medication Review 2) Pain Screening 3) Functional Status Assessment	Care of Older Adult measures to increase through provider education and dissemination of provider tools.	OneCare Only: 1) Medication Review: 87% (CMS 5 star goal) 2) Pain Screening: 88% (CMS 5 star goal) 3) Functional Status Assessment: 74% (CMS 4 star goal)	2017 April, July, October
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with OneCare & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medicare: <10% Readmission rate (CMS 4 star goal)	2017 April, July, October
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in OC and OCC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	Medicare: 74% (CMS 4 star goal)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
**HEDIS/STARS: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC and OCC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	Medicare: 51% (CMS 4 start goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC and OCC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	Medicare: 71% (CMS 4 star goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of breast cancer screening (BCS)	Increase the breast cancer screening for OC and OCC members to meet goal	Increase breast cancer screening through member and provider outreach as well as ways to decrease barriers to screening	Medicare: 76% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of monitoring physical activity	Increase the monitoring of physical activity for OC and OCC members to meet goal	Increase of monitoring of physical activity through provider outreach and education and dissemination of provider tools	Medicare: 57% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of controlling blood pressure (CBP)	Increase of controlling blood pressure rate	Increase of controlling blood pressure rate through provider and member outreach and education	Medicare: 75% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS: Improvement: Rheumatoid Arthritis Management	Increase of rheumatoid arthritis management rate	Increase of rheumatoid arthritis management through provider education	Medicare: 72% (CMS 3 star goal)	2017 April, July, October
**HEDIS: Follow-up after Hospitalization for Mental Illness (7 days / 30 days)	Increase follow-up after hospitalization for mental illness	Increase follow-up after hospitalization through collaboration with our behavioral health partner to conduct provider education and member outreach through reminders.	Medicare: 56% (Quality Withhold Goal)	2017 April, July, October
**HOS/STARS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: 1) Reducing Risk of Falls 2) Improving Physical Health Status 3) Improving Mental Health Status	Medicare: 1) Reducing Risk of Falls: 73% (CMS 5 star goal) 2) Improving Physical Health Status: 72% (CMS 4 star goal) 3) Improving Mental Health Status: 87% (CMS 5 star goal	2017 Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

C. Improve CAHPS measures listed on "Measures" worksheet

Owner: Kelly Rex-Kimmet Director, Quality Analytics

The Approach

1. Objective

- Achieve 3.0 CAHPS score
- Attain 4.0 CMS STAR rating
- Meet CMS STAR Goals

2. Activity

- See Measures worksheet for specific activities

3. Goals

- See Measures worksheet

CAHPS MHEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion
CAHPS: Rating of Health Plan	Increase CAHPS score on Rating of Health Plan	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	50th Percentile or higher	20167 Mar Jun Sep Dec
CAHPS: Getting Needed Care	Increase CAHPS score on Getting Needed Care	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating	50th Percentile or higher (2.52)	20167 Mar Jun Sep Dec

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion~~
		~~of Getting Needed Care.~~		
~~CAHPS: Getting Care Quickly~~	~~Increase CAHPS score on Getting Care Quickly~~	~~Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Care Quickly.~~	~~50th Percentile or higher~~	~~20167 Mar Jun Sep Dec~~
~~CAHPS: How Well Doctors Communicate~~	~~Increase CAHPS score on How Well Doctors Communicate~~	~~Tips on "Preparing for your Dr. Visit," toolkits/decision tools for PCPs, and provider and office staff in-service on customer service will improve rating on How Well Doctors Communicate.~~	~~50th percentile or higher~~	~~20167 Mar Jun Sep Dec~~
~~CAHPS: Customer Service~~	~~Increase CAHPS score on Customer Service~~	~~Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service.~~	~~50th percentile or higher~~	~~20167 Mar Jun Sep Dec~~

Scope	Objective	Activity	Goals or Baseline	Target Completion
STARS: CAHPS: Rating of Health Plan	Increase CAHPS score on Rating of Health Plan	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	Medicaid: 50th Percentile or higher Medicare: 82% (CMS 3 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Getting Needed Care	Increase CAHPS score on Getting Needed Care	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Needed Care.	Medicaid: 50th Percentile or higher (2.52) Medicare: 79% (CMS 2 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Getting Care Quickly	Increase CAHPS score on Getting Care Quickly	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider	Medicaid: 50th Percentile or higher	2017 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion
		capacity and geoaccess standards will improve rating of Getting Care Quickly.	Medicare: 72% (CMS 2 star goal)	
CAHPS: How Well Doctors Communicate	Increase CAHPS score on How Well Doctors Communicate	Tips on "Preparing for your Dr. Visit," toolkits/decision tools for PCPs, and provider and office staff in-service on customer service will improve rating on How Well Doctors Communicate.	Medicaid: 50th percentile or higher	2017 Mar Jun Sep Dec
STARS:CAHPS: Customer Service	Increase CAHPS score on Customer Service	Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service.	Medicaid: 50th percentile or higher Medicare: 86% (CMS 3 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Getting Needed Prescription Drugs	Increase CAHPS score on Getting Needed Prescription Drugs		Medicare: 89% (CMS 3 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Care Coordination	Increase CAHPS score on Care Coordination	Provider and office staff in-service on best practices to better coordinate care for members will improve rating on Care Coordination.	Medicare: 82% (CMS 2 star goal)	2017 Mar Jun Sep Dec
STARS: CAHPS: Overall Rating of Health Care Quality	Increase CAHPS score on Overall Rating of Health Care Quality	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	Medicare: 82% (CMS 2 star goal)	2017 Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

D. STARS-Medication Related Measures

Owner: Kris Gericke, Pharm.D., Director, Pharmacy Management

The Approach

1. Objective

- Optimal Performance in the CMS Pharmacy Star and Display Measures.

2. Activity

- Decrease utilization of high-risk medications
  - Formulary controls
  - Prior authorization criteria
  - Prescriber education
- Antipsychotic use in members with dementia in nursing homes

- Prescriber education
- LTC quality incentive program

- Appropriate dosing of oral diabetes medications
  - Formulary controls
  - Prior authorization criteria
  - Prescriber education
- Medication Adherence
  - Comprehensive member and & provider outreach to identified members who appear non-adherent with medication management (interventions based on unique member characteristics)
  - Interventions include:
    - Outreach
    - Pre-Assessment: Modified Morisky Scale (MMS) for knowledge, /motivation and confidence
    - Mailings - lL etter with member's action plan, Healthy You, medication log;
    - Ffollow--up calls as needed
  - Outcomes include:
    - Pre –and Post--PDC rates to measure program success
    - Evaluate member's improvement in knowledge, motivation (MMS) and confidence
    - Evaluate member survey results

3. Goals

- Scores above the national MA-PD average as reported by CMS

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion
***STARS Improvement -** Medication Adherence Measures	Improve the 3 Medication Adherence Measures to achieve 4 Star performance in each measure	Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)	4 Stars	2016~~7~~ Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

E. HEDIS: Health Network support of HEDIS & CAHPS improvement

Owner: Kelly Rex-Kimmet, Director, Quality Analytics

The Approach

1. Objective

- Provider regular reporting to the Health Networks to ensure HEDIS improvement for expected measures

2. Activity

- Provide ongoing reports to Health Networks on their specific HEDIS & CAHPS performance, including patient lists for intervention
- Gather feedback from Health Networks on tools to assist in HEDIS & CAHPS improvement activities

3. Goals

- 24.33%

HEDIS Measures **Owner: Marsha Choo, Manager, QA**

	Results / Metric	Next Steps	Target Completion
Diabetes Ccare			
Controlling Blood Pressure			
30- Day ReadmmsionsReadmissions			
Flu & PheumoccalPneumococcal Rates			
Prenatal Care			
Post PartumPost-Partum			
ADMHD			
Antidepressant Medication MgmtManagement			
Osteoporosis MgmtManagement			

Antibiotics Use/ Bronchitis			
Childhood Immunizations. Combo 10			
Adolescent Immunizations	Not on HEDIS Measures worksheet		
Low Back Pain			
Adult Access to Preventive Care (AAP)			

CAHPS Measures Team — **Owner: Member Experience**

	Results / Metric	Next Steps	Target Completion
Rating of Health			
Getting Needed Care			
Getting Care Quickly			
How ~~W~~well Doctors Communicate			
Customer Service			

STARS **Owner: Kris Gericke, PharmDPharm.D, Director, Pharmacy**

	Results / Metric	Next Steps	Target Completion
Cholesterol			
Hypertension			
Diabetes			

Health Outcomes Survey **Owner: Marsha Choo, Manager, QA**

	Results / Metric	Next Steps	Target Completion
Reducing Risk of Falls			
Improving Physical Health Status			
Improving Mental Health Status			

X. Delegation Oversight

~~**A. Delegation Oversight of CM** **Owner: Tracy Hitzeman, Director, CM**~~

~~**The Approach**~~

~~**1. Objective**~~
- ~~Regular review of the Health Network's performance of CM functions~~

~~**2. Activity**~~
- ~~Assure compliance to all regulatory and accreditation delegation oversight requirements~~
- ~~**Report from DOC~~

~~**3. Goals**~~
- ~~100%~~

A. Delegation Oversight of CM **Owner: Sloane Petrillo, Interim D~~irec~~tor, CM**

The Approach

1. Objective
- Regular review of the Health Network's performance of CM functions

2. Activity
- Review of 100% of MOC files with monthly feedback provided to Health Networks
- Assure compliance to all regulatory and accreditation delegation oversight requirements
- **Report from DOC

3. Goals
- 90%

201~~6~~7 Quality Improvement Work Plan--Delegation Oversight Owner: ~~Tracy Hitzeman~~Sloane Petrillo, Interim Di~~rec~~t~~o~~r, CM

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

X. Delegation Oversight

B. Quality of Care and & Service of UM through Ddelegation oOversight rReviews ——— Owner: Solange Marvin Directore, Audit & Oversight

The Approach

1. **Objective**
   - Delegation Oversight of Health Networks to assess compliance
2. **Activity**
   - Delegated entity oversight supports how UM delegated activities are performed
   - to expectations and compliance with standards, such as Prior Authorizations
   - **Report from DAOC
3. **Goals**
   - 98%

20167 Quality Improvement Work Plan- Delegation Oversight Owner: Solange Marvin, Director, Audit & Oversight

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

X. Delegation Oversight

C. Delegation oversight of BH Services

Owner: ~~Solange Marvin~~Dr. Edwin Poon, Di~~rec~~tor, ~~Audit & Oversight~~BH~~I~~SI

The Approach

1. **Objective**
   - Regular review of the MBHO's performance of BH functions

2. **Activity**
   - Assure compliance to all regulatory and accreditation delegation oversight requirements
   - **Report from ~~D~~AOC

3. **Goals**
   - 98%

2016~~6~~7 Quality Improvement Work Plan- Delegation Oversight ——— Owner: ~~Solange Marvin~~Dr. Edwin Poon, D~~irec~~t~~o~~r, ~~Audit & Oversight~~BH~~!~~SI

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

~~XI. Organizational Projects~~

~~A. Implementation of the 2016 Value Based P4P Program~~ ~~Owner: Medical Director, Quality & Analytics~~

~~The Approach~~

~~1. Objective~~

- ~~Confirm and implement the 2016 Value Based P4P Program (Medi-Cal & OCC)~~

~~2. Activity~~

- ~~Complete review of 2014 & 2015; confirm measures, align with auto-assignment quality measures and define weighting for 2016~~
- ~~Incentivize Health Networks via a P4P to achieve high quality scores on targeted accreditation, health plan rating and STARS measures~~

~~3. Goals~~

- ~~Improve performance over 2015~~

~~2016~~7 Quality Improvement Work Plan- Organizational Projects ~~Owner: Medical Director, QA~~

~~Monitoring~~	~~Assessments, Findings, Monitoring of Previously Identified Issues~~	~~Next Steps~~	~~Target Completion~~
~~Q1~~			
~~Q2~~			
~~Q3~~			
~~Q4~~			
~~Year End~~			
~~Outcomes~~	~~Results / Metrics~~	~~Next Steps~~	~~Target Completion~~
~~Q1~~			
~~Q2~~			
~~Q3~~			
~~Q4~~			
~~Year End~~			

XI. Organizational Projects

~~B. Value Based P4P 2016-2019~~ ~~Owner: Kelly Rex-Kimmet, Director, QA~~

~~The Approach~~

~~1. Objective~~

- ~~Design longer term Value Based P4P Program and gain board approval by 7/1/16~~

~~2. Activity~~

- ~~Design new program in conjunction with provider/ Health Network Stakeholders, PAC & MAC input; develop COBAR for presentation to board~~
- ~~Define analytics and matching resources to support new P4Value Program~~

~~3. Goals~~

- ~~National & State Benchmarks~~

A. Value Based P4P 2017- Owner: Sandeep Mital, Manager, Quality P4V

The Approach

1. Objective

- Present MY~~MY~~2017 P4V program to QAC and Board of Directors by 3/1/17
- Re-Evaluate Auto Assignment Quality Measures and Recommend Changes to measures and algorithm
- Design 2018 P4Value program based on interim measures

2. Activity

- Design new program in conjunction with provider/ Health Network s~~S~~takeholders,
- PAC & MAC input
- ~~;~~ D~~d~~evelop COBAR for presentation to board
- Define analytics and matching resources to ~~support~~define ~~new~~2018 P4Value Program

3. Goals

- Implement 2017 prospective rates by 3/1/17
- Design 2018 P4V by 4th Quarter, 2017

2016~~7~~ Quality Improvement Work Plan- Organizational Projects Owner: ~~Kelly Rex-Kimmet~~Sandeep Mital, ~~Director~~Manager, ~~Quality~~ QAP4V

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

XII. Organizational Projects

B. MOC Dashboard

Owner: Esther~~.~~ Okajima, D~~irec~~tor, Q~~uality I~~mprovement

The Approach

~~Objective~~
~~Activity~~

1. ~~Goal~~Objective
   - Present OC/OCC & SPD MOC Quality Matrix to QAC and Board of Directors by 2nd Quarter, 2017
   - Re-e~~E~~valuate measurements through data analysis

2. Activity
   - Define analytics and resources to support the Model of Care for OC/OCC & SPD members
   - Implement activities to meet or exceed measures

3. Goals
   - Meet or exceed defined MOC metrics

G:\Model of Care\CalOptima Model of Care\MOC Dashboard\Latest version\MOC Dashboard_12.12.16.xlsx

- (right click and select "open hyperlink)

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
2	**Program Structure:**									
3	QI Program Description (submission date)	Date	Esther	Annual	Apr-15	Met	Apr-16	Met		
4	QI Work Plan (submission date)	Date	Esther	Annual	Apr-15	Met	Apr-16	Met		
5	QI Evaluation (submission date)	Date	Esther	Annual	Apr-16	Met				
6										
7	**Network Management**									
8	Strong Network (Access)-Survey	See report	Marsha C.	Annual	See access report	N/A				
9	Strong Network (Availability)-Quarterly Report	See report	Marsha C.	Quarterly	See availability report	N/A				
10	Behavioral Health Access (BH Access & Availability)	See report	Dr. Poon	Quarterly	See Member Satisfaction Survey Report	N/A				
11	LTSS Access & Availability	TBD	Marie E.	Quarterly						
12	Complaints associated with Network Access	%/1000	Janine	Quarterly	0%	Y				
13	Use of Dental Benefit	41.50%	Lizeth	Monthly						
14	Complaints associated with use of Dental Benefit	1.80%	Janine	Quarterly	15%	N				
15	Utilization of Taxi Benefit (Transportation Services)	29.80%	Belinda	Annual	19.43%	Y				
16	Complaints associated with Taxi Benefit (Transportation Services)	2.70%	Janine	Quarterly	8%	N				
17										

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
18	**Coordination of Care**									
19	% of calls resolved at first call	85%	Belinda	Quarterly	NA					
20	Member voluntary disenrollment rate	3.00%	Belinda	Quarterly	14.25%	N				
21	Transitions of Care									
22	Sending Member's Care Plan to Next Care Setting	% sent	Denise	Quarterly						
23	Notification to PCP of Transition	% notified	Denise	Quarterly						
24	HRA Outreach Completion Rate	90%	Cecelia	Quarterly	99%	Met				
25	HRA completion rate	TBD	Cecelia	Quarterly	22.90%					
26	ICP/ICT									
27	ICP (% of members with ICP)	90%	Denise	Quarterly						
28	ICT (% of members with ICT)	TBD	Denise	Quarterly						
29	DM inclusion in ICP (CCN)	30%	Pshyra	Quarterly						
30	Over/Under-Utilization of Services (Unused Auths?)			Quarterly	See HN rpt tab					
31	In-Patient Admits/1000	Admits/1000	Debra/Solange	Semi-Annual	See HN rpt tab					
32	Readmission Rate	<9.9%	Debra/Solange	Semi-Annual	See HN rpt tab					
33	Reduction in ER Visits (visit/1000 members)	585/1000	Debra/Solange	Quarterly	See HN rpt tab					
34	ALOS	4	Debra/Solange	Monthly	See HN rpt tab					
35	Response to Key Events (Need definition)	TBD	Denise	Quarterly						
36	F/Up after MH hospitalization (7 & 30 day)	50th %tile	Paul J	Annual	7 day = 81.35% 30 day = 85.49% (One Care)					
37	LTSS:									
38	Access to LTSS (utilization of LTSS services)	TBD	Marie E.	Quarterly						
39	Inpatient Days/1000 LTSS	Days/1000	Marie E.	Quarterly	Process not finalized in 2015					

"Attachment A"

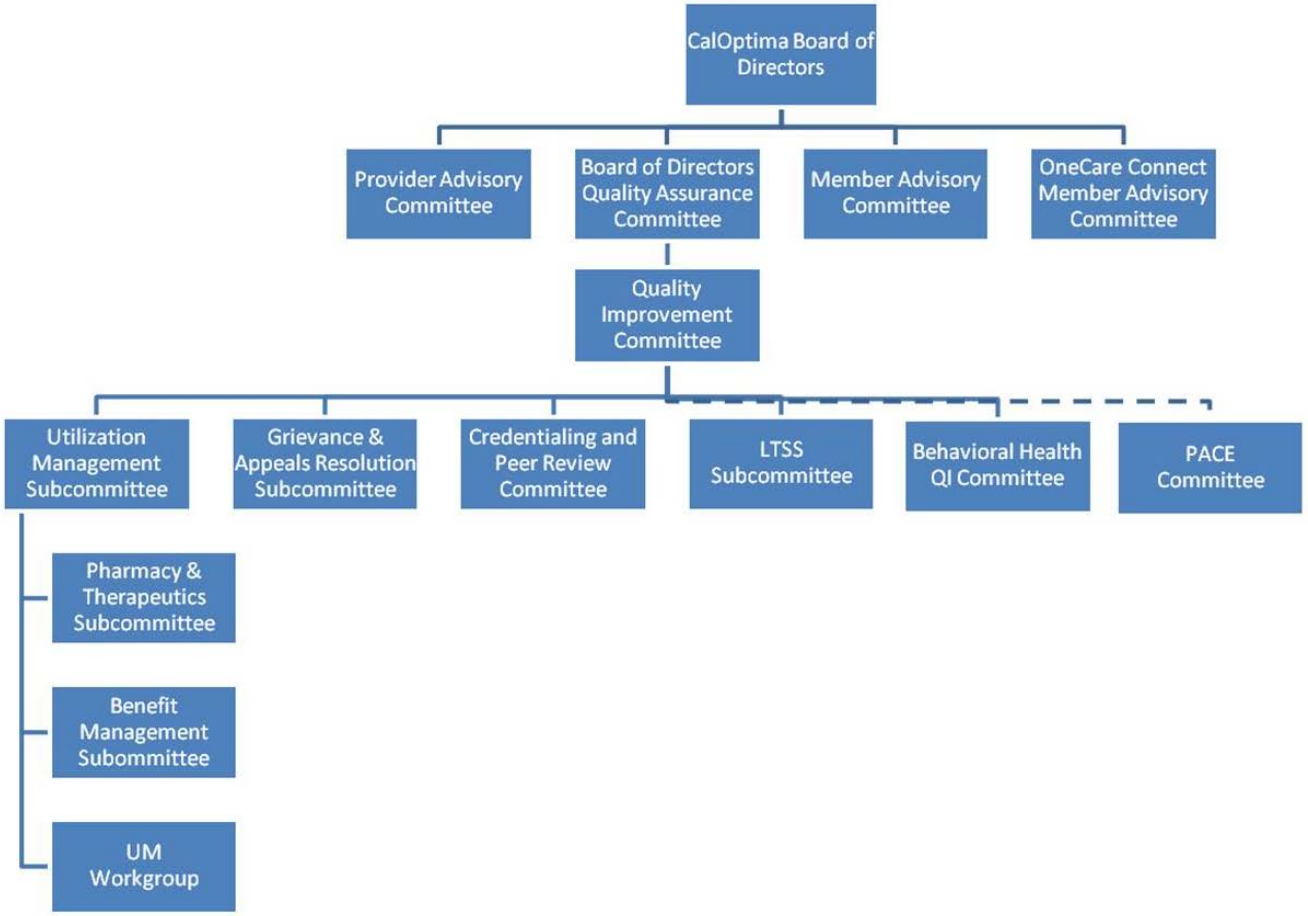
	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
40	ER Visits (visits/1000)	Visits/1000	Marie E.	Quarterly	Process not finalized in 2015					
41	Annual Analysis of Risk Level Classification (% Low/% High)	TBD	Cecelia	Quarterly	74%/26%					
42	Disease Mgmt penetration for Basic CM members	30%	Pshyra	Quarterly						
43	Other									
44										
45	**QIP/CCIP**									
46	Topic : Improving In-Home Supportive Services Care Coordination	% improvement	Marie E./Marsha C	Quarterly	PIP not in place for 2015; 2016 only					
47	Topic: Readmission within 30 days	baseline year	Tracy/ Marsha C	Quarterly	QIP not in place for 2015; 2016 only					
48										

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
49	**Health Outcomes**									
50	HEDIS performance (Stars Measure)				One Care Results for 2015					
51	Improvement in Adult Preventive Service	94.8% (50th %tile)	Paul J	Annual	93.61%	N				
52	Measure 1 (Controlling Blood Pressure)	4 Star Goal	Paul J	Annual	69.68%					
53	Measure 2 (Diabetes Care - A1C Control)	4 Star Goal	Paul J	Annual	72.51%					
54	Measure 3 (Diabetes Care - Nephropathy Monitoring)	4 Star Goal	Paul J	Annual	95.15%					
55	Measure 4 (Breast Cancer Screening)	69.80%	Paul J	Annual	68.69%	N				
56	Measure 5 (Colorectal Cancer Screening)	54.70%	Paul J	Annual	64.36%	Y				
57	Measure 6 (Acute Phase Depression Tx)	63.40%	Paul J	Annual	55.25%	N				
58	Measure 7 (Rheumatoid Arthritis)	4 Star Goal	Paul J	Annual	66.00%					
59	Measure 8 (Osteoporosis)	4 Star Goal	Paul J	Annual	44.87%					
60	Pharmacy Measures									
61	Medication Adherence - Hypertension	4 Star Goal	Nicki	Annual	5 stars (86%)	Y				
62	Medication Adherence - Diabetes	4 Star Goal	Nicki	Annual	4 stars (82%)	Y				
63	Medication Adherence - Cholesterol	4 Star Goal	Nicki	Annual	5 stars (82%)	Y				
64	HOS performance									

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
65	Maintaining or improving physical health status	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016					
66	Maintaining or improving mental health status	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016					
67	Reducing the risk of falling	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016					
68										
69	**Member Experience**									
70	CAHPS Performance (Stars Measures)				One Care Results for 2015					
71	Getting Needed Care	4 Star Goal	Marsha C	Annual	77%	Not Met				
72	Rating of Drug Plan	4 Star Goal	Marsha C	Annual	82%	Not Met				
73	Customer Service	4 Star Goal	Marsha C	Annual	85%	Not Met				
74	Getting Appointments & Care Quickly	4 Star Goal	Marsha C	Annual	70%	Not Met				
75	Getting Needed Prescription Drugs	4 Star Goal	Marsha C	Annual	88%	Not Met				
76	Care Coordination	4 Star Goal	Marsha C	Annual	80%	Not Met				
77	Overall Rating of Plan	4 Star Goal	Marsha C	Annual	82%	Not Met				
78	Overall Rating of Health Care Quality	4 Star Goal	Marsha C	Annual	81%	Not Met				

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
79	**Medical Record Review (HN compliance to policies)**									
80	MRR results - CalOptima	Clinical Ops	Esther	Annual						
81										
82	**IRR for UM activities**									
83	Annual IRR for Staff	90%	Debra	Annual	96-100%	Y				
84	Annual IRR for RX	TBD	Solange	Annual	Completed?					
85	**Delegated functions oversight**									
86	Health Network performance	A/O Report	Solange	Quarterly						
87	MRR results - HN	A/O Report	Esther	Quarterly						
88	IRR for Delegates	A/O Report	Solange	Annual	Completed?					
89	**Clinical Practice Guidelines**									
90	Reviewed annually (linked with DM)	QIC minutes	Pshyra	Annual						

~~Quality Improvement Committee Structure~~ – 2016



2017 Quality Improvement
Program Description and Work Plan

Board of Directors' Quality Assurance Committee Meeting

February 15, 2017

Richard Bock, MD, Deputy Chief Medical Officer

Caryn Ireland, Executive Director, Quality Analytics

2017 QI Program Description

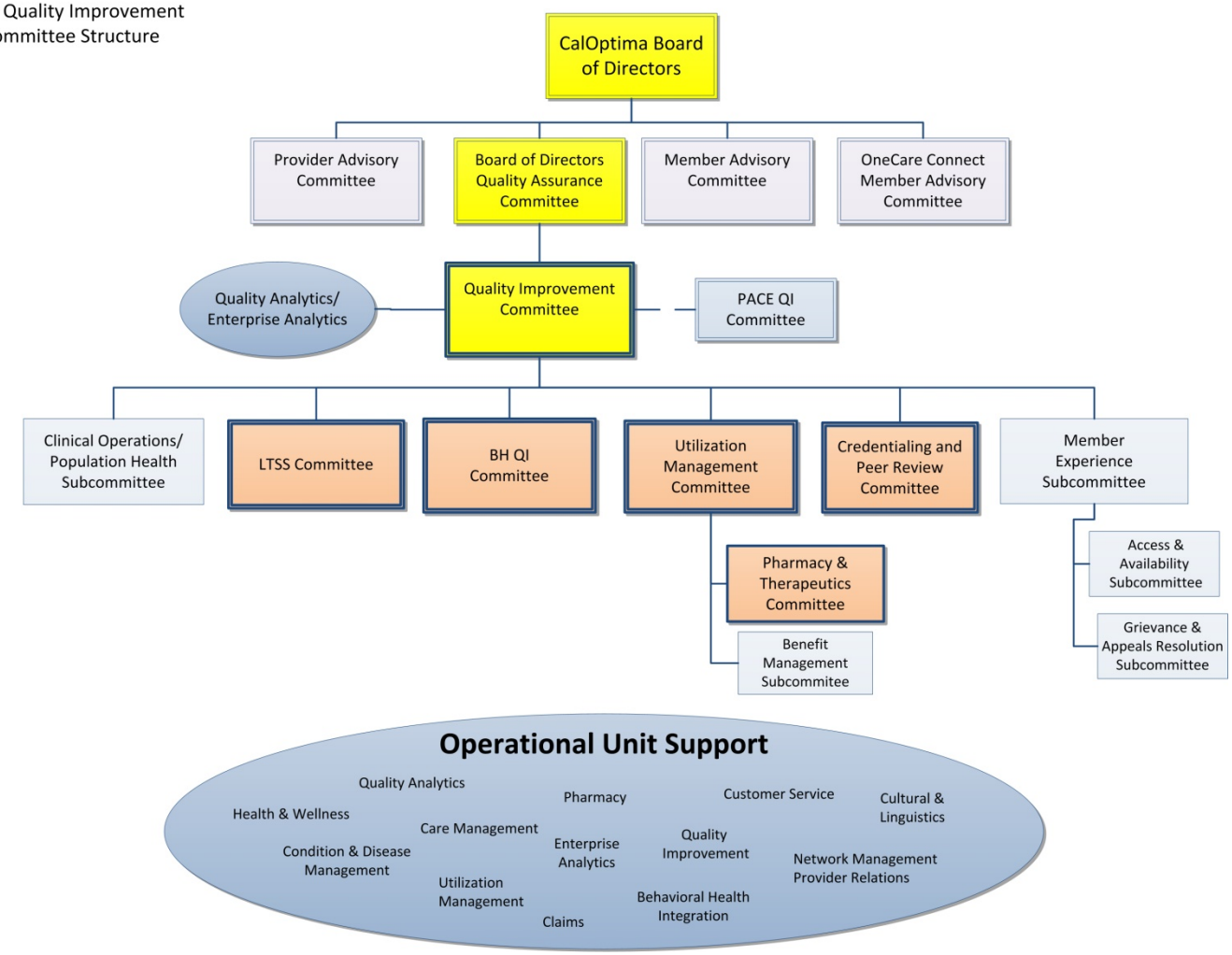
- Our program description:
  - Encompasses all clinical care, clinical services and organizational services provided to our members
  - Uses evidence-based guidelines, data and best practices tailored to our populations
  - Utilizes support systems for our members with vulnerabilities, disabilities and chronic illnesses

2017 Program Description Revisions

- Updates our introduction to align with CalOptima's Vision, Mission and Strategic Plan for 2017-19
- Updates our Health Network and Behavioral Health Delegate information
- Reflects the adoption of the annual UM Program Description and UM Work Plan
- Updates the Advisory Committees and Quality Committees/Subcommittees that support the QI Program
- Incorporates our Delegation and Oversight grid (Attachment B), identifying the function and responsibility of our various delegated organizations

2017 Program Description Revisions

2017 Quality Improvement Committee Structure



2017 QI Work Plan Enhancements

- Goals set to meet or exceed previous year's achievement(s)
- Health Risk Assessments (OC/OCC/SPD) & Interdisciplinary Care Teams
- Behavioral Health Access & Coordination of Services
- LTSS Initiatives, including Placement, Over/Underutilization of services
- Pharmacy Initiatives, including Opioid Reduction
- Initial Health Assessment Initiatives

2017 QI Work Plan Enhancements

- Continuous quality improvement projects for DHCS and CMS
- Patient Safety Initiatives & Monitoring
- PACE QI Work Plan Information Sharing
- Continued focus on Member Experience - multiple areas
  - Including Access & Availability
- Improvement Initiatives for HEDIS/STARS/CAHPS
- Further implementation of our Pay For Value Program
- Incorporates our Model of Care Quality Goals

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Richard Helmer, Chief Medical Officer, (714) 246-8400

Recommended Action

Recommend Board of Directors' approval of the 2017 CalOptima PACE Quality Assessment and Performance Improvement (QAPI) Plan.

Background

The Board of Directors first authorized the Chief Executive Officer to submit CalOptima's application to become a PACE Provider on October 7, 2010. The CalOptima PACE program opened its doors for operation in October of 2013. PACE is viewed as a natural extension of CalOptima's commitment to integration of acute and long-term care services for its members. This program provides the link between our healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. PACE takes care of the frail elderly by integrating acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents and continues to grow. As of January 1, 2017, CalOptima PACE had 186 members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes. [1]

PACE organizations are required to have a written Quality Assessment and Performance Improvement (QAPI) Plan that is reviewed and approved annually by the PACE governing body and, if necessary, revised. The plan is comprised of the QAPI Program Description and the QAPI Work Plan. It reflects the full range of services furnished by CalOptima PACE. The goal of the CalOptima PACE QAPI Plan is to improve future performance through effective improvement activities driven by identifying key, objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff.

Discussion

The 2017 CalOptima PACE QAPI Plan updates are based on the first three full years of data collection, review and analysis with specific data driven goals and objectives. The objectives were developed based on the opportunities for quality improvement that were revealed in the 2015

[1] Hirth, Baskins and Dever-Bumba. Program of All-Inclusive Care (PACE): Past, Present, and Future, J Am Med Dir Assoc 2009; 10: 155-160

CalOptima PACE QAPI Work Plan evaluation and from the preliminary 2016 CalOptima PACE QAPI Work Plan evaluation. The target goals are based on national benchmarks, CalPACE data, or internal CalOptima PACE metrics.

Fiscal Impact

There is no fiscal impact for the recommended action to have a written CalOptima PACE Quality Assessment and Performance Improvement (QAPI) Plan.

Rationale for Recommendation

The Centers for Medicare and Medicaid Services (CMS) requires all PACE organizations to establish a Quality Assessment and Performance Improvement (QAPI) Plan. This plan is required to be reviewed and approved annually by the CalOptima's Board of Directors to assure effective organizational oversight. CMS and the State shall review the plan during subsequent monitoring visits.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Proposed 2017 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Plan
2. PowerPoint Presentation – 2017 PACE Quality Assurance Performance Improvement (QAPI) Plan

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

02/10/2017 — **Date**

CALOPTIMA PACE

QUALITY ASSESSMENT
PERFORMANCE IMPROVEMENT PLAN

20176

Quality Improvement Subcommittee Chairperson:

Richard Helmer, M.D. **Date**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

Paul Yost~~Viet Van Dang~~, M.D. **Date**

Board of Directors Chairperson:

Mark Refowitz **Date**

Introduction

The Quality Assessment Performance Improvement ~~Plan~~ (QAPI) Plan ~~-~~at CalOptima's Program of All Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous quality improvement for all the PACE organizations' services. It is comprised of this program description and the work plan **(See Appendix B for Work Plan)**. It is designed and organized to support the mission, values, and goals of CalOptima PACE.

Overview

- The goals of the CalOptima PACE QAPI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff.
- The CalOptima PACE QAPI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima's governing body, the Board of Directors has the final authority to review, approve and, if necessary, revise the QAPI Plan annually. (See Appendix A) It is comprised of both the Program Description and specific goals and objectives described in the Work Plan. (See Appendix B)
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QAPI Plan. The PACE QI Coordinator will ensure timely collection and completeness of data.
- CalOptima PACE QAPI Committee will complete an annual evaluation of the approved QAPI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QAPI Plan goals and objectives for the following year.

Goals

- To provide quality health care services for all CalOptima PACE participants through comprehensive service delivery leading to improved clinical outcomes
- To coordinate all QAPI activities into a well-integrated system that oversees quality of care services
- To achieve a coordinated ongoing and effective QAPI Program that involves all providers of care
- To ensure that all levels of care are consistent with professionally recognized standards of practice
- To assure compliance with regulatory requirements of all responsible agencies.
- To promote continuing education and training of staff, practitioners, administration and the executive board
- To analyze data and studies for outcome patterns and trends
- To annually assess the effectiveness of the QAPI Plan and enhance the program by finding opportunities to improve the CalOptima PACE QAPI Plan

Objectives

- Improve the quality of health care for participants
  - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care.
  - Professional standards of CalOptima PACE Staff will be measured against those outlined by their respective licensing agency in the State of California (i.e. The State Board of Nursing of California).
  - Implement population health management techniques for specific participant populations, such as immunizations.
  - Identify and address areas for improvement that arise from unusual incidents, sentinel events, and annual death review.
  - Meet or exceeds minimum levels of performance on standardized quality measures as established by the Centers for Medicare & Medicaid Services (CMS) and the State Administering Agency (SAA) w~~y CMS and the SAA w~~hich includes achieving an immunization rate for both influenza and pneumococcal vaccinations of 80% for the participant population that is appropriate.
  -
- Improve on the patient experience
  - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
  - Provide education to staff on the multiple dimensions of patient experience.
  - Identify and implement ways to better engage participants in the PACE experience, i.g~~e~~., menu selection, PACE Member Advisory Committee (PMAC).
  -
- Ensure appropriate use of resources
  - Review and analyze utilization data regularly including hospital admissions,~~ns, hospital readmissions,~~ ER visits, and hospital 30-day all-cause readmission.
  -
- Provide oversight of contracted services
  - Meet or exceed community standards for credentialing of licensed providers and perform due diligence in assuring that contracted facilities meet community and regulatory standards for licensure.
  - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
  - Review documentation and coordination of care for participants receiving care in institutional settings and perform site visits on an ongoing-basis.
  - Monitor staff and contractors to ensure that appropriate standards of care are met.
  -
- Communication of Quality and Process Improvement Activities and Outcomes
  - Communicate all QAPI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee, and the Board of Directors.
  - Share results of QAPI identified benchmarks with staff and contracted providers at least annually.~~Results of QAPI identified benchmarks are shared with staff and contracted providers at least annually.~~

- Reduce potential risks to safety and health of PACE participants through ongoing Risk Management
    - Ensure that every member of the PACE staff takes responsibility for risks assessment and management.~~Every member of the PACE staff organization has responsibility for risk assessment and management.~~
    - Monitor, analyze and report the aggregated data elements required by CMS via the Health Plan Management System in order to identify areas needing ~~g of~~ quality improvement.
    - Monitor, report and perform a Root Cause Analysis on all participant-involved events, resulting in a significant adverse outcome for the purpose of identifying areas for quality improvement.

Organizational and Committee Structure (See Appendix A for Organizational Chart)
CalOptima Board of Directors provides oversight and direction to CalOptima PACE Organization. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QAPI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the CalOptima quality improvement programs, including the PACE QAPI Program, to the CalOptima Board of Directors' Quality Assurance Committee (QAC). The QAC performs ~~at CalOptima. t This includes the CalOptima PACE QAPI Program, to the CalOptima Board of Director's Quality Assurance Committee (QAC), which performs t~~he functions of the Quality Improvement Committee (QIC) described in CalOptima's State and Federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The CalOptima Board of Director's QAC is a subcommittee of the Board and consists of currently active Board members. The CalOptima Board of Director's QAC reviews the quality and utilization data that are discussed during the PACE Quality Improvement Committee (PQIC). The CalOptima Board of Director's QAC provides progress reports, reviews the annual PACE QAPI Plan and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

CalOptima PACE Quality Improvement Committee (PQIC)
Purpose
This committee provides oversight for the overall administrative and clinical operations of the organization. The PQIC may create new committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. Twice a quarter, ~~On a quarterly basis,~~ the PQIC will review all QAPI Plan initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods in order to address quality problems in any clinical or administrative process. The PQIC~~It~~ will also discuss all of the Level One reporting requirement data and any Level Two reporting incident data~~Level One data and Level Two incidents.~~ Potential areas for improvement will be identified through analysis of the data and through Level Two root cause analysis. This meeting will be facilitated by the PACE Medical Director who will report its activities up to the CalOptima Board of Director's QAC, who will then report up to the Board. The PACE Director or the PACE QA Coordinator may report up to the CalOptima Board of Director's

QAC if the PACE Medical Director is not available.

Membership
Membership shall be composed~~be comprise of~~ of the PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE Clinical Medical Director, PACE QA Manager and the QA Coordinator, and Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing Chair of the committee. See Appendix **C** for QI Committee Minutes Template.

CalOptima PACE Member Advisory Committee (PMAC)
Purpose
This committee provides advice to the Board on issues related to participant care concerns that arise from ~~with~~ participant care decisions and program operations~~s from a community perspective.~~ A member of the PMAC shall report its activities to both the PQIC and the CalOptima Board of Directors' QAC, which then will be reported to the Board.

Membership
The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing Chair and will facilitate for the committee.

CalOptima PACE Focused Review Committees
Purpose
These committees will be formed to respond to or to proactively address specific quality issues which rise to the level of warranting further study and action. Key performance elements are routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization.

Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Clinical Medical Director, PACE QA Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QA Coordinator, and Intake/Enrollment Coordinator or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director or PACE QA Manager. ~~. If the PACE Medical Director is not a member of the committee, then the committee will be chaired by the PACE Director.~~ The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC. This Committee will be responsible for managing all peer review activities performed by independent reviewers related to adverse outcomes.

~~**CalOptima PACE Member Advisory Committee (PMAC)**~~

~~Purpose~~
~~This committee provides advice to the Board on issues related to participant care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to both the PQIC and the CalOptima Board of Directors' QAC, which then will be reported to the Board.~~

~~Membership~~
~~The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing Chair and will facilitate for the committee.~~

~~**CalOptima PACE Ethics Advisory Committee**~~
~~Purpose~~
~~The purpose of this committee is to provide a forum to discuss ethical dilemmas in the provision of care and to respond to participant, family member or staff requests for information on ethical aspects of participant care. It allows for a case review and non-binding recommendations to the Interdisciplinary Team (IDT). The committee or consultants will report and advise the IDT and the PQIC. In addition, it can advise the Board on policy development related to ethics.~~

~~Membership~~
~~It will be composed of five members. The PACE Director will act as the standing Chair of the committee. Community professionals with expertise in geriatrics and long-term care, and who do not have a significant affiliation with CalOptima PACE, will compose at least one-half of the membership Committee seats. At least 3 members will constitute a quorum of the Ethics Committee.~~

Quality and Performance Improvement Activities, Outcomes and Reporting

Quality Indicators and Opportunities for Improvement
Routine quality indicators appropriate for the CalOptima PACE population are identified on analysis and trending of data related to the care and services provided at PACE. Other indicators and opportunities for performance improvement are identified through:

- Utilization of Services
    - CalOptima PACE will collect, analyze and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization
    - Data analysis will allow for analyzing both over and under utilization for areas of quality improvement
    - Transportation services will be monitored through monthly metrics, grievance trending, and a transportation incident log. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE QI department will validate the transportation data by comparing the raw GPS data and unannounced ride along data against the reports submitted.
    - Meal quality will be monitored through daily checks of food temperatures as well as

comments solicited by the CalOptima PACE Member Advisory Committee.

- Participant and Caregiver Satisfaction
  - The organization shall survey the participants and their caregivers on at least an annual basis. Additionally, we will continue to look for other opportunities for feedback in order to improve quality of services.
  - Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
  - The PACE Member Advisory Committee shall provide direct feeback on satisfaction to both the PACE leadership staff and the CalOptima Board of Directors, Quality Assuarnace Committee.
- Outcome mMeasures fFrom the QAPI work plan elements as well as the clininically relavant HPMS data. Data Collected During Patient Assessments
  - This will include the CMS mandated immunization elements would include evaluations from all Interdisciplinary Team Members.
  - Physiological and clinical well-being, functional status, cognitive functioning, and emotional and mental health status assessments maywill be used. Standardized, evidenced based assessments will be used whenever available.
- Effectiveness and safety of staff-provided and contract-provided services
  - This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team with each reassessment, review of medical records, and success of infection control efforts
  - All clinical and certain non-clinical positions have competency profiles specific to their positions
  - CalOptima PACE staff will monitor providers by methods such as review of providers' quality improvement activities, medical record review, grievance investigations, observation of care, and interviews
  - Unannounced visits to inpatient provider sites will be made by CalOptima PACE staff as necessary
- Non-clinical areas

The PACE PQIC has oversight to all activities offered by PACE

Member Grievances will be forwarded to the QA Coordinator for tracking, trending and data gathering. These results will be forwarded to the PACE Director and PACE Medical Director for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of decisions and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.

Member AppealsMember Appeals will be forwarded to the QA Coordinator for tracking, trending and data gathering and the . This will be forwarded to the PACE Director and PACE Medical Director for review. If the PACE Director determines that the appeal is for clinical services, it will be forwarded to the PACE Medical Director for review. If the PACE Direcor or PACE Medical Director disagrees with decision made by the IDT, they will approve the service and communicate this decision to IDT. If the PACE Director or PACE Medical Director agree with IDT's decision, the case will be forwarded to a third party for review. The third party review's decision shall be reviewed by either the PACE Director or the PACE Medical Director and will be immediatelyand decision

~~implementation and~~ shared with the Interdisciplinary Team who will inform caregivers and participants of the decision. If the appeal is denied, the Interdisciplinary Team~~s~~ will inform the members of their additional appeal rights under Medicare and Medical and will ~~and~~ assist them with furtherment of thi~~s~~e process as needed. ~~.~~

-
- Other Monitoring Activities
    - Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills as well as regulatory agency inspections.

~~- Transportation services will continue to be monitored through monthly metrics and grievance trending and reported via quarterly PQIC meetings.~~

~~- Meal quality will be monitored through daily checks of food temperatures as well as comments solicited by the CalOptima PACE Member Advisory Committee.~~

~~- Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills as well as regulatory agency inspections.~~

~~- Plans of correction on problems noted will be implemented by center staff and reviewed by the PACE Program Director, PACE Medical Director or the PACE QA Manager.~~

~~-~~ The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

-

Priority setting for performance improvement initiatives is based on

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life
- Potential impact on participant access to necessary care or services
- Potential impact on participant safety
- Participant, caregiver, or other customer satisfaction
- Potential impact on efficiency and cost-effectiveness
- Potential mitigation of high risk, high volume, or high frequency events
- Relevance to the mission and values of CalOptima PACE

External Monitoring and Reporting

CalOptima PACE will report both aggregate and individual-level data to CMS and State Administering Agencies to allow them to monitor CalOptima's PACE performance. This includes Level One and Level Two Reporting, Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported up through the PACE monitoring module of the Health Plan Management System (HPMS).

- CMS implemented changes to the Level One event reporting structure. On a quarterly basis, the following events are reports to CMS via the Health Plan Management System (HPMS):
    - Grievances
    - Appeals
    - Burnes
    - Medication Errors
    - Immunizations

- Enrollment/Disenrollment
- Falls without Injury
- ER Visits
- Kennedy Terminal Ulcer

~~Level II events, formerly known as sentinel events, are reported as they occur.~~

- ~~Level One Reporting Indicators~~
- ~~Routine Immunizations~~
- ~~Grievances and Appeals~~
- ~~Enrollments~~
- ~~Disenrollments~~
- ~~Prospective Enrollees~~
- ~~Readmissions~~
- ~~Emergency (Unscheduled) Care~~
- ~~Unusual Incidents~~
- ~~Deaths~~

~~Level Two Reporting Indicators~~

- ~~When unusual incidents reach specified thresholds, CalOptima must notify CMS and the State Administering Agency in the required timetables, complete a Root Cause Analysis and present the results of the analysis on a conference call with both agencies as well as internally at the PACE QIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Level Two Events are:~~
- ~~Deaths related to suicide or homicide, unexpected and with active coroner investigation~~
- ~~Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall~~
- ~~Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame~~
- ~~Pressure ulcer acquired while enrolled in the PACE Program~~
- ~~Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function~~
- ~~Any elopement~~
- ~~Health Outcomes Survey-Modified (HOS-M)~~
- ~~CalOptima PACE will participate in the annual HOS-M to assess the frailty of the population in our center~~
- ~~Other External Reporting Requirements~~

- Level Two Reporting Indicators
  - When unusual incidents reach specified thresholds, CalOptima must notify CMS and the State Administering Agency in the required timetables, complete a Root Cause Analysis and present the results of the analysis on a conference call with both agencies as well as internally at the PACE QIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Level Two Events are:
  - Deaths related to suicide or homicide, unexpected and with active coroner investigation

- F alls that result in death, a fracture or an injury requiring hospitalization related directly to the fall
- Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame
- Pressure ulcer acquired while enrolled in the PACE Program
- Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function
- Any elopement
- ~~Suspected elder abuse shall be reported to appropriate state agency~~
- ~~Equipment failure or serious adverse reaction to any administered medications will be reported to the FDA~~
- ~~Any infectious disease outbreak will be reported to the CDC~~

- Health Outcomes Survey-Modified (HOS-M)
  - CalOptima PACE will participate in the annual HOS-M to assess the frailty of the population in our center

- Other External Reporting Requirements
  - Suspected elder abuse shall be reported to appropriate state agency
  - Equipment failure or serious adverse reaction to any administered medications will be reported to the FDA
  - Any infectious disease outbreak will be reported to the CDC

Corrective Action Plans

- When opportunities for improvement are identified, a corrective plan will be created.
- Each corrective plan will include an explanation of the problem, the individual who is responsible for implementing the corrective plan, the time frame for each step of the plan, and an evaluation process to determine effectiveness
- Corrective Action Plans from contracted providers will be requested by the QA Manager or other member of the PQIC, as appropriate

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the CalOptima PACE Medical Director and the CalOptima PACE Director
- The QA Manager or QA Coordinator will consult with relevant CalOptima PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately

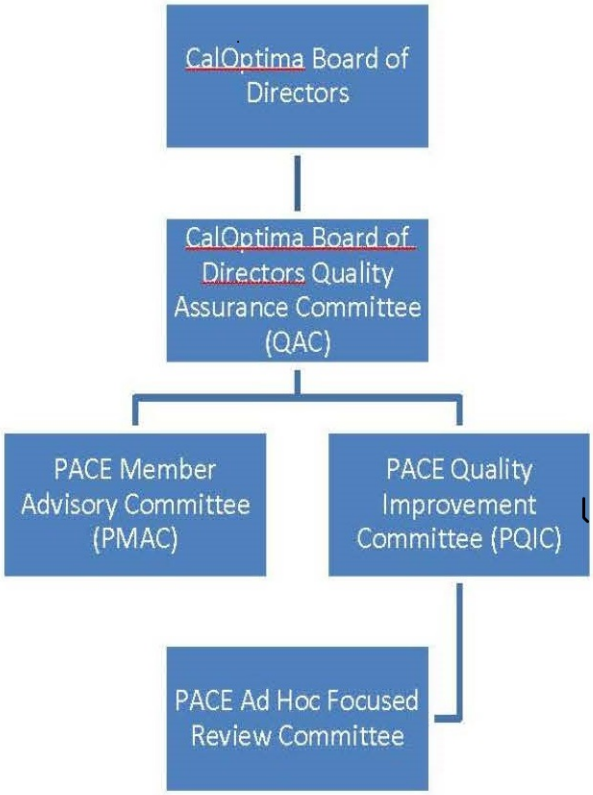
Re-Evaluation and Follow-up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
    - Severity of the problem
    - Frequency of occurrence
    - Impact of the problem on participant outcomes
    - Feasibility of implementation
    -
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Annual Review of PACE QAPI Plan

- The PACE QAPI Plan will be assessed annually for effectiveness
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QAPI Plan
- The CalOptima Board of Directors will review, revise and approve the CalOptima PACE QAPI Plan to assure organizational oversight and commitment

Appendix A: 20176 CalOptima PACE QAPI Program Reporting Structure



Proposed 2017 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Work Plan

QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion
QAPI17.01	**Quality of Care**	**2016 PACE QAPI Plan and Work Plan Annual Evaluation**	PACE QAPI Plan and Work Plan will be evaluated annually.	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation	PACE Medical Director	Annually	March, 2017
QAPI17.02	**Quality of Care**	**2017 PACE QAPI Plan and Work Plan Annual Oversight**	PACE QAPI Plan and Work Plan will be reviewed and updated annually	QAPI and QAPI Work Plan will be approved and adopted on an annual basis	Annual Adoption	PACE Medical Director	Annually	March, 2017
QAPI17.03	**Quality of Care**	**Influenza Immunization Rates**	Increase Influenza immunization rates for all eligible PACE participants	Improve compliance with influenza immunization recommendations	> 90% of members will have influenza vaccination	Clinical Operations Manager	Quarterly	12/31/2017
QAPI17.04	**Quality of Care**	**Pneumococcal Immunization Rates**	Increase Pneumococcal immunization rates for all eligible PACE participants	Improve compliance with pneumococcal immunization recommendations	> 90% of members will have pneumococcal vaccination	Clinical Operations Manager	Quarterly	12/31/2017
QAPI17.05	**Quality of Care**	**Infection Control**	Reduce common infections in PACE participants (Urinary and Skin)	Monitor and analyze the incidence of Urinary and Skin infectinos in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement	Maintain common infection rates less than the following national benchmarks: Urinary Tract 0.46-4.4 episodes/1000 participant days. Skin and Soft Tissue 0.1-2.1 episodes/1000 participant days	Clinical Operations Manager	Quarterly	12/31/2017
QAPI17.06	**Quality of Care**	**Diabetes: Annual Diabetic Eye Exams**	Increase the percentage of PACE participants with diabetes who get their annual diabetic eye exam completed	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement	> 90% of members with diabetes will have their annual eye exam completed	PACE Medical Director	Quarterly	12/31/2017
QAPI17.07	**Quality of Care**	**Care for Older Adults: Advance Directive Planning**	Increase POLST utilization for PACE participants	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization	>75% of members will have a POLST	PACE Center Manager	Quarterly	12/31/2017
QAPI17.08	**Quality of Care**	**Care for Older Adults: Medication Review**	Increase the percentage of PACE participants who have their medications reviewed	Ensure all PACE participants have a medication review	100%	PACE Center Manager	Quarterly	12/31/2017
QAPI17.09	**Quality of Care**	**Care for Older Adults: Functional Status Assessment**	Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS.	Ensure all PACE participants have a functional status assessment completed every 6 months	100%	PACE Center Manager	Quarterly	12/31/2017
QAPI17.10	**Quality of Care**	**Care for Older Adults: Pain Screening**	Increase the percentage of PACE participants who are screened regularly for pain.	Ensure all PACE participants have a pain screening	100%	PACE Center Manager	Quarterly	12/31/2017
QAPI17.11	**Quality of Care**	**Potentially Harmful Drug/Disease Interactions in the Elderly (DAE): Dementia + tricyclic antidepressant or anticholinergic agents**	Reduce potentially harmful drug-diease interactions	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	>38.82% (2016 HEDIS Prospective One Care Connect 90th Percentile Rate)	PACE Pharmacist	Quarterly	12/31/2017

QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion
QAPI17.12	**Quality of Care**	**Potentially Harmful Drug/Disease Interactions in the Elderly (DAE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs**	Reduce potentially harmful drug-disease interactions	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	>3.93% (2016 HEDIS Prospective One Care Connect 90th Percentile Rate)	PACE Pharmacist	Quarterly	12/31/2017
QAPI17.13	**Access and Availability**	**Specialty Care**	Improve access to specialty practitioners	Appointments for specialty care will be scheduled within 7 business days to improve access to specialty care for initial consultations	> 80% of specialty care authorizations will be scheduled within 7 business days	PACE Clinical Operations Manager	Quarterly	12/31/2017
QAPI17.14	**Utilization Management**	**Acute Hospital Day Utilization**	Reduce the rate of acute hospital days by PACE participants	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	< 2,104 hospital days per 1000 per year (CalPACE avg in 2015)	PACE Medical Director	Quarterly	12/31/2017
QAPI17.15	**Utilization Management**	**Emergency Room Utilization**	Reduce the rate of ER utilization by PACE participants	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	< 458 emergency room vists per 1000 per year (CalPACE avg in 2015)	PACE Medical Director	Quarterly	12/31/2017
QAPI17.16	**Utilization Management**	**30-Day All Cause Readmission Rates**	Reduce the 30-day all cause readmission rates by PACE participants	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	<10% 30-day all cause readdmission (CalOptima PACE avg in 2016)	PACE Medical Director	Quarterly	12/31/2017
QAPI17.18	**Utilization Management**	**Long Term Care Placement**	Decrease the percentage of participants who are placed in a long term care facility	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	<4% of members (CalPACE utilization in 2016) will reside in long term care	PACE Center Manager	Quarterly	12/31/2017
QAPI17.17	**Participant Satisfaction**	**Disenrollments**	Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment.	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Reduce the annualized rate below 50/k/year (20% reduction from 2016)	PACE Center Manager	Quarterly	12/31/2017
QAPI17.18	**Participant Satisfaction**	**Overall Satisfaction**	Improve the overall satisfaction of participants and their families with the CalOptima PACE program	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	> 90% will answer Good, Very Good or Excellent on this question	PACE Director	Annually	12/31/2017
QAPI17.19	**Participant Satisfaction**	**Transportation**	Improve response time to transportation incidents reported by staff and participants	Monitor and analyze incidents reported in the Transportation Incident Log to identify opportunities for improvement to resolve issues within 48 hours of report	>90% of incidents are resolved within 48 hours	PACE Center Manager	Quarterly	12/31/2017

QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion
QAPI17.20	**Delegation Oversight**	**Transportation**	Improve PACE transportation ride times to less than 60 minutes per trip	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	0 trips > 60 minutes in duration	PACE Director	Quarterly	12/31/2017
QAPI17.21	**Delegation Oversight**	**Transportation**	Improve participant experience by providing timely transportation services	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports by sampling GPS records and monthly ride-along	>90% on-time performance	PACE Director	Quarterly	12/31/2017

2017 CalOptima PACE QAPI Work Plan Measures and Definitions

QAPI measure	Description	Definition of Measure	Data Source
QAPI17.01	PACE QAPI Plan and Work Plan will be evaluated annually.	N/A	N/A
QAPI17.02	PACE QAPI Plan and Work Plan will be reviewed and updated annually	N/A	N/A
QAPI17.03	Increase Influenza immunization rates for all eligible PACE participants	Immunization rate = (Recieved immunization + Prior Immunization) / (Total Participants - Medical Contraindications - Refused)	TruChart Immunization portal
QAPI17.04	Increase Pneumococcal immunization rates for all eligible PACE participants	Immunization rate = (Recieved immunization + Prior Immunization) / (Total Participants - Medical Contraindications - Refused). Pneumococcal vaccination valid within 5 years.	TruChart Immunization portal
QAPI17.05	Reduce common infections in PACE participants (Urinary and Skin)	Infection Rate = (Espisodes per Quarter/Member Months) / 30 days x 1,000	TruChart report of ICD-10s
QAPI17.06	Increase the percentage of PACE participants with diabetes who get their annual diabetic eye exam completed	See HEDIS standard. Annual diabetic eye exam rate = # diabetic participants with completed eye exams within 12 months / # of participants with DM	TruChart report of ICD-10s (DM); TruChart service recording portal
QAPI17.07	Increase POLST utilization for PACE participants	POLST utilization rate = # of participants who are currently enrolled for at least 6 months that have a POLST / # of participants who are currently enrolled for at least 6 months	TruChart Health Wishes portal; TruChart Enrollment report
QAPI17.08	Increase the percentage of PACE participants who have their medications reviewed	See HEDIS standard. Medical Records to audit TruChart for evidence of medication review by PharmD, MD, NP or RN within 6 months. Evidence may be in the form of a progress note or assessment.	Quarterly Medical Record Review (5% of charts per quarter)
QAPI17.09	Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS.	See HEDIS standard. Medical Records to audit TruChart for evidence of functional assessment by PCP, RN, MSW and RT every 6 months. Evidence must be in the form of an assessment.	Quarterly Medical Record Review (5% of charts per quarter)
QAPI17.10	Increase the percentage of PACE participants who are screened regularly for pain.	See HEDIS standard. Medical Records to audit TruChart for evidence of pain assessment by RN every 6 months. Evidence must be in the form of an assessment.	Quarterly Medical Record Review (5% of charts per quarter)
QAPI17.11	Reduce potentially harmful drug-disease interactions for participants with dementia diagnosis	See HEDIS standard. Rate of drug/disease interactions = # of participants on drug combination / # of participants with dementia diagnosis	TruChart report of ICD-10s (dementia); Pharmacy report of prescriptions
QAPI17.12	Reduce potentially harmful drug-disease interactions for participants with chronic renal failure diagnosis	See HEDIS standard. Rate of drug/disease interactions = # of participants on drug combination / # of participants with chronic renal failure diagnosis	TruChart report of ICD-10s (chronic renal failure); Pharmacy report of prescriptions
QAPI17.13	Improve access to specialty practitioners	Turn Around Time Rate = # of appointments scheduled within 7 business days from authorization / # of appointments scheduled	TruChart Specialty Care report
QAPI17.14	Reduce the rate of acute hospital days by PACE participants	Annualized Rate = (Number of Bed Days for a year / MM for a year) x 1000 x 12	TruChart Admit report
QAPI17.15	Reduce the rate of ER utilization by PACE participants	Annualized Rate = (#ER Visits for a year / MM for a year) x 1000 x 12	TruChart Admit report
QAPI17.16	Reduce the 30-day all cause readmission rates by PACE participants	Readmission Rate = # of readmissions / # of admits	TruChart Admit report
QAPI17.18	Decrease the percentage of participants who are placed in a long term care facility	LTC utilization rate = # participants residing in custodial SNF level of care / # of participants enrolled	TruChart Admit report
QAPI17.17	Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment.	Controllable Disenrollments Within 90 Days Rate = (# of controllable disenrollments within 90 days of enrollment for a year / MM for a year) x 1000 x 12	TruChart Disenrollment report; Controllable vs Non-Controllable Disenrollment report
QAPI17.18	Improve the overall satisfaction of participants and their families with the CalOptima PACE program	Annual Vital Research survey via CalPACE membership	Annual Participant Satisfaction Survey
QAPI17.19	Improve response time to transportation incidents reported by staff and participants	Response rate to incidents = # of incidents resolved within 48 hours / # of incidents	Transportation Incident Log
QAPI17.20	Improve PACE transportation ride times to less than 60 minutes per trip	Rides >60 minutes	Secure Transportation reports
QAPI17.21	Improve participant experience by providing timely transportation services	On-time performance = # of rides with actual departure +/- 15 min of scheduled time / # of rides	Secure Transportation reports

Appendix C: PACE QAPI Committee Meeting Minutes Template

PACE Quality Improvement Committee Meeting Minutes Date Time: Place: PACE conference Room 109		
Meeting Attendees: PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QA Coordinator, and the PACE Intake/Enrollment Manager.		
Meeting Notes Taker: QA Coordinator		
Topic	Presentation/Discussion	Recommendation/Action
Roll Call and Introduction		
Review and Approval of Last PQIC Meeting Minutes		
Old Business:		
New Business:		
Level II Issues		
HPMS Data Analysis		
Standing Agenda Item		
Clinical Logs and Updates		
Operational Logs and Updates		
Site Logs and Updates		
PMAC Update Report		

2017 PACE Quality Assurance Performance Improvement (QAPI) Description and Work Plan

Board of Directors' Quality Assurance Committee Meeting

February 15, 2017

Miles Masatsugu, M.D.

Medical Director

2017 Program Description

- Encompasses all clinical care, clinical services & organizational services provided to our members
- Aligns with our vision and mission
- Focuses on optimal health outcomes for our members
- Uses evidence-based guidelines, data and best practices tailored to our populations

2017 PACE QAPI Work Plan Elements

- Preventative Care
- Quality Of Care
- Infection Control
- Access & Availability
- Utilization Management
- Delegation Oversight
- Patient Satisfaction/Member Experience

Opportunities for Improvement in 2017

- Specialty Care, Transportation and Patient Satisfaction
- Utilization of Services
- Additional Quality of Care elements focused on the elderly population

2017 QAPI Revised Work Plan Elements

- Physician's Orders for Life-Sustaining Treatment (POLST)
- 30-Day-All-Cause Readmissions
- Transportation
  - One-hour violations
  - On-time performance
  - Incident resolution
- Access and Availability: Specialty Care

2017 QAPI New Work Plan Elements

- Quality of Care for Older Adults
  - Medication Review
  - Functional Status Assessment
  - Pain Screening
- Potentially Harmful Drug-Disease Interactions in the Elderly
  - Chronic Renal Failure with NSAIDS
  - Dementia with Tricyclic Antidepressants or Anticolinergic Agents
- Utilization Management: Long Term Placement
- Patient Satisfaction: Disenrollments

Recommended Action

- Recommend Board of Directors' approval of the 2017 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Plan

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

Recommend Board of Directors approval of the MY 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.

Unpaid Incentive Dollars

The CMO will have authority to allocate unpaid incentive funds for quality improvement initiatives in areas where rates failed to meet benchmarks/goals and areas that are part of quality or strategic goals. Quality initiatives may include direct to physician incentives, bonus payments to health networks for improved performance, member and provider interventions, and participation in QI projects. Any incentive dollars that remain unspent may roll forward to the next fiscal year to be used for quality improvement initiatives or may be retained in the general fund.

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

Attachments

1. MY 2017 Medi-Cal Pay for Value Program
2. MY 2017 OneCare Connect P4V Program
3. PowerPoint Presentation - 2017 Pay for Value Programs

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

02/10/2017 — **Date**

Attachment 1: FY 2018 (MY 2017) Medi-Cal Pay for Value Program Measurement Set

Adult Measures	**2017 Measurement Year / HEDIS 2018 Specifications** **Anticipated Payment Date: Q3 2018**	**Measurement Assessment Methodology**
Clinical Domain - HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	<u>Prevention:</u> • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) <u>Diabetes:</u> • HbA1c Testing • Retinal Eye Exams <u>Access to Care</u>: • Adults Access to Preventive/Ambulatory Care <u>Respiratory</u>: • Medication Management for People with Asthma (MMA)	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percentile Improvement
Patient Experience Domain - CAHPS Weight: 40%	<u>Adult Satisfaction Survey (Adult CAHPS):</u> 1. Getting appointment with a Specialist 2. Timely Care and Service 3. Rating of PCP 4. Rating of all Healthcare	A relative point system by measure based on: • NCQA California CAHPS percentiles • Percentile Improvement

Pediatric Measures	**2017 Measurement Year / HEDIS 2018 Specifications** **Anticipated Payment Date: Q3 2018**	**Measurement Assessment Methodology**
Clinical Domain - HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	<u>Respiratory:</u> • Medication Management for People with Asthma (MMA) • Appropriate Testing for Children with Pharyngitis (CWP) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) <u>Prevention:</u> • Childhood Immunization Status Combo 10 (CIS) • Well-Care Visits in the 3-6 Years of Life (W34) • Adolescent Well-Care Visits (AWC) <u>Access to Care:</u> • Children's Access to Primary Care Physician	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percentile Improvement
Patient Experience Domain - CAHPS Weight: 40%	<u>Child Satisfaction Survey (Child CAHPS)</u> • Getting Appointment with a Specialist • Timely Care and Service • Rating of PCP • Rating of all Healthcare	A relative point system by measure based on: • NCQA California CAHPS percentiles • Percentile Improvement

Attachment 2: FY 2018 (MY 2017) OneCare Connect Pay for Value Program

OneCare Connect Measures	**2017 Measurement Year / HEDIS 2018 Specifications** **Anticipated Payment Date: Q3 2018**	**Measurement Assessment Methodology**
Clinical Domain - HEDIS Weight: 60.00% Each measure weighted equally	<u>Measures:</u> • Plan All Cause Readmissions • Antidepressant Medication Management Outcome Measures • Blood Pressure Control • Part D Medication Adherence for Diabetes	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percent Improvement **For the Part D Medication Adherence Measure**: A relative point system by measure based on: • CMS Star Rating Percentiles • Percentile Improvement
Patient Experience Domain - CAHPS Weight: 40%	<u>Adult Satisfaction Survey (Adult CAHPS):</u> • Getting appointment with a Specialist • Timely Care and Service • Rating of PCP • Rating of all Healthcare	A relative point system by measure based on: • 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.

Pay for Value 2017 Program

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

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

Caryn Ireland, Executive Director, Quality

2016 Total Medi-Cal Allocations (MY 2015) (Clinical and CAHPS Measures)

Total Accrual	HEDIS Allocation	Survey Allocation	Total Amount Paid	Remaining Unallocated Dollars*	Percent Remaining
$ 14,845,614.00	$ 2,642,309.93	$ 1,293,032.75	$ 3,935,342.68	$ 10,910,271.32	73.49%

* Remaining unallocated dollars will not be paid.

2016 Allocations by Health Network (MY 2015) (Medi-Cal Measures)

Health Network	% HEDIS Earned	% Survey Earned	% of Total Amount Paid	Percentage Remaining
HN - A	21.67%	0.00%	21.67%	78.33%
HN - B	10.83%	10.00%	20.83%	79.17%
HN - C	5.42%	5.63%	11.04%	88.96%
HN - D	16.25%	12.50%	28.75%	71.25%
HN - E	32.50%	8.75%	41.25%	58.75%
HN - F	10.83%	16.25%	27.08%	72.92%
HN - G	10.83%	8.13%	18.96%	81.04%
HN - H	5.42%	0.00%	5.42%	94.58%
HN - I	21.67%	11.88%	33.54%	66.46%
HN - J	21.67%	15.00%	36.67%	63.33%
HN - K	21.67%	10.00%	31.67%	68.33%
TOTAL	**17.80%**	**8.71%**	**26.51%**	**73.49%**

2016 Total Allocations (MY 2015) (OneCare Measures)

Total Accrual	HEDIS Allocation	Survey Allocation	Total Amount Paid	Remaining Unallocated Dollars*	Percent Remaining
$2,492,469.84	$ 327,068.28	$258,186.00	$ 585,254.28	$ 1,907,215.56	76.52%

* Remaining unallocated dollars will not be paid

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2016 Allocation by Health Networks (MY 2015) (OneCare Measures)

Health Network	% HEDIS Earned	%Survey Earned	% of Total Amount Paid	Percentage Remaining
HN-I	5.35%	12.52%	17.88%	82.12%
HN-II	16.06%	3.13%	19.19%	80.81%
HN-III	0.00%	0.00%	0.00%	100.00%
HN-IV	5.35%	3.13%	8.48%	91.52%
HN-V	10.71%	18.79%	29.49%	70.51%
HN-VI	0.00%	12.52%	12.52%	87.48%
HN-VII	32.12%	0.00%	32.12%	67.88%
HN-VIII	0.00%	12.52%	12.52%	87.48%
TOTAL	**13.12%**	**10.36%**	**23.48%**	**76.52%**

Medi-Cal P4V Clinical Measures

Measurement Year 2017 Measures	
Adult Measures	**Child Measures**
Adult's Access to Preventive Care Services (AAP)	Children's Access to Primary Care Physicians (CAP)
Breast Cancer Screening (BCS)	Well-Child Visits in the 3-6 Years of life (W34)
Cervical Cancer Screening (CCS)	Adolescent Well-Care Visits (AWC)
Comprehensive Diabetes Care (CDC): HbA1C Testing	Childhood Immunization Status (CIS) Combo 10
Comprehensive Diabetes Care (CDC): Retinal Eye Exams	Appropriate Testing for Children with Pharyngitis (CWP)
Medication Management for People with Asthma (MMA)	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
* No change in clinical measures from 2016	Medication Management for People with Asthma (MMA)

MediCal P4V CAHPS Measures

Measurement Year 2017 Measures
Child and Adult Measures
Getting Appointment with a Specialist
Timely Care & Service
Rating of Primary Care Physician
Rating of All HealthCare
* No change in survey measures from 2016

OCC P4V Clinical Measures

Measurement Year 2017 Measures
1. Plan All Cause Readmissions
2. Behavioral Health: • Antidepressant Medication Management
3. Controlling Blood Pressure
4. Medication Adherence for Oral Anti-Diabetes Medications (Part D measure)

* No change in clinical measures from 2016;
* Clinical measures weight changed from 100% to 60% due to addition of Member Experience component for 2017

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OCC P4V CAHPS Measures

Measurement Year 2017 Measures
Child and Adult Measures
Getting Appointment with a Specialist
Timely Care & Service
Rating of Primary Care Physician
Rating of All HealthCare
* Weight=40%

Proposed 2017 Display Measures

- Display Measures are new measures that may be included in future pay for value programs
- These measures were not eligible for payment for 2016 measurement year performance
- CalOptima will include display measures on the monthly health network P4V prospective rate reports for monitoring purposes
- Display Measure:
  - ❖Initial Health Assessment (IHA)—will remain display measure for 2017
- Retired Display Measures:
  - ❖Ambulatory Care (Outpatient and ER visits)
  - ❖Readmissions

2017 Payment Methodology, Proposed

Population Included	
Total # of Adults in Health Network	Total # of Children in Health Network
Apply Acuity Score (SPD Weight 4X, TANF Weight 1X)	
Scoring for Measure Performance:	
A relative point system, by measure, based on: • NCQA National HEDIS Percentiles (clinical) 50th percentile minimum • NCQA California CAHPS Percentiles (satisfaction) • Relative HN Improvement year-over-year x CalOptima (CO) improvement YOY • Minimum denominator size for eligible measure reduced from 100 to 30 members	
Clinical Measures = **60%** of the Total	**CAHPS Measures** = **40%** of the Total
(**Performance = 50%)** (relative performance x weighted pmpm)	**(Improvement = 50%** (relative Impr x CO Impr factor x pmpm)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Action

Provide final approval for staff to develop and implement Member and Provider incentive programs in the amounts listed on Attachment 1, subject to applicable regulatory approval and guidelines.

Background

In CalOptima's 2013-2016 Strategic Plan, one of the strategic priorities was related to Quality Programs and Services. As a part of this strategic priority, CalOptima has worked diligently to provide members with access to quality health care services and ensure optimal health outcomes for all our members.

At the December 1, 2016, meeting, the CalOptima Board of Directors approved the Medi-Cal quality improvement and accreditation activities for Fiscal Year 2016-17. Specifically, the Board:

- Directed Staff to develop member and provider incentive programs in the amounts listed in Attachment 1, subject to applicable regulatory approval and guidelines, and final approval by the Board prior to implementation; and
- Authorized unbudgeted expenditures not to exceed $1.1 million to implement a budget augmentation for current quality initiatives (i.e., Surveys & NCQA fees, Consulting services, Quality Initiatives in flight, Required Training) and new requests for quality initiatives.

Discussion

Attachment 1 provides the requested additional detail on the HEDIS measures and proposed member and provider incentives. During the development of these incentive programs, staff has been able to more precisely identify the scope and cost per incentive. Some incentives are designed as pilot programs, in order to evaluate their effectiveness prior to launching to a larger number of members or providers. As such, Attachment 2 provides further detail on the proposed revisions to the expenditures for Medi-Cal Quality Improvement and Accreditation activities from the December 1, 2016, Board action.

Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives.

Fiscal Impact
There is no additional fiscal impact for the recommended action.

Rationale for Recommendation
CalOptima staff believes that by partnering with our Health Network and provider community, targeted, impactful interventions will result in improvements in our quality scores, to maintain our NCQA Commendable status.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: Proposed Member and Provider Incentive Plan
2. Revision to Expenditures for Medi-Cal Quality Improvement and Accreditation Activities
3. Board Action dated December 1, 2016, Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million

/s/ Michael Schrader — *02/10/2017*
Authorized Signature — **Date**

Proposed Member and Provider Incentive Plan

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

Caryn Ireland
Executive Director, Quality and Analytics

Introduction

- All proposed incentives are pilot projects; results of each incentive will be brought back to the Board when analyzed
- No additional funds are requested
- Staff has refined the originally proposed costs to reflect expenditures during FY16-17 vs. through year end
- Staff has incorporated DHCS guidance on best practices for member incentives
  - Member incentives will be in the form of gift cards
- Offices/clinics identified for the Provider incentives will be based on the following criteria:
  - High Volume Providers, in good standing with CalOptima

Postpartum: Member Incentive

	Description
Objectives	To increase the number of members who had a delivery to obtain their postpartum visit within the prescribed timeframe. CalOptima's goal is to increase the HEDIS postpartum visit rate to above the 25th percentile.
Target Population	Medi-Cal members with a delivery between March 1 – June 30, 2017 (postpartum visit may occur after July 1st)
Requirements	• Voluntary participation in the postpartum incentive program. • Member must complete a postpartum visit with a provider within prescribed timeframe after delivery. • Member must complete and return required form provided by CalOptima to verify postpartum visit to obtain member incentive.
Incentive Type/Amount:	• $25 gift card per participating member •Additional entrance into a monthly opportunity drawing [50 members will be given a $100 gift card every month through opportunity drawing].
Duration:	• March 1- June 30, 2017
Total Cost:	**$90, 682** Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017

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Postpartum: Provider Office Staff Incentive

	Description
Objectives	Provide “just in time” training on Medical Records documentation of postpartum visits in order to improve our postpartum chart review results. Incomplete medical record documentation contributes to our declining postpartum score. Staff have analyzed postpartum medical record documentation that contributed to lack of compliance. Goal is to raise rates on Postpartum Care.
Target Population	Three PCPs, Clinics or OB/GYN offices with the highest number of members who had a delivery between January-June, 2017
Requirements	•Clinic staff must participate in a review 2016 medical record results with CalOptima staff for training on documentation which may lead to low rates. (March) •Clinic staff will implement changes within their office processes to ensure complete documentation; •Clinic staff will review sample of medical records with CalOptima team for training (April, May, June) •Requires Office Manager & Clinical Staff participation in all sessions
Incentive Type/Amount:	• $1000 per provider office or clinic for participation in the program • $1000 per provider office for demonstrated improvement
Duration:	4 months (Mar-June 30, 2017)
Total Cost:	**$10,000 (includes payments to providers and chart review resources)**

Cervical Cancer Screening: Member Incentive

	Description
Objectives	To improve cervical cancer screening HEDIS rates
Target Population	Medi-Cal members between the ages of 50-64 years old.
Requirements	• Voluntary participation in the cervical cancer screening incentive program. • Member must complete a cervical cancer screening between February 15 – August 31, 2017. • Member must complete and return required form provided by CalOptima to verify cervical cancer screening to obtain member incentive.
Incentive Type/Amount:	• $15 gift card/member for completing cervical cancer screening. • Additional entrance into a monthly opportunity drawing [75 members will be given a $100 gift card every month through opportunity drawing].
Duration:	6 months (February 15 - August 31, 2017)
Total Cost:	**$87,505 by June 30, 2017** • 4,167 members to complete cervical cancer screening by June 30, 2017 • 4,167 members x 15 = $62,505, plus $25,000 in opportunity drawing = $87,505. •Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017

Cervical Cancer: Provider Office Staff Incentive

	Description
Objectives	1) To improve cervical cancer screening rates (HEDIS CCS) at targeted office sites by incentivizing staff to assist CalOptima members to get a pap test in greater volume than their current monthly average. CalOptima staff to calculate monthly average of completed pap tests for each targeted office. This may include helping to schedule appts for members, helping with transportation services, providing follow-up reminder calls, etc. 2) To understand and learn about any barriers at the provider level in an effort to provide resources and support.
Target Population	1) Target 5 High volume Medi-Cal provider offices, and 5 High volume Medi-Cal clinics, focus on office staff to help member get and keep appointments for pap tests. 2) Additional offices may be added to the campaign
Requirements	• Voluntary participation in the Provider Office Staff incentive program. • Conduct member outreach efforts (outbound calling, scheduling, record-keeping, maintaining communication with CalOptima). • Monthly communication/update with CalOptima.
Incentive Type/Amount:	• Two (2) meals will be provided at Provider Offices; Once at program launch and a second time at program completion. • $10/member above the monthly cervical cancer screening average for the office
Example for $10 incentive: Dr. John Smith	Avg. # Cervical Cancer Screenings for CalOptima Members: 25 Completed # of Cervical Cancer Screenings in February, 2017: 55 Increase over average screening rate: 30 (validated via claim/encounter submission) Total Incentive Earned for February, 2017: $300 (10 X $30=$300) Incentive may be earned for each month of the program , but amount will vary depending upon the number of members screened above the monthly average .
Duration:	6 months (February 15 – August 31, 2017)
Total Cost:	**$ Up to 72,500;** Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017

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Cervical Cancer: Extended Hours Initiative

	Description
Objectives	To promote women's health (breast and cervical cancer screenings) and improve screening rates at targeted provider offices.
Target Population	Target 1-2 high volume PCP offices. * Additional offices may be added to the campaign
Requirements	• Voluntary participation in the Provider Office Extended Hours Initiative. • Extend office hours for CalOptima members at least two (2) times per month for 3 months. Extended hours could be evening or weekends; targeting 8 additional hours per month per provider office. • Conduct member outreach efforts (outbound calling, scheduling appointments, record-keeping, maintaining communication with CalOptima). • Conduct well-women exams to include pap test, exclusively for CalOptima members during extended hours.
Incentive Type/Amount:	• Each office may receive up to $200/hour (up to a maximum of 16 hours over 3 months) to cover the cost of extending office hours, staffing resources and others. • Cost may vary between offices due to staffing resources and extended hours.
Duration:	3 months (March 1 – June 30, 2017)
Total Cost:	**$10,000**

Breast Cancer Screening: Member Incentive

	Description
Objectives	To improve breast cancer screening HEDIS rates
Target Population	Medi-Cal members between the ages of 50 -74 years old.
Requirements	• Voluntary participation in the breast cancer screening incentive program. • Member must complete a breast cancer screening between February 1 – August 31, 2017. • Member must complete and return required form provided by CalOptima to verify breast cancer screening to obtain member incentive.
Incentive Type/Amount:	• $10 gift card/member for completing breast cancer screening. • Additional entrance into a monthly opportunity drawing [50 members will be given a $100 gift card every month through opportunity drawing].
Duration:	• 6 months (February 15 – August 31, 2017)
Total Cost:	**$82, 500 by June 30, 2017** • 5,750 members to complete breast cancer screening by August 31, 2017 • 5,750 x 10 = $57,000; plus $25,000 in opportunity drawing = $82,500 •Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017

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Attachment 2: Revision to Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

	12/1/16 Board Action		Recommended Action	
Item	**Detail**	**Total Amount (Not to Exceed)**	**Detail**	**Total Amount (Not to Exceed)**
Member Programs	• Prenatal/postpartum incentive (Increase volume of outreach): $10,887 • Breast cancer screening (Downward trend; Reminder mailing & incentive): $99,900 • Cervical cancer screening (Below MPL; Reminder mailing & incentive): $149,900	$260,687	• Prenatal/postpartum incentive: $90,682 • Breast cancer screening: $82,500 • Cervical cancer screening: $87,505	$260,687
Provider Programs	• Physician office extended hours pilot project - MPL measures: $10,000 • Prenatal/postpartum provider office incentive: $5,000 • PCP office staff incentives for well women visits/screenings: $75,000 • Physician office extended hours initiative mailing: $2,500	$92,500	• Postpartum provider office staff incentive: $10,000 • Cervical cancer provider office staff incentive: $72,500 • Cervical cancer extended hours initiative: $10,000	$92,500

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million

Contact

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

Recommended Actions

1. Approve the Quality Improvement activities listed on Attachment 1;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to contract with new vendors and amend existing vendor contracts, as appropriate, for quality improvement-related services, including NCQA consulting and provider coaching services, incentive distribution and tracking services, PSA development services, survey implementation services, and material and print services selected consistent with CalOptima's Board-approved procurement process;
3. Direct staff to develop Member and Provider incentive programs in the amounts listed on Attachment 1., subject to applicable regulatory approval and guidelines, and final approval by the CalOptima Board prior to implementation; and
4. Authorize unbudgeted expenditures not to exceed $1.1 million to implement these initiatives.

Background

In CalOptima's 2013-2016 Strategic Plan, one of the strategic priorities was related to Quality Programs and Services. As a part of this strategic priority, CalOptima has worked diligently to provide members with access to quality health care services and ensure optimal health outcomes for all our members.

One of the areas of focus within Quality Programs and Services is CalOptima's performance in the National Committee for Quality Assurance (NCQA) accreditation and ratings. The evaluation criterion for the NCQA health plan ratings consists of three dimensions: Prevention, Treatment and Member Satisfaction. According to the most recent NCQA Health Plan Ratings, (NCQA's Medicaid Health Insurance Plan Ratings 2015-2016) CalOptima scored 4 out of 5 on Prevention, 3.5 out of 5 on Treatment, and 2.5 out of 5 in Customer Service. Health Plans are rated on a 5 point scale. CalOptima achieved an overall rating of 4 out of 5. CalOptima has the distinction of being the top rated Medicaid Health plan in California for the past three years. CalOptima is proud to be the only California Medicaid health plan accredited at the "commendable" level by NCQA. Additionally, CalOptima has achieved a 3.5 out of 5.0 "STAR" rating for Medicare by the Centers for Medicare & Medicaid Services (CMS).

Although CalOptima has achieved much success in our quality programs, we have also identified two measures that were below the minimum performance level (MPL) established by the California

Department of Health Care Services (DHCS), and we have prospectively identified other quality measures on the decline that are required for NCQA accreditation and health plan ratings. In order to maintain or exceed our quality performance levels, it is imperative to consider additional interventions which are necessary to achieve these goals, as referenced in our 2016 QI Program Description (Clinical Data Warehouse section, pg 41). These include utilizing multiple levers (direct-to-member, direct-to-provider, incentives, communication strategies, etc.) and programs planned as ongoing strategies throughout the calendar year.

In preparing the CalOptima FY 2016-17 Operating Budget, staff applied the regular budgeting methodology which used the past year's actual run-rate assumptions to allocate funds to various categories, units and lines of business. Upon further review, it became clear that additional funding was necessary to meet existing program commitments for Medi-Cal quality monitoring, reporting and improvement as well as new and expanded quality programs.

Discussion

Maintaining CalOptima's "commendable" accreditation status and rating by NCQA as a top Medicaid plan in California requires ongoing investment in innovative quality initiatives focused on underperforming measures as well as measures aligned with NCQA accreditation, health plan ratings, as well as DHCS and CMS requirements. Funding is also requested to maintain current vendor contracts utilized for quality reporting and to support annually required trainings for quality staff.

Expenditures requested are classified as:

• Budget augmentation for current quality initiatives:	$ 457,740
• New requests for quality initiatives:	$ 605,839
Total Request	$1,063,579

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities provides additional detail on the quality related programs, initiatives and proposed incentives. Member and provider incentive programs will be established by CalOptima. Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives. All member and provider incentive programs will be fully developed and returned for Board approval prior to implementation, as well as regulatory approval, as applicable.

Fiscal Impact

The recommended action to appropriate and authorize expenditures of up to $1.1 million for Medi-Cal quality improvement and accreditation activities is an unbudgeted item. Management is requesting Board approval to authorize an additional amount of up to $1.1 million in medical expenses to fund the cost of the quality improvement activities.

Rationale for Recommendation

CalOptima staff believes that by partnering with our Health Network and provider community, targeted, impactful interventions will result in improvements in our quality scores, to maintain our NCQA Commendable status.

Concurrence

Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer
Board of Directors' Quality Assurance Committee
Board of Directors' Finance and Audit Committee

Attachments

- Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities
- PowerPoint Presentation: Quality Analytics Budget

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

11/22/2016 — **Date**

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

A. Budget Augmentation for Current Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Surveys & NCQA Fees	• Addition of CG CAHPs - Adult & Child • Fee increases for regular CAHPS • Implement SPD CAHPS • Additional record retrieval for Medical Record Review • Increase in NCQA required fees • Timely Access Survey	$252,937
NCQA Consultant	• RFP results did not produce viable option; completed bid exception for known entity due to timeframe	$17,375
Quality Initiatives in Flight	• Flu/pneumococcal shot reminders • Preventive care visits • Pharyngitis kits • Readmissions project (CMS QIP) • Member & provider communications (more non-adherent members; more measures to move) •	$138,793
	• Member and provider incentives	$12,380
Required Training	• Annual Inovalon & HEDIS Best Practices training • CME expenses for physician training • Provider education activities • New hire equipment	$28,480
Miscellaneous		$7,775
Total		**$457,740**

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

B. New Request for Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Member Programs	• Prenatal/postpartum incentive (Increase volume of outreach; $10,887 • Breast cancer screening -Downward trend Reminder mailing & incentive; $99,900 • Cervical cancer screening -Below MPL Reminder mailing & incentive; $149,900	$260,687
Provider Programs	• Physician office extended hours pilot project - MPL measures ($10,000) • Prenatal/postpartum provider office incentive ($5,000) • PCP office staff incentives for well women visits/screenings ($75,000) • Physician office extended hours initiative mailing ($2,500)	$92,500
Member Experience Initiatives	• Member focus groups, supplemental survey, provider CME ($72,525) • Practice coaches for member experience ($18,840)	$91,365
Provider Toolkits	• AWARE toolkit on antibiotic use ($5,000) • Provider Outreach/Education on AAB Measure (Below MPL; $1,500)	$6,500
Outreach Projects	• PSA for well women visits (Feb & May) - Culturally-specific radio stations ($99,900) • Child & Adolescent Outreach and Events for Childhood Immunizations (13% decrease; $44,887) • Educational posters/print ads for physician offices for Women's Wellness Campaign ($10,000)	$154,787
Total		**$605,839**

Quality Analytics Budget

Board of Directors' Quality Assurance Committee Meeting
November 16, 2016

Board of Directors' Finance and Audit Committee Meeting
November 17, 2016

Richard Bock, MD, Deputy CMO
Caryn Ireland, Executive Director, Quality

FY 2016-2017 Budget

- Budget augmentation for current quality initiatives: $457,740
  - Surveys & NCQA Fees
  - NCQA Consultant
  - Quality Initiatives in Flight
  - Required Training
  - Miscellaneous

- New requests for quality initiatives: $605,839
  - Member Programs
  - Provider Programs
  - Member Experience Initiatives
  - Provider Toolkits
  - Outreach Projects

Budget Augmentation for Current Quality Initiatives: $457,740

- Surveys & NCQA Fees: $252,937
  - Addition of CG CAHPS – Adult & Child
  - Fee increases for regular CAHPS
  - Implement SPD CAHPS
  - Additional record retrieval for Medical Record Review
  - Increase in NCQA required fees
  - Timely Access Survey
- NCQA Consultant: $17,375
  - RFP results did not produce viable option; completed bid exception for known entity due to timeframe
- Quality Initiatives in Flight: $151,173
  - Flu/pneumococcal shot reminders
  - Preventive care visits
  - Pharyngitis kits
  - Readmissions project (CMS QIP)
  - Member communications (more non-adherent members; more measures to move)
  - Member and provider incentives

Budget Augmentation for Current Quality Initiatives (cont.)

- Required Training $28,480
  - Annual Inovalon & HEDIS Best Practices training
  - CME expenses for physician training
  - Provider education activities
  - New hire equipment

- Miscellaneous $7,775

Funding for Additional Program: $605,839

- **Member Programs** — $260,687
  - Prenatal/postpartum incentive (Increase volume of outreach)
  - Breast Cancer Screening (Downward trend)
  - Cervical Cancer Screening (Below MPL)
- **Provider Programs** — $92,500
  - Physician office extended hours pilot project – MPL measures
  - Prenatal/postpartum provider office incentive
  - PCP office staff incentives for well women visits/screenings
  - Physician office extended hours initiative mailing
- **Member Experience Initiatives** — $91,365
  - Member focus groups, supplemental survey, provider CME
  - Practice coaches for member experience
- **Provider Toolkits** — $6,500
  - AWARE toolkit on antibiotic use
  - Provider outreach/education on AAB Measure (Below MPL)
- **Outreach Projects:** — $154,787
  - PSA for well women visits (Feb & May) – Culturally-specific radio stations
  - Child & adolescent outreach and events for childhood immunizations (13% decrease)
  - Educational posters/print ads for physician offices for Women's Wellness Campaign

Description of Additional Programs	Amount
Member Programs	$260,687
Prenatal/postpartum incentive (Increase volume of outreach)	$10,887
Breast cancer screening (Downward trend)	$99,900
Cervical cancer screening (Below MPL) - Reminder mailing and member incentives	$149,900
Provider Programs	$92,500
Physician office extended hours pilot project – MPL measures	$10,000
Prenatal/postpartum provider office incentive	$5,000
PCP office staff incentives for well women visits/screenings	$75,000
Physician office extended hours initiative mailing	$2,500
Member Experience	$91,365
Member focus groups ($50K), supplemental survey ($20,475), provider CME ($7K)	$72,525
Practice coaches for member experience	$18,840
Provider Tool Kits	$6,500
AWARE Toolkit on antibiotic use	$5,000
Provider outreach/education on AAB Measure (Below MPL)	$1,500
Outreach Projects	$154,787
PSA for well women visits (Feb & May) – Culturally-specific radio stations	$99,900
Child & adolescent outreach and events for childhood immunizations (13% decrease)	$44,887
Educational posters/print ads for physician offices for Women's Wellness Campaign	$10,000
Total	**$605,839**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Richard Helmer, Chief Medical Officer, (714) 246-8400

Recommended Actions

Recommend the Board of Directors authorize:

1. Issuance of a Request for Proposal (RFP) to identify community partner(s) experienced with providing Medi-Cal-covered perinatal support services; and
2. The Chief Executive Officer (CEO), with the assistance of Legal Counsel, to contract with qualifying RFP responders and in compliance with Medi-Cal Perinatal support program requirements established by the California Department of Health Care Services (DHCS).

Background

The Comprehensive Perinatal Support Program (CPSP) provides a wide range of culturally competent services to Medi-Cal pregnant women, from conception through 60 days postpartum. In addition to standard obstetric services, women receive enhanced services in the areas of nutrition, psychosocial and health education. The Legislature enacted CPSP in 1984 in response to findings from the OB Access Project, indicating that a comprehensive approach reduced both low birth weight rates and health care costs in women and infants. CPSP became a Medi-Cal benefit in 1987. Medi-Cal Managed Health Care Plans are required to provide access to CPSP-comparable services for pregnant Medi-Cal eligible recipients.[1] In 1995, CalOptima was mandated by the State to provide Perinatal Support Services (PSS). CalOptima in turn fully delegated this responsibility to its contracted health networks.

In 2006, a review of health network data revealed areas of concern due to marked variation in usage of PSS services. The variation resulted from a fragmented referral process, eligibility timing issues, and challenges related to coordination of referrals between OB physicians and PSS providers. The resulting recommendation post review was to consolidate the referral process and transition responsibility from the health networks back to CalOptima. On May 6, 2008, the CalOptima Board approved a consolidated capitation contract for Comprehensive Perinatal Services Program with MOMS Orange County (MOMs). CalOptima initially entered into a one year capitated agreement with MOMS in 2008, at a capitation rate of $.55 per member per month (pmpm) based on the total CalOptima Medi-Cal membership. The contract included two extension options of one year each. The contract was subsequently amended (Amendment II) effective May 1, 2011 to renew automatically on an annual upon Board approval. This agreement also included monetary incentives, projected at $234,000 annually, for early referrals, completed initial assessments and increased participation.

[1] CA.GOV MO-07-0074 CPSP

In addition to the capitated services provided by MOMs, certified non-MOMs providers have also been providing CPSP services. These non-MOMs providers are paid by CalOptima at 100% of the CalOptima Medi-Cal fee schedule for providing these services.

Due to Medi-Cal expansion and contract language supporting capitation for all Medi-Cal members lines of business and gender, program costs have increased year-over-year and more recently from $2 million to $3.5 million for the 2013 - 2015 period (i.e., capitation has been paid based on total CalOptima Medi-Cal membership irrespective of the individual member's potential PSS needs). In comparison, CalOptima member births have increased more modestly during the same period, with approximately 7,000 deliveries in 2013, compared to 8,500 deliveries in 2015. Additionally, records indicate that member engagement with Perinatal Support Services providers decreased dramatically during the same 2013 - 2015 period, after the first encounter from 50% of identified pregnancy referrals to 15%, with continued declines reported throughout the remaining trimesters and through postpartum.

Discussion

The new proposed program is designed to provide a more comprehensive approach, and strategically increase utilization, coordination of services and member engagement. Proposed program components include additional data analysis, stratification for low, moderate and high risk, as well as engagement strategies to increase identification and utilization of Perinatal Support Services. CalOptima staff will coordinate care with health network case management and OBs for members at high risk for poor pregnancy outcomes, in a similar manner to current efforts. CalOptima Health Education staff or identified vendor(s) from the proposed RFP process will outreach to members each trimester and provide trimester-specific coaching, nutrition education, and reassess changes in pregnancy risk status. Third trimester outreach will include support and coordination of post partum visits, including member incentives for visits completed within the HEDIS-specified time period. After delivery, members will receive support resources and reminders on the importance of the Well Child Visit and Initial Health Visit during the first 15 months of life.

Perinatal Support Services is a covered benefit and may be re-delegated back to the Health Networks. Quality and Health Education programs are not delegated to the Health Network. CalOptima staff in the Quality and Health Education departments work in partnership with the Health Networks in the delivery of program interventions. Management proposes that the Quality and Health Education departments retain responsibility for the PSS benefit during the period of program redesign while working in partnership with the Health Networks. CalOptima staff may re-engage with the Health Networks on their capability and/or interest in re-delegation after staff has fully developed and tested the new program design.

The proposed RFP could result in awarding contracts to multiple providers. However, the current fee for service (FFS) CPSP providers would not be expected to respond to the RFP, but could continue to provide services and be paid 100% of the CalOptima Medi-Cal fee schedule for services provided to qualifying CalOptima members.

Fiscal Impact
The recommended action to initiate an RFP for a CPSP vendor(s) is expected to be budget neutral. We anticipate new contracts for the vendors identified to support the revised CPSP program based on program goals and achievements (e.g. not a capitated model for all members). While the RFP process is expected to result in a more effective quality program, staff will return to the Board with a financial plan if expected expenses exceed those anticipated with the current model.

Rationale for Recommendation
As identified through CalOptima's latest HEDIS results, it is imperative for CalOptima to redefine its Perinatal Support Services program to increase the identification and intersection with the member and provider throughout the member's pregnancy. CalOptima staff proposes to conduct an RFP process to identify partner(s) to meet the requirements of the new program design for Perinatal Care for CalOptima members. The new program is designed to provide a more comprehensive approach, and strategically increase utilization, coordination of services and member engagement.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Power Point Presentation – Perinatal Support Services
2. Board Action dated May 6, 2008, Approve the CalOptima Perinatal Support Services Program and Ratify CalOptima's Contract with MOMS (Maternal Outreach Management System) for Perinatal Support Services

/s/ Michael Schrader — *02/10/2017*
Authorized Signature — **Date**

Perinatal Support Services

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

Pshyra Jones
Director, Health Education & Disease Management

Why do we need a perinatal support services program?

- Pregnancy and childbirth can be a common reason for inpatient admissions.
- Perinatal care is important for the mother and the baby — and is underutilized.
- We hope to improve outcomes for mothers and babies.
- CalOptima has contractual requirements to provide members with access to a comprehensive perinatal support program.
- CalOptima is working to improve our member experience.
- We need to improve our HEDIS scores.

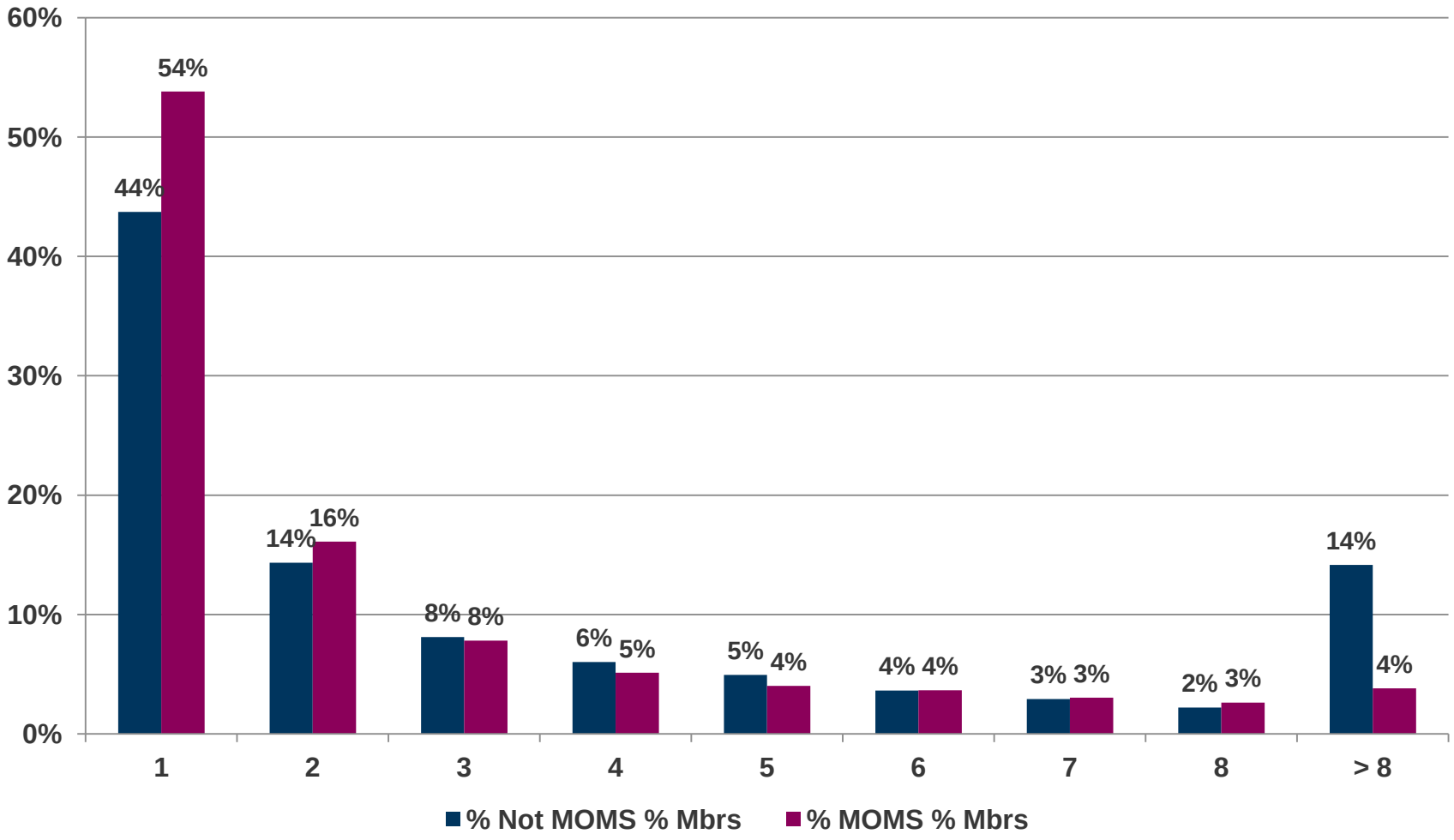
DHCS Perinatal Services Requirements

- Ensure the provision of all medically necessary services for pregnant members.
- Implement a comprehensive risk assessment using standards or guidelines of the American Congress of Obstetricians and Gynecologists.
  - Assessment and care plan should include health education, nutrition and psychosocial risk components.
  - Assessment should be administered at the initial prenatal visit, each trimester thereafter and postpartum.
- Ensure pregnant members at high risk of a poor pregnancy outcome are provided timely referral to specialist and delivery services.

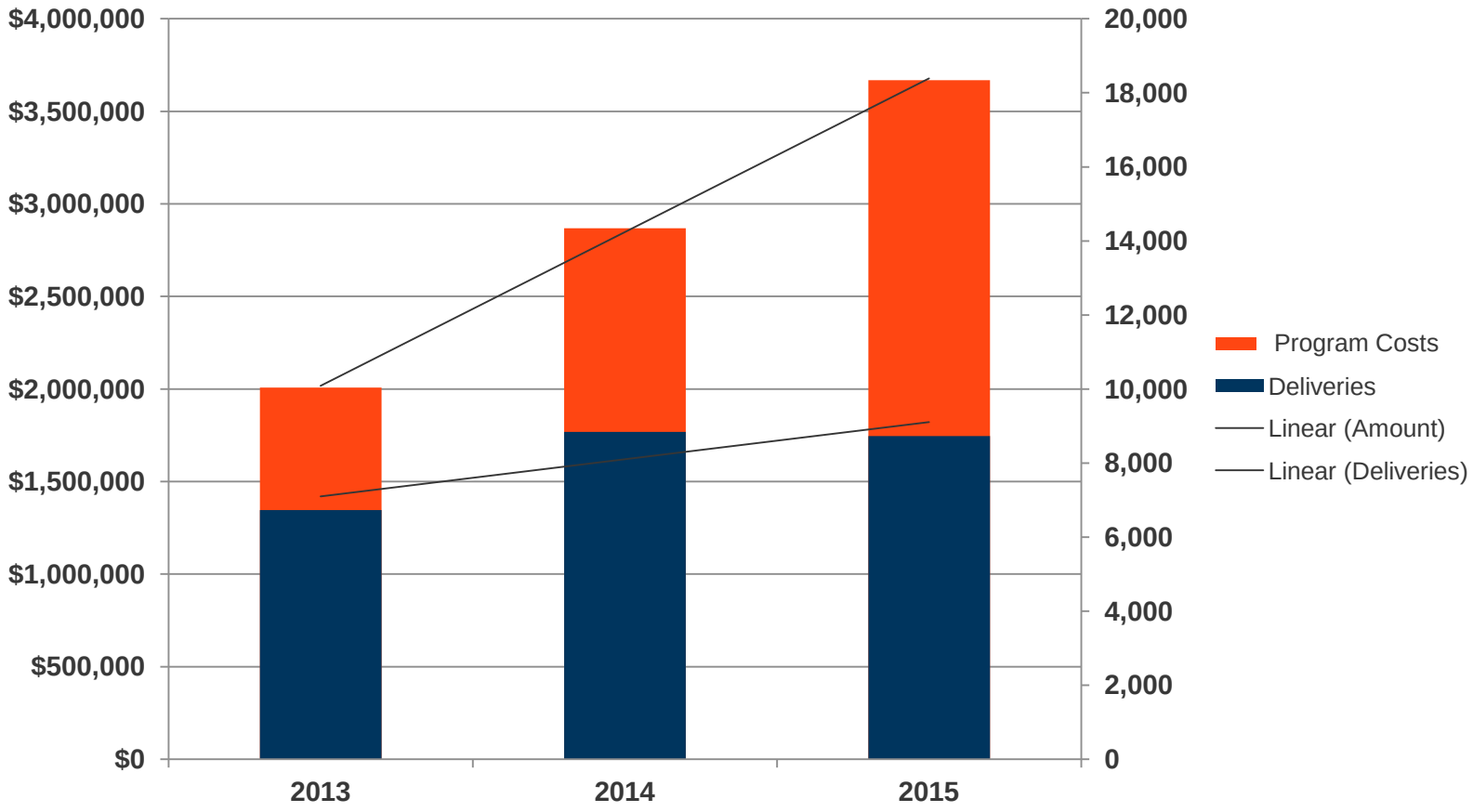
Current Fragmented Program Model

- CalOptima contracts with MOMS Orange County for perinatal support services
- Comprehensive Perinatal Services Program (CPSP) is also provided by fee-for-service OB providers
- Redundancy of services for members assigned to CPSP providers
- Existing model makes minimal contributions toward prenatal and postpartum HEDIS performance
- Single source for program entry—Pregnancy Notification Referral Form (PNR)
- PMPM based on entire CalOptima Medi-Cal membership

Average # Member Visits (2013–15)



Deliveries vs. Program Costs



CalOptima Prenatal and Postpartum Services (PPC) HEDIS Rates

HEDIS PPC16 Denominator Count and Numerator Count			
Sub Measure	Denominator Count	Numerator Count	Rate
Prenatal	6,694	4,754	71.02%
Postpartum	6,694	3,315	49.52%

PPC Measure is a QIC Focus Area—CalOptima is currently below the 50th percentile and nearing the 25th percentile.

MOMS Matching Members Denominator Count and Numerator Count			
Sub Measure	Denominator Count	Numerator Count	Rate
Prenatal	628	470	74.84%
Postpartum	628	371	59.08%

MOMS Birth Outcomes contributed 9.38 percent to PPC16 measure.

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The New Approach

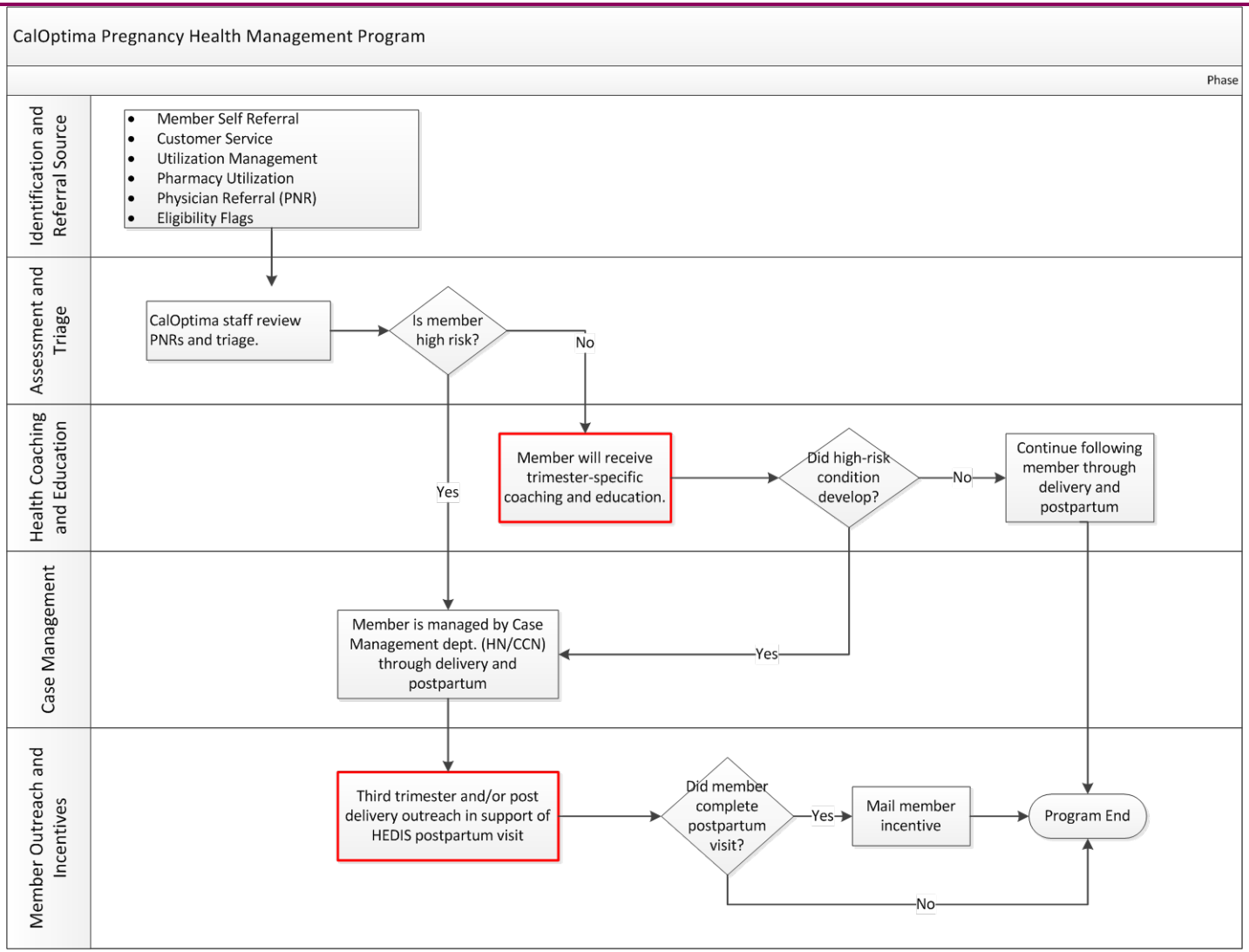
- Comprehensive, coordinated program
- More emphasis on member-initiated activity
- Coordination with CPSP providers, OB/GYNs, complex case management and community resources
- Member support with health education, nutrition and psychosocial needs
- Outreach and program marketing strategy to increase identification and member engagement

Program Components

- Identification of pregnant members
- Assessment
- Health coaching and education*
- High-risk case management
- HEDIS reminders and member outreach*
- Incentives
- Outcomes

* Program components included in RFP

New Program Model



Recommended Action

- Recommend the Board of Directors authorize:
  - Issuance of Request for Proposal (RFP) to identify community partner(s) experienced with providing Medi-Cal-covered perinatal support services; and
  - The CEO, with the assistance of Legal Counsel, to contract with qualifying RFP responders and in compliance with Medi-Cal perinatal support program requirements established by the California Department of Health Care Services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 6, 2008
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Approve the CalOptima Perinatal Support Services Program and Ratify CalOptima's Contract with MOMS (Maternal Outreach Management System) for Perinatal Support Services

Contact

Gertrude S. Carter, M.D., Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Approve the proposed CalOptima Perinatal Support Services Program; and
2. Ratify CalOptima's Contract with MOMS for Perinatal Support Services.

Background

The Comprehensive Perinatal Support Program (CPSP) is a Medi-Cal benefit developed in 1992 by the State of California. This benefit was designed in response to poor birth outcomes in the California Medi-Cal population. The goal of the program is to improve the overall health status of pregnant mothers and their newborn babies. CPSP services are comprised of direct OB physician services and Perinatal Support Services (PSS). The PSS services consist of health education, nutritional and psycho-social counseling and OB-focused case management. In 1995, CalOptima was mandated by the State to provide PSS services. CalOptima in turn fully delegated this responsibility to its contracted health networks.

Last year, a review of health network 2006 data revealed areas of concern with marked variation in usage of PSS services. The variation resulted from a fragmented referral process, eligibility timing issues, and coordination of referrals between OB physician and PSS provider. The resultant recommendation post review was to consolidate the referral process at the CalOptima level.

Discussion

As part of CalOptima's transfer of PSS, the established health network contractual relationships were consolidated into a CalOptima preferred capitation contract with MOMS (Maternal Outreach Management System) and the assumption of network-specific fee-for-service contracts those independent OB physician providers. It was anticipated that this re-contracting effort would recapture funds sufficient to cover the costs of the program. However, upon close review there were additional costs associated with the consolidation. Three factors have contributed to the additional costs of the program: 1) contract costs; 2) preservation of alternatives; and, 3) incentives to increase early referral.

Contract Costs It was originally anticipated that CalOptima would have an exclusive contract with MOMS on a capitated basis for all PSS services provided to CalOptima members. Outlays under this contract were expected to be equivalent to the original outlays that had been expended by the health networks for PSS services. Effective January 1, 2008, CalOptima entered into a one-year capitated agreement with MOMs with two extension options of one year each. However, upon review it was realized that some coordination activities would need to continue to be performed by the health network and accordingly, a portion of the capitation would have to remain at the health network level to pay for those functions.

Preservation of Alternatives While it was the intent of the revised program to move PSS services into an entirely capitated program under CalOptima as of January 1, 2008, it became evident in the transition planning process that doing so would create potential issues of program access, as well as interference with existing physician-patient relationships for members who had a previous history of receiving PSS services from certain traditional PSS providers. As a result, the original plan was modified to preserve the option for members to see these traditional PSS providers on a fee-for-service basis outside of the capitation arrangement with MOMS to ensure access and preserve physician-patient relationships.

Incentives to Increase Early Referrals Finally, the goals of the program are to improve member access, increase participation rates, and improve coordination. There was recognition that the earliest possible referral to the program provides the chance of the best outcome. To ensure the fastest, most effective results, the decision was made to provide an incentive for early referral. This has proven to be a successful strategy. Results from the first three months of calendar 2008 show first trimester referrals increasing from 21% to 42%, and third trimester visits decreasing from 30% to 12% over prior year levels.

Fiscal Impact

The fiscal impact of decreased health network capitation of $.55 per-member per-month in appropriate aid codes along with increased costs related to contracting, preservation of alternatives, and providing incentives to increase early referrals results in a net increase in costs of a maximum of $117,000 above the budgeted amount for FY08-09, or a projected $234,000 on an annualized basis. Going forward, these additional expenditures will be included in the budget.

Rationale for Recommendation

The Perinatal Support Services benefit was moved from the health network level to the CalOptima level in response to the identification of the need for greater coordination of PSS services. The goal for this realignment of program responsibilities is to improve utilization of PSS services through improved coordination and outreach.

Concurrence
Procopio, Cory, Hargreaves and Savitch, LLP

Attachments
None

/s/ Richard Chambers *05/01/2008*
Authorized Signature **Date**

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

PACE Member Advisory Committee (PMAC) Update

PMAC Meeting December 12, 2016

Updates from the Director

- Staffing Update: Participants were told about the new team members starting at PACE and the positions that are still being filled.
- Specialty appointment scheduling: Provided background on the scheduling process at PACE that includes extensive coordination between transportation, contracted services, the participants, and the caregivers. PACE has also engaged the assistance of Process Excellence Department to streamline the process.

New Items Discussed

- Participant Satisfaction Survey
    - Overall Satisfaction increased from 84% in 2015 to 89% in 2016
    - Did better in every aspect except for recreational therapy and the willingness to refer a friend which went down to 65% from 69% in 2015
    - In order to get a better understanding and to address satisfaction concerns, surveys will be provided to participants throughout the year on topics including meal and activity preference.
    - A copy of the results will be printed and made available for participants.
- New Participant Orientation began in January 2017. The sessions will be held on a monthly basis and all participants are welcome to attend. The orientations are offered in multiple languages.
- Transportation Update: One-hour violations have decreased significantly since July 2016. Secure Transportation is now utilizing affiliate vendors to accommodate transportation needs; a new Customer Service Representative from Secure Transportation is now on site daily.

Participant Suggestions/Comments

- Request to have more information regarding participants' individual specialty appointments prior to attending, including details on any follow-up appointments that have been scheduled.
- Participants noted that at times, it may take up to 15 minutes on the bus waiting for another participant to be ready to board. The Director explained that the transportation policy now addresses this issue by not waiting longer than 5 minutes (and sending another vehicle for the delayed participant).
- Participants shared their appreciation for PACE as their second home and family and thanked staff for opportunities to volunteer at the PACE center.

Executive Summary

Quality Improvement Committee (QIC) 4th Quarter 2016

- Introduced a new Work Plan Dashboard – includes each goal and progress towards meeting year end goal (red, yellow, green)
- Presented NCQA Accreditation results from mock audit
- Quarterly reports provided by all key areas
- Completed 100% outreach for Health Risk Assessments for OCC, OC, SPD members
- Reported progress on improving our Initial Health Assessment rates
- Reported findings from Primary Care Physician Satisfaction Survey as well as CAHPS (Member Experience) results
- Reported the Quality Measurement & Performance Improvement monitoring and results for the Model of Care
- Provided an update on the 2016 Pay-for-Value program and plans for 2017
- Identified priority quality initiatives to improve HEDIS measures, including those measures close to the Minimum Performance Level for DHCS
- Provided an update on the Customer Services metrics and Timely Access/Appointment Availability
- Presented an update on Behavioral Health services and Initiatives
- Provided the quarterly Audit & Oversight and Delegation monitoring reports
- Reported Member Grievances by type and provider
- Provided an update on PACE quality improvement activities

Quality Improvement Committee (QIC) 4th Quarter Update

Board of Directors' Quality Assurance Committee Meeting

February 15, 2017

Caryn Ireland

Executive Director, Quality and Analytics

QIC Reporting By Department

- The following departments report to the QIC quarterly at a minimum:
  - Case Management and Complex Case Management
  - Behavioral Health (BH)
  - Customer Service
  - Health Education and Disease Management (HE/DM)
  - Grievance & Appeals Resolution Services (GARS)
  - Long-Term Services and Support (LTSS)
  - Provider/Network Management
  - OneCare
  - PACE
  - Pharmacy
  - Utilization Management (UM)

Committee Updates & Dashboard

- Reviewed and Approved:
  - UM Committee Report and Minutes (December 13, 2016)
  - GARS Sub-Committee Report (December 13, 2016)
  - LTSS Sub-Committee Report Tabled to January 2017
  - BH Sub-Committee Report (December 13, 2016)
- Introduced QI Dashboard
  - Reports progress on QI Work Plan Goals & Activities
  - Red-Yellow-Green rating system
  - Produced at least quarterly

QI Work Plan Dashboard

2016 QI Work Plan Title	Goal	Owner	Red-50% Yellow 75 % Green 90%+
Case Management			
Quality of Clinical Care- Review of health risk assessments to OCC, OC, SPD members	OCC, OC, SPD:100% of eligible population improvement over 2016	Tracy Hitzeman	Completion OCC OneCare SPD Collection
Quality of Clinical Care- Continuity & Coordination of Medical/BH	85%	Tracy Hitzeman	
Quality of Clinical Care- Review of emergency department communications with PCPs	85%	Tracy Hitzeman	
Patient Safety, Quality of Care Case Management- High ER utilization	35%	Tracy Hitzeman	
Quality of Clinical Care-Review of member satisfaction with CM programs	Satisfaction with Case Management:85%	Tracy Hitzeman	
Quality of Identification of Complex Case Management	Health Networks are identifying members eligible for Complex Case Management	Tracy Hitzeman	
Behavioral Health			
Quality of Clinical Care: Integration of BH services	10% improvement over 2015	Dr. Donald Sharps	
Quality of Care- Clinical BH Practice Guidelines adoption for Medi-Cal line of business	100%	Dr. Donald Sharps	
Quality of Service and Quality of Clinical Care- Review of behavioral health providers communications with PCPs	85%	Dr. Donald Sharps	
LTSS			
Safety of Clinical Care and Quality of Clinical Care- Review and assess LTSS placement for members participating with each organization/program	2% CBAS; Establishing goals in 2016 for IHSS, LTC, & MSSP	Marie Earvolino	
Safety of Clinical Care and Quality of Clinical Care- Review and assess emergency department visits for LTSS members participating with each organization/program	9% CBAS; Establishing goals in 2016 for IHSS, LTC, & MSSP	Marie Earvolino	
Safety of Clinical Care and Quality of Clinical Care- Review and assess readmissions for LTSS Members participating with each organization/program: Hospital Readmission	2.5% CBAS; Establishing goals in 2016 for IHSS, LTC, & MSSP	Marie Earvolino	
Safety of Clinical Care and Quality of Clinical Care-Review and Assess Readmissions for LTSS members participating with each organization/program: Long Term Care Admissions	2% CBAS; Establishing goals in 2016 for IHSS, LTC, & MSSP	Marie Earvolino	
Quality of Clinical Care- Review of health risk assessment (HRA) for OneCare Connect (OCC) Long Term Care (LTC) Members	100%	Marie Earvolino	
CBAS Member Satisfaction	5% improvement over previous year	Marie Earvolino	
SNF Member Satisfaction	5% Improvement over Previous Year	Marie Earvolino	
Health Education & Disease Management			
Quality of Care- All new members will complete the Initial Health Assessment and related IHEBA/SHAs	Improve plan performance over 2015 by 10%	Pshyra Jones	
Quality of Clinical Care, review of Disease Management Program (Asthma)	Increase to 50th percentile for members between 5-18 yrs old	Pshyra Jones	
...lity of Clinical Care, review of Disease Management Program (Diabetes)	Maintain 90th percentile for Medi-Cal; increase to	Pshyra Jones	OneCare Medi-Cal
...y of Clinical Care, review of Disease Management Program (CHF)	1. CHF-Establish baseline for unplanned readmissions with an admitting diagnosis of heart failure for members in the Heart Failure DM Program 2. Satisfactions with DM-90%	Pshyra Jones	
...y of Care- Clinical Practice Guidelines adoption for Medi-Cal line ...iness	100%	Pshyra Jones	
...y of Clinical Care, review of member satisfaction with DM ...ms	90% satidfaction with the DM program	Pshyra Jones	Yellow→Green
...y of Clinical Care- Review of cardiovascular Disease	As determined by CMS	Pshyra Jones	
...mentation of the Childhood Obesity (Shape Your Life) Program	Implement revised program design-2017; Evaluate progress semi-annually	Pshyra Jones	
...ment Weight Watchers (WW) for Medi-Cal Members	Implement revised program design-2017; Evaluate progress semi-annually	Pshyra Jones	
...ment Home Assessments for member participating in Care ...gement Programs	Implement revised program design-2016; Evaluate progress semi-annually	Pshyra Jones	
...t 2016 Group Needs Assessment (GNA)	Complete GNA requirement for 2016	Pshyra Jones	
Access & Availability			
...y of Service and Quality of Clinical Care- Review of notification to ...ers	85%	Laura Grigoruk	
... to Care- Credentialing of provider network is monitored	100%	Esther Okajima	
... to Care- Recredentialing of provider network is monitored	100%	Esther Okajima	
...ibility: Review of access to care	Appt.: 90% Phone: <5%	Marsha Choo	
...bility: Review of availability of practitioners	1:2,00; 1:2,000; 1:5,000; 95%; 90%; 1:100; 100%	Marsha Choo & Dr. Donald Sharps	
Patient Safety			
...of Clinical Care- Providers shall have timely and complete facility ...views	80%	Esther Okajima	
...of Clinical Care- Review and follow-up on member's potential ...y of Care Complaints	To achieve a turnaround time of 90 day of case received; Assure patient safety and enhance patient experience by timeliness of clinical care reviews	Sandra Friend	
...of Clinical Care and Quality of Clinical Care- reviewed through ...acy Management	100%	Kris Gericke, PharmD	
...and Quality of Clinical Care- review of Specialty	TBD	Kris Gericke, PharmD	
...v and assessment of CBAS Quality Monitoring	100% CDA Audit Results	Sandra Friend	
...v and assessment of SNF Quality Monitoring	100% DHCS Audit Results	Sandra Friend	
...- Review of antibiotic usage	68.53%; 91.21%	Kelly Rex-Kimmet	
...e new PBM	Meet Performance Guarantee Per Contract	Kris Gericke, PharmD	
Member Experience			
...view of Member Satisfaction	Annual CAHPS Results	Kelly Rex-Kimmet	
...viewed through customer service first call resolutio	85% of calls resolved at first call	Belinda Abeyta	OneCare OCC Medi-Cal
...viewed through customer service access	ASA 30 Seconds <3% Hold time under 30 Seconds First Call Resolution 85%	Belinda Abeyta	OneCare OCC Medi-Cal
...vice reviewed through GARS & PQI (MOC)	Employ data-based Quality Improvement Measures to upgrade performance	Janine Kodama & Sandra Friend	
HEDIS/STARS Improvement			
...DIS Measures listed on "Measures" worksheet	See Measures Worksheet	Kelly Rex-Kimmet	
...ARS measures listed on "Measure" worksheet	See Measures Worksheet	Kelly Rex-Kimmet	Yellow→Green
...ures listed on "Measures" worksheet	See Measures Worksheet	Kelly Rex-Kimmet	
...ic wellness clinic	See Measures Worksheet	Kelly Rex-Kimmet	
...Medication Adherence Measures	4 Stars	Kris Gericke	
...k support of HEDIS & CAHPS Improvement	24.33%	Kelly Rex-Kimmet	
Delegation Oversight			
...of CM	100%	Tracy Hitzeman	
...vice of UM through delegation oversight reviews	98%	Solange Marvin	
...of BH Services	98%	Dr. Edwin Poon	
Organizational Projects			
Implementation of the 2016 Value Based P4P program	Improve Performance over 2015	Kelly Rex-Kimmet	
Value Based P4P 2016-2019	National & State Benchmarks	Kelly Rex-Kimmet	

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CalOptima A Public Agency Better. Together.

UMC 3rd Quarter Update

- UM Redesign
- BH Integration
- UM Data Management
- UM Delegated Group Oversight
- Over/Under Utilization
- UM Pattern Outlier Trends
- Operational Performance — UM, Pharmacy and LTSS
- Emergency Department Goals and Trends
- Community Network Development
- Benefit Management Subcommittee Update
- Audit and Oversight Update
- Multipurpose Senior Services Program (MSSP) Utilization Profile

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NCQA Accreditation Update

- Currently in Look-back period: May 23, 2016 – May 22, 2018
- Just completed mock audit, Oct 11-13, 2016
- On track with NCQA requirements, maintaining quality program activities continuously
- Mock survey identified strong work in progress with minimal gaps
- Strong documented processes, also many cases best practices for analysis and reports
- Need more QIC policy decisions and follow-up documented
- In 2017, planning 2 more mock-audits May and Nov

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QIC Highlights

Credentialing Activity	3rd Quarter, 2016
Total number of initial and re-credential files completed	242
Number of clean files completed	212
Number of files with issues – presented to CPRC	30
Number of issue files requiring CPRC action	3
Timeliness for Initials – Goal Met (Within 180 days)	100%
Timeliness for Recreds – Goal Not Met *(Within 36 Months)*	99.4%

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QIC Highlights (cont.)

Facility Site Review (FSR), Medical Record Review (MRR), Physical Accessibility Review (PAR)

- Continue to conduct Initial and Full Scope FSR/MRR surveys for primary care providers (PCP)
  - 89 FSR/MRR completed
- Continue to conduct initial and tri-annual PAR surveys for all PCPs and high volume specialists
  - 132 PARs completed
- FSR, MRR and Critical Element corrective action plans issued where deficiencies were identified — 85 percent closed within defined turnaround time (TAT)

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QIC Highlights (cont.)

Potential Quality Issue (PQI): July - Sept, 2016

Description:	Count:
Number of PQI Cases Opened	277
Number of PQI Cases Closed	302
Number of Cases Opened	111
Number of Cases >90 Days (Presently)	8

QIC Highlights (cont.)

- 85 percent of PQI's: no quality of care or service issues identified
- Of the remainder:

Medi-Cal Primary Complaint	
Inappropriate patient/provider/office behavior (42)	15%
Treatment: delay, failure, inappropriate or complications (36)	19%
Mismanaged care (33)	13.4%
Authorization denied or delayed (22)	6.3%
Access to care (19)	8%
Delay of Service	5.1%
OneCare Connect Primary Complaint	
Treatment: delay, failure, inappropriate or complications (10)	26.3%

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QIC Highlights (cont.)

Patient Safety – CBAS & SNF

- Continued assessment of CBAS facilities for patient safety issues
  - 29 facilities were issues Corrective Action Plans – 21 received, 8 pending
  - Results show better care plans, improved flow sheets, improved communication , better compliance with regulations
- Member Satisfaction
  - Implemented 2016 Member Satisfaction Survey 3rd Quarter; results expected at year end
- Completed Plan of Correction reviews for each SNF facility
  - Common findings included incomplete documentation, failure to conduct staff in-services, lack of organization of facility audit logs
  - Recommendations given to SNFs to help with corrective action plans
- Critical Incidents:
  - 2 critical incidents were reported (1 CBAS, 1 SNF)

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QIC Highlights (cont.)

Audit and Oversight

- Delegation of Credentialing/Recredentialing
- Monthly File Audit Results Presented for each Health Network & CalOptima Internal
- Delegation Oversight Committee continues to monitor and recommend corrective action plans for any deficiencies

Unused Authorizations (Over/Under Utilization)

- Report by Health Network of Unused Authorizations
- Rates compared year-over-year
- % of unused authorizations varies from 37% to 74%
- Next Steps:
  - Establish threshold for unused authorization rates
  - Further standardize the content and format for data submission

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QIC Highlights (cont.)

Case Management

- Health Risk Assessments OCC, OC, SPD members
  - Outreach across all Lines of Business – 100%
- Continuity & coordination of Medical/BH
  - BHI participation in ICT = 100%
- Review of ED communications with PCPs
  - ER post discharge process produces 100% notification of PCPs of member's ER visits
  - Receiving some confirmations of post ER PCP visits from physicians
- Member Satisfaction with CM programs
  - Satisfaction above threshold
- Identification of Complex Cases (Health Networks)
  - Targeted outreach & inclusion at JOMs to improve case identification

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QIC Highlights (cont.)

Health Education (HE), Disease Management (DM)

- Childhood Obesity (Shape Your Life)
  - Recruitment for Program Manager underway
- Initial Health Assessment (IHA) improvement plan update
  - IHA initial results (fully and partially met): 29.4 percent
  - Initiated welcome calls to CCN members
    - Outreach results: 37.6 percent
- Designed Weight Watchers benefit for CalOptima Medi-Cal members age 19 years or older
  - Developed Scope of Work; Preparing COBAR for February 2017 QAC
- 2016 Group Needs Assessment (GNA)
  - Requirements completed for DHCS
  - Findings presented October 7th

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QIC Highlights (cont.)

Pregnancy Health Management Program

- Redesigning current program
  - Current program fragmented; low HEDIS scores
  - Low engagement after 1st visit from Outreach efforts
- New approach – comprehensive & coordinated
  - Better identification – high risk, moderate, low risk
  - Link with OB/GYNs, members, families, other care providers
  - Provide better education and support during pregnancy

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QIC Highlights (cont.)

QIPs & PIPs Update – all program modules on track

- Medi-Cal:
  - Diabetes HbA1c Testing
  - Initial Health Assessment
- One Care:
  - Diabetes HbA1c Testing
- OneCare Connect:
  - Readmissions
- LTSS:
  - IHSS Staff Participation in ICTs

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QIC Highlights (cont.)

Primary Care Physician Satisfaction Survey Results:

- Overall satisfaction with the CalOptima program' was stable from 2015 to 2016.
  - Nearly 9 in 10 physicians are satisfied with the program and more than one-third indicated that they are completely satisfied.
- 1 measure was above 90%
- 7 measures were below the 80% threshold
  - 4 of the measures are related to Behavioral Health Continuity of Care measures
- 3 measures of the CalOptima program had a statistically significant decrease in rate from 2015 to 2016.
- Positive aspects: good communication and information.
- Common concerns: authorization, referral and claim denial issues

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QIC Highlights (cont.)

Primary Care Physician Satisfaction Survey Results – Concerns with Specialty Availability:

- Not enough CalOptima specialty providers
- Mental health availability
- Providers do not accept CalOptima members
- Referrals and authorizations issues
- Specialists are far for patients (transportation issues)
- Inaccurate/not up-to-date specialty list

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QIC Highlights (cont.)

CAHPS Survey Results:

- Medi-Cal Child: 4 Measures below 25th percentile
  - Getting Needed Care
  - Getting Care Quickly
  - How Well Doctors Communicate
  - Customer Service
- Medi-Cal Adult: 3 Measures below 25th percentile
  - Rating of Health Plan
  - Getting Needed Care
  - Getting Care Quickly
- Activities to Improve Member Experience:
  - Evaluate member pain points
  - Develop member experience provider scorecard
  - Explore Provider Coaching options

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QIC Highlights (cont.)

Safety of clinical care and quality of clinical care reviewed through Pharmacy Management

- Over and underutilization
- Opioid overutilization interventions
- Provide ongoing monitoring of specialty drug trends: Hepatitis C
- Review of Specialty Drug Utilization
  - Specialty Hepatitis C medications
  - Physician-administered drugs
- Medication Adherence Measures – Progress Towards Goals
  - Cholesterol Medications
  - Antihypertensive Medications
  - Diabetes Medications

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QIC Highlights (cont.)

Provider Relations

- Continuity & Coordination of Care
  - Achieved standard of 30 day notice when a primary care provider is terminated (goal is 85%)

Model of Care (MOC)

- Element monitored for MOC
  - Identification & stratification of the population
  - Care Coordination
  - Provider Network
  - Quality Measurement & Performance Improvement
- Measures defined & goals established for OC/OCC

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QIC Highlights (cont.)

Quality Analytics

- P4V Update:
  - Scoring methodology approved by QAC for Medi-Cal; vetting OCC program
  - Design for 2017 P4V in process (minimal changes expected)
  - Program & Reporting Enhancements:
    - P4V Manual for participants
    - Monthly HN reports to include estimated dollars earned YTD
    - Provider-specific profiles in development
- Auto Assignment:
  - Proposing alignment of measures and scoring methodology with P4Value program
  - Include both clinical and satisfaction measures
- P4P Results (MY 2015)
  - Medi-Cal Allocations – 73.49% unallocated
  - OneCare Allocations – 76.52% unallocated

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QIC Highlights (cont.)

Quality Initiatives Update

- Measures near Minimum Performance Level (MPL)
  - Avoidance of Antibiotic Treatment
  - Cervical Cancer Screening
  - Postpartum Care
- HEDIS measures added to 2016QI Work Plan (based on prospective rates):
  - Adult Access to Preventive Care
  - Children's Access to Primary Care Practitioners
  - Well Child Visits in the 1st 15 months
  - Breast Cancer Screening
  - Colorectal Cancer Screening (OC/OCC)
- Update on initiatives
  - Women's Health Campaign
  - Health & Wellness Events

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QIC Highlights (cont.)

Customer Service

- Reviewed 3rd Quarter 2016 call center results
  - Met all call center targets for 2016
    - Abandonment Rate
    - Average Speed of Answer
- Reviewed results of Medi-Cal Telephone Member Survey
  - First call resolution statistics
  - Top callback categories
    - OneCare Connect
      - Transportation Services
    - OneCare
      - Dental Services
    - Medi-Cal
      - Provider Information
      - Pharmacy Services

QIC Highlights (cont.)

Access & Availability (Timely Access/Appointment Availability):

- Medi-Cal: 4 of the 8 standards were MET
- OneCare:3 of the 7 standards were MET
- OneCare Connect: 2 of the 2 standards were MET
- Non-compliance areas
  - Urgent care appt w/in 48 hrs of request
  - Non-urgent care w/in 3 bus days
  - Urgent appt w prior auth in 96 hrs
  - Spec appt w/in 15 bus days
  - 1st Prenatal appt w/in 10 bus days

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QIC Highlights (cont.)

Behavioral Health (BH)

- Presented progress on quality of clinical care and service
  - Continuity and coordination of care
  - Antidepressant Medication Management and attention-deficit/hyperactivity disorder (ADHD) interventions
  - Follow up after hospitalization progress towards goal
  - Review of BH provider communication with PCPs
  - Clinical Practice Guidelines:
    - Depression — Adult in primary care
    - ADHD in primary care for school-age children and adolescents
- Presented progress on availability for behavioral health practitioners
- Delegation oversight of BH services
  - Monitored through Delegation Oversight Committee

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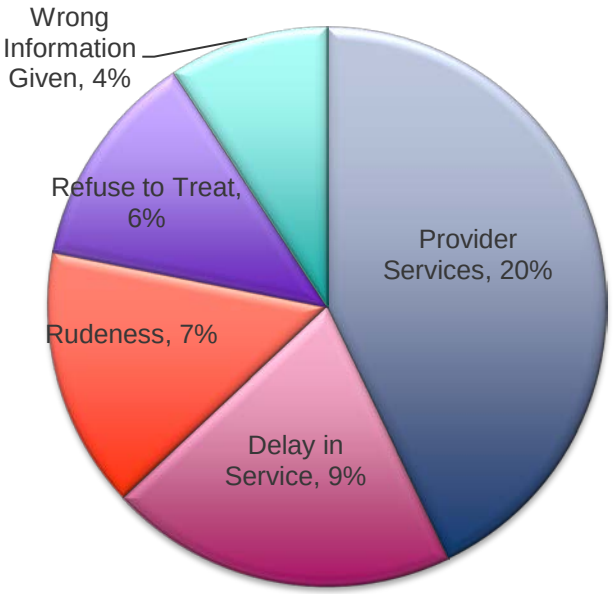
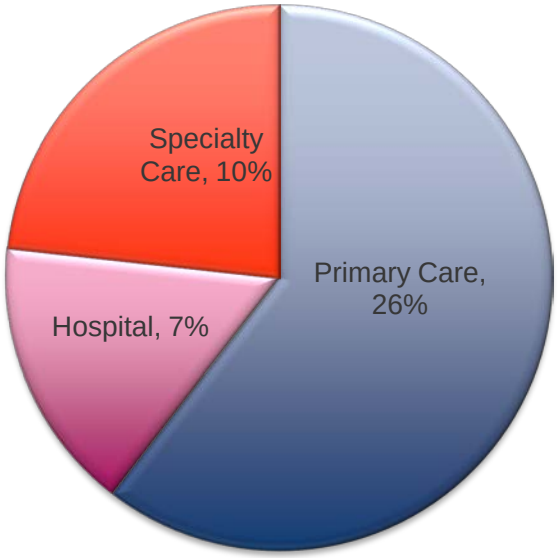
QIC Highlights (cont.)

- Member complaints and grievances
  - Presented member grievances by type and provider and analysis of providers with higher volume of complaints/grievances





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PACE QI Update

Presented updates on the following elements:

- Immunizations
- Infection Control
- POLST
- Access and Availability
- Medical Utilization
- Annual Diabetic Eye Exams
- Patient Satisfaction
- EMR Implementation

Audit Results showed areas for improvement:

- Transportation
- Infection Control

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Member Trend Report
3rd Quarter 2016

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

Janine Kodama
Director, Grievance and Appeals

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Overview

- Trend of the rate of complaints (appeal/grievance) per thousand members for all CalOptima programs for the third quarter in 2016.
  - Appeal — A request by the member for review of any decision to deny, modify or discontinue a covered service.
  - Grievance — An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.
- Breakdown of the complaints by type
- Interventions based on trends as appropriate

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Quality of Service and Quality of Care

- Quality of Service (QOS) are issues resulting in inconvenience or dissatisfaction to the member.
- Quality of Care (QOC) concerns occur if the member feels there was a problem with the care they received or that they did not receive enough care.

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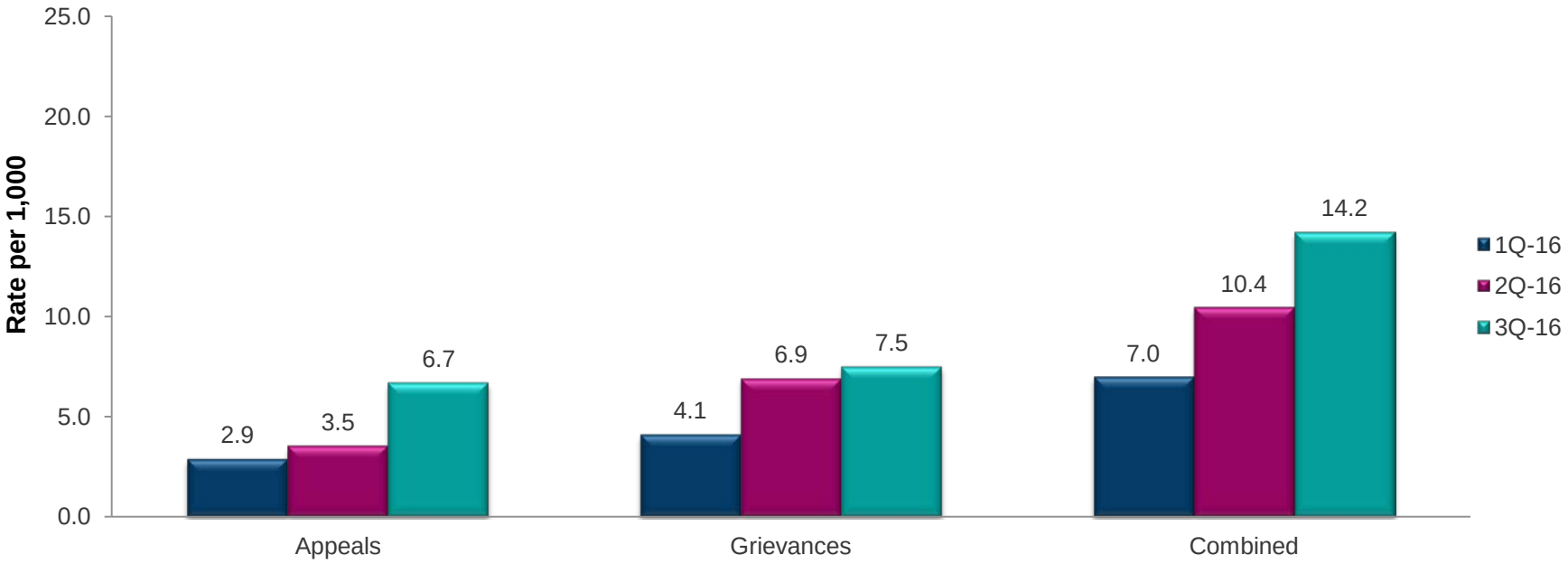
Overall OneCare Connect (OCC) Member Complaints



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

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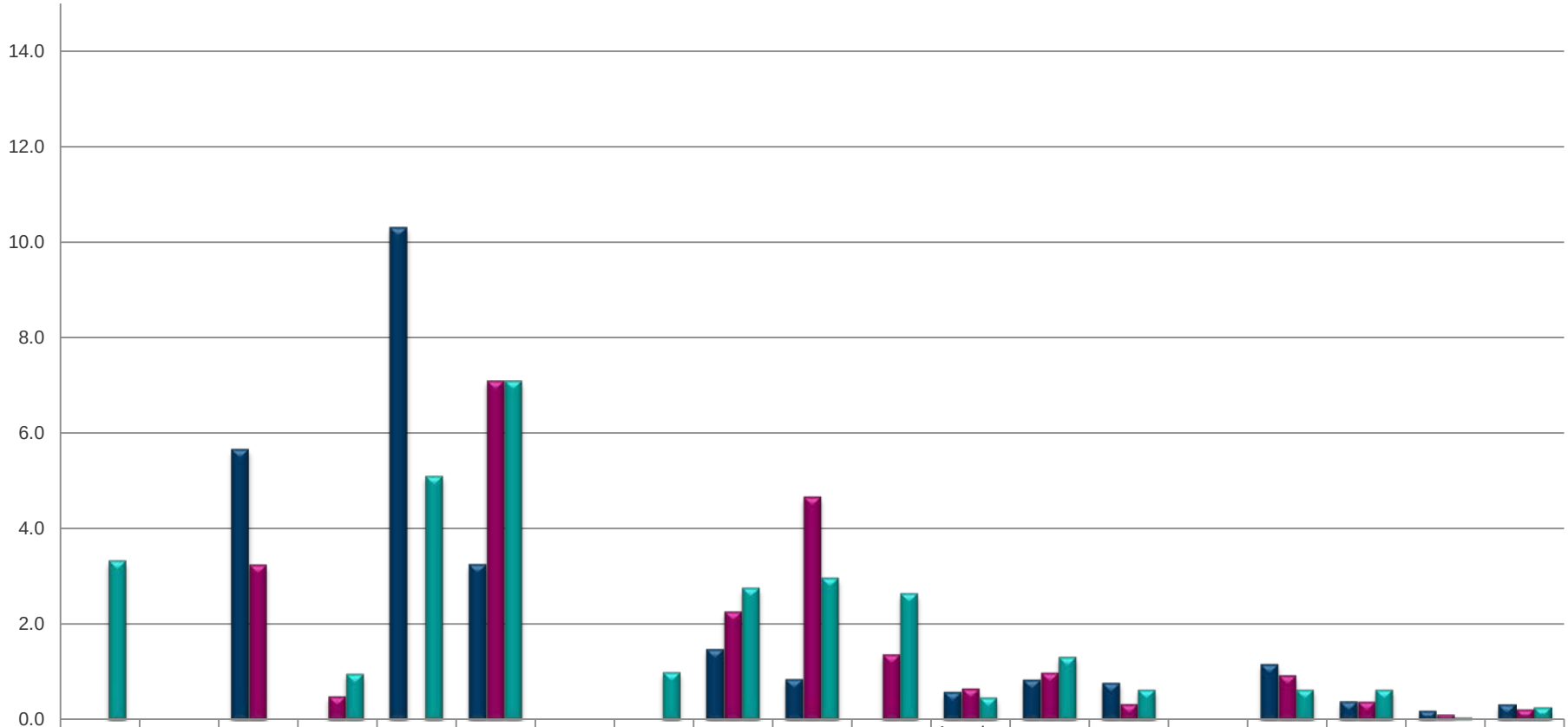
OCC Member Grievances Quarterly Rate/1,000



	Alta Med Health (592)	AMVI Care (737)	Arta (722)	Family Choice (2,015)	Heritage (260)	Monarch (5,686)	Noble (533)	OC Adv (131)	Prospect (3,497)	Talbert (1,303)	UCMG (733)	American Logistics (18,123)	Liberty Dental (18,317)	CCN (18,317)	MLTSS (18,317)	OCC Prog (18,317)	OCC Pharm (18,317)	VSP (18,317)	Windstone (18,317)
1Q-16 (15,340)	0.0	0.0	5.7	0.0	10.3	3.3	0.0	0.0	1.5	0.9	0.0	0.6	0.8	0.8	0.0	1.2	0.4	0.2	0.3
2Q-16 (18,123)	0.0	0.0	3.3	0.5	0.0	7.1	0.0	0.0	2.3	4.7	1.4	0.7	1.0	0.3	0.0	0.9	0.4	0.1	0.2
3Q-16 (18,317)	3.3	0.0	0.0	1.0	5.1	7.1	0.0	1.0	2.8	3.0	2.6	0.5	1.3	0.6	0.0	0.6	0.6	0.1	0.3

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Summary

- Although Alta Med, Heritage and UCMG seem to report a higher quarterly rate/1,000 grievances, It's mainly due to their low membership.
  - Alta Med - Two (2) grievances received out of 592 members.
  - Heritage – One (1) grievance received out of 260 members.
  - UCMG – Two (2) grievances received out of 733 members.
- OCC Pharmacy grievances increased from 7 in Q2 to 12 in Q3. The increase was in complaints filed against the pharmacy vendors and were filed by one unique member.
- No specific trends identified with the Physician Medical Group or providers.
- All quality of care concerns are referred to Quality Improvement department for investigation.

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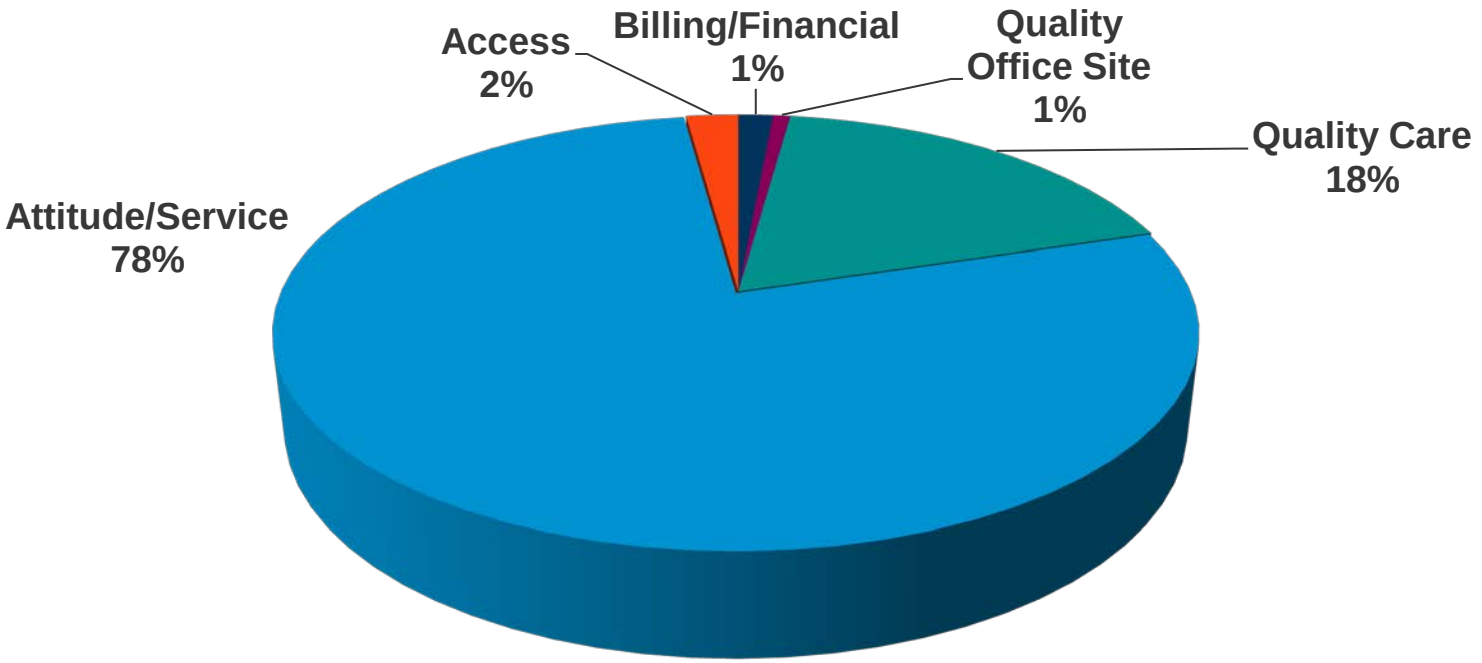
OCC Grievances By Category



- Total of 138 grievances filed by 102 unique members in Q3, 2016.
  - Of these,107 grievances (78%) were related to QOS and 25 grievances (18%) were related to QOC concerns.
  - Note: The percentage by categories represent the historic trend.
- The QI department continues to review for QOC issues and potential trending.

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Common QOS and QOC Concerns

- Delay in service (QOS)
- Dental (QOS)
  - Billing
  - Coverage
- Provider services (QOS)
- Transportation vendor (QOS)
  - Late/No show
  - Rudeness
- Question diagnosis/treatment (QOC)

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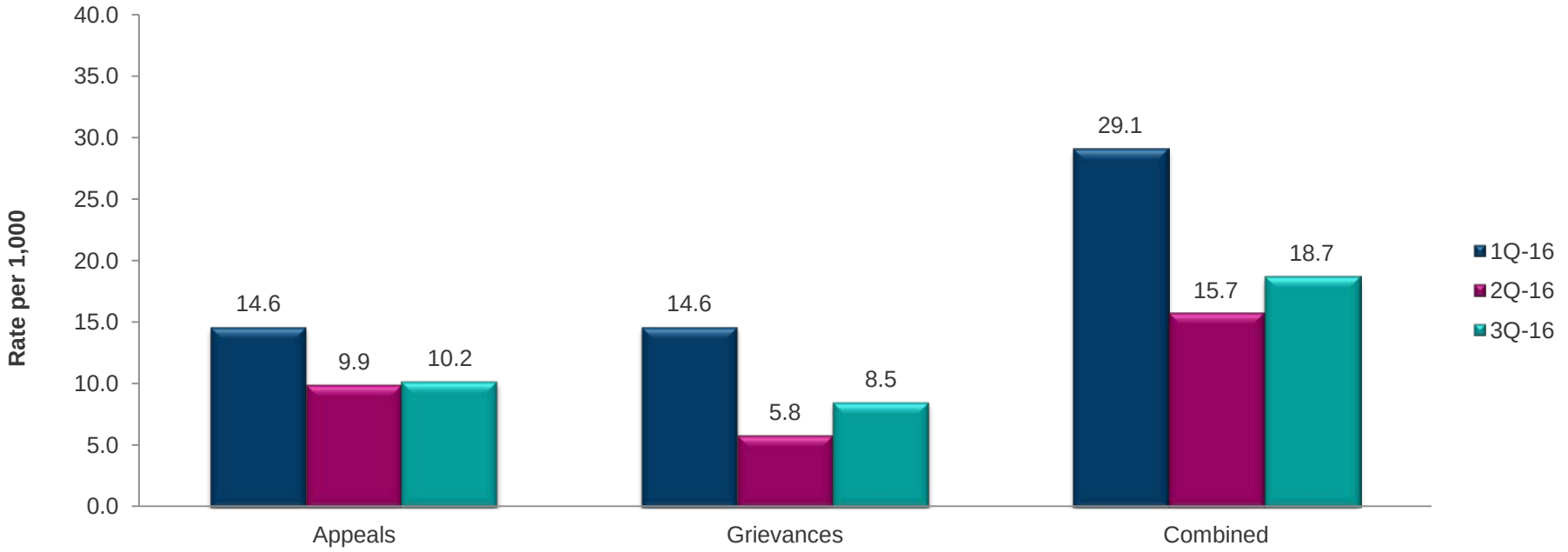
Overall OneCare (OC) Member Complaints



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

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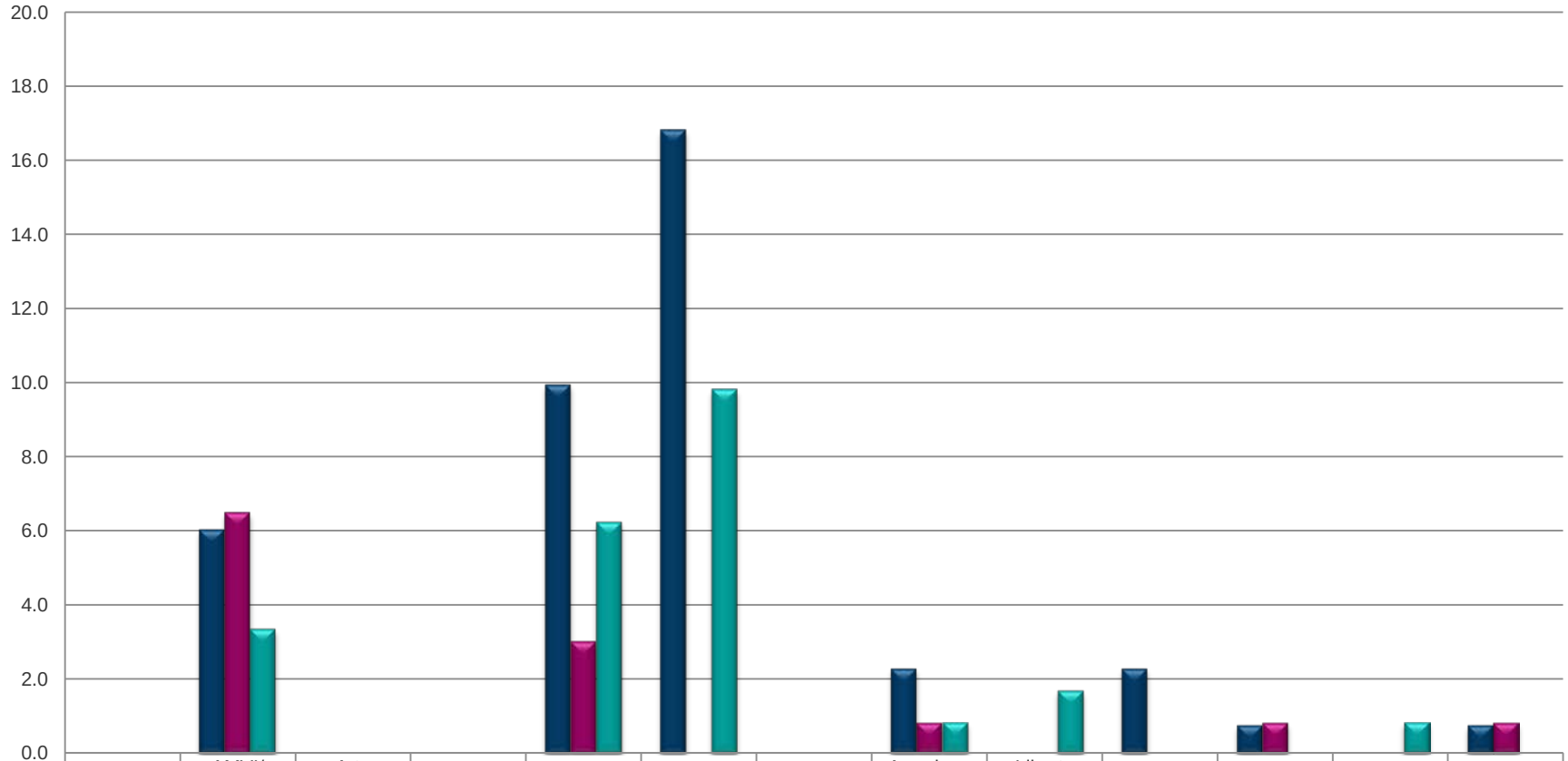
OC Member Grievances Quarterly Rate/1,000



	Alta Med Health (23)	AMVI/ Prospect (298)	Arta Western (35)	Family Choice (59)	Monarch (643)	Talbert (102)	UCMG (13)	American Logistics (1,177)	Liberty Dental (1,177)	OC Ops (1,177)	OC Pharm (1,177)	VSP (1,177)	Windstone (1,177)
1Q-16 (1,305)	0.00	6.04	0.00	0.00	9.94	16.81	0.00	2.3	0.0	2.3	0.8	0.0	0.8
2Q-16 (1,208)	0.00	6.48	0.00	0.00	3.03	0.00	0.00	0.8	0.0	0.0	0.8	0.0	0.8
3Q-16 (1,177)	0.00	3.36	0.00	0.00	6.22	9.80	0.00	0.8	1.7	0.0	0.0	0.8	0.0

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Summary

- Although Monarch, Talbert and Liberty Dental seem to report a higher quarterly rate/1,000 grievances, it's mainly due to the overall low membership.
  - Monarch – Four (4) grievances received out of 643 members.
  - Talbert – One (1) grievance received out of 102 members.
  - Liberty Dental – Two (2) grievances received out of 1,177 members.
- No specific trending of issues or providers identified.

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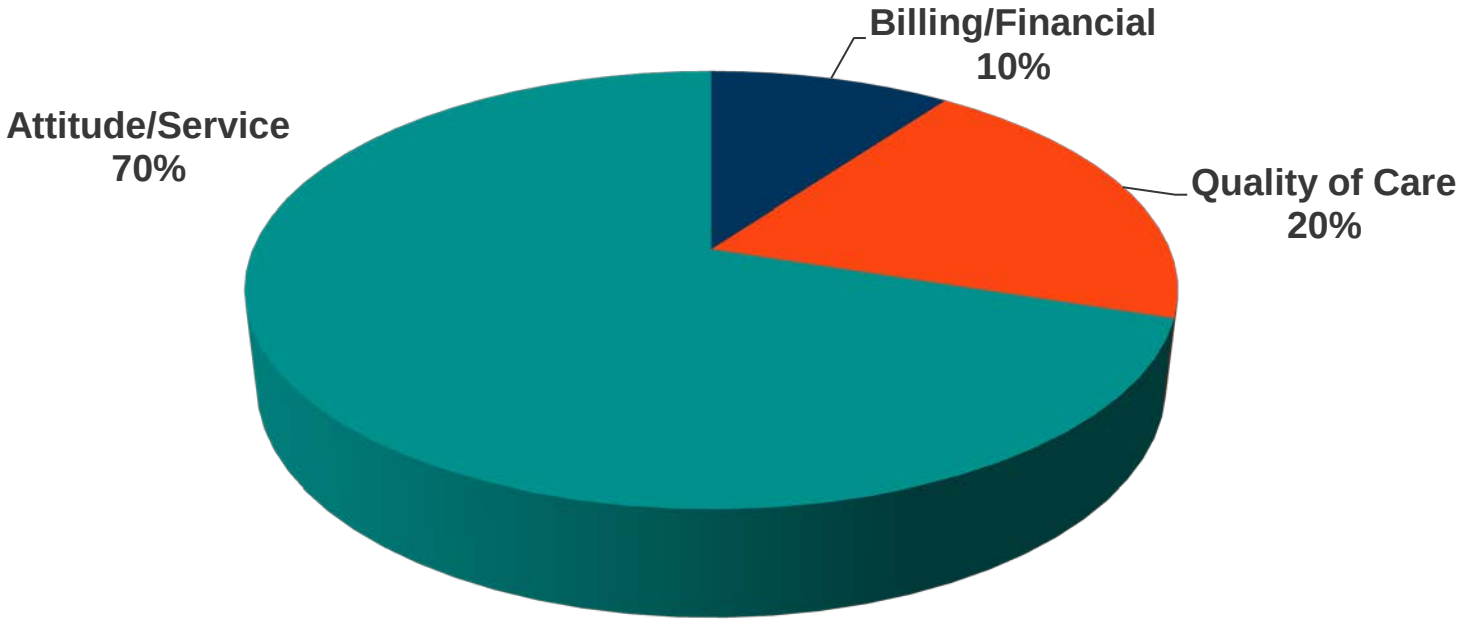
OC Grievances By Category



- Total of 10 grievances filed by 8 unique members in Q3 2016.
  - Of these, 7 grievances (70%) were related to QOS and 2 grievances (20%) were related to QOC concerns.
  - Note: The percentage by categories represent the historic trend.
- The QI department continues to review for QOC issues and potential trending.

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Common QOS and QOC Concerns

- Provider services (QOS)
  - Dissatisfied with staff, doctor and office site
- Office wait time (QOS)
  - Long office wait
- Transportation vendor (taxi – supplemental services) (QOS)
  - Dissatisfied with driver
- Question treatment (QOC)
  - Dissatisfied with diagnosis and care

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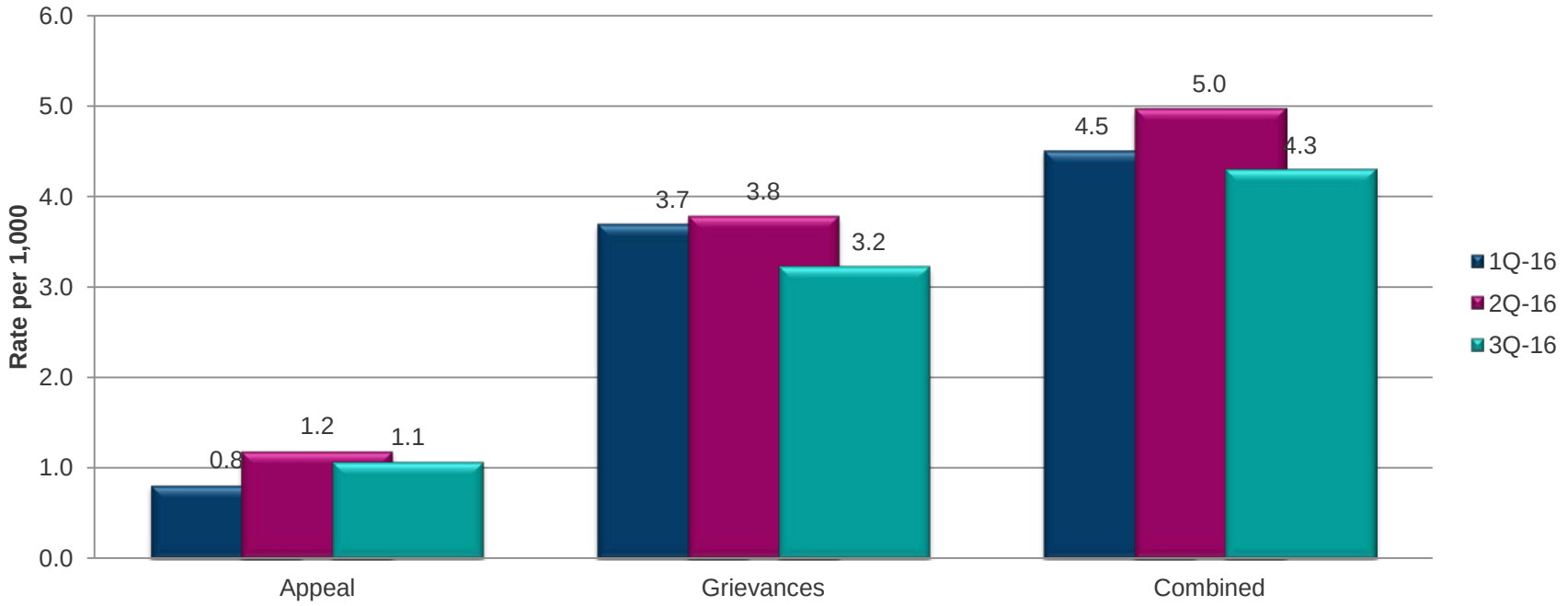
Overall Medi-Cal Member Complaints



	Total Complaints	Appeals	Grievances	Membership
1Q-2016	856	154	702	769,385
2Q-2016	958	229	729	770,487
3Q-2016	838	210	628	772,927

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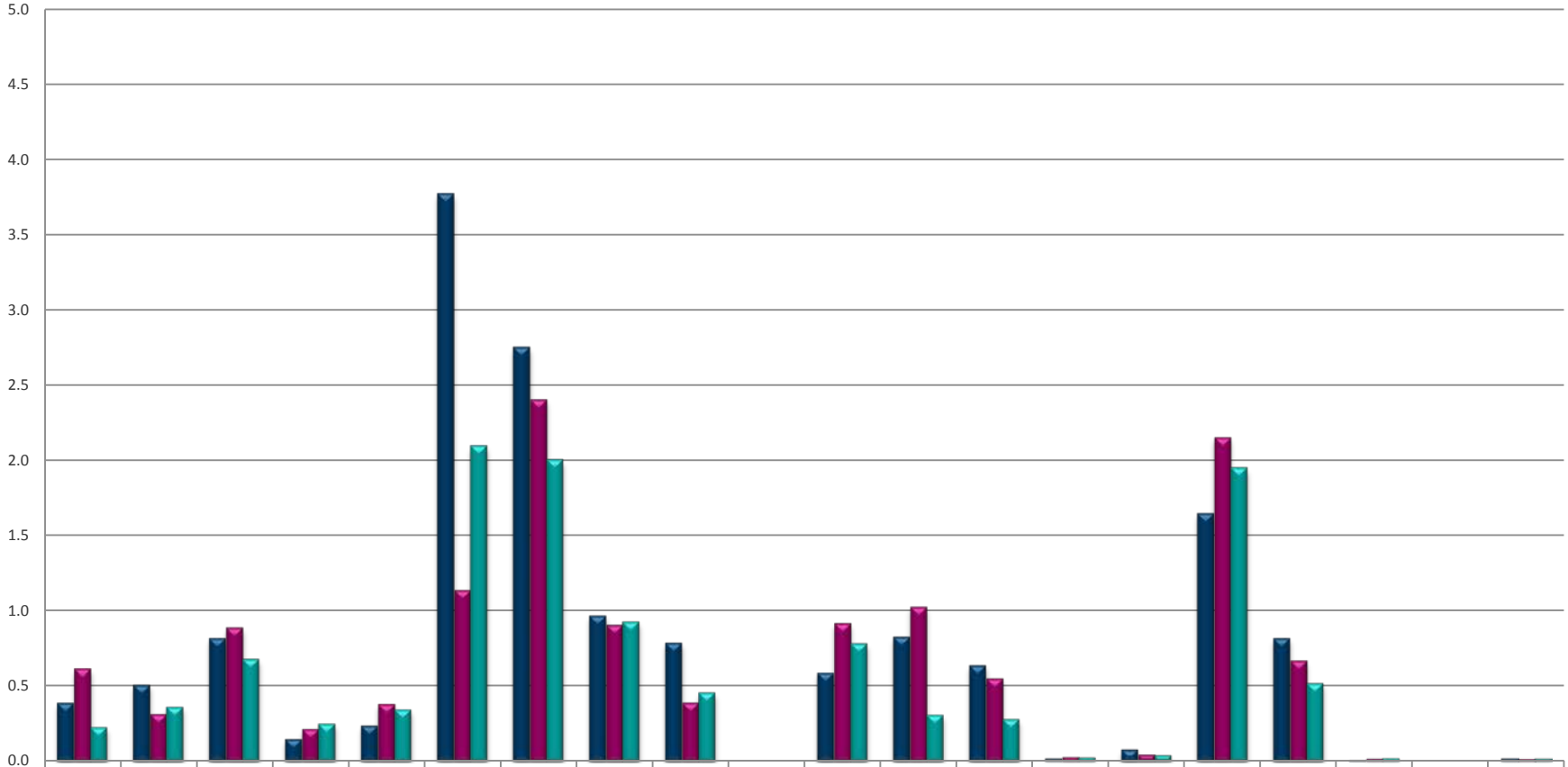
Medi-Cal Member Grievances
Quarterly Rate/1,000



	AltaMed (38,915)	AMVI (25,185)	Arta (79,447)	CHA (155,530)	Family Choice (49,595)	Heritage (2,637)	Kaiser (45,024)	Monarch (90,242)	Noble (34,980)	OC Advantage (761)	Prospect (37,005)	Talbert (26,147)	UCMG (35,866)	CO Prog (778,808)	CO Pharm (778,808)	CCN (64,506)	COD (91,940)	Beacon (778,808)	MLTSS (732,784)	VSP (732,784)
1Q-16 (769,385)	0.39	0.51	0.82	0.15	0.24	3.77	2.75	0.97	0.79	0.00	0.59	0.83	0.64	0.02	0.08	1.65	0.82	0.01	0.00	0.02
2Q-16 (772,164)	0.62	0.32	0.89	0.22	0.38	1.14	2.40	0.91	0.39	0.00	0.92	1.03	0.55	0.03	0.05	2.15	0.67	0.02	0.00	0.02
3Q-16 (778,808)	0.23	0.36	0.68	0.25	0.35	2.09	2.00	0.93	0.46	0.00	0.78	0.31	0.28	0.03	0.04	1.95	0.52	0.02	0.00	0.02

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CalOptima A Public Agency Better. Together.

Summary

- Increase in member billing for out of state services during peak vacation months.
- Heritage reported a higher quarterly rate/1,000 grievances due to low membership. Five (5) grievances were received out of 2,637 members.
- Review of the quality of service concerns for all heath networks did not identify specific trending for provider or staff.
- Overall grievances as a rate/1,000 members remain low at 3.2 in Q3 2016, a slight decrease from 3.8 in Q2 2016.

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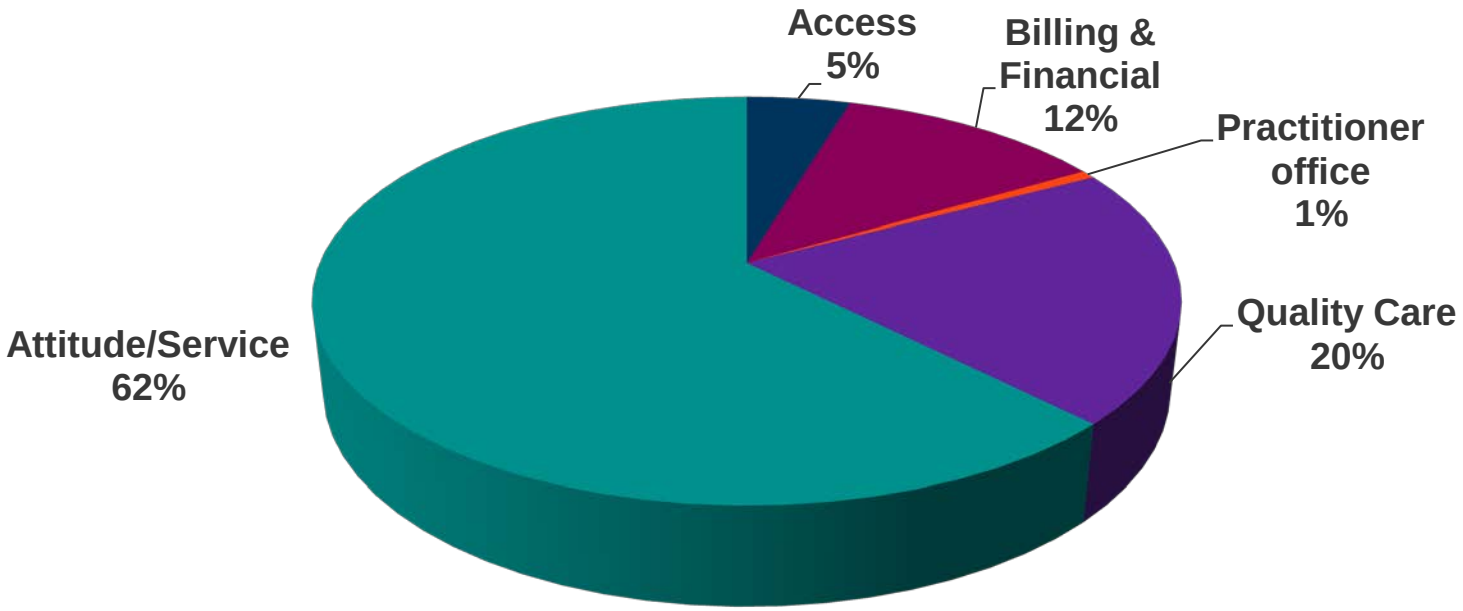
Medi-Cal Grievances By Category



- Total of 628 grievances filed by 574 unique members in Q3 2016.
  - Of these, 392 grievances (62%) were related to QOS and 128 grievances (20%) were related to QOC concerns.
  - The percentage by categories represent the historic trend.
- The QI department continues to review for QOC issues and potential trending.

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Common QOS Concerns

- Delay in service
  - Referrals
  - Rx's
  - General response from doctor
- Provider services
  - Dissatisfied with staff, doctor or program
- Rudeness
- Refusal to treat
  - Lack of prior authorization
  - Lack of walk in appointment availability
  - Lack of care during appointment

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Common QOC Concerns

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

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Interventions

- All quality of care concerns are referred to the Quality Improvement department for investigation.
- CalOptima works with all our networks (by sharing the grievance and appeals data specific to each network) and providers to improve in these areas including QOS and QOC concerns.

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