



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

**WEDNESDAY, MAY 18, 2016
5:30 P.M.**

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

Board of Directors' Quality Assurance Committee

Viet Van Dang, M.D., Chair

Ellen Ahn

Theresa Boyd

Samara Cardenas, M.D.

Tricia Nguyen

CHIEF EXECUTIVE OFFICER

Michael Schrader

CHIEF COUNSEL

Gary Crockett

CLERK OF THE BOARD

Suzanne Turf

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

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

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

CALL TO ORDER

Pledge of Allegiance

Establish Quorum

PUBLIC COMMENTS

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

CONSENT CALENDAR

1. [Approve Minutes of the March 23, 2015 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee](#)

REPORTS

2. [Recommend Board of Directors' Approval of Proposed Technical Changes to Policy GG.1643: Minimum Physician Standards](#)

INFORMATION ITEMS

3. [PACE Member Advisory Committee Update](#)
4. [Behavioral Health Request for Proposal Update](#)
5. [Quality Improvement Committee Update](#)
6. [Member Experience Update](#)

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

NEXT REGULAR MEETING: Wednesday, September 21, 2016 at 5:30 p.m.

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

March 23, 2016

CALL TO ORDER

Chair Viet Van Dang, M.D., called the meeting to order at 5:32 p.m., and led the Pledge of Allegiance.

Members Present: Viet Van Dang, M.D., Chair; Ellen Ahn; Samara Cardenas, M.D.; Tricia Nguyen (at 5:42 p.m.)

Members Absent: Theresa Boyd

Others Present: Michael Schrader, Chief Executive Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Ladan Khamseh, Interim Chief Operating Officer; Gary Crockett, Chief Counsel; Suzanne Turf, Clerk of the Board

PUBLIC COMMENTS

Pam Pimentel, R.N., MOMS Orange County – Oral re: Highlights of recently published evaluation of the impact of MOMS program on birth outcomes.

CONSENT CALENDAR

1. Approve the Minutes of the November 18, 2015 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: *On motion of Director Cardenas, seconded and carried, the Committee approved the Minutes of the November 18, 2015 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Directors Boyd and Nguyen absent)*

REPORTS

2. Receive and File the 2015 CalOptima Quality Improvement Work Plan and Evaluation

Caryn Ireland, Executive Director of Quality and Analytics, presented the 2015 CalOptima Quality Improvement (QI) Work Plan and Evaluation. It was reported that the 2015 QI Program achieved its key performance goals during the year based on the 2015 QI Work Plan. A review of the 2015 accomplishments was provided, including: long-term support services program initiatives pertaining to safety, quality and clinical initiatives; access and availability monitoring; clinical quality measures;

participation in projects related to all-cause readmissions and prenatal visit rates for pregnant women; member experience improvement; and member cultural and linguistic needs.

Ms. Ireland also reviewed opportunities for 2016, including continuity and coordination of care between medical and behavioral health, continued improvement of HEDIS, Stars, and CAHPS scores, and continued enhancement of the Model of Care.

Action: *On motion of Director Cardenas, seconded and carried, the Committee received and filed the 2015 CalOptima Quality Improvement Work Plan and Evaluation as presented. (Motion carried 3-0-0; Directors Boyd and Nguyen absent)*

3. Recommend Board of Directors' Approval of the CalOptima 2016 Quality Improvement (QI) Program and 2016 Quality Improvement Work Plan

Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend Board of Directors' approval of the recommended revisions to the CalOptima 2016 QI Program and 2016 QI Work Plan. Dr. Bock provided an overview of the revisions for 2016, including updated information pertaining to the Behavioral Health network, the adoption of the annual Utilization Management Work Plan that complements the QI Program, and goals and responsibilities of the Credentialing and Peer Review Committee. Dr. Bock also reported on the 2016 program description revisions and the 2016 work plan enhancements.

Action: *On motion of Director Cardenas, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima 2016 Quality Improvement Program and 2016 Work Plan as presented. (Motion carried 4-0-0; Director Boyd absent)*

4. Receive and File the 2015 CalOptima Utilization Management Work Plan and Evaluation

Frank Frederico, Utilization Management Medical Director, provided an overview of the 2015 CalOptima Utilization Management (UM) Work Plan and Evaluation. The projects and initiatives during 2015 included the integration of a new medical management system, improved reporting and review of appropriate use of specialty drugs, improved data collection and reporting of behavioral health for Medicare and Medi-Cal, and improved oversight and monitoring of UM delegate performance. Operational and utilization performance was also reviewed with the Committee.

Action: *On motion of Director Nguyen, seconded and carried, the Committee received and filed the 2015 CalOptima Utilization Management Work Plan and Evaluation as presented. (Motion carried 4-0-0; Director Boyd absent)*

5. Recommend Board of Directors' Approval of the CalOptima 2016 Utilization Management Program and 2016 Utilization Management Work Plan

Debra Armas, Utilization Management Director, presented the action to recommend Board of Directors' approval of the CalOptima 2016 Utilization Management Program and 2016 Utilization Management (UM) Work Plan. A review of the recommended changes to the UM Program for 2016 was provided, including the addition of long-term services and support guidelines, pharmacy turnaround time guidelines, pharmacy denial and appeals rights and process, and updated information pertaining to Behavioral Health services.

Action: *On motion of Director Cardenas, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima 2016 Utilization Management Program and 2016 UM Work Plan as presented. (Motion carried 4-0-0; Director Boyd absent)*

6. Receive and File the 2015 Program of All-inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement (QAPI) Plan Evaluation

Miles Masatsugu, M.D., Medical Director, presented a review of the 2015 PACE QAPI evaluation. Accomplishments during 2015 included the successful completion of the year two audit by the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services, the addition of bilingual/multilingual staff, a new dementia care day program, outdoor day program, and two rehabilitation exercise programs. Opportunities for improvement in 2016 include the implementation electronic medical records, access and availability monitoring, the addition of a patient satisfaction quality improvement project, and implementing new utilization management metrics and a new PACE UM committee.

Action: *On motion of Director Cardenas, seconded and carried, the Committee received and filed the 2015 PACE QAPI as presented. (Motion carried 4-0-0; Director Boyd absent)*

7. Recommend Board of Directors' Approval of the 2016 PACE QAPI Plan

Dr. Masatsugu presented the action to recommend Board of Directors' approval of the 2016 PACE QAPI Plan and 2016 QAPI Work Plan. The 2016 program includes new patient satisfaction metrics and goals, changed goals regarding Physician Orders for Life-Sustaining Treatment, new clinical measures for diabetes, detailed utilization management metrics to enhance oversight, and updated CMS guidance to report unusual incidents. The enhancements to the 2016 QAPI Work Plan include formal reporting of work plan elements with the Quality Improvement Committee, patient satisfaction and member experience metrics, and a focus on utilization management.

Action: *On motion of Director Cardenas, seconded and carried, the Committee recommended Board of Directors' approval of the 2016 PACE QAPI and 2016 QAPI Work Plan as presented. (Motion carried 4-0-0; Director Boyd absent)*

8. Recommend Board of Directors' Approval of the Expenditure of Intergovernmental Transfer (IGT) Funds to Expand the Shape Your Life Program Countywide

Dr. Masatsugu presented the action to recommend Board of Directors' approval of the use of \$250,000 of the allocated \$500,000 in IGT 1 funds to expand the Shape Your Life program to be used on a consultant to assist staff in refining and expanding the program countywide. As proposed, a RFP process will be conducted to complete an evaluation of CalOptima's current childhood obesity intervention providers to determine capacity, refine the current childhood obesity risk stratification, develop evidence-based core curriculum, outcome metrics, and sustainable reimbursement rates for moderate and high-risk obesity interventions. An analysis will be completed after the first year of the expansion to examine costs and outcome metrics.

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

Action: ***On motion of Director Cardenas, seconded and carried, the Committee directed staff to continue further study and return to the full Board with recommendations for consideration. (Motion carried 4-0-0; Director Boyd absent)***

9. Recommend Board of Directors' Approval of Measurement Year CY 2016 Pay for Value Programs for Medi-Cal and OneCare Connect

Dr. Bock presented the action to recommend Board of Directors' approval of the Measurement Year CY 2016 Pay for Value Programs for Medi-Cal and OneCare Connect, subject to regulatory approval, as applicable. The proposed Measurement Year CY 2016 Medi-Cal Pay for Value (P4V) program is a one-year program using calendar year 2016 HEDIS measurements for which payments will be made in 2017. Dr. Bock reviewed the changes for the Medi-Cal P4V, which include performance for both adult and child care that addresses the needs of children in all health networks, the introduction of an "acuity" calculation to address the unique health needs in the populations, the addition of measures for adult access to preventative and ambulatory care services, and children's access to primary care physicians. It was noted that the measures for Provider Satisfaction with the Health Network and UM Process will be retired.

It was reported that the OneCare Pay for Value program will be retired due to the transition of the majority of former OneCare members to OneCare Connect. The OneCare Connect P4V measures are pending regulatory approval. It was also recommended to reinstate P4V measures for Windstone Behavioral Health.

Action: ***On motion of Director Cardenas, seconded and carried, the Committee recommended Board of Directors' approval of the Measurement Year CY 2016 Pay for Value Programs for Medi-Cal and OneCare Connect as presented. (Motion carried 4-0-0; Director Boyd absent)***

10. Recommend Board of Directors' Approval and Reinstatement of Updated Policy GG.1643 Minimum Physician Standards

Ms. Ireland presented the action to recommend Board of Directors' approval and reinstatement of Policy GG.1643 Minimum Physician Standards (MPS). It was noted that the MPS were approved in 2002 and retired in 2010, and the requirements were recently included in the credentialing applications. The proposed updated policy differs from the retired policy as follows: MPS will only apply to all new (first time applicants to CalOptima) Physicians (Doctors of Medicine, Doctors of Osteopathy, and Doctors of Podiatric Medicine), who are applying to participate in a CalOptima or a CalOptima delegated network; new objective criteria added that the applicant practitioner must not currently be on probation or have an accusation pending with their licensing board; and, added a section that the applicant must be board certified in their specialty. The proposed MPS will be distributed to physicians as part of a pre-application attestation process. Physicians would have to satisfy all of the minimum physician standards to be credentialed in CalOptima or through a CalOptima delegated network.

Action: ***On motion of Director Cardenas, seconded and carried, the Committee recommended Board of Directors' approval and reinstatement of updated Policy GG.1643, Minimum Physician Standards as presented. (Motion carried 4-0-0; Director Boyd absent)***

INFORMATION ITEMS

The following Information Items were accepted as presented.

11. PACE Member Advisory Committee Update
12. Quarterly Reports to the Quality Assurance Committee

ADJOURNMENT

Hearing no further business, Chair Dang adjourned the meeting at 7:22 p.m.

/s/ Suzanne Turf

Suzanne Turf
Clerk of the Board

Approved: May 18, 2016

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 18, 2016 **Regular Meeting of the CalOptima Board of Directors** **Quality Assurance Committee**

Report Item

2. Recommend Board of Directors' Approval of Proposed Technical Changes to Policy GG.1643: Minimum Physician Standards

Contact

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

Recommended Action

Recommend Board of Directors' approval of the proposed technical changes to Policy GG.1643: Minimum Physician Standards.

Background

On April 7, 2016, the CalOptima Board of Directors approved a new policy, GG.1643: Minimum Physician Standards. Under that policy, physicians wishing to participate as contracted providers in CalOptima Direct are required to attest that they meet a set of minimum physician standards, which are then verified by CalOptima staff, before being provided a credentialing application. Health Networks are required to ensure that all physicians meet the same minimum standards before providing services to any CalOptima Members, but Health Networks are free to choose the manner in which they integrate the minimum standard requirements into their credentialing process.

Discussion

Certain technical language issues requiring modification or clarification were identified subsequent to approval of Policy GG.1643. Staff proposes the following technical changes to Policy GG.1643 as reflected in the attached draft amended policy:

- Since Healthcare Delivery Organizations (HDOs) are not delegated to credential physicians, HDOs were removed from an earlier draft of the policy. The proposed revision is to also delete the definition of HDO as it is not necessary.
- The effective date placeholder was inadvertently left in the policy as approved. Section III.A. should have reflected a July 1, 2016, effective date. The proposed revised policy adds this date.
- A reference to "Physician Assistants" was inadvertently left included in Section III.A.2. However, the proposed policy does not cover Physician Assistants such that this change removes this reference.

The reference in Section III.A.8 limiting the coverage of that subsection to physicians is not necessary as the policy is limited to physicians. Therefore, the proposed revised policy deletes that limitation, and adds a reference to the fact that there are exemptions in the Board Certification Policy that may affect some applicants.

- Section IV.A. is modified to clarify that the process outlined in this Section only applies to prospective CalOptima Direct physicians, and not to Health Network physicians. Health Networks may implement the minimum standard requirements as they choose as long as the physicians meet the same standards before providing services to CalOptima members. In addition, all references to Health Networks in Section IV.A. are proposed to be removed to avoid confusion.
- Section IV.B. is revised to clarify that, while Health Networks must ensure that their physicians meet the Minimum Physician Standards identified in Policy GG.1643 before they render services to CalOptima members, the manner in which the Health Networks incorporate verification of the Minimum Physician Standards in their processes is left to their discretion.

Fiscal Impact

It is not anticipated that the proposed changes will have any fiscal impact.

Rationale for Recommendation

The policy as adopted contained some elements that might lead to confusion. The proposed revisions will correct the potentially confusing elements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

- Proposed Revised Policy GG.1643: Minimum Physician Standards (redlined and clean versions) with Attachment
- PowerPoint Presentation – Minimum Physician Standards

/s/ Michael Schrader

Authorized Signature

05/13/2016

Date

Policy #: GG.1643Δ
 Title: **Minimum Physician Standards**
 Department: Medical Affairs
 Section: Quality Improvement
 CEO Approval: Michael Schrader _____

Effective Date: ~~TBD~~07/0
 Last Review Date: 1/16
 Last Revised Date: N/A
 N/A

This policy shall apply to the following CalOptima line of business (LOB):

- Medi-Cal
- OneCare
- OneCare Connect
- PACE

1
2
3
4
5
6
7
8

I. PURPOSE

To identify the Minimum Physician Standards that must be met in order for a Physician to be credentialed for participation in CalOptima programs.

II. DEFINITIONS

Term	Definition
Accusation	A legal document that begins the formal disciplinary process after an investigation finds evidence that the Physician has violated the laws governing the Physician’s practice area, and the violation warrants disciplinary action. An accusation lists the charges and/or the section(s) of law alleged to have been violated, and is served on the Physician.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Delivery Organization	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Physician	For the purposes of this policy, a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Podiatric Medicine (DPM).

9
10
11
12
13
14
15
16
17
18
19

III. POLICY

A. Effective ~~[DATE]~~ July 1, 2016, CalOptima requires that all new Physicians (as defined above) who wish to provide services to CalOptima Members, whether through CalOptima Direct or a CalOptima Health Network meet the Minimum Physician Standards as defined in this policy and be credentialed in accordance with CalOptima GG.1609Δ: Credentialing and Recredentialing. The Minimum Physician Standards include:

1. Current valid California license to practice;

2. Current valid Drug Enforcement Agency (DEA) certificate ~~(for Physicians and Surgeons or Physician Assistants);~~
 3. Current professional liability (malpractice) insurance or self-insurance (e.g. trust, escrow accounts, etc.) coverage in the minimum amounts of \$1 million per occurrence and \$3 million aggregate per year;
 4. Not currently excluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs;
 5. Not currently on probation or have an Accusation pending, with their licensing board.
 6. Never been excluded from participation in Federal or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in Title 42, United States Code, Section 1320a-7(a) as follows:
 - a. A conviction of a criminal offense related to the delivery of an item or service under Federal or State health care programs;
 - b. A felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service;
 - c. A felony conviction related to health care fraud; or
 - d. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
 7. No felony conviction in the ten (10) year period prior to the date of execution of the attestation containing these Minimum Physician Standards.
 8. ~~If a physician,~~ Board certified in their specialty in accordance with CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians, unless exempt from the certification requirements as set forth under that policy.
- B. Health Networks that are delegated to perform credentialing and recredentialing shall incorporate the Minimum Physician Standards into their credentialing processes.
- C. A Health Network shall establish policies and procedures to evaluate and select Physicians to participate in CalOptima that, at minimum, meet the requirements as outlined in this policy.
- D. The Minimum Physician Standards will apply to all new, first-time Physician applicants to CalOptima who wish to provide covered services to CalOptima members, without exception.
- E. All new Physicians must meet the Minimum Physician Standards to contract with CalOptima or its Health Networks to furnish services to CalOptima Members and bill and receive reimbursement for such services (subject to compliance with all other applicable CalOptima Policies).

IV. PROCEDURE

- 1 A. For Physicians who wish to provide services to CalOptima Members through CalOptima Direct,
2 CalOptima's Provider Relations staff will distribute the Minimum Physician Standards attestation to
3 Physicians as part of a pre-application process. Physicians must satisfy all of the Minimum
4 Physician Standards to be eligible to be credentialed in CalOptima ~~or through a CalOptima~~
5 ~~delegated Health Network.~~ Any incomplete attestations shall be returned to the Physician by
6 Provider Relations staff.
7
- 8 1. If the Physician does not fully complete the attestation within one hundred eighty (180) days
9 after receipt of the attestation, the Physician's attestation shall be considered expired.
 - 10 2. CalOptima's Quality Improvement Department shall review the attestation and documentation
11 and communicate results to Provider Relations. A Physician shall ensure that all information
12 included in the attestation is no more than six (6) months old.
 - 13 3. A Physician whose completed attestation reflects that he or she meets all of the Minimum
14 Physician Standards is eligible to receive a credentialing application, and if the credentialing
15 application is approved, a contract to participate in the CalOptima Program.
 - 16 4. A Physician whose attestation reflects that he or she does not meet one (1) or more of the
17 Minimum Physician Standards shall not be eligible to participate in the CalOptima Program.
 - 18 5. CalOptima's Quality Improvement (QI) department shall verify all answers and notify the
19 Physician by certified mail that the Physician did not meet the Minimum Physician Standards
20 within three (3) business days of receipt of a signed and completed attestation.
 - 21 6. If CalOptima ~~or a Health Network~~ is unable to render a decision within one hundred eighty
22 (180) calendar days after receipt of the attestation for any Physician, the Physician's attestation
23 shall be considered expired.
- 24
- 25
- 26 B. Health Networks that are delegated to perform credentialing and recredentialing shall adopt a
27 procedure to ensure that new Physicians seeking to contract with that Health Network to provide
28 services to CalOptima Members satisfy all Minimum Physician Standards ~~before receiving a~~
29 ~~credentialing application or any contract documents for the CalOptima program.~~
- 30 C. CalOptima or a Health Network, shall verify the information provided through primary or
31 secondary source verification using industry-recognized verification sources or a credentials
32 verification organization according to CalOptima Policy GG.1609Δ: Credentialing and
33 Recredentialing.
34

35 **V. ATTACHMENTS**

- 36 A. CalOptima Minimum Physician Standards Attestation

37 **VI. REFERENCES**

- 38 A. CalOptima Compliance Plan
39 B. CalOptima Contract With Department of Health Care Services (DHCS)
40 ~~C.A. Contract For Health Care Services~~
41 ~~D.C. CalOptima Policy~~ GG.1609Δ: Credentialing and Recredentialing
42 ~~E.D. CalOptima Policy~~ GG.1633Δ: Board Certification Requirements for Physicians

1 E. Contract For Health Care Services

2 F. Title 42, United States Code, ~~section §~~ 1320a-7(a)

3 G. Welfare and Institutions Code ~~section §~~ 14043.36

4
5 **VII. REGULATORY APPROVALS**

6
7 None to Date

8
9 **VIII. BOARD ACTIONS**

10
11 None to Date

12
13 **IX. REVIEW/REVISION HISTORY**

14

Version	Version Date	Policy Number	Policy Title
Original- Date	DATE 07/01/2016	GG.1643	Minimum Physician Standards

15

Policy #: GG.1643Δ
 Title: **Minimum Physician Standards**
 Department: Medical Affairs
 Section: Quality Improvement
 CEO Approval: Michael Schrader _____

Effective Date: 07/01/16
 Last Review Date: N/A
 Last Revised Date: N/A

This policy shall apply to the following CalOptima line of business (LOB):

- Medi-Cal
- OneCare
- OneCare Connect
- PACE

1
2
3
4
5
6
7
8

I. PURPOSE

To identify the Minimum Physician Standards that must be met in order for a Physician to be credentialed for participation in CalOptima programs.

II. DEFINITIONS

Term	Definition
Accusation	A legal document that begins the formal disciplinary process after an investigation finds evidence that the Physician has violated the laws governing the Physician’s practice area, and the violation warrants disciplinary action. An accusation lists the charges and/or the section(s) of law alleged to have been violated, and is served on the Physician.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Physician	For the purposes of this policy, a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Podiatric Medicine (DPM).

9
10
11
12
13
14
15
16
17
18
19
20
21

III. POLICY

A. Effective July 1, 2016, CalOptima requires that all new Physicians (as defined above) who wish to provide services to CalOptima Members, whether through CalOptima Direct or a CalOptima Health Network meet the Minimum Physician Standards as defined in this policy and be credentialed in accordance with CalOptima GG.1609Δ: Credentialing and Recredentialing. The Minimum Physician Standards include:

1. Current valid California license to practice;
2. Current valid Drug Enforcement Agency (DEA) certificate;

3. Current professional liability (malpractice) insurance or self-insurance (e.g. trust, escrow accounts, etc.) coverage in the minimum amounts of \$1 million per occurrence and \$3 million aggregate per year;
 4. Not currently excluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs;
 5. Not currently on probation or have an Accusation pending, with their licensing board.
 6. Never been excluded from participation in Federal or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in Title 42, United States Code, Section 1320a-7(a) as follows:
 - a. A conviction of a criminal offense related to the delivery of an item or service under Federal or State health care programs;
 - b. A felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service;
 - c. A felony conviction related to health care fraud; or
 - d. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
 7. No felony conviction in the ten (10) year period prior to the date of execution of the attestation containing these Minimum Physician Standards.
 8. Board certified in their specialty in accordance with CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians, unless exempt from the certification requirements as set forth under that policy.
- B. Health Networks that are delegated to perform credentialing and recredentialing shall incorporate the Minimum Physician Standards into their credentialing processes.
- C. A Health Network shall establish policies and procedures to evaluate and select Physicians to participate in CalOptima that, at minimum, meet the requirements as outlined in this policy.
- D. The Minimum Physician Standards will apply to all new, first-time Physician applicants to CalOptima who wish to provide covered services to CalOptima members, without exception.
- E. All new Physicians must meet the Minimum Physician Standards to contract with CalOptima or its Health Networks to furnish services to CalOptima Members and bill and receive reimbursement for such services (subject to compliance with all other applicable CalOptima Policies).

IV. PROCEDURE

- A. For Physicians who wish to provide services to CalOptima Members through CalOptima Direct, CalOptima's Provider Relations staff will distribute the Minimum Physician Standards attestation to Physicians as part of a pre-application process. Physicians must satisfy all of the Minimum

Physician Standards to be eligible to be credentialed in CalOptima. Any incomplete attestations shall be returned to the Physician by Provider Relations staff.

1. If the Physician does not fully complete the attestation within one hundred eighty (180) days after receipt of the attestation, the Physician’s attestation shall be considered expired.
 2. CalOptima’s Quality Improvement Department shall review the attestation and documentation and communicate results to Provider Relations. A Physician shall ensure that all information included in the attestation is no more than six (6) months old.
 3. A Physician whose completed attestation reflects that he or she meets all of the Minimum Physician Standards is eligible to receive a credentialing application, and if the credentialing application is approved, a contract to participate in the CalOptima Program.
 4. A Physician whose attestation reflects that he or she does not meet one (1) or more of the Minimum Physician Standards shall not be eligible to participate in the CalOptima Program.
 5. CalOptima’s Quality Improvement (QI) department shall verify all answers and notify the Physician by certified mail that the Physician did not meet the Minimum Physician Standards within three (3) business days of receipt of a signed and completed attestation.
 6. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days after receipt of the attestation for any Physician, the Physician’s attestation shall be considered expired.
- B. Health Networks that are delegated to perform credentialing and recredentialing shall adopt a procedure to ensure that new Physicians seeking to contract with that Health Network to provide services to CalOptima Members satisfy all Minimum Physician Standards.
- C. CalOptima or a Health Network shall verify the information provided through primary or secondary source verification using industry-recognized verification sources or a credentials verification organization according to CalOptima Policy GG.1609Δ: Credentialing and Recredentialing.

V. ATTACHMENTS

- A. CalOptima Minimum Physician Standards Attestation

VI. REFERENCES

- A. CalOptima Compliance Plan
- B. CalOptima Contract With Department of Health Care Services (DHCS)
- C. CalOptima Policy GG.1609Δ: Credentialing and Recredentialing
- D. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
- E. Contract For Health Care Services
- F. Title 42, United States Code, § 1320a-7(a)
- G. Welfare and Institutions Code § 14043.36

VII. REGULATORY APPROVALS

None to Date

1
2
3
4
5
6
7
8

VIII. BOARD ACTIONS

None to Date

IX. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title
Original	07/01/2016	GG.1643	Minimum Physician Standards

DRAFT

CalOptima Minimum Physician Standards Attestation

CalOptima’s Board of Directors approved “minimum physician standards” for medical doctors, doctors of osteopathic medicine, and doctors of podiatric medicine, who wish to contract with CalOptima to provide services to CalOptima Members. All physicians in these categories who wish to participate in the CalOptima program must meet all minimum physician standards in order to submit an application for credentialing, the successful approval of which is a pre-requisite to contracting with CalOptima or its contracted Health Networks. All potential providers who have not contracted with CalOptima prior to _____ must submit this Attestation in order to be considered for issuance of a credentialing application.

Please answer the following questions either Yes (Y) or No (N).

A. Do you have a current valid California license to practice the profession for which you are seeking participation in CalOptima?	Y <input type="checkbox"/>	N <input type="checkbox"/>
B. Do you possess a current valid DEA certificate?	Y <input type="checkbox"/>	N <input type="checkbox"/>
C. (1) were you certified in your specialty within five years of the completion of your residency training, and do you continue to be so certified, by a CalOptima-approved specialty Board, or (2) has it been less than five years since completion of your residency training, and you have been making adequate progress towards being so certified before the expiration of five years from the completion of my residency training, or (3) were you first licensed to practice medicine in a United States jurisdiction before January 1, 2008?	Y <input type="checkbox"/>	N <input type="checkbox"/>
D. Do you have current professional liability (malpractice) insurance or self-insurance (e.g. trust, escrow accounts, etc.) coverage in the minimum amounts of \$1 million per occurrence and \$3 million aggregate per year that covers all aspects of your practice?	Y <input type="checkbox"/>	N <input type="checkbox"/>
E. Are you currently excluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs?	Y <input type="checkbox"/>	N <input type="checkbox"/>
F. Are you currently on probation with the board that issued your license to practice?	Y <input type="checkbox"/>	N <input type="checkbox"/>
G. Do you currently have an accusation or other disciplinary proceeding pending against you with the board that issued your license to practice?	Y <input type="checkbox"/>	N <input type="checkbox"/>

(over)

H. Have you ever been excluded from participation in Federal and/or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in 42 U.S.C. § 1396a-7(a) as follows: (1) a conviction of a criminal offense related to the delivery of an item or service under Federal and/or State health care programs; (2) a felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service; (3) a felony conviction related to health care fraud and/or (4) a felony conviction related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance?

Y N

I. Do you have any felony convictions in the ten (10)-year period prior to the date of execution of this questionnaire set forth below?

Y N

By signing this attestation, I hereby: (1) give CalOptima permission to investigate and verify the accuracy of any and all statements and representations in this Attestation; and (2) authorize any relevant person or entity to provide information requested by CalOptima that may be related to any and all statements and representations made in this Attestation.

I declare, under penalty of perjury, under the laws of the State of California, that all statements contained in this Attestation are true and correct. I understand that any and all statements made in this Attestation are subject to verification and that any false or dishonest statement may be grounds for limiting or terminating my participation in CalOptima programs.

Print Name Here: _____ **License #:** _____

Physician Signature: _____ **Date:** _____
(Stamped Signature is NOT acceptable)



CalOptima
Better. Together.

Minimum Physician Standards

**Board of Directors' Quality Assurance Committee Meeting
May 18, 2016**

**Richard Bock, MD
Deputy Chief Medical Officer**

Minimum Physician Standards (MPS)

On April 7, the CalOptima Board of Directors adopted a set of Minimum Physician Standards for *first time* credentialing applicants to the CalOptima program, including the following:

Standards
Valid California license to practice medicine
Current professional liability insurance
Able to fully participate in State or Federal health care programs
No felony convictions within the 10 years prior to applying
Never been excluded from participation in State or Federal programs
Applicant physician must not currently be on probation for any reason
Applicant must not have an Accusation pending before their licensing board

MPS

- The Standards apply to all physicians newly credentialed either by CalOptima or its delegated networks
 - “Physicians” include Doctors of Medicine, Doctors of Osteopathy, and Doctors of Podiatric Medicine
 - “Accusation” has nothing to do with malpractice allegations. “Accusation” is a legal document from MBC that begins with *formal disciplinary process* after an investigation finds evidence that the physician has violated disciplinary action. An accusation lists the changes and/or the section(s) of law alleged to have been violated, and is served on the physician.
- The Process of Pre-application attestation applies only to CCN
 - A physician whose attestation reflects that he or she does not meet one (1) or more of the minimum physician standards would not be eligible and would not receive an application and/or proposed contract.
- While the pre-application attestation requirement does not apply to Health Networks, they are required to incorporate the Minimum Physician Standards into their credentialing process for all physicians who will be providing services to CalOptima Members

Proposed Revisions

After the Board approved the new Minimum Physician Standards policy, certain technical language issues were identified that need to be corrected. Staff is proposing the following changes:

- Delete the definition of Healthcare Delivery Organization (not used in the policy)
- Replace the date placeholder with the intended policy effective date of July 1, 2016
- Remove references related to the inclusion of physician assistants in an earlier draft of the policy
- Clarify that Health Networks must ensure that physicians providing services to CalOptima Members meet the Minimum Physician Standards, but may choose how to integrate those standards into their processes.



Board of Directors' Quality Assurance Committee Meeting May 18, 2016

PACE Member Advisory Committee (PMAC) Update

PMAC Meeting April 25, 2016

CalOptima PACE held a quarterly meeting of the PACE Membership Advisory Committee on April 25, 2016.

The PACE Director reviewed the items requiring follow up from the previous meeting, including an update on the Transportation Department and a follow up regarding Specialty appointments.

The Director informed the Committee that PACE now has a new Transportation Coordinator (TC) from Secure Transportation, Rene Ramos. Rene started in April and will train with current TC for six weeks. The Director also reported that, due to the growth in census, Secure Transportation will be adding another van to the PACE fleet (this happens periodically as the program grows).

The Director also informed the Committee that PACE is working with community providers to expand the network and ensure that all scheduled specialty appointments are necessary. Per the PACE program philosophy, the primary care physician (PCP) can provide most of the care and may refer to consultations with specialists as is medically indicated.

A staffing update was given to the Committee as well, including the announcement of Christine Sisil, RN, starting her role as the Clinical Operations Manager on April 25, two Personal Care Attendants being promoted to Medical Assistants in the Clinic, and two team members currently on leave.

New topics of discussion included:

1. Patient-Centered Care: Team members from PACE attended a seminar regarding the provision of Patient-Centered Care. We purchased the videos and training materials and are currently in the process of educating the entire team on this manner of providing individualized care.

The meeting concluded with the PMAC member forum. Topics of discussion included:

1. Mallory Vega, our community representative stated that she reports the events of this meeting to the Quality Committee of the Board of Directors and that PMAC voices are heard.
2. The group discussed physician hours and Participants were told that as the census continues to grow, the provider hours will continue to increase.
3. Many complements were extended to the staff – they are very dedicated and this contributes directly to Participants' high level of satisfaction with CalOptima PACE.

Next meeting is scheduled for July 25, 2016 at 11:00 a.m.



CalOptima
Better. Together.

Behavioral Health Request for Proposal Update

**Board of Directors' Quality Assurance Committee Meeting
May 18, 2016**

**Edwin Poon, PhD
Director, Behavioral Health Services**

Today's Agenda

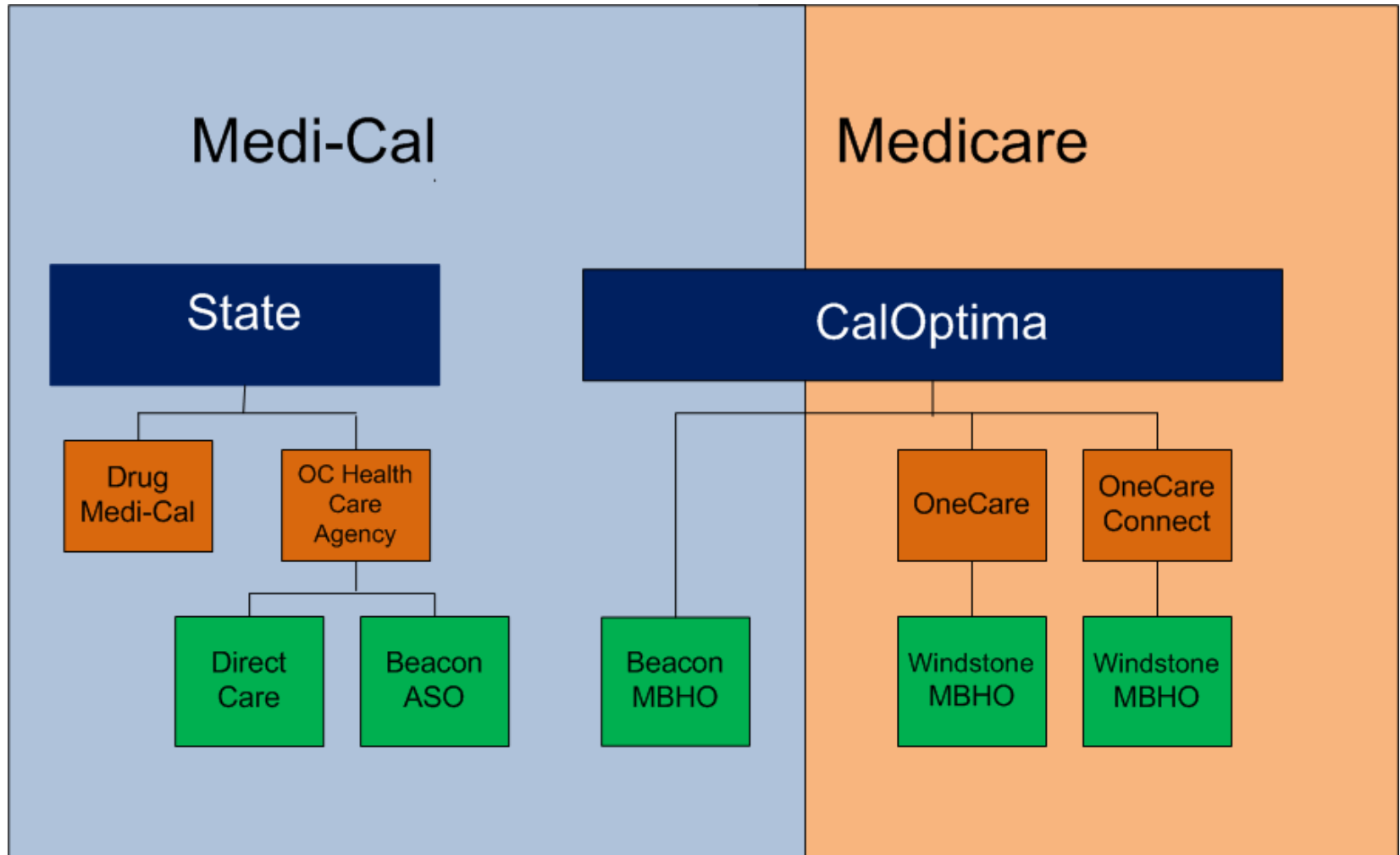
- Behavioral Health history at CalOptima
- Behavioral Health background
- Traditional MBHO Services
- RFP Opportunities
- RFP Planned Scope Highlights
- RFP Timeline
- Board Action Recommendation

BH History at CalOptima

- OneCare (Medicare Duals Special Needs)
 - Began January 1st, 2007
 - Windstone Behavioral Health has provided behavioral health management since inception of the benefit

- Managed Care Plan Medi-Cal
 - Affordable Care Act began 1/1/2014
 - CHIPA/Beacon contracted to provide managed behavioral health services

BH History at CalOptima (cont'd)

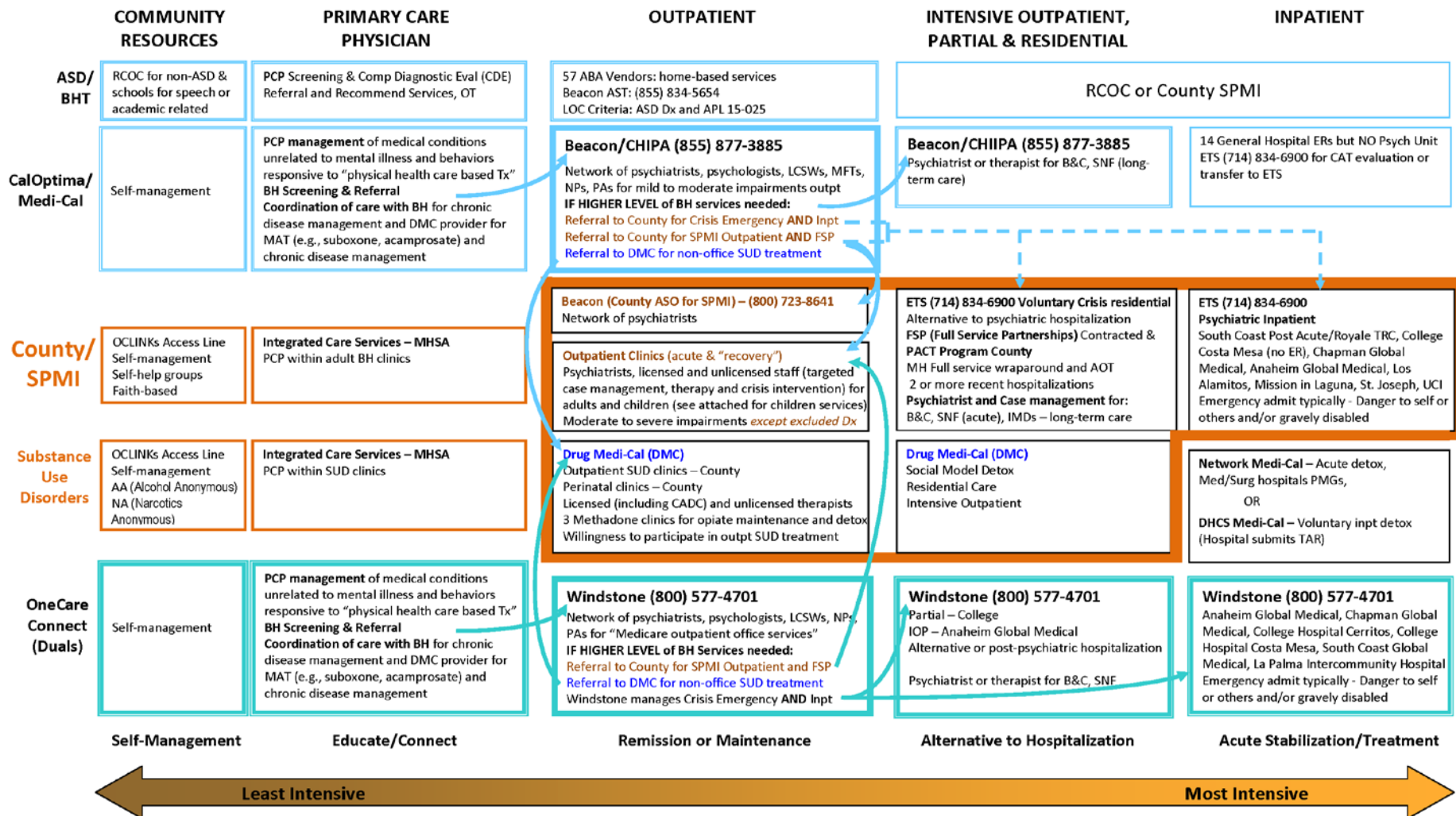


BH History at CalOptima (cont'd)

- Autism Spectrum Disorder Behavioral Health Treatment
 - Benefit for Medi-Cal began September 2014
 - CHIPA/Beacon contract amended to include ASD BHT

- OneCare Connect (Medicare Duals Pilot)
 - Benefit began 7/1/2015
 - Windstone contracted to provide managed behavioral health services

BH History at CalOptima (cont'd)



Behavioral Health Background

- CalOptima has an opportunity to enhance the overall health of its members through the effective management of its behavioral health benefits
- Like many managed care plans, CalOptima has used Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of BH benefits

Traditional MBHO Services

- MBHOs can support Managed Care plans by providing efficiency and subject matter expertise with:
 - BH Provider Network and Provider Relations
 - BH specific Credentialing
 - Call Center management
 - Eligibility verification
 - Level of care determinations
 - Claims payment and processing
 - Utilization management
 - Care management
 - Quality Improvement and certifications
 - Value based payment management

Upcoming RFP Opportunities

- Potential to contract with one vendor for all services
 - Better coordination among lines of business and products
 - Operational efficiencies
 - Administrative simplicity for providers and CalOptima
 - Though one vendor is a preference, it is not going to be a requirement during the bid process

Upcoming RFP Opportunities (cont'd)

- Update contracts to align with current standards and requirements
 - Updated standards for service level agreements
 - Accountability on key performance metrics
- Innovation and best practices
 - Behavioral health management has evolved over time
 - Opportunity to partner with vendors who are on the leading edge of integration, population health, analytics, outcomes and value based reimbursement

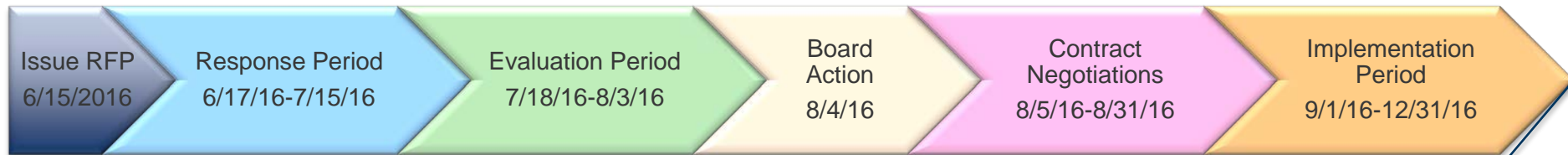
RFP Planned Scope Highlights

Key Evaluation Metrics

- Local Support
- Experienced working with Medi-Cal and managed Medicare
- NCQA accredited
- Focus on Triple Aim
- Demonstrated success
- Operational efficiency and flexibility
- Ability to manage all lines of business and products



RFP Timeline



Contract Start Date
1/1/17



CalOptima
Better. Together.

Quality Improvement Committee – 1st Quarter Update

**Board of Directors' Quality Assurance Committee Meeting
May 18, 2016**

**Caryn Ireland
Executive Director, Quality and Analytics**

[Back to Agenda](#)

Annual Program Documents

- Reviewed & Approved:

- 2015 QI Program Evaluation
- 2015 UM Program Evaluation
- 2015 Case Management Program Evaluation
- 2015 Disease Management and Health Education Program Evaluation
- 2016 QI Program Description and Work Plan
- 2016 UM Program Description and Work Plan
- 2016 Case Management Program and Work Plan
- 2016 Disease Management Program and Work Plan

In addition, all documents were approved by the Quality Assurance Committee and the Board of Directors.

QIC Reporting Department

The following departments report to the QIC quarterly at a minimum:

- Case Management
- Behavioral Health
- Case Management
- Customer Service
- Health Education
- GARS
- Long Term Services and Support
- Provider/Network Management
- OneCare
- PACE
- Pharmacy
- Utilization Management

Highlights:

- Cultural and Linguistic Services

- Met the overall male and female gender standard with ratios
- Met the language standard of 1:500 for Spanish, Vietnamese, Farsi & Korean. All other standards for language met for the remaining health networks.

- Disease Management

- Presented 2015 Program Effectiveness for each Program
 - Member Participation Rates
 - HEDIS Rates, ED, IP, or RX related utilization
- Presented work plans for Childhood Obesity, Home Assessments for members participating in CM
- Presented strategies for improving IHA & Group Needs Assessment survey participation

Highlights

Credentialing Activity	CY 2015	1 st Quarter, 2016
Number of clean files completed	596	168
Number of initial/recredentialing files in process	N/A	99
Number of files with issues – to CPRC	46	17
Number of issue files requiring follow-up	3	2
Number of issues identified through ongoing monitoring of external sites for adverse activity	79	24

Highlights: Potential Quality Issues

Outcome Score	Description	# of Cases Closed	Actions
0	No quality of care issue identified	408 (90%)	336 – No further action 4 – More information Requested 56 – Track & Trend 6 – Physician Letter 1 – Health Network CAP 5 – Provider Education
1	Reflects a health care delivery system problem	21 (5%)	10 – No further action 10 – Track & Trend 1 – Health Network CAP
2	Clinical issue or judgment impacting Member care with potential for mild to moderate effect	7 (1%)	1 – No further action 1 – Track & Trend 4 – Physician Letter 1 – Provider Education
3	Clinical issue or judgment impacting Member care with potential for significant to serious effect	6 (1%)	6 – Track & Trend
4	Clinical issue with significant adverse outcome, including unnecessary prolonged treatment, complications, readmission, or Member management resulting in impairment, disability or death	0	
SO	No quality of care issue (service issue)	13 (3%)	13 – No further action

Highlights (Continued)

- Potential Quality Issues – Severity Level 3 Details
 - Improper management
 - Delay of Service
 - Allergic Reaction
 - Medication Administration Error
 - Medication Reaction
 - Non-compliant member

Highlights (Continued)

- Case Management

- Continued focus on improving HRA outreach for OCC and SPD members
- Continued monitoring of participation in ICT/ICPs
- Plans for 2016 include continue oversight, monitoring and feedback focusing on opportunities to increase completion of outreach

- Quality Analytics

- Presented new Pay-for-Value program for 2016
 - Measures include both Adult and Child measures for all Health Networks
 - Population complexity (acuity) is considered in score and payment
 - Program is weighted 60% clinical measures, 40% CAHPS measures
- HEDIS Preparation
 - Medical Record Review, Data Mining for HEDIS rates is in process
 - CAHPS surveys have been fielded (Medi-Cal and OneCare)
 - Striving to achieve NCQA Commendable Status

Highlights (Continued)

- LTSS

- Presented CBAS profile and performance reports and CBAS critical incident reporting
- Reviewed & approved CBAS quality work plan

- Audit & Oversight

- Reviewed Health Network QI Work Plan report and areas requiring Corrective Action Plans
 - 63% of Health Network Work Plans were out of compliance (i.e. did not contain all necessary elements)
 - Most common areas of non-compliance: No Goal, Rates, Signatures Interventions

- PACE

- Presented results from CMS/DHCS Annual Audit
 - 11 Elements Met; 5 Elements Met with Note
 - 3 Elements Not Met
 - Appeals Process; Participant Assessment; Service Delivery & Emergency Care were the areas not met
 - Action plans have been developed and submitted for all 3 areas

Highlights (Continued)

- Customer Service

- Reviewed 2015 Call center results

- Met all Call Center Targets for 2015

- Implemented Medi-Cal Telephone Member Survey

1. Was this the first time you called regarding this issue?
2. Did the Customer Service representative provide you with information or help to resolve your concerns during the call?
3. Did the customer service representative seem knowledgeable to you?
4. Did the customer service representative explain things in a way that was easy to understand?
5. Did the customer service representative treat you with courtesy and respect during your call?
6. Overall, are you satisfied with the customer service you receive from your health plan?

- Survey results analyzed and areas for improvement identified (linked to Member Experience Initiatives)



CalOptima
Better. Together.

Member Experience Update

**Board of Directors' Quality Assurance Committee Meeting
May 18, 2016**

**Kelly Rex-Kimmet
Director, Quality & Analytics**

As you recall....

- CalOptima is the top rated Medicaid Plan in California, receiving a 4 out of 5 rating by NCQA
- Our rating showed good clinical scores, as well as opportunities for improvement in member satisfaction
- Our goal is to raise member experience Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores. CAHPS scores impact both our annual NCQA accreditation rating and national rating.
- We formed an enterprise-wide Member Experience Work Group
 - Senior leadership executive sponsors from operations, medical affairs and provider network are participating in the work group
- Our Strategy
 - Identify the focus areas and implement strategies

And then....

- We analyzed the CAHPS results (child and adult) and identified 5 common areas for improvement
- We completed a Member Experience RFI to gather market intelligence on methods to gather further member experience data
- We administered our own Supplemental Survey
- And we started to implement process improvements at CalOptima and with our Health Networks

CAHPS Analysis

- Proposed Areas of Focus (in red)
- Findings similar between Child and Adult CAHPS

Measures	Benchmarks
Rating of all health care	Above the 50 percentile
Rating of personal doctor	Above the 50 th percentile
Rating of specialist seen often	Above the 25 th percentile
Rating of health plan (RHP)	Below the 25th percentile
Getting needed care (GNC)	Below the 25th percentile
Getting care quickly (GCQ)	Below the 25th percentile
How well doctors communicate (HWDC)	Below the 25th percentile
Customer service (CS)	Below the 25th percentile
Shared decision making	Below the 25 th percentile

Member Experience RFI

- Five vendors submitted formal responses to the RFI
- Recommended strategies included
 - Surveys, Focus Groups, One-on-One In-Person Interviews, Enhanced Access & Appointment Availability Study
- Two vendors recommended against focus groups due to limited dollars available for member incentives based on DHCS requirements
- One vendor recommended conducting multiple focus groups matching our cultural membership mix
- Costs varied from \$76,000 - \$187,000

Supplemental Survey

- Survey was developed and administered by CalOptima to obtain qualitative information about member pain points
- Survey was fielded to 27,509 members; Survey field dates: 11/4/15-2/8/16
- 3794 surveys were returned; Response rate: 13.79%
- Over 630 Unique Providers were represented in the survey
- Results were analyzed by LOB and Language
- Preliminary Findings
 - The Supplemental Survey results were generally higher than CAHPS results on Rating of Healthcare, Rating of Doctor and Rating of Health Plan
 - Getting Needed Care, Getting Care Quickly and How Doctors Communicate results are more in line with CAHPS results
 - Korean-speaking Medi-Cal members scored lower levels of satisfaction than other language groups
- Further analysis is in progress regarding provider specific results and other qualitative analysis

Qualitative Analysis-Member Pain Points

Count of Comments	Description	Alignment
151	Coordination of care (includes problems with referrals, processes, too many phone calls)	GNC/GCQ
136	Kudos (positive Comment about CalOptima or Dr.)	-
102	Access to speciality care (comments about length of time to get appointment to specialist or referrals for specialty care)	GCQ
89	Poor communication by Dr. (does not explain things well, does not listen to my questions, I don't understand what Dr. is saying)	HWDC/GCQ
87	Wait time to get PCP appointment	GCQ
67	Feeling rushed during appointment	HWDC/GCQ
58	Wait time for appointment (after arriving in the office)	GCQ
49	RX(Denials, formulary, didn't get what I asked for)	GNC
30	Rude office staff	CS
26	Lack of consistent care by same Dr.-wants to see same Dr. every visit, not PA	GNC
25	Dental Benefit	-
21	Language/Cultural barrier (need Dr. or help in another language)	CS
15	Please contact me to discuss; assistance requested	-
14	Vision Benefit	-
14	Distance to care is too far	GNC/GCQ

Proposed Analysis and Actions

- Analyze physician data based on overall survey score (above/below 80%) and based on patient volume (physicians with 10 or more respondents)
- Develop and distribute provider-specific summary reports on barriers to care
- Report data by Physician, by Clinic and by Health Network (including CCN)
- Work with Network Management/Provider Services on outreach strategies
- Implement CG-CAHPS in the Fall 2016
- Increase the weighting of Member Experience/CAHPS results in the Pay-for-Value Program

Telephonic Member Satisfaction Survey

- Implemented Six Question Survey in June 2015
 - Based on CAHPS survey question focusing on Customer Service
 - Medi-Cal members only
 - In all threshold languages as of January 2016
 - 54,641 surveys completed as of April 2016
 - Results show rating of 96% to 98% for Customer Service Representative in: knowledgeable staff, easy to understand, providing help to resolve issue, and treated with courtesy and respect
 - 81% of members indicate it was their first time calling about the issue
- December 2015
 - Data can be tied back to Customer Service Representative who handled call
- 2nd Quarter 2016
 - Expand survey to OneCare and OneCare Connect membership
 - Expand survey questions to include who they called first
 - Identify top reasons for multiple calls
 - Additional training for specific staff or department as identified
- 3rd Quarter 2016
 - Option to leave voice message

Alignment of Activities

Categories

- Getting Needed Care
- Getting Care Quickly

Issues

- Coordination of Care
- Access to Care
- Wait Times
- Lack of Consistent Care
- Distance too far

Actions

- **Partner with Health Networks: CAHPS-specific reports - distributed November, 2015 (completed)**
- **Health Network Specific Action Plans – received February, 2016**
- **Member Education on referrals/PA processes – included in February 2016 Member Newsletter (completed)**
- Follow-up on Health Network Action Plans – reports due May, 2016
- Pursue education “team” and education for PCPs and office staff to help improve service and reduce barriers to care within the office setting (in development)

Alignment of Activities (Continued)

Categories

- How Well Doctors Communicate

Issues

- Poor Dr. Communication
- Does not understand what my Dr. is saying
- Does not explain things well

Actions

- **Tips to members on “preparing for your Dr. visit” – in February 2016 Member Newsletter (completed)**
- Pursue education “team” and education for PCPs and office staff to help improve service and reduce barriers to care within the clinic setting (in development)

Alignment of Activities (Continued)

Categories

- Customer Service (Plan-Level & Provider Level)

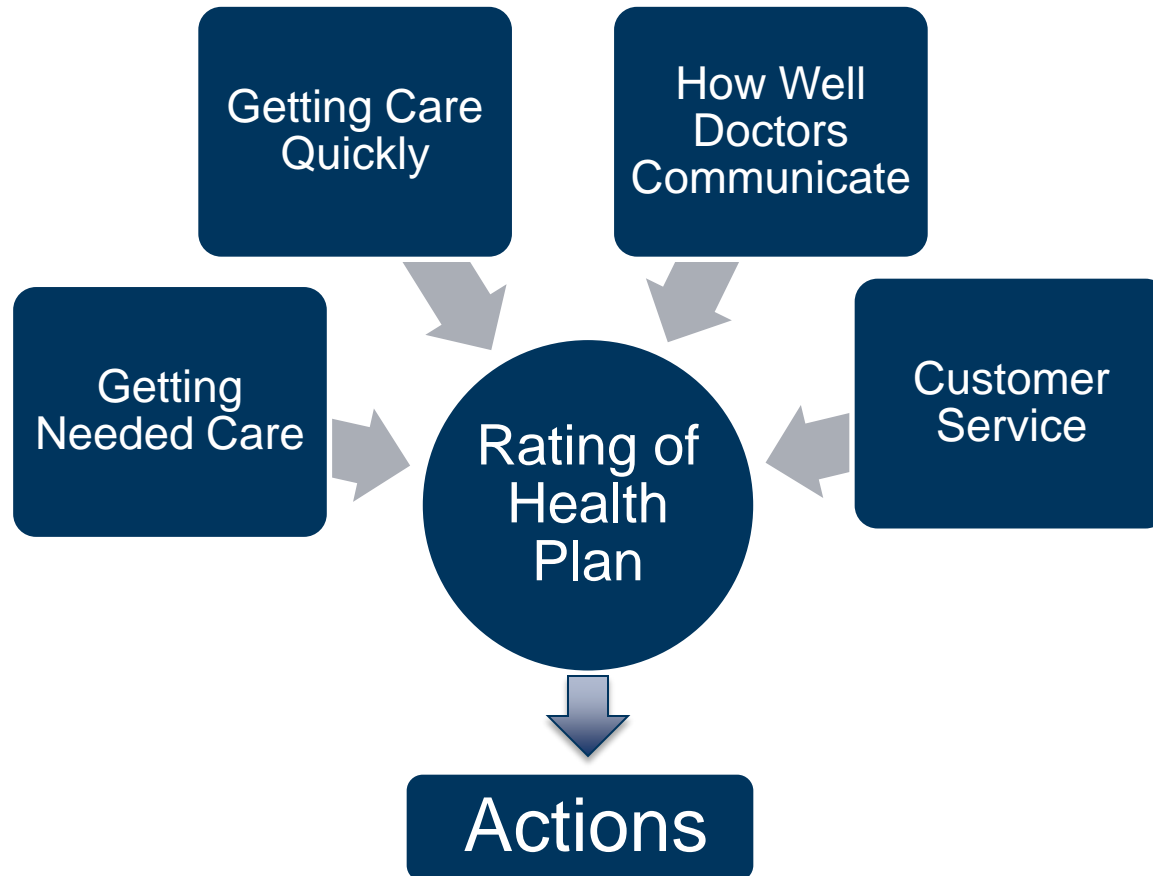
Issues

- Language/Cultural Barriers
- Rude Office Staff
- Feeling Rushed

Actions

- **Customer Service Post Call Survey (first call resolution) – implemented June 2015 to current (completed)**
- **Evaluation and trending on member pain points (complaints, grievances, appeals) - ongoing**
- Pursue education “team” and education for PCPs and office staff to help improve service and reduce barriers to care within the clinic setting (in development)

Alignment of Activities Summary



Additional Member Experience Initiatives

- Continue analysis and identify actions to reduce member issues
 - Access
 - Member complaints – trends (GARS, PQIs)
 - Referral/Prior Authorization process
- Continue customer service post call survey to identify staff training and education opportunities
- Support Health Network Member Experience Initiatives
- Pursue educational “team” approach to working with PCPs on barriers to care
- Implement CG-CAHPS for more frequent member experience feedback
- Consider repeating supplemental survey for qualitative data

CalOptima's Mission

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



CalOptima

Better. Together.



Medi-Cal

CalOptima

Better. Together.



OneCare (HMO SNP)

CalOptima

Better. Together.



OneCare Connect

CalOptima

Better. Together.



PACE

CalOptima

Better. Together.