



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

**WEDNESDAY, MARCH 15, 2023
3:00 P.M.**

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

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE

Trieu Tran, M.D., Chair
José Mayorga, M.D.
Nancy Shivers, RN

CHIEF EXECUTIVE OFFICER

Michael Hunn

OUTSIDE GENERAL COUNSEL

KENNADAY LEAVITT

Troy R. Szabo

CLERK OF THE BOARD

Sharon Dwiars

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_UqbOXdVTSP28NINF-cSi-w and Join the Meeting.

Webinar ID: 870 1812 4375

Passcode: 449619 -- Webinar instructions are provided below.

CALL TO ORDER

Pledge of Allegiance
Establish Quorum

MANAGEMENT REPORTS

1. [Chief Medical Officer Report](#)

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

2. [Approve Minutes of the December 14, 2022 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee](#)

REPORTS/DISCUSSION ITEMS

3. [Receive and File 2022 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan Evaluation and Recommend Board of Directors Approval of the 2023 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan](#)
4. [Receive and File 2022 CalOptima Health Quality Improvement Program Evaluation and Recommend Board of Directors Approval of the 2023 CalOptima Health Quality Improvement Program and Work Plan](#)
5. [Recommend Board of Directors Approve Revision to the Measurement Set for the CalOptima Health's Measurement Year 2023 Medi-Cal Quality Pay for Value Program](#)
6. [Recommend Board of Directors Approval of New CalOptima Health Policy GG.1132: Medi-Cal Annual Wellness Visit Program](#)

INFORMATION ITEMS

7. [Update on Assessment of Quality](#)
8. [Program of All-Inclusive Care for the Elderly Member Advisory Committee Update](#)
9. Quarterly Reports to the Quality Assurance Committee
 - a. [Quality Improvement Committee Report](#)
 - b. [Program of All-Inclusive Care for the Elderly Report](#)
 - c. [Member Trend Report](#)

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors' Special Quality Assurance Committee on March 15, 2023 at 3:00 p.m. (PST)

To **Register** in advance for this webinar:

https://us06web.zoom.us/webinar/register/WN_UqbOXdVTSP28NINF-cSi-w

To **Join** from a PC, Mac, iPad, iPhone or Android device:

Please click this URL to join.

<https://us06web.zoom.us/j/87018124375?pwd=S2NYSmM5YURJWkQyWWdtVldqZE9UUT09>

Passcode: **449619**

Or One tap mobile:

+16694449171,,87018124375#,,,,*449619# US

+12532050468,,87018124375#,,,,*449619# US

Or join by phone:

Dial (for higher quality, dial a number based on your current location):

US: +1 669 444 9171 or +1 253 205 0468 or +1 253 215 8782 or +1 346 248 7799 or +1 719 359 4580 or +1 720 707 2699 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 or +1 309 205 3325 or +1 312 626 6799 or +1 360 209 5623

Webinar ID: 870 1812 4375

Passcode: 449619

International numbers available: <https://us06web.zoom.us/j/87018124375?pwd=S2NYSmM5YURJWkQyWWdtVldqZE9UUT09>



MEMORANDUM

DATE: February 28, 2023

TO: CalOptima Health Quality Assurance Committee

FROM: Richard Pitts, D.O., Ph.D., Chief Medical Officer

SUBJECT: CMO Report — March 15, 2023, Board of Directors Quality Assurance

COPY: Committe Sharon Dwiers, Clerk of the Board

a. **Member and Provider Initiatives to Promote Quality**

At the December 2022 Board of Directors meeting, the Board approved the following member and provider initiatives to promote quality. Outcomes will be shared with Quality Assurance Committee at upcoming quarterly meetings.

1. Five-Year Hospital Quality Program

CalOptima Health will invest \$153.5 million over a five-year period in a new Hospital Quality Program beginning on January 1, 2023, through December 31, 2027. The Hospital Quality Program for CalOptima Health-contracted hospitals is intended to improve quality of care to our members through increased patient safety efforts and performance-driven processes. The program is comprised of two initiatives: Hospital Incentive Quality Pool and Hospital Reporting Incentive Payments.

- Quality Pool Incentive awards will be based on performance compared to quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.
- CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During the ramp-up period, CalOptima Health will provide hospital reporting incentive payments of \$150,000 per eligible hospital per calendar year. CalOptima Health will provide hospital reporting incentive payments to eligible hospitals that have submitted a written agreement to participate in CMS/Leapfrog reporting in CY 2023.

2. Five-Year Comprehensive Community Cancer Screening and Support Program

CalOptima Health will invest \$50.1 million in a five-year Comprehensive Community Cancer Screening and Support Program. The goal is for all of Orange County to have the lowest in the nation late-stage cancer incidence rate for breast, cervical, colon, and lung cancer in certain smokers.

The program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures. The goal will be to dramatically decrease late-stage cancer incidence and ensure that all Medi-Cal members have equitable access to high-quality care.

3. Medi-Cal and OneCare Pay for Value (P4V) Program

CalOptima Health will invest \$25 million to implement a OneCare P4V program in addition to the existing Medi-Cal P4V program to improve the quality of care and outcomes for all members. In addition, CalOptima Health is committed to demonstrating breakthrough improvement in all quality measures, maintaining high-performing Medi-Cal managed care plan status and achieving 5-Star status. Health networks and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the P4V programs.

4. Three-Year Skilled Nursing Facility Access Program

CalOptima Health will launch a three-year, up to \$10 million program with Skilled Nursing Facilities (SNFs) to enhance quality through better access and further strengthen the safety net system across Orange County for individuals who require SNF post-hospitalization care. SNF bed unavailability creates a challenge for hospitals, emergency departments, and LTACs to ensure members receive the right care at the right level at the right time. Working with CalOptima Health's SNF providers will enhance the safety net for these complex members who require timely SNF placement and continued medical care. Through the SNF Access Program, CalOptima Health seeks to ensure that the SNFs remain strong quality partners in care for all CalOptima Health members.

5. Medi-Cal Annual Wellness Visit Initiative

CalOptima Health will implement a \$15 million Medi-Cal Annual Wellness Visit (AWV) initiative for Medi-Cal members aged 45 years or older to improve member access to annual visits, comprehensive care and preventive services to improve member quality of care and health outcomes. The recommended Medi-Cal AWV Initiative would provide a visit rate of \$125 per visit, a provider incentive rate of \$100 per completed and reviewed attestation, and a member incentive up to \$50 (non-monetary gift card) per eligible member per calendar year.

6. In-Home Care Pilot Program with the University of California Irvine Family Health Center

The UCI Family Health Center is a Federally Qualified Health Center that services nearly 28,000 CalOptima Health direct and delegated members and provides over 100,000 patient care visits per year. CalOptima Health will invest \$2 in a two-year pilot project to test and evaluate the effectiveness of a home-based program. The pilot will also test the ability to provide access to services that are available to commercially insured members, to CalOptima Health Medi-Cal members. The pilot will measure the following outcomes:

- Emergency room utilization
- Urgent care utilization
- Inpatient readmission

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS’
QUALITY ASSURANCE COMMITTEE

December 14, 2022

A Regular Meeting of the CalOptima Health Board of Directors’ Quality Assurance Committee was held on December 14, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings.

Chair Trieu Tran called the meeting to order at 3:01 p.m., and Sharon Dwiers, Clerk of the Board, led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Trieu Tran, M.D., Chair; José Mayorga, M.D.; Nancy Shivers, R.N. (at 3:04 p.m.) (all members participated via teleconference)

Members Absent: None

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Troy R. Szabo, Outside General Counsel, Kennaday Leavitt; Sharon Dwiers, Clerk of the Board

MANAGEMENT REPORTS

1. Chief Medical Officer Report

Richard Pitts, D.O., Ph.D., Chief Medical Officer, provided a verbal update highlighting actions that the CalOptima Health Board of Directors approved at its December 1, 2022, meeting to improve outcomes for members in several areas, including cancer screening. Dr. Pitts also noted that CalOptima Health is working on a skilled nursing facility (SNF) incentive program to ensure members are treated at appropriate levels of care.

Dr. Pitts also reported that CalOptima Health received a monetary sanction notice from the Department of Health Care Services (DHCS) due to not meeting the required minimum performance levels (MPL) for calendar year 2021. He noted the two areas that did not meet the required MPLs were: well-child visits in the first 15 months and the well-child visits age 15 to 30 months. CalOptima Health will submit a revised comprehensive quality strategy to DHCS before January 31, 2023.

Director Mayorga commented that he is excited to see the cancer screening initiative and noted the importance of collaborating with CalOptima Health’s radiological partners, hospitals, and health networks. Many providers have certain vendors they use for imaging services, which ultimately limits access. Director Mayorga asked if there is a way to make this an open network so that members would be able to get screened for lung, breast, and other cancers at multiple locations.

Director Mayorga also inquired if CalOptima Health is aware of any other health plans that received a similar sanction. Yunkyung Kim, Chief Operating Officer, responded that most of the state's medical plans received a similar notice of varying ranges of performance in 2021.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

2. Approve the Minutes of the September 14, 2022 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

Action: On motion of Director Mayorga, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 3-0-0)

INFORMATION ITEMS

3. Blood Lead Screening Update

Leslie Martinez, QA Analyst, Population Health Management, provided an update on blood lead screening. Ms. Martinez noted that for CalOptima Health and Orange County, there are opportunities for improvement in screening children for lead in their blood. Overall, only 1% of children in Orange County have received a blood lead screening. She noted that no amount of lead in the body is safe, and for children lead in the body can affect the ability to pay attention and limit academic achievement, not allowing them to reach their maximum potential. Ms. Martinez also noted that lead in the body can damage the brain and nervous system and cause a lot of learning and behavioral problems, as well as hearing and speech problems. Most of the symptoms of lead exposure are not obvious, so blood lead testing is extremely important for younger children. She added that low-income children and children of color are disproportionately at risk for lead exposure, and these children are in publicly funded programs, such as CalOptima Health.

Ms. Martinez reported that CalOptima Health is trying to get a better understanding of where lead lies in the environment, which involves a lot of research. There are multiple case studies that have emerged that really pinpoint where lead is in the environment. She noted that researchers from University of California Irvine have reviewed samples from Santa Ana and they were able to identify and characterize 11 census tracts within this area as high risk for lead exposure. Many of the areas identified as having higher lead content in the environment are where a large number of CalOptima Health members reside. These areas are close to historic roadways, and research indicates that gasoline is a strong contributor.

As an organization, CalOptima Health is taking a multi-pronged approach that not only targets CalOptima Health's members, but also its providers through education and call campaigns. In addition, CalOptima Health supplies providers with a blood lead tool to help with documentation when blood lead tests are refused. CalOptima Health also provides quarterly reports to its health networks, which is basically a list of members who have not met the screening requirements in accordance with the California State mandate.

The Committee members expressed an interest in knowing the trends on blood lead testing and results for various networks and sharing of strategies that are working well for the higher performing networks.

4. Population Health Management Strategy Update

Katie Balderas, Director, Population Health Management, presented an update on CalOptima Health's Population Health Management (PHM) Strategy. Ms. Balderas noted that CalOptima Health's PHM strategy builds upon the momentum of California Advancing and Innovating Medi-Cal (CalAIM) by focusing its efforts on upstream prevention and whole-person care. DHCS has provided guidance for this strategy that will require making changes to the way managed care plans deliver the PHM program starting January 1, 2023. This strategy also includes PHM Service, which is a technological service that supports DHCS's PHM vision by integrating data from disparate sources, performing population health functions, and allowing for multiparty data access and sharing. The PHM Service is scheduled to launch statewide in July 2023. Ms. Balderas reviewed the PHM program details and the timeline with Committee members.

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

Monica Macias, Director, PACE Program, provided an update on the recent activities of the PACE Member Advisory Committee (PMAC). Ms. Macias shared that the PMAC members are continuing to meet in person. She noted that the participants continue to provide great feedback in terms of how the program is doing. Ms. Macias also announced that CalOptima Health PACE has a new medical director, Dr. Donna Frisch, who brings a wealth of knowledge, and CalOptima is thrilled to have her on board.

Agenda Items 6.a. through 6.c. were accepted as presented.

6. Quarterly Reports to the Quality Assurance Committee

- a. Quality Improvement Committee Report
- b. Program of All-Inclusive Care for the Elderly Report
- c. Member Trend Report

COMMITTEE MEMBER COMMENTS

Director Mayorga thanked the staff for all their work and for always responding to his many questions quickly.

Director Shivers commented that she continues to be awed by the level of commitment and dedication of CalOptima Health staff in serving their members.

Chair Tran thanked Leslie Martinez, Katie Balderas, and Monica Macias for their informative presentations.

The Committee wished everyone a Happy Holiday and Happy New Year.

ADJOURNMENT

Hearing no further business, Chair Tran adjourned the meeting at 3:51 p.m. The next Quality Assurance Committee meeting is scheduled for March 8, 2023.

/s/ Sharon Dwiars

Sharon Dwiars
Clerk of the Board

Approved: March 15, 2023

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 15, 2023

Special Meeting of the CalOptima Health Board of Directors’ Quality Assurance Committee

Report Item

3. Receive and File 2022 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan Evaluation and Recommend Board of Directors Approval of the 2023 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Donna Frisch, M.D., PACE Medical Director, (714) 468-1044

Monica Macias, LCSW, PACE Director, (714) 468-1077

Recommended Actions

- Receive and file the 2022 CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement (QI) Plan Evaluation, and
- Recommend that the CalOptima Health Board of Directors Approve the 2023 PACE QI Plan.

Background

PACE is viewed as a natural extension of CalOptima Health’s commitment to integration of acute and long-term care services for its members. This program provides the link between healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. As of December 31, 2022, CalOptima Health PACE has 434 active members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes and participant satisfaction.

PACE organizations are required to have a written QI Plan that is evaluated annually. The results of the evaluation can directly lead to the revisions made to the following year’s QI Plan. The QI Plan reflects the full range of services furnished by CalOptima Health PACE. The goal of the QI Plan is to improve future performance through effective improvement activities driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.

The 2022 PACE QI Plan Evaluation analyzes core clinical and service indicators to determine if the 2022 QI Plan has achieved its key performance goals for the year. In 2023, CalOptima Health PACE continues to expand participants services and update quality element goals and continued efforts to ensure comprehensive care. The 2023 PACE QI Plan reflects CalOptima Health’s efforts to continue a high level of quality while also focusing on improving health outcomes and access for program participants.

Discussion

In 2022, the continued COVID-19 pandemic created challenges that significantly impacted CalOptima Health PACE. PACE faced these challenges head-on and continued to provide direct care to hundreds of the county's frail and senior population who are most at risk of contracting the COVID-19 virus. As a quality element, PACE was able to assist 98% of participants in becoming vaccinated against COVID-19 with >95% of those eligible also receiving *at least one* COVID-19 booster dose. Despite COVID-19, the PACE program was still able to meet quality work plan goals while also maintaining overall participant satisfaction with services above the national level for PACE centers.

CalOptima Health PACE has updated the 2023 QI Work Plan to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner. The 2023 PACE QI Plan, created through a collaboration of the PACE leadership members, refines the PACE quality elements based on the current population's health needs. The 2023 PACE QI Plan challenges the PACE team to strive for improvement in areas of treatment, service, and health outcomes.

In 2023 PACE proposes:

1. To add an element focused on the identification of osteoporosis in those who have had a fall, in order to reduce bone loss and lower risk of fracture through treatment.
2. To ensure that eligible participants receive their *bivalent* COVID-19 vaccine boosters to prevent infection and hospitalization.
3. To continue to strive for Medicare Quality Compass HEDIS 95th percentiles for diabetic care elements.
4. To assist in providing participants in completing advanced health care directives.
5. To focus on preventing falls with injury and repeated falls among participants.
6. To continue to provide excellent service to participants in areas of transportation, meals, and overall satisfaction with the PACE program.

Rationale for Recommendation

The Centers for Medicare and Medicaid requires PACE organizations to develop, implement, maintain, and evaluate an effective, data-driven QI program. As part of the QI program, the PACE organization must have a written QI Plan that is collaborative and interdisciplinary in nature. The PACE governing body must review the QI Plan annually and revise it, if necessary.

CalOptima Health Board Action Agenda Referral
Receive and File 2022 CalOptima Health
Program of All-Inclusive Care for the Elderly
Quality Improvement Plan Evaluation and
Recommend Board of Directors Approval of the 2023
CalOptima Health Program of All-Inclusive Care for the Elderly
Quality Improvement Plan
Page 3

Fiscal Impact

The recommended action to approve the 2023 PACE QI Plan has no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2022-23 Operating Budget. Staff will include expenditures for the period of July 1, 2023, through December 31, 2023, in the FY 2023-24 Operating Budget.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. 2022 CalOptima PACE QI Program Evaluation
2. Proposed 2023 PACE Quality Improvement Program and Work Plan (Redline version)
3. Proposed 2023 Quality Improvement Program and Work Plan (Clean version)
4. PowerPoint Presentation: 2022 PACE QI Work Plan Evaluation
5. PowerPoint Presentation: 2023 PACE QI Work Plan

/s/ Michael Hunn
Authorized Signature

03/01/2023
Date



**CALOPTIMA HEALTH PROGRAM OF ALL-
INCLUSIVE CARE FOR THE ELDERLY**

2022

**QUALITY IMPROVEMENT PLAN
ANNUAL EVALUATION**

SIGNATURE PAGE

PACE Quality Improvement Committee Chairperson:

**Dr. Donna Frisch , M.D.
Medical Director, PACE**

Date

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Tran, M.D.

Date

Board of Directors Acting Chairperson:

Clayton Corwin

Date

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2022 CALOPTIMA HEALTH PACE

QUALITY IMPROVEMENT (QI) PLAN ANNUAL EVALUATION

EXECUTIVE SUMMARY

As the COVID-19 pandemic continued into 2022, unprecedented challenges continue to impact all areas of life. CalOptima Health PACE faced these challenges head-on and continued to provide direct care to hundreds of our county's frail and senior population who are most at risk of contracting the COVID-19 virus.

When the pandemic was first declared, the scope of delivery of health care services had to instantly adjust to numerous health orders and recommendations from the national, state and county levels. We have continued to closely follow all updated mandates to provide a safe environment for our staff and participants.

PACE along with others in the health care community, received a waiver from the Centers for Medicare & Medicaid Services (CMS), to provide the flexibilities needed to take care of patients during the continued public health emergency. This has improved our ability to provide services beyond the existing walls of the PACE Center and assume a more home-based model, called "PACE without Walls." We continued with our service delivery matrix to provide existing PACE care services including: medical management, nursing services, social services, therapies such as physical, occupational and speech therapies, dietary services and personal care services. Additional "PACE without Walls" services delivered by our transportation team included care packages containing items such as activity books, calendars, and games. Participants eagerly awaited these care packages and the opportunity to connect with others beyond their home.

Understanding the importance of continuing to provide preventive health services, we continued drive-through flu immunizations and as well as drive-through COVID-19 testing throughout 2022. A collaboration between the PACE clinic, the Quality Improvement department and the PACE scheduling team led to increased COVID vaccination numbers. We were able to end 2022 with a 98% participant COVID-19 vaccination rate. Additionally, efforts were made throughout the year to provide participants with the latest recommended booster doses, whereby >95% of eligible PACE participants received *at least* one COVID-19 booster dose.

Understanding the profound importance of maintaining contact with our PACE participants through the ongoing pandemic, we continued with our previously implemented "wellness calls" to check in on the well-being of our participants. As of the end of 2022, close to 66,000 wellness calls have kept participants connected with PACE since the start of the COVID-19 pandemic.

Following state and local guidelines, PACE Day center attendance slowly increased throughout 2022. All CDC guidelines were put into place to ensure safety protocols are being followed. Participants remain grouped into "pods" where they join with a small number of other participants to promote social distancing, with two staff members assigned per pod. Participants are chosen for day center attendance by IDT based on who needed the most support and who were able to follow the CDC guidelines (i.e., wear a mask, stay 6 feet apart). Any participants attending day center services must also be fully vaccinated against COVID-19 with both initial doses, as well as a booster dose. Additionally, despite several COVID-19 surges, we were able to provide more face-to-face services for participants with their providers, clinic, and rehabilitation staff. We have

worked diligently to provide as many in-person services to our participants as possible, while also assessing risk factors for spread of disease and implementing processes to mitigate these risks. In July of 2022 we implemented the requirement for all staff and participants to wear KN-95 level masks while in the PACE building, to further expand our efforts against disease transmission.

Despite the continuing challenges of COVID-19 we continued to enroll new participants and saw our highest enrollment numbers by the close of 2022. When CalOptima Health PACE first opened for operations on October 1, 2013 we had 13 participants. We have seen continued growth in enrollment through the years and at the end of 2022, we had 434 participants enrolled. The multi-cultural background and the diversity of our participant population provides a very vibrant and engaging environment at PACE. Out of our 434 participants, the primary languages are 63% Spanish, 16% Vietnamese, and 14% English and other languages spoken include Arabic, Tagalog, Chinese, Urdu, Hindu, Persian and Telugu. CalOptima Health PACE ensures that participants are always provided with opportunities to communicate in their preferred language using professional interpreter services and that PACE staff provide culturally competent care to each of our members.

The purpose of the CalOptima Health PACE QI Plan is to improve the quality of health care for participants, improve on the patient experience, ensure appropriate use of resources, provide oversight to contracted services, communicate all quality and process improvement activities and outcomes, and reduce the potential risk to safety and health of PACE participants through ongoing risk management. This is done via data-driven assessments of the program which in turn drives continuous QI for the entire PACE organization. It is designed and organized to support the mission, values, and goals of CalOptima Health PACE.

The goal of the CalOptima Health PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff. The 2022 PACE QI Evaluation helps to identify key areas that offer opportunities for improvement that will be incorporated into the 2023 PACE QI Plan.

SECTION 1: PROGRAM STRUCTURE

The CalOptima Health PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). It is then reviewed and approved by the CalOptima Health Board of Directors' Quality Assurance Committee (QAC) and then approved by the CalOptima Health Board of Directors annually. The 2022 PACE QI Plan was reviewed and approved by the CalOptima Health Board of Directors on April 7th 2022.

The CalOptima Health PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI manager will ensure timely collection and completeness of data with the support of the PACE QI program specialists. Overall, oversight of the PACE QI Plan is provided by the CalOptima Health Board of Directors.

The CalOptima Health PACE QI Plan incorporates continuous QI methodology that focuses on the specific needs of CalOptima Health's PACE participants.

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

SECTION 2: PACE QAPI PROGRAM

Major Accomplishments

In 2022, CalOptima Health PACE's accomplishments include:

1. Swift response to updates regarding the COVID-19 pandemic, to follow all federal, state, and local guidance.
2. Use of telehealth modalities that enabled participants to "visit" their providers from their homes.
3. Connected with participants through 6,381 wellness calls, 40,591 home delivered meals and provision of 1405 wellness care packages throughout 2022.
4. Provided infection control training to all staff in accordance with CDC, DHCS and CDPH directives.
5. Oversight of PACE contractors to ensure compliance to state and federal COVID-19 vaccination guidelines.
6. Implemented robust staff COVID-19 safety compliance, including decision to require staff to wear KN95 face masks when in the PACE facility and to maintain social distancing with other staff.
7. Implemented robust participant COVID-19 booster vaccination initiative, with 95% of eligible participants having received *at least one* booster dose by the end of 2022.
8. Implemented a plan to assist eligible participants with receiving the bivalent COVID-19 booster which became available in September 2022.
9. Implemented a plan to increase PACE Day center activities and attendance in accordance with infection control guidelines.
10. Continued COVID-19 visitor vaccination protocols, which included proof of vaccination for those accessing the PACE Center and rapid antigen testing for unvaccinated caregivers who accompany participants for PACE services
11. Weekly COVID-19 updates to the leadership team and monthly updates during our all-staff meetings.
12. 93% of participants received their annual influenza vaccine.
13. 88% of participants completed their Pneumococcal vaccine series.
14. Continued enhanced care coordination program for participants on dialysis.
15. 100% of participants had their medications reconciled within 15 days of hospital discharge.
16. Prompt review by clinical pharmacist of specialty medications ordered by outside specialists.
17. Retrospective reviews of medication utilization were performed daily and monthly. Recommendations were immediately addressed with the PACE provider and/or IDT.
18. Quality of Diabetes Care
 - a. 96% of participants with diabetes completed an annual eye exam.
 - b. 100% of participants with diabetes had nephropathy monitoring.
19. Utilization:
 - a. Only 3.8% participants were placed in long-term care in 2022.
 - b. Continued the PACE Emergency Room (ER) Diversion program.
 - c. Continued to provide in-house specialist care including podiatry, psychiatry, nephrology and dental services for improved access and coordination of care.

- d. Morning clinical huddles continue to be incorporated into the IDT meetings for all teams.
20. Transportation:
 - a. On-time performance of 98%.
 21. Participant Satisfaction
 - a. 89% overall satisfaction with care received compared to the national average of 88.6%.
 - b. 84% satisfaction with Recreational Therapy compared to national average of 79.1%
 - c. 82% satisfaction with Meals compared to national average of 71.1%
 22. 100% of staff competency assessments were completed. Year-round staff trainings were provided covering a broad area of topics included infection control, emergency responses, grievances, appeals, service delivery requests, and participant rights.

SECTION 3: STRATEGIC GOALS AND OBJECTIVES

Accomplishments

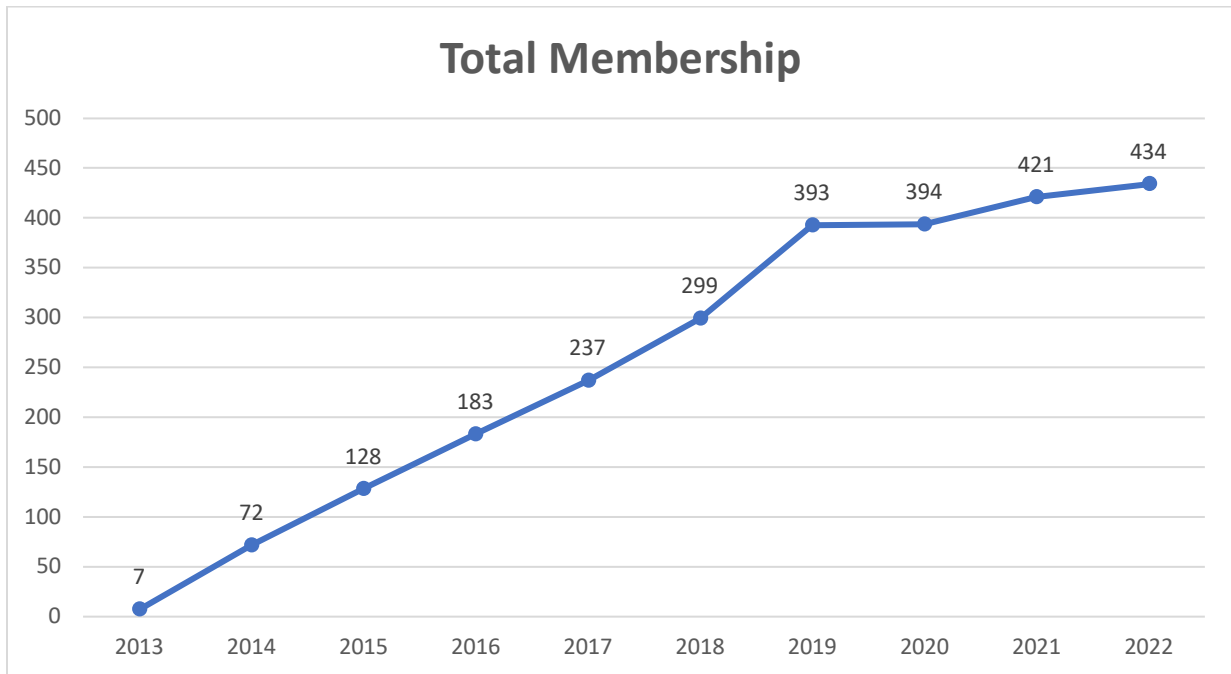
1. The QI program is organized to identify and analyze significant opportunities for improvement in clinical services, care, and utilization. Accomplished and evidenced by:
 - a. The ongoing Health Plan Management System (HPMS) and QI individual metric data collection and analysis.
 - b. The ongoing PACE QI activities and initiatives.
2. The quality of clinical care and services and patient safety provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population. Accomplished and evidenced by:
 - a. The ongoing HPMS and QI individual metric data collection and analysis.
 - b. The ongoing PACE QI initiatives.
 - c. The monitoring of member grievances and complaints, and regular review of delegated entities.
 - d. The monthly meeting with the transportation vendor.
 - e. The daily morning inpatient and nursing facility clinical reviews by medical case manager.
 - f. The ongoing infection control activities, specifically tracking, reporting, and treatment of all infectious disease cases.
 - g. Collaboration with the CalOptima Health Compliance department for identification of potential quality issues that may involve fraud, waste, abuse, confidentiality, security, etc.
 - h. The annual approval of up-to-date Clinical Practice Guidelines and the National PACE Association Preventative Guidelines.
 - i. The PACE Clinic Workflow to efficiently address participant care issues during the COVID-19 pandemic.
3. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners. Accomplished and evidenced by:
 - a. The Interdisciplinary Care Team (IDT) meetings at CalOptima Health PACE.

- b. Continued presence of physicians and nurse practitioners during IDT meetings.
 - c. Addition of preferred specialists who regularly provide services within the PACE clinic.
 - d. The coordination of care found in the ER Diversion Program.
- 4. The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population. Accomplished and evidenced by:
 - a. The number of grievances that have been tracked and trended.
 - b. Podiatry, nephrology, dental and psychiatry staff providing on-site care.
- 5. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service. Accomplished and evidenced by:
 - a. The credentialing and peer review process.
 - b. Annual evaluations of all CalOptima Health PACE employees.
- 6. Member and provider satisfaction, including the timely resolution of complaints and grievances. Accomplished and evidenced by:
 - a. The 2022 PACE Participant Satisfaction Survey showing that PACE member satisfaction is higher than national average.
 - b. The summary of grievance and appeals activities.
 - c. The ongoing input from the PACE Member Advisory Committee meetings.
- 7. Risk prevention and risk management processes. Accomplished and evidenced by:
 - a. The QI activities which occur around all Unusual Incidents and including root cause analyses and recommendation for improvement and follow up.
 - b. Physical therapy driven groups designed to prevent falls.
- 8. Compliance with regulatory agencies and accreditation standards. Accomplished and evidenced by:
 - a. The successful submission of data as required by CMS and DHCS each quarter.
- 9. Compliance with clinical practice guidelines and evidence-based medicine. Accomplished and evidenced by:
 - a. The adoption of the National PACE Association Preventative Guidelines.
 - b. The use of Uptodate.com clinical practice standards.
 - c. On-going PACE staff training.
- 10. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently. Accomplished and evidenced by:
 - a. Tracking, trending, and analyzing utilization management (UM) data monthly.
 - b. The provider incentive program.
 - c. The coordination of care found in the ER Diversion Program.
 - d. The weekly PACE leadership team meetings.
 - e. The participation in the CalOptima Health QI, UM, and Credentialing and Peer Review Committee meetings.
 - f. The participation in the CalOptima Health Board of Directors and the Board of Directors' Quality Assurance Committee meetings.

SECTION 4: SUMMARY OF ACCOMPLISHMENTS, BARRIERS, AND ACTIONS

PACE Membership at a Glance

CalOptima Health PACE offers a community-based program that provides all necessary medical care coordination and social services support in one location to the frail and elderly within our community. The goal of keeping seniors healthy in their homes and maintaining their independence continues to be our mission eight years later. At the end of 2013, we had seven participants enrolled and now, nine years later, we have 434 active participants.



As illustrated in the membership graph, PACE has seen a steady enrollment trend over the years. Due to the COVID-19 pandemic, there was almost no growth noted in 2020. However, despite continued challenges, in 2021 and 2022 PACE once again saw an upward trend in enrollment numbers.



In 2023, our goals for program growth remain intact and strategies are already being put into place to accommodate participants post-pandemic. We continue our aggressive marketing strategies which includes print, radio and television media to reach a wider audience throughout Orange County.

2022 Quality Improvement Work Plan — Elements by Category:

Quality of Care and Services

QI22.01 PACE QAPI Plan and Work Plan will be evaluated annually

Approved by the CalOptima Health Board of Directors on April 7, 2022.

QI22.02 PACE QAPI Plan and Work Plan will be reviewed and updated annually

Approved by the CalOptima Health Board of Directors on April 7, 2022.

QI22.03 Increase Influenza immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their annual influenza vaccination by December 31, 2022.

Goal: Not Met

Data/Analysis: 93% percent of participants received the influenza vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

With a year-end vaccination rate of 93%, we fell short in meeting our goal by only one percentage point, an improvement from 2021’s end of year performance of 91%. Vaccines were pre-ordered in late spring from our distributor, and we began to vaccinate participants when vaccines arrived in August 2022. PACE used strategies to reach all eligible participants, such as an aggressive flu vaccination campaign which included vaccine clinic events at PACE. Monthly reports were generated by our QI department identifying those participants who still required the vaccine, and this was shared with the PCP and RN’s who personally reached out to the unvaccinated

participants. It is important to note that CalOptima Health PACE reported zero influenza outbreaks among our participants or staff in 2022. Our influenza vaccination efforts for the 2022/2023 flu season will extend through Quarter 1 of 2023 where we will continue to reach out to the unvaccinated.

QI22.04 Increase Pneumococcal immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their PCV23 pneumococcal vaccination by December 31, 2022.

Goal: Not Met

Data/Analysis: 88% of participants received the pneumococcal vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2022, 88% of our participants had completed pneumococcal vaccination, not meeting our goal for 2022. The PACE QI department provided detailed reports to the clinic which specified which participants still needed the vaccination. It was then shared with all participant's medical providers. As with previous years, one of our challenges was the complex interval periodicity between the Pneumococcal 13 and Pneumococcal 23 vaccines. In 2022, a new vaccine was introduced to PACE- Pneumococcal 20, which is a one dose vaccine that eliminates the timing and dosage challenges of the previously approved pneumococcal series. In 2023, we anticipate that the identification of those needing vaccine through review in the California Immunization Registry (CAIR2) in addition to the new one dose vaccine will increase our ability to meet and maintain the 94% goal moving forward.

QI22.05 Increase COVID-19 immunization rates for all eligible PACE participants

Goal: Greater than or equal to 95% of eligible participants will have their COVID-19 vaccination by December 31, 2022.

Goal: Met

Data/Analysis: 98% of participant received COVID-19 vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2022, 98% of PACE participants had received either 1 dose of Janssen or 2 doses of Moderna or Pfizer COVID-19 vaccine. Additionally, we were able to further our efforts by assisting with the process of getting participants their recommended booster doses as well, discussed in the quality initiative section. In 2023, we plan to continue our efforts to ensure that all PACE participants are fully vaccinated against COVID-19 by changing this quality element goal to "80% will be vaccinated with the *Bivalent* COVID-19 vaccine" which is the latest recommended vaccine by the Centers For Disease Control.

QI22.06 Increase Physician Orders for Life-Sustaining Treatment (POLST) utilization for PACE participants

Goal: Greater than or equal to 95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2022.

Goal: Not Met

Data/Analysis: 94% of participants enrolled in the PACE program for 6 months had POLST by the end of 2021.

Quarters 2022	Completion Rate
Q1	90%
Q2	92%
Q3	96%
Q4	94%
EOY	94%

Summary and Key Findings/Opportunities for Improvement:

We did not meet our goal in 2022, being only 1% below our target goal. However, through the efforts of our Primary Care Providers and the Associate Clinical Medical Director we were able to improve on our 2021 end of year performance of 91%. End-of-life decisions are reviewed with the participant by the Provider to complete this important document that respects the wishes of each participant. End-of-life and palliative care discussions continue to be integrated into our Interdisciplinary Team meetings (IDT) and are documented in the participant’s care plan.

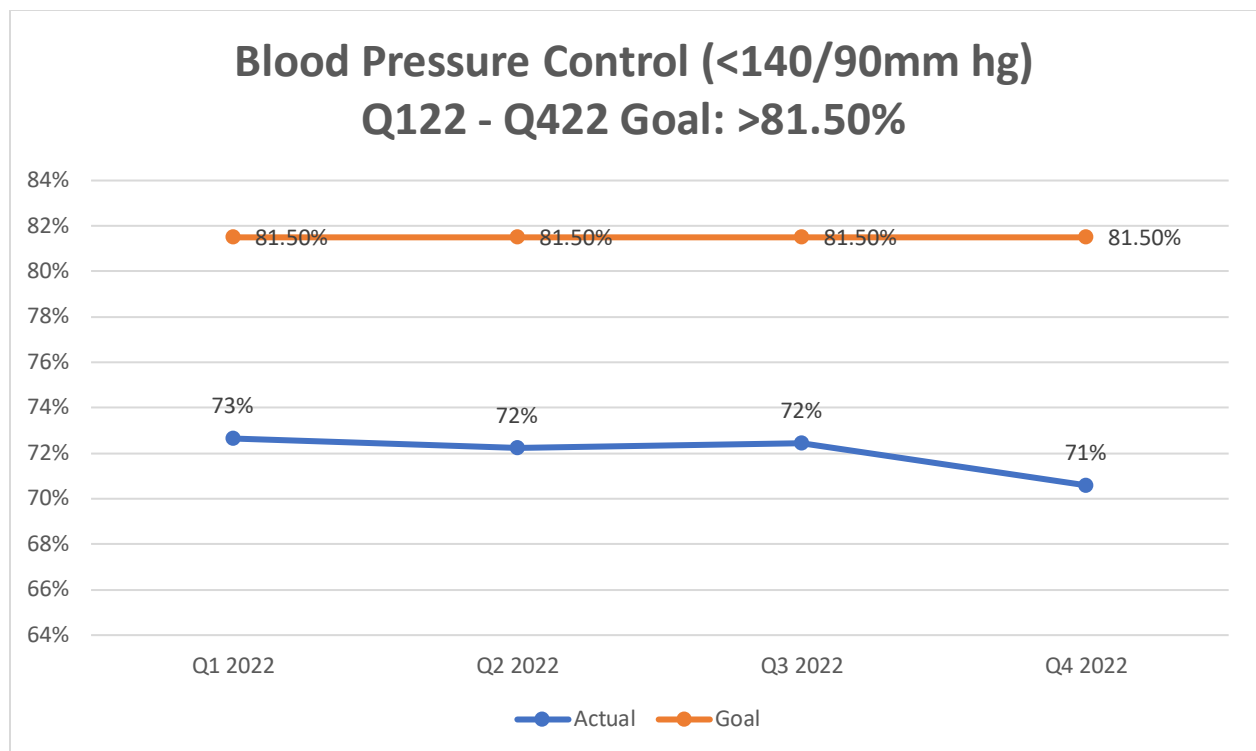
In 2023, we plan to continue our efforts to ensure that our participants have a POLST in place. In addition to the PACE Clinical Operations Manager having oversight of this element, the PACE Medical Director will also be assisting with plans to reach our goal in 2023.

Q122.07 Increase the percentage of PACE participants with diabetes who have controlled blood pressured (<140/90 mm hg)

Goal: > 81.50% of Diabetics will have a Blood Pressure of <140/90

Goal: Not Met

Data/Analysis: The 2022 final average was 72%.



Diabetics with Controlled Blood Pressure					
2020 Medicare Quality Compass					
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	95th Percentile
72%	58.64%	65.69%	72.02%	77.86%	81.51%

Summary and Key Findings/Opportunities for Improvement:

We did not meet our goal in 2022. Some reasons for this may have been that the pandemic limited face to face appointments and closer intervention of BP management, fewer participants were in the day center getting healthy meals and home diets may have been less optimal due to inflated cost of healthy foods. For 2023 we will be taking measured steps to meeting the HEDIS 95th percentile by implementing the following:

- We will identify participants with the diagnosis of frailty on the care plan and those patients will be excluded.
- If BP high on first reading MA will repeat prior to participant leaving. If still high participant will have follow with RN to check home readings and if still high provider will review and adjust medications and offer dietician.
- We are increasing the day center participation so that we can directly monitor diet and blood pressure in our participants.
- We will be giving out more home BP monitors.
- We are doing more face-to-face appointments in all departments.

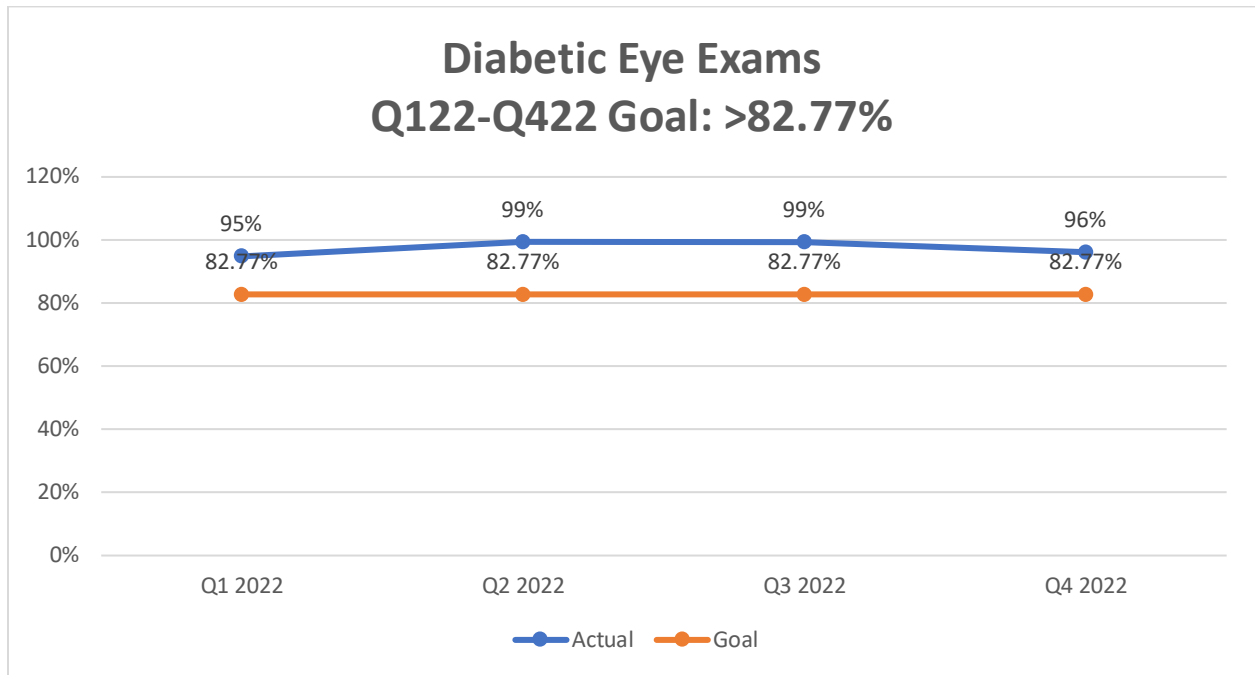
This goal will be updated to 84.21% for 2023 to reflect changes in HEDIS goals for 2023. (Comparable to the MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2023 QI Work Plan)

QI22.08 Increase the percentage of PACE participants with diabetes who have had their annual diabetic eye exam completed

Goal: Greater than 82.77% of Diabetics will have an Annual Eye Exam

Goal: Met

Data/Analysis: The 2022 final rate was 96%.



Comprehensive Diabetes Care: Annual Diabetic Eye Exam					
2020 Medicare Quality Compass					
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	95th Percentile
96%	62.56%	69.34%	76.3%	80.78%	82.77%

Summary and Key Findings/Opportunities for Improvement:

We exceeded our target goal, with 96% of diabetic participants having received an annual eye exam in 2022. With the assistance of monthly reports generated by the PACE QI team, providers were alerted to those participants who required eye exams. Those participants were then scheduled for an appointment with their PCP on an annual and semi-annual basis. Contracted ophthalmologists and optometrists are very diligent in their follow-up and provide our medical team with timely specialty reports. These results are above the 2020 Medicare HEDIS Quality Compass 95% percentile. In 2023, the goal will be changed to >85.42% of Diabetics will have an Annual Eye Exam (Comparable to the MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2023 QI Work Plan). We anticipate no difficulty in once again exceeding this goal in 2023.

QI22.09 Increase the percentage of PACE participants with diabetes who receive nephropathy monitoring

Goal: Greater than 98.30% of Diabetics will have Nephropathy Monitoring

Goal: Met

Data/Analysis: The 2022 final rate was 100%.

Comprehensive Diabetes Care: Medical Attention for Nephropathy

	2020 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	95th Percentile
100%	92.46%	94.74%	96.11%	97.81%	98.3%

Summary Key Findings/Opportunities for Improvement: In 2022, 100% of our diabetic participants received nephropathy monitoring, matching our success from 2021. The PACE QI department works closely with the medical team in providing data generated reports identifying which participants required nephropathy screening/monitoring. These results are comparable to a 2020 Medicare HEDIS Quality Compass 95th percentile. PACE will increase this goal to 98.78% to reflect the changes to the HEDIS Quality Compass 95th percentile. (Comparable to the MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2023 QI Work Plan). We anticipate no difficulty in once again exceeding this goal in 2023.

QI22.10 Ensure participants with Osteoporosis are receiving treatment

Goal: Greater than or equal to 90% of participants with the diagnosis of Osteoporosis will have treatment initiated by PCP

Goal: Met

Data/Analysis: The 2022 final rate was 98%.

Quarter 2022	Rate
Q1	97%
Q2	98%
Q3	99%
Q4	98%
EOY	98%

Summary Key Findings/Opportunities for Improvement: In 2022, 98% of our participants with Osteoporosis were actively receiving treatment including medications such as bisphosphonates with a goal to stop bone loss and improve bone density. PACE providers have been diligent in the treatment of this disease which can lead to disfunction and increased fractures in the elderly. Moving into 2023, we will be focusing on ensuring that all participants who sustain a fall will have been identified for Osteoporosis and bone fracture risk using Dual-energy X-ray absorptiometry (DEXA) scans.

QI22.11 Decrease the number of falls classified as CMS reportable quality incidents

Goal: <207 Falls per 1000 member months falls that resulted in fracture, hospitalization, or death.

Goal: Met

Data/Analysis:

The 2022 rate was 59 falls per 1000 member months:

Quarter 2022	# Falls Per 1000 Per Year

Q1	49.00
Q2	53.00
Q3	54.00
Q4	59.00
EOY	59.00

Summary Key Findings/Opportunities for Improvement:

We met our goal for falls with serious injury in 2022. We have developed multiple strategies for prevention of recurring falls. After each fall, the rehabilitation team of licensed physical and occupational therapists determines if fall is mechanical or related to any medical problems of participant. The primary care provider and nursing team will check on medical factors and provide referrals and other interventions, as necessary. Pharmacy and provider work together to check medications if need to be adjusted for cases that concerns loss of balance, dizziness, or muscle weakness. Rehabilitation, homecare coordinator, and social provide interventions for mechanical falls such as tripping and or any changes in participant’s environment and living situation. All other disciplines provide their inputs and interventions as the need arises. In 2023 we will continue our increased surveillance of repeat faller by instituting mandatory home assessments and follow up completed by PACE to reduce total number of falls at home.

QI22.12 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents

Goal: <27.24%

Goal: Met

Data/Analysis: The 2022 rate was 19%

DDE: Dementia + Tricyclic Antidepressant or Anticholinergic Agents					
2020 Medicare Quality Compass					
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	95th Percentile
19%	43.4 %	37.36%	32.58%	27.24%	24.03%

Summary and Key Findings/Opportunities for Improvement:

In 2022, only 19% of our participants who were diagnosed with dementia were prescribed a tricyclic antidepressant or anticholinergic agent. The PACE QI department worked closely with the medical team and generated reports of participants with dementia who were also prescribed the cautionary medications. On a monthly basis our medical providers, clinical pharmacists and data specialists, review in detail all the medications that are considered “red flags” per CMS and Beer’s criteria. This is shared with other clinical medical providers and alternative medication options are discussed during provider meetings. Our clinical pharmacist is instrumental in reviewing medications ordered by providers, confirming that there are no contraindications to the drugs and then recommending alternative medication options, thereby preventing adverse outcomes. These results are comparable to the Medicare HEDIS Quality Compass 95th percentile. Based on 2022 updates to HEDIS guidelines, we will be changing our goal from <24.03% to <24.64%

(Comparable to the MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2023 QI Work Plan) and feel confident that we will once again exceed this goal.

QI22.13 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDs or Cox2 Selective NSAIDs

Goal: <3.47%

Goal: Met

Data/Analysis: The 2022 rate was 2.0%.

DDE: CKD+ Nonaspirin NSAIDs or Cox2 Selective NSAIDs					
	2020 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	95th Percentile
2%	13.31 %	9.24%	6.25%	3.47%	2.47%

Summary and Key Findings/Opportunities for Improvement:

Careful review of participants with chronic kidney disease who are prescribed NSAIDs is an important factor in limiting the progression of kidney disease. Our in-house clinical pharmacist is a vital asset in monitoring potential drug/disease interactions and presenting therapeutic alternatives to the medical provider. The continued coordinated efforts of the PACE medical providers and the PACE clinical pharmacist will assure optimal scrutiny in the use of NSAIDs among our participants with chronic kidney disease. These results are comparable to the 2020 Medicare HEDIS Quality Compass 95th percentile. Based on 2022 updates to HEDIS guidelines, we will be changing our goal from <3.47% to <2.62% (Comparable to the MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2023 QI Work Plan) and feel confident that we will once again exceed this goal.

QI22.14 Monitor participants who are receiving prescription opioids for 15 days or more days at an average milligram morphine equivalent (MME) dose of 90mg

Goal: 100% of participants receiving opioids for 15 or more days at an average MME 90mg will be reevaluated monthly by their treating provider.

Goal: Met

Data/Analysis: The 2022 rate was 100%

Quarters 2022	# Participants on high dose opioids with PCP follow up
Q1	1 out of 1 participant reevaluated (100%)
Q2	1 out of 1 participant reevaluated (100%)
Q3	1 out of 1 participant reevaluated (100%)

Q4	1 out of 1 participant reevaluated (100%)
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Summary and Key Findings/Opportunities for Improvement:

In the 2022 we were able to fully meet our goal of 100% for each quarter. It should be noted that we have very few participants who exceed the established recommendations of daily morphine MME dosing. The PACE QI department works in concert with pharmacy to identify any participants who may be taking high dosage opioids. These specific participants are then automatically added onto the provider’s monthly schedule so that appropriate participant/PCP follow-up can occur. We will continue to track and monitor this in 2023 and anticipate that we will again achieve 100% in 2023.

QI22.15 Increase the percentage of participants for whom medications were reconciled within 30 days of hospital discharge

Goal: ≥ 90% of participants will have their medications reconciled within 15 days of hospital discharge in 2022

Goal: Met

Data/Analysis: 99% of participants had medications reconciled within 15 days post discharge in 2022.

Quarters 2022	# Participants with Medication Reconciliation within 14 days of discharge
Q1	100%
Q2	100%
Q3	100%
Q4	96%

Summary and Key Findings/Opportunities for Improvement:

Medication reconciliation post hospital discharge remains one of our top priorities. Our clinic staff maintain a close relationship with our participants and take care of our participants across all levels of care thereby improving continuity of care. This partnership allows for prompt medication reconciliation after hospital discharge. Our clinical pharmacist plays a vital part in the reconciliation process as well as a dedicated additional clinical staff members who handle medication reconciliation for hospital and SNF discharges. In 2023, we plan to change the goal of Post-Discharge Medication Reconciliation from within 15 days after discharge to within 10 days after discharge from hospital or SNF to home, to better ensure that our participants post-discharge needs are met in a timely manner to help prevent recurrent hospital admissions.

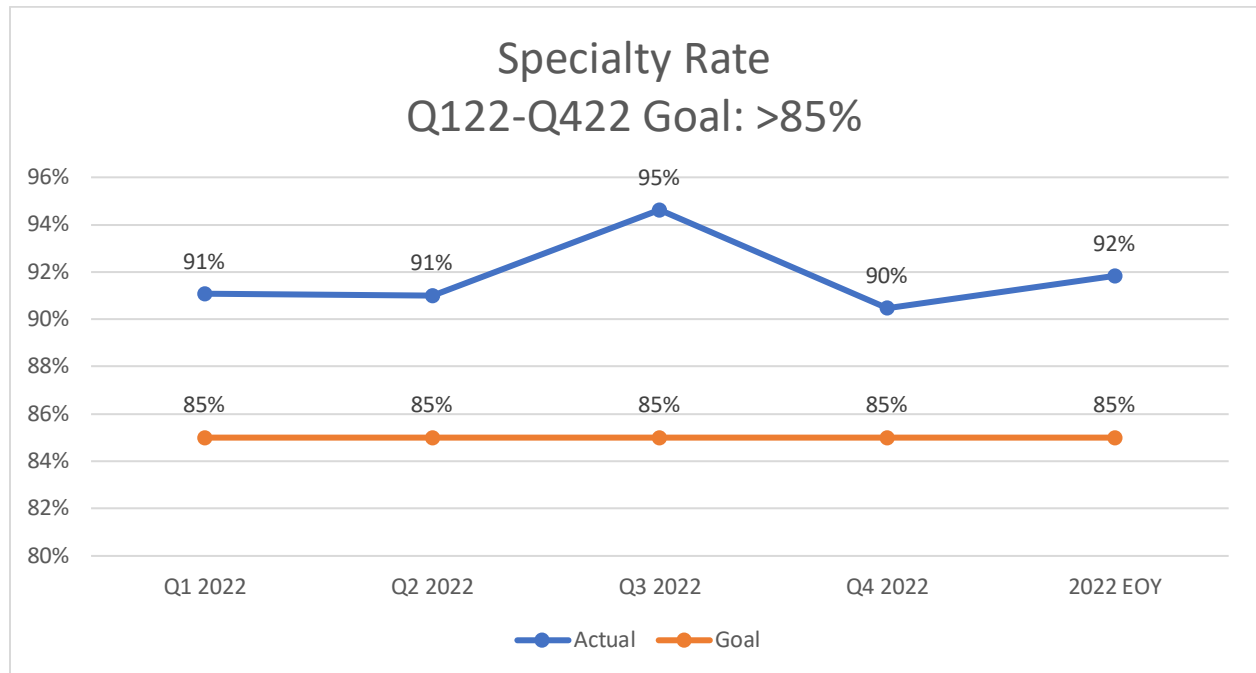
Access and Availability

QI21.17 Improve access to specialty practitioners

Goal: $\geq 85\%$ of specialty care authorizations will be scheduled within 14 business days in 2022

Goal: Met

Data/Analysis: The 2022 rate was 92%.



Summary and Key Findings/Opportunities for Improvement:

Our PACE scheduling department continues to utilize strategies put in place to improve access to specialty care. In the past, we expanded the number of staff dedicated to scheduling specialty appointments. Specialty scheduling is rather complex in that the staff member not only schedules the appointment for the participant, but also handles appointment confirmation, coordinating transportation needs, and submitting relevant medical records to the specialist. Additionally, we continue to have a scheduler who is assigned to each of our IDT teams and focuses on coordinating all these activities.

We continued to provide dentistry services on-site as well as a nurse practitioner dedicated to primary care podiatry issues in 2022. We also utilized on-site psychiatry services and nephrology services. Throughout 2022, we have been able to increase some of those in house specialist activities, following strict COVID protocols. As part of our operational Work Plan for 2023, we will look to identify additional core specialists, such as ophthalmology, who understand the PACE model of care and are willing to work closely with the program. This will improve scheduling access as well as care coordination through prompt consult notes and real-time dialogue between the specialist and the PACE medical provider. In 2023 we are maintaining our benchmark goal that $\geq 85\%$ of specialty care authorizations will be scheduled within 14 business days.

QI22.17 Improve access to telehealth

Goal: $\geq 66\%$ of participants will have access to telehealth.

Goal: Not Met

Data/Analysis: 54% of participants had noted access to telehealth modalities by the end of 2022.

Summary/Key Findings/Opportunities for Improvement

PACE did not meet the benchmark of $\geq 65\%$ of participants having access to engage in telehealth visits. Telehealth access is measured by the percentage of participants who are able install and correctly use the telehealth platform VSEE or other video conferencing applications. There are several challenges to providing video telehealth visits for our specific participant population, including a lack of accessibility to participants who may not have smart devices, bandwidth, or the physical/cognitive capability of using these types of applications. In 2022, despite the continued pandemic, participants were being seen in person at the center again, and so the need for video conferencing lessened. It is PACE's preference to perform in-person assessments and hands-on care within our PACE clinic and center. Due to the many complexities involved, in 2023 we will remove this element while continuing to operationally strategize on how to provide telehealth access to more of our members moving forward.

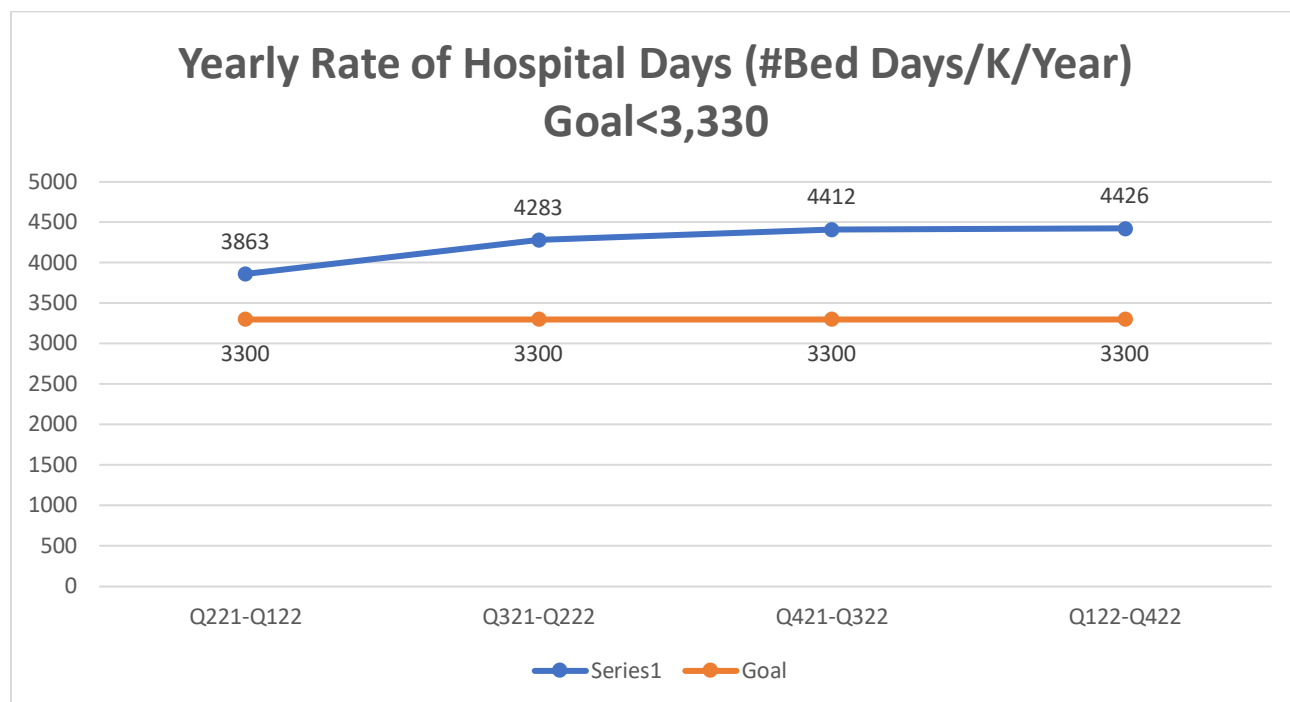
Utilization Management

QI22.18 Reduce the rate of acute hospital days by PACE participants

Goal: < 3,330 hospital days per 1000 per year

Goal: Not Met

Data/Analysis: The 2022 rate was 4,426 bed days per 1000 per year.



Summary/Key Findings/Opportunities for Improvement

CalOptima Health PACE did not meet our goal of <3,300 hospital days per 1000 per year in 2022. The main reason for this is the high number of medically complex patients that are part of our program, including participants who required extended stays in Long Term Acute Care Hospitals

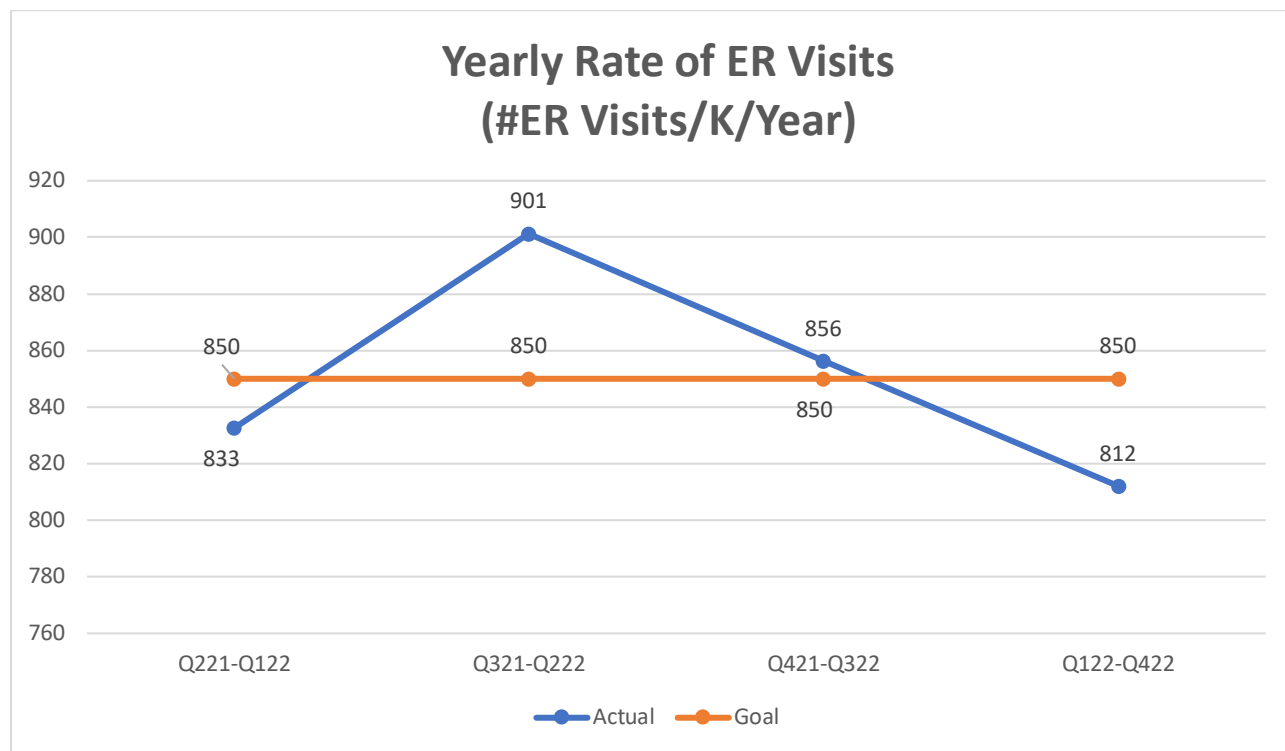
due to medical need, which contribute to overall hospital bed days. Despite the high level of care needs of our participants, PACE will continue to strive for this same goal in 2023. PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education.

QI22.19 Reduce the rate of ER utilization by PACE participants

Goal: < 810 emergency room visits per 1000 per year

Goal: Met

Data/Analysis: The 2022 rate was 810 emergency room only visits per 1000 per year.



Summary and Key Findings/Opportunities for Improvement:

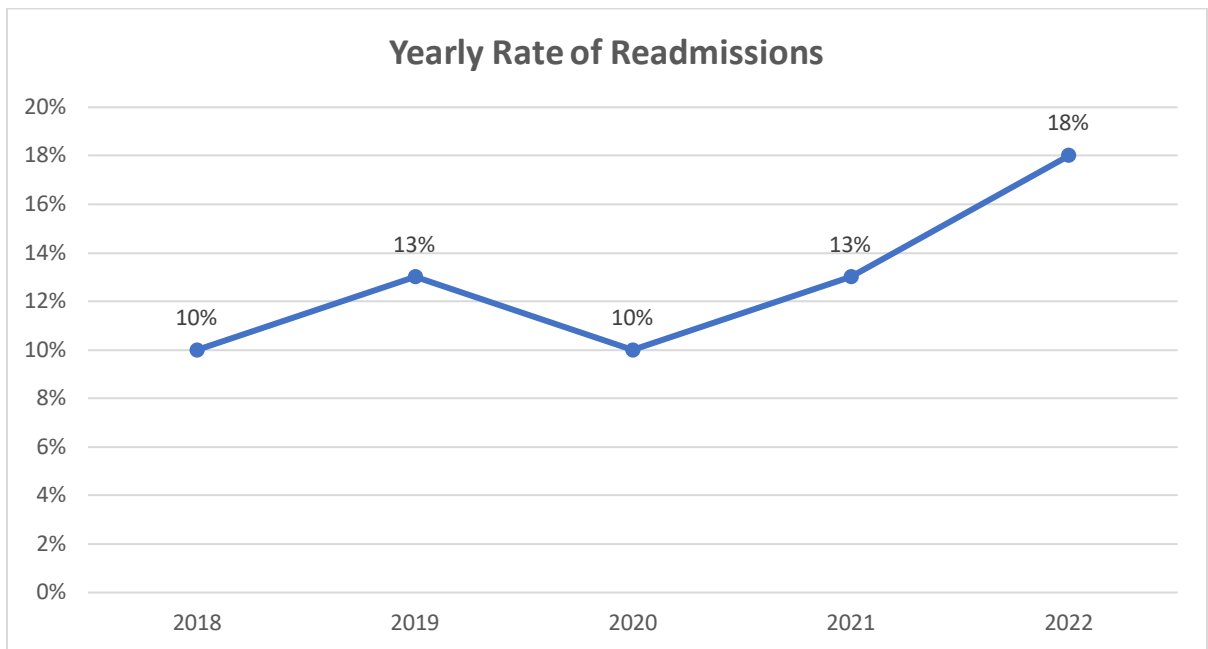
Emergency rooms visits increased throughout Q2 of 2022, but then steadily dropped in Q3 and Q4, allowing us to meet our final goal for 2022. Similar to our hospital utilization rates, we will be maintaining our goal of < 810 emergency room visits per 1000 per year in 2023. ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education.

QI22.20 Reduce the 30-day all cause readmission rates by PACE participants

Goal: Less than 14% 30-day all cause readmissions

Goal: Not Met

Data/Analysis: The 2022 rate was 18%.



Summary and Key Findings/Opportunities for Improvement:

The readmission rates tend to have a great deal of variance year to year due to the small total number of participants and readmissions. We ended 2022 with an 18% 30-day readmission rate which is a 3% increase from 2021. Our major challenges in readmissions are the medical complexity of our participants, non-compliance on the part of the participant and lack of family support. In 2022, we continued to incorporate the morning clinical huddles into the interdisciplinary team meetings (IDT). Additionally, PCPs utilized telehealth to triage participants health needs before they required emergency services, such as following up on wellness calls as necessary and providing telemedicine services through the afterhours clinic line. PCPs also followed up with participants soon after their hospital discharge in order reassess the participants immediate health needs following hospitalization as well as any long-term need for changes in care plan to prevent future hospitalizations. For 2023, we strive to reach lower readmission rates and will maintain our goal of a <14% readmission rate.

QI22.21 Decrease the percentage of participants who are placed in a long-term care facility

Goal: < 4% of participants will reside in long-term care (LTC)

Goal: Met

Data/Analysis: 2022 rate was 3.4% of the PACE enrollment resided in long-term care.

Summary and Key Findings/Opportunities for Improvement:

One of the most important tenets of the PACE program is to help our participants continue to live safely at home for as long as possible. We ended 2022 with 3.4 % of our participants residing in LTC, meeting our intended goal. There are several issues which contribute to a rise in PACE LTC census for our high-risk participants, especially for those with multiple advanced chronic conditions. These are participants whose outpatient management has been unsuccessful in the home, assisted living facility (ALF) or board and care (B&C) environment. Families and

caregivers may be unable or unwilling to assist with necessary care tasks at home. Poor family support and fragile living environments can lead to increased ER and hospital utilization. On some occasions, participants need temporary placement in LTC as a custodial care measure. These are participants with complex medical conditions that require complicated workups, specialty care, and who have difficulty with maintaining their care plan on their own at home. For example, participants who are noncompliant with their prescribed medications, refuse to attend their hemodialysis sessions, or have recurrent falls where all other fall prevention measures have failed. These participants benefit from placement in LTC facilities until their health is stabilized and they can be reassessed and reeducated regarding their health plan. In 2023, we plan to maintain our benchmark and investigate solutions to address the individualized care needs of our unique population.

Enrollment

QI22.22 Increase the Qualified Lead to Enrollment conversion rate

Goal: Increase the Qualified Lead to Enrollment conversion rate to 60%

Goal: Met

Data/Analysis: Final rate was 76%.

Quarter 2022	Rate
Q1	79%
Q2	74%
Q3	73%
Q4	76%
EOY	76%

Summary and Key Findings/Opportunities for Improvement:

In 2022, we exceeded our goal in the percentage of qualified leads to enrollment. This afforded the frail and elderly in our community greater access to health care in an environment which also supports their physical, rehabilitative, and psychosocial needs.

Several strategies led to successful enrollment:

1. Our screening, intake, and assessment tools to screen-out enrollees including those who were too high-functioning and would not be eligible per State certification, although they initiated an inquiry.
2. Utilization of data indicating origins of referrals to PACE.
3. Redesigned marketing collateral which educated the community in the benefits of enrolling in PACE.

In 2023 we will continue to review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies improve on our conversion rates. In 2023 we will increase our conversion rate goal from 60% to 65%.

Transportation

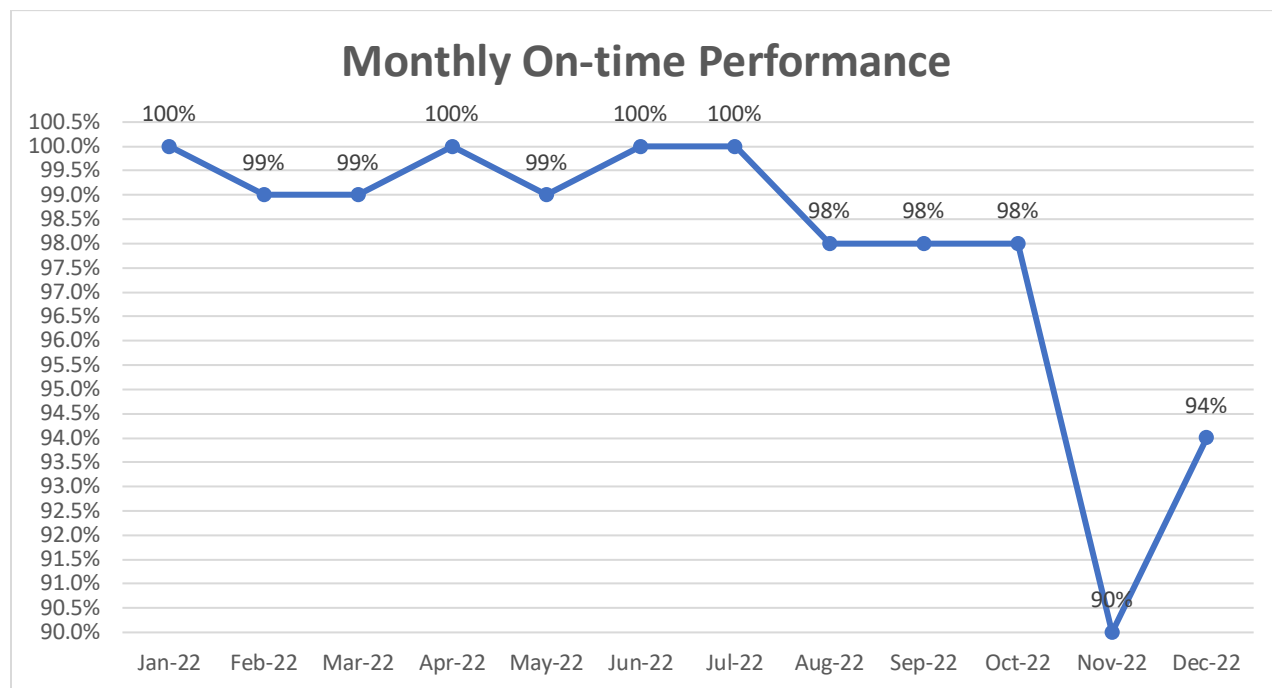
QI22.23 and QI22.24: Transportation Performance

Goal QI22.23: 100% of transportation trips will be less than 60 minutes in 2022

Goal: Met

Goal QI22.24: $\geq 92\%$ of all transportation rides will be on-time in 2022

Goal: Met



Summary and Key Findings/Opportunities for Improvement:

2022 was a transitional time for the transportation department. Due to the ongoing pandemic, the transportation department continued to be utilized for drive-through immunization and COVID-19 testing, as well as delivery of care packages and durable medical equipment. Additionally, through 2022, PACE continued to slowly increase day center attendance. Despite increased demands and ever-changing protocols, transportation has continued to meet their performance benchmark. For the year, transportation completed 2022 with an on-time performance of 98%. In 2023 we will continue to actively monitor trends in transportation, not just in terms of timely performance, but also for participant satisfaction with services.

QI22.25: Transportation Satisfaction

Goal: $\geq 92\%$ on the Overall Satisfaction with Transportation Services summary score on the 2022 PACE Satisfaction Survey

Goal: Not Met

Data/Analysis: 2022 rate was 89% Overall Satisfaction with Transportation.

Summary and Key Findings/Opportunities for Improvement:

Unfortunately, we fell short of our Transportation Satisfaction Goal in 2022. Despite this, 88% of participants surveyed stated that van service was *Good* to *Excellent*. We take participant satisfaction with services very seriously and always strive to maintain the highest level of satisfaction. In 2023 we will raise our goal to $\geq 93.6\%$ to compare with 2022 national averages. Our 2023 Quality Workplan also includes a Quality Initiative to address participant concerns with transportation in an effort to raise satisfaction and reduce grievances.

Meals

QI21.26 Improve the overall satisfaction of participants with meals within the PACE program

Goal: $\geq 71\%$ on Satisfaction with Meals summary score on the 2022 PACE Satisfaction Survey

Goal: Met

Data/Analysis: 82% overall weighted participant satisfaction summary score on the 2022 Participant Survey Satisfaction with Meals Domains.

Domain	2021	2022	2022 National Average
Do the lunches taste good?	75%	76%	61.8%
Do you get a variety of foods here?	80%	89%	82.1%
Meal satisfaction composite score	80%	82%	71.1%

Summary and Key Findings/Opportunities for Improvement:

In 2022, we met our benchmark with 82% of PACE participants indicating satisfaction with their meals, far exceeding the PACE national average of 71.1%. In 2022, we once again engaged the services of a research entity which surveyed participant satisfaction for PACE programs statewide. One of the domains surveyed was a participant's satisfaction with meals. Survey responses indicated that most participants are satisfied with meals provided by PACE. In 2022 we made an active effort to present a variety of meals which were not only nutritious, but also consistent with the cultural background of our participants.

Most participants indicated that the meals looked appealing, tasted good and were varied. Our dietary team monitored participant meals, frequently adjusting menus to be consistent with therapeutic diet parameters as well as an individual's preference. We will continue to monitor this domain in 2023.

Participant Satisfaction

QI22.27 Improve the overall satisfaction of participants and their families with the CalOptima Health PACE program

Goal: Greater than or equal to 88% on the Overall Satisfaction Weighted Average on the 2022 PACE Satisfaction Survey.

Goal: Met

Data/Analysis: 89% overall weighted participant satisfaction summary score.

2022 Participant Survey Domains

Domain	2021	2022	2022 National Averages
Transportation	96%	89%	93.6%
Center Aids	95%	96%	91.7%
Home Care	90%	85%	85.8%
Medical Care	93%	87%	89.7%
Health Care Specialist	88%	85%	89.0%
Social Worker	97%	95%	94.5%
Meals	80%	82%	71.1%
Rehabilitation Therapy and Exercise	91%	93%	93.0%
Recreational Therapy	81%	84%	79.1%
General Service Delivery	92%	92%	86.4%
Weighted Summary Score	91%	89%	88.6%

Summary and Key Findings/Opportunities for Improvement:

In Fall 2022, CalOptima Health PACE contracted with Vital Research to conduct the Participant Satisfaction Survey. Vital Research interviewed 101 of our 434 participants via telephone, to gauge the participant's satisfaction with CalOptima Health PACE services. This is a standardized survey completed by most of the PACE programs in the country.

The overall satisfaction score was 89%. Despite numerous challenges faced by CalOptima Health PACE including the continued need for pandemic related adaptations to service, as well as unprecedented levels of staffing turnover as part of the nationwide "Great Resignation" we were still able to excel in several areas of satisfaction in 2022.

We saw an increase in satisfaction scores from 2021 in areas such as Center Aids, Rehabilitation Therapy and Exercise, Meals and Recreational Therapy. We remained at our above national averages in areas such as Social Worker Satisfaction and General Service Delivery.

Our weighted summary score was 89%, slightly above the national average for overall participant satisfaction. In 2023 we hope to have our PACE day center reach full capacity again, reduce transportation related grievances, and maintain the highest possible level of service satisfaction in all domains.

SECTION 5: 2022 HEALTH PLAN MANAGEMENT SYSTEM (HPMS)

2022 HPMS: Unusual Quality Incidents and are reported to CMS on a quarterly basis via the Health Plan Management System (HPMS). The following elements are reported:

1. Grievances
2. Appeals
3. Unusual Quality Incidents
4. Medication Errors
5. Immunizations (evaluated in the Quality-of-Care section of this report)
6. Falls without Injury
7. ER Visits (evaluated in the Utilization Management section of this report)
8. Denials of Prospective Enrollees

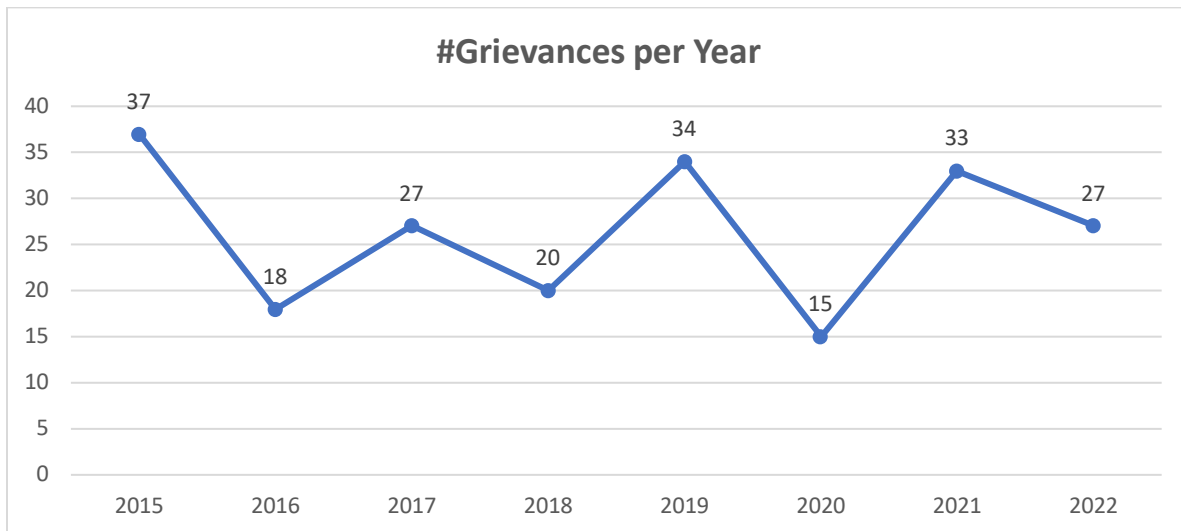
Grievances

Data Analysis:

Quarterly Grievances Q1 2022–Q4 2022

	CENTER							CLINIC			
	# Grievances	Other	Food	Home Care	Transportation			Clinical Care/Service/ Treatment		Comm- unication about care	Scheduling/ Communication
					Timeliness	Prt-Driver Interaction	Quality of service	Dissatisfaction	Timeliness		
Q1 2022	4	0	0	0	3	0	0	0	1	0	0
Q2 2022	8	0	0	0	3	0	2	0	1	2	0
Q3 2022	7	0	0	0	4	1	0	0	0	2	0
Q4 2022	8	0	0	0	1	1	1	2	1	2	0

Grievances Per Year 2015–2022



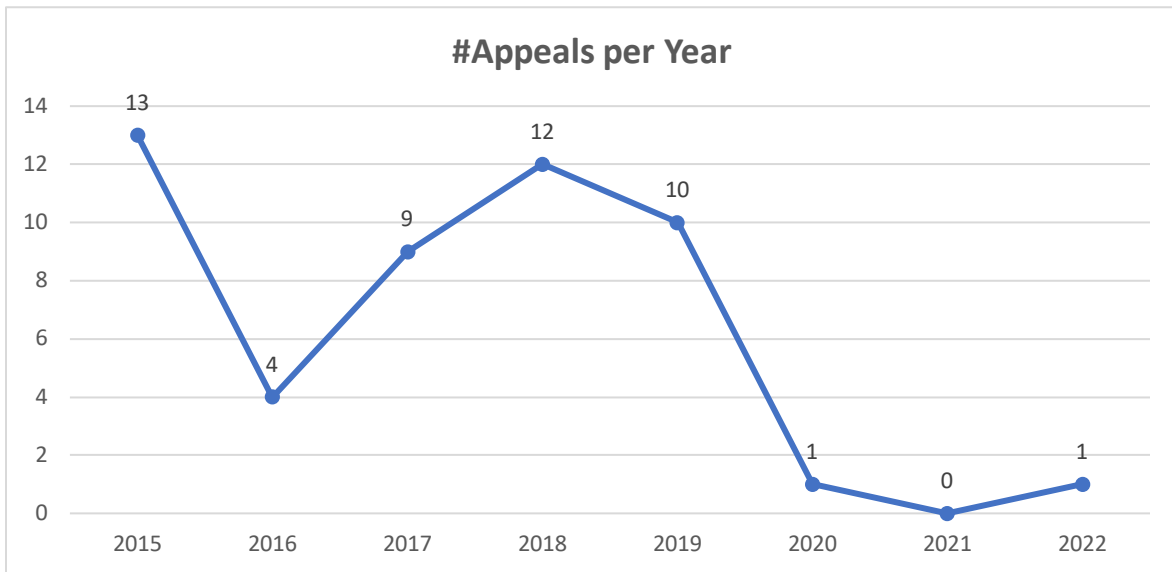
In 2022, we saw a decrease in the number of grievances filed by participants. Many of the grievances that were filed were transportation related issues such as being picked up late. All grievances are investigated by our QI department and a resolution to the grievance is provided to the participant within a 30-day period. To fully resolved all transportation related grievances, in early 2022 we began sharing all grievances directly with our contracted transportation provider, Secure Transportation, and their Quality Assurance department. The Secure QA department thoroughly researchers each grievance and provides us with their investigation and resolution notes. Additionally, grievance issues are discussed during our monthly scheduled Secure Transportation meeting with the transportation leadership team. Corrective action plans are used as needed.

Most participants filing grievances are satisfied with the resolutions reached by the PACE QI department. As with previous years, we will continue to monitor and observe for trends with grievances filed.

Appeals

Data Analysis:

Appeals Per Year 2015–2022

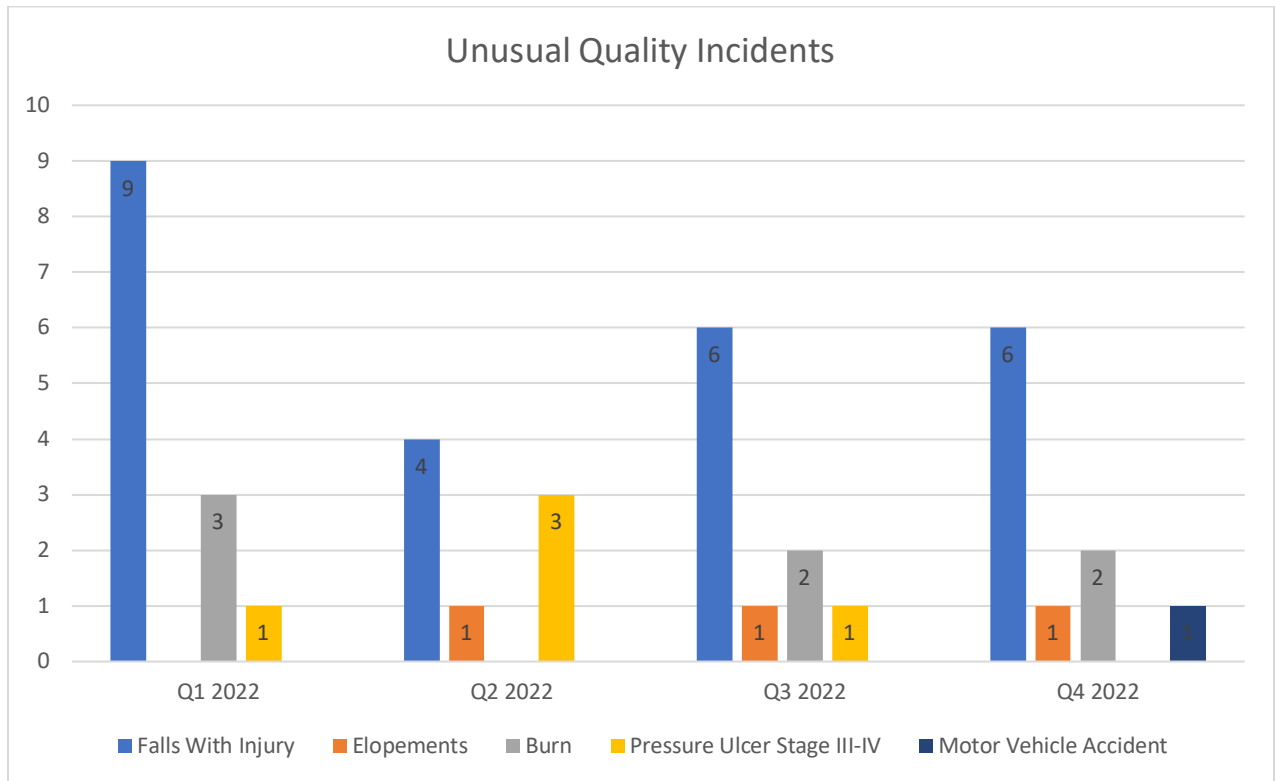


Appeals by participants continued to be minimal in 2022. Only 1 appeal was submitted in 2022 and a third-party review team upheld CalOptima PACE’s IDT’s decision. This reduction in appeals over the past several years is due in part to the time the IDT takes in explaining the reasons for denials to our participants and ensuring all their questions are answered and other resources are provided as necessary.

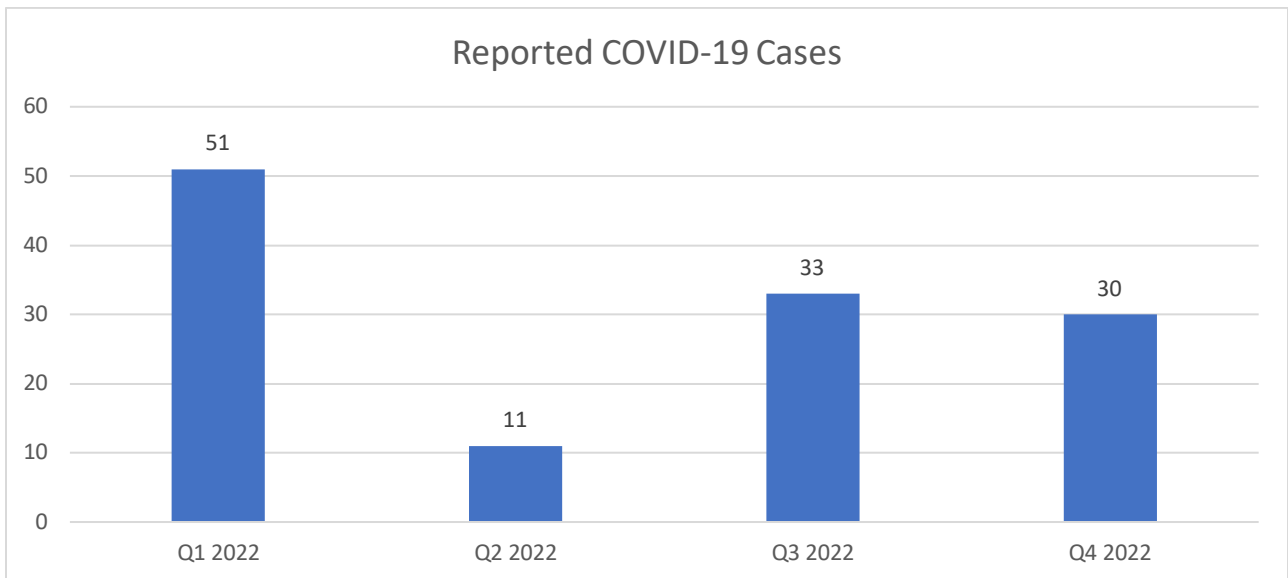
Unusual Quality Incidents

Description of Reportable Incidents: Unusual quality incidents (formerly referred to as Level II events) are monitored by the PACE QI team. Unusual quality events including falls with injury, elopements, burns, pressure ulcers (stage III–IV, unstageable), motor vehicle accidents and infectious disease outbreaks and are reported to CMS and DHCS on a quarterly basis. Essentially, the objective is to monitor the health and safety of PACE participants as well as the effectiveness of our risk management and QI program. All unusual quality incidents are reported to the QI team with an ensuing root cause analysis (RCA) completed on each incident. The RCA begins with the QI team investigating the incident (what, where and when) then followed by a meeting of appropriate disciplines such as nursing, social worker, and rehabilitation services. Potential causes of the incident are discussed and interventions to prevent further occurrences are implemented. In 2022, there were two quality incidents that required corrective action. One was related to elopement, and one was related to a minor motor vehicle accident. Neither incident resulted in serious injury to the participant.

Data Analysis: See graph below



Falls with injury are usually one of the most prevalent unusual quality events at PACE. As with the previous years, most falls are either a result of non-use of durable medical equipment or lack of family supervision of participants who are at risk for falls at home. In 2022, due to the ongoing COVID-19 pandemic, we saw an increase in reporting of infectious disease cases especially in Quarter 1 and in Quarter 3 with different COVID-19 Omicron subvariant related surges. All COVID-19 cases by PACE participants are reported to CMS and DHCS, as well as state and local government.



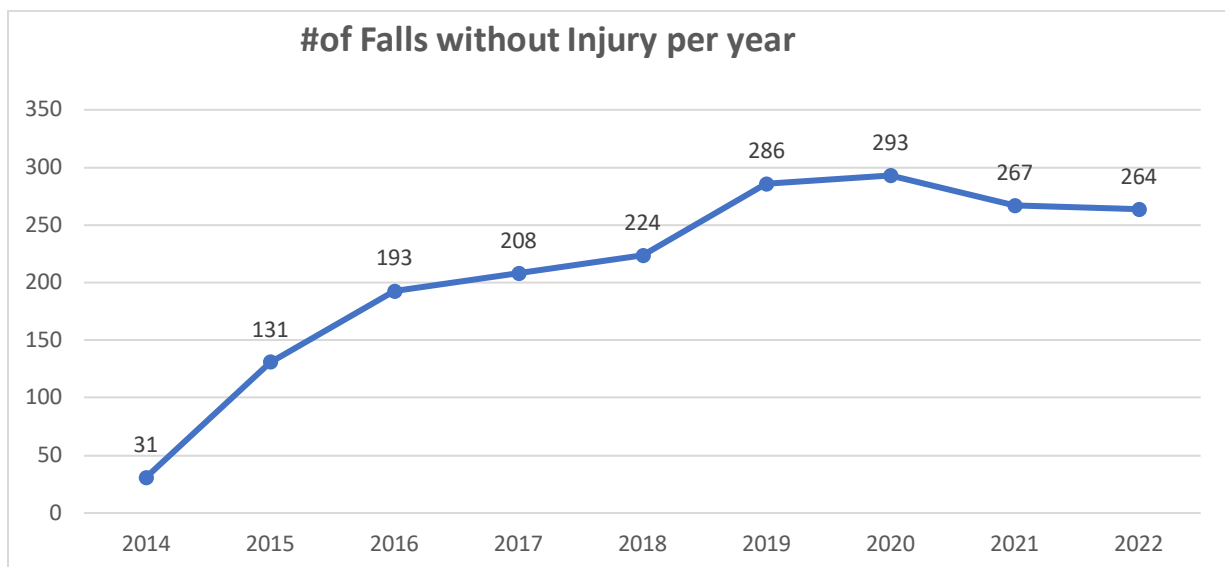
Medication Errors

A total of 2 medication errors were reported in 2022, both in Q3. One of the medication errors (timing) was attributable to PACE clinic staff error. In response to the staff error, education and training were implemented for the staff member as well as all nurses. Another error (dosage) was made by a technician at contracted pharmacy. In this case, we requested a corrective action plan from the pharmacy, and they complied with this request. Neither error resulted in any injury to participants. No further incidents have occurred.

Falls Without Injury

Data Analysis:

Falls without Injury 2014–2022



As in previous years, we have continued to maintain a relatively low number of falls. In 2022, we saw a decrease from 2021 figures. Most falls are continuing to occur in the community, specifically in the participant’s home environment. CalOptima Health PACE has spearheaded fall prevention groups among the high fall risk participants, with the goal of continued decreasing fall trends.

Disciplines, including physicians, nurses, social workers, physical and occupational therapy, and clinical pharmacy, continue to collaborate to develop participant-specific strategies for fall prevention. PACE is using an individualized approach to falls. Once any of the disciplines get information from participants and/or families via wellness calls related to a fall, they will send a Clinic Service Request to clinic and rehab for quick intervention. Rehab then reaches out to participant/family to provide immediately education and follow-up. If further evaluation and skilled rehab is warranted, PACE will ask the participant to do an in-person visit at PACE center. In this way, PACE maintains a direct response to each and every fall reported in a timely manner.

Denials of Prospective Enrollees

In 2022, three prospective enrollees were denied enrollment by the State. In each case, the prospective enrollee's health and safety would be jeopardized by living in a community setting.

Quality Initiatives

In 2022, we focused on our Quality Initiatives to improve the participant experience and assure optimal clinical outcomes through the COVID-19 pandemic. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis. The program's three quality initiatives in 2022 were:

- COVID-19 Booster Vaccine Quality Initiative.
 - This initiative focused on vaccine education, outreach, and vaccine distribution coordination with a goal of getting at least 80% of eligible participants their COVID-19 booster by the end of December 2022. Through massive coordination efforts by PACE staff, we were able to exceed this goal and >95% of eligible participants ended 2022 with *at least* 1 booster dose of vaccine.
- Telehealth Engagement Quality Initiative
 - This initiative focused on accelerating the adoption and utilization of telehealth by the PACE participants. The goal for 2022 was that \geq 66% of participants will have access to telehealth platforms such as VSEE. Unfortunately, we were unable to meet this goal in 2022, but will continue to research way to improve telehealth access for our participant population in 2023.
- Advance Health Care Directive
 - This initiative focused on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of \geq 50% of participants having a completed AHCD in 2022. At the end of 2022 we had reached 40% of participants with a scanned AHCD. In 2023 we will keep this quality intuitive and with a fully staffed and trained social work team, we anticipate meeting our goal in 2023.

SECTION 5: OPPORTUNITIES FOR IMPROVEMENT IN 2023

1. Improve the Quality of Care (QOC) for Participants

- a. Updating the COVID-19 booster immunization quality element to ensure as many eligible participants are vaccinated against COVID-19 with the latest recommended vaccines.
- b. Raising goals in care of diabetic participants to match the new highest level of care (HEDIS 95th percentiles) in areas such as eyes exams, and blood pressure and nephropathy monitoring.
- c. Ensuring that all participants receive preventative health care and diagnostic monitoring such as DEXA scans to look at bone mineral density.
- d. Continued efforts to reduce falls at home including new element to include home assessment review for repeat fallers.

2. Ensure the Safety of Clinical Care

- a. The grievances and potential quality issues involving downstream vendors will continue to be tracked and trended to assure no service or clinical trend is emerges. New quality initiatives related to dental grievances are introduced in the 2023 Quality Workplan.
 - b. Participants receiving more than an average MME dose of 90 MME will continue to be closely monitored.
 - c. Raising goals in reducing potential harmful drug/disease interactions in the elderly to match the highest level of care (HEDIS 95th percentiles).
- 3. Ensure the Appropriate Use of Resources**
- a. Inpatient/ER Utilization
 - i. Further expansion of our complex case management program with individualized interventions with a focus on high-risk participants.
 - ii. Continue to refine the ER Diversion program to treat participants with minor ailments in their homes using the PACE clinic team as well as after hours on-call physicians services.
 - b. Specialty Care
 - i. Increase the number of core PACE specialists who are willing to work closely with the PACE program, receive training in the PACE Model of Care.
 - ii. PACE will continue to leverage CalOptima Health’s Provider Relations department to ensure that the specialist network meets the needs of PACE.
- 4. Improve Participant Experience**
- a. Grievances and potential quality issues will be monitored and analyzed to find opportunities for improvement. Use of transportation logs to resolve participant minor transportation issues immediately as they are reported.
 - b. Once participants return to the PACE Day center at full capacity, we will restart the monthly meal satisfaction surveys and make refinements to our meal program based on the feedback.
- 5. Ensure Appropriate Access and Availability**
- a. Reopening of access to ACS sites will continue through 2023.
 - b. Continued development of our list of preferred specialists who are willing to work closely with PACE, be trained in the PACE model of care and attend occasional interdisciplinary care team meetings.
 - c. Will continue to bring specialists in to provide specialty care within the PACE clinic.

SUMMARY

CalOptima Health PACE developed and implemented systems using evidence-based guidelines that incorporate data and best practices tailored to the frail and elderly participants within our community. Our focus is to prevent institutionalization of these participants and enable them to live safely in our community with the support of PACE services. To accomplish our goals, we target many aspects of the health care continuum, such as preventive care, care management and disease management, closing any potential gaps in care. Through our ongoing data analysis, we are positioned to identify opportunities for improvement resulting in optimal clinical outcomes and

participant satisfaction. Although individual measures may vary in their level of accomplishment, our overall effort has been a considerable success. As we continue to monitor our performance and refine our methods, we are confident that our QI efforts will continue to make a positive impact amongst our participants.

APPENDIX: 2022 PACE QI EVALUATION

2022 CalOptima PACE Quality Improvement (QI) Work Plan																	
QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI22.01	Improve the Quality of Care for Participants	2021 PACE QAPI Plan and Work Plan Annual Evaluation	2021 PACE QAPI Plan will be evaluated by March 1st, 2022	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2022	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met	Met
QI22.02	Improve the Quality of Care for Participants	2022 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2022	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2022	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met	Met
QI22.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2022	Improve compliance with influenza immunization recommendations	Q1, Q3 and Q4 2022	12/31/2022	PACE Clinical Operations Manager	91%	Not Met	N/A	N/A	53%	Not Met	93%	Not Met	93%	Not Met
QI22.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have had their PCV23 pneumococcal vaccination by December 31st, 2022	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2022)	Quarterly	12/31/2022	PACE Clinical Operations Manager	95%	Met	88%	Not Met	87%	Not Met	88%	Not Met	88%	Not Met
QI22.05	Improve Quality of Care for Participants	COVID-19 Immunization Rates	≥95% of eligible participants will have had their COVID-19 vaccination by December 31st, 2022	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2022)	Quarterly	12/31/2022	PACE Clinical Operations Manager	97%	Met	98%	Met	98%	Met	98%	Met	98%	Met
QI22.06	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2022	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2022	PACE Clinical Operations Manager and PACE Clinical Medical Director	90%	Not Met	92%	Not Met	96%	Met	94%	Not Met	94%	Not Met
QI22.07	Improve the Quality of Care for Participants	Diabetes Care	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director	74%	Not Met	72%	Not Met	72%	Not Met	71%	Not Met	72%	Not Met
QI22.08	Improve the Quality of Care for Participants	Diabetes Care	> 82.77% of Diabetics will have an Annual Eye Exam (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director	95%	Met	99%	Met	99%	Met	96%	Met	96%	Met
QI22.09	Improve the Quality of Care for Participants	Diabetes Care	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI22.10	Improve the Quality of Care for Participants	Osteoporosis	≥ 90% of participants with the diagnosis of Osteoporosis will have treatment initiated by PCP	PACE participants with diagnosis of osteoporosis will be managed by their PCP using appropriate therapy resulting in a decrease risk of fracture.	Quarterly	01/01/2022	PACE Clinical Medical Director	97%	Met	98%	Met	98%	Met	99%	Met	98%	Met
QI22.11	Ensure the Safety of Clinical Care	Falls at Home Classified as CMS Reportable Quality Incidents	≤ 207 Falls per 1000 per year	Falls with injury will be monitored by PACE QI department who will work with the interdisciplinary teams and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Center Manager	49	Met	53	Met	54	Met	59	Met	59	Met
QI22.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<27.24% (Comparable to the 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director	17%	Met	18%	Met	19%	Met	22%	Met	19%	Met
QI22.13	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDs or Cox2 Selective NSAIDs	<3.47% (Comparable to the 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director	3%	Met	6.1%	Not Met	0.0%	Met	0.0%	Met	2.0%	Met
QI22.14	Ensure the Safety of Clinical Care	Decrease the Use of Opioids at High Dosage (UOD)	100% of members receiving opioids for 15 or more days at an average of 90 MME/day will be reevaluated monthly by their treating provider in 2022.	The PACE QI Department will monitor any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day	Quarterly	12/31/2022	PACE Clinical Medical Director	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI22.15	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥90% of participants will have their medications reconciled within 15 days of hospital discharge in 2022	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2022	PACE Pharmacist	100%	Met	100%	Met	100%	Met	96%	Met	99%	Met
QI22.16	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥85% of specialty care authorizations will be scheduled within 14 business days in 2022 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within 14 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2022	PACE Clinical Operations Manager	91%	Met	91%	Met	95%	Met	90%	Met	92%	Met
QI22.17	Ensure Appropriate Access and Availability	Improve Access to PACE Care: Increase Telehealth Engagement	≥66% of members will be able to engage in telehealth visits	Increase the % of participants who are utilizing the telehealth platform.	Quarterly	12/31/2022	Community-Based Program Manager	54%	Not Met	53%	Not Met	51%	Not Met	57%	Not Met	54%	Not Met
QI22.18	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<3,330 hospital days per 1000 per year	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2022	PACE Clinical Director	3,863	Not Met	4,283	Not Met	4,412	Not Met	4,426	Not Met	4,426	Not Met
QI22.19	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<850 emergency room visits per 1000 per year	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2022	PACE Clinical Director	833	Met	901	Not Met	856	Not Met	810	Met	810	Met

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI22.20	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<14% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2022	PACE Clinical Director	16%	Not Met	14%	Not Met	19%	Not Met	23%	Not Met	18%	Not Met
QI22.21	Ensure Appropriate Use of Resources	Long Term Care Placement	<4% of members will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2022	PACE Center Manager	3.12%	Met	4.2%	Not Met	4.17%	Not Met	3.69%	Met	3.80%	Met
QI22.22	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to 60% in 2022	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2022	PACE Marketing and Enrollment Manager	79%	Met	74%	Met	73%	Met	76%	Met	76%	Met
QI22.23	Improve Participant Experience	Transportation	100% of transportation trips will be less than 60 minutes in 2022	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2022	PACE Center Manager	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI22.24	Improve Participant Experience	Transportation	≥92% of all transportation rides will be on-time in 2022	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2022	PACE Center Manager	99%	Met	100%	Met	99.0%	Met	94%	Met	98%	Met
QI22.25	Improve Participant Experience	Transportation	≥92% on the Overall Satisfaction with Transportation Services - Weighted Average (2021 PACE National Average) on the 2022 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families' satisfaction with the PACE Transportation program	Annually	12/31/2022	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	89%	Not Met
QI22.26	Improve Participant Experience	Increase Participant Satisfaction with Meals	≥71% on Satisfaction with Meals summary score (2020 PACE National Average) on the 2022 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families' satisfaction with the meals within the PACE program.	Annually	12/31/2022	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	82%	Met
QI22.27	Improve Participant Experience	Increase Overall Participant Satisfaction	≥88% on the Overall Satisfaction Weighted Average (2020 PACE National Average) on the 2022 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families' satisfaction with the PACE program	Annually	12/31/2022	PACE Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	89%	Met



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~~CALOPTIMA~~ CALOPTIMA HEALTH PROGRAM ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) QUALITY IMPROVEMENT PLAN DESCRIPTION

2023~~2~~

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PACE Quality Improvement Subcommittee Chairperson:

Donna Frisch~~Richard Helmer~~, M.D. _____ Date
Medical Director, PACE

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Board of Directors' Quality Assurance Committee Chairperson:

Trieu Tran, M.D. _____ Date

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Board of Directors Acting Chairperson:

Clayton Corwin~~Andrew Do~~ _____ Date

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| **Supervisor, First District**

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INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima [Health](#)'s Program of All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous QI for all the services at [CalOptima-CalOptima Health](#) PACE. It is designed and organized to support the mission, values, and goals of PACE.

Overview

- The goal of the [CalOptima-CalOptima Health](#) PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.
- The [CalOptima-CalOptima Health](#) PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima [Health](#)'s governing body, the Board of Directors has the final authority to review and approve the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix A).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- The [CalOptima-CalOptima Health](#) PACE QI Committee (PQIC) will complete an annual evaluation of the approved QI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QI Plan to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
 - Ensure all QI activities fit into a well-integrated system that oversees quality of care and coordination of all services.
 - Ensure the QI program involves all providers of care within the PACE program.
 - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
 - Identify and address areas for improvement that arise from unusual incidents, and sentinel events.
 - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) to identify areas needing quality improvement.
 - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the Board of Directors.
 - Share results of QI identified benchmarks with staff and contracted providers at least annually.
 - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. Professional standards of [CalOptima-CalOptima Health](#) PACE staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g.

- California Board of Nursing, etc.).
- Ensure that all levels of care are consistent with professionally recognized standards of practice.
- ⊖ Assure compliance with regulatory requirements of all responsible agencies.

- **Improve the participant experience.**
 - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
 - Provide education to staff on the multiple dimensions of patient experience.
 - Identify and implement ways to better engage participants in the PACE experience (e.g., menu selection and PMAC).
 - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
 - Monitor and track transportation services in terms of on-time performance and trips less than 60 minutes in duration.
 - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) and in an Advanced Health Care Directives which honors members' wishes as well as advance directive rights.
- **Ensure the appropriate use of resources.**
 - Review and analyze utilization data regularly, including hospital admissions, Emergency Room (ER) visits, and hospital 30-day all-cause readmissions, to identify high-risk members and opportunities for improvement.
 - Review documentation and coordination of care for participants receiving care in institutional settings and investigate any potential infractions in the quality of care provided in these settings.
 - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
 - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
 - Review and analyze clinic medical records to ensure appropriate documentation and coding.
- **Ensure the safety of clinical care.**
 - Reduce potential risks to safety and health of PACE participants through ongoing risk management.
 - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
 - Monitor, report and perform a Root Cause Analysis on all participant-involved events resulting in a significant adverse outcome, for the purpose of identifying areas for quality improvement.
 - Monitor and track falls occurring in the PACE Day Center, ~~and~~ in the home and within the community.
 - Monitor and track the use of opioids at high dosages.
 - Meet or exceed community standards for credentialing of licensed providers.
 - Monitor staff and contractors to ensure that appropriate standards of care are met.
- **Ensure appropriate access and availability.**
 - Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
 - Monitor and analyze access to specialty care.
 - Continue to develop the network of Alternate Care Setting (ACS) sites to ensure the program can provide services to all Orange County residents who qualify and are interested in joining the PACE program.

Organizational and Committee Structure

~~CalOptima~~ CalOptima Health Board of Directors provides oversight and direction to ~~CalOptima~~ CalOptima Health PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at ~~CalOptima~~ CalOptima Health — including the ~~CalOptima~~ CalOptima Health PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima Health's Quality Improvement Committee (QIC) described in CalOptima Health's state and federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed during the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI Plan, and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE Quality Improvement Committee

Purpose

This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a quarter. The PQIC will review all QI initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods to address quality problems in any clinical or administrative process that have been identified as critical to participants, ~~families~~ families, or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director who will report its activities up to QIC, QAC, and the Board. The PACE Clinical Medical Director, PACE Program Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Clinical Medical Director, PACE Program Director or the PACE QI Manager may report up to QAC if the PACE Medical Director is not available.

Membership

Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Clinical Medical Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, PACE Program Manager, PACE QI Coordinator, Manager of Community-Based Programs, and PACE Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing chair of the committee.

PACE Focused Review Committees

Purpose

These committees will be formed to respond to or to proactively address specific quality issues that rise to the level of warranting further study and action. Key performance elements are routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that

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indicate significant over/under utilization.

Membership

Membership will be flexible based on those with knowledge of the specific issues being ~~addressed, but~~ addressed but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE Program Manager, PACE QI Coordinator, PACE Intake/Enrollment Manager or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Center Manager or PACE QI Manager. The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC.

PACE Member Advisory Committee

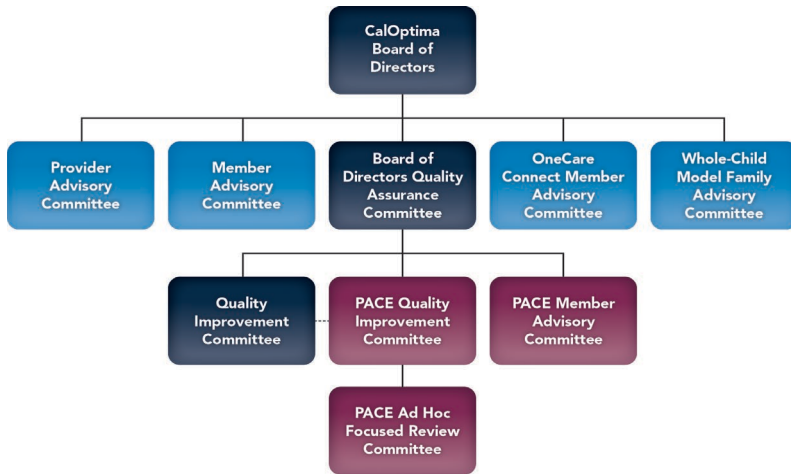
Purpose

The PACE Member Advisory Committee (PMAC) provides recommendations to the Board on issues related to participant care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to QAC, which then will be reported to the Board. The PACE Program Director or the PACE Center Manager shall report its activities to the PQIC.

Membership

The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. PMAC membership is open to all participants and/or caregivers and no application process is required. Information related to upcoming PMAC meetings is disseminated through announcements at the PACE Day Center floor and email/telephonic correspondence and all interested participants are invited to join. -Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing chair and will facilitate for the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

2023~~2~~ Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services

- PACE will collect, analyze, and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization including:
 - Hospital Bed Days
 - ER Visits
 - 30-Day All-Cause Readmissions
 - Participants residing in Long-Term Care
- Data analysis will allow for analyzing both overutilization and underutilization for areas of quality improvement.

Participant and Caregiver Satisfaction

- PACE shall survey the participants and their caregivers on at least an annual basis. Additionally, PACE will look for other opportunities for feedback to improve quality of services.
- Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
- The PMAC shall provide direct feedback on satisfaction to both the PACE leadership staff and QAC.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.
- PACE will monitor the percentage of participants who disenroll from the PACE program within 90 days for controllable reasons.

- The qualified lead to enrollment conversion rate will be monitored to ensure the program continues to have a smooth enrollment process.

Clinically Relevant ~~HPMS~~ Data

- Unusual Incidents/Reportable Quality Incidents
- Medication Errors
- Falls without Injury
- Clinical measures from the QI Work Plan elements which include:
 - Influenza Immunizations Rates
 - Exclusion criteria:
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - Participants with diagnosis of Guillain Barre
 - Participants who allergic to Influenza vaccine
 - Pneumococcal Immunizations Rates
 - Exclusion criteria:
 - Participants who enrolled in the program in December 2023
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - Participants who allergic to Pneumococcal vaccine
 - COVID-19 Bivalent Booster Immunization Rates
 - Exclusion criteria:
 - Participants who enrolled in the program in December 2022
 - Participants who enroll in the program in December 2023
 - Participants who have not already received their initial doses of COVID-19 vaccine
 - Participants who have recently tested positive for COVID-19, or at provider's discretion based on health history.
 - ~~Infection Control: Respiratory Infection Rates~~
 - Advanced Health Care Planning: POLST Completion
 - Exclusion criteria:
 - Participants who have been enrolled <6 months.
 - Diabetes Care: Blood Pressure Control
 - The following inclusion and exclusion criteria will be in place for this measure:
 - Inclusion criteria:
 - Enrolled for at least six months during measurement year
 - For Q1 2023, look at October 1 2022 or earlier
 - Exclusion criteria:
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - Participants who have a dx of Frailty, ICD-10 R54
 - Participants who are 76 years and older as of December 31, 2023
 - Participants with End Stage Renal Disease, noted as ESRD or STAGE 5 renal disease.
 - ~~Advance Health Care Planning: Advanced Health Care Directive Completion~~
 - Diabetes Care: Annual Eye Exams

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- The following inclusion and exclusion criteria will be in place for this measure:
 - Inclusion criteria:
 - Diagnosis of Diabetes Mellitus
 - Enrolled for at least six months during measurement year
 - For Q1 2023, look at October 1 2022 or earlier
 - Exclusion criteria:
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - Participants who are 76 years and older as of December 31, 2023
 - Participants who are legally blind.

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- ~~Inclusion criteria:~~
- ~~Enrolled for at least six months during measurement year~~
- ~~Exclusion criteria:~~
- ~~Participants who are end of life (less than six months)~~
- ~~Participants who are 76 years and older as of December 31, 2021~~
 - ~~Diabetes Care: Nephropathy Monitoring and Blood Pressure Control~~
 - The following inclusion and exclusion criteria will be in place for this measure:
 - Inclusion criteria:
 - Diagnosis of Diabetes Mellitus
 - Enrolled for at least six months during measurement year
 - For Q1 2023, look at October 1 2022 or earlier
 - Exclusion criteria:
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - Participants who are 76 years and older as of December 31, 2023
 - Participants with End Stage Renal Disease
 - ~~The following inclusion and exclusion criteria will be in place for this measure:~~
 - ~~Inclusion criteria:~~
 - ~~Enrolled for at least six months during 2021~~
 - ~~Exclusion criteria:~~
 - ~~Participants who are end of life (less than six months)~~
 - ~~Participants who are 76 years and older as of December 31, 2021~~
 - ~~Participants with End Stage Renal Disease~~
- ~~Monitoring of treatment for Participants for with Osteoporosis~~
 - The following inclusion and exclusion criteria will be in place for this measure:
 - Inclusion criteria
 - Any participant who has a fall in 2023
 - Reduction of all reported fall through home visits and follow up by Rehabilitation team with repeat fallers. Falls at Home Classified as CMS Reportable Quality Incidents
 - Exclusion criteria:

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- Participants who have a fall in a hospital or skilled nursing facility.
- Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent
 - The following inclusion and exclusion criteria will be in place for this measure:
 - ~~Inclusion criteria:~~Inclusion criteria:
 - Diagnosis of Dementia
 - Continuous enrollment throughout year (enrolled for at least a year)
 - For Q1 2023, Look at enrollment from 3/1/22 and before
 - For Q2 2023, Look at enrollment from 6/1/22 and before
 - For Q3 2023, Look at enrollment from 9/1/22 and before
 - For Q4 2023, Look at enrollment from 12/1/22 and before
 - Participants who are 66 years and older as of December 31, 2023
 - Exclusion criteria:
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - Participants with Schizophrenia or Bipolar Disorder
 - ~~Continuous enrollment throughout year~~
 - ~~Participants who are 66 years and older as of December 31, 2022~~
 - ~~Exclusion criteria:~~
 - ~~Participants who are end of life (less than six months)~~
 - ~~Participants with Schizophrenia or Bipolar Disorder~~
- Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Kidney Disease plus Nonaspirin NSAIDs or Cox2 Selective NSAIDs
 - The following inclusion and exclusion criteria will be in place for this measure:
 - Inclusion criteria:
 - Participants with diagnosis of CKD 3,4, or 5/End Stage Renal Disease.
 - Continuous enrollment throughout year
 - For Q1 2023, Look at enrollment from 3/1/22 and before
 - For Q2 2023, Look at enrollment from 6/1/22 and before
 - For Q3 2023, Look at enrollment from 9/1/22 and before
 - For Q4 2023, Look at enrollment from 12/1/22 and before
 - Participants who are 66 years and older as of December 31,

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2023

- Exclusion criteria:
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - TOPICAL NSAIDS such as Voltaren (Diclofenac) gel may be excluded from this list since they have minimal systemic absorption.
- ~~Inclusion criteria:~~
 - ~~Continuous enrollment throughout year~~
 - ~~Participants who are 66 years and older as of December 31, 2022~~
- ~~Exclusion criteria:~~
 - ~~Participants who are end of life (less than six months)~~
- Opioids at High Dosage Monitoring by PCPs.
- Medication Reconciliation Post Discharge from Hospital or Skilled Nursing Facility.
- Access to Specialty Care services.

Effectiveness and Safety of Staff-Provided and Contract-Provided Services

- This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team (IDT) with each reassessment, review of medical records, and success of infection control efforts.
- All clinical and certain non-clinical positions have competency profiles specific to their positions.
- Annual competency evaluations of PACE staff.
- PACE ~~staff~~ will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE staff, as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as ~~CalOptima~~ CalOptima Health guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight ~~of~~ all activities offered by PACE.
- Member grievances will be forwarded to the PACE QI Department for investigation, tracking, trending, and data gathering. These results will be ~~shared with~~ forwarded to the PACE Director for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations, ~~decisions~~ and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
- Member appeals will be forwarded to the PACE QI Department for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be forwarded to a third-party with the appropriate licensure for review. The third-party reviewer's decision shall be reviewed by The PACE QI manager as well as either the PACE Director or the PACE Medical Director and will be immediately shared with via telephone

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~~and/or written letter with information about additional rights to appeal. the IDT who will inform caregivers and participants of the decision and assist them with furtherment of the process as needed.~~

- Continued integration of telehealth to expand access to care through the continued COVID-19 pandemic and beyond.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE Center Manager QI department will monitor transportation services with periodic ride alongsalongs. The times gathered during the ride alongsalongs will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through participant satisfaction surveys as well as comments solicited by the PMAC.
- Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills, as well as regulatory agency inspections.
- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority Setting for Performance Improvement Initiatives

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life.
- Potential impact on participant access to necessary care or services.
- Potential impact on participant safety.
- Participant, caregiver, or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high volume, or high frequency events.
- Relevance to the mission and values of PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS ~~and SAA~~ to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents ~~(previously referred to as Level II Events)~~, Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported ~~up~~ through the PACE monitoring module of ~~_~~HPMS.

The following data is reported to CMS via the HPMS on a quarterly basis:

- Grievances
- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents

- When unusual incidents ~~meet~~reach specified thresholds, PACE must notify CMS on a quarterly basis through HPMS. PACE must complete a Root Cause Analysis and present the results of the analysis on a conference call with both CMS and the Department of Health Care Services (DHCS) as well as internally at PQIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Unusual Quality Incidents include:
 - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
 - Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall.
 - Infectious disease outbreaks that meet the threshold of three or more cases linked to the same infectious agent within the same time frame, including COVID-19 infections.
 - Pressure injuries acquired while enrolled in PACE.
 - Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.
 - Elopement by cognitively impaired participants.
 - Adverse drug reactions.
 - Foodborne disease outbreak.
 - Burns 2nd degree or higher.
 - ~~COVID-19 infections~~
- HOS-M
 - PACE will participate in the annual HOS-M to assess the frailty of the population in our center.
- Other external reporting requirements
 - Suspected elder abuse shall be reported to appropriate state agency.
 - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
 - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency.

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another member of the PQIC, as appropriate.

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the PACE Medical Director and the PACE Director.
- The QI Manager or QI Coordinator will consult with relevant PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification.
- Urgent corrective measures will be discussed during IDT morning meetings and, when

- appropriate, with participants.
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately.

Re-Evaluation and Follow-Up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
 - Severity of the problem
 - Frequency of occurrence
 - Impact of the problem on participant outcomes
 - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement.
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of PACE Quality Initiatives ~~are is~~ presented to the PQIC on a quarterly basis. The program's ~~three~~ quality initiatives in 2023~~2~~ are:
 - ~~COVID-19 Booster Vaccine Quality Initiative.~~
 - ~~This initiative will focus on vaccine education, outreach, and vaccine distribution coordination with a goal of getting at least 80% of eligible participants their COVID-19 booster by the end of December 2022.~~
 - ~~Telehealth Engagement Quality Initiative~~
 - ~~This initiative will focus on accelerating the adoption and utilization of telehealth by the PACE participants. It will involve education, training and ensuring our participants have the hardware to utilize our telehealth services. The PACE Community Based Services Program Manager will implement a plan to increase prt telehealth access. The goal for 2022 is ≥ 66% or participants will have access to telehealth platforms such as VSEE.~~
 - Advance Health Care Directive
 - This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 50% of participants having a completed AHCD in 2023~~2~~.
 - Dental Satisfaction
 - This initiative will focus on increasing participant satisfaction with

contracted dental services, to provide participants with comprehensive education regarding the process for dental procedures with a focus on reduced pain and increased function. The PACE Enrollment Coordinators will highlight for new enrollees what dental services are provided (ex/routine cleanings) and what are not (ex/cosmetic dentistry). Clinic administrative staff will follow up each month with 5 randomly chosen participants who received dental services from a specialist *outside of PACE*, to find any areas of dissatisfaction that can be addressed in a timely manner. The goal will be for PACE to have ≤ 1 dental related grievance per quarter in 2023.

o Transportation Satisfaction

- This initiative will focus on reducing the number of PACE participants who have been dissatisfied with contracted transportation services, as identified by transportation grievances. The PACE leadership team has created a plan to be implemented by the PACE Center manager to utilize the transportation logs and to follow up with participants to assess their satisfaction and to identify any areas of concern or miscommunication regarding provision of services. The goal will be for PACE to have ≤ 3 transportation related grievance per quarter.

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ANNUAL REVIEW OF PACE QI PLAN

- The PACE QI Plan will be assessed annually for effectiveness.
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

APPENDIX A (SEE ATTACHMENT)

2022 2023 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI22-01-QI23.01	Improve the Quality of Care for Participants	2022 2022 PACE QAPI Plan and Work Plan Annual Evaluation	2024 2022 PACE QAPI Plan will be evaluated by CalOptima Health Quality Assurance Committee in March 2023 March 1st, 2022	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2022 3/8/22	PACE Medical Director
QI22-02-QI23.02	Improve the Quality of Care for Participants	2022 2023 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by CalOptima Health Quality Assurance Committee March 2023 1st, 2022	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2022 3/8/22	PACE Medical Director
QI22-03-QI23.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2023 2022	Improve compliance with influenza immunization recommendations	Q1, Q3 and Q4 2023 2022	12/31/2022-12/31/2023	PACE-Clinical-Operations-Manager-PACE Medical Director
QI22-04-QI23.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have completed their had their PCV23- pneumococcal vaccination by December 31st, 2023 2022	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2023 2022)	Quarterly	12/31/2022-12/31/2023	PACE-Clinical-Operations-Manager-PACE Medical Director
QI22-05-QI23.05	Improve Quality of Care for Participants	COVID-19 Booster Immunization Rates	≥ 80 95% of eligible participants will have had their COVID-19 Bivalent Booster Vaccine vaccination by December 31st, 2023 2022	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2023 2022)	Quarterly	12/31/2022-12/31/2023	PACE-Clinical-Operations-Manager-PACE Medical Director
QI22-06-QI23.06	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2022-2023	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2022-12/31/2023	PACE Clinical Operations Manager and PACE Medical Director
QI22-07-QI23.07	Improve the Quality of Care for Participants	Diabetes Care	>84.21% 84.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2021 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement in maintaining healthy blood pressure.	Quarterly	12/31/2022-12/31/2023	PACE- Clinical -Medical Director
QI22-08-QI23.08	Improve the Quality of Care for Participants	Diabetes Care	> 85.42% 82.77% of Diabetics will have an Annual Eye Exam (Comparable to the 2021 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement in maintaining healthy vision.	Quarterly	12/31/2022-12/31/2023	PACE- Clinical -Medical Director
QI22-09-QI23.09	Improve the Quality of Care for Participants	Diabetes Care	> 98.78% 98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2021-2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement in maintaining kidney function.	Quarterly	12/31/2022-12/31/2023	PACE- Clinical -Medical Director
QI22-10-QI23.10	Improve the Quality of Care for Participants	Osteoporosis	≥= 90% of participants with the diagnosis of Osteoporosis will have treatment initiated by PCP—100% of participants who have a fall will have a bone density scan to assess for osteoporosis	PACE participants with diagnosis of osteoporosis will be managed by their PCP using appropriate therapy resulting in a decrease risk of fracture.— Medical records of participants who have a fall will be reviewed to see if they have had a bone density scan within the past 2 years. If not, a scan will be completed on that participant within 6 months of reported fall	Quarterly	12/31/2022-12/31/2023	PACE- Clinical -Medical Director

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI22.14-QI23.11	Ensure the Safety of Participants Clinical Care	Falls at Home Classified as CMS Reportable Quality Incidents Reduce Percentage of Falls Reported by PACE Enrollees	<= 207 Falls per 1000 per year <72 falls reported per quarter in 2023	Falls with Injury will be monitored by PACE QI department who will work with the interdisciplinary teams and clinical teams to develop strategies for improvement. The PACE Center manager will work with the Rehabilitation Department to review all participants who have repeated falls within each quarter. Participants who have repeated falls will have a documented home assessment and follow up completed by PACE to reduce total number of falls.	Quarterly	12/31/2022-12/31/2023	PACE Center Manager
QI22.12-QI23.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<24.64% 27.24% (Comparable to the 2021 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2022-12/31/2023	PACE Clinical -Medical Director
QI22.13-QI23.13	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDs or Cox2 Selective NSAIDs	<2.62% 3.47% (Comparable to the 2021 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2022-12/31/2023	PACE Clinical -Medical Director
QI22.14-QI23.14	Ensure the Safety of Clinical Care	Decrease the Use of Opioids at High Dosage (UOD)	100% of members receiving opioids for 15 or more days at an average of 90 MME/day will be reevaluated monthly by their treating provider in 2023.	The PACE QI Department will monitor any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day. (Exclusion: Participants who have a diagnosis of Palliative Care)	Quarterly	12/31/2022-12/31/2023	PACE Clinical -Medical Director
QI22.15-QI23.15	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥90% of participants will have their medications reconciled within 10 45 days of hospital and/or skilled nursing facility discharge in 2022 2023	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2022-12/31/2023	PACE Pharmacist
QI22.16-QI23.16	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥ 88 85% of specialty care authorizations will be scheduled within 14 business days in 2022 2023 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within 14 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2022-12/31/2023	PACE Clinical Operations Manager
QI22.17-QI23.17	Ensure Appropriate Access and Availability	Improve Access to PACE Care: Increase Telehealth Engagement	≥66% of members will be able to engage in telehealth visits	Increase the % of participants who are utilizing the telehealth platform.	Quarterly	12/31/2022-12/31/2023	Community Based Program Manager
QI22.18-QI23.17	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<3,330 hospital days per 1000 per year	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education. (Exclusion: Participants who have Long Term Acute Care Hospitalizations of >90days).	Quarterly	12/31/2022-12/31/2023	PACE Clinical -Medical Director

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI22.19- QI23.18	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<850 emergency room visits per 1000 per year	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2022-12/31/2023	PACE-Clinical-Medical Director
QI22.20- QI23.19	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<14% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2022-12/31/2023	PACE-Clinical-Medical Director
QI22.21- QI23.20	Ensure Appropriate Use of Resources	Long Term Care Placement	<4% of members will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2022-12/31/2023	PACE Center Manager
QI22.22- QI23.21	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to 60 65% in 2022	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2022-12/31/2023	PACE Marketing and Enrollment Manager
QI23.22	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths, to develop strategies for improvement.	Quarterly	12/31/2023	PACE Marketing and Enrollment Manager
QI23.23	Improve Participant Experience	Disenrollment	Maintain a PACE participant attrition rate of ≤10 %	PACE will create focus groups to identify areas that need operational improvement to strategically support growth and increase census to 450 participants.	Quarterly	12/31/2022-12/31/2023	PACE Center Manager and PACE Director
QI22.23- QI23.24	Improve Participant Experience	Transportation Performance	100% of transportation trips will be less than 60 minutes in 2023 2022	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation.	Quarterly	12/31/2022-12/31/2023	PACE Center Manager
QI22.24- QI23.25	Improve Participant Experience	Transportation Performance	≥92% of all transportation rides will be on-time in 2023 2022	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2022-12/31/2023	PACE Center Manager
QI22.25- QI23.26	Improve Participant Experience	Transportation Satisfaction	≥93.6 92 % on the Overall Satisfaction with Transportation Services (2020-2022 PACE National Average) on the 2023 2022 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE Transportation program	Annually	12/31/2022-12/31/2023	PACE Center Manager

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI22.26 QI23.27	Improve Participant Experience	Increase Participant Satisfaction with Meals	≥71.1% on Satisfaction with Meals summary score (2020-2022 PACE National Average) on the 2023 2022 -PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Annually	12/31/2022 -12/31/2023	PACE Center Manager
QI22.27 QI23.28	Improve Participant Experience	Increase Overall Participant Satisfaction	≥88.6% on the Overall Satisfaction-Weighted Average (2020-2022 PACE National Average) on the 2023 2022 -PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2022 -12/31/2023	PACE Director



**CALOPTIMA HEALTH PROGRAM ALL-INCLUSIVE CARE
FOR THE ELDERLY (PACE)
QUALITY IMPROVEMENT PLAN DESCRIPTION
2023**

PACE Quality Improvement Subcommittee Chairperson:

Donna Frisch, M.D.
Medical Director, PACE

Date

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Tran, M.D.

Date

Board of Directors Acting Chairperson:

Clayton Corwin

Date

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INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous QI for all the services at CalOptima Health PACE. It is designed and organized to support the mission, values, and goals of PACE.

Overview

- The goal of the CalOptima Health PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.
- The CalOptima Health PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima Health's governing body, the Board of Directors has the final authority to review and approve the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix A).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- The CalOptima Health PACE QI Committee (PQIC) will complete an annual evaluation of the approved QI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QI Plan to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
 - Ensure all QI activities fit into a well-integrated system that oversees quality of care and coordination of all services.
 - Ensure the QI program involves all providers of care within the PACE program.
 - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
 - Identify and address areas for improvement that arise from unusual incidents, and sentinel events.
 - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) to identify areas needing quality improvement.
 - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the Board of Directors.
 - Share results of QI identified benchmarks with staff and contracted providers at least annually.
 - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. Professional standards of CalOptima Health PACE staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g. California Board of Nursing, etc.).

- Ensure that all levels of care are consistent with professionally recognized standards of practice.
- Assure compliance with regulatory requirements of all responsible agencies.
- **Improve the participant experience.**
 - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
 - Provide education to staff on the multiple dimensions of patient experience.
 - Identify and implement ways to better engage participants in the PACE experience (e.g., menu selection and PMAC).
 - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
 - Monitor and track transportation services in terms of on-time performance and trips less than 60 minutes in duration.
 - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) and in an Advanced Health Care Directives which honors members' wishes as well as advance directive rights.
- **Ensure the appropriate use of resources.**
 - Review and analyze utilization data regularly, including hospital admissions, Emergency Room (ER) visits, and hospital 30-day all-cause readmissions, to identify high-risk members and opportunities for improvement.
 - Review documentation and coordination of care for participants receiving care in institutional settings and investigate any potential infractions in the quality of care provided in these settings.
 - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
 - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
 - Review and analyze clinic medical records to ensure appropriate documentation and coding.
- **Ensure the safety of clinical care.**
 - Reduce potential risks to safety and health of PACE participants through ongoing risk management.
 - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
 - Monitor, report and perform a Root Cause Analysis on all participant-involved events resulting in a significant adverse outcome, for the purpose of identifying areas for quality improvement.
 - Monitor and track falls occurring in the PACE Day Center, in the home and within the community.
 - Monitor and track the use of opioids at high dosages.
 - Meet or exceed community standards for credentialing of licensed providers.
 - Monitor staff and contractors to ensure that appropriate standards of care are met.
- **Ensure appropriate access and availability.**
 - Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
 - Monitor and analyze access to specialty care.
 - Continue to develop the network of Alternate Care Setting (ACS) sites to ensure the

program can provide services to all Orange County residents who qualify and are interested in joining the PACE program.

Organizational and Committee Structure

CalOptima Health Board of Directors provides oversight and direction to CalOptima Health PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at CalOptima Health — including the CalOptima Health PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima Health's Quality Improvement Committee (QIC) described in CalOptima Health's state and federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed during the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI Plan, and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE Quality Improvement Committee

Purpose

This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a quarter. The PQIC will review all QI initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods to address quality problems in any clinical or administrative process that have been identified as critical to participants, families, or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director who will report its activities up to QIC, QAC, and the Board. The PACE Clinical Medical Director, PACE Program Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Clinical Medical Director, PACE Program Director or the PACE QI Manager may report up to QAC if the PACE Medical Director is not available.

Membership

Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Clinical Medical Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, PACE Program Manager, PACE QI Coordinator, Manager of Community-Based Programs, and PACE Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing chair of the committee.

PACE Focused Review Committees

Purpose

These committees will be formed to respond to or to proactively address specific quality issues that rise to the level of warranting further study and action. Key performance elements are

routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization.

Membership

Membership will be flexible based on those with knowledge of the specific issues being addressed but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE Program Manager, PACE QI Coordinator, PACE Intake/Enrollment Manager or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Center Manager or PACE QI Manager. The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC.

PACE Member Advisory Committee

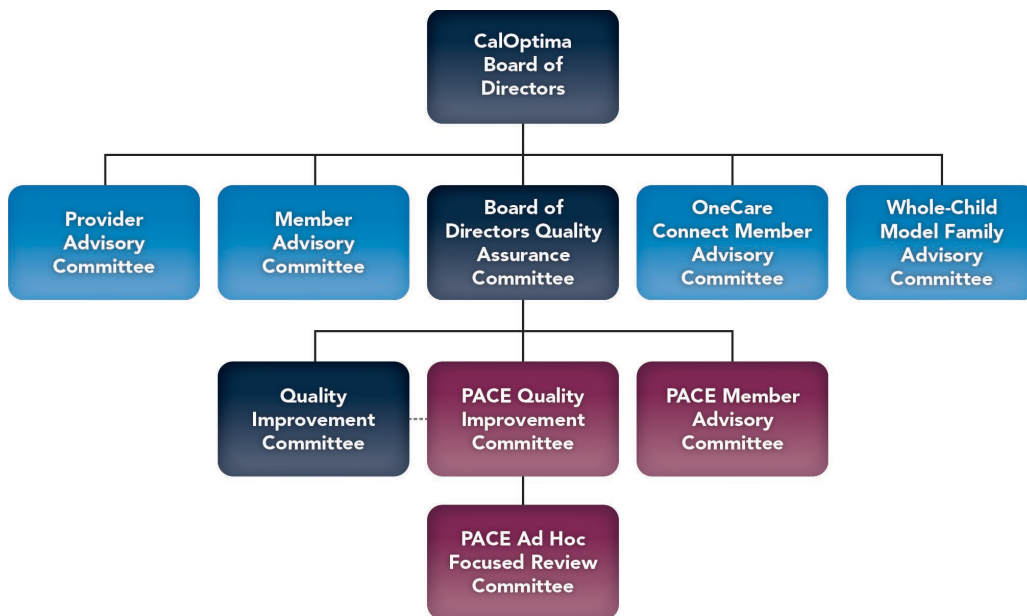
Purpose

The PACE Member Advisory Committee (PMAC) provides recommendations to the Board on issues related to participant care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to QAC, which then will be reported to the Board. The PACE Program Director or the PACE Center Manager shall report its activities to the PQIC.

Membership

The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. PMAC membership is open to all participants and/or caregivers and no application process is required. Information related to upcoming PMAC meetings is disseminated through announcements at the PACE Day Center floor and email/telephonic correspondence and all interested participants are invited to join. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing chair and will facilitate for the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

2023 Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services

- PACE will collect, analyze, and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization including:
 - Hospital Bed Days
 - ER Visits
 - 30-Day All-Cause Readmissions
 - Participants residing in Long-Term Care
- Data analysis will allow for analyzing both overutilization and underutilization for areas of quality improvement.

Participant and Caregiver Satisfaction

- PACE shall survey the participants and their caregivers on at least an annual basis. Additionally, PACE will look for other opportunities for feedback to improve quality of services.
- Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
- The PMAC shall provide direct feedback on satisfaction to both the PACE leadership staff and QAC.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.
- PACE will monitor the percentage of participants who disenroll from the PACE program within 90 days for controllable reasons.

- The qualified lead to enrollment conversion rate will be monitored to ensure the program continues to have a smooth enrollment process.

Clinically Relevant Data

- Unusual Incidents/Reportable Quality Incidents
- Medication Errors
- Falls without Injury
- Clinical measures from the QI Work Plan elements which include:
 - Influenza Immunizations Rates
 - Exclusion criteria:
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - Participants with diagnosis of Guillain Barre
 - Participants who allergic to Influenza vaccine
 - Pneumococcal Immunizations Rates
 - Exclusion criteria:
 - Participants who enroll in the program in December 2023
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - Participants who allergic to Pneumococcal vaccine
 - COVID-19 Bivalent Booster Immunization Rates
 - Exclusion criteria:
 - Participants who enroll in the program in December 2023
 - Participants who have not already received their initial doses of COVID-19 vaccine
 - Participants who have recently tested positive for COVID-19, or at provider's discretion based on health history.
 - Advanced Health Care Planning: POLST Completion
 - Exclusion criteria:
 - Participants who have been enrolled <6 months.
 - Diabetes Care: Blood Pressure Control
 - The following inclusion and exclusion criteria will be in place for this measure:
 - Inclusion criteria:
 - Enrolled for at least six months during measurement year
 - For Q1 2023, look at October 1 2022 or earlier
 - Exclusion criteria:
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - Participants who have a dx of Frailty, ICD-10 R54
 - Participants who are 76 years and older as of December 31, 2023
 - Participants with End Stage Renal Disease, noted as ESRD or STAGE 5 renal disease.
 - Diabetes Care: Annual Eye Exams
 - The following inclusion and exclusion criteria will be in place for this measure:
 - Inclusion criteria:
 - Diagnosis of Diabetes Mellitus

- Enrolled for at least six months during measurement year
 - For Q1 2023, look at October 1 2022 or earlier
 - Exclusion criteria:
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - Participants who are 76 years and older as of December 31, 2023
 - Participants who are legally blind.
- Diabetes Care: Nephropathy Monitoring
 - The following inclusion and exclusion criteria will be in place for this measure:
 - Inclusion criteria:
 - Diagnosis of Diabetes Mellitus
 - Enrolled for at least six months during measurement year
 - For Q1 2023, look at October 1 2022 or earlier
 - Exclusion criteria:
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - Participants who are 76 years and older as of December 31, 2023
 - Participants with End Stage Renal Disease
- Monitoring Participants for Osteoporosis
 - The following inclusion and exclusion criteria will be in place for this measure:
 - Inclusion criteria
 - Any participant who has a fall in 2023
- Reduction of repeat falls through home visits and follow up by Rehabilitation team with repeat fallers.
 - Exclusion criteria:
 - Participants who have a fall in a hospital or skilled nursing facility.
- Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent
 - The following inclusion and exclusion criteria will be in place for this measure:
 - Inclusion criteria:
 - Diagnosis of Dementia
 - Continuous enrollment throughout year (enrolled for at least a year)
 - For Q1 2023, Look at enrollment from 3/1/22 and before
 - For Q2 2023, Look at enrollment from 6/1/22 and before
 - For Q3 2023, Look at enrollment from 9/1/22 and before
 - For Q4 2023, Look at enrollment from 12/1/22 and before

- Participants who are 66 years and older as of December 31, 2023
- Exclusion criteria:
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - Participants with Schizophrenia or Bipolar Disorder
- Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Kidney Disease plus Nonaspirin NSAIDS or Cox2 Selective NSAIDS
 - The following inclusion and exclusion criteria will be in place for this measure:
 - Inclusion criteria:
 - Participants with diagnosis of CKD 3,4, or 5/End Stage Renal Disease.
 - Continuous enrollment throughout year
 - For Q1 2023, Look at enrollment from 3/1/22 and before
 - For Q2 2023, Look at enrollment from 6/1/22 and before
 - For Q3 2023, Look at enrollment from 9/1/22 and before
 - For Q4 2023, Look at enrollment from 12/1/22 and before
 - Participants who are 66 years and older as of December 31, 2023
 - Exclusion criteria:
 - Participants who have dx of Palliative Care Approach, ICD-10 Z515
 - TOPICAL NSAIDS such as Voltaren (Diclofenac) gel may be excluded from this list since they have minimal systemic absorption.
- Opioids at High Dosage Monitoring by PCPs.
- Medication Reconciliation Post Discharge from Hospital or Skilled Nursing Facility.
- Access to Specialty Care services.

Effectiveness and Safety of Staff-Provided and Contract-Provided Services

- This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team (IDT) with each reassessment, review of medical records, and success of infection control efforts.
- All clinical and certain non-clinical positions have competency profiles specific to their positions.
- Annual competency evaluations of PACE staff.
- PACE will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE staff, as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE

regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as CalOptima Health guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight of all activities offered by PACE.
- Member grievances will be forwarded to the PACE QI Department for investigation, tracking, trending, and data gathering. These results will be shared with the PACE Director for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
- Member appeals will be forwarded to the PACE QI Department for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be forwarded to a third-party with the appropriate licensure for review. The third-party reviewer's decision shall be reviewed by The PACE QI manager as well as either the PACE Director or the PACE Medical Director and will be immediately shared with via telephone and/or written letter with information about additional rights to appeal.
- Continued integration of telehealth to expand access to care through the continued COVID-19 pandemic and beyond.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE Center Manager will monitor transportation services with periodic ride-alongs. The times gathered during the ride-alongs will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through participant satisfaction surveys as well as comments solicited by the PMAC.
- Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills, as well as regulatory agency inspections.
- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority Setting for Performance Improvement Initiatives

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life.
- Potential impact on participant access to necessary care or services.
- Potential impact on participant safety.
- Participant, caregiver, or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high volume, or high frequency events.
- Relevance to the mission and values of PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents, Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported through the PACE monitoring module of HPMS. The following data is reported to CMS via the HPMS on a quarterly basis:

- Grievances
- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents

- When unusual incidents meet specified thresholds, PACE must notify CMS on a quarterly basis through HPMS. PACE must complete a Root Cause Analysis and present the results of the analysis on a conference call with both CMS and the Department of Health Care Services (DHCS) as well as internally at PQIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Unusual Quality Incidents include:
 - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
 - Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall.
 - Infectious disease outbreaks that meet the threshold of three or more cases linked to the same infectious agent within the same time frame, including COVID-19 infections.
 - Pressure injuries acquired while enrolled in PACE.
 - Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.
 - Elopement by cognitively impaired participants.
 - Adverse drug reactions.
 - Foodborne disease outbreak.
 - Burns 2nd degree or higher.
- HOS-M
 - PACE will participate in the annual HOS-M to assess the frailty of the population in our center.
- Other external reporting requirements
 - Suspected elder abuse shall be reported to appropriate state agency.
 - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
 - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency.

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another member of the PQIC, as appropriate.

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the PACE Medical Director and the PACE Director.
- The QI Manager or QI Coordinator will consult with relevant PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification.
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants.
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately.

Re-Evaluation and Follow-Up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
 - Severity of the problem
 - Frequency of occurrence
 - Impact of the problem on participant outcomes
 - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement.
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of PACE Quality Initiatives are presented to the PQIC on a quarterly basis. The program's quality initiatives in 2023 are:
 - Advance Health Care Directive
 - This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of $\geq 50\%$ of participants having a completed AHCD in 2023.

- Dental Satisfaction
 - This initiative will focus on increasing participant satisfaction with contracted dental services, to provide participants with comprehensive education regarding the process for dental procedures with a focus on reduced pain and increased function. The PACE Enrollment Coordinators will highlight for new enrollees what dental services are provided (ex/routine cleanings) and what are not (ex/cosmetic dentistry). Clinic administrative staff will follow up each month with 5 randomly chosen participants who received dental services from a specialist *outside of PACE*, to find any areas of dissatisfaction that can be addressed in a timely manner. The goal will be for PACE to have ≤ 1 dental related grievance per quarter in 2023.

- Transportation Satisfaction
 - This initiative will focus on reducing the number of PACE participants who have been dissatisfied with contracted transportation services, as identified by transportation grievances. The PACE leadership team has created a plan to be implemented by the PACE Center manager to utilize the transportation logs and to follow up with participants to assess their satisfaction and to identify any areas of concern or miscommunication regarding provision of services. The goal will be for PACE to have ≤ 3 transportation related grievance per quarter.

ANNUAL REVIEW OF PACE QI PLAN

- The PACE QI Plan will be assessed annually for effectiveness.
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

APPENDIX A (SEE ATTACHMENT)

2023 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI23.01	Improve the Quality of Care for Participants	2022 PACE QAPI Plan and Work Plan Annual Evaluation	2022 PACE QAPI Plan will be evaluated by CalOptima Health Quality Assurance Committee in March 2023	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/8/2023	PACE Medical Director
QI23.02	Improve the Quality of Care for Participants	2023 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by CalOptima Health Quality Assurance Committee March 2023	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/8/2023	PACE Medical Director
QI23.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2023	Improve compliance with influenza immunization recommendations	Q1, Q3 and Q4 2023	12/31/2023	PACE Medical Director
QI23.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have completed their pneumococcal vaccination by December 31st, 2023	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2023)	Quarterly	12/31/2023	PACE Medical Director
QI23.05	Improve Quality of Care for Participants	COVID-19 Booster Immunization Rates	≥ 80% of eligible participants will have had their COVID-19 Bivalent Booster Vaccine by December 31st, 2023	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2023)	Quarterly	12/31/2023	PACE Medical Director
QI23.06	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st,2023	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2023	PACE Clinical Operations Manager and PACE Medical Director
QI23.07	Improve the Quality of Care for Participants	Diabetes Care	>84.21% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement in maintaining healthy blood pressure.	Quarterly	12/31/2023	PACE Medical Director
QI23.08	Improve the Quality of Care for Participants	Diabetes Care	> 85.42% of Diabetics will have an Annual Eye Exam (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement in maintaining healthy vision.	Quarterly	12/31/2023	PACE Medical Director
QI23.09	Improve the Quality of Care for Participants	Diabetes Care	> 98.78% of Diabetics will have Nephropathy Monitoring (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement in maintaining kidney function.	Quarterly	12/31/2023	PACE Medical Director
QI23.10	Improve the Quality of Care for Participants	Osteoporosis	100% of participants who have a fall will have a bone density scan to assess for osteoporosis	Medical records of participants who have a fall will be reviewed to see if they have had a bone density scan within the past 2 years. If not, a scan will be completed on that participant within 6 months of reported fall.	Quarterly	12/31/2023	PACE Medical Director

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI23.11	Ensure the Safety of Participants	Reduce Percentage of Falls Reported by PACE Enrollees	<72 falls reported per quarter in 2023	The PACE Center manager will work with the Rehabilitation Department to review all participants who have repeated falls within each quarter. Participants who have repeated falls will have a documented home assessment and follow up completed by PACE to reduce total	Quarterly	12/31/2023	PACE Center Manager
QI23.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<24.64% (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2023	PACE Medical Director
QI23.13	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDs or Cox2 Selective NSAIDs	<2.62% (Comparable to the 2021 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2023	PACE Medical Director
QI23.14	Ensure the Safety of Clinical Care	Decrease the Use of Opioids at High Dosage (UOD)	100% of members receiving opioids for 15 or more days at an average of 90 MME/day will be reevaluated monthly by their treating provider in 2023.	The PACE QI Department will monitor any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day. (Exclusion: Participants who have a diagnosis of Palliative Care)	Quarterly	12/31/2023	PACE Medical Director
QI23.15	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥90% of participants will have their medications reconciled within 10 days of hospital and/or skilled nursing facility discharge in 2023	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2023	PACE Pharmacist
QI23.16	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥ 88 % of specialty care authorizations will be scheduled within 14 business days in 2023	Appointments for specialty care will be scheduled within 14 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2023	PACE Clinical Operations Manager
QI23.17	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<3,330 hospital days per 1000 per year	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education. (Exclusion: Participants who have Long Term Acute Care Hospitalizations of >90days).	Quarterly	12/31/2023	PACE Medical Director
QI23.18	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<850 emergency room visits per 1000 per year	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2023	PACE Medical Director

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI23.19	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<14% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2023	PACE Medical Director
QI23.20	Ensure Appropriate Use of Resources	Long Term Care Placement	<4% of members will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2023	PACE Center Manager
QI23.21	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to 65% in 2022	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2023	PACE Marketing and Enrollment Manager
QI23.22	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths, to develop strategies for improvement	Quarterly	12/31/2023	PACE Marketing and Enrollment Manager
QI23.23	Improve Participant Experience	Disenrollment	Maintain a PACE participant attrition rate of ≤10 %	PACE will create focus groups to identify areas that need operational improvement to strategically support growth and increase census to 450 participants.	Quarterly	12/31/2023	PACE Center Manager and PACE Director
QI23.24	Improve Participant Experience	Transportation Performance	100% of transportation trips will be less than 60 minutes in 2023	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2023	PACE Center Manager
QI23.25	Improve Participant Experience	Transportation Performance	≥92% of all transportation rides will be on-time in 2023	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2023	PACE Center Manager
QI23.26	Improve Participant Experience	Transportation Satisfaction	≥93.6% Satisfaction with Transportation Services (2022 PACE National Average) on the 2023 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve participant satisfaction with the PACE Transportation program	Annually	12/31/2023	PACE Center Manager
QI23.27	Improve Participant Experience	Participant Satisfaction with Meals	≥71.1% Satisfaction with Meals (2022 PACE National Average) on the 2023 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant satisfaction with the meals within the PACE program.	Annually	12/31/2023	PACE Center Manager

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI23.28	Improve Participant Experience	Overall Participant Satisfaction	≥88.6% on the Overall Satisfaction-Weighted Average (2022 PACE National Average) on the 2023 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant satisfaction with the PACE program	Annually	12/31/2023	PACE Director



2022 PACE Quality Improvement Plan Evaluation

Special Quality Assurance Committee Meeting

March 15, 2023

Dr. Donna Frisch, PACE Medical Director

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.

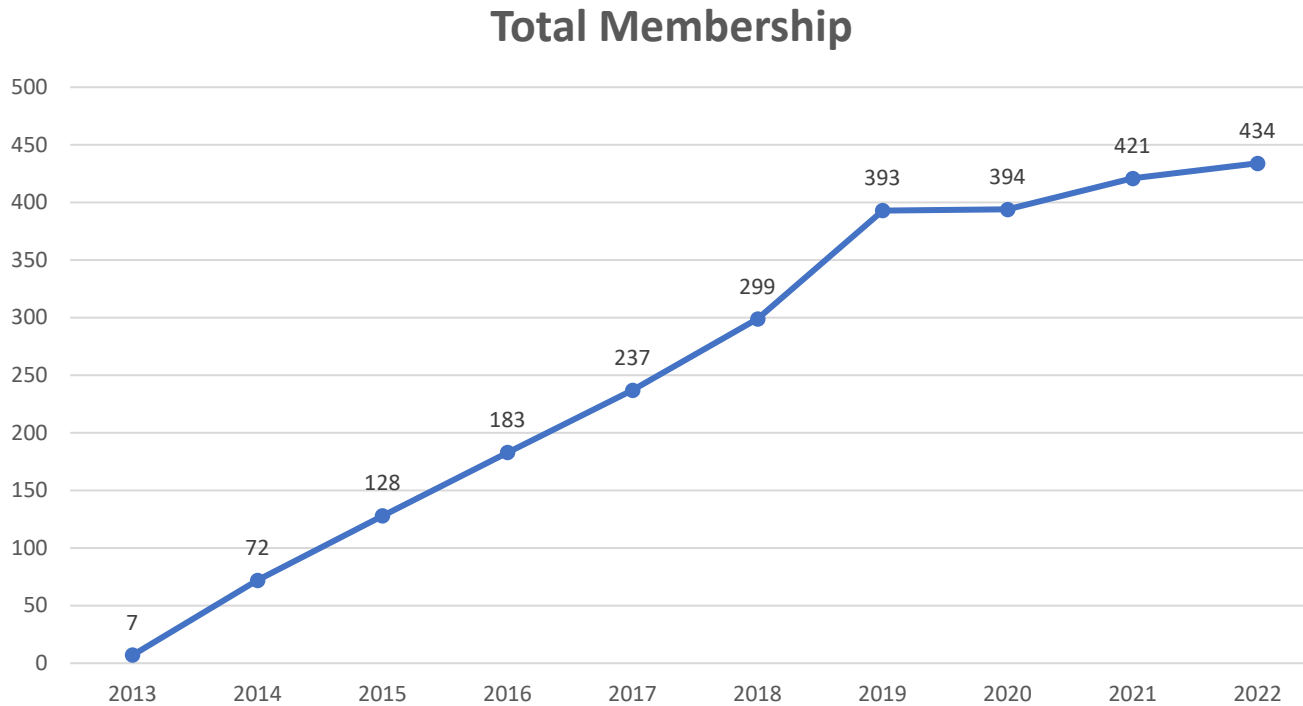
2022 PACE Accomplishments

- PACE has continued to maintain and follow the Public Health Emergency COVID-19 guidance to ensure we are following all protocols
- Only 3.8% of participants resided in Long-Term Care
- 93% influenza immunization rate
- 98% COVID-19 immunization rate
 - 95% with at least one additional booster dose
- Quality of Diabetes Care
 - 96% had annual eye exam completed
 - 100% had nephropathy monitoring

2022 PACE Accomplishments

- 100% medication reconciliation within 14 days following a hospital discharge
- 94% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed
- Transportation on-time performance of 98%
- Overall participant satisfaction score of 89% compared to national average of 88.5%

PACE Membership Growth 2013-2022



2022 saw PACE's highest number of active enrollees since opening in 2013

Elements 8 & 9: Comprehensive Diabetes Care

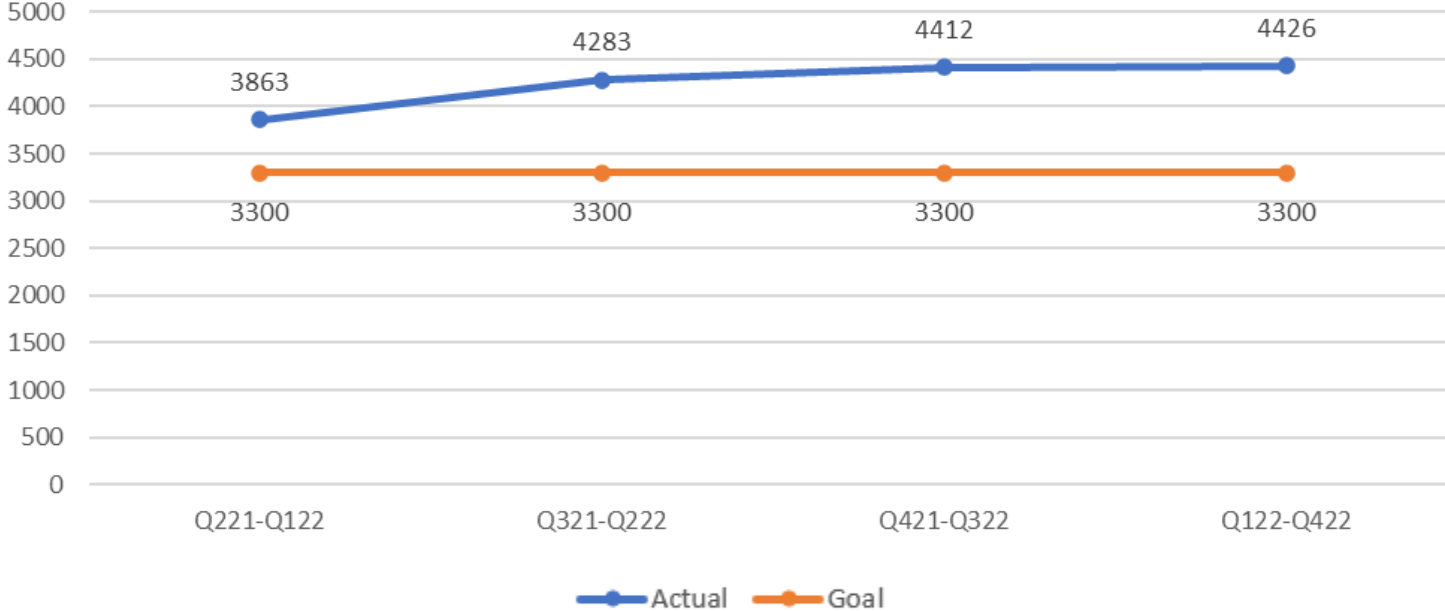
Higher Is Better		Medicare Quality Compass 2020 HEDIS Percentiles			
Domain	2022 PACE Rate	50th Percentile	75th Percentile	90th Percentile	95th Percentile
Annual Diabetic Eye Exams	96%	69.34%	76.3%	80.78%	82.77%
Nephropathy Monitoring	100%	94.74%	96.11%	97.81%	98.3%

Elements 12 & 13: Potential Harmful Drug/Disease Interactions in the Elderly

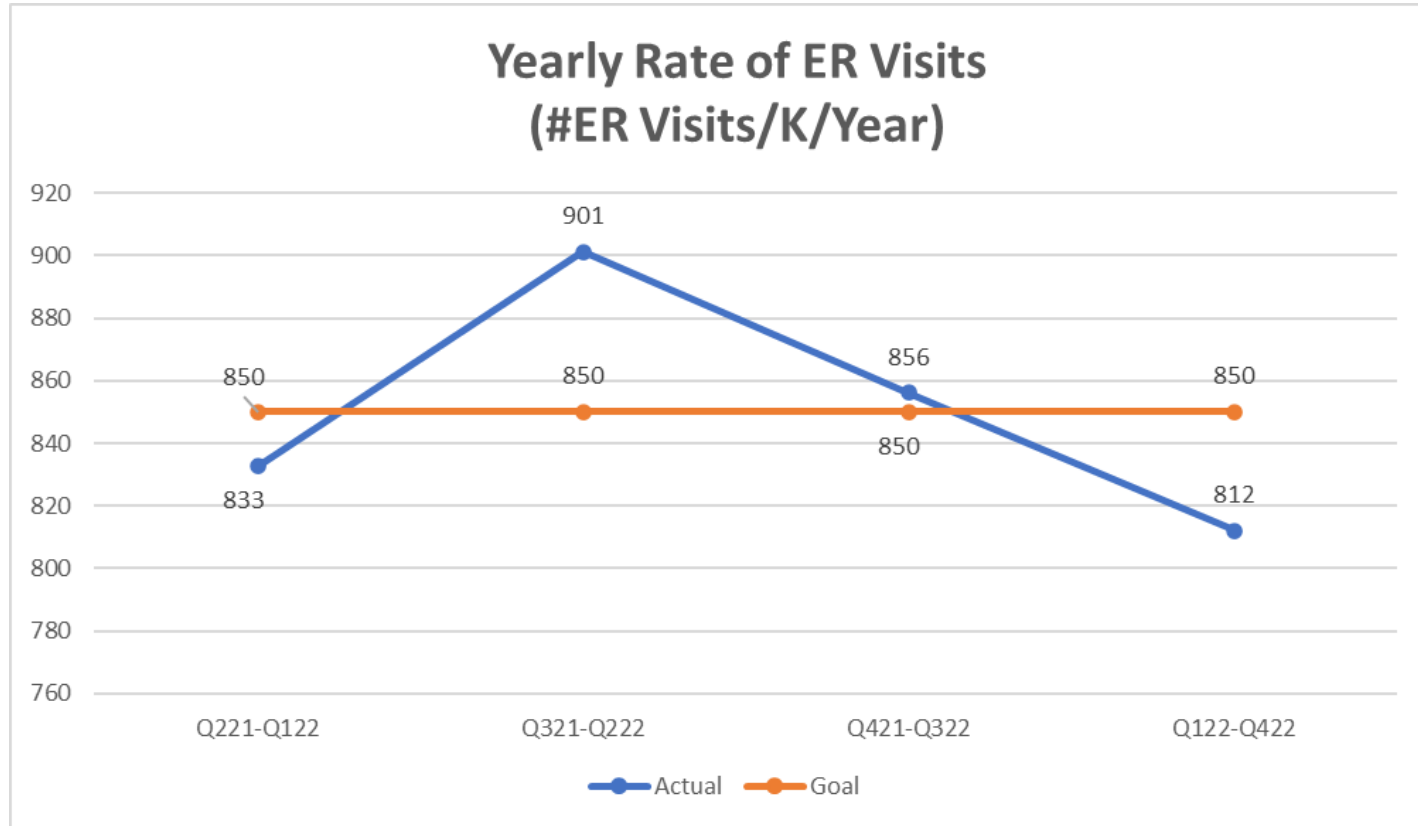
Lower Is Better		Medicare Quality Compass 2020 HEDIS Percentiles			
Domain	2022 PACE Rate	50th Percentile	75th Percentile	90th Percentile	95th Percentile
Dementia + Tricyclic Antidepressants or anticholinergic Agents	19%	37.26%	32.58%	27.24	24.03%
Chronic Renal Failure + NSAID	2%	9.24%	6.25%	3.47%	2.47%

Element 18: Hospital Bed Days

Yearly Rate of Hospital Days (#Bed Days/K/Year) Goal < 3,330



Element 19: ER Utilization



Goal of reducing ER visits met in 2022

Element 27: Annual Participant Satisfaction Survey Results (Goal: $\geq 88\%$ on Overall Weighted Score)

Domain	2021 CalOptima PACE	2022 CalOptima PACE	2022 National PACE Average
Transportation	96%	89%	93.6%
Center Aids	95%	96%	91.7%
Home Care	90%	85%	85.8%
Medical Care	93%	87%	89.7%
Health Care Specialist	88%	85%	89.0%
Social Worker	97%	95%	94.5%
Meals	80%	82%	71.1%
Rehabilitation Therapy and Exercise	91%	93%	93.0%
Recreational Therapy	81%	84%	79.1%
General Service Delivery	92%	92%	86.4%
Overall Weighted Score	91%	89%	88.6%

Opportunities for Improvement in 2023

- Improve the Quality of Care (QOC) for Participants
 - Updating COVID-19 booster immunization quality element to ensure as many eligible participants are vaccinated against the latest recommended vaccines.
 - Raising goals in care of diabetic participants to match the highest level of care (HEDIS 95th percentiles) in areas such as eyes exams, and blood pressure and nephropathy monitoring.
 - Ensuring that all participants receive preventative health care and diagnostic monitoring such as DEXA scans to look at bone mineral density.
 - Continued efforts to reduce falls at home including new element to include home assessment review for repeat fallers.

Opportunities for Improvement in 2023

- Ensure the Safety of Clinical Care
 - The grievances and potential quality issues involving downstream vendors will continue to be tracked and trended to assure no service or clinical trend is emerges. New quality initiatives related to dental grievances are introduced in the 2023 Quality Workplan.
 - Participants receiving more than an average MME dose of 90 MME will continue to be closely monitored.
 - Raising goals in reducing potential harmful drug/disease interactions in the elderly to match the highest level of care (HEDIS 95th percentiles).

Opportunities for Improvement in 2023

- Ensure the Appropriate Use of Resources
 - Inpatient/ER Utilization
 - Further expansion of our complex case management program with individualized interventions with a focus on high-risk participants.
 - Continue to refine the ER Diversion program to treat participants with minor ailments in their homes using the PACE clinic team as well as after hours on-call physicians services.
 - Specialty Care
 - Increase the number of core PACE specialists who are willing to work closely with the PACE program, receive training in the PACE Model of Care. PACE will continue to leverage CalOptima Health's Provider Relations department to ensure that the specialist network meets the needs of PACE.

Opportunities for Improvement in 2023

- Improve Participant Experience
 - Grievances and potential quality issues will be monitored and analyzed to find opportunities for improvement. Use of transportation logs to resolve minor transportation issues immediately when they are reported.
 - Once participants return to the PACE Day center at full capacity, we will restart the monthly meal satisfaction surveys and make refinements to our meal program based on the feedback.

Opportunities for Improvement in 2023

- Ensure Appropriate Access and Availability
 - Reopening of access to Alternate Care Setting sites will continue through 2023.
 - Continued development of our list of preferred specialists who are willing to work closely with PACE, be trained in the PACE model of care and attend occasional interdisciplinary care team meetings.
 - Will continue to bring specialists in to provide specialty care within the PACE clinic.

Questions?



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2023 PACE Quality Improvement Plan Description

Special Quality Assurance Committee Meeting
March 15, 2023

Dr. Donna Frisch, PACE Medical Director

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.

2023 PACE Quality Improvement (QI) Program Description

- Encompasses all clinical care, clinical services and organizational services provided to our participants
- Aligns with our vision and mission
- Focuses on optimal health outcomes for our participants
- Uses evidence-based guidelines, data and best practices tailored to our populations
- Updated to address COVID-19 vaccination recommendations

2023 PACE (QI) Work Plan Goals

- Improve the Quality of Care for Participants
- Ensure the Safety of Clinical Care
- Ensure Appropriate Access and Availability
- Ensure Appropriate Use of Resources
- Improve Participant Experience
- Additional Focus on COVID-19

2023 PACE (QI) Work Plan Elements Removed, Added and Modified

○ Removed

■ *Improve Access to PACE Care: Increase Telehealth Engagement.*

- In 2022, PACE was able to return to many of our in-person services including scheduled assessments and request for clinic services for immediate needs. Because of this, we are removing the telehealth element from our workplan, however, we do plan to continue exploring way to expand telehealth access and utilization with our PACE participants as an operational issue in 2023.

2023 PACE (QI) Work Plan Elements Removed, Added and Modified

○ Modified Elements

- *Falls at Home Classified as CMS Reportable Quality Incidents*
 - This element has been modified for 2023 to address that PACE is interested in a reduction of repeat falls. The element description is now *“Reduce Percentage of Falls Reported by PACE Enrollees”*. The PACE Center manager will work with the Rehabilitation Department to review all participants who have repeated falls within each quarter. Participants who have repeated falls will have a documented home assessment and follow up completed by PACE to reduce total number of falls.

2023 PACE (QI) Work Plan Elements Removed, Added and Modified

○ Modified Elements Continued

■ *Osteoporosis*

- This element has been modified for 2023 to change the focus from ensuring that participants with osteoporosis are treated (consistently above goal in 2022) to make sure PACE is assessing all participants for osteoporosis regardless of risk factors. For this element, the medical records of participants who have a fall will be reviewed to see if they have had a bone density scan within the past 2 years. If not, a scan will be completed on that participant within 6 months of the reported fall.

2023 PACE (QI) Work Plan Elements Removed, Added and Modified

○ Added Elements

■ *Enrollment/Disenrollment*

- The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%. PACE will review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths, to develop strategies for improvement.

■ *Disenrollment/Attrition*

- Maintain a PACE participant attrition rate of $\leq 10\%$. PACE will create focus groups to identify areas that need operational improvement to strategically support growth and increase census to 450 participants in 2023.

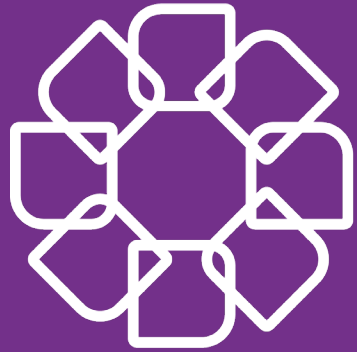
2023 PACE Quality Initiatives

- Advanced Health Care Directive
 - The goal for 2023 is $\geq 50\%$ of participants having a completed AHCD in 2023.
- Dental Services Satisfaction
 - The goal for 2023 is ≤ 1 dental related grievance per quarter in 2023.
- Transportation Services Satisfaction
 - The goal for 2023 is ≤ 3 transportation related grievance per quarter in 2023.

Recommended Action

- Recommend approval of the 2023 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Plan Description

Questions?



PACE
CalOptima Health

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 15, 2023

Special Meeting of the CalOptima Health Board of Directors’ Quality Assurance Committee

Report Item

4. Receive and File 2022 CalOptima Health Quality Improvement Program Evaluation and Recommend Board of Directors Approval of the 2023 CalOptima Health Quality Improvement 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

- Receive and File the 2022 CalOptima Health Quality Improvement Program Evaluation, and
- Recommend Board of Directors Approval of the 2023 CalOptima Health Quality Improvement Program and Work Plan.

Background

CalOptima Health’s Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer service provided to CalOptima Health members, which aligns with its vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all members. The QI Program 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 QI Program is reviewed, evaluated, and approved annually by the Board of Directors. The QI Program defines the structure within which QI activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima Health members.

The 2022 Quality Improvement Program Evaluation analyzes the core clinical and service indicators to determine if the 2022 QI Program has achieved its key performance goals during the year.

CalOptima Health had the following achievements in 2022:

- September 2022: Received a 4 out of 5 in NCQA’s Medicaid Health Plan rating.
- October 2022: Chief Executive Officer Michael Hunn and Chief Medical Officer Richard Pitts, D.O., Ph.D., were recognized as 2022 Orange County (OC) Visionaries in a special publication of the LA Times OC.

- November 2022: CalOptima Health and the Orange County Health Care Agency won the Public-Private Partnership Award from the Orange County Business Council Turning Red Tape Into Red Carpet Awards.
- November 2022: Received the mPulse award for Most Improved Consumer Experience with its multilingual, two-way SMS texting program that addressed language barriers around food security.

In 2022, CalOptima Health remained committed to innovative approaches to improving quality of care and quality of service. CalOptima Health expanded strategies to improve member health outcomes, member experience, and provider engagement by adding a OneCare Pay for Value program to promote improvement in quality of care for the dual eligible member population. CalOptima Health also added a Hospital Quality Program to improve health outcomes and patient safety in the acute care setting.

Discussion

CalOptima Health staff has updated the 2023 QI Program and Workplan to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner across all lines of business.

The 2023 QI Program is based on the Board-approved 2022 QI Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all 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 existing program initiatives to align with health equity and current operational practices.
2. Updated 2023 quality improvement goals and objectives:
 - Goal 1 – Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational, and community levels.
 - Goal 2 – Improve quality of care and member experience by obtaining NCQA Health Plan Rating of 5.0, and at least a Four-Star Rating for Medicare.
 - Goal 3 – Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare, and a Hospital Quality.
3. Updated new program initiatives
 - Health Equity Framework.

- Comprehensive Community Cancer Screening and Support Program.
 - Five-Year Hospital Quality Program.
4. Updated the QI Program staffing and resources to reflect current organizational structure.
 5. Updated the QI Committee Structure by removing OneCare Connect committees.
 6. Removed programs that sunset in 2022.
 7. Updated sections in the QI Program to reflect current operational processes and workflows.

The 2023, the CalOptima Health QI Program and Work Plan will be flexible and able to align with strategic goals and objectives as defined by the Board of Directors. Staff will remain agile in the shifting health care landscape while continuing to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

2023 QI Program Recommendations:

1. Increase emphasis on preventive measures and screenings that may have been neglected during the pandemic with programs that support
2. Early detection and cancer screening for breast, cervical, colorectal and lung cancer
3. Targeted interventions and member engagement to well-child visits, blood lead screening and childhood immunizations.
4. Incorporate Social Determinants of Health (SDOH) factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
5. Expand quality initiatives to improve member experience, focused on increasing member access to care.

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

Fiscal Impact

The recommended action to approve the 2023 QI Program has no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2022-23 Operating Budget. Staff will include expenditures for the period of July 1, 2023, through December 31, 2023, in the FY 2023-24 Operating Budget.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. 2022 Quality Improvement Program Evaluation
2. 2023 Quality Improvement Program and Work Plan DRAFT FINAL (Redline version)
3. Proposed 2023 Quality Improvement Program and Work Plan DRAFT FINAL (Clean version)
4. PowerPoint Presentation: 2022 QI Evaluation, 2023 QI Program and Work Plan

/s/ Michael Hunn
Authorized Signature

03/01/2023
Date



2022

QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION





**2022 QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION
SIGNATURE PAGE**

Quality Improvement Committee Chair:

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

Date

Board of Directors - Quality Assurance Committee Chair:

Trieu Tran, M.D.

Date

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2022 Quality Improvement Program Evaluation of Overall Effectiveness

EXECUTIVE SUMMARY

The 2022 Quality Improvement (QI) Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved key performance goals during the year. This evaluation focuses on quality activities initiated during measurement years 2021 and 2022, which impacted results in 2022, to improve health care and services available to CalOptima Health members.

The QI Program for 2022 outlined the major program initiatives. Threaded into the initiatives continued to be impact of the COVID-19 pandemic and the ongoing public health emergency that began in 2020. The Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) issued several guidance documents with flexibility in regulations addressing member access to care during the pandemic.

In December 2020, when the COVID-19 vaccine became available, CalOptima Health pivoted to quickly and equitably assist our members in protecting themselves and their families. Strategies included providing each member a \$25 Target gift card incentive per dose, participating in the DHCS COVID-19 Vaccination Incentive Program, and collaborating with Orange County Health Care Agency on the Vaccine Equity Pilot Program, which directly allocated COVID-19 vaccine doses to health network providers and community health centers. CalOptima Health also conducted multifaceted member engagement and outreach and supported vaccination clinics for diverse communities to address vaccine hesitancy. CalOptima Health is committed to continuing member outreach, targeting disproportionately affected communities and increasing vaccination rates until community immunity is reached.

In 2022, the QI Program Initiatives aligned with CalOptima Health's strategic priorities with a focus on health equity, social determinants of health, member engagement, improved access to care and improved quality outcomes. CalOptima Health remained focused on advancing QI initiatives to achieve 2022 QI goals and objectives to provide members with access to quality health care services. CalOptima Health continued to utilize the Plan-Do-Study-Act (PDSA) approach to developing initiatives in 2021 that continued into 2022. These initiatives are focused on long-term improvement efforts for selected high-priority measures. In 2023, based on the 2022 QI Program Evaluation, QI will continue to support a strategy, as identified in the 2023 QI Program, that aligns with CalOptima Health's strategic priorities and regulatory requirements and focuses on activities and incentives that will improve member engagement, access to care and quality outcomes. The 2023 QI Work Plan will profile key areas that offer opportunities for improvement to be implemented or continued as outlined in the 2023 QI Program.



2022 Achievements

Awards and Recognitions

September 2022: CalOptima Health received a rating of 4 out of 5 in the National Committee for Quality Assurance’s Medicaid Health Plan Ratings 2022. No other Medi-Cal Plan in California earned a rating higher than 4 out of 5. This is the eighth year in a row that CalOptima Health has received this distinction.

October 2022: Chief Executive Officer Michael Hunn and Chief Medical Officer Richard Pitts, D.O., Ph.D., were recognized as 2022 OC Visionaries in a special publication of the LA Times OC. Their selection acknowledges their noteworthy accomplishments and impact at CalOptima Health and in Orange County. Fewer than 20 individuals were recognized within the health care industry.

November 2022: CalOptima Health won an award from mPulse Mobile for Most Improved Consumer Experience with its multilingual, two-way SMS texting program that addressed language barriers around food security. The program educated members on the availability and benefits of CalFresh, which provides monthly food benefits to low-income individuals and families, encouraging members to apply through a direct link provided in two-way text workflows. The innovative program expanded to seven languages and allowed members to respond in their native language with simple statements like, “I already have CalFresh” or “I want to apply.”

November 2022: CalOptima Health and the Orange County Health Care Agency won the Public-Private Partnership Award from the Orange County Business Council Turning Red Tape Into Red Carpet Awards. The award recognizes both agencies for the launch of Be Well OC’s campus in the city of Orange as a first-of-its-kind center that provides comprehensive behavioral health care to improve mental health and substance use disorder services for Orange County residents.



Review of 2022 Recommendations

CalOptima Health's QI Goals and Objectives were aligned with the agency's 2022–23 Strategic Goals.

- Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational and community levels.
- Improve quality of care and member experience by maintaining NCQA Health Plan Rating of 4.0, and at least a Four-Star Rating for Medicare.
- Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare and Hospital Quality.

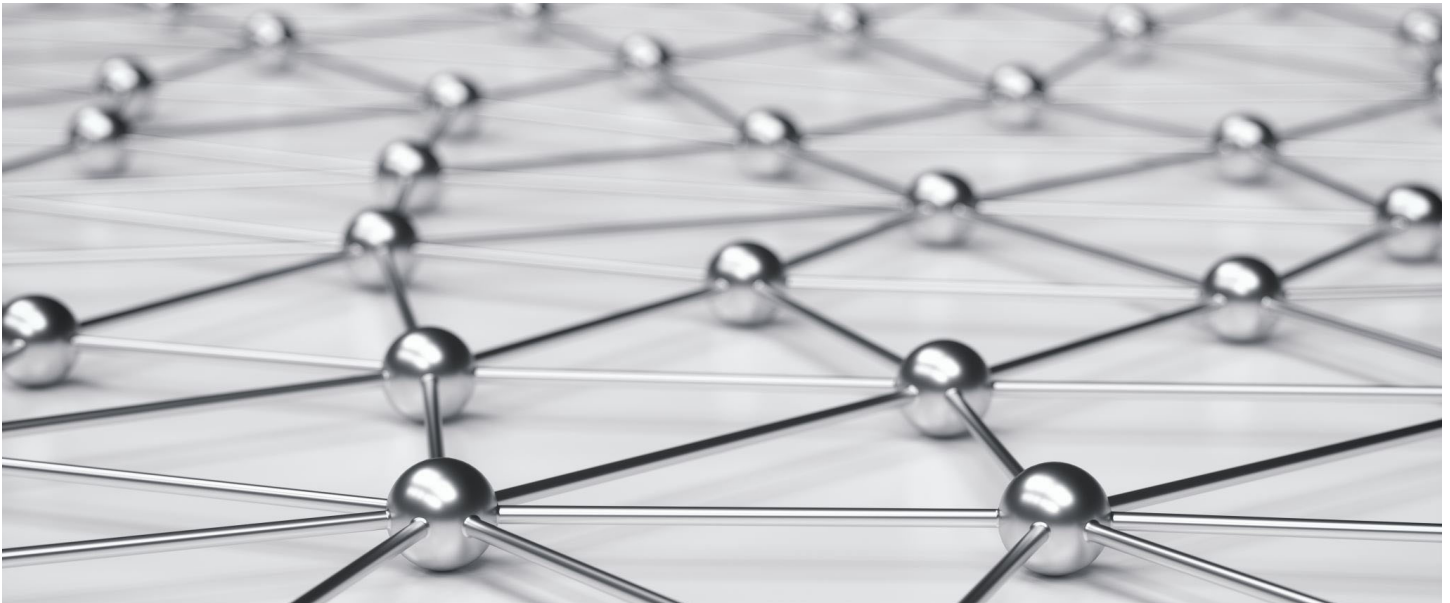
These top three priority goals were chosen to be aligned with CalOptima's strategic objectives, the COVID-19 pandemic, as well as continued goals related to access to care and NCQA accreditation. The 2022 QI Work Plan details the planned activities to meet the COVID-19 vaccine aim, which include strategies for immunization, targeted communication and member incentives. The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards, as measured by the annual Timely Access study. All goals and sub-goals will be measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

Recommendations for 2023

This past year continued to bring uncertainty in health care delivery due to the unprecedented COVID-19 pandemic that has impacted lives locally, nationally and globally. CalOptima Health's QI Program and Work Plan for 2023 will be flexible to align with the new strategic goals and objectives as defined by the Board of Directors. Staff will remain agile in the shifting health care landscape while continuing to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

Based on the 2022 QI Program Evaluation, in addition to continuing to advance CalOptima Health's mission and improve quality outcomes of members, we recommend the following initiatives and projects to drive improvements that impact members.

- Incorporate Social Determinants of Health (SDOH) factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs
- Collaborate with external stakeholders and partners in comprehensive assessments of members.
- Develop robust community-based interventions using analytical tools, such as geo-mapping, in collaboration with community partners and entities that have a good understanding of the target population barriers and behaviors
- Strategize and streamline member outreach by using multiple modes of communication via contracted external vendors, including through website, direct mailings, email, Interactive Voice Response (IVR) calls, mobile texting, targeted social media campaigns and robocall technology
- Expand collaboration on quality initiatives in partnership with health networks to broaden and expand the reach of coordinated data sharing to close gaps in care
- Continue to implement Enhanced Care Management (ECM) and Community Supports as part of California Advancing and Innovating Medi-Cal (CalAIM)
- Increase emphasis on preventive measures and screenings that may have been neglected during the pandemic with programs that support:
 1. Early detection and cancer screening for breast, cervical, colorectal and lung cancer.
 2. Targeted interventions and member engagement for well-child visits, blood lead screening and childhood immunizations.
- Align initiatives to support the DHCS 2022 Comprehensive Quality Strategy
- Implement DHCS Population Health Management Program
- Expand CalAIM team to support implementation of oversight strategy, and provision of services that best meet member needs
- Continue to promote treatment for healthy cholesterol levels for members with diabetes and support compliance with diabetic HbA1c testing and eye exams through provision of member incentives and education
- Implement Homeless Response team and Street Medicine Program to support members experiencing homelessness
- Expand behavioral health interventions to support complex mental health needs and improve follow up after hospital utilization
- Promote prenatal and postpartum care for members through provision of member incentives and education and reduce health disparities through targeted interventions
- Expand quality initiatives to improve member experience, focused on increasing member access to care



SECTION 1: QUALITY IMPROVEMENT PROGRAM STRUCTURE

Activities in the 2022 Quality Improvement (QI) Program and associated Work Plan focused on refining the structure and process of care delivery, with the emphasis on member-centric activity and consistency with regulatory and accreditation standards. All activities were undertaken in direct support of the Mission, Vision, Values and Strategic Initiatives of CalOptima Health's Board of Directors.

For 2022, CalOptima Health had adequate staffing and resources and a well-defined quality committee structure in place to meet the required needs of the QI Program. The QI Program structure includes a Quality Improvement Committee (QIC), with several subcommittees reporting to the QIC, which included the Whole-Child Model Clinical Quality Committee (WCM CAC), Utilization Management Committee (UMC), Credentialing and Peer Review Committee (CPRC), Member Experience Committee (MEMX), and Grievance Appeal and Resolution Services (GARS) Committee.

The QIC consists of eight CalOptima Health medical directors, four CalOptima Health staff and seven health network medical director representatives, plus an Orange County Health Care Agency behavioral health representative. The Committee is supported by additional CalOptima Health staff. The QIC had exceptional participation from external and internal practitioners as well as staff. Annually, a draft of the QI Program is presented to the QIC for review and approval. Committee members are asked to provide feedback on quality initiatives and activities presented in the program. QIC has oversight of the QI Program and Work Plan. Thorough the year, CalOptima Health staff and practitioners review progress reports and updates on quality activities that address necessary improvements in the quality of care delivered by all providers in any setting and take appropriate action to improve upon Health Equity.

Components of the QI Program and Structure

The components of the QI Program are closely aligned to meet the goal of continuously improving the quality of care for members.

QI Program Documents

- Annual Evaluation — Completed a comprehensive evaluation of the QI Program and QI Work Plan at the end of the fiscal year that assesses the performance on measures and indicators.
- Program Description — Developed and implemented a robust written QI Program description that focused on improving standards of care and addressing gaps in care identified in the prior year’s evaluation. The organization enhanced the QI Program by including “new initiatives” in the QI Program description that will outline measurable goals and objectives that CalOptima Health will focus on in subsequent years.
- Work Plan — Created to monitor and evaluate performance of QI measures and interventions on an ongoing basis. This is a dynamic document that may change throughout the year based on priorities and opportunities.
- Policies and Procedures — Ensure that the organization has developed and implemented appropriate policies and procedures that are needed to provide care to members and align with regulatory and accreditation requirements.
- Delegation Grid — Describes activities delegated to the health networks.
- Organizational Chart — Provides a visual presentation of the reporting structure of the QI Committee, its subcommittees, and its relationship to the CalOptima Health Board of Directors

Reviews of QI Documents

- CalOptima Health successfully completed reviews of all of the above documents with the QI committees during 2022. The documents were reviewed and approved by the CalOptima Health Board of Directors.
- Feedback from the practitioners who participated in the QI committee meetings was included in program documents (i.e., Program Description, Work Plan and Annual Evaluation).

Quality Improvement Committee (QIC)

- The QIC is the primary committee that is responsible for the QI Program, Work Plan and Evaluation, and reports to the Quality Assurance Committee (QAC) of the CalOptima Health Board of Directors
- The committee provides critical feedback and guidance to the QI department on key initiatives. The QIC also reviewed and approved all the key QI documents in a timely manner
- The QIC reviewed and provided feedback on key clinical and other coordination of care initiatives, including member outreach, provider education and outreach, incentives, educational materials and more
- The committee reviewed and approved the policies and procedures and made recommendations regarding policy decisions
- The committee reviewed and provided feedback on key reports: annual analysis of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) access to care; and complaints and appeals. Part of the feedback included specific actions that CalOptima Health could take to improve performance
- The committee received quarterly reports from the Credentialing and Peer Review Committee (CPRC), Utilization Management Committee (UMC), Member Experience Committee (MEMX), Grievance and Appeals Resolution Services (GARS) and Whole Child Model Clinical Advisory Committee (WCM CAC). These reports were summarized and presented quarterly to the QAC

Assessment of QI Staff and Resources

CalOptima Health continues to dedicate significant resources and staffing to meet the needs of the QI Program. In 2022, the QI department added staff to support anticipated changes to the Department of Health Care Services (DHCS) requirements for Facility Site Review (FSR). In Q3 2022, the DHCS FSR and Medical

Record Review (MRR) tools and standards were implemented. Staff in Potential Quality Issues (PQI) were shifted to support quality of care grievance reviews. Credentialing delegation oversight was transferred from QI to the Audit & Oversight department in December 2022. To support the development of the Health Equity Framework, a Manager of Population Health Management focusing on health equity was created. In addition, an Executive Director of Quality position was created, and this position will work closely with the Executive Director of Population Health Management to ensure staff has adequate support to meet the needs of the QI Program. The QI department also received support from other key departments within the organization, including but not limited to the following:

- Quality Analytics
- Population Health Management
- Behavioral Health Integration
- Case Management
- Member Services (including outreach and engagement)
- Provider Relations and Contracting

Review of System Resources

CalOptima Health has dedicated significant resources to ensuring there are adequate systems in place to monitor and evaluate performance of QI programs on an ongoing basis. The resources include HEDIS analysts for reporting, plus extensive analytic staff support. Additional support and collaboration were provided by the Provider Relations, Network Management, GARS and Customer Service departments.

CalOptima Health also utilizes three enterprise systems for utilization and care management (GuidingCare by Altruista), claims payment (Facets) as well as credentialing data management (Cactus by Symplr). Although these systems are not integrated, data from the systems are stored in a data warehouse, and resources are allocated to create robust tools utilizing Tableau to analyze and generate quality reports, gaps in care reports and other relevant reports needed to support the QI Program. There is a robust data integration flow in place that allows the organization to use data from different sources and identify improvement opportunities. The team also has an adequate number of business analysts as well as an ITS department that can support the reporting needs of the organization.

CalOptima Health issued a Request for Proposal (RFP) for both the utilization and care management system and credentialing, contracting and provider data management system. In 2022, CalOptima Health sought to contract with vendors who best meet system and business needs.

Overall Assessment of Program Structure

CalOptima Health had adequate staffing and resources required to meet the needs of the QI Program, in addition to organizational program requirements. CalOptima Health will continue to evaluate the needs of the program through the Work Plan, on a quarterly basis, and add staffing and additional resources, as needed, to supplement the QI department. The organization receives adequate feedback from its community practitioners about the development and implementation of the QI initiatives and programs. CalOptima Health continues to have significant participation from the medical directors in the development and implementation of clinical initiatives and programs throughout the year. The medical directors and QI directors report the information to senior leadership.

The Charter was reviewed, and the following modifications were made: the committees may meet virtually or in-person, the Deputy Chief Medical Officer and Quality Medical Director were added and the subcommittees

of QIC were updated. In addition, the purpose and desired outcome of the committee will be added to each agenda, and the following responsibilities were added: review and assess compliance with QI and Health Equity standards and oversight of compliance issues including but not limited to timeliness of clinical care and services provided to members.

Program Oversight



2022 UM Program Evaluation

CalOptima Health direct networks CalOptima Health Community Network (CCN) and CalOptima Health Direct Network (COD) saw a downward movement between Q1 2022 to Q3 2022 in volume for one-day stays in inpatient facilities. There was a slight uptick in Q2 2022 by 0.5% and a decrease by 0.88% in Q3 for one-day stays. CalOptima health worked with the highest volume facility for one-day stays to pilot a treatment authorization nurse that was embedded in the Emergency Department (ED) to promote real time support for members to approve and coordinate ambulatory care prior to leaving the ED. All three quarters of 2022 showed Sepsis as the top diagnosis for inpatient, one-day stays. CalOptima health implemented weekly inpatient rounds with all nine adult facilities with the top 10 high-volume facilities and the pediatric weekly rounds are slated to start in Q1 of 2023. All-cause readmissions had a slight increase from Q1 22 to Q2 by .003% and a 14% decrease from Q1 to Q3 for all-cause readmits within 30 days for CalOptima Health's direct networks. -CalOptima Health had implemented rounds by Q3 with all five of the top facilities with greatest volume of readmissions within 30 days that included support of the internal complex discharge team and referrals to complex case management, Enhanced Case Management and CalAIM community supports. These efforts will continue into 2023 to address inpatient utilization trends.

Credentialing and Peer Review Committee (CPRC) Oversight

The purpose of the CPRC is to maintain a peer review and credentialing program that aligns with the regulatory and accreditation standards, promotes continuous improvement of the quality of health care provided by the CalOptima Health network, conducts peer-level review and evaluation of provider performance and credentialing information against CalOptima Health requirements and appropriate clinical standards, and investigates patient care outcomes that raise quality and safety concerns for corrective actions. In 2022, the committee met monthly, cancelling one meeting.

This year, the CPRC had one community physician resign due to retirement. In June, a new community physician was added who specializes in pulmonary and critical care medicine, and neurological critical care, and represents the Noble Mid-Orange health network. Additionally, the Committee added new CalOptima Health medical directors as they came aboard. In October, the Chair of the Committee transitioned to a new medical director. To date, the Committee consists of nine CalOptima Health medical directors and four community physicians representing various health networks. CalOptima staff and General Counsel provide support to the CPRC.

The CPRC continued to review credentialing, recredentialing, ongoing monitoring and peer review activities and trends. The committee also reviewed changes to all QI policies and procedures including those related to credentialing, potential quality issues and FSRs. This year, two separate Judicial Hearing Committees (JHC) were commenced and concluded in two separate cases. CPRC adopted the recommendation of each of the JHCs, which led to the termination and an 805 action against one physician.

In 2023, the committee plans to meet monthly and maintain committee member composition. The committee will review applicable NCQA audit measures and report any noncompliance of regulatory and/or accreditation to QIC.

Grievance and Appeals Resolution Services (GARS) Committee

The committee met quarterly in 2022. In an ongoing effort to identify initiatives to improve access to care and services, the committee analyzes member experience results. The GARS Committee reviewed for trends in dissatisfaction quarterly and the GARS department reports on actions taken to correct/improve the trend. The review includes categories of dissatisfaction, provider trends in quality of care and service complaints, complaints related to vendors, denial rates and reasons.

Reported during the year were efforts to improve trends including telephone accessibility, appointment availability and transportation.

In 2023, the committee plans to meet quarterly and maintain committee member composition. The committee will review applicable NCQA audit measures and report any noncompliance of regulatory and/or accreditation to QIC.

Member Experience Committee (MEMX) Oversight

The purpose of the MEMX is to improve the member experience and drive initiatives to achieve member experience goals established by the corporate strategic plan or QI Work Plan. The MEMX also ensures members have access to quality health care services for all product lines and programs.

In 2022, the committee met bimonthly, though one meeting was canceled. The committee is chaired by the Executive Director of Operations, has membership including the Chief Medical Officer and Quality Medical

Director, is represented by the business units that impact the member experience and is supported by staff in Quality Analytics. Reporting to the committee are the following workgroups: Timely Access and Network Adequacy Workgroups.

The committee reviewed the charter and made the following changes:

- Changed the title of the Co-Chair to Chair
- Added the Executive Director, Behavioral Health Services, and Director, Program Initiatives
- Added the Provider Action Workgroup to address non-clinical provider issues.

In 2022, the committee reviewed the Provider Satisfaction Survey questions and methodology. The survey was created to retrieve feedback from contracted providers as to what CalOptima Health does well and areas that need improvement. The survey was finalized, fielded July to September 2022, and resulted in the following areas of feedback:

- Increase reimbursement rates
- Difficulty contacting Claims, Customer Service and GARS departments
- Enhance online tools
- Issues with authorizations and referrals
- Improve contracting and credentialing processes
- Poor access to resources such as preauthorization denials and medications
- Difficulty contacting staff at CalOptima Health.

The committee also reviewed the Whole Child Model program for California Children's Services (CCS) participation in each specialty. It was identified that one health network was noncompliant for Physical Medicine and Rehabilitation. Action was escalated by the committee for resolution by the health network.

Finally, the committee reviewed non-clinical issues related to providers. The Provider Action Workgroup was developed to review and address these issues, which may include, for example, panel closures.

In 2023, the committee plans to meet quarterly and maintain committee member composition. The committee will review applicable NCQA audit measures and report any noncompliance of regulatory and/or accreditation to QIC.

Utilization Management Committee (UMC)

The purpose of the UMC is to provide oversight and direction for continuous improvements to the UM functions and activities performed by CalOptima Health that aligns with overall strategic goals and priorities. 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 efficiencies of the care and services provided to members.

The UM committee reviews and approves on an annual basis the core mission-aligned, regulatory and NCQA required artifacts including but not limited to UM Program description, Medical Necessity Criteria, UMC charter and UM program description. The committee provides guidance to the Pharmacy and Therapeutics and Benefits Subcommittees, both of which report to UMC.

UMC Scope and Responsibilities:

Provides oversight and overall direction for the continuous improvement of the UM Program consistent with CalOptima Health's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima Health and its delegated Health Networks as appropriate

- Oversees the UM activities and compliance with federal and state statutes and regulations, and contractual and NCQA requirements that govern the UM process,
- Reviews and approves the UM Program Description, Medical Necessity Criteria, UMC Charter and UM Program Evaluation on an annual basis
- Reviews and analyzes UM Operational and Outcome data, and reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM Metric targets and goals
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects
- Promotes a high level of satisfaction with the UM Program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives
- Reviews, assesses and recommends UM best practices used for selected diagnoses or disease classes
- Conducts under/over utilization monitoring in accordance with UM Policy and Procedure GG.1532 Over and Under Utilization Monitoring, and sets appropriate upper and lower thresholds for over/under utilization trend reports

The committee met quarterly in 2022 and plans to meet quarterly in 2023. The committee will continue to provide oversight and direction of UM functions and will report any noncompliance of regulatory and/or accreditation to QIC.

Pharmacy and Therapeutics (P&T) Committee

The CalOptima Health Pharmacy and Therapeutics (P&T) Committee is responsible for development of the drug formularies, which are based on sound clinical evidence, and are reviewed at least annually by practicing practitioners and pharmacists. The committee includes 13 voting members who are practicing physicians or pharmacists. At least one physician and one pharmacist are required to be experts in the treatment of elderly or disabled persons.

The P&T Committee meets a minimum of four times per year and reports to the UM Committee. In 2022, the committee met on February 17, May 19, August 18 and November 17.

P&T Committee Goals:

- To promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima members.
- To meet DHCS and CMS formulary regulatory requirements.
- Provide overall direction for the continuous improvement process and oversee that activities are consistent with CalOptima Health's strategic goals and priorities.
- Promote an interdisciplinary approach to driving continuous improvement in pharmacy utilization.
- Support compliance with regulatory and licensing requirements and accreditation standards related to pharmacy-related initiatives.
- Monitor, evaluate and act on pharmacy-related care and services members are provided to promote quality of care outcomes.

P&T Committee Responsibilities:

- Review new medications and prior authorization criteria as outlined in CalOptima Health policy GG.1409: Drug Formulary Development and Management and policy MA.6103: Pharmacy and Therapeutics Committee.

- Review individual requests for changes to the formularies from practitioners in the community.
- Review and update the formularies on an ongoing basis to ensure access to quality pharmaceutical care that is consistent with the program’s scope of benefits.
- Review anticipated and actual utilization trends overall as well as for specific drug classes.
- Review and evaluate pharmacy-related issues related to delivery of health care to CalOptima Health members.
- Assess outcomes of pharmacy-related HEDIS and Medicare Star measures to drive improvements.
- Review and evaluate patterns of pharmaceutical care and key utilization performance indicators.
- Evaluate and make recommendations on pharmacy issues that pertain to CalOptima Health-wide initiatives, such as treatment guidelines, disease management programs, QI studies, etc.
- Review and make recommendations on selected pharmaceutical provider educational activities.
- Recommend pharmacy-related policy decisions.

In 2023, the P&T Committee plans to continue to meet quarterly and maintain the current committee member composition. They will report any noncompliance of regulatory and/or accreditation to QIC.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to evaluate and maintain the benefit set. The committee determines if new or revised codes require a prior authorization for each line of business within CalOptima Health that is aligned with regulatory, statutory, contractual or clinical best practice standards. The committee, as a subcommittee to UMC, oversees all revised and updated authorization rules.

In 2022, the committee met eight times, and in 2023, it plans to meet at least six times. The committee will maintain the current committee members composition and will report any noncompliance of regulatory and/or accreditation to QIC.

Whole Child Model Clinical Advisory Committee (WCM CAC)

In 2022, the committee met quarterly. At the February meeting, the committee revised its charter to add a pediatric pulmonologist since several of the California Children’s Services (CCS)-related conditions require evaluation from a pulmonologist. The committee reviewed the following quality initiatives this year:

- Discussed an effort to engage UCLA providers to participate in the CalOptima Health network. UCLA agreed to move forward with pediatric organ transplantation for people younger than 21 years of age.
- Informed CalOptima Health providers of Neonatal Intensive Care Unit (NICU) MCG guideline changes.
- Analyzed Customer Service data identifying notable trends related to WCM members and recommended strategies for improvement.
- Developed workgroups to address members experiencing transplantation, hemophilia, aging-out of CCS services, and care coordination with the goal of ensuring a smooth transition of care.
- Reviewed data related to WCM members from supporting departments, including HEDIS MY2021 rates, utilization, behavioral health, grievance and customer data, influenza and COVID-19 immunization rates, and health network adequacy.

One physician left the committee in November, and that seat will be filled in 2023. Additionally, the committee added new CalOptima Health medical directors as they came aboard in 2022. The committee consists of eight CalOptima Health medical directors, one Orange County Health Care Agency psychiatrist, and nine community physicians representing various health networks. CalOptima Health staff provided support to the committee.

In 2023, the committee plans to meet at least quarterly and maintain the current committee member composition. The committee will review NCQA standards and report noncompliance of regulatory and/or accreditation to QIC.

Program Initiatives for 2022



Mitigate Impact and Improve Health Equity: COVID-19 Pandemic

The COVID-19 pandemic created a public health emergency (PHE) that has changed the landscape of delivering quality health care to members. The 2022 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the Long-Term Care (LTC) Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, as well as the COVID-19 Vaccination and Communication strategy. Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity have existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in September 2021 revealed that Latinx people account for 45.9% of coronavirus deaths, in a state where they are 38.9% of the population, and Black people account for 6.7% of the deaths but are only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima Health identified opportunities to improve health equity as part of the QI Work Plan.

Orange County COVID-19 Nursing Home Prevention Program

The University of California, Irvine (UCI) COVID-19 Skilled Nursing Facility (SNF) Prevention Program developed a toolkit and implemented training to improve prevention and readiness and to restrict, to the extent

possible, the impact of the anticipated COVID-19 surge to Orange County SNFs and the local systems of care. The project included collaboration with Orange County Health Care Agency (OCHCA) and leveraging their efforts in developing the local public health response to clusters and cases in SNFs, as well as incorporating CDC and public health guidance.

Interventions

- UCI Prevention Team provided consultative services for COVID-19 prevention to contracted OC SNFs. Twelve SNFs received intensive training with weekly feedback of staff safety metrics. A total of 150 hours of consultation was provided to 31 additional SNFs.
- UCI created a free online toolkit available to all OC SNFs. Receiving more than 3,000 web views, the kit contained three modules, 51 documents and 20 videos.
- UCI distributed training materials to more 55 OC SNFs, including 1,100 informational wall-clings and 90 binders filled with education materials.
- UCI launched a confidential helpline for COVID-19 questions. More than 250 helpline inquiries addressing questions about COVID-19 prevention, vaccines, safety, etc. were received.
- UCI hosted seven free webinars with invitations to all staff at OC SNFs.

Findings

UCI continued to conduct point prevalence sweeps of residents for multidrug-resistant organisms. UCI trained 12 SNFs for collection of surveillance samples.

Facility Type	Average Percentage of Residents with Completed Primary Vaccinations	Average Percentage of Staff with Completed Primary Vaccination	Average Residents Total Confirmed COVID-19	Average Residents Total COVID-19 Deaths	Average Staff Total Confirmed COVID-19	Average Staff Total COVID-19 Deaths
Intensive Training Group	90.6%	96%	114	16	118	1
All Other OC SNFs	89.6%	96.8%	85	11	93	>1
CA SNFs	89.6%	95.1%	78	8	82	>1

Intensive Training Group = 12 OC SNFs received intensive, hands-on prevention training; All Other OC SNFs = Did not receive intensive hands-on training, but had access to all training materials and consultations; CA SNFs = All California SNFs outside Orange County, did not receive prevention training from UCI

1. Analysis

This was an educational outreach project to reduce the spread of COVID-19 in OC SNFs. It was a two-year project, ending May 31, 2022. Baseline data was not collected. Although UCI met all the objectives, the data collected by CMS in August 2022 indicates the program was minimally effective when compared with SNFs not receiving prevention training.

2. Barriers

- High SNF staff turnover made it difficult to ensure all staff received the COVID-19 prevention training.

- Data was difficult to collect. UCI spent a sizeable amount of time measuring vaccine uptake, those receiving a vaccine, in OC SNFs. They found the actual uptake was far lower than the reported numbers. This was largely due to the challenge of identify staff due to time-off and staff working at multiple facilities.

3. Opportunities for Improvement

This program concluded in May 2022, so no further activity will be reported. Should CalOptima Health perform future programs with UCI, measurable goals and baseline metrics will be established, and will be reported quarterly.



COVID-19 Vaccination and Communication Strategy

On December 11, 2020, the Food and Drug Administration (FDA) used an Emergency Use of Authorization (EUA) to allow the administration of the COVID-19 vaccine in the United States.

On January 7, 2021, the CalOptima Health Board of Directors (BOD) approved the COVID-19 Member Vaccine Incentive Program (VIP). The goal of this program was to motivate members to obtain the required doses of COVID-19 vaccination by providing nonmonetary gift cards. The proposed efforts were funded through Intergovernmental Transfer (IGT) funds and awarded a \$25 nonmonetary gift card per dose of the COVID-19 vaccine. The organizational goal was set to achieve a COVID-19 vaccination rate of 80% for all eligible members.

Today, the COVID-19 VIP eligibility has expanded to other brands, doses and younger age groups to align with the most up-to-date vaccination recommendations. Members who are 6 months of age and older may now qualify for a gift card. CalOptima Health also expanded the COVID-19 VIP eligibility criteria to include Kaiser Medi-Cal members as an eligible population. In addition to offering nonmonetary incentives, an essential strategy to promote vaccination efforts was tailored member education. The member education materials focused on the importance of vaccination, aimed to correct misconceptions and promoted community vaccination events.

1. COVID-19 Member Vaccine Incentive Program (VIP)

CalOptima Health has been committed to executing interventions that promote COVID-19 vaccinations. These include member health rewards as a part of the COVID-19 VIP; member and provider publications; social media messaging; text message campaigns; and vaccination events through collaborations with the Orange County Health Care Agency, community-based organizations and schools.

- COVID-19 VIP: CalOptima Health currently offers up to three health rewards to qualifying members who are vaccinated with the COVID-19 vaccine.
- Multiple member and provider campaigns were launched throughout the year providing education about COVID-19 and the vaccines. The campaigns included member and provider publications, social media posts on Facebook, Instagram and Twitter, and text messaging campaigns to members.
- CalOptima Health collaborated with the Orange County Health Care Agency, community-based organizations and schools to coordinate vaccination events. There was a total of 23 vaccination events in which qualified members for the COVID-19 VIP received a \$25 gift card upon getting vaccinated.

2. Findings

As of October 31, 2022, out of all CalOptima Health eligible members ages 6 months and up (933,791), the total vaccinated membership was 553,542, which yields a total vaccination percentage of 59.3%. Review of the vaccination rates by race/ethnicity shows that most categories have achieved at least a 50% vaccination rate with Asian being the highest at 80.5% and Black being the lowest at 46.5%. See Table A: COVID-19 Vaccination Rates by Race/Ethnicity.

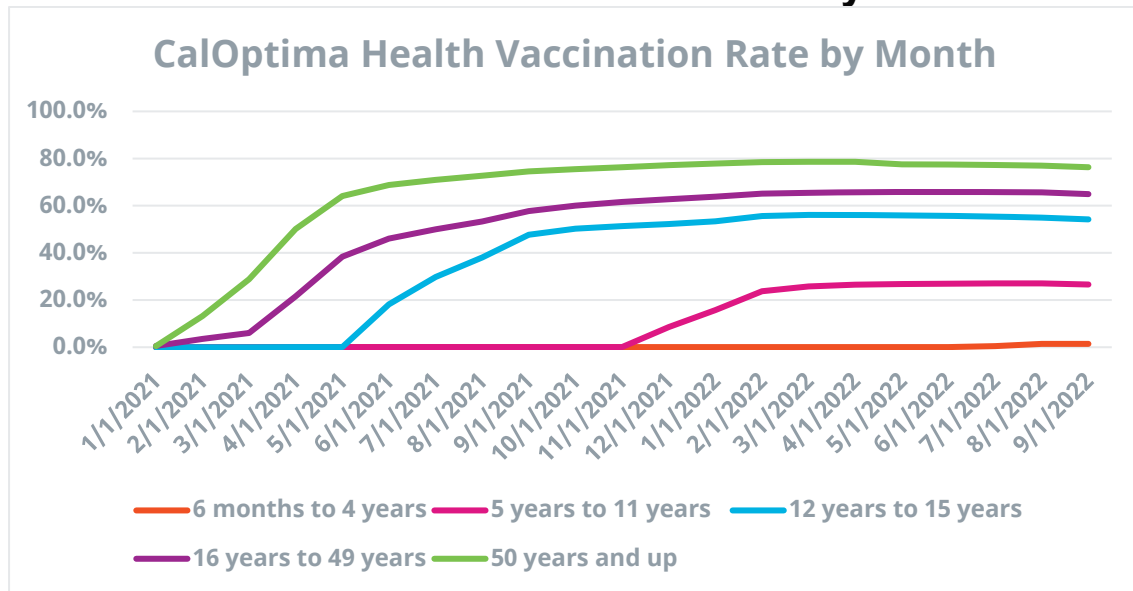
Table A: COVID-19 Vaccination* Rates by Race/Ethnicity

Vaccination Rates as of 10/31/2022	Race/Ethnicity					
	<i>Alaskan Native/ American Indian</i>	<i>Asian</i>	<i>Black</i>	<i>Hispanic</i>	<i>Others</i>	<i>White</i>
Numerator	788	147,894	7,872	215,760	98,027	83,201
Denominator	1,565	183,612	16,940	409,533	167,399	154,742
Rate	50.4%	80.5%	46.5%	52.7%	58.6%	53.8%

*Vaccination rate includes members who have been vaccinated with at least 1 dose of the COVID-19 vaccine.

- CalOptima Health's COVID-19 VIP eligibility focuses on members in three programs. As of 10/31/2022, OneCare Connect (OCC) had reached an 81.8% vaccination rate, OneCare (OC) 83.9% and Medi-Cal (MC) 58.8%.
- Upon review of vaccination rates by age bands per month, there is a plateauing trend for most age groups. See Chart A: COVID-19 Member Vaccination Rates by Month.

Chart A: COVID-19 Member Vaccination* Rates by Month

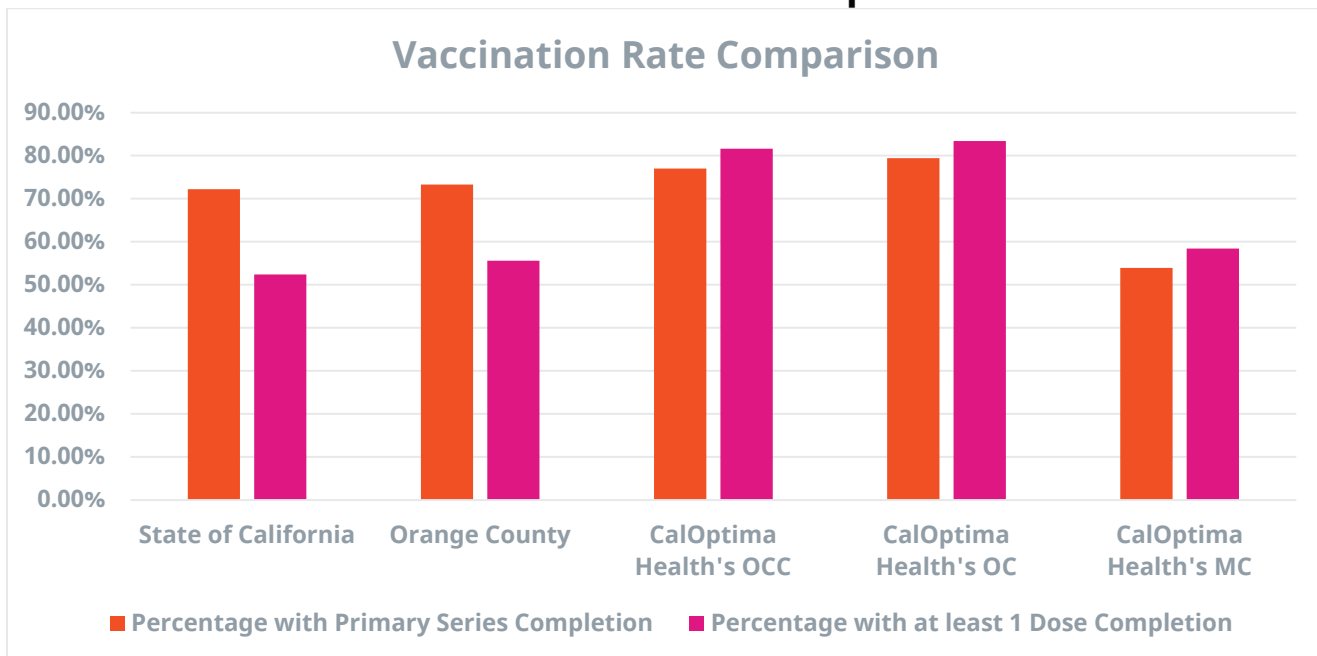


*Vaccination rate includes members who have been vaccinated with at least 1 dose of the COVID-19 vaccine.

3. Analysis

- a. OC and OCC vaccination rates have surpassed the organizational goal of 80% vaccination rate. OC and OCC populations were among the first group to be recommended the COVID-19 vaccine based risk level, and they have had the most time to begin inoculation. In addition, several outreach efforts have been performed by CalOptima Health since the inception of the COVID-19 VIP.

Chart B: COVID-19 Vaccination Rate Comparison



State and County data pulled from: <https://www.dhcs.ca.gov/Documents/COVID-19/DHCS-COVID-19-Vaccine-Stats.pdf> CalOptima Health data pulled from: <https://dwtabpr.caloptima.org/#/site/CO/views/CalOptimaCOVID-19VaccineAnalysis/COVID-19VaccinatedMembersbyVaccinationStatusFullvsPartial?iid=1>

- b. The continuous recommendations for age expansions and increase in dose approvals has made the denominator for the COVID-19 VIP MC population grow and has had an effect on vaccination rates for MC members. Upon further analysis, vaccinations among younger populations were met with increased hesitancy and Chart A shows that ages 6 months to 4 years have had a slow start after CDC approval.
- c. Most members vaccinated with at least one dose of the COVID-19 vaccine have plateauing trends and do not show increasing numbers. This means that in general, most age groups are not starting their vaccination series at this time and the likelihood of beginning COVID-19 vaccine inoculation for those who are not vaccinated at all is minimal.
- d. COVID-19 interventions focused on encouraging vaccinations and providing education through various means of communication. These strategies have been successful in driving member vaccinations as seen in vaccination rates among OC/OCC members. MC members ages 16 and up have plateaued at 70% and further interventions are needed for younger age groups to boost the overall MC vaccination rate of 58.8%.

4. Barriers

- CDC's continuous efforts to build on recommendations for the COVID-19 vaccine may have led to confusion surrounding vaccination guidelines for different age bands.
- Some members experienced COVID-19 vaccination hesitancy, especially for younger ages groups (6 months to 4 years).
- COVID-19 VIP is a passive gift card assignment; members do not need to submit any documentation to CalOptima Health to receive a health reward. Instead, CalOptima Health relies on multiple sources to receive member vaccination data (i.e., California Immunization Registry, claims and encounter data). The multiple data sources, and state lag time increased various data inaccuracies. This caused many members to experience a waiting period of several months after completing their COVID-19 vaccinations to receive incentives.
- COVID-19 VIP is not aligned with CDC's current recommendations. Staff is recommending a modification to the COVID-19 VIP to continue to encourage vaccine adherence and give younger age groups sufficient time start their inoculation.

5. Opportunities for Improvement

- CalOptima Health will provide continued updated booster promotion via publications to minimize misconceptions and provide education.
- CalOptima Health will create text messaging campaigns to survey members about the COVID-19 VIP program and provide educational links while encouraging members to get their updated boosters.
- CalOptima Health will work with multiple departments to continue to align recommendations for the COVID-19 VIP system flow and logic that feeds into assignment of COVID-19 health rewards.
- CalOptima Health will create a call center members to ask about the COVID-19 VIP program. This would bring value to the member experience because it gives members the opportunity to get clarification on questions or unclear guidelines and minimizes frustration that members may have about COVID-19 VIP program.
- Staff received approval of three modifications to the COVID-19 VIP program from the CalOptima Health Board in November 2022, which included an extension of the COVID-19 VIP to June 30, 2023, to provide ample time for younger age groups to receive vaccinated status, an increase of the rewards to four rewards to all qualifying members to encourage updated booster vaccinations, and to update all

communication tools to provide clear health reward guidelines and encourage member inoculation before the end of the COVID-19 VIP.

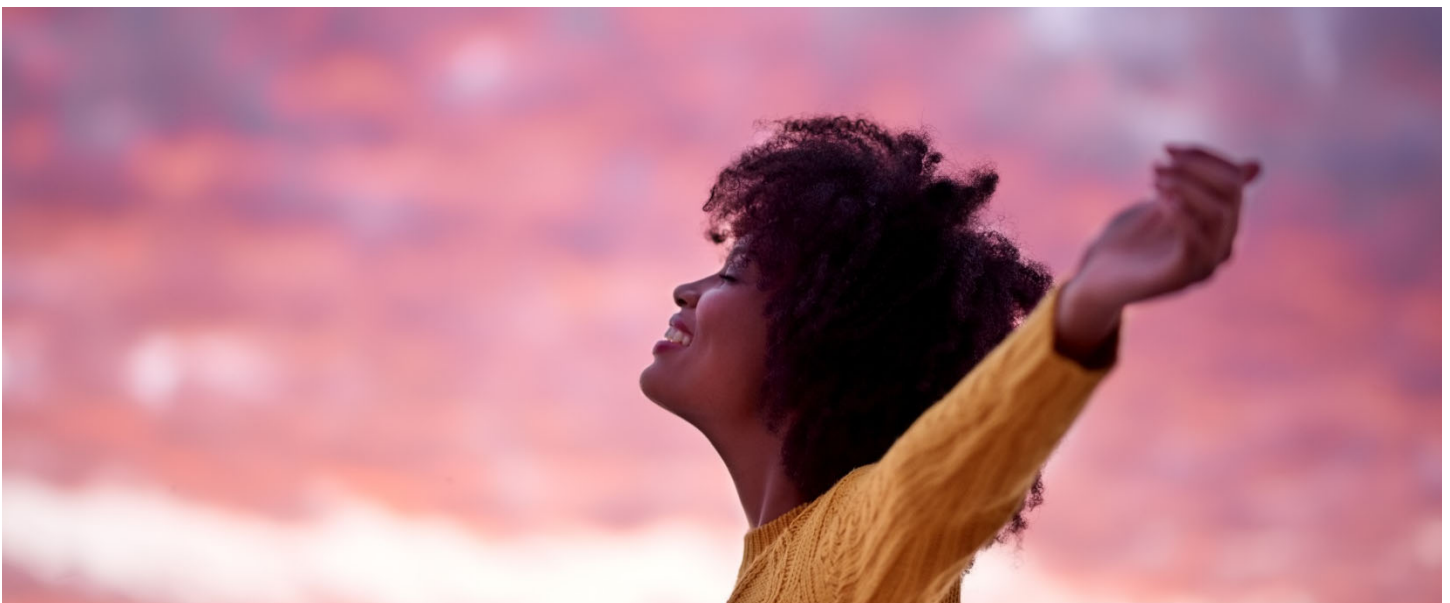
Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

In February 2022, DHCS launched the Comprehensive Quality Strategy (CQS), a 10-year quality vision to improve quality of life and eliminate health disparities focused on integrating a whole-system, person-centered and population health approach to care and building partnerships with Medi-Cal members and organizations in the community. The CQS focuses on the three target clinical areas: (1) Children’s preventive care, (2) Behavioral Health Integration and (3) Maternal Care. It also establishes a CalAIM Population Health Management (PHM) Strategy to address member needs across a continuum of care.

Interventions

1. Continue to implement CalAIM
2. Plan and prepare for Health Equity Accreditation
 - a. Purchased Health Equity Accreditation Standards
 - b. Contracted with an NCQA Consultant to conduct a gap analysis related to Health Equity Accreditation
3. Conducted a PHM Readiness Assessment
4. Developed a CalOptima Health PHM Strategy that aligns with the DHCS PHM Strategy and Roadmap

Elements of the CQS are evaluated separately and the evaluation of each element can be found throughout the QI Evaluation.



Health Equity Workgroup and Social Determinants of Health (SDOH) Workgroup

In January 2022, the Health Equity and SDOH Workgroup (the workgroup) was formed as part of a larger organization-wide Equity Initiative, which aimed to create a culture of equity throughout the organization. Since its inception, the workgroup has remained active and engaged in building foundational knowledge of health equity concepts, co-creating a health equity definition and adapting a framework to guide health equity efforts.

Evaluation

1. Interventions/Strategies

Leveraging the Institute for Healthcare Improvement's health equity framework, the workgroup is anchoring their efforts in five areas: (1) Make health equity a strategic priority, (2) Develop structure and process to support health equity work, (3) Deploy specific strategies to address SDOH, (4) Develop partnerships with community organizations to improve health, and (5) Ensure COVID-19 vaccination and communication strategy incorporate health equity. The following activities support work in these areas:

Developed of survey to collect feedback from PHM staff to inform development of operational plans for the Overcoming Health Disparity Strategic priority (*Fig. 1*).

- Adopted a framework (*Fig. 2*) to guide health equity efforts.

Established action teams to focus on the following projects:

- Health Equity and SDOH Data – to explore SDOH Data, utilization of SDOH Z Codes by providers, and inventory of internal health assessment utilized to capture SDOH-related needs.
- Health Equity Training – to develop a health equity training program, including an assessment to identify specific training needs.

Engaged with Orange County's Equity in OC initiative — a CDC-funded, community-informed and data-driven initiative to address health inequities and disparities in Orange County by laying the foundation for creating a healthier, more resilient and equitable community.

- Four workgroup participants are currently participating in the Population Health Equity Collectives focused on the Latinx, Black, LGBTQ+ and Older Adults populations. The collectives are tasked with creating a health equity plan, including landscape analysis of the respective populations, defining SDOH-focused areas and outlining strategies and projects.

Supported efforts to promote COVID-19 vaccination, including:

- Tailoring member education on the importance of vaccination.
- Sending targeted text messages to population segments who are at high risk for not getting vaccinated.
- Providing member incentives to ensure health equity across race, ethnicity and socioeconomic status (extended our COVID-19 incentive program until 2023, which far surpasses what other health plans have done).
- Coordinated with the Orange County Health Care Agency and other community partners to plan community-based clinics.

Findings

There is a strong organizational commitment to advance health equity and CalOptima Health is taking unprecedented steps to address health inequities, including:

- Changing the mission and vision to reflect the evolution of the organization and our member population.
- Dedicating one of the five strategic priorities in the strategic plan framework exclusively to overcoming health disparities.
- Approving a Chief Health Equity Officer position to start active recruitment ahead of the DHCS's 2024 contracting requirement.
- Purchasing the NCQA Health Equity Accreditation standards to begin reviewing and exploring the application process ahead of the DHCS' 2026 contracting requirement.
- Contracting with a NCQA consultant to conduct a gap analysis in preparation for Health Equity Accreditation.

Research conducted by the Health Equity Data Action Teams regarding SDOH data found the following:

- Low utilization of SDOH Z-Codes in claims submitted by providers:
 - i. 6.70 % of providers are using SDOH Z Codes
 - ii. .45% of total claims/encounters include SDOH Z Codes
 - iii. 3.14% total members have claims with SDOH Z Codes

No evidence-based, validated SDOH screening tool is used consistently across member-facing departments:

1. 13 known assessments in GuidingCare, of which nine include SDOH-related fields (two known assessments for food insecurity, 10 known assessments for housing)

Research conducted by the Health Equity Training Action Teams found the following:

- CalOptima Health University has more than 350 training modules referencing health equity at the manager level and close to 200 results at the individual contributor level.

1. There are two types of subscriptions, each with access to different content. One of the subscriptions is only available to staff in leadership level positions, thus the difference in access to courses.

Analysis

Based on the five areas prioritized by the workgroup to guide and evaluate their impact, the activities that took place in 2022 demonstrate significant contributions by the workgroup, in some areas more than others.

- There were significant gains in making health equity a strategic priority, developing structure and process to support health equity work, and ensuring COVID-19 vaccination and communication strategy incorporate health equity.
- Under deploying specific strategies to address SDOH, the work was significant in the exploration and research face and recommendations were drafted by the workgroup to develop strategies. This will be an area of focus for 2023.
- Under developing partnerships with community organizations to improve health and equity, the workgroup is exploring potential opportunities (listed below) and will make this an area of focus for 2023.

Barriers

- Work produced by the workgroup is done in addition to current job responsibilities.
- The workgroup is mostly PHM staff and lacks cross-functional expertise from other departments.
- Doing health equity requires dedicated time and resources.
- Staff come from different levels of awareness and building foundational knowledge requires intentionality.
- Data to inform strategy development for SDOH is limited to claim data, which current analysis demonstrated low utilization of SDOH Z Codes in claims submitted by providers.
- No evidence-based, validated SDOH screening tool is used consistently across member-facing departments.

Opportunities for Improvement

- a. Engage additional CalOptima Health staff from cross-functional areas to participate in the workgroup.
- b. Recognize workgroup participants who have remain engaged in the workgroup.
- c. Expediate hiring of Chief Health Equity Officer, reactivate other Equity Initiative workgroups and dedicate a team to work on health equity efforts across the organizations.
- d. Incentivize and encourage utilization of SDOH Z Codes among providers.
- e. Promote network/provider SDOH screening using evidence-based screening tools (ex: PRAPARE, utilization of SDOH Z Codes).
- f. Use the transition to a new care management platform (JIVA) to ask consistent, evidence-based questions across all member-facing departments/programs and link members to resources for social needs using closed-loop referral system (such as FindHelp, Unite Us, etc.).
- g. Work with Human Resources to catalog existing health equity training content within CalOptima Health University, curate content to select short videos that can be sent out to staff and/or assigned by managers.
- h. Extend CalOptima Health University subscription to eliminate tiers and ensure all materials available at the leadership level are available across all employee levels.
- i. Conduct an organization-wide health equity and/or SDOH benchmarking assessment.
- j. Administer a survey to inform training needs and opportunities for capacity building.
- k. Research best practices, develop training plan and work with vendor management to contract a health equity trainer.
- l. Conduct a landscape analysis of community-based organizations and expand partnerships and level of engagement.

Overcoming Health Disparities Strategic Priority

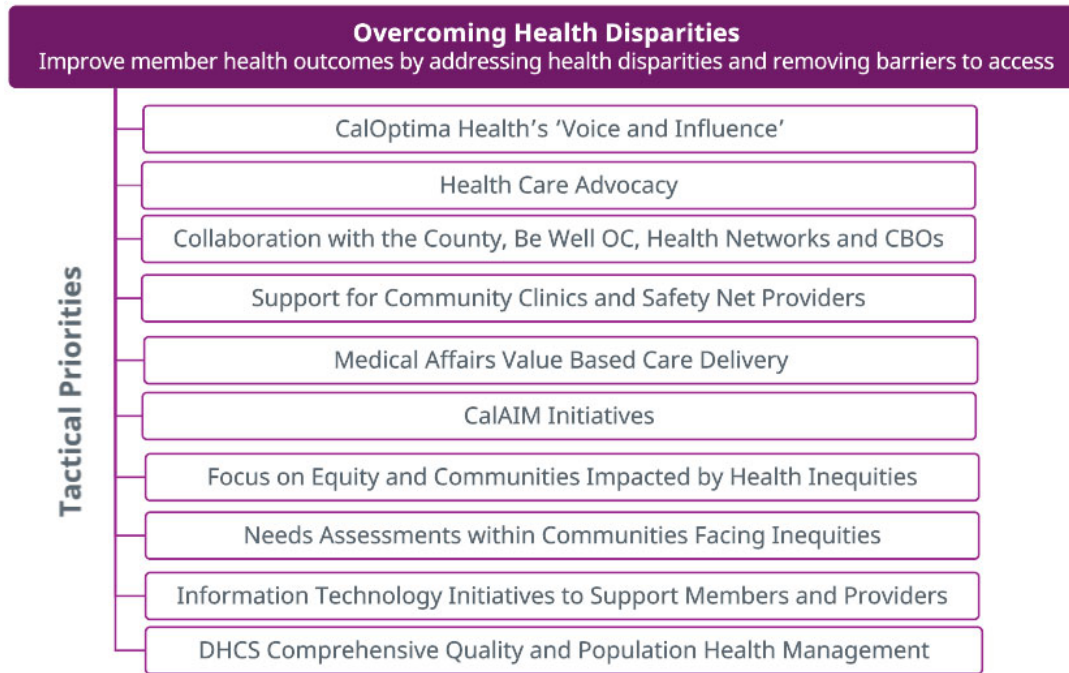


Fig. 1: Overcoming Health Disparities Strategic Priority

Framework



Fig. 2: Health Equity and SDOH Workgroup framework



California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reforms. CalAIM has three primary goals:

1. Identify and manage member risk and need through whole-person care approaches and addressing SDOH.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
3. Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Interventions

a. Enhanced Care Management and Community Supports

Beginning on January 1, 2022, CalOptima Health implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Community Supports are medically appropriate, flexible, wrap-around services that addresses the member's complex medical and social needs. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits and discharge delays.

CalOptima Health's implementation of ECM and Community Supports built upon the Health Homes Program (HHP) and Whole-Person Care (WPC) Pilot infrastructures by preserving existing member relationships with HHP and WPC service providers. CalOptima Health's HHP Community- Based Care Management Entities have transitioned to become ECM providers. This means that CalOptima Health and our delegated health networks have been providing ECM services as ECM providers to eligible populations. Members participating in WPC and/or HHP were automatically transitioned into ECM. These providers are responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

1. Outreach and engagement
2. Comprehensive assessment and care management plan
3. Enhanced coordination of care
4. Health promotion
5. Comprehensive transitional care
6. Member and family supports
7. Coordination of and referral to community and social support services

b. Enhanced Care Management

Beginning January 1, 2022, ECM went live for the following populations of focus:

1. Individuals and families experiencing homelessness
2. Adults at risk for avoidable hospital or Emergency Department (ED) utilization
3. Adults with serious mental illness (SMI) or substance use disorder (SUD)
4. Adults with Intellectual or Developmental Disabilities (I/DD)
5. Adults transitioning from incarceration
6. Adult pregnant and postpartum individuals at-risk for adverse perinatal outcomes

Beginning January 1, 2023, the following additional populations of focus will go live:

1. Adults eligible for long-term care
2. Adult nursing facility residents

And then on July 1, 2023, the last population of focus will go live:

1. Children with special conditions: high utilizers, serious emotional disturbance (SED), California Children's Services (CCS), Whole-Child Model (WCM), child welfare and transitioning from incarceration

c. Community Supports

Community Supports services include the 14 captured below. CalOptima Health launched these services on the following dates:

On January 1, 2022, the following services went live:

- i. Housing transition navigation services
- ii. Housing deposits
- iii. Housing tenancy and sustaining services
- iv. Recuperative care (medical respite)

On July 1, 2022, the next round of services went live:

- i. Short-term post-hospitalization housing
- ii. Day habilitation
 - i. Personal care and homemaker services
 - ii. Medically tailored meals
- iii. Sobering centers

On January 1, 2023, the last of the supports went live: 10) Respite services, 11) Environmental accessibility adaptations (home modifications), 12) Nursing facility transition/diversion to assisted living facilities, 13) Community transition services/nursing facility transition to a home, and 14) Asthma remediation.

d. Building the Provider Network

CalOptima Health has prioritized building a diverse provider network over the past year, ensuring culturally relevant and accessible care. The CalAIM team has engaged in numerous meet and greets, attended service provider meetings, trained providers at any opportunity offered, and taken the time to really get to know providers, the members they serve and how we can best help them meet members’ needs. Further, the team has found that engaging providers by touring their facilities, trying their meals and allowing them to share their many accomplishments has built a solid foundation for partnership. Once engaged and interested in partnering, the CalAIM team has served as liaisons to support and assist providers on their journey to becoming a CalOptima Health provider. The team starts by being transparent and educating on the onboarding process, keeping in routine contact, providing updates on their status, responding quickly to inquiries, and holding individualized training sessions. These various efforts have allowed for growth of the provider network. With the launch of services in January, CalOptima Health has 53 providers. While building the provider network, the CalAIM team has seen firsthand that an investment in providers is an investment in CalOptima Health members.

1. Findings

Table A

Community Support	Key Performance Indicator	Total
CalAIM Members	# of unique members in CalAIM	5,065
	# of Community Supports only members	1,045
	# of Community Supports to ECM members	362
Recuperative Care	# of unduplicated members of receiving recuperative care	308
	# of recuperative care days provided	14,684
	Average length of stay	28
Housing Navigation	# of unduplicated members receiving housing navigation services	1,452
Housing Deposits	# of unduplicated members receiving deposits	177
	Average amount spent on each member for housing deposits	\$2,192.72

Housing Sustainability	# of unduplicated members receiving Housing Sustainability services	429
Short-Term Post Hospitalization (STPH)	# of members receiving STPH	22
	# of STPH days provided	671
	# of members rolling over from recuperative care	20
	Average length of stay	30
Day Habilitation	# of members receiving Day Habilitation	38
	# of Day Habilitation days provided	82
Medically Tailored Meals	# of members receiving meals	45
	# of children/youth <= 21	1
	# of Adults > 21 and <65	37
	# of Seniors 65+	7
	# of meals served/provided	2,737
	Average number of meals provided	60
Sobering Centers	# of members receiving sobering services	22
Enhanced Care Management	# of members receiving ECM	1,398
	# of members receiving both ECM and Community Supports	524
	# of members in Population of Focus (POF) 1: Individuals and Families Experiencing Homelessness	1,165
	# of members in POF 2: Adult High Utilizers	888
	# of members in POF 3: Adult SMI/SUD	149
	# of members that are children/youth	192
	# of members outreached	4,020
	# of members self-referred	362
	# of members declined ECM services	2,000
	# of discontinued ECM services	613

2. Table caption: Data demonstrating the growth of ECM and Community Supports benefits.

Analysis

- a. CalAIM has seen considerable growth since launching in January 2022; data as of mid-November demonstrates 5,065 unique members have been served with ECM, Community Supports or both. Table A demonstrates the number of unique members benefitting from each of the nine Community Supports that were available first.
- b. Because CalAIM only launched in January 2022, there are no findings from the previous year by which to compare.
- c. The following objectives in the annual QI plan were met:
 - Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022. All HHP members were successfully transitioned to CalAIM ECM without an interruption in service.
 - Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022. While objective was not met in Q1 2022, all WPC members were successfully transitioned to CalAIM ECM without an interruption in service in Q2.

- Establish DHCS reporting process was completed in Q3. A DHCS reporting process has been established. ITS leads the data collection and Care Management, LTSS and CalAIM teams review and attest to the data before DHCS submission. Monthly data improvement calls are hosted to ensure data captured is accurate and up to date.

d. The following objectives in the annual QI plan are in progress:

- Establish oversight strategy for the CalAIM program. The team has begun this effort but has spent more time launching the program and ensuring services are accessible and being delivered. Next year, building out this strategy and implementing it will be priorities for the team.

Barriers

Most objectives have been accomplished for this program. EMC and Community Supports services have been launched, members are being connected to services, and the CalAIM team continues to build out the provider network to adequately serve the members' unique and diverse needs and backgrounds. With so much effort concentrated on launching the program, designing the benefits, engaging providers and ensuring services are accessible, the team has not fully designed the oversight strategy for CalAIM programs. This will be the focus in 2023.

Opportunities for Improvement

CalOptima Health continues to build its CalAIM team. Additional team members will help support the workload to establish and launch the oversight strategy. Furthermore, the team is designing reporting templates to monitor utilization of these benefits. By establishing, reviewing and acting on these reports, the team will continue to evolve the services to best meet member needs.



Homeless Health Initiatives (HHI)

In 2019, CalOptima Health’s Board of Directors allocated \$100 million toward increasing access to health care and housing support services for unhoused individuals in Orange County. Programs included Clinical Field Teams, Homeless Clinic Access Program and Homeless Response Team among others. DHCS launched the Housing and Homelessness Incentive Program (HHIP) in January 2022. The remaining, unspent funds for HHI, totaling \$40.1 million, were then approved by the Board for reallocation to be used as community investments in support of HHIP. Prior to the September reallocation of HHI funds, the Board approved staff’s request to proceed with development of a new street medicine program.

Homeless Response Team

1. Interventions

- a. The Homeless Response Team (HRT) continued with virtual hours at shelters in the area during the first two quarters. In the third quarter, the HRT began providing in-person shelter outreach. CalOptima Health members were able to connect with a Homeless Response Team Personal Care Coordinator directly. The Personal Care Coordinators assisted members with scheduling PCP appointments, replacing CalOptima Health identification cards, and answering questions about authorizations, transportation, Denti-Cal and CalFresh as well as other services. Members are also often referred to Case Management, Enhanced Care Management and Community Supports as applicable.
- b. The Clinical Field Teams (CFTs) provided urgent care services to individuals experiencing homelessness throughout 2022. These urgent care services included wound care, evaluation of physical signs and symptoms, such as cough or pain, and assessments for recuperative care. The CFTs were available six days/week (Monday–Saturday). HRT often coordinates and collaborates with the CFT to mutually support members.

2. Findings

- a. Virtual outreach to shelters was expanded in 2022 to include two additional shelters: Huntington Beach Navigation Center and Costa Mesa Shelter. The HRT continued virtual outreach to Yale Navigation Center, and in the third quarter, began providing in-person assistance there. With the observed benefits to CalOptima Health members experiencing homelessness, expansion of in-person outreach is continuously being explored with a plan to add three additional shelters in the fourth quarter.
- b. The CFT program dispatches contract community health centers to provide urgent care, on-call services wherever the individual is located — More than 99% of all visits for care are completed face-to-face. From January 1, 2022, through November 30, 2022, HRT received 421 calls and dispatched the CFTs a total of 404 times. Of those calls dispatched, 375 individuals were treated, and 289 (77%) were CalOptima Health members. The CFTs made 81 referrals to Recuperative Care. Orange County’s Outreach & Engagement (O&E) and the Mental Health Association (MHA) are the top two referring agencies, producing 76% of all referrals made to the HRT dispatch line.

3. Analysis

- a. The HRT met its objectives of expanding its virtual shelter outreach in quarters one and two and beginning in-person outreach in quarter three.
- b. When comparing 2021 data to 2022, the CFT program saw increases across the board on nearly all key process measures except for referrals to Recuperative Care, which decreased. The percentage of time where visits were conducted face-to-face remained consistent at over 99%. A comparison of the data can be found in the table below:

Process Measure	2021	2022	% Change*
Calls Received by HRT	355	421	19%
Total Number of Dispatches	339	404	19%
Total Number of Individuals Treated	305	375	23%

Members Treated	241	289	20%
Referrals to Recuperative Care	91	81	-12%

*Rounded up to the nearest whole number

4. Barriers

The main barrier to expanding the virtual outreach in quarters one and two were the technical limitations of the shelters to provide phone and video access for members. Physical space at the shelters was available as they have been receptive and open to HRT’s presence.

5. Opportunities for Improvement

The HRT will continue to increase its presence in the community by providing in-person assistance to members at high-volume shelters.

Street Medicine Pilot Program

The goal of street medicine is to provide health care services, both preventive and urgent, to unhoused members where they are located. The selected providers for the Street Medicine Pilot Program will be contracted before the end of 2022. The preliminary plan is to launch the program in early 2023.

1. Interventions

- a. A Request for Qualifications (RFQu) was launched in July 2022 to solicit proposals from providers to participate in the inaugural Street Medicine Pilot Program. Through that process, two providers were selected to participate in and support the launch of an innovative two-pronged street outreach and medicine program that targets both unsheltered and sheltered individuals in Orange County.
- b. This pilot will launch in Garden Grove, where we hope to establish a collaborative service delivery model between the service providers, local stakeholders, Be Well, other related county agencies, and homeless service providers. The planning phase is anticipated to begin in December 2022, with actual services launching in early 2023.

2. Findings

There are no findings from the previous year as this is a pilot program.

3. Analysis

CalOptima Health staff met their objectives of developing a scope of work, administering an RFQu, and selecting two providers to begin providing services in Garden Grove. The remaining objective is to finalize the Street Medicine scope of work with selected providers, develop payment terms and execute contracts.

4. Barriers

- a. CalOptima Health staff do not anticipate hitting any barriers to achieving the remaining objectives, as noted on item 3a above. Moreover, while it was established that the program would only launch in Garden Grove, staff recognize the need to scale services throughout Orange County, though a timeline for scaling the pilot program is still to be determined.

5. Opportunities for Improvement

- a. CalOptima Health staff will continue collaboration with the two providers who will be contracted to provide services through this pilot program to build out a plan for expanding service reach throughout the county in a timely manner.

Housing and Homelessness Incentive Program

1. Interventions

- a. The CalAIM team implemented the Housing and Homelessness Incentive Program (HHIP), in coordination with the local continuum of care (CoC) and other key stakeholders, to increase capacity and develop partnerships among homeless services providers — serving a more active role in reducing and preventing homelessness in Orange County. The team implemented the Investment Plan to meet specific measures around increased data integration, access to culturally appropriate care, and building up the infrastructure to support more complete and comprehensive systems.

2. Findings

- a. HHIP began in January 2022, thus, there are no points for comparison to the previous year. The first incentive payment of \$4.1 million for completion of the Local Homelessness Plan (LHP) was transmitted to CalOptima Health in October 2022.
- b. Staff initiated community investment recommendations to CalOptima Health Board of Directors. Staff began the process to execute identified contracts and/or launch opportunities for a competitive bidding process for certain activities. These activities were funded by HHI funds (\$40.1 million) that the Board approved for reallocation.
- c. There are no findings from the previous year as the program launched January 1, 2022.

3. Analysis

- a. Staff met the initial objectives for HHIP by submitting a LHP and Investment Plan (IP) to DHCS by the specified deadlines (June 30, 2022, and September 30, 2022, respectively).
- b. Staff achieved their objective to involve/inform the community at large to the greatest extent possible in Q3 of 2022. This includes but is not limited to:
 - i. Convening a public listening session in August 2022.

- ii. Seeking approval and/or feedback of staff recommendations for the IP at CalOptima Health's Board of Directors and various Advisory Committee meetings.
- iii. Presented the draft IP to Orange County's CoC and obtained a signed letter of support (a key elements for submission of the IP to DHCS).

4. Barriers

- a. DHCS requirements for obtaining full points for achieving HHIP measures continue to cause concern.
- b. Administrative lift and timing related to development and implementation of both contracts and competitive funding opportunities.
- c. Overlap with other funding can potentially lead to duplication of services. There is also a significant amount of funding that needs to be disbursed into the community, and it needs to be done in a fair, consistent and meaningful way.

5. Opportunities for Improvement

- a. Continue to meet with other HHIP participating managed care plans and communicate with DHCS about concerns, while also proposing potential alternatives to ensure plans can maximize incentive funds earned.
- b. Collaborate with key internal and external stakeholders to effectively navigate any administrative barriers, ensuring processes are as streamlined as possible.
- c. Map out the county homelessness service continuum and implement appropriate and impactful strategies to minimize systemic redundancy. Consider best practices to ensure the greatest return on investment without sacrificing service quality.



Quality Withhold for OneCare Connect (OCC)

To better align quality with cost of care, DHCS and CMS have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A and B capitation to health plans. The amounts of the withhold are 1% for Year One (calendar year 2015), 2% for Year Two (calendar year 2016), and 3% for Years Three, Four and Five (calendar years 2017–19). All or a part of the withhold may be earned back based on a percentage of quality withhold measures that achieved benchmarks established by DHCS and CMS. Measures and benchmarks are based on final guidance received from CMS and DHCS.

The CalOptima Health Pay for Value (P4V) team monitors the OCC withhold measures on a quarterly basis.

Quality withhold payments are determined based on the percentage of all withhold measures, including CMS core and state-specific measures, each managed care plan (MCP) meets. All measures are weighted equally, with no distinction made between measures that earned a “met” designation by meeting the benchmark and measures that earned a “met” designation by meeting the gap closure target. In general, benchmarks for CMS core measures are established using national data such that all MCPs across demonstrations are held to a consistent level of performance. For state-specific measures, benchmarks are developed by states using state-specific data, as well as national data when available/appropriate

For MY2022, CalOptima Health has passed 6 of 10 as of September 30, 2022. The four measures that we will be closely monitoring for the last quarter include:

1. Controlling Blood Pressure
2. Encounter Data Submission
3. Follow-up After Hospitalization 30 days
4. Interaction with Care Team

DY8 (CY2022) Preliminary Analysis

Quality Withhold Analysis – 4% Withhold	
Quarter 3 Results	
Total number of measures	10
Total number of measures passed	6
Percent of measures passed	60%
Percent of withhold plan receives	75%



Quality Analytics Program Updates (Health Network Quality Rating, 1MCAS, P4V, Data Mining/Bridge Efforts)

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. CalOptima Health currently has P4V programs for Medi-Cal and OCC. All CalOptima Health networks (HNs), including the directly managed CalOptima Health Community Network (CCN), and primary care providers (PCPs) are eligible to participate in the P4V programs.

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

¹ MCAS = Managed Care Accountability Set

- a. Recognize and reward HNs and their physicians for demonstrating quality performance;
- b. Provide comparative performance information for members, providers and the public on CalOptima Health's performance; and
- c. Provide industry benchmarks and data-driven feedback to HNs and physicians on their quality improvement efforts.

A new methodology for the Medi-Cal P4V Program was adopted for measurement year (MY) 2020–21, aiming for greater transparency, consistency and administrative simplification. This new HN Quality Rating (HNQR) methodology aligns with changes to measures for CalOptima Health's National Committee for Quality Assurance (NCQA) Accreditation status, CMS Star Rating status, DHCS (MCAS) and overall NCQA Health Plan Rating. Having a standard Quality Rating Methodology provides CalOptima Health with one reliable methodology to establish an overall quality rating score for each Health Network. The quality rating score may be used for future P4V payment methodology, incorporated into the new Auto Assignment policy, or other future programs to improve health care quality for CalOptima Health members.

- a. Each HN quality rating score will be calculated annually.
- b. The HN quality rating score will be derived from the most recently available audited, plan-level HEDIS results, which are based on the administrative methodology. For measures that have a hybrid method option, the additional percentage from medical records collection (i.e., the difference between CalOptima's hybrid and administrative result) will be added to each HN's results.
- c. HN-level Adult and Child Consumer Assessment of Healthcare Providers and Systems (CAHPS) results will be used for member experience scoring.
- d. NCQA Quality Compass National Medicaid percentiles will be used as benchmarks.
- e. All Managed Care Accountability Set (MCAS) measures that are required for Minimum Performance Level (MPL) by DHCS are used.
- f. CAHPS measures are used for member experience.
- g. Measures with small denominators (HEDIS < 30; CAHPS < 100) are not used in the score calculation.

The new methodology was approved by the CalOptima Health Board of Directors on February 6, 2020. The Board of Directors also approved an increase in the per member per month (PMPM) incentive for CCN providers and HNs from \$2.00 PMPM to \$5.00 PMPM.



Development of the Pay-for-Value (P4V) OneCare Program for MY2023

CalOptima Health's P4V team compiled a set of Medicare Part C, Part D and Member Experience measures as proposed metrics for the measurement year (MY) 2023 OneCare P4V program, which was approved by the CalOptima Health Board of Directors.

The OneCare measures for MY2023 are as follows:

- a. Part C Measures: Breast Cancer Screening, Colorectal Cancer Screening, Diabetes Care – Eye Exam, Diabetes Care – Hemoglobin A1c Control, and Controlling Blood Pressure.
- b. Controlling Blood Pressure Part D Measures: Medication Adherence for Diabetes, Medication Adherence for Hypertension, Medication Adherence for Cholesterol and Statin Use in Persons with Diabetes
- c. Member Experience Measures: Care Coordination, Getting Care Quickly and Getting Needed Care

Development of Hospital Quality Program

In December 2022, the CalOptima Health Board approved a new Hospital Quality Program for CalOptima Health contracted hospitals for calendar year 2023 to 2027. The goal of the program is to improve quality of care to our members through increased patient safety efforts and performance-driven processes. Hospitals holding a direct Medi-Cal contract with CalOptima Health are eligible to participate in the Hospital Quality Program. The Hospital Quality Program will establish a process to measure performance and incentivize contracted hospitals to deliver quality care. The program will:

- Leverage publicly available hospital data and performance listed on CMS Care Compare and the Leapfrog Group to minimize hospital burden

- Require contracted hospital participation in CMS Care Compare (for hospital inpatient, hospital outpatient, PPS-exempt cancer, or inpatient psychiatric measures) and/or Leapfrog Group Hospital Rating
 - Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital Rating.
 - Contracted hospitals not listed on either CMS Care Compare or Leapfrog will not qualify for incentive payments.
- Allocate a maximum of \$30 million per year for five years
- Hospital incentive payments distribution
 - Incentive awards will be based on performance compared with quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

Measurement Area	Data Source	Percent of Incentive Pool	Performance Range	Incentive
Quality	CMS Care Compare or Leapfrog Hospital Rating	40%	5 stars 4 stars 3 stars 1 – 2 stars	100% of incentive 75% of incentive 50% of incentive 0% of incentive
Patient Experience	CMS Care Compare or Leapfrog Hospital Rating	40%	5 stars 4 stars 3 stars 1 – 2 stars	100% of incentive 75% of incentive 50% of incentive 0% of incentive
Hospital Safety	Leapfrog Hospital Safety Grade	20%	Grade A Grade B Grade C Grade D or F	100% of incentive 75% of incentive 50% of incentive 0% of incentive

CalOptima Health recognizes that hospitals may not currently participate in these public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During this time, CalOptima Health will provide hospital reporting incentive payments in an amount of \$150,000 per eligible hospital per calendar year.



Performance Improvement Projects (PIP)

The following is a summary of the PIPs for all lines of business.

Health Equity Performance Improvement Project (PIP) — Medi-Cal

DHCS requires that Medi-Cal MCPs conduct a PIP that targets health care disparity that is related to a Managed Care Accountability Set (MCAS) metric on which the MCP is performing below the minimum performance level. Particular focus may be on a disparity that may have been exacerbated by COVID-19 pandemic.

CalOptima Health's PIP focused on Breast Cancer Screening (BCS) based on a decreased breast cancer screening rate from 63.4% in HEDIS MY2019 to 59.52% in HEDIS MY2020. In addition, of the approximately 33,774 female Medi-Cal members ages 50–74 identified, 14,519 did not have a BCS between 1/1/2020 and 12/31/2020. When we categorize members based on written language, we see that Korean and Chinese have the lowest rate of BCS of 58% and 45% respectively, and Vietnamese has the highest rate 67%. Because of this disparity, CalOptima Health chose to focus the PIP on female members ages 50–74 who have their written language identified as Korean and Chinese. Interventions focused on increasing culturally appropriate outreach and education to the Korean and Chinese Medi-Cal membership population about the importance of screening and the no-cost screening benefit for CalOptima Health members.

Intervention

Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Health Medi-Cal Members (March 1, 2020–December 31, 2022)

- a. Per the HEDIS Technical Specification, the description of the BCS measure is: The percentage of women ages 50–74 who had a mammogram to screen for breast cancer.
- b. CalOptima Health estimates that there are 1,272 Medi-Cal members ages 50–74 who have their written language identified as Korean and Chinese who are eligible to complete a mammogram to screen for breast cancer.

- i. **Goal:** By 12/31/2022, increase the percentage of breast cancer screening among Korean and Chinese Medi-Cal member ages 50–74 from 53.62% to 57.63%
 - ii. **Target Population:** Total number of Korean and Chinese CalOptima Health Med-Cal members ages 50–74 as of December 31.
 - iii. **Intervention:** Mobile Mammography Community Event Clinic. Members ages 50–74 were mailed a mobile mammography event letter and completed a mammogram at the mobile mammography community event.
 - iv. **Activity:** CalOptima Health partnered with Provider Office A and a mobile mammography vendor for multiple mobile mammography community events to eligible CalOptima Health members held once per quarter.
- c. Two additional events were held August 15 and October 24, 2022.

Findings

- d. Table 1 shows the results for Cycle 1 mobile mammography community event intervention held in February 2022, and Cycle 2 held in May 2022.

Table 1: Health Equity PIP Cycle 1 and 2 Results

Testing Period	Numerator	Denominator	Percentage
1/12/2022–2/2/2022	4	71	5.63%
2/3/2022–5/17/2022	10	112	8.93%

Numerator: Number of Korean and Chinese CCN Medi-Cal members ages 50-74 for Provider Office A who were mailed a mobile mammography event letter and completed a mammogram at the mobile mammography community event. Denominator: Total number of Korean and Chinese CCN Medi-Cal members ages 50–74 for Provider Office A who are eligible to complete a mammogram to screen for breast cancer and in the mailing for the mobile mammography community event letter.

Analysis

Provider Office A became a new site for mobile mammography community event. This gave members access to breast cancer screenings in a familiar environment. Provider office A staff was available to assist members with check-in for their appointment and completing necessary paperwork in the member’s preferred language. Provider Office A had previously stated that members had a language barrier when visiting a radiography facility.

In January 2022, of the 71 members who were mailed the mobile mammography event letter, 4 members completed a mammogram at the mobile mammography event held on February 2022. The percentage of eligible Korean and Chinese CalOptima Health CalOptima Community Network (CCN) Medi-Cal members ages 50–74 for Provider Office A who were mailed a mobile mammography event letter and completed a mammogram at the mobile mammography community event was 5.63% (4/71). In April 2022, of the 112 members who were mailed the mobile mammography event letter, 10 members completed a mammogram at the mobile mammography event held on May 2022. The percentage of eligible Korean and Chinese CalOptima Health CCN Medi-Cal members ages 50–74 for Provider Office A who were mailed a mobile mammography event letter and completed a mammogram at the mobile mammography community event was 8.93% (10/112).

Barriers

Two barriers that were being addressed by hosting a mobile mammography event at Provider Office A were language barrier and an access barrier. Provider Office A discussed the challenges that are faced by their members when going to the radiology facility. During the events, Provider Office A staff was available to provide interpretation services to the members. Hosting the mobile mammography event at the clinic, the members were familiar with the location.

Additional Barriers Included:

- a. The data that was used for the mailing was not up to date for Korean and Chinese members who were due for breast cancer screening for 2022. CalOptima Health was only able to identify 71 current members who were due for breast cancer screening.
- b. The mobile mammography vendor required a minimum of 25 scheduled appointments for the event to occur. The vendor scheduled members under their Every Women Counts (EWC) outreach database to fill open time slots to ensure the required capacity.
- c. Only 10 members from the mailing of the 112 that were identified attended the event. The additional members were scheduled via Provider Office A health navigator telephonic outreach.

Opportunities for Improvement

- a. For the proceeding events, current data of Korean and Chinese members due for breast cancer screening will be obtained for the event mailing.
- b. Only members who are assigned to Provider Office A will be scheduled.
- c. Part of intervention step was to share the outreach mailing list with the Provider Office A health navigator. CalOptima Health will request that the Health Navigator conduct follow-up calls after mailing to Korean and Chinese members identified on the mailing list.
- d. In MY2023, the PIP will expand by adding a mobile mammography community event to Provider Office A new site location to target more of the Chinese CalOptima Health CCN Medi-Cal members.



2020-22 Well-Child Visits in the First 30 Months of Life (W30-6+) Performance Improvement Project (PIP)

DHCS requires that Medi-Cal MCPs conduct a PIP that targets a child and adolescent health metric related to the Managed Cared Accountability Set (MCAS) on which the MCP performance is below the minimum performance level and has been exacerbated by COVID-19 pandemic.

CalOptima Health's overall Well-Child Visits in the First 15 Months of Life (W15) HEDIS® rate, which has been revised to Well-Child Visits in the First 30 Months of Life (W30-6+) HEDIS® measure, has declined over the past six years while the National Quality Compass benchmarks continue to grow. The rates have been trending downward from 70.37% (2014) to 51.09 % (2018). The rates continued to decline with the Medicaid expansion in 2014 where CalOptima Health increased its membership by 234,000 members.

Well-child visits are the foundation of pediatric health and wellness. At these visits, medical providers provide immunizations, assess the child's growth and development, and provide anticipatory guidance for parents. The Bright Futures/American Academy of Pediatrics (AAP) developed a periodicity schedule for preventative pediatric health care best practices from infancy to adolescence. These best practices are highlighted in the HEDIS® Well-Child Visits in the First 30 Months of Life (W30) measure which requires six or more well-child visits in the first 15 months of life, and additionally two or more well-child visits between 15–30 months of life. These visits must be completed by a PCP.

Based on decreasing performance and the importance of well-child visits, CalOptima Health initiated a well-child PIP in 2020 and continued the PIP through 2022.

Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Health Medi-Cal members with Provider Office A (June 1, 2021–December 31, 2021)

- a. Per the HEDIS Technical Specifications, the description of the W30-6+ measure is the percentage of members who had the following number of well-child visits with a PCP during the last 15 months during the measurement year: six or more well-child visits.
- b. CalOptima Health established a data sharing procedure between the MCO and the provider office to identify members due for outreach. The W30-6+ target list was shared with the provider office on a quarterly basis. The provider office had approximately 60 days to reconcile the target list with their internal records and provide the list back to CalOptima Health. The provider office aimed to outreach to members who had not completed their visits. The intervention was implemented in late October 2021 and ran through the end of December 2022.
 - i. **Goal:** By 12/31/2022, use key driver diagram interventions to increase the percentage of well-care visits among Medi-Cal members turning 15 months old for Provider Office A, from 39.47% to 44.96%.
 - ii. **Target Population:** Medi-Cal members assigned to Provider Office A, who turn 15 months old during the measurement year.
 - iii. **Intervention:** CalOptima Health established a data sharing procedure between MCO and the provider office to identify members due for outreach. The W30-6+ target list was shared with the provider office on a quarterly basis. The provider office had approximately 60 days to reconcile the target list with their internal records and provide the list back to CalOptima Health. The provider office aimed to outreach to members who were due for their visit. The intervention was implemented in late October 2021 and ran through the end of December 2022.

Findings

Table 1: W30 PIP Cycle 1–3 Outcomes

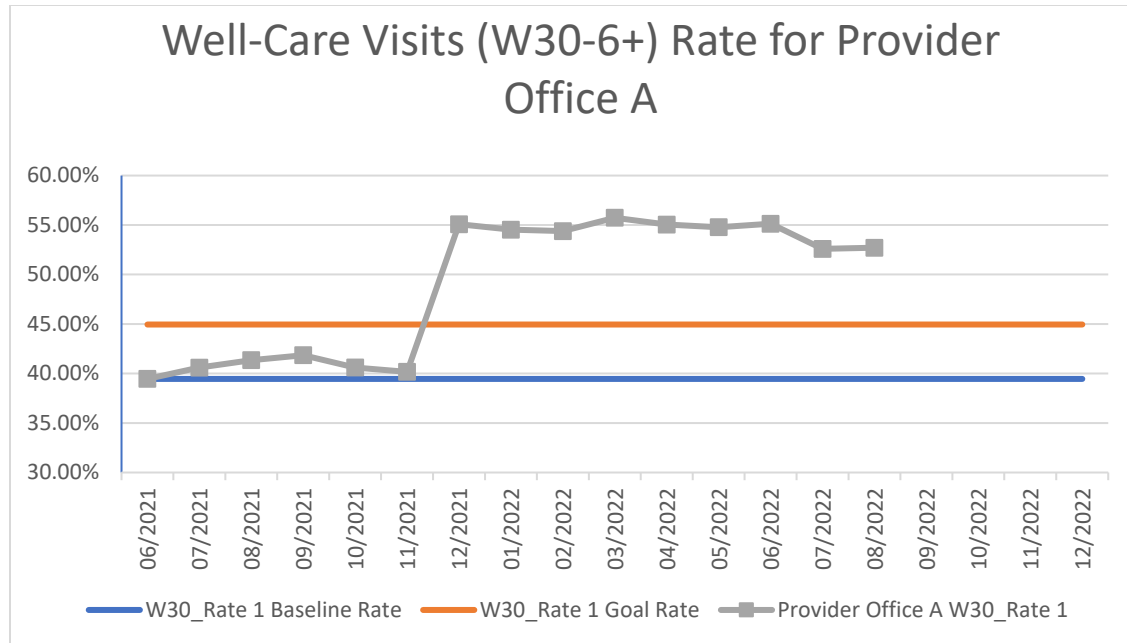
Outcomes	W30 PIP Intervention Cycles			
	Cycle 1	Cycle 2	Cycle 3	Cycle 4
Intervention period	10/2021–12/2021	04/2022–06/2022	07/2022–09/2022	10/2022–12/2022
Status	Completed	Completed	Completed	In Progress
Denominator	467	487	672	672
Numerator negative	319	435	588	384
Data reconciliation completion rate	100%	100%	100%	N/A
Number of members found to have completed their well-child visits (6+)	153	176	283	N/A
Administrative data variance rate	47.96%	40.46%	48.13%	N/A

Denominator is defined as the provider office's member population who meet the W30 HEDIS specifications. Numerator negative is defined as the number of members who have not completed 6+ well-child visits. Data reconciliation rate is defined as number of records in the target list shared reconciled with provider office's electronic medical records. Administrative data variance rate is defined as the number of member records found to be inaccurate as a result of the target list reconciliation intervention.

Analysis

- a. Cycles 1–3 findings indicate there is a data gap between services rendered and what is captured through claims and encounter data. On average, 45.52% of the members who were indicated as missing well-child visits were found to have completed 6 or more well-child visits.
- b. CalOptima Health was able to establish a data sharing procedure with Provider Office A to send their W30-6+ target list on a quarterly basis.
- c. Provider Office A was able to reconcile their target list with their internal records for Cycles 1–3. The target list has allowed the office to readily identify which members fell into the W30-6+ denominator and close gaps by outreaching to members who have not yet completed their visits and submitting supplemental data for services rendered.
- d. The intervention period is in progress, but as shown in Figure 1, the provider office W30-6+ rate, based on a 12-month rolling methodology, to evaluate intervention impact, demonstrates that they have surpassed the goal rate of 44.96%. As of December 2021, the office has shown a steady trend between 54.38%–55.73%. The next steps are to continue to monitor their W30-6+ rate to see if the performance is maintained through the end of 2022.

Figure 1: The Percentage of Well-Care Visits for Children in Their First 30 Months of Life (W30-6+) for CalOptima Health Medi-Cal Members with Provider Office A PIP Control Chart



Provider Office A Well-Child visits in the First 30 Months of Life-First 15 (W30-6+) rate was established using a 12-month rolling methodology and removes continuous enrollment criteria. The W30-6+ baseline rate is: 39.47%, goal rate: 44.96%. Intervention was implemented late October 2021 and will continue through December 2022.

Barriers

- CalOptima Health Prospective Rates Report do not capture all the services rendered by a provider office for well-child visits. Each cycle showed a discrepancy between what is captured through claims and encounters data and the information found in the provider office’s electronic health record system.
- Provider offices who are contracted with multiple health networks must access different platforms and files to identify their true W30-6+ denominator.
- Not all provider offices are aware of which well-child visits are captured or not captured by the MCP.
- Staff turnover in the provider offices creates a gap in the continuous intervention process.
- Members are unable to schedule future well-child visit appointment(s) due to scheduling system limitations. Schedules are not open more than 2–3 months out from current date.
- Members are unable to attend well-child visits because of scheduling conflicts related to work and provider office hour availability.
- Members are unaware of the importance of well-child visits and are unaware of the number of visits recommended in the first few years of life.

- Transportation and ease of accessibility is a barrier for members to attend their well-child visits. Members are not aware of CalOptima Health’s Medi-Cal transportation benefit. Some parents prefer a location closer to home (e.g., community health event) rather than their assigned PCP office.

Opportunities for Improvement

- a. For future collaborations with provider offices, CalOptima Health will consider providing the member population specifications to the office to identify their own target list for more accurate information.
- b. We will consider providing one singular opportunity gap report that includes all members assigned to the provider office which will include the date of service for the various well-child visits needed to meet HEDIS measure, regardless of health network.
- c. CalOptima Health will work with provider offices to proactively identify and outreach to newborn members versus waiting until the measurement year when the members turn 15 months to start interventions. This action will help to foster well-child visits following the Bright Futures Periodicity Table visits in a timely fashion.
- d. We will collaborate with the provider offices to understand their challenges, successes and current process with regard to well-child visits. We will develop a best practice guide for providers to better operationalize and close the gaps in ensuring timely well-child visits.
- e. CalOptima Health will increase the telephonic call campaigns from an annual to a quarterly campaign to catch members before they age out of the measure. This campaign will allow us to remind parents or guardians to schedule their child’s next well-child visit and other preventative care (e.g., vaccinations, blood lead test).



Quality Improvement Projects

The following are a summary of all Quality Improvement Projects (QIP) for all lines of business.

COVID-19 Quality Improvement Plan (COVID-19 QIP)

DHCS required all MCPs to submit a COVID-19 Quality Improvement Plan (COVID-19 QIP). The initial submission included three strategies related to the Managed Care Accountability Set (MCAS) measure domains, one of which must address the behavioral health domain. The three domains CalOptima Health chose to focus on were the behavioral health domain, women’s health, and child and adolescent health. The initial COVID-19 QIP submissions were due to DHCS on September 31, 2021, and the six-month progress submission was due to DHCS on March 31, 2022.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

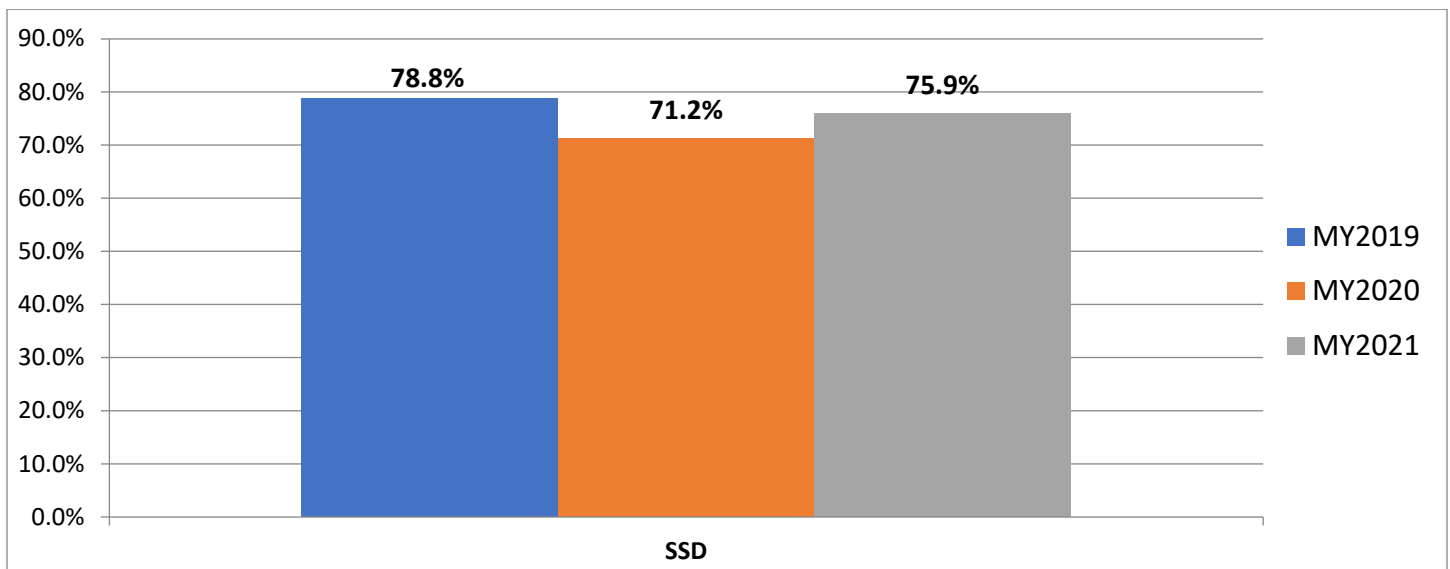
CalOptima Health’s program assesses the percentage of members ages 18–64 with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Members with severe mental illness who use antipsychotics are at increased risk of diabetes. In the United States, diabetes is among one of the leading causes of death. Lack of care for individuals with diabetes who use antipsychotic medications can lead to deteriorating health and death. Screening and monitoring of these conditions are important.

Interventions

- a. The BHI Quality Team worked with Quality Analytics to develop a report to identify members ages 18–64 with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and did not have a diabetes screening test.
- b. In 2021, BHI Quality Team conducted provider outreach targeted to the top 50 prescribing providers of antipsychotic medications in the CalOptima Health network:
 - i. Provider offices were contacted telephonically to confirm that provider was still practicing at that location and confirm the provider’s fax number is accurate to protect patient privacy in adherence with HIPAA regulations.
 - ii. A letter was sent to prescribing providers. The letter contained a comprehensive list of members with the name of the member’s PCP, the PCP contact information and an SSD provider educational tool tip sheet, which indicates industry best practices.

Below are the findings for the Measurement Year 2021

Graph A



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic medications (SSD)	74.94%	78.90%	82.53%	73.69%	HPR

Analysis

- a. In 2021, CalOptima Health met the HEDIS goal of 73.69% for the SSD measure going slightly higher by 2.21%. This was a slight increase from the final rate for MY 2020 (71.2%). The rates indicate a slight improvement in the number of members completing a diabetes screening for MY 2021. With the interventions being implemented at the end of the year we anticipate seeing a decrease of members needing a diabetic screening test in the upcoming measurement year 2022.

Barriers

- a. The BHI department came across some barriers while completing interventions related to obtaining the contact information for the prescribing providers such as phone numbers, fax numbers, address and providers no longer practicing. This was due to inaccurate provider information within the system. Providers may forget to update their information. Providers are also being reminded of the need to update information during outreach efforts.
- b. Prescribing provider offices have shared some of the barriers they experience, such as patients do not always visit their PCP and a lack of transportation.
- c. Due to the impact of the pandemic, individuals may have been less likely to attend routine or follow-up appointments and complete health services recommended by their providers.

Opportunities for Improvement

- a. CalOptima Health's BHI department has chosen to work on improving the number of members completing a blood glucose or HbA1c test that have a diagnosis of schizophrenia and were dispensed an antipsychotic medication. Discussions on various opportunities are being explored within the Behavioral Health Quality Improvement (BHQI) Workgroup such as:
 - Continue to identify members in need of a diabetes screening test, conducting outreach to help raise awareness to the prescribing providers of the need to have members get a blood glucose or an HbA1c test.
 - Possible collaboration with county behavioral health. Given the severity of the diagnoses included in the HEDIS measure, it is believed that a number of members may be receiving antipsychotic medications from one of the county clinic-based providers. This may also assist in identifying providers listed as prescribers who are not in the CalOptima Health network.

Women's Health Strategy

- a. A hybrid HEDIS and MCAS measure, Cervical Cancer Screening (CCS), examines the percentage of women age 21–64 who received one or more screening tests for cervical cancer during or within the three years prior to the measurement year, or five years for women ages 30–64 with Human Papilloma Virus (HPV) co-testing.

- b. The goal of the intervention is to increase the number of Medi-Cal members age 21–64 years of age who were screened for cervical cancer. The intervention will test if member outreach reminders via letter and/or phone call increase CCS rates among eligible CalOptima Health members. The focus is on Medi-Cal members age 21–64 assigned to a specific HN and selected provider office sites. The member outreach modality was chosen by each provider office site based on staffing and resources.
- i. **Goal 1:** By the end of March 2022, an outreach attempt to CalOptima Health members for the completing of the cervical cancer screening will be performed for at least 90% of the target list at the selected HN provider offices. If goal 1 was met, the provider office staff received a predetermined incentive based on the count of the target outreach (Table 2).
 - ii. **Target Population:** Medi-Cal members ages 21–64 who are due to complete the cervical cancer screening.
 - iii. **Interventions:** CalOptima Health, in collaboration with the contracted HN, identified provider offices that have a high volume of CalOptima Health Medi-Cal members who are due for CCS and are performing low for the measure. Five of the HN provider offices agreed to participate in the intervention. Combined, the CCS denominator of members was 5,035, with a target outreach population of 2,671 members.

Findings (6-month progress)

- a. Women’s Health Strategy 2
- a. Provider Office 1: There were 1,347 members eligible to complete their cervical cancer screening. Staff chose to do telephonic outreach as the outreach method. A total number of 576 members were outreached to by telephone. The result for this intervention indicated that 42.76% of members on the target list had been contacted, and, therefore, the ²SMART AIM goal 1 was not reached (Table 1). The provider office did not receive the staff incentive (Table 2).
 - b. Provider Office 2: There were 494 members eligible to complete cervical cancer screening. Staff chose to do telephone outreach followed by member mailing as their outreach methodologies. The total number of members who were contacted were 494. The result for this intervention indicated that 100.00% of members on the target list had been contacted, therefore, the SMART AIM goal 1 was reached (Table 1). Provider office staff received the provider office staff incentive (Table 2).
 - c. Provider Office 3: There were 331 members eligible to complete cervical cancer screening. Staff chose to do telephone outreach as their outreach method. The total number of members that were outreached was 86. The result for this intervention indicated that 25.98% of members on the target list had been contacted. The SMART AIM goal 1 was not reached (Table 1). The provider office staff did not receive provider office staff incentive (Table 2).

² SMART - Specific, Measurable, Attainable, Relevant, Time-bound

Table 1: Cycle 1 Provider Office Cervical Cancer Screening Member Outreach

Provider Office	Count of Member on Target List	SMART AIM Goal 1: 90% of Target List	Cycle 1 Count of Member Outreach	Outreach Rate	Cycle 1 Goal Met
Provider Office 1	1,347	1,212	576	42.76%	No
Provider Office 2	494	445	494	100.00%	Yes
Provider Office 3	331	298	86	25.98%	No
Total	2,172	1,955	1,156	53.22%	No

Women's Health Strategy Results/Progress member outreach at 6 months

Table 2: Provider Office Staff Incentive for Cycle 1

Provider Office	Gift Card Amount	Gift Card Quantity	Monthly Total	Frequency	Total per office for the cycle
Provider Office 1	\$75.00	15	\$1,125.00	1	\$1,125.00
Provider Office 2	\$75.00	5	\$375.00	1	\$375.00
Provider Office 3	\$75.00	2	\$150.00	1	\$150.00

Table caption: Women's Health Strategy 2 cycle 1 provider office staff incentive by provider office

- a. Table 3 shows the breakdown for all 135 members who were scheduled by the provider offices. The breakdown was as follows: provider office 1 had 126 members scheduled, provider Office 2 had three members scheduled, and provider office 3 had six members scheduled. Appointments scheduled were outside of the cycle 1 timeframe. During the cycle 2, the focus will be on the number of completed cervical cancer screenings from those members who were contacted during cycle 1.
- b. Member outreach was able to identify eight members who had a hysterectomy and therefore will be excluded for the cervical cancer screening measure.
- c. During the member outreach, provider staff were able to schedule appointments for 135 members for cervical cancer screening; three members were referred to a gynecologist for cervical cancer screening (Table 3).
- d. The provider office staff identified 13 members who had cervical cancer screening completed elsewhere. The provider office staff will follow-up on closing care gaps by obtaining the medical records for these members.
- e. There were 76 members who were contacted who requested call-back at a later date. The provider office staff will follow-up with these members (Table 3).

Table 3: Cycle 1 Provider Office Cervical Cancer Screening Member Outreach Outcomes

Provider Office	Member Scheduled	Referral Created	Member Requested a call back
Provider Office 1	126	1	71
Provider Office 2	3	0	0
Provider Office 3	6	2	5
Total	135	3	76

Table caption: Women’s Health Strategy 2 outcomes in cycle 1. Member was schedule for appointment, referral created to see specialist, or member requested call back at a later date.

Analysis

At the initiation of this intervention, five HN provider offices agreed to participate in the intervention. Only three provider offices continued their participation after 6 months. Two provider offices did not initiate outreach during the cycle 1 period due to the lack of staff resources. Table 1 above shows the results at the end of cycle 1 for the three provider offices that conducted member outreach efforts. The total number of members in the target outreach list was 2,172. The combined outreach rate at the end of cycle 1 was 53.22% (1,156/2,172).

Barriers

Two of the five initial provider offices were unable to complete the member outreach. Provider Office 1 had a reorganization to their outreach department that led them to be short staffed and unable to reach their goal. Provider Office 3 had limited staff resources and were unavailable to perform outreach functions. Provider Office 1 and 2 have a team who perform outreach as part of their role. Provider Office 3 has only one staff member available to conduct member outreach.

Opportunities for Improvement

- CalOptima health will attempt different engagement strategies. For members who are hard-to-reach via phone, a member mailing will be sent out after telephone outreach to increase awareness about cervical cancer screenings.
- Obtaining Provider Office staff feedback is crucial to intervention implementation success. HN staff reported more frequently when they were notified that the member outreach was delayed due to staff availability.
- More time is needed to determine if the member reminder notice was successful (voice mail messages, mailing) and if members are willing to schedule cervical cancer screening. For cycle 2, provider offices will continue to outreach members on the target list and monitor if they were able to schedule or completed cervical cancer screening.
- Receiving tracking logs quarterly, allowed the HN staff to address issues and provide feedback to CalOptima Health that may not be identified until the end of the year. We were able to identify members (13 members) who had received cervical cancer screenings elsewhere.
- The intervention completed in this cycle focused on provider office staff reaching out to members to schedule cervical cancer screenings. For cycle 2, provider office staff will continue to focus on

contacting members to schedule cervical cancer screening. CalOptima Health plans to add a provider office staff incentive that focuses on the number of completed cervical cancer screenings.



Pediatric Strategy 3- Increase Childhood Immunization Status (CIS-Combo 10) Rate for CalOptima Medi-Cal Members with Provider Office A (October 1, 2021–September 30, 2022)

CalOptima Health identified provider offices that had a high volume of CalOptima Health Medi-Cal members due for childhood vaccinations and low performing for the Childhood Immunization Status (CIS-Combo 10) HEDIS measure. Vaccinations included: DTAP, IPV, MMR, HiB, Hep B, VZV, Pneumococcal conjugate, Hep A, RV, Influenza.³

- a. **Goal:** COVID 19 QIP Strategy 3 aimed to increase immunization rates of Medi-Cal members turning 2 years of age who were due for vaccinations.
- b. **Target Audience:** Provider Office A had 663 Medi-Cal members who fell in the CIS-Combo 10 denominator for MY 2021. The target outreach population was 611 child members
- c. **Intervention:** The Provider Office had a CIS-Combo 10 rate of 7.84% based on claims and encounters processed through August 2021. The NCQA 50th Percentile Benchmark for CIS-10 is 38.20%. The intervention included a single provider office contacting the parent, or guardian, via telephone whose child was due for an immunization(s). The purpose of the intervention was to increase immunization rates. CalOptima Health provided a target list of

³ DTAP – diphtheria, tetanus toxoid, acellular pertussis; IPV – inactivated poliovirus; MMR – measles, mumps, rubella; HiB – haemophilus influenzae type b; Hep B – hepatitis B; VZV – varicella zoster virus; Hep A – hepatitis A; RV - rotavirus

members due for an immunization to the provider office which contacted the parent, or guardian, to educate them on the importance of vaccinations, schedule appointment(s) and complete visits/vaccinations. These efforts were measured and equated to the provider office staff incentive (POSI). The provider office staff incentive tier payment system was based on metrics as established by CalOptima Health.

Findings

- a. Cycle 1: October 2021–December 2021
 - i. Metric 1: POSI was based on the percentage of members contacted with outcomes tracked on the member target list by 12/31/21. The provider office contacted all of their target list. Out of 611 members who were due for vaccinations, 557 were successfully contacted on the first call attempt. Furthermore, 26 additional members were successfully reached on second call attempt. Of the 28 members unable to be reached by telephone, 18 received a letter by mail. For 10 members, no additional outreach was performed since the member had not established care with the provider.
 - ii. Metric 2: POSI was based on the percentile Provider Office’s MY 2021 CIS-Combo 10 rate meets by 12/31/21. This will be based on administrative data only.
 1. Based on December 2021 Prospective Rate Report, Provider Office CIS-Combo 10 rate, the Provider Office rate was 44.34%, which is the 66th percentile based on NCQA Quality Compass Benchmarks as of September 24, 2021.
- b. Cycle 2: January 2022–March 2022
 - i. Due to HEDIS data limitations, no target list was provided to the Provider Office during this measurement period. CalOptima Health continued to provide guidance and acted as a liaison for inquiries for the Provider Office staff. Cycle 2 allowed for data collection through claims and encounters to establish baseline for calendar year 2022. Based on February 2022 Prospective Rates, Provider Office CIS-Combo 1, the office rate was 31.91% (216/677).
- c. Cycle 3: April 2022–June 2022
 - i. Metric 1: POSI was based on the percentage of member records reconciled and an outreach was attempted. Call outcomes were tracked on the member target list by 06/30/2022.
 1. Provider Office reconciled and provided documentation demonstrating that they made an outreach attempt to 100% of their target list.
 - ii. Metric 2: POSI was based on the number of members who completed their scheduled appointments. The Provider Office documented scheduled appointments on the member target list and indicated if the visit was completed. Visits were validated through claims and encounters data. The time period was 04/18/2022–06/30/2022.

1. The Provider Office was able to meet a 72% scheduling rate. There are 339 members who have not aged out of the measure and were due for vaccinations. CalOptima Health was able to confirm through data reconciliation that 100 members were compliant; 10 members were removed from the denominator due to being ineligible or other factors. Furthermore, 78 members had a successful appointment from 04/01/2022, 7 members completed their visit after 6/30/2022 and, 48 members were in on-hold while waiting for the influenza vaccine to become available.
- d. Cycle 4: July 2022–September 2022
1. Intervention cycle was completed. The validation findings are still pending.

Analysis

- a. The Provider Office was able to successfully reconcile 100% of the target list with internal medical records and provided feedback.
- b. The Provider Office was able to contact the parent or guardian of the members who were due for vaccinations and schedule their appointments.
- c. The Provider Office was also able to document the reasons why members were unable to complete all of their vaccinations, e.g., refused the influenza vaccination.

Barriers

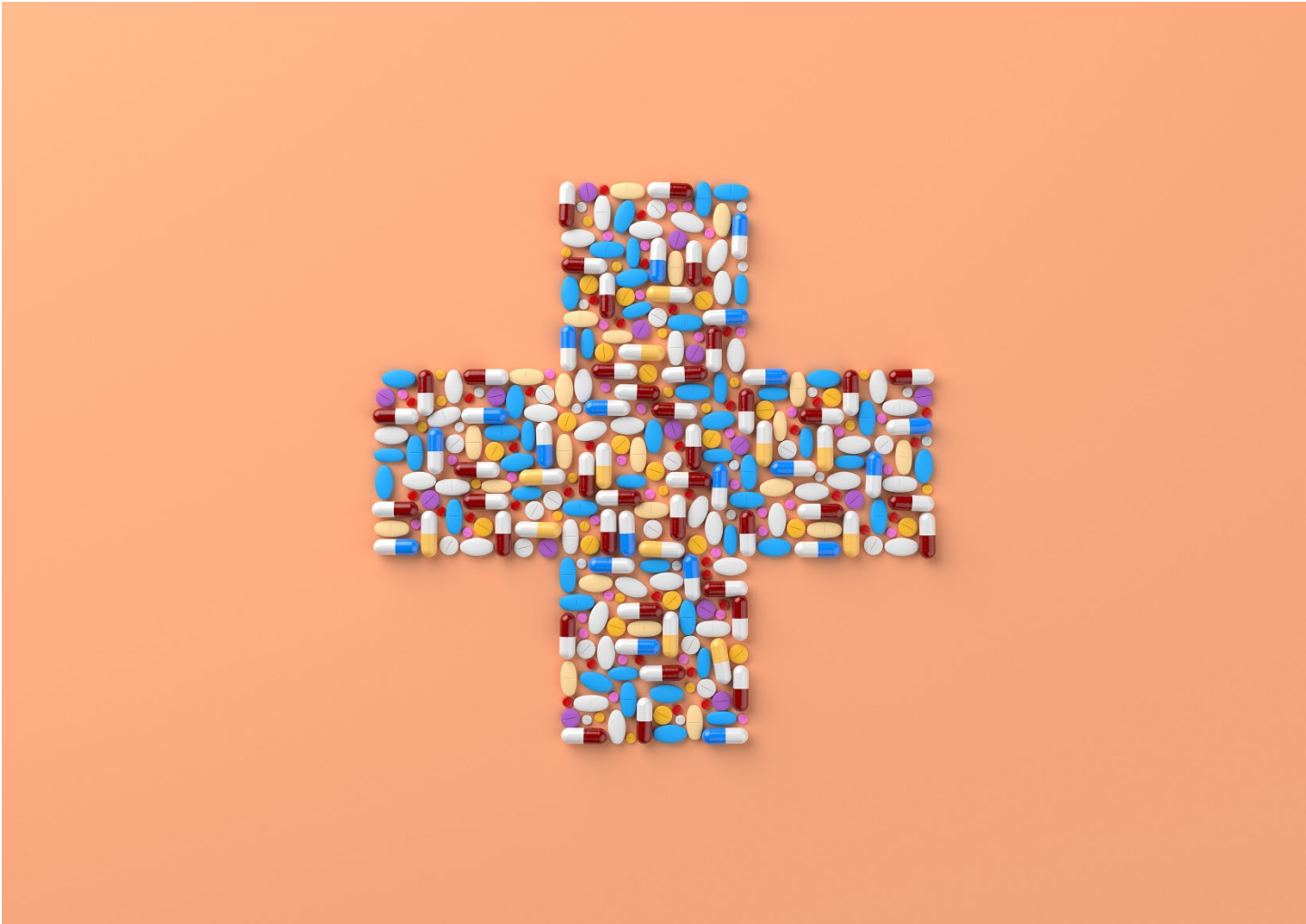
- a. Members refused the influenza vaccination.
- b. Members missing rotavirus vaccination and completing the dosage off-schedule.
- c. Influenza vaccine availability may impact the member's compliance.
- d. The vaccination schedule begins at birth. If a member is off-schedule and is trying to catch-up, it makes it difficult to complete all 10 vaccinations by 2 years of age.

Opportunities for Improvement

- a. CalOptima Health will begin contacting members who are due for vaccinations early-on instead of waiting until the measurement year when member turns 2 years old.
- b. CalOptima Health will develop member health education tools regarding vaccinations to aid the conversation between providers and members, and to reduce the rate of vaccination refusal.

Patient Safety QIP– OneCare Connect Population and Medi-Cal

To improve statin adherence for patients with diabetes intervention, a mailing was sent that targets all three lines of business: Medi-Cal (MC), OneCare (OC) and OneCare Connect (OCC). The Medi-Cal results are reported to NQQA to satisfy the Patient Safety standard. The OneCare Connect results are reported to CMS as part of a QIP.



Improving Statins Use for Patients with Diabetes (SPD) 2019-21

- a. Per the MY 2021 HEDIS Technical Specifications, the description of the SPD measures is the percentage of members ages 40–75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who meet the following criteria. Two rates are reported:
- b. Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year.
- c. Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.
- d. The improving statin adherence for patients with diabetes intervention is a mailing that targets all three lines of business: Medi-Cal (MC), OneCare (OC) and OneCare Connect (OCC).
 - i. **Goal:** By the end of the year, the goal was to reduce the rate of members who have yet to receive therapy/maintain adherence by five percentage points.

- ii. **Target Population:** All CalOptima Health members who are diagnosed with diabetes.
- iii. **Interventions:** A member-focused multi-modal promotion campaign was implemented to reduce cardiovascular risk among CalOptima Health members diagnosed with diabetes. A SPD member mailing was sent in tandem with an existing provider focused program to promote statin use among members diagnosed with diabetes and to encourage members to have a discussion with their health care provider about whether a statin is best for them.
- iv. **Activities:** Quarterly mailings were initiated to encourage members to consider the benefits of preventing cardiovascular complications. This mailer was sent to an average of 4,476 members in 2021. Data collection was performed by LOB to track and monitor throughout 2021.

Findings

- a. For 2021, the baseline was modified and updated because members who have yet to receive therapy/maintain adherence in the SPD adherence and therapy sub measures in Q1 2021 were included. This updated baseline was set at 29.96%. This represents the rate of members who have yet to receive therapy/maintain adherence in the SPD Adherence and Therapy sub-measure. For each quarter, members who have yet to receive therapy/maintain adherence were sent the statin mailer. The overall goal of this intervention in 2021 was to reach the target goal of $\leq 24.96\%$ (a lower percentage is an improvement) a 5-percentage point decrease. Toward the end of 2021, the numerator and denominator decreased. However, the rate of members who have yet to receive therapy/maintain adherence in the SPD Adherence and Therapy sub-measures was 32.58% and did not meet the target goal of 24.96%. There was a 7.89 percentage point increase of members who have yet to receive therapy/maintain adherence.

Table 1: SPD Adherence Sub-measure

	Description	Baseline 2020	2020 Results
	Total Number of Population	1,242	1,562
B1a	Number of Enrollees who have yet to maintain adherence (adherence measure):	260	291
B1b	Number of Enrollees who were in adherence measure:	1,242	1,562
B1	Results and/or Percentage:	20.93%	18.63%

SPD Adherence 2020 Prospective Rate Data and 2021 SPD Mailer Data

Table 2: SPD Therapy and Adherence Sub-measure

	Description	Baseline 2021	2021 Results
	Total Number of Population	2,193	2,004
B1	Number of Enrollees who have yet to receive therapy/maintain adherence (therapy & adherence measures):	657	653
B1b	Number of Enrollees who were in therapy & adherence measures:	2,193	2,004
B1	Results and/or Percentage:	29.96%	32.58%

SPD Therapy Adherence 2021 Prospective Rate Data 2021 SPD Mailer Data

- a. We unable to compare the 2021 result to 2020 result since it is not a direct correlation to trend year over year due to the change in measurement methodology. Towards the end of 2020, the rate was 18.63% but this is only for the SPD non-adherent (members who have yet to maintain adherence) members only. The SPD adherence sub-measure was the focus of the intervention in 2020, but in 2021 the SPD Therapy sub-measure was included. A better comparison of the 2021 rate will be available in the next evaluation, since the 2022 methodology includes both members who have yet to receive therapy/maintain adherence in the SPD Adherence and Therapy sub-measures.
- b. Table 5 and Table 6 depict the ethnic breakdown of the SPD sub-measures. The Vietnamese, Filipino and Asian or Pacific Islander ethnic groups met the key performance indicator (KPI) for these two sub-measures. The Hispanic, White and Black did not meet the KPI and will be the focus of priority in 2023. The categories of No response and Other do not contain enough information to make any determination.

Table 5: SPD Statin Adherence

All LOBs	Race/Ethnicity									
	Hispanic	Vietnamese	White	No response	Other	Filipino	Asian or Pacific Islander	Korean	Black	Asian Indian
HEDIS MY 2021										
Numerator	4,678	2,939	1,716	1,676	452	450	385	62	167	190
Denominator	7,045	3,529	2,409	2,245	613	529	488	344	259	259
Rate	66.40%	83.28%	71.23%	74.65%	73.74%	85.07%	78.89%	81.98%	64.48%	73.36%
KPI (QC 50th %)	78.76%	78.76%	78.76%	78.76%	78.76%	78.76%	78.76%	78.76%	78.76%	78.76%
Met/Not Met	Not Met	Met	Not Met	Not Met	Not Met	Met	Met	Met	Not Met	Not Met

HEDIS MY 2021 SPD Statin Adherence sub measure results. Based on the top 10 highest race/ethnicity denominators. Four out of the 10 Race/Ethnicity met the 50th percentile for Hemoglobin A1c Testing.

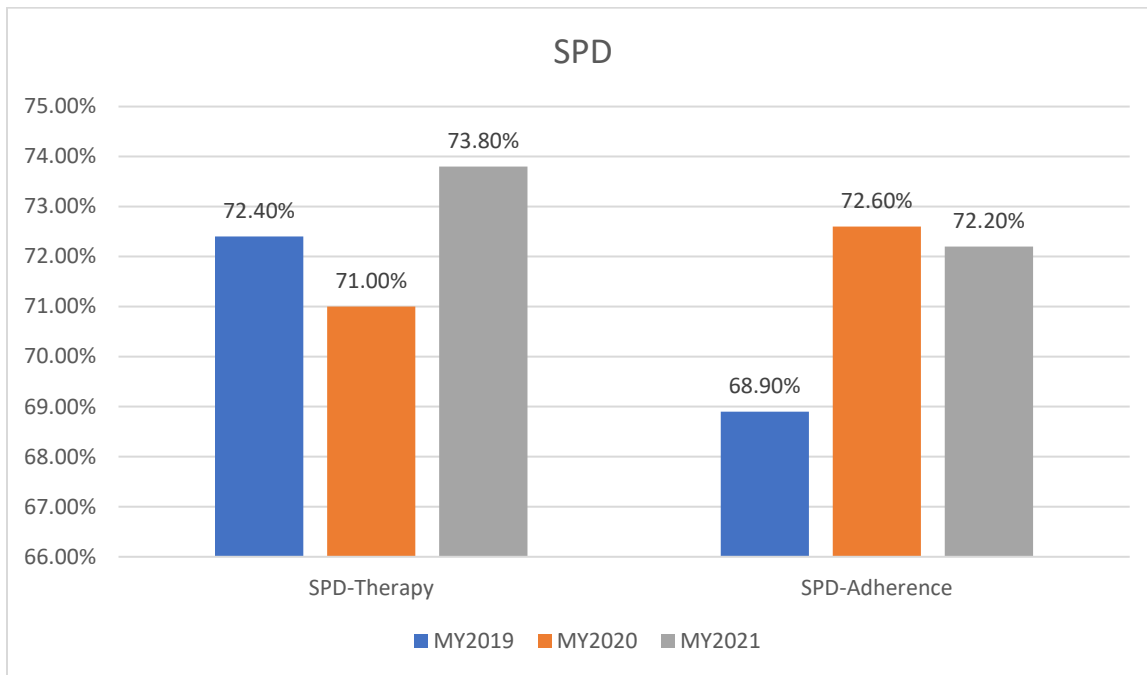
Table 6: SPD Received Statin Therapy

All LOBs	Race/Ethnicity									
	Hispanic	Vietnamese	White	No Response	Other	Filipino	Asian/Pacific Islander	Korean	Black	Asian Indian
HEDIS MY 2021										
Numerator	7,045	3,529	2,409	2,245	613	529	488	344	259	259
Denominator	9,849	4,148	3,515	3,042	806	629	621	427	411	334
Rate	71.53%	85.08%	68.53%	73.80%	76.05%	84.10%	78.58%	80.56%	63.02%	77.54%
KPI (QC 50th %)	74.00%	74.00%	74.00%	74.00%	74.00%	74.00%	74.00%	74.00%	74.00%	74.00%
Met/Not Met	Not Met	Met	Not Met	Not Met	Met	Met	Met	Met	Not Met	Met

HEDIS MY2021 SPD Received Statin Therapy sub-measure results. Based on the top 10 highest race/ethnicity denominators. Six out of the 10 Race/Ethnicity met the 50th percentile for Hemoglobin A1c Testing.

- a. Figure 1 shows the Medi-Cal HEDIS MY 2019, MY 2020, MY 2021 results for SPD Therapy and SPD Adherence. When comparing MY 2020 to MY 2021 SPD Therapy rates, the rate increased by 2.80 percentage points. When comparing MY 2020 to MY 2021 SPD Adherence rates, the rate decreased by 0.40 percentage points.

Figure 1: SPD HEDIS MY 2021 Results: Medi-Cal



SPD Therapy and Adherence rates by measurement year (MY)

- a. Table 7 identifies the reporting requirements and goals for SPD and its sub-measures. This is used to track progress and ensure compliance as a health plan.

Table 7: SPD HEDIS MY 2021 Goals, Medi-Cal

HEDIS Measure	Percentile, Goal, Reporting Requirements					
HEDIS MY 2021 Medi-Cal	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile		Goal	Reporting Requirements*
Statin Therapy for Patients with Diabetes (SPD) - therapy	63.47%	68.57%	72.23%	72.23%	HPR	
Met/Not Met			Met MY 2021 Goal, met 90th percentile			
Statin Therapy for Patients with Diabetes (SPD) - adherence	64.95%	71.95%	80.00%		73.43%	HPR
Met/Not Met		Did not met MY 2021 Goal, met 66th percentile				

SPD Therapy and Adherence results MY 2021 Medi-Cal. ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

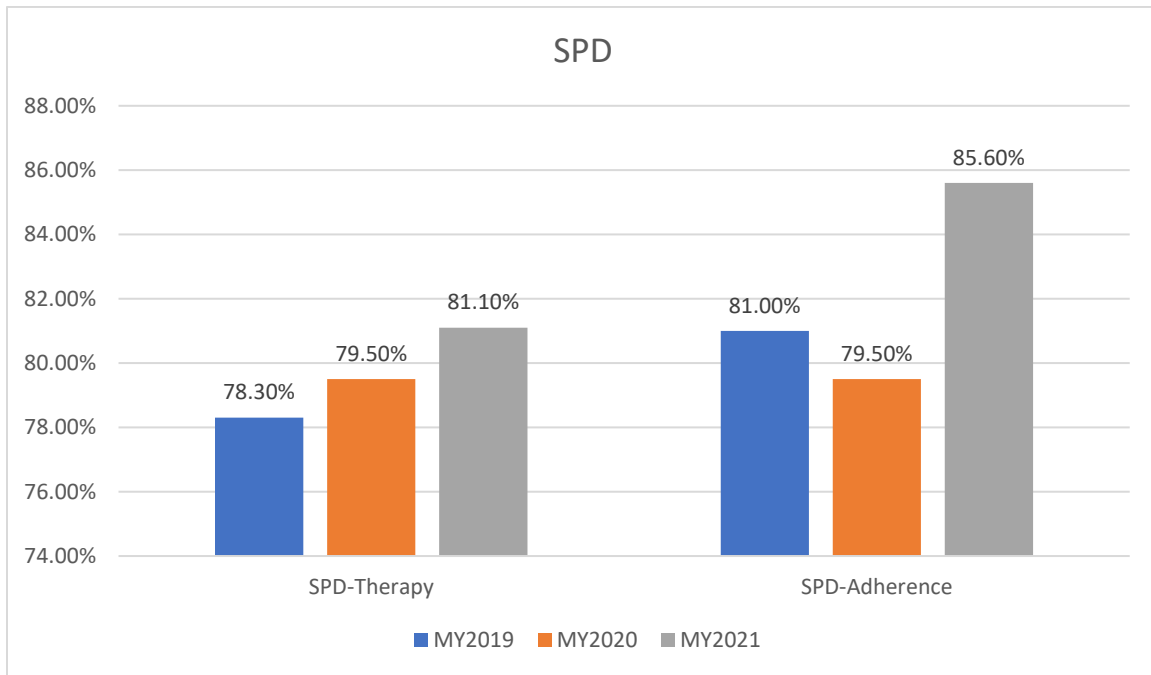
- a. Figure 2 shows the OneCare Connect HEDIS MY 2019, MY 2020, MY 2021 results for SPD Therapy and SPD Adherence. When comparing MY 2020 to MY 2021 SPD Therapy rates, the rate increased by 1.60 percentage points. When comparing MY 2020 to MY 2021 SPD Adherence rates, the rate increased by 6.10 percentage points.
- b. Table 8 shows the 2021 and 2022 SPD Therapy and Adherence measure Prospective Rate Data for Medi-Cal. When comparing the rates from September 2022 and September 2021, both SPD measures show a 4.5 percentage point increase for Statin Adherence and a 0.55 percentage point increase for Statin Therapy. This reflects the positive impact of the SPD intervention.

Table 8: September Prospective Rates for SPD – Medi-Cal

September Prospective Rates Medi-Cal	SPD Statin Adherence		SPD Statin Therapy	
	September 2021	September 2022	September 2021	September 2022
Numerator	7,665	8,589	15,308	17,871
Denominator	15,308	17,871	21,831	25,503
Rate	50.07%	48.06%	70.12%	70.07%
KPI (QC 50th %)	64.25%	68.75%	65.92%	66.47%
Met/Not Met	Not Met	Not Met	Met	Met

SPD Therapy and Adherence 2021 Prospective Rate Data 2021

Figure 2: SPD HEDIS MY 2021 Results – OneCare Connect



SPD Therapy and Adherence rates by measurement year (MY)

- Table 9 identifies the reporting requirements and goals for SPD and its sub-measures. This is used to track progress and ensure compliance as a health plan.

Table 9: Goals, OneCare Connect

HEDIS Measure	Percentile, Goal, Reporting Requirements				
	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
HEDIS MY 2021 OneCare Connect					
Statin Therapy for Patients with Diabetes (SPD) - therapy	81.00%	84%	89%	81.00%	Star
Met/Not Met	Met MY 2021 goal, met 33rd Percentile				
Statin Therapy for Patients with Diabetes (SPD) - adherence	83.23%	87.35%	90.94%	82.27%	CMS
Met/Not Met	Met MY 2021 goal, met 33rd Percentile				

SPD Therapy and Adherence results MY 2021 OneCare Connect. *Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference

- a. Table 10 shows the 2021 and 2022 SPD Therapy and Adherence measure Prospective Rate Data for OneCare. When comparing the rates from September 2022 and from September 2021, both SPD measures show a 4.5 percentage point increase for Statin Adherence and a 0.55 percentage point increase for Statin Therapy. This reflects the positive impact of the SPD intervention.

Table 10: September Prospective Rates for SPD – OneCare

September Prospective Rates OneCare Connect	SPD Statin Adherence		SPD Statin Therapy	
	September 2021	September 2022	September 2021	September 2022
Numerator	946	931	1,585	1,694
Denominator	1,585	1,694	2,007	2,105
Rate	59.68%	54.96%	78.97%	80.48%
KPI (QC 50th %)	78.03%	83.76%	74.13%	77.77%
Met/Not Met	Not Met	Not Met	Met	Met

SPD Therapy and Adherence 2021 Prospective Rate Data 2021

Analysis

- a. CalOptima Health’s desired outcome was to help reduce the number of non-adherent members by targeting outreach efforts. To meet this objective, the pharmacy department provided a list of members for outreach to provider offices every quarter in 2021. The Pharmacy department met their objectives for 2021 by strategizing their outreach methodology.
- b. CalOptima Health’s Population Health Management department similarly utilized the Pharmacy department’s member list for a statin information and education mailer. The statin member mailer included a cover letter to encourage members to talk to their doctor about statins as well as the “What is a Statin?” fact sheet document and provided contact information for members with questions. The objectives of this initiative were met since the mailer was sent to 100% of the members on the priority list.
- c. When analyzing the 2021 results in the table above, the results show that there was an increase in the SPD Therapy and Adherence sub-measure rate. By having multiple methods to target providers and members, the rate for 2021 improved.

Barriers

- a. Claims lag created a challenge for this intervention. Since a direct correlation could not be established, data needed to be compared at the end of the year. Data was checked to see if the members had filled a statin medication and if the member remained on a statin medication of any intensity for at least 80% of the treatment period.
- b. Changing the members’ behavior toward medication adherence is another barrier. It may take time and multiple attempts for these interventions to take effect since medication adherence is behavior dependent.

- c. Members may be reluctant going to the pharmacy to get their medications due to the impact of the COVID-19 pandemic.
- d. Obtaining the medication may also be a factor. Providers reported that socioeconomic status may affect the members' ability access to medication. Lack of transportation plays a factor in the access to medication as well as members may be unable to get to the pharmacy. It was also reported that members were concerned regarding the potential interactions of statins with other medications or alcohol, causing some members to wait for their body to process the alcohol or other medications first and before taking the medication.
- e. In Q3 2021, the mailing distribution was delayed due to an urgent COVID-19 ad-hoc mailer that required distribution during the same timeframe.
- f. In Q4 2021, the mailing distribution was delayed due to a DHCS audit that occurred during the same timeframe.

Opportunities for Improvement

- a. If the drug medication formulary changes for statins changes, the "What is a Statin?" document may need to be updated. Providing the member with a medication list that is consistent with the formulary will help ensure the medication is covered. Completing the fulfillment of statin mailers as early as possible will ensure timely dissemination.
- b. Working with CalOptima Health's Pharmacy department is considered a best practice for this intervention. This multipronged approach not only provided a medium for providers to outreach to those non-adherent members, but it also allowed Population Health Management to target specific members and reduce the number of non-adherent members. Also, utilizing the Pharmacy department's "What is a Statin?" fact sheet document for our member mailers ensures consistent messaging and statin information. In addition, the "What is a Statin?" fact sheet document also encouraged members to speak with their doctor about statin medication, which is aligned with improving statin use and adherence among these members.
- c. For future member targeted efforts beyond 2022, Population Health Management will consider pulling its own member list eliminating the dependency on the Pharmacy department and improving the time needed for printing, fulfillment and distribution of the mailing.



Chronic Care Improvement Programs (CCIPs) (All Lines of Business)

On December 9, 2019, CMS informed Medicare Advantage Organizations and Medicare-Medicaid Plans that they are required to attest that they have, or will have, an ongoing Chronic Care Improvement Program (CCIP) with a focus on promoting effective management of chronic disease. CalOptima Health chose to focus on diabetes, particularly members who fall in the category of “emerging risk,” defined as a new lab hemoglobin A1c (HbA1c) levels 8.0–9.0 when previously under 8%, as the target condition for this CCIP. These members are at higher risk of having uncontrolled diabetic management. The rationale for targeting this population is to assist members with newly emerging risk before they reach the point of poor HbA1c control, defined as a HbA1c levels 9.1 or above, and assist with their management to return below an HbA1c of 8%.

Emerging Risk Health Coaching Telephonic Outreach CCIP

- a. In an effort to address emerging risks in a timely fashion, 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 were identified as Emerging Risk members. Telephonic outreach was conducted by a health coach to identify solutions for Emerging Risk members to manage their HbA1c levels below 8.0%.

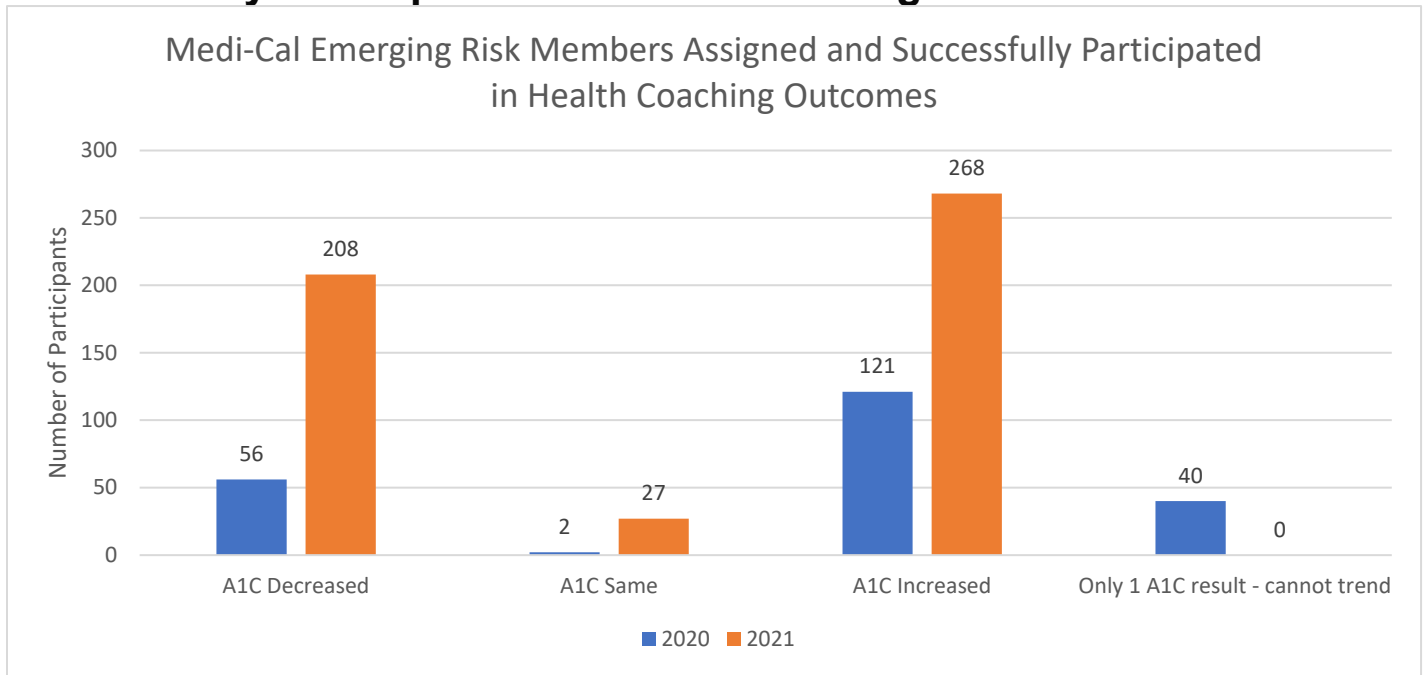
Findings

- a. Medi-Cal: When comparing the rates of Emerging Risk members with a successful outreach by a Health Coach for each quarter in 2020 to the respective quarter in 2021, there was trend of increased successful outreach for each quarter.
- b. On a quarterly basis when the outreach outcomes were compared from 2020 and 2021, there is an upward trend. Figure 1 depicts the improvement of successful outreach attempts to members in 2021 when compared with the same quarter the previous year in 2020.

Figure 1: Medi-Cal Emerging Risk Member Health Coach Telephonic Outreach

- a. In 2022, the Health Coach telephonic outreach to Emerging Risk Medi-Cal members was 57.74% to 67.11.% each quarter, and it was higher every quarter than in outreach attempts in 2021.
- b. Emerging Risk is defined as a HbA1c between 8.0 to 9.0. During the intervention, members were tracked to identify how many Emerging Risk members improved their HbA1c, stayed the same or worsened. When comparing the 2020 HbA1c trend to the 2021 HbA1c trend, there was an increased number of members with a reduced HbA1c result in 2021. Figure 2 illustrates in 2021 208 participants had HbA1c outcomes reduced while 268 participants had HbA1c outcomes increased.

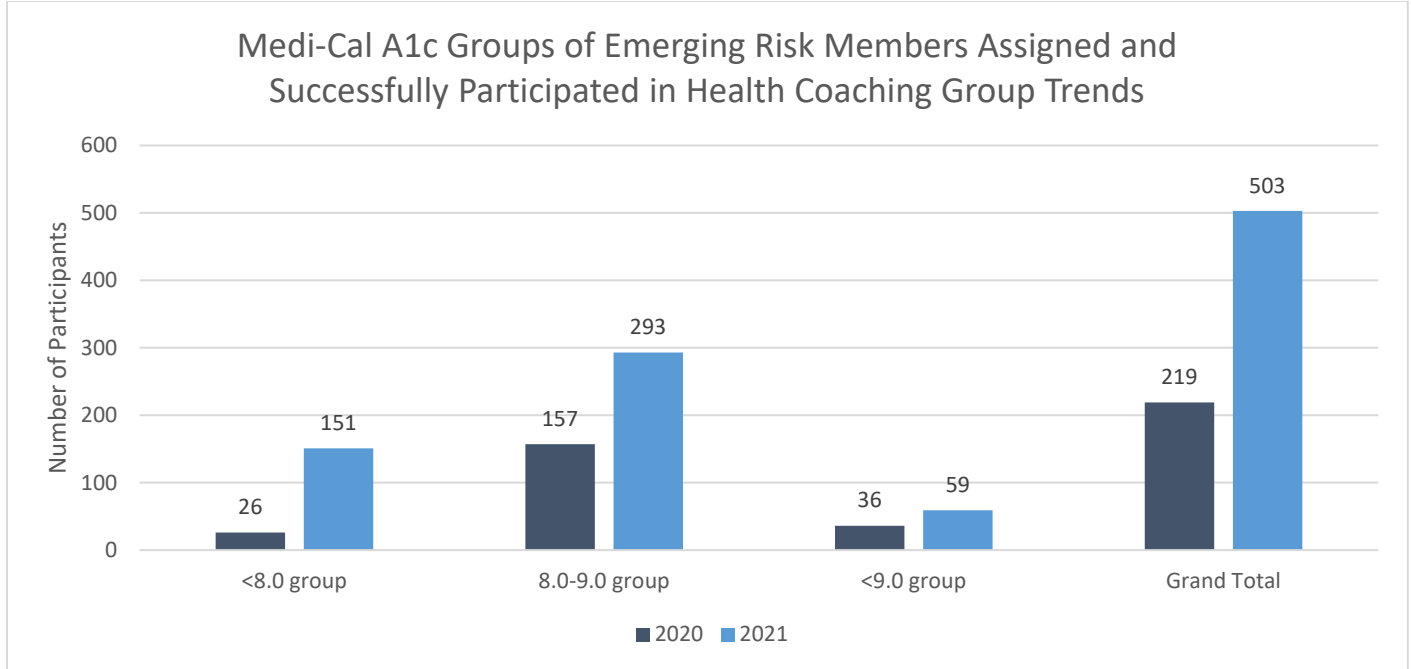
Figure 2: 2020 and 2021 Emerging Risk Members Assigned and Successfully Participated in Health Coaching Outcomes



The chart above indicates the results in 2020 and 2021 of the Emerging Risk members' HbA1c Trend when comparing their most current HbA1c test against their immediately previous HbA1c result. If a member only had a total of 1 HbA1c result on their record, they were categorized as "Only 1 HbA1c result-Cannot trend." These members were assigned to a Health Coach for telephonic outreach and successfully participated in Health Coaching.

- a. When comparing the rate of 2020 Emerging Risk HbA1c Group of Emerging Risk members that fell into "A1c <8.0 group" ($26/219 = 11.87\%$) against the 2021 HbA1c Emerging Risk HbA1c <8.0 group figures ($151/503 = 30.02\%$), the rate improved by 18.15%. Members who participated in telephonic outreach experienced a reduction in their HbA1c. Yet, in 2021, there were 293 members who fell into the Emerging Risk category who had an increase when compared with 2020.

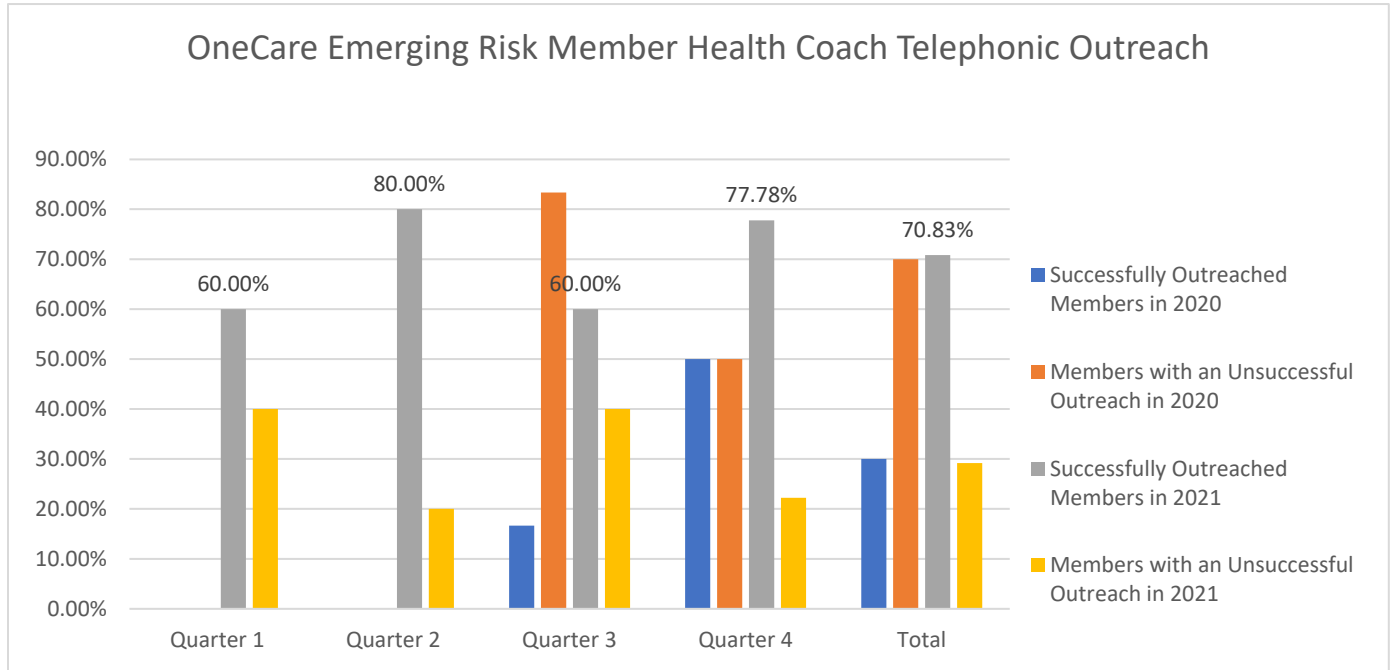
Figure 3: 2020 Medi-Cal HbA1c Groups of Emerging Risk Members Assigned and Successfully Participated in Health Coaching Group Trends



The chart above shows the HbA1c groups of assigned Emerging Risk members who successfully participated in Health Coaching and which HbA1c Groups they fell into at the end of 2020 and 2021.

- a. OneCare: When comparing the rates of Emerging Risk members with a successful contact by a Health Coach for each quarter in 2020 to the respective quarter in 2021, there was trend of increased successful outreach for each quarter. Figure 4 showcased the rate of outreach per assigned member in 2020 and 2021. There was a significant improvement in the rate of successful outreach attempts to members in 2021.

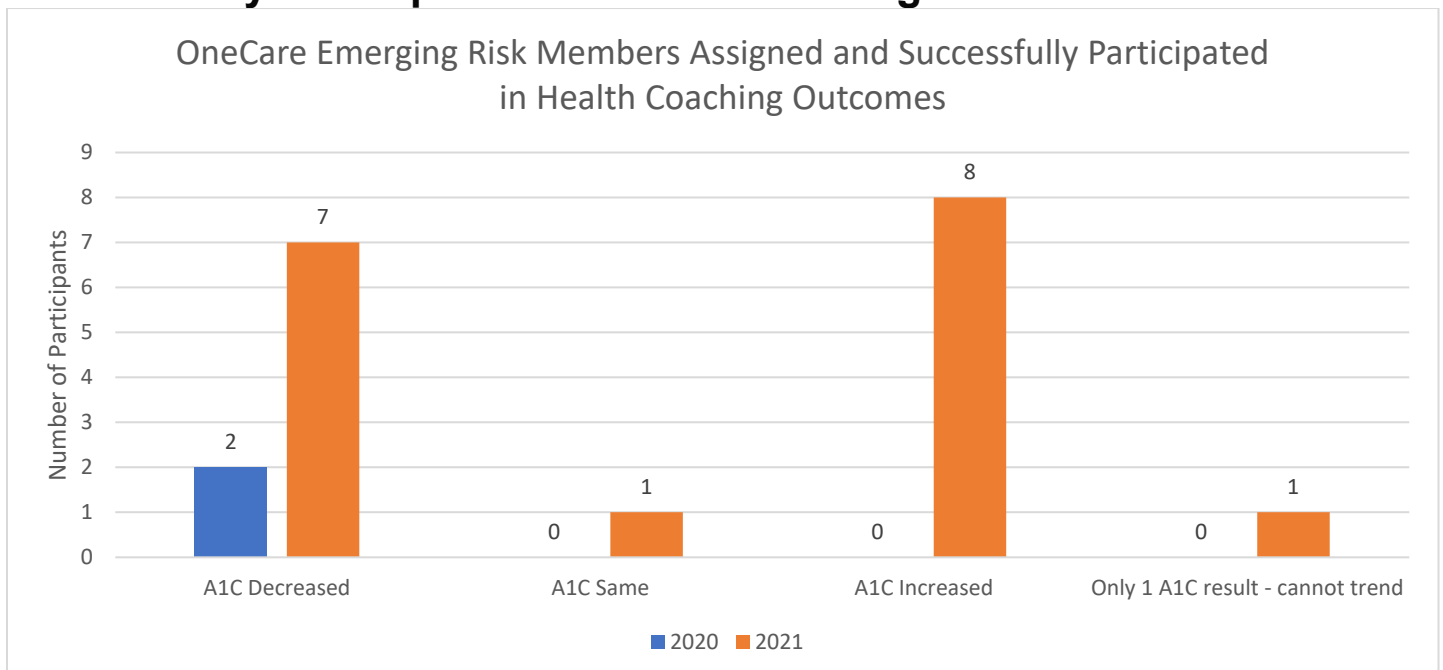
Figure 4: OneCare Emerging Risk Member Health Coach Telephonic Outreach



The chart above shows results of the intervention in 2020 and 2021 by quarter. The number of Emerging Risk members (2nd column), the rate of assigned Emerging Risk members with a successful outreach by a health coach (3rd column) and rate of assigned Emerging Risk members with an unsuccessful outreach (4th column).

- When comparing the 2020 HbA1c trend to the 2021 HbA1c trend, there was an increased number of members with a decreased HbA1c result in 2021. Yet, there was a significant number of members whose HbA1c increased after participating in the program, as depicted in Figure 5.

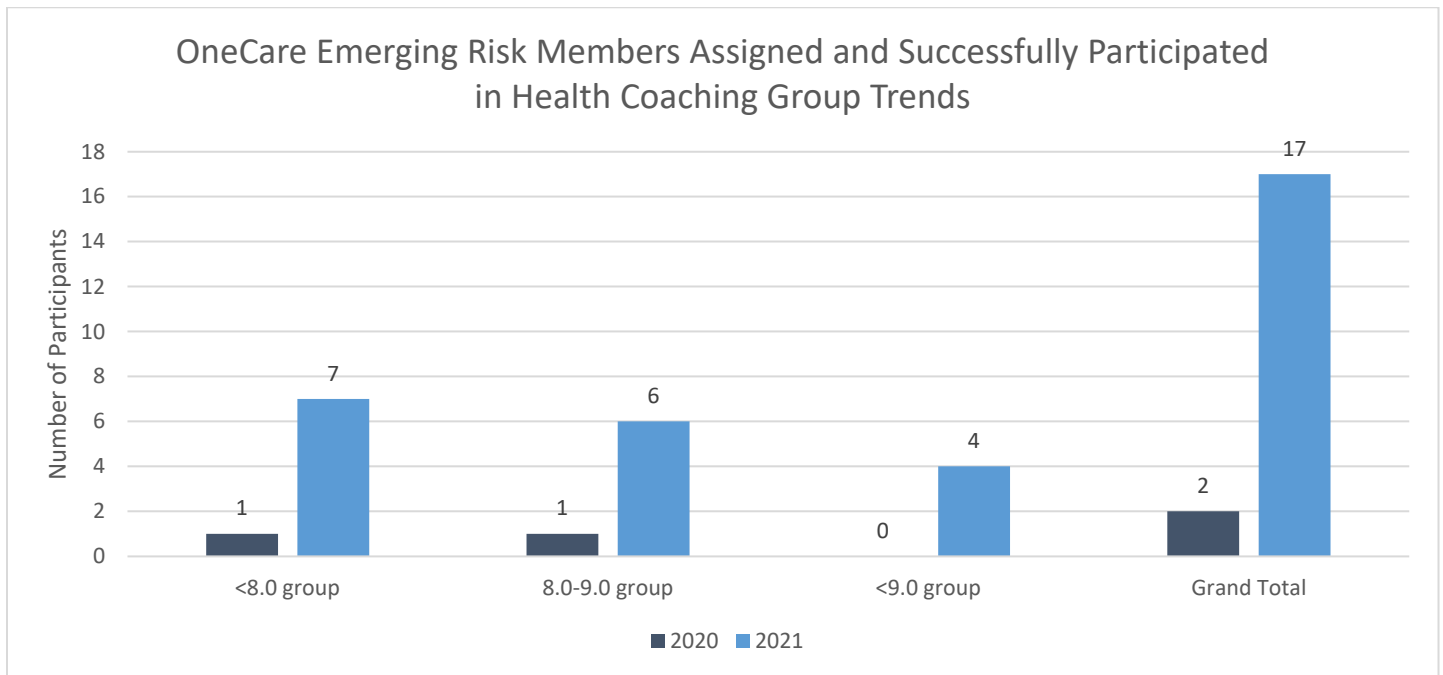
Figure 5: OneCare Emerging Risk Members Assigned and Successfully Participated in Health Coaching Outcomes



The chart above indicates the results in 2020 and 2021 of the Emerging Risk members' HbA1c Trend when comparing their most current HbA1c test against their immediately previous HbA1c result. If a member only had a total of only 1 HbA1c result on their record, they were categorized as "Only 1 HbA1c result-Cannot trend." These members were assigned to a Health Coach for telephonic outreach and successfully participated in Health Coaching.

- a. When comparing the rate of 2020 Emerging Risk HbA1c Group of Emerging Risk members that fell into "HbA1c <8.0 group" (1/2 = 50.00%) against the 2021 HbA1c Emerging Risk HbA1c <8.0 group figures (7/17 = 41.18%), the rate improved by 8.82% but there were more members who were assigned and fell into the HbA1c <8.0 group in 2021. Further details are depicted in Figure 6.

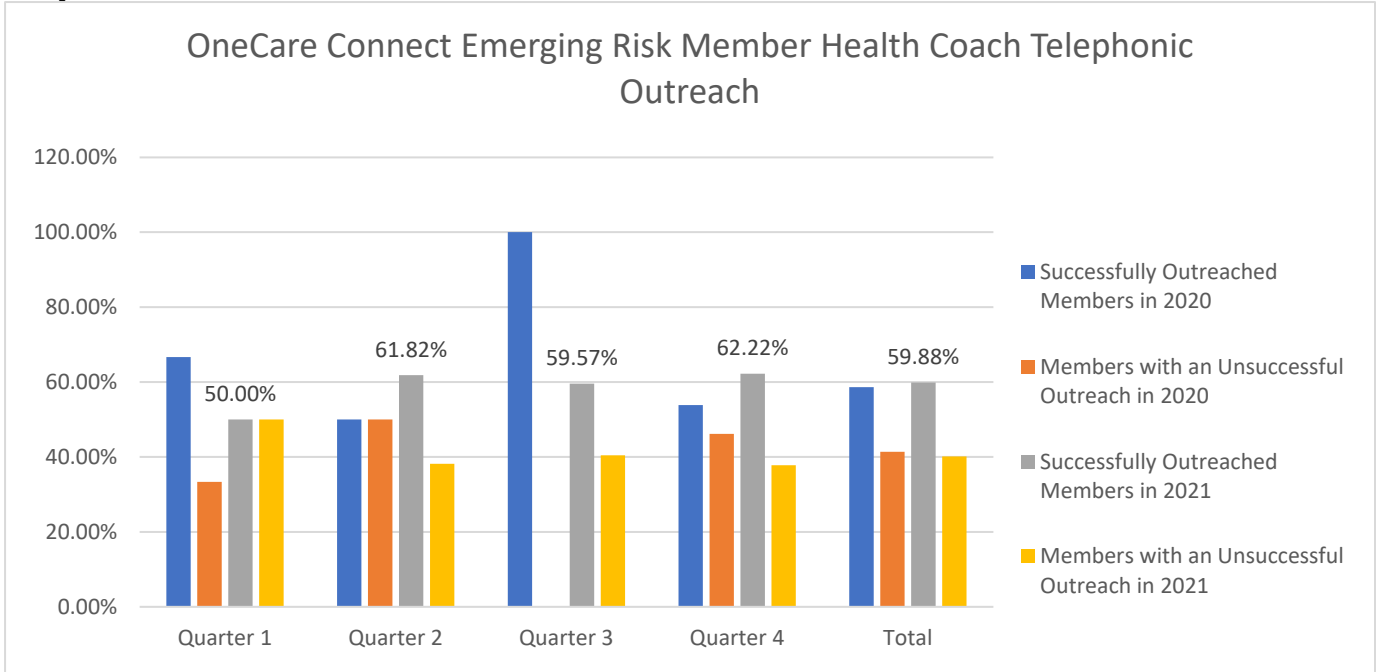
Figure 6: OneCare HbA1c Groups of Emerging Risk Members Assigned and Successfully Participated in Health Coaching Group Trends



The chart above shows the HbA1c groups of assigned Emerging Risk members who successfully participated in Health Coaching and which HbA1c groups they fell into at the end of 2020 and 2021.

- b. OneCare Connect (OCC): When comparing the rates of Emerging Risk members with a successful outreach by a Health Coach for each quarter in 2020 to the respective quarter in 2021, the trend varied for each quarter but overall, there was an improvement in 2021 by 1.26%.

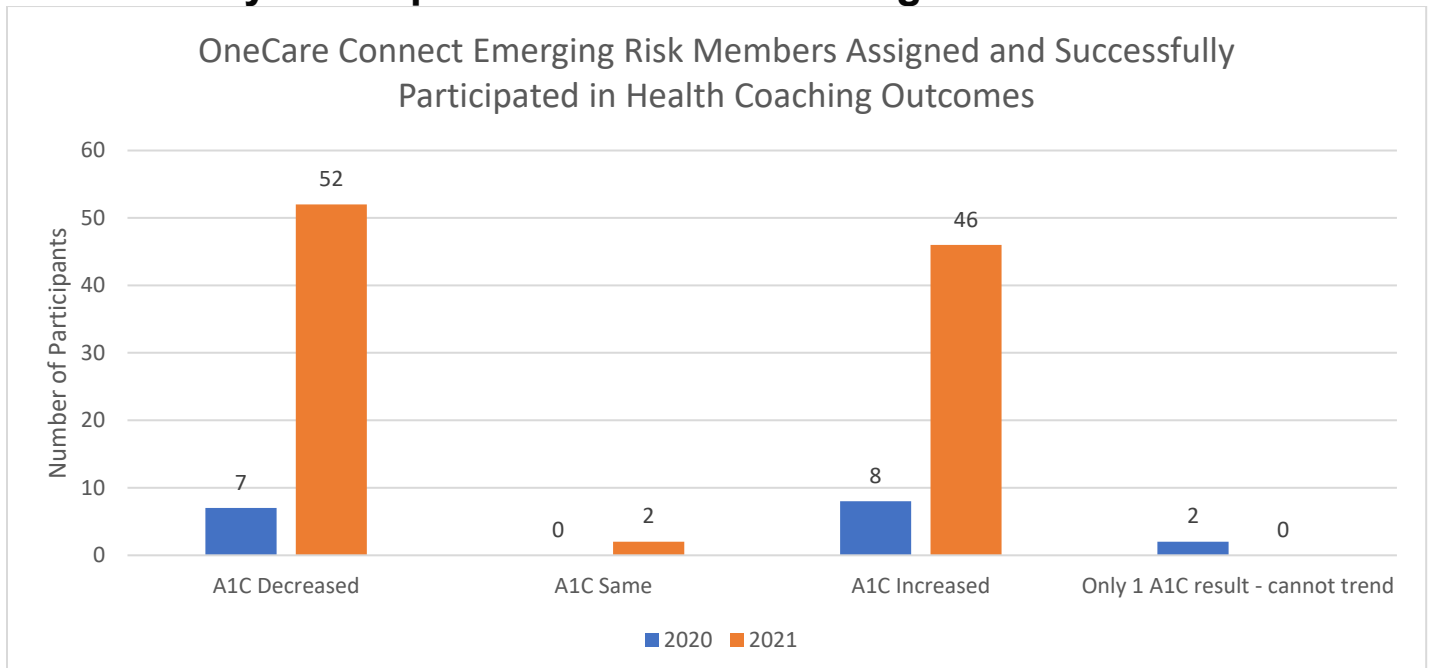
Figure 7: OneCare Connect Emerging Risk Member Health Coach Telephonic Outreach



The chart above shows results of the intervention in 2020 and 2021 by quarter. The number of Emerging Risk members (2nd column), the rate of assigned Emerging Risk members with a successful outreach by a health coach (3rd column) and rate of assigned Emerging Risk members with an unsuccessful outreach (4th column).

- a. When comparing the 2020 HbA1c trend to the 2021 HbA1c trend, there was an increased number of members with a decreased HbA1c result in 2021. Figure 8 demonstrates that for the OneCare Connect population in 2021 this program helped reduce the HbA1c for most participants.

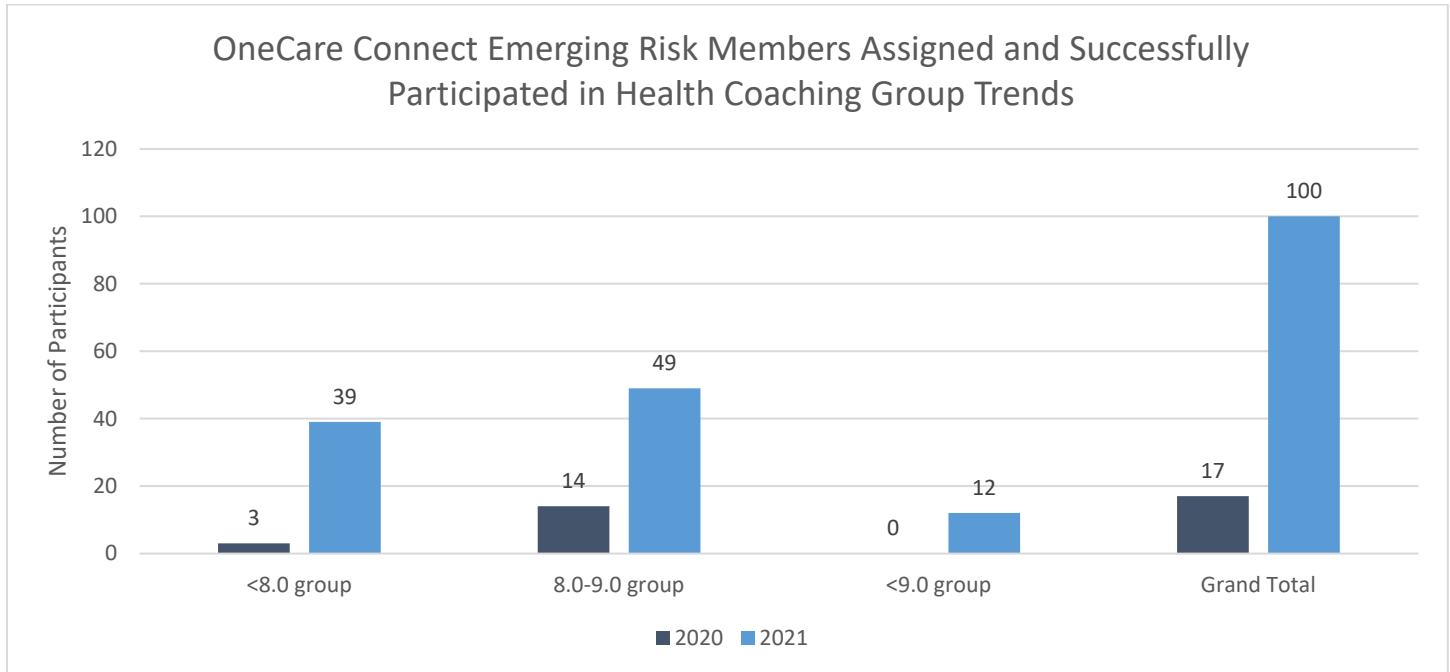
Figure 8: OneCare Connect Emerging Risk Members Assigned and Successfully Participated in Health Coaching Outcomes



The chart above indicates the results in 2020 and 2021 of the Emerging Risk members' HbA1c trend when comparing their most current HbA1c test against their immediately previous HbA1c result. If a member only had a total of only 1 HbA1c result on their record, they were categorized as "Only 1 HbA1c result-Cannot trend." These members were assigned to a Health Coach for telephonic outreach and successfully participated in Health Coaching.

- a. When comparing the rate of 2020 Emerging Risk HbA1c Group of Emerging Risk members that fell into "HbA1c <8.0 group" ($3/17 = 17.65\%$) against the 2021 HbA1c Emerging Risk HbA1c <8.0 group figures ($39/100 = 39.00\%$), rate improved by 21.35%.

Figure 9: OneCare Connect HbA1c Groups of Emerging Risk Members Assigned and Successfully Participated in Health Coaching Group Trends



The chart above shows the HbA1c groups of assigned Emerging Risk members who successfully participated in Health Coaching and which HbA1c Groups they fell into at the end of 2020 and 2021.

- a. Table 1 illustrates the HEDIS rate based on race and ethnic breakdown.

Table 1: All LOBs HEDIS MY 2021 Rates by Race/Ethnicity CDC HbA1c Testing

Table S	Race/Ethnicity									
HEDIS MY 2021	Hispanic	White	Vietnamese	No Response	Other	Filipino	Asian/Pacific Islander	Black	Korean	Asian Indian
Numerator	14,589	4,993	5,190	4,427	1,157	913	758	598	571	480
Denominator	17,274	6,182	5,719	5,223	1,372	1,022	865	753	667	548
Rate	84.46%	80.77%	90.75%	84.76%	84.33%	89.33%	87.63%	79.42%	85.61%	87.59%
KPI (QC 50th %)	89.30%	89.30%	89.30%	89.30%	89.30%	89.30%	89.30%	89.30%	88.66%	89.30%
Met/Not Met	Not Met	Not Met	Met	Not Met	Not Met	Met	Not Met	Not Met	Not Met	Not Met

HEDIS MY 2021 CDC HbA1c Testing sub-measure results. Based on the top 10 highest race/ethnicity denominators. Two out of the 10 Race/Ethnicity met the 50th percentile for HbA1c Testing.

Analysis

a. Medi-Cal

- i. Goal: By 12/31/2021, the target goal of this intervention would be to reduce the number of Medi-Cal emerging risk members by 5% for those who participated in the telephonic health coaching intervention.
- ii. As shown in the findings section, out of the 503 members who successfully participated in Health Coaching, 151 members fell into the <8.0 group, which gives a rate of 30.02%. There were 293 members that remained in the 8.0–9.0 group (Emerging Risk) from the 503 members that successfully participated in Health Coaching, which gives a rate of 58.25%. The target goal for this intervention was to reduce the number of Medi-Cal Emerging Risk members by 5% by 12/31/2021, for those who participated in the telephonic health coaching intervention. At the end of 2021, the total number of members who received the telephonic health coaching intervention was 503. To achieve a 5% reduction of that figure, we needed at least 26 Emerging Risk members to be placed in the <8.0 group by the end of the year. The 2021 outcomes show that there were 151 Emerging Risk members who participated in the telephonic health coaching outreach placed in the <8.0 Group (good control). This indicates that we met the goal of reducing the emerging risk members by 5%.

b. OneCare

- i. Goal: By 12/31/2021, the target goal of this intervention would be to reduce the number of OneCare Emerging Risk members by 50% for those who participated in the telephonic health coaching intervention.

- ii. As shown in the findings section out of the 17 members that successfully participated in Health Coaching, 7 members fell into the <8.0 group, which gives a rate of 41.18%. There were 6 members who remained in the 8.0–9.0 group (Emerging Risk) from the 17 members who successfully participated in Health Coaching, which gives a rate of 35.29%. The target goal for this intervention was to reduce the number of OneCare Emerging Risk members by 50% (from baseline of 5) by 12/31/2021, for those who participated in the telephonic health coaching intervention. At the end of 2021, the total number of members who received the telephonic health coaching intervention was 17. To achieve a 50% reduction of that figure we needed at least 9 Emerging Risk members to be placed in the <8.0 group by the end of the year. The 2021 outcomes show that there were 7 Emerging Risk members who participated in the telephonic health coaching outreach placed in the <8.0 Group (good control). This indicates that we did not meet the goal of reducing the Emerging Risk members by 50%.
- c. OneCare Connect
- i. Goal: By 12/31/2021, the target goal of this intervention would be to reduce the number of OneCare Connect Emerging Risk members by 5% for those who participated in the telephonic health coaching intervention.
 - ii. As shown in the findings section, out of the 100 members who successfully participated in Health Coaching, 39 members fell into the <8.0 group, which gives a rate of 39%. There were 49 members that remained in the 8.0–9.0 group (Emerging Risk) from the 100 members who successfully participated in Health Coaching, which gives a rate of 49%. The target goal for this intervention was to reduce the number of OneCare Connect Emerging Risk members by 5% by 12/31/2021, for those who participated in the telephonic health coaching intervention. At the end of 2021, the total number of members that received the telephonic health coaching intervention was 100. To achieve a 5% reduction of that figure we needed at least 5 Emerging Risk members to be placed in the <8.0 group by the end of the year. The 2021 outcomes show that there were 39 Emerging Risk members who participated in the telephonic health coaching outreach placed in the <8.0 Group (good control). This indicates that we met the goal of reducing the Emerging Risk members by 5%.

Barriers

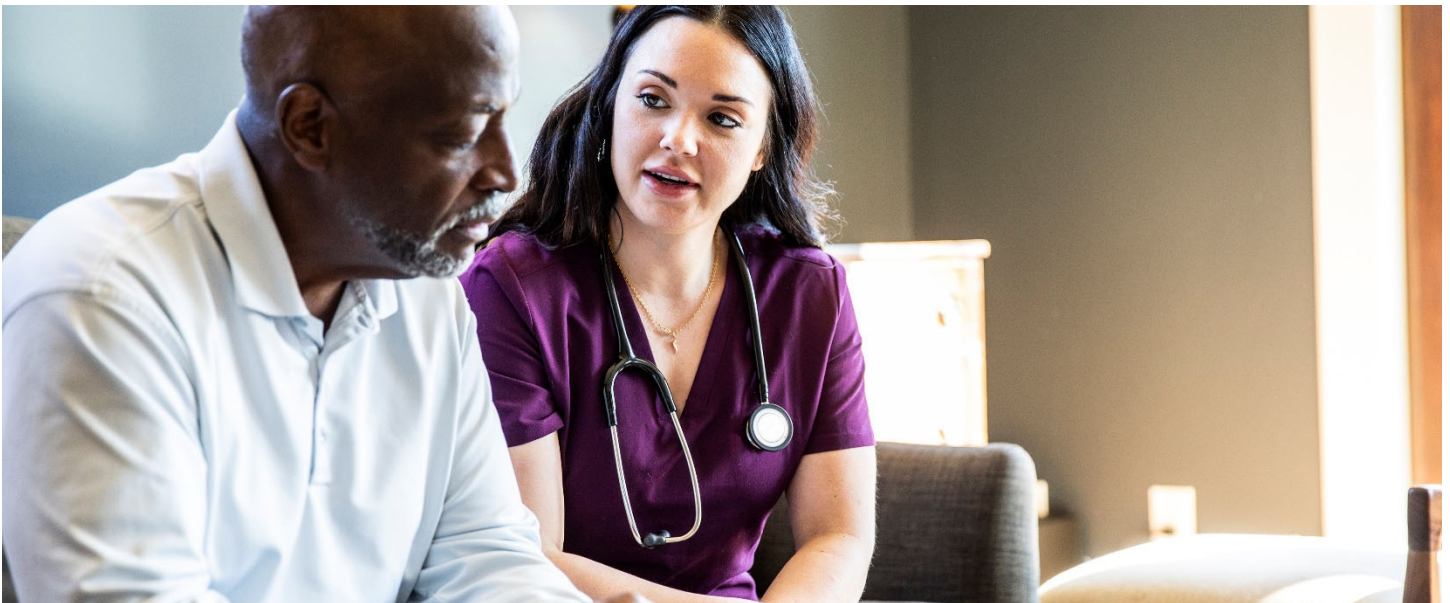
Barriers encountered during the Health Coach telephonic outreach include:

- a. Limited capacity for the health educators to conduct outbound calls due to their competing volume of daily tasks.
- b. Difficulty with scheduling appointments. Appointments are very far away, especially with endocrinologist due to limited office hours.
- c. With the COVID-19 pandemic, telehealth appointments were difficult for some members due to the lack of access to a smartphone or not understanding the instructions on how to connect to video calls.
- d. Members relying on natural remedies to reduce their blood sugar.
- e. Members face challenges with access to broadband internet based on their economic status or place of residence.

- f. Members may require transportation to attend appointments and may be unaware of their transportation benefits.

Opportunities for Improvement

- a. Instruct Health Coaches to assist members with scheduling appointments whenever possible. Teach members how to navigate the health system and telehealth appointments. Encourage members to communicate needs and challenges timely to their provider.
- b. During outbound calls conduct a short questionnaire screening for social determinants of health and connect members with other resources to assist specific needs.
- c. Update telephonic scripting to offer resources for members with diabetes and provide information regarding telehealth services.
- d. Seek ways to improve data needs and streamline how members are assigned to the Health Coaches, moving from manual to an automated method.
- e. Conduct a multi-layered analysis of membership data by volume, ZIP code, ethnicity and age groups to determine if social determinants of health are creating barriers for CalOptima Health members. Moving forward, additional analysis is needed to create appropriate programs that will make an impact to address barriers and inequities among the targeted groups in the regions we serve.



Model of Care: Plan Performance Monitoring and Evaluation and Quality Improvement Program Effectiveness – Health Risk Assessments

Monitoring of dashboard performance and effectiveness by Case Management for OneCare and OneCare Connect in 2022 continued with the same metrics as performed in 2021. Two additional metrics were added related to Health Risk Assessment (HRA)s, in the Long-Term Care (LTC) population; and a goal-target for California Medicare-Medicaid plans (CA) 1.5 was defined.

OneCare and OneCare Connect

Interventions

Case Management’s interventions for OneCare and OneCare Connect monitored the outreach efforts for HRA collection, both initial and annual. The volume of HRAs sent to delegated networks was tracked and involved 100% oversight review of each bundle and the designation of a care management level. Additionally, when each bundle was returned, interventions demonstrate 100% review of each bundle with goal of this review being completed within 10-business days of receipt. Several regulatory measures were monitored for the OneCare Connect model: CA 1.5 Individualized Care Plan (ICP) completion for high and low risk members; CA 1.6 documentation of care goal discussion; and Medicare-Medicaid (MMP) 3.2 Members with ICP completed in 90 days of enrollment. Finally, members in Long-Term Care were identified and ensured to receive their HRAs according to the Model of Care.

Findings

Table A

Line of Business	Performance Area	Goal	Qtr Q1 2022	Qtr 2 2022	Qtr 3 2022
OneCare	HRA <i>Initial Outreach</i>	95%	99%	100%	100%
	HRA <i>Annual Outreach</i>	95%	100%	99%	100%
	<i>Each HRA reviewed and sent</i> for care plan development	90%	100%	100%	100%
	<i>Each Care Plan bundle reviewed within 10 business days</i> from bundle return	10 days; or 90%	Jan: 100% Feb: 100% Mar: 88%	Apr: 33% May: 20 days Jun: 25 days	Jul: 30days Aug: 17days Sep: Pending
OneCare Connect	HRA <i>Initial Outreach</i>	95%	100%	100%	100%
	HRA <i>Annual Outreach</i>	95%	99%	100%	100%
	<i>Each HRA reviewed and sent</i> for care plan development	90%	100%	100%	100%
	<i>Each Care Plan bundle reviewed within 10 business days</i> from bundle return	10 days; or 90%	Jan: 100% Feb: 94% Mar: 48%	Apr: 21% May: 30days Jun: 30days	Jul: 30days Aug: 17days Sep: 18days
Regulatory Monitoring	1.5 Care Plan - High risk	75%	85%	87%	89%
	1.5 Care Plan - Low risk	75%	78%	81%	83%
	1.6 Care Goal Discussion	95%	98%	99%	99%
	3.2 ICP Completion	85%	85%	81%	89%
LTC HRA	HRA Outreach Missing	0	3	7	0

Analysis

- a. HRA outreach met the benchmarks for 2022 and is consistent with the 2021 data.

- b. Health Network MOC Oversight tracks two variables. The benchmark for review of HRA and CML setting has met benchmarks for 2022 and is consistent with 2021 data. ICP review in a 10-business-day turnaround has not met benchmarks that were effectively met in 2021. This is an internal standard and not a regulatory standard. ICP bundles returned are being reviewed but at longer than expected interval and barriers are outlined below.
- c. CA 1.5 had benchmark goal set and met for 2022 data.
- d. CA 1.6 members with an ICP and care goal discussion is a withhold measure and benchmark of 95% has been met for 2022 and is consistent with 2021 data.
- e. MMP 3.2 newly eligible members with ICP completed in 90 days of enrollment is also a withhold measure with benchmark of 85% and is on track to be met for 2022. Data is consistent with 2021.
- f. LTC HRA monitoring on quarterly basis to confirm members flagged as LTC are outreached for the HRA process. This was new monitoring and feedback provided in Q1 and Q2. Q3 has demonstrated this new monitoring and process change as all LTC members received HRA outreach in Q3. All members from Q1 and Q2 have since been outreached to for the HRA process.

Barriers

- a. There are multiple factors that have lengthened turnaround times for ICP review. One barrier surrounds the medical management system and changes made to file-listening process in March 2022. The changes prevented or delayed access and visibility by oversight to the ICP files needing review. Ongoing technical issues led to challenges in receiving files.
- b. New processes implemented for members who either declined or where unable to be contacted for HRA. This group of members now require review for a data ICP and a CML setting. This evaluation is prioritized above review of returned ICP files. The prioritization of HRAs amplified in May 2022 when DHCS expanded Medi-Cal eligibility.

Opportunities for Improvement

- a. Case Management's oversight role and function will be restructured and implemented in phases. The first phase was implemented in November 2022 and will continue into 2023. Improvement efforts for 2022 oversight benchmarks are tempered with this awareness. The Model of Care (MOC) tracking file was modified for OneCare and OneCare Connect in November 2022. Health Networks submitted a revised MOC tracking file that contained additional data fields to ensure compliance with MOC. For 2023, restructuring of oversight will occur in which a select number of members will be reviewed allowing for improved efficiencies, minimizing technical challenges, and alignment of audit and oversight practices.



Behavioral Health

Applied Behavior Analysis Pay for Value Performance Program

The Applied Behavior Analysis (ABA) is a type of Behavioral Health Treatment (BHT) service. It is a Medi-Cal covered service under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for members under 21 years of age. ABA therapy is intense, with treatment hours averaging 9 to 10 per week. It has been identified as an evidenced-based approach for preventing or minimizing the adverse effects of behaviors that interfere with learning and social interaction. The course of treatment can last for several years or longer. Most of the direct services are rendered by paraprofessionals who are unlicensed and require ongoing supervision. Since DHCS implemented the BHT benefit in 2014, CalOptima Health has followed the State Plan Amendment (SPA 14-026) regarding the types of providers allowed to supervise paraprofessionals:

- Board Certified Behavior Analyst (BCBA)
- Behavior Management Consultant (BMC)
- Behavior Management Assistant (BMA)
- Board Certified Assistant Behavior Analyst (BCaBA)

The BCBA and BMC are considered the top tier supervisor types, while BMA and BCaBA fall under the mid-tier level. When a paraprofessional is supervised by a mid-tier provider, a BCBA or BMC is still required to oversee the work to ensure quality of care. In 2018, CalOptima Health proposed to phase out the mid-tier level (BMAs and BCaBAs) within a one-year period. The rationale for phasing out mid-tier was to raise the overall quality of care and align our approach with most commercial insurance plans and the Regional Center of Orange County. At that time, ABA providers expressed concerns over lack of available CBAs and the associated cost. As a result, CalOptima Health has continued to maintain the 3-Tier model approach.

In 2019, DHCS conducted a medical audit. The file review showed some ABA providers were not providing the hours as stated in individual members' treatment plans. DHCS noted that when ABA providers insufficiently deliver direct service hours, members may not receive effective treatment and consequently, the quality of care may be compromised.

ABA P4V Performance Metrics

To improve the quality of ABA services, Behavioral Health Integration (BHI) addressed the quality issues by implementing an ABA Pay for Value (P4V) program starting January 1–December 2021 and received Board of Directors approval to extend the program through December 31, 2022. The program was designed to incentivize ABA provider groups who demonstrate improvement in supervision hours and utilization of one-on-one (1:1) services. There are no HEDIS or standardized measures for the quality of ABA services. Two performance metrics were proposed and approved by the Board of Directors:

- Applied Behavior Analysis Hours (ABAH) - ABA Supervision Hours termed as the percentage of supervision hours completed by a BCBA or BMC
- Applied Behavior Analysis Utilization (ABAU) - ABA Utilization is termed as the percentage of 1:1 hours utilized vs. authorized

To establish a baseline period for the performance metrics, claims data from January 1–December 31, 2020, was used. However, if an ABA provider group did not have an established 2020 baseline rate, 2021 claims data were used to establish their baseline. The ABA provider group had to reach the metric targeted goal percentage/rate to receive an incentive payment. The payments were set at four incentive tier levels and were no more than 4% of the provider group’s annual claims.

Incentive Tier Levels	1	2	3	4
Incentive by annual claims paid	0.50%	1.00%	1.50%	2.00%

- a. ABAH Metric – goal is to obtain 50% or higher to receive an incentive payment

Incentive Tier Levels	1	2	3	4
Metric Target Goal	50.00%	65.00%	80.00%	95.00%

- b. ABAU Metric – goal is to obtain a higher percentage than the baseline rate

			1	2	3	4
Baseline rate			Metric Target Goal			
70%	and	up	72.50%	75.00%	77.50%	80.00%
65%	to	69%	68.75%	72.50%	76.25%	80.00%
60%	to	64%	65.00%	70.00%	75.00%	80.00%
55%	to	59%	61.25%	67.50%	73.75%	80.00%
50%	to	54%	57.50%	65.00%	72.50%	80.00%
45%	to	49%	53.75%	62.50%	71.25%	80.00%
40%	to	44%	50.00%	60.00%	70.00%	80.00%
0%	to	39%	46.25%	57.50%	68.75%	80.00%

- c. Example

	ABAH	ABAU
Y2020 Baseline Rate	40%	38%
Y2021 Measurement Rate	50%	46.25%
Incentive by Annual Claims Paid	0.50% (tier level 1)	0.50% (tier level 1)
Provider qualifies for a total of 1% incentive based on their Y2021 claims \$400,000 = payout \$4,000 Q1 2022		

Program Analysis

	CY 2020 (Baseline)	Program Year 1 CY 2021 (Measurement period)	Program Year 1 CY 2022 (Measurement period)
Metric ABAU	56.1%	56.6%	TBD
Metric ABAH	51.7%	50.4%	TBD

- 94 ABA provider groups were eligible to participate in the program; 73 of the 94 (78%) received an ABA P4V incentive payment.
- The 1:1 utilization rate for 2021 was 56.6% and the BCBA/BMC Supervision rate for 2021 was 50.4%. The incentive payout for year 2021 was \$621,980.28.
- For 2021, metric percentages were calculated by looking at authorizations completed in 2021. Due to the limitations of utilizing 6-month authorization claims data with services still occurring, the same logic was applied to the 2022 program year.

Program Barriers

- The supervision metric addressed a concern since the start of CalOptima Health's ABA program. At that time, CalOptima Health met with ABA provider groups, and it was agreed to phase out the mid-tier level (BMAs and BCaBAs) within a one-year period. Approximately 50% of supervisions were conducted by the mid-tier level supervisors, which all providers agreed was not ideal.
- The rationale for phasing out mid-tier level supervisors was to raise the overall quality of care provided to members, align our approach with commercial insurance plans and the Regional Center of Orange County. This did not happen as quickly as was expected, perhaps due to the unexpected increase in the members receiving ABA.

Opportunities for Improvement

The program will end December 31, 2022. For 2022, the metrics performance will be evaluated, reported and ABA provider groups incentive payments will be issued in Q2 2023.



Behavioral Health Integration Incentive Program (BHIIP)

DHCS initiated a statewide BHIIP funded under Proposition 56 (excise tax rate increase on cigarettes and tobacco products). The primary objectives of the program were to incentivize MCPs to improve physical and behavioral health outcomes, care delivery efficiency and patient experience, and to establish or expand fully integrated care in their network. CalOptima Health summoned interested network provider groups to complete a BHIIP application identifying which of the six DHCS-approved project/project options they would choose to build an infrastructure to meet the objectives of the program. CalOptima Health submitted the applications to DHCS, and seven provider groups representing Federally Qualified Health Centers (FQHCs) and a behavioral health provider were approved by DHCS to participate in the program. The BHIIP was targeted to begin on April 1, 2020, however, due to COVID-19, the program’s start date was delayed. In November 2020, DHCS announced that CalOptima Health had been approved to implement its BHIIP starting January 1, 2021, and continue through December 31, 2022. CalOptima Health’s responsibility is/was to oversee the provider groups’ project performance and issuance of the incentive payments for their project’s completed milestones. CalOptima Health continues to be eligible to earn a total incentive payment of up to \$13.2 million. This amount includes:

- \$2.5 million earnable once the approved selected provider groups signed their Memorandums of Understanding (MOUs)
- \$5.3 million earnable for achievement of Project Milestones in Program Year 1 (January 1, 2021–December 31, 2021)
- \$5.3 million earnable for achievement of Project Milestones in Program Year 2 (January 1, 2022–December 31, 2022)

BHIIP Project Options

a. Basic Behavioral Health Integration (Project Option Identifier 3.1)

- **Population Goal** — Improve evidence-based medical and behavioral health integration practices with a primary care, specialty care or behavioral health provider’s office or clinic. This package is best suited for practices that are new to behavioral health integration.

- b. Maternal Access to Mental Health and Substance Use Disorder (SUD) Screening and Treatment (Project Option Identifier 3.2)
 - Population Goal — Increase prenatal and postpartum access to mental health and substance use disorder screening and treatment.
- c. Medication Management for Beneficiaries with Co-Occurring Chronic Medical and Behavioral Diagnoses (Project Option Identifier 3.3)
 - Population Goal — Improve evidence-based behavioral health prescribing and management of psychotropic, opioid use disorder (OUD), and alcohol use disorder medications.
- d. Diabetes Screening and Treatment for People with Serious Mental Illness (SMI) (Project Option Identifier 3.4)
 - Population Goal — Improve health indicators for patients with both diabetes and serious mental illness.
- e. Improving Follow-Up After Hospitalization for Mental Illness (Project Option Identifier 3.5)
 - Population Goal — Improve timely follow up after hospitalization for mental illness.
- f. Improving Follow-Up After Emergency Department Visit for Behavioral Health Diagnosis (Project Option Identifier 3.6)
 - Population Goal — Improve timely follow-up after emergency department visit for mental illness and substance use disorder.

3. CalOptima Network Provider Groups Approved by DHCS to Participate in the BHIP

- Families Together of Orange County
- KCS Health Center
- Providence St. Joseph Heritage Healthcare
- North Orange County Regional Health Foundation
- Share Our Selves
- Southland Integrated Services Inc.
- Harbor Psychiatry and Mental Health

4. CalOptima Provider Groups and Approved Selected Project Option(s)

Provider Group	Project Options					
	3.1	3.2	3.3	3.4	3.5	3.6
Families Together of Orange County		X	X	X		
Harbor Psychiatry and Mental Health					X	
KCS Health Center			X			X
North Orange County Regional Health Foundation	X					
Providence St. Joseph Heritage Healthcare (#225)	X					
Share Our Selves	X					
Southland Integrated Services Inc.	X			X	X	

Findings

- Due to the delayed start of BHIIP, provider groups were not able to establish a 2020 baseline prior to the start of the program. CalOptima Health received approval from DHCS to have Program Year 1 2021 act as the baseline year and Program Year 2 2022 to act as the measurement year.
- As of Q3 2022, six of the seven provider groups continue to participate in the program and are submitting their project milestones and supporting documentation quarterly as directed.
- By Q2 2022, CalOptima Health has invoiced and received payments in the amount of \$5.2 million (97% of the eligible funding) from DHCS for Program Year 1 2021 and \$2.3 million for Program Year 2 2022. These payments are used to incentivize the provider groups for completing their quarterly milestones as outlined in their MOUs.
- Due March 31, 2023, CalOptima Health will submit an annual report to DHCS showing the program performance measure results for the 2022 measurement year.

Analysis

- Each BHIIP provider group is required to submit a quarterly milestone reporting template listing the projects anticipated quarterly milestones and its associated payment as identified in their MOU(s). The provider group must provide documentation supporting the milestone's completion.
- Milestone completion rate for Program Year 1 — 91%

Barriers

Due to the delayed start of BHIIP, during late 2021, one of the provider groups was unable to establish the required infrastructure to support their selected project, therefore, they were unable to complete the project's quarterly milestones and opted out of the program per DHCS guidance.

Opportunities for Improvement

The program ends December 31, 2022; however, the provider groups are encouraged to maintain the enhancements, health programs and patient experience activities they have deployed during the BHIIP operations duration.



Student Behavioral Health Incentive Program (SBHIP)

As a component of the Child and Youth Behavioral Health Initiative (CYBHI) and in accordance with State law AB 133, Welfare & Institutions Code Section 5961.3, DHCS designed the SBHIP to support early identification and treatment through school-affiliated behavioral health services and reduce progression to serious mental illness and substance use disorders (SUDs). The program has a statewide funding allocation of \$389 million designated over a three-year period January 1, 2022–December 31, 2024. The program will provide incentive payments when SBHIP goals and metrics are met by CalOptima Health. Increasing the coordination among Local Education Agencies (LEAs), behavioral health community services and the county mental health plan agency will significantly impact the delivery systems.

The SBHIP goals and metrics are associated with targeted interventions approved by DHCS to increase access for preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for TK–12 children in public schools. Developing partnerships between LEAs and community resources will create a comprehensive and continuous system of care for Medi-Cal students to access the entire scope of available benefits consistent with the national movement of increasing access to Medicaid services in schools.

SBHIP Goals

- Break down silos and improve coordination of child and adolescent student behavioral health services through increased communication with schools, school-affiliated programs, managed care providers, counties and mental health providers.
- Increase the number of TK–12 students enrolled in Medi-Cal receiving behavioral health services through schools, school-affiliated providers, county behavioral health departments and county offices of education.
- Increase non-specialty services on or near school campuses.
- Address health equity gaps, inequalities and disparities in access to behavioral health services.

SBHIP Performance Outcome Metrics

- a. Performance Outcome Metric #1: Increase access to behavioral health services (capacity, infrastructure, sustainability, behavioral health service) for Medi-Cal beneficiaries on or near campus
- b. Performance Outcome Metric #2: Increase access to behavioral health services (capacity, infrastructure, sustainability, behavioral health service) for Medi-Cal beneficiaries provided by school-affiliated behavioral health providers

SBHIP Partners

All 29 Orange County school districts will be participating in SBHIP.

SBHIP Targeted Interventions

- Behavior Health Screenings and Referrals: Enhance Adverse Childhood Experiences and other age and developmentally appropriate behavioral health screenings to be performed on or near school campuses, and build out referral processes in schools (completed by behavioral health provider), including when positive screenings occur, providers taking immediate steps, including providing brief interventions (e.g., motivational interviewing techniques) on or near school campuses and ensuring access or referral to further evaluation and evidence-based treatment, when necessary.
- Building Stronger Partnerships to Increase Access to Medi-Cal Services: Build stronger partnerships between schools, MCPs and county behavioral health plans so students have greater access to Medi-Cal covered services. This may include providing for technical assistance, training, toolkits, and/or learning networks for schools to build new or expand capacity of Medi-Cal services for students, integrate local resources, implement proven practices, ensure equitable care and drive continuous improvement.
- Technical Assistance Support for Contracts: Medi-Cal managed care plans execute contracts with county behavioral health departments and/or schools to provide preventive, early intervention and behavioral health services. It is expected that this targeted intervention would go above and beyond the MOU requirement.
- Technology Enhancements for Behavioral Health Services: Implement information technology and systems for cross-system management, policy evaluation, referral, coordination, data exchange, and/or billing of health services between the school and the MCP and county behavioral health department.

PSBHIP Funding Allocation and Targeted Intervention Incentive Payments

- DHCS has allocated \$25 million to Orange County, representing 29 LEA/school districts within the county. Incentive payments will be dispersed by DHCS based on the completion of all DHCS SBHIP requirements.
- CalOptima Health may earn up to 20% of the maximum allocation for each targeted intervention. The remaining 20% may be earned for one additional targeted intervention or be divided among the targeted interventions as deemed appropriate by the MCP.
- Each targeted intervention is capped at 40% of the maximum allocated.

Program Year 1 – 2022: Required Program Deliverables and Due Dates

Deliverable	Due Date	Description
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Needs Assessment Package	12/31/2022	Stakeholder Meetings Attestation Data Collection Strategy Needs Assessment Template LEA and Community Resource Map LEA and External Referral Process
Project Plans	12/31/2022	Project Plan(s) outlined for each Targeted Intervention(s).
Receive funding allocation for approved 2022 deliverables	04/2023	Needs Assessment: Up to 50% of Assessment allocation Project Plan: 50% of the Targeted Intervention allocation



Performance Outcomes

Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)

Cervical Cancer Screening (CCS)

A hybrid HEDIS¹ and MCAS² measure, Cervical Cancer Screening (CCS) measures the percentage of women ages 21–64 who received one or more screening tests for cervical cancer during or within the three years prior to the measurement year, or five years for women ages 30–64 with HPV co-testing.

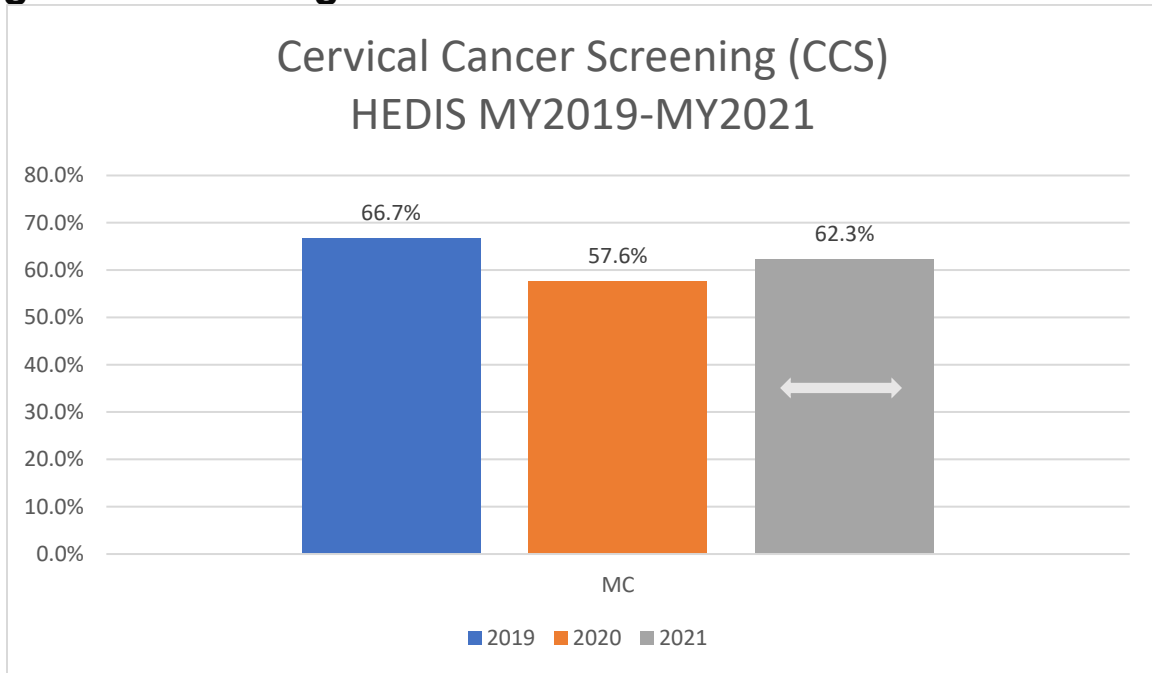
Interventions

The 2021 CCS member health reward was promoted through the CalOptima Health website, member newsletters, electronic newsletters and provider newsletters.

Findings

Figure 1 below compares CalOptima Health Medi-Cal CCS rates for HEDIS MY 2019–MY2021. The rate increased by 4.7 percentage points from the prior year but there is statistically no difference between MY 2020 to MY 2021. The rate met the minimum performance level (MPL) and the internal goal of 59.12% by 3.2 percentage points (Table 1).

CCS Figure 1: Trending HEDIS Rates MY 2019–MY 2021 Results: MC



CCS hybrid rate shown. ↓↑ statistically higher or lower ↔ statistically no difference

CCS Table 1: CCS Measure Medi-Cal Percentiles, Goal and Report Requirements

HEDIS Measure	Percentile, Goal, Reporting Requirements					
	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Goal Met/Not Met	Reporting Requirements**
Cervical Cancer Screening (CCS)	54.01%	61.08%	67.99%	59.12%	Met	HPR, *MPL, P4V

*MPL met ++ measure triple weighted for Health Plan Ratings **HPR is health plan ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value.

Table 2 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator for the administrative HEDIS MY 2021 rate (n=170,402) population. Race/Ethnicity rates that fell below MPL of 59.12% for Hispanic, White, No Response, Other, Korean, Black, Filipino, Chinese, and Asian/Pacific Islander population. The lowest rate was for members that identified as Other (39.86%) followed by members who identified as Korean (42.27%). Vietnamese members have the highest rates at 65.65% and met the 75th percentile (63.66%) followed by Hispanic members 57.05%.

CCS Table 2: Medi-Cal Administrative HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY 2021	Hispanic	White	Vietnamese	No Response	Other	Korean	Black	Filipino	Chinese	Asian/Pacific Islander
Numerator	34,256	17,023	17,359	13,238	2,786	1,797	1,582	1,455	975	963
Denominator	60,041	34,961	26,443	23,966	6,989	4,251	3,150	2,947	2,245	2,036
Rate	57.05%	48.69%	65.65%	55.24%	39.86%	42.27%	50.22%	49.37%	43.43%	47.30%
KPI (QC 50th %= 59.12%)*	Not Met	Not Met	Met 75th	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met

Top 10 race/ethnicity by denominator count. *Medicaid Quality Compass MY2020 50th percentile.

Table 3 examines rates by age groups for the administrative HEDIS MY 2021 rate (n= 170,402) population. Age groups that fell below MPL of 59.12% were 21–30, 31–44 and 60–64. The lowest rate was for members in age category 21–30 (45.79%) followed by members in age category 60–64. Members in age category 45–59 have the highest rates at 60.07% and met 50th percentile (59.12%)

CCS Table 3: Medi-Cal Administrative HEDIS MY 2021 Rate by Age

Admin	Age Group				
HEDIS MY 2021	21–30	31–44	45–59	60–64	Grand Total
Numerator	20,368	31,397	31,718	9,526	93,009
Denominator	44,482	55,411	52,801	17,708	170,402
Rate	45.79%	56.66%	60.07%	53.79%	54.58%
KPI (QC 50th %= 59.12%)*	Not Met	Not Met	Met 50th	Not Met	Not Met

Medi-Cal CCS administrative rate by age group. *Medicaid Quality Compass MY 2020 50th percentile.

a. CCS Member Health Reward

- CCS health reward mailing was not conducted for MY 2021. There was a decrease in the number of member health rewards submissions from 1,165 in MY 2020 to 555 in MY 2021 (Table 4).

CCS Table 4: 2021 Cervical Cancer Screening Member Health Reward

Forms Received	HEDIS Qualified	HEDIS Denominator*	HEDIS Eligible Participation Rate
555	458	169,047	0.27%

The HEDIS administrative denominator was used to calculate the participation rate. * Medi-Cal HEDIS denominator dual eligible beneficiaries are removed.

Analysis

There was a total of 555 CCS health reward submissions with 533 approved to receive the \$25 gift card. Of the 555 health reward submissions, 458 CCS health reward form submissions remained in the CCS measure denominator and 445 were approved to receive the gift card. The health reward participation rate for the HEDIS MY 2021 CCS measure was 0.27% (458/169,047).

Barriers

- Members may not be able to complete cervical cancer screening because of lack of general knowledge about the test itself or the physical or psychological discomfort associated with the screening.
- Members may also have a fear about the test and test results and avoid getting screened.
- Members may not be aware of the frequency of screening especially after having a previous screening with a negative result. Approximately 12% of members who remained unscreened at the end of MY 2021 had a history of previously completing a cervical cancer screening.
- There was no direct mailing to members about the CCS health reward mailing in MY 2021, which resulted in a low participation rate.
- The member health reward form requires a signed/stamped attestation by the provider performing the CCS. This may prevent some members from participating in the CCS health reward.
- Providers may be unaware of members who are due for CCS.
- Provider offices may not have the capability of in-office screening and must refer members to specialists.
- Continued hesitancy of going into the medical office for preventive screenings like CCS continued due to COVID-19 pandemic, which may have also affected member submissions of the health reward forms.

5. Opportunities for Improvement

CCS Table 5: MY 2022 Medi-Cal CCS Prospective Rate Results

September 2021		September 2022		
Denominator	Rate	Denominator	Numerator	Rate
172,335	52.48%	191,605	98,507	51.41%

Claims/Encounters processed through September 2022

- As of September 2022, the CCS prospective rate was 51.41%, which is lower than the September 2021 prospective rate of 52.48% by 1.07 percentage points (Table 5).
- The hybrid CCS measure reached MPL in MY 2021. The new national benchmark was released in September 2022 and the MPL has decreased from 59.12% to 57.64%. Opportunity remains to increase the hybrid CCS measure to the pre-pandemic level of MY 2019 of 66.7%. The measure should continue to be a high priority for quality initiatives and member engagement.
- In MY 2022, member engagement initiatives that were placed on hold, due to the COVID-19 pandemic and Telephone Consumer Protection Act (TCPA), resumed. These included member reminders and enhanced promotion of the CCS member health rewards. Multiple modes of communication, including direct member mailing, Interactive Voice Response (IVR) campaigns, passive social media posts, and a mobile texting campaign, were performed. The multiple methods of communication will continue in MY 2023.
- At the conclusion of MY 2021, the Population Health Management department identified the top cities and languages for unscreened members who were due for CCS. In collaboration with the

Communications department, this information was used in MY 2022 to develop a digital ad campaign and paid social media campaign in English, Spanish and Vietnamese. These campaigns will continue in MY 2023.

- Additional mass media efforts that began in MY 2022 and will continue for MY 2023. They included radio ads in Spanish and Vietnamese and television ad campaigns on Public Broadcasting Service (PBS).
- Messaging will be more targeted for members previously screened and members will be provided with health education about the frequency of each screening.
- Target higher-risk members with health inequities caused by age or race. For the Medi-Cal population, when examining the top three race/ethnicity groups, White members have the lowest rate of screening as compared with Hispanic and Vietnamese members. In addition, we see that women ages 21–30 are less likely to be screened than women ages 31–44 and women ages 45–59.
- Continue the CCS member health reward through 2023 to allow more time for members to become aware of the reward, and to improve promotion and member engagement efforts.
- Promote the CCS health reward among providers to increase participation in the program and motivate members to schedule and complete their cervical cancer screening. Have greater direct collaboration with CCN providers and health network quality teams.
- CalOptima Health will retain CCS on the 2023 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization by conducting multicomponent interventions to increase demand for cervical cancer screening.

Colorectal Cancer Screening (COL)

A hybrid HEDIS measure, Colorectal Cancer Screening (COL), measures the percentage of members ages 50–75 who had appropriate screening for colorectal cancer, which includes either fecal occult blood test (FOBT) during the measurement year, a flexible sigmoidoscopy during the past five years, or a colonoscopy within the past 10 years.

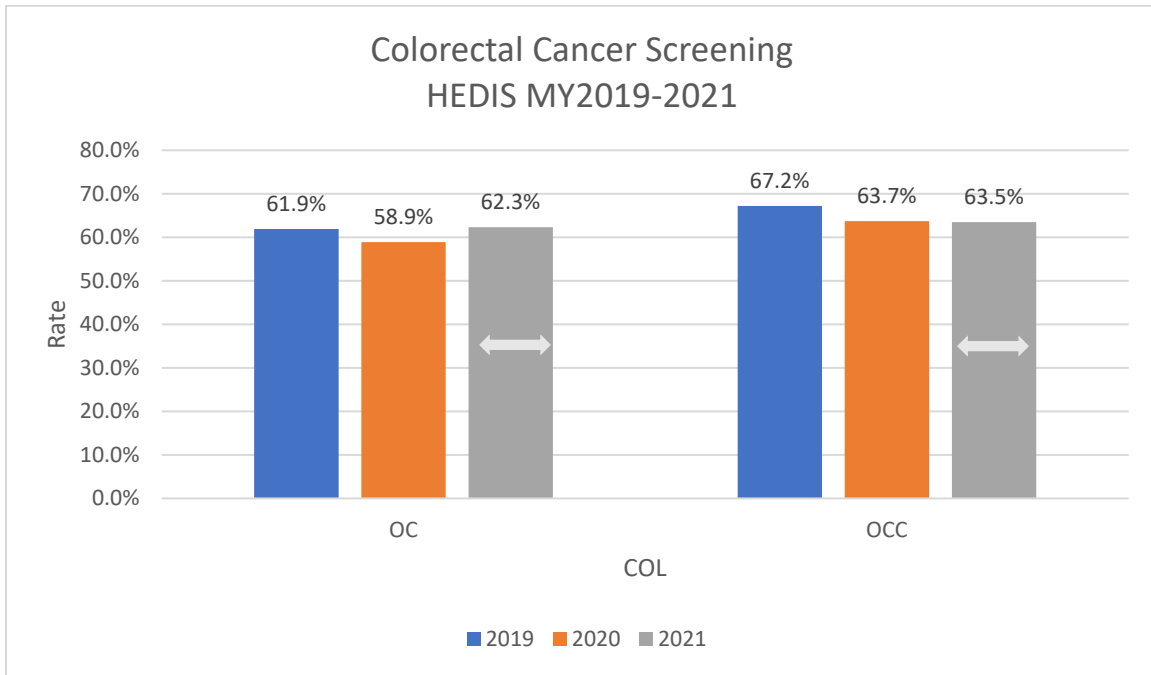
Interventions

From 1/1/2021 to 12/31/2021, CalOptima Health offered a \$50 gift card to eligible CalOptima Health OneCare and OneCare Connect members who completed a sigmoidoscopy or colonoscopy between January to December 2021. The 2021 COL member health reward was promoted through the CalOptima Health website, member newsletters, electronic newsletters, provider newsletters and member mailings.

Findings

Figure 1 below compares CalOptima Health COL rates for HEDIS MY 2019–MY 2021 by line of business. The MY 2021 COL hybrid rate for OneCare (OC) was 62.3% (Figure 1). The rate increased by 3.4 percentage points from the prior year but was statistically no difference between MY 2020 to MY 2021. The rate met the projected 3-Star and the internal goal of 62% by 0.3 percentage points (Table 1). The MY 2021 rate for OneCare Connect (OCC) was 63.5%. The rate decreased by 0.2 percentage points from the prior year but was statistically no different between MY 2020 to MY 2021. The rate met the projected 3-Star and the internal goal of 62% by 1.5 percentage points (Table 1).

COL Figure 1: Trending HEDIS Rates MY 2019–MY2021 Results: OC, OCC



COL Hybrid Rate Shown ↓↑ statistically higher or lower ↔ statistically no difference

COL Table 1: COL Measure OC and OCC Percentiles, Goal and Report Requirements

HEDIS Measure	Percentile, Goal, Reporting Requirements					
	HEDIS MY2021	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Goal Met/Not Met
OC Colorectal Cancer Screening (COL)	62%	71%	80%	62%	Met	Star
OCC Colorectal Cancer Screening (COL)	62%	71%	80%	62%	Met	Star, P4V

**Star cut points are previous year

OneCare: Table 2 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator for the administrative OneCare HEDIS MY 2021 rate (n=1,338) population. Race/ethnicity rates that fell below the CMC MY 2020 Quality Compass 50th percentile of 72.02% for White, Hispanic, No response, Vietnamese, Other, Filipino, Black, and Asian Indian members. The lowest rate is for members that identified as Other (40.00%) but this group has a low denominator count. The lowest rate with substantial denominator count (n > 100) is for Vietnamese members (44.53%). Asian/Pacific Islander members have the highest rate at 84.62% followed by Chinese members at 80.00% but both groups have a low denominator count. The highest rate with substantial denominator count (n>100) is for members who identified as No response (57.54%) followed by White members (55.08%).

COL Table 2: OneCare Administrative HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY 2021	White	Hispanic	No Response	Vietnamese	Other	Filipino	Black	Asian/Pacific Islander	Asian Indian	Chinese
Numerator	271	211	103	61	14	19	13	11	6	8
Denominator	492	392	179	137	35	31	20	13	10	10
HEDIS Rates	55.08%	53.83%	57.54%	44.53%	40.00%	61.29%	65.00%	84.62%	60.00%	80.00%
KPI (QC 50th % 72.02%) *	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Met 90th	Not Met	Met 75th

Top 10 race/ethnicity by denominator count. *CMC benchmark are from Quality Compass MY 2020 50th percentile

OneCare Connect: Table 3 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator for the administrative OneCare Connect HEDIS MY 2021 rate (n= 6,439) population. Race/ethnicity rates that fell below the CMC MY 2020 Quality Compass 50th percentile of 72.02% for Hispanic, White, No response, Vietnamese, Other, Asian/Pacific Islander, Black, Filipino and Unknown. The lowest rate was for No response (77.59%) followed by Asian/Pacific Islander members (52.84%). Chinese members have the highest rate at 78.69% followed by members identified as Unknown at 62.20% but both groups have a low denominator count. The highest rate with substantial denominator count (n>100) is for members that identified as Filipino (60.15%) followed by Hispanic members (59.10%).

COL Table 3: OneCare Connect Total HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY 2021	Hispanic	White	No Response	Vietnamese	Other	Asian/Pacific Islander	Black	Filipino	Unknown	Chinese
Numerator	1,075	858	566	379	249	149	79	80	51	45
Denominator	1,819	1,578	1,079	708	429	282	140	133	82	58
Rate	59.10%	54.37%	52.46%	53.53%	58.04%	52.84%	56.43%	60.15%	62.20%	77.59%
KPI (QC 50th % 72.02%) *	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Met 75th

Top 10 race/ethnicity by denominator count. *CMC benchmark are from Quality Compass MY 2020 50th percentile

OneCare: Table 4 examines age group rates for the administrative OneCare HEDIS MY 2021 rate (n=1,338). All age groups fell below the CMC MY 2020 Quality Compass 50th percentile of 72.02%. The lowest rate was for members in age category 75–99 (50.00%) but the category had a low denominator count. The lowest rate with substantial denominator count (n>100) is for age category 65–74 (52.85%). Members in age category 60–64 have the highest rates at 58.60%.

COL Table 4: OneCare Administrative HEDIS MY 2021 Rate by Age

Admin	Age Group				
HEDIS MY 2021	50–59	60–64	65–74	75–99	Grand Total
Numerator	135	109	482	1	727
Denominator	238	186	912	2	1,338
Rate	56.72%	58.60%	52.85%	50.00%	54.33%
KPI (QC 50th % 72.02%) *	Not Met	Not Met	Not Met	Not Met	Not Met

OneCare COL administrative rate by age group. *CMC benchmark are from Quality Compass MY 2020 50th percentile

OneCare Connect: Table 5 examines age groups rates for the administrative OneCare Connect HEDIS MY 2021 rate (n=6,439). All age groups fell below the CMC MY 2020 Quality Compass 50th percentile of 72.02%. The lowest rate was for members in age category 50–59 (51.39%). Members in age category 60–64 have the highest rate at 57.84%.

COL Table 5: OneCare Connect Administrative HEDIS MY 2021 Rate by Age

Admin	Age Group				
HEDIS MY 2021	50–59	60–64	65–74	75–99	Grand Total
Numerator	371	358	2,671	205	3,605
Denominator	722	619	4,743	355	6,439
Rate	51.39%	57.84%	56.31%	57.75%	55.99%
KPI (QC 50th % 72.02%) *	Not Met	Not Met	Not Met	Not Met	Not Met

Medi-Cal CCS administrative rate by age group. *CMC benchmark are from Quality Compass MY 2020 50th percentile

OneCare: Table 6 examines gender group rates for the administrative OneCare HEDIS MY 2021 rate (n=1,338). All gender groups fell below the CMC MY 2020 Quality Compass 50th percentile of 72.02%. The lowest rate was the male category (52.89%).

COL Table 6: OneCare Administrative HEDIS MY 2021 Rate by Gender

Admin	Gender		
HEDIS MY 2021	Female	Male	Grand Total
Numerator	398	329	727
Denominator	716	622	1,338
Rate	55.59%	52.89%	54.33%
KPI (QC 50th % 72.02%) *	Not Met	Not Met	Not Met

Medi-Cal CCS administrative rate by age group. *CMC benchmark are from Quality Compass MY 2020 50th percentile

OneCare Connect: Table 7 examines gender group rates for the administrative OneCare Connect HEDIS MY 2021 rate (n=6,439). All gender groups fell below the CMC MY 2020 Quality Compass 50th percentile of 72.02%. The lowest rate was the male category (54.59%).

COL Table 7: OneCare Connect Administrative HEDIS MY 2021 Rate by Gender

Admin	Gender		
HEDIS MY 2021	Female	Male	Grand Total
Numerator	1,986	1,619	3,605
Denominator	3,473	2,966	6,439
Rate	57.18%	54.59%	55.99%
KPI (QC 50th % 72.02%) *	Not Met	Not Met	Not Met

Medi-Cal CCS administrative rate by age group. *CMC benchmark are from Quality Compass MY 2020 50th percentile

a. COL Member Health Reward

The COL health reward mailing occurred in June 2021 to 310 OC HEDIS unscreened members and to 2,042 OCC HEDIS unscreened members who opted to receive CalOptima Health member mailing (Table 8). There was an increase in the number of member health rewards submissions from 0 in MY 2020 to 5 in MY 2021 for OC and 30 in MY 2020 to 42 in MY 2021 for OCC.

COL Table 8: MY 2021 Colorectal Cancer Screening Health Reward Mailing Campaign

Line of Business	Forms Mailed	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
OneCare	310	5	4	1,338	0.30%
OneCare Connect	2,042	42	35	6,439	0.54%

The HEDIS administrative denominator was used to calculate the participation rate.

Analysis

a. OneCare

- i. In June 2021, of the 310 members who were mailed the health reward form, 246 members remained in the denominator for the administrative HEDIS MY 2021 COL measure. Sixty-eight (68) members completed a COL screening after the mail drop date with a rate of 5.08% (68/1,338). Of the 5 COL health reward submissions, 4 COL health reward form submissions remained in the COL measure denominator. The health reward participation rate for the HEDIS MY 2021 COL measure was 0.30% (4/1,338).

b. OneCare Connect

- i. In June 2021, of the 2,042 members who were mailed the health reward form, 1,825 members remained in the denominator for the administrative HEDIS MY 2021 COL measure. A total of 410 members completed a COL screening after the mail drop date with a rate of 6.36% (410/6,439). Of the 41 COL health reward submissions, 35 COL health reward form submissions remained in the COL measure denominator. The health reward participation rate for the HEDIS MY 2021 COL measure was 0.54% (35/6,439).

Barriers

- Members may not complete their colorectal cancer screening because of lack of general knowledge about the test itself or the physical or psychological discomfort associated with the screening.
- Members may also have a fear about the test and test results and avoid getting screened.
- Members are not aware of the multiple screening options that are available to them and the frequency of screening for each option. CalOptima Health currently does not offer member health incentive for completing colorectal cancer screening via a home testing kit, requiring the member to see a provider to get a test ordered/performed.
- Members may not be aware of the frequency of each screening type especially after having a previous screening with a negative result. For example, approximately 30% of OneCare members who remained unscreened at the end of 2021 had a history of previously completing a colorectal cancer screening.
- The member health reward form requires a signed/stamped attestation by the provider. This may prevent some members from participating in the program.
- The PCP may be unaware of assigned members who are due for COL screenings. PCP offices must refer members to a specialist to complete screening.
- Continued hesitancy of going into medical office for preventive screening like COL continues due to the COVID-19 pandemic, which may have affected member submission of the health reward forms.

Opportunities for Improvement

COL Table 9: MY 2022 OC and OCC COL Prospective Rate Results

Line of Business	September 2021		September 2022		
	Denominator	Rate	Denominator	Numerator	Rate
OneCare	1,280	47.50%	1,973	97391	46.68%
OneCare Connect	6,561	50.10%	6,790	3,566	52.52%

Claims/Encounters processed through September 2022

- As of September 2022, the COL OneCare prospective rate is at 46.68%, which is lower than the September 2021 prospective rate of 47.50% by 0.82 percentage points. The COL OneCare Connect prospective rate is at 52.52%, which is higher than the September 2021 rate of 50.10% by 2.42 percentage points (Table 9). On December 31, 2022, the OneCare Connect plan will end and members will transition to OneCare, which may impact rates going forward.
- The hybrid COL measure reached the projected 3 Star rating but did not meet the CMC Quality Compass MY 2020 50th percentile for both OneCare and OneCare Connect. The new national benchmark was released in October 2022 and the 50th percentile has decreased from 72.02% to 71.78%. Opportunity remains to increase the Hybrid COL measure above the pre-pandemic level of MY 2019 of 61.9% for OneCare and 67.2% for OneCare Connect. The COL measure will change in MY 2024 to only reporting via electronic clinical data systems (ECDS). The measure will continue to be a high priority for quality initiatives and member engagement.
- In MY 2022, CalOptima Health resumed member engagement initiatives that were placed on hold due to COVID-19 pandemic and Telephone Consumer Protection Act (TCPA). Member reminders and enhanced participation in the COL member health reward were conducted. Multiple modes of communication were used, including direct member mailing, IVR campaigns and passive social media campaigns. The multi-modes of communication will continue in MY 2023 with the addition of a texting campaign for the Medi-Cal population as the Medicaid product line was added to the administrative data collection method and the age range was revised from ages 50–75 to ages 45–75 in MY 2022.
- At the conclusion of MY 2021, the Population Health Management department identified the top cities and languages for unscreened members due for COL. In collaboration with the Communication department, this information was used in MY 2022 to develop a digital and print ad campaign and paid social media campaign in English, Spanish and Vietnamese. These campaigns will continue in MY 2023.
- Messaging could be more targeted to members who were previously screened. In the messaging, CalOptima Health will include information about the screening options and frequency.
- Target higher-risk members with health inequities caused by age, race or gender. In MY 2022, HEDIS added new data element tables for race and ethnicity stratification reporting to the COL measure. CalOptima Health will target higher-risk members due to health inequities caused by age or ethnicity. For OC and OCC populations, when examining ethnicity, White members had the lowest rate of screening when compared with other ethnic groups. In addition, members ages 65–75 are less likely to be screened than members ages 60–64.
- CalOptima Health will continue the COL member health reward through 2023 to allow more time for members to be aware of the health reward offered. In MY 2022, new rewards and incentive program regulations from CMS require offering rewards uniformly and without discrimination to all enrollees who qualify for the incentive's services; therefore, HEDIS measure age eligibility was removed from the health reward for OneCare and OneCare Connect.
- CalOptima Health will promote the COL health reward among providers to increase participation in the program and motivate members to schedule and complete their colorectal cancer screening. CalOptima Health will seek greater collaboration with CCN providers and health network quality teams.
- CalOptima Health will retain COL for the 2023 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization through multimedia awareness messaging and communication.

Breast Cancer Screening (BCS)

The administrative HEDIS and MCAS measure, Breast Cancer Screening (BCS), measures the percentage of members who are women in the age range of 50–74 years, and have received one or more mammograms on or between October 1 two years prior to the measurement year and December 31 of the measurement year. Figure 1 below compares CalOptima Health BCS rates for HEDIS MY 2019–MY2021 by line of business.

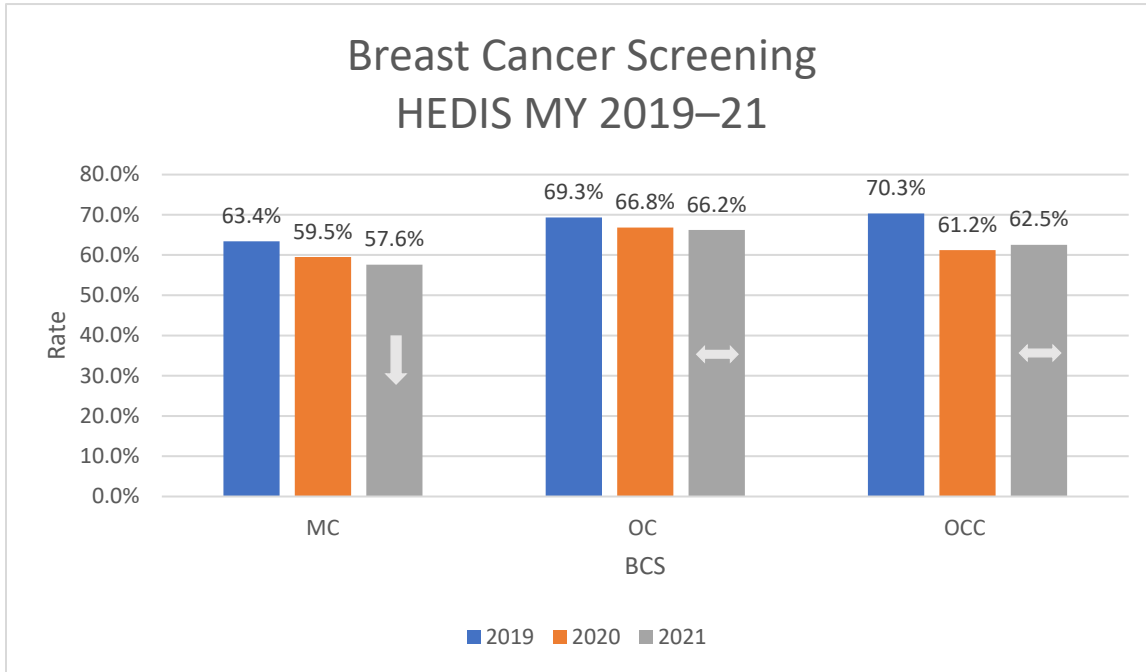
Interventions

From 1/1/2021 to 12/31/2021, CalOptima Health offered a \$25 gift to eligible Medi-Cal members ages 50–74 and OneCare and OneCare Connect members who completed a breast cancer screening mammogram between January to December 2021. The 2021 BCS member health reward program was promoted through the CalOptima Health website, member newsletters, electronic newsletters, provider newsletters and member mailings.

Findings

- a. Medi-Cal: CalOptima Health’s HEDIS MY 2021 BCS rate for Medi-Cal (MC) was 57.6% (Figure 1). The rate decreased by 1.9 percentage points from the prior year and was a statistically significant decrease between MY 2020 to MY 2021. The rate met the minimum performance level (MPL) of 53.93% but did not meet the internal goal of 61.24% (Table 1).
- b. OneCare: CalOptima Health’s HEDIS MY 2021 BCS administrative rate for OneCare (OC) was 66.2% (Figure 1). The rate decreased by 0.6 percentage points from the prior year but there was statistically no difference between MY 2020 to MY 2021. The rate met the projected 3-Star of 61% but did not meet the internal goal of 69% (Table 2).
- c. OneCare Connect: CalOptima Health HEDIS MY 2021 BCS administrative rate for OneCare Connect (OCC) was 62.5% (Figure 1). The rate increased by 1.3 percentage points from the prior year but there was statistically no difference between MY 2020 to MY 2021. The rate met the projected 3-Star of 61% but did not meet the internal goal of 69% (Table 2).

BCS Figure 1: Trending HEDIS Rates MY 2019–21 Results: MC, OC, OCC



BCS Rate Shown ↓ statistically higher or lower ↔ statistically no difference

BCS Table 1: BCS Measure Medi-Cal Percentiles, Goal and Report Requirements

HEDIS Measure	Percentile, Goal, Reporting Requirements					
HEDIS MY 2021	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Goal Met/Not Met	Reporting Requirements**
Breast Cancer Screening (BCS)	51.20%	56.72%	63.77%	61.24%	Not Met	HPR, *MPL, P4V

*MPL met **HPR is health plan ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value

BCS Table 2: BCS Measure OC and OCC Percentiles, Goal and Report Requirements

HEDIS Measure	Percentile, Goal, Reporting Requirements					
HEDIS MY 2021	Projected 3-Star**	Projected 4-Star**	Projected 5-Star**	Goal	Goal Met/Not Met	Reporting Requirements**
OC Breast Cancer Screening (BCS)	61%	69%	76%	69%	Not Met	Star
OCC Breast Cancer Screening (BCS)	61%	69%	76%	69%	Not Met	Star, P4V

**Star cut points are previous year

Medi-Cal: Table 3 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator for the administrative Medi-Cal HEDIS MY 2021 rate (n= 43,983) population. Race/Ethnicity rates fell below MPL of 53.93% for White, Other, Chinese and Black population. The lowest rate was for members who identified as Chinese (46.71%) followed by members who identified as Other (47.05%). Vietnamese members have the highest rate at 66.03% followed by Hispanic members 60.94% and met the 90th percentile (63.77%) and the 75th percentile (58.70%), respectively.

BCS Table 3: Medi-Cal Administrative HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2021	<i>Hispanic</i>	<i>Vietnamese</i>	<i>White</i>	<i>No Response</i>	<i>Other</i>	<i>Korean</i>	<i>Filipino</i>	<i>Asian/Pacific Islander</i>	<i>Chinese</i>	<i>Black</i>
Denominator	12,738	10,210	8,666	5,432	1,560	1,212	890	866	775	587
Numerator	7,762	6,742	4,119	3,162	734	663	520	476	362	293
HEDIS Rates	60.94%	66.03%	47.53%	58.21%	47.05%	54.70%	58.43%	54.97%	46.71%	49.91%
KPI (QC 50th % 53.93%)	Met 75th	Met 90th	Not Met	Met 50th	Not Met	Met 50th	Met 50th	Met 50th	Not Met	Not Met

Top 10 race/ethnicity by denominator count. *Medicaid Quality Compass MY2020 50th percentile.

Table 4 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator for the administrative OneCare HEDIS MY 2021 rate (n= 668) population. Race/ethnicity rates that fell below CMC MY 2020 Quality Compass 50th percentile of 70.34% for Hispanic, White, Filipino, Other, Black, Asian Indian and Chinese members. The lowest rate is for Chinese members (50.00%) but this group has a low denominator count (n< 100). The lowest rate with substantial denominator count (n>100) is for White members (58.57%). Asian/Pacific Islander members have the highest rate at 85.71% followed by Vietnamese members at 78.26% but both groups have a low denominator count. The highest rate with substantial denominator count (n>100) is for Hispanic members at 68.89%.

BCS Table 4: OneCare Administrative HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2021	<i>Hispanic</i>	<i>White</i>	<i>No Response</i>	<i>Vietnamese</i>	<i>Filipino</i>	<i>Other</i>	<i>Black</i>	<i>Asian/Pacific Islander</i>	<i>Asian Indian</i>	<i>Chinese</i>
Numerator	155	123	66	54	9	9	6	6	4	2
Denominator	225	210	93	69	17	14	11	7	6	4
HEDIS Rates	68.89%	58.57%	70.97%	78.26%	52.94%	64.29%	54.55%	85.71%	66.67%	50.00%
KPI (QC 50th % 70.34%)	Not Met	Not Met	Met 50th	Met 75th	Not Met	Not Met	Not Met	Met 90th	Not Met	Not Met

Top 10 race/ethnicity by denominator count. *CMC benchmark from Quality Compass MY2020 50th percentile.

OneCare Connect: Table 5 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator for the administrative OneCare Connect HEDIS MY 2021 rate (=3,074) population. Race/ethnicity rates that fell below the CMC MY 2020 Quality Compass 50th percentile of 70.34% for Hispanic, White, No Response, Vietnamese, Other, Asian Pacific Islander, Black and Unknown. The lowest rate is for White members (52.17%) followed by members who did not respond to race/ethnicity (56.47%). Filipino members have the highest rate at 84.51% but this group has a low denominator count (n<100). The highest rate with substantial denominator count (n>100) is for Hispanic members at 69.29%.

BCS Table 5: OneCare Connect Administrative HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY 2021	Hispanic	White	No Response	Vietnamese	Other	Asian/Pacific Islander	Black	Filipino	Unknown	Chinese
Numerator	625	372	310	204	127	85	51	60	31	20
Denominator	902	713	549	299	194	139	73	71	45	27
HEDIS Rates	69.29%	52.17%	56.47%	68.23%	65.46%	61.15%	69.86%	84.51%	68.89%	74.07%
KPI (QC 50th % 70.34%)	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Met 90th	Not Met	Met 50th

Top 10 race/ethnicity by denominator count. *CMC benchmark from Quality Compass MY 2020 50th percentile.

Medi-Cal: Table 6 examines rate by age group for the administrative Medi-Cal HEDIS MY 2021 rate (n=43,983) population. All age groups reached MPL of 53.93%. The lowest rate was for members in age category 65–74 (55.67%) followed by members in age category 50–59 (57.46%). Members in age category 60–64 have the highest rate at 58.81% and met 75th percentile (58.70%).

BCS Table 6: Medi-Cal HEDIS MY 2021 Rate by Age

Admin	Age Group			
HEDIS MY 2021	50–59	60–64	65–74	Grand Total
Numerator	13,063	8,622	3,668	25,353
Denominator	22,734	14,660	6,589	43,983
Rate	57.46%	58.81%	55.67%	57.64%
KPI (QC 50th % 53.93%)*	Met 50th	Met 75th	Met 50th	Met 50th

Medi-Cal BCS rate by age group. *Medicaid Quality Compass MY 2020 50th percentile.

OneCare: Table 7 examines rate by age group for the administrative OneCare HEDIS MY 2021 rate (n= 668) population. Age groups that fell below MPL of 70.34% were 45–59 and 65–74. The lowest rate was for members in age category 65–74 (64.23%) followed by members in age category 50–59. Members in age category 60–64 have the highest rate at 78.16% and met 75th percentile (76.36%).

BCS Table 7: OneCare HEDIS MY 2021 Rate by Age

Admin	Age Group			
	50–59	60–64	65–74	Grand Total
HEDIS MY 2021	50–59	60–64	65–74	Grand Total
Numerator	58	68	316	442
Denominator	89	87	492	668
Rate	65.17%	78.16%	64.23%	66.17%
KPI (QC 50th % 70.34%)*	Not Met	Met 75th	Not Met	Not Met

OneCare BCS rate by age group. *CMC benchmark are from Quality Compass MY 2020 50th percentile

OneCare Connect: Table 8 examines rate by age group for the administrative OneCare Connect HEDIS MY 2021 rate (n= 3,074) population. Age groups that fell below MPL of 70.34% were 45–59, 60–64 and 65–74. The lowest rate was for members in age category 50–59 (53.62%) followed by members in age category 65–74. Members in age category 60–64 have the highest rate at 63.77%.

BCS Table 8: OneCare Connect HEDIS MY 2021 Rate by Age

Admin	Age Group			
	50–59	60–64	65–74	Grand Total
HEDIS MY 2021	50–59	60–64	65–74	Grand Total
Numerator	148	169	1,605	1,922
Denominator	276	265	2,533	3,074
Rate	53.62%	63.77%	63.36%	62.52%
KPI (QC 50th % 70.34%)*	Not Met	Not Met	Not Met	Not Met

OneCare Connect BCS rate by age group. *CMC benchmark are from Quality Compass MY 2020 50th percentile

BCS Health Reward

The BCS health reward mailing occurred in June 2021. The mailing was sent to 222 OC HEDIS unscreened members, 1,785 OCC HEDIS unscreened members, and in November 2021 to 1,069 HEDIS unscreened members that lived within 5 miles from a mobile mammography event location and who opted to receive CalOptima Health member mailings (Table 9). There was a decrease in the number of member health rewards submissions from 681 in MY 2020 to 454 in MY 2021 for MC. There was an increase in the number of member health rewards submissions from 3 in MY 2020 to 10 MY 2021 for OC and 72 in MY 2020 to 87 in MY 2021 for OCC.

BCS Table 9: MY 2021 Breast Cancer Screening Health Reward Mailing Campaign.

Line of Business	Forms Mailed	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
Medi-Cal*	1,069	454	242	40,247	0.60%
OneCare	222	10	10	668	1.50%
OneCare Connect	1,785	87	81	3,074	2.64%

The HEDIS administrative denominator was used to calculate the participation rate. *Medi-Cal HEDIS denominator dual eligible beneficiaries are removed.

Analysis

a. Medi-Cal

In November 2021, of the 1,069 members who were mailed the health reward form, 1,053 members remained in the denominator for the administrative HEDIS MY 2021 BCS measure. Three members completed a breast cancer screening after the mail drop date with a rate of 0.007% (3/40,247). Of the 454 BCS health reward submissions, 242 BCS health reward submissions remained in the BCS measure denominator. The health reward participation rate for the HEDIS MY 2021 BCS measure was 0.60% (242/40,247).

b. OneCare

- i. In June 2021, of the 222 members who were mailed the health reward form, 181 members remained in the denominator for the administrative HEDIS MY 2021 BCS measure. Forty-two members completed a breast cancer screening after the mail drop date with a rate of 6.59% (42/668). Of the 10 BCS health reward submissions, 10 BCS health reward form submissions remained in the BCS measure denominator. The health reward participation rate for the HEDIS MY 2021 BCS measure was 1.50% (10/668).

c. OneCare Connect

- i. In June 2021, of the 1,785 members who were mailed the health reward form, 1,582 remained in the denominator for the administrative HEDIS MY 2021 BCS measure. Two hundred eighty-two members completed a breast cancer screening after the mail drop date with a rate of 9.17% (282/3,074). Of the 87 BCS health reward submissions, 81 BCS health reward form submissions remained in the BCS measure denominator. The health reward participation rate for the HEDIS MY 2021 BCS measure was 2.64% (81/3,074).

Barriers

- Members may not complete their breast cancer screening because of a lack of general knowledge about the test itself or the physical or psychological discomfort associated with the the screening.
- Members may also have a fear about the test and test results and avoid getting screened.
- Members may not be aware of the frequency of screening especially after having a previous screening with a negative result. For example, approximately 30% of Medi-Cal members who were unscreened in 2021 had a history of previously completing a mammogram.

- There was no large direct member mailing to Medi-Cal members about the BCS health reward in MY 2021, which resulted in low participation.
- The member health reward form requires a signed/stamped attestation by the PCP or imaging center, which may prevent some members from participating in the BCS health reward.
- PCPs may be unaware of the assigned members who are due for BCS. Members may be unable to schedule a timely appointment at an imaging center.
- Hesitancy of going into a medical office for preventive screenings continued due to the COVID-19 pandemic, which may have affected member submissions of the health reward forms.

Opportunities for Improvement

BCS Table 10: MY 2022 MC, OC and OCC BCS Prospective Rate Results

Line of Business	September 2021		September 2022		
	Den	Rate	Den	Num	Rate
Medi-Cal	44,821	50.82%	53,514	29,065	54.31%
OneCare	633	57.35%	1,001	616	61.54%
OneCare Connect	3,124	56.47%	3,200	1,983	61.97%

Claims/Encounters processed through September 2022

- As of September 2022, the BCS Medi-Cal prospective rate is 54.31%, which is higher than the September 2021 rate of 50.82% by 3.49 percentage points. The BCS OneCare prospective rate is 61.54%, which is higher than the September 2021 prospective rate of 57.35% by 4.19 percentage points. The BCS OneCare Connect prospective rate is at 61.97% which is higher than the September 2021 rate of 56.47% by 5.50 percentage points (Table 10). On December 31, 2022, the OneCare Connect plan ended and members transitioned to OneCare, which may impact the OneCare rate going forward.
- The BCS measure reached MPL in MY 2021. The new national benchmark for Medi-Cal was released in September 2021 and the MPL has decreased from 53.93% to 50.95%. The BCS measure reached the projected 3-Star rating but did not meet the CMC Quality Compass MY 2020 50th percentile for both OneCare and OneCare Connect. The new national benchmark for Medicare was released in October 2022 and the 50th percentile has decreased from 70.34% to 69.58%. In MY 2023, opportunity remains to increase the BCS measure to the pre-pandemic level of MY 2019 of 63.4% for MC, 69.03% for OC. In MY 2023, the BCS measure will transition to electronic clinical data systems (ECDS) only reporting, and the measure should continue to be a high priority for quality initiatives and member engagement.
- In MY 2022, CalOptima Health resumed member engagement initiatives that were placed on hold due to COVID-19 pandemic and Telephone Consumer Protection Act (TCPA). CalOptima Health conducted member reminders and enhanced participation in the BCS member health reward. Multiple modes of communication including direct member mailing, IVR campaigns, passive social media campaign, as well as the initiation of a texting campaign for Medi-Cal members-only were utilized.
- CalOptima Health also resumed community events in MY 2022. There were collaborative community events with CalOptima Health Community Network (CCN) mobile mammography vendors for the

purpose of informing CCN members of the importance of completing their mammogram. CalOptima Health will continue to promote mobile mammography community events to CCN members in MY2023.

- Mass media efforts, such as a television ad campaign on Public Broadcasting Service (PBS), which began in MY 2022, will continue in MY 2023.
- At the conclusion of MY 2021, the Population Health Management department identified the top cities and languages for unscreened members due for BCS. In collaboration with the Communication department, this information was used in MY 2022 to develop digital and print ad campaigns and paid social media campaigns in English, Spanish and Vietnamese. These campaigns will continue in MY 2023.
- Messaging could be more targeted for members previously screened and the frequency of screening could be provided.
- CalOptima Health will target higher risk members due to health inequities caused by age or race. In MY 2023, HEDIS will add a new data element table for race and ethnicity stratification reporting to the BCS measure. For the MC, OC and OCC population, when looking at the top three race/ethnicity results, White members have the lowest rate of screening when compared with Hispanic and Vietnamese members. In addition, women ages 65–74 are less likely to be screened than women 60–64 years of age.
- CalOptima Health will continue the BCS health reward program through 2023 to allow more time for members to be aware of the health reward offered. In MY 2022, new rewards and incentive program regulation from CMS required to offer rewards uniformly and without discrimination to all enrollees who qualify for the incentive's services. As such, the HEDIS measure age eligibility was removed from the health reward for OneCare and OneCare Connect.
- CalOptima Health will promote the BCS health reward among providers and imaging centers to increase participation in the program. CalOptima Health will seek to improve direct collaboration with CCN providers and health network quality teams.
- CalOptima Health will retain BCS on the 2023 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization through multimedia awareness messaging and communication.



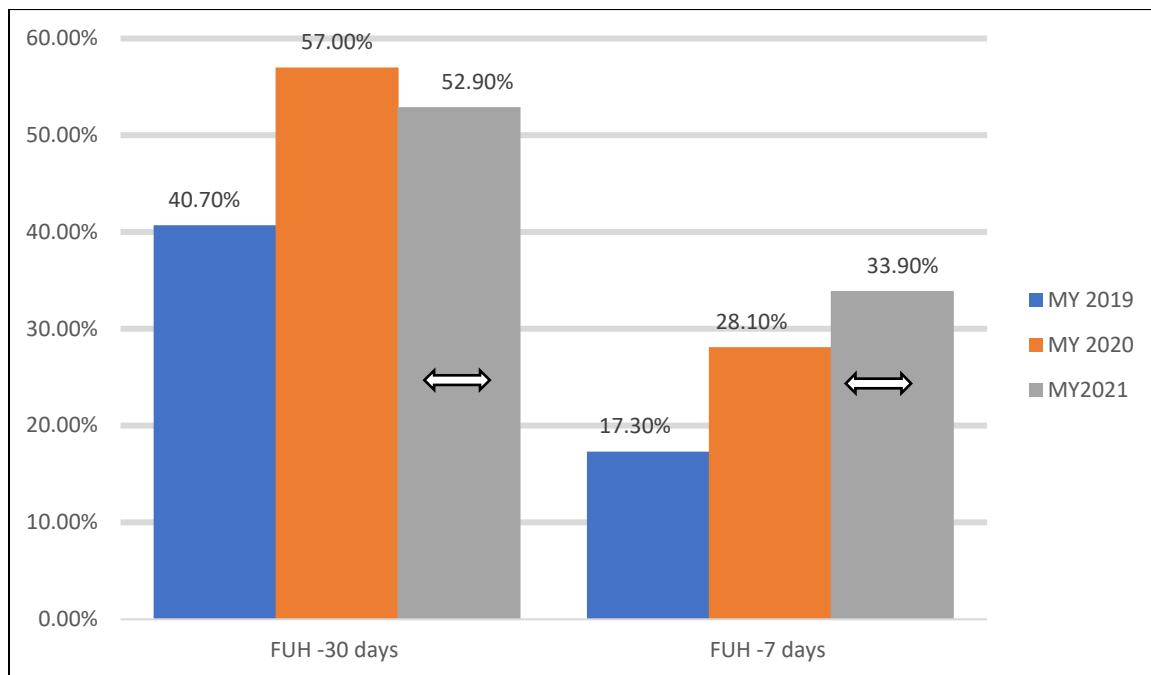
Follow-Up After Hospitalization for Mental Illness Within 7 and 30 Days of Discharge (FUH)

CalOptima Health’s program assesses the percentage of discharges for members ages 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are measured in this program: the percentage of discharges for which the member received follow-up care within 30 days of discharge, as well as the percentage of discharges for the member who received follow-up care within 7 days after discharge.

Interventions

- The Transition of Care Management (TCM) team continued outreach to members post-discharge to coordinate follow-up appointments and address potential barriers (e.g., transportation). The team continued to build relationships with facilities, behavioral health (BH) providers, and county staff that further increased engagement.
- The TCM team continued weekly clinical round meetings to discuss concurrent reviews and internal coordination interventions.
- In January 2021, CalOptima Health launched the Behavioral Health Integration Incentive Program (BHIIP). The DHCS incentive program allowed plan providers to apply for various projects focused on improving health outcomes, care delivery efficiency and patient experience. Two provider groups were selected for the Improving Follow-Up After Hospitalization for Mental Illness project. In June, the Behavioral Health Integration (BHI) quality team attended a learning collaborative meeting. This meeting provided a discussion regarding successes and barriers for the providers focused on follow-up visits post-discharge.

Findings



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-Up After Hospitalization for Mental Illness (FUH) – 30 Days	41.22%	54.93%	73.03%	56.0%*	Withhold
Follow-Up After Hospitalization for Mental Illness (FUH) – 7 Days ++	22.22%	34.67%	50.74%	34.67%	CMS

*=less than 3 - Star or 33rd percentile, ++ measure triple weighted for Health Plan Ratings, **Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference

Analysis

In 2021, CalOptima Health’s Health Effectiveness Data Information Set (HEDIS) goal for OCC FUH-30 days was 56%; CalOptima Health fell short of the goal by 3.10 percentage points with a final rate of 52.90%. The goal for FUH-7 days was set at 34.67%. CalOptima Health missed this goal by 0.77 percentage points with a final rate of 33.90%. The 30-day follow-up decreased in 2021 by 4.10 percentage points from the previous year. We have continued to establish a significant upward pattern over the past few years in the 7-day follow-up appointments, which had an increase of 5.8 percentage points in 2021.

Barriers

- Due to invalid member contact information, the TCM team had difficulty in reaching members and were unable to assist with linkage or confirm follow-up appointments. This issue is especially true for those members experiencing homelessness.
- Rapid readmissions into the hospital after an initial discharge did not allow the TCM team a chance to outreach to some members, which resulted in a missed opportunity for appointment linkage.
- An increased number of members have declined assistance with Outpatient Behavioral Health appointment linkage.

Opportunities for Improvement

- The TCM team will continue to monitor and conduct post discharge outreach to ensure members are able to schedule and attend follow-up appointments.
- The BHI management team will visit additional hospitals with inpatient psychiatric units to discuss CalOptima Health’s concurrent review and transition of care process and address any questions or concerns.
- The BHI management team will improve collaboration efforts with provider groups selected for the BHIIP project to improve follow-up after hospitalization.



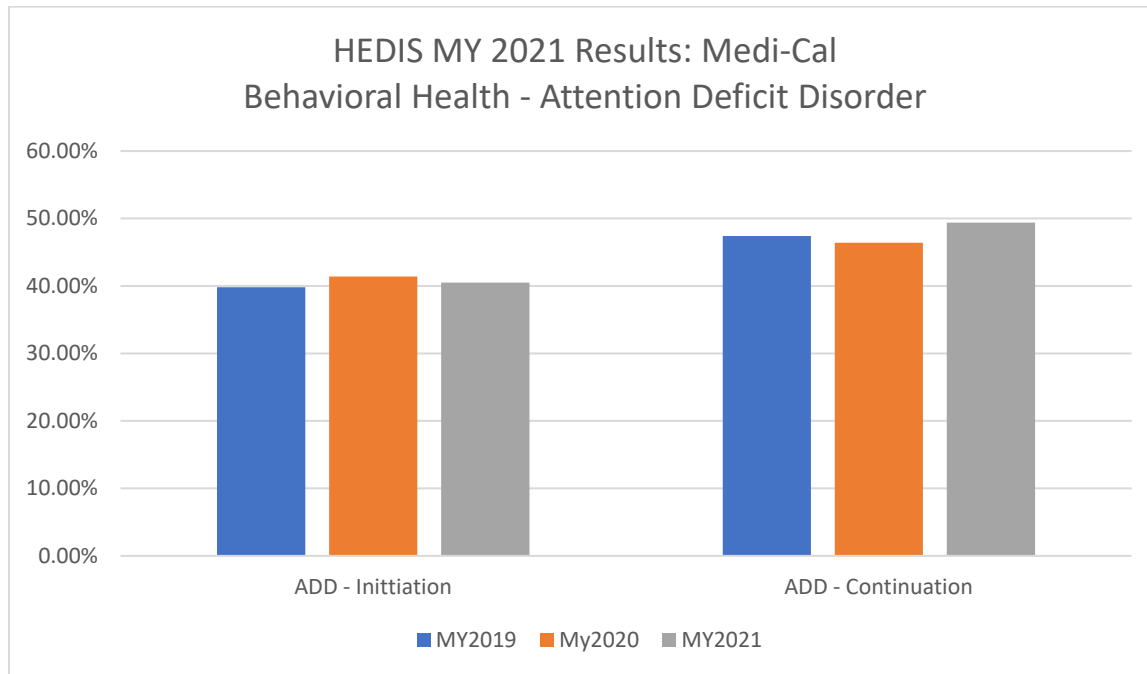
Follow-Up Care for Children with Prescribed ADHD Medication (ADD)

CalOptima Health’s program monitors the percentage of children with newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who have at least three follow-up care visits within a 10-month period. The measure focuses on two phases. The Initiation Phase requires that the first follow-up visit occurs within 30 days of the initial ADHD medication being dispensed. The Continuation Phase includes those members who remained on medication for at least 210 days and attended at least two additional follow-up visits within nine months following the Initiation Phase.

Interventions

- The BHI Quality Team tracked providers who showed as noncompliant for follow-up visits with members. Providers with a high frequency of noncompliance were sent a letter to educate them on the ADD measure requirements and the importance of follow-up visits with members prescribed ADHD medications.
- The BHI Quality Team tracked members who filled an initial ADHD medication and conducted member outreach to ensure a 30-day follow-up appointment had been scheduled.
- The BHI Quality Team submitted an article for the Spring 2022 edition of CalOptima Health’s member newsletter to educate on the importance of attending follow-up visits with a provider.

Findings



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-up Care for Children Prescribed ADHD Medication (ADD) – Initiation Phase	40.17%	47.74%	55.99%	44.51%	
Follow-up Care for Children Prescribed ADHD Medication (ADD) – Continuation Phase	48.92%	60.35%	67.61%	55.96%	HPR

Analysis

CalOptima Health’s 2021 HEDIS Initiation Phase final rate was 40.5%, which did not meet the intended goal of 44.51%. The 2021 HEDIS Continuation Phase final rate was 49.4%, which also did not meet the intended goal of 55.96%. The Initiation Phase has not demonstrated slight change over the past three years. The Continuation Phase has demonstrated slight change over the past three years.

Barriers

- The provider letter was faxed to the fax number on record. We are aware that the fax may not always go to the intended provider to whom the letter was faxed.
- Due to the ongoing COVID-19 PHE, there was limited access to appointment scheduling in a timely manner for the member. This could be attributed to ongoing provider office staffing issues during the PHE.

Opportunities for Improvement

- The BHI Quality Team will continue to monitor providers not meeting the ADD requirements and conduct outreach efforts to provide education on the importance of follow-up visits with members prescribed ADHD medication.
- The BHI Quality Team will continue to explore opportunities for member outreach to remind families of the importance of attending follow-up visits and will work to identify barriers and assist members with appointment scheduling.
- ADD materials will be updated yearly and the team will distribute new materials to providers and members as part of the outreach effort.



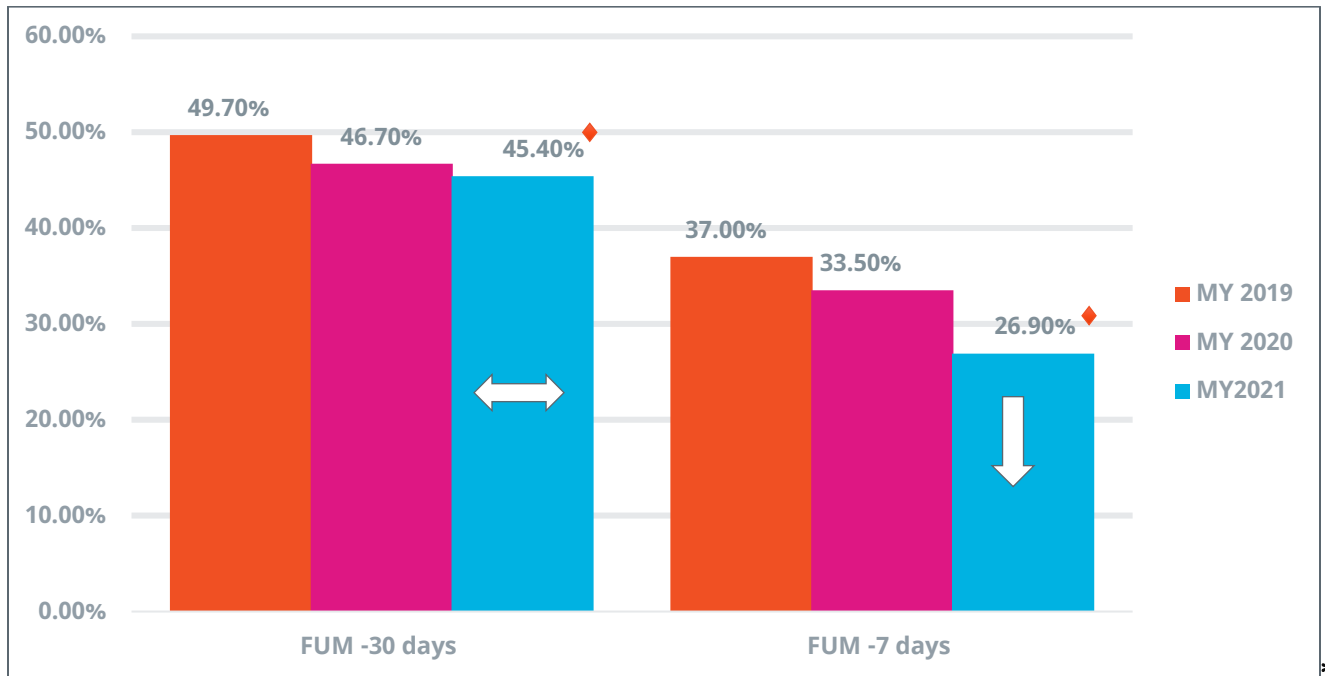
Follow-Up After Emergency Department Visit for Mental Illness (FUM)

CalOptima Health’s program assesses the percentage of emergency department (ED) visits for members age 6 and older with a principal diagnosis of mental illness or intentional self-harm diagnoses and who had a follow-up visit for mental illness. Two rates are measured in this program, the percentage of ED visits for which the member received follow-up care within 30 days of ED visit, as well as the percentage of ED visits for which the member received follow-up care within 7 days of ED visit.

Interventions

- Measure identified as a Health Network (HN) Pay 4 Value (P4V) in MY 2022.
- BHI worked with Information Technology Services (ITS) to create an internal Tableau report to assist in identifying and analyzing potential trends in data (i.e., potential trends for health networks, ED facilities, members, providers, etc.).
- BHI participated in a pilot program to facilitate linkage to BH services post ED visits for a medical condition when a BH need is identified with a few of the local EDs in Orange County.

Findings



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-Up After ED visit for Mental Illness (FUM) – 30 Days	48.41%	60.94%	74.39%	53.54%	
Follow-Up After ED visit for Mental Illness (FUM) – 7 Days ++	32.49%	46.38%	61.36%	38.55%	HPR

◆ =less than 33rd percentile, ++ measure triple weighted for Health Plan Ratings, **Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR = Health plan ratings, MPL= DHCS Minimum Performance Level, P4V= Pay for Value

Analysis

Findings reflect 2022 reporting year HEDIS Final Rates for MY 2021 data in table above. The BHI department began monitoring year-to-date rates in MY 2022.

Barriers

- The main barrier for the FUM measures has been obtaining real-time data for ED visits in order to conduct interventions to assist in follow-up visit attendance. Through MY 2022, BHI had access to year-to-date rates from claims data.
- Scheduling appointments with mental health providers may have been challenging for members due to the ongoing pandemic.

Opportunities for Improvement

CalOptima Health recently began exploring opportunities with the vendor Collective Medical, which provides real-time data related to ED visits. With the ED visit data from Collective Medical, BHI will explore opportunities to conduct member outreach to engage and assist members in providing linkage and support in scheduling follow-up visits.



Improve HEDIS Measures Related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control

The HEDIS measure Comprehensive Diabetes Care (CDC): HbA1c Poor Control is part of the Medi-Cal Managed Care Accountability Set (MCAS), which is required to meet the minimum performance level (MPL) of 50th percentile as defined by the NCQA National Quality Compass Benchmarks. CDC is defined as members ages 18–75 with diabetes (type 1 and type 2) who had a recent HbA1c level of >9.0% or who are missing a result, or if an HbA1c test was not done during the measurement year (lower is better).

CDC: HbA1c Poor Control

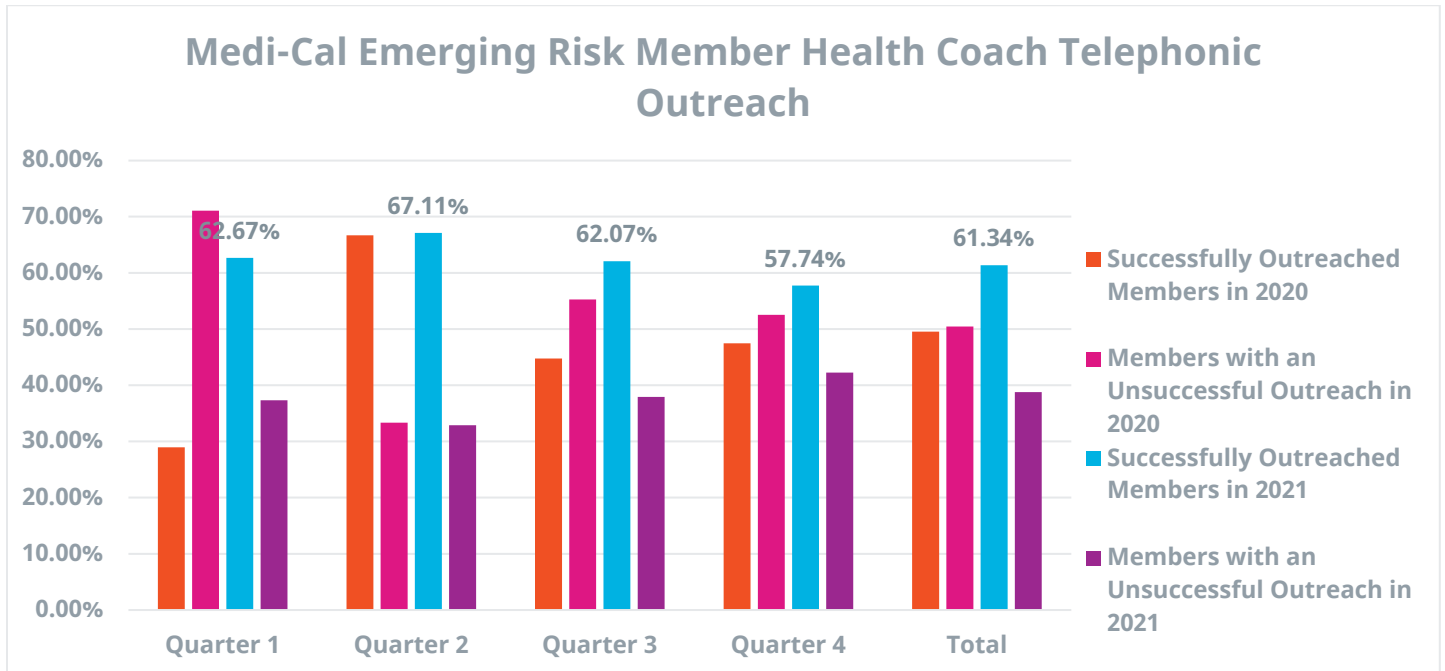
Interventions

- **Health Coaching:** To address an emerging risk in a timely fashion, 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 were identified as Emerging Risk members. Telephonic outreach is conducted by a health coach to identify solutions for Emerging Risk members to manage their HbA1c levels below 8.0%.
- **Member Incentive:** CalOptima Health offered a \$25 gift card to eligible Medi-Cal members ages 18–75 who completed an HbA1c test between January to December 2021. The 2021 HbA1c test member health reward programs was promoted through the CalOptima Health website, member and provider newsletters, and social media including Facebook, Instagram and Twitter.

Findings

The rate of Emerging Risk members with a successful outreach by a Health Coach showed an increase in the trend of successful outreach attempts for each quarter. There was an increased number of members with a reduced HbA1c result in 2021.

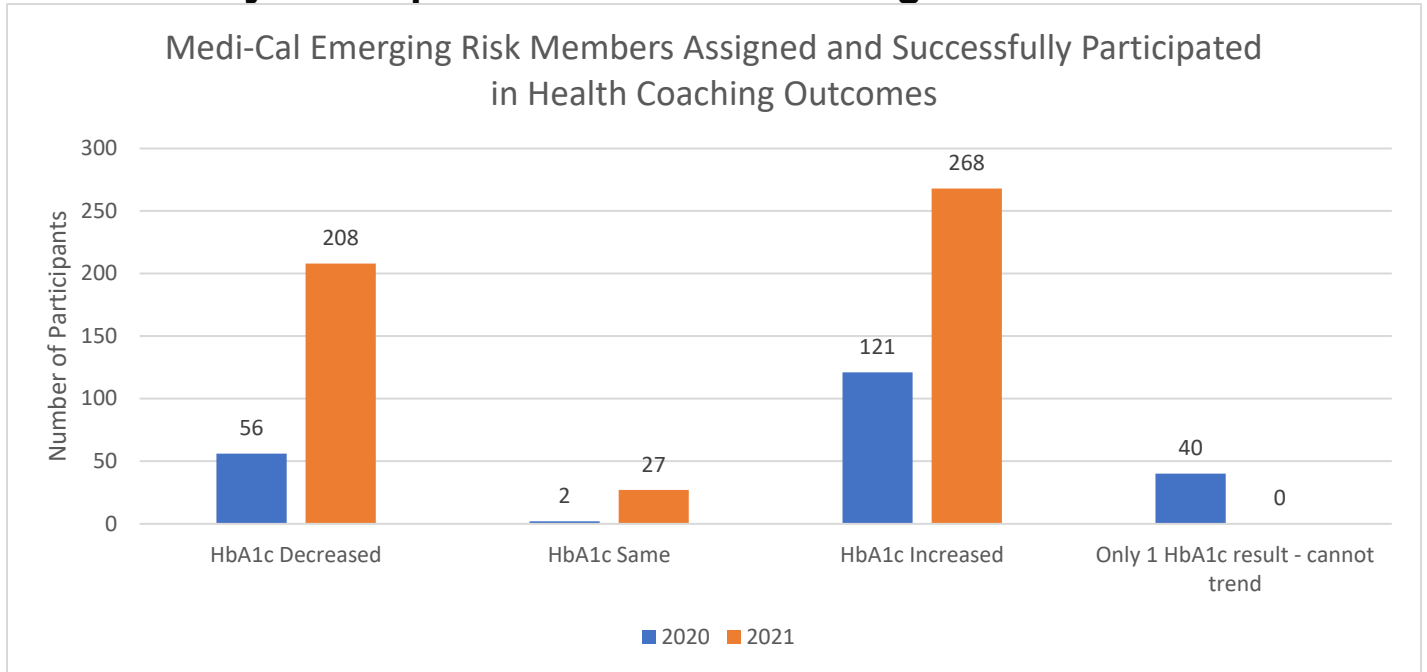
Figure 1: Medi-Cal Emerging Risk Member Health Coach Telephonic Outreach



The chart above shows results of the intervention in 2020 and 2021 by quarter. The number of Emerging Risk members (second column), the rate of assigned Emerging Risk members with a successful outreach by a health coach (third column) and rate of assigned Emerging Risk members with an unsuccessful outreach (fourth column).

When comparing the 2020 HbA1c trend to the 2021 HbA1c trend, there was an increased number of members with a reduced HbA1c result in 2021. Figure 2 illustrates in 2021 208 participants had HbA1c outcomes reduced while 268 participants had HbA1c outcomes increased.

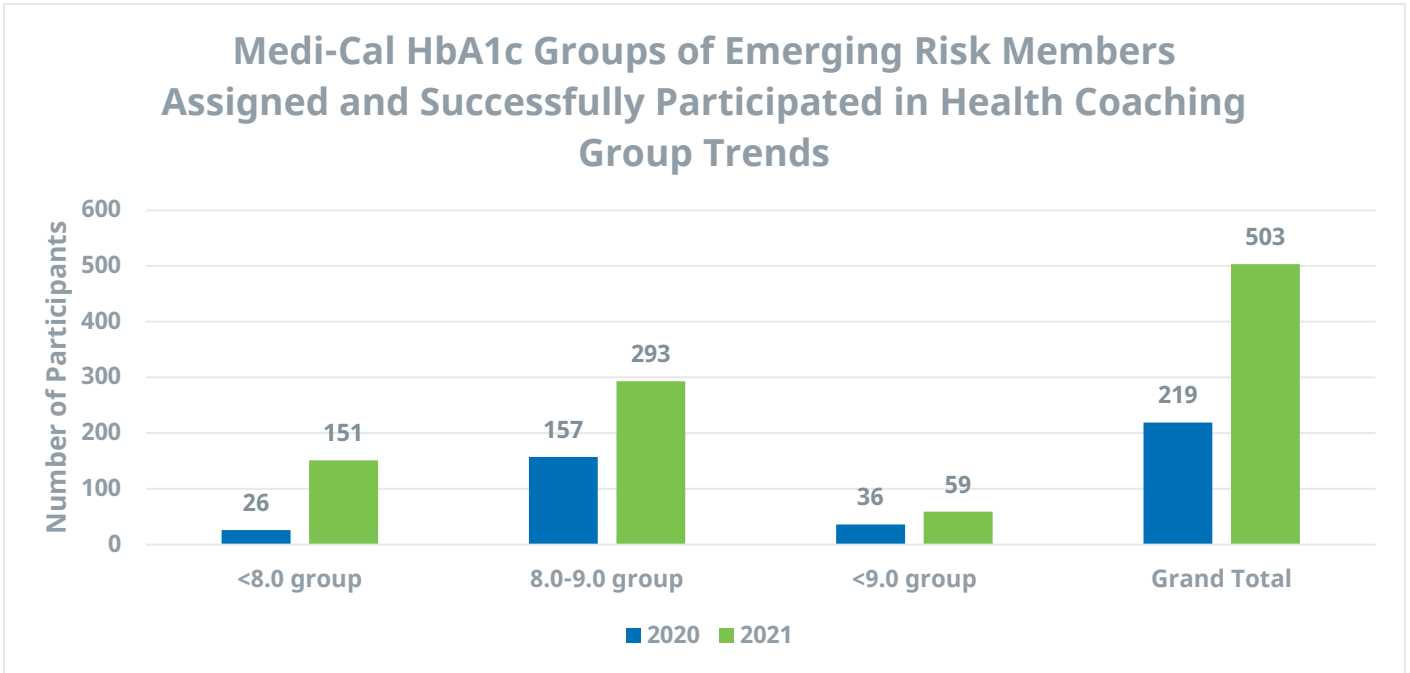
Figure 2: 2020 and 2021 Emerging Risk Members Assigned and Successfully Participated in Health Coaching Outcomes



The chart above indicates the results in 2020 and 2021 of the Emerging Risk members' (HbA1c 8.0–9.0) HbA1c trend when comparing their most current HbA1c test against their immediately previous HbA1c result. If a member only had a total of only 1 HbA1c result on their record, they were categorized as "Only 1 HbA1c result-cannot trend." These members were assigned to a Health Coach for telephonic outreach and successfully participated in Health Coaching.

When comparing the rate of 2020 Emerging Risk HbA1c Group of Emerging Risk members that fell into "HbA1c <8.0 group" ($26/219 = 11.87\%$) against the 2021 HbA1c Emerging Risk HbA1c <8.0 group figures ($151/503 = 30.02\%$), the rate improved by 18.15%. Members who participated in telephonic outreach experienced a reduction in their HbA1c. Yet, in 2021 there were 293 members who fell into the Emerging Risk category, an increase when compared with 2020.

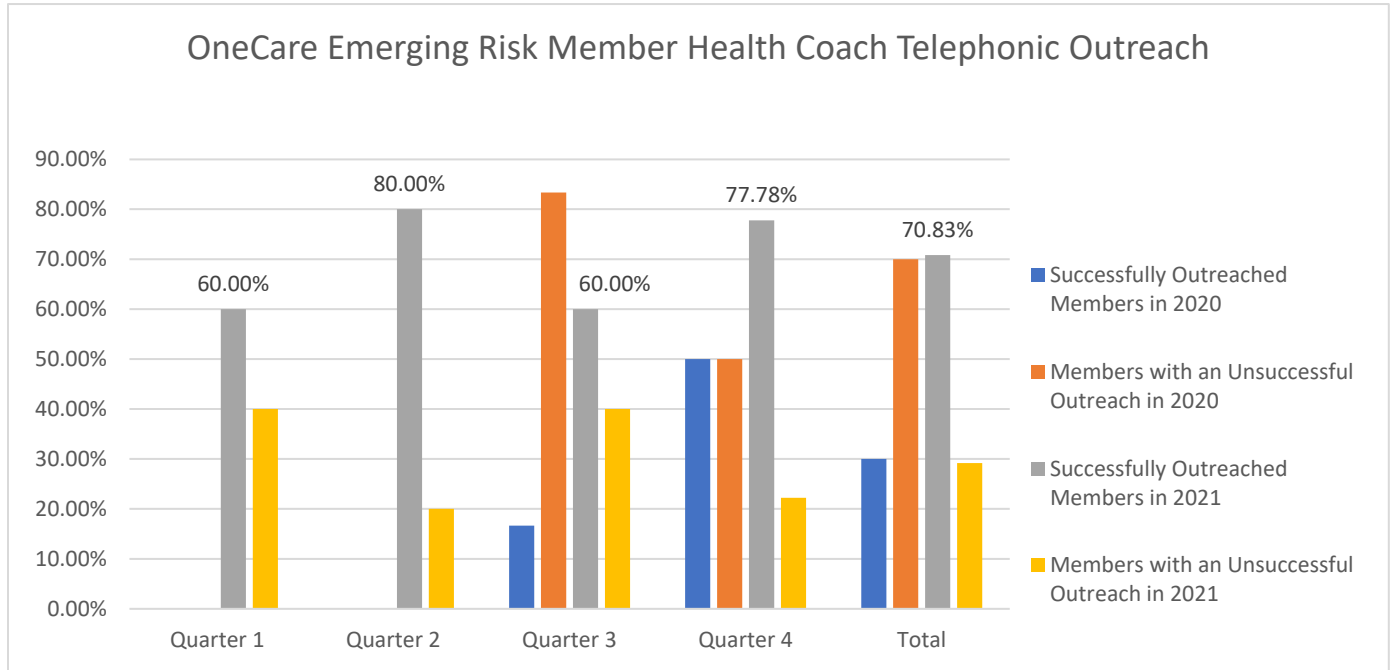
Figure 3: 2020 Medi-Cal HbA1c Groups of Emerging Risk Members Assigned and Successfully Participated in Health Coaching Group Trends



The chart above shows the HbA1c groups of assigned Emerging Risk members who successfully participated in Health Coaching and which HbA1c Groups they fell into at the end of 2020 and 2021.

OneCare: When comparing the rates of Emerging Risk members with a successful outreach by a Health Coach for each quarter in 2020 to the respective quarter in 2021, there was trend of increased successful outreach for each quarter. Figure 4 showcases the rate of outreach per assigned member in 2020 and 2021. There was a significant improvement in the rate of successful outreach to members in 2021.

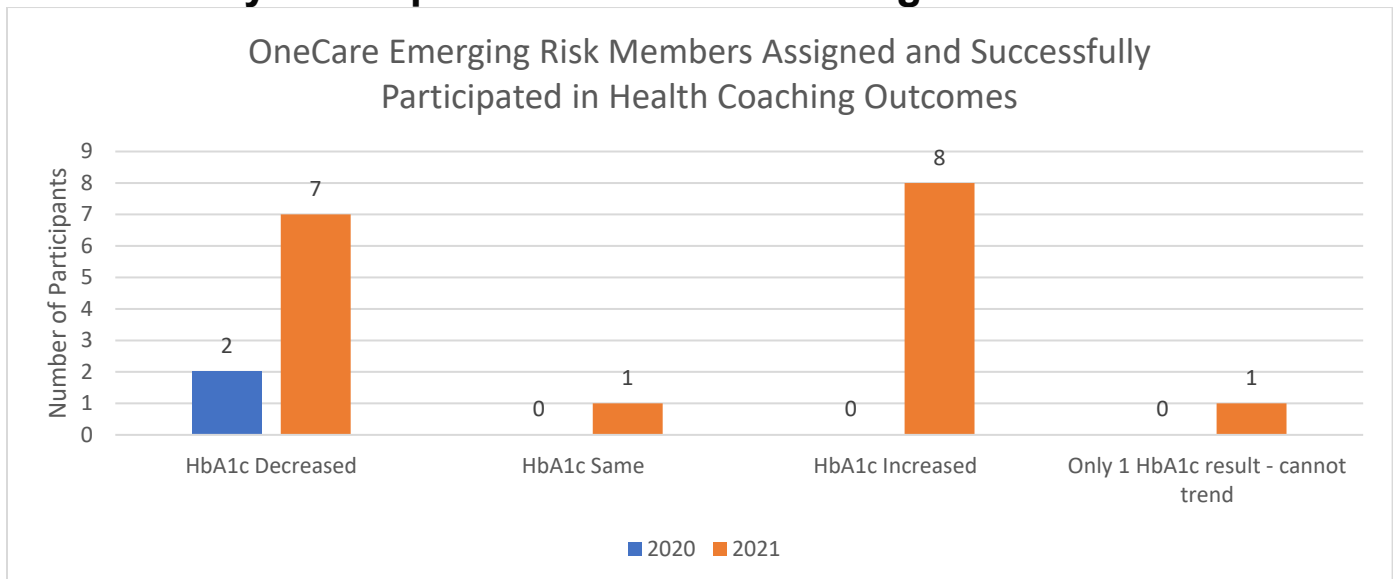
Figure 4: OneCare Emerging Risk Member Health Coach Telephonic Outreach



The chart above shows results of the intervention in 2020 and 2021 by quarter. The number of Emerging Risk members (second column), the rate of assigned Emerging Risk members with a successful outreach by a health coach (third column) and rate of assigned Emerging Risk members with an unsuccessful outreach (fourth column).

When comparing the 2020 HbA1c trend to the 2021 HbA1c trend, there was an increased number of members with a decreased HbA1c result in 2021. Yet, there was a significant number of members whose HbA1c increased after participating in the program, as depicted in Figure 5.

Figure 5: OneCare Emerging Risk Members Assigned and Successfully Participated in Health Coaching Outcomes

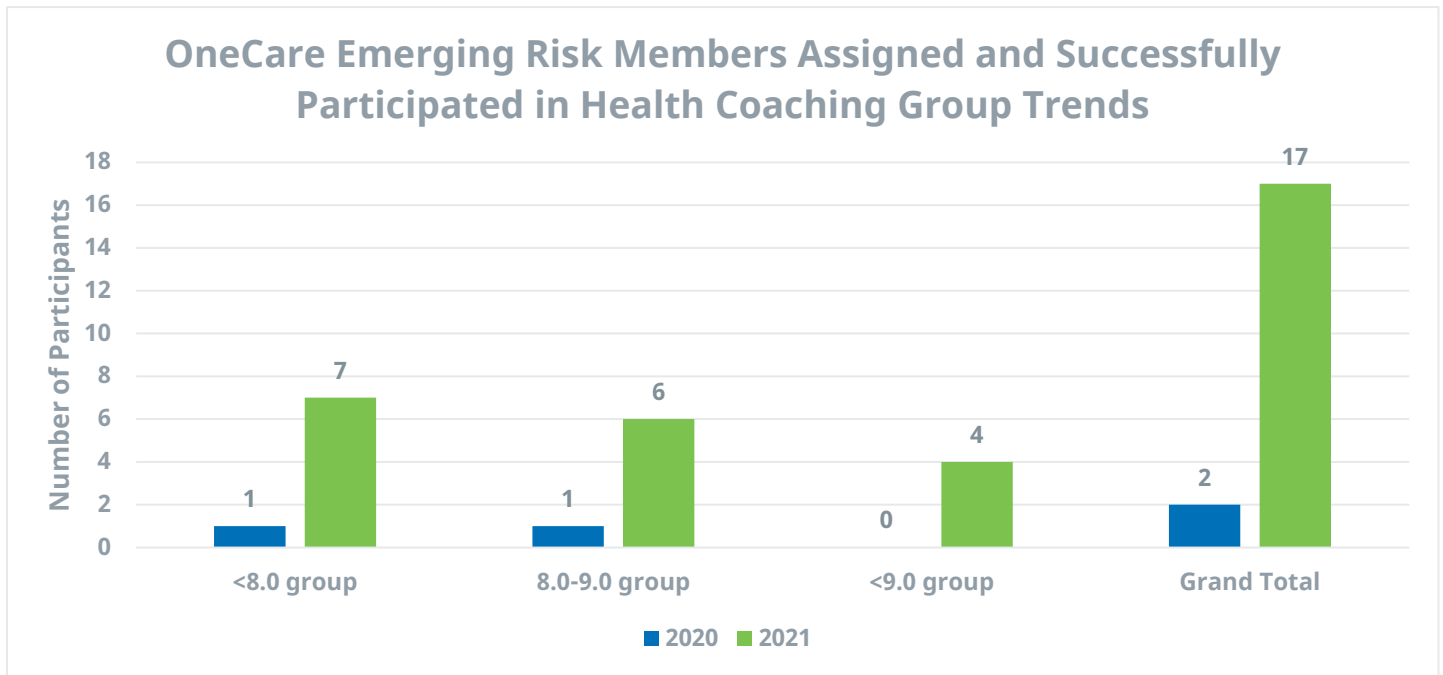


The chart above indicates the results in 2020 and 2021 of the Emerging Risk members' (HbA1c 8.0–9.0) HbA1c trend when comparing their most current HbA1c test against their immediately previous HbA1c result. If a member only had a total of only 1 HbA1c result on their record, they were

categorized as “Only 1 HbA1c result-Cannot trend.” These members were assigned to a Health Coach for telephonic outreach and successfully participated in health coaching.

When comparing the rate of 2020 Emerging Risk HbA1c Group of Emerging Risk members that fell into “HbA1c <8.0 group” (1/2 = 50.00%) against the 2021 HbA1c Emerging Risk HbA1c <8.0 group figures (7/17 = 41.18%), the rate improved by 8.82% but there were more members who were assigned and fell into the HbA1c <8.0 group in 2021. Further details are in Figure 6.

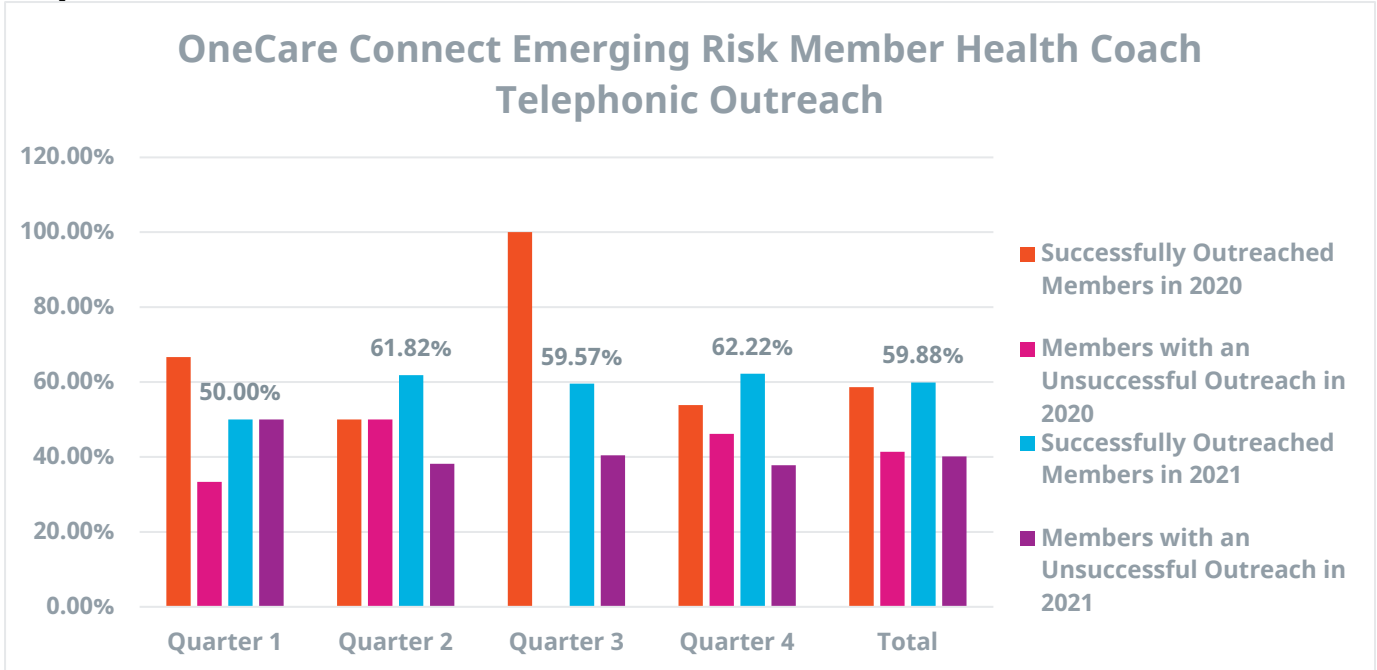
Figure 6: OneCare HbA1c Groups of Emerging Risk Members Assigned and Successfully Participated in Health Coaching Group Trends



The chart above shows the HbA1c groups of assigned Emerging Risk members who successfully participated in Health Coaching and which HbA1c Groups they fell into at the end of 2020 and 2021.

OneCare Connect: When comparing the rates of Emerging Risk members with a successful outreach by a Health Coach for each quarter in 2020 to the respective quarter in 2021, the trend varied for each quarter but overall, there was an improvement in 2021 by 1.26%.

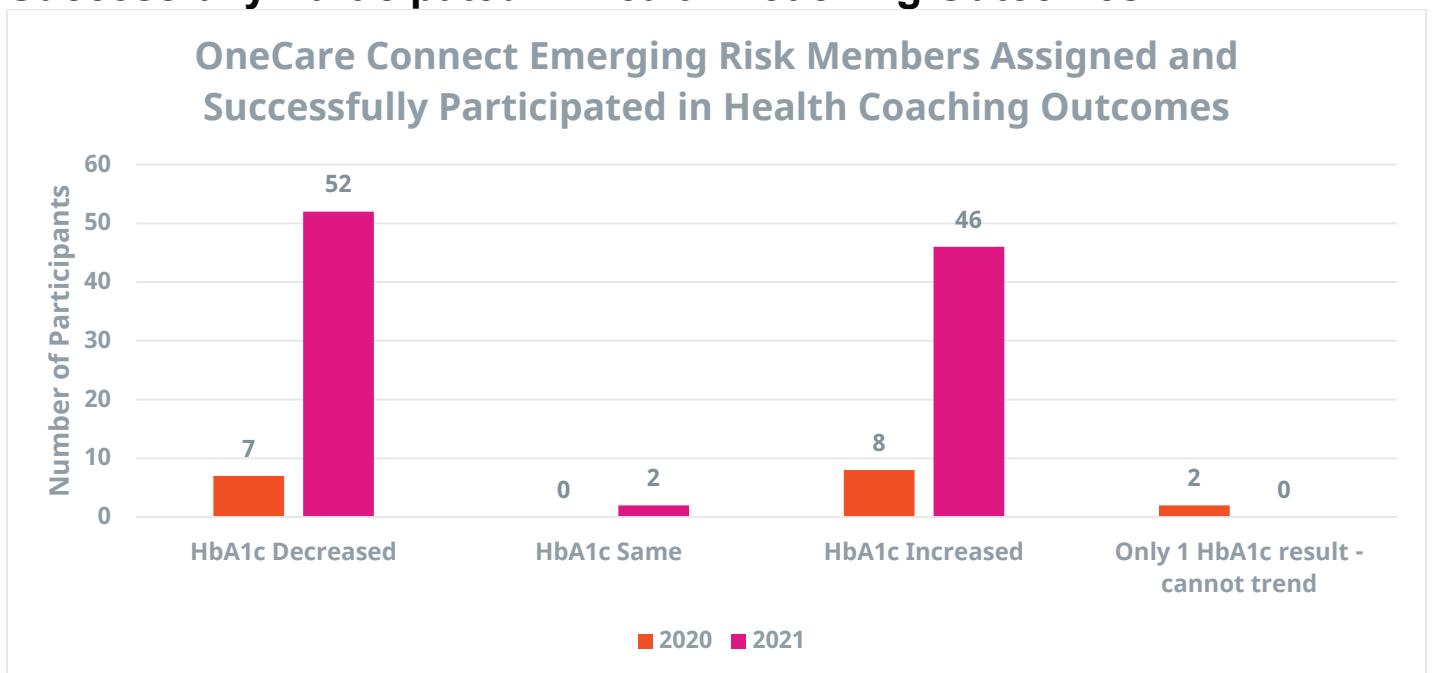
Figure 7: OneCare Connect Emerging Risk Member Health Coach Telephonic Outreach



The chart above shows results of the intervention in 2020 and 2021 by quarter. The number of Emerging Risk members (second column), the rate of assigned Emerging Risk members with a successful outreach by a health coach (third column) and rate of assigned Emerging Risk members with an unsuccessful outreach (fourth column).

When comparing the 2020 HbA1c trend to the 2021 HbA1c trend, there was an increased number of members with a decreased HbA1c result in 2021. Figure 8 demonstrates that for the OneCare Connect population in 2021 this program helped reduce the HbA1c for most participants.

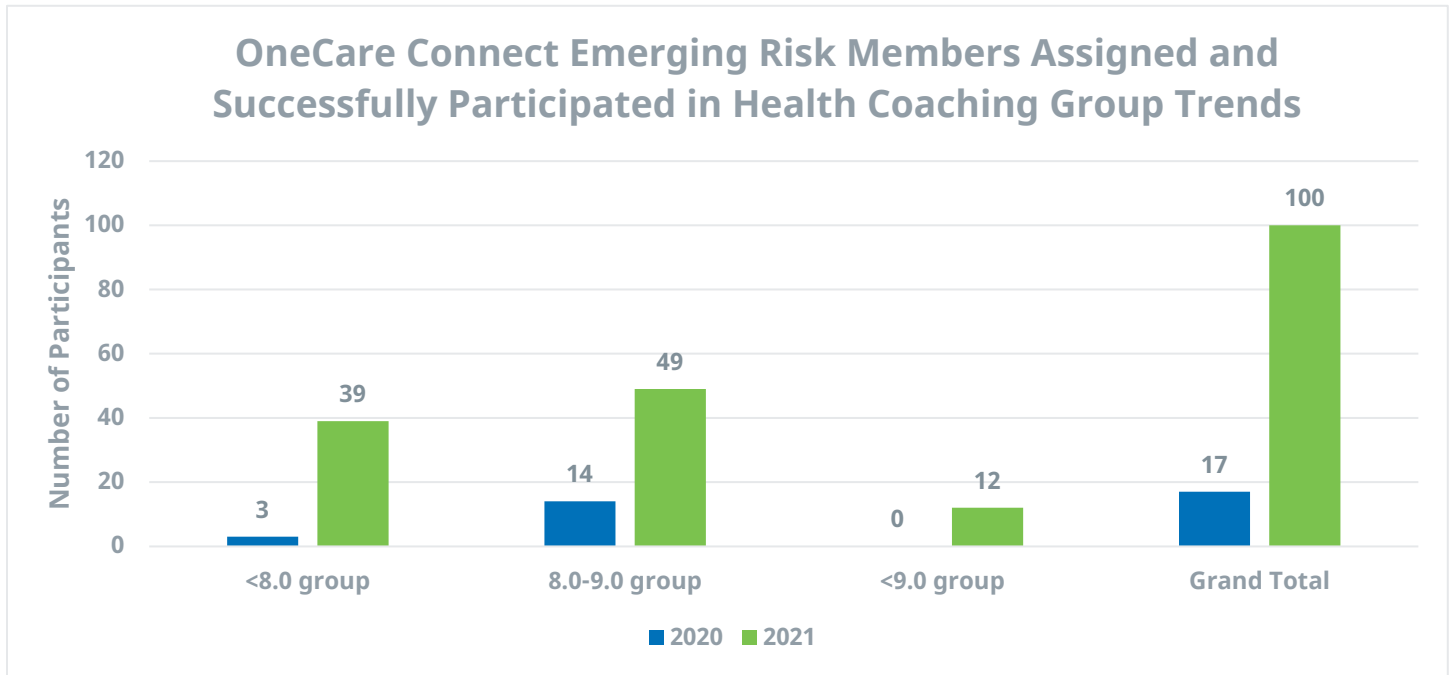
Figure 8: OneCare Connect Emerging Risk Members Assigned and Successfully Participated in Health Coaching Outcomes



The chart above indicates the results in 2020 and 2021 of the Emerging Risk members' (HbA1c 8.0–9.0) HbA1c Trend when comparing their most current HbA1c test against their immediately previous HbA1c result. If a member only had a total of only 1 HbA1c result on their record, they were categorized as "Only 1 HbA1c result-Cannot trend." These members were assigned to a Health Coach for telephonic outreach and successfully participated in health coaching.

When comparing the rate of 2020 Emerging Risk HbA1c Group of Emerging Risk members who fell into "A1c <8.0 group" ($3/17 = 17.65\%$) against the 2021 HbA1c Emerging Risk HbA1c <8.0 group figures ($39/100 = 39.00\%$), rate improved by 21.35 percentage points.

Figure 9: OneCare Connect HbA1c Groups of Emerging Risk Members Assigned and Successfully Participated in Health Coaching Group Trends



The chart above shows the HbA1c groups of assigned Emerging Risk members who successfully participated in health coaching and which HbA1c groups they fell into at the end of 2020 and 2021.

Table 1: All LOBs HEDIS MY 2021 Rates by Race/Ethnicity CDC HbA1c Testing

Table 1	Race/Ethnicity									
HEDIS MY 2021	Hispanic	White	Vietnamese	No Response	Other	Filipino	Asian/Pacific Islander	Black	Korean	Asian Indian
Numerator	14,589	4,993	5,190	4,427	1,157	913	758	598	571	480
Denominator	17,274	6,182	5,719	5,223	1,372	1,022	865	753	667	548
Rate	84.46%	80.77%	90.75%	84.76%	84.33%	89.33%	87.63%	79.42%	85.61%	87.59%
KPI (QC 50th %)	89.30%	89.30%	89.30%	89.30%	89.30%	89.30%	89.30%	89.30%	88.66%	89.30%
Met/Not Met	Not Met	Not Met	Met	Not Met	Not Met	Met	Not Met	Not Met	Not Met	Not Met

HEDIS MY 2021 CDC HbA1c Testing submeasure results. Based on the top 10 highest race/ethnicity denominators. Two out of the 10 Race/Ethnicity met the 50th percentile for HbA1c Testing.

Member Incentive

Table 2 shows the HbA1c Test member incentive results and participation. When comparing the 2020 response rate to the 2021 response rate, it decreased by 2.98 percentage points.

Table 2: MY 2020 and MY 2021 Medi-Cal Member Incentive: HbA1c Test

Measure	HEDIS Non-Compliant Members Eligible		Health Reward Forms Received		Response Rate	
	2020	2021	2020	2021	2020	2021
HbA1c Test	20,532	18,368	863	225	4.20%	1.22%

HEDIS Rates

Table 3 below shows the 2021 and 2022 HbA1c Poor Control Prospective Rate Data for Medi-Cal. When comparing the rates from September 2022 and from September 2021, the HbA1c Poor Control measure showed a 5.72 percentage point increase.

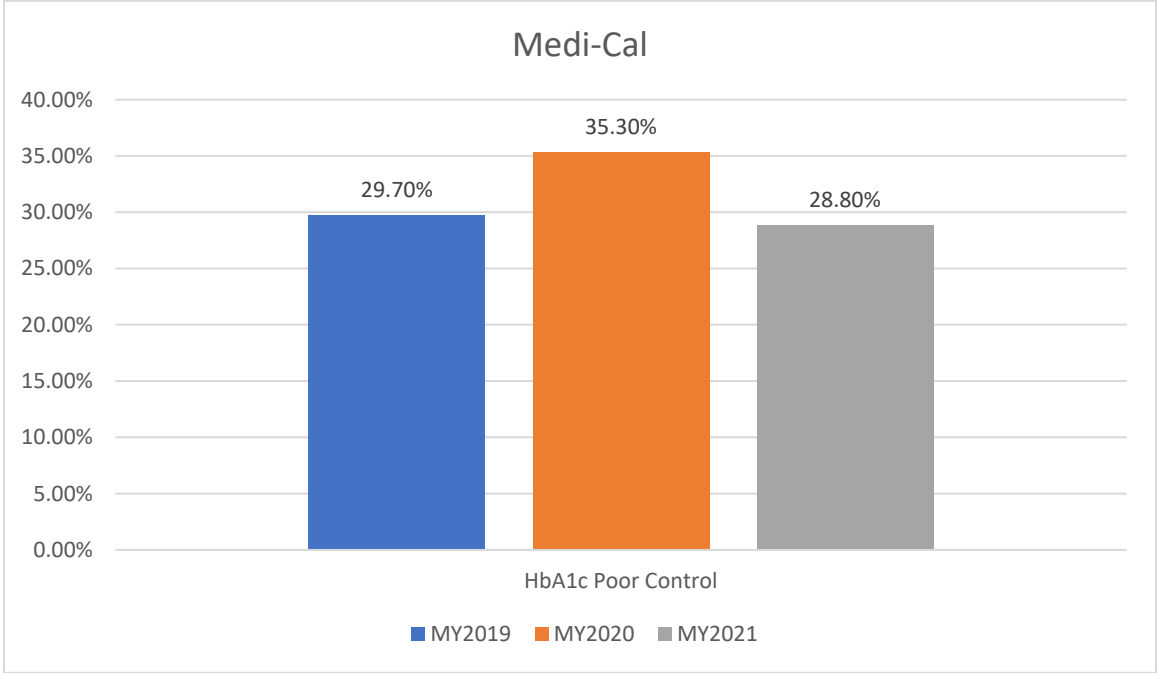
Table 3: HbA1c Poor Control

MY 2021 and MY 2022 Prospective Rates	HbA1c Poor Control (This measure evaluates % of members with poor A1C control — lower rate is better)	
Medi-Cal	September 2021	September 2022
Numerator	20,028	21,891
Denominator	34,991	38,738
Rate	57.24%	56.51%
KPI (QC 50th %)	37.47%	43.19%

Met/Not Met	Not Met	Not Met
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The Figure 10 shows the Medi-Cal HEDIS MY 2019, MY 2020, MY 2021 results for HbA1c Poor Control. When comparing MY 2020 to MY 2021 HbA1c Poor Control rates, the rate decreased by 6.5 percentage points.

Figure 10: CDC HbA1c Poor Control HEDIS Results by Measurement Year: Medi-Cal

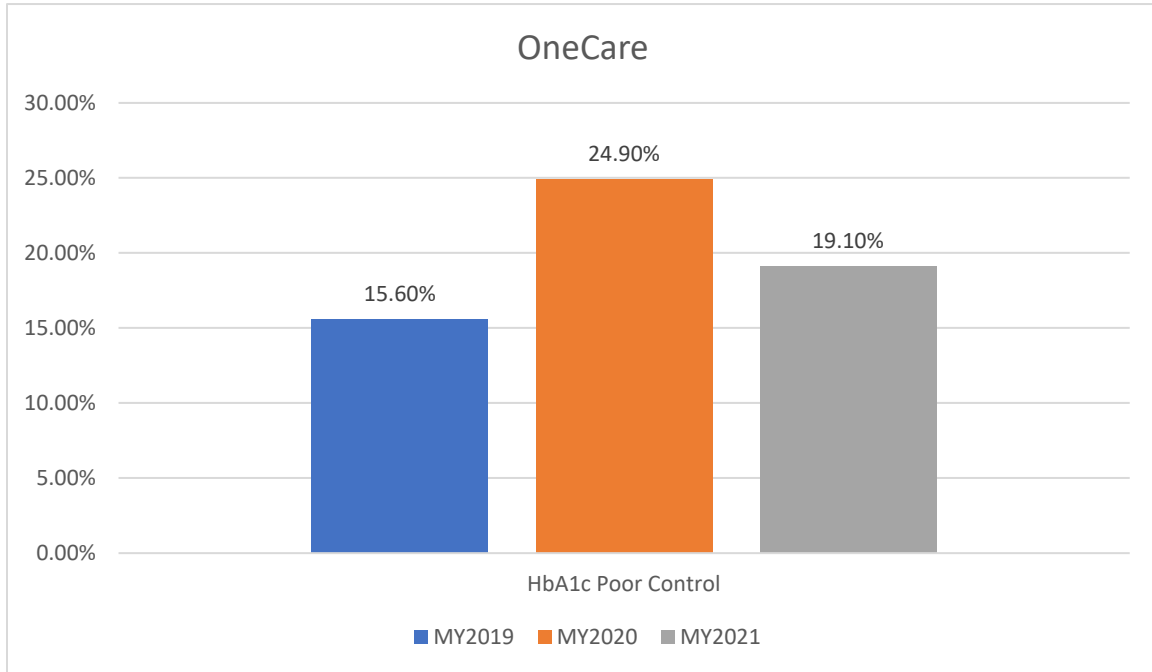


HEDIS Measure	Percentile, Goal, and Reporting Requirements				
	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
HEDIS MY 2021 Medi-Cal					
HbA1c Poor Control (>9.0%) (Lower is better)	48.18%	39.66%	34.06%	34.06%	++MPL, P4V
Goal Met/Not Met			Goal Met in MY 2021 90th Percentile		

Met 90th percentile in MY 2021 for Medi-Cal. * MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

Figure 11 shows the OneCare HEDIS MY 2019, MY 2020, MY 2021 results for HbA1c Poor Control. When comparing MY 2020 to MY 2021 HbA1c Poor Control rates, the rate decreased by 5.8 percentage points.

Figure 11: CDC HbA1c Poor Control HEDIS Results by Measurement Year: OneCare



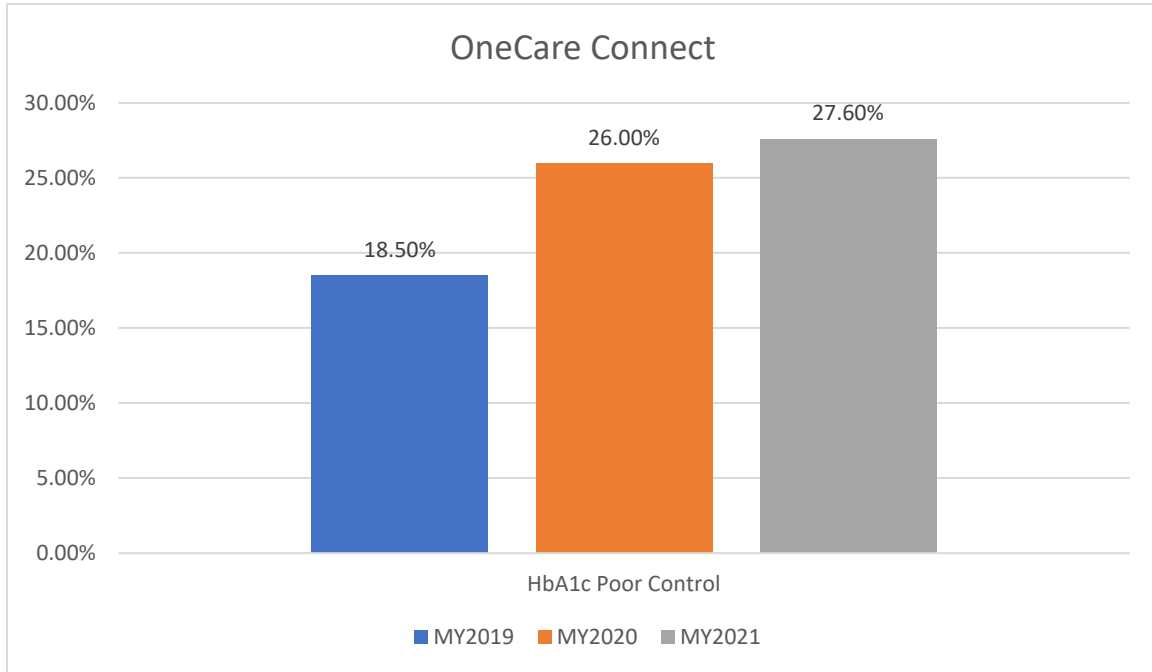
HEDIS Measure	Percentile, Goal, and Reporting Requirements				
	3-Star/33rd percentile	4-Star/66th percentile	5-Star/90th percentile	Goal	Reporting Requirements**
HEDIS MY 2021 OneCare	3-Star/33rd percentile	4-Star/66th percentile	5-Star/90th percentile	Goal	Reporting Requirements**
HbA1c Poor Control (>9.0%) (Lower is better)	40%	28%	19%	19%	Star
Goal Met/ Not Met		Not Met in MY 2021, reached 66th percentile			

Met the 4-Star/66th percentile in MY 2021 for OneCare.

**Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference

Figure 12 shows the OneCare Connect HEDIS MY 2019, MY 2020, MY 2021 results for HbA1c Poor Control. When comparing MY 2020 to MY 2021 HbA1c Poor Control rates, the rate increased by 1.60 percentage points.

Figure 12: CDC HbA1c Poor Control HEDIS Results by Measurement Year: OneCare Connect



HEDIS Measure	Percentile, Goal, and Reporting Requirements				
	3-Star/33rd percentile	4-Star/66th percentile	5-Star/90th percentile	Goal	Reporting Requirements**
HEDIS MY 2021 OneCare Connect					
HbA1c Poor Control (>9.0%) (Lower is better)	40%	28%	19%	19%	Star, P4V
Goal Met/Not Met		Not Met in MY 2021, reached 66th percentile			

Met the 4-Star/66th percentile in MY 2021 for OneCare Connect.

**Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference.

Analysis

a. Health Coaching

i. Medi-Cal

1. Goal: By 12/31/2021, the target goal of this intervention is to reduce the number of Medi-Cal Emerging Risk members by 5% for those who participated in the telephonic health coaching intervention.

2. As shown in the Findings section, out of the 503 members who successfully participated in health coaching, 151 members fell into the <8.0 group, which gives a rate of 30.02%. There were 293 members who remained in the 8.0–9.0 group (Emerging Risk) from the 503 members who successfully participated in health coaching, which gives a rate of 58.25%. The target goal for this intervention was to reduce the number of Medi-Cal Emerging Risk members 5% by 12/31/2021, for those who participated in the telephonic health coaching intervention. At the end of 2021, the total number of members who received the telephonic health coaching intervention was 503. To achieve 5%, 26 emerging risk members were needed to be placed in the <8.0 group by the end of the year. The data shows that the Emerging Risk members at the end of 2021 were reduced by 151 Emerging Risk members who participated in the telephonic health coaching outreach being in the <8.0 Group (good control). This indicates that the goal of reducing the Emerging Risk members by 5% was met.

ii. OneCare

1. Goal: By 12/31/2021, the target goal of this intervention is to reduce the number of OneCare Emerging Risk members by 50% for those who participated in the telephonic health coaching intervention.
2. As shown in the Findings section, out of the 17 members who successfully participated in health coaching, 7 members fell into the <8.0 group, which gives a rate of 41.18%. There were 6 members who remained in the 8.0–9.0 group (Emerging Risk) from the 17 members who successfully participated in health coaching, which gives a rate of 35.29%. The target goal for this intervention was to reduce the number of OneCare Emerging Risk members 50% (from baseline of 5) by 12/31/2021, for those who participated in the telephonic health coaching intervention. At the end of 2021, the total number of members who received the telephonic health coaching intervention was 17. To achieve a 50% reduction of that figure, we needed at least 9 Emerging Risk members to be placed in the <8.0 group by the end of the year. The data shows that the 7 Emerging Risk members at the end of 2021 who participated in the telephonic health coaching outreach were placed in the <8.0 Group (good control). This indicates that we did not meet the goal of reducing the Emerging Risk members by 50%.

iii. OneCare Connect

1. Goal: By 12/31/2021, the target goal of this intervention is to reduce the number of OneCare Connect emerging risk members by 5% for those who participated in the telephonic health coaching intervention.

2. As shown in the Findings section, out of the 100 members who successfully participated in health coaching, 39 members fell into the <8.0 group, which gives a rate of 39%. There were 49 members who remained in the 8.0–9.0 group (Emerging Risk) from the 100 members who successfully participated in health coaching, which gives a rate of 49%. The target goal for this intervention was to reduce the number of OneCare Connect Emerging Risk members by 5% by 12/31/2021, for those who participated in the telephonic health coaching intervention. At the end of 2021, the total number of members who received the telephonic health coaching intervention was 100. To achieve a 5% reduction of that figure, at least 5 Emerging Risk members needed to be placed in the <8.0 group by the end of the year. The data shows that 39 Emerging Risk members at the end of 2021 who participated in the telephonic health coaching outreach were placed in the <8.0 Group (good control). This indicates that we met the goal of reducing the Emerging Risk members by 5%.

b. Member Incentive

- i. In MY 2020 of the 20,532 who were eligible for the HbA1c Test member health reward, 863 submitted HbA1c Test health reward forms, yielding a 4.20% response rate.
- ii. In MY 2021 of the 20,532 who were eligible for the HbA1c Test member health reward, 863 submitted HbA1c Test health reward forms, yielding a 4.20% response rate.

Barriers

c. Barriers encountered during the Health Coach telephonic outreach include:

- i. There was limited capacity for the health educators to conduct outbound calls due to their competing volume of daily tasks.
- ii. The Health Coaches had difficulty with scheduling appointments. Appointments are scheduled far out, especially for endocrinologists due to their limited office hours.
- iii. With the COVID-19 pandemic, telehealth appointments were difficult for some members to perform due to the lack of access to a smartphone or not understanding the instructions on how to connect to a video call.
- iv. Members rely on natural remedies to reduce their blood sugar.
- v. Members face challenges with access to broadband/internet based on their economic status or place of residence.
- vi. Members may require transportation to attend appointments and may not be aware of their transportation benefits.

d. Barriers encountered for member incentive include:

- i. Members may continue to be reluctant to go to their provider's office due to the COVID-19 pandemic.

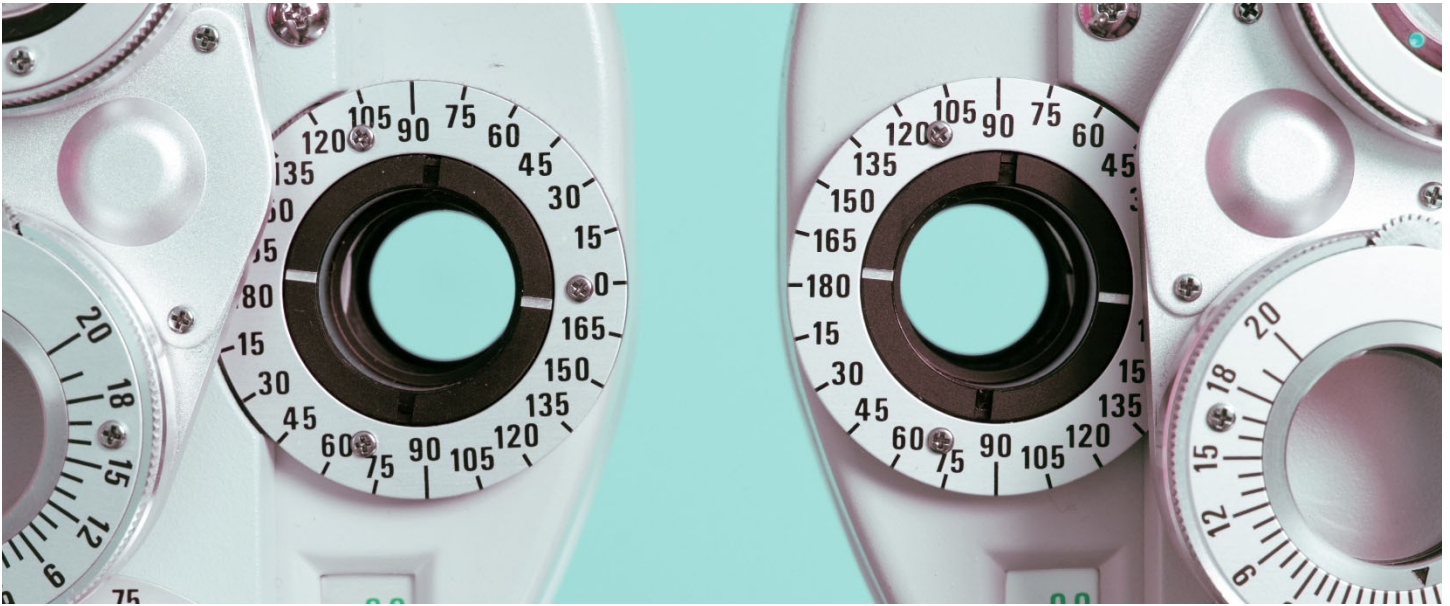
- ii. Incomplete Forms: HbA1c test reward forms regularly came back with the HbA1c value field empty, or members completed the form themselves with a blood sugar value reading rather than a HbA1c test value.
- iii. Our current process may be a barrier for members to complete forms and acquire signatures.
- iv. Many members completed and submitted the forms without having the test performed. Some of the forms submitted contained old dates of service, which disqualified them for receiving the member incentive.
- v. Members gave the form to their provider assuming the provider will fax the completed form to CalOptima Health. However, CalOptima Health often did not receive those submissions.
- vi. Members submit the form but with a date of service outside the incentive timeframe.
- vii. The HbA1c testing is usually performed quarterly or as directed by a provider. This may have led to member lab visit fatigue due to the frequent lab visits for testing.
- viii. In 2021, CalOptima Health did not conduct member mailers for HbA1c due to budget limitations with mailing health reward forms to eligible members.
- ix. It was observed that the Electronic Health Record (EHR) often lacked data or was missing lab data. This impacted the measure because we were unable to distinguish compliant from noncompliant members.
- x. Members who did not qualify for the member incentive rewards, including OneCare, OneCare Connect and Kaiser members, attempted to participate in the program.
- xi. Members who were not diagnosed as diabetic attempted to participate in member incentive rewards.

Opportunities for Improvement

e. Health Coaching

- i. Instruct Health Coaches to assist members with scheduling appointments whenever possible. Teach members how to navigate the health system and telehealth appointments. Encourage members to communicate needs and challenges timely to their provider.
- ii. During outbound calls, conduct a short questionnaire screening for social determinants of health and connect members with other resources to assist with specific needs.
- iii. Update telephonic scripting to mention diabetic resources and telehealth options.
- iv. Seek ways to improve data needs and streamline how members are assigned to Health Coaches moving from manual to an automated method.

- v. Conduct a multilayered analysis of membership data by volume, ZIP code, ethnicity and age groups to determine if social determinants of health that may be creating barriers for CalOptima Health members. Moving forward, additional analysis is needed to create appropriate programs that will make an impact to address barriers and inequities among the targeted groups in the regions we serve.
- f. Member Incentive
- i. Need to improve and place a greater emphasis on compliance with diabetic HbA1c testing and eye exams. Along with all other incentives, there should be a more concerted effort for greater promotion and marketing of the diabetes member rewards through the health networks, CCN providers and the community.
 - ii. Reiterate the importance of fully completing the member health reward forms and following up with the provider, through provider fax updates or phone calls to the provider offices.
 - iii. Consider adding mail distribution costs to the budget for the mailing of health reward forms to eligible members to increase awareness.
 - iv. Leverage social media as a platform to encourage HbA1c testing.
 - v. Allocate resources to improve data collection and access to an EHR by improving lab data completion.
 - vi. Collaborate closely with community partners when implementing health rewards to raise member awareness.
 - vii. Conduct current member data analysis considering age groups, ethnicity and ZIP codes for non-compliance trends and to strategize for better outcomes.



Improve HEDIS Measures Related to Comprehensive Diabetes Care (CDC): Eye Exam

Comprehensive Diabetes Care (CDC): Eye Exam is defined as members ages 18–75 with diabetes (type 1 and type 2) who had a recent retinal eye exam during the measurement year. Screening or monitoring for diabetic retinal disease as identified by administrative data.

CDC: Eye Exam

Interventions

Member Incentive: CalOptima Health offered a \$25 gift card to eligible Medi-Cal members ages 18–75 who completed a diabetes retinal eye exam test between January to December 2021. The 2021 Eye Exam member health reward was promoted through the CalOptima Health website, member and provider newsletters, and social media, including Facebook, Instagram and Twitter.

Findings

Member Incentive: Table 1 below shows the Eye Exam member incentive results. When comparing the 2020 response rate to the 2021 response rate, it decreased by 4.21 percentage points.

Table 1: Member Incentive

MY 2020 – MY 2021 Medi-Cal Member Incentive: Eye Exam						
	<i>HEDIS Non-Compliant Members Eligible</i>		<i>Health Reward Forms Received</i>		<i>Response Rate</i>	
Measure	2020	2021	2020	2021	2020	2021
Eye Exam	15,196	22,884	736	144	4.84%	0.63%

Table 2 shows the 2021 and 2022 Eye Exam Prospective Rate Data for Medi-Cal. When comparing the rates from September 2022 and from September 2021, the Eye Exam measure showed a 7.28 percentage point decrease.

Table 2: Eye Exam

MY 2021 and Prospective Rates for MY 2022	Eye Exam	
Medi-Cal	September 2021	September 2022
Numerator	16,044	17,524
Denominator	34,991	38,738
Rate	45.85%	45.24%
KPI (QC 50th %)	58.64%	51.36%
Met/Not Met	Not Met	Not Met

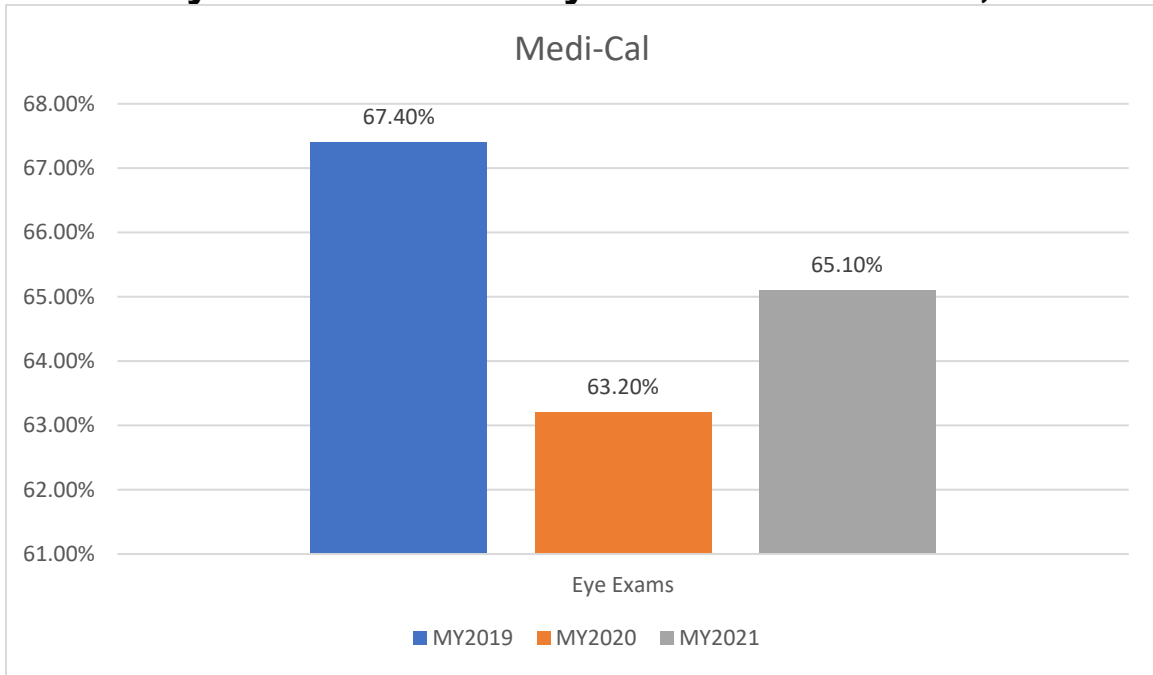
Table 3: All LOBs HEDIS MY 2021 Rates by Race/Ethnicity CDC Eye Exam

Admin	Race/Ethnicity									
HEDIS MY 2021	Hispanic	White	Vietnamese	No Response	Other	Filipino	Asian/Pacific Islander	Korean	Black	Asian Indian
Numerator	8,614	2,484	3,295	2,442	580	542	423	384	327	285
Denominator	15,715	5,358	5,294	4,591	1,149	890	714	654	653	499
Rate	54.81%	46.36%	62.24%	53.19%	50.48%	60.90%	59.24%	58.72%	50.08%	57.11%
KPI (QC 50th %)	63.35%	63.35%	63.35%	63.35%	63.35%	63.35%	63.35%	63.35%	62.15%	63.35%
Met/Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met

HEDIS MY 2021 CDC Eye Exam submeasure results. Based on the top 10 highest race/ethnicity denominators. Out of the 10 Race/Ethnicity listed above, none met the 50th percentile for Eye Exam.

Figure 1 below shows the Medi-Cal HEDIS MY 2019, MY 2020, MY 2021 results for Eye Exam. When comparing MY 2020 to MY 2021 Eye Exam rates, the rate increased by 1.9 percentage points.

Figure 1: CDC Eye Exam Results by Measurement Year, Medi-Cal

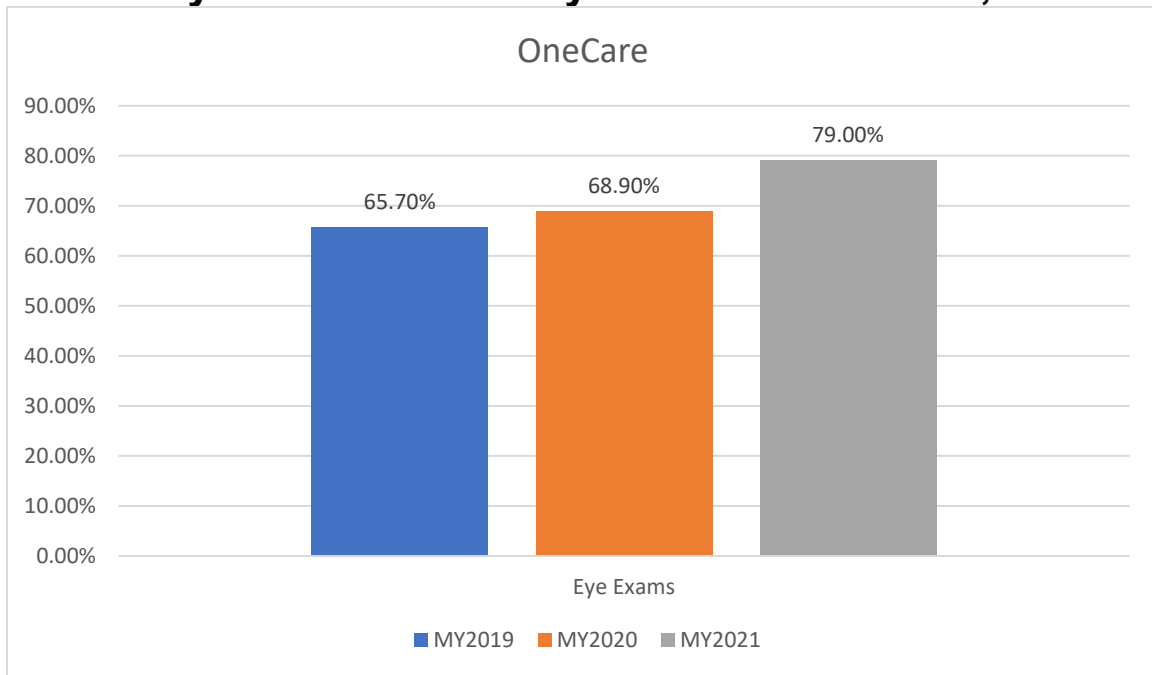


HEDIS Measure	Percentile, Goal and Reporting Requirements				
	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
HEDIS MY 2021 Medi-Cal					
Eye Exam	54.26%	63.26%	71.23%	71.23%	HPR
Goal Met/Not Met		Goal not met in MY 2021, met 66th Percentile			

Met 66th percentile in MY 2021 for Medi-Cal. ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

Figure 2 shows the OneCare HEDIS MY 2019, MY 2020, MY 2021 results for Eye Exam. When comparing MY 2020 to MY 2021 Eye Exam rates, the rate increased by 10.1 percentage points.

Figure 2: CDC Eye Exam Results by Measurement Year, OneCare

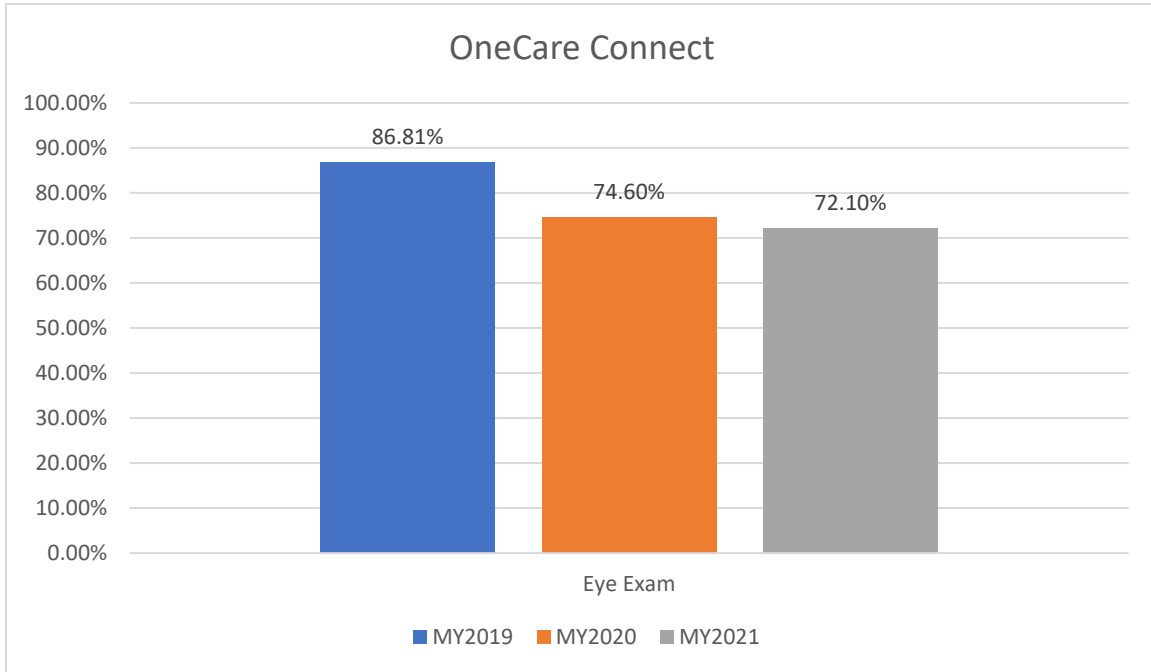


HEDIS Measure	Percentile, Goal and Reporting Requirements				
	3-Star/33rd percentile	4-Star/66th percentile	5-Star/90th percentile	Goal	Reporting Requirements**
HEDIS MY 2021 OneCare					
Eye Exam	62%	71%	79%	71%	Star
Goal Met/Not Met			Goal met in MY 2021, met 90th Percentile		

*Met 5-Star/90th percentile in MY 2021 for OneCare. **Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference*

Figure 3 shows the OneCare Connect HEDIS MY 2019, MY 2020, MY 2021 results for Eye Exam. When comparing MY 2020 to MY 2021 Eye Exam rates, the rate decreased by 2.50 percentage points.

Figure 3: CDC Eye Exam Results by Measurement Year, OneCare Connect



HEDIS Measure	Percentile, Goal and Reporting Requirements				
	3-Star/33rd percentile	4-Star/66th percentile	5-Star/90th percentile	Goal	Reporting Requirements**
HEDIS MY 2021 OneCare Connect					
Eye Exam	62%	71%	79%	79%	Star
Goal Met/Not Met		Goal not met in MY 2021, met 66th Percentile			

Met 4-Star/66th percentile in MY 2021 for OneCare Connect. **Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference

Analysis

Member Incentive: In MY 2020 of the 15,196 who were eligible for the Eye Exam member health reward, 736 submitted Eye Exam health reward forms, yielding a 4.84% response rate. In MY 2021, the response rate was 0.63% yielding 144 of the 22,884 who were eligible.

Barriers

- a. Barriers encountered for the member incentives include:
 - i. Members may still be reluctant to go to their provider’s office due to the COVID-19 pandemic.
 - ii. The Eye Exam reward forms were often returned, incomplete, contained incorrect information, were not signed by the provider or were illegible.

- iii. Many members completed and submitted the forms without having the test performed or submitted the forms with old dates of service, which disqualified them for receiving the member incentive.
- iv. Members gave the form to their provider assuming the provider will fax the completed form to CalOptima Health. However, CalOptima Health often did not receive those submissions.
- v. In 2021, CalOptima Health did not conduct member mailers for Eye Exam due to budgetary limitations with mailing health reward forms to eligible members.
- vi. It was observed that the Electronic Health Record (EHR) often lacked data or was missing lab data causing us to be unable to distinguish compliant from noncompliant members.
- vii. Members who did not qualify for the member incentive rewards, including OneCare and OneCare Connect and Kaiser members, attempted to participate in the program.
- viii. Members who were not diagnosed as diabetic attempted to participate in member incentive rewards

Opportunities for Improvement

b. Member Incentive

- i. CalOptima Health will consider having the diabetes reward available to all CalOptima Health members with diabetes to encourage yearly eye exams.
- ii. CalOptima Health needs to improve and place a greater emphasis on compliance with Diabetes HbA1c Testing and Eye Exam and will make a greater effort for promotion and marketing of the diabetes member rewards through the health networks, CCN providers and the community.
- iii. CalOptima Health will reiterate the importance of completing health reward forms in full and following through with the submission of forms.
- iv. CalOptima Health will consider budgeting for mailing health reward forms to eligible members to increase awareness.
- v. CalOptima Health will leverage social media as a platform to encourage obtaining Eye Exams.
- vi. CalOptima Health will allocate resources to EHR to improve data collection and access, which will reduce issues related to missing data.

c. Improve collaborations with key stakeholders

- i. CalOptima Health will collaborate closely with community partners when implementing health rewards to raise awareness of the program for members.

- ii. CalOptima Health will conduct current member data analysis considering age groups, ethnicity and ZIP codes for noncompliance trends and to strategize for better outcomes.
- iii. In 2022, CalOptima Health implemented a co-branding reminder letter with VSP Vision Plan to improve the Diabetic Annual Eye Exam completion rate.



Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care

Prenatal and Postpartum Care (PPC) is a hybrid measure and Managed Care Accountability Set (MCAS) measure with two components: the Timeliness of Prenatal Care, and Postpartum Care. PPC measures the percentage of deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year in which the members: 1) received a prenatal care visit in the first trimester, and 2) obtained a postpartum care visit on or between 7 and 84 days (1–12 weeks) after delivery. PPC is held to the minimum performance level (MPL) as determined by the NCQA National Quality Compass Benchmarks.

Interventions

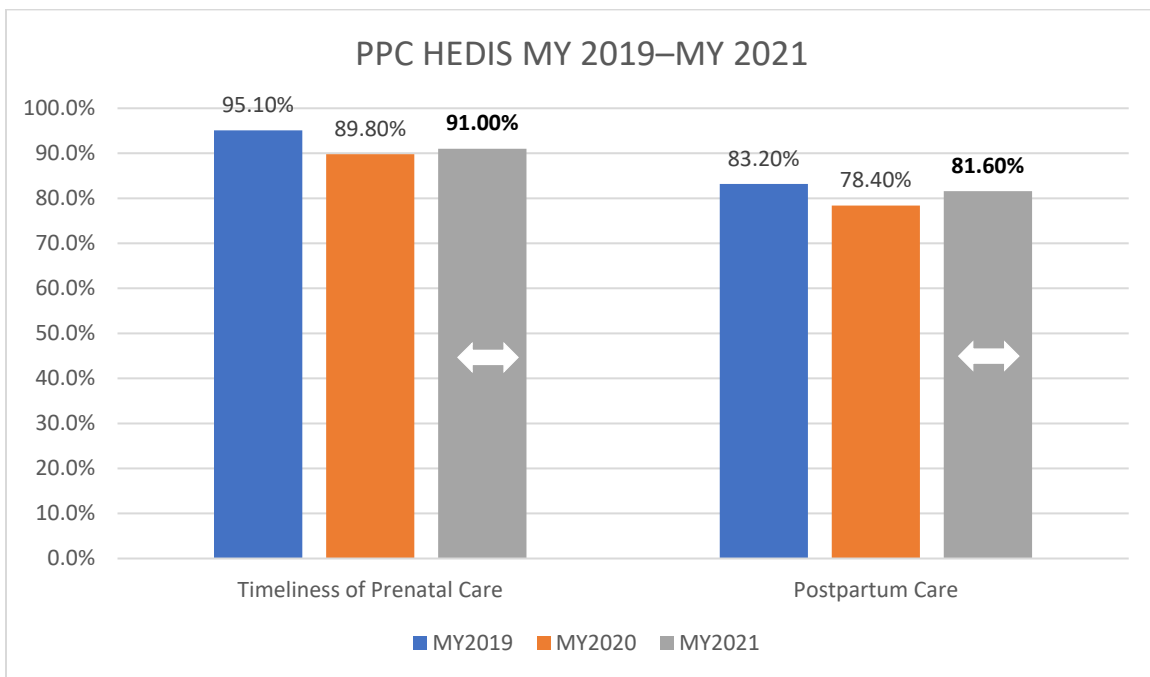
- a. Bright Steps Program (BSP) for Perinatal and Postpartum Members: BSP is a CalOptima Health program that offers education, educational materials, resources and support for mom and baby via phone calls throughout each trimester and the postpartum timeframe. BSP was launched in September 2018. Since then, the program has evolved to include a post BSP well-child follow up call initiative to support the member’s continuum of care.
 - i. Members engaged in Comprehensive Perinatal Services Program (CPSP) through a CPSP certified provider. During the 2021 calendar year, the BSP conducted outreach to 4,128 members for a total of 1,148 completed assessments.
 - ii. BSP offers participants a member mailing with topics related to prenatal and postpartum care. During the 2021 calendar year, 1,988 members received a BSP packet mailing.
- b. Medi-Cal members received a \$50 Postpartum Checkup Health Reward for completing a postpartum checkup. The health reward was promoted to members via CalOptima Health website, Medi-Cal member newsletter and BSP. During the 2021 calendar year, 400 members were approved for the health reward.

- c. Additional intervention included Pay 4 Value (P4V) metrics for prenatal and postpartum care, social media campaign, CalOptima Health website promotion, Healthcare Chat Video, member newsletter, and provider newsletter and fax.

Findings

Prenatal and Postpartum Care achieved the HEDIS MPL rate, 91.00% and 81.60% respectively. See Figure 1. Statistically there was no difference from MY 2020 to MY 2021 rates. Postpartum care rates are lower than prenatal care rates, thus interventions should continue to drive postpartum care efforts.

Figure 1: PPC Trending HEDIS Rates MY 2019–MY 2021 Results: Medi-Cal Timeliness of Prenatal Care and Postpartum Care



*Trend analysis of final HEDIS rates for Prenatal Care and Postpartum Care (PPC). **Bold** percentile indicates that the organization’s goal was met. White arrow indicates that there was no statistical significance in rates when compared to the year prior.*

- d. In addition to meeting the MPL, Prenatal and Postpartum Care met the organization’s percentile goal, 90.75% and 79.56% respectively. See Table 1.

Table 1: Prenatal and Postpartum Care Measure Medical Percentiles and Organization Goal

HEDIS Measure	Percentile, Goal Reporting Requirements						Metrics Met
	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Final HEDIS Rate	Goal	Reporting Requirements**	
HEDIS MY 2021							
Prenatal Care	81.51%	88.32%	92.21%	91.00%	90.75%	HPR, MPL, P4V	Organization goal, MPL
Postpartum Care	73.72%	78.35%	83.70%	81.60%	79.56%	HPR, MPL, P4V	Organization goal, MPL

**HPR is health plan ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value

Table 2 examines prenatal and postpartum care rates by ethnicity. When analyzing timely prenatal care by ethnicity, Korean members have the highest rates of timely prenatal care (90.41%) compared with other groups. Korean members along with other groups (e.g., Filipino, Chinese, Asian or Pacific Islander) represent a small portion of the total denominator. The Hispanic group represents the highest volume with more than half of the HEDIS denominator, but overall compliance is 82.60%. When analyzing timely postpartum care by ethnicity, Vietnamese members have the highest rates of timely postpartum care (85.25%) compared with other groups but represent a small volume. In terms of volume, the Hispanic group is the largest, but their rate of timely postpartum care is 70.70%. See Table 2.

Table 2: MY 2021 Prenatal and Postpartum Care HEDIS Results by Ethnicity

Hybrid	Ethnicity									
	Hispanic	Other	White	Vietnamese	No response	Black	Filipino	Korean	Asian or Pacific Islander	Chinese
HEDIS MY 2021										
Denominator	3,942	1,335	953	488	326	136	77	73	47	35
Prenatal Care Numerator	3,256	1,088	734	375	264	109	58	66	35	28
Prenatal Care Rate	82.60%	81.50%	77.02%	76.84%	80.98%	80.15%	75.32%	90.41%	74.47%	80.00%
Postpartum Care Numerator	2,787	948	608	416	222	93	53	58	39	27
Postpartum Care Rate	70.70%	71.01%	63.80%	85.25%	68.10%	68.38%	68.83%	79.45%	82.98%	77.14%

Table 2 displays top 10 ethnicities with the highest denominator based on total HEDIS population and the completion rates of timely prenatal and postpartum care. Prenatal and Postpartum are hybrid measures. The total rate does not indicate the final HEDIS rate. Note: Includes Kaiser members.

Table 3 examines postpartum care rates by member written language. The highest postpartum care completion rate is among Vietnamese members (84.87%), although this group represents less than 5% of the total denominator (n=7,497). The lowest rate is among English speaking members (69.37%), but the group represents the largest percentage of the total denominator (74.60%). MY 2021 findings are consistent with MY 2020 findings.

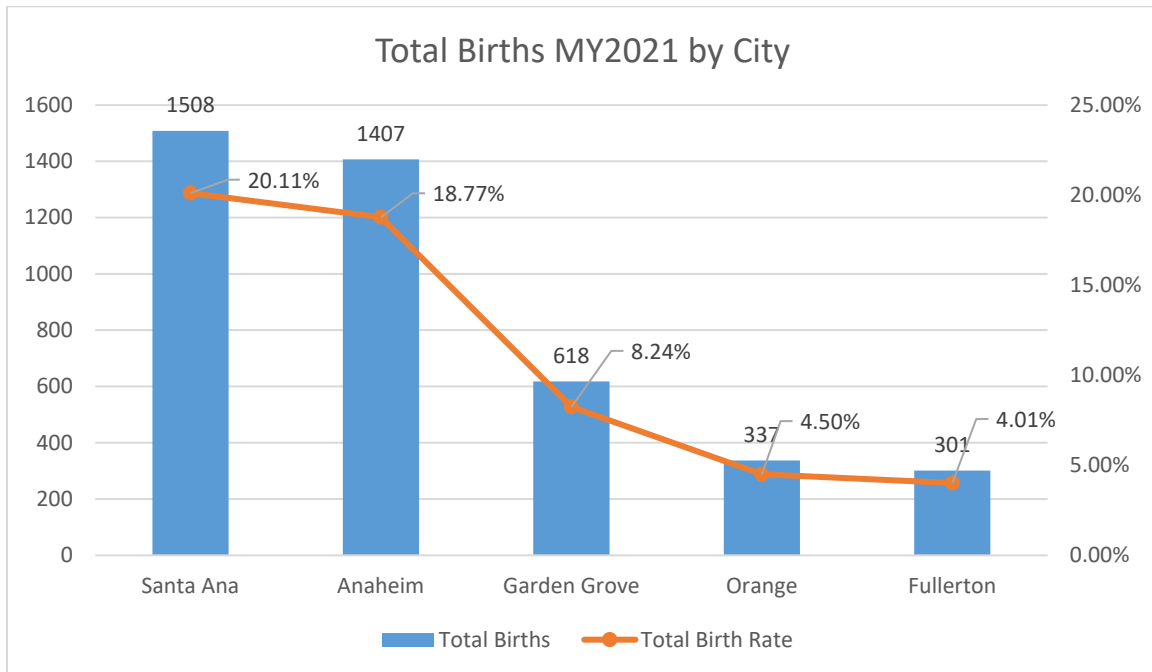
Table 3: MY 2021 Postpartum Care HEDIS Results by Threshold Language

Hybrid	Threshold Language					
	English	Spanish	Vietnamese	Arabic	Korean	Farsi
HEDIS MY 2021						
Numerator (completed postpartum care)	3,880	1,044	286	37	23	20
Denominator	5,593	1,441	337	52	31	28
Postpartum Care Completion Rate	69.37%	72.44%	84.87%	71.15%	74.19%	71.43%
% of Total Denominator	74.60%	19.22%	4.50%	0.69%	0.41%	0.37%

Table 3 displays the top threshold languages for members. The numerator indicates the members with that preferred language who received postpartum care. Note: Based on member written language preference; includes Kaiser members.

Figure 2 examines total births by city. Santa Ana, Anaheim and Garden Grove have the highest birth rate in Orange County at 20.11%, 18.77% and 8.24% respectively. This finding is consistent with the MY 2020 findings; no statistical significance and aligns with the total membership volume by city. Furthermore, these cities have the highest rate of members who do not receive timely prenatal and postpartum care, which is also consistent with MY 2020 findings.

Figure 2: Total Births in MY 2021 by City



Top 5 cities that represent the highest births in MY 2021.

- a. Out of the total births (n=7,497) in MY 2021, 6,072 (81.00%) members completed prenatal care in a timely manner, 5,302 (70.72%) completed postpartum care, and 4,596 (61.03%) completed both prenatal and postpartum care, which represents a 1.23 percentage point increase from the MY 2020 rate (59.80%).
- b. When analyzing members who received both timely prenatal and postpartum care, members 19 years of age and under have lower timely care rates (55.43%) than other age groups. When analyzing prenatal and postpartum care independently, differences can be seen across different age groups. Members who are 19 years of age and under have the lowest timely prenatal care rates (77.12%) compared with other age groups. See Table 4. Members ages 35–39 (69.02%) had lower completion rates of postpartum care, followed by those 19 years of age and younger (69.80%).

Table 4: Prenatal and Postpartum Care HEDIS Measure Rate by Age

Hybrid	Age Group						
	≤19	≤20-24	≤25-29	≤30-34	≤35-39	≤40-44	≥45
HEDIS MY 2021							
MY 2021 Denominator	341	1,720	2,333	1,796	1,007	281	19
Prenatal Care Numerator	263	1,410	1,911	1,448	805	220	15
Prenatal Care Rate	77.12%	81.98%	81.91%	80.62%	79.94%	78.29%	78.94%
Postpartum Care Numerator	238	1,211	1,640	1,298	695	203	17
Postpartum Care Rate	69.80%	70.41%	70.30%	72.27%	69.02%	72.24%	89.47%

A total of 2,211 PNRs were received into the Bright Steps program, a 29.49% of the total births in MY 2021.

Analysis

Member engagement with BSP increased in MY 2021 by 5.49%. See Table 5. BSP engagement is defined as a member who successfully is outreach to during the second, third or fourth (postpartum) trimester and completes a BSP assessment.

Table 5: BSP Engagement in MY 2020 and MY 2021

HEDIS MY	BSP Engagement (Includes members who did not receive timely PPC)	HEDIS Denominator	BSP Engagement Rate
2020	787	7,223	10.90%
2021	1,229	7,497	16.39%

Bright Steps Program (BSP) engagement is defined as successful outreach and assessment completion during the second, third or fourth (postpartum) trimester.

- e. In MY 2021, 77.62% of members who engaged in BSP received timely postpartum care, compared with members who were not outreached at all (69.77%). This represents <1% increase from MY 2020. In addition, we analyzed members who were successfully outreached during the postpartum timeframe by BSP and 78.30% received timely postpartum care. While most members are under the care of a CPSP provider for services comparable to BSP, this finding suggests that BSP supports timely postpartum care.
- f. Postpartum health reward participation rate (10.53%) among members who completed a Bright Steps postpartum assessment (n=940) was lower than MY 2020. Members who are achieving timely postpartum care may be opting not to participate in the reward program or the postpartum member health reward may not be a contributing factor to timely care. This is consistent with MY 2020.
- g. Ongoing provider education and monitoring may support increased provider and Health Network awareness of the requirement to submit PNRs. The provider fax and mailing interventions did not drive a statistically significant improvement in the PNR submission rate.

- h. Table 6 examines the Medi-Cal prenatal and postpartum care measure prospective rates. There is an increase in the September 2022 rates for prenatal care (80.30%) and postpartum care (64.36%) compared with the previous year’s rate in the same month.

Table 6: MY 2022 Medi-Cal Prenatal and Postpartum Care Prospective Rate Results

HEDIS Prospective Rates	<i>Prenatal Care September 2021</i>	<i>Prenatal Care September 2022</i>	<i>Postpartum Care September 2021</i>	<i>Postpartum Care September 2021</i>
Numerator	5,427	5,436	4,228	4,357
Denominator	6,917	6,770	6,917	6,770
Rate	78.86%	80.30%	61.12%	64.36%

Claims/Encounters processed through September 2022. Prenatal and Postpartum Care are hybrid measures. Prospective rates are solely administrative and do not consider the hybrid sample.

Barriers

- BSP outreach is predominantly driven by a PNR to CalOptima Health. No notification form results in a missed opportunity for outreach, program engagement as well as resource linkage to members.
- Similarly, a late pregnancy notification results in a missed opportunity to provide support and critical information early in the member’s pregnancy.
- The national COVID-19 PHE continued throughout MY 2021. This may have contributed to instances where members sought care in later stages of their pregnancy, thus impacting the timeliness of prenatal care and the timeliness in which a PNR was submitted to CalOptima Health. The PHE also led to reduced office visits due to the concerns about exposure for an expectant mother.
- BSP engages only a small portion of the HEDIS denominator. Engagement in the Bright Steps and Postpartum member health reward has increased, but the overall participation rates remain low among members who receive timely prenatal and postpartum care indicating that members may not be aware of or may not be taking advantage of these programs. Limited participation creates challenges in identifying the impact of these programs on completing timely care.
- Lack of Telephone Consumer Protection Act (TCPA) consent did not allow for member text message campaigns to launch in 2021. In addition, a limited number of members have TCPA consent on record, which places limitations on the members who can be outreached.
- Delays in claims and encounter data do not allow for the timely identification of a pregnancy or a delivery, which impacts the timeliness of member engagement.

Opportunities for Improvement

- Opportunities remain to increase promotion of and leverage the postpartum health reward to support timely postpartum care among members.
- As of April 1, 2022, the Medi-Cal postpartum benefit was expanded to one year after delivery. Subsequently the BSP also expanded services to offer additional member education to include maternal mental health, infant development and milestones among other important topics. This expansion may drive support during the postpartum experience.
- In MY 2022, the Spring and Summer Medi-Cal newsletter were programmed to include an article on the importance of prenatal care and advise members of the postpartum coverage expansion.
- As of July 1, 2022, DHCS added Community Health Worker (CHW) services as a Medi-Cal benefit. Maternal health quality metrics are being integrated into the organization’s CHW scope of work. As

trusted members of the communities they serve, CHWs may bring opportunities for maternal and child health education, may identify and address member barriers to care, and facilitate the coordination of care with the member's OB/GYN provider.

- Beginning January 1, 2023, DHCS will be adding a doula benefit to the list of preventive services covered under Medi-Cal. Doula services include personal support throughout the pregnancy, childbirth and postpartum experience. The doula benefit may help maternal health outcomes for black and other persons of color while supporting safe and healthy deliveries. Doula care has been found to improve birth outcomes and reduce health disparities, by providing emotional and physical support to women during pregnancy, childbirth and the postpartum period. The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine found that continuous labor support is among the most effective tools to improve labor and delivery outcomes.⁴
- In MY 2022, prenatal and postpartum rates were analyzed by ZIP code and language. The results were used to develop targeted prenatal and postpartum social media and digital ad campaigns to cities with the lowest rates. The ads were developed in English, Spanish and Vietnamese and launched throughout the 2022 calendar year. These languages are consistent with high-volume threshold languages (see Table 3).
- CalOptima Health will continue to expand on the member communication and engagement strategy to include multimodal approach via: Medi-Cal member newsletters, paid digital media campaigns, PBS TV campaigns, CalOptima Health website, and live calls.
- CalOptima Health will continue to expand on a provider communication and engagement strategy to include a multimodal approach via the following platforms: Provider Press Newsletters, Provider Update, CCN Virtual Meetings, and collaboration with high volume/high opportunity providers. In MY 2022, an article that discusses PNR requirements went into the Fall Provider Press newsletter.
- Opportunities remain in linking maternal and child health together to drive positive health behaviors early in the pregnancy, which will carry through the entire pregnancy and infant's life. In MY 2022, BSP transitioned workflows to conduct well-child follow-up calls at the 6- and 12-month period in support of a member continuum of care and participated in six diaper-day community events with a focus on resource linkages to address social determinants of health. At the end of Q3 MY 2022, a maternal and child health proposal draft was finalized to support DHCS' Comprehensive Quality Strategy and Bold Goals that places maternal and child health as a priority for CalOptima Health.
- There are opportunities to close gaps in care and support reductions in health disparities by conducting targeted interventions such as a live-call campaign to racial/ethnic groups that have not completed a timely postpartum visit and who represent less than 5% of the total population. A live-call campaign intervention can include a member barrier analysis, support a positive member experience and encourage a positive relationship for the member with their primary care provider. However, because Hispanic members represent the largest group in volume for the PPC measure, interventions should continue to target this group.
- Opportunities remain in augmenting partnerships that support data exchange to facilitate the early identification of pregnancies as well as deliveries for early outreach, education and resource linkage.

⁴ Caughey, A. B., Cahill, A. G., Guise, J. M., & Rouse, D. J. (2014). Safe prevention of the primary cesarean delivery. *American Journal of Obstetrics and Gynecology*, 210(3), 179–193.



Pediatric and Adolescent Well-Care Visits and Immunizations – Includes Well-Child Visits in the First 30 Months of Life (W30), Childhood Immunization Status (CIS Combo 10), Child and Adolescent Well-Care Visits (WCV) and Immunizations for Adolescents (IMA Combo 2)

Well-Child Visits in the First 30 Months of Life (W30)

Well-Child Visits in the First 30 Months of Life (W30) HEDIS measure is a part of the Medi-Cal Managed Care Accountability Set (MCAS), which is required to meet the minimum performance level (MPL) of 50th percentile as defined by the NCQA National Quality Compass Benchmarks. MY 2021 is the first year reported rate. W30 evaluates the percentage of members who had the following number of well-child visits with a PCP during the past 15 months.

Interventions

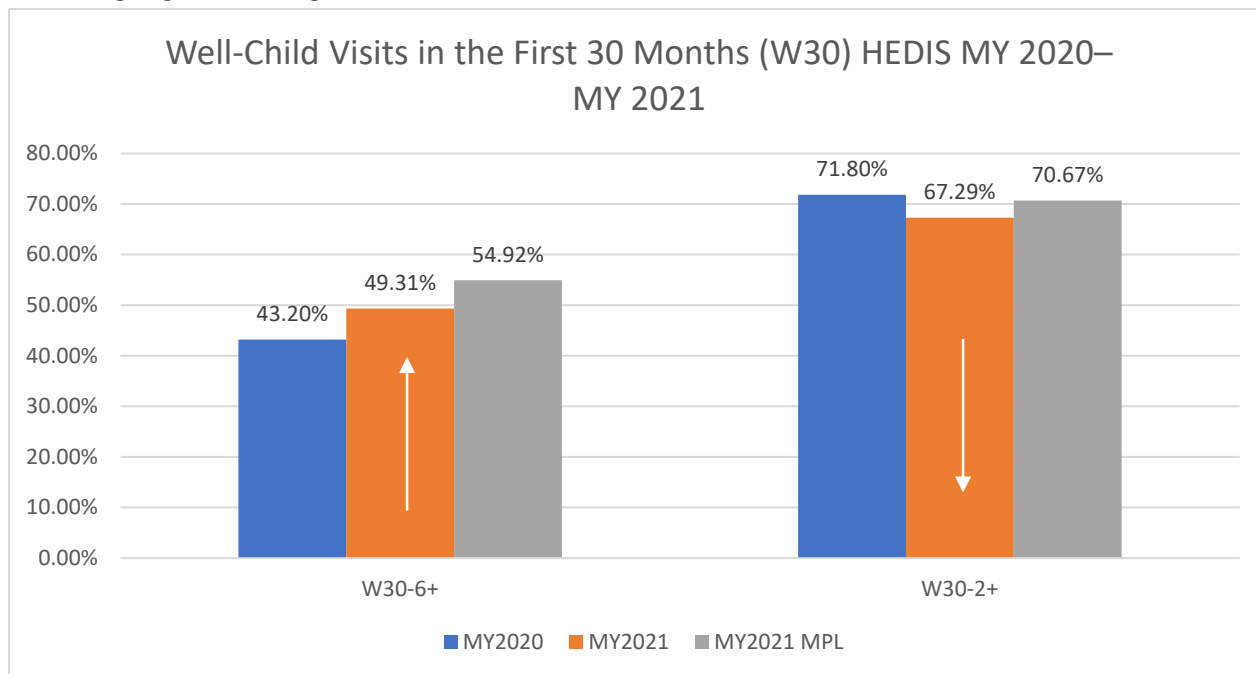
CalOptima Health has been committed to interventions that promote well-child visits. These include utilizing the BSP for follow-up phone calls, community newsletters and television advertisements.

Findings

CalOptima Health's HEDIS MY 2021 W30 did not meet MPL, see Figure 1 below. The W30-6+ rate (49.31%) increased by 6.1 percentage points and had significant improvement compared with last year and met the 33rd percentile (48.90%). The W30-2+ rate (67.30%) did not have significant improvement and decreased 4.5 percentage points compared with last year.

Figure 1 shows the increase in W30-6+ rate and a decline in W30-2+ rate compared with MY 2020. There was significant improvement in the W30-6+ rate but unfortunately did not meet the MPL of 54.92%. Additionally, W30-2+ did not meet the MPL of 70.67%. As such, improvement projects will stem from HEDIS MY 2021 results to ensure efforts are made to increase the W30 measure to meet MPL for HEDIS MY 2023.

Figure 1: Well-Child Visits in the First 30 Months of Life Final HEDIS MY 2020–MY 2021



W30 HEDIS MY 2020 was a display measure. W30 HEDIS MY 2021 was first year reported. MPL is the 50th percentile for Quality Compass Benchmarks. W30 is an administrative measure.

- a. The Post Bright Steps Well-Child Follow-Up Call Initiative began in September 2020, and for HEDIS MY 2021, only W30-2+ members would be impacted by the outreach.
 - i. 109 of 8,749 members were outreached via the Bright Steps Program Well-Baby Call Initiative. 72 unique members were successfully outreached, which means a live-person contact was made and the script questions were answered. 17 unique members were unsuccessfully outreached, which means no script questions were answered and no notes were captured by the Health Educator.
 - ii. 44 of the 72 members who were successfully outreached completed at least six well-child visits in their first 15 months of life (W30-6+).

Table 1 examines the HEDIS MY 2021 W30-6+ rates by race/ethnicity, which includes the total population N=8,749, n (compliant members) = 4,314, yielding a final rate of 49.31%. 8 out of 10 subpopulations displayed did not meet MPL, with White, Chinese and Black members having the lowest rates (40.39%-41.98%). Moreover, in examination of ethnicities within the Asian population (denominator greater than 30) Chinese, Filipino and Korean members have a lower W30-6+ rate when compared to Vietnamese (67.14%) population who met MPL. This indicates an opportunity to develop interventions targeting subpopulations within each race category.

Table 1: Medi-Cal Well-Child Visits in the First 30 Months of Life (W30-6+), First 15 Months, HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
<i>HEDIS MY 2021</i>	<i>Hispanic</i>	<i>No Response</i>	<i>Other</i>	<i>White</i>	<i>Vietnamese</i>	<i>Black</i>	<i>Korean</i>	<i>Filipino</i>	<i>Asian/Pacific Islander</i>	<i>Chinese</i>
Numerator	2,225	750	528	330	333	34	31	23	20	14
Denominator	4,386	1,620	1,107	817	496	81	61	48	36	34
Rate	50.73%	46.30%	47.70%	40.39%	67.14%	41.98%	50.82%	47.92%	55.56%	41.18%
KPI, 50th Percentile	Not Met	Not Met	Not Met	Not Met	Met 75th	Not Met	Not Met	Not Met	Met 50th	Not Met

Table displays top 10 race/ethnicities with the highest denominator based on total population. W30 is an administrative measure.

Table 2 examines the HEDIS MY 2021 W30-2+ rates by race/ethnicity which includes the total population, N=12,025, n (compliant members) = 8,092, yielding a final rate of 67.29%. 7 of 10 subpopulations displayed did not meet MPL, with Black, White and Chinese members having the lowest rates (51.09%–61.39%). Interestingly, for this latter submeasure of well-child visits between 15–30 months of life, Koreans and Filipino populations met the MPL but did not for the first 15 months. There is opportunity to develop a targeted intervention for the Black population as they were 19.58 percentage points from meeting the MPL.

Table 2: Medi-Cal, Well-Child Visits in the First 30 Months of Life (W30-2+), 15 to 30 Months, HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
<i>HEDIS MY 2021</i>	<i>Hispanic</i>	<i>No Response</i>	<i>White</i>	<i>Other</i>	<i>Vietnamese</i>	<i>Black</i>	<i>Korean</i>	<i>Chinese</i>	<i>Filipino</i>	<i>Asian/Pacific Islander</i>
Numerator	4,689	1,054	795	528	595	94	90	62	60	45
Denominator	6,799	1,597	1,326	917	709	184	122	101	80	65
Rate	68.97%	66.00%	59.95%	57.58%	83.92%	51.09%	73.77%	61.39%	75.00%	69.23%
KPI, 50th Percentile	Not Met	Not Met	Not Met	Not Met	Met 90th	Not Met	Met 50th	Not Met	Met 50th	Not Met

Table displays top 10 race/ethnicities with the highest denominator based on total population including administrative and hybrid measure counts.

Analysis

- The Post Bright Steps Well-Child Follow-Up Call Initiative was implemented throughout MY 2021. Newborn members were identified through their parent or guardian who participated in the BSP. This allowed for an early identification and outreach to members prior to HEDIS reporting year. The call script included questions and guidance on both well-child visits and immunizations.
- CalOptima Health did not meet the goals set for W30 in MY 2021. As shown in Table 3, W30-6+ did not meet goal by 5.61 percentage points and W30-2+ did not meet goal by 7.13 percentage points.

Table 3: MY 2022 Medi-Cal W30 Goal

<i>HEDIS Measure</i>	<i>HEDIS MY 2021 Final Rate</i>	<i>MY 2021 Goal Rate</i>	<i>Variance</i>
Well-Child Visits in the First 30 Months of Life (W30-6+) 0–15 Months	49.31%	54.92%	-5.61 percentage points
Well-Child Visits in the First 30 Months of Life (W30-2+) 15–30 Months	67.29%	74.42%	-7.13 percentage points

Table displays the final HEDIS 2021 results and the goal for each measure.

Barriers

- The Bright Steps Well-Child Follow-Up Calls are limited to members whose parent or guardian participated in the BSP and are also CalOptima Health Medi-Cal members.
- The Telephone Consumer Protection Act (TCPA) halted text message campaign efforts in 2021.
- Administratively, in the situation where members who completed well-child visits under their parent or guardian’s medical record number and they are not CalOptima Health members, it is difficult to obtain those records for HEDIS reporting. This creates a data gap for members who receive care before establishing medical care with CalOptima Health.
- Since HEDIS captures members who turn either 15 months old or 30 months old for W30 in the measurement year, there is difficulty in identifying members timely to impact the first few recommended well-child visits by Bright Futures and American Academy of Pediatrics.
- The provider office had limited availability for scheduling appointments.
- The provider office did not have an appointment reminder system (e.g., email, text message or phone call reminder).
- The provider office wait times and total time spent in the office were too long.
- The provider office schedules did not allow for future well-child visits to be scheduled. The parent or guardian must call when the child gets closer to age-based well-child visit date.
- The member’s well-child visit may have been replaced by a sick visit, which impacted their well-child visit schedule.
- The member’s parent or guardian was unable to attend the well-child visit due to transportation limitations.
- The member’s parent or guardian preferred to obtain care closer to home and with a trusted community partner (e.g., at a health fair).
- The member’s parent or guardian may have been unaware about the timeliness and importance of well-child visits.
- The member’s parent or guardian forgot to schedule and attend the well-child visits.

Opportunities for Improvement

Based on September 2022 Prospective Rate Report, W30-6+ (33.05%) and W30-2+ (67.46%) HEDIS rates are performing higher than last year, see Table 4. The latter measure, W30-2+ (15–30 months) has met MPL (65.83%). Opportunity remains to increase the W30 measure as the Quality Compass Benchmark was lowered due to all plans performing lower than MPL in MY 2021.

Table 4: MY 2022 Medi-Cal W30 Prospective Rates

HEDIS Measure	September 2021		September 2022		
	Denominator	Rate	Denominator	Numerator	Rate
W30-6+	8,768	28.30%	8,521	2,816	33.05%
W30-2+	12,046	63.31%	12,357	8,336	67.46%

Prospective Rates reflect claims/encounters processed through September 2022.

- b. As an identified strategy to increase the W30 rate from MY 2021, a multimodal approach was implemented in MY 2022 that positively impacted the rate. Interventions and activities included telephonic outreach and call campaign, robocall campaigns, targeted mailing, mobile text messaging, targeted advertisements, and television advertisements.
- c. A limitation of said interventions above was obtaining member consent for outreach. CalOptima Health will seek a concerted effort to increase TCPA consent so that more members may be included in robocall and text messaging campaigns.
- d. Live-person telephonic call campaigns have proven to be effective in reaching members since there are less outreach limitations. It not only serves as a reminder to members, but CalOptima Health is able to obtain qualitative data on barriers to care. CalOptima Health will consider building an internal call center to conduct telephonic call campaigns more regularly to connect with members before they age-out of the measure.
- e. Member surveys were conducted to obtain member feedback for areas of improvement.

Childhood Immunization Status (CIS-10)

Childhood Immunization Status – Combination 10 (CIS-10) HEDIS measure is a part of the Medi-Cal MCAS, which is required to meet the MPL of 50th percentile as defined by the NCQA National Quality Compass Benchmarks. CIS evaluates the percentage of children 2 years of age who had the following vaccinations: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. Combination 10 includes all vaccinations listed.

Interventions

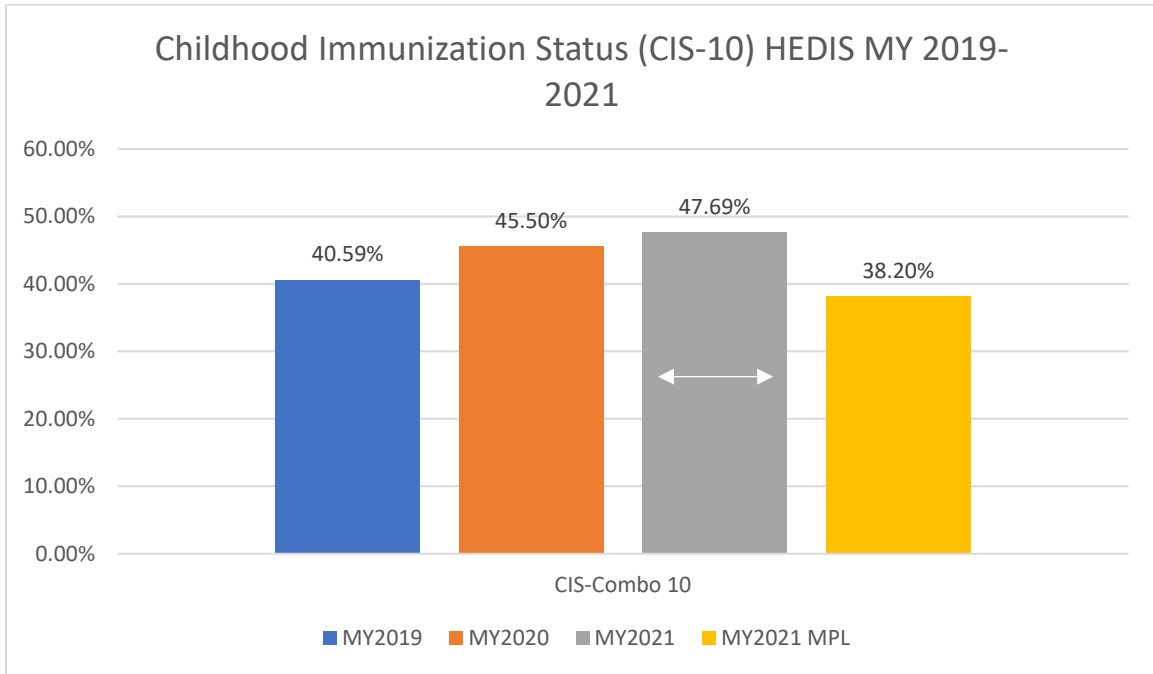
CalOptima Health has been committed to interventions that promote childhood immunizations. Interventions included utilizing the BSP for phone calls, community newsletters, television advertisements and social media campaigns.

Findings

- a. CalOptima Health’s HEDIS MY 2021 CIS-Combo 10 met MPL, see Figure 1 below. The CIS-Combo 10 rate (47.69%) increased by 2.19 percentage points but did not have significant improvement compared to last year and met the 75th percentile (45.50%).

- b. Figure 1 shows the increase in CIS-Combo 10 rate compared to previous years. There was no significant improvement compared to MY 2020 but did meet the 75th percentile (45.50%).

Figure 1: Childhood Immunization Status Final HEDIS MY 2019–MY 2021



CIS-Combo 10 is a hybrid measure. CIS-Combo 10 HEDIS MY2019 rate was rotated: previous year's rate (2018) was reported. MPL is the 50th percentile for Quality Compass Benchmarks.

- c. The Post Bright Steps Well-Child Follow-Up Call Initiative began in September 2020, for HEDIS MY 2021, no impact outcome is measured for CIS-Combo 10 since members who were outreached have not turned 2 years old in HEDIS MY 2021 reporting year.
- d. Table 1 examines the HEDIS MY 2021 CIS-Combo 10 rates by race/ethnicity which includes the total population, N=13,082, n (compliant members) = 4,920, yielding a final rate of 37.61%. 4 of 10 subpopulations displayed did not meet MPL, identify Black members as having the lowest rate of 23.21%. There is opportunity to develop a targeted intervention for the Black population as they were 14.99 percentage points from meeting the MPL.

Table 1: Medi-Cal, Childhood Immunization Status (CIS-Combo 10), Combination 10, HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
<i>HEDIS MY 2021</i>	<i>Hispanic</i>	<i>No Response</i>	<i>White</i>	<i>Other</i>	<i>Vietnamese</i>	<i>Black</i>	<i>Korean</i>	<i>Chinese</i>	<i>Filipino</i>	<i>Asian/Pacific Islander</i>
Numerator	2,774	696	429	390	378	39	51	43	30	33
Denominator	7,102	2,011	1,351	1,224	727	168	119	99	77	71
Rate	39.06%	34.61%	31.75%	31.86%	51.99%	23.21%	42.86%	43.43%	38.96%	46.48%
KPI, 50th Percentile	Met 50th	Not Met	Not Met	Not Met	Met 75th	Not Met	Met 50th	Met 50th	Met 50th	Met 75 th

Table displays top 10 race/ethnicities with the highest denominator based on total population including administrative and hybrid measure counts.

Analysis

- a. The Post Bright Steps Well-Child Follow-Up Call Initiative was implemented throughout MY 2021. Newborn members were identified through their parent or guardian who participated in the BSP. This allowed for an early identification and outreach to members prior to HEDIS reporting year. The call script included questions and guidance on both well-child visits and immunizations.
- b. CalOptima Health did not meet the goal for CIS-Combo 10 in MY 2021. As shown in Table 3, CIS-Combo 10 did not meet the goal by 1.89 percentage points.

Table 2: MY 2022 Medi-Cal CIS-Combo 10 Goal

HEDIS Measure	<i>HEDIS MY 2021 Final Rate</i>	<i>MY 2021 Goal Rate</i>	<i>Variance</i>
Childhood Immunization Status (CIS) Combination 10	47.69%	49.58%	1.89 percentage points

Barriers

- The Bright Steps Well-Child Follow-Up Calls are limited to members whose parent or guardian participated in the BSP and are also CalOptima Health Medi-Cal members.
- The Telephone Consumer Protection Act (TCPA) halted text message campaign efforts in 2021.
- CIS-Combo 10 includes the completion of 10 vaccine types and its respective doses. If a member is receiving their vaccinations off schedule, it decreases the likelihood of completing them within the CIS timeframe.
- Since HEDIS captures members who turn 2 years old for CIS in the measurement year, there is difficulty in identifying members timely to impact the first few recommended vaccinations by Bright Futures and American Academy of Pediatrics.
- The provider office had limited availability for scheduling appointments, may have long office wait times and may not have an appointment reminder system in place.
- The provider office schedule does not allow for future immunizations to be scheduled. The parent or guardian must call when it gets closer to age-based well-child visit date.

- The member’s parent or guardian prefers to obtain care closer to home and with a trusted community partner (e.g., at a health fair).
- The member’s parent or guardian is unaware of the timeliness and importance of vaccinations or forgot to schedule and attend well-child visits to obtain vaccinations for their child.
- The member’s parent or guardian is fearful of the vaccinations or refuses the provider’s recommendation for vaccinations.

Opportunities for Improvement

- Based on September 2022 Prospective Rate Report, CIS-Combo 10 (30.57%) HEDIS rates are performing higher than last year and has not met MPL (34.79%), see Table 3. Opportunities remain to increase the CIS-Combo 10 rate.

Table 3: MY 2022 Medi-Cal Prospective Rates

HEDIS Measure	September 2021		September 2022		
	Denominator	Rate	Denominator	Numerator	Rate
Childhood Immunization Status (CIS) Combination 10	12,702	30.26%	11,789	3,604	30.57%

Prospective Rates reflect claims/encounters processed through September 2022.

- As an identified strategy to increase CIS-Combo 10 rate from MY 2021, a multimodal approach was implemented in MY 2022, which has shown to positively impact the rate. Interventions and activities included member telephonic outreach, targeting mailings, mobile texting, targeted advertisements and television advertisements.
- A limitation of the interventions was due to the challenge in obtaining member consent for outreach. CalOptima will seek a concerted effort to obtain more TCPA consents so more members can be included in robocall campaigns and text message campaigns.
- Since Well-Child Visits in the First 30 Months of Life (W30) and Childhood Immunization Status (CIS) populations overlap there are opportunities to complete singular interventions to target both populations.
- Additionally, live-person telephonic call campaigns have proven to be effective in reaching members since there are fewer outreach limitations. It not only serves as a reminder to members, but CalOptima Health is able to obtain qualitative data on barriers to care. CalOptima Health will consider building an internal call center to conduct telephonic call campaigns more regularly to connect with members before they age out of the measure.



Child and Adolescent Well-Care Visits (WCV)

Child and Adolescent Well-Care Visits (WCV) HEDIS measure is a part of the Medi-Cal MCAS, which is required to meet the MPL of 50th percentile as defined by the NCQA National Quality Compass Benchmarks. WCV evaluates the percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

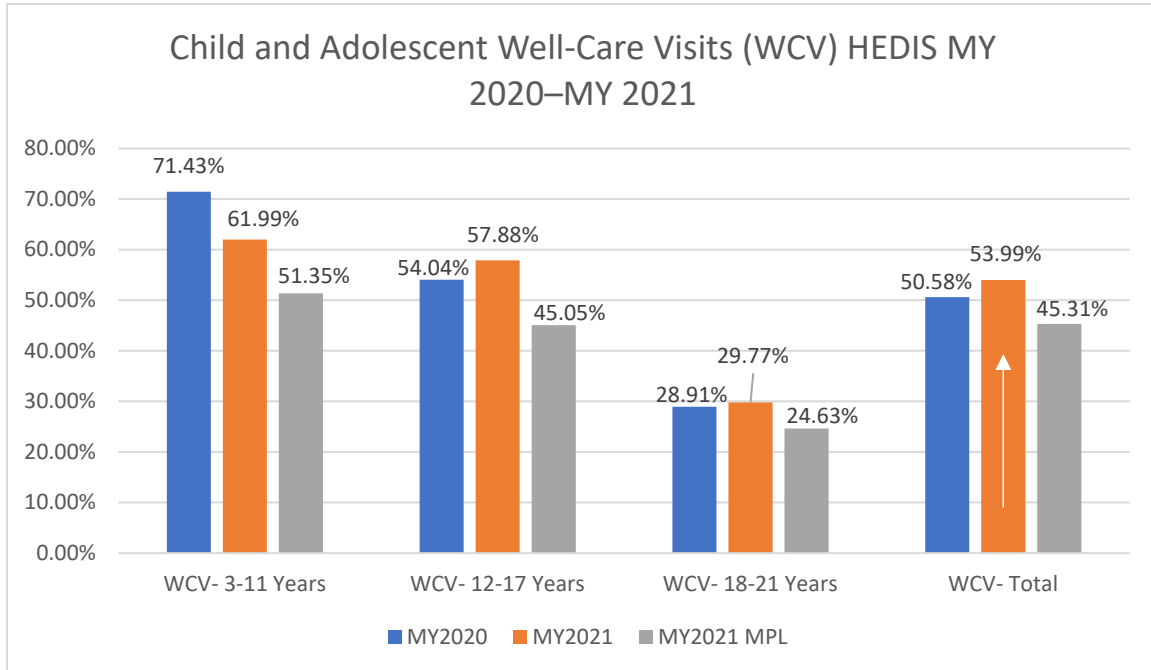
Interventions

CalOptima Health has been committed to interventions that promote child and adolescent Well-Care Visits. Interventions included member and community newsletters, robocall campaigns and social media campaigns.

Findings

- a. CalOptima Health's HEDIS MY 2021 WCV-Total met MPL, see Figure 1 below. The WCV-Total rate (53.99%) increased by 3.14 percentage points and had significant improvement compared to last year. WCV-Total met the 75th percentile (53.83%).
- b. Figure 1 shows an increase in WCV-Total rate compared to MY 2020. There was significant improvement compared to MY 2020 and met the 75th percentile (53.83%).

Figure 1: Child and Adolescent Well-Care Visits Final HEDIS MY 2020–MY 2021



WCV HEDIS MY 2020 was a display measure. WCV HEDIS MY 2021 was first year reported. WCV-Total is reported and held to the MPL. MPL is the 50th percentile for Quality Compass Benchmarks. WCV is an administrative measure.

- c. 45,649 of 302,266 WCV members received the Health Guide 3-6 Newsletter Mailing. Of those 20,782 members completed their well-care visit after receiving the mailing.
- d. 30,163 of 302,266 WCV members were included in the DHCS Preventative Outreach IVR campaign. 2,277 members successfully played message to live voice or received voice mail and completed their well-care visit after receiving this campaign.
- e. Table 1 examines the HEDIS MY 2021 WCV-Total rates by race/ethnicity which includes the total population, N=302,275, n (compliant members) = 163,213, yielding a final rate of 53.99%. 3 of 10 subpopulations displayed did not meet MPL, identifying White and Black members as having the lowest rates of 39.14% and 42.07%, respectively. There is opportunity to develop a targeted intervention for the White and Black population to meet the MPL.

Table 1: Medi-Cal, Child and Adolescent Well-Care Visits (WCV), Total, HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
<i>HEDIS MY 2021</i>	<i>Hispanic</i>	<i>White</i>	<i>Vietnamese</i>	<i>No Response</i>	<i>Other</i>	<i>Korean</i>	<i>Black</i>	<i>Filipino</i>	<i>Chinese</i>	<i>Asian/Pacific Islander</i>
Numerator	110,277	13,989	14,817	9,332	4,390	2,851	2,051	1,469	1,350	901
Denominator	192,550	35,744	23,937	18,023	9,993	5,436	4,875	3,039	2,893	1,965
Rate	57.27%	39.14%	61.90%	51.78%	43.93%	52.45%	42.07%	48.34%	46.66%	45.85%
KPI, 50th Percentile	Met 75th	Not Met	Met 75th	Met 50th	Not Met	Met 50th	Not Met	Met 50th	Met 50th	Met 50th

Table displays top 10 race/ethnicities with the highest denominator based on total population including administrative and hybrid measure counts.

Analysis

- a. It is undetermined if there’s a correlation between the Health Guide 3-6 Newsletter Mailing and the DHCS Preventative Outreach IVR campaign having an impact on the WCV rate, however, 1,338 members received both interventions and were compliant. WCV 3-11 Years Denominator: 133,884
 - i. $1,338 / 133,884 = 1.00\%$ impact to the submeasure, WCV 3-11 Years
- b. CalOptima Health met the goal set for MY 2021. As shown in Table 2, WCV met the goal set by 0.16 percentage points.

Table 2: MY 2022 Medi-Cal WCV Goal

HEDIS Measure	<i>HEDIS MY 2021 Final Rate</i>	<i>MY 2021 Goal Rate</i>	<i>Variance</i>
Child and Adolescent Well-Care Visits (WCV) Total	53.99%	53.83%	+0.16 percentage points

Barriers

- The WCV population is large at 302,266 members. It is difficult to implement an intervention that will impact the larger population to improve the HEDIS rate.
- Despite IVR campaigns having the capacity for a large reach, landline phone numbers limit the number of members who can receive the IVR message.
- The Telephone Consumer Protection Act (TCPA) halted text message campaign efforts in 2021.
- The provider offices have limited availability for scheduling appointments, may not have an appointment reminder system and may have long office wait times.
- The member’s well-care visit is replaced by a sick visit, which may lead to the parent or guardian forgetting to schedule another well-care visit.
- The member’s parent or guardian is unable to attend well-care visit due to transportation limitations.
- The member’s parent or guardian prefers to obtain care closer to home and with a trusted community partner (e.g., at a health fair).

- The member’s parent or guardian was unaware about the timeliness and importance of well-care, or forgot to schedule and attend well-care visits.
- Members may be reluctant to attend well-care visits as it’s not required to attend school. Incoming kindergarteners are the exception.

Opportunities for Improvement

- a. Based on September 2022 Prospective Rate Report, WCV-Total (30.05%) HEDIS rates are performing higher than last year but have not met MPL (48.93%), see Table 3. Opportunities remain to increase the WCV rate.

Table 3: MY 2022 Medi-Cal WCV Prospective Rates

HEDIS Measure	September 2021		September 2022		
	Denominator	Rate	Denominator	Numerator	Rate
Child and Adolescent Well-Care Visits (WCV) Total	305,149	32.58%	317,273	111,196	35.05%

Prospective Rates reflect claims/encounters processed through September 2022.

- b. As an identified strategy to increase WCV rate from MY 2021, a multimodal approach has been implemented in MY 2022 that has shown to positively impact the rate. Interventions and activities included newsletters, robocall campaigns, mobile text message campaigns, targeted advertisements, and television advertisements.
- c. A limitation of the interventions was due to the challenge in obtaining member consent for outreach. CalOptima will seek a concerted effort to obtain more TCPA consents so more members may be included in robocall campaigns and text message campaigns especially as electronic outreach is feasible for the large population of the WCV HEDIS measure.
- d. Since Child and Adolescent Well-Care Visits (WCV), Lead Screening in Children (LSC), Immunizations for Adolescents (IMA) have overlapping member populations, there are opportunities to do a concerted effort for interventions to include all these members.
- e. Opportunities to collaborate with community-based organizations (CBOs) and school districts to promote well-care visits for students of all ages. Past community events proved parents and/or guardians see their child’s school and CBOs as trusted resources and are more likely to respond and follow through with the guidance.



Immunizations for Adolescents (IMA-2)

Immunizations for Adolescents (IMA) HEDIS measure is a part of the Medi-Cal MCAS, which is required to meet the MPL of 50th percentile as defined by the NCQA National Quality Compass Benchmarks. IMA evaluates the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

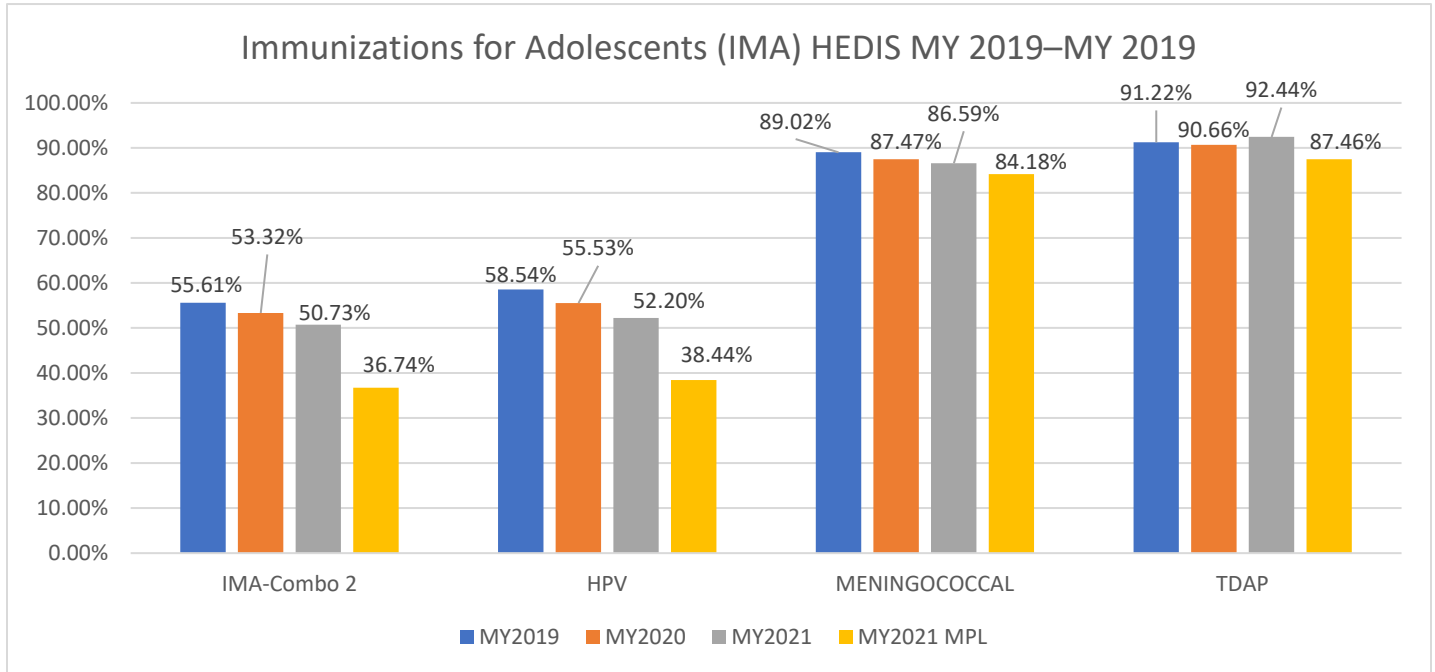
Interventions

CalOptima Health supports interventions that promote adolescent immunizations. Interventions included back-to-school vaccination events, member and community newsletters, website promotion and social media campaigns.

Findings

- a. CalOptima Health's HEDIS MY 2021 IMA-Combo 2 met MPL (36.74%), see Figure 1 below. The IMA-Combo 2 rate (50.73%) decreased by 2.59 percentage points and did not have significant improvement compared to last year. IMA-Combo 2 met the 90th percentile (50.61%).
- b. Figure 1 shows a decrease in IMA-Combo 2 rate compared to previous years. There was no significant improvement compared to MY 2020 but did meet the 90th percentile (50.61%).

Figure 1: Immunizations for Adolescents Final HEDIS MY 2019–MY 2021



IMA is a hybrid measure. MPL is the 50th percentile for Quality Compass Benchmarks. IMA-Combo 2 is reported and held to the MPL. MPL is the 50th percentile for Quality Compass Benchmarks.

- c. In summation of all the Back-To-School Vaccination Event participants, only 16 fell in the IMA denominator. Furthermore, only 2 of the 16 members became compliant after attending the event.
- d. 3,722 CalOptima Health Medi-Cal members ages 11–17 were included in the DHCS Preventative Outreach IVR Campaign. Only 2,256 of 17,445 IMA members received robocall. Of those, 398 members successfully played a message to live voice or received voice message. Nine members completed their vaccinations series after receiving the outreach.
- e. Table 1 examines the HEDIS MY 2021 IMA-Combo 2 rates by race/ethnicity, which includes the total population, N=17,855, n (compliant members) = 8,127, yielding a final rate of 45.52%. 5 of 10 subpopulations displayed did not meet MPL, with White, Black and Asian/Pacific Islanders having the lowest rates. There is opportunity to develop a targeted intervention for these identified subpopulations to help meet the MPL.

Table 1: Medi-Cal, Immunizations for Adolescents (IMA-Combo 2), Combination 2, HEDIS MY 2021 Rate by Race/Ethnicity

Admin	Race/Ethnicity									
	Hispanic	White	Vietnamese	No Response	Other	Korean	Black	Chinese	Filipino	Asian/Pacific Islander
HEDIS MY 2021										
Numerator	5,914	522	835	261	109	129	74	66	74	43
Denominator	12,240	1,878	1,363	735	333	305	302	160	160	125
Rate	48.32%	27.80%	61.26%	35.51%	32.73%	42.30%	24.50%	41.25%	46.25%	34.40%
KPI, 50th Percentile	Met 75th	Not Met	Met 90th	Not Met	Not Met	Met 50th	Not Met	Met 50th	Met 75th	Not Met

Table displays top 10 race/ethnicities with the highest denominator based on total population including administrative and hybrid measure counts. IMA-Combination 2 includes adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

Analysis

- a. It is undetermined if there’s a correlation between the DHCS Preventative Outreach IVR campaign having an impact on the IMA-Combo 2 rate.
- b. CalOptima Health met the goal set for IMA-Combo 2 in MY 2021. As shown in Table 2, IMA-Combo 2 met the goal set by 0.12 percentage points.

Table 2: MY 2022 Medi-Cal IMA-Combo 2 Goal

HEDIS Measure	HEDIS MY 2021 Final Rate	MY 2021 Goal Rate	Variance
Immunizations for Adolescents (IMA) Combination 2	50.73%	50.61%	+0.12%

Table displays the final HEDIS 2021 results and the goal for each measure.

Barriers

- Back-To-School Vaccination Events required collaboration across multiple organizations with high reach potential, but low impact. As discussed above, only 16 members fell in the IMA denominator.
- With the availability of the COVID-19 vaccine in 2021, clinics’ availability to support Back-To-School Vaccination events was limited as they were in process of operationalizing internal vaccine clinics.
- The Telephone Consumer Protection Act (TCPA) halted text message campaign efforts in 2021.
- The provider offices have limited availability for scheduling appointments, did not have an appointment reminder system or the wait times were too long.
- The provider office schedule did not allow for future immunizations to be scheduled. The parent or guardian had to call the office to schedule the appointment when the child was closer to the age-based well-child visit date.
- The member’s parent or guardian preferred to obtain care closer to home and with a trusted community partner (e.g., at a health fair).
- The member’s parent or guardian was unaware of the timeliness and importance of vaccinations.
- The member’s parent or guardian forgot to schedule and attend well-child visits to obtain vaccinations for their child.

- The member’s parent or guardian or the child had a fear of vaccinations or refused the provider’s recommendation for vaccinations.

Opportunities for Improvement

- Based on September 2022 Prospective Rate Report, IMA-Combo 2 (44.34%) HEDIS rates are performing lower than last year and have met the MPL (35.04%), see Table 3. IMA-Combo 2 has met the 66th percentile (39.16%). Opportunities remain to increase the IMA-Combo 2 rate as MY 2022 performance is lower than MY 2021.

Table 3: MY 2022 Medi-Cal IMA-Combo 2 Prospective Rates

HEDIS Measure	September 2021		September 2022		
	Denominator	Rate	Denominator	Numerator	Rate
Immunizations for Adolescents (IMA) Combination 2	17,464	45.68%	17,574	7,793	44.34%

Prospective Rates reflect claims/encounters processed through September 2022.

- As an identified strategy to increase IMA rate from MY 2021, a multimodal approach has been implemented in MY 2022 that has shown to positively impact the rate. Interventions included back-to-school vaccination events, member and community newsletters, website promotion and social media campaigns.
- There was a limitation of the interventions due to the challenge in obtaining member consent for outreach. CalOptima Health will seek a concerted effort to obtain more TCPA consents so that more members may be included in robocall campaigns and text message campaigns.
- Additionally, live-person telephonic call campaigns have proven to be effective in reaching members since there are fewer outreach limitations. It not only serves as a reminder to members, but CalOptima Health is able to obtain qualitative data on barriers to care. CalOptima Health will consider building an internal call center to conduct telephonic call campaigns more regularly to connect with members before the member ages out of the measure.
- CalOptima Health has opportunities to collaborate with CBOs and school districts to promote vaccinations for students. Past community events proved parents and/or guardians see their child’s school and CBOs as trusted resources and are more likely to respond and follow through with the guidance.



Blood Lead Screening (BLS) Lead Screening in Children (LSC)

Lead Screening in Children (LSC) is a hybrid HEDIS and MCAS measure that is currently not held to the MPL. LSC measures the percentage of children who are 2 years of age and had one or more capillary or venous blood test for lead poisoning by their second birthday.

Beginning MY 2022, managed care plans (MCPs) will be held to the MPL. In addition, through All Plan Letter (APL) 20-016: Blood Lead Screening in Young Children, DHCS issued regulatory requirements for MCPs to ensure timely BLS among eligible child members. APL mandates differ from HEDIS and require two BLS, one at 12 months and a second at 24 months of age with catch-up testing if these recommendations are not met.

CalOptima Health has engaged in efforts to ensure compliance with the DHCS APL 20-016 and increase the BLS rates through various provider and member-based efforts that emphasize the importance of timely BLS. Meeting the testing mandates outlined in the APL will support improved testing rates for the LSC HEDIS measure, thus blood lead testing is an opportunity for CalOptima Health to prioritize pediatric preventive care measures such as LSC.

Interventions

- Spring 2021 Medi-Cal Newsletter: April 2021 was mailed to all 535,741 head of household members in seven threshold languages.
- Health Guide 3-6 Newsletter and “How Protect Your Family from Lead Poisoning” handout: April 2021 was mailed to 47,901 Medi-Cal children ages 3–6.
- Social Media Engagement: October 2021 Social media post on Facebook, Instagram and Twitter during National Lead Poisoning Prevention week.
- Be Aware of Lead Poster: During October 6–29, 2021, 325 English, Spanish and Vietnamese posters were distributed to 65 high-volume provider offices that described the health effects of lead, who must be screened for lead and preventing exposure to lead.
- DHCS Blood Lead Postcard Resource Guide: November 2021

- Quarterly BLS Gap Reports: April 2021
 - i. In accordance with regulatory and operational requirements, the BLS gap reports were sent to all Health Networks. The first gap report was sent in April 2021 and identified children 6–72 months of age who have not been screened for lead as recommended. CalOptima Health also provided information to the Health Networks through Provider Update, Provider Press Newsletter, Quality 1:1 quarterly meetings with Health Networks.

Findings

- b. The HEDIS LSC measure was not held to MPL during MY2021. The final HEDIS rate was 63.99%.
- c. In reviewing the testing rate by ethnicity for the LSC measure, see Table 1, Hispanic child members represent the majority of the child population (54.28%) and had a 64.19% testing rate. Black child members represent 1.28% of the child population, however, were among the groups that had the lowest testing rates (42.86%). Additionally Chinese, Filipino and Asian/Pacific Islander child members represent less than 1% of the total population but were among the groups with the lower testing rates.

Table 1: MY 2021 LSC HEDIS Results by Ethnicity

Hybrid	Ethnicity										
HEDIS MY 2021	Hispanic	No response	White	Other	Vietnamese	Black	Korean	Chinese	Filipino	Asian/Pacific Islander	Total
Numerator	4,559	1,080	655	667	480	72	83	59	45	30	7,802
Denominator	7,102	2,011	1,351	1,224	727	168	119	99	77	71	13,082
Rate	64.19%	53.70%	48.48%	54.49%	66.02%	42.86%	69.75%	59.60%	58.44%	42.25%	59.64%
% of Total Population	54.29%	15.37%	10.33%	9.36%	5.56%	1.28%	0.91%	0.76%	0.59%	0.54%	59.63%

Table A displays top 10 ethnicities with the highest denominator based on total population. LSC is a hybrid measure. The total rate does not indicate the final HEDIS rate.

- d. Claims from January 1, 2021–May 23, 2022, related to blood lead diagnosis were analyzed. Out of 199 claims, 95 (47.7%) members have diagnosis Z77.011 – Contact with and (suspected) exposure to lead. Santa Ana (15.85%), Anaheim (14.73%) and Laguna Beach (10.52%) are the top three geographic areas of members being diagnosed with “contact with/and suspected exposure to lead.” Results are consistent with the environmental risk factors present in the communities of Santa Ana and Anaheim as a result of pre-1978 housing.

- e. One research study¹¹ analyzed the concentration of lead in soil samples throughout Santa Ana and concluded that census tracts with lower-income households have higher concentrations of lead in the soil. In addition, 11 census tracts within Santa Ana were identified as high risk for lead exposure. In August 2022, lead testing rates were analyzed using May 2022 prospective rates, and it was found that 39.1% of children living in these 11 high risk census tracts remained untested.
- f. Lead paint has historically been the greatest source of lead exposure, but children can be exposed to lead through additional sources. In one study¹², researchers mapped historical roads, traffic patterns and housing in Santa Ana. They found greater concentrations of lead in areas that experienced higher traffic volumes over a longer period of time. It was concluded that concentration of lead in soil is due to pollution from vehicle emissions, which poses a risk for lead exposure and lead poisoning.
- a. Beginning MY 2022, the HEDIS LSC measure will be held to the MPL. As of September 2022, the LSC prospective rate was 58.94%, which is a 1.51 percentage points higher than the September 2021 prospective rate of 57.43%. See Table B.

Table 2: MY 2022 Medi-Cal LSC Prospective Rate Results

HEDIS Prospective Rates	September 2021	September 2022
Numerator	7,295	6,949
Denominator	12,702	11,789
Rate	57.43%	58.94%

Claims/Encounters processed through September 2022. LSC is a hybrid measure. Prospective Rates are solely administrative and do not take into account hybrid sample.

2. Analysis

- a. The first quarterly BLS gap reports issued in April 2021 contained data from January through March 31, 2021. The BLS gap report identified child members who have not been screened for lead in accordance with the California Code of Regulations. This is intended to support Health Networks with their efforts to close gaps in blood lead screening.
- b. Multiple interventions were focused on driving member awareness and providing education related to BLS. It is key to continue to drive member education efforts, but there are opportunities to expand on interventions that focus on providers and high-volume offices. In addition, there are opportunities to better understand the potential systematic barriers that may be preventing members from getting a blood lead test.
- c. September 2022 Prospective Rates are higher than the same time in September 2021. Lower prospective rates in 2021 may be a result of the impact of the COVID-19 pandemic on well-child visit attendance and subsequently blood lead testing.

¹¹ Masri S, LeBrón A, Logue M, Valencia E, Ruiz A, Reyes A, Lawrence JM, Wu J. Social and spatial distribution of soil lead concentrations in the City of Santa Ana, California: Implications for health inequities. *Sci Total Environ.* 2020 Nov 15;743:140764. doi: 10.1016/j.scitotenv.2020.140764. Epub 2020 Jul 6. PMID: 32663692; PMCID: PMC7492407

¹² Rubio, J M, Masri, S., LeBrón, A., Torres, I .R., Sun, Y., Villegas, K., Flores, P., Logue, M.D., Reyes A., Lebron. A., Wu, J. Use of historical mapping to understand sources of soil-lead contamination: Case study of Santa Ana, CA. *Environmental Research.* 22 Sept. 212. doi: <https://doi.org/10.1016/j.envres.2022.113478>

Barriers

- On July 6, 2021, Magellan Diagnostics issued a recall on LeadCare II, LeadCare Plus and LeadCare Ultra Blood Lead Tests. The recall was expanded two additional times. Distribution of the products did not resume until March 30, 2022. This recall had the potential to contribute to systematic barriers with the shortage of blood lead testing supplies and pose additional challenges with the distribution of available supplies. In addition, the recall may have contributed to member barriers if the provider was not able to perform a blood lead test in office and required the member to go to a lab for testing.
- Laboratories may have reduced their ability for testing due to limited point of care testing supplies as a result of the Magellan Diagnostics recall.
- Providers may not have had the capability to conduct point of care testing for lead in their offices and must refer members to complete a lead test in a laboratory.
- The national COVID-19 PHE continued throughout MY 2021. Since the onset of the pandemic, there has been a decrease in well-child visits, which has led to significant delays in the provision of recommended screenings including lead testing. There are cohorts of children who remain behind on these regular routine visits or may follow an alternative schedule.
- Parents or guardians of children may opt not to complete a lead screening because they may be unaware of the importance of blood lead testing or the recommended testing cadence at 12 and 24 months of age. Parents or guardians may also have concerns related to the physical discomfort associated with testing.
- The Telephone Consumer Protection Act (TCPA) consent restrictions did not allow for member text message campaigns to launch in 2021. In addition, a limited number of members have TCPA consent on record, which places limitations on the members who can be outreached.
- Low-income communities face the burden of geospatial barriers that increased the risk of lead exposure. Disproportionate rates of lead exposure are the result of the lack of regulations related to lead, discrimination in housing and poor housing quality, and high concentrations of lead in the soil that are not being addressed. Lack of effective policies and investment efforts to address environmental factors will continue to result in persistent lead, heightened exposure risk and ongoing health consequences as a result of exposure.

Opportunities for Improvement

- The LSC measure was not held to MPL in MY 2021, however the measure will be held to MPL in MY 2022. In addition, DHCS issued APL 20-016 in November 2020 to mandate two blood lead tests with the opportunity to complete catch up testing through 72 months of age. Meeting the regulatory requirements for testing will support the LSC measure that mandates one test at minimum, thus blood lead testing should be a high priority for quality initiatives.
- Exposure to lead is an environmental justice and health equity issue. Research indicates that lead exposure disproportionately affects low-income communities and children of color. Addressing lead screening rates provides an opportunity to address health equity issues, however it requires a multiprong approach. Blood lead testing is the best and only way to identify lead exposure in children.
- In Q3 of MY 2022, CalOptima Health conducted in-person (n=28) and telephonic (n=113) barrier analysis among parents/guardians of child members to understand the root causes that influence blood lead testing or the lack thereof. Out of the 28 parents surveyed, 20 (71.42%) tested for lead, and 18 (85.71%) of those that tested did so as a result of a provider recommendation. Conclusion: Providers are an important factor for childhood blood lead testing. Out of the 113 parents surveyed, 57 (50.44%) tested for lead, 45 (39.82%) did not test for lead and 27 (51.11%) of those who did not test did not know about lead testing. In conclusion, opportunities exist for member education efforts to advise of the importance of blood lead screenings.

- Opportunities remain to conduct a provider barrier analysis to understand their perception of the factors that influence blood lead testing among child members or the lack thereof.
- CalOptima Health will continue to expand on the member communication and engagement strategy to include multimodal approach via: Medi-Cal member newsletters, texting, robocalls, paid digital media campaigns, PBS TV campaigns, CalOptima Health website and live calls.
- CalOptima Health will continue to expand on a provider communication and engagement strategy to include a multimodal approach via: Provider Press Newsletters, Provider Update, Continuing Medical Education (CME) events, and collaboration with high-volume/high-opportunity providers.
- Opportunities remain to tailor initiatives to untested members. Testing rates were analyzed by ZIP code and languages and were used to develop targeted social media and digital ad campaigns in English, Spanish and Vietnamese that launched throughout MY 2022.
- There are opportunities to close gaps in care and support reduce health disparities by conducting targeted interventions such as a live call campaign to racial/ethnic groups that are untested per the LSC measure and who represent less than 5% of the total population. A live call campaign intervention can include a member barrier analysis, support a positive member experience and encourage a positive relationship with their PCP. However, because Hispanic members represent the largest group in volume, interventions should continue to target this group.
- The BSP is transitioning workflows to conduct well-child follow-up calls at the 6- and 12-month period to parents who participated in the BSP to support a continuum of care. BSP follow-up calls will include educating parent/guardian on testing, analyzing potential barriers for testing and discussing potential sources of lead.
- In MY 2022, LSC was included in the Pay 4 Value (P4V) program to drive Health Network performance. Inclusion may support the increase of blood lead screening rates.
- In MY 2022, TCPA consent was resumed and a robocall campaign was conducted in July 2022 to remind members who were untested, per the LSC measure, to get a blood lead test. Additionally, a text campaign launched December 2022 and advised parents/guardians of the health effects associated with lead exposure and encouraged blood lead testing.
- Opportunities remain for the organization to expand on the modalities to obtain member TCPA consent to maximize member engagement.
- In October 2022, a process was implemented among Health Networks to attest to operational and regulatory requirements, which include retrieving, reviewing and distributing quarterly gap report data to providers. Provider are urged to test these members for lead. Additional attestation components include ensuring the documentation of the refusals of blood lead testing and following standards of care for testing and follow-up care.
- CalOptima Health will enhance quarterly blood lead reports to include a provider summary of member testing rates to support Health Networks with analysis and continued monitoring of lead screening rates by providers.
- Opportunities remain to offer a member health reward for members who complete a blood lead test at 12 and 24 months. Lead testing is interdependent with well-child visits. Offering a member health reward may also drive the completion of pediatric quality measures.
- A new Community Health Worker (CHW) benefit may bring opportunities for member education on lead testing, identify and address member barriers to testing, and facilitate the coordination of care with member's PCPs.



Member Experience (CAHPS)

CalOptima Health annually monitors member satisfaction and identifies areas for improvement for all lines of business. CalOptima Health assesses member satisfaction by identifying the appropriate population and collecting valid data from the affected population about various areas of their health care experience. Opportunities for improvement are identified from this information and specific evidence-based interventions are implemented. The goal is to improve the overall member experience by better meeting our members' needs.

Overview of Consumer Assessment of Healthcare Providers and Systems (CAHPS)

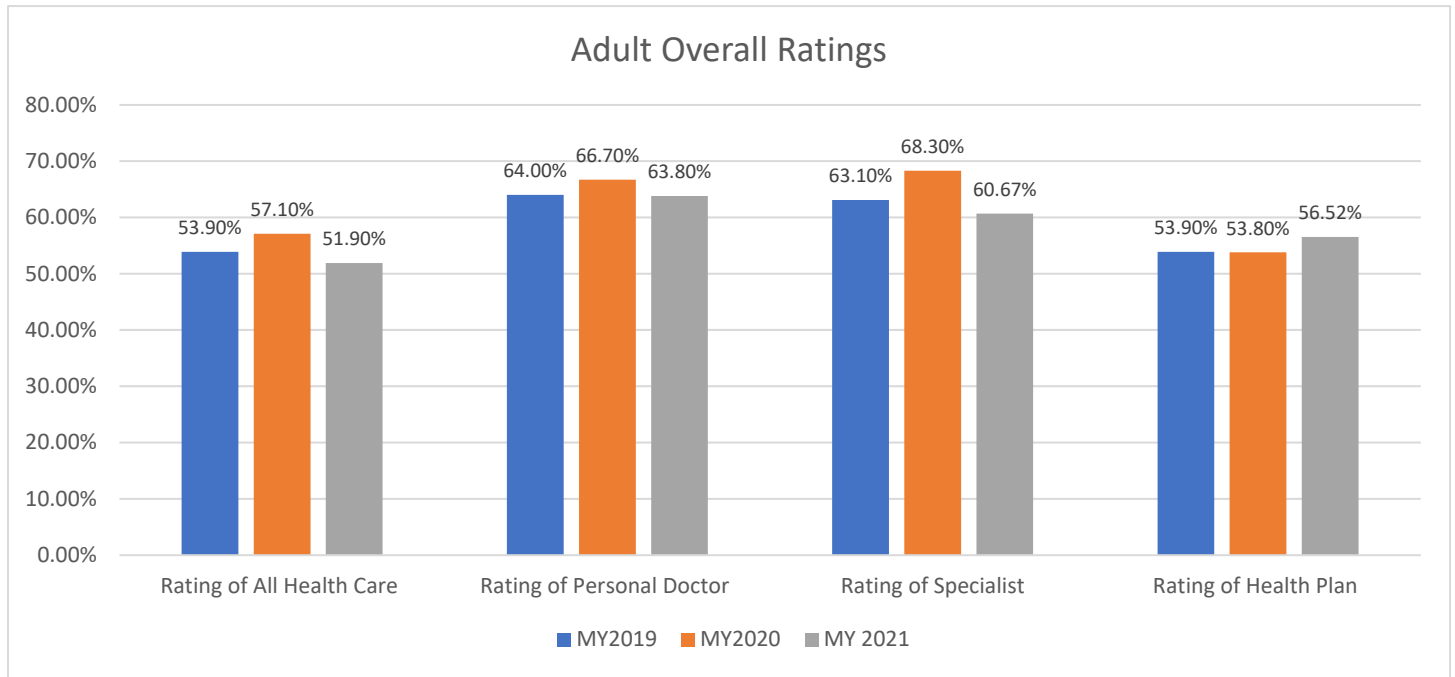
- a. CalOptima Health monitors member experience using the CAHPS survey and results, particularly the achievement score at various levels including plan and health network. The achievement score is the calculation of positive responses, typically identified as “Usually” or “Always” or rated top scores of “9 or 10.”
- b. Although the COVID-19 pandemic may have contributed, CalOptima Health’s response rates have continued to decrease in the past few years despite oversampling efforts. A lower response rate in 2022 has led to CalOptima Health’s inability to report a valid adult CAHPS rate to NCQA for five measures due to a small denominator (N<100). As a result, CalOptima Health is further increasing its oversample in the next survey cycle.
- c. To align with NCQA’s Health Plan Ratings methodology, CalOptima Health benchmarks the plan’s CAHPS performance against the 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles for Medi-Cal. For OneCare, the Medicare Star Rating cut points will be used to benchmark CAHPS performance.

Findings: Grievances and CAHPS Survey Results

The following graphs display CAHPS survey results for MY 2021.

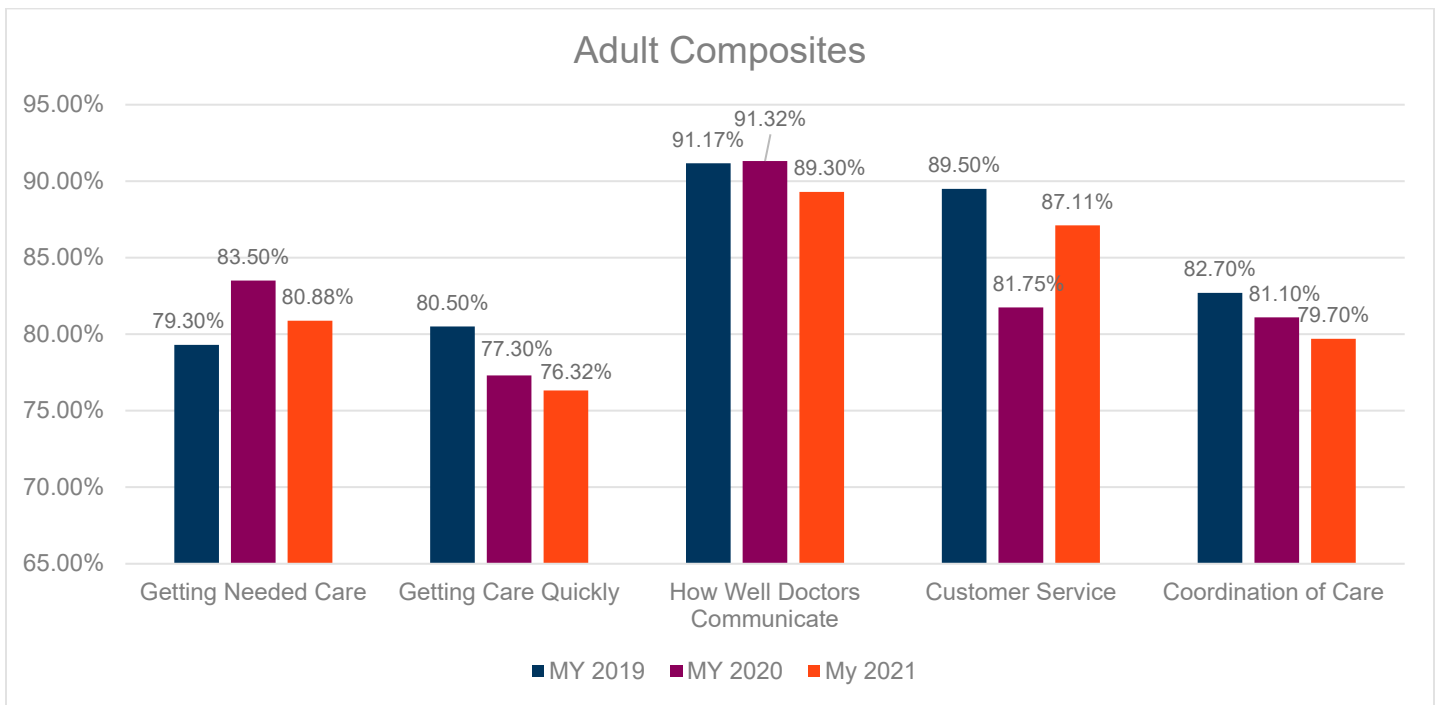
Medi-Cal Adult CAHPS Survey Results

Goal: To meet the 66th percentile when compared with National Medicaid Benchmarks.



National Quality Compass	CalOptima Health MY 2021	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Rating of All Health Care	51.9%	49.34	54.22	58.77	63.02
Rating of Personal Doctor	63.8%	61.79	65.34	71.14	75
Rating of Specialist Seen Most Often	*60.67%	61.94	66.34	70	75.47
Rating of Health Plan	56.52%	53.85	59.78	64.94	70.09

*Denotes performance below the 10th percentile.

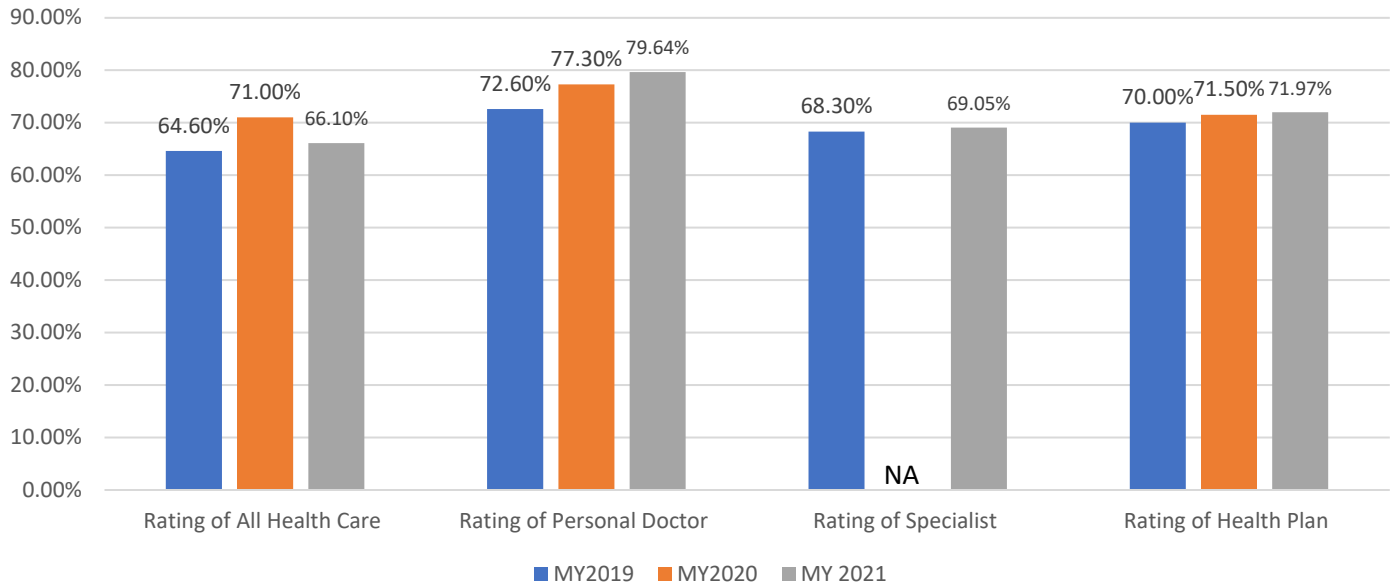


National Quality Compass	CalOptima Health MY 2021	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Getting Needed Care	80.88%	75.64	80.37	84.6	87.47
Getting Care Quickly	76.32%	70.19	77.9	83.82	86.85
How Well Doctors Communicate	89.3%	89.04	92.01	93.78	95.37
Customer Service	87.11%	84.05	87.86	90.7	92.34
Coordination of Care	79.7%	79.17	81.75	86.26	89.52

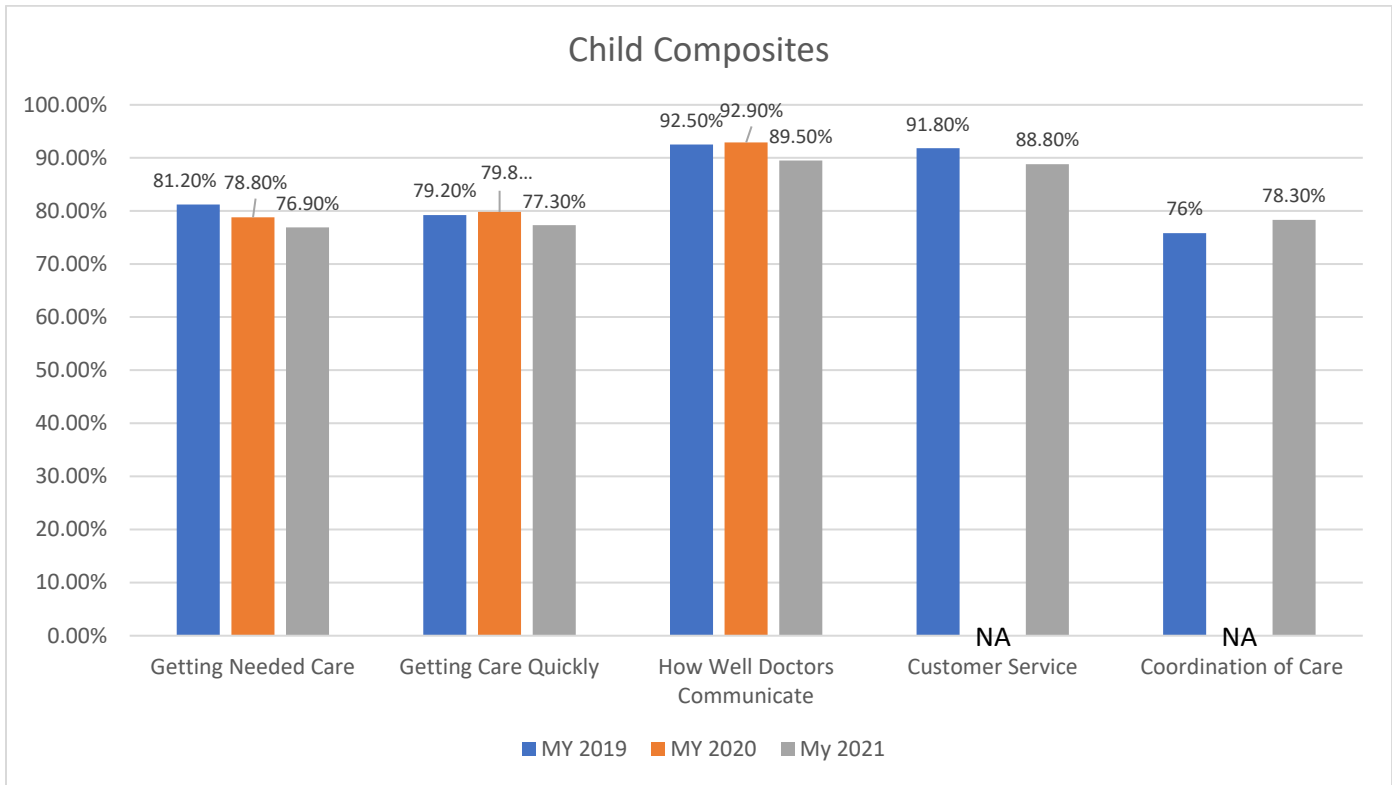
Medi-Cal Child CAHPS Survey Results

Goal: To meet the 66th percentile when compared with National Medicaid Benchmarks.

Child Overall Ratings



National Quality Compass	CalOptima Health MY 2021	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Rating of All Health Care	66.10%	65.35	68.39	73.19	77.06
Rating of Personal Doctor	79.64%	71.82	75.46	78.81	82.18
Rating of Specialist Seen Most Often	69.05%	68.22	70.34	74.07	80.36
Rating of Health Plan	71.97%	65.22	69.57	74.36	78.64



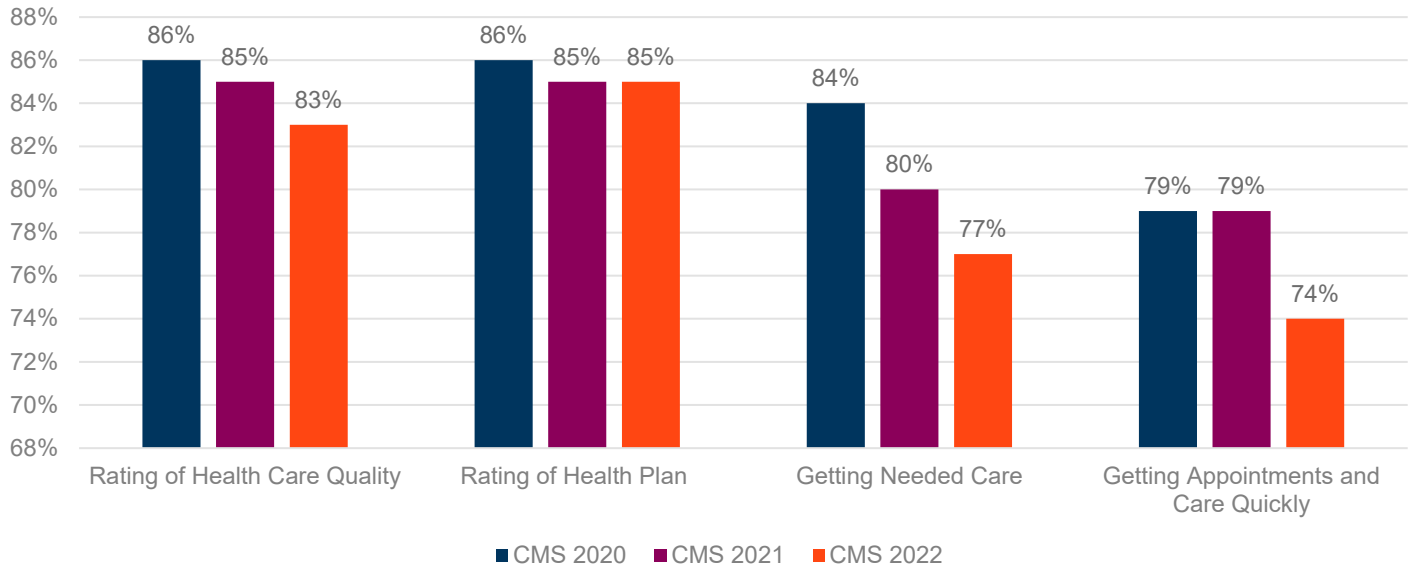
National Quality Compass	CalOptima Health MY 2021	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Getting Needed Care	76.9%	76.18	83.02	86.66	89.48
Getting Care Quickly	*77.3%	79.85	85.31	89.34	91.9
How Well Doctors Communicate	*89.5%	91.61	94.22	96.04	96.75
Customer Service	88.8%	84.83	86.79	89.32	91.67
Coordination of Care	*78.3%	78.81	83.2	86.73	90.12

*Denotes performance below the 10th percentile.

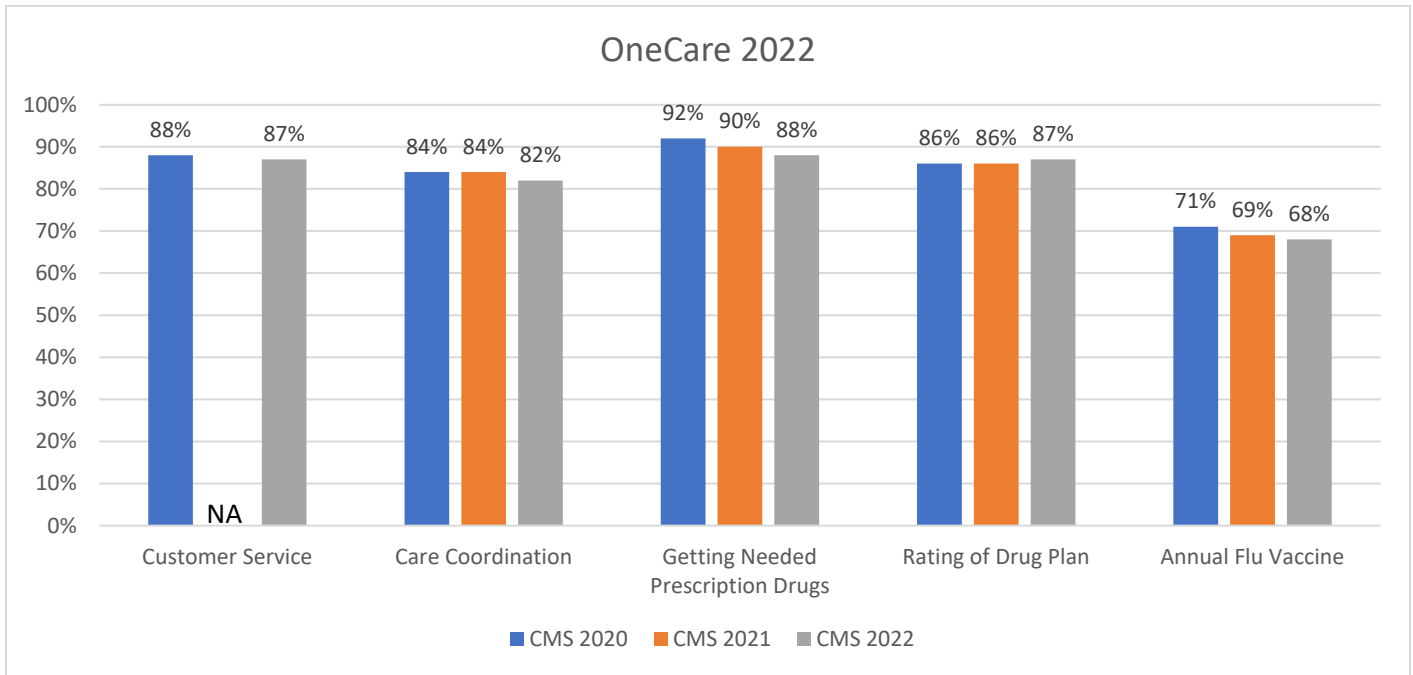
OneCare CAHPS Survey Results

Goal: To meet the CMS 3-Star Rating.

OneCare 2022



CAHPS Measure	Mean Score	Statistical Significance	Star Rating for 2022 CAHPS Score	Star Rating for 2021 CAHPS Score	Star Rating for 2020 CAHPS Score
Rating of Health Care Quality	83	Below Average	1	2	3
Rating of Health Plan	85	Below Average	2	2	3
Getting Needed Care	77	Below Average	1	2	4
Getting Appointment and Care Quickly	74	Below Average	2	3	4



CAHPS Measure	Mean Score	Statistical Significance	Star Rating for 2022 CAHPS Score	Star Rating for 2021 CAHPS Score	Star Rating for 2020 CAHPS Score
Customer Service	87	Below Average	1	N/A	2
Care Coordination	82	Below Average	1	2	2
Getting Needed Prescription Drugs	88	Below Average	2	2	4
Rating of Drug Plan	87	No Difference	4	3	4
Annual Flu Vaccine	68	Below Average	2	2	3

OneCare Connect CAHPS Survey Results

Goal: To meet the CMS National Medicare-Medicaid Plan (MMP) Average.

CAHPS Measure	CMS 2019 Results	CMS 2021 Results	CMS 2022 Results	CMS National MMP Results	Statistical Significance
Getting Needed Care	3.27	3.37	3.31 (-)	3.38	Below Average
Getting Appointment and Care Quickly	3.2	3.14	3.19 (-)	3.28	Below Average
Rating of Health Care Quality	8.2	8.6	8.6 (+)	8.5	No Difference
Rating of Health Plan	8.5	8.5	8.5 (-)	8.6	Below Average
Customer Service	3.58	3.62	3.59 (-)	3.68	Below Average
Care Coordination	3.47	3.52	3.53 (-)	3.55	Below Average
Getting Needed Prescription Drugs	3.57	3.65	3.63 (-)	3.68	Below Average
Rating of Drug Plan	8.3	8.5	8.5 (-)	8.7	Below Average

Case mix adjusted mean on a 1-4 scale. +/- = score increase/decrease from 2021.

a. Grievances:

Analysis of grievances as they relate to member experience showed the following as a percentage of total grievances for CalOptima: Access 19%, Attitude and Service 62%, and Quality of Care 8%.

Analysis

- a. CalOptima Health reviewed all MY 2021 CAHPS rates in detail and compared them with the benchmarks.
- Apart from one child measure at the 66th percentile (Rating of Personal Doctor), the remaining CAHPS measures remain below the 66th percentile for Medi-Cal.
 - For OneCare, one measure, Rating of Drug Plan, received a CMS 4-Star rating with the remainder of the Star measures below a CMS 4-Star Rating.
 - OneCare Connect measures were all considered “Below Average” except for “No Difference” for the measure of Health Care Quality.
 - CalOptima Health did not meet the goals set for CAHPS apart from one OneCare CAHPS measure meeting a CMS 3-Star Rating and one Medi-Cal measure meeting the Quality Compass 66% benchmark. OneCare CAHPS performed “Below Average” for eight measures and OneCare Connect performed “Below Average” for seven measures. The “Below Average” for OneCare measures are Rating of Health Care Quality, Rating of Health Plan, Getting Needed Care, Getting Appointments and Care Quickly, Customer Service, Care Coordination, Getting Prescription Drugs and Annual Flu Vaccine. “Below Average” for OneCare Connect are Getting Needed Care, Getting Appointments and Care Quickly, Rating of Health Plan, Customer Service, Care Coordination, Getting Needed Prescription Drugs and Rating of Drug Plan. Medi-Cal performed below the 10th percentile for four measures. Those

measures are adult Rating of Specialist and child Getting Care Quickly, Care Coordination and How Well Doctors Communicate.

- There was improvement in OneCare’s performance from a 3 to a 4 CMS star rating for Rating of Drug Plan.
- Response rates for CAHPS continue to decline for CalOptima’s adult and child populations. The adult population response rate declined 4.01% and the child declined .47%. The OneCare response rate increased by 2.5% and the OneCare Connect response rate improved by 4.1%.
- b. Member grievances related to member experience showed an increase in grievances by 7% for Access, a decrease of 2% for Attitude and Service and a decrease of 3% for Quality of Care.

Barriers

- Response rates continue to decline for CAHPS surveys.
- Appointment Timeliness and Availability: Members were unable to obtain timely appointments for routine and urgent care. Providers continue to offer telehealth services instead of in-person for the first initial visit. Many members prefer in-person appointments. The lack of extended office hours for urgent appointments and overcapacity of members for PCPs contributed to appointment access issues.
- Members experienced challenges with reaching providers for a variety of reasons, including provider not seeing new patients, provider cancelled appointment and phone calls not being answered.
- Referrals expired because patient could not get an appointment or provider canceled/changed appointment. During the pandemic, members did not go to providers for many routine care services during pandemic, resulting in doctor offices being behind on preventive screening services.

Opportunities for Improvement

- To improve response rates, CalOptima Health will further increase the survey oversample for those populations affected.
- CalOptima Health is in discussions with our contracted survey vendor to use a QR code that will allow the member to access their survey electronically for ease of use to improve response rates.
- CalOptima Health is exploring engaging with a predictive analytics vendor that would provide CalOptima Health with a defined path and process to improve CAHPS scores. Next steps are to bring vendors in for demonstration with potential for RFP.
- CalOptima Health to issue Corrective Action Plans (CAPs) to nine health networks with Medi-Cal Member Experience Health Network Quality Ratings below 2.5.
- Improve access to appointment availability and telephone accessibility by educating and outreaching to providers with challenges in providing care timely.
- CalOptima Health sent out 1,643,233 text messages from April to December 2021. All messages were COVID-19 related and informed members they were eligible for the vaccine and/or booster, promoted vaccine events, provided information homebound members on how to get the vaccine at home and promoted CalOptima Health’s COVID-19 vaccine gift card incentive.



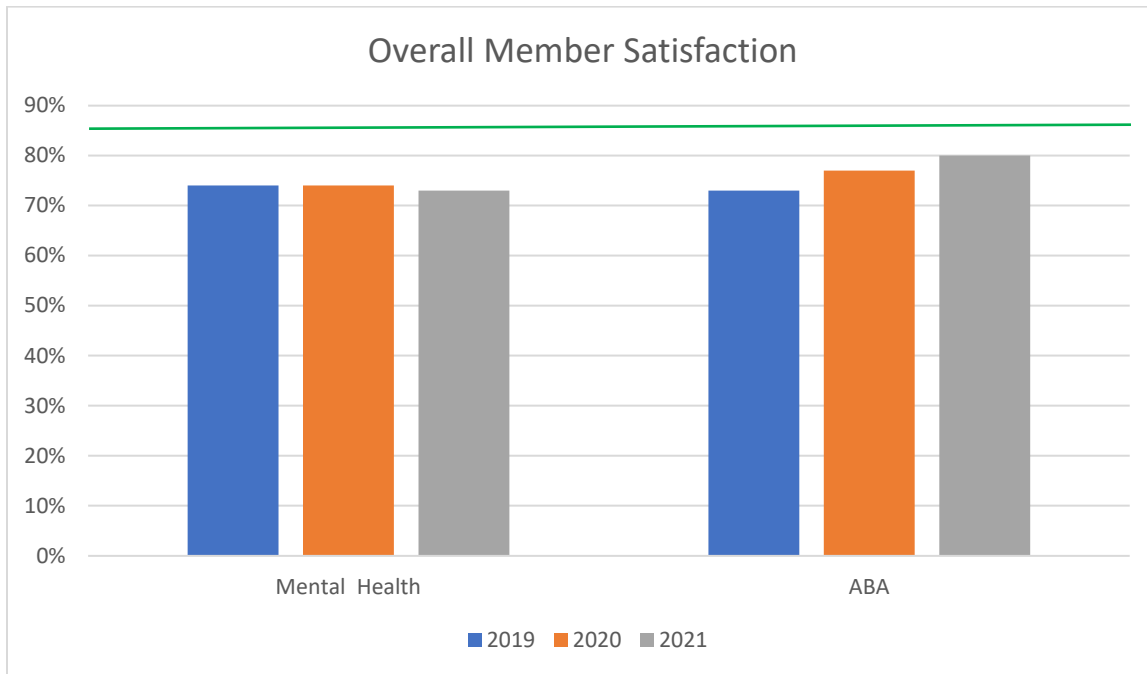
Member Experience (Behavioral Health Survey)

CalOptima Health conducts comprehensive behavioral health surveys and analyses annually to assess member satisfaction regarding behavioral health (BH) services. CalOptima Health worked with an outside vendor to field the 2022 Behavioral Health Member Experience Surveys to measure member satisfaction on BH services received in 2021. Two separate surveys were administered: the Behavioral Health Member Satisfaction: Applied Behavior Analysis (ABA) Services Survey and the Behavioral Health Member Satisfaction: Mental Health (MH) Services Survey. The MH version of the survey assesses for both psychotherapy and medication services, whereas the ABA version is solely for ABA services. The consistent areas surveyed annually since managing BH services in house (i.e., non-delegated model) are Access to Services, Treatment Experience and As a Result of My Treatment. Additional questions on telehealth services, duration of treatment and overall experience were included based on feedback received from the Behavioral Health Quality Improvement (BHQI) Workgroup, Member Experience Committee and Quality Improvement Committee (QIC).

Interventions

- a. A two-wave mailout survey methodology using a random sample size of 4,739 members to carry out the survey. Members of all ages and genders were surveyed. The survey was available to all members in their preferred language. Questions were scored on a five-point Likert scale that allowed the members to express how much they agree or disagree with a particular statement and included an option of Not Applicable (NA). The response rate for the MH services survey was 10% for a total of 406 completed surveys and 19% for a total of 89 completed surveys for ABA services.
- b. CalOptima Health Behavioral Health Quality Team increased the sample size of members surveyed for the MH Services Survey from 1,572 in the prior year to 4,246 with the intent to capture a representative sample and receive more responses. Similarly, the ABA Services Survey sample size was also increased from 228 members in the prior year to 493 members.

Findings



Benchmark Goal = 85% Satisfaction Rate

Analysis

CalOptima Health has established an overall satisfaction goal of 85%. The Overall Member Experience Survey rates for areas surveyed consistently year-to-year (i.e., Access to Services, Treatment Experience and As a Result of My Treatment) did not meet the intended goal of 85%. The MH survey fell short at 73% with a 12 percentage point gap to goal in 2021. ABA received an 80% satisfaction rate but missed the goal by 5 percentage points.

Barriers

The CalOptima Health BHQI Workgroup identified potential barriers and reviewed them at the Member Experience Committee and QIC.

- c. Process Perspective: Reviewed survey questions, length of survey, methodology (e.g., mail verses other mediums, best time to administer, etc.), and survey burnout/fatigue and member abrasion.
- d. Quality Perspective: Access to services was an area that resulted in lower satisfaction rates. With the ongoing public health emergency for the COVID-19 pandemic initiated in March 2020, the impact was still being felt in 2021. During this time many provider offices were closed or made changes to their schedules. Appointments were hard to obtain, and members preferred not to go in person. In addition, the number of members accessing services increased.

Opportunities for Improvement

- Shortening the surveys in an attempt to increase response rate and address member abrasion.
- Fielding the surveys after the holidays.
- Improving access to services by increasing provider availability.

- i. Increasing provider rates: the CalOptima Health Board of Directors approved rate increases for ABA and MH providers. The hope is that this will open up panels that have been closed and recruit new providers allowing more availability of providers for members.
- ii. Increase Network: DHCS Children and Youth Behavioral Health Initiative (CYHBI) investments focused on increasing access through offering additional opportunities for mental health. For instance, the Student Behavioral Health Incentive Program (SBHIP) will allow youth to receive mental health services on or near a school campus. In addition, a new fee schedule will allow CalOptima Health to reimburse for such services in 2024.



Improving Access to Care

Improving Access: Annual Network Certification (ANC)

DHCS established network adequacy standards and assesses and certifies the adequacy of managed care plan's provider network at least annually through the ANC process.

- 1. Changes to Annual Network Certification in Draft APL Network Certification and Timely Access**
 - a. DHCS to set an 80% minimum performance for Timely Access Standards.
 - b. Non-urgent follow-up appointments for non-physician mental health providers to change from 20 business days to 10 business days.

- c. DHCS to provide a list of mandatory provider types for health plans to confirm whether the provider is contracted and in the network.
- d. DHCS to run the time/distance analysis on behalf of the health plans using ArcGIS and a new set of population data points.
- e. Health plans are not allowed to use telehealth to cover areas not meeting time/distance standards, if the telehealth ratio is met.

2. 2022 ANC Submission

- a. CalOptima Health completed the ANC submission in Q4 2022, with the exception of the time/distance submission.
 - i. Time/distance analysis to be provided to health plans by DHCS in December and health plans will have 30 days to submit.
- b. CalOptima Health met requirements for Mandatory Provider Type.
- c. CalOptima Health did not meet 113 areas (provider type/ZIP code combinations) for time/distance analysis.
 - i. Currently awaiting DHCS detailed analysis. For each area of non-compliance, CalOptima Health will submit evidence of contracting or outreach efforts.

Subcontracted Network Certification (SNC)

For managed care plans with subcontracted delegates, DHCS expects plans to assess and certify the adequacy of the plan's provider network at least annually through the SNC process, beginning in 2023.

1. Changes to Subcontracted Network Certification

- a. DHCS to stagger submissions for network certification and delayed the SNC submission until after the ANC submission.
- b. DHCS plans to issue an SNC APL in Q1 2023. Submission likely to reflect ANC submission.

2. Actions to Prepare for ANC

- a. CalOptima Health shares health network-specific SNC performance with each health network quarterly
 - i. Report includes Mandatory Provider Types, Provider to Member Ratios, Time/Distance Analysis and Timely Access (annual data)
- b. Health networks have implemented the following:
 - i. Conducted data validations
 - ii. Identified Out-of-Network providers to cover access gaps
 - iii. Submitted PDSAs to address timely access



Improving Access: Appointment Availability and Telephone Access

CalOptima Health contracted with a health care survey vendor to field a telephone survey to our network providers to assess their compliance with CalOptima Health’s Timely Access Standards to monitor telephone and appointment wait times. The survey used a combination of a “mystery shopper” methodology, in which the interviewer posed as a family member seeking the earliest appointment for a relative, and a “direct script” methodology, in which the callers identified themselves on calling on behalf of CalOptima Health in order to obtain appointment data. Callers then followed the script verbatim in order to collect the data. The direct script methodology was also used to collect administrative compliance data, for example, how long it takes to triage patients, and if providers are currently accepting new patients.

Three unique scripts were developed to collect appointments for several provider categories, including Primary Care, OB/GYN, Specialty Care, Non-Physician Behavioral Health Care, Psychiatric Care, and Ancillary Care across all programs Medi-Cal, OneCare and OneCare Connect.

The data pull methodology included both census and sampling data. Census data was used for provider types with universes with less than 100 providers. Sampling was used for provider types with universes of 100 and more and included a pull of a random sample to ensure a minimum of 30 completed surveys. For the 2021–22 survey, the total universe included 2,828 unique provider records, and a total of 3,828 contact records, which included providers with more than one location.

CalOptima Health established a MPL of 80% or better at the plan and health network level.

The most recent survey was fielded during business hours September 14, 2021, through July 1, 2022. Providers were not called on weekends or holidays and for each contact, the surveyor made three attempts maximum to reach a live person to participate in the survey. The surveyor collected first and second appointment availability, but data included in this evaluation represents availability for first appointment only.

Findings

The following tables represents Timely Access Survey results for the past three years, 2019 through 2021. The first table represents appointment availability results and the second represents administrative-telephone access. Telephone access was monitored for two years, from 2020 to 2021.

The goal was MPL of 80% or better at the plan and health network level.

Appointment Availability Results By Year (2020–21)

Appointment Types	2019	2020	2021	Met MPL	Difference 2020-2021
Primary Routine (10 business days)	67%	76.2%	69.2%	Not Met	-7
Primary Care Urgent (48 hours)	21%	68.4%	62.0%	Not Met	-6.4
Primary Care Physical Exam (30 calendar days)	81%	84.6%	75.8%	Not Met	-8.8
Ob/Gyn Prenatal (OC/OCC: 2 weeks; MC: 10 business days)	70%	80.4%	77.1%	Not Met	-3.3
Ob/Gyn Urgent (48 hours)	-	59%	74%	Not Met	+15
Specialist Routine (15 business days)	58%	67.7%	60.6%	Not Met	-7.1
Specialist Urgent (96 hours)	16%	56.1%	63.7%	Not Met	+7.6
Psychiatrist Routine (15 business days)	45%	78.4%	61.9%	Not Met	--16.5
Psychiatrist Urgent (48 hours)	-	42.9%*	34.4%	Not Met	-8.5
Psychiatrist Follow-up (30 calendar days)	100%*	91.4%	66.7%	Not Met	-24.7
Non-Physician Behavioral Health Routine (10 business days)	75%	76.7%	76.0%	Not Met	-0.7
Non-Physician Behavioral Health Urgent (48 hours)	-	49.2%	60.0%	Not Met	+10.8
Non-Physician Behavioral Health Follow-up (20 calendar days)	97%	85.1%	70.6%	Not Met	-14.5
Ancillary Routine (15 business days)	75%	91.4%	88.9%	Met	-2.5

*Survey methodology changed from 2019 to 2020 resulting in the data not being trendable. Therefore, 2019 data presented is for informational purposes only. – (Dash) indicates no data available * Indicates denominator is less than 10*

Administrative-Telephone Access Results By Year (2020–21)

Standards	2020	2021	Met MPL	Difference
Call back time within 24 hours (Mystery-routine)	80.0%*	50.0%*	Not Met	-30.0
Phone triage patients within 30 minutes	93.7%	95.3%	Met	+1.6
Flexibility in scheduling members with disabilities	95.4%	97.0%	Met	+1.6
Instructs caller to ER/911	31.6%	20.8%	Not Met	-10.8
Informs caller of return call time	34.3%	14.1%	Not Met	-20.2
Call back time within 30 minutes (Direct-urgent)	28.6%	20.6%	Not Met	-8.0
Live person answers within 30 seconds	69.6%	72.5%	Not Met	+2.9
Currently offering telehealth	82.1%	76.3%	N/A	-5.8
Currently accepting new patients	52.6%	84.7%	N/A	+32.1
Currently accept CalOptima Health patients	86.1%	86.7%	N/A	-0.6
Call hold time does not exceed 5 minutes	82.6%	86.3%	N/A	+3.7

N/A indicates standard is not a requirement and is for informational purposes only.

** Indicates denominator is less than 10*

Analysis

Appointment Availability

A review of the 2021–22 timely access study results shows that appointment access is an area of concern. The data shows there are opportunities for improvement for both routine and urgent appointment types, for almost

all provider types. The largest fluctuation in rates was noted in standards related to psychiatry and non-physician behavioral health.

- a. For 2021 results for Routine Appointments, all provider types were below the 80% MPL except Ancillary.
- b. For 2021 results for Urgent Appointments, all provider types were below the 80% MPL.
- c. From 2019–21, both Primary Care and Specialist Urgent Appointments have experienced an increase in rates by at least 40 percentage points.

Overall, there is a noted increase in appointment availability from 2019 to 2020, with a decrease in 2021 most likely due to COVID-19 and the PHE.

Administrative – Telephone Compliance Measures

A review of the 2021–22 timely access study results shows that telephone access is another area of concern. Of the seven required standards, two measures, “Phone Triage within 30 Minutes” and “Offering Flexibility in Scheduling Members with Disabilities,” met the 80% MPL.

In reviewing the data, compliance rates trended downward from 2020 to 2021 and one measure, “Call back time within 24 hours” experienced the largest decrease from 80% to 50%, but it is important to note that the denominator was less than 10.

Barriers

- Some PCPs have too many members in their panel making it difficult to get an appointment. There may be an adequate number of practitioners in CalOptima Health’s network, but not all of the providers have open panels or are available to see new patients.
- There are not enough specialists in the network. In certain areas of South Orange County, CalOptima Health is currently contracted with a low number of specialists, with several not meeting the 80% MPL for both routine and urgent appointments: cardiology/interventional cardiology, endocrinology, gastroenterology, neurology, psychiatry and pulmonology.
- Specialty care appointments require referrals and authorizations. The overall process takes too long and is cumbersome.
- For both PCPs and specialists, CalOptima is a Medi-Cal plan and reimburses providers utilizing the Medi-Cal reimbursement rate structure, which is significantly lower than reimbursement rates for commercial contracts.
- The health care industry recently experienced a shortage in labor, especially with the onset of COVID-19.
- Due to COVID-19 and the PHE, more members may have stayed home and avoided going to provider offices. Now that restrictions have been lifted and COVID vaccines are in place, members are more comfortable going out and seeking appointments. This may have put unexpected strain on provider offices with so many members playing catch-up for the past two years and seeking access virtually at the same time.

Interventions

- Monitored PCPs panel capacity on a monthly basis. Issued quarterly notifications of closure for PCPs who have a panel of more than 2,000 CalOptima Health members to prevent members from being assigned to PCPs who do not have the capacity to provide appointments timely due to a large panel of members.

- i. As of CY 2021, identified 54 PCPs nearing or over capacity, 44 panels closed and seven re-opened.
- Provider Relations focused on expanding the network through the Provider Data Validation project. Provider Relations focused on outreaching and reviewing submissions from providers on the validation forms to possibly re-open panels for those who were not overcapacity, which in turn expands the network for new patients. As of third quarter, Provider Relations has outreached to approximately 70% of the providers on the outreach list.
- Provider Relations outreached to providers who were nearing and overcapacity for closed panels, inquiring about additional providers, including mid-levels to add to credentialing process.
- Issued CAPs to health networks not meeting timely access standards to improve appointment availability and telephone access.
 - i. In January 2022, CalOptima Health issued corrective action to 12 health networks for the following three areas in the form of Plan-Do-Study-Acts (PDSAs):
 - a. Improve member access to PCPs
 - b. Improve member access to specialists
 - c. Telephone access
 - d. Improve member access for Medi-Cal population.
 - ii. Submission was received for all 36 PDSAs with the majority of the networks choosing to “Adopt,” meaning implement the PDSA. Popular interventions include:
 - a. Reopen the number of PCPs with closed panels.
 - b. Reduce non-compliance on pre-recorded telephone message.
 - c. Educate providers on telephone access.
- In 2020, CalOptima Health began issuing letters to providers who were identified as non-compliant with Timely Access standards. Letters clearly addressed areas not met, including recommended list of best practices and a copy of CalOptima Health’s Timely Access standards. Letters are sent to providers via USPS mail, and providers’ contracted health networks are notified as well. Once a provider is identified as non-compliant for a measure, they are monitored for up to an additional two years. There are a total of three different letters that can be issued to a provider for consecutive non-compliance.
 - i. Education letter – Year 1: Letter is sent when provider is identified as non-compliant for a measure the first year.
 - ii. Warning letter – Year 2: Letter is sent when a provider is identified as non-compliant for the same measure two consecutive years.
 - iii. Escalation CAP letter – Year 3: Letter is sent when a provider is identified as non-compliant for the same measure for three consecutive years.
 - iv. For the second year, letters were mailed to providers in Q4 2021. Education Letters (first-year notification) – 1,425 notices mailed. Warning Letters (second-year notification) – 123 notices mailed.
- Expanded current network by continued outreach and recruiting efforts to add new providers, with a focus on specialty types identified as not meeting MPL.
 - i. In 2021, CalOptima Health successfully contracted with more than 234 PCPs and 460 specialists.
- f. Provider Relations representatives met with provider offices to ensure provider directory validations were being returned. Provider Relations representatives and the director met with FQHCs to alert providers of the open/closed panel topic.

Opportunities for Improvement

- During the provider survey, CalOptima Health tracked call disposition for those calls that were not able to be completed for various reasons, e.g., wrong number, provider name not recognized, provider left practice etc. CalOptima Health will take this disposition information and use it as an opportunity for data cleanup and validation within our internal data systems. One project, in particular, will include updating the provider directory to ensure contact information is correct and members are able to access their providers.
- Based on the 2021–22 Timely Access results, issue new letters for non-compliance. This set of letters will include a CAP for providers who have been identified as non-compliant for the same standard for three consecutive years.
- For providers identified as being non-compliant for two consecutive years and who receive a letter for the second time, notify one of their contracted networks to conduct education on Timely Access standards.
- Survey providers to identify providers' biggest challenges/barriers in providing timely access to care.
- Develop a process for monitoring and escalating providers with a pattern of not being available to offer members to access care.



Improving Access: Mandatory Provider Types, Provider/Member Ratios, and Time/Distance

1. Overview

CalOptima Health routinely assesses the provider network for all programs including Medi-Cal, OneCare and OneCare Connect to ensure our members have appropriate access to care. This includes evaluating trends, determining if any gaps exist in a particular health network or with specific practitioner specialties, identifying opportunities for improvement, prioritizing those opportunities, and taking action to improve the network.

CalOptima Health established network adequacy in accordance with state and federal law and regulations to ensure members have adequate accessibility to available services at both the plan and health network levels. Mandatory Provider Types (MPTs) standards apply only to the Medi-Cal program and Network Adequacy includes all three programs.

- a. MPTs (Medi-Cal only) standards require CalOptima Health and contracted health networks to contract with at least one of the following MPTs for each contracted service area, where available: Federally Qualified Health Center (FQHC), Freestanding Birthing Centers (FBC), Certified Nurse Midwives (CNM) and Licensed Midwife (LM).
- b. Provider network data is pulled quarterly to run an analysis for MPTs and Provider-to-Member Ratio (PMR) at the plan and health network level and compared to standards used to ensure members have the appropriate types of providers and an adequate number of practitioners in the network to access care. This analysis is used to determine whether CalOptima Health is compliant with the standards identified in CalOptima Health Access and Availability Policies: GG.1600 and MA.7007.
CalOptima uses the Quest Analytics Suite to conduct accessibility analyses and mapping to meet Time/Distance standards identified in CalOptima Health Access and Availability Policies: GG.1600 and MA.7007. The accessibility analyses must demonstrate coverage of the entire service area. CalOptima Health establishes network adequacy standards in accordance with state and federal regulations.

2. Findings

2022 Medi-Cal Mandatory Provider Types

2022	Q1		Q2		Q3		Q4	
	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met
	FQHC	25	Met	39	Met	39	Met	39
CNM	3	Met	115	Met	111	Met	115	Met
LM	2	Met	4	Met	4	Met	4	Met

2022 Medi-Cal Provider-to-Member Ratios by Specialty Type

2022	Medi-Cal Specialty	Q1		Q2		Q3		Q4	
	Provider to Member Ratio	Ratio	Met/Not Met	Ratio	Met/Not Met	Ratio	Met/Not Met	Ratio	Met/Not Met
PCP	Family Medicine	1:444	Met	1:455	Met	1:475	Met	1:482	Met
PCP	Pediatrics	1:383	Met	1:385	Met	1:195	Met	1:190	Met
PCP	Internal Medicine	1:853	Met	1:863	Met	1:905	Met	1:942	Met
PCP	Total Primary Care Providers	1:170	Met	1:218	Met	1:228	Met	1:233	Met
Specialist	Cardiology/Interventional Cardiology	1:1,857	Met	1:1,629	Met	1:1,670	Met	1:1,693	Met
Specialist	Gastroenterology	1:2,320	Met	1:1,977	Met	1:2,004	Met	1:2,026	Met
Specialist	General Surgery	1:1,043	Met	1: 960	Met	1:199	Met	1:984	Met
Specialist	Hematology/Oncology	1:2,785	Met	1:3,408	Met	1:2,760	Met	1:2,786	Met
Specialist	Nephrology	1:3,392	Met	1:2,921	Met	1:3,028	Met	1:2,955	Met

Specialist	Neurology	1:2,561	Met	1:2,313	Met	1:2,325	Met	1:2,290	Met
Specialist	OB/GYN	1:426	Met	1:421	Met	1:217	Met	1:217	Met
Specialist	Ophthalmology	1:927	Met	1:1,859	Met	1:1,928	Met	1:1,882	Met
Specialist	Orthopedic Surgery	1:1,937	Met	1:1,855	Met	1:1,914	Met	1:1,940	Met
Specialist	Pulmonology	1:3,234	Met	1:2,922	Met	1:3,028	Met	1:3,009	Met

2022 OneCare Provider-to-Member Ratios by Specialty Type

2022	Specialty	Standard	Q1		Q2		Q3		Q4	
	Provider to Member Ratio	Minimum # of Providers	# of Providers	Met/ Not Met	# of Providers	Met/ Not Met	# of Providers	Met/ Not Met	# of Providers	Met/ Not Met
PCP	Primary Care	72	765	Met	748	Met	740	Met	733	Met
Specialist	Allergy and Immunology	3	24	Met	24	Met	24	Met	24	Met
Specialist	Cardiology	12	116	Met	116	Met	110	Met	108	Met
Specialist	Cardiothoracic Surgery	1	33	Met	32	Met	32	Met	31	Met
Specialist	Chiropractor	5	24	Met	24	Met	24	Met	24	Met
Specialist	Dermatology	7	58	Met	56	Met	57	Met	59	Met
Specialist	Endocrinology	2	44	Met	44	Met	45	Met	42	Met
Specialist	ENT/Otolaryngology	3	56	Met	55	Met	55	Met	54	Met
Specialist	Gastroenterology	6	85	Met	87	Met	82	Met	82	Met
Specialist	General Surgery	13	86	Met	86	Met	85	Met	85	Met
Specialist	Gynecology, OB/GYN	2	138	Met	132	Met	126	Met	126	Met
Specialist	Infectious Diseases	2	42	Met	43	Met	43	Met	43	Met
Specialist	Nephrology	4	73	Met	74	Met	76	Met	77	Met
Specialist	Neurology	6	97	Met	100	Met	98	Met	98	Met
Specialist	Neurosurgery	1	33	Met	33	Met	33	Met	33	Met
Specialist	Oncology - Medical, Surgical	9	101	Met	100	Met	99	Met	98	Met
Specialist	Oncology - Radiation/Radiation Oncology	3	27	Met	27	Met	26	Met	27	Met
Specialist	Ophthalmology	11	130	Met	128	Met	126	Met	122	Met
Specialist	Orthopedic Surgery	9	103	Met	102	Met	98	Met	97	Met
Specialist	Physiatry, Rehabilitative Medicine	2	23	Met	24	Met	24	Met	23	Met
Specialist	Plastic Surgery	1	25	Met	25	Met	25	Met	25	Met
Specialist	Podiatry	9	63	Met	62	Met	62	Met	61	Met
Specialist	Psychiatry	7	86	Met	84	Met	85	Met	83	Met
Specialist	Pulmonology	6	60	Met	61	Met	61	Met	61	Met
Specialist	Rheumatology	4	22	Met	22	Met	19	Met	19	Met
Specialist	Urology	6	49	Met	49	Met	50	Met	49	Met
Specialist	Vascular Surgery	1	21	Met	18	Met	18	Met	18	Met

2022 OneCare Connect Provider-to-Member Ratios by Specialty Type

2022 OCC	Specialty	Standard	Q1		Q2		Q3		Q4	
	Provider to Member Ratio	Minimum # of Providers	# of Providers	Met/Not Met	# of Providers	Met/Not Met	# of Providers	Met/Not Met	# of Providers	Met/Not Met
PCP	Primary Care	26	933	Met	921	Met	907	Met	900	Met
Specialist	Allergy and Immunology	1	28	Met	28	Met	28	Met	29	Met
Specialist	Cardiology	3	173	Met	172	Met	171	Met	171	Met
Specialist	Cardiothoracic Surgery	1	35	Met	35	Met	35	Met	34	Met
Specialist	Chiropractor	1	31	Met	30	Met	30	Met	30	Met
Specialist	Dermatology	1	91	Met	87	Met	86	Met	90	Met
Specialist	Endocrinology	1	64	Met	62	Met	64	Met	61	Met
Specialist	ENT/Otolaryngology	1	66	Met	66	Met	64	Met	61	Met
Specialist	Gastroenterology	2	116	Met	116	Met	115	Met	114	Met
Specialist	General Surgery	4	123	Met	123	Met	123	Met	125	Met
Specialist	Gynecology, OB/GYN	1	207	Met	206	Met	209	Met	209	Met
Specialist	Infectious Diseases	1	53	Met	53	Met	52	Met	53	Met
Specialist	Nephrology	2	96	Met	98	Met	95	Met	98	Met
Specialist	Neurology	2	125	Met	130	Met	128	Met	133	Met
Specialist	Neurosurgery	1	47	Met	47	Met	47	Met	46	Met
Specialist	Oncology - Medical, Surgical	2	149	Met	151	Met	151	Met	153	Met
Specialist	Oncology - Radiation/Radiation Oncology	1	40	Met	41	Met	43	Met	43	Met
Specialist	Ophthalmology	3	187	Met	184	Met	187	Met	185	Met
Specialist	Orthopedic Surgery	2	132	Met	131	Met	129	Met	128	Met
Specialist	Physiatry, Rehabilitative Medicine	2	38	Met	38	Met	39	Met	38	Met
Specialist	Plastic Surgery	1	34	Met	35	Met	34	Met	34	Met
Specialist	Podiatry	3	82	Met	81	Met	81	Met	82	Met
Specialist	Psychiatry	4	104	Met	101	Met	101	Met	99	Met
Specialist	Pulmonology	2	77	Met	77	Met	79	Met	83	Met
Specialist	Rheumatology	1	28	Met	29	Met	26	Met	26	Met
Specialist	Urology	1	59	Met	59	Met	60	Met	62	Met
Specialist	Vascular Surgery	1	35	Met	36	Met	34	Met	35	Met

2022 Medi-Cal Time/Distance Analysis – Non-Compliance Count by ZIP Code

2022	Non-Compliance ZIP Code Count for Contracted Providers							
	Q1		Q2		Q3		Q4	
	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
Medi-Cal	0	Met	0	Met	0	Met	0	Met

2022 OneCare/OneCare Connect Time/Distance Analysis – Non-Compliance Count by ZIP Code

2022	Non-Compliance Zip Code Count for Contracted Providers															
	Q1 Specialties		Q1 Facilities		Q2 Specialties		Q2 Facilities		Q3 Specialties		Q3 Facilities		Q4 Specialties		Q4 Facilities	
	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met
OneCare Connect	0	Met	0	Met	0	Met	1	Met	0	Met	1	Met	0	Met	1	Met
OneCare	0	Met	0	Met	0	Met	1	Not Met	0	Met	1	Not Met	0	Met	1	Not Met

Analysis

Mandatory Provider Types:

- The 2022 results show MPTs were met monthly for all three MPTs at the plan level only.
- In 2022, CalOptima Health monitored 13 health networks for MPTs. Fourth quarter findings show all health networks met for FQHC except Kaiser Permanente. Twelve did not meet for CNM and 10 did not meet for LM.
- As of date, we have several health networks in the works to contract with both a CNM and LM utilizing the State’s list CalOptima Health provided to them. Health networks are not required to meet the FBC MPT requirement at this time, since there are no active providers meeting this requirement in the service area.

Member Ratios

- The Medi-Cal Provider-to-Member Ratios table shows all specialty types met the provider-to-member ratios, and Pediatrics and OB/GYN showed improvement in the ratio by the end of 4th quarter. At the health network level, two networks, Arta Western (Ophthalmology) and Monarch (Orthopedic Surgery), consistently showed as non-compliant for the same specialty for all four quarters.
- The OneCare Provider-to-Member Ratios plan level results show all specialty types met all four quarters in 2022. At the health network level, with the exception of Monarch, seven out of eight networks consistently showed as non-compliant for Chiropractor for all four quarters.

- c. The OneCare Connect Provider-to-Member Ratios plan level results show all specialty types met all four quarters in 2022. At the health network level, AMVI consistently showed as non-compliant for the following specialties for all four quarters: Chiropractor, Neurosurgery, Psychiatry and Pulmonology.

Time/Distance:

- d. In 2022, the Time/Distance tables show CalOptima Health was compliant at the plan level for all three programs (Medi-Cal, OneCare and OneCare Connect). Over 25 different specialties were monitored for each program, and all were at 100% compliance, at minimum for either Time or Distance.
 - i. At the health network level, CCN is the only contracted health network (out of 12) to consistently meet the Time/Distance standards for Medi-Cal.
 - ii. At the health network level, none of the 11 contracted networks met the Time/Distance specialist standards for OneCare Connect.
 - iii. At the health network level, Monarch is the only network (out of eight) to consistently meet the Time/Distance specialist standards for OneCare.
- b. Time/Distance is measured by facility type for OneCare and OneCare Connect programs. In 2022, most of the facility types were met by both programs, with the exception of Speech Therapy not meeting minimum performance for three quarters in OneCare.

Interventions

- CalOptima Health targeted reducing gaps within the provider network and improving upon Provider-to-Member ratios and Time/Distance performance.
- CalOptima Health actively recruited hard-to-access specialties for the CCN network in 2020 and 2021, with a focus on out-of-networks (General Surgery, Ophthalmology and Orthopedic Surgery).
- During the Provider Data Validation, CalOptima Health's Provider Relations department encouraged providers who have requested to close their panels for various reasons other than over-capacity, to consider re-opening to improve access.
- CalOptima Health worked with contracted health networks to certify for Sub-Contracted Network Adequacy (SNC) and issued Timely Access PDSAs.
- CalOptima Health provided health networks with Alternative Access Templates (AATs) to help health networks identify providers for each ZIP code identified as non-compliant using CCN's universe.
- Process Excellence led a provider onboarding end-to-end process that included a review of the provider recruiting process and workflow. In review of the OON data, it was determined that most of the requests were made by health networks and not CCN.
- CalOptima Health is working on developing a regular reporting tool to share with health networks on OON performance as part of the Subcontracted Network Certification Summary Quarterly report.
- Provide health networks with an updated copy of State's MPT lists at least annually.

Barriers

- Provider data is collected and housed across multiple databases at CalOptima Health and contracted networks. Counts may not be truly reflective of what is contracted within the network.

- Databases may have limitations and only be capable of holding information one specialty type per provider. This can potentially result in an undercounting of providers when a provider is credentialed in more than one specialty.
- CalOptima Health is a Medi-Cal plan and reimburses providers utilizing the Medi-Cal reimbursement rate structure. This rate is generally lower than commercial and non-medical rates, making it less appealing for providers and specialists to contract with CalOptima Health.
- CalOptima Health uses different software than the State to monitor Medi-Cal time/distance; therefore, it is challenging to tie back to State calculations to validate. A few health networks use programs like Google Maps, which is an additional challenge due to low accuracy.
- DHCS requirements for CNM and LM require specific licensure that is not common.
- MPT data source “274-File” does not reflect the required licensure type as listed in the APL, even if the practitioner has correct taxonomy code(s).

Opportunities for Improvement

- Continue targeted outreach to and recruitment of providers and specialists.
- Issue CAPs to both health networks and individual providers for access and availability.
- Invest in advanced software, e.g., ArcGIS to align with DHCS in Time/Distance analysis.
- Update the data source for “274-File” to reflect the correct licensure type or modify APL to reflect the correct licensure type as in the data source.
- Streamline the provider onboarding process for providers to increase the ease of entering into the CalOptima Health provider network.
- Develop an access scorecard or dashboard to better monitor our provider access performance.



Improving Patient Safety

Post-Acute Infection Prevention Quality Initiative (PIPQI)

PIPQI is a CalOptima Health quality initiative program aimed at reducing antibiotic-resistant bacteria in nursing homes. Participating nursing facilities utilize Chlorhexidine Gluconate (CHG) soap for all baths and showers and Iodophor nasal swabs 5 days per week every other week. The program ended on 6/30/2022.

Prior to the implementation of PIPQI, the University of California, Irvine (UCI) conducted a program called SHEILD following the same infection prevention principles.

Interventions

- a. The PIPQI team uses one training video, created by the UCI SHEILD Team, to review with all participating nursing facilities monthly since March 2020.
- b. Hospital-Acquired Infections (HAI) scores are submitted each month by the nursing facility staff members to the CalOptima Health PIPQI nurses. Using this data, the CalOptima Health nurses track and trend HAI events in each nursing facility and provide feedback to the facilities on their individual trends.
- c. The PIPQI team collects invoices showing proof of product purchasing.
 - i. In 2021, we began to look at the quantitative data in more detail to track trends from individual nursing facilities to assist them with ensuring they have adequate quantities available for their residents.
 - ii. A data set was created in January 2021 that determined a product quantity for each facility based on the 75% of the licensed beds being filled.

- iii. Once that was completed, we compared the amount projected for the facilities to the actual invoices given by the PIPQI staff.
- d. The PIPQI team has updated all training materials and distributed them to the participating nursing facilities.
- e. In person, hands-on training sessions provided the nursing facilities with a greater emphasis on the compliance of their staff and residents with following the PIPQI protocols.

Findings

- a. The chart below shows the average HAI Score for all facilities throughout the course of 2022. Lower scores indicate fewer infections in the nursing homes, and the staff works with facilities to decrease or maintain their individual HAI scores.

Month	Average HAI Score for all 26 Facilities
January 2022	6.31%
February 2022	5.14%
March 2022	5.04 %
April 2022	4.61%
May 2022	3.83 %

- b. As predicted, we see that as we transition from the winter months into the summer months, the HAI scores trend downward.
- c. The CHG and Iodophor invoice data collected shows there are still ongoing gaps in product purchasing and the data being made accessible to CalOptima Health. The facilities continue to not submit the CHG and Iodophor invoices despite the in-person, telephonic and email reminders.

Analysis

- a. The original financing for PIPQI ended in March 2022. A new request was granted by the CalOptima Health Board of Directors to continue the program another three months at a decreased reimbursement rate. The extension of the program beyond the original ask did not result in any improvements in the quality or quantity of the data being submitted by the nursing facilities, so the program concluded in June 2022.
- b. In 2020–21, the average HAI scores for all months was 4.26% and in 2022 the average score was 4.98%.

Barriers

- Nursing facilities are short staffed and overworked leaving little time to participate in PIPQI monitoring protocol.
- High turnover rates in facilities create a need for constant PIPQI training.

- Due to COVID-19, CalOptima Health nurses were not allowed to conduct on-site visits for monitoring or training of facility staff from March 2020 until March 2021.
- High staff turnover rate in the nursing facilities, including central supply and housekeeping employees, due to the effects of the pandemic
- The census in the nursing facilities have been fluctuating and there are times when they are at less than 75% capacity; however, this is a rare occurrence and only contributes to a small margin of data.
- Of the invoices submitted, there is only a small margin that is purchasing at or above the projected quantities. Since these quantities are based on each resident following the protocols as directed, (4oz. bath/shower every other day and 10 Iodophor Swabs/month) we are seeing facilities show compliance with or above average utilization of the products.

Opportunities for Improvement

- a. The original financing for PIPQI ended in March 2022. A new request was granted by the CalOptima Health Board of Directors to continue the program another three months at a decreased reimbursement rate. The extension of the program beyond the original ask did not result in any improvements in the quality or quantity of the data being submitted by the nursing facilities, so the program concluded in June 2022.

I. PROGRAM OVERSIGHT

- A. 2022 QI Annual Oversight of Program and Work Plan
- B. 2021 QI Program Evaluation
- C. 2022 UM Program
- D. 2021 UM Program Evaluation
- E. Population Health Management Strategy
- F. Credentialing Peer Review Committee (CPRC) Oversight
- G. Grievance and Appeals Resolution Services (GARS) Committee
- H. Member Experience (MEMX) Committee Oversight
- I. Utilization Management Committee (UMC) Oversight
- J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
- K. Quality Withhold for OCC
- L. New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, OC P4V, Data Mining/Bridge efforts)
- M. Improvement Projects (All LOB)PIPs
- N. Improvement Projects (All LOB)QIPs
- O. Improvement Projects (All LOB)CCIP's
- P. PPME/QIPE: HRA's
- Q. BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V
- R. Homeless Health Initiatives (HHI): Homeless Response Team (HRT)
- S. CalAIM
- T. Health Equity
- U. DHCS Comprehensive Quality Strategy
- V. Student Behavioral Health Incentive Program (SBHIP)

II. QUALITY OF CLINICAL CARE- Adult Wellness

- A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
- B. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

- A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).
- B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.
- C. Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)(Medicaid only)
- D. Follow-Up After Emergency Department Visit for Mental Illness (FUM)

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

- A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)
- B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam
- C. Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot

INITIAL WORK PLAN AND APPROVAL:


Submitted and approved by QIC:

Date:


Submitted and approved by QAC:

Date:

Quality Improvement Committee Chairperson:


Richard Pitts, D.O., Ph.D. 2/15/2022
Date:

Board of Directors' Quality Assurance Committee Chairperson:


Trieu Thanh Tran, M.D. 4/11/2022
Date:

V. QUALITY OF CLINICAL CARE- Maternal Child Health

- A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

- A. Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA
- B. Blood Lead Screening (BLS) (LSC)

VII. QUALITY OF SERVICE- Access

- A. Improve Access: Reducing gaps in provider network
- B. Improve Access: Expanding Network of Providers Accepting New Patients
- C. Improve Access: Timely Access (Appointment Availability)
- D. Improve Access: Telephone Access
- E. Improving Access: Subcontracted Network Certification

VIII. SAFETY OF CLINICAL CARE

- A. Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.
- B. Post-Acute Infection Prevention Quality Incentive (PIPQI)
- C. Orange County COVID Nursing Home Prevention Program.

2022 Quality Improvement Work Plan (1Q)

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I. PROGRAM OVERSIGHT										
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		Green
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		Green
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2022	Mike Shook	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		Green
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by April 2022	Mike Shook	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		Green
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Marie Jeannis/Kelly Giardina	QIC	MC,OC,OCC	X	Strategy is current. We will need to update to align with 2022 HP NCQA requirements and DHCS.	Meeting will be scheduled in 2Q2022 to update.	Yellow
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	Quarterly Adoption of Report	Marsha Choo/Laura Guest	QIC	MC,OC,OCC	X	<p>I. FSR/PARS/NF/CBAS Subject: Anticipated launch of new DHCS FSR/MRR tools and standards July 1, 2022. □ Point of Information: Anticipate CBAS in-person services to begin July 1, 2022.</p> <p>II. Credentialing/Recredentialing Subject: Identified in March 2022: Organizational Providers - OneCare Project. For CCN and BH, there were 57 group practices that were identified as not credentialed, although the individual practitioners were credentialed.</p> <p>III. PQI Subject: Since cases are being reviewed while a grievance, the % of cases leveled as QOC has increased from 4-7% prior to 2021 to now at 21%. Subject: Fair Hearing for Notice of Termination - Potential 805 Reporting 1. PQI and FWA investigations - PM physician was billing for PT and psychotherapy services under his NPI 1, billing for 99215 for services rendered by a LVN, and was unable to produce medical records for several members due to destroying the medical records while converting to an EHR. 2. PQI Investigation - PCP attending at hospital for member who was admitted for hand cellulitis, had precipitous drop in Hgb, never referred to GI or hematology for etiology, and unexpectedly expired.</p>	<p>I. FSR/PARS/NF/CBAS Actions: A. Working with PR, HNR and communications to send educational materials and tools for provider office B. Training providers and their staff, and the FSR Nurses C. Implementing changes to on-line tool data collection D. MRR tool preventive section has doubled for both peds and adult Concern: May lead to an increase in: 1) failed FSR and/or MRR audits, and 2) FSR/MRR CAPs issued</p> <p>II. Credentialing/Recredentialing Actions: A. As of May 31, 37 were processed for credentialing, including 5 PCPs. B. 14 OPs were identified for termination for various reasons. Concerns: A. Several OPs are missing required documentation for credentialing, which may lead to termination; B. May result in a drop in network adequacy for some specialties and/or PCP by geographic region.</p> <p>III. PQI Action: Continue with QOC grievance review by RN and MD Concern: Volume of PQIs are climbing again from 42 in December to 100 in May Action: Fair Hearings Commencing in Q2 Concerns: Results of Fair Hearing will be reported to QIC in Q3 and terminations may affect several networks. 1. PM- Provider termination will only affect the CCN network. 2. PCP - HPN/Regal, CCN, Optum-Arta, Optum-Talbert, Prospect and UCMG will all be affected by potential termination. HNs will be notified if Fair Hearing results in termination. □</p>	Yellow

2022 Quality Improvement Work Plan
(1Q)

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Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health networks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Tyronda Moses	QIC	MC,OC,OCC	X	On March 8th 2022, GARS Committee presented to QIC 4Q Member and Provider Complaint results. - Medi-Cal Complaints: 9% increase in total complaints; 7% decrease in member appeals; 5% increase in member grievances; 25% increase in provider appeals - Medi-Cal Grievances by Category: QOS continues to be the highest Grievance category. QOS increased by 11% from Q3 to Q4. CCN and Veyo continue to have the highest number of QOS grievances. -- Other Increases: Quality of Care increased by 32% (from 206 in Q3 to 272 in Q4). AltaMed, Monarch, CCN, COD had the most noticeable increase in QOC grievances. -- Decreases: Billing decreased by 2%; Access decreased by 17% (from 731 in Q3 to 609 in Q4); Appointment Availability (177 grievances); Telephone Accessibility (122 grievances) Specialty Care (101 grievances); Practitioner office site decreased 33% (from 9 in Q3 to 6 in Q4) - Medi-Cal BH Grievances: 28% decrease in BH grievances; Access decreased by 27%; QOS decreased by 32%; QOC decreased by 30%; Billing decreased by 6% - OCC Complaints: 10% decrease in total complaints; 32% decrease in appeals; 13% decrease in grievances; 22% increase in provider appeals - OCC BH Grievances: BH grievances increased by 4 in Q3 to 9 in Q4. - OC Complaints: 25% decrease in total complaints; Member appeals remained the same from Q3 to Q4; 12% decrease in member grievances; 59% decrease in provider appeals	Grievance trends are reviewed for repeated issues. High grievance count by providers are tracked and trended. Results are shared with a Provider Action workgroup for recommended action or escalation to the Member Experience Committee. Next GARS Committee is scheduled for QIC on June 14th.	
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo	QIC	MC,OC,OCC	X	In Q1, MemX Committee has reviewed/discussed the following: <u>2/9/22:</u> •Updates -Q4 workplan updates due 2/11 •Charter Review •DHCS Audit Findings •UM Dept Update •2022 Workplan Review •HN Improvement Plan	In Q2 MEMX Committee has one meeting scheduled, April 5.	
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook	Utilization Management/ QIC	MC,OC,OCC	X	UMC reported to QIC on 2/15/2022. Presented 2021 3rd Quarter and Annual Trends (11/18/2021), - 3Q 2021 Operational Performance (MC,OC,OCC) Medical Auth 3 HN below goal for Urgent TAT, 1 for routine TAT - 3Q 2021 Utilization Outcomes (MC, OCC) Medical Measures met Goals, OCC measure Beddays and Readmissions did not meet goals - 3Q 2021 Operational Performance WCM goals are to TBD. - Prior Authorization (PA) Backlog update (Person: Leadership accountability and oversight, UM role vacancies, Process: Workflows lacked efficiency and visibility Lack of prioritization and planning System/Technology Clinical platform upgrade and ongoing maintenance, Staff readiness for platform upgrade) - Over/Under Utilization Monitoring, Benefit Management Subcommittee (BMSC), Pharmacy Over/Under Utilization Monitoring, BH UM Update, BHI. - QIC accepted and filed meeting minutes from UMC Meeting (8/26/21).QIC Accepted and filed all documents.	UMC is scheduled to present Quarterly update to QIC on 4/12/2022. Along with DRAFTs of 2022 UM Program, 2021 UM Evaluation and List of Board Certified Consultants (AMR/MRlpa/Internal.)	

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Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD	QIC	MC	X	WCM CAC met on February 15, 2022 and approved the November 16, 2021 meeting minutes. Committee annual Conflict of Interest and Attestation forms were completed by all attendees. An update on the CalAim program was presented by Case Management Director, Sloane Pettillo. An update on Magellan Rx backlog issues of prior authorizations was shared with the Committee. CalOptima with collaboration of CHOC and UCI held meetings with Magellan in response to the issue. Magellan has hired additional staff and many prior authorization requirements were removed and the backlog issue has been caught up. Committee has concerns of a back log issue recurring when the prior auths are lifted in May. Will present an update at the next WCM CAC. Standing agenda updates for WCM Measures, GARS, and WCM Customer Service Inquires were presented. DHCS notice updates of CCS Medical Therapy Program Step 3b Guidance Related to Return to In-Person Services and DCHS Numbered Letter 03-0421 related to CCS program were also shared.	Next meeting scheduled for May 17, 2022 with an update to the Magellan RX backlog issue to be reported along with the standing recurring agenda items.	Green
Quality Withhold for OCC	Earn 75% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Sandeep Mital	QIC	OCC	X	Preliminary analysis of MY2021 performance on the measures indicates that CalOptima has passed 7 of the 10 measures, which would make us eligible to receive 75% of the OneCare Connect Quality Withhold dollars back.	We will receive final confirmation of MY2021 performance from CMS in 2023 and then calculate and distribute health network withheld dollars.	Green
Quality Analytics Program Updates (Health Network Quality Rating, MCAS, P4V, OC P4V, Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps Activities requiring intervention are listed below in the Quality of Clinical Care measures. [NEW] Development of the OC P4V program for MY2023	Quarterly Report or As needed	Kelly Rex-Kimmel/ Paul Jiang/Sandeep Mital	QIC	MC,OC,OCC	X	HEDIS MY2021 results achieved MPL for all DHCS selected measures except the newly added well child visits (W30) measure.	We are continuing to monitor performance in 2022 on a monthly basis. Next update to QIC will be in Sept .	Green
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of specific goals All LOB PIPs MC PIPs: 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members.(March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Successfully met all required criteria for Module 3. Began testing intervention. Mobile Mammography Event Q1: Completed 12 BCS for KCS CCN members. 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members. Module 1-3 Submitted and approved. Began testing intervention.	1) Continue testing intervention through the end of the PIP December 31, 2022. Scheduled KCS Mobile Mammography Events for for 5/17, 8/15, and 10/24. 2) Continue testing intervention through the end of the PIP December 31, 2022. New target list for 2022 denominator provided to office (April).	Green
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs MC QIP: 1) COVID QIP Phase 2 - a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)- N. Zavala b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	Quarterly/Annual Assessment	Natalie Zavala/Helen Syn	QIC	MC,OC,OCC	X	MC QIP 1) COVID QIP Phase 2- a. SSD update provided under Quality of Clinical Care Behavioral Health section below. b. CCS- Cycle 1: 3 provider offices conducted member outreach with combined CCS denominator of 4,235 and target outreach population of 2,172. The combined outreach rate at the end of cycle 1 was 53.22 % (1156/2172). Provider office staff received predetermined incentive based on the count of the target outreach list if 90% of members identified on target list were outreached. c. CIS Combo 10- Cycle 1 (10/14/21-12/31/21): Provide Office outreach and reconciled 100% of their target list of 663 members. Based on 2021 Annual Prospective Rate Report, provider office CIS-10 rate met the 66th percentile. Rate =44.24% (292/660). Cycle 2 (01/01/22- 03/31/22): data collection (claims/encounters) period to establish provider office rate for MY 2022 to pull new target list for office. 2) Q1 2022 results pending, reliant on Q2 2022 Statin Pharmacy data (slated for mid/late May 2022) to obtain results.	a1) Continue tracking members in need of diabetes screening test. a2) Continue prescribing provider outreach. b. CCS- For cycle 2 Provider Offices staff will still focus on outreaching to members to schedule cervical cancer screening but CalOptima plans to add a provider office staff tiered staff incentive that focuses on the number of completed cervical cancer screenings by June 2022. c. CIS Combo 10- Cycle 3 (04/18/22-06/30/22) Provider office received new target list of 677 members. Intervention includes, reconciling their target list, outreaching to members who are noncompliant, scheduling appointments and confirming if appointments were kept.	Yellow

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Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on All LOB CCIPs 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	ALL LOB CCIPs 1) Emerging Risk Health Coach Outreach OC CCIP 3 members, 1 Assigned, 1 No Longer Eligible. Emerging Risk Health Coach Outreach OCC CCIP 46 members, 27 Assigned, 1 Unable to Contact, 3 No Longer Emerging Risk, 7 No Longer Eligible. 2) Q1 2022 results pending, reliant on Q2 2022 Statin Pharmacy data (slated for mid/late May 2022) to obtain results	1) Continue Emerging Risk Telephonic Health Coach Outreach 2) Continue SPD Statin quarterly mailers	
PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPes 1) PME (OC): HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) 2) QIPE (OCC): HRA's ICP High/Low Risk, ICP Completed within 90 days, HN MOC 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion.	Quarterly/Annual Assessment	Sloane Petrillo/S. Hickman/D. Hood	QIC	OC, OCC	X	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPes 1) PME (OC): a) HRA's Initial: Jan 100% outreach completed; Feb results after 4/30 and Mar results after 5/31/22. Annual: Jan, Feb, and March with 100% outreach completed. b) HN MOC Oversight(Review of MOC ICP/ICT bundles) 100% of bundles returned were reviewed in 10 business day TAT for both Jan and Feb. March is pending. 2) QIPE (OCC): a) HRA's Initial: Jan 99% outreach completed; Feb and Mar 100% outreach completed. Annual: Jan, Feb, and March at 99% outreach completed. b) ICP High/Low Risk CA MMP 1.5 goal is 75%: High risk 85% and Low Risk 78% for Q1 2022 c) CA MMP 1.6 Care Goal Discussion: Q1 2022 is 98% for both initial and revised ICP. d) ICP Completed within 90 days MMP 3.2: Q1 2022 is 85% e) HN MOC 100% of bundles returned in January were reviewed in 10 business day TAT; February 96% were reviewed within 10 business days. March data is pending. 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion. Quarterly monitoring.	1)PME (OC): a) HRA's Continue same process. b) HN MOC Oversight(Review of MOC ICP/ICT bundles) Continue same process. 2) QIPE (OCC): a) HRA's Continue same process. b) ICP High/Low Risk CA MMP 1.5 goal is 75%: Continue same process. c) CA MMP 1.6 Care Goal Discussion: Continue same process. d) ICP Completed within 90 days MMP 3.2: Continue same process. e) HN MOC Continue same process 3) LTSS HRA OCC: Ongoing Process.	
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January 2022.	Quarterly Adoption of Report	Natalie Zavala/Sheri Hopson	QIC	MC	X	BHIIP: 5 provider groups submitted Q4 milestone reports, overall 97% of the targeted milestones were completed and reported to DHCS by 3/1/22. One provider group reported challenges completing milestones for Q3 & Q4 of 2021, and Q1 2022 and performance measures. The group selected new performance measures from an approved list provided by DHCS; MOU amended to reflect changes. A corrective action plan (CAP) was issued to address uncompleted milestones. CAP returned by 3/1 and reviewed by BHI and additional information requested. ABA P4V: Downloaded stats from Tableau to prepare the last ABA P4V report card for 2021. Requested Provider Relations to email the report cards to the providers by 2/2. Several discussions/meetings with medical director, sr reporting analyst, and P4V team to finalize the calculation methodology for the measurement year 2021 incentive payments.	BHIIP Q1 activities: 1) Prepare PY2 Q1 2022 milestone report for distribution in May to DHCS; 2) Review provider group's revisions to CAP and finalize; and 3) Prepare Q2 2021 incentive payment once received from DHCS expected in April. ABA P4V: 1) Prepare check request for the incentive payout by 3/31. 2) Discuss with ITS for report cards to be distributed bi-annually using the portal.	
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1) Regular planned visits to shelters, hot spots and recuperative care facilities- to resume post-COVID-19 addition of virtual outreach visits to shelters. 2)Primary point of contact for coordinating care with collaborating partners and HNs 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19	Quarterly Report	Katie Balderas/S. Hickman	QIC	MC,OC,OCC	X	1) Regular planned visits to shelters, hot spots and recuperative care facilities- to resume post-COVID-19: Outreaches are virtual and telephonic to three shelters: Yale Navigation Center, Costa Mesa Shelter, and Huntington Beach Navigation Center. In contact with recuperative care facilities telephonically to coordinate care with members. 2)Primary point of contact for coordinating care with collaborating partners and HNs: Through the Homeless Respons Team phone line. 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19. Clinical Field Team has worked with clinics to support outreach services to encampments. 4) Clinical Field Teams had 109 dispatches with a total of 94 individuals treated in Q1 2022. We added two additional referral sources for the CFT program in Q1 Be well Mobile Crisis Unit and Huntington Beach Police Mobile Unit.	1) Regular planned visits to shelters, hot spots and recuperative care facilities- to resume post-COVID-19: Continue to look for additional opportunities for virtual and telephonic outreach to other shelters. 2)Primary point of contact for coordinating care with collaborating partners and HNs: Script will be implemented in Q2 to better track contacts. 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19. Continue to work with the county and other external partners to support their efforts at encampments. 4) CalOptima will continue to explore additional referral sources for the CFT program.	

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CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Quarterly Report	Sherry Hickman/Gail McMillen	QIC	MC	X	1) HHP transition members outreach completed. 2)WPC transition members outreach nearly complete. POF member outreach has begun and between these three groups 660 members have had outreach and 183 enrolled. 3)DHCS reporting Creation and implementation of weekly ECM activity log with validation process for health networks. Internal submission expected on 5/6 for one time and quarterly implementation. 4) Oversight Strategy for CalAIM-Undetermined at this time. First of two round review completed.	1) HHP transition members ongoing management of enrolled ECM members. 2)WPC transition members ongoing management of enrolled ECM members. 3)DHCS reporting Ongoing monitoring of weekly ECM activity log to support reporting metrics. 4)Oversight Strategy for Cal-Aim: Once 2nd round of reviews completed, a decision on frequency of monitoring. 5) working POF list for outreach to potentially eligible members.	
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1) Make health equity a strategic priority 2) Develop structure and process to support health equity work 3) Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4) Develop partnerships with community organizations to improve health and equity 5) Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Katie Balderas/Marsha Choo	QIC	MC, OC, OCC	x	CalOptima issued an RFP in search of an NCQA consultant for both Health Plan Accreditation (HPA) as well as for Health Equity Accreditation (HEA). Standards for both HPA and HEA have been purchased. CalOptima launched a Health Equity Workgroup, developed a shared definition of Health Equity, and began developing a roadmap for advancing health equity that includes: 1) Making an explicit commitment to advancing health equity to internal and external stakeholders 2) Identifying existing and needed organizational assets, resources and leadership 3) Measuring health inequities and identifying impactful strategies focused on social determinants of health 4) Implementing short- and long-term strategies focused at the member, organizational and community level 5) Ongoing data collection, shared lessons and expanded capacity	NOCA consultant to be contracted and launch kick-off for both HPA and HEA. Next steps in the development of the Health Equity Framework include refining the overarching goals and creating more specific objectives.	
DHCS Comprehensive Quality Strategy	Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.	[NEW] to 2022 QI Work Plan 1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy	12/31/2022	Marsha Choo/Katie Balderas/Kelly Rex-Kimmitt	QIC	MC, OC, OCC		CalOptima Quality reviewed a draft of the 2022 DHCS Quality Strategy and provided feedback. DHCS' final draft has been submitted to CMS.	Educate other areas on the elements of the 2022 DHCS Quality Strategy and focus on incorporating and aligning these elements with our QI Workplan.	
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	[NEW] to 2022 QI Work Plan SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.	12/31/2022	Natalie Zavala	QIC	MC		1) Met DHCS deadlines: submitted Letter of Intent (LOI) to participate in SBHIP in January; submitted SBHIP Partner form in March. 2) Provided update at Special Joint MAC and PAC Meeting on March 10th. 3) Continued weekly internal meetings with Core Team. 4) Continued bi-weekly collaboration meetings with Orange County Department of Education (OCDE).	1) Meet with school districts on April 19th to review expectations and begin assessment phase of program. 2) Hold stakeholder workgroup in May. 3) Provide SBHIP update at WCM CAC 5/17.	

**2022 Quality Improvement Work Plan
(1Q)**

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Report to Committee	LOB	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Concern Green - On Target
II. QUALITY OF CLINICAL CARE- Adult Wellnes										
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events.	12/31/2022	Helen Syn	QIC	MC	X	1a. 2022 Member Health Rewards processed as of 3/31/22: BCS: 81 for MC and 2 for OCC; CCS: 149 for MC; COL: 1 for OC 1b. Transition to Member Health Reward Vendor Contract with vendor fully executed on 2/14/22. In the development stages of transitioning membership data, member health reward process, and identification of member health reward types. 2. Pending complete transition to member health reward vendor to define and set deadlines to implement. 3. Member Engagement Strategy:Texting: CCS texting campaign total= 11,512 IVR: CCS Total 2,800= 2,239 Message Left + 561 Message played; COL Total 512= 344 Message Left + 168 Message played; Social Media: CCS Static Social Media Post; COL Static Social Media Post Digital Ad: CCS digital ad; COL digital ad; Direct Mailing: 67,079 CCS MC member mailing; 17,069 BCS MC member mailing Community Connections: CCS article 4. Community Events: Mobile Mammography: KCS event 12 CCN members completed 5. 2022 February Prospective Rates (PR): Breast Cancer Screening MC: 44.42%, OC: 52.57%, OCC: 50.41% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). Cervical Cancer Screening MC: 43.77% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Colorectal Cancer Screening OC: 35.6%, OCC: 38.53% Measure is performing higher than same time last year for both OC/OCC and is currently below the 50th percentile.	1a. Continue to track BCS, CCS and COL member health reward. 1b. Complete transition to member health reward vendor is set to be executed by August 2022. 2. Targeted member engagement and outreach campaigns to identified zip codes. 3. Member Engagement <u>Texting</u> : BCS texting campaign scheduled in May <u>IVR</u> : BCS scheduled for Q3/Q4 <u>Social Media</u> : BCS scheduled for Q3/Q4 <u>Digital Ad</u> : BCS scheduled <u>Print Ad</u> : COL scheduled Q2, BCS scheduled <u>Direct Mailing</u> : COL scheduled for Q2; CCS, BCS, COL scheduled for Q4 <u>Community Connections</u> : Article scheduled for Q2/Q4 <u>Member Newsletter</u> : CCS, BCS, COL article scheduled for Spring and Summer issue <u>Live Call Campaign</u> : Pending new contract 4. Community Connections: Ongoing mobile mammography events	
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	12/31/2022	Helen Syn	QIC	MC	X	1. COVID texting campaigns continued in Q4 2. COVID community vaccine events were held in partnership with OCHCA ongoing. 3. Vendor has processed a total of 604,521 incentives (cumulative) *PHM has processed a total of 133,572 incentives (cumulative). This total includes incentives processed in-house & through vaccine events. *Vaccine Events: <input type="checkbox"/> January 15th: 346 <input type="checkbox"/> January 22nd: 165 <input type="checkbox"/> February 19th: 170 <input type="checkbox"/> March 12th: 71 <input type="checkbox"/> March 19th: 85 <input type="checkbox"/> March 26th: 37 <input type="checkbox"/> Total vaccine events: 874 <input type="checkbox"/> As a reminder, the breakdown of the vaccine event totals may be different to the numbers reported by Community Relations. Community Relations totals represent all CalOptima members vaccinated and PHM numbers represent all that were handed a gift card. 4. VIP reimbursement data set provided to DHCS for First Submission. 5. VRP responses to DHCS coordinated by COVID Vaccination Workgroup	Texting campaigns continue. New texting messages will be updated to include expanded age ranges and booster shot eligibility. Ongoing COVID messaging to go out in Member Newsletter and Provider Newsletters about the importance of boosters and new eligibility with expanding age sets. COVID vaccine incentive processing continues, CAIR registry data and logic improvements to assist with identification and more timely processing. COVID vaccine events with OCHCA continue Future Vaccine Events: April 9th: 67, April 16th: 54, April 23rd: 42, May 17th, June 7th	
III. QUALITY OF CLINICAL CARE- Behavioral Health										
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	HEDIS MY2021 Goal: FUH 30-Days: MC: NA; OCC: NA; OCC: 48.40% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:27.07%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	12/31/2022	Natalie Zavala	QIC	OCC	X	PR HEDIS Rates Q1 (February): 30 day- 16.67%, 7 day- 16.67%; BHI real-time report Jan-March: 30 day- 44%, 7 day- 29%. 1) Continued outreach to members post-discharge to coordinate follow-up appointments. Difficulties included: members not attending follow-up appointments due to readmission; member declining assistance; and inability reaching members due to invalid phone numbers. 2) Continued weekly BHI clinical round meetings to discuss concurrent reviews and internal coordination interventions.	1) Continue conducting post discharge outreach. 2) Continue tracking members and outreach to those who are not attending follow-up appointments within 7 days of discharge.	

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Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2021 Goal: MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	12/31/2022	Natalie Zavala	QIC	MC	X	PR HEDIS Rates Q1 (February): Initiation Phase- 41.04%, Continuation and Maintenance Phase- 59.57% 1) Continued monitoring of CORE report to track members who filled an initial ADHD Rx. This is a manual process, but addresses barrier of limited resources for developing a real-time report to track member f/u visits for provider outreach to schedule visits. 2) Continued member outreach for those who filled initial ADHD Rx (script and workflow to track phone calls made to members). 3) Created and submitted tip sheet on Treatment for Children with ADHD to communications for CalOptima Member Spring Newsletter.	1) Continue member outreach for those who filled an initial ADHD prescription. 2) Update data collection for compliant and non-compliant provider letters. 3) Distribute non-compliant provider letters.	Green
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)	[NEW] to 2022 QI Work Plan 1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	12/31/2022	Natalie Zavala	QIC	MC, OC, OCC		PR HEDIS Rates Q1 (February): M/C: 20.73%, OC: N/A, OCC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test. 2) Conduct outreach to prescribing provider via phone, then fax to include (a) list of members in need of diabetes screening (b) best practice guidelines reminder (c) members' primary care physician (PCP) name and contact information (to promote coordination of care by requesting prescribers to contact the PCP with lab results). Difficulties: attaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing.	1) Continue tracking members in need of diabetes screening test. 2) Continue prescribing provider outreach.	Yellow
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)	[NEW] to 2022 QI Work Plan 1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.	12/31/2022	Natalie Zavala	QIC	MC		PR HEDIS Rates Q1 (February): 30 day- 24.94%, 7 day-16.12% Measure has been identified as a Health Network (HN) P4V. The main barrier is obtaining real-time data for ED visits in order to conduct interventions to assist in follow-up visit attendance.	1) Develop report on member ED visits to identify trends. 2) Attend at least 1 HN Quality meeting to discuss/ address barriers.	Yellow
IV. QUALITY OF CLINICAL CARE- Chronic Conditions										
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1c control- lower rate is better)	MY2021 HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) HbA1c Test Health Rewards: 13 Processed, 9 approved, 4 denied 1b) Transition to Member Health Reward vendor. Contract with vendor fully executed on 2/14/22. In the development stages of transitioning membership data, member health reward process, and identification of member health reward types. 2) Diabetes A1c member mailers MC 7,803, OC 84, OCC 637 = 8,524 mailers Emerging Risk Health Coach Outreach: MC 185 Assigned, 3 No Longer Eligible, 4 No Longer Emerging Risk, 1 Opt Out, 3 Unable to Contact OC 3 members, 1 Assigned, 1 No Longer Eligible. OCC 46 members, 27 Assigned, 1 Unable to Contact, 3 No Longer Emerging Risk, 7 No Longer Eligible. 3) Member Engagement Strategy: Texting: CDC texting campaign content submitted to DHCS for approval, currently under review. IVR: Campaign content completed and approved, pending launch date. Social Media: Content under development. 4) Prop 56 provider value based payments for diabetes care measures. 5) 2022 February Prospective Rates (PR): There were no A1c Testing rates for Feb 2022 PR A1c Adequate Control <8.0 MC: 1.99%, OC: 1.82%, OCC: 2.81% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). A1c Poor Control >9 MC: 97.98 %, OC: 98.00%, OCC: 96.81% Measure is performing better for all LOBs than same time last year (lower rate is positive trend) and below the 50th percentile (MPL).	1) Track and monitor until the end of member incentive year. Complete transition to member health reward vendor is set to be executed by August 2022. 2) Continue the Emerging Health Coach outreach to the end of 2022. 3) Texting: Pending DHCS approval launch date slated for Q4 2022. IVR: Approximate launch date slated for end of June 2022. Social Media: Campaign slated to launch Q3-Q4 2022.	Green

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Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals: MC 63.2% OC: 71% OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) Eye Exam 5 Processed, 5 approved, 0 denied 1b) Transition to Member Health Reward vendor. Contract with vendor fully executed on 2/14/22. In the development stages of transitioning membership data, member health reward process, and identification of member health reward types. 2) Diabetes Eye Exam member mailers MC 7,803, OC 84, OCC 637 = 8,524 mailers 3) Member Engagement Strategy: Texting: CDC texting campaign content submitted to DHCS for approval, currently under review. IVR: Campaign content completed and approved, pending launch date. Social Media: Content under development. 4) Prop 56 provider value based payments for diabetes care measures 5) 2022 February Prospective Rates (PR): Diabetes Eye Exams MC: 26.65%, OC: 35.45%, OCC: 35.32% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). 6) Identified VSP data fields needed from HNs for data sharing criteria.	1) Track and monitor until the end of member incentive year. Complete transition to member health reward vendor is set to be executed by August 2022. 2) Analyze if a need for additional member mailers are necessary. 3) Texting: Pending DHCS approval launch date slated for Q4 2022. IVR: Approximate launch date slated for end of June 2022. Social Media: Campaign slated to launch Q3-Q4 2022. 6) Submitted ticket to IS on 3/31/2022. Slated for completion Q2 2022.	Green
Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot	1) lower HbA1c level to avoid complications 2) reduce emergency department (ED) visits 3) reduce hospitalization rates 4) reduce costs for diabetic medications 5) improve member and provider satisfaction; and 6) optimize diabetes medication management during the transition to Medi-Cal Rx.	There are four parts to this multidisciplinary approach: 1) Pharmacist Involvement and Intervention- Nicki G. • CalOptima Pharmacist's role will include individual member outreach and provider consultations for members enrolled in the pilot program. CalOptima pharmacists will promote proper medication utilization, provide medication adherence counseling, and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dietitians/case managers. 2) Health Coach/Registered Dietician Intervention - Jocelyn J. • CalOptima Health Coaches will provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dietitians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. 3) Member Health Rewards - Helen Syn • CalOptima would like to support member engagement and compliance by providing members with health rewards (non- monetary incentives). 4) Provider Incentives - TBD • In order to have successful provider buy-ins, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.	12/31/2024	Nicki Ghazanfarpour /Helen Syn/ Jocelyn Johnson	QIC		X	Planned activities being revisited for revised proposal and will pend approval by CMO/BOD	Planned activities being revisited for revised proposal and will pend approval by CMO/BOD	Yellow
V. QUALITY OF CLINICAL CARE- Maternal Child Health										
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 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) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	12/31/2022	Ann Mino/Helen Syn	QIC	MC	X	1) Member Health Reward for Postpartum care has been agreed by the business owners to not transition to the Health Reward Vendor due to the small volume and complexity of processing. 2) Process for the first quality Initiative mailing is being finalized. First mailing is projected to go out in Q2 2022. Mailing will target members that recently delivered and encourage timely postpartum care. Prenatal care article included in the Spring 2022 Medi-Cal newsletter, healthcare chat video on prenatal visits on immunizations on social media platforms, and social media posts related to prenatal/postpartum care. 3) Provider communication on Postpartum Care Extension. 4) Bright Steps Program conducted initial outreach to 1793 unique members. 1034 outreach attempts made to 623 for postpartum members, 238 postpartum assessments completed. 5) Total # of PPC health rewards approved for Q1: 63. 6) Planning for Diaper Day events in collaboration with CalFresh and community partners is continuing. Tentative schedule is being created for community events to take place in Q2 2022. 7) Prop 56 provider value based performance incentives for prenatal and postpartum care visits. February 2022 Prospective Rates: Timeliness of Prenatal Care: 80.49% Measure is performing higher than same time last year and has not met the 50th percentile. Postpartum Care: 53.16%. Measure is performing higher than same time last year and has not met the 50th percentile.	1) Postpartum quality initiative mailing is projected to begin Q2 2022. 2) Prenatal and postpartum social media campaign is projected for Q2 2022. 3) Diaper Day + CalFresh community events to promote Bright Steps. 4) Medi-Cal newsletter article on postpartum care articulated in Medi-Cal summer newsletter. 5) Postpartum Care Extension newsletter article in Medi-Cal summer newsletter.	Green

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VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS MY2021 Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2022	Helen Syn	QIC	MC	X	1) Targeted member engagement and outreach campaigns in coordination with health network partner	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Health Guide 0-2 Newsletter, Well-Child Visits Flyer and Lead Poisoning Fact Sheet mailing slated for April 2022 - Targeted ad campaign for Well-Care Pediatrics and Immunizations via digital and social media - April World Immunization Week observance on social media - Community Connections April Newsletter for World Immunization Week observance - Medi-Cal member newsletter article on adolescent immunizations - Live call campaign for mi-year push for well-child and immunization measures. 2) Plan and attend community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics - Attend community events targeting the pediatric and adolescent population. - Plan back-to-school vaccination events. 3) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures	
Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) HEDIS MY2021 Goal (3 Year Goal): Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2) Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	12/31/2022	Helen Syn	QIC	MC	X	1) Shared report in January 2022 to health networks with Q4 2021 data on members that have not been screen as recommended for blood lead screening. Worked with ITS to leverage new provider portal and share blood lead screening report with CCN providers. Report to CCN is on track for Q2 2022. Beginning the implementation process for a health network attestation to ensure that HNs are sharing member detail blood lead reports with their providers. 2) Member education efforts: blood lead screening campaign on social media in March 2022, blood lead article in Medi-Cal newsletter in Spring 2022. 3) Prop 56 provider value based payments for Blood Lead Screening. February 2022 Prospective Rates Lead Screening in Children (in 2022 became an MCAS measure that will have to meet MPL). MC: 49.25% Measure is performing lower than the same time last year and has not met the 50th percentile (MPL).	1) Provider communication on blood lead screening testing and management through communication platforms, including Health Network Qualify Forum. 2) Blood Lead Screening report sharing to CCN Providers.	
VII. QUALITY OF SERVICE- Access										
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	12/31/2022	Marsha Choo/Jennifer Bamberg/Maggi e Hart	MEMX	MC,OC,OCC	X	The function of recruiting providers transitioned from Provider Relations to Contracting Department. In addition, the staff identified for recruiting providers has been on FMLA.	CalOptima is currently engaged in a provider onboarding end-to-end process led by Process Excellence that includes a review of the provider recruiting process and workflow.	
Improve Access: Expanding Network of Providers Accepting New Patients	Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%	[NEW] to 2022 QI Work Plan 1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC		In Q1, the Provider Directory Validation Template was being revised and a new format has now been implemented which PR began using in Q2.	Provider Relations is now requesting PCPs and SCPs open panels during Provider Data Validation on a quarterly basis.	
Improve Access: Timely Access (Appointment Availability)	Improve timely access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) No update for Q1 but non-compliant letters issued to providers last fall, in Q4-2021. 2)PDSA issued to 12 HNs for not meeting Timely Access Standard in January 2022. Networks are required to complete 3 separate PDSAs: •Improve Member Access to PCPs •Improve Member Access to Specialists •Improve Telephone Access to Medi-Cal pop. •Technical Assistance calls held February 2022 •Reviewed and approved "Plan" section of PDSAs	1) Final results from 2021/22 Timely Access survey due by July. Review and issue corrective action to individual providers not meeting timely access standards 2) A&A workgroup to review HNs final PDSA submissions due in June and provide final status and feedback: Completed, Closed, or Other	

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Improve Access: Telephone Access	Reduce the rate of No Live Contacts After 3 Attempts from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) In Q1, the Provider Directory Validation Template was being revised and a new format has now been implemented which PR began using in Q2. 2) Awaiting 2021/22 Timely Access Survey results from vendor with estimated arrival date in July.	1) Provider Relations has 9% or 115 contracted TINS (780 unique providers) validations to date. Provider Relations and Provider Data Management Services (PDMS) continues to complete analysis and update the system of record for the Monthly and Quarterly Provider Data Quality Checks/Audits. 2) Review survey results in summer, and issue letters of noncompliance based on the following escalation order: •Education (1st yr of non-compliance) •Warning (2nd yr ...) •Escalation (3rd yr...)	Green
Improving Access: Subcontracted Network Certification	Certify all HNs for network adequacy	[NEW] 2022 QI Work Plan 1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.	7/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC		Network Adequacy Standards: Medi-Cal Plan Level: •Mandatory Provider Types: Met •Provider to Member Ratios: Met •Time/Distance Standards: Met Medi-Cal HN Level: •Mandatory Provider Types: Not Met. (Certified Nurse Midwives and Licensed Midwives) •Provider to Member Ratios: oPCPs: Met oSpecialists: Not Met •Time/Distance: Not Met Medi-Cal Timely Access: •PDSAs issued to 12 HNs for not meeting Timely Access Standard - January 2022 •Continue to field 2021/22 Timely Access Survey	Continue to monitor quarterly If Net Adequacy standard (s) not met, outreach to network to directly. Review HNs final submission for PDSAs in June. Continue to prep for new 2022 Timely Access Survey with target fielding dates, June-November	Green
VIII. SAFETY OF CLINICAL CARE										
Plan All-Cause Readmissions (PCR)	HEDIS MY2021 Goal: MC - NA OC 8%; OCC 1.0 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access 3) Continue to engage work group to address barriers, thereby achieving increased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regarding the importance of having a post discharge visit with the members PCP.	12/31/2022	Mike Shook	QIC	MC, OC,OCC	X	No update. Current initiative specific to MC LOBs only	Need follow up meeting to be scheduled to further discuss	Yellow
Post-Acute Infection Prevention Quality Incentive (PIPQI)	1) To reduce the number of nosocomial infections for LTC members. 2) To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses will be visiting each facility/ out reach minimally once a week. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. And administer Iodofo (nasal swabs) per PIPQI Protocols. 3) CalOptima will pay participating facilities via reimbursement for product purchasing and quarterly quality incentive payments. 4) CalOptima will market and expand the PIPQI Program into additional CalOptima Contracted Nursing facilities providing onboarding training, new branding and educational materials.	12/31/2022	Michelle Findlater/Scott Robinson	QIC	MC,OC,OCC	X	The HAI scores trended upward in Q4 of 2021, and then had a slight downward trend in Q1 however we are still over a point above the average which is now 4.51 Invoice submission for CHG and Iodophor increase in Q1 however we continue to see nearly 1/3 of the invoices not being submitted per program requirements Of the submitted invoices, we continue to see that more than 50% are not purchasing even half the amount needed to complete the bathing and Iodophor protocols	The PIPQI Program was set to run out its funding in March 2022. The PIPQI Team took and extension to the Board in April 2022. Extension asked for additional \$275,000 to extend program through the end of the fiscal year 21-22. New budget based on removing \$7500 quarterly incentive Reduce baths from every other day to 2 per week and offer product reimbursement based on that reduction Remove 6 least complaint facilities	Yellow
Orange County COVID Nursing Home Prevention Program.	Conduct in-person training of 12 CalOptima contracted nursing facilities in collaboration with UCI to reduce the spread of COVID/Infections in nursing facilities; toolkit, consultative services and webinars provided to all Orange County nursing homes free of charge	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2022. Planned activities include: 1) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 2) Provide guidance, protocols for preventing spread of COVID 3) Support training on how to stock and use protective gear 4) Develop high compliance processes for protection of staff and residents. 5) Make toolkit available for free at www.ucihealth.org/stopcovid 6) Provide COVID prevention helpline to offer guidance and information to nursing home staff 7) Conduct point prevalence sweeps of residents for multi-drug organisms	5/31/2022	Cathy Osborn/Scott Robinson	QIC	MC,OC,OCC	X	UCI provided: 1. Consultative service: 12 nursing homes received intensive training with weekly feedback of staff safety metrics; 31 additional OC nursing homes received phone consultation services. 2. Confidential helpline for COVID questions and inquiries: To date, 250 helpline inquiries have been addressed. 3. Point prevalence sweeps of residents and staff. 4. Monthly progress meetings with CalOptima.	UCI is on track to successfully complete project by 5/31/2022. 1. UCI will continue to provide education to nursing homes. 2. UCI will continue to conduct point prevalence sweeps of residents for multidrug-resistant organisms and analyze results.	Green

2022 QI Work Plan
(2Q)

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I. PROGRAM OVERSIGHT										
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2022	Mike Shook	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by April 2022	Mike Shook	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Marie Jeannis/Kelly Giardina	QIC	MC,OC,OCC	X	Strategy is current. We will need to update to align with 2022 HP NCQA requirements and DHCS.	Meeting will be scheduled in 2Q2022 to update.	
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	Quarterly Adoption of Report	Marsha Choo/Laura Guest	QIC	MC,OC,OCC	X	I. FSR/PARS/INF/CBAS A. FSR • Updated DHCS FSR and MRR Tools and Standards implemented on 7.1.1022 • Moderate updates to FSR Tool • Substantial updates to MRR Tool • Decrease in number of failed FSR and/or MRR from Q1 to Q2 • Increase in number of CAPs from Q1 to Q2 B. PARS • Significant increase in number of PARS completed from Q1 to Q2 • % of sites with BASIC access increased slightly from Q1 to Q2 C. Quality Oversight - CBAS • Full congregate in-person services scheduled for 10/1/2022 • Virtual audits completed for look back period 2021 II. Credentialing/Rec credentialing Subject: Identified in March 2022: Organizational Providers - OneCare Project. For CCN and BH, there were 117 group practices that were identified as not credentialed, although the individual practitioners were credentialed. Actions: As of the end of Q2, 57 completed credentialing. Three providers are in process, 5 were terminated for not meeting credentialing requirements; 41 the application was not received; 2 the requirements were not met and 9 credentialing was not required. III. PQI Subject: Cases leveled at QOC were 20% in Q2; 21% in Q1. Subject: Fair Hearing for Notice of Termination - Potential 805 Reporting 1. PQI and FWA investigations - PM physician was billing for PT and psychotherapy services under his NPI 1, billing for 99215 for services rendered by a LVN, and was unable to produce medical records for several members due to destroying the medical records while converting to an EHR. 2. PQI Investigation - PCP attending at hospital for member who was admitted for hand cellulitis, had precipitous drop in Hgb, never referred to GI or hematology for etiology, and unexpectedly expired.	I. FSR/PARS/INF/CBAS A. FSR • Educational materials and communications sent in June 2022. (On-site education, CalOptima.org, CalOptima Weekly Communication, Provider Alert-Fax Blast • 2 auditors-1 day or 1 auditor-2 days • Hiring of additional staff to assist with audits and CAPs • Updates to FSR web application completed B. PARS • Educational materials and communications sent in June 2022. (On-site education, CalOptima.org, CalOptima Weekly Communication, Provider Alert-Fax Blast • 2 auditors-1 day or 1 auditor-2 days • Hiring of additional staff to assist with audits and CAPs • Updates to FSR web application completed C. Quality Oversight - CBAS • QI Nurse Specialist-LVN completing virtual audits to review Temporary Alternative Services (TAS) for look back period 2021 • QI Nurse Specialist-LVN to begin on-site CBAS Center visits in September 2022. Goal of 37 contracted CBAS centers by 12.31.2022. II. Credentialing/Rec credentialing Actions: Continue to credential the OPs is process. III. PQI Action: Continue with QOC grievance review by RN and MD Concern: Volume of PQIs continue to climb as the number of PQIs have increased and we've had an open nurse position since May. The position will be filled in Q4. The main category of PQIs continued to be Medical Care related to treatment delay, failure, inappropriate or complications. Action: Fair Hearing of PM physician was held in Q2. Second half of the Hearing was held in Q3. Determination will be reported in Q3. The Fair Hearing of the PCP was delayed until Q3 due to the availability of the participants. The second half of the Hearing will be completed in Q3, so we anticipate the determination to be reported in Q3.	
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health networks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Tyronda Moses/Heather Sedillo	QIC	MC,OC,OCC	X	Medi-Cal Complaints: 3% decrease in member appeals; 4% decrease in member grievances; 9% increase in provider appeals from Q1 Medi-Cal Grievances by Category: QOS continues to be the highest Grievance category. QOS decreased by 1.4% from Q1 to Q2. CCN and Veyo continue to have the highest number of QOS grievances. Other Increases: Quality of Care increased by 54% (from 245 in Q1 to 377 in Q2). AltaMed, Monarch, CCN, Arta had the most noticeable increase in QOC grievances. Access increased by 16% (from 503 in Q1 to 585 in Q2) Decreases: Billing decreased by 11.3% from Q1 Medi-Cal BH Grievances: 16% increase in BH grievances; Access increased by 20%; QOS decreased by 7%; Billing decreased by 33% (18 in Q1 and 12 in Q2) OCC Complaints: 56% decrease in appeals; 5% increase in grievances; 8% decrease in provider appeals from Q1 OCC BH Grievances: BH grievances decreased from 6 in Q1 to 3 in Q2 all in the QOS category. OC Complaints: Member appeals increased from 5 in Q1 to 11 in Q2; 16% increase in member grievances (19 in Q1 to 22 in Q2); 46% increase in provider appeals (13 in Q1 to 19 in Q2)	All trends are reviewed for repeated issues. High grievance count by providers are tracked and trended. Results are reported to Provider Relations for additional outreach and shared with a Provider Action workgroup. Recommendations for actions may include an onsite visit, additional education/training and/or escalation to the Member Experience Committee. Highest Trends identified during the quarter were related to transportation (late pick ups, no shows and complaints against drivers) GARS continues to work with Veyo to identify barriers and obstacles on a bi-weekly basis	

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Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo	QIC	MC,OC,OCC	X	In Q2, MemX Committee has reviewed/discussed the following: 4/5/22: •Updates: -CAPs issued to HNs -2022 TAS Changes •Charter Approved •Provider Sat Survey •SNC •2022 Workplan Review-deferred	In Q2 MEMX Committee has one meeting scheduled, August 10th.	Green - On Target
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook	Utilization Management/ QIC	MC,OC,OCC	X	UMC reported to QIC on 4/12/2022. Presented 2021 4th Quarter and Annual Trends (12/24/2022). - 4Q 2021 Operational Performance (MC,OC,OCC) -Continue to have some HN/CCN not meeting goal; Only trend noted CCN due to backlog – resolved 1/27/22. - 4Q 2021 Utilization Outcomes (MC, OCC) Medical Measures met Goals - 4Q 2021 Operational Performance WCM goals are to TBD. - Medi-Cal Over/Underutilization Monitoring Dashboard, Benefit Management Subcommittee (BMSC), Pharmacy Over/Under Utilization Monitoring, BH UM Update, BHI. - DRAFTs of 2022 UM Program, 2021 UM Evaluation and List of Board Certified Consultants (AMR/MRIP/Internal, with summary of Changes was presented to QIC Committee. - Committee reviewed and approved the 2021 UM Program Evaluation and 2022 UM Program Description as presented.	UMC is scheduled to present 1st Quarter 2022 update to QIC on 7/12/2022.	Green - On Target
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD	QIC	MC	X	WCM gave a Committee update on the meeting they had on February 15, 2022 and approved the November 16, 2021 WCM CAC meeting minutes. A copy was submitted for QIC to receive and file. Annual Committee Conflict of Interest and Attestation forms were completed. Committee recommended to add Susan Gage, CHOC Pulmonary specialist to the Committee. Case Management Director, Sloane Petrillo presented an update on CalAIM. Approximately 2,000 members were transitioned from Whole Person Care (WPC) Pilot and the Health Homes Program to the new Enhanced Care Management (ECM) program and Community Supports Services Pharmacy Director, Dr. Gericke provided Medi-Cal Rx update with relief of backlog with DHCS decision to remove prior authorization requirement UM, GARS, and CS gave a report on measures.	WCM is scheduled to give Committee update on July 12, 2022.	Green - On Target
Quality Withhold for OCC	Earn 75% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Sandeep Mital	QIC	OCC	X	Scheduled to give update when we receive final scores from CMS in 2Q of 2023	Continue to monitor performance on the various measures	Green - On Target
Quality Analytics Program Updates (Health Network Quality Rating, MCAS, P4V, Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Report or As needed	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital	QIC	MC,OC,OCC	X	All MCAS selected measures having MPL requirement achieved MPL except the newly added Well-Child Visits in the First 30 Months of Life measure (W30-15months; W30-30months)	Start health disparity analysis to further refine focus areas	Green - On Target
Development of the OneCare program for MY2023	Develop and finalize the CMS measures for the, scoring and payment methodology for the OneCare P4V program	P4V team has compiled a set of Part C, Part D, and Member Experience measures as proposed metrics for the MY2023 OneCare P4V program. Awaiting approval from the various committees and the Board of Directors.	Quarterly Report or As needed	Kelly Rex-Kimmet/Sandeep Mital	QIC			Need approval from the Board Of Directors so that we can share the measures and payment methodology with health networks.	Need approval from the Board Of Directors so that we can share the measures and payment methodology with health networks.	Yellow - Caution
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	MC PIPs: 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members.(March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Submitted BCS Health Equity PIP Progress Check-In. Continued testing intervention. Mobile Mammography Event Q2: Completed 25 BCS for KCS CCN members. 2) Submitted W30 PIP Progress Check-In. Continued testing intervention. Provider office has reached SMART aim goal (44.96%).	1) BCS Health Equity PIP Progress Checkin feedback expected in Q3. Continue testing intervention through the end of the PIP December 31, 2022. Scheduled KCS Mobile Mammography Events for 8/15, and 10/24. 2) W30 PIP Progress Check-In feedback expected in Q3. Continue testing intervention and monitoring HEDIS rate through the end of PIP December 31, 2022.	Green - On Target
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs MC QIP: 1) COVID QIP Phase 2 - a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)- N. Zavala b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	Quarterly/Annual Assessment	Natalie Zavala/Helen Syn	QIC	MC,OC,OCC	X	MC QIP 1) COVID QI Phase 2-a. SSD update provided under Quality of Clinical Care Behavioral Health section below. b. CCS - Cycle 2 completed on 6/30/22. Pending tracker results from participating providers. c. CIS Combo 10 completed April-June intervention. Provider Office successfully reconciled 677 records and outreached to 663 members (metric 1). 64 members were scheduled an appointment for this period and 107 members are awaiting the availability of the flu vaccine to complete measure (metric 2). May 2022 CIS-10 PR for provider office: 41.28%. 2) 2022 June Prospective Rates (PR):Statin Therapy for Patients With Diabetes (SPD)Statin AdherenceMC: 4.65%, OC: 1.85%, OCC: 1.62% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). Statin TherapyMC: 67.22%, OC: 76.67%, OCC: 76.90% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL).	1) COVID QI Phase 2- a. SSD b. CCS For cycle 3 Provider Offices staff will still focus on outreaching to members to schedule cervical cancer screening but CalOptima plans to add a provider office staff incentive that focuses on provider office cervical cancer screening rate by September 2022. c. CIS Combo 10- Target list for Cycle 4 (07/01/2022 - 09/30/2022) is shared with Provider Office for July - September implementation. Intervention includes outreaching to noncompliant members to schedule appointments, and tracking the number of newly compliant members. a-1) Continue tracking members in need of diabetes screening test. a-2) Continue prescribing provider outreach.	Green - On Target
Improvement Projects (All LOB) CCIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on All LOB CCIPs 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Emerging Risk Health Coach Outreach OC CCIP 8 members, 5 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC CCIP 44 members, 32 Assigned, 6 Unable to Contact, 0 No Longer Emerging Risk, 0 No Longer Eligible. 2) Results pending, final data slated at end of Q4 2022.	1) Continue Emerging Risk Telephonic Health Coach Outreach 2) Continue SPD Statin quarterly mailers	Green - On Target

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PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PME (OC): HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) 2) QIPE (OCC): HRA's ICP High/Low Risk, ICP Completed within 90 days, HN MOC 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion.	Quarterly/Annual Assessment	Sloane Petrillo/S. Hickman/D. Hood	QIC	OC, OCC	X	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PPME (OC): a. HRA's: Q1 completed with 100% outreach for both initial and annual members. Q2 April initials complete with 100%; May and June are pending. Q2 Annual outreach completed at 99%. b. HN MOC Oversight(Review of MOC ICP/ICT bundles) 100% for HRAs reviewed; Care Plans reviewed within 10 business days did not reach benchmark of 90% for quarter. 2) QIPE (OCC): a. HRA's: Q1 Initial outreach completed at 100% and annual at 99%. Q2 initial outreach for April and May is 100% and June is pending. Q2 annual outreach is 99%. b. HN MOC Oversight (Review of MOC ICP/ICT bundles) 100% for HRAs reviewed; Care Plans reviewed within 10 business days did not meet benchmark of 90% for quarter. c. 1.5 ICP initial care plan for high risk members 87% d. 1.5 ICP initial care plan for low risk members 81% e. 1.6 Care goal discussion 99% f. 3.2 ICP within 90 days of eligibility 81% 3) LTSS HRA OCC: Active monitoring and reporting to the manager on outreach completion and timeliness. Q2 27 files reviewed.	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PPME (OC): a. HRA's: Continue monitoring HRA outreach completion rates on monthly basis for both initial and annual. b. HN MOC Oversight(Review of MOC ICP/ICT bundles) Continue with process of HRA review; Care Plans are being reviewed and this data is being tracked monthly and reported to A&O. Oversight process to be restructured as early as Q3 and workplan will need to be modified. 2) QIPE (OCC): a. HRA's: Continue monitoring HRA outreach completion rates on monthly basis for both initial and annual. b. HN MOC Oversight (Review of MOC ICP/ICT bundles) Continue with process of HRA review; Care Plans are being reviewed and this data is being tracked monthly and reported to A&O. Oversight process to be restructured as early as Q3 and workplan will need to be modified. c&d. Continue to track MMP 1.5 results on quarterly basis. e. Continue to track 1.6 Care goal discussion on quarterly basis. f. Continue to track MMP 3.2 ICP and identify any logic concerns that can explain the drop from 85% benchmark that was met in 2021. 3) LTSS HRA OCC: Continue review of HRA for LTSS on monthly basis.	
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics - % of supervision hours completed by BCBA/BMC and % of 1.1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January 2022.	Quarterly Adoption of Report	Natalie Zavala/Sheri Hopson	QIC	MC	X	BHIIP: 1) Prepared and completed Program Year 2 Q1 milestone report 5/3, due to DHCS 5/27/22 2) Reviewed provider group's revisions to the issued CAP; resolution was for the group to revise their milestones to be more obtainable and able to report 3) MOU amendments were issued to DHCS for 2 provider groups (1 group opted-out of the program, 1 group revised their milestones). 4) Milestone incentive payment funding was received from DHCS for Q2 and Q3 2021; check requests processed and incentive payments distributed to the provider groups. Q4 received in June and check request being processed. ABA P4V: 1) Prepared check requests for the 73 provider groups who met their targeted goals, checks were mailed week of 4/4/22	BHIIP: 1) Q2 2022 Milestone Reporting Template due 8/27/22 2) 2021 Performance Measures/Baseline Report due 8/29/22 3) Q4 2021 Milestone Incentive Payments to be distributed ABA P4V: 1) Planning to revise/update Tableau report in order to distribute a P4V report card to the ABA provider groups to show their status of the performance metrics from Jan thru June 2022. Targeting distributing report card by end of August.	
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1) Regular planned visits to shelters, hot spots and recuperative care facilities- to resume post-COVID-19. (CM) addition of virtual outreach visits to shelters. 2) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19 3) Develop and implement Street Medicine Program 4) Implement DHCS Housing & Homelessness Incentive Program (HHIP) to meet specific measures around increased data integration, member housing supports, and homeless services for members	Quarterly Report	Katie Balderas/Gail McMillen	QIC	MC,OC,OCC	X	OCC BH Grievances: BH grievances decreased from 6 in Q1 to 3 in Q2 all in the QOS category.	1) The HRT is preparing to return into the field in Q3, and will be establishing new partnerships with American Family Housing Casa Paloma, the Hope Center in North OC, and other homeless service provider to provide expanded services and care coordination for unsheltered CalOptima members. 3) RFP will launch in July 2022 to identify street medicine providers that will implement street-based outreach and healthcare services by end of Q4. 4) CalOptima will develop HHIP Investment plan and submit to DHCS by September 30, 2022. CalOptima will also seek to increase integration with HMIS to increase members access to housing-related services.	
CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Quarterly Report	Mia Arias/Andrew Kilgust	QIC	MC	X	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process: Ongoing Q2 reporting due internally to RAC on 8/8/2022. 4) Establish oversight strategy for the CalAIM program	CalAIM updates will be provided by Business Integration starting 3Q.	
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1) Make health equity a strategic priority 2) Develop structure and process to support health equity work 3) Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4) Develop partnerships with community organizations to improve health and equity 5) Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Katie Balderas	QIC	MC, OC, OCC	x	In January 2022, the Health Equity & SDOH Workgroup formed, comprised of CalOptima staff from a variety of roles and departments. The workgroup co-created a working definition of health equity, reviewed a number of existing health equity frameworks, and drafted a framework for CalOptima's health equity efforts that involves five core areas: 1) Organizational Commitment, 2) Assess & Build Organizational Capacity, 3) Use Data & Narrative to Describe Inequities & Root Causes, 4) Design & Implement Strategies to Transform Practices, Policies, and Systems, and 5) Track Progress, Share Learnings & Strengthen Capacity. In the FY 2023 Budget, CalOptima's Board of Directors approved a Chief Health Equity Officer position. Additionally, CalOptima staff are currently reviewing the NCQA Health Equity Plus Accreditation Standards.	The Health Equity & SDOH Workgroup will gather data on the utilization of SDOH Z-Codes, with a focus on increasing screening, documentation, and resource referrals for individuals who need additional supports for their SDOH. The Workgroup is also planning a staff survey to gather information on health equity learning needs. CalOptima will work with the consultant and impacted departments towards the development of an plan for Health Equity Plus Accreditation in Q3.	
DHCS Comprehensive Quality Strategy	Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.	[NEW] to 2022 QI Work Plan 1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy	12/31/2022	Marsha Choo/Katie Balderas/Kelly Rex-Kimmatt	QIC	MC, OC, OCC		Presented the DHCS Comprehensive Quality Strategy to the Quality Improvement Committee to share DHCS' vision.	Will present the DHCS Comprehensive Quality Strategy (CQS) to the September Quality Assurance Committee. QI Staff will begin to draft the QI Program and align it with the CQS.	

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Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	[NEW] to 2022 QI Work Plan SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.	12/31/2022	Natalie Zavala	QIC	MC		1) Continued collaboration with with Orange County Department of Education (OCDE) and OC Health Care Agency (HCA). Attending weekly Mental Health Superintendent Work Group. 2) Continued collaboration with School Districts (SDs). Held 2nd meeting SD Workgoup April 19th to review expectations and begin assessment phase of program. Holding bi-weekly office hours to support SD in completing Needs Assessment Template. 2) Provided update at the following meetings: WCM Clinical Advisory Committee (CAC) 5/17; WCM Family Advisory Committee (FAC) 4/26. 3) Continued weekly internal meetings with Core Team.	1) SDs to submit Needs Assessment Template responses by 7/15. 2) Continue routine meetings with OCDE and OC HCA. 3) Hold external stakeholder workgroup next quarter.	Green - On Target
II. QUALITY OF CLINICAL CARE- Adult Wellness										
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events.	12/31/2022	Helen Syn	QIC	MC	X	1a. 2022 Member Health Rewards processed as of 6/30/22: BCS: 239 for MC 2 for OCC and 4 for OCC; CCS: 400 for MC; COL: 4 for OC on 3 for OCC 1b. Transition to Member Health Reward Vendor Contract with vendor fully executed on 2/14/22. In the development stages of transitioning membership data, member health reward process, and identification of member health reward types. 2. Pending complete transition to member health reward vendor to define and set deadlines to implement. 3. Member Engagement Strategy: Texting: BCS texting campaign total= 4,788 Social Media (Passive): BCS, CCS, COL Static Social Media Post for National Cancer Control Month; BCS, CCS National Women's Health Week Social Media (Paid): COL, CCS Digital Ad: CCS digital ad; COL digital ad Print Ad: COL print ad Direct Mailing: 618 COL OC and 2,906 COL OCC member mailing Community Connections: BCS, CCS, COL April is National Cancer Control Month article MC Member Newsletter: CCS How to Protect Yourself from Cervical Cancer 4. Community Events: Mobile Mammography: KCS event 25 CCN members completed 5. 2022 June Prospective Rates (PR): Breast Cancer Screening MC: 51.03%, OC: 58.57%, OCC: 57.68% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). Cervical Cancer Screening MC: 48.67% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Colorectal Cancer Screening OC: 43.07%, OCC: 47.95% Measure is performing higher than same time last year for both OC/OCC and is currently below the 50th percentile.	1a. Continue to track BCS, CCS and COL member health reward. 1b. Complete transition to member health reward vendor is set to be executed by August 2022. 2. Targeted member engagement and outreach campaigns to identified zip codes. 3. Member Engagement Texting: BCS texting campaign scheduled Q3/Q4 IVR: BCS scheduled for Q3/Q4 Social Media: BCS scheduled for Q3/Q4 Digital Ad: BCS scheduled Print Ad: BCS scheduled Direct Mailing: CCS, BCS, COL scheduled for Q4 Community Connections: Article scheduled for Q3/Q4 Member Newsletter: CCS, BCS, COL article scheduled for Spring and Summer issue 4. Community Connections: Ongoing mobile mamography events	Green - On Target
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	12/31/2022	Helen Syn	QIC	MC	X	1. COVID texting campaigns continued in Q1 2. Vendor has processed a total of 604,521 incentives (cumulative) Processing Totals As of 7/27/2022, processing totals (not unique member count) are as follows: • Vendor has processed a total of 854,755 incentives (cumulative). o Vendor is still working on processing the recent batch print (once done, will update processed #s). o PHM has processed a total of 149,643 incentives (cumulative). o PHM will be working on processing OC in-house (once done, will update processed #s). •Total: 1,004,398 3. VIP reimbursement data requested for Phase 2 submission	1) Texting campaigns continue. New texting messages will be updated to include expanded age ranges and booster shot eligibility. 2) COVID community vaccine events are planned in partnership with CHOC Future Vaccine Events: August 18, September 17 Ongoing COVID messaging to go out in Member Newsletter and Provider Newsletters about the importance of boosters and new eligibility with expanding age sets. Social Media, Targeted ad campaigns scheduled. COVID vaccine incentive processing continues, CAIR registry data and logic improvements to assist with identification and more timely processing.	Yellow - Caution
III. QUALITY OF CLINICAL CARE- Behavioral Health										
Follow-up After Hospitalization for Mental Illness within 7 and 30 days of discharge (FUH).	HEDIS MY2021 Goal: FUH 30-Days: MC: NA; OC: NA; OCC: 48.40% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:27.07%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	12/31/2022	Natalie Zavala	QIC	OCC	X	PR HEDIS Rates Q2 (May): 30 day- 30.30%, 7 day- 18.18%; BHI real-time report April - June: 30 day- 50%, 7 day- 46% . 1) Continued outreach to members post-discharge to coordinate follow-up appointments. Difficulties included: Higher rate of readmissions among members, members not attending follow-up appointments due to readmission; members declining assistance from PCC or IP facility in assisting member with creating OP BH appointment, and inability reaching members due to invalid phone numbers or answering and then hanging up. 2) Continued weekly BHI clinical round meetings to discuss concurrent reviews and internal coordination interventions.	1) Continue conducting post discharge outreach. 2) Continue tracking members and outreach to those who are not attending follow-up appointments within 7 days of discharge.	Green - On Target
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2021 Goal: MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	12/31/2022	Natalie Zavala	QIC	MC	X	PR HEDIS Rates Q2 (May): Initiation Phase- 42.36%, Continuation and Maintenance Phase- 46.81% 1) Continued monitoring of CORE report to track members who filled an initial ADHD Rx. This is a manual process, but addresses barrier of limited resources for developing a real-time report to track member f/u visits for provider outreach to schedule visits. 2) Continued member outreach for those who filled initial ADHD Rx (script and workflow to track phone calls made to members). 3) Treatment for Children with ADHD (submitted October 2021) article intended to educate members on ADHD did not make it into the 2022 CalOptima Member Spring Newsletter per Communications. Article not able to be included until 2023 Spring edition. BHI to look at alternative ways to share information with members. 4) Received updated compliant and non-compliant provider list.	1) Continue member outreach for those who filled an initial ADHD prescription. 2) Identify trends in compliant and non-compliant provider letters. 3) Distribute non-compliant provider letters.	Yellow - Caution
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)	[NEW] to 2022 QI Work Plan 1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	12/31/2022	Natalie Zavala	QIC	MC, OC, OCC		PR HEDIS Rates Q2 (May): M/C: 47.84%, OC: N/A, OCC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test. 2) Conduct outreach to prescribing provider via phone, then fax to include (a) list of members in need of diabetes screening (b) best practice guidelines reminder (c) members' PCP name and contact information (to promote coordination of care by requesting prescribers to contact the PCP with lab results). Difficulties: attaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing. 3) Working with ITS to develop ongoing report to identify and monitor members and their prescribing providers. Currently, reports are done by request and require manual maintenance.	1) Continue tracking members in need of diabetes screening test. 2) Continue prescribing provider outreach.	Yellow - Caution

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Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)	[NEW] to 2022 QI Work Plan 1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.	12/31/2022	Natalie Zavala	QIC	MC		PR HEDIS Rates Q2 (May): 30 day- 26.86%, 7 day-16.81% Measure has been identified as a Health Network (HN) P4V. The main barrier is obtaining real-time data for ED visits in order to conduct interventions to assist in follow-up visit attendance. 1) Working with ITS to develop report to analyze trends on ED visit data.	1) Finalizing Completion of Tableau report on member ED visits to identify trends. 2) Attend at least 1 HN Quality meeting to discuss/ address barriers.	Yellow
IV. QUALITY OF CLINICAL CARE- Chronic Conditions										
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	MY2021 HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) HbA1c Test Health Rewards: 212 Processed, 193 approved, 19 denied 1b) Transition to Member Health Reward vendor (Icario). Contract with vendor fully executed on 2/14/22. Tentative Go Live date slated for 8/1/2022. Communication Strategy being finalized, reward process design in progress. 2) Emerging Risk Health Coach Outreach: MC 513 members, 328 Assigned, 1 No Longer Eligible, 28 No Longer Emerging Risk, 2 Opt Out, 28 Unable to Contact OC 8 members, 5 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC 44 members, 32 Assigned, 6 Unable to Contact, 0 No Longer Emerging Risk, 0 No Longer Eligible. 3) Member Engagement Strategy: Texting: CDC texting campaign launch date slated for Q4 2022. IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachable/no answer Social Media: Content under development. 4) Prop 56 provider value based payments for diabetes care measures. 5) 2022 June Prospective Rates (PR): Note: A1C Testing submeasure was removed from 2022 HEDIS specs. A1C Adequate Control <8.0 MC: 27.75%, OC: 32.67%, OCC: 41.27% Measure is performing higher for all LOBs than same time last year except for OC LOB and below the 50th percentile (MPL). A1C Poor Control >9 MC: 67.12%, OC: 61.63%, OCC: 52.20% Measure is performing better for all LOBs than same time last year (lower rate is positive trend) except for OC LOB and below the 50th percentile (MPL).	1) Track and monitor until the end of member incentive year. Complete transition to member health reward vendor is set to be executed by August 2022. Tentative Go Live date slated for 8/1/2022. 2) Continue the Emerging Health Coach outreach to the end of 2022. 3) Texting: launch date slated for Q4 2022. IVR: next campaign slated for 2023. Social Media: Campaign slated to launch Q3-Q4 2022.	Yellow
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals:: MC 63.2% OC: 71% OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) Eye Exam 101 Processed, 85 approved, 16 denied 1b) Transition to Member Health Reward vendor (Icario). Contract with vendor fully executed on 2/14/22. Communication Strategy being finalized, reward process design in progress. 2) VSP Eye Exam Reminder Letters slated for Q3/Q4 2022 distribution 3) Member Engagement Strategy: Texting: CDC texting campaign launch date slated for Q4 2022. IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachable/no answer Social Media: Content under development. 4) Prop 56 provider value based payments for diabetes care measures 5) 2022 June Prospective Rates (PR): Diabetes Eye Exams MC: 39.19%, OC: 50.23%, OCC: 53.55% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). 6) Identified VSP data fields needed from HNs for data sharing criteria.	1) Track and monitor until the end of member incentive year. Complete transition to member health reward vendor is set to be executed by August 2022. Tentative Go Live date slated for 8/1/2022. 2) Analyze if a need for additional member mailers are necessary. 3) Texting: launch date slated for Q4 2022. IVR: next campaign slated for 2023. Social Media: Campaign slated to launch Q3-Q4 2022. 6) Pending feedback from 1 HN to finalize VSP data fields.	Green
Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot	1) lower HbA1c level to avoid complications 2) reduce emergency department (ED) visits 3) reduce hospitalization rates 4) reduce costs for diabetic medications 5) improve member and provider satisfaction; and 6) optimize diabetes medication management during the transition to Medi-Cal Rx.	There are four parts to this multidisciplinary approach: 1) Pharmacist Involvement and Intervention- Nicki G. • CalOptima Pharmacist's role will include individual member outreach and provider consultations for members enrolled in the pilot program. CalOptima pharmacists will promote proper medication utilization, provide medication adherence counseling, and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dietitians/case managers. 2) Health Coach/Registered Dietician Intervention - Jocelyn J. • CalOptima Health Coaches will provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dietitians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. 3) Member Health Rewards - Helen Syn • CalOptima would like to support member engagement and compliance by providing members with health rewards (non- monetary incentives). 4) Provider Incentives - TBD • In order to have successful provider buy-ins, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.	12/31/2024	Nicki Ghazanfarpour /Helen Syn/ Jocelyn Johnson/ Joanne Ku	QIC		X	CMO is supportive of developing a new, innovative diabetes program, but he recommended that we conduct user research first to clarify what really would benefit our members with poorly controlled diabetes. Therefore, the multidisciplinary diabetes workgroup decided to revisit the program design and narrow down the target population. Prototyping with a small sample (n=20) would help the workgroup answer the critical questions around the pilot program's desirability, feasibility, and viability. The workgroup has been meeting bi-weekly and plans to conduct a few key informant interviews with community leaders so we can learn more about our target population and build a pilot program that has our community partners' input and insights. Due to the change in direction, updates for the Member Health Rewards CCN Pilot will be discontinued moving forward. For provider side, the workgroup also decided to look for other ways to support provider offices and collaborate. Therefore, we will not be providing incentives, but we will identify provider champions who would like to work with us to provide more coordinated care for our members with poorly controlled diabetes.	The workgroup will move forward with having key informant interviews to learn more about our target population and see what tailored interventions would be helpful to them. The workgroup is also planning to integrate Community Health Workers (CHWs) into the intervention. We are hoping to have CHWs as part of the interdisciplinary team so they can help us thinking about what we are doing to best serve our members (shifting the focus from just checking the boxes). We are also considering having an introductory meeting with high volume PCPs and Endocrinologists so we can identify a couple of provider champions to launch this pilot together. The goal is to launch the pilot by Q4 of 2022.	Green

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V. QUALITY OF CLINICAL CARE- Maternal Child Health										
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 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) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	12/31/2022	Ann Mino/Helen Syn	QIC	MC	X	1) Member Health Reward of \$50 for Postpartum Care visit within 1-12 weeks after delivery is continuing. 2) Process for the first quality Initiative mailing is being finalized. First mailing projected date moved to go out in Q3 2022, not Q2 2022 as anticipated. Mailing will target members that recently delivered (identified via and encourage timely postpartum care. 3) Bright Steps Program conducted initial outreach to 781 unique members for a total of 1,278 outreach attempts. 1,179 outreach attempts made to 760 for postpartum members, 263 postpartum assessments completed. 4) Targeted digital social media campaign for Prenatal Care ran through May - June 2022. Digital ads received a total of 430,279 impressions for English, Spanish, and Vietnamese altogether. Social Media ads for Prenatal care ran May - June 2022 and reached 85,953 persons, and made 126,878 impressions (English, Spanish, and Vietnamese). 5) Bright Steps Program received a total of 996 new Pregnancy Notification Reports and conducted outreach to engage members with the program. 6) Total # of PPC health rewards approved through Q2: 146. 7) Implemented a series of four Diaper Day events in collaboration with CalFresh and community partners. A total of 66,846 diapers distributed. 8) Prop 56 provider value based performance incentives for prenatal and postpartum care visits. June 2022 Prospective Rates: Timeliness of Prenatal Care: 79.97% Measure is performing higher than same time last year and has not met the 50th percentile. Postpartum Care: 62.21%. Measure is performing higher than same time last year and has not met the 50th percentile.	1) Postpartum quality initiative mailing is projected to begin Q3 2022. 2) Prenatal and postpartum social media campaign is projected to extend through Q3 2022. 3) Prenatal and postpartum text campaign is projected for Q3 2022. 4) Exploring how the approved Medi-Cal Community Health Worker benefit can be implemented to support prenatal and postpartum care.	
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS MY2021 Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2022	Helen Syn	QIC	MC	X	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Health Guide 0-2 Newsletter, Well-Child Visits Flyer and Lead Poisoning Fact Sheet mailing went out 4/26/22 to 27,346 members. - Targeted ad campaign for Well-Care Pediatrics April - June 2022. Digital = 814, 522 impressions; Social Media = 468,182 impressions. - April World Immunization Week (WIW) observance on social media. Including a Health Care Chat video 4/28/22. - Community Connections April Newsletter 4/20/22 for World Immunization Week observance. - Medi-Cal member newsletter article on adolescent immunizations dropped 4/27/22. - Live call campaign for mid-year push for well-child and immunization measures. Well-Child (0-30 Months) Robocall Campaign dropped 6/13 - 6/16/22 to 3,070 members. Well-Care (12-17 Years) Robocall Campaign dropped 6/20-7/1/22 to 24,603 members. 2) Plan and attend community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Attended Pretend City School Readiness Fair 3/26/22 and YMCA Health and Wellness Event on 5/1/22 to promote health education. Continuing outreach to CBOs and Clinics to confirm back-to-school vaccination events. 6 events are confirms for July-August 2022. 3) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures. Regular meetings with health network partners to share activities, help address concerns, and share best practices. 4) June 2022 Prospective Rates: CIS Combo 10: 29.57%; has not met MPL. Rate is lower than last year. IMA Combo 2: 41.90%; met MPL. Rate is higher than last year and has met 66th percentile (41.81%) W30 First 15 Months: 25.41%; have not met MPL (54.92%). First year with benchmarks to monitor PR. W30 15-30 Months: 63.81%; have not met MPL (70.67%). First year with benchmarks to monitor PR. WCV: 21.40%; have not met MPL (45.31%). First year with benchmarks to monitor PR.	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Texting campaign and social media campaign for National Immunization Awareness Month - Health Guide 7-12 mailing - Targeted ad campaign for pediatric immunizations - Plan for PBS Kids ads 2) Plan and attend community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics - Execute planned back-to-school events - Event promotion: website, targeted member mailing, text message campaign, boost social media post 3) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures	
Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) HEDIS MY2021 Goal (3 Year Goal): Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2) Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	12/31/2022	Helen Syn	QIC	MC	X	1) Shared report in April 2022 to health networks with Q1 2022 data on members that have not been screen as recommended for blood lead screening. Q1 2022 report for CCN Providers shared via Provider Portal. 2) Targeted digital campaign efforts: blood lead screening campaign on social media run May - June 2022. Digital campaigns had a total of 430,279 digital impressions. Social media targeted ad campaigns had a total reach of 106,960 (Eng, Spa, and Viet) and had a total of 150,849 impressions. 3) Prop 56 provider value based payments for Blood Lead Screening. 4) CalOptima Policy Blood Lead Screening of Young Children GG.1717 revised to include preliminary DHCS audit results intended to improve Provider adherence to anticipatory guidance for blood lead screenings. June 2022 Prospective Rates Lead Screening in Children (in 2022, LSC became an MCAS measure that will have to meet the minimum performance level- MPL). MC: 56.82% Measure is performing higher than the same time last year and has not met the 50th percentile. (MPL)	1) Continue to share blood lead gap reports and DHCS blood lead supplemental data reports to HNs and CCN Providers. Reports are in process of being revised to highlight provider requirements such as the need for anticipatory guidance to parent/guardian of members. 2) Preparing to offer two Provider CME events focused on blood lead screening requirements. 3) Blood Lead IVR call campaign is being prepared to launch July 2022. 4) Blood lead member text campaign is planned to launch during Q3.	
VII. QUALITY OF SERVICE- Access										
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	12/31/2022	Marsha Choo/Jennifer Bamberg/Maggie Hart	MEMX	MC,OC,OCC	X	CalOptima reviewed the OON results by HN and determined that a large volume of OON requests were requests made by HNs and not CCN. CalOptima has already reached out to 2 HNs to address this issue.	Staff is working to develop regular reporting to share HN specific OON performance with the HN as part of the Subcontracted Network Certification Summary Quarterly Report and request that all HNs identify the 3 areas/provider types with the most OON requests and how they plan to address this concern.	
Improve Access: Expanding Network of Providers Accepting New Patients	Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%	[NEW] to 2022 QI Work Plan 1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC		Reaching Goal. PR is currently at a 33% using the new updated template for the provider directory. Submissions of the open/close panels continue to be received by PR until end of Q4.	PR Reps are meeting with provider offices to ensure provider directory validations are being returned; PR Rep and PR Director meeting with FQHC's, Lunch and Learn scheduled for first week of October to alert providers of open/closed panel topic.	

2022 QI Work Plan
(2Q)

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Report to Committee	LOB	Con't Monitoring from 2021	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
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) No action was taken in Q2 as the 2021 Timely Access Survey was in the field. Upon receive of the results and the provider level detail file, non-compliant letters will issued to providers in Q3. 2) Received PDSA submissions from all 12 HN on the three Timely Access PDSAs. PDSAs are current under review.	1) Review and conduct quality checks to the 2021-22 Timely Access Results. Upon completion of the review, letters will send to providers and corrective actions letters to individual providers with 3 consecutive instances of non-compliance. 2) Access workgroup to review HNs submission and close out and/or determine next steps for HN.	Green - On Target
Improve Access: Telephone Access	Reduce the rate of No Live Contacts After 3 Attempts from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) Reaching goal. PR is currently at a 33% using the new updated template for the provider directory. Submissions of the open/close panels continue to be received by PR until end of Q4. 2) 2021/22 Timely Access Survey fielding occurred during Q2 and results will be made available in Q3. Analysts will be conducting quality checks of the data for accuracy.	1) PR Reps are meeting with provider offices to ensure provider directory validations are being returned; PR Rep and PR Director meeting with FQHC's, Lunch and Learn scheduled for first week of October to alert providers of open/closed panel topic. 2) Once data has been thoroughly reviewed, staff will issue non-compliant letters to providers. Target fall-2022	Yellow - Caution
Improving Access: Subcontracted Network Certification	Certify all HNs for network adequacy	[NEW] 2022 QI Work Plan 1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.	7/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC		Network Adequacy Standards: Medi-Cal Plan Level: •Mandatory Provider Types: Met •Provider to Member Ratios: Met •Time/Distance Standards: Met Medi-Cal HN Level: •Mandatory Provider Types: Not Met. (Certified Nurse Midwives and Licensed Midwives) •Provider to Member Ratios: -PCPs: Met -Specialists: Not Met (Arta, KP, Monarch) •Time/Distance: Not Met Medi-Cal Timely Access •Received responses to all three individual Timely Access PDSAs from all 12 HNs •HNs were provided a quarterly Subcontract Network Certification Summary report with their HN network adequacy performance. •Continued to work with all HNs to identify providers in and out of their HN to ensure coverage for their members. •Closed out fielding 2021/22 Timely Access Survey in July1	Continue to monitor quarterly and notify HNs of areas of non-compliance. If Net Adequacy standard(s) not met, HNs will identify out of network providers to ensure coverage of services. Review HNs final submission for PDSAs by end of third quarter. Access Workgroup to review responses and close-out and/or determine next steps. Workgroup to discuss how to certify HNs and how to issue corrective action to HNs with non-compliance.	Green - On Target
VIII. SAFETY OF CLINICAL CARE										
Plan All-Cause Readmissions (PCR)	HEDIS MY2021 Goal: MC - NA OC 8%; OCC 1.0 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access 3) Continue to engage work group to address barriers, thereby achieving increased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regarding the importance of having a post discharge visit with the members PCP.	12/31/2022	Mike Shook	QIC	MC, OC,OCC	X	Working with team to develop communication strategy to providers and members related to scheduled post discharge visits with PCP.	Meeting scheduled with Team on 7/19/2022	Yellow - Caution
Post-Acute Infection Prevention Quality Incentive (PIPQI)	1) To reduce the number of nosocomial infections for LTC members. 2) To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses will be visiting each facility/ out reach minimally once a week. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. And administer Iodofoor (nasal swabs) per PIPQI Protocols. 3) CalOptima will pay participating facilities via reimbursement for product purchasing and quarterly quality incentive payments. 4) CalOptima will market and expand the PIPQI Program into additional CalOptima Contracted Nursing facilities providing onboarding training, new branding and educational materials.	12/31/2022	Michelle Findlater/Scott Robinson	QIC	MC,OC,OCC	X	Objectives not met: Due to constraints related to the COVID-19 pandemic Nusing Facility compliance with utilization of CHG and Iodophor remained low throughout the program. Invoice submission showing proof of product purchase also remained low and despite multiple outreaches and educational opportunities with the facilities, the decision was made by the CalOptima Finance department that there was not enough evidence to support the continuation of the program past the June 30, 2022 date because the clinical outcomes were not as expected.	1) Activites for the program ended on June 30, 2022. 2) All PIPQI created and translated documents remain available to educate NF staff and residents about decolonization protocols 3) All participating PIPQI facilities received final training inservice prior to June 30th, 2022.	Yellow - Caution

2022 QI Work Plan
(3Q)

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Report to Committee	LOB	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)	Next Steps Interventions / Follow-up Actions State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan; add a specific new process, etc.)	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT										
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2022	Kelly Giardina/Teresa Smith	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by April 2022	Kelly Giardina/Teresa Smith	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Katie Balderas	QIC	MC,OC,OCC	X	PHM Strategy is currently being reviewed and will be updated to align with CalAIM Population Health Management Strategy. PHM Department will be taking a CalAIM Population Health Management Strategy update to the next QIC.	CalAIM PHM Strategy update will be given at the 10/11/2022 QIC.	
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	Quarterly Adoption of Report	Marsha Choo/Laura Guest	QIC	MC,OC,OCC	X	<p>I. FSR/PARS/NF/CBAS A. FSR: Updated DHCS FSR and MRR Tools and Standards implemented on 7.1.1022; Decrease in number of failed FSR and/or MRR from Q2 to Q3; Increase in number of CAPs from Q2 to Q3 (96 vs.119) B. PARS • Decrease in number of PARS completed from Q2 to Q3 (212 vs. 195) • % of sites with BASIC access decreased from Q2 to Q3 (41% vs. 36%) • Backlog of 2021 HVS PARS completed. Outreach Specialists working on 2022 list. C. Quality Oversight - CBAS • Full congregate in-person services resumed 10/1/2022 • QI Nurse Specialist-LVN resumed on-site CBAS Center visits in September 2022. Goal of reviewing 37 contracted CBAS centers by 12.31.2022.</p> <p>II. Credentialing - TBD A. Identified in March 2022: Organizational Providers (OP) - OneCare Project. For CCN and BH, there were 117 group practices (with an NPI2) that were identified as not credentialed, although the individual practitioners were credentialed. As of Q3, 49% of these providers were credentialed. A query has been submitted to DHCS for guidance on credentialing on group practices. B. Significant increase in volume of credentialing applications to credential from Q1 – Q3, which include OP, CalAIMs and practitioners. C. Fall-out report, a report to identify contracted providers not yet credentialed, is in the final stage of testing. (Data compares cactus to facets). Fall-out report 90% complete. D. DHCS issued a revised All Plan Letter (APL) on Screening and Enrollment and Credentialing and Re-Credentialing and QI has updated all credentialing policies. Policies were presented to CPRC. E. Process improvements: Update the Request to Credential form and new reports to identify recredentialing</p> <p>III. PQI Subject: Cases leveled at OOC were 23% in Q3; 20% in Q2; 21% in Q1. Subject: Fair Hearing for Notice of Termination - Potential 805 Reporting 1. PQI and FWA investigations - PM physician was billing for PT and psychotherapy services under his NPI 1, billing for 99215 for services rendered by a LVN, and was unable to produce medical records for several members due to destroying the medical records while converting to an EHR. 2. PQI Investigation - PCP attending at hospital for member who was admitted for hand cellulitis, had precipitous drop in Hgb, never referred to GI or hematology for etiology, and unexpectedly expired.</p>	<p>I. FSR/PARS/NF/CBAS A. FSR: Updated DHCS FSR and MRR Tools and Standards implemented on 7.1.1022; Decrease in number of failed FSR and/or MRR from Q2 to Q3; Increase in number of CAPs from Q2 to Q3 (96 vs.119) B. PARS: Decrease in number of PARS completed from Q2 to Q3 (212 vs. 195); % of sites with BASIC access decreased from Q2 to Q3 (41% vs. 36%); Backlog of 2021 HVS PARS completed. Outreach Specialists working on 2022 list.; C. Quality Oversight - CBAS; Full congregate in-person services resumed 10/1/2022; QI Nurse Specialist-LVN resumed on-site CBAS Center visits in September 2022. Goal of reviewing 37 contracted CBAS centers by 12.31.2022.</p> <p>II. Credentialing - TBD A. QI continues to work with Contracting and Provider Relations on the OC project to credential all identified medical groups.; B. Cross train Credentialing Coordinators to credential all credentialing types, practitioner, mid-level, allied, BH, Organizational Providers, CalAIM, ABA and all areas of credentialing (intake, verification); C. Finalize the Fall-out Report and utilize to consistently identify contracted providers to credential; D. Review and update the current workflows and update the desktop procedures to reflect a streamlined process.; E. Finalize the Request to Credential (RTC) form and launch the (RTC) form for Contracting to use. Utilize the new recredentialing reports to monitor compliance and streamline recredentialing process to integrate the process for practitioners and organizational practitioners. III. PQI: Action: Continue with QOC grievance review by RN and MD. Concern: Volume of PQIs continue to climb as the number of PQIs opened is double that of the same time last year. The main category of PQIs continued to be Medical Care related to treatment delay, failure, inappropriate or complications. Action: Fair Hearing of PM physician was held in Q2. Second half of the Hearing was held in Q3. Determination will be reported in Q4. The Fair Hearing of the PCP was delayed until Q3 due to the availability of the participants. The second half of the Hearing will be completed in Q3, so we anticipate the determination to be reported in Q4.</p>	
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health networks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Tyronda Moses/Heather Sedillo	QIC	MC,OC,OCC	X	<p>Slight increase in total number of grievances in 3Q over 2Q. Attributing to the increase in Q3 were complaints regarding access quality of care, and transportation issues. No specific trends were identified, however we continue to monitor these two areas very closely and also work with QI and Provider Relations to address our findings.</p> <p>3Q Trending Medi-Cal Grievances: Access to Care- Appointment availability, Limited resources, Phone/technical issues impacting member's access. Member billing concerns- Billing member for non-contracted HNs, Non contracted groups providing services at the hospitals, Hospitalist group contract termination. Quality of Care- Delay in treatment and lack of follow-up. Quality of Service- Transportation issues- No shows, Early/Late pickup.</p> <p>3Q Medi-Cal Member Appeals: Rate/1,000 for Medi-Cal remained constant in 3Q- (259 received), highest amount received from CCN- 90 and Monarch- 46. No significant trends identified; overturns were made based on additional information received to support medical necessity for the requested services.</p> <p>3Q OCC Member Appeals (Rate per 1000): Total Member Appeals received increased from 32 to 51 from 2Q 2022 to 3Q 2022 this was primarily related to an increase in member claims denials/reimbursement requests. We continue to promote proactive outreach and identify the members who could possibly benefit from the assistance of a PCC or CM. Due to the low volume of OCC population the overturn rate is always a bit skewed since 1 overturn will cause a significant overturn rate.</p> <p>All denials for OCC which were overturned were due to medical necessity met with additional information and include overturns for specialists' visits and claims denials.</p> <p>3Q OneCare Member Appeals (Rate per 1000): The low membership creates a higher rate/1000. Decrease in the total number of appeals received for OneCare in 3Q (4). 1 out of the 4 was overturned based on medical necessity met for Part B medication.</p>	<p>All trends are reviewed for repeated issues.</p> <p>High grievance count by providers are tracked and trended. Results are reported to Provider Relations for additional outreach and shared with a Provider Action workgroup. Recommendations for actions may include an onsite visit, additional education/training and/or escalation to the Member Experience Committee.</p> <p>GARS continues to work with Veyo to identify barriers and obstacles on a bi-weekly basis</p>	
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	K. Jenkins/Marsha Choo/C. Matthews	QIC	MC,OC,OCC	X	<p>In Q3, MemX Committee has reviewed/discussed the following: 8/10/22:</p> <ul style="list-style-type: none"> • Updates: <ul style="list-style-type: none"> ◦ APL 22-xxx ◦ ANC Time or Distance • Provider Sat Survey • Member Experience PDSA • CAHPS Medi-Cal MY 2021 Results • Provider tools to educate members on referral/auth process 	In Q4 MemX Committee has two meetings scheduled, October 12 and December 8	

2022 QI Work Plan
(3Q)

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Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Kelly Giardina/Teresa Smith	Utilization Management/ QIC	MC,OC,OCC	X	UMC reported to QIC on 7/12/2022. Presented 2022 1st Quarter Annual Trends (5/26/2022), - 1Q1 2022 Operational Performance – Goals are being met for Pharmacy auth, BH Auth, LTSS Inquiry/Auth and Unused Authorization. One caution for TAT for processing of referrals due to the backlog had other than that CalOptima's internal CCN/COD TAT's are above 99% across the board since February. Medical Authorization performance goal ≥ 98%: CCN is below goal for this quarter due to low compliance in January 2022; February and March compliance are above goal. - Q4 2021 Utilization Outcomes – All measures are being met for Medi-Cal and OCC - Q4 2021 Operational Performance WCM – For the select metrics data lags a quarter behind. In identifying the denials reported there's nothing unusual to report. - Medi-Cal Over/Underutilization Monitoring Dashboard, Benefit Management Subcommittee (BMSC), Pharmacy Over/Under Utilization Monitoring, BHI UM Update, BHI. - Committee reviewed and approved UMC meeting minutes (5/26/22), BMSC Meeting Minutes (2.23.22), BMSC Meeting Minutes (3.23.22), P&T Meeting Minutes (11.18.21)	UMC is scheduled to present 2st Quarter 2022 update to QIC on 10/11/2022.	Green
Whole Child Model - Clinical Advisory Committee (WCM CAC) Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD	QIC	MC	X	WCM CAC met August 16, 2022. Follow up action items were discussed and closed. Pharmacy Medi-Cal Rx, Whole-Child Model Measures, Grievance and Resolution Services, and Whole-Child Model Customer Service Inquiries provided quarterly updates. PHM gave an update related to CalOptima Health Homeless Health Initiatives, update related to the Population Needs Assessment, and an update related to COVID-19 vaccination rates amongst CalOptima Health Members, specifically the youngest members from age 0-18. At the next PHM report, the committee wants to see numbers that reflect up through the age of 20 years old to get a more precise pediatric count because that's a time where for hard conditional work CalOptima Health could help the family coordinate their care and transition to adult services. An update on CalOptima Health's three-year plan on Student Behavioral (SBHIP) was given resulting in feedback for CalOptima Health staff to create a page of resource or similar kind of sheet where available resources can be easily located and shared for those working with members. Posting the information on website will to allow for updating information as needed. The next WCM CAC meeting is scheduled for 11/16/22.	WCM CAC is scheduled to presented an update to QIC on 10/11/2022.	Green
Quality Withhold for OCC	Earn 75% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Sandeep Mital	QIC	OCC	X	Scheduled to give update when we receive final scores from CMS in Q2 of 2023	Continue to monitor performance on the various measures	Green
Quality Analytics Program Updates (Health Network Quality Rating, MCAS, P4V, Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Report or As needed	Paul Jiang/Sandeep Mital	QIC	MC,OC,OCC	X	All MCAS selected measures having MPL requirement achieved MPL except the newly added Well-Child Visits in the First 30 Months of Life measure (W30-15months; W30-30months)	Start health disparity analysis to further refine focus areas	Yellow
Development of the OneCare program for MY2023	Develop and finalize the CMS measures for the scoring and payment methodology for the OneCare P4V program	P4V team has compiled a set of Part C, Part D, and Member Experience measures as proposed metrics for the MY2023 OneCare P4V program. Awaiting approval from the various committees and the Board of Directors.	31-Dec-22	Sandeep Mital	QIC			CalOptima Health Board of Directors approved the OneCare COBAR on December 1, 2022 with the proposed Part C, Part D, and Member Experience measures for the MY2023 OneCare P4V program	Pay for Value team will start generating monthly Prospective Rate reports for CalOptima Health and all health networks to monitor performance on the OneCare Part C and Part D measures	Green
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/annual oversight of specific goals All LOB PIPs MC PIPs: 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members.(March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Received BCS Health Equity PIP Progress Check-In HSAG feedback no resubmission required at this time. Mobile Mammography Event Q3: Completed 29 BCS for KCS CCN members. Continue to test intervention through the PIP end date, December 31, 2022. 2) W30 PIP Progress Check-In feedback completed in Q3. Continue testing intervention and monitoring HEDIS rate through the end of PIP December 31, 2022.	1) BCS Health Equity: HSAG TBD submission date for the final PDSA worksheet and Module 4. Continue testing intervention and monitoring HEDIS rate through the end of PIP December 31, 2022. 2) W30 PIP Progress Check-In feedback expected in Q4. Continue testing intervention and monitoring HEDIS rate through the end of PIP December 31, 2022.	Green
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs MC QIP: 1) COVID QIP Phase 2 - a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)- N. Zavala b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	Quarterly/Annual Assessment	Natalie Zavala/Helen Syn	QIC	MC,OC,OCC	X	1) COVID QI Phase 2- a. SSD - SSD update provided under Quality of Clinical Care Behavioral Health section below. b. CCS - Cycle 2 provider staff incentive completed. Cycle 3 completed on 9/30/22. Pending final provider office rates from participating providers. c. CIS Combo 10 - Target list for Cycle 4 (07/01/2022 - 09/30/2022) is shared with Provider Office for July - September implementation. Intervention includes outreaching to noncompliant members to schedule appointments, and tracking the number of newly compliant members. 2)Statin Adherence MC: 29.56% (below 50th), OC: 30.71% (below 50th), OCC: 34.81 % (below 50th) Measure is performing higher for MC and OCC LOB than same time last year and are below the 50th percentile (MPL). OC performing lower than same time last year and below 50th percentile. Statin Therapy MC: 69.23% (above 50th), OC: 78.88% (above 50th), OCC: 79.44% (above 50th) Measure is performing higher for MC and OCC LOBs than same time last year. All LOBs are above the 50th percentile (MPL).	1) COVID QI Phase 2- a. SSD - b. CCS - Cycle 3 intervention completed. Pending evaluation of cycle 3 in Q4. c. CIS Combo 10 - Intervention period completed.Will evaluation CIS-10 QIP Cycle 4 (July-Sept) data in Q4 2022. 2) Continue Statin Mailers	Green

2022 QI Work Plan
(3Q)

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Report to Committee	LOB	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)	Next Steps Interventions / Follow-up Actions State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan; add a specific new process, etc.)	Red - At Risk Yellow - Concern Green - On Target
Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on All LOB CCIPs 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Emerging Risk Health Coach Outreach OC CCIP 0 members, 0 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC CCIP 26 members, 21 Assigned, 0 Unable to Contact, 3 No Longer Emerging Risk, 0 No Longer Eligible. 2) Results pending, final data slated at end of Q4 2022.	1) Continue Emerging Risk Telephonic Health Coach Outreach 2) Continue SPD Statin quarterly mailers	
PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PME (OC): HRAs: HN MOC Oversight(Review of MOC ICP/ICT bundles) 2) QIPE (OCC): HRAs: ICP High/Low Risk, ICP Completed within 90 days, HN MOC 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion.	Quarterly/Annual Assessment	Gail McMillen/S. Hickman/D. Hood	QIC	OC, OCC	X	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PME (OC): HRAs: Quarter 2 finished at 100% for both initial and annual HRA outreach; Quarter 3 initial is 100% for July, August/September still in process. HN MOC Oversight(Review of MOC ICP/ICT bundles in 10 day TAT) 1% for Q2; Benchmarks were not met in Q3; Benchmark met at 30 business day TAT for July; and improved to 17 business days for August; September is still pending. 2) QIPE (OCC): HRAs: Quarter 2 finished at 100% for initial and annual HRA outreach; Quarter 3 finished at 100% for both initial and annual HRA outreach. HN MOC Oversight(Review of MOC ICP/ICT bundles in 10 day TAT) 1% for Q2. Benchmarks were not met in Q3; Benchmark met at 30 business day TAT for July; and improved to 18 business days for August; September is still pending. ICP High/Low Risk: MMP 1.5 High risk 89%, Low risk 83%, ICP Completed within 90 days, HN MOC: MMP 3.2 for Q3 is 89%; MMP 1.6 Care Goal Discussion 99% 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion. Members flagged as LTC on HRA outreach had outreach 100%	Continue to Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PME (OC): HRAs:MOC Oversight(Review of MOC ICP/ICT bundles in 10 day TAT) Continue to monitor and complete pre-cap on monthly basis. 2) QIPE (OCC): HRAs: HN MOC Oversight(Review of MOC ICP/ICT bundles in 10 day TAT) Continue to monitor and complete pre-cap on monthly basis. ICP High/Low Risk: ICP Completed within 90 days, Care Goal Discussion 99% 3) LTSS HRA OCC: Continue to Monitor for timeliness on outreach for completion.	
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January	Quarterly Adoption of Report	Natalie Zavala/Sheri Hopson	QIC	MC	X	BHIIP: 1) Prepared and completed Program Year 2 Q2 milestone report due to DHCS 8/29/22, all expected milestones were completed 2) Prepared and completed 2021 Baseline - Performance Measures report due to DHCS 8/27/22 3) Q4 2021 Milestone Incentive Payments received from DHCS, processed and issued to provider groups 7/5/22 ABA P4V: 1) During the ABA Provider webinar held in June, 2021 ABA P4V program results were shared with the meeting attendees: ABAU 2021 - 56.90% / 2020 - 56.13% ABAH 2021 - 51.67% / 2020 - 50.42% 2) There is a correction to what was reported last quarter's update --> Prepared check requests for 73 groups, the correct number is 57 provider groups received an incentive check	BHIIP: 1) Prepare Program Year 2 Q3 milestone report due to DHCS 11/29/22 2) Prepare the Q1 2022 Milestone Incentive Payments expected to receive the funding from DHCS around September 28, 2022 ABA P4V: 1) Planning for an internal evaluation of the program's performance 2) Planning to obtain ABA provider groups feedback for the program 3) Establish next steps for program continuance	
Homeless Health Initiatives (HHI); Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1) Regular planned visits to shelters, hot spots and recuperative care facilities- to resume post-COVID-19. (CM) addition of virtual outreach visits to shelters. 2) Serve as a resource in pre-enforcement engagements, as needed, to resume post-COVID-19 3) Develop and implement Street Medicine Program 4) Implement DHCS Housing & Homelessness Incentive Program (HHIP) to meet specific measures around increased data integration.	Quarterly Report	Sarah Nance/Danielle Cameron	QIC	MC,OC,OCC	X	1) Onsite outreach was started in Quarter 3 at Yale Navigation Center 1x/week for 2 hours per outreach. Virtual and telephonic outreach was continued with the Costa Mesa Shelter and Huntington Beach Navigation Center. Telephonic support by the Homeless Response Team was continued for Members who required the services of the Clinical Field Teams. 2) No support for pre-enforcement activities was requested during Quarter 3. 3) An RfQ was conducted to solicit qualifications from potential providers of the street medicine program. From that process, two providers were selected to operationalize a two-pronged street outreach and medicine program that targeted reaching people experiencing homelessness both unsheltered on the streets (encampments, hot spots, etc) and in local shelters. This pilot will launch in Garden Grove, where we hope to establish a collaborative service delivery model between the service providers, local stakeholders, Be Well and related county entities. The planning phase is anticipated to begin in December 2023, with services launching in early 2023. 4) CalOptima Health solicited stakeholder input into an Investment Plan, which identified key investment strategies to tackle the barriers identified in the Local Homelessness Plan. The CalOptima Health Board approved this plan, which was submitted to DHCS. DHCS has indicated that the first payment of \$4.1M was transmitted to CalOptima Health in support of this work. The CalAIM community investment team will be distributing these initial funds using the approved Investment Plan.	1) The Homeless Response team will continue increasing their presence in the community by expanding onsite outreach at other shelters and at American Family Housing Casa Paloma. 2) The Homeless Response Team will provide support for pre-enforcement activities as needed and requested. 3) Street Medicine providers will be contracted and will begin the planning process to execute the new program and services. 4) The CalAIM team will continue to implement the Housing & Homelessness Incentive Program, including integration with the local continuum of care and increased referral and access of housing community supports. The CalAIM team will also implement the Investment Plan.	
CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Quarterly Report	Mia Arias/Andrew Kilgust	QIC	MC	X	1 & 2. All HHP and WPC members were successfully transitioned to CalAIM ECM without an interruption in service. 3. A DHCS reporting process has been established; ITS leads the data collection and Care Management, LTSS and CalAIM teams review and attest to the data before DHCS submission. Monthly data improvement calls are hosted to ensure data captured is accurate and up-to-date. 4. An oversight strategy is in development.	The CalAIM team will focus on developing and launching the oversight strategy for the CalAIM program. Many lessons were learned during the first year of implementation and those lessons will inform the oversight strategy going forward. Much of this work will launch in 2023.	
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1) Make health equity a strategic priority 2) Develop structure and process to support health equity work 3) Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4) Develop partnerships with community organizations to improve health and equity 5) Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Katie Balderas	QIC	MC, OC, OCC	X	The Health Equity Data Action Team looked into the utilization of SDOH Z-Codes and found the following: Provider utilization of SDOH Z-Codes in claims is very low 6.70 % of providers are using SDOH Z-Codes, documents on .45% of total claims/encounters for only 3.14% total members Additionally, there are inconsistent mechanisms for collecting SDOH data across CalOptima. Thirteen known health assessments in Guiding Care, of which 9 include SDOH-related fields No evidence-based, validated SDOH screening tool used consistently across member-facing departments.	Incentivize and encourage utilization of SDOH Z-code screening among providers through annual wellness visits Promote network/provider SDOH screening using evidence-based screening tools (ex: PRAPARE, utilization of SDOH Z-Codes) Utilize the transition to a new care management platform (JIVA) to ask consistent, evidence-based questions across all member-facing departments/ programs and link members to resources for social needs using closed-loop referral system (such as FindHelp, Unite Us, etc.)	

2022 QI Work Plan
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DHCS Comprehensive Quality Strategy	Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.	[NEW] to 2022 QI Work Plan 1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy	12/31/2022	Marsha Choo/Katie Balderas	QIC	MC, OC, OCC		DHCS Quality Strategy was presented to the September QAC. Created and hired an Executive Director of Quality to focus on developing the quality strategy. CalOptima Health has completed the Population Health Readiness Assessment and drafting a PHM strategy, a part of the overall quality strategy, to implement in 2023. Staff is working with NCQA consultants to educate staff on Health Equity Standards for Accreditation. Continued efforts to on Phase 3 of CalAIM.	ED of Quality to begin Q1 of 2023. Begin implementation of PHM Strategy in Q1 2023. Develop a timeline for Health Equity Accreditation. Develop a QI Work Plan to address the DHCS Bold Goals. Continued efforts in CalAIM.	Green
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	[NEW] to 2022 QI Work Plan SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.		Natalie Zavala	QIC	MC		1) Continued collaboration with Orange County Department of Education (OCDE) and OC Health Care Agency (HCA). Attended Mental Health Superintendent Work Group. External workgroup meetings did not occur; will once materials from LEAs received. 2) Continued internal meetings with Core Team updating project plan on a bi-weekly basis. 3) Provided update at the Q3 WCM Clinical Advisory Committee (CAC) on 8/16/22. 4) 9/30/22 due date for LEAs to submit SBHIP Assessment materials: Needs Assessment Template, Data Collection Strategy, Referral Process, Resource Maps.	1) CalOptima Health team to compile LEA SBHIP Assessment responses for submission to DHCS by 12/31/22. 2) Continue routine meetings with OCDE and OC HCA. 3) Hold external stakeholder workgroup next quarter. 4) Identify targeted interventions and population, and complete Project Plan for submission to DHCS by 12/31/22.	Green

II. QUALITY OF CLINICAL CARE- Adult Wellness

Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the member health reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events.	12/31/2022	Helen Syn	QIC	MC	X	1a. 2022 Member Health Rewards processed as of 9/30/22: BCS: 346 for MC 5 for OC and 8 for OCC; CCS: 506 for MC; COL: 6 for OC and 19 for OCC 1b. Transition from Member Health Reward vendor (Icaro) to be done in-house. Reward process design in progress. 2. Targeted member engagement and outreach campaigns to identified zip codes for paid Social Media Campaigns. 3. Member Engagement Strategy: Social Media (Paid): CCS, BCS Digital Ad: CCS digital ad; BCS digital ad 4. Community Events: Mobile Mammography: KCS event 29 CCN members completed 5. 2022 August Prospective Rates (PR): Breast Cancer Screening MC: 53.24%, OC: 60.10%, OCC: 60.58% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). Cervical Cancer Screening MC: 50.59% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Colorectal Cancer Screening OC: 45.66%, OCC: 51.24% Measure is performing higher than same time last year for both OC/OCC and is currently below the 50th percentile.	1a. Continue to track BCS, CCS and COL member health reward. 1b. Transition to in-house member health reward process. 2. Targeted member engagement and outreach campaigns to identified zip codes. 3. Member Engagement Texting: BCS texting campaign scheduled Q4 IVR: BCS scheduled for Q4 Social Media: BCS scheduled for Q4 Digital Ad: BCS scheduled Print Ad: BCS scheduled Direct Mailing: BCS scheduled for Q4 Community Connections: BCS article scheduled for Q4 Member Newsletter: CCS, BCS, COL article scheduled for Spring and Summer issue 4. Community Events: Ongoing mobile mammography events	Yellow
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	12/31/2022	Helen Syn	QIC	MC	X	1) COVID texting campaigns continued in Q3. 2) COVID community vaccine events were held in partnership with OCHCA ongoing. A. Vaccine Events include: • 8/18/2022: 144 total health rewards • 9/17/2022: 116 total health rewards • 9/21/2022: 107 total health rewards B. Vaccine Event Totals: 367 health rewards 3) Vendor has processed a total of 1,049,633 incentives (cumulative) and PHM has processed a total of 1,202,925 incentives (cumulative) as of 10/6/2022. 4) VIP reimbursement data submitted for part 2.	1) Texting campaigns continue. Upon approval from the Board of Directors (BOD), new texting messages will be updated to include expanded age ranges and incentive eligibility. 2) COVID community vaccine events are continuously planned by Community Relations. 3) Ongoing COVID messaging to go out in Member Newsletter and Provider Newsletters about the importance of boosters and new eligibility with expanding age sets. Social Media, Targeted ad campaigns scheduled. 4) COVID vaccine incentive processing continues, CAIR registry data and logic improvements to assist with identification and more timely processing.	Yellow

2022 QI Work Plan
(3Q)

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III. QUALITY OF CLINICAL CARE- Behavioral Health										
Follow-up After Hospitalization for Mental Illness within 7 and 30 days of discharge (FUH).	HEDIS MY2021 Goal: FUH 30-Days: MC: NA; OC: NA; OCC: 48.40% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:27.07%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	12/31/2022	Natalie Zavala	QIC	OCC	X	PR HEDIS Rates Q3 (August): 30 day- 34.925%, 7 day- 17.46%; BHI real-time report Q3 (July-Sept): 30 day- 38% , 7 day- 22% . 1) Continued outreach by BH Personal Care Coordinator (PCC) to members post-discharge to coordinate follow-up appointments. 2) Continued weekly BHI clinical round meetings to discuss concurrent reviews and internal coordination interventions. *Barriers included: Decrease in initial admissions but increase in member Re-admissions. Members not attending follow-up appointments due to readmission; members declining assistance from PCC or inpatient facility in assisting member with creating outpatient BH appointment, and inability reaching members due to invalid phone numbers or answering and then hanging up.	1) Continue conducting post discharge outreach. 2) Continue tracking members and outreach to those who are not attending follow-up appointments within 7 days of discharge.	Yellow
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2021 Goal: MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	12/31/2022	Natalie Zavala	QIC	MC	X	PR HEDIS Rates Q3 (August): Initiation Phase- 42.62%, Continuation and Maintenance Phase- 48.15% 1) Continued monitoring of CORE report to track members who filled an initial ADHD Rx. This is a manual process, but addresses barrier of limited resources for developing a real-time report to track member follow/up visits for provider outreach to schedule visits. 2) Continued member outreach for those who filled initial ADHD Rx (script and workflow to track phone calls made to members). 3) Reviewing data for compliant and non-compliant providers.	1) Continue member outreach for those who filled an initial ADHD prescription. 2) Identify trends in compliant and non-compliant provider letters. 3) Distribute non-compliant provider letters. 4) Submit article on Treatment for Children with ADHD to educate members on ADHD will be included in the Medi-Cal Member newsletter Spring edition.	Green
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)	[NEW] to 2022 QI Work Plan 1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	12/31/2022	Natalie Zavala	QIC	MC, OC, OCC		PR HEDIS Rates Q3 (August): M/C: 63.97%, OC: N/A, OCC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test. 2) Conduct outreach to prescribing provider via phone, then fax to include (a) list of members in need of diabetes screening (b) best practice guidelines reminder (c) members' primary care physician (PCP) name and contact information (to promote coordination of care by requesting prescribers to contact the PCP with lab results). Barriers included: Receiving timely data, obtaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing. Other difficulties we have come to know is that some members with this diagnosis don't see their PCP because of trust issues.	1) Finalize new data source through Tableau. 2) Continue tracking members in need of diabetes screening test. 3) Continue prescribing provider outreach.	Green
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)	[NEW] to 2022 QI Work Plan 1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.	12/31/2022	Natalie Zavala	QIC	MC		PR HEDIS Rates Q3 (August): 30 day- 25.69%, 7 day-15.61% Measure has been identified as a Health Network (HN) P4V. The main barrier is obtaining real-time data for ED visits in order to conduct interventions to assist in follow-up visit attendance. On 9/7/22, BHI attended CalOptima Health Quality Forum to present on FUM and discuss with HNs their experience, barriers, opportunities for improvement. However, due to time constraints, presentation was rescheduled to next meeting in December.	1) Finalize FUM Tableau report to identify trends. 2) Present FUM data at Quality Forum in December to discuss/ address barriers.	Yellow

2022 QI Work Plan
(3Q)

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IV. QUALITY OF CLINICAL CARE- Chronic Conditions

Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	MY2021 HEDIS Goals: MC: 34.06%; OC: 19%; OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) HbA1c Test Health Rewards: 338 Processed, 304 approved, 34 denied 1b) Transition from Member Health Reward vendor (Icario) to be done in-house. Reward process design in progress. 2) Emerging Risk Health Coach Outreach: MC 398 members, 249 Assigned, 5 No Longer Eligible, 28 No Longer Emerging Risk, 3 Opt Out, 7 Unable to Contact OC 0 members, 0 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC 26 members, 21 Assigned, 0 Unable to Contact, 3 No Longer Emerging Risk, 0 No Longer Eligible. 3) Member Engagement Strategy: Texting: CDC texting campaign launch date slated for Q4 2022. IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachable/no answer Social Media: slated for distribution late October 2022 / early November 2022. 4) Prop 56 provider value based payments for diabetes care measures. 5) 2022 August Prospective Rates (PR): Note: A1C Testing submeasure was removed from 2022 HEDIS specs. A1C Adequate Control <8.0 MC: 35.12% (green, below 50th), OC: 41.82% (red, below 50th), OCC: 49.91% (green, below 50th) Measure is performing higher for MC and OCC LOBs than same time last year except for OC LOB and all LOBs are below the 50th percentile (MPL). A1C Poor Control >9 MC: 58.88% (green, above 50th), OC: 50.65% (neutral, above 50th), OCC: 43.07% (green, above 50th) Measure is performing better for all LOBs than same time last year (lower rate is positive trend) except for OC LOB and above the 50th percentile (MPL). (Lower is better)	1) Track and monitor until the end of member incentive year. Transition from Member Health Reward vendor to be done in-house. Reward process design in progress. 2) Continue the Emerging Health Coach outreach to the end of 2022. 3) Texting: launch date slated for Q4 2022. IVR: next campaign slated for 2023. Social Media: Campaign slated to launch Q4 2022. 4) Contract with health reward vendor was canceled, looking for alternative plan for transition.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals: MC 63.2% OC: 71%; OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) Eye Exam 201 Processed, 172 approved, 29 denied 1b) Transition from Member Health Reward vendor (Icario) to be done in-house. Reward process design in progress. 2) VSP Eye Exam Reminder Letters slated for Q4 2022 distribution 3) Member Engagement Strategy: Texting: CDC texting campaign launch date slated for Q4 2022. IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachable/no answer Social Media: slated for distribution late October 2022 / early November 2022. 4) Prop 56 provider value based payments for diabetes care measures 5) 2022 August Prospective Rates (PR): Diabetes Eye Exams MC: 44.34% (green, below 50th), OC: 55.86% (red, below 50th), OCC: 59.86% (green, below 50th) Measure is performing higher for all LOBs than same time last year except for OC LOB and below the 50th percentile (MPL). 6) Identified VSP data fields needed from HNs for data sharing criteria.	1) Track and monitor until the end of member incentive year. Transition from Member Health Reward vendor to be done in-house. Reward process design in progress. 2) Analyze if a need for additional member mailers are necessary. 3) Texting: launch date slated for Q4 2022. IVR: next campaign slated for 2023. Social Media: Campaign slated to launch Q4 2022. 4) SFTP setup for HN in progress. 5) Contract with health reward vendor was canceled, looking for alternative plan for transition	
Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot	1) Lower HbA1c to avoid complications; 2) reduce emergency department (ED) visits and hospitalizations /readmission rates; 3) improve member and provider satisfaction; and 4) optimize diabetes medication management.	Program Design: 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement	12/31/2024	Nicki Ghazanfarpour/ Jocelyn Johnson/ Joanne Ku	QIC		X	Since the initiative is still in the planning stage, there are no results or metrics to report at this time. However, the workgroup has conducted literature reviews and found that the results support our multidisciplinary program approach. 1. Literature demonstrates that pharmacist involvement is effective. 2. Literature indicates that diabetes interventions should include culturally relevant resources, family support, and diabetes self-management skills education.	Community Health Worker (CHW) initiative design in planning stages, staff workflow in progress. 1) The workgroup conducted key informant interviews with community partners. The workgroup plans to go back to community partners and share our final pilot program design. 2) The workgroup is currently working with ITS to build member stratification for this project. 3) The workgroup also plans to host a provider webinar or similar engagement activity (targeted for high volume CCN PCPs) so we can have providers' buy-in and commitment to make this work.	

V. QUALITY OF CLINICAL CARE- Maternal Child Health

Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1)Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 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) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	12/31/2022	Ann Mino/Helen Syn	QIC	MC	X	1) Member Health Reward of \$50 for Postpartum Care visit within 1-12 weeks after delivery is continuing. 2) Postpartum Mailing Initiative: Process for the first quality Initiative mailing is still being developed. Mailing projected to go out by end of Q4 2022. Mailing will target members that recently delivered (identified via and encourage timely postpartum care. 3) Bright Steps Program conducted initial outreach to 1724 unique members. Total of 1,008 outreach attempts made to 630 postpartum members. 248 postpartum assessments completed. 4) Continuing member engagement strategy: -Postpartum Care digital add campaign August - September 2022 = 206,682 impressions (Eng, Spa, and Viet) -Postpartum Care targeted social media ad campaign August - September 2022 = 142,855 Reach, and made 365,687 impressions - Medi-Cal member newsletter article on Postpartum Care Extension is Here!" dropped 09/07/22. 5) Bright Steps Program received a total of 916 new Pregnancy Notification Reports and conducted outreach to engage members with the program. 6) Total # of PPC health rewards approved July - September: 81 7) Perinatal and Postpartum Bright Steps Program participated in 2 Diaper Day events in collaboration with the Westminster Family Resource Center and WIC Santa Ana location. A total of 350 persons were outreach in these public events. 8) Prop 56 provider value based performance incentives for prenatal and postpartum care visits. August 2022 Prospective Rates: Timeliness of Prenatal Care: 80.00% Measure is performing higher than same time last year and has not met the 50th percentile. Postpartum Care: 63.63%. Measure is performing higher than same time last year and has not met the 50th percentile.	1) Postpartum quality initiative mailing is projected to begin by end of Q4 2022. 2) Continue to expand member engagement strategy to ensure multi-modal approach to include the following elements: text campaigns, IVR robocalls, social media, etc. 3) Exploring integration of the Medi-Cal Community Health Worker benefit can be implemented to support prenatal and postpartum care. 4) Contract with health reward vendor was canceled, looking for alternative plan for transition	
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2022 QI Work Plan
(3Q)

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Report to Committee	LOB	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)	Next Steps Interventions / Follow-up Actions State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan; add a specific new process, etc.)	Red - At Risk Yellow - Concern Green - On Target
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS MY2021 Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2022	Helen Syn	QIC	MC	X	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Targeted ad campaign for Well-Care Pediatrics August - September 2022. Digital = 206,682 impressions; Social Media = 437,118 impressions. - Targeted ad campaign for Immunizations August - September 2022. Digital = 206,682 impressions; Social Media = 410,377 impressions. - Medi-Cal member newsletter article on "Let's Get Ready for School. Get your Vaccines" dropped 09/07/22. - Texting campaign and social media campaign for National Immunization Awareness Month. WCV = 9027; IMA = 793 - Health Guide 7-12 mailing, in progress, REQ submitted - PBS Ad: Flu campaign started running in September 2022. 2) Plan and attend community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. - Back-To-School Vaccination Event: total of 7 events. 443 families attended CalOptima Health table at these events. 72 vaccinations provided (41 were CalOptima Health members). Vision screening, dental screening and developmental screening were available at select events. - Event promotion: website, targeted member mailing, text message campaign, boost social media post 3) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures. Regular meetings with health network partners to share activities, help address concerns, and share best practices. 4) August 2022 Prospective Rates: CIS Combo 10: 30.37%; has not met MPL. IMA Combo 2: 43.68%; met MPL. Rate is LOWER than last year and has met 66th percentile (41.81%) W30 First 15 Months: 30.85%; have not met MPL (54.92%). First year with benchmarks to monitor PR. W30 15-30 Months: 66.75%; have not met MPL (70.67%). First year with benchmarks to monitor PR. WCV: 30.43%; have not met MPL (45.31%). First year with benchmarks to monitor PR.	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Health Guide 7-12 Newsletter mailing - Well-Child (0-30 Months) IVR and text message campaign - Well-Care 12-17 Years IVR campaign - Well-Care (3-17 Years) Text message campaign - LSC, CIS, W30 in-house call campaign for year end push (noncompliant members) 2) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures. Regular meetings with health network partners to share activities, help address concerns, and share best practices.	
Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) HEDIS MY2021 Goal (3 Year Goal): Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2) Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	12/31/2022	Helen Syn	QIC	MC	X	1) Shared report in July 2022 to health networks with Q2 2022 data on members that have not been screened as recommended for blood lead screening. Q2 2022 report for CCN Providers shared via Provider Portal. 2) Continuing member engagement strategy. Member IVR lead campaign launched in July. Member reach: 1,156 3) Worked on starting provider engagement strategy. Including updates to health networks on matters related to blood lead (e.g., gap reports, HN attestation process, internal policy updates) 4) Conducted member barrier analysis to identify root cause of lack of blood lead tests among members. 5) Prop 56 provider value based payments for Blood Lead Screening. 6) Finalized Evidence of Blood Lead Refusal form and HN Attestation Process for Health Networks to adhere to regulatory requirements that include Provider adherence to the provision of anticipatory guidance for blood lead screenings. August 2022 Prospective Rates Lead Screening in Children (in 2022, LSC became an MCAS measure that will have to meet the minimum performance level- MPL). MC: 58.54% Measure is performing higher than the same time last year and has not met the 50th percentile. (MPL)	1) Continue to share blood lead gap reports and DHCS blood lead supplemental data reports to HNs and CCN Providers. Reports are in process of being revised to highlight provider requirements such as the need for anticipatory guidance to parent/guardian of members. 2) Continuing strategy to update providers. Preparing to offer two Provider CME events focused on blood lead screening requirements scheduled for Q4 2022. Preparing Provider Press blood lead article for Q4 2022 3) Continue expanding member engagement strategy to include multi-modal approach via: texting, robocalls, social media. Planning PBS TV campaign that is projected to start in Q4 2022. 4) Continue with revisions to internal policy GG.1717 Blood Lead Screening in Young Children to support adherence to regulatory requirements.	

2022 QI Work Plan
(3Q)

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Report to Committee	LOB	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)	Next Steps Interventions / Follow-up Actions State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	Red - At Risk Yellow - Concern Green - On Target
VII. QUALITY OF SERVICE- Access										
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	12/31/2022	Marsha Choo/Jennifer Bamberg/Maggie Hart	MEMX	MC,OC,OCC	X	Transition of recruitment efforts from Contracting department to Provider Relations are finalized	Provider Relations will now be responsible for provider recruitment; created letter templates, created workflow and finalizing all documents to ensure reporting of all recruitment efforts are documented	
Improve Access: Expanding Network of Providers Accepting New Patients	Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%	[NEW] to 2022 QI Work Plan 1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC		Providers are actively returning the provider validations but delayed for those offices that are not tech savvy, new excel format was provided and assisting with navigating the spreadsheet caused delay	PR Reps continue to obtain confirmation of open and or closed panel, documenting requests via Facets, significant improvement to 70% of total CHCN network	
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC	X	1)2021-22 Timely Access Results reviewed and QC'd; working with vendor on development of non-compliance tracker. Non-Compliance letters being updated with CAP for those with non-compliance for a single measure 3 consecutive years. 2) HN Timely Access PDSA's submissions reviewed and additional follow-up requested by workgroup on three networks responses before close-out.	1) Next steps include finalizing non-compliance tracker and templates for letters. Issue non-compliance letters to providers and CAPs to HNs by end of 4th quarter. 2) Obtain clarification from three HNs regarding their PDSA submission. Access Workgroup to review final responses and close-out and/or determine next steps. Present final recommendations to Member Experience.	
Improve Access: Telephone Access	Reduce the rate of No Live Contacts After 3 Attempts from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETS (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	12/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) Update- improved provider data of 70% of total CCN provider TIN's acknowledging changes and/or updates to provider data, including phone numbers, office hours and open/closed panels 2) 2021-22 Timely Access Survey results reviewed and QC'd. Working with vendor on finalizing non-compliance tracker to assist with issuing letters to providers.	1) Finalizing last outreach effort for end of year push through office face-to-face visits, and phone calls 2) Finalize non-compliance tracker, issue non-compliance letters to providers, share TAS results in SNC November Report, and issue CAPs to HNs by end of 4th quarter.	
Improving Access: Subcontracted Network Certification	Certify all HNs for network adequacy	[NEW] 2022 QI Work Plan 1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.	7/31/2022	Marsha Choo/Jennifer Bamberg	MEMX	MC		Network Adequacy Standards: Medi-Cal Plan Level: •Mandatory Provider Types: Met •Provider to Member Ratios: Met •Time/Distance Standards: Met Medi-Cal HN Level: •Mandatory Provider Types: Not Met. (Certified Nurse Midwives and Licensed Midwives) •Provider to Member Ratios: -PCPs: Met for all HNs, except CHOC IM-PCP -Specialists: Not Met (Arta, Monarch) •Time/Distance: Not Met Medi-Cal Timely Access •Timely Access PDSAs were reviewed at workgroup mtg and additional follow-up requested on three networks responses before close-out. •HNs were provided a quarterly Subcontract Network Certification Summary report with their network adequacy performance August 31st •Provided HN with DHCS Provider List to help close the providers gaps for time/distance and MPT standards.	Continue to monitor quarterly and notify HNs of areas of non-compliance. If Net Adequacy standard(s) not met, HNs will identify out of network providers to ensure coverage of services. Seek clarification from three HNs regarding their PDSA submission. Access Workgroup to review responses and close-out and/or determine next steps. Present final recommendations to Member Experience. Workgroup to discuss how to certify HNs and how to issue corrective action to HNs with non-compliance.	
VIII. SAFETY OF CLINICAL CARE										
Plan All-Cause Readmissions (PCR)	HEDIS MY2021 Goal: MC - NA OC 8%; OCC 1.0 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access 3) Continue to engage work group to address barriers, thereby achieving increased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regarding the importance of having a post discharge visit with the members PCP.	12/31/2022	Kelly Giardina	QIC	MC, OC,OCC	X	1) Leveraging Collective Medical for additional ED/ PCP follow up 2) Pilot ED/ Rounds program to help inpatient facilities with escalations and support to secure pre-discharge appointments 3) Continued meetings to discuss open items and data analysis to shift approach as needed.	Collect Data and write up report send to consultant for review. Follow up meeting with Consultant to review report to be scheduled in 1Q2023.	

2022 QI Work Plan
(4Q)

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Report to Committee	LOB	Con't Monitoring from 2021	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 in 2023 (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	Red - Did not Meet Goal Green - Met Goal
I. PROGRAM OVERSIGHT										
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by April 2022	Marsha Choo	QIC	MC,OC,OCC	X	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2022	Kelly Giardina/ Teresa Smith	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by April 2022	Kelly Giardina/ Teresa Smith	QIC	MC,OC,OCC	X	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Katie Balderas	QIC	MC,OC,OCC	X	PHM Readiness Deliverables submitted to DHCS in October 2022 and additional clarifications were submitted in December 2022 and approved shortly thereafter by DHCS.	Departments are currently updating policies and procedures in alignment with PHM Strategy. Organizationwide PHM Strategy Steering Committee will launch Q1 2023.	
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	Quarterly Adoption of Report	Marsha Choo Laura Guest	QIC	MC,OC,OCC	X	I. FSR/PARS/NF/CBAS: A. FSR: Drop in FSRs Q3-Q4 (56 to 47); Increase in MRRs Q3-Q4 (46 to 58); Increase in failed FSR and MRR audits Q3-Q4 (7 to 11); Drop in CAPs Q3-Q4 (119 to 109); Increase % of Periodic FSRs completed by due date Q3-Q4 (33% to 41%); 394 CAPs issued in 2022 - 114 Critical Element, 174 FSR, 106 MRR; 505 audits completed in 2022 -37 Initial FSRs, 30 Initial MRRs, 204 Periodic FSRs, 230 Periodic MRRs, 4 MRR Focused Reviews. B. PARS: Drop in PARS Q3-Q4 (195 to 175); Increase in % of BASIC access Q3-Q4 (36% to 45%); Working on 2022 high-volume specialist (HVS) PARS list.; 685 PARS completed in 2022. 270=BASIC access 415=LIMITED access. C. CBAS: In-person services resumed 10/1/22.; 28 on-site visits in Q4; 35 virtual reviews in 2022. D. NF: On-site visits resumed Q3; 27 reviews in 2022; 3 unannounced visits at NFs in 2022. II. Credentialing: A. Identified in 03/22: OP - OC Project. CCN & BH, 117 group practices not credentialed, although practitioners were credentialed. As of Q4, 50 providers outstanding. QI meeting with legal to review DHCS's response to query on credentialing of group practices.; B. Significant increase in volume of cred apps to credential from Q1-Q4, including OP, CalAIM and practitioners. Anticipate credentialing of new provider types, such as doulas and community health workers.; C. Fallout report, report to identify contracted providers not credentialed, in final stage of testing; 95% complete; D.Process improvements: Request to credential submitted in 1 inbox to streamline & avoid duplicate submissions. III. PQI - Fair Hearings concluded in Q4; CPRC upheld recommendation of Fair Hearing Committees. PM MD terminated and reported to MBC. PCP at hospital-no further action. Q4, QI began reviewing Declined Grievances referred by CS for a PQOC. Added 30 more PQIs/month. Cases leveled QOC were 19% in Q4; 23% in Q3; 20% in Q2; 21% in Q1. PQIs closed in 2022 were 350; 2021 in 767. Cases presented to CPRC were 37 in 2022; 32 in 2021. The % of cases leveled as QOC were 11% in 2021; 18% in 2022.	I. FSR/PARS/NF/CBAS A. FSR: Plan to add 2 RN FSR positions in 2023. B. PARS: Plan to add 1 Outreach Specialist-PARS position in 2023. C. CBAS: Complete on-site visits at all contracted CBAS centers. D. NF: Re-evaluate current processes. One LVN retiring 3/1/2023. Other LVN on FMLA 02/23. II. Credentialing A.QI working with Legal and business areas on OC project to credential all medical groups. If providers need to be credentialed, analysis performed and effort made prior to termination. B. Cross train Credentialing Coord. to credential all cred types and all areas of cred (intake, verification) - particularly OPs. C.Finalize Fallout Report and utilize to consistently identify contracted providers to credential D. Continue to review and update current workflows and update desktop procedures to reflect a streamlined process. E. Finalize provider Onboarding Packet to include cred app. Utilize new reced reports to monitor compliance and streamline reced process to integrate process for practitioners and OPs. Assign reced and initials to cred coordinators to credential the entire file. Provider groups to be assigned to one cred coordinator. III. PQI 1. Review QOC grievances, Declined grievances and PQIs. Assess need for additional staffing to accommodate additional workload. 2. Create report to monitor TAT of Declined Grievance PQIs with goal of MD review completed in 30 days and TAT of PQIs with a goal of MD review completed in 90 days.	
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health networks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Tyronda Moses Heather Sedillo	QIC	MC,OC,OCC	X	Slight decrease in total number of grievances in 4Q over 3Q. . No specific trends were identified, however we continue to monitor these two areas very closely and also work with QI and Provider Relations to address our findings. 4Q Grievance Trending Medi-Cal Grievances: Access to Care- Appointment availability, Telephone accessibility. Member Billing- Members being billed directly. Quality of Care- Delay I treatment, Lack of follow-up. Quality of Service- Transportation- Driver issues, Early /Late pickup. 4Q Medi-Cal Member Appeals: Rate/1,000 for Medi-Cal remained constant in 4Q (262 received), highest amount received from CCN- 106 and Monarch- 66. No significant trends identified; overturns were made based on additional information received to support medical necessity for the requested services. 4Q OCC Member Appeals (Rate per 1000): Total member appeals received remained the same from 3Q (51). Monarch had 21 denials appealed and 9 were overturned for medical necessity. CCN had 14 denials appealed and 8 were overturned based on medical necessity met, 7 related to claims denials and 1 for diagnostic testing. 4Q OneCare Member Appeals (Rate per 1000): The low membership creates a higher rate/1000. Increase in the total number of appeals received for OneCare in 4Q (9). 4 out of the 9 were overturned based on medical necessity met- 2 related to denial of payments for specialist office, 1 for outpatient surgery and 1 for foot orthotics.	All trends are reviewed for repeated issues. High grievance count by providers are tracked and trended. Results are reported to Provider Relations for additional outreach and shared with a Provider Action workgroup. Recommendations for actions may include an onsite visit, additional education/training and/or escalation to the Member Experience Committee. GARS continues to work with Veyo to identify barriers and obstacles on a bi-weekly basis1	

2022 QI Work Plan
(4Q)

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Report to Committee	LOB	Con't Monitoring from 2021	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 in 2023 (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	Red - Did not Meet Goal Green - Met Goal
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Karen Jenkins Marsha Choo Carol Matthews	QIC	MC,OC,OCC	X	In Q4, MemX Committee has reviewed/discussed the following: 10/12/22 •Action Items: o Invite GARS to Access workgroup mtgs o Internal workgroup to discuss CAHPS PDSA Process •2022 BH Member Experience Results •Network Adequacy •Provider Satisfaction Survey Results •Provider Action for Non-Clinical Issues 12/08/22 •Action Items: o Close out HN Timely Access PDSAs o Convene Provider Action workgroup to review data and make decisions moving forward •GARS Update •Network Adequacy •OC/OCC CAHPS Scores •Member Experience workplan	Committee will continue to meet and monitor activities on the 2023 Workplan and as needed	
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Kelly Giardina Teresa Smith	Utilization Management/ QIC	MC,OC,OCC	X	UMC Q3 2022 Utilization report scheduled to report to QIC 1/17/2023. UMC Q2 2022 Utilization report to QIC on 11/08/2022. - Q3 2022 Operational Performance –	Continue to review utilization reports and trends in quarterly UMC in 2023 and report up through QIC meetings to discuss findings and data analysis to shift approach as needed.	
Whole Child Model - Clinical Advisory Committee (WCM CAC) - Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD	QIC	MC	X	WCM CAC met November 16, 2022 Whole Child Model Network Adequacy report of two HN not meeting DHCS standards. Both are now in compliance. -Reports on WCM measures for Behavioral Health, GARS, UM, and HEDIS Pediatric Measures were presented -OC CCS & CalOptima Health Collaboration:DHCS Integrated California Children's Services & Whole Child Model Dashboard.CalOptima Health data were comparable or better than other health plans -No pharmacy update was needed -DHCS Notice Update: CCS Information Notice 22-04 - Palivizumab for Immunoprophylaxis of Respiratory Syncytial Virus Infection during 2022- 2023 was shared	Will schedule 2023 Meeting dates. The next meeting is scheduled for 2/21/23.	
Quality Withhold for OCC	Earn 75% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Sandeep Mital	QIC	OCC	X	Scheduled to give update when we receive final scores from CMS in Q2 of 2023	Continue to monitor performance on the various OneCare Connect measures	
Quality Analytics Program Updates (Health Network Quality Rating, MCAS, P4V, Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Report or As needed	Paul Jiang Sandeep Mital	QIC	MC,OC,OCC	X	Scheduled to give updates for Health Network Quality Ratings when we receive final HEDIS and CAHPS scores in Q4 of MY2023	Continue to monitor performance on the various HEDIS clinical measures	

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Development of the OneCare program for MY2023	Develop and finalize the CMS measures for the scoring and payment methodology for the OneCare P4V program	P4V team has compiled a set of Part C, Part D, and Member Experience measures as proposed metrics for the MY2023 OneCare P4V program. Awaiting approval from the various committees and the Board of Directors.	end of 4Q2022	Sandeep Mital	QIC			CalOptima Health Board of Directors approved the Pay for Value (P4V) OneCare COBAR on December 1, 2022 with the proposed Part C, Part D, and Member Experience measures for the MY2023 OneCare P4V program	Pay for Value team will start generating monthly Prospective Rate reports for CalOptima Health and all health networks to monitor performance on the OneCare Part C and Part D measures from Q1 of 2023	
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of specific goals All LOB PIPs MC PIPs: 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members. (March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Mobile Mammography Event Q4: Completed 26 BCS for KCS CCN members. Intervention testing completed December 31,2022 waiting for updated HEDIS rate for December 2022. 2) W30 PIP Progress Check-In feedback completed in Q4. Intervention implementation completed and pending HEDIS rate results for December 2022.	These PIPs are now completing the 3-year period and are being sunsetted with final Module 4 submissions pending in April 2023. 1) BCS PIP Module 4 is due April 2023. Completing rolling 12 month SMART Aim Measure data. Pending updated data due to continuous enrollment specification changes. 2) W30 PIP Module 4 is due April 2023. Currently waiting for data refresh to obtain last few data points to evaluate intervention effectiveness.	
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs MC QIP: 1) COVID QIP Phase 2 - a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)- N. Zavala b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	end of 4Q2022	Natalie Zavala Helen Syn	QIC	MC,OC,OCC	X	MC QIP 1) COVID QI Phase 2- a. SSD update provided under Quality of Clinical Care Behavioral Health section below. b. CCS- Completed. For cycle 3 one of three providers reached 50th percentile for measure and provider office staff incentive was paid out. c. CIS Combo 10. Provider office submitted target list October 2022. Provider office had 75 successful appointments during intervention period, 7/1/22 - 9/30/22. Additionally, 21 newly compliant members during this period. 2) Improving Statin Use for People with Diabetes (SPD) Statin Adherence MC: 69.26% (above 50th), OC: 74.84% (below 50th), OCC: 77.20% (below 50th) Measure is performing lower for MC, OC and OCC LOBs than same time last year and are below the 50th percentile (MPL). MC is above 50th percentile. OC & OCC below 50th percentile. Statin Therapy MC: 71.43% (above 50th), OC: 81.46% (above 50th), OCC: 81.90% (above 50th) Measure is performing lower for MC and OC LOBs than same time last year. Measure is performing lower for OCC LOB than same time last year. All LOBs are above the 50th percentile (MPL).	a-1) Continue tracking members in need of diabetes screening test. a-2) Continue outreach to prescribing providers. b- QIP complete. For RY 2022, MCPs not required to submit COVID-QIP. Pending delivery of provider staff incentive for cycle 1 and 2 for other provider office. c- Pending data availability. Evaluation intervention effectiveness which includes provider office's final CIS Combo 10 rate (administratively). 2) Completed 3-year period on 12/31/2022, will end this initiative. It was confirmed that a QIP is not a DHCS nor a CMS Medicare requirement for 2023.	
Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on All LOB CCIPs 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Quarterly/Annual Assessment	Helen Syn	QIC	MC,OC,OCC	X	1) Emerging Risk Health Coach Outreach OC CCIP 6 members, 3 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC CCIP 24 members, 13 Assigned, 0 Unable to Contact, 2 No Longer Emerging Risk, 1 No Longer Eligible. 2) 2022 baseline was set at 26.02%, represents the rate of members who have yet to receive therapy/maintain adherence in the SPD Adherence and Therapy sub-measure. The goal of this intervention is to reach the target goal of ≤21.02% (a lower percentage is an improvement) a 5-percentage point decrease. The rate of members who have yet to receive therapy/maintain adherence in the SPD Adherence and Therapy sub-measures was 15.46% at the end of 2022 and met the target goal of ≤21.02%.	1) Completed 3-year period on 12/31/2022, will end this initiative. 2) Completed 3-year period on 12/31/2022, will end this initiative.	

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PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Quarterly/Annual Assessment	Sherry Hickman Denise Hood	QIC	OC, OCC	X	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PME (OC): HRAs: HN MOC Oversight(Review of MOC ICP/ICT bundles) HRA outreach for Annual 100%; Initial outreach 100% for October and November; December still in process; HRA reviewed 100% prior to sending to the networks; TAT for bundle review: October files met 90% at 15 business days. November files met at 95% at 20 business days; December is in process. 2) QIPE (OCC): HN MOC Oversight(Review of MOC ICP/ICT bundles) HRAs: Completed outreach for Initial HRA 100%. Completed outreach for Annual HRA 100%. Members have transitioned to OC and OCC has sunset. HRAs reviewed 100% by oversight prior to sending to the networks. TAT for bundle review on return: Octobers files met 92% at 15 days; November files met 96% at 25 days; and December is in process. 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion. All LTSS HRAs outreach completed. 4) Monitor CA MMP 1.5 High risk 89% and low risk 83% for Q4 and may change prior to regulatory submission in 2/2023 5) Monitor results CA 1.6 99% 6) Monitor results MMP 3.2 81% as of 1/18/2023, and may change prior to regulatory submission.	1) PME (OC): HRAs: This process is changing and will no longer be a goal in 2023. 2023 will move to benchmarks for collection of an HRA and ICP within 90 days for newly eligible members. Our interventions will reflect regulatory expectations for 2.1 and 3.2 regulatory measures. 2) QIPE (OCC):HRAs: This will not carry over to 2023 as OCC sunsets on 12/31/2022. 3) LTSS HRA OCC: Resolved and will fall off the Q1 work plan for 2023. 4) MMP 1.5 will fall off the Q1 work plan for 2023. 5) CA 1.6 will fall off the Q1 work plan for 2023. 6) MMP 3.2 will continue in 2023 work plan with benchmark of 90%	
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January 2022.	Quarterly Adoption of Report	Natalie Zavala Sheri Hopson	QIC	MC	X	BHIIIP: 1) Program ended 12/31/22, only administrative activities remain and will be completed during Q1 2023 2) Prepared Program Year 2 Q3 milestone report 11/9/22, due to DHCS 11/29/22 2) Prepared the Q1 2022 Milestone Incentive Payments 10/13/22, payments issued to the provider groups 10/21/22 ABA P4V: 1) Program ended 12/31/22 per executive leadership directive, administrative activities remain and will be completed during Q1 2023 2) Prepared program ending email notification for the ABA providers; forwarded the notification to Provider Relations requesting it be emailed to all the ABA provider groups by 12/15/22 (request has been confirmed as completed). 3) Finalized reporting configurations for BH P4V report card distribution using the provider portal	BHIIIP and ABA P4V commenced on December 31, 2022	
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1) Regular planned visits to shelters, hot spots and recuperative care facilities- to resume post-COVID-19. (CM) addition of virtual outreach visits to shelters. 2) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19 3) Develop and implement Street Medicine Program 4) Implement DHCS Housing & Homelessness Incentive Program (HHIP) to meet specific measures around increased data integration, member housing supports, and homeless services for members	Quarterly Report	Sarah Nance Danielle Cameron	QIC	MC,OC,OCC	X	1) Onsite continued in Quarter 4 at Yale Navigation Center 1x/week for 2 hours per outreach and at Casa Paloma. Virtual and telephonic outreach was continued with the Costa Mesa Shelter and Huntington Beach Navigation Center. Telephonic support by the Homeless Response Team was continued for Members who required the services of the Clinical Field Teams. 2) No support for pre-enforcement activities was requested during Quarter 4. 3) An RfQu was conducted to solicit qualifications from potential providers of the street medicine program. From that process, two providers were selected to operationalize a two-pronged street outreach and medicine program that targeted reaching people experiencing homelessness both unsheltered on the streets (encampments, hot spots, etc) and in local shelters. This pilot will launch in Garden Grove, where we hope to establish a collaborative service delivery model between the service providers, local stakeholders, Be Well and related county entities. The planning phase began in December 2023, with services launching in early 2023. 4) CalOptima Health solicited stakeholder input into an Investment Plan, which identified key investment strategies to tackle the barriers identified in the Local Homelessness Plan. The CalOptima Health Board approved this plan, which was submitted to DHCS. DHCS has indicated that the first payment of \$4.1M was transmitted to CalOptima Health in support of this work and the second payment of \$8.3M was authorized to CalOptima Health. The CalAIM community investment team will be distributing these initial funds using the approved Investment Plan.	1 - HRT will be ending at the close of 2023. These services are provided by a number of other organizations and CalOptima Health is designing a more effective way to use these team members' time. 2 - Support for pre-enforcement activities will discontinue with the disbanding of HRT. These services are also provided by other entities within Orange County. 3 - Street medicine services will launch on 4/1/2023 in Garden Grove. 4 - HHIP newly funded projects will launch 4/1/23.	

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CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Quarterly Report	Mia Arias Andrew Kilgust Danielle Cameron	QIC	MC	X	1 & 2. All HHP and WPC members were successfully transitioned to CalAIM ECM without an interruption in service. 3. A DHCS reporting process has been established; ITS leads the data collection and Care Management, LTSS and CalAIM teams review and attest to the data before DHCS submission. Monthly data improvement calls are hosted to ensure data captured is accurate and up-to-date. 4. An oversight strategy is in development.	The CalAIM team will focus on developing and launching the oversight strategy for the CalAIM program. Many lessons were learned during the first year of implementation and those lessons will inform the oversight strategy going forward. Much of this work will launch in 2023.	Green
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1) Make health equity a strategic priority 2) Develop structure and process to support health equity work 3) Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4) Develop partnerships with community organizations to improve health and equity 5) Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Katie Balderas	QIC	MC, OC, OCC	x	Focus for Q4 was on submitting the DHCS PHM Strategy Readiness Deliverables, which center health equity and will enhance member connection to SDOH. Received demo of closed-loop referral tools for social needs and began drafting scope of work for RFP. Reviewed evidence-based SDOH assessments to include in future member care coordination efforts.	Health Equity workgroup will reconvene in Q1 to determine objectives for 2023. This objective will be sunset in lieu of one focused on food security as a social determinant of health.	Green
DHCS Comprehensive Quality Strategy	Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.	1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy	12/31/2022	Marsha Choo Katie Balderas	QIC	MC, OC, OCC		The Comprehensive Quality Strategy is being operationalized through the CalAIM Population Health Management (PHM) Strategy. PHM Readiness Deliverables submitted to DHCS in October 2022 and additional clarifications were submitted in December 2022 and approved shortly thereafter by DHCS.	Departments are currently updating policies and procedures in alignment with PHM Strategy. Organizationwide PHM Strategy Steering Committee will launch Q1 2023.	Green
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.		Natalie Zavala Carmen Katsarov	QIC	MC		1) BHI completed and reviewed the SBHIP Assessment Components (stakeholder meeting attestation, data collection strategy, needs assessment, LEA/community resource map and LEA/external provider behavioral health referral process) submitted to DHCS 12/27 2) 4 Targeted interventions discussed and the selection of 4 agreed upon by BH, OCHA, and external partner (CHOC) 3) 4 Project Plans completed - one completed for each targeted intervention selected, submitted to DHCS 12/27 4) SBHIP presented during the Advisory Committee meeting - 12/8	1) DHCS will provide status and score for the submitted SBHIP assessment components, expected in April 2) BH will continue conducting project planning sessions to identify significant implementation needs for each targeted intervention 3) Conduct discussions with Contracting re the development of MOU, Contract, and scope of work templates 4) Continue regular meetings with OCHA, CHOC, and OCDE	Green

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II. QUALITY OF CLINICAL CARE- Adult Wellness										
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events.	12/31/2022	Helen Syn	QIC	MC	X	1a. 2022 Member Health Rewards processed as of 12/31/22: BCS: 490 for MC 9 for OC and 23 for OCC; CCS: 695 for MC; COL: 5 for OC and 38 for OCC 1b. Transition from Member Health Reward vendor (Icario) to be done in-house. Reward process design in progress. 2. Targeted member engagement and outreach campaigns to identified zip codes for paid Social Media Campaigns. 3. Member Engagement Strategy: Social Media (Paid): BCS Digital Ad: BCS digital ad Print Ad: BCS print ad Radio Ad: CCS radio ad Television: PBS-Women's Cancer Screenings (BCS/CCS) 4. Community Events: Mobile Mammography: KCS event 26 CCN members completed 5. 2022 November Prospective Rates (PR): Breast Cancer Screening MC: 56.31%, OC: 63.94%, OCC: 63.69% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). Cervical Cancer Screening MC: 53.05% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Colorectal Cancer Screening OC: 49.00%, OCC: 54.98% Measure is performing lower than same time last year for OC and higher than same time last year for OCC and is currently below the 50th percentile.	1a. Continue to track BCS, CCS and COL member health reward. 1b. Transition to in-house member health reward process. 2. Targeted member engagement and outreach campaigns to identified zip codes. 3. Member Engagement Texting: CCS texting campaign scheduled Q1 IVR: BCS scheduled for Q1 Social Media: CCS, COL scheduled for Q1 Digital Ad: CCS scheduled for Q1 Print Ad: COL scheduled for Q1 Radio Ad: CCS scheduled for Q1 Television: PBS Women's Cancer Screening (BCS/CCS) scheduled Q1 Direct Mailing: CCS scheduled for Q1 Community Connections: CCS article scheduled for Q1 Member Newsletter: CCS, BCS, COL article scheduled for Spring and Summer issue 4. Community Events: Ongoing mobile mammography events 5. Pending further details from CalOptima Health Comprehensive Cancer Screening Program for 2023.	Red
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	12/31/2022	Helen Syn	QIC	MC	X	1) COVID texting campaigns continued in Q4. 2) COVID community vaccine events were held in partnership with OCHCA ongoing. A. Vaccine Events include: • 10/8/2022: 55 total health rewards 3) Vendor has processed a total of 1,049,633 incentives (cumulative) and total processed (including in-house processing) is 1,209,806 incentives (cumulative) as of 1/6/2023.	1) Texting campaigns continue. CalOptima Health's Board of Directors approved new incentive guidelines of providing up to 4 health rewards with end date for unvaccinated members. New texting messages will be finalized to include incentive eligibility. 2) COVID community vaccine events are planned by Community Relations. 3) Ongoing COVID messaging to go out in Member Newsletters and Provider publications about the importance of updated booster vaccinations and new approved health reward eligibility guidelines. Social Media, Targeted ad campaigns scheduled. 4) COVID vaccine incentive processing continues, CAIR2 registry data and logic improvements to assist with identification and more timely processing. 5) COVID VIP will end June 30, 2023 as was board approved, but incentive rewards will be distributed through the end of 2023.	Green
III. QUALITY OF CLINICAL CARE- Behavioral Health										
Follow-up After Hospitalization for Mental Illness within 7 and 30 days of discharge (FUH)	HEDIS MY2021 Goal: FUH 30-Days: MC: NA; OC: NA; OCC: 48.40% (Quality Withhold measure) 7-Days: MC: NA; OC: NA; OCC: 27.07%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	12/31/2022	Natalie Zavala	QIC	OCC	X	PR HEDIS Rates Q4 (November): 30 day- 40.48 %, 7 day-17.86%; BHI real-time report Q4 : 30 day- % , 7 day- % 1) Continued outreach to members post-discharge to coordinate follow-up appointments. 2) Continued weekly BHI clinical round meetings to discuss concurrent reviews and internal coordination of interventions. Barriers encountered: Decrease in initial admissions but increase in member Re-admissions. Members not attending follow-up appointments due to readmission; members declining assistance from PCC or IP facility in assisting member with creating OP BH appointment, and inability reaching members due to invalid phone numbers or answering and then hanging up.	1) Continue conducting post discharge outreach to members. 2) Continue tracking members and outreach for those who are not attending follow-up appointments within 7 days of discharge.	Green
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2021 Goal: MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	12/31/2022	Natalie Zavala	QIC	MC	X	PR HEDIS Rates Q4 (November): Initiation Phase- 42.66%, Continuation and Maintenance Phase- 48.47% 1) Continued monitoring of CORE report to track members who filled an initial ADHD Rx. This is a manual process, but addresses barrier of limited resources for developing a real-time report to track member follow-up visits for provider outreach to schedule visits. 2) Continued member outreach for those who filled initial ADHD Rx (script and workflow to track phone calls made to members). 3) Reviewing data for compliant and non-compliant providers. 4) Submitted article on Treatment for Children with ADHD to educate members on ADHD which will be included in the Medi-Cal Member newsletter Spring edition 2023. 5) Distributed non-compliant provider letters.	1) Continue member outreach for those members who filled an initial ADHD prescription. 2) Identify trends in compliant and non-compliant provider letters.	Green

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Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)	1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	12/31/2022	Natalie Zavala	QIC	MC, OC, OCC		PR HEDIS Rates Q4 (December): M/C: 72.71% OC: N/A, OCC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau. 2) Conduct outreach to prescribing provider via phone, then fax to include (a) list of members in need of diabetes screening (b) best practice guidelines reminder (c) members' primary care physician (PCP) name and contact information (to promote coordination of care by requesting prescribers to contact the PCP with lab results). Barriers included: Receiving timely data, obtaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing. Other difficulties we have come to know is that some members with this diagnosis do not see their PCP regularly.	1) Continue tracking members in need of diabetes screening test. 2) Continue outreach to prescribing providers.	
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)	1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.	12/31/2022	Natalie Zavala	QIC	MC		PR HEDIS Rates Q4 : 30 day- 25.07 %, 7 day- 14.58% Measure has been identified as a Health Network (HN) P4V. The main barrier is obtaining real-time data for ED visits in order to conduct interventions to assist in follow-up visit attendance. On 12/7/22, BHI attended CalOptima Health Quality Forum to present on FUM and discuss with HNs their experience, barriers, opportunities for improvement. HNs did express concern regarding lack of Health Information Exchange in a timely manner.	1) Finalize FUM Tableau report to identify trends. 2) Present FUM data at the next HN Quality meeting to discuss findings. 3) Obtain real-time data from vendor and develop process to alert or notify HNs of ED visit for mental illness.	
IV. QUALITY OF CLINICAL CARE- Chronic Conditions										
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	MY2021 HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) HbA1c Test Health Rewards: 454 Processed, 404 approved, 50 denied 1b) Transition from Member Health Reward vendor (Icario) to be done in-house. 2) Emerging Risk Health Coach Outreach: MC 460 members, 214 Assigned, 3 No Longer Eligible, 9 No Longer Emerging Risk, 0 Opt Out, 5 Unable to Contact OC 6 members, 3 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC 24 members, 13 Assigned, 0 Unable to Contact, 3 No Longer Emerging Risk, 1 No Longer Eligible. 3) Member Engagement Strategy: Texting: CDC texting campaign 2,444 Medi-Cal members identified IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachable/no answer Social Media: Nov 2022-Jan 2023 ESV Total reach (the number of unique users the ad reached)=133,975 Impressions(the number of times an ad appears in all user feeds, can appear to same user more than once)= 297,851 4) Prop 56 provider value based payments for diabetes care measures.	1) Track and monitor until the end of member incentive year. Transition from Member Health Reward vendor to be done in-house. 2) Completed 3-year period on 12/31/2022. will end this initiative. 3) Texting: relaunch text campaign in 2023. IVR: relaunch IVR campaign in 2023. Social Media: continue campaign in 2023.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals: MC 63.2% OC: 71%; OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn	QIC	MC,OC,OCC	X	1a) Eye Exam 345 Processed, 305 approved, 40 denied 1b) Transition from Member Health Reward vendor (Icario) to be done in-house. 2) VSP Eye Exam Reminder Letters distributed on 11/15/2022 MC=7,688 OC=180 OCC=1,891 3) Member Engagement Strategy: Texting: CDC texting campaign 2,444 Medi-Cal members identified IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachable/no answer Social Media: Nov 2022-Jan 2023 ESV Total reach (the number of unique users the ad reached)=133,975 Impressions(the number of times an ad appears in all user feeds, can appear to same user more than once)= 297,851 4) Prop 56 provider value based payments for diabetes care measures	1) Track and monitor until the end of member incentive year. Transition from Member Health Reward vendor to be done in-house. 2) Continue to have VSP send Eye Exam Reminder letters to our members monthly. 3) Texting: relaunch text campaign in 2023. IVR: relaunch IVR campaign in 2023. Social Media: continue campaign in 2023.	

2022 Q1 Work Plan
(4Q)

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Implement multi-disciplinary approach to improving diabetes care for CHCN Members Pilot	1) Lower HbA1c to avoid complications; 2) reduce emergency department (ED) visits and hospitalizations /readmission rates; 3) improve member and provider satisfaction; and 4) optimize diabetes medication management.	Program Design: 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement	12/31/2024	Nicki Ghazanfarpour Jocelyn Johnson Joanne Ku	QIC		X	1) The workgroup reviewed and finalized the workflow for the pilot program. 2) The workgroup continued working with ITS to build member stratification for the pilot program. 3) For provider engagement, in lieu of hosting a provider webinar, the workgroup discussed visiting the high volume PCP offices in-person in 2023 (once member stratification is completed) and seek their participation.	1) Finalize the member stratification list and PCP list by the end of January 2023 (dependent on ITS). 2) Finalize necessary documents/artifacts for the pilot program (e.g., scripts, one-page flyer, SharePoint scheduler, etc.). 3) Launch the pilot program by the end of Q1.	Green
V. QUALITY OF CLINICAL CARE- Maternal Child Health										
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	12/31/2022	Ann Mino Helen Syn	QIC	MC	X	1) Member Health Reward of \$50 for Postpartum Care visit within 1-12 weeks after delivery is continuing. Total # of PPC health rewards approved October through December: 197. 2) Postpartum Mailing Initiative: Process for the first quality Initiative mailing is still being developed. Mailing projected to go out by end of Q1 2023. Mailing will target members that recently delivered (identified via and encourage timely postpartum care. 3) Bright Steps Program conducted initial outreach to 687 unique members. Total of 999 outreach attempts made to 635 postpartum members. 222 postpartum assessments completed. 4) Bright Steps Program received a total of 670 new Pregnancy Notification Reports and conducted outreach to engage members with the program. 5) Perinatal and Postpartum Bright Steps Program participated in 2 community events that combined resulted in outreach to 265 individuals. Collaborated with Gilbert High School in Anaheim (October 2022) to provide as part of teen pregnancy program to provide education and CalFresh + Resource event in Huntington Beach (November 2022). A combined total of 350 persons were outreached through these public events. 6) Prop 56 provider value based performance incentives for prenatal and postpartum care visits. November 2022 Prospective Rates: Timeliness of Prenatal Care: 80.45%- Measure is performing higher than same time last year and has not met the 50th percentile. Postpartum Care: 69.43%- Measure is performing higher than same time last year and has not met the 50th percentile.	1) Continue to expand member engagement strategy to ensure multi-modal approach to include the following elements: text campaigns, IVR robocalls, social media, member mailings etc. 2) Exploring integration of the Medi-Cal Community Health Worker benefit can be implemented to support prenatal and postpartum care. 3) Continue to expand on provider engagement strategy to ensure PNR submission and increase Bright Steps Program Outreach.	Red
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS MY2021 Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2022	Helen Syn	QIC	MC	X	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Health Guide 7-12 Newsletter mailing, delayed to Q1 2023 due to rebranding of newsletter - Well-Child 0-30 Months Text Message Campaigns (W30, CIS) in October: 1904 and November: 3969 members. - Well-Child 0-30 Months IVR Campaign (W30) in October: 274, and December: 4716 members. - Well-Care 12-17 Years IVR campaign (WCV 12-17) in October: 11686, and December 13854 members. - Well-Care 3-17 Years Text Message Campaigns (WCV 3-17) in October: 11577 and December: 10568 members. - In-House Live Call Campaign for LSC, CIS, W30 in October to 2391 members - In-House Live Call Campaign for W30-First 15 in November to 191 members. - In-House Live Call Campaign for W30-18-21 Years in November-December to 3540 members. - LSC, CIS, W30 in-house call campaign for year end push (noncompliant members), completed - PBS TV Ad Campaign - Well Care Visits in December. 2) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures. Regular meetings with health network partners to share activities, help address concerns, and share best practices. 4) November 2022 Prospective Rates. Note 50th percentile benchmarks have been updated. New benchmarks became available 9/30/22. CIS Combo 10: 30.93%; has not met MPL. IMA Combo 2: 44.90%; met MPL. Rate is LOWER than last year and has met 66th percentile. W30 First 15 Months: 35.91%; have not met MPL (55.72%). First year with benchmarks to monitor PR. W30 15-30 Months: 66.75%; have not met MPL (65.83%). First year with benchmarks to monitor PR. WCV: 42.34%; have not met MPL (48.93%). First year with benchmarks to monitor PR.	1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. - Health Guide 0-2, and 7-12 Newsletter mailing in Q1 2023 - Well-Child (0-30 Months) IVR, text message, and in-house live-call campaign - Well-Care (3-17 Years) IVR and text message campaign 2) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures. Regular meetings with health network partners to share activities, help address concerns, and share best practices.	Red

2022 Q1 Work Plan
(4Q)

2022 Q1 Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Report to Committee	LOB	Con't Monitoring from 2021	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 in 2023 (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)	Red - Did not Meet Goal Green - Met Goal
Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) HEDIS MY2021 Goal (3 Year Goal): Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2) Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	12/31/2022	Helen Syn	QIC	MC	X	1) Shared report in October 2022 to health networks with Q2 2022 data on members that have not been screened as recommended for blood lead screening. Launched HN attestation process for HN to attest to receiving report and additional lead operational and regulatory requirements. For CCN Providers, launched capability for attestation in December via Provider Portal. 2) Continuing member engagement strategy. Member text campaign launched on December 6 that reached 864 unique members; PBS TV campaign ad "Protect Your Child from Lead Poisoning" launched mid December; Live call campaign (In-House) to support closure of HEDIS gaps for LSC, CIS, W30 in October: 2391 members 3) Continued with provider education: conducted two blood lead CE/CME's in October; shared updates with health networks on matters related to blood lead (e.g., gap reports, HN attestation process, internal policy updates) via 1:1 quality meetings, Quality Forum, Health Network Quality Forum, CCN Virtual Meeting. 4) Updated internal policy GG.1717 to reflect HN and CCN provider requirements related to attestation requirements, documentation of blood lead refusals, etc. 5) LSC continued to be part of Pay for Value program. November 2022 Prospective Rates Lead Screening in Children (in 2022, LSC became an MCAS measure that will have to meet the minimum performance level- MPL). MC: 59.95% Measure is performing higher than the same time last year. Measure has not met the 50th percentile (MPL).	1) Continue to share blood lead gap reports and DHCS blood lead supplemental data reports to HNs and CCN Providers. Enhance reports to include provider summary to support HNs and CCN providers with total untested members. 2) Continuing strategy to engage and update providers of blood lead testing requirements. 3) Continue expanding member engagement strategy to include multi-modal approach via: texting, robocalls, social media. PBS TV campaign expected to continue through Q1 2023. 4) Bright Steps Program, expansion of calls to include follow-up of child members at 6 and 11 months. This follow-up is in alignment with well-child visits. Calls will provide reminders to encourage well-child visits and provide education on lead and blood lead testing recommendations for child members.	Green
VII. QUALITY OF SERVICE- Access										
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	12/31/2022	Marsha Choo Jennifer Bamberg	MEMX	MC,OC,OCC	X	Q4, Provider Relations finalized the provider recruitment communication, including "No Thank You" letters, "Welcome letters" credentialing packets as required. All forms were reviewed by QI, Contracting and PDMS to ensure all provide data will be captures.	Creating packets on PDF fillable friendly forms	Green
Improve Access: Expanding Network of Providers Accepting New Patients	Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%	1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.	12/31/2022	Marsha Choo Jennifer Bamberg	MEMX	MC,OC,OCC		Q4, Provider Relations will continue to conduct provider directory validations and submit to PDMS for changes	Discussion around provider directory implementation and provider portal enhancement to include automation	Yellow
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards	12/31/2022	Marsha Choo Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) Planned Activities -Implemented •Non-compliance tracker completed and 1,800+ non-compliance letters for appointment and telephone access mailed to providers via USPS at the end of December. This year's mailing included escalation letter which includes a CAP for providers who were identified as non-compliant for a measure for three consecutive years. Providers who recieved a warning letter which is a second year notice of non-compliance, were assigned to one HN for education and follow-up. In most cases, assignment was based on where most of the provider membership was held. 2) Planned Activities -Implemented •Timely Access PDSAs issued to HNs in January 2022, were officially closed in October and email notifications sent to networks. •Based on the 2021-22 Timely Access results, the HNs struggled meeting the 80% MPL for a high percentage of the Access standards and therefore, all HNs with the exception of KP were issued a CAP in late December via email. Goal for Urgent Specialists-Met: Goal: 61.1%; 2021-22 Actual: 64%	Improving Timely Access Appointment Availability will continue to be monitored for 2023 with modifications to activities. 1) •Provider submissions to CAPs due at end of Jan. Will review and determine next steps. •Will review HNs feedback on provider outreach and education on non-compliance standards at end of Q1/early Q2. 2) HN submissions to CAPs due end of Jan. Will review and determine next steps.	Green

**2022 QI Work Plan
(4Q)**

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Improve Access: Telephone Access	Reduce the rate of No Live Contacts After 3 Attempts from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	12/31/2022	Marsha Choo Jennifer Bamberg	MEMX	MC,OC,OCC	X	1) Provider Relations conducted provider directory validations through calendar year with a total of 97% completion rate. All updates/changes were submitted to PDMS for data updates. 2) Non-compliance tracker completed and 1,800+ non-compliance letters for appointment and telephone access mailed to providers via USPS at the end of December. Assigned HN to outreach and provide education to those who received a warning "2nd" year letter. No Live Contacts After 3 Attempts: 27.5% (not met)	1)Provider Relations will maintain process for directory validation and update customizing validation template on provider portal. Work request submitted to ITS and Provider Portal Workgroup. 2)Improving telephone access will continue to be monitored in 2023 with minor modifications to activities •Provider submissions to CAPs due at end of Jan. Will review and determine next steps. •Will review HNs feedback on provider outreach and education on non-compliance standards at end of Q1/early Q2.	Green
Improving Access: Subcontracted Network Certification	Certify all HNs for network adequacy	1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.	7/31/2022	Marsha Choo Jennifer Bamberg	MEMX	MC		Network Adequacy Standards: Medi-Cal Plan Level: •Mandatory Provider Types: Met •Provider to Member Ratios: Met •Time/Distance Standards: Met Medi-Cal HN Level: •Mandatory Provider Types: Met •Provider to Member Ratios: -PCPs: Met for all HNs -Specialists: Not Met (Arta, Monarch) •Time/Distance: Not Met Medi-Cal Timely Access •Timely Access PDSAs (issued Jan-2022) were reviewed and closed out. Official email sent to networks October 27th. •HNs were provided a quarterly Subcontract Network Certification Summary report with their network adequacy performance for November. •Provided HN with DHCS Provider List to help close the providers gaps for time/distance and MPT standards.	Throughout the year, CalOptima consistently met Net-Adequacy standards at the Plan level. Continue to monitor and notify HNs of areas of non-compliance.	Green
VIII. SAFETY OF CLINICAL CARE										
Plan All-Cause Readmissions (PCR)	HEDIS MY2021 Goal: MC - NA OC 8%; OCC 1.0 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access 3) Continue to engage work group to address barriers, thereby achieving increased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regarding the importance of having a post discharge visit with the members PCP.	12/31/2022	Kelly Giardina	QIC	MC, OC,OCC	X	1) The CORE report has been updated to include Medi-Cal LOB. 2) PCP Discharge letter was updated to include this language: "Please verify that this member is scheduled with your office for discharge follow up care." "CalOptima Health is dedicated to preventing re-admissions and request your assistance with facilitating the scheduling of this important appointment. We request this member be seen by his/her PCP within 1-3 days of discharge." The member unable to contact (UTC) letter has also been updated but is not programmed into the system yet. There was also a memo drafted by CM for the hospitals, and it was sent to the consultant for review. 3) Launched the pilot ED/Facility Rounds programs.	Continue meetings to discuss open items and data analysis to shift approach as needed. Finalize the communication (provider memo) to hospitals based on the consultant's recommendation.	Green



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QUALITY IMPROVEMENT PROGRAM





CalOptima Health



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2023 QUALITY IMPROVEMENT PROGRAM

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Quality Improvement Committee Chair:

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

Board of Directors' Quality Assurance Committee Chair:

Trieu Tran, M.D. _____ *Date*

~~Board of Directors Chair:~~

~~Supervisor Andrew Do~~ _____ ~~Date~~

Quality Improvement Committee Chair:

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

Board of Directors' Quality Assurance Committee Chair:

Trieu Tran, M.D. _____ Date

Board of Directors

Chair:

Clayton M. Corwin _____ Date
Acting Chair

~~Supervisor Andrew Do~~ _____ ~~Date~~

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Abbreviations

<u>s With/Health Is</u> <u>Committee for & Provider Service Plan</u>	
<u>ABBREVIATION</u>	<u>DEFINITION</u>
A	
<u>ACE</u>	<u>Adverse Childhood Event</u>
<u>ADA</u>	<u>Americans With Disabilities Act of 1990</u>
<u>ADHD</u>	<u>Attention-Deficit Hyperactivity Disorder</u>
<u>APL</u>	<u>All Plan Letter</u>
<u>AUD</u>	<u>Alcohol Use Disorder</u>
B	
<u>BHI</u>	<u>Behavioral Health Integration</u>
<u>BHT</u>	<u>Behavioral Health Treatment</u>
<u>BHIIP</u>	<u>Behavioral Health Integration Incentive Program</u>
<u>BMSC</u>	<u>Benefit Management Subcommittee</u>
C	
<u>CalAIM</u>	<u>California Advancing and Innovating Medi-Cal</u>
<u>CAHPS</u>	<u>Consumer Assessment of Healthcare Providers and Systems survey</u>
<u>CAP</u>	<u>Corrective Action Plan</u>
<u>CBAS</u>	<u>Community-Based Adult Services centers</u>
<u>CCN</u>	<u>CalOptima Health Community Network</u>
<u>CCIP</u>	<u>Chronic Care Improvement Project</u>
<u>CCO</u>	<u>Chief Compliance Officer</u>
<u>CCS</u>	<u>California Children’s Services</u>
<u>CHRO</u>	<u>Chief Human Resources Officer</u>
<u>CEO</u>	<u>Chief Executive Officer</u>
<u>CIO</u>	<u>Chief Information Officer</u>
<u>CMO</u>	<u>Chief Medical Officer</u>
<u>CMS</u>	<u>Centers for Medicare & Medicaid Services</u>
<u>COPD</u>	<u>Chronic Obstructive Pulmonary Disease</u>
<u>COO</u>	<u>Chief Operating Officer</u>
<u>COS</u>	<u>Chief of Staff</u>
<u>COD-A</u>	<u>CalOptima Health Direct-Administrative</u>
<u>CPRC</u>	<u>Credentialing and Peer Review Committee</u>
<u>CQS</u>	<u>Comprehensive Quality Strategy</u>
<u>CR</u>	<u>Credentialing</u>
D	
<u>DC</u>	<u>Doctor of Chiropractic Medicine</u>
<u>DCMO</u>	<u>Deputy Chief Medical Officer</u>
<u>DDS</u>	<u>Doctor of Dental Surgery</u>
<u>DHCS</u>	<u>California Department of Health Care Services</u>
<u>DMHC</u>	<u>California Department of Managed Health Care</u>
<u>DO</u>	<u>Doctor of Osteopathy</u>
<u>DPM</u>	<u>Doctor of Podiatric Medicine</u>
<u>D-SNP</u>	<u>Dual-Eligible Special Needs Plan</u>
E	
<u>ED PHM</u>	<u>Executive Director, Population Health Management</u>
<u>ED BH</u>	<u>Executive Director, Behavioral Health Integration</u>
<u>BH</u>	<u>Behavioral Health</u>
<u>ED CO</u>	<u>Executive Director, Clinical Operations</u>
<u>ED MP</u>	<u>Executive Director, Medicare Programs</u>
<u>ED PA</u>	<u>Executive Director, Public Affairs</u>
<u>ED NO</u>	<u>Executive Director, Network Operations</u>

	<u>ED O</u>	<u>Executive Director, Operations</u>
	<u>ED Q</u>	<u>Executive Director, Quality</u>
<u>F</u>		
	<u>FDR</u>	<u>First Tier, Downstream and Related Entities</u>
	<u>FSR</u>	<u>Facility Site Review</u>
<u>G</u>		
	<u>GARS</u>	<u>Grievance and Appeals Resolution Services</u>
<u>H</u>		
	<u>HEDIS</u>	<u>Healthcare Effectiveness Data and Information Set</u>
	<u>HIPAA</u>	<u>Health Insurance Portability and Accountability Act</u>
	<u>HMO</u>	<u>Health Maintenance Organization</u>
	<u>HN</u>	<u>Health Network</u>
	<u>HNA</u>	<u>Health Needs Assessment</u>
	<u>HOS</u>	<u>Health Outcomes Survey</u>
	<u>HRA</u>	<u>Health Risk Assessment</u>
<u>I</u>		
	<u>ICT</u>	<u>Interdisciplinary Care Team</u>
	<u>ICP</u>	<u>Individualized Care Plan</u>
	<u>IRR</u>	<u>Inter-Rater Reliability</u>
<u>L</u>		
	<u>LTC</u>	<u>Long--Term Care</u>
	<u>LTSS</u>	<u>Long--Term Services and Supports</u>
<u>M</u>		
	<u>MAC</u>	<u>Member Advisory Committee</u>
	<u>MD</u>	<u>Medical Doctor</u>
	<u>ME</u>	<u>Member Experience</u>
	<u>MED</u>	<u>Medicaid Module</u>
	<u>MEMX</u>	<u>Member Experience Committee</u>
	<u>MOC</u>	<u>Model of Care</u>
	<u>MOU</u>	<u>Memorandum of Understanding</u>
	<u>MRR</u>	<u>Medical Record Review</u>
	<u>MRSA</u>	<u>Methicillin resistant Staphylococcus aureus</u>
	<u>MSSP</u>	<u>Multipurpose Senior Services Program</u>
	<u>MY</u>	<u>Measurement Year</u>
	<u>NCQA</u>	<u>National Coalition ofCommittee for Quality Assurance</u>
	<u>NET</u>	<u>Network</u>
	<u>NF</u>	<u>Nursing Facilities</u>
<u>O</u>		
	<u>OC</u>	<u>Orange County</u>
	<u>OCC</u>	<u>OneCare Connect</u>
	<u>OCHCA or HCA</u>	<u>Orange Country Health Care Agency</u>
	<u>OP</u>	<u>Organizational Providers</u>
	<u>OC SSA or SSA</u>	<u>County of Orange Social Services Agency</u>
<u>Q</u>		
	<u>QAC</u>	<u>Quality Assurance Committee</u>
	<u>QI</u>	<u>Quality Improvement</u>
	<u>QIC</u>	<u>Quality Improvement Committee</u>
	<u>QIP</u>	<u>Quality Improvement Project</u>
<u>P</u>		
	<u>P4V</u>	<u>Pay for Value</u>
	<u>P&T</u>	<u>Pharmacy and Therapeutics Committee</u>
	<u>PAC</u>	<u>Provider Advisory Committee</u>

	<u>PACE</u>	<u>Program of All-Inclusive Care for the Elderly</u>
	<u>PARS</u>	<u>Physical Accessibility Review Survey</u>
	<u>PBM</u>	<u>Pharmacy Benefit Manager</u>
	<u>PCP</u>	<u>Primary Care PhysicianProvider</u>
	<u>PDSA</u>	<u>Plan-Do-Study-Act</u>
	<u>PHM</u>	<u>Population Health Management</u>
	<u>PHC</u>	<u>Physician/Hospital Consortia</u>
	<u>PIP</u>	<u>Performance Improvement Project</u>
	<u>PPC</u>	<u>Personal Care Coordinator</u>
	<u>POI</u>	<u>Potential Quality Issue</u>
	<u>PSS</u>	<u>Perinatal Support Services</u>
<u>S</u>		
	<u>SABIRT</u>	<u>Alcohol and Drug Screening Assessment, Brief Interventions and Referral to Treatment</u>
	<u>SBHIP</u>	<u>Student Behavioral Health Incentive Program</u>
	<u>SDOH</u>	<u>Social Determinants of Health</u>
	<u>SNP</u>	<u>Special Needs Plan</u>
	<u>SNF</u>	<u>Skilled Nursing Facility</u>
	<u>SPD</u>	<u>Seniors and Persons with Disabilities</u>
	<u>SRG</u>	<u>Shared-Risk Group</u>
	<u>SUD</u>	<u>Substance Use Disorder</u>
<u>T</u>		
	<u>TPL</u>	<u>Third-Party Liability</u>
<u>U</u>		
	<u>UM</u>	<u>Utilization Management</u>
	<u>UMC</u>	<u>Utilization Management Committee</u>
<u>V</u>		
	<u>VS</u>	<u>Vision Service</u>
	<u>VSP</u>	<u>Vision Services ProgramService Plan</u>
<u>W</u>		
	<u>WCM</u>	<u>Whole-Child Model Program</u>
	<u>WCM CAC</u>	<u>Whole-Child Model Clinical Advisory Committee</u>
	<u>WCM FAC</u>	<u>Whole-Child Model Family Advisory Committee</u>

~~We Are CalOptima~~ CalOptima Health Overview

Caring for the people of Orange County has been ~~CalOptima~~ 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~~ 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 ~~provide members with access to quality health care services delivered in a cost-effective and compassionate manner~~ serve member health with excellence and dignity, respecting the value and needs of each person.

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

Our Vision

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

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.



C	Collaboration
A	Accountability
R	Respect
E	Excellence
S	Stewardship

~~Our Values — CalOptima~~CalOptima Health CARES

Collaboration

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

Accountability

~~We were created by the community, for the community and are accountable to the community. Meetings open to the public are:~~

~~Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory~~

~~Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee.~~

~~Respect~~

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

~~We treat members with dignity in our words and actions.~~

~~We respect the privacy rights of our members.~~

~~We speak to our members in their languages.~~

~~We respect the cultural traditions of our members.~~

~~We respect and care about our partners.~~

~~We develop supportive working relationships with providers,
community health centers and community stakeholders.~~

~~Excellence~~

~~We base our decisions and actions on evidence, data analysis
and industry-recognized standards so our providers and
community stakeholders deliver quality programs and services that
meet our members' health needs. We embrace innovation and~~

~~welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.~~

Stewardship

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

~~We are “Better. Together.”~~

~~We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members’ health care needs. We are “Better. Together.”~~

Our Strategic Plan

~~In late 2019, CalOptima CalOptima Health’s Board of Directors and executive team worked together to develop our next three-year 20223—2025 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019 June 2022. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima CalOptima Health. 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:

- ~~Innovate and Be Proactive~~Organizational and Leadership Development
- ~~Expand CalOptima~~CalOptima Health's Member-Centric Focus~~Overcoming Health Disparities~~
- ~~Strengthen Community Partnerships~~Finance and Resource Allocation
- ~~Increase Value and Improve Care Delivery~~Accountabilities and Results Tracking
- ~~Enhance Operational Excellence and Efficiency~~Future Growth

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

Centers for Medicare and 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.

Quality Mission: All people receive equitable, high-quality and value-based care.

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 Goals:

1. Embed Quality into the Care Journey: Incorporate quality as a foundational component to delivering value as a part of the overall care journey. Quality includes ensuring optimal care and best outcomes for individuals of all ages and backgrounds as well as across service delivery systems and settings. Quality also extends across payer types.
2. Advance Health Equity: Address the disparities that underlie our health system, both within and across settings, to ensure equitable access and care for all.
3. Promote Safety: Prevent harm or death from health care errors.
4. Foster Engagement: Increase engagement between individuals and their care teams to improve quality, establish trusting relationships, and bring the voices of people and caregivers to the forefront.
5. Strengthen Resilience: Ensure resilience in the health care system to prepare for, and adapt to, future challenges and emergencies.
6. Embrace the Digital Age: Ensure timely, secure, seamless communication and care coordination between providers, plans, payers, community organizations, and individuals through interoperable, shared, and standardized digital data across the care continuum.
7. Incentivize Innovation & Technology: Accelerate innovation in care delivery and incorporate technology enhancements (e.g., telehealth, machine learning, advanced analytics, new care advances) to transform the quality of care and advance value.
8. Increase Alignment: Develop a coordinated approach to align performance metrics, programs, policy, and payment across CMS, federal partners, and external stakeholders to improve value. Strive to create a simplified national picture of quality measurement that is comprehensible to individuals, their families, providers, and payers.

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

The 2022 Draft-CQS lays out DHCS' quality and health equity strategy 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 stress 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

Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.

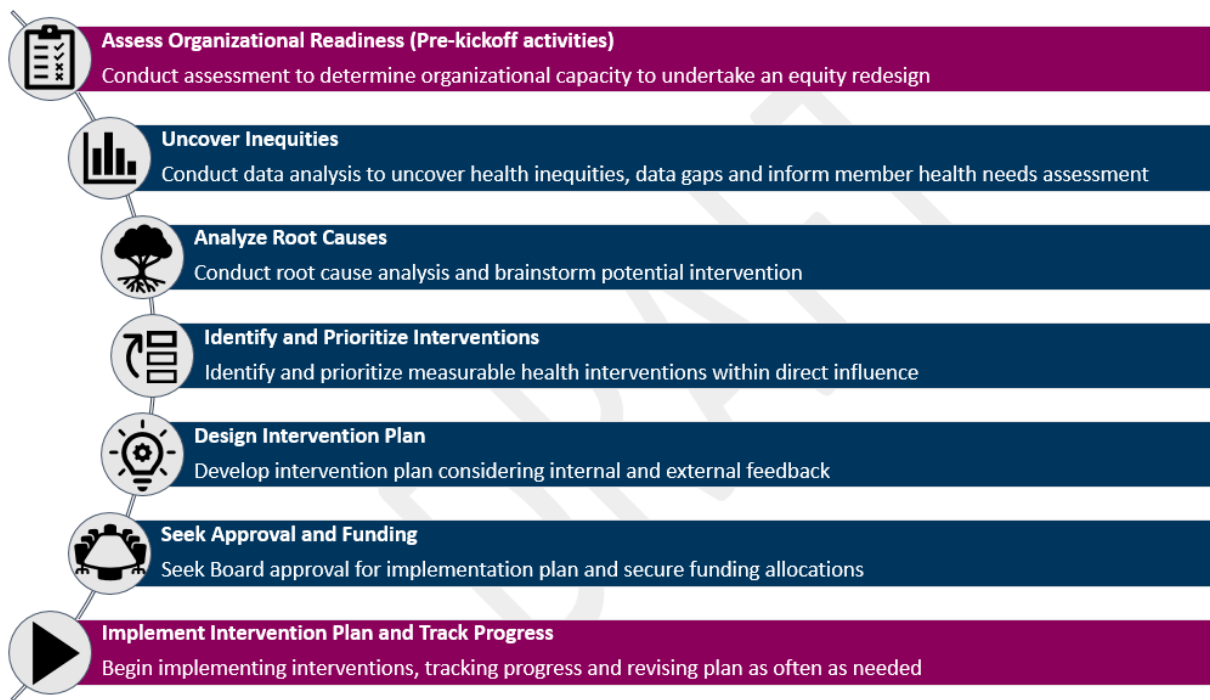
- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

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).

Social Determinants of Health (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.



Comprehensive Community Cancer Screening and Support Program

WHAT IS CALOPTIMA ~~CALOPTIMA HEALTH?~~

CalOptima Health strives to be the health care exemplar for all Orange County (OC) residents. The goal is for all of Orange County to have the lowest in the nation late-stage cancer incidence rate for breast, cervical, colon, and lung cancer in certain smokers. In other words:

- With rare exception, no one should die from breast cancer;
- With rare exception, no one should die from cancer of the cervix;
- With rare exception, no one should die from cancer of the colon
- With rare exception, no one should die from lung cancer in certain heavy smokers;

~~**WITH RARE EXCEPTION, NO ONE SHOULD DIE FROM LUNG CANCER IN CERTAIN HEAVY SMOKERS.**~~

~~**OUR UNIQUE DUAL ROLE**~~

~~**CALOPTIMA CalOptima Health is unusual in that it is both a public agency and a community health plan.**~~

~~**AS BOTH, CALOPTIMA CalOptima Health must:**~~

- ~~**PROVIDE QUALITY HEALTH CARE TO ENSURE optimal health outcomes for our members**~~
- ~~**SUPPORT MEMBER AND PROVIDER ENGAGEMENT AND satisfaction**~~
- ~~**BE good stewards of public funds by making the best use of our resources and expertise**~~

- ~~ENSURE TRANSPARENCY IN OUR GOVERNANCE PROCEDURES, INCLUDING PROVIDING OPPORTUNITIES FOR STAKEHOLDER INPUT~~
- ~~BE ACCOUNTABLE FOR THE DECISIONS WE MAKE~~

CalOptima Health seeks to create a new Orange County health ethos with respect to cancer care by going after these four specific cancers that are relatively easy to detect compared ~~to~~with many more occult cancers. Early detection of these specific cancers has an incredible return on investment. CalOptima Health intends to build this new ethos by leveraging the key cancer centers and community opinion makers to the point where cancer detection for these specific cancers is part of the community’s daily discussions. Additionally, having the lowest late-stage cancer detection in the nation will be a source of intense community pride.

The Comprehensive Community Cancer Screening and Support Program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

It will create a culture of cancer prevention, early detection and collaboration with partners towards a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have

-equitable access to high quality care. The ~~P~~program will use a phased-in approach to invest over the next five years ~~toward~~in the following three pillars:

- 1) Increasing community and member awareness and engagement;
- 2) Increasing access to cancer screening; ~~and~~
- 3) Improving member experience throughout cancer treatment.

As of November 14, 2022, 3,925 CalOptima Health members were newly diagnosed with cancer. Of these ~~cases~~carecases, 480 are lung cancer, 565 are breast cancer, 120 are cervical cancer, and 477 are colorectal cancer. The COVID-19 pandemic has significantly disrupted preventive care and cancer screenings, leading to a decrease in early detection and treatment¹. Between 2019 and 2021, Medi-Cal Healthcare Effectiveness Data and Information Set (HEDIS) rates decreased by approximately 5% for breast and cervical cancer screenings. Currently, more than one-third of eligible members have not received their cervical, breast, or colorectal cancer screenings.

Increasing these cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life, and reducing health care costs. For example, the five-year survival rate for colorectal cancer that has spread is only 15% ~~percent~~, compared ~~to~~with a ~~90 percent~~90% survival rate when detected earlier at a localized stage. Yet every year in Orange County, an average of 1,500 community members are diagnosed with late-stage cancer of the breast, cervix, or colon². Additionally, trends in late-stage colorectal cancer diagnoses significantly increased over the most recent ~~ten~~10-year period in Orange County, and in 2022, colorectal cancer will likely continue to be the ¹second leading cause of cancer-related deaths following lung cancer¹.

Staff plan to collaborate with the Orange County Cancer Coalition, providers, health networks, and community-based organizations to ensure that funds are utilized equitably to address

¹ <https://www.science.org/doi/10.1126/science.abd3377>

disparities and build sustained capacity in the cancer screening and treatment community infrastructure.

Five-Year Hospital Quality Program

CalOptima Health's hospitals and their affiliated physicians are integral components of the delivery of health services to members and play a critical role in the delivery of care to CalOptima Health's members. For many years, CalOptima Health has been providing quality incentive payments to its Health Networks to drive improvement in quality outcomes and member satisfaction. CalOptima Health has established a Hospital Quality Program for its contracted hospitals to improve quality of care to members through increased patient safety efforts and performance-driven processes. Hospital performance measures would serve to:

- Support hospital quality standards for Orange County in support of CalOptima Health's mission;
- Provide industry benchmarks and data-driven feedback to hospitals on their quality improvement efforts;
- Recognize hospitals demonstrating quality performance;
- Provide comparative information on CalOptima Health hospital performance; ~~and~~
- Identify areas for improvement and for working collaboratively with these hospitals to ensure the provision of quality care for CalOptima Health members;

The program launches January 1, 2023, and extends through December 31, 2027. ~~It is comprised of two (2) includes two~~ initiatives:- Hospital Incentive Quality Pool and Hospital Reporting Incentive Payments.

This initiative will include the following principles:

1. Leverage publicly available, industry-standard measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Group including:
 - a. CMS Quality;
 - b. CMS Patient Experience;
 - c. Leapfrog Hospital and Surgery Center Rating; ~~and~~
 - d. Leapfrog Hospital Safety Grade;
2. Require contracted hospital participation in CMS quality reporting programs (hospital inpatient, hospital outpatient, prospective payment systems-exempt cancer, or inpatient psychiatric) or Leapfrog Group Hospital and Surgery Center Rating for measurement as follows:
 - a. Contracted hospitals will be assessed on CMS quality reporting programs as reported on CMS Care Compare;
 - b. Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital and Surgery Center Rating; ~~and~~
 - c. Contracted hospitals not listed on either CMS Care Compare or Leapfrog Hospital ~~and~~
 - d. Surgery Center Rating will not qualify for incentive payments;
3. Require contracted hospital participation in Leapfrog Hospital Safety Grade reporting
4. Allocate a maximum amount of a budget for a ~~five (5) five~~-year period from 2023—2027 to fund the hospital incentive pool. The amount that each hospital may earn will be based

on their proportion of services provided to CalOptima Health members, i.e., proportion of total bed days. Funding will be used to reward performance and unearned incentive dollars will be forfeited.

Incentive awards will be based on performance compared ~~to~~with quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

CalOptima Health recognizes that hospitals may not currently participate in CMS/Leapfrog public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During the ramp-up period, CalOptima Health will provide hospital reporting incentive payments to eligible hospitals.

CalOptima Health Programs

- “Better. Together.” is our 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 fourthree major programs:

What We Offer

CalOptima Health Programs

Medi-Cal

In California, Medicaid is known as Medi-Cal. CalOptima CalOptima Health marked 25 years of service to Orange County’s Medi-Cal population in 2020.

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 CalOptima Health Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima 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 CalOptima Health through the Whole-Child Model (WCM) Program that went into effect in 2019.

CalOptima Health provides eEnhanced eCare mManagement and eCommunity sSupports services to address social drivers of health. In 2023, we expand our eCommunity sSupports services from four4 to allthe 14 options listed below:

- [1. Housing transition navigation services](#)
- [2. Housing deposits](#)
- [3. Housing tenancy and sustaining services](#)
- [4. Short-term post-hospitalization housing](#)
- [5. Recuperative care \(medical respite\)](#)
- [6. Respite services](#)
- [7. Day habilitation programs](#)
- [8. Nursing facility transition/diversion to assisted living facilities](#)
- [9. Community transition services/nursing facility transition to a home](#)
- [10. Personal care and homemaker services](#)
- [11. Environmental accessibility adaptations \(home modifications\)](#)
- [12. Medically tailored meals/medically supportive foods](#)
- [13. Sobering centers](#)
- [14. Asthma remediation](#)

Certain services are not covered by ~~CalOptima~~[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 (HCA)
- Substance use disorder services are administered by HCA
- 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~~[CalOptima Health](#) has developed specialized [easecare](#) management services. These [easecare](#) 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~~[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 HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

~~Since In~~ July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for ~~CalOptima~~[CalOptima Health](#) Medi-Cal members. ~~CalOptima~~[CalOptima Health](#) ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)

- Multipurpose Senior Services Program (MSSP)

CalOptima Health ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

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.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and people with disabilities. CalOptima Health LTSS monitors the levels of member access to, utilization of and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima Health LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Emergency Department Diversion Pilot

OneCare (HMO D-SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for ~~our members~~ them to get the health care they need. Since 2005, ~~CalOptima~~ CalOptima Health has been offering OC OneCare to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OC OneCare has extensive experience serving the complex needs of the frail, disabled, ~~dual dual~~-eligible members in Orange County. ~~With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.~~

~~OneCare provides a comprehensive scope of services for dual dual-eligible members enrolled in Medi-Cal and Medicare Parts A and B. 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 sStar measures.~~

To be a member of ~~OC~~[OneCare](#), a person must live in Orange County and ~~not be eligible for~~ ~~OC~~[be eligible for both Medicare and Medi-Cal](#). Enrollment in ~~OC~~[OneCare](#) is voluntary and by member choice.

Scope of Services

OneCare provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. 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~~[Star](#) measures.

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, ~~CalOptima~~[CalOptima Health](#) ~~OC~~[OneCare](#) members are eligible for enhanced services, such as gym memberships.

~~OneCare~~[Connect](#)

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

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

~~At no extra cost, OCC adds benefits such as vision care, gym benefits and an out-of-the-country urgent/emergency care benefit. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support—all to ensure each member receives the services they need when they need them.~~

~~OneCare Connect achieves these advancements via ~~CalOptima~~[CalOptima Health](#)'s innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create 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.~~

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

The Cal MediConnect demonstration program is ending in 2022, and CalOptima CalOptima Health is planning to transition OCC members to OC, effective January 1, 2023.

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits and over-the-counter benefits. OCC also includes personalized services through the PCCs to ensure each member receives the services they need when they need them.

PROGRAM INITIATIVES

Mitigate Impact and Improve Health Equity: COVID-19 Pandemic

The COVID-19 pandemic created a public health emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2022 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, as well as the COVID-19 Vaccination and Communication strategy.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity have existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in September 2021 revealed that Latinx account for 45.9% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 6.7% of the deaths, but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima CalOptima Health identified opportunities to improve health equity as part of the QI Work Plan.

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 ~~you~~the member's home, in the community or at the CalOptima Health ~~our~~ 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

— Hospital care and emergency services ~~ADD DESCRIPTION~~

—
—

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

— ~~The 2022 Draft CQS lays out DHCS’ quality and health equity strategy 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 stress 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~~

—

— ~~Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS’ multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.~~

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

—

— ~~Health Equity Framework~~ —

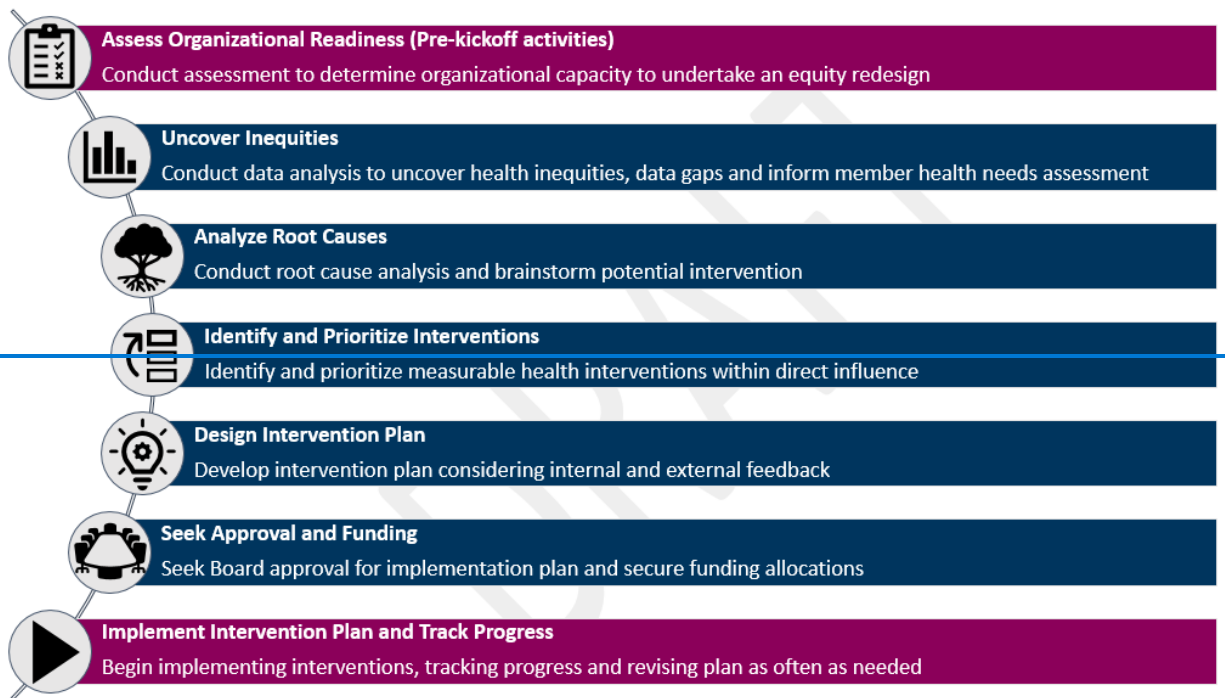
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— ~~Health equity is achieved when an individual has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of~~

social position or other socially determined circumstances” (Centers for Disease Control and Prevention).

Social Determinants of Health (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.



California Advancing and Innovating Medi-Cal (CalAIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reforms.

CalAIM has three primary goals:

1. Identify and manage member risk and need through whole-person care approaches and addressing SDOH.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.

3. ~~Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.~~

~~Enhanced Care Management and Community Supports~~

~~Beginning on January 1, 2022, CalOptima Health implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Community Supports are medically appropriate, flexible, wrap-around services that address the member's complex medical and social needs. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits and discharge delays.~~

~~CalOptima Health's implementation of ECM and Community Supports build upon the Health Homes Program (HHP) and Whole Person Care (WPC) Pilot infrastructures by preserving existing member relationships with HHP and WPC service providers. CalOptima Health's HHP Community-Based Care Management Entities will transition to become ECM Providers. This means that CalOptima Health and our delegated health networks (HNs) will provide ECM services as ECM providers to eligible populations. These providers will be responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:~~

- ~~1. Outreach and engagement~~
- ~~2. Comprehensive assessment and care management plan~~
- ~~3. Enhanced coordination of care~~
- ~~4. Health promotion~~
- ~~5. Comprehensive transitional care~~
- ~~6. Member and family supports~~
- ~~7. Coordination of and referral to community and social support services~~

~~Beginning January 1, 2022, ECM went live for the following populations of focus:~~

- ~~• Members experiencing homelessness (adults and children)~~
- ~~• High-utilizer adults~~
- ~~• Adults with Serious Mental Illness (SMI)/Substance Use Disorder (SUD)~~

~~Additionally, members participating in WPC and/or HHP automatically transitioned into ECM.~~

~~HHP and WPC service providers will continue to provide services under Community Supports as CalOptima Health works to expand the network of Community Supports providers that have the expertise and capacity to provide the specific types of services. Members eligible for Community Services must consent to participate and receive services. Community Support services include the following:~~

- ~~1. Housing transition navigation services~~
- ~~2. Housing deposits~~
- ~~3. Housing tenancy and sustaining services~~
- ~~4. Short-term post-hospitalization housing~~
- ~~5. Recuperative care (medical respite)~~
- ~~6. Respite services~~

7. ~~Day habilitation programs~~
8. ~~Nursing facility transition/diversion to assisted living facilities~~
9. ~~Community transition services/nursing facility transition to a home~~
10. ~~Personal care and homemaker services~~
11. ~~Environmental accessibility adaptations (home modifications)~~
12. ~~Medically tailored meals/medically supportive foods~~
13. ~~Sobering centers~~
14. ~~Asthma remediation~~

~~Beginning January 1, 2022, CalOptima Health offers the following four Community Supports services:~~

1. ~~Housing transition navigation services~~
2. ~~Housing deposits~~
3. ~~Housing tenancy and sustaining services~~
4. ~~Recuperative care (medical respite)~~

~~CalOptima Health will continue to assess the needs of members and collaborate with community stakeholders to add new Community Supports:~~

~~2021-22 CalOptima Health Community Network (CCN) Pilot Program~~

~~**Diabetes Mellitus Program to Improve Health Care Quality for Medi-Cal Members With Poorly Controlled Diabetics**~~

~~To address high rates of poorly controlled diabetics identified in the CCN network, the following pilot program was proposed and approved by the CalOptima Health Board of Directors:~~

~~1. Pharmacist Involvement and Intervention:~~

~~CalOptima Health pharmacists' role will be extended to include individual member outreach and provider consultations. CalOptima Health believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with primary care providers (PCPs) and health coaches/registered dietitians/case managers.~~

~~2. Health Coach/Registered Dietitian Management Intervention:~~

~~CalOptima Health health coaches will provide CCN focused interventions such as assessment/care planning, motivational interviewing, member education materials and referral to other community resources based on needs. Health coaches/registered dietitians will also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention.~~

~~3. Non-Monetary Member Incentives:~~

~~CalOptima Health would like to support member engagement and compliance by providing members with health rewards (non-monetary incentives). The non-monetary incentives will be provided as gift cards subject to DHCS approval in the near future.~~

~~4. Provider Incentives:~~

~~In order to have successful provider support, CalOptima Health proposes providing incentives for their dedicated participation in this multidisciplinary diabetes program. Providers are eligible for incentives when they manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.~~

Pharmacy Administration Changes

Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx. Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima Health retained responsibilities will include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for Medi-Cal only and does not affect OC, OCC or PACE.

8.

OneCare Connect

On January 1, 2023, ~~the CalOptima Health's OneCare Connect plan program sunseeded as a CalOptima Health Program.~~ Members in this program were transitioned to OneCare.

With Whom We Work CalOptima Health Provider Partners

Contracted Health Networks/Contracted Network Providers

Providers have options for participating in ~~CalOptima Health's~~ programs to provide health care to ~~CalOptima Health~~ members. Providers can contract through ~~CalOptima Health~~ Direct, ~~CalOptima Health~~ Direct-Administrative and/or ~~CalOptima Health~~ Community Network (CCN) and/or contract with a ~~CalOptima Health~~ Health Network (HN). ~~CalOptima Health~~ members can choose CCN or one of 12 HNs representing more than 9,400 ~~practitioners/providers~~.

CalOptima Health Direct (COD)

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

- ~~CalOptima Health~~ Direct-Administrative (COD-A)

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

CalOptima CalOptima Health Contracted Health Networks

~~CalOptima~~ 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 Groups (SRG)

Through our delegated HNs, ~~CalOptima~~ CalOptima Health members have access to more than 1,500 PCPs, more than 7,900 specialists, 40 acute and rehabilitative hospitals, 31 community health centers and nearly 100 long-term care facilities.

~~CalOptima~~ CalOptima Health contracts with the following HNs:

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

Optum Care Network - Talbert	SRG	SRG
Prospect Medical Group	HMO	-
United Care Medical Group	SRG	SRG
Delegated <u>Vendor</u>	Medi-Cal	OneCare
Vision Service Plan	VS	VS
<u>MedImpact</u>		<u>PBM</u>

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, the HNs contracted entities may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex easecare management
- Claims
- Contracting
- Credentialing of practitioners
- Customer service

Membership Demographics

Membership Data* (as of October 31, 2022)

Total CalOptima Health Membership	Program	Members
937,584	Medi-Cal	919,992
	OneCare Connect	14,198
	OneCare (HMO D-SNP)	2,964
	Program of All-Inclusive Care for the Elderly (PACE)	430
	*Based on unaudited financial report and includes prior period adjustment	

Membership Data* (as of December 31, 2022)

Total CalOptima Health Membership	Program	Members
944,975	Medi-Cal	927,086
	OneCare Connect	14,385
	OneCare (HMO D-SNP)	3,067
	Program of All-Inclusive Care for the Elderly (PACE)	437
	*Based on unaudited financial reports and includes prior period adjustment. Data from prior to the OneCare Connect program end on January 1, 2023.	

Member Age

0 to 5	9%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65 +	12%

Language Preference

English	58%
Spanish	27%
Vietnamese	10%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category

Temporary Assistance for Needy Families	40%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	9%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

Member Demographics (as of December 31, 2022)**Member Age**

0 to 5	9%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65 +	12%

Language Preference

English	59%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category

Temporary Assistance for Needy Families	40%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	9%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

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

Membership Data from December 31, 2021, Financial Information

Total CalOptima Membership 870,489	Program	Members
	Medi-Cal*	852,805
	OneCare Connect	14,933
	OneCare (HMO SNP)	2,330
	Program of All-Inclusive Care for the Elderly (PACE)	421

Note: Fiscal Year 2021–22 Membership Data began on July 1, 2021.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)	Languages Spoken (All Programs)	Medi-Cal Aid Categories
9% 0 to 5	59% English	41% Temporary Assistance for Needy Families
27% 6 to 18	26% Spanish	35% Expansion
33% 19 to 44	10% Vietnamese	3% Optional Targeted Low-income Children
19% 45 to 64	2% Other	9% Seniors
12% 65+	1% Korean	5% People with Disabilities
	1% Farsi	<1% Long-Term Care
	<1% Chinese	<1% Other
	<1% Arabic	

Financial Information FY 2021–22 Budget

Program	Annual Budgeted Revenue	% Total Budgeted Revenue
Medi-Cal	\$3,249,878,660	88.89%
OneCare Connect	\$339,332,450	9.28%
OneCare	\$25,409,771	0.69%
PACE	\$40,274,039	1.10%
MSSP**	\$1,218,536	0.03%

Total Budgeted Annual Revenue

\$3.7 billion

Note: Fiscal Year 2021–22 Operating Budget began on July 1, 2021.
** Multipurpose Senior Services Program (MSSP)

CalOptima spends nearly 96 cents of every dollar on member care.



Quality Improvement Program

CalOptima Health's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer-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 our 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 Quality Improvement Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency 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 HR 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 Program Purpose

The purpose of the [CalOptimaCalOptima Health](#) QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to [CalOptimaCalOptima Health](#) members through [CalOptimaCalOptima Health](#) CCN and COD-A, as well as our contracted HNs. Through the QI Program — and in collaboration with providers and community partners — [CalOptimaCalOptima Health](#) strives to continuously improve the structure, processes, and outcomes of ~~its~~the health care delivery system to serve our members.

The [CalOptimaCalOptima Health](#) QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of [CalOptimaCalOptima Health](#)'s multiple customers (members, health care providers, community-based organizations, and government agencies). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance [CalOptimaCalOptima 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 QI 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 agencywide practices that support accreditation by NCQA and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QI Program'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 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.
- Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensuring certain contracted facilities report to [the public health authority \(OCHCA\)](#) outbreaks of conditions and/or diseases, which may include, but are not limited to, methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, ~~etc~~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 assure that steps are taken to resolve and prevent recurrences.
- Educating the workforce and promoting a continuous quality improvement culture at ~~CalOptima~~ CalOptima Health.
- Ensure the annual review and acceptance of the UM Program Description, 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 QI Program ensures the following standards or outcomes are carried out and achieved by ~~CalOptima~~ CalOptima Health's contracted HNs, including CCN and/or COD network providers serving ~~CalOptima~~ CalOptima Health's various populations:

- Support the agency's strategic quality and business goals by utilizing 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.
- ~~Timely~~ Identify in a timely manner the important clinical and service issues facing the Medi-Cal and ~~OC~~ OneCare and ~~OC~~ populations relevant to their demographics, high 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~~ 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 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 medicine.

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple [CalOptima CalOptima Health](#) departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

Authority, Board of Directors' Committees and Responsibilities

Board of Directors

The [CalOptima CalOptima Health](#) Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to [CalOptima 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 CalOptima Health](#)'s state and federal contracts — and to [CalOptima 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 QI Program annually.

The QI Program 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 QI Program. Such recommendations shall be aligned with federal and state regulations, contractual obligations and fiscal parameters.

~~CalOptima~~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~~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 QI Program. QAC routinely receives progress reports from the QIC 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 of the QI Program aimed to achieve the Institute for Healthcare Improvement’s Quadruple Aim: ~~(which expands on CMS’ Triple Aim):~~

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
- ~~4. Enhancing provider satisfaction~~
- 4.

Member Advisory Committee

The Member Advisory Committee (MAC) has 15 voting members, with each seat representing a constituency served by ~~CalOptima~~CalOptima Health. The MAC ensures that ~~CalOptima~~CalOptima Health members’ values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI Program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a ~~monthly~~bimonthly basis and reports directly to the ~~CalOptima~~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
- ~~• HCA~~
- ~~• LTSS~~
- Medi-Cal beneficiaries
- ~~• Medical safety net~~
- Member Advocate
- County of Orange Social Services Agency (OC SSA)

- OneCare Member (2 seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

~~Two~~One of the 15 positions — held by ~~HCA and~~ OC SSA — ~~are is a standing seat permanent~~. Each of the remaining ~~14~~3 appointed members may serve ~~two~~two consecutive three-year terms ~~with no term limits~~.

~~OneCare Connect Member Advisory Committee~~

~~The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima~~CalOptima Health Board of Directors. ~~The OCC MAC has 10 voting members, each seat representing a~~

~~constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the program.~~

~~The OCC MAC membership includes representatives from the following constituencies:~~

~~OCC beneficiaries or family members of OCC beneficiaries (three seats)~~

~~CBAS provider representative~~

~~Home and Community-Based Services (HCBS) representative serving persons with disabilities~~

~~HCBS representative serving seniors~~

~~HCBS representative serving members from an ethnic or cultural community~~

~~In-Home Supportive Services (IHSS) provider or union representative~~

~~LTC facility representative~~

~~Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society or Public Law Center~~

~~Non-voting liaisons include seats representing the following county agencies:~~

~~HCA Behavioral Health~~

~~OC SSA~~

~~OC Community Resources Agency, Office on Aging~~

~~OC IHSS Public Authority~~

~~The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The bimonthly meetings are open to the public.~~

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the ~~CalOptima~~CalOptima Health Board of Directors to advise the Board on issues impacting the ~~CalOptima~~CalOptima Health provider community. The PAC members represent the broad provider community that serves ~~CalOptima~~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 HCA, which maintains a standing seat. PAC ~~meets monthly and is~~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
- HCA (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 (seven 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 age 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 (four seats)
 - Community-based organizations; or
 - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC ~~meets bimonthly, and quarterly~~ meetings are open to the public.

~~Role of CalOptima Health Officers' Role for in~~ the Quality Improvement Program

~~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 (c). On-going monitoring is performed to ensure that no medical director is listed on state or federal exclusion or preclusion lists.~~

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 QI Committee (QIC) satisfies all remaining requirements of the QI 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 Customer Service, Information Technology Services, Enterprise Project Management Office Implementation, Process Excellence, 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 of the QI Program and supports efforts so that the QI Program

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

~~**Chief Information Officer** (CIO) provides oversight of CalOptima 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 agency's risk exposure.~~

~~**Chief Operating Officer** (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Program Implementation, Process Excellence, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, and Coding Initiatives.~~

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 ~~ED-CCO~~ serves as the State Liaison and is responsible for legislative advocacy. Also, the ~~ED-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 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. ~~The CHRO~~ 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's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

~~**Chief Medical Officer** (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima CalOptima Health's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI Program and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.~~

Deputy Chief Medical Officer* (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to ~~CalOptima CalOptima Health~~'s medical care delivery system. The DCMO collaborates with ~~directors~~ Directors and ~~medical~~ Medical Directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, ~~Case~~ Care Management, Population Health Management, 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 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 agency’s risk exposure.](#)

Medical Director* (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The ~~medical-Medical director~~ Director provides direction and support to ~~CalOptimaCalOptima Health’s~~ Quality and Population Health Management teams to ensure QI Program objectives are met. ~~The medical director is also the physician designee who chairs the Credentialing Peer Review Committee (CPRC).~~

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

Executive Director, Quality & Population Health Management (ED Q&PHMI) 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&PHM 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&PHM are the ~~directors-Directors~~ of Quality Analytics, Quality Improvement, and ~~Population Health Management~~Credentialing.

[Executive Director, Population Health Management \(ED PHM\) is responsible for the development and implementation of companywide Population Health ManagementPHM 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 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. The Director of Population Health Management reports to the ED PHM. ~~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 Q&PHM serves as a member of the executive team, 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 Q&PHM are the directors of Quality Analytics, Quality Improvement and Population Health Management.~~](#)

Executive Director, Behavioral Health ~~Integration Initiative~~Integration (ED BHI) is responsible for oversight of ~~CalOptimaCalOptima 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, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex ~~Case~~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 and ED ~~Q&PHM~~, makes certain that Medical Affairs is aligned with ~~CalOptima~~CalOptima Health's strategic and operational priorities.

Executive Director, ~~Program Implementation~~Medicare Programs (ED ~~PI~~MP) is responsible for ~~maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED PI is the director of Process Excellence.~~ strategic and operational oversight of Medicare programs including OneCare and PACE.

~~**Executive Director, Public Affairs (ED PA)** is responsible for CalOptimaCalOptima Health's Communications, Government Affairs, Community Relations and Strategic Development departments. ED PA is charged with assisting the CEO in carrying out organizational goals, including overseeing the development of the CalOptimaCalOptima Health Strategic Plan and implementation of communications strategies to highlight CalOptimaCalOptima Health programs and priorities. Under ED PA's leadership, the Public Affairs team members collaborate on efforts that support the CalOptimaCalOptima Health mission and reach internal and external audiences, ranging from employees and members to government officials and the media. Reporting to ED PA are the directors of both Communications and Strategic Development.~~

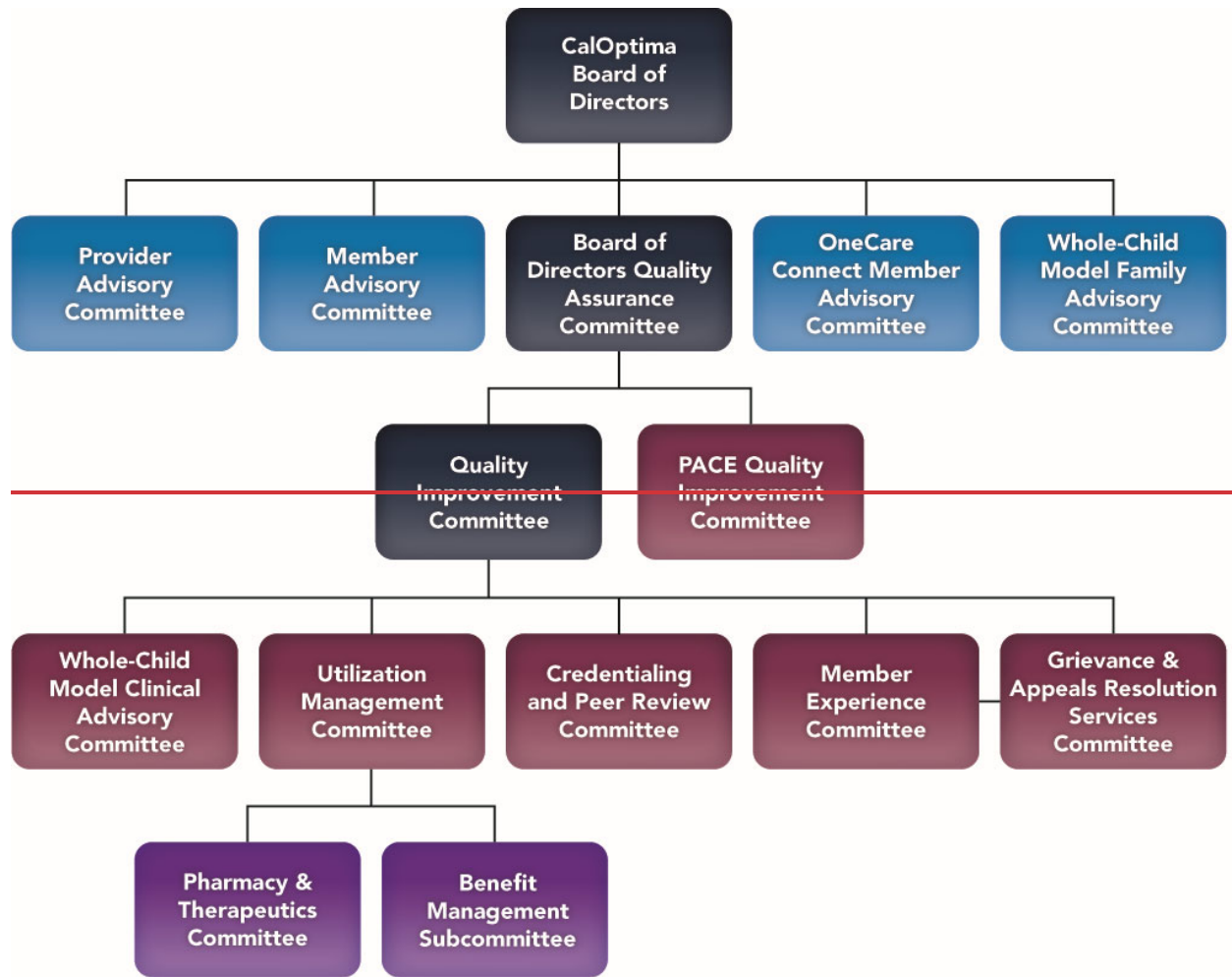
~~**Executive Director, Compliance (ED C)** is responsible for monitoring and driving interventions so that CalOptimaCalOptima Health and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration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

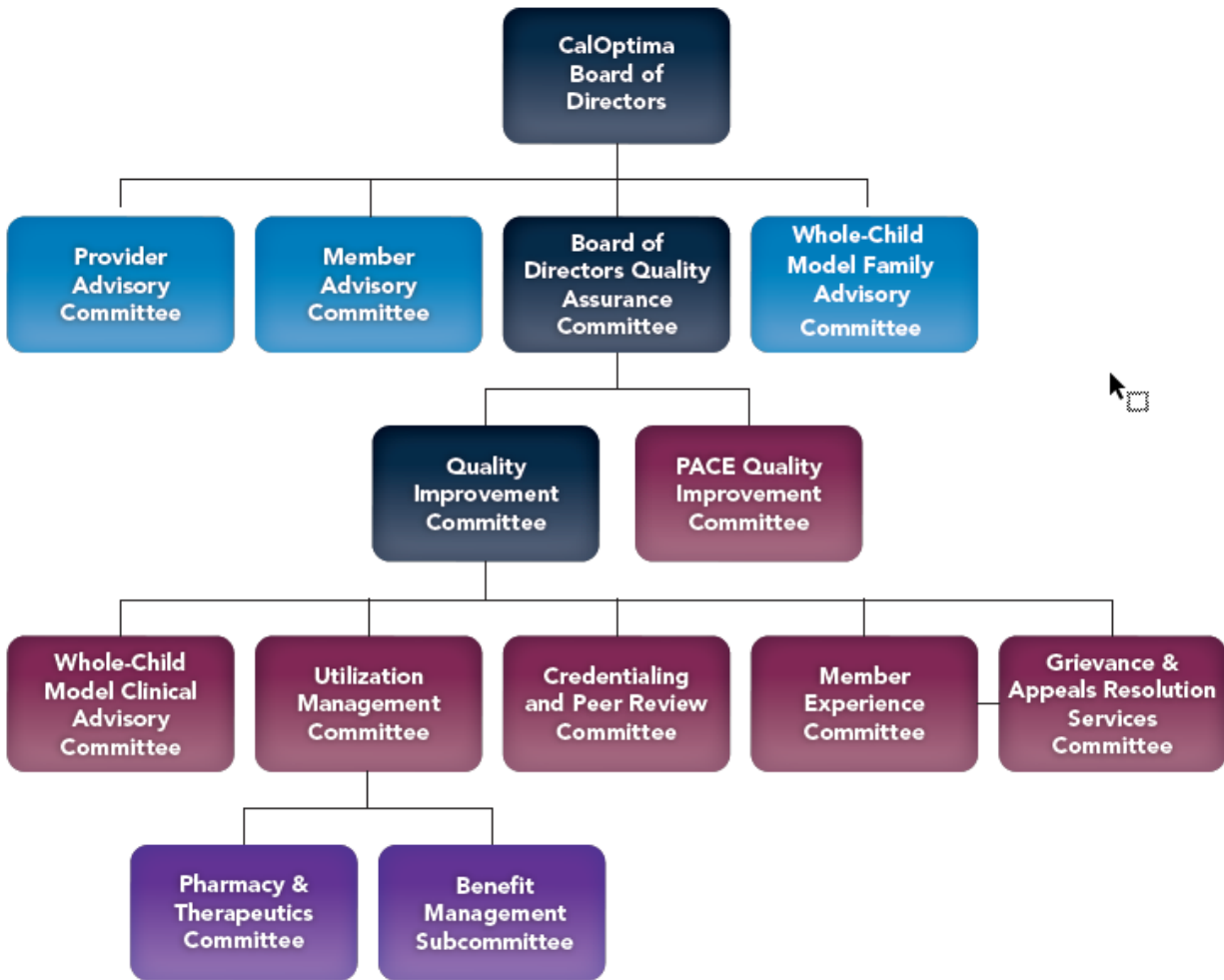
Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the HNs and coordinates organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve ~~CalOptima~~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 (c). ~~On-going~~Ongoing monitoring is performed to ensure that no ~~medical~~Medical ~~director~~Director is listed on state or federal exclusion or preclusion lists.~~

Committee Organization Structure – Diagram





Quality Improvement Committees and Subcommittees

Quality Improvement Committee (QIC)

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

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

The composition of the QIC includes participating 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, [easecare](#) review as needed, and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with ~~CalOptima~~[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 QI Projects, activities and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored and reported through the QIC.

Responsibilities of the QIC ~~Committee~~ include:

- Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives.;
- Overseeing the analysis and evaluation of QI activities.;
- Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI Program activities.;
- Identifying and prioritizing needed actions and interventions to improve quality.;
- Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions.;
- Monitoring overall quality compliance for the organization to quickly resolve deficiencies that affect members.

Practice patterns of providers, practitioners and delegated HNs are evaluated, such as UM over/under utilization in collaboration with ~~applied behavioral analysis~~[Applied Behavior Analysis](#) utilization. Recommendations are made to promote practices so that all members receive medical and behavioral health care that meets ~~CalOptima~~[CalOptima Health](#) standards.

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

The QIC also recommends strategies for dissemination of all study results to ~~CalOptima~~[CalOptima Health](#)-contracted providers and practitioners, and delegated HNs.

~~The QI Program adopts the classic Continuous Quality Improvement cycle with four basic steps:~~

- ~~Plan~~ — ~~Goals with detailed description of an implementation plan~~
- ~~Do~~ — ~~Implementation of the plan~~
- ~~Study~~ — ~~Data collection~~
- ~~Act~~ — ~~Analyze data and develop conclusions~~

The composition of the QIC is defined in the QIC ~~Charter~~[charter](#) and includes, ~~but may not be limited~~ 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~~[CalOptima Health](#) Chief Medical Officer (Chair or Designee)
- [CalOptima Health Deputy Chief Medical Officer](#)
- ~~CalOptima~~[CalOptima Health](#) Medical Directors
- [CalOptima Health Quality Improvement Medical Directors](#)
- ~~CalOptima~~[CalOptima Health](#) Behavioral Health Integration Medical Director (or Designee)
- [CalOptima Health](#) Executive Director, ~~Quality & Population Health Management~~
- [CalOptima Health](#) Executive Director, ~~Population Health Management~~
- ~~CalOptima Health~~
- Executive Director, ~~Clinical Operations~~
- [CalOptima Health](#) Executive Director, ~~Network Management~~
- [CalOptima Health](#) Executive Director, ~~Operations~~

The QIC is supported by [CalOptima Health departments including but not limited to the following](#):

- ~~Director, Quality Improvement~~
- ~~Director, Quality Analytics~~
- ~~Director, Population Health Management~~
- ~~Director, Behavioral Health Integration~~
- [CaseCare Management](#)
- ~~Long-Term Care~~[Services and Supports](#)
- [Population Health Management](#)
- [Quality Analytics](#)
- [Quality Improvement](#)
- [Utilization Management](#)
- ~~Committee Recorder as assigned~~

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, ~~or~~ participation by telephone [or participation by video conference](#).

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

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

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

- Goals and objectives outlined in the QIC ~~C~~ charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate ~~Quality Management/Improvement~~ QI information to network providers and practitioners
- Tracking of QI Work ~~P~~-Plan activities

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

The QIC provides to the QAC quarterly written progress reports of the QIC that describes actions taken, process in meetings QI Program objectives, and improvements made.

Credentialing and Peer Review Committee (CPRC)

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

The CPRC reviews, investigates and evaluates the credentials of all ~~CalOptima~~ 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~~ CalOptima Health's contracted providers, delegated HNs and OPs to ensure member safety aiming for zero defects. The CPRC, chaired by the ~~CalOptima~~ CalOptima Health CMO or physician designee, consists of CalOptima Health Medical Directors and representation of active physician representativess from CCN and HNs. Physician participants represent a range of practitioners and specialties from ~~CalOptima~~ CalOptima Health's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The 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, ~~behavioral health~~^{BH} and LTSS services for CCN and ~~through the~~ 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 agency standards. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a behavioral health practitioner*) and the quorum requirements of the UMC are defined in its charter.

* Behavioral Health practitioner is defined as ~~M~~^{medical} ~~D~~^{irector}, 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~~^{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~~^{CalOptima Health's} members. The P&T includes practicing physicians (including both ~~CalOptima~~^{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 plan 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~~^{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~~^{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, ~~but is not limited to~~, analyzing regulations and guidance that impacts the benefit

sets and [CalOptima 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 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 QIC. 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 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 ~~for Medi-Cal, OC and OCC~~. 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 ~~is designed to assess~~ assesses information and data directly from members, which include the annual results of [CalOptima CalOptima Health](#)'s Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and member complaints, grievances, and appeals. Then MEMX and identifies opportunities and 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, including access and availability; reviewing customer service metrics, and evaluating complaints, grievances, appeals, authorizations and referrals for "pain points" in health care that impact our members at the plan and HN level (including CCN), where appropriate. In 2023, the MEMX committee, which includes the Access and Availability workgroups 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 the MY 2022 and MY 2023 CAHPS survey results and meet regulatory requirements related to access.

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 CalOptima Health](#) are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS Committee serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all [CalOptima 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 QIC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Confidentiality

~~CalOptima~~CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all ~~CalOptima~~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 QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a confidentiality agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the state contract.

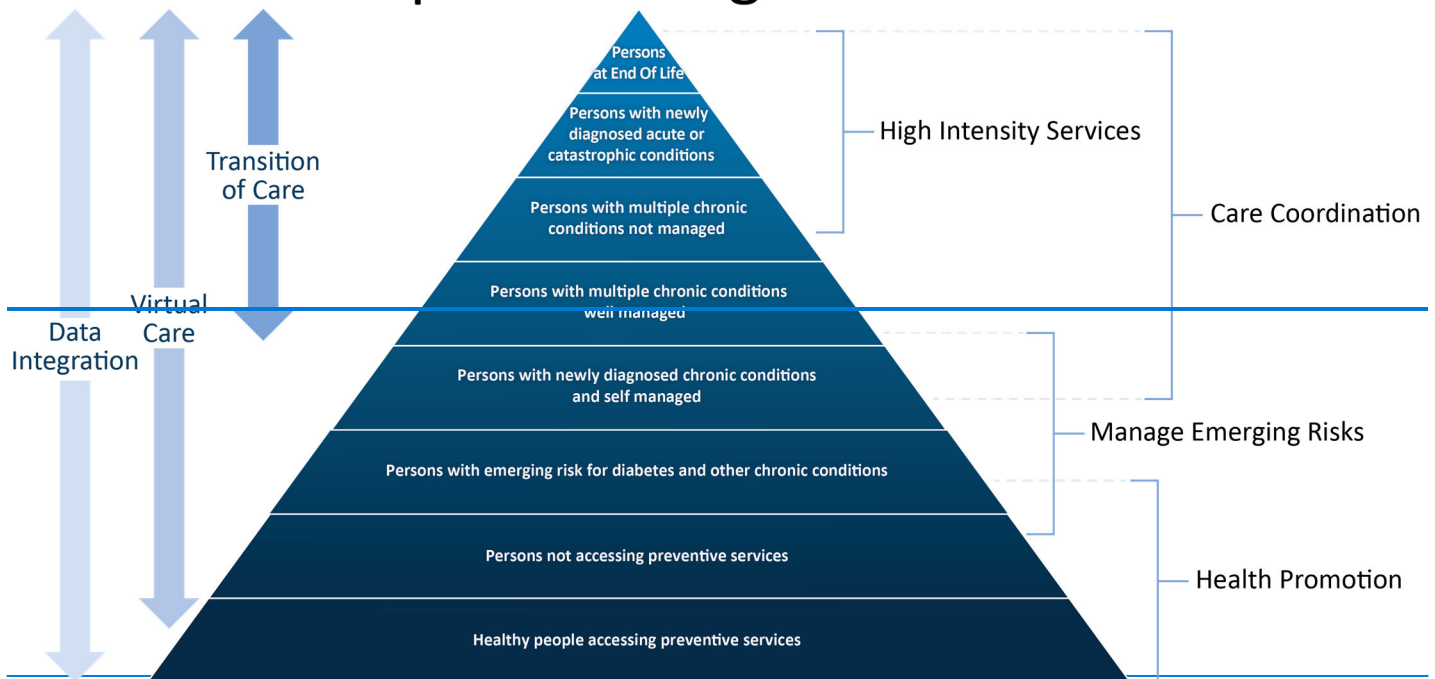
Conflict of Interest

~~CalOptima~~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~~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 QI/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.

Quality Improvement Strategic Goals

~~The QI Program and structure provides operational support and oversight to a member-centric Population Health Management (PHM) approach, by stratifying the population based on their health needs, conditions and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima~~CalOptima Health's existing innovative Model of Care (MOC), the 2022 QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.

Population Segments



~~CalOptima Health's MOC recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is effective in managing the health care needs of high-risk members one by one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.~~

2022-2023 QI Goals and Objectives

~~CalOptima Health's QI Goals and Objectives are aligned with CalOptima Health's 2022-23-25 Strategic Goals.~~

- 1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational, and community levels.
- ~~2) Ensure member's safety during COVID-19 pandemic by aiming for 80% COVID-19 vaccine rate or community immunity~~
- ~~3) Improve quality of care and member experience by maintaining-attaining an NCQA Health Plan Rating of 54.0, and at least a Three-Four-Star Rating for Medicare.~~
- ~~2)~~
- ~~4) Engage providers through the provision of new Pay for Value (P4V) programs for Medi-Cal, and the new OneCare, and Hospital Quality, e programs through incentivize measures related to our STAR rating~~
- ~~3)~~

These top ~~three~~^{four} priority goals were chosen to be aligned with ~~CalOptima~~^{CalOptima Health}'s strategic objectives, ~~the pandemic~~, as well as continued goals related to access to care and NCQA accreditation. -The ~~2022-2023~~ QI Work ~~P~~^Plan details the ~~planned activities to meet the COVID-19 vaccine aim, which include~~ strategies for ~~childhood, COVID-19 and other~~ immunizations, ~~including~~ ~~n~~, targeted communication and ~~a~~ member incentives. The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). All goals and sub-goals will be measured and monitored in the QI Work ~~P~~^Plan, reported to QIC quarterly and evaluated annually.

~~QI Measurable Goals for the Model of Care~~

~~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 OC and OCC. 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.~~

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and the Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. A QI 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 QI Work Plan is the operational and functional component of the QI Program and is based on ~~CalOptima~~[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 QI Program guides the development and implementation of an annual QI Work Plan, which includes, but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program 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 QI Program

Priorities for QI activities based on ~~CalOptima~~[CalOptima Health](#)'s organizational needs and specific needs of ~~CalOptima~~[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~~[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 QI Work Plan. ~~Additional COVID-19 focused initiatives are integrated into the 2022 QI Work Plan.~~

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

See Appendix A — 202~~32~~ QI Work Plan

[Quality Improvement Projects Methodology](#)

QI Project Selections and Focus Areas

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

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to:
 - ~~(a) P~~potential quality issue (PQI) review processes
 - ~~(b) P~~provider and facility reviews;
 - ~~(e) P~~preventive care audits
 - ~~A, (d)~~access to care studies
 - ~~M, (e)~~member experience surveys
 - ~~(f)~~HEDIS results
 - Other opportunities for improvement as identified by subcommittee's data analysis
 - ~~and (g) other opportunities for improvement as identified by subcommittee's data analysis~~
- Measures required by regulators, such as DHCS and CMS:

The QI Project methodology described below will be used to continuously review, evaluate and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, 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 Seniors and Persons with Disabilities (SPD)
- Provisions of chronic, complex [easecare](#) management and [easecare](#) 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, QIC, UMC, etc., based upon the scope of work and impact of the effort.
- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QI Project Measurement Methodology

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

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~~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.

~~CalOptima~~CalOptima Health also uses a variety of QI methodologies depending on the type of opportunity for improvement identified. 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 many include enhanced monitoring and/or re-measurement activities.

Types of QI 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 QIC

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

Improvement Standards

A. Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality 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 QI Projects

Documentation of all aspects of each QI 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](#)

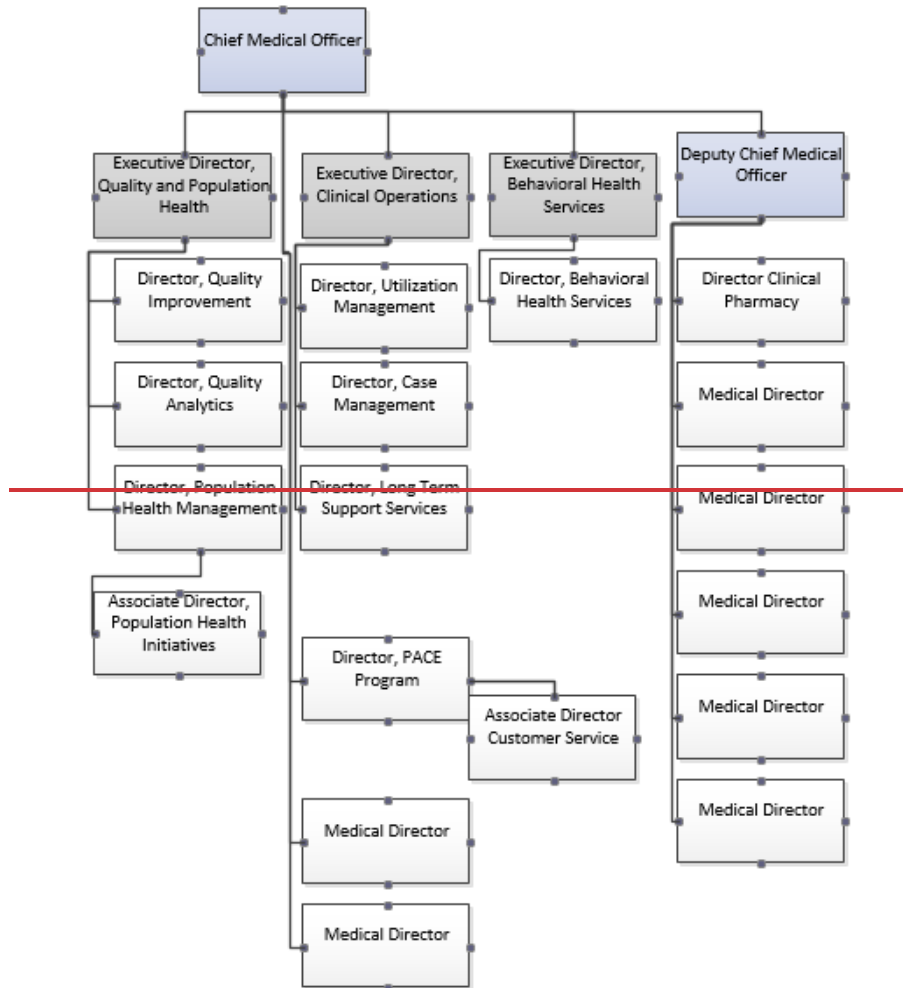
Communication of QI Activities

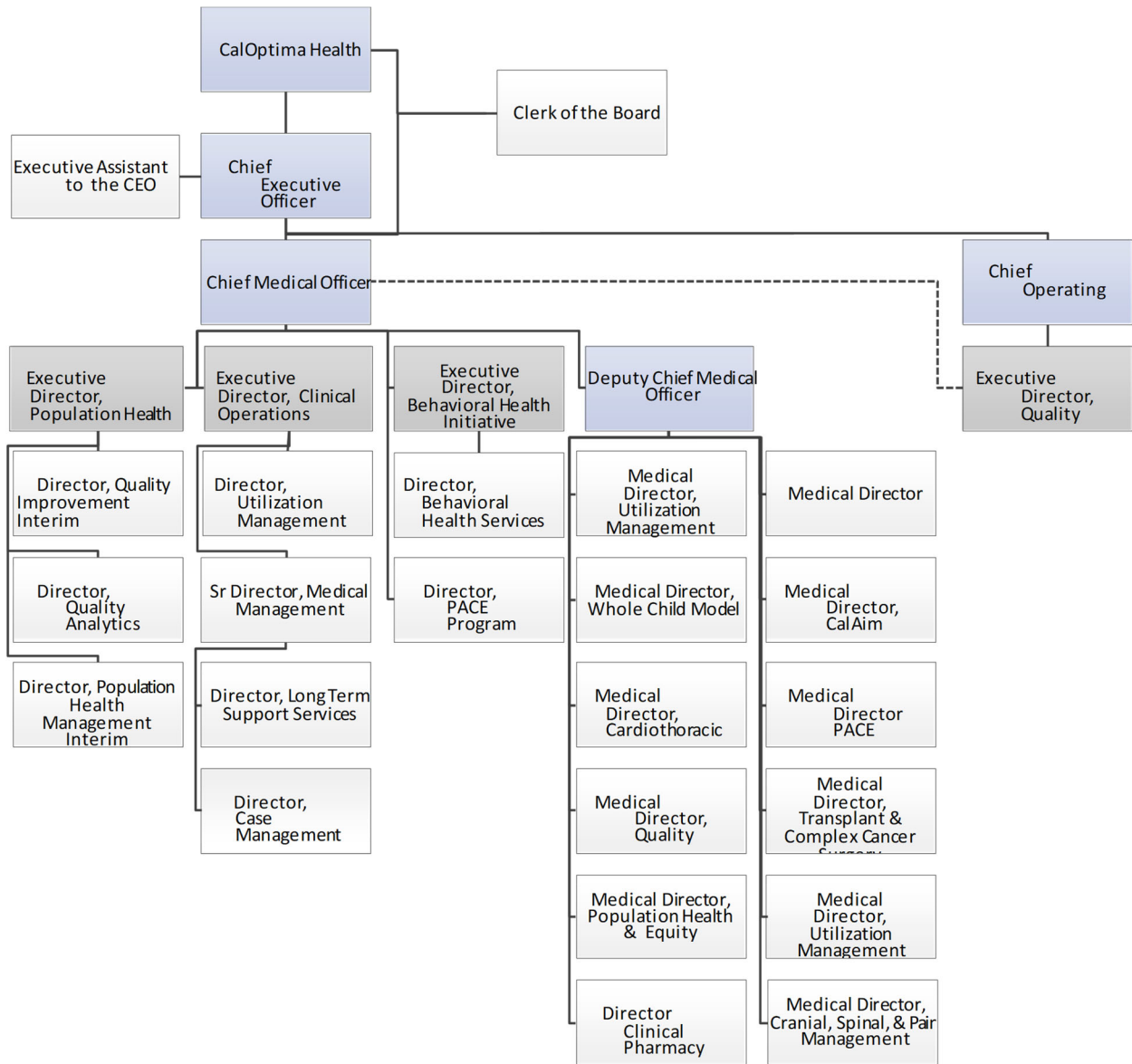
Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QI Work Plan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

- Practitioner participation in the QIC and its subcommittees
- HN Forums, ~~medical~~ [Medical Directors' Meetings](#), Quality Forums and other ongoing ad hoc meetings
- MAC, ~~OCC MAC, WCM FAC and PAC~~ [PAC and WCM FAC](#)

Quality Program Organization Structure Diagram

As of February 2023





Quality Improvement Program Resources

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

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

In addition to ~~CalOptima~~CalOptima Health's CMO, ~~ED of Quality~~Q and ~~ED of~~ and ~~ED,~~ Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement

Responsibilities include assigned day-to-day operations of the Quality Management functions, including credentialing, ~~FSRs~~facility site reviews (FSRs), physical accessibility compliance and working with the ED ~~of,~~Quality&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

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 (PQI)
- ~~___~~ Supervisor, Quality Improvement (~~Nursing Facilities~~)(CBAS) (FSR, ~~CR~~)
- ~~___~~ Supervisor, Quality Improvement (PARS)
- ~~___~~ Supervisor, Quality Improvement (Credentialing)
- QI Nurse Specialists (RN) (LVN)
- ~~___~~ Program Policy Analyst
- ~~___~~ Project Manager
- ~~___~~ Program Manager
- Credentialing Coordinators
- ~~___~~ Program Specialists
- ~~___~~ (including Intermediate and Senior)
- Program Assistants
- Outreach Specialists
- Auditor, ~~___~~ Credentialings

Director, Quality Analytics

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

The following positions report to the Director, Quality Analytics:

- Manager, Quality Analytics (HEDIS)
- Manager, Quality Analytics (~~Pay for Value~~P4V)
- Manager, Quality Analytics (Network Adequacy)
- Manager, Quality Analytics (Data Analytics)
- Data Analysts
- Project Managers
- Program Coordinators
- Program Specialists
- Quality Analyst
- Program Assistant

Director, Population Health Management

Provides direction for program development and implementation for agencywide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with CaseCare Management, UM, Pharmacy Management and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC Model of Care implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

The following positions report to the Director, Population Health Management:

- ~~Associate Director, Population Health Initiatives~~
- ~~Population Health Management Manager (Quality Initiatives)~~
- Population Health Management Manager (Clinical Operations)
- Population Health Management Manager (Health Education)
- Population Health Management Manager (Maternal Health)
- Population Health Management Supervisors
- Program Managers
- Health Coaches
- Registered Dieticians
- Senior Health Educators
- Health Educators
- Quality Analysts
- Program Specialists
- Program Assistants

Director, Behavioral Health Integration

Provides 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 CalOptima Health members across all lines of business. The director is responsible for the management and strategic direction of the Behavioral Health Integration 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

Assists in 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 QIC and the BMSC.

Director, Clinical Pharmacy Management

Leads 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 [easecarescases](#) 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, [CaseCare](#) Management

Responsible for [CaseCare](#) Management, Transitions of Care, Complex [CaseCare](#) Management and the clinical operations of Medi-Cal, [OCC](#) and [OCCOneCare](#). 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.

[Add: Director, Credentialing](#)

Staff Orientation, Training and Education

[CalOptimaCalOptima 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:

- [CalOptimaCalOptima Health](#) New Employee Orientation and Boot Camp ([CalOptimaCalOptima Health](#) programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training

- Use of technical equipment (phones, computers, printers, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency, ~~Reducing Bias~~ and ~~Promoting Inclusion~~ Training
- ~~and~~ Trauma-Informed Care training

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

~~CalOptima~~ 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~~ CalOptima Health. Each year, a specific budget is set for education reimbursement for employees.

Annual Program Evaluation

The objectives, scope, organization and effectiveness of ~~CalOptima~~ CalOptima Health's QI Program are reviewed and evaluated annually by the QIC and QAC, and approved by the Board of Directors, as reflected in the QI 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 QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

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

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

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

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the ~~CalOptima~~ 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 aspects 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
- Preventive care, including:
 - Initial Health ~~Assessment~~ Appointment
 - ~~Initial Health Education~~
 - Behavioral Assessment
- Diagnosis, care and treatment of acute and chronic conditions
- ~~Complex eCase management~~ including complex care management: For members with multiple and/or complex conditions to obtain access to care and services via the UM and Case Management departments
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management
- Member experience
- Patient safety

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics

- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- ~~Customer satisfaction~~
- Fraud and abuse* as it relates to quality of care

* ~~CalOptima~~ 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~~ CalOptima Health program.

Quality of Clinical Care ~~QUALITY OF CLINICAL CARE~~

Quality Improvement

The QI department is responsible for monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services. ~~The department~~ The department ensures that care and services are rendered appropriately and safely to all ~~CalOptima~~ 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 agencywide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain agencywide practices that support accreditation and meet regulatory requirements

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical ~~staff~~ Directors triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care ~~ease~~ care ~~cases~~ are reviewed by a ~~medical~~ Medical Director who determines a proposed action, dependent on the severity of the ~~ease~~ care ~~case~~. The ~~medical~~ Medical Director presents these ~~ease~~ care ~~cases~~ to CPRC, which provides the final action(s). As ~~ease~~ care ~~cases~~ are presented to CPRC, the discussion of the ~~ease~~ care includes appropriate action and leveling of the ~~ease~~ care, which results in committee-wide inter-rated reliability process. The QI department tracks, monitors and trends PQI ~~ease~~ care ~~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 ~~ease~~ care ~~case~~ referrals are sent to the QI department from multiple areas at ~~CalOptima~~ CalOptima Health, which include, but are not limited to, ~~P~~ prior authorization Authorization, ~~e~~ concurrent Concurrent review Review, ~~ease~~ Care management Management, ~~legal~~ Legal, ~~e~~ compliance Compliance, ~~e~~ customer Customer service Service, ~~pharmacy~~ 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 Grievance and Appeals Department GARS to assist the staff on the identification of potential quality issues. -Potential quality of care grievances are reviewed by a ~~m~~ Medical Director with clinical feedback provided to the member. -Declined grievances captured by the Customer Service ~~D~~ department are similarly reviewed by a ~~m~~ Medical Director.

Comprehensive Credentialing Program Standards

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~~ CalOptima Health contracted delivery system.

Practitioners are credentialed and recredentialled 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 ~~behavioral health~~ 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~~ CalOptima Health direct environments. Credentialing and recredentialing activities for CCN are performed at ~~CalOptima~~ CalOptima Health and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

~~CalOptima~~ CalOptima Health performs credentialing and recredentialing of ~~OPs~~ 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.

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~~ [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 Survey

~~CalOptima~~ [CalOptima Health](#) does not delegate PCP site and medical records review to contracted HMOs, PHCs and SRGs, with the exception of Kaiser Permanente. ~~CalOptima does, however, delegate this function to designated health plans~~ in accordance with standards set forth by APL ~~20-006~~ [22-017](#). ~~CalOptima~~ [CalOptima Health](#) assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. ~~CalOptima~~ [CalOptima Health](#) retains coordination, maintenance and oversight of the FSR/MRR process. ~~CalOptima~~ [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~~ [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 20-006 and ~~CalOptima~~ [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~~ [CalOptima Health](#) may review sites more frequently per local collaborative decisions or when deemed necessary based on monitoring, evaluation or ~~corrective action plan (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 room
- Exam table/scale

Medical Record Documentation Standards

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 Audit & 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 QIC. 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~~Medical ~~director~~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.

Quality Analytics

The Quality Analytics (QA) department fully aligns with the QI and PHM 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~~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 ~~compared to~~ evaluate goals, establish trends, and identify root cause
- 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 QI Program, 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

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

- Claims [information/activity data](#)
- Encounter data
- Utilization data
- Case management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings data
- Population Needs Assessment
- HEDIS [performance results](#)
- Member and provider satisfaction surveys

By analyzing data that [CalOptima 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 CalOptima Health](#) and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Population Health Management

[CalOptima CalOptima Health](#) strives to provide integrated physical health, behavioral health, LTSS, care coordination and complex [easecare](#) management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. [CalOptima CalOptima Health](#)'s PHM strategy outlines programs that will focus on four key strategies:

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

This is achieved through functions described below in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

[CalOptima CalOptima Health](#) developed a comprehensive PHM Strategy that includes a plan of action for addressing our culturally diverse member needs across the continuum of care. [CalOptima CalOptima Health](#)'s PHM Strategy aims to ensure the care and services provided to members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner.

The PHM Strategy is based on numerous efforts to assess the health and well-being of [CalOptima CalOptima Health](#) members. Additionally, [CalOptima CalOptima Health](#)'s annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Plans) will aid the PHM Strategy further in identifying member health status and behaviors, member health

education and cultural and linguistic needs, health disparities and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual and environmental stressors, to improve health outcomes. ~~CalOptima~~ 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 that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs and CCIPs. Quality Initiatives for 2022 are tracked in the QI Work Plan and reported to the QIC.

~~In 2023, the PHM Strategy will include greater focus on addressing health inequities and SDOH. The COVID-19 pandemic brought worldwide attention to health disparities and inequity. PHM identified opportunities to expand outreach and initiate new initiatives focused on SDOH and health equity as follows:~~

- ~~• Back to school immunization clinics for school-aged children (Tdap, COVID-19 vaccine, etc.)~~
- ~~• COVID-19 Member Health Rewards for CalOptima members, with special focus on those experiencing homelessness~~
- ~~• Improving COVID-19 vaccine access for homebound members and other high-risk populations~~
- ~~• Mobile diaper banks for families of infants and adolescent members in collaboration with Women, Infants & Children (WIC) and the Community Action Partnership~~
- ~~• Improving access for eligible CalOptima members to CalFresh benefits~~
- ~~• Improving access to breast cancer screenings for Korean and Chinese members via mobile mammography~~
- ~~• Remote monitoring for members with chronic conditions~~
- ~~• Escape The Vape (Great American Smoke Out) annual event that offers vape and tobacco prevention to school-aged children~~
- ~~• Shape Your Life Childhood Obesity Program, with group classes to improve awareness of good nutrition and physical fitness for adolescents~~

~~Member Health Needs Assessment~~ In 2023, the PHM Strategy will continue to focus on addressing health inequities and meeting member's social needs. The COVID-19 pandemic brought worldwide attention to health disparities and inequity. PHM identified opportunities to expand outreach and initiate new initiatives focused on advancing health equity as follows:

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- 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 Orange County's Equity in OC Initiative.
- Implementing new Medi-Cal benefits that cover doula and community health worker services.
- Resuming in-person group health education classes in the community to promote healthy eating and active living.
- Implementing a multidisciplinary diabetes program and initiating additional interventions for gestational diabetes and chronic kidney disease.

- Launching the Comprehensive Cancer Screening & Support program to create an ethos of cancer screening across Orange County.

•

~~The PHM team also focuses on improvement projects, such as 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, as part of the PHM program. Interventions for each project must:~~

~~Be clearly defined and outlined~~

~~Have specific objectives and timelines~~

~~Specify responsible departments and individuals~~

~~Be evaluated for effectiveness~~

~~Be tracked by QIC~~

~~For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with~~

~~appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member-specific interventions, such as reminder notices and informational communication, are developed and implemented.~~

~~Improvement Standards~~

~~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.~~

~~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.~~

~~CalOptimaCalOptima Health may choose to continue the project or pursue another topic.~~

~~Documentation of QI Projects~~

~~Documentation of all aspects of each QI 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~~

Health Education and Promotion

~~The PHM department Health Education~~ provides program development and implementation for agencywide 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. They 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.

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 supports [CalOptima 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
- ~~Execution and coordination of programs with Case Management, QA and HN providers~~

Managing Members With Emerging Risk

[CalOptima 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 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 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 [CaseCare](#) Management

[CalOptima 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, 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) ~~or Health Needs Assessment (HNA)~~ for [MOC OneCare](#), [SPD](#), and [WCM](#) members.

- Multiple avenues for referral to [easecare](#) 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 ~~are relevant to 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.
- Ongoing assessment of outcomes.

~~CalOptima~~ [CalOptima Health](#)'s [CaseCare](#) Management program includes three care management levels that reflect the acuity of needs: complex [easecare](#) management, care coordination and basic [easecare](#) management. Members within defined MOCs — SPD, WCM, ~~CCC~~ 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~~ Medical Director ~~Director~~, specialist(s), easecare manager, behavioral health 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 easecare 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~~ CalOptima Health for CCN members.
 - Team Composition: member, caregiver or authorized representative, HN ~~medical~~ Medical Director, PCP and/or specialist, ambulatory easecare manager, hospitalist, hospital easecare manager and/or discharge planners, HN UM staff, behavioral health BH specialist and social worker
 - Roles and responsibilities of this team:
 - Identification and management of planned transitions
 - Care coordination or complex easecare management
 - CaseCare 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 [easecare](#) 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

MOC:--Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC) /OC and OCC

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 ~~OC-OneCare~~and ~~OCC~~. 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.

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

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

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

- Complex [easecare](#) 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 [easecare](#) 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 ~~at~~ high-risk individuals-
- Hospital [easecare](#) 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.

Seniors and Persons with Disability (SPD)

~~The goal of case 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 case management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima 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 case 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.~~

CalAIM's Enhanced Care Management (ECM)

Effective January 1, 2022, ECM is a whole person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs. These members are among the most vulnerable and highest need Medi-Cal managed care members. ECM reflects a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high touch and person-centered. The goal of ECM is to coordinate all primary, acute, behavioral, developmental, oral, social and long-term needs for members. Eligible members may participate in ECM and/or Community Supports through CalAIM.

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long Term Care:

- CalOptima 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 LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home and Community Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and people with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive home and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

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 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 CalOptima Health](#) provides direct oversight, review and authorization of BHT services.

[CalOptima 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 misuse counseling 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 CalOptima Health](#) members can access mental health services directly, without a physician referral, by contacting the [CalOptima CalOptima Health](#) Behavioral Health Line at 855-877-3885. A [CalOptima 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 [behavioral health BH](#) practitioners within the [CalOptima 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 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 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 CalOptima Health](#) is participating in two of DHCS' incentive programs focused on improving [behavioral health BH](#) care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is designed to improve physical and [behavioral health BH](#) outcomes, care delivery efficiency and member experience. [CalOptima 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 [behavioral health BH](#) services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county [behavioral health BH agencies](#) and [CalOptima 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.

OC OneCare Behavioral Health and OCC

In 2022, OC OneCare and OCC behavioral health BH continues to be fully integrated within CalOptima CalOptima Health internal operations. OC OneCare and OCC members can access mental health services by calling the CalOptima CalOptima Health Behavioral Health Line. Members will be connected to a CalOptima CalOptima Health representative for behavioral health assistance.

CalOptima 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 misuse counseling 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).

Utilization Management

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, and 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 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 2022 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 physician reviewer, 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 2022-2023 UM Program Description.

Safety of Clinical Care~~AFETY OF CLINICAL CARE~~

Patient Safety Program

Member-Patient safety is very important to ~~CalOptima~~CalOptima Health; it aligns with ~~CalOptima~~CalOptima Health's mission statement: *To ~~provide members with access to quality health care services delivered in a cost-effective and compassionate manner~~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.

Member-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. ~~Our member safety endeavors are clearly articulated both internally and externally and include strategic efforts.~~

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~~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

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, ~~Physical Accessibility Review Survey (PARS)~~ and medical record review 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 ~~flu~~-influenza and pneumonia vaccines
 - COVID-19 infection prevention and protective equipment
 - ~~MRSA prevention program—Shared Healthcare Intervention to Eliminate Life-Threatening Dissemination of Multi-drug Resistant Organisms (SHIELD)~~
- Administrative offices
 - Fire, disaster and evacuation plan testing and annual training

Emergency Department Diversion Pilot

In the effort to support hospital partners, members and reduce inappropriate Emergency Department (ED) visits, CalOptima Health implemented an ED Diversion pilot program. The program has been piloted at one hospital. ~~In 2023, it is planned to~~ We plan to expand the program to additional hospital partners in 2023.

The program has ~~the~~ four major goals of:

- Promote communication and member access across all CalOptima Health Networks
- Increase CalAIM Community Supports Referrals
- Increase PCP follow-up visit within 30 days of an ED visit
- Decrease inappropriate ED Utilization
- 4. Decrease inappropriate ED Utilization

This program provides referrals to CalAIM eCommunity sSupports, assists members with appointments to their PCP and specialists, refers members to CaseCare Management, completes Prior Authorizations, and assists the member with transportation and medication issues.

Member Experience

MEMBER EXPERIENCE AND PROVIDER NETWORK

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.

NCQA’s Health Insurance Plan Ratings measure customer satisfaction as one of the three dimensions. :- prevention, treatment and customer satisfaction.

Annually, CalOptima Health performs and assesses the results from member-reported experiences and how well the plan providers are meeting members’ expectation and goals. of the Annually, CalOptima Health² fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both Medi-Cal and dual-eligible Dual-Mmembers. 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 the following:

Monitors its provider network for adequacy as well as access and availability. Review customer service metrics; and, and evaluates complaints, grievances, appeals, authorizations and referrals for “pain points” in health care that impact our members at the plan and HN level (including CCN), where appropriate.

Quality of Service

Access to Care

With the rapid growth in CalOptima Health's ~~M~~membership, access to care is a major area of concern for the plan and hence the organization has dedicated a significant amount of resources to measuring and improving access to care. ~~Marsha...~~

CalOptima Health monitors the following to ensure that members ~~have timely can~~ access to care ~~timely~~:

Availability of Practitioners

- CalOptima Health monitors the availability of PCPs, ~~S~~specialists and Behavioral Health ~~BH~~ Ppractitioners and assesses them against established standards quarterly or when there is a significant change to the network.
- The performance standards are based on ~~S~~state, NCQA, and industry benchmarks.
- CalOptima Health has established quantifiable standards for both the number and geographic distribution of its network of Ppractitioners.
- CalOptima Health uses a geo-mapping application to assess the 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, ~~S~~specialists and Behavioral Health ~~PBH~~ providers and assesses them against established standards at least annually.
- In order to measure performance, CalOptima Health collects appointment access data from Ppractitioner 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 re-measured 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 ~~Member Services~~Customer Service Department on quarterly basis.
- In order 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 re-measured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Cultural & Linguistic Services

As a health care organization in the diverse community of Orange County, ~~CalOptima~~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~~CalOptima Health has developed a 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; and member information materials translated into [CalOptima CalOptima Health](#)'s threshold languages and in alternate formats, such as braille, large-print or audio.

The seven most common languages spoken for all [CalOptima CalOptima Health](#) programs are: English, 59%; Spanish, 26%; Vietnamese, 10%; Farsi, 1%; Korean, 1%; Chinese, less than 1%; and Arabic, less than 1%. [CalOptima CalOptima Health](#) provides member materials as follows:

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

[CalOptima CalOptima Health](#) 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 Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the 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.
- Providing information, training and tools to staff and practitioners to support culturally competent communication

Delegated And Non-Delegated Activities

~~CalOptima~~CalOptima Health has an annual and continuing monitoring process for delegation oversight to ensure compliance with statutory, regulatory, and accreditation requirements. ~~and compliance to the CalOptima Quality program to ensure continuous improvement of the contracted delegate delegates certain functions and/or processes to delegated HNs that are required to meet all contractual, statutory and regulatory requirements, as well as accreditation standards, CalOptima policies and other guidelines applicable to the delegated functions.~~

Delegation Oversight

Participating entities are required to meet ~~CalOptima~~CalOptima Health's QI standards and to participate in ~~CalOptima~~CalOptima Health's QI Program. ~~CalOptima~~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 Audit & 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 ~~sa-s~~ systems to audit and monitor HMO, PHC, SRG, VSP, and PMG delegated entities' internal operations on a regular basis.

Delegation Oversight Performance Monitoring includes, but is not limited to the following:

- Quality Improvement (QI) – Kaiser only, CaseCare Management (CM), Network Management (NET), Credentialing (CR), Utilization Management (UM), Member Experience (ME), Claims, Third Party Liability (TPL), Medicaid Module (MED) and Second Opinion.

Non-Delegated Activities

The following activities are not delegated to CalOptima Health's contracted HNs with the exception of Kaiser Permanente, and remain the responsibility of ~~CalOptima~~CalOptima Health:

- QI, as delineated in the Contract for Health Care Services
- QI Program for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- Behavioral Health BH for Medi-Cal and, OCOneCare and OCC

- 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 [easescases](#)
- ~~Potential Quality Issue~~[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 credentialing and recredentialing standards for both practitioners and OPs~~
- ~~Credentialing and recredentialing of OPs~~
- Development of UM and [CaseCare](#) Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

~~Further details of the delegated and non-delegated activities can be found in the 2022 Delegation Grid~~

~~See Appendix B – 2022 2023 Delegation Grid~~

~~In Summary~~

~~As stated previously, CalOptima CalOptima Health cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders to provide quality health care to members. Together, we can be innovative in developing~~

~~solutions that meet our diverse members' health care needs. We are truly "Better. Together."~~

Appendix A — ~~2022~~ 2023 QI Work Plan

2023 Quality Improvement Work Plan

I. PROGRAM OVERSIGHT

- A. 2023 QI Annual Oversight of Program and Work Plan
- B. 2022 QI Program Evaluation
- C. 2023 UM Program
- D. 2022 UM Program Evaluation
- E. Population Health Management Strategy
- F. Credentialing Peer Review Committee (CPRC) Oversight
- G. Grievance and Appeals Resolution Services (GARS) Committee
- H. Member Experience (MEMX) Committee Oversight
- I. Utilization Management Committee (UMC) Oversight
- J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
- K. Managed Care Accountability Set (MCAS)
- L. Health Network Quality Rating
- M. OneCare Performance measures
- N. Improvement Projects PIP
- O. Improvement Projects PIP (BH)
- P. Improvement Projects OneCare CCIP's
- Q. PPME/QIPE: HRA's
- R. CalAIM
- S. Health Equity
- T. NCQA Accreditation
- U. Student Behavioral Health Incentive Program (SBHIP)

II. QUALITY OF CLINICAL CARE- Adult Wellness

- A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
- B. CalOptima Health Comprehensive Community Cancer Screening Program
- C. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

- A. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.
- B. Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)(Medicaid only)
- C. Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- D. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- E. Depression Remission or Response for Adolescents and Adults (DRR-E)
- F. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

- A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)
- B. Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)
- C. Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot
- D. STARs Measures Improvement

V. QUALITY OF CLINICAL CARE- Maternal Child Health

- A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

- A. MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs
- B. Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA
- C. Blood Lead Screening DHCS APL

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC: _____ Date: _____
Submitted and approved by QAC: _____ Date: _____

Quality Improvement Committee Chairperson:

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

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. Date: _____

2023 Quality Improvement Work Plan

VII. QUALITY OF SERVICE- Access

- A. Improve Network Adequacy: Reducing gaps in provider network
- B. Improve Access: Timely Access (Appointment Availability)
- C. Improve Access: Telephone Access
- D. Improve Access: Access Dashboard
- E. Improving Access: Subcontracted Network Certification
- F. Increase primary care utilization

VIII. QUALITY OF SERVICE- Member Experience

- A. STARs Measures Improvement
- B. Improve Member Experience/CAHPS

IX. SAFETY OF CLINICAL CARE

- A. Emergency Department Diversion Pilot
- B. Plan All-Cause Readmissions (PCR)

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Attention Green - On Target
I. PROGRAM OVERSIGHT										
2023 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Quality Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by April 2023	Marsha Choo	QIC		X			
2022 Quality Improvement Program Evaluation	Complete Evaluation 2022 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by January 2023	Marsha Choo	QIC		X			
2023 Utilization Management Program	Obtain Board Approval of 2023 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	QIC		X			
2022 Utilization Management Program Evaluation	Complete Evaluation of 2022 UM Program	UM Program will be evaluated for effectiveness on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	QIC		X			
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption Feb 2023	Katie Balderas	QIC		X			
CalAIM	Improve Health & Access to care for enrolled members	1) Launch ECM Academy; a pilot program to bring on new ECM providers. 2) Increase CalOptima Health's capacity to provide community supports through continued expansion of provider network. 3) Continue to increase utilization of benefits. 4) Establish oversight strategy for the CalAIM program. 5) Implement Street Medicine Program 6) Select and fund HHIP projects through Notice of Funding Opportunity. 7) Design and launch the Shelter Clinic Partnership Program (HCAP 2.0)	1) 1Q 2023 2) 4Q 2023 3) 4Q 2023 4) 3Q 2023 5) 1Q, 2Q 2023 6) 1Q 2023 7) 3Q 2023	Mia Arias	QIC	SDOH	X			
Health Equity	Increase member screening and access to resources that support the social determinants of health	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 project	1) 4Q 2022 2) 4Q 2022 3) 3Q 2022	Katie Balderas	QIC	Health Equity	x			
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Laura Guest	QIC		X			
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health networks. Trends and results are presented to the committee quarterly.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Tyronda Moses	QIC		X			

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Attention Green - On Target
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2023 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & 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.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Marsha Choo	QIC		X			
Utilization Management Committee (UMC) Oversight Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	1Q23 update (4/11 QIC) 2Q23 update (7/11 QIC) 3Q23 update (10/10 QIC) 4Q23 update (Jan 2024 QIC)	Kelly Giardina	Utilization Management/ QIC		X			
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.		Meet quarterly to provide clinical and behavioral service advice regarding Whole Child Model operations 2023 Meeting Schedules WCM CAC Q1: 2/21 WCM CAC Q2: May 16, 2023 WCM CAC Q3: August 15, 2023 WCM CAC Q4: November 14, 2023	1Q23 update (4/11 QIC) 2Q23 update (7/11 QIC) 3Q23 update (10/10 QIC) 4Q23 update (Jan 2024 QIC)	T.T. Nguyen, MD	QIC		X			
Health Network Quality Rating	Achieve 4 or above	Will share HN performance on all P4V HEDIS Measures via prospective rates report each month	end of 4Q 2023	Sandeep Mital	QIC					
Improvement Projects OneCare CCIP's	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 Topic TBD	end of 1Q2023	Helen Syn	QIC		X			

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Warning Green - On Target
Improvement Projects Medi-Cal PIP	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025); 1) Clinical PIP - Health Disparity remediation for W30 6+ measure (Jan) Pending January Module Training January 2023 projected. Please note that the focus for the Clinical and Non-Clinical PIP topics is related to DHCS' "50 by 2025: Bold Goals Initiatives". See links for more information on the Bold Goals Initiatives: https://www.dhcs.ca.gov/Documents/Budget-Highlights-Add-Docs/Equity-and-Practice-Transformation-Grants-May-Revise.pdf or https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf	Quarterly Status update on modules as they are completed.	Helen Syn	QIC	Health Equity	X			
Improvement Projects Medi-Cal PIP(BH)	Meet and exceed goals set forth on all improvement projects	Non-Clinical PIP - FUM/FUA 1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	QIC					
Managed Care Accountability Set (MCAS)	Achieve 50th percentile on all MCAS measures in 2021	Share results to Quality Improvement Committee annually	end of 3Q 2023	Paul Jiang	QIC					
OneCare Performance measures	Achieve 4 or above	1) Implement Star Improvement Program 2) Track measures monthly 3) Implement OC Pay4Value	1. 1Q2023 2. 1Q2023 3. 3Q2023	Linda Lee	QIC					
PPME/QIPE: HRA and ICP	3.2 ICP completion 90 days Benchmark 90% adjusted. 2.1 Initial HRA collected in 90 days from eligibility Benchmark: 95% adjusted.	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.	1Q23 (5/9 QIC) 2Q23 (8/8 QIC) 3Q23 (11/14 QIC) 4Q23 (February 2024 QIC)	S. Hickman/D. Hood/M. Dankmyer/H. Kim	QIC		X			

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Attention Green - On Target
NCQA Accreditation	CalOptima Health must have full NCOA Health Plan Accreditation (HPA) and NCOA Health Equity Accreditation by no later than January 1, 2026.	1) Continue to Work with Business owners to collect all required documents for upcoming HP re-accreditation. (Must collect all Year one required documents by 2Q2023. 2) Complete Gap Analysis for Health Equity Accreditation.	1) end of 1Q2023 2) end of 2Q2023	Veronica Gomez	QIC	Health Equity				
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	1) Implement SBHIP DHCS targeted interventions 2. bi-quarterly reporting to DHCS	1.4Q2023 2.4Q2023	Diane Ramos/ Natalie Zavala	QIC	Health Equity				
II. QUALITY OF CLINICAL CARE- Adult Wellness										
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	MY 2023 Goals: CCS: MC 62.53% BCS: MC 61.27% OC 70% COL: OC 71%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	1) Quarterly Updates 2) Per Quality Initiatives Calendar - ongoing updates	Helen Syn	QIC	Health Equity	X			
CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	1) Assess community infrastructure capacity for cancer screening and treatment 2) Establish the the Comprehensive Cancer Screening and Support Program Stakeholder Collaborative (in our Case I want to leverage OC3) 3) Develop comprehensive outreach campaign to outreach to members due for cancer screenings (mobile mammography, outbound calls, community health workers) 4) Integrate new community health worker benefit into cancer outreach and treatment services.	1) 1Q2023 2) 2Q2023 2) 3Q2023 3) 4Q2023	Katie Balderas/ Barbara Kidder	QIC					
COVID-19 Vaccination and Communication Strategy	Increase the rate of first time COVID vaccinated members by #%, and increase the rate of fully boosted vaccinated members to #%	1) Communication Strategy of COVID vaccination incentive program through June 30, 2023 end date, focusing on unvaccinated, and missed booster opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for boosters	1) end of 1Q2023 2) end of 4Q2023	Helen Syn	QIC		X			
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2023 Goal: MC - Init Phase - 42.77% MC -Cont Phase - 51.78%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on provider responsibilities on related to follow-up visits. 3) Continue member outreach (through multiple modalities telephonic, newsletter, mobile device) to improve appointment follow up adherence.	1. 2Q2023 2. 4Q2023 3. 3Q2023	Diane Ramos/ Natalie Zavala	QIC		X			

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Attention Green - On Target
III. QUALITY OF CLINICAL CARE- Behavioral Health										
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2023 Goal: MC 77.48% OC (Medicaid only)	1) Identify members through internal data reports in need of diabetes screening test. 2) Conduct outreach to prescribing provider and/or primary care physician (PCP) to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	1. 2Q2023 2. 3Q2023 3. 2Q2023	Diane Ramos/ Natalie Zavala	QIC					
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS MY2023 Goal: MC 30-Day: 54.51%; 7-day: 31.97% OC (Medicaid only)	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	QIC					
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	MY2023 Goals: MC: 30-days: 21.24%; 7-days: 8.93%	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	QIC					
Depression Remission or Response for Adolescents and Adults (DRR-E)	No benchmark	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 1 educational events on depression screening, treatment, and follow up 3) Educate providers on depression screening via provider newsletters 4) Educate members on depression and the importance of screening and follow-up visits via member newsletters and other social media.	1. 2Q2023 2. 3Q2023 3. 4Q2023 4. 2Q2023	Diane Ramos/ Natalie Zavala	QIC					
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	No benchmark	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 1 educational events on depression screening and treatment 3) Educate providers on depression screening via provider newsletters 4) Educate members on depression and the importance of screening and follow up visits via member newsletters and other social media.	1. 2Q2023 2. 3Q2023 3. 4Q2023 4. 2Q2023	Diane Ramos/ Natalie Zavala	QIC					

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Attention Green - On Target
IV. QUALITY OF CLINICAL CARE- 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)	MY2023 Goals: MC: 30.9%; OC: 17%	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation	Helen Syn	QIC		X			
Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)	MY2023 HEDIS Goals: MC 63.75% OC: 79%;	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures 3) VSP Collaborative gaps in care bridging efforts.	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation 3) End of Q2 2023	Helen Syn	QIC		X			
Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot	1) Lower HbA1c to avoid complications (baseline: A1c ≥ 8%; varies by individual); 2) Improve member and provider satisfaction	<u>Final Pilot Program Design:</u> 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement <u>Planned Activities:</u> Finalize member stratification Outreach to high volume PCPs Launch the pilot program	Finalize member stratification - end of Jan 2023 Outreach to high volume PCPs - end of Q1 Launch the pilot program - end of Q1	Joanne Ku	QIC		X			
STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. Measures include Special Needs Plan (SNP), Care Management, Centers for Disease Control (CDC) and Care for Older Adults (COA)	1) end of 4Q2023	TBD	QIC					
V. QUALITY OF CLINICAL CARE- Maternal Child Health										
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2023 Goal: Postpartum: 84.18% Prenatal: 91.89%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 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	1) Annual Evaluation 2) Per quality initiatives calendar - ongoing updates 3) Ongoing updates 4) 4Q2023 5) 3Q2023	Ann Mino/ Helen Syn	QIC	Health Equity	X			

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Attention Green - On Target
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs	Meet and exceed MPL for DHCS MCAS Corrective Action	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.	Quarterly Status update on modules as they are completed.	Helen Syn	QIC	Health Equity				
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	<p>HEDIS MY2023 Goal</p> <p>CIS-Combo 10: 49.76%</p> <p>IMA-Combo 2: 48.42%</p> <p>W30-First 15 Months: 55.72%</p> <p>W30-15 to 30 Months: 69.84%</p> <p>WCV (Total): 57.44%</p>	<p>1) Targeted member engagement and outreach campaigns in coordination with health network partners.</p> <p>2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. Examples: EPSDT DHCS promotional campaign; Back-to-School Immunization Clinics with Community Relations; expansion of Bright steps comprehensive maternal health program through 1 year postpartum to include infant health, well-child visits, and immunization education and support</p> <p>3) Early Identification and Data Gap Bridging Remediation for early intervention.</p>	<p>1) 3Q2023</p> <p>2) Per quality initiatives calendar - ongoing updates</p> <p>3) End of Q22023</p>	Helen Syn	QIC	Health Equity	X			
Blood Lead Screening DHCS APL	<p>1) Comply with APL requirements including quarterly reports of members missing blood lead screening</p> <p>2) Increase Rates of successfully screened members to #%</p> <p>3) Put process in place to identify refusal of blood lead consent forms</p>	<p>-PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead.</p> <p>-Update Policy GG.1717 to include Health Network Attestation and conduct Health Network/Provider education</p> <p>-Add blood lead screening resources to CalOptima Health website: Comprehensive Health Assessment Forms, CDPH anticipatory guidance handout,</p> <p>-Launch IVR campaign to members with untested children</p> <p>-Member mailing campaign to members</p> <p>-Lead texting campaign for members</p> <p>-Medi-Cal member newsletter article(s)</p>	All activities will be complete by 3Q, 2023	Helen Syn	QIC					X
VII. QUALITY OF SERVICE- Access										
Improve Network Adequacy: Reducing gaps in provider network	Reduce OON requests by 25%	<p>1) Actively recruit top 3 out-of-network (OON) specialties as shown on QMRT</p> <p>2) Targeted outreach campaign and incentive to open their panels</p> <p>3) Business consideration to require providers to participate in all programs.</p> <p>4) Provider incentive for transportation vendor</p>	by end of 4Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX					X
Improve Timely Access: Appointment Availability	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	<p>1) Provider incentive to meet timely access standards</p> <p>2) Provider incentive for extending office hours</p>	by end of 2Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX					X
Improve Access: Telephone Access	Live Contacts Rate After 3 Attempts to meet 80%	<p>1) Improve provider data in FACETS (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits)</p> <p>2) Individual Provider Outreach and Education (Timely Access Survey)</p>	by end of 4Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX					X
Improve Access: Access Dashboard	Develop an access dashboard for HN performance	<p>1) Identify access measures to include in performance monitoring</p> <p>2) Develop a methodology to monitor performance</p>	by end of 2Q, 2023	Marsha Choo	MEMX					

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Caution Green - On Target
Improving Access: Subcontracted Network Certification	Certify all HNs for network adequacy	1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access	by end of 4Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX					
Increase primary care utilization	Increase rates of Initial Health Appointments for new members, annual wellness visits for all members.	1) Increased Health Network/Provider education and oversight 2) Enhanced member outreach (IVR, digital engagement)	1) 1Q2023 2) 2Q2023	Katie Balderas	QIC					
VIII. QUALITY OF SERVICE- Member Experience										
STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. CAHPS Composites, and overall ratings; TTY Foreign language interpreter and Members Choosing to Leave Plan	by end of 4Q, 2023	TBD	QIC					
Improve Member Experience/CAHPS	Increase CAHPS to meet goal	1) Issue an RFI to obtain information on CAHPS improvement vendors and strategies, contract and launch program 2) Member outreach to all OneCare members 3) Track measures for monitoring individual provider performance (ie. number of grievances, number of CAPs issued) and take action based on committee action	by end of 3Q, 2023	Marsha Choo	QIC					
IX. SAFETY OF CLINICAL CARE										
Emergency Department Diversion Pilot	Pilot has been implemented. In 2023 plan to expand the program to additional hospital partners.	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	by end of 4Q, 2023	Michelle Findlater	QIC					
Plan All-Cause Readmissions (PCR)	UM/CM/LTC to collaborate and set goals on improving care coordination after discharge. For example, including but not limited to improving PCP follow up post discharge rate by 10% (focus on getting discharge plans w/ PCP appt from hospitals)	<u>Planned Activities:</u> 1) Set up a Transition of Care workgroup among UM, CM and LTC to discuss ways to increase post hospitalization visits with PCP and address barriers. 2) Update the UTC letter for members that UM/CM are unable to reach post discharge.	Setting up the workgroup - end of 1Q 2023 Updating the UTC letter - end of 2Q 2023	UM Director CM Director LTC Director	QIC		X			



2023

QUALITY IMPROVEMENT PROGRAM





2023 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

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

CalOptima Health Chief Medical Officer

Date

Board of Directors' Quality Assurance Committee Chair:

Trieu Tran, M.D.

Date

Board of Directors

Chair:

Clayton M. Corwin

Acting Chair

Date

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Abbreviations

	ABBREVIATION	DEFINITION
A		
	ACE	Adverse Childhood Event
	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 survey
	CAP	Corrective Action Plan
	CBAS	Community-Based Adult Services centers
	CCN	CalOptima Health Community Network
	CCIP	Chronic Care Improvement Project
	CCO	Chief Compliance Officer
	CCS	California Children's Services
	CHRO	Chief Human Resources Officer
	CEO	Chief Executive Officer
	CIO	Chief Information Officer
	CMO	Chief Medical Officer
	CMS	Centers for Medicare & Medicaid Services
	COPD	Chronic Obstructive Pulmonary Disease
	COO	Chief Operating Officer
	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	California Department of Health Care Services
	DMHC	California Department of Managed Health Care
	DO	Doctor of Osteopathy
	DPM	Doctor of Podiatric Medicine
	D-SNP	Dual-Eligible Special Needs Plan
E		
	ED PHM	Executive Director, Population Health Management
	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 and Related Entities
	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	Individualized Care Plan
	IRR	Inter-Rater Reliability
L		
	LTC	Long-Term Care
	LTSS	Long-Term Services and Supports
M		
	MAC	Member Advisory Committee
	MD	Medical Doctor
	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 Facilities
O		
	OC	Orange County
	OCC	OneCare Connect
	OCHCA or HCA	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
	QIC	Quality Improvement 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
	PCP	Primary Care Provider
	PDSA	Plan-Do-Study-Act
	PHM	Population Health Management
	PHC	Physician/Hospital Consortia
	PIP	Performance Improvement Project
	PPC	Personal Care Coordinator
	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 Determinants 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

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.

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.



C	Collaboration
A	Accountability
R	Respect
E	Excellence
S	Stewardship

Our Strategic Plan

CalOptima Health’s Board of Directors and executive team worked together to develop our 2023–2025 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.

Quality Mission: All people receive equitable, high-quality and value-based care.

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 Goals:

1. Embed Quality into the Care Journey: Incorporate quality as a foundational component to delivering value as a part of the overall care journey. Quality includes ensuring optimal care and best outcomes for individuals of all ages and backgrounds as well as across service delivery systems and settings. Quality also extends across payer types.
2. Advance Health Equity: Address the disparities that underlie our health system, both within and across settings, to ensure equitable access and care for all.
3. Promote Safety: Prevent harm or death from health care errors.
4. Foster Engagement: Increase engagement between individuals and their care teams to improve quality, establish trusting relationships, and bring the voices of people and caregivers to the forefront.
5. Strengthen Resilience: Ensure resilience in the health care system to prepare for, and adapt to, future challenges and emergencies.
6. Embrace the Digital Age: Ensure timely, secure, seamless communication and care coordination between providers, plans, payers, community organizations and individuals through interoperable, shared and standardized digital data across the care continuum.
7. Incentivize Innovation & Technology: Accelerate innovation in care delivery and incorporate technology enhancements (e.g., telehealth, machine learning, advanced analytics, new care advances) to transform the quality of care and advance value.
8. Increase Alignment: Develop a coordinated approach to align performance metrics, programs, policy and payment across CMS, federal partners and external stakeholders to improve value. Strive to create a simplified national picture of quality measurement that is comprehensible to individuals, their families, providers and payers.

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

The 2022 CQS lays out DHCS' quality and health equity strategy 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 stress 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

Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.

- 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).

Social Determinants of Health (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.



Comprehensive Community Cancer Screening and Support Program

CalOptima Health strives to be the health care exemplar for all Orange County residents. The goal is for all of Orange County to have the lowest in the nation late-stage cancer incidence rate for breast, cervical, colon and lung cancer in certain smokers. In other words:

- With rare exception, no one should die from breast cancer
- With rare exception, no one should die from cancer of the cervix
- With rare exception, no one should die from cancer of the colon
- With rare exception, no one should die from lung cancer in certain heavy smokers

CalOptima Health seeks to create a new Orange County health ethos with respect to cancer care by going after these four specific cancers that are relatively easy to detect compared with many more occult cancers. Early detection of these specific cancers has an incredible return on investment. CalOptima Health intends to build this new ethos by leveraging the key cancer centers and community opinion makers to the point where cancer detection for these specific cancers is part of the community's daily discussions. Additionally, having the lowest late-stage cancer detection in the nation will be a source of intense community pride.

The Comprehensive Community Cancer Screening and Support Program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

It will create a culture of cancer prevention, early detection and collaboration with partners toward a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care. The program will use a phased-in approach to invest over the next five years in the following three pillars:

- 1) Increasing community and member awareness and engagement
- 2) Increasing access to cancer screening

3) Improving member experience throughout cancer treatment

As of November 14, 2022, 3,925 CalOptima Health members were newly diagnosed with cancer. Of these cases, 480 are lung cancer, 565 are breast cancer, 120 are cervical cancer and 477 are colorectal cancer. The COVID-19 pandemic has significantly disrupted preventive care and cancer screenings, leading to a decrease in early detection and treatment. Between 2019 and 2021, Medi-Cal Healthcare Effectiveness Data and Information Set (HEDIS) rates decreased by approximately 5% for breast and cervical cancer screenings. Currently, more than one-third of eligible members have not received their cervical, breast or colorectal cancer screenings.

Increasing these cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life and reducing health care costs. For example, the five-year survival rate for colorectal cancer that has spread is only 15%, compared with a 90% survival rate when detected earlier at a localized stage. Yet every year in Orange County, an average of 1,500 community members are diagnosed with late-stage cancer of the breast, cervix or colon. Additionally, trends in late-stage colorectal cancer diagnoses significantly increased over the most recent 10-year period in Orange County, and in 2022, colorectal cancer will likely continue to be the ¹second leading cause of cancer-related deaths following lung cancer¹.

Staff plan to collaborate with the Orange County Cancer Coalition, providers, health networks, and community-based organizations to ensure that funds are utilized equitably to address disparities and build sustained capacity in the cancer screening and treatment community infrastructure.

Five-Year Hospital Quality Program

CalOptima Health's hospitals and their affiliated physicians are integral components of the delivery of health services to members and play a critical role in the delivery of care to members. For many years, CalOptima Health has been providing quality incentive payments to its Health Networks to drive improvement in quality outcomes and member satisfaction. CalOptima Health has established a Hospital Quality Program for its contracted hospitals to improve quality of care to members through increased patient safety efforts and performance-driven processes. Hospital performance measures serve to:

- Support hospital quality standards for Orange County in support of CalOptima Health's mission
- Provide industry benchmarks and data-driven feedback to hospitals on their quality improvement efforts
- Recognize hospitals demonstrating quality performance
- Provide comparative information on CalOptima Health hospital performance
- Identify areas for improvement and for working collaboratively with these hospitals to ensure the provision of quality care for CalOptima Health members

The program launches January 1, 2023, and extends through December 31, 2027. It includes two initiatives: Hospital Incentive Quality Pool and Hospital Reporting Incentive Payments.

This initiative will include the following principles:

¹ <https://www.science.org/doi/10.1126/science.abd3377>

1. Leverage publicly available, industry-standard measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Group including:
 - a. CMS Quality
 - b. CMS Patient Experience
 - c. Leapfrog Hospital and Surgery Center Rating
 - d. Leapfrog Hospital Safety Grade
2. Require contracted hospital participation in CMS quality reporting programs (hospital inpatient, hospital outpatient, prospective payment systems-exempt cancer, or inpatient psychiatric) or Leapfrog Group Hospital and Surgery Center Rating for measurement as follows:
 - a. Contracted hospitals will be assessed on CMS quality reporting programs as reported on CMS Care Compare
 - b. Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital and Surgery Center Rating
 - c. Contracted hospitals not listed on either CMS Care Compare or Leapfrog Hospital
 - d. Surgery Center Rating will not qualify for incentive payments
3. Require contracted hospital participation in Leapfrog Hospital Safety Grade reporting
4. Allocate a maximum amount of a budget for a five-year period from 2023–2027 to fund the hospital incentive pool. The amount that each hospital may earn will be based on their proportion of services provided to CalOptima Health members, i.e., proportion of total bed days. Funding will be used to reward performance and unearned incentive dollars will be forfeited.

Incentive awards will be based on performance compared with quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

CalOptima Health recognizes that hospitals may not currently participate in CMS/Leapfrog public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During the ramp-up period, CalOptima Health will provide hospital reporting incentive payments to eligible hospitals.

CalOptima Health Programs

“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 went into effect in 2019.

CalOptima Health provides Enhanced Care Management and Community Supports services to address social drivers of health. In 2023, we expand our Community Supports services to the 14 options listed below:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Short-term post-hospitalization housing
5. Recuperative care (medical respite)
6. Respite services
7. Day habilitation programs
8. Nursing facility transition/diversion to assisted living facilities
9. Community transition services/nursing facility transition to a home
10. Personal care and homemaker services
11. Environmental accessibility adaptations (home modifications)
12. Medically tailored meals/medically supportive foods
13. Sobering centers
14. Asthma remediation

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 (HCA)
- Substance use disorder services are administered by HCA

- 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 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 HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

In July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Health Medi-Cal members. CalOptima Health ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

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

CalOptima Health ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

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.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and people with disabilities. CalOptima Health LTSS monitors the levels of member access to, utilization of and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for

institutionalization. CalOptima Health LTSS monitors the level of member access to the program 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 the frail, disabled, dual-eligible members in Orange County.

To be a member of OneCare, a person must 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 a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. 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 enhanced services, 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

OneCare Connect

On January 1, 2023, CalOptima Health's OneCare Connect plan ended. Members were transitioned to OneCare.

CalOptima Health Provider Partners

Providers have options for participating in CalOptima Health's programs to provide health care to CalOptima Health members. Providers can contract through CalOptima Health Direct, CalOptima Health Direct-Administrative and/or CalOptima Health Community Network (CCN) and/or contract with a CalOptima Health Network (HN). CalOptima Health members can choose CCN or one of 12 HNs representing more than 9,400 providers.

CalOptima Health Direct (COD)

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

- CalOptima Health Direct-Administrative (COD-A)

CalOptima Health Direct-Administrative 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 1,500 PCPs, more than 7,900 specialists, 40 acute and rehabilitative hospitals, 31 community health centers and nearly 100 long-term care facilities.

CalOptima Health contracts with the following HNs:

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

- Contracting
- Credentialing of practitioners
- Customer service

Membership Demographics

Membership Data* (as of December 31, 2022)

Total CalOptima Health Membership 944,975	Program	Members
	Medi-Cal	927,086
	OneCare Connect	14,385
	OneCare (HMO D-SNP)	3,067
	Program of All-Inclusive Care for the Elderly (PACE)	437
<small>*Based on unaudited financial reports and includes prior period adjustment. Data from prior to the OneCare Connect program end on January 1, 2023.</small>		

Member Demographics (as of December 31, 2022)

Member Age		Language Preference		Medi-Cal Aid Category	
0 to 5	9%	English	59%	Temporary Assistance for Needy Families	40%
6 to 18	25%	Spanish	27%	Expansion	37%
19 to 44	34%	Vietnamese	9%	Optional Targeted Low-Income Children	8%
45 to 64	20%	Other	2%	Seniors	9%
65 +	12%	Korean	1%	People With Disabilities	5%
		Farsi	1%	Long-Term Care	<1%
		Chinese	<1%	Other	<1%
		Arabic	<1%		

Quality Improvement Program

CalOptima Health’s Quality Improvement (QI) Program 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 our 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 Quality Improvement Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency 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 HR 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 Program Purpose

The purpose of the CalOptima Health QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to members through CalOptima Health CCN and COD-A, as well as our contracted HNs. Through the QI Program — 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 our members.

The CalOptima Health QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima Health’s multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program 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 QI 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 agencywide practices that support accreditation by NCQA and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QI Program’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 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.
- Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensuring certain contracted facilities 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 assure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement culture at CalOptima Health.
- Ensure the annual review and acceptance of the UM Program Description, 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 QI Program 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 agency's strategic quality and business goals by utilizing 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, high 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 medicine.

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima Health departments, support the organization's mission and strategic goals,

and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

Authority, Board of Directors' Committees and Responsibilities

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 QI Committee 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 QI Program annually.

The QI Program 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 QI Program. Such recommendations shall be aligned 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 QI Program. QAC routinely receives progress reports from the QIC 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 of the QI Program aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim:

1. Enhancing patient experience

2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) has 15 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, operation and evaluation of the overall QI Program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, 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
- Member Advocate
- County of Orange Social Services Agency (OC SSA)
- OneCare Member (2 seats)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

One of the 15 positions — held by OC SSA — is a standing seat. Each of the remaining 14 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 HCA, 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
- HCA (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 (seven 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 age 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 (four 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.

CalOptima Health Officers’ Role in the Quality Improvement Program

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 QI Committee (QIC) satisfies all remaining requirements of the QI 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 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 of the QI Program and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

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 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. 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'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, 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 agency's risk exposure.

Medical Director* (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The Medical Director provides

direction and support to CalOptima Health's Quality teams to ensure QI Program objectives are met..

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

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, 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 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. The Director of Population Health Management reports to the ED PHM.

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, 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 and ED PHM, makes certain that Medical Affairs is aligned with CalOptima Health's strategic and operational priorities.

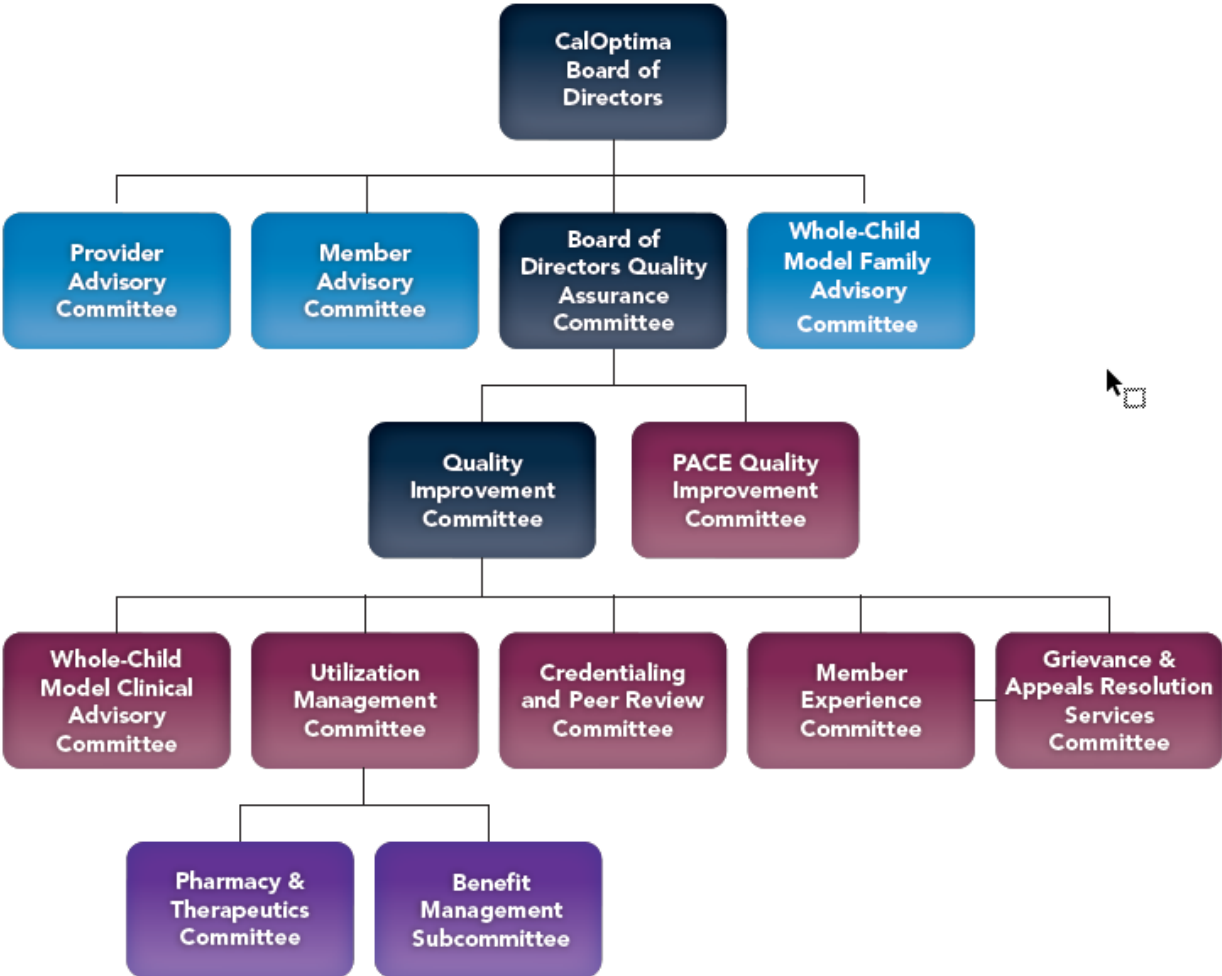
Executive Director, Medicare Programs (ED MP) is responsible for strategic and operational oversight of Medicare programs including OneCare and PACE.

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 (c). Ongoing monitoring is performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.

Committee Organization Structure – Diagram



Quality Improvement Committees and Subcommittees

Quality Improvement Committee (QIC)

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

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

The composition of the QIC includes participating 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 QIC 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 QI Projects, activities and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored and reported through the QIC.

Responsibilities of the QIC include:

- Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives
- Overseeing the analysis and evaluation of QI activities
- Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI Program activities
- Identifying and prioritizing needed actions and interventions to improve quality
- Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and intervention.
- Monitoring overall quality compliance for the organization to quickly resolve deficiencies that affect members

Practice patterns of providers, practitioners and delegated HNs are evaluated, such as UM over/under utilization in collaboration with Applied Behavior Analysis utilization. Recommendations are made to promote practices so that all members receive medical and behavioral health care that meets CalOptima Health standards.

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

The QIC also recommends strategies for dissemination of all study results to CalOptima Health-contracted providers and practitioners, and delegated HNs.

The composition of the QIC is defined in the QIC 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 Deputy Chief Medical Officer
- CalOptima Health Medical Directors
- CalOptima Health Quality Improvement Medical Director
- CalOptima Health Behavioral Health Integration Medical Director (or Designee)
- CalOptima Health Executive Director, Quality
- CalOptima Health Executive Director, Population Health Management

- CalOptima Health Executive Director, Clinical Operations
- CalOptima Health Executive Director, Network Management
- CalOptima Health Executive Director, Operations

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

- Behavioral Health Integration
- Care Management
- Long-Term Services and Supports
- Population Health Management
- Quality Analytics
- Quality Improvement
- Utilization Management

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, participation by telephone or participation by video conference.

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

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

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

- Goals and objectives outlined in the QIC charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate QI information to network providers and practitioners
- Tracking of QI Work Plan activities

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

The QIC provides to the QAC quarterly written progress reports of the QIC that describes actions taken, process in meetings QI Program objectives, and improvements made.

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 QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The 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 agency standards. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a behavioral health practitioner*) and the quorum requirements of the UMC are defined in its charter.

* Behavioral Health 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 plan 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 QIC. 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 and 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 2023, 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 the MY 2022 and MY 2023 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 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 QIC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

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

Quality Improvement Strategic Goals

2023 QI Goals and Objectives

CalOptima Health's QI Goals and Objectives are aligned with CalOptima Health's 2022–25 Strategic Goals.

- 1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational and community levels.
- 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.
- 3) Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare and Hospital Quality.

These top three priority goals were chosen to be aligned with CalOptima Health's strategic objectives as well as continued goals related to access to care and NCQA accreditation. The 2023 QI Work Plan details the strategies for childhood, COVID-19 and other immunizations, including targeted communication and member incentives. The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). All goals and sub-goals will be measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and the Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. A QI 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 QI Work Plan is the operational and functional component of the QI Program 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 QI Program guides the development and implementation of an annual QI Work Plan, which includes but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program 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 QI Program

Priorities for QI 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 QI Work Plan.

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

See Appendix A — 2023 QI Work Plan

Quality Improvement Projects

QI 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

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 Seniors and Persons with Disabilities (SPD)
- 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, QIC, UMC, etc., based upon the scope of work and impact of the effort.
- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QI Project 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.

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 many include enhanced monitoring and/or re-measurement activities.

Types of QI 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 QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan 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 QI Projects

Documentation of all aspects of each QI 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

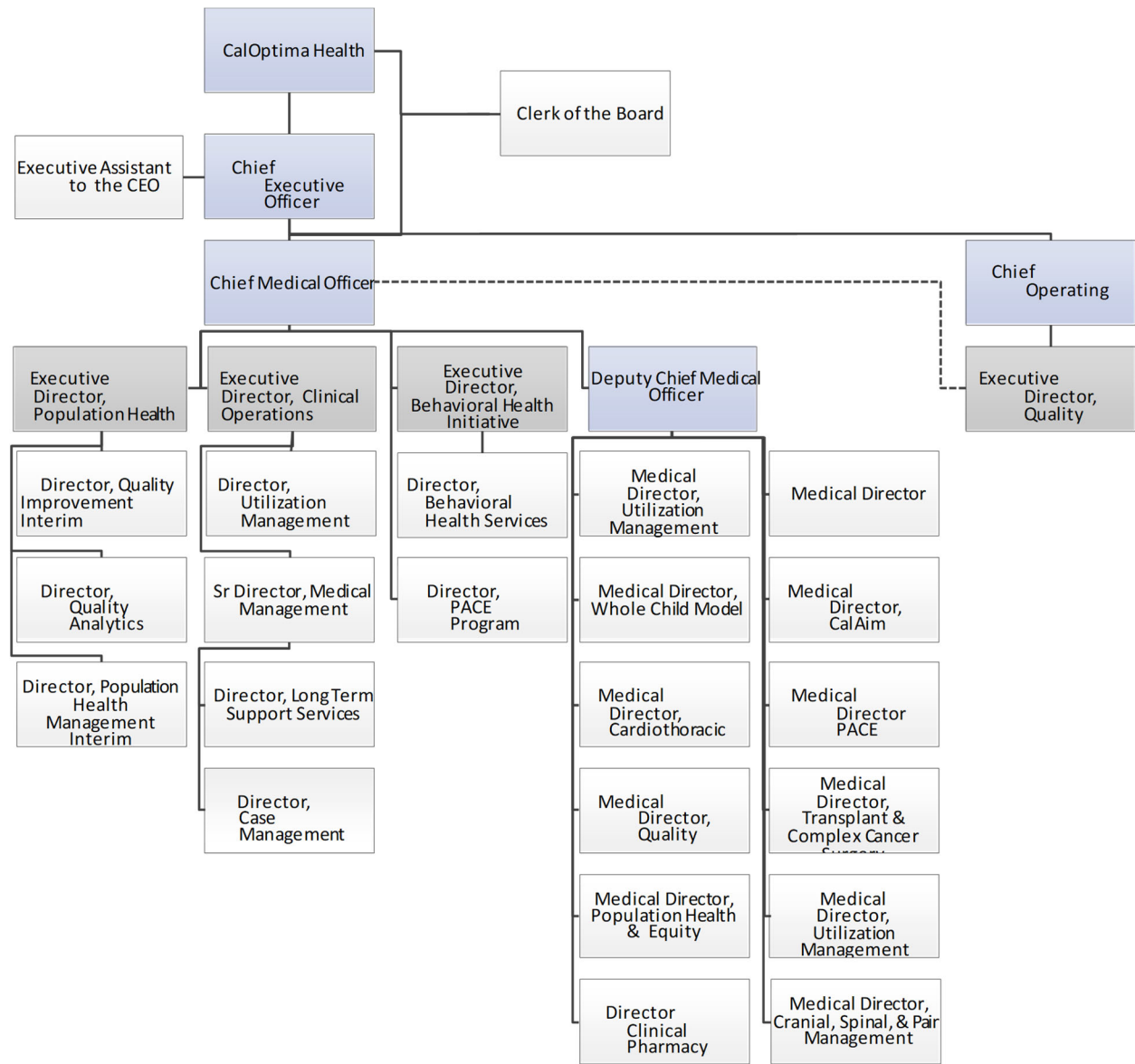
Communication of QI Activities

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 QI Work Plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the 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 QIC and its subcommittees
- HN Forums, Medical Directors' Meetings, Quality Forums and other ongoing ad hoc meetings
- MAC, PAC and WCM FAC

Quality Program Organization Structure – Diagram

As of February 2023



Quality Improvement Program Resources

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

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

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

Director, Quality Improvement

Responsibilities include assigned day-to-day operations of the Quality Management functions, including credentialing, facility site reviews (FSRs), physical accessibility compliance and working with the ED Quality to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

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

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

The following positions report to the Director, Quality Analytics:

- Manager, Quality Analytics (HEDIS)
- Manager, Quality Analytics (P4V)
- Manager, Quality Analytics (Network Adequacy)
- Manager, Quality Analytics (Data Analytics)

- Data Analysts
- Project Managers
- Program Coordinators
- Program Specialists
- Quality Analyst
- Program Assistant

Director, Population Health Management

Provides direction for program development and implementation for agencywide population health initiatives. Ensures linkages supporting a whole-person perspective to health care with Care Management, UM, Pharmacy Management and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the Model of Care implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

The following positions report to the Director, Population Health Management:

- Population Health Management Manager (Clinical Operations)
- Population Health Management Manager (Health Education)
- Population Health Management Manager (Maternal Health)
- Population Health Management Supervisors
- Program Managers
- Health Coaches
- Registered Dietitians
- Senior Health Educators
- Health Educators
- Quality Analysts
- Program Specialists
- Program Assistants

Director, Behavioral Health Integration

Provides 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

Assists in 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 QIC and the BMSC.

Director, Clinical Pharmacy Management

Leads 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.

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

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

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.

Annual Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's QI Program are reviewed and evaluated annually by the QIC and QAC, and approved by the Board of Directors, as reflected in the QI 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 QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

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

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

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

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima 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 aspects 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
- Preventive care, including:
 - Initial Health Appointment
 - Behavioral Assessment
- Diagnosis, care and treatment of acute and chronic conditions
- Care management including complex care management
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management
- Member experience
- Patient safety

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- 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 of Clinical Care

Quality Improvement

The QI department is responsible for monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services. The 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 agencywide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain agencywide 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 Standards

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 recredentialed 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 recredentialed 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.

Use of QI Activities in the Recredentialed Process

Findings from QI activities and other performance monitoring are included in the recredentialed 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 recredentialed periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima Health does not delegate PCP site and medical records review to contracted HMOs, PHCs and SRGs, with the exception of Kaiser Permanente in accordance with standards set forth by APL 22-017. 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 20-006 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 Standards

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 QIC. 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.

Quality Analytics

The Quality Analytics (QA) department fully aligns with the QI and PHM 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 cause
- 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 QI Program, 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

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

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.

Population Health Management

CalOptima Health strives to provide integrated physical health, behavioral health, LTSS, care coordination and complex care management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima Health's PHM strategy outlines programs that will focus on four key strategies:

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

This is achieved through functions described below in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima Health developed a comprehensive PHM Strategy that includes a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima Health's PHM Strategy aims to ensure the care and services provided to members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima Health members. Additionally, CalOptima Health's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Plans) will aid the PHM Strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual and environmental stressors, to improve health outcomes. 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 that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs and CCIPs. Quality Initiatives for 2022 are tracked in the QI Work Plan and reported to the QIC.

In 2023, the PHM Strategy will continue to focus on addressing health inequities and meeting member's social needs. The COVID-19 pandemic brought worldwide attention to health disparities and inequity. PHM 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 Orange County's Equity in OC Initiative.
- Implementing new Medi-Cal benefits that cover doula and community health worker services.
- Resuming in-person group health education classes in the community to promote healthy eating and active living.
- Implementing a multidisciplinary diabetes program and initiating additional interventions for gestational diabetes and chronic kidney disease.
- Launching the Comprehensive Cancer Screening and Support program to create an ethos of cancer screening across Orange County.

Health Education and Promotion

The PHM department provides program development and implementation for agencywide 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. They 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.

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 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, 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
- Ongoing assessment of outcomes

CalOptima Health’s Care Management program includes three care management levels that reflect the acuity of needs: complex care management, care coordination and basic care management. Members within defined MOCs — 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

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 misuse counseling 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 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

OneCareBH 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. Members will be connected to a CalOptima Health representative for assistance.

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 misuse counseling 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).

Utilization Management

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 2022 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 2023 UM Program Description.

Safety of Clinical Care

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

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 medical record review 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

Emergency Department Diversion Pilot

In the effort to support hospital partners, members and reduce inappropriate Emergency Department (ED) visits, CalOptima Health implemented an ED Diversion pilot program. The program has been piloted at one hospital. We plan to expand the program to additional hospital partners in 2023.

The program has four major goals:

- Promote communication and member access across all CalOptima Health Networks
- Increase CalAIM Community Supports referrals
- Increase PCP follow-up visit within 30 days of an ED visit
- Decrease inappropriate ED utilization

This program provides referrals to CalAIM Community Supports, assists members with appointments to their PCP and specialists, refers members to Care Management, completes Prior Authorizations, and assists the member with transportation and medication issues.

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.

NCQA’s Health Insurance Plan Ratings measure customer satisfaction as one of the three dimensions.

CalOptima Health performs and assesses the results from member-reported experiences and how well the plan providers are meeting members’ expectation and goals. Annually, CalOptima Health fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for both Medi-Cal and dual-eligible 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.

Quality of Service

Access to Care

With the rapid growth in CalOptima Health’s membership, access to care is a major area of concern for the plan and hence the organization has dedicated a significant amount of resources to measuring and improving access to care. CalOptima Health monitors the following to ensure that members have timely access to care:

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 state, 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 the 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.
- In order 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 re-measured 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 quarterly basis.
- In order 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 re-measured and tracked and follow-up action may include education, enhanced monitoring and/or issuance of a corrective action.

Cultural & Linguistic Services

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 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; and member information materials translated into CalOptima Health's threshold languages and in alternate formats, such as braille, large-print or audio.

The seven most common languages spoken for all CalOptima Health programs are: English, 59%; Spanish, 26%; Vietnamese, 10%; Farsi, 1%; Korean, 1%; Chinese, less than 1%; and Arabic, less than 1%. 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 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 Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the 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
- Providing information, training and tools to staff and practitioners to support culturally competent communication

Delegated And Non-Delegated Activities

CalOptima Health has an annual and continuing monitoring process for delegation oversight to ensure compliance with statutory, regulatory and accreditation requirements.

Delegation Oversight

Participating entities are required to meet CalOptima Health's QI standards and to participate in CalOptima Health's QI Program. 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 following:

- QI – Kaiser only, Care Management, Network Management, Credentialing, Utilization Management, Member Experience, Claims, Third Party Liability, Medicaid Module and Second Opinion.

Non-Delegated Activities

The following activities are not delegated to CalOptima Health's contracted HNs with the exception of Kaiser Permanente, and remain the responsibility of CalOptima Health:

- QI, as delineated in the Contract for Health Care Services
- QI Program for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- 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 — 2023 QI Work Plan

2023 Quality Improvement Work Plan

I. PROGRAM OVERSIGHT

- A. 2023 QI Annual Oversight of Program and Work Plan
- B. 2022 QI Program Evaluation
- C. 2023 UM Program
- D. 2022 UM Program Evaluation
- E. Population Health Management Strategy
- F. Credentialing Peer Review Committee (CPRC) Oversight
- G. Grievance and Appeals Resolution Services (GARS) Committee
- H. Member Experience (MEMX) Committee Oversight
- I. Utilization Management Committee (UMC) Oversight
- J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
- K. Managed Care Accountability Set (MCAS)
- L. Health Network Quality Rating
- M. OneCare Performance measures
- N. Improvement Projects PIP
- O. Improvement Projects PIP (BH)
- P. Improvement Projects OneCare CCIP's
- Q. PPME/QIPE: HRA's
- R. CalAIM
- S. Health Equity
- T. NCQA Accreditation
- U. Student Behavioral Health Incentive Program (SBHIP)

II. QUALITY OF CLINICAL CARE- Adult Wellness

- A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
- B. CalOptima Health Comprehensive Community Cancer Screening Program
- C. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

- A. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.
- B. Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)(Medicaid only)
- C. Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- D. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- E. Depression Remission or Response for Adolescents and Adults (DRR-E)
- F. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

- A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)
- B. Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)
- C. Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot
- D. STARs Measures Improvement

V. QUALITY OF CLINICAL CARE- Maternal Child Health

- A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

- A. MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs
- B. Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA
- C. Blood Lead Screening DHCS APL

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC: _____ Date: _____

Submitted and approved by QAC: _____ Date: _____

Quality Improvement Committee Chairperson:

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

Date:

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D.

Date:

2023 Quality Improvement Work Plan

VII. QUALITY OF SERVICE- Access

- A. Improve Network Adequacy: Reducing gaps in provider network
- B. Improve Access: Timely Access (Appointment Availability)
- C. Improve Access: Telephone Access
- D. Improve Access: Access Dashboard
- E. Improving Access: Subcontracted Network Certification
- F. Increase primary care utilization

VIII. QUALITY OF SERVICE- Member Experience

- A. STARs Measures Improvement
- B. Improve Member Experience/CAHPS

IX. SAFETY OF CLINICAL CARE

- A. Emergency Department Diversion Pilot
- B. Plan All-Cause Readmissions (PCR)

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Attention Green - On Target
I. PROGRAM OVERSIGHT										
2023 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2023 Program and Workplan	Quality Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by April 2023	Marsha Choo	QIC		X			
2022 Quality Improvement Program Evaluation	Complete Evaluation 2022 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Adoption by January 2023	Marsha Choo	QIC		X			
2023 Utilization Management Program	Obtain Board Approval of 2023 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	QIC		X			
2022 Utilization Management Program Evaluation	Complete Evaluation of 2022 UM Program	UM Program will be evaluated for effectiveness on an annual basis.	Annual Adoption by April 2023	Kelly Giardina	QIC		X			
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption Feb 2023	Katie Balderas	QIC		X			
CalAIM	Improve Health & Access to care for enrolled members	1) Launch ECM Academy; a pilot program to bring on new ECM providers. 2) Increase CalOptima Health's capacity to provide community supports through continued expansion of provider network. 3) Continue to increase utilization of benefits. 4) Establish oversight strategy for the CalAIM program. 5) Implement Street Medicine Program 6) Select and fund HHIP projects through Notice of Funding Opportunity. 7) Design and launch the Shelter Clinic Partnership Program (HCAP 2.0)	1) 1Q 2023 2) 4Q 2023 3) 4Q 2023 4) 3Q 2023 5) 1Q, 2Q 2023 6) 1Q 2023 7) 3Q 2023	Mia Arias	QIC	SDOH	X			
Health Equity	Increase member screening and access to resources that support the social determinants of health	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 project	1) 4Q 2022 2) 4Q 2022 3) 3Q 2022	Katie Balderas	QIC	Health Equity	x			
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews);Quality of Care cases leveled by committee.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Laura Guest	QIC		X			
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health networks. Trends and results are presented to the committee quarterly.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Tyronda Moses	QIC		X			

2023 QI Work Plan

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Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2023 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & 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.	1Q23 update (6/13 QIC) 2Q23 update (9/12 QIC) 3Q23 update (12/12 QIC) 4Q23 update (TBD 2024 QIC)	Marsha Choo	QIC		X			
Utilization Management Committee (UMC) Oversight Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	1Q23 update (4/11 QIC) 2Q23 update (7/11 QIC) 3Q23 update (10/10 QIC) 4Q23 update (Jan 2024 QIC)	Kelly Giardina	Utilization Management/ QIC		X			
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.		Meet quarterly to provide clinical and behavioral service advice regarding Whole Child Model operations 2023 Meeting Schedules WCM CAC Q1: 2/21 WCM CAC Q2: May 16, 2023 WCM CAC Q3: August 15, 2023 WCM CAC Q4: November 14, 2023	1Q23 update (4/11 QIC) 2Q23 update (7/11 QIC) 3Q23 update (10/10 QIC) 4Q23 update (Jan 2024 QIC)	T.T. Nguyen, MD	QIC		X			
Health Network Quality Rating	Achieve 4 or above	Will share HN performance on all P4V HEDIS Measures via prospective rates report each month	end of 4Q 2023	Sandeep Mital	QIC					
Improvement Projects OneCare CCIP's	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 Topic TBD	end of 1Q2023	Helen Syn	QIC		X			

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Warning Green - On Target
Improvement Projects Medi-Cal PIP	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025); 1) Clinical PIP - Health Disparity remediation for W30 6+ measure (Jan) Pending January Module Training January 2023 projected. Please note that the focus for the Clinical and Non-Clinical PIP topics is related to DHCS' "50 by 2025: Bold Goals Initiatives". See links for more information on the Bold Goals Initiatives: https://www.dhcs.ca.gov/Documents/Budget-Highlights-Add-Docs/Equity-and-Practice-Transformation-Grants-May-Revise.pdf or https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf	Quarterly Status update on modules as they are completed.	Helen Syn	QIC	Health Equity	X			
Improvement Projects Medi-Cal PIP(BH)	Meet and exceed goals set forth on all improvement projects	Non-Clinical PIP - FUM/FUA 1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	QIC					
Managed Care Accountability Set (MCAS)	Achieve 50th percentile on all MCAS measures in 2021	Share results to Quality Improvement Committee annually	end of 3Q 2023	Paul Jiang	QIC					
OneCare Performance measures	Achieve 4 or above	1) Implement Star Improvement Program 2) Track measures monthly 3) Implement OC Pay4Value	1. 1Q2023 2. 1Q2023 3. 3Q2023	Linda Lee	QIC					
PPME/QIPE: HRA and ICP	3.2 ICP completion 90 days Benchmark 90% adjusted. 2.1 Initial HRA collected in 90 days from eligibility Benchmark: 95% adjusted.	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.	1Q23 (5/9 QIC) 2Q23 (8/8 QIC) 3Q23 (11/14 QIC) 4Q23 (February 2024 QIC)	S. Hickman/D. Hood/M. Dankmyer/H. Kim	QIC		X			

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Attention Green - On Target
NCQA Accreditation	CalOptima Health must have full NCOA Health Plan Accreditation (HPA) and NCOA Health Equity Accreditation by no later than January 1, 2026.	1) Continue to Work with Business owners to collect all required documents for upcoming HP re-accreditation. (Must collect all Year one required documents by 2Q2023. 2) Complete Gap Analysis for Health Equity Accreditation.	1) end of 1Q2023 2) end of 2Q2023	Veronica Gomez	QIC	Health Equity				
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	1) Implement SBHIP DHCS targeted interventions 2. bi-quarterly reporting to DHCS	1.4Q2023 2.4Q2023	Diane Ramos/ Natalie Zavala	QIC	Health Equity				
II. QUALITY OF CLINICAL CARE- Adult Wellness										
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	MY 2023 Goals: CCS: MC 62.53% BCS: MC 61.27% OC 70% COL: OC 71%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	1) Quarterly Updates 2) Per Quality Initiatives Calendar - ongoing updates	Helen Syn	QIC	Health Equity	X			
CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	1) Assess community infrastructure capacity for cancer screening and treatment 2) Establish the the Comprehensive Cancer Screening and Support Program Stakeholder Collaborative (in our Case I want to leverage OC3) 3) Develop comprehensive outreach campaign to outreach to members due for cancer screenings (mobile mammography, outbound calls, community health workers) 4) Integrate new community health worker benefit into cancer outreach and treatment services.	1) 1Q2023 2) 2Q2023 2) 3Q2023 3) 4Q2023	Katie Balderas/ Barbara Kidder	QIC					
COVID-19 Vaccination and Communication Strategy	Increase the rate of first time COVID vaccinated members by #%, and increase the rate of fully boosted vaccinated members to #%	1) Communication Strategy of COVID vaccination incentive program through June 30, 2023 end date, focusing on unvaccinated, and missed booster opportunities. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups for boosters	1) end of 1Q2023 2) end of 4Q2023	Helen Syn	QIC		X			
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2023 Goal: MC - Init Phase - 42.77% MC -Cont Phase - 51.78%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on provider responsibilities on related to follow-up visits. 3) Continue member outreach (through multiple modalities telephonic, newsletter, mobile device) to improve appointment follow up adherence.	1. 2Q2023 2. 4Q2023 3. 3Q2023	Diane Ramos/ Natalie Zavala	QIC		X			

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Attention Green - On Target
III. QUALITY OF CLINICAL CARE- Behavioral Health										
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2023 Goal: MC 77.48% OC (Medicaid only)	1) Identify members through internal data reports in need of diabetes screening test. 2) Conduct outreach to prescribing provider and/or primary care physician (PCP) to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	1. 2Q2023 2. 3Q2023 3. 2Q2023	Diane Ramos/ Natalie Zavala	QIC					
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS MY2023 Goal: MC 30-Day: 54.51%; 7-day: 31.97% OC (Medicaid only)	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	QIC					
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	MY2023 Goals: MC: 30-days: 21.24%; 7-days: 8.93%	1) Track real-time ED data for participating facilities on contracted vendor. 2) Establish reports for data sharing with Health Networks and/or established behavioral health provider to facilitate faster visibility of the ED visit. 3) Participate in educational events on provider responsibilities on related to follow-up visits. 4) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 5) Implement new behavioral health virtual provider visit for increase access to follow-up appointments.	1. 2Q2023 2. 4Q2023 3. 3Q2023 4. 4Q2023 5. 4Q2023	Diane Ramos/ Natalie Zavala	QIC					
Depression Remission or Response for Adolescents and Adults (DRR-E)	No benchmark	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 1 educational events on depression screening, treatment, and follow up 3) Educate providers on depression screening via provider newsletters 4) Educate members on depression and the importance of screening and follow-up visits via member newsletters and other social media.	1. 2Q2023 2. 3Q2023 3. 4Q2023 4. 2Q2023	Diane Ramos/ Natalie Zavala	QIC					
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	No benchmark	1) Develop a HEDIS reporting tip sheet to educate providers on the requirements 2) Participate in 1 educational events on depression screening and treatment 3) Educate providers on depression screening via provider newsletters 4) Educate members on depression and the importance of screening and follow up visits via member newsletters and other social media.	1. 2Q2023 2. 3Q2023 3. 4Q2023 4. 2Q2023	Diane Ramos/ Natalie Zavala	QIC					

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Attention Green - On Target
IV. QUALITY OF CLINICAL CARE- 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)	MY2023 Goals: MC: 30.9%; OC: 17%	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation	Helen Syn	QIC		X			
Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED)	MY2023 HEDIS Goals: MC 63.75% OC: 79%;	1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 2) Quality Incentives impact on quality measures 3) VSP Collaborative gaps in care bridging efforts.	1) Per Quality Initiatives Calendar - ongoing updates 2) Annual Evaluation 3) End of Q2 2023	Helen Syn	QIC		X			
Implement multi-disciplinary approach to improving diabetes care for CHCN Latino Members Pilot	1) Lower HbA1c to avoid complications (baseline: A1c ≥ 8%; varies by individual); 2) Improve member and provider satisfaction	<u>Final Pilot Program Design:</u> 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement <u>Planned Activities:</u> Finalize member stratification Outreach to high volume PCPs Launch the pilot program	Finalize member stratification - end of Jan 2023 Outreach to high volume PCPs - end of Q1 Launch the pilot program - end of Q1	Joanne Ku	QIC		X			
STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. Measures include Special Needs Plan (SNP), Care Management, Centers for Disease Control (CDC) and Care for Older Adults (COA)	1) end of 4Q2023	TBD	QIC					
V. QUALITY OF CLINICAL CARE- Maternal Child Health										
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2023 Goal: Postpartum: 84.18% Prenatal: 91.89%	1) Track member health reward impact on HEDIS rates for cancer screening measures. 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	1) Annual Evaluation 2) Per quality initiatives calendar - ongoing updates 3) Ongoing updates 4) 4Q2023 5) 3Q2023	Ann Mino/ Helen Syn	QIC	Health Equity	X			

2023 QI Work Plan

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VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness										
MCAS Performance Measures - Improvement Plan: Plan, Do, Study, Acts - PDSAs	Meet and exceed MPL for DHCS MCAS Corrective Action	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.	Quarterly Status update on modules as they are completed.	Helen Syn	QIC	Health Equity				
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS MY2023 Goal CIS-Combo 10: 49.76% IMA-Combo 2: 48.42% W30-First 15 Months: 55.72% W30-15 to 30 Months: 69.84% WCV (Total): 57.44%	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. Examples: EPSDT DHCS promotional campaign; Back-to-School Immunization Clinics with Community Relations; expansion of Bright steps comprehensive maternal health program through 1 year postpartum to include infant health, well-child visits, and immunization education and support 3) Early Identification and Data Gap Bridging Remediation for early intervention.	1) 3Q2023 2) Per quality initiatives calendar - ongoing updates 3) End of Q22023	Helen Syn	QIC	Health Equity	X			
Blood Lead Screening DHCS APL	1) Comply with APL requirements including quarterly reports of members missing blood lead screening 2) Increase Rates of successfully screened members to #% 3) Put process in place to identify refusal of blood lead consent forms	-PBS television ad campaign that advises parents/guardians that a lead test is the only way to identify if a child has been exposed to lead. -Update Policy GG.1717 to include Health Network Attestation and conduct Health Network/Provider education -Add blood lead screening resources to CalOptima Health website: Comprehensive Health Assessment Forms, CDPH anticipatory guidance handout, -Launch IVR campaign to members with untested children -Member mailing campaign to members -Lead texting campaign for members -Medi-Cal member newsletter article(s)	All activities will be complete by 3Q, 2023	Helen Syn	QIC					X
VII. QUALITY OF SERVICE- Access										
Improve Network Adequacy: Reducing gaps in provider network	Reduce OON requests by 25%	1) Actively recruit top 3 out-of-network (OON) specialties as shown on QMRT 2) Targeted outreach campaign and incentive to open their panels 3) Business consideration to require providers to participate in all programs. 4) Provider incentive for transportation vendor	by end of 4Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX					X
Improve Timely Access: Appointment Availability	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	1) Provider incentive to meet timely access standards 2) Provider incentive for extending office hours	by end of 2Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX					X
Improve Access: Telephone Access	Live Contacts Rate After 3 Attempts to meet 80%	1) Improve provider data in FACETS (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	by end of 4Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX					X
Improve Access: Access Dashboard	Develop an access dashboard for HN performance	1) Identify access measures to include in performance monitoring 2) Develop a methodology to monitor performance	by end of 2Q, 2023	Marsha Choo	MEMX					

2023 QI Work Plan

2023 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion (i.e. 2Q 2023) for each activity	Responsible Business owner	Report to Committee	Health Equity and/or SDOH	Con't Monitoring from 2022	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Caution Green - On Target
Improving Access: Subcontracted Network Certification	Certify all HNs for network adequacy	1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access	by end of 4Q, 2023	Marsha Choo/Jennifer Bamberg	MEMX					
Increase primary care utilization	Increase rates of Initial Health Appointments for new members, annual wellness visits for all members.	1) Increased Health Network/Provider education and oversight 2) Enhanced member outreach (IVR, digital engagement)	1) 1Q2023 2) 2Q2023	Katie Balderas	QIC					
VIII. QUALITY OF SERVICE- Member Experience										
STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts. CAHPS Composites, and overall ratings; TTY Foreign language interpreter and Members Choosing to Leave Plan	by end of 4Q, 2023	TBD	QIC					
Improve Member Experience/CAHPS	Increase CAHPS to meet goal	1) Issue an RFI to obtain information on CAHPS improvement vendors and strategies, contract and launch program 2) Member outreach to all OneCare members 3) Track measures for monitoring individual provider performance (ie. number of grievances, number of CAPs issued) and take action based on committee action	by end of 3Q, 2023	Marsha Choo	QIC					
IX. SAFETY OF CLINICAL CARE										
Emergency Department Diversion Pilot	Pilot has been implemented. In 2023 plan to expand the program to additional hospital partners.	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	by end of 4Q, 2023	Michelle Findlater	QIC					
Plan All-Cause Readmissions (PCR)	UM/CM/LTC to collaborate and set goals on improving care coordination after discharge. For example, including but not limited to improving PCP follow up post discharge rate by 10% (focus on getting discharge plans w/ PCP appt from hospitals)	<u>Planned Activities:</u> 1) Set up a Transition of Care workgroup among UM, CM and LTC to discuss ways to increase post hospitalization visits with PCP and address barriers. 2) Update the UTC letter for members that UM/CM are unable to reach post discharge.	Setting up the workgroup - end of 1Q 2023 Updating the UTC letter - end of 2Q 2023	UM Director CM Director LTC Director	QIC		X			



2022 Quality Improvement Program Evaluation, 2023 Quality Improvement Program and Work Plan

Special Quality Assurance Committee Meeting

March 15, 2023

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.

Quality Improvement (QI) Evaluation

- Annually, CalOptima evaluates the effectiveness of the QI Program:
 - Achievements from the previous year
 - Program structure
 - Responsibility and success of QI initiatives
 - Identification of new initiatives
- Based upon the evaluation of the previous year, the QI Program is revised and updated for the following year.
- The QI Workplan provides the detail of how CalOptima will design, implement and measure the initiatives outlined in the QI Program.

2022 QI Program Achievements

- **September 2022:** CalOptima Health received a rating of 4 out of 5 in the NCQA's¹ Medicaid Health Plan Ratings 2022.
 - No other Medi-Cal Plan in California earned a rating higher than 4 out of 5.
 - This is the eighth year in a row that CalOptima Health has received this distinction.
- **October 2022:** Chief Executive Officer Michael Hunn and Chief Medical Officer Richard Pitts, D.O., Ph.D., were recognized as 2022 OC Visionaries in a special publication of the LA Times OC.
- **November 2022:** CalOptima Health won an award from mPulse Mobile for Most Improved Consumer Experience with its multilingual, two-way SMS texting program that addressed language barriers around food security.
 - The program educated members on the availability and benefits of CalFresh

2022 QI Program Achievements Cont.

- **November 2022:** CalOptima Health and the Orange County Health Care Agency won the Public-Private Partnership Award from the Orange County Business Council Turning Red Tape Into Red Carpet Awards.
 - The award recognizes both agencies for the launch of Be Well OC's campus in the city of Orange as a first-of-its-kind center that provides comprehensive behavioral health care to improve mental health and substance use disorder services for Orange County residents.

NCQA¹ - National Committee for Quality Assurance

DHCS² - Department of Health Care Services

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Review of 2022 Priority Goals

Priority Goals	Accomplishments
<p>1. Develop and implement a comprehensive Health Equity framework</p>	<ul style="list-style-type: none"> • Created Health Equity and SDOH Workgroup in Jan 2022 • Developed stakeholder survey to collect feedback • Adopted a framework to guide health equity efforts • Established action teams to focus on Health Equity and SDOH Data and Training
<p>2. Improve quality of care and member experience by maintaining NCQA Health Plan Rating of 4.0, and at least a Four-Star Rating for Medicare.</p>	<ul style="list-style-type: none"> • Received a rating of 4 out of 5 in the National Committee for Quality Assurance’s Medicaid Health Plan Ratings in 2022 • Received a Three-Star Overall Rating for Medicare (OneCare) <ul style="list-style-type: none"> ▪ OneCare’s CAHPS performance dropped significantly in each category, resulting in a Part C rating of 2.5
<p>3. Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare, and Hospital Quality</p>	<ul style="list-style-type: none"> • Implemented 2022 P4V Programs for Medi-Cal and OneCare Connect • Developed a P4V for OneCare for MY 2023 • Created 2023-2027 Hospital Quality Program

NCQA¹ - National Committee for Quality Assurance

DHCS² – Department of Health Care Services

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QI Evaluation Highlights: Program Structure and Oversight

- Added Staffing to Support Quality
 - Executive Director of Quality
 - Quality Medical Director
- Quality Improvement Committee (QIC) met 11 times in 2022
 - 7 Quality Sub-Committees met at least quarterly in 2022
- Updating the QI Committee and Program to include health equity
 - Quality Improvement Health Equity Transformation Program (QIHETP) and Quality Improvement Health Equity Committee (QIHEC)

QI Evaluation Highlights: Program Initiatives

- Implemented the COVID-19 Vaccination Incentive Program (VIP)
 - 59% of eligible members were vaccinated*
 - OCC and OC have a vaccination rate of 81.8% and 83.9%, respectively; met 80% goal
- Implemented two CalAIM components:
 - Enhanced Care Management (ECM) – 1,045 member participation
 - Community Supports (CS) = 362 member participation
- Implemented the Homeless Health Initiative Program (HHIP)
 - Homeless Response Team (HRT) received and addressed 421 calls
 - Clinical Field Team treated 375 individuals
 - Street Medicine Request for Qualification was launched in July 2022 and providers were selected for pilot to be launched in 2023

*As of October 31, 2022; eligible members: CalOptima Health members ages 6 months and up

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QI Evaluation Highlights: Performance Outcomes

- Met 13 of 15 MCAS¹ HEDIS measures held to MPL²
 - Well-Child Visits in the First 30 Months of Life (First 15 Months) not met
 - CalOptima Health to implement a DHCS³ required PIP to address this measure; awaiting technical guidance from DHCS³
 - Well-Child Visits in the First 30 Month of Life (15 Months - 30 Months) not met
 - CalOptima Health to implement a DHCS³ PDSA⁴: By 02/28/2023, complete a minimum of 2 outreach attempts to at least 90% of members (approximately 150) with sub-populations with underutilization.

MCAS¹ – Medi-Cal Managed Care Accountability Set; goal is 50th percentile

MPL² – Minimum Performance Level

DHCS³ – Department of Health Care Services

PDSA⁴ – Plan Do Study Act

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QI Evaluation Highlights: Member Experience

- Member Experience (CAHPS¹) Surveys were fielded at both the plan and network level in 2022
 - NCQA Health Plan Rating for Patient Experience at 2 Stars (Medi-Cal)
 - CMS Star Rating
 - Rating of Health Plan at 2 Stars (OneCare)
 - Rating of Health Care Quality 1 Stars (OneCare)
- CalOptima Health submitted all deliverables to DHCS for Annual Network Certification and to CMS² for the Triennial Network Adequacy Review
 - We anticipate meeting requirements for mandatory providers types (Medi-Cal Only) and provider to member ratios
 - Area of focus: Timely Access (appointment availability) and Time/Distance Standards

CAHPS¹ – Consumer Assessment of Healthcare Providers and Systems

CMS² – Center of Medicare and Medicaid Services

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QI Evaluation Highlights: Patient Safety

- The Post-Acute Infection Prevention Quality Initiative (PIPQI) to reduce antibiotic-resistant bacteria in nursing homes continued in 2022
 - From January to June 2022, the average HAI score decreased from 6.31% to 3.83% (lower HAI score indicate fewer infections in the nursing home)
 - Grant funded ended and program concluded on June 30, 2022.

Recommendations for 2023

- Increase emphasis on preventive measures and screenings that may have been neglected during the pandemic with programs that support
 - Early detection and cancer screening for breast, cervical, colorectal and lung cancer
 - Targeted interventions and member engagement to well-child visits, blood lead screening and childhood immunizations.
- Incorporate Social Determinants of Health (SDOH) factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
- Expand quality initiatives to improve member experience, focused on increasing member access to care.

2023 Quality Improvement Program Description (Work Plan)

Board of Directors' Special Quality Assurance Committee
March 15, 2023

Linda Lee, Executive Director, Quality Improvement

Quality Improvement (QI) Program Process

- The QI Program provides a formal process to systematically monitor and objectively evaluate, track and trend quality, efficiency and effectiveness.
- The QI Workplan provides the detail of how CalOptima will design, implement and measure the initiatives outlined in the QI Program.

2023 QI Program Description

- Describes the quality and safety of clinical care, and organizational services provided to our members
- Aligns with the CalOptima Health's five Strategic Priorities and Objectives:
 - Organizational and Leadership Development
 - Overcoming Health Disparities
 - Finance and Resource Allocation
 - Accountabilities and Results Tracking
 - Future Growth
- Aligns with the priorities of our state and federal regulators:
 - Center for Medicare and Medicaid Services (CMS) National Quality Strategy
 - Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

2023 QI Program Description (cont.)

- Describes the scope of services for each line of business
- Describes the provider network
- Established the 2023 QI Goals and Objectives
 - Goal 1 - Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational, and community levels.
 - Goal 2 - Improve quality of care and member experience by obtaining NCQA¹ Health Plan Rating of 5.0, and at least a Four-Star Rating for Medicare.
 - Goal 3 - Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare, and a Hospital Quality.

2023 QI Program Description and Revision Highlights

- Updated new program initiatives
 - Health Equity Framework
 - Comprehensive Community Cancer Screening and Support Program
 - Five-Year Hospital Quality Program
- Updated the QI Program Staffing and Resources to reflect current organizational structure
- Updated the QI Committee Structure – removing OneCare Connect committees
- Updated sections in the QI Program to reflect current operational processes and workflows

2023 QI Work Plan Focus Areas

- Preventive measures and screenings that were impacted during the pandemic with programs that support
 - Early detection and cancer screening for breast, cervical, colorectal and lung cancer
 - Targeted interventions and member engagement to well-child visits, blood lead screening and childhood immunizations.
- Social Determinants of Health (SDoH) factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
- Quality initiatives to improve member experience, focused on increasing member access to care.

2023 QI Work Plan Revisions: Program Structure and Oversight

Change	Programs
Revised	<ul style="list-style-type: none">• Elements of the DHCS Comprehensive Quality Strategy now tracked under CalAIM and Population Health Management Strategy
Added	<ul style="list-style-type: none">• OneCare Pay-for-Value Program for MY 2023• NCQA Health Equity Accreditation by January 2026
Removed	<ul style="list-style-type: none">• Quality Withhold for OneCare Connect (ending of OCC program)• BHI Incentive Program (program ended 12/31/22)• Homeless Health Initiatives (now part of CalAIM)

2023 QI Work Plan Revisions: Quality of Care

Change	Programs
Revised	<ul style="list-style-type: none"> Multi-Disciplinary Approach to Improving Diabetes Care now focused on CalOptima Health Community Network Latino Members
Added	<ul style="list-style-type: none"> CalOptima Health Comprehensive Community Cancer Screening Program STARs Measures Improvement MCAS Performance Measures – Improvement Plans <ul style="list-style-type: none"> Focus on Well-Child Visits in the First 30 Months Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) Depression Remission or Response for Adolescents and Adults (DRR-E) Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

*As of October 31, 2022; eligible members: CalOptima Health members ages 6 months and up

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2023 QI Work Plan Revisions: Quality of Service

Change	Programs
Added	<ul style="list-style-type: none"> • Access - Increase Primary Utilization • Increase the Initial Health Appointments for new members and annual wellness visits for all members • Member Experience - Stars Measure Improvement • Review and identify STARS measures for focused improvement efforts. • CAHPS Composites, and overall ratings; TTY Foreign language interpreter and Members Choosing to Leave Plan • Improve Member Experience - CAHPS outcomes • Improve Access: Access Dashboard
Removed	<ul style="list-style-type: none"> • Improve Access: Expanding Network of Providers Accepting New Patients (part of a PIP that ended in 2022)

*As of October 31, 2022; eligible members: CalOptima Health members ages 6 months and up

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2023 QI Work Plan Revisions: Quality of Service Safety of Clinical Care

Change	Programs
Added	<ul style="list-style-type: none">Emergency Department Diversion Pilot
Removed	<ul style="list-style-type: none">Post-Acute Infection Prevention Quality Incentive (PIPQI) (program ended in June 2022)Orange County COVID Nursing Home Prevention Program (grant ended May 31, 2022)

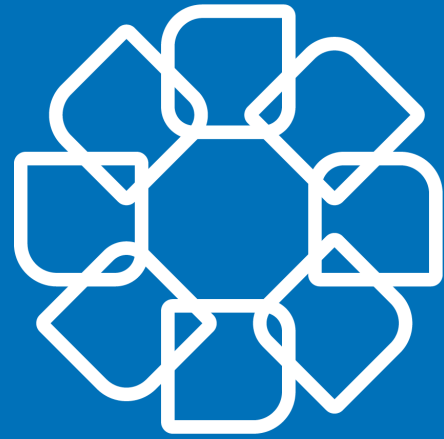
*As of October 31, 2022; eligible members: CalOptima Health members ages 6 months and up

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Questions





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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 15, 2023 Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

Report Item

5. Recommend Board of Directors Approval of Revision to the Measurement Set for the CalOptima Health's Measurement Year 2023 Medi-Cal Quality Pay for Value Program

Contacts

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

Recommended Action

1. Recommend Board of Directors Approval of Modification of the Measurement Set for the 2023 Health Network Medi-Cal Pay for Value Performance Program for the Measurement Period Effective January 1, 2023, through December 31, 2023.

Background

At the December 1, 2022 meeting, the CalOptima Health Board of Directors reviewed and approved the 2023 Medi-Cal Pay for Value (P4V) program. At that time, the Department of Health Care Services (DHCS) had proposed a draft Medi-Cal Managed Care Accountability Set (MCAS) for measurement year (MY) 2022/reporting year 2023. CalOptima Health staff based the Medi-Cal P4V program on the draft measurement set available at that time. DHCS revised the measurement set on December 31, 2022.

Discussion

Staff proposes revisions to the approved Medi-Cal P4V measurement set to align with the DHCS MCAS measures released on December 31, 2022. The following revisions are recommended:

Measures Approved on December 1, 2022	Recommended Revisions
Follow-up After ED Visit for Substance use – within 7 days	Replace with: Follow-up After ED Visit for Substance use – within 30 days
Comprehensive Diabetes Care – Blood Pressure Control <140/90	remove
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	remove
Prenatal Immunization Status	remove
Follow Up Care for Children Prescribed ADHD Medications - Initiation phase and Continuation/ maintenance phase	remove
Diabetes Screening for People with Schizophrenia or bipolar disorder who are using Antipsychotic medications	remove

See attachment 1 for the full set of measures, including those that do not require revision for alignment with the DHCS MCAS measurement set. Those measures will be used to evaluate CalOptima Health's delegated and direct networks.

Fiscal Impact

The fiscal impact for the Medi-Cal P4V Performance Program for the measurement period of January 1, 2023, through December 31, 2023, will be no more than ten percent (10%) of the professional capitation (base rate only) or its equivalent for CalOptima Direct network. Since the funding period will be July 1, 2023, through June 30, 2024, Management will include related expenses in the Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation

Alignment with the DHCS MCAS measures promotes consistency with CalOptima Health strategic and quality goals and supports CalOptima Health's efforts to achieve quality outcomes.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachment

1. [CalOptima Health's Measurement Year 2023 Quality Incentive Programs](#)

/s/ Michael Hunn
Authorized Signature

03/01/2023
Date

Attachment 1

CalOptima Health Measurement Year (MY) 2023 Medi-Cal Pay for Value Program Revised Measurement Set

Revised MY 2023 Medi-Cal Pay for Value (P4V)

CalOptima Health recommends aligning measurement set with the DHCS Medi-Cal Managed Care set released on December 31, 2022 as follows:

Recommended modifications for MY 2023 Medi-Cal P4V

MY 2023 Pay for Value Measures	
Measurement Set Approved December 1, 2022	Proposed Measurement Set
HEDIS	HEDIS
Breast Cancer Screening	Breast Cancer Screening
Cervical Cancer Screening	Cervical Cancer Screening
Child and Adolescent Well-Care Visits: Total	Child and Adolescent Well-Care Visits: Total
Childhood Immunization Status: Combination 10	Childhood Immunization Status: Combination 10
Chlamydia Screening in Women: Total	Chlamydia Screening in Women: Total
Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (> 9%)	Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (> 9%)
Controlling High Blood Pressure	Controlling High Blood Pressure
Follow-Up After ED Visit for Mental Illness: 30 Days	Follow-Up After ED Visit for Mental Illness: 30 Days
Immunizations for Adolescents: Combination 2	Immunizations for Adolescents: Combination 2
Lead Screening in Children	Lead Screening in Children
Timeliness of Prenatal Care	Timeliness of Prenatal Care
Postpartum Care	Postpartum Care
Well-Child Visits (WCV) in the First 30 Months of Life: WCV in the First 15 Months (W30)	Well-Child Visits (WCV) in the First 30 Months of Life: WCV in the First 15 Months (W30)
Well-Child Visits (WCV) in the First 30 Months of Life: WCV for Age 15 Months – 30 Months (W30)	Well-Child Visits (WCV) in the First 30 Months of Life: WCV for Age 15 Months – 30 Months (W30)
Follow-up After ED Visit for Substance use – within 7 days	Replace- Follow-up After ED Visit for Substance use – within 30 days
Comprehensive Diabetes Care – Blood Pressure Control <140/90	remove
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	remove
Prenatal Immunization Status	remove
Follow Up Care for Children Prescribed ADHD Medications - Initiation phase and Continuation/ maintenance phase	remove
Diabetes Screening for People with Schizophrenia or bipolar disorder who are using Antipsychotic medications	remove
CAHPS: Member Experience	CAHPS: Member Experience
Care Coordination	Care Coordination
Customer Service	Customer Service
Getting Care Quickly	Getting Care Quickly
Getting Needed Care	Getting Needed Care

Attachment 1

**CalOptima Health Measurement Year (MY) 2023
Medi-Cal Pay for Value Program Revised Measurement Set**

MY 2023 Pay for Value Measures	
Measurement Set Approved December 1, 2022	Proposed Measurement Set
Rating of Health Care	Rating of Health Care
Rating of Health Network	Rating of Health Network
Rating of PCP	Rating of PCP
Rating of PCP	Rating of PCP
Rating of Specialist	Rating of Specialist

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 15, 2023

Special Meeting of the CalOptima Health Board of Directors’ Quality Assurance Committee

Report Item

6. Recommend Board of Directors Approval of New CalOptima Health Policy GG.1132: Medi-Cal Annual Wellness Visit Program

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Marie Jeannis, RN, MSN, CCM, Executive Director, Population Health Management, (714) 246-8591

Linda Lee, MPH, Executive Director, Quality, (657) 900-1069

Recommended Action

Recommend Board of Directors Approval of new CalOptima Health Policy GG.1132: Medi-Cal Annual Wellness Visit Program

Background/Discussion

CalOptima Health regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements, contractual obligations, laws, and CalOptima Health operations.

In December 2022, the CalOptima Health Board of Directors (Board) approved the Medi-Cal Annual Wellness Visit Initiative. The Medi-Cal Annual Wellness Visit Initiative is a program that gives providers incentives for conducting annual wellness visits, assessing social determinants of health, and reviewing preventive services to improve member quality of care and health outcomes. CalOptima Health also gives incentives to members who complete an annual wellness visit. This program does not include dual eligible members and does not apply to Kaiser Foundation Health Plan Inc.

Policy GG.1132 defines the guidelines for an Annual Wellness Visit for CalOptima Health’s Medi-Cal members who are forty-five (45) years or older. The policy outlines program and documentation requirements, criteria for member and provider incentives, and methodology for claims reimbursement.

Fiscal Impact

The recommended action has no additional fiscal impact. A previous Board action on December 1, 2023, allocated up to \$3.75 million from existing reserves to fund the Medi-Cal Annual Wellness Visit Program through June 30, 2023.

Rationale for Recommendation

CalOptima Health staff recommends that the Board approve new policy GG.1132 to ensure CalOptima Health’s continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. [CalOptima Health Policy GG.1132 – Medi-Cal Annual Wellness Visit Program](#)

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 1, 2022	Approve Actions Related to the Medi-Cal Annual Wellness Visit Initiative	April 1, 2023 – June 30, 2023	\$3.75 million

/s/ Michael Hunn
Authorized Signature

03/01/2023
Date

Policy: GG.1132p
Title: **Medi-Cal Annual Wellness Visit Program**
Department: Medical Management
Section: Quality Improvement

CEO Approval: /s/

Effective Date: 04/01/2023
Revised Date: Not Applicable

Applicable to: Medi-Cal
 OneCare
 PACE
 Administrative

1 **I. PURPOSE**

2
3 This policy defines the program to promote, provide, and document Annual Wellness Visits (AWV) for
4 adult Medi-Cal Members that are forty-five (45) years or older, excluding dual eligible members and
5 members assigned to Kaiser Foundation Health Plan Inc as their Health Network.
6

7 **II. POLICY**

8
9 A. The Medi-Cal AWV program aims to ensure that Members complete a comprehensive annual
10 wellness visit with their primary care provider. Members will receive an incentive for completion of
11 an AWV. Qualified Providers will receive an incentive for providing a comprehensive AWV,
12 reporting confirmed condition diagnosis codes, capturing Social Determinants of Health (SDOH)
13 factors,) and properly documenting such information in Medical Records.
14

15 B. The Medi-Cal AWV Program includes the following four (4) components:

16
17 1. Provision of a comprehensive AWV including:

- 18 a. Patient and family health history
19 b. physical exam
20 c. assessment for cognitive, behavioral health, functional status, pain, risk factors, SDOH
21 factors, and other health issues as appropriate
22 d. preventive screening
23 e. education and counseling services
24 f. advance care planning
25 g. medication review
26

27 2. Provider payment for validated AWVs for the target population: Qualified Providers shall be
28 reimbursed one hundred twenty-five dollars (\$125) per assigned Member per year for each
29 completed, submitted and verified AWV billed under Current Procedural Terminology (CPT)
30 code 99205 with modifier 33 for new patient or 99215 with modifier 33 for established patients.
31 To qualify for the \$125 incentive appropriate CPT codes must be submitted via claims or
32 encounter data.

33 3. Provider incentive for completion of the Primary Care Engagement and Clinical Documentation
34 Integrity Program Attestation Form, used to support provider documentation during the AWV.
35 Qualified Providers may earn supplemental payment of one hundred dollars (\$100) per Member

1 per Qualified Provider per year after completing an AWV with their assigned Member and
2 completing an attestation form for each Member. The attestation form is used to document
3 clinical conditions, preventive screens, and diagnosis codes to ensure accuracy and
4 completeness.
5
6
7

- 8 4. Member incentive: CalOptima Health shall distribute a fifty-dollar (\$50) gift card to Members
9 who receive an AWV with a maximum of once per Service Year.

10 C. For dates of service on or after April 1, 2023, a Qualified Provider is eligible for incentives, if:

- 11
12
13 1. The assigned Member is eligible for Medi-Cal and forty-five (45) years or older as of December
14 31 of the Service Year;
15
16 2. The Qualified Provider conducts an AWV with the assigned Member within the Service Year;
17
18 3. The Qualified Provider addresses and documents all health conditions as noted on the
19 attestation during the AWV and as provided in Section II.B.1;
20
21 4. The Qualified Provider submits the completed attestation form to CalOptima Health with
22 supporting Medical Records by the required deadline; and
23
24

25 **III. PROCEDURE**

- 26
27 A. CalOptima Health shall conduct provider education and provide technical assistance to improve
28 provider accuracy and completeness of clinical documentation.
29
30 B. CalOptima Health shall provide each Qualified Provider via the CalOptima Health Provider Portal,
31 an attestation form and Medical Records submission instruction documents for each of their
32 assigned Members.
33
34 C. The AWV must be completed in a face-to-face setting, including but not limited to in person and/or
35 telehealth utilizing a real-time asynchronous audio-video platform.
36
37 D. The Qualified Provider shall complete all AWVs in the time period required by Service Year.
38
39 E. Upon completion of an AWV with an assigned Member, the Qualified Provider shall document, as
40 appropriate, regarding clinical assessment, preventive health screenings, SDOH factors, and health
41 conditions on the attestation form.
42
43 F. The Qualified Provider shall submit the verified attestation form (Attachment A), as well as
44 supporting Medical Records to the CalOptima Health via CalOptima Health Provider Portal, within
45 the Submission Period, but no later than January 31 following the Service Year.
46
47 G. The Qualified Provider must appropriately document all of the required elements in the attestation
48 form, with supporting Medical Records, including, but not limited to:
49
50 1. Member name;
51
52 2. Date of Service;
53

- 1 3. Preventive Health Screening section;
- 2
- 3 4. Year-Over-Year Chronic and Non-Chronic Conditions sections;
- 4
- 5 5. SDOH Questionnaire;
- 6
- 7 6. Acceptable Qualified Provider signature with credentials; and
- 8
- 9 7. Date of authentication

10 Note: condition diagnosis code(s) (existing and/or new) must be coded according to the *ICD-10*
11 *Clinical Modification Guidelines for Coding and Reporting*.

- 12
- 13
- 14 H. Within thirty (30) calendar days from the end of the Submission Period, the CalOptima Health
15 Coding Initiatives shall review the Qualified Provider's attestation form and supporting Medical
16 Records to ensure each condition diagnosis code submitted by the Qualified Provider has
17 appropriate clinical documentation.
 - 18
 - 19 1. Upon receipt of Medical Records, CalOptima Health shall retain the Medical Records as set
20 forth in CalOptima Health Policy GG.1603: Medical Records Maintenance.
21
- 22 I. In the event the CalOptima Health verifies the Qualified Provider has met the conditions as
23 specified in Sections III.E, III.F and III.G of this Policy, CalOptima Health shall make a
24 supplemental payment in accordance with Section II.B..a. of this policy:
 - 25
 - 26 1. CalOptima Health Finance shall process check request and make a supplemental payment of
27 one hundred dollars (\$100) per completed and verified attestation form, with supporting
28 Medical Records per Member per Qualified Provider per year.
29
 - 30 2. CalOptima Health shall make supplemental payments to the Qualified Provider on a monthly
31 basis.
32
 - 33 3. CalOptima Health shall make supplemental payments within forty-five (45) calendar days from
34 the end of the Submission Month.
35
- 36 J. In the event the CalOptima Health determines that the attestation form or supporting Medical
37 Record(s) is incomplete, lacking clinical justification, or the condition diagnosis codes/SDOH
38 factors are not reported on a claim or encounter file that reflects the codes documented on the
39 attestation form, CalOptima Health staff will deny payment and provide written notification within
40 thirty (30) calendar days to the Qualified Provider of the determination and rationale for the
41 rejection.
42
- 43 K. Upon receipt of CalOptima Health's notification of incomplete Medical Records, the Qualified
44 Provider may correct or dispute the findings within thirty (30) calendar days and resubmit the
45 completed attestation form, with supporting documentation and/or Medical Records.
46
- 47 L. CalOptima Health will remove and not submit any condition diagnosis codes to the Department of
48 Health Care Services (DHCS) that are not supported in the Medical Records to ensure data
49 reliability and program integrity.
50
- 51 M. CalOptima Health may provide additional provider education and technical assistance and/or make
52 a referral to the Office of Compliance should CalOptima Health determine that a Qualified Provider

1 has not accurately reported condition diagnosis codes and/or does not have Medical Records
2 supporting the attestation and/or reported condition diagnosis codes.

- 3
4 N. Should CalOptima Health determine that a Qualified Provider has not accurately reported condition
5 diagnosis codes and/or does not have Medical Records supporting the attestation and/or reported
6 condition diagnosis codes, and such issues negatively impact quality of care or service delivered to
7 a Member, such matters may be referred as a Potential Quality Issue (PQI) in accordance with
8 CalOptima Health Policy GG.1611: Potential Quality Issues Review Process or referred to the
9 Office of Compliance for further review and investigation depending on the nature and scope of the
10 inaccurate reporting.

11
12 **IV. ATTACHMENT(S)**

13
14 Not Applicable

15
16 **V. REFERENCE(S)**

- 17
18 A. 2023 Primary Care Engagement and Clinical Documentation Integrity Program Attestation Form
19 B. Accountable Health Communities Health-Related Social Needs Screening Tool
20 C. CalOptima Health Policy GG.1603: Medical Records Maintenance
21 D. CalOptima Health Policy GG.1611: Potential Quality Issues Review Process
22 E. ICD-10-CM Official Guidelines for Coding and Reporting

23
24 **VI. REGULATORY AGENCY APPROVAL(S)**

25
26 None to Date

27
28 **VII. BOARD ACTION(S)**

29

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

30
31 **VIII. REVISION HISTORY**

32

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2023	GG.1132	Medi-Cal Annual Wellness Visit	Medi-Cal

33
34 **IX. GLOSSARY**

Term	Definition
Annual Wellness Visit (AWV)	An Annual Wellness Visit (AWV) is a yearly visit to develop or update a personalized prevention plan (PPP) to promote health and help prevent disease based on a Member's health risk factors.
Medical Record	Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.

Term	Definition
Potential Quality Issue (PQI)	Any issue whereby a Member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Qualified Provider	For purposes of this policy, contracted Primary Care Provider (PCP), or when applicable, other affiliated PCP, nurse practitioner or physician assistant operating within the provider group.
Social Determinants of Health (SDOH)	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.
Service Year	January 1 through December 31 (12 months).
Submission Month	The month within the submission period in which the attestation form (Attachment A) is submitted to CalOptima Health.
Submission Period	January 1 of the Service Year through January 31 following the Service Year (13 months).

1



Update on Assessment of Quality

Special Quality Assurance Committee Meeting

March 15, 2023

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.

Background

- Launched an assessment in January for both Medi-Cal and OneCare on the quality infrastructure, policies, processes, and programs
- Assessment involves a thorough review of the quality strengths, risks, and opportunities for improvement
- Remediation actions for identified areas of concern are in place; further analysis and initiatives in progress

Overview of Findings To-Date

Strengths

- Experienced HEDIS reporting and audit process
- Established Medi-Cal Pay for Value program
- Standardized facility site reviews incorporating ADA-compliance
- Improved process for medical director review of potential quality issues

Risks

- Decreased performance for OneCare star ratings
- Medi-Cal Well-Child Visits in the First 30 Months of Life(W30) below minimum performance level
- Access and availability results below established performance standards

Opportunities

- Need to expand NCQA accreditation resources to prepare for Health Equity accreditation
- Expand scope and integration of reporting to quality and operational committees
- Augment resources for increased credentialing volume
- Integrate quality initiatives and analytics to focus on all products and priorities

Medi-Cal Quality Findings and Actions

Medi-Cal Findings	Action Plan
<p>DHCS Medi-Cal Accountability Set Outcomes</p> <ul style="list-style-type: none">Well-Child Visits in the First 30 Months of Life below minimum performance levelOngoing discussions with DHCS to provide updates on progress	<ul style="list-style-type: none">Data analysis to identify barriers is completedMeeting with each Medi-Cal Health Network to identify action planData improvement and outreach efforts in place
<p>Provider Credentialing</p> <ul style="list-style-type: none">Modified process to screen CalAIM providers that do not have a state enrollment pathway	<ul style="list-style-type: none">Screening process implemented for CalAIM providersIssuing RFP to contract with credentialing verification organization to assist with increased volume of provider credentialing
<p>Access and Availability</p> <ul style="list-style-type: none">Appointment timeframes for PCP, OB/GYN, specialist, and behavioral health were below standards	<ul style="list-style-type: none">Corrective action plans were issued to Health Networks and providers

OneCare Quality Findings and Actions

OneCare Findings	Action Plan
<p>Medicare Star Ratings</p> <ul style="list-style-type: none">• Overall Star rating decreased from 4 stars to 3 stars• Driven by low performance in member satisfaction, health risk assessment (HRA) completion, and call center availability• CMS issued a corrective action plan (CAP) to OneCare for Part C STARS• Decreased star ratings will result in decreased quality bonus payments which decreases budget available for 2024 OneCare product bid	<ul style="list-style-type: none">• Developing CAP response to CMS• Implementing stars improvement strategy• Implemented call center system fix, daily monitoring• Increased call attempts to complete HRA• Developed provider education kit for member satisfaction best practices• Strategy meetings with each OneCare Health Network

Next Steps

- Quality staff continue to assess organizational quality processes, capacity, and resources
- Staff will continue to report findings and progress quarterly to the Board Quality Assurance Committee

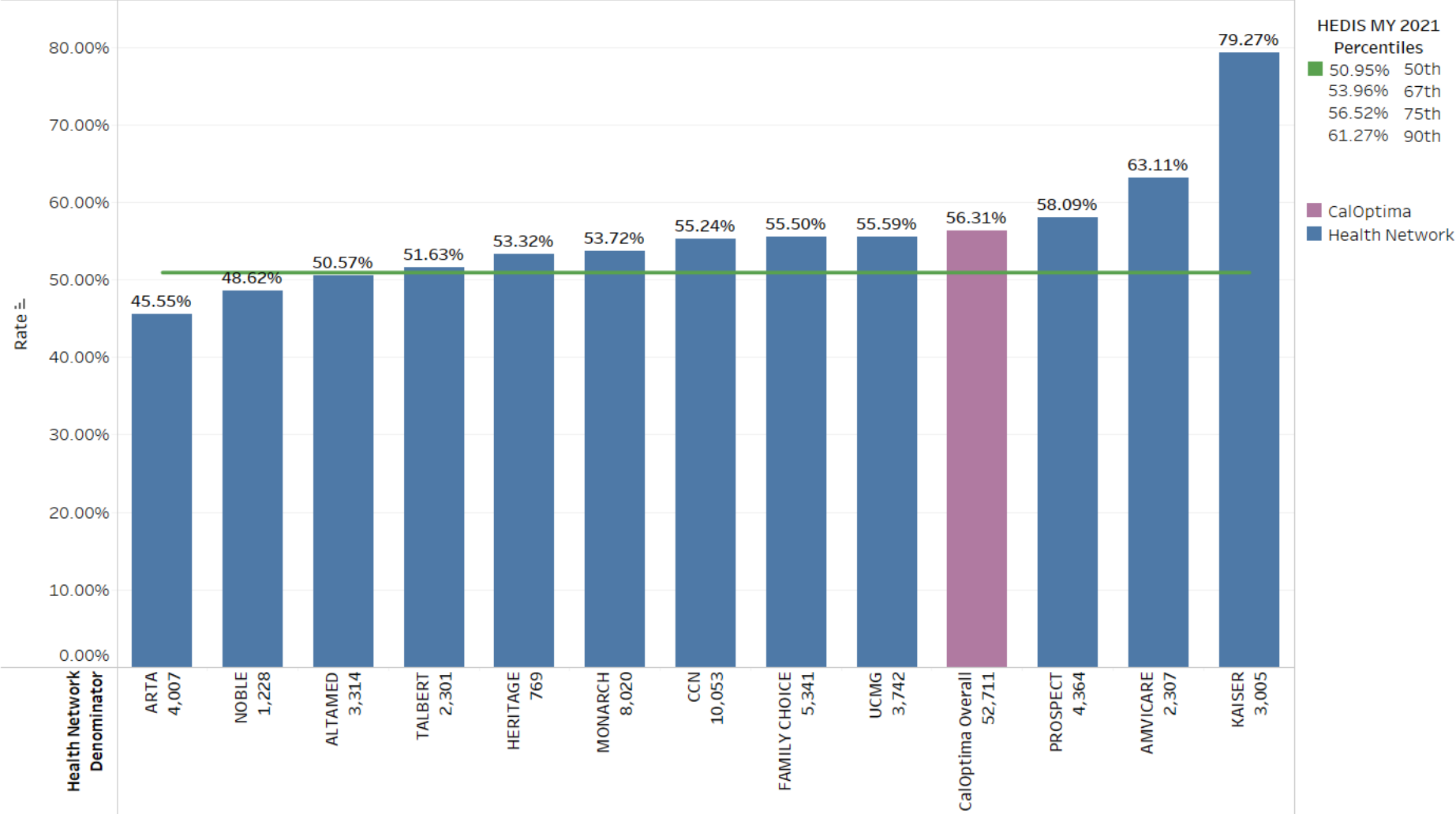
APPENDIX: DHCS MCAS Preliminary MY2022 Results

Overview

- CalOptima Health has conducted a preliminary review of Measurement Year (MY) 2022 DHCS MCAS performance by health network (HN)
 - MY 2022 DHCS MCAS had 15 measures with a minimum performance level
- Rates from January – November 2022:
 - Shared with HNs – November Prospective Rates Report distributed in December
 - Includes claims, encounter, pharmacy, lab and vaccine data received through November 2022
 - Does not include supplemental health network data files and medical record review*

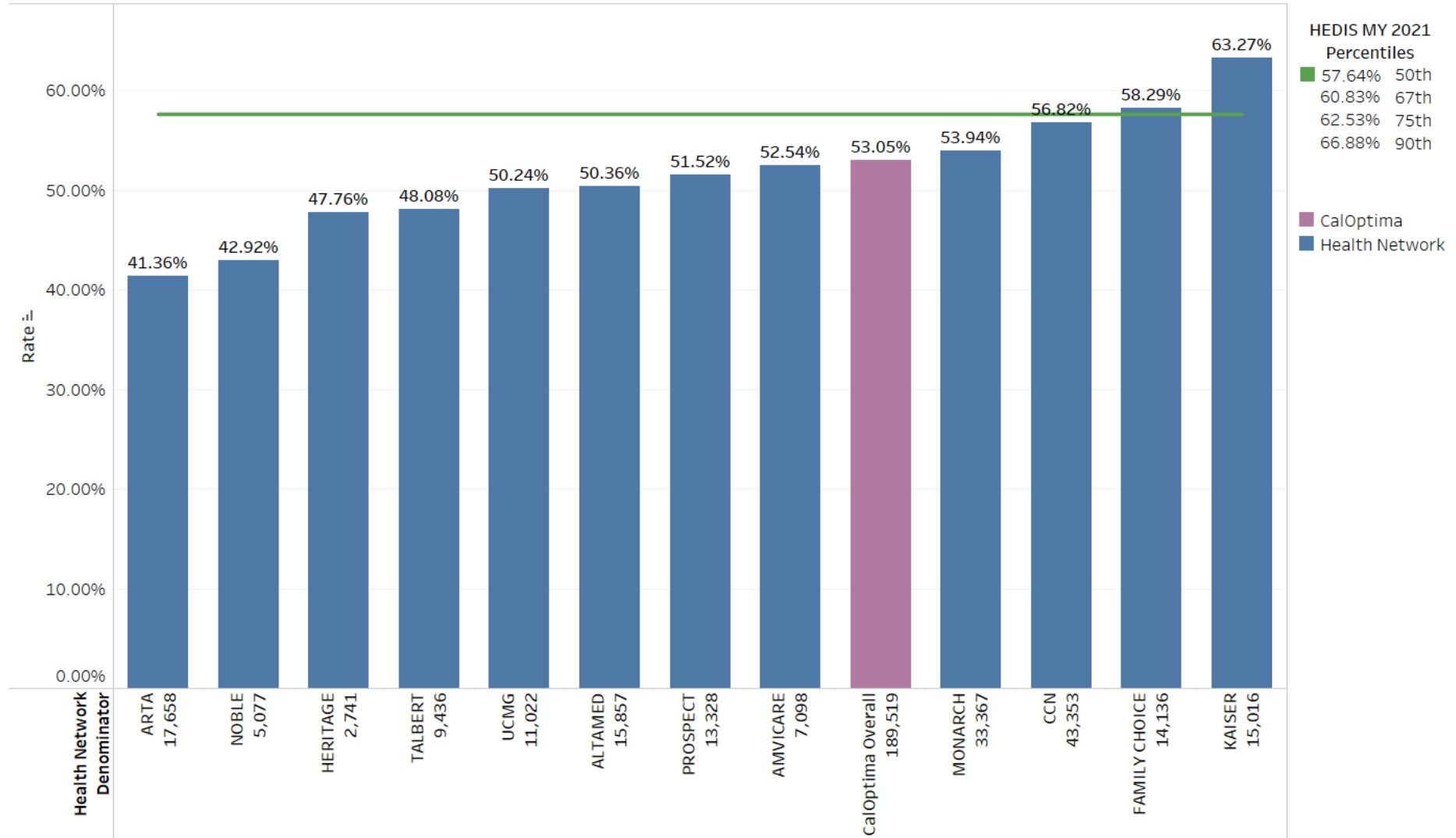
* Supplemental data review occurs from 10/2022-1/2023 and HEDIS medical record review from 2/2023-5/2023
[Back to Agenda](#)

**Medi-Cal
Breast Cancer Screening (BCS)
January 2022 - November 2022**



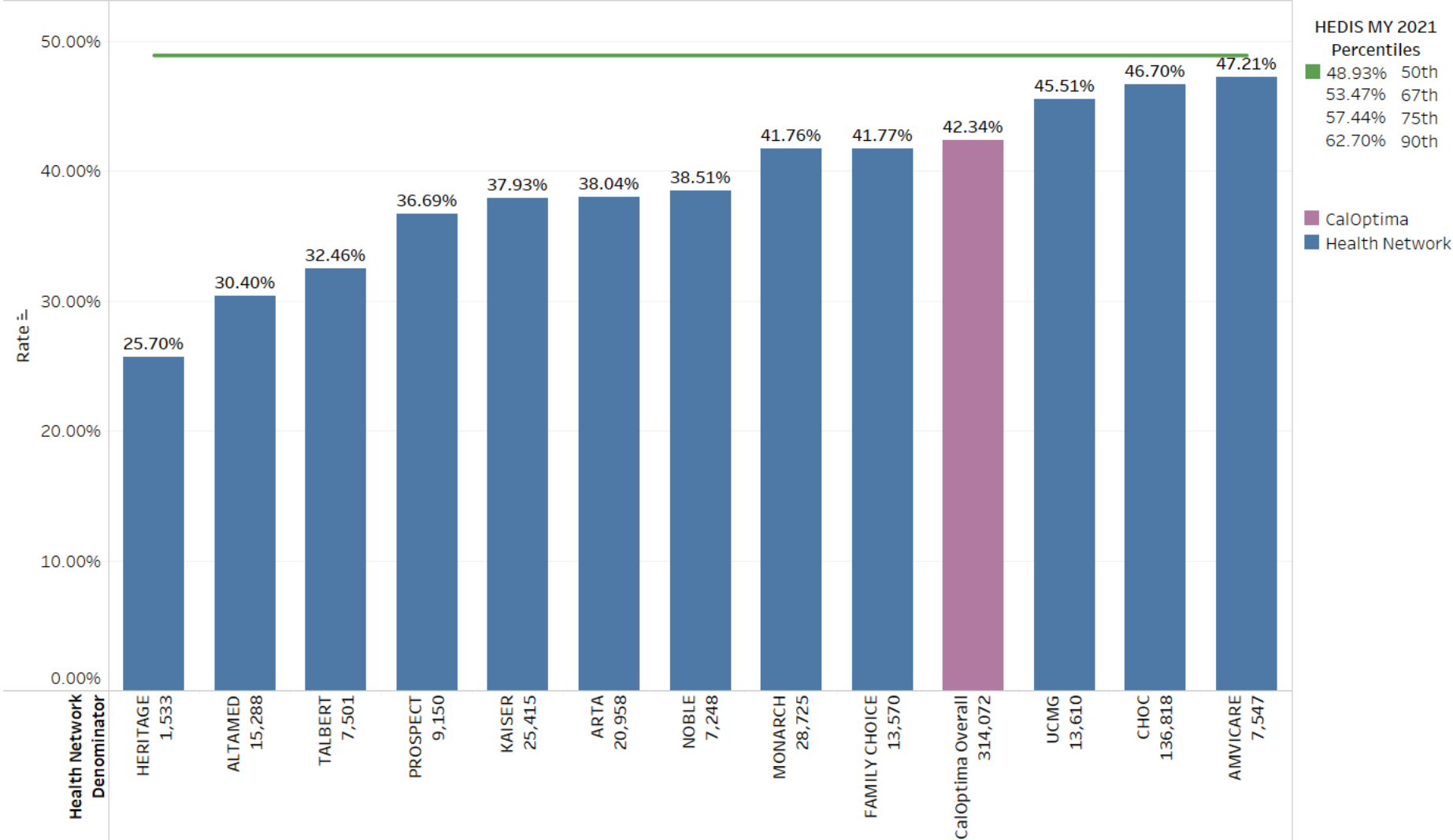
Denominator = number of members eligible for measure
 Administrative measure
 Pay for Value

Medi-Cal
Cervical Cancer Screening (CCS)
January 2022 - November 2022



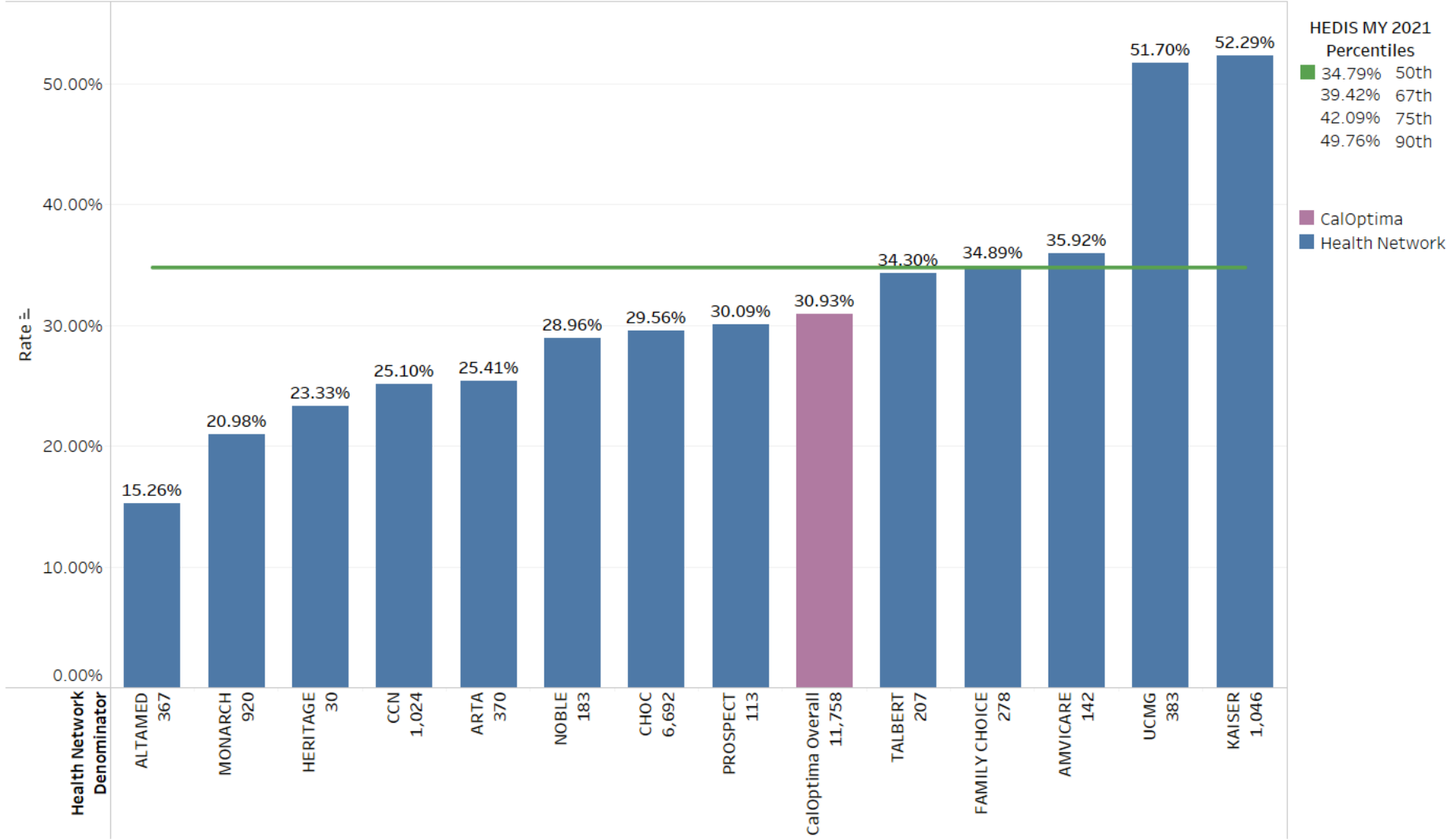
Denominator = number of members eligible for measure
 Hybrid measure
 Pay for Value

**Medi-Cal
Child and Adolescent Well-Care Visits (WCV) Total
January 2022 - November 2022**



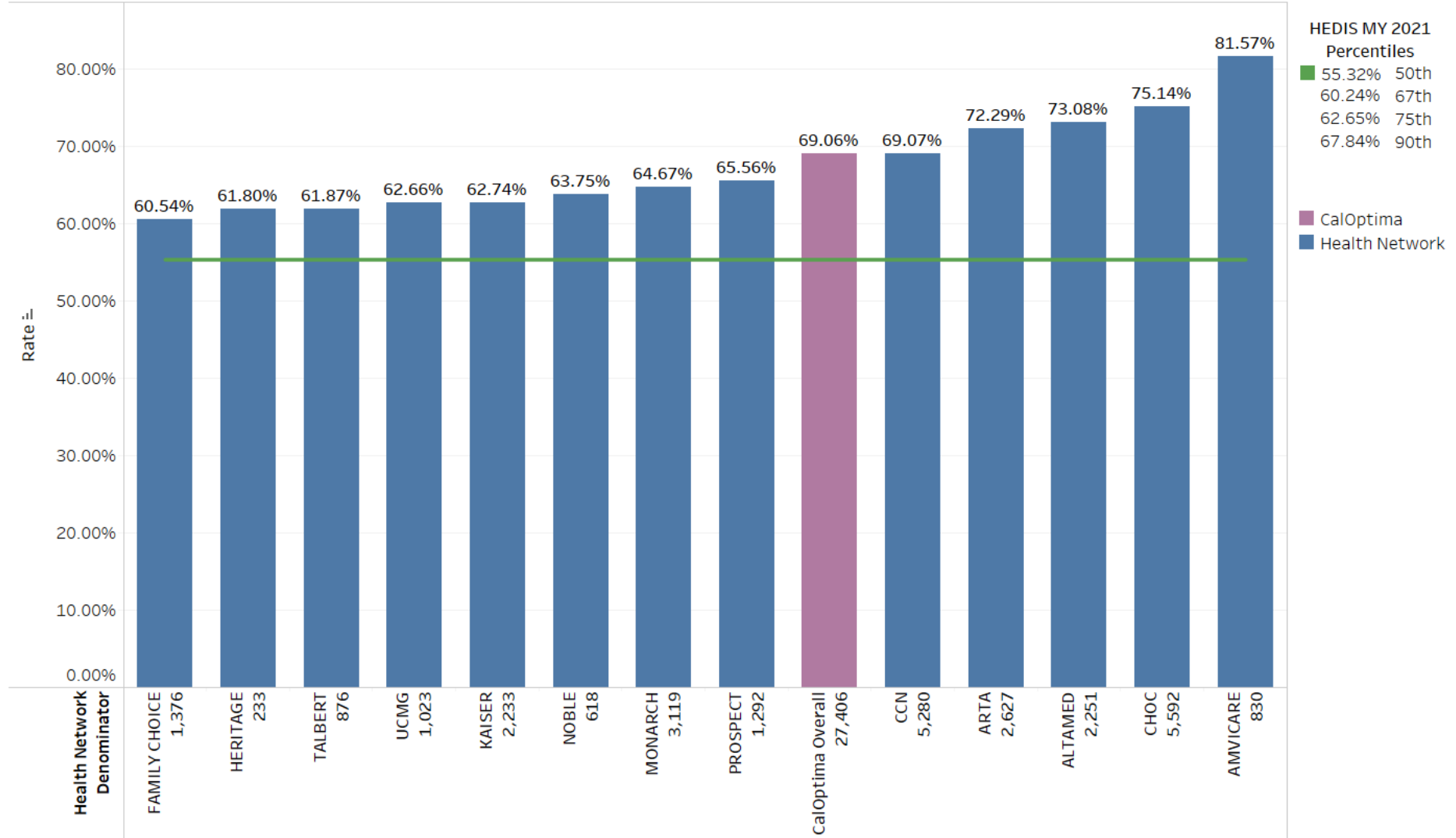
Denominator = number of members eligible for measure
 Administrative measure
 Pay for Value

**Medi-Cal
Childhood Immunization Status (CIS) Combination 10
January 2022 - November 2022**



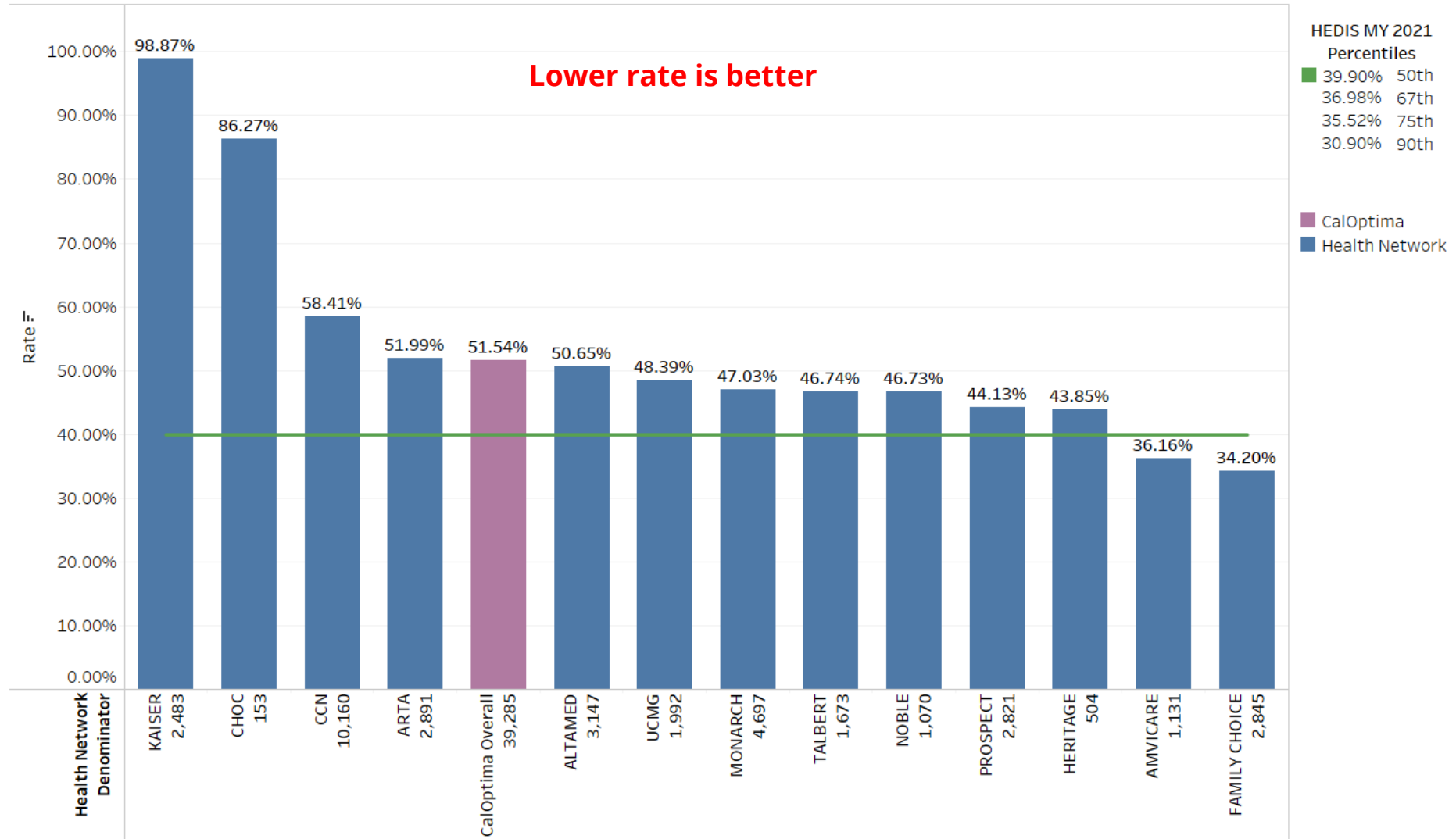
Denominator = number of members eligible for measure
 Hybrid measure
 Pay for Value

**Medi-Cal
Chlamydia Screening in Women (CHL) Total
January 2022 - November 2022**



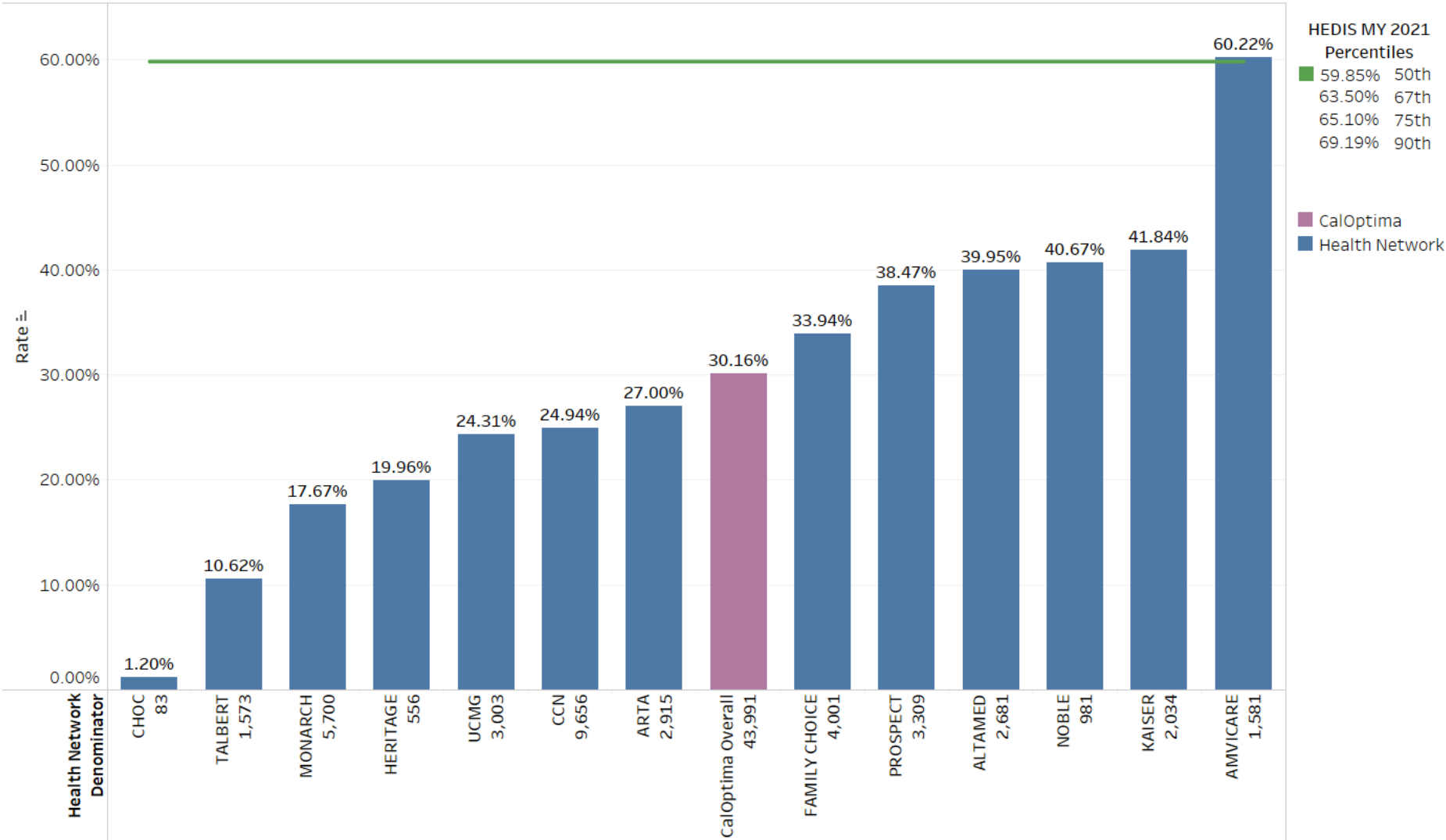
Denominator = number of members eligible for measure
 Administrative measure
 Pay for Value

**Medi-Cal
Comprehensive Diabetes Care (CDC) HbA1c Poor Control (>9)
January 2022 - November 2022**



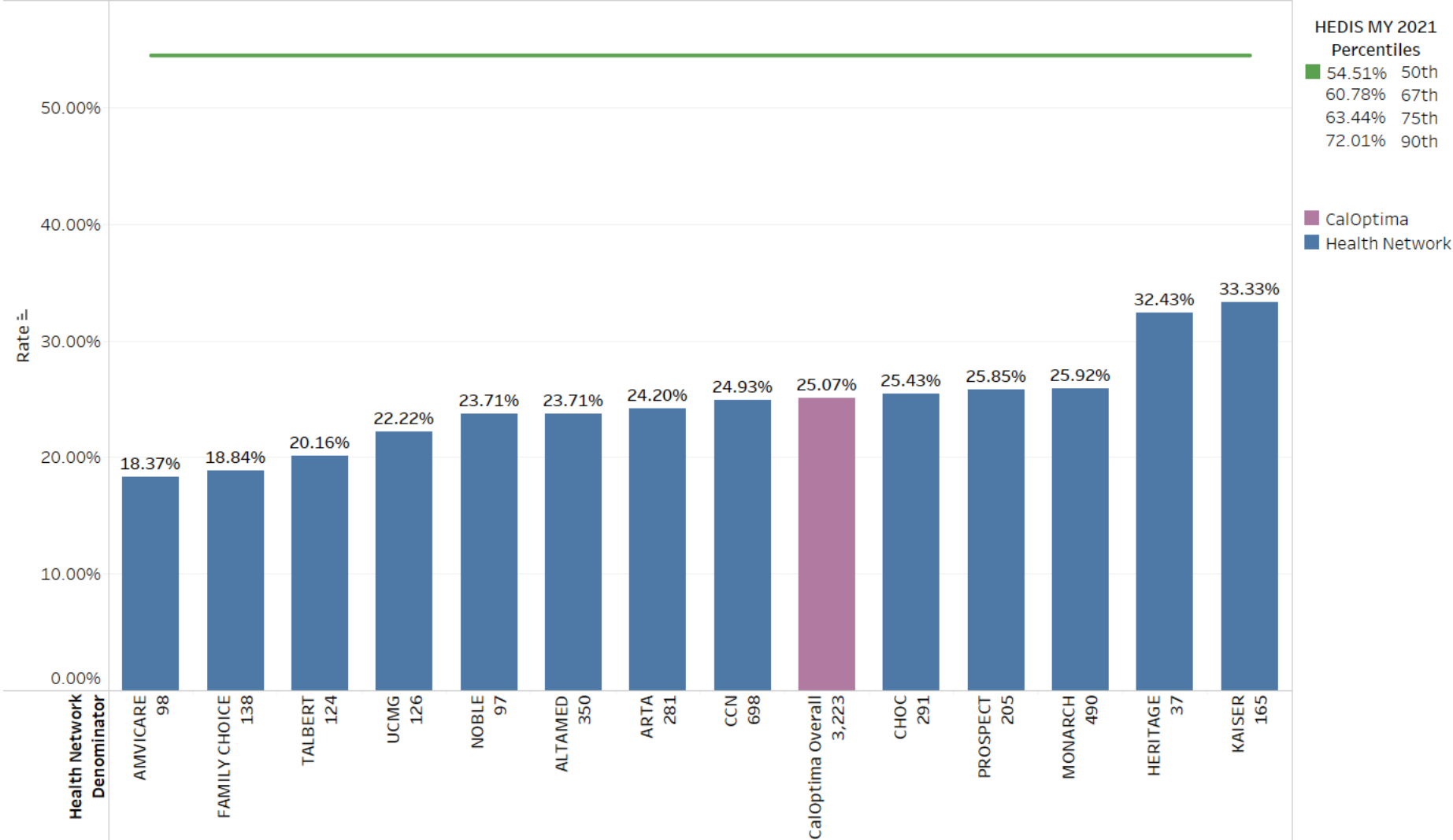
Denominator = number of members eligible for measure
Hybrid measure
Pay for Value

**Medi-Cal
Controlling Blood Pressure (CBP)
January 2022 - November 2022**



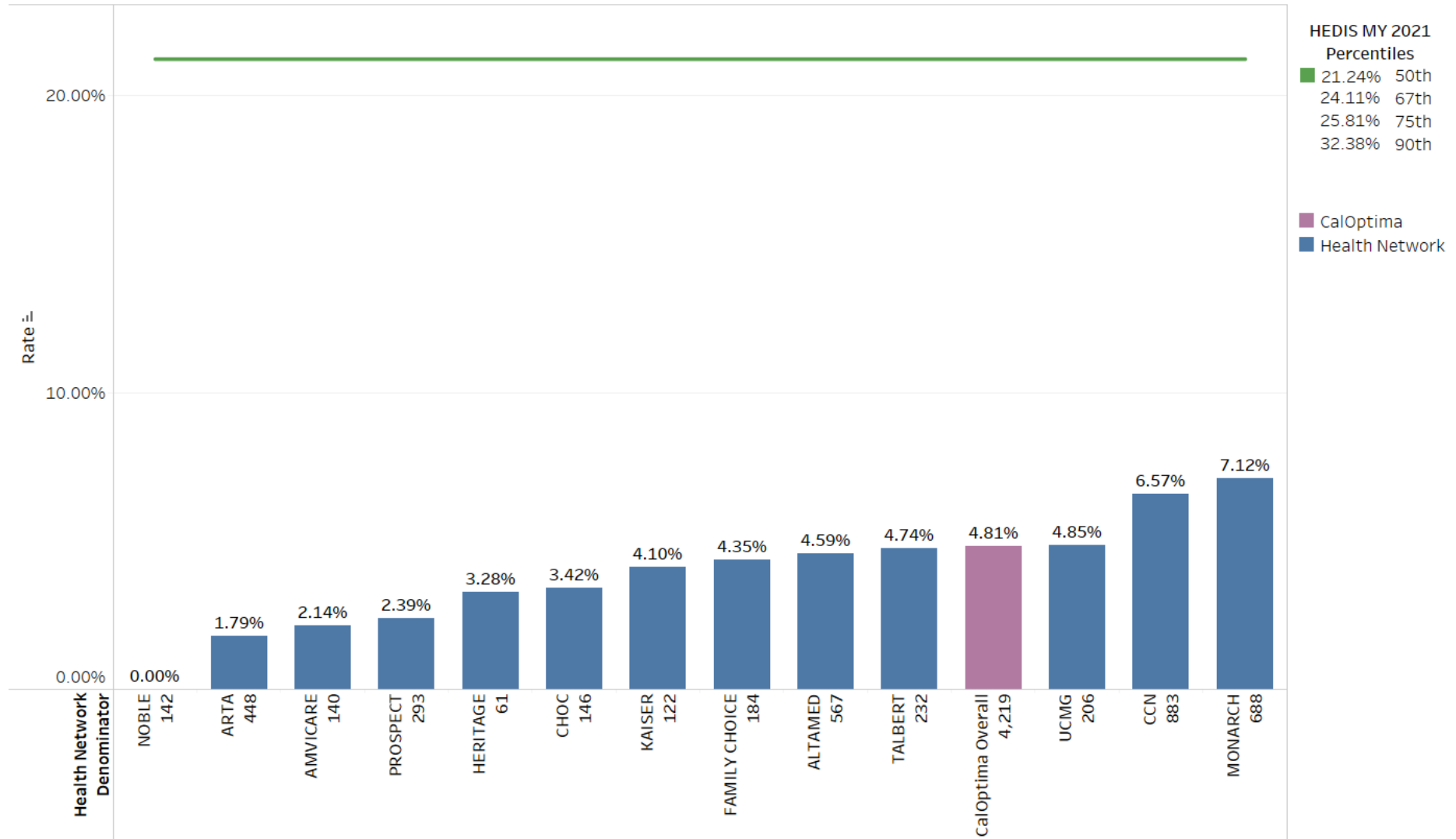
Denominator = number of members eligible for measure
 Hybrid measure
 Pay for Value

Medi-Cal
Follow-Up After ED Visit for mental Illness (FUM) 30 days
January 2022 - November 2022



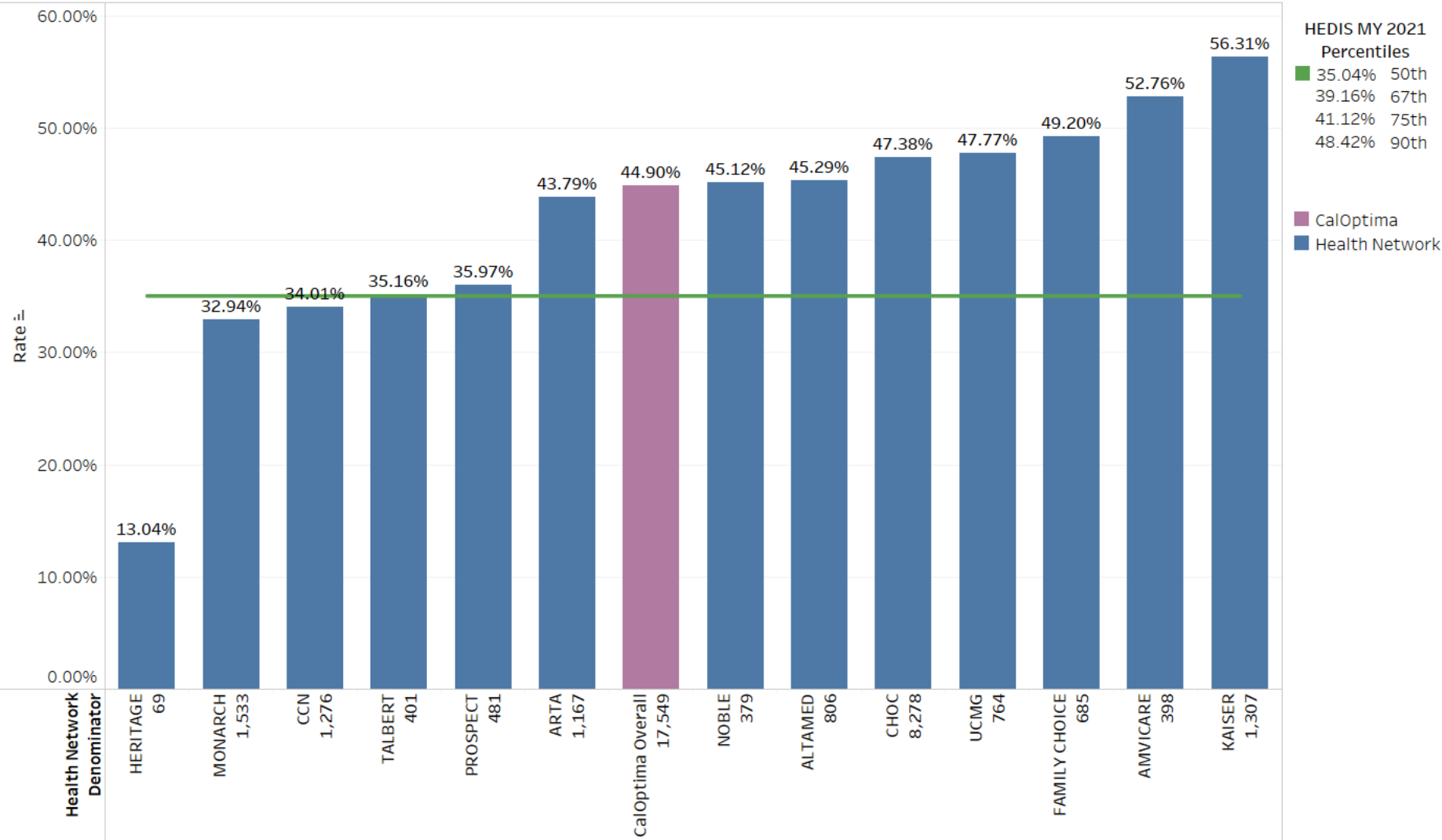
Denominator = number of members eligible for measure
 Administrative measure
 Pay for Value

Medi-Cal
Follow-Up After ER Visit for Alcohol and Other Drug Abuse or Depend (FUA) 30 Day Total
January 2022 - November 2022



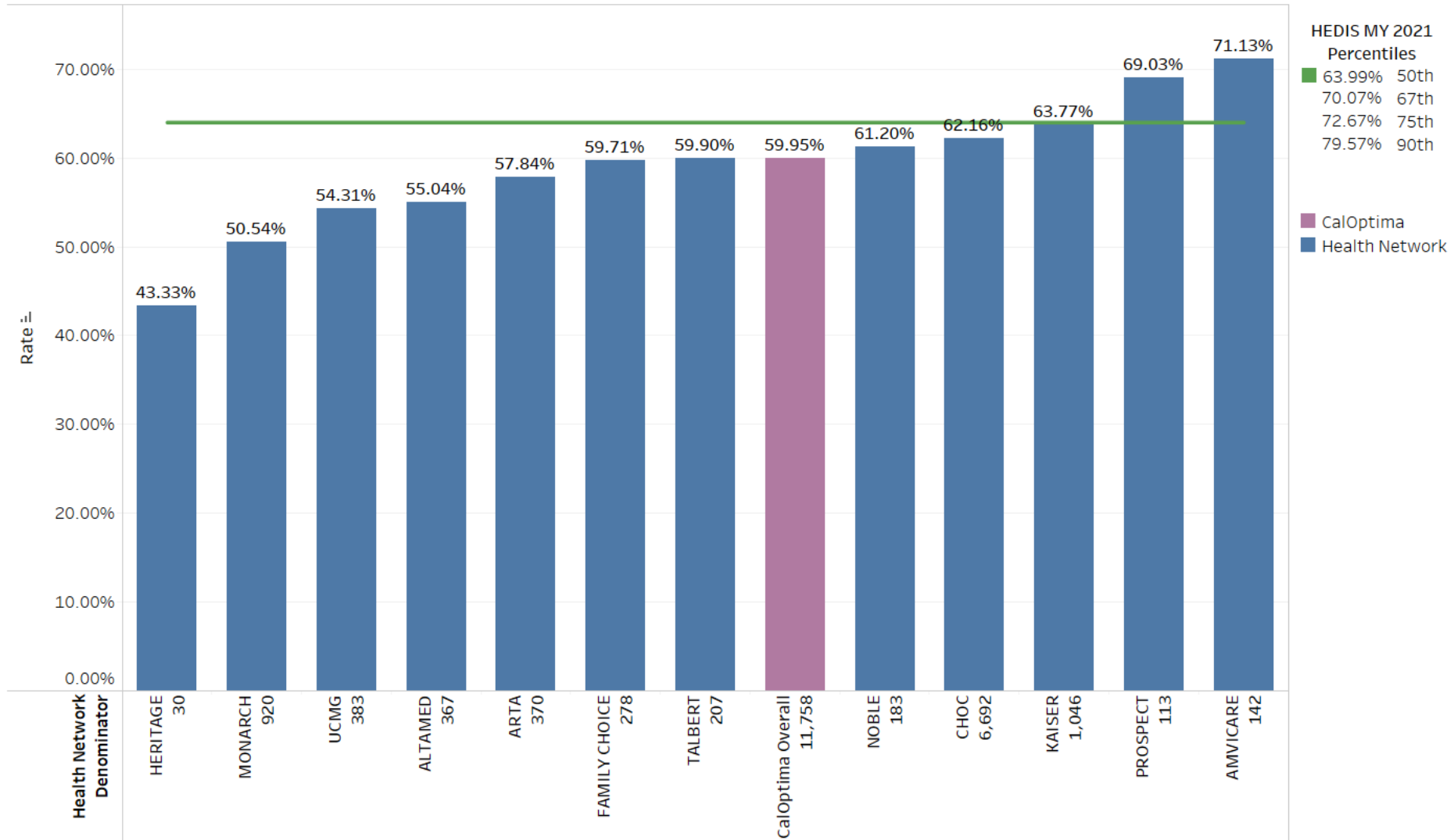
Denominator = number of members eligible for measure
 Administrative measure
 Not Pay for Value

**Medi-Cal
Immunizations for Adolescents (IMA) Combination 2
January 2022 - November 2022**



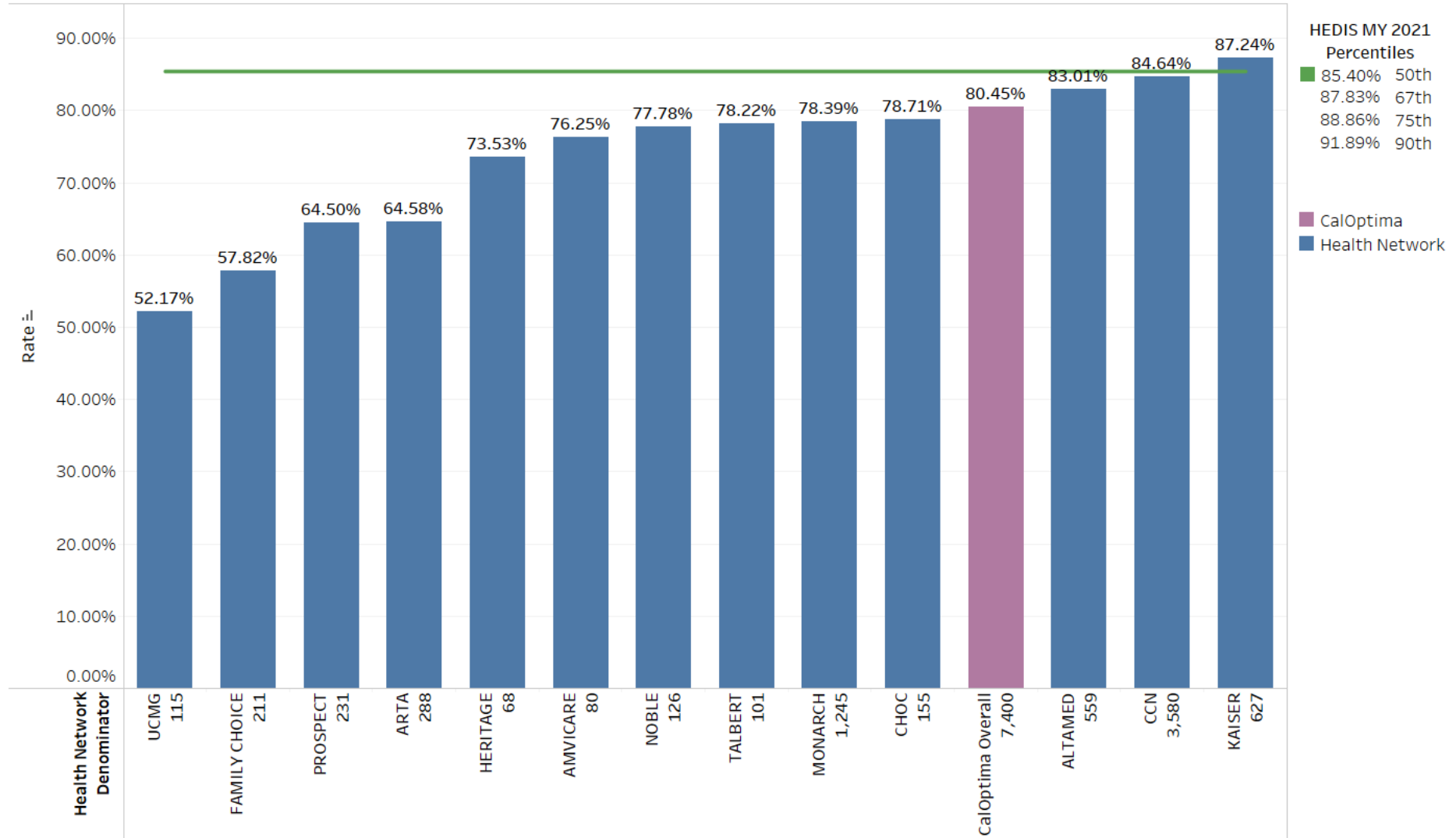
Denominator = number of members eligible for measure
 Hybrid measure
 Pay for Value

**Medi-Cal
Lead Screening in Children (LSC)
January 2022 - November 2022**



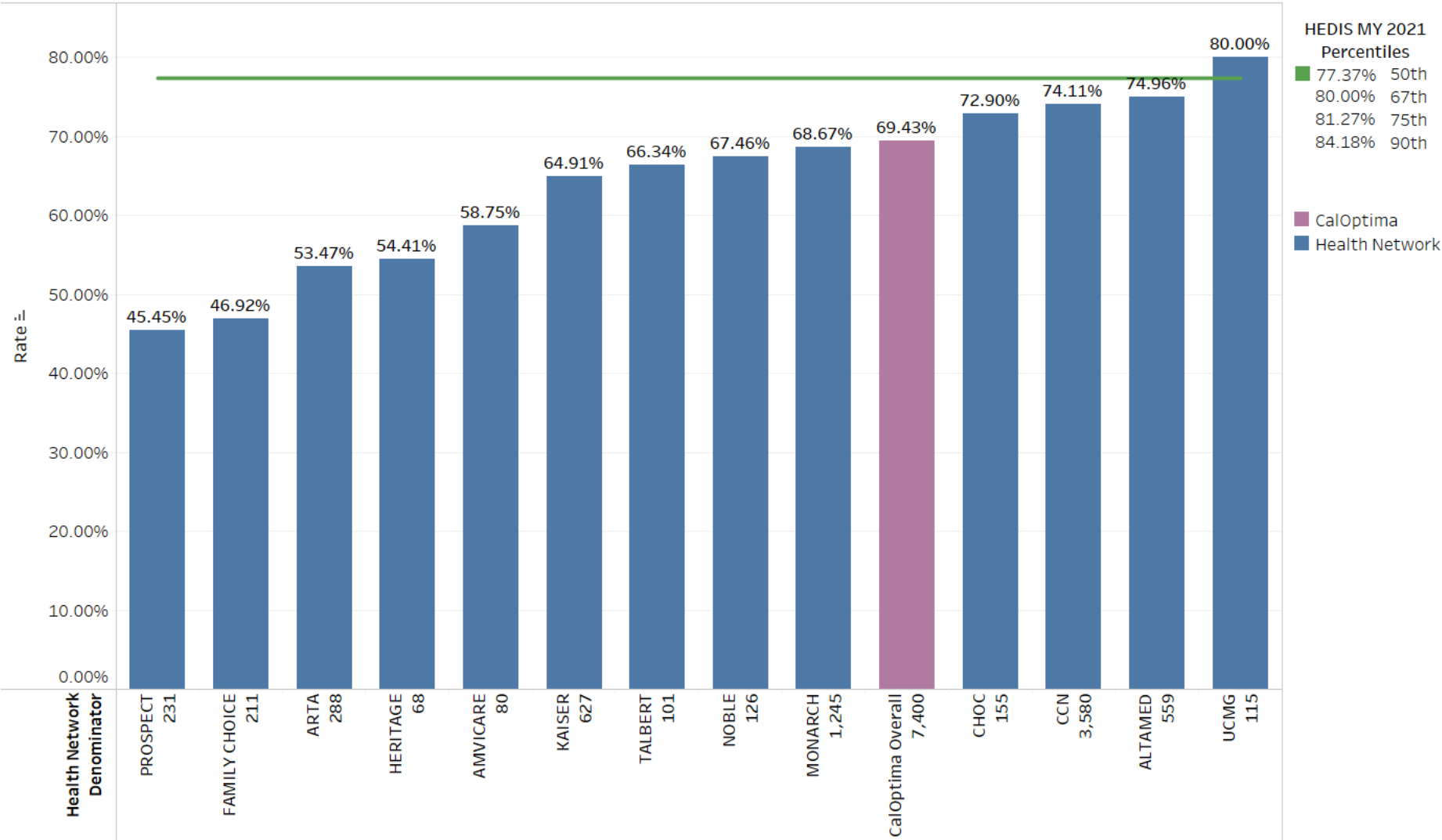
Denominator = number of members eligible for measure
 Hybrid measure
 Pay for Value

**Medi-Cal
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care
January 2022 - November 2022**



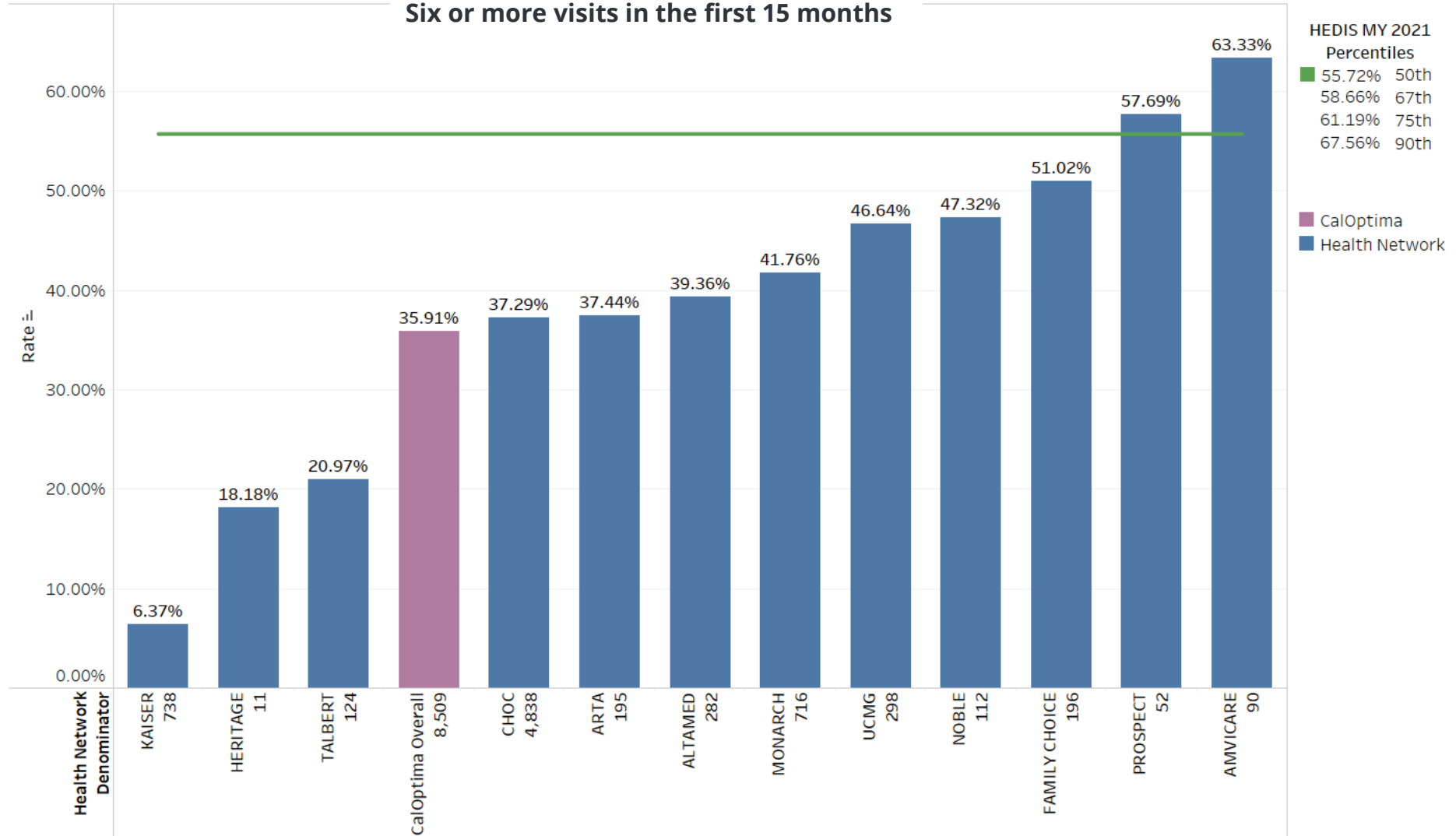
Denominator = number of members eligible for measure
 Hybrid measure
 Pay for Value

**Medi-Cal
Prenatal and Postpartum Care (PPC) Postpartum Care
January 2022 - November 2022**



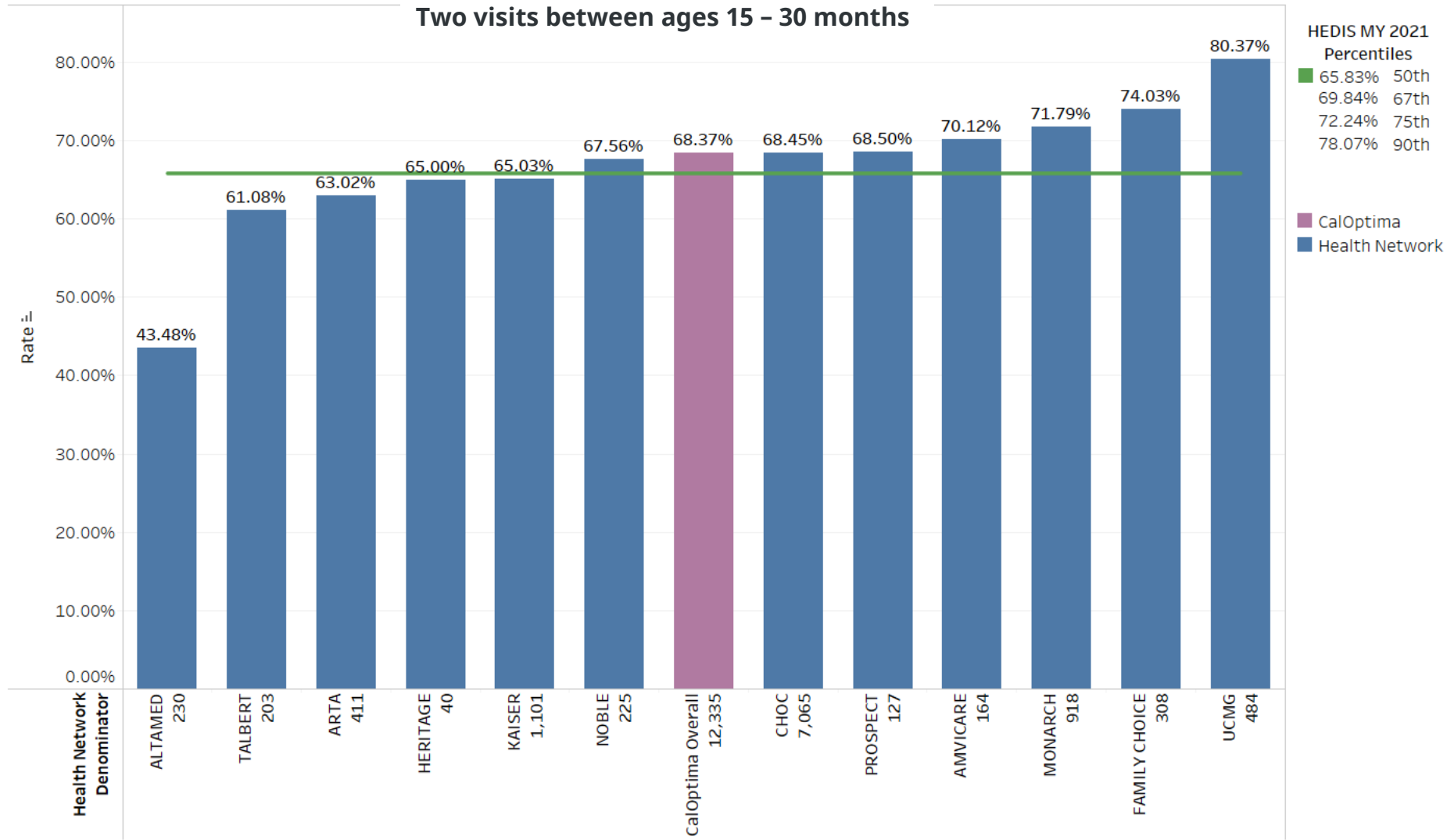
Denominator = number of members eligible for measure
 Hybrid measure
 Pay for Value

Medi-Cal
Well-Child Visits in the First 30 Months of Life (W30) Well-Child Visits in the First 15 Months
January 2022 - November 2022
Six or more visits in the first 15 months



Denominator = number of members eligible for measure
 Administrative measure
 Pay for Value

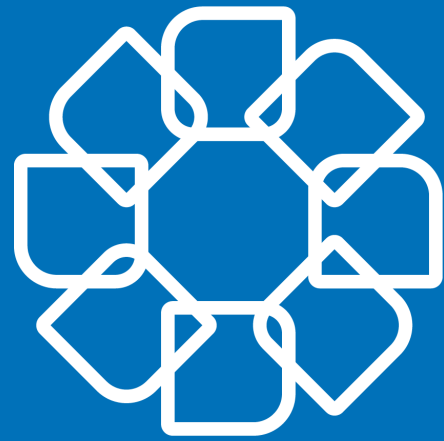
Medi-Cal
Well-Child Visits in the First 30 Months of Life (W30) Well-Child Visits for Age 15 Months - 30 Months
January 2022 - November 2022



Denominator = number of members eligible for measure
 Administrative measure
 Pay for Value

Next Steps

- MY2022
 - CalOptima Health is in the process of collecting and preparing audited MY2022 data
 - Data collection includes medical records and supplemental data to augment administrative data
 - CalOptima Health will partner with Health Networks to identify improvement strategies to impact MY2022 and beyond
- MY2023
 - CalOptima Health will meet individually with each Health Network to share best practices and discuss improvement strategies



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Board of Directors' Special Quality Assurance Committee Meeting March 15, 2023

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

Committee Overview

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

December 14, 2022: PMAC Meeting Summary

Updates from the Director

Director Monica Macias thanked PMAC members for joining the meeting in person for the fourth time since the pandemic. Members were updated on the status of the program, particularly around staffing and open positions. PACE is slowly allowing participants to return to the day center. Currently, we have two shifts (am/pm), allowing up to 30 participants per shift totaling 60 per day. We continue to monitor any trends and adjust operations as needed. All participants are assigned to pods, with social distancing in mind, and must wear mask. The clinic and skilled rehabilitation appointments continue to operate as usual. In addition, our transportation is operating back to normal. Director also shared the great news; PACE has our new Medical Director, and we are really excited to have her join our team. Dr. Donna Frisch will be invited to our next PMAC for a formal introduction. Director ended with information on what is next: assess COVID numbers and determine when we can increase day center attendance, other improvements that will be made to the center, and BIVALENT initiatives.

COVID-19 Updates

Jennifer Robinson, Quality Improvement Manager, provided updates related to COVID-19 numbers and status. Jennifer provided an update on COVID-19, she reported case numbers and hospitalizations going down. At the center we have seen a decrease in positive cases. We continue to require masking at the center with KN95 for everyone's safety. PACE is continuing our vaccination efforts and providing education to participants. Current vaccination rates, 98% have received their initial (2 doses) and 94% have received their 3rd dose (first booster). Jennifer also provided education around the 4th dose (2nd booster) and shared with the group that PACE is working on a BIVALENT vaccine event. Jennifer reminded the participants how to protect against the virus (social distancing, wash hands, wear a mask, vaccines). We also provided reminders to inform their provider if they are having any symptoms or test positive and reminded them that we have test kits for home if needed. Jennifer shared the providers can prescribe medications when test positive and/or have a cough.

PMAC Member Forum

- Participants mentioned that transportation has been slightly better, however, there is still room for improvement. They suggested that the drivers have reminders to call them in advance prior to pick-up.
- Participants asked if PACE would increase day center attendance even more. It was noted that the plans are to continue to increase with caution and safety in mind.
- Participants requested for Director to assess meals as they feel the food quality has changed.
- Participants were reminded of the suggestion box in the center if they have any concerns or compliments, they would like to share with the staff.



**CalOptima Health Board of Directors’
Special Quality Assurance Committee Meeting
March 15, 2023**

Quality Improvement Committee Fourth Quarter 2022 Report

Summary

- Quality Improvement Committee (QIC) met on October 11, 2022; November 8, 2022; and December 13, 2022
- The following departments and subcommittees reported to QIC in Quarter 4 (Q4):
 - Behavioral Health Integration (BHI) Department
 - Credentialing and Peer Review Committee (CPRC)
 - Grievance & Appeals Resolution Services Committee (GARS)
 - Member Experience Committee (MEMX)
 - Population Health Management Department
 - Utilization Management (UM) Department
 - Utilization Management Committee (UMC)
 - Benefits Management Subcommittee (BMSC)
 - Pharmacy & Therapy (P&T)
 - Whole-Child Model Clinical Advisory Committee (WCM CAC)
 - Quality Improvement (QI) Department
 - Quality Analytics (QA) Department
- Approved the following:
 - QIC Charter
 - Policy GG.1110: Primary Care Practitioner Definition, Role and Responsibilities
 - Policy GG.1603: Medical Records Maintenance
 - Policy GG.1604: Confidentiality of Credentialing Files
 - Policy GG.1620: Quality Improvement Committee
 - Policy GG.1628: Confidentiality of Quality Improvement Activities
 - Policy GG.1629: Quality Improvement Program
 - Policy MA.7025: Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Health CCN Contracted Providers
 - Policy GG.1602: Non-Physician Medical Provider (NMP) Scope of Practice

- Policy GG.1604: Confidentiality of Credentialing Files
- Policy GG.1616: Fair Hearing Plan for Practitioners
- Policy GG.1618: Member Request for Medical Records
- Policy GG.1621: Community-Based Adult Services (CBAS) Quality Assurance and Site Visits
- Policy GG.1633: Board Certification Requirements for Physicians
- Policy GG.1639: Post-Hospital Discharge Medical Supply
- Policy GG.1643: Minimum Physician Credentialing Standards
- Policy GG.1655: Reporting Provider Preventable Conditions (PPC)
- Policy GG.1656: Quality Improvement and Utilization Management Conflict of Interest
- Policy GG.1658: Suspend, Restrict or Terminate Practitioner Participation in CalOptima’s Network
- GG.1659: System Controls of Credentialing Provider Data
- Accepted and filed minutes and QI Work Plan from the following committees and subcommittees:
 - 2022 Quality Improvement (QI) Work Plan Q4
 - BMSC Meeting Minutes of April 27, 2022
 - BMSC Meeting Minutes of June 22, 2022
 - MEMX meeting minutes of May 17, 2022
 - P&T Meeting Minutes of February 17, 2022
 - P&T Meeting Minutes of May 19, 2022
 - UMC Meeting Minutes of August 25, 2022
 - WCM CAC Meeting Minutes of May 17, 2022
- In December of 2022 Dr. Marchese resigned from QIC membership effective 2023

QIC Quarter 4 2022 Highlights

QI Program Element	Key Activity
Program Oversight	Updated QIC Charter
QI Program Resources	Added new medical director staff: <ul style="list-style-type: none"> • Mohini Sinha, MD was assigned as new Medical Director for Quality • Shilpa Jindani, MD is the new Medical Director for Population Health Management • Donna Frisch, MD is the new Medical Director of PACE • Tanu Pandey, MD is the new Medical Director
Clinical Practice Guidelines	Dr. Sinha presented guidelines according to the Medical Board of California guidelines for Patient Termination notification.

QI Program Element	Key Activity
Quality Compliance Concerns	In December, Member Experience Committee has some concerns with the Whole Child Model Network Adequacy results and Marsha Choo reported in the Member Experience Subcommittee report.
Monitoring Quality Metrics	<ul style="list-style-type: none"> • Paul Jiang, Manager of Quality Analytics provided a follow up to the committee’s previous question regarding transition of care measure regarding notification of inpatient admission, discharge information, and medication reconciliation. • CCN performed better than most of delegated Health Network. • Kelly Giardina, Executive Director provided update on UM Q2 of 2022 operational performance and trends for all lines of business. All UM metrics maintained the compliance rates once the existing logic was updated in July. • Carmen Katsarov, Executive Director presented the utilization for Outpatient Mental Health for Medi-Cal throughout 2021. The metric and goals are being met.
Strategic Initiatives	<p>CalAIM update</p> <ul style="list-style-type: none"> • This is the core part of Medi-Cal that requires the delivery systems to develop and maintain a whole system person centered PHM program. • By January 2026, all managed care plans will be required to obtain NCQA HealthEquity accreditation, which is a newer accreditation. • The initial program design will target managed care plans such as CalOptima Health, and it launches January 2023
Strategic Initiatives	<p>Health Equity and Social Determinants of Health (SDOH) Workgroup</p> <ul style="list-style-type: none"> • Developed a training logic-model to serve as a guide for increasing internal knowledge of health equity, drivers of inequity, and the role everyone plays in advancing health equity. • Currently are working on developing a survey to assess health equity and SDOH training needs building upon master questions developed by the workgroup and other external assessment tools (e.g., Improving Health Equity: Assessment Tool for Health Care Organizations).
Quality Improvement Projects	<ul style="list-style-type: none"> • COVID-19 Vaccination in 5–11-year-old <ul style="list-style-type: none"> ○ CalOptima Health efforts have been broad and wide-ranging from ongoing and consistent text messages to campaigns to members. Many ads have been sent in social media, print and digital ads related to promoting the COVID-19 vaccine amongst this age population as well as a series of e-mail and publication announcements to both

QI Program Element	Key Activity
	<p>health networks and to provider networks. Staff also sent many COVID-19 vaccine incentive programs and the Board approval to extend this program.</p>
<p>Quality Improvement Projects</p>	<p>Maternal and Child Health Proposal was presented by Leslie Martinez, Quality Analyst, Population Health Management (PHM)</p> <ul style="list-style-type: none"> • DCHS have set the 2022 DHCS Comprehensive Quality Strategy that calls for the urgent improvement in three clinical areas being the children's preventive care, maternal care, and birth equity, as well as behavioral health integration • Proposed interventions for post-partum and well child visit reminders that are member focused, first being the Text Message Campaign, incentive for blood lead screening, and First Birthday Card
<p>Quality Improvement Projects</p>	<p>Behavioral Health Integration (BHI) update provided by Natalie Zavala, Director, Behavioral Health Integration</p> <ul style="list-style-type: none"> • Student Behavioral Health Incentive Program (SBHIP) • Focuses on establishing partnerships within the counties, the school districts, managed care plans and the county behavioral health to build capacity for services on or near school campuses to prepare for the 2024 new medical fee schedule that the state will be issuing, which will allow managed care plans to reimburse for these mental health services on the school campus or near school campus. • All 29 school districts are participating in SBHIP
<p>Plan Performance Monitoring and Evaluation (PPME)/Quality Improvement Program Effectiveness (QIPE)</p>	<ul style="list-style-type: none"> • All lines of business are in compliance with outreach for the Health Risk Assessment • For the regulatory monitoring on 3.2, the ICP completion is up at 81%, the goal is 85%.
<p>Credentialing</p>	<ul style="list-style-type: none"> • Staff has noticed an increase in volume of credentialing applications that is increasing with the expansion of the CalAIM program as well as providing providers for other supplemental benefits. • Credentialing policies to be updated due to the release of the following All Plan Letters (APLs): Screening and Enrollment and Credentialing and Recredentialing, Street Medicine, and Community Health Workers

QI Program Element	Key Activity
Community-Based Adult Services (CBAS)	<ul style="list-style-type: none"> • Full congregate in-person services were supposed to start earlier in the year but was delayed until October 1, 2022. • CBAS centers continue to have COVID outbreaks and are closing intermittently for 2 weeks at a time. • Due to center closures, the previous goal of reviewing all 37 contracted CBAS centers by December 31, 2022, will not be achieved due to this change.
Blood Lead Screening	<ul style="list-style-type: none"> • There is a large age group, particularly those children that are six years and under that are at risk for lead due to their physiology and overall that age group represents about 25% of CalOptima Health population. • From January 2021 through May 2022 over 100 members have been confirmed to have high levels of lead in the blood. • Staff is focusing member interventions primarily focusing on member education and increasing awareness on the importance of testing. • Dr. Thanh-Tam Nguyen suggested utilizing collaboration with the Orange County School District with back school events and add lead screening to the events. Dr. Jacob Sweidan suggested the option to conduct lead testing in the provider offices during office visits. Dr. Nguyen adding to monitor Electronic Health Records for lead screening at six years old or flag delayed immunization, no flu vaccine, and have the test done at any appointment, rather than wait for the next well child visit.

Attachments

[Approved at QIC throughout Q4 2022: 2022 QI Workplan – Third Quarter](#)

2022 Q1 Work Plan 3Q

2022 Q1 Work Plan Element Description	Goals	Planned Activities	Staff Responsible	Report to Committee	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Watch Green - On Target
I. PROGRAM OVERSIGHT							
2022 Q1 Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 Q1 Program and Workplan	Q1 Program and Q1 Work Plan will be adopted on an annual basis; Q1 Program Description-QIC-BOD; Q1 Work Plan-QIC-QAC	Marsha Choo	QIC	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2021 Q1 Program Evaluation	Complete Evaluation 2021 Q1 Program	Q1 Program and Q1 Work Plan will be evaluated for effectiveness on an annual basis	Marsha Choo	QIC	Approved: QIC 2/15/2022, QAC 3/9/2022, BOD 4/7/2022		
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Kelly Giardina/Teresa Smith	QIC	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Kelly Giardina/Teresa Smith	QIC	Completed and will be sent to UMC for eVote by 4/15/2022. Scheduled to give status update to QIC on 4/16/2022.		
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Katie Balderas	QIC	PHM Strategy is currently being reviewed and will be updated to align with CalAIM Population Health Management Strategy. PHM Department will be taking a CalAIM Population Health Management Strategy update to the next QIC.	CalAIM PHM Strategy update will be given at the 10/11/2022 QIC.	
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	Marsha Choo/Laura Guest	QIC	<p>I. FSR/PARS/NF/CBAS</p> <p>A. FSR</p> <ul style="list-style-type: none"> Updated DHCS FSR and MRR Tools and Standards implemented on 7.1.1022; Decrease in number of failed FSR and/or MRR from Q2 to Q3; Increase in number of CAPs from Q2 to Q3 (96 vs.119) <p>B. PARS</p> <ul style="list-style-type: none"> Decrease in number of PARS completed from Q2 to Q3 (212 vs. 195); % of sites with BASIC access decreased from Q2 to Q3 (41% vs. 36%); Backlog of 2021 HVS PARS completed. Outreach Specialists working on 2022 list. <p>C. Quality Oversight - CBAS</p> <ul style="list-style-type: none"> Full congregate in-person services resumed 10/1/2022 QI Nurse Specialist-LVN resumed on-site CBAS Center visits in September 2022. Goal of reviewing 37 contracted CBAS centers by 12.31.2022. <p>II. Credentialing - TBD</p> <p>A. Identified in March 2022: Organizational Providers (OP) - OneCare Project. For CGN and BH, there were 117 group practices (with an NPI2) that were identified as not credentialed, although the individual practitioners were credentialed. As of Q3, 49% of these providers were credentialed. A query has been submitted to DHCS for guidance on credentialing on group practices.</p> <p>B. Significant increase in volume of credentialing applications to credential from Q1 - Q3, which include OP, CalAIMs and practitioners.</p> <p>C. Fallout report, a report to identify contracted providers not yet credentialed, is in the final stage of testing. (Data compares cactus to facets). Fallout report 90% complete.</p> <p>D. DHCS issued a revised All Plan Letter (APL) on Screening and Enrollment and Credentialing and Re-Credentialing and QI has updated all credentialing policies. Policies were presented to CPRC.</p> <p>E. Process improvements: Update the Request to Credential form and new reports to identify recredentialing</p> <p>III. POI</p> <p>Subject: Cases leveled at QOC were 23% in Q3, 20% in Q2, 21% in Q1.</p> <p>Subject: Fair Hearing for Notice of Termination - Potential R05 Reporting</p> <p>1. POI and FWA investigations - PM physician was billing for PT and psychotherapy services under his NPI 1, billing for 99215 for services rendered by a LVN, and was unable to produce medical records for several members due to destroying the medical records while converting to an EHR. 2. POI Investigation - PCP attending at hospital for member who was admitted for hand cellulitis, had precipitous drop in Hgb, never referred to GI or hematology for etiology, and unexpectedly expired.</p>	<p>I. FSR/PARS/NF/CBAS</p> <p>A. FSR: Updated DHCS FSR and MRR Tools and Standards implemented on 7.1.1022; Decrease in number of failed FSR and/or MRR from Q2 to Q3; Increase in number of CAPs from Q2 to Q3 (96 vs.119)</p> <p>B. PARS: Decrease in number of PARS completed from Q2 to Q3 (212 vs. 195); % of sites with BASIC access decreased from Q2 to Q3 (41% vs. 36%); Backlog of 2021 HVS PARS completed. Outreach Specialists working on 2022 list</p> <p>C. Quality Oversight - CBAS: Full congregate in-person services resumed 10/1/2022. QI Nurse Specialist-LVN resumed on-site CBAS Center visits in September 2022. Goal of reviewing 37 contracted CBAS centers by 12.31.2022.</p> <p>II. Credentialing - TBD: A. QI continues to work with Contracting and Provider Relations on the OC project to credential all identified medical groups.</p> <p>B. Cross train Credentialing Coordinators to credential all credentialing types, practitioner, mid-level, allied, BH, Organizational Providers, CalAIM, ABA and all areas of credentialing (intake, verification)</p> <p>C. Finalize the Fallout Report and utilize to consistently identify contracted providers to credential</p> <p>D. Review and update the current workflows and update the desktop procedures to reflect a streamlined process.</p> <p>E. Finalize the Request to Credential (RTC) form and launch the (RTC) form for Contracting to use. Utilize the new recredentialing reports to monitor compliance and streamline recredentialing process to integrate the process for practitioners and organizational practitioners.</p> <p>III. POI: Action: Continue with QOC grievance review by RN and MD. Concern: Volume of POIs continue to climb as the number of POIs opened is double that of the same time last year. The main category of POIs continued to be Medical Care related to treatment delay, failure, inappropriate or complications. Action: Fair Hearing of PM physician was held in Q2. Second half of the Hearing was held in Q3. Determination will be reported in Q4. The Fair Hearing of the PCP was delayed until Q3 due to the availability of the participants. The second half of the Hearing will be completed in Q3, so we anticipate the determination to be reported in Q4.</p>	
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health networks. Trends and results are presented to the committee quarterly.	Tyronda Moses/Heather Sedilo	QIC	<p>2Q when state's restrictions began to lift and many locations re-opened, CalOptima Health saw a significant increase in grievances around access to care, specifically appointment availability and quality of service complaints, regarding delays in service and transportation services. Slight increase in total number of grievances in 2Q over 1Q. Attributing to the increase in Q2 were complaints regarding access and quality of care. No specific trends were identified, however we continue to monitor these two areas very closely and also work with QI and Provider Relations to address our findings.</p> <p>Grievance Trending Medi-Cal Grievances 2Q: Delays in referrals by plan or provider, Transportation-delays in pickup, driver service issues and no shows. Unable to schedule timely appointments, Quality of Service (consents with treatment and/or diagnosis), Member billing concerns-ER service bills and member reimbursement request</p> <p>Medi-Cal Member Appeals</p> <p>Appeal Summary by All Lines Business was presented.</p> <p>No trends in type of services</p> <p>Decreases in rate/1,000: Noble appeals decreased from 5 to 3, Alta Med appeals decreased from 12 to 11</p> <p>Increases in rate/1,000 All others</p> <p>OCC Member Appeals (Rate per 1000): Total Member Appeals received decreased from 73 to 32 from Q1 2022 to Q2 2022. We continue to promote proactive outreach and identify the members who could possibly benefit from the assistance of a PCC or CM. Due to the low volume of OCC population the overturn rate is always a bit skewed since 1 overturn will cause a significant overturn rate. However, we did review for trends, and found no issues to report for Q2.</p> <p>All denials for OCC which were overturned were due to medical necessity met with additional information and include overturns for DME, specialists' visits and diabetic shoes.</p> <p>OneCare Member Appeals (Rate per 1000): The low membership creates a higher rate/1000. Total of 11 appeals were received for OneCare in Q2. Monarch had an increase in appeals from 3 in Q1 2022 to 7 appeals in Q2 2022.</p> <p>All denials for OneCare were overturned based on medical necessity met and include overturns for DME, specialists' visits and diabetic shoes.</p>	All trends are reviewed for repeated issues.	High grievance count by providers are tracked and trended. Results are reported to Provider Relations for additional outreach and shared with a Provider Action workgroup. Recommendations for actions may include an onsite visit, additional education/training and/or escalation to the Member Experience Committee.
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & 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.	K. Jenkins/Marsha Choo/C. Matthews	QIC	<p>In Q3, MemX Committee has reviewed/discussed the following:</p> <p>8/10/22.</p> <ul style="list-style-type: none"> Updates: <ul style="list-style-type: none"> oAPL 22-xxx oANC Time or Distance oProvider Sat Survey Member Experience PDSA CAHPS Medi-Cal MY 2021 Results Provider tools to educate members on referral/auth process 	In Q4 MemX Committee has two meetings scheduled, October 12 and December 8	

2022 Q1 Work Plan 3Q

2022 Q1 Work Plan Element Description	Goals	Planned Activities	Staff Responsible	Report to Committee	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - On Track Green - On Target
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.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Kelly Giardina/Teresa Smith	Utilization Management /QIC	<p>UMC reported to QIC on 7/12/2022. Presented 2022 1st Quarter Annual Trends (5/26/2022).</p> <ul style="list-style-type: none"> - 1Q1 2022 Operational Performance -- Goals are being met for Pharmacy auth, BH Auth, LTSS Inquiry/Auth and Unused Authorization. One caution for TAT for processing of referrals due to the backlog had other than that - CalOptima's internal CCN/COD TAT's are above 99% across the board since February. Medical Authorization performance goal ≥ 98%: CCN is below goal for this quarter due to low compliance in January 2022; February and March compliance are above goal. - Q4 2021 Utilization Outcomes -- All measures are being met for Medi-Cal and OCC - Q4 2021 Operational Performance WCM -- For the select metrics data lags a quarter behind. In identifying the denials reported there's nothing unusual to report. - Medi-Cal Over/Underutilization Monitoring Dashboard, Benefit Management Subcommittee (BMSC), Pharmacy Over/Under Utilization Monitoring, BHI UM Update, BHI. - Committee reviewed and approved UMC meeting minutes (5/26/22), BMSC Meeting Minutes (2.23.22), BMSC Meeting Minutes (3.23.22), P&T Meeting Minutes (11.18.21) 	UMC is scheduled to present 2st Quarter 2022 update to QIC on 10/11/2022.	
Whole Child Model - Clinical Advisory Committee (WCM CAC) . Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	T.T. Nguyen, MD	QIC	<p>WCM CAC met August 16, 2022. Follow up action items were discussed and closed, Pharmacy Medi-Cal Rx, Whole-Child Model Measures, Grievance and Resolution Services, and Whole-Child Model Customer Service Inquiries provided quarterly updates.</p> <p>PHM gave an update related to CalOptima Health Homeless Health Initiatives, update related to the Population Needs Assessment, and an update related to COVID-19 vaccination rates amongst CalOptima Health Members, specifically the youngest members from age 0-18. At the next PHM report, the committee wants to see numbers that reflect up through the age of 20 years old to get a more precise pediatric count because that's a time where for hard conditional work CalOptima Health could help the family coordinate their care and transition to adult services.</p> <p>An update on CalOptima Health's three-year plan on Student Behavioral (SBHIP) was given resulting in feedback for CalOptima Health staff to create a page of resource or similar kind of sheet where available resources can be easily located and shared for those working with members. Posting the information on website will allow for updating information as needed.</p> <p>The next WCM CAC meeting is scheduled for 11/16/22.</p>	WCM CAC is scheduled to presented an update to QIC on 10/11/2022.	
Quality Withhold for OCC	Earn 75% of Quality Withhold Dollars back for OneCare Connect in OCC Q1W program end of MY 2021	Monitor and report to QIC	Sandeep Mital	QIC	Scheduled to give update when we receive final scores from CMS in Q2 of 2023	Continue to monitor performance on the various measures	
Quality Analytics Program Updates (Health Network Quality Rating, MCAS, P4V, Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	<p>Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps</p> <p>Activities requiring intervention are listed below in the Quality of Clinical Care measures.</p>	Paul Jiang/Sandeep Mital	QIC	All MCAS selected measures having MPL requirement achieved MPL except the newly added Well-Child Visits in the First 30 Months of Life measure (W30-15months; W30-30months)	Start health disparity analysis to further refine focus areas	
Development of the OneCare program for MY2023	Develop and finalize the CMS measures for the scoring and payment methodology for the OneCare P4V program	P4V team has compiled a set of Part C, Part D, and Member Experience measures as proposed metrics for the MY2023 OneCare P4V program. Awaiting approval from the various committees and the Board of Directors.	Sandeep Mital	QIC	P4V team has compiled a set of Part C, Part D, and Member Experience measures as proposed metrics for the MY2023 OneCare P4V program	Awaiting approval from the various committees and the Board of Directors	
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	<p>Conduct quarterly/Annual oversight of specific goals All LOB PIPs</p> <p>MC PIPs:</p> <ol style="list-style-type: none"> 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022) 	Helen Syn	QIC	<ol style="list-style-type: none"> 1) Received BCS Health Equity PIP Progress Check-In HSAG feedback no resubmission required at this time. Mobile Mammography Event Q3: Completed 29 BCS for KCS CCN members. Continue to test intervention through the PIP end date, December 31, 2022. 2) W30 PIP Progress Check-In feedback completed in Q3. Continue testing intervention and monitoring HEDIS rate through the end of PIP December 31, 2022. 	<ol style="list-style-type: none"> 1) BCS Health Equity: HSAG TBD submission date for the final PDSA worksheet and Module 4. Continue testing intervention and monitoring HEDIS rate through the end of PIP December 31, 2022. 2) W30 PIP Progress Check-In feedback expected in Q4. Continue testing intervention and monitoring HEDIS rate through the end of PIP December 31, 2022. 	
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	<p>Conduct quarterly/Annual oversight of specific goals All LOB QIPs</p> <p>MC QIP:</p> <ol style="list-style-type: none"> 1) COVID QIP Phase 2 - <ul style="list-style-type: none"> a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)- N, Zavala b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD) 	Natalie Zavala/Helen Syn	QIC	<ol style="list-style-type: none"> 1) COVID QI Phase 2- <ul style="list-style-type: none"> a. SSD - SSD update provided under Quality of Clinical Care Behavioral Health section below. b. CCS - Cycle 2 provider staff incentive completed. Cycle 3 completed on 9/30/22. Pending final provider office rates from participating providers. c. CIS Combo 10- Target list for Cycle 4 (07/01/2022 - 09/30/2022) is shared with Provider Office for July - September implementation. Intervention includes outreach to noncompliant members to schedule appointments, and tracking the number of newly compliant members. 2) Statin Adherence <ul style="list-style-type: none"> MC: 29.56% (below 50th), OC: 30.71% (below 50th), OCC: 34.81 % (below 50th) Measure is performing higher for MC and OCC LOB than same time last year and are below the 50th percentile (MPL). OC performing lower than same time last year and below 50th percentile. 3) Statin Therapy <ul style="list-style-type: none"> MC: 69.23% (above 50th), OC: 78.88% (above 50th), OCC: 79.44% (above 50th) Measure is performing higher for MC and OCC LOBs than same time last year. All LOBs are above the 50th percentile (MPL). 	<ol style="list-style-type: none"> 1) COVID QI Phase 2- <ul style="list-style-type: none"> a. SSD - b. CCS - Cycle 3 intervention completed. Pending evaluation of cycle 3 in Q4. c. CIS Combo 10 - Intervention period completed. Will evaluation CIS-10 QIP Cycle 4 (July-Sept) data in Q4 2022. 2) Continue Statin Mailers 	

2022 Q1 Work Plan 3Q

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Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on All LOB CCIPs 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Helen Syn	QIC	1) Emerging Risk Health Coach Outreach OC CCIP 0 members, 0 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC CCIP 26 members, 21 Assigned, 0 Unable to Contact, 3 No Longer Emerging Risk, 0 No Longer Eligible. 2) Results pending, final data slated at end of Q4 2022.	1) Continue Emerging Risk Telephonic Health Coach Outreach 2) Continue SPD Statin quarterly mailers	
PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PME (OC): HRAs: HN MOC Oversight(Review of MOC ICP/ICT bundles) 2) QIPE (OCC): HRAs: ICP High/Low Risk, ICP Completed within 90 days, HN MOC 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion.	Gail McMillen/S. Hickman/D. Hood	QIC	Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PME (OC): HRAs: Quarter 2 finished at 100% for both initial and annual HRA outreach; Quarter 3 initial is 100% for July, August/September still in process. HN MOC Oversight(Review of MOC ICP/ICT bundles in 10 day TAT) 1% for Q2. Benchmarks were not met in Q3; Benchmark met at 30 business day TAT for July, and improved to 17 business days for August; September is still pending. 2) QIPE (OCC): HRAs: Quarter 2 finished at 100% for initial and annual HRA outreach; Quarter 3 finished at 100% for both initial and annual HRA outreach. HN MOC Oversight(Review of MOC ICP/ICT bundles in 10 day TAT) 1% for Q2. Benchmarks were not met in Q3; Benchmark met at 30 business day TAT for July, and improved to 18 business days for August; September is still pending. ICP High/Low Risk: MMP 1.5 High risk 89%, Low risk 83%, ICP Completed within 90 days, HN MOC: MMP 3.2 for Q3 is 89%; MMP 1.6 Care Goal Discussion 99% 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion. Members flagged as LTC on HRA outreach had outreach 100%	Continue to Conduct quarterly/Annual oversight of specific goals OC and OCC PPME and QIPEs 1) PME (OC): HRAs:MOC Oversight(Review of MOC ICP/ICT bundles in 10 day TAT) Continue to monitor and complete pre-cap on monthly basis. 2) QIPE (OCC): HRAs: HN MOC Oversight(Review of MOC ICP/ICT bundles in 10 day TAT) Continue to monitor and complete pre-cap on monthly basis. ICP High/Low Risk: ICP Completed within 90 days, Care Goal Discussion 99% 3) LTSS HRA OCC: Continue to Monitor for timeliness on outreach for completion.	
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January 2022.	Natalie Zavala/Shei Hopson	QIC	BHIPP: 1) Prepared and completed Program Year 2 Q2 milestone report due to DHCS 8/29/22, all expected milestones were completed 2) Prepared and completed 2021 Baseline - Performance Measures report due to DHCS 8/27/22 3) Q4 2021 Milestone Incentive Payments received from DHCS, processed and issued to provider groups 7/5/22 ABA P4V: 1) During the ABA Provider webinar held in June, 2021 ABA P4V program results were shared with the meeting attendees: ABAU 2021 - 56.90% / 2020 - 56.13% ABAH 2021 - 51.67% / 2020 - 50.42% 2) There is a correction to what was reported last quarter's update --> Prepared check requests for 29 groups, the correct number is 57 provider groups received an incentive check.	BHIPP: 1) Prepare Program Year 2 Q3 milestone report due to DHCS 11/29/22 2) Prepare the Q1 2022 Milestone Incentive Payments expected to receive the funding from DHCS around September 28, 2022 ABA P4V: 1) Planning for an internal evaluation of the program's performance 2) Planning to obtain ABA provider groups feedback for the program 3) Establish next steps for program continuance	
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1) Regular planned visits to shelters, hot spots and recuperative care facilities- to resume post-COVID-19. (CM) 2) addition of virtual outreach visits to shelters. 2) Serve as a resource in pre-enforcement engagements, as needed..to resume post-COVID-19 3) Develop and implement Street Medicine Program 4) Implement DHCS Housing & Homelessness Incentive Program (HHIP) to meet specific measures around increased data integration, member housing supports, and homeless services for members	Sarah Nance/Danielle Cameron	QIC	1) Onsite outreach was started in Quarter 3 at Yale Navigation Center 1x/week for 2 hours per outreach. Virtual and telephonic outreach was continued with the Costa Mesa Shelter and Huntington Beach Navigation Center. Telephonic support by the Homeless Response Team was provided for Members who required the services of the Clinical Field Teams. 2) No support for pre-enforcement activities was requested during Quarter 3. 3) An RFIQ was conducted to solicit qualifications from potential providers of the street medicine program. From that process, two providers were selected to operationalize a two-pronged street outreach and medicine program that targeted reaching people experiencing homelessness both unsheltered on the streets (encampments, hot spots, etc) and in local shelters. This pilot will launch in Garden Grove, where we hope to establish a collaborative service delivery model between the service providers, local stakeholders, Be Well and related county entities. The planning phase is anticipated to begin in December 2023, with services launching in early 2023. 4) CalOptima Health solicited stakeholder input into an Investment Plan, which identified key investment strategies to tackle the barriers identified in the Local Homelessness Plan. The CalOptima Health Board approved this plan, which was submitted to DHCS. DHCS has indicated that the first payment of \$4.1M was transmitted to CalOptima Health in support of this work. The CalAIM community investment team will be distributing these initial funds using the approved Investment Plan.	1) The Homeless Response team will continue increasing their presence in the community by expanding onsite outreach at other shelters and at American Family Housing Casa Paloma. 2) The Homeless Response Team will provide support for pre-enforcement activities as needed and requested. 3) Street Medicine providers will be contracted and will begin the planning process to execute the new program and services. 4) The CalAIM team will continue to implement the Housing & Homelessness Incentive Program, including integration with the local continuum of care and increased referral and access of housing community supports. The CalAIM team will also implement the Investment Plan.	
CaAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CaAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CaAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CaAIM program	Mia Arias/Andrew Kilgust	QIC	1 & 2. All HHP and WPC members were successfully transitioned to CaAIM ECM without an interruption in service. 3. A DHCS reporting process has been established; ITS leads the data collection and Care Management, LTSS and CaAIM teams review and attest to the data before DHCS submission. Monthly data improvement calls are hosted to ensure data captured is accurate and up-to-date. 4. An oversight strategy is in development.	The CaAIM team will focus on developing and launching the oversight strategy for the CaAIM program. Many lessons were learned during the first year of implementation and those lessons will inform the oversight strategy going forward. Much of this work will launch in 2023.	
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1) Make health equity a strategic priority 2) Develop structure and process to support health equity work 3) Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4) Develop partnerships with community organizations to improve health and equity 5) Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Katie Balderas	QIC	The Health Equity Data Action Team looked into the utilization of SDOH Z-Codes and found the following: Provider utilization of SDOH Z-Codes in claims is very low 6.70 % of providers are using SDOH Z-Codes, documents on 45% of total claims/encounters for only 3.14% total members Additionally, there are inconsistent mechanisms for collecting SDOH data across CalOptima. Thirteen known health assessments in Guiding Care, of which 9 include SDOH-related fields No evidence-based, validated SDOH screening tool used consistently across member-facing departments.	Incentivize and encourage utilization of SDOH Z-code screening among providers through annual wellness visits Promote network/provider SDOH screening using evidence-based screening tools (ex. PRAPARE, utilization of SDOH Z-Codes) Utilize the transition to a new care management platform (JIVA) to ask consistent, evidence-based questions across all member-facing departments/ programs and link members to resources for social needs using closed-loop referral system (such as FindHelp, Unite Us, etc.)	

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DHCS Comprehensive Quality Strategy	Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.	[NEW] to 2022 Q1 Work Plan 1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy	Marsha Choo/Katie Balderas	QIC	DHCS Quality Strategy was presented to the September QAC. Created and hired an Executive Director of Quality to focus on developing the quality strategy. CalOptima Health has completed the Population Health Readiness Assessment and drafting a PHM strategy, a part of the overall quality strategy, to implement in 2023. Staff is working with NQA consultants to educate staff on Health Equity Standards for Accreditation. Continued efforts to on Phase 3 of CalAIM.	ED of Quality to begin Q1 of 2023. Begin implementation of PHM Strategy in Q1 2023. Develop a timeline for Health Equity Accreditation. Develop a QI Work Plan to address the DHCS Bold Goals. Continued efforts in CalAIM.	Green
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	[NEW] to 2022 Q1 Work Plan SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.	Natalie Zavala	QIC	1) Continued collaboration with Orange County Department of Education (OCDE) and OC Health Care Agency (HCA). Attended Mental Health Superintendent Work Group. External workgroup meetings did not occur; will once materials from LEAs received. 2) Continued internal meetings with Core Team updating project plan on a bi-weekly basis. 3) Provided update at the Q3 WCM Clinical Advisory Committee (CAC) on 8/16/22. 4) 9/30/22 due date for LEAs to submit SBHIP Assessment materials: Needs Assessment Template, Data Collection Strategy, Referral Process, Resource Maps.	1) CalOptima Health team to compile LEA SBHIP Assessment responses for submission to DHCS by 12/31/22. 2) Continue routine meetings with OCDE and OC HCA. 3) Hold external stakeholder workgroup next quarter. 4) Identify targeted interventions and population, and complete Project Plan for submission to DHCS by 12/31/22.	Green
II. QUALITY OF CLINICAL CARE- Adult Wellness							
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies, eg. Mobile Mammography Events.	Helen Syn	QIC	1a. 2022 Member Health Rewards processed as of 9/30/22: BCS: 346 for MC 5 for OC and 8 for OCC; CCS: 506 for MC; COL: 6 for OC on 19 for OCC 1b. Transition from Member Health Reward vendor (Iario) to be done in-house. Reward process design in progress. 2. Targeted member engagement and outreach campaigns to identified zip codes for paid Social Media Campaigns. 3. Member Engagement Strategy: Social Media (Paid): CCS, BCS Digital Ad: CCS digital ad; BCS digital ad 4. Community Events: Mobile Mammography: KCS event 29 CCN members completed 5. 2022 August Prospective Rates (PR): Breast Cancer Screening MC: 53.24%, OC: 60.10%, OCC: 60.58% Measure is performing higher for all LOBs than same time last year and below the 50th percentile (MPL). Cervical Cancer Screening MC: 50.59% Measure is performing lower than same time last year and is below the 50th percentile (MPL). Colorectal Cancer Screening OC: 45.66%, OCC: 51.24% Measure is performing higher than same time last year for both OC/OCC and is currently below the 50th percentile.	1a. Continue to track BCS, CCS and COL member health reward. 1b. Transition to in-house member health reward process. 2. Targeted member engagement and outreach campaigns to identified zip codes. 3. Member Engagement Texting: BCS texting campaign scheduled Q4 IVR: BCS scheduled for Q4 Social Media: BCS scheduled for Q4 Digital Ad: BCS scheduled Print Ad: BCS scheduled Direct Mailing: BCS scheduled for Q4 Community Connections: BCS article scheduled for Q4 Member Newsletter: CCS, BCS, COL article scheduled for Spring and Summer issue 4. Community Events: Ongoing mobile mammography events	Yellow
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID DIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	Helen Syn	QIC	1) COVID texting campaigns continued in Q3. 2) COVID community vaccine events were held in partnership with OCHCA ongoing. A. Vaccine Events include: • 8/18/2022: 144 total health rewards • 9/17/2022: 116 total health rewards • 9/21/2022: 107 total health rewards B. Vaccine Event Totals: 367 health rewards 3) Vendor has processed a total of 1,049,633 incentives (cumulative) and PHM has processed a total of 1,202,925 incentives (cumulative) as of 10/6/2022. 4) VIP reimbursement data submitted for part 2.	1) Texting campaigns continue. Upon approval from the Board of Directors (BOD), new texting messages will be updated to include expanded age ranges and incentive eligibility. 2) COVID community vaccine events are continuously planned by Community Relations. 3) Ongoing COVID messaging to go out in Member Newsletter and Provider Newsletters about the importance of boosters and new eligibility with expanding age sets. Social Media, Targeted ad campaigns scheduled. 4) COVID vaccine incentive processing continues. CAIR registry data and logic improvements to assist with identification and more timely processing.	Yellow
III. QUALITY OF CLINICAL CARE- Behavioral Health							
Follow-up After Hospitalization for Mental Illness within 7 and 30 days of discharge (FUH).	HEDIS MY2021 Goal: FUH 30-Days: MC: NA; OC: NA; OCC: 48.40% (Quality Withhold measure) 7-Days: MC: NA; OC: NA; OCC: 27.07%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	Natalie Zavala	QIC	PR HEDIS Rates Q3 (August): 30 day- 34.925%, 7 day- 17.46%; BHI real-time report Q3 (July-Sept): 30 day- 38% , 7 day- 22% . 1) Continued outreach by BH Personal Care Coordinator (PCC) to members post-discharge to coordinate follow-up appointments. 2) Continued weekly BHI clinical round meetings to discuss concurrent reviews and internal coordination interventions. *Barriers included: Decrease in initial admissions but increase in member Re-admissions. Members not attending follow-up appointments due to readmission; members declining assistance from PCC or inpatient facility in assisting member with creating outpatient BH appointment, and inability reaching members due to invalid phone numbers or answering and then hanging up.	1) Continue conducting post discharge outreach. 2) Continue tracking members and outreach to those who are not attending follow-up appointments within 7 days of discharge.	Yellow
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	HEDIS MY2021 Goal: MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	Natalie Zavala	QIC	PR HEDIS Rates Q3 (August): Initiation Phase- 42.62%, Continuation and Maintenance Phase- 48.15% 1) Continued monitoring of CORE report to track members who filled an initial ADHD Rx. This is a manual process, but addresses barrier of limited resources for developing a real-time report to track member follow-up visits for provider outreach to schedule visits. 2) Continued member outreach for those who filled initial ADHD Rx (script and workflow to track phone calls made to members). 3) Reviewing data for compliant and non-compliant providers.	1) Continue member outreach for those who filled an initial ADHD prescription. 2) Identify trends in compliant and non-compliant provider letters. 3) Distribute non-compliant provider letters. 4) Submit article on Treatment for Children with ADHD to educate members on ADHD will be included in the Medi-Cal Member newsletter Spring edition.	Green

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Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)	[NEW] to 2022 Q1 Work Plan 1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	Natalie Zavala	QIC	PR HEDIS Rates Q3 (August): M/C: 63.97%, OC: N/A, OCC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test. 2) Conduct outreach to prescribing provider via phone, then fax to include (a) list of members in need of diabetes screening (b) best practice guidelines reminder (c) members' primary care physician (PCP) name and contact information (to promote coordination of care) by requesting prescribers to contact the PCP with lab results). Barriers included: Receiving timely data, obtaining the correct contact information for the prescribing providers such as phone numbers, fax numbers, and providers no longer practicing. Other difficulties we have come to know is that some members with this diagnosis don't see their PCP because of trust issues.	1) Finalize new data source through Tableau. 2) Continue tracking members in need of diabetes screening test. 3) Continue prescribing provider outreach.	Green
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)	[NEW] to 2022 Q1 Work Plan 1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.	Natalie Zavala	QIC	PR HEDIS Rates Q3 (August): 30 day- 25.69%, 7 day-15.61% Measure has been identified as a Health Network (HN) P4V. The main barrier is obtaining real-time data for ED visits in order to conduct interventions to assist in follow-up visit attendance. On 9/17/22, BHI attended CalOptima Health Quality Forum to present on FUM and discuss with HNs their experience, barriers, opportunities for improvement. However, due to time constraints, presentation was rescheduled to next meeting in December.	1) Finalize FUM Tableau report to identify trends. 2) Present FUM data at Quality Forum in December to discuss/ address barriers.	Yellow
IV. QUALITY OF CLINICAL CARE- Chronic Conditions							
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	MY2021 HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	Helen Syn	QIC	1a) HbA1c Test Health Rewards: 338 Processed, 304 approved, 34 denied 1b) Transition from Member Health Reward vendor (Icario) to be done in-house. Reward process design in progress. 2) Emerging Risk Health Coach Outreach: MC 398 members, 249 Assigned, 5 No Longer Eligible, 28 No Longer Emerging Risk, 3 Opt Out, 7 Unable to Contact OC 0 members, 0 Assigned, 0 No Longer Eligible. Emerging Risk Health Coach Outreach OCC 26 members, 21 Assigned, 0 Unable to Contact, 3 No Longer Emerging Risk, 0 No Longer Eligible. 3) Member Engagement Strategy: Texting: CDC texting campaign launch date slated for Q4 2022. IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachable/no answer Social Media: slated for distribution late October 2022 / early November 2022. 4) Prop 56 provider value based payments for diabetes care measures. 5) 2022 August Prospective Rates (PR): Note: A1C Testing submeasure was removed from 2022 HEDIS specs. A1C Adequate Control <8.0 MC: 35.12% (green, below 50th), OC: 41.82% (red, below 50th), OCC: 49.91% (green, below 50th) Measure is performing higher for MC and OCC LOBs than same time last year except for OC LOB and all LOBs are below the 50th percentile (MPL). A1C Poor Control >9 MC: 58.88% (green, above 50th), OC: 50.65% (neutral, above 50th), OCC: 43.07% (green, above 50th) Measure is performing better for all LOBs than same time last year (lower rate is positive trend) except for OC LOB and above the 50th percentile (MPL). (Lower is better)	1) Track and monitor until the end of member incentive year. Transition from Member Health Reward vendor to be done in-house. Reward process design in progress. 2) Continue the Emerging Health Coach outreach to the end of 2022. 3) Texting: launch date slated for Q4 2022. IVR: next campaign slated for 2023. Social Media: Campaign slated to launch Q4 2022. 4) Contract with health reward vendor was canceled, looking for alternative plan for transition.	Green
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals: MC 63.2% OC: 71% OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	Helen Syn	QIC	1a) Eye Exam 201 Processed, 172 approved, 29 denied 1b) Transition from Member Health Reward vendor (Icario) to be done in-house. Reward process design in progress. 2) VSP Eye Exam Reminder Letters slated for Q4 2022 distribution 3) Member Engagement Strategy: Texting: CDC texting campaign launch date slated for Q4 2022. IVR: Campaign: 3,108 successful, 686 left message, & 11,351 unreachable/no answer Social Media: slated for distribution late October 2022 / early November 2022. 4) Prop 56 provider value based payments for diabetes care measures 5) 2022 August Prospective Rates (PR): Diabetes Eye Exams MC: 44.34% (green, below 50th), OC: 55.86% (red, below 50th), OCC: 59.86% (green, below 50th) Measure is performing higher for all LOBs than same time last year except for OC LOB and below the 50th percentile (MPL). 6) Identified VSP data fields needed from HNs for data sharing criteria.	1) Track and monitor until the end of member incentive year. Transition from Member Health Reward vendor to be done in-house. Reward process design in progress. 2) Analyze if a need for additional member mailers are necessary. 3) Texting: launch date slated for Q4 2022. IVR: next campaign slated for 2023. Social Media: Campaign slated to launch Q4 2022. 4) SFTP setup for HN in progress. 5) Contract with health reward vendor was canceled, looking for alternative plan for transition	Green
Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot	1) Lower HbA1c to avoid complications; 2) reduce emergency department (ED) visits and hospitalizations (readmission rates); 3) improve member and provider satisfaction; and 4) optimize diabetes medication management.	Program Design: 1) CalOptima Health Pharmacist Involvement and Intervention 2) CalOptima Health CHW Involvement and Intervention (for the purpose of the prototype study, the workgroup will leverage Population Health Management department's Health Educators as CHW proxies) 3) PCP Engagement	Nicki Ghazanfarpour/ Jocelyn Johnson/ Joanne Ku	QIC	Since the initiative is still in the planning stage, there are no results or metrics to report at this time. However, the workgroup has conducted literature reviews/user research and found that the results support our multidisciplinary program approach. 1. Literature demonstrates that pharmacist involvement is effective. 2. Literature indicates that diabetes interventions should include culturally relevant resources, family support, and diabetes self-management skills education. Barrier: Health Education 1. 60.91% of the members reported not receiving any diabetes education in the past. 2. 45.80% of the members said that they do not know the causes of high and low blood sugar and do not know what to do when it is high and/or low. Barrier: Medications 1. Other health conditions that are most prevalent among these members are high blood pressure (20.75%) and high cholesterol (22.62%). 2. 43.84% of these emerging risk members reported that they do not understand how to take their medications properly. 3. Over half of these emerging risk members (52.26%) had lower scores (0 to 3) on the Morisky Scale, which indicates lower medication adherence.	Community Health Worker (CHW) initiative design in planning stages, staff workflow in progress. 1) The workgroup conducted key informant interviews with community partners. The workgroup plans to go back to community partners and share our final pilot program design. 2) The workgroup is currently working with ITS to build member stratification for this project. 3) The workgroup also plans to host a provider webinar or similar engagement activity (targeted for high volume CCN PCPs) so we can have providers' buy-in and commitment to make this work.	Green

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V. QUALITY OF CLINICAL CARE- Maternal Child Health							
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	<p>HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75%</p> <p>Based on HEDIS MY2020 NCOA Quality Compass Benchmarks (released September 2021)</p>	<p>1) Transition to the Member Health Reward vendor to continue rewards established for Postpartum care.</p> <p>2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes.</p> <p>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</p> <p>4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners</p> <p>5) Prop 56 provider value based performance incentives for prenatal and postpartum care visits</p>	Ann Mino/Helen Syn	QIC	<p>1) Member Health Reward of \$50 for Postpartum Care visit within 1-12 weeks after delivery is continuing.</p> <p>2) Postpartum Mailing Initiative: Process for the first quality Initiative mailing is still being developed. Mailing projected to go out by end of Q4 2022. Mailing will target members that recently delivered (identified via and encourage timely postpartum care.</p> <p>3) Bright Steps Program conducted initial outreach to 1724 unique members. Total of 1,008 outreach attempts made to 630 postpartum members. 248 postpartum assessments completed.</p> <p>4) Continuing member engagement strategy: -Postpartum Care digital add campaign August - September 2022 = 206,682 impressions (Eng, Spa, and Viet) -Postpartum Care targeted social media ad campaign August - September 2022 = 142,855 Reach, and made 365,687 impressions - Medi-Cal member newsletter article on Postpartum Care Extension is Here!" dropped 09/07/22.</p> <p>5) Bright Steps Program received a total of 916 new Pregnancy Notification Reports and conducted outreach to engage members with the program.</p> <p>6) Total # of PPC health rewards approved July - September: 81</p> <p>7) Perinatal and Postpartum Bright Steps Program participated in 2 Diaper Day events in collaboration with the Westminster Family Resource Center and WIC Santa Ana location. A total of 350 persons were outreach in these public events.</p> <p>8) Prop 56 provider value based performance incentives for prenatal and postpartum care visits.</p> <p>August 2022 Prospective Rates: Timeliness of Prenatal Care: 80.00% Measure is performing higher than same time last year and has not met the 50th percentile. Postpartum Care: 63.63%. Measure is performing higher than same time last year and has not met the 50th percentile.</p>	<p>1) Postpartum quality initiative mailing is projected to begin by end of Q4 2022.</p> <p>2) Continue to expand member engagement strategy to ensure multi-modal approach to include the following elements: text campaigns, IVR robocalls, social media, etc.</p> <p>3) Exploring integration of the Medi-Cal Community Health Worker benefit can be implemented to support prenatal and postpartum care.</p> <p>4) Contract with health reward vendor was canceled, looking for alternative plan for transition</p>	
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness							
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	<p>HEDIS MY2021 Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83%</p> <p>Based on HEDIS MY2020 NCOA Quality Compass Benchmarks (released September 2021)</p>	<p>1) Targeted member engagement and outreach campaigns in coordination with health network partners.</p> <p>2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes.</p> <p>3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits</p> <p>4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics</p> <p>5) Prop 56 provider value based payments for relevant child and adolescent measures</p>	Helen Syn	QIC	<p>1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes.</p> <p>- Targeted ad campaign for Well-Care Pediatrics August - September 2022. Digital = 206,682 impressions; Social Media = 437,118 impressions.</p> <p>- Targeted ad campaign for Immunizations August - September 2022. Digital = 206,682 impressions; Social Media = 410,377 impressions.</p> <p>- Medi-Cal member newsletter article on "Let's Get Ready for School. Get your Vaccines" dropped 09/07/22.</p> <p>- Texting campaign and social media campaign for National Immunization Awareness Month. WCV = 9027; IMA = 793</p> <p>- Health Guide 7-12 mailing, in progress, REQ submitted</p> <p>- PBS Ad: Flu campaign started running in September 2022.</p> <p>2) Plan and attend community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates.</p> <p>- Back-To-School Vaccination Event: total of 7 events. 443 families attended CalOptima Health table at these events. 72 vaccinations provided (41 were CalOptima Health members). Vision screening, dental screening and developmental screening were available at select events.</p> <p>- Event promotion: website, targeted member mailing, text message campaign, boost social media post</p> <p>3) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures. Regular meetings with health network partners to share activities, help address concerns, and share best practices.</p> <p>4) August 2022 Prospective Rates: CIS Combo 10: 30.37%; has not met MPL IMA Combo 2: 43.68%; met MPL. Rate is LOWER than last year and has met 66th percentile (41.81%) W30 First 15 Months: 30.85%; have not met MPL (54.92%). First year with benchmarks to monitor PR. W30 15-30 Months: 66.75%; have not met MPL (70.67%). First year with benchmarks to monitor PR. WCV: 30.43%; have not met MPL (45.31%). First year with benchmarks to monitor PR.</p>	<p>1) Continue expanding member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes.</p> <p>- Health Guide 7-12 Newsletter mailing</p> <p>- Well-Child (0-30 Months) IVR and text message campaign</p> <p>- Well-Care 12-17 Years IVR campaign</p> <p>- Well-Care (3-17 Years) Text message campaign</p> <p>- LSC, CIS, W30 in-house call campaign for year end push (noncompliant members)</p> <p>2) Collaborate with health network partners to coordinate campaigns to improve HEDIS measures. Regular meetings with health network partners to share activities, help address concerns, and share best practices.</p>	
Blood Lead Screening (BLS) (LSC)	<p>1) Comply with APL requirements as stated</p> <p>2) Send quarterly reports to CalOptima contracted PCPs timely</p> <p>3) HEDIS MY2021 Goal (3 Year Goal): Lead Screening 50th percentile 71.53%</p>	<p>1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule.</p> <p>2) Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners</p> <p>3) Prop 56 provider value based payments for Blood Lead Screening</p>	Helen Syn	QIC	<p>1) Shared report in July 2022 to health networks with Q2 2022 data on members that have not been screened as recommended for blood lead screening. Q2 2022 report for CCN Providers shared via Provider Portal.</p> <p>2) Continuing member engagement strategy. Member IVR lead campaign launched in July. Member reach: 1,156</p> <p>3) Worked on starting provider engagement strategy. Including updates to health networks on matters related to blood lead (e.g., gap reports, HN attestation process, internal policy updates)</p> <p>4) Conducted member barrier analysis to identify root cause of lack of blood lead tests among members.</p> <p>5) Prop 56 provider value based payments for Blood Lead Screening.</p> <p>6) Finalized Evidence of Blood Lead Refusal form and HN Attestation Process for Health Networks to adhere to regulatory requirements that include Provider adherence to the provision of anticipatory guidance for blood lead screenings.</p> <p>August 2022 Prospective Rates Lead Screening in Children (in 2022, LSC became an MCAS measure that will have to meet the minimum performance level- MPL). MC: 58.54% Measure is performing higher than the same time last year and has not met the 50th percentile. (MPL)</p>	<p>1) Continue to share blood lead gap reports and DHCS blood lead supplemental data reports to HNs and CCN Providers. Reports are in process of being revised to highlight provider requirements such as the need for anticipatory guidance to parent/guardian of members.</p> <p>2) Continuing strategy to update providers. Preparing to offer two Provider CME events focused on blood lead screening requirements scheduled for Q4 2022. Preparing Provider Press blood lead article for Q4 2022</p> <p>3) Continue expanding member engagement strategy to include multi-modal approach via: texting, robocalls, social media. Planning PBS TV campaign that is projected to start in Q4 2022.</p> <p>4) Continue with revisions to internal policy GG.1717 Blood Lead Screening in Young Children to support adherence to regulatory requirements.</p>	

2022 Q1 Work Plan 3Q

2022 Q1 Work Plan Element Description	Goals	Planned Activities	Staff Responsible	Report to Committee	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <i>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)</i>	Next Steps Interventions / Follow-up Actions <i>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.)</i>	Red - At Risk Yellow - Needs Attention Green - On Target
VII. QUALITY OF SERVICE- Access							
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	Marsha Choo/Jennifer Bamberg/Maggie Hart	MEMX	Transition of recruitment efforts from Contracting department to Provider Relations are finalized	Provider Relations will now be responsible for provider recruitment; created letter templates, created workflow and finalizing all documents to ensure reporting of all recruitment efforts are documented	
Improve Access: Expanding Network of Providers Accepting New Patients	Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%	[NEW] to 2022 Q1 Work Plan 1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.	Marsha Choo/Jennifer Bamberg	MEMX	Providers are actively returning the provider validations but delayed for those offices that are not tech savvy, new excel format was provided and assisting with navigating the spreadsheet caused delay	PR Reps continue to obtain confirmation of open and or closed panel, documenting requests via Facets, significant improvement to 70% of total CHCN network	
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards	Marsha Choo/Jennifer Bamberg	MEMX	1)2021-22 Timely Access Results reviewed and QC'd; working with vendor on development of non-compliance tracker. Non-Compliance letters being updated with CAP for those with non-compliance for a single measure 3 consecutive years. 2) HN Timely Access PDSA's submissions reviewed and additional follow-up requested by workgroup on three networks responses before close-out.	1) Next steps include finalizing non-compliance tracker and templates for letters. Issue non-compliance letters to providers and CAPs to HNs by end of 4th quarter. 2) Obtain clarification from three HNs regarding their PDSA submission. Access Workgroup to review final responses and close-out and/or determine next steps. Present final recommendations to Member Experience.	
Improve Access: Telephone Access	Reduce the rate of No Live Contacts After 3 Attempts from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETS (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	Marsha Choo/Jennifer Bamberg	MEMX	1) Update- improved provider data of 70% of total CCN provider TIN's acknowledging changes and/or updates to provider data, including phone numbers, office hours and open/closed panels 2) 2021-22 Timely Access Survey results reviewed and QC'd. Working with vendor on finalizing non-compliance tracker to assist with issuing letters to providers.	1) Finalizing last outreach effort for end of year push through office face-to-face visits, and phone calls 2) Finalize non-compliance tracker, issue non-compliance letters to providers, share TAS results in SNC November Report, and issue CAPs to HNs by end of 4th quarter.	
Improving Access: Subcontracted Network Certification	Certify all HNs for network adequacy	[NEW] 2022 Q1 Work Plan 1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.	Marsha Choo/Jennifer Bamberg	MEMX	<p>Network Adequacy Standards:</p> <p>Medi-Cal Plan Level:</p> <ul style="list-style-type: none"> •Mandatory Provider Types: Met •Provider to Member Ratios: Met •Time/Distance Standards: Met <p>Medi-Cal HN Level:</p> <ul style="list-style-type: none"> •Mandatory Provider Types: Not Met. (Certified Nurse Midwives and Licensed Midwives) •Provider to Member Ratios: <ul style="list-style-type: none"> -PCPs: Met for all HNs, except CHOC IM-PCP -Specialists: Not Met (Arta, Monarch) •Time/Distance: Not Met <p>Medi-Cal Timely Access</p> <ul style="list-style-type: none"> •Timely Access PDSAs were reviewed at workgroup mtg and additional follow-up requested on three networks responses before close-out. •HNs were provided a quarterly Subcontract Network Certification Summary report with their network adequacy performance August 31st •Provided HN with DHCS Provider List to help close the providers gaps for time/distance and MPT standards. 	<p>Continue to monitor quarterly and notify HNs of areas of non-compliance.</p> <p>If Net Adequacy standard(s) not met, HNs will identify out of network providers to ensure coverage of services.</p> <p>Seek clarification from three HNs regarding their PDSA submission. Access Workgroup to review responses and close-out and/or determine next steps. Present final recommendations to Member Experience.</p> <p>Workgroup to discuss how to certify HNs and how to issue corrective action to HNs with non-compliance.</p>	
VIII. SAFETY OF CLINICAL CARE							
Plan All-Cause Readmissions (PCR)	HEDIS MY2021 Goal: MC - NA OC 8% OCC 1.0 (O/E Ratio)	<p>1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11)</p> <p>2) Improve PCP Visit Access</p> <p>3) Continue to engage work group to address barriers, thereby achieving increased post hospitalization visits with PCP</p> <p>Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regarding the importance of having a post discharge visit with the members PCP.</p>	Kelly Giardina	QIC	<p>1) Leveraging Collective Medical for additional ED/ PCP follow up</p> <p>2) Pilot ED/ Rounds program to help inpatient facilities with escalations and support to secure pre-discharge appointments</p> <p>3) Continued meetings to discuss open items and data analysis to shift approach as needed.</p>	Collect Data and write up report send to consultant for review. Follow up meeting with Consultant to review report to be scheduled in 1Q2023.	



**Board of Directors' Special Quality Assurance Committee Meeting
March 15, 2023**

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

November 1, 2022: Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Committee (QIC) (PQIC) and PACE Infection Control Subcommittee Summary Health Plan Monitoring Data and PACE Quality Initiatives

- All PQIC members except for Noe Zuniga, Marketing and Enrollment Manager present
- Infection Control Subcommittee: PACE's Response to COVID-19:
 - Staff and participants continue to wear mask inside the PACE center but no longer screen their temperature at front door. In July 2022, updated masking policy to make KN95 masks mandatory for extra protection.
 - PACE Staff to report exposure/illness to their supervisor and HR. And reminded not to come in if feeling sick.
 - PACE staff must be fully vaccinated + booster or tested weekly in outside facility.
 - Participants must also have their COVID vaccine and booster to attend day center. Currently capacity is 60 per day but averaging 41 per day. Continue to be in separated cohorts for social distancing.
 - Participants who have not received booster dose yet must be tested for COVID using rapid antigen before receiving services in the center.
 - At the end of Q3, Bivalent vaccines were introduced and booster vaccine event was facilitated by ExcelCare at the PACE Center on 10/03/22 to 10/07/22, 135 bivalent shots were given.
 - Continue to schedule for COVID vaccinations mainly at ExcelCare pharmacy on Saturdays.
 - Vaccination status tracked and monitored by QI. 98% of participants have received initial doses, 94% of eligible participants have received a booster dose; 45% of eligible participants have received the 2nd booster dose (4th dose), 3.4% have received 3rd booster dose (5th dose, all bivalent).
 - DHHS extended the COVID 19 Public Health Emergency until 1/11/23
 - Continue to use telehealth modalities for participant encounters, when appropriate.
 - Q3, had a total of 33 cases, all recovered. No death and hospitalization reported.

- All new cases of COVID reported to CalPACE, NPA, and CMS and telehealth follow up by providers (PCP f/u on symptom improvement and O2 levels).
- Treatment- Paxlovid oral antiviral when appropriate.
- Weekly COVID 19 updates in Leadership meetings and monthly updates during All-Staff meetings.
- Continue to follow State and local guidance regarding COVID safety updates.
- Presentation of Q3 2022 HPMS Elements:
 - Enrollment. Figures presented. Q3 ended with 432 total enrolled, an increase of 4 from Q2. Goal of 458 was not met.
 - Immunizations
 - Pneumococcal Immunization rate is at 83%. 360 received, 35 prior immunizations, 18 refused and 19 missed opportunities.
 - 19 Missed Opportunities – 8 ordered and 11 not ordered yet.
 - Covid-19 Immunizations is at 98%. Goal of 95% has been met.
 - Falls without Injury. Q3 ended with 51, a decrease from 79 from Q2. Center manager noted that it is due to having the intervention in place. Rehab to continue to do home visit especially for repeat fallers and suggested changes. Repeat faller numbers were cut in half.
 - Grievances. Decreased from to 8 in Q2 to 7 in Q3. 5 were transportation related, 2 related to Medical Care/Miscommunication. All transportation grievances are sent to Secure for them to review and resolve.
 - Emergency Room Visits. 85 ER visits, a decrease from 105 in Q2. 40 were d/c to home without hospital admission. 40 admitted to hospital (5 for observation only). Most common admission diagnoses were chest pain, heart failure and weakness.
 - Medication Error Without Injury. Medication Error w/out Injury in Q3 2022. An increase from 0 in Q2.
 - 2022 Q3 HPMS Quality Indicators
 - Enrollment Data – 432 total enrolled
 - Immunizations:
 - Pneumococcal – 360
 - Covid-19 Initial Dose - 423
 - Falls Without Injury-51
 - Denials of Prospective Enrollees - 2
 - Appeals - 1
 - Grievances- 7
 - Emergency Room Visits- 85
 - Medication Administration Errors - 2
 - Quality Incidents- 10

- Quality Incidents with RCA
 - Falls with Injury – 6
 - Elopements – 1
 - Burn – 2
 - Pressure Ulcer - 1
- Presentation of Q3 2022 PACE Quality Initiative Data
 - COVID-19 Vaccine Booster Quality Initiative. Goal was 80% booster dose. 94% of eligible participants received a booster dose (3rd dose of vaccine). Goal Met. PACE has been providing assistance to participants to get the newly approved bivalent COVID vaccine.
 - Telehealth Engagement Quality Initiative.
 - Goal for 2022 is that $\geq 66\%$ of members will be able to engage in telehealth visits by having telehealth access such as VSEE, Google Duo or Facetime capabilities. Currently at 51%.
 - Plan to have a social work team update telehealth status alert during initial and reassessment of participants.
 - Advanced Health Care Directive. Q3 ended 41%, goal is 50% by end of 2022. This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team.
 - Identify solution for participants who do not have AHCD.

November 8, 2022: PACE Quality Improvement Committee (PQIC) Summary Quality Assurance and Performance Improvement Work Plan

- All PQIC members present
- Membership. Figures presented. Q3 ended with 432 total enrolled.
- Presentation of the Quality Work Plan Elements
 - Elements 3 – 5: Immunizations
 - Influenza Immunization rate is at 52%. Goal of 95% was not met yet- Deadline is December 31.
 - Pneumococcal Immunization rate is at 87%. Goal of 94% was not met yet.
 - Covid-19 Immunizations is at 98%. Goal of 95% has been met.
 - Element 6: POLST. Goal is 95%. In Q3, 96% of participants have POLST added to their chart. Goal met.
 - Elements 7 – 9: Diabetes Care.
 - Blood Pressure Control. Goal is 81.50% having a blood pressure of $<140/90$ mm. Rate is 72%.

- Diabetic Eye Exams. Goal of 82.77%. Rate is 99%. Goal met.
- Nephropathy Monitoring. Goal is 98.30%, Rate is 100% in monitoring Diabetes patients.
- Element 10: Osteoporosis Treatment. Goal of 90%. Rate is 98% of participants with Osteoporosis receiving treatment.
- Element 11: Falls at Home classified as CMS Reportable Quality Incidents. Falls those results in fracture, hospitalization, and death. Q3 ended with 6, with a Rate of 54, well below the Goal of <207 per 1000 participants per year.
- Elements 12 - 13: Potentially Harmful Drug/Disease Interactions in the Elderly.
 - Dementia - Goal is <27.24%. Rate is 19%.
 - CKD – Goal is <3.47%. Rate is 0%. Excluded topical NSAID from monitoring this element.
- 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. Met goal. One participant is receiving a dose greater than 90 MME and had PCP follow up each month in Q3 2022.
- Element 15: Medication Reconciliation Post Discharge (MRP). Goal is 90% within 15 days. Rate is 100%.
- Element 16: Access to Specialty Care. Goal is 85% to be scheduled within 14 business days. 95% in Q3 2022.
- Element 17: Telehealth Access. Goal is >=66%. Rate is 51%. Out of 432 participants, 221 participants have telehealth access.
- Element 18: Acute Hospital Days. Goal <3,330 in 2022. Goal was not met. In Q3, bed days increased from to 4412.
- Element 19: Emergency Room Visits. Rate is 856. Slightly above the goal of 850 emergency room visits per 1000 per year.
- Element 20: 30-Day All Cause Readmissions. Goal is <14%. Rate went up from 14% to 19% Goal was not met.
- Element 21: Long Term Care Placement. Goal is <4%. Rate is 4.17 in Q3. Long Term Care Placement are participants placed in custodial care in SNF in any period.
- Element 22: Enrollment Conversion. Goal is 60%. Rate is 73%. Goal met.
- Element 23: Transportation <60 minutes. Based on the data from Secure, there were 0 Violations.
- Element 24: Based on the data from Transportation on time performance was 100% in July, 98% in August and 98% in Sept 2022.

November 28, 2022: PACE Quality Improvement Committee (PQIC) Ad Hoc Meeting to discuss QI Workplan for 2023

- Jennifer Robinson, Monica Macias, Christine Sisil, Katia Suarez, Corrine Enos, and Karen Bonilla present
- Presentation of the Quality Work Plan elements for review and discussion
 - Flu Rate Element
 - Current Goal is 94% will have had vaccine by last day of year.
 - Element is reported in Q1, Q3, and Q4. Clinic gets monthly report from QI to see who is missing vaccine.
 - Currently at 77% as of meeting date. Clinic will investigate barriers to reaching goal.
 - Goal of 94% was not met last year, we ended 2021 at 91%.
 - Discussed refusal issues and how to address participants who consistently refuse.
 - Agreed to maintain goal of 94% for 2023 workplan
 - Pneumococcal Rate Element
 - Previous goal centered on PCV23, will now be changed to “Completed Pneumococcal Vaccine.” Goal to remain greater than or equal to 94% by end of year, for 2023. Currently at 87% as of last review.
 - Now giving PCV20 in clinic, which is a one dose completion for vaccination, as opposed to previous process of giving more than one dose of different vaccines.
 - QI changed report to clinic from quarterly to monthly, to increase visibility of those with incomplete vaccinations. QI to create flowchart to clarify conditions for vaccination based on CDC guidelines. Clinic to follow up with providers to make sure they are reviewing the information and scheduling vaccination.
 - Owner of this element will now be the PACE Medical Director.
 - COVID-19 Vaccine Rate Element
 - Previous goal centered on getting first two doses, but that goal needs to change for 2023 to address updates in vaccination related to bivalent COVID vaccine.
 - Changing goal to “80% of participants of eligible will receive a bivalent dose of vaccine” for 2023.
 - How to achieve- additional bivalent event at PACE Day center to be given by pharmacist coming to center, previous event was successful.

- Exclusion- participants who enroll in the last month of the year (no change to previous exclusion).
- Falls as Reportable Incidents Element
 - Goal has been <207 falls per 1000 per year, however we have been way over our goal. Discussed changing the metrics to raw data numbers, ex/ less than 10 falls per quarter.
 - Further discussion is needed to create an element that will reduce total number of falls.
 - Fall committee: Medical director, rehab staff, nurse, pharmacy.
- Access to Specialty Care Element
 - Goal has been 85% of specialty care visits will be scheduled within 14 business days in 2022. We have consistently met that goal due to improvements in staffing and improved review of participant needs by provider.
 - Will change the goal to 88% to strive for even better service for 2023.
- Telehealth Access Element
 - Goal has been 66% of participants will have access to telehealth visits. We have not been meeting that goal in 2022 for a number of reasons including staffing changes and disenrollment's of participants, and issues with the current telehealth platform in use.
 - Our priority has shifted to in-person visits. We will still assess participants for telehealth capabilities.
- Long Term Care Placement Element
 - Not meeting the goal in 2022. Staff need more training on what long term care placement means, what other resources are available to prevent long term care, how to strategize for issues that arise.
 - Per clinical medical director our goal is reflective of averages at other PACE centers, goal will remain at 4%.
- Enrollment- Qualified Leads to Enrollment Conversion Element
 - Current goal is that the qualified lead to enrollment conversion rate will be 60% or greater. We have consistently met that goal each quarter
 - Consideration for raising goal to 70% instead.
- Discussion related to creating new element(s) to address disenrollment
 - New element to reduce attrition rates. Create focus groups to identify areas that may need operational improvement to help maintain part satisfaction and support a lowered attrition rate. Identify interventions related to improving customer service check.

- Ask participants who want to disenroll what their top three things they would like to see changed, look for disenrollment trends.
 - Focus groups to identify areas that may need operational improvement to help maintain customer satisfaction.
 - Discussion of how hospice care is considered a controllable disenrollment, and that PACE can provide end of life care without participant enrolling in outside hospice.
- Transportation Elements
 - Follow up with Transportation regarding their exact definitions of;
 - 60 minutes violations- any exclusions?
 - On time performance
 - Follow up doing ride-along to ensure service requirements are being met
- Satisfaction Survey Scores for 2022
 - Transportation
 - Meals
 - Overall Satisfaction
 - Look at our satisfaction scores for 2022 and increase them for 2023 to be at or above the national average.
- Discussion of the 2023 Quality Initiatives
 - No longer need booster initiative since we have updated the COVID-19 vaccine element for 2023.
 - Maintain Advance Health Care Directive
 - Not meeting goal at this time, due to turnover and lack of staffing within the social work department.
 - Center manager will reapproach now that social work staff have been hired.
 - Maintain same 50% goal for 2023.
 - Exclude participants who have been enrolled less than 6 months.
 - Exclude mini-mental below 16.
 - Create Quality Initiative to look at satisfaction with dental services.
 - Satisfaction survey does not have specific questions regarding dentist services, however open comments section for 2021 noted written dental complaints.
 - Follow up questionnaire after dental visits to find any issues ahead of a grievance and work with participants to solve. Random audit of dental visits, done by survey, with collection of feedback.
 - Management of dental expectations before and during enrollment and initial assessment process. Find out what their expectations are for joining the question related to dental care.

- Goal is ≤ 1 dental related grievance per quarter.
- Create Quality Initiative to look at satisfaction with transportation.
 - This initiative will focus on increasing the participant satisfaction with contracted transportation services, to provide participants with timely resolutions to transportation related issues before they become formal grievance requests. PACE Center manager in conjunction with Secure transportation manager, PACE Clinic Manager, and PACE Clinical Support Services Supervisor will review and follow up on all complaints received by PACE participants regarding PACE transportation in a timely manner.



CalOptima Health

Member Trend Report 4th Quarter 2022

Special Quality Assurance Committee Meeting

March 15, 2023

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.

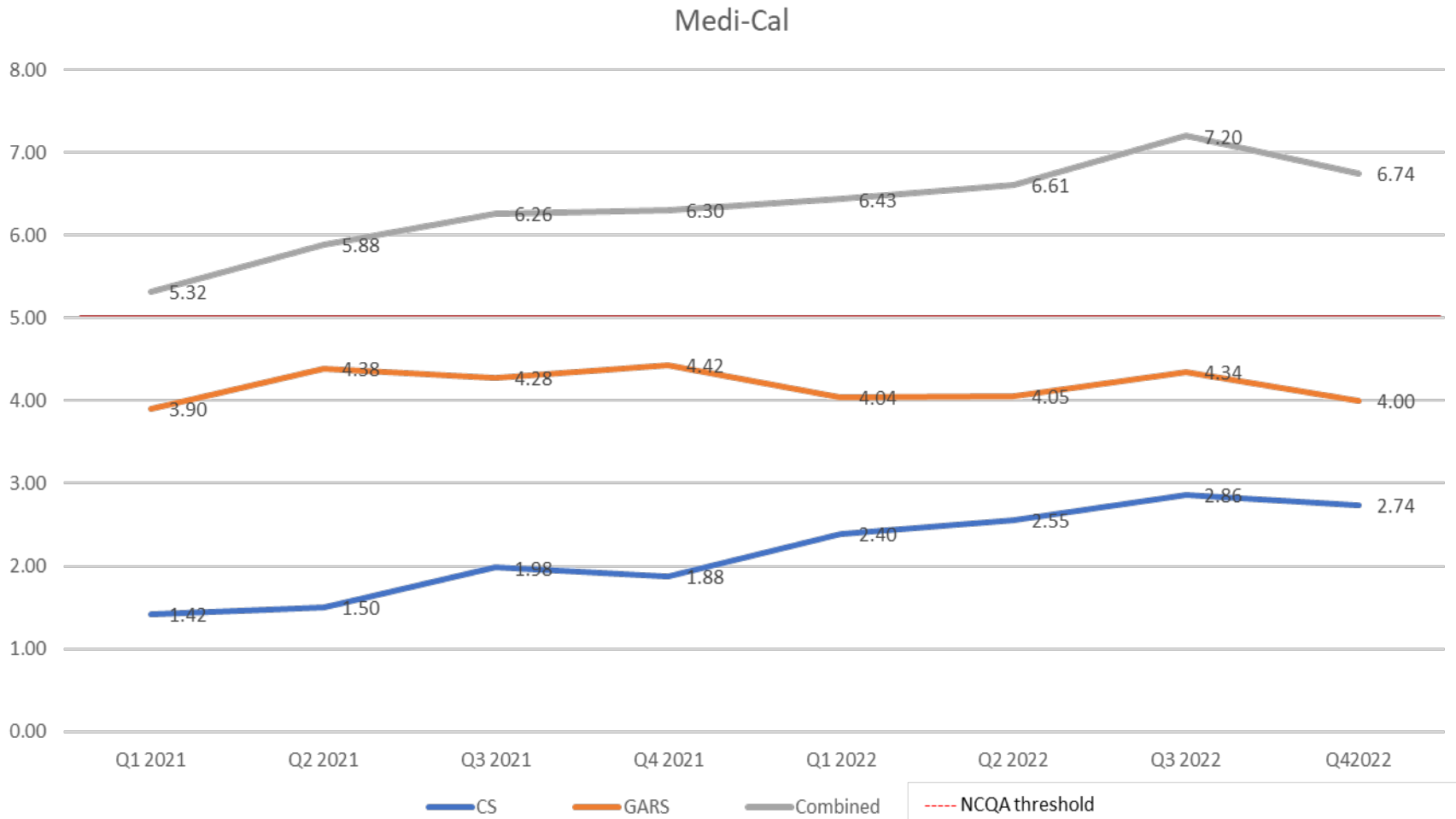
Overview of Presentation

- Definitions
- Grievances by Line of Business
 - Per 1,000 Member Month (M/M)
 - Trends
- Appeals Summary
- Summary of Trends and Remediations

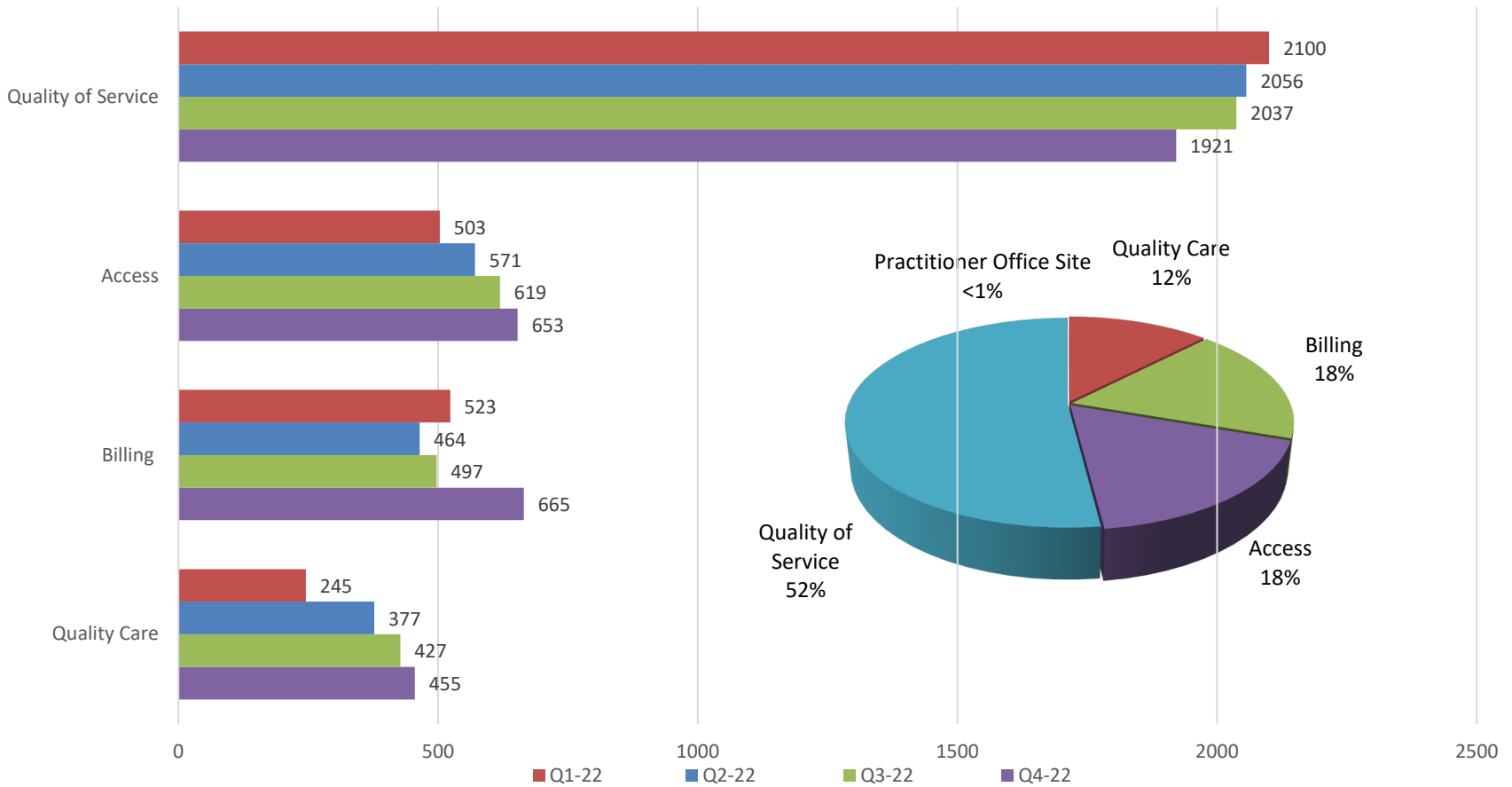
Definitions

- 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

Medi-Cal Total Grievances – Per 1,000/Member Months



Medi-Cal Member Grievances by Category

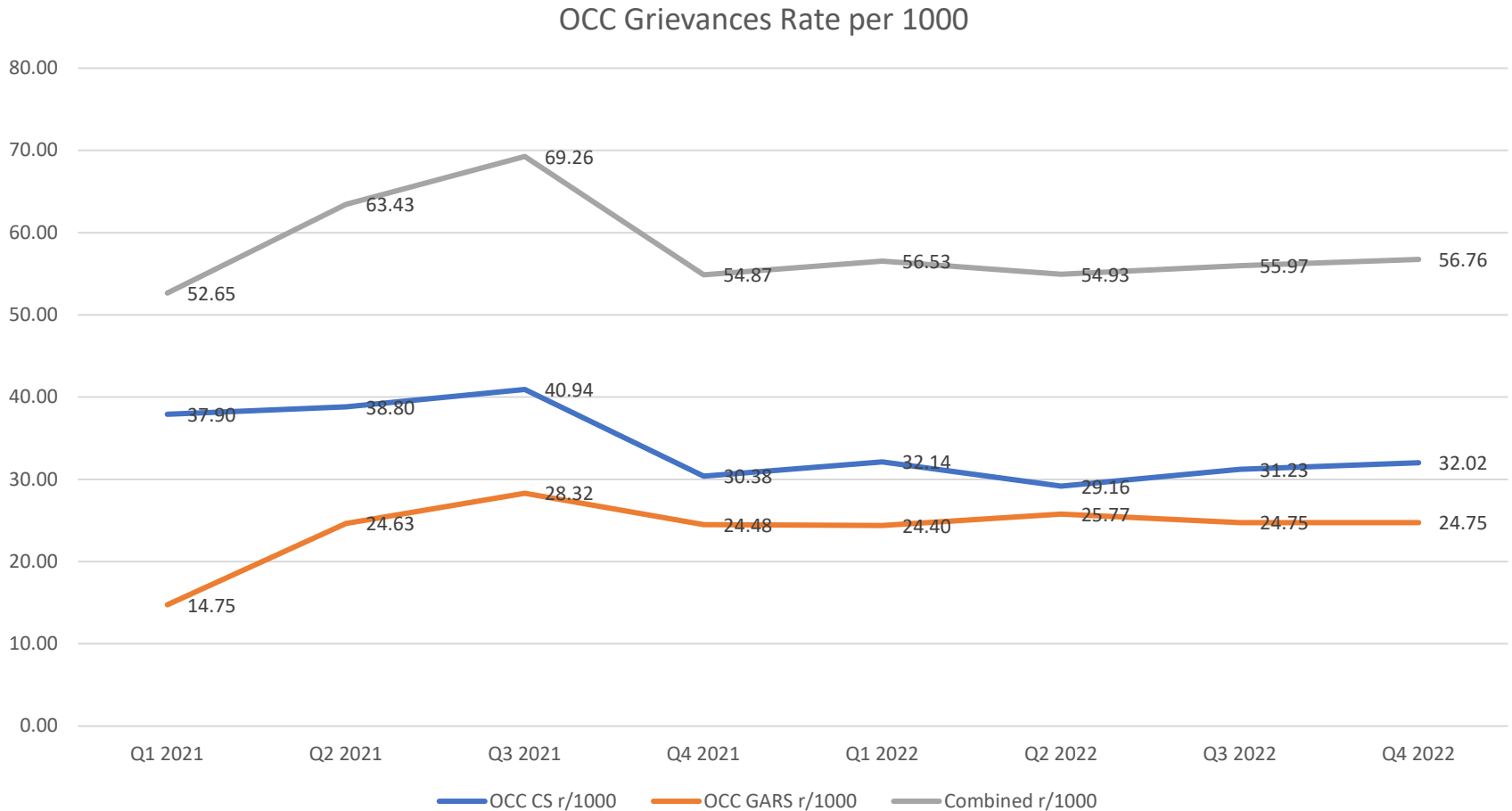


Grievance Trending

Medi-Cal Member Grievances Q4

- Quality of service- Transportation related concerns were due to delays in pickup, driver service issues and no shows
- Access- Related to appointment availability and telephone accessibility
- Billing – Member being billed instead of the health network or reimbursement request
- Quality of Care- Concerns with treatment and/or diagnosis

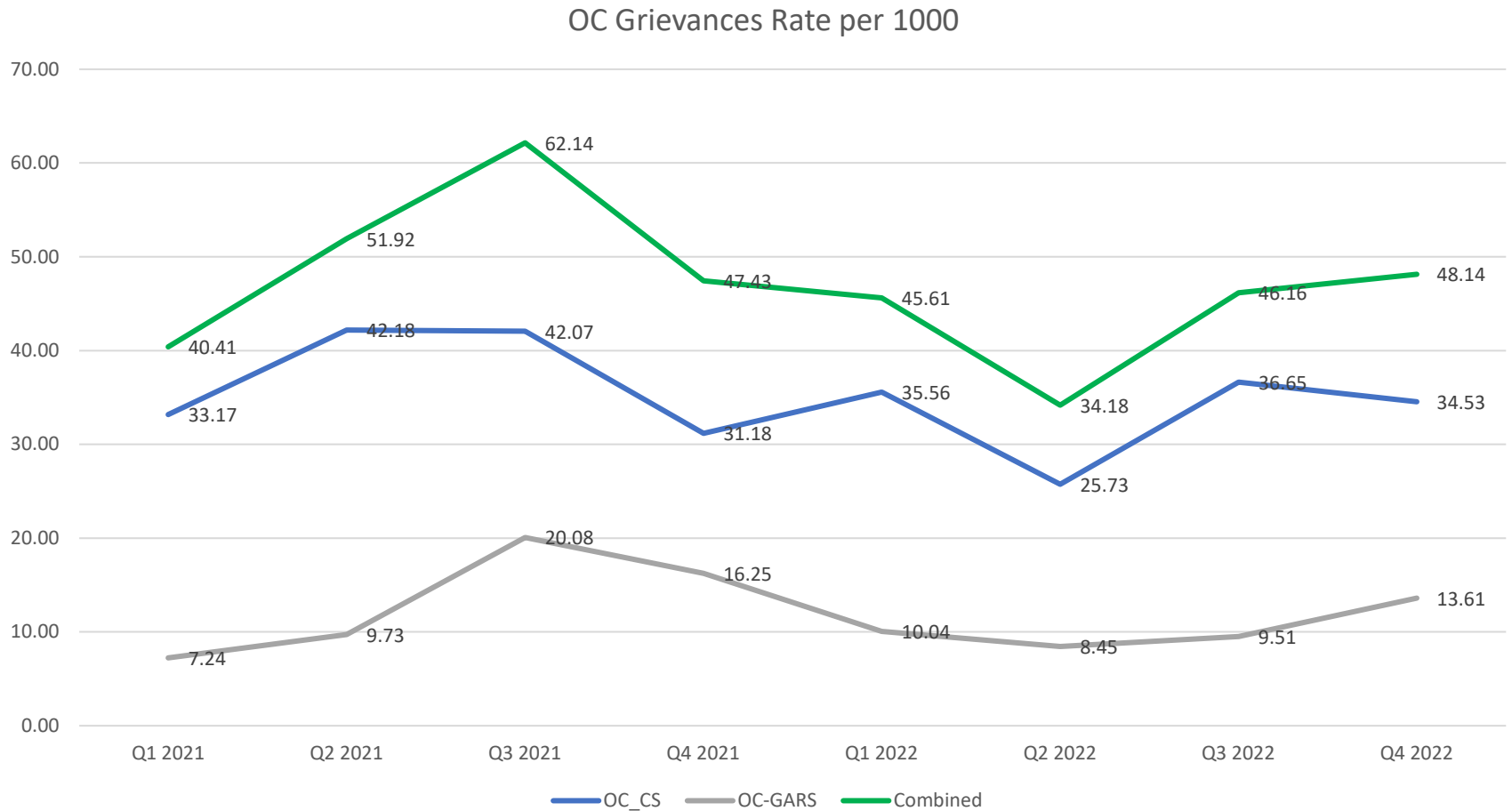
OneCare Connect Total Grievances – Rate Per 1,000/Member Months



Trends: OCC Grievances

- Grievances slightly decreased from 355 in Q3 to 354 in Q4 2022.
- Grievances were due to the following:
 - Transportation – no shows/late pickup
 - HN/PMG – delays in authorization or incorrect authorizations
 - Provider/staff – demeanor and inconvenience
 - CalOptima staff – GARS, CS, Weekend CS, Case Management
 - Delays and availability of appointments and/or treatment or care
 - Questions/Concerns with treatment

OneCare Total Grievances – Per 1,000/Member Month

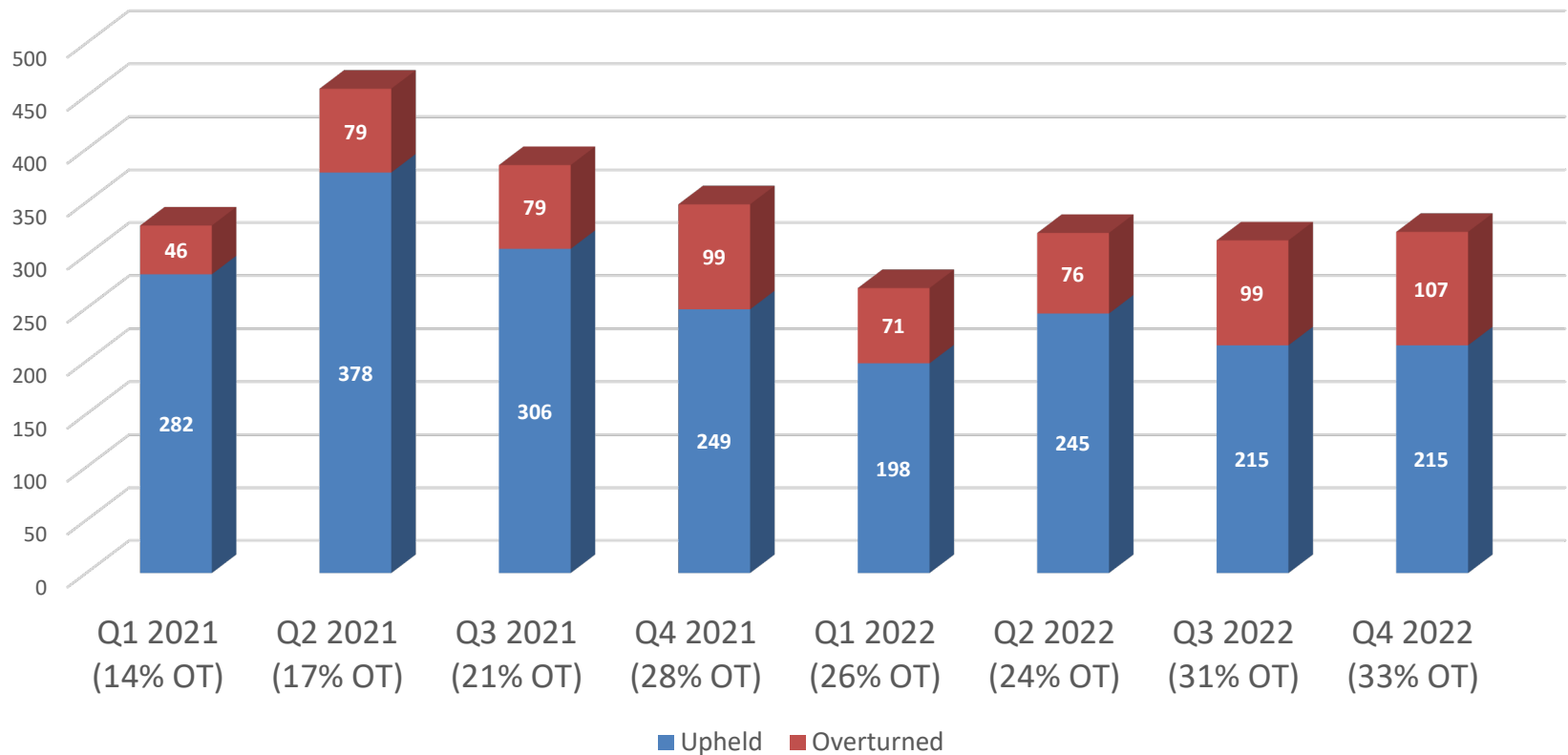


Trends: OC Member Grievances

- Grievances increased 51.8% from 27 in Q3 to 41 in Q4 2022.
- Grievances were due to the following:
 - Transportation – no shows/late pickup
 - HN/PMG – auth cancelled without notification
 - Provider/staff – demeanor and inconvenience
 - CalOptima staff – demeanor
 - Long wait times – services and care

Appeals - All Lines of Business Q1 2021 – Q4 2022

Appeals Comparison
Q1 2021-Q4 2022



No trends or concerns identified. GARS continues to track and trend.

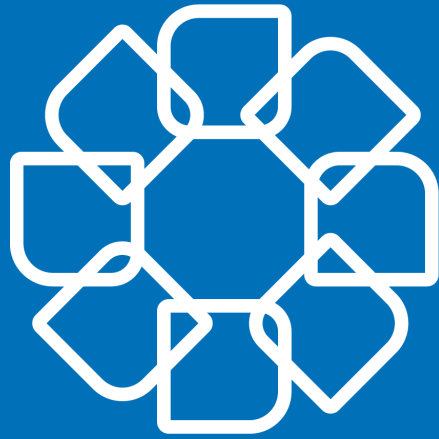
Summary of Trends and Remediations

Trending Factors for Grievances

Category	Issue	Remediation
Access to Care	<ul style="list-style-type: none"> • Appointment availability • Telephone accessibility 	<ul style="list-style-type: none"> • Redirected members as appropriate • Assisted members with scheduling • Reporting to Access and Availability workgroup for next steps • Health Network Reporting • GARS assist with obtaining updated numbers and assisting each member with making appointments
Member Billing	<ul style="list-style-type: none"> • Members being billed directly - not the Health Network 	<ul style="list-style-type: none"> • Educated providers on insurance/billing information on the individual cases • Provider Relations made outreach to the trending providers for additional education and reminders.

Trending Factors Contd.

Category	Issue	Remediation
Quality of Care	<ul style="list-style-type: none"> • Delay in treatment • Questions in treatment • Lack of follow-up 	<ul style="list-style-type: none"> • Individual Provider/Member engagement as appropriate • Reviewing for trends for PR or HNR education • Reporting identified trends to Member Experience • GARS collaborates with QI to review QOC grievances • Trending providers are reported to Member Experience for next steps
Quality of Service	Transportation <ul style="list-style-type: none"> • Driver Issue • Early/Late Pickup 	<ul style="list-style-type: none"> • Monitoring of repeat members • Ongoing call cadence with vendor leadership



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