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

WEDNESDAY, June 12, 2024
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
Maura Byron
José Mayorga, M.D.

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL KENNADAY LEAVITT	CLERK OF THE BOARD
Michael Hunn	Troy R. Szabo	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 materials are available for review at CalOptima Health, 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 Health website at www.caloptima.org.

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at: https://us06web.zoom.us/webinar/register/WN_dX2FT18qS9m6GMcnslNZVw and Join the Meeting.
Webinar ID: **810 3819 0308**
Passcode: **397590** -- 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 13, 2024 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

REPORT/DISCUSSION ITEMS
2. Recommend that the Board of Directors Receive and File a Revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan

3. Recommend that the Board of Directors Approve CalOptima Health's Calendar Year 2025 Member Health Rewards

4. Recommend Appointments to the CalOptima Health Whole-Child Model Family Advisory Committee

ADVISORY COMMITTEE UPDATES
5. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update

6. Whole-Child Model Family Advisory Committee Report

INFORMATION ITEMS
7. Update on Quality Improvement Programs

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

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee on June 12, 2024 at 3:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_dX2FT18qS9m6GMcnslNZVw

To **Join** from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join. .
https://us06web.zoom.us/s/81038190308?pwd=vf6Zr5nSfdK7uGM0cag1hjsGP9jgqf.1

Passcode: **397590**

Or One tap mobile:
+16694449171,,81038190308#,,,,*397590# US
+13462487799,,81038190308#,,,,*397590# US (Houston)

Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 346 248 7799 or +1 719 359 4580 or +1 720 707 2699 or +1 253 205 0468 or +1 253 215 8782 or +1 309 205 3325 or +1 312 626 6799 or +1 360 209 5623 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000 or +1 646 558 8656 or +1 646 931 3860 or +1 689 278 1000 or +1 301 715 8592 or +1 305 224 1968

Webinar ID: **810 3819 0308**
Passcode: **397590**
International numbers available: **https://us06web.zoom.us/u/ksNvrhoMW**

MINUTES

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

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

March 13, 2024

A Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee (Committee) was held on March 13, 2024, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Chair Trieu Tran called the meeting to order at 3:05 p.m., welcomed Maura Byron to the Committee, and asked Director Byron to lead the Pledge of Allegiance.

CALL TO ORDER

Members Present: Trieu Tran, M.D., Chair; Maura Byron
(All Committee members participated in person)

Members Absent: José Mayorga, M.D.

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Troy Szabo, Outside General Counsel, Kennaday Leavitt; Linda Lee, Executive Director, Quality Improvement; Monica Macias, Director, PACE; Sharon Dwiers, Clerk of the Board

MANAGEMENT REPORTS

1. Chief Medical Officer Report

Richard Pitts, D.O., Ph.D., Chief Medical Officer, reviewed the Chief Medical Officer Report with the Committee and started off by providing an update on the Jiva project. Dr. Pitts noted that Jiva, CalOptima Health's care management program, successfully went live on February 1, 2024. He thanked staff for their hard work to meet the target go-live date, noting that approximately 310 million records were transferred from Guiding Care, CalOptima Health's previous care management program, into the new Jiva platform.

Dr. Pitts also provided an update on the Skilled Nursing Facilities (SNF) Access Program. He noted that the purpose of CalOptima Health's SNF Access Program is to enhance quality through better access and further strengthen the safety net system across Orange County for individuals who require SNF post-hospitalization care. Dr. Pitts reported that as of December 2023, CalOptima Health has 68 actively contracted SNFs in Orange County (out of 72 SNFs), 32 SNFs contracted out-of-county, and 16 contracts in progress for both in and out-of-county.

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Dr. Pitts responded to Committee member questions.

PUBLIC COMMENTS
David Robertson, Empathy Now: Oral report regarding Agenda Items 3 and 5.

CONSENT CALENDAR
2. Approve the Minutes of the December 13, 2023, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

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

REPORT/DISCUSSION ITEMS
3. Receive and File 2023 CalOptima Health Quality Improvement Evaluation and Recommend Board of Directors Approval of the 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan
Linda Lee, Executive Director, Quality Improvement, presented the 2023 annual evaluation of CalOptima Health's Quality Improvement (QI) Program. She started with the achievements, noting that in September 2023, for the nineth year in a row, CalOptima Health was among the top performers. Ms. Lee also reported that two community-based organizations honored CalOptima Health for its work in serving vulnerable populations. Community Action Partnership of Orange County presented CalOptima Health with a Community Hero Award for its work on housing and food security, and the Ely Home presented CalOptima Health with a Humanitarian Award for its contributions to serving abused and unhoused children and families. Ms. Lee reported on the many awards that CalOptima Health and its leadership received in 2023.

Ms. Lee reviewed the 2023 priority goals and accomplishments. Priority Goal 1: Developing CalOptima Health's Health Equity Framework. The accomplishments for Priority Goal 1 included developing the framework that begins with assessing organizational readiness and included several milestones to implement interventions, plan activities, and track progress. Priority Goal 2: Improve quality of care and member experience by attaining an NCQA Health Plan Rating of 5.0, and at least a Four-Star Rating for Medicare. The accomplishments for Priority Goal 2 included receiving a four out of five in the NCQA Medicaid Health Plan Ratings in 2023 and receiving an overall Three-Star Rating for Medicare (OneCare). Priority Goal 3: Engage providers through the provision of Pay for Value (P4V) Programs for Medi-Cal, OneCare, and Hospital Quality. The accomplishments for Priority Goal 3 for P4V included generating monthly prospective rate reports for Health Networks (HNs) and CalOptima Health Community Network Clinics; sharing HN report cards with HNs; issuing P4V payment checks in Q4 2023; and adopting the Integrated Healthcare Association (IHA) pay for performance methodology, which aligns with Department of Health Care Services (DHCS) Managed Medi-Cal Accountability for Medi-Cal and CMS Star measures for OneCare. Accomplishments for the P4V Hospital Quality Program in Priority Goal 3 included developing and distributing to each contracted hospital baseline scorecards indicating hospital performance for measure year 2022.

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Ms. Lee reviewed the 2023 QI Evaluation highlights regarding program structure and oversight, program initiatives, performance outcomes, member experience, and patient safety. Ms. Lee also reviewed the recommendations for 2024 based on the 2023 QI Evaluation, which included collaborating with external stakeholders and partners in comprehensive assessments of members; enhancing member and provider data collection to ensure the practitioner network can meet member cultural and linguistic needs; incorporating feedback provided by members and network providers in the design, planning, and implementation of CalOptima Health's continuous quality improvement activities, focusing on access to care; incorporating social determinants of health factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs; and strategizing and streamlining member outreach by using multiple modes of communication via contracted external vendors, including through website, direct mailings, email, interactive voice response calls, mobile texting, targeted social media campaigns and robocall technology.

Ms. Lee reviewed in detail the 2024 QI Program and Work Plan, including the following priority areas: Maternal Health; Children's Preventive Care; Behavioral Health Care; and Program Goals. She also highlighted the revisions for 2024, including incorporating a health equity focus into the QI Program, now named Quality Improvement and Health Equity Transformation Program (QIHETP). CalOptima Health updated priority areas and goals, updated sections in the QIHETP to reflect current operational processes and workflows for NCQA accreditation, grievance and appeals, and encounter data review. Ms. Lee reviewed the updated program staffing and resources to reflect the current organizational structure, which included adding a Chief Health Equity Officer, adding additional Medical Directors to support a medical model, adding a Director, Medicare Stars and Quality Initiatives, and adding a Director, Medicare Programs. She also reviewed in detail the 2024 annual work plan focus areas as well as revisions in the 2024 program structure and oversight, quality of clinical care, and quality of service and safety of clinical care.

Ms. Lee and Michael Hunn, Chief Executive Officer, responded to Committee members' questions and comments.

CalOptima Health received public comment from Dave Robertson, Empathy Now on this item.

Action: ***On motion of Chair Tran, seconded and carried, the Committee recommended that the Board of Directors receive and file the 2023 CalOptima Health Quality Improvement Evaluation, and recommend the Board of Directors approve the 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan. n. (Motion carried 2-0-0; Director Mayorga absent)***

4. Recommend that the Board of Directors Approve the 2023 CalOptima Health Utilization Management Program Evaluation and the 2024 CalOptima Health Integrated Utilization Management/Case Management Program Description

Kelly Giardina, Executive Director, Clinical Operations, reviewed the 2023 CalOptima Health Utilization Management (UM) Program Evaluation, noting that the lookback period was the fourth quarter of 2022 through the third quarter of 2023. Ms. Giardina also noted that the UM program description is revised each year based on the previous year's evaluation to ensure ongoing alignment

with evolving healthcare standards and to optimize UM performance. Ms. Giardina reviewed the accomplishments for the lookback period, which included adding Medical Directors with expertise in internal medicine, emergency medicine and trauma, child/adolescent psychiatry and pharmacy, and family addiction medicine. Additional accomplishments included improved reporting and workflows to prioritize treatment authorization to exceed turnaround time; provider portal enhancements and the design, configuration, and preparation for the new medical management clinical documentation platform Jiva, which went live in February 2024. Ms. Giardina reviewed other improvements and enhancements in the 2023 UM Program Evaluation, which included, refinement of hospital utilization measurement, including bed days goals; launched a brain/spine/pain care coordination workgroup; continuity-of-care protocol refinements, and transplant program enhancements. Ms. Giardina reported in detail key takeaways of the 2023 UM Program Evaluation, including areas of focus and opportunities for improvement.

Stacie Oakley, RN, Director, Utilization Management, reviewed the 2024 UM Program goals and initiatives based on the outcomes of the 2023 UM Program Evaluation. Ms. Oakley noted the goal of the UM program is to manage appropriate utilization of medically necessary covered services to ensure access to quality and cost-effective health care for CalOptima Health members through timely and efficient treatment authorizations; coordination and continuity of care; support of members through transition of care, including addressing complex discharge needs; oversight and support of access, availability, and timeliness of care; member and provider satisfaction; identifying and addressing over and under-utilization of care; and the promotion of health literacy, prevention and improved member outcomes. She reported that CalOptima Health's integration of Quality Program Initiatives, such as the Comprehensive Community Cancer Screening and Support Program that was launched in January 2023 and the five-year Hospital Quality Program (2023-2027), are designed to improve member quality of care through early detection of cancers and increased patient safety efforts through performance-driven processes. Ms. Oakley also reported that CalOptima Health and DHCS combined strategic goals for maternal health, children's preventive care, and behavioral health care, providing details of the combined strategic goals. She also reviewed various topics discussed at the CalOptima HN Forums, where HNs and CalOptima Health have joint discussions on programmatic enhancements and changes to the implementation and operation of medical management programs. Ms. Oakley also reviewed the various UM sub-workgroups created to ensure member needs are addressed on a timely basis to produce the best outcomes.

Ms. Giardina and Mr. Hunn responded to Committee members' questions and comments and provided additional details.

Action: ***On motion of Chair Tran, seconded and carried, the Committee recommended Board of Directors' approval of the 2023 CalOptima Health Utilization Management Program Evaluation, and recommended Board of Directors' approval of the 2024 CalOptima Health Integrated Utilization Management and Case Management Program Description. (Motion carried 2-0-0; Director Mayorga absent)***

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5. Receive and File 2023 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation and Recommend Board of Directors Approval of the 2024 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Donna Frisch, M.D., PACE Medical Director, presented the 2023 CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan Evaluation and the CalOptima Health PACE QI Plan for 2024. Dr. Frisch started with the PACE accomplishments for 2023, which included maintaining all guidance through the end of the COVID-19 Public Health Emergency and PACE's collaboration with CalOptima Health Long Term Support Services (LTSS) to significantly reduce the number of PACE participants residing in long-term care facilities. She also shared that PACE had an 89% influenza and 93.5% pneumococcal immunization rates by the fourth quarter of 2023. For quality of diabetes care, 89% of the annual eye exams were completed and 100% of nephropathy monitoring of diabetic members. Dr. Frisch also shared that CalOptima Health had a rate of 100% medication reconciliation within 10 days following a hospital or skilled nursing discharge and 96% of PACE participants had a Physician's Order for Life-sustaining Treatment (POLST) completed. She added that the CalOptima Health PACE overall participant satisfaction score was 94% compared to the national average of 88.6% and the CalPACE score of 89%. Dr. Frisch reviewed PACE workplan elements and scores achieved in 2023. She also reviewed in detail the opportunities for improvement in 2024.

Dr. Frisch and Mr. Hunn responded to Committee members' questions and comments and provided additional details regarding the PACE QI Plan.

Action: ***On motion of Chair Tran, seconded and carried, the Committee recommended that the Board of Directors' Receive and File the 2023 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan Evaluation, and recommended that the CalOptima Health Board of Directors approve the 2024 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan. (Motion carried 2-0-0; Director Mayorga absent)***

6. Recommend that the Board of Directors Approve Recommendation for Vice Chair Appointment to the Whole-Child Model Family Advisory Committee

Yunkyung Kim, Chief Operating Officer, introduced this item.

Action: ***On motion of Director Byron, seconded and carried, the Committee recommended that the Board of Directors approve the appointment of Erika Jewell as the Vice Chair to fulfill a remaining term through June 30, 2025 as recommended by the Whole-Child Model Family Advisory Committee. (Motion carried 2-0-0; Director Mayorga absent)***

ADVISORY COMMITTEE UPDATES

Chair Tran noted that the Advisory Committee Updates for Agenda Items 7 and 8 were in the meeting materials, unless there were questions from Committee members.

7. Program of All-Inclusive Care for the Elderly Members Advisory Committee Update

8. Whole-Child Model Family Advisory Committee Report

INFORMATION ITEMS

9. Applied Behavior Analysis and Behavioral Health Pay-for-Value Program

Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration, provided an overview of the Applied Behavior Analysis (ABA) and Behavioral Health (BH) P4V Programs. By way of background, Ms. Katsarov reviewed the previous ABA P4V Program timeframe, which was January 2, 2021, to December 31, 2022, with the P4V Program Evaluation taking place between December 2022 and March 2023. CalOptima Health contracted with an ABA consultant who met with ABA providers during that time and learned that CalOptima Health needed a clearer understanding of the data used, more frequent payouts of incentive dollars, and to increase collaboration. Ms. Katsarov reviewed in detail the new ABA P4V Program elements, including the target percentage and the weighting of those targets. She also reviewed the program methodology, which included data collection, measurement and scoring methodology, the provider attestation form, the care experience digital parent survey, and the measurement period and payout. Ms. Katsarov noted that providers will be able to earn up to 10% of the paid claims during each measurement period by achieving any or all the program elements. She also reviewed in detail the BH P4V methodology, including measurement set and benchmarks, as well as the measurement period and payout.

Ms. Katsarov responded to Committee members' questions and comments.

The following items were accepted as presented.

10. Quarterly Reports to the Quality Assurance Committee
    a. Quality Improvement Health Equity 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 4:57 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: June 12, 2024

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 12, 2024
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

2. Recommend that the Board of Directors Approve the Revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, Medical Management, (714) 246-8491
Linda Lee, MPH, Executive Director, Quality Improvement, (714) 867-9655

Recommended Actions

Recommend that the Board of Directors approve the revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan.

Background

CalOptima Health's Quality Improvement and Health Equity Transformation Program (QIHETP) encompasses all clinical care, health and wellness services, and customer service provided to its members, which aligns with CalOptima Health's vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all members. The QIHETP is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks.

CalOptima Health's QIHETP is reviewed, evaluated, and approved annually by the Board of Directors. The QIHETP defines the structure within which quality improvement (QI) and health equity activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima Health members.

Discussion

CalOptima Health staff has revised the 2024 QIHETP and Workplan to ensure that it is aligned with health equity and cultural linguistic improvement efforts and requirements. This will ensure that all regulatory requirements and National Committee for Quality Assurance (NCQA) Health Plan and Health Equity accreditation standards are met in a consistent manner across the organization.

The revised 2024 QIHETP is based on the 2024 QIHETP approved by the Board of Directors in April 2024 and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all lines of business to ensure they are consistent with regulatory requirements, NCQA standards, and CalOptima Health's strategic initiatives.

The revisions are summarized as follows:

1. Updated QIHETP staffing and resources to reflect current organizational structure with a renamed Equity and Community Health Department (formerly known as the Population Health Management Department).

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2. Updated sections in the QI Program to reflect current operational processes and workflows.
3. Added the Cultural and Linguistic Appropriate Services Program to the QIHETP as Appendix D.
4. Added cultural linguistic and health equity goals and planned activities to the QIHETP Annual Work Plan.

The recommended changes to CalOptima Health's QIHETP reflect current clinical operations and are necessary to meet the requirements specified by the Centers for Medicare and Medicaid Services and the Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact

The recommended action to approve the revised 2024 QIHETP and Work Plan has no additional fiscal impact beyond what was incorporated in the proposed Fiscal Year 2024-25 Operating Budget.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Revised 2024 Quality Improvement and Health Equity Transformation Program and Work Plan DRAFT FINAL (Redline version)
2. Revised 2024 Quality Improvement and Health Equity Transformation Program and Work Plan DRAFT FINAL (Clean version)
3. PowerPoint Presentation: 2024 Revised Quality Improvement and Health Equity Transformation Program and Work Plan

/s/ Michael Hunn *06/07/2024*
Authorized Signature **Date**

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2024 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

EFFECTIVE DATE: APRIL 1~~JANUARY 1~~, 2024 TO DECEMBER 31, 2024

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2024 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM SIGNATURE PAGE

Quality Improvement and Health Equity Committee Chairperson:

_____ _____

Richard Pitts, D.O., Ph.D. **Date**
CalOptima Health Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Trieu Tran, M.D. **Date**

Board of Directors Chairperson:

_____ _____

Clayton M. Corwin **Date**

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CalOptima Health Overview

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

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health (SDOH).

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

Our Strategic Plan

CalOptima Health's Board of Directors and executive team worked together to develop our 2022–2025 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in June 2022. Our core strategy is the "inter-agency" co-creation of services and programs, together with our delegated networks, providers and community partners, to support the mission and vision.

The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

CalOptima Health aligns our strategic plan with the priorities of our federal and state regulators.

Centers for Medicare & Medicaid Services (CMS) National Quality Strategy

The CMS national quality strategy aims to set and raise the bar for a resilient, high-value health care system that promotes quality outcomes, safety, equity and accessibility for all individuals, especially for people in historically underserved and under-resourced communities. The strategy focuses on a person-centric approach from birth to end of life as individuals journey across the continuum of care, from home or community-based settings to hospital to post-acute care, and across payer types, including Traditional Medicare, Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP) and Marketplace coverage.

Quality Mission: To achieve optimal health and well-being for all individuals.

Quality Vision: As a trusted partner, shape a resilient, high-value American health care system to achieve high-quality, safe, equitable and accessible care for all.

CMS National Quality Strategy has four priority areas, each with two goals.

1. Outcomes and Alignment
    a. Outcomes: Improve quality and health outcomes across the care journey.
    b. Alignment: Align and coordinate across programs and settings.
2. Equity and Engagement
    a. Advance health equity and whole-person care.
    b. Engage individuals and communities to become partners in their care.
3. Safety and Resiliency
    a. Safety: Achieve zero preventable harm.
    b. Resiliency: Enable a responsive and resilient health care system to improve quality.
4. Interoperability and Scientific Advancement
    a. Interoperability: Accelerate and support the transition to a digital and data-driven health care system.

b. Scientific Advancement: Transform health care using science, analytics and technology.

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 CQS lays out DHCS' quality and health equity strategy that leverages a whole-system, person-centered, and population health approach to support a 10-year vision for Medi-Cal, whereby people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM) and emphasize DHCS' commitment to health equity, member involvement and accountability in all program initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and member-centered chronic disease management
- Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement

CQS outlines specific clinical goals across the Medi-Cal program. Centered on specific clinical focus areas, the CQS introduces DHCS' Bold Goals: 50x2025 initiative that, in partnership with stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025.

Bold Goals: 50x2025:

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow-up for mental health and substance disorder by 50%
- Ensure all health plans exceed the 50th percentile for all children's preventive care measures

DHCS recognizes that inequities are embedded within our health care system. DHCS has developed a Health Equity Framework to identify, catalog and eliminate health disparities through:

- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention).

SDOH are the conditions that exist in the places where people are born, live, learn, work, play, worship and age that affect health outcomes (Henry J. Kaiser Family Foundation).

In response to CalOptima Health's strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes and designing a comprehensive intervention plan to planning and tracking progress. It begins with a comprehensive readiness assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.

Program Structure

"Better. Together." Is CalOptima Health's motto, and it means that by working together, we can make things better — for our members and community. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's single largest health insurer, we provide coverage through three major programs:

Medi-Cal

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

Scope of Services

Under our Medi-Cal program, CalOptima Health provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) Program that began in 2019.

CalOptima Health provides Enhanced Care Management (ECM) and all 14 Community Supports to address social drivers of health and assist members with finding stable or safe housing, accessing healthy food, transitioning back to home or getting support in the home.

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

- Specialty mental health services are administered by the Orange County Health Care Agency (OCHCA)
- Substance use disorder services are administered by OCHCA
- Dental services are provided through the Medi-Cal Dental Program

Members With Special Health Care Needs

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

Additionally, CalOptima Health works with community programs to ensure that members with special health care needs (or with high-risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with

certain community agencies, including OCHCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

On July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Health Medi-Cal members. CalOptima Health ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS includes both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

These integrated LTSS benefits include the following programs:

- In-Home Supportive Services (IHSS): IHSS provides in-home assistance to eligible aged, blind and disabled individuals as an alternative to out-of-home care and enables members to remain safely in their own homes.

- Nursing Facility Services for Long-Term Care: CalOptima Health LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B and Subacute levels of care. CalOptima Health LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

- Community-Based Adult Services (CBAS): CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. CalOptima Health LTSS monitors the levels of member access to, utilization of and satisfaction with CBAS.

- Multipurpose Senior Services Program (MSSP): Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid institutionalization. CalOptima Health LTSS monitors the level of member access to MSSP as well as its role in diverting members from institutionalization.

OneCare (HMO D-SNP)

Our OneCare members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for them to get the health care they need. Since 2005, CalOptima Health has been offering OneCare to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OneCare has extensive experience serving the complex needs of frail, disabled, dual-eligible members in Orange County.

To be a member of OneCare, a person must be age 21 or older, live in Orange County and be eligible for both Medicare and Medi-Cal. Enrollment in OneCare is voluntary and by member choice.

Scope of Services

OneCare provides comprehensive services for dual eligible members enrolled in Medi-Cal and Medicare Parts A, B and D. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member. CalOptima Health monitors quality for OneCare through regulatory measures, including Part C, Part D and CMS Star measures.

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, OneCare members are eligible for supplemental benefits, such as gym memberships.

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

CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

PACE combines health care and adult day care for people with multiple chronic conditions. These can be offered in the member's home, in the community or at the CalOptima Health PACE Center:

1. Routine medical care, including specialist care
2. Prescribed drugs and lab tests
3. Personal care for things like bathing, dressing and light chores
4. Recreation and social activities
5. Nutritious meals
6. Social services
7. Rides to health-related appointments, and to and from the program
8. Hospital care and emergency services

PACE maintains a separate PACE Quality Improvement Program, work plan and evaluation.

Provider Partners

Providers have options for participating in CalOptima Health's programs to provide health care to CalOptima Health members. Providers can contract directly with CalOptima Health through CalOptima Health Direct, which consists of CalOptima Health Direct-Administrative and CalOptima Health Community Network (CCN). Providers also have the option to contract directly with a CalOptima Health Health Network (HN). CalOptima Health members can choose CCN or one of nine HNs representing more than 8,000 providers.

CalOptima Health Direct (COD)

CalOptima Health Direct has two elements: CalOptima Health Direct-Administrative and CCN.

CalOptima Health Direct-Administrative (COD-A)

COD-A is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in OneCare), share-of-cost members, newly eligible members transitioning to a HN and members residing outside of Orange County.

CalOptima Health Community Network (CCN)

CCN doctors have an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and available for HN-eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Health Contracted Health Networks

CalOptima Health has contracts with delegated HNs through a variety of risk models to provide care to members. The following contract risk models are currently in place:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to more than 1,200 Primary Care Providers (PCPs), more than 9,000 specialists, 43 acute and rehabilitative hospitals, 52 community health centers and 106 long-term care facilities.

CalOptima Health contracts with the following HNs:

Health Network	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
AMVI Care Medical Group	PHC	PHC
CHOC Health Alliance	PHC	-
Family Choice Medical Group	HMO	SRG
HPN-Regal Medical Group	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Optum Care Network	HMO	HMO
Prospect Medical Group	HMO	HMO
United Care Medical Group	SRG	SRG

CalOptima Health contracts with vendors that provide benefits for our members. These vendors are responsible for maintaining a contracted network of providers, coordinating services and providing direct services. They may also be delegated for plan functions.

Vendor	Medi-Cal	OneCare
Vision Service Plan	VS	VS
MedImpact	-	PBM

HMO=Health Maintenance Organization; PHC=Physician/Hospital Consortium; SRG=Shared-Risk Group; VS=Vision Service; PBM=Pharmacy Benefit Manager

Upon successful completion of readiness reviews and audits, contracted entities may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex care management
- Claims
- Credentialing

Membership Demographics

Membership Data* (as of November 30, 2023)

Total CalOptima Health Membership

963,968

Program	Members
Medi-Cal	945,874
OneCare (HMO D-SNP)	17,648
Program of All -Inclusive Care for the Elderly (PACE)	446

*Based on unaudited financial report and includes prior period adjustment

Membership Demographics (as of November 30, 2023)

Member Age

0 to 5	8%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65+	13%

Language Preference

English	58%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category

Temporary Assistance for Needy Families	39%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Quality Improvement and Health Equity Transformation Program (QIHETP)

CalOptima Health's Quality Improvement and Health Equity Transformation Program (QIHETP) encompasses all clinical care, health and wellness services, and quality of service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all members.

CalOptima Health developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and subacute care to long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, special health care needs and chronic illnesses.

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

CalOptima Health is committed to promoting diversity in practices throughout the organization, including Human Resources best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias and inclusion.

Quality Improvement and Health Equity Transformation Program (QIHETP) Purpose

The purpose of the CalOptima Health QIHETP is to establish objective methods for systematically evaluating and improving the quality of care provided to members. Through the QIHETP, and in collaboration with providers and community partners, CalOptima Health strives to continuously improve the structure, processes and outcomes of the health care delivery system to serve members. We aim to identify health inequities and to develop structures and processes to reduce disparities, ensuring that all members receive equitable and timely access to care.

CalOptima Health applies the principles of continuous quality improvement (CQI) to all aspects of service delivery system through analysis, evaluation and systematic enhancements of the following:

- Quantitative and qualitative data collection and data-driven decision-making
- Up-to-date evidence-based practice guidelines
- Feedback provided by members and providers in the design, planning and implementation of CQI activities
- And other issues identified by CalOptima Health or its regulators

The CalOptima Health QIHETP incorporates the CQI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima Health's multiple customers and

stakeholders (members, health care providers, community-based organizations and government agencies). The QIHETP is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima Health's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.

- Focus on quality improvement and health equity activities carried out on an ongoing basis to support early identification and timely correction of quality-of-care issues to ensure safe care and experiences.

- Maintain organizationwide practices that support health plan and health equity accreditation by National Committee for Quality Assurance (NCQA) and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QIHETP's ongoing responsibilities include the following:

- Setting expectations to develop plans to design, measure, assess and improve the quality of the organization's governance, management, delivery system and support processes.

- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers. Recommending delivery system reform to ensure high quality and equitable health care.

- Monitoring quality of care and services from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

- Ensuring contracted facilities, as required by federal and state laws, report to OCHCA outbreaks of conditions and/or diseases, which may include but are not limited to methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, and since 2020, COVID-19.

- Promoting member safety and minimizing risk through the implementation of safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related organizational providers (OPs) to ensure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement and health equity culture at CalOptima Health.

- Ensure the annual review and acceptance of the UM CM Program Description, UM CM Evaluation Population Health Programs, including the Population Health Strategy and Work Plans.

- Provide operational support and oversight to a member-centric Population Health Management (PHM) Program.

In collaboration with the Compliance Audit & Oversight departments, the QIHETP ensures the following standards or outcomes are carried out and achieved by CalOptima Health's contracted HNs, including CCN and/or COD network providers serving CalOptima Health's various populations:

- Support the organization's strategic quality and business goals by using resources appropriately, effectively and efficiently.
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- Identify in a timely manner the important clinical and service issues facing the Medi-Cal and OneCare populations relevant to their demographics, risks, disease profiles for both acute and chronic illnesses, and preventive care.
- Ensure continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities.
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population.
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.
- Ensure the reliability of risk prevention and risk management processes.
- Ensure compliance with regulatory agencies and accreditation standards.
- Ensure the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans.
- Promote the effectiveness and efficiency of internal operations.
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs.
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima Health's strategic direction in support of its mission, vision and values.
- Ensure compliance with up-to-date Clinical Practice Guidelines and evidence-based practice.

Authority and Accountability

Board of Directors

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement and Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

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

The QIHETP is based on ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QIHETP in alignment with federal and state regulations, contractual obligations, and fiscal parameters.

CalOptima Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QIHETP and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity contractual and regulatory standards and the DHCS Comprehensive Quality Strategy. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QIHETP and the Work Plan of the QIHETP.

Member Advisory Committee

CalOptima Health is committed to member-focused care through member and community engagement. The Member Advisory Committee (MAC) has 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operations and evaluation of the overall QIHETP. The MAC provides advice and recommendations on

community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- Medi-Cal beneficiaries or Authorized Family Members (two seats)
- Member Advocate
- County of Orange Social Services Agency (OC SSA)
- OneCare Member or Authorized Family Members (-four seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

One of the 17 positions, held by OCSSA, is a standing seat. Each of the remaining 16 appointed members may serve two consecutive three-year terms.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. The PAC members represent the broad provider community that serves CalOptima Health members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of OCHCA, which maintains a standing seat. PAC meetings are open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- OCHCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC includes the following 11 voting seats:

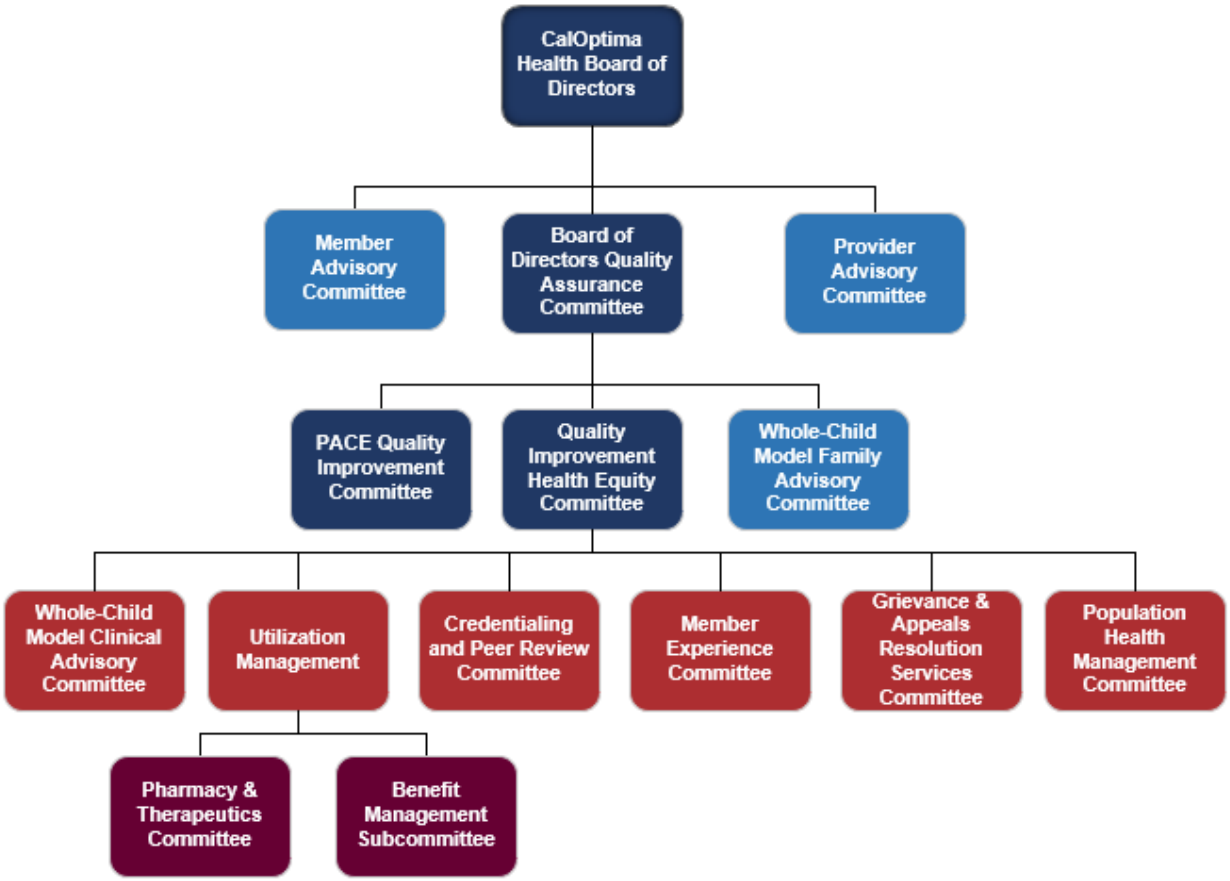
- Family representatives (nine seats)
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
    - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
    - Current CalOptima Health members over the age of 21 who transitioned from CCS services

- Interests of children representatives (two seats)
    - Community-based organizations; or
    - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC quarterly meetings are open to the public.

Quality Improvement and Health Equity Transformation Program Committee Structure

Quality Improvement and Health Equity Transformation Program Committee Organization Structure — Diagram



Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is the foundation of the QIHETP and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer (CHEO), and in collaboration, develop and oversee the QIHETP and QIHETP Work Plan activities.

The purpose of the QIHEC is to assure that all QIHETP activities are performed, integrated and communicated internally and to the contracted delegated HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

The composition of the QIHEC includes a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, subcontractors, downstream

subcontractors, community health workers, other non-clinical providers and members. The QIHEC participants are representative of the composition of the CalOptima Health's provider network and include, at a minimum, network providers who provide health care services to members affected by health disparities, Limited English Proficiency (LEP) members, children with special health care needs, Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions. QIHEC participants are practitioners who are external to CalOptima Health, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, care review as needed, and identification of opportunities to improve care.

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

Responsibilities of the QIHEC include:

- Analyze and evaluate the results of QIHE activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other quality committees
- Recommend policy decisions and priority alignment of the QIHETP subcommittees for effective operation and achievement of objectives
- Oversee the analysis and evaluation of QIHETP activities
- Ensure practitioner participation through attendance and discussion in the planning, design, implementation and review of QIHETP activities
- Identify, prioritize and institute needed actions and interventions to improve quality
- Ensure appropriate follow up of quality activities to determine the effectiveness of quality improvement-related actions and remediation of identified performance deficiencies.
- Monitor overall quality compliance for the organization to quickly resolve deficiencies that affect members
- Evaluate practice patterns of providers, practitioners and delegated HNs, including over/under utilization of physical and behavioral health care services
- Recommend practices so that all members receive medical and behavioral health care that meets CalOptima Health standards.

The QIHEC oversees and coordinates member outcome-related QIHE actions. Member outcome-related QIHE actions consist of well-defined, planned QIHE projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services. The QIHEC also recommends strategies for dissemination of all study results to CalOptima Health-contracted providers and practitioners, and delegated HNs.

The composition of the QIHEC is defined in the QIHEC charter and includes but is not limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- Orange County Behavioral Health Representative
- CalOptima Health Chief Medical Officer (Chair or Designee)
- CalOptima Health Chief Health Equity Officer (Chair or Designee)
- CalOptima Health Deputy Chief Medical Officer
- CalOptima Health Quality Improvement Medical Director
- CalOptima Health Behavioral Health Integration Medical Director
- CalOptima Health Medical Directors
- CalOptima Health Executive Director, Quality Improvement
- CalOptima Health Executive Director, ~~Population Health Management~~Equity and Community Health
- CalOptima Health Executive Director, Behavioral Health Integration
- CalOptima Health Executive Director, Clinical Operations
- CalOptima Health Executive Director, Network Management
- CalOptima Health Executive Director, Operations

The QIHEC is supported by CalOptima Health departments including but not limited to:

- Behavioral Health Integration
- Care Management
- Long-Term Services and Supports
- ~~Population Health Management~~Equity and Community Health
- Quality Analytics
- Quality Improvement
- Utilization Management
- Director, Customer Service
- Cultural and Linguistic Services

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person, by telephone or by video conference.

The QIHEC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

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

Minutes of the QIHEC and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the committee chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIHEC meeting include but are not limited to:

- Goals and objectives outlined in the QIHEC charter
- Active discussion and analysis of quality improvement and health equity activities, outcomes, and issues
- Reports from various committees and subcommittees
- Tracking and trending of quality outcomes
- Recommendations for improvement, actions and follow-up actions
- Monitoring of quality improvement and health equity activities of delegates
- Plans to disseminate QIHE information to network providers
- Tracking of QIHETP Work Plan activities

All agendas, minutes, reports and documents presented to the QIHEC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

The QIHEC provides to the QAC quarterly written progress reports of the QIHEC that describes actions taken, progress in meeting QIHETP objectives, and improvements made. A written summary of the QIHEC's quarterly activities is also publicly available on the CalOptima Health website.

Under the QIIHETP, there are six subcommittees that report, at minimum, quarterly to the QIHEC.

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima Health practitioner and provider selection process and determines corrective actions, as necessary, to ensure that all practitioners and providers who serve CalOptima Health members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima Health practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima Health's contracted providers, delegated HNs and OPs to ensure member safety aiming for zero defects. The CPRC, chaired by the CalOptima Health CMO or physician designee, consists of CalOptima Health Medical Directors and physician representatives from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima Health's network. CPRC meets a minimum of six times per year and reports through the QIHEC quarterly. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

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

The UMC monitors the utilization of medical, BH and LTSS services for CCN and delegated HNs to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other organization standards. These clinical practice guidelines and nationally recognized evidence-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIHEC. The voting member composition (including a BH practitioner*) and the quorum requirements of the UMC are defined in its charter.

* BH practitioner is defined as Medical Director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost-effective pharmaceutical care for all CalOptima Health members. It reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima Health members. The P&T includes practicing physicians (including both CalOptima Health employee physicians and participating provider physicians), and the membership represents a cross-section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all members. The P&T provides written decisions regarding all formulary development decisions and revisions. The P&T meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate and maintain a consistent benefit system as it relates to CalOptima Health's responsibilities for administration of member benefits, prior authorization and financial responsibility requirements. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima Health staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance department provides technical support to the subcommittee, which includes analyzing regulations and guidance that impacts the benefit sets and CalOptima Health's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima Health WCM program. The WCM CAC works in collaboration with county CCS, the WCM FAC and HN CCS providers. The WCM CAC meets four times a year and reports to the QIHEC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima Health. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system. NCQA's Health Insurance Plan Ratings measure three dimensions: prevention, treatment and customer satisfaction, and the committee's focus is to improve customer satisfaction. The MEMX committee assesses information and data directly from members, which include the annual results of CalOptima Health's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, member complaints, grievances and appeals. Then MEMX identifies opportunities to implement initiatives to improve our members' overall experience. The Access and Availability Workgroups, which report to the MEMX committee, monitor a member's ability get needed care and get care quickly, by monitoring the provider network, reviewing customer service metrics, and evaluating authorizations and referrals for "pain points" in health care that impact our members at the plan and HN level (including CCN), where appropriate. In 2024, the MEMX committee, which includes the Access and Availability Workgroups, will continue to meet at least quarterly and will be held accountable to meet regulatory requirements related to access and implement targeted initiatives to improve member experience and demonstrate significant improvement in subsequent CAHPS survey results.

Grievance and Appeals Resolution Services (GARS) Committee

The GARS Committee serves to protect the rights of members, promote the provision of quality health care services and ensure that the policies of CalOptima Health are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS Committee also serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima Health providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS Committee meets at least quarterly and reports through the QIHEC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Population Health Management Committee (PHMC)

The PHMC provides overall direction for continuous process improvement and oversight of population health activities, monitors compliance with regulatory requirements, and ensures that population health initiatives meet the needs of CalOptima Health members. The committee also

ensures that all population health initiatives are performed, monitored and communicated according to the PHM Strategy and Work Plan. The PHMC is responsible for reviewing, assessing and approving the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Work Plan progress and outcomes and recommend evidence-based and/or best practice activities to improve population health outcomes and advance health equity.

Confidentiality

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

All records and proceedings of the QIHEC and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code Section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QIHEC and the subcommittees sign a confidentiality agreement. This agreement requires committee members to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QIHE reports required by law or by the state contract.

Conflict of Interest

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

2024 Quality Improvement and Health Equity Priority Areas and Goals

CalOptima Health's QIHE Priority Areas and Goals are aligned with CalOptima Health's Strategic Plan and DHCS Bold Goals.

1. Maternal Health

    - Close racial/ethnic disparities in well-child visits and immunizations by 50%
    - Close maternity care disparity for Black and Native American persons by 50%

2. Children's Preventive Care
    - Exceed the 50th percentile for all children's preventive care measures

3. Behavioral Health Care
    - Improve maternal and adolescent depression screening by 50%
    - Improve follow-up for mental health and substance disorder by 50%

4. Program Goals
    - Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set (MCAS)
    - OneCare: Attain a Four-Star Rating for Medicare

Quality Improvement and Health Equity Transformation Program Work Plan

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

The QIHETP Work Plan is the operational and functional component of the QIHETP and is based on CalOptima Health strategic priorities and the most recent and trended HEDIS, CAHPS, Stars and Health Outcomes Survey (HOS) scores, physician quality measures and other measures identified for attention, including any specific requirements mandated by the state or accreditation standards, where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QIHETP guides the development and implementation of an annual QIHETP Work Plan, which includes but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service

- Member experience
- QIHETP oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QIHETP

Priorities for QIHE activities based on CalOptima Health's organizational needs and specific needs of CalOptima Health's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual care aids in the development of QI studies based on quality-of-care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QIHETP Work Plan.

The QIHETP Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QIHETP and applicable policies and procedures. The 2024 QIHETP Work Plan includes all quality improvement focus areas, goals, improvement activities, progress made toward goals, and timeframes. Planned activities include strategies to improve access care, the delivery of services, quality of care, over and under utilization, and member population health management. All goals will be measured and monitored in the QIHETP Work Plan, reported to QIHEC quarterly, and evaluated annually. A copy of the QIHETP Work Plan are also publicly available on the CalOptima Health website.

For more details on the 2024 QIHETP Work Plan see Appendix A: 2024 QIHETP Work Plan

Quality Improvement and Health Equity Projects

QIHE Project Selection and Focus Areas

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

- Areas for improvement identified through continuous internal monitoring activities, including but not limited to:
  - Potential quality issue (PQI) review processes
  - Provider and facility reviews
  - Preventive care audits
  - Access to care studies
  - Member experience surveys
  - HEDIS results
  - Other opportunities for improvement as identified by subcommittee's data analysis
- Measures required by regulators, such as DHCS and CMS, with a focus on meeting or exceeding the following:
  - DHCS established Minimum Performance Level (MPL) for each required Quality Performance Measure of Health Equity measures selected by DHCS.
  - Health disparity reduction targets for specific populations and measures as identified by DHCS.

- Performance Improvement Projects (PIPs) required by CMS or DHCS.

The QI Project methodology described below will be used to continuously review, evaluate and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, LTSS and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD members
- Provisions of chronic, complex care management and care management services
- Access to and provision of preventive services

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

- Staff, administration and physicians provide vital information necessary to support continuous performance improvement and occurs at all levels of the organization.
- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.
- Other prioritization criteria include the expected impact on performance (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high-risk, high-volume or problem-prone processes.
- Project coordination occurs through the various leadership structures: Board of Directors, management, QIHEC, UMC, etc., based upon the scope of work and impact of the effort.
- CalOptima Health collaborates with delegated business partners to coordinate QI activities for all lines of business through the following:
  - Health Network Forums – Monthly
  - HN Quality Forums – Quarterly
  - Joint Operation Meetings (JOM) with Health Networks – Quarterly
- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QIHE Project Measurement Methodology

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

QI Projects shall include the following:

- Measurement of performance using objective quality indicators
- Implementation of equity-focused interventions to achieve improvement in the access to and quality of care
- Evaluation of the effectiveness of the intervention based on the performance measures
- Planning and initiation of activities for increasing or sustaining improvement

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5%–10% over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411 and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima Health's previous year's score. Also, smaller sample size

may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30 can be statistically significant for QI pilot projects.

The PDSA model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s) including barrier analysis
4) Develop an action plan
Do 5) Communicate change plan
6) Implement change plan
Study 7) Review and evaluate result of change
8) Communicate progress
Act 9) Reflect and act on learning
10) Standardize process and celebrate success
11) As needed, initiate Corrective Action Plan(s), which may include enhanced monitoring and/or re-measurement activities.

Types of QIHE Projects

CalOptima Health implements several types of improvement projects, including QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for members.

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

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

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

Improvement Standards

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

B. Sustained Improvement

Sustained improvement is documented through the continued remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both demonstrated and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima Health may choose to continue the project or pursue another topic.

Documentation of QIHE Projects

Documentation of all aspects of each QIHE Project is required. Documentation includes but is not limited to:

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

Communication of QIHE Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QIHETP Work Plan or calendar. The QIHE subcommittees will report their summarized information to the QIHEC at least quarterly in order to facilitate communication along the continuum of care. The QIHEC reports activities to the QAC of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima Health's contracted entities, practitioners and providers is through the following:

- Practitioner participation in the QIHEC and its subcommittees
- HN Forums, Medical Directors' Meetings, Quality Forums and other ongoing ad hoc meetings
- MAC, PAC and WCM FAC

Quality Improvement and Health Equity Program Evaluation

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

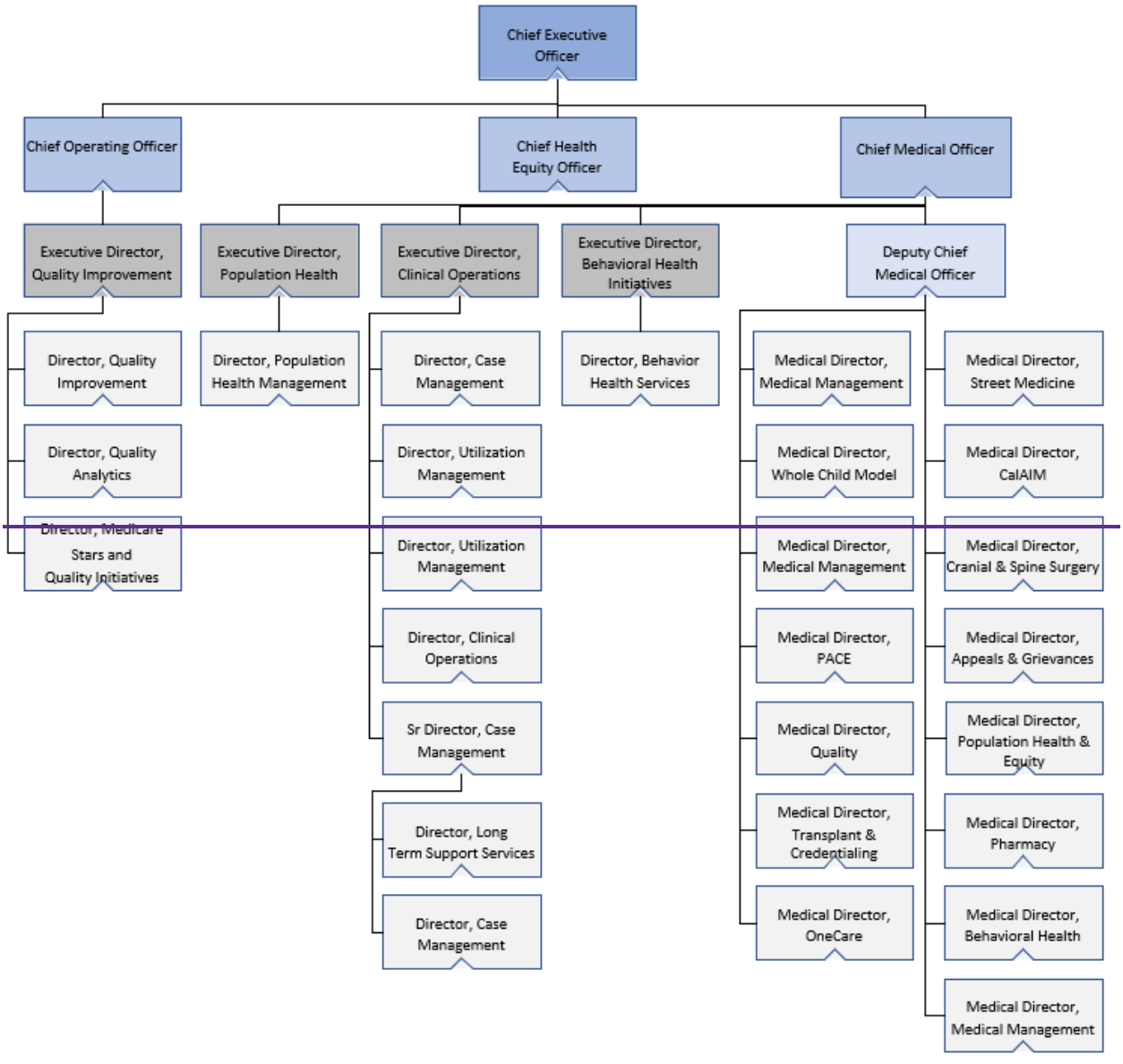
- A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of services, including the achievement or progress toward goals, as outlined in the QIHETP Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of QIHE activities, including QIPs, PIPs, PDSAs and CCIPs.
- An evaluation of the effectiveness of member satisfaction surveys and initiatives.
- A report to the QIHEC and QAC summarizing all quality measures and identifying significant trends.
- A critical review of the organizational resources involved in the QIHETP through the CalOptima Health strategic planning process.
- Recommended changes included in the revised QIHETP Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

A copy of the QIHETP Evaluation is also publicly available on the CalOptima Health website.

Quality Improvement and Health Equity Transformation Program Organizational Structure

Quality Program Organizational Chart — Diagram

As of ~~December 2023~~May 2024



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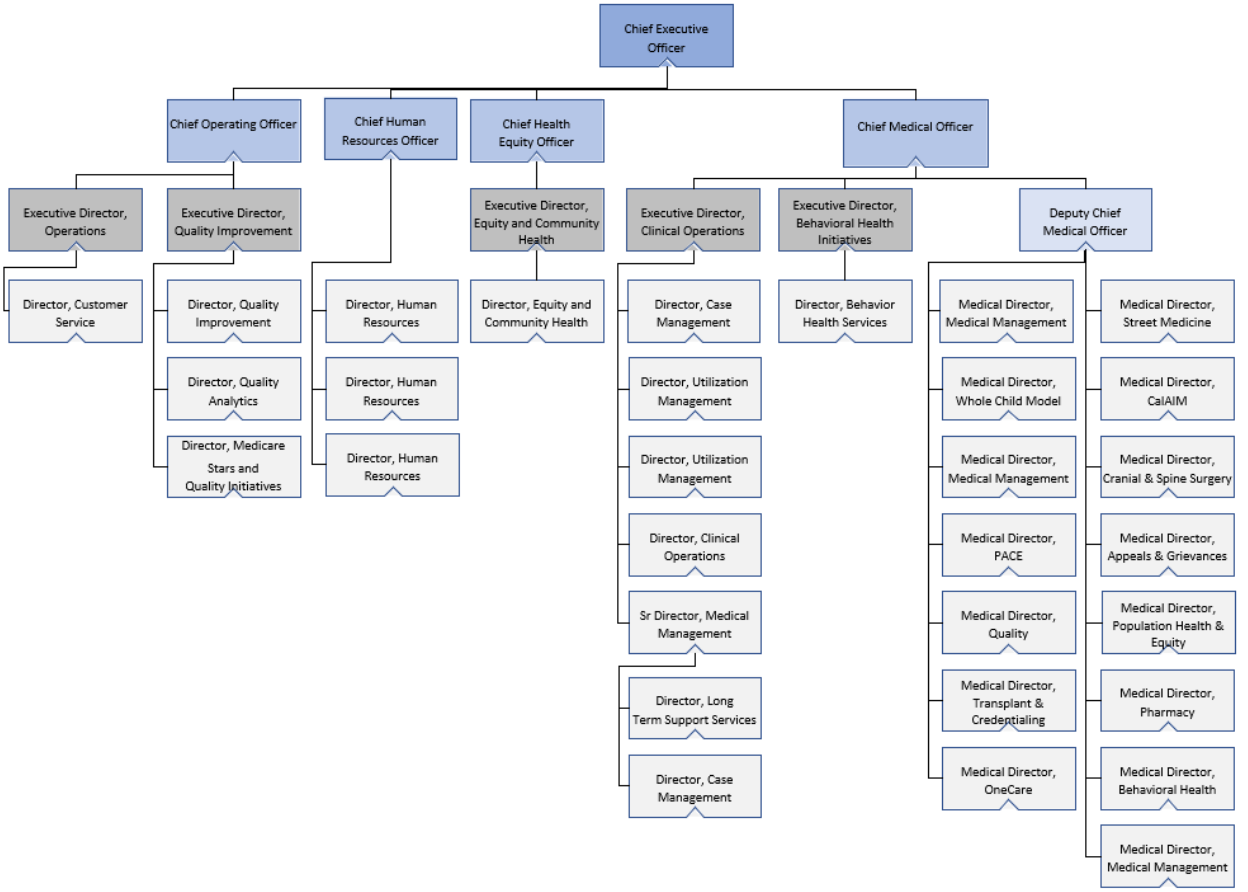

Quality Improvement and Health Equity Transformation Program Organizational Structure

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima Health departments, support the organization's mission and strategic goals. These areas oversee the processes to monitor, evaluate and implement the QIHETP so that members receive high-quality care and services. Below lists the QI Program's functional areas and responsibilities.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Medical Officer* (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. The CMO has overall responsibility for the QIHETP and supports efforts so that the QIHETP objectives are

coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QIHE activities to the Board of Directors' Quality Assurance Committee.

Chief Compliance Officer (CCO) is responsible for monitoring and driving interventions so that CalOptima Health and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of HNs and other functional areas. The CCO serves as the State Liaison and is responsible for legislative advocacy. Also, the CCO oversees CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to state and federal requirements.

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima Health. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima Health's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Deputy Chief Medical Officer* (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO collaborates with Directors and Medical Directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Care Management, ~~Population Health Management,~~Equity and Community Health, Pharmacy Management, LTSS and other medical management programs.

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. The COS is responsible for achieving operational efficiencies to support CalOptima Health's strategic plan, goals and objectives.

Chief Information Officer (CIO) provides oversight of CalOptima Health's ~~enterprisewide~~enterprise wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the organization's risk exposure.

Medical Director* (Behavioral Health) is the designated behavioral health care physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC) and CPRC. The Medical Director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Medical Director* (CalAIM) [California Advancing and Innovating Medi-Cal] is responsible for the clinical oversight of CalAIM initiatives that include clinical programs and related

services, such as Enhanced Care Management, Community Supports and justice-involved services.

Medical Director* (Credentialing and Peer Review) is the designated physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC). The Medical Director is also the chair of the Credentialing and Peer Review Committee (CPRC).

Medical Director* (OneCare) is responsible for oversight of the senior members in OneCare, working on quality improvements to raise CalOptima Health's Star rating and collaborating with others on behalf of members via the interdisciplinary care teams.

Medical Director* (~~Population Health and Equity~~Equity and Community Health) [ECH] is the designated physician who chairs the Population Health Management Committee and is responsible for overseeing the Population Health Management (PHM) functions. The Medical Director provides direction and support to the CalOptima Health ~~PHM~~ ECH staff to ensure objectives from the Population Health Management Strategy are met.

Medical Director* (Quality Improvement) is the physician designee who chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Medical Director* (Street Medicine) is responsible for the clinical oversight of the street medicine initiative that includes patient medical assessments and management, urgent care medical interventions, pharmacology management and utilization and the coordination of street medicine services with a multidisciplinary team.

Medical Director* (Whole Child Model) is the physician designee who chairs the Whole Child Model Clinical Advisory Committee and is responsible for overseeing QIHE activities and quality management functions related to Whole Child Model (WCM). The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives related to WCM are met.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high-performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, ~~Population Health Management~~Equity and Community Health (ED ECH~~PHM~~) is responsible for ~~the~~ oversight of ~~development and implementation of~~ comprehensive population ~~companywide PHM~~ strateg~~y~~ies to improve member experience ~~,~~ and increase access to care through the promotion of community-based programs~~promote optimal health outcomes, ensure efficient care and improve health equity~~. The ED ~~PHM~~ ECH serves as a member of the executive team, and with the CHEO, CMO, DCMO, ED CO and ED BHI, ~~and~~

~~Executive Director, Clinical Operations,~~ supports efforts to promote optimal health outcomes, ensure efficient care, address mental wellness, disparities and improve health equity~~adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served~~. ~~The Director of Population Health Management~~Equity and ~~Community Health reports to the ED PHM~~ECH.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for oversight of CalOptima Health's Behavioral Health (BH) program, including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Medi-Cal and CalAIM is responsible for the implementation and oversight of CalAIM, a whole-system, person-centered delivery system reform to improve quality and care to members.

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

Executive Director, Medicare Programs (ED MP) is responsible for strategic and operational oversight of Medicare programs, including OneCare and PACE.

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

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

*Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the California Knox Keene Act Section 1367.01 I. Ongoing monitoring is performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.

Quality Improvement and Health Equity Program Resources

CalOptima Health's budgeting process includes personnel, Information Technology Services resources and other administrative costs projected for the QIHETP. The resources are revisited on a regular basis to promote adequate support for CalOptima Health's QIHETP.

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

In addition to CalOptima Health's CMO and ~~,~~ ED QI ~~and ED PHM~~ECHP~~,~~ the following staff positions provide direct support for organizational and operational QIHETP functions and activities:

Director, Quality Improvement
Responsible for day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement (PQI)
- Manager, Quality Improvement (FSR/PARS/MRR)
- Manager, Quality Improvement (Credentialing)
- Supervisor, Quality Improvement (FSR)
- Supervisor, Quality Improvement (PARS)
- QI Nurse Specialists (RN) (LVN)
- Project Manager
- Program Manager
- Credentialing Coordinators
- Program Specialists
- Program Assistants
- Outreach Specialists
- Auditor, Credentialing

Director, Quality Analytics
Responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the agencywide QIHETP.

The following positions report to the Director, Quality Analytics:

- Manager, Quality Analytics (HEDIS)
- Manager, Quality Analytics (Data Analytics)
- Data Analysts
- Project Managers
- HEDIS medical record review nurses

Director, Medicare Stars and Quality Initiatives
Responsible for leading implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and

availability, and Medicare Stars. Provides data analytical direction to support quality measurement activities for the ~~organizationwide~~organization wide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

The following positions report to the Director, Medicare Stars and Quality Initiatives:

- Manager, Quality Analytics
- Manager, Quality Initiatives
- Project Managers
- Program Coordinators
- Program Specialists
- Data Analyst
- Quality Analyst
- Program Assistant

Director, ~~Population Health Management~~Equity and Community Health (ECH)
Responsible for program development and implementation of the PHM program and strategies for ~~organizationwide~~ comprehensive ~~population~~ health initiatives ~~while ensuring linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy and BHI~~. This position oversees programs that promote health and wellness services for all CalOptima Health members. ~~PHM~~ ECH services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.~~PHM ECH also supports the MOC implementation for members. Reports program progress and effectiveness to QIHEC and other committees to support compliance with regulatory and accreditation organization requirements.~~

~~In April 2024, the Population Health Management department was renamed Equity and Community Health. The newly named team will support all members in staying healthy by increasing access to care through the promotion of community-based programs such as Maternal and Child Health Programs, Wellness and Prevention Programs and Chronic Disease Programs – focusing efforts and resources on key initiatives that positively impact members and support the CalOptima Health mission. Moreover, these programs will be framed with an 'equity lens' and will also address mental wellness and the social drivers of health that impact our members.~~

~~The following positions report to the Director, Population Health Management~~Equity and ~~Community Health:~~

- ~~Equity and Community Health Managers:Population Health Management Manager (Clinical Operations)~~

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- ~~Equity and Community Health:Population Health Management Manager (Health Education)~~
- ~~Equity and Community Health:Population Health Management Manager (Maternal Health)~~
- ~~Equity and Community Health:Population Health Management Manager (Strategic Initiatives)~~
- ~~Equity and Community Health:Population Health Management Supervisors~~
- ~~Program Managers and Senior Program Managers~~
- ~~Health Coaches~~
- ~~Registered Dietitians~~
- ~~Health Educators and Senior Health Educators~~
- ~~Program Specialists~~
- ~~Program Assistants~~
- ~~Program Coordinators~~

Director, Behavioral Health Integration
Responsible for program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima Health members across all lines of business. The director is responsible for the management and strategic direction of the BHI department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Utilization Management
Responsible for the development and implementation of the UM program, policies and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the UM committees and participates in the QIHEC and the BMSC.

Director, Clinical Pharmacy Management
Responsible for the development and implementation of the Pharmacy Management program, develops and implements Pharmacy Management department policies and procedures, ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of pharmacy-related clinical affairs, and serves on the P&T and UMC. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Care Management
Responsible for Care Management, Transitions of Care, Complex Care Management and the clinical operations of Medi-Cal and OneCare. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports (LTSS)

Responsible for LTSS programs, which include CBAS, LTC and MSSP. The position supports a member-centric approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures and processes related to LTSS program operations and quality measures.

Director, Medicare Programs
Responsible for the medical management team and providing physician leadership in the Medical Management division, serving as liaison to other CalOptima Health operational and support departments. The director collaborates with the other Medical Directors and clinical, nursing and non-clinical leadership staff across the organization in areas including Quality, Utilization and Care Management, Health Education/Disease Management, Long-Term Care, Pharmacy, Behavioral Health Integration, PACE as well as support departments, including Compliance, Information Technology Services, Claims, Contracting and Provider Relations.

~~**Sr. Director, Medical Management**~~
~~[Add Description]~~

Sr. Director, Clinical Operations
The Sr Director, Clinical Operations oversees the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct.

Director, Human Resources
-The Director (Human Resources Administrative Services) is responsible for leading and overseeing the Human Resources Information Systems (HRIS) team and function, including its services, related policies, initiatives, programs, and processes.

Director, Customer Service
~~Provide leadership, in~~Responsible for the day-to-day management, strategic direction and support to the CalOptima's Customer Services operations; Medi-Cal Call Center, Behavioral Health Call Center, OneCare Call Center, OneCare Connect Call Center, Member Liaison, Customer Service Data Analysts, Cultural & Linguistic, Member Communications, Enrollment & Reconciliation, Member Advisory Committees and CalOptima Member Portal.

Staff Orientation, Training and Education

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

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

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)

- HIPAA Rules and Compliance
- Disability Awareness Fraud, Waste and Abuse
- Compliance and Code of Conduct Training
- Cybersecurity Awareness
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Health Equity
- Cultural Competency
- Seniors and Persons with Disabilities Awareness training
- Trauma-Informed Care
- Diversity, Inclusion and Unconscious Bias

Employees, contracted providers and practitioner networks with responsibilities for OneCare are trained at least annually on the Model of Care (MOC). The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

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

Key Business Processes, Functions, Important Aspects of Care and Service

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

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

- Primary care, by definition, is accessible, comprehensive, coordinated and continual care delivered by accountable providers of personal health services.
- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

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

- Clinical care and service
- Behavioral health care
- Access and availability
- Continuity and coordination of care

- Transitions of care
- Prenatal and postpartum care
- Preventive care, including:
  - Initial Health Appointment
  - Behavioral Assessment
  - Immunizations
  - Blood Lead Screenings
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Diagnosis, care and treatment of acute and chronic conditions
- Care management including complex care management
- Prescription drug services
- Hospice care
- Palliative care
- Major organ transplants
- Long-Term Care Services and Supports
- Enhanced Care Management
- Community Supports
- Transportation
- Health education and promotion
- Disease management
- Member experience
- Patient safety

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Provider training
- Organizational ethics
- Effective utilization of resources including monitoring of over and under utilization
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Fraud and abuse* as it relates to quality of care

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

Quality Improvement

The QI department is responsible for implementation of the QIHETP, monitoring quality of care and service, and assuring that credentialing standards, policies, and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with departments throughout the organization to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services. The QI department ensures that care and services are rendered appropriately and safely to all CalOptima Health members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both department-specific and organizationwide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain organizationwide practices that support accreditation and meet regulatory requirements

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical Directors triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). As cases are presented to CPRC, the discussion of the care includes appropriate action and leveling of the care, which results in committee-wide inter-rated reliability process. The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima Health, which include but are not limited to Prior Authorization, Concurrent Review, Care Management, Legal, Compliance, Customer Service, Pharmacy or GARS, as well as from providers and other external sources.

The QI department provides training guidance for the non-clinical staff in Customer Service and GARS to assist the staff on the identification of potential quality issues. Potential quality of care grievances are reviewed by a Medical Director with clinical feedback provided to the member. Declined grievances captured by the Customer Service department are similarly reviewed by a Medical Director.

Comprehensive Credentialing Program

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

Practitioners are credentialed and recredentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, Dos, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic

medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include but are not limited to non-physician BH practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima Health direct environments. Credentialing and recredentialing activities for CCN are performed at CalOptima Health and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

CalOptima Health performs credentialing and recredentialing of OPs, including but not limited to acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with state and federal regulatory agencies.

CalAIM Providers

CalOptima Health performs credentialing or vetting of CalAIM providers to ensure providers are qualified to provide Enhanced Care Management and Community Supports to our members. CalAIM providers include but are not limited to the following providers: FQHCs, street medicine providers, homeless navigation centers, transitional housing centers, CBAS centers, home health agencies, school-based clinics, community-based organizations, recuperative care and respite providers, sobering centers, medical tailored meals, and personal care and homemaker services.

Use of QI Activities in the Recredentialing Process

Findings from QI activities and other performance monitoring are included in the recredentialing process.

Monitoring for Sanctions and Complaints

CalOptima Health has adopted policies and procedures for ongoing monitoring of sanctions, which include but are not limited to state or federal sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between recredentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review

CalOptima Health does not delegate PCP facility site, physical accessibility, and medical records review to contracted HMOs, PHCs and SRGs. CalOptima Health assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima Health retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima Health collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima Health completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR and Physical Accessibility Review Survey (PARS) on all PCP sites that intend

to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for precontracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review and CalOptima Health policies. An Initial Medical Record Review shall be completed within 90 calendar days from the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima Health may review sites more frequently per local collaborative decisions or when deemed necessary based on monitoring, evaluation or CAP follow-up issues. If the provider is unable to meet the requirements through the CAP review, then the provider will be recommended for contract termination.

Physical Accessibility Review Survey for Seniors and Persons With Disabilities (SPD)

CalOptima Health conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas, including the exam room
- Restroom
- Exam table/scale

Medical Record Documentation

The medical record provides legal proof that the member received care. CalOptima Health requires that contracted delegated HNs make certain that each member's medical record is maintained in an accurate, current, detailed, organized and easily accessible manner. Medical records are reviewed for format, legal protocols and documented evidence of the provision of preventive care and coordination and continuity of care services. All data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.)

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

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state law and must be maintained by the provider for a minimum of 10 years.

Corrective Action Plan(s) to Improve Quality of Care and Service

When monitoring by either CalOptima Health's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima Health's functional areas will be overseen by the QI department as overseen by and reported to QIHEC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams using continuous improvement tools (i.e., quality improvement plans or PDSA) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

National Committee for Quality Assurance (NCQA) Accreditation

CalOptima Health is a National Committee for Quality Assurance (NCQA) accredited Health Plan and achieved its initial commendable accreditation in August 2012. In July 2021, CalOptima Health completed triannual renewal survey for NCQA Health Plan Accreditation and received 100% of the allowable points through the document submission and file review process. From this renewal survey, CalOptima Health received Accredited Status, which is effective through July 27, 2024.

The QI department staff support CalOptima Health accreditation efforts by conducting the NCQA Steering Committee to provide all internal departments with NCQA standards and updates, survey readiness management and NCQA survey process management. CalOptima Health has acquired NCQA consulting services to support document review and survey readiness prior to submission.

CalOptima Health is seeking another renewal for Health Plan Accreditation and will be completing the submission by April 30, 2024. In addition to Health Plan Accreditation, CalOptima is also seeking Health Equity Accreditation with NCQA by January 2026.

Quality Analytics

The Quality Analytics (QA) department fully aligns with the QI and ~~PHM~~ ECH teams to support the organizational mission, strategic goals, required regulatory quality metrics, programs and

processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima Health members.

The QA department activities include design, implementation and evaluation of processes and programs to:

- Report, monitor and trend outcomes
- Conduct measurement analysis to evaluate goals, establish trends and identify root causes
- Establish measurement benchmarks and goals
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required
- Participate in various reviews through the QIHETP, including but not limited to network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize HNs and providers to meet quality performance targets and deliver quality care
  Design and develop member, provider and organization-wide initiatives to improve - quality of care

Data sources available for identifying, monitoring and evaluating opportunities for improvement and intervention effectiveness include but are not limited to:

- Claims data
- Encounter data
- Utilization data
- Care management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings data
- Population Needs Assessment
- HEDIS results
- Member and provider satisfaction surveys
- Timely Access Survey
- Provider demographic information

By analyzing data that CalOptima Health currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS scores and CMS Star Ratings. This information will guide CalOptima Health and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Quality Performance Measures

CalOptima Health annually collects, tracks and reports all quality performance measures required by CMS and DHCS, including the DHCS Medi-Cal Accountability Set (MCAS), Medicare reporting set and Star measures. Measure rates are validated by a NCQA-certified auditor and reported to NCQA, CMS, DHCS and other entities as required.

Value-Based Payment Program

CalOptima Health's Value-Based Payment Performance Program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. HNs, including CCN, and HNs' PCPs are eligible to participate in the Value-Based Payment Programs. CalOptima Health has adopted the Integrated Healthcare Association (IHA) pay-for-performance methodology to assess performance. Performance measures are aligned with the DHCS MCAS for Medi-Cal and a subset of CMS Star measures for OneCare.

Five-Year Hospital Quality Program 2023–2027

CalOptima Health has developed a hospital quality program to improve quality of care to members through increased patient safety efforts and performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience and patient safety. Hospitals may earn annual incentives based on achievement of benchmarks.

Population Health Management

Population Health Management (PHM) aims to ensure that member care and services are delivered in a whole-person-centered, safe, timely, efficient and equitable manner across the entire health care continuum and life span. PHM integrates physical health, behavioral health, long-term support services and complex case management to improve the coordination of care between managed care teams. PHM care coordination includes basic population health management, complex care management, enhanced care management (ECM) and transitional care services. PHM's streamlined care coordination interactions are designed to optimize member care to meet their unique and comprehensive health needs.

At least annually, CalOptima Health engages with multidisciplinary care teams, members, community partners and stakeholders to update the PHM Strategy. The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also shares our creative upstream approach to address SDOH and close gaps in care that lead to health disparities among our members. In addition, CalOptima Health aligns our PHM Strategy with the priorities of our federal and state regulators and follows the standards outlined by NCQA.

CalOptima Health's PHM Strategy addresses the following areas of focus:

- Keeping members healthy
- Managing members with emerging risks
- Patient safety or outcomes across settings
- Managing members with multiple chronic conditions

To inform our PHM Strategy, CalOptima Health has several processes in place to review collected data that is used to understand our member needs, develop strategies to address those needs and evaluate the impact of those strategies. Mainly CalOptima Health's Population Needs Assessment (PNA) is used to summarize the results of an annual assessment on a variety of member data. The intent of the PNA is to review the characteristics and needs of our organization's member population and relevant focus populations to support data-driven planning and decision-making. In addition, CalOptima Health uses PNA key findings to inform a comprehensive PHM Work Plan.

The PHM Work Plan addresses the unique needs and challenges of specific ethnic communities, including social drivers of health that include but are not limited to economic, social and environmental stressors, to improve health outcomes. CalOptima Health will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services. These quality initiatives can be expected to have a beneficial effect on health outcomes and member satisfaction, and may include quality improvement projects (QIPs), program improvement projects (PIPs), Plan-Do-Study-Act (PDSAs) and chronic care improvement projects (CCIPs). Quality Initiatives are tracked in the QIHETP Work Plan and reported to the QIHEC.

In 2024, the PHM Work Plan will continue to focus on addressing health inequities and meeting member's social needs. ~~PHM~~ CalOptima Health identified opportunities to expand outreach and initiate new initiatives focused on advancing health equity as follows:

- Improving screening for member social needs and connections to resources through an integrated closed-loop referral platform.
- ~~Increasing CalOptima Health's organizational health literacy through the Health Literacy for Equity project, with support from the Equity in Orange County Initiative (EiOC).~~
- Expanding Street Medicine services to connect unhoused members with whole person care approaches and addressing social drivers of health.
-
- Expanding in-person group health education classes in the community to promote healthy eating and active living.
- Initiating interventions for members with hypertension and chronic kidney disease.
- Implementing the Comprehensive Community Cancer Screening and Support program that aims to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses.
- Collaborating with the Orange County Health Care Agency to reduce disparities in childhood blood lead and maternal depression screening rates.

Further details of the Population Health Management Program, activities and measurements can be found in the 2024 Population Health Management Strategy (Appendix B)

Health Education and Promotion

In April 2024, the Population Health Management department was renamed Equity and Community Health. The newly named team will support all members in staying healthy by increasing access to care through the promotion of community-based programs such as Maternal and Child Health Programs, Wellness and Prevention Programs and Chronic Disease Programs – focusing efforts and resources on key initiatives that positively impact members and support the CalOptima Health mission.

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

The ~~PHM~~ Equity and Community Health (ECH) department ~~provides program development and implementation for organizationwide PHM programs. PHM~~ programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members. Moreover, these programs will be framed with an 'equity lens' and will also address mental wellness and the social drivers of health that impact our members. The programs~~y~~ are designed to achieve behavioral change and are reviewed on an annual basis. Program topics include exercise, nutrition, hyperlipidemia, hypertension, perinatal health, Shape Your Life/weight management, tobacco cessation, asthma, immunizations and well-child visits.

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

~~PHM~~ ECH supports CalOptima Health members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources

Managing Members With Emerging Risk

CalOptima Health staff provide a comprehensive system of caring for members with chronic illnesses. The systemwide, multidisciplinary approach entails the formation of a partnership between the member, the health care practitioner and CalOptima Health. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members, and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the California Surgeon General and Proposition 56 requirements for Adverse Childhood Event (ACE) screening, as well as identification of SDOH. It proactively identifies those members in need of closer management, coordination and intervention. CalOptima Health assumes responsibility for the PHM program for all lines of business; however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Care Management

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

- Standardized mechanisms for member identification through use of data, including Health Risk Assessment (HRA) for OneCare, SPD and WCM members
- Multiple avenues for referral to care management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidence-based guidelines distributed to providers who address chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD)
- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources
- Development of individualized care plans that include input from the member, caregiver, PCP, specialists, social worker and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing and modifying the plan of care to drive appropriate service quality, timeliness and effectiveness
- Establishing consistent provider-patient relationships
- Ongoing assessment of outcomes

CalOptima Health's Care Management (CM) program includes three care management levels that reflect the acuity of needs: complex care management, care coordination and basic care management. Members within defined models of care, (SPD, WCM and OneCare) are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy.

Health Risk Assessment (HRA) and Health Needs Assessment (HNA)

The comprehensive risk assessment facilitates care planning and offers actionable items for the ICT. Risk assessments are completed in person, telephonically or by mail and accommodate language preference. The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. Risk assessments are completed with the initial visit and then on an annual basis.

Interdisciplinary Care Team (ICT)

An ICT is linked to members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), depending on the results of the member's HRA and/or evaluation or changes in health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of the member) and PCP. For members with more needs, other disciplines are included, such as a Medical Director, specialist(s), care manager, BH specialist, pharmacist, social worker, dietitian and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

The ICT levels are:

- ICT for Low-Risk ~~Members occurs~~Members occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic care management, including advanced care planning
      - Medication reconciliation
      - Identification of member at risk of planned and unplanned transitions
      - Referral and coordination with specialists
      - Development and implementation of an Individual Care Plan (ICP)
      - Communication with members or their representatives, vendors and medical group
      - Review and update the ICP at least annually, and when there is a change in health status
      - Referral to the primary ICT, as needed

- ICT for Moderate- to High-Risk ~~Members occurs~~Members occurs at the HN, or at CalOptima Health for CCN members.
  - Team Composition: member, caregiver or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory care manager, hospitalist, hospital care manager and/or discharge planners, HN UM staff, BH specialist and social worker
    - Roles and responsibilities of this team:
      - Identification and management of planned transitions
      - Care coordination or complex care management
      - Care management of high-risk members
      - Coordination of ICPs for high-risk members
      - Facilitating communication among member, PCP, specialists and vendors
      - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Individual Care Plan (ICP)

The ICP is developed through the ICT process. The ICP is a member-centric plan of care with prioritization of goals and target dates. Attention is paid to needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up per care management level. The ICP is updated annually and with change in condition.

Seniors and Persons with Disability (SPD)

The goal of care management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. The model involves risk stratification and HRA that contributes to the ICT and ICP development.

Whole-Child Model (WCM)

The goal of care management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima Health coordinates the full scope of health care needs inclusive of preventive care, specialty health, mental health, education and training. WCM ensures that each CCS-eligible member receives care management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs the ICT and ICP development.

OneCare Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC)

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

The MOC goals are:

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

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

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

- Complex care management program for a subset of members whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional care management program focused on evaluating and coordinating transition needs for members who may be at risk of rehospitalization

- High-risk and high-utilization program for members who frequently use emergency department services or have frequent hospitalizations, and high-risk individuals
- Hospital care management program to coordinate care for members during an inpatient admission and discharge planning

Care Management Program focuses on member-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Behavioral Health Integration Services

CalOptima Health is responsible for providing quality behavioral health care focusing on prevention, recovery, resiliency and rehabilitation. As part of the QI Program with direction and guidance from the QIHEC, the BHI other supporting departments continue to monitor the behavioral health care that CalOptima Health providers our member and continue to seek ways to improve behavioral health care.

Medi-Cal Behavioral Health (BH)

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

In addition, CalOptima Health covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima Health provides direct oversight, review and authorization of BHT services.

CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief counseling on misuse is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

CalOptima Health members can access mental health services directly, without a physician referral, by contacting the CalOptima Health Behavioral Health Line at 1-855-877-3885. A CalOptima Health representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to BH practitioners within the CalOptima Health provider network. If the member has moderate to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima Health ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of care. Communication with both the medical and mental

health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access.

CalOptima Health directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services and quality improvement.

CalOptima Health is participating in two of DHCS' incentive programs focused on improving BH care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is designed to improve physical and BH outcomes, care delivery efficiency and member experience. CalOptima Health is providing program oversight, including readiness, milestones tracking, reporting and incentive reimbursement for the seven provider groups approved to participate in 12 projects. The second incentive program is the Student Behavioral Health Incentive Program (SBHIP), part of a state effort to prioritize BH services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH agencies and CalOptima Health by developing infrastructure to improve access and increase the number of transitional kindergarten through 12th-grade students receiving early interventions and preventive BH services.

OneCare Behavioral Health

OneCare covers inpatient and outpatient behavioral health care services through a directly contracted behavioral health network. OneCare BH continues to be fully integrated within CalOptima Health internal operations. OneCare members can access mental health services by calling the CalOptima Health Behavioral Health Line.

Utilization Management (UM)

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan, member eligibility at the time of service, subject to medical necessity, and are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease or injury consistent with CalOptima Health medical policy and not furnished primarily for the convenience of the member, attending physician or other provider.

Use of evidence-based, peer reviewed, industry-recognized criteria ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2024 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a Medical Director or other qualified reviewer, such as a licensed psychologist or clinical pharmacist.

Further details of the UM Program, activities and measurements can be found in the 2024 Integrated UM and CM Program Description.

Patient Safety Program

Patient safety is very important to CalOptima Health; it aligns with CalOptima Health's mission statement: *To serve member health with excellence and dignity, respecting the value and needs of each person*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed members and families are vital members of the health care team.

Patient safety is integrated into all components of enrollment and health care delivery and is a significant part of our quality and risk management functions. This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima Health members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on risk assessment
- Health education and health promotion
- Over/under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service
- Care provided in various health care settings
- Sentinel events
- Disease Surveillance and reporting

To ensure member safety, activities for prevention, monitoring and evaluation include:

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

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Using FSRs, PARS and MRR results from providers and health care delivery organization at the time of credentialing to improve safe practices, and incorporate ADA and SPD site reviews into the general FSR process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

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

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster and evacuation plan testing and annual training

- Institutional settings, including CBAS, SNF and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address postoperative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of influenza and pneumonia vaccines
  - COVID-19 infection prevention and protective equipment

- Administrative offices
  - Fire, disaster and evacuation plan testing and annual training

Encounter Data Review

CalOptima Health's HNs must submit complete, timely, reasonable, and accurate encounter data that adheres to the guidelines specified in the companion guides for facility and professional claim types and data format specifications. A HN submits encounter data through the CalOptima Health File Transfer Protocol (FTP) site.

CalOptima Health annually measures a HN's compliance with performance standards with regards to the timely submission of complete and accurate encounter data, in accordance with Policy EE.1124 Health Network Encounter Data Performance Standards. CalOptima Health utilizes retrospective encounter data to conduct its evaluation. The measurement year is the twelve (12) month calendar year. CalOptima Health provides a HN with a HN Encounter Data Scorecard to report a HN's progress check score and annual score relating to the status of the HN's compliance with encounter data performance standards.

Member Experience

Improving member experience is a top priority of CalOptima Health and has a strategic focus on the issues and factors that influence the member's experience with the health care system. CalOptima Health performs and assesses the results from member-reported experiences and how well the plan providers are meeting members' expectations and goals. Annually, CalOptima Health fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both Medi-Cal and OneCare members. Focus is placed on coordinating efforts intended to improve performance on CAHPS survey items for both the adult and child population.

Additionally, CalOptima Health reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for "pain points" that impact members at the plan and HN level (including CCN), where appropriate.

Grievance and Appeals

CalOptima Health has a process for reviewing member and provider complaints, grievances and appeals. Grievances and appeals are tracked and trended on a quarterly basis for timeliness of acknowledgment and resolution, issue types and by provider type. The grievance and appeals process includes a thorough investigation and evaluation to ensure timely access to care and the delivery of quality care and/or services. In this process, potential quality of care issues are identified and referred to an appropriately-licensed professional for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case. The quarterly report is presented and reviewed by the Grievance and Resolutions (GARS) Committee that reports to the QIHEC quarterly.

Access to Care

Access to care is a major area of focus for the plan and hence the organization has dedicated significant resources to measuring and improving access to care.

CalOptima Health participates in the following to monitor and improve network adequacy and access to our members:

- Annual Network Certification (ANC) with DHCS
- Subcontracted Network Certification (SNC) with DHCS
- Network Adequacy Validation with the EQRO
- Network Adequacy Monitoring with CMS

CalOptima Health monitors the following to ensure that we have robust provider networks for our members to access care and that members have timely access to care to primary and specialty healthcare providers and services:

Availability of Practitioners

- CalOptima Health monitors the availability of PCPs, specialists and BH practitioners and assesses them against established standards quarterly or when there is a significant change to the network.
- The performance standards are based on DHCS, CMS, NCQA and industry benchmarks.
- CalOptima Health has established quantifiable standards for both the number and geographic distribution of its network of practitioners.
- CalOptima Health uses a geo-mapping application to assess geographic distribution.
- Data is tracked and trended and used to inform provider outreaching and recruiting efforts.

Appointment Access

- CalOptima Health monitors appointment access for PCPs, specialists and BH providers and assesses them against established standards at least annually.
- To measure performance, CalOptima Health collects appointment access data from practitioner offices using a timely access survey.

- CalOptima Health also evaluates the grievances and appeals data quarterly to identify potential issues with access to care. A combination of both these activities helps CalOptima Health identify and implement opportunities for improvement.
- Providers not meeting timely access standards are remeasured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Telephone Access

- CalOptima Health monitors access to its Customer Service department on a quarterly basis.
- To ensure that members can access their provider via telephone to obtain care, CalOptima Health monitors access to ensure members have access to their primary care practitioner during business hours.
- Providers not meeting timely access standards are remeasured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Cultural & Linguistic Services Program

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services Program that integrates culturally and linguistically appropriate services at all levels of the operation. Services include but are not limited to face-to-face interpreter services, including American Sign Language, at key points of contact; 24-hour access to telephonic interpreter services; member information materials translated into CalOptima Health's threshold languages and in alternate formats, such as braille, large-print or audio; and referrals to culturally and linguistically appropriate community services programs.

The seven most common languages spoken for all CalOptima Health programs are: English, 58%; Spanish, 27%; Vietnamese, 9%; Farsi, 1%; Korean, 2%; Chinese, less than 1%; and Arabic, less than 1%; and other less than 2%. CalOptima Health provides member materials as follows:

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

CalOptima Health's Cultural and Linguistic Services Program is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of our diverse population. Beginning with identification of needs through a Population Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the MAC and PAC prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Serving a culturally and linguistically diverse membership includes:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-, ethnic-, language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group
- Implementing and maintaining annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical).

Further details of the Culture and Linguistics program, activities and measurements can be found in the 2024 Culture and Linguistics Appropriate Services Program ~~and Work Plan~~.

Delegated And Non-Delegated Activities

While CalOptima Health is accountable for all QIHE functions, CalOptima Health does delegate responsibilities to subcontractors and downstream subcontractors and specifies these requirements in a mutually agreed upon delegation agreement. CalOptima Health evaluates the delegates ability to perform the delegated activities to ensure compliance with statutory, regulatory and accreditation requirements as part of an annual and continuous monitoring process for delegation oversight.

Delegation Oversight

Participating entities are required to meet CalOptima Health's QI standards and to participate in CalOptima Health's QIHETP. CalOptima Health has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate's ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Delegation Oversight Committee, reporting to the Compliance Committee.

CalOptima Health, via a mutually-agreed-upon delegation agreement document, describes the responsibilities and activities of the organization and the delegated entity.

CalOptima Health conducts oversight based on regulatory, CalOptima Health and NCQA standards and has a system to audit and monitor delegated entities' internal operations on a regular basis.

Delegation Oversight Performance Monitoring includes but is not limited to the CalOptima Health delegates and monitors the following functions:

- Care Management, Credentialing, Utilization Management, and Claims.

Non-Delegated Activities

The following activities are not delegated to CalOptima Health's contracted HNs and remain the responsibility of CalOptima Health:

- QI, as delineated in the Contract for Health Care Services
- QIHETP for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- Health Equity
- BH for Medi-Cal and OneCare
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health education, as applicable
- Grievance and appeals process for all lines of business, and peer review process on specific, referred cases
- PQI investigations
- Development of systemwide measures, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second-level review of provider grievances
- Development of UM and Care Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

APPENDIX:

A – 2024 QIHETP WORK PLAN
B – 2024 POPULATION HEALTH MANAGEMENT STRATEGY
C – CALOPTIMA HEALTH MEASUREMENT YEAR (MY) 2024 MEDI-CAL AND ONECARE PAY FOR VALUE PROGRAMS
D – 2024 CULTURAL AND LINGUISTIC APPROPRIATE SERVICES PROGRAM

ABBREVIATIONS

	ABBREVIATION	DEFINITION
A		
	ACE	Adverse Childhood Experience
	ADA	Americans With Disabilities Act of 1990
	ADHD	Attention-Deficit Hyperactivity Disorder
	APL	All Plan Letter
	AUD	Alcohol Use Disorder
B		
	BHI	Behavioral Health Integration
	BHT	Behavioral Health Treatment
	BHIIP	Behavioral Health Integration Incentive Program
	BMSC	Benefit Management Subcommittee
C		
	CalAIM	California Advancing and Innovating Medi-Cal
	CAHPS	Consumer Assessment of Healthcare Providers and Systems
	CAP	Corrective Action Plan
	CBAS	Community Based Adult Services
	CCIP	Chronic Care Improvement Project
	CCO	Chief Compliance Officer
	CCS	California Children's Services
	CHCN	CalOptima Health Community Network
	CHEO	Chief Health Equity Officer
	CHRO	Chief Human Resources Officer
	CEO	Chief Executive Officer
	CIO	Chief Information Officer
	CLAS	Cultural and Linguistic Appropriate Service
	CMO	Chief Medical Officer
	CMS	Centers for Medicare & Medicaid Services
	COO	Chief Operating Officer
	COPD	Chronic Obstructive Pulmonary Disease
	COS	Chief of Staff
	COD-A	CalOptima Health Direct-Administrative
	CPRC	Credentialing and Peer Review Committee
	CQS	Comprehensive Quality Strategy
	CR	Credentialing
D		
	DC	Doctor of Chiropractic Medicine
	DCMO	Deputy Chief Medical Officer
	DDS	Doctor of Dental Surgery
	DHCS	Department of Health Care Services
	DMHC	Department of Managed Health Care
	DO	Doctor of Osteopathy
	DPM	Doctor of Podiatric Medicine
	D-SNP	Dual-Eligible Special Needs Plan
E		
	ECH	Equity and Community Health
	ED ~~PHM~~ECH	Executive Director, Equity and Community Health ~~Population Health Management~~
	ED BH	Executive Director, Behavioral Health Integration
	BH	Behavioral Health

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	ED CO	Executive Director, Clinical Operations
	ED MP	Executive Director, Medicare Programs
	ED NO	Executive Director, Network Operations
	ED O	Executive Director, Operations
	ED Q	Executive Director, Quality
F		
	FDR	First Tier, Downstream or Related Entity
	FSR	Facility Site Review
G		
	GARS	Grievance and Appeals Resolution Services
H		
	HEDIS	Healthcare Effectiveness Data and Information Set
	HIPAA	Health Insurance Portability and Accountability Act
	HMO	Health Maintenance Organization
	HN	Health Network
	HNA	Health Needs Assessment
	HOS	Health Outcomes Survey
	HRA	Health Risk Assessment
I		
	ICT	Interdisciplinary Care Team
	ICP	Individual Care Plan
	IRR	Inter-Rater Reliability
L		
	LTC	Long Term Care
	LTSS	Long Term Services and Supports
M		
	MAC	Member Advisory Committee
	MD	Doctor of Medicine
	ME	Member Experience
	MED	Medicaid Module
	MEMX	Member Experience Committee
	MOC	Model of Care
	MOU	Memorandum of Understanding
	MRR	Medical Record Review
	MRSA	Methicillin resistant Staphylococcus aureus
	MSSP	Multipurpose Senior Services Program
	MY	Measurement Year
	NCQA	National Committee for Quality Assurance
	NET	Network
	NF	Nursing Facility
O		
	OC	Orange County
	OCHCA	Orange Country Health Care Agency
	OP	Organizational Providers
	OC SSA or SSA	County of Orange Social Services Agency
Q		
	QAC	Quality Assurance Committee
	QI	Quality Improvement
	QIHE	Quality Improvement and Health Equity

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	QIHEC	Quality Improvement and Health Equity Committee
	QIP	Quality Improvement Project
P		
	P4V	Pay for Value
	P&T	Pharmacy & Therapeutics Committee
	PAC	Provider Advisory Committee
	PACE	Program of All-Inclusive Care for the Elderly
	PARS	Physical Accessibility Review Survey
	PBM	Pharmacy Benefit Manager
	PCC	Personal Care Coordinator
	PCP	Primary Care Practitioner/physician
	PDSA	Plan-Do-Study-Act
	PHM	Population Health Management
	PHC	Physician Hospital Consortium
	PIP	Performance Improvement Project
	PPC	Prenatal and Postpartum Care
	PPC	Provider Preventable Condition
	PQI	Potential Quality Issue
	PSS	Perinatal Support Services
S		
	SABIRT	Alcohol and Drug Screening Assessment, Brief Interventions and Referral to Treatment
	SBHIP	Student Behavioral Health Incentive Program
	SDOH	Social Drivers of Health
	SNP	Special Needs Plan
	SNF	Skilled Nursing Facility
	SPD	Seniors and Persons with Disabilities
	SRG	Shared Risk Group
	SUD	Substance Use Disorder
T		
	TPL	Third Party Liability
U		
	UM	Utilization Management
	UMC	Utilization Management Committee
V		
	VS	Vision Service
	VSP	Vision Service Plan
W		
	WCM	Whole-Child Model Program
	WCM CAC	Whole-Child Model Clinical Advisory Committee
	WCM FAC	Whole-Child Model Family Advisory Committee

Submitted and approved by QIHEC: 05/14/2024
Quality Improvement Health Equity Committee Chairperson:

Richard Pitts, D.O., Ph.D. Date

Submitted and approved by QAC: 06/12/2024
Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. Date

2024 QIHETP Work Plan Updated 4.1.24

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Delayed Green - On Target
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X			
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	~~QIHETP~~ Quality Improvement Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X			
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley	ED of Clinical Operations	Director of UM	Utilization Management	X			
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley	ED of Clinical Operations	Director of UM	Utilization Management	X			
Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: Population Needs Assessment (PNA) Risk stratification Screening and Assessment Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Katie Balderas	Barbara Kidder/Hannah Kim/HM/Director of Care Management	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	X			
Program Oversight	2024 Population Health Management (PHM) Strategy Evaluation	Complete the Evaluation of the 2024 Population Health Managemet (PHM) Strategy	The Population Heath Management (PHM) Strategy will be evaluated for effectiveness on an annual basis.	QIHEC: 11/XX/24 QAC: 12/XX/24 Annual BOD Adoption by January 2025	Katie Balderas	Barbara Kidder/Hannah Kim/HM/Director of Care Management	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	**New**			
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Albert Cardenas	Carlos Soto	Manager of Customer Service	~~TBD~~ Manager of Cultural and Linguistics	Cultural and Linguistic Services	X			
Program Oversight	2024 Cultural and Linguistic Services Program Evaluation	Complete the Evaluation of the 2024 Cultural and Linguistic Services Program	The Cultural and Linguistic Services Program will be evaluated for effectiveness on an annual basis.	QIHEC: 11/XX/24 QAC: 12/XX/24 Annual BOD Adoption by January 2025	Albert Cardenas	Carlos Soto	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	**New**			
Program Oversight	**Population Health Management (PHM) Committee** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder/Hannah Kim	Director of Equity and Community Health	~~TBD~~ Manager of Equity and Community Health/ Director Case Management	Equity and Community Health	**New**			
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	Report committee activities, findings from data analysis, and recommendations to QIHEC	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Laura Guest	Marsha Choo Rick Quinones Katy Noyes	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X			
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.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	Director of Grievance and Appeals	Manager of GARS	GARS	X			
Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Director of Medicare Stars and Quality Initiatives	Project Manager Quality Analytics	Quality Analytics	X			
Program Oversight	**Utilization Management Committee (UMC) Oversight** - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. **P&T and BMSC** reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Kelly Giardina	Stacie Oakley	Director of Utilization Management	Manager of UM	Utilization Management	X			
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	T.T. Nguyen, MD/H.Kim	Gloria Garcia	Whole Child Model Medical Director / Director of Case Management	Program Assistant QI	Medical Management	X			
Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Megan Dankmyer	TBD	Director of Care Management	TBD	Medical Management	**New**			
Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activites.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accredication standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Monica Herrera	Zulema Gomez John Robertson	Director of Audit and Oversight	~~TBD~~ Manager of Audit and Oversight (Delegation)/ Manager Delegation Oversight	Delegation Oversight	**New**			
Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Elisa Mora	Director of PHM	~~TBD~~ Manager of Equity and Community Health	Equity and Community Health	**New**			
Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: Evaluation of current utilization of health education services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Anna Safani/Katie Balderas	Thanh Mai Dinh	Director of Equity and Community Health/Manager of Health Education	TBD Manager of Equity and Community Health	Equity and Community Health	**New**			
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024 Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	x			
Program Oversight	Long-Term Support Services (LTSS)	Implement LTSS	Report on the following activities: Evaluation of current utilization of LTSS Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	Director of LTSS	~~TBD~~ Manager of LTSS	Long Term Care	**New**			
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activites for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Veronica Gomez	Marsha Choo	Program Manger of QI	Director of Quality Improvement	Quality Improvement	X			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Delayed Green - On Target
Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of QA	Quality Improvement	X			
Program Oversight	Value Based Payment Program	Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Manager of Quality Analytics	~~TBD~~ Manager Quality Analytics	Quality Analytics	X			
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1 02/11/2025	Paul Jiang	Terri Wong	Director of Quality Analytics	~~TBD~~ Manager Quality Analytics	Quality Analytics	X			
Program Oversight	School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Sherie Hopson	Director of Behavioral Health Integration	Project Manager BHI	Behavioral Health Integration	X			
Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Katie Balderas	Barbara Kidder	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X			
Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.86% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	X			
Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Int Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collaboritively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second quater. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow-up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Health Equity/Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Director of Behavioral Health Integration	~~TBD~~ Program Specialist of Behavioral Health Integration	Behavioral Health	**New**			
Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primay Care Providers (PCP) for members in need of merabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to the next top 50 prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs) 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care.	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Director of Behavioral Health Integration	~~TBD~~ Program Specialist of Behavioral Health Integration	Behavioral Health Integration	**New**			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Director of Behavioral Health Integration	~~TBD~~ Program Specialist of Behavioral Health Integration	Behavioral Health Integration	**New**			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaborotively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward Program.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP:Improve the percentage of members enrolled into care management, Caloptima Helath community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz/Mary Barranco	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration/ Quality Analytics	X			
Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 68.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD: HbA1c Poor Control (this measure evaluates % of members with poor A1C control- lower rate is better) MY2024 Goals: MC: 29.44%; OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Delayed Green - On Target
Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Equity and Community Health/ Quality Analytics	X			
Quality of Clinical Care	Maternal and Adolescent Depression Screening	Medi-Cal Only - Meet the following goals For MY2024 HEDIS: DSF-E Depression Screening and Follow-up for Adolescent and Adults - Screening: 2.97% PND-E Prenatal Depression Screening and Follow-up - Screening: 8.81% PDS-E Postpartum Depression Screening and Follow-up: 27.77%	1) Identification and distribution of best practices to health network and provider partners. 2) Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion. 3) Targeted member engagement and outreach campaigns in coordination with health network partners. 4) Provider education (CE/CME) in Q3.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson/Natalie Zavala	Kelli Glynn/Diane Ramos	Director of Operations Management / Director of Behavioral Health Integration	Manager of Quality Analytics / Manager of Behavioral Health Integration	Operations Management/ Behavioral Health Integration	**New**			
Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s) In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS **MY2024** Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits. Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data submited by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 04/09/2024 Q4: 10/08/2024	Kelly Klipfel	Lorena Dabu	Director of Finance	Manager of Finance	Finance	**New**			
Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC: Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025 Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Marsha Choo	Katy Noyes	Director Qualty Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Laura Guest	Director Qualty Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Director Qualty Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Director of Quality Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	S. Hickman/M. Dankmyer/H. Kim	QI Nurse Specialist	Director Medical Management/Case Management	QI Nurse Specialist	Case Management	X			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Delayed Green - On Target
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	1) Quynh Nguyen 2) Tory Vazquez 3) Jane Flannigan Brown	Mahmoud Elaraby Provider Relations	1) Director of Provider Network 2) Director of Contracting	~~TBD~~ Analyst of Quality Analytics	Contracting	X			
Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely acces. 3) Continue to educate providers on timely acces standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Director of Medicare Stars and Quality Initiatives	~~TBD~~ Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	X			
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for Improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Karen Jenkins/Mahmoud Elaraby	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst	Network Operations/Quality Analytics	X			
Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Katie Balderas	Anna Safari	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X			
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Mahmoud Elaraby/Johnson Lee	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	~~TBD~~ Quality Analyst for Quality Analytics/ Manager of Provider Data Management Services	Provider Data Management Services	**New**			
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Carol Matthews/Helen Syn	Director of Medicare Stars and Quality Initiatives	QA Project Manager	Quality Analytics	X			
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	Director of GARS	Manager of GARS	GARS	**New**			
Quality of Service	~~Medi-Cal~~ Customer Service	Implement customer service process and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Andrew Tse	Mike Erbe	Director of Customer Service	~~TBD~~ Manager of Customer Service	Customer Service				
Quality of Service	Medi-Cal Customer Service Performance Improvement Project	To meet Medi-Cal Customer Service KPIs by December 31, 2024: Internal call abandonment rate of 5% or lower, DHCS' 10 minutes average speed of answer	1) Partnering with HR to onboard more permanent and temporary staff to service inbound calls. 2) Interacting with various departments involved with member engagement campaigns and determine if they're able to update instructions for targeted members (i.e., instead of calling customer service, have them utilize the member portal).	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Andrew Tse	Mike Erbe	Associate Director of Customer Services	Manager of Customer Service	Customer Service	**New**			
~~Safety of Clinical Care~~	~~Coordination of Care: Member movement across settings~~	~~Improve care coordination between the hospital and primary care physician (PCP) following patient discharge from an acute care setting~~	~~Assess and report the following activities:~~ ~~1) Collaborative meetings between teams to identify best practices to implement~~ ~~2) Provider and member education~~	~~UMC Committee report to QIHEC:~~ ~~Q2: 06/11/2024~~ ~~Q3: 09/10/2024~~ ~~Q4: 12/10/2024~~ ~~Q1 03/11/2025~~	~~Stacie Oakley~~	~~TBD~~	~~Director of Utilization Management~~	~~TBD~~	~~Utilization Management~~	~~New~~			
Safety of Clinical Care	Coordination of Care: Member movement across ~~settings~~ practitioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Megan Dankmyer	TBD	Director of Case Management	TBD	Medical Management	**New**			
Safety of Clinical Care	Emergency Department Visits	Emergency Department Diversion Pilot Pilot has been implemented. In 2024 plan to expand the program to additional hospital partners.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	Director of LTSS	Manager of LTSS	LTSS	X			
Safety of Clinical Care	Coordination of Care: Member movement across settings - Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% from Q4 2023 by end of December 31,2024.	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Stacie Oakley Hannah Kim Scott Robinson	Joanne Ku	Director of UM, CM and LTSS	~~TBD~~ Manager of Medical Management	Utilization Management Case Management Long Term Care	X			
~~Quality of Clinical Care,~~ Cultural and Linguistic Appropriate Services	Performance Improvement Projects (PIPs) Medi-Cal	~~Meet and exceed goals set forth on all improvement projects~~ Increase well-child visit appointments for Black/African American members (0-15 months) from 41.90% to 55.78% by 12/31/2024..	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	X			
~~Quality of Clinical Care,~~ Cultural and Linguistic Appropriate Services	Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Maintain business for current programs Improve process for handling these services	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Albert Cardenas	Carlos Soto	Director of Customer Service	Manager of Customer Service	Cultural and Linguistic Services				
Cultural and Linguistic Appropriate Services	Maternity Care for Black and Native American Persons	~~Meet the following goals For MY2024 HEDIS: PPC Postpartum: Black 74.74%, Native American 63.22% PPC Prenatal: Black 72.37%, Native American 59.43%~~ 1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima's Black members from 67.48% to 74.74% and Native Americans from 44.44 to 63.22% by 12/31/24. 2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima's Black members from 53.77 to 72.37% and Native Americans from 27.78% to 59.43% by 12/31/24.	Assess and report the following activities: 1) Determine the primary drivers to noncompliance via member outreach and literature review 2) Targeted member engagement and outreach campaigns in coordination with health network partners 3) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 4) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 5) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 6) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Manager Equity and Community Health/ Director of Operations Management	Program Manager of Quality Analytics/ Manager of Quality Analytics	Equity and Community Health	**New**			
Cultural and Linguistic Appropriate Services	Data Collection on Member Demographic Information	Implement a process to collect member SOGI data by December 31, 2024.	1) Develop and implement a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 3) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 4) Develop and implement a survey to distribute during the monthly New member orientation sessions. 5) Share member demographic information with practitioners.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Albert Cardenas	Carlos Soto	Director of Customer Service	Manager of Customer Service	Customer Service	**New**			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Delayed Green - On Target
Cultural and Linguistic Appropriate Services	Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.	1) Develop and implement a survey to collect practitioner REL data 2) Enter REL data into provider data system and ensure ability to retrieve and utilize for CLAS improvement. 3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership. 4) Assess the provider network's capacity to meeting CalOptima Health's culturally diverse member needs. 5) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Quynh Nguyen	Johnson Lee	Director of Provider Data Management Services	Manger Provider Data management System	Provider Data Management Services	**New**			
Cultural and Linguistic Appropriate Services	Experience with Language Services	Evaluate language services experience from member and staff	1) Develop and implement a survey to evaluate the effectiveness related to cultural and lingustic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Albert Cardenas	Carlos Soto	Director of Customer Service	Manager of Customer Service	Customer Service	**New**			

2024

POPULATION HEALTH MANAGEMENT STRATEGY & WORK PLAN

Responsible Staff:

Shilpa Jindani, MD
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Director, Population Health Management
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INTRODUCTION

Agency Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. We believe that our members deserve the highest quality of care and service. To achieve this, CalOptima Health works in collaboration with members, providers, community stakeholders and government agencies guided by our mission and vision.

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Strategy Purpose

To meet the unique and comprehensive health needs of our members, CalOptima Health engaged with multidisciplinary care teams, community partners and stakeholders to co-create the Population Health Management (PHM) Strategy.

The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also shares our creative upstream approach to address social determinants of health (SDOH) and close gaps in care that lead to health disparities among our members.

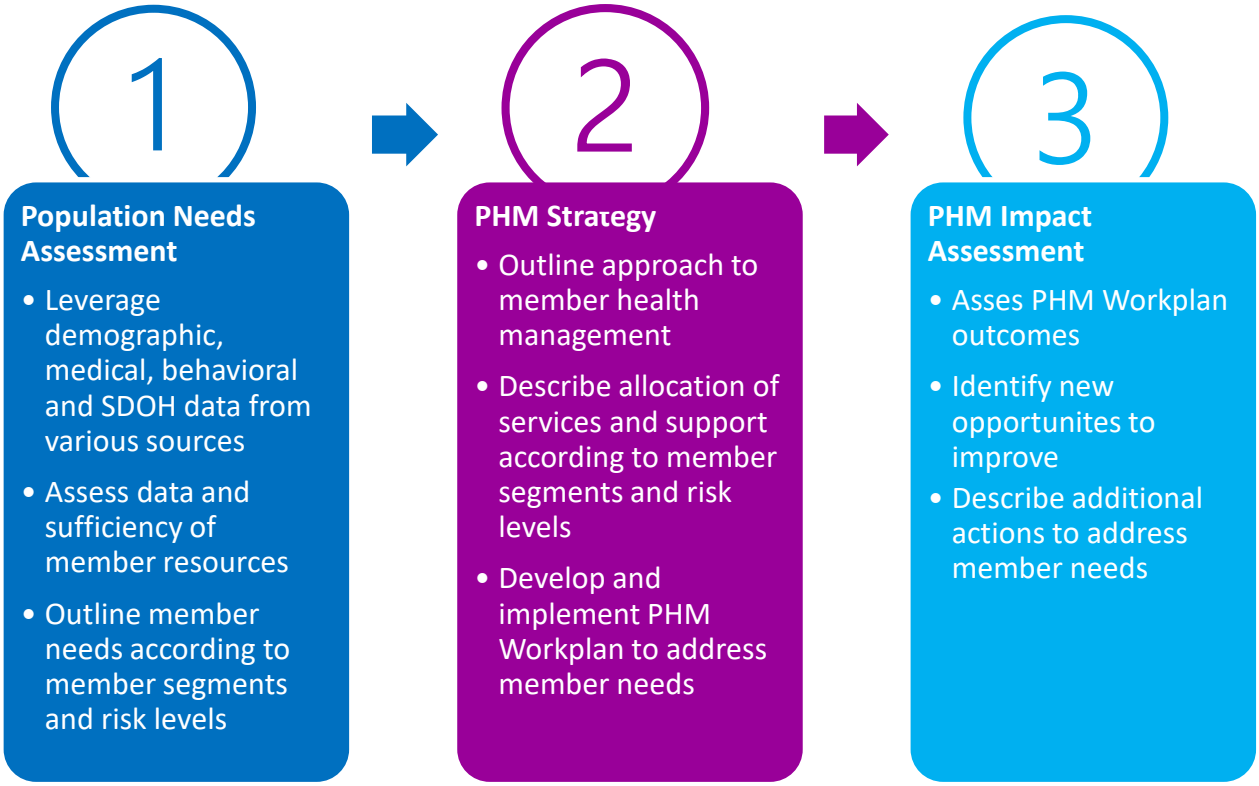
In addition, CalOptima Health aligns our PHM Strategy with the priorities of our federal and state regulators and follows the standards outlined by the National Accreditation of Quality Assurance (NCQA).

CalOptima Health's PHM Strategy addresses the following areas of focus:

1. Keeping members healthy
2. Managing members with emerging risks
3. Member safety
4. Managing members with multiple chronic conditions

Strategic Management

To inform our PHM Strategy and programs, CalOptima Health has several processes in place to review collected data that is used to understand our member needs, develop strategies to address those needs and evaluate the impact of those strategies through a comprehensive PHM Workplan. The following diagram illustrates the relationship of these activities:



Population Needs Assessment

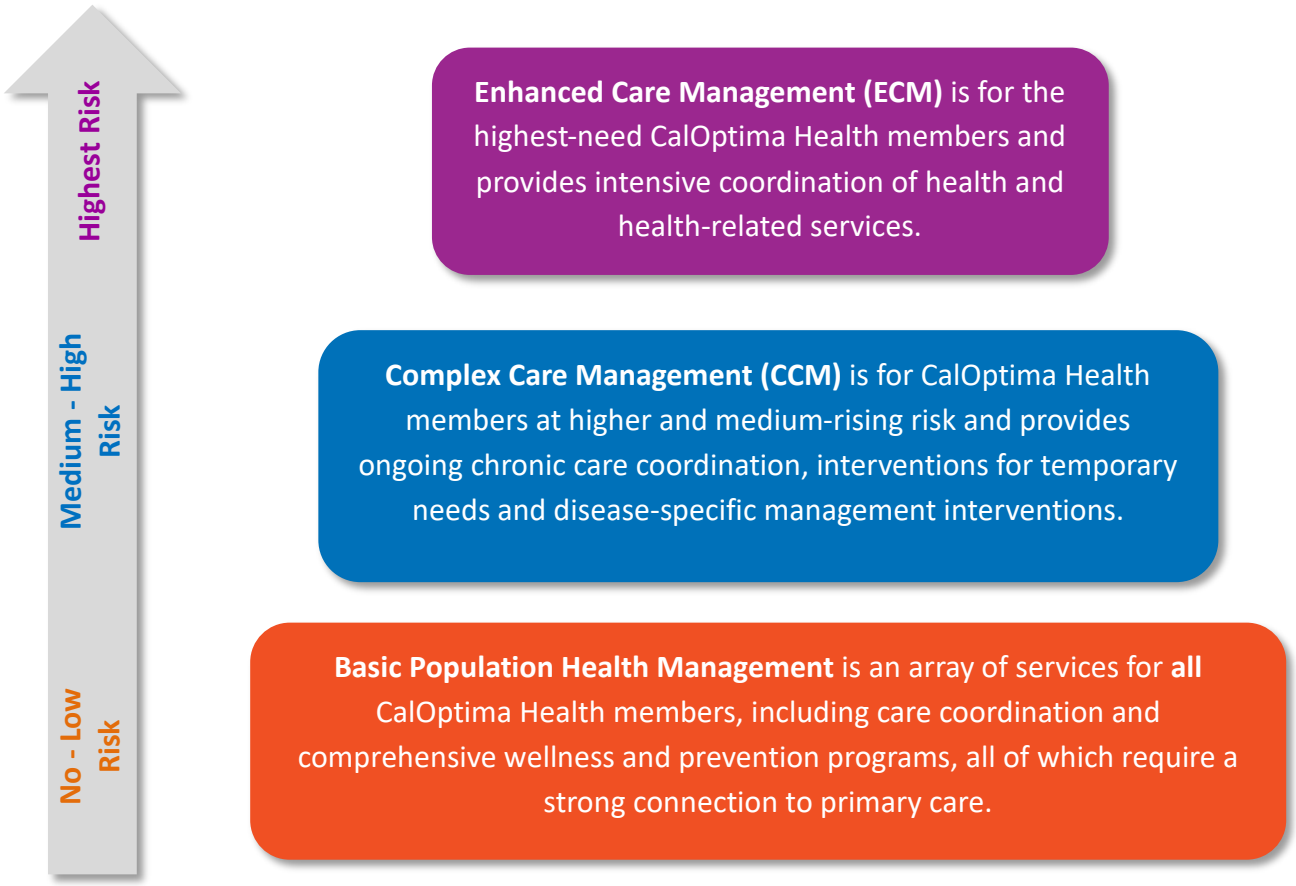
CalOptima Health's Population Needs Assessment (PNA) summarizes the results of an annual assessment on a variety of data. The intent of the PNA is to review the characteristics and needs of our agency's member population and relevant focus populations to support data-driven planning and decision-making. This report specifically focuses on CalOptima Health's:

- Overall member population, including SDOH
- Children and adolescent members ages 2–19 years old
- Members with disabilities
- Members with serious and persistent mental illness (SPMI)
- Members according to racial and ethnic groups
- Members with limited English proficiency
- Relevant focus populations

CalOptima Health uses PNA key findings to inform the PHM Strategy and Workplan which aim to address gaps in member care through intervention strategies and quality initiatives. Report findings also helped identify the need for process updates and resource allocation.

Population Segmentation and Care Coordination

CalOptima Health's PHM program aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner across the entire health care continuum and life span. The PHM program integrates physical health, behavioral health, long-term support services, care coordination and complex case management to improve coordination of care between managed care teams. The PHM program includes basic population health management, complex care management, Enhanced Care Management (ECM) and transitional care services.



PHM Strategy and Workplan

The following table provides a high-level overview of CalOptima Health's 2024 PHM Strategy and Workplan. This table shows how CalOptima Health aligns federal and state guidance with NCQA standards to guide our PHM Program efforts.

CalOptima Health 2024 PHM Workplan Overview

Area of Focus	Program/Service	Description
Keeping Members Healthy	**Blood Lead Testing in Children**	In babies and young children, whose brains are still developing, even a small amount of lead can cause learning disabilities and behavioral problems. CalOptima Health works with providers and members to ensure that all young children are tested for lead at age-appropriate intervals.
	Well-Child Visits	Well-child visits are important during the early months of a child's life to assess growth, development and identify and address any concerns early. CalOptima Health promotes preventive care for its youngest members to help them live long, happy and healthy lives.
	Health Disparity Remediation for Well-Child Visits	CalOptima Health aims to reduce the racial/ethnic disparities in well child visits in support of the statewide goals. Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate among African American child members has the potential to improve their overall health status.
	Childhood Immunizations	Childhood vaccinations are a safe and effective way to protect children from a variety of serious or potentially fatal diseases. CalOptima Health works to promote immunizations and ensure that children are healthy, growing and ready to learn.
	Comprehensive Community Cancer Screening and Support Program	CalOptima Health partnered with external stakeholders in the fight against cancer to launch this program. Together, we aim to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses through early screening.
	Bright Steps Program	CalOptima Health's prenatal and postpartum care program aims to inform and provide resources to pregnant members to help them have a healthy pregnancy, delivery and baby.
	Shape Your Life	CalOptima Health offers no-cost, in-person and virtual group classes for children ages 5 to 18 and their families. Topics include healthy eating, physical activity and other ways to build healthy habits.
Emerging Risk	**Chronic Condition Care and Self- Management Program**	CalOptima Health's programs promote self-management skills for people with chronic conditions to enable them to manage their health on a day-to-day basis and to take an active role in their health care.
Patient Safety	**CalAIM Community Supports**	California Advancing and Innovating Medi-Cal (CalAIM) is a five-year initiative by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by addressing social drivers of health and breaking down barriers in accessing care. Community Supports are a core component of CalAIM.
	Street Medicine Program	CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's un-housed individuals and families through whole person care approaches and addressing social drivers of health.
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	CalOptima Health's program assesses the percentage of emergency department (ED) visits for members aged 6 and older with a principal diagnosis of alcohol and other drug abuse or dependence to ensure our members receive appropriate follow-up care.
Multiple Chronic Conditions	**Complex Case Management Program**	Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

NOTE: Please see CalOptima Health's 2024 PHM Workplan for a detailed list of programs and services, SMART objectives and related activities.

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PHM Program

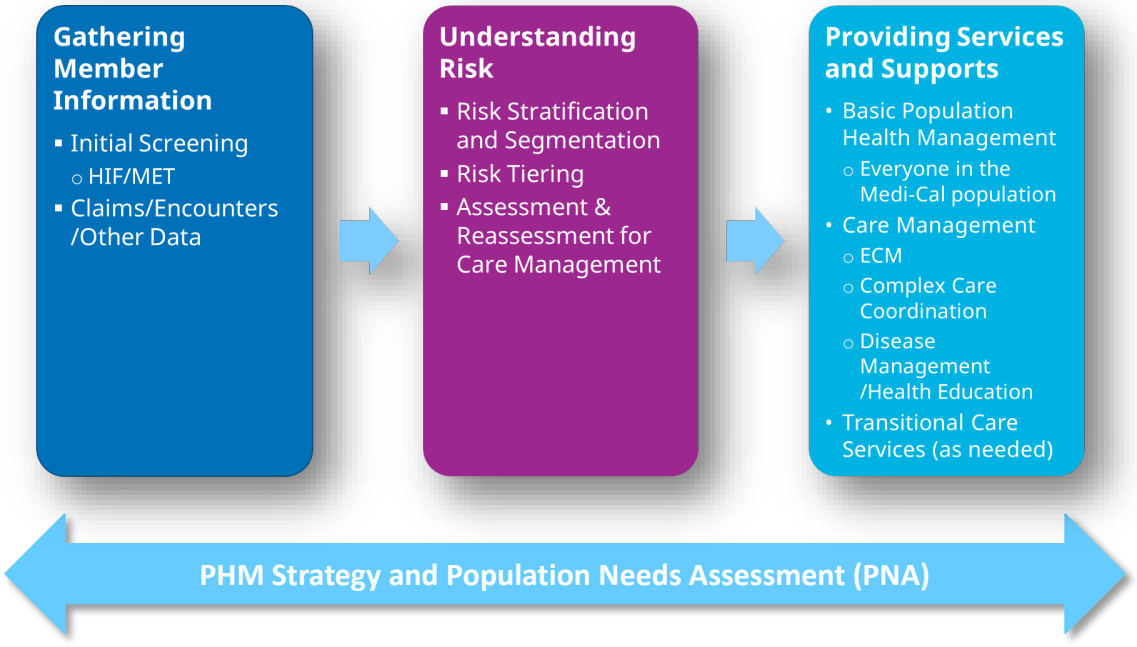
The PHM Strategy serves to guide CalOptima Health's PHM Program that aims to motivate, educate and empower members to become self-advocates in their healthcare, manage conditions, prevent acute episodes and enhance their quality of life. Our PHM Program and related services are also developed by a multidisciplinary team of health professionals, community partners and stakeholders. Together, we ensure that our PHM Program is committed to health equity, member involvement and accountability. This is achieved by:

- Building trust and meaningful engagement with members.
- Using data-driven risk stratification and predictive analytics to address gaps in care.
- Revising and standardizing assessment processes.
- Providing care management services for all high-risk members.
- Creating robust transitional care services (TCS) to promote continuity of care and limit service disruptions.
- Developing effective strategies to address health disparities, SDOH and upstream drivers of health.
- Implementing interventions to support health and wellness for all members.

PHM Framework

CalOptima Health adopted guiding principles of the PHM Framework to plan, implement and evaluate the PHM Program and our delivery of care. The diagram below outlines the key components used to operationalize the PHM Program, which includes:

- ***Population needs assessment and PHM Strategy*** that are used to measure health disparities and identify the health priorities and social needs of our member population, including cultural and linguistic, access and health education needs.
- ***Gathering member information*** on preferences, strengths and needs to connect every member to services at the individual level, and to allocate resources.
- ***Understanding risk*** to identifying opportunities for more efficient and effective interventions.
- ***Providing services and supports*** to address members needs across a continuum of care.



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PHM Program Coordination

CalOptima Health's PHM Program spans across several settings, providers and levels of care in an effort to meet our members' needs. To streamline PHM Program activities and avoid duplication, CalOptima Health utilizes a care management system to facilitate the coordination of care and data management for members among several care teams including:

- Behavioral Health Integration
- Case Management
- Long Term Care and Support
- Program of All-inclusive Care for the Elderly (PACE)
- Population Health Management
- Pharmacy
- Utilization Management

Through the agency's care management system, CalOptima Health can determine member eligibility for services, share data to identify and address care gaps, and coordinate care across settings. The system is available to all care team staff responsible for member care and enables them to:

- Create links between all systems that allow appropriate coordination of care and support delivered at the proper time, while minimizing duplication of effort between the coordinating teams.
- Access member records to expedite and view all relevant data in one location.
- Identifying member needs through established system logics or from providers and member self-referrals to plan an appropriate level of support whereby a staff (e.g., Personal Care Coordinator) is assigned to help the member with managing their health and social needs.
- Provide members with appropriate assessments and educational materials, derived from evidence-based tools and standardized practices.
- Create an individualized Care Plan with prioritized goals and facilitate services that minimize or eliminate barriers to care for optimal health outcomes.
- Inform Interdisciplinary Care Team (ICT) of member care needs, related activities and health goal progress.

Informing Members about PHM Programs

CalOptima Health deploys several interactive methods to inform members about PHM programs. These interactive methods are designed to share program eligibility and how to use program services. All PHM programs are voluntary. Based on members' language preferences, they are informed of various health promotion programs or how to contact care management staff via initial mailed Member Welcome Packet, member informing materials (e.g., newsletters, program/service letters, benefit manuals, etc.), CalOptima Health's member website, text messaging, personal phone outreach, robocalls and/or in person.

The following descriptions provide more details on how CalOptima Health's eligible members are informed about PHM programs:

- ***Eligibility to participate***: CalOptima Health's PHM programs are accessible to members from Medi-Cal and OneCare lines of business that meet the PHM program criteria. When a member has a referral into a PHM program, the member is directed to the appropriate staff for assistance with enrollment to the program best matching the member's level of need.

- ***Use of services***: CalOptima Health provides instruction on how to use these services in multiple languages and with appropriate health literacy levels.
- ***Accepting or declining services:*** CalOptima Health honors member choice; hence, all the PHM programs are voluntary. Members can self-refer to any PHM program by contacting CalOptima Health. When CalOptima Health conducts outreach to eligible members identified through risk stratification or provider referral, members are informed that the program is voluntary, and they are able to opt-out at any time.

PHM Impact Assessment

CalOptima Health's annual PHM Impact assessment measures the effectiveness of the agency's PHM Strategy and related programs to address member care needs. Through this analysis, CalOptima Health also identifies and addresses opportunities for improvement. Specifically, the assessment focuses on the:

- Clinical impact of programs
- Cost and/or utilization impact of programs
- Member experience with programs

CalOptima Health uses key performance indicators (e.g., primary care, ambulatory care, emergency department visit, inpatient utilization) and quality measures (e.g., Healthcare Effectiveness Data and Information Set [HEDIS®]) to assess the effectiveness of the PHM program and adjust it to meet the needs of our members. The PHM Impact findings are shared with our care management team, stakeholders and regulatory agencies at least annually.

PROMOTING HEALTH EQUITY

CalOptima Health is working to advance health equity throughout our strategic management process to ensure that PHM programs and services support our members in attaining their highest level of health. Health equity is not something that a person can do for themselves. 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. In response, CalOptima Health has prioritized health equity so that all members are empowered and able to access resources to be as healthy as possible, regardless of background and identity. In 2022, CalOptima Health launched an organization-wide Equity Initiative, with focus areas in:

- Health equity and SDOH
- Communications and narrative change
- Diversity, equity and inclusion for CalOptima Health workforce
- Stakeholder engagement

To meet the needs of members who are impacted by the greatest health inequities, CalOptima Health has develop a roadmap to meet the following overarching goals:

- Make an explicit commitment to advance health equity to internal and external stakeholders.
- Identify existing and needed organizational assets, resources and leadership.
- Measure health inequities and identify impactful strategies focused on SDOH.
- Implement short- and long-term strategies at the member, organizational and community level.
- Enhance data collection, shared lessons and expanded capacity.

CalOptima Health has operationalized our health equity efforts through a broad range of programs and services.

Social Determinants of Health

To guide our effort in healthy equity, CalOptima Health developed the Member Risk Dashboard to help us understand the impact that SDOH has on our members. This dashboard is informed by the Chronic Illness and Disability Payment System (CDPS) + Rx risk model which assigns a risk score to each member using diagnosis codes from claims and encounters plus pharmacy data to help assess the effective disease burden a population may face. The Member Risk Dashboard can overlay risk with several different factors (e.g., gender, ethnicity, age, health conditions, SDOH factors, etc.) to stratify and segment members. Furthermore, the SDOH data collected using diagnosis codes present on claims and encounters is categorized as follows:

- Adverse family events
- Criminal justice involved
- Housing instability
- Indications of extreme poverty
- Psychosocial circumstances

Among the different features available through this dashboard are the SDOH Profile and SDOH Comparison. The SDOH Profile provides an overview of how SDOH factors impact CalOptima Health members. The SDOH Comparison is used to compare health metrics between SDOH categories such as:

- Condition prevalence
- Hospital readmissions
- Emergency room visits
- Dental visits
- Uncontrolled A1c
- Unused authorizations

The Member Risk Dashboard serves to highlight CalOptima Health's current efforts to better identify and address the health disparities seen in our member population that are caused by SDOH. CalOptima Health plans to continue enhancing our understanding of the impact that SDOH has on our members through the expansion of data collection efforts and community engagement.

ACTIVITIES AND RESOURCES

CalOptima Health recognizes the importance of mobilizing multiple resources to support our members' health needs. At least annually, CalOptima Health conducts a strategic review of existing structures, programs, activities and resources using its PNA and dashboards. This strategic assessment helps CalOptima Health leaders set new program priorities, re-calibrate existing programs, re-distribute resources to ensure health equity and proactively mitigate emerging risks. Please see the annual PNA Report for details of this review and a description of the activities and resources supported by CalOptima Health.

In addition, CalOptima Health describes activities that are designed to support the PHM Strategy, including activities not directed at individual members, in our PHM Workplan. Indirect member activities apply to multiple areas of focus to and include:

- Building partnerships with community-based organizations, local health care agencies, hospitals and clinics, universities and more to streamline efforts and leverage resources.
- Developing toolkits and resources to support health network providers and community partners.
- Conducting improvement projects (e.g., Plan, Do, Study, Act (PDSA) and Performance Improvement Projects (PIP)) to address health disparities.
- Investing in community implementation and expansion efforts to support PHM programs and services.
- Regularly sharing guidance and information relevant to members with staff, providers and stakeholders using multimodal communication strategies (e.g., newsletters, web portals, meetings, etc.)
- Exchanging data between CalOptima Health and supporting health entities (e.g., Health Network providers, local health agencies, etc.)
- Facilitating continuous education, training and professional development opportunities for staff and providers.

DELIVERY SYSTEM SUPPORTS

Providers and practitioners play an integral role in helping CalOptima Health members meet their highest level of health. Therefore, CalOptima Health works intentionally and collaboratively to support our provider and practitioner community to fulfill PHM goals. CalOptima Health offers ongoing support to providers and practitioners in our health networks, such as sharing patient-specific data, offering evidenced-based or certified decision-making aids, continuing education sessions and providing comparative quality and cost information. These supports are described below:

Information Sharing

CalOptima Health provides member-level prospective rates (or gaps in care) reports for providers on a monthly basis to support preventive care outreach and engagement. CalOptima Health will continue to improve information sharing using integrated and actionable data. Additionally, CalOptima Health facilitates ongoing collaboration and open lines of communication regarding member health outcomes through quarterly Joint Operations Meetings and quarterly Health Network Forums to discuss strategies, barriers and opportunities for improvement.

Shared Decision-Making Aids

CalOptima Health aligns decision-making aids with our clinical practice guidelines to promote shared decision making among providers and their members. These are approved by CalOptima Health's Quality Improvement Committees, posted to CalOptima Health's provider website and promoted through our providers newsletters. Shared Decision-Making Aid topics include:

- Cardiac Conditions
- Treatment for Opioid Use Disorder
- Diabetes Medication Choice
- Heart Disease
- Hypertension
- Treatment for Kidney Failure

Transformation Support

CalOptima Health's Orange County Population Health and Transition to Value-Based Care Initiative (PHVBC) aims to support participating health centers and their providers in transforming access to quality of care while strengthening the safety net system across OC. Over the course of five years, teams from local community clinics will advance their internal systems and implement projects that strengthen their population health capacities and readiness for high-quality and value-based care with the incentives provided by the $50 million PHVBC initiative. Activities will focus on advancing population and community supports (i.e., advocating for support, expanding access to coverage and quality of care) provided to disproportionately impacted communities in Orange County; ultimately, shifting from the idea that the volume of services rendered can serve as a proxy for better health outcomes to a value- and team-based model of care that focuses on the whole person.

The Institute for High Quality Care (IHCQ) will provide technical assistance throughout the initiative, and the Center for Community Health and Evaluation (CCHE) will be the initiative evaluator. Furthermore, the IHCQ will provide a variety of technical assistance to support participating teams throughout the initiative, including training, topic-specific working groups, coaching and curating best

practices and other resources. These supports will be designed and tailored on the PHVBC health centers' specific project and areas of interest and/or need.

CalOptima Health will use the provider profiles to identify practitioners, organizations or communities that do not meet accepted standards of care. Profiling can be used to evaluate both the overuse and underuse of appropriate services. This will help them transform their practices to be more quality and outcome focused. CalOptima Health will use the profiles as a mechanism to administer its financial incentives program for providers to improve quality. The incentives are designed to support practitioners with the necessary funding so they can focus more on care coordination and preventive care. It will provide clinics with the resources to bring on additional staff that can coordinate member care across the spectrum of providers. CalOptima Health will establish goals for providers that align with the quality improvement goals to focus on high priority measures.

Training on Equity, Cultural Competency, Bias, Diversity and Inclusion

CalOptima Health's Cultural Competency training is required for all health care providers and staff who care for our members. The training is available on CalOptima Health's website for providers to complete. The training provides an overview of CalOptima Health's diverse membership, helps providers identify members with potential cultural or language needs where alternate communication methods are needed, and ensures that persons interacting with CalOptima Health members understand how culture and language may influence health.

Pay for Value (P4V)

CalOptima Health's Pay for Value (P4V) program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks and CalOptima Health Community Network (CCN) PCPs are eligible to participate in the P4V programs.

The purpose of CalOptima Health's P4V program is to:

1. Recognize and reward health networks and their physicians for demonstrating quality performance;
2. Provide comparative performance information for members, providers and the public on CalOptima Health's performance; and
3. Provide industry benchmarks and data-driven feedback to health networks and physicians on their quality improvement efforts.

The Medi-Cal P4V program incentivizes performance on all HEDIS® measures that are included in the DHCS Managed Care Accountability Sets (MCAS) required to achieve a minimum performance levels (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures.

PHM Structure

PHM operations at CalOptima Health are supported by a leadership team, allied health professionals and administrative staff. PHM assumes responsibility for health education and disease management programs for all CalOptima Health members. In addition, PHM oversees the strategic management efforts including the identification the health and wellness needs of CalOptima Health members and aligning

organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. The following is a description of PHM team roles and responsibility.

Team Roles and Responsibilities

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the PHM Program, as specified in the state and federal contracts.

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

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members, including Population Health Management. At least quarterly, the CMO presents reports on PHM activities to the Board of Directors' Quality Assurance Committee.

Chief Health Equity Officer (CHEO) leads the development and implementation of health equity as a core competency through collaboration with leaders across CalOptima Health and serves as the voice and content expert on health equity for CalOptima Health's members, affiliates and partners, providing strategic direction around clinical interventions, benefit design, engagement strategies and participates in testing and evaluation initiatives.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Population Health Management (PHM), Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Population Health Management (ED PHM) is responsible for the development and implementation of companywide PHM strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the Chief Medical Officer (CMO), Deputy Chief Medical Officer (DCMO) and Executive Directors from Behavioral Health, Quality, and Clinical Operations Departments, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Clinical Operations functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the Executive Director of Quality and Population Health Management.

Executive Director, Quality (ED QI) is responsible for facilitating the companywide QI Program deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement and Credentialing.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for the management and oversight of CalOptima's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED BHI leads strategies for integrating behavioral health across the health care delivery system and populations served.

Medical Director, Population Health Management and Equity is responsible for advancing population-wide health and well-being for CalOptima Health members by providing clinical guidance for PHM strategies and programs, conducting staff and provider trainings on relevant PHM issues, reviewing and approving health education materials, group class curricula, clinical practice guidelines, shared decision-making aids, and consulting on individual member cases within PHM programs.

Director, Population Health Management (PHM Director) is responsible for advancing population-wide health and well-being for CalOptima Health members by coordinating the development and implementation of a comprehensive population health management plan and health equity framework aligned with the organization's strategic goals. PHM Director provides oversight and supervision of staff to monitor the implement organization-wide population health initiatives amongst internal departments, contracted providers health networks and external stakeholders aligned with CalOptima's overall mission and strategic goals. The PHM Director ensures that the department meets ongoing regulatory compliance and accreditation standards. PHM Director plays a key leadership role, interacting with all levels of CalOptima staff and external stakeholders to implement programs and Quality Improvement (QI) processes that improve cost savings, quality outcomes and member and provider satisfaction.

The following staff support the implementation of strategies within the Population Health Management department:

Managers, Population Health Management (PHM Managers) in Health Education, Disease Management, Maternal Health and Strategic Initiatives:

- Assist with the development of PHM goals and program priorities.
- Analyze best practices for population management and generating ideas to improve operational efficiency within the department.
- Oversee processes to ensure all regulatory requirements are met and exceed all standards.

Supervisors, Population Health Management (PHM Supervisors) in Health Education and Disease Management:

- Provide guidance and support for the implementation of special projects and pilots, or directly handling complex PHM requests from members, providers or staff.

- Monitor staff goals and productivity.
- Ensure compliance with cultural and linguistic requirements and processes, desktop procedures, organizational policies or contractual requirements.

Program Managers, Population Health Management (PHM Program Managers) in strategic initiatives:

- Develop cross-agency workstreams to meet standards in population health as outlined by regulatory entities, strategic priorities and Board directives.
- Plan, implementing and/or evaluating new interventions, programs and interventions.
  Keep current on the local, state, and federal healthcare environment, identifying issues that may impact CalOptima's medical management programs.

Health Educator, Population Health Management (PHM HEs) team:

- Provides health education coaching to individuals or group classes using a member-centric approach.
- Prepares written materials for distribution to members in the appropriate formats and literacy levels as needed.
- Delivers health education interventions through various methods and techniques that are effective to CalOptima Health's members.

Health Coaches, Population Health Management (PHM HCs) team:

- Assesses and develops self-management plans for CalOptima Health members benefiting from chronic condition management, nutrition management and/or psychosocial support.
- Shares the member's specific self-management goals, progress and other pertinent information with their health care team to ensure consistency of member goals.
- Monitors member's health condition and self-management goal outcomes.

Registered Dietitians, Population Health Management (PHM RDs) team:

- Provides individual nutrition assessments, counseling and education by phone or in person using a patient-centered approach.
- Develops nutrition education materials to promote prevention, management of chronic illness and healthy living.
- Works closely with other departments and medical support staff to assist with member care planning.

Personal Care C*oordinators*, *Population Health Management (PHM PCCs)* team:

- Provides outreach to members to coordinate completion of trimester specific assessments including postpartum following CPSP protocols.
- Collaborates with licensed professionals in the development of an initial care plan for each member, incorporating all assessment findings.
- Facilitates warm transfers to member's assigned case manager in accordance with member needs, when appropriate. Notifies member's care team of key event triggers.

Program Coordinator, Population Health Management (PHM PC):

- Provides analytical support to Population Health Management functions, including program development, evaluation and targeted initiatives.
- Manages department calendar by updating and bringing awareness to upcoming milestones and events.
- Acts as administrative support for company-wide and department-specific projects, such as generating reports and maintaining the department's tracking logs, including, but not limited to, action items and executive briefs.

Program Specialists*, Population Health Management (PHM PS)* team:

- Participates in cross-functional teams responsible for the identification, implementation and evaluation of health education activities.
- Supports management in the development, running and evaluation of new population-based disease management programs that support department initiatives.
- Supports management by developing and/or overseeing the process of written tools for programmatic use including program plans, surveys and evaluation instruments.

PHM Oversight

CalOptima Health strives to ensure that PHM strategic management processes are co-created, monitored and evaluated with input from members, providers, stakeholders and leadership. This helps ensure that all PHM programs and services are informed by multidisciplinary experts and approved through careful leadership consideration. The following description provides a high-level summary of our PHM strategic management oversight process.

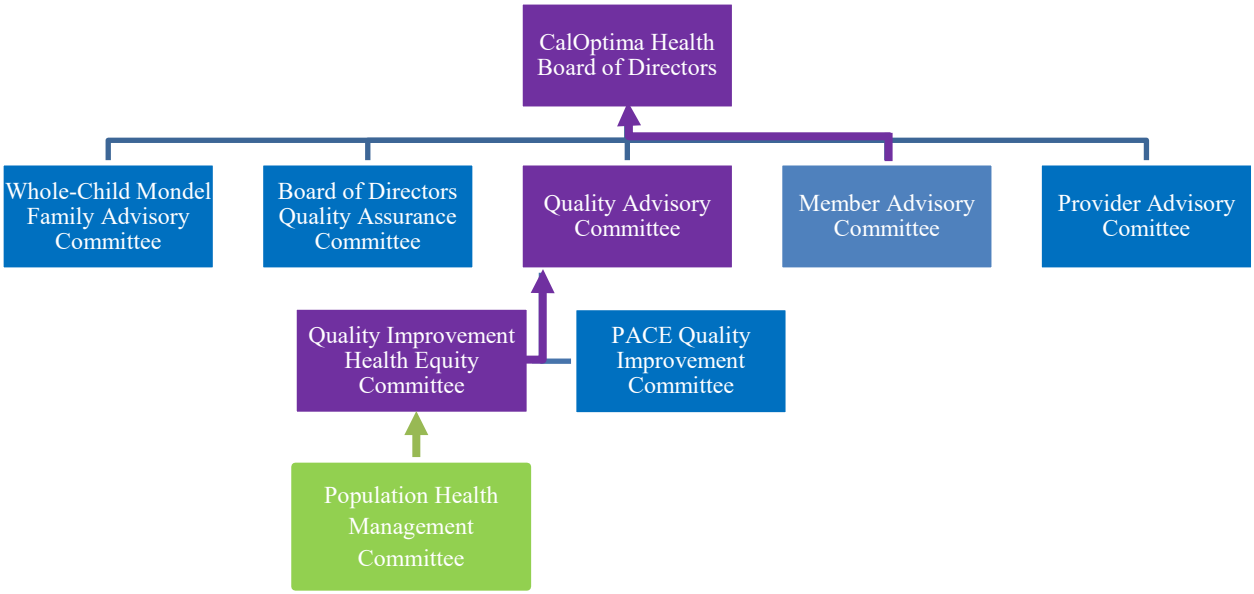
PHM Oversight Responsibilities

Dedicated staff from PHM, in collaboration with other multidisciplinary work teams throughout the agency and guidance from CalOptima Health leadership, assess service utilization patterns, disease burden and SDOH factors to identify gaps in member care. This comprehensive assessment is summarized in an annual PNA. Key findings of the PNA are shared with CalOptima Health's Member Advisory Committee, multidisciplinary care teams and stakeholders to propose new interventions to overcome member gaps in care. Proposed interventions are reviewed by Population Health Management Committee (PHMC) and documented as part of the annual PHM Strategy and Workplan proposals. The PHM Strategy and Workplan proposals are presented to the Quality Improvement Health Equity Committee (QIHEC) for approval. CalOptima Health's QIHEC reports summarize approved PHM Strategy and Workplans to the Board of Director's Quality Assurance Committee (QAC).

Committee Approval Descriptions

The diagram below illustrates the pathway of approval and oversight of the PHM Strategic Management activities along with committee descriptions.

PHM Approval Diagram



Population Health Management Committee (PHMC)

The purpose of the PHMC is to provide overall direction for continuous process improvement and oversight of the PHM Program; ensure PHM activities are consistent with CalOptima Health's strategic goals and priorities; and monitor compliance with regulatory requirements.

Quality Improvement Health Equity Committee (QIHEC)

The purpose of the QIHEC is to assure that all quality improvement activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members.

Board of Directors' Quality Assurance Committee (QAC)

The QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations.

CalOptima Health Board of Directors

The Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima Health's state and federal contracts — and to CalOptima Health's CEO.

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

MY 2024 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the Medi-Cal P4V program.

Recommended for MY 2024 Medi-Cal P4V

1. Include measures held to an MPL in the MY2024 MCAS measure set.

MY 2024 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Chlamydia Screening in Women
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Postpartum Care
Child and Adolescent Well-Care Visits	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	CAHPS- Rating of Health Plan: Adult and Child
Lead Screening in Children	CAHPS- Rating of Health Care: Adult and Child
Topical Fluoride in Children	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Getting Needed Care: Adult and Child
Asthma Medication Ratio	CAHPS- Getting Care Quickly: Adult and Child
Controlling High Blood Pressure*	CAHPS- Coordination of Care: Adult and Child
Hemoglobin A1c Control for Patients with Diabetes- HbA1c Poor Control (>9%) lower is better*	

   - Utilize both Child and Adult CAHPS scores.
     - To calculate performance, average scores
2. Maintain program funding methodology at ten percent (10%) of professional capitation (base rate only).
3. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

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Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS measures weighted 1.0
  - CAHPS measures weighted 1.5
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

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Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on areas with the greatest opportunity for improvement and incentivizes performance on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

Recommended for MY 2024 OneCare P4V

Alignment with the CMS Star program and the following components:

1. Utilize the following CMS Star Part C and Part D measures, measure weights, and Star thresholds as benchmarks:

Measure Category	Measure
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Controlling Blood Pressure*
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – HbA1c Poor Control
	Kidney Health Evaluation for Patients with Diabetes
	Transitions of Care*
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Plan Quality
	Rating of Health Plan
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults
	Rating of Drug Plan
	Getting Needed Prescription Drugs

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS process measures weighted 1.0
  - CAHPS measures weighted 2.0
  - Outcome measures weighted 3.0
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

3. Apply a program funding methodology of $20 PMPM

2024 Culturally and Linguistically Appropriate Services (CLAS) Program Description

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Table of Contents

CalOptima Health Overview

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

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health (SDOH).

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

Who We Serve

As a public agency and Orange County's single largest health insurer, CalOptima Health offers health insurance coverage through three major programs:

- **Medi-Cal**– California's Medicaid Program for low-income children, adults, seniors, and people with disabilities, offering comprehensive health care coverage.
- **OneCare (HMO-DSNP)** – Medicare Advantage Special Needs Plan for seniors and people with disabilities who qualify for both Medicare and Medi-Cal.
- **Program of All-Inclusive Care for the Elderly (PACE)** – PACE for frail older adults, providing a full range of health and social services so seniors can remain living in the community.

Membership Demographics

Membership Data* (as of March 31, 2024)

Total CalOptima Health Membership	Program	Members
932,168	Medi-Cal	914,417
	OneCare (HMO D-SNP)	17,277
	Program of All-Inclusive Care for the Elderly (PACE)	474

*Based on unaudited financial report and includes prior period adjustment

Member Demographics (as of March 31, 2024)

Member Age	
0 to 5	8%
6 to 18	23%
19 to 44	36%
45 to 64	20%
65 +	13%

Language Preference	
English	55%
Spanish	30%
Vietnamese	9%
Other	2%
Korean	2%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	39%
Expansion	38%
Optional Targeted Low-Income Children	7%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services Program, a program that is a part of the Quality Improvement and Health Equity Transformation Program (QIHETP) that integrates culturally and linguistically appropriate services at all levels of the operation.

Objectives for service a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Board of Directors

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement and Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

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

Board of Directors' Quality Assurance Committee

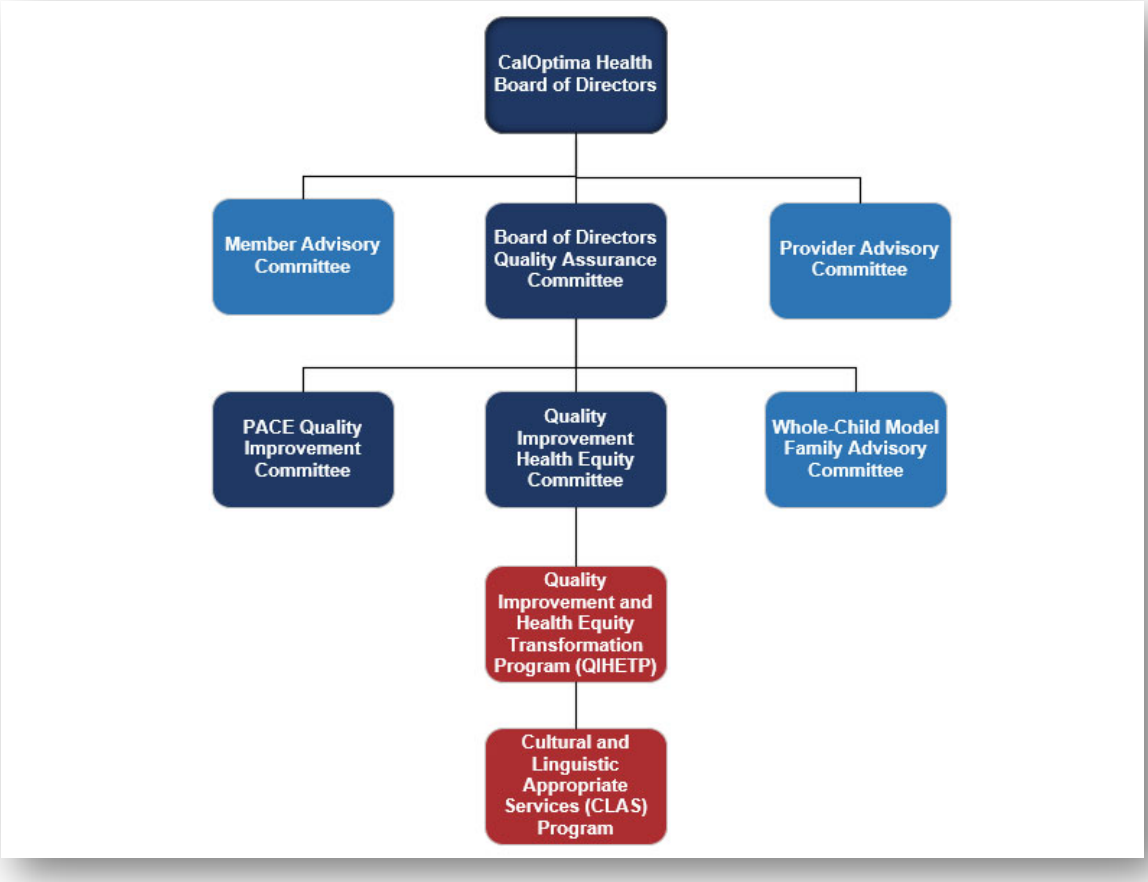
The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QIHETP, including the CLAS Program, and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI, Health Equity and CLAS contractual and regulatory standards and the DHCS Comprehensive Quality Strategy. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QIHETP and the Work Plan of the QIHETP.

Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is the foundation of the QIHETP, which includes the Cultural and Linguistic Appropriate Services (CLAS) Program, and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer (CHEO), and in collaboration, develop and oversee the QIHETP and QIHETP Work Plan activities.

The purpose of the QIHEC is to assure that all QIHETP activities are performed, integrated, and communicated internally and to the contracted delegated HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

CLAS Reporting Structure



Community and Member Engagement

CalOptima Health is committed to member-focused care through member and community engagement. CalOptima Health intends to engage members through the Member Advisory Committee (MAC) and seek input and advice related to the Cultural and Linguistic and Health Equity goals. The MAC has 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services in order to ensure that the CLAS Program meets the needs of the population. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

MAC represents the diversity of its membership. The following table depicts the current MAC break down by ethnic diversity. MAC includes individuals representing the ethnicity and language groups that represent at least 5% of the population. Please note that as of April 1, 2024, one Family Support Representative and two OneCare member seats remain unfilled and are currently under recruitment.

Ethnicity	Ethnicity Membership Percentage	Language	Language Membership Percentage	Number of Members	Corresponding Seats
Hispanic	46%	Spanish	31%	5	4 OneCare Members 1 Behavioral/Mental Health Representative
White	17%	English	55%	8	1 Adult Beneficiaries 1 Children 1 Foster Children 2 Medi-Cal Beneficiaries or Authorized Family Members 1 Persons with Special Needs 1 Recipients of CalWORKs 1 Seniors
Vietnamese	13%	Vietnamese	9%	1	1 Persons with Disabilities
Korean	3%	Korean	1%	1	1 Member Advocate

In addition to engaging MAC members, CalOptima Health intends to gather member input through community focus groups or meetings and survey, such as implementing a health equity and cultural needs member survey that will be distributed to new members during the monthly New Member Orientation Meetings.

Goals

The following are the goals of the CLAS Program:

1. Implement a process to collect, store and retrieve member SOGI data.
2. Evaluate language services experience from members and staff.
3. Implement a process to collect, store and retrieve practitioner race/ethnicity/languages (REL) data.
4. Improve practitioner support in providing language services.

CLAS Work Plan

The CLAS Work Plan is a subset of and is imbedded within the QIHETP Work Plan and outlines key activities for the upcoming year. It is reviewed and approved by the QIHEC and the Board of Directors' QAC. The CLAS Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the CLAS Work Plan is monitored throughout the year.

The CLAS Program guides the development and implementation of an annual CLAS Work Plan, which includes but is not limited to:

- Network cultural responsiveness
- Language services
- Program scope

- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the CLAS Program

The CLAS Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the CLAS Program and applicable policies and procedures. The 2024 CLAS Work Plan includes all cultural and linguistic focus areas, goals, improvement activities, progress made toward goals, and timeframes. Planned activities include strategies to improve collection, storing, retrieval and sharing of race/ethnicity, language, sexual orientation and gender identity data. All goals will be measured and monitored in the CLAS Work Plan, reported to QIHEC quarterly, and evaluated annually. A copy of the QIHETP (and CLAS) Work Plans are also publicly available on the CalOptima Health website.

For more details on the 2024 CLAS Work Plan see Appendix A: 2024 QIHETP Work Plan

CLAS Monitoring Progress

To ensure that the CLAS Program meets the needs of our diverse member population, CalOptima Health continuously monitors progress against CLAS goals. At least quarterly, dedicated staff from Cultural and Linguistic (C&L) department, in collaboration with multidisciplinary work teams throughout the agency, collect and track indicators and activities specific to CLAS goals, outcomes, and outputs. C&L staff prepares quarterly findings and identifies potential risks to share with CalOptima Health leadership at Quality Improvement Health Equity Committee (QIHEC) meetings. CalOptima Health's QIHEC reviews, offers feedback and approves quarterly CLAS monitoring reports. QIHEC summarizes the CLAS monitoring reports and shares them with CalOptima Health's Board of Director's Quality Assurance Committee (QAC).

CLAS Evaluation

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

- A description of completed and ongoing CLAS activities that address cultural and linguistic needs or our members, including the achievement or progress toward goals, as outlined in the CLAS Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality, accuracy and utilization of

translation and interpreter services.

- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of CLAS activities, including QIPs, PIPs, and PDSAs.
- An evaluation of the effectiveness of member experience surveys related to cultural and linguistic services.
- A report to the QIHEC and QAC summarizing all CLAS measures and identifying significant trends.
- A critical review of the organizational resources involved in the CLAS Program through the CalOptima Health strategic planning process.
- Recommended changes included in the revised CLAS Program Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

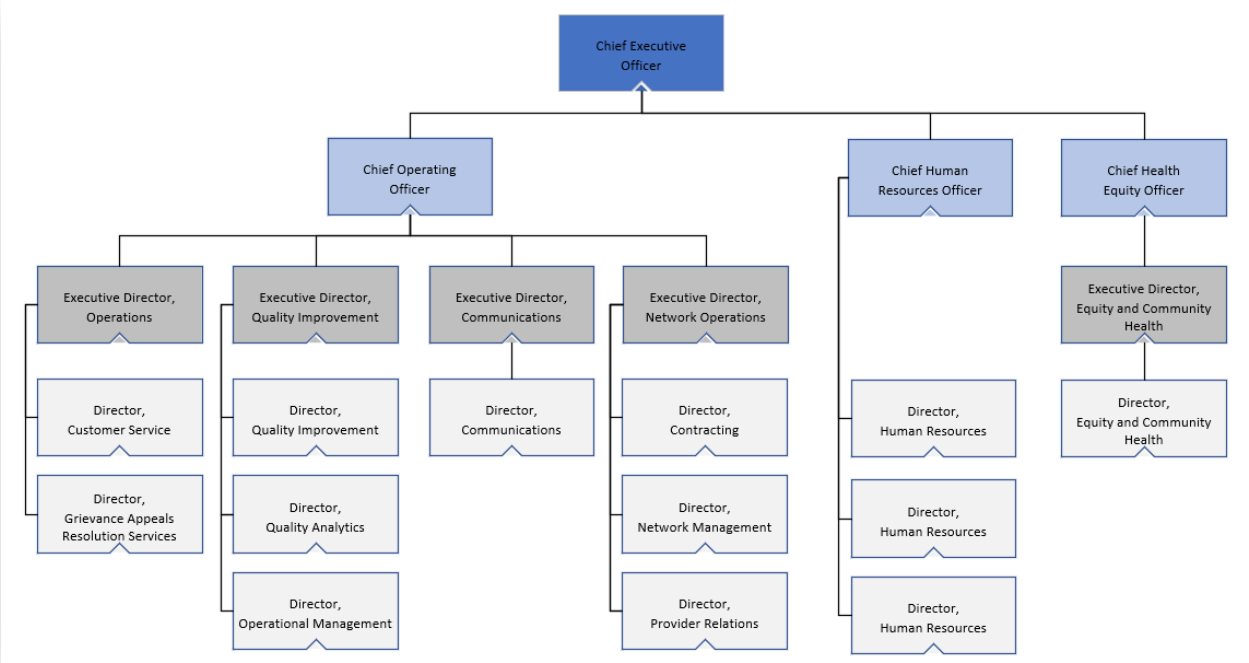
A copy of the CLAS Evaluation is also publicly available on the CalOptima Health website.

The C&L department consists of the Director of Customer Service/Cultural & Linguistics, Manager of Cultural and Linguistics, and nine Program Specialists who are responsible for translation of documents and coordinating cultural and linguistic services with contracted vendors. The Cultural and Linguistics department is supported by CalOptima Health departments including but not limited to:

- Communications
- Contracting
- Customer Service
- Equity and Community Health
- Human Resources
- Network Management
- Provider Relations
- Quality Analytics

CalOptima Health

Cultural and Linguistic Service Organizational Chart Structure



Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima Health. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima Health's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high-performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, Network Operations (ED NO) is responsible for the plan's provider delivery system; leads delivery system operations across multiple models; implements strategies that achieve the established program objectives and to leverage the core competencies of the plan's existing administrative infrastructure; directs the integrated operations of the provider network contracted under the various programs and coordinates organizational efforts; responsible for the overall success of network operations for the planning and implementation to fulfill the plan's strategic objectives as related to contracting and operations of the provider delivery system; and responsible for provider relations and support, including provider education and problem resolution.

Executive Director, Equity and Community Health (ED ECH) is responsible for oversight of comprehensive population strategies to improve member experience and increase access to care through the promotion of community-based programs. The ED ECH serves as a member of the executive team, and with the CHEO, CMO, DCMO, ED CO and ED BHI, supports efforts to promote optimal health outcomes, ensure efficient care, address mental wellness, disparities and improve health equity. The Director of Equity and Community Health reports to the ED ECH.

Director, Customer Service is responsible for day-to-day management, strategic direction and support to CalOptima Health Customer Service operations including Medi-Cal Call Center, Behavioral Health Call Center, OneCare Call Center, OneCare Connect Call Center, Member Liaison, Customer Service Data Analysts, Cultural & Linguistic Services, Member Communications, Enrollment & Reconciliation, and CalOptima Member Portal.

Director, Grievance Appeals Resolution Services is responsible for the day-to-day operations of the Grievance and Appeals Resolution Services (GARS) department, including to ensure service standards and established policies and procedures regarding the appeals and grievance processes adhere to regulatory requirements.

Director, Quality Improvement is responsible for day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

Director, Quality Analytics is responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the agencywide QIHETP.

Director, Operational Management is responsible for leading implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. Provides data analytical direction to support quality measurement activities for the organization wide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

Director, Communications is responsible for coordinating and implementing CalOptima Health's internal and external communications in a manner that promotes and preserves CalOptima Health, its mission, and strategic goals and objectives. Interact with CalOptima Health's executive management and legal counsel, as well as members of the media and general public.

Director, Contracting is responsible for the development and implementation of contracting strategies for providers and other business entities, management and monitoring of contractual relationships with existing provider networks and contractors. The Director of Contracting also conducts and coordinates financial analysis to determine and design contracting strategies for CalOptima Health and negotiate provider contracts.

Director, Network Management is responsible for all operational aspects of the Network Management department. The incumbent will oversee the onboarding of all new provider partners, provider data management and analysis and provider directory production. The Director of Network Management is responsible for ensuring CalOptima Health meets and exceeds access and availability standards; implements strategies that achieve the established CalOptima Health objectives; meet regulatory requirements and National Committee for Quality Assurance (NCQA) standards; leverage the core competencies of CalOptima Health's existing administrative infrastructure to build an effective and efficient operational unit to serve members and ensure the delivery of healthcare services throughout CalOptima Health's service delivery network.

Director, Provider Relations is responsible for providing leadership and direction to ensure proactive development, management, communication, support, and issue resolution for all CalOptima Health contracted providers. The Director of Provider Relations serves as the strategic, operational and communications lead between CalOptima Health and these critical partners. The Director of Provider Relations develops the overarching provider engagement and partnership strategy to ensure quality member care, provider satisfaction, provider compliance with contractual and regulatory requirements, and active provider engagement in CalOptima Health's goals and priorities.

Director, Human Resources (Administrative Services) is responsible for leading and overseeing the Human Resources services, policies, and programs for CalOptima which may include benefits and wellness programs, classification and compensation, employee engagement, employee relations, human resources information systems (HRIS), leaves programs, performance management, Workers' Compensation as determined by the Chief Human Resources Officer..

Director, Equity and Community Health (ECH) is responsible for program development and implementation for comprehensive population health initiatives while ensuring linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position oversees programs that promote health and wellness services for all CalOptima Health members. ECH services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). ECH also supports the MOC implementation for members. Reports program progress and effectiveness to QIHEC and other committees to support compliance with regulatory and accreditation organization requirements.

Key Business Processes, Functions, Important Aspects of Cultural and Linguistic Services

Language Services

CalOptima Health's Culturally and Linguistically Appropriate Services (CLAS) ensures all members have access to health care related interpreter services in any language and translated member materials in CalOptima's threshold languages.

Services Included:

- Free access to translations of Member Handbooks/Evidence of Coverage and other important information are available in English, Spanish, Vietnamese, Arabic, Farsi, Korean, and Chinese.
- Provide oral translation for other languages upon request or as needed, by a qualified translator at no cost.

- Provide routine and immediate translation of member notices pertaining to a denial, limitation, termination, delay, or modification of benefits, and the right to file a Grievance or Appeal at no cost.
- Free access to materials in alternative format such as Braille, large print, data, and audio files.
- Free access to 24 hours access to telephonic interpreter services to members with limited English proficiency at no cost.
- Free Remote video interpreting.
- Free access to face-to-face interpreters at the provider's office at no cost.
- Free access to American Sign Language interpretation assistance for deaf or hard-of-hearing members.
- Tactile signing assistance for deaf-blind members.

CalOptima Health ensures members are informed of the availability of and their right to linguistic and translation services through:

- "Language Interpreting Services" poster in the reception area where members can point to their preferred language
- Member handbook/Evidence of Coverage
- Summary of Benefits
- Quarterly/Annual Newsletters
- New member orientations
- Customer Service Call Center
- Health education workshops
- C&L "We Speak Your Language" brochure
- CalOptima Health website
- Member Portal
- Presentations/trainings at community-based organizations (CBOs) and public agencies

CalOptima Health provides informational materials to members written at a no higher than a sixth (6th) grade reading level and translated into CalOptima Health's threshold languages. DHCS threshold and concentration language requirements for Orange County are:

- Eligible beneficiaries residing in CalOptima Health's service area who indicate their primary language as a language other than English, and that meet a numeric threshold of 3,000 or five percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and

- Eligible beneficiaries residing in the CalOptima Health's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).

Cultural Competency and Training

Cultural Competence is the ability to understand, communicate with and effectively interact with people across different cultures, while continuing self-assessment regarding culture, acceptance and respect for differences, ongoing development of cultural knowledge and resources and the dynamic and flexible application of service models to meet the needs of minority populations. Cultural Competence includes awareness with:

- Race: any of the different varieties or populations of human beings distinguished by physical traits such as hair color and texture, eye color, skin color or body shape;
- Ethnicity: a group having a common cultural heritage or nationality, as distinguished by customs, language, common history, etc.
- Culture: the ideas, customs, skills, arts, etc. of a people or group, that are transferred, communicated, or passed along, as in or to succeeding generations.

Some factors influencing culture are age, gender, socioeconomic status, ethnicity, national origin, religion, geographical location, migration, sexual orientation, and gender identity.

During onboarding of new employees, on an annual basis, and as needed, CalOptima health ensures CalOptima health staff, Providers, Health Networks, and other delegated entities receive Disability Awareness and Sensitivity, and Cultural Competency training as outlined in HR policy AA.1250 and Provider Relations policy EE.1103. Trainings include:

- CalOptima Health staff cultural competency training (Initial and Annual)
- CalOptima Health staff new Employee “Boot Camp” C&L Overview (Initial)
- Provider Cultural Competency training (Initial and Annual)
- Provider Disability Training (Initial and Annual)
- Provider Cultural and Linguistic Requirements (Initial and Annual)

Promotion of Diversity

CalOptima Health is committed to reducing bias and improving diversity, equity and inclusion and supports initiatives to recruit, retain and train a diverse healthcare workforce that reflects the cultural and linguistic diversity of the communities serviced. This includes the following:

- Inclusive job descriptions and hiring practices.
- Trainings on the following topics for leaders:
    - Diversity, Inclusion & Conscious Bias
    - Disability Awareness
    - Cultural Competency
- Mentorship program for career development
- Conduct regular pay equity analysis
- Offer benefits and perks to support the diverse needs of employees (ie. Flexible work

arrangements)

Data Collect and Analysis

CalOptima Health is committed to collecting information that helps provide better culturally and linguistically appropriate services. Focused is placed on collecting, storing and retrieving member health care data in order to better address our members' needs. The following data is collected to monitor disparities and inform targeted information.

- Member demographics include but are not limited to race/ethnicity, language, gender identify and sexual orientation.
- Health outcomes
- Language preferences

CalOptima Health uses this data to assess the existence of disparities and to focus on quality improvement efforts toward improving the provision of culturally and linguistically appropriate services and decreasing health care disparities. Quality performance and health care data are stratified by race, ethnicity, language, and other demographic factors to identify disparities. Opportunities for improvement are identified when a disparity is identified and added to the CLAS Work Plan where progress of planned activities is tracked towards achieving health equity and CLAS goals. Data is trended to determine whether performance is improving, declining or remaining stable.

2024 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

EFFECTIVE DATE: APRIL 1, 2024 TO DECEMBER 31, 2024

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2024 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM SIGNATURE PAGE

Quality Improvement and Health Equity Committee Chairperson:

_____ _____

Richard Pitts, D.O., Ph.D. **Date**
CalOptima Health Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Trieu Tran, M.D. **Date**

Board of Directors Chairperson:

_____ _____

Clayton M. Corwin **Date**

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CalOptima Health Overview

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

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health (SDOH).

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

Our Strategic Plan

CalOptima Health's Board of Directors and executive team worked together to develop our 2022–2025 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in June 2022. Our core strategy is the "inter-agency" co-creation of services and programs, together with our delegated networks, providers and community partners, to support the mission and vision.

The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

CalOptima Health aligns our strategic plan with the priorities of our federal and state regulators.

Centers for Medicare & Medicaid Services (CMS) National Quality Strategy

The CMS national quality strategy aims to set and raise the bar for a resilient, high-value health care system that promotes quality outcomes, safety, equity and accessibility for all individuals, especially for people in historically underserved and under-resourced communities. The strategy focuses on a person-centric approach from birth to end of life as individuals journey across the continuum of care, from home or community-based settings to hospital to post-acute care, and across payer types, including Traditional Medicare, Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP) and Marketplace coverage.

Quality Mission: To achieve optimal health and well-being for all individuals.

Quality Vision: As a trusted partner, shape a resilient, high-value American health care system to achieve high-quality, safe, equitable and accessible care for all.

CMS National Quality Strategy has four priority areas, each with two goals.

1. Outcomes and Alignment
    a. Outcomes: Improve quality and health outcomes across the care journey.
    b. Alignment: Align and coordinate across programs and settings.
2. Equity and Engagement
    a. Advance health equity and whole-person care.
    b. Engage individuals and communities to become partners in their care.
3. Safety and Resiliency
    a. Safety: Achieve zero preventable harm.
    b. Resiliency: Enable a responsive and resilient health care system to improve quality.
4. Interoperability and Scientific Advancement
    a. Interoperability: Accelerate and support the transition to a digital and data-driven health care system.

b. Scientific Advancement: Transform health care using science, analytics and technology.

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 CQS lays out DHCS' quality and health equity strategy that leverages a whole-system, person-centered, and population health approach to support a 10-year vision for Medi-Cal, whereby people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM) and emphasize DHCS' commitment to health equity, member involvement and accountability in all program initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and member-centered chronic disease management
- Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement

CQS outlines specific clinical goals across the Medi-Cal program. Centered on specific clinical focus areas, the CQS introduces DHCS' Bold Goals: 50x2025 initiative that, in partnership with stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025.

Bold Goals: 50x2025:

- Close racial/ethnic disparities in well-child visits and immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow-up for mental health and substance disorder by 50%
- Ensure all health plans exceed the 50th percentile for all children's preventive care measures

DHCS recognizes that inequities are embedded within our health care system. DHCS has developed a Health Equity Framework to identify, catalog and eliminate health disparities through:

- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention).

SDOH are the conditions that exist in the places where people are born, live, learn, work, play, worship and age that affect health outcomes (Henry J. Kaiser Family Foundation).

In response to CalOptima Health's strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes and designing a comprehensive intervention plan to planning and tracking progress. It begins with a comprehensive readiness assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.

Program Structure

"Better. Together." Is CalOptima Health's motto, and it means that by working together, we can make things better — for our members and community. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's single largest health insurer, we provide coverage through three major programs:

Medi-Cal

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

Scope of Services

Under our Medi-Cal program, CalOptima Health provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) Program that began in 2019.

CalOptima Health provides Enhanced Care Management (ECM) and all 14 Community Supports to address social drivers of health and assist members with finding stable or safe housing, accessing healthy food, transitioning back to home or getting support in the home.

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

- Specialty mental health services are administered by the Orange County Health Care Agency (OCHCA)
- Substance use disorder services are administered by OCHCA
- Dental services are provided through the Medi-Cal Dental Program

Members With Special Health Care Needs

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

Additionally, CalOptima Health works with community programs to ensure that members with special health care needs (or with high-risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with

certain community agencies, including OCHCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

On July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Health Medi-Cal members. CalOptima Health ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS includes both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

These integrated LTSS benefits include the following programs:

- In-Home Supportive Services (IHSS): IHSS provides in-home assistance to eligible aged, blind and disabled individuals as an alternative to out-of-home care and enables members to remain safely in their own homes.

- Nursing Facility Services for Long-Term Care: CalOptima Health LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B and Subacute levels of care. CalOptima Health LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

- Community-Based Adult Services (CBAS): CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. CalOptima Health LTSS monitors the levels of member access to, utilization of and satisfaction with CBAS.

- Multipurpose Senior Services Program (MSSP): Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid institutionalization. CalOptima Health LTSS monitors the level of member access to MSSP as well as its role in diverting members from institutionalization.

OneCare (HMO D-SNP)

Our OneCare members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for them to get the health care they need. Since 2005, CalOptima Health has been offering OneCare to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OneCare has extensive experience serving the complex needs of frail, disabled, dual-eligible members in Orange County.

To be a member of OneCare, a person must be age 21 or older, live in Orange County and be eligible for both Medicare and Medi-Cal. Enrollment in OneCare is voluntary and by member choice.

Scope of Services

OneCare provides comprehensive services for dual eligible members enrolled in Medi-Cal and Medicare Parts A, B and D. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member. CalOptima Health monitors quality for OneCare through regulatory measures, including Part C, Part D and CMS Star measures.

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, OneCare members are eligible for supplemental benefits, such as gym memberships.

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

CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.

PACE combines health care and adult day care for people with multiple chronic conditions. These can be offered in the member's home, in the community or at the CalOptima Health PACE Center:

1. Routine medical care, including specialist care
2. Prescribed drugs and lab tests
3. Personal care for things like bathing, dressing and light chores
4. Recreation and social activities
5. Nutritious meals
6. Social services
7. Rides to health-related appointments, and to and from the program
8. Hospital care and emergency services

PACE maintains a separate PACE Quality Improvement Program, work plan and evaluation.

Provider Partners

Providers have options for participating in CalOptima Health's programs to provide health care to CalOptima Health members. Providers can contract directly with CalOptima Health through CalOptima Health Direct, which consists of CalOptima Health Direct-Administrative and CalOptima Health Community Network (CCN). Providers also have the option to contract directly with a CalOptima Health Health Network (HN). CalOptima Health members can choose CCN or one of nine HNs representing more than 8,000 providers.

CalOptima Health Direct (COD)

CalOptima Health Direct has two elements: CalOptima Health Direct-Administrative and CCN.

CalOptima Health Direct-Administrative (COD-A)

COD-A is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in OneCare), share-of-cost members, newly eligible members transitioning to a HN and members residing outside of Orange County.

CalOptima Health Community Network (CCN)

CCN doctors have an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and available for HN-eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Health Contracted Health Networks

CalOptima Health has contracts with delegated HNs through a variety of risk models to provide care to members. The following contract risk models are currently in place:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to more than 1,200 Primary Care Providers (PCPs), more than 9,000 specialists, 43 acute and rehabilitative hospitals, 52 community health centers and 106 long-term care facilities.

CalOptima Health contracts with the following HNs:

Health Network	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
AMVI Care Medical Group	PHC	PHC
CHOC Health Alliance	PHC	-
Family Choice Medical Group	HMO	SRG
HPN-Regal Medical Group	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Optum Care Network	HMO	HMO
Prospect Medical Group	HMO	HMO
United Care Medical Group	SRG	SRG

CalOptima Health contracts with vendors that provide benefits for our members. These vendors are responsible for maintaining a contracted network of providers, coordinating services and providing direct services. They may also be delegated for plan functions.

Vendor	Medi-Cal	OneCare
Vision Service Plan	VS	VS
MedImpact	-	PBM

HMO=Health Maintenance Organization; PHC=Physician/Hospital Consortium; SRG=Shared-Risk Group; VS=Vision Service; PBM=Pharmacy Benefit Manager

Upon successful completion of readiness reviews and audits, contracted entities may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex care management
- Claims
- Credentialing

Membership Demographics

Membership Data* (as of November 30, 2023)

Total CalOptima Health Membership	Program	Members
963,968	Medi-Cal	945,874
	OneCare (HMO D-SNP)	17,648
	Program of All -Inclusive Care for the Elderly (PACE)	446
	*Based on unaudited financial report and includes prior period adjustment	

Membership Demographics (as of November 30, 2023)

Member Age

0 to 5	8%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65+	13%

Language Preference

English	58%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category

Temporary Assistance for Needy Families	39%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Quality Improvement and Health Equity Transformation Program (QIHETP)

CalOptima Health's Quality Improvement and Health Equity Transformation Program (QIHETP) encompasses all clinical care, health and wellness services, and quality of service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all members.

CalOptima Health developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and subacute care to long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities, special health care needs and chronic illnesses.

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

CalOptima Health is committed to promoting diversity in practices throughout the organization, including Human Resources best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias and inclusion.

Quality Improvement and Health Equity Transformation Program (QIHETP) Purpose

The purpose of the CalOptima Health QIHETP is to establish objective methods for systematically evaluating and improving the quality of care provided to members. Through the QIHETP, and in collaboration with providers and community partners, CalOptima Health strives to continuously improve the structure, processes and outcomes of the health care delivery system to serve members. We aim to identify health inequities and to develop structures and processes to reduce disparities, ensuring that all members receive equitable and timely access to care.

CalOptima Health applies the principles of continuous quality improvement (CQI) to all aspects of service delivery system through analysis, evaluation and systematic enhancements of the following:

- Quantitative and qualitative data collection and data-driven decision-making
- Up-to-date evidence-based practice guidelines
- Feedback provided by members and providers in the design, planning and implementation of CQI activities
- And other issues identified by CalOptima Health or its regulators

The CalOptima Health QIHETP incorporates the CQI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima Health's multiple customers and

stakeholders (members, health care providers, community-based organizations and government agencies). The QIHETP is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima Health's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.

- Focus on quality improvement and health equity activities carried out on an ongoing basis to support early identification and timely correction of quality-of-care issues to ensure safe care and experiences.

- Maintain organizationwide practices that support health plan and health equity accreditation by National Committee for Quality Assurance (NCQA) and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QIHETP's ongoing responsibilities include the following:

- Setting expectations to develop plans to design, measure, assess and improve the quality of the organization's governance, management, delivery system and support processes.

- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers. Recommending delivery system reform to ensure high quality and equitable health care.

- Monitoring quality of care and services from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

- Ensuring contracted facilities, as required by federal and state laws, report to OCHCA outbreaks of conditions and/or diseases, which may include but are not limited to methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, and since 2020, COVID-19.

- Promoting member safety and minimizing risk through the implementation of safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related organizational providers (OPs) to ensure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement and health equity culture at CalOptima Health.

- Ensure the annual review and acceptance of the UM CM Program Description, UM CM Evaluation Population Health Programs, including the Population Health Strategy and Work Plans.

- Provide operational support and oversight to a member-centric Population Health Management (PHM) Program.

In collaboration with the Compliance Audit & Oversight departments, the QIHETP ensures the following standards or outcomes are carried out and achieved by CalOptima Health's contracted HNs, including CCN and/or COD network providers serving CalOptima Health's various populations:

- Support the organization's strategic quality and business goals by using resources appropriately, effectively and efficiently.
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- Identify in a timely manner the important clinical and service issues facing the Medi-Cal and OneCare populations relevant to their demographics, risks, disease profiles for both acute and chronic illnesses, and preventive care.
- Ensure continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities.
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population.
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.
- Ensure the reliability of risk prevention and risk management processes.
- Ensure compliance with regulatory agencies and accreditation standards.
- Ensure the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans.
- Promote the effectiveness and efficiency of internal operations.
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs.
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima Health's strategic direction in support of its mission, vision and values.
- Ensure compliance with up-to-date Clinical Practice Guidelines and evidence-based practice.

Authority and Accountability

Board of Directors

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement and Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

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

The QIHETP is based on ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QIHETP in alignment with federal and state regulations, contractual obligations, and fiscal parameters.

CalOptima Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QIHETP and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity contractual and regulatory standards and the DHCS Comprehensive Quality Strategy. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QIHETP and the Work Plan of the QIHETP.

Member Advisory Committee

CalOptima Health is committed to member-focused care through member and community engagement. The Member Advisory Committee (MAC) has 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operations and evaluation of the overall QIHETP. The MAC provides advice and recommendations on

community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- Medi-Cal beneficiaries or Authorized Family Members (two seats)
- Member Advocate
- County of Orange Social Services Agency (OC SSA)
- OneCare Member or Authorized Family Members (four seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

One of the 17 positions, held by OCSSA, is a standing seat. Each of the remaining 16 appointed members may serve two consecutive three-year terms.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. The PAC members represent the broad provider community that serves CalOptima Health members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of OCHCA, which maintains a standing seat. PAC meetings are open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- OCHCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC includes the following 11 voting seats:

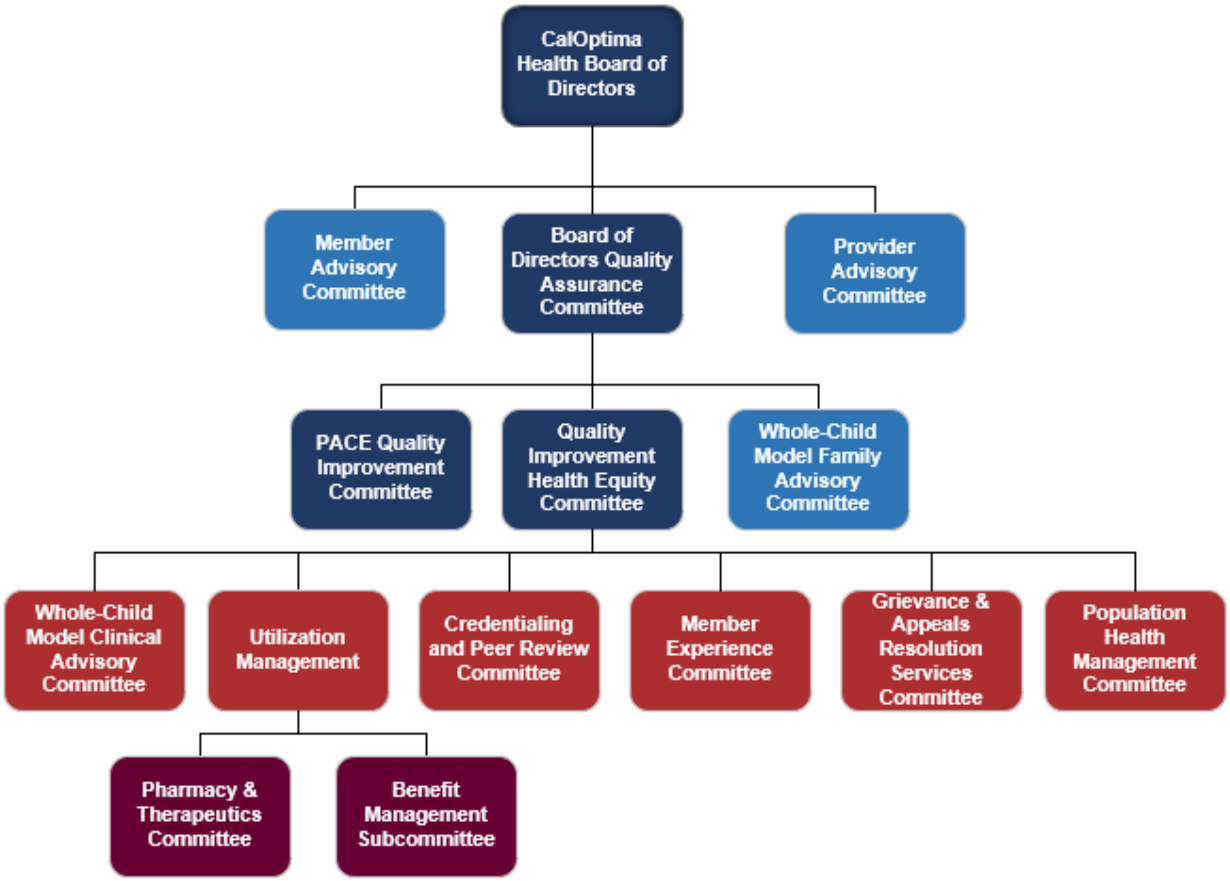
- Family representatives (nine seats)
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
    - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
    - Current CalOptima Health members over the age of 21 who transitioned from CCS services

- Interests of children representatives (two seats)
    - Community-based organizations; or
    - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC quarterly meetings are open to the public.

Quality Improvement and Health Equity Transformation Program Committee Structure

Quality Improvement and Health Equity Transformation Program Committee Organization Structure — Diagram



Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is the foundation of the QIHETP and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer (CHEO), and in collaboration, develop and oversee the QIHETP and QIHETP Work Plan activities.

The purpose of the QIHEC is to assure that all QIHETP activities are performed, integrated and communicated internally and to the contracted delegated HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

The composition of the QIHEC includes a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, subcontractors, downstream

subcontractors, community health workers, other non-clinical providers and members. The QIHEC participants are representative of the composition of the CalOptima Health's provider network and include, at a minimum, network providers who provide health care services to members affected by health disparities, Limited English Proficiency (LEP) members, children with special health care needs, Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions. QIHEC participants are practitioners who are external to CalOptima Health, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, care review as needed, and identification of opportunities to improve care.

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

Responsibilities of the QIHEC include:

- Analyze and evaluate the results of QIHE activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other quality committees
- Recommend policy decisions and priority alignment of the QIHETP subcommittees for effective operation and achievement of objectives
- Oversee the analysis and evaluation of QIHETP activities
- Ensure practitioner participation through attendance and discussion in the planning, design, implementation and review of QIHETP activities
- Identify, prioritize and institute needed actions and interventions to improve quality
- Ensure appropriate follow up of quality activities to determine the effectiveness of quality improvement-related actions and remediation of identified performance deficiencies.
- Monitor overall quality compliance for the organization to quickly resolve deficiencies that affect members
- Evaluate practice patterns of providers, practitioners and delegated HNs, including over/under utilization of physical and behavioral health care services
- Recommend practices so that all members receive medical and behavioral health care that meets CalOptima Health standards.

The QIHEC oversees and coordinates member outcome-related QIHE actions. Member outcome-related QIHE actions consist of well-defined, planned QIHE projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services. The QIHEC also recommends strategies for dissemination of all study results to CalOptima Health-contracted providers and practitioners, and delegated HNs.

The composition of the QIHEC is defined in the QIHEC charter and includes but is not limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- Orange County Behavioral Health Representative
- CalOptima Health Chief Medical Officer (Chair or Designee)
- CalOptima Health Chief Health Equity Officer (Chair or Designee)
- CalOptima Health Deputy Chief Medical Officer
- CalOptima Health Quality Improvement Medical Director
- CalOptima Health Behavioral Health Integration Medical Director
- CalOptima Health Medical Directors
- CalOptima Health Executive Director, Quality Improvement
- CalOptima Health Executive Director, Equity and Community Health
- CalOptima Health Executive Director, Behavioral Health Integration
- CalOptima Health Executive Director, Clinical Operations
- CalOptima Health Executive Director, Network Management
- CalOptima Health Executive Director, Operations

The QIHEC is supported by CalOptima Health departments including but not limited to:

- Behavioral Health Integration
- Care Management
- Long-Term Services and Supports
- Equity and Community Health
- Quality Analytics
- Quality Improvement
- Utilization Management
- Director, Customer Service
- Cultural and Linguistic Services

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person, by telephone or by video conference.

The QIHEC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

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

Minutes of the QIHEC and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the committee chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIHEC meeting include but are not limited to:

- Goals and objectives outlined in the QIHEC charter
- Active discussion and analysis of quality improvement and health equity activities, outcomes, and issues
- Reports from various committees and subcommittees
- Tracking and trending of quality outcomes
- Recommendations for improvement, actions and follow-up actions
- Monitoring of quality improvement and health equity activities of delegates
- Plans to disseminate QIHE information to network providers
- Tracking of QIHETP Work Plan activities

All agendas, minutes, reports and documents presented to the QIHEC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

The QIHEC provides to the QAC quarterly written progress reports of the QIHEC that describes actions taken, progress in meeting QIHETP objectives, and improvements made. A written summary of the QIHEC's quarterly activities is also publicly available on the CalOptima Health website.

Under the QIIHETP, there are six subcommittees that report, at minimum, quarterly to the QIHEC.

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima Health practitioner and provider selection process and determines corrective actions, as necessary, to ensure that all practitioners and providers who serve CalOptima Health members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima Health practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima Health's contracted providers, delegated HNs and OPs to ensure member safety aiming for zero defects. The CPRC, chaired by the CalOptima Health CMO or physician designee, consists of CalOptima Health Medical Directors and physician representatives from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima Health's network. CPRC meets a minimum of six times per year and reports through the QIHEC quarterly. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimal utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the

UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, BH and LTSS services for CCN and delegated HNs to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other organization standards. These clinical practice guidelines and nationally recognized evidence-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIHEC. The voting member composition (including a BH practitioner*) and the quorum requirements of the UMC are defined in its charter.

* BH practitioner is defined as Medical Director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost-effective pharmaceutical care for all CalOptima Health members. It reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima Health members. The P&T includes practicing physicians (including both CalOptima Health employee physicians and participating provider physicians), and the membership represents a cross-section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all members. The P&T provides written decisions regarding all formulary development decisions and revisions. The P&T meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate and maintain a consistent benefit system as it relates to CalOptima Health's responsibilities for administration of member benefits, prior authorization and financial responsibility requirements. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima Health staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance department provides technical support to the subcommittee, which includes analyzing regulations and guidance that impacts the benefit sets and CalOptima Health's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima Health WCM program. The WCM CAC works in collaboration with county CCS, the WCM FAC and HN CCS providers. The WCM CAC meets four times a year and reports to the QIHEC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima Health. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system. NCQA's Health Insurance Plan Ratings measure three dimensions: prevention, treatment and customer satisfaction, and the committee's focus is to improve customer satisfaction. The MEMX committee assesses information and data directly from members, which include the annual results of CalOptima Health's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, member complaints, grievances and appeals. Then MEMX identifies opportunities to implement initiatives to improve our members' overall experience. The Access and Availability Workgroups, which report to the MEMX committee, monitor a member's ability get needed care and get care quickly, by monitoring the provider network, reviewing customer service metrics, and evaluating authorizations and referrals for "pain points" in health care that impact our members at the plan and HN level (including CCN), where appropriate. In 2024, the MEMX committee, which includes the Access and Availability Workgroups, will continue to meet at least quarterly and will be held accountable to meet regulatory requirements related to access and implement targeted initiatives to improve member experience and demonstrate significant improvement in subsequent CAHPS survey results.

Grievance and Appeals Resolution Services (GARS) Committee

The GARS Committee serves to protect the rights of members, promote the provision of quality health care services and ensure that the policies of CalOptima Health are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS Committee also serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima Health providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS Committee meets at least quarterly and reports through the QIHEC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Population Health Management Committee (PHMC)

The PHMC provides overall direction for continuous process improvement and oversight of population health activities, monitors compliance with regulatory requirements, and ensures that population health initiatives meet the needs of CalOptima Health members. The committee also ensures that all population health initiatives are performed, monitored and communicated

according to the PHM Strategy and Work Plan. The PHMC is responsible for reviewing, assessing and approving the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Work Plan progress and outcomes and recommend evidence-based and/or best practice activities to improve population health outcomes and advance health equity.

Confidentiality

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

All records and proceedings of the QIHEC and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code Section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QIHEC and the subcommittees sign a confidentiality agreement. This agreement requires committee members to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QIHE reports required by law or by the state contract.

Conflict of Interest

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

2024 Quality Improvement and Health Equity Priority Areas and Goals

CalOptima Health's QIHE Priority Areas and Goals are aligned with CalOptima Health's Strategic Plan and DHCS Bold Goals.

1. Maternal Health

    - Close racial/ethnic disparities in well-child visits and immunizations by 50%
    - Close maternity care disparity for Black and Native American persons by 50%

2. Children's Preventive Care
    - Exceed the 50th percentile for all children's preventive care measures

3. Behavioral Health Care
    - Improve maternal and adolescent depression screening by 50%
    - Improve follow-up for mental health and substance disorder by 50%

4. Program Goals
    - Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set (MCAS)
    - OneCare: Attain a Four-Star Rating for Medicare

Quality Improvement and Health Equity Transformation Program Work Plan

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

The QIHETP Work Plan is the operational and functional component of the QIHETP and is based on CalOptima Health strategic priorities and the most recent and trended HEDIS, CAHPS, Stars and Health Outcomes Survey (HOS) scores, physician quality measures and other measures identified for attention, including any specific requirements mandated by the state or accreditation standards, where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QIHETP guides the development and implementation of an annual QIHETP Work Plan, which includes but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service

- Member experience
- QIHETP oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QIHETP

Priorities for QIHE activities based on CalOptima Health's organizational needs and specific needs of CalOptima Health's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual care aids in the development of QI studies based on quality-of-care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QIHETP Work Plan.

The QIHETP Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QIHETP and applicable policies and procedures. The 2024 QIHETP Work Plan includes all quality improvement focus areas, goals, improvement activities, progress made toward goals, and timeframes. Planned activities include strategies to improve access care, the delivery of services, quality of care, over and under utilization, and member population health management. All goals will be measured and monitored in the QIHETP Work Plan, reported to QIHEC quarterly, and evaluated annually. A copy of the QIHETP Work Plan are also publicly available on the CalOptima Health website.

For more details on the 2024 QIHETP Work Plan see Appendix A: 2024 QIHETP Work Plan

Quality Improvement and Health Equity Projects

QIHE Project Selection and Focus Areas

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

- Areas for improvement identified through continuous internal monitoring activities, including but not limited to:
  - Potential quality issue (PQI) review processes
  - Provider and facility reviews
  - Preventive care audits
  - Access to care studies
  - Member experience surveys
  - HEDIS results
  - Other opportunities for improvement as identified by subcommittee's data analysis
- Measures required by regulators, such as DHCS and CMS, with a focus on meeting or exceeding the following:
  - DHCS established Minimum Performance Level (MPL) for each required Quality Performance Measure of Health Equity measures selected by DHCS.
  - Health disparity reduction targets for specific populations and measures as identified by DHCS.

- Performance Improvement Projects (PIPs) required by CMS or DHCS.

The QI Project methodology described below will be used to continuously review, evaluate and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, LTSS and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD members
- Provisions of chronic, complex care management and care management services
- Access to and provision of preventive services

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

- Staff, administration and physicians provide vital information necessary to support continuous performance improvement and occurs at all levels of the organization.
- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.
- Other prioritization criteria include the expected impact on performance (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high-risk, high-volume or problem-prone processes.
- Project coordination occurs through the various leadership structures: Board of Directors, management, QIHEC, UMC, etc., based upon the scope of work and impact of the effort.
- CalOptima Health collaborates with delegated business partners to coordinate QI activities for all lines of business through the following:
  - Health Network Forums – Monthly
  - HN Quality Forums – Quarterly
  - Joint Operation Meetings (JOM) with Health Networks – Quarterly
- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QIHE Project Measurement Methodology

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

QI Projects shall include the following:

- Measurement of performance using objective quality indicators
- Implementation of equity-focused interventions to achieve improvement in the access to and quality of care
- Evaluation of the effectiveness of the intervention based on the performance measures
- Planning and initiation of activities for increasing or sustaining improvement

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5%–10% over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411 and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima Health's previous year's score. Also, smaller sample size

may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30 can be statistically significant for QI pilot projects.

The PDSA model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s) including barrier analysis
4) Develop an action plan
Do 5) Communicate change plan
6) Implement change plan
Study 7) Review and evaluate result of change
8) Communicate progress
Act 9) Reflect and act on learning
10) Standardize process and celebrate success
11) As needed, initiate Corrective Action Plan(s), which may include enhanced monitoring and/or re-measurement activities.

Types of QIHE Projects

CalOptima Health implements several types of improvement projects, including QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for members.

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

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

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

Improvement Standards

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

B. Sustained Improvement

Sustained improvement is documented through the continued remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both demonstrated and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima Health may choose to continue the project or pursue another topic.

Documentation of QIHE Projects

Documentation of all aspects of each QIHE Project is required. Documentation includes but is not limited to:

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

Communication of QIHE Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QIHETP Work Plan or calendar. The QIHE subcommittees will report their summarized information to the QIHEC at least quarterly in order to facilitate communication along the continuum of care. The QIHEC reports activities to the QAC of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima Health's contracted entities, practitioners and providers is through the following:

- Practitioner participation in the QIHEC and its subcommittees
- HN Forums, Medical Directors' Meetings, Quality Forums and other ongoing ad hoc meetings
- MAC, PAC and WCM FAC

Quality Improvement and Health Equity Program Evaluation

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

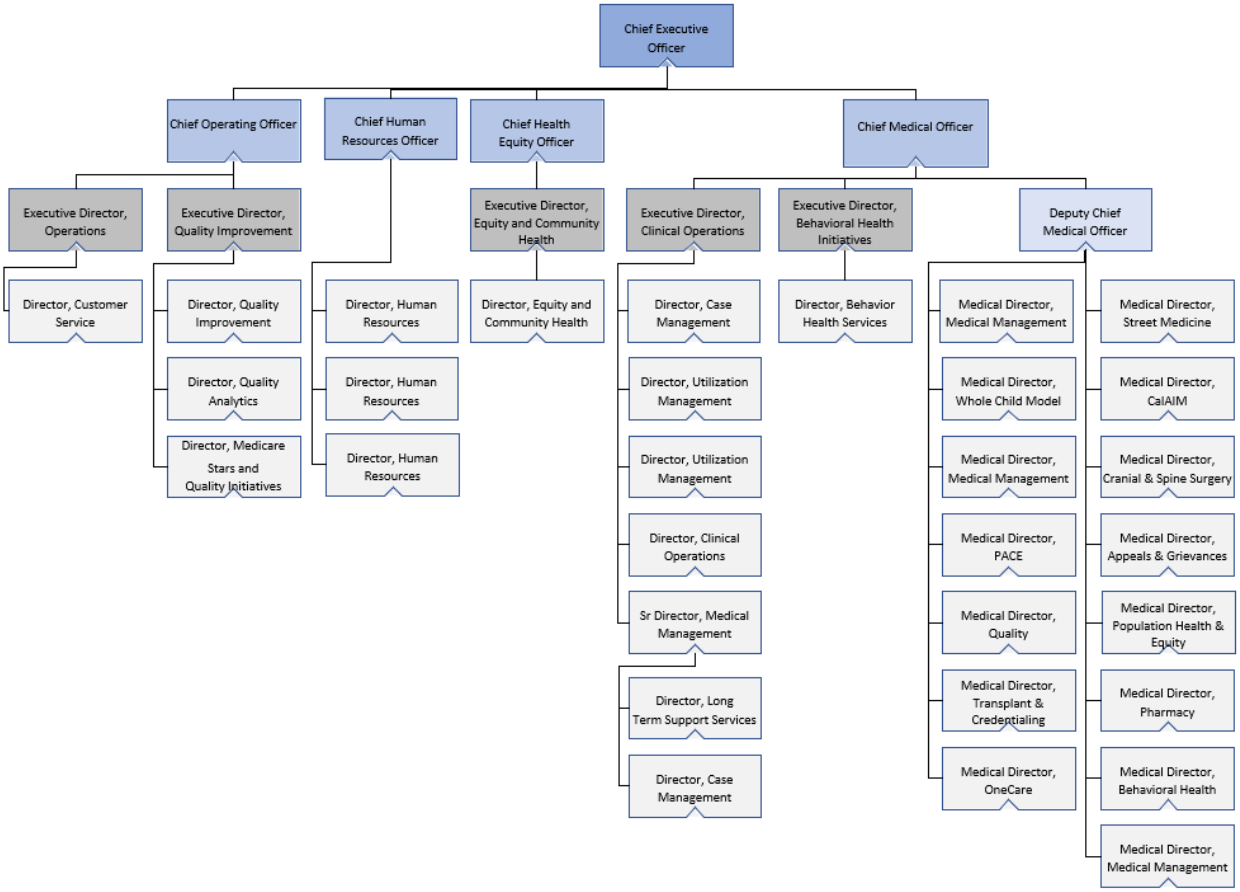
- A description of completed and ongoing QIHE activities that address quality and safety of clinical care and quality of services, including the achievement or progress toward goals, as outlined in the QIHETP Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of QIHE activities, including QIPs, PIPs, PDSAs and CCIPs.
- An evaluation of the effectiveness of member satisfaction surveys and initiatives.
- A report to the QIHEC and QAC summarizing all quality measures and identifying significant trends.
- A critical review of the organizational resources involved in the QIHETP through the CalOptima Health strategic planning process.
- Recommended changes included in the revised QIHETP Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

A copy of the QIHETP Evaluation is also publicly available on the CalOptima Health website.

Quality Improvement and Health Equity Transformation Program Organizational Structure

Quality Program Organizational Chart — Diagram

As of May 2024



Quality Improvement and Health Equity Transformation Program Organizational Structure

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima Health departments, support the organization's mission and strategic goals. These areas oversee the processes to monitor, evaluate and implement the QIHETP so that members receive high-quality care and services. Below lists the QI Program's functional areas and responsibilities.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Medical Officer* (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. The CMO has overall responsibility for the QIHETP and supports efforts so that the QIHETP objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QIHE activities to the Board of Directors' Quality Assurance Committee.

Chief Compliance Officer (CCO) is responsible for monitoring and driving interventions so that CalOptima Health and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of HNs and other functional areas. The CCO serves as the State Liaison and is responsible for legislative advocacy. Also, the CCO oversees CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to state and federal requirements.

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima Health. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima Health's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Deputy Chief Medical Officer* (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO collaborates with Directors and Medical Directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Care Management, Equity and Community Health, Pharmacy Management, LTSS and other medical management programs.

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. The COS is responsible for achieving operational efficiencies to support CalOptima Health's strategic plan, goals and objectives.

Chief Information Officer (CIO) provides oversight of CalOptima Health's enterprise wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the organization's risk exposure.

Medical Director* (Behavioral Health) is the designated behavioral health care physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC) and CPRC. The Medical Director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Medical Director* (CalAIM) [California Advancing and Innovating Medi-Cal] is responsible for the clinical oversight of CalAIM initiatives that include clinical programs and related services, such as Enhanced Care Management, Community Supports and justice-involved services.

Medical Director* (Credentialing and Peer Review) is the designated physician in the QIHETP who serves as a participating member of the QIHEC, as well as the Utilization Management Committee (UMC). The Medical Director is also the chair of the Credentialing and Peer Review Committee (CPRC).

Medical Director* (OneCare) is responsible for oversight of the senior members in OneCare, working on quality improvements to raise CalOptima Health's Star rating and collaborating with others on behalf of members via the interdisciplinary care teams.

Medical Director* (Equity and Community Health) [ECH] is the designated physician who chairs the Population Health Management Committee and is responsible for overseeing the Population Health Management (PHM) functions. The Medical Director provides direction and support to the CalOptima Health ECH staff to ensure objectives from the Population Health Management Strategy are met.

Medical Director* (Quality Improvement) is the physician designee who chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Medical Director* (Street Medicine) is responsible for the clinical oversight of the street medicine initiative that includes patient medical assessments and management, urgent care medical interventions, pharmacology management and utilization and the coordination of street medicine services with a multidisciplinary team.

Medical Director* (Whole Child Model) is the physician designee who chairs the Whole Child Model Clinical Advisory Committee and is responsible for overseeing QIHE activities and quality management functions related to Whole Child Model (WCM). The Medical Director provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives related to WCM are met.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high-performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, Equity and Community Health (ED ECH) is responsible for oversight of comprehensive population strategies to improve member experience and increase access to care through the promotion of community-based programs. The ED ECH serves as a member of the executive team, and with the CHEO, CMO, DCMO, ED CO and ED BHI, supports efforts to promote optimal health outcomes, ensure efficient care, address mental wellness, disparities and improve health equity..

Executive Director, Behavioral Health Integration (ED BHI) is responsible for oversight of CalOptima Health's Behavioral Health (BH) program, including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Medi-Cal and CalAIM is responsible for the implementation and oversight of CalAIM, a whole-system, person-centered delivery system reform to improve quality and care to members.

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

Executive Director, Medicare Programs (ED MP) is responsible for strategic and operational oversight of Medicare programs, including OneCare and PACE.

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

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

*Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the California Knox Keene Act Section 1367.01 I. Ongoing monitoring is performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.

Quality Improvement and Health Equity Program Resources

CalOptima Health's budgeting process includes personnel, Information Technology Services resources and other administrative costs projected for the QIHETP. The resources are revisited on a regular basis to promote adequate support for CalOptima Health's QIHETP.

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

In addition to CalOptima Health's CMO and ED QI the following staff positions provide direct support for organizational and operational QIHETP functions and activities:

Director, Quality Improvement
Responsible for day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement (PQI)
- Manager, Quality Improvement (FSR/PARS/MRR)
- Manager, Quality Improvement (Credentialing)
- Supervisor, Quality Improvement (FSR)
- Supervisor, Quality Improvement (PARS)
- QI Nurse Specialists (RN) (LVN)
- Project Manager
- Program Manager
- Credentialing Coordinators
- Program Specialists
- Program Assistants
- Outreach Specialists
- Auditor, Credentialing

Director, Quality Analytics
Responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the agencywide QIHETP.

The following positions report to the Director, Quality Analytics:

- Manager, Quality Analytics (HEDIS)
- Manager, Quality Analytics (Data Analytics)
- Data Analysts
- Project Managers
- HEDIS medical record review nurses

Director, Medicare Stars and Quality Initiatives
Responsible for leading implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. Provides data analytical direction to support quality

measurement activities for the organization wide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

The following positions report to the Director, Medicare Stars and Quality Initiatives:

- Manager, Quality Analytics
- Manager, Quality Initiatives
- Project Managers
- Program Coordinators
- Program Specialists
- Data Analyst
- Quality Analyst
- Program Assistant

Director, Equity and Community Health (ECH)
Responsible for program development and implementation of the PHM program and strategies for comprehensive health initiatives. This position oversees programs that promote health and wellness services for all CalOptima Health members. ECH services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Integration
Responsible for program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima Health members across all lines of business. The director is responsible for the management and strategic direction of the BHI department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Utilization Management
Responsible for the development and implementation of the UM program, policies and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the UM committees and participates in the QIHEC and the BMSC.

Director, Clinical Pharmacy Management
Responsible for the development and implementation of the Pharmacy Management program, develops and implements Pharmacy Management department policies and procedures, ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of pharmacy-

related clinical affairs, and serves on the P&T and UMC. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Care Management
Responsible for Care Management, Transitions of Care, Complex Care Management and the clinical operations of Medi-Cal and OneCare. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports (LTSS)
Responsible for LTSS programs, which include CBAS, LTC and MSSP. The position supports a member-centric approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures and processes related to LTSS program operations and quality measures.

Director, Medicare Programs
Responsible for the medical management team and providing physician leadership in the Medical Management division, serving as liaison to other CalOptima Health operational and support departments. The director collaborates with the other Medical Directors and clinical, nursing and non-clinical leadership staff across the organization in areas including Quality, Utilization and Care Management, Health Education/Disease Management, Long-Term Care, Pharmacy, Behavioral Health Integration, PACE as well as support departments, including Compliance, Information Technology Services, Claims, Contracting and Provider Relations.

Sr. Director, Clinical Operations
The Sr Director, Clinical Operations oversees the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct.

Director, Human Resources
The Director (Human Resources Administrative Services) is responsible for leading and overseeing the Human Resources Information Systems (HRIS) team and function, including its services, related policies, initiatives, programs, and processes.

Director, Customer Service
Responsible for the day-to-day management, strategic direction and support to the CalOptima's Customer Services operations; Medi-Cal Call Center, Behavioral Health Call Center, OneCare Call Center, OneCare Connect Call Center, Member Liaison, Customer Service Data Analysts, Cultural & Linguistic, Member Communications, Enrollment & Reconciliation, Member Advisory Committees and CalOptima Member Portal.

Staff Orientation, Training and Education

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

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

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)
- HIPAA Rules and Compliance
- Disability Awareness Fraud, Waste and Abuse
- Compliance and Code of Conduct Training
- Cybersecurity Awareness
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Health Equity
- Cultural Competency
- Seniors and Persons with Disabilities Awareness training
- Trauma-Informed Care
- Diversity, Inclusion and Unconscious Bias

Employees, contracted providers and practitioner networks with responsibilities for OneCare are trained at least annually on the Model of Care (MOC). The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

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

Key Business Processes, Functions, Important Aspects of Care and Service

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

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

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

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

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

- Clinical care and service
- Behavioral health care
- Access and availability
- Continuity and coordination of care
- Transitions of care
- Prenatal and postpartum care
- Preventive care, including:
  - Initial Health Appointment
  - Behavioral Assessment
  - Immunizations
  - Blood Lead Screenings
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Diagnosis, care and treatment of acute and chronic conditions
- Care management including complex care management
- Prescription drug services
- Hospice care
- Palliative care
- Major organ transplants
- Long-Term Care Services and Supports
- Enhanced Care Management
- Community Supports
- Transportation
- Health education and promotion
- Disease management
- Member experience
- Patient safety

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Provider training
- Organizational ethics
- Effective utilization of resources including monitoring of over and under utilization
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Fraud and abuse* as it relates to quality of care

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

Quality Improvement

The QI department is responsible for implementation of the QIHETP, monitoring quality of care and service, and assuring that credentialing standards, policies, and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with departments throughout the organization to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services. The QI department ensures that care and services are rendered appropriately and safely to all CalOptima Health members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both department-specific and organizationwide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain organizationwide practices that support accreditation and meet regulatory requirements

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical Directors triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). As cases are presented to CPRC, the discussion of the care includes appropriate action and leveling of the care, which results in committee-wide inter-rated reliability process. The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima Health, which include but are not limited to Prior Authorization, Concurrent Review, Care Management, Legal, Compliance, Customer Service, Pharmacy or GARS, as well as from providers and other external sources.

The QI department provides training guidance for the non-clinical staff in Customer Service and GARS to assist the staff on the identification of potential quality issues. Potential quality of care grievances are reviewed by a Medical Director with clinical feedback provided to the member.

Declined grievances captured by the Customer Service department are similarly reviewed by a Medical Director.

Comprehensive Credentialing Program

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

Practitioners are credentialed and recredentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, Dos, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include but are not limited to non-physician BH practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima Health direct environments. Credentialing and recredentialing activities for CCN are performed at CalOptima Health and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

CalOptima Health performs credentialing and recredentialing of OPs, including but not limited to acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with state and federal regulatory agencies.

CalAIM Providers

CalOptima Health performs credentialing or vetting of CalAIM providers to ensure providers are qualified to provide Enhanced Care Management and Community Supports to our members. CalAIM providers include but are not limited to the following providers: FQHCs, street medicine providers, homeless navigation centers, transitional housing centers, CBAS centers, home health agencies, school-based clinics, community-based organizations, recuperative care and respite providers, sobering centers, medical tailored meals, and personal care and homemaker services.

Use of QI Activities in the Recredentialing Process

Findings from QI activities and other performance monitoring are included in the recredentialing process.

Monitoring for Sanctions and Complaints

CalOptima Health has adopted policies and procedures for ongoing monitoring of sanctions, which include but are not limited to state or federal sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between recredentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review

CalOptima Health does not delegate PCP facility site, physical accessibility, and medical records review to contracted HMOs, PHCs and SRGs. CalOptima Health assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima Health retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima Health collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima Health completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR and Physical Accessibility Review Survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for precontracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review and CalOptima Health policies. An Initial Medical Record Review shall be completed within 90 calendar days from the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima Health may review sites more frequently per local collaborative decisions or when deemed necessary based on monitoring, evaluation or CAP follow-up issues. If the provider is unable to meet the requirements through the CAP review, then the provider will be recommended for contract termination.

Physical Accessibility Review Survey for Seniors and Persons With Disabilities (SPD)

CalOptima Health conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas, including the exam room
- Restroom
- Exam table/scale

Medical Record Documentation

The medical record provides legal proof that the member received care. CalOptima Health requires that contracted delegated HNs make certain that each member's medical record is maintained in an accurate, current, detailed, organized and easily accessible manner. Medical records are reviewed for format, legal protocols and documented evidence of the provision of

preventive care and coordination and continuity of care services. All data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.)

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

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state law and must be maintained by the provider for a minimum of 10 years.

Corrective Action Plan(s) to Improve Quality of Care and Service

When monitoring by either CalOptima Health's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima Health's functional areas will be overseen by the QI department as overseen by and reported to QIHEC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams using continuous improvement tools (i.e., quality improvement plans or PDSA) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

National Committee for Quality Assurance (NCQA) Accreditation

CalOptima Health is a National Committee for Quality Assurance (NCQA) accredited Health Plan and achieved its initial commendable accreditation in August 2012. In July 2021, CalOptima Health completed triannual renewal survey for NCQA Health Plan Accreditation and received 100% of the allowable points through the document submission and file review process. From this renewal survey, CalOptima Health received Accredited Status, which is effective through July 27, 2024.

The QI department staff support CalOptima Health accreditation efforts by conducting the NCQA Steering Committee to provide all internal departments with NCQA standards and updates, survey readiness management and NCQA survey process management. CalOptima

Health has acquired NCQA consulting services to support document review and survey readiness prior to submission.

CalOptima Health is seeking another renewal for Health Plan Accreditation and will be completing the submission by April 30, 2024. In addition to Health Plan Accreditation, CalOptima is also seeking Health Equity Accreditation with NCQA by January 2026.

Quality Analytics

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

The QA department activities include design, implementation and evaluation of processes and programs to:

- Report, monitor and trend outcomes
- Conduct measurement analysis to evaluate goals, establish trends and identify root causes
- Establish measurement benchmarks and goals
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required
- Participate in various reviews through the QIHETP, including but not limited to network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize HNs and providers to meet quality performance targets and deliver quality care
  Design and develop member, provider and organization-wide initiatives to improve - quality of care

Data sources available for identifying, monitoring and evaluating opportunities for improvement and intervention effectiveness include but are not limited to:

- Claims data
- Encounter data
- Utilization data
- Care management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings data
- Population Needs Assessment
- HEDIS results
- Member and provider satisfaction surveys

- Timely Access Survey
- Provider demographic information

By analyzing data that CalOptima Health currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS scores and CMS Star Ratings. This information will guide CalOptima Health and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Quality Performance Measures

CalOptima Health annually collects, tracks and reports all quality performance measures required by CMS and DHCS, including the DHCS Medi-Cal Accountability Set (MCAS), Medicare reporting set and Star measures. Measure rates are validated by a NCQA-certified auditor and reported to NCQA, CMS, DHCS and other entities as required.

Value-Based Payment Program

CalOptima Health's Value-Based Payment Performance Program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. HNs, including CCN, and HNs' PCPs are eligible to participate in the Value-Based Payment Programs. CalOptima Health has adopted the Integrated Healthcare Association (IHA) pay-for-performance methodology to assess performance. Performance measures are aligned with the DHCS MCAS for Medi-Cal and a subset of CMS Star measures for OneCare.

Five-Year Hospital Quality Program 2023–2027

CalOptima Health has developed a hospital quality program to improve quality of care to members through increased patient safety efforts and performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience and patient safety. Hospitals may earn annual incentives based on achievement of benchmarks.

Population Health Management

Population Health Management (PHM) aims to ensure that member care and services are delivered in a whole-person-centered, safe, timely, efficient and equitable manner across the entire health care continuum and life span. PHM integrates physical health, behavioral health, long-term support services and complex case management to improve the coordination of care between managed care teams. PHM care coordination includes basic population health management, complex care management, enhanced care management (ECM) and transitional care services. PHM's streamlined care coordination interactions are designed to optimize member care to meet their unique and comprehensive health needs.

At least annually, CalOptima Health engages with multidisciplinary care teams, members, community partners and stakeholders to update the PHM Strategy. The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima

Health also shares our creative upstream approach to address SDOH and close gaps in care that lead to health disparities among our members. In addition, CalOptima Health aligns our PHM Strategy with the priorities of our federal and state regulators and follows the standards outlined by NCQA.

CalOptima Health's PHM Strategy addresses the following areas of focus:

- Keeping members healthy
- Managing members with emerging risks
- Patient safety or outcomes across settings
- Managing members with multiple chronic conditions

To inform our PHM Strategy, CalOptima Health has several processes in place to review collected data that is used to understand our member needs, develop strategies to address those needs and evaluate the impact of those strategies. Mainly CalOptima Health's Population Needs Assessment (PNA) is used to summarize the results of an annual assessment on a variety of member data. The intent of the PNA is to review the characteristics and needs of our organization's member population and relevant focus populations to support data-driven planning and decision-making. In addition, CalOptima Health uses PNA key findings to inform a comprehensive PHM Work Plan.

The PHM Work Plan addresses the unique needs and challenges of specific ethnic communities, including social drivers of health that include but are not limited to economic, social and environmental stressors, to improve health outcomes. CalOptima Health will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services. These quality initiatives can be expected to have a beneficial effect on health outcomes and member satisfaction, and may include quality improvement projects (QIPs), program improvement projects (PIPs), Plan-Do-Study-Act (PDSAs) and chronic care improvement projects (CCIPs). Quality Initiatives are tracked in the QIHETP Work Plan and reported to the QIHEC.

In 2024, the PHM Work Plan will continue to focus on addressing health inequities and meeting member's social needs. CalOptima Health identified opportunities to expand outreach and initiate new initiatives focused on advancing health equity as follows:

- Improving screening for member social needs and connections to resources through an integrated closed-loop referral platform.
- Expanding Street Medicine services to connect unhoused members with whole person care approaches and addressing social drivers of health.
- Expanding in-person group health education classes in the community to promote healthy eating and active living.
- Initiating interventions for members with hypertension and chronic kidney disease.
- Implementing the Comprehensive Community Cancer Screening and Support program that aims to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses.
- Collaborating with the Orange County Health Care Agency to reduce disparities in childhood blood lead and maternal depression screening rates.

Further details of the Population Health Management Program, activities and measurements can be found in the 2024 Population Health Management Strategy (Appendix B)

Health Education and Promotion

In April 2024, the Population Health Management department was renamed Equity and Community Health. The newly named team will support all members in staying healthy by increasing access to care through the promotion of community-based programs such as Maternal and Child Health Programs, Wellness and Prevention Programs and Chronic Disease Programs – focusing efforts and resources on key initiatives that positively impact members and support the CalOptima Health mission.

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

The Equity and Community Health (ECH) department programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members. Moreover, these programs will be framed with an 'equity lens' and will also address mental wellness and the social drivers of health that impact our members. The programs are designed to achieve behavioral change and are reviewed on an annual basis. Program topics include exercise, nutrition, hyperlipidemia, hypertension, perinatal health, Shape Your Life/weight management, tobacco cessation, asthma, immunizations and well-child visits.

ECH supports CalOptima Health members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources

Managing Members With Emerging Risk

CalOptima Health staff provide a comprehensive system of caring for members with chronic illnesses. The systemwide, multidisciplinary approach entails the formation of a partnership between the member, the health care practitioner and CalOptima Health. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members, and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the California Surgeon General and Proposition 56 requirements for Adverse Childhood Event (ACE) screening, as well as identification of SDOH. It proactively identifies those members in need of closer management, coordination and intervention. CalOptima Health assumes responsibility for the PHM program for all lines of business; however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Care Management

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

- Standardized mechanisms for member identification through use of data, including Health Risk Assessment (HRA) for OneCare, SPD and WCM members
- Multiple avenues for referral to care management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidence-based guidelines distributed to providers who address chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD)
- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources
- Development of individualized care plans that include input from the member, caregiver, PCP, specialists, social worker and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing and modifying the plan of care to drive appropriate service quality, timeliness and effectiveness
- Establishing consistent provider-patient relationships
- Ongoing assessment of outcomes

CalOptima Health's Care Management (CM) program includes three care management levels that reflect the acuity of needs: complex care management, care coordination and basic care management. Members within defined models of care, (SPD, WCM and OneCare) are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy.

Health Risk Assessment (HRA) and Health Needs Assessment (HNA)

The comprehensive risk assessment facilitates care planning and offers actionable items for the ICT. Risk assessments are completed in person, telephonically or by mail and accommodate language preference. The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. Risk assessments are completed with the initial visit and then on an annual basis.

Interdisciplinary Care Team (ICT)

An ICT is linked to members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), depending on the results of the member's HRA and/or evaluation or changes in health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of the member) and PCP. For members with more needs, other disciplines are included, such as a Medical Director, specialist(s), care manager, BH specialist, pharmacist, social worker, dietitian and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

The ICT levels are:

- ICT for Low-Risk Members occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic care management, including advanced care planning
      - Medication reconciliation
      - Identification of member at risk of planned and unplanned transitions
      - Referral and coordination with specialists
      - Development and implementation of an Individual Care Plan (ICP)
      - Communication with members or their representatives, vendors and medical group
      - Review and update the ICP at least annually, and when there is a change in health status
      - Referral to the primary ICT, as needed

- ICT for Moderate- to High-Risk Members occurs at the HN, or at CalOptima Health for CCN members.
  - Team Composition: member, caregiver or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory care manager, hospitalist, hospital care manager and/or discharge planners, HN UM staff, BH specialist and social worker
    - Roles and responsibilities of this team:
      - Identification and management of planned transitions
      - Care coordination or complex care management
      - Care management of high-risk members
      - Coordination of ICPs for high-risk members
      - Facilitating communication among member, PCP, specialists and vendors
      - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

Individual Care Plan (ICP)

The ICP is developed through the ICT process. The ICP is a member-centric plan of care with prioritization of goals and target dates. Attention is paid to needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an

established plan for monitoring outcomes and ongoing follow-up per care management level. The ICP is updated annually and with change in condition.

Seniors and Persons with Disability (SPD)

The goal of care management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. The model involves risk stratification and HRA that contributes to the ICT and ICP development.

Whole-Child Model (WCM)

The goal of care management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima Health coordinates the full scope of health care needs inclusive of preventive care, specialty health, mental health, education and training. WCM ensures that each CCS-eligible member receives care management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs the ICT and ICP development.

OneCare Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC)

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

The MOC goals are:

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

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

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

- Complex care management program for a subset of members whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services

- Transitional care management program focused on evaluating and coordinating transition needs for members who may be at risk of rehospitalization
- High-risk and high-utilization program for members who frequently use emergency department services or have frequent hospitalizations, and high-risk individuals
- Hospital care management program to coordinate care for members during an inpatient admission and discharge planning

Care Management Program focuses on member-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Behavioral Health Integration Services

CalOptima Health is responsible for providing quality behavioral health care focusing on prevention, recovery, resiliency and rehabilitation. As part of the QI Program with direction and guidance from the QIHEC, the BHI other supporting departments continue to monitor the behavioral health care that CalOptima Health providers our member and continue to seek ways to improve behavioral health care.

Medi-Cal Behavioral Health (BH)

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

In addition, CalOptima Health covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima Health provides direct oversight, review and authorization of BHT services.

CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief counseling on misuse is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

CalOptima Health members can access mental health services directly, without a physician referral, by contacting the CalOptima Health Behavioral Health Line at 1-855-877-3885. A CalOptima Health representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to BH practitioners within the CalOptima Health provider network. If the member has moderate to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima Health ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access.

CalOptima Health directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services and quality improvement.

CalOptima Health is participating in two of DHCS' incentive programs focused on improving BH care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is designed to improve physical and BH outcomes, care delivery efficiency and member experience. CalOptima Health is providing program oversight, including readiness, milestones tracking, reporting and incentive reimbursement for the seven provider groups approved to participate in 12 projects. The second incentive program is the Student Behavioral Health Incentive Program (SBHIP), part of a state effort to prioritize BH services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH agencies and CalOptima Health by developing infrastructure to improve access and increase the number of transitional kindergarten through 12th-grade students receiving early interventions and preventive BH services.

OneCare Behavioral Health

OneCare covers inpatient and outpatient behavioral health care services through a directly contracted behavioral health network. OneCare BH continues to be fully integrated within CalOptima Health internal operations. OneCare members can access mental health services by calling the CalOptima Health Behavioral Health Line.

Utilization Management (UM)

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan, member eligibility at the time of service, subject to medical necessity, and are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease or injury consistent with CalOptima Health medical policy and not furnished primarily for the convenience of the member, attending physician or other provider.

Use of evidence-based, peer reviewed, industry-recognized criteria ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2024 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a Medical Director or other qualified reviewer, such as a licensed psychologist or clinical pharmacist.

Further details of the UM Program, activities and measurements can be found in the 2024 Integrated UM and CM Program Description.

Patient Safety Program

Patient safety is very important to CalOptima Health; it aligns with CalOptima Health's mission statement: *To serve member health with excellence and dignity, respecting the value and needs of each person*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed members and families are vital members of the health care team.

Patient safety is integrated into all components of enrollment and health care delivery and is a significant part of our quality and risk management functions. This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima Health members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on risk assessment
- Health education and health promotion
- Over/under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service
- Care provided in various health care settings
- Sentinel events
- Disease Surveillance and reporting

To ensure member safety, activities for prevention, monitoring and evaluation include:

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

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Using FSRs, PARS and MRR results from providers and health care delivery organization at the time of credentialing to improve safe practices, and incorporate ADA and SPD site reviews into the general FSR process

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

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

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster and evacuation plan testing and annual training

- Institutional settings, including CBAS, SNF and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address postoperative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of influenza and pneumonia vaccines
  - COVID-19 infection prevention and protective equipment

- Administrative offices
  - Fire, disaster and evacuation plan testing and annual training

Encounter Data Review

CalOptima Health's HNs must submit complete, timely, reasonable, and accurate encounter data that adheres to the guidelines specified in the companion guides for facility and professional claim types and data format specifications. A HN submits encounter data through the CalOptima Health File Transfer Protocol (FTP) site.

CalOptima Health annually measures a HN's compliance with performance standards with regards to the timely submission of complete and accurate encounter data, in accordance with Policy EE.1124 Health Network Encounter Data Performance Standards. CalOptima Health utilizes retrospective encounter data to conduct its evaluation. The measurement year is the twelve (12) month calendar year. CalOptima Health provides a HN with a HN Encounter Data Scorecard to report a HN's progress check score and annual score relating to the status of the HN's compliance with encounter data performance standards.

Member Experience

Improving member experience is a top priority of CalOptima Health and has a strategic focus on the issues and factors that influence the member's experience with the health care system. CalOptima Health performs and assesses the results from member-reported experiences and how well the plan providers are meeting members' expectations and goals. Annually, CalOptima Health fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys

for both Medi-Cal and OneCare members. Focus is placed on coordinating efforts intended to improve performance on CAHPS survey items for both the adult and child population.

Additionally, CalOptima Health reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for "pain points" that impact members at the plan and HN level (including CCN), where appropriate.

Grievance and Appeals

CalOptima Health has a process for reviewing member and provider complaints, grievances and appeals. Grievances and appeals are tracked and trended on a quarterly basis for timeliness of acknowledgment and resolution, issue types and by provider type. The grievance and appeals process includes a thorough investigation and evaluation to ensure timely access to care and the delivery of quality care and/or services. In this process, potential quality of care issues are identified and referred to an appropriately-licensed professional for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case. The quarterly report is presented and reviewed by the Grievance and Resolutions (GARS) Committee that reports to the QIHEC quarterly.

Access to Care

Access to care is a major area of focus for the plan and hence the organization has dedicated significant resources to measuring and improving access to care.

CalOptima Health participates in the following to monitor and improve network adequacy and access to our members:

- Annual Network Certification (ANC) with DHCS
- Subcontracted Network Certification (SNC) with DHCS
- Network Adequacy Validation with the EQRO
- Network Adequacy Monitoring with CMS

CalOptima Health monitors the following to ensure that we have robust provider networks for our members to access care and that members have timely access to care to primary and specialty healthcare providers and services:

Availability of Practitioners

- CalOptima Health monitors the availability of PCPs, specialists and BH practitioners and assesses them against established standards quarterly or when there is a significant change to the network.
- The performance standards are based on DHCS, CMS, NCQA and industry benchmarks.
- CalOptima Health has established quantifiable standards for both the number and geographic distribution of its network of practitioners.
- CalOptima Health uses a geo-mapping application to assess geographic distribution.
- Data is tracked and trended and used to inform provider outreaching and recruiting efforts.

Appointment Access

- CalOptima Health monitors appointment access for PCPs, specialists and BH providers and assesses them against established standards at least annually.
- To measure performance, CalOptima Health collects appointment access data from practitioner offices using a timely access survey.
- CalOptima Health also evaluates the grievances and appeals data quarterly to identify potential issues with access to care. A combination of both these activities helps CalOptima Health identify and implement opportunities for improvement.
- Providers not meeting timely access standards are remeasured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Telephone Access

- CalOptima Health monitors access to its Customer Service department on a quarterly basis.
- To ensure that members can access their provider via telephone to obtain care, CalOptima Health monitors access to ensure members have access to their primary care practitioner during business hours.
- Providers not meeting timely access standards are remeasured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Cultural & Linguistic Services Program

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services Program that integrates culturally and linguistically appropriate services at all levels of the operation. Services include but are not limited to face-to-face interpreter services, including American Sign Language, at key points of contact; 24-hour access to telephonic interpreter services; member information materials translated into CalOptima Health's threshold languages and in alternate formats, such as braille, large-print or audio; and referrals to culturally and linguistically appropriate community services programs.

The seven most common languages spoken for all CalOptima Health programs are: English, 58%; Spanish, 27%; Vietnamese, 9%; Farsi, 1%; Korean, 2%; Chinese, less than 1%; and Arabic, less than 1%; and other less than 2%. CalOptima Health provides member materials as follows:

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

CalOptima Health's Cultural and Linguistic Services Program is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of our diverse population. Beginning with identification of needs through a Population Needs Assessment,

programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the MAC and PAC prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Serving a culturally and linguistically diverse membership includes:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-, ethnic-, language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group
- Implementing and maintaining annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related trainings (e.g., providing gender affirming care) for employees and contracted staff (clinical and non-clinical).

Further details of the Culture and Linguistics program, activities and measurements can be found in the 2024 Culture and Linguistics Appropriate Services Program.

Delegated And Non-Delegated Activities

While CalOptima Health is accountable for all QIHE functions, CalOptima Health does delegate responsibilities to subcontractors and downstream subcontractors and specifies these requirements in a mutually agreed upon delegation agreement. CalOptima Health evaluates the delegates ability to perform the delegated activities to ensure compliance with statutory, regulatory and accreditation requirements as part of an annual and continuous monitoring process for delegation oversight.

Delegation Oversight

Participating entities are required to meet CalOptima Health's QI standards and to participate in CalOptima Health's QIHETP. CalOptima Health has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate's ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Delegation Oversight Committee, reporting to the Compliance Committee.

CalOptima Health, via a mutually-agreed-upon delegation agreement document, describes the responsibilities and activities of the organization and the delegated entity.

CalOptima Health conducts oversight based on regulatory, CalOptima Health and NCQA standards and has a system to audit and monitor delegated entities' internal operations on a regular basis.

Delegation Oversight Performance Monitoring includes but is not limited to the CalOptima Health delegates and monitors the following functions:

- Care Management, Credentialing, Utilization Management, and Claims.

Non-Delegated Activities

The following activities are not delegated to CalOptima Health's contracted HNs and remain the responsibility of CalOptima Health:

- QI, as delineated in the Contract for Health Care Services
- QIHETP for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- Health Equity
- BH for Medi-Cal and OneCare
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health education, as applicable
- Grievance and appeals process for all lines of business, and peer review process on specific, referred cases
- PQI investigations
- Development of systemwide measures, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second-level review of provider grievances
- Development of UM and Care Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

APPENDIX:

A – 2024 QIHETP WORK PLAN
B – 2024 POPULATION HEALTH MANAGEMENT STRATEGY
C – CALOPTIMA HEALTH MEASUREMENT YEAR (MY) 2024 MEDI-CAL AND ONECARE PAY FOR VALUE PROGRAMS
D – 2024 CULTURAL AND LINGUISTIC APPROPRIATE SERVICES PROGRAM

ABBREVIATIONS

	ABBREVIATION	DEFINITION
A		
	ACE	Adverse Childhood Experience
	ADA	Americans With Disabilities Act of 1990
	ADHD	Attention-Deficit Hyperactivity Disorder
	APL	All Plan Letter
	AUD	Alcohol Use Disorder
B		
	BHI	Behavioral Health Integration
	BHT	Behavioral Health Treatment
	BHIIP	Behavioral Health Integration Incentive Program
	BMSC	Benefit Management Subcommittee
C		
	CalAIM	California Advancing and Innovating Medi-Cal
	CAHPS	Consumer Assessment of Healthcare Providers and Systems
	CAP	Corrective Action Plan
	CBAS	Community Based Adult Services
	CCIP	Chronic Care Improvement Project
	CCO	Chief Compliance Officer
	CCS	California Children's Services
	CHCN	CalOptima Health Community Network
	CHEO	Chief Health Equity Officer
	CHRO	Chief Human Resources Officer
	CEO	Chief Executive Officer
	CIO	Chief Information Officer
	CLAS	Cultural and Linguistic Appropriate Service
	CMO	Chief Medical Officer
	CMS	Centers for Medicare & Medicaid Services
	COO	Chief Operating Officer
	COPD	Chronic Obstructive Pulmonary Disease
	COS	Chief of Staff
	COD-A	CalOptima Health Direct-Administrative
	CPRC	Credentialing and Peer Review Committee
	CQS	Comprehensive Quality Strategy
	CR	Credentialing
D		
	DC	Doctor of Chiropractic Medicine
	DCMO	Deputy Chief Medical Officer
	DDS	Doctor of Dental Surgery
	DHCS	Department of Health Care Services
	DMHC	Department of Managed Health Care
	DO	Doctor of Osteopathy
	DPM	Doctor of Podiatric Medicine
	D-SNP	Dual-Eligible Special Needs Plan
E		
	ECH	Equity and Community Health
	ED ECH	Executive Director, Equity and Community Health
	ED BH	Executive Director, Behavioral Health Integration
	BH	Behavioral Health
	ED CO	Executive Director, Clinical Operations

	ED MP	Executive Director, Medicare Programs
	ED NO	Executive Director, Network Operations
	ED O	Executive Director, Operations
	ED Q	Executive Director, Quality
F		
	FDR	First Tier, Downstream or Related Entity
	FSR	Facility Site Review
G		
	GARS	Grievance and Appeals Resolution Services
H		
	HEDIS	Healthcare Effectiveness Data and Information Set
	HIPAA	Health Insurance Portability and Accountability Act
	HMO	Health Maintenance Organization
	HN	Health Network
	HNA	Health Needs Assessment
	HOS	Health Outcomes Survey
	HRA	Health Risk Assessment
I		
	ICT	Interdisciplinary Care Team
	ICP	Individual Care Plan
	IRR	Inter-Rater Reliability
L		
	LTC	Long Term Care
	LTSS	Long Term Services and Supports
M		
	MAC	Member Advisory Committee
	MD	Doctor of Medicine
	ME	Member Experience
	MED	Medicaid Module
	MEMX	Member Experience Committee
	MOC	Model of Care
	MOU	Memorandum of Understanding
	MRR	Medical Record Review
	MRSA	Methicillin resistant Staphylococcus aureus
	MSSP	Multipurpose Senior Services Program
	MY	Measurement Year
	NCQA	National Committee for Quality Assurance
	NET	Network
	NF	Nursing Facility
O		
	OC	Orange County
	OCHCA	Orange Country Health Care Agency
	OP	Organizational Providers
	OC SSA or SSA	County of Orange Social Services Agency
Q		
	QAC	Quality Assurance Committee
	QI	Quality Improvement
	QIHE	Quality Improvement and Health Equity
	QIHEC	Quality Improvement and Health Equity Committee

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	QIP	Quality Improvement Project
P		
	P4V	Pay for Value
	P&T	Pharmacy & Therapeutics Committee
	PAC	Provider Advisory Committee
	PACE	Program of All-Inclusive Care for the Elderly
	PARS	Physical Accessibility Review Survey
	PBM	Pharmacy Benefit Manager
	PCC	Personal Care Coordinator
	PCP	Primary Care Practitioner/physician
	PDSA	Plan-Do-Study-Act
	PHM	Population Health Management
	PHC	Physician Hospital Consortium
	PIP	Performance Improvement Project
	PPC	Prenatal and Postpartum Care
	PPC	Provider Preventable Condition
	PQI	Potential Quality Issue
	PSS	Perinatal Support Services
S		
	SABIRT	Alcohol and Drug Screening Assessment, Brief Interventions and Referral to Treatment
	SBHIP	Student Behavioral Health Incentive Program
	SDOH	Social Drivers of Health
	SNP	Special Needs Plan
	SNF	Skilled Nursing Facility
	SPD	Seniors and Persons with Disabilities
	SRG	Shared Risk Group
	SUD	Substance Use Disorder
T		
	TPL	Third Party Liability
U		
	UM	Utilization Management
	UMC	Utilization Management Committee
V		
	VS	Vision Service
	VSP	Vision Service Plan
W		
	WCM	Whole-Child Model Program
	WCM CAC	Whole-Child Model Clinical Advisory Committee
	WCM FAC	Whole-Child Model Family Advisory Committee

Submitted and approved by QIHEC: 05/14/2024
Quality Improvement Health Equity Committee Chairperson:

Richard Pitts, D.O., Ph.D. Date

Submitted and approved by QAC: 06/12/2024
Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. Date

2024 QIHETP Work Plan Updated 4.1.24

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Delayed Green - On Target
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X			
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	Quality Improvement Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X			
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley	ED of Clinical Operations	Director of UM	Utilization Management	X			
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley	ED of Clinical Operations	Director of UM	Utilization Management	X			
Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: Population Needs Assessment (PNA) Risk stratification Screening and Assessment Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Katie Balderas	Barbara Kidder/Hannah Kim/HM/Director of Care Management	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	X			
Program Oversight	2024 Population Health Management (PHM) Strategy Evaluation	Complete the Evaluation of the 2024 Population Health Managemet (PHM) Strategy	The Population Heath Management (PHM) Strategy will be evaluated for effectiveness on an annual basis.	QIHEC: 11/0520/24 QAC: 12/11/2024 Annual BOD Adoption by January 2025	Katie Balderas	Barbara Kidder/Hannah Kim/HM/Director of Care Management	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	**New**			
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Albert Cardenas	Carlos Soto	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	X			
Program Oversight	2024 Cultural and Linguistic Services Program Evaluation	Complete the Evaluation of the 2024 Cultural and Linguistic Services Program	The Cultural and Linguistic Services Program will be evaluated for effectiveness on an annual basis.	QIHEC: 11/05/2024 QAC: 12/11/2024 Annual BOD Adoption by January 2025	Albert Cardenas	Carlos Soto	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	**New**			
Program Oversight	**Population Health Management (PHM) Committee** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder/Hannah Kim	Director of Equity and Community Health	Manager of Equity and Community Health/ Director Case Management	Equity and Community Health	**New**			
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	Report committee activities, findings from data analysis, and recommendations to QIHEC	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Laura Guest	Marsha Choo Rick Quinones Katy Noyes	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X			
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.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	Director of Grievance and Appeals	Manager of GARS	GARS	X			
Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Director of Medicare Stars and Quality Initiatives	Project Manager Quality Analytics	Quality Analytics	X			
Program Oversight	**Utilization Management Committee (UMC) Oversight** - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. **P&T and BMSC** reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Kelly Giardina	Stacie Oakley	Director of Utilization Management	Manager of UM	Utilization Management	X			
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	T.T. Nguyen, MD/H.Kim	Gloria Garcia	Whole Child Model Medical Director / Director of Case Management	Program Assistant QI	Medical Management	X			
Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Megan Dankmyer	TBD	Director of Care Management	TBD	Medical Management	**New**			
Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activites.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accredication standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Monica Herrera	Zulema Gomez John Robertson	Director of Audit and Oversight	Manager of Audit and Oversight (Delegation)/ Manager Delegation Oversight	Delegation Oversight	**New**			
Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Elisa Mora	Director of PHM	Manager of Equity and Community Health	Equity and Community Health	**New**			
Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: Evaluation of current utilization of health education services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Anna Safani/Katie Balderas	Thanh Mai Dinh	Director of Equity and Community Health/Manager of Health Education	Manager of Equity and Community Health	Equity and Community Health	**New**			
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024 Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	x			
Program Oversight	Long-Term Support Services (LTSS)	Implement LTSS	Report on the following activities: Evaluation of current utilization of LTSS Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	Director of LTSS	Manager of LTSS	Long Term Care	**New**			
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activites for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Veronica Gomez	Marsha Choo	Program Manger of QI	Director of Quality Improvement	Quality Improvement	X			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Delayed Green - On Target
Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of QA	Quality Improvement	X			
Program Oversight	Value Based Payment Program	Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Manager of Quality Analytics	Manager Quality Analytics	Quality Analytics	X			
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1 02/11/2025	Paul Jiang	Terri Wong	Director of Quality Analytics	Manager Quality Analytics	Quality Analytics	X			
Program Oversight	School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Sherie Hopson	Director of Behavioral Health Integration	Project Manager BHI	Behavioral Health Integration	X			
Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Katie Balderas	Barbara Kidder	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X			
Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	X			
Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collabortively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second quater. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow-up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Health Equity/Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health	**New**			
Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primay Care Providers (PCP) for members in need of merabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to the next top 50 prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs) 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care.	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	**New**			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	**New**			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaborotively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward Program.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP:Improve the percentage of members enrolled into care management, Caloptima Helath community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz/Mary Barranco	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration/ Quality Analytics	X			
Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	X			
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 68.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD: HbA1c Poor Control (this measure evaluates % of members with poor A1C control- lower rate is better) MY2024 Goals: MC: 29.44%; OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Delayed Green - On Target
Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Equity and Community Health/ Quality Analytics	X			
Quality of Clinical Care	Maternal and Adolescent Depression Screening	Medi-Cal Only - Meet the following goals For MY2024 HEDIS: DSF-E Depression Screening and Follow-up for Adolescent and Adults - Screening: 2.97% PND-E Prenatal Depression Screening and Follow-up - Screening: 8.81% PDS-E Postpartum Depression Screening and Follow-up: 27.77%	1) Identification and distribution of best practices to health network and provider partners. 2) Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion. 3) Targeted member engagement and outreach campaigns in coordination with health network partners. 4) Provider education (CE/CME) in Q3.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson/Natalie Zavala	Kelli Glynn/Diane Ramos	Director of Operations Management / Director of Behavioral Health Integration	Manager of Quality Analytics / Manager of Behavioral Health Integration	Operations Management/ Behavioral Health Integration	**New**			
Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s) In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS **MY2024** Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits. Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data submited by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 04/09/2024 Q4: 10/08/2024	Kelly Klipfel	Lorena Dabu	Director of Finance	Manager of Finance	Finance	**New**			
Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC: Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025 Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Marsha Choo	Katy Noyes	Director Qualty Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Laura Guest	Director Qualty Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Director Qualty Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Director of Quality Improvement	Manager Quality Improvement	Quality Improvement	**New**			
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X			
Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	S. Hickman/M. Dankmyer/H. Kim	QI Nurse Specialist	Director Medical Management/Case Management	QI Nurse Specialist	Case Management	X			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - In Progress Green - On Target
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	1) Quynh Nguyen 2) Tory Vazquez 3) Jane Flannigan Brown	Mahmoud Elaraby Provider Relations	1) Director of Provider Network 2) Director of Contracting	Analyst of Quality Analytics	Contracting	X			
Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely acces. 3) Continue to educate providers on timely acces standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	X			
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for Improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Karen Jenkins/Mahmoud Elaraby	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst	Network Operations/Quality Analytics	X			
Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Katie Balderas	Anna Safari	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X			
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Mahmoud Elaraby/Johnson Lee	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst for Quality Analytics/ Manager of Provider Data Management Services	Provider Data Management Services	**New**			
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Carol Matthews/Helen Syn	Director of Medicare Stars and Quality Initiatives	QA Project Manager	Quality Analytics	X			
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	Director of GARS	Manager of GARS	GARS	**New**			
Quality of Service	Customer Service	Implement customer service process and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Andrew Tse	Mike Erbe	Director of Customer Service	Manager of Customer Service	Customer Service				
Quality of Service	Medi-Cal Customer Service Performance Improvement Project	To meet Medi-Cal Customer Service KPIs by December 31, 2024: Internal call abandonment rate of 5% or lower, DHCS' 10 minutes average speed of answer	1) Partnering with HR to onboard more permanent and temporary staff to service inbound calls. 2) Interacting with various departments involved with member engagement campaigns and determine if they're able to update instructions for targeted members (i.e., instead of calling customer service, have them utilize the member portal).	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Andrew Tse	Mike Erbe	Associate Director of Customer Services	Manager of Customer Service	Customer Service	**New**			
Safety of Clinical Care	Coordination of Care: Member movement across pracitioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Megan Dankmyer	TBD	Director of Case Management	TBD	Medical Management	**New**			
Safety of Clinical Care	Emergency Department Visits	Emergency Department Diversion Pilot Pilot has been implemented. In 2024 plan to expand the program to additional hospital partners.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	Director of LTSS	Manager of LTSS	LTSS	X			
Safety of Clinical Care	Coordination of Care: Member movement across settings - Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% from Q4 2023 by end of December 31,2024.	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Stacie Oakley Hannah Kim Scott Robinson	Joanne Ku	Director of UM, CM and LTSS	Manager of Medical Management	Utilization Management Case Management Long Term Care	X			
Cultural and Linguistic Appropriate Services	Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from 41.90% to 55.78% by 12/31/2024..	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	X			
Cultural and Linguistic Appropriate Services	Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Maintain business for current programs Improve process for handling these services	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Albert Cardenas	Carlos Soto	Director of Customer Service	Manager of Customer Service	Cultural and Linguistic Services				
Cultural and Linguistic Appropriate Services	Maternity Care for Black and Native American Persons	1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima's Black members from 67.48% to 74.74% and Native Americans from 44.44 to 63.22% by 12/31/24. 2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima's Black members from 53.77 to 72.37% and Native Americans from 27.78% to 59.43% by 12/31/24.	Assess and report the following activities: 1) Determine the primary drivers to noncompliance via member outreach and literature review 2) Targeted member engagement and outreach campaigns in coordination with health network partners 3) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 4) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 5) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 6) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Manager Equity and Community Health/ Director of Operations Management	Program Manager of Quality Analytics/ Manager of Quality Analytics	Equity and Community Health	**New**			
Cultural and Linguistic Appropriate Services	Data Collection on Member Demographic Information	Implement a process to collect member SOGI data by December 31, 2024.	1) Develop and implement a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 3) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 4) Develop and implement a survey to distribute during the monthly New member orientation sessions. 5) Share member demographic information with practitioners.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Albert Cardenas	Carlos Soto	Director of Customer Service	Manager of Customer Service	Customer Service	**New**			

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Delayed Green - On Target
Cultural and Linguistic Appropriate Services	Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.	1) Develop and implement a survey to collect practitioner REL data 2) Enter REL data into provider data system and ensure ability to retrieve and utilize for CLAS improvement. 3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership. 4) Assess the provider network's capacity to meeting CalOptima Health's culturally diverse member needs. 5) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Quynh Nguyen	Johnson Lee	Director of Provider Data Management Services	Manger Provider Data management System	Provider Data Management Services	**New**			
Cultural and Linguistic Appropriate Services	Experience with Language Services	Evaluate language services experience from member and staff	1) Develop and implement a survey to evaluate the effectiveness related to cultural and lingustic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Albert Cardenas	Carlos Soto	Director of Customer Service	Manager of Customer Service	Customer Service	**New**			

2024

POPULATION HEALTH MANAGEMENT STRATEGY & WORK PLAN

Responsible Staff:

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INTRODUCTION

Agency Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. As a public agency, CalOptima Health was founded by the community as a County Organized Health System that offers health insurance programs for low-income children, adults, seniors and people with disabilities. We believe that our members deserve the highest quality of care and service. To achieve this, CalOptima Health works in collaboration with members, providers, community stakeholders and government agencies guided by our mission and vision.

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Strategy Purpose

To meet the unique and comprehensive health needs of our members, CalOptima Health engaged with multidisciplinary care teams, community partners and stakeholders to co-create the Population Health Management (PHM) Strategy.

The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also shares our creative upstream approach to address social determinants of health (SDOH) and close gaps in care that lead to health disparities among our members.

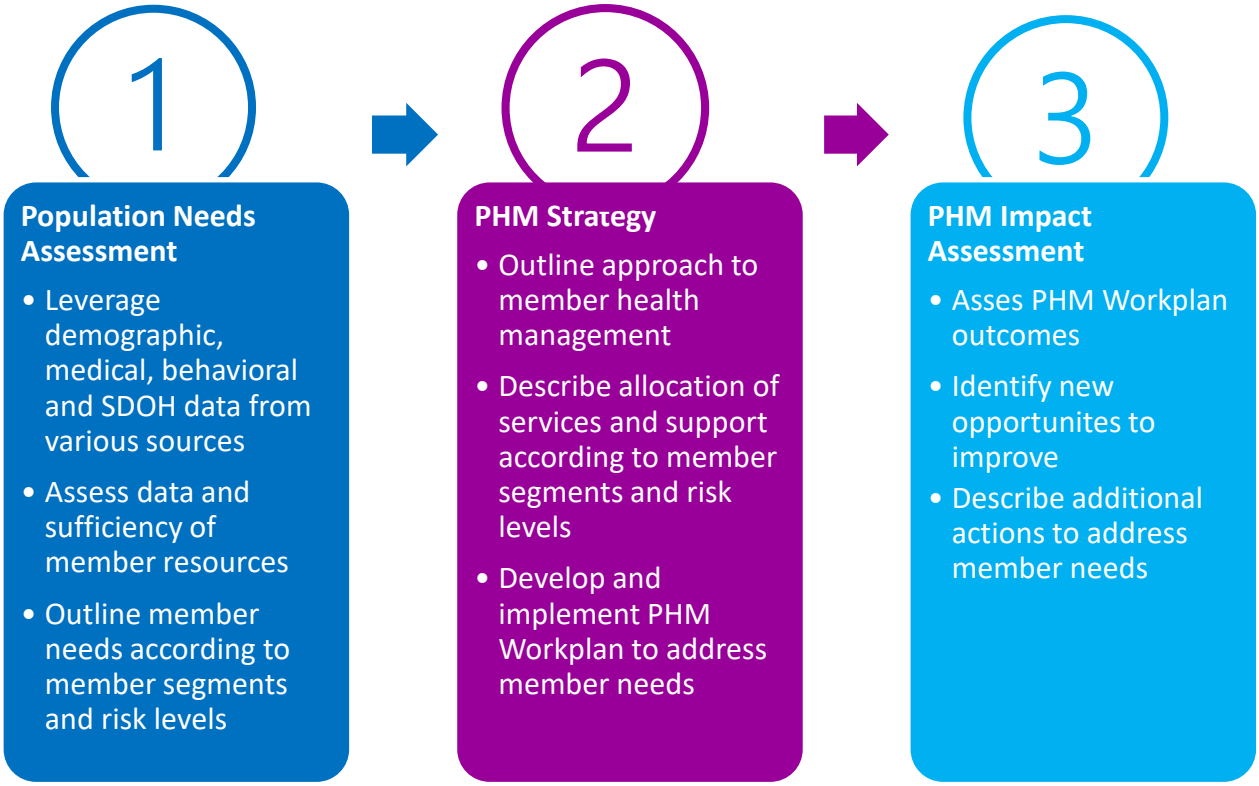
In addition, CalOptima Health aligns our PHM Strategy with the priorities of our federal and state regulators and follows the standards outlined by the National Accreditation of Quality Assurance (NCQA).

CalOptima Health's PHM Strategy addresses the following areas of focus:

1. Keeping members healthy
2. Managing members with emerging risks
3. Member safety
4. Managing members with multiple chronic conditions

Strategic Management

To inform our PHM Strategy and programs, CalOptima Health has several processes in place to review collected data that is used to understand our member needs, develop strategies to address those needs and evaluate the impact of those strategies through a comprehensive PHM Workplan. The following diagram illustrates the relationship of these activities:



Population Needs Assessment

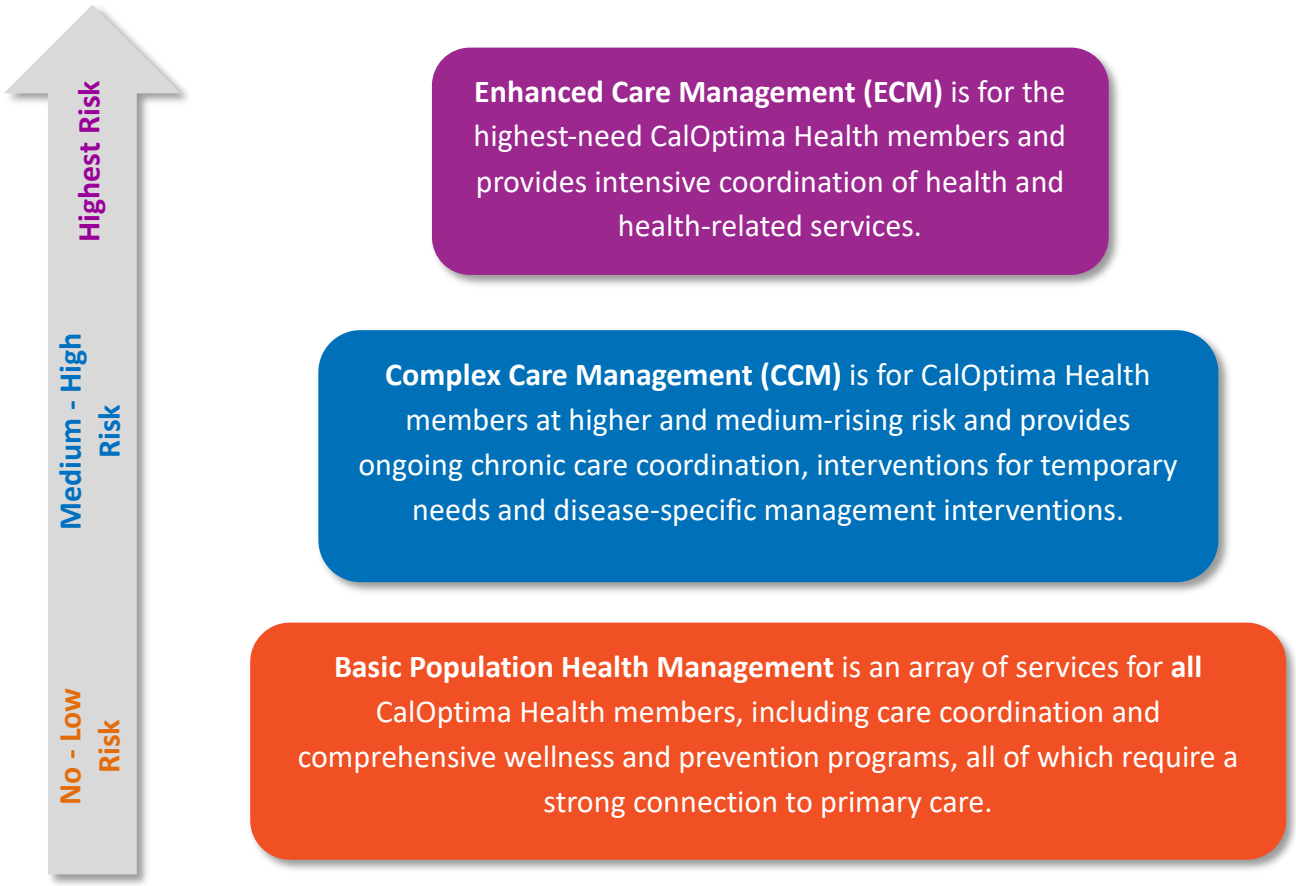
CalOptima Health's Population Needs Assessment (PNA) summarizes the results of an annual assessment on a variety of data. The intent of the PNA is to review the characteristics and needs of our agency's member population and relevant focus populations to support data-driven planning and decision-making. This report specifically focuses on CalOptima Health's:

- Overall member population, including SDOH
- Children and adolescent members ages 2–19 years old
- Members with disabilities
- Members with serious and persistent mental illness (SPMI)
- Members according to racial and ethnic groups
- Members with limited English proficiency
- Relevant focus populations

CalOptima Health uses PNA key findings to inform the PHM Strategy and Workplan which aim to address gaps in member care through intervention strategies and quality initiatives. Report findings also helped identify the need for process updates and resource allocation.

Population Segmentation and Care Coordination

CalOptima Health's PHM program aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner across the entire health care continuum and life span. The PHM program integrates physical health, behavioral health, long-term support services, care coordination and complex case management to improve coordination of care between managed care teams. The PHM program includes basic population health management, complex care management, Enhanced Care Management (ECM) and transitional care services.



PHM Strategy and Workplan

The following table provides a high-level overview of CalOptima Health's 2024 PHM Strategy and Workplan. This table shows how CalOptima Health aligns federal and state guidance with NCQA standards to guide our PHM Program efforts.

CalOptima Health 2024 PHM Workplan Overview

Area of Focus	Program/Service	Description
Keeping Members Healthy	**Blood Lead Testing in Children**	In babies and young children, whose brains are still developing, even a small amount of lead can cause learning disabilities and behavioral problems. CalOptima Health works with providers and members to ensure that all young children are tested for lead at age-appropriate intervals.
	Well-Child Visits	Well-child visits are important during the early months of a child's life to assess growth, development and identify and address any concerns early. CalOptima Health promotes preventive care for its youngest members to help them live long, happy and healthy lives.
	Health Disparity Remediation for Well-Child Visits	CalOptima Health aims to reduce the racial/ethnic disparities in well child visits in support of the statewide goals. Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate among African American child members has the potential to improve their overall health status.
	Childhood Immunizations	Childhood vaccinations are a safe and effective way to protect children from a variety of serious or potentially fatal diseases. CalOptima Health works to promote immunizations and ensure that children are healthy, growing and ready to learn.
	Comprehensive Community Cancer Screening and Support Program	CalOptima Health partnered with external stakeholders in the fight against cancer to launch this program. Together, we aim to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses through early screening.
	Bright Steps Program	CalOptima Health's prenatal and postpartum care program aims to inform and provide resources to pregnant members to help them have a healthy pregnancy, delivery and baby.
	Shape Your Life	CalOptima Health offers no-cost, in-person and virtual group classes for children ages 5 to 18 and their families. Topics include healthy eating, physical activity and other ways to build healthy habits.
Emerging Risk	**Chronic Condition Care and Self- Management Program**	CalOptima Health's programs promote self-management skills for people with chronic conditions to enable them to manage their health on a day-to-day basis and to take an active role in their health care.
Patient Safety	**CalAIM Community Supports**	California Advancing and Innovating Medi-Cal (CalAIM) is a five-year initiative by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by addressing social drivers of health and breaking down barriers in accessing care. Community Supports are a core component of CalAIM.
	Street Medicine Program	CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's un-housed individuals and families through whole person care approaches and addressing social drivers of health.
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	CalOptima Health's program assesses the percentage of emergency department (ED) visits for members aged 6 and older with a principal diagnosis of alcohol and other drug abuse or dependence to ensure our members receive appropriate follow-up care.
Multiple Chronic Conditions	**Complex Case Management Program**	Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

NOTE: Please see CalOptima Health's 2024 PHM Workplan for a detailed list of programs and services, SMART objectives and related activities.

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PHM Program

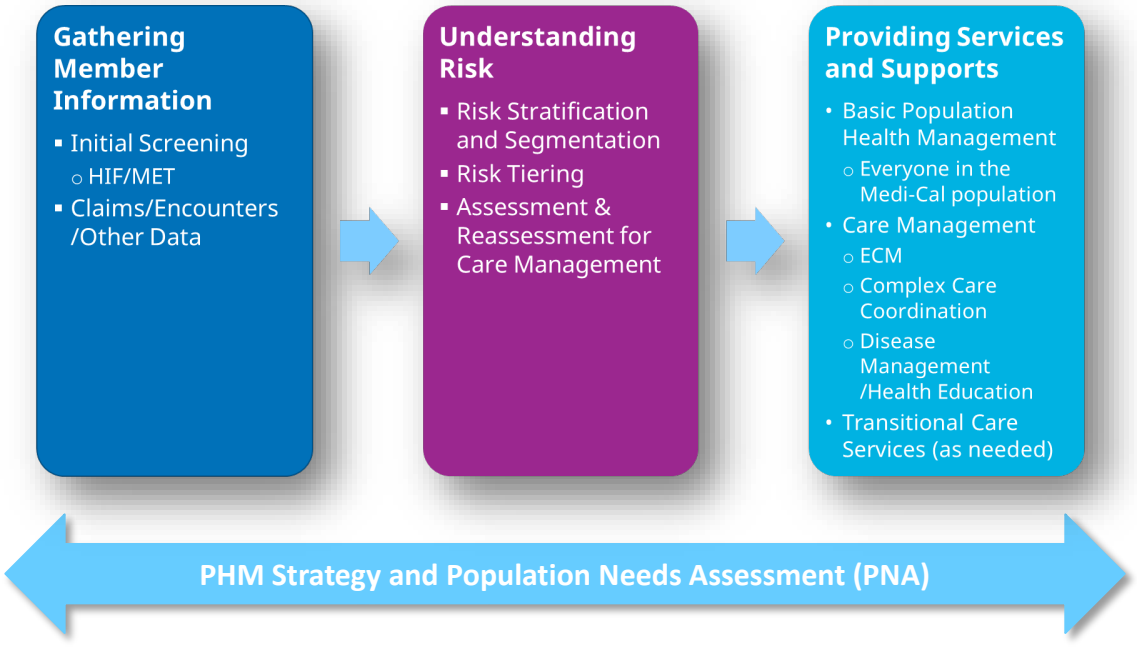
The PHM Strategy serves to guide CalOptima Health's PHM Program that aims to motivate, educate and empower members to become self-advocates in their healthcare, manage conditions, prevent acute episodes and enhance their quality of life. Our PHM Program and related services are also developed by a multidisciplinary team of health professionals, community partners and stakeholders. Together, we ensure that our PHM Program is committed to health equity, member involvement and accountability. This is achieved by:

- Building trust and meaningful engagement with members.
- Using data-driven risk stratification and predictive analytics to address gaps in care.
- Revising and standardizing assessment processes.
- Providing care management services for all high-risk members.
- Creating robust transitional care services (TCS) to promote continuity of care and limit service disruptions.
- Developing effective strategies to address health disparities, SDOH and upstream drivers of health.
- Implementing interventions to support health and wellness for all members.

PHM Framework

CalOptima Health adopted guiding principles of the PHM Framework to plan, implement and evaluate the PHM Program and our delivery of care. The diagram below outlines the key components used to operationalize the PHM Program, which includes:

- ***Population needs assessment and PHM Strategy*** that are used to measure health disparities and identify the health priorities and social needs of our member population, including cultural and linguistic, access and health education needs.
- ***Gathering member information*** on preferences, strengths and needs to connect every member to services at the individual level, and to allocate resources.
- ***Understanding risk*** to identifying opportunities for more efficient and effective interventions.
- ***Providing services and supports*** to address members needs across a continuum of care.



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PHM Program Coordination

CalOptima Health's PHM Program spans across several settings, providers and levels of care in an effort to meet our members' needs. To streamline PHM Program activities and avoid duplication, CalOptima Health utilizes a care management system to facilitate the coordination of care and data management for members among several care teams including:

- Behavioral Health Integration
- Case Management
- Long Term Care and Support
- Program of All-inclusive Care for the Elderly (PACE)
- Population Health Management
- Pharmacy
- Utilization Management

Through the agency's care management system, CalOptima Health can determine member eligibility for services, share data to identify and address care gaps, and coordinate care across settings. The system is available to all care team staff responsible for member care and enables them to:

- Create links between all systems that allow appropriate coordination of care and support delivered at the proper time, while minimizing duplication of effort between the coordinating teams.
- Access member records to expedite and view all relevant data in one location.
- Identifying member needs through established system logics or from providers and member self-referrals to plan an appropriate level of support whereby a staff (e.g., Personal Care Coordinator) is assigned to help the member with managing their health and social needs.
- Provide members with appropriate assessments and educational materials, derived from evidence-based tools and standardized practices.
- Create an individualized Care Plan with prioritized goals and facilitate services that minimize or eliminate barriers to care for optimal health outcomes.
- Inform Interdisciplinary Care Team (ICT) of member care needs, related activities and health goal progress.

Informing Members about PHM Programs

CalOptima Health deploys several interactive methods to inform members about PHM programs. These interactive methods are designed to share program eligibility and how to use program services. All PHM programs are voluntary. Based on members' language preferences, they are informed of various health promotion programs or how to contact care management staff via initial mailed Member Welcome Packet, member informing materials (e.g., newsletters, program/service letters, benefit manuals, etc.), CalOptima Health's member website, text messaging, personal phone outreach, robocalls and/or in person.

The following descriptions provide more details on how CalOptima Health's eligible members are informed about PHM programs:

- ***Eligibility to participate***: CalOptima Health's PHM programs are accessible to members from Medi-Cal and OneCare lines of business that meet the PHM program criteria. When a member has a referral into a PHM program, the member is directed to the appropriate staff for assistance with enrollment to the program best matching the member's level of need.

- ***Use of services***: CalOptima Health provides instruction on how to use these services in multiple languages and with appropriate health literacy levels.
- ***Accepting or declining services:*** CalOptima Health honors member choice; hence, all the PHM programs are voluntary. Members can self-refer to any PHM program by contacting CalOptima Health. When CalOptima Health conducts outreach to eligible members identified through risk stratification or provider referral, members are informed that the program is voluntary, and they are able to opt-out at any time.

PHM Impact Assessment

CalOptima Health's annual PHM Impact assessment measures the effectiveness of the agency's PHM Strategy and related programs to address member care needs. Through this analysis, CalOptima Health also identifies and addresses opportunities for improvement. Specifically, the assessment focuses on the:

- Clinical impact of programs
- Cost and/or utilization impact of programs
- Member experience with programs

CalOptima Health uses key performance indicators (e.g., primary care, ambulatory care, emergency department visit, inpatient utilization) and quality measures (e.g., Healthcare Effectiveness Data and Information Set [HEDIS®]) to assess the effectiveness of the PHM program and adjust it to meet the needs of our members. The PHM Impact findings are shared with our care management team, stakeholders and regulatory agencies at least annually.

PROMOTING HEALTH EQUITY

CalOptima Health is working to advance health equity throughout our strategic management process to ensure that PHM programs and services support our members in attaining their highest level of health. Health equity is not something that a person can do for themselves. 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. In response, CalOptima Health has prioritized health equity so that all members are empowered and able to access resources to be as healthy as possible, regardless of background and identity. In 2022, CalOptima Health launched an organization-wide Equity Initiative, with focus areas in:

- Health equity and SDOH
- Communications and narrative change
- Diversity, equity and inclusion for CalOptima Health workforce
- Stakeholder engagement

To meet the needs of members who are impacted by the greatest health inequities, CalOptima Health has develop a roadmap to meet the following overarching goals:

- Make an explicit commitment to advance health equity to internal and external stakeholders.
- Identify existing and needed organizational assets, resources and leadership.
- Measure health inequities and identify impactful strategies focused on SDOH.
- Implement short- and long-term strategies at the member, organizational and community level.
- Enhance data collection, shared lessons and expanded capacity.

CalOptima Health has operationalized our health equity efforts through a broad range of programs and services.

Social Determinants of Health

To guide our effort in healthy equity, CalOptima Health developed the Member Risk Dashboard to help us understand the impact that SDOH has on our members. This dashboard is informed by the Chronic Illness and Disability Payment System (CDPS) + Rx risk model which assigns a risk score to each member using diagnosis codes from claims and encounters plus pharmacy data to help assess the effective disease burden a population may face. The Member Risk Dashboard can overlay risk with several different factors (e.g., gender, ethnicity, age, health conditions, SDOH factors, etc.) to stratify and segment members. Furthermore, the SDOH data collected using diagnosis codes present on claims and encounters is categorized as follows:

- Adverse family events
- Criminal justice involved
- Housing instability
- Indications of extreme poverty
- Psychosocial circumstances

Among the different features available through this dashboard are the SDOH Profile and SDOH Comparison. The SDOH Profile provides an overview of how SDOH factors impact CalOptima Health members. The SDOH Comparison is used to compare health metrics between SDOH categories such as:

- Condition prevalence
- Hospital readmissions
- Emergency room visits
- Dental visits
- Uncontrolled A1c
- Unused authorizations

The Member Risk Dashboard serves to highlight CalOptima Health's current efforts to better identify and address the health disparities seen in our member population that are caused by SDOH. CalOptima Health plans to continue enhancing our understanding of the impact that SDOH has on our members through the expansion of data collection efforts and community engagement.

ACTIVITIES AND RESOURCES

CalOptima Health recognizes the importance of mobilizing multiple resources to support our members' health needs. At least annually, CalOptima Health conducts a strategic review of existing structures, programs, activities and resources using its PNA and dashboards. This strategic assessment helps CalOptima Health leaders set new program priorities, re-calibrate existing programs, re-distribute resources to ensure health equity and proactively mitigate emerging risks. Please see the annual PNA Report for details of this review and a description of the activities and resources supported by CalOptima Health.

In addition, CalOptima Health describes activities that are designed to support the PHM Strategy, including activities not directed at individual members, in our PHM Workplan. Indirect member activities apply to multiple areas of focus to and include:

- Building partnerships with community-based organizations, local health care agencies, hospitals and clinics, universities and more to streamline efforts and leverage resources.
- Developing toolkits and resources to support health network providers and community partners.
- Conducting improvement projects (e.g., Plan, Do, Study, Act (PDSA) and Performance Improvement Projects (PIP)) to address health disparities.
- Investing in community implementation and expansion efforts to support PHM programs and services.
- Regularly sharing guidance and information relevant to members with staff, providers and stakeholders using multimodal communication strategies (e.g., newsletters, web portals, meetings, etc.)
- Exchanging data between CalOptima Health and supporting health entities (e.g., Health Network providers, local health agencies, etc.)
- Facilitating continuous education, training and professional development opportunities for staff and providers.

DELIVERY SYSTEM SUPPORTS

Providers and practitioners play an integral role in helping CalOptima Health members meet their highest level of health. Therefore, CalOptima Health works intentionally and collaboratively to support our provider and practitioner community to fulfill PHM goals. CalOptima Health offers ongoing support to providers and practitioners in our health networks, such as sharing patient-specific data, offering evidenced-based or certified decision-making aids, continuing education sessions and providing comparative quality and cost information. These supports are described below:

Information Sharing

CalOptima Health provides member-level prospective rates (or gaps in care) reports for providers on a monthly basis to support preventive care outreach and engagement. CalOptima Health will continue to improve information sharing using integrated and actionable data. Additionally, CalOptima Health facilitates ongoing collaboration and open lines of communication regarding member health outcomes through quarterly Joint Operations Meetings and quarterly Health Network Forums to discuss strategies, barriers and opportunities for improvement.

Shared Decision-Making Aids

CalOptima Health aligns decision-making aids with our clinical practice guidelines to promote shared decision making among providers and their members. These are approved by CalOptima Health's Quality Improvement Committees, posted to CalOptima Health's provider website and promoted through our providers newsletters. Shared Decision-Making Aid topics include:

- Cardiac Conditions
- Treatment for Opioid Use Disorder
- Diabetes Medication Choice
- Heart Disease
- Hypertension
- Treatment for Kidney Failure

Transformation Support

CalOptima Health's Orange County Population Health and Transition to Value-Based Care Initiative (PHVBC) aims to support participating health centers and their providers in transforming access to quality of care while strengthening the safety net system across OC. Over the course of five years, teams from local community clinics will advance their internal systems and implement projects that strengthen their population health capacities and readiness for high-quality and value-based care with the incentives provided by the $50 million PHVBC initiative. Activities will focus on advancing population and community supports (i.e., advocating for support, expanding access to coverage and quality of care) provided to disproportionately impacted communities in Orange County; ultimately, shifting from the idea that the volume of services rendered can serve as a proxy for better health outcomes to a value- and team-based model of care that focuses on the whole person.

The Institute for High Quality Care (IHCQ) will provide technical assistance throughout the initiative, and the Center for Community Health and Evaluation (CCHE) will be the initiative evaluator. Furthermore, the IHCQ will provide a variety of technical assistance to support participating teams throughout the initiative, including training, topic-specific working groups, coaching and curating best

practices and other resources. These supports will be designed and tailored on the PHVBC health centers' specific project and areas of interest and/or need.

CalOptima Health will use the provider profiles to identify practitioners, organizations or communities that do not meet accepted standards of care. Profiling can be used to evaluate both the overuse and underuse of appropriate services. This will help them transform their practices to be more quality and outcome focused. CalOptima Health will use the profiles as a mechanism to administer its financial incentives program for providers to improve quality. The incentives are designed to support practitioners with the necessary funding so they can focus more on care coordination and preventive care. It will provide clinics with the resources to bring on additional staff that can coordinate member care across the spectrum of providers. CalOptima Health will establish goals for providers that align with the quality improvement goals to focus on high priority measures.

Training on Equity, Cultural Competency, Bias, Diversity and Inclusion

CalOptima Health's Cultural Competency training is required for all health care providers and staff who care for our members. The training is available on CalOptima Health's website for providers to complete. The training provides an overview of CalOptima Health's diverse membership, helps providers identify members with potential cultural or language needs where alternate communication methods are needed, and ensures that persons interacting with CalOptima Health members understand how culture and language may influence health.

Pay for Value (P4V)

CalOptima Health's Pay for Value (P4V) program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks and CalOptima Health Community Network (CCN) PCPs are eligible to participate in the P4V programs.

The purpose of CalOptima Health's P4V program is to:

1. Recognize and reward health networks and their physicians for demonstrating quality performance;
2. Provide comparative performance information for members, providers and the public on CalOptima Health's performance; and
3. Provide industry benchmarks and data-driven feedback to health networks and physicians on their quality improvement efforts.

The Medi-Cal P4V program incentivizes performance on all HEDIS® measures that are included in the DHCS Managed Care Accountability Sets (MCAS) required to achieve a minimum performance levels (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures.

PHM Structure

PHM operations at CalOptima Health are supported by a leadership team, allied health professionals and administrative staff. PHM assumes responsibility for health education and disease management programs for all CalOptima Health members. In addition, PHM oversees the strategic management efforts including the identification the health and wellness needs of CalOptima Health members and aligning

organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. The following is a description of PHM team roles and responsibility.

Team Roles and Responsibilities

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the PHM Program, as specified in the state and federal contracts.

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

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members, including Population Health Management. At least quarterly, the CMO presents reports on PHM activities to the Board of Directors' Quality Assurance Committee.

Chief Health Equity Officer (CHEO) leads the development and implementation of health equity as a core competency through collaboration with leaders across CalOptima Health and serves as the voice and content expert on health equity for CalOptima Health's members, affiliates and partners, providing strategic direction around clinical interventions, benefit design, engagement strategies and participates in testing and evaluation initiatives.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Population Health Management (PHM), Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Population Health Management (ED PHM) is responsible for the development and implementation of companywide PHM strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the Chief Medical Officer (CMO), Deputy Chief Medical Officer (DCMO) and Executive Directors from Behavioral Health, Quality, and Clinical Operations Departments, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Clinical Operations functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the Executive Director of Quality and Population Health Management.

Executive Director, Quality (ED QI) is responsible for facilitating the companywide QI Program deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement and Credentialing.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for the management and oversight of CalOptima's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED BHI leads strategies for integrating behavioral health across the health care delivery system and populations served.

Medical Director, Population Health Management and Equity is responsible for advancing population-wide health and well-being for CalOptima Health members by providing clinical guidance for PHM strategies and programs, conducting staff and provider trainings on relevant PHM issues, reviewing and approving health education materials, group class curricula, clinical practice guidelines, shared decision-making aids, and consulting on individual member cases within PHM programs.

Director, Population Health Management (PHM Director) is responsible for advancing population-wide health and well-being for CalOptima Health members by coordinating the development and implementation of a comprehensive population health management plan and health equity framework aligned with the organization's strategic goals. PHM Director provides oversight and supervision of staff to monitor the implement organization-wide population health initiatives amongst internal departments, contracted providers health networks and external stakeholders aligned with CalOptima's overall mission and strategic goals. The PHM Director ensures that the department meets ongoing regulatory compliance and accreditation standards. PHM Director plays a key leadership role, interacting with all levels of CalOptima staff and external stakeholders to implement programs and Quality Improvement (QI) processes that improve cost savings, quality outcomes and member and provider satisfaction.

The following staff support the implementation of strategies within the Population Health Management department:

Managers, Population Health Management (PHM Managers) in Health Education, Disease Management, Maternal Health and Strategic Initiatives:

- Assist with the development of PHM goals and program priorities.
- Analyze best practices for population management and generating ideas to improve operational efficiency within the department.
- Oversee processes to ensure all regulatory requirements are met and exceed all standards.

Supervisors, Population Health Management (PHM Supervisors) in Health Education and Disease Management:

- Provide guidance and support for the implementation of special projects and pilots, or directly handling complex PHM requests from members, providers or staff.

- Monitor staff goals and productivity.
- Ensure compliance with cultural and linguistic requirements and processes, desktop procedures, organizational policies or contractual requirements.

Program Managers, Population Health Management (PHM Program Managers) in strategic initiatives:

- Develop cross-agency workstreams to meet standards in population health as outlined by regulatory entities, strategic priorities and Board directives.
- Plan, implementing and/or evaluating new interventions, programs and interventions.
  Keep current on the local, state, and federal healthcare environment, identifying issues that may impact CalOptima's medical management programs.

Health Educator, Population Health Management (PHM HEs) team:

- Provides health education coaching to individuals or group classes using a member-centric approach.
- Prepares written materials for distribution to members in the appropriate formats and literacy levels as needed.
- Delivers health education interventions through various methods and techniques that are effective to CalOptima Health's members.

Health Coaches, Population Health Management (PHM HCs) team:

- Assesses and develops self-management plans for CalOptima Health members benefiting from chronic condition management, nutrition management and/or psychosocial support.
- Shares the member's specific self-management goals, progress and other pertinent information with their health care team to ensure consistency of member goals.
- Monitors member's health condition and self-management goal outcomes.

Registered Dietitians, Population Health Management (PHM RDs) team:

- Provides individual nutrition assessments, counseling and education by phone or in person using a patient-centered approach.
- Develops nutrition education materials to promote prevention, management of chronic illness and healthy living.
- Works closely with other departments and medical support staff to assist with member care planning.

Personal Care C*oordinators*, *Population Health Management (PHM PCCs)* team:

- Provides outreach to members to coordinate completion of trimester specific assessments including postpartum following CPSP protocols.
- Collaborates with licensed professionals in the development of an initial care plan for each member, incorporating all assessment findings.
- Facilitates warm transfers to member's assigned case manager in accordance with member needs, when appropriate. Notifies member's care team of key event triggers.

Program Coordinator, Population Health Management (PHM PC):

- Provides analytical support to Population Health Management functions, including program development, evaluation and targeted initiatives.
- Manages department calendar by updating and bringing awareness to upcoming milestones and events.
- Acts as administrative support for company-wide and department-specific projects, such as generating reports and maintaining the department's tracking logs, including, but not limited to, action items and executive briefs.

Program Specialists*, Population Health Management (PHM PS)* team:

- Participates in cross-functional teams responsible for the identification, implementation and evaluation of health education activities.
- Supports management in the development, running and evaluation of new population-based disease management programs that support department initiatives.
- Supports management by developing and/or overseeing the process of written tools for programmatic use including program plans, surveys and evaluation instruments.

PHM Oversight

CalOptima Health strives to ensure that PHM strategic management processes are co-created, monitored and evaluated with input from members, providers, stakeholders and leadership. This helps ensure that all PHM programs and services are informed by multidisciplinary experts and approved through careful leadership consideration. The following description provides a high-level summary of our PHM strategic management oversight process.

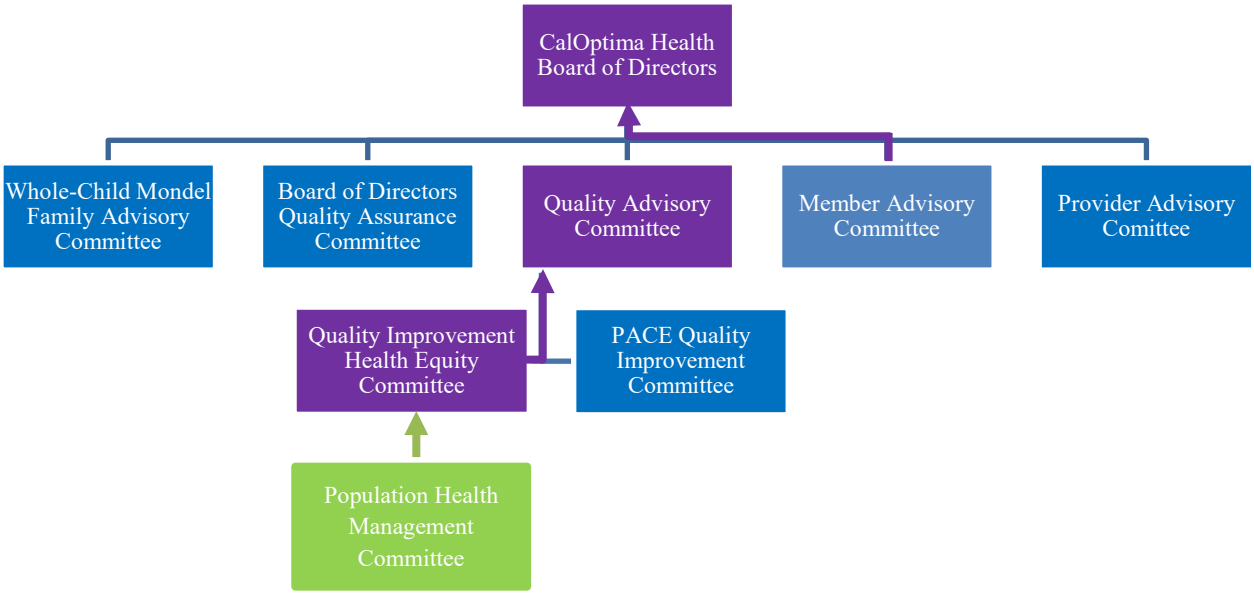
PHM Oversight Responsibilities

Dedicated staff from PHM, in collaboration with other multidisciplinary work teams throughout the agency and guidance from CalOptima Health leadership, assess service utilization patterns, disease burden and SDOH factors to identify gaps in member care. This comprehensive assessment is summarized in an annual PNA. Key findings of the PNA are shared with CalOptima Health's Member Advisory Committee, multidisciplinary care teams and stakeholders to propose new interventions to overcome member gaps in care. Proposed interventions are reviewed by Population Health Management Committee (PHMC) and documented as part of the annual PHM Strategy and Workplan proposals. The PHM Strategy and Workplan proposals are presented to the Quality Improvement Health Equity Committee (QIHEC) for approval. CalOptima Health's QIHEC reports summarize approved PHM Strategy and Workplans to the Board of Director's Quality Assurance Committee (QAC).

Committee Approval Descriptions

The diagram below illustrates the pathway of approval and oversight of the PHM Strategic Management activities along with committee descriptions.

PHM Approval Diagram



Population Health Management Committee (PHMC)

The purpose of the PHMC is to provide overall direction for continuous process improvement and oversight of the PHM Program; ensure PHM activities are consistent with CalOptima Health's strategic goals and priorities; and monitor compliance with regulatory requirements.

Quality Improvement Health Equity Committee (QIHEC)

The purpose of the QIHEC is to assure that all quality improvement activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members.

Board of Directors' Quality Assurance Committee (QAC)

The QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations.

CalOptima Health Board of Directors

The Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima Health's state and federal contracts — and to CalOptima Health's CEO.

Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

MY 2024 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the Medi-Cal P4V program.

Recommended for MY 2024 Medi-Cal P4V

1. Include measures held to an MPL in the MY2024 MCAS measure set.

MY 2024 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Chlamydia Screening in Women
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Postpartum Care
Child and Adolescent Well-Care Visits	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	CAHPS- Rating of Health Plan: Adult and Child
Lead Screening in Children	CAHPS- Rating of Health Care: Adult and Child
Topical Fluoride in Children	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Getting Needed Care: Adult and Child
Asthma Medication Ratio	CAHPS- Getting Care Quickly: Adult and Child
Controlling High Blood Pressure*	CAHPS- Coordination of Care: Adult and Child
Hemoglobin A1c Control for Patients with Diabetes- HbA1c Poor Control (>9%) lower is better*	

   - Utilize both Child and Adult CAHPS scores.
     - To calculate performance, average scores
2. Maintain program funding methodology at ten percent (10%) of professional capitation (base rate only).
3. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

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Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS measures weighted 1.0
  - CAHPS measures weighted 1.5
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

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Attachment 1

CalOptima Health Measurement Year (MY) 2024
Medi-Cal and OneCare Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on areas with the greatest opportunity for improvement and incentivizes performance on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

Recommended for MY 2024 OneCare P4V

Alignment with the CMS Star program and the following components:

1. Utilize the following CMS Star Part C and Part D measures, measure weights, and Star thresholds as benchmarks:

Measure Category	Measure
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Controlling Blood Pressure*
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – HbA1c Poor Control
	Kidney Health Evaluation for Patients with Diabetes
	Transitions of Care*
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Plan Quality
	Rating of Health Plan
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults
	Rating of Drug Plan
	Getting Needed Prescription Drugs

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile.
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
- National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
- Measure weighting
  - HEDIS process measures weighted 1.0
  - CAHPS measures weighted 2.0
  - Outcome measures weighted 3.0
- Performance incentive allocations will be distributed upon final calculation and validation of and each health network's performance.

3. Apply a program funding methodology of $20 PMPM

2024 Culturally and Linguistically Appropriate Services (CLAS) Program Description

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Table of Contents

CalOptima Health Overview

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

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health (SDOH).

Our Values

CalOptima Health abides by our core values in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

Who We Serve

As a public agency and Orange County's single largest health insurer, CalOptima Health offers health insurance coverage through three major programs:

- **Medi-Cal**– California's Medicaid Program for low-income children, adults, seniors, and people with disabilities, offering comprehensive health care coverage.
- **OneCare (HMO-DSNP)** – Medicare Advantage Special Needs Plan for seniors and people with disabilities who qualify for both Medicare and Medi-Cal.
- **Program of All-Inclusive Care for the Elderly (PACE)** – PACE for frail older adults, providing a full range of health and social services so seniors can remain living in the community.

Membership Demographics

Membership Data* (as of March 31, 2024)

Total CalOptima Health Membership	Program	Members
932,168	Medi-Cal	914,417
	OneCare (HMO D-SNP)	17,277
	Program of All-Inclusive Care for the Elderly (PACE)	474

*Based on unaudited financial report and includes prior period adjustment

Member Demographics (as of March 31, 2024)

Member Age	
0 to 5	8%
6 to 18	23%
19 to 44	36%
45 to 64	20%
65 +	13%

Language Preference	
English	55%
Spanish	30%
Vietnamese	9%
Other	2%
Korean	2%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	39%
Expansion	38%
Optional Targeted Low-Income Children	7%
Seniors	10%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services Program, a program that is a part of the Quality Improvement and Health Equity Transformation Program (QIHETP) that integrates culturally and linguistically appropriate services at all levels of the operation.

Objectives for service a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Board of Directors

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement and Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

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

Board of Directors' Quality Assurance Committee

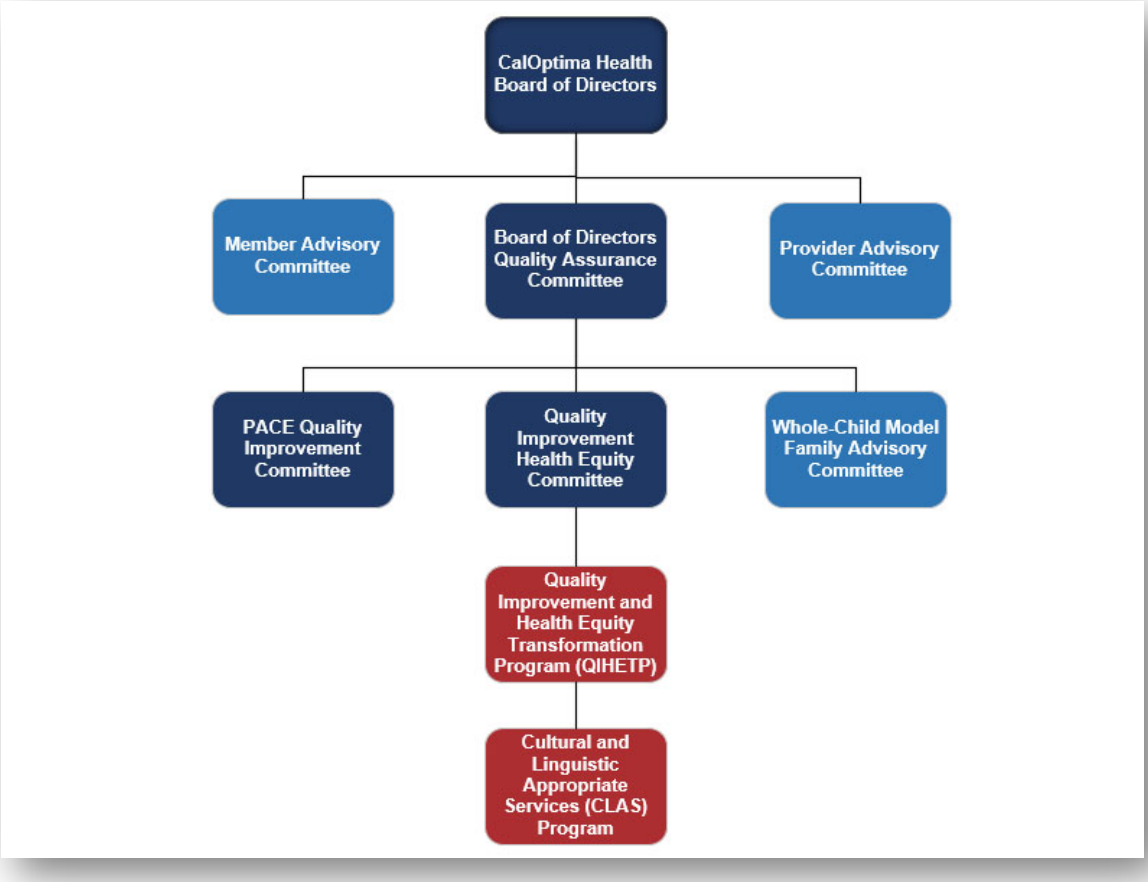
The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QIHETP, including the CLAS Program, and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI, Health Equity and CLAS contractual and regulatory standards and the DHCS Comprehensive Quality Strategy. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QIHETP and the Work Plan of the QIHETP.

Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is the foundation of the QIHETP, which includes the Cultural and Linguistic Appropriate Services (CLAS) Program, and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer (CHEO), and in collaboration, develop and oversee the QIHETP and QIHETP Work Plan activities.

The purpose of the QIHEC is to assure that all QIHETP activities are performed, integrated, and communicated internally and to the contracted delegated HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

CLAS Reporting Structure



Community and Member Engagement

CalOptima Health is committed to member-focused care through member and community engagement. CalOptima Health intends to engage members through the Member Advisory Committee (MAC) and seek input and advice related to the Cultural and Linguistic and Health Equity goals. The MAC has 17 voting members, with each seat representing a constituency served by CalOptima Health. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services in order to ensure that the CLAS Program meets the needs of the population. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

MAC represents the diversity of its membership. The following table depicts the current MAC break down by ethnic diversity. MAC includes individuals representing the ethnicity and language groups that represent at least 5% of the population. Please note that as of April 1, 2024, one Family Support Representative and two OneCare member seats remain unfilled and are currently under recruitment.

Ethnicity	Ethnicity Membership Percentage	Language	Language Membership Percentage	Number of Members	Corresponding Seats
Hispanic	46%	Spanish	31%	5	4 OneCare Members 1 Behavioral/Mental Health Representative
White	17%	English	55%	8	1 Adult Beneficiaries 1 Children 1 Foster Children 2 Medi-Cal Beneficiaries or Authorized Family Members 1 Persons with Special Needs 1 Recipients of CalWORKs 1 Seniors
Vietnamese	13%	Vietnamese	9%	1	1 Persons with Disabilities
Korean	3%	Korean	1%	1	1 Member Advocate

In addition to engaging MAC members, CalOptima Health intends to gather member input through community focus groups or meetings and survey, such as implementing a health equity and cultural needs member survey that will be distributed to new members during the monthly New Member Orientation Meetings.

Goals

The following are the goals of the CLAS Program:

1. Implement a process to collect, store and retrieve member SOGI data.
2. Evaluate language services experience from members and staff.
3. Implement a process to collect, store and retrieve practitioner race/ethnicity/languages (REL) data.
4. Improve practitioner support in providing language services.

CLAS Work Plan

The CLAS Work Plan is a subset of and is imbedded within the QIHETP Work Plan and outlines key activities for the upcoming year. It is reviewed and approved by the QIHEC and the Board of Directors' QAC. The CLAS Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the CLAS Work Plan is monitored throughout the year.

The CLAS Program guides the development and implementation of an annual CLAS Work Plan, which includes but is not limited to:

- Network cultural responsiveness
- Language services
- Program scope

- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the CLAS Program

The CLAS Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the CLAS Program and applicable policies and procedures. The 2024 CLAS Work Plan includes all cultural and linguistic focus areas, goals, improvement activities, progress made toward goals, and timeframes. Planned activities include strategies to improve collection, storing, retrieval and sharing of race/ethnicity, language, sexual orientation and gender identity data. All goals will be measured and monitored in the CLAS Work Plan, reported to QIHEC quarterly, and evaluated annually. A copy of the QIHETP (and CLAS) Work Plans are also publicly available on the CalOptima Health website.

For more details on the 2024 CLAS Work Plan see Appendix A: 2024 QIHETP Work Plan

CLAS Monitoring Progress

To ensure that the CLAS Program meets the needs of our diverse member population, CalOptima Health continuously monitors progress against CLAS goals. At least quarterly, dedicated staff from Cultural and Linguistic (C&L) department, in collaboration with multidisciplinary work teams throughout the agency, collect and track indicators and activities specific to CLAS goals, outcomes, and outputs. C&L staff prepares quarterly findings and identifies potential risks to share with CalOptima Health leadership at Quality Improvement Health Equity Committee (QIHEC) meetings. CalOptima Health's QIHEC reviews, offers feedback and approves quarterly CLAS monitoring reports. QIHEC summarizes the CLAS monitoring reports and shares them with CalOptima Health's Board of Director's Quality Assurance Committee (QAC).

CLAS Evaluation

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

- A description of completed and ongoing CLAS activities that address cultural and linguistic needs or our members, including the achievement or progress toward goals, as outlined in the CLAS Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality, accuracy and utilization of

translation and interpreter services.

- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of CLAS activities, including QIPs, PIPs, and PDSAs.
- An evaluation of the effectiveness of member experience surveys related to cultural and linguistic services.
- A report to the QIHEC and QAC summarizing all CLAS measures and identifying significant trends.
- A critical review of the organizational resources involved in the CLAS Program through the CalOptima Health strategic planning process.
- Recommended changes included in the revised CLAS Program Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

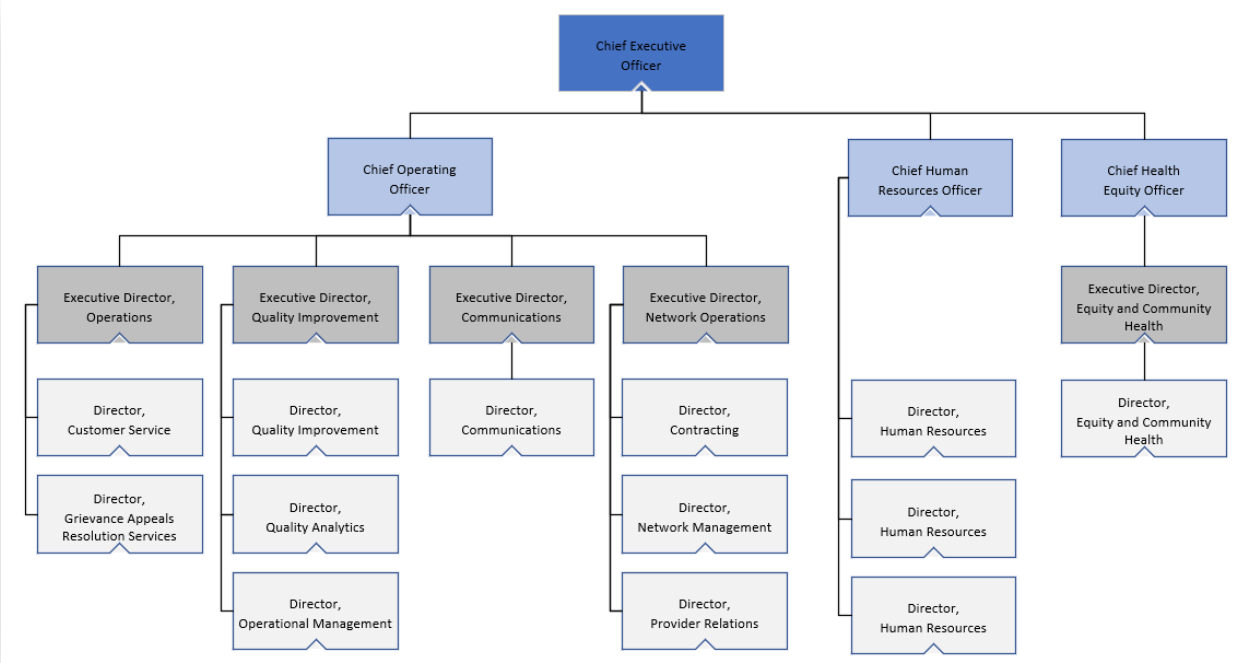
A copy of the CLAS Evaluation is also publicly available on the CalOptima Health website.

The C&L department consists of the Director of Customer Service/Cultural & Linguistics, Manager of Cultural and Linguistics, and nine Program Specialists who are responsible for translation of documents and coordinating cultural and linguistic services with contracted vendors. The Cultural and Linguistics department is supported by CalOptima Health departments including but not limited to:

- Communications
- Contracting
- Customer Service
- Equity and Community Health
- Human Resources
- Network Management
- Provider Relations
- Quality Analytics

CalOptima Health

Cultural and Linguistic Service Organizational Chart Structure



Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of the human resources departments, functions, policies and procedures, benefits, and retirement programs for CalOptima Health. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima Health's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high-performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, Network Operations (ED NO) is responsible for the plan's provider delivery system; leads delivery system operations across multiple models; implements strategies that achieve the established program objectives and to leverage the core competencies of the plan's existing administrative infrastructure; directs the integrated operations of the provider network contracted under the various programs and coordinates organizational efforts; responsible for the overall success of network operations for the planning and implementation to fulfill the plan's strategic objectives as related to contracting and operations of the provider delivery system; and responsible for provider relations and support, including provider education and problem resolution.

Executive Director, Equity and Community Health (ED ECH) is responsible for oversight of comprehensive population strategies to improve member experience and increase access to care through the promotion of community-based programs. The ED ECH serves as a member of the executive team, and with the CHEO, CMO, DCMO, ED CO and ED BHI, supports efforts to promote optimal health outcomes, ensure efficient care, address mental wellness, disparities and improve health equity. The Director of Equity and Community Health reports to the ED ECH.

Director, Customer Service is responsible for day-to-day management, strategic direction and support to CalOptima Health Customer Service operations including Medi-Cal Call Center, Behavioral Health Call Center, OneCare Call Center, OneCare Connect Call Center, Member Liaison, Customer Service Data Analysts, Cultural & Linguistic Services, Member Communications, Enrollment & Reconciliation, and CalOptima Member Portal.

Director, Grievance Appeals Resolution Services is responsible for the day-to-day operations of the Grievance and Appeals Resolution Services (GARS) department, including to ensure service standards and established policies and procedures regarding the appeals and grievance processes adhere to regulatory requirements.

Director, Quality Improvement is responsible for day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

Director, Quality Analytics is responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the agencywide QIHETP.

Director, Operational Management is responsible for leading implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. Provides data analytical direction to support quality measurement activities for the organization wide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

Director, Communications is responsible for coordinating and implementing CalOptima Health's internal and external communications in a manner that promotes and preserves CalOptima Health, its mission, and strategic goals and objectives. Interact with CalOptima Health's executive management and legal counsel, as well as members of the media and general public.

Director, Contracting is responsible for the development and implementation of contracting strategies for providers and other business entities, management and monitoring of contractual relationships with existing provider networks and contractors. The Director of Contracting also conducts and coordinates financial analysis to determine and design contracting strategies for CalOptima Health and negotiate provider contracts.

Director, Network Management is responsible for all operational aspects of the Network Management department. The incumbent will oversee the onboarding of all new provider partners, provider data management and analysis and provider directory production. The Director of Network Management is responsible for ensuring CalOptima Health meets and exceeds access and availability standards; implements strategies that achieve the established CalOptima Health objectives; meet regulatory requirements and National Committee for Quality Assurance (NCQA) standards; leverage the core competencies of CalOptima Health's existing administrative infrastructure to build an effective and efficient operational unit to serve members and ensure the delivery of healthcare services throughout CalOptima Health's service delivery network.

Director, Provider Relations is responsible for providing leadership and direction to ensure proactive development, management, communication, support, and issue resolution for all CalOptima Health contracted providers. The Director of Provider Relations serves as the strategic, operational and communications lead between CalOptima Health and these critical partners. The Director of Provider Relations develops the overarching provider engagement and partnership strategy to ensure quality member care, provider satisfaction, provider compliance with contractual and regulatory requirements, and active provider engagement in CalOptima Health's goals and priorities.

Director, Human Resources (Administrative Services) is responsible for leading and overseeing the Human Resources services, policies, and programs for CalOptima which may include benefits and wellness programs, classification and compensation, employee engagement, employee relations, human resources information systems (HRIS), leaves programs, performance management, Workers' Compensation as determined by the Chief Human Resources Officer..

Director, Equity and Community Health (ECH) is responsible for program development and implementation for comprehensive population health initiatives while ensuring linkages supporting a whole-person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position oversees programs that promote health and wellness services for all CalOptima Health members. ECH services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). ECH also supports the MOC implementation for members. Reports program progress and effectiveness to QIHEC and other committees to support compliance with regulatory and accreditation organization requirements.

Key Business Processes, Functions, Important Aspects of Cultural and Linguistic Services

Language Services

CalOptima Health's Culturally and Linguistically Appropriate Services (CLAS) ensures all members have access to health care related interpreter services in any language and translated member materials in CalOptima's threshold languages.

Services Included:

- Free access to translations of Member Handbooks/Evidence of Coverage and other important information are available in English, Spanish, Vietnamese, Arabic, Farsi, Korean, and Chinese.
- Provide oral translation for other languages upon request or as needed, by a qualified translator at no cost.

- Provide routine and immediate translation of member notices pertaining to a denial, limitation, termination, delay, or modification of benefits, and the right to file a Grievance or Appeal at no cost.
- Free access to materials in alternative format such as Braille, large print, data, and audio files.
- Free access to 24 hours access to telephonic interpreter services to members with limited English proficiency at no cost.
- Free Remote video interpreting.
- Free access to face-to-face interpreters at the provider's office at no cost.
- Free access to American Sign Language interpretation assistance for deaf or hard-of-hearing members.
- Tactile signing assistance for deaf-blind members.

CalOptima Health ensures members are informed of the availability of and their right to linguistic and translation services through:

- "Language Interpreting Services" poster in the reception area where members can point to their preferred language
- Member handbook/Evidence of Coverage
- Summary of Benefits
- Quarterly/Annual Newsletters
- New member orientations
- Customer Service Call Center
- Health education workshops
- C&L "We Speak Your Language" brochure
- CalOptima Health website
- Member Portal
- Presentations/trainings at community-based organizations (CBOs) and public agencies

CalOptima Health provides informational materials to members written at a no higher than a sixth (6th) grade reading level and translated into CalOptima Health's threshold languages. DHCS threshold and concentration language requirements for Orange County are:

- Eligible beneficiaries residing in CalOptima Health's service area who indicate their primary language as a language other than English, and that meet a numeric threshold of 3,000 or five percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and

- Eligible beneficiaries residing in the CalOptima Health's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).

Cultural Competency and Training

Cultural Competence is the ability to understand, communicate with and effectively interact with people across different cultures, while continuing self-assessment regarding culture, acceptance and respect for differences, ongoing development of cultural knowledge and resources and the dynamic and flexible application of service models to meet the needs of minority populations. Cultural Competence includes awareness with:

- Race: any of the different varieties or populations of human beings distinguished by physical traits such as hair color and texture, eye color, skin color or body shape;
- Ethnicity: a group having a common cultural heritage or nationality, as distinguished by customs, language, common history, etc.
- Culture: the ideas, customs, skills, arts, etc. of a people or group, that are transferred, communicated, or passed along, as in or to succeeding generations.

Some factors influencing culture are age, gender, socioeconomic status, ethnicity, national origin, religion, geographical location, migration, sexual orientation, and gender identity.

During onboarding of new employees, on an annual basis, and as needed, CalOptima health ensures CalOptima health staff, Providers, Health Networks, and other delegated entities receive Disability Awareness and Sensitivity, and Cultural Competency training as outlined in HR policy AA.1250 and Provider Relations policy EE.1103. Trainings include:

- CalOptima Health staff cultural competency training (Initial and Annual)
- CalOptima Health staff new Employee “Boot Camp” C&L Overview (Initial)
- Provider Cultural Competency training (Initial and Annual)
- Provider Disability Training (Initial and Annual)
- Provider Cultural and Linguistic Requirements (Initial and Annual)

Promotion of Diversity

CalOptima Health is committed to reducing bias and improving diversity, equity and inclusion and supports initiatives to recruit, retain and train a diverse healthcare workforce that reflects the cultural and linguistic diversity of the communities serviced. This includes the following:

- Inclusive job descriptions and hiring practices.
- Trainings on the following topics for leaders:
    - Diversity, Inclusion & Conscious Bias
    - Disability Awareness
    - Cultural Competency
- Mentorship program for career development
- Conduct regular pay equity analysis
- Offer benefits and perks to support the diverse needs of employees (ie. Flexible work

arrangements)

Data Collect and Analysis

CalOptima Health is committed to collecting information that helps provide better culturally and linguistically appropriate services. Focused is placed on collecting, storing and retrieving member health care data in order to better address our members' needs. The following data is collected to monitor disparities and inform targeted information.

- Member demographics include but are not limited to race/ethnicity, language, gender identify and sexual orientation.
- Health outcomes
- Language preferences

CalOptima Health uses this data to assess the existence of disparities and to focus on quality improvement efforts toward improving the provision of culturally and linguistically appropriate services and decreasing health care disparities. Quality performance and health care data are stratified by race, ethnicity, language, and other demographic factors to identify disparities. Opportunities for improvement are identified when a disparity is identified and added to the CLAS Work Plan where progress of planned activities is tracked towards achieving health equity and CLAS goals. Data is trended to determine whether performance is improving, declining or remaining stable.

2024 Revised Quality Improvement and Health Equity Transformation Program and Work Plan

Quality Assurance Committee Meeting
June 12, 2024

Linda Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Revised 2024 Quality Improvement Health Equity Transformation Program (QIHETP) and Annual Work Plan

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QIHETP and Work Plan Revisions

- Purpose for Revisions
  - Population Health Management (PHM) Department was renamed to Equity and Community Health (ECH) Department, so the department's name reflects their focus on collaborating/co-designing with the community to develop programs with an "equity lens."
  - Added the Cultural and Linguistic Appropriate Services (CLAS) Program to QIHETP appendix to ensure CalOptima Health continually improves its services to meet the needs of multicultural populations.
    - CLAS is a regulatory requirement (DHCS Contract and NCQA Health Equity Accreditation)
- The following QIHETP Documents were revised:
  - 2024 QIHETP Written Description
  - Appendix: 2024 QIHETP Work Plan
  - Appendix: Cultural and Linguistic Appropriate Services (CLAS) Program (NEW)

2024 Population Health Management (PHM) Strategy and the 2024 Pay-For-Value Program did not require revisions are not presented.

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Updates to the QIHETP Description

- Changed all mention of the PHM Department to the ECH Department:
  - ECH Department role in the QIHETP and Quality Improvement Health Equity Committee (QIHEC), including subcommittees
  - Quality Organization Chart
  - Title and description of positions supporting ECH, such as the Executive Director, Medical Director and Director of Equity and Community Health
- Updated language in the Work Plan to reflect current operations
- Updated the glossary

Cultural and Linguistic Appropriate Services (CLAS) Program

- CLAS Program is part of the appendix of the QIHETP
  - CLAS Work Plan elements are incorporated into the QIHETP Work Plan
  - CLAS Evaluation to be a part of the appendix of QIHETP Evaluation
- Added the CLAS Program Description
  - Our commitment to CLAS
  - Authority and Accountability to the Quality Assurance Committee (QAC) of the Board of Directors
  - CLAS reporting structure to QIHEC
  - Community and Member Engagement through the Member Advisory Committee (MAC)
  - Resources to support CLAS

Cultural and Linguistic Appropriate Services (CLAS) Program

- CLAS Goals
  - Implement a process to collect, store and retrieve member Sexual Orientation and Gender Identify (SOGI) data.
  - Evaluate language services experience from members and staff.
  - Implement a process to collect, store and retrieve practitioner race/ethnicity/languages (REL) data.
  - Improve practitioner support in providing language services.
- Key Business, Processes, Functions and Aspects of CLAS
  - Language Services
  - Cultural Competency and Training
  - Promotion of Diversity
  - Data Collection and Analysis

CLAS Work Plan Elements

2024 QIHETP Work Plan Element Description	Goal(s)
Performance Improvement Project (PIP) Medi-Cal - Increasing W30 6+ measure rate among Black/African American Population	Meet and exceed goals set forth on all improvement projects
Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services
Maternity Care for Black and Native American Persons	Meet the following goals For MY2024 HEDIS: PPC Postpartum: Black 74.74%; Native American 63.22% PPC Prenatal: Black 72.37%; Native American 59.43%
Experience with Language Services	Evaluate language services experience from member and staff
Data Collection on Member Demographic Information	Implement a process to collect member SOGI data by December 31, 2024.
Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 12, 2024
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

3. Recommend that the Board of Directors Approve CalOptima Health's Calendar Year 2025 Member Health Rewards

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action

1. Recommend that the Board of Directors Approve CalOptima Health's Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare.

Background

CalOptima Health provides health rewards to members in the form of physical gift cards and plans to explore providing digital e-card and flex card reward options to eligible members to improve member health and quality outcomes. In calendar year (CY) 2024, CalOptima Health provided Medi-Cal and OneCare members with health rewards for preventive services, including annual wellness visit, blood lead test(s), breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes tests (multiple), postpartum care, osteoporosis testing, and follow-up care for children prescribed ADHD medication. Member incentives are awarded based on provider attestations using an incentive form and passive rewards based on qualifying claims and encounter data.

Medi-Cal

The Medi-Cal member health rewards program utilizes both provider attestations and passive rewards to issue incentives. Annual wellness visits, health risk assessment, and diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications are historically passively rewarded incentives. The remaining member incentives require a provider attestation.

OneCare

For OneCare members, staff has discussed leveraging a preloaded "flex card" (debit card), to directly reward members for their participation in health rewards program activities. Currently, the OneCare member health rewards program is a passively rewarded program, where members are identified through claims and encounters data and are automatically issued a member health reward. Since there is no provider attestation and form submission required, adapting the reward process to payout through the flex card will increase health reward processing efficiency and minimize turnaround time for members to receive their rewards. CalOptima Health's OneCare flex benefit vendor has the capability to include member health rewards in the flex card for CY 2025. CalOptima Health plans to implement member health rewards in the flex card starting 2025 and will evaluate program effectiveness.

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Discussion

Health rewards motivate members to establish primary care relationships and get recommended preventive care and screenings. Rewards may encourage members to receive important tests and reinforce health behaviors. Health rewards were selected based on clinical areas with the largest opportunity for improvement and those measures where CalOptima Health has performed below established benchmarks.

Staff recommends maintaining the following health rewards from CY 2024 for CY 2025:

Current	
Medi-Cal	**OneCare**
Annual Wellness Visit- $50	Annual Wellness Visit- $50
Blood Lead Test 12 Months of Age- $25	Breast Cancer Screening- $25
Blood Lead Test 24 Months of Age- $25	Colorectal Cancer Screening- $50
Breast Cancer Screening- $25	Diabetes A1c Test- $25
Cervical Cancer Screening- $25	Diabetes Eye Exam- $25
Colorectal Cancer Screening- $50	Health Risk Assessment- $25
Diabetes A1c Test- $25	Osteoporosis Screening- $25
Diabetes Eye Exam- $25	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications- $25	
Follow-up Care for Children Prescribed ADHD Medication- $25	
Postpartum Checkup- $50	

Staff also recommends revising the following health rewards for CY 2025. This includes piloting the change from attestation-based to passive identification and rewarding to enhance member experience for Blood Lead Test and to reduce the reward amount from $50 to $25 for Postpartum Checkup to align with other Medi-Cal rewards.

Changes	
Medi-Cal	**OneCare**
Blood Lead Test 12 Months of Age (change rewarding to passive)	N/A
Blood Lead Test 24 Months of Age (change rewarding to passive)	
Postpartum Checkup- $25 (decrease reward value)	

Members will receive health reward gift cards contingent upon completed member encounters with appropriate and complete coding. At the time of budgeting, staff assumed a member participation rate of 15%* based on past participation rates and an anticipated increase in member participation. In the event participation rates are higher than assumed and exceed the budgeted amounts, staff will return to the Board of Directors for additional funding requests at future meetings.

**For passive health rewards: Blood Lead Test 12 and 24 Months (Medi-Cal) participation rate is*

assumed at 62.79%, which is the current DHCS minimum performance level. Health Risk Assessment (OneCare) participation rate is assumed at 75% as aligned with the current CMS 4-star rating. Annual Wellness Visit (Medi-Cal and OneCare) participation rate is assumed at 15% as aligned with Medi-Cal DHCS Member Incentive goal and previous year's participation rate. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Medi-Cal) participation rate is assumed at 79.05%, which is the current DCHS minimum performance level.

Fiscal Impact

Medi-Cal:

The estimated cost for CY 2025 Medi-Cal Member Health Rewards program is $4.87 million. Funding included in the proposed CalOptima Health Fiscal Year (FY) 2024-25 Operating Budget and unearned funds from the Measurement Year 2023 Medi-Cal Pay for Value Performance program will be sufficient to fund the program.

OneCare:

The estimated cost for CY 2025 OneCare Member Health Rewards program is $660,000 and is a budgeted item in the proposed FY 2024-25 Operating Budget. Management will include expenses for the period of July 1, 2025, through December 31, 2025, in the FY 2025-26 Operating Budget.

Rationale for Recommendation

A member health reward program will strengthen the primary care provider-patient relationship, improve the quality of care delivered to CalOptima Health members by promoting preventive care, early identification, chronic care management, and identify opportunities to coordinate care based on an annual wellness visit.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachment

1. Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare Presentation

/s/ Michael Hunn *06/07/2024*
Authorized Signature **Date**

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Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare

Quality Assurance Committee Meeting

June 12, 2024

Linda M. Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Current 2024 Member Health Reward Program

- CalOptima Health provides health rewards and incentives to members for completing preventive services
- Rewards in the form of retailer physical gift cards
  - Exploring digital e-cards and flex card reward options
- OneCare member health rewards are passively rewarded
  - Reward is based on identified claims and encounters
  - Health Risk Assessment (OC only), Annual Wellness Visit (MC and OC), and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (MC only) are passively rewarded.
- Medi-Cal member health rewards are attestation-based
  - Reward is based on provider attestation and form submission

MC: Medi-Cal

OC: OneCare

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2024 Program and 2025 Proposed Changes

Medi-Cal	OneCare
Annual Wellness Visit- $50	Annual Wellness Visit- $50
Blood Lead Test 12 Months of Age- $25 *Change from Attestation-based to Passive Rewarding	Breast Cancer Screening- $25
Blood Lead Test 24 Months of Age- $25 *Change from Attestation-based to Passive Rewarding	Colorectal Cancer Screening- $50
Breast Cancer Screening- $25	Diabetes A1c Test- $25
Cervical Cancer Screening- $25	Diabetes Eye Exam- $25
Colorectal Cancer Screening- $50	Health Risk Assessment- $25
Diabetes A1c Test- $25	Osteoporosis Screening- $25
Diabetes Eye Exam- $25	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications- $25	
Follow-up Care for Children Prescribed ADHD Medication- $25	
Postpartum Check Up- $25 *Change from $50 to $25	

*Proposed changes for 2025

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2025 Proposed Revisions

- Retain all member health rewards from calendar year 2024 with the following changes:
  - **Blood Lead Test 12 and 24 Months of Age**
    - Pilot to change from attestation-based to passive identification and rewarding to enhance member experience.
  - **Postpartum Checkup**
    - Reduce amount from $50 to $25 reward to align with other Medi-Cal rewards.

Summary of Fiscal Impact

- Estimated Cost at 15% Response Rate*
  - Medi-Cal: approximately $4,870,000
  - OneCare: approximately $660,000

	2024	2025	Budget Difference
Medi-Cal	$4,665,000	$4,865,244	$200,244
OneCare	$530,625	$656,130	$125,505

*For passive rewarded incentives: Blood Lead Test 12 and 24 Months (Medi-Cal) participation rate is assumed at 62.79% which is DHCS minimum performance level. Health Risk Assessment (OneCare) participation rate is assumed at 75% as aligned with CMS 4-star rating. Annual Wellness Visit (Medi-Cal and OneCare) participation rate is assumed at 15% as aligned with Medi-Cal DHCS Member Incentive goal and previous year's participation rate. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Medi-Cal) participation rate is assumed at 79.05% which is the DHCS minimum performance level.

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Appendix

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2025 Proposed Incentives Cost Projections

Member Health Reward	Amount	Medi-Cal Eligible Members	OneCare Eligible Members	Estimated Cost at 5% Response Medi-Cal	Estimated Cost at 5% Response OneCare	Estimated Cost at 15% Response Medi-Cal	Estimated Cost at 15% Response OneCare
Annual Wellness Visit**	$50	198,562	17,233	$496,405	$43,083	$1,489,215[A]	$129,248
Blood Lead Test at 12 Months of Age**	$25	11,584	-	$176,830[B]	-	$181,840[C]	-
Blood Lead Test 24 Months of Age**	$25	11,584	-	$176,830[B]	-	$181,840[C]	-
Breast Cancer Screening	$25	78,524	5,466	$98,155	$6,833	$294,465	$20,498
Cervical Cancer Screening	$25	229,229	-	$286,536	-	$859,609	-
Colorectal Cancer Screening	$50	196,563	10,995	$491,408	$27,488	$1,474,223	$82,463
Diabetes A1C Test	$25	44,566	3,949	$55,708	$4,936	$167,123	$14,809
Diabetes Eye Exam	$25	44,566	3,949	$55,708	$4,936	$167,123	$14,809
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications**	$25	1,659	-	$2,074	-	$32,790[G]	-
Follow-up Care for Children Prescribed ADHD Medication	$25	1,265	-	$1,581	-	$4,744	-
Health Risk Assessment	$25	-	17,583	-	$272,537[D]	-	$329,681[E]
Osteoporosis Screening	$25	-	17,233[F]	-	$21,541	-	$64,624
Postpartum Checkup	$25	3,273	-	$4,091	-	$12,274	-
Totals				$1,845,325	$381,353	$4,865,244	$656,130

Eligible members are identified using the February 2024 Prospective Rate HEDIS denominator, but reward is not limited to condition or diagnosis. Annual Wellness Visit, Health Risk Assessment, and Osteoporosis Screening eligible population is based on health reward program eligibility criteria.

**Passive identification and rewarding. (continued next slide)

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2025 Proposed Incentives Cost Projections (Continued)

A. Medi-Cal Annual Wellness Visit goal is 15% response rate.
B. Lead Screening estimated response rate is calculated based on administrative compliance rate for MY2023, 61.06%.
C. Lead Screening estimated response rate is calculated based on minimum performance level for MY2024, 62.79%.
D. Health Risk Assessment estimated for 3 STARs at 62% participation rate.
E. Health Risk Assessment estimated for 4 STARs at 75% participation rate.
F. Osteoporosis Screening eligible population is based on all OneCare members who are eligible and not restricted to specifications dictated in the HEDIS measure requirements for: Osteoporosis Management in Women Who Had a Fracture (OMW).
G. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications Follow-up Care for Children Prescribed ADHD Medication estimated response rate is calculated based on minimum performance level for MY2024, 79.05%.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 12, 2024
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

4. Recommend Appointments to the CalOptima Health Whole-Child Model Family Advisory Committee

Contacts

Ladan Khamseh, Executive Director, Operations, (714) 246-8866
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

Approve the Whole-Child Model Family Advisory Committee's recommendations and in turn recommend that the Board of Directors approve those recommendations as follows:

1. Reappoint the following individuals to each serve a two-year term on the Whole-Child Family Advisory Committee, effective upon Board of Directors approval:
    a. Jessica Putterman as an Authorized Family Member Representative for a term ending June 30, 2026;
    b. Kristen Rogers as an Authorized Family Member Representative for a term ending June 30, 2026; and
    c. Erika Jewell as a Community Based Organization Representative for a term ending June 30, 2026.

2. Newly appoint the following individuals to each serve a two-year term on the Whole-Child Model Family Advisory Committee, effective upon Board of Directors approval:
    a. Jody Bullard as an Authorized Family Member Representative for a term ending June 30, 2026; and
    b. Jennifer Heavener as a Consumer Advocate Representative for a term ending June 30, 2026.

Background

Senate Bill 586 (SB 586) was signed into law on September 25, 2016, and authorized the establishment of the Whole-Child Model (WCM), incorporating California Children's Services (CCS)-covered services for Medi-Cal eligible children and youth into specified County-Organized Health System plans. A provision of the WCM program requires each participating health plan to establish a family advisory committee. Accordingly, the CalOptima Health Board of Directors (Board) established the Whole-Child Model Family Advisory Committee (WCM FAC) by resolution on November 2, 2017, to report and provide input and recommendations to the CalOptima Health Board relative to the WCM program.

The WCM FAC is comprised of 11 voting members, nine of whom are designated as Authorized Family Member Representatives and two of whom are designated as Community Based Organization/Consumer Advocate Representatives who represent the interests of children receiving CCS services. While two of the WCM FAC's 11 seats are designated as Community Based Organization/Consumer Advocate Representative seats, WCM FAC candidates representing the community may be considered for up to

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two additional WCM FAC seats if there are not enough Authorized Family Member Representative candidates to fill the nine designated seats.

Discussion
CalOptima Health conducted comprehensive outreach, including sending notifications to community-based organizations, conducting targeted community outreach to agencies and community-based organizations serving the various open positions, and posting recruitment materials on the CalOptima Health website and CalOptima Health's social media sites, such as LinkedIn and Facebook.

With the fiscal year ending on June 30, 2024, five WCM FAC seats will expire: three Authorized Family Member Representatives and two Community Based Organization/Consumer Advocate Representatives. In addition to the five expiring seats, there is one open seat for an Authorized Family Member Representative to fulfill an existing term, and staff continues to recruit for this important seat.

The WCM FAC Nominations Ad Hoc Subcommittee, composed of WCM FAC members Monica Maier, Sofia Martinez, and Janis Price, evaluated each of the applicants for the current openings. The WCM FAC Nominations Ad Hoc Subcommittee proposed the slate of candidates for the five vacancies and forwarded the recommended slate of candidates for consideration at the June 12, 2024, Quality Assurance Committee meeting.

The candidates for the open positions are as follows:

Authorized Family Member Representatives

Jody Bullard (New Appointment)
Jody Bullard is a former social worker and the current caregiver to her 14-year-old son who was born with a rare genetic syndrome. Prior to leaving employment to become her son's full-time caregiver, Ms. Bullard used her social worker skills for advocating within the CCS system and she would like to assist other WCM participants.

Jessica Putterman (Reappointment)
Jessica Putterman is the mother of a special needs child who currently receives CCS and Medi-Cal services. After 10 years of navigating with her son through CCS, Ms. Putterman would like to assist other parents with her knowledge and expertise in this area, as she has made it a point to learn all that she can to advocate on behalf of her child.

Kristen Rogers (Reappointment)
Kristen Rogers is the mother of a teenager who receives CCS services and is currently a CalOptima member. Ms. Rogers is an active volunteer at Children's Hospital Orange County (CHOC) and has been a member in good standing of the WCM FAC since 2018. Since March 2019, Ms. Rogers has been on the CCS Advisory Group, which meets quarterly in Sacramento, California, where she represents CalOptima and the WCM FAC. Ms. Rogers is currently the WCM FAC Chair and represents the committee at the Family Voices/Lucille Packard Foundation network meetings.

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Community-Based Organization Representative

Erika Jewell (Reappointment)
Erika Jewell is the manager of case management and social services at CHOC where she works closely with CHOC Health Alliance and other Medi-Cal patients and families to ensure they receive the social services support they need. Ms. Jewell is a licensed clinical social worker who has worked with CCS patients for over 22 years and participates in local stakeholder groups that benefit CCS patients. She also serves on the Tustin Unified School District's Special Education Advisory Committee. Ms. Jewell serves as the Vice-Chair of the WCM FAC.

Consumer Advocate Representative

Jennifer Heavener (New Appointment)
Jennifer Heavener has been navigating the Medi-Cal and CCS world for the past 20 years with her special needs child, who is a high consumer of medical services. Ms. Heavener's experience as an advocate and caregiver gives her a unique perspective that will help other families with transition through the WCM program. Ms. Heavener has previously served on the WCM-FAC as an Authorized Family Member Representative but would like to continue on the committee as a Consumer Advocate Representative since her son has aged out of CCS and Ms. Heavener is no longer eligible to serve as an Authorized Family Member Representative.

Fiscal Impact
Each WCM FAC member may receive a stipend of up to $50 per committee meeting attended. Funding for the stipends is a budgeted item in the Fiscal Year 2024-25 CalOptima Health Operating Budget.

Rationale for Recommendation
As stated in policy AA.1271, the WCM FAC established a Nominations Ad Hoc Subcommittee to review the potential candidates for vacancies on the committee. The WCM FAC Nominations Ad Hoc Subcommittee forwards the recommended candidates to the Board of Directors' Quality Assurance Committee for consideration and recommendation to the Board of Directors.

Concurrence
Whole-Child Model Family Advisory Committee Nominations Ad Hoc Subcommittee
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *06/07/2024*
Authorized Signature **Date**

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Board of Directors' Quality Assurance Committee Meeting
June 12, 2024

PACE Member Advisory Committee Update

Committee Overview
The PACE 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 13, 2024: PMAC Meeting Summary

Updates from the Director
Director Monica Macias thanked PMAC members for joining the meeting in person. Members were updated on the status of the program, open positions, respiratory illnesses updates, and transportation. The director welcomed new members who were joining us for the first time. Director shared that we are currently hiring for one scheduler and looking to hire new positions for the growth. Expect more participants and in the building. We are also exploring options to have additional access to parking spots in the building. Director reassured PACE participants as our census grows so will the staffing needs and vans for trips. In addition, the director shared that we continue to monitor any trends in cases and adjust operations if deemed necessary around respiratory illnesses. Finally, the director shared the results of our participant satisfaction scores and noted ranking second among the other PACE programs in California.

Respiratory Illness Updates
Jennifer Robinson, Quality Improvement Manager, provided updates related to respiratory illnesses. Jennifer reminded everyone that we are currently in respiratory illness season (September to March). We are still seeing flu and COVID cases and it's important to continue to stay at home when not feeling well. In addition, members were reminded that the PACE clinic provides vaccinations for both Flu and Covid. We are hoping as we enter spring and summer the cases will continue to decrease.

PMAC Member Forum

- Participants mentioned that transportation continues to fluctuate.
- The participants would like to have a review of the scheduling process.
- Participants expressed feeling content about the growth and satisfaction results.

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Board of Directors'
Quality Assurance Committee Meeting
June 12, 2024

Regular Meeting of the
Whole-Child Model Family Advisory Committee
Report to the Quality Assurance Committee

On March 19, 2024, the Whole-Child Model Member Family Advisory Committee (WCM FAC) conducted its quarterly meeting in-person and telephonically using Zoom Webinar technology.

Doris Billings, Interim Division Manager/Chief Therapist, California Children's Service (CCS), Orange County Health Care Agency, provided an update on the Orange County CCS program and noted that Orange County had implemented an inter-county transfer process per the Department of Health Care Services (DHCS) All Plan Letter (APL). She noted that DHCS had created a checklist tool to use between the sending and receiving counties to better facilitate communication between the counties and to ensure continued services for children with special needs who are switching between counties. Ms. Billings also provided an update on the Medical Therapy Units (MTU) as they continue to provide services, including occupational therapy and physical therapy, and answered questions from members of the committee.

Mia Arias, Director, CalAIM, provided a CalAIM update to the committee and discussed the 42 community-based organizations contracted to provide Enhanced Care Management services to members. Ms. Arias discussed how CalAIM is improving services by collaborating with all providers, coordinating care and engaging the community to ensure members' voices drive the evolution of services. She also discussed respite services to children with special needs through contracted providers and noted that any caregiver can refer themselves or be referred through the regional center.

Yunkyung Kim, Chief Operating Officer, provided an update to the committee and noted that CalOptima Health has approximately 9,600 Whole-Child Model members with Children's Hospital Orange County (CHOC) and CalOptima Health being the largest health networks for these members. Ms. Kim also informed the committee that CalOptima Health had been ranked third among all Medicare managed care plans in California and she also discussed how input from advisory committee members had increased funding for the Workforce Development Grant to address provider shortages in Orange County.

The WCM FAC appreciates and thanks the CalOptima Board Directors' Quality Assurance Committee for the opportunity to present input and updates on its current activities.

Update on Quality Improvement Programs

Quality Assurance Committee Meeting
June 12, 2024

Linda Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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Agenda

- Credentialing
- National Committee for Quality Assurance (NCQA) Health Plan Accreditation
- NCQA Health Equity Accreditation
- Quality Initiatives

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CalOptima Health

Credentialing

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Credentialing Status Update

Status	Actions	Timeline
Completed	• Executed a contract with a Credentialing Verification Organization (CVO) • CalOptima/CVO Implementation Kick-Off Meeting	March 2024 April 2024

In Progress	• CVO Implementation process
	  ○ Weekly implementation meetings
	  ○ Document preparation
	  ○ Workflow creation
	  ○ Data exchange
		April-June 2024

Next Steps	• Go-Live: CVO begins Credentialing • Post-Go-Live: transition and monitoring period	Mid-June 2024 30-days

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CalOptima Health

NCQA Health Plan Accreditation

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CalOptima Health

NCQA Health Plan Accreditation Renewal Timeline

	Key Dates	Status Update
Review Period	April 30, 2022- April 30, 2023 April 30, 2023- April 30, 2024	**Completed** ✓
Submission Date	April 30, 2024	**Completed** ✓
Outstanding Issues Received from NCQA	May 20, 2024	**Completed** ✓
Outstanding Issues Conference Call with NCQA	May 29, 2024	**Completed** ✓
File Selection	June 3, 2024	To be determined
Outstanding Issues follow-up documents due	June 4, 2024	In progress
Prepare Selected Files (CCN/Delegates)	June 3, 2024- June 16, 2024	Prepare files for consultant review before virtual file review with NCQA
Virtual File Review with NCQA surveyors	June 17-18, 2024	Draft agenda sent to NCQA

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CalOptima Health

NCQA Health Equity Accreditation

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CalOptima Health

NCQA Health Equity (HE) Accreditation

- The Department of Health Care Services (DHCS) will require all Health Plans to obtain Health Equity accreditation by January 1, 2026.
- CalOptima Health's goal is to be accredited by **Q3 2025.**
- CalOptima Health engaged our NCQA consultant to conduct a readiness assessment and gap analysis.
- NCQA consultant provided recommendations and developed a work plan.
- CalOptima Health developed a HE Steering Committee and five work groups for implementation.
- We will submit survey application and fees by September 2024.

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Health Equity Accreditation Standards

- NCQA's health equity accreditation is built on the premise that high quality care is equitable care
- The goal for health plans is to create a system and structure that enables every part of the organization to contribute to health equity and quality goals of improving member care and health.
- Health equity standards are built on a framework of:

HE1: Organizational readiness Diverse staff Promoting diversity among staff	HE4: Practitioner Network cultural responsiveness
HE2: Collection of race/ethnicity, gender identity, and sexual orientation data	HE5: Culturally and linguistically appropriate services program
HE3: Access and availability of language services	HE6: Reducing health care disparities

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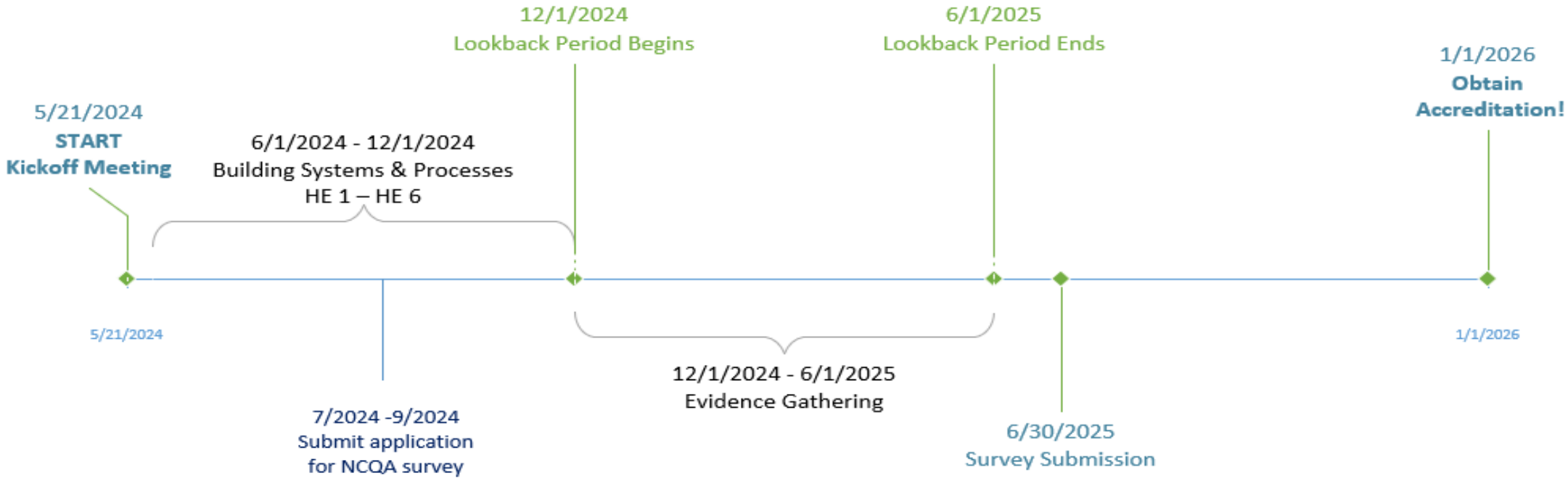
CalOptima Health

NCQA Health Equity Accreditation
Project Timeline



Assumptions:

Aiming for accreditation based on 2025 standards.

This is a draft timeline and subject to change based on updated standards and/or readiness.

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Quality Initiatives

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Performance Improvement Projects (PIP) Medi-Cal

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CalOptima Health

Well-Child Visits in the First 15 Months of Life PIP

- DHCS-required topic to address health disparities for Black/African-American members
- MY2022 baseline rate: 34.64% (n=153 members)
  - Overall rate: 45.76% (n=12,369)
- Intervention: Call campaign started 5/1/24 (85 members)
  - Well-child visit education
  - Reminders to complete well-child visits
  - Appointment coordination for visits
  - Barrier survey with $25 gift card for participation

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CalOptima Health

Plan-Do-Study-Act (PDSA) Project

- **Well-Child Visits in the First 30 Months of Life, 15 to 30 Months PDSA** (2023)
  - Cycle 3: 7/31/23 - 11/30/23
  - Intervention: telephonic call campaign and birthday card mailer.
  - Findings: Members who had two successful telephonic outreaches (87.50%) had a comparable compliance rate to those who had three successful telephonic outreaches and a birthday card mailing (88.89%).
  - Recommendation: Aim for two successful telephonic outreaches, and if member is unreachable, then a birthday card mailing is recommended.

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Behavioral Health Non-Clinical PIP

- This PIP aims to increase the enrollment of CalOptima Health Medi-Cal only members into Care Management (CM), Complex Case Management (CCM), or Enhanced Care Management (ECM) for members diagnosed with Specialty Mental Health (SMH)/Substance Use Disorder (SUD) to achieve better health outcomes, reduce emergency department visits, reduce health care cost and linkage to services.
- Activities:
  - Baseline data collected and initial report created
  - First draft of PIP submitted to DHCS
  - Technical Assistance requested and utilized
  - PIP resubmitted, reviewed, and validated.

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2024 Behavioral Health Quality Interventions

- Text message campaigns
- Member health rewards
- Member outreach
- Member Newsletter
- Automation via CalOptima Health provider portal
- Provider Communication: Tip sheets, Best Practice Letters

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Blood Lead Screening

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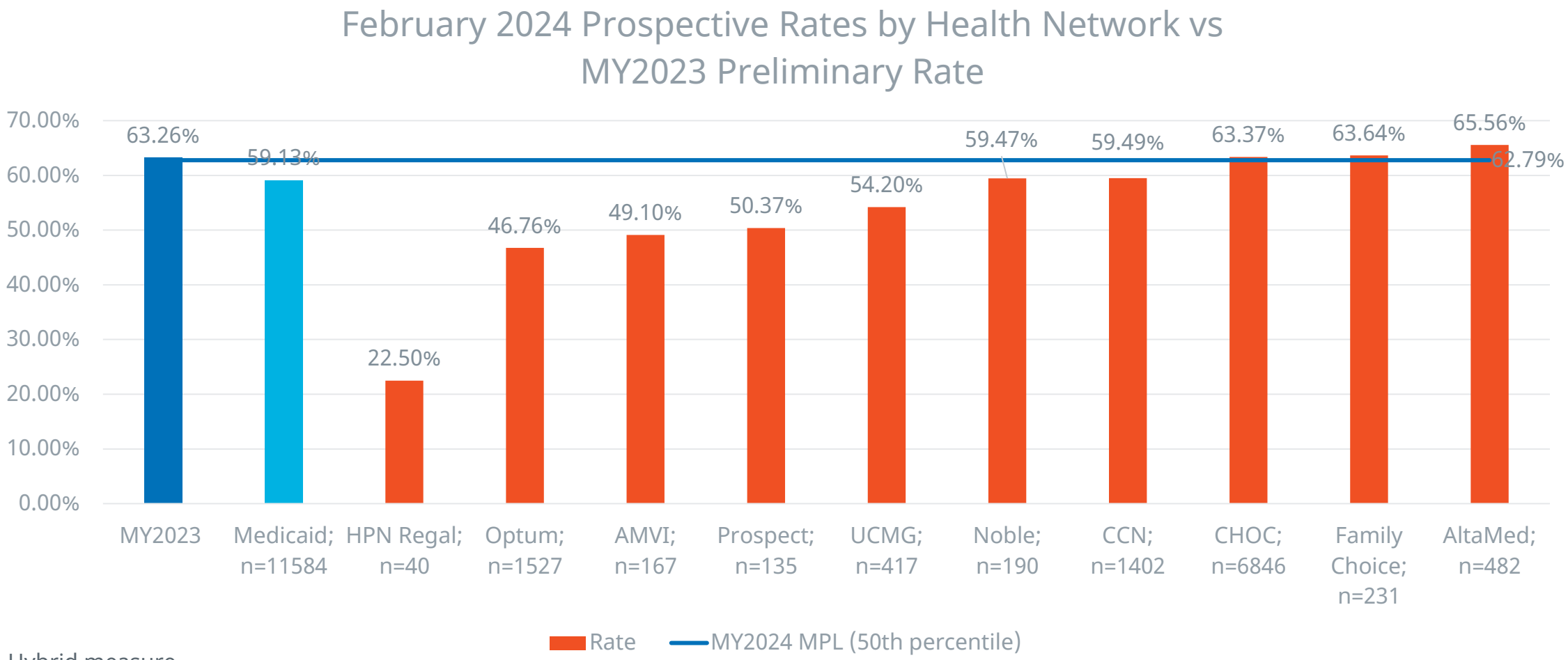
CalOptima Health

Lead Screening in Children (LSC) MY2024 Prospective Rate by Health Network



Hybrid measure
3 health networks have attained the 50th percentile; n= members in denominator
February 2024 rates are non-continuous data
MY2023 rate preliminary and based on continuous enrollment data

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CalOptima Health

Blood Lead Screening Initiatives

- 2024: Implemented Member Health Reward for Blood Lead Test at 12-Months and 24-Months of Age
  - March 2024- launched on CalOptima Health website
- One-way text campaign for blood lead screening to members that are untested for lead as defined by the lead screening in children (LSC) measure.
- Live-call campaign to close HEDIS gaps slated for June 2024.
- Two-way text campaign reminders to test for lead at 12- and 24-months of age projected for Q3 2024.

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Chronic Care Improvement Project OneCare

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OneCare Chronic Care Improvement Program (CCIP)

- **Medication Adherence for Diabetes Medication PDSA,** *completed*
  - Cycle 1: 10/1/2023-12/31/2023
    - Telephonic outreach to remind members to refill their medication and other preventative screenings they may be eligible for.
- **Emerging Risk for Poor HbA1c Control**
  - 1/2024-12/2025
    - Eligible members with diabetes who had an HbA1c test result below 8.0% but tested between 8.0% and 9.0% in their most recent HbA1c test identified as emerging risk members.
    - Telephonic outreach by a health coach to identify solutions for emerging risk members to manage their HbA1c levels below 8.0%.
    - Health coaches will provide general diabetes health education, blood sugar management, nutrition and exercise, and preventative care reminders.

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CalOptima Health Board of Directors'

Quality Assurance Committee Meeting

June 12, 2024

Quality Improvement Health Equity Committee (QIHEC) First Quarter 2024 Report

QIHEC Summary		
QIHEC Chair(s)	Quality Medical Director Chief Health Equity Officer	
Reporting Period	Quarter 1, 2024	
QIHEC Meeting Dates	January 9, 2024; February 13, 2024; and March 12, 2024	
Topics Presented and Discussed in QIHEC during the reporting period	• Chief Medical Officer updates • OneCare CMS Star rating low performance remediation • Access and Availability • Adult Wellness and Prevention • Behavioral Health Integration (BHI) • Blood Lead Screening • Board Certified Specialty List • CalAIM • CalOptima Health Comprehensive Community Cancer Screening Program • Care Management and Care Coordination • Chronic Conditions Management • Continuity & Coordination of Care (Behavioral Health) • COVID-19 Vaccination • Credentialing and Recredentialing • Cultural and Linguistic • Customer Service	• National Committee for Quality Assurance (NCQA) Accreditation • OneCare Model of Care • Pay for Value • Pediatric Wellness and Prevention • Performance Improvement Projects • Policies • Population Health Management • Potential Quality Issues (PQIs) • Prenatal and Postpartum Care • Maternal Care • Quality Compliance Report • Quality Improvement Program and Work Plan • Quality Improvement and Health Equity Program and Work Plan • Quality Metrics • Skilled Nursing Facility and Community Based Adult Services (CBAS)

	• Diabetes Care • Delegation Oversight • Facility Site Review (FSR)/Medical Record Review (MRR)/Physical Accessibility Review Survey (PARS) • Grievance & Appeals Resolution Services • Health Education • HEDIS • Initial Health Assessment • Member Experience	• Medicare Advantage Star Program Rating/Consumer Assessment of Healthcare Providers and Systems (CAHPS) • Regulatory Corrective Action Plan • Transitional Care Services • Utilization Management Program and Activities • Whole Child Model

QIHEC Actions in Quarter 1, 2024

QIHEC Approved the Following Items:

- December 12, 2023, QIHEC Meeting Minutes
- January 9, 2024, QIHEC Meeting Minutes
- February 13, 2024, QIHEC Meeting Minutes
- Approved a new Population Health Management Committee
- 2023 Quality Improvement Evaluation
- 2024 QIHETP Description with 2024 QI Work Plan, Pay Value Program, and Population Health Management Strategy
- 2023 Utilization Management Program Evaluation
- 2024 Utilization Management and Case Management Integrated Program Description
- Quality Improvement Work Plan Q4 2023
- Approved and accepted Board-Certified Consultants 2024
- Healthcare Effective Data and Information Set (HEDIS) Goal Setting Methodology for Measurement Year 2024

Policies:

- All Utilization Management Policies (43)
- GG.1629 Quality Improvement and Health Equity Transformation Program
- GG.1110_Primary Care Practitioner Definition, Role, and Responsibilities
- GG.1602 Non-Physician Medical Practitioner (NMP) Scope of Practice
- GG.1643 Minimum Physician Credentialing Standards
- GG.1657 - State Licensing and National Practitioner Data Bank (NPDB) Reporting
- GG.1659 System Controls of Provider Credentialing Information
- GG.1713 - Certified Nurse Midwives Scope of Practice

QIHEC Actions in Quarter 1, 2024
Accepted and filed the following items: • Utilization Management Committee Meeting Minutes: November 16, 2023, and January 25, 2024 • Whole Child Model Clinical Advisory Committee Meeting Minutes: November 7, 2023 • Grievance and Resolutions Services Committee Meeting Minutes: November 14, 2023

Committee Membership Updates:
• The committee welcomed the following members to QIHEC:
  o Dr. Sarah Marchese, FAAP Medical Director, County of Orange Social Services Agency
  o Dr. Hsien Chiang, CalOptima Health Medical Director, CalAIM
  o Dr. Alan Adler, Medical Director for Conifer Health
• Dr. Gordon Lowell termed with Family Choice Medical Group Health Network. His last QIHEC meeting was January 2024.

QIHEC Quarter 1 2024 Highlights

• Chief Medical Officer updated the committee on the following:
  o CalOptima Health's contractual relationship with four Prime facilities in Orange County has been terminated. Delegated networks and hospital partners supported CalOptima Health by ensuring members were transferred, if needed, in a timely manner.
  o The new care management system, Jiva, will go-live 2/1/2024.
• The OneCare CMS Star Corrective Action Plan (CAP) was closed upon CalOptima Health's remediation efforts to improve low performance.
• Staff identified areas of potential NCQA standard noncompliance where denial notices did not address the requesting practitioner and letter templates were missing required language. A remediation plan was developed and implemented with the following: call between CalOptima Health's CMO and the CMO of leadership from the HN delegates, implementation of a letter template checklist to ensure all entities adhering to NCQA requirements, and ongoing file review was performed to monitor compliance. Internal reviews of UM files demonstrated improvement from the previous quarter.
• CalOptima Health conducted annual audits and issued CAPs for the following HNs in the quarter: AltaMed Health Services Corp., Optum Care Network – Arta, Optum Care Network – Monarch, and Optum Care Network – Talbert. The following UM trends were identified: timeliness of decision and notification, translation of member and NOA notifications, required attachments to communications not current or missing, and PCS forms not accounted for in Non-Emergency Medical Transportation (NEMT) reviews.
• "Just In Time" outreach began in January 2024 with mailers and live calls prior to the fielding of the CAHPS member experience survey.

QIHEC Quarter 1 2024 Highlights
• Cultural and Linguistic staff identified that members were not aware of translations services available, and staff will monitor utilization and work with other departments to promote services. • For Medi-Cal, six Managed Care Accountability Set measures are at-risk for not meeting the 50th percentile. There is one measure that has met the 90th percentile (chlamydia screening) and one measure that is at the 75th percentile (immunizations for adolescence combo 2). • For OneCare, there are four measures at-risk for not meeting 3 Stars. One measure, Medication Adherence, is already at four stars. • Blood Lead Screening remains an area of focus. Members' lack of awareness of risk related to lead exposure is a barrier and staff will focus on the following member education and outreaches: Interactive Voice Response, text, newsletters, health reward and education flyers. • Initial Health Appointment remains an area of focus with a compliance rate of 37%. Staff will focus on HN and provider education, chart review, provider portal and member outreach. • 2023 Case Management Member Satisfaction Survey showed a decline in response and satisfaction. A focus group will be conducted to identify ways to improve the program.

QIHEC Subcommittee Report Summary in Quarter 1, 2024	

Credentialing and Peer Review Committee (CPRC)	• CPRC met on 10/18/2023, 11/16/2023, and 12/14/2023.
	• Revised and approved the following:
	  ○ CPRC charter to include oversight of Facility Site Reviews (FSRs) and Physical Accessibility Reviews (PARs).
	  ○ Five policies related to peer review and credentialing.
	  ○ The Potential Quality Issues (PQIs) Cases and Trend Reports, the Credentialing Clean Lists, and the Credentialing Record Closing Lists each month.
	• Reviewed PQI and credentialing cases.
	• Two physicians were recommended for de-credentialing.
	• CalOptima Health is not meeting the 60-day credentialing requirement for BH practitioners. Temporary staff were hired to address the backlog. CalOptima Health is seeking to contract with a Credentialing Verification Organization (CVO) to assist with credentialing.
	• CalOptima Health is sending a letter was sent to each Skill Nursing Facilities reminding them to report critical incidents.
	• 60 FSR Corrective Actions Plans (CAPs), 38 MRR CAPs, and 10 CBAS CAPs were issued. Barriers identified and staff conducts regular provider office staff training.

Grievance & Appeals Resolution	• GARS Committee met on 2/14/2024. • Q3 trends by line of business.

QIHEC Subcommittee Report Summary in Quarter 1, 2024	
Services Committee (GARS)	• Reviewed Q3 trends. • Reviewed access and availability including the timely access. • Medi-Cal grievances increased throughout 2023, where grievances were related to access issues, related to appointment availability, telephone access and non-medical transportation timely access. • A dedicated GARS team was formed to address the transportation related service complaints. They reviewed assignments to FQHC's for capacity and reported trending providers to Provider Relations for Education • Quality of Care (QoC) grievances increased throughout 2023, related to delays in treatment, questions in treatment/diagnosis. Actions to remediate include referrals to Quality Improvement (QI) for PQI investigation, MTM weekly meetings, collaborating with the Provider Relations department for provider education, and launch of a new transportation vendor.
Member Experience Committee (MemX)	• MemX met on 3/4/2024. • Reviewed the 2024 Quality Work Plan and MEMx recommended improvement in telephone call trees to members and provider directory improvements. • Demonstrated the new OPUS analytic tool to improve rates for member experience surveys. • CalOptima Health fielding of the Timely Access Survey concluded in December 2023. Results are expected to be available in March 2024. Provider notification and education to follow. • CalOptima Health is partnering with Sullivan Luallin Group to conduct provider education and coaching with focus on access and member experience. The first Lunch and Learn is scheduled for May 2024. • 2023 Annual Network Certification (ANC) was submitted in January 2024 and is currently in Phase 2 of the submission. Two zip codes did not meet time and distance standards. Staff are outreaching to contract with providers in the zip codes and submitting and Alternate Access Standard request to Department of Health Care Services.

Utilization Management Committee (UMC)
• Benefits Management Subcommittee (BMSC)
	• UMC met on February 22, 2024
	• Approved the 2024 UMC Charter including the following changes:
	  ○ Updated voting members to add the Medical Director for California Advancing and Innovating Medi-Cal (CalAIM) and the Medical Director of Delegation Oversight and Health Networks
	  ○ Revised quorum from three outside practitioners to two outside practitioners.
	• Topics discussed include:

QIHEC Subcommittee Report Summary in Quarter 1, 2024	
• Pharmacy and Therapeutics Committee (P&T)	○ Q4 2023 UM Program and Evaluation ○ 2024 UMC Charter • 2023 Utilization Metrics for 3rd Quarter: Reviewed over and under-utilization rates against goals. During the Q4 UM Program Evaluation, most of the UM Metrics (Admits/PTMPY, Days/PTMPY, ALOS, Readmit %) performed below the targeted goal. • Actions include data enhancement and examine data trends/outliers with the new JIVA platform, ongoing oversight and outreach for Transitional Care Services (TCS) program and activities and improvements on examining the data in the Admission, Discharge, Transfer (ADT) feed.
Whole-Child Model Clinical Advisory Committee (WCM CAC)	• WCM CAC met on February 20, 2024. • Added representative from Regional Center of Orange County (RCOC) and County of Orange Social Services Agency (SSA) to the committee. • Reviewed WCM utilization and service data and there were no out-of-range issues reported.

For more detailed information on the workplan activities, please refer to the First Quarter of the 2024 QIHETP Work Plan.

Attachment

Approved at QIHEC throughout Q1 2024: First Quarter 2024 QIHETP Work Plan 1Q

2024 QIHETP Work Plan - Q1 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Caution Green - On Target
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Quality Improvement	X	2024 QIHETP Description and Annual Work Plan was approved by QIHEC on 2/13/24, by QAC on 3/13/24, and by the BOD on 4/4/24.	A copy of the BOD approved 2024 QIHETP and Work Plan will be posted on COH public website.	
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	~~QIHETP~~ QI Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Quality Improvement	X	Evaluation of 2023 QI Program and Annual Work Plan were approved by QIHEC on 2/13/24; QAC on 3/13/24 and BOD on 4/4/24.	Evaluation of the 2023 QI Program and the four quarters of 2023 Work Plan will be posted on COH public website.	
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley	Utilization Management	X	The 2024 Integrated UM & CM Program Description was approved by the Board on 3/13/24.	None at this time	
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley	Utilization Management	X	The 2023 Integrated UM & CM Program Description evaluation was drafted & presented to UMC on 1/5/24, presented to QIHEC on 2/13/24 & to the Board on 3/13/24	None at this time	
Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: Population Needs Assessment (PNA) Risk stratification Screening and Assessment Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Katie Balderas	Barbara Kidder/Hannah KimHM/Director of Care Management	Equity and Community Health	X	1) Drafted SOW for Member and Population Health Needs Assessment (**MPHNA)** vendor to better stratify members based on risk and identify opportunities for improvement in access, prevention, and service delivery. 2) In March 2024, CalOptima Health Quality Assurance Committee accepted the **2024 PHM Strategy**, which outlines our efforts for this year. 3) Currently working with department leads throughout the organization to update the **2024 PHM Strategy Workplan** which outlines our PHM programs/initiatives, related activities, and related SMART objectives for the year. 4) Collaborating with Orange County Health Care Agency (OCHCA) and Kaiser Permanente (KP) to co-develop shared SMART Goals for inclusion in the PHM Strategy and identify opportunities to collaborate on the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).	1) Obtain Board approval in April 2024. MPHNA RFP vendor selection is planned for August 2024. 2-3) 2024 PHM workplan to be finalized and presented to CalOptima Health Board of Directors in April 2024 and PHMC in May 2024 for approval. 4) Will be working to finalize SMART Goals, implementation plans, and the Local Health Department (LHD) + Managed Care Plan (MCP) collaboration worksheet due in August 2024.	
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	X	The 2024 Program and Workplan approval at QAC and BOD was held in order to include Health Equity elements.	Updated the workplan with additional goals related the Health Equity Accreditation and present at the next QAC meeting	
Program Oversight	**Population Health Management (PHM) Committee** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder/Hannah Kim	Equity and Community Health	**New**	1.) In February 2024, we created and launched the **PHM Committee** which will oversee PHM activities related to DHCS and NCQA. This committee includes executive representative from across the agency as well as community leaders.	1) Continue to assists this committee by reviewing relevant guidance, agenda setting, and presentation development, and deliverables shared with QIHEC. 2)Finalize approval calendar, charter, and related polices 3) Next PHMC meeting is scheduled for May 2024.	
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	Report committee activities, findings from data analysis, and recommendations to QIHEC	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Laura Guest	Marsha Choo Rick Quinones Katy Noyes	Quality Improvement	X	Credentialing: CCN Initial Credentialing=59; CCN Recredentialing=119; BH Initial Credentialing=43; BH Recredentialing=25 Seven PQIs were presented to CPRC in Q1. One PQI resulted in a recommendation by CPRC for decredentialing, for which the provider has requested a Fair Hearing. There were no PPCs identified through data mining due to staff limitations, nor were any PPCs reported to CalOptima Health by the hospitals or HNs. There were 5 critical incidents all regarding a COVID-19 outbreak at a CBAS center.	Credentialing: Continue to credentialing and recredentialing of CCN and BH providers. Have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial credentialing and recredentialing files. We have also hired two Credentialing Auditors to assist with the CVO and delegation oversight for our delegated groups. There are currently 5 physicians undergoing the Fair Hearing process. Claims reports will be mined for PPCs when additional staff are hired and trained trained on the PQI team. Critical incidents will continue to be monitored and reported quarterly to DHCS.	
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.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	GARS	X	On 2/14/2024 GARS Comittee met to review Q4 metrics and discussed CY2023 trends in both lines of business and types to include: - Member Grievances - Member Appeals - Provider Disputes - Provider Appeals Discussed the 2 overturned cases by the External Indepdent Reviews - SFH (Medi-Cal) and Maximus (Medicare) Q3 2023 minutes were approved.	GARS Committee is scheduled for May 14 where Q1 trends will be discussed and the remediation activities presented for additional recommendations.	
Program Oversight	**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Quality Analytics	X	In Q1, MemX Committee met 3/14/24 and reviewed/discussed the following: •Access to Care Issues •Compliance Rates for BH •Provider Education Opportunities through CHCN Lunch & Learns •Overview of Decision Point's CAHPS Predictive Analytics •Discussion on Outreach Calls	Q2 meeting is scheduled for: 5/22/24	
Program Oversight	**Utilization Management Committee (UMC) Oversight** - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. **P&T and BMSC** reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Kelly Giardina	Stacie Oakley	Utilization Management	X	In Q1 2024 UMC held meetings on 1/5/24 and 2/22/24. On 1/5/24 UMC members approved the following items: *11/16/23 meeting minutes *2023 UM Program Evaluation *2024 Integrated UM/CM Program Description *2024 UM Policies & Procedures On 1/26/24 UMC members approved the 2024 hierarchy of UM criteria via an eVote On 2/22/24 the UMC members approved the 1/25/24 meeting minutes.	None at this time	
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. Pediatric Risk Stratification Process (PRSP) monitoring	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	T.T. Nguyen, MD/H.Kim	Gloria Garcia	Medical Management	X	WCM CAC met on 2/20/24. They approved the 11/7/23 meeting minutes and submitted a copy to QIHEC. WCM CAC attendees completed annual Conflict of Interest and Confidentiality forms. Regional Center Orange County and Orange County Social Service Agency representatives joined the Commitee. WCM data including BH services was presented and no out of compliance or issues were reported. There are no recomendaions for QIHEC at this time.	The next WCM CAC meeting is scheduled for 5/20/24	
Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Megan Dankmyer	TBD	Medical Management	**New**	Report on the following activities: Enhanced Care Management (ECM): Develop process for ECM Lead Care Manager to communicate TCS activity. Complex Case Management (CCM): Reviewed with Health Networks NCQA Element E, Factors 1-5. Case Management continues monthly real time reviews of delegated Health Networks per NCQA requirements. Basic PHM/CM: Case Management Quarterly audit for MOC for delegated Health Networks. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: See Next steps Transitional care services: Work with IT to develop reporting for analyzing outcomes on TCS response.	Report on the following activities: Enhanced Care Management (ECM): 1. Implement process for ECM Lead Care Manager to communicate TCS Activity. Complex Case Management (CCM): 1. Continue real time Monthly NCQA file audits. Basic PHM/CM: Ongoing Case Management Quarterly audit for MOC for delegated Health Networks. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: Institute multi-department EPSDT workgroup. Transitional care services: 1. Analyze outcomes by Health Network and present in JOMS to track and trend to guide future conversations and interventions. 2. Work with ECM Providers to obtain ECM reporting data for KPI 5	
Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activites.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accredication standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Monica Herrera	Zulema Gomez John Robertson	Delegation Oversight	**New**	2024 DOAA Findings: - Compliance file review - Credentialing file review - Customer Service file review - Provider Relations file review - Utilization Management file review	Next Steps: A Corrective Action Plan (CAP) is issued for each finding that addresses each deficiency identified. Remediation of the CAP is then implemented based on current CAP policy, HH.2005.	
Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Elisa Mora	Equity and Community Health	**New**	1) Provided extensive training to staff on the new care management system (Jiva) implemented on 2/1/2024 to ensure smooth implementation and efficient operation. 2) Implemented a Chronic Kidney Disease (CKD) pilot targeting 68 CCN Members with CKD stage 3 A or B and 2 chronic conditions (diabetes, hypertension, heart disease) and not seeing a nephrologist. Staff were able to enroll 7 out 68 members in the program. 3) Developed 2-way text campaign on asthma and diabetes to promote PCP engagement and DM program opt-in. Submitted text to DHCS for approval. 4) Piloted 2-way text as an option for members to complete the Disease Management Satisfaction Surveys. Introducing text message as a survey option improved survey response rates and convenience for members. 5) In February 2024, we resumed the New Member Mailing, providing information on our DM services and condition-specific handouts on asthma and diabetes for low risk members. This mailing will occur every other month. 6) The diabetes monthly stratification criteria were revised to improve high risk member identification. The look back period was shortened and the A1c requirement was dropped to 8% to better identify the emerging risk members. This change could potentially lead to earlier interventions for high-risk members.	1) Continuing to provide ongoing training to staff as the care management system continues to be enhanced for efficiency. 2) Analyzing the results of the CKD pilot to fine-tune the program prior implementation. 3) Launch text campaigns contingent upon DHCS approval. Evaluate effectiveness of text campaigns. 4) Revise stratification criteria for asthma and congestive heart failure.	

2024 QI Work Plan - Q1 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Caution Green - On Target
Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: Evaluation of current utilization of health education services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Anna Safari/Katie Balderas	Thanh Mai Dinh	Equity and Community Health	**New**	1) Evaluation of current utilization of health education services **Goal being met:** During 2024 Q1, 749 referrals were assigned to health education services, very similar count from previouse year as 748 referrals were assigned to health education services during Q1 in 2023. However, during 2024 Q1, there was an increase in community class intake. Class attendance was 50 in 2023 Q1, compared to 183 attendees in 2024 Q1. Classes take more efforts to recruit participants, prepare, and follow up, therefore participation increse is gradual. 2) Maintain business for current programs and support for community **Goal being met:** 68 community classes have been confirmed for 2024, and topics continue to expand. Hypertension education was added to the series in March 2024. Community partners include a collaboration with Northgate Markets offering market tours accompanied by nutrition education. Participating in community collaboration including the Tobacco and Vape Free (TVFREE) Coalition. 3) Improve process of handling member and provider requests **Goal being met:** a. The draft electronic referral form is being reviewed and will be used to help improve member self-referral experience. This is so that members who do not want to call in or providers can directly send referrals to the Health Education team. b. Health and Wellness services are promoted at at all continuing education training in 2024, along with reminders on how and where to send member referrals.	Implementation of an electronic referral form, and continue with the plan as listed. However, with the recent department name/vision change to focus more on Equity and Community Health, it's anticipated that there is will more community engagement efforts and possibly, less one on one coaching approach. Such service will be offered based on providers and members requests.	
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024 Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder	Equity and Community Health	x	1) SDOH assessment is being tested for integration to the member portal. SDOH assessment will be built into CalOptima Health's healthcare management system (JIVA) as part of the closed-loop referral integration. 2) Closed-loop referral vendor was selected and contracting process in underway. 3) HL4E certificate programs is ongoing with 59 out of 164 staff having completed the certificate program.	1) Published SDOH assessment in member portal and build the SDOH assessment into JIVA 2) Finalize contract with selected closed-loop referral vendor and integrate into JIVA 3) Continue to encourage staff to complete their mini-credentials to earn their certification. Train the trainer program on the teach-back method is planned for May 2024.	
Program Oversight	Long-Term Support Services (LTSS)	Implement LTSS	Report on the following activities: Evaluation of current utilization of LTSS Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	Long Term Care	**New**	LTSS remains compliant with all TAT's. LTC, CBAS and MSSP continue to provide timely and efficient member services. 1st quarter FY goal is to review and revise department DTP's to coincide with the Jiva implementation.	Continue everyday LTSS standup meetings with the LTSS Manager and Supervisors to monitor and adjust staffing and caseloads to comply with TAT's.	
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activites for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Veronica Gomez	Marsha Choo	Quality Improvement	X	1. **Health Plan Accreditation:** CalOptima Health is on track to submit for HP re-accreditation which is scheduled for 4/30/24. An additional Program Manager has been hired to help support HP and HE accreditation in preparation for the next HP accreditation. 2. **Health Equity Accreditation:** Consultant completed a review of all the applicable standards.Developed a work plan. Several working sessions have taken place to meet with owners and identify gaps in meeting specific elements. Requested additional Project Management support for Health Equity Accreditation.	**1. HP Accreditation:** An additional Program Manager has been hired to help support HP and HE accreditation in preparation for the next HP accreditation. Virtual File review with NCQA surveyors is scheduled for June 17th-18th, 2024. **2. HEA Accreditation:** 2 project managers will be assigned to support Health Equity Accreditation. CalOptima Health also has an Enterprise Project Management Office with resources to provide additional support, if needed.	
Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Quality Improvement	X	MY2024 priority measures identified: OMW, PCR, FMC, CBP, COA (medication review), TRC (average), HbA1c. Stars Steering Committee started in Q1.	Continue with plan as listed	
Program Oversight	Value Based Payment Program	Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Quality Analytics	X	HN performance for all P4V HEDIS measures have been shared continuously on a monthly basis. In addition, high level details for the quality improvement grant process were shared with all HNs during the April HN Quality Forum. NOFO planned for Q3.	Continue with plan as listed	
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1 02/11/2025	Paul Jiang	Terri Wong	Quality Analytics	X	Awaiting for HEDIS results.	HEDIS results will be reported in Q2.	
Program Oversight	School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Sherie Hopson	Behavioral Health Integration	X	1) 1st quarter 2024 SBHIP Progress Reports from CHOC, Hazel Health, WYS, and OCDE reporting implementations are on track. 2) Monitoring SBHIP implementation progress through regularly scheduled OCDE SBHIP Collaborative Meetings and SBHIP Planning Meetings facilitated by BHI. 3) School district contracting Visio workflow finalized for internal departments Contracting, Credentialing, Provider Relations - focused on providing a "concierge service" to help the school district through the process. 4) Reviewed and approved 10 school districts budget plans from detailing their use of SBHIP funds. 5) Received DHCS approval 3/13 for the December 2023 Biquarterly Reports.	1) 2nd quarter 2024 SBHIP Partners Progress Reports receive and review. 2) Coordinate and monitor progress through regularly scheduled meetings with OCDE and SBHIP Partners. 3) Prepare DHCS Biquarterly Reports for June submission. 4) Prepare 2nd SBHIP partner funding distribution/check request process. 5) Review and approve school district budget plan submissions.	
Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Katie Balderas	Barbara Kidder	Equity and Community Health	X	1) Developed a competitive grant program to support activities that increase early detection and decrease late-stage discovery. We released a noticed of funding opportunity in February 2024 and received grant applications from 22 organizations. We anticipate grant implementation of selected grantees will begin in July 2024, pending Board approval in June 2024. 2) Launched the Awareness and Education Campaign with a marketing firm. Discovery phase took place from January to March with 15 discovery sessions that included internal and external stakeholder input from CBOs, health networks and providers.	1) Currently reviewing applications for selection. Board approval is planned for June 2024. Grant Contracts and go-live planned for July 2024. 2) Present findings from Discovery Phase to leadership and work with Marketing Firm for concept development and strategic recommendations; Test concept/messaging with consumers;	
Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	X	1. Member Health Reward: CCS:MC 25; BCS:MC 18; BCS:OC 2. COL:OC 2 2. Text Message Campaign: Jan: CCS 60,762; Feb BCS MC 21,642 OC 596; Mar; COL OC 1256 members 3. Member Health Reward Survey: MC 3,376 OC 2,276 4. Kick off of CCN OC COL GI outreach pilot programs. 5. February 2024 Prospective Rate Data: CCS: MC 36.12% BCS: MC 38.81%; BCSL: OC 50%; COL: OC 48%	1. Continue to track CCS, BCS MC OC, COL OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and MC/OC live call campaigns. 3. Continue to monitor CCN OC COL GI outreach pilot program. 4. Develop 2 way text message campaigns for each cancer screening measure by line of business.	
Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collabortively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second quater. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Behavioral Health Integration	X	PR HEDIS RATES Q1 (February): Initiation Phase-41.25% Continuation and Maintenance Phase- 51.13% 1) Created and finalized working collaboratively with QI for the Member Health Reward flyer to distribute to eligible members. 2) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 3) Text Messaging outreach to members sent in January and February. 4) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding imortance of quality measure	1) Q2 data will be pulled to initiate fax blast for Provider best practices letter and tip-sheet to non-compliant providers. 2) Member outreach for those who filled an initial ADHD prescription. 3) Mail out Member Health Rewards flyer to eligible members. 4) Continue monthly data pull for text messaging campaign.	
Quality of Clinical Care	Health Equity/Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health	**New**	1) ACEs presentation to inform the group of our progress as a Health plan and educate on the importance of this screening given by BHI Executive Director at the BHQI Workgroup Meeting in April.	1) Continue collaborative meetings between teams to identify best practices to implement. 2) Continue Provider and member education. 3) Continue to participate in the ACEs stakeholder meetings.	
Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primay Care Providers (PCP) for members in need of merabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to the next top 50 prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs) 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	X	PR HEDIS RATES Q1 (February) : Blood Glucose all ages: 13.11%, Cholesterol all ages: 5.62%, Glucose & Cholesterol Combined all ages: 5.43% 1) Barriers included: Receiving timely data and accurate information. a)Submeasure names for this measure changed in 2024, causing delay in receiving data. 2) Identified members prescribed antipsychotic medication still in need of diabetes screening, cholesterol screening, and both cholesterol and diabetes screening test through Tableau Report. 3) The following materials have been disseminated to Providers: a) Provider Best Practices Letter. b) APM Provider Tip Sheet. 4) Collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 5) Mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 6) Text Messaging Campaign was sent out to members in the month of January. 7) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 8) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding imortance of quality measure.	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue data pull for text messaging campaign. 3) Continue mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 4) Continue with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	**New**	PR HEDIS RATES Q1 (February) :Effective Phase Treatment 62.27%, Effective Continuation Phase 36.64% 1) Worked with Quality Analytics to delvelop a data report 2) Drafted the following materials: a)Text Messaging script b)Drafted APM Provider Tip Sheet 3) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding imortance of quality measur	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Submit Text Messaging draft for internal review process. 3)Submit Provider Best Practices Letter for internal review process.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	**New**	PR HEDIS Rates Q1 (Feb): M/C:18.59% OC: N/A 1) We are monitoring this measure and met our goal last year.	1) Continue to monitor prospective rates on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Caution Green - On Target
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz	Behavioral Health Integration	X	PR HEDIS Rates Q1 (February): 30 day- 17.90%, 7 day- 11.65% 1) The main barrier has been not having the bandwidth for outreach to members that we have been receiving on a daily basis. 2) Working with vendor to create a cohort report of FUM data only. 3) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis. 4) Bi-weekly Member text messaging. 5) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 6) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding imortance of quality measure. 7) Article emphasizing importance of Follow up appointment after ED visit created and will be included in Spring Member Newsletter (Medi-Cal and OneCare).	1) Pull data for Data Analyst to send out bi-weekly text messages based on real time ED data. 2) BHI is in the process of developing and implementig a Pilot project for CCN members identified who meet FUM criteria. BH Telehealth provider to conduct the outreach and assist with member linakge. 3) Collaborate with NAMI to share real-time ED data for member outreach.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collabortively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward Program.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	X	PR HEDIS Rates Q1 (Feb): MC:23.51% OC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau Report. 2) Conducted a text message campaign to reach out to members re: getting their glucose lab screening. 3) Barriers included: Receiving timely data, obtaining the correct contact information for members such as phone numbers. 4) In process of developing new outreach strategies working with internal depts (Case Management) to help reach out to members. 5) Member $25 Reward Program to incentivise members to get glucose screening. 6) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 7) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding imortance of quality measure	1) Continue tracking members in need of glucose screening test. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Continue data pull for text messaging campaign 4) Mail out member health rewards flyer to eligible members.	
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP:Improve the percentage of members enrolled into care management, Caloptima Helath community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMI/HSUD.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz/Mary Barranco	Behavioral Health Integration/ Quality Analytics	X	Conduct quarterly/Annual oversight of MC Non Clinical PIPs (Jan 2023 - Dec 2025) Improve the percentage of members enrolled: Baseline Measurement Period: 01/01/23-12/31/23 Remeasurment 1 Period : 01/01/24 -12/31/24 Remeasurment 2 Period : 01/01/25-12/31/25	1) Working with Caloptima Health Vendor to receive Real-Time ED data on a daily basis for CCN and COD members. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. Telehealth provider will conduct the outreach to members who meet FUM criteria and assist with linkage. Internal BHI PCC's to conduct outreach to members meeting FUA criteria and assist with linkage. Vendor and PCC's will also provide information about case management including ECM and referrals. 3) Develop outreach and outcome data related to the percentage of members enrolled in CCM and ECM for CCN members identified who meet FUM/FUA criteria for the duration of each measurement period. 4) Work in collabration with internal Privacy dept to ensure compliance of data sharing with vendor.	
Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Behavioral Health Integration	X	PR HEDIS Rates Q1 (February): 30-Day- 17.90%, 7-Day-11.47% 1) Sharing real-time ED data with our Health Networks on a secured FTP Site. 2) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis 3) Bi-weekly member text messaging 4) Article emphasizing importance of Follow up appointment after ED visit created and will be included in Spring Member Newsletter (Medi-Cal and OneCare). 5) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding imortance of quality measure	1) Data anaylst scrub data for bi-weekly text messaging. 2) BHI is in the process of developing and implementig a Pilot project for CCN members identified who meet FUA criteria.	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	X	1. Member Health Reward: EED:MC 3 ; EED:OC 1 2. Text Message Campaign: Jan: MC EED 9,903 OC EED 325 members 3. EED VPS mailing for Jan to Mar: 1,443 4. Member Health Reward Survey: MC 3,376 OC 2,276 5. February 2024 Prospective Rate Data: EED:MC 24.7%; EED:OC 37%	1. Continue to track EED MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3.Develop 2 way text message campaigns for diabetes by line of business.	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better) MY2024 Goals: MC: 29.44%; OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	X	1. Member Health Reward: HBD:MC 4; HBD:OC 2 2. Text Message Campaign: Jan: MC HBD 9,903 OC HBD 325 members 3. Member Health Reward Survey: MC 3,376 OC 2,276 4. February 2024 Prospective Rate Data: HBD PC: MC 91.29%; HBD PC: OC 91%	1. Continue to track HBD MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3.Develop 2 way text message campaigns for diabetes by line of business.	
Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Equity and Community Health/ Quality Analytics	X	**Community Initiatives:** 1) Digital ads for postpartum ran Jan, Feb & March 2024. 2) Digital promotion of doula benefit March 2024 **Member based initiatives:** 1) Bright Steps Program - - 794 perinatal referrals - 1,201 maternal and infant assessment completed - 204 unique postpartum assessments completed. 2) Postpartum health reward- 32 health rewards issued during Q1 2024. **Performance:** 1) Februrary 2024 HEDIS rate (based on non continuous enrollment): Timeliness of Prenatal Care:66.76% Postpartum Care: 54.60%. Both have not met the MPL.	1) Data - continue to identify mechanisms to access ADT data to be leveraged to support member outreach modalities which include: mailing, text, IVR, and live-call campaigns. 2) Continue member education efforts such as Medi-Cal newsletters. 3) Develop text and email campaign messaging. 4) Continue with provider, clinic and health network education efforts. 5) Continue with partnership with OCHCA in support of maternal mental health.	
Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s) In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Quality Analytics	X	**Provider based initiatives:** 1) Blood Lead Performance Report shared monthly on Jan, Feb, and March 2024 with CCN providers via Provider Portal and health networks via FTP. 2) Sharing of blood lead resources via HN weekly communication in March 2024. **Community Initiatives:** 1) Radio ads ran in Feb & March 2024; PBS TV ad ran Jan & March 2024. **Member based initiatives:** 1) Blood lead education to Bright Steps Program participants at 6 and 12 months old. 2) New scripting in development for lead text campaign to target members turning 12 and 24 months old through new vendor (Ushur). 3) NEW- 12 and 24 month blood lead testing health reward available on website as of March 2024. **Performance:** 1) Preliminary results based on December 2023 prospective rates (continuous enrollment) indicate that the lead screening in children measure met MPL for MY2023. HEDIS results to be reported in Q2. 2) February 2024 HEDIS rate (based on non continuous enrollment): 59.13%. Has not met the MPL: 62.79%	1) Continue with planned targeted member outreach campaigns such as member mailing, text, IVR, and live-call campaigns. 2) Development of 2-way blood lead text message for lead testing at 12 and 24 months of age. 3) Development of email blood lead campaign for lead testing at 12 and 24 months of age. 4) Data- Continue sharing Blood Lead Performance Report with health networks and CCN providers. 5) Continue with provider education efforts. 6) Continue with partnership with OCHCA to increase blood lead testing rates throughout Orange County.	
Quality of Clinical Care	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS **MY2024** Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Quality Analytics	X	1) First and Second Birthday Card mailer for April - June birthdays to 4,961 members. 2) January Text Message Campaigns. W30: 32,911; WCV 3-17: 180,567; WCV 18-21: 73,552 members. 3) W30 Member Detail Report (Dec 2023 PR) shared with health networks via FTP. 4) Based on February 2024 Prospective Rate Data: none of the measures have met goal. CIS-Combo 10: 17.67%; IMA-Combo 2: 34.04%; W30-First 15 Months: 17.49%; W30-15 to 30 Months: 52.64%; WCV (Total): 4.22%.	1) Continue with planned targeted member outreach campaigns such as birthday card mailing, text, IVR, and live-call campaigns. 2) Development of 2-way pediatric wellness text message campaigns specific to each developmental milestone. 3) Ad hoc W30 Noncompliant Member List shared with health networks and clinics who've established supplemental data sharing to close out HEDIS MY2023 efforts. 4) Continue sharing W30 Member Detail Report with health network.	
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Quality Analytics	X	There were barriers related to the timeliness in which member data was obtained (i.e. 2024 data will not be available until the week of 4/22/2024).	1) PIP data is currently being prepared for the PHM department to assist with calls. 2) PIP call campaign to begin before the end of April 2024. The goal of the campaign is to assist members in closing gaps in well-child visits and assess for parent/guardian barriers to well-child visits.	
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits. Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Quality Analytics	X	W30-2+ PDSA, Cycle 3 was approved (1/21/2024). Findings: members who had 2 successful telephonic outreaches had a comparable W30-2+ compliance rate to those who had 3 successful telephonic outreaches and a birthday card mailing.	Based on the PDSA findings, aiming to conduct at least 2 call campaigns per year to impact the W30 rate. If member is unreachable, send a wellness visit reminder mailer.	
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data submited by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 04/09/2024 Q4: 10/08/2024	Kelly Klipfel	Lorena Dabu	Finance	**New**	Medi-Cal: 1) HMOs and PHCs met 7 of 8 measures 2) CHOC met 5 of 6 measures 3) SRGs met 5 of 6 measures OneCare: 1) 4 networks met all measures 2) 5 networks met 3 of 4 measures 3) 1 network met 2 of 4 measures	None; continue to work with all HNs to ensure complete encounter data submitted	
Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibilty Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025 Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Marsha Choo	Katy Noyes	Quality Improvement	**New**	FSR/MRR/PARS, NF and CBAS Oversight A.FSR: Initial FSRs=4; Initial MRRs=6; Periodic FSRs=27; Periodic MRRs=18; On-Site Interims=42; Failed FSRs=2; Failed MRRs=5; CAPs: CE=31; FSR=22; MRR=32 B.PARS: Competed PARS=110 (Basic Access=60 Limited Access=50) C. CBAS: Critical Incidents=6; All Critical Incidents reported were COVID cases. Non-Critical Incidents=12; Falls=7; Completed Audits= 8: CAPs=4; Unannounced Visits=1 NF: 1 Critical Incident was reported in Q1. On-Site Visits=27; Unannounced Visits=1	I. FSR/MRR/PARS, NF and CBAS Oversight **A.** FSR: Continue to audit. Complete Periodic FSR within 36 months from previous audit. Close all issued CAPs by due dates. Currently training an new QI Nurse Specialist-FSR and interviewing for one more position. This will decrease the number of audits assigned to each nurse and increase turn-around-time. **B.** PARS: Continue to complete PARS reviews for PCP, HVS, and Ancillary sites. **C.** CBAS: Continue to complete annual audits and unannounced visits. Remind centers to report critical incidents. **D.** SNF: Two new LVN hires. Working on re-evaluating current processes and procedures.	
Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Laura Guest	Quality Improvement	**New**	PQI is undergoing a system change which is expected to be implemented in Q2 2024. PQI data is unable to be pulled during this transition period. In Q1, PQI hired one new RN and one LVN is no longer with CalOptima.	PQI anticipates the new system, Jiva, to be implemented in Q2 2024. PQI data will be reported once the system implementation and reporting is completed. PQI anticipates hiring and training a new RN during Q2 2024, as this position is currently under recruitment.	

2024 QI Work Plan - Q1 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Caution Green - On Target
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC: Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Quality Improvement	**New**	Initial BH Credentialing Q1 = 43; Initial CCN Credentialing Q1 =57	Initial credentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial credentialing.
Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Quality Improvement	**New**	BH Recredentialing - Q1 =24; CCN Recredentialing Q1 =115. For Q1 we did not have any recredentialing files out of compliance.	Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the recredentialing of providers. This will ensure that we continue with compliance and timeliness of the recredentialing files.
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	X	1. Member Health Reward: EED:OC 1; HBD PC:OC 2 2. EED VPS mailing for Jan to Mar: 599 members 3. Text Message Campaign: OC HBD/EED 325 members 4. Febnuary 2024 Prospective Rate Data: EED: OC 37%; KED: OC 8.21%; HBD PC: OC 91%; MAD: OC Data Received in May; SUPD: OC Data Received in May	1. Continue to track HBD MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3. Develop 2 way text message campaigns for diabetes by line of business. 4. Begin emerging risk call campaign.
Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	S. Hickman/M. Dankmyer/H. Kim	QI Nurse Specialist	Case Management	X	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. Core Report CO2258 in phase II Jiva Remediation for ICT/ICP/HRA data. Q1 DHCS reporting for HRA1 and ICP1 due on 5/30/2024 and data pending validation process. As of 3/31/2024 22% of HRAs completed to date for the year. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. Communications to Health Networks in January, February and March on ICP development status for newly effective members. Addition of annual ICP development status on the March file. Communication included identification of members who were also ECM-Like. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring. Ongoing quarterly audits of delegated health networks.	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. Submit Q1 ICP1/HRA2 report by 5/30/2024. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. Continue to communicate monthly to Health Networks on ICP development status for both initial and annual members, ECM-Like eligibility. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring. Continue quarterly audits of delgated networks; Implementation audit in development.
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	1) Quynh Nguyen 2) Tory Vazquez 3) Jane Flannigan Brown	Mahmoud Elaraby Provider Relations	Contracting	X	Resource constraints and competing priorities.	>In the process of transitioning Network Adequacy from QI to Provider Ops team. >In the process of hiring a PM to manage network adequacy. > Contracting and PR dependent on Network Adequacy be completed w/ identified gaps in order to develop provider network recruitment strategy.
Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely acces. 3) Continue to educate providers on timely acces standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Quality Analytics	X	Of the eleven Timely Access CAPs issued to HNs in Dec-2023, we have received responses back from eight networks. Of the 117 Timely Access CAPs issued to individual providers, 23 responses received, two termed/terming and one provider passed away.	For CAP responses received, Access workgroup to review and determine next steps. For CAP submissions still outstanding, follow-up and escalate as needed. Planning to field interim access survey in Q2-2023 to re-measure compliance for provider offices who were identified as non-compliant with outgoing telephone message instructing caller to go to ER/call 911 in case of emergency.
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for Improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Karen Jenkins/Mahmoud Elaraby	Network Operations/Quality Analytics	X	Time or Distance: Geomapping conducted in November 2023 showed that Subcontractor no longer met time or distance standards for the core specialists in a dense county as listed in "CalOptima Health EX.2_supplement Orange" file. Member to Provider Ratios: - Provider network report conducted in November 2023 showed Subcontractor non compliant with provider to member ratios - Kaiser Foundation Health Plan: N/A Subcontractor is no longer in CalOptima Health's Networks effective 1/1/2024 Mandatory Provider Types: Provider network report conducted in November 2023 showed fully delegated Subcontractor (Kaiser Foundation Health Plan) non compliant with MPTs: Federally Quality Health Centers	Time or Distance: - For identified areas of non-compliance CalOptima Health issued a corrective action plan (CAP) to the subcontractor. Subcontractor will attempt to find the specialists within time or distance. - Kaiser: Subcontractor is no longer in CalOptima Health's Networks effective 1/1/2024 - Arta, Monarch & Talbert: are integrated with Optum health network and will be reassessed as part of Optum organization effective 1/1/2024 - Will reassess Subcontractor compliance at next quarterly geomapping analysis Member to Provider Ratios: - CalOptima Health issued corrective action plan for identified areas for non-compliance and will monitor Subcontractor through the corrective action process where they will be required to submit a corrective action plan, carry out that plan and demonstrate progress/improvements - CalOptima Health will reassess Subcontractor on a quarterly basis - Kaiser: Subcontractor is no longer in CalOptima Health's Networks effective 1/1/2024 Mandatory Provider Types: - Kaiser: Subcontractor is no longer in CalOptima Health's Networks effective 1/1/2024
Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Katie Balderas	Anna Safari	Equity and Community Health	X	1) Increase health network and provider communications, trainings, and resources a. Sent communication reminders out to Health Networks and CCN Providers b. Presented Health Networks (HNs) as planned at 5 JOMs, 1 QIHEC Meeting, 1 CCN Virtual Lunch and Learn Meeting, 1 FQ/CC . Provided IHA education at Cancer Screening CME for Providers. c. Incorporating IHA into Provider Toolkit, Created document created for providers with steps on how to access IHA Report and PCP Member Roster on Provider Portal. 2). Expand oversight of provider IHA completion a. Launched IHA Chart Review Audits (CCN) to engage low performing community clinics for IHA Chart Review Audits on at least 30 member files per clinic. b. Reviewing and following up on underperforming HNs; Meetings held with Optum and AltaMed to discuss opportunities to improve performance. c. Established and informed all HNs of the expectation to meet the minimum IHA completion rate of 50%; d. Established a plan for process to visit providers and bring IHA data and related resources to implement in Q2 3) Increase member outreach efforts a. Developing text campaign for new members +IHA; Currently in review with internal team and vendor	1) Increase health network and provider communications, trainings, and resources -Scheduled HN Forum Presentation for Q2 (Goal present twice annually) -IHA Updates will be presented at Health Network Collaborative Quality Forum beginning in April. 2). Expand oversight of provider IHA completion **-IHA Chart Review Audits** (CCN): Staff working with department Medical Director to follow up with non-responsive clinics via clinic executive leadership. - Scheduled meeting with Delegation Oversight during Q2 to agree on the approach for establishing remediation activities (including but not limited to: education, corrective action plans, etc.)
Quality of Service	Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards Maintain business for current programs Improve process for handling these services	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services		Quarter 1 2024 Assessment C&L assessed the member utilization for interpreter services (in any language) and written translations in CalOptima Health's threshold languages. The assessment concluded that Spanish is the highest utilized LEP language for telephonic and face to face interpreter services as well as written translations. • Telephonic Interpreter Services Spanish 52%; Vietnamese 23%; Farsi: 5%; Arabic 4%; Chinese 4%; Korean 4%; Other 8% • Face to Face Interpreter Services Spanish 35%; Vietnamese 9%; Farsi: 11%; Arabic 14%; Chinese 2%; Korean 14%; American Sign Language 5% Other 9% • Documents Translated Spanish 72%; Vietnamese 8%; Farsi: 6%; Arabic 5%; Chinese 3%; Korean 4% Utilization results aligned with CalOptima's Health membership and therefore C&L findings is goals are being met.	• Continue monitoring CalOptima Health Members' interpreter and translations services needs. • Continue to explore technological improvement opportunities with our contracted Interpreter Services and Translations vendors for all C&L processes and services.
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Mahmoud Elaraby/Johnson Lee	Provider Data Management Services	**New**	Phase 1: ANC Roster provided by DHCS has been completed and submitted for the following: 1-ANC 2023 Cancer Center Validation_CalOptima Health 2-ANC 2023_Exhibit A-3 MPT Validation_CalOptima Health 3-ANC 2023_Exhibit A-5 Hospital Validation_CalOptima Health Phase 2: Time or Distance: CalOptima Health: CalOptima Health did not meet Time or Distance standards for 54 provider type/population combinations in two zip codes (92678 and 92679).	**Phase 1:** ANC Roster provided by DHCS has been completed and submitted for the following: 1) ANC 2023 Cancer Center Validation_CalOptima Health 2) ANC 2023_Exhibit A-3 MPT Validation_CalOptima Health 3) ANC 2023_Exhibit A-5 Hospital Validation_CalOptima Health No further action required **Phase 2:** Time or Distance: CalOptima Health: Based on DHCS' time or distance analysis for this submission, CalOptima Health is submitting AAS requests. CalOptima Health used DHCS Medi-Cal Fee-for-Service Providers to identify the nearest OON providers to meet Time or Distance standards for 54 provider type/population combinations in two zip codes (92678 and 92679).
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Carol Matthews/Helen Syn	Quality Analytics	X	1) 144,837 mailings were sent to Medi-Cal members and 2,743 were sent to OneCare members 2) Medi-Cal- 90,237 member call attempts were made and 13,933 reached/scheduled callback (18.7%), OneCare-1,498 member call attempts were made and 541 reached (36.1%)	Continue with plan as listed
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	GARS	**New**	1) provider trends - highest trending provider group are several of the FQHC's - appointment availability, delays in referrals, delays in service, telephone accessibility. 2) transportation trends - NMT, MTM delays and no shows 3) access trend - impacted by the providers who were trending and missed appointments caused by the transportation delays of MTM 4) quality of care - missed appointments No trends identified in member appeals Provider appeals/disputes trends - past timely filing, no authorization on file and underpayment 1 of 16 SFH overturned - Medi-Cal 1 of 40 Maximus overturned - Medicare	The department will continue to perform quarterly and year to date reviews to identify trends. This information will be presented to GARS Committee as opportunities to improve operations across the organization. The department will host the next GARS Committee meeting on May 14.

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	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 - Caution Green - On Target	
Quality of Service	Customer Service	Implement customer service and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Andrew Tse	Mike Erbe	Customer Service		DHCS' average speed of answer of not exceeding 10 minutes: Goal was not met (15 min and 15 sec). Internal business goal of abandonment rate not exceeding 5% not met (20.2%). Challenges: call center experienced a large spike in call volume (159,664) due to transitions (Optum consolidation, Adult Expansion, Kaiser) and member engagement campaigns (i.e., text messaging, telephonic surveys).	Continue working with HR to onboard additional staff (permanent vacant positions or temporary staff), maintain the telephonic call back offering, and partner with other departments (QA, Equity and Community Health, etc.) to determine if replacing customer service phone number with member portal features would be a feasible option or containing member engagement interactions within the original mode of engagement (i.e., text messaging).	
Safety of Clinical Care	Coordination of Care: Member movement across settings	Improve care coordination between the hospital and primary care physician (PCP) following patient discharge from an acute care setting	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Stacie Oakley	TBD	Utilization Management	**New**	Refer to the TCS element	Refer to the TCS element	
Safety of Clinical Care	Coordination of Care: Member movement across settings	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Megan Dankmyer	TBD	Medical Management	**New**	MY2022 Eye Exam for Patients with Diabetes is a 62.6% and did not meet the 2023 CalOptima Health goal. November 2023 prospective rates is at 48.68% and below the hybrid goal. Final HEDIS rates for MY2023 is not yet available.	Staff to review the data and determine whether Eye Exam will continue to be the area of focus for monitoring continuity and coordination of care for members moving between practitioners.	
Safety of Clinical Care	Emergency Department Visits	Emergency Department Diversion Pilot Pilot has been implemented. In 2024,plan to expand the program to additional hospital partners.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	LTSS	X	The program has not been operationalized due to negotiations with UCI regarding the BAA and data useage agreement. New goal is 1st quarter of FY 2024-2025.	Continue to work with CalOptima Health contract department and UCI to monitor progress on executing the agreement.	
Safety of Clinical Care	Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% from Q4 2023 by end of December 31,2024.	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Stacie Oakley Hannah Kim Scott Robinson	Joanne Ku	Utilization Management Case Management Long Term Care	X	• Established TCS support line for low-risk members • A TCS support line flyer with CalOptima Health and HN contact information developed • Revised EA's report that identifies TCS high-risk members • Updated TCS County In-patient psychiatric hospital process workflow • Explored a texting campaign leveraging the Usher platform • Developed texting campaign messaging	•Gather data/reports on trends for TCS KPI/IPP measures •Work with ECM Providers to obtain ECM reporting data for KPI 5 •Implement texting campaign using Ushur platform •Update DTPs as appropriate	

Board of Directors' Quality Assurance Committee Meeting
June 12, 2024

Program of All-Inclusive Care for the Elderly (PACE)
Quality Improvement Committee
First Quarter 2024 Meeting Summaries

January 30, 2024: PACE Quality Improvement Committee (PQIC) and PACE Infection Control Subcommittee Summary of the Health Plan Monitoring Data and PACE Quality Initiatives

- Infection Control Subcommittee: PACE's Response to COVID-19:
  - PACE will continue to report on any updates in recommendations regarding COVID and any outbreaks or reporting trends for quality purposes
  - In Q4 there was a decline in the number of COVID-19 cases reported among staff and participants. There were 25 participant cases in Q3 and 14 cases in Q4.
  - PACE Staff to report exposure/illness to their supervisor and HR, and not to come in if feeling sick.
  - In October 2023 the CDC began recommending a newly approved 1-dose COVID vaccine regardless of past vaccination history. This vaccine is referred to as the "2023–2024 updated COVID-19 vaccine" and is produced by Pfizer, Moderna and Novavax.
  - As of December 31, 2023, 189 participants have received the 2023-2024 update vaccine- approximately 42.7% of participants.
- Presentation of Q4 2024 HPMS Elements:
  - Membership data presented. In terms of total membership, Q4 ended with 442 total enrolled. The goal of 479 was not met.
  - Immunizations
    - Pneumococcal Immunization rate is at 87% (no exclusions) 396 received, 32 prior immunizations, 21 refused and 7 missed opportunities.
    - The influenza Immunization rate is 81% (no exclusions). 370 received, 25 prior immunizations, 29 refused and 32 missed opportunities.
  - Falls without Injury. Q4 ended with 77. Most happened in the bedroom to go to the bathroom, and from not using DME. Loss of balance and Dizziness are the main contributing factors. Rehab continues to provide home visits for those who fell twice.

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  - Grievances. Decrease from 3 in Q3 to 2 in Q4. Both were transportation related.
  - Emergency Room Visits. 75 ER visits, a decrease of 23 from Q3. Trends in admission diagnoses: GI complaint, falls and UTI/Kidney/Urinary Issues.
  - Medication Errors Without Injury. 1 Medication Error reported in Q4 due to staff error. Actions taken to correct were staff education, in-service training done with the RNs and LVNs on 12/6/23.
  - Quality Incidents with Root Cause Analysis. 9 Falls with Injury, 1 Suicide Attempt (Participant has been discharged from PACE to family member), 2 Burn Injuries and 1 Unexpected Death (Drug Overdose).
- Presentation of the Q4 2023 PACE Quality Initiative Data
  - Advanced Health Care Directive
    - Goal: ≥ 50% of participants will have completed AHCD in 2023. Q4 ended at 36%. Though this initiative was not met in 2023, we will continue this initiative throughout 2024, increasing our goal to 70% of participants will have a completed AHCD by end of 2024.
  - Dental Satisfaction Quality Initiative.
    - Goal: ≤ 1 dental related grievance per quarter in 2023
    - 0 dental grievance reported in Q4 2023, goal met.
  - Transportation Satisfaction Quality Initiative
    - Goal is ≤ 3 **valid** transportation related grievance per quarter in 2023
    - Valid transportation grievances received in Q3 2023: 2, goal met.

January 30, 2024: PACE Quality Improvement Committee (PQIC) Summary Quality Assurance and Performance Improvement Work Plan

- Presentation of the 2023 Quality Work Plan Elements
  - *Elements 3 – 5: Immunizations*
    - Pneumococcal Immunization rate is at 93.5%. Goal of 94% was not met. No changes to this quality element in 2024.
    - Influenza Immunization rate is 89.27%. Goal of 94% was not met. No changes to this quality element in 2024.
    - Covid-19 Bivalent Booster is at 62.9%. Goal of 80% by end of 2023 was not met, however, this element was discontinued for Q4 2023, as the bivalent booster is no longer available. In 2024, Participants will receive the 2023-2024 Updated COVID booster. Goal is >50% with the latest CDC recommended COVID vaccine. At 42.7% at the end of Q4 2023.

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- *Element 6: POLST.* Goal is 95%. In Q4, 98% of participants had POLST added to their chart. Goal met. In 2024, there will be no changes to this quality element.
- *Elements 7 – 9: Diabetes Monitoring*
  - Blood Pressure Control. Goal is 84.21% having a blood pressure of <140/90mm. Rate is 89%. Goal not met. In 2024, significant changes to this Quality Element. In 2024, blood pressure will also be monitored for non-diabetic enrollees who meet certain criteria.
  - Diabetic Eye Exams. Goal of 85.42%. Rate is 89%. Goal met. In 2024, there will be no major changes to this Quality Element. The goal percentage will shift to 87.29% to match Medicare Quality Compass Goals.
  - Nephropathy Monitoring. Goal is 98.78%, Rate is 100% in monitoring Diabetes patients. This element has been removed for 2024 due to consistently being at 100% each quarter.
- *Element 10: Osteoporosis Treatment.* Goal of 100%. The rate is 82% of participants with Osteoporosis receiving treatment. Goat not met. This element has been changed for 2024. PACE will widen eligibility for DEXA scanning beyond only participants who fall.
- *Element 11: Reduce Percentage of Falls reported by PACE Enrollees.* Falls those results in fracture, hospitalization, and death. Q4 2023 ended with 87, with the number of 85 falls, higher than the Goal of <72 falls per quarter in 2023. Excluded were falls in a hospital or SNF is 2. In Q4, there was an increase of 7 falls, 3 participants with 4 or more falls and 11 participants with 2 falls each. In 2024, no changes to Quality Element.
- *Elements 12 - 13: Potentially Harmful Drug/Disease Interactions in the Elderly*
  - Dementia and Drug Interactions- Goal is <26.64% % of participants with Dementia will be prescribed a tricyclic antidepressant or anticholinergic agent. Excluded are participants with Palliative Care Approach dx and those with schizophrenia or bipolar disorder. Rate is 18%, goal met. In 2024, no major changes to Quality Element. Goal percent will shift to 25% to match Medicare Quality Compass Goals
  - CKD and drug interactions–Goal of <2.62% % of participants with CKD 3,4, or 5 (end stage) will be prescribed a Nonaspirin NSAIDS or Cox2 Selective NSAIDs. Rate is 1.2%, goal met. 2024- This element has been removed for 2024 due to consistently meeting goals each quarter.

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- *Element 14: Decrease the Use of Opioids at High Dosage.* Goal: 100% of members receiving opioids for 15 or more days at an average milligram morphine dose of (MME) 90mg will be reevaluated monthly by their treating provider. Actual: Met goal. Only 1 participant received a dose greater than 90 MME and had PCP follow up each month in Quarter 4 2023
- *Element 15: Medication Reconciliation Post Discharge (MRP)*. Goal is 90% within 15 days. Rate is 100%, goal met. The goal percentage will increase from 90% to 93% in 2024.
- *Element 16: Access to Specialty Care.* Goal is ≥ 88% to be scheduled within 14 business days. 83% in Q4 2023. Goal not met. Contributing factors for not meeting goals are shortage of staff and holidays in December. In 2024 specialty appointments will be scheduled within 14 calendar days (vs. *business days* in 2023).
- *Element 17: Acute Hospital Days.* Goal is <3,330 in 2022. There was a significant decrease of the bed days in Q4 2023, goal met. In Q4, bed days are 2,760.
- *Element 18: Emergency Room Visits.* Rate is 801. Below the goal of 850 emergency room visits per 1000 per year. In 2024, goal will change to 825 ER visits per 1000 per year.
- *Element 19: 30-Day All Cause Readmissions.* Goal is <14%. The rate significantly went down from 26% to 7%, goal met. 2024, there will be no significant changes to Quality Element. Participants who are readmitted for scheduled treatment, such as cancer treatment, will now be excluded.
- *Element 20: Long Term Care Placement.* Goal is <4%. Rate was 0% in Q4, goal met. Long Term Care Placement are participants placed in custodial care in SNF in any period.
- *Element 21: Enrollment Conversion*. Goal is >65%. Rate is 71%. Goal met. In 2024, the goal will change from 65% to 70%.
- *Element 22*: *90 Day Disenrollment* Goal is > 6.5%. Rate is 0%, goal met. Total disenrollments were 20, 0 was controllable and 1 was uncontrollable. The goal will change from 6.5% to 6% in 2024.
- *Element 23: Attrition Rate*. Goal is <10%. Rate is 4.53%, goal met. The goal will change from 10% to 8% in 2024.
- *Element 24: Transportation <60 minutes.* In Q1 2024 we were alerted to an error in the data validation and reporting of one-hour violations to the PACE program. CMS/DHCS as well as the Secure Transportation Executive team and CalOptima Health regulatory compliance teams were notified. Secure team has been placed on a corrective action plan which is

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ongoing. This corrective action plan includes daily reports to PACE leadership regarding 60 minutes violations.

- *Element 25: Transportation on Time Performance.* On time performance data gathered directly from Secure transportation report to reflect on time trips with a +/- 15-minute window. The goal is ≥92% of all transportation rides will be on-time. Rate is 80%. Goal not met.
- *Element 26-28: Participant Satisfaction*
  - Element 26: Transportation Satisfaction. Satisfaction with transportation increased significantly in 2023. Satisfaction rate of 95% compared to 89% in 2022- 6 percentage points above the previous year and above the national average for 2023. In 2024, the same goal of ≥93.6% will be maintained to compare with 2023 national PACE averages. 2024 Quality Workplan also includes a Quality Initiative to address participant concerns with transportation to maintain continued satisfaction and reduce grievances.
  - Element 27: Meal Satisfaction. Satisfaction with meals increased in 2023, well above the national PACE average. Satisfaction rate of 88% in 2023 compared to 82% in 2022. In 2023, an active effort was made to present a variety of meals which were not only nutritious, but also consistent with the cultural background of the participants. Most participants surveyed indicated that the meals looked good, tasted good and were varied. The dietary team monitored participant meals, frequently adjusting menus to be consistent with therapeutic diet parameters as well as an individual's preference. This domain will continue to be monitored in 2024.
  - Element 28: Overall Satisfaction. Overall Satisfaction increased significantly in 2023 and exceeded the goal of maintaining the national average or above. Rate of 94% in 2023 compared to 89% in 2022. The national average rate is 88.6%. In 2024, the plan is to have all alternative care settings in use, reduce transportation related grievances, and maintain the highest possible level of service satisfaction across all domains.
- New Elements for 2024
  - Colorectal Cancer Screening. This element has been added for 2024 to improve compliance with recommendations for colorectal screening of older adults. Goal: >65% of eligible participants will have had a screening for colorectal cancer by December 31st, 2024.

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- Breast Cancer Screening. This element has been added for 2024 to improve compliance with recommendations for breast cancer screening of older adults. Goal: >82.56% of eligible participants will have a screening for breast cancer by December 31st, 2024.
- Diabetic Blood Sugar Monitoring. This element has been added for 2024 to improve compliance with recommendation for monitoring of HbA1c in our participant population. Goal: <11.78% of Diabetic participants will have an HbA1c measurement of >9%
- Improve Utilization of Alternative Care Sites (ACS). This element has been added for 2024 to ensure we are properly utilizing the ACS that we currently have available to PACE. Goal: ≥15% of all eligible PACE Enrollees will utilize day center services at one of the PACE Alternative Care Settings by the end of 2024.

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Member Trend Report 1st Quarter 2024

Quality Assurance Committee Meeting
June 12, 2024

Tyronda Moses, Director, Grievance and Appeals

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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Overview of Presentation

- Definitions
- Grievances by Line of Business
  - Per 1,000 Member Month (M/M)
  - Trends
- Appeals Overturned by Line of Business
- Trends Identified and Remediation Activities

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CalOptima Health

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

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CalOptima Health

Grievances by Line of Business

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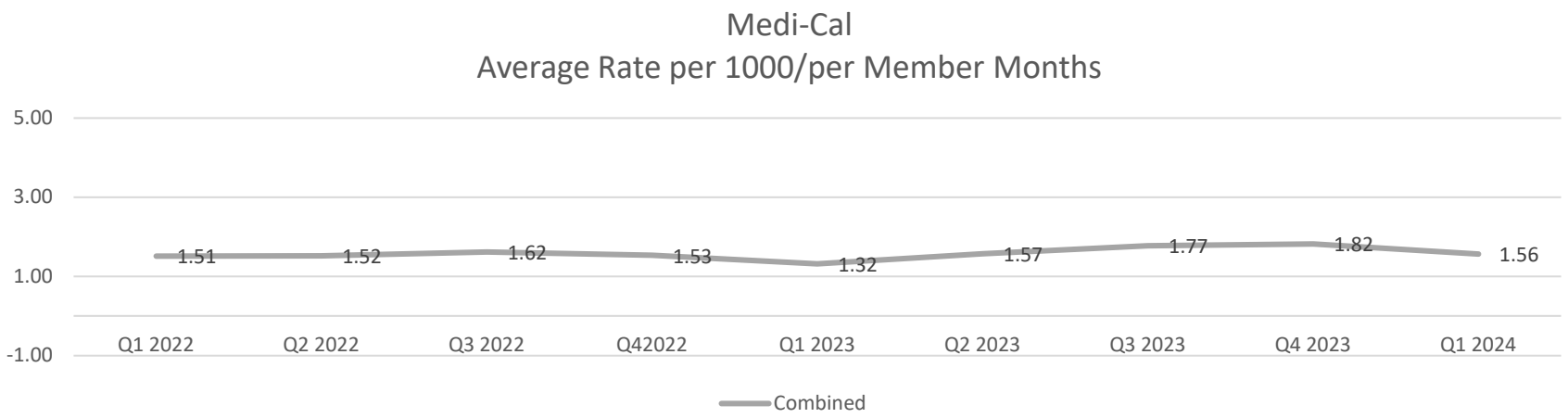
Medi-Cal Grievances Rate per 1,000



Quarter	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024
Customer Serv. r/1000	.17	.16	.17	.20	.18	.24	.34	.38	.42
Customer Serv. Ct	428	438	461	553	507	719	995	1030	1153
GARS r/1000	1.35	1.35	1.45	1.33	1.14	1.33	1.42	1.44	1.14
GARS Ct.	3491	3599	3940	3694	3278	3923	4127	4090	3127
Combined r/1000	1.51	1.52	1.62	1.53	1.32	1.57	1.76	1.82	1.56
Combined Ct.	3919	4037	4401	4247	3785	4642	5122	5180	4280

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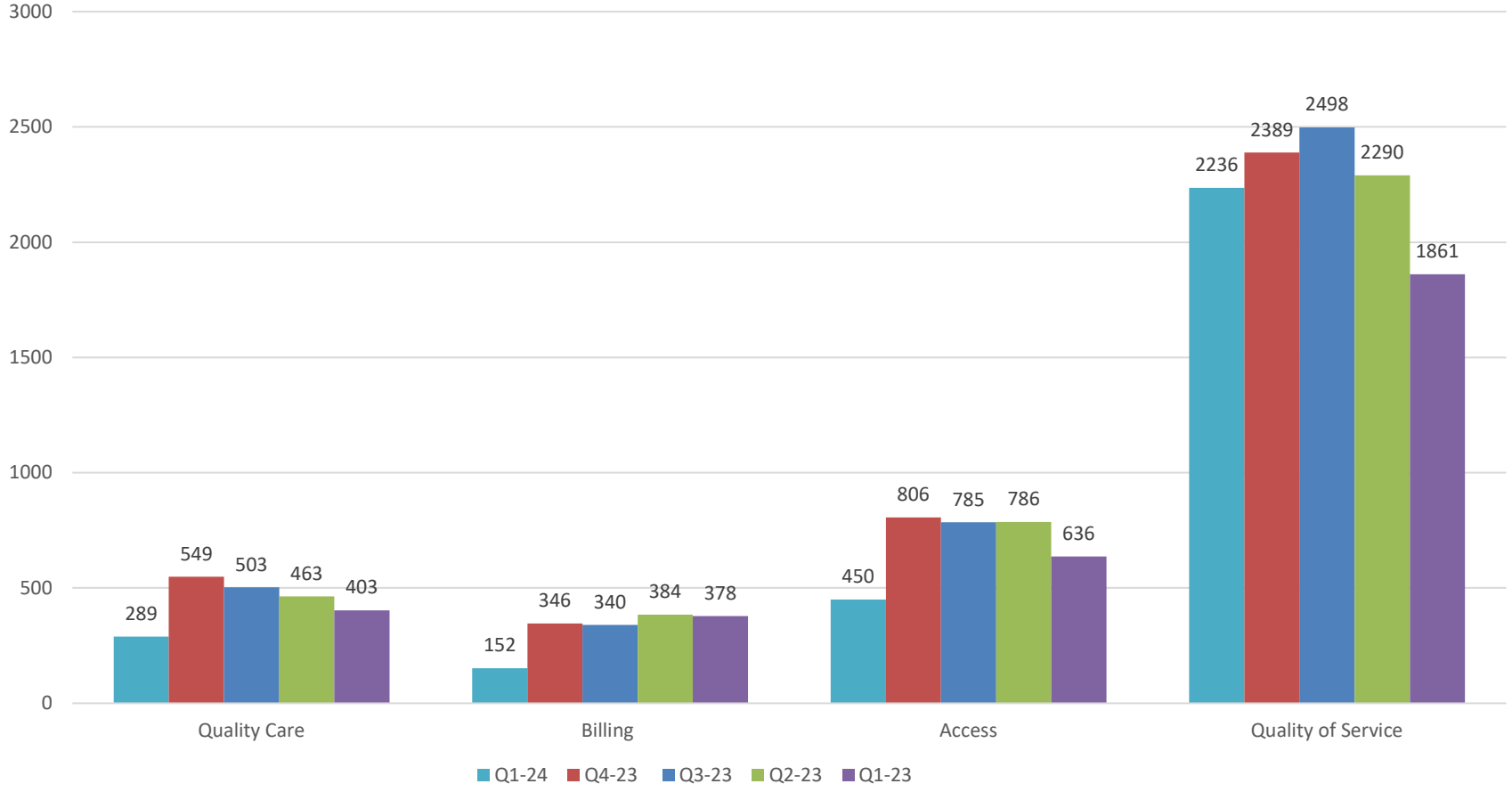
CalOptima Health

Medi-Cal Member Grievances by Category



Trends within Categories:
Quality of Service – Transportation, Delay in Referral Provider
Access – Appointment Availability and Referral Related
Billing – Member Billing-HN, Member Billing –COD
Quality of Care – Question in Treatment, Delay in Treatment

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CalOptima Health

Medi-Cal Member Grievances by Health Network

	Billing & Financial 10%	Quality of Care 12%	Access 20%	Attitude/ Quality Service 58%			
Health Network	**Q1 Total (rate/thousand)**	**Q1 Total (rate/thousand)**	**Q1 Total (rate/thousand)**	**Q1 Total (rate/thousand)**	**1st Qtr Total**	**1st Qtr Rate per 1000/ per MM**	**Membership Avg**
CCN	32 (0.08)	113 (0.27)	160 (0.38)	751 (1.76)	1056	2.48	141,962
Heritage	1 (0.03)	6 (0.19)	8 (0.26)	26 (0.84)	41	1.32	10,362
Optum	57 (0.09)	69 (0.11)	141 (0.23)	517 (0.86)	784	1.31	200,032
Prospect	6 (0.04)	21 (0.16)	13 (0.10)	65 (0.49)	105	0.79	44,583
UCMG	6 (0.04)	5 (0.04)	17 (0.12)	65 (0.48)	93	0.68	45,448
AltaMed	3 (0.01)	23 (0.11)	21 (0.10)	90 (0.42)	137	0.63	71,966
COD	31 (0.07)	10 (0.02)	30 (0.07)	157 (0.37)	228	0.53	142,982
Noble	2 (0.03)	6 (0.08)	4 (0.06)	23 (0.32)	35	0.48	24,212
Family Choice	4 (0.03)	5 (0.03)	7 (0.05)	37 (0.25)	53	0.36	48,525
CHA	6 (0.01)	10 (0.02)	26 (0.06)	100 (0.21)	142	0.31	155,126
AMVI	2 (0.02)	3 (0.03)	4 (0.05)	13 (0.15)	22	0.25	29,107
Plan Provided							
Vision Services	1 (0.00)	0 (0.00)	1 (0.00)	7 (0.00)	9	0.00	914,304
Behavioral Health	1 (0.00)	9 (0.00)	12 (0.00)	46 (0.02)	68	0.02	914,304
NMT Transportation	0 (0.00)	9 (0.00)	6 (0.00)	338 (0.12)	353	0.13	914,304
Grand Total	152	289	450	2236	**3127**	**1.14**	**914,304**

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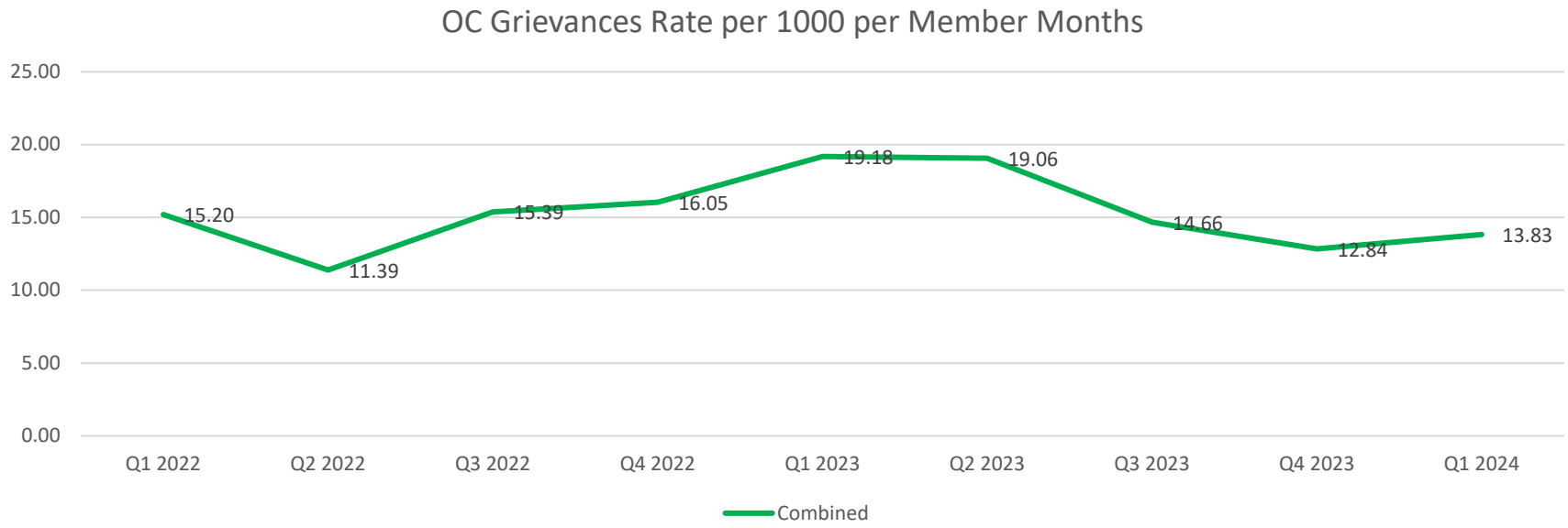
CalOptima Health

OneCare Grievances



Quarter	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024
OC_Customer Serv. r/1000	11.85	8.58	12.22	11.51	4.45	4.70	4.43	3.48	4.81
OC-Customer Serv. Ct	85	67	104	104	232	251	236	184	250
OC-GARS r/1000	3.35	2.82	3.17	4.54	14.74	14.35	10.23	9.36	9.02
OC-GARS Ct.	24	22	27	41	769	766	545	495	469
Combined r/1000	15.20	11.39	15.39	16.05	19.18	19.06	14.66	12.84	13.83
Combined Ct.	109	89	131	145	1001	1017	781	679	719

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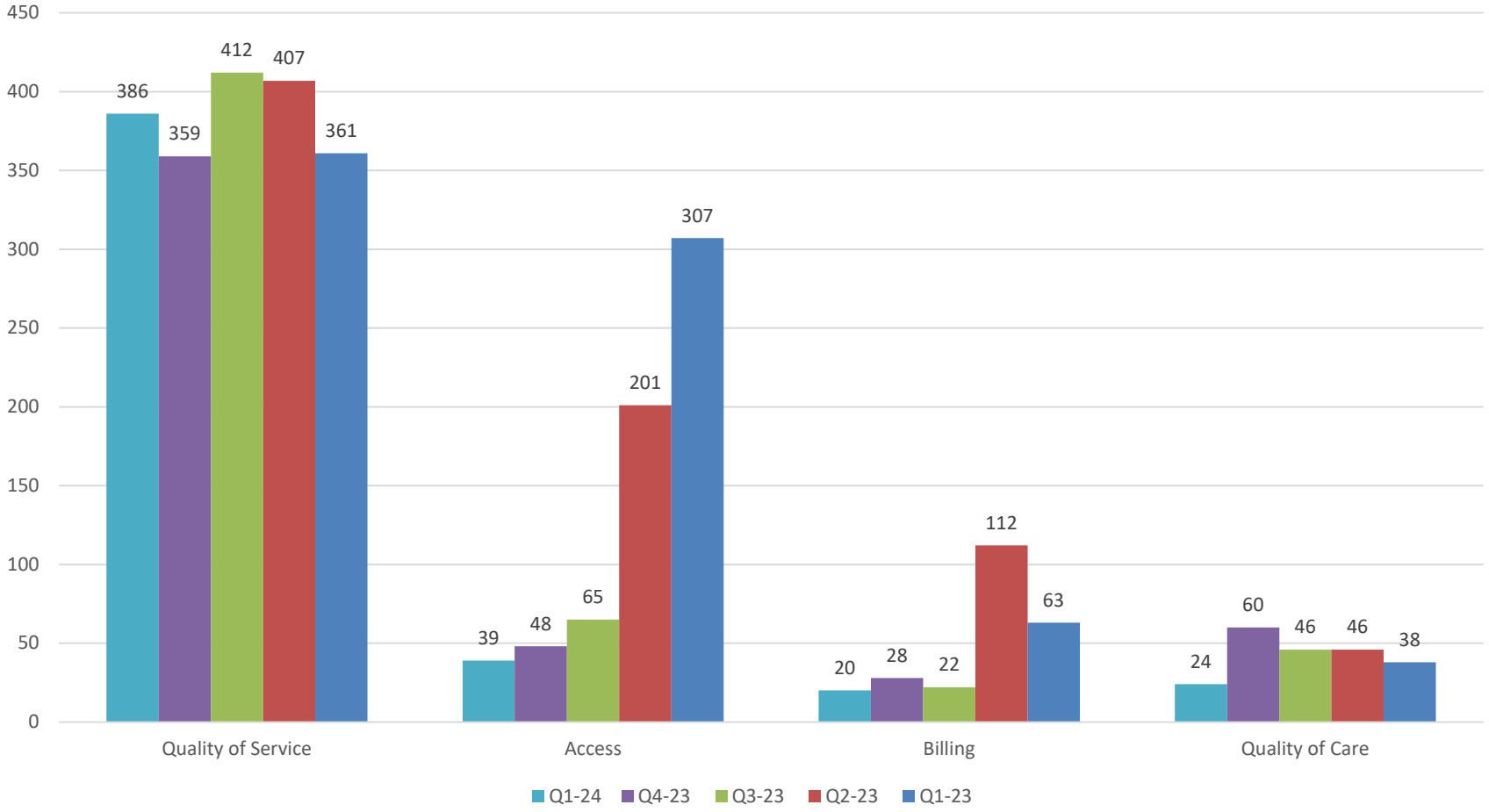
OneCare CalOptima Health

OneCare Member Grievances by Category



Top Reasons by Category

Quality of Care: Question Treatment, Delay in Treatment
Billing: Member Billing COD, Member Billing HN
Access: Referral related, Telephone Accessibility
Quality of Service: Transportation, Provider Services

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OneCare CalOptima Health

OneCare Member Grievances by Health Network (Q1 Total (rate/thousand))

	Billing/ Financial 4%	Quality of Care 5%	Access 8%	Attitude/ Quality Service 82%		
Health Network	**Q1**	**Q1**	**Q1**	**Q1**	**Qtr1 Total**	**QTR1 Rate per 1000 per month**
Prospect	1 (0.15)	3 (0.44)	8 (1.18)	41 (6.05)	**53**	**7.8**
Optum	15 (0.65)	14 (0.61)	18 (0.78)	128 (5.55)	**175**	**7.6**
CCN OC	4 (0.47)	5 (0.59)	5 (0.59)	51 (5.97)	**65**	**7.6**
Alta Med Health	0 (0.00)	0 (0.00)	5 (1.73)	9 (3.12)	**14**	**4.9**
Regal	0 (0.00)	0 (0.00)	0 (0.00)	3 (4.33)	**3**	**4.3**
Family Choice	0 (0.00)	1 (0.18)	0 (0.00)	11 (1.93)	**12**	**2.1**
UCMG	0 (0.00)	0 (0.00)	0 (0.00)	4 (1.81)	**4**	**1.8**
AMVI Care	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.92)	**1**	**0.9**
Noble	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	**0**	**0.0**
Plan Provided						
Behavioral Health	0 (0.00)	0 (0.00)	0 (0.00)	1 (0.02)	**1**	**0.0**
Convey Health (OTC)	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	**0**	**0.0**
Silver and Fit	0 (0.00)	0 (0.00)	0 (0.00)	0 (0.00)	**0**	**0.0**
Vision Services	0 (0.00)	1 (0.02)	0 (0.00)	1 (0.02)	**2**	**0.0**
NMT Transportation	0 (0.00)	0 (0.00)	1 (0.02)	133 (2.56)	**134**	**2.6**
Grand Total	**20**	**24**	**39**	**386**	**469**	**9.0**
YTD	**20**	**24**	**39**	**386**		

Q2 2023 Grievance Total: 766
Q3 2023 Grievance Total: 545
Q4 2023 Grievance Total: 495
Q1 2024 Grievance Total: 469

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OneCare CalOptima Health

Appeals Overturned

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Overall Member Appeals Summary

- Member Appeals decreased from 420 in Q4, 2023 to 407 in Q1, 2024 for all LOB.

- Overturn rate on appeals for Q1 2024: (129/407) 32%
  - Overturn reasons:
    - Additional records received
    - Medical criteria not applied on the initial review used at the appeal level to support the requests
    - Missing information not available at the initial review received at the time of appeal

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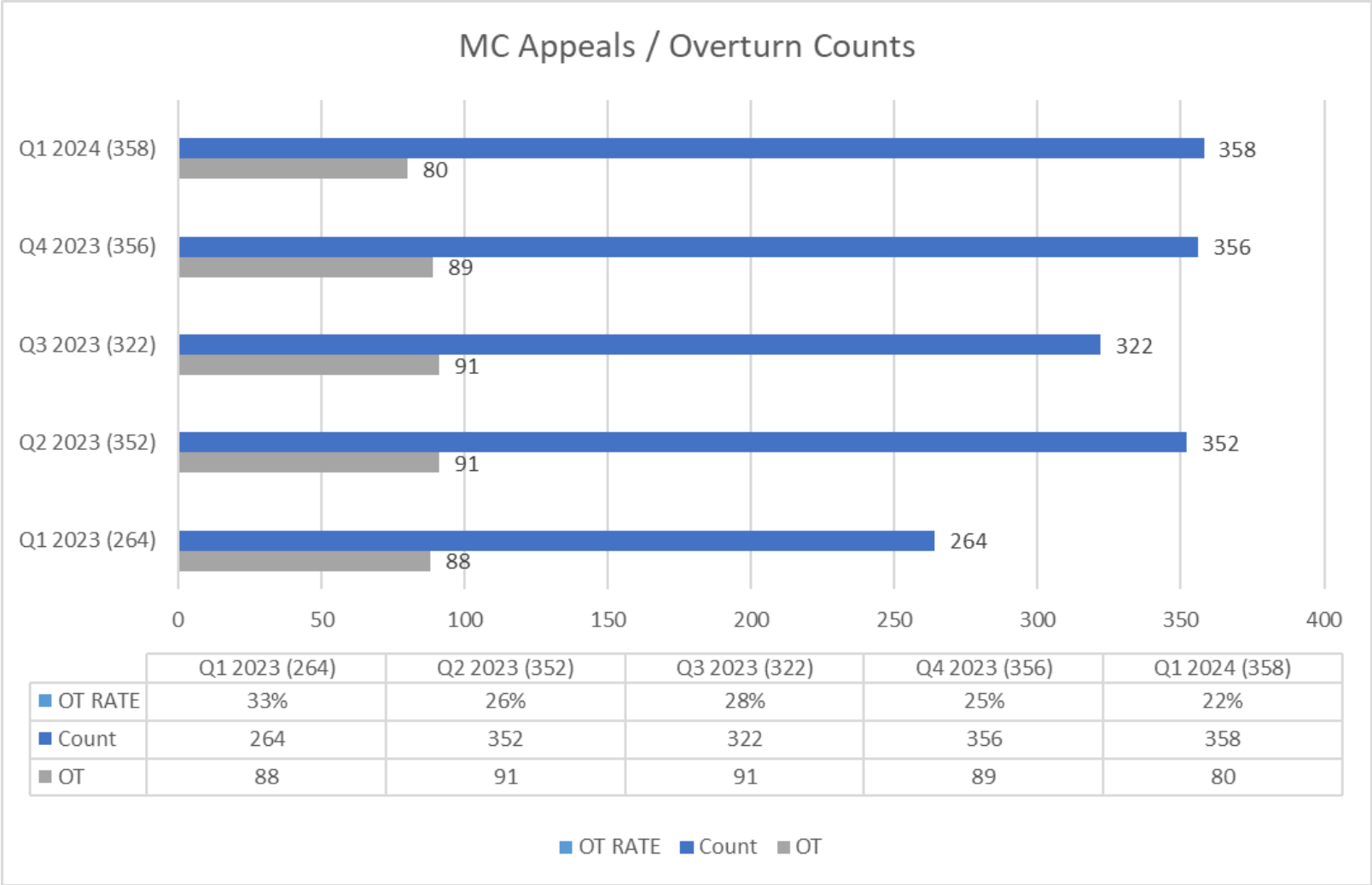
CalOptima Health

Medi-Cal Appeals – Overturns by Quarter



	Q1 2023 (264)	Q2 2023 (352)	Q3 2023 (322)	Q4 2023 (356)	Q1 2024 (358)
OT RATE	33%	26%	28%	25%	22%
Count	264	352	322	356	358
OT	88	91	91	89	80

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Medi-Cal State Hearings

11 Hearings Requested in Q1 2024

Decision	Reason	Total
Upheld/Partial	• Medical necessity not met • Out of Network	3
Dismissed	• Dismissed by State	7
Overturned	• Medical Necessity met	1

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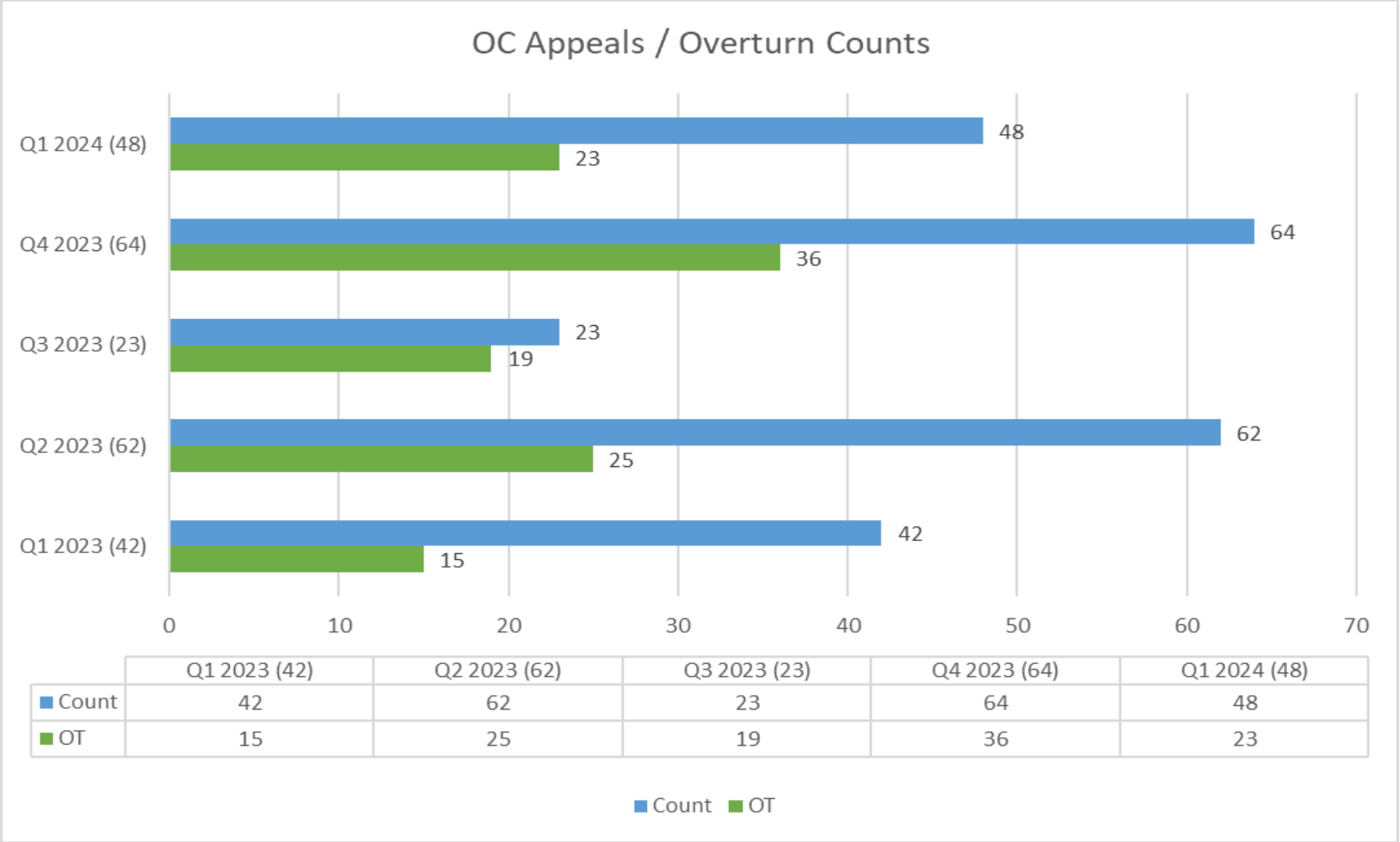
Medi-Cal
CalOptima Health

OneCare Appeals – Overturns by Quarter



	Q1 2023 (42)	Q2 2023 (62)	Q3 2023 (23)	Q4 2023 (64)	Q1 2024 (48)
Count	42	62	23	64	48
OT	15	25	19	36	23

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OneCare CalOptima Health

OneCare External Appeals Q1 2024

Medicare Quality Improvement Organization (QIO), Livanta, appeals:

Total Received	Upheld	Overturned
25	19	6

Independent Review Entity (IRE): Maximus, Level 2 appeals:

Total Received	Upheld	Overturned
26	22	4

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Remediation Activities

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Claims Overview

Identified Issues	Remediation Activities
Place of Service (POS) 10 Telehealth denied incorrectly	Medi-Cal adopted POS 10 on 1/1/2023. Facets system update was made on 12/19/2023. Claims Administration to run a report for a claims sweep to adjust all related claims previously processed. This should be completed by end of May.
CPT code T4541 (Incontinence product, disposable underpad) with Universal Product Number 090891706143 denied as invalid	This product/manufacturer combination was added to the Medi-Cal list of Contracted Incontinence Absorbent Products effective 12/01/2023. Update made to the Incontinence/Medical Supplies Calculator on 03/20/2024 (in Facets). Update allows new claims to price correctly. Claims Administration to run a report for a claims sweep to adjust all related claims previously processed. This should be completed by end of June.

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Network Operations Overview

Identified Issues	Remediation Activities
Prospect denying Out of Area (OOA) Hospital claims as Health Plan's risk	Prospect is an HMO and at risk for OOA claims. Health Network Relations has requested the health network educate their claims team or update their system to ensure OOA for OC and MC members are paid.
Family Choice Medical Group denying GEMT add-on reimbursement rates	Provider, Emergency Ambulance Services, requested CalOptima intervention - High outstanding balance due to non-payment of the GEMT add-on rate - Reported to Network Relations as likely systemic issue – asking for a claim sweep on May 5th.
Delays from Optum: Effectuation - obtaining authorization on Overturned Appeals Response for records request	Escalation Process has been utilized for these cases: - Leadership at Optum is called - Network Relations has had to escalate in some instances as well GARS is monitoring Optum closely – logging concerns for scheduled meetings with Optum. Optum created distinct fax numbers (department specific) that separate grievances from appeals. They have indicated that this will allow for priority by complaint type. We should see a decrease in delays in Q2.
Authorization denial or redirection	• Trending for tertiary level of care providers • Recommendation made to remove them from the directory (UCI) • PDMS is reviewing for consideration.

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Customer Service Overview

Identified Issues	Remediation Activities
Medi-Cal – increased in member withdrawn grievances	• Monthly meeting workgroup between GARS and CS to review identified grievance cases closed as withdrawn. • Case reviews include listening to CS calls. • Validation to determine if member was requesting service assistance or requesting to submit a grievance. • Review of cases for training opportunities. • Adherence to APL 21-011 guidance: if member declines to file a grievance, the complaint must still be categorized as a grievance and not an inquiry

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Medical Management Overview

Identified Issues	Remediation Activities
OneCare members receiving denials with Medi-Cal verbiage which may impact the cases that need to be submitted to Maximus. Per regulation, denial letters should be integrated and cite both Medicare and Medi-Cal verbiage.	• Discussed this finding with UM leadership in Q4 and was advised the authorization process is a split between HN and CalOptima for Medicare vs. Medi-Cal benefits which may cause the issue. • Internal Audit team recently performed an audit on OneCare UM, awaiting their feedback related to this issue. • Discussions with UM, Compliance and Medicare Operations on whether member will receive one integrated denial letter. • Request For Guidance (RFG) submitted to Compliance on 5/3/2024 for further information.
Behavioral Health – ABA denials	• Trend identified in February (via Call Center, Grievances and Appeals) • Root Cause – denials implemented for incomplete records. Previously passed through with education to the provider. • Provider Training on appropriate submission completed May 9
Expedited Discharge Appeals/Grievances	• Increased volume of expedited request due to members receiving discharge information • Met with CM/UM in April – Transition of Care contacts at all Health Networks was shared with GARS • To continue the discussion in Q2 2024

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