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

WEDNESDAY, JUNE 8, 2022
3:00 P.M.

505 CITY PARKWAY WEST, SUITE 108-N
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE
Trieu Tran, M.D., Chair
José Mayorga, M.D.
Nancy Shivers, RN

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL	CLERK OF THE BOARD
Michael Hunn	Troy R. Szabo KENNADAY LEAVITT	Sharon Dwiers

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

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

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

To ensure public safety and compliance with emergency declarations and orders related to the COVID-19 pandemic, individuals are encouraged not to attend the meeting in person. As an alternative, members of the public may:

1) **Participate via Zoom Webinar at:**
https://us06web.zoom.us/webinar/register/WN_WzDabAsASuitnz6_CLPmJw
and Join the Meeting.
Webinar ID: **819 3164 2686**
Passcode: **474939** -- Webinar instructions are provided below.

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 March 9, 2022 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

2. Approve Modifications to CalOptima Policy GG.1611: Potential Quality Issue Review Process

3. Approve New CalOptima Policy GG.1666p: Mobile Texting Program

INFORMATION ITEMS
4. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update

5. Quarterly Reports to the Quality Assurance Committee
   a. Quality Improvement Committee Report
   b. Program of All-Inclusive Care for the Elderly Report
   c. Member Trend Report
   d. Health Equity Update

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

TO JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee on June 8, 2022 at 3:00 p.m. (PST)

Join from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join.
https://us06web.zoom.us/webinar/register/WN_WzDabAsASuitnz6_CLPmJw

Or One tap mobile:
+12532158782,,81931642686#,,,,*474939# US (Tacoma)
+13462487799,,81931642686#,,,,*474939# US (Houston)

Or join by phone:
Dial (for higher quality, dial a number based on your current location):
US: +1 253 215 8782 or +1 346 248 7799 or +1 720 707 2699 or +1 301 715 8592 or +1 312 626 6799 or +1 646 558 8656

Webinar ID: 819 3164 2686
Passcode: 474939

International numbers available: https://us06web.zoom.us/u/kIr7nPZkB

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

March 9, 2022

A Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on March 9, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings.

Chair Trieu Tran, called the meeting to order at 3:02 p.m. and Director Shivers led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Trieu Tran, M.D., Chair; Nancy Shivers, R.N. (all members participated via teleconference)

Members Absent: José Mayorga, M.D.

Others Present: Yunkyung Kim, Chief Operating Officer; Richard Pitts, M.D., Chief Medical Officer; Monica Macias, Director PACE, Marsha Choo, Interim Director of Quality Implementation; Sharon Dwiers, Clerk of the Board

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the December 8, 2021 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

2. Approve Modifications to CalOptima Quality Improvement Policies: GG. 1603, GG. 1607, GG. 1650, FF. 1651, and GG. 1655

Action: ***On motion of Director Shivers, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 2-0-0; Director Mayorga absent)***

Back to Agenda

REPORTS

3. Receive and File 2021 CalOptima Quality Improvement Program Evaluation and Recommend Board of Directors Approval of the 2022 Quality Improvement Program and 2022 Quality Improvement Program

Marsha Choo, Interim Director, Quality Improvement, introduced the item and provided an overview of the 2021 Quality Improvement Program Evaluation. Ms. Choo highlighted several accomplishments achieved in 2021, which included the following: in July 2021, achieved National Committee for Quality Assurance (NCQA) accreditation through 2024; in September 2021, received 4 out of 5 in NCQA's Medicaid Health Plan rating, also in September 2021, received a mPulse award for Achieving Health Equity related to health care innovation, and received Orange County Chapter of the Public Relations Society of America's Award of Excellence for COVID-19 response. Ms. Choo added, that in October 2021, Assemblywoman Cottie Petrie-Norris recognized CalOptima's Program of All-Inclusive Care for the Elderly (PACE) program for its use of telehealth technology, and in November 2021, CalOptima received the Department of Health Care Services (DHCS) 2021 Consumer Satisfaction Award for the Adult population for a large-scale health plan.

Ms. Choo noted that the 2021 evaluation is used to help staff formulate the 2022 Quality Improvement Program and Workplan. For 2022, CalOptima will incorporate social determinants of health (SDOH) and health equity in targeted quality initiatives. Ms. Choo reviewed the goals for 2022, which also include working closely with CalOptima's health networks, providers, and community stakeholders.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors: Receive and File 2021 CalOptima Quality Improvement Program Evaluation; and Approval of the 2022 Quality Improvement Program. (Motion carried 2-0-0; Director Mayorga absent)***

4. Receive and File 2021 CalOptima Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation and Recommend Board of Directors Approval of the 2022 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Monica Macias, Director, PACE, introduced the item and provided and overview of the 2021 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan Evaluation. Ms. Macias highlighted several of the 2021 PACE accomplishments, which included the following: 100% medication reconciliation rate following a hospital discharge; 91% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed; 99% on-time performance for transportation with 30,696 one-ways trips; Overall participant satisfaction score of 91% compared to national average of 88.5%; and PACE met 25 of 29 work plan element goals.

Ms. Macias noted the 2021 Quality Assessment and Performance Improvement Plan Evaluation assists staff in developing the 2022 PACE Quality Improvement Plan. She reviewed the several of the quality initiatives and goals for 2022, which included the following: adding a COVID-19 booster related quality initiative for 2022; monitoring participants with Osteoporosis diagnosis to ensure that they are receiving treatment to prevent fractions; and added an advanced health care directive as a

new quality initiative for 2022. Ms. Macias also reported that 2022 PACE Quality Improvement Plan aligns with CalOptima's vision and mission and focuses on optimal health outcomes for its participants.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended that the Board of Directors: Receive and File 2021 CalOptima PACE Quality Improvement Plan Evaluation, and Approval of the 2022 PACE Quality Improvement Plan (Motion carried 2-0-0; Director Mayorga absent)***

INFORMATION ITEMS

5. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update
Ms. Macias provided an update on the recent activities of the PACE Member Advisory Committee.

The following items were accepted as presented.

6. Quarterly Reports to the Quality Assurance Committee
   a. Quality Improvement Committee Report
   b. Program of All-Inclusive Care for the Elderly Report
   c. Member Trend Report

COMMITTEE MEMBER COMMENTS
The Committee members thanked staff for the work that went into preparing for the meeting.

ADJOURNMENT
Hearing no further business, Chair Tran adjourned the meeting at 3:36 p.m.

_____
Sharon Dwiers
Clerk of the Board

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 8, 2022
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Consent Calendar

2. Approve Modifications to CalOptima Policy GG.1611: Potential Quality Issue Review Process

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Marie Jeannis, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Action

Approve recommended modifications to the following existing policy GG.1611: Potential Quality Issue Review Process.

Background/Discussion

CalOptima staff regularly review agency policies and procedures to ensure that they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations, laws, as well as CalOptima operations.

Below is a description of the impacted policy, followed by a list of recommended substantive changes to the policy, which are reflected in the attached redlines. The list does not include non-substantive changes that may also be reflected in the redline (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

Policy Section	Change
Page 1 Section II. E.1 Lines 25-26 & Page 4 Section III.C	Defined both "pattern" and "trend" for Potential Quality Issues (PQI), and updated language to report trends to the Credentialing and Peer Review Committee (CPRC).
Page 2 Section III.A.2 Lines 11-13	Added language to reflect immediate review of Quality-of-Care grievances by the CMO or their Designee.
Page 2 Section III.B.1 Line 39	Removed policy language to have letters sent to the Member for Potential Quality Issues. Members already receiving letters as part of the Grievance process from GARS.
Page 2-3 Section III.B.1 Lines 53-2	Removed timeliness requirements related to Potential Quality Issues investigations. There is no regulatory requirement.
Page 4 Section III.B.11	In lieu of sending resolution letters to Health Networks, CalOptima will continue to submit quarterly reports to the Health Networks.

Fiscal Impact

The recommended action to approve changes to GG.1611 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Back to Agenda

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with all applicable laws, regulations, rules, and accreditation standards. CalOptima staff recommends that the Board of Directors approve and adopt the presented CalOptima policy and procedure. The updated policy and procedure will supersede prior versions.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachment

1. CalOptima Policy GG. 1611: Potential Quality Issue Review Process (redline & clean versions)

/s/ Michael Hunn — **Authorized Signature**

06/03/2022 — **Date**

Back to Agenda

Policy:	GG.1611
Title:	**Potential Quality Issue Review Process**
Department:	Medical Management
Section:	Quality Improvement
~~*Interim* CEO Approval:~~	*/s/*
Effective Date:	01/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the ~~process~~procedure for reviewing and processing of a Potential Quality Issue (PQI) referred to the CalOptima Quality Improvement (QI) Department.

II. POLICY

A. ~~All~~ CalOptima departments, Practitioners, Providers, Health Networks, and Healthcare Delivery Organizations (HDOs) shall refer a Potential Quality Issue (PQI) to the CalOptima Quality Improvement (QI) Department for review and investigation.

B. The QI Department shall conduct a review of all PQIs by appropriately trained and qualified staff, including QI nurses and Medical Directors.

C. The QI Department shall conduct an investigation and request medical records and/or other CalOptima records as well as pertinent documentation from Providers, as needed.

D. CalOptima's Chief Medical Officer (CMO) or Designee shall refer PQI cases to the CalOptima Credentialing and Peer Review Committee (CPRC) for further evaluation and action, pursuant to the CalOptima Quality Improvement Program.

E. The QI Department shall trend and analyze individual Practitioner, Provider, Health Network, and HDO PQI data every six (6) months to identify emerging patterns.

1. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels 1, 2, 3, H1, and Health Delivery System (HDS).

~~1.~~2. This data shall be reviewed by the CMO or Designee who shall report any issues and/or emerging patterns to the CalOptima CPRC for further evaluation and action, as necessary.

F. The QI Department shall prepare a summary report of all QI case activities and submit the report for review to the CalOptima CPRC.

G. The CPRC shall report a summary of trends and activities to the CalOptima Quality Improvement Committee (QIC) and to the Board of Directors' Quality Assurance Committee (QAC).

Back to Agenda Back to Item

H. CalOptima shall maintain confidentiality of quality improvement case review information, in accordance this Policy.

III. PROCEDURE

A. Case Referral and Identification

1. Providers, Practitioners, Health Networks, and HDOs may identify and refer a PQI to CalOptima's QI Department.

2. For Grievances related to potential QOC issues received from the Grievance and Appeals Resolution Services (GARS) Department, the QI Department shall immediately refer such Grievances to the CMO or Designee for review.

~~2.~~3. A PQI may be referred from an internal CalOptima department, including but not limited to, ~~Grievance & Appeals Resolution Services (GARS),~~ Behavioral Health Integration, Customer Service, Pharmacy Management, Utilization Management (UM), Case Management and the Office of Compliance.

~~3.~~4. Supporting documentation (e.g., correspondence, grievances, claims data, case management notes) shall accompany the referral.

a. Any entity referring a PQI case~~,~~ shall identify if the Member chooses to remain anonymous.

~~4. A QI Nurse shall perform an initial clinical review within three (3) business days and determine:~~

~~a. If the case is a Quality of Care (QOC) or Quality of Service (QOS) based on the initial information received; and~~

~~b. If the Member has any urgent clinical issues, care coordination will be provided by the QI Nurse.~~

B. Process, Review, and Evaluation of PQI Cases

1. PQI cases will be opened by the CalOptima PQI team and documented in CalOptima's care management system.

~~a. The CalOptima PQI team shall send an acknowledgement letter to the Member.~~

~~b.~~a. If the Member chooses to remain anonymous, the case will be flagged as confidential ~~and no acknowledgement letter will be sent to the Member~~in the electronic system.

~~c. If the case was not referred by a Member or a Member's representative, no acknowledgement letter will be sent to the Member.~~

b. A QI Nurse shall perform an initial clinical review upon receipt, determine if the Member has any urgent clinical issues, and provide care coordination interventions as needed.

~~d.~~c. The QI nurse shall request pertinent medical records and a response to the ~~Member's~~ complaint from the appropriate Provider(s), Practitioner(s), Health Network, and/or HDO(s) that rendered medical services or were involved in rendering the medical service(s), as needed. ~~A Provider, Practitioner, Health Network, or HDO shall submit such records and~~

~~response to the CalOptima QI Department within fourteen (14) calendar days after receipt of the request.~~

i. Medical records and a response may or may not be able to be obtained for confidential cases in order to maintain the Member's anonymity.

~~i.~~ii. If a Provider, Practitioner, Health Network, or HDO fails to respond ~~within the required timeframe~~:

~~a) The CalOptima QI Department shall follow up with a minimum of three (3) attempts within thirty (30) business days to obtain the requested information.~~

~~b) CalOptima may request a written and signed explanation for any delay in submitting records or responding to a request for a case review. This document shall become a permanent part of the review record.~~

~~c)~~a) ~~If there is no reasonable or acceptable explanation provided by the Provider, Practitioner, Health Network, or HDO, or if the delay continues,~~ CalOptima's QI Department, in consultation with a Medical Director, may take any and all reasonable actions it deems to be in the best interest of Member, including the issuance of a Corrective Action Plan (CAP), pursuant to CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners.

2. CalOptima's QI Department may deem it appropriate to deploy CalOptima's copying vendor to copy and provide medical records.

3. CalOptima's QI Department shall target to complete its preliminary review upon the receipt of the case review response, medical records, and/or other supporting documentation, within ~~one hundred twenty (120~~ninety (90) calendar days.

4. ~~If the case is determined by~~After review of the medical records and response from the Provider, if the QI Nurse determines the case to be a Quality of Service (QOS) issue, the case shall be closed, and a provider resolution letter will be sent by the PQI team.

   a. If the case was referred by an internal CalOptima Department, notification of the QOS determination will be communicated to the referring department for educational purposes.

   ~~b. The CalOptima PQI team shall send a resolution letter to the Member.~~

   ~~c. If the Member chooses to remain anonymous, the case will be flagged as confidential and no resolution letter will be sent to the Member.~~

   ~~d. If the case was not referred by a Member or a Member's representative, no resolution letter will be sent to the Member.~~

   ~~e.~~b. If the case is determined by the QI Nurse to be a QOC issue, findings will be summarized for evaluation by the CalOptima Medical Director.

5. The CalOptima Medical Director shall review ~~with QOC~~the case. Based upon the outcome of the case review, the Medical Director shall assign an outcome score to the ~~QOC~~ case that reflects the severity of the outcome.

Outcome Score	Description of Outcome Score
0	No quality of care or quality of service issue identified.
1	Mild clinical judgment or operational issue with or without an adverse outcome.
2	Moderate clinical judgment or operational issue with or without an adverse outcome.
3	Severe clinical judgment or operational issue with or without an adverse outcome.
H1	Potential clinical care issue with or without an adverse outcome which occurs in a hospital.
S0	Service-related issue, unable to verify.
S1	Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.
HDS	Healthcare delivery system issue with or without an adverse outcome.

6. CalOptima shall utilize an external review entity if a second opinion is determined to be needed by a Medical Director.

7. If the CalOptima Medical Director does not identify a QOC issue, the case will be given an outcome score and no further action regarding the review process shall occur.

8. If the CalOptima Medical Director identifies a QOC issue, the case will be given an outcome score and, based on severity, be closed by the CalOptima Medical Director, or be presented to the CalOptima CPRC for recommendation(s).

    a. Higher severity cases will be presented to CPRC for discussion and recommendation of action.
    b. Other cases may be presented to CPRC upon Medical Director's discretion.

9. If a case is presented to CPRC and the committee confirms that the identified issue is a QOC issue, the CPRC may recommend further action.

    a. A corrective action from the specific CalOptima department, Health Network, HDO, Practitioner, or Provider;

    b. Require the Practitioner, Provider, Health Network, HDO, or CalOptima department to perform additional educational training; or

    c. Require other appropriate action(s) as recommended by the CPRC.

10. QI Staff shall present a summary of closed cases to the CPRC; this includes any remediation needed from CAPs issued to the Health Network, HDO, Practitioner, Provider, or CalOptima Department.

11. Once the review process is completed, a provider resolution letter will be sent to ~~the Health Network,~~ the Provider ~~and the Member, if the case was member generated and not a confidential case.~~.

a. If the case was a confidential case, the Member information will be blinded in the Provider resolution letter.

b. If the Provider disagrees with the determination, they may file a complaint pursuant to CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

C. Reporting Requirements and Follow up Actions

1. The QI Department shall generate trend reports of PQI cases and shall report to the CPRC~~:~~ at least every six (6) months.

~~e. Practitioners, Providers, and HDOs whose PQI rate is greater than practitioner, provider or HDO specialty;~~

~~f. Open and closed cases; and~~

~~g. Severity levels and categories of issues.~~

2. Patterns that are identified in the trend report as described in Section II.E. of this Policy, will be presented to CPRC to determine if any action is needed.

~~2.~~3. The QI Department shall submit all case findings and recommended actions to the CalOptima CPRC.

~~3.~~4. The QI Department shall follow-up on all actions that the CPRC recommends, ensuring compliance and appropriate remediation.

~~4.~~5. CPRC shall submit a summary report of all case reviews, including the conclusions and recommendations of the CPRC, to the Quality Improvement Committee (QIC) on a quarterly basis.

~~5.~~6. Additionally, the CalOptima CMO, his or her Designee, and/or the Executive Director of Quality & Analytics, shall submit summary reports on behalf of CPRC and QIC to the CalOptima Board of Directors' Quality Assurance Committee (QAC), in accordance with the CalOptima QI Plan.

~~6.~~7. The QI Department shall extract relevant information from case reviews, including those where no quality issues were identified, for trending and future study.

~~7.~~8. The QI Department shall include a summary of the case review findings in the Provider or Practitioner's Credentialing file. Information shall be brought forward at time of Recredentialing.

~~8.~~9. The QI Department shall submit a quarterly report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network. Members who choose to remain confidential will have their information blinded in the report.

IV. ATTACHMENT(S)

A. Medical Records Request Form

B. Potential QOC Issue Request for Information Template
C. Health Network Resolution Letter
~~D. Member Resolution Letter (Medi-Cal)~~
~~E. Member Resolution Letter (OneCare)~~
~~F. Member Resolution Letter (OneCare Connect)~~
~~G. Member Acknowledgement Letter (Medi-Cal)~~
~~H. Member Acknowledgement Letter (OneCare)~~
~~I. Member Acknowledgement Letter(OneCare Connect)~~
~~J.~~D. Provider Resolution Letter

V. REFERENCE(S)

A. California Business and Professions Code, §§805 and 1000-1
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
D. CalOptima Three-way Agreement with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners
F. CalOptima Policy HH.1101: Provider Complaint Process
G. CalOptima Policy MA.9006: Provider Complaint Process
~~F.~~H. CalOptima Quality Improvement Plan
I. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates
~~G.~~J. Title 22, California Code of Regulations (C.C.R), §51051
~~H.~~K. Title 28, California Code of Regulations (C.C.R), §1300.85.1
~~I.~~L. Title 42, Code of Federal Regulations (C.F.R), §422.152(a)(3), (c)(2), and (d)
~~J.~~M. Title 42, Code of Federal Regulations (C.F.R.), §438.330(d)

~~VI.~~

~~VII.~~VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/23/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/03/2022	Department of Health Care Services (DHCS)	File and Use

~~VIII.~~VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of the CalOptima Board of Directors

~~IX.~~VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal

Back to Agenda Back to Item

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	11/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	03/04/2021	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect

~~X.~~IX. GLOSSARY

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The Credentialing and Peer Review Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement Committee (QIC).
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role. For the purposes of this policy, a designee acting on behalf of the CalOptima Chief Medical Officer (CMO) shall be a CalOptima Medical Director.
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. One-Care: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an adverse benefit determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "complaint."
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to members assigned to that Health Network.

Back to Agenda Back to Item

Term	Definition
Healthcare Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Member	An enrollee-beneficiary of a CalOptima program.
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing covered services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes covered services.
Quality Improvement Committee (QIC)	The CalOptima committee that is responsible for the Quality Improvement (QI) process.
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima QI Registered Nurse (RN) or a CalOptima QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	~~Service issue resulting in inconvenience or dissatisfaction to Member.~~Defined as, adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS providers and services; Continuity and coordination of care across all care and services settings, and for transitions in care; and Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.
Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in CalOptima's programs.

1

Policy:	GG.1611
Title:	**Potential Quality Issue Review Process**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	01/01/1996
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the procedure for reviewing and processing of a Potential Quality Issue (PQI) referred to the CalOptima Quality Improvement (QI) Department.

II. POLICY

A. CalOptima departments, Practitioners, Providers, Health Networks, and Healthcare Delivery Organizations (HDOs) shall refer a Potential Quality Issue (PQI) to the CalOptima Quality Improvement (QI) Department for review and investigation.

B. The QI Department shall conduct a review of all PQIs by appropriately trained and qualified staff, including QI nurses and Medical Directors.

C. The QI Department shall conduct an investigation and request medical records and/or other CalOptima records as well as pertinent documentation from Providers, as needed.

D. CalOptima's Chief Medical Officer (CMO) or Designee shall refer PQI cases to the CalOptima Credentialing and Peer Review Committee (CPRC) for further evaluation and action, pursuant to the CalOptima Quality Improvement Program.

E. The QI Department shall trend and analyze individual Practitioner, Provider, Health Network, and HDO PQI data every six (6) months to identify emerging patterns.

1. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels 1, 2, 3, H1, and Health Delivery System (HDS).

2. This data shall be reviewed by the CMO or Designee who shall report any issues and/or emerging patterns to the CalOptima CPRC for further evaluation and action, as necessary.

F. The QI Department shall prepare a summary report of all QI case activities and submit the report for review to the CalOptima CPRC.

G. The CPRC shall report a summary of trends and activities to the CalOptima Quality Improvement Committee (QIC) and to the Board of Directors' Quality Assurance Committee (QAC).

Back to Agenda Back to Item

H. CalOptima shall maintain confidentiality of quality improvement case review information, in accordance this Policy.

III. PROCEDURE

A. Case Referral and Identification

1. Providers, Practitioners, Health Networks, and HDOs may identify and refer a PQI to CalOptima's QI Department.

2. For Grievances related to potential QOC issues received from the Grievance and Appeals Resolution Services (GARS) Department, the QI Department shall immediately refer such Grievances to the CMO or Designee for review.

3. A PQI may be referred from an internal CalOptima department, including but not limited to, Behavioral Health Integration, Customer Service, Pharmacy Management, Utilization Management (UM), Case Management and the Office of Compliance.

4. Supporting documentation (e.g., correspondence, grievances, claims data, case management notes) shall accompany the referral.

    a. Any entity referring a PQI case shall identify if the Member chooses to remain anonymous.

B. Process, Review, and Evaluation of PQI Cases

1. PQI cases will be opened by the CalOptima PQI team and documented in CalOptima's care management system.

    a. If the Member chooses to remain anonymous, the case will be flagged as confidential in the electronic system.

    b. A QI Nurse shall perform an initial clinical review upon receipt, determine if the Member has any urgent clinical issues, and provide care coordination interventions as needed.

    c. The QI nurse shall request pertinent medical records and a response to the complaint from the appropriate Provider(s), Practitioner(s), Health Network, and/or HDO(s) that rendered medical services or were involved in rendering the medical service(s), as needed.

        i. Medical records and a response may or may not be able to be obtained for confidential cases in order to maintain the Member's anonymity.

        ii. If a Provider, Practitioner, Health Network, or HDO fails to respond:

            a) CalOptima's QI Department, in consultation with a Medical Director, may take any and all reasonable actions it deems to be in the best interest of Member, including the issuance of a Corrective Action Plan (CAP), pursuant to CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners.

2. CalOptima's QI Department may deem it appropriate to deploy CalOptima's copying vendor to copy and provide medical records.

3. CalOptima's QI Department shall target to complete its preliminary review upon the receipt of the case review response, medical records, and/or other supporting documentation, within ninety (90) calendar days.

4. After review of the medical records and response from the Provider, if the QI Nurse determines the case to be a Quality of Service (QOS) issue, the case shall be closed, and a provider resolution letter will be sent by the PQI team.

    a. If the case was referred by an internal CalOptima Department, notification of the QOS determination will be communicated to the referring department for educational purposes.

    b. If the case is determined by the QI Nurse to be a QOC issue, findings will be summarized for evaluation by the CalOptima Medical Director.

5. The CalOptima Medical Director shall review the case. Based upon the outcome of the case review, the Medical Director shall assign an outcome score to the case that reflects the severity of the outcome.

Outcome Score	Description of Outcome Score
0	No quality of care or quality of service issue identified.
1	Mild clinical judgment or operational issue with or without an adverse outcome.
2	Moderate clinical judgment or operational issue with or without an adverse outcome.
3	Severe clinical judgment or operational issue with or without an adverse outcome.
H1	Potential clinical care issue with or without an adverse outcome which occurs in a hospital.
S0	Service-related issue, unable to verify.
S1	Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.
HDS	Healthcare delivery system issue with or without an adverse outcome.

6. CalOptima shall utilize an external review entity if a second opinion is determined to be needed by a Medical Director.

7. If the CalOptima Medical Director does not identify a QOC issue, the case will be given an outcome score and no further action regarding the review process shall occur.

8. If the CalOptima Medical Director identifies a QOC issue, the case will be given an outcome score and, based on severity, be closed by the CalOptima Medical Director, or be presented to the CalOptima CPRC for recommendation(s).

    a. Higher severity cases will be presented to CPRC for discussion and recommendation of action.

Back to Agenda Back to Item

b. Other cases may be presented to CPRC upon Medical Director's discretion.

9. If a case is presented to CPRC and the committee confirms that the identified issue is a QOC issue, the CPRC may recommend further action.

   a. A corrective action from the specific CalOptima department, Health Network, HDO, Practitioner, or Provider;

   b. Require the Practitioner, Provider, Health Network, HDO, or CalOptima department to perform additional educational training; or

   c. Require other appropriate action(s) as recommended by the CPRC.

10. QI Staff shall present a summary of closed cases to the CPRC; this includes any remediation needed from CAPs issued to the Health Network, HDO, Practitioner, Provider, or CalOptima Department.

11. Once the review process is completed, a provider resolution letter will be sent to the Provider.

    a. If the case was a confidential case, the Member information will be blinded in the Provider resolution letter.

    b. If the Provider disagrees with the determination, they may file a complaint pursuant to CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

C. Reporting Requirements and Follow up Actions

1. The QI Department shall generate trend reports of PQI cases and shall report to the CPRC at least every six (6) months.

2. Patterns that are identified in the trend report as described in Section II.E. of this Policy, will be presented to CPRC to determine if any action is needed.

3. The QI Department shall submit all case findings and recommended actions to the CalOptima CPRC.

4. The QI Department shall follow-up on all actions that the CPRC recommends, ensuring compliance and appropriate remediation.

5. CPRC shall submit a summary report of all case reviews, including the conclusions and recommendations of the CPRC, to the Quality Improvement Committee (QIC) on a quarterly basis.

6. Additionally, the CalOptima CMO, his or her Designee, and/or the Executive Director of Quality & Analytics, shall submit summary reports on behalf of CPRC and QIC to the CalOptima Board of Directors' Quality Assurance Committee (QAC), in accordance with the CalOptima QI Plan.

7. The QI Department shall extract relevant information from case reviews, including those where no quality issues were identified, for trending and future study.

8. The QI Department shall include a summary of the case review findings in the Provider or Practitioner's Credentialing file. Information shall be brought forward at time of Recredentialing.

9. The QI Department shall submit a quarterly report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network. Members who choose to remain confidential will have their information blinded in the report.

IV. ATTACHMENT(S)

A. Medical Records Request Form
B. Potential QOC Issue Request for Information Template
C. Health Network Resolution Letter
D. Provider Resolution Letter

V. REFERENCE(S)

A. California Business and Professions Code, §§805 and 1000-1
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
D. CalOptima Three-way Agreement with the Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners
F. CalOptima Policy HH.1101: Provider Complaint Process
G. CalOptima Policy MA.9006: Provider Complaint Process
H. CalOptima Quality Improvement Plan
I. Department of Health Care Services All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates
J. Title 22, California Code of Regulations (C.C.R), §51051
K. Title 28, California Code of Regulations (C.C.R), §1300.85.1
L. Title 42, Code of Federal Regulations (C.F.R), §422.152(a)(3), (c)(2), and (d)
M. Title 42, Code of Federal Regulations (C.F.R.), §438.330(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/23/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/03/2022	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal

Back to Agenda Back to Item

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	11/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	03/04/2021	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect

1

IX. GLOSSARY

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The Credentialing and Peer Review Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement Committee (QIC).
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role. For the purposes of this policy, a designee acting on behalf of the CalOptima Chief Medical Officer (CMO) shall be a CalOptima Medical Director.
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an adverse benefit determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "complaint."
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to members assigned to that Health Network.

Back to Agenda Back to Item

Term	Definition
Healthcare Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Member	An enrollee-beneficiary of a CalOptima program.
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing covered services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes covered services.
Quality Improvement Committee (QIC)	The CalOptima committee that is responsible for the Quality Improvement (QI) process.
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima QI Registered Nurse (RN) or a CalOptima QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	Defined as, adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS providers and services; Continuity and coordination of care across all care and services settings, and for transitions in care; and Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.
Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in CalOptima's programs.

1

FACSIMILE TRANSMITTAL

Date:	**Pages:** (incl. cover)
To:	**From:** (Intake Staff), QI Program Assistant
Fax:	**Fax:**
Phone:	**Phone:** (Phone)

Attempt: ❒ 1st ❒ 2nd ❒ 3rd ❒ **URGENT PLEASE RESPOND ASAP**

Member Name:	
DOB:	
CIN:	
Date(s) of Service:	
Case #:	

Dear Medical Records/Health Information Management:

We are in the process of reviewing professional services rendered for the CalOptima member indicated above. Please submit a copy of the following reports **to my attention**:

❒ Discharge Summary
❒ Consultation Reports
❒ Medication Records
❒ Laboratory Reports
❒ Microbiology Reports
❒ Admission History & Physical
❒ Operative and Procedure Reports
❒ X-ray/Diagnostic/Radiology Imaging Reports
❒ Emergency Room Medical Records
❒ (Other Reports)

The authorization to release such information is granted by Title 22, California Code of Regulations, Section 51009. All records shall be held confidential in accordance with California law. Please address your **"CONFIDENTIAL"** response via or by mail to:

CalOptima
Quality Improvement Department
505 City Parkway West
Orange, CA 92868

I appreciate your prompt attention to this matter by (Date). Should you have any questions regarding this request, please contact me at **NURSE'S PHONE.**

Sincerely,

NURSE'S NAME
QI Nurse Specialist
Quality Improvement

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

CONFIDENTIALITY WARNING: Information contained in this FAX is CONFIDENTIAL. This is intended for the use of the individual or entity named above. If the reader of this FAX message is not the intended recipient, the employee, or agent responsible to deliver it to the intended recipient, you are hereby on notice that you are in possession of confidential information. Any unauthorized distribution, copying, or dissemination of this communication is STRICTLY PROHIBITED. If you have received this communication in error, please notify CalOptima by telephone toll-free at **888-587-8088** and/or return this fax message to the following fax number **657-900-1615**.

CalOptima
A Public Agency
Better. Together.

FACSIMILE TRANSMITTAL

Date:	**Pages:** (incl. cover)
To:	**From:**
Fax:	**Fax:**
Phone:	**Phone:**

Attempt: ❒ 1st ❒ 2nd ❒ 3rd ❒ **URGENT PLEASE RESPOND ASAP**

Potential Quality of Care Issue / Request for Information

1. Please submit the information requested by **DUE DATE**. If the deadline is missed, CalOptima may have to resolve the complaint without the benefit of your information and/or response.

2. **Type of Complaint**:
   - ❒ Quality of Care issue filed by the member
   - ❒ Quality of Care issue filed by the family member
   - ❒ Clinical issue filed by CalOptima staff

3. **Member Name:** **Case Number:**
   DOB: **CIN:**

   Provider/Facility Name:
   DOS:

4. **Medical Records Requested:**
   - ❒ Provider Notes
   - ❒ Problem List
   - ❒ Medication List
   - ❒ Labs
   - ❒ OTHER
   - ❒ Diagnostic Reports

Dear Provider:

In order to ensure a balanced review, your input is vital. At this time, CalOptima's Quality Improvement department is requesting a **written response** from your office regarding the member's concerns.
COMPLAINT

The nurse assigned to this case is **NURSE'S NAME**. For **clinical questions** regarding the response or records, please call the nurse at **NURSE'S PHONE**. For all other inquiries, please contact the sender at the phone number listed at the top of the fax.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

CONFIDENTIALITY WARNING: Information contained in this FAX is CONFIDENTIAL. This is intended for the use of the individual or entity named above. If the reader of this FAX message is not the intended recipient, the employee, or agent responsible to deliver it to the intended recipient, you are hereby on notice that you are in possession of confidential information. Any unauthorized distribution, copying, or dissemination of this communication is STRICTLY PROHIBITED. If you have received this communication in error, please notify CalOptima by telephone toll-free at **888-587-8088** and/or return this fax message to the following fax number **657-900-1615**.

CalOptima
A Public Agency
Better. Together.

Quality Improvement Department
Potential Quality of Care Issue

DATE

Peer Review Conclusion

Dear HEALTH NETWORK:

The CalOptima Credentialing and Peer Review Committee (CPRC) recently reviewed the case below. According to the documentation received, the committee reviewed and closed this case on DATE and assigned an outcome score of SEVERITY CODE — SEVERITY CODE DESCRIPTION.

Member Name:
CIN #: **DOB:**
Date Complaint Sent to HN:
Case Number:
Name of Provider:
Summary of Complaint: COMPLAINT CATEGORY-COMPLAINT SUBCATEGORY
Final Determination: RESOLUTION SUBCATEGORY
Reviewed by: MEDICAL DIRECTOR
Confidential Case*: ❒ Yes | ❒ No

Please contact me if you have any further questions at **(Phone Number)**. Thank you for your commitment and continued efforts to deliver quality service to the communities we serve.

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

Sincerely,

(Name)
(TITLE), Quality Improvement

*Confidential cases are those cases where the member chooses to remain anonymous or the member does not want to file a grievance. CalOptima representatives believe there is a quality of care component to the issue, so the case is referred to Quality Improvement for review.

Quality Improvement Department
Potential Quality of Care Issue

DATE

PROVIDER
ADDRESS
CITY, STATE ZIP CODE

Peer Review Conclusion

Dear PROVIDER:

The CalOptima Credentialing and Peer Review Committee (CPRC) recently reviewed the case below. According to the documentation received, the committee reviewed and closed this case on DATE and assigned an outcome score of SEVERITY CODE and SEVERITY CODE DESCRIPTION.

Member Name:
CIN #: **DOB:**
Case Number:
Date of Incident:
Name of Health Network:
Summary of Complaint: COMPLAINT CATEGORY — COMPLAINT SUBCATEGORY)
Final Action:
Confidential Case*: ☐ **Yes** | ☐ **No**

Please note that the records and results of the investigation are confidential pursuant to California law, known as Evidence Code Section 1157, Health and Safety Code, Section 1370; as well as the Business and Professions Code, section 805. This means that you will not receive the results of our research into your complaint. Please be assured that we will take the appropriate action, as necessary, to make sure members receive quality health care services.

Please contact QI **(Title) (Name)**, if you have any questions at **(Phone)**. Thank you for your commitment and continued efforts to deliver quality service to the communities we serve.

Sincerely,

(Name)
Medical Director
qualityofcare@caloptima.org

* Confidential cases are those cases where the member chooses to remain anonymous or the member does not want to file a grievance. CalOptima representatives believe there is a quality of care component to the issue, so the case is referred to Quality Improvement for review.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Consent Calendar

3. Approve New CalOptima Policy GG.1666p: Mobile Texting Program

Contacts

Richard Pitts, Chief Medical Officer, (714) 246-8491
Marie Jeannis, RN, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Action

Approve new CalOptima Policy GG.1666p: Mobile Texting Program, in accordance with all regulatory requirements.

Background

In May 2020, the CalOptima Board of Directors authorized CalOptima to contract with vendor mPulse Mobile, a Mobile Health Interactive Text Messaging Services vendor, as part of CalOptima's Virtual Care Strategy to address timely access to care during the COVID-19 pandemic. CalOptima originally used mobile texting to support COVID-19 related member outreach and engagement. The use of mobile texting has been successful in getting information quickly to members about the availability of COVID-19 vaccines, boosters, and vaccine events. CalOptima continues to expand the use of mobile texting to strengthen member outreach, engagement, support health promotion, education, and preventive care messaging.

Discussion

CalOptima establishes new policies and procedures to implement Federal and State laws, programs, regulations, contacts, and business practices. Additionally, CalOptima staff performs an annual policy review to add or update internal policies and procedures to ensure compliance with applicable requirements.

The new policy ensures the processes and procedures for the mobile texting program are in compliance with the Telephone Consumer Protection Act (TCPA), Health Insurance Portability and Accountability Act (HIPAA), Department of Health Care Services (DHCS) Texting Program and Texting Campaign requirements, and all regulatory, contractual, and operational guidelines.

Fiscal Impact

The recommended action to approve CalOptima Policy GG.1666p is operational in nature and has no additional fiscal impact. A previous Board action on May 7, 2020, allocated up to $3.9 million in intergovernmental transfer (IGT) 9 funds for a three-year period to provide a text messaging solution for all CalOptima member communications.

Back to Agenda

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the Board of Directors approve and adopt CalOptima Policy GG.1666p: Mobile Texting Program.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. New CalOptima Policy GG.1666p: Mobile Texting Program
2. GG.1666p Attachment A. Texting Program & Campaign Submission Form

/s/ Michael Hunn — *06/02/2022*

Authorized Signature — **Date**

Back to Agenda

Policy:	GG.1666p
Title:	**CalOptima Mobile Texting Program**
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the CalOptima Mobile Texting Program for Medi-Cal Members.

II. POLICY

A. The CalOptima Mobile Texting Program aims to strengthen communication outreach opportunities to Members through Mobile Health Interactive Text Messaging Services. CalOptima's Texting Program aims to achieve the following goals:

1. Member engagement communication pathway for the following but not limited to: Member notifications, call to action for gaps in care, share of secure links to benefit information, health promotion, and emergency messaging;
2. Delivery of digital health rewards;
3. Promote healthy behaviors among Members (including preventative care visits, health rewards, and health information);
4. Facilitate behavior change;
5. Provide support through impactful media (including supporting statewide regulatory efforts);
6. Promote wellness and preventive care, including in support of Healthcare Effectiveness Data and Information Set (HEDIS) measures;
7. Improve clinical outcomes;
8. Encourage adherence to recommended care practices; and
9. Serve as an alternative or support to common modalities to Members including mail or telephone outreach.

Back to Agenda Back to Item

B. The CalOptima Mobile Texting Program text messages are:

1. Conducted in compliance with the Telephone Consumer Protection Act (TCPA), the Health Insurance Portability and Accountability Act (HIPAA), and applicable regulatory and contractual requirements;

2. Sent to Members only after CalOptima receives approval from the California Department of Health Care Services (DHCS) to implement a Text Message Campaign;

3. Approved by a Qualified Health Educator (for general health education messages) in accordance with CalOptima Policy GG.1206Δ: Readability and Suitability of Written Health Education Materials;

4. Provided to Members at or below the sixth-grade reading level, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services;

5. Sent in the Member's preferred Threshold Language;

6. Sent when CalOptima call center staff is available to support Member inquiries, but never between the hours of 9 p.m. and 8 a.m.;

7. Not used to conduct any marketing outreach to non-members for the purpose of potential enrollment;

8. Sent to Members for whom CalOptima has verified as eligible with the CalOptima Medi-Cal program based on the review of the monthly 834 file and from whom CalOptima has obtained prior express consent as described in Section III.A. of this Policy. CalOptima may only send text messages to Members without evidence of prior express consent when such automated texts messages are necessary to protect the health and safety of citizens pursuant to the TCPA "Emergency Purposes" exception.; or

   a. For text messages related to renewals, sent only to Members on the monthly 834 file with an HCP status of "05" and from whom CalOptima has obtained prior express consent as described in Section III.A. of this Policy; or

   b. For "Healthcare Related" text messages per the exemption allowed by TCPA.

9. Reviewed for compliance with Health Insurance Portability and Accountability Act (HIPAA), the HIPAA Security Rule, and CalOptima Policy HH.3011Δ: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations. CalOptima shall not send messages that contain Protected Health Information (PHI) or Personal Identifying Information (PII)

C. A Health Network shall submit all Member Health Education Materials, including Health Education Texting Campaigns, to the CalOptima Health Education Department for readability and suitability review and DHCS approval prior to distribution to Members in accordance with this policy and CalOptima Policy GG.1206Δ: Readability and Suitability of Written Health Education Materials.

III. PROCEDURE

A. In compliance with TCPA guidelines, CalOptima shall obtain prior express consent from a Member to participate (i.e., Member consent, release of information) in the CalOptima Mobile Texting Program as follows:

Back to Agenda Back to Item

1. Written consent for Members mailed the mobile texting member consent form with pre-paid business reply envelope; or

2. Written consent for Members accessing CalOptima's Member portal or other digital opt-in message links including text and email and completion of communications preferences; or

3. Documented verbal consent for Members dialing into any CalOptima call center (Customer Service, Population Health Management, and Behavioral Health Integration); or

4. Documented consent from other texting campaigns via opt-in consent links provided through third party mobile texting provider that fall under the TCPA Exception Guidelines for Healthcare Providers or for the sole purpose of obtaining consent; or

5. Free To End User (FTEU) welcome message to Members on the monthly 834 file as described in Section III. C. of this policy

6. CalOptima is not required to obtain prior express consent from a Member for texting campaigns that are for "Emergency Purposes" as defined by the TCPA.

    a. "Emergency Purposes" includes calls made necessary in any situation affecting the health and safety of consumers. The "Emergency Purposes" exception is intended for "instances [that] pose significant risks to public health and safety, and [where] the use of prerecorded message calls could speed the dissemination of information regarding potentially hazardous conditions to the public."

    b. The caller must be from a hospital, or be a health care provider, state or local health official, or other government official as well as a person under the express direction of such an organization and acting on its behalf. The content of the call must be solely informational.

    c. In order to qualify for the emergency exemption, the caller must be from a hospital, or be a health care provider, state or local health official, or other government official, or as a person under the express direction of such an organization and acting on its behalf, and the message delivered must be informational only, made necessary by the situation affecting the health and safety of Members, and directly related to the imminent risk created by the situation affecting the health and safety of Members.

7. CalOptima is not required to obtain prior express consent from a Member for texting campaigns that are for "Healthcare Related" purposes as exempted by TCPA for healthcare providers defined by HIPAA and that meet the following guidelines:

    a. Text messages must be sent only to the wireless telephone number provided by member.

    b. Text messages must state the name and contact information of the healthcare provider.

    c. CalOptima must not include any telemarketing, solicitation, or advertising; may not include accounting, billing, debt collection, or other financial content; must comply with HIPAA privacy rules; and are strictly limited to purposes for which there is exigency or that have a healthcare treatment purpose.

    d. Text message must be concise.

    e. CalOptima may initiate only one message per day, up to a maximum of three combined per week to a member.

f. CalOptima must offer recipients within each message an easy means to opt of future messages as outlined in Section III.D of this policy.

g. Must honor the opt-out requests immediately.

B. DHCS Texting Program and Texting Campaign Requirements

4. For a new Mobile Texting Program, CalOptima shall submit all required elements of the DHCS Texting Program & Campaign Submission Form as well as a signed Text Messaging Campaign Indemnification Agreement to DHCS for review and approval at least sixty (60) calendar days prior to the proposed start date of the CalOptima Mobile Texting Program (Attachment A).

5. For an additional individual Mobile Texting Campaign and upon approval by DHCS of the Texting Program, CalOptima shall complete only Section A and Section C of Attachment A as well as submit a signed Text Messaging Campaign Indemnification Agreement.

C. To protect data costs incurred by Members and to fully inform Members of such possible costs, Members will receive one (1) Free to End User (FTEU) message through a special short code to welcome them to the CalOptima Mobile Texting Program. This welcome message:

1. Is sent at no charge to the Member;

2. Informs the Members that message charges (depending on their data plan) may apply to future text messages; and

3. Notifies Members that they can opt-out of the program with a "STOP" reply to the welcome message at no charge to the Member. Once a Member replies "STOP," a confirmation message will be sent out at no charge to the Member. If a Member does not reply "STOP," the Member will continue to receive text messages from CalOptima.

D. Members may opt-out of the CalOptima Mobile Texting Program at any time by replying "STOP" or by contacting CalOptima Customer Service at 1-888-587-8088 Toll-free or 1-800-735-2929 TDD/TTY. The CalOptima Customer Service Department shall immediately update a Member's record in the FACETS system upon a Member's call requesting to opt-out.

1. For opt-out requests received by a third-party mobile texting vendor, the vendor shall indicate the phone number as an opt-out in the daily files submitted to CalOptima. CalOptima shall update the Member record in the FACETS systems the next business day and the Member will be removed from the CalOptima Mobile Texting Program until such time as the Member changes his or her consent status with CalOptima.

2. Prior to initiating a Mobile Texting Campaign, CalOptima shall validate identified Members' phone numbers against FACETS systems for opt-out status. the CalOptima "Do Not Call" list.

E. For Members who are minors, CalOptima will send text messages to the minor's parent(s), legal guardian, or other Personal Representative. To address custody/guardianship/parent situations, CalOptima will verify the appropriate Personal Representative using information available, including DHCS member eligibility files and Member-reported information.

F. CalOptima shall document a Member's consent response to include the date consent is received from the Member in the FACETS system. Updates to a Member's consent status will be tracked and recorded in the FACETS system. CalOptima shall use the consent received for the most recent date to initiate a Mobile Texting Campaign to targeted populations.

Back to Agenda Back to Item

G. Any third-party vendor contract/business agreement used to conduct texting on behalf of CalOptima will be submitted to DHCS for approval. Vendor contract must adhere to DHCS policies, procedures, contract, and regulatory requirements.

H. For ongoing texting campaigns, CalOptima shall submit outcome data for mobile texting campaigns on an annual basis to DHCS forty-five (45) calendar days from the annual anniversary of the initiation of the campaign. For programs that are time limited, CalOptima shall submit outcome data to DHCS six (6) months after a campaign ends.

I. CalOptima and its Business Associates shall apply appropriate Sanctions against its Business Associates where there has been a violation of compliance with HIPAA, as amended, and the regulations promulgated thereunder, and/or CalOptima privacy and security policies up to, and including termination of contracts, as applicable and in accordance with CalOptima Policy HH.2002Δ: Sanctions.

IV. ATTACHMENT(S)

A. DHCS Texting Program & Campaign Submission Form / Text Messaging Campaign Indemnification Agreement (October 2020)

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Policy GG.1206Δ: Readability and Suitability of Written Health Education Materials
D. CalOptima Policy HH.2002Δ: Sanctions
E. CalOptima Policy HH.3011Δ: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations. CalOptima shall not send messages that contain Protected Health Information (PHI) or Personal Identifying Information (PII)
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-016: Readability and Suitability of Written Health Education Material
G. Title 45, Code of Federal Regulations (C.F.R.), Part 160 and Part 164 (subparts A and C)
H. Telephone Consumer Protection Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
03/03/2021	Department of Health Care Services

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	GG.1666	CalOptima Mobile Texting Program	Medi-Cal

Back to Agenda Back to Item

IX. GLOSSARY

Term	Definition
Business Associates	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such Covered Entity or of an organized health care arrangement (as defined in this section) in which the Covered Entity participates, but other than in the capacity of a Member of the Workforce of such Covered Entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the Workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such Covered Entity, or to or for an organized health care arrangement in which the Covered Entity participates, where the provision of the service involves the Disclosure of protected health information from such Covered Entity or arrangement, or from another Business Associate of such Covered Entity or arrangement, to the person. A Covered Entity may be a Business Associate of another Covered Entity. Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a Covered Entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a Covered Entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Term	Definition
Emergency Purposes	Calls made necessary in any situation affecting the health and safety of consumers. The caller must be from a hospital, or be a health care provider, state or local health official, or other government official as well as a person under the express direction of such an organization and acting on its behalf. The content of the call must be solely informational, made necessary by the situation affecting the health and safety of Members, and directly related to the imminent risk created by the situation affecting the health and safety of Members.
FDR	First Tier, Downstream or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Health Education Materials	Materials designed to assist Members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes, includes updates on current health conditions, self-care, and management of health conditions. Topics may include messages about preventive care, health promotion, screenings, disease management, healthy living, and health communications.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy, and security of health information, and as subsequently amended.
Health Network	A Health Network is a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
HIPAA Security Rule	National standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.
Healthcare Effectiveness Data and Information Set (HEDIS)	A set of standardized performance measures designed to provide purchasers and consumers with relevant information on health plan performance and facilitate the comparison of managed care organizations. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Mobile Texting Campaign	Specific text message(s) aimed to address an identified objective (e.g., Preventive Care Reminders, New Member Orientation, etc.).
Mobile Texting Program	Overall program design and infrastructure utilized to implement individual text messaging campaigns.

Term	Definition
Personal Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: Access, Use, and Disclosure of PHI to a Member's Personal Representative.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.
Qualified Health Educator	A qualified health educator is defined as a health educator with one (1) of the following qualifications: 1. Master of Public Health (MPH) degree with a health education or health promotion emphasis; 2. Master's degree in community health with a specialization in health education or health promotion; or 3. MCHES (Master Certified Health Education Specialist) awarded by the National Commission for Health Education Credentialing, Inc.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

1

TEXTING PROGRAM & CAMPAIGN

SUBMISSION FORM

INSTRUCTIONS:
This form is required for all Medi-Cal managed care plans' (MCP) texting program and/or its individual texting campaign(s). Complete this form, including the Indemnification Agreement and email it to your DHCS Contract Manager for approval. DHCS will review and respond within 60 days of submission of the form.

Email subject line must include "For your approval: MCP name, Subplan name if applicable, Texting, and Campaign(s). For example:

- For a campaign submission: "For your approval: PlanA_Texting_New MemberOrientation"
- For multiple campaigns submission: "For your approval: PlanA_Texting_MultipleCampaigns"

MCP is required to complete **all sections (Sections A-C)** when MCP first seeks an approval for a new Texting Program. Once MCP's new texting program has been approved and MCP would like to add additional campaigns, MCP will need to complete **Section A** and **Section C** only. The exception to this is if the MCP has already received approval on an emergency text campaign. These campaigns only require a one-time submission and approval.

MCP can replicate **Section C** for additional campaigns if MCP desires to submit multiple campaigns for approval at the same time.

As a condition of approval for any text messaging campaign, a designee within the MCP who holds signatory authority is required to execute the attached Indemnification Agreement. Approval of the campaign is not considered final until the MCP receives a signed copy of the Indemnification Agreement back from the DHCS.

Key definitions

1. Texting Program: MCP's overall program design and infrastructure utilized to implement individual text messaging campaigns.
2. Texting Campaign: MCP's specific text message(s) aimed to address an identified objective (e.g., Preventive Care Reminders, New Member Orientation, etc.).

SECTION A: GENERAL INFORMATION

1. Managed Care Plan:_____ Date: ____
2. Submitted on behalf of a subcontracting MCP: _____ ☐ N/A
3. List the county or counties where you conduct your texting campaign(s):

_____

SECTION B: TEXTING PROGRAM POLICY & PROCEDURE

1. Does the MCPs policy describe the process the MCP will use to obtain Members' Agreement to Participate (i.e., release of information) either through active opt-in or assumed opt-in approach and explain how a member can opt-out and the timeline associated with processing such requests? Please attach MCP's program policy and procedure (PnP) and process workflow. If no, please describe.

   ☐ Yes

   ☐ No

2. Does MCP's policy describe any financial costs that MCP's Members may incur from receiving the Agreement to Participate message(s) and any potential costs of future messages? If no, please describe.

   ☐ Yes

   ☐ No

3. Is the MCPs proposal related to redetermination outreach?

   ☐ Yes

   ☐ No

If yes, does the MCPs policy indicate outreach will only be made to members who are on the MCPs monthly 834 file showing an HCP status of 05?

☐ Yes

☐ No

4. Has the MCP provided texting script(s) to obtain MCP's Members' Agreement to Participate, or texting script(s) to allow MCP's members to opt-out?

☐ Yes

☐ No

5. Are the texting script(s) provided to members at the sixth grade reading level, per Exhibit A, Attachment 13, 4(C) of the contract with DHCS?

☐ Yes

☐ No

6. Does the texting script have any health education information? If yes, has the campaign script been reviewed and approved by the MCP health educator in accordance with APL 18-016?

☐ Yes

☐ No

7. Does the MCPs policy describe how the MCP considers privacy concerns and custody/guardianship situations based upon information available to MCP? If no, please describe.

☐ Yes

☐ No

8. Does the MCPs policy describe how the MCP protects Members' PII and/or PHI andmeet requirements of Exhibit G of the contract with DHCS? If no, please describe

☐ Yes

☐ No

9. Is the MCP using a third-party vendor? If yes, who is the vendor? If MCP has not already sent the vendor's Master Service Agreement and all contract amendments to DHCS, attach them to this application.

☐ Yes

☐ No

10. Does the vendor's Master Service Agreement comply with all applicable state and federallaw and contract requirements in particular, Exhibit G of the contract with DHCS?

☐ Yes

☐ No

SECTION C: [SPECIFIC TEXTING CAMPAIGN NAME]

1. What is the overall purpose of campaign? Circle one.
   a. Providing health education information
   b. Providing written member information
   c. Reminding of preventive care visits
   d. Supporting statewide regulatory efforts on digital communications
   e. Emergency Messaging
   f. Other(s): _____

   Disclaimers: MCP certifies that any health education information provided through the campaign has been reviewed and approved by the MCP health educator in accordance with APL 18-016.

   Information on eligibility redetermination cannot be included in text campaign.

2. Describe the objectives of the campaign.

3. Does the campaign include any member incentives?

   ☐ Yes
   ☐ No

   If yes, has the incentive been reviewed and approved by DHCS health educators in accordance with APL 16-005?

   ☐ Yes
   ☐ No

4. Does the campaign include Personal Identification Information (PII) and/or Protected Health Information (PHI)? If yes, confirm the answer to question 7 in Section B above is checked "yes."

   ☐ Yes
   ☐ No

5. Who is the campaign's target population?

6. Who will be excluded from the campaign based upon information available to MCP (e.g., Members with SUDS, HIV/AIDS, behavioral health, minors in family planning, etc.)?

7. Does MCP require additional Members' Agreement to Participate for this specific texting campaign (i.e., extra opt-in requirement for sensitive services or PHI/PII content)?

   ☐ Yes

   ☐ No

8. What is the campaign length? When will it start and end?

9. What is the frequency of text messaging?

10. In what language(s) will the campaign be available? Will members have an option to receive text messages in their primary language (i.e. Spanish)?

11. Provide content script of the campaign.

12. What is the expected outcome of the campaign?

Attestations:

☐ For new campaign submission only (Section C), MCP attests that the Texting Program submission (Section B) that was previously approved contains no changes. Each new campaign will require an executed Indemnification Agreement.

☐ For ongoing texting programs, MCP will report to the DHCS Contract Manager the outcomes of plan texting campaigns on an annual basis, 45 days from the annual anniversary of the campaigns initiation. For time-limited campaigns, MCP will report outcomes six months after a program ends.

FOR DHCS USE ONLY (OR USE ALTERNATE DHCS AIR FORM)

1. DHCS Reviewer's Name: _____ Date: _____
2. DHCS Reviewer's Title: _____
3. DHCS Reviewer's Decision:

☐ Approved as submitted

☐ Approved with the following changes:

_____

☐ Denied

Reason (s): _____

_____

☐ Request for more information: _____

_____

_____

TEXT MESSAGING CAMPAIGN INDEMNIFICATION AGREEMENT

In consideration of the Department of Health Care Services' approval of [INSERT HEALTH PLAN NAME's] [INSERT NAME OF TEXT MESSAGING CAMPAIGN] [INSERT TYPE OF CAMPAIGN eg., Call Campaign, texting campaign], [INSERT HEALTH PLAN NAME] agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred to the extent DHCS is required to provide notice to affected beneficiaries and any other costs associated with any actual or alleged breach of the Health Insurance Portability and Accountability Act of 1996 Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 and the Information Practices Act, California Civil Code section 1798 et seq. by [INSERT HEALTH PLAN NAME] and any vendor, contractor, subcontractor that [INSERT HEALTH PLAN NAME] contracts with for the approved text messaging campaign.

[INSERT HEALTH PLAN NAME] also agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred from claims that the mobile application caused cellular data usage overages as a result of downloading, updates or usage of [INSERT HEALTH PLAN NAME]'s text messaging campaign.

[INSERT HEALTH PLAN NAME also agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred from claims that [INSERT HEALTH PLAN NAME]'s [INSERT NAME OF TEXT MESSAGING CAMPAIGN] [INSERT TYPE OF CAMPAIGN eg., Call Campaign, texting campaign] violates the Telephone Consumer Protection Act of 1991, 47 U.S.C. section 227 et seq. and/or related Federal Communications Commission regulations.

_____	_____
Health Plan Representative	DHCS Contract Manager
_____	_____
Date	Date

Back to Agenda Back to Item

TEXTING PROGRAM & CAMPAIGN

SUBMISSION FORM

INSTRUCTIONS:
This form is required for all Medi-Cal managed care plans' (MCP) texting program and/or its individual texting campaign(s). Complete this form, including the Indemnification Agreement and email it to your DHCS Contract Manager for approval. DHCS will review and respond within 60 days of submission of the form.

Email subject line must include "For your approval: MCP name, Subplan name if applicable, Texting, and Campaign(s). For example:

- For a campaign submission: "For your approval: PlanA_Texting_New MemberOrientation"
- For multiple campaigns submission: "For your approval: PlanA_Texting_MultipleCampaigns"

MCP is required to complete **all sections (Sections A-C)** when MCP first seeks an approval for a new Texting Program. Once MCP's new texting program has been approved and MCP would like to add additional campaigns, MCP will need to complete **Section A** and **Section C** only. The exception to this is if the MCP has already received approval on an emergency text campaign. These campaigns only require a one-time submission and approval.

MCP can replicate **Section C** for additional campaigns if MCP desires to submit multiple campaigns for approval at the same time.

As a condition of approval for any text messaging campaign, a designee within the MCP who holds signatory authority is required to execute the attached Indemnification Agreement. Approval of the campaign is not considered final until the MCP receives a signed copy of the Indemnification Agreement back from the DHCS.

Key definitions

1. Texting Program: MCP's overall program design and infrastructure utilized to implement individual text messaging campaigns.
2. Texting Campaign: MCP's specific text message(s) aimed to address an identified objective (e.g., Preventive Care Reminders, New Member Orientation, etc.).

SECTION A: GENERAL INFORMATION

1. Managed Care Plan:_____ Date: ____
2. Submitted on behalf of a subcontracting MCP: _____ ☐ N/A
3. List the county or counties where you conduct your texting campaign(s):

_____

Back to Agenda Back to Item

SECTION B: TEXTING PROGRAM POLICY & PROCEDURE

1. Does the MCPs policy describe the process the MCP will use to obtain Members' Agreement to Participate (i.e., release of information) either through active opt-in or assumed opt-in approach and explain how a member can opt-out and the timeline associated with processing such requests? Please attach MCP's program policy and procedure (PnP) and process workflow. If no, please describe.

   ☐ Yes

   ☐ No

2. Does MCP's policy describe any financial costs that MCP's Members may incur from receiving the Agreement to Participate message(s) and any potential costs of future messages? If no, please describe.

   ☐ Yes

   ☐ No

3. Is the MCPs proposal related to redetermination outreach?

   ☐ Yes

   ☐ No

If yes, does the MCPs policy indicate outreach will only be made to members who are on the MCPs monthly 834 file showing an HCP status of 05?

☐ Yes

☐ No

4. Has the MCP provided texting script(s) to obtain MCP's Members' Agreement to Participate, or texting script(s) to allow MCP's members to opt-out?

☐ Yes

☐ No

5. Are the texting script(s) provided to members at the sixth grade reading level, per Exhibit A, Attachment 13, 4(C) of the contract with DHCS?

☐ Yes

☐ No

6. Does the texting script have any health education information? If yes, has the campaign script been reviewed and approved by the MCP health educator in accordance with APL 18-016?

☐ Yes

☐ No

7. Does the MCPs policy describe how the MCP considers privacy concerns and custody/guardianship situations based upon information available to MCP? If no, please describe.

☐ Yes

☐ No

8. Does the MCPs policy describe how the MCP protects Members' PII and/or PHI andmeet requirements of Exhibit G of the contract with DHCS? If no, please describe.

☐ Yes

☐ No

9. Is the MCP using a third-party vendor? If yes, who is the vendor? If MCP has not already sent the vendor's Master Service Agreement and all contract amendments to DHCS, attach them to this application.

☐ Yes

☐ No

10. Does the vendor's Master Service Agreement comply with all applicable state and federallaw and contract requirements in particular, Exhibit G of the contract with DHCS?

☐ Yes

☐ No

SECTION C: [SPECIFIC TEXTING CAMPAIGN NAME]

1. What is the overall purpose of campaign? Circle one.
   a. Providing health education information
   b. Providing written member information
   c. Reminding of preventive care visits
   d. Supporting statewide regulatory efforts on digital communications
   e. Emergency Messaging
   f. Other(s): _____

   Disclaimers: MCP certifies that any health education information provided through the campaign has been reviewed and approved by the MCP health educator in accordance with APL 18-016.

   Information on eligibility redetermination cannot be included in text campaign.

2. Describe the objectives of the campaign.

3. Does the campaign include any member incentives?

   ☐ Yes

   ☐ No

   If yes, has the incentive been reviewed and approved by DHCS health educators in accordance with APL 16-005?

   ☐ Yes

   ☐ No

4. Does the campaign include Personal Identification Information (PII) and/or Protected Health Information (PHI)? If yes, confirm the answer to question 7 in Section B above is checked "yes."

   ☐ Yes

   ☐ No

5. Who is the campaign's target population?

6. Who will be excluded from the campaign based upon information available to MCP (e.g., Members with SUDS, HIV/AIDS, behavioral health, minors in family planning, etc.)?

7. Does MCP require additional Members' Agreement to Participate for this specific texting campaign (i.e., extra opt-in requirement for sensitive services or PHI/PII content)?

   ☐ Yes

   ☐ No

8. What is the campaign length? When will it start and end?

9. What is the frequency of text messaging?

10. In what language(s) will the campaign be available? Will members have an option to receive text messages in their primary language (i.e. Spanish)?

11. Provide content script of the campaign.

12. What is the expected outcome of the campaign?

Attestations:

☐ For new campaign submission only (Section C), MCP attests that the Texting Program submission (Section B) that was previously approved contains no changes. Each new campaign will require an executed Indemnification Agreement.

☐ For ongoing texting programs, MCP will report to the DHCS Contract Manager the outcomes of plan texting campaigns on an annual basis, 45 days from the annual anniversary of the campaigns initiation. For time-limited campaigns, MCP will report outcomes six months after a program ends.

FOR DHCS USE ONLY (OR USE ALTERNATE DHCS AIR FORM)

1. DHCS Reviewer's Name: _____ Date: _____
2. DHCS Reviewer's Title: _____
3. DHCS Reviewer's Decision:

☐ Approved as submitted

☐ Approved with the following changes:

_____

☐ Denied

Reason (s): _____

_____

☐ Request for more information: _____

_____

_____

TEXT MESSAGING CAMPAIGN INDEMNIFICATION AGREEMENT

In consideration of the Department of Health Care Services' approval of [INSERT HEALTH PLAN NAME's] [INSERT NAME OF TEXT MESSAGING CAMPAIGN] [INSERT TYPE OF CAMPAIGN eg., Call Campaign, texting campaign], [INSERT HEALTH PLAN NAME] agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred to the extent DHCS is required to provide notice to affected beneficiaries and any other costs associated with any actual or alleged breach of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 and the Information Practices Act, California Civil Code section 1798 et seq. by [INSERT HEALTH PLAN NAME] and any vendor, contractor, subcontractor that [INSERT HEALTH PLAN NAME] contracts with for the approved text messaging campaign.

[INSERT HEALTH PLAN NAME] also agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred from claims that the mobile application caused cellular data usage overages as a result of downloading, updates or usage of [INSERT HEALTH PLAN NAME]'s text messaging campaign.

[INSERT HEALTH PLAN NAME also agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred from claims that [INSERT HEALTH PLAN NAME]'s [INSERT NAME OF TEXT MESSAGING CAMPAIGN] [INSERT TYPE OF CAMPAIGN eg., Call Campaign, texting campaign] violates the Telephone Consumer Protection Act of 1991, 47 U.S.C. section 227 et seq. and/or related Federal Communications Commission regulations.

_____	_____
Health Plan Representative	DHCS Contract Manager
_____	_____
Date	Date

Board of Directors' Quality Assurance Committee Meeting
June 8, 2022

Program of All-Inclusive Care for the Elderly
Member Advisory Committee Update

Committee Overview
The Program of All-Inclusive Care for the Elderly Member Advisory Committee (PMAC) meets quarterly to share information and engage PACE participants in a discussion on recommendations to inform CalOptima PACE leadership on the PACE care delivery system. The committee is primarily comprised of PACE participants.

March 30, 2022: PMAC Meeting Summary

Updates from the Director
Director Monica Macias thanked PMAC members for joining the meeting in person for the first time in two years since the pandemic. Members were updated on the status of the program. PACE is slowly allowing participants to return to the day center. Currently, we have two shifts (am/pm), allowing up to 20 participants per shift. All participants are assigned to pods, with social distancing in mind, and must wear mask. The clinic and skilled rehabilitation appointments continue to operate as usual. Our staff is slowly returning to the center. Members were also updated with our recent participant satisfaction results and noted that participants are 91% satisfied with our services. Wellness kits continue to be delivered to participant residences 1–2 times per month, and wellness calls are being made daily to address any concerns that participants may have.

COVID-19 Updates
Jennifer Robinson, Quality Improvement Manager, provided updates related to COVID-19 numbers and status. Jennifer provided an update on COVID-19, specifically the Omicron Subvariant BA2. Jennifer also shared current COVID-19 vaccination rates, 96% have received their initial 2 doses and over 79% have received their 3rd dose. Jennifer also shared that a 4th dose was recently approved for immunocompromised patients, and we are working on identifying participants who qualify at this time. The recommendation is that participants continue to wear their mask.

PMAC Member Forum
- A participant shared that he is seeing improvement in our transportation services, but he noted that some more things can be looked at.
- Participants noted that they are starting to see our new advertisement on buses and are excited to see that in the community.
- Members also commented that there are other PACE programs in OC and wonder what impact this may have on our center.
- Participants were so excited to be back in person for our PMAC committee and thrilled that day center is slowly getting back to normal. They also shared being so happy to see staff.

Back to Agenda

CalOptima Board of Directors'
Quality Assurance Committee Meeting
June 8, 2022

Quality Improvement Committee First Quarter 2022 Report

Summary

- Quality Improvement Committee (QIC) met twice in the first quarter. The January 11, 2022 QIC meeting was cancelled due to scheduling conflicts and resumed back February 15, and March 8, 2022.
- The following departments and subcommittees reported to QIC in Quarter 1 (Q1):
  - Quality Improvement (QI) Department
  - Quality Analytics (QA) Department
  - Behavioral Health Integration (BHI) Department
  - Pharmacy Department
  - Utilization Management (UM) Department
  - Utilization Management Committee (UMC)
  - Whole-Child Model Clinical Advisory Committee (WCM CAC)
  - Credentialing and Peer Review Committee (CPRC)
  - Member Experience Committee (MEMX)
  - Grievance & Appeals Resolution Services Committee (GARS)
- Approved and filed the following:
  - 2021 CalOptima QI Program Evaluation
  - 2022 QI Program Description and Work Plan
- Accepted and filed minutes and Quality Improvement (QI) Work Plan from the following committees and subcommittees:
  - WCM CAC meeting minutes: November 16, 2021
  - MEMX meeting minutes: November 4, 2021
  - 2021 Quality Improvement (QI) Work Plan Q4
- Change in Quality Improvement Committee Members
  - Dr. John Kelly closed his business terminating his contract with CalOptima and stepped down from the Committee.
  - Dr. Lance Brunner attended the meeting on behalf of Dr. Todd Newton from Kaiser Permanente who joined QIC.

QIC Quarter 1 2022 Highlights

- **Chief Medical Officer (CMO) Updates** — Each month at QIC, the CMO provides guidance and feedback related to committee activities and CalOptima statistics and updates. There were no CMO updates in Q1. However, the committee did welcome Dr. Pitts, CalOptima's new CMO, at the February 2022 meeting.

Back to Agenda

- **Quality Program Highlights**
  - 2021 QI Evaluation and 2022 QI Program Description and Work Plan were presented by QI staff and approved at the February QIC. The 2022 Program Delegation Grid is an Appendix to the Program Description. These documents were presented and approved at the March QAC.
- **Medi-Cal Pharmacy Carve Out (Medi-Cal Rx)** update was provided by Dr. Kris Gericke. Magellan did not anticipate the number of prior authorizations that would be created from the transition. There was a large backlog of prior authorizations, where instead of a 24-hour turnaround time, they were upwards of 7 to 10 days. This also caused their call center to be backed up. To address these issues, Magellan removed rejections for several issues related to drug interactions and removed some prior authorization requirements. More recently, the Magellan is processing prior authorizations and addressing member calls timely. The only issue that remained a concern for CalOptima is that the interventions of removing the rejects was temporary and if turned back on May 1, 2022, may be an issue.
- **California Advancing and Innovating Medi-Cal (CalAIM)** Sloane Petrillo presented the CalAIM program with the committee and that CalOptima implemented four new community supports in CalAIM 1) Housing Transition Navigation Services 2) Housing Deposits 3) Housing Tenancy and Sustaining Services and 4) Recuperative Care (Medical Respite). About 1800 individuals have been transitioned into Enhanced Care Management (ECM) from Whole Person Care and about 1,011 have been involved in community supports.
- **Auto Assignment (AA) Update**
  - CalOptima QA staff proposed an auto assignment methodology that will adopt DHCS Managed Care Accountability Set (MCAS) minimum performance measures to replace existing quality performance measure set which would align with the current Pay for Value (P4V) Program.
  - The goal is to move away from a "home grown" scoring system and adopt a nationally established and tested quality scoring system.
  - Minimum Quality Score (Quality Gate) of 2.5 (of 5), based on Health Network Quality Rating (HNQR), must be achieved annually to be eligible to receive auto assignment.
  - Corrective action plan will be issued to HNs below 2.5. HNs who do not meet minimum quality score of 2.5 will be suspended from AA for one year until their quality score is above minimum performance level.
  - Higher overall HNQR scores earns higher percentage of auto assignment.
- **Behavioral Health Integration (BHI)**
  - BH Member Experience Report - Overall Experience members indicate they are satisfied with their providers. There was an overall 74% Mental Health satisfaction rate and 77% Applied behavioral analysis (ABA) satisfaction rate for areas of Access to Service, Treatment Experience and As a Result of My Treatment.
  - Opportunities for improvement were identified:
    - Recognized need to increase sample size to increase response rates.
    - Survey results were shared with Provider Relations to discuss potential barriers (i.e. software incompatible issues)

Back to Agenda

- BH Clinical Quality Measures – Natalie Zavala presented on the Behavioral Health (BH) Quality Measures and interventions for improvement:
  - Follow-up after hospitalization (FUH) for mental illness within 7 or 30 days after discharge include member outreach post-discharge to coordinate follow-up appointments and efforts to improve non-medical transportation for follow-up visits. Rates are significantly higher than the same time the year prior.
  - Follow-up care for children with prescribed ADHD medication (ADD) interventions include 30-day limit for initial fill of ADHD medication to encourage members to follow-up with their prescriber within 30 days and member/provider education on the importance of follow-up visits. Rates are significantly higher than last year, but not meeting goal. In Q4 2021, staff conducted member outreach to caregivers within the initiation phase. Most caregivers reported having a 30-day appointment scheduled and expressed appreciation for the outreach. Some caregivers shared concerns and medication noncompliance, allowing staff to educate and emphasizing the importance of sharing information with provider.
  - Antidepressant Medication Management (AMM) and Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF) interventions include provider education and fact sheets for member education along with education on social media sites. Met goal for all lines of business. Staff continue to provide education material and continues to monitor rates.
- BHI Incentive Programs (BHIIP) – 32 out of 37 milestones were completed for Q4 as of February 10, 2022. Incentive dollars have been received for quarter 2 and will be distributed to providers.

- **UMC**
  - A UM report was presented to QIC by the Director of Utilization Management Mike Shook, which included data presented at the November 18, 2021, committee meeting. UM presented on 2021 3rd quarter and annual trends:
  - Operational performance goals were met with the exception of:
    - Medical Authorization: 3 health networks were below goal for urgent turnaround times (TAT) and 1 health network was below goal for routine TAT (goal = 98%)
    - Utilization Outcomes: Beddays and Readmissions measures were not met for OCC.
  - Prior Authorization Backlog
    - August 2021 – TAT compliance issue identified by UM leaders through aged inventory on daily report
    - UM initiated remediation efforts to facilitate approval of authorizations from September 2021 to January 2022
    - As of January 27, 2022 – backlog was officially cleared
  - Over/Under Utilization – Medi-Cal CCN Network – data presented
  - Benefit Management Subcommittee (BMSC) meetings were held September 22, 2021 where 52 codes were reviewed and 31 were identified as prior authorization (PA) required and 21 codes were determined that no PA was required.

Back to Agenda

  - BHI UM update was presented by Dr. Sharps, and he shared there was a decrease in Psychiatric and Psychotherapy PTMPY that can be explained by the claims lag.
- **Member Experience –** Marsha Choo presented an update on the Member Experience subcommittee that met on November 4, 2021. OneCare Connect (OCC) Disenrollment Survey and 2021 Member Experience (CAHPS) Survey Results were presented.
  - **2021 OC and OCC CAHPS Survey.** OneCare performance remained the same or had a slight decrease. Star Ratings have dropped from the previous reporting year. Rating of Health Plan and Annual Flu Vaccine are below the national average. OneCare Connects performance improved from the previous year, but measures continue to perform below the National MMP Average and other regions in CA, particularly in the access related measures for Getting Need Care and Getting Care Quickly.
  - **Health Network Medi-Cal Member Experience Performance.** Based on MY 2019, four HNs were issued PDSAs (HNQR below 2.5 and showing no improvement) to improve member experience. Two of the four HNs showed improvement. Based on Measurement Year (MY) 2020, nine HNs will be issued 2 PDSAs (HNQR below 2.5) to improve member experience.
  - **2020 Timely Access and In-Office Wait Time Surveys** - CalOptima fielded a Timely Access Survey to monitor telephone and appointment wait times of members from November 2020 thru May 2021 with a sample size of 3,629. The plan level compliance rates increased significantly from the previous year, particularly around urgent wait time. Six of the 13 appointment availability standards and 7 of 11 telephone wait time standards met the 80% internal threshold. As part of the next steps is the education through provider fax blast, provider alert and newsletter as well as to issue Plan-Do-Study-Act (PDSA) to all HNs (rates below 80%) and send education (1 instance of non-compliance) and warning (2 instances of non-compliance) Letters to providers noncompliant with appointment and telephone wait time include in-office wait time.
  - **Network Adequacy Update** - CalOptima continues to meet the following DHCS network adequacy standards at the plan level. For Mandatory Provider Types, HNs are not meeting the standards for Certified Nurse Midwives and Licensed Midwives, with the exception of Kaiser Permanente. All HNs met the standards for provider to member ratios. Time/Distance standards are met by CCN, but HN are having challenges covering the north-east and south parts of the county for specific specialties. CalOptima will share HN level network adequacy results with the HNs and work with HN to address gaps as part of DHCS Subcontracted Network Certification (SNC).
  - **Member Experience Workplan Updates** - mPulse (Member Texting) COVID-19 immunization campaigns has reached over 890,000 members on COVID-19 vaccines, incentives and boosters as well as flu vaccines. Virtual visits with PACE clinicians continue with PACE Telehealth Solutions (VSee) where 13% of encounters were tied to telehealth and there was a 57%-member engagement. eConsult Initiative are in process to finalize contract negotiations. At the end of Q4, CalOptima executed 31 agreements with targeted provider specialty types and 6 are in credentialing.
- **WCM CAC**

Back to Agenda

- Dr. Thanh-Tam Nguyen presented a summary of the WCM CAC meeting held November 16, 2021, where Dr. Fonda shared news of awards that were granted to CalOptima. CMS Audit results were also shared with the Committee. The WCM CAC Charter was approved with no significant changes and Dr. Desmond Lew was added into the Committee as Health Network Medical Director Representative.
- An update on Medi-Cal Pharmacy Carve Out (Medi-Cal Rx) was provided by the Pharmacy Department and committee members expressed concerns as this transition may have caused disruption to our member's access.
- Mike Shook provided WCM measure updates. Tyronda Moses presented a Grievance and Resolution Services update, then Vy Nguyen and Natalie Zavala provided an update on Whole-Child Model Customer Service Inquiries.
- Dr. Nguyen shared DHCS CCS Number Letter Updates proving a copy of CCSIN-21-03-Palivizumab-Synagis-for-RSV-21-22.

- **CPRC**
  - Laura Guest presented an update on CPRC.
  - In 2021 Health Plan Medical Board Licensing actions taken were as follow: 805 Disciplinary Action Taken (0) Probations reported (30), Accusation 1st, 2nd, and 3rd Amended (95), License Revoked (16), Suspended, Surrendered or Cease Practice, Public Reprimand or Citations (38).
  - The Exclusion and Preclusion activity and DHCS Restricted Provider Database started in 2020. In 2021 CMS Preclusion List (8), Medicare Opt-Out (10), Office of Inspector General (OIG) (1), System for Award Management (SAM) (0), Medi-Cal Suspended and Ineligible (S&I) (0), and DHCS Restricted Provider Database (5).
  - Site Review Activity Previous quarter it was reported that there was an increase of PCP Corrective Action Plan's issued for FSR's. The committee has asked staff to report back the reason for the increase. Staff reviewed the data and reported back that the increase in CAPs occurred due to the increase in overall site visits.
  - There was a total of 272 PARS completed in 2021 with 97 or 25% obtaining BASIC Access and 175 obtaining Limited Access. The percentage of providers that have the basic access has declined from a year ago.
  - There were no Incident Reports in 2020 and 2021 because CBAS centers were closed. There were some Non-Critical and some falls. Most of that was related to the State asking CBAS Centers to start reporting any COVID infections or exposures and that's why the numbers went up so high.
  - The nursing facilities had a dramatic drop in reporting and CalOptima reminded them to report incidents to CalOptima as well as DHCS.
  - For the multi-purpose senior services program (MSSP), most incidents were not issues related to providers but issues with the member's caregiver and usually issues of abuse, neglect, or self-neglect.
  - Potential Quality Issues (PQI) - There was a sharp decline of PQIs, likely due to the change in workflow for Quality of Care grievances. In 2021 CalOptima terminated the Credentialing of two providers as a result of a PQI investigation.

Back to Agenda

- GARS/PQI process was implemented November 2020. Medical Director's clinical recommendations are incorporated into the member's Grievance Resolution letter. The number of PQIs opened because member grievance has declined from an average of 114/month in 2020 down to 17/month in 2021. A decrease in the backlog of PQI cases from 522 in January 2021 to 42 in December 2021.

- **GARS**
  - Laden Khamseh presented an update on grievance and appeals trends Q4 2021.
  - For Medi-Cal, there was a decrease in the terms of the number of combined grievances. Overall decreases, 9% increase in total complaints, 7% decrease in member appeals, 5% increase in member grievances, and 25% increase in provider appeals.
    - Quality of Service (QOS) continues to be the highest category with an increase in 11% from Q3 to Q4.
    - Top Access type of issues that come up is availability for appointments for members with their physicians or phone access being able to get ahold of their health plan or their physician.
    - Quality of Care type of issues is when members question their treatment or not happy with treatment documentation and delays in treatment.
    - Quality of Service will be any issues related to delays in referral by the health plan and then also transportation, Veyo, for non-medical transportation.
    - QOS has the largest percentage of the type of calls that CalOptima receives, followed by Access Availability.
  - Medi-Cal Behavioral Health Grievances – There was a decrease in overall BH grievances. A breakdown of the type of grievances is Access (53%) as the highest in terms of the percentage, QOS (36%), Billing (6%) and QOC (5).
  - OneCare Connect Member Grievances – There was a volume decrease on all levels of Appeals, 10% decrease in total complaints, 32% decrease in appeals, 13% decrease in grievances, and 22% increase in provider appeals.
    - Grievances by the type of issues that the members calling.
    - Top category of grievances was Access and that would be specialty Care and Telephone Access.
    - The majority of grievances are related QOS related to non-medical transportation or member being unhappy with the provider, or even the HN or CalOptima staff services provided.
    - Next top category is QOC which is when member questions treatment.
  - OneCare Connect Behavioral Health Grievances – Behavioral Health grievances increase from Q3 to Q4. Grievances were related to Telephone accessibility, questioning treatment by provider, medication changes, and dissatisfaction with their providers with the services that were provided for them.

  - OneCare Member Grievances were smaller compared to the other lines of business. Total complaints for Q4 was 55 and 9 member appeals.

Back to Agenda

Attachments

2021 QI Work Plan – Fourth Quarter

Back to Agenda

Evaluation Category	2021 QI Work Plan Element Description	**Planned Activities**	**Staff Responsible**	LOB	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT							
Program Oversight	2020 QI Program Evaluation	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Esther Okajima	MC,OC, OCC	Approved: QIC QIC 1/12/2021, QAC 2/25/21, BOD 4/1/21		
Program Oversight	2021 QI Annual Oversight of Program and Work Plan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Esther Okajima	MC,OC, OCC	Approved: QIC 1/12/2021, QAC 2/25/21, BOD 4/1/21		
Program Oversight	2021 UM Program	UM Program will be adopted on an annual basis.	Mike Shook	MC,OC, OCC	2021 UM Program approved QIC 2/16/21, QAC 2/25/21, BOD 3/4/2021		
Program Oversight	2020 UM Program Evaluation	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Mike Shook	MC,OC, OCC	2020 UM Evaluation approved QIC 2/16/21, QAC 2/25/21, BOD 3/4/2021		
Program Oversight	Population Health Management Strategy	Review and adopt on an annual basis.	Pshyra Jones	MC,OC, OCC	Strategy is complete and current. We will need to update to align with 2022 NCQA requriments.	Will be meeting with Team to DRAFT the revisions to the PHM Strategy.	
Program Oversight	**Credentialing Peer Review Committee (CPRC) Oversight** - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	M. Choo/Laura Guest	MC,OC, OCC	1) The number of providers credentialed and recredentialed remained consistent with an uptick in Q4. We had no 805 reporting's in Q4. We completed the NCQA Audit Q3 and scored 100% on all Credentialing elements. 2) Q4 FSR Productivity: 11 Initial FSRs, 66 Periodic FSRs 3 Initial MRRs, 59 Periodic MRRs. CAP issued: 34 Critical Element (CE) CAPs, 51 FSR CAPs, 23 MRR CAPs. 6 PCP panels were closed (1 failed FSR, 4 failed MRRs, 1 non-compliant CAP). Q4 PARS Productivity: 64 PARS completed (19 Basic Access, 45 Limited Access). FSR and PARS are continuing to complete the backlog of audits due to suspension of on-site activities. Additionally, most FSR and PARS due since the resumption of on-site activities are being completed by the assigned due dates. 3) The CDPH resumed performing on-site recertificate surveys for NF in Q3 2021. On-site audits of NF are also being completed. 4) Neither the California Department of Aging (CDA) nor the Department of Health Care Services (DHCS) have authorized CBAS centers to open or allow on-site audits. Annual audits of the CBAS centers continue to be performed virtually. On-site audits will resume when authorization by CDA and DHCS is granted. 5) The number of PQI cases closed in Q4 was 79, as compared to 321 (Q1), 248 (Q2) and 131 (Q3). The reason for the drop is related to the drop in opening of PQIs since Quality of Care grievances are now reviewed while still a grievance. For those cases leveled as Quality of Care, the greatest category remains to be "Medical Care." In Q4, we terminated one ABA group related to a PQI investigation.	1) In Credentialing, we continue to perform on-going monitoring of the CalOptima provider network, and will take action of providers on any exclusion or preclusion list. QI Credentialing has 100% compliance for Recreds in Q3. 2) FSR and PARS are continuing to complete the backlog of audits due to suspension of on-site activities. Additionally, FSR and PARS due since the resumption of on-site activities are being completed by the assigned due dates. 3) For PQIs, we are moving more of our outcomes to a CAP-model so that we can follow-up with providers with issues. 4) As the CDPH has resumed performing recertificate surveys, on-site audits of the NF are also being completed. CDA and DHCS have not yet authorized CBAS centers to open or allow on-site audits. Annual virtual audits of the CBAS centers continue to be performed. On-site audits will resume when authorization by CDA and DHCS is granted.	
Program Oversight	**Grievance and Appeals Resolution Services (GARS) Committee** - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Tyronda Moses	MC,OC, OCC	Member and Provider Complaints Q3 results were shared at the December 14, 2021 QIC Meeting. There was a Overall decreases, 7% decrease in total complaints, 27% decrease in member appeals, 1% decrease in member grievances, 15% decrease in provider appeals. **Medi Cal Grievances:** QOS continues to be the highest Grievance category. QOS increased by 1% from Q2 to Q3, Access increased by 6%, Practitioner office s te increased 80% (from 5 in Q2 to 9 in Q3), Bi ling increased by 1% and QOC decreased by 30%. **Medical BH Grievances:** 1% increase in BH grievances, 368 grievances filed by 348 unique members, B lling decreased by 27% (22 in Q2 to 16 in Q3) - out of pocket reimbursement requests for office visits, Access continues to increase since Q3 2021, this quarter it increased 4% (from 29 in Q4 to 116 in Q1 to 183 in Q2 to 190 in Q3), QOS increased by just under 1% (.7%) (141 in Q2 to 142 in Q3), QOC increased by 18% (17 in Q2 to 20 in Q3) **OneCare Connect Grievance by Category:** QOS continues to be the highest Grievance category. QOS increased by 17% from Q2 to Q3, QOC decreased by 18%, Access increased by 31%; yet st ll only accounts for 4% of the grievances filed (17 of 420) **OneCare Connect BH Grievances:** Behavioral Health grievances remain low, OCC BH grievances decreased for the first time since Q3 2020 (Q3 (1) to Q4 (3) to Q1 (5) to Q2 (10) to Q3 (4). **OneCare Complaints:** 103% increase in total complaints, 13% increase in member appeals, 133% increase in member grievances, 120% increase in provider appeals. One member filed 5 grievances (4 of 5 were transportation), and another filed 4 (general service by provider and one transportation), Provider appeals – 5 filed for one member for medical supplies (non contracted provider/payment denials)	1) Grievance trends are reviewed for repeated issues. 2) High grievance count by providers are tracked and trended. 3) Results are shared with Member Experience Committee for recommended action or escalation.	

Back to Agenda

Back to Item

Evaluation Category	2021 QI Work Plan Element Description	Planned Activities	Staff Responsible	LOB	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.	The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & ava lability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Kelly Rex-Kimmet/Marsha Choo	MC,OC, OCC	In Q4, MEMX Committee has reviewed /discussed the following in Q4meetings (11/4) •DHCS Award for Member Experience •Q3 MemX Workplan •Post Call Member Survey Workgroup •Referral and Auth workgroup •BH Member Experience Results •CAHPS Plan Results- OC/OCC •CAHPS HN Quality Rating - PDSA •2020 TImely Access Survey Results	In Q1 MEMX Committee has one meeting schedule for Feb 9th.	
Program Oversight	**Utilization Management Committee (UMC) Oversight** - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.	UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Mike Shook	MC,OC, OCC	UMC reported to QIC on 10/12/21. Presented 2021 2nd Quarter and Annual Trends (8/26/2021), 2Q 2021 Operational Performance, 2Q 2021 Utilization Outcomes, 2Q 2021 Operational Performance WCM, Over/Under Utilization Monitoring, Benefit Management Subcommittee (BMSC), Pharmacy Over/Under Utilization Monitoring, BH UM Update, BHI. QIC accepted and filed meeting minutes from UMC Meeting (8/26/21).QIC Accepted and filed all documents.	UMC is scheduled to present Quarterly update to QIC on 2/15/2022.	
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.	Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	T.T. Nguyen, MD	MC	WCM CAC gave an update to QIC on 10/12/2021. They met on Aug 17, 2021. Dr. Fonda gave an up to date COVID Update. Pshyra presented a follow up update on Shape your Life to support WCM members participation on the program. This will allow members to adopt healthy behaviors. Pharmacy carve out update to start January 1, 2022. Regular WCM updates to regarding WCM measures, GARS, WCM CS Inquiries. QIC accepted and files their 6/15/21 meeting minutes. WCM will meet again on 11/16/2021.	WCM CAC will give an update to QIC is on January 11, 2022. They will present an update on WCM Quality Measures, Pharmacy Medi-Cal RX update, WCM Measures, GARS, WCM CS Inquires, DHCS Notice Updates	
Program Oversight	Quality Withhold for OCC	Monitor and report to QIC	Kelly Rex-Kimmet/ Sandeep Mital	OCC	Per a memo released by CMS dated July 29, 2020, in light of the impacts from the Corona-virus disease and public health emergency, Medicare-Medicaid plans (MMPs) will automatically receive the full quality withhold payment of 100% from CMS and the state for CY2020, provided that the MMP fully reports all applicable quality withhold measures.	Pay for Value team will continue to monitor CalOptima performance on all quality withhold measures for MY2021.As of November 30, 2021 CalOptima has passed 8 of 10 total number of measures and is expected to receive 100% payment for CY2020. CMS has announced that "extreme circumstances" will not be applied to MY2021 performance.	
Program Oversight	New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, Data Mining/Bridge efforts)	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, Collaboration with OC Coalition of Clinics to receive their aggregated EMR data, efforts to immunization registry (CAIR) and lab data gaps (Blood Lead Testing results for example) Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital	MC,OC, OCC	Please see attached for final DHCS MCAS measure set for MY2022 . Other than the "Follow up after ED visit for Substance Abuse" (FUA), all the other measures that DHCS will hold health plans accountable to MPL will be part of Pay for Value measures for this year.	Next Quarter will give an update on the new DHCS Quality Strategy and proposed OC P4V Program.	
Program Oversight	Improvement Projects (All LOB) QIPE/PPME: Emerging Risk (A1C), HRA's, HN MOC	Conduct quarterly oversight of spec fic goals on Improvement Projects (IPs), and QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **MC PIPs:** 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members 2) Improving Well-Care Vis ts for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal members with Provider Office A **MC QIP:** 1) COVID QIP Workplan Year 2 - 3 New Strategies -Increase the number of diabetes screenings for members 18-64 years of age with schizophrenia, schizoaffective or bipolar disorder who were dispensed an antipsychotic medication. -Increase the number of Medi-Cal members 21-64 years of age who were screened for cervical cancer. -Increase the immunization rates of Medi-Cal members turning 2 years of age who are due for vaccinations. **OC and OCC CCIP:** Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% **MC and OCC QIP:** Improving Statin Use for People with Diabetes (SPD) **PPME (OC) Sloane:** HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC) Sloane:** HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC Oversight (review of MOC ICP/ICT Bundles) **PDSA:** 1) Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents- Michelle Findlater - **CMS Onhold** 2) Improving Cervical Cancer Screening Rates through Provider Engagement	Helen Syn/Sloane Petrillo/Michelle Findlater/ Natalie Zavala	MC,OC, OCC	**PPME (OC)-** **HRA's outreach completed:** Newly eligible members OCT at 100% while NOV and DEC are in process and on target. Annual completed at 100% for Q4. **HN MOC Oversight** Q4 All Networks above w thhold threshold. **QIPE (OCC)** **HRA's outreach completed:** Newly e igible members 100% and Annual at 100% for OCT and NOV; 99% for DEC **Q4 MMP 1.5** ICP High 65.4% Low Risk 51% (goal for 2022 is 75%. Logic is being updated) **Q4 MMP 3.2** ICP Completed within 90 days 84.5% (withhold at 85%) **Annual 2022 1.6** Care Goal Discussions Initial 91.8% for initial; annual 92% (withhold at 95% there is logic being updated). **HN MOC Oversight** Q4 All Networks above w thhold threshold. **MC PIPs:** 1) Health Equity PIP The Improving Access to Acute/Preventive Care Services to Medi-Cal Members Experiencing Homelessness in Orange County, CA transitioned into a PIP focusing on Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members - Module 1-3 approved 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal members w th Provider Office A - Module 1-3 approved **MC QIP:** 1) COVID QIP Workplan -Year 2 of COVID QIP was submitted and approved 3 New Strategies -Increase the number of diabetes screenings for members 18-64 years of age with schizophrenia, schizoaffective or bipolar disorder who were dispensed an antipsychotic medication. -Increase the number of Medi-Cal members 21-64 years of age who were screened for cervical cancer. -Increase the immunization rates of Medi-Cal members turning 2 years of age who are due for vaccinations. **OC and OCC CCIP** Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% - Ongoing interventions **MC and OCC QIP** Improving Statin Use for People with Diabetes (SPD) - Ongoing interventions **PDSA** Increasing CCS rates through Provider Outreach was completed and closed	PPME (OC)- HRA's Continue current process. HN MOC Oversight: Continue current process. QIPE (OCC)- HRA's Continue current process. MMP 1.5 monitor compliance post logic change with new goal of 75%. Q4 MMP 3.2 ICP: Continue current process. 1.6 Care Goal Discussions: Continue current process. Monitor for initial and annual which is withhold measure. . HN MOC Oversight: Continue to monitor for threshold compliance.	

Evaluation Category	2021 QI Work Plan Element Description	**Planned Activities**	**Staff Responsible**	LOB	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Program Oversight	BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. CalOptima will be responsible for program oversight, including readiness, milestones tracking, reporting and incentive reimbursement. Quarterly program update at QIC. 2) Monthly provider report on two metrics: % of BCBA supervision and % of utilized direct service hours. The ABA P4V will be available to all contracted ABA providers starting January 2021. Incentive will be paid out in Q1 2022.	Natalie Zavala/Sheri Hopson	MC	1)BHIIP - 6 of the 7 provider groups submitted Q3 milestone reports, overall 91% of the targeted milestones were completed. The Q3 milestone report was submitted to DHCS 11/29/21. Discussion with DHCS held 11/19/21, to address the issue about some of the provider groups inability to gather data and report on their project's required performance measures. DHCS requested the following ad-hoc deliverables 1) provide a performance measure status report outlining each provider group's revised list of performance measures 2) MOU amendments for the provider groups who selected new measures or reduced the number of performance measures to report. One of the provider groups encountered challenges implementing their project design, after receive a CAP and discussions with DHCS, the group has confirmed opting-out of the program. The incentive funding from DHCS for Q1 milestone reporting was received 10/7/21; the check request process completed and funding issued to providers 10/19/21. 2) ABA P4V: Performance measures ABAU and ABAH reporting was completed for the report cards August through November .	BHIIP - Providers are expected to complete their Q4 milestones by 12/31/21 and submit their reporting template and supporting documentation by 2/1/22. BH to review the reports/supporting documentation and compile the Q4 milestone reporting template for DHCS submission due date 3/1/22. BHIIP - Submit requested ad-hoc deliverables to DHCS 1) performance measure status reports for each provider group and 2) MOU amendments for the provider groups who made revisions to their list of performance measures. ABA P4V - Generate December report card and plan for 1st quarter ABA Provider webinar.	
Program Oversight	Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	1. Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 2. Special population PCCs accompany CFT to provide assistance with administrative needs of homeless individuals.-to resume post-COVID-19 3. Primary point of contact for coordinating care with collaborating partners and HNs 4. Serve as a resource in pre-enforcement engagements, as needed.	Sloane Petrillo	MC,OC, OCC	1. Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19: Virtual visits at set times with two shelters. Regular communication with Recuperative Care Facilities. 2. Special population PCCs accompany CFT to provide assistance with administrative needs of homeless individuals.- on hold due to public health emergency. To resume post-COVID-19. PCCs follow up with members via telephone with CFT dispatch and send updates to PCPs and health networks, requesting follow up after visits. 3. Primary point of contact for coordinating care with collaborating partners and HNs. Ongoing. 4. No pre enforcement engagement requests this quarter.	1. Ongoing communication with Recuperative Care Facilities. 2. Ongoing PCC follow up telephonically with CFT dispatch and communication to PCPs and Health Networks. 3. Ongoing primary point of contact for coordinating care with collaborating partners and HNs. 4. Ongoing availability should pre enforcement engagement requests come in.	
Program Oversight	Homeless Health Initiatives (HHI): Health Homes Program Phase 2	1. Incorporate new data to DHCS reporting re: Housing Navigation. 2. Streamline process for referrals to HHP. 3. Enhance oversight of program. 4. Developed process to coordinate referral with County for members with SMI.. 5. Focus on telephonic outreach d/t COVID-19 6. Addition of supervisor to Homeless Team to provide additional support for the program.	Sloane Petrillo	MC	1. Incorporate new data to DHCS reporting re: Housing Navigation. Ongoing tracking of housing navigation partners. 2. Streamline process for referrals to HHP. Completed. Program is sunsetted as of 12/31/21. 3. Enhance oversight of program. Completed. Program is sunset as of 12/31/21 4. Developed process to coordinate referral with County for members with SMI. Complete. Program is sunsetted. 5. Focus on telephonic outreach d/t COVID-19. Complete. 6. Addition of supervisor to Homeless Team to provide additional support for the program. Program is sunsetted and members transitioned to CalAIM ECM.	HHP sunsetted on 12/31/21. Enrolled HHP members were transitioned to CalAIM ECM on 1/1/2022.	
Program Oversight	Health Equity	1. Make health equity a strategic priority 2. Develop structure and process to support health equity work 3. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4. Develop partnerships with community organizations to improve health and equity 5. Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Marie Jeannis/ Katie Balderas	MC, OC, OCC	1) Conducted landscape analysis of health equity frameworks and developed draft framework for CalOptima's Health Equity initiative. 2) Participated in Sprint 1 of ACAP's Social Determinants of Health Learning Collaborative with a focus on Alignment, Strategy & Organizational Structure 3) Recruited interdepartmental CalOptima workgroup to focus on Health Equity and Social Determinants of Health to launch in Q1 of 2022. 4) Developed relationship with OCHCA's Office of Population Health and Equity to identify potential areas of cross-collaboration 5) Partner with OCHCA to conduct community-based vaccination clinics for CalOptima members and promote vaccination information in partnership with trusted messengers from communities with low vaccine participation rates.	1) Launch and facilitate interdepartmental workgroup on Health Equity and Social Determinants of Health in Q1. 2) Finish Sprint 1 of ACAP's Social Determinants of Health Learning Collaborative with a focus on Alignment, Strategy & Organizational Structure 3) Finalize health equity framework and develop measurable objectives related to the goals. 4) Facilitate ongoing collaboration with OCHCA Office of Population Health and Equity and obtain feedback on health equity framework. 5) Partner with OCHCA to conduct community-based vaccination clinics for CalOptima members and promote vaccination information in partnership with trusted messengers from communities with low vaccine participation rates.	

Evaluation Category	2021 QI Work Plan Element Description	**Planned Activities**	**Staff Responsible**	LOB	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
II. QUALITY OF CLINICAL CARE- Adult Wellness							
Quality of Clinical Care	Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	CCS 1) Continue $25 member incentive program for completing a CCS. 2) Targeted member engagement and outreach campaigns to promote cervical cancer screenings in coordination with health network partners 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach campaigns 5) Member Health Rewards RFP and Vendor Contract COL 1) Continue member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy) 3) Targeted member engagement and outreach campaigns to promote colorectal cancer screenings in coordination w th health network partners 4) Member Health Rewards RFP and Vendor Contract BCS 1) Continue $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted member engagement outreach campaigns to promote breast cancer screenings in coordination with health network partners. 3) Coordinate mob le mammography clinics in zip codes with low incidence of screening. 4) Track the number of mammograms scheduled through targeted outreach. 5) Member Health Rewards RFP and Vendor Contract	Pshyra Jones/ Helen Syn	MC	1. Member Health Rewards are available on CalOptima Website, and shared with all Health Networks to promote in their outreach campaigns. 2. # of BCS 2021 Member Health Rewards processed as of 1/07/22: 370 for Medi-Cal, 10 for OC, and 84 for OCC # of CCS 2021 Member Health Rewards processed as of 1/07/22: 502 for Medi-Cal # of Colorectal CS 2021 Member Health Rewards processed as of 1/07/21: 5 for OC and 41 for OCC 2. 2021 Nov Prospective Rates (PR): Breast Cancer Screening MC: 53.72%, OC: 62.50%, OCC: 59.68% Measure is performing lower for MC and OC than same time last year and below the 50th percentile (MPL). Measure is performing higher for OCC than same time last year and below the 50th percentile (MPL). Rate is negatively impacted by the COVID-19 pandemic. Members are not going in for preventive care visits. **Cervical Cancer Screening** MC: 54.37% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Rate is negatively impacted by the COVID-19 pandemic. Members are not going in for preventive care visits. **Colorectal Cancer Screening** OC: 50.68%, OCC: 52.64% Measure is performing better than same time last year for OC and lower than same time last year for OCC and is currently below the 50th percentile. Rate is negatively impacted by the COVID-19 pandemic. Many members are not going in for preventive care visits	1. Targeted member engagement through mailings, IVR, mobile texting, social media campaigns, community events and collaboration, community and member publications to be planned with the new fiscal budget allowances. 2. Community Mobile Mammography events in collaboration with community partners and community clinics scheduled for remainder of year. 3. Member Health Reward and Member Engagement Vendor Selected. Contract pending and program for member engagement likely to begin in Q1 2022. 4. Social Media Posts: October for Breast Cancer Awareness Month; January 2022 for Cervical Cancer Awareness Month; March 2022 for Colorectal Cancer Awareness Month	
Quality of Clinical Care	COVID-19 Vaccination and Communication Strategy	1) Implement immunization strategy for CalOptima adult members 16 years and older 2) Create Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions. - Mailing to all members with info on the vaccine - Targeted outreach via text messaging campaign. When different priority groups become available to be vaccinated, we send out targeted messages to these members letting them know that: a. They are now eligible to be vaccinated. b. Where they need to go to be vaccinated (when available) c. This is also likely to begin in February, but may extend into the fall depending on the vaccine distribution timeline. - Targeted outreach via phone calls to targeted groups of people who are at high risk for not getting the vaccine. 3) Implement Incentive Strategy for COVID-19 vaccination a.Coordinate efforts with OC HCA Vaccine Sites and Health Networks to distribute $25 nonmonetary gift cards after the first and second doses b.Coordinate efforts with the Coalition to distribute $25 food voucher to local restaurants after the first and second doses for members experiencing housing insecurity	Pshyra Jones/ Helen Syn/	MC	1) COVID texting campaigns continued in Q4 2) COVID community vaccine events were held in partnership with OCHCA ongoing. 3) Vendor has processed a total of 413,067 incentives (cumulative) - The vendor has processed 39797 out of the 90k we sent to them. PHM has processed a total of 113,165 incentives (cumulative). This total includes incentives processed in-house & through vaccine events. - Recent Vaccine Events: December 4th: 224 December 8th: 84 December 22nd: 222 Total vaccine events: 530 - As a reminder, the breakdown of the vaccine event totals may be different to the numbers reported by Community Relations. Community Relations totals represent all CalOptima members vaccinated and PHM numbers represent all that were handed a gift card.	Texting campaigns continue. New texting messages w ll be updated to include expanded age ranges and booster shot eligibility. COVID vaccine incentive processing continues, CAIR registray data and logic improvements to assist with identification and more timely processing. COVID vaccine events with OCHCA continue	
III. QUALITY OF CLINICAL CARE- Behavioral Health							
Quality of Clinical Care	Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	1) Visit additional hospitals with inpatient psychiatric unit to discuss CalOptima concurrent review and transition of care process 2) Use strategies to engage and motivate members to participate in their own care 3) Collaborate with the two BHI Incentive Prgoram projects to improve follow up after hospitalization	Natalie Zavala	OCC	PR HEDIS Rates (November) Q4: 30 day- 44.07%, 7 day- 27.97% 1) Continued outreach to members post-discharge to coordinate follow-up appointments. 2) Continued weekly BHI clinical round meetings to discuss concurrent reviews and internal coordination interventions. 3) Numbers were impacted by the following barriers: difficulty initiating or confirming linkage process as many members continue to have invalid phone numbers on file; members referred to out of network providers, unable to verify if member attended appointment and confirm linkage; members with several readmissions initially declined OP BH linkage, however upon acceptance of assistance and linkage readmissions appeared to cease; and members linked after 30 day period.	1) Continue conducting post discharge outreach. 2) Continue tracking members and outreach to those not attending follow-up appointments within 7 days of discharge. 3) Identify at least 1 intervention in the next BHI Incentive Program Learning Collaborative that can be implemented to improve follow up.	
Quality of Clinical Care	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	1) Continue the non-compliant providers letter activity 2) Conduct member outreach to improve appointment scheduling 3) Update and distribute member and provider educational materials for ADD	Natalie Zavala	MC	PR HEDIS Rates (November) Q4: Initiation Phase- 40.44%, Continuation and Maintenance Phase- 48.13% 1) Pharmacy related intervention placing a 30-day limit for the initial fill of ADHD medication to encourage members to follow up with the prescriber within 30 days continued through December 31, 2021. 2) Conductong outreach reminding members to attend visit within 30 days of filling initial ADHD Rx. Tracking phone calls made to members to identify trends. 3) Updating compliant and non-compliant provider report in order to send letters to non-compliant providers.	1) Continue conducting member outreach for those who filled an initial ADHD prescription. 2) Complete data collection for compliant and non-compliant provider and issue letters.	

Evaluation Category	2021 QI Work Plan Element Description	**Planned Activities**	**Staff Responsible**	LOB	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Quality of Clinical Care	Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 2 educational events on depression screening and treatment 3) Continue to educate providers on depression screening via provider newsletters 4) Continue to educate members on depression and the imortance of screening and follow up visits via member newsletters and other social media.	Natalie Zavala	MC	PR HEDIS Rates (Nov) Q4: N/A; Not at risk for meeting the standard due to no benchmark set, however there are some barriers in implementing activities. 1) Data collection continues to be a major challenge due to the lack of mechanisms for capturing provider data. 2) Continued with member outreach campaign using social media platforms (i.e., Instagram and Facebook) by posting mental health-related information. Dates of social media postings are as follows: 10/6/2021, 10/8/2021, 12/14/2021 and 12/17/2021. 3) Scheduling for provider educational events was challenging due to the ongoing pandemic. As a result, no educational events occurred due to COVID-19.	1) Continue to educate members on depression and importance of speaking with providers regarding their symptoms using social media platforms (i.e., Instagram and Facebook).	
Quality of Clinical Care	Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Educate members the importance of depression medication adherence via member newsletters and social media.	Natalie Zavala	MC,OC, OCC	PR HEDIS Rates (November) Q4: M/C: 47.43%, OC: 57.58%, OCC: 58.27% 1) Continued with member outreach campaign using social media platforms (i.e., Instagram and Facebook) by posting mental health-related information. Dates of social media postings are as follows: 10/6/2021, 10/8/2021, 12/14/2021 and 12/17/2021. 2) Scheduling for provider educational events was challenging due to the ongoing pandemic. As a result, no educational events occurred due to COVID-19.	1) Continue to educate members on depression, and importance of medication adherence and speaking with providers regarding their symptoms using social media platforms (i.e., Instagram and Facebook).	
IV. QUALITY OF CLINICAL CARE- Chronic Conditions							
Quality of Clinical Care	Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization 4) Targeted member engagement and outreach campaigns to promote Diabetes Eye Exam in coordination with health network partners 5) Member Health Rewards RFP and Vendor Contract 6) Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot 7) Prop 56 provider value based payments for diabetes care measures	Pshyra Jones/ Helen Syn	MC,OC, OCC	1) Member Health Rewards are available on CalOptima Website, and shared with all Health Networks to promote in their outreach campaigns. 2) # of Eye Exam 2021 Medi-Cal Member Health Rewards processed as of 1/7/2022: 122 3) Diabetic member eligibilty file specifications being ironed out between CalOptima and VSP. 4) 2021 November Prospective Rates (PR): CDC Eye Exam MC:49.98%, OC:63.92%, OCC:63.97% Measure is performing better than same time last year for MC, but has not yet reached the 33rd percentile (MPL). Measure is performing better than same time last year for OC & OCC but has not yet reached the 25th percentile (MPL).	1) Targeted member engagement through mailings, IVR, mobile texting, social media campaigns, community events and collaboration, community and member publications to be planned with the new fiscal budget allowances. 2)VSP eligibility file upload identifying diabetic members 3) Member Health Reward and Member Engagement Vendor Selected. Contract pending and program for member engagement likely to begin in Q1 2022. 4)Diabetes Awareness Month Social Media post slated for distribution on Oct 2022/Nov 2022	
Quality of Clinical Care	Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Control (this measure evaluates % of members with poor A1C control-lower rate is better)	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out 2) Targeted member engagement and outreach campaigns to promote Diabetes A1C testing in coordination with health network partners 3) Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot 4) Member Health Rewards RFP and Vendor Contract 5) Prop 56 provider value based payments for diabetes care measures	Pshyra Jones/ Helen Syn	MC,OC, OCC	1) Member Health Rewards are available on CalOptima Website, and shared with all Health Networks to promote in their outreach campaigns. 2) # of A1C Testing 2021 Medi-Cal Member Health Rewards processed as of 01/7/22: 189 3)2021 November Prospective Rates (PR): CDC A1C Poor Control (>9) MC: 51.94%% OC: 39.41%, OCC: 34.74% Measure is performing better than same time last year (lower is better) for MC, but has not yet reached the 33rd percentile (MPL). Measure is performing better than same time last year (lower is better) for OC & OCC but has not yet reached the 25th percentile (MPL).	1)Targeted member engagement through mailings, IVR, mobile texting, social media campaigns, community events and collaboration, community and member publications to be planned with the new fiscal budget allowances. 2)Diabetic members who had an A1C <8% but are not over 8% will receive health coach outreach once next set of data is ava lable in January/February 2022. 3)Member Health Reward and Member Engagement Vendor Selected. Contract pending and program for member engagement likely to begin in Q1 2022. 4)Diabetes Awareness Month Social Media post slated for distribution on Oct 2022/Nov 2022.	
V. QUALITY OF CLINICAL CARE- Maternal Child Health							
Quality of Clinical Care	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	1) Continue $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments 5) Member Health Rewards RFP and Vendor Contract 6) Implement Collaborative Member Engagement Event with OC Diaper Bank (3-4 times yearly) 7) Prop 56 provider value based performance incentives for prenatal and postpartum care visits nad birth control	Ann Mino/ Helen Syn	MC	1) Member Health Rewards continue to be shared through CalOptima Website, and shared with all Health Networks to promote in their outreach campaigns. 2) Total # of PPC health rewards approved for Q4: 105. 3) Bright Steps outreach to 538 postpartum members, 923 assessment attempts made, 204 Bright Steps assessment completed. 4) Health Reward and Engagement Vendor contract pending and in progress. 5) Community Diaper Days. Events are on hold at the moment due to COVID-19. Tentative dates established for 2022. 6) Prenatal and Postpartum Care continues to be a P4V measure. November 2021 Prospective Rates: Timeliness of Prenatal Care: 78.46% Measure is performing lower than same time last year and has not met the 50th percent le. Rate is negatively impacted by the COVID-19 pandemic. Postpartum Care: 66.27% Measure is performing lower than same time last year and has not met the 50th percent le. Rate is negatively impacted by the COVID-19 pandemic.	1) Continue prenatal and postpartum assessments. 2) Continue to promote Bright Steps with provider, members, and community-based organizations. 3) Leverage member engagement strategies of Health Reward and Engagement Vendor. 4) Member education efforts through member publications and targeted social media campaigns planned for 2022. 5) Targeted member mailing for postpartum women planned for Q2 2022.	

Evaluation Category	2021 QI Work Plan Element Description	**Planned Activities**	**Staff Responsible**	LOB	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness							
Quality of Clinical Care	Pediatric Well-Care Visits - Includes measures such as W30, Child and Adolescent well care, Childhood vaccinations,	1) Targeted outreach campaigns in coordination with health network partners 2) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 3) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents; and track the number of participants for targeted adolescent "Back-to-School" events. 4) Prop 56 provider value based payments for relevant child and adolescent measures	Pshyra Jones/ Helen Syn	MC	1) Targeted member engagement through mailings, IVR, mobile texting, social media campaigns, community events and collaboration, community and member publications to be planned with the new fiscal budget allowances. - COVID text message campaign emphasizing Preventative Care Planned for Q4 Well Care Visits, Immunizations for members ages 0-30 months and 3-17 years. -Mobile Texting Campaign for 0-30 months and 3-17 years old delayed due to COVID-19 vaccination event mobile texting campagins. Well-Child text messages will go out in February 2022. 2) PBS Well Child and Immunization Campaign PSA - ran through end of 11/2022 3) PBS COVID-19 and Flu Campaign PSA - 11/2021 - 02/2022 4) Collaborate with community partners to participate in holiday/vaccination events. - Collaborated with Boys & Girls Club to promote well-child visits and immunizations at their Holiday Events, 12/11/2021 5) 2021 November Prospective Rates (PR): Childhood Immunization Status (CIS) CIS: 30.72%; Measure is performing better than same time last year. Measure is currently below the 50th percentile. Immunizations for Adolescents (IMA) Combo 1: 79.48%; Combo 2: 46.44%; HPV: 48.67%; Meningococcal: 81.61%; Tdap: 86.64%. Measures are performing lower than same time last year. IMA-Combo 2 and HPV submeasure met the 66th Percentile. All other submeasures is currently below the 50th percentile. Rate is negatively impacted by the COVID-19 pandemic. Members are not going into their PCP's office timely. Child and Adolescent Well-Care Visits (WCV) Age 3-11 years: 45.22%; Age 12-17 years: 42.58%; Age 18-21 years: 23.43%; Total: 39.87%. NEW MEASURE. No benchmark has yet been established for MPL. Members are not going into their PCP's office timely. Well-Child Visits in the First 30 Months of Life (W30) First 15 months: 6+ Visits: 30.81%; 15 Months - 30 Months: 2+ Visits: 64.29%; NEW MEASURE. No benchmark has yet been established for MPL. Members are not going into their PCP's office timely.	1) Targeted member engagement through mailings, IVR, mobile texting, social media campaigns, community events and collaboration, community and member publications to be planned with the new fiscal budget allowances. - COVID text message campaign emphasizing Preventative Care Planned for Q4 Well Care Visits, Immunizations for members ages 0-30 months and 3-17 years, estimated drop 02/14/2022 2) PBS COVID-19 and Flu Campaign 01/2022 - 02/2022 3) PBS Well Child Campaign 02/2022 - 06/2022	
Quality of Clinical Care	Blood Lead Screening	1) Create new policy 2) Create quarterly report sent to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 3) Create member and provider educational materials 4)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 5) Prop 56 provider value based payments for Blood Lead Screening	Pshyra Jones/ Helen Syn/ Leslie Martinez	MC	1) Policy GG.1717 Blood Lead Screening of Young Children revisions complete and approved on 11/3/2021. 2) Ongoing. Quarterly report strategy continued into Q4. Health Networks received Q4 blood lead screening report on 1/11/2022. 3) Be Aware of Lead Poisoning and Protect Your Family from Lead education materials updated in December 2021 to align with APL language. Social media post on October 2021 related to lead awareness. 4) Provider Relations supported distriubtion of Be Aware of Lead Poisnoning education posters 66 CCN providers/57 CCN offices. 5) Blood Lead Screening measure will transition to P4V. November 2021 Prospective Rates (PR): MC: 57.66%,The 50th percentile is 73.11% Measure is performing lower than same time last year for MC. The measure has not reached the 50th percentile but is not held to the MPL.	1) Member education and awareness efforts through social media campaigns and targeted ads planned for 2022. 2) Quarterly reports to CCN providers are transitioning to be shared through new in-house provider portal by Q3 2022. 3) Quarterly reports to be revised to include a summary dashboard of data at-a-glance by Q2 2022. 4) Distribution of CalOptima quarterly reports planned throughout 2022.	
VII. QUALITY OF SERVICE- Access							
Quality of Service	Improve Access: Reducing gaps in provider network	1) Actively recruit hard to access specialties for CCN	Michelle Laughlin/Jennifer Bamberg	MC,OC, OCC	In Q4 2021, CalOptima has outreached to providers and contracted with the following: BCBA: 4 As of Q4: 1 Gastroenterology, 1 Nephrology, 3 Ophthalmology, 1 Optometry, 7 Psychology, 1 Endocrinology, 4 LCSW, 7 LMFT, 1 FM, 1 Psychology, 3 ABA, 1 Cardiovascular Surgery and 6 NP providers are in credentialing.	Continue with plan - CCN recruitment is moving from the Provider Relations Department to the Contracting Department. Continue to pursue contracting with hard to access specialists.	
Quality of Service	Improve Access: Telephone Access	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Provider Outreach and Education (Timely Access Survey)	Marsha Choo/Jennifer Bamberg	MC,OC, OCC	Individual letters were mailed to non-compliant providers for Timely Access in Q4 for: •In-Office Wait Times •Appointment Availability	In Q12022 MEMX Committee has one meeting schedule for Feb 9th.	
Quality of Service	Improve Access: Timely Access (Appointment Ava lability)	1) Communication and corrective action to providers not meeting timely access standards 2) See Virtual Care Strategies	Marsha Choo/Jennifer Bamberg	MC,OC, OCC	Individual letters were mailed to non-compliant providers for Timely Access in Q4 for: •Telephone wait times	Continue with plan - CCN recruitment is moving from the Provider Relations Department to the Contracting Department. Developing a Subcontracted Network Certification (SNC) Summary Report HN individual reports with Timely Access results to share with Health Networks. Issuing corrective action in the form of a PDSA to HNs not meeting timeliness standards.	

Evaluation Category	2021 QI Work Plan Element Description	**Planned Activities**	**Staff Responsible**	LOB	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Quality of Service	Improve Access: Virtual Care Strategies	1) Pace Telehealth 2) BH Virtual Care Visit (Bright Heart) 3) e-Visit (After Hours Urgent Care) 4) Participate in eConsult implementation 5) Member Texting Platform (mPulse)	Marsha Choo/Rick Cabral	MC,OC, OCC	**1) PACE Telehealth:** PACE Q4 results: 13% of encounters are telehealth. As of Jan 2022 57% for telehealth engagement. **2) BH Virtual Care** Bright Heart is limited to members who speak English only. We have reports from members of the lengthy intake process to access services. Bright Heart is given as a provider option when appropriate. **3)e-Visit (After Hours Urgent Care)** •Temporary hold with transiition of CMO position • Renamed Virtual Visits • Contract completed for RFP **4)eConsult** •Continue to negotiate contracts with SafetyNet Connect (SNC) and eConsult Provider. •Target to complete SNC contract early Jan and submit COBAR to Q2-2022 Board mtg. •Program design adjusted: Cardio, Derm, Endo, ID, Rheum, Neuro **5)mPulse:** in Q4, 892,738 text messages were sent to members with information about COVID-19 vaccine clinics, incentives, and boosters. Texts were also sent to remind members about the importance of flu vaccines.	**1) Pace Telehealth** •Continue to monitor trends **2) BH Virtual Care** Continue to monitor **3) e-Visits** •Re-issue RFP •Select vendor, establish contract negotiations and prepare COBAR for Board Approval. •Obtain Board approval for COBAR •Execute contract and plan implementation **4) eConsult** Finalize contract negotiations, prepare COBAR and obtain Board Approval. Execute contract and plan implementation. **5) mPulse**: In Q1 2022, text campaigns will focus on Feb vaccine event with trusted messenger video, Mar and Apr CalOptima vaccine events, Well Child Visits, and preventive care. Text messaging will be part of upcoming CalFresh strategy to enroll eligible CalOptima members into the program.	
VIII. QUALITY OF SERVICE- Member Engagement							
Quality of Service/Member Experience	Improve Member Experience: Member Engagement	1) Member Portal 2) Member Outreach Calls	(1)Mauricio Flores (2)AndrewTse /Nancy Martinez	MC,OC, OCC	1)-Member Portal Release 8 of the member portal was completed in production on 12/7/2021. The list of enhancements included Health Network rebranding for Optum support for Guiding Care and Facets upgrades, redesign of the application footer for improved readability, messaging updates for transition of pharmacy benefit to Medi-Cal RX, updates to the display of member profile, implementation of error log remediation system, improved automated tasks for Forgot Username, Forgot Password, and Update User profile views. 2)- Member Outreach : Member outreaches continue. Outreaching efforts involve informing members - specific primary care providers terminating from the plan and assisting members with locating a new primary care provider - who are deeming and educating members on how to resolve their Medi-Cal eligibility issue - who have a share of cost and educating members on contacting social services to assist with share of cost status and/or questions - following up with new enrollees after 45's day of being enrolled with the plan to check in on how everything is working and offer assistance if necessary. - Outreaching to members to wish them a Happy Birthday	1)Discussions and sprint plans for next release have started but there is no deployment date for release 9 at this time. 2) Based on inbound call volume and existing staffing resources, member outreach calls will be conducted.	
IX. SAFETY OF CLINICAL CARE							
Safety of Clinical Care	Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access	Mike Shook	OC,OCC	Medi-Cal: Performance through Oct 31, 2021 reveals that 39-40% of members discharged from acute care hospital have a follow up apppointment to see their PCP.	Discussed opportunities to understand barriers and work with high volumes facilities to identify opportunities to improve members having a follow up appointment with PCP when leaving the hospital. Next step is develop a communication/survey to guage engagement by high volume facilities, as well as develop a member communication on the importance of follow up appointments after hospital discharge.	
Safety of Clinical Care	Quality of Care Grievances and Potential Quality Issue (GARS/PQI) Processing	1) Implement new GARS/PQI process to improve response to quality of care grievances which will include clinical recommendations in the GARS resolution letter to member. 2) Reduce the number of PQIs related to quality of service grievances, and overall PQIs being investigated	Laura Guest/Tyronda Moses	MC,OC, OCC	In Q4 2020, we instituted a new GARS/PQI process in response to the Annual DHCS audit and CAP. In the new process, the QI Nurse reviews QOC grievances referred by GARS initially for any urgent clinical issues that need to be addressed. When GARS receives the response from the provider, the QI Nurse summarized the issue, the provider's response and makes recommendations. This is reviewed by the medical director, who makes the final recommendations which are included in the member's grievance resolution letter. The medical director will recommend opening a PQI investigation if more information is needed to determine if there was a quality of care issue. An additional advantage of this process is that it has resulted in a dramatic decline of cases referred by GARS, from an average of 112 per month in 2020 to 17 per month in 2021. In Q4, 2021, PQI closed 79 cases, of which 62 were referred by the medical director after reviewing the quality of care grievance. After the investigation was completed, three of these cases were leveled as quality of care.	Have an ongoing review of the process and identify opportunities for improvement or refinement in our methodology.	

Evaluation Category	2021 QI Work Plan Element Description	**Planned Activities**	**Staff Responsible**	LOB	**Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues** *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	**Next Steps Interventions / Follow-up Actions** *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Safety of Clinical Care	Post-Acute Infection Prevention Quality Incentive (PIPQI)	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer Iodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	**Michelle Findlater**/Scott Robinson	MC,OC, OCC	1. LTSS PIPQI nurses continue to conduct onsite visits to the 26 Nursing Facilities participating. Staff interview CalOptima Members for protocol understanding and check compliance rates with NF staff. Ongoing training provided to new and seasoned employees. 2. PIPQI Nurses have been collecting data regarding CHG and Iodophor Purchase quantities and reviewing data with NF DSD/IP. Despite multiple efforts(In person, Telephone and E-mail requests), there are still high volumes of noncomplaince with invoice submission. The complaince with CHG submission has increased slightly from 54% to 68%. (43/78 Iodophor missing) (25/78 CHG missing) 73% of all facilities ordered less than half the quantity needed to complete the Iodophor Protocol 60% of all facilities ordered less than half the quantity needed to complete the CHG Protocol 3. Since the return of Onsite visits the average facility HAI score increased in Quarter 4 from 4.13 to 5.66% based on data given by facilities.	1. LTSS has partnered with Enterprise Analytics to recreate a PIPQI dashboard that views trends regarding HAI scores, and Product Purchasing. The dashboard compares facilities based on which phase of the program they initially enrolled in as well as can be sorted by geographical location or corporate ownership to find and assess trends. 2. Continue with current payments based on licensed beds and incentive payments quarterly. 3. Outreach ongoing to all leadership teams at the facilities to educate on the importance of product ordering aligning with facility census. LTSS Management team has met with 20/26 facility administrators to provide them with a facility progress report showing their HAI score and product purchasing trends.	
Safety of Clinical Care	Orange County COVID Nursing Home Prevention Program.	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2021. Planned activities include: 1) Outfit OC nursing homes to prevent COVID-19 as soon as possible 2) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 3) Provide guidance, protocols for preventing spread of COVID 4) Support training on how to stock and use protective gear 5) Develop high compliance processes for protection of staff and residents. 6) Make toolkit available for free at www.ucihealth.org/stopcovid	Cathy Osborn/**Scott Robinson**	MC,OC, OCC	This is the final list of all P4V measures for MY2022:	1. Continue to meet with UCI monthly for updates. 2. UCI will continue to monitor 12 nursing facilities via video surveillance. 3. UCI will continue point prevalence sweeps or residents for multidrug-resistant organisms and analyze the results. 4. UCI will conduct a point prevalence sweep of staff and residents from 5 nursing homes during the 2021 winter cold/flu season to detect any resurgence of COVID-19. 5. UCI will produce biweekly video montages and quantified tracking of infection prevention practices for the 12 nursing homes to feedback opportunities for improvement and hardwire prevention practices. All training materials available at: www.ucihealth.org/stopcovid	

Board of Directors' Quality Assurance Committee Meeting
June 8, 2022

Program of All-Inclusive Care for the Elderly
Quality Improvement Committee
First Quarter 2022 Meeting Summaries

February 15th, 2022: Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC) and PACE Infection Control Subcommittee Summary Q4 HPMS Data and Analysis and QAPI Elements

- All PQIC members present
- Infection Control Subcommittee: PACE's Response to COVID-19:
  - Omicron variant surge- increased cases on COVID-19 in January 2022.
  - Continuation of Wellness calls and COVID-screening prior to appointments.
  - Continued coordination of Covid-19 vaccinations for participants, including booster updates. 70% of participants received booster dose already.
  - Per public health order, all PACE staff required to be fully vaccinated with booster dose or must test weekly for COVID-19.
  - Weekly Covid-19 updates are provided during Leadership Meetings.
  - Monthly Covid-19 updates are provided during All-Staff Meetings.
- Presentation of HPMS Elements:
  - Enrollment- Q4 census ended with 421 participants enrolled.
  - Immunizations: Pneumococcal Immunization rate is at 94%. Goal of 94% has been met.
  - Falls Without Injury: Q4 ended with 61 falls without injury. Down from 76 in Q3.
  - Grievances: Number of grievances increased in Q4, mostly transportation related. PACE met with Secure Transportation team. Secure Transportation Grievances Department will now take over investigation and resolution of PACE related grievances.
  - Quality Incidents with Root Cause Analysis: 5 falls with injury, 2 pressure ulcer, 1 burn, 1 elopement were noted. A root cause analysis is conducted for each quality incident
  - Covid-19 Vaccine Quality Initiative: Currently 96.3% of participants are fully vaccinated and we have met the goal of 80%. 70% of eligible participants have also received a booster dose.

Back to Agenda

  - Telehealth Engagement Quality Initiative: New Program Manager will take over this, when they start. Still in process.
  - Immunization Dashboard: Per Clinical Medical Director, there is a new Pneumococcal vaccine, PCV 20, which CDC now recommends as of October 2021. This is a combo of 13 and 23 but is *one shot* as opposed to two. Using this will help providing this vaccine in the future. Is less confusing for prts and will help with vaccine workflow.
- Presentation of Q4 Quality Assurance and Performance Elements:
  - Immunizations
    - Pneumococcal Immunization rate is at 94%. Goal of 94% has been met.
    - Covid-19 Immunizations is at 96%. Goal of 80% has been met.
  - Membership continues to steadily rise. Remained above net goals in Q4 2021 despite COVID-19.
  - POLST: Due to pandemic, social workers have not been able to see participants in person. POLST will now be done with assistance from clinic staff/providers. Q4 ended at 93%. Slightly below goal of 95%
  - Advanced Health Care Directive. Q4 ended 42%, above goal of 40%.
  - Function Status Assessment. Q4 ended 100% of participants had functional assessments done on time.
  - Diabetes Care – Blood Pressure Control. Q4 at 89% and above goal of 81.50%.
  - Diabetic Care – Diabetic Eye Exams. Q4 at 95% and above goal of 85.33%.
  - Diabetic Care – Nephropathy Monitoring. At 100% and above goal of 98.38%, thanks to in-house nephrologist.
  - Falls at Home or in the PACE Center. No fall reported at the center in Q4. Therapy team providing safety education. In terms of recurring falls rate, Q4 was 84% and above goal of 17%. Falls are usually from not following PT's advice or tripping over things (mechanical falls) and medical issues. Also, post COVID-weakness and stiffer joints in cold weather.
  - Potentially Harmful Drug/Disease Interactions in the Elderly.
    - Dementia – above goal for reduced risk
    - CKD – above goal reduced risk
  - Decrease the Use of Opioids at High Dosage. Met goal of 100%. One participant is receiving a dose greater than 90 MME and both had PCP follow up in Q4.
  - Medication Reconciliation Post Discharge. Consistently at 100%.
  - Access to Specialty Care. Once order is received, it is processed within 10 days. Q4 at 87% and met goal of 85%.

Back to Agenda

  - Telehealth Access: Decreased from 66% to 59% as more participant are now being seen face-to-face.
  - Acute Hospital Days: Q4, acute hospital days continue to increase. Per Clinical Medical Director, there is a disconnect between participant, case manager and family. Proposal that after every admission there be a face-to-face patient care conference with case manager, PCP, family, everyone involved to discuss the cause of the admission, plan going forward, specialist consults, medication reconciliation, discussion of palliative care, etc…
  - Emergency Room Visits: Discussion of ER diversion tactics including afterhours phone calls.
  - 30-Day All Cause Readmissions. Q4 is 9%, PACE met goal of less than 15% readmission for the quarter.
  - Long Term Care Placement. Q4 is 2.1% in long ter, custodial. We met goal of less than 4%.
  - Enrollments/Disenrollments. 1 uncontrollable disenrollment in Q4 within 90 days. No controllable disenrollments in Q4 2021, goal was met in Q4.
- Discussion of 2021 Workplan Evaluation and 2022 Workplan
  - 2021 PACE Accomplishments for the year:
    - Swift response to updated regulation regarding the COVID-19 pandemic, to follow all federal, state, and local guidance.
    - Only 2.8% of participants resided in Long-Term Care
    - 94% pneumococcal immunization rate
    - 91% influenza immunization rate
    - 96% COVID-19 immunization rate
    - Quality of Diabetes Care
      - 95% had annual eye exam completed
      - 100% had nephropathy monitoring
      - 89% had blood pressure controlled
    - 100% medication reconciliation rate following a hospital discharge
    - 91% of participants had a Physician's Order of Life-sustaining Treatment (POLST) completed
    - Transportation with 30,696 one-way trips with an on-time performance of 99%
    - Overall participant satisfaction score of 91% compared to national average of 88.5%
    - Met 25 of 29 work plan element goals
  - Opportunities for Improvement in 2022
    - Add COVID-19 booster related quality initiative for 2022

Back to Agenda

- Monitor participants with Osteoporosis diagnosis to ensure that they are receiving treatment to prevent fractures.
- Continued use of the PACE telehealth program
- Reopening of the PACE Day Center based on safety
- Continue the Emergency Room Diversion program
- Increase the number of PACE core specialists willing to work closely with the PACE program

- 2022 Work Plan (changes from 2021 plan)
  - Removed: Infection Control: Respiratory Rates. Consistently above benchmark; Care for Older Adults (COA): Functional Status Assessment. Consistently at 100% and this is tracked elsewhere as a regulatory issue; Advanced Care Planning: Advance Health Care Directive. This will now be a Quality Initiative for 2022; Enrollment/Disenrollment: Disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%. Consistently above benchmark. Will continue to monitor as an operational issue.
  - New Quality Element: Monitoring of participants with diagnosis of Osteoporosis to ensure appropriate management of disease. >= 90% of participants with the diagnosis of Osteoporosis will have treatment initiated by PCP
  - Modified: Changed Falls related element to focus on prevention of Falls with Injury
  - 2022 Quality Initiatives:
    - COVID-19 Vaccine Booster Quality Initiative: Goal of getting at least 80% of eligible participants their COVID-19 booster by the end of December 2022.
    - Telehealth Engagement Quality Initiative: The goal for 2022 is ≥ 66% or participants will have access to telehealth platforms such as VSEE.
    - Advance Health Care Directive: The goal for 2022 is ≥ 50% of participants having a completed AHCD in 2022.
  - Recommended Action: Approve 2022 CalOptima PACE Workplan. PACE Leadership team approved Workplan 2/15/22.

Back to Agenda

A Public Agency

CalOptima

Better. Together.

Member Trend Report 4th Quarter 2021

Quality Assurance Committee Meeting
June 8, 2022

Tyronda Moses, Director, Grievance and Appeals

Back to Agenda

Definitions

- Appeal: A request by the member for review of any decision to deny, modify or discontinue a covered service
- Grievance: An oral or written expression indicating dissatisfaction with any aspect of a CalOptima program
- Quality of Service (QOS): Issues that result in member inconvenience or dissatisfaction
- Quality of Care (QOC): Concerns regarding care the member received or feels should have been received

Back to Agenda

CalOptima
A Public Agency

Medi-Cal Summary

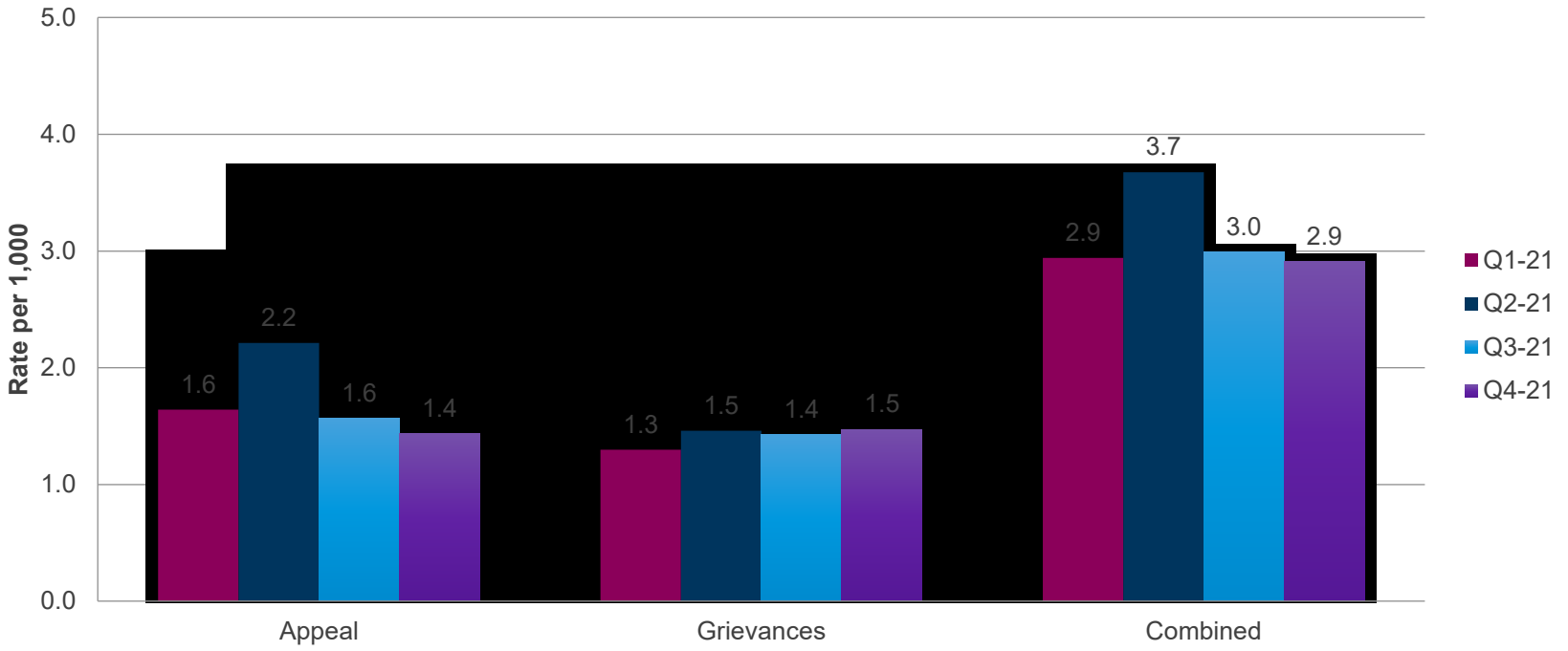
Grievances had an increase of 5% from Q3 2021 to Q4 2021

- Attributing factors:
  - Delays in referrals
  - Member transportation concerns
  - Service issues (billing, providers not on plan, provider services)
- Remediation efforts:
  - Worked daily with UM Team to secure referrals while backlog was also being worked by their Team.
  - Weekly meetings with Veyo to discuss progress in securing additional drivers and rectifying services issues.
  - Reviewing for trends for additional outreach opportunities for member/provider education.

CalOptima
A Public Agency

Back to Agenda

Medi-Cal Total Complaints

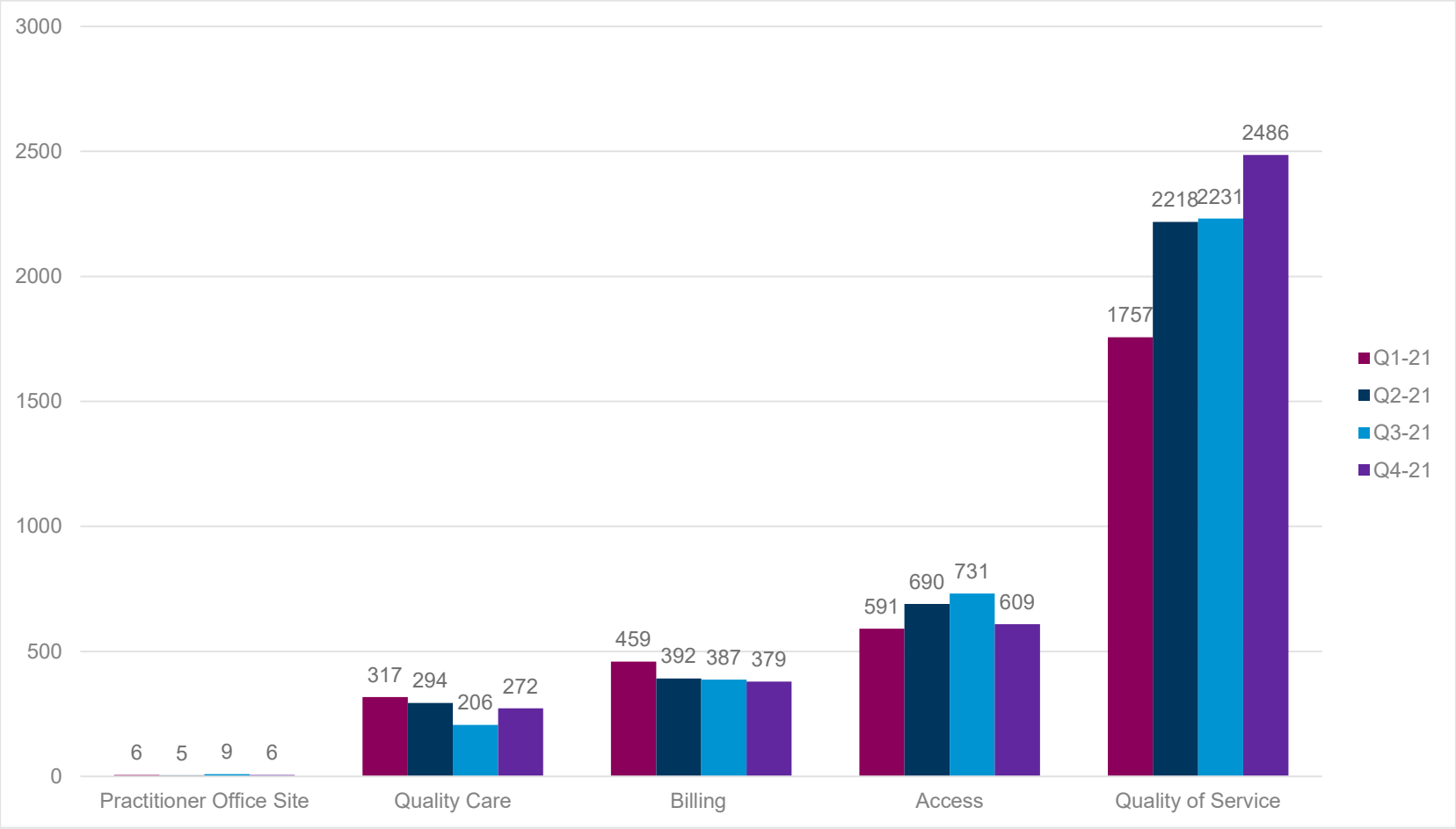


	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2021	3455	325	3130	803,071
Q2-2021	4052	453	3599	811,976
Q3-2021	3893	329	3564	833,634
Q4-2021	4059	307	3752	826,480

CalOptima
A Public Agency

Back to Agenda

Medi-Cal Member Grievances by Category



CalOptima
A Public Agency

Back to Agenda

OneCare Connect Summary

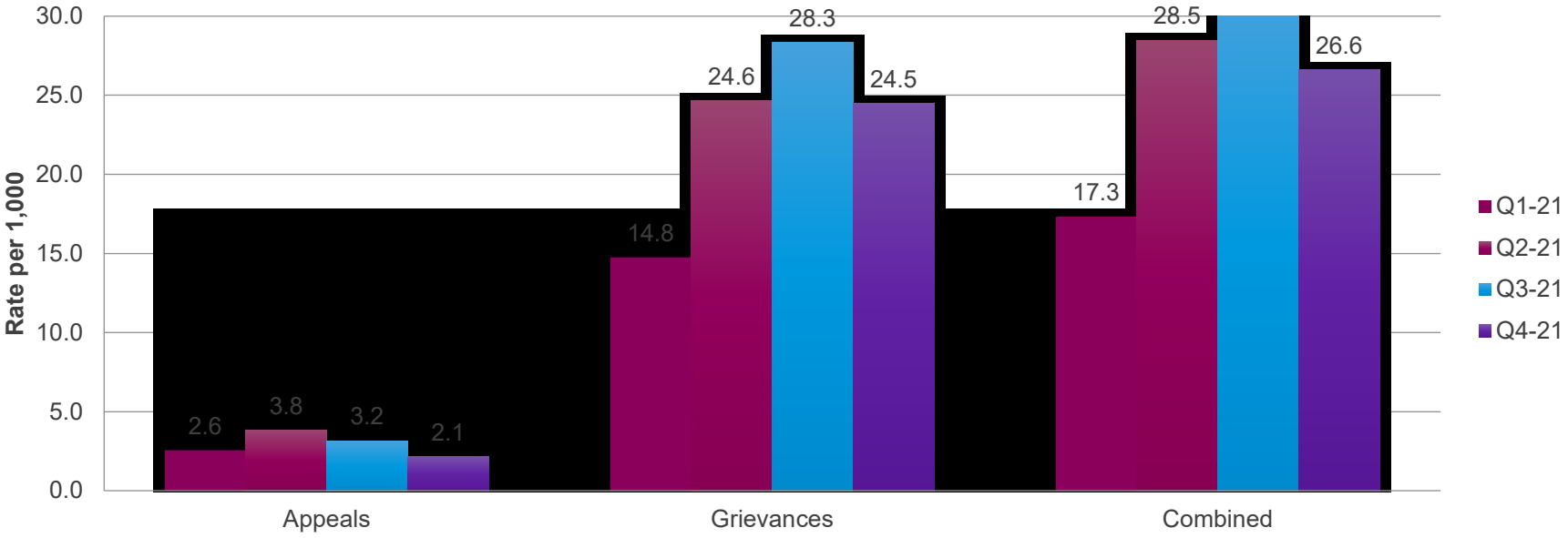
Grievances decreased by 13% from Q3 2021 to Q4 2021

- Attributing factors - decreases were in the following categories:
  - Quality of Service
    - Transportation (Non-medical transportation)
    - Provider/staff demeanor
- Remediation efforts continuing:
    - Reviewing for trends for additional outreach/education
    - Weekly meetings with Veyo to discuss complaints, trends and remediation efforts
    - Notifying Provider Relations of any trends with Providers and/or Health Networks

Back to Agenda

CalOptima
A Public Agency

OneCare Connect Total Complaints



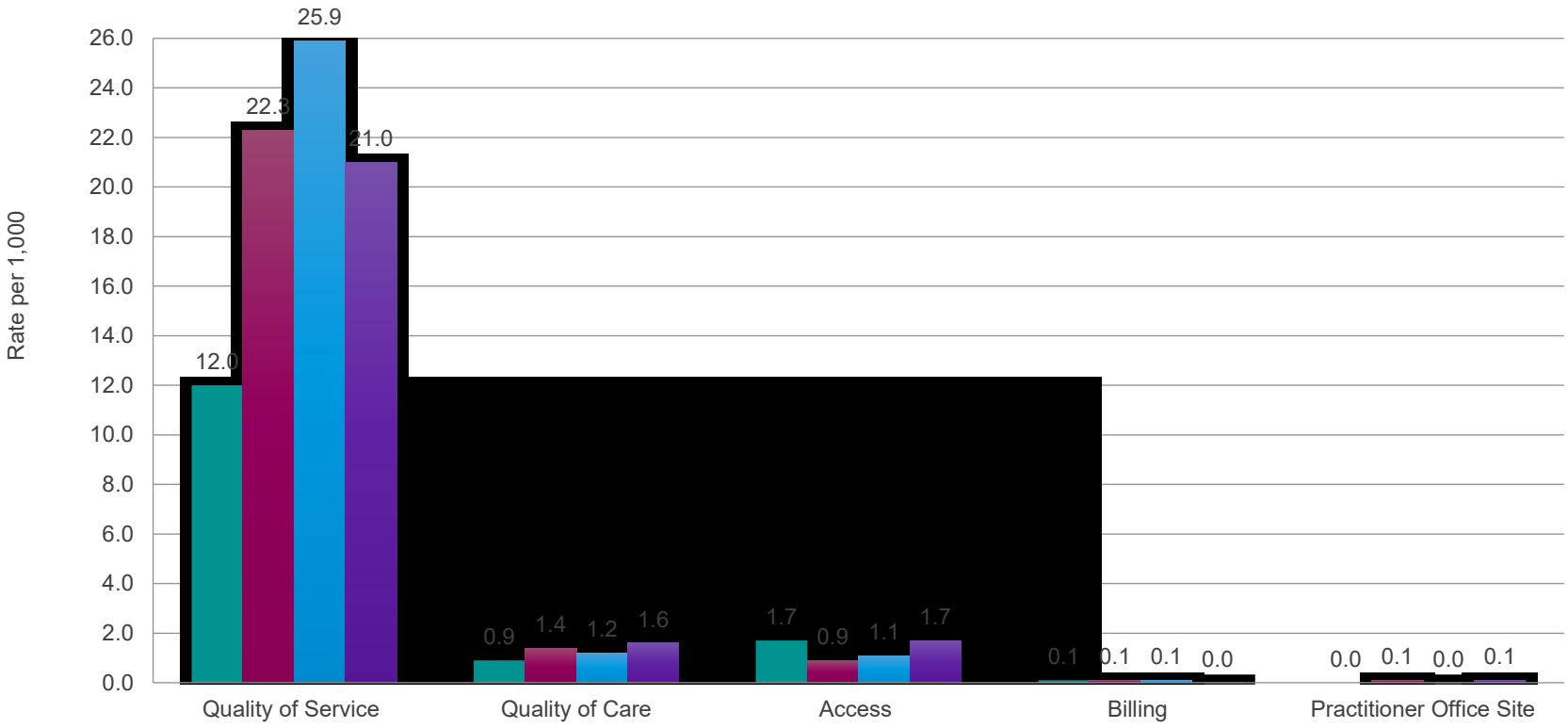
	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2021	256	38	218	14776
Q2-2021	422	57	365	14798
Q3-2021	467	47	420	14828
Q4-2021	397	32	365	14909

Per 1,000 members for OneCare Connect program

Back to Agenda

CalOptima
A Public Agency

OneCare Connect Grievances by Category



Back to Agenda

CalOptima
A Public Agency

OneCare Summary

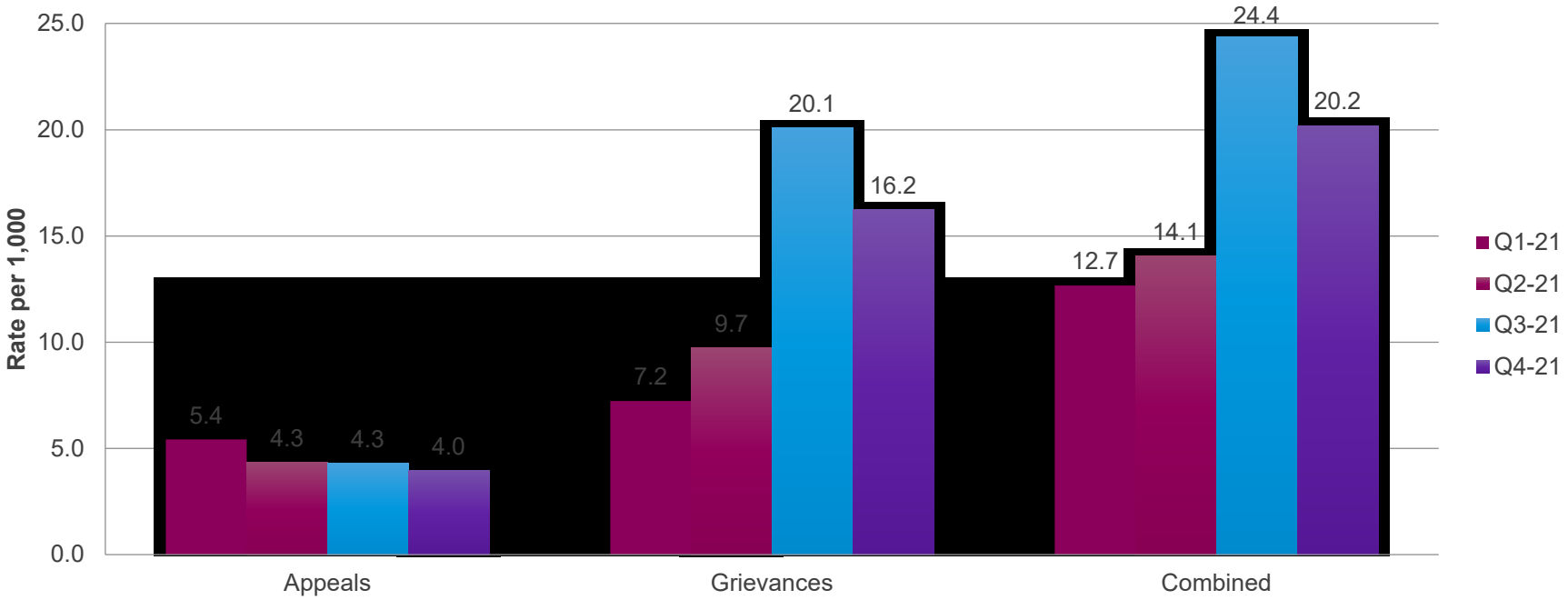
Grievances decreased from 42 in Q3 2021 to 37 in Q4 2021

- Attributing factors:
  - Transportation (NMT) decreased from 12 to 6.
  - Complaints regarding Internal Staff/HN Staff services provided
- Remediation efforts continuing:
  - Reviewing for trends for additional outreach/education
  - Working with our transportation vendor for additional monitoring
  - Education to all stakeholders when inappropriate behavior or incorrect information has been provided.

Back to Agenda

CalOptima A Public Agency

OneCare Total Complaints



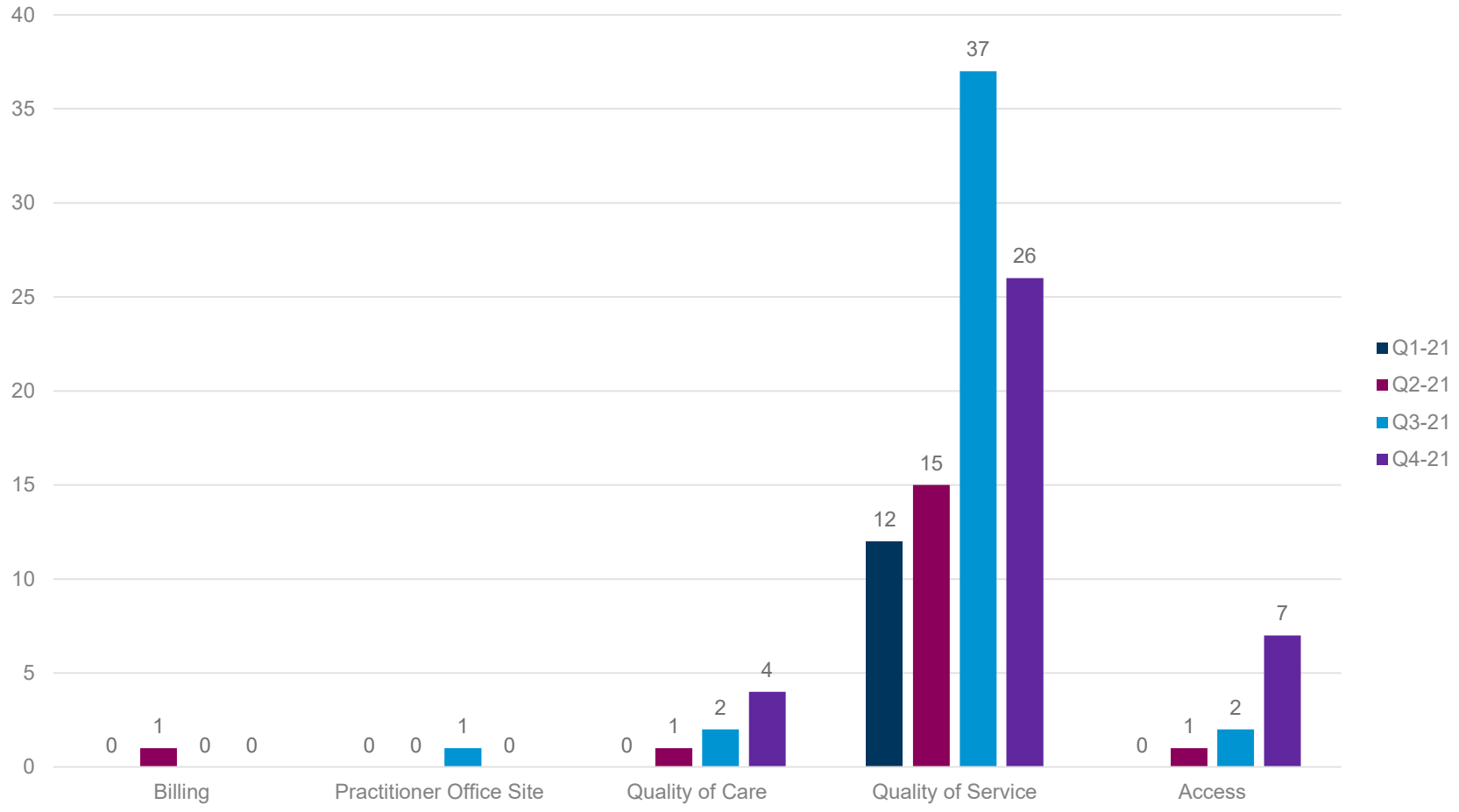
	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2021	21	9	12	1658
Q2-2021	26	8	18	1849
Q3-2021	51	9	42	2092
Q4-2021	46	9	37	2277

Per 1,000 members for OneCare program

Back to Agenda

CalOptima
A Public Agency

OneCare Grievances by Category



CalOptima
A Public Agency

Back to Agenda

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

CalOptima's Vision by 2027

- Same-Day Treatment Authorizations
- Real-Time Claims Payments
- Annual Assessments of Members' Social Determinants of Health

Connect with Us

www.caloptima.org

@CalOptima

CalOptima
A Public Agency

Back to Agenda

A Public Agency

CalOptima

Better. Together.

Health Equity Update

Quality Assurance Committee Meeting
June 8, 2022

Katie Balderas, MPH
Interim Director, Population Health Management

Back to Agenda

What is Health Equity?

- Health equity is when everyone has the power and ability to access resources to be as healthy as possible, regardless of background and identity.
- Health equity is not something that a person can do for themselves alone.
- It requires commitment from community, healthcare organizations and governments to remove obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with a living wage, quality education and housing, safe environments, and health care.

Back to Agenda

CalOptima
A Public Agency

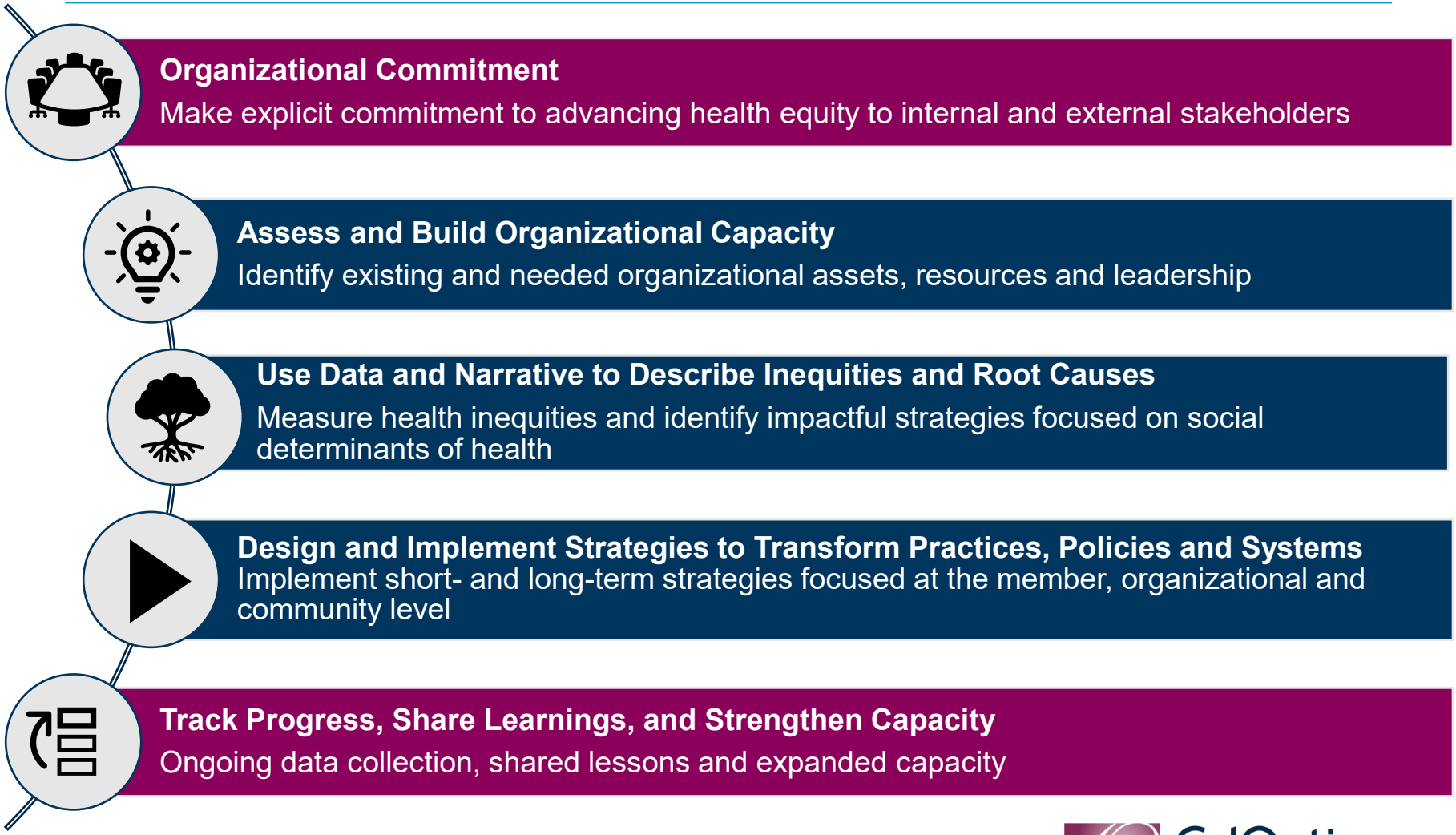
Accomplishments to Date

- Developed Health Equity 101 presentation
- Launched Interdepartmental Health Equity Workgroup
- Developed shared definition of health equity
- Conducted landscape analysis of health equity frameworks
  - IHI, CDC, Robert Wood Johnson Foundation, Human Impact Partners, etc.
- Developed draft health equity framework and currently building out roadmap

Back to Agenda

CalOptima
A Public Agency

CalOptima Health Equity Framework



CalOptima
A Public Agency

Back to Agenda

Thank you!

CalOptima
A Public Agency

Back to Agenda

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

CalOptima's Vision by 2027

- Same-Day Treatment Authorizations
- Real-Time Claims Payments
- Annual Assessments of Members' Social Determinants of Health

Connect with Us

www.caloptima.org

@CalOptima

Back to Agenda

CalOptima
A Public Agency