



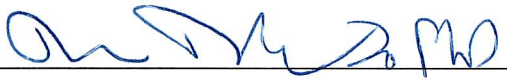
# **2024 QUALITY IMPROVEMENT HEALTH EQUITY TRANSFORMATION PROGRAM EVALUATION**



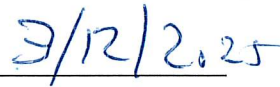


2024 QUALITY IMPROVEMENT HEALTH EQUITY TRANSFORMATION  
PROGRAM EVALUATION SIGNATURE PAGE

***Quality Improvement Health Equity Committee Chair:***



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

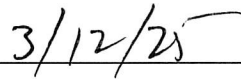


**Date**

***Board of Directors' Quality Assurance Committee Chair:***



**Jose Mayorga, M.D.**

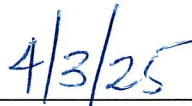


**Date**

***Board of Directors Chair:***



**Isabel Becerra**



**Date**

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# 2024 CalOptima Health Quality Improvement Health Equity Transformation Program Annual Evaluation

## Section 1: CalOptima Health Overview

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

### Our Mission

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

### Our Vision

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

### Our Values

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



## Our Strategic Plan

CalOptima Health's Board of Directors and executive team worked together to develop our 2022–2025 Strategic Plan. After engaging with 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.

CalOptima Health is in the process of developing a strategic plan for 2025–2028 that may go into effect this year pending adoption by our Board of Directors.

## Section 2: Executive Summary

The 2024 Quality Improvement Health Equity Transformation Program (QIHETP) Evaluation analyzes the core clinical service indicators to determine if the QIHETP has achieved key performance goals throughout 2024. This evaluation focuses on quality activities implemented during measurement year (MY) 2024 that impacted performance to improve health care and services available to CalOptima Health members. The look-back period for the 2024 QIHETP Evaluation is Quarter (Q)1 2024 through the end of Q4 2024.

The QIHETP for 2024 outlined major program initiatives. Threaded into the initiatives continued to be interventions that support both the Department of Health Care Services (DHCS) Comprehensive Quality Strategy and the Centers for Medicare & Medicaid Services (CMS) National Quality Strategy. These strategies aim for care that is equitable, high-quality and value-based and considers the needs of the whole person.

In 2024, QIHETP initiatives aligned 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 Quality Improvement and Health Equity (QIHE) initiatives to achieve 2024 QIHE goals and objectives to provide members with access to quality health care services. CalOptima Health continued to utilize the Plan-Do-Study-Act (PDSA) and continuous quality improvement (CQI) approach to developing initiatives in 2024, which has continued into 2025. These initiatives are focused on long-term improvements in selected high-priority measures.

In 2025, based on the 2024 QI Program Evaluation, CalOptima Health will continue to support a strategy, as identified in the 2025 QIHETP, 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 2025 QIHETP Annual Work Plan will profile key areas that offer opportunities for improvement to be implemented or continued as outlined in the 2025 QIHETP.

### 2.1 2024 Achievements

**April 2024:** CalOptima Health approved nearly \$25 million in workforce education grants to seven institutions in Orange County. These grants mark the first phase of the \$50 million Provider Workforce Development Initiative, the largest workforce grant ever awarded by CalOptima Health. The Initiative will help to address health disparities and better secure the future delivery of medical and behavioral health care by safety net providers. It also seeks to ease predicted shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population.

**June 2024:** CalOptima Health approved an investment of \$526.2 million to increase rates paid to health networks, hospitals, physicians, community clinics, behavioral health providers and ancillary services providers in Orange County. This investment is intended to support timely access to critical health care services for members and promote the managed care network's long-term financial stability over a 30-month period from July 2024 through December 2026.



**August 2024:** CalOptima Health held its largest community event ever, the Back-to-School Health and Wellness Fair, attracting more than 5,200 people to receive free services and resources to help children and families.

**Summer 2024:** In August, CalOptima Health launched its second Street Medicine Program in Costa Mesa in partnership with Celebrating Life Community Health Center. The following month, the CalOptima Health Street Medicine Program began in Anaheim. Across the new cities and the original program in Garden Grove, more than 500 members have received medical, behavioral and social services as part of this unique care delivery model that focuses on building trust and meeting individuals where they are.

**December 2024:** CalOptima Health partnered with Illumination Foundation, an Orange County-based nonprofit, to open the nation's first recuperative care center to serve medically vulnerable children and families experiencing homelessness. A \$3.5 million CalOptima Health grant helped to purchase the property. We also collaborated to design a payment structure that will sustain the center's services.

Throughout the year, our executives were honored for their successful leadership at CalOptima Health. This recognition includes:

- Nancy Huang, Chief Financial Officer, was a finalist in the April 2024 Second Annual Los Angeles Times B2B OC Inspirational Women Awards, recognizing accomplished female leaders from corporations and nonprofit organizations throughout Orange County.
- Yunkyung Kim, Chief Operating Officer, was honored by the Coalition of Orange County Community Health Centers with a Community Health Center Ambassador Award in August 2024. The award recognizes CalOptima Health's work to raise awareness and support the community health movement.
- Marie Jeannis, RN, MSN, CCM, Executive Director of Equity and Community Health, was inducted into the National Coalition of 100 Black Women Inc. in August 2024. She will serve in the health education program and be part of the Orange County Chapter.
- Kelly Bruno-Nelson, DSW, Executive Director of Medi-Cal/California Advancing and Innovating Medi-Cal (CalAIM), was appointed to Orange County's Commission to End Homelessness. She will serve a two-year term, ending January 22, 2026. The Commission implements and coordinates strategies to address homelessness in Orange County.

## 2.2 Review of 2024 Quality Improvement Health Equity Transformation Program Goals

### Goal 1: Maternal Health

- a. Close racial/ethnic disparities in well-child visits and immunizations by 50%

CalOptima Health focused on a performance improvement project to increase well-child visit appointments for African American members (0–15 months) from 41.90% to 55.78% by December 31, 2024. While the target was set for the 2024 measurement year, the formal DHCS Performance Improvement Project (PIP) timeframe spans from 2023 to 2026. CalOptima Health conducted

outreach to 85 members through telephone, email and text and reached 40% (34). The rate for well-child visits (0–15 months) for African American members for MY2023 is 45.05%. While there was an increase in the rate from the year before, the goal was not met for this project and will remain an area of focus for the next year.

- b. Close maternity care disparity for African American and Native American persons by 50%

CalOptima Health focused on increasing prenatal and postpartum appointments for African American and Native American members. Planned activities for these initiatives included outreach and promotion of the Bright Steps program, doula services and enhanced care management services. Goals set for the African American population were met. Rates were unavailable for the Native American population as there were no live births identified for this population in 2024. Since the denominator is low for Native Americans, CalOptima Health will focus on strategies and interventions to improve rates for prenatal and postpartum appointments in the African American population in 2025. CalOptima Health will continue to monitor rates for the Native American population and identify opportunities for improvement if a health disparity is identified for this population.

#### Goal 2: Children's Preventive Care

- a. Exceed the 50th percentile for all children's preventive care measures

For MY2023, CalOptima Health met or exceeded the 50th percentile for all children's preventive measures.

#### Goal 3: Behavioral Health Care

- a. Improve maternal and adolescent depression screening by 50%

For maternal depression screening, the rate increased from 8.73% in MY2022 to 14.52% in MY2023, with a 66.3% increase in material screening. For adolescent depression screening, the rate increased from 1.93% in MY2022 for both adolescents and adults to 6.75% in MY2023 for only adolescents, with over a 50% increase in the rate.

- b. Improve follow-up care for mental health and substance abuse disorder by 50%

For follow-up care of mental health after an emergency room visit, the rate for follow-up within 30 days decreased from 58.83% in MY 2022 to 35.73% in MY2023, with a 39.2% decrease in follow-up care. For follow-up care of substance abuse after an emergency room visit, the rate for follow-up within 30 days decreased from 24.05% in MY2022 to 21.41% in MY2023, with an 11.0% decrease in follow-up care.

#### Goal 4: Program Goals

- a. Medi-Cal: Exceed the minimum performance levels (MPLs) for Medi-Cal Managed Care Accountability Set (MCAS)

All MCAS measures exceeded the MPLs except for Follow-up After ED Visit for Alcohol and Other Drug Dependence within 30 Days (FUA) and Follow-up After ED Visit for Mental Illness within 30 Days (FUM). These two measures will be a focus area for CalOptima Health in 2025.

- b. OneCare: Attain a four-star rating for Medicare

CalOptima Health met a 2.5 overall star-rating for MY2023 and did not meet the goal of attaining a four-star rating.

## 2.3 Recommendations for 2025

For 2025, CalOptima Health will develop and implement the Quality Improvement and Health Equity Transformation Program (QIHTP) and QIHETP Work Plan. QIHETP will align with CalOptima Health's strategic goals and objectives as defined by the Board of Directors as well as with the priorities of our federal and state regulators, as identified in the CMS National Quality Strategy and the DHCS Comprehensive Quality Strategy. The QIHETP Work Plan will remain flexible, and 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 dignified and equitable manner.

Based on the 2024 QIHETP Evaluation, CalOptima Health will continue to focus on the following initiatives and projects to drive improvements that impact members.

- A. Incorporate SDOH factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
- B. Collaborate with external stakeholders and partners in comprehensive assessments of members.
- C. 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's barriers and behaviors.
- D. Strategize and streamline member outreach by using multiple modes of communication via contracted external vendors, including through the website, direct mailings, email, interactive voice response (IVR) calls, mobile texting, targeted social media campaigns and robocall technology.
- E. 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.
- F. Expand quality initiatives to improve member experience, focused on increasing member access to care.
- G. Monitor, evaluate and take timely action to address necessary improvements in the quality of care delivered by all providers in any setting and take appropriate action to improve upon health equity.
- H. Incorporate feedback provided by members and network providers in the design, planning and implementation of CQI activities, particularly on interpreter services and access to care.
- I. Enhance member and provider data collection to ensure the provider network can meet the cultural and linguistic needs of our members.

CalOptima Health also recommends the following new initiatives and projects to drive improvements that impact members.

- A. Implement a Diversity, Equity and Inclusion Training Program for staff, our health networks and our network providers that includes sensitivity, diversity, cultural competency and cultural humility, and health equity training programs.
- B. Leverage technology and automation in order to streamline quality operations and enhance productivity.

## **2.4 Recommended Priority Areas and Goals for 2025**

Based on the evaluation of the 2024 QIHETP Evaluation, CalOptima Health has extended the following goals from 2024 into 2025. CalOptima Health added a goal to attain National Committee for Quality Assurance (NCQA) Health Equity Accreditation. These recommended priority areas and goals are aligned with CalOptima Health's 2022–2025 Strategic Goals and DHCS Bold Goals.

### **Goal 1: Maternal Health**

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

### **Goal 2: Children's Preventive Care**

- a. Exceed the 50th percentile for all children's preventive care measures

### **Goal 3: Behavioral Health Care**

- a. Improve maternal and adolescent depression screening by 50%
- b. Improve follow-up care for mental health and substance abuse disorder by 50%

### **Goal 4: Program Goals**

- a. Medi-Cal: Exceed the MPLs for MCAS
- b. OneCare: Attain a Four-Star Rating for Medicare
- c. Attain NCQA Health Equity Accreditation

## Section 3: Program Oversight

3.1 Quality Improvement Health Equity Transformation Program Documents	
Business Owner: Marsha Choo	Department: Quality Improvement
Support Staff: Gloria Garcia	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Complete documents and obtain Board of Directors' (BOD) approval of all 2024 quality-related programs and work plans.	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <ul style="list-style-type: none"> <li>All quality documents will be completed, reviewed and approved by the following committees in Q1 2024, and by their appropriate subcommittee, where applicable. <ul style="list-style-type: none"> <li>QIHEC: 02/13/2024</li> <li>QAC: 03/13/2024</li> <li>Annual Board of Directors adoption by April 2024</li> </ul> </li> </ul>	
Status: <input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing	
<p>Background:</p> <p>Annually, CalOptima Health develops the following quality documents:</p> <ul style="list-style-type: none"> <li>2024 Quality Improvement and Health Equity Transformation Program (QIHETP) Description - Developed and implemented a robust written QIHETP description that focused on improving standards of care and addressing gaps in care identified in the prior year's evaluation. The organization enhanced the QIHETP by including "new initiatives" in the program description that will outline measurable goals and objectives that CalOptima Health will focus on in subsequent years. The following quality improvement documents are included as part of the overall QIHETP: <ul style="list-style-type: none"> <li>The 2024 Population Health Strategy</li> <li>The 2024 Cultural and Linguistic Program</li> <li>The 2024 Pay for Value Program</li> </ul> </li> <li>2024 Quality Improvement and Health Equity Transformation Program (QIHETP) Work Plan — Created to monitor and evaluate the 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</li> <li>2023 QI Program Evaluation — Completed a comprehensive evaluation of the 2023 QI Program and QI Work Plan at the end of the year that assesses the performance on measures and indicators, and the assessment laid the groundwork for the 2024 QIHETP</li> <li>2024 Utilization Management (UM) Case Management (CM) Integrated Program — Developed and implemented a written UM Program that defines the oversight and delivery of CalOptima Health's structure, clinical processes and programmatic approach to review health care services, treatment and supplies, and provide quality, coordinated health care services to CalOptima Health members</li> <li>2023 UM Evaluation — Completed a comprehensive evaluation of the 2023 UM Program at the end of the year that evaluates the impact of the UM Program</li> <li>CalOptima Health successfully completed reviews of all the above documents with the Quality Improvement Health Equity Committee (QIHEC) and/or subcommittees during 2024. The documents were reviewed and approved by both the Quality Assurance Committee of CalOptima Health's BOD and CalOptima Health's BOD</li> </ul> <p>Feedback from the providers who participated in the QIHEC and/or subcommittees meetings was included in program documents (i.e., program description, work plan and evaluation).</p> <p>Actions/Interventions Implemented in 2024:</p>	

Quarter 1:	<ul style="list-style-type: none"> <li>2024 QIHETP Description and Annual Work Plan was approved by QIHEC on 2/13/24, by QAC on 3/13/24 and by the BOD on 4/4/24</li> <li>A copy of the BOD-approved 2024 QIHETP and Work Plan was posted on CalOptima Health's public website</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>2024 QIHETP Description and Annual Work Plan was first adopted by BOD on 4/4/24. Revisions were made to the QIHETP and Work Plan, and they were approved by QAC on 6/12/24: <ul style="list-style-type: none"> <li>Updated QIHETP staffing and resources to reflect the current organizational structure and renamed the Population Health Managed Department as the Equity and Community Health Department</li> <li>Updated section in the QIHETP to reflect current operational and workflows</li> <li>Added Cultural and Linguistic Appropriate Services Program (CLAS) to QIHETP as Appendix D</li> <li>Added cultural linguistic and health equity goals and planned activities to the QIHETP Annual Work Plan</li> </ul> </li> <li>The revised 2024 QIHETP Description and Work Plan was submitted for BOD approval at the 8/1/24 meeting</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>The revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan was approved by the BOD on 8/1/2024, and a copy was posted on CalOptima Health's public website</li> <li>Staff initiated collaboration to begin developing the 2025 QIHETP Description and Work Plan</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Staff developed a draft of the 2024 QIHETP Evaluation and the 2025 QIHETP and Work Plan to be approved in Q1 2025</li> </ul>
Program Results:	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>The fourth quarter of the year is very busy for staff to complete the QIHETP Description, the Work Plan and the Evaluation.</li> </ul>	<ul style="list-style-type: none"> <li>Quality staff will begin drafting the 2026 QIHETP and Work Plan shortly after Healthcare Effectiveness Data and Information Set (HEDIS) rates have been finalized for the year and compared to goals in Q3 of 2025. This would allow staff to focus on the evaluation documents in Q4.</li> <li>Team collaboration to identify how best to draft the evaluation without having staff write the same evaluation in multiple documents. Consider having staff complete a template to populate both sections of the report and develop a table of contents for the evaluation prior to writing the evaluation sections</li> </ul>
Conclusion: All documents were prepared and approved by the Quality Improvement Health Equity Committee (QIHEC), the Quality Assurance Committee (QAC) and the Board of Directors on time.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>Quality staff to begin working on quality documents beginning in September 2025</li> </ul>	

### 3.2 Quality Improvement Health Equity Committee (QIHEC) and Subcommittees

Author: Marsha Choo

Department: Quality Improvement

Support Staff: Gloria Garcia

#### Committee Purpose and Background:

The QIHEC provides overall direction for continuous quality improvement processes, oversees activities that are consistent with CalOptima Health's strategic goals and priorities, and monitors compliance with regulatory and licensing requirements related to QI projects and activities. QIHEC aims to achieve improved care and services for members and ensure that members are provided with optimal quality of care. There are six subcommittees that report to the QIHEC at least quarterly:

- 1) Utilization Management Committee (UMC)
  - a. Pharmacy & Therapeutics Committee (P&T)
  - b. Benefit Management Subcommittee (BMS)
- 2) Grievance and Appeals Resolution Services (GARS) Committee
- 3) Credentialing and Peer Review Committee (CPRC)
- 4) Member Experience Committee (MEMx)
- 5) Population Health Management Committee (PHMC)
- 6) Whole Child Model Clinical Advisory Committee (WCM CAC)

The QIHEC is the primary committee responsible for QIHETP, the QIHETP Work Plan and QIHETP Evaluation. It reports to the CalOptima Health Board of Directors' Quality Assurance Committee (QAC). The QIHEC is comprised of the Chief Medical Officer (CMO), Deputy Chief Medical Officer (DCMO), CalOptima Health Chief Health Equity Officer (CHEO), CalOptima Health medical directors, CalOptima Health external physicians and community partners.

The committee is responsible for providing overall direction for continuous quality improvement processes, overseeing activities that are consistent with CalOptima Health's strategic goals and priorities, and monitoring compliance with regulatory and licensing requirements related to QIHE projects and activities. The committee provides critical feedback and guidance to the QI department on key initiatives. The QIHEC also reviews and approves all the key QIHE documents in a timely manner.

Committee chair: Quality Medical Director, a designee of the CMO

#### Voting Members:

The QIHEC consists of a minimum of four physicians or practitioners, with at least two practicing physicians or practitioners.

#### Meeting Dates:

The QIHEC meets at least eight times per calendar year.

#### Committee Changes in 2024:

- In January, Kaiser representative left the committee.
- In March, the medical director from Conifer joined as a committee member.

#### QIHEC charter updates were approved:

- Selected QIHEC members must meet specific membership requirements
- Changed list of CalOptima Health support from departments to staff titles
- Added that external participants must report changes in membership status (i.e. retired, leave place of work, quit) to the committee chair
- Added the following responsibilities:
  - Programs for QIHEC to approve, oversee and evaluate the Cultural and Linguistically Appropriate Service (CLAS) Program and the Population Health Management (PHM) Strategy
  - Review and evaluate the Medi-Cal and OneCare Pay for Value Programs
  - Added policy recommendations as a QIHEC responsibility

<ul style="list-style-type: none"> <li>○ Added that QIHEC annually reviews and assesses the compliance of the DEI training program</li> <li>○ Added a written summary of QIHEC activities, findings, recommendations and actions prepared after each meeting. <ul style="list-style-type: none"> <li>● Provide a quarterly written summary of the QIHEC activities publicly available on CalOptima Health's website</li> </ul> </li> </ul>	
<p>Committee Actions in 2024:</p> <ul style="list-style-type: none"> <li>● In February 2024, launched the PHM Committee to oversee PHM activities related to DHCS and NCQA. This committee includes executive representatives from across the agency as well as community leaders. A new PHMC committee was developed in 2024 to provide overall guidance to the implementation and oversight of the Population Health Management Strategy.</li> <li>● The QIHEC met monthly in 2024 to review and provide feedback on key clinical and other coordination of care initiatives, including member outreach, provider education and outreach, incentives, educational materials, and more</li> <li>● The committee reviewed and approved the 2024 QIHE Program Description, the 2024 QIHETP Work Plan, the 2023 QI Evaluation, the 2024 UM CM Program and the 2023 UM Evaluation. The QIHEC also reviewed and approved the PHM Strategy and the CLAS Program</li> <li>● The committee reviewed and approved the policies and procedures and made recommendations regarding policy decisions</li> <li>● The committee reviewed and provided feedback on key reports: Annual analysis of 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</li> <li>● The committee received quarterly reports from CPRC, PHMC, UMC, MEMx, GARS and WCM CAC. These reports were summarized and presented quarterly to the QAC</li> <li>● A new PHMC committee was developed in 2024 to provide overall guidance to the implementation and oversight of the Population Health Management Strategy.</li> </ul>	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>● Subcommittee workflow and processes are inconsistent and do not match that of the QIHEC</li> <li>● There are a lot of items to cover in one committee meeting and the committee would like more time to allow for discussion.</li> </ul>	<ul style="list-style-type: none"> <li>● Committees align their workflow and processes surrounding the following: how minutes are taken, when and how to move an item to consent, how to recruit and vet potential committee members, and how to send out documents/surveys for committee members to complete.</li> </ul>
<p>Conclusion:</p> <p>All committees were successful this year in monitoring the QIHETP and annual work plan. Quality activities in the work plan, analysis and findings were presented to committees at a quarterly cadence. Committees were able to successfully provide feedback and guidance while maintaining a clear focus on the goals.</p>	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>● Continue to hold committee meetings as scheduled in the calendar</li> <li>● Quality Improvement staff to collaborate with other committee chairs and administrative support staff to identify ways to align and streamline the committee process</li> </ul>	

### 3.2.1 Credentialing Peer Review Committee (CPRC)

Author: Laura Guest, RN, ANP, Manager	Department: Quality Improvement
Responsible Parties: Marsha Choo, Laura Guest and Rick Quinones	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No



<p>Work Plan Goal/Objective:</p> <ul style="list-style-type: none"> <li>Report committee activities, findings from data analysis and recommendations to QIHEC</li> </ul>	
<p>Goal Met:    <input checked="" type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Partial</p>	
<p>Work Plan Planned Activities:</p> <ul style="list-style-type: none"> <li>Review of Initial and Recredentialing applications approved and denied; Facility Site Review (FSR) (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions</li> <li>The committee meets at least eight times a year, maintains and approves minutes, and reports to the QIHEC quarterly</li> </ul>	
<p>Status:    <input type="checkbox"/> Completed    <input checked="" type="checkbox"/> Ongoing</p>	
<p>Committee Purpose and Background:</p> <p>Chairperson:</p> <p>Chief Medical Officer (CMO), Deputy Chief Medical Officer (DCMO) or physician designee, CalOptima Health.</p> <p>Voting Members:</p> <p>The CPRC consists of a minimum of five practitioners selected as a representation of practitioners from the CalOptima Health Community Network (CHCN) and the health networks. Committee members represent a range of practitioners and specialties from CalOptima Health's network. Members of the CPRC must be licensed practitioners, clinically practicing, credentialed and in good standing with CalOptima Health. CalOptima Health Medical Directors, which includes CalOptima Health's Behavioral Health Medical Director, are voting members.</p> <p>Meeting Frequency:</p> <p>The CPRC meets a minimum of six times per year. Ad hoc CPRC meetings may be scheduled as determined by the CPRC Chair.</p> <p>Goals:</p> <ul style="list-style-type: none"> <li>Maintain a peer review and credentialing program that aligns with regulatory (DHCS, DMHC, CMS) and accreditation (NCQA) standards</li> <li>Promote continuous improvement of the quality of health care provided by providers in CalOptima Health Direct/CHCN and its delegated health networks</li> <li>Conduct peer-level review and evaluation of provider performance and credentialing information against CalOptima Health requirements and appropriate clinical standards</li> <li>Investigate patient care outcomes that raise quality and safety concerns for corrective actions, as appropriate</li> </ul>	
<p>Committee Changes in 2024:</p> <ul style="list-style-type: none"> <li>At the February 22, 2024, meeting, it was announced that one community physician would no longer be a member of CPRC since he had retired from practice</li> <li>At the February 22, 2024, meeting, it was announced that one community OB/GYN physician will no longer be a member of CPRC since he had retired from practice</li> </ul>	
<p>Committee Actions in 2024</p>	
<p>Quarter 1:</p>	<p>The Committee met on January 25, 2024, January 29, 2024 (ad hoc), February 22, 2024, and March 28, 2024.</p> <p>Informed:</p> <ul style="list-style-type: none"> <li>The backlog of the timeliness of behavioral health credentialing applications. Temporary staff were hired to help remedy the backlog</li> <li>Fair Hearing status update for five physicians</li> <li>A university health system acquired four hospitals in Orange County</li> </ul>

	<ul style="list-style-type: none"> <li>• CalOptima Health is launching a cancer initiative of \$50M</li> <li>• The BH Medical Director joined the Council of Trustees for Mission Plasticos, a not-for-profit organization to improve lives through reconstructive surgery</li> <li>• CalOptima Health terminated its contract with a four-hospital group</li> <li>• CalOptima Health was engaged in an audit by DHCS</li> <li>• Fair Hearing status update for five physicians</li> </ul> <p>Approved:</p> <ul style="list-style-type: none"> <li>• Policy GG.1651: Corrective Action Plan for Practitioners and Organizational Providers</li> <li>• Policy GG.1659: System Controls of Provider Credentialing Information</li> <li>• A certified or psychologist licensed in another state for 180 days if they have applied for Medi-Cal enrollment</li> <li>• American Board of General Practice/American Academy of General Physicians</li> <li>• Practitioner Credentialing Clean List 12/11/2023, 12/15/2023, 12/21/2023, 12/29/2023, 01/18/2024, 01/31/2024, 02/15/2024, 02/29/2024</li> <li>• Practitioner Credentialing Closure List December 2023, January, February and March 2024</li> <li>• Minutes of December 14, 2023, January 25, 2024, January 29, 2024 and February 22, 2024</li> <li>• CPRC Committee Charter</li> </ul> <p>Analyzed:</p> <ul style="list-style-type: none"> <li>• Potential Quality Issue (PQI) quarterly update data and trend report, requesting detailed data on the subcategory of mismanaged care which was presented at the following meeting</li> <li>• Birth outcome data was reviewed since the committee had reviewed several PQIs with negative birth outcomes in recent months. It was found that CalOptima Health performed better than Orange County and California</li> </ul> <p>Recommendations:</p> <ul style="list-style-type: none"> <li>• Approval of the recredentialing of three practitioners with issues</li> <li>• Obtain additional details on the malpractice settlements for one practitioner who was approved at the next meeting</li> <li>• PQI leveling and actions on six PQI cases PQIs</li> <li>• One PQI was recommended for termination for cause; one PQI was recommended for termination for non-cause</li> </ul>
Quarter 2:	<p>The Committee met on April 25, 2024, May 23, 2024, and June 27, 2024</p> <p>Informed:</p> <ul style="list-style-type: none"> <li>• CalOptima Health's grant of \$15M to support late-stage cancer discovery</li> <li>• Fair Hearing status update for five physicians</li> <li>• Credentialing report</li> <li>• FSR, MRR, PARS reports</li> <li>• Incident and Critical Incident reports</li> <li>• PQI has transitioned to a new computer system called Jiva</li> <li>• Provider Preventable Conditions (PPCs)</li> <li>• The NCQA Accreditation Review Survey was completed, and CalOptima Health has been fully accredited for three years</li> <li>• Two primary care providers (PCPs) were identified for contract termination for failing to pass MRR audits for three consecutive years</li> </ul> <p>Approved:</p> <ul style="list-style-type: none"> <li>• Minutes of March 28, 2024, April 25, 2024, and May 23, 2024</li> </ul>

	<ul style="list-style-type: none"> <li>• Policy GG.1650: Credentialing and Recredentialing of Practitioners</li> <li>• Policy GG.1651: Assessment and Reassessment of Organizational Providers</li> <li>• Policy GG.1639: Post-Hospital Discharge Meds</li> <li>• Practitioner Credentialing Clean List 03/15/2024, 03/29/2024, 04/19/2024, 04/30/2024, 05/01/2024, 05/16/2024, 05/31/2024</li> <li>• Practitioner Closure List April, May and June 2024</li> </ul> <p>Recommendations:</p> <ul style="list-style-type: none"> <li>• PQI leveling and actions on 11 PQI cases</li> <li>• One provider PQI was recommended for a non-cause termination based on the PQI findings</li> <li>• One PQI was recommended for letter to the MBC (non-805 action)</li> <li>• Approval of the recredentialing of four practitioners with issues</li> </ul>
Quarter 3:	<p>The committee met on July 25, 2024, and September 26, 2024.</p> <p>Informed:</p> <ul style="list-style-type: none"> <li>• Going forward, all practitioners will be deidentified when presented to the committee</li> <li>• Fair Hearing status update for five physicians</li> <li>• PQI Statistics Q1 and Q2 2024</li> <li>• CalOptima Health is focusing on improving STAR ratings</li> <li>• CalOptima Health now has Street Medicine in Anaheim, which is the third city to participate in the program</li> </ul> <p>Approved:</p> <ul style="list-style-type: none"> <li>• Minutes of June 23, 2024 and July 25, 2024</li> <li>• Practitioner Credentialing Clean List 06/20/2024, 06/28/2024, 7/17/2024, 7/31/2024</li> <li>• Practitioner Closure Report June, July and August 2024</li> </ul> <p>Recommendations:</p> <ul style="list-style-type: none"> <li>• PQI leveling and actions on 10 PQI cases</li> <li>• One provider was recommended for a non-cause termination based on the PQI findings</li> <li>• Approval of the recredentialing of nine practitioners with issues; three practitioners were recommended for monthly monitoring, and one was recommended for monitoring of the grievances</li> <li>• Recognition of the physicians with a Canadian board certification</li> <li>• Practitioner Credentialing Clean List 06/20/2024, 06/28/2024, 7/17/2024, 7/31/2024</li> <li>• Practitioner Closure Report June, July and August 2024</li> <li>• Two of the physicians undergoing the Fair Hearing process were approved for probation with contingencies in lieu of termination</li> </ul>
Quarter 4:	<p>The committee met on October 24, 2024, November 21, 2024 and December 19, 2024</p> <p>Informed:</p> <ul style="list-style-type: none"> <li>• CalOptima Health is collaborating with the health networks to improve medication adherence, close gaps in care and encourage annual wellness visits.</li> <li>• PQI statistics presented in Q3 showed that most cases are categorized as a Medical Care issue. Further details of these cases were presented in Q4 with the explanation that this data is of closed cases, all of which were reviewed and leveled by a medical director.</li> <li>• Fair Hearing status update for five physicians.</li> </ul>

	<ul style="list-style-type: none"> <li>CalOptima Health implemented a Diversity, Equity and Inclusion (DEI) survey to staff and committee participants for the development of DEI resources and for the following purposes: <ul style="list-style-type: none"> <li>Identify needs that require support</li> <li>Explore opportunities for creating a stronger work environment that can enhance engagement and support within the workplace</li> <li>Celebrate and leverage our diverse backgrounds to foster a more inclusive and innovative workplace</li> </ul> </li> </ul> <p>Approved:</p> <ul style="list-style-type: none"> <li>Minutes of September 26, 2024 and October 24, 2024</li> <li>Practitioner Credentialing Clean List 09/30/2024 and 10/31/2024</li> <li>Practitioner Closure Report September and October</li> <li>CalOptima Health Policies: <ul style="list-style-type: none"> <li>GG.1604 Confidentiality of Credentialing Files</li> <li>GG.1607 Monitoring Adverse Actions</li> <li>GG.1633 Board Certification Requirements for Physicians</li> <li>GG.1651 Assessment and Re-Assessment of Organizational Providers</li> <li>GG.1657 State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting</li> <li>GG.1659 System Controls of Provider Credentialing Information</li> </ul> </li> </ul> <p>Analyzed: None</p> <p>Recommendations:</p> <ul style="list-style-type: none"> <li>PQI leveling and actions on three PQI cases.</li> <li>On-going Monitoring: One physician assistant and one OB/GYN will be monitored with no further action required.</li> <li>Approval of the recredentialing of four practitioners with issues</li> <li>FSR statistical report showed a marked increase in the number of corrective action plans (CAPs) and failed audits. The committee requested the total numbers and percentages be included in future presentations to better monitor this trend.</li> <li>The committee requested the details of critical incident events, not just the totals, in future presentations to better understand the issues arising for the long-term support services (LTSS) members.</li> </ul>
<p>Identified Barriers:</p> <ul style="list-style-type: none"> <li>The committee is challenged with finding another community OB/GYN physician to sit on the committee.</li> </ul>	<p>Identified Opportunities for Improvement:</p> <ul style="list-style-type: none"> <li>The committee identified the Canadian board as an acceptable board and is reviewing the boards of other countries to see if they may be accepted in the future.</li> <li>After receiving additional information, the committee was willing to allow physicians to be placed on probation rather than continue termination through the fair hearing process.</li> <li>Recruit an OB/GYN to sit on CPRC and/or consider paying for clinical expertise in that specialty.</li> </ul>
<p>Conclusion:</p> <p>The committee was successful in conducting peer review in 2024. The committee participants remained engaged and active.</p>	
<p>Activities/Interventions to continue/add next year:</p> <ul style="list-style-type: none"> <li>Maintain a peer review and credentialing program that aligns with regulatory (DHCS, DMHC, CMS) and accreditation (NCQA) standards.</li> </ul>	

- Promote continuous improvement of the quality of health care provided by providers in CalOptima Health Direct/CHCN and its delegated health networks.
- Conduct peer-level review and evaluation of provider performance and credential information against CalOptima Health requirements and appropriate clinical standards.
- Investigate patient care outcomes that raise quality and safety concerns for corrective actions, as appropriate.

### 3.2.2 Grievance and Appeals Resolution Services (GARS) Committee

Business Owner: Heather Sedillo	Department: GARS
Support Staff: Amanda Acosta, Ismael Bustamante, Jamar Phillips	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective:	
<ul style="list-style-type: none"> <li>• Report committee activities, findings from data analysis and recommendations to QIHEC</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities:	
<ul style="list-style-type: none"> <li>• The GARS Committee reviews the grievances, appeals and resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. Trends and results are presented to the committee on a quarterly basis.</li> <li>• The committee meets at least quarterly, maintains and approves minutes, and reports to the QIHEC quarterly.</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Committee Purpose and Background:	
The GARS Committee serves to protect the rights of our members, to promote the provision of quality health care services and to ensure that the policies of CalOptima Health are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring.	
Roles and Responsibilities:	
The GARS committee reviews GARS performance and any trends and provides recommendations and/or addresses each as needed.	
Meetings: The committee meets quarterly. In 2024, the committee met on the following dates: May 14, August 14 and November 13. Q4 committee scheduled for February 11, 2025.	
Committee Changes in 2024	
<ul style="list-style-type: none"> <li>• Added the following member: GARS Intake Manager</li> </ul>	
Committee Actions in 2024	
Quarter 1:	<ul style="list-style-type: none"> <li>• Recommend a discussion with Utilization Management (UM) and Regulatory Affairs and Compliance (RAC) departments related to the issue of OneCare members receiving Medi-Cal denials for "wrap benefit" services.</li> <li>• Identified a trend of increased applied behavioral analysis (ABA) appeals, root cause was denials issued for incomplete medical records. Provider training has been scheduled.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Identified an increase in expedited discharge appeals/grievances — Met with Case Management (CM) and UM in April – Transition of care contacts at all health networks was shared with GARS</li> <li>• Informed BH providers of the appeals process and what to include in their authorization requests during a BH provider training completed in May 2024.</li> </ul>

Quarter 3:	<ul style="list-style-type: none"> <li>Recommended and conducted a meeting with University of California, Irvine (UCI) related to appointment availability and referral delays.</li> <li>Analyzed transportation grievance trends and continued with the transportation workgroup.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Meeting schedule for February 11, 2025.</li> </ul>
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>New GARS system implementation in Q1 of 2024</li> </ul>	<ul style="list-style-type: none"> <li>GARS worked closely with Zeomega and Information Technology Systems (ITS) department to map the system and create reports that better align with the department's needs for tracking and trending and committee reporting.</li> </ul>
<p>Conclusion: Overall, the committee was successful and has contributed to the implementation of process improvements which resulted in more positive outcomes for our members and providers. The committee also provides a forum for open dialogue and recommendations to be discussed between multiple departments involved in the Appeals and Grievances process.</p>	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>The committee will meet at a minimum quarterly, maintain and approve minutes and report to the QIHEC quarterly.</li> </ul>	

<b>3.2.3 Member Experience (MEMx) Committee</b>	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Helen Syn/Carol Matthews	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Report committee activities, findings from data analysis and recommendations to QIHEC	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <ul style="list-style-type: none"> <li>The MEMx Subcommittee reviews the annual results of CalOptima Health's CAHPS or member experience surveys, monitors the provider network, including access and availability (CHCN and the health networks), reviews customer service metrics, and evaluates complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.</li> <li>The committee meets at least quarterly, maintains and approves minutes, and reports to the QIHEC.</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Committee Purpose and Background:</p> <p>The purpose of MEMx is to improve the member experience and drive initiatives to achieve member experience goals established by the corporate strategic plan or quality improvement work plan. The subcommittee also ensures members have access to quality health care services for all product lines and programs. The committee is comprised of a variety of business units that impact member experience.</p> <p>Committee Changes in 2024:</p> <ul style="list-style-type: none"> <li>Changed title from Chair to Co-Chair. The committee is co-chaired by the Executive Director, Operations and the Executive Director, Quality Improvement.</li> <li>Removed the following members: <ul style="list-style-type: none"> <li>Chief Medical Officer</li> <li>Executive Director, Clinical Operations</li> </ul> </li> </ul>	

- Executive Director, Behavioral Health
- Executive Director, Quality and Population Health Management
- Director, Program Implementation
- Added the following members:
  - Director, Contracting
  - Senior Director, Case Management
  - Director, Medicare Programs
  - Director, Operations Management
  - Director, Stars and Quality Initiatives
- Titles changed for the following members:
  - Director, Population Health Management to Director, Equity and Community Health

Meetings: The committee meets quarterly in the first month of the quarter. In 2024 the committee met on the following dates: March 24, May 22, July 16, October 9 (an ad hoc meeting) and October 15.

#### MEMx Roles and Responsibilities

The co-chair or designee is responsible for leading the MEMx committee in reviewing information, making recommendations and presenting MEMx at the QIHEC meetings.

The MEMx committee's responsibilities are to:

- Measure and improve the member experience to achieve organizational goals.
- Facilitate member engagement to enhance the overall experience resulting in better health outcomes.
- Review and analyze data tied to member experience and engagement and identify opportunities for improvement including, but not limited to: Access and Availability, CAHPS, Grievance and Appeals, Authorizations and Referrals, Provider Action for Non-Clinical Issues, and Potential Quality Issues (PQIs) related to member experience.
- Identify opportunities for improvement utilizing member experience and access data to enhance member experience and access to quality care.
- Review, assess and recommend industry best practices for Provider performance, member experience and access.
- Identify workgroup leads and oversee the implementation of improvement initiatives to achieve desired performance results.
- Monitor network adequacy and appointment availability standards compliant with regulatory and accrediting agency standards including but not limited to NCQA, DHCS, DMHC and CMS.
- Monitor health equity and disparities as it relates to member experience and access to care.

#### Committee Actions in 2024

Quarter 1:	<ul style="list-style-type: none"> <li>• Recommended to monitor tertiary level of care physicians in the CalOptima Health directory and remove them if not readily available.</li> <li>• Updated and streamlined the corrective action process for timely access.</li> <li>• Recommended communication to behavioral health providers about the TRI-rates and Proposition 56 so they understand the changes and understand the pay scale</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Recommended adding the Behavioral Health Integration (BHI) Department to quarterly key performance indicators (KPI) updates.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• Recommended to educate PCPs about collaboration codes with PCP and Behavioral Health visits.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• Recommended formation of a workgroup to improve member CAHPS scores.</li> <li>• Recommended improving ease of access to home blood pressure monitors by members.</li> </ul>

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Ensuring a timely quorum.</li> </ul>	<ul style="list-style-type: none"> <li>Ensuring all areas have reporting backup when they are unable to attend committee meetings.</li> </ul>
<p>Conclusion: The MEMx committee was successfully restructured in 2024, resulting in a committee structure that reports on member experience activities, provides a mechanism for multi-disciplinary engagement and collaboration, and recommends initiatives that will improve the overall member experience.</p>	
Activities/interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>The committee will meet at a minimum quarterly, maintain and approve minutes and report to the QIHEC quarterly.</li> </ul>	

<b>3.2.4 Population Health Management Committee (PHMC)</b>	
Business Owner: Katie Balderas	Department: Equity and Community Health
Support Staff: Barbara Kidder Garcia /Janette Valladolid	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Work Plan Goal/Objective:	
<ul style="list-style-type: none"> <li>Report committee activities, findings from data analysis and recommendations to QIHEC.</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities:	
<ul style="list-style-type: none"> <li>Review, assess and approve the Population Needs Assessment (PNA), PHM strategy activities and PHM Workplan progress and outcomes.</li> <li>The committee meets at least quarterly, maintains and approves minutes, and reports to the QIHEC quarterly.</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Committee Purpose and Background:</p> <p>Background: The PHMC was created to ensure that all PHM initiatives meet the needs of CalOptima Health members across the continuum of care.</p> <p>Purpose: To provide overall direction for continuous process improvement and oversight of the PHM program, ensure PHM activities are consistent with CalOptima Health's strategic goals and priorities and monitor compliance with regulatory requirements.</p> <p>Chair: Medical Director, Population Health and Equity</p> <p>Committee Members: Committee members include internal stakeholders from CalOptima Health and external partners with relevant expertise and experience. The voting members consist of the following individuals or their designee:</p> <ul style="list-style-type: none"> <li>Medical Director, Population Health and Equity</li> <li>Chief Health Equity Officer</li> <li>Executive Director of Behavioral Health</li> <li>Executive Director of Clinical Operations</li> <li>Executive Director of Equity and Community Health</li> <li>Executive Director of Medi-Cal CalAIM</li> <li>Executive Director of Network Management</li> <li>Executive Director of Operations Management</li> <li>Director of Operational Management</li> </ul>	



- Executive Director of Quality
- Executive Director of Strategic Development

External partners that represent:

- Community-based organizations that serve CalOptima Health members – Health Equity for African American’s League (HEAAL) Executive Director
- Health network medical directors contracted to serve CalOptima Health members (CHOC Health Alliance –Senior Medical Director)
- Orange County Health Care Agency (HCA) – Assistant Deputy Director, Quality Management Services (QMS) and Behavioral Health Services (BHS)

Supported by:

- Program Manager, Sr., Equity and Community Health
- Program Manager, Equity and Community Health
- Program Coordinator, Equity and Community Health

PHMC Roles and Responsibilities:

- The chair or designee is responsible for leading the PHMC in reviewing information, making recommendations and representing the PHMC at the QIHEC meetings.
- Voting members of the PHMC are responsible for adhering to the priorities of our federal and state regulators and following the standards outlined by the NCQA, including:
  - Review, contribute to and approve the PNA annually.
  - Review, contribute to and approve the PHM Strategy annually.
  - Review, contribute to and approve the PHM Workplan annually.
  - Perform an annual evaluation of the effectiveness of the PHM Strategy, including a barrier analysis and goals.
  - The PHMC will ensure PHM Strategy and Workplan activities will:
    - Keep all members healthy by focusing on wellness and prevention services
    - Identify and manage members with high and rising risk
    - Identify and address members’ health-related social needs
    - Implement separate strategies focused on members less than 21 years of age
    - Ensure effective transition planning across delivery systems or settings
    - Identify and mitigate member access, experience, and clinical outcome disparities by race, ethnicity and language to advance health equity
  - Facilitate ongoing process improvement that incorporates member feedback and the needs of the population.
  - Ensure multidisciplinary oversight of PHM initiatives to achieve desired performance results.
  - Measure and improve upon PHM initiatives to achieve PHM Strategy goals.
  - Review and evaluate PHM activities and key utilization performance indicators.
  - Review, analyze and react to results of reports for PHM initiatives including (but not limited to):
    - DHCS PHM Key Performance Indicators
    - CalOptima Health’s internal member data reports
    - Various Orange County data reports
  - Institute actions to address performance deficiencies and ensure appropriate follow-up of identified performance deficiencies.

Meeting Dates: The PHMC meets quarterly, at least three times per calendar year. In 2024, the PHMC met virtually on February 29, 2024, May 16, 2024, August 15, 2024, and November 21, 2024.

Committee Changes in 2024: HCA Director of Population Health and Equity resigned in August 2024, and HCA Assistant Deputy Director, QMS and BHS accepted an invitation to join PHMC in October 2024.	
Committee Actions in 2024	
Quarter 1:	<ul style="list-style-type: none"> <li>The PHMC launched in February 2024.</li> <li>PHMC members reviewed and approved the 2024 PHM Strategy and Workplan at Q4 PHMC meeting in February 2024.</li> <li>Per the recommendation of the PHMC, Health Equity for African American Leagues (HEAAL) Collective and Shape Your Life (SYL) Program leadership met in March 2024 following a SYL presentation at the PHMC to discuss future collaboration efforts to expand CalOptima Health's nutrition and weight management services to Second Baptist Church.</li> <li>Provided PHMC update for QIHEC in March 2024.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>PHMC met in May 2024, which included both internal CalOptima Health updates on PHMC programs/initiatives and Community Spotlight presentation on Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) facilitated by OC HCA.</li> <li>PHMC reviewed and approved Q1 Meeting Minutes, 2024 Charter, Annual Reporting Calendar and Policy GG. 1667 (CalAIM PHM Program).</li> <li>At the request of CHOC Health Alliance (PHMC Voting Member), Equity and Community Health reviewed and revised the Maternal Health and Blood Lead Screening Local Health Jurisdiction (LHJ) Collaborative goals and objectives to include pediatricians as a focus population.</li> <li>Provided PHMC update for QIHEC in June 2024.</li> <li>Developed and published PHMC SharePoint site to house committee materials.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>PHMC met in August 2024, which included both internal CalOptima Health updates on PHM programs/initiatives and Community Spotlight presentation on the 2023 OC Black and African American's Health Equity Survey Report facilitated by HEAAL Collective.</li> <li>PHMC reviewed and approved Q2 Meeting Minutes.</li> <li>Per the recommendation of the PHMC, HEAAL Collective and CalOptima Health's Chronic Conditions program leadership met in August 2024 to initiate a partnership to develop educational materials to meet the nutritional needs of members, explore interventions for congestive heart failure and increase blood pressure monitoring utilization among CalOptima Health members.</li> <li>Provided PHMC update for QIHEC in July 2024.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>PHMC met in November 2024, which included both internal CalOptima Health updates on PHM programs/initiatives and Community Spotlight presentation on the Equity in OC Initiative: Improving Organizational Health Literacy facilitated by the Institutes for Healthcare Advancement.</li> <li>PHMC reviewed and approved Q3 Meeting Minutes and 2024 Population Needs Assessment at Q4 PHMC meeting in November 2024.</li> <li>HEAAL Collective and CalOptima Health's Behavioral Health Integration leadership met in October 2024 to explore opportunities to collaborate in future community events (e.g., Black Health Summit, OC Black History Parade and Unity Festival, Mental Health Benefits Webinar for Black CalOptima Health Members).</li> <li>Provided PHMC update for QIHEC in December 2024.</li> </ul>
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Ensuring timely quorum</li> </ul>	<ul style="list-style-type: none"> <li>Sharing meeting dates in advance</li> </ul>

Conclusion: Overall, the PHMC has proven to be a successful addition to CalOptima Health's committee structure by ensuring oversight on PHMC activities and creating space for a more engaged dialogue and input from committee members.
Activities/Interventions to continue/add next year:
<ul style="list-style-type: none"> <li>• PHMC plans to review, assess, and approve the 2025 PNA, PHM Strategy activities, and PHM Workplan progress and outcomes.</li> <li>• The committee plans to meet at least quarterly, maintain and approve minutes, and report to the QIHEC quarterly.</li> </ul>

3.2.5 Utilization Management Committee (UMC)	
Business Owner: Stacie Oakley	Department: Utilization Management
Support Staff: Lorena Moore	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective:	
<ul style="list-style-type: none"> <li>• Report committee activities, findings from data analysis and recommendations to QIHEC.</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities:	
<ul style="list-style-type: none"> <li>• UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. The committee meets at least quarterly, maintains and approves minutes, and reports to the QIHEC quarterly.</li> <li>• P&amp;T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Committee Purpose and Background: CalOptima Health's UMC was first established in 2002. The committee is led by a CalOptima Health Medical Director and meets quarterly. The UMC reports to the QIHEC and QAC before reporting to the Board of Directors.</p> <p>Purpose: The purpose of the UMC is to promote optimum utilization of health care services and provide comprehensive support to the UM Program while maximizing the effectiveness of the care and services provided to the members.</p> <p>Roles and Responsibilities:</p> <ul style="list-style-type: none"> <li>• Provides oversight and direction for the continuous improvement of the UM program, consistent with CalOptima Health's strategic goals and priorities. This includes an oversight of UM functions and activities performed by both CalOptima Health and the delegated health networks.</li> <li>• Oversees UM activities and compliance with federal and state regulations, as well as contractual and NCQA requirements.</li> <li>• Reviews and approves UM Program Description, medical necessity criteria, UMC Charter, UM policies and the UM Program Evaluation on an annual basis.</li> <li>• Reviews and analyzes UM operational and outcome data, reviews trends and/or utilization patterns, and makes recommendations for further action.</li> <li>• Reviews and approves annual UM metric targets and goals and reviews progress toward these goals</li> <li>• Promotes a high level of satisfaction with the UM program.</li> <li>• Reviews, assesses and recommends utilization management best practices used for selected diagnoses or disease classes.</li> <li>• Reviews under/over utilization monitoring and makes recommendations for improving performance on identified over/under utilization.</li> </ul>	

- Reviews and provides recommendations for improvement, as needed, to reports submitted by BMSC and P&T.
- Reports to the QIHEC on a quarterly basis.
- Reports to the Board of Directors routinely through QAC.

Chair: Medical Director Medical Management

Meeting Frequency: The committee meets quarterly

- Jan. 25, 2024 – This was an ad hoc meeting
- Feb. 22, 2024
- May 23, 2024
- Nov. 21, 2024

#### Committee Changes in 2024:

In 2024 a Medical Director of Health Network oversight was added to the UMC. The following updates were made to the UMC charter in 2024:

- Defined the area medical directors oversee in addition to their specialty.
- Indicated the line of business the UMC supports.
- Indicated the subcommittees that report to the UMC.
- Indicated the departments that report relevant information to the UMC.
- Added a conflict-of-interest language in addition to the attestation.
- Indicated mandatory external practitioners' attendance.
- Removed that the UMC revises and updates CalOptima Health's referral intelligence rules.

#### Committee Actions in 2024

Quarter 1:	<ul style="list-style-type: none"> <li>• Ad hoc meeting was held on January 25, 2024, and the regular Quarter I 2024 meeting was held on February 22, 2024</li> <li>• Review and approval of the 2023 UM Program Evaluation</li> <li>• Review and approval of the 2024 UM/CM Integrated Program Description</li> <li>• Review and approval of the 2024 UM criteria and hierarchy for clinical decision-making</li> <li>• Review and approval of the 2024 UM Policies and Procedures</li> <li>• Review and approval of the UMC charter</li> <li>• Approval of November 16, 2023 and the January 25, 2024, meeting minutes</li> <li>• Review of the 2024 IRR results</li> <li>• Review of ABA best practices</li> <li>• Review of Quarter 4 2023 UM over/under utilization and metrics to include but not limited to, acute inpatient, prior authorization, emergency department (ED), Whole Child Model (WMC), pharmacy, behavioral health and Long-Term Services &amp; Support (LTSS)</li> <li>• Review of CalOptima Health membership</li> <li>• Review of CPT code changes approved by BMSC on October 25, 2023</li> <li>• Launched clinical sub-workgroups that report programmatic and utilization enhancements and outcomes to UMC.</li> <li>• Review of UM strategic plan improvements</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• The Quarter II 2024 meeting was held on May 23, 2024</li> <li>• Review of available board-certified consultants available for UM clinical decision-making of complex cases</li> <li>• Review and approval of the 2024 UMC Charter</li> </ul>

	<ul style="list-style-type: none"><li>• Presentation by CalOptima Health ITS department resolution to Jiva fax receipt acknowledgment issues</li><li>• Review and approval of UM goals</li><li>• Review of Quarter 1 2024 UM over/under utilization and metrics to include but not limited to, acute inpatient, prior authorization, ED, WMC, pharmacy, behavioral health and LTSS</li><li>• Review of CalOptima Health membership</li><li>• Review of CPT code changes approved by BMSC on February 28, 2024</li><li>• Review of UM strategic plan improvements</li><li>• Presentation regarding the transition to Modivcare for non-emergency medical transportation (NEMT)/non-medical transportation (NMT)</li><li>• Review and approval of UM policies and procedures</li><li>• Presentation of adverse childhood experiences (ACEs) by the Medical Director of Behavioral Health</li><li>• Updates from the clinical sub workgroups</li></ul>		
Quarter 3:	<ul style="list-style-type: none"><li>• The Quarter III 2024 meeting was held on August 22, 2024</li><li>• Approval of May 23, 2024, meeting minutes</li><li>• UM compliance update presentation</li><li>• Review of Quarter II 2024 UM over/under utilization and metrics to include but not limited to, acute inpatient, prior authorization, ED, WMC, pharmacy, behavioral health, LTSS and NEMT/NMT services</li><li>• Review of CalOptima Health membership</li><li>• Review of CPT code changes approved by BMSC on June 19, 2024</li><li>• Review of UM strategic plan improvements</li><li>• Review and approval of UM policies and procedures</li><li>• Presentation of ACEs survey effort by the Medical Director of Behavioral Health</li><li>• Review of the February 15, 2024, P&amp;T Committee Minutes</li><li>• Updates from the clinical sub workgroups</li></ul>		
Quarter 4:	<ul style="list-style-type: none"><li>• The Quarter IV 2024 meeting was held on November 21, 2024</li><li>• Approval of the August 22, 2024, meeting minutes</li><li>• UM compliance update presentation</li><li>• Review of Quarter III 2024 UM over/under utilization and metrics to include but not limited to, acute inpatient, hospital facility, prior authorization, ED, WMC, pharmacy, behavioral health, LTSS and NEMT/NMT services</li><li>• Review of CalOptima Health membership</li><li>• Review of CPT code changes approved by BMSC on July 31, 2024</li><li>• Review of UM strategic plan improvements</li><li>• Diversity, Equity and Inclusion (DEI) Survey presentation by the Medical Director, Quality</li><li>• 2024 Inter-Rater Reliability assessment results review</li><li>• Operational performance updates of the following sub-work groups, High-Risk Management, Over/Under Utilization, Gender Affirming Care, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT)</li><li>• Review and approval of UM policies and procedures</li><li>• Enhanced Care Management (ECM) update presentation by the Director CalAIM Operations</li></ul>		
Identified Barriers:		Identified Opportunities for Improvement:	
<ul style="list-style-type: none"><li>• Jiva reporting</li></ul>		<ul style="list-style-type: none"><li>• Enhanced reporting</li></ul>	

<ul style="list-style-type: none"> <li>• WCM reporting not aligned with DHCS specifications</li> <li>• Outgoing provider fax notification issues</li> <li>• ED utilization and readmission rate due to complex psychosocial challenges</li> </ul>	<ul style="list-style-type: none"> <li>• Refinement of UM goals</li> <li>• Refinement of staffing metrics and productivity standards</li> <li>• Enhanced prior authorization workflows</li> <li>• Enhanced referral intelligence rules</li> <li>• Enhanced provider portal capabilities</li> <li>• UM participation in the Stars Workgroup</li> <li>• Established an Over/Underutilization Workgroup and the EPSDT Workgroup</li> </ul>
Conclusion: The UM program continues to refine programs and oversight to address member needs and clinical outcomes.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>• Continue to monitor over/underutilization patterns</li> <li>• Integration of case management and UM interventions to promote transitional care services.</li> <li>• Clinical operations IT configuration leader identified and expected to start Q1 2025</li> <li>• Interdisciplinary bi-weekly reporting consortium to address ongoing reporting needs</li> </ul>	

3.2.5.1 Benefit Management Subcommittee (BMSC) Committee	
Business Owner: Stacie Oakley	Department: Utilization Management
Support Staff: Lorena Moore	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Goal/Objective: <ul style="list-style-type: none"> <li>• Ensure new benefits are implemented in accordance with regulatory requirements, ensure new and existing codes comply with regulatory requirements, and report changes, additions or modifications to benefits to the UMC.</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Planned Activities: <ul style="list-style-type: none"> <li>• Review new and revised CPT/HCPC codes to determine if prior authorization is required and recommend prior authorization requirements for new and existing benefits.</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Committee Purpose and Background: <p>Background: BMSC is a subcommittee of the UMC and was established to create clinical oversight and governance of prior authorization codes.</p> <p>Chair: Medical Director Medical Management</p> <p>Purpose: The BMSC is charged by the UMC with providing prior authorization to new codes, ongoing review of existing codes and governance of the enterprise prior authorization list. The BMSC reports to UMC.</p> <p>Roles and Responsibilities:</p> <ul style="list-style-type: none"> <li>• Review of new and revised codes to determine prior authorization requirements</li> <li>• Communication of changes to the UMC</li> <li>• Oversight of enterprise prior authorization list</li> <li>• Oversight of approval intelligence rules</li> </ul>	

Frequency: The BMSC meets monthly.	
Committee Changes in 2024	
<ul style="list-style-type: none"> <li>In 2024, a Medical Director of Health Network oversight was added to the BMSC.</li> <li>The following updates were made to the UMC charter in 2024: Removed maintenance of the benefit set.</li> </ul>	
Committee Actions in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>Meetings were held on February 28, 2024, March 13, 2024, and March 27, 2024.</li> <li>Recommended a formal process for medical director review of codes.</li> <li>Review of 84 codes determined to require prior authorization.</li> <li>Review of 62 codes determined not to require prior authorization</li> <li>Review of 19 codes approved for removal from the prior authorization list.</li> <li>Review and approval of the 2024 Charter</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>One meeting was held on June 19, 2024.</li> <li>Review of 13 codes determined to require prior authorization.</li> <li>Review of 2 codes determined not to require prior authorization.</li> <li>Review of four codes approved for removal from the prior authorization list.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Meetings were held on July 31, 2024, and August 28, 2024.</li> <li>Review of 41 codes determined to require prior authorization.</li> <li>Review of three codes determined not to require prior authorization.</li> <li>Review of three codes approved for removal from the prior authorization list.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Meetings were held on October 30, 2024, and an ad-hoc discussion took place on November 14, 2024.</li> <li>Review of 17 codes determined to require prior authorization.</li> <li>Review of 23 codes determined not to require prior authorization</li> <li>Review of specialty mental health codes. Two codes approved for removal from the prior authorization list.</li> <li>Review of four mental health services electroconvulsive therapy (ECT) determined to require prior authorization.</li> </ul>
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Frequency and volume of code review.</li> </ul>	<ul style="list-style-type: none"> <li>Include a consultant physician from a delegated health network.</li> </ul>
Conclusion: The BMSC continues to refine prior authorization requirements and oversight.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>Continue to review new codes for prior authorization recommendation.</li> <li>Add a consultant physician from a delegated health network.</li> </ul>	

3.2.5.2 Pharmacy and Therapeutics (P&T) Committee	
Business Owner: Kris Gericke, Pharm.D.	Department: Pharmacy Management
Support Staff: Julie Dulaney	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare Remove	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Goal/Objective:	
<ul style="list-style-type: none"> <li>Report committee activities, findings from data analysis and recommendations to QIHEC.</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	

<b>Planned Activities:</b> <ul style="list-style-type: none"> <li>Review applicable policies, medications and medication classes for formulary evaluation. Reviewed DUR projects and over/underutilization.</li> </ul>	
<b>Status:</b> <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<b>Committee Purpose and Background:</b> The P&T Committee is responsible for the development of the drug formularies, which are based on sound clinical evidence and 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 committee chairperson is a CalOptima Health Medical Director.	
<b>P&amp;T Committee Goals:</b> <ul style="list-style-type: none"> <li>Promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima Health members.</li> <li>Meet CMS formulary regulatory requirements.</li> <li>Provide overall direction for the continuous improvement process and oversee that activities are consistent with CalOptima Health's strategic goals and priorities.</li> <li>Promote an interdisciplinary approach to driving continuous improvement in pharmacy utilization.</li> <li>Support compliance with regulatory and licensing requirements and accreditation standards related to pharmacy-related initiatives.</li> <li>Monitor, evaluate and act on pharmacy-related care and services provided to promote quality of care outcomes to members.</li> </ul>	
<b>P&amp;T Committee Responsibilities:</b> <ul style="list-style-type: none"> <li>Review new medications and prior authorization criteria as outlined in CalOptima Health policy GG.1409: Physician Administered Drug Prior Authorization Required List Development and Management and policy MA.6103: Pharmacy and Therapeutics Committee.</li> <li>Review individual requests for changes to the formularies from practitioners in the community.</li> <li>Review and update the OneCare formulary and Medi-Cal prior authorization list on an ongoing basis to ensure access to quality pharmaceutical care that is consistent with the program's scope of benefits.</li> <li>Review anticipated and actual utilization trends overall as well as for specific drug classes.</li> <li>Review and evaluate pharmacy-related issues related to the delivery of health care to CalOptima Health members.</li> <li>Assess outcomes of pharmacy-related Healthcare Effectiveness Data and Information Set (HEDIS) and Medicare Star measures to drive improvements.</li> <li>Review and evaluate patterns of pharmaceutical care and key utilization performance indicators.</li> <li>Evaluate and make recommendations on pharmacy issues that pertain to CalOptima Health-wide initiatives, such as treatment guidelines, disease management programs, QI studies, etc.</li> <li>Review and make recommendations on selected pharmaceutical provider educational activities.</li> <li>Recommend pharmacy-related policy decisions.</li> </ul>	
The P&T Committee meets a minimum of four times per year and reports to the UM Committee.	
<b>Committee Changes in 2024</b> <ul style="list-style-type: none"> <li>None</li> </ul>	
<b>Committee Actions in 2024</b>	
<b>Quarter 1:</b>	<ul style="list-style-type: none"> <li>Reviewed medications and medication classes for formulary evaluation. Reviewed DUR projects and over/underutilization.</li> </ul>



Quarter 2:	<ul style="list-style-type: none"> <li>Reviewed medications and medication classes for formulary evaluation. Reviewed DUR projects and over/underutilization.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Reviewed medications and medication classes for formulary evaluation. Reviewed DUR projects and over/underutilization.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Reviewed medications and medication classes for formulary evaluation. Reviewed DUR projects and over/underutilization.</li> </ul>
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Physicians are resistant to following requirements for Star and HEDIS measures.</li> </ul>	<ul style="list-style-type: none"> <li>Mechanism to refer physicians for poor performance in Star and HEDIS measures.</li> </ul>
<p>Conclusion: Continue quarterly meetings and reporting.</p>	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>Continue all current P&amp;T Committee activities.</li> </ul>	

3.2.6 Whole Child Model Clinical Advisory Committee (WCM CAC)	
Business Owner: Dr. Thanh-Tam Nguyen	Department: Medical Management
Support Staff: Hannah Kim/Gloria Garcia	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective:	
<ul style="list-style-type: none"> <li>Report committee activities, findings from data analysis, and recommendations to QIHEC.</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities:	
<ul style="list-style-type: none"> <li>WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations.</li> <li>The committee meets at least quarterly, maintains and approves minutes, and reports to the QIHEC quarterly.</li> <li>Pediatric Risk Stratification Process (PRSP) monitoring</li> </ul>	
Status: <input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing	
Committee Purpose and Background	
<ul style="list-style-type: none"> <li>WCM CAC was formed in 2018 to advise on clinical issues relating to California Children's Services (CCS) conditions, including treatment authorization guidelines and serving as clinical advisers on other clinical issues relating to CCS conditions.</li> <li>CalOptima Health Chief Medical Officer or Medical Director designee chairs the WCM CAC.</li> <li>Committee participants include CCS-paneled physicians or practitioners, county CCS Medical Director, state agency Medical Director and nonprofit organization contracted by the State of California.</li> <li>WCM CAC meets at least four times per calendar year and reports to QIHEC quarterly</li> <li>Signed and dated minutes are kept for each meeting, and copies are provided to QIHEC.</li> <li>Quality Improvement staff collects annual Conflict of Interest and Confidentiality forms from all WCM CAC meeting attendees.</li> </ul>	
Committee Changes in 2024	
<p>WCM CAC charter was updated in May 2024.</p> <ul style="list-style-type: none"> <li>Updated the purpose following All Plan Letter (APL) 23-034 to include advice on clinical issues relating to CCS conditions.</li> <li>The state agency medical director and nonprofit organization contracted by the State of California were added as voting members.</li> </ul>	

Committee Actions in 2024:	
<ul style="list-style-type: none"> <li>• Approved WCM CAC charter updates.</li> <li>• The committee unanimously voted to keep meeting virtually.</li> <li>• Monitored Pediatric Risk Stratification Process (PRSP).</li> <li>• Provided clinical expert advice related to the access and care of the WCM population.</li> </ul>	
Quarter 1:	<ul style="list-style-type: none"> <li>• Reviewed the report and evaluation of WCM data</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Reviewed the report and evaluation of WCM data</li> <li>• Regional Center Orange County and Orange County Social Service Agency representatives joined the Committee.</li> <li>• CHOC CCS representative resigned from serving on WCM CAC.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• Reviewed the report and evaluation of WCM data</li> <li>• A replacement was found to represent CHOC</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• Reviewed criteria and rate for 30-day readmission.</li> <li>• New request for seven-day readmission.</li> </ul>
Identified Barriers:	
Identified Opportunities for Improvement:	
<ul style="list-style-type: none"> <li>• Low immunization rate.</li> </ul>	<ul style="list-style-type: none"> <li>• Enhanced collaboration with external stakeholders.</li> <li>• Improve immunization rate</li> </ul>
Conclusion:	
<ul style="list-style-type: none"> <li>• Continue meeting quarterly and review WCM data.</li> <li>• Continue collaborating with CCS stakeholders.</li> </ul>	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>• Continue all current WCM CAC activities.</li> </ul>	

### 3.3 Assessment of QI Staff and Resources

Author: Marsha Choo

Department: Quality Improvement

CalOptima Health continues to dedicate significant resources and staffing to meet the needs of the QIHETP. At the beginning of 2024, there were many vacant positions supporting quality and the QIHEC. However, throughout the year, CalOptima Health's Human Resources department worked with the business areas to fill needed positions to support the QIHETP.

In 2024, the following areas were impacted by workforce changes:

- Data Analytics Team in Quality Analytics – Data Analytics transitioned to the Enterprise Analytics team.
- Credentialing Team in Quality Improvement – Conducting provider verifications transitioned to a NCQA-certified Credentialing Verification Organization (CVO)

In 2024, CalOptima Health added the following:

- NCQA team (a manager and two program managers)
- Director of Customer Service
- Senior Director of Equity and Community Health

In 2024, CalOptima Health filled the following vacant positions:

- Chief Information Officer to support technology
- Director or Delegation Oversight
- Director of Health Network Relations

The QI Program also received support from the following key departments within the organization, including but not limited to the following:

- Quality Improvement
- Quality Analytics
- Equity and Community Health
- Behavioral Health Integration
- Case Management
- Customer Service (including outreach and engagement)
- Provider Relations and Contracting

In addition, positions were added to the quality organizational charts as they have been identified as supporting the QIHETP.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>• There are a lot of quality performance measures to monitor</li> <li>• Improvement in outcomes may require additional resources.</li> </ul>	<ul style="list-style-type: none"> <li>• Add additional resources to support the Credentialing team with managing the inboxes, intake and expedited in-house credentialing.</li> </ul>
<p>Conclusion: CalOptima Health has leveraged vendors and technology to support the QIHETP.</p>	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>• Continue to fill any vacant positions</li> </ul>	

### 3.4 Review of System Resources

Business Owner: Marsha Choo	Department: Quality Improvement
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#### Background:

CalOptima Health dedicated significant resources to ensuring there are adequate systems in place to monitor and evaluate performance of QIHETP on an ongoing basis. CalOptima Health utilizes three enterprise data systems for utilization and care management (Jiva), claims payment (Facets) and credentialing data management (Cactus by Symplr). Data from these systems are stored in a data warehouse and integrated through data workflows to identify improvement opportunities. Business and IT resources are allocated to create robust tools utilizing Tableau to analyze and generate quality reports, gaps in care reports and other relevant reports to support the QIHETP.

In 2024, CalOptima Health transitioned to a new care management platform, Jiva Healthcare Enterprise Platform. Jiva represents a comprehensive set of AI-power solutions that integrate data, apply advanced analytics, automate workflows, and optimize team efficiency and effectiveness with clinical content-driven care pathways. Jiva also developed a module to support potential quality issues (PQIs)

CalOptima Health contracted with an NCQA-certified credential vendor organization (CVO) in August 2024 to conduct credentialing for our providers. The implementation process took three months and the CVO credentialing provider files in Q4 2024.

CalOptima Health transitioned to a new HEDIS software engine, CitiusTech, to optimize HEDIS data processing. With this technology, CalOptima Health can conduct quality reporting, such as running monthly prospective rates, to share with providers.

CalOptima Health also contracted with Decision Point Analytics to run predictive analytics of our CAHPS data to predict patient experiences as measured by CAHPS, allowing CalOptima Health to identify individuals most likely to provide negative feedback and proactively address potential issues to improve overall patient satisfaction scores.

In addition, CalOptima Health also contracted with a single integrated provider lifecycle management (PLM) system for credentialing, contracting and provider data management in 2024. This system aims to integrate the process and data for the identified business units as part of the provider lifecycle management. CalOptima Health conducted implementation for most of 2024, and the platform is planned to launch in May 2025.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>• Jiva reports still needed to be developed after go-live to meet regulatory reporting requirements</li> <li>• CVO does not use email to send out applications</li> <li>• A lot of workarounds needed to be developed with the CVO for the team to credential and approve files. Working with the CVO still requires a lot of administrative and manual work</li> <li>• Current credentialing system is outdated as CalOptima Health has not upgraded to the web-based system</li> <li>• Staff has been dedicating a lot of time to attend meetings to support these systems</li> </ul>	<ul style="list-style-type: none"> <li>• Collaborate with ITS to identify solutions around automation</li> <li>• Adding additional resources to support the credentialing area</li> <li>• Utilize vendors to conduct data analytical support.</li> </ul>
<p>Conclusion: The transition and implementation of newly contracted vendors was successful in 2024. With ITS support, all go-live dates were met and staff have been able to successfully access vendor services.</p>	
<p>Activities/Interventions to continue/add next year:</p> <ul style="list-style-type: none"> <li>• Continue to work with vendors and ITS to improve the current process.</li> <li>• Continue to support PLM launch in May 2025</li> </ul>	

### 3.5 Overall Review of QIHETP

Business Owner: Marsha Choo

Support Staff: Gloria Garcia

#### Assessment:

CalOptima Health had adequate staffing and resources required to meet the needs of the QIHETP requirements. CalOptima Health will continue to evaluate the needs of the program on a quarterly basis through the Work Plan, and add staffing and resources, as needed, to supplement the departments supporting the QI Program.

The organization receives adequate feedback from its community practitioners about the development and implementation of the QIHE initiatives and programs. Currently, there are 11 physicians participating at the QIHEC, representing the Orange County Social Service Agency, HCA, our delegated health networks and community-based organizations. In addition, there are network providers also participating in the subcommittees that report to the QIHEC.

Staff present QIHETP activities to the Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC). CalOptima Health engages members through the MAC to seek input, advice and guidance related to QIHETP goals. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs, needs assessment, member survey results, access to health care, and preventive services to ensure that the QIHETP meets the needs of the population. The PAC provides advice and recommendations to the Board on CalOptima Health programs and services as a liaison on items of interest to the provider community. The PAC meets with the MAC on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC/PAC meetings are open to the public.

CalOptima Health continues to have significant participation from the medical directors in the development and implementation of clinical initiatives and programs throughout the year. CalOptima Health's Quality Medical Director chairs the QIHEC, along with the Chief Health Equity Officer. There are 13 medical directors supporting QIHETP, and they actively participate in the review and analysis of quality performance measures and the development of quality initiatives. All medical directors are invited to attend and participate in QIHEC meetings. Four of the six subcommittees are also chaired by a CalOptima Health medical director.

Currently, QIHETP activities are reported quarterly to either the QIHEC or the subcommittee. All the subcommittees report committee findings, actions and recommendations to the QIHEC to ensure that the QIHEC has oversight of the entire QIHETP and work plan. At this time, there is no need to make any changes or restructure the program.

### 3.6 Cultural and Linguistic Appropriate Services Program

Business Owner: Albert Cardenas

Support Staff: Carlos Soto

Executive summary:

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, medical history and health education, CalOptima Health developed a Cultural and Linguistically Appropriate Services (CLAS) Program, a part of the QIHETP that integrates culturally and linguistically appropriate services at all levels of the operation. Objectives for 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.

The following are the 2024 goals of the QIHEC/CLAS Program:

Goal 1: Implement a process to collect, store and retrieve member Race Ethnicity, Language (REL) and Sexual Orientation Gender Identity (SOGI) data.

- Developed a survey to collect data from members
- Added new fields in CalOptima Health's core system to store SOGI data
- Enhanced the core system to capture race/ethnicity in accordance with the Office of Management and Budget (OMB) standards
- Surveys were launched in September 2024
- Created a new Policy and Procedure to support the collection and storage of member data.

This goal was met and will continue to be an area of focus for 2025.

Goal 2: Evaluate language services experience from members and staff.

- Developed member and staff surveys to collect feedback on interpreter and translation services experience.
- Target implementation is Q1 2025

This goal was not met and will be carried over to the 2025 QIHEC/CLAS work plan.

Goal 3: Implement a process to collect, store and retrieve practitioner race/ethnicity/languages.

- Developed a provider satisfaction survey and launched it in September 2024.
- Store provider responses in CalOptima Health core eligibility system

This goal was met and will continue to be an area of focus for 2025.

Goal 4: Improve practitioner support in providing language services.

- Members' language preference is available in CalOptima Health's provider portal.
- Inform providers of member's language preference during customer service interactions.
- Evaluated CalOptima Health's contracted health networks' cultural and linguistics process to ensure members' language needs are being met.

This goal was met and will continue to be an area of focus for 2025.

Overall, the CLAS Program met the needs of our diverse member population, and CalOptima Health continuously monitored the progress of the CLAS goals. On a quarterly basis dedicated staff from Cultural and Linguistic (C&L) department, in collaboration with multidisciplinary work teams throughout the agency, collect and track indicators and activities specific to CLAS goals, outcomes and outputs. C&L staff prepared quarterly findings and identified potential risks to share with CalOptima Health leadership at QIHEC meetings. The CLAS goals updates were shared with CalOptima Health's MAC and PAC.

### 3.7 Delegation Oversight (DO)

Business Owner: Stacy Baker/ Zulema Gomez/John Robertson	Department: Delegation Oversight
Support Staff:	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Implement annual oversight and performance monitoring for delegated activities.	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: <ul style="list-style-type: none"><li>• Report on the implementation of annual delegation oversight activities and monitor delegates for regulatory and accreditation standard compliance that, at minimum, includes comprehensive annual audits.</li></ul>	
Status: <input checked="" type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	

**Background:**

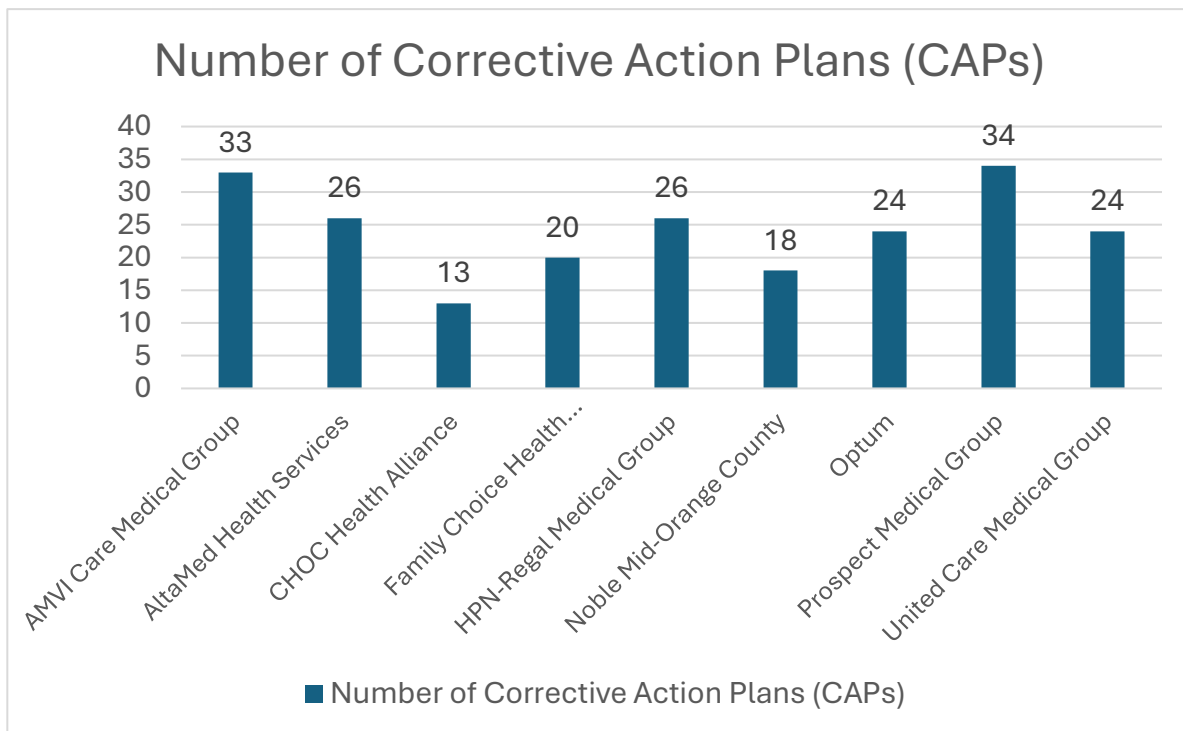
CalOptima Health contracts with health care providers who are delegated to perform certain administrative services and functions as part of their agreements with CalOptima Health. CalOptima Health performs regular oversight of the delegate's performance to ensure adherence to regulatory, contractual and operational requirements. Each year, on a regular and periodic basis, CalOptima Health requires delegates to submit reports to substantiate its performance for each administrative service and function delegated. Oversight activities include but are not limited to, annual audits of the delegate, ad hoc focused audits, and review of monthly and quarterly reports submitted by the delegate. The oversight is intended to assess the delegate's performance against benchmarks and thresholds and validate regulatory and contractual compliance.

**Methodology:**

An audit tool and audit preparation guide were developed for 2024, and staff utilized the tool to conduct audits for each health network in 2024.

**Actions/Interventions Implemented in 2024:**

Quarter 1:	• Number of Health Network (HN) Audits Completed: 1
Quarter 2:	• Number of HN Audits Completed: 1
Quarter 3:	• Number of HN Audits Completed: 4
Quarter 4:	• Number of HN Audits Completed: 3

**Program Results:****Chart A****Quantitative Analysis:**

- CalOptima Health conducted an annual audit of all nine HN delegates in 2024, where one delegate was audited in Q1 2024, one was audited in Q2 2024, four were audited in Q3 2024 and three were audited in Q4 2024.
- All delegates were issued CAPs in 2024, with CHA receiving the least number of CAPs at 13 and AMVI Care Medical Group receiving the greatest number at 33 CAPs.

In 2024, a total of 218 CAPs were issued to the nine HN delegates to ensure that they are meeting their contractual obligations.	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Director of Delegation Oversight position was vacant.</li> <li>HNs were dissatisfied with certain aspects of the oversight process.</li> </ul>	<ul style="list-style-type: none"> <li>In 2024, the executive team reconfigured the DO Department reporting hierarchy</li> <li>Delegation oversight audit tools were reconfigured</li> </ul>
Conclusion: Annual audits were conducted for each contracted delegate, and CAPs were issued to health networks when findings were identified.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>Continue to remain collaborative and transparent with the delegates. Avoid transactional communication but instead develop partnerships to provide our CalOptima Health members with the best member experience and quality work.</li> </ul>	

3.8 Health Equity	
Business Owner: Katie Balderas	Department: Equity and Community Health
Support Staff: Barbara Kidder/Tristynne Tran	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: <ul style="list-style-type: none"> <li>Identify health disparities</li> <li>Increase member screening and access to resources that support SDOHs</li> <li>Report on quality improvement efforts to reduce disparities</li> </ul>	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
Work Plan Planned Activities: <ul style="list-style-type: none"> <li>Increase members screened for social needs (ongoing)</li> <li>Implement a closed-loop referral system with resources to meet members' social needs. (ongoing)</li> <li>Implement an organizational health literacy (HL4E) project (completed)</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: The CalOptima Health Board of Directors approved the 2022–2025 Strategic Plan, which elevated overcoming health disparities as a key strategic priority. This priority continues to guide the development and implementation of strategic initiatives aimed at the prevention and reduction of health disparities to improve member health outcomes and eliminate care barriers.  The Health Equity intervention within the Equity and Community Health department is designed to ensure that members are assessed for SDOHs, are connected to resources needed, and have access to high-quality and equitable care. Ongoing efforts include significant investments in technology that enhance both member and provider experiences as well as collaboration with stakeholders to improve health literacy as a pathway to health equity.	
Methodology: The work plan activities are geared toward the implementation of systems and processes to support the program goals. Therefore, data was gathered in the form of progress towards implementation of the different interventions. Where available data was collected on interventions and reported as part of different strategic initiatives, we included it in this evaluation.	
Actions/Interventions Implemented in 2024:	



Quarter 1:	<ul style="list-style-type: none"> <li>• SDOH assessment was tested for integration with the member portal. SDOH assessment will be built into Jiva as part of the closed-loop referral integration.</li> <li>• The closed-loop referral vendor was selected, and the contracting process began</li> <li>• Among 164 staff who signed up for the HL4E training program, 59 (35%) completed the program and received their certificate.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• SDOH member assessment went live in the member portal, and the team continued to build out the assessment for integration into Jiva.</li> <li>• Fully executed contract was completed with FindHelp as the selected closed-loop referral vendor, and working with Jiva for integration was initiated.</li> <li>• HL4E certificate program continued through the end of the year to allow staff to complete their certifications. As of Q2, 73 out of 164 (45%) staff completed their certification program, and four CalOptima Health staff participated in a teach-back method of Train the Trainer training.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• The SDOH member assessment was updated with additional questions, and integration into Jiva continued.</li> <li>• Integration meetings with FindHelp and Jiva were kicked off, and a training space for staff was developed.</li> <li>• HL4E certificate program continued through the end of the year to allow staff to complete their certifications. Currently, 74 out of 164 staff have completed their certification program.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• The SDOH assessment was updated, and work was done to align the assessment in the member portal, Jiva and FindHelp.</li> <li>• The integration with FindHelp and Jiva began, and a dedicated training space for staff was developed. The integration was anticipated to be completed by January 2025, after which the focus would shift to staff training and tracking outcomes.</li> <li>• HL4E certificate program was completed December 2024, with 75 out of 164 (46%) staff having completed their certification. Any staff in the process of completing their certificate would be able to do so independently through 2025.</li> </ul>

#### Program Results:

##### Quantitative Analysis:

##### A. SDOH Screening

##### 1. Member Portal

- a. Successfully developed and integrated an SDOH assessment within the member portal to enhance the documentation of SDOH needs. Through these assessments, members are connected to community resources and support services.

##### 2. SDOH Screening Question for AWV

##### a. Provider Incentive

- i. This initiative was successfully implemented through the Medi-Cal Annual Wellness Visit (AWV) program focused on members 45 years or older, which introduced an incentive for qualified providers starting April 1, 2023. This incentive encourages providers to conduct comprehensive AWVs, report confirmed diagnoses, capture SDOH factors and document them appropriately in medical records. Incentives were issued based on completed services and compliant documentation, with payments made on a rolling basis. As of year-to-date, 30,846 Medi-Cal members have completed their AWVs, 15,351 of which were screened for SDOHs.

##### b. Provider Education

- i. At the provider level, the intervention encourages the use of SDOH Z-codes to better capture and document SDOHs. To assist providers, a comprehensive SDOH ICD-10-

CM coding and reporting reference guide has been developed to ensure the accurate documentation of priority SDOH data. The tool is in the process of being reviewed and approved for broader dissemination amongst providers.

3. Jiva Integration

- a. The SDOH assessment was also incorporated into Jiva to facilitate the annual assessment of members, refer them to non-medical resources and services, and collect data to inform targeted interventions.
- b. Currently, as part of a closed-loop referral integration into Jiva, we are enhancing the SDOH assessment with additional questions.

B. Closed-Loop Referral

1. The goal of the Closed-Loop Referral initiative is to be able to support members by facilitating navigation, provider referrals, and coordination of health services across health care delivery systems and community-based organizations. Efforts to achieve these goals are progressing well.
2. Released RFP and formalized a contractual agreement with FindHelp to implement a closed-loop referral solution.
3. Collaborating with FindHelp to integrate the closed-loop referral solution into Jiva, with implementation targeted for January 2025.
4. A training schedule has been established to train super-users, with completion planned before the go-live date at the end of December 2024.
5. CalOptima Health is on track to meet the regulatory requirement for implementation by January 2025.

C. HL4E Program

1. The program aimed to enhance organizational health literacy across various systems in Orange County through collaborative efforts. CalOptima Health partnered with the Institute for Healthcare Advancement (IHA), Social Services Agency, HCA, St. Jude Health Center and community residents as part of HCA's Equity in OC Initiative. These partners worked to improve health literacy within organizations across the county. The following activities are included:
  - a. Health Literacy (HL) 101: Two educational videos were developed to introduce organizational health literacy (OHL). A total of 418 CalOptima Health staff completed the video training.
  - b. Health Literacy Specialist Certificate. This is a rigorous program that provides deep learning for enrollees on health literacy principles. It is composed of seven "micro-credentials:" Organizational Systems and Policies, Communications, Education, Public Health, Ethics and Language Culture and Diversity. The program was estimated to take 55–80 hours to complete, including exams. A total of 152 CalOptima Health staff enrolled in the certificate program. The program is targeted to be completed in December 2024, with 75 out of 164 staff completing their certification program. Any staff currently in the process of completing their certificate may do so independently through 2025.
  - c. CalOptima Health participated in a comprehensive OHL assessment conducted by IHA. This assessment is part of a comprehensive review of CalOptima Health's organizational health literacy, conducted by IHA's Chief Policy and Research Officer, Marian Ryan, Ph.D. The aim of the assessment was to identify and prioritize improvement projects to increase OHL. The assessment includes a scan of CalOptima Health's external communications for members, including:
    - i. Employee Surveys: The employee survey achieved a strong response rate, with 430 completed surveys representing 24 departments and units. This survey provides valuable insights that will guide future initiatives to enhance workforce development, quality and communication.

- ii. Facility “walkthroughs:” The facility walkthrough revealed that the facility has clear signage at the main entrance, but parking directions and visitor spaces are not easily visible. The CalOptima Health building is fully accessible for individuals with disabilities. Reception staff are welcoming, use plain language and assist visitors effectively. Signage is clear and multilingual (English, Spanish, Vietnamese) in the reception area. The overall experience was positive.
- iii. Phone calls to CalOptima Health's main number: Four phone calls were made (two in English, two in Spanish) with response times ranging from five to 11 minutes. Staff were generally friendly, clear and patient. Two calls provided CalOptima Health information, while two others explained they couldn't assist due to the caller not being a CalOptima Health member. “Teach-back” was not used to confirm understanding.
- iv. Website reviews: The website received a high score for organization (4.9), with clear navigation and well-structured content. However, it received a lower score for content (3.0) due to the lack of essential information above the fold, especially on mobile, and the absence of tailored content. CalOptima Health meets 82% of accessibility recommendations.
- v. Teach-Back Method Workshop: IHA facilitated a four-hour workshop for staff enrolled in the HL Specialist Certification Program to learn and practice the teach-back method. A total of 20 staff from different business units were trained, and five staff participated in a train-the-trainer course to build expertise within the organization.

Identified Barriers:

Identified Opportunities for Improvement:

<p>A. SDOH Screening</p> <ul style="list-style-type: none"> <li>Foster collaboration between different departments to develop and implement a uniform set of SDOH questions to be used across all platforms, providers and departments to ensure consistency and comparability of data.</li> </ul> <p>B. Closed-Loop Referral</p> <ul style="list-style-type: none"> <li>Identifying a compatible vendor with the capability to integrate into our current health management system.</li> <li>Extensive contracting process given the magnitude of the project.</li> <li>Aggressive implementation timelines with dependencies on vendors setting up training space for super-user training completion.</li> <li>Integration of Community Partners into FindHelp is still pending.</li> </ul> <p>C. HL4E Program</p> <ul style="list-style-type: none"> <li>The certificate program is a rigorous program that requires time and dedication which makes it difficult for staff to balance with their regular workload and other competing priorities.</li> </ul>	<p>A. SDOH Screening</p> <ul style="list-style-type: none"> <li>Establish continuous collaboration between the Case Management, Equity and Community Health and Quality Improvement departments to ensure alignment on regulatory requirements, SDOH questions and assessment tools.</li> </ul> <p>B. Closed-Loop Referral</p> <ul style="list-style-type: none"> <li>Provide cross-training for member-facing staff to ensure consistency in how SDOH assessments are conducted.</li> <li>Train staff and community partners on referral workflows.</li> <li>Continue to work with FindHelp for integration and onboarding of trusted community partners</li> </ul> <p>C. HL4E Program</p> <ul style="list-style-type: none"> <li>Integrate the teach-back method into training and member interactions to ensure understanding and retention of key information. This method is useful in training super-users and ensuring that members fully understand the information being communicated.</li> <li>Ensure essential information is displayed above the fold on both desktop and mobile versions of the website for easier accessibility and to enhance user experience.</li> </ul>
<p>Conclusion:</p> <p>The Health Equity initiatives and interventions outlined in the work plan are progressing well toward their goals of reducing health disparities and improving member health outcomes through enhanced screening, closed-loop referrals and health literacy. We've made incredible strides over the past year, such as the integration of SDOH assessments into the member portal and Jiva, the selection and contract with FindHelp for closed-loop referrals, and the health literacy certification program. While some challenges were encountered, they are being addressed through targeted improvements and cross-departmental collaboration. The program is on track to meet its goals, with efforts to streamline processes, enhance member support and foster community partnerships. Future activities will focus on completing staff training, refining screening tools and launching the closed-loop referral platform for seamless member navigation and support.</p>	
<p>Activities/Interventions to continue/add next year:</p> <ul style="list-style-type: none"> <li>Continue to monitor improvement for SDOH Z-codes utilization</li> <li>Continue to monitor SDOH assessments</li> <li>Staff training on streamlined screening questions and assessments will be conducted</li> <li>Launch the closed-loop referral platform as integrated into Jiva</li> </ul>	

### 3.9 Long-Term Services and Supports

Business Owner: Scott Robinson

Department: Long Term Care Supports:

Support Staff: Cathy Osborn	
Work Plan Element: Long-Term Support Services (LTSS)	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: 95% compliance with TAT	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
Work Plan Planned Activities:	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>Medi-Cal Managed Long Term Services and Supports (MLTSS) includes two categories with three programs. The purpose of LTSS is to prevent or delay member institutionalization by providing support to CalOptima Health members who require consistent and ongoing caregiving assistance through the coordination of three primary programs:</p> <ul style="list-style-type: none"> <li>• Home and Community Based Services (HCBS)</li> <li>• Community Adult Based Services (CBAS)</li> <li>• Multipurpose Seniors Services Program (MSSP)</li> <li>• Institutional/ Nursing Facility</li> <li>• Long Term Care (includes, Sub-Acute care, Hospice and ICF/DD Homes)</li> </ul> <p>Program Goals:</p> <ul style="list-style-type: none"> <li>• Increase access to HCBS</li> <li>• Safely decrease LTC nursing facility utilization while supporting our members to remain living in the community.</li> <li>• Improve clinical and quality of living outcomes.</li> <li>• Build on member choice.</li> </ul>	
<p>Methodology:</p> <p>Utilized the Jiva UM TAT detail report.</p>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>• Met TAT goals of 95%</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Met TAT goals of 95%</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• Met TAT goals of 95%</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• LTC/CBAS met TAT goals of 95%. CalAIM did not meet the goal. Additional staff have been hired to address the authorization backlog, and daily monitoring is performed. Evaluating process improvement opportunities.</li> </ul>
Program Results:	
<p>Quantitative Analysis:</p> <p>LTSS met goals for the first three quarters of the year. However, for Q4, LTC/CBAS met TAT goals of 95%, but CalAIM measures did not meet the 95% TAT goal.</p> <p>November TAT =91.12%, December TAT = 56.87% (60% below goal) 1,681 authorizations out of compliance.</p>	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>• Authorization backlog</li> <li>• Short staffing due to terminations and leave of absences</li> <li>• Increase in authorization volume due to changes in the referral process, the eligibility criteria, and the authorization process for several community supports.</li> </ul>	<ul style="list-style-type: none"> <li>• Monitor daily</li> <li>• Crosstrain staff</li> <li>• Obtain staff support from other clinical areas such as UM/CM</li> <li>• Employ temporary nursing staff and medical authorization assistants</li> <li>• Recruit nurses and medical authorization assistants</li> </ul>

<ul style="list-style-type: none"> <li>General increase volume of CalAIM referrals and requests for authorizations.</li> </ul>	<ul style="list-style-type: none"> <li>Implement mandatory overtime</li> </ul>
<p>Conclusion: Program met TAT goals. CalAIM TAT goals were not met in Q4 2024. Staff will evaluate the process and identify opportunities for improvement.</p>	
<p>Activities/Interventions to continue/add next year:</p>	
<ul style="list-style-type: none"> <li>Additional staff have been hired to address the authorization backlog, and daily monitoring is performed.</li> <li>Evaluating process improvement opportunities.</li> </ul>	

### 3.10 National Committee for Quality Assurance (NCQA) Accreditation

3.10.1 Health Plan Accreditation	
Business Owner: Marsha Choo	Department: Quality Improvement
Support Staff: Veronica Gomez	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: <ul style="list-style-type: none"> <li>Implement activities for NCQA standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024.</li> </ul>	
Status: <input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing	
Background: CalOptima Health has been accredited by NCQA for its Medicaid line of business since 2012. In July 2024, CalOptima Health completed its fourth renewal for NCQA Health Plan Accreditation for the Medicaid-HMO product line, successfully securing accredited status through July 10, 2027. Our accreditation scores are based on annual HEDIS and CAHPS results, with the survey conducted every three years.  The next submission date for CalOptima Health is scheduled for April 6, 2027, covering a look-back period from April 6, 2025, to April 6, 2027. Additionally, CalOptima Health will be required to complete a virtual file audit on May 24–25, 2027.	
Methodology: CalOptima Health undergoes re-accreditation every three years. NCQA has a look-back period of two years.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>CalOptima Health submitted a delegation worksheet, agenda for virtual file review and PHM Worksheet that list programs that involve with Interactive Contract</li> <li>NCQA program manager provided status updates to stakeholders on the status of open items and areas of risk</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>NCQA renewal submission was on April 30, 2024. Document submission included more than 400 documents and file review universes.</li> <li>CalOptima Health had a virtual file review audit with NCQA surveyors on June 17–18, 2024. UM appeals (CHCN), UM medical denials (BH, Pharmacy) for both CHCN and delegate files, credentialing/recredentialing (CHCN and delegate), complex case management (CHCN and delegates)</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Received final report and decision results letter from NCQA on August 6, 2024.</li> </ul>

	<ul style="list-style-type: none"> <li>• Quality Improvement (QI) developed a remediation plan for elements/factors missed.</li> <li>• NCQA released the 2025 Health Plan (HP) Standards, which were shared with internal stakeholders in September 2024.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• NCQA consultants developed an HP work plan to monitor and track all of the deliverables needed.</li> <li>• Consultants performed standards training October–November 2024 (Quality Improvement, network management, member experience, UM, credentialing and recredentialing, PHM).</li> <li>• Consultants performed file review audits in November 2024 on UM appeals (CHCN), UM medical denials (BH, Pharmacy) for both CHCN and delegate files, credentialing/recredentialing (CHCN and delegate), complex case management (CHCN and delegates).</li> <li>• Consultants performed analytical reports training in December 2024.</li> </ul>
<p style="text-align: center;">Program Results:</p> <ul style="list-style-type: none"> <li>• CalOptima Health was once again awarded accredited status for the fifth time in July 2024. Our NCQA Health Plan accreditation will be valid through July 10, 2027.</li> <li>• CalOptima Health achieved a score of 135.50 out of a possible 140 points.</li> <li>• Our NCQA Health Plan Rating was updated on September 15, 2024, and achieved a rating of 3.5 Stars.</li> </ul>	
<p>Quantitative Analysis:</p> <p>Document submission included more than 400 documents along with file review universes. CalOptima Health lost points in the NET and ME domains but still met the 80% threshold required to meet accreditation.</p> <p>Point Loss Areas</p> <ul style="list-style-type: none"> <li>• Network Management: Three issues were identified <ul style="list-style-type: none"> <li>○ NET3A-C: Annual reports did not reflect out-of-network utilization data for non-behavioral and BH services.</li> </ul> </li> <li>• Member Experience: Three issues were identified <ul style="list-style-type: none"> <li>○ ME2B: Member newsletters did not include a link or direction to specific information on the website to access subscriber information.</li> <li>○ ME7C: Annual assessment reports of nonbehavioral complaints and appeals missing out-of-network utilization.</li> <li>○ ME8C: Review of semiannual reports missing.</li> </ul> </li> </ul>	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>• Conflicting feedback between consultants when assessing reports.</li> <li>• Report writing seems to be challenging for some business owners.</li> <li>• File review continues to have some challenges for some delegates and internal staff.</li> </ul>	<ul style="list-style-type: none"> <li>• (QI) Update Policy GA.8060: Recruitment, Selection, and Hiring.</li> <li>• (PHM) Update policy GG.1211: Health Appraisals and Self-Management Tools.</li> <li>• (NET) sample size and response rates must be in all reports. Annual reports will need to include missing out-of-network data identified during the survey, and the CalOptima Health website needs to be updated to include hospital accreditation status.</li> <li>• (CR) Update Policy GG.1659: System Controls of Provider Credentialing Information. The Annual CR Audit report will need to be clearer to avoid confusion identified during submission.</li> </ul>

	<ul style="list-style-type: none"> <li>• (ME) Annual reports will need to include missing out-of-network data identified during the survey. Member newsletter minor edits needed to add missing factors.</li> <li>• Hire additional staff to oversee NCQA accreditation.</li> <li>• Train delegates on universe submission</li> <li>• Delegates need training on how to prepare files for NCQA audits.</li> <li>• Report writing training</li> </ul>
Conclusion: Overall, the NCQA HP renewal was successful. NCQA stakeholders will work on the areas where points were lost to ensure full compliance in upcoming reports. We anticipate a successful renewal in April 2027.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>• Begin HPA document review</li> <li>• Begin development of HPA gap assessment</li> <li>• Kick-off meeting to begin document review and collection for the new document review look-back period (April 6, 2025–April 6, 2027)</li> <li>• Continue to manage the NCQA project and assist business areas in meeting all deliverables needed.</li> <li>• Submit NCQA HP renewal application.</li> <li>• Train two new program managers who will oversee NCQA Health Plan and Health Equity Accreditation submission.</li> </ul>	

3.10.2 Health Equity Accreditation	
Business Owner: Marsha Choo	Department: Quality Improvement
Support Staff: Veronica Gomez	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Work Plan Goal/Objective:	
<ul style="list-style-type: none"> <li>• CalOptima Health must have full Health Equity Accreditation by January 1, 2026.</li> </ul>	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
Work Plan Planned Activities:	
<ul style="list-style-type: none"> <li>• Develop strategy and work plan for Health Equity Accreditation with 50% document collection for submission.</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: DHCS requires all health plans to obtain Health Equity Accreditation by January 1, 2026. We have a submission date of October 7, 2024. To meet this requirement, CalOptima Health has established a Health Equity Committee, which includes five workgroups. The Health Equity Committee receives regular status updates, while the workgroups convene frequently to share progress reports. Our look-back period is the six-month span from April 7, 2025, to October 7, 2025.	
To earn accreditation, CalOptima Health must meet at least 80% of applicable points.	
Methodology: To help organizations identify disparities, address social risk factors, and work toward dismantling the systemic and structural barriers that generate bias or discrimination in health care, CalOptima Health will be pursuing an initial Health Equity Accreditation which will have a six-month look-back period.	



<p>Health Equity standards evaluate organizations on:</p> <ul style="list-style-type: none"> <li>• HE1: Organization Readiness</li> <li>• HE2: Race/Ethnicity, Language, Gender Identity and Sexual Orientation Data</li> <li>• HE3: Access and Availability of Language Services</li> <li>• HE4: Practitioner Network Cultural Responsiveness</li> <li>• HE5: Cultural and Linguistically Appropriate Service Programs</li> <li>• HE6: Reducing Health Care Disparities</li> <li>• HE7: Delegation of Health Equity Activities</li> </ul>	
<p>Actions/Interventions Implemented in 2024:</p>	
<p>Quarter 1:</p>	<ul style="list-style-type: none"> <li>• Purchased current 2024 Health Equity Standards</li> <li>• CalOptima Health engaged our NCQA consultant to conduct a readiness assessment and gap analysis.</li> <li>• NCQA consultants provided recommendations and developed a work plan.</li> <li>• CalOptima Health developed a Health Equity Steering Committee and five work groups for implementation. A project manager was assigned to each of the workgroups.</li> <li>• Reviewed 2024 HE Standards (HE1)</li> <li>• Work started on the member survey to collect data from members (HE2)</li> <li>• Evaluated existing documentation and reports provided by the previous consultant and identified the next steps (HE3)</li> <li>• Developed a high-level project plan</li> </ul>
<p>Quarter 2:</p>	<ul style="list-style-type: none"> <li>• Health Equity Accreditation project kickoff meeting on May 21, 2024</li> <li>• Health Equity Guidelines and Elements Training on June 11, 2024</li> <li>• Built systems and processes for the domains HE1–HE6 May 1, 2024–December 1, 2024</li> <li>• CalOptima Health is engaged with NCQA consultants to conduct a readiness assessment and perform a gap analysis which was shared with executive leadership and stakeholders</li> <li>• Consultants provided recommendations and developed a work plan.</li> <li>• Identified key documents for review and/or creation (HE1)</li> <li>• New fields were added to the core system to collect and store all the data elements required. (Added: Sexual orientation, gender identity: was already collecting race, ethnicity and language [HE2])</li> <li>• Developed the survey to collect data from members (HE2)</li> <li>• Revised Notice of Privacy Practice (NPP) to meet the standards (HE2)</li> <li>• Collect current contract amendments related to translation vendors (HE3)</li> <li>• Reviewed current desktop procedures (HE3)</li> <li>• Screenshots related to practitioner training, copies of training (HE3)</li> <li>• Identified team members that play a key role in meeting the elements and factors (HE4)</li> <li>• Identified the documents (desktop procedures, policies, and forms) that would need to be updated. (HE4)</li> <li>• Conducted HE5/6 discovery. (HE5/6)</li> <li>• Developed HE5/6 work plan and timelines. (HE5/6)</li> <li>• Vetted subject matter experts to participate in workstream. (HE5/6)</li> <li>• NCQA-HE5 Workstream launched on May 21, 2024. Developed 2024 CLAS Program, SMART goals and work plan. (HE5/6)</li> <li>• Implemented Health Disparity Remediation Well-Child Call Campaign for Black/African American members. (HE5/6)</li> </ul>

Quarter 3:	<ul style="list-style-type: none"> <li>• Health Management Associates (HMA) was retained by CalOptima Health to provide guidance and assistance in achieving both Health Plan (HPA) and Health Equity Accreditation (HEA)</li> <li>• Consultants completed kick-off meetings with CalOptima Health and HMA teams</li> <li>• The CalOptima Health team began uploading documents for review and has continued to share documents with the HMA team as they become available</li> <li>• Confirmed definitions for staff/leadership, committees and governing bodies. (HE1)</li> <li>• Analyzed results from Great Places to Work Survey from April 2024. (HE1)</li> <li>• Surveys were mailed out to members (new members over 18 years) (HE2)</li> <li>• Umbrella policy was drafted to document CalOptima Health's process to collect and store member data (HE2)</li> <li>• Worked with Communications to ensure updated tag lines were included in the annual newsletter for non-discrimination notices (HE3)</li> <li>• Confirmed how provider race/ethnicity, language fluency and practice languages will be collected (HE4)</li> <li>• Developed process on how data will be housed in Facets (HE4)</li> <li>• CalOptima Health Board of Directors approved 2024 CLAS Program and Workplan. (HE5/6)</li> <li>• Implemented 2024 CLAS Program and Workplan monitoring. (HE5/6)</li> <li>• Met with Inland Empire Health Plan to explore best practices to survey member experience on language services (HE6)</li> <li>• Established monthly monitoring reports for language service utilizations (HE6)</li> <li>• Stratified and analyzed CBP, HBD, PPC and WVC HEDIS measures by race and ethnicity (HE6)</li> <li>• Stratified and analyzed HBD HEDIS measures by language and gender (HE6)</li> <li>• Stratified and analyzed CAHPS measures by language and race/ethnicity (HE6)</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• CalOptima Health is engaged with NCQA consultants to conduct a readiness assessment and perform a gap analysis</li> <li>• Consultants have been providing recommendations and have developed a work plan.</li> <li>• Submitted NCQA HE application and given a survey date of October 7, 2025</li> <li>• Legal, Chief Health Equity Officer and Chief Human Resources Officer review of surveys and informational text (HE1)</li> <li>• Chief Human Resources Officer announcement during November All-Staff CalTeams Meeting (HE1)</li> <li>• Submitted documents to Communications for review and approval (HE1)</li> <li>• Privacy Protection Policy was finalized and approved by the board (HE2)</li> <li>• Provided member-facing staff with access to members' pronouns (HE2)</li> <li>• NPP will be distributed to members in the December Member Newsletter; surveys will be available in the member portal by the end of December 2024 (HE2)</li> <li>• In progress: Working with Customer Service to draft summary report (Net 1 A-Annual Availability of Practitioners Cultural Needs and Preferences) to be reviewed by the consultant (HE3)</li> <li>• Survey was sent out to all contracted providers (HE4)</li> <li>• All documents were finalized and updated per HE4 requirements. (HE4)</li> <li>• Began drafting 2024 CLAS Program Evaluation. Describing complete and ongoing activities, trending measures and barrier analysis (HE5/6)</li> <li>• Began drafting 2025 CLAS Program Description (HE5/6)</li> <li>• Developed CLAS satisfaction surveys for staff and members (HE5/6)</li> <li>• Developed survey dissemination plan (HE5/6)</li> </ul>

	<ul style="list-style-type: none"> <li>Implemented Health Disparity Remediation Perinatal Care Call Campaign for Black/African American/Native America members (HE5/6)</li> <li>Drafted evaluation to measure the effectiveness of the interventions to improve CLAS and reduce health inequities (HE5/6)</li> </ul>
<p style="text-align: center;">Program Results:</p> <p>HE1 Workstream</p> <ul style="list-style-type: none"> <li>New DEI Umbrella Policy (Feb 2025 Board Meeting) <ul style="list-style-type: none"> <li>Updated HR policy GA.8060: Recruitment, Selection and Hiring (Dec 2024 Board Meeting)</li> <li>DEI surveys for staff/leadership, QIHEC committees and board advisory committees support documents for exemption from governance bodies' requirements</li> </ul> </li> </ul> <p>HE2 Workstream:</p> <ul style="list-style-type: none"> <li>Developed and completed survey to collect data</li> <li>Developed and completed the Privacy Protection Policy</li> <li>Developed and completed the NPP</li> <li>Developed policy for Collection of Race, Ethnicity, Language, Sexual Orientation and Gender Identity Data Process (in final phase of revision and approval)</li> </ul> <p>HE3 Workstream:</p> <ul style="list-style-type: none"> <li>Updated the following Desktop Procedures (DTPs) to include content/evidence related to NCQA certification <ol style="list-style-type: none"> <li>DTP-Process for Translation Competency Test</li> <li>DTP-Procedure for Auditing Translation Services</li> <li>DTP-Procedure for Coordinating Interpreter Request via Facets and K2 Update</li> <li>Provider Calls DTP</li> <li>DTP- Processed for Translation and Review Services Timelines</li> </ol> </li> <li>In the process of drafting NET1A summary report to share via website to our practitioners</li> <li>Drafted taglines for annual nondiscrimination notice</li> </ul> <p>HE4 Workstream:</p> <ul style="list-style-type: none"> <li>Provider Satisfaction Survey that included health equity questions was created and sent out to all contracted practitioners</li> <li>DTP "Provider Data Collection for Cultural Responsiveness" was created to document the process of collecting provider data</li> <li>Crosswalk for Practitioner Race and Ethnicity created to include required OMB categories for the Customer Service department to use</li> <li>Provider directory updates to include HE 4 data</li> <li>New policy EE.1146 developed and created to describe the provider directory to include practitioner race/ethnicity, language fluency and practice language.</li> <li>Notification went out to members informing them that race/ethnicity data will be available if wanted.</li> </ul> <p>HE5/6 Workstream:</p> <ul style="list-style-type: none"> <li>2024 CLAS Program Description and SMART goals were developed and approved by CalOptima Health's Board of Directors.</li> <li>HE6-Reporting on stratified measures</li> <li>HE6-Analysis to identify disparities.</li> <li>HE6-Developed CLAS satisfaction surveys for staff and members</li> </ul> <p>Quantitative Analysis:</p> <ul style="list-style-type: none"> <li>Consultants have reviewed a total of 116 documents</li> </ul>	

<ul style="list-style-type: none"> <li>• Responded to 49 questions</li> <li>• Completed two gap assessment reports.</li> <li>• To be determined: Pending survey results in January 2025 (HE1)</li> <li>• 24 contracted practitioners completed the survey with Health Equity data. (HE4)</li> <li>• CLAS SMART goals were on track to meet as of third quarter. Final results will be available as part of the 2024 QIHETP Evaluation. (HE5/6)</li> </ul>	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>• No authority over CalOptima Health's Board of Directors membership (HE1)</li> <li>• No identified barriers (HE3)</li> <li>• Low participation on the Provider Satisfaction Survey (&lt; 1%) (HE4)</li> <li>• Capacity to implement interventions to meet SMART goals (HE5/6)</li> </ul>	<ul style="list-style-type: none"> <li>• Expanding capacity in terms of staffing, community collaborations and allocation of resources (HE5/6)</li> </ul>
Conclusion: All workstreams are progressing well and are on schedule to meet the submission deadline.	
Activities/Interventions to continue/add next year:	
<p>HE1 Workstream</p> <ul style="list-style-type: none"> <li>• Collect and analyze survey results</li> <li>• Identify opportunities and draft an action plan</li> <li>• Collect training documents</li> <li>• Collect training results reports</li> </ul> <p>HE3 Workstream</p> <ul style="list-style-type: none"> <li>• Follow up with contracting if new amendments are drafted.</li> <li>• Update DTPs (if applicable)</li> <li>• Finalize annual Net1 A report and share it with practitioners</li> <li>• Update screenshots based on the revised CalOptima Health website</li> </ul> <p>HE4 Workstream</p> <ul style="list-style-type: none"> <li>• Draft, review and analyze the NET1A report</li> <li>• Update Customer Service DTP to include how to provide race/ethnicity data when requested. Include HE4 data in the new Salesforce system to be implemented in 2025.</li> </ul> <p>HE5/6 Workstream</p> <ul style="list-style-type: none"> <li>• Leveraging support cross-agency support to carry out SMART goals. Continue building partnerships with the community</li> </ul>	

### 3.11 Quality Performance Measures

3.11.1 Medi-Cal: Managed Care Accountability Set (MCAS)	
Business Owner: Paul Jiang	Department: Quality Analytics
Support Staff: Terri Wong	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective:	
<ul style="list-style-type: none"> <li>• Track and report quality performance measures required by regulators</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	

<b>Work Plan Planned Activities:</b> <ul style="list-style-type: none"> <li>Track rates monthly</li> <li>Share final results with QIHEC annually</li> </ul>	
<b>Status:</b> <input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing	
<b>Background:</b> DHCS releases the MCAS measures each year. Part of the measures have a minimum performance level (MPL) requirement, which is the 50th percentile based on the Quality Compass.	
<b>Methodology:</b> Quality Analytics generates monthly MCAS measures performance reports, which monitor performance at the CalOptima Health and HN levels. The final results are reported to DHCS in June 2024.	
<b>Actions/Interventions Implemented in 2024:</b>	
Quarter 1:	<ul style="list-style-type: none"> <li>Begin HEDIS Measurement Year (MY) 2023 data collection and reporting activities</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>Continue MY2023 data collection and reporting including finalizing HEDIS compliance audit</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Final results reported at QIHEC in August 2024</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Analyze MY2023 against goals and establish goals for the following year</li> </ul>
<b>Program Results:</b>	
<b>Quantitative Analysis:</b> <ul style="list-style-type: none"> <li>Six out of 18 MCAS selected measures that have an MPL requirement achieved the MPL</li> <li>Follow-up After ED Visit for Alcohol and Other Drug Dependence within 30 days (FUA) did not meet MPL</li> <li>Follow-up After ED Visit for Mental Illness within 30 days (FUM) didn't meet MPL</li> </ul>	
<b>Identified Barriers:</b> <ul style="list-style-type: none"> <li>BH benefits are partially carved out</li> <li>Unable to identify the ED visits in a timely manner</li> </ul>	<b>Identified Opportunities for Improvement:</b> <ul style="list-style-type: none"> <li>Lack of data for the BH services not paid by CalOptima Health</li> </ul>
<b>Conclusion:</b> Unable to identify the ED visits in a timely manner to schedule a follow-up visit and lack of data for the BH services not paid by CalOptima Health because of BH benefits carved out.	
<b>Activities/Interventions to continue/add next year:</b> <ul style="list-style-type: none"> <li>Using ADT data feed to notify providers of ED visits</li> <li>Working on data exchanges with the county BH service agency.</li> </ul>	

3.11.2 OneCare: Stars Performance Measures	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Kelli Glynn	
Products: <input type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Work Plan Goal/Objective:</b> <ul style="list-style-type: none"> <li>Achieve 4 or above</li> </ul>	
<b>Goal Met:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
<b>Work Plan Planned Activities:</b> <ul style="list-style-type: none"> <li>Review and identify Stars measures for focused improvement efforts.</li> </ul>	
<b>Status:</b> <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<b>Background:</b> CalOptima Health annually collects, tracks and reports quality performance measures, including the CMS Star measures, to CMS. Measures are calculated and reported at the required reporting unit	

level and are stratified according to requirements. The results are compared against NCQA national percentiles and the Star cut points as benchmarks.	
<p>Methodology:</p> <p>Star ratings data are collected in various ways. For HEDIS measures, we use the HEDIS methodology. We also have survey-based measures for member experience (CAHPS) and member health outcomes (HOS). Appeals and complaints information is gathered through CMS vendors and CMS directly, in addition to call surveillance by CMS. Pharmacy data is also collected through prescription drug event data.</p>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>Stars Steering Committee</li> <li>Just in Time CAHPS outreach</li> <li>Ushur text campaigns</li> <li>Member incentives</li> <li>Bi-monthly quality meetings with HNs</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>SullivanLuallin Group lunch and learns</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Stars working sessions</li> <li>Exact Sciences program for colorectal cancer screening</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Pharmacy strike force team</li> <li>SullivanLuallin Group Site coaching</li> <li>Executive Stars Steering Committee</li> </ul>
Program Results:	
<p>Quantitative Analysis:</p> <p>Overall performance was lower for Stars compared to the previous year. The main area of concern is the member experience CAHPS survey, where there was not a single measure above 2 Stars. In addition to CAHPS, Part D measure performance continues to decrease from previous years.</p>	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Timeliness of data</li> <li>Ability to consume data from external partners on a recurring and timely basis</li> <li>Vendor challenges (Transportation)</li> </ul>	<ul style="list-style-type: none"> <li>Member experience (CAHPS)</li> <li>Part D performance</li> <li>Expand ADT data to allow for better coordination of care and timeliness of discharge-based measures</li> </ul>
<p>Conclusion: While there has been improvement in some areas, overall, the performance of the program has either decreased or been stagnant. Increased awareness and education of Stars is a key component that must improve organizationally.</p>	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>Continue with all identified interventions above</li> <li>Stars Analytics Tool – Q1 2025</li> <li>Optimized reporting from new HEDIS software</li> </ul>	

### 3.12 Utilization Management Program

Business Owner: Stacie Oakley

Support Staff: Lorena Moore

Executive Summary: CalOptima Health transitioned into a new clinical documentation platform in February 2024 impacting variations in the layout of reporting UM data compared to previous versions. Workflow process improvements were enhanced and implemented in February 2024 including the transition to a new clinical documentation platform, Jiva. Efforts are reflected in the UM referral

statistics outlined above. Medi-Cal and OC prior authorization turnaround time compliance remained above goal of 95% from Q4 2023 – Q3 2024. In addition, pharmacy turnaround time compliance remained above of 95% from Q4 2023 – Q3 2024.

TANF 18+ and TANF under 18 remained above goal with the exception of TANF 18+ in Q4 2023 which was under the inpatient bed day goal. Medi-Cal and OneCare inpatient turnaround time goals were above goal in Q4 2023-Q3 2024 with the exception of February 2024 for urgent cases. Retrospective goals were not met in several quarters in Q4 2023 – Q3 2024. The utilization data showed an increase in volume of obstetric admissions in TANF 18+ and Neonatal in TANF under 18 that will be reviewed in greater detail by the medical director and clinical leadership team in routine utilization sub-workgroups, targeted UM and CM workgroups and UMC for formal reporting.

Additional improvements included the addition of one (1) Medical Director to support Medical Management Departments. Process improvements contributing to the 2024 UM Program include but are not limited to improved workflows, standardized documentation templates, enhanced LOA process, enhanced continuity of care process, enhancements of a TCS program, oversight of over and underutilization patterns, and UM oversight of CalOptima Health's delegated entities. In addition, the following workgroups were developed to concentrate on specific areas within Medical Management, Case Management Workgroup and the EPSDT Workgroup.

Staffing metrics and productivity standards were enhanced to ensure staff are working to their full capability and to address staffing needs.

The UMC, UM Medical Directors and Behavioral Health Medical Director continue to guide and support the CalOptima Health integrated UM/CM Program (medical, behavioral and pharmacy). The UMC, QIHEC and Medical Director's continued to guide and support process improvement, review and address over and under-utilization trends and continues to enhance the CalOptima Health UM/CM Program through Committee and Workgroup efforts.

### 3.13 Value-Based Payment

3.13.1 Health Network Quality Rating – Pay for Value	
Business Owner: Linda Lee	Department: Quality Analytics
Support Staff: Paul Jiang	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
Work Plan Planned Activities: Share HN performance on all P4V HEDIS Measures via prospective rates report each month.	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: CalOptima Health's Pay for Value Performance Program (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. HNs and CHCN PCPs are eligible to participate in the P4V program.	
Methodology: Data is gathered through the HEDIS data collection methodology and through member experience CAHPS survey methodology.	

Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>• Generate and share monthly prospective rate reports with HNs and CHCN clinics and providers to show their performance on all clinical HEDIS P4V measures</li> <li>• Bi-monthly quality meetings with HNs</li> <li>• Quarterly Health Network Collaborative Quality Forum</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Health Network Comparison reporting showing performance of HNs relative to peers</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• Develop P4V Program for the following year</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• Health Network Report Cards that summarize their performance and Health Network Quality Rating on all clinical HEDIS P4V measures and CAHPS member experience surveys.</li> </ul>
Program Results:	



Table A

Health Network Quality Rating Member Experience – Medi-Cal	Survey	# Measures	Total Weight	Total Points	CAHPS Rating
<b>CalOptima Health</b>	Adult	8	12	27	2.5
<b>AltaMed</b>	Adult	8	12	40.5	3.5
<b>AMVI Care</b>	Adult	8	12	13.5	1
<b>CHCN</b>	Adult	8	12	37.5	3
<b>CHOC</b>	Adult	5	7.5	26.5	3.5
<b>Family Choice</b>	Adult	8	12	16.5	1.5
<b>Heritage-Regal</b>	Adult	8	12	26.5	2
<b>Noble</b>	Adult	8	12	36	3
<b>Optum</b>	Child	6	9	19.5	2
<b>Prospect</b>	Adult	8	12	25.5	2
<b>UCMG</b>	Adult	8	12	15	1.5

Table B

Health Network Quality Rating HEDIS – Medi-Cal	# HEDIS Measures	Total Weight	Total Points	HEDIS Rating
<b>CalOptima Health</b>	15	15	53	3.5
<b>AltaMed</b>	15	15	51	3.5
<b>AMVI Care</b>	15	15	52	3.5
<b>CHCN</b>	15	15	53	3.5
<b>CHOC</b>	13	13	39	3
<b>Family Choice</b>	15	15	48	3
<b>Heritage-Regal</b>	11	11	27	2.5
<b>Noble</b>	15	15	45	3
<b>Optum</b>	15	15	43	3
<b>Prospect</b>	15	15	46	3
<b>UCMG</b>	15	15	47	3

Table C

Health Network Quality Rating Overall – Medi-Cal	# Measures	Total Weight	Total Points	Overall Rating
CalOptima Health	23	27	80	3.5
AltaMed	23	27	91.5	4
AMVI Care	23	27	65.5	3
CHCN	23	27	90.5	4
CHOC	18	20.5	64.5	3.5
Family Choice	23	27	64.5	3
Heritage-Regal	19	23	52.5	3
Noble	23	27	81	3.5
Optum	21	24	62.5	3
Prospect	23	27	71.5	3
UCMG	23	27	62	3

Table D

Health Network Quality Rating Member Experience – OneCare	# Measures	Total Weight	Total Points	CAHPS Rating
CalOptima Health	3	12	24	2
AltaMed	3	12	44	3.5
AMVI Care	3	12	28	2.5
CHCN	3	12	40	3.5
Family Choice	3	12	44	3.5
Heritage-Regal	3	12	48	4
Noble	3	12	40	3.5
Optum	3	12	52	4.5
Prospect	3	12	44	3.5
UCMG	3	12	44	3.5

Table E

<b>Health Network Quality Rating HEDIS – OneCare</b>	<b># HEDIS Measures</b>	<b>Total Weight</b>	<b>Total Points</b>	<b>HEDIS Rating</b>
<b>CalOptima Health</b>	5	7	26	3.5
<b>AltaMed</b>	5	7	29	4
<b>AMVI Care</b>	5	7	32	4.5
<b>CHCN</b>	5	7	23	3.5
<b>Family Choice</b>	5	7	27	4
<b>Heritage-Regal</b>	5	7	31	4.5
<b>Noble</b>	5	7	19	2.5
<b>Optum</b>	5	7	23	3.5
<b>Prospect</b>	5	7	23	3.5
<b>UCMG</b>	5	7	27	4

Table F

<b>Health Network Quality Rating Part D – OneCare</b>	<b># Part D Measures</b>	<b>Total Weight</b>	<b>Total Points</b>	<b>Part D Rating</b>
<b>CalOptima Health</b>	4	10	27	2.5
<b>AltaMed</b>	4	10	16	1.5
<b>AMVI Care</b>	4	10	32	3
<b>CHCN</b>	4	10	23	2.5
<b>Family Choice</b>	4	10	38	4
<b>Heritage-Regal</b>	4	10	22	2
<b>Noble</b>	4	10	16	1.5
<b>Optum</b>	4	10	26	2.5
<b>Prospect</b>	4	10	27	2.5
<b>UCMG</b>	4	10	43	4.5

Table G

Health Network Quality Rating Overall - OneCare	# Measures	Total Weight	Total Points	Overall Rating
CalOptima Health	12	29	77	3
AltaMed	12	29	89	3.5
AMVI Care	12	29	92	3.5
CHCN	12	29	86	3.5
Family Choice	12	29	109	4.5
Heritage-Regal	12	29	101	4
Noble	12	29	75	3
Optum	12	29	101	4
Prospect	12	29	94	3.5
UCMG	12	29	114	4.5
Quantitative Analysis: For the Medi-Cal population, two HNs saw an increase in their overall performance, three saw a decrease and five stayed the same year over year. Results were similar for the OneCare population.				
Identified Barriers:		Identified Opportunities for Improvement:		
<ul style="list-style-type: none"><li>• Timeliness of data</li><li>• Limited supplemental data</li></ul>		<ul style="list-style-type: none"><li>• Optimize reporting from new HEDIS software</li><li>• Increase frequency of supplemental data feeds from external partners</li></ul>		
Conclusion: Overall, the program continues to be successful with room for improvement. The program serves as an incentive to continue to seek quality improvement.				
Activities/Interventions to continue/add next year:				
<ul style="list-style-type: none"><li>• Quality Grant Program – Utilizing unrealized P4V dollars to award grants to HNs for quality improvement initiatives</li></ul>				

### 3.13.2 Five-Year Hospital Quality Program

Business Owner: Linda Lee	Department: Quality Analytics
Support Staff: Ruby Nunez	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Work Plan Goal/Objective:	
<ul style="list-style-type: none"> <li>• Report on calculation of performance, distribution of incentives, and solicitation of feedback.</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities:	
<ul style="list-style-type: none"> <li>• Share hospital quality program performance</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	

**Background:** In 2023, CalOptima Health established a Hospital Quality Program to encourage eligible facilities to improve quality of care through increased patient safety efforts and performance-driven processes. Using MY2023 data, the first incentive payments were awarded to facilities in 2024.

**Methodology:** The Hospital Quality Program consists of three metrics: Quality performance, Patient Experience and Hospital Safety. Hospital quality performance and patient experience data is gathered from Hospital Compare, ranging from 1 to 5 Stars. Hospital safety data is gathered from the Leapfrog Group, ranging from a grade of A to F. Hospitals not listed on Hospital Compare for quality and patient experience will be assessed using the Leapfrog rating.

**Actions/Interventions Implemented in 2024:**

Quarter 1:	<ul style="list-style-type: none"> <li>Review hospital quality program at joint operations meetings</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>Review hospital quality program at joint operations meetings</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Calculate hospital performance and incentive amounts</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Distribute individual hospital scorecards and incentive awards</li> </ul>

**Program Results:**

Hospital	Hospital Quality STARS Rating	Hospital Patient Survey Rating	Leapfrog Hospital Safety Guide	Maximum Incentive Possible	Incentive Earned
Anaheim Regional Medical Center	★★★	★★	B	\$1,413,638	\$494,773
Anaheim Global Medical Center	N/A	★★	C	\$265,834	\$26,583
Chapman Global Medical Center	★	★	D	\$155,157	\$0
Children's Hospital of Orange County	★★★★★	★★★★★	B	\$3,598,119	\$3,418,213
Foothill Regional Medical Center	N/A	★	N/A	\$627,218	\$0
Fountain Valley Regional Hospital & Medical Center	★★	★	D	\$3,456,890	\$0
Hoag Memorial Hospital Presbyterian	★★★★★	★★★★★	A	\$1,940,663	\$1,746,597
Los Alamitos Medical Center	★	★★	D	\$404,816	\$0
Memorial Care Long Beach Medical Center	★★	★★★	C	\$207,276	\$62,183
Memorial Care Miller Children's and Women's Hospital	★★	★★★	C	\$	- \$ -
Memorial Care Orange Coast Medical Center	★★★★	★★★	C	\$1,120,696	\$672,418
Memorial Care Saddleback Medical Center	★★★	★★★	B	\$412,305	\$226,768
Orange County Global Medical Center	★	★★	D	\$2,013,149	\$0
Placentia Linda Hospital	★★	★★★	C	\$360,336	\$108,101
Pomona Valley Hospital Medical Center	★★★★	★★★	A	\$29,354	\$20,548
Providence Mission Hospital	★★★★	★★★	B	\$1,305,806	\$848,774
Providence St. Joseph Hospital	★★★★	★★★★	B	\$2,881,640	\$2,161,230
Providence St. Jude Medical Center	★★★★	★★★	B	\$1,355,978	\$881,386
South Coast Global Medical Center	N/A	★	D	\$359,887	\$0
UCI Medical Center	★★★★	★★★★	A	\$5,881,296	\$4,705,037
Whittier Hospital Medical Center	★★★	★★	B	\$53,167	\$18,608
<b>Totals</b>				<b>\$27,843,225</b>	<b>\$15,391,219</b>

**Quantitative Analysis:** As this is the first year of the Hospital Quality Program, these results will be used as a baseline. Of the total incentive available, 53% was awarded to the facilities. However, nearly half of the eligible facilities, 44%, received zero of their eligible incentive dollars.

<b>Identified Barriers:</b>	<b>Identified Opportunities for Improvement:</b>
<ul style="list-style-type: none"> <li>Not every hospital is able to report data</li> </ul>	<ul style="list-style-type: none"> <li>Discussing alternative measurement sets (i.e. pediatric hospitals)</li> <li>Significant pool of unearned incentive funds</li> </ul>

**Conclusion:**

The hospital quality program aims to improve quality through tracking of public data. Recognizing that improvement efforts take time to realize an impact, the hospital quality program is a multi-year initiative. 2023 is the first year of the program and establishes a foundation of performance. Future improvements

are aimed at improving performance, expanding measurement sets for hospitals that do not report to CMS, and providing options for use of unearned incentive funds.
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Activities/Interventions to continue/add next year:
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- |  |
|--|
| <ul style="list-style-type: none"><li>• Develop options to use unearned incentive funds for quality improvement initiatives</li><li>• Expanding measurement sets for pediatric hospitals</li></ul> |
|--|

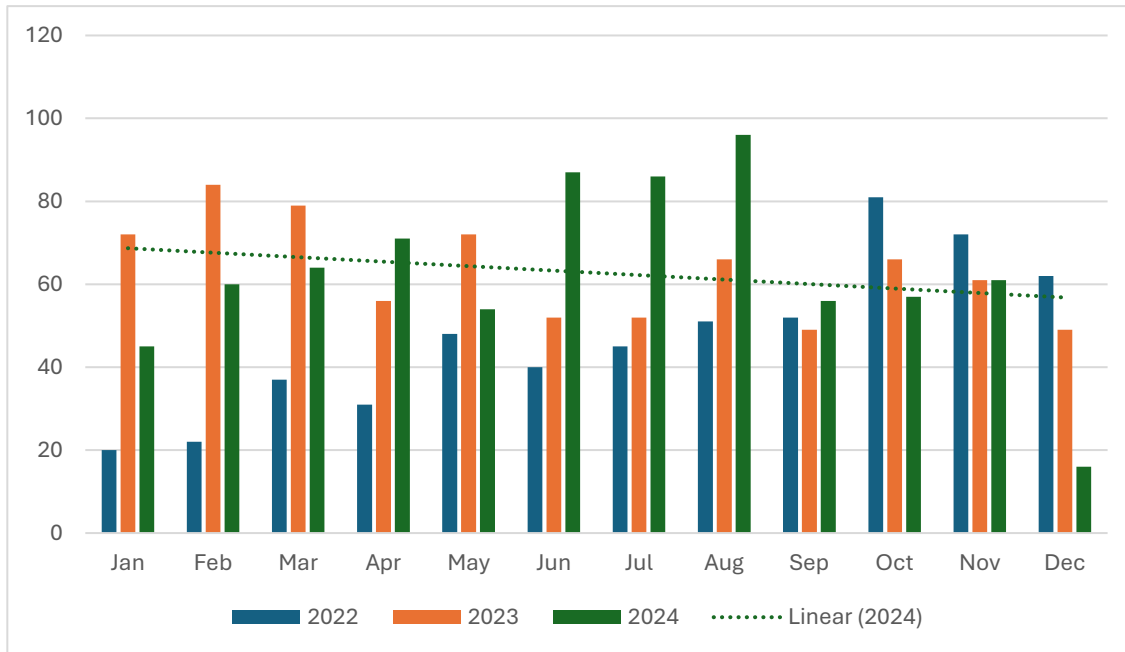
## Section 4: Quality of Clinical Care

### 4.1 Quality Oversight

4.1.1 Potential Quality Issues (PQI) and Provider Preventable Conditions	
Author: Laura Guest, Manager	Department: Quality Improvement
Responsible Party: Laura Guest, Manager	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>Work Plan Goal/Objective: Referred quality of care grievances and PQIs are reviewed in a timely manner</p> <p>Identify quality-of-care issues and trends and implement appropriate actions.</p> <ul style="list-style-type: none"> <li>○ PQI case initially reviewed by the medical director within 90 days of opening the case.</li> <li>○ Declined Grievances reviewed by the medical director in 30 days. We have defined Declined Grievances as grievances that have a quality-of-care component, but the members choose not to file a formal grievance and are investigated as a PQI.</li> </ul>	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <p>Review and report if conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings and recommendations for actions are made, which may include a presentation to the CPRC for peer review.</p>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <ul style="list-style-type: none"> <li>• PQIs are clinical investigations of providers to determine if the care provided meets evidence-based and community standards. Investigations include the review of all provider types in the CalOptima Health provider network, including physicians, mid-level practitioners, hospitals, home health agencies, etc. Information, which is specific to the case and may include medical records and a response to the issue, is obtained and summarized by a nurse. A medical director reviews the information, levels the case according to the severity of the findings and makes a recommendation for action, which ranges from “no action” to presenting the case to the CPRC. Some cases are sent to contracted external specialists for expert review. Cases presented to CPRC may result in a recommendation such as a best practice letter or an 805 reporting to the appropriate state board.</li> <li>• The nurses also support the review of quality-of-care grievances by determining and intervening on urgent clinical issues and assisting the medical directors with a clinical response, which is included in the member grievance letter sent by the GARS team.</li> </ul>	
Actions/Interventions Implemented in 2024:	
<ul style="list-style-type: none"> <li>• In May 2024, CalOptima Health implemented a new care management system (Jiva). A new module of the system, Jiva by ZeOmega, was developed specifically for PQI. Important aspects of the system were to ensure the data is solely accessible by the PQI team and that the data is provider-centric.</li> <li>• One additional nurse was hired in 2024 to help with the volume of PQI cases and to provide coverage for quality-of-care grievances when needed.</li> <li>• In July 2024, the nurses began providing coverage for the quality-of-care grievances on Fridays and the day prior to a holiday weekend until 5 p.m. to ensure that we meet the TAT for quality-of-care grievances for GARS.</li> </ul>	

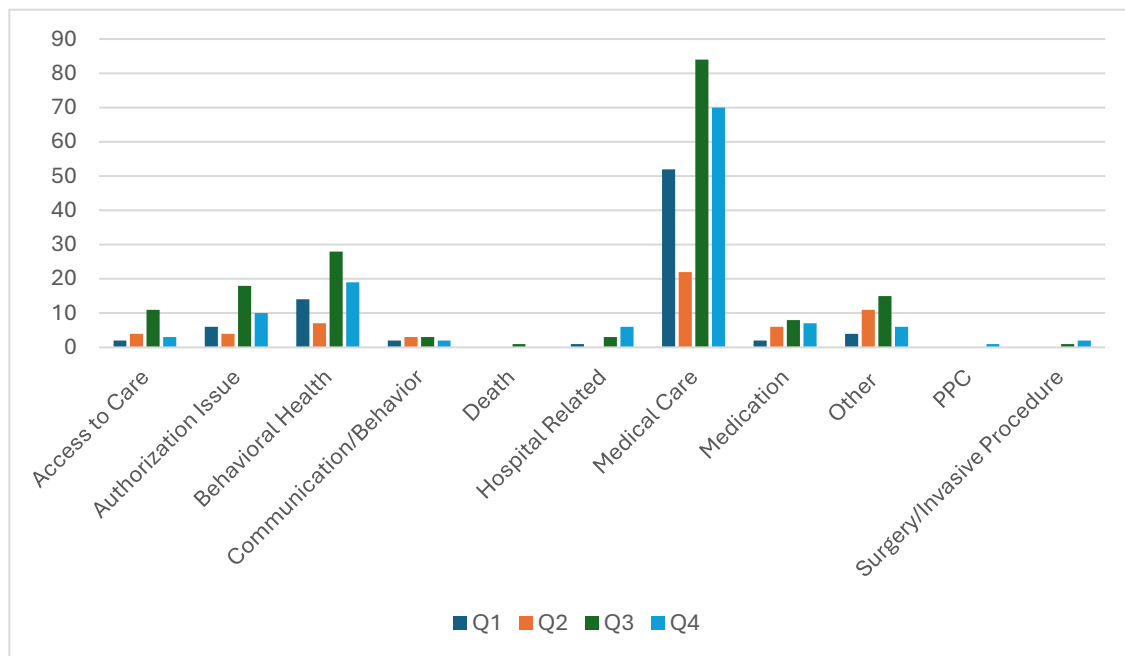
## Program Results:

Chart A – Number of Newly Opened PQIs by Month 2022 to 2024



*In 2024 the number of cases opened each month spiked in June, July and August, but dropped thereafter.*

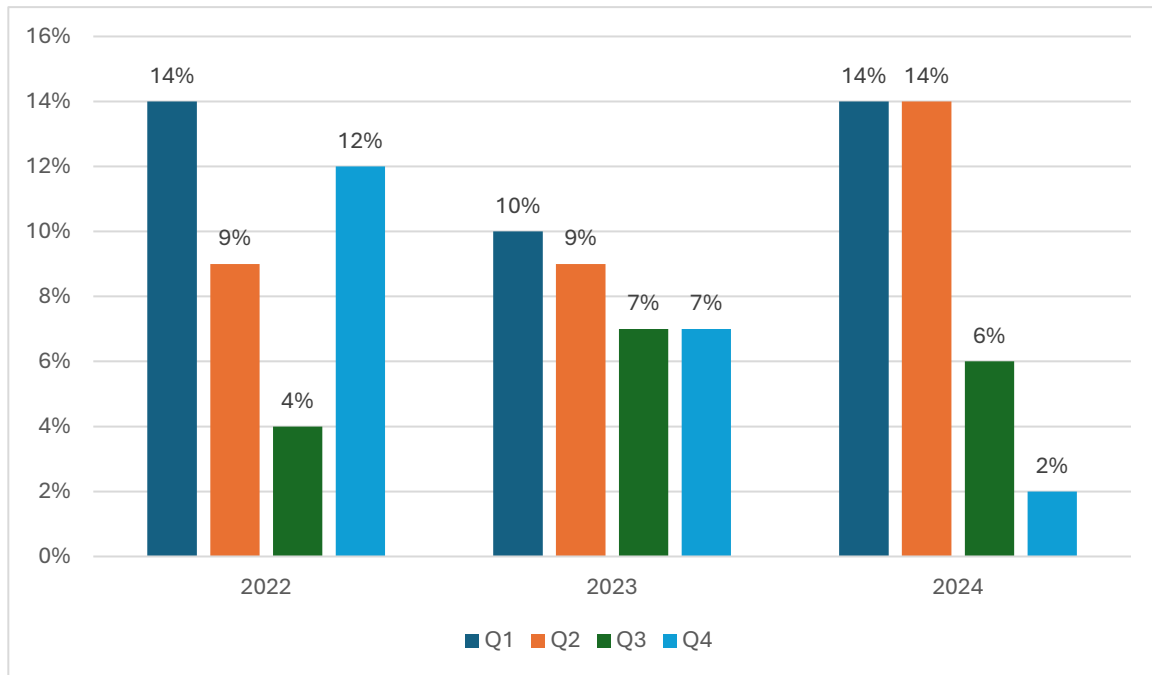
Chart B – Number of PQIs by Category by Quarter



*The number of cases categorized as related to Medical Care was the most of all categories quarter over quarter.*



Chart C – Percent of PQIs Cases Presented to CPRC



*The percent of cases presented was very high in Q1 and Q2 at 14% but appears deflated in Q3 and Q4 due to the increased denominator of number of cases closed.*

**Quantitative Analysis:**

- The overall volume of PQIs remained high in 2024. This trend continues as the medical directors are identifying more PQIs from behavioral health, appeals and inpatient stays.
- The number of cases presented to CPRC was high for Q1 and Q2. It appears to have dropped in Q3 and Q4, but the lower percentage is due to a higher number of cases closed in those quarters (the denominator).
- Quarter-over-quarter, the greatest category of PQI cases was regarding medical care.

<p>Identified Barriers:</p> <ul style="list-style-type: none"> <li>• The PQI team transitioned from the previous care management system and utilized a shared spreadsheet to track PQIs while the Jiva system was being finalized. Use of the spreadsheet created a loss of data integrity.</li> <li>• From February to December 2024, the TAT was unable to be tracked in 2024 due to the change in care management system.</li> <li>• As PQI is a new part of the system for Jiva, there have been a number of design elements identified that need to be modified in order to make the system fully functional. Additionally, Jiva has had extensive performance issues for PQI, severely handicapping the ability of the team to complete their work efficiently.</li> <li>• Some medical directors have been opening PQIs for quality-of-service issues for the purpose of sending educational letters to the providers. This increased the number of PQI investigations for non-quality-of-care activities and took time away from the completion of quality-of-care investigations.</li> </ul>	<p>Identified Opportunities for Improvement:</p> <ul style="list-style-type: none"> <li>• Work with ITS to develop additional reporting for Jiva, including reports that will track productivity and TAT.</li> <li>• Continue to work with ZeOmega to re-design elements of Jiva for PQI bringing it to the baseline functionality currently in use by other departments.</li> <li>• Continue to work with ZeOmega to identify and resolve the performance issues for PQI.</li> <li>• Develop a separate process to address quality-of-service issues organizationally that offers step-wise actions to address the identified provider issues.</li> </ul>
<p>Conclusion:</p> <ul style="list-style-type: none"> <li>• The transition of the care management system to one that is provider-centric has created challenges with regard to data integrity, reporting and functionality.</li> <li>• PQI continues to support GARS in the review and member response to quality-of-care grievances.</li> <li>• The development of a process to address quality-of-service provider issues will assist departments organizationally and allow the PQI team to focus on quality-of-care investigations.</li> </ul>	

4.1.2 Facility Site and Medical Record Review	
Author: Katy Noyes	Department: Quality Improvement
Responsible Party(ies): Marsha Choo, Katy Noyes	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

<p>Work Plan Goal/Objective:</p> <ul style="list-style-type: none"> <li>• PCP and high-volume specialist sites are monitored utilizing the DHCS audit tool and methodology.</li> <li>• Conduct initial FSRs and verify each contracted PCP site has a passing score. If CAPs are issued, the site must correct all deficiencies to close CAP prior to adding the providers to the CalOptima Health provider network and assigning members to the providers.</li> <li>• Conduct initial MRRs 90–180 days following the assignment of members.</li> <li>• Conduct subsequent site reviews, consisting of an FSR and MRR, beginning no later than three years after the initial FSR, and at least every three years thereafter.</li> <li>• Utilize DHCS' most current FSR and MRR tools and standards when conducting site reviews.</li> <li>• Properly document and monitor the site review status of each contracted PCP site.</li> <li>• Follow the established DHCS timeline for CAP notification and completion.</li> <li>• Critical Element (CE) CAPs are due within 10 business days</li> <li>• FSR and MRR CAPs timelines are due within 30 calendar days</li> <li>• Monitor and evaluate the CE criteria for all PCP sites between each regularly scheduled site review.</li> <li>• Review the minimum number of medical records according to the number of PCPs and general patient population distribution.</li> </ul>	
<p>Goal Met:    <input checked="" type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Partial</p>	
<p>Work Plan Planned Activities:</p> <ul style="list-style-type: none"> <li>• Review and report conducted initial reviews for all sites with a PCP or high-volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.</li> </ul>	
<p>Status:    <input type="checkbox"/> Completed    <input checked="" type="checkbox"/> Ongoing</p>	
<p>Background: FSRs are conducted to ensure that all contracted PCP sites have sufficient capacity to provide appropriate primary health care services and can maintain patient safety standards and practices. The FSR confirms the PCP site operates in compliance with all applicable local, state, and federal laws and regulations. MRRs are conducted to review medical records for format, legal protocols and documented evidence of the provision of preventive care and coordination and continuity of care services. The medical record provides legal proof that the patient received care. Incomplete records and/or lack of documentation imply the PCP did not provide quality, timely or appropriate medical care.</p>	
<p>Methodology: To ensure compliance with DHCS contractual requirements, CalOptima Health is required to perform initial and subsequent PCP site reviews, consisting of an FSR and a MRR, using the DHCS FSR and MRR tools and standards.</p>	
<p>Actions/Interventions Implemented in 2024:</p>	
Quarter 1:	<ul style="list-style-type: none"> <li>• Complete initial FSRs and MRRs per DHCS requirements.</li> <li>• Complete periodic FSRs and MRRs within DHCS-established timelines.</li> <li>• Close all issued CE, FSR and MRR CAPs within DHCS-established timelines.</li> <li>• Provide training and technical assistance to PCP sites.</li> <li>• New QI Nurse Specialist-FSR hire and training.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Complete initial FSRs and MRRs per DHCS requirements.</li> <li>• Complete periodic FSRs and MRRs within DHCS-established timelines.</li> <li>• Close all issued CE, FSR and MRR CAPs within DHCS-established timelines.</li> <li>• Provide training and technical assistance to PCP sites.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• Complete initial FSRs and MRRs per DHCS requirements.</li> <li>• Complete periodic FSRs and MRRs within DHCS-established timelines.</li> <li>• Close all issued CE, FSR and MRR CAPs within DHCS-established timelines</li> <li>• Provide training and technical assistance to PCP sites.</li> <li>• QI Nurse Specialist-FSR completed DHCS Certified Site Review training.</li> </ul>

	<ul style="list-style-type: none"> <li>• New QI Nurse Specialist-FSR hire and training</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• Complete initial FSRs and MRRs per DHCS requirements.</li> <li>• Complete periodic FSRs and MRRs within DHCS-established timelines.</li> <li>• Close all issued CE, FSR and MRR CAPs within DHCS-established timelines.</li> <li>• Provide training and technical assistance to PCP sites.</li> </ul>

**Program Results:**

**Table A**

Type of Reviews	Number of FSRs, MRRs Completed and CAPs Issued by Month												
	Totals:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
<b>MY2024</b>													
Number of Initial FSRs Completed	45	1	3	0	3	11	4	3	5	7	6	2	5
Number of Initial MRRs Completed	36	3	0	3	11	2	0	4	0	4	5	4	5
Number of Periodic FSRs Completed	195	3	5	19	15	24	22	24	25	17	24	17	13
Number of Periodic MRRs Completed	200	2	3	13	17	21	28	31	26	19	23	17	16
Number of Annual FSRs Completed	23	1	2	2	0	3	1	1	4	1	5	3	1
Number of Annual MRRs Completed	24	0	1	3	0	3	1	1	4	3	5	3	0

**Table B**

Periodic FSR and CE, FSR, and MRR CAP Timeliness												
MY 2024	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Percentage of Periodic FSRs Completed by Due Dates	0% (N=3)	100% (N=5)	95% (N=18)	93% (N=14)	100% (N=24)	100% (N=22)	96% (N=23)	100% (N=25)	94% (N=16)	92% (N=22)	88% (N=2)	92% (N=1)
Percentage of CE CAPs Closed by Due Dates	70% (N=7)	88% (N=7)	100% (N=13)	100% (N=14)	88% (N=15)	100% (N=8)	100% (N=14)	100% (N=16)	100% (N=9)	95% (N=18)	80% (N=)	90% (N=1)
Percentage of FSR CAPs Closed by Due Dates	75% (N=3)	80% (N=4)	92% (N=12)	93% (N=13)	96% (N=21)	69% (N=11)	91% (N=21)	96% (N=21)	100% (N=18)	77% (N=20)	70% (N=14)	92% (N=1)
Percentage of MRR CAPs Closed by Due Dates	100% (N=6)	100% (N=9)	100% (N=17)	92% (N=22)	95% (N=18)	95% (N=20)	100% (N=21)	95% (N=19)	95% (N=19)	91% (N=21)	82% (N=14)	79% (N=3)
<p>Quantitative Analysis:</p> <ul style="list-style-type: none"> <li>Initial FSRs and MRRs: Initial FSRs and MRRs were completed within established DHCS timelines. All issued CAPs were closed before providers were added to the CalOptima Health provider network and assigned members.</li> <li>Periodic FSRs: The number of periodic FSRs increased from 116 in 2023 to 195 in 2024.</li> <li>Periodic MRRs: The number of periodic MRRs increased from 136 in 2023 to 200 in 2024.</li> <li>CE CAPs: The percentage of CE CAPs closed within established DHCS timelines ranged from 70% to 100%. The average percentage of CE CAPs closed on time was 93%.</li> <li>FSR CAPs: The percentage of FSR CAPs closed within established DHCS timelines ranged from 69% to 100%. The average percentage of FSR CAPs closed on time was 87%.</li> <li>MRR CAPs: The percentage of MRR CAPs closed within established DHCS timelines ranged from 79 to 100%. The average percentage of MRR CAPs closed on time was 96%.</li> </ul>												
Identified Barriers:							Identified Opportunities for Improvement:					

<ul style="list-style-type: none"> <li>Rescheduling of audits to dates after the assigned due dates. At times, provider offices will cancel their scheduled audit and not be available until after the assigned due date. Reasons for rescheduling include staffing issues at sites, COVID cases and non-compliant providers/staff. Periodic FSRs are scheduled three months in advance; it is difficult to find available days to reschedule.</li> <li>Since the updates to the DHCS FSR and MRR Tools and Standards, there has been an increase in failed audits. After a failed score, an annual FSR and MRR are required.</li> <li>Since the updates to the DHCS FSR and MRR Tools and Standards, there has been an increase in audit deficiencies. This increase leads to an increase in the size and number of CAPs issued.</li> <li>Sites with outstanding CAPs submit incomplete documentation. If supporting documents or CAP templates are not received in a timely manner, the CAPs are not closed per DHCS timelines.</li> </ul>	<ul style="list-style-type: none"> <li>Additional QI Nurse Specialist staff hired and in training.</li> <li>Keep days available on calendar to complete rescheduled audits to meet three-year turnaround time.</li> <li>Proactive communication and outreach to sites regarding pending CAPs. Emails, faxes and phone call reminders are sent.</li> </ul>
Conclusion: FSR and MRR audits for PCP sites were completed per DHCS requirements and timelines. The program is successful.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>Complete initial FSR and MRR audits per DHCS requirements</li> <li>Complete periodic FSR and MRR audits within established DHCS timelines.</li> <li>Close all issued CE, FSR and MRR CAPs within established DHCS timelines.</li> <li>Provide training and technical assistance to PCP sites</li> </ul>	

#### 4.1.3 Physical Accessibility Review Surveys

Author: Katy Noyes	Department: Quality Improvement
Responsible Party(ies): Marsha Choo, Katy Noyes	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>Work Plan Goal/Objective:</p> <ul style="list-style-type: none"> <li>PCP and high-volume specialist sites are monitored utilizing the DHCS audit tools and methodology.</li> </ul> <p>Other goals:</p> <ul style="list-style-type: none"> <li>Conduct initial PARS for PCP sites in conjunction with the DHCS requirements for initial FSR.</li> <li>Conduct initial PARS for high-volume specialty (HVS) sites when a newly contracted high-volume specialty provider joins the CalOptima Health provider network.</li> <li>Conduct periodic PARs for PCP and HVS sites at least every three years in accordance with DHCS requirements.</li> <li>Use DHCS PARS Tool Attachment C to assess the physical accessibility of PCP and HVS sites.</li> <li>Conduct PARS for providers of ancillary services using DHCS PARS Tool Attachment D.</li> <li>Conduct PARS for Community-Based Adult Service (CBAS) centers using DHCS PARS Tool Attachment E.</li> <li>Document level of access results met per site as either basic access or limited access.</li> </ul>	

Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities:	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: To ensure compliance with DHCS contractual requirements, CalOptima Health is required to access the level of physical accessibility of PCP sites, HVS provider sites, providers of ancillary services and CBAS Centers that serve a high volume of seniors and persons with disabilities (SPDs).	
Methodology: To ensure compliance with DHCS contractual requirements, CalOptima Health is required to perform PARS using DHCS PARS Tool Attachment D.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>• Conducted initial PARS for PCP sites in conjunction with initial FSRs.</li> <li>• Conducted initial PARS for HVS site when a newly contracted provider joins the CalOptima Health provider network.</li> <li>• Conducted periodic PARS for PCP and HVS sites at least every three years.</li> <li>• Conducted periodic PARS for CBAS centers at least every three years.</li> <li>• Conducted periodic PARS for providers of ancillary services at least every three years.</li> <li>• Documented level of access results as basic or limited.</li> <li>• Identified potential accessibility barriers and provide recommendations to increase accessibility and use of facilities.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Conducted initial PARS for PCP sites in conjunction with initial FSRs.</li> <li>• Conducted initial PARS for HVS site when a newly contracted provider joins the CalOptima Health provider network.</li> <li>• Conducted periodic PARS for PCP and HVS sites at least every three years.</li> <li>• Conducted periodic PARS for CBAS centers at least every three years.</li> <li>• Conducted periodic PARS for providers of ancillary services at least every three years.</li> <li>• Documented level of access results as basic or limited.</li> <li>• Identified potential accessibility barriers and provide recommendations to increase accessibility and use of facilities.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• Conducted initial PARS for PCP sites in conjunction with initial FSRs.</li> <li>• Conducted initial PARS for HVS site when a newly contracted provider joins the CalOptima Health provider network.</li> <li>• Conducted periodic PARS for PCP and HVS sites at least every three years.</li> <li>• Conducted periodic PARS for CBAS centers at least every three years.</li> <li>• Conducted periodic PARS for providers of ancillary services at least every three years.</li> <li>• Documented level of access results as basic or limited.</li> <li>• Identified potential accessibility barriers and provide recommendations to increase accessibility and use of facilities.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• Conducted initial PARS for PCP sites in conjunction with initial FSRs.</li> <li>• Conducted initial PARS for HVS site when a newly contracted provider joins the CalOptima Health provider network.</li> <li>• Conducted periodic PARS for PCP and HVS sites at least every three years.</li> <li>• Conducted periodic PARS for CBAS centers at least every three years.</li> <li>• Conducted periodic PARS for providers of ancillary services at least every three years.</li> <li>• Documented level of access results as basic or limited.</li> </ul>

	<ul style="list-style-type: none"><li>Identified potential accessibility barriers and provide recommendations to increase accessibility and use of facilities.</li></ul>											
Program Results:												
Table A												
	The Number of PARS Completed, Number of Basic/Limited Access, and Percentage of Basic/Limited Access per Month											
PARS MY 2024	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Number of PARS	47	24	27	45	40	29	30	41	39	22	31	29
Results with Basic Access	27	12	11	20	16	13	10	18	16	6	8	12
Results with Limited Access	20	12	16	25	24	16	20	23	23	14	23	17
Percentage of PARS with Basic Access	57%	50%	41%	44%	40%	45%	33%	44%	41%	27%	26%	41%
Percentage of PARS with Limited Access	43%	50%	59%	56%	60%	55%	67%	56%	59%	73%	74%	59%
Quantitative Analysis: <ul style="list-style-type: none"><li>Initial and periodic PCP and HVS PARS were conducted according to DHCS requirements. The range of PARS completed each month ranged from 22 to 47. There are a greater number of sites with limited access than basic access.</li><li>PARS for ancillary service provider sites were completed using DHCS PARS Tool Attachment D.</li></ul>												
Identified Barriers: <ul style="list-style-type: none"><li>The results of FSR Attachment C are informational and do not require corrective action. Although deficiencies are shared with sites, efforts to enhance access for the SPD population are encouraged, and additional information to make changes to better accommodate this population is offered, very few sites want to make changes/updates to their facilities.</li><li>One of the PARS outreach specialists was on extended jury duty in 2024.</li></ul>						Identified Opportunities for Improvement: <ul style="list-style-type: none"><li>Complete updates to ancillary PARS templates in web-based application.</li></ul>						
Conclusion: PARS for PCP sites, HVS sites, providers of ancillary services and CBAS centers were completed per DHCS requirements and timelines. The program is successful.												
Activities/Interventions to continue/add next year: <ul style="list-style-type: none"><li>Conduct initial PARS for PCP sites in conjunction with initial FSRs.</li><li>Conduct initial PARS for HVS sites when a newly contracted provider joins the CalOptima Health provider network.</li></ul>												



- Conduct periodic PARS for PCP, ancillary and HVS sites at least every three years.
- Document level of access results as basic or limited.

#### 4.1.4 Provider-Preventable Conditions (PPCs)

Business Owner: Marsha Choo		Department: Quality Improvement	
Support Staff: Laura Guest			
Work Plan Element: Quality-of-Care			
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare		New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Work Plan Goal/Objective: Identify PPCs for reporting to DHCS, overpayment recovery and Potential Quality Issue (PQI) investigation.			
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial			
Work Plan Planned Activities: Ongoing identification of PPCs through monthly review of claims data and medical record review was performed by nurses.			
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing			
Background: CalOptima Health is required by DHCS to report PPC events in accordance with Title 42, Code of Federal Regulations (C.F.R), Section 438.3(g) and DHCS guidance, including APL 17-009: Reporting Requirements Related to Provider-Preventable Conditions. PPCs primarily occur in the hospital, but Other Provider-Preventable Conditions (OPPC) may occur in any health care setting.			
Methodology: <ul style="list-style-type: none"> <li>• PPCs are identified by the medical directors when they are reviewing inpatient medical records and through claims and medical record review by nurses</li> <li>• When a PPC is identified, it is reported to DHCS via their web portal, reported to the Claims department for overpayment recovery and investigated as a PQI.</li> </ul>			
Actions/Interventions Implemented in 2024:			
Quarter 1:	No PPCs were identified.		
Quarter 2:	No PPCs were identified.		
Quarter 3:	One PPC was identified at an acute care hospital as a deep vein thrombosis/pulmonary embolism. The incident occurred on June 10, 2022, was reported to DHCS on September 4, 2024, and reported to Claims on October 3, 2024.		
Quarter 4:	No PPCs were identified.		
Program Results:			
One PPC was identified in 2024.			
Quantitative Analysis: In 2023, two PPCs were identified, while only one was identified in 2024.			
Identified Barriers: <ul style="list-style-type: none"> <li>• The nurses have had limited time to perform the claims and medical records review to identify PCCs for the following reasons: <ul style="list-style-type: none"> <li>○ The nurses who perform the claims and medical records audit for PCCs also perform PQI investigations and as-needed coverage for quality-of-care grievances.</li> <li>○ The nurses have been challenged with the care management system transition,</li> </ul> </li> </ul>		Identified Opportunities for Improvement: <ul style="list-style-type: none"> <li>• Schedule dedicated time for nurses to review the claims and order/review medical records to identify possible PPCs.</li> </ul>	

continue to support the efforts to identify and resolve issues, and support the medical directors in use of the PQI system.	
<b>Conclusion:</b> PPCs are being appropriately identified and reported though dedicated time is needed to ensure all PPCs are captured.	
<b>Activities/Interventions to continue/add next year:</b> <ul style="list-style-type: none"> <li>Management will work with the nurses to schedule dedicated time each week to analyze claims data and request/review medical records.</li> </ul>	

4.1.5 Provider Credentialing Program	
Author: Rick Quinones	Department: Quality Improvement
Responsible Party: Rick Quinones	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Work Plan Goal/Objective:</b> <ul style="list-style-type: none"> <li>All providers are credentialed according to regulatory requirements</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
<b>Work Plan Planned Activities:</b>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<b>Background:</b> The Credentialing department is responsible for ensuring all practitioners are appropriately qualified to provide care to our members. Providers must be appropriately licensed and experienced in their field. This is accomplished by applying rigorous standards that verify a practitioner's license, education, training, experience, certification, malpractice history, work history and quality of care attributes. To become a participating provider in the CalOptima Health provider network, each provider must meet the minimum qualifications outlined by DHCS, NCQA and CMS.	
<b>Program Goals:</b> <ul style="list-style-type: none"> <li>Credential and re-credential CHCN and BH providers</li> <li>Initial credentialing of all providers to be completed 180 days from attestation date</li> <li>Recredentialing to be completed within 36 months of the last credentialing date</li> </ul>	
<b>Actions/Interventions Implemented in 2024:</b>	
Quarter 1:	<ul style="list-style-type: none"> <li>Hired auditors to help with the ongoing monitoring, auditing of internal files, oversight of delegated entities and the CVO.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>Contracted with the CVO to ensure compliance and timeliness of the initial credentialing and re-credentialing files.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>CVO implemented and the CVO went live.</li> <li>Reorganization of staff within the Credentialing department.</li> <li>Contracted with vendor, Salesforce/Accenture, a provider lifecycle management system, to design and implement a single integrated solution to support the business functions: Credentialing, Contract Management and Provider Data Management.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Brought in temporary position to help with data entry due to the increase of initial providers and other duties</li> </ul>
<b>Results:</b> The tables below depict the 2023/2024 Credentialing report for CalOptima Health.	

**Table A - CalOptima Health Credentialing Statistics (CHCN Delegated Groups and CHCN Non-Delegated)**

	Q4 2023	Q1 2024	Q2 2024	Q3 2024
<b>Initials</b>	236	186	281	223
<b>Recredentialials</b>	744	574	674	617
<b>Total</b>	980	760	955	840

**Table B - Credentialing Statistics – CHCN Delegated Groups**

	Q4 2023	Q1 2024	Q2 2024	Q3 2024
<b>Initials</b>	177	132	226	205
<b>Recredentialials</b>	649	46	579	569
<b>Total</b>	826	596	805	774

**Table C - Credentialing Statistics – CHCN Non-Delegated**

	Q4 2023	Q1 2024	Q2 2024	Q3 2024
<b>Initials</b>	59	54	55	18
<b>Recredentialials</b>	95	110	95	48
<b>Total</b>	154	164	150	66

**Quantitative Analysis:**

- In Q1–Q3 2024, 127 practitioners completed the initial credentialing process, and 253 practitioners completed the re-credentialing process.
- Of those re-credentialed, 99% of those were re-credentialed successfully and timely.
- The number of those re-credentialed in a 36-month timeframe was 251.
- Initial CHCN providers credentialed show an increase from years 2021–2024.
- Increase occurred mostly with BH providers

Identified Barriers:

Identified Opportunities for Improvement:

<ul style="list-style-type: none"> <li>DHCS has created provisions for providers to be added to the provider network if they are pending Medi-Cal enrollment. This requires the team to develop new processes and workflows.</li> <li>With the implementation of CalAIM, there has been an increase in credentialing (or vetting) non-traditional providers (i.e., doulas, etc.).</li> <li>Considerable staff reduction in the Credentialing department after outsourcing to Credentialing Verification Organization (CVO).</li> <li>Identification of issues in processes and workflows with CVO.</li> <li>CVO contacts providers by mail.</li> <li>Large volume of emails in the inbox</li> </ul>	<ul style="list-style-type: none"> <li>Promote communication to improve credentialing provider approval notification.</li> <li>Implement desktop procedures.</li> <li>Weekly meetings with CVO to identify issues.</li> <li>Clear all credentialing inboxes</li> </ul>
<p>Conclusion:</p> <ul style="list-style-type: none"> <li>CalOptima Health has worked with consultants to identify strengths and opportunities for improvement. Strengths include: <ul style="list-style-type: none"> <li>a. Staff has adapted to changing priorities for credentialing files.</li> <li>b. Staff have been cross-trained and are well-rounded in multiple types of files to credential.</li> </ul> </li> <li>Contracted with a PLM, a single integrated solution to support the business functions: credentialing, contract management and provider data management.</li> <li>Contract with a vendor to obtain a single integrated provider lifecycle management system for credentialing, contracting and provider data management.</li> </ul>	
<p>Activities/Interventions to continue/add next year:</p> <ul style="list-style-type: none"> <li>Clear the credentialing inboxes to ensure that we provide a timely response to providers</li> <li>Require providers who are eligible to use the Council for Affordable Quality Healthcare (CAQH), electronic web-based credentialing application</li> <li>Explore issuing an RFP to contract with another CVO.</li> <li>CalOptima Health to launch a provider life cycle management system to integrate the contracting, credentialing and provider data systems into one so we can streamline the onboarding workflow and reduce manual work.</li> <li>Hiring of additional staff to help with in-house credentialing, intake and additional duties</li> </ul>	

4.1.6 Incident Reports	
Business Owner: Marsha Choo	Department: Quality Improvement
Support Staff: Laura Guest	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Goal/Objective:	
<ul style="list-style-type: none"> <li>Collect incident reports, report critical incidents and open PQI investigations as appropriate.</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Planned Activities:	
<ul style="list-style-type: none"> <li>Nursing facilities were educated on how to report critical incidents to CalOptima Health.</li> <li>Incident report statistics were reported to CPRC and QIHEC.</li> <li>Critical incidents for nursing facilities and CBAS centers were reported to DHCS in January (Q4 2023), April (Q1 2024), July (Q2 2024) and October (Q3 2024).</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	

**Background:**

Incidents for CBAS centers, including COVID-19 outbreaks, falls, and members with medical issues, are reported as they occur. Critical incidents are reported for all LTSS programs and include epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes, and unusual occurrences which threaten the welfare, safety, or health of patients, and any instances of suspected or alleged abuse, neglect, exploitation, and/or mistreatment as defined by DHCS.

**Methodology:**

The reports are submitted to the Quality Improvement department by the nursing facilities, CBAS centers and the social workers for MSSP when an incident occurs. The report is reviewed to determine if it is an incident or a critical incident. If it is a critical incident, the report is reviewed to see if the incident was reported to Adult Protective Services (APS) or if reporting is still required. If it has not been reported, the QI will report it to APS. The incident will also be reviewed to determine if a PQI investigation is warranted, and one will be opened as needed.

**Actions/Interventions Implemented in 2024:**

Quarter 1: • In Q1, 11 critical incidents for Q4 2023 were reported to DHCS.

Quarter 2: • In Q2, six critical incidents for Q1 2024 were reported to DHCS.

Quarter 3: • In Q3, two critical incidents for Q2 2024 were reported to DHCS.

Quarter 4: • In Q4, 13 critical incidents for Q3 2024 were reported to DHCS.

**Program Results:**

The total number of incidents and critical incidents are listed in Tables A and B below.

**Table A**

Incident Reports					
LTSS Program	Q1	Q2	Q3	Q4	TOTAL
CBAS - Non-Critical	8	12	12	17	49
CBAS - Falls	7	6	10	14	37
CBAS - COVID-19 Infections	6	22	16	2	46
Total	21	37	38	14	110

The table provides the number of incidents that occurred in CBAS centers.

**Table B**

Critical Incident Reports					
LTSS Program	Q1	Q2	Q3	Q4	TOTAL
CBAS	0	1	0	0	1
MSSP	3	11	6	6	26
Nursing Facilities	1	9	5	6	21
<b>Total</b>	<b>11</b>	<b>23</b>	<b>21</b>	<b>19</b>	<b>74</b>

The table provides the number of crucial incidents by LTSS program.

#### Quantitative Analysis:

- The number COVID-19 infections increased in Q2 and Q3 at CBAS centers.
- The overall number of incidents declined in CBAS centers in Q4.
- The overall number of critical incidents increased for nursing facilities in 2024 (21) as compared to 2023, when none were reported.

#### Identified Barriers:

- Prior to the pandemic, the nursing facilities regularly reported critical incidents to CalOptima Health as required by contract. However, during the pandemic and until 2024, few were reported. We believe this to be due to the frequent turnover of administrators and directors-of-nursing (DON) at the nursing facilities who are unaware of the facility's contract requirements with CalOptima Health.

#### Identified Opportunities for Improvement:

- In 2024, QI nurses made on-site visits to nursing facilities, educating the administrator and DON on the requirement to submit critical incident reports to CalOptima Health when the reports are submitted to the California Department of Public Health (CDPH).

#### Conclusion, Activities and Interventions

- We are unable to determine if there was an actual increase in the number of critical incidents or if this is simply improved reporting. Further analysis and monitoring will be performed over the course of the next year to compare 2024 with 2025.
- Regular education is recommended at nursing facilities to ensure continued reporting of critical incidents to CalOptima Health.

#### Activities/Interventions to continue/add next year:

- Further analysis and monitoring will be performed over the course of the next year to compare 2024 with 2025.
- Regular education is needed in the nursing facilities

#### 4.1.7 Encounter Data Review

Author: Kelly Klipfel/Marsha Choo	Department: Finance
Responsible Party(ies): Lorena Dabu	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Conduct regular review of encounter data submitted by health networks	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	

Work Plan Planned Activities: Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data	
Status: <input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing	
<p>Background:</p> <p>CalOptima Health's health networks must submit complete, timely, reasonable and accurate encounter data that adheres to the guidelines specified in the companion guides for facility and professional claim types and data format specifications. A health network submits encounter data through the CalOptima Health File Transfer Protocol (FTP) site.</p>	
<p>Methodology:</p> <p>CalOptima Health semi-annually measures a health network's compliance with performance standards with regard to the timely submission of complete and accurate encounter data in accordance with Policy EE.1124 Health Network Encounter Data Performance Standards. CalOptima Health utilizes retrospective encounter data to conduct its evaluation. The measurement year is the 12-month calendar year. CalOptima Health provides each health network with a Health Network Encounter Data Scorecard to report a health network's progress check score and annual score relating to the status of the health network's compliance with encounter data performance standards</p>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>Results were shared with the health networks via email in February and at the February CalOptima Health Delegation Oversight Committee meeting</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>N/A</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Annual CY23 report published; worked with one health network that did not meet the minimum number of measures</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>N/A</li> </ul>
Program Results:	

Table A

**Encounter Performance Summary of Health Networks**  
CY 2023 Semi-Annual

	Completeness									Accuracy		Timeliness		
	Inpatient Match	ER Match	PMPY¹			Lab Services PMPY	Radiology Services PMPY	PCP/ Member Match	Rejected- Records¹		Encounter Timeliness	Total	Goal	
			Ages 0 to 2	Ages 3 to 19	AGED Mbrs				Prof	Fac				
HMO04 - Kaiser	★ 98%	★ 98%	6.2	3.2	4.9	★ 9.8	★ 2.0	★ 100%	★ 0%	1%	★ 98%	7	8	
HMO15 - Heritage	★ 94%	★ 95%	2.9	1.8	4.5	★ 21.0	★ 3.0	★ 100%	★ 1%	1%	★ 97%	7	8	
HMO16 - Monarch	★ 93%	★ 90%	4.7	2.2	4.2	★ 12.7	★ 2.3	★ 100%	★ 0%	3%	★ 97%	7	8	
HMO17 - Prospect	★ 93%	★ 95%	5.0	2.2	4.8	★ 19.5	★ 2.6	★ 100%	★ 0%	2%	★ 98%	7	8	
HMO83 - Family Choice	★ 97%	★ 96%	5.6	3.0	5.3	★ 14.7	★ 1.9	★ 100%	★ 0%	0%	★ 98%	7	8	
PHC20 - CHOC	★ 87%	★ 94%	★ 5.5	2.3				65%	★ 0%	0%	★ 100%	5	6	
PHC58 - AMVI Care	★ 93%	★ 93%	4.7	1.9	2.4	★ 9.8	★ 1.8	★ 100%	★ 0%	1%	★ 98%	7	8	
Standard	75%	75%	4.0	1.5	6.0	2.5	0.6	75%	5%	5%	75%		8	
Average	94%	94%	4.9	2.4	4.0	14.6	2.3	95%	0%	1%	98%	7		
SRG64 - Noble		96%	4.0	2.0	4.3	★ 10.2	★ 1.7	★ 90%	★ 0%		★ 96%	5	6	
SRG65 - Talbert		96%	3.9	1.8	4.2	★ 13.0	★ 2.5	★ 100%	★ 0%		★ 98%	5	6	
SRG66 - ARTA		97%	3.3	1.6	2.9	★ 11.2	★ 1.7	★ 78%	★ 0%		★ 98%	5	6	
SRG69 - Alta Med		96%	3.8	2	4.5	★ 11.4	★ 2.1	★ 100%	★ 0%		★ 98%	5	6	
SRG82 - UCMG		96%	5.4	2.6	3.6	★ 9.4	★ 1.3	★ 100%	★ 0%		★ 97%	5	6	
Standard			4.0	1.5	6.0	2.5	0.6	75%	5%		75%		6	
Average		96%	4.1	2.0	3.9	11.0	1.9	94%	0%		97%	5		

<sup>1</sup>Must meet all standards

PHC20 CHOC Lab and Radiology Services are informational only

ER Gap Scores are informational only for SRG Health Networks

HMO/PHC must meet 6 to avoid a CAP

SRG must meet 5 to avoid a cap

Semi Annual PMPY is annualized. Dates of Service = 1/1/2023 - 6/30/2023; Dates of Submission for Accuracy and Timeliness = 2/1/2023 - 7/31/2023

Table B

**Encounter Performance Summary of Health Networks**  
CY 2023 Semi-Annual

	Completeness		Accuracy	Timeliness	Total	Goal
	PMPY		Rejected-Records	Encounter Timeliness		
	Overall Encounters	E&M Visits	Prof			
HMO15 - Heritage	★ 25.8	★ 9.4	★ 1%	★ 98%	4	4
HMO16 - Monarch	★ 24.4	★ 7.5	★ 0%	★ 99%	4	4
HMO17 - Prospect	★ 20.9	★ 6.3	★ 0%	★ 99%	4	4
PHC58 - AMVI	16.5	4.6	★ 0%	★ 99%	2	4
PMG21 - Family Choice	16.1	★ 6.2	★ 0%	★ 100%	3	4
PMG52 - Talbert	★ 21.0	★ 5.8	★ 0%	★ 99%	3	4
PMG64 - Noble	19.1	★ 6.3	★ 0%	★ 98%	3	4
PMG66 - Arta	17.2	★ 6.7	★ 0%	★ 99%	3	4
PMG69 - Alta Med	★ 28.0	★ 7.1	★ 0%	★ 99%	4	4
PMG82 - UCMG	17.5	★ 6.3	★ 0%	★ 98%	3	4
Standard	20.0	6.0	5%	90%		4
Average	20.7	6.6	0.0	99%	3.3	

Must meet 3 to avoid CAP

Table C



**Encounter Performance Summary of Health Networks  
CY 2023 Annual**

	Completeness						Accuracy			Timeliness			
	Inpatient Match	ER Match	PMPY <sup>1</sup>			Lab Services PMPY	Radiology Services PMPY	PCP/Member Match	Rejected-Records <sup>1</sup>		Encounter Timeliness	Total	Goal
			Ages 0 to 2	Ages 3 to 19	AGED Mbrs				Prof	Fac			
HMO04 - Kaiser	★ 98%	★ 98%	6.3	3.6	5.1	★ 9.7	★ 2.2	★ 100%	★ 0%	1%	★ 96%	7	8
HMO15 - Heritage	★ 94%	★ 94%	3.8	1.8	4.9	★ 20.3	★ 3.1	★ 100%	★ 1%	1%	★ 94%	7	8
HMO16 - Monarch	★ 93%	★ 87%	5.4	2.6	5.1	★ 15.1	★ 2.5	★ 100%	★ 0%	2%	★ 64%	6	8
HMO17 - Prospect	★ 93%	★ 93%	4.6	2.2	4.7	★ 19.2	★ 2.8	★ 100%	★ 0%	3%	★ 96%	7	8
HMO83 - Family Choice	★ 87%	★ 90%	5.6	2.5	5.2	★ 15.3	★ 2.0	★ 100%	★ 0%	1%	★ 94%	7	8
PHC20 - CHOC	★ 97%	★ 96%	★ 5.5	3.0				★ 80%	★ 0%	0%	★ 99%	6	6
PHCS8 - AMVI Care	★ 93%	★ 91%	4.5	2.1	2.4	★ 9.8	★ 1.9	★ 100%	★ 0%	1%	★ 96%	7	8
Standard	75%	75%	4.0	1.5	6.0	2.5	0.6	75%	5%	5%	75%	8	
Average	93%	93%	5.1	2.5	4.4	14.9	2.4	97%	0%	1%	91%	7	
SRG64 - Noble		49%	3.8	1.9	4.3	★ 10.3	★ 1.6	★ 100%	★ 0%		★ 94%	5	6
SRG65 - Talbert		53%	3.8	1.8	4.1	★ 11.0	★ 2.0	★ 100%	★ 0%		★ 96%	5	6
SRG66 - ARTA		48%	3.7	2.0	3.6	★ 5.8	★ 1.6	★ 100%	★ 0%		★ 96%	5	6
SRG69 - Alta Med		48%	3.9	2.1	4.8	★ 14.0	★ 2.3	★ 100%	★ 0%		★ 97%	5	6
SRG82 - UCMG		50%	5.1	2.4	3.7	★ 9.4	★ 1.4	★ 100%	★ 0%		★ 95%	5	6
Standard			4.0	1.5	6.0	2.5	0.6	75%	5%		75%	6	
Average		49%	4.1	2.0	4.1	10.1	1.8	100%	0%		96%	5	

<sup>1</sup>Must meet all standards

ER Gap Scores are informational only for SRG Health Networks

HMO/PHC must meet 6 to avoid a CAP

SRG must meet 5 to avoid a cap

Table D

**OneCare  
CY 2023 Annual**

	Completeness		Accuracy		Timeliness	Total	Goal
	PMPY		Rejected- Records		Encounter Timeliness		
	Overall Encounters	E&M Visits	Prof	Fac			
HMO15 - Heritage	★ 26.6	★ 10.0	★ 0%	0%	★ 94%	4	4
HMO16 - Monarch	★ 24.1	★ 7.6	★ 0%	0%	★ 94%	4	4
HMO17- Prospect	★ 22.4	★ 7.4	★ 0%	0%	★ 97%	4	4
PHC58 - AMVI	15.3	5.0	★ 0%	0%	★ 96%	2	4
PMG21 - Family Choice	16.0	★ 6.3	★ 0%	0%	★ 97%	3	4
PMG52 - Talbert	★ 22.0	★ 6.5	★ 0%	0%	★ 97%	4	4
PMG64 - Noble	19.0	★ 6.2	★ 0%	0%	★ 95%	3	4
PMG66 - Arta	19.0	★ 7.6	★ 0%	0%	★ 97%	3	4
PMG69 - Alta Med	★ 27.0	★ 7.3	★ 0%	0%	★ 97%	4	4
PMG82 - UCMG	17.0	★ 6.5	★ 0%	1%	★ 97%	3	4
Standard	20.0	6.0	5%	5%	90%		4
Average	20.8	7.0	0.0	0.0	96%	3.4	

PMG must meet 3 to avoid CAP

Quantitative Analysis:

For Table A:

- Health Maintenance Organizations (HMOs) and Physician-Hospital Consortia (PHCs) met seven of eight measures
- Children's Hospital of Orange County (CHOC) met five of six measures
- Shared Risk Groups (SRGs) met five of six measures

- The 6.0 Evaluation and Management (E&M) Per Member Per Year (PMPY) standard for the members in the aged aid category challenges most networks
- Telehealth Services are included as part of the E&M PMPY Calculations
- No CAPS are issued for Semiannual Reports, per policy

For Table B:

- Networks met all measures
- Networks met three of four measures
- One network met two of four measures
- Telehealth Services are included as part of the E&M PMPY Calculations
- No CAPS are issued for Semiannual Reports, per policy

For Table C:

- HMOs and PHCs met at least six of eight measures
- CHOC met six of six measures
- SRGs met five of six measures
- The 6.0 E&M PMPY standard for the members in the aged aid category challenges most networks
- Telehealth services are included as part of the E&M PMPY Calculations

Table D:

- Five networks met all measures
- Networks met three of four measures
- One network met two of four measures
- Telehealth Services are included as part of the E&M PMPY Calculations

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>• One health network for OneCare did not meet the minimum number of measures</li> </ul>	<ul style="list-style-type: none"> <li>• Encounters are working with this health network to identify reasons</li> </ul>
Conclusion: The majority of health networks are meeting the reporting standards.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>• Scorecard will be changing for 2025 to report encounter timeliness and rejection rates only</li> </ul>	

## 4.2 Population Health Management

### 4.2.1 2024 CalOptima Health Membership (Risk Stratification)

Business Owner: Katie Balderas

Support Staff: Barbara Kidder/Hannah Kim

Description:

At least annually, CalOptima Health segments and stratifies its entire member population based on potential risk factors such as health outcomes, utilization and claims data. This process aims to target focused interventions for members who are most likely to benefit. The segmentation and risk stratification methodology informs resource allocation and the development of tailored interventions such as program access and eligibility for specific services.

CalOptima Health divides its member population into segments using information collected from population assessments and other sources. These segments are defined by shared needs, characteristics, identities, conditions or behaviors and include the following:

- Low risk
- Medium risk

- High risk
- Highest risk

Based on these risk levels, members may receive a variety of services and interventions, including but not limited to:

- Basic Population Health Management
- Chronic Condition Management
- Complex Care Management
- Enhanced Care Management

CalOptima Health's Enterprise Analytics (EA) developed internal SQL queries to calculate each sub-population. This monthly identification and stratification process leverages paid claims, encounters, utilization, authorizations, pharmacy records and lab data. Members are stratified based on severity of condition, comorbidities and utilization characteristics. Practitioners are updated annually on the risk level of their members and may be informed more frequently when significant changes in utilization characteristics occur.

Further details of CalOptima Health Membership Segmentation and Risk Stratification can be found in Appendix B: 2024 CalOptima Health Membership (Risk Stratification)

#### 4.2.2 Population Health Management Strategy with Population Need Assessment (PNA)

Business Owner: Katie Balderas

Support Staff: Barbara Kidder/ Janette Valladolid/ Maria Nguyen

Work Plan Goal/Objective:

Implement PHM Strategy and complete the Evaluation of the 2024 PHM Strategy

Goal Met: ☒ Yes ☐ No ☐ Partial

Executive summary:

The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of members across the continuum of care. CalOptima Health's PHM Strategy addresses the following areas of focus:

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

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

- Overall member population, including member's physical, behavioral and social health needs
- Children and adolescent members ages 2–19 years old
- Members with disabilities
- Disparities among members based on their racial and ethnic identity
- Disparities among members with limited English proficiency
- Relevant focus populations, including pregnant members and members experiencing homelessness

Key findings from the PNA are used to inform the PHM Strategy and Workplan, which aim to address gaps in member care through intervention strategies and quality initiatives. A majority of the goals within the PHM Strategy and Workplan are on pace to be met pending MY2024 final rates to be released. A

subgoal under the Street Medicine Program is not being met based on the lack of affordable housing opportunities for unhoused residents of Orange County.

Full details of the 2024 PHM Strategy Evaluation can be found in Appendix C: 2024 Population Health Management Impact Report.

#### 4.2.3 Initial Health Appointment

Business Owner: Katie Balderas | Department: Equity and Community Health

Support Staff: Anna Safari/Stephanie Johnson

Products: ☒ Medi-Cal ☐ OneCare | New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective:

- Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.

The program aims to strengthen primary care and promote prevention and wellness for all CalOptima Health members. As of January 2023, DHCS notified that primary care visits and screenings will be proxy measures for IHA completion. Therefore, primary efforts were made to increase overall Initial Health Appointment (IHA) completion rates. To reach this goal, the following initiatives were arranged:

1. Increase communication and provide training to health networks and CHCN providers.
2. Enhance member outreach efforts by conducting outreach to all newly enrolled members in the following methods: Interactive Voice Response (IVR) calls, Medi-Cal member newsletters, Medi-Cal New Member Handbook, New Member Packet and IHA Member Outreach Script for Member-facing staff
3. Improve oversight of the IHA processes:
  - a. Health Networks (including CHCN): Effective in 2024, CalOptima Health's key performance indicator (KPI) for the IHA is benchmarked at 50% for all health networks. CalOptima Health will meet regularly with the health networks to monitor IHA performance and inform them of updates and their IHA completion performance rates.
  - b. CHCN Providers: CalOptima Health has incorporated a Chart Review Pilot process for CHCN providers to enhance monitoring of IHA compliance. This process involves a detailed review of member medical records to verify that IHAs are completed accurately and in a timely manner. By analyzing documentation in patient charts, CHCN providers can ensure compliance with IHA requirements, identify areas needing improvement and support quality care standards. This initiative aims to improve the overall IHA completion rates and quality compliance to support providers in meeting established key performance indicators, contributing to more effective member engagement and health outcomes.

Goal Met: ☐ Yes ☒ No ☐ Partial

Work Plan Planned Activities:

Assess and report the following activities:

- Increase health network and provider communications, trainings and resources
- Expand oversight of provider IHA completion
- Increase member outreach efforts
- Other planned activities
  1. Data and Reports
  2. Oversight and Monitoring
  3. Member Outreach
  4. Health Network Education and Engagement
  5. Provider Training and Resources

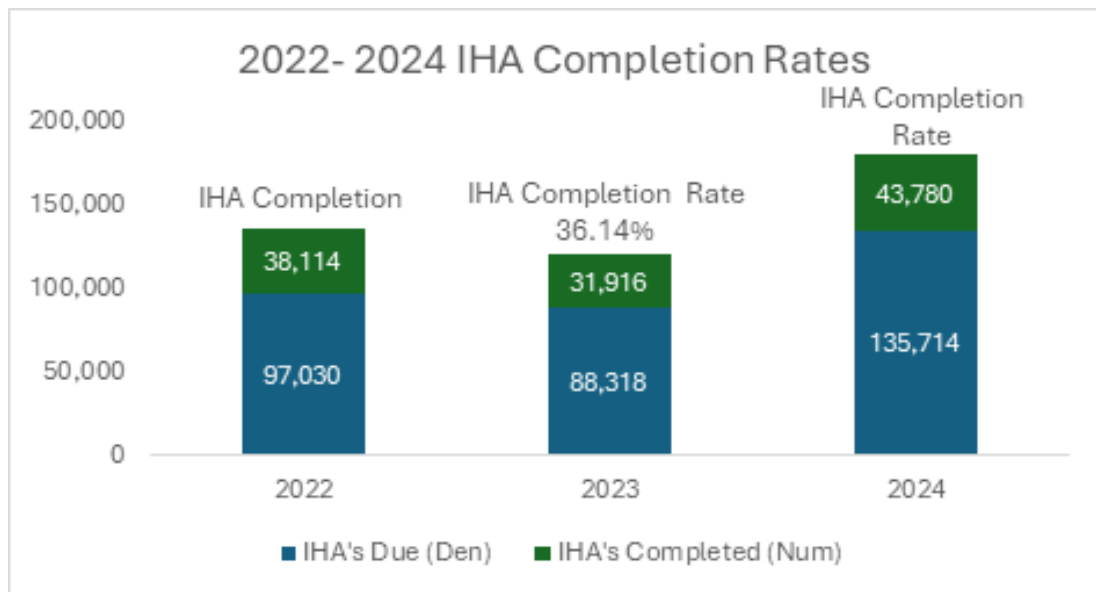
<p>Status:    <input type="checkbox"/> Completed    <input checked="" type="checkbox"/> Ongoing</p>
<p>Background:</p> <p>DHCS requires that all newly enrolled members be offered and provided access to an IHA within the first 120 days of their enrollment date. The IHA is a comprehensive assessment completed during the member's first visit with their selected or assigned PCP. The IHA must be provided in a way that is culturally and linguistically appropriate for the member. For members under the age of 21, the IHA should be offered within 120 days following the date of enrollment or within the most recent Bright Futures periodicity timelines established by the American Academy of Pediatrics for ages 2 and younger, whichever is less. The IHA encompasses gathering the member's physical and behavioral health history, identifying risks, assessing the need for preventive screenings or services and health education, and establishing a diagnosis and treatment plan for any identified diseases.</p>
<p>Methodology:</p> <p>CalOptima Health uses claims and encounters data and quality measures</p> <p>1. Claims and Encounters for IHA Completion:</p> <p>The IHA Performance Report continuously extracts and processes claims data to track the completion of IHA for eligible members. The report aligns claims data with members' enrollment dates and filters for specific billing codes to confirm an IHA has been completed. This data is aggregated and integrated into the Delegation Oversight Committee (DOC) Dashboard monthly. The DOC Dashboard is leveraged to track IHA completion rates across health networks. In 2023, CalOptima Health increased the IHA KPI benchmark for all health networks from 17% to 50%. This increase aligns with DHCS standards to ensure improved access to comprehensive preventive care for Medi-Cal members. Furthermore, these adjustments aim to address gaps in care by holding health networks accountable for prioritizing IHA completion, which plays a foundational role in improving health outcomes and reducing disparities. Additionally, the DOC Dashboard is used to share IHA performance rates with health networks, so they are aware of their compliance with this measure.</p> <p>2. Quality Measures for IHA Proxy:</p> <p>CalOptima Health leverages MCAS and HEDIS measures specific to adult preventive visits and infant/child/adolescent well-being visits as a proxy for IHA completion. MY2024 Prospective Rate Report for CalOptima Health Medi-Cal (P4V) is produced by CalOptima Health's Quality Analytics for each health network and CHCN, demonstrating monthly quality measure performance metrics. The Prospective Rate Report demonstrates health network performance on the quality measures used as a proxy for IHA completion. IHA completion is tied to quality and compliance utilizing the MCAS measures that help track preventive care and overall member engagement. This information is shared with each HN at their respective bimonthly Quality Update Meeting.</p> <ul style="list-style-type: none"> <li>• Depression Screening and Follow-Up for Adolescents and Adults</li> <li>• Child and Adolescent Well-Care Visits</li> <li>• Childhood Immunization Status — Combination 10</li> <li>• Developmental Screening in the First Three Years of Life</li> <li>• Immunizations for Adolescents — Combination 2</li> <li>• Lead Screening in Children</li> <li>• Topical Fluoride for Children</li> <li>• Well-Child Visits in the First 30 Months of Life — 0 to 15 Months — Six or More Well-Child Visits</li> <li>• Well-Child Visits in the First 30 Months of Life — 15 to 30 Months — Two or More Well-Child Visits</li> <li>• Chlamydia Screening in Women</li> <li>• Breast Cancer Screening</li> <li>• Cervical Cancer Screening</li> <li>• Adults' Access to Preventive/Ambulatory Health Services</li> </ul>
<p>Actions/Interventions Implemented in 2024:</p>

Quarter 1:	<ul style="list-style-type: none"> <li>• Joint Operation Meetings (JOM) Presentations: JOM ongoing monthly presentations are provided to all health networks in efforts to offer IHA updates, performance rates and reminders. IHA was presented at six JOMs in Quarter 1.</li> <li>• CHCN Virtual Learn: Ongoing quarterly presentations are provided to CHCN to offer IHA updates, performance and reminders. Presentation at Q1 CHCN Virtual Learn Meeting held on February 29, 2024.</li> <li>• Provider Newsletter: Monthly CalOptima Health updates to providers. IHA updates are shared in the March Provider Newsletter.</li> <li>• Health Network Newsletter: Weekly newsletter sent out to all health networks with important updates and upcoming events from CalOptima Health. Notification on IHA updates sent in Health Network Weekly Newsletter for week of February 12–16, 2024.</li> <li>• QIHEC: Meeting with CalOptima Health leaders to provide direction and oversight of quality improvement processes related to regulatory requirements. IHA updates shared on February 13, 2024.</li> <li>• IHA Reference Guide for PCPs: A guide for PCPs to complete the IHA within 120 days from the member's enrollment date with CalOptima Health. This document is shared on the <a href="http://www.caloptima.org">www.caloptima.org</a> website and provided as a resource during trainings.</li> <li>• Community Health Centers Monthly Forum: A monthly meeting to collaborate and provide important updates from CalOptima Health. IHA updates shared on February 29, 2024.</li> <li>• Implement Quarterly IHA Chart Review Audit Pilot for CHCN providers.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Quality Update Meetings: Bimonthly quality presentations are to all health networks in an effort to offer IHA updates, performance rates and reminders. IHA was presented to all health networks in May.</li> <li>• CHCN Virtual Learn: IHA updates shared at Q2 CHCN Virtual Learn Meeting held on July 8, 2024.</li> <li>• Provider Newsletter: IHA updates shared in the May and June provider newsletters.</li> <li>• Provider Onboarding: Training provided to all new CHCN contracted providers. Training was reviewed and updated in the overall presentation given to newly contracted CHCN providers. This training was updated in April and uploaded to the Provider section of <a href="http://www.caloptima.org">www.caloptima.org</a></li> <li>• Provider Annual Training: Yearly training for CHCN contracted providers to discuss updates and ongoing education. This training was updated in April and uploaded to the Provider section of <a href="http://www.caloptima.org">www.caloptima.org</a></li> <li>• Health Network Collaborative Quality Forum: Quarterly meeting held with all health networks to provide updates on various quality measures. IHA updates were presented on April 11, 20 24.</li> <li>• Health Network Forum: Quarterly meeting held for purposes of planning, collaboration and providing updates. IHA updates presented on April 18, 2024.</li> <li>• QIHEC: IHA updates shared on June 11, 2024.</li> <li>• PHMC: IHA updates shared at meeting held on May 16, 2024.</li> <li>• Quarterly IHA Chart Review Audit Pilot for CHCN providers.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• Quality Update Meetings: IHA was presented to all health networks in July and September.</li> <li>• PHMC: Shared IHA updates on May 16, 2024.</li> <li>• Health Network Collaborative Quality Forum: IHA updates shared on April 10, 2024.</li> <li>• Health Network Newsletter: Notification to promote IHA CME sent newsletter for week of August 5–9, 2024.</li> </ul>

	<ul style="list-style-type: none"> <li>Continuing Medical Education: An annual webinar for medical professionals to learn more about the IHA requirements and best practices to complete the IHA with their patients. Webinar held on August 14, 2024.</li> <li>CHCN Virtual Learn: IHA updates shared at Q3 CHCN Virtual Learn Meeting held on September 25, 2024.</li> <li>QIHEC: IHA updates shared on August 13, 2024.</li> <li>PHMC: IHA updates shared at meeting held on August 15, 2024.</li> <li>Quarterly IHA Chart Review Audit Pilot for CHCN providers.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Quality Update Meetings: IHA was presented to all health networks in November.</li> <li>CHCN Virtual Learn: IHA updates shared at Q4 CHCN Virtual Learn Meeting held on December 5, 2024.</li> <li>Health Network Forum: IHA updates presented on November 21, 2024.</li> <li>QIHEC: IHA updates shared on November 5, 2024.</li> <li>PHMC: IHA updates shared at meeting held on November 21, 2024.</li> <li>QAC: IHA updates shared at meeting held on October 9, 2024.</li> <li>Quarterly IHA Chart Review Audit Pilot for CHCN providers.</li> </ul>

Program Results:

Chart A: 2022-2024 IHA Completion Rates: Three consecutive annual trends of IHA compliance rates



\* Please note data was generated on 12/5/2024 from IHA Core Report CC0163B. IHA completion rates are retrieved from claims data and require at least 3 months to be retrieved after the reporting period to account for any claims data lag; data pulled for 2024 is preliminary.

**Table A: 2024 IHA Completion Performance: Quarterly Rates for All Ages vs. Members ≤18 Months Compared to 50% KPI Benchmark**

**2024 IHA Performance**

	<i>Num</i>	<i>Den</i>	<i>Qtr. 1</i>	<i>Num</i>	<i>Den</i>	<i>Qtr. 2</i>	<i>Num</i>	<i>Den</i>	<i>Qtr. 3</i>	<i>Num</i>	<i>Den</i>	<i>Qtr. 4</i>
<b>All Ages</b>	6300	14929	<b>42.2%</b>	17359	60153	<b>28.86%</b>	10669	27985	<b>38.12%</b>	6001	16541	<b>36.28%</b>
<b>≤ 18 months</b>	1471	2003	<b>73.4%</b>	1687	2408	<b>70.06%</b>	1810	2645	<b>68.43%</b>	1191	2146	<b>55.50%</b>

*\* Please note data was generated on 12/4/2024 from IHA Core Report CC0163, and Quarter 4 data is trending. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after reporting period to account for any claims data lag.*

**Table B: 2022–2024 IHA Completion Rates: Annual rates for IHA completion over three consecutive years**

	<b>2022–2024 IHA Completion Rates</b>		
	<i>2022</i>	<i>2023</i>	<i>2024</i>
<b>IHAs Due (Denominator)</b>	97,030	88,318	135,714
<b>IHAs Completed (Numerator)</b>	38,114	31,916	43,780
<b>IHA Completion Rate</b>	38.12%	36.14%	32.25%

*\* Please note data was generated on 12/5/2024 from IHA Core Report CC0163B. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after the reporting period to account for any claims data lag; data pulled for 2024 is preliminary.*



**Table C: 2024 IHA Completion Rates by Health Network: Quarterly Performance Against 50% KPI Benchmark**

2024 IHA Performance				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CalOptima Health Community Network (CHCN)	48.71%	40.96%	51.02%	46.76%
CalOptima Health Direct (CHD)	92.43%	58.75%	57.80%	57.33%
Alta Med	29.32%	23.30%	28.07%	26.15%
AMVI	27.01%	20.52%	29.56%	25.12%
CHOC	66.67%	57.51%	61.21%	54.97%
Family Choice	31.68%	20.08%	28.67%	25.25%
HPN-Regal	21.67%	17.88%	23.37%	17.20%
Noble	21.08%	13.72%	22.37%	19.94%
Optum	30.61%	19.97%	30.85%	25.41%
Prospect	26.86%	20.90%	28.43%	23.35%
United Care	27.46%	21.06%	29.02%	27.36%

*\* Please note data was generated on 12/4/2024 from IHA Core Report CC0163, and Quarter 4 data is trending. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after reporting period to account for any claims data lag.*

**Table D: 2024 IHA Chart Review Pilot Compliance: Gaps by Component**

IHA Component	Compliant %	Num/Den
Timely- 120 Days	84.59%	302/357
Outreach Attempts (3), When No IHA Completed	5.74%	7/122
<b>All Components Covered:</b>		
Physical Health History	96.64%	345/357
Mental Health History	90.76%	324/357
Physical Exam	95.24%	340/357
Identification of Risks	96.36%	344/357
Diagnosis	96.92%	346/357
Plan for Treatment	97.20%	347/357
Preventive Services	97.76%	349/357
Health Education	93.00%	332/357
<b>Additional Components (Ages 6-72 Months)</b>		
Anticipatory Guidance on Harms of Blood Lead Exposure	68.18%	15/22
BLL Testing	50.00%	11/22
IHA Completed by PCP Type	100%	350/350

*\* Please note that data was generated on 12/5/2024 from IHA Chart Review tracking. IHA compliance is preliminary as the ECH team continues to conduct ongoing IHA Chart Reviews.*

#### Quantitative Analysis:

A collective review of IHA performance among completion and compliance rates provides a comprehensive review that accounts for the quantity of IHAs due and completed that are being validated through claims data. The IHA Chart Review process checks for compliance with IHA requirements, encompassing quality of care.

In 2024, the ECH Department introduced the IHA Chart Review Audit Pilot for CHCN providers. This process is key in the oversight of compliance with IHA requirements. It allows CalOptima Health to effectively monitor provider performance by identifying those who fall below the 90% compliance threshold and enables detailed insight into documentation and delivery of care gaps. The 2024 IHA compliance rates are reflected in Table D, which shows gaps in documentation by component for completed chart reviews. Overall, providers who completed IHAs scored fairly high in completing the IHA components but fell short in blood lead measures for children. Furthermore, for IHAs that were not completed, providers reviewed did not have sufficient documentation of outreach attempts to schedule members for their IHA visit.

Table C shows the health network IHA performance by quarter. In 2024, the IHA completion rates among health networks showed varied performance, with the top three performing networks—CalOptima Health Direct (CHD), CHOC, and CalOptima Community Network (CHCN)—meeting or exceeding the 50% KPI benchmark. CHD led with an impressive 92.43% completion rate in Q4, consistently exceeding the benchmark throughout the year, while CHOC and CHCN demonstrated significant improvement, achieving 66.67% and 51.02% in Q4. However, most other networks, including AltaMed, AMVI, and Optum, fell short of the goal, with marginal improvements and rates below 32%. In 2024, the Medi-Cal Expansion significantly increased Medi-Cal enrollment by broadening eligibility, resulting in a surge of new members requiring an IHA, reflected in quarter 2 and even into quarter 3, when these IHAs were due. The Medi-Cal expansion significantly increased the number of members requiring an IHA due to a surge in enrollment that allowed more individuals (specifically low-income adults without dependent children) to qualify for coverage, which directly led to an increase in the denominator in compliance calculations, necessitating robust strategies to track and manage appointments. The increase in newly enrolled members is evident in Chart A, where the number of IHAs due rose significantly from 88,318 in 2023 to 135,714 in 2024, indicating a 54% rise. Despite a decrease in IHA overall completion rate from 36.14% to 32.26% in 2024, the number of IHAs completed increased by 11,864 from 2023 to 2024, highlighting an improvement in absolute completions amidst the surge in demand. This reflects the challenges in scaling resources and operational capacity to meet the growing demand. The sharp rise in the denominator significantly outpaced the growth in numerators, underscoring the need for process enhancements and greater provider engagement to sustain compliance and performance amidst rising member volumes.

Furthermore, Table A indicates the rise in adult enrollment into Medi-Cal through the Medi-Cal expansion, when observing the variation in denominator values: 14,929 in quarter 1; 60,153 in quarter 2; 27,985 in quarter 3; and 16,541 in quarter 4. Quarter 2 showed significant delays in completing IHAs due to the overflow from quarter 1 enrollments due to the growing demands from expanding the Medi-Cal member base. These operational delays led to the lowest performance rates during 2024. Interventions to improve communication with health networks and providers were implemented to address the concerns with low rates. As communication increased and Medi-Cal expansion stabilized, the rates in quarter 3 started to recover. By the end of quarter 3, 2024, 34,328 IHAs had been completed compared to the 31,916 IHAs completed over the full year for 2023.

Identified Barriers:	Identified Opportunities for Improvement:
<p>Operational Barriers</p> <ul style="list-style-type: none"> <li>• Medi-Cal Expansion: Increased Medi-Cal enrollment in early 2024, which led to a surge in IHAs due in Q2 and Q3</li> <li>• Leveraging reports and data produced by other teams within CalOptima Health for IHA performance</li> <li>• Outdated member contact information</li> <li>• IHA Reports: Methodology does not account for members who may not have had continuous enrollment or disenrolled prior to 120 days and are therefore considered exempt from IHA completion, which can be inflating the denominator and ultimately bringing the overall completion rate down</li> <li>• Lack of staff with scope of competency skills dedicated to IHA process and oversight</li> </ul> <p>Health Network Barriers</p> <ul style="list-style-type: none"> <li>• Unclear Accountability Structure: An unclear network structure made it difficult for ECH to hold health networks accountable for meeting IHA benchmarks</li> <li>• Lack of responsiveness to Delegation Oversight Dashboard Response (DODR) form.</li> <li>• High staff turnover required ongoing training of new staff</li> </ul> <p>Provider Barriers</p> <ul style="list-style-type: none"> <li>• Access to Provider Portal: unaware of how to access IHA reports</li> <li>• Non-responsive clinics</li> <li>• Data format variability</li> <li>• Clinic staffing shortages</li> </ul>	<p>Operational</p> <ul style="list-style-type: none"> <li>• Building stronger working collaborations with Quality Improvement and Delegation Oversight departments</li> <li>• IHA Reports: Make enhancements to methodology for IHA reports used to report IHA completion rates so members who are exempted from IHA completion are not included in the data, leading to more accurate data to report</li> <li>• Hire dedicated IHA team</li> </ul> <p>Health Network</p> <ul style="list-style-type: none"> <li>• DO assigned representatives to oversee network IHA performance oversight and remediation efforts to support and hold networks accountable; Delegation Oversight Dashboard Response Forms presented to all health networks to fill out and return to CalOptima Health so we can track their efforts for improvement on IHA performance</li> <li>• In 2025, DO will be working with ECH to begin issuing CAPs to health networks who are not making efforts to improve performance rates</li> <li>• Elicit CHCN CEO supper and intervention</li> </ul> <p>Provider</p> <ul style="list-style-type: none"> <li>• Direct outreach efforts via in-person site visits</li> <li>• Targeted staff training on the submission of chart review records through the secured file transmission protocol (SFTP)</li> <li>• Initiated virtual chart review audits</li> <li>• Granting appropriate extensions for record submission</li> </ul>
<p>Conclusion:</p> <p>The findings of this report reveal the progressive achievements and areas for improvement in the IHA program. While the overall completion rates decreased to 32.26% in 2024 due to the surge in newly enrolled Medi-Cal members, the number of IHAs completed increased by 11,864 from 2023 to 2024, signifying progress amidst the rising demand for IHAs. Additionally, the 2024 data highlight the variability in IHA completion rates across health networks, with only a few networks meeting or exceeding the increased KPI benchmark of 50%. While some networks, such as CHOD and CHOC, demonstrated strong performance and effective strategies for handling the surge in IHAs, most networks underperformed, indicating challenges in addressing barriers. The program's success is evident in networks that implemented robust workflows, member engagement strategies and provider support, which could serve as a model for underperforming networks. This mixed performance suggests that while the program has made progress in aligning with DHCS standards and improving IHA completion, it is not yet universally successful across all networks.</p>	

Overall, the program successfully expands access to preventative care and improves IHA compliance through the IHA Chart Review process. The collaboration between ECH and DO is pivotal in ensuring health networks meet IHA completion and compliance standards. Through this partnership, DO leverages performance monitoring tools, such as the DOC Dashboard, and issues remediation efforts.
Activities/Interventions to continue/add next year:
<ul style="list-style-type: none"> <li>All activities listed under the “Actions/Interventions Implemented in 2024” section will continue in 2025.</li> <li>CAP implementation processes will begin for health networks not meeting the KPI metric threshold for IHA performance, and for CHCN providers that do not pass their IHA Chart Review audits per the written process.</li> </ul>

## 4.2.4 Special Needs Plan (SNP) Model of Care (MOC)

4.2.4.1 OneCare Model of Care: Health Risk Assessment (HRAs)	
Author: Sherry Hickman	Department: Case Management
Responsible Party(ies): Hannah Kim, Megan Dankmyer	
Products: <input type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective:	
<ul style="list-style-type: none"> <li>Percentage of Members reached and willing to complete HRA: Goal 100% of DHCS adjusted scoring</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities:	
<ul style="list-style-type: none"> <li>Ongoing monitoring of initial HRA completion for achieving three Stars.</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: Newly enrolled OneCare members are required to have outreach and Health Risk Assessment (HRA) collection within the first 90 days of enrollment. The HRA informs the development of a member-centric care plan by the care team. Members are required to have annual HRA outreach at a minimum on an annual basis with a collection of HRA <365 days from the prior HRA. Data from initial and annual HRA collection is reported to both DHCS and CMS.	
Methodology: HRA1: Members must have a qualifying outreach that occurs within the first 90 days of eligibility. Qualify outreach: Members who decline to participate, members who are unable to be contacted after a minimum of three telephonic attempts on different days or members who complete an assessment.	
Methodology: CMS qualifying HRA: The initial HRA must be collected within 90 days of eligibility, and there must be less than 365 days between HRAs on an annual basis.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>Utilize newly developed monthly reporting to validate and oversee outreach and completion of HRA1 per regulatory guidance.</li> <li>As of March 31, 2024, 22% of HRAs completed to date for measure year 2024.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>Q1 HRA1 DHCS adjusted score: Members reached and willing to complete HRA is 100%</li> <li>CMS 2 Star Rating achieved on June 30, 2024, with 41% of HRAs completed.</li> <li>Usher text messaging reminders for members who were UTC and due in April</li> <li>OC HRA incentive flyer finalized, approved and mailed to 1,000 reset members.</li> <li>Usher online HRA distributed to team members to begin utilization</li> <li>Usher pilot launched to complete HRA through Short Message Service (SMS)</li> </ul>

	<ul style="list-style-type: none"> <li>HRA flyer mailed to 1,000 reset members</li> <li>Continue to use monthly reporting to validate and oversee outreach and completion of HRA1</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Q2 HRA1 DHCS adjusted score: Members reached and willing to complete HRA is 100%</li> <li>CMS increased cut points for Star Measure on HRA completion by 4%</li> <li>Continue to use monthly reporting to validate and oversee outreach and completion of HRA1</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Q3 HRA1 DHCS adjusted score: Members reached and willing to complete HRA is 100%</li> <li>Additional reminders in October and November to initial and annual members due for HRA who did not respond after four or more call attempts via texting.</li> <li>Staff volunteered at community event to complete HRAs in person.</li> <li>Achieved 62% HRA completion on October 23, 2024 which equates to a CMS 3 Star rating.</li> <li>CareNet outreach to members with no HRA in 2023 or 2024.</li> </ul>

Program Results:

Table A

Reporting Period 2024	Members Newly Enrolled	Members Who Declined	Members Who Were UTC	% Members Who Were UTC	Members Who Completed HRA	% Members Who Completed HRA	Members reached, Willing & Completed HRA
Quarter 1	652	15	77	12%	559	86%	100%
Quarter 2	732	40	68	9%	624	85%	100%
Quarter 3	845	15	110	13%	720	85%	100%
Quarter 4*	*NA	*NA	*NA	*NA	*NA	*NA	*NA

HRA1 Members with Health Risk Assessment completed within 90 days of enrollment as reported to DHCS.

\*Quarter 4 in process and not yet finalized at time of submission.

**Table B**

Reporting Period 2023	Members Newly Enrolled	Members Who Declined	Members Who Were UTC	% Members Who Were UTC	Members Who Completed HRA	% Members Who Completed HRA	Members reached, Willing & Completed HRA
Quarter 1	952	93	252	26%	605	64%	100%
Quarter 2	879	45	159	18%	675	77%	100%
Quarter 3	814	28	149	18%	637	78%	100%
Quarter 4	678	22	97	14%	559	82%	100%

*HRA1 Members with Health Risk Assessment completed within 90 days of enrollment as reported to DHCS*

**Table C**

SNP Care Management Measure	Percent of Qualifying HRAs collected	Star Rating
2021 Measurement Year	36%	One
2022 Measurement Year	35%	One
2023 Measurement Year	52%	Two
2024 Measurement Year (in process)	64% as of 12/5/2024	Three

*CMS HRA Star Rating.*

**Quantitative Analysis:**

- HRA outreach and collection meet program objectives.
- HRA1 results for UTC and Completed HRA are stable for 2024 (Table A).
- When HRA1 is compared with 2023 HRA1 reporting (Table B) there is a decrease in members who are UTC and increase in members who completed the HRA.
- Table C shows CMS ratings for the past four measurement years demonstrating significant increase in volume of qualifying HRAs collected.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>• Members who are UTC despite numerous attempts to reach.</li> </ul>	<ul style="list-style-type: none"> <li>• Decrease the percentage of members who are UTC</li> </ul>

**Conclusion:** The process for HRA outreach and collection is successful and demonstrates improvement from prior year results. This improvement contributes to the CMS Star Ratings.

**Activities/Interventions to continue/add next year:**

- Continue: Monitoring of HRA1 completion for DHCS quarterly reporting
- Continue: HRA outreach by external vendor, CareNet
- Continue: HRA outreach through Usher using SMS

- Continue: Member incentive for HRA completion
- Continue: Monitor percentage of HRA Completion for CMS Star ratings
- Add: Evaluation of race and ethnicity in the UTC population for identification of disparity.
- Add: Report on HRA2 DHCS 2024 annual reporting in Quarter 1 2025

4.2.4.2 OneCare Model of Care Interdisciplinary Care Team (ICT) and Individual Care Plan (ICP)	
Author: Sherry Hickman	Department: Case Management
Responsible Party(ies): Hannah Kim, Megan Dankmyer	
Products: <input type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: <ul style="list-style-type: none"> <li>• Percentage of Members with ICP: Goal 100% of DHCS adjusted scoring for members reached and willing to complete a care plan.</li> <li>• Percentage of Members with ICT: Goal 100%</li> </ul>	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
Work Plan Planned Activities: <ul style="list-style-type: none"> <li>• Assess and report the following activities:             <ul style="list-style-type: none"> <li>○ Utilize newly developed monthly reporting to validate and oversee outreach and completion of ICP per regulatory guidance.</li> <li>○ Develop communication process with networks for tracking outreach and completion to meet benchmarks.</li> <li>○ Creation and implementation of the oversight audit tool.</li> <li>○ Updated oversight process implementation and monitoring.</li> </ul> </li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: Newly enrolled OneCare members are required to have an Individualized Care Plan (ICP) developed within 90 days of eligibility through the Interdisciplinary Care Team (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 HRA and by the ICT. The member's care plan is updated at least annually and when there is a change in health status. Data for the initial and annual ICP development is reported to DHCS.	
Methodology ICP1: Members must have qualifying outreach for purposes of developing the ICP. Members may decline to participate or may be considered as UTC if at least three attempts are made within 90 days of eligibility. Data on ICP1 is reported to DHCS quarterly.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>• Core Report CC0258 in phase II Jiva Remediation for ICT/ICP data.</li> <li>• Communications to health networks in January, February and March on ICP development status for newly effective members.</li> <li>• Addition of annual ICP development status on the March file.</li> <li>• Communication included identification of members who were also ECM-Like.</li> <li>• Ongoing quarterly audits of delegated health networks.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Core Report CC0258 continues in phase II Jiva Remediation for ICT/ICP/HRA data.</li> <li>• Q1 ICP1 DHCS quarterly reported adjusted score: Members reached and willing to complete ICP is 64%</li> <li>• ICT rates pending Jiva Phase II remediation</li> <li>• Communications to CHCN and health networks in April and May on ICP development status for newly effective members Q1 and Q2</li> <li>• Addition of annual ICP development status on April and May file</li> <li>• Communication of ECM-like eligibility and members missing face-to-face interaction</li> </ul>

	<ul style="list-style-type: none"> <li>• Ongoing quarterly audits of delegated health networks</li> <li>• Creation and implementation of the oversight audit tool.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• CC0258 partially remediated</li> <li>• Q2 ICP1 DHCS quarterly reported adjusted score: Members reached and willing to complete ICP is 91%</li> <li>• ICT reporting pending Jiva remediation and development of SNPE reporting</li> <li>• Ongoing monthly communications to CHCN and health networks for ICP1 development status for newly effective member</li> <li>• Continue to provide feedback on annual ICP development and missing face-to-face interactions.</li> <li>• Audit tool under review for updates</li> <li>• Ongoing quarterly audits</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• CC0258 partially remediated and will resume per JIVA remediation priorities</li> <li>• Q3 ICP2 DHCS quarterly reported adjusted score 98%</li> <li>• ICT-pending Jiva remediation and development of SNPE reporting.</li> <li>• MOC tracking file revision in development to add additional ICT Metrics</li> <li>• ICP dashboard created by EA for CM implementation in monthly communication</li> </ul>

Program Results:

Table A

Reporting Period 2024	Members Newly Enrolled	Members Who Declined	Members Who Were UTC	% Members Who Were UTC	Members Who Completed Care Plan	% Members Who Completed Care Plan	Members reached, Willing & Completed care plan
Quarter 1	652	163	261	40%	147	23%	64%
Quarter 2	732	200	310	42%	203	28%	91%
Quarter 3	845	228	382	45%	231	27%	98%
Quarter 4*	*NA	*NA	*NA	*NA	*NA	*NA	*NA

ICP1 Members with Individual Care Plan completed within 90 days of enrollment as reported to DHCS.

\*Quarter 4 in process and not yet finalized.

Table B



Reporting Period 2023	Members Newly Enrolled	Members Who Declined	Members Who Were UTC	% Members Who Were UTC	Members Who Completed Care Plan	% Members Who Completed Care Plan	Members reached, Willing & Completed Care Plan
Quarter 1	952	99	133	14%	206	43%	56%
Quarter 2	879	82	178	20%	371	54%	76%
Quarter 3	814	124	185	23%	471	46%	73%
Quarter 4	678	147	228	34%	406	30%	68%

ICP1 Members with Individual Care Plan completed within 90 days of enrollment as reported to DHCS.

Quantitative Analysis:

- DHCS ICP1 adjusted quarterly completion rate did not meet goal for Q1 and Q2 (Table A).
- Goal was within benchmark for Q3 with 98% of members having ICP completed within 90 days.
- When ICP1 for 2024 is compared to ICP1 2023 there is significant movement in percentage of members reached and willing to participate in ICP development.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"><li>Members who are UTC despite outreach attempts.</li></ul>	<ul style="list-style-type: none"><li>Interventions to reduce UTC rates</li></ul>

Conclusion: Results for DHCS reporting on ICP1 demonstrate improvement. Consistent communication to the delegated networks that identify gaps or care plans coming due contributes to this improvement. There is an opportunity to evaluate interventions that may lower the UTC rates.

Activities/Interventions to continue/add next year:

- Continue: Monitoring of ICP1 completion for DHCS quarterly reporting using MOC tracking file, Core CC0258 and ICP Dashboard
- Continue: Communications to CHCN/HN for ICP status for both initial and annual care plans
- Continue: Identification of members who are missing face-to-face interactions in the past 12 months
- Continue: Quarterly audits of delegated health networks.
- Add: Implement revision of MOC tracking for ICT monitoring
- Add: Share UTC trends for 2024 with CHCN/HN
- Add: Report on ICP2 DHCS 2024 annual reporting in Quarter 1 2025

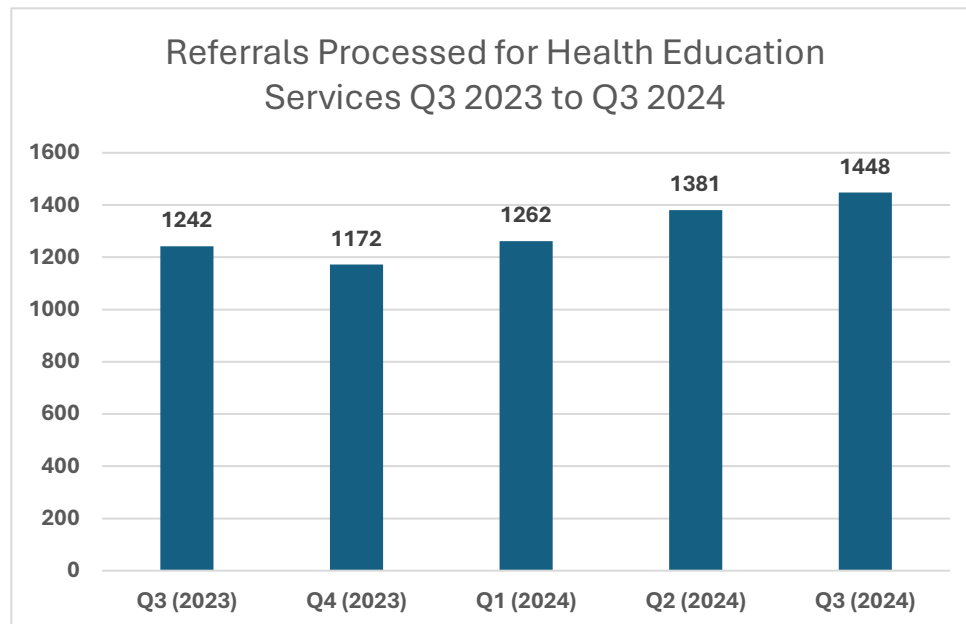
## 4.3 Keeping Members Healthy

<b>4.3.1 Health Education Services</b>	
Business Owner: Thanh Mai/Katie Balderas	Department: Equity and Community Health
Support Staff: Michael Molina/Anna Safari	
Work Plan Element: Implement Health Education Program	
Products: <input type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective:	
<ul style="list-style-type: none"> <li>Increase member participation in health education services</li> </ul>	

<ul style="list-style-type: none"> <li>Establish new partnerships for class locations to increase Shape Your Life (SYL) Program participation by 50% from Q2 to Q4</li> <li>By December 31st, 2024, at least 40% of the SYL participants who completed the pre- and post-assessment will increase their knowledge of basic nutrition and healthy lifestyle.</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: <ol style="list-style-type: none"> <li>1) Evaluation of current utilization of health education services</li> <li>2) Maintain business for current programs and support for the community</li> <li>3) Improve the process of handling member and provider requests</li> </ol>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: Health Education programs and services are tailored to member needs with a “no wrong door” approach for accessing services. While the majority of health education referrals are sent by PCPs, many members also self-refer to services seeking support to make healthy lifestyle changes. Many members choose to receive telephonic health education services provided by trained health educators. Once a member is assigned to a team member, they will participate in assessments, individualized coaching and education, including receiving personalized health education materials by mail. Additionally, Shape Your Life (SYL) is a weight management program provided by the ECH department designed for children ages 5–18 and their families. Sessions foster healthy living through education about nutrition, physical activity and healthy habits, including sleep and stress management. Classes are provided virtually and in person, customized based on location and audience needs. SYL classes are open to the community and are provided in English, Spanish and Vietnamese.	
Methodology: <ol style="list-style-type: none"> <li>1. Referrals for health education services are received by email, fax and phone from providers, caregivers, community partners, health networks, CM department and members directly. The ECH department programs provide for the identification, assessment, stratification and implementation of appropriate interventions for all members, focusing on health conditions, including chronic diseases. Programs and materials use educational strategies and methods suitable for members, families and caregivers to make informed health decisions or modify health behaviors across the lifespan.</li> <li>2. Shape Your Life measures the participant’s knowledge of the class topic in an assessment of pre and post-multiple-choice questions (before and after the lesson). The assessments are implemented in both in-person and virtual classes, in the participant’s primary language.            Numerator = SYL participant who completed the pre and post-assessment with a gain.            Denominator = SYL participant who completed the pre and post-assessment with the exclusion of those who scored 100% on both pre and post-assessment.</li> </ol>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>Health and wellness services were promoted at all continuing education training sessions in 2024, along with reminders on how and where to send member referrals.</li> <li>1,242 referrals were processed for health education services. This was on track with similar referral counts for Q1 2023. Most incoming referrals were for weight management, but hypertension continued to be one of the top conditions.</li> <li>SYL class attendance was 50 in 2023 Q1, compared to 183 attendees in 2024 Q1. This includes 60 virtual and eight in-person classes.</li> <li>Promoted community classes using a standalone class flier and explored schools for further collaboration at new locations and for new topics.</li> </ul>

	<ul style="list-style-type: none"> <li>• Explored available services and blood pressure monitor utilization in relation to hypertension diagnoses, to identify gaps in services for members.</li> <li>• Worked on implementing a member self-referral form for health and wellness services.</li> <li>• Promoted Shape Your Life through Health Network Provider Relations department monthly emails to contracted providers and provider networks.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• 1,381 referrals were processed for health education services.</li> <li>• 67 SYL classes were completed with 568 participants. This includes 33 virtual and 34 in-person classes.</li> <li>• Virtual SYL classes were piloted two times a day on Tuesday, Wednesday and Thursday in English and Spanish.</li> <li>• The first Vietnamese in-person SYL class was implemented at a community center in Westminster.</li> <li>• The draft electronic member self-referral form was tested with participants attending virtual SYL classes. The form continues to be reviewed with the purpose of improving the member's self-referral experience.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• 1,448 referrals were processed for health education services. 48 SYL classes were completed with 540 attendees. This included 24 virtual and 24 in-person classes.</li> <li>• Based on SYL virtual class pilot results, virtual class options were reduced to two evening classes once a week in English and Spanish.</li> <li>• Work to implement an electronic referral form on the organization's website has been paused as the organization is prioritizing a complete website re-design, anticipated to launch in March 2025.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• 1,224 referrals were processed for health education services.</li> <li>• 14 virtual SYL classes were provided to 90 attendees.</li> </ul>
Program Results:	

Chart A



Referral sources: Provider, Pharmacy, Member/Family/Caregiver, Health Network, Customer Service and Case Management

Chart B

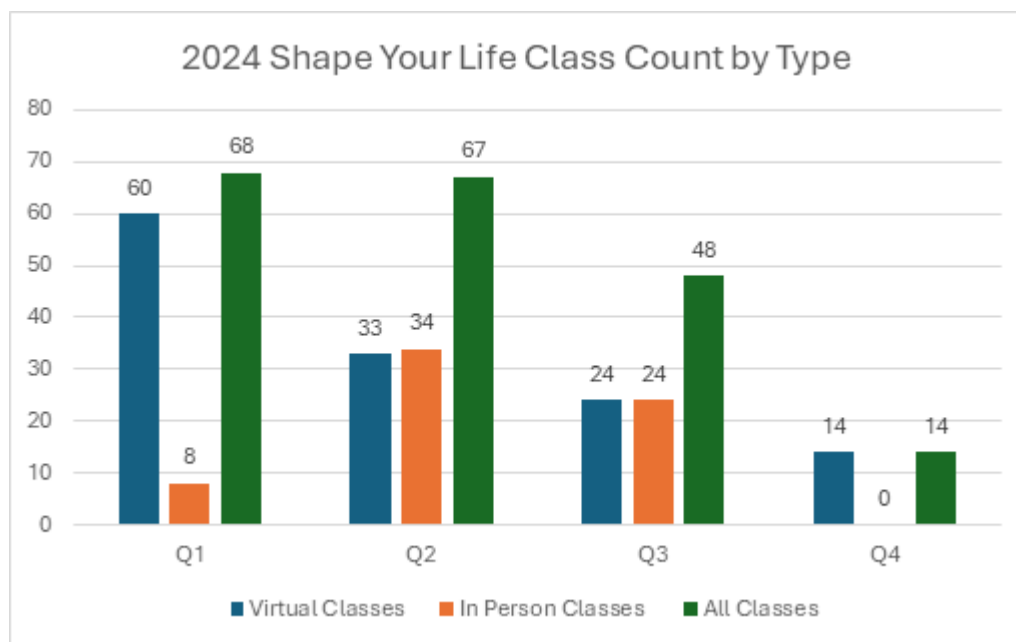
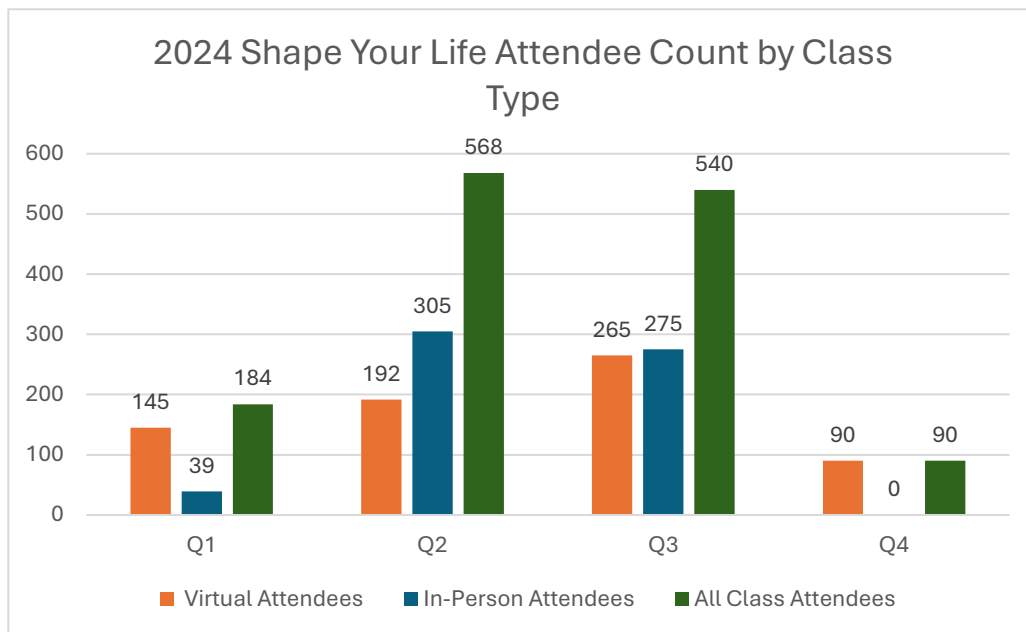


Chart C



2024 SYL Pre and Post Assessment Results by Quarter

	Child Assessment	Adult Assessment	Combined
Q1	20% (1 out of 5)	64.8% (46 out of 71)	61.8% (47 out of 76)
Q2	50.9% (56 out of 110)	54.7% (93 out of 170)	53.2% (149 out of 280)
Q3	29.7% (19 out of 64)	39.4% (63 out of 160)	34.2% (82 out of 240)
Q4	0% (0 out of 3)	62.1% (23 out of 37)	57.5% (23 out of 40)
<b>Total (Q1-Q4)</b>	<b>41.7% (76 out of 182)</b>	<b>51.3% (225 out of 438)</b>	<b>47.3% (301 out of 636)</b>

#### Quantitative Analysis:

Both program goals were met.

- Referrals for health education services steadily increased from Q1 to Q3, at a rate not previously seen. Traditionally, referrals were highest in Q1, decreasing throughout the year.
- In 2024, 47% of SYL participants who completed the pre and post assessment increased their knowledge on basic nutrition and healthy lifestyle. Results exceeded the goal.
- New partnerships for class locations were achieved, increasing from two community partners in 2023 to six community partners in 2024.
- The goal to achieve 50% increase in participation from Q2 to Q4 was also met due to the pilot and implementation of weekly virtual classes. Attendance increased by 209% from Q1 to Q2. Looking only at in-person classes, this goal was also met, with the highest participation in Q2.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Administratively, CalOptima Health implemented a new medical management system that did not align with established customized reports for referral counts, which delayed assessments and required staff to manually track referrals.</li> <li>Translation of SYL class materials, based on staff and attendee feedback, was identified as a minor challenge in gathering correct pre- and post-assessment responses.</li> <li>Participants' comprehension of how to take and understand the assessment was identified as a challenge.</li> </ul>	<ul style="list-style-type: none"> <li>Improvement areas for the SYL pre and post assessment included:               <ol style="list-style-type: none"> <li>1) Emphasizing information from the assessment during class,</li> <li>2) Providing pre-assessment after the group checked in to allow more time for completion and</li> <li>3) Dedicating time to explicitly instructing members where to navigate the poll questions and encouraging them to submit their responses.</li> </ol> </li> <li>Offer more classes in Vietnamese to additional locations or more often.</li> </ul>
<p><b>Conclusion:</b>            The referral data indicates that health education efforts at provider and community awareness campaigns have paid off, increasing member participation in health education programming using new and existing service options. In addition, virtual classes had a higher attendance compared to in-person classes, which was expected for a population that often faces challenges with transportation and childcare.</p> <p>The SYL class data conveys that the program curriculum and components address relevant issues that match attendee priorities. In addition, the delivery of these educational sessions is conducted in a manner that is conducive for increasing knowledge on basic nutrition and healthy lifestyle strategies. The use of formative evaluation among class facilitators and support staff was an important process step, to quickly address barriers for meeting the program goal.</p>	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>The SYL in-person class locations for 2025 have increased to 10, six of which are new.</li> <li>Identify priority chronic conditions using CalOptima Health claims and encounter data to expand class topics for general audiences.</li> <li>Implement a weight management presentation for general adult audiences emphasizing chronic condition prevention.</li> </ul>	

## 4.3.2 Adult Wellness

4.3.2.1 Adult Preventive Screenings (CCS, BCS, COL)	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Melissa Morales/ Kelli Glynn	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	
Goal Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities:	
Assess and report the following activities:	

- Targeted member engagement and outreach campaigns in coordination with health network partners.
- Strategic Quality Initiatives Intervention Plan — Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.

Status: ☐ Completed ☒ Ongoing

**Background:**

According to the American Cancer Society, one in two men and one in three women will be diagnosed with cancer in their lifetime. Breast cancer is the second most common cancer for American women, while cervical cancer is one of the most common causes of cancer death for American women. In addition, colorectal cancer is the fourth most common cancer in men and women and the fourth leading cause of cancer-related deaths in the United States.

U.S. Preventive Services Task Force (USPSTF) has recommended screening for cervical, breast and colorectal cancers. Cancer screening tests can help find cancer at an early stage before symptoms appear. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower health care costs.

The following is an evaluation of the cancer screening performance measures for HEDIS. Cervical Cancer Screening and Breast Cancer Screening are part of DHCS' MCAS for annual reporting by Medi-Cal managed care health plans. These measures are held to the MPL established by NCQA Quality Compass Medicaid 50th percentile. Breast Cancer Screening and Colorectal Cancer Screening measures are part of the CMS 5-Star quality rating system.

**Methodology:** Followed the HEDIS data collection methodology.

Goal methodology for MY2023 is based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2023 is based on the MY2021 reported performance results compared to the national percentile from the MY2021 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile. The OneCare goal setting for MY2023 is based on the MY2021 reported performance results compared to the Star Rating cutoff. If the current reported rate reached the Star cutoff, then the goal was set to the next Star cutoff.

Goal methodology for MY2024 is set based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2024 is based on the MY2022 reported performance results compared to the national percentile from the MY2022 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile. The OneCare goal setting for MY2024 is based on the MY2022 reported performance results compared to the Star Rating cutoff. If the current reported rate reached the Star cutoff, then the goal was set to the next Star cutoff.

For health disparity analysis, the data is pulled from the member enrollment file. The data is uploaded to the NCQA certified HEDIS software for rate calculation. The stratified rates are rolled up by denominator and numerator based on the rate/ethnicity, language or gender information uploaded. Disparity analysis was conducted for CCS, BCS and COL measures based on the HEDIS September MY2024 top 10 race/ethnicity administrative data by denominator.

Medi-Cal Results:

Table A

Table below reviews the Medi-Cal final rates for HEDIS MY2023 and goals for MY2023.

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Me/Not Met
CCS	Cervical Cancer Screening	62.28%	57.73%	58.31%	62.53%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
BCS	Breast Cancer Screening	57.64%	57.81%	58.39%	61.27%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Table B

Table below reviews the Medi-Cal final rates for HEDIS MY2023 and goals for MY2023.

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Me/Not Met
CCS	Cervical Cancer Screening	62.28%	57.73%	58.31%	62.53%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
BCS	Breast Cancer Screening	57.64%	57.81%	58.39%	61.27%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Table C

Table below reviews the Medi-Cal final rates for HEDIS MY2023 and goals for MY2023.

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Me/Not Met
CCS	Cervical Cancer Screening	62.28%	57.73%	58.31%	62.53%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
BCS	Breast Cancer Screening	57.64%	57.81%	58.39%	61.27%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No



Table D

Table below reviews the Medi-Cal rates for September HEDIS MY2023-MY2024 and goals for MY2024.

Acronym	Measure	MY 2023 Sept Medi-Cal Rate	MY 2024 Sept Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Me/Not Met
CCS	Cervical Cancer Screening	50.33%	45.81%	59.85%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
BCS	Breast Cancer Screening	51.72%	53.44%	62.67%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

OneCare Results:

Table E

Table below reviews the OneCare final rate for HEDIS MY2023 and goals for MY2023.

Acronym	Measure	MY 2021 OneCare Rate	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2023 OneCare Goal	MY 2023 Goal Me/Not Met
BCS	Breast Cancer Screening	66.17%	65.20%	66.88%	70%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
COL	Colorectal Cancer Screening	62.34%	64.23%	66.84%	71%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Table F

Table below reviews the OneCare rates for September HEDIS MY2023-MY2024 and goals for MY2024.

Acronym	Measure	MY 2023 Sept OneCare Rate	MY 2024 Sept OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Me/Not Met
BCS	Breast Cancer Screening	60.48%	63.80%	71%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
COL	Colorectal Cancer Screening	57.77%	60.89%	71%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Table G

Table below reviews September MY2024 Cervical Cancer Screening by Race/Ethnicity Based on Administrative Data.

Admin	Race/Ethnicity									
HEDIS Sept MY2024	Hispanic	White	Vietnamese	No response, client declined to state	Other	Korean	Black	Filipino	Chinese	Asian or Pacific Islander
Numerator	42345	12772	14650	5943	9089	1701	1223	1215	973	795
Denominator	99823	32891	25169	18164	17954	4582	3158	3041	2861	2041
Rate	42.42 %	38.83 %	58.21 %	32.72 %	50.62 %	37.12 %	38.73 %	39.95 %	34.01 %	38.95 %

Table caption: Table displays the top 10 ethnicities with the highest denominator based on total HEDIS Medi-Cal population.

Table H

Table below reviews September MY2024 Breast Cancer Screening by Race/Ethnicity Based on Administrative Data.

Admin	Race/Ethnicity									
HEDIS Sept MY2024	Hispanic	Vietnamese	White	Other	No response, client declined to state	Korean	Filipino	Chinese	Asian or Pacific Islander	Black
Numerator	16591	8162	4948	3418	2381	921	785	562	466	353
Denominator	30979	13784	12480	6706	5942	2106	1566	1476	1012	917
Rate	53.56 %	59.21 %	39.65 %	50.97 %	40.07 %	43.73 %	50.13 %	38.08 %	46.05 %	38.50 %

Table caption: Table displays the top 10 ethnicities with the highest denominator based on total HEDIS Medi-Cal and OneCare population combined.

Table I

Table below reviews September MY2024 Colorectal Cancer Screening by Race/Ethnicity Based on Administrative Data.

Admin	Race/Ethnicity									
HEDIS Sept MY2024	Hispanic	White	Vietnamese	Other	No response, client declined to state	Korean	Filipino	Chinese	Black	Asian or Pacific Islander
Numerator	27661	10791	14915	6439	4495	1694	1269	1115	838	867
Denominator	79844	33025	30484	16017	15932	4693	3275	3084	2670	2395
Rate	34.64 %	32.68 %	48.93 %	40.20 %	28.21 %	36.10 %	38.75 %	36.15 %	31.39 %	36.20 %

Table caption: Table displays the top 10 ethnicities with the highest denominator based on total HEDIS Medi-Cal and OneCare population combined.

Actions/Interventions Implemented in 2024:

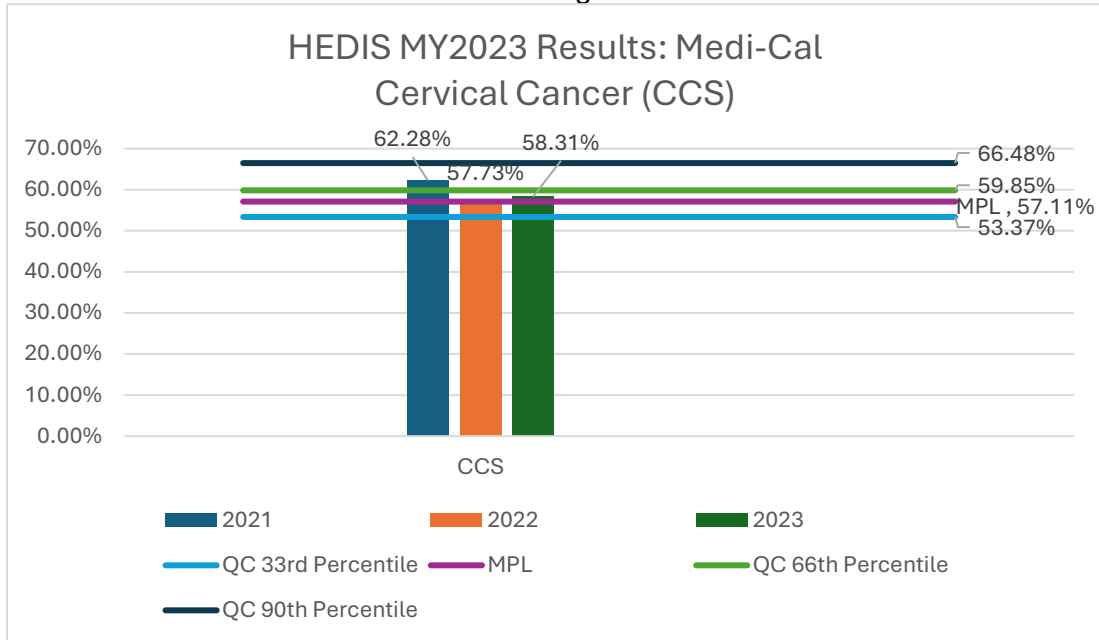
Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Member Health Reward	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	CCS BCS COL
2. Member Mailing	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	CCS BCS COL
3. IVR	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	CCS BCS COL
4. Text Messaging	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	CCS BCS COL
5. Telephonic Outreach	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	CCS BCS COL
6. Standing Orders Program	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	BCS COL
7. Gap-in-Care Reporting	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	CCS BCS COL
8. Specialty Collaboration with Gastroenterology	<input type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	COL
9. Cologuard	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	COL

MC = Medi-Cal; OC= OneCare

## Results:

### Chart A

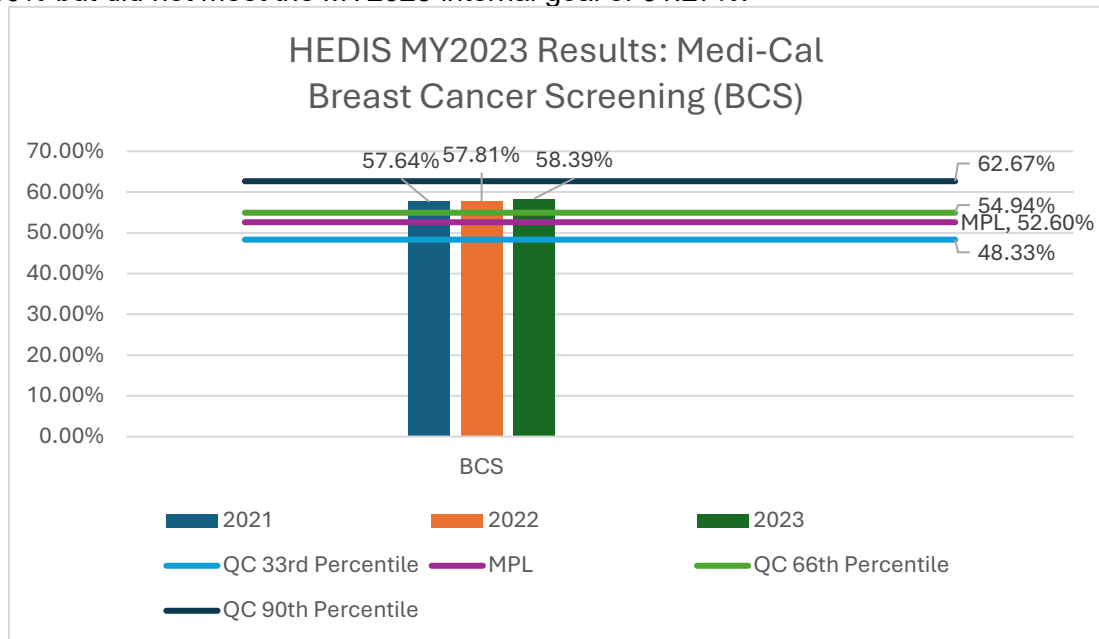
- CalOptima Health's HEDIS MY2023 CCS hybrid rate for Medi-Cal was 58.31% and met the MPL of 57.11% but did not meet the MY2023 internal goal of 62.53%.



*Per HEDIS 2022 Quality Compass Percentile*

### Chart B

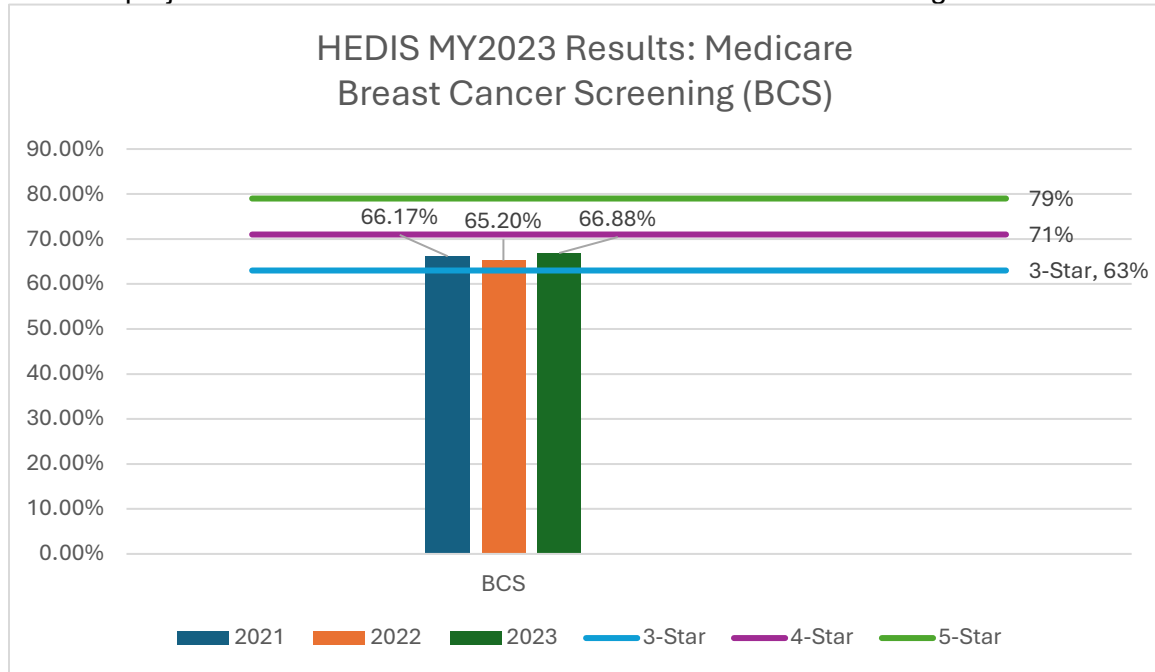
- CalOptima Health HEDIS MY2023 BCS rate for Medi-Cal was 58.39% and met the MPL of 52.60% but did not meet the MY2023 internal goal of 61.27%.



*Per HEDIS 2022 Quality Compass Percentile*

### Chart C

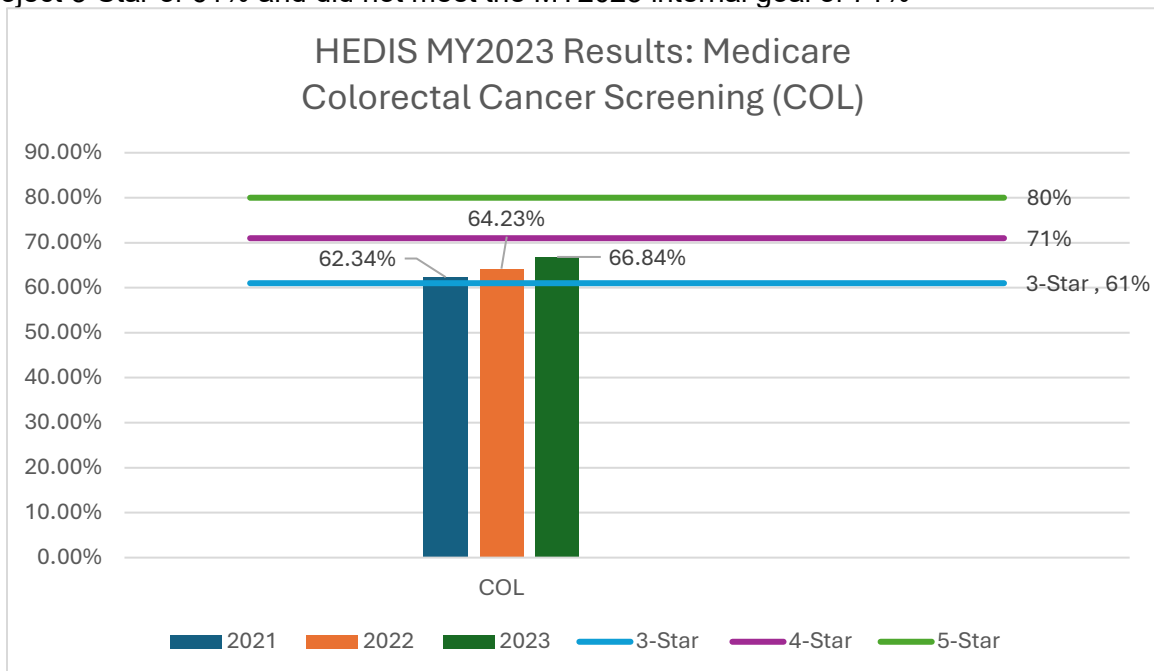
- CalOptima Health's HEDIS MY2023 BCS administrative rate for OneCare was 66.88% and met the projected 3-Star of 63% but did not meet the MY2023 internal goal of 70%.



CMS 2024 Stars Benchmarks

### Chart D

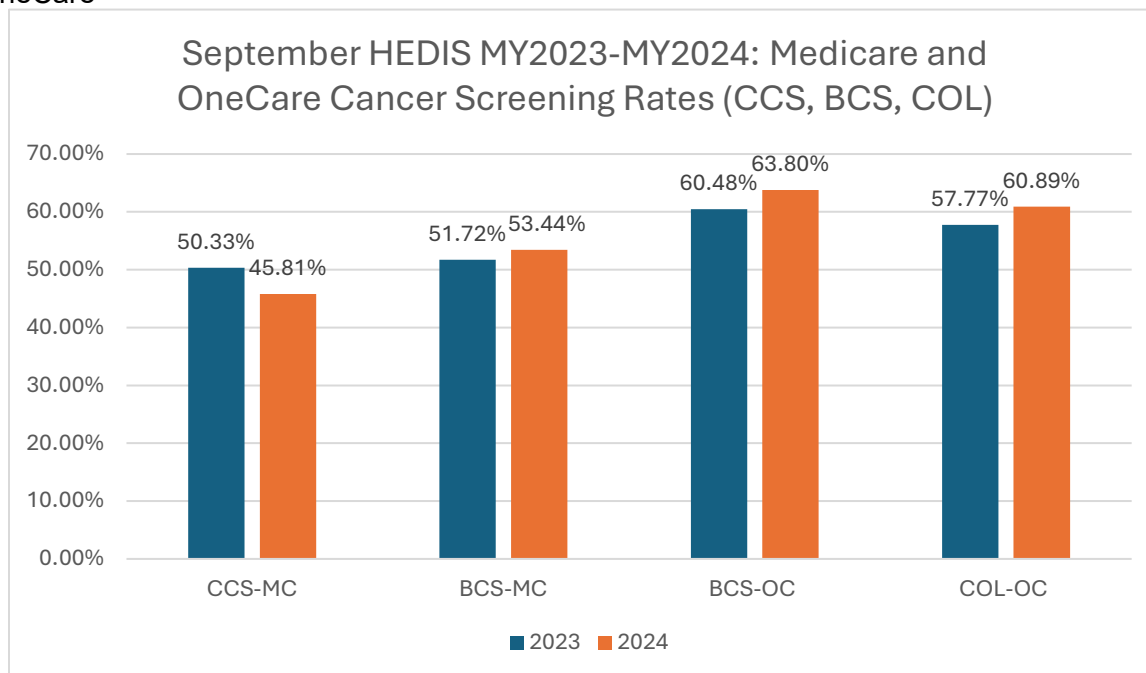
- CalOptima Health's HEDIS MY2023 COL hybrid rate for OneCare was 66.84% and met the project 3-Star of 61% and did not meet the MY2023 internal goal of 71%



CMS 2024 Stars Benchmarks

### Chart E

- CalOptima Health Cancer screening rates for September HEDIS MY2023–2024 for Medi-Cal and OneCare



*Claims/encounters processed through September 2024*

#### Quantitative Analysis:

Comparing CalOptima Health Medi-Cal cancer screening prospective rates for September HEDIS MY2023-MY2024. The rates are based on the administrative data and represent the claims/encounters process through the month of September for each respective year.

- Cervical Cancer Screening (CCS): As of September 2024, the CCS prospective rate was 45.81%, which is lower than the September 2023 prospective rate of 50.33% by 4.52 percentage points.
- Breast Cancer Screening (BCS-MC): As of September 2024, the BCS prospective rate was 53.44%, which is higher than the September 2023 prospective rate of 51.72% by 1.72 percentage points.
- Breast Cancer Screening (BCS-OC): As of September 2024, the BCS prospective rate was 63.80%, which is higher than the September 2023 prospective rate of 60.48% by 3.32 percentage points.
- Colorectal Cancer Screening (COL-OC): As of September 2024, the COL prospective rate was 60.89%, which is higher than the September 2023 prospective rate of 57.77% by 3.12 percentage points.

#### Disparity Analysis:

CCS: When looking at the top three race/ethnicity groups by denominator count, the Vietnamese group had the highest rate, at 58.21%, while the group identified as White had the lowest rate, at 38.83%.

BCS-MC, OC: When looking at the top three race/ethnicity groups by denominator count, the Vietnamese group had the highest rate at 53.56%. While the group identified as White had the lowest rate at 39.65%.

COL-MC, OC: When looking at the top three race/ethnicity groups by denominator count, the Vietnamese group had the highest rate at 48.93%, while the group identified as White had the lowest rate at 32.68%.	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Members did not visit their PCP during MY2024, so they were not educated or reminded of the cancer screenings they were due for.</li> <li>Members may not complete their cancer screening because of discomfort associated with the procedure and/or fear of knowing the test results.</li> <li>Members may not be aware of the importance of cancer screening and/or frequency of screening, especially after having a previous screening with a negative result.</li> <li>Appointment access could be limited due to scheduling limitations and/or staff shortages, resulting in long wait times.</li> <li>Due to data lag of approximately 90 days, the September 2024 prospective rate may not provide the most accurate rate of completion of cancer screening measures.</li> <li>Hybrid measures like Cervical Cancer Screening for Medi-Cal require medical record review; therefore, the actual final rate for MY2024 may be higher.</li> </ul>	<ul style="list-style-type: none"> <li>Data optimization</li> <li>Provider and health network quality committee meetings provide input on quality-related opportunities, helping identify barriers, develop and implement effective approaches</li> <li>Develop member journey campaigns with new text messaging vendor to diminish member outreach abrasion.</li> <li>Member outreach specific to factors such as age.</li> <li>Internal member-facing departments will remind members of gaps in care during calls.</li> <li>Educate eligible members of direct access to imaging centers and gastroenterology specialists that no referral is needed.</li> <li>Engagement with specialists, such as OB/GYNs</li> </ul>
<p>Conclusion:</p> <p>Although we did not meet the internal CalOptima Health goal, we did reach MPL for Medi-Cal measures and 3-Star for OneCare Measures. On October 2024, the 2025 Star ratings were published, and for OneCare, BCS and COL reached 3-Star. CalOptima Health will retain CCS, BCS and COL measures on the 2025 QI Work Plan and continue to focus on preventative care screenings to address expected dips in utilization by conducting multicomponent interventions (mailers, automated calls and text messaging, e-mail) to increase demand for cancer screenings.</p>	
Activities/interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>Continue health rewards for eligible CalOptima Health members for CCS, BCS and COL measures. In anticipation of the COL measure possibly being held to the MPL for MCAS, CalOptima Health expanded health reward offering to include COL member health reward for eligible Medi-Cal members. Will continue to increase participation in the program and motivate members to schedule and complete cancer screenings.</li> <li>The hybrid CCS measure reached MPL in MY2023 by a small margin. The new national benchmark was released in September 2024 and the MPL has increased from 57.11% to 57.18%. Opportunity remains to increase the CCS measure. MCAS announced that they are removing the hybrid reporting method for CCS and transitioning to Electronic Clinical Data Systems (ECDS) reporting in MY2025, which may have an impact on MCAS reporting in 2026. Accordingly, in MY2025, CalOptima Health will explore EMR integration with high-volume providers.</li> <li>In MY2024, CalOptima Health removed the prior authorization for OneCare colorectal cancer screening. Will expand removal of prior authorization for breast cancer screening.</li> </ul>	



- In MY2024, CalOptima Health awarded ~\$2.1 million dollars in quality improvement grants to health network partners and CHCN providers. Many of the grant programs will focus on the CCS, BCS and COL measures.
- In MY2024, CareNet conducted live agent calls to members with multiple gaps in care. In MY2025, internal member-facing staff will have access to Decision Point to remind members of cancer screenings that they are due for at the point of member contact.
- Cancer screening measures are part of the CalOptima Health Comprehensive Community Cancer Screening Program and grant funding has been dispersed to organizations to work towards increasing awareness and access to cancer screening.
- In MY2025, CalOptima Health will increase breast cancer screening access by offering mobile mammography.
- Staff will use disparity analysis to develop interventions to target higher-risk members with health inequities caused by race/ethnicity.

4.3.2.2 CalOptima Health Comprehensive Community Cancer Screening Program	
Business Owner: Dr. Richard Pitts	Department: Medical Management
Support Staff: Joanne Ku	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective:	
<ul style="list-style-type: none"> <li>• Increase capacity and access to cancer screening for breast, colorectal, cervical and lung cancer.</li> </ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: Assess and report the following:	
<ul style="list-style-type: none"> <li>• Establish the Comprehensive Community Cancer Screening and Support grants program</li> <li>• Work with a vendor to develop a comprehensive awareness and education campaign for members</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: On December 1, 2022, the Board of Directors approved \$50.1 million to support the CalOptima Health Comprehensive Cancer Screening and Support Program. The goal of this large-scale initiative is to increase cancer screening rates for breast, cervical, colon and lung cancers in order to improve the health and well-being of members in Orange County.	
Methodology: For the awareness and education campaign, Maricich (contracted vendor) used the following metrics to assess digital performance: education, impressions/views, appointments and click-through rate (CTR)/web engagement. For community grants, there is no data collected at this time, as the first progress report is due December 31, 2024.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>• Developed a competitive grant program to support activities that increase early detection and decrease late-stage discovery. We released a notice of funding opportunity in February 2024 and received grant applications from 22 organizations. We anticipate grant implementation of selected grantees will begin in July 2024, pending Board approval in June 2024.</li> <li>• Launched the awareness and education campaign with a marketing firm. Discovery phase took place from January to March, with 15 discovery sessions that included internal and external stakeholder input from community-based organizations (CBOs), health networks and providers.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Reviewed, scored and selected 15 grant proposals for Board approval recommendation. Timeline for Board approval moved from June to August 2024.</li> </ul>

	<ul style="list-style-type: none"> <li>Insight from the stakeholder sessions informed campaign strategy and approach, and staff is currently engaged with marketing firm in the development of creative concepts.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Board approved 15 grant proposals from 13 organizations on August 1, 2024.</li> <li>Executed all grant agreements in early September 2024. Completed the first grant payment.</li> <li>Currently engaged in weekly meetings with mPulse to develop and refine Short Message Service (SMS) content, with the goal of improving member engagement and scheduling of screening appointments.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Held the grantees' kickoff meeting on October 2, 2024.</li> <li>Hosted a virtual webinar to provide reporting instructions on November 8, 2024</li> <li>Met with individual grantees (ACS, TFG) to provide support.</li> <li>Submitted SMS contents to DHCS for approval.</li> <li>Worked on an RFP for a research and evaluation initiative.</li> </ul>
Program Results:	
<p>Awareness and Education Campaign: Timeframe: August 2024–October 2024</p> <ul style="list-style-type: none"> <li>16.6 million campaign digital ad impressions to date</li> <li>0.28% CTR digital channels</li> <li>8.2 million digital added value impressions to date</li> <li>784K completed video views (video assets launched in October)</li> <li>46K digital clicks to landing page</li> </ul> <p>Community Grants:</p> <ul style="list-style-type: none"> <li>Received 22 grant applications.</li> <li>Awarded 15 grants to 13 organizations, with two organizations receiving multiple grants</li> </ul>	
Quantitative Analysis: No quantitative analysis is available yet as we are still in the early phase of the program. The first progress report from the grantees is due December 31, 2024.	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Due to a change in project management leadership, several critical operational requirements were delayed, including the Business Associate Agreement (BAA), external data exchange request form, grant amendment process and overlapping member lists for grantees' outreach activities.</li> </ul>	<ul style="list-style-type: none"> <li>Consider a whiteboard session to strategize and plan oversight of all program components.</li> </ul>
Conclusion: As we kicked off 2024 with a successful launch, awarding the first round of grants and launching a digital media campaign, we've set a strong foundation for this important initiative. It was inspiring to see all grantees come together, fostering collaboration and synergy.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>Continue quarterly grantee meetings</li> <li>Produce a high-impact report that analyzes data to inform future strategies</li> <li>Launch the research and evaluation RFP</li> <li>Develop more concrete plans for the OC3 Collaborative and Member Journey Interventions initiatives.</li> </ul>	

### 4.3.3 Maternal Health

4.3.3.1 Prenatal and Postpartum Care (PPC)	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Kelli Glynn/Leslie Vasquez	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: TOPC: 91.89%, PPC: 84.18%	
Goal Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <ol style="list-style-type: none"> <li>1. Targeted member engagement and outreach campaigns via collaboration with health networks and utilizing multiple communication channels</li> <li>2. Expansion of Bright Steps</li> <li>3. Collaborative member engagement events with community-based partners</li> <li>4. Expansion of member engagement through direct services such as the doula benefit and educational classes</li> </ol> <p>The planned activities/initiatives outlined in the section below are reflective of the Work Plan's activities.</p>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>Joint guidelines published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) recommend a prenatal visit in the first trimester for all birthing persons. ACOG also recommends that all birthing persons have a comprehensive postpartum visit which provides an opportunity to address physical, mental and emotional health early on, followed by ongoing care as needed</p> <p>Prenatal and Postpartum Care (PPC) is a hybrid quality performance measure for HEDIS and is part of the DHCS MCAS that is held to a minimum performance level established by NCQA. HEDIS plays a critical role in supporting maternal health by assessing the quality and timeliness of care provided to birthing persons before and after childbirth.</p> <p>PPC has two components that assess the following for deliveries on or between October 8 of the year prior to October 7 of the current measurement year:</p> <ol style="list-style-type: none"> <li>1. Timeliness of Prenatal Care (TOPC): The percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization</li> <li>2. PPC: The percentage of deliveries that received a postpartum care visit on or between seven and 84 days (one–12 weeks) after delivery.</li> </ol>	
<p>Methodology:</p> <p>CalOptima Health follows the HEDIS data collection methodology to assess performance with prenatal and postpartum care. The methodology for the MY2023 goal is based on the MY2021 reported performance results compared to the MY2021 NCQA Quality Compass national percentile (benchmark). If the performance rate meets the NCQA Quality Compass benchmark, CalOptima Health will set its goal to the next NCQA percentile to encourage continued performance improvement. However, if the measure rate falls below the 50th percentile, then CalOptima Health sets the 50th percentile as the organizational goal.</p> <p>NCQA stratified select measures like PPC for race and ethnicity to support the identification of disparities amongst the patient population. Race and ethnicity data for MY2023 reflect these</p>	

stratification requirements. PPC data was stratified by race and ethnicity and compared to the overall PCC rate to identify any disparities.

Medi-Cal Results: The table below indicates the final Medi-Cal rates for HEDIS MY2023 and how the rate fares against the goal set for MY2023.

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met/Not Met
TOPC (hybrid)	PPC: Timeliness of Prenatal Care	91.0%	88.10%	88.10%	91.89%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
PPC (hybrid)	PPC: Postpartum Care	81.60%	81.2%	80.00%	84.18%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

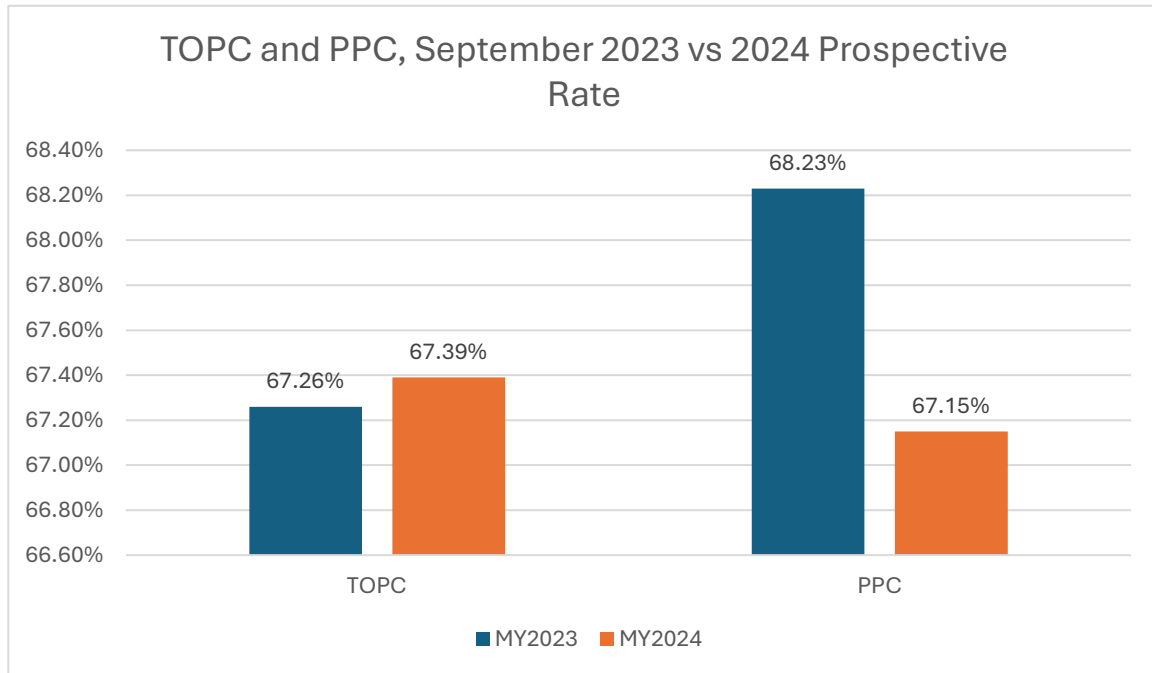
In MY2023, TOPC did not meet the MY2023 organizational goal; however, TOPC met the NQCA Quality Compass benchmark of 84.23%. Similarly, PPC did not meet the desired MY2023 organizational goal. PPC did meet the NQCA Quality Compass benchmark of 78.1% for MY2023.

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Postpartum health reward	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	PPC
2. Bright Steps Program — CalOptima Health’s maternal health program provides nutrition, health education, psychosocial support and resource referrals to members during and for one year post-pregnancy.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	TOPC PPC
3. Paid Digital and Social Media Ads — Provide education regarding the importance of prenatal and postpartum care  Ads were in English, Spanish, and Vietnamese and targeted lower performing zip codes across those member languages.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	TOPC PPC
4. PBS TV ad for maternal health	<input type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input checked="" type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	TOPC PPC
5. Member newsletter	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	TOPC PPC
6. Provider education — Provider education efforts include presenting on the PPC measure and coding requirements.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input checked="" type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	TOPC PPC
7. Postpartum care reminder call campaign	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	PPC

<p>8. Planned: Provider education</p> <p>The development of a coding guide to support practitioners who conduct bundled coding is planned for Q4 to support increased data capture for the PPC measure.</p>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input type="checkbox"/> On-going <input checked="" type="checkbox"/> Incomplete	TOPC PPC
<p>9. P4V program</p>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	TOPC PPC
<p>10. Planned: Report development utilizing available admit, discharge transfer (ADT) data to support the early identification of members that delivered for postpartum education</p>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input checked="" type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input type="checkbox"/> On-going <input checked="" type="checkbox"/> Incomplete	PPC
MC = Medi-Cal OC= OneCare					
Results:					

Chart A. MY2023 and MY2024 September Prospective Rate for TOPC and PPC



*Prospective rate (PR) methodology includes continuous enrollment criteria. PPC and TOPC are hybrid measures. Prospective rates are solely based on administrative data and are not final.*

- TOPC performance in September 2024 is performing relatively similar to September 2023. The increase in the rate for 2024 is not statistically significant.
- PPC is performing 1.08% lower in September 2024 compared to September 2023.

Table A. MY2023 Timeliness of Prenatal Care Rates by NCQA Ethnicity

NCQA Ethnicity	Hispanic/Latino	Unknown	Total
Numerator	4,256	2,500	6,756
Denominator	5,190	3,214	8,404
Rate	82.00%	77.78%	80.39%

*Table A displays timeliness of prenatal care rates per NCQA ethnicity specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. Comparisons were made against the total rate of 80.39%. Members that identify as Hispanic/Latino have a higher compliance rate (82.00%) than members whose ethnicity is unknown (77.78%).*

Table B. MY2023 Timeliness of Prenatal Care Rates by NCQA Race

NCQA Race	Unknown	Other	White	Asian	Black	Native Hawaiian and Other Pacific Islander	American Indian and Alaskan Native	Total
Numerator	4,713	718	621	575	106	13	10	6,756
Denominator	5,762	890	827	754	140	21	10	8,404
Rate	81.79%	80.67%	75.09%	76.26%	75.71%	61.90%	100%	80.39%

*Table B displays Timeliness of Prenatal Care rates per NCQA race specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. See Quantitative Analysis.*

**Table C. MY2023 Postpartum Care Rates by NCQA Ethnicity**

NCQA Ethnicity	Hispanic/Latino	Unknown	Total
Numerator	3,928	2,311	6,239
Denominator	5,190	3,214	8,404
Rate	75.68%	71.90%	74.24%

*Table C displays postpartum care rates per NCQA ethnicity specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. Comparisons were made against the total rate 74.24%. Similar to TOPC, the group with the unknown ethnicity performed lower than both the Hispanic/Latino group and the overall total rate.*

**Table D. MY2023 Postpartum Care Rates by NCQA Race**

NCQA Race	Unknown	Other	White	Asian	Black	Native Hawaiian and Other Pacific Islander	American Indian and Alaskan Native	Total
Numerator	4,338	664	549	572	100	10	6	6,239
Denominator	5,762	890	827	754	140	21	10	8,404
Rate	75.29%	74.61%	66.38%	75.86%	71.43%	47.62%	60%	74.24%

*Table D displays Postpartum Care rates per NCQA race specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. See Quantitative Analysis.*

**Quantitative Analysis:**

- When assessing final rates (hybrid) for both TOPC and PPC, there has been no significant improvement in performance between MY2021 and MY2023.
- Tables A and B showcase race and ethnicity data, respectively, per NCQA specifications for TOPC. When assessing for race, a large portion of the population was identified as Unknown. Native



<p>Hawaiian and Other Pacific Islander represent the smallest ethnic group, however their TOPC rate was the lowest at 61.90% when compared to the overall total rate of 80.39%.</p> <ul style="list-style-type: none"> <li>• Timeliness of Prenatal Care performance was assessed among racial groups with 100 or more members. Data stratified by racial groups were then compared to the overall rate for PPC Two additional racial groups that performed lower than the total rate (overall population) were White and Black, 75.09% and 75.71%, respectively, indicating an opportunity for targeted initiatives.</li> <li>• Tables C and D showcase race and ethnicity data, respectively, per NCQA specifications for PPC. When assessing for race, a large portion of the population was identified as Unknown. The following three racial groups performed the lowest for PPC: White (66.38%), American Indian and Alaskan Native (60%) followed by Native Hawaiian and Other Pacific Islander (47.62%), American Indian and Alaskan Native (60%), followed by White (66.38%) when compared to the overall rate of 74.24%. This represents opportunities for targeted initiatives for these three groups.</li> <li>• Across all racial groups, performance with postpartum care was lower compared to prenatal care. This represents opportunities for the health plan to explore the implementation of culturally appropriate messages in the prenatal period to support postpartum care as well as logistical issues (e.g., transportation) that may impede timely postpartum care.</li> </ul>	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>• Delays of claims and encounter data present challenges for the timely identification of a delivery, which impacts the modalities in which CalOptima Health can leverage communication to outreach to members, support care coordination and reminders for care.</li> <li>• Prenatal and postpartum care have varying coding practices. Bundled billing practices, in particular, can present challenges when the appropriate codes are not utilized, thus affecting the identification of care issued to members.</li> <li>• CalOptima Health serves a diverse population. Cultural factors may contribute to gaps related to prenatal and postpartum care. Cultural factors may impact the timeline for which members seek timely prenatal care. Cultural practices and observations after delivery may impact the timeliness in which members seek the completion of a postpartum visit. Member perception as it relates to the value and importance of timely prenatal and postpartum care may impact member practices.</li> </ul>	<ul style="list-style-type: none"> <li>• Report development utilizing ADT data to support early identification for postpartum care.</li> <li>• Development of a guide for practitioners practicing bundled billing for maternal care.</li> <li>• Continue a multi-modal approach for members when issuing education about the importance of timely care. Outreach efforts should be representative of the various groups.</li> </ul>
<p>Conclusion:</p> <p>A comprehensive strategy is needed to address the following:</p> <ul style="list-style-type: none"> <li>• Proactive member outreach — Leverage data (e.g., claims, prescriptions) to trigger early member identification and engagement</li> <li>• Provider education and training — Ongoing messaging and support to reduce disparities in maternal care, education on coding practices and cultural sensitivity</li> <li>• Culturally tailored approach — Design campaigns that acknowledge cultural practices surrounding pregnancy and postpartum care</li> <li>• Enhanced partnerships — CBOs can provide insight into barriers or facilitators of health that managed care plans may not have insight on.</li> </ul>	

Activities/interventions to continue/add next year:

- Continue the postpartum health reward and implement a broader promotion strategy
- Continue to promote postpartum care during the prenatal period and assess for barriers prior to delivery
- Targeted member outreach via various modalities: mailing, text, IVR calls
- Enhanced partnership with CBOs
- Continue to partner with health networks to identify providers to partner with for efforts that improve care delivery or reduce member barriers to care
- Develop initiatives (e.g., culturally appropriate material) aimed at reducing disparities amongst lower performing racial groups for improved TOPC and PPC performance.

#### 4.3.3.2 Maternal Health Programs (Bright Steps and Perinatal Support Services)

Business Owner: Katie Balderas

Department: Equity & Community Health

Support Staff: Ann Mino

Products: ☒ Medi-Cal ☐ OneCare

New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective: The Bright Steps Program did not have an assigned goal but was used as an activity for all maternal health goals.

Goal Met: ☒ Yes ☐ No ☐ Partial

Work Plan Planned Activities:

- 1) Provide prenatal and postpartum education to participating members.
- 2) Continue the expansion of the Bright Steps Program through community partnerships, provider/health network partnerships and member engagement.
- 3) Continue the expansion of the Bright Steps Program through community partnerships, provider/health network partnerships, the doula benefit and member engagement.

Status: ☐ Completed ☒ Ongoing

Background: The Bright Steps Program was initiated in 2018 to support perinatal members with nutrition education, health education, social support and referrals/resources needed to obtain a healthy pregnancy. This telephonic program assesses members on a trimester basis, at postpartum and through the first year after delivery (infant assessments and maternal mental health). Based on members' responses and needs, internal and community referrals and resources are provided to the members. Through its expansion, the Bright Steps Program has implemented and supported community events

Methodology: Data collected included the number of referrals to the program (pregnancy notification reports, self-referral, health network referrals, etc.). From those referrals, it is determined how many members were assessed, declined participation or were UTC, as well as additional assessments for the infant/postpartum period.

#### Actions/Interventions Implemented in 2024:

Quarter 1:	<ul style="list-style-type: none"> <li>• Telephonic outreach to pregnant and postpartum members</li> <li>• Support doula benefit implementation</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Telephonic outreach to pregnant and postpartum members</li> <li>• Support doula benefit implementation</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• Telephonic outreach to pregnant and postpartum members</li> <li>• Support doula benefit implementation</li> <li>• Breastfeeding event</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• Telephonic outreach to pregnant and postpartum members</li> <li>• Support doula benefit implementation</li> <li>• Clinic day event at UCI Santa Ana</li> </ul>

<ul style="list-style-type: none"><li>Clinic day event at UCI Anaheim</li></ul>				
Program Results:				
Chart A: Member Outreach (unique)				
BSP Unique Member Outreach	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Maternal Members Assessed	471	319	348	283
Member Decline	13	9	4	13
Unable to Contact (UTC)	418	467	425	205
Total Unique Member Outreach	902	795	777	501
Quantitative Analysis: The objectives/goals were met. The numbers remain steady over the year. Additionally, referrals remain steady over the year as well. While these goals were met, there is a huge opportunity for expansion to serve additional members. Currently, CHCN members are primarily serviced through the Bright Steps Program and self-referring members, but this could be expanded.				
Identified Barriers:		Identified Opportunities for Improvement:		
<ul style="list-style-type: none"><li>High UTC rate</li><li>Identification of pregnant members can be difficult</li><li>PNRs can be difficult to get from providers</li></ul>		<ul style="list-style-type: none"><li>Member opt-in program</li><li>Improve pregnancy data</li><li>Continue to improve access to doulas, community support and care management for perinatal members</li></ul>		
Conclusion: The program is successful. However, there are areas of improvement that should be considered to better support prenatal and postpartum HEDIS rates including appointments, screening and vaccines. Increasing the community and provider-partnered focus had successful outcomes and expansion of those services should be considered.				
Activities/Interventions to continue/add next year:				
<ul style="list-style-type: none"><li>Community events</li><li>Clinic days/partner with providers</li><li>Expand doula services</li></ul>				

### 4.3.4 Pediatric/Adolescent Wellness

<b>4.3.4.1 Preventive Care (CIS-Combo 10, W30 First 15 and 15-30, IMA-Combo 2, WCV- total)</b>	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Kelli Glynn/Leslie Vasquez	
Work Plan Element: Yes	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>Work Plan Goal/Objective:</p> <p>HEDIS MY2024 Goal</p> <p>CIS-Combo 10: 45.26%, IMA-Combo 2: 48.80%, W30-First 15 Months: 58.38%, W30-15 to 30 Months: 71.35%, WCV (Total): 51.78%</p>	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <ul style="list-style-type: none"> <li>Targeted member engagement and outreach campaigns in coordination with health network partners.</li> </ul>	

<ul style="list-style-type: none"> <li>• Quality Initiatives Intervention Plan — Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.</li> <li>• Early identification and data gap bridging remediation for early intervention</li> </ul>
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing
<p>Background:</p> <p>According to the CDC, well-child visits and recommended vaccinations are essential for good health. Well-child visits are essential for tracking growth and development milestones, discussing any concerns about a child’s health, and is the time for children to receive scheduled vaccinations to prevent illnesses and receive recommended screenings (e.g., blood lead testing, developmental screenings). CalOptima Health focused on the following measures</p> <ul style="list-style-type: none"> <li>• Childhood Immunization Status — Combination 10 (CIS-Combo10)</li> <li>• Well-Child Visits in the First 30 Months of Life (W30), two key components:             <ul style="list-style-type: none"> <li>• Well-Child Visits in the First 15 Months (W30-First 15 Months)</li> <li>• Well-Child Visits for Age 15 Months–30 Months (W30–15 to 30 Months)</li> </ul> </li> <li>• Immunizations for Adolescents-Combination 2 (IMA-Combo2)</li> <li>• Child and Adolescent Well-Care Visits (WCV-Total)</li> </ul> <p>These measures are aligned with the DHCS Medi-Cal MCAS and held to the benchmarks established by the NCQA Quality Compass.</p>
<p>Methodology:</p> <p>CalOptima Health follows HEDIS data collection methodology to assess performance with prenatal and postpartum care. The methodology for MY2024 goal is based on the MY2022 reported performance results compared to the MY2022 NCQA Quality Compass national percentile benchmark. If the performance rate meets the NCQA Quality Compass benchmark, CalOptima Health will set its goal to the next NCQA percentile to encourage continued performance improvement. However, if the measure rate falls below the 50th percentile, then CalOptima Health sets the 50th percentile as the organizational goal.</p> <p>For health disparity analysis, the data is pulled from the member enrollment file. The data is uploaded to the NCQA certified HEDIS software for rate calculation. The stratified rates are rolled up by denominator and numerator based on the rate/ethnicity, language or gender information uploaded.</p>
Medi-Cal Results:

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met / Not Met
CIS-Combo 10 (hybrid)	Childhood Immunization Status	47.4%	39.4%	36.50%	49.76%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
IMA-Combo 2 (hybrid)	Immunizations for Adolescents-Combo 2	50.7%	51.8%	47.5%	48.42%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
W30-First 15 Months (admin)	Well-Child Visits in the First 30 Months of Life	49.3%	55.8%	55.8%	55.72%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
W30-15 to 30 Months (admin)	Well-Child Visits in the First 30 Months of Life	67.3%	71.2%	72.4%	69.84%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
WCV-Total (admin)	Child and Adolescent Well-Care Visits	54.0%	51.5%	53.0%	57.44%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

The following analysis pertains to the final rate trends from MY2021–MY2023.

- CIS-Combo 10 has steadily declined in performance. While the measure did not meet its organizational goal of 49.7%, it did meet the national benchmark of 30.9%.
- IMA-Combo 2 has a slight increase in MY2022 from MY2021, but rates declined in MY2023 compared to MY2022. While the measure did not meet the organizational goal for MY2023, it surpassed the national benchmark of 34.31% by more than 10%.
- W30-First 15 Months' performance has remained the same between MY2022 and MY2023. For MY2023, the measure met its organizational goal as well as the national benchmark goal of 58.38%.
- W30-15 to 30 Months' performance improved slightly in MY2023, up 1.2% from MY2022. However, this slight increase is not statistically significant. The measure met its organizational goal as well as the national benchmark goal of 66.76% for MY2023.
- WCV-Total rate performance improved slightly in MY2023, up 1.5% from MY2022. The change is not statistically significant. The measure did not meet the organizational goal for MY2023; however, it met the national benchmark goal of 48.07%.

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Member mailings (e.g., first and second birthday cards, member newsletters)	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	CIS, IMA, W30 WCV
2. Telephonic outreach (vendor-supported pediatric call campaign)	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	CIS IMA W30 WCV
3. Provider education (e.g., pediatric quality measures guide for HEDIS)	<input type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	CIS IMA W30 WCV
4. Targeted paid ads: digital, social media, radio, TV  Ads were available in English, Spanish, and Vietnamese member languages and targeted zip codes that were performing lower than the overall measure rate.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	CIS IMA W30 WCV
5. Well-Child Visits in the First 30 Months of Life Member Detail Report (monthly) — Reports outline the total number of visits completed along with visit dates.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	W30
6. Well Child Visit in the First 30 Months of Life Report — Identifying members with one or two visits pending.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	W30
7. Pediatric text campaigns — Issued to remind members of various period health assessment recommendations.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	CIS IMA W30 WCV
8. P4V Program	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	CIS IMA W30 WCV

<p>9. W30 Performance Improvement Project (PIP) to improve W30 well child visits in the first 15 months for Black children.</p> <p>Please refer to 4.7.1 Performance Improvement Project (PIP) in this evaluation and section 9.1 Evaluate the PIP of the 2024 Culturally and Linguistic Appropriate Services Program Evaluation for more information about this initiative.</p>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	W30
MC = Medi-Cal OC= OneCare					
Results:					

### Disparity Analysis:

Methodology: Prospective rates with claims/encounters processed through September 2024 were analyzed for current performance by race/ethnicity. CalOptima Health viewed race/ethnic groups with more than 30 members in the denominator and identified the groups with the lowest performance for pediatric immunizations and pediatric well-care visits. For adolescent well-care performance, CalOptima Health analyzed race/ethnic groups with more than 400 members in the denominator and identified the groups with the lowest performance.

Chart A. Pediatric Immunization Rates by Race/Ethnicity, September 2024

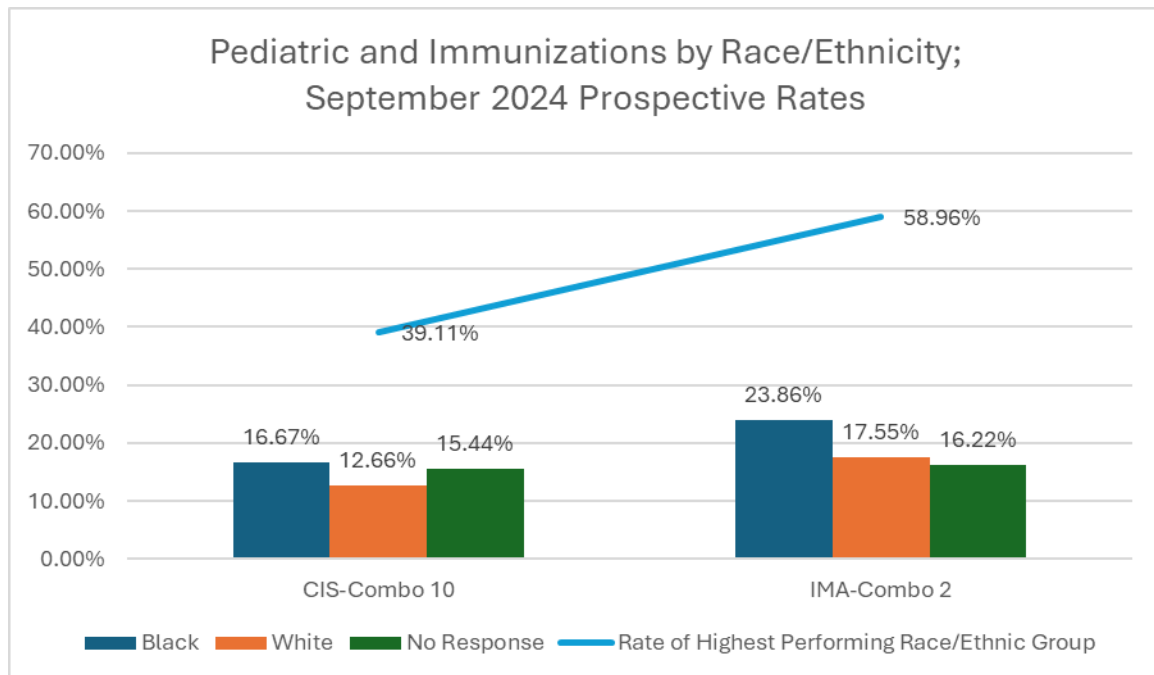


Chart A shows the CIS-Combo 10 and IMA-Combo 2 rates by race/ethnicity for prospective rates through September 2024. For both measures, Black, White and members that identified as “No Response” are performing the lowest across both measures. Vietnamese members are the highest-performing group in both pediatric and adolescent immunizations.



Chart B. Pediatric Well-Child Visits by Race/Ethnicity, September 2024

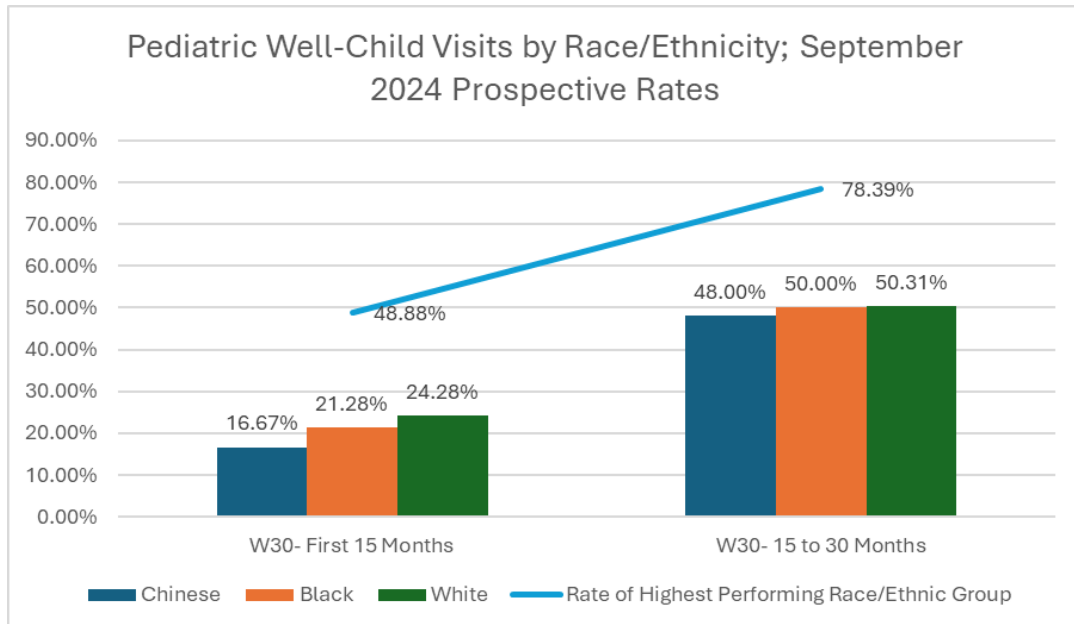


Chart B shows the rates for W30-First 15 Months and W30-15-30 Months by race/ethnicity for prospective rates through September 2024. For both measures, Chinese, Black and white members are performing the lowest across both measures. Vietnamese members are the highest-performing group for pediatric well-child visits.

Chart C. Pediatric Well-Care Visits by Race/Ethnicity, September 2024

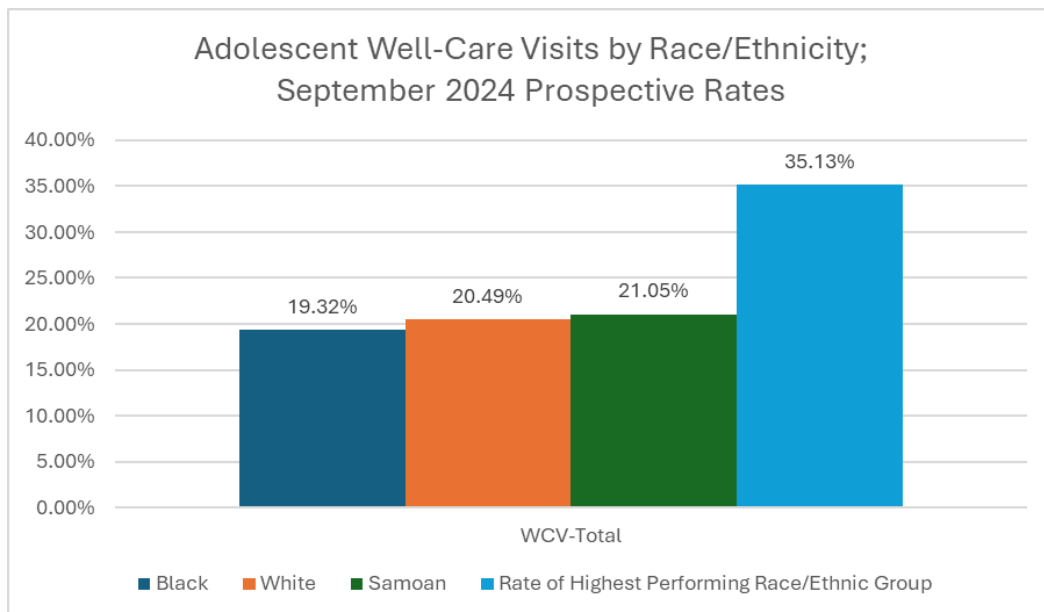
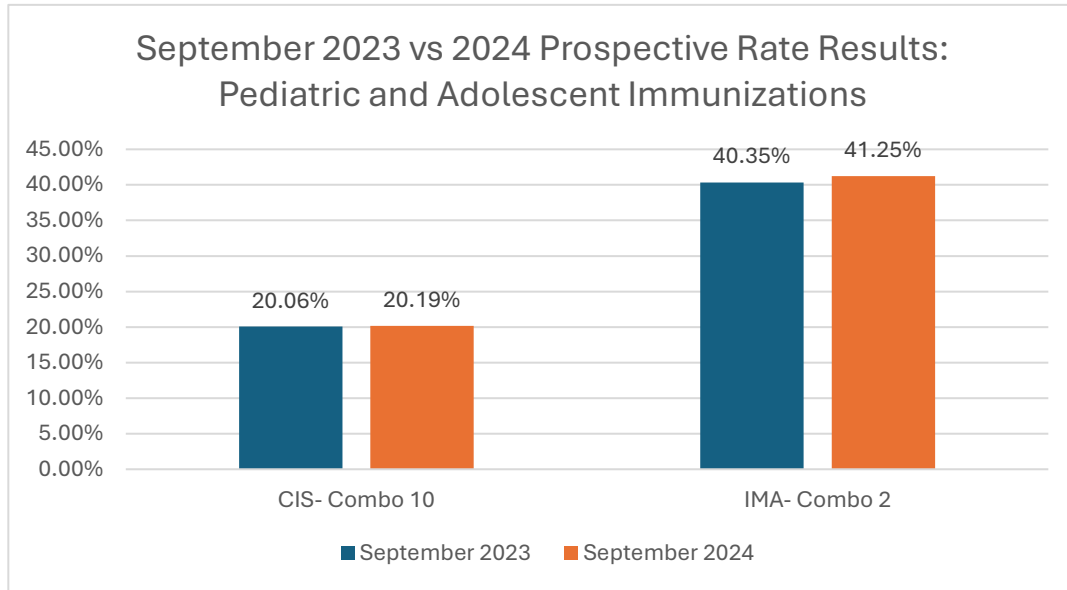
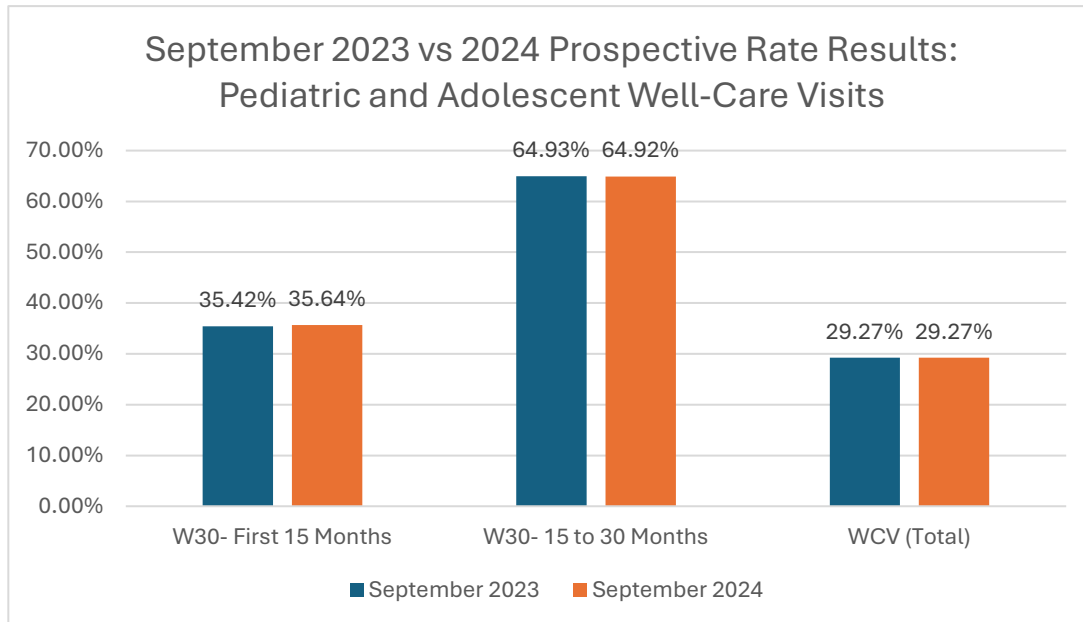


Chart C shows the rates for WCV-Total by race/ethnicity for prospective rates through September 2024. For both measures, Chinese, Black and white members are performing the lowest across both measures. Vietnamese members are the highest-performing group for pediatric well-child visits.

#### Chart D: MY2023 and MY2024 Pediatric and Adolescent Immunizations



#### Chart E: MY2023 and MY2024 Pediatric and Adolescent Well-Care Visit Measures



Prospective rate methodology includes continuous enrollment criteria. CIS-Combo 10 and IMA-Combo 2 are hybrid measures, while W30 and WCV are administrative. Prospective rates are based on claims/encounters processed through September. Prospective rates in Chart A and Chart B are

solely based on administrative data and are not final. Charts D and E compare September prospective rates for 2024 to the prospective rate in the previous year.

- Chart D: CIS-Combo 10 performance remains relatively similar to 2023 with no statistically significant improvement. IMA-Combo 2's performance increased slightly from 2023.
- Chart E: W30-First 15 Months of Life and W30-15–30 Months, as well as WCV Total, have not demonstrated any significant improvement in performance, thus indicating opportunities to continue implementing initiatives aimed at improving rates.

Table A

Submeasure	Denominator	Numerator	Administrative Numerator	Supplemental Numerator	Required Exclusions	Rate
<b>Native Hawaiian and Other Pacific Islander Direct</b>	704	247	226	21	0	35.09%
<b>American Indian and Alaska Native Direct</b>	213	75	69	6	0	35.21%
<b>White Direct</b>	32,312	12,419	11,420	999	10	38.43%
<b>Black or African American Direct</b>	4,616	1,872	1,739	133	2	40.55%
<b>Unknown (Ethnicity)</b>	109,890	53,501	50,601	2,900	21	48.69%
<b>Some Other Race Direct</b>	21,381	11,088	10,438	650	1	51.86%
<b>Unknown Race</b>	206,381	112,932	106,327	6,605	24	54.72%
<b>Hispanic or Latino Direct</b>	194,200	107,744	101,541	6,203	23	55.48%
<b>Asian Direct</b>	38,483	22,612	21,923	689	7	58.76%

**Quantitative Analysis:**

As noted in the Results section above, there has been no significant increase in performance amongst all pediatric and adolescent immunization and well-child/well-care visit rates. CalOptima Health began targeted pediatric text campaigns in 2024 that allow for widespread outreach at the various timeframes for which a periodic health assessment is recommended. CalOptima Health has also refined its methodology with pediatric call campaigns to move away from general vaccination information to now sharing with parents/guardians what specific vaccinations are pending for the members. In addition, the plan has refined its messaging in text messages to speak to more than just vaccines. Often, parents/guardians may attribute well-child visits to just vaccines. However, there are other important screenings and care that are delivered at well-child visits.

**Disparity Analysis:**

As shown in Table A, the overall total rate for the Child and Adolescent Well-Care Visits (WCV) measure in MY2023 was 53.03%. Using the total rate as a reference point, all ethnic groups except for Hispanic or Latino and Asian performed lower than 53.03%. The compliance rate for all ethnic groups except for Hispanic or Latino and Asian did not meet or exceed the MPL of 48.07%. The highest-performing ethnic group was Asian at 58.76%; the lowest-performing ethnic group was Native

Hawaiian and Other Pacific Islander at 35.09%. In conclusion, CalOptima Health will continue to implement initiatives aimed at improving WCV performance across all ethnic groups.	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Providers/health networks report that, since COVID-19, they have noted an increased hesitancy with vaccinations.</li> <li>Telephonic and text campaigns are dependent on having the correct contact information, and often, members opt not to pick up telephonic calls.</li> <li>Staffing shortages impact appointment availability making it difficult to complete well-child visits and important care (e.g., vaccinations).</li> </ul>	<ul style="list-style-type: none"> <li>Promote the messaging of HPV vaccination recommendation at an earlier timeframe to support dosage completion.</li> <li>Limited outreach success with text/calls indicates an opportunity to improve on rapport building with members, tailoring messages so that they meet different parental needs or concerns (e.g., vaccine safety), and leverage data on optimal call times.</li> </ul>
<p>Conclusion:</p> <ul style="list-style-type: none"> <li>Perceptions are changing around the importance of well-child visits and vaccinations after COVID-19. There is a need to augment messaging in communities about the importance of these visits and address vaccination hesitancy. Messages need to occur through various modalities.</li> <li>There is a need to continue to connect with health networks, clinics and provider offices to understand their challenges, successes and current process with well-care visits and vaccinations.</li> <li>Across all pediatric measures, both Black and White race/ethnic groups are the two performing the lowest. CalOptima Health should continue to work with providers and health networks to understand the contributing factors to this performance and tailor initiative to address the varying challenges/concerns with each population.</li> </ul>	
Activities/Interventions to continue/add next year:	
<p>CalOptima Health to continue the following efforts:</p> <ul style="list-style-type: none"> <li>Connect with health networks, clinics and provider offices to understand their challenges, successes and current process with well-care visits and vaccinations.</li> <li>Work with providers and health networks to understand best practices that are working to improve the delivery of well-care visits/vaccinations and share these best practices with others.</li> <li>Promote the CalOptima Health Pediatric HEDIS Guide to support performance and gap closure.</li> <li>Targeted member engagement and outreach campaigns in coordination with health network partners. <ul style="list-style-type: none"> <li>Multi-modal efforts: Mail, text, IVR calls, etc.</li> </ul> </li> <li>Early identification and data gap bridging remediation for early intervention and promotion of well-child visits as well as data capture in support of gap closure.</li> <li>Enhance the promotion of the CalOptima Health Pediatric HEDIS Guide to support performance and gap closure.</li> <li>Assess the effectiveness of the text campaigns newly implemented in 2024 and revise the member communication strategy as needed.</li> <li>Continue to leverage race and ethnicity performance data to drive initiatives aimed at reducing disparities in 2023.</li> </ul>	

#### 4.3.4.2 Blood Lead Screening

Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Kelli Glynn/Leslie Vasquez	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Work Plan Goal/Objective: HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure: 63.99%						
Goal Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial						
Work Plan Planned Activities: <ul style="list-style-type: none"> <li>• A multi-modal, targeted member approach as well as provider and health network collaborative efforts. Activities will include but not be limited to: IVR calls, texting, mailing, newsletter articles</li> <li>• Partnership with key local stakeholders (e.g., HCA)</li> </ul>						
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing						
Background: <p>Lead exposure can cause serious health issues, including brain and nervous system damage, and intellectual and behavioral problems. Since children often show no symptoms, lead poisoning may go unrecognized. According to the CDC, there is no safe blood lead level, and screening is the best way to detect exposure. If not caught early, the effects can be permanent.</p> <p>California regulations recommend that Medi-Cal children be tested for lead at 12 and 24 months and receive catch-up tests if missed. Lead Screening in Children (LSC) is a key quality performance measure for HEDIS and part of the DHCS MCAS, reported annually by Medi-Cal MCPs. Starting in MY2022, MCPs are held to the NCQA Quality Compass Medicaid 50th percentile for LSC. DHCS also issued requirements for MCPs to ensure timely screenings in line with California regulations.</p> <p>LSC is a hybrid HEDIS and MCAS measure that evaluates the percentage of children who receive a lead test by their second birthday. LSC is a proxy for how well children are being tested for lead in accordance with state regulations.</p>						
Methodology: <p>CalOptima Health follows the HEDIS data collection methodology to assess LSC performance. The methodology for the MY2024 goal is based on the MY2022 reported performance results compared to the MY2022 NCQA Quality Compass national percentile benchmark. If the performance rate meets the NCQA Quality Compass benchmark, CalOptima Health will set its goal to the next NCQA percentile to encourage continued performance improvement. However, if the measure rate falls below the 50th percentile, then CalOptima Health sets the 50th percentile as the organizational goal.</p> <p>CalOptima Health stratified race and ethnicity for the LSC measure in MY2024 to assess potential disparities. However, this methodology differs from NCQA's approach to race and ethnicity stratification, meaning the identified groups may not align with those in NCQA's stratified data. It's important to note that NCQA does not require race and ethnicity stratification for the LSC measure.</p>						
Medi-Cal Results:						
Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met / Not Met
LSC	Lead Screening in Children	64.00%	63.00%	63.8%	63.99%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

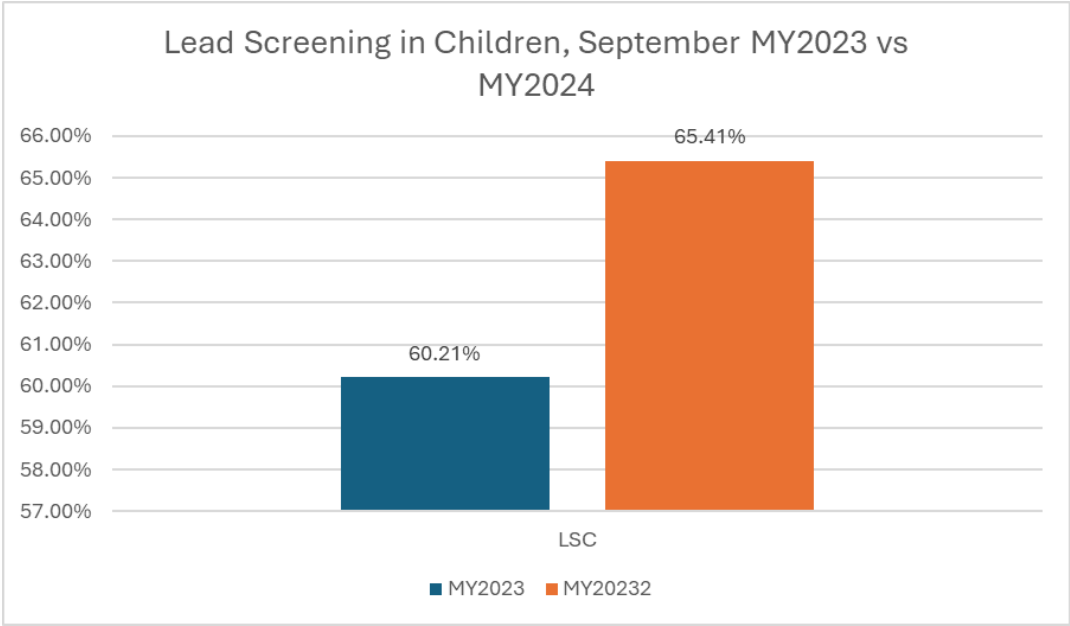
Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Member health reward for blood lead testing at 12 and 24 months of age	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	LSC
2. Texting campaigns — Members are issued general pediatric wellness texts along with blood lead-specific texts.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	LSC
3. Telephonic outreach	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	LSC
4. Blood Lead Screening Reports — Highlights members who are overdue for lead tests at 12 and 24 months of age. Highlights members that will be due for lead testing.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	LSC
5. Provider education: Various efforts, including presentations, provider continuing education and the Blood Lead Testing Guide. Education offered via fax, email, provider monthly update and provider newsletter.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	LSC
6. Targeted Paid Ads: Digital, social media, radio	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input checked="" type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	LSC
7. Community partnerships with local health care agency and Childhood Lead Poisoning Prevention Program focused on increasing blood lead testing	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input checked="" type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	LSC
8. Planned: Medical record review process to support monitoring of lead requirements.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input type="checkbox"/> On-going <input checked="" type="checkbox"/> Incomplete	LSC
9. Planned: Point-of-Care Lead Pilot	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input type="checkbox"/> On-going <input checked="" type="checkbox"/> Incomplete	LSC

10. P4V program	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	LSC
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MC = Medi-Cal; OC= OneCare

Results:

Chart A. MY2023 and MY2024 September Prospective Rates for LSC



Prospective rate methodology includes continuous enrollment criteria. LSC is a hybrid measure. Prospective rates showcased in Chart A are solely based on administrative data and are not final.

Chart A compares prospective rates; claims/encounters processed through September. LSC performance in September 2024 was much higher than the rate in September 2023 and trending 5% higher. LSC MY2024 rates are not final, however the measure is on pace to meet the established NCQA Quality Compass benchmark.

**Table A. MY2024 LSC Administrative Rates by Race/Ethnicity**

Admin	Race/Ethnicity									
HEDIS MY2024	Hispanic	No Response	Other	White	Vietnamese	Black	Chinese	Korean	Filipino	Asian or Pacific Islander
Numerator	4456	1112	810	405	367	61	46	48	35	36
Denominator	6260	1949	1307	885	496	114	81	80	63	52
Rate	71.18%	57.05%	61.97%	45.76%	73.99%	53.51%	56.79%	60.00%	55.56%	69.23%

Table A displays LSC administrative rates by race/ethnicity. Table A showcases the top 10 race/ethnic groups based on denominator, moving from the highest denominator (right) to lowest (far left).

**Quantitative Analysis:**

- LSC performance in September 2024 was much higher than the rate in September 2023 and trending 5% higher. LSC MY2024 rates are not final, however, the measure is on pace to meet the established NCQA Quality Compass benchmark.
- When assessing final rates (hybrid) for LSC from MY2021–MY2023, there has been no significant improvement in performance. In MY2022, the performance rate was decreased by 1% when compared to MY2021. In MY2023, the performance rate increased slightly (0.8%) from MY2022. Refer to Medi-Cal Results and Chart A.
- CalOptima Health set its organizational goal based on the MY2022 NCQA Quality Compass benchmark of 63.99%. MY2023 benchmarks were released subsequently, and the 50th percentile was set to 62.79%. CalOptima Health kept the 63.99% goal, which it did not meet. However, it should be noted that CalOptima Health did meet the 50th percentile of 62.79% for MY2023, with a final rate of 63.80%. See Medi-Cal rates above.
- Table A showcases MY2024 data by race and ethnicity data. Hispanic members account for the largest portion of the LSC denominator. When assessing for lead testing by race/ethnicity, the three groups with the lowest performance are as follows: White (45.76%), Black (53.51%) and Filipino (55.56%). Final rates are pending, but based on these trends, these groups may benefit from targeted interventions to support lead testing.

**Identified Barriers:**

- Lack of parent/guardian awareness related to the importance of lead testing for the identification of lead exposure and potential lead poisoning.
- Limited point-of-care lead testing practices
- Providers report that there are high costs associated with obtaining point-of-care lead testing machines and lead testing supplies

**Identified Opportunities for Improvement:**

- Ongoing need to support parental education on lead testing and reducing barriers to care.
- CalOptima Health to support a pilot to implement point-of-care testing in select provider offices.

**Conclusion:**

The latest September 2024 prospective rates showcase a slightly more than 5% increase in lead testing based on the same time last year. This indicates that the combined efforts for lead testing have made a positive impact on LSC performance. Additional activities, such as the medical record review and implementation of the point-of-care lead testing pilot, aim to support further increased rates in LSC performance. Results for these efforts are pending.



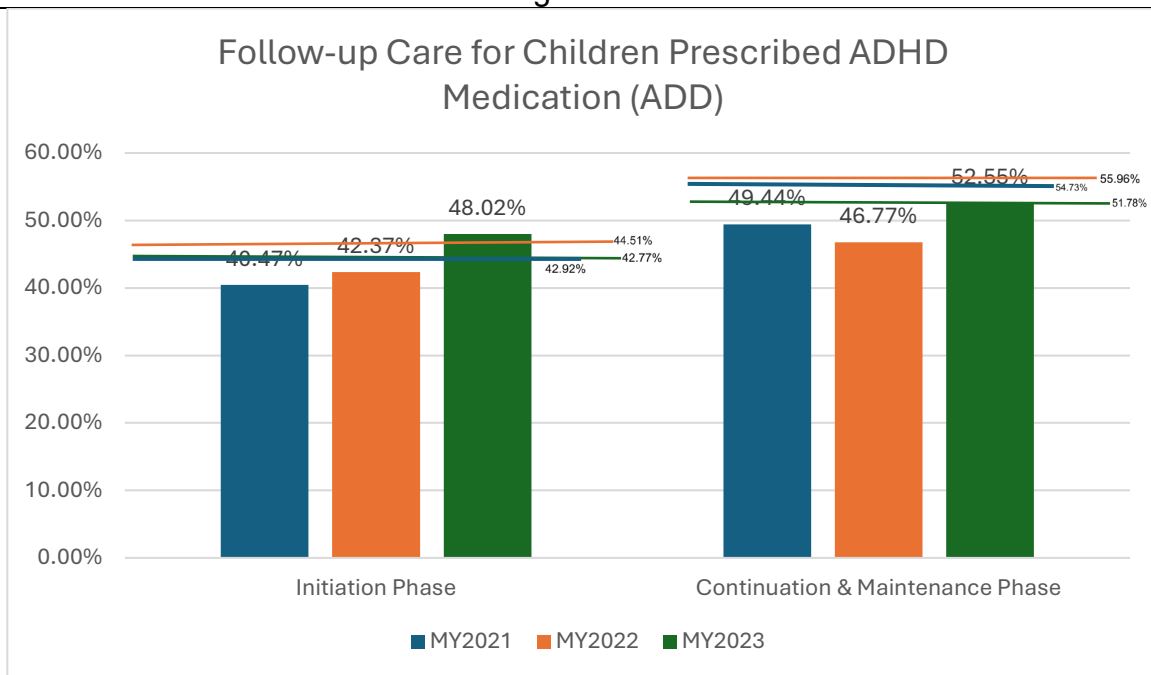
Activities/Interventions to continue/add next year:
<ul style="list-style-type: none"> <li>Continue the member health reward to encourage lead testing completion amongst members.</li> <li>Targeted member outreach via various modalities: mailing, text, IVR calls</li> <li>Complete the point-of-care lead testing pilot to support increased lead testing rates and reduce barriers for providers seeking to offer point-of-care testing in the office.</li> <li>Initiate medical record review to assess and monitor provider and health networks for state-issued lead requirements.</li> </ul>

## 4.4 Behavioral Health

<b>4.4.1 Behavioral Health (ADD)</b>	
Author: Valerie Venegas	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>Work Plan Goal/Objective: MC-Init Phase — 44.22%, MC-Cont Phase — 50.98% Work Plan goal.</p> <p>To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practices and technological options.</p>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <ul style="list-style-type: none"> <li>Work collaboratively with the Communications department to fax non-compliant providers letter activity (approximately 200 providers) by the fourth quarter.</li> <li>Participate in provider educational events, related to follow-up visits and best practices.</li> <li>Continue member outreach to improve appointment follow-up adherence. <ul style="list-style-type: none"> <li>a. Member newsletter (Fall)</li> <li>b. Monthly member two-way text messaging (approximately 60—100 members)</li> </ul> </li> <li>Member health reward program</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>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 occur 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.</p>	
<p>Methodology:</p> <p>There are two phases within this measure: The Initiation Phase (one visit within the first 30 days) and The Continuation and Maintenance Phase (two visits in the next nine months for those who remain on the medication). Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends.</p>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>Created and finalized working collaboratively with QI for the member health reward flyer to distribute to eligible members.</li> </ul>

	<ul style="list-style-type: none"> <li>Met with ITS to discuss data sourcing automation for the Provider Portal information sharing monthly.</li> <li>Text messaging outreach to members sent in January and February.</li> <li>Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Community Health Centers and Medical Provider Forum on March 15, 2024, regarding importance of quality measure.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>Approved printing vendor for printed flyers to send out member health rewards.</li> <li>Member health reward approved by DHCS and added to CalOptima Health website for members to access.</li> <li>Text messaging outreach to members sent May and June.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Monthly text messaging outreach to members sent in July, August and September.</li> <li>Member health reward flyers mailed to 620 eligible members.</li> <li>Developed new text message script for member health reward.</li> <li>ADD data is now available through the Provider Portal.</li> <li>Presented at The Coalition of Orange County Community Health Center meeting and Medical Provider Forum regarding BH Quality Measures on September 20, 2024.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Monthly text messaging outreach to members sent in October, November and December.</li> <li>Member health reward flyers mailed to 800 eligible members.</li> <li>A new text message script for member health reward will be launched in 2025.</li> </ul>

#### Program Results:



#### HEDIS Final Rates Trend Analysis

#### Quantitative Analysis:

CalOptima Health's 2023 HEDIS Initiation Phase final rate was 48.02%, which met the intended goal of 42.77%. The 2023 HEDIS Continuation Phase final rate was 52.55%, which also met the intended

goal of 51.78%. The ADD measure has demonstrated an increase in change over the past three years in the trend analysis.	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>• Provider letters are faxed to the number on record. We are aware that the fax may not always go to the intended provider to whom the letter was faxed.</li> <li>• Provider availability is still a barrier for members to get an appointment scheduled with the 30-day follow-up requirement.</li> </ul>	<ul style="list-style-type: none"> <li>• While provider engagement was initiated, additional strategies may be necessary to enhance awareness and compliance among providers. Such as uploading data directly to the provider portal.</li> <li>• The BHI quality team will explore opportunities to continue member outreach to identify barriers and assist members.</li> </ul>
<p>Conclusion:</p> <p>CalOptima Health has chosen to continue working on improving the number of members who are newly prescribed ADHD medications and have a follow-up visit within 30 days. The BHI quality team will continue to send letters to providers who do not meet the ADD requirements. Text message campaigns will continue to be sent to members as a reminder to follow up with providers after filling out their ADHD medication, and a new text message campaign will be launched to inform members about the member health reward.</p>	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>• Continue to send letters to providers who are not meeting the ADD requirements.</li> <li>• Continue to work with text messaging vendor to send text messages to members for follow-up visits.</li> <li>• Send text message campaign of the member health rewards flyer to eligible members.</li> </ul>	

<b>4.4.2 Behavioral Health (APM)</b>	
Author: Mary Barranco	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>Work Plan Goal/Objective:</p> <p>Blood Glucose-All Ages: 58.43%, Cholesterol-All Ages: 40.50%, Glucose and Cholesterol Combined-All Ages: 39.01%</p> <p>To improve metabolic monitoring among children and adolescents prescribed antipsychotic medications. Specifically, educating health care providers and members to increase the rates of blood glucose and cholesterol testing.</p>	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <ul style="list-style-type: none"> <li>• Monthly review of metabolic monitoring data to identify prescribing providers and PCPs for members in need of metabolic monitoring.</li> <li>• Work collaboratively with Provider Relations to conduct monthly face-to-face provider outreach to the top 10 prescribing providers to remind them of best practices for members in need of screening.</li> <li>• Monthly mailing to the next top 50 prescribing providers to remind them of the best practices for members in need of screening.</li> <li>• Send a monthly reminder text message to members (approximately 600 members).</li> <li>• Information sharing via provider portal to PCPs on best practices, with a list of members who need a diabetes screening.</li> </ul>	

Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:</p> <ul style="list-style-type: none"> <li>• The percentage of children and adolescents on antipsychotics who received blood glucose testing.</li> <li>• The percentage of children and adolescents on antipsychotics who received cholesterol testing.</li> <li>• The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.</li> </ul>	
<p>Methodology:</p> <p>The data is uploaded to Tableau by CalOptima Health's Quality Analytics team. BHI then downloads the data and filters it to evaluate the measure's needs. Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends.</p>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>• Worked with Quality Analytics to develop a data report.</li> <li>• Drafted the following materials: <ul style="list-style-type: none"> <li>○ Text messaging script</li> <li>○ APM Provider Tip Sheet</li> </ul> </li> <li>• Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Health Centers and Medical Provider Forum on March 15, 2024, regarding the importance of quality measure.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Worked with Quality Analytics/Financial Analysis team to develop a data report.</li> <li>• Drafted following materials: <ul style="list-style-type: none"> <li>○ Text messaging script (approved by DHCS)</li> <li>○ APM Provider Tip Sheet</li> </ul> </li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• The following materials have been disseminated to providers: <ul style="list-style-type: none"> <li>○ Provider Best Practices Letter</li> <li>○ APM Provider Tip Sheet</li> </ul> </li> <li>• Collaborated with Provider Relations to conduct in-person provider outreach with top 10 providers monthly.</li> <li>• Mailed provider materials (Best Practices Letter and Provider Tip Tool Sheet) to the next top 50 providers monthly.</li> <li>• Continued text messaging campaign.</li> <li>• Presented at The Coalition of Orange County Community Health Center meeting and Medical Provider Forum regarding BH Quality Measures on September 20, 2024.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• Continued text messaging campaign.</li> <li>• Started mailings to providers (letter).</li> <li>• Collaborated with Provider Relations to conduct in-person provider outreach with top 10 providers monthly.</li> <li>• Mailed provider materials (Best Practices Letter and Provider Tip Tool Sheet) to the remaining providers monthly.</li> </ul>
Program Results:	

### Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

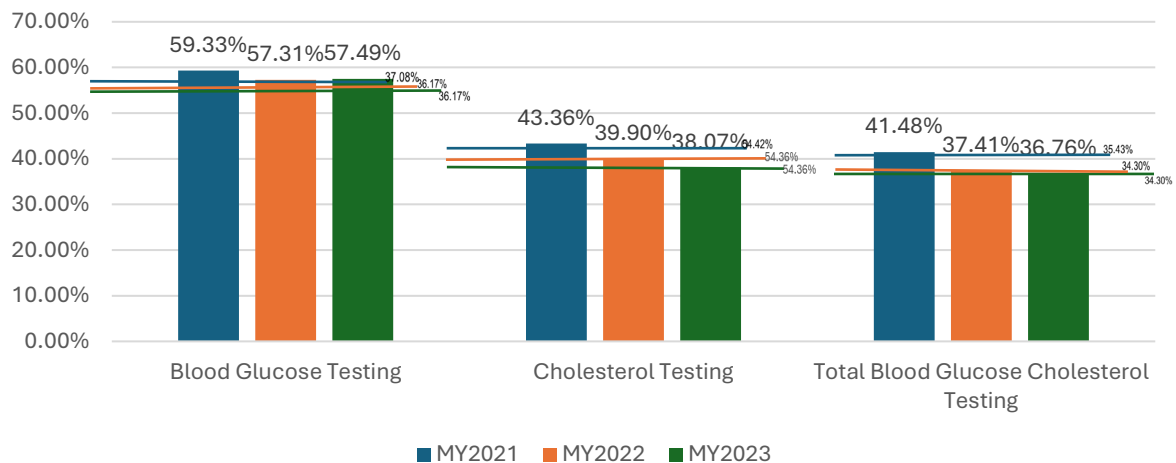


Chart caption: HEDIS Final Rates Trend Analysis

#### Quantitative Analysis:

Due to outreach efforts, CalOptima Health did meet the goal of 34.30%. The final rate was 36.76% for Total Blood Glucose and Cholesterol Monitoring. The decline from the previous year's rate (38.07%) is due to timely access to data.

#### Identified Barriers:

- Timely access to data was problematic, affecting our ability to monitor progress effectively.
- Identified members prescribed antipsychotic medication still in need of diabetes screening, cholesterol screening, and both cholesterol and diabetes screening test through Tableau Report.

#### Identified Opportunities for Improvement:

- While provider engagement was initiated, additional strategies may be necessary to enhance awareness and compliance among both providers and members (e.g., uploading data directly to the provider portal).

#### Conclusion:

While we did not achieve the desired outcome, the insights gained provided a valuable foundation for future improvements. By enhancing data accessibility and continuing to engage both providers and members, we can work towards better outcomes for APM.

#### Activities/Interventions to continue/add next year:

- Continuing current interventions
  - Maintain existing provider outreach to maintain engagement levels via provider mailings and provider outreach by our Provider Relations department.
  - Text messaging campaigns will continue going out to members.
- Enhance data accessibility
  - Implement the upload of member information to the provider portal, enabling providers with more detailed member information.
- Expand educational efforts
  - Increase the frequency of initiatives targeting both providers and members about the importance of metabolic monitoring.

- Monitor and adjust strategies
  - Regularly review and adapt outreach strategies based on ongoing data analysis to address identified barriers.

#### 4.4.3 Behavioral Health (AMM)

Author: Mary Barranco		Department: Behavioral Health Integration (BHI)	
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov			
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare		New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Work Plan Goal/Objective: Acute Phase — 74.16%, Continuation Phase — 58.06% To improve monitoring of members' adherence to antidepressant medication.			
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial			
Work Plan Planned Activities: <ul style="list-style-type: none"> <li>• Educate providers on the importance of follow-up appointments through outreach to increase follow-up appointments for prescription management associated with the AMM treatment plan.</li> <li>• Educate members on the importance of follow-up appointments through newsletters/outreach to increase follow-up appointments for prescription management associated with AMM treatment plan.</li> <li>• Track number of educational events on depression screening and treatment.</li> </ul>			
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing			
Background: The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported: <ol style="list-style-type: none"> <li>1. Effective Acute Phase Treatment: The percentage of members who remained on antidepressant medication for at least 84 days (12 weeks).</li> <li>2. Effective Continuation Phase Treatment: The percentage of members who remained on antidepressant medication for at least 180 days (six months).</li> </ol>			
Methodology: The data is emailed to our program specialist by our Financial Analysis team. We download the data and filter it to evaluate the measure's needs. Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends.			
Actions/Interventions Implemented in 2024:			
Quarter 1:	<ul style="list-style-type: none"> <li>• Worked with Quality Analytics to develop a data report.</li> <li>• Drafted the following materials:               <ul style="list-style-type: none"> <li>◦ Text messaging script</li> <li>◦ AMM Provider Tip Sheet</li> </ul> </li> <li>• Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Health Centers and Medical Provider Forum on March 15, 2024, regarding the importance of quality measure.</li> </ul>		
Quarter 2:	<ul style="list-style-type: none"> <li>• Worked with Quality Analytics/Financial Analysis team to develop a data report.</li> <li>• Drafted following materials:               <ul style="list-style-type: none"> <li>◦ Text messaging script (approved by DHCS)</li> <li>◦ AMM Provider Tip Sheet</li> </ul> </li> </ul>		
Quarter 3:	<ul style="list-style-type: none"> <li>• Data report received monthly.</li> <li>• Drafted following materials:               <ul style="list-style-type: none"> <li>◦ AMM Provider Tip Sheet letter submitted for internal review process.</li> </ul> </li> </ul>		

	<ul style="list-style-type: none"> <li>○ Text message campaign launched.</li> <li>• Presented at The Coalition of Orange County Community Health Center meeting and Medical Provider Forum regarding BH Quality Measures on September 20, 2024.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• Continued text messaging campaign.</li> <li>• Continued mailings to providers (provider letter tip sheet).</li> </ul>

Program Results:

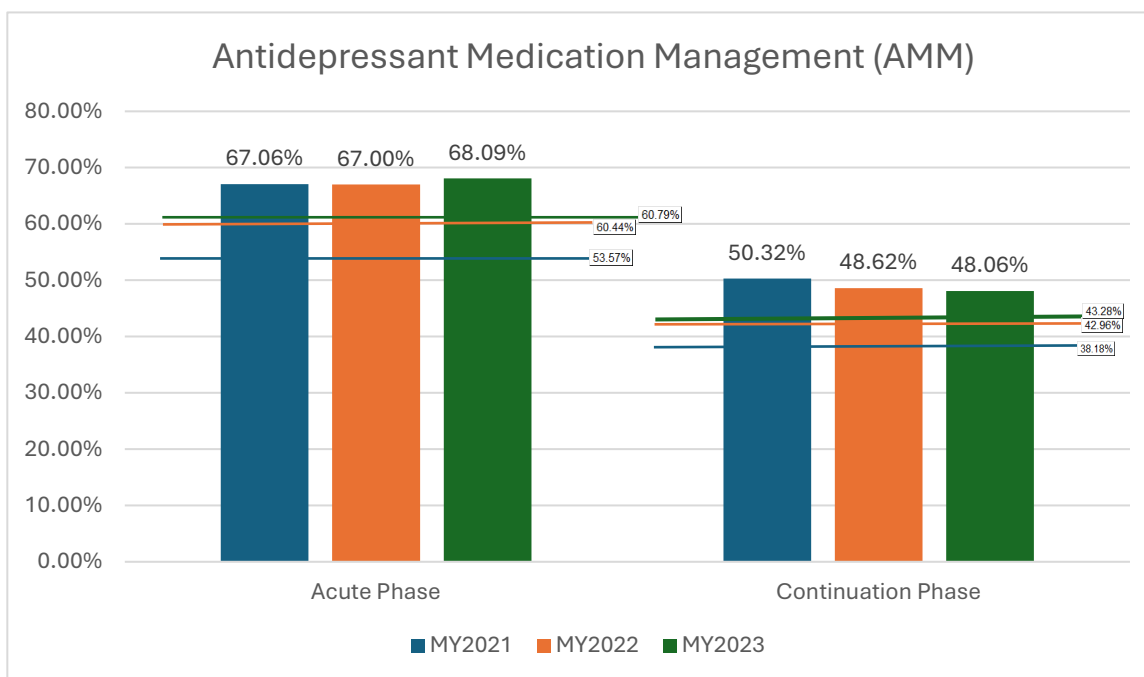


Chart caption: HEDIS Final Rate Trend Analysis

Quantitative Analysis:

The final rate of the Acute Phase was 68.09%, and the final rate of the Continuation Phase was 48.06%; neither goal was met. The decline from the previous year is due to AMM not actively being a monitored measure prior to 2024.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>• Data report development</li> <li>• Timely access to data was problematic, affecting our ability to monitor progress effectively.</li> </ul>	<ul style="list-style-type: none"> <li>• While provider engagement was initiated, additional strategies may be necessary to enhance awareness and compliance among both providers and members. Such as uploading data directly to the provider portal.</li> </ul>
<p>Conclusion:</p> <p>For the upcoming year 2025, the BHI quality team will actively monitor AMM to track and trend the eligible member population who are prescribed antidepressant medication.</p>	
<p>Activities/Interventions to continue/add next year:</p> <ul style="list-style-type: none"> <li>• The following interventions will be disseminated in 2025: <ul style="list-style-type: none"> <li>○ The BHI quality team will continue to mail a best practices letter/tool tip sheet to prescribing providers identified.</li> </ul> </li> </ul>	

<ul style="list-style-type: none"> <li>○ BHI will be working with the Financial Analysis team to further identify data elements needed to address the members' PCPs or prescribing providers for further intervention outreach.</li> <li>○ In 2025 BHI will work closely with ITS to deliver this member information electronically via the CalOptima Health Provider Portal. The use of modern technology will allow CalOptima Health to deliver this important information and best practices to providers in a timely manner, while streamlining workflows and processes in the BHI Quality Department.</li> </ul>
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<b>4.4.4 Behavioral Health (SMD)</b>	
Author: Nathalie Pauli	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Work Plan Goal/Objective: MC: 76.66% To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	
Goal Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: <ul style="list-style-type: none"> <li>• Collaborative meetings between teams to identify best practices to implement</li> <li>• Provider and member education</li> <li>• We have just monitored this measure. No activities have been set. This is the first year of us reporting on this measure in the work plan.</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: CalOptima Health's program assesses the percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who completed both a low-density lipoprotein cholesterol (LDL-C; a blood test to assess for risk of cardiovascular events) and a hemoglobin (HbA1C; a plasma glucose concentration [diabetes risk] test) throughout the year. Those who suffer from severe and persistent mental illness (SPMI) are a vulnerable population and are at an increased risk of developing physical health issues. Care coordination between medical and behavioral health care is critical to improving health outcomes. The Diabetes Monitoring for Members with Diabetes and Schizophrenia (SMD) measure allows us to evaluate the prevalence of screening being completed and assess whether opportunities for improvement are needed.	
Methodology: CalOptima Health encourages members with severe mental illness to take part in the laboratory analysis prior to receiving medication remedies. The SMD measure focuses on the percentage of members 18–64 years of age with a diagnosis of schizophrenia or schizoaffective disorder and diabetes who completed both an LDL-C and HbA1C test. Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends, and the HEDIS data is reported based on the measurement period.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>• Monitored measure.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Drafted fall member newsletter for members.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• Fall member newsletter approved July 2024</li> <li>• SMD data available through CalOptima Health Provider Portal on August 15, 2024.</li> <li>• Presented at The Coalition of Orange County Community Health Center meeting and Medical Provider Forum regarding BH Quality Measures on September 20, 2024.</li> </ul>



Quarter 4:	<ul style="list-style-type: none"> <li>Continued monitoring this measure.</li> </ul>
Program Results:	

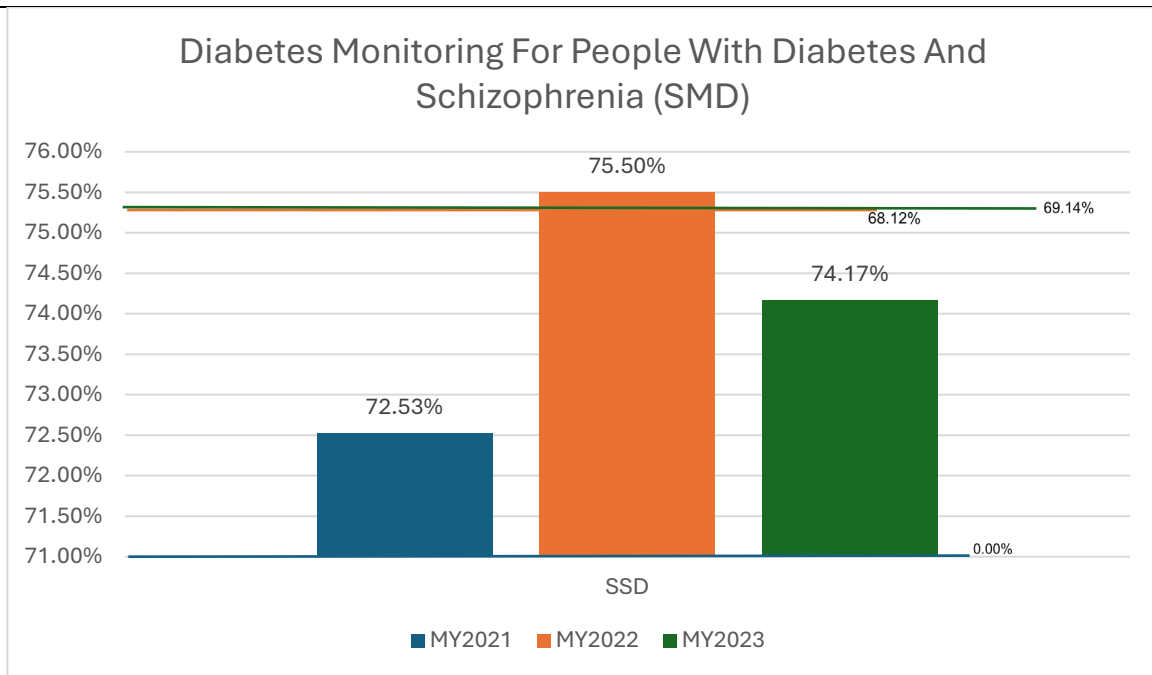


Chart caption: HEDIS Final Rates Trend Analysis

#### Quantitative Analysis:

CalOptima Health's 2023 SMD Measurement of Effectiveness of Opportunity HEDIS final rate was 74.17% which did not meet the intended goal of 76.66%. The final rate has demonstrated a slight decrease.

#### Identified Barriers:

- Timely data sharing

#### Identified Opportunities for Improvement:

- Attend collaborative meetings between teams to identify the best practices to implement.
- Attend provider and member education.

#### Conclusion:

In summary, CalOptima Health did not achieve the SMD Measurement of Effectiveness of Opportunity HEDIS goal of 76.66%. The data did show a slight decline from the year prior and missed the targeted HEDIS goal. The BHI department will continue to monitor this measure.

#### Activities/Interventions to continue/add next year:

- CalOptima Health will continue to monitor the SMD measure in 2025.

### 4.4.5 Behavioral Health (FUM)

Author: Jeni Diaz	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: MC 30-Day: 60.08%; 7-day: 40.59%	

To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	
Goal Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <ul style="list-style-type: none"> <li>• Share real-time emergency department (ED) data with our health networks on a secured FTP site.</li> <li>• Participate in provider educational events related to follow-up visits.</li> <li>• Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members to connect with a follow-up after ED visit.</li> <li>• Implement new behavioral health virtual provider visits to increase access to follow-up appointments.</li> <li>• Bi-weekly member text messaging (approximately 500 members).</li> <li>• Member newsletter (spring).</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>CalOptima Health's QIHETP program assesses the percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm diagnoses and who had a follow-up visit for mental illness.</p>	
<p>Methodology:</p> <p>Two rates are reported for this measure: The percentage of ED visits for which the member received follow-up care within seven days and 30 days an ED visit. Data is based on measurement year final HEDIS results and behavioral health care claims.</p>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>• Pulled data for BH data analyst to send out bi-weekly text messages based on real-time ED data.</li> <li>• Development of a pilot project for CHCN members identified who meet FUM criteria. BH telehealth provider to conduct outreach and assist with member linkage for identified FUM members.</li> <li>• Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Health Centers and Medical Provider Forum on March 15, 2024, regarding the importance of quality measure.</li> <li>• Collaborated with National Alliance on Mental Illness (NAMI) to share real-time ED data for member outreach.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Continued to pull data for BH data analyst to send out bi-weekly text messages based on real-time ED data.</li> <li>• Continued development of pilot project for CHCN members identified who meet FUM criteria. BH telehealth provider to conduct outreach and assist with member linkage for identified FUM members.</li> <li>• Continued collaboration with NAMI to share real-time ED data for member outreach.</li> <li>• Collaborated with telehealth vendor and internal ITS team to develop implementation plan for member outreach.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• Continued bi-weekly text messages to members based on real-time ED data.</li> <li>• Continued sharing ED data with health networks via SFTP and weekly health network communication.</li> <li>• Collaborated with NAMI to share real-time ED data for member outreach/NAMI by Your Side.</li> <li>• Continued to collaborate with telehealth vendor and internal ITS team to develop implementation plan for member outreach.</li> </ul>

	<ul style="list-style-type: none"> <li>Developed listening sessions for providers to educate/train on how to obtain BH data via CalOptima Health Provider Portal.</li> <li>Collaborated with the vendor to create an IVR campaign for ED Follow-up.</li> <li>FUM data became available through provider portal.</li> <li>Presented at The Coalition of Orange County Community Health Center meeting and Medical Provider Forum regarding BH Quality Measures on September 20, 2024.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Continued bi-weekly text message campaign.</li> <li>Continued sharing ED data with health networks via SFTP site.</li> <li>Telehealth vendor began Phase 1 launch (December 3, 2024) of outbound calls to members to schedule follow-up after ED appointments.</li> <li>Continued collaboration with vendor to create campaign for the IVR calls for ED follow-up.</li> <li>Educated members on the importance of ED follow-up appointments via fall member newsletter.</li> </ul>

#### Program Results:

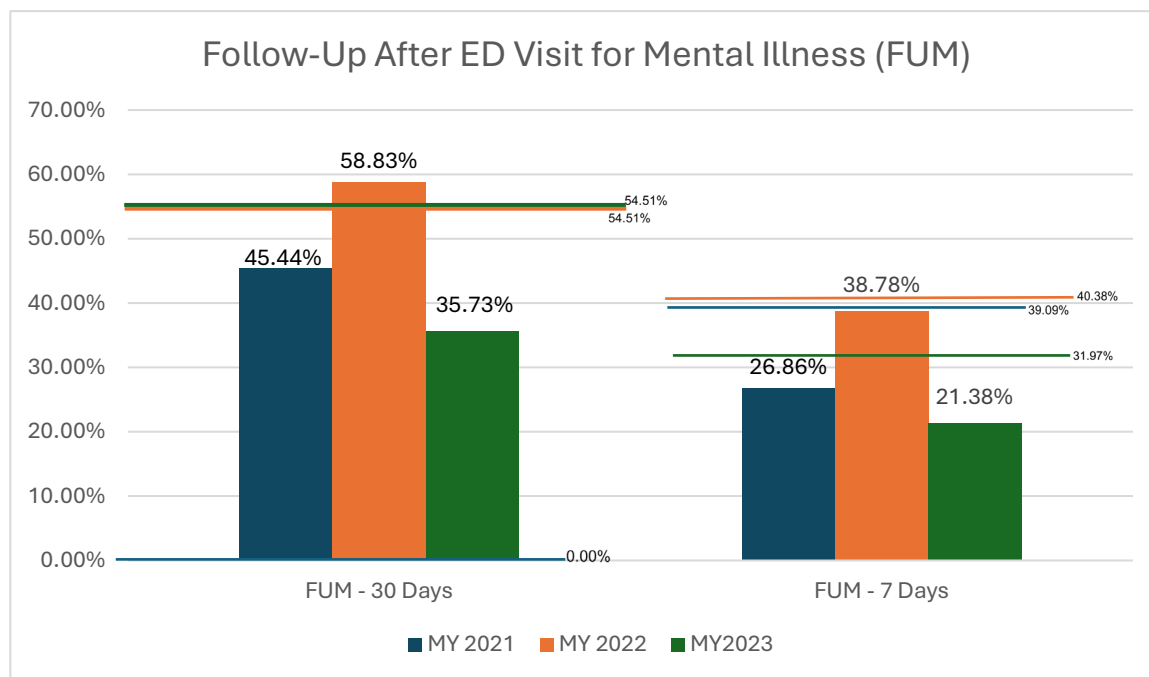


Chart caption: HEDIS Final Rates Trend Analysis

#### Quantitative Analysis:

The final 30-day rate for MY2023 was 35.73% which did not meet the intended goal of 54.51%. The final seven-day rate for MY2023 was 21.38% which also did not meet the intended goal of 31.97%. The FUM HEDIS measure demonstrated a significant decline in MY2023.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Not having the bandwidth to outreach to members who fall into the FUM measure daily.</li> </ul>	<ul style="list-style-type: none"> <li>Use of available technology such as texting and telehealth services may allow better access to follow-up appointments for members as well as new forms of member outreach via IVR and telehealth providers.</li> </ul>

<ul style="list-style-type: none"> <li>Data collection and data sharing with the HCA has been difficult due to privacy laws.</li> </ul>	<ul style="list-style-type: none"> <li>Participation with HCA for DHCS initiative to improve follow up after ED visits for mental health (FUM) rates.</li> </ul>
<p>Conclusion:</p> <p>Due to the measure not meeting the intended goal, we plan to continue to engage with both providers and members to achieve the desired outcome for FUM and improve data accessibility.</p>	
<p>Activities/Interventions to continue/add next year:</p> <ul style="list-style-type: none"> <li>IVR calls to members who fall under the FUM measure</li> <li>BH telehealth vendor will outreach to members from the daily ED data feed</li> <li>Continue bi-weekly member text messaging</li> <li>Member outreach with NAMI By Your Side (NBYS)</li> <li>Regular collaboration meetings between CalOptima Health and HCA.</li> </ul>	

<b>4.4.6 Behavioral Health (SSD)</b>	
Author: Nathalie Pauli	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>Work Plan Goal/Objective:</p> <p>MC: 77.40%</p> <p>To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.</p>	
Goal Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <ul style="list-style-type: none"> <li>Identify members in need of diabetes screening.</li> <li>Conduct provider outreach, work collaboratively with the communications department to fax best practices and lists of members still in need of screening to prescribing providers and/or PCPs.</li> <li>Information sharing via provider portal to PCP on best practices, with a list of members who need a diabetes screening.</li> <li>Send monthly reminder text messages to members (approximately 1,100 members).</li> <li>Member health reward program.</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>CalOptima Health's program assesses the percentage of members 18–64 years of age 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 these conditions are important.</p>	
<p>Methodology:</p> <p>CalOptima Health promotes diabetes screening for early detection and management for members who take antipsychotic medication and are diagnosed with schizophrenia, schizoaffective disorder or bipolar disorder. Antipsychotic medications raise the risk of developing diabetes. This measure focuses on the percentage of members 18–64 years of age who fall under the SSD criteria and complete a diabetes screening during the MY. Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends; the HEDIS data is reported based on the measurement period.</p>	
Actions/Interventions Implemented in 2024:	

Quarter 1:	<ul style="list-style-type: none"> <li>Continued tracking members in need of glucose screening test.</li> <li>Used provider portal to communicate follow-up best practices and guidelines for follow-up visits.</li> <li>Continued data pull for text messaging campaign.</li> <li>Mailed member health rewards flyer to eligible members.</li> <li>Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Health Centers and Medical Provider Forum on March 15, 2024, regarding the importance of quality measure.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>Continued tracking members in need of glucose screening test.</li> <li>Used provider portal to communicate follow-up best practices and guidelines for follow-up visits.</li> <li>Continued data pull for text messaging campaign.</li> <li>Mailed member health rewards flyer to eligible members.</li> <li>Mailed to all prescribing providers with the following: <ul style="list-style-type: none"> <li>Medical Director Letter</li> <li>Provider Tool Tip Sheet</li> </ul> </li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Continued tracking members in need of glucose screening test.</li> <li>Used provider portal to communicate follow-up best practices and guidelines for follow-up visits.</li> <li>Continued data pull for text messaging campaign.</li> <li>Mailed member health rewards flyer to eligible members.</li> <li>Mailed to all prescribing providers with the following: <ul style="list-style-type: none"> <li>Medical Director Letter</li> <li>Provider Tool Tip Sheet</li> <li>Member Health Reward Flyer</li> </ul> </li> <li>Presented at The Coalition of Orange County Community Health Center meeting and Medical Provider Forum regarding BH Quality Measures on September 20, 2024.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Continued tracking members in need of glucose screening test.</li> <li>Continued data pull for text messaging campaign.</li> <li>Mailed member health rewards flyer to eligible members.</li> <li>Mailed to all prescribing providers with the following: <ul style="list-style-type: none"> <li>Medical Director Letter</li> <li>Provider Tool Tip Sheet</li> <li>Member Health Reward Flyer</li> </ul> </li> </ul>
Program Results:	

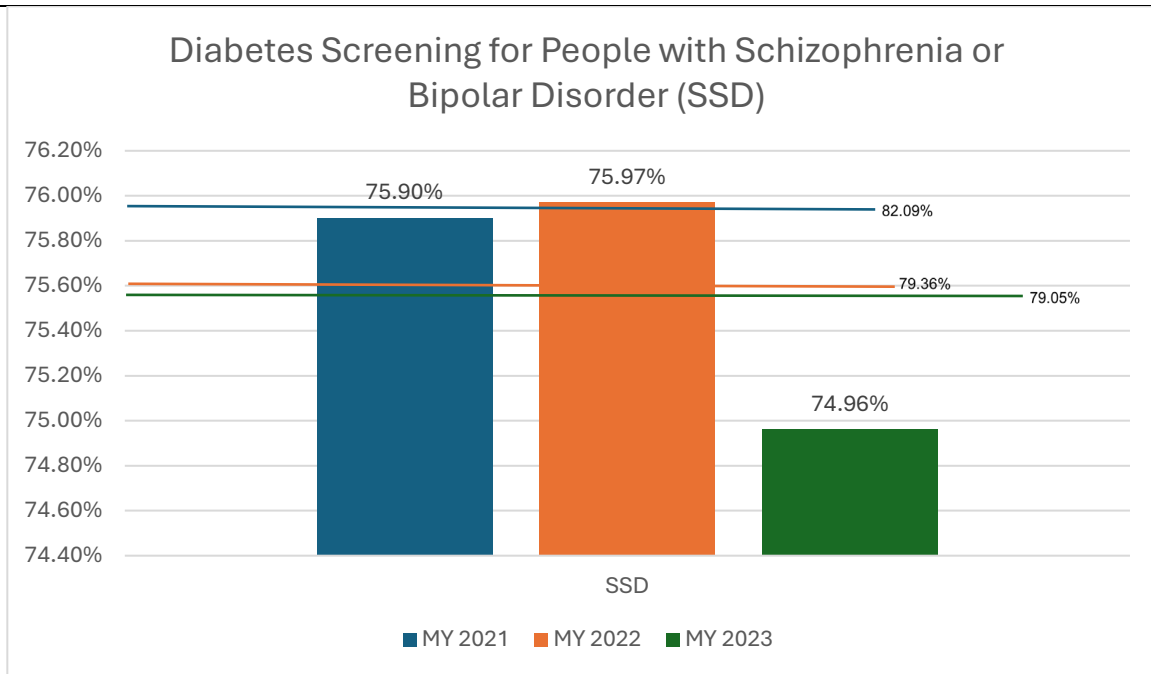


Chart caption: HEDIS Final Rates Trend Analysis

**Quantitative Analysis:**

CalOptima Health's 2023 SSD Measurement of Effectiveness of Opportunity HEDIS final rate was 74.96%, which did not meet the intended goal of 77.48%. The final rate has demonstrated a slight decrease.

**Identified Barriers:**

- No first quarter data available from ITS Data Warehouse team.
- Some members with this diagnosis may not see their PCP regularly.
- Some members may refuse to get their lab work completed.

**Identified Opportunities for Improvement:**

- Use provider portal to communicate follow-up best practices and guidelines for follow-up visits.
- Mail out member health rewards flyers to eligible members.
- Mail out all prescribing providers with the following:
  - Medical Director Letter
  - List of members/patients in need of screening
  - Provider Tool Tip Sheet

**Conclusion:**

In summary, CalOptima Health did not achieve the SSD Measurement of Effectiveness of Opportunity HEDIS goal of 77.48%. The data did show a slight decline from the year prior and missed the targeted HEDIS goal. Based on the provider's feedback, CalOptima Health is aware that some of the members may be having a difficult time getting the lab work completed. The BHI department will continue to monitor this measure and has begun to implement member-focused engagement and incentives to assist and encourage our members to complete the necessary screenings.

**Activities/interventions to continue/add next year:**

- Continue tracking members in need of glucose screening test.
- Use provider portal to communicate follow-up best practices and guidelines for follow-up visits.
- Continuing data pull for text messaging campaign
- Mail out member health rewards flyers to eligible members.
- Mail out the top 60 providers with the following:
- Medical director letter

- List of members/patients in need of screening
- Provider Tool Tip Sheet

#### 4.4.7 Behavioral Health (FUA)

Author: Valerie Venegas	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Work Plan Goal/Objective: MC: 30-days: 36.34%; 7-days: 20.0% To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	
Goal Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: <ul style="list-style-type: none"> <li>• Share real-time ED data with our health networks on an SFTP site.</li> <li>• Participate in provider educational events related to follow-up visits.</li> <li>• Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members with a follow-up after ED visit.</li> <li>• Implement new behavioral health virtual provider visits to increase access to follow-up appointments.</li> <li>• Bi-weekly member text messaging (approximately 500 members).</li> <li>• Member newsletter (Spring).</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: CalOptima Health's program assesses the percentage of ED visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose for which there was follow-up.	
Methodology: Two rates are reported in this program, the percentage of ED visits for which the member received follow-up within 30 days, as well as the percentage of ED visits for which the member received follow-up within seven days. Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>• Shared real-time ED data with our health networks on an SFTP Site.</li> <li>• Met with ITS to discuss data sourcing automation for the provider portal information sharing monthly.</li> <li>• Bi-weekly member text messaging.</li> <li>• Drafted article for Spring member newsletter.</li> <li>• Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Health Centers and Medical Provider Forum on March 15, 2024, regarding the importance of quality measure.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Shared real-time ED data with our health networks on an SFTP site.</li> <li>• Bi-weekly member text messaging.</li> <li>• Spring member newsletter (April 2024).</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• SFTP folders have been established, and BH ED data was sent to health networks daily, as well as weekly reminders in HN communication.</li> <li>• Bi-weekly member text messaging.</li> </ul>

	<ul style="list-style-type: none"> <li>Article promoting Telemed2U and telehealth services will be included in Fall member newsletter. The article will help with possible provider access issues and increase the likelihood of ED follow-up visits.</li> <li>Developed IVR calls for ED follow-up.</li> <li>FUA data became available through provider portal.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>SFTP folders have been established and BH ED data is being sent to health networks daily, as well as weekly reminders in HN communication.</li> <li>Bi-weekly member text messaging.</li> <li>Finalized IVR script calls for ED follow-up.</li> </ul>

Program Results:

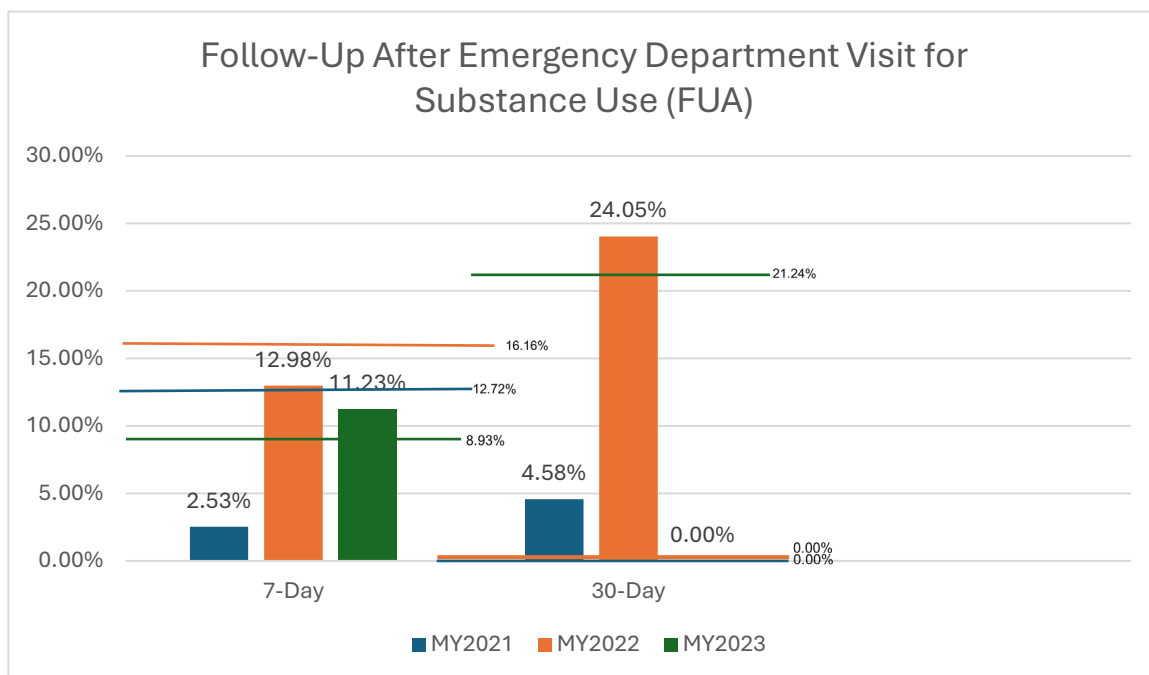


Chart caption: HEDIS Final Rates Trend Analysis

Quantitative Analysis:

CalOptima Health's MY2023 HEDIS final seven-day rate was 11.23% which met the intended goal of 8.93%. The final 30-day rate was 21.41%, which also met the intended goal of 21.24%. The data demonstrates a slight increase in members attending follow-up visits post-ED visits. The pattern appears to be continuing into MY2024.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Not having the bandwidth to outreach to members who fall into the FUA measure daily.</li> <li>Data collection and data sharing with the HCA has been difficult.</li> </ul>	<ul style="list-style-type: none"> <li>Use of available technology such as texting and telehealth services may allow better access to follow-up appointments for members as well as new forms of member outreach via IVR and telehealth providers.</li> </ul>

Conclusion:

Due to the measure not meeting the intended goal, we plan to continue to engage with both providers and members to achieve the desired outcome for FUA and improve data accessibility.

Activities/Interventions to continue/add next year:



- IVR calls to members who fall under the FUA measure
- BH Telehealth vendor will outreach to members from the daily ED data feed
- Continue bi-weekly member text messaging
- Member outreach with NAMI By Your Side (NBYS)

#### 4.4.8 Improving Adverse Childhood Experiences (ACES) Screening

Author: Nathalie Pauli | Department: Behavioral Health Integration (BHI)

Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov

Products: ☒ Medi-Cal ☐ OneCare | New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective: Improve Adverse Childhood Experiences (ACES) Screening

Goal Met: ☒ Yes ☐ No ☐ Partial

Work Plan Planned Activities:

Assess and report on the following activities:

- Collaborative meetings between teams to identify best practices to implement
- Provider and member education

Status: ☐ Completed ☒ Ongoing

Background:

CalOptima Health continues to recognize the importance of preventive health care to improve the health and well-being of our members and their families. Research has shown that trauma impacts brain function, coping and patient well-being. DHCS launched a statewide effort starting in January 2020 to screen for childhood trauma and treat the impacts of toxic stress. Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood (0–17 years). ACEs are linked to chronic health problems, mental illness and substance use disorder problems in adolescence and adulthood. ACEs can also negatively impact education, job opportunities and earning potential. ACEs are costly. In California, ACEs-related health consequences cost an estimated economic burden of \$112.5 billion in 2020 alone. CalOptima Health continues to reimburse providers in the amount of \$29 for each qualifying ACEs screening, including the requirement for providers to attest to having completed a certified trauma-informed care training program before they could be reimbursed for screenings. This report summarizes our progress on the implementation of the initiative.

Methodology:

CalOptima Health provides comprehensive support on the design and implementation of the ACEs initiative. During an appointment, an age-appropriate ACEs screening tool is administered to parents or caregivers for younger patients and directly to individuals who are adolescents or adults. There are several versions of the qualified screening tool, such as the Pediatric ACEs and Related Life-Events Screener (PEARLS) for members ages 0–19 years old and the Adverse Childhood Experience Questionnaire for members who are 18 years and older. Providers are eligible for reimbursement once per year for children, on a 12-month basis from the date of service, while the screening is reimbursable once in a lifetime for an adult.

Actions/Interventions Implemented in 2024:

- |            |   |
|------------|---|
| Quarter 1: | <ul style="list-style-type: none"> <li>• Continued collaborative meetings between teams to identify best practices to implement.</li> <li>• Continued provider and member education.</li> <li>• Continued to participate in ACEs-related stakeholder meetings.</li> <li>• Continued to review the quarterly ACES report.</li> </ul> |
| Quarter 2: | <ul style="list-style-type: none"> <li>• Continued collaborative meetings between teams to identify best practices to implement.</li> <li>• Continued provider and member education.</li> </ul>   |

	<ul style="list-style-type: none"> <li>Continued to participate in ACEs-related stakeholder meetings.</li> <li>Continue to review the quarterly ACES report.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Attended collaborative meetings between teams to identify best practices to implement.</li> <li>Attended provider and member education.</li> <li>Participated in ACEs-related stakeholder meetings.</li> <li>Continued to review the quarterly ACES report.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Attended collaborative meetings between teams to identify best practices to implement.</li> <li>Attended provider and member education.</li> <li>Continued to review the quarterly ACES report.</li> </ul>

#### Program Results:

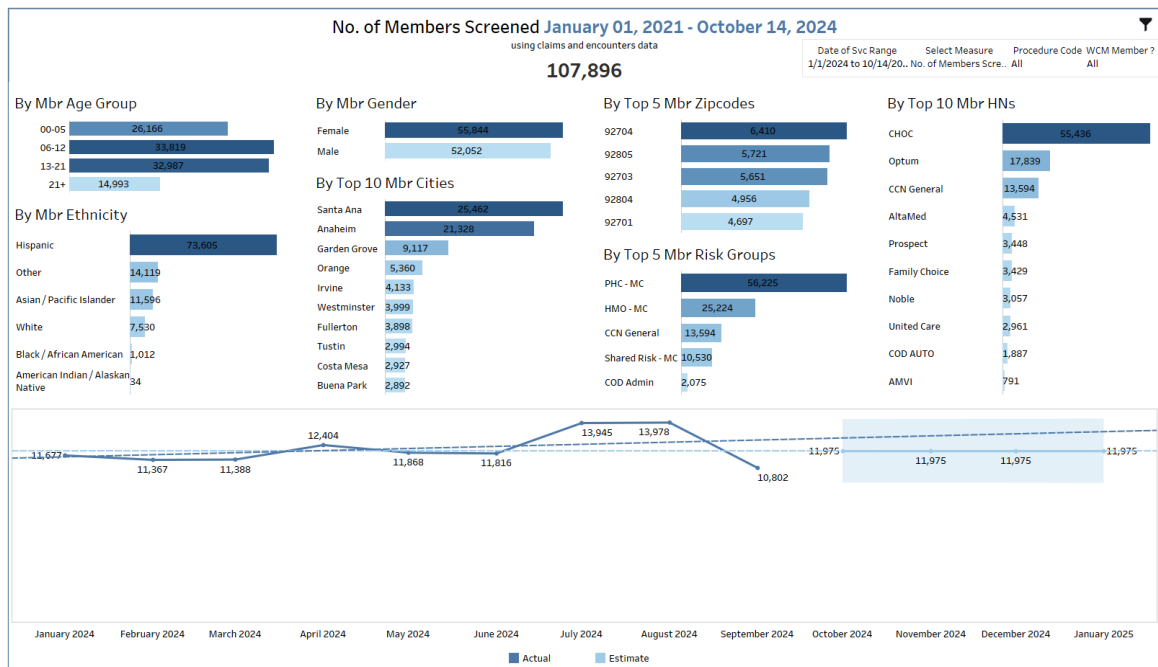


Chart caption: Number of members screened for ACEs

#### Quantitative Analysis:

CalOptima Health's data analyst calculated and published the rates for the measures in April 2024. The number of completed screenings (68,969) in RY2024 exceeded the goal of 41,793 screenings by 27,176 screenings. Thus, the goal was met. The RY2024 screenings of 68,969 decreased by 3,593 from the RY2023 screenings of 72,562. The RY024 screenings were 5,986 screenings higher than the RY2022 screenings of 62,983.

In addition, the ACEs Aware website displays quarterly ACES data across California. The most current September 2024 data shows Orange County has conducted the most ACEs screenings in CA, with over 42.4% of Medi-Cal members ages 0-20 screened to date.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Timely data sharing</li> </ul>	<ul style="list-style-type: none"> <li>CalOptima Health has continued to exceed the goal for the number of completed ACEs screenings.</li> </ul>
Conclusion:	

In summary, CalOptima Health intervention resulted in an increase in ACEs screenings completed. Our efforts have included the distribution of the ACEs Aware provider toolkit via provider training and our website and offering CME and CE events. Our data continues to show an improvement in the number of ACEs screening in both age groups. ACEs screening will continue to be a high priority for CalOptima Health to continue to improve the healthcare outcomes for our members.
Activities/Interventions to continue/add next year:
<ul style="list-style-type: none"> <li>Continue to review the quarterly ACES data and continue to report to QIHEC or other committees as appropriate.</li> </ul>

4.4.9 School Based Mental Health Services (SBHIP)	
Business Owner: Diane Ramos, Natalie Zavala, Carmen Katsarov	Department: Behavioral Health Integration (BHI)
Support Staff: Sherie Hopson	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Report on activities to improve access to preventive, early intervention and BH services by school-affiliated BH providers.	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: Assess and report on the following Student Behavioral Health Incentive Program (SBHIP) activities: <ul style="list-style-type: none"> <li>Implement SBHIP DHCS targeted interventions.</li> <li>Bi-quarterly reporting to DHCS</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: SBHIP was created by state law and managed by DHCS over the program's three-year timeline (January 1, 2022–December 31, 2024). Medi-Cal MCPs across California were eligible for up to \$389 million in incentive payments for developing programs that increase access to preventive, early intervention and behavioral health services with school-affiliated behavioral health providers and meeting performance metrics associated with these programs. DHCS has allocated up to \$25,459,676 for CalOptima Health as Orange County's MCP.	
Methodology: CalOptima Health SBHIP Partners (CHOC, Hazel Health, Western Youth Services, Orange County Department of Education (OCDE) and all 29 school districts) complete their DHCS-approved targeted interventions and SBHIP board-approved funded program/project by the close of SBHIP December 31, 2024. The targeted interventions are: <ul style="list-style-type: none"> <li>Behavior health screenings and referrals</li> <li>Building stronger partnerships to increase access to Medi-Cal services</li> <li>Technical assistance support for contracts</li> <li>IT enhancements for behavioral health services</li> </ul>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>CHOC hired a school transition coordinator and began serving youth in their Mental Health Crisis Clinic' School Reintegration Program. A total of 118 youths from the inpatient psychiatric unit and 11 from the emergency department were served.</li> <li>CHOC Deaf and Hard of Hearing Mental Health Services psychologist started working with elementary schools on an educational package to help schools educate staff and parents about the mental health needs of deaf/hard of hearing students.</li> </ul>

	<ul style="list-style-type: none"> <li>• CHOC and OCDE completed design walkthroughs for all 10 selected SBHIP-funded WellSpaces.</li> <li>• Hazel Health executed a no-cost memorandum of understanding directly with 20 of the 29 public school districts. Ten school districts launched Hazel Health telehealth services.</li> <li>• Hazel Health executed a CalOptima Health Behavioral Health Master Service Agreement.</li> <li>• CalOptima Health received DHCS approval for four December 2023 Biquarterly Reports.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• CHOC served youths in their Mental Health Crisis Clinic' School Reintegration Program, 101 from the inpatient psychiatric unit and 26 from the emergency department.</li> <li>• CHOC SBHIP-funded WellSpaces, the first of 10 installations completed at Marco Forster Middle School in the Capistrano Unified School District.</li> <li>• The Autism Comprehensive Care Program started recruitment for at least six patients to pilot the program.</li> <li>• A total of 16 public school districts launch Hazel Health telehealth services for their students at home or at the student's home.</li> <li>• OCDE: 22 of the 29 public school districts have expanded their behavioral staff, resulting in an overall 17% increase.</li> <li>• CalOptima Health received from DHCS the second of four SBHIP incentive payments for the four December 2023 Biquarterly Reports.</li> <li>• Four June Biquarterly Report submitted to DHCS.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• The CHOC School Reintegration program served 149 children hospitalized in their inpatient psychiatric unit and 21 from the emergency department.</li> <li>• CHOC Deaf and Hard of Hearing Mental Health Services' psychologist drafted an educational package to help schools educate staff and parents about the mental health needs of deaf and hard of hearing students.</li> <li>• CHOC SBHIP-funded WellSpaces, eight of 10 have been installed.</li> <li>• CHOC Autism Comprehensive Care Program's curriculum and workflows for referral are finalized.</li> <li>• A total of 19 public school districts have launched Hazel Health telehealth services for their students. Referred students' total count continues to increase monthly.</li> <li>• SBHIP aided in funding OCDE's 2nd Annual Mental Health Summit. The objective was to broaden access to mental health resources such as electronic health record vendors along with vendors representing various behavior screeners for the educators and mental health staff to gain more knowledge about these products. Approximately 400 were in attendance, twice as many as the previous year.</li> <li>• Western Youth Services deployed their on-demand virtual Behavioral Health Curriculum library for the school district staff and began conducting in-person training and post-training consultative support.</li> <li>• CalOptima Health received from DHCS the third of four SBHIP incentive payments for the four June Biquarterly Reports.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• Four Project Outcome Reports completed for DHCS SBHIP funding final payment.</li> <li>• SBHIP-funded CHOC's Autism Comprehensive Care Program revised launch date is projected for January 2025.</li> <li>• Eight of 10 SBHIP-funded WellSpace installations completed; the last two projected installation dates are late January/early February 2025.</li> </ul>
Quantitative Analysis:	

The operational portion of SBHIP is on target to close December 31, 2024. The partnerships developed during SBHIP will remain and regularly scheduled meetings will be established to monitor and report utilization and sustainability.	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>No barriers identified</li> </ul>	None
<p>Conclusion:</p> <p>The SBHIP has been successful due to DHCS having approved each bi-quarterly submission; therefore, the funding tied to each submission has been awarded.</p>	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>The operational portion of SBHIP is on target to close December 31, 2024. The partnerships developed during SBHIP will remain and regularly scheduled meetings will be established to monitor and report utilization and sustainability.</li> </ul>	

4.4.10 Adolescent Depression Screening	
Business Owner: Natalie Zavala	Department: Behavioral Health Integration
Support Staff: Diane Ramos	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>Work Plan Goal/Objective:</p> <p>DSF-E Depression Screening and Follow-up for Adolescent and Adults – Screening: 2.97%</p>	
Goal Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <ul style="list-style-type: none"> <li>Identification and distribution of best practices to health network and provider partners.</li> <li>Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion.</li> <li>Targeted member engagement and outreach campaigns in coordination with health network partners.</li> <li>Provider education (CE/CME) in Q3.</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>CalOptima Health monitors the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.</p>	
<p>Methodology:</p> <p>DSF-E has two rates:</p> <ul style="list-style-type: none"> <li>Depression Screening — The percentage of members who were screened for clinical depression using a standardized instrument.</li> <li>Follow-Up on Positive Screen — The percentage of members who received follow-up care within 30 days of a positive depression screen finding.</li> </ul>	
Medi-Cal Results:	

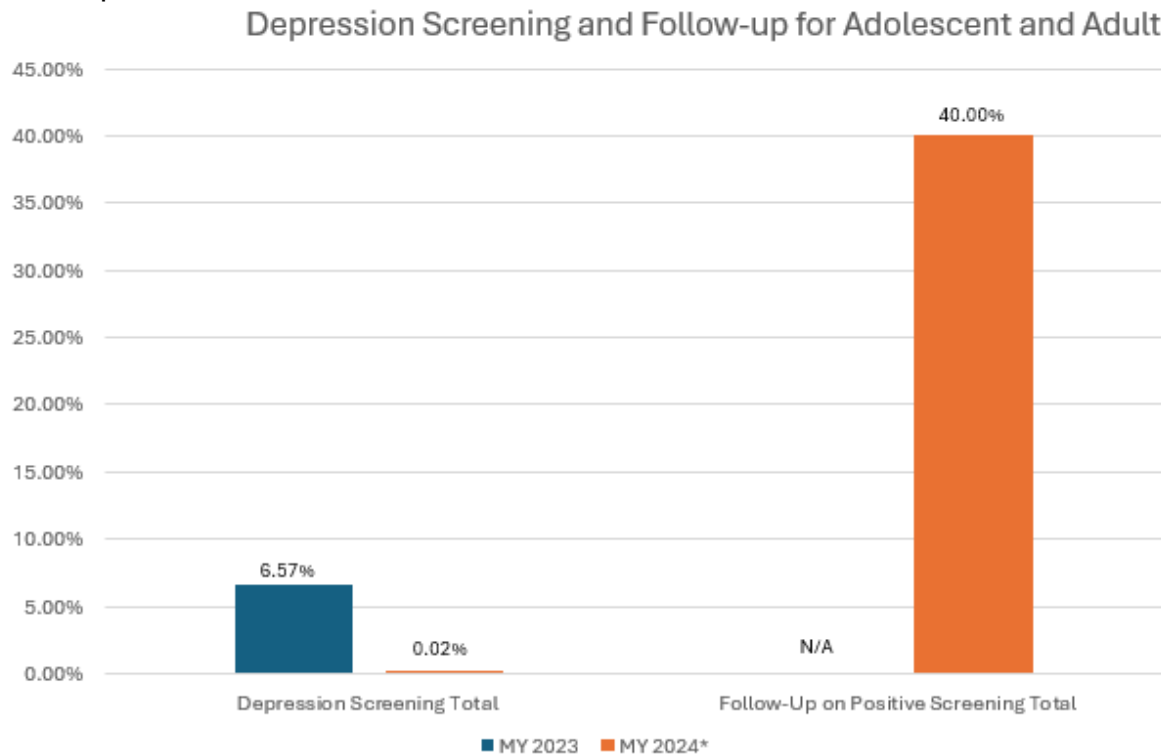
Acronym	Measure	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met / Not Met
DSF-E	Depression Screening and Follow-up for Adolescents and Adults: 12–17	6.80%	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
DSF-E	Depression Screening and Follow-up for Adolescent and Adults: 18–64	5.27%	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
DSF-E	Depression Screening and Follow-up for Adolescents and Adults: 65+	27.01%	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
DSF-E	Depression Screening and Follow-up for Adolescents and Adults: Total	6.57%	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A

Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Drafted provider tip sheet; letter submitted for internal review process.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	DSF-E
2. Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on September 20, 2024.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input checked="" type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	DSF-E
3. Monthly health network communication BH updates.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	DSF-E
4. Continued mailings to providers (provider letter tip sheet).	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	DSF-E

MC = Medi-Cal; OC= OneCare

Results:

Chart A: MY2023 and MY2024 September Prospective Rate for Depression Screening and Follow-up for Adolescents and Adults



\*MY 2024 Reflects September Prospective Rates

Chart caption: Chart A displays depression screening rates for 2023 (Final Rates) and September 2024 (Prospective Rates).

Quantitative Analysis:  
DSF-E: No Final Rates for Reporting Year 2024

Identified Barriers:	Identified Opportunities for Improvement:
DSF-E: <ul style="list-style-type: none"> <li>Data collection was the main barrier. Only supplemental data available.</li> </ul>	DSF-E: <ul style="list-style-type: none"> <li>The Behavioral Health Quality Improvement Workgroup is exploring ways to obtain additional supplemental data to better capture completed screenings and follow-up visits.</li> </ul>
Conclusion: DSF-E: For 2025, the BHI quality team will be actively monitoring DSF measures to track and trend the eligible member population.	
Activities/Interventions to continue/add next year:	
DSF-E: The following interventions are planned in 2025: <ul style="list-style-type: none"> <li>The BHI quality team will continue to mail a best practices letter/tool tip sheet to identified prescribing providers.</li> <li>BHI will be working with the appropriate team to identify data elements needed to track depression screening and follow-up care.</li> </ul>	

<b>4.4.11 Maternal Depression Screening</b>	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Kelli Glynn	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Work Plan Goal/Objective: Medi-Cal only — Meet the following goals For MY2024 HEDIS: <ul style="list-style-type: none"> <li>• PND-E Prenatal Depression Screening and Follow-up Screening: 8.81%</li> <li>• PDS-E Postpartum Depression Screening and Follow-up: 27.77%</li> </ul> Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: <ol style="list-style-type: none"> <li>1) Clinic provider days – Collaborative events to support non-compliant members to complete HEDIS measure activities.</li> <li>2) Complete maternal depression screenings during prenatal and postpartum assessment through the Bright Steps Program</li> <li>3) Refer members identified at risk through the Bright Steps assessments to BH or provide TeleMed2U information</li> <li>4) Provide community partners and contracted providers with maternal mental health training</li> </ol>	
Status: <input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing	
Background: Perinatal depression encompasses both minor and major depressive episodes that occur during pregnancy and the first 12 months following childbirth. Research shows that depression is a prevalent condition that significantly impacts the well-being and functionality of both birthing persons and their families. A study conducted by Jo, et al., found that the prevalence of depression in pregnant and postpartum persons, ranges from 12 to 15%, with some areas in the United States reporting as high as 20% prevalence.  Untreated depression during pregnancy can increase the risk of postpartum depression, suicide and complications to the infant, such as premature birth or low birth weight. Postpartum depression also impairs essential caregiving and disrupts the mother-to-infant bonding, which in turn can lead to long-term developmental issues for the child, issues which can persist well into the adolescent period.  Routinely assessing for depression utilizing a standardized tool during the prenatal and postpartum period can identify potential symptoms of depression and allow for early intervention and treatment if needed.  The Prenatal and Depression Screening and Follow-up measures are quality performance measures for HEDIS and are part of the reportable DHCS MCAS measures. These measures directly align with DHCS's Population Health Management Bold Goals by focusing proactively on identifying and addressing the mental health needs of birthing persons.	



Prenatal Depression Screening and Follow-up assesses the percentage of deliveries in which birthing persons were screened for clinical depression while pregnant and, if screened positive, received follow-up care.

Postpartum Depression Screening and Follow-up assesses the percentage of deliveries in which members were screened for clinical depression during the postpartum period and, if screened positive, received follow-up care.

**Methodology:**

CalOptima Health follows the HEDIS data collection methodology to assess performance with prenatal and postpartum depression screening and follow-up. Furthermore, the plan utilizes the previous year's performance and the NCQA Quality Compass benchmarks to set organizational goals. MY2024 is the first year in which rates were introduced for these measures. NCQA established a Medicaid 50th percentile rate for these two measures. However, the measures are not yet associated with an MPL; thus, the 50th percentile rate is a guide to direct CalOptima Health's work.

**Medi-Cal Results:**

- 1) Two clinic days were completed (UCI Family Health in Santa Ana and Anaheim). All members that attended these events were screened for prenatal or postpartum depression. A total of 48 members were screened, and six of these members indicated a positive screening for depression. The members who screened positive were provided additional support with an LCSW and provided with follow-up care.
- 2) CalOptima Health's Bright Steps program screened 316 pregnant members and 350 postpartum members for maternal depression with PHQ-2 and PHQ-9 screeners.
- 3) CalOptima Health partnered with Postpartum Support International to provide eight training sessions on maternal mental health. The Fall 2024 cohort had 135 registered individuals who serve CalOptima Health members at a range of provider offices, CBOs, hospitals and other agencies.

Acronym	Measure	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met / Not Met
PND-E	Prenatal Depression Screening and Follow-Up: Depression Screening Total	14.52%	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
PND-E	Prenatal Depression Screening and Follow-Up: Follow-Up on Positive Screening Total	52.8%	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
PDS-E	Postpartum Depression Screening and Follow-up: Depression Screening Total	17.33%	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
PDS-E	Postpartum Depression Screening and Follow-Up: Follow-Up on Positive Screen	56.84%	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A

Acro nym	Measure	MY 2021 OneC are Rate	MY 2022 OneC are Rate	MY 2023 OneC are Rate	MY 2023 OneC are Goal	MY 2023 Goal Me/Not Met	
<p>Actions/Interventions Implemented in 2024:</p> <p>Efforts to increase maternal depression screening include a collaborative maternal mental health program with HCA, providing the Bright Steps Program for prenatal and postpartum members and their babies through 1 year of age and a Postpartum Member Health Reward.</p> <p>The Maternal Depression Screening Workgroup, comprised of HCA, CalOptima Health and First Five OC, completed the following activities in 2024:</p> <ul style="list-style-type: none"> <li>• Implemented a provider survey to assess barriers to completion of maternal depression screening and follow-up care.</li> <li>• Facilitation of a Continuing Medical Education/Continuing Education (CME/CE) workshop on July 10, 2024, for physicians and health care professionals titled Maternal Mental Health Conditions, Screenings and Resources.</li> <li>• The Orange County Perinatal &amp; Infant Mental Health and Substance Use Toolkit was updated and shared online to promote best practices for maternal depression screening and support. Link: <a href="https://everyparentoc.org/pimhtoolkit/">https://everyparentoc.org/pimhtoolkit/</a></li> <li>• CalOptima Health sponsored 135 participants in the Postpartum Support International Maternal Mental Health Certificate Training Course. Participants include individuals who provide perinatal health services to pregnant and postpartum Medi-Cal members in Orange County, including OB/GYNs, pediatricians, midwives, PCPs, doulas, clinic staff, mental health professionals and paraprofessionals, maternal health educators, etc.</li> </ul>							
<p>Results:</p> <p>Both the prenatal and depression screening and follow-up measures are new. There are no benchmark rates set for MY2023, so CalOptima Health is not able to assess progress. Rates for both measures were introduced in MY2024. NCQA set forth a Medicaid 50th percentile for these two measures. CalOptima Health utilized the MY2024 rates set by NCQA as a guide to direct the work; however, there are no performance benchmarks set for both measures.</p> <p>When CalOptima Health assessed the MY2024 performance against the Medicaid 50th percentile for MY2024, it was evident that the plan met the goal.</p>							

**Chart A: MY2023 and MY2024 September Prospective Rate for Prenatal and Depression Screening**

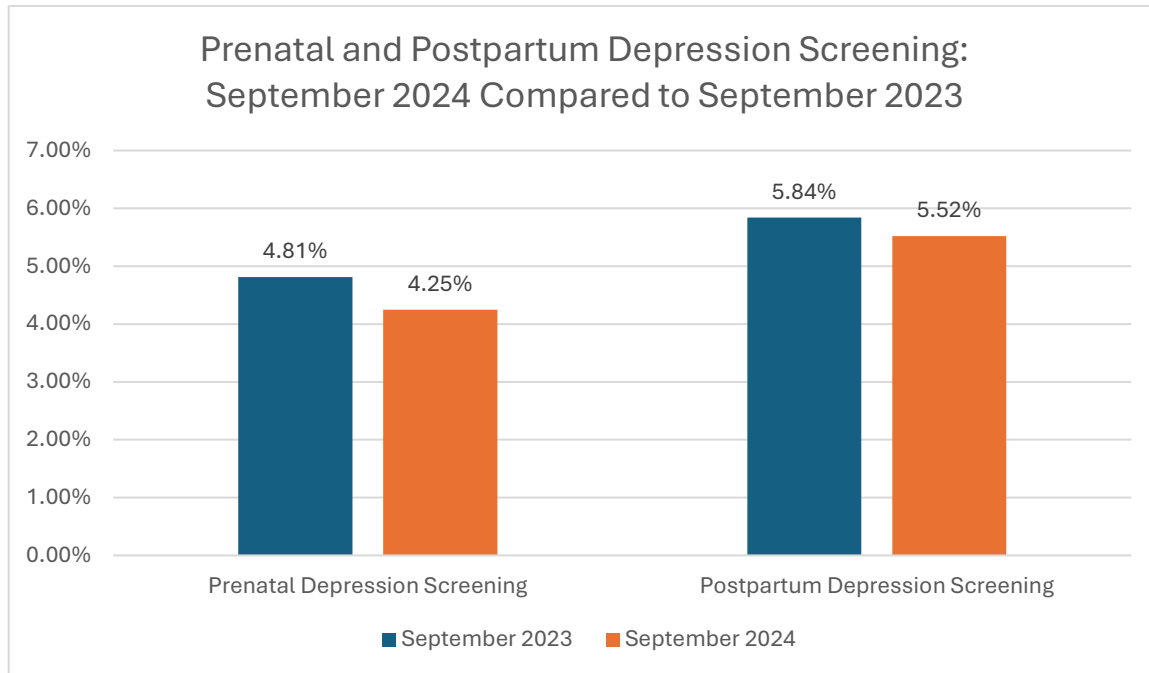


Chart caption: Chart A displays prenatal and postpartum depression screening rates for September 2023 compared to September 2024.

*Prospective rate methodology includes continuous enrollment criteria. Prospective rates are solely based on data received and are not final.*

**Quantitative Analysis:**

- Prenatal Depression Screening: When assessing the September 2024 prospective performance rate, the rate dropped less than 1% compared to September 2023. The decrease is not significant, but the plan will continue to monitor.
- Postpartum Depression Screening: When assessing the September 2024 prospective performance rate, the rate dropped less than 1% compared to September 2023. The decrease is not significant, but the plan will continue to monitor.
- Data limitations: For 2023, there were no positive screens identified for prenatal or postpartum care, so CalOptima Health could not draw comparisons between 2024 and the previous year. This is likely due to the challenges associated with obtaining this data.
- Accurate documentation of screenings is critical to assess performance for the delivery of care. For the methodology in which providers document the screening, the data systems can pose barriers to capturing the care that is being delivered. For example, these screenings are often associated with a LOINC code that is not received through the standard claim and encounter process. Consequently, these rates are likely an underestimation of the care that is being delivered. For example, follow-up care may have taken place, but it might not be recorded in a way that can be easily tracked in data systems.

**Identified Barriers:**

- Low HEDIS rates for maternal depression screening are often due to challenges in data

**Identified Opportunities for Improvement:**

- Improving HEDIS maternal depression screening rates requires targeted efforts to

<p>collection, reporting and standardization rather than a lack of actual screening.</p> <ul style="list-style-type: none"> <li>Many providers perform screenings but fail to document them in a way that is visible for HEDIS reporting, often because of gaps in electronic health record (EHR) systems, incomplete or incorrect coding or the use of non-reportable screening tools.</li> <li>Workflows and high workloads may deprioritize documentation, while fragmented data systems and lack of integration between behavioral health and medical care further hinder accurate reporting.</li> <li>Additionally, some patients decline screenings due to stigma or privacy concerns and missed postpartum visits reduce opportunities for screening and documentation.</li> </ul>	<p>enhance data accuracy and capture. This includes training providers and clinic staff on proper documentation and coding, optimizing EHR systems to prompt and record screenings, and improving interoperability between medical, behavioral health, and health network systems.</p> <ul style="list-style-type: none"> <li>Patient education can help reduce stigma and encourage participation in screening and follow-up for care for those who need additional support.</li> </ul>
<p><b>Conclusion:</b></p> <p>While the performance rates for prenatal and postpartum depression screenings have remained relatively stable from 2023 to 2024, the absence of positive screens in 2023 and the challenges with documentation make it difficult to definitively determine whether the maternal health program has been entirely successful. We must continue to monitor screening rates and improve data documentation processes to ensure a more accurate assessment of care delivery. Despite these challenges, the program is showing a consistent effort in screening and follow-up, and further improvements are anticipated with continued monitoring and enhancement of data systems. Ultimately, while there have been some minor decreases, these do not significantly impact the overall success of the program at this stage, and steps will be taken to address any gaps identified in future evaluations.</p>	
<p><b>Activities/Interventions to continue/add next year:</b></p> <ul style="list-style-type: none"> <li>Pursue direct EHR integrations with CHCN providers/community clinics to extract depression screening results for care gap closure.</li> <li>Provide CHCN providers/community clinics with the inbound supplemental data file layout that can be utilized to capture depression screening results.</li> <li>Provide CHCN providers/community clinics and health network partners with depression screening coding education, such as the utilization of LOINC codes.</li> <li>Explore the ability to capture depression screenings completed in an inpatient setting via vendor PointClickCare.</li> <li>Continue to increase provider awareness about maternal depression screenings and resources.</li> <li>Continue community/clinic-based screening events to meet members where they are.</li> </ul>	

## 4.5 Managing Members with Chronic Conditions

4.5.1 Diabetes Care (HBD, EED)	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Melissa Morales/Kelli Glynn	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Work Plan Goal/Objective: EED: MC 66.33% OC 81% HBD: MC 29.44% OC 20%
Goal Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial
<p>Work Plan Planned Activities:</p> <p>Targeted member engagement and outreach campaigns in coordination with health network partners.</p> <p>Strategic Quality Initiatives Intervention Plan — Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.</p>
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing
<p>Background: According to the Centers of Disease Control and Prevention (CDC), diabetes raises the risk for high blood pressure, which increases a person's chances of heart disease, stroke, vision loss and kidney disease. Tests and screenings are necessary for people with diabetes to catch any changes before they turn into major health problems. They can also help providers create specific treatment plans based on their patients' needs.</p> <p>The following is an evaluation of the diabetes care measure for HEDIS. Hemoglobin A1C Control for Patients with Diabetes – HbA1C Poor Control &gt; 9% (HBD) is part of DHCS MCAS for annual reporting by Medi-Cal MCPs. This measure is held to the MPL established by NCQA Quality Compass Medicaid 50th percentile. HBD and Eye Exam for Patients with Diabetes (EED) measures are part of the CMS 5-Star quality rating system.</p> <p>Methodology: Followed the HEDIS data collection methodology.</p> <p>Goal methodology for MY2023 is set based on the current reported performance and the most current available benchmark. The Medi-Cal goal setting for MY2023 is based on the MY2021 reported performance results compared to the national percentile from the MY2021 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile. The OneCare goal setting for MY2023 is based on the MY2021 reported performance results compared to the Star Rating cutoff. If the current reported rate reached the Star cutoff, then the goal was set to the next Star cutoff.</p> <p>Goal methodology for MY2024 is set based on the current reported performance and the most current available benchmark. The Medi-Cal goal setting for MY2024 is based on the MY2022 reported performance results compared to the national percentile from the MY2022 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile. The OneCare goal setting for MY2024 is based on the MY2022 reported performance results compared to the Star Rating cutoff. If the current reported rate reached the Star cutoff, then the goal was set to the next Star cutoff.</p> <p>For health disparity analysis, the data is pulled from the member enrollment file. The data is uploaded to the NCQA certified HEDIS software for rate calculation. The stratified rates are rolled up by denominator and numerator based on the rate/ethnicity, language or gender information uploaded.</p>
Medi-Cal Results:

Acronym	Measure	MY2021 Medi-Cal Rate	MY2022 Medi-Cal Rate	MY2023 Medi-Cal Rate	MY2023 Medi-Cal Goal	MY2023 Goal Met/ Not Met
HBD	Hemoglobin A1C Control for Patients with Diabetes — HbA1C Poor Control (>9%)	28.75%	30.41%	29.34%	30.90%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
EED	Eye Exam for Patients with Diabetes	65.11%	62.63%	63.52%	63.75%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Acronym	Measure	MY2023 Sept Medi- Cal Rate	MY2024 Sept Medi- Cal Rate	MY2024 Medi-Cal Goal	MY2024 Goal Met / Not Met
HBD	Hemoglobin A1C Control for Patients with Diabetes — HbA1C Poor Control (>9%)	57.05%	56.90%	29.44%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
EED	Eye Exam for Patients with Diabetes	44.09%	41.79%	66.33%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

### HEDIS MY 2023 Rates by Gender for the Hemoglobin A1C Control for Patients with Diabetes Measure (Medi-Cal LOB)

SUBMEASURE_ KEY	GENDER_CODE	DENOMINATOR COUNT	NUMERATOR COUNT	RATE
HBA1C8	F	26113	12779	48.94%
HBA1C8	M	20920	9118	43.59%
		47033	21897	46.56%

### Analysis

- As shown in the above table, the overall total rate for the HbA1C Control <8 (HBD) measure in MY2023 was 46.56% (prior to hybrid lift). Using the total rate as a reference point, female members performed higher than male members, with a compliance rate of 48.94% compared to 43.59% respectively. Neither gender met nor exceeded the MPL of 52.31%. In conclusion, CalOptima Health will continue to implement initiatives aimed at improving HBD performance across the entire population.

### HEDIS MY 2023 Rates by Language for the Hemoglobin A1C Control for Patients with Diabetes Measure (Medi-Cal LOB)

SUBMEASURE_ KEY	SPOKEN LANGUAGE	DENOMINATOR COUNT	NUMERATOR COUNT	RATE
HBA1C8	AltLang - Braille	1	0	0.00%
HBA1C8	American Sign language	13	7	53.85%
HBA1C8	Arabic	539	295	54.73%
HBA1C8	Armenian	4	1	25.00%
HBA1C8	Audio - Arabic	1	1	100.00%
HBA1C8	Audio - English	2	0	0.00%
HBA1C8	Audio - Farsi	1	1	100.00%
HBA1C8	Audio - Vietnamese	1	0	0.00%
HBA1C8	Bengali	31	22	70.97%
HBA1C8	Burmese	5	2	40.00%
HBA1C8	Cambodian	84	51	60.71%
HBA1C8	Cantonese	22	19	86.36%
HBA1C8	Chinese	64	32	50.00%
HBA1C8	Czech	1	0	0.00%
HBA1C8	Egyptian	18	9	50.00%
HBA1C8	English	20939	9433	45.05%
HBA1C8	Estonian	3	3	100.00%
HBA1C8	Farsi	575	342	59.48%
HBA1C8	Finnish	2	1	50.00%
HBA1C8	French	4	3	75.00%
HBA1C8	Greek	2	0	0.00%
HBA1C8	Gujarati	45	23	51.11%
HBA1C8	Hebrew	4	2	50.00%
HBA1C8	Hindi	72	38	52.78%
HBA1C8	Hmong	2	0	0.00%
HBA1C8	Indian	3	2	66.67%
HBA1C8	Indonesian	12	5	41.67%
HBA1C8	Japanese	8	6	75.00%
HBA1C8	Korean	477	294	61.64%
HBA1C8	Lao	14	9	64.29%
HBA1C8	Large Print - Arabic	2	1	50.00%
HBA1C8	Large Print - English	16	10	62.50%
HBA1C8	Large Print - Spanish	10	6	60.00%
HBA1C8	Large Print - Vietnamese	5	3	60.00%
HBA1C8	Maltese	1	0	0.00%

HBA1C8	Mandarin	136	77	56.62%
HBA1C8	Marathi	1	0	0.00%
HBA1C8	Member Declined	4	3	75.00%
HBA1C8	No Valid Data Reported	290	118	40.69%
HBA1C8	Other	39	22	56.41%
HBA1C8	Other Chinese Languages	2	1	50.00%
HBA1C8	Other Non English	36	16	44.44%
HBA1C8	Portuguese	12	6	50.00%
HBA1C8	Punjabi	13	7	53.85%
HBA1C8	Romanian	22	7	31.82%
HBA1C8	Russian	28	17	60.71%
HBA1C8	Samoan	10	4	40.00%
HBA1C8	Sign Language	5	2	40.00%
HBA1C8	South Indian	2	2	100.00%
HBA1C8	Spanish	18184	7922	43.57%
HBA1C8	Swahili	5	4	80.00%
HBA1C8	Tagalog	201	115	57.21%
HBA1C8	Tamil	4	2	50.00%
HBA1C8	Teluga	5	4	80.00%
HBA1C8	Thai	12	3	25.00%
HBA1C8	Turkish	9	4	44.44%
HBA1C8	Ukranian	2	1	50.00%
HBA1C8	Urdu	48	23	47.92%
HBA1C8	Uzbek	3	3	100.00%
HBA1C8	Vietnamese	4977	2913	58.53%
		47033	21897	46.56%

## Analysis

- b. As shown in the above table, the overall total rate for the HbA1C Control <8 (HBD) measure in MY2023 was 46.56% (prior to hybrid lift). Using the total rate as a reference point, below are some observations:
  - a. The largest population is English-speaking members (20,939 out of the total 47,033). As compared to the reference point, English-speaking members perform slightly lower (at 45.05%). English-speaking members did not meet or exceed the MPL of 52.31%.
  - b. The second largest population is Spanish-speaking members (18,184 out of the total 47,033). As compared to the reference point, Spanish-speaking members perform lower (at 43.57%). Spanish-speaking members did not meet or exceed the MPL of 52.31%.



- c. The third largest population is Vietnamese-speaking members (4,977 out of the total 47,033). As compared to the reference point, Vietnamese-speaking members perform higher (at 58.53%). Vietnamese-speaking members also exceeded the MPL of 52.31%.
- d. There are several groups that met or exceeded the MPL of 52.31%, including:
  - i. Estonian
  - ii. Uzbek
  - iii. South Indian
  - iv. Cantonese
  - v. Swahili
  - vi. Teluga
  - vii. Japanese
  - viii. French
  - ix. Bengali
  - x. Indian
  - xi. Lao
  - xii. Korean
  - xiii. Cambodian
  - xiv. Russian
  - xv. Farsi
  - xvi. Vietnamese
  - xvii. Tagalog
  - xviii. Mandarin
  - xix. Arabic
  - xx. American Sign language
  - xxi. Punjabi
  - xxii. Hindi
- e. There are several groups that did not meet or exceed the MPL of 52.31%, including:
  - i. Greek
  - ii. Hmong
  - iii. AltLang – Braille
  - iv. Czech
  - v. Maltese
  - vi. Marathi
  - vii. Thai
  - viii. Armenian
  - ix. Romanian
  - x. Samoan
  - xi. Burmese
  - xii. Sign Language
  - xiii. Indonesian
  - xiv. Spanish
  - xv. Other Non English
  - xvi. Turkish
  - xvii. English
  - xviii. Urdu
  - xix. Chinese

- xx. Egyptian
- xxi. Portuguese
- xxii. Hebrew
- xxiii. Tamil
- xxiv. Finnish
- xxv. Other Chinese Languages
- xxvi. Ukranian
- xxvii. Gujarati

f. In conclusion, CalOptima Health will continue to implement initiatives aimed at improving HBD performance across the entire population.

**OneCare Results:**

Acronym	Measure	MY2021 OneCare Rate	MY2022 OneCare Rate	MY2023 OneCare Rate	MY2023 OneCare Goal	MY2023 Goal Met/ Not Met
HBD	Hemoglobin A1C Control for Patients with Diabetes — HbA1C Poor Control (>9%)	19.13%	21.67%	15.30%	17%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
EED	Eye Exam for Patients with Diabetes	78.96%	73.33%	75.14%	79%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Acronym	Measure	MY2023 Sept OneCare Rate	MY2024 Sept OneCare Rate	MY2024 OneCare Goal	MY2024 Goal Met/ Not Met
HBD	Hemoglobin A1C Control for Patients with Diabetes — HbA1C Poor Control (>9%)	42.97%	51.45%	20%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
EED	Eye Exam for Patients with Diabetes	59.33%	59.48%	81%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Table below reviews September MY2024 Hemoglobin A1C Control for Patients with Diabetes — HbA1C Poor Control (>9%) by race/ethnicity based on administrative data.

Admin	Race/Ethnicity									
HEDIS Sept MY2024	Hispanic	White	Vietnamese	Other	No response, client declined to state	Filipino	Asian or Pacific Islander	Korean	Black	Asian Indian
Numerator	17194	3460	3298	2203	2251	606	411	323	427	240
Denominator	28304	6218	5936	4192	3643	1122	741	739	718	460
Rate	60.75%	55.64%	55.56%	52.55%	61.79%	54.01%	55.47%	43.71%	59.47%	52.17%

Table caption: Table displays the top 10 ethnicities with the highest denominator based on total HEDIS Medi-Cal and OneCare population combined.

Table below reviews September MY2024 Eye Exam for Patients with Diabetes by race/ethnicity based on administrative data.

Admin	Race/Ethnicity									
HEDIS Sept MY2024	Hispanic	White	Vietnamese	No response, client declined to state	Other	Filipino	Asian or Pacific Islander	Black	Asian Indian	Chinese
Numerator	1046	371	318	215	194	87	42	43	35	24
Denominator	1759	725	492	365	324	150	82	77	50	31
Rate	59.47%	51.17%	64.63%	58.90%	59.88%	58.00%	51.22%	55.84%	70.00%	77.42%

Table caption: Table displays the top 10 ethnicities with the highest denominator based on total HEDIS Medi-Cal and OneCare population combined.

Actions/Interventions Implemented in 2024:

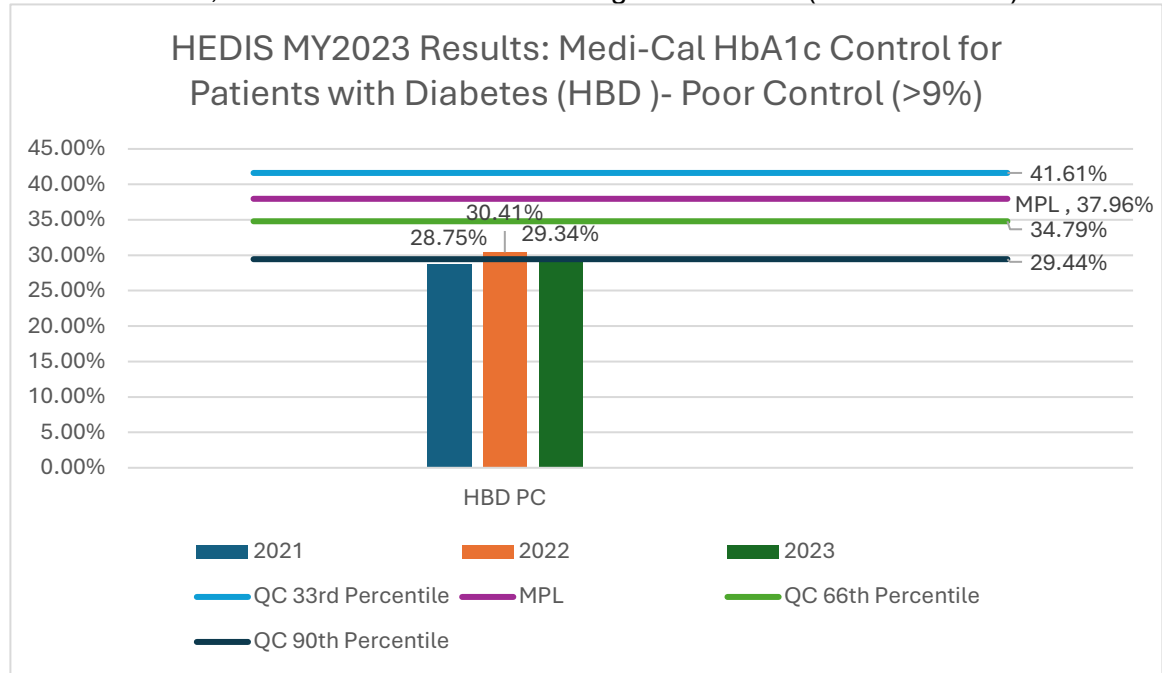
Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Member health reward	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	HBD EED
2. Member mailing	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	HBD EED
3. Text messaging	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	HBD EED
4. Telephonic outreach	<input type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	HBD EED
5. VSP vision care data exchange	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input checked="" type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	EED
6. Ophthalmologist provider outreach project	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	EED
7. Health coach diabetes management program for emerging risk population	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	HBD

☐ Other

MC = Medi-Cal; OC= OneCare

#### Results:

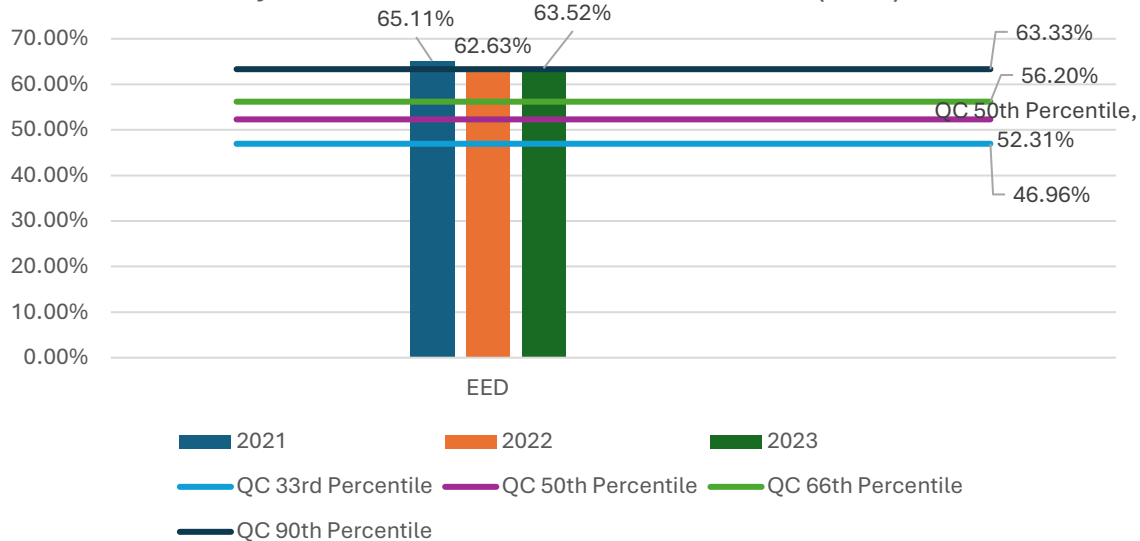
- CalOptima Health's HEDIS MY2023 HBD hybrid rate for Medi-Cal was 29.34% and met the MPL of 37.96%, and met the MY2023 internal goal of 30.9%. (Lower is better)



*Per HEDIS 2022 Quality Compass Percentile*

- CalOptima Health's HEDIS MY2023 EED hybrid rate for Medi-Cal was 63.52% and met 50th percentile of 52.31% but did not meet the MY2023 internal goal of 63.75%.

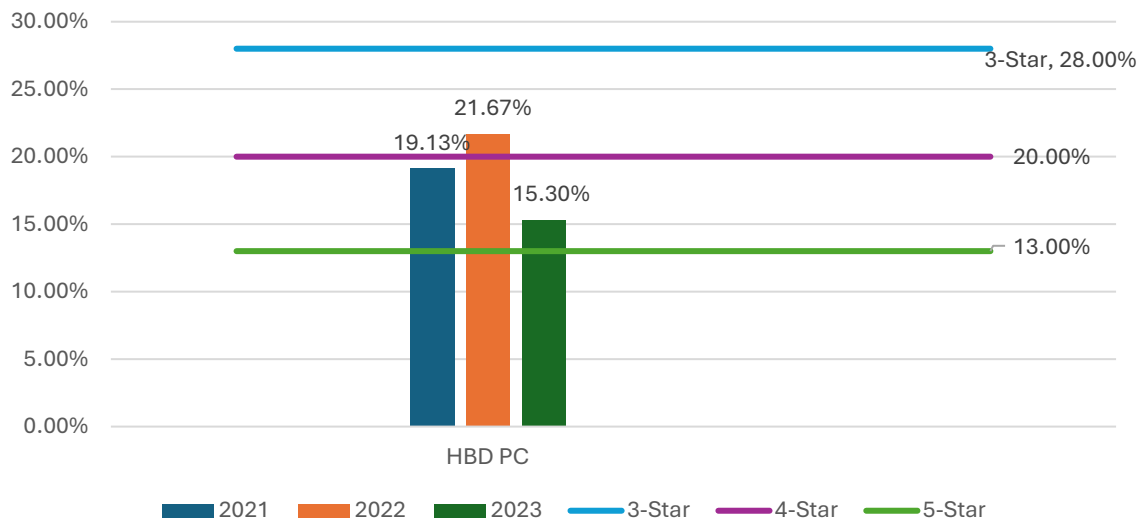
### HEDIS MY2023 Results: Medi-Cal Eye Exam for Patients with Diabetes (EED)



*Per HEDIS 2022 Quality Compass Percentile*

- CalOptima Health's HEDIS MY2023 hybrid rate for OneCare was 15.30% and met the projected 3-Star of 28% and the MY2023 internal goal of 17%. (Lower is better)

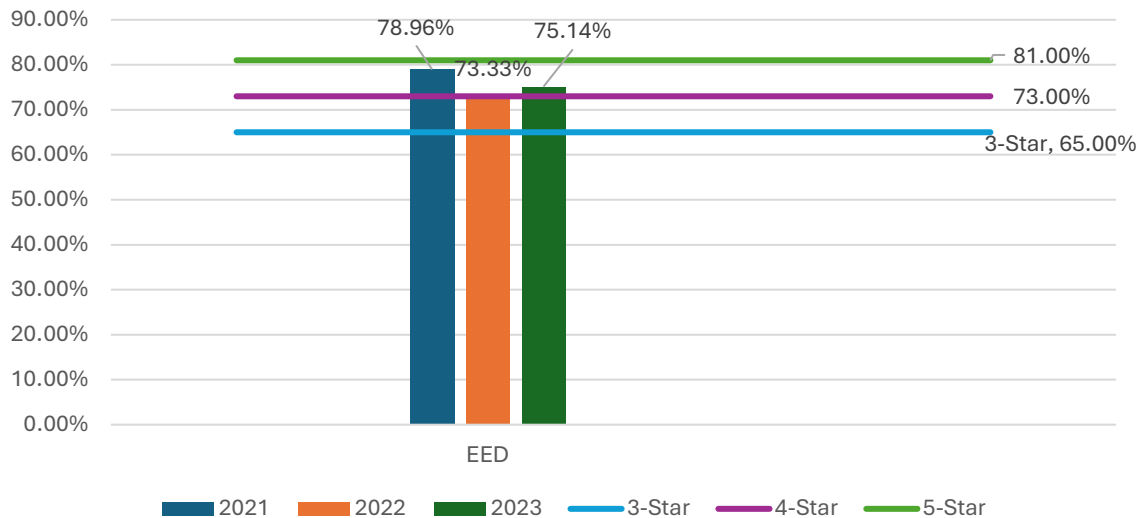
### HEDIS MY2023 Results: OneCare HbA1c Control for Patients with Diabetes (HBD )- Poor Control (>9%)



*CMS 2024 Benchmarks*

- CalOptima Health's HEDIS MY2023 hybrid rate for OneCare was 75.14% and met the projected 3-Star of 65% but did not meet the MY2023 internal goal of 79%.

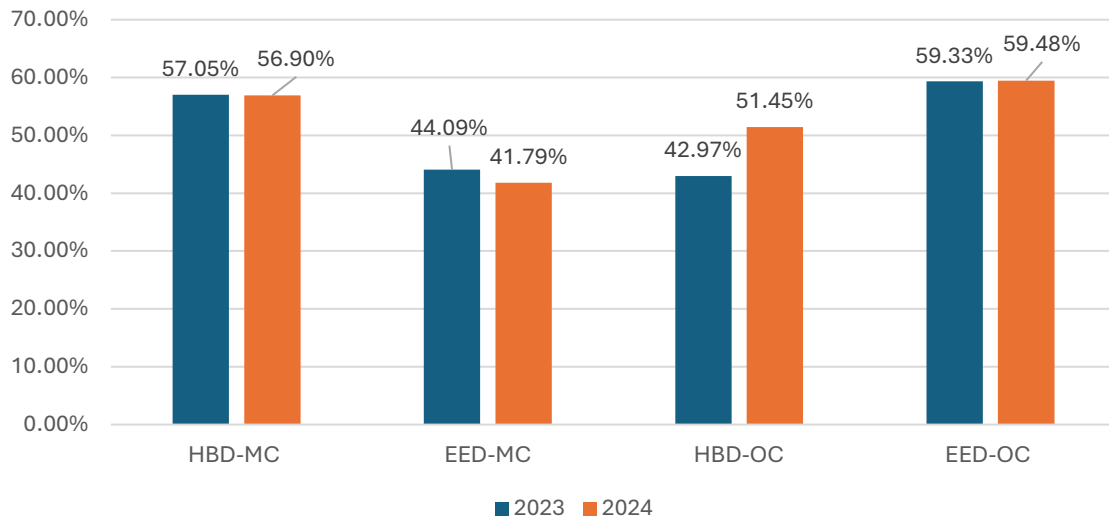
### HEDIS MY2023 Results: Medi-Cal Eye Exam for Patients with Diabetes (EED)



#### CMS 2024 Benchmarks

- CalOptima Health diabetes care rates for September HEDIS MY2023–2024 for Medi-Cal and OneCare.

### September HEDIS MY2023-MY2024: Medi-Cal and OneCare Diabetes Care Rates (HBD, EED)



#### Quantitative Analysis:

Comparing CalOptima Health Medi-Cal diabetes care rates for September HEDIS MY2023–MY2024. The rates are based on the administrative data and represent the claims/encounters process through the month of September for each respective year.

HBD-MC: As of September 2024, the HBD-PC prospective rate was 56.90%, which is lower than the September 2023 prospective rate of 57.05% by 0.15 percentage points (lower is better).

EED-MC: As of September 2024, the EED prospective rate was 41.79%, which is lower than the September 2023 prospective rate of 44.09% by 2.30 percentage points.

HBD-OC: As of September 2024, the HBD-PC prospective rate was 51.45%, which is higher than the September 2023 prospective rate of 42.97% by 8.48 percentage points (lower is better).

EED-OC: As of September 2024, the EED prospective rate was 59.48%, which is higher than the September 2023 prospective rate of 59.33% by 0.15 percentage points.

#### Disparity Analysis:

Using the total rate as a reference point (58.32%), below are some observations:

Hemoglobin A1c Control for Patients with Diabetes- HbA1c Poor Control (>9%) (HBD-MC, OC): When looking at the top three race/ethnicity groups by denominator count, the Vietnamese group had the lowest rate at 55.56% (lower is better), which is 2.68 percentage points lower than the total rate (58.32%). While the group identified as Hispanic had the highest rate at 60.75%, which is 2.43 percentage points higher than the total rate (58.32%).

Using the total rate as a reference point (58.64%), below are some observations:

Eye Exam for Patients with Diabetes (EED-MC, OC): When looking at the top three race/ethnicity groups by denominator count, the Vietnamese group had the highest rate at 64.63%, which is 5.99 percentage points higher than the total rate (58.64%). While the group identified as White had the lowest rate at 51.17%, which is 7.47 percentage points lower than the total rate (58.64%).

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>The ability to reach members (mail, phone, text) creates challenges around providing members with information on diabetes care.</li> <li>Members did not visit their PCP during MY2024 and did not receive assistance for their diabetes management.</li> <li>Lack of knowledge of the importance of A1C testing and retinal eye exam.</li> <li>Appointment access could be limited due to scheduling ability and/or staff shortage, resulting in long waiting times for appointments</li> <li>Lack of medical release forms between specialist and PCP of diabetic retinal eye exam results.</li> <li>Lack of data sharing between VSP due to contract restrictions between CalOptima Health and VSP provider network, prohibiting direct data share to any health network and only permitting sharing data via the health plan.</li> </ul>	<ul style="list-style-type: none"> <li>Data optimization</li> <li>Provider and health network quality committee meetings provide input on quality-related opportunities, helping identify barriers, develop and implement effective approaches</li> <li>Develop member journey campaigns with new text messaging vendor to diminish member outreach abrasion</li> <li>Internal member-facing departments will remind members of gaps in care during calls.</li> <li>Member outreach specific to factors such as race/ethnicity</li> <li>Internal member-facing departments will remind members of gaps in care during calls.</li> <li>Engagement with specialists, such as ophthalmologists for direct member reminder and appointment scheduling</li> </ul>



<ul style="list-style-type: none"> <li>• Due to data lag of approximately 90 days, the September 2024 prospective rate may not provide the most accurate rate of completion of diabetic measures.</li> <li>• Hybrid measures like HBD and EED require medical record review; therefore, the actual final rate for MY2024 may be lower and higher, respectively.</li> </ul>	
<p>Conclusion: We did meet the internal CalOptima Health goal for the HBD measure but not for the EED measure. Both HBD and EED measures Medi-Cal MY2023 final rates achieved 90th percentile. In October 2024, the 2025 Star rating was published, and for OneCare, HBD reached a 4-Star while EED reached a 3-Star rating. Because both measures are reported by the hybrid method it is important to continue to monitor these measures. CalOptima Health will retain HBD and EED measures on the 2025 QI Work Plan and continue to focus on diabetic care.</p>	
<p>Activities/Interventions to continue/add next year:</p>	
<ul style="list-style-type: none"> <li>• Health rewards program will continue for eligible CalOptima Health members for HBD and EED measures. We continue to focus on initiatives to increase participation in the program and motivate members to schedule and complete their screenings.</li> <li>• In MY2024, live agent calls were conducted by CareNet to members who have multiple gaps in care. In MY2025, we will have internal member-facing staff access Decision Point to remind members of cancer screenings that they are due for at the point of member contact.</li> <li>• In MY2024, CalOptima Health awarded ~\$2.1 million dollars in quality improvement grants to Health Network partners and CHCN providers. Many of the grant programs will focus on the CCS, BCS and COL measures.</li> <li>• Since HBD and EED perform well historically, CalOptima Health will continue to monitor both HBD and EED measures closely. We will continue with having our members get their tests/labs done by conducting multi-component interventions (mailers, live call outreach, automated calls and text messaging).</li> <li>• Will use disparity analysis to develop interventions to target high-risk members with health inequities caused by race/ethnicity.</li> </ul>	

4.5.2 Disease Management Program	
Business Owner: Katie Balderas	Department: Equity and Community Health
Support Staff: Elisa Mora	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>Work Plan Goal/Objective:</p> <p>Implement Disease Management (DM).</p> <p>The goal of the program is to increase effective self-management of chronic conditions through behavioral change. Through increasing positive disease management behaviors such as medication adherence, self-monitoring and trigger avoidance, the program aims to achieve the following outcomes:</p> <ul style="list-style-type: none"> <li>• Reduced emergency visits and inpatient hospitalizations due to disease exacerbations</li> <li>• Empowered members who are better equipped to manage their own health</li> <li>• Improved quality of life</li> </ul>	

In 2024, the DM program focused on exploring new strategies to increase member engagement and reduce cold calls.	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: <ul style="list-style-type: none"> <li>• Evaluation of current utilization of disease management services</li> <li>• Maintain business for current programs and support for community</li> <li>• Improve process of handling member and provider requests</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: CalOptima Health's DM Program promotes self-management for members with low- and moderate-risk chronic conditions through comprehensive assessments, individualized telephonic health and nutritional coaching, and providing resources as needed. The DM Program meets the Basic PHM requirement as defined by the DHCS CalAIM PHM Program, and NCQA standards for health plan accreditation.	
Methodology: A monthly stratification is in place to identify members for the program. Moderate-risk members receive a health coach intervention, and members identified as low-risk receive an educational package through the mail.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>• Piloted Chronic Kidney Disease (CKD) intervention with selected health coaches focused on 68 CHCN members identified with CKD stage 3 A or B and two chronic conditions (diabetes, hypertension, heart disease) and not seeing a nephrologist.</li> <li>• Developed two-way text campaign on asthma and diabetes to promote PCP engagement and DM program opt-in. Submitted text to DHCS for approval.</li> <li>• Established a new member mailing intervention to provide, providing information on our DM services and condition-specific handouts on asthma and diabetes for low-risk members. This mailing will occur every other month.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• A two-way text message campaign focused on members with asthma was implemented on June 19, 2024. In response to the text, 232 members requested a call back from a health coach.</li> <li>• A column was added to the monthly diabetes stratification results identifying members with CKD Stage 3 and 4.</li> <li>• Ongoing monitoring of the bi-monthly new member mailing for low-risk members with asthma and diabetes.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• Initiated planning to send the Disease Management Satisfaction Survey. Collaborating with the Usher team to distribute the survey via text message to identified members.</li> <li>• Implemented two-way text message to promote the asthma program and identify members who wished to receive a call from health coach was successful. The enrollment rate significantly increased.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• Survey results analyzed</li> <li>• Plan to mail additional 500 surveys due to the low response rate.</li> <li>• Initiated collaboration with Usher to explore other methods for obtaining timely feedback from members.</li> <li>• Collaborated with the credentialing/contracting team to add Yumlish as a web-based provider for the CDC Diabetes Prevention Program (DPP).</li> <li>• Worked towards enhancing the monthly stratification list to include HEDIS measures that members are still missing, enabling health coaches to educate and support members in completing these measures.</li> </ul>
Program Results:	

**Table A: 2024 Member Satisfaction Survey Results**

Question	Satisfaction	Neutral	Dissatisfaction	Goal Met
<b>Q.1 The information I received from my health coach while participating in the program helped me to better manage my health.</b>	97% N=32	3% N=1	0% N=0	Yes
<b>Q.2 My health coach helped me follow my doctor's recommendations.</b>	91% N=30	6% N=2	3% N=1	Yes
<b>Q.3 I was included when making decisions about my care plan.</b>	91% N=30	6% N=2	3% N=1	Yes
<b>Q.4 The information and resources I have received from my health coach have been useful.</b>	97% N=32	0%	3% N=1	Yes
<b>Q.5 My health coach helped me manage my health needs and concerns.</b>	100% N=25	0% N=0	0% N=0	Yes
<b>Q.6 My health coach helped me meet my care plan goals.</b>	100% N=25	0% N=0	0% N=0	Yes
<b>Q.7 I am satisfied with CalOptima's Health Management program.</b>	96% N=24	4% N=1	0% N=0	Yes

**Quantitative Analysis:**

The goal of achieving 85% satisfaction across all categories was successfully met, as indicated by the survey results. The data suggests that positive interactions with health coaches played a significant role in members' overall satisfaction with CalOptima Health's DM programs. This finding is further supported by numerous positive member comments.

Survey results also indicate that 100% of members felt that their health coach effectively helped them manage their health needs, address concerns and achieve care plan goals. This data suggests strong effectiveness of health coach involvement, contributing to positive health outcomes and member satisfaction.

This year, a new question was added to assess member preferences for engaging with health coaches. The results revealed the following preferences:

- 76% of members prefer phone calls as their primary method of communication
- 20% prefer in-person interactions
- 4% favor video sessions
- 0% prefer group classes

These results suggest a strong preference for phone calls, which may inform future program delivery strategies.

<p>The response rate to the DM Satisfaction Survey this year was 4.3%, which is lower than previous years, which could limit the representativeness of the feedback. In response, we plan to mail 500 additional surveys to a diverse group of members, which will help us increase the response rate and obtain more comprehensive data to better evaluate the program.</p>	
<p>Identified Barriers:</p> <ul style="list-style-type: none"> <li>• Low response rate when using only two-way text message to collect feedback from members.</li> <li>• Lengthy process for requesting changes to the survey</li> </ul>	<p>Identified Opportunities for Improvement:</p> <ul style="list-style-type: none"> <li>• Use multiple feedback collection methods: Offer various options for collecting feedback from members, including two-way text messaging, mail and QR codes.</li> <li>• Expand language options: Provide additional language options to ensure broader accessibility and inclusivity.</li> <li>• Survey timing improvement: Explore the possibility of launching the survey immediately after an intervention, instead of conducting it once a year.</li> </ul>
<p>Conclusion: While the data shows that members are highly satisfied with the DM program, a higher response rate would provide more comprehensive data, allowing for a better evaluation of the program.</p>	
<p>Activities/Interventions to continue/add next year:</p> <ul style="list-style-type: none"> <li>• Mail additional 500 surveys to increase response rate</li> <li>• Translate the survey into all CalOptima Health threshold languages</li> <li>• Collaborate with Usher to develop a platform that allows staff to launch the survey to members immediately after intervention</li> </ul>	

4.6 Care Management Programs	
Author: Sherry Hickman	Department: Case Management
Responsible Party(ies): Hannah Kim, Megan Dankmyer	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Report on key activities of Case Management (CM) program, analysis compared to goal and improvement efforts	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: Report on the following activities: ECM, Complex Case Management (CCM), Basic PHM/CM, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM, and transitional care services (TCS)	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>The CM programs encompass members at different levels of risk and acuity: Basic Care Management (BCM), Care Coordination (CC), CCM and ECM. Members in CM programs may experience a critical event or diagnosis that requires extensive use of resources and/or have a need for help in navigating the appropriate delivery of care and services. TCS support collaboration, communication and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners and service providers to facilitate safe and successful transitions.</p>	
<p>Methodology: Monitoring of CCM enrollment month over month through Core CC0251. Members must be enrolled for a minimum of one day. Monitoring of members enrolled in ECM who have a lead care manager (LCM) identified on SafetyNet Connect portal.</p>	
Actions/Interventions Implemented in 2024:	

Quarter 1:	<ul style="list-style-type: none"> <li>• Developed process for ECM LCM to communicate TCS activity.</li> <li>• Reviewed NCQA Element E, Factors 1–5, with health networks</li> <li>• Monthly real-time reviews of delegated health networks per NCQA requirements</li> <li>• Case Management Quarterly Audit for SPD/WCM MOC for delegated health networks.</li> <li>• Instituted multi-department EPSDT workgroup in Q2</li> <li>• Worked with IT to develop reports for analyzing outcomes on TCS response.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• CalAIM ECM provider report documenting LCM in SafetyNet Connect showed improvement from 3% to 44%. This ensures the LCM is notified of any admissions. The expectation moving forward is to have ECM providers continue to document accurately.</li> <li>• NCQA Accreditation Audit passed with a score of 100%</li> <li>• Continued Monthly NCQA file audit for CHCN and health networks.</li> <li>• CM's quarterly audit for MOC for delegated health networks.</li> <li>• The multi-department workgroup was implemented to discuss EPSDT requirements meetings on May 21, 2024, and July 1, 2024.</li> <li>• Health network training on EPSDT on April 18, 2024</li> <li>• Analysis with IT support for TCS response pending Phase II Jiva remediation</li> <li>• Shared of TCS qualifying discharge events with ECM providers to track successful outreach</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• Audit tool created by SafetyNet Connect for ECM providers to validate that their enrolled members have LCM identified.</li> <li>• Continued communication to ECM providers for TCS outcomes for enrolled high-risk members.</li> <li>• Continued monthly NCQA file audits for CHCN and HN members open to CCM level of care.</li> <li>• Continued quarterly audits of delegated health networks for MOC oversight.</li> <li>• Continued discussion in workgroup to obtain data and operationalize oversight for EPSDT.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• LCM is identified in 61% of ECM enrolled members as of October 21, 2024</li> <li>• Continued communication to ECM providers for TCS outcomes for enrolled high-risk members.</li> <li>• Continued monthly NCQA file audits for CHCN and HN members open to CCM level of care.</li> <li>• Continued quarterly audits of delegated health networks for MOC oversight.</li> <li>• Continued discussion in workgroup to obtain data and operationalize oversight.</li> </ul>
Program Results:	
Table A	

Health Network	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	Oct	Nov
CHCN	54	54	47	53	17	88	141	138	139	164	123
Prospect	46	42	34	29	31	33	29	43	42	38	48
AltaMed	0	0	15	15	26	30	40	34	27	35	27
UCMG	17	15	12	15	20	17	13	16	17	20	25
AMVI	11	9	9	13	12	9	8	7	8	8	7
CHOC	8	6	7	7	7	5	4	4	4	3	2
Regal	1	1	1	3	3	3	2	2	1	1	1
Noble	0	0	1	1	1	3	5	6	3	3	3
Family Choice	1	1	2	0	0	0	0	0	0	2	2
Optum	0	0	0	0	0	0	0	0	0	0	0

Table caption: Members open to CCM month over month in 2024 based on health network assignment. CCM enrollment is reported to DHCS monthly. December data is not yet reported.

Chart A

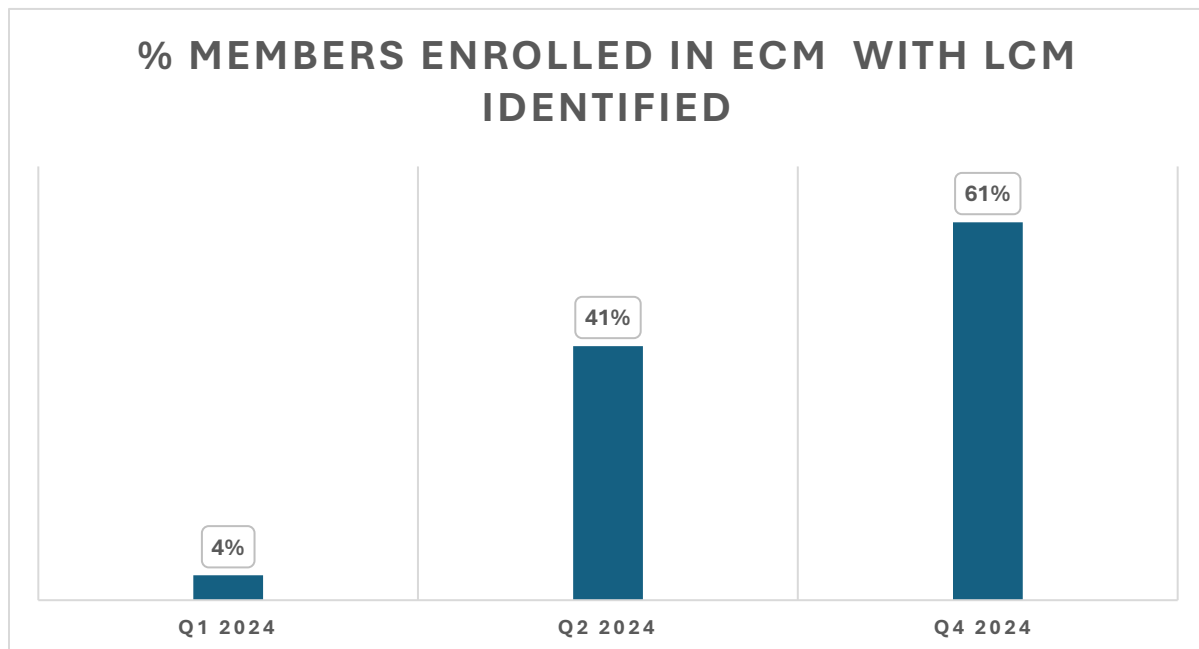


Table caption: Members enrolled in ECM who have LCM identified in SafetyNet Portal.

Quantitative Analysis: Overall, CCM enrollment increased from January 2024 to October 2024. The increase is not evenly distributed with growth and is seen primarily in two of the delegated health

networks: CHCN and AltaMed (Table A). There is improvement in the percentage of members who have their LCM identified in SafetyNet Connect (Chart A).	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Consistent identification of LCM for members enrolled in ECM in SafetyNet Connect</li> </ul>	<ul style="list-style-type: none"> <li>Increase number of members open to CCM.</li> </ul>
Conclusion: Multiple care management programs will continue to support members and explore opportunities for improvement.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>Continue communication to ECM providers for TCS outcomes for enrolled high-risk members.</li> <li>Continue monthly NCQA file audits for CHCN and HN members open to CCM level of care.</li> <li>Continue quarterly audits of delegated health networks for MOC oversight.</li> <li>Continued discussion in workgroup to obtain data and operationalize oversight</li> <li>Add: ECM opportunity to be identified through the ECM Clinical Oversight Sub-work group</li> </ul>	

## 4.7. Improvement Projects

4.7.1 Performance Improvement Project (PIP)	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Leslie Vasquez/Kelly Glynn	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>Work Plan Goal/Objective:</p> <p>Meet and exceed goals set forth on all improvement projects.</p> <p>Increase well-child visit appointments for African American members (0–15 months) from 41.90% to 55.78% by December 31, 2024. This target was set for MY2024, however, the PIP timeframe spans from 2023 to 2026.</p>	
Goal Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <p>Action: Improve well-child visit rates in the first 30 months of life for African American child members.</p> <p>MY2024 PIP activities consisted of a telephonic outreach campaign to the parents/guardians of African American child members turning 15 months of age in the measurement year. The telephonic outreach campaign aimed to provide the following:</p> <ol style="list-style-type: none"> <li>1. Education on well-child visits</li> <li>2. Reminders to complete well-child visits</li> <li>3. Appointment coordination for well-child visits</li> <li>4. Data gathering on barriers and facilitators to well-child visits</li> </ol>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>The California 2020 Health Disparities Report identified disparities for most of the indicators of the Children's Health domain. Per this report, the African American group fared lower than other groups across all six key indicators.</p> <p>The PIP aims to reduce the racial/ethnic disparities in W30-6 visits in support of the statewide goals. In alignment with the recommendations in the Health Equity Framework, this PIP will involve the African American population, the group most affected by health care disparities,</p>	

through a survey call campaign to understand firsthand the experiences with well-child visits and the barriers to and facilitators for attending well-child visits.

Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate has the potential to improve member health status among these key indicators. Insight into the barriers to attending well-child visits has the potential to identify key areas that may improve member satisfaction across health care services.

PIP intends to address the following barriers to well-child visits:

- Parent/guardian gaps in knowledge as it relates to the purpose and value of well-child visits.
- Lack of reminders for parents/guardians to complete well-child visits.
- Lack of available resources for health networks to coordinate well-child visit appointments with a primary care provider for African American child members

Methodology:

CalOptima Health followed HEDIS data collection methodology for the W30 — First 15 Months (noncontinuous enrollment). CalOptima Health then identified child members identified as African American to monitor for rates.

Medi-Cal Results:

Chart A. Rates for W30 — First 15 Months

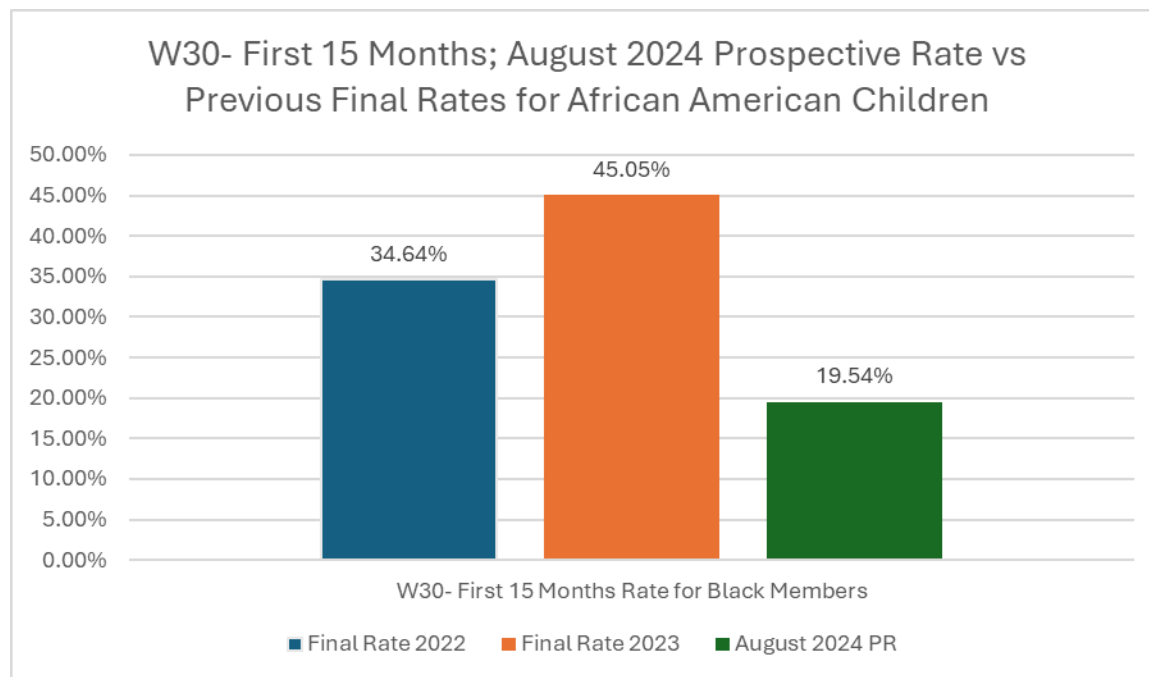


Chart A shows the final MY2022 and MY2023 W30 — First 15 Months rates for African American child members compared to the most recent 2024 prospective rate. The performance improvement project is set for 2023 to 2026. As part of the process, the MY2022 rate (34.64%) was used to confirm the population of interest — African American children — that would be targeted for the project. The chart demonstrates an increase in rates for MY2023 compared to



MY2022. Final MY2024 rates are pending; however, the rate (19.54%) of claims/encounters processed through August 2024 is shown.

**Actions/Interventions Implemented in 2024:**

Planned Activities/Interventions	Product	Status	Measure(s) (Acronym)
1. Telephonic outreach campaign — Two calls were provided to each of the 85 members.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	W30 (First 15 Months)
2. Email campaign — To members with an email who were not successfully outreached via the telephonic campaign.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	W30 (First 15 Months)
3. Pediatric text campaign	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	W30 (First 15 Months)

MC = Medi-Cal; OC= OneCare

**Quantitative Analysis:**

- For the 2024 calendar year, 85 African American members were identified as needing to complete six or more well-child visits by 15 months of age. Staff successfully contacted 34 (40%) of parents/guardians, providing reminders to complete well-child visits and addressing gaps in knowledge related to the importance and value of well-child visits.
- As part of the attempt to increase contact with members, letters were issued to the 51 parents/guardians who could not be contacted telephonically.
- Appointment coordination was offered to all 34 parents/guardians of child members who were successfully outreached. All 34 parents/guardians declined appointment coordination and refused support with appointment coordination for future well-child visits. This refusal may be driven by many reasons, including long call wait times, lack of urgency and competing priorities at the time in which the parent was called. based on feedback gained from the call campaign.

**Identified Barriers:**

- Member contact information — Member contact lists contain outdated or incorrect information, contributing to a high rate of unsuccessful outreach. Other issues included the inability to leave voicemails or parent/guardian refusal to take the call.
- As part of an attempt to increase contact with members, letters were issued to the 51 parents/guardians who could not be contacted telephonically. Parents or guardians did not respond to the letter.

**Identified Opportunities for Improvement:**

- Opportunities to improve member contact information to maximize outreach.
- Opportunities to partner with health networks to support care coordination for child members.

**Conclusion:**

<ul style="list-style-type: none"> <li>• There is an opportunity to continue to inform members about the importance and cadence of well-child visits and what makes each of these visits unique to support adherence. Education about these visits should begin as early as possible including prenatal and postpartum timeframe.</li> <li>• There is an opportunity for PCPs to revise their workflows to allow for the scheduling of the next visit prior to the family leaving the existing visit.</li> <li>• Members feel that they benefit when their child's assigned PCP has appointment availability that fits the parents' schedules. PCP offices should continue to implement reminders for these visits.</li> <li>• There are opportunities to increase awareness of the Medi-Cal transportation benefit as well as inform parents of who the child's PCP is.</li> </ul>
Activities/Interventions to continue/add next year:
<ul style="list-style-type: none"> <li>• Efforts to include improved coordination with health networks to delivery care for African American child members.</li> </ul>

4.7.2 Chronic Care Improvement Program (CCIP)	
Author: Mike Wilson	Department: Quality Analytics
Responsible Party(ies): Melissa Morales/Kelly Glynn	
Products: <input type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Meet and exceed goals set forth on all improvement projects. By December 31, 2024, 5% of members identified as emerging risk* and who participated in the program will lower their HbA1C to less than 8.0%.	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
Work Plan Planned Activities: Conduct quarterly/annual oversight of specific goals for OneCare CCIP (January 2023–December 2025): CCIP Study — Comprehensive Diabetes Monitoring and Management	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: CMS requires all Medicare Advantage (MA) and Special Needs Plans (SNP) to conduct a CCIP as part of their required QI Program over a three-year period. The purpose of the CCIP is to promote effective chronic disease management and the improvement of care and health outcomes for members with chronic conditions. For this three-year CCIP program beginning in 2023 and ending in December 2025, CalOptima Health has chosen to focus on diabetes as the target condition with a focus on increasing diabetes management. The target population for the CCIP interventions is OneCare members identified with diabetes (type 1 and 2). CalOptima Health chose to focus on members who fall in the category of “emerging risk” (A1C levels 8.0%–9.0%) as the target condition for this CCIP. Emerging risk is defined by members that were previously controlled <8.0% A1C level but had a recent A1C level result of 8.0% to 9.0%. These members were selected due to a higher chance of improving A1C results when targeting members with A1C results between 8.0% and 9.0% than members with an A1C >9.0% result.	
Methodology: <ul style="list-style-type: none"> <li>• Two-year look back period for member's A1C results (2022–2023) and current measurement years.</li> <li>• Quality Analytics generated A1C report and identified members that were below 8.0%, 8.0% to 9.0% and above 9.0%. Also included was whether the A1C result decreased, increased, remained the same or no prior result was available.</li> <li>• Quality improvement specialist filtered list for target population: Members between 8.0% and 9.0% with an increase in A1C result.</li> </ul>	

<ul style="list-style-type: none"><li>• Worked with Diabetes Management Program to finalize outreach list. Outreach included members who were part of the “emerging risk” category and the Diabetes Management stratification to keep outreach list manageable.</li><li>• Health coaches outreached to “emerging risk” members.</li><li>• Track outreach completion by using Jiva activity report.</li><li>• Data refresh occurs on a quarterly basis.</li></ul>			
Actions/Interventions Implemented in 2024:			
Quarter 1:	<ul style="list-style-type: none"><li>• Finalize “emerging risk” report.</li></ul>		
Quarter 2:	<ul style="list-style-type: none"><li>• Telephonic outreach by health educators</li></ul>		
Quarter 3:	<ul style="list-style-type: none"><li>• Telephonic outreach by health educators</li></ul>		
Quarter 4:	<ul style="list-style-type: none"><li>• Telephonic outreach by health educators</li></ul>		
Program Results:			
OneCare Outreach Results			
Date	Emerging Risk List OneCare Members	Outreach Members	Outreach Rate
June 2024	28	3	10.7%
September 2024	97	113	85.8%
Table caption: Members that were outreached were those identified as “emerging risk” and were part of the Diabetes Management Program stratification.			
Quantitative Analysis: For data report created in June 2024, health coaches attempted to call 10.7% of call list. For data report created in September 2024, health coaches attempted to call 85.8% of the call list. The CCIP goal has not been met since the program has an end date of December 31, 2025. CalOptima Health will evaluate whether the member was reached and accepted help for diabetes management. Also, will continue to track A1C values for members identified as “emerging risk” and participated in health coaching.			
Identified Barriers:		Identified Opportunities for Improvement:	
<ul style="list-style-type: none"><li>• Delay due to the transition to CalOptima Health’s new managed care system (Jiva), which created the need to update emerging risk methodology.</li><li>• Data issue A1C values were missing, which may have affected emerging risk assignment.</li><li>• Outreach list included members that were already assigned to case management, so they were not outreached.</li><li>• Unable to contact “emerging risk” category members.</li></ul>		<ul style="list-style-type: none"><li>• Work with Case Management department on members who are outreached by case managers but have been identified as emerging risk.</li><li>• Update emerging risk report with Diabetes Management Program report to make identification and assignment more efficient.</li></ul>	
Conclusion: Will need additional time to obtain more recent A1C results and health coaching activity.			
Activities/Interventions to continue/add next year:			
<ul style="list-style-type: none"><li>• Identify barriers at the end of the intervention period for telephonic outreach by health educators and case managers.</li><li>• Evaluate member outreach and A1C trend.</li></ul>			

4.7.3 BH Performance Improvement Project (PIP)	
Business Owner: Diane Ramos, Natalie Zavala, Carmen Katsarov	Department: Behavioral Health Integration (BHI)
Support Staff: Jeni Diaz	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Work Plan Goal/Objective: Meet and exceed goals set forth on all improvement projects.	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: Non-Clinical PIP: Improve the percentage of members enrolled in CM, CHCN, CCM or ECM within 14 days of an ED visit where the member was diagnosed with SMH/SUD.	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: Improve the percentage of CHCN/COD Medi-Cal-only members enrolled in CM, CCM or ECM, within 14 days of a provider (ED) visit where the member was diagnosed with SMH/SUD.	
Methodology: Internal report was developed to identify members who enroll in CM, CCM or ECM after being diagnosed with SMH/SUD at ED visit.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>Conducted quarterly/annual oversight of MC Non-Clinical PIP (January 2023–December 2025).</li> <li>Baseline Measurement Period: January 1, 2023–December 31, 2023</li> <li>Remeasurement 1 Period: January 1, 2024–December 31, 2024</li> <li>Remeasurement 2 Period: January 1, 2025–December 31, 2025</li> <li>Continued to develop an internal report to identify baseline data for members who enroll in CM, CCM or ECM after being diagnosed with SMH/SUD at ED visit.</li> <li>Conducted collaboration meetings with internal business units to identify process and reporting specifications.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>Continued collaboration meetings with internal business units to identify process and reporting specifications.</li> <li>Reviewed and analyzed report produced to verify data integrity.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Continued collaboration meetings with internal business units to identify process and reporting specifications.</li> <li>Reviewed and analyzed report produced to verify data integrity.</li> <li>September 29, 2024–2025 nonclinical initial PIP validation submission.</li> <li>October 31, 2024 reviewed feedback and suggestions from HSAG of nonclinical initial PIP validation.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>November 27, 2024 resubmission of the nonclinical PIP validation.</li> <li>Continued collaboration meetings with internal business units to identify process and reporting specifications.</li> <li>Reviewed and analyzed report produced to verify data integrity.</li> <li>CalOptima Health telehealth provider began member outreach (December 3, 2024) for members who visited the ED and were diagnosed with SMH/SUD.</li> </ul>
Program Results: Results pending, no data from 2024 available currently. Only baseline data from MY2023 is available currently.	
Quantitative Analysis:	

Results pending, no data from 2024 available currently. Only baseline data from MY2023 is available currently.	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>• Data integrity – Codes identified that should not be included in data set.</li> <li>• Coordinating/engaging internal stakeholder departments due to competing priorities.</li> <li>• Given the diagnosis there is difficulty in connecting with this member population.</li> <li>• Implementation of new CM system February 2024.</li> <li>• PHI data sharing with community partners, for coordination of care and outreach.</li> <li>• Lack of data exchange with the county mental health plan system.</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly collaboration meetings with internal departments to develop workflow for member outreach and engagement. Barriers are identified in these collaboration meetings. The group works to identify and develop solutions to barriers.</li> <li>• Collaboration with county mental health plan to ensure timely data exchange.</li> </ul>
Conclusion: Ongoing, too early to determine a conclusion.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>• Continue to receive daily reports from vendor containing real-time ED data for CHCN and COD members.</li> <li>• Collaborate with telehealth provider and internal ITS team to develop implementation plan for member outreach. Vendor to provide information about case management including ECM and referrals.</li> <li>• Working with CalOptima Health vendor to receive real-time ED data daily for CHCN and COD members.</li> <li>• BHI is in the process of developing a pilot project for CHCN members identified who meet FUM/FUA criteria. Telehealth provider will conduct the outreach to members who meet FUM criteria and assist with linkage. Internal BHI patient care coordinators (PCC) to conduct outreach to members meeting FUA criteria and assist with linkage. Vendor and PCCs will also provide information about case management including ECM and referrals.</li> <li>• Develop outreach and outcome data related to the percentage of members enrolled in CCM and ECM for CHCN members identified who meet FUM/FUA criteria for the duration of each measurement period.</li> <li>• Work in collaboration with the internal privacy department to ensure compliance of data sharing with vendor.</li> </ul>	

## Section 5: Quality of Service

### 5.1 Member Experience

5.1.1 Member Experience Survey (CAHPS)	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Carol Matthews/Helen Syn	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Improve CAHPS performance to meet goal.	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
Work Plan Planned Activities: Conduct outreach to members in advance of 2024 CAHPS survey, campaign mailings and phone calls to members deemed likely to respond negatively to CAHPS survey, and discussions with health networks regarding CAHPS performance and P4V.	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>CalOptima Health is committed to annually monitoring member experience and identifying areas for improvement for all lines of business. By actively seeking feedback from members, CalOptima Health assesses the current state of member satisfaction and experiences and identifies specific areas for improvement. Collecting valid data ensures that the insights gained are reliable, which allows for the development and implementation of evidence-based interventions. The goal is to improve the overall member experience by better meeting our members' needs.</p>	
<p>Methodology: CalOptima Health utilizes the CAHPS survey to measure member experience. The CAHPS program is overseen by the U.S. Department of Health and Human Services and the CAHPS surveys are a nationally recognized tool developed by the Agency for Healthcare Research and Quality (AHRQ). The CAHPS process has standardized tools, questionnaires and data collection protocols. CalOptima Health submits CAHPS rates to NCQA for accreditation and to CMS as part of the Stars ratings for health plans.</p> <p>In addition to the standard CAHPS survey, CalOptima Health annually fields a survey at the contracted health network level. The survey instrument used for the health network survey was an adaptation of the CAHPS 5.1 adult Medicaid core survey that was developed and tested nationally for use in assessing health plan performance. The health network survey instrument used consisted of 43 questions. Most questions addressed the domains of member experience, such as getting needed care, getting care quickly, communicating with doctors, overall satisfaction with health care and overall satisfaction with the health network.</p> <p>The sampling goal was to draw a random sample of 900 members and an oversample of 360 additional members from each of CalOptima Health's 10 health networks. The final selected sample size for the entire CalOptima Health Medi-Cal adult project was 12,600. Selection of cases for analysis surveys was considered complete if respondents did not say 'no' to Q1 (in California, many people covered by Medi-Cal are enrolled in a health plan. In Orange County, CalOptima Health is the Medi-Cal health plan. Are you enrolled in CalOptima Health?) and if they provided a valid response to at least one survey question. Complete interviews were obtained from 1,593 members, and the overall CalOptima Health response rate was 12.7%.</p> <p>Language Analysis Methodology Among Health Network Respondents</p> <p>CalOptima Health's survey vendor uses collected data and conducts analysis of selected demographic categories for the CAHPS overall ratings and composites to better understand</p>	

differences in member experience. The categories are gender, age (18–44 and 45+), education (low education, through high school graduate or GED; and high education, some college and beyond), ethnicity (Hispanic or Latino and not Hispanic or Latino), language survey was fielded in (English, Spanish, Vietnamese, Chinese, Arabic, Farsi, Korean) and race (White, Black or African American, Asian, American Indian or Alaska native, Native Hawaiian or Pacific Islander, and other).

The disparity analysis was conducted across all health network surveys and all threshold languages. A disparity was recognized when the rate was lower than 5% or more than the CalOptima aggregate health network reference point.

**Medi-Cal Results:**

Acronym	Adult Measure	MY2021 Medi-Cal Rate	MY2022 Medi-Cal Rate	MY2023 Medi-Cal Rate	MY2023 Medi-Cal Goal	MY2023 Goal Met/Not Met
RHC	Rating of All Health Care	51.9	51.61	55.67	33rd percentile	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
RPD	Rating of Personal Doctor	63.80	61.71	69.88	33rd percentile	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
RS	Rating of Specialist	NA	62.50	63.70	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
RHP	Rating of Health Plan	56.52	52.34	57.22	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
GNC	Getting Needed Care	NA	79.72	76.26	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
GCQ	Getting Care Quickly	NA	76.04	75.35	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
CS	Customer Service	NA	87.05	87.89	33rd percentile	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
CC	Coordination of Care	NA	79.55	79.53	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
HWDC	How Well Doctors Communicate	89.30	88.10	90.80	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Acronym	Child Measure	MY2021 Medi-Cal Rate	MY2022 Medi- Cal Rate	MY2023 Medi-Cal Rate	MY2023 Medi-Cal Goal	MY2023 Goal Met/Not Met
RHC	Rating of All Health Care	66.10	64.20	67.94	33rd percentile	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
RPD	Rating of Personal Doctor	79.64	72.27	67.34	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
RS	Rating of Specialist	69.05	NA	NA	33rd percentile	<input type="checkbox"/> Yes <input type="checkbox"/> No
RHP	Rating of Health Plan	71.97	66.51	63.61	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
GNC	Getting Needed Care	76.90	77.80	75.18	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
GCQ	Getting Care Quickly	77.30	82.29	77.81	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
CS	Customer Service	88.80	88.08	85.17	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
CC	Coordination of Care	78.30	76.42	77.97	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
HWDC	How Well Doctors Communicate	89.50	93.99	91.34	33rd percentile	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
OneCare Results:						



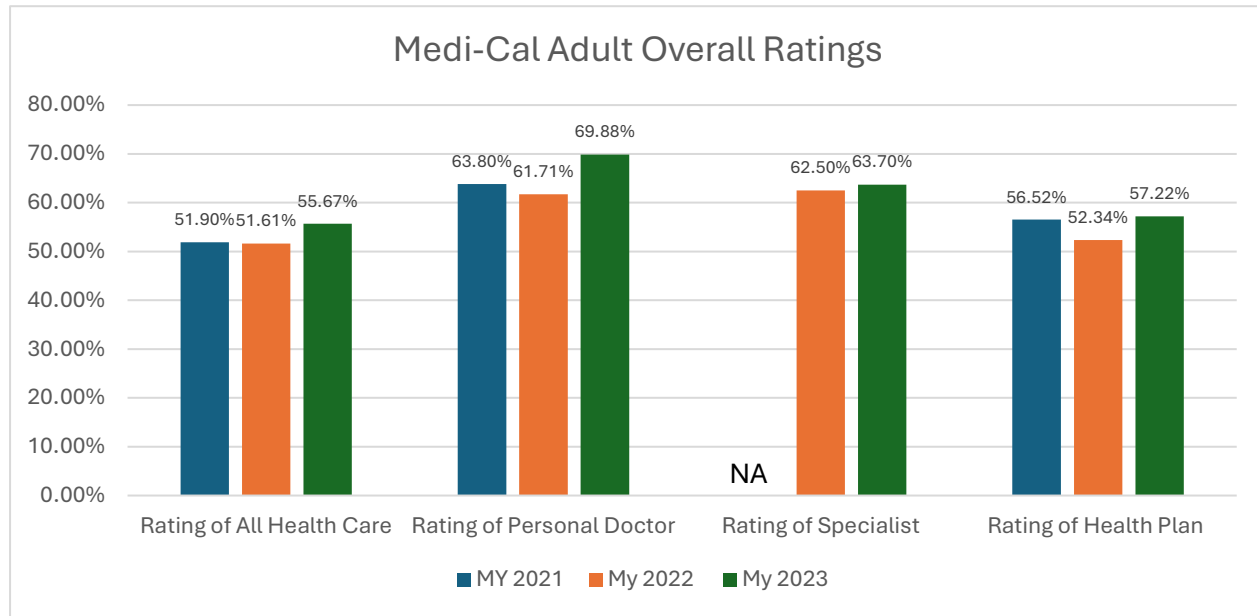
Acronym	OneCare Measure	MY2021 OneCare Rate	MY2022 OneCare Rate	MY2023 OneCare Rate	MY2023 OneCare Goal	MY2023 Goal Met/Not Met
RHCQ	Rating of Health Care Quality	83	86	83	4 Star	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
RHP	Rating of Health Plan	85	86	84	4 Star	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
RDP	Rating of Drug Plan	87	88	85	4 Star	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
GNC	Getting Needed Care	77	75	75	3 Star	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
GCQ	Getting Appointments and Care Quickly	74	73	76	3 Star	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
CS	Customer Service	87	87	86	3 Star	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
CC	Care Coordination	82	80	83	3 Star	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
GNPD	Getting Needed Prescription Drugs	88	88	86	3 Star	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Actions/Interventions Implemented in 2024:						

Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Conduct outreach to members in advance of the 2024 CAHPS survey.	<input type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	All
2. Just-in-time mailings and phone calls to members deemed likely to respond negatively to CAHPS survey.	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	All
3. Discussions with health networks about CAHPS performance and P4V.	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	All
4. Implement provider training for identified high-priority providers consisting of webinars, practice site training and provider shadow coaching.	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	All

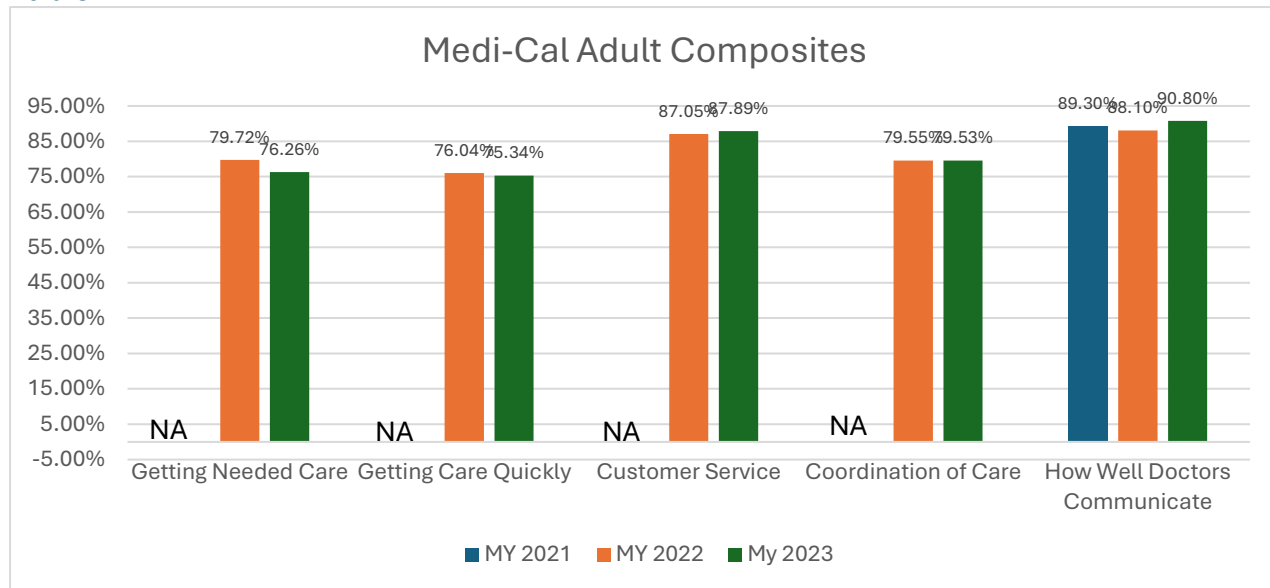
MC = Medi-Cal; OC= OneCare

**Results:**

**Table A**

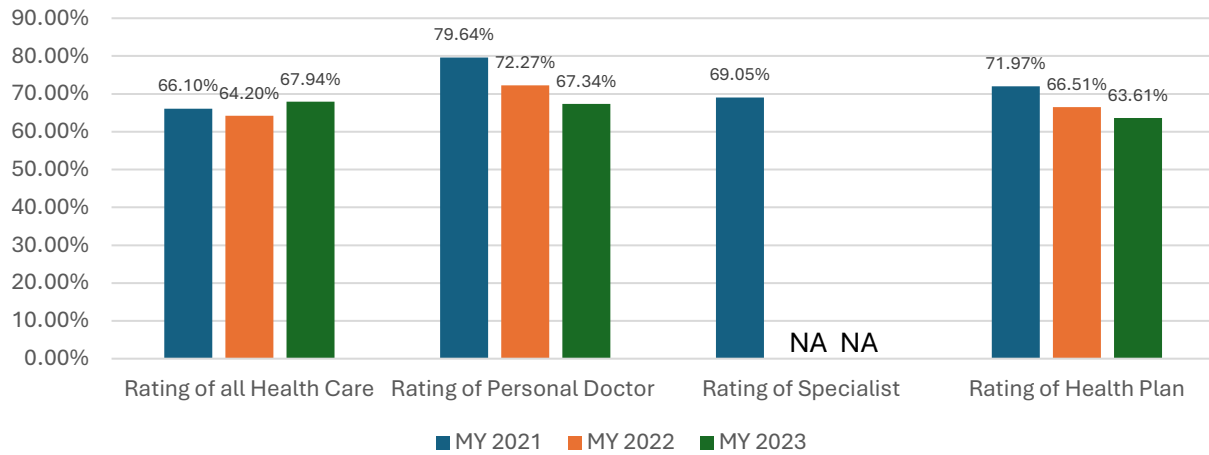


**Table B**



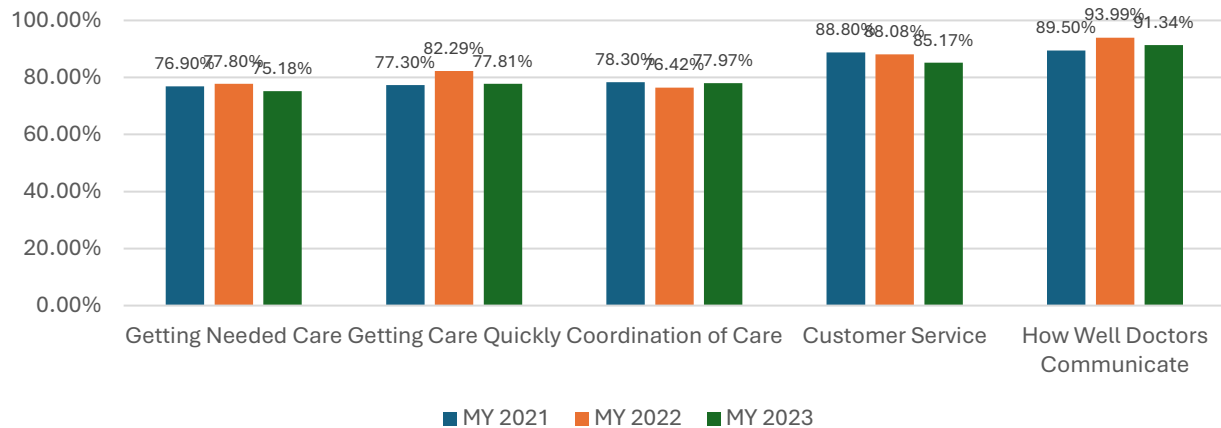
**Chart C**

### Medi-Cal Child Overall Ratings



### Chart D

### Medi-Cal Child Composites



### Chart E

OneCare Adult CAHPS

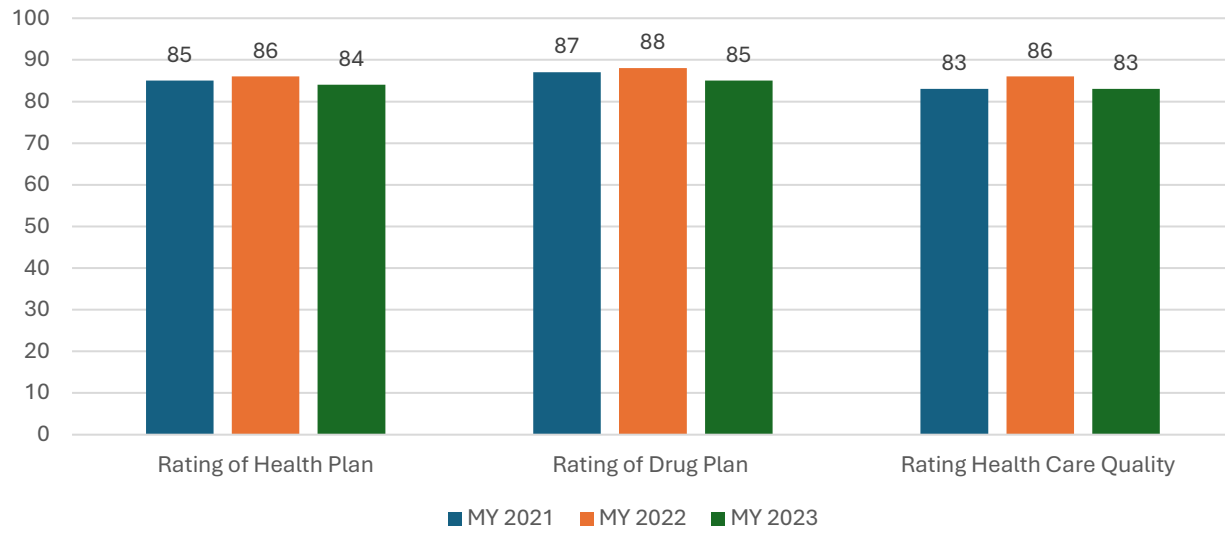
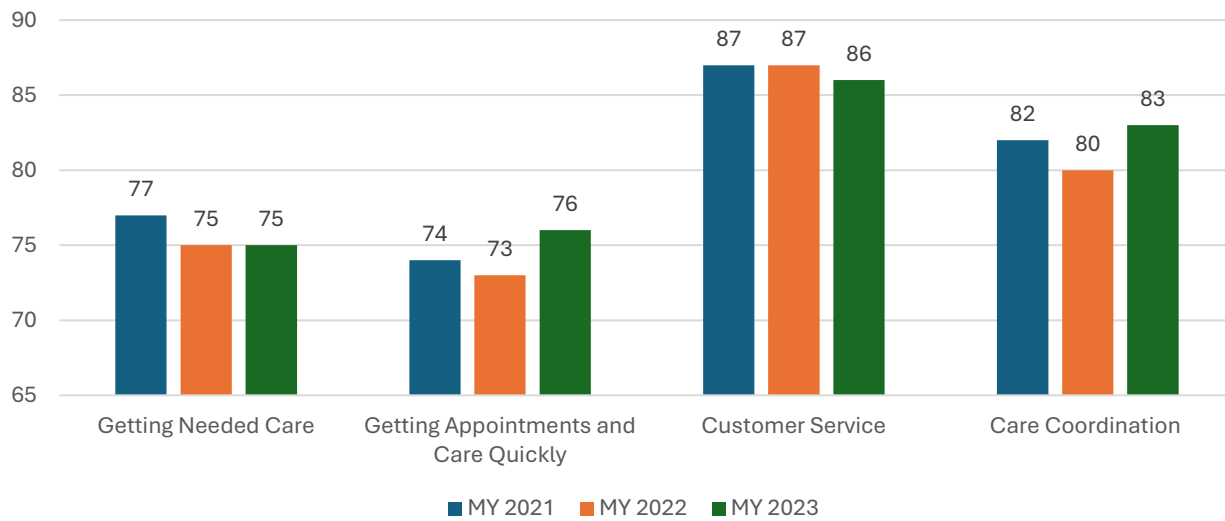


Chart F

OneCare Adult CAHPS



\*Denotes <11 cases

<b><u>Adult Overall Ratings</u></b>	<b>Aggregate Health Network Reference Point</b>	<b>English Survey</b>	<b>Spanish Survey</b>	<b>Vietnamese Survey</b>	<b>Farsi Survey</b>	<b>Korean Survey</b>	<b>Arabic Survey</b>	<b>Chinese Survey</b>
Rating of All Health Care	73.9%	67.8%	82.2%	74.1%	86.7%	75	66.7%*	75%*
Rating of Personal Doctor	84.3%	84.3%	86.1%	82.2%	94.4%	85%	66.7%*	87.5%*
Rating of Specialist	79.5%	75%	91.5%	76.6%	72.7%	57.1%*	50%*	100*
Rating of health Network	75.0%	70.6%	86%	72%	65%	54.2%	60%*	63.5%
<b><u>Adult Composites</u></b>								
Getting Needed Care	76.9%	77.6%	82%	70.2%	87.6%	78.1%	58.3%*	53.8%*
Getting Care Quickly	75.2%	75.7%	74.9%	72.8%	94.7%	93.8%	62.5%*	53.6%*
How Well Doctors Communicate	89.4%	93.8%	87.8%	85.2%	94.4%	81.3%	68.8%*	95.8%*
Customer Service	84.8%	87.2%	90.1%	80.3%	88.9%*	71.4%*	66.7%*	66.7%*
Coordination of Care	79.7%	82%	80.2%	74.5%	90%*	71.4%*	100*	75%*
*Denotes <11 cases								

<b><u>Child Overall Ratings</u></b>	<b>Aggregate Health Network Reference Point</b>	<b>English Survey</b>	<b>Spanish Survey</b>	<b>Vietnamese Survey</b>	<b>Farsi Survey</b>	<b>Korean Survey</b>	<b>Arabic Survey</b>	<b>Chinese Survey</b>
Rating of All Health Care	79.5%	74.9%	85.2%	78.8%	100%*	85.7%*	83.3%	54.5%
Rating of Personal Doctor	85.7%	86%	90.3%	79.7%	100%*	71.4%	84.6%	71.4%
Rating of Specialist	83.2%	77.9%	95%	78.9%	66.7%*	100%*	50%*	100%*
Rating of Health Network	78.8%	73%	91.5%	70.8%	87.5%*	46.7%	81%	50%
<b><u>Child Composites</u></b>								
Getting Needed Care	73.2%	71.9%	78.5%	68%	100%*	100%*	79.2%	57.6%
Getting Care Quickly	80.9%	76.7%	83.7%	82.8%	100%*	78.6%*	77.1%	94.4%*
How Well Doctors Communicate	92.2%	93.7%	92.4%	89.7%	100%*	93.8%*	93.2%	87.5%*
Customer Service	82.5%	88%	87.2%	76.2%	100%*	75%*	90%*	66.7%*
Coordination of Care	74.6%	78.4%	79.8%	63%	50%*	0%*	50%*	0%*

\*Denotes <11 cases

<b><u>One Care Overall Ratings</u></b>	<b>Aggregate Health Network Reference Point</b>	<b>English Survey</b>	<b>Spanish Survey</b>	<b>Vietnamese Survey</b>	<b>Farsi Survey</b>	<b>Korean Survey</b>	<b>Arabic Survey</b>	<b>Chinese Survey</b>
Rating of All Health Care	79.53 %	75.7%	85.1%	80.7%	55.2%	100%*	75%	75.8%
Rating of Personal Doctor	90.35 %	88.1%	93.1%	91.4%	81.68	100%*	100%	83.3%
Rating of Specialist	85.4%	82.7%	91.2%	85.7%	73.7%	-	75%*	75%
Rating of Health Network	82.94 %	79.4%	90.8%	80.9%	65.4 %	100%*	93.3%	76.7%
Rating of Prescription Drug Plan	88.75 %	87.7%	92.8%	86.7%	96.4%	100%*	92.3%	66.7%
<b><u>Composites</u></b>								
Getting Needed Care	81.8%	82.1%	86.6%	77.4%	73%	100%*	87.5%	65.9%
Getting Care Quickly	75.8%	78.3%	72.9%	72.6%	84.1%	100%*	79.7%	83%
How Well Doctors Communicate	93.2%	94.3%	94.4%	90.4%	87.9%	100%*	93.8%	97.2%
Customer Service	84.6%	87.9%	88.6%	77.8%	90.6%	66.7%*	94.4%	70.2%
Care Coordination	86.8%	87.6%	86.6%	86%	86.2%	75%*	91.9%	82.4%
Getting Needed Prescription Drugs	93.7%	94.2%	94%	92.6%	94%	100%*	96.4%	92.3%

\*Denotes <11 cases

#### Quantitative Analysis:

CalOptima Health reviewed all MY2023 CAHPS rates in detail and compared them to the benchmarks. For the health disparity analysis, all stratified rates were compared to the overall or aggregate score (reference point).



- **Adult Survey CAHPS Summary:**
  - For Medi-Cal adult CAHPS surveys the goal is set at the 33rd NCQA Quality Compass percentile for all measures.
  - CalOptima Health met the goal for the following measures: Rating of all health care, rating of personal doctor and customer service.
  - CalOptima Health did not meet the goal and performed at the 10th percentile for the following measures: Rating of specialist, rating of plan, getting needed care, getting care quickly and how well doctors communicate.
  - CalOptima Health did not meet the goal and performed below the 10th percentile for care coordination.
  - Disparity analysis: The adult health network survey had the following measures 5% or lower than the aggregate score. English: rating of all health care. Vietnamese: getting needed care and coordination of care. Farsi: rating of specialist and rating of health network. Korean: rating of health network, how well doctors communicate and rating of specialist and coordination of care. Rating of specialist and coordination of care had <11 respondents. Arabic: rating of personal doctor, rating of specialist, rating of health network, getting needed care, getting care quickly, how well doctors communicate and customer service (all measures had <11 respondents). Chinese: rating of health network as well as the following measures that were <11 respondents getting needed care, getting care quickly, customer service and coordination of care.
- **Child Survey CAHPS Summary:**
  - For Medi-Cal child CAHPS surveys the goal is set at the 33rd NCQA Quality Compass percentile for all measures.
  - CalOptima Health met the goal for rating of all health care.
  - CalOptima Health did not meet the goal and performed at the 10th percentile for the following measures: How well doctors communicate, customer service and care coordination.
  - CalOptima Health did not meet the goal and performed below the 10th percentile for the following measures: Rating of personal doctor, rating of plan, getting needed care and getting care quickly.
  - Disparities analysis: The child health network survey had the following measures 5% or lower than the aggregate score: English: rating of specialist and rating of health network. Vietnamese: rating of health network, getting needed care, customer service and coordination of care. Farsi: <11 respondents for care coordination. Korean: rating of personal doctor, rating of health network, and customer service (<11 respondents). Arabic: <11 respondents for rating of specialist and coordination of care. Chinese: rating of all health care, rating of personal doctor, rating of health network, getting needed care and customer service (<11 respondents).
- **OneCare Adult Survey CAHPS Summary:**
  - For OneCare the goal is set at the CMS 4-star level for the following measures: Rating of health care quality, rating of health plan and rating of drug plan. Getting needed care, getting care quickly, customer service, care coordination and getting needed prescription drugs goals are set at the CMS 3-star level. CalOptima Health did not meet any goals.
  - Rating of health and rating of drug plan performed at the 2-star level.

<ul style="list-style-type: none"> <li>○ Getting needed care, getting appointments and care quickly, rating of health care quality, customer service, care coordination and getting needed prescription drugs performed below the 1-star level.</li> <li>○ Disparity analysis: The OC health network survey had the following measures 5% or lower than the aggregate score: Vietnamese: customer service. Farsi: rating of all health care, rating of personal doctor, rating of specialist, rating of health network, getting needed care, and how well doctors communicate. Korean: customer service and care coordination with &lt;11 respondents. Arabic: rating of specialist with &lt;11 respondents. Chinese: rating of specialist, rating of health network, rating of drug plan, getting needed care and customer service.</li> <li>• Response rates for all surveys remain stable yet lower than their pre-pandemic years.</li> <li>• In calendar year 2023, Medi-Cal grievances increased by 8%. Member grievances increased for the following areas from the calendar year 2022: <ul style="list-style-type: none"> <li>○ Access: +24%</li> <li>○ Quality of care: + 25%</li> <li>○ Quality of service: +11%</li> </ul> </li> </ul> <p>There were decreases in the following category:</p> <ul style="list-style-type: none"> <li>○ Billing: -35%</li> </ul> <p>Due to changes to CalOptima Health's Medicare product line (transitions of OneCare Connect membership to OneCare), grievances trending would not be comparable from 2022 to 2023.</p>	
<p>Identified Barriers:</p> <ul style="list-style-type: none"> <li>• Lack of organization-wide commitment to improving member experience.</li> <li>• Low member response rates to surveys.</li> <li>• Access: <ul style="list-style-type: none"> <li>○ PCPs have too many members in their panels, resulting in decreased appointment availability for members.</li> <li>○ Specialist access in certain geographic areas is limited.</li> <li>○ Shorter appointment times for members by providers.</li> </ul> </li> </ul>	<p>Identified Opportunities for Improvement:</p> <ul style="list-style-type: none"> <li>• Adopt an organization-wide commitment to improving member experience, ensuring every department understands its role and impact on member experience.</li> <li>• Continue oversampling as appropriate.</li> <li>• Encourage providers to expand office capacity by hiring non-physician practitioners.</li> <li>• Target contracting with provider types not meeting standards.</li> <li>• Network Adequacy and Timely access workgroups to monitor and develop solutions to address and improve network and access gaps.</li> </ul>
<p>Conclusion: CalOptima Health improved in some areas of CAHPS performance, but many areas remain low. Delays in implementing member initiatives may have impacted results.</p>	
<p>Activities/Interventions to continue/add next year:</p> <ul style="list-style-type: none"> <li>• Conduct member outreach prior to 2025 CAHPS survey fielding.</li> <li>• Implement member just in time outreach targeted mailings and phone calls to members likely to respond negatively to the CAHPS survey.</li> <li>• Discuss with health networks CAHPS results, best practices and the P4V program.</li> <li>• Conduct member focus groups to collect information about issues adversely affecting their member experience.</li> <li>• Implement listening posts that consist of targeted outreach to members to solicit their input and respond to their needs regarding their health.</li> <li>• Improve member education regarding the referral process and educate providers about best practices for optimizing the appointment availability and referral process to specialists.</li> </ul>	

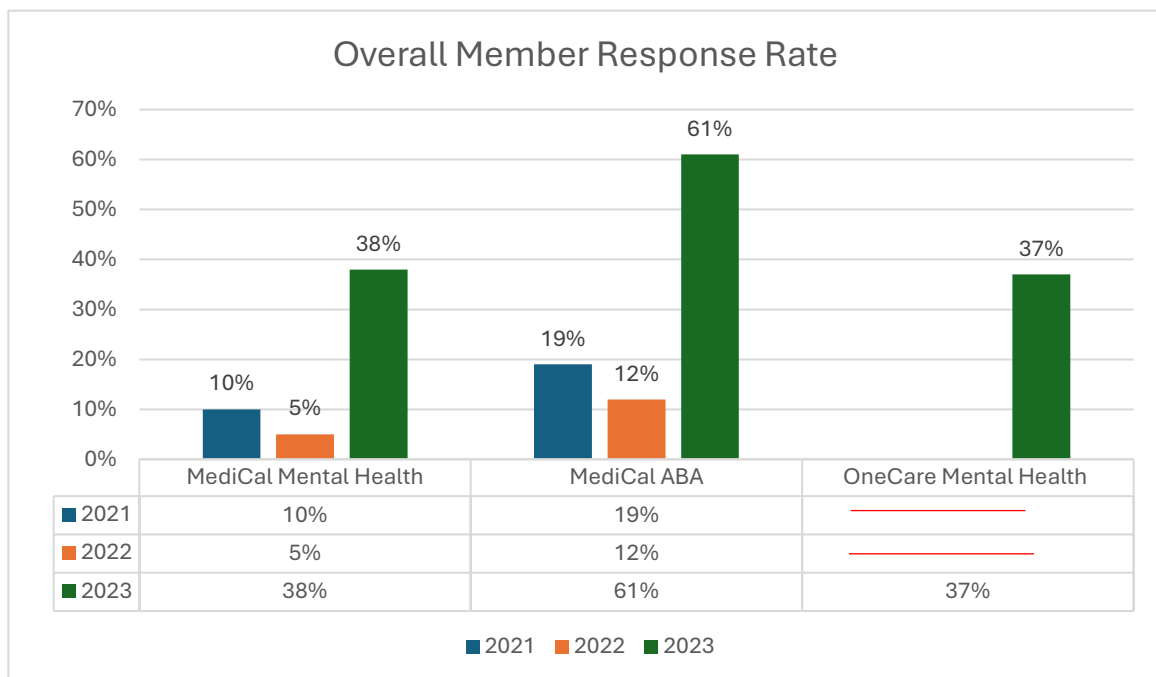
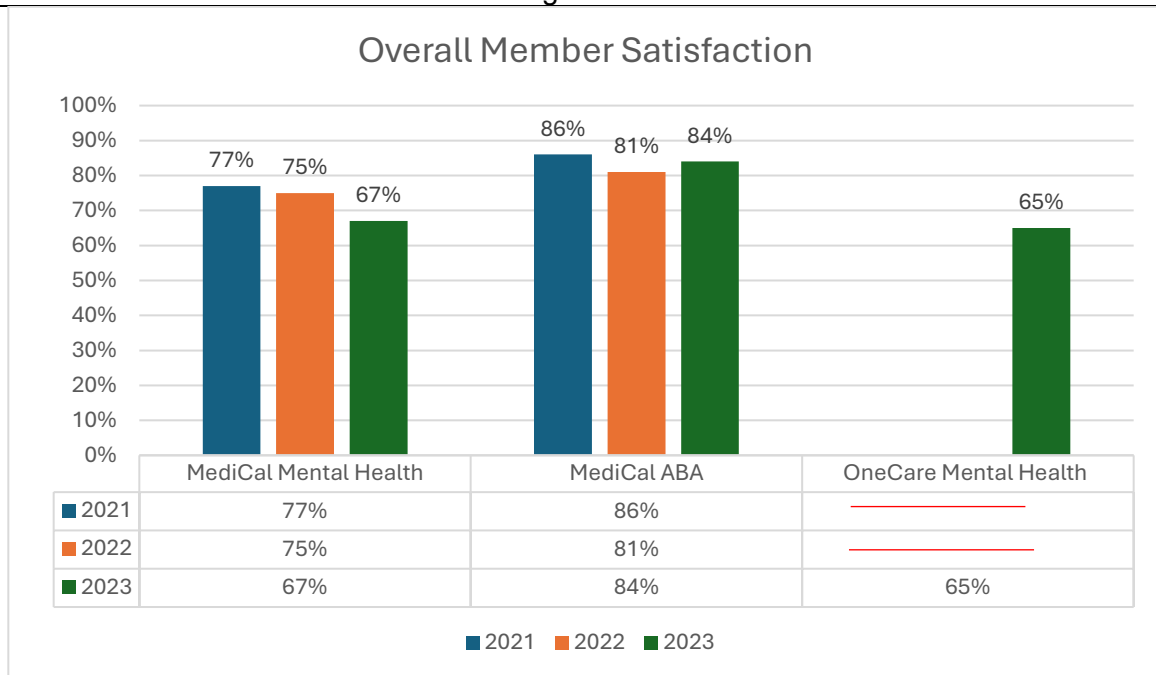
- Implement shadow coaching and office staff and provider training for identified high-volume providers to improve service delivery and member experience in provider offices.
- Distribute provider tips sheets to improve CAHPS scores for Getting Care Quickly and Getting Needed Care.
- Monitor Quality Improvement P4V grants issued to improve member experience.

#### 5.1.2 BH Member Experience

Business Owner: Diane Ramos, Natalie Zavala, Carmen Katsarov		Department: Behavioral Health Integration (BHI)	
Support Staff: Jeni Diaz			
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare		New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Work Plan Goal/Objective: CalOptima Health has established an overall satisfaction goal of 85%			
Goal Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial			
Work Plan Planned Activities: Not listed on workplan			
Status: <input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing			
<p>Background:</p> <p>CalOptima Health conducts comprehensive behavioral health surveys and analyses annually to assess member satisfaction regarding BH services. CalOptima Health's BHI department worked internally to conduct the 2024 Behavioral Health Member Experience Surveys. These surveys measured member satisfaction with BH services received in 2023. 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 both psychotherapy and medication services, whereas the ABA version is solely for ABA services. The survey questions focused on four main areas: telehealth services, access to services, treatment experience and overall experience.</p>			
<p>Methodology:</p> <p>A random sample of 900 members was used to conduct the member survey, which included:</p> <ul style="list-style-type: none"> <li>• 300 Medi-Cal members who utilized MH services.</li> <li>• 300 OneCare members who utilized MH services.</li> <li>• 300 Medi-Cal members who utilized ABA services.</li> <li>• 2024 was the first time that the Member Experience Survey was conducted telephonically and the first year that OneCare members were included.</li> <li>• Outbound phone Administration. Calls started December 4, 2023</li> <li>• Data collection end date: March 1, 2024</li> </ul> <p>The BHI Program Specialist team called out to the members and made three attempts to speak with the members and complete the survey. Questions were scored on a five-point Likert scale with options of: Strongly Disagree, Disagree, Neutral, Agree and Strongly Agree. A Not Applicable (NA) optional response was also included apart from the five-point scale.</p> <p>The survey was available to all members in their preferred language via CalOptima Health's telephonic interpreter services.</p>			
Actions/Interventions Implemented in 2024:			
Quarter 1:	<ul style="list-style-type: none"> <li>• Reviewed and analyzed data collected.</li> </ul>		
Quarter 2:	<ul style="list-style-type: none"> <li>• Presented findings at Behavioral Health Quality Improvement Workgroup (BHQI) to solicit feedback.</li> </ul>		

	<ul style="list-style-type: none"> <li>Discussed the use of different modalities to administer the surveys, as well as using available technology to collect timely results.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Collaborated with the text messaging vendor to develop a text campaign to administer the BH Member Experience survey.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Phase 1 of the text campaign was administered on September 26, 2024.</li> <li>Phase 2 began November 19, 2024</li> </ul>

#### Program Results:



#### Quantitative Analysis:

<p><b>Overall Satisfaction Rates</b></p> <p>Analysis of 2022 (75%) compared to 2023 (67%) exhibited a decrease in the Medi-Cal MH survey's overall satisfaction rates. The rate dropped by 8%. The OneCare MH survey's overall satisfaction rate for 2023 was 65%. The ABA overall satisfaction rates increased by 3% from 2022 (81%) to 2023 (83%), respectively.</p>	
<p><b>Overall Response Rates</b></p> <p>Analysis of 2022 compared to 2023 exhibited a significant increase in both the Medi-Cal MH and the ABA survey response rates. The Medi-Cal MH response rate increased from 5% in 2022 to 38% in 2023, and the ABA response rate increased from 12% to 61%.</p>	
<p>The OneCare Mental Health survey response rate for 2023 was 37%.</p>	
<p><b>Identified Barriers:</b></p> <ul style="list-style-type: none"> <li>Members experiencing survey fatigue.</li> <li>Invalid phone numbers for members.</li> </ul>	<p><b>Identified Opportunities for Improvement:</b></p> <ul style="list-style-type: none"> <li>Utilization of different modalities to enhance member engagement.</li> </ul>
<p><b>Conclusion:</b></p> <p>The change in methodology allowed for more personal interaction with the members. Members were more receptive to completing the survey over the phone than via a mailed survey.</p>	
<p><b>Activities/Interventions to continue/add next year:</b></p> <ul style="list-style-type: none"> <li>Continue collaboration with text messaging vendor to develop a text campaign to administer the BH Member Experience survey.</li> <li>Increase the sample size of members.</li> </ul>	

5.1.3 Customer Service	
Business Owner: Andrew Tse	Department: Customer Service
Support Staff: Mike Erbe	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p><b>Work Plan Goal/Objective:</b></p> <p>Implement customer service process and monitor against standards. The telephonic wait time shall not exceed 10 minutes for members to speak with a customer service representative.</p>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
<p><b>Work Plan Planned Activities:</b></p> <p>Leverage call back offering for those who do not want to wait in queue Hire additional staff to help with the inbound call volume Partner with various departments to stagger their member engagement campaigns</p>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p><b>Background:</b></p> <p>Customer Service department providing telephonic assistance to CalOptima Health members.</p>	
<p><b>Methodology:</b></p> <p>Inbound call data from contact center system</p>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>Leverage call back offering for those who do not want to wait in queue</li> <li>Hired additional staff to help with the inbound call volume</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>Partnered with various departments to stagger their member engagement campaigns</li> </ul>

	<ul style="list-style-type: none"><li>Leveraged call back offering for those who do not want to wait in queue</li><li>Hired additional staff to help with the inbound call volume</li></ul>								
Quarter 3:	<ul style="list-style-type: none"><li>Hired additional staff to help with the inbound call volume</li><li>Leveraged call back offering for those who do not want to wait in queue</li><li>Partnered with various departments to stagger their member engagement campaigns</li></ul>								
Quarter 4:	<ul style="list-style-type: none"><li>Hired additional staff to help with the inbound call volume</li><li>Leveraged call back offering for those who do not want to wait in queue</li><li>Partnered with various departments to stagger their member engagement campaigns</li></ul>								
Program Results:									
Average Speed of Answer (Goal: Not to exceed 10 minutes)									
<table><tr><th>Quarter 1</th><th>Quarter 2</th><th>Quarter 3</th><th>Quarter 4</th></tr><tr><td>15:15</td><td>2:01</td><td>1:45</td><td>1:35</td></tr></table>		Quarter 1	Quarter 2	Quarter 3	Quarter 4	15:15	2:01	1:45	1:35
Quarter 1	Quarter 2	Quarter 3	Quarter 4						
15:15	2:01	1:45	1:35						
Quantitative Analysis:									
Average speed of answer continues to improve quarter after quarter and the goals were met for quarters 2 and 3.									
Identified Barriers:	Identified Opportunities for Improvement:								
<ul style="list-style-type: none"><li>For quarter 1, it's typical to experience high call volume. However, the call center received a large spike in call volume that was attributed to additional factors (various transitions involving Optum, Adult Expansion, Kaiser and other departments conducting member engagement campaigns).</li></ul>	<ul style="list-style-type: none"><li>Partnered with various departments to stagger their member engagement campaigns</li><li>Hired additional staff to help with the inbound call volume</li><li>Offered callback requests within the phone tree (i.e., prevent callers from waiting in the queue for a prolonged time, calling back multiple times)</li></ul>								
Conclusion:									
On a quarterly basis, the average speed of answer has improved.									
Activities/Interventions to continue/add next year:									
<ul style="list-style-type: none"><li>Partner with various departments to stagger their member engagement campaigns</li><li>Leverage call back offering for those who do not want to wait in queue</li><li>Perpetual recruiting and hiring additional staff to help with the inbound call volume</li></ul>									

<b>5.1.4 GARS</b>	
Business Owner: Heather Sedillo	Department: GARS
Support Staff: Amanda Acosta, Ismael Bustamante, Jamar Phillips	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Implement grievance and appeals and resolution process	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
Work Plan Planned Activities: <ul style="list-style-type: none"> <li>Track and trend member and provider grievances and appeals for opportunities for improvement.</li> <li>Maintain business for current programs.</li> </ul>	

<ul style="list-style-type: none"> <li>Improve process of handling member and provider grievances and appeals</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: GARS handles all member and provider complaints and appeals for Medi-Cal and OneCare lines of business.	
Methodology: All Grievances and Appeals received in 2024.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>Worked with UM and RAC to improve the process related to integrated benefits for OneCare members.</li> <li>Worked with BH to identify the issues around an increase in ABA appeals in Q1.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>Met with UM/CM to discuss an increase in discharge appeals and grievances.</li> <li>BH provider training conducted in Q2 related to the appeals increase in Q1.</li> <li>Partnered with other departments to improve member access to providers.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Partnered with other departments to improve member access to providers.</li> <li>Hired additional clinical staff.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Clinical Manager was hired.</li> <li>Continued partnership with other departments to improve member access to providers.</li> </ul>
Quantitative Analysis: Grievance increases related to transportation remain our highest volume, under Quality of Service. GARS continues remediations to ensure members have access to their transportation needs.	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Transportation services</li> </ul>	<ul style="list-style-type: none"> <li>Workgroup with the transportation vendor, GARS leadership and CalOptima Health Transportation Program manager.</li> </ul>
Conclusion: The addition of the GARS tracking and trending reports offers a clearer picture of trending issues and assists the department in determining where to focus for continued process improvement and member satisfaction.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>Track and trend member and provider grievances and appeals for opportunities for improvement.</li> <li>Improve the process of handling member and provider grievances and appeals</li> <li>Maintain business for current programs.</li> </ul>	

## 5.2 Access and Availability

5.2.1 Network Adequacy	
Business Owner: Quynh Nguyen	Department: Provider Data Operations
Support Staff: Cathy Dela Cruz/Tory Vazquez/Jane Flannigan Brown/Mike Wilson	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Increase provider network to meet regulatory access goals	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network	

2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for members	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background: CalOptima Health routinely assesses the provider network for all programs, including Medi-Cal and OneCare, to ensure our members have appropriate access to care. This includes evaluating trends, determining if any gaps exist in a particular HN or with specific practitioner specialties, identifying opportunities for improvement, prioritizing those opportunities, and taking action to improve the network.</p> <p>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 HN levels. Network adequacy applies to both Medi-Cal and OneCare, with mandatory provider types (MPTs) standards applicable only to the Medi-Cal Program.</p>	
<p>Methodology:</p> <p>CalOptima Health conducted network adequacy gap analysis using the following methodology:</p> <ol style="list-style-type: none"> <li>1. CalOptima Health uses the 274 file as the provider network data for network adequacy gap analysis.</li> <li>2. Provider network data is pulled quarterly to run an analysis for MPTs, network capacity ratio (FTE) and provider-to-member ratio (PMR). This data is compared with 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.</li> <li>3. For the OneCare plan, the minimum number of providers varies per provider type according to CMS annual Health Service Delivery (HSD) reference table.</li> <li>4. CalOptima Health uses the Quest Analytics Suite to conduct accessibility analyses and mapping to meet time/distance standards identified in CalOptima Health Access and Availability Policies referenced earlier. The accessibility analyses must demonstrate coverage of the entire service area. CalOptima Health establishes network adequacy standards in accordance with state and federal regulations. <ol style="list-style-type: none"> <li>a. Medi-Cal 100% compliance with time and distance standards for primary care and specialist</li> <li>b. OneCare: 90% compliance with time and distance standards for primary care and specialist</li> </ol> </li> <li>5. Medi-Cal: Changed the methodology for time/distance from assigned membership to anticipated membership for plan level. No change for the health network level.</li> <li>6. OneCare: Starting in Q3, changed the methodology for time and distance from anticipated membership to CMS 2025 Beneficiary file to comply with regulations.</li> </ol>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>Identified resource constraints and competing priorities as barriers, with the solution of hiring a PM to manage network adequacy</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>CalOptima Health hired senior program manager dedicated to network adequacy</li> <li>Established a process for gap closure with health networks not meeting time and distance requirements</li> <li>Closed CAPS for two health networks with time and distance gaps</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Transitioned network adequacy from QA to Provider Data Operations except for timely access</li> </ul>



	<ul style="list-style-type: none"> <li>• Network Adequacy Workgroup conducted two meetings to discuss network adequacy gaps, formulated an action plan to reduce gaps in time and distance and provider-to-member ratio</li> <li>• Provider Data Operations curated leads list to close identified gaps at the plan level and CHCN level</li> <li>• Provider Relations and Contracting collaborated on expanding provider network through new contracts with providers targeted to close identified gaps in Q3</li> <li>• CalOptima Health worked with HNs to establish alternative access standards and closed four out of six HNs outstanding 2023 SNC CAP for time and distance</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• Approved alternative access standards request for remaining two HNs, closing out 2023 SNC.</li> <li>• Provider Data Operations curated additional leads list to close identified gaps</li> <li>• Network Adequacy Workgroup continued to work on solutions to reduce gaps, and monitor progress</li> </ul>

Program Results:

**Medi-Cal: MPT**

Standard: Must contract with at least one MPT for FQHC, CNM and LM.

Mandatory Provider type	Q1		Q2		Q3		Q4	
	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met
<b>FQHC</b>	40	Met	47	Met	47	Met	45	Met
<b>CNM</b>	26	Met	4	Met	3	Met	2	Met
<b>LM</b>	0	Not Met	5	Met	6	Met	5	Met

### Medi-Cal: Provider to Member Ratios by Specialty Type

Provider Type	Quarter in 2024	Q1		Q2		Q3		Q4	
	Medi-Cal Specialty	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met
PCP	General/Family Medicine	1:1933	Met	1:1821	Met	1:1801	Met	1:1936	Met
PCP	Internal Medicine	1:2941	Not Met	1:1936	Met	1:1949	Met	1:1918	Met
PCP	Pediatric	1:955	Met	1:978	Met	1:917	Met	1:883	Met
PCP	Total PCP	1:741	Met	1:768	Met	1:784	Met	1:768	Met
Specialist	Cardiology/Intervention at Cardiology	1:3224	Met	1:3249	Met	1:2963	Met	1:2955	Met
Specialist	Gastroenterology	1:5756	Not Met	1:5940	Not Met	1:5452	Not Met	1:5182	Not Met
Specialist	General Surgery	1:2251	Met	1:2248	Met	1:2045	Met	1:1983	Met
Specialist	Hematology/Oncology	1:3100	Met	1:3134	Met	1:2908	Met	1:2766	Met
Specialist	Nephrology	1:7462	Met	1:7580	Met	1:6654	Met	1:6879	Met
Specialist	Neurology	1:4658	Met	1:4574	Met	1:4132	Met	1:3946	Met
Specialist	OB/GYN	1:1162	Met	1:1129	Met	1:1098	Met	1:1099	Met
Specialist	Ophthalmology	1:4502	Met	1:4398	Met	1:4436	Met	1:4367	Met
Specialist	Orthopedic Surgery	1:6296	Not Met	1:6368	Not Met	1:5993	Not Met	1:5844	Not Met
Specialist	Pulmonology	1:6660	Met	1:6921	Met	1:5378	Met	1:5217	Met

#### Standards: Provider to Member Ratios

A. PCP-to-member ratio is 1:2,000 or better

B. Specialists:

1. OB/GYN is 1:2,000 or better

2. Nephrology, pulmonology and psychiatry is 1:10,000 or better

3. All other specialist-to-member is 1:5,000 or better

### OneCare: Primary Care Time/Distance Analysis — Non-Compliance County by Zip Code (YoY)

Non-Compliance ZIP Code Count for Contracted PCP				
	Q1	Q2	Q3	Q4

	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met
<b>2024</b>	0	Met	0	Met	0	Met		
<b>2023</b>	1	Not Met	1	Not Met	1	Not Met	1	Not Met

**OneCare: Specialist Time/Distance Analysis — Non-Compliance County by Zip Code (YoY)**

Non-Compliance ZIP Code Count for Contracted Providers								
	Q1 Specialties		Q2 Specialties		Q3 Specialties		Q4 Specialties	
	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
<b>2024</b>	0	Met	0	Met	0	Met		
<b>2023</b>	8	Not Met	9	Not Met	8	Not Met	8	Not Met
<b>2022</b>	0	Met	0	Met	0	Met	0	Met

**OneCare: Facility Time/Distance Analysis — Non-Compliance County by Zip Code (YoY)**

Non-Compliance ZIP Code Count for Contracted Providers								
	Q1 Facilities		Q2 Facilities		Q3 Facilities		Q4 Facilities	
	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
<b>2024</b>	0	Met	0	Met	0	Met		
<b>2023</b>	31	Not Met	29	Not Met	30	Not Met	30	Not Met
<b>2022</b>	0	Met	1	Not Met	1	Not Met	1	Not Met

## Quantitative Analysis:

### Medi-Cal

- CalOptima Health was compliant with network capacity ratio (FTE), as well as time and distance standards for primary care, specialty care and hospitals.
- 2024 MPT quarterly results show standards met in Q1 were FQHC, Certified Nurse Midwife (CNM). CalOptima Health did not meet standards for Licensed Midwife (LM). However, beginning in Q2 and onward, all standards for MPT were met.
- Provider-to-Member Ratio:
  - Internal medicine did not meet standards in Q1 and became compliant from Q2 onwards.
  - Specialty types gastroenterology and orthopedic surgery are not meeting the standard for ratios. However, the downward trend shows consistent improvement in this metric quarter over quarter.
  - Most ratios are trending downward, signifying less members per provider except for General/Family Medicine and General Surgery which are both trending upward.

### OneCare

- Provider-to-member ratios data show OneCare consistently meeting standards. Quarterly data shows an upward trend count overall, indicating that the provider network is expanding. Primary care, ophthalmology and oncology-medical/surgical are the top specialties that experienced the highest increase in provider count from Q1 to Q3. Plastic surgery, neurosurgery, infectious diseases and cardiothoracic surgery, however, all showed a small decrease in provider count.
- In 2023, the time/distance data shows CalOptima Health was non-compliant for all four quarters for PCPs, specialists and facilities. CalOptima Health is now compliant with meeting this standard.

### Identified Barriers:

- While CalOptima Health is meeting time and distance standards, our analysis shows South Orange County continues to remain an area where time and distance gaps tend to occur
- Contracting and PR are dependent on network adequacy analysis to identify gaps to inform provider network recruitment strategy
- Compliance rates in terms of PMR may not be enough to ensure access and availability

### Identified Opportunities for Improvement:

- Adding program manager headcount dedicated to managing the network adequacy program will allow the organization better monitoring and reporting capability
- CalOptima Health worked on raising rates for Medi-Cal providers, to help incentivize providers to prioritize seeing its members and improve retention. This was implemented July 2024
- Formed a Network Adequacy Workgroup focused on addressing adequacy gaps and ideating solutions to increase and expand provider network

### Conclusion:

CalOptima Health's goal to increase the provider network to improve access is ongoing. It has been successful at expanding the provider network in the OneCare program, which can be positively correlated with OneCare now meeting time and distance standards.

CalOptima Health remediated the constraint to monitoring and network adequacy by hiring a senior program manager focused on network adequacy programs. Even though there were challenges, having this resource allowed the transition of this program from QA to Provider Data Operations to be completed.

CalOptima Health changed the methodology for calculating time and distance network adequacy component back to anticipated membership for the plan level for Medi-Cal, and from anticipated membership to using the 2025 Beneficiary File for OneCare, to align with state and federal regulations.

In July, CalOptima Health instituted a program-wide provider rate increase for Medi-Cal. This intervention is an opportunity prioritized by CalOptima Health to help incentivize providers to see members and to improve provider retention. CalOptima Health will look to analyze the impact of this solution on network adequacy in the future.

Activities/Interventions to continue/add next year:

CalOptima Health will continue to monitor network adequacy on a quarterly basis by running reports to evaluate whether the plan meets all network adequacy components under Medi-Cal and OneCare.

- Continue to conduct gap analysis of our network to identify the areas to target for provider network expansion
- Continue conducting outreach and implement recruiting efforts to address network gaps to increase access to members
- Take a deeper dive into the data between provider network and membership to better understand the impact of provider recruitment strategy
- Continue to conduct Network Adequacy Workgroup to discuss gaps and operationalize solutions

### 5.2.2 Timely Access Program

Business Owner: Mike Wilson

Department: Quality Analytics

Support Staff: Karen Jenkins/Helen Syn

Products: ☒ Medi-Cal ☒ OneCare

New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective: Improve timely access compliance with appointment wait times to meet 80% MPL

Goal Met: ☐ Yes ☐ No ☒ Partial

Work Plan Planned Activities:

- Issue corrective action for areas of non-compliance
- Collaborative discussion between CalOptima Health medical directors and providers to develop actions to improve timely access
- Continue to educate providers on timely access standards
- Develop and/or share tools to assist with improving access to services.

Status: ☐ Completed ☒ Ongoing

Background:

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 appointment and telephone wait times. The survey was fielded from September 26, 2023, through December 1, 2023, and utilized a direct survey methodology in which the callers identified themselves as calling on behalf of CalOptima Health to obtain appointment data. Over 2,700 providers were surveyed, including the following provider categories: primary care, OB/GYN, specialty care, non-physician behavioral health care, psychiatric care and ancillary care for both Medi-Cal and OneCare. The minimum performance level is set at 80%.

**Methodology:**

The data pull methodology included both census and sampling data. With a few exceptions, census data was used for provider types with universes of 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. Providers were not called on weekends or holidays, and for each contact, the surveyor made a maximum of three attempts to reach a live person.

The 2023 Timely Access Survey included several changes in its methodology, including the use of a direct script only in lieu of a hybrid (mystery-direct) script. A single script was developed to collect appointment times, and callers followed the script verbatim. The survey was also adjusted to take into consideration the availability of other providers at the same location who could possibly see the patient sooner. The tables below show both compliance rates for illustrative purposes, but when determining compliance CalOptima Health took the highest compliance rate.

In 2023, CMS made moderate changes to the OneCare appointment measures, and therefore, we are reporting them separately from the Medi-Cal population. OneCare changes are as follows:

<i>2022 OneCare</i>	<i>2023 OneCare</i>
Primary Care Non-Urgent (10 business days)	Primary Care — Services Not Emergent or Urgently Needed but Requires Medical Attention (Seven business days)
Primary Care Physical Exam (30 calendar days)	Primary Care Routine and Preventive Care (Physical Exam) (30 business days)
Psychiatrist Non-Urgent (15 business days)	Psychiatrist Routine and Preventive Care (30 business days)
Non-Physician BH Non-Urgent (10 business days)	Non-Physician BH Routine and Preventive Care (30 business days)

**Actions/Interventions Implemented in 2024:**

Quarter 1:	<ul style="list-style-type: none"> <li>Continuous contracting efforts to add new providers to the network.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>Mailed over 1,400 letters of non-compliance and CAPs to individual providers who did not meet the minimum performance level based on the 2023 Timely Access Survey. Mailing included a copy of CalOptima Health's call script to facilitate appointment scheduling with patients.</li> <li>Revamped the process for monitoring compliance to facilitate standardization and better monitoring of the non-compliance process, including developing a new CAP evaluation tool (internal use only), updated flow charts, timelines and escalation process.</li> <li>Developed a RFP for potential new vendor in 2025.</li> <li>Continuous contracting efforts to add new providers to the network.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>CalOptima Health's Provider Relations department and select health networks conducted outreach to providers who were issued a CAP to confirm receipt and address any potential questions and/or concerns provider may have.</li> <li>Partnered with SullivanLuallin Group to offer a patient experience program to providers, including workshops and provider shadow coaching to educate and facilitate best practices.</li> </ul>

	<ul style="list-style-type: none"> <li>• The contracted vendor fielded an in-office wait time survey to measure office wait time among providers, August through November.</li> <li>• The Access and Availability workgroup began reviewing provider CAP submissions and tagging for escalation for medical director review and potential peer-to-peer meetings.</li> <li>• Continuous contracting efforts to add new providers to the network.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>• Issued CAPs to HNs not meeting timely access standards in December 2024</li> <li>• Began scheduling collaborative meetings with CalOptima Health medical directors and select providers for peer-to-peer meetings to develop a plan of action.</li> <li>• CalOptima Health hosted a Timely Access Q&amp;A session for providers to discuss access monitoring, changes for 2024 and 2025, barriers and interventions and next steps.</li> <li>• 2024 Timely Access Survey kick off on October 15th.</li> <li>• Continuous contracting efforts to add new providers to the network.</li> </ul>
Program Results:	

## Medi-Cal

Appointment Types	2021	2022	2023 Individual Provider	2023 Another Office Provider	Met MPL	Difference (2022 vs highest rate for 2023)
Primary Care Non-Urgent (10 business days)	72%	61%	75%	88%	Met	+27
Primary Care Urgent (48 hours)	63%	59%	60%	75%	Not Met	+16
Primary Care Physical Exam (30 calendar days)	79%	79%	81%	87%	Met	+8
Specialists Non-Urgent (Non-Urgent)	59%	49%	58%	74%	Not Met	+25
Specialists Urgent (96 hours)	64%	55%	47%	59%	Not Met	+4
OB/GYN Non-Urgent (15 business days)	81%	81%	64%	74%	Not Met	-7
OB/GYN Urgent (48 hours)	76%	70%	34%	64%	Not Met	-6
Psychiatrist Non-Urgent (15 business days)	54%	59%	67%	89%	Met	+30
Psychiatrists Urgent (48 hours)	24%	86%	46%	47%	Not Met	-39
Psychiatrists Follow-Up (30 calendar days)	59%	32%	64%	85%	Met	+53
Non-Physician BH Non-Urgent (10 business days)	75%	67%	77%	83%	Met	+16
Non-Physician BH Urgent (48 hours)	57%	69%	44%	70%	Not Met	+1
Non-Physician BH Follow-Up (20 calendar days)	71%	67%	79%	81%	Met	+14
Ancillary Non-Urgent (15 business days)	85%	73%	64%	-	Not Met	-9



## OneCare

Appointment Types	2023 Individual Provider	2023 Another Office Provider	Met MPL (Highest rate for 2023)
<b>Primary Care — Services Not Emergent or Urgently Needed but Requires Medical Attention (Seven business days)</b>	66.3%	79.6%	Not Met
<b>Primary Care Routine and Preventive Care - Physical Exam (30 business days)</b>	87.6%	92.8%	Met
<b>Psychiatrist Routine and Preventive Care (30 business days)</b>	91.7%	96.8%	Met
<b>Non-Physician BH Routine and Preventive Care (30 business days)</b>	93.9%	94.7%	Met

### Quantitative Analysis:

In 2023, CalOptima Health modified its survey methodology to take into account the availability of other providers who can see the patient sooner at the same location. Therefore, to determine compliance, the highest rate was selected between the provider who was selected to participate in the survey and the availability of the other provider. With this modification, there were some gains in compliance, but overall results show there is still room for improvement for both urgent and routine appointments.

Medi-Cal: Out of the 14 measures for the Medi-Cal program, six met the 80% MPL. This more than doubled in comparison to the previous year. Out of the six standards that were identified as compliant, four are from the Behavioral Health area. No provider types met the Urgent Appointment type category.

OneCare: CMS made significant changes to the OneCare standards, and therefore, the data for OneCare is not trendable. However, findings for 2023 were favorable, as out of the four measures being evaluated, three met the 80% MPL. The one measure that did not meet, Non-Urgent Appointment Services – Not Emergent or Urgently Needed but Requires Medical Attention was very close to meeting the threshold at 79.6%

### Identified Barriers:

- Newly contracted providers and staff may not be aware of CalOptima Health Timely Access Standards
- PCPs have too many members in their panels.
- Closing of panel to potential new patients

### Identified Opportunities for Improvement:

- Encourage providers to hire non-physician medical practitioners to expand office capacity
- Encourage providers to make appointments more interchangeable to be able to better accommodate patient preference regarding in person vs telehealth appointments.

<ul style="list-style-type: none"> <li>Higher rate of rescheduling or cancellation from the provider office resulting in frustration from members</li> <li>Shorter appointment times with patients</li> <li>Provider offices that offer both in-person and telehealth appointments, at times may only have telehealth appointment availability, but patients decline because they want in-person.</li> <li>Network does not have enough contracted specialists in certain areas of the county.</li> </ul>	<ul style="list-style-type: none"> <li>Target contracting with provider types not meeting standards.</li> </ul>
<p>Conclusion: 2023 survey findings indicate that modifications to the survey methodology were positive as compliance rates tended to show an increase from 2022. However, there is still work to be done as many measures remain below the 80% threshold.</p>	
<p>Activities/Interventions to continue/add next year:</p>	
<ul style="list-style-type: none"> <li>Field survey earlier in the year to make it more actionable.</li> <li>Simplify the CAP process, so determination of a CAP can be made over a shorter time frame of one year, instead of three.</li> <li>Perform interim surveys after main survey fielded to confirm compliance</li> <li>Utilize provider communication tools such as Provider Update email to educate and reiterate access standards and changes.</li> </ul>	

<b>5.2.3 Telephone Access</b>	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Karen Jenkins/Helen Syn	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>Work Plan Goal/Objective:</p> <ol style="list-style-type: none"> <li>Issue corrective action for areas of non-compliance</li> <li>Collaborative discussion between CalOptima Health medical directors and providers to develop actions to improve timely access</li> <li>Continue to educate providers on timely access standards</li> <li>Develop and/or share tools to assist with improving access to services.</li> <li>Meet 80% MPL for all access standards.</li> </ol>	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
Work Plan Planned Activities:	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>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 and to monitor appointment and telephone wait times. The survey was fielded from September 26, 2023, through December 1, 2023, and utilized a direct survey methodology in which the callers identified themselves as calling on behalf of CalOptima Health in order to obtain appointment data. Over 2,700 providers were surveyed, including the following provider categories: primary care, OB/GYN, specialty care, non-physician behavioral health care, psychiatric care and ancillary care for both Medi-Cal and OneCare. The minimum performance level is set at 80%.</p>	
<p>Methodology:</p> <p>The data pull methodology included both census and sampling data. With a few exceptions, census data was used for provider types with universes of less than 100 providers. Sampling was</p>	

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. Providers were not called on weekends or holidays, and for each contact, the surveyor made a maximum of three attempts to reach a live person.

The 2023 Timely Access Survey included several changes in its methodology, including the use of a direct script only in lieu of a hybrid (mystery-direct) script. A single script was developed to collect appointment times, and callers followed the script verbatim.

#### **Actions/Interventions Implemented in 2024:**

<b>Quarter 1:</b>	<ul style="list-style-type: none"> <li>None</li> </ul>
<b>Quarter 2:</b>	<ul style="list-style-type: none"> <li>Mailed over 1,400 letters of non-compliance and CAPs to individual providers who did not meet the MPL based on the 2023 Access survey.</li> </ul>
<b>Quarter 3:</b>	<ul style="list-style-type: none"> <li>Conducted an interim telephone audit on 738 providers identified as non-compliant for telephone measure Instruct Caller to ER or Dial 911 in Case of Emergency. Results show approximately 67% (511) are now compliant with this measure.</li> </ul>
<b>Quarter 4:</b>	<ul style="list-style-type: none"> <li>Issued CAPs to HNs not meeting the timely access standards.</li> <li>CalOptima Health hosted a Timely Access Q&amp;A session for providers to discuss access monitoring, changes for 2024 and 2025, barriers and interventions, and next steps.</li> </ul>

#### **Program Results:**

#### **CalOptima Health Plan Level**

<b>Types</b>	<b>CalOptima Health Plan Level</b>				
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>Met MPL</b>	<b>Difference</b>
<b>Instructs Caller to ER/911</b>	20.8%	19.7%	62.1%	Not Met	+42.4
<b>Informs Caller of Return Call Time</b>	14.1%	10.8%	20.9%	Not Met	+10.1
<b>Phone Triage Patients within 30 Minutes</b>	95.3%	98.0%	92.0%	Met	-6.0
<b>Callback Time within 24 hours</b>	50.0%	71.4%	68.1%	Not Met	-3.3
<b>Callback Time within 30 minutes</b>	20.6%	14.6%	0%	Not Met	-14.6
<b>Flexibility in Scheduling Members with Disabilities</b>	97.0%	97.8%	95.9%	Met	-1.9

#### **Quantitative Analysis:**

2023 Access survey results show telephone access continues to be an area of opportunity. Out of the six measures surveyed, only two met the standards Instructs Caller to ER and Informs Caller of Return Call Time. Both experienced improvement of more than 10 percentage points, but overall failed to meet the threshold.

It is worth noting that the following measures are no longer identified as a regulatory requirement for monitoring in 2024:

- Callback Time within 30 minutes
- Callback Time within 24 hours
- Flexibility in Scheduling Members with Disabilities

Identified Barriers:

Identified Opportunities for Improvement:

<ul style="list-style-type: none"> <li>• CalOptima Health Provider Directory may not always have current contact information.</li> <li>• Members are unable to reach provider office because the contact information (phone, address) they have is outdated</li> <li>• Provider offices may not be up to date on CalOptima Health's telephone standards</li> <li>• Smaller provider offices may not have phone systems and/or the staff to handle large volumes of calls and/or outgoing voice messages.</li> <li>• Providers are overwhelmed with notices of non-compliance from plans and health networks, and therefore, notices are sometimes unintentionally disregarded</li> </ul>	<ul style="list-style-type: none"> <li>• Educate and collaborate more with provider offices on standards by providing tips and tools on best practices, offer Q&amp;A access call sessions, email/newsletters updates, etc.</li> <li>• Field more interim surveys to enhance monitoring of telephone access</li> </ul>
<p>Conclusion: For the three telephone measures that remain in effect for 2024, tighter monitoring is needed for Instructs Caller to ER/911 and Informs Caller of Return Phone Call as both failed to meet the threshold. The addition of interim surveying will facilitate more timely intervention and increased compliance.</p>	
<p>Activities/Interventions to continue/add next year:</p> <ul style="list-style-type: none"> <li>• Conduct interim surveys to monitor telephone compliance.</li> <li>• Host Q&amp;A Access Call Session at least annually</li> </ul>	

5.2.4 Annual Network Certification (ANC)	
Business Owner: Quynh Nguyen	Department: Provider Data Operations
Support Staff: Cathy Dela Cruz/Karen Jenkins	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Comply with Annual Network Certification Requirements	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <p>Comply with Annual Network Certification requirements.</p> <ol style="list-style-type: none"> <li>1. Annual submission of ANC to DHCS with AAS</li> <li>2. Implement improvement efforts</li> <li>3. Monitor for improvement</li> </ol>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>In April of 2021, DHCS issued APL 21-006, Network Certification Requirements, which established network adequacy standards at the MCP level, a process to assess and certify MCPs for network adequacy at least annually through the ANC process to ensure that each MCP's provider network meets state and federal network adequacy and access requirements.</p> <p>In January of 2023, DHCS issued APL 23-001 Network Certification Requirements to amend and add additional requirements which CalOptima Health codified under policies GG. 7111 and GG.1600.</p> <p>In addition to the annual schedule, network certification will be performed if CalOptima Health's network experiences a change that substantially affects how they service members.</p>	

**Methodology:**

CalOptima Health complies with ANC using the following methodology:

1. ANC monitors the following for 100% compliance
  - a. Mandatory provider type (including cancer center)
  - b. Provider-to-member ratio (FTE)
    - i. PCP: 1:2,000 ratio
    - ii. Physician: 1:1,2000 ratio
  - c. Time or distance
  - d. Timely access
2. CalOptima Health uses the November 274 and November member data for health network membership to run the analysis for provider-to-member ratio (FTE) compared against the 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 a subcontracted health network is compliant with the standards identified in CalOptima Health Access and Availability Policies: GG.1600
3. CalOptima Health uses the Quest Analytics Suite to conduct accessibility analyses and mapping to meet time/distance standards identified in the CalOptima Health Access and Availability Policies referenced earlier. The accessibility analyses must demonstrate coverage of the entire service area.

**Actions/Interventions Implemented in 2024:**

Quarter 1:	<ul style="list-style-type: none"><li>ANC Phase 2 Submission with AAS completed March 20,2024</li></ul>
Quarter 2:	<ul style="list-style-type: none"><li>Updated ANC policy to ensure adherence with regulations</li><li>Quarterly monitoring of ANC requirements and gap analysis</li></ul>
Quarter 3:	<ul style="list-style-type: none"><li>Quarterly monitoring of ANC requirements and gap analysis</li><li>Transitioned ANC program from QI to Provider Data Operations department</li></ul>
Quarter 4:	<ul style="list-style-type: none"><li>Quarterly monitoring of ANC requirements and gap analysis</li><li>DHCS approved CalOptima Health's AAS request, and CalOptima Health began implementing requirements associated with this approval</li></ul>

**Program Results:**

Quantitative Analysis: CalOptima Health met requirements for MPT, provider-to-member ratios and time/distance. This is an improvement on MPT, which was not met in 2023. CalOptima Health did not meet requirements for Timely Access

**Identified Barriers:**

- DHCS uses ArcGIS to run network adequacy for ANC, while CalOptima Health uses Quest, which will result in variance in gap analysis due to the differences in how each software calculates time or distance

**Identified Opportunities for Improvement:**

- CalOptima Health transitioned ANC program from QI to Provider Data Operations for operational efficiency, consolidating owner of provider data and monitoring/reporting into the same department

**Conclusion:**

CalOptima Health improved compliance in meeting ANC from 2023 as we are now meeting MPTs.

CalOptima Health examined potentially switching to ArcGIS to run network adequacy, however, we decided not to implement since DHCS does not require MCP's to use the same program.

Furthermore, DHCS acknowledges and accepts that there will be a variance in analyses when utilizing two different pieces of geomapping software.

As a result, while our own monitoring and reporting activities show compliance with time and distance requirements, there is a possibility that we will still have gaps due to the difference in geomapping program/methodology that CalOptima Health uses compared to what DHCS uses for ANC.

Activities/Interventions to continue/add next year:

- Continue monitoring ANC component compliance
- Finalize ANC policy

#### 5.2.5 Subcontracted Network Certification (SNC)

Business Owner: Quynh Nguyen | Department: Provider Data Operations

Support Staff: Cathy Dela Cruz/ Karen Jenkins

Products: ☒ Medi-Cal ☐ OneCare | New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective: Comply with Subdelegate Network Certification Requirements

Goal Met: ☒ Yes ☐ No ☐ Partial

Work Plan Planned Activities:

1. Annual submission of SNC to DHCS with AAS or CAP
2. Monitor for improvement
3. Communicate results and remediation process to HN

Status: ☐ Completed ☒ Ongoing

Background:

On March 20, 2023, DHCS issued APL 23-006 Delegation and Subcontract Network Certification, which established network adequacy standards at the subcontractor and downstream subcontractor level, a process for MCPs to assess and certify subcontractor and downstream subcontractor for network adequacy at least annually through the SNC process to ensure that each subcontractor and downstream subcontractor provider network meets state and federal network adequacy and access requirements.

On May 2024, DHCS approved CalOptima Health's SNC submission and recategorized previously fully delegated CalOptima Health subcontractors as partially delegated, thus removing the MPT element previously included for some health networks, beginning reporting year 2024.

Methodology:

CalOptima Health conducted SNC using the following methodology:

1. CalOptima Health uses the November 274 and November member data for health network membership to run the analysis for provider-to-member ratio (PMR) compared against the 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 a subcontracted health network is compliant with the standards identified in CalOptima Health Access and Availability Policies: GG.1600
2. CalOptima Health uses the Quest Analytics Suite to conduct accessibility analyses and mapping to meet time/distance standards identified in the CalOptima Health Access and Availability Policies referenced earlier. The accessibility analyses must demonstrate coverage of the entire service area.
3. SNC monitors the following components:
  - a. Provider-to-member ratio (FTE)
  - b. Time or distance
  - c. Timely access

d. Provider directory																																																												
Actions/Interventions Implemented in 2024:																																																												
Quarter 1:	<ul style="list-style-type: none"><li>Closed AltaMed and CHOC 2023 time and distance CAPs</li></ul>																																																											
Quarter 2:	<ul style="list-style-type: none"><li>Submitted Q2 CAP updates to DHCS</li><li>Updated Health Network Certification policy for SNC</li></ul>																																																											
Quarter 3:	<ul style="list-style-type: none"><li>Organized focused efforts to help HNs close CAP</li><li>Closed Heritage-Regal 2023 time and distance CAP</li><li>Developed an alternative access standard process and set up office hours to walk HNs through the process</li><li>Closed four 2023 time and distance CAPs through AAS</li><li>Submitted Q3 CAP updates to DHCS</li><li>Organized a Network Adequacy Workgroup to discuss HN gaps and ideate solutions to increase provider network and access to care</li></ul>																																																											
Quarter 4:	<ul style="list-style-type: none"><li>Closed remaining two 2023 issued time and distance CAP through AAS</li><li>Submitted Q4 CAP updates to DHCS</li><li>Completed SNC Landscape Analysis submission</li><li>Completed 2024 SNC analysis for all health networks</li><li>Completed 2024 SNC submission for DHCS</li></ul>																																																											
Program Results:																																																												
	<table><tr><th>SNC Components</th><th>Timely Access</th><th>Directory Review</th><th>Network Capacity/Ratio (FTE)</th><th>Time and Distance</th></tr><tr><td>Subcontracted Health Network</td><td>MY 2023</td><td>Q3</td><td>Q4</td><td>Q4</td></tr><tr><td>AltaMed Health Services</td><td>Not Met</td><td>Met</td><td>Met</td><td>Not Met</td></tr><tr><td>AMVI Care Health Network</td><td>Not Met</td><td>Met</td><td>Met</td><td>Not Met</td></tr><tr><td>CHOC Physicians Network</td><td>Not Met</td><td>Met</td><td>Met</td><td>Not Met</td></tr><tr><td>Family Choice Health Services</td><td>Not Met</td><td>Met</td><td>Met</td><td>Not Met</td></tr><tr><td>Heritage Provider network</td><td>Not Met</td><td>Met</td><td>Met</td><td>Not Met</td></tr><tr><td>Nobel Mid-Orange County</td><td>Not Met</td><td>Met</td><td>Met</td><td>Not Met</td></tr><tr><td>OPTUM</td><td>Not Met</td><td>Met</td><td>Met</td><td>Not Met</td></tr><tr><td>Prospect</td><td>Not Met</td><td>Met</td><td>Met</td><td>Not Met</td></tr><tr><td>United Care Medical Group</td><td>Not Met</td><td>Met</td><td>Met</td><td>Not Met</td></tr></table>	SNC Components	Timely Access	Directory Review	Network Capacity/Ratio (FTE)	Time and Distance	Subcontracted Health Network	MY 2023	Q3	Q4	Q4	AltaMed Health Services	Not Met	Met	Met	Not Met	AMVI Care Health Network	Not Met	Met	Met	Not Met	CHOC Physicians Network	Not Met	Met	Met	Not Met	Family Choice Health Services	Not Met	Met	Met	Not Met	Heritage Provider network	Not Met	Met	Met	Not Met	Nobel Mid-Orange County	Not Met	Met	Met	Not Met	OPTUM	Not Met	Met	Met	Not Met	Prospect	Not Met	Met	Met	Not Met	United Care Medical Group	Not Met	Met	Met	Not Met				
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Quantitative Analysis: <ul style="list-style-type: none"><li>All health networks are meeting the required provider-to-member ratio for PCP (1:2000) and physician (1:1,200) full-time equivalent</li><li>All health networks are not meeting both timely access and time or distance standards.</li><li>Time or distance gaps per health network are generally decreasing, with Q2 seeing the highest decrease in ZIP codes not meeting standards, except for UCMG, whose gaps increased in Q2 by 53%.</li></ul>																																																												
Identified Barriers:		Identified Opportunities for Improvement:																																																										

<ul style="list-style-type: none"> <li>• 2023 was the first year that MCPs had to certify their subcontractors. There was not a process in 2024 to manage the CAPs issued in December 2023.</li> <li>• There was a resource constraint to implementing and executing the follow-up activities needed for monitoring CAPS and HN contracting efforts</li> </ul>	<ul style="list-style-type: none"> <li>• CalOptima Health hired a dedicated senior program manager to manage the network adequacy programs</li> <li>• Facilitated educational meetings with health networks to explain the SNC process and how to formally close CalOptima Health-issued CAPs with each impacted health network impacted</li> <li>• Created a process for issuing alternative access to close CAP</li> <li>• Build a more detailed program plan to improve program transparency</li> </ul>
<p>Conclusion:</p> <p>The SNC process is still new, and as a result, many processes are not fully in place, which gave rise to a lot of confusion and lack of understanding of what this program entails and what responsibilities fall under the health networks and why.</p> <p>Health networks issued 2023 time or distance CAPS were inconsistent in meeting CalOptima Health's deadlines for DHCS-mandated quarterly updates. There was a lot of confusion in terms of what was needed and why certain information was requested.</p> <p>Hiring a dedicated program manager at the end of Q2 to manage the program allowed for more communication and transfer of information, giving health networks an available contact person to monitor and provide guidance on the program. As a result, CalOptima Health was able to meet DHCS SNC quarterly update deadlines which showed progression, closing CAPs through contracting and operational efforts, as well as using alternative access standards.</p> <p>Activities/Interventions to continue/add next year:</p>	
<ul style="list-style-type: none"> <li>• Formalize alternative access policy</li> <li>• Finalize policy</li> <li>• Continue to monitor HNs on SNC components quarterly to help them pass requirements for annual certification</li> <li>• Continue to educate health networks on the SNC process</li> <li>• Continue to provide guidance to health networks on how to expand the provider network to address lack of providers identified in quarterly monitoring of network adequacy</li> </ul>	



## Section 6: Safety of Clinical Care

6.1 Emergency Department Member Support: Emergency Department Diversion Pilot	
Business Owner: Scott Robinson	Department:
Support Staff: Cathy Osborn	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Work Plan Goal/Objective: Emergency Department Diversion Pilot has been implemented. In 2024, we plan to expand a virtual program to additional hospital partners, starting with UCI.	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
Work Plan Planned Activities:	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: The ED diversion program was developed during 2024 and is planned to launch in January 2025 at the UCI Medical Center Emergency Department. Program Description and Objectives: <ul style="list-style-type: none"> <li>• Provide care coordination for CalOptima Health members who present in the ED.</li> <li>• Support community access after an ED visit without a hospital stay, prevent future ED visits that could be handled at a lower level of care for better coordinated access, and ensure the member's ambulatory care is in place and SDOH needs are met.</li> <li>• Provide expedited care management between ED and CalOptima Health to promote ambulatory care and connection to appropriate CalOptima Health internal teams and external community supports.</li> <li>• Develop relationships between the ED and CalOptima Health to ensure CalOptima Health members receive the best care in the location of their choice.</li> </ul>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Program objectives developed
Quarter 2:	• Planning with CalOptima Health and UCI
Quarter 3:	• Approval of staff job descriptions and hiring
Quarter 4:	• One RN and one social worker hired and trained
Conclusion:	

6.2 Coordination of Care Between Settings: Transitional Care Services (TCS)	
Business Owner: Michelle Evans	Department: Medical Management
Support Staff: Joanne Ku/Mimi Cheung	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: UM/CM/LTC to improve care coordination by 10% from Q4 2023 to December 31, 2024, by increasing successful interactions for TCS for high-risk members within seven days of their discharge by 10%. Monitoring the percentage of acute hospital stay discharges that had follow-up ambulatory visits within seven days post-hospital discharge.	
Goal Met: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: 1) Use of Usher platform to outreach to members post-discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for high-risk members in need of TCS.	

4) Ongoing monthly validation process for health network TCS files used for oversight and DHCS reporting.	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: UM/CM/LTC to improve care coordination by increasing successful interactions for members within seven days of their discharge by 10% from Q4 2023 (45.0%) to December 31, 2024.	
Methodology: IPP Appendix B: Technical Specifications and Submission Guidance	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>Continued outreaching to TCS high-risk members</li> <li>Established TCS support line for low-risk members</li> <li>Developed a TCS support line flyer with CalOptima Health and HN contact information.</li> <li>Updated report that identifies TCS high-risk members</li> <li>Updated TCS county in-patient psychiatric hospital process workflow</li> <li>Explored texting campaign options by leveraging the Usher platform</li> <li>Developed texting campaign messaging content</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>Continued outreach to TCS high-risk members</li> <li>Initiated motivational interview trainings with staff</li> <li>Hired staff for the TOC outreach to pregnant members who are not enrolled in the Bright Steps program.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Conducted motivational interview trainings</li> <li>Continued outreach efforts for TOC (non-Bright Steps members receive targeted outreach).</li> <li>Reviewed DHCS Iont resource guide for enhancement opportunities</li> <li>Developed process for identifying FFS Medicare members in need of TCS</li> <li>Trained CalAIM ECM provider to document LCMs in CalOptima Health Connect system.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Launched texting campaign using the Usher platform (Q4)</li> <li>Conducted motivational interview trainings</li> <li>Continued outreach efforts for TOC (non-Bright Steps members receive targeted outreach).</li> </ul>
Program Results:	

### CalOptima Health - Ambulatory Follow Up Within 7 Days Post-Discharge by Quarter

Source: CAL\_DIM (Claims & Encounters)

Population: All lines of business, all health networks

Denominator: Live discharges

Numerator: Ambulatory follow up with any provider within 7 days post-discharge

Exclusions: OB or pregnancy related inpatient stays, discharges to LTC

\*Note: Any data within 12 months of current will likely be incomplete due to claim lag with most recent being most impacted

Year	Quarter	Numerator	Denominator	Rate (%)
2021	Q1	4,703	11,444	41.09577071
	Q2	5,386	13,021	41.36395054
	Q3	5,461	13,744	39.73370198
	Q4	5,235	13,476	38.84683882
		<b>20,785</b>	<b>51,685</b>	<b>40.2147625</b>
2022	Q1	4,979	12,888	38.63283675
	Q2	5,383	13,638	39.47059686
	Q3	6,028	14,705	40.99285957
	Q4	5,905	14,703	40.16187173
		<b>22,295</b>	<b>55,934</b>	<b>39.85947724</b>
2023	Q1	6,104	15,294	39.91107624
	Q2	6,371	15,323	41.57801997
	Q3	6,556	15,654	41.88066948
	Q4	6,402	15,645	40.92042186
		<b>25,433</b>	<b>61,916</b>	<b>41.07661994</b>
2024 (to date)*	Q1	6,355	15,524	40.93661427
	Q2	6,501	15,738	41.30766298
	Q3	6,014	15,130	39.74884336
	Q4 (to date)	1,756	5,076	34.59416864
		<b>20,626</b>	<b>51,468</b>	<b>40.07538665</b>

#### Quantitative Analysis:

The internal goal of 45.0% (10% improvement from baseline [Q4 2023]) was not met as the rates remain consistent, ranging from 39% to 41% (Quarters 1–3) this year. The data for Quarter 4 is still pending as data collection is still in progress through the end of this year.

#### Identified Barriers:

- Provider availability to schedule appointments within seven days of discharge.
- Inability to reach members.

#### Identified Opportunities for Improvement:

- Research options to improve timely access to providers post-discharge.
- Add more targeted texting campaigns for outreach to members.
- Targeted outreach to hospitals/facilities to discuss ambulatory discharge rates and opportunities for improvement.
- Meet with health network partners in monthly JOMs to go over progress and discuss opportunities for improvement.

#### Conclusion:

CalOptima Health implemented new activities and interventions this year for TCS. More time is needed to evaluate their effectiveness. The texting campaign, implemented at the end of this year, has resulted in increased member engagement since its launch.

Since the data is consistent within the 39%–41% range for ambulatory follow-up within seven days post-discharge, the team recommends reassessing the goal with further discussion in the TCS workgroup regarding the goal.

Activities/Interventions to continue/add next year:

- Evaluate options for enhancements of texting campaigns.
- Educate health networks on their performance in HN JOM meetings.
- Educate hospital partners on their performance in JOM meetings.
- Research options to improve timely access to providers post-discharge.

### 6.3 Coordination of Care Across Practitioners: Diabetes Eye Care

Business Owner: Mike Wilson

Department: Quality Analytics

Support Staff: Melissa Morales/Kelli Glynn

Products: ☒ Medi-Cal ☒ OneCare

New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective: Improve coordination of care, prevention of complications and facilitation of best practice diabetes care management between vision care specialists (VSP) and PCPs

Goal Met: ☐ Yes ☐ No ☒ Partial

Work Plan Planned Activities:

Collaborative meetings between teams to identify the best practices to implement; provider and member education

Status: ☐ Completed ☒ Ongoing

Background: Identified barrier to coordination of care and sharing of data between specialists and PCP for diabetic eye care. No automated process to share claims from VSP with CalOptima Health's contracted health networks. Due to contract restrictions, data exchange is not permitted from VSP as a vendor to contracted health networks. It is only permitted by VSP and CalOptima Health. With the absence of automated data exchange rates reflected could be lower than reality.

Methodology: VSP and CalOptima Health started development of a HEDIS supplemental report for purpose of distribution by CalOptima Health to share with all contracted health networks. The process to establish an SFTP secure site for data share. VSP provided raw data by line of business, and data file was parsed by delegated health network. Additional report elements were included, and the file was socialized among participating delegated health networks for feedback.

Actions/Interventions Implemented in 2024:

Quarter 1: N/A

Quarter 2:

- Discuss sending VSP quality data to health networks
- Held information sessions with health network IT teams and CalOptima Health IT team to discuss file format.

Quarter 3:

- Interested health networks received test files before a production file was created.

Quarter 4:

- Final production files loaded to health networks that approved the test file and would be receiving files monthly.

Program Results:

Table below shows production file pickup by health network.

Health Network	Status Production File Pickup
Altamed Health Services	Yes

<b>Optum Care Network</b>	Yes
<b>Noble Mid-Orange County</b>	Yes
<b>CHOC Health Alliance</b>	Yes
<b>Regal Medical Group</b>	No
<b>Prospect Medical Group</b>	Yes
<b>Family Choice Health Services</b>	Yes
Quantitative Analysis: Automated process to share claims from VSP with CalOptima Health contracted health networks was completed.	
<b>Identified Barriers:</b>	<b>Identified Opportunities for Improvement:</b>
<ul style="list-style-type: none"> <li>Identifying correct IT staff at the health network level.</li> <li>Delay in the creation of the test file.</li> <li>Difficulty for health network to locate the testing SFTP site, which further delayed completion of the production file.</li> <li>Health network feedback received that there may be duplication in report.</li> </ul>	<ul style="list-style-type: none"> <li>Resolve the issue of duplicative claims.</li> <li>Evaluate at health network level the added value of data.</li> </ul>
Conclusion: Will need additional time to obtain feedback from health networks on the value of VSP claims data received.	
<b>Activities/Interventions to continue/add next year:</b>	
<ul style="list-style-type: none"> <li>Ensure that all health networks are accessing the production file monthly.</li> <li>Evaluate the effectiveness of data sharing.</li> </ul>	

#### APPENDIX:

A - 2024 QIHETP Work Plan Q1-Q4

B - 2024 CalOptima Health Membership (Risk Stratification)

C - 2024 Population Health Management Impact Report

D – 2024 Cultural and Linguistically Appropriate Services (CLAS) Evaluation

2024 Q1 Work Plan - Q1 Update

Evaluation Category	2024 QHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <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 Green - On Target
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QHETP) Description and Annual Work Plan will be adopted on an annual basis. QHETP-QHIEC-BOD, Annual Work Plan-QHIEC-QAC.	QHIEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Quality Improvement	X	2024 QHETP Description and Annual Work Plan was approved by QHIEC on 2/13/24, by QAC on 3/13/24, and by the BOD on 4/4/24.	A copy of the BOD approved 2024 QHETP and Work Plan will be posted on COH public website.	
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	QHETP-QI Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QHIEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Quality Improvement	X	Evaluation of 2023 QI Program and Annual Work Plan were approved by QHIEC on 2/13/24, QAC on 3/13/24 and BOD on 4/4/24.	Evaluation of the 2023 QI Program and the four quarters of 2023 Work Plan will be posted on COH public website.	
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QHIEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Kelly Gardina	Stacie Oakley	Utilization Management	X	The 2024 Integrated UM & CM Program Description was approved by the Board on 3/13/24.	None at this time	
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QHIEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Kelly Gardina	Stacie Oakley	Utilization Management	X	The 2023 Integrated UM & CM Program Description evaluation was drafted & presented to UMC on 1/5/24, presented to QHIEC on 2/13/24 & to the Board on 3/13/24	None at this time	
Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: Population Needs Assessment (PNA) Risk stratification Screening and Assessment Wellness and prevention	PHMC report to QHIEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Katie Baldaras	Barbara Kidder/Hannah Kent/IMD/Director of Care Management	Equity and Community Health	X	1) Drafted SOW for Member and Population Health Needs Assessment (MPHNA) vendor to better stratify members based on risk and identify opportunities for improvement in access, prevention, and service delivery. 2) In March 2024, CalOptima Health Quality Assurance Committee accepted the <b>2024 PHM Strategy</b> , which outlines our efforts for this year. 3) Currently working with department leads throughout the organization to update the <b>2024 PHM Strategy Workplan</b> which outlines our PHM programs/initiatives, related activities, and related SMART objectives for the year. 4) Collaborating with Orange County Health Care Agency (OCHCA) and Kaiser Permanente (KP) to co-develop shared SMART Goals for inclusion in the PHM Strategy and identify opportunities to collaborate on the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).	1) Obtain Board approval in April 2024. MPHNA RFP vendor selection is planned for August 2024. 2-3) 2024 PHM workplan to be finalized and presented to CalOptima Health Board of Directors in April 2024 and PHMAC in May 2024 for approval. 4) Will be working to finalize SMART Goals, implementation plans, and the Local Health Department (LHD) + Managed Care Plan (MCP) collaboration worksheet due in August 2024.	
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QHIEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	X	The 2024 Program and Workplan approval at QAC and BOD was held in order to include Health Equity elements.	Updated the workplan with additional goals related the Health Equity Accreditation and present at the next QAC meeting	
Program Oversight	Population Health Management (PHM) Committee - Oversight of population health management activities to improve population health outcomes and advance health equity	Report committee activities, findings from data analysis, and recommendations to QHIEC	PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. Committee meets at least quarterly, maintains and approve minutes, and reports to the QHIEC quarterly.	PHMC report to QHIEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Baldaras	Barbara Kidder/Hannah Kim	Equity and Community Health	New	1.) In February 2024, we created and launched the <b>PHM Committee</b> which will oversee PHM activities related to DHCS and NCQA. This committee includes executive representative from across the agency as well as community leaders.	1) Continue to assist this committee by reviewing relevant guidance, agenda setting, and presentation development, and deliverables shared with QHIEC. 2) Finalize approval calendar, charter, and related policies 3) Next PHMC meeting is scheduled for May 2024.	
Program Oversight	Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee activities, findings from data analysis, and recommendations to QHIEC	Review of Initial and Recredentialing applications approved and denied. Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)) Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QHIEC quarterly.	CPRC report to QHIEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Laura Guest	Marsha Choo Risk Quinones Katy Noyes	Quality Improvement	X	Credentialing: CCN Initial Credentialing=59; CCN Recredentialing=119; BH Initial Credentialing=43; BH Recredentialing=25 Seven PQIs were presented to CPRC in Q1. One PQI resulted in a recommendation by CPRC for decredentialing, for which the provider has requested a Fair Hearing. There were no PPCs identified through data mining due to staff limitations, nor were any PPCs reported to CalOptima Health by the hospitals or HMC. There were 5 critical incidents all regarding a COVID-19 outbreak at a OBAS center.	Credentialing: Continue to credentialing and recredentialing of CCN and BH providers. Have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial credentialing and recredentialing files. We have also hired two Credentialing Auditors to assist with the CVO and delegation oversight for our delegated groups. We have also hired two Credentialing Auditors to assist with the CVO and delegation oversight for our delegated groups. There are currently 5 physicians undergoing the Fair Hearing process. Claims reports will be mined for PPCs when additional staff are hired and trained trained on the PQI team. Critical Incidents will continue to be monitored and reported quarterly to DHCS.	
Program Oversight	Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee activities, findings from data analysis, and recommendations to QHIEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QHIEC quarterly.	GARS Committee Report to QHIEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	GARS	X	On 2/14/2024 GARS Committee met to review Q4 metrics and discussed CY2023 trends in both lines of business and types to include: - Member Grievances - Member Appeals - Provider Disputes - Provider Appeals Discussed the 2 overturned cases by the External Independent Review - SFH (Medi-Cal) and Maximus (Medicare)  Q3 2023 minutes were approved.	GARS Committee is scheduled for May 14 where Q1 trends will be discussed and the remediation activities presented for additional recommendations.	
Program Oversight	Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee activities, findings from data analysis, and recommendations to QHIEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HMC), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QHIEC quarterly.	MemX Committee report to QHIEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helm Syn	Quality Analytics	X	In Q1, MemX Committee met 3/14/24 and reviewed/discussed the following: - Access to Care Issues - Compliance Rates for BH - Provider Education Opportunities through CHCN Lunch & Learns - Overview of Decision Point's CAHPS Predictive Analytics - Discussion on Outreach Calls	Q2 meeting is scheduled for: 5/22/24	
Program Oversight	Utilization Management Committee (UMC) Oversight - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care	Report committee activities, findings from data analysis, and recommendations to QHIEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. Committee meets at least quarterly, maintains and approve minutes, and reports to the QHIEC quarterly. <b>P&amp;T</b> and <b>BMSG</b> reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QHIEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Kelly Gardina	Stacie Oakley	Utilization Management	X	In Q1 2024 UMC held meetings on 1/5/24 and 2/22/24. On 1/5/24 UMC members approved the following items: - 11/16/23 meeting minutes - 2023 UM Program Evaluation - 2024 Integrated UMC/CM Program Description - 2024 UM Policies & Procedures  On 1/26/24 UMC members approved the 2024 hierarchy of UM criteria via an eVote  On 2/22/24 the UMC members approved the 1/25/24 meeting minutes.	None at this time	
Program Oversight	Whole Child Model - Clinical Advisory Committee (WCM CAC) - Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QHIEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QHIEC quarterly.  Pediatric Risk Stratification Process (PRSP) monitoring	WCM CAC report to QHIEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	T.T. Nguyen, MD/IMH	Gloria Garcia	Medical Management	X	WCM CAC met on 2/20/24. They approved the 11/7/23 meeting minutes and submitted a copy to QHIEC. WCM CAC attendees completed annual Conflict of Interest and Confidentiality forms. Regional Center Orange County and Orange County Social Service Agency representatives joined the Committee. WCM data including BH services was presented and no out of compliance or issues were reported. There are no recommendations for QHIEC at this time.	The next WCM CAC meeting is scheduled for 5/20/24	
Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QHIEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Megan Dankmyer	TBD	Medical Management	New	Report on the following activities: Enhanced Care Management (ECM): Develop process for ECM Lead Care Manager to communicate TCS activity. Complex Case Management (CCM): Reviewed with Health Networks NCQA Element E, Factors 1-5. Case Management continues monthly real time reviews of delegated Health Networks per NCQA requirements. Basic PHM/CM: Case Management Quarterly audit for MOC for delegated Health Networks. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: See Next steps Transitional care services: Work with IT to develop reporting for analyzing outcomes on TCS response.	Report on the following activities: Enhanced Care Management (ECM): 1. Implement process for ECM Lead Care Manager to communicate TCS Activity. Complex Case Management (CCM): 1. Continue real time Monthly NCQA file audits. Basic PHM/CM: Ongoing Case Management Quarterly audit for MOC for delegated Health Networks. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: Institute multi-department EPSDT workgroup. Transitional care services: 1. Analyze outcomes by Health Network and present in JOMS to track and trend to guide future conversations and interventions. 2. Work with ECM Providers to obtain ECM reporting data for KPI 5	
Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accreditation standard compliance that, at minimum, include comprehensive annual audit.	Report to QHIEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Monica Herrera	Zulema Gomez John Robertson	Delegation Oversight	New	2024 DOAA Findings: - Compliance file review - Credentialing file review - Customer Service file review - Provider Relations file review - Utilization Management file review	Next Steps: A Corrective Action Plan (CAP) is issued for each finding that addresses each deficiency identified. Remediation of the CAP is then implemented based on current CAP policy, H4.2005.	
Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QHIEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Baldaras	Elsa Mora	Equity and Community Health	New	1) Provided extensive training to staff on the new care management system (Jiva) implemented on 2/1/2024 to ensure smooth implementation and efficient operation. 2) Implemented a Chronic Kidney Disease (CKD) pilot targeting 68 CCN Members with CKD stage 3 A or B and 2 chronic conditions (diabetes, hypertension, heart disease) and not seeing a nephrologist. Staff were able to enroll 7 out of 68 members in the program. 3) Developed 2-way text campaign on asthma and diabetes to promote PCP engagement and DM program opt-in. Submitted text to DHCS for approval. 4) Pketed 2-way text as an option for members to complete the Disease Management Satisfaction Surveys. Introducing text message as a survey option improved survey response rates and convenience for members. 5) In February 2024, we resumed the New Member Mailings, providing information on our DM services and condition-specific handouts on asthma and diabetes for low risk members. This mailing will occur every other month. 6) The diabetes monthly stratification criteria were revised to improve high-risk member identification. The look back period was shortened and the A1c requirement was dropped to 8% to better identify the emerging risk members. This change could potentially lead to earlier interventions for high-risk members.	1) Continuing to provide ongoing training to staff as the care management system continues to be enhanced for efficiency. 2) Analyzing the results of the CKD pilot to fine-tune the program prior implementation. 3) Launch text campaign contingent upon DHCS approval. Evaluate effectiveness of text campaigns. 4) Revise stratification criteria for asthma and congestive heart failure.	

2024 Q1 Work Plan - Q1 Update

Evaluation Category	2024 QHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <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 Green - On Target
Program Oversight	Health Education		Report on the following activities: Evaluation of current utilization of health education services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QHETC: Q2: 06/1/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1: 03/11/2025	Anna Safar/Katie Balderas	Thanh Mai Dinh	Equity and Community Health	New	1) Evaluation of current utilization of health education services <b>Goal being met:</b> During 2024 Q1, 749 referrals were assigned to health education services, very similar count from previous year as 748 referrals were assigned to health education services during Q1 in 2023. However, during 2024 Q1, there was an increase in community class intake. Class attendance was 90 in 2023 Q1, compared to 185 attendees in 2024 Q1. Classes take more efforts to recruit participants, prepare, and follow up, therefore participation increase is gradual. 2) Maintain business for current programs and support for community <b>Goal being met:</b> 68 community classes have been confirmed for 2024, and topics continue to expand. Hypertension education was added to the series in March 2024. Community partners include a collaboration with Hurdgate Markets offering market tour accompanied by nutrition education. Participating in community collaboration including the Tobacco and Vape Free (TVFREE) Coalition. 3) Improve process of handling member and provider requests <b>Goal being met:</b> a. The draft electronic referral form is being reviewed and will be used to help improve member self-referral experience. This is so that members who do not want to call in or providers can directly send referrals to the Health Education team. b. Health and Wellness services are promoted at all continuing education training in 2024, along with reminders on how and where to send member referrals.	Implementation of an electronic referral form, and continue with the plan as listed. However, with the recent department name/mission change to focus more on Equity and Community Health, it's anticipated that there is will more community engagement efforts and possibly, less one on one coaching approach. Such service will be offered based on providers and members requests.	
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health. Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	Update from PHMC to QHETC: Q2: 06/1/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1: 03/11/2025	Katie Balderas	Barbara Kidder	Equity and Community Health	x	1) SDOH assessment is being tested for integration to the member portal. SDOH assessment will be built into CaOptima Health's healthcare management system (JIVA) as part of the closed-loop referral integration. 2) Closed-loop referral vendor was selected and contracting process is underway. 3) HL4E certificate programs is ongoing with 59 out of 164 staff having completed the certificate program.	1) Published SDOH assessment in member portal and build the SDOH assessment into JIVA 2) Finalize contract with selected closed-loop referral vendor and integrate into JIVA 3) Continue to encourage staff to complete their mini-credentials to earn their certification. Train the trainer program on the teach-back method is planned for May 2024.	
Program Oversight	Long-Term Support Services (LTSS)	Implement LTSS	Report on the following activities: Evaluation of current utilization of LTSS Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from UMC to QHETC: Q2: 06/1/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1: 03/11/2025 1) By April 30, 2024 2) By December 2024	Scott Robinson	Manager of LTSS	Long Term Care	New	LTSS remains compliant with all TATs, LTC, CBAS and MSPR continue to provide timely and efficient member services. 1st quarter FY goal is to review and revise department OTPs to coincide with the Jiva implementation.	Continue everyday LTSS standup meetings with the LTSS Manager and Supervisors to monitor and adjust staffing and schedules to comply with TATs.	
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CaOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activities for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and worksheet for Health Equity Accreditation with 50% document collect for submission.	Report program update to QHETC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Veronica Gomez	Marsha Choo	Quality Improvement	x	1. <b>Health Plan Accreditation:</b> CaOptima Health is on track to submit for HP re-accreditation which is scheduled for 4/30/2024. An additional Program Manager has been hired to help support HP and HE accreditation in preparation for the next HP accreditation. 2. <b>Health Equity Accreditation:</b> Consultant conducted a review of all the applicable standards. Developed a work plan. Several working sessions have taken place to meet with owners and identify gaps in meeting specific elements. Requested additional Project Management support for Health Equity Accreditation.	1. <b>HP Accreditation:</b> An additional Program Manager has been hired to help support HP and HE accreditation in preparation for the next HP accreditation. Virtual file review with NCQA reviewers is scheduled for June 17th-18th, 2024. 2. <b>HEA Accreditation:</b> 2 project managers will be assigned to support Health Equity Accreditation. CaOptima Health also has an Enterprise Project Management Office with resources to provide additional support, if needed.	
Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARs measures for focused improvement efforts.	Report program update to QHETC Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Quality Improvement	x	MY2024 priority measures identified: OMW, PCR, FMC, CBP, COA (medication review), TRC (average), HbA1c. Stars Steering Committee started in Q1.	Continue with plan as listed	
Program Oversight	Value Based Payment Program	Report on progress made towards achievement of goals, distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QHETC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Quality Analytics	x	HN performance for all P4V HEDIS measures have been shared continuously on a monthly basis. In addition, high level details for the quality improvement grant process were shared with all HNs during the April HN Quality Forum. NGPO planned for Q3.	Continue with plan as listed	
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QHETC annually	Report program update to QHETC Q2: 06/14/2024 Q3: 08/12/2024 Q4: 11/05/2024 Q1: 02/11/2025	Paul Jiang	Terr Wong	Quality Analytics	x	Awaiting for HEDIS results.	HEDIS results will be reported in Q2.	
Program Oversight	School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities: 1) Implement SBHIP DHCS targeted interventions 2) Bi-Quarterly reporting to DHCS	Report program update to QHETC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Sherie Hopson	Behavioral Health Integration	x	1) 1st quarter 2024 SBHIP Progress Reports from CHOC, Hazen Health, WYS, and OCDE reporting implementations are on track. 2) Monitoring SBHIP implementation progress through regularly scheduled OCDE SBHIP Collaborative Meetings and SBHIP Planning Meetings facilitated by BHI. 3) School district contracting Visit workflow finalized for internal departments Contracting, Credentialing, Provider Relations - focused on providing a "concierge service" to help the school district through the process. 4) Reviewed and approved 10 school district budget plans from detailing their use of SBHIP funds. 5) Received DHCS approval 3/13 for the December 2023 Biquarterly Reports.	1) 2nd quarter 2024 SBHIP Partners Progress Reports receive and review. 2) Coordinate and monitor progress through regularly scheduled meetings with OCDE and SBHIP Partners. 3) Prepare DHCS Bipartely Reports for June submission. 4) Prepare 2nd SBHIP partner funding distribution/check request process. 5) Review and approve school district budget plan submissions.	
Program Oversight	CaOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QHETC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Katie Balderas	Barbara Kidder	Equity and Community Health	x	1) Developed a competitive grant program to support activities that increase early detection and decrease late-stage discovery. We released a notice of funding opportunity in February 2024 and received grant applications from 22 organizations. We anticipate grant implementation of selected grantees will begin in July 2024, pending Board approval in June 2024. 2) Launched the Awareness and Education Campaign with a marketing firm. Discovery phase took place from January to March with 15 discovery sessions that included internal and external stakeholder input from CBOs, health networks and providers.	1) Currently reviewing applications for selection. Board approval is planned for June 2024. Grant Contracts and go-live planned for July 2024. 2) Present findings from Discovery Phase to leadership and work with Marketing Firm for concept development and strategic recommendations; Test concept/messaging with consumers;	
Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 98.86% BCS+E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QHETC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	x	1. Member Health Reward: CCS:MC 26, BCS:MC 18, COL:OC 2, COL:OC 2 2. Text Message Campaign: Jan: CCS:60.76%; Feb:BCS:MC 21.64%; OC 596; Mar: COL:OC 1256 members 3. Member Health Reward Survey: MC 3.37% OC 2.276 4. Kick off of CCN OC COL GI outreach pilot program. 5. February 2024 Prospective Rate Data: CCS: MC 36.12%, BCS: MC 38.81%; BCSL: OC 50%, COL: OC 48%	1. Continue to track CCS, BCS MC OC, COL OC member health reward 2. Continue member outreach campaigns: mailing, IVR, text and MCOC live call campaigns. 3. Continue to monitor CCN OC COL GI outreach pilot program. 4. Develop 2 way text message campaigns for each cancer screening measure by line of business.	
Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC: Init Phase - 44.22% MC: Cont Phase - 50.88%	Assess and report the following activities: 1) Work collaboratively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second quarter. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) d. Member Health Reward Program e) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QHETC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Behavioral Health Integration	x	PR HEDIS RATES Q1 (February): Initiation Phase-41.25% Continuation and Maintenance Phase- 51.13% 1) Created and finalized working collaboratively with QI for the Member Health Reward flyer to distribute to eligible members. 2) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 3) Text Messaging outreach to members sent in January and February. 4) Community Clinica/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding importance of quality measure	1) Q2 data will be pulled to initiate fax blast for Provider best practices letter and tip-sheet to non-compliant providers. 2) Member outreach for those who filed an initial ADHD prescription. 3) Mail out Member Health Rewards flyer to eligible members 4) Continue monthly data pull for text messaging campaign.	
Quality of Clinical Care	Health Equity/Mental Health Services Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACEs) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QHETC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health	New	1) ACEs presentation to inform the group of our progress as a Health plan and educate on the importance of this screening given by BHI Executive Director at the BHIQ Workgroup Meeting in April.	1) Continue collaborative meetings between teams to identify best practices to implement. 2) Continue Provider and member education. 3) Continue to participate in the ACEs stakeholder meetings.	
Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-AI Ages: 58.43% Cholesterol-AI Ages: 40.50% Glucose and Cholesterol Combined-AI Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primary Care Providers (PCP) for members in need of metabolic monitoring. 2) Collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to the next top 50 prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs) 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QHETC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	x	PR HEDIS RATES Q1 (February) : Blood Glucose all ages: 13.11%, Cholesterol all ages: 5.62%, Glucose & Cholesterol Combined all ages: 6.45% 1) Barriers included: Receiving timely data and accurate information. 2) [Sub]measure names for this measure changed in 2024, causing delay in receiving data. 3) Identified members prescribed antipsychotic medication still in need of diabetes screening, cholesterol screening, and both cholesterol and diabetes screening test through Tableau Report. The following materials have been disseminated to Providers: a) Provider Best Practices Letter. b) APM Provider Tip Sheet 4) Collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 5) Mailings of Provider materials (Best Practices letter and Provider tip tool sheet), to the next top 50 providers on a monthly basis. 6) Text Messaging Campaign was sent out to members in the month of January. 7) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 8) Community Clinica/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding importance of quality measure	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue data pull for text messaging campaign. 3) Continue mailings of Provider materials (Best Practices letter and Provider tip tool sheet), to the next top 50 providers on a monthly basis. 4) Continue with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis.	
Quality of Clinical Care	Mental Health Services Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QHETC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	New	PR HEDIS RATES Q1 (February): Effective Phase Treatment 62.27%, Effective Continuation Phase 36.64% 1) Worked with Quality Analytics to develop a data report 2) Drafted the following materials: a) Text Messaging script b) Drafted APM Provider Tip Sheet 3) Community Clinica/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding importance of quality measure	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Submit Text Messaging draft for internal review process. 3) Submit Provider Best Practices Letter for internal review process.	
Quality of Clinical Care	Mental Health Services Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.68%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QHETC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	New	PR HEDIS Rates Q1 (Feb): MC:18.89% OC: NA 1) We are monitoring this measure and met our goal last year.	1) Continue to monitor prospective rates on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement.	



2024 Q1 Work Plan - Q1 Update

Evaluation Category	2024 QHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics, Assessments, Findings, and Monitoring of Previous Issues <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 Green - On Target
Quality of Clinical Care	Mental Health Services Continuity and Coordination Between Medical Care and Behavioral Healthcare-Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QHIEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz	Behavioral Health Integration	X	PR HEDIS Rates Q1 (February): 30-day: 17.80%, 7-day: 11.65% 1) The main barrier has been not having the bandwidth for outreach to members that we have been receiving on a daily basis. 2) Working with vendor to create a cohort report of FUM data only. 3) All PIP leaders have been established and BH ED data is being sent to Health networks on a daily basis. 4) Bi-weekly Member text messaging. 5) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 6) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding importance of quality measure. 7) Article emphasizing importance of Follow up appointment after ED visit created and will be included in Spring Member Newsletter (Medi-Cal and OneCare).	1) Pull data for Data Analyst to send out bi-weekly text messages based on real time ED data. 2) BH is in the process of developing and implementing a Pilot project for CCN members identified who meet FUM criteria. BH Telehealth provider to conduct the outreach and assist with member linkage. 3) Collaborate with NAMI to share real-time ED data for member outreach.	
Quality of Clinical Care	Mental Health Services Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (BSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaboratively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Forward Program.	Report progress to QHIEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	X	PR HEDIS Rates Q1 (Feb): MC 23.51% OC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau Report. 2) Conducted a text message campaign to reach out to members getting their glucose lab screening. 3) Barriers included: Receiving timely data, obtaining the correct contact information for members such as phone numbers. 4) In process of developing new outreach strategies working with internal dept. Case Management to help reach out to members. 5) Member \$25 Reward Program to incentivise members to get glucose screening. 6) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 7) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding importance of quality measure	1) Continue tracking members in need of glucose screening test. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Continue data pull for text messaging campaign. 4) Mail out member health rewards flyer to eligible members.	
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP-Improve the percentage of members enrolled into care management, Caloptima Health community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMI/BD.	Report progress to QHIEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz/Mary Baranco	Behavioral Health Integration/ Quality Analytics	X	Conduct quarterly/Annual oversight of MC Non Clinical PIPs (Jan 2023 - Dec 2025) Improve the percentage of members enrolled: Baseline Measurement Period: 01/01/23-12/31/23 Reassessment 1 Period: 01/01/24 -12/31/24 Reassessment 2 Period: 01/01/25-12/31/25	1) Working with Caloptima Health Vendor to receive Real-Time ED data on a daily basis for CCN and COD members. 2) BH is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. Telehealth provider will conduct outreach to members who meet FUM criteria and assist with linkage. Internal BH PCC's to conduct outreach to members meeting FUA criteria and assist with linkage. Vendor and PCC's will also provide information about case management including ECM and referrals. 3) Develop outreach and outcome data related to the percentage of members enrolled in CCM and ECM for CCN members identified who meet FUM/FUA criteria for the duration of each measurement period. 4) Work in collaboration with Internal Privacy dept to ensure compliance of data sharing with vendor.	
Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QHIEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Behavioral Health Integration	X	PR HEDIS Rates Q1 (February): 30-Day: 17.80%, 7-Day:11.47% 1) Sharing real-time ED data with our Health Networks on a secured FTP Site. 2) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 3) Bi-weekly member text messaging. 4) Article emphasizing importance of Follow up appointment after ED visit created and will be included in Spring Member Newsletter (Medi-Cal and OneCare). 5) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding importance of quality measure	1) Data analyst scrub data for bi-weekly text messaging. 2) BH is in the process of developing and implementing a Pilot project for CCN members identified who meet FUA criteria.	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC: 66.33% OC: 81%.	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QHIEC: Q2: 06/11/2024 Q3: 09/01/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Melissa Morales/Kelli Gynn	Quality Analytics	X	1. Member Health Reward: EED-MC 3 - EED-OC 1 2. Text Message Campaign: Jan: MC EED 6.903 OC EED 325 members 3. EED PIV mailing for Jan to Mar: 1,443 4. Member Health Reward Survey: MC 3.37% OC 2.27% 5. February 2024 Prospective Rate Data: EED-MC 24.7%; EED-OC 37%	1. Continue to track EED MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3. Develop 2 way text message campaigns for diabetes by line of business.	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control; lower rate is better) MY2024 Goals: MC: 28.44% OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Update from PHMC to QHIEC: Q2: 06/11/2024 Q3: 09/01/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Melissa Morales/Kelli Gynn	Quality Analytics	X	1. Member Health Reward: HBD-MC 4 - HBD-OC 2 2. Text Message Campaign: Jan: MC HBD 6.903 OC HBD 325 members 3. Member Health Reward Survey: MC 3.37% OC 2.27% 4. February 2024 Prospective Rate Data: HBD-MC 31.29%; HBD-PC: OC 91%	1. Continue to track HBD MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3. Develop 2 way text message campaigns for diabetes by line of business.	
Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy): HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: VIC Coordination, Daper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP, Daper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QHIEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Gynn	Equity and Community Health/ Quality Analytics	X	<b>Community Initiatives:</b> 1) Digital ads for postpartum ran Jan, Feb & March 2024 2) Digital promotion of doula benefit March 2024 <b>Member based initiatives:</b> 1) Bright Steps Program - 794 perinatal referrals 2) 1,201 maternal and infant assessment completed 3) 204 unique postpartum assessments completed 2) Postpartum health reward- research health rewards issued during Q1 2024. <b>Performance:</b> 1) February 2024 HEDIS rate (based on non continuous enrollment): Timeliness of Prenatal Care:66.76% Postpartum Care: 84.65%. Both have not met the MPL <b>Provider based initiatives:</b> 1) Blood Lead Performance Report shared monthly on Jan, Feb, and March 2024 with CCN providers via Provider Portal and health networks via FTP. 2) Sharing of blood lead resources via HN weekly communication in March 2024. <b>Community Initiatives:</b> 1) Radio ads ran in Feb & March 2024. PBS TV ad ran Jan & March 2024. <b>Member based initiatives:</b> 1) Blood lead education to Bright Steps Program participants at 6 and 12 months old. 2) New scripting in development for lead text campaign to target members turning 12 and 24 months old through new vendor (Ushur). 3) NEW: 12 and 24 month blood lead testing health reward available on website as of March 2024. <b>Performance:</b> 1) Preliminary results based on December 2023 prospective rates (continuous enrollment) indicate that the lead screening in children measure met MPL for MY2023. HEDIS results to be reported in Q2. 2) February 2024 HEDIS rate (based on non continuous enrollment): 58.13%. Has not met the MPL: 62.79%	1) Data - continue to identify mechanisms to access ADT data to be leveraged to support member outreach modalities which include: mailing, text, IVR, and live-call campaigns. 2) Continue member education efforts such as Medi-Cal newsletters. 3) Develop text and email campaign messaging. 4) Continue with provider, clinic and health network education efforts. 5) Continue with partnership with OCHCA in support of maternal mental health.	
Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter articles  In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QHIEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Gynn	Quality Analytics	X	1) Blood Lead Performance Report shared monthly on Jan, Feb, and March 2024 with CCN providers via Provider Portal and health networks via FTP. 2) Sharing of blood lead resources via HN weekly communication in March 2024. <b>Community Initiatives:</b> 1) Radio ads ran in Feb & March 2024. PBS TV ad ran Jan & March 2024. <b>Member based initiatives:</b> 1) Blood lead education to Bright Steps Program participants at 6 and 12 months old. 2) New scripting in development for lead text campaign to target members turning 12 and 24 months old through new vendor (Ushur). 3) NEW: 12 and 24 month blood lead testing health reward available on website as of March 2024. <b>Performance:</b> 1) Preliminary results based on December 2023 prospective rates (continuous enrollment) indicate that the lead screening in children measure met MPL for MY2023. HEDIS results to be reported in Q2. 2) February 2024 HEDIS rate (based on non continuous enrollment): 58.13%. Has not met the MPL: 62.79%	1) Continue with planned targeted member outreach campaigns such as member mailing, text, IVR, and live-call campaigns. 2) Development of 2-way blood lead text message for lead testing at 12 and 24 months of age. 3) Development of email blood lead campaign for lead testing at 12 and 24 months of age. 4) Data: Continue sharing Blood Lead Performance Report with health networks and CCN providers. 5) Continue with provider education efforts. 6) Continue with partnership with OCHCA to increase blood lead testing rates throughout Orange County.	
Quality of Clinical Care	EP/SOT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS MY2024 Goal: CIS-Combo 15: 45.26% MA-Combo 2: 48.80% W30-Fair 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCY (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QHIEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Noble/Kelli Gynn	Quality Analytics	X	1) First and Second Birthday Card mailed for April - June birthdays to 4,861 members. 2) January Text Message Campaigns: W30: 32,911; WCY 3-17: 180,967; WCY 18-21: 73,552 members. 3) W30 Member Detail Report (Dec 2023 PIR) shared with health networks via FTP. 4) Based on February 2024 Prospective Rate Data: none of the measures have met goal. CIS-Combo 10: 17.67%; MA-Combo 2: 34.04%; W30-Fair 15 Months: 17.49%; W30-15 to 30 Months: 52.64%; WCY (Total): 4.22%.	1) Continue with planned targeted member outreach campaigns such as birthday card mailing, text, IVR, and live-call campaigns. 2) Development of 2-way pediatric wellness text message campaigns specific to each developmental milestone. 3) Ad hoc W30 Noncompliant Member List shared with health networks and clinics who've established supplemental data sharing to close out HEDIS MY2023 efforts. 4) Continue sharing W30 Member Detail Report with health network.	
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025) 1) Clinical PIP - Increasing W30 6+ measure rate among Black/African American Population	Report progress to QHIEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Gynn	Quality Analytics	X	There were barriers related to the timeliness in which member data was obtained (i.e. 2024 data will not be available until the week of 4/22/2024).	1) PIP data is currently being prepared for the PHM department to assist with calls. 2) PIP call campaign to begin before the end of April 2024. The goal of the campaign is to assist members in closing gaps in well-child visits and assess for parent/guardian barriers to well-child visits.	
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits.  Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QHIEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Noble/Kelli Gynn	Quality Analytics	X	W30-2+ PDSA, Cycle 3 was approved (1/21/2024). Findings: members who had 2 successful telephonic outreaches had a comparable W30-2+ compliance rate to those who had 3 successful telephonic outreaches and a birthday card mailing.	Based on the PDSA findings, aiming to conduct at least 2 call campaigns per year to impact the W30 rate. If member is unreachable, send a wellness visit reminder mailer.	
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data submitted by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QHIEC Q2: 04/09/2024 Q4: 10/08/2024	Kelly Kipfel	Lorena Dabu	Finance	New	<b>Medi-Cal</b> 1) HMOs and PPOs met 7 of 8 measures 2) CHOC met 5 of 6 measures 3) SRGs met 5 of 6 measures <b>OneCare</b> 1) 4 networks met all measures 2) 5 networks met 3 of 4 measures 3) 1 network met 2 of 4 measures	None: continue to work with all HNs to ensure complete encounter data submitted	
Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPHC to QHIEC: Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025  Compliance details to QHIEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025) Update from CPHC to QHIEC: Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Katy Noyes	Quality Improvement	New	1)FSR/MRR/PARS, NF and CBAS Oversight A.FSR: Initial FSRs=4, Initial MRRs=6; Periodic FSRs=27; Periodic MRRs=18; On-Site Interims=42; Failed FSRs=2; Failed MRRs=5; CAPs: CE=31; FSRs=22; MRRs=2 B. PARS: Completed PARS=110 (Basic Access=60) Limited Access=50) C. CBAS: Critical Incidents=12; All other Critical Incidents were COVID cases. Non-Critical Incidents=12; Failed7; Completed Audits=8; CAPs=4; Unannounced Visits=1 NF: 1 Critical Incident was reported in Q1. On-Site Visits=27; Unannounced Visits=1	1) FSR/MRR/PARS, NF and CBAS Oversight A. FSR: Continue to audit. Complete Periodic FSR within 36 months from previous audit. Close all issued CAPs by due dates. Currently training an new QI Nurse Specialist-FSR and interviewing for one more position. This will decrease the number of audits assigned to each nurse and increase turn-around-time. B. PARS: Continue to complete PARS review for PCP, HVS, and Ancillary sites. C. CBAS: Continue to complete annual audits and unannounced visits. Remind centers to report critical incidents. D. SNF: Two new LVN hires. Working on re-evaluating current processes and procedures.	
Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Laura Guest	Quality Improvement	New	PQI in undergoing a system change which is expected to be implemented in Q2 2024. PQI data is unable to be pulled during this transition period. In Q1, PQI fired one new RN and one LVN is no longer with CalOptima.	PQI anticipates the new system, Jiva, to be implemented in Q2 2024. PQI data will be reported once the system implementation and reporting is completed. PQI anticipates hiring and training a new RN during Q2 2024, as this position is currently under review.	



2024 Q1 Work Plan - Q1 Update

Evaluation Category	2024 QHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <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 <i>Interventions / Follow-up Actions</i> <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 Green - On Target
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialled according to regulatory requirements	Review and report providers are credentialled according to regulatory requirements and are current within 180 days of review and approval (80 days for BH providers)	Update from CPRC to QHIEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Quality Improvement	New	Initial BH Credentialing Q1 = 43, Initial CCN Credentialing Q1 =57	Initial credentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial credentialing.	
Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialled according to regulatory requirements	Review and report providers are re-credentialled within 36 months according to regulatory requirements	Update from CPRC to QHIEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Quality Improvement	New	BH Recredentialing - Q1 =24, CCN Recredentialing Q1 =115. For Q1 we did not have any recredentialing files out of compliance.	Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the recredentialing of providers. This will ensure that we continue with compliance and timeliness of the recredentialing files.	
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management  Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QHIEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glyn	Quality Analytics	X	1. Member Health Reward: EED-OC 1, HBD PC-OC 2 2. EED VPS mailing for Jan to Mar: 599 members 3. Text Message Campaign: OC HBD/EED 325 members 4. February 2024 Prospective Rate Data: EED: OC 37%; KED: OC 8.21%; HBD PC: OC 91%; MAD: OC Data Received in May; SUPD: OC Data Received in May	1. Continue to track HBD MC OC member health reward. 2. Continue member outreach campaigns: mailing, VR, text and OC live call campaigns. 3. Develop 2 way text message campaigns for diabetes by line of business. 4. Begin emerging risk call campaign.	
Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1) Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring.	Report progress to QHIEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	S. Hickman/M. Danimayeh/ H. Kim	Qi Nurse Specialist	Case Management	X	Assess and report the following activities: 1) Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. Core Report CC0258 in phase II Java Remediation for ICT/ICPHRA data. Q1 DHCS reporting for HRA1 and ICP1 due on 5/30/2024 and data pending validation process. As of 3/31/2024 22% of HRAs completed to date for the year. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. Communications to Health Networks in January, February and March on ICP development status for newly effective members. Addition of annual ICP development status on the March file. Communication included identification of members who were also ICDM-like. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring. Ongoing quarterly audits of delegated health networks.	Assess and report the following activities: 1) Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. Submit Q1 ICP1/HRA2 report by 5/30/2024. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. Continue to communicate monthly to Health Networks on ICP development status for both initial and annual members. ICDM-like eligibility. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring. Continue quarterly audits of delegated networks. Implementation audit in development.	
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QHIEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	1) Quynh Nguyen 2) Tony Vazquez 3) Jane Flannigan Brown	Mahmoud Elaraby Provider Relations	Contracting	X	Resource constraints and competing priorities.	Pin the process of transitioning Network Adequacy from Q1 to Provider Ops team. Pin the process of bring a PM to manage network adequacy. Pin Contracting and PR dependent on Network Adequacy be completed w identified gaps in order to develop provider network recruitment strategy.	
Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely access. 3) Continue to educate providers on timely access standards. 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QHIEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Quality Analytics	X	Of the eleven Timely Access CAPs issued to HNs in Dec-2023, we have received responses back from eight networks. Of the 117 Timely Access CAPs issued to individual providers, 23 responses received, two learned/termining and one provider passed away.	For CAP responses received, Access workgroup to review and determine next steps. For CAP submissions still outstanding, follow-up and escalate as needed. Planning to field interim access survey in Q2-2023 to re-measure compliance for provider offices who were identified as non-compliant with outgoing telephone message instructing caller to go to ER/call 911 in case of emergency.	
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024  Update from MemX to QHIEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Karen Jenkins/Mahmoud Elaraby	Network Operations/Quality Analytics	X	Time or Distance: Geomapping conducted in November 2023 showed that Subcontractor no longer met time or distance standards for the core specialists in a dense county as listed in "CalOptima Health EX-2, "supplement Orange" file. Member to Provider Ratios: - Provider network report conducted in November 2023 showed Subcontractor non-compliant with provider to member ratios - Kaiser Foundation Health Plan: N/A Subcontractor is no longer in CalOptima Health's Networks effective 1/1/2024 Mandatory Provider Types: Provider network report conducted in November 2023 showed fully delegated Subcontractor (Kaiser Foundation Health Plan) non-compliant with MPT Federally Qualified Health Centers	Time or Distance: - For identified areas of non-compliance CalOptima Health issued a corrective action plan (CAP) to the subcontractor. Subcontractor will attempt to find the specialists within time or distance. - Kaiser: Subcontractor is no longer in CalOptima Health's Networks effective 1/1/2024 - Alta, Monarch & Tabert are integrated with Optum Health network and will be reassessed as part of Optum organization effective 1/1/2024 - Will reassess Subcontractor compliance at next quarterly geomapping analysis Member to Provider Ratios: - CalOptima Health issued corrective action plan for identified areas for non-compliance and will monitor Subcontractor through the corrective action process where they will be required to submit a corrective action plan, carry out that plan and demonstrate progress/improvements. CalOptima Health will reassess Subcontractor on a quarterly basis - Kaiser: Subcontractor is no longer in CalOptima Health's Networks effective 1/1/2024 Mandatory Provider Types: - Kaiser: Subcontractor is no longer in CalOptima Health's Networks effective 1/1/2024	
Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2) Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QHIEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Katie Baldaras	Anna Safari	Equity and Community Health	X	1) Increase health network and provider communications, trainings, and resources 2) Sent communication reminders out to Health Networks and CCN Providers 3) Trained Health Networks (HNs) as planned at 5 JOMs, 1 QHIEC Meeting, 1 CCN Virtual Lunch and Learn Meeting, 1 FOICC. Provided IHA education at Cancer Screening CME for Providers. 4) Incorporated IHA into Provider Toolkit, Created document created for providers with steps on how to access IHA Report and PCP Member Roster on Provider Portal. 5) Expand oversight of provider IHA completion a. Launched IHA Chart Review Audits (CCN) to engage low performing community clinics for IHA Chart Review Audits on at least 30 member files per clinic. b. Reviewing and following up on underperforming HNs; Meetings held with Optum and AltaMed to discuss opportunities to improve performance c. Established and informed at HNs of the expectation to meet the minimum IHA completion rate of 50%. d. Established a plan for process to visit providers and bring IHA data and related resources to implement in Q2 3) Increase member outreach efforts a. Developing text campaign for new members - IHA. Currently in review with internal team and vendor	1) Increase health network and provider communications, trainings, and resources 2) Scheduled HN Forum Presentation for Q2 (Goal present twice annually) - IHA Updates will be presented at Health Network Collaborative Quality Forum beginning in April. 3) Expand oversight of provider IHA completion - IHA Chart Review Audits (CCN): Staff working with department Medical Director to follow up with non-responsive clinics via clinic executive leadership. - Scheduled meeting with Delegation Oversight during Q2 to agree on the approach for establishing remediation activities (including but not limited to: education, corrective action plans, etc.)	
Quality of Service	Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs.  Comply with regulatory standards Maintain business for current programs Improve process for handling these services	Report progress to QHIEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services		Quarter 1 2024 Assessment C&L assessed the member utilization for interpreter services (in any language) and written translations in CalOptima Health's threshold languages. The assessment concluded that Spanish is the highest utilized LEP language for telephonic and face to face interpreter services as well as written translations.  • Telephonic Interpreter Services Spanish 52%, Vietnamese 23%, Farsi: 5%; Arabic 4%; Chinese 4%; Korean 4%; Other 8%  • Face to Face Interpreter Services Spanish 35%, Vietnamese 9%; Farsi: 11%, Arabic 14%; Chinese 2%; Korean 14%; American Sign Language 5% Other 9%  • Documents Translated Spanish 72%, Vietnamese 8%; Farsi: 6%; Arabic 5%; Chinese 3%; Korean 4% Utilization results aligned with CalOptima's Health membership and therefore C&L findings its goals are being met.	• Continue monitoring CalOptima Health Members' interpreter and translations services needs. • Continue to explore technological improvement opportunities with our contracted Interpreter Services and Translations vendors for all C&L processes and services.	
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for improvement	Submission: 1) By June 2024 2) By December 2024  Update from MemX to QHIEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Mahmoud Elaraby/Johnson Lee	Provider Data Management Services	New	Phase 1: ANC Roster provided by DHCS has been completed and submitted for the following: 1) ANC 2023 Cancer Center Validation, CalOptima Health 2) ANC 2023 Exhibit A-3 MPT Validation, CalOptima Health 3) ANC 2023 Exhibit A-5 Hospital Validation, CalOptima Health Phase 2: Time or Distance: CalOptima Health: CalOptima Health did not meet Time or Distance standards for 54 provider type/population combinations in two zip codes (92676 and 92679).	Phase 1: ANC Roster provided by DHCS has been completed and submitted for the following: 1) ANC 2023 Cancer Center Validation, CalOptima Health 2) ANC 2023 Exhibit A-3 MPT Validation, CalOptima Health 3) ANC 2023 Exhibit A-5 Hospital Validation, CalOptima Health Phase 2: Time or Distance: CalOptima Health: Based on DHCS' time or distance analysis for this submission, CalOptima Health is submitting ANC requests. CalOptima Health used DHCS Medi-Cal Fee-for-Service Providers to identify the nearest CCN providers to meet Time or Distance standards for 54 provider type/population combinations in two zip codes (92676 and 92679).	
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all PAX discussions with HNs.	Update from MemX to QHIEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Carol Matthews/Helen Syn	Quality Analytics	X	1) 144,837 mailings were sent to Medi-Cal members and 2,743 were sent to OneCare members 2) Medi-Cal: 90,237 member call attempts were made and 13,953 reached/scheduled callback (16.7%). OneCare-1,498 member call attempts were made and 541 reached (36.1%)	Continue with plan as listed	
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs Improve process of handling member and provider grievance and appeals	GARS Committee Report to QHIEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	GARS	New	1) provider trends - highest trending provider group are several of the FQHC's - appointment availability, delays in referrals, delays in service, telephone accessibility. 2) transportation trends - NMT, MTM delays and no shows 3) access trend - impacted by the providers who were trending and missed appointments caused by the transportation delays of MTM 4) quality of care - missed appointments  No trends identified in member appeals Provider appeals/disputes trends - past timely filing, no authorization on file and underpayment  1 of 16 SFH overturned - Medi-Cal 1 of 40 Maximus overturned - Medicare	The department will continue to perform quarterly and year to date reviews to identify trends. This information will be presented to GARS Committee as opportunities to improve operations across the organization.  The department will host the next GARS Committee meeting on May 14.	

2024 QI Work Plan - Q1 Update

Evaluation Category	2024 QHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues <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 - Watchlist Green - On Target
Quality of Service	Customer Service	Implement customer service and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/09/2024) Q1 2025 Update (01/14/2025)	Andrew Tse	Mike Erbe	Customer Service		DHCS' average speed of answer of not exceeding 10 minutes; Goal was not met (15 min and 15 sec). Internal business goal of abandonment rate not exceeding 5% not met (20.2%). Challenges: call center experienced a large spike in call volume (159,664) due to transitions (Optum consolidation, Adult Expansion, Kaiser) and member engagement campaigns (i.e., text messaging, telephonic surveys).	Continue working with HR to onboard additional staff (permanent vacant positions or temporary staff), maintain the telephonic call back offering, and partner with other departments (QA, Equity and Community Health, etc.) to determine if replacing customer service phone number with member portal features would be a feasible option or containing member engagement interactions within the original mode of engagement (i.e., text messaging).	
Safety of Clinical Care	Coordination of Care: Member movement across settings	Improve care coordination between the hospital and primary care physician (PCP) following patient discharge from an acute care setting	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	UMC Committee report to QIHEC: Q2: 08/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Stacie Oakley	TBD	Utilization Management	New	Refer to the TCS element	Refer to the TCS element	
Safety of Clinical Care	Coordination of Care: Member movement across settings	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SFPs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Megan Dankmyer	TBD	Medical Management	New	MY2022 Eye Exam for Patients with Diabetes is a 62.6% and did not meet the 2023 CalOptima Health goal. November 2023 prospective rates is at 48.68% and below the hybrid goal. Final HEDIS rates for MY2023 is not yet available.	Staff to review the data and determine whether Eye Exam will continue to be the area of focus for monitoring continuity and coordination of care for members moving between practitioners.	
Safety of Clinical Care	Emergency Department Visits	Emergency Department Diversion Pilot Pilot has been implemented. In 2024 plan to expand the program to additional hospital partners.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Support Referral rate 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Update from UMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	LTSS	X	The program has not been operationalized due to negotiations with UCI regarding the BAA and data usage agreement. New goal is 1st quarter of FY 2024-2025.	Continue to work with CalOptima Health contract department and UCI to monitor progress on executing the agreement.	
Safety of Clinical Care	Transitional Care Services (TCS)	UMCOMLTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% from Q4 2023 by end of December 31, 2024.	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	UMC Committee report to QIHEC: Q2: 08/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Stacie Oakley Hannah Kim Scott Robinson	Joanne Ku	Utilization Management Case Management Long Term Care	X	• Established TCS support line for low-risk members • A TCS support line flyer with CalOptima Health and HN contact information developed • Revised EA's report that identifies TCS high-risk members • Updated TCS County in-patient psychiatric hospital process workflow • Explored a texting campaign leveraging the Ushur platform • Developed texting campaign messaging	• Gather data/reports on trends for TCS KPI/PP measures • Work with ECM Providers to obtain ECM reporting data for KPI 5 • Implement texting campaign using Ushur platform • Update DTPs as appropriate	

2024 QI Work Plan - Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Quality Improvement	2024 QIHETP Description and Annual Work Plan was first adopted by BOD on 4/4/24. Revisions were made to the QIHETP and Work Plan and was approved by QAC on 6/12/24. 1. Updated QIHETP staffing and resources to reflect current organizational structure and renamed Equity and Community Health Department formally known as the Population Health Management Department. 2. Updated section in the QIHETP to reflect current operational and workflows. 3. Added Cultural and Linguistic Appropriate Services Program to QIHETP as Appendix D. 4. Added cultural linguistic and health equity goals and planned activities to the QIHETP Annual Work Plan.	The revised 2024 QIHETP Description and Work Plan was submitted for BoD approval at the 8/1/24 meeting.	
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	Quality Improvement Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Quality Improvement	2023 Quality Improvement Program Evaluation was approved by BoD on 4/5/24.	Goal was completed	
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley/Jennifer Harlow	Utilization Management	The 2024 UM and CM Program was presented at the March 2024 BOD and approved	Goal Completed. Next steps not needed.	
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Kelly Giardina/Jennifer Harlow	Stacie Oakley	Utilization Management	The 2023 UM and CM Program Evaluation was presented at the March 2024 BOD and approved. Based on the approval of the 2023 UM/CM Program Evaluation, the 2024 UM/CM Program was written.	The 2024 UM/Program will be evaluated in Q1 2025.	
Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: (1) Population Needs Assessment (PNA) (2) Risk stratification (3) Screening and Assessment (4) Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Katie Balderas	Barbara Kidder/Hannah Kim/HMDirector of Care Management	Equity and Community Health	1) PNA: Completed 2024 Population Needs Assessment Report Draft. Engaged with OCHCA to begin implementation of collaborative Community Health Assessment for 2027 and beyond.	1) PNA: Report 2024 PNA Key Findings to MAC, PAC, and PHMC; Publish 2024 PNA to CalOptima Health Website	
Program Oversight	2024 Population Health Management (PHM) Strategy Evaluation	Complete the Evaluation of the 2024 Population Health Managemet (PHM) Strategy	The Population Health Management (PHM) Strategy will be evaluated for effectiveness on an annual basis.	QIHEC: 11/05/2024 QAC: 12/11/2024  Annual BOD Adoption by January 2025	Katie Balderas	Barbara Kidder/Hannah Kim/HMDirector of Care Management	Equity and Community Health	DHCS paused reporting on PHM Program Key Performance Indicators (KPIs) until they update technical specifications. Developing shared SMART Goals with OCHCA related to improving outcomes for Maternal Depression and Childhood Blood Lead poisoning.	Evaluation of goals and KPIs to be included in PHM Strategy Evaluation in Q4 2024.	
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	Presented and approved in the June 2024 QAC meeting and set to go for Board approval in July 2024. The workplan was embedded in the QI workplan and also approved in the June 2024 QAC meeting.	Obtain BoD approval in July 2024.	
Program Oversight	2024 Cultural and Linguistic Services Program Evaluation	Complete the Evaluation of the 2024 Cultural and Linguistic Services Program	The Cultural and Linguistic Services Program will be evaluated for effectiveness on an annual basis.	QIHEC: 11/05/2024 QAC: 12/11/2024  Annual BOD Adoption by January 2025	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	No activities in April-June.	Evaluation assessment to begin Q3 or Q4 2024.	
Program Oversight	Population Health Management (PHM) Committee - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	(1) PHMC reviews, assesses, and approves the Population Needs Assessment (PNA). (2) PHM Strategy activities, and PHM Workplan progress and outcomes. (3) Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder/Hannah Kim	Equity and Community Health	• Held second quarter PHM Committee Meeting in May 2024 which included both internal CalOptima Health updates on PHM Program and Community Spotlight on CHA/CHIP facilitated by OC HCA. • Provided PHM Committee update for QIHEC in June 2024. • Finalized the approval and reporting calendar, charter, and Policy GG. 1667. • Developed and published PHM Committee SharePoint site to house committee materials	• Continue to assist this committee by reviewing relevant guidance, agenda setting, and presentation development, and deliverables shared with QIHEC. • Next PHM Committee meeting is scheduled for August 2024 • Report committee update to QIHEC in September 2024	
Program Oversight	Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee activities, findings from data analysis, and recommendations to QIHEC	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Laura Guest	Marsha Choo Rick Quinones Katy Noyes	Quality Improvement	There remain five physicians undergoing the Fair Hearing process. Six PQI cases leveled 1, 2 or 3 were presented to CPRC. Two PQIs were brought back to CPRC and the physicians were recommended for an administrative termination. In Q2, 2024, PQI launched a new system to track PQI cases called Jiva. PQI reporting is still being developed, so trends will be reported when the reports are available. We can report that we have 629 open PQI cases. At the end of Q1, we completed the annual audit of contracted hospitals to ensure they have a policy and procedure for ensuring a 72 supply of medications at discharge. 10 hospitals were audited and all were in compliance. There were no new PPCs or OPPCs identified in Q2. Two policies were presented: GG. 1650 and GG. 1651 with minor changes.	Two of the Fair Hearings are scheduled to commence in Q3, 2024. In Q3, 2024, we aim to have reporting available for PQI developed and be able to report trends for Q1 and Q2. We will continue to monitor claims data for PPCs and OPPCs.	
Program Oversight	Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyonda Moses	Heather Sedilo	GARS	GARS Committee met on May 14 to review the trends and actions taken for the trends identified in Q1. During that discussion the following were presented: <b>Program - Grievances:</b> Medi-Cal received 3,713 grievances in Q1 and 15,420 appeals/payment disputes = 19,133 OneCare Connect received 2 Grievances in Q1 and 99 appeals/payment disputes = 101 OneCare received 475 grievances in Q1 and 1098 appeals/payment disputes = 20,807  There were no HM over the NCOA threshold Trending Health Networks for MediCal included - CCN at 2.48 per 1000 MM; Heritage at 1.32 per 1000 MM and Optum at 1.31 per 1000 MM Trending Health Networks for OneCare included - Prospect at 7.8 per 1000 MM; Optum at 7.6 MM and CCN at 7.6 MM  Top reasons included transportation delays, provider service and CalOptima Services. Both Access to Care and Member Billing both saw a decrease in the volume over Q4.  <b>Appeals:</b> No trends identified in appeals. Overturn rate in Q1 was 32% and the overturn reasons were consistent with prior quarters - additional records received, medical criteria not applied on the initial review used at the appeal level to support the request and missing information not available at the initial review received at the time of appeal.	The department will continue to perform quarterly reviews to identify trends. This information will be presented to GARS Committee as opportunities to improve operations across the organization.  The department will host the next GARS Committee meeting on August 14 to discuss trends identified and any remediation activities found in Q2 2024.	

2024 QI Work Plan - Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	<b>Member Experience (MEMX) Committee Oversight</b> - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1: 03/11/2025	Mike Wilson	Karan Jenkins/ Carol Matthews/Helen Syn	Quality Analytics	In Q2, MemX Committee met 5/22/24 and reviewed/discussed the following: -Charter review and Committee approved the updates -Created quarterly reporting schedule -Reviewed Behavioral Health Member Experience Survey Results -Timely Access: Appointment Availability and Telephone Access: Reviewed the number of Provider and HN CAPS issued and received and DHOS audit findings. -Network Adequacy: SNC 2023 submitted 1/19/24 and revisions and corrective action plans submitted on 5/3/24. CalOptima's next quarterly update is due 7/1/24. ANC: phase 1 ANC 2023 submitted 2/1/24 and phase 2 ANC 2023 submitted 3/20/24. NAV audit: pre-virtual audit activities completed March-May 2024. CalOptima's virtual audit-7/25/24. -Improve Member Experience: Reviewed current response rates for HN and Plan level CAHPS. -KPI Updates: All KPIs for Customer Service, Health Ed, GARS, UM and CM were presented and are being monitored and addressed in respective committees.	Q3 meeting is scheduled for: 7/16/24	
Program Oversight	<b>Utilization Management Committee (UMC) Oversight</b> - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. <b>P&amp;T and EMSC</b> reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1: 03/11/2025	Kelly Giardina/Jennifer Harlow	Stacie Oakley	Utilization Management	Internal and External oversight monitoring established by the Bed Reduction Strategy sub work group and presented for approval at the 5/23/2024 UMC Committee. The goals were approved by the committee. Utilization information will continue to be shared in UMC meetings to monitor these goals going forward. The UMC Committee information was presented to QIHEC at the 6/11/2024 meeting. The Committee information will be presented next in September.	On track - UMC scheduled for 8/22 where information will be reviewed, and next report out scheduled for September QIHEC meeting.	
Program Oversight	<b>Whole Child Model - Clinical Advisory Committee (WCM CAC)</b> - Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.  Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1: 03/11/2025	T.T. Nguyen, MD/H.Kim	Gloria Garcia	Medical Management	WCM CAC met 5/20/2024. They approved the 2/20/2024 meeting minutes and submitted a copy to QIHEC. WCM CAC unanimously voted to keep meeting virtually. The WCM CAC Charter updates were approved. Dr. Wymen La CHOC CCS representative resigned from serving on WCM CAC. Dr. James Chu, from CHOC is being considered to replace Dr. Lai.  The Committee reviewed WCM data, pediatric quality improvement measures, pediatric CalAIM services.	CalOptima Health staff will continue active monitoring of WCM Health Network adequacy, collaborate with quality improvement staff on quality improvement strategies.  Pediatric Risk Stratification Process (PRSP) monitoring will be reported at the next WCM CAC meeting scheduled for August 20, 2024.	
Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1: 03/11/2025	Megan Dankmyer	TBD	Medical Management	Enhanced Care Management (ECM): a)CalAIM ECM provider report documenting Lead Care Managers in CalOptima Connect showed an improvement from 3% to 44%. This ensures the Lead Care Manager is notified of any admissions. Expectation moving forward is to have ECM Providers continue to document accurately. Complex Case Management (CCM) a) NCQA Accreditation Audit-passed 100% b) Continue Monthly NCQA file audit for CCN and Health Networks. Basic PHM/CM: Case Management's quarterly audit for MOC for delegated Health Networks. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) a) CM: Implemented a multi-department work group to discuss EPSDT requirements meetings on 5/21/2024 and 7/1/2024. b) Health Network training 4/19/2024 on EPSDT Transitional care services: a) Refer to Row 61 for TCS Updates. b) IT support for reporting to analyze outcomes on TCS response pending Phase II Jiva remediation c) Sharing of TCS qualifying discharge events with ECM providers to track successful outreach	Report on the following activities: Enhanced Care Management (ECM): a) Safety Net Connect to create self-reporting tool for Lead Care Manager to share contact information. Complex Case Management (CCM): a) Continue monthly NCQA file audits for CCN and HN members open to CCM level of care. Basic PHM/CM: Continue quarterly audits of delegated Health Networks for MOC oversight. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: a) continued workgroup to discuss requirements for EPSDT Transitional care services: a) See Row 61 for TCS updates. b) Outcome analysis of Health Networks for JOMS presentation pending IT support post JIVA Phase II remediation. c) continued requests to ECM providers for information on TCS outreach day 1-7 post qualifying discharge event.	
Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accreditation standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1: 03/11/2025	Monica Herrera	Zulema Gomez John Robertson	Delegation Oversight	Delegate: Family Choice Health Services/Conifer Health Solutions (MSO) (83) Family Choice Medical Group/Conifer Health Solutions (MSO) (21)  Area(s) Assessed: Case Management; Claims; Compliance; Credentialing; Customer Service; Provider Network Contracting; Provider Relations; Sub-Contractual; Utilization Management  Corrective Action Plan(s) Issued: Claims (Medi-Cal) – Accepted & Closed Compliance, Staff Initial Training (All Lines of Business) - Accepted & Closed Customer Service (All Lines of Business) – Monitoring Utilization Management, Concurrent Review (Medi-Cal) – Monitoring Utilization Management, Expedited & Standard Denials (Medi-Cal) – Monitoring Utilization Management, Physician Administered Drugs (All Lines of Business) – Accepted & Closed Utilization Management, Notice of Medicare Non-Coverage (OneCare) – Accepted & Closed Utilization Management, ODAG Denials (OneCare) – Monitoring Utilization Management, Physician Administered Drugs (All Lines of Business) – Accepted & Closed	Continue to monitor CAPs in "Monitoring" status through acceptance & closure.	
Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1: 03/11/2025	Katie Balderas	Elisa Mora	Equity and Community Health	1) A 2 way text messages targeting members with asthma was implemented on 6/19/2024. In responding to the text, there were 232 members that requested a call back from a health coach. 2) A column was added to the monthly diabetes stratification results identifying members with Chronic Kidney Disease Stage III and IV. 3) Currently piloting stratification/segmentation data from PointClickCare to identify members with Congestive Heart Failure and from Decision Point Opus to identify members with Asthma for outreach by the health coaches. 4) Monitoring the bi-monthly New Member Mailing for low-risk members with asthma and diabetes taking place since February 2024. 5) Collaboration with CalAIM to refer asthma members to the Asthma Housing Remediation Community Supports program. 6) Process has been established between the CalOptima Health Pharmacy department to conduct the medication therapy management for members receiving health coaching and interventions from Registered Dietitians. 7) CalOptima Health RDs are able to assess and submit their own Medically Tailored Meals referrals for qualifying members.	1. A new risk stratification has been proposed for the chronic condition programs pending approval from the leadership team. 2. Working toward expanding the Diabetes Prevention Program services. Currently, working to identify vendors. 3. Plan to initiate Registered Dietitian Member Satisfaction Survey via text message. 4. Plan to create separate condition-specific assessment in Jiva to identify members enrolled by conditions.	
Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: (1) Evaluation of current utilization of health education services (2) Maintain business for current programs and support for community. (3) Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1: 03/11/2025	Anna Safari/Katie Balderas	Thanh Mai Dinh	Equity and Community Health	1) Evaluation of current utilization of health education services:  -Most incoming referral are for weight control but hypertension continues to be one of the top health conditions. Exploring ways to target members who have high blood pressure, and to include efforts for making the blood pressure monitors more easily accessible as a covered benefit.  2) Maintain business for current programs and support for the community:  -Expanded community classes and added ongoing Tuesdays and Thursdays virtual Zoom classes in English and Spanish.  3) Improve the process of handling member and provider requests:  -Working on implementing a member self-referral form so that members can direly refer to health and wellness services.	1) Exploring available services, blood pressure cuff utilization among members, contracted pharmacies locations and major gaps in services for members with hypertension.  2) Promoting community classes via a new standalone class flier, and exploring school interests for further collaboration with new community locations and potential new topics.  3) Seeking member feedback on the draft referral form.	

2024 QI Work Plan - Q2 Update

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Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HLAE) project	By December 2024  Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1: 03/11/2025	Katie Balderas	Barbara Kidder	Equity and Community Health	(1) SDOH Member assessment went live in the Member Portal and we continued to build out the assessment for integration into JIVA  (2) Fully executed contract with FindHelp as the selected closed-loop referral vendor and working with JIVA for integration  (3) HLAE certificate program continues through the end of the year to allow staff to complete their certifications. Currently, 73 out of 164 staff have completed their certification program. Four CalOptima Health staff participated in the Teach-back method Train the Trainer training.	(1) Update SDOH assessment in the Member portal to reflect updates done as part of the SDOH assessment integration into JIVA  (2) Continue to work on integration of the closed-loop referral system into JIVA  (3) Continue to encourage staff to complete their mini-credentials to earn their certification. Develop a Teach -Back method module to train new member facing staff as part of their onboarding process	
Program Oversight	Long-Term Support Services (LTSS)	95% compliance with TAT	CalAIM Turnaround Time (TAT): Determination completed within 5 business days CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days CSAS Turnaround Time (TAT): Determination completed within 5 business days LTC Turnaround Time (TAT): Determination completed within 5 business days	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1: 03/11/2025	Scott Robinson	Cathy Osborn	Long Term Care	CalAIM TAT: Met - 99.68% CBAS TAT: Met 99.66%  CBAS Inquiry to Determination TAT: Met - 100% LTC TAT: Met 99.93%	Continue to monitor TAT.	
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activities for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024  Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Veronica Gomez	Marsha Choo	Quality Improvement	1) <b>HP Accreditation:</b> Successfully submitted all required documents by the submission deadline of 4/30/2024. Completed Virtual File Review with NCQA Surveyors on UM Appeals, UM Denials (BH, Pharmacy, Credentialing/Recred), and Complex Case Management (CCN and Delegates). We scored 100% on all File review elements. 2) <b>HE Accreditation:</b> Initial GAP analysis report received on preliminary discovery meetings. Health Equity Workstreams Kick-Off meetings with project managers. Health Equity Guidelines and Elements Training. Currently building systems and processes (workstreams) in preparation for new GAP analysis meetings. 3) <b>NCQA Consultants:</b> Contracted with new NCQA Consultants Health Management Associates (HMA) to assist with the initial accreditation of 2025 Health Equity (HE) and 2027 Health Plan (HP) re-accreditation.  Preliminary results indicate CalOptima Health met the required points to maintain NCQA HP Accreditation status.	1) <b>HP Accreditation:</b> Pending final report and decision letter from NCQA. Quality Improvement (QI) will develop a remediation plan for element/refactors missed. Share CalOptima Health's final HP accreditation results to the Oct QIHEC. 2) <b>HE Accreditation:</b> Schedule a meeting with PMs and new consultants for a new GAP Analysis. Submit Application for NCQA HE Survey by 9/2024. 3) <b>NCQA Consultants:</b> Kick-off meeting with new NCQA consultants scheduled July 24th.	
Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024  Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Quality Improvement	Created monthly workgroups for Operations, Equity and Community Health, Case Management / Utilization Management / Behavioral Health, and Pharmacy. Created process metrics and deliverables for all workgroups. Created glidepaths for all measures with monthly targets to track performance to goal (4 or 5 Stars). Created call scripts and workflow for the Case Management team to begin member outreach for the OMW measure. Ongoing telephonic outreach to members across multiple measures via vendor Carenet. All measures are performing better in 2024 as compared to same time last year except for OMW.	Continue with plan as listed.	
Program Oversight	Value Based Payment Program	Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Quality Analytics	There have been delays in sending monthly HN performance for P4V measures. Quality improvement grant process is on track.	Confer with the HEDIS team re: P4V reporting. Release the Medi-Cal NOFO as planned in Q3, and the OneCare NOFO as planned in Q4.	
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1: 02/11/2025	Paul Jiang	Terri Wong	Quality Analytics	HEDIS MY2023 preliminary rates reported to May QIHEC.FUA and FUM measures are below the MPL.	Final rates will be presented to QIHEC in August.	
Program Oversight	School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities: 1. Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Sherie Hopson	Behavioral Health Integration	1) SBHIP Partners completed and sent their Q2 progress reports - first of 10 OCDE/CHOC WellSpaces installed; grand opening held on May 3rd at Marco Forster Middle School. 2) SBHIP Partners Meetings include Kaiser; SBHIP Collaboration Meeting with OCDE, and their mental health leaders have been scheduled for 2024-25. 3) Prepared 4 DHCS Biquarterly Reports for June submission. 4) June the 2nd SBHIP payment/check request was completed and issued to CHOC, HAZEL, OCDE, and WYS. 5) Reviewed and approved 14 OCDE school district budget plans. 6) Hazel Health began sending monthly dashboards showing the number of referrals and student visits	1) Individual meetings with CHOC, HAZEL, WYS, and OCDE to review their SBHIP-funded project level of implementation for the remainder of the program. 2) CalOptima Health will be represented at the OCDE Mental Health Summit on August 22. 3) Discuss and confirm the installment dates for the remaining WellSpaces with CHOC. 4) Review the school-based mental health training curriculum with WYS 5) Priority topics selected with OCDE for the SBHIP Collab Meeting (plan for end-of-year accomplishments)	
Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Katie Balderas	Barbara Kidder	Equity and Community Health	1) Reviewed, scored and selected 15 grant proposals for Board approval recommendation. Timeline for Board approval moved from June to August 2024.  2) Insight from the stakeholder sessions informed campaign strategy and approach, and staff is currently engaged with marketing firm in the development of creative concepts.	1) Subject to Board approval and contracting process, implementation of grant activities is expected to commence in September 2024.  2) Campaign soft launch is anticipated for Fall 2024.	
Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS: E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	1. Member Health Reward:CCS:MC 290; BCS:MC 136; BCS:OC 20; COL: OC 7 2. CCS Mailing: 127,684 members; COL mailing 535 members; Text Campaign: CCS 85014 members; BCS MC 25538 members OC 1455; MC/OC live call campaign 3. Continuation of CCN OC COL GI outreach pilot program 4. Planning Phase for CCN Cologuard Project with Exact Sciences 5. May 2024 Prospective Rate Data: CCS: MC 38.27% BCS: MC 43.75%; BCS: OC 56%; COL: OC 52%	1. Continue to track CCS, BCS MC OC, COL OC member health reward 2. Continue member outreach campaigns: Mailing, IVR, text and MC/OC live call campaigns 3. Continue to monitor CCN OC COL GI outreach pilot program. 4. Kick off CCN Cologuard Project with Exact Sciences	
Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADCD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC - Cont Phase - 50.98%	Assess and report the following activities: 1) Work collaboratively with the Communications department to Fax blast non-compliant providers letter activity ( approx. 200 providers) by second quatr. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Behavioral Health Integration	PR HEDIS RATES Q2 (May): Initiation Phase-46.50% Continuation and Maintenance Phase- 52.08%  1) Approved for printing vendor for printed flyers to send out for Member Health rewards. 2) Member Health reward approved by DHCS and added to CalOptima Health Website for members to access. 3) Text Messaging outreach to members sent May and June	1) Q3 data will be pulled to initiate fax blast for Non-Compliant Providers Provider best practices letter and tip-sheet to non-compliant providers. 2) Mail out Member Health Rewards flyer to eligible members. 3) Continue monthly data pull for text messaging campaign.	

2024 QI Work Plan - Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Health Equity/Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health	1) ACEs presentation to inform the group of our progress as a Health plan and educate on the importance of this screening given by BHI Executive Director at the BHQI Workgroup Meeting in April.	1) Continue collaborative meetings between teams to identify best practices to implement. 2) Continue Provider and member education. 3) Continue to participate in the ACEs stakeholder meetings.	
Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primary Care Providers (PCP) for members in need of metabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening 3) Monthly mailing to the next top 50 prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs) 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	PR HEDIS RATES Q2 (May) : Blood Glucose all ages: 29.61%, Cholesterol all ages: 16.75%, Glucose & Cholesterol Combined all ages: 16.10% 1) Barriers included: Receiving timely data and accurate information. a) Submeasure names for this measure changed in 2024, causing delay in receiving data. 2) Identified members prescribed antipsychotic medication still in need of diabetes screening, cholesterol screening, and both cholesterol and diabetes screening test through Tableau Report. 3) The following materials have been disseminated to Providers: a) Provider Best Practices Letter b) APM Provider Tip Sheet. 4) Collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 5) Mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 6) Text Messaging Campaign	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue data pull for text messaging campaign. 3) Continue mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 4) Continue with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	PR HEDIS RATES Q2 (May) :Effective acute Phase Treatment: 63.60%, Effective Continuation Phase Treatment: 39.66% 1) Worked with Quality Analytics/Financial Analysis team to develop a data report 2) Drafted following materials: a) Text Messaging script 1. Approved by DHCS b) Drafted AMM Provider Tip Shee	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Send out Text Messaging campaign. 3) Submit Provider Best Practices Letter for internal review process.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	PR HEDIS Rates Q2 (May): M/C:45.33% OC: N/A 1) We are currently monitoring this measure. 2) Member Fall Newsletter for members.	1) Continue to monitor prospective rates on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz	Behavioral Health Integration	PR HEDIS Rates Q2 (May): 30 day- 22.66%, 7 day- 12.72% 1) The main barrier has been not having the bandwidth for outreach to members that we have been receiving on a daily basis. 2) Working with vendor to create a cohort report of FUM data only. 3) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis. 4) Bi-weekly Member text messaging 5) Article emphasizing importance of Follow up appointment after ED visit created and will be included in Spring Member Newsletter.	1) Pull data for Data Analyst to send out bi-weekly text messages based on real time ED data. 2) BHI is in the process of developing, and implementing a Pilot project for CCN members identified who meet FUM criteria. BH Telehealth provider to conduct the outreach and assist with member linkage. 3) Collaborate with NAMI to share real-time ED data for member outreach. 4) Collaborate with Telemed2U vendor and internal ITS team to develop implementation plan for Member Outreach.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaboratively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward Program.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	PR HEDIS Rates Q2 (May): M/C:46.75% OC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau Report. 2) Conducted a text message campaign to reach out to members re: getting their glucose lab screening. 3) Barriers included: Receiving timely data, obtaining the correct contact information for members such as phone numbers. 4) Member Health reward approved by DHCS and added to CalOptima Health Website for members to access. 5) Mailed out Member Health reward flyer to eligible members. 6) Met with Quality Analytics Team to discuss data sourcing automation for Tableau on a monthly basis 7) Member Fall Newsletter for members.	1) Continue tracking members in need of glucose screening test. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits 3) Continue data pull for text messaging campaign 4) Mail out member health rewards flyer to eligible members. 5) Mail out to top 60 providers with the following: - Medical Director Letter - List of members/patients in need of screening - Provider Tool Tip Sheet	
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP:Improve the percentage of members enrolled into care management, Caloptima Health community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMHSUD.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz/Mary Barranco	Behavioral Health Integration/ Quality Analytics	Conduct quarterly/Annual oversight of MC Non Clinical PIPs (Jan 2023 - Dec 2025) Improve the percentage of members enrolled. Baseline Measurement Period: 01/01/23-12/31/23 Remeasurement 1 Period : 01/01/24 -12/31/24 Remeasurement 2 Period : 01/01/25-12/31/25	1) Working with Caloptima Health Vendor to receive Real-Time ED data on a daily basis for CCN and COD members. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. Telehealth provider will conduct the outreach to members who meet FUM criteria and assist with linkage. Internal BHI PCC's to conduct outreach to members meeting FUA criteria and assist with linkage. Vendor and PCC's will also provide information about case management including ECM and referrals. 3) Develop outreach and outcome data related to the percentage of members enrolled in CCM and ECM for CCN members identified who meet FUM/FUA criteria for the duration of each measurement period. 4) Work in collaboration with internal Privacy dept to ensure compliance of data sharing with vendor.	
Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Behavioral Health Integration	PR HEDIS Rates Q2 (May): 30-Day- 19.29%, 7-Day-9.94% 1) Sharing real-time ED data with our Health Networks on a sFTP Site. 2) Bi-weekly member text messaging 3) Member Newsletter Spring edition	1) Data analyst scrub data for bi-weekly text messaging. 2) BHI is in the process of developing and implementing a Pilot project for CCN members identified who meet FUA criteria.	



2024 QI Work Plan - Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC: 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	1. Member Health Reward: EED:MC 73; EED:OC 13 2. Text Message Campaign: MC 22254; OC 1190 3. EED VPS mailing for Jan to Jun: MC 3013; OC 988 4. VSP data sharing with HN kickoff 5. February 2024 Prosepective Rate Data: EED: MC 35.36%; EED: OC 51%	1. Continue to track EED MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3. 2 way text message campaigns for diabetes by line of business 4. Finalize VSP data sharing with HN for production	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better) MY2024 Goals: MC: 29.44% OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	1. Member Health Reward: HBD:MC 90; HBD:OC 25 2. Text Message Campaign: MC 22254; OC 1190 3. February 2024 Prosepective Rate Data: HBD PC: MC 77.34%; HBD PC:76% OC	1. Continue to track HBD MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3. 2 way text message campaigns for diabetes by line of business	
Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy): HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 81.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Equity and Community Health/ Quality Analytics	Member Initiatives: - Bright Steps Program - Member Health Reward for postpartum care  Community Initiatives - Prenatal social media ads  May 2024 Prospective Rate: Timeliness of Prenatal Care: 67.74%, performing slightly lower than this same time last year. Postpartum Care: 63.19% performing slightly higher than this same time last year.	Planned: Maternal health workgroup meeting in Q3. Continue with public awareness and education campaigns (e.g., radio digital, social media).	
Quality of Clinical Care	Maternal and Adolescent Depression Screening	Medi-Cal Only - Meet the following goals For MY2024 HEDIS: DSF-E Depression Screening and Follow-up for Adolescent and Adults - Screening: 2.97% PND-E Prenatal Depression Screening and Follow-up - Screening: 8.81% POS-E Postpartum Depression Screening and Follow-up: 27.77%	1) Identification and distribution of best practices to health network and provider partners. 2) Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion. 3) Targeted member engagement and outreach campaigns in coordination with health network partners. 4) Provider education (CE/CME) in Q3.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson/Natalie Zavala	Kelli Glynn/Diane Ramoa	Operations Management/ Behavioral Health Integration	<b>Maternal</b> Timely identification: QA has a maternal health workgroup planned for Q3 to discuss member journey and data management which is inclusive of early identification of members for postpartum visit.  Prenatal Depression Screening and Follow Up and Postpartum Depression Screening and Follow Up are new measure that will be held to the MPL beginning MY2025. Prenatal Depression Screening: 6.74% Prenatal Screening Follow Up: 90% Postpartum Depression Screening: 10.35% Postpartum Screening Follow Up: 66%	Planned: Maternal health workgroup meeting in Q3. Fall 2024 Medi-Cal member newsletter article "Let's Talk About Mental Health and Pregnancy"	
Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%;  Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead testing campaign for members - Medi-Cal member newsletter article(s)  In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Quality Analytics	<b>Member Facing Initiatives:</b> - May: Launched an SMS text campaign via mPulse to encourage lead testing. - June: Launched telephonic outreach via CareNet vendor for members that are due for lead testing based on HEDIS and state testing requirements. - June: Launched 2-way SMS via Ushur for multiple pediatric age groups as part of pediatric wellness campaign. - Member health reward for members that test for lead at 12 months and 24 months of age. <b>Widespread Education Efforts:</b> May: FBIS TV ad and radio ad for blood lead screening <b>Provider Facing Initiatives:</b> May: Presented at community health clinic forum on optimizing EMR processes to support state lead requirements. June: Developed provider facing education "Stay Compliant with State-Issued Lead Requirements." June: Email blast to providers who provide care to members ages 0-6. Email blast contained <i>Stay Compliant with State-Issued Lead Requirements</i> guide, informed providers of available health rewards including sample form, and attached OC HCA form to order free lead based educational materials for members.  HEDIS measure is performing slightly higher than this same time around last year. March 2024 rate: 60.54%, MPL is 62.79%. Measure has not met MPL, therefore highlighted in yellow.	Continue with plan as listed.  Planned: - Fax blast to providers to share lead based education - Continue with CareNet member outreach - CE/CME for in support of lead testing	
Quality of Clinical Care	EPSTD/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS MY2024 Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-Final 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Noble/Kelli Glynn	Quality Analytics	Launched 2-way SMS via Ushur for multiple pediatric age groups (launched on 6/20/24 and outreached to 4,292 members). Presented well-child visit best practices during the June monthly Community Clinic forum. Launched telephonic outreach via vendor Carenet. CIS performance is behind as compared to same time last year; as such, metric listed as yellow - concern. W30 performance is ahead of same time last year.	Continue with plan as listed and explore provider-facing education around parent declination for vaccines and parent-facing education around the importance of preventive care / well-child visits.	
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+): To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits.  Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Noble/Kelli Glynn	Quality Analytics	Launched 2-way SMS via Ushur for multiple pediatric age groups (launched on 6/20/24 and outreached to 4,292 members). Presented well-child visit best practices during the June monthly Community Clinic forum. Launched telephonic outreach via vendor Carenet.	Continue with plan as listed and explore parent-facing education around the importance of preventive care / well-child visits.	
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data submitted by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 04/09/2024 Q4: 10/08/2024	Kelly Klipfel	Lorena Dabu	Finance	No activities in April-June	N/A	
Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025  Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Marsha Choo	Katy Noyes	Quality Improvement	A. FSR: FSR/MRR/PARS, NF and CBAS Oversight Initial FSRs=18; Initial MRRs=13; Periodic FSRs=61; Periodic MRRs=66; On-Site Interims=19; Failed FSRs=3; Failed MRRs=13 CAPs: CE=39; FSR=54; MRR=64; 60 Periodic FSRs completed before 36 month due date. B. PARS Limited Access=65(57%)  C. CBAS: Completed PARS=114 (Basic Access=49/43%  Critical Incidents=23; 22 Critical Incidents reported were COVID cases. Non-Critical Incidents=14; Falls=5; Completed Audits=10; CAPs=; Unannounced Visits=0 D. NF: Unannounced Visits=2  Critical Incidents=1; On-Site Visits=8;	Continue with plan as listed.	

2024 QI Work Plan - Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Laura Guest	Quality Improvement	There remain five physicians undergoing the Fair Hearing process. Six PQI cases leveled 1, 2 or 3 were presented to CPRC. Two PQIs were brought back to CPRC and the physicians were recommended for an administrative termination. In Q2, 2024, PQI launched a new system to track PQI cases called Jiva. PQI reporting is still being developed so trends will be reported when the reports are available. We can report that we have 629 open PQI cases.	Two of the Fair Hearings are scheduled to commence in Q3, 2024. In Q3, 2024, we hope to have reporting available for PQI developed and be able to report trends for Q1 and Q2. An open position for a RN for PQI has been recruited and the individual is expected to begin in early Q3.	
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Quality Improvement	Initial BH Credentialing Q2 = 71; Initial CCN Credentialing Q2 = 59. For Q2 we did not have any initial credentialing files out of compliance.	Initial credentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial credentialing.	
Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Quality Improvement	BH Recredentialing - Q2 =23; CCN Recredentialing Q2 =99. For Q2 we did not have any recredentialing files out of compliance.	Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the recredentialing of providers. This will ensure that we continue with compliance and timeliness of the recredentialing files.	
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025):  CCIP Study - Comprehensive Diabetes Monitoring and Management  Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	1. Health Coaches began calls from emerging risk call list.	1. Continue calls and refresh data. 2. Review completed assessment.	
Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	S. Hickman/M. Dankmyer/H. Kim	QI Nurse Specialist	Case Management	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. a) Core Report CC0258 continues in phase II Jiva Remediation for ICT/ICP/HRA data. b) Q1 DHCS reporting for HRA1 and ICP1 submitted to DHCS reflecting for HRA1 members who were reached and willing to complete HRA at 100%; for ICP1 members who were reached and willing to complete ICP at 64%. c) as 6/30/2024 41% of HRAs completed to date achieving two star rating d) ICT rates pending Jiva Phase II remediation. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. a) Communications to CCN and Health Networks in April and May on ICP development status for newly effective members Q1 and Q2. b) Addition of annual ICP development status on April and May file. c) Communication of ECM-Like eligibility and members missing face-to-face interaction 3) Creation and implementation of the Oversight audit tool. a) Ongoing quarterly audits of delegated health networks.	Assess and report the following activities: 1)Continue to use monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. a) Core Report CC0258 remediation should be completed by 8/30/2024 b) Q2 DHCS reporting for HRA1 and ICP1 will be submitted by 8/30/2024. CM will share adjusted score for both HRA1 and HRA2 of members who were reached and willing to complete HRA and ICP. c) Share % of HRAs completed to date per HRA Star Dashboard. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. a) Continue communications to CCN and Health Networks for ICP1 development status for newly effective members Q2 and Q3. b) Continue to provide feedback on annual ICP development and missing face-to-face interactions. 3) Creation and implementation of the Oversight audit tool. a) Ongoing quarterly audits of delegated health networks.	



2024 QI Work Plan - Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHEC Q2: 08/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	1) Mike Wilson 1)Quynh Nguyen 2) Tory Vazquez 3) Jane Flannigan Brown	Mahmoud Elaraby Provider Relations	Contracting	1. Hired PM 2. Established process for gap closure with Health Networks not meeting time and distance requirements 3. Closed CAPS for 2 health networks with Time and Distance gaps  Transition - QI finalizing transition plan	>Finalize transition plan, develop priorities of transition > Implement processes for network adequacy programs > Set up network adequacy workgroups to review gaps and trends	
Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely access. 3) Continue to educate providers on timely access standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q2: 08/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Quality Analytics	2023 CAP Responses: -In Q2, Timely Access subgroup/subgroup reviewed 8 (out of 11) HN CAP responses received. -Of the 117 Timely Access CAPs issued to individual providers, a total of 71 responses received by Q2, two termed and one provider passed away.  June 2024, mailed approx 1400 non-compliance letters to individual providers based on the 2023 Access Survey (9/26-12/1/2023). -Education letters: 1034 -Warning letters: 281 -Escalation/CAP letters: 110  RFP in the works for potential new vendor in 2025 and process will include additional surveying of those initially found non-compliant with annual survey.  In June 2024, CareNet conducted an interim audit on providers who were identified as non-compliant with the 2022 survey results for telephone measure "instruct caller to dial 911 or go to nearest ER" to identify current status.  Directors and Timely Access workgroup in the process of developing workflows and additional tools to facilitate standardization and better monitoring of the non-compliance and corrective action process.	For the three HN CAP responses not received, in the process of scheduling a meeting in July to discuss further with Optum.  Issue HN Level CAPs in Q3 or Q4.  Prep for fielding 2024 Timely Access Survey with a September target date  Prep for fielding an In-Office wait Time Survey	
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024  Update from MemX to QIHEC: Q2: 08/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Karen Jenkins/Mahmoud Elaraby/Catherine de la Cruz	Network Operations/Quality Analytics	SNC Report Q2 2024: May 274 File. Submitted quarterly CAP status and reviewed 7 of 7 updates from HNs. Optum integration decreased HN updates requested by 2. One HN closed their CAP (Regal). Six remain with open CAPS.  1.Time/Distance: In compliance with the regulatory guidelines specified in APL 23-006, Assigned membership methodology to pull the report form May 274 file. For plan level 2 zip codes did not meet for PCP Adult and Pediatric Core Specialty, and for Specialists Gastroenterology and Orthopedic surgery. Meetings with HNs to review gaps and discuss options for gap closures.  For HN level: PCP (Internal Meds) è AltaMed and CHOC_OBGyn: AltaMed_Ophthalmology: AltaMed and Optum_Hematology & Oncology: AMVI, Noble, Optum_Neurology: AMVL_Pulmonology: AMVI, UCMG_Gastro: Optum_Orthopedic Surgery: Regal & Optum  AMVI then Noble have the greatest number of non-compliance zip codes. The specialties with the most non-compliance zip codes are: Physical Med and Rehab then Endocrinology 2.Out-of-Network (CON): using MCFD - OON Data Q1 2024 submissions to DHCS. 99 total requested for OON referral requests. 3.Network Capacity and Ratios were met. 4. PCP Overcapacity: For Q2 2024, we reopened the panel for 7 provider and closed one panel for Dr. Mobarak and send a notification letter as certified mail. 5.Timely Access: The 2023 Timely Access Survey was fielded September 26 through December 1, 2023, and letters of non-compliance and Corrective Action Plans will be mailed to individual providers in late June or early July 2024. 6.California Children's Services (CCS) Program/Whole Child Model (WCM: 0 deficiencies. Plan Statewide Level - all specialties met. All networks confirmed as met, with exception of UCMG, although AMVI showed non-compliant for 6 specialties. CalOptima Health is in receipt of a HN Agreement between AMVI and CHOC.		
Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2) Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Katie Balderas	Anna Safari	Equity and Community Health	1) Increase health network and provider communications, trainings, and resources Goal being met, see below. a. HN and Provider Communications/Presentations: -Provider Monthly Newsletter: Send messaging out at least once per quarter: messaging sent in April and June. -Health Network Communication/ Presentations: Began meeting with each HN via Health Network Quality Update Meetings starting in May; Further follow-up Meetings began with HNs individually to discuss CAP process which includes the Delegation Oversight Dashboard Response Form; Meeting Presentations and individual follow up meetings replaced email communication in HN Weekly Update. b. Training/Presentations with IHA Updates: -Planning for a provider CME in August 2024. -Provider toolkit that includes the IHA is in progress.  2) Expand oversight of provider IHA completion: Goal being met, see below. a. Continue to audit CHCN clinics. b. Continuing to inform all HNs of the expectation to meet the minimum IHA completion rate of 50%; Still in discussion with management regarding the approach for establishing Corrective Action Plan. c. Provider office visits (CHCN): Established and implemented a process to visit providers and bring IHA data (or give staff presentations) and related resources. 3) Increase member outreach efforts: Goal being met, see below. a. Developing text campaign for new members «IHA: Message currently in review with internal team and vendor for DHCS submission preparation. b. Continuing IVR campaign twice monthly to new members. c. Message to new members on the IHA continues to be sent out in the new member handbook and in the Medi-Cal newsletter.	1) Continue collaboration with HNs and providers via Presentations and Newsletter updates.  2) Continue chart review efforts and provider office visits.  3) Continue identifying new members monthly and sending targeted messages via text, IVR and mailings.	
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for improvement	Submission: 1) By June 2024 2) By December 2024  Update from MemX to QIHEC: Q2: 08/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Mahmoud Elaraby/Johnson Lee	Provider Data Management Services	All ANC Phase 2 Time and Distance submissions were completed in March 2024, including Mandatory Provider Types Roster, P&Ps, MPT and Facility Validation supporting documentation, Alternative Access Standard Analysis.	Ongoing monitoring in transition to PDMS.	
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q2: 08/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Carol Matthews/Helen Syn	Quality Analytics	1. 217,988 members were outreached to through live calls, text messaging and mailings for both lines of business. 2. CalOptima's Just in Time campaign used live calls and text messaging to reach members that were likely to respond negatively. 13,239 live calls and 57,169 text messages were sent to members in both lines of business. 3. CAHPS continues to be part of the P4V for the HN. Final CAHPS reports have not been received. Distribution to health networks is pending final reports due in July.	1. Closed 2. Closed 3. Share HNQR with the HN when available	
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals	GARS Committee Report to QIHEC Q2: 08/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	GARS	GARS identified and reported a non-compliance issue to the Committee regarding untimely Discrimination cases submitted to DHCS. Regulation APL21-004 requires that the named discrimination grievance coordinator properly investigates and responds to all complaints within 30 days of receipt. Additionally, within <b>10 calendar days</b> of mailing the discrimination grievance resolution letter to a member, CalOptima Health must submit a copy to DHCS. CalOptima Health did not consistently submit within 10 days. Root cause: lack of reporting. Remediation: documented a process to be followed in Jira that provides the ability to track not only the date of closure but also the date of submission to DHCS.	GARS will continue to identify and report any Compliance Issues to QIHEC related to either the GARS process, internal departments, providers and/or Health Networks at least quarterly. This report will include any remediation activities if applicable.	
Quality of Service	Customer Service	Implement customer service process and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Andrew Tse	Mike Erbe	Customer Service	Customer Service ran KPI data and reported results to QIHEC. DHCS' average speed of answer of not exceeding 10 minutes: Goal was met (2 min and 1 sec). Internal business goal of abandonment rate not exceeding 5% met (exactly 5% for Q2). Accomplishments: Hired additional staff, various departments staggered member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	Continue working with HR to onboard additional staff (permanent vacant positions or temporary staff), maintain the telephonic call back offering, and partner with other departments (QA, Equity and Community Health, etc.) to stagger their member engagement campaigns (i.e., text messaging).	

2024 QI Work Plan - Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Quality of Service	Medi-Cal Customer Service Performance Improvement Project	To meet Medi-Cal Customer Service KPIs by December 31, 2024: Internal call abandonment rate of 5% or lower, DHCS 10 minutes average speed of answer	1) Partnering with HR to onboard more permanent and temporary staff to service inbound calls 2) Interacting with various departments involved with member engagement campaigns and determine if they're able to update instructions for targeted members (i.e., instead of calling customer service, have them utilize the member portal).	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (07/09/2024) Q1 2025 Update (02/11/2025) Q1 2025 Update (01/14/2025)	Andrew Tse	Mike Erbe	Customer Service	Customer Service ran KPI data and reported results to QIHEC. DHCS average speed of answer of not exceeding 10 minutes: Goal was met (2 min and 1 sec). Internal business goal of abandonment rate not exceeding 5% met (exactly 5% for Q2). Accomplishments: Hired additional staff, various departments staggered member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	Continue working with HR to onboard additional staff (permanent vacant positions or temporary staff), maintain the telephonic call back offering, and partner with other departments (QA, Equity and Community Health, etc.) to stagger their member engagement campaigns (i.e., text messaging).	
Safety of Clinical Care	Coordination of Care: Member movement across practitioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement. 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Megan Dankmyer/Katie Balderas/Kelli Glynn	TBD	Medical Management	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement a) Work-Plan goal revised on May 9 for multi-department approach between CM, PHM, QA, and other departments as indicated. b) Inter-department training not previously reported by PHM for CM department on 3/27/2024: Health Education Materials and Chronic Conditions Coaching TipsElisa Mora, MPH, RD, Manager, Chronic Conditions, PHM Noushin Dehbozorgi, MSN, PHN,RN,CCM, Health Coach, PHMPHM 2) Provider and member education a) existing information on CalOptima Website for both Provider and Member under Health and Wellness with links to Diabetes Management resources in video, download, or print format with language preference b) existing Health Education materials for members on sharepoint that Case Managers can print and mail.	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement a. Meeting on 7/8 between Claims, UM, and QA to discuss authorization requirement for diabetic eye exam and feasibility for this potential barrier to be eliminated. 2) Provider and member education a. Continue with existing Health Educational resources on Sharepoint and CalOptima Website. b. Member and Provider education in the event changes to authorization process are implemented.	
Safety of Clinical Care	Emergency Department Member Support	Emergency Department Diversion Pilot has been implemented. In 2024 plan to expand a virtual program to additional hospital partners starting with UCI.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/1/2025	Scott Robinson	Cathy Osborn	LTSS	Establishing the virtual program has not been accomplished due to the inability to execute a data usage agreement.	Two staff members (MSW & RN) were approved in the 2024/2025 budget to be embedded in the UCI emergency department. Currently in the process of developing job descriptions to begin recruitment. The plan is to have UCI ED embedded staff in place by the end of September 2024.	
Safety of Clinical Care	Coordination of Care: Member movement across settings - Transitional Care Services (TCS)	UMCM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% from Q4 2023 by end of December 31,2024.	1) Use of Usher platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/1/2025	Stacie Oakley Hannah Kim Scott Robinson	Joanne Ku	Utilization Management Case Management Long Term Care	-PP4 4.3 report (percentage of members who had ambulatory visits within 7 days post hospital discharge) – Enterprise Analytics updated report with the correct technical specifications. It helps monitor the effectiveness of TCS (mirror the state's monitoring approach). -CalAIM ECM provider report documenting Lead Care Managers in CalOptima Connect showed an improvement from 3% to 44%. This ensures the Lead Care Manager is notified of any admissions. Expectation moving forward is to have ECM Providers continue to document accurately.	-Develop a texting campaign leveraging the Usher platform -Develop report for FFS Medicare members -Develop process and desktop procedure outreach to pregnant members (TCS high-risk) not enrolled in the Bright Steps program. -Continue motivational interviewing trainings (started in June).	
Cultural and Linguistic Appropriate Services	Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from 41.90% to 55.78% by 12/31/2024.	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Quality Analytics	1. 85 African American members were identified for outreach. 34 parents/guardians were successfully outreached to. Members that were unsuccessfully reached via telephone were sent an unable to contact letter advising of attempt to reach and encouraged a call back to CalOptima Health. 2. Out of the 51 unsuccessful members, 10 were identified as having a email and CalOptima Health provided outreach to encourage reaching out to provider to make well-child visit. Out of the 10 emails, we encountered an error with one email and did not receive a response from the 9 other members outreached to.  <b>Barriers:</b> Within the organization there was a data transition that contributed to delays in the identification of members in the population of focus. Data for member outreach was not available until April 2024 which resulted in delayed outreach. Barriers to member outreach: Various members has incorrect contact information.  <b>Findings:</b> Final summary pending. Findings suggest that in scenarios where members were successfully outreached, many children had a well-child visit scheduled or one that was recently completed. When offered assistance to schedule future well-child visits, parents declined. Data suggests that parents are unaware of how often well-child visits should take place during the first few years of life.	Submission of results in September 2024. Quality Analytics team will utilize survey findings to inform interventions for 2025.	
Cultural and Linguistic Appropriate Services	Cultural and Linguistics and Language Accessibility	Enhance interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Initiate Request for Proposal (RFP) to add and/or replace the translation and interpreter services vendors to improve the member experience.	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	The Request for Proposal (RFP) Scope of Work draft has been completed and currently under review by Vendor Management.	>Finalize Scope of Work and submit RFP bid.  <i>The RFP's Scope of Work (SOW) is currently being reviewed by Vendor Management.</i>	
Cultural and Linguistic Appropriate Services	Maternity Care for Black and Native American Persons	1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima's Black members from 67.48% to 74.74% and Native Americans from 44.44 to 63.22% by 12/31/24.  2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima's Black members from 53.77 to 72.37% and Native Americans from 27.78% to 59.43% by 12/31/24.	Assesse and report the following activities: 1) Determine the primary drivers to noncompliance via member outreach and literature review 2) Targeted member engagement and outreach campaigns in coordination with health network partners 3) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 4) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 5) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 6) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Equity and Community Health	Data as of May 2024: PPC - Postpartum Care: - 63.10% compliance rate for the entire population - 63.10% compliance rate for the Black population - 46.27% compliance rate for the Black population - 45.45% compliance rate for the Native American population  PPC - Timeliness of Prenatal Care: - 67.74% compliance rate for the entire population - 55.22% compliance rate for the Black population - 63.64% compliance rate for the Native American population	Planned: Continue with public awareness and education campaigns (e.g., radio digital, social media). Continue to develop identification of eligible members to enroll with CalAIM providers. Continue to build doula provider network to ensure person-centered, culturally competent care that supports the racial, ethnic, linguistic and cultural diversity of members	
Cultural and Linguistic Appropriate Services	Data Collection on Member Demographic Information	Implement a process to collect member SOGI data by December 1st, 2024.	1) Develop and implement a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 3) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 4) Develop and implement a survey via the Member Portal, mail to new members and other methods. 5) Share member demographic information with practitioners.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (11/05/2024) Q1 2025 Update (02/11/2025) Q4 2024 Update (01/14/2025)	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	-The SOGI survey was submitted to Compliance and to The Department of Managed Health Services (DHCS) for review. -The survey has been approved by DHCS and translated in CalOptima Health's threshold languages. -The survey has been submitted to ITS to start the process of implementing into the Member Portal. -Facets Core system where data will be stored has been updated with the capabilities to store SOGI data that is collected from members.	-ITS to complete upload survey to the Member Portal. -Work with Communications to create a new member mailing packet for mailing to new CalOptima members (over the age of 18 years of age) -ITS to upgrade XXI in Facets for the survey to upload properly to prepare for the integration of the survey.	

2024 QI Work Plan - Q2 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Cultural and Linguistic Appropriate Services	Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.	1) Develop and implement a survey to collect practitioner REL data 2) Enter REL data into provider data system and ensure ability to retrieve and utilize for GLAS improvement. 3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership. 4) Assess the provider network's capacity to meeting CalOptima Health's culturally diverse member needs. 5) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Quynh Nguyen	Johnson Lee	Provider Data Management Services	1. Meetings scheduled to plan 2. Develop plan for key activities 3. Identified stakeholders 4. Completed analysis of requirements	1. Set up indicators in Facets 2. Identify methods for collecting data 3. Survey and collect data 4. Enter data in FACETS 5. Set up on going process for collecting information	
Cultural and Linguistic Appropriate Services	Experience with Language Services	Evaluate language services experience from member and staff	1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC quarterly: <del>Q2-2024 Update (08/13/2024)</del> Q2 2024 Update (07/09/2024) <del>Q3-2024 Update (11/06/2024)</del> Q3 2024 Update (10/08/2024) <del>Q4-2024 Update (02/11/2025)</del> Q4 2024 Update 01/14/2025)	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	-Draft language experience Surveys for both members and staff has been completed and has been distributed to Health Equity workgroup for review and feedback. -C&L met with contracted vendors and internal workgroups on best approach to implement the member and staff survey -C&L met with contracted vendors and confirmed vendors, currently, cannot support CalOptima with conducting a member survey.	-Complete the review of draft surveys with internal workgroups. -Send draft surveys to consultants for review and feedback -Explore other options for conducting the survey including texting campaigns and live outreach.	

## 2024 QI Work Plan – Q3 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	The revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan was approved by BoD on 8/1/2024 and a copy was posted on CalOptima Health's public website.	Staff will draft timeline and collaborate with QI business owners to write the 2025 QIHETP Description and Work Plan.	
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	Quality Improvement Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	Goal was completed 5/5/2024.	No next step.	
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of UM	Utilization Management	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description completed on time and received approval from BOD.	Continue with the plan as defined for 2025.	
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of UM	Utilization Management	2024 Program Evaluation completed on time and received approval from BOD.	Continue with the plan as defined for 2025.	
Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: (1) Population Needs Assessment (PNA) (2) Risk stratification (3) Screening and Assessment (4) Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	(1) Presented 2024 PNA finding to CHA/CHIP Steering Committee for recommendations; Revised 2024 PNA according to CHA/CHIP Steering Committee feedback; finalized collaborative blood lead and maternal health SMART goals with OC HCA (3) Working to update risk stratification based on HIF-MET (4) Exploring vendor platforms for member wellness and prevention health appraisals.	(1) PNA: Report 2024 PNA Key Findings to MAC, PAC, and PHMC; Publish 2024 PNA to CalOptima Health Website 4) Review vendor options for member wellness and prevention health appraisals.	
Program Oversight	2024 Population Health Management (PHM) Strategy Evaluation	Complete the Evaluation of the 2024 Population Health Managemet (PHM) Strategy	The Population Heath Management (PHM) Strategy will be evaluated for effectiveness on an annual basis.	QIHEC: 11/0520/24 QAC: 12/11/2024  Annual BOD Adoption by January 2025	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	•Equity and Community Health has met with Quality Improvement to plan for the PHM Strategy Evaluation; •Quarterly PHM Workplan monitoring	•Quarterly PHM Workplan monitoring •Finalize template PHM Strategy Evaluation	
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for	QIHEC: 02/13/2024 QAC: 03/13/2024	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	The 2024 Program and Workplan apporval at QAC and BOD was held in order to include Health Equity elements.	Annual BOD Adoption by April 3 2025	

## 2024 QI Work Plan – Q3 Update

			effectiveness on an annual basis	Annual BOD Adoption by April 2024						
Program Oversight	2024 Cultural and Linguistic Services Program Evaluation	Complete the Evaluation of the 2024 Cultural and Linguistic Services Program	The Cultural and Linguistic Services Program will be evaluated for effectiveness on an annual basis.	QIHEC: 44/05/2024 01/14/2025 QAC: 42/44/2024 03/12/2025  Annual BOD Adoption by January 2025-April 3 2025	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	The BOD approved the Revised 2024 CalOptima Health 2024 Cultural and Linguistic Services Program Evaluation and Work Plan on August 1, 2024.	Annual BOD Adoption by April 3 2025.	
Program Oversight	<b>Population Health Management (PHM) Committee</b> - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	(1) PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), (2) PHM Strategy activities, and PHM Workplan progress and outcomes. (3) Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health	Manager of Equity and Community Health/ Director Case Management	Equity and Community Health	<ul style="list-style-type: none"> <li>Held third quarter PHM Committee Meeting in August 2024 which included both internal CalOptima Health updates on PHM Program and Community presentation from Second Baptist Church on Health Equity for African American's League (HEAAL)</li> <li>Provided PHM Committee update for QIHEC in August 2024.</li> </ul>	<ul style="list-style-type: none"> <li>Continue to assists this committee by reviewing relevant guidance, agenda setting, and presentation development, and deliverables shared with QIHEC.</li> <li>Next PHM Committee meeting is scheduled for November 2024</li> <li>Report committee update to QIHEC in November 2024</li> </ul>	
Program Oversight	<b>Credentialing Peer Review Committee (CPRC) Oversight</b> - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee activities, findings from data analysis, and recommendations to QIHEC	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	Of the five physicians undergoing the Fair Hearing process, three remain in process. The Committee decided to move two physicians to probation for 1 year with requirements. Nine PQIs leveled 1, 2 or 3 were presented to CPRC. PQI trends for 1/1/24-6/30/24 identified an ABA group and a acute care hospital. During this time frame, most quality of care PQIs were categorized as medical care, and most were either mismanaged care or treatment (delay, failure, inappropriate or complications). Five providers were presented for on-going monitoring. Three providers were reviewed for recredentialing. The Committee also voted to recognize the Canadian Boards. There were no physicians reported for failing a FSR or MRR, and there were no PPCs reported.	The Committee will continue to monitor providers through on-going monitoring, credentialing/recredentialing, and PQIs. Policies relevant to these processes will continue to be reviewed by the Committee.	
Program Oversight	<b>Grievance and Appeals Resolution Services (GARS) Committee</b> - Conduct oversight of Grievances and Appeals to resolve	Report committee activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Grievance and Appeals	Manager of GARS	GARS	GARS Committee met on August 14 to review Q2 metrics for both lines of business and types to include: - Member Grievances and Appeals - CalOptima Health remains compliant with processing timeliness both monthly and quarterly - NCQA GARS Goals are met	GARS Committee is scheduled for November 13 where Q3 trends will be discussed and any remediation activities presented for additional recommendations.	

## 2024 QI Work Plan – Q3 Update

	complaints and appeals for members and providers in a timely manner.		providers for CalOptima Health's network and the delegated health networks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.					<ul style="list-style-type: none"> <li>- Grievances are under the DHCS Enterprise Average of 3.1 grievances per 1,000 member months</li> <li>- Q2 MC Grievance Rate per 1000 MM = 1.97, which is an increase over Q1 (1.56)</li> <li>- Q2 OC Grievance Rate per 1000 MM = 11.72, which is down compared to Q1 (13.83)</li> <li>- Q2 MC Appeals Count = 362 with 35% Rate Overturned</li> <li>- Q2 OC Appeals Count = 68 with 41% Rate Overturned</li> <li>- Provider Disputes received in Q2 = 10,577</li> <li>- Total Claims to Disputes received is 0.5%</li> <li>- 33% of the disputes received were overturned</li> </ul> <p>Trends for each type by line of business was discussed. Actions taken to remediate trends were also discussed.</p> <p>Q1 2024 minutes were approved.</p>		
Program Oversight	<b>Member Experience (MEMX) Committee Oversight</b> - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Project Manager Quality Analytics	Quality Analytics	<p>In Q3. Member Experience Committee met on July 16. 2024 and reviewed and discussed the following: timely access: reviewed DHCS wait time results for Q1 2024 and CalOptima's internal timely access survey for 2023, whole child model network adequacy: reviewed results for Q2 2024 for both plan and network level, SNC/ANC: reviewed status of CAP updates due 7/1/2024, NAV audit timeline with confirmed audit date of July 25, 2024, PCP overcapacity including provider panels that need to be re-opened or closed, OneCare data analysis and reporting: with all requirements met, and a CAHPS update: all MC plan and HN reports were received and the final CAP submission by HN received 6/13/24.</p> <p>KPI Reporting: Customer Service reported on call volume, abandonment rate, and average speed of answer. Health Education reported on referral process improvement and collaborations. Utilization Management reported prior auth TAT for routine and urgent referrals 2023-Jan 2024, average TAT for urgent and routine referrals. BH reported on routine authorizations processed within 5 days and appointments offered with a mental health appointment within 10 business days of request.</p>	Next meeting October 15. 2024	
Program Oversight	<b>Utilization Management Committee (UMC) Oversight</b> - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. Committee meets at	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Utilization Management	Manager of UM	Utilization Management	UMC reviewed status update on Goals at Committee meeting August 22, 2024. A summary of this presentation was provided at the September 10th QIHEC Committee meeting. The High Risk Management Workgroup (previously titled Bed Day Reduction Strategy) continues to meet and pursue opportunities to improve member care for high risk members.	Continue with the plan as listed - The High Risk Management Workgroup will continue to pursue opportunities such as explore oversight of ECM Providers, explore expansion of our Nurseline offerings, and continue to develop ER Reduction strategies. Actions and goal outcomes will be reported at UMC	



## 2024 QI Work Plan – Q3 Update

			least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. <b>P&amp;T and BMSC</b> reports to the UMC, and minutes are submitted to UMC quarterly.						November 21, 2024. and QIHEC December 10, 2024.	
Program Oversight	<b>Whole Child Model - Clinical Advisory Committee (WCM CAC)</b> - Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.  Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Whole Child Model Medical Director / Director of Case Management	Program Assistant QI	Medical Management	WCM CAC met scheduled for August 20, 2024. Introduced Dr. Chu as formal WCM CAC member however he was not present. CalOptima Health staff will continue active monitoring of WCM Health Network adequacy, review UM, GARS, BH, and CS. CalAIM data was tabled to the next meeting.  Committee recommended for WCM CAC members to bring up clinically relevant matters for discussion. For example, orthopedic specialist at Medical Therapy Conference and Medical Therapy Units.	Staff will review 7-day readmission (new request) and criteria for 30-day readmission data and report it to Q4 2024 WCM CAC on 11/X/24.	
Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Care Management	TBD	Medical Management	Enhanced Care Management (ECM): a) Safety Net Connect created an audit tool for ECM providers to validate that their enrolled members have identified the Lead Care Manager. b) Ongoing communication to ECM providers for TCS outcomes for enrolled high-risk members. Complex Case Management (CCM): a) Continue monthly NCQA file audits for CCN and HN members open to CCM level of care. Basic PHM/CM: Continue quarterly audits of delegated Health Networks for MOC oversight. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: a) continued discussion in workgroup to obtain data and operationalize oversight. Transitional care services: a) See TOC/Row 61 for TCS updates.	Enhanced Care Management (ECM): a) Assess if there has been improvement to enrolled members with Lead Care Manager contact information populated. b) Ongoing communication to ECM providers for TCS outcomes for enrolled high-risk members. Complex Case Management (CCM): a) Continue monthly NCQA file audits for CCN and HN members open to CCM level of care. b) Potential Q4 MOC Audit with NCQA consulting vendor Basic PHM/CM: Continue quarterly audits of delegated Health Networks for MOC oversight. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: a) continued discussion in	

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									workgroup to obtain data and operationalize oversight. Transitional care services: a) See TOC/Row 61 for TCS updates.	
Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accreditation standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Audit and Oversight	Manager of Audit and Oversight (Delegation)/ Manager Delegation Oversight	Delegation Oversight	<p>Delegate:</p> <ul style="list-style-type: none"><li>• CHOC Health Alliance/Rady's Children's MSO (20)</li><li>• AMVI Care Health Network/Prospect MSO (58)</li></ul> <p>Area(s) Assessed:</p> <ul style="list-style-type: none"><li>• Case Management;</li><li>• Claims; Compliance;</li><li>• Credentialing;</li><li>• Customer Service;</li><li>• Provider Network Contracting;</li><li>• Provider Relations;</li><li>• Sub-Contractual;</li><li>• Utilization Management</li></ul> <p>Corrective Action Plan(s) Issued – CHOC Health Alliance/Rady's Children's MSO:</p> <ul style="list-style-type: none"><li>• Claims (Medi-Cal) – Accepted &amp; Closed</li><li>• Credentialing (All Lines of Business) – Accepted &amp; Closed</li><li>• Customer Service (Medi-Cal) – Accepted &amp; Closed</li><li>• Provider Relations (All Lines of Business) – Accepted &amp; Closed</li><li>• Utilization Management, Concurrent Review (Medi-Cal) – Accepted</li><li>• Utilization Management, Expedited &amp; Standard Denial (Medi-Cal) – Accepted</li></ul> <p>Corrective Action Plan(s) Issued – AMVI Care Health Network/Prospect MSO:</p> <ul style="list-style-type: none"><li>• Case Management (Medi-Cal) – Accepted &amp; Closed</li><li>• Claims (Medi-Cal) – Accepted</li><li>• Claims, Provider Dispute Resolutions (Medi-Cal) – Not Accepted</li><li>• Credentialing (All Lines of Business) – Accepted</li><li>• Provider Relations (All Lines of Business) – Accepted &amp; Closed</li><li>• Utilization Management, Policy (Medi-Cal) – Accepted &amp; Closed</li><li>• Utilization Management, Carve Out (Medi-Cal) – Accepted</li><li>• Utilization Management, Concurrent Review (Medi-Cal) – Accepted</li><li>• Utilization Management, Expedited &amp; Standard Denial (Medi-Cal) – Accepted</li><li>• Utilization Management, Non-Emergency Medical Transportations (Medi-Cal) – Accepted</li><li>• Utilization Management, Physician Administered Drugs (Medi-Cal) – Accepted</li><li>• Utilization Management, Notice of Medicare Noncoverage (OneCare) – Accepted</li><li>• Utilization Management, Organizational Determinations (, Appeals, &amp; Grievances) (OneCare)</li></ul>	Continue to monitor CAPs in "Monitoring" status through acceptance & closure.	



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								– Accepted & Closed • Utilization Management, Physician Administered Drugs (OneCare) – Accepted		
Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of PHM	Manager of Equity and Community Health	Equity and Community Health	1) The implementation of the 2-way text message to promote the asthma program and identify members who wished to receive a call from health coach was successful. The enrollment rate significantly increased to 41% compared to just 10% with cold calls. 2) Plan to continue using PointClickCare to identify members with congestive heart failure (CHF) who have recently been discharged from the hospital and have a primary diagnosis of CHF, enabling early intervention. 3) The Chronic Conditions team continues to collaborate with the QA team's emerging risk outreach initiative. Members identified through the monthly diabetes stratification are matched with the emerging risk list and prioritized for outreach. 4) The Disease Management Satisfaction survey will be sent earlier this year. We have initiated collaboration with the Ushur team to distribute the survey via text message to identified members.	1) We initiated collaboration with the Ushur team to develop an ongoing campaign targeting members identified in the monthly asthma and diabetes stratifications. This campaign aims to promote chronic conditions services and identify members interested in receiving a call from a health coach, thereby reducing the need for cold calls. 2) Disease Management Survey will be launched via text message on 10/6. 3) Enhancements to the monthly stratification list will include adding HEDIS measures that members are still missing, enabling health coaches to educate and support members in completing these measures. 4) Currently working on incorporating Zoom option for members who prefer video calls for coaching sessions. 5) Considering developing a live outbound call campaign using Carenet to contact individuals from the stratification list and schedule appointments with health coaches. 6) We are collaborating with the credentialing/contracting team to add Yumlish as a web-based provider for the CDC Diabetes Prevention Program (DPP).	
Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: (1) Evaluation of current utilization of health education services (2) Maintain business for current programs and support for community. (3) Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health/Manager of Health Education	Manager of Equity and Community Health	Equity and Community Health	1) Evaluation of current utilization of health education services <b>Goal being met:</b> During 2024 Q2, 728 referrals were assigned for health education services very close to the number of referrals in Q1, where 749 referrals were assigned to health education services, similar trends were observed during Q1 and Q2 in 2023 with referrals counts in 700s for both quarters. Classes take more effort to recruit participants, prepare and follow up, therefore participation increase is gradual. In Q2 2024, virtual classes were piloted two times a day on Tuesday, Wednesday and Thursday. Based on attendance, virtual classes were reduced to two evening classes once a week in English and Spanish each. Aside from health education referrals, class participants were 568 in total. This is an increase compared to 183 attendees in Q1 of 2024, and 50 attendees in Q1 of 2023.	Work to implement a services awareness text message and will support the organization-wide referral intake process to help expedite service delivery. With the recent department name/vision change focusing on Equity and Community Health, the department is being restructured with more emphasis on community engagement and yet provide individual interactions for members who choose that option.	

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								<p>2) Maintain business for current programs and support for community  <b>Goal being met:</b> During 2024 Q2, 568 participants attended 67 classes, specifically 33 virtual and 34 in-person classes. Community partners continue to be added for Shape Your Life program expansion. New partners include Prospect Elementary in Orange where 4 parent classes were provided. Collaboration efforts with Northgate Supermarkets during Q2 included 6 market tour events that focused on nutrition education and food demonstrations. Health Education staff continues participating in monthly community collaborations with the Tobacco and Vape Free (TVFREE) Coalition.  3) Improve process of handling member and provider request  <b>Goal being met:</b>  a. The Health Education team developed an electronic referral form that was field tested with participants attending virtual Shape Your Life classes for feedback. The form is on hold for now due an organization-wide approach to referral intake processes. Meanwhile, the team is working on a text message campaign to inform members of available services.  b. Health and Wellness services are mentioned in the new member packages and continue to be promoted at all continuing education training sessions in 2024, along with reminders on how and where to send member referrals.</p>		
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024  Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	<p>1) Updated SDOH member assessment with additional questions and continue to integrate into JIVA  2) Kicked off integration meetings with FindHelp and JIVA and developed training space for staff  3) HL4E certificate program continues through the end of the year to allow staff to complete their certifications. Currently, 74 out of 164 staff have completed their certification program.</p>	<p>(1) Update SDOH Member Assessment in the Member Portal and continue to integrate assessment into JIVA  (2) Continue integration of Find Help into JIVA and train staff  (3) Continue to encourage staff to complete their mini-credentials to earn their certification. Develop a Teach -Back method module to train new member facing staff as part of their onboarding process</p>	
Program Oversight	Long-Term Support Services (LTSS)	95% compliance with TAT	CalAIM Turnaround Time (TAT): Determination completed within 5 business days CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days CBAS Turnaround	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of LTSS	Manager of LTSS	Long Term Care	<p>CalAIM TAT: 99.75% (Met)  CBAS Inquiry to Determination TAT: 99.63% (Met)  CBAS TAT: 99.57% (Met)  LTC TAT: 98.99% (Met)</p>	Continue with plan. Monitor daily inventory and TAT.	

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			Time (TAT): Determination completed within 5 business days LTC Turnaround Time (TAT): Determination completed within 5 business days							
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activities for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024  Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Program Manager of QI	Director of Quality Improvement	Quality Improvement	<b>HP Accreditation:</b> 1) CalOptima Health successfully renewed our health plan accreditation status on July 10, 2024, and was awarded Accredited status. 2) Our NCQA Health Plan Rating was updated on September 15, 2024, to a rating of 3.5 stars. 3) NCQA released the 2025 HP Standards, which were shared with internal stakeholders in September 2024. <b>HE Accreditation:</b> 1) DHCS will require all health plans to obtain HE accreditation by January 1, 2026 2) CalOptima Health is engaged with NCQA consultants to conduct a readiness assessment and perform a gap analysis 3) Consultants have been providing recommendations and have developed a work plan. 4) CalOptima Health has established a Health Equity committee and five work groups. Status updates are shared with the HE committee, and workstreams 5) meet frequently to provide updates. 6) Submitted NCQA Health Equity pre-application on September 13th, 2024, and were given a survey date of October 7, 2025.	<b>1) HP Accreditation:</b> Consultants will perform a Kick-off webinar to go over standards and how to interpret standards in October 2024. A separate training session with stakeholders on analytical reports will be scheduled in October 2024. Consultants will be scheduling file reviews in November 2024. Delegates will be notified in advance of the audits. <b>2) Health Equity Accreditation:</b> Five workgroups continue to work on deliverables needed. Our consultants to perform another GAP analysis to see where we are in 4Q2024.	
Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARs measures for focused improvement efforts.	By December 2024  Report program update to QIHEC Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024 11/5/2024 Q1: 01/14/2025	Director of Medicare Stars and Quality Initiatives	Manager of QA	Quality Improvement	Continued monthly workgroup meetings for Operations, Equity and Community Health, Case Management, and Pharmacy. Created a revised Star Rating tracker in conjunction with Rex Wallace Consulting; utilizes a '3 Ways to Win' approach and provides goals for each Stars measure. Launched a weekly huddle with the Case Management team to address the OMW measure. Ongoing telephonic outreach to members across multiple measures via vendor Carenet. Provided multiple teams with training on the Decision Point Insights platform.	Continue with plan as listed	
Program Oversight	Value Based Payment Program	Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 11/5/2024 Q1: 01/14/2025	Manager of Quality Analytics	Manager Quality Analytics	Quality Analytics	HN prospective rate reports have been distributed on a monthly basis. Quality update calls with each Health Network continue to be held every other month. The Medi-Cal Quality Improvement Grant awards for Health Networks were announced in September. Seventeen (17) proposals across five (5) Health Network partners were approved (over \$1.8 M in funding and support for 16 quality measures).	Continue with plan as listed	

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			hospital quality program performance							
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1 02/11/2025	Director of Quality Analytics	Manager Quality Analytics	Quality Analytics	Follow-up after ED visit for mental illness (FUM) and Follow-up after ED visit for alcohol and other drug abuse or depend (FUA) are below 33rd percentile. Have high risk not meet MPL for MY2024.  An update will be presented by Mike Wilson from QA team at the 11/5/24 QIHEC.	working with BH team for additional data source	
Program Oversight	School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Director of Behavioral Health Integration	Project Manager BHI	Behavioral Health Integration	1) Full installation of 5 SBHIP-funded WellSpaces completed brings the total to 7 out of 10 installed 2) Hazel Health surpassed 1,000 care inquiry referrals, also the number of students with visits has increased since the start of school. 3) Individual meetings with CHOC, HAZEL, WYS, and OCDE were conducted to review their SBHIP-funded project level of implementation for the remaining time of the program. 4) CalOptima Health co-sponsored and attended the OCDE Mental Health Summit on August 22, over 400 MH school staff attended. 5) Received DHCS approval notice for the June Biquarterly Report.	1) Complete 4 project outcomes reports by 12/31/24, these are the last reports required for the program 2) Work with Contracting to amend the initial OCDE SBHIP MOU - the term is to be extended 3) Discussions with Contracting to continue regarding the development of an agreement for the coordination of care and needed as the final deliverable for one of the project outcome reports 4) Work with internal departments SMEs to fulfill the requirements to support paying the CYBHI fee schedule services through DHCS third-party administrator Carelon Behavioral Health	
Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Medical Management	1) Board approved 15 grant proposals from 13 organizations on August 1, 2024 2) Executed all grant agreements in early September 2024. Completed the first grant payment. 3) Held the grantees' kickoff meeting on October 2, 2024. 4) Currently engaged in weekly meetings with mPulse to develop and refine short messaging services (SMS) content, with the goal of improving member engagement and scheduling of screening appointments.	1) Host a virtual webinar to provide reporting instructions. 2) Meet with individual grantees to provide support (if requested). 3) Submit SMS content(s) to DHCS for approval. 4) Finalize the research & evaluation contract with UCI	
Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	1. Member Health Reward: CCS (MC) - 959; BCS (MC) - 398; BCS (OC) - 135; COL (OC) - 65 2. Mailings: CCS MC 127684; BCS (MC)- 36488; BCS (OC)- 2331 3. CareNet Live Call: CCS (MC)- 30694; BCS (MC)- 25280; BCS (OC)- 1550; COL (OC)- 3081 3. Continuation of CCN OC and MC COL GI outreach pilot program plus elimination of prior authorization for GI screening consult for the OC population 4. Prep for CCN Cologuard launch with Exact Sciences (go live in October) 5. August 2024 Prospective Rate Data: CCS (MC) -	Continue with plan as listed	

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			channel targeted member, provider and health network engagement and collaborative efforts.					41.92%; BCS (MC) - 47.48%; BCS (OC) - 59%; COL (OC) - 56%		
Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collaboratively with the Communications department to Fax blast non-compliant providers letter activity ( approx. 200 providers) by second quarter. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/202410/08/2024) Q4 2024 Update (02/11/2025 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS RATES Q3 (July): Initiation Phase-46.67% Continuation and Maintenance Phase- 51.04%  1) Monthly text messaging outreach to members.(July, August, September) 2) Member Health Reward flyers mailed to 459 eligible members on 07/15/2024 and 161 eligible members on 09/10/2024. 3) Developed new text message script for Member Health Reward and presented at BHQI Workgroup for approval on 07/18/2024. 4) ADD data is now available through the Provider Portal 08/15/2024. 5) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 6) Monthly Health Network Communication BH Updates.	1) Q4 data will be pulled to initiate best practices letter and tip-sheet to non-compliant providers through the provider portal. 2) Continue to mail out Member Health Rewards flyer to eligible members. 3) Awaiting for DHCS approval of text message script for Member Health Rewards. 4) Work with text messaging vendor to enter new Member Health Reward campaign on vendor platform. 5) Develop listening sessions with Providers to educate/train on how to obtain BH data.	
Quality of Clinical Care	Health Equity/Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/202410/08/2024) Q4 2024 Update	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Goals Met. 1) Attended collaborative meetings between teams to identify best practices to implement. (UMC,WCM) 2) BHI continued to monitor monthly ACES report through Tableau.	1) Continue monitor ACES tableau report on a monthly basis.	

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				(02/11/2025 01/14/2025)						
Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined- All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primary Care Providers (PCP) for members in need of metabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to the next top 50 prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs) 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/202410/08/2024) Q4 2024 Update (02/11/2025 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS RATES Q3 (Ju;y) : Blood Glucose all ages: 36.18%, Cholesterol all ages: 20.23%, Glucose & Cholesterol Combined all ages: 19.08% 1) Barriers included: Identifying members prescribed antipsychotic medication still in need of diabetes screening, cholesterol screening, and both cholesterol and diabetes screening test through Tableau Report. 2) The following materials have been disseminated to Providers (July, August, September): a) Provider Best Practices Letter. b) APM Provider Tip Sheet. 3) Collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis (July, August, September). 4) Mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis (July, August, September). 5) Text Messaging Campaign (July, August, September). 6) APM data is now available through the Provider Portal on 08/15/2024. 7) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 8) Monthly Health Network Communication BH Updates.	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue data pull for text messaging campaign. 3) Continue mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 4) Continue with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 5) Schedule listening sessions with Providers to educate/train on how to obtain BH data.	
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/202410/08/2024) Q4 2024 Update (02/11/2025 01/14/2025)	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	PR HEDIS RATES Q3 (July) :Effective Acute Phase Treatment: 64.79%, Effective Continuation Phase Treatment: 43.33% 1) Data report received monthly 2) Drafted following materials: a) AMM Provider Tip Sheet letter submitted for internal review process 3) Text message campaign launched (July, August, September). 4) AMM data now available through Provider Portal on 08/15/2024. 5) Quality Champions meeting with The Coalition of	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue Text Messaging campaign. 3) Start mailings to providers (letter). 4) Schedule listening sessions with Providers to educate/train on how to obtain BH data.	



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			associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.					Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 6) Monthly Health Network Communication BH Updates		
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025) 01/14/2025)	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	PR HEDIS Rates Q3 (July): M/C:57.74% OC: N/A 1) We are currently monitoring this measure. 2) Member Fall Newsletter approved 07/2024. 3) SMD data now available through Provider Portal on 08/15/2024. 4) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 5) Monthly Health Network Communication BH Updates.	1) Continue to monitor prospective rates on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement. 3) Schedule listening sessions with Providers to educate/train on how to obtain BH data.	
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025) 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q3 (July): 30 day- 25.02%, 7 day- 13.98% 1) The main barrier has been not having the bandwidth for outreach to members from daily vendor ED report. 2) Working with vendor to create a cohort report of FUM data only. 3) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis as well as weekly reminder in HN communication. 4) Bi-weekly Member text messaging. 5) Article promoting Telemed2U, telehealth services, will be included in Fall member newsletter. Article will help with possible provider access issues and increase likelihood of ED follow up visits. 6) FUM data now available through the Provider Portal. 7) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 8) Developing IVR calls for ED follow-up. 9) Monthly Health Network Communication BH Updates.	1) Continue bi-weekly text messages based on real time ED data. 2) Continue sharing ED data with HN's via sFTP and weekly HN Communication. 3) Collaborate with NAMI to share real-time ED data for member outreach/NAMI by Your Side. 4) Collaborate with Telemed2U provider and internal ITS team to develop implementation plan for Member Outreach 5) Schedule listening sessions with Providers to educate/train on how to obtain BH data. 6) Work with vendor to create campaign for the IVR calls for ED Follow-up.	

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			Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)							
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare-Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaboratively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward Program.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025) 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q3 (July): M/C:58.40% OC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau Report in August and September. 2) Conducted a text message campaign to reach out to members re: getting their glucose lab screening (July, August, September). 3) Mailed out Member Health reward flyer to 1,164 eligible members on 08/01/2024, and mailed to 287 providers on 08/01/2024. 4) Continue to collaborate with Quality Analytics Team to retrieve data sourcing automation for Tableau on a monthly basis, confirmed that 1583 members received Member Health reward on 09/16/2024. 5) Member Fall Newsletter approved 07/2024. 6) SSD data now available through Provider Portal on 08/15/2024. 7) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 8) Monthly Health Network Communication BH Updates.	1) Continue tracking members in need of glucose screening test. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Continue data pull for text messaging campaign 4) Mail out member health rewards flyer to eligible members. 5) Mail out to top 60 providers with the following: a.) Medical Director Letter b.) List of members/patients in need of screening c.) Provider Tool Tip Sheet 6) Schedule listening sessions with Providers to educate/train on how to obtain BH data.	
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP: Improve the percentage of members enrolled into care management, CalOptima Health community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025) 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration/ Quality Analytics	Conduct Annual oversight of MC Non Clinical PIPs (Jan 2023 - Dec 2025) Improve the percentage of members enrolled: Baseline Measurement Period: Submitted to DHCS 09/09/2024. Remeasurment 1 Period : 01/01/24 -12/31/24 Remeasurment 2 Period : 01/01/25-12/31/25	1) Receiving daily report from vendor which contains Real-Time ED data for CCN and COD members. 2) Internal report developed that identifies members enrolled in CCM and ECM for CCN who meet FUM/FUA criteria for the duration of each measurement period. 3) Collaborate with telehealth provider, Telemed2U, and internal ITS team to develop implementation plan for Member Outreach. Vendor to provide information about case management including ECM and referrals	



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Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025) 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q3 (July): 30-Day- 21.05%, 7-Day- 11.51% 1) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis as well as weekly reminder in HN communication. 2) Bi-weekly member text messaging 3) Article promoting Telemed2U, telehealth services, will be included in Fall member newsletter. Article will help with possible provider access issues and increase likelihood of ED follow up visits. 4) Developing IVR calls for ED follow-up. 5) FUA data now available through Provider Portal. 6) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 7) Monthly Health Network Communication BH Updates.	1) Continue bi-weekly text messages based on real time ED data. 2) Continue sharing ED data with HN's via sFTP and weekly HN Communication. 3) Collaborate with Telemed2U provider and internal ITS team to develop implementation plan for Member Outreach. 4) Work with vendor to create campaign for the IVR calls for ED Follow-up. 5) Schedule listening sessions with Providers to educate/train on how to obtain BH data.	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: EED (MC) - 185; EED (OC) - 79 2. EED VSP mailing from January to September: MC - 5144; OC - 1449 3. Diabetes mailing September: MC- 30362 OC- 3093 4. CareNet Live Call from June to September: OC- 1344 5. VSP data sharing to Health Network partners; multiple Health Networks are now receiving Production data and the remaining ones are completing testing 6. August 2024 Prospective Rate Data: EED (MC) - 40.79%; EED (OC) - 59%	Continue with plan as listed	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better) MY2024 Goals:	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: HBD (MC) - 385; HBD (OC) - 125 2. Diabetes mailing September: MC- 30362 OC- 3093 3. CareNet Live Call from June to September: OC- 2048 4. August 2024 Prospective Rate Data: HBD (MC) - 70.37%; HBD (OC) - 67%	Continue with plan as listed	

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		MC: 29.44%; OC: 20%	channel targeted member, provider and health network engagement and collaborative efforts							
Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy): HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Equity and Community Health/ Quality Analytics	Member initiatives: 1) Bright Steps Program: prenatal and posptartum education to participating members. 2) Ongoing: Postpartum Health Reward for members that complete postpartum care between 1-12 weeks after delivery.  1) August 2024: Maternal Health workgroup meeting to discuss member journey. QA will develop a prenatal and postpartum care journey to support member messaging. 2) Community Clinic Forum presentation to support compliance for providers and clinics that utilized bundled coding practices.  Per August 2024 prospective rates, Timeliness of Prenatal Care is performing slightly lower than this time time last year with a rate of 67.26% and Postpartum Cre is performing slightly higher than this time time last year with a rate of 65.83%.	Continue with plan as listed. Postpartum member call campaign planned for Q4 Development of guide for providers that participate in bundled billing for prenatal and postpartum care.	
Quality of Clinical Care	Maternal and Adolescent Depression Screening	Medi-Cal Only - Meet the following goals For MY2024 HEDIS:	1) Identification and distribution of best practices to health	Report progress to QIHEC quarterly: Q2 2024 Update	Director of Operations Management /	Manager of Quality Analytics /	Operations Management/	DSF-E PR HEDIS Rates Q3 (July): Screening Total 0.02%; Follow Up Total 36.36% 1) Data collection is still the main barrier. Currently	DSF-E: Distribute best practice guidelines for follow-up visits to providers and health network.	

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		DSF-E Depression Screening and Follow-up for Adolescent and Adults - Screening: 2.97% PND-E Prenatal Depression Screening and Follow-up - Screening: 8.81% PDS-E Postpartum Depression Screening and Follow-up: 27.77%	network and provider partners. 2) Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion. 3) Targeted member engagement and outreach campaigns in coordination with health network partners. 4) Provider education (CE/CME) in Q3.	(08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Behavioral Health Integration	Manager of Behavioral Health Integration	Behavioral Health Integration	capturing information by supplemental data. The Behavioral Health Quality Improvement Workgroup exploring ways to obtain additional supplemental data to better capture completed screenings and follow up visits. 2) Drafted Provider Tip Sheet letter submitted for internal review process. 3) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 4) Monthly Health Network Communication BH Updates.		
Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%;  Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s)  In partnership with the Orange County Health Care Agency, CalOptima Health	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Member Initiatives: 1) Ongoing: Blood Lead Health Rewards for testing at 12 and 24 months of age. 2) 2-way SMS campaign via Ushur and in alignment with AAP periodicity schedule for well-child visits. Campaigning included reminders for lead testing. 3) Live call campaign via vendor CareNet to educate and encourage lead testing.  Monitoring Initiatives: 1) In progress: Development of medical record review process to monitor CalOptima Health providers and the adherence to lead requirements (e.g., testing, follow-up, anticipatory guidance)  Provider Initiatives: 1) July 2024: Provider fax campaign to providers assigned to children ages 0-6. Fax campaign provided focus on providing resources related to lead requirements such as anticipatory guidance, patient educational materials, etc. 2) July 2024: Posting of Stay Compliant with State-Issued Lead Requirements on CalOptima Health website.  Per August 2024 prospective rates, Lead Screening in Children measure is 65.03% and is on track to meet the 50th percentile.	Continue with plan as listed	

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			will co-develop educational toolkit on blood lead testing.							
Quality of Clinical Care	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS <b>MY2024</b> Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Member Initiatives: 1) 2-way SMS via Ushur for multiple pediatric age groups in place. 2) Ongoing telephonic outreach to pediatric members for multiple measures via Carenet.  Provider/HN Initiatives: 1) Detailed W30 reports continue to be distributed regularly.  CIS performance continues to trend lower than same point-in-time last year; as such, Carenet was provided with a Q4 focus report of members due for CIS that are still actionable (haven't reached their 2nd birthday yet).	Continue with plan as listed	
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits.  Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Member Initiatives: 1) 2-way SMS via Ushur for multiple pediatric age groups in place. 2) Ongoing telephonic outreach to pediatric members for multiple measures via Carenet.  Provider/HN Initiatives: 1) Detailed W30 reports continue to be distributed regularly.	Continue with plan as listed	
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data	Monitors health network's compliance with	Semi-Annual Report to QIHEC Q2: 04/09/2024	Director of Finance	Manager of Finance	Finance	Medi-Cal: HMOs and PHCs met at least 6 of 8 measures; CHOC met 6 of 6 measures; SRGs met 5 of 6 measures. OneCare: 5 networks met all	Encounters team is working with AMVI to review root causes of low submissions and plans for	

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		submitted by health networks	performance standards regarding timely submission of complete and accurate encounter data.	Q4: 10/08/2024 postponed to 11/5/2024				measures; 4 networks met 3 of 4 measures; 1 network met 2 of 4 measures	remediation. They can be subject to a Corrective Action Plan.	
Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025  Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	<b>FSR/MRR/PARS, Community-based Adult Services (CBAS) and Nursing Facilities (NF) Oversight</b> <b>A. FSR:</b> Initial FSRs=15; Initial MRRs=8; Periodic FSRs=66; Periodic MRRs=76; On-Site Interims=4; Failed FSRs=0 Failed MRRs=12 CAPs: CE=39; FSR=63; MRR=61 <b>B. PARS:</b> Completed PARS=110 (Basic Access=44 Limited Access=66 <b>C. CBAS Oversight:</b> Critical Incidents=16 (16 COVID cases); Non-Critical Incidents=22; Falls=10; Audits Completed=12; CAPs Issued=8; Unannounced Visits=0 <b>D. NF Oversight:</b> Critical Incidents=14; On-Site Visits=12; Unannounced Visits=0	FSR/MRR: In order to avoid, a third subsequent failed audit (FSR and/or MRR) and removal from the CalOptima Health provider network, extensive education and additional resources are being provided to sites with two subsequent FSR and/or MRR failed audits. PARS: Continue with plan, as listed.	
Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	202 PQIs closed in Q3; 57 (28%) were declined grievances. 36 (18%) were leveled QOC; 166 (82%) QOS. We have 721 PQIs currently open. Nine PQIs leveled 1, 2 or 3 were presented to CPRC. PQI trends for 1/1/24-6/30/24 identified an ABA group and a acute care hospital. During this time frame, most quality of care PQIs were categorized as medical care, and most were either mismanaged care or treatment (delay, failure, inappropriate or complications).	In order to reduce the number of PQIs being opened, we are meeting with departments to find other ways to address issues with providers that are not truly a PQI. One strategy is to develop a Provider Action Workgroup where departments may bring providers for action. The policy and charter is in development with a desired completion by Q1 2025.	
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	Initial BH Credentialing Q3 = 5; Initial CCN Credentialing Q3 = 18	Initial credentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial credentialling.	
Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Quality Improvement	Manager Quality Improvement	Quality Improvement	BH Recredentialing - Q3 = 18; CCN Recredentialing Q13 = 49. For Q3 we did not have any recredentialing files out of compliance	Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the recredentialing of providers. This will ensure that we continue with compliance and	

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									timeliness of the recredentialing files.	
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	<p>Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025):</p> <p>CCIP Study - Comprehensive Diabetes Monitoring and Management</p> <p>Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes</p>	<p>Report progress to QIHEC</p> <p>Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)</p>	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	<p>1. Member Health Reward: EED (OC) - 79; HBD (OC) - 125</p> <p>2. EED VSP mailing from January to September: OC - 1449</p> <p>3. Diabetes mailing September: MC- 30362 OC- 3093</p> <p>4. CareNet Live Call from June to September: EED (OC)- 1344 HBD (OC)- 2048</p> <p>5. Emergin Risk (telephonic outreach via Equity and Communiy Helath department staff)</p> <p>5. August 2024 Prospective Rate Data: EED (OC) - 59%; KED (OC)- 45%; HBD PC (OC)- 67%; MAD (OC)- 93%; SUPD (OC)- 85%</p>	Continue with plan as listed	
Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	<p>Assess and report the following activities:</p> <p>1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance.</p> <p>2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks.</p> <p>3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring.</p>	<p>Report progress to QIHEC</p> <p>Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)</p>	Director Medical Management/Case Management	QI Nurse Specialist	Case Management	<p>1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance.</p> <p>a) CC0258 partially remediated;</p> <p>b) CMS raised cut points for Star Measure on HRA completion by 4% and Case Mangement is on track to acheive HRA collection to meet three stars in Q4.</p> <p>c) Q2 HRA1 adjusted score: Members reached and willing to complete HRA is 100%</p> <p>d) Q2 ICP2 adjusted score: Members reached and willing to complete ICP is 91%</p> <p>e) ICT-pending Jiva remediation and development of SNPE reporting.</p> <p>2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks.</p> <p>a) Ongoing monthly communications to CCN and Health Networks for ICP1 development status for newly effective members.</p> <p>b) Continue to provide feedback on annual ICP development and missing face-to-face interactions. Continue communication process with Network</p> <p>3) Creation and implementation of the Oversight audit tool.</p> <p>a) Audit tool review for updates.</p>	<p>1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance.</p> <p>a) CC0258 partially remediated and will resume per JIVA remediation priorities;</p> <p>b) Ongoing monitoring of initial HRA completion for acheiving three stars.</p> <p>c) Report on Q3 HRA1 adjusted score.</p> <p>d) Report on Q3 ICP2 adjusted score.</p> <p>e) ICT-pending Jiva remediation and development of SNPE reporting.</p> <p>2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks.</p> <p>a) Ongoing monthly communications to CCN and Health Networks for ICP1 development status for newly</p>	

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									<p>effective members.</p> <p>b) Continue to provide feedback on annual ICP development and missing face-to-face interactions. Continue communication process with Network</p> <p>3) Creation and implementation of the Oversight audit tool.</p> <p>a) Share Audit tool with Health Network.</p>	
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	<p>Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members</p>	<p>Update from MemX to QIHECQ2: 06/11/2024Q3: 09/10/2024Q4: 12/10/2024Q1 03/11/2025</p>	<p>1) Director of Provider Network2) Director of Contracting</p>	Analyst of Quality Analytics	Contracting/Provider Data Operations	<p>1. Transition from QA to Provider Data Operations completed2. Network Adequacy Workgroup conducted first monthly meeting to discuss network adequacy as a whole, Q3 gaps, and an action plan to reduce gaps specific to PMR on plan level and T&amp;D for CCN HN level3. Provider Data Ops provided leads list to Contracting &amp; PR to help close CCN time and distance gaps4. No HN closed CAP this quarter. Based on continued good faith efforts of HNs to contract providers, COH establish and authorized AAS process to close outstanding CAPs 5. 4 out of 6 HNs closed CAP via AAS (FCHS, Noble, Optum, Prospect). AMVI and UCMG issued Non-Compliance notice for not meeting deadline submission for AAS.</p>	<p>1. Provider Data Ops collaborating with PR to receive needed AAS from AMVI and UCMG2. PR conducting provider outreach based on leads list to gauge contracting interest to close CCN time and distance gap3. Provider Data Ops - Program Mgmt &amp; Analytics working on provider leads list to help close Plan level gaps identified in Q3</p>	
Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	<p>Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely access. 3) Continue to educate providers on timely access standards 4) Develop and/or share tools to assist with improving access to services.</p>	<p>Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025</p>	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	<p>All eleven HN CAPs issued in December 2023 (2022 Timely Access Survey results) have been closed.</p> <p>In June-2024, 110 CAPs were issued to individual providers based on 2023 Timely Access Survey findings.</p> <ul style="list-style-type: none"> <li>As of mid-October, received responses from 65 (59%) of the providers</li> <li>Review of the responses and validation of compliance for select telephone measures began in September</li> <li>Timely Access workflows and tools completed. Moving forward will be updated as needed.</li> </ul> <p>In June 2024, Carenet conducted an interim telephone audit on 758 providers identified as non-compliant for telephone measure “instruct caller to ER or Dial 911 in case of an emergency” . Results are as follows and additional follow-up is taking place with those who remain non-compliant:</p> <ul style="list-style-type: none"> <li>Non-Compliant: 245</li> <li>Compliant: 511</li> <li>Unreachable: 2</li> </ul> <p>Carenet is currently fielding an In-Office Wait Time survey to members. Survey started in August and scheduled to conclude in November.</p>	<p>2024 Timely Access Survey scheduled to start October 15.</p> <p>HN Timely Access CAPs to be issued in Q4 based on 2023 Access Survey findings</p> <p>Continue to outreach to non-compliant providers for Timely Access and review responses to CAPs.</p>	
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	<p>1) Annual submission of SNC to DHCS with AAS or CAP</p>	<p>Submission: 1) By end of January 15, 2024 2) By end of Q2 2024</p>	Director of Provider Network / Director of Medicare Stars	Quality Analyst	Network Operations Provider Data Operations/Quality Analytics	<p>Submitted 2023 Quarterly CAP status update - 4 of 6 HNs closed via AAS; AMVI and UCMG still open SNC Report Q3 2024: August 274 file results: communicated to HNs</p>	<p>1. PR reaching out to AMVI and UCMG regarding CAP closure 2. Verify that approved AAS have been posted by HNs to their</p>	



## 2024 QI Work Plan – Q3 Update

			2) Monitor for Improvement 3) Communicate results and remediation process to HN	3) By end of Q3 2024  Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	and Quality Initiatives			-Time/Distance: all HN did not meet. Top 5 gaps were Phys Med/Rehab, Endocrinology, Dermatology, Neurology and HIV/AIDS Specialist/Infectious Diseases. South County remains as the general area where the gaps are occurring - OON: using MCPD-OON Data Q2 2024 submission to DHCS - BH: 16; GC:139 - Network Capacity/Ration (FTE): HNs met standards -PMR: 7 HNs now meet PMR, up 3 from Q2; ongoing gaps are in Orthopedic Surgery, Ophthalmology, and Gastroenterology. AMVI is only 1 unique provider short of meeting requirements under Neurology and Pulmonology; AltaMed's current gap may be due to their provider network beign reloaded - PCP: re-opened 3 panels and no new closures - WCM: Plan level met all specialties. All HNs confirmed met (UCMG & AMVI closed gaps) FINDINGS: Throughout Q3, as health networks worked on closing 2023 SNC CAPs for time and distance, they expanded their provider networks which resulted in an overall decrease of time and distance gaps from Q2 to Q3. The only exception is UCMG which increased in gaps, mostly in Dermatology. Timely Access: All eleven HN CAPs issued in December 2023 (2022 Timely Access Survey results) have been closed.	website by due date of October 30th 3. PR to do recruitment outreach to close CCN time and distance gap 4. Timely Access: HN Timely Access CAPs to be issued in Q4 based on 2023 Access survey findings	
Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	1) <u>Increase health network and provider communications, training, and resources</u> a. Communication: Reminder to HNs via HN Weekly Communication to sign up for IHA CME; Most HN updates have been moved over to HN Quality Update Meeting (bimonthly) b. Presentations and Trainings HNs/Providers: 1 HN Collaborative Quality Forum Meeting, 21 HN Quality Update Meetings, 2 QIHEC, 2 CHCN Virtual Meetings, 2 PHMC Meetings, 1 CME, 2 QIHEC Meetings, 1 DOC Meeting c. Provider Toolkit Resource: The document was placed on hold due to the website redesign; Components of the Provider Toolkit document are linked on the website. d. Provider Portal: Promoting IHA Report and Member Roster at HN and provider trainings and presentations. 2). <u>Expand oversight of provider IHA completion</u> a. IHA Chart Review Audits: Encountered barriers with communication and responsiveness from PCP offices; escalated communication to Medical Director for Clinic Leadership outreach, office direct calls, and provider office visits b. Provider Office Visits: 7 Provider office visits in addition to Teams meetings with all providers selected for chart review audits for Q3 c. KPI Metric Expectation for HNs: Individually met with all HNs at least once; provided them each with the Delegation Oversight Dashboard Response Form	1) <u>Increase health network and provider communications, training, and resources</u> -Provider Toolkit: Resume development upon COMMS confirmation of the website redesign project completion. -Communication, Presentations and Trainings- HNs/Providers: Continue to present and provide trainings on IHA; HN Forum IHA presentation was rescheduled to Q4 2). <u>Expand oversight of provider IHA completion</u> -IHA Chart Review Audits: Establish an approach to handle providers/clinics that are not responsive to records requests (including but not limited to education, failed chart review, corrective action plan, etc.) -KPI Metric Expectation for HNs: Implement Corrective Action Plans to any Health Network that did not return Delegation Oversight Dashboard Response Forms and to the lowest performing HN(s) -KPI Metric Tracking: Continue	



2024 QI Work Plan – Q3 Update

								to fill out to report back on what actions they are taking to increase rates and track their performance d. KPI Metric Tracking: Tracking HN performance and sharing at HN Quality Update Meetings and during individual HN meetings <u>3) Increase member outreach efforts</u> a. Text Message campaign for new members + IHA: Approved by DHCS on 9/26/2024; translation completion date 10/10/2024. Current Step: The text message is being processed, following the COMMS text message request process, in 7 threshold languages (can take up to 2 months). b. Ongoing IVR Campaign: Sent out twice monthly to new members	tracking HN performance and sharing at HN Quality Update Meetings and during individual HN meetings <u>3) Increase member outreach efforts</u> - Text Message campaign for new members + IHA: Anticipated launch in December. - IVR Campaign: Continue ongoing campaign, twice monthly	
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024  Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst for Quality Analytics/ Manager of Provider Data Management Services	Provider Data Operations Management Services	1. ANC monitoring has transitioned to Provider Data Operations - Program Management 2. Per Q3 Network Adequacy Report, the plan meets requirements for MPT, capacity/ratio (FTE) and time/distance 3. No update on AAS request submitted in March	1. Prepare requirements for 2024 Annual Network Certification 2. Update changes to policies and procedures	
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	QA Project Manager	Quality Analytics	1. Closed 2. Closed 3. Pending receipt of HNQR.	1. Closed 2. Closed 3. Analysis of HNQR when available and identify next steps for low performing Health Networks.	
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of GARS	Manager of GARS	GARS	Trends identified in <u>Member Appeals</u> : tertiary level of care/specialty care denials and continuity of care - State Fair Hearings: 22 Received (10) Upheld (2) Overturned - COC w/OON Pain Management (12) Dismissed - Maximus: 32 Submitted (27) Upheld (1) Dismissed (4) Overturned - OO Country Reim, COC w/Wound Care Provider, In Home Physical Therapy, COC w/Vascular Surgeon  Trends identified in <u>Provider Appeals/Disputes</u> : clinical edits denials, level of payment disputes, failure to obtain authorizations. Additional trends worth noting	The department will continue to perform quarterly and year to date reviews to identify trends. This information will be presented to GARS Committee as opportunities to improve operations across the organization. Next GARS Committee meeting is scheduled for November 13, where Q3 data will be presented.	

## 2024 QI Work Plan – Q3 Update

			grievance and appeals					were - CalAim Provider Denials due to incorrect billing and Cotiviti Overturns Increased 20% over Q1  Trends identified in <u>Grievances</u> : Authorization Delays, Plan Customer Service, Provider/Staff Attitude, Provider Availability and Transportation.		
Quality of Service	Customer Service	Implement customer service process and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Associate Director of Customer Services	Manager of Customer Service	Customer Service	Customer Service ran KPI data and reported results to QIHEC. DHCS' average speed of answer of not exceeding 10 minutes: Goal was met (1 min and 45 sec). Internal business goal of abandonment rate not exceeding 5% met: Goal was met (4.8%). Accomplishments: Hired additional staff, various departments staggered member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	Continue with plan	
Quality of Service	Medi-Cal Customer Service Performance Improvement Project	To meet Medi-Cal Customer Service KPIs by December 31, 2024: Internal call abandonment rate of 5% or lower, DHCS' 10 minutes average speed of answer	1) Partnering with HR to onboard more permanent and temporary staff to service inbound calls. 2) Interacting with various departments involved with member engagement campaigns and determine if they're able to update instructions for targeted members (i.e., instead of calling customer service, have them utilize the member portal).	Report progress to QIHEC quarterly: Q2-2024 Update (08/13/2024) Q3-2024 Update (11/05/2024) Q3 2024 Update (07/09/2024) Q4-2024 Update (02/11/2025) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Associate Director of Customer Services	Manager of Customer Service		Goals met	No further action required.	
Safety of Clinical Care	Coordination of Care: Member movement across practitioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement: 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Case Management	TBD	Medical Management	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement: a. Multiple meetings with Claims, UM, PR, Customer Service, and other teams to discuss eliminating prior auth for preventive screenings (including the diabetic eye exam measure). 2) Provider and member education: a. Ongoing production data obtained from VSP and posted to Health Networks: CHOC: posted on 9/5 Noble: posted on 9/5 Prospect: posted on 9/10 b. Ongoing communication to members monthly basis from VSP for those in need of eye exam.	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement: a. Ongoing monthly meetings b. Several eye exam CPT codes to be removed from Prior Authorization list effective 10/1/2024. 2) Provider and member education: a. Ongoing plan to send VSP data to health network partners to close data gaps for the Eye Exam Diabetes measure. b. Ongoing communications to members monthly basis from VSP on need for eye exam.	

## 2024 QI Work Plan – Q3 Update

Safety of Clinical Care	Emergency Department Member Support	Emergency Department Diversion Pilot has been implemented. In 2024 plan to expand a virtual program to additional hospital partners starting with UCI.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of LTSS	Manager of LTSS	LTSS	No metrics to report, still in development.	Two staff members (MSW & RN) were hired in September and are starting the end of October. They will go through CalOptima Health LTSS and UCI emergency department orientation for approximately 30 - 45 days. After orientation they will be embedded in the UCI ED approximately 80% of their time and remainder working virtually to support members in the ED.	
Safety of Clinical Care	Coordination of Care: Member movement across settings - Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% from Q4 2023 by end of December 31,2024.	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of UM, CM and LTSS	Manager of Medical Management	Utilization Management Case Management Long Term Care	1) IPP 4.3 Report (percentage of members who had ambulatory visits within 7 days post hospital discharge) = 40.03% 2) Established reports for FFS Medicare program [Post-discharge Dashboard] 3) Developed a process and procedures for outreaching to pregnant members (TCS high-risk) not enrolled in Bright Steps. Hired a Care Manager to conduct these outreaches [July 2024] 4) Developed the Ushur texting campaigns to promote TCS	1) Launch texting campaign using the Ushur platform (Q4) 2) Continue with motivational interviewing trainings 3) Continue improving outreach efforts for TOC. (Non-Bright Steps members are receiving targeted outreach) 4) Review DHCS LTSS resource guide for enhancement opportunities 5) Develop a process for identifying FFS Medicare members in need of TCS 6) Continue educating CalAIM ECM Provider to documenting Lead Care Managers in CalOptima Connect.	
Cultural and Linguistic Appropriate Services	Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from 41.90% to 55.78% by 12/31/2024.	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	Findings: As part of the parental/guardain reminders, call also assessed for barriers and facilitators to well-child visits. Challenges included limitations with successfully being able to outreach to parents/guardians of child members. Out of 85 members, was only able to successfully reach 24 members. Key highlights: • Parental knowledge- CalOptima Health assessed for knowledge as it relates to the importance of well-child visits and what should be expected at these visits. 21.18% expressed having knowledge of the importance of the visits and 18.82% did not express having any understanding. Some parents drew on the knowledge from their previous experiences with other children. • Scheduling- When inquired about the scheduling of the next well-child visit, 67.65% (n=23) responded not having a visit scheduled, or being unsure, followed by 32.35% reporting that they had the next well-visit	Utilize findings to develop new intervention for 2025	

## 2024 QI Work Plan – Q3 Update

								<p>scheduled with the PCP.</p> <p>When attempting to assess for barriers and facilitators, 6 of the 34 parents declined to proceed with the call. The following narrative is based on 28 successful parental interactions.</p> <ul style="list-style-type: none"> <li>Barriers to well-child visits- 35.29% (n=12) of parents reported experiencing challenges that impact their ability to attend well-child visits. Factors included: family law where custody for the child varied, scheduling conflicts with parental work schedules or PCP schedule that did not align with the parent's needs, lack of childcare, and lack of transportation.</li> <li>Facilitators to well-child visits- 32.35% (n=11) reported on various facilitators to attending these visits. PCP availability was mentioned the most, followed by transportation benefit, office reminders to attend, knowing who the child's PCP is.</li> </ul> <p>PIP Steps 1-8 submitted in September 2024 with the findings noted above.</p>		
Cultural and Linguistic Appropriate Services	Cultural and Linguistics and Language Accessibility	Enhance interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements. Initiate Request for Proposal (RFP) to add and/or replace the translation and interpreter services vendors to improve the member experience.	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	<p>The goal for this element has changed. The new approach is to extend the current contracts of the 5 contracted vendors in lieu of going out for Request for Proposal (RFP). To COBAR has been completed and will be presented at the November Board of Directors meeting. If approved, Vendor Management will work on extending the existing contracts.</p>	Pending next steps after the November Board meeting.	
Cultural and Linguistic Appropriate Services	Maternity Care for Black and Native American Persons	<p>1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima's Black members from 67.48% to 74.74% and Native Americans from 44.44 to 63.22% by 12/31/24.</p> <p>2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima's Black members from 53.77 to 72.37% and Native</p>	<p>Assess and report the following activities:</p> <p>1) Determine the primary drivers to noncompliance via member outreach and literature review</p> <p>2) Targeted member engagement and outreach campaigns in coordination with health network partners</p> <p>3) Strategic Quality Initiatives Intervention Plan -</p>	<p>By December 2024</p> <p>Report progress to QIHEC</p> <p>Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)</p>	Manager Equity and Community Health/ Director of Operations Management	Program Manager of Quality Analytics/ Manager of Quality Analytics	Equity and Community Health	<p>Development of member messaging for prenatal and postpartum care is still taking place to support the goal of multimodal outreach and targeted engagement.</p>	Continue with plan as listed	

2024 QI Work Plan – Q3 Update

		Americans from 27.78% to 59.43% by 12/31/24.	Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 4) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 5) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 6) Expand member engagement through direct services such as the Doula benefit and educational classes							
Cultural and Linguistic Appropriate Services	Data Collection on Member Demographic Information	Implement a process to collect member SOGI data by December 1st, 2024.	1) Develop and implement a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 3) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q2 2024 Update (07/09/2024) Q3 2024 Update (11/05/2024) Q3 2024 Update (10/08/2024) Q4 2024 Update (02/11/2025) Q4 2024 Update 01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	The SOGI survey been implemented and began mailing in September 2024 to new members 18 years of age and older.  The REL/SOGI draft policy has been submitted to the consultants for review. Traget date for submission to the Board is December 2024	Continue to collect member REL/SOGI data  Build Core report to capture Race/Ethnicity data in OMB format  Submit draft REL/SOGI data collection policy to the Board and DHCS for approval.	

## 2024 QI Work Plan – Q3 Update

			4) Develop and implement a survey via the Member Portal, mail to new members and other methods. 5) Share member demographic information with practitioners.							
Cultural and Linguistic Appropriate Services	Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.	1) Develop and implement a survey to collect practitioner REL data 2) Enter REL data into provider data system and ensure ability to retrieve and utilize for CLAS improvement. 3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership. 4) Assess the provider network's capacity to meeting CalOptima Health's culturally diverse member needs. 5) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Provider Data Management Services	Manger Provider Data management System	Provider Data Management Services	1. Set up Facets system to capture data 2. Established data needs and sent out surveys to providers 3. Working with web design team to update provider search tool to reflect information in searches	1. Providers to complete survey and submit to CalOptima 2. Ensure search tool will display information collected 3. Ensure Salesforce system will be configured to store data 4. Establish process for providers to update informaiton via the annual providers attestation process.	
Cultural and Linguistic Appropriate Services	Experience with Language Services	Evaluate language services experience from member and staff	1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q2 2024 Update (07/09/2024) Q3 2024 Update (11/05/2024) Q3 2024 Update (10/08/2024) Q4 2024 Update (02/11/2025) Q4 2024 Update (01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	Member and staff language service experience surveys in development stage:  The Staff Language Survey has been finalized, currently with Communications. The survey design and layout is currently in process.  The Member Language Survey being finalized and will be forward to Communications for design and layout.	Q3 2024 Update presented QIHEC on 10/08/2024  Q4 2024 Update will be presented QIHEC on 01/14/2025	

## 2024 QI Work Plan – Q4 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	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
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	2024 QIHETP Description and Annual Work Plan was adopted earlier this year. In Q4 QI staff started evaluation of the 2024 QIHETP and Work Plan.	Write a report on the evaluation of the 2024 QIHETP Description an Work Plan and create the 2025 QIHETP Description and Work Plan.	
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	Quality Improvement Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	Goal was completed 5/5/2024.	No next step.	
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of UM	Utilization Management	2024 UM / CM Integrated Program Description completed on time and received approved the BOD	Draft the 2025 UM / CM Program Description and present to UMC 1/23/25 for approval	
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of UM	Utilization Management	2024 Program Evaluation completed on time and received approval from BOD.	Draft the 2024 Program Evaluation and present to UMC 1/23/25 for approval	

## 2024 QI Work Plan – Q4 Update

Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: (1) Population Needs Assessment (PNA) (2) Risk stratification (3) Screening and Assessment (4) Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	Developed the 2025 PHM Strategy and Work Plan (1) 2024 PNA was discussed at MAC/PAC, provided to PHMC and posted to CalOptima Health's website. (2) Continued to work to update risk stratification based on HIF-MET (3) Continued to work to update risk stratification based on HIF-MET (4) Initiated updates to care continuum in partnership with Clinical Operations, including enhancements to wellness and prevention programs for all members. Continued contracting process with WebMD for integration of health education materials into Jiva.	Present to 2025 PHM Strategy and Work Plan to QIHEC, PHMC, QAC and Board (1) 2025 PNA planning, outline and data pull. (2) Starting in 2025, Medical Management leading risk stratification efforts. (3) Care continuum will consider vendors that can support screening and assessment through multimodal channels (4) Contract with WebMD to be executed in Q1 2025. Will request approval for expansion of health ed. materials into website via WebMD's Health Hub product.	On Target
Program Oversight	2024 Population Health Management (PHM) Strategy Evaluation	Complete the Evaluation of the 2024 Population Health Management (PHM) Strategy	The Population Health Management (PHM) Strategy will be evaluated for effectiveness on an annual basis.	QIHEC: 11/05/24 QAC: 12/11/2024  Annual BOD Adoption by January 2025	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	<ul style="list-style-type: none"> <li>Quarterly 2024 PHM Workplan monitoring.</li> <li>Drafted 2024 PHM Impact (Evaluation) Report.</li> </ul>	<ul style="list-style-type: none"> <li>Continue quarterly 2025 PHM Workplan monitoring</li> <li>Present 2024 PHM Impact report QIHEC, PHMC, QAC and Board</li> </ul>	On Target
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024  Annual BOD Adoption by April 2024	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	<ul style="list-style-type: none"> <li>Board approval was obtained in Q2.</li> <li>Workplan status updates and results were presented at the MAC/PAC December meeting.</li> <li>Worked on 2025 Workplan, added new goals and carried over existing goals that were not completed.</li> </ul>	The Cultural and Linguistic Services Program Work Plan will be submitted to the QAC for review and approval and to the Board of Directors in March 2025.	
Program Oversight	2024 Cultural and Linguistic Services Program Evaluation	Complete the Evaluation of the 2024 Cultural and Linguistic Services Program	The Cultural and Linguistic Services Program will be evaluated for effectiveness on an annual basis.	QIHEC: 11/05/2024 01/14/2025 QAC: 12/11/2024 03/12/2025  Annual BOD Adoption by January 2025-April 3 2025	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	<ul style="list-style-type: none"> <li>Evaluation was conducted and completed on 1/19/2025</li> <li>Evaluation was submitted for executive review and submitted for consultant review and feedback on 1/20/2025</li> </ul>	<ul style="list-style-type: none"> <li>Pending executive and consultant feedback.</li> <li>Submit to the QAC for review in March 2025 and approval and to the Board of Directors in April 2025.</li> </ul>	



## 2024 QI Work Plan – Q4 Update

Program Oversight	<b>Population Health Management (PHM) Committee</b> - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	(1) PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), (2) PHM Strategy activities, and PHM Workplan progress and outcomes. (3) Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health	Manager of Equity and Community Health/ Director Case Management	Equity and Community Health	<ul style="list-style-type: none"> <li>▪ Held fourth quarter PHM Committee Meeting in November 2024 which included both internal CalOptima Health updates on PHM Program and community presentation from the Institute for Healthcare Advancement.</li> <li>▪ PHMC reviewed and approved 2024 PNA.</li> <li>▪ Provided PHM Committee update for QIHEC in December 2024.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Continue to assist this committee by reviewing relevant guidance, agenda setting, presentation development, and deliverables shared with QIHEC.</li> <li>▪ Next PHM Committee meeting is scheduled for February 2025.</li> <li>▪ Report committee update to QIHEC in March 2025.</li> </ul>	
Program Oversight	<b>Credentialing Peer Review Committee (CPRC) Oversight</b> - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee activities, findings from data analysis, and recommendations to QIHEC	Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	The Committee met on 11/21/24, 12/19/24. Three physicians continue undergoing the Fair Hearing process. Seven PQIs leveled as 1, 2 or 3 were presented to CPRC for leveling and actions. Policies GG.1651, GG.1657, GG.1633, GG.1659, GG.1643, GG.1604 and GG.1607 were approved. Two providers were presented for on-going monitoring. Six providers with issues were presented was presented and approved for recredentialing. Approved the Credentialing Clean List for 09/30/2024, 10/31/2024, 11/14/2024, 11/27/2024. Approved the Practitioner Closure List for 09/30/2024, 10/31/2024, 11/27/2024. The Committee approved the addition of Behavioral Health (BH) qualified physicians who have additional CME in BH to contract in this function. Credentialing, FSR and Incident statistics were presented with no action identified.	The Committee will continue to monitor the provider network through on-going monitoring, credentialing/recredentialing, PQIs and FSR audits. Policies relevant to these processes will continue to be reviewed by the Committee.	

2024 QI Work Plan – Q4 Update

Program Oversight	<b>Grievance and Appeals Resolution Services (GARS) Committee</b> - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Grievance and Appeals	Manager of GARS	GARS	Q3 GARS Committee was held on 11/13/2024. Q2 committee meeting minutes were approved. Discussions were had around HN delays in authorizations and appointment availability. Grievance trends related to transportation were also presented and discussed.	Continue with plan	
Program Oversight	<b>Member Experience (MEMX) Committee Oversight</b> - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Project Manager Quality Analytics	Quality Analytics	In Q4 Member Experience Committee held an ad hoc committee meeting on October 9, 2024 to discuss the 2024 CAHPS results and the regular Member Experience Committee meeting was held on October 15, 2024. The following were reviewed and discussed at the ad hoc meeting for CAHPS: plan and HN level results for both Medi-Cal and OneCare. At the regular meeting the following were reviewed and discussed: <b>Timely Access:</b> Q2 2024 DHCS wait time results, timely access survey 2023 plan level results fielded by CalOptima for Medi-Cal and OneCare that indicates appointment availability compliance rates for individual provider and compliance rate for another office provider and telephone results for pre-recorded messages, callbacks, telephone triage and flexibility for scheduling members with disabilities. An update to the 2023 provider corrective action letters that were mailed as of 10/1 had a 59% response rates, health networks conducted outreach calls to encourage providers to complete the CAP submission by the due date, validation calls were made to confirm compliance with phone measures and in September 2024 the new Corrective Action Review Checklist tool was	Timely Access: 2024 timely Access survey to start fielding October 15, issue health network CAPs by end of November 2024, and continue to outreach to providers to collect CAP responses. Work with AMVI and UCMG to close SNC time and distance CAP.	

2024 QI Work Plan – Q4 Update

								<p>being utilized. <b>Network Adequacy: SNC and ANC:</b> 2023 SNC CAP time and distance: CalOptima authorized Alternative Access Standards (AAS) to close the remaining 6 Health Network CAPs, 4 Health Networks closed CAPs via AAS, AMVI and UCMG remain CAPs remain open. CalOptima submitted 3rd quarter required updates to DHCS on October 1st. 2024 pre-SNC activities began with SNC kickoff in November. <b>Network Adequacy Validation Audit:</b> HSAG had a full day audit on July 25 and CalOptima was notified that the audit was formally closed on September 30. Plan specific validation rating determinations will be shared late November 2024. <b>Medi-Cal Quarterly: Reporting PCP Over Capacity:</b> CalOptima re-opened 3 PCP panels <b>Whole Child Model:</b> Q3 results plan and HN level all specialties and HN met requirement of one for every core specialists at the plan and HN level <b>OneCare Data Analysis and Reporting:</b> Except Speech Therapy all specialties met time and distance requirements <b>CAHPS:</b> An overview of CAHPS was presented at the October 9, 2024 meeting with the recommendation to establish a workgroup to improve CAHPS scores. <b>KPI updates:</b> <b>Customer Service Health Education Grievance and Appeals UM Behavioral Health</b></p>		
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2024 QI Work Plan – Q4 Update

Program Oversight	<b>Utilization Management Committee (UMC) Oversight</b> - Conduct internal and external oversight of UM activities to ensure over and underutilization patterns do not adversely impact member's care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. The committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. <b>P&amp;T and BMSC</b> reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Utilization Management	Manager of UM	Utilization Management	UMC reviewed status update on Goals at Committee meeting November 21, 2024. A summary of this presentation was provided at the December 10th QIHEC Committee meeting including an update on the mitigation strategies implemented for the Notification Compliance initiative. IRR results for UM and Pharmacy were also presented. The High-Risk Management Workgroup, Over-Under Utilization workgroup, Gender Affirming Care Workgroup, EPSDT, and ECM Clinical Oversight groups continue to meet and pursue opportunities to improve member care.	UMC will convene February 20, 2025, to review data from Q3 2024, P&Ps, and receive updates on current active initiatives. High Risk Workgroup to continue collaboration for ED Diversion program and strategies for utilization of data.	
Program Oversight	<b>Whole Child Model - Clinical Advisory Committee (WCM CAC)</b> - Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. The committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.  Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Whole Child Model Medical Director / Director of Case Management	Program Assistant QI	Medical Management	WCM CAC met 11/12/2024. Approved their 08/20/24 meeting minutes. Discussed how to improve pediatric immunization rates. One strategy is having specialty clinics offering vaccines. Pharmacy who are Vaccine for Children providers can give vaccines. Quality Network Adequacy, Utilization (criteria for 30-day readmission data), Appeals and Grievances, Case Management, Behavioral Health, and Customer Service data were reviewed. Pediatric CalAIM ECM audit starts in 2025. Pharmacy 90-day notification.	WCM CAC will continue meeting quarterly in 2025. Review Whole Child Model data for clinical and behavioral service advice from committee members regarding Whole Child Model operations. Oversight of Annual Pediatric Risk Stratification Process.	

2024 QI Work Plan – Q4 Update

Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Care Management	TBD	Medical Management	Report on the following activities: Enhanced Care Management (ECM) a) LCM contact information has increased from 41% to 61% in October 2024 Complex Case Management (CCM) a) continue monthly NCQA file audits for CCN and Health network members. b) 11/20/2024 moc-NCQA audit with 100% of points achieved. Basic PHM/CM a) ongoing quarterly audits of delegated health networks for MOC oversight. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 12/12/2024 Education and review on EPSDT services for Health Networks.  Transitional care services: See Items #61	Report on the following activities with revisions for 2025: Enhanced Care Management (ECM) moved to stand-alone category on 2025 with CalAIM as BO.  Complex Case Management (CCM) moved to stand alone category on 2025 work plan. a) Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/situations. b) Ongoing training and support for new and existing staf2f. c) Continue to gather member feedback to improve outcomes. d) Training and Education on member centric care plans. Basic PHM/CM a) Ongoing quarterly audits of delegated health networks for MOC oversight. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM a) ongoing work group discussions for oversight of EPSDT. b) explore potential texting campaigns for overdue services for Vision, Dental, and Hearing.  Transitional care services: See Items #61.	
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2024 QI Work Plan – Q4 Update

Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accreditation standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Audit and Oversight	Manager of Audit and Oversight (Delegation)/ Manager Delegation Oversight	Delegation Oversight	<div>Delegate:</div> <ul style="list-style-type: none"><li>Prospect Medical Group (17)</li><li>United Care Medical Group (82)</li><li>HPN-Regal Medical Group (15)</li><li>Noble Mid-Orange County (64)</li><li>Optum (16)</li><li>AltaMed Health Services, Corp. (69)</li></ul> <div>Area(s) Assessed:</div> <ul style="list-style-type: none"><li>Case Management</li><li>Claims</li><li>Compliance</li><li>Credentialing</li><li>Customer Service</li><li>Provider Network Contracting</li><li>Provider Relations</li><li>Sub-Contractual</li><li>Utilization Management</li></ul> <div>Corrective Action Plan(s)</div> <div>Issued – Prospect Medical Group:</div> <ul style="list-style-type: none"><li>Case Management (Medi-Cal) – Accepted &amp; Closed</li><li>Claims (Medi-Cal) – Accepted &amp; Closed</li><li>Claims, Provider Dispute Resolutions (Medi-Cal) – Accepted &amp; Closed</li><li>Utilization Management, Policy (Medi-Cal) – Accepted</li><li>Utilization Management, Expedited &amp; Standard Denial (Medi-Cal) – Accepted</li><li>Utilization Management, Non-Emergency Medical Transportations (Medi-Cal) – Accepted</li><li>Utilization Management, Physician Administered Drug (PAD) (Medi-Cal) – Accepted &amp; Closed</li><li>Utilization Management, Policy (OneCare) – Accepted</li><li>Utilization Management, Carve Out (OneCare) – Accepted</li><li>Utilization Management, Organizational Determinations (, Appeals, &amp; Grievances) (OneCare) – Accepted</li><li>Utilization Management, Physician Administered Drug</li></ul>	Continue to monitor CAPs in “Monitoring” status through acceptance & closure.	
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2024 QI Work Plan – Q4 Update

								<div>(PAD) (OneCare) – Accepted &amp; Closed</div> <div><div>• Credentialing, Organizational Provider (All Lines of Business) – Accepted</div><div>• Provider Relations (All Lines of Business) – Accepted &amp; Closed</div></div> <div>Corrective Action Plan(s) Issued – United Care Medical Group:</div> <div><div>• Claims, Provider Dispute Resolutions (Medi-Cal) – Accepted &amp; Closed</div><div>• Utilization Management, Expedited &amp; Standard Denial (Medi-Cal) – Accepted</div><div>• Utilization Management, Non-Emergency Medical Transportations (Medi-Cal) – Accepted</div><div>• Utilization Management, Physician Administered Drugs (Medi-Cal) – Accepted &amp; Closed</div><div>• Utilization Management, Notice of Medicare Noncoverage (OneCare) – Accepted &amp; Closed</div><div>• Utilization Management, Organizational Determinations (, Appeals, &amp; Grievances) (OneCare) – Accepted</div><div>• Utilization Management, Physician Administered Drugs (OneCare) – Accepted &amp; Closed</div><div>• Credentialing, Organizational Provider (All Lines of Business) – Accepted &amp; Closed</div><div>• Provider Relations, Provider Training (All Lines of Business) – Accepted &amp; Closed</div></div> <div>Corrective Action Plan(s) Issued – HPN-Regal Medical Group:</div> <div><div>• Case Management (Medi-Cal) – Accepted</div><div>• Claims (Medi-Cal) – Accepted</div><div>• Claims, Provider Dispute Resolutions (Medi-Cal) – Accepted</div><div>• Customer Service (Medi-Cal) – Accepted &amp; Closed</div><div>• Utilization Management,</div></div>		
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2024 QI Work Plan – Q4 Update

								<div>Policy (Medi-Cal) – Accepted</div> <div>• Utilization Management, Carve Out (Medi-Cal) – Accepted</div> <div>• Utilization Management, Non-Emergency Medical Transportations (Medi-Cal) – Accepted</div> <div>• Utilization Management, Physician Administered Drugs (Medi-Cal) – Accepted</div> <div>• Utilization Management, Post-Stabilization Authorization (Medi-Cal) – Accepted</div> <div>• Customer Service (OneCare) – Accepted &amp; Closed</div> <div>• Utilization Management, Policy (OneCare) – Accepted</div> <div>• Utilization Management, Carve Out (OneCare) – Accepted</div> <div>• Utilization Management, Post-Stabilization Authorization (OneCare) – Accepted</div> <div>Corrective Action Plan(s) Issued – Noble Mid-Orange County:</div> <div>• Claims (Medi-Cal) – Accepted &amp; Closed</div> <div>• Claims, Provider Dispute Resolutions (Medi-Cal) – Accepted &amp; Closed</div> <div>• Utilization Management, Expedited &amp; Standard Denial (Medi-Cal) – Not Accepted</div> <div>• Utilization Management, Physician Administered Drugs (Medi-Cal) – Not Accepted</div> <div>• Utilization Management, Notice of Medicare Noncoverage (OneCare) – Accepted &amp; Closed</div> <div>• Utilization Management, Physician Administered Drugs (OneCare) – Not Accepted</div> <div>Corrective Action Plan(s) Issued – Optum:</div> <div>• Case Management (Medi-Cal) – Not Accepted</div> <div>• Claims, Provider Dispute Resolutions (Medi-Cal) – Accepted</div> <div>• Utilization Management, Policy (Medi-Cal) – Not Accepted</div>		
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2024 QI Work Plan – Q4 Update

								<ul style="list-style-type: none"><li>• Utilization Management, Expedited &amp; Standard Denial (Medi-Cal) – Accepted</li><li>• Utilization Management, Physician Administered Drugs (Medi-Cal) – Not Accepted</li><li>• Utilization Management, Organizational Determinations (, Appeals, &amp; Grievances) (OneCare) – Accepted</li><li>• Utilization Management, Physician Administered Drugs (Medi-Cal) – Not Accepted</li><li>• Customer Service (OneCare) – Accepted</li><li>• Credentialing, Organizational Provider (All Lines of Business) – Accepted &amp; Closed</li></ul> <p>Corrective Action Plan(s) Issued – AltaMed Health Services, Corp.:</p> <ul style="list-style-type: none"><li>• Claims, Provider Dispute Resolutions (Medi-Cal) – Not Accepted</li><li>• Utilization Management, Expedited &amp; Standard Denial (Medi-Cal) – Accepted</li><li>• Utilization Management, Physician Administered Drugs (Medi-Cal) – Not Accepted</li><li>• Utilization Management, Post-Stabilization Authorization (OneCare) – Accepted</li><li>• Claims, Provider Dispute Resolutions (OneCare) – Not Accepted</li><li>• Utilization Management, Policy (OneCare) – Accepted</li><li>• Utilization Management, Notice of Medicare Noncoverage (OneCare) – Accepted &amp; Closed</li><li>• Utilization Management, Organizational Determinations (, Appeals, &amp; Grievances) (OneCare) – Not Accepted</li><li>• Utilization Management, Physician Administered Drugs (OneCare) – Not Accepted</li><li>• Compliance, Staff Training (All Lines of Business) – Not Accepted</li><li>• Credentialing, Organizational Provider (All Lines of Business) – Accepted &amp; Closed</li></ul>		
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2024 QI Work Plan – Q4 Update

Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	<p>1) A DM satisfaction survey was sent in October 2024 to eligible members via two-way text message through USHUR. The goal of achieving 85% satisfaction was met across all 7 categories, with satisfaction rates ranging from 91% to 100%. The data indicates that positive interactions with health coaches significantly contributed to members' overall satisfaction. This is further supported by numerous positive member comments. While the data shows high satisfaction with the DM program, a higher response rate would provide more comprehensive data. In light of this, a decision was made to mail an additional 500 surveys.</p> <p>2) Exploring and testing strategies for incorporating gaps in care into disease management stratification, including a new report supported by Enterprise Analytics and Decision Point</p> <p>3) Zoom accounts have been created for all member-facing staff. Training on Zoom and proper Zoom etiquette for staff will be conducted in Q1, prior to implementation.</p> <p>4)The Yumlish web-based provider for the CDC Diabetes Prevention Program is still under review by credentialing. An application to provide an incentive to members who complete the program will be submitted to DHCS for approval when the program is launched.</p> <p>5)Ongoing collaboration with CalAIM community services continues to refer eligible members to the asthma remediation program.</p> <p>6)Enhancements have been made to Jiva to improve the</p>	<p>1) Collaborating with USHUR to develop a weblink that will allow staff to deploy the DM survey via two-way text message after the intervention is completed. Estimated launch date: February 2025.</p> <p>2) Developing a monthly text campaign for members who meet the medium-risk criteria in the asthma and diabetes stratification. The text will ask if they would like to receive a call from a health coach. This initiative aims to reduce the number of cold calls and instances where members cannot be contacted, while also allowing staff to focus on members who opt into the program. Estimated launch date: March 2025.</p> <p>3) Working toward the implementation of Yumlish and the creation of an incentive program for members who participate in the program.</p> <p>4) Collaborating with other teams to create a standing order for blood pressure monitors. This will allow health coaches to request a blood pressure monitor for members with diabetes and hypertension who do not have one at home. This initiative supports the HEDIS measure for blood pressure control in patients with diabetes.</p>	
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2024 QI Work Plan – Q4 Update

								identification of engagement rates for members identified as diabetes emerging risk.		
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## 2024 QI Work Plan – Q4 Update

Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: (1) Evaluation of current utilization of health education services (2) Maintain business for current programs and support for community. (3) Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health/Manager of Health Education	Manager of Equity and Community Health	Equity and Community Health	(1) In prior years, referrals for health education services were highest in Q1 and decreased by Q4, but in 2024, referrals were higher than average. In Q4, there were 1,418 referrals received and assigned, higher than the quarterly average of 1,362 referrals received in Quarters 1-3 of 2024. This may be in response to more members resuming preventive health visits with providers post-COVID and due to increased outreach efforts via text messages or mail campaigns. (2) During Q4 2024, 14 participants attended 2 virtual SYL classes. (3) The team has expanded text message campaigns to inform members about health education services and classes, as well as to encourage new members to see their providers in the first 90 days of enrollment. Health and Wellness services continue to be mentioned in new member packages and at all continuing education training sessions, along with reminders on how and where to send member referrals.	Member self-referrals as well as a list of future ECH community classes are still slated to be available on the new website being implemented March 2025. These new activities are on hold as the Communications team continues the build out.	
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024  Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	(1) Continued working on updates to SDOH Member Assessment in the Member Portal and continue to integrate assessment into JIVA. (2) Continued process to integrate Find Help into JIVA and developed training plan for staff. (3) Completed the HL4E project.	(1) Continue supporting process to update SDOH Member Assessment in Member Portal and collaborate with other departments on integration of member assessment into JIVA. (2) Continue to participate in FindHelp integration workgroup and completion of training plan for staff. (3) No further action as the HL4E project concluded.	

2024 QI Work Plan – Q4 Update

Program Oversight	Long-Term Support Services (LTSS)	95% compliance with TAT	CalAIM Turnaround Time (TAT): Determination completed within 5 business days CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days CBAS Turnaround Time (TAT): Determination completed within 5 business days LTC Turnaround Time (TAT): Determination completed within 5 business days	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of LTSS	Manager of LTSS	Long Term Care	CalAIM Turnaround Time (TAT): Routine 65.29%; Expedited 86.49% CBAS Inquiry to Determination (TAT): 100%      CBAS Turnaround Time (TAT): 95.76%      LTC Turnaround Time (TAT): 97.67%	LTSS approved OT to work on CalAIM authorizations/referrals; Daily authorization assignments to nurses to ensure timely completion; Daily monitoring by LTSS and Executive leadership; Report out to UMC; Collaboration with CalAIM Operations team and executive to improve vendor processes.	
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activities for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024  Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Program Manger of QI	Director of Quality Improvement	Quality Improvement	<b>HP Accreditation:</b> 1. NCQA released the 2025 HP Standards to internal stakeholders in September 2024. 2. A kickoff webinar was held to review these standards. 3. A file review audit assessed readiness for Complex Case Management, Utilization Management denials (BH and non-BH), Pharmacy, Appeals, and Credentialing with CCN and delegate files. 4. NCQA Consultants provided training on writing Analytical Reports. <b>HE Accreditation:</b> 1. Consultants have made recommendations and created a work plan. 2. CalOptima Health established a Health Equity Committee that receives status updates from five ongoing work groups.	<b>HP Accreditation:</b> 1. Executive leadership will receive the file review results at the January 2025 QIHEC meeting, where delegates have also been notified of the audit results. 2. The following items will be reviewed and approved at the January meeting: the 2025 Annual QIHETP, 2025 PHM Strategy, and 2025 CLAS Program. 3. In February 2025, QIHEC will review the 2024 QIHETP Evaluation, 2025 QI Work Plan, 2025 UM/CM Program, and 2024 UM Evaluation. 4. The Quality Improvement (QI) team will create a comprehensive work plan and schedule a kick-off meeting with stakeholders. <b>Health Equity Accreditation:</b> Document collection for submission starts in April 7. 2025, with the submission survey date set for October 7, 2025. <b>Overall Status on Both Accreditations:</b> Health Equity accreditation is on track, with no identified issues we have a look-back period starting April 7, 2025. The Health Plan Accreditation is also ready for its look-back period beginning April 6, 2025.	

2024 QI Work Plan – Q4 Update

Program Oversight	OneCare STARS Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024 11/5/2024 Q1: 01/14/2025	Director of Medicare Stars and Quality Initiatives	Manager of QA	Quality Improvement	1) Bimonthly working sessions focused on Stars measures improvement with Operations, Equity and Community Health, Case Management, Pharmacy, Utilization Management, Customer Service, Health Network Relations, and GARS.  2) Continued utilization of the Star Rating tracker to communicate performance with each Stars workgroup / measure owner.  3) Continued weekly huddle with the Case Management team to address the OMW measure. Outbound calls to members due for bone density testing.  4) Ongoing telephonic outreach to members across multiple measures via vendor Carenet.  5) Case Management and Equity and Community Health team utilization of the Decision Point Insights platform to discuss open care gaps with members.  6) Launch of a detailed Stars project plan in conjunction with EPMO and Rex Wallace Consulting, coupled with a weekly project update meeting.  7) Launch of Listening Posts member experience surveying via Ushur; collected feedback from members who missed a medication refill, or began a new medication related to the medication adherence measures.  8) Launch of the OneCare Quality Improvement Grant program. Awarded \$568,846.92 to 4 Health Networks for quality initiatives that will improve OneCare measure performance.	Continue with plan as listed and implement additional initiatives outlined in QA's 2025 strategic project list	
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2024 QI Work Plan – Q4 Update

Program Oversight	Value Based Payment Program	Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 11/5/2024 Q1: 01/14/2025	Manager of Quality Analytics	Manager Quality Analytics	Quality Analytics	Hospital Quality program performance: No additional updates for the Hospital since November. No update to provide at the 1/11/25 QIHEC.  Quality update calls with each Health Network continue to be held every other month.  The Medi-Cal Quality Improvement Grant awards for Health Networks were announced in September. Seventeen (17) proposals across five (5) Health Network partners were approved (over \$1.8 M in funding and support for 16 quality measures). All contracts were executed in Q4 and funds were distributed to Health Networks on 1/13/25.	Continue with plan as listed and implement additional initiatives outlined in QA's 2025 strategic project list	
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1 02/11/2025	Director of Quality Analytics	Manager Quality Analytics	Quality Analytics	Final HEDIS Rates were presented last quarter. Continue analysis to identify opportunities and focus areas for 2025.	Plan and prepare for <Y2024 HEDIS data collection.	

2024 QI Work Plan – Q4 Update

Program Oversight	School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report on the following Student Behavioral Health Incentive Program (SBHIP) activities: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Director of Behavioral Health Integration	Project Manager BHI	Behavioral Health Integration	1) 4 Project Outcome Reports due 12/31/24: BH Screening and Referrals; Building Stronger Partnerships; IT Support Systems; Technical Assistance for Contracts. 2) OCDE SBHIP MOU amendment executed, CalOptima Health and OCDE will monitor school districts SBHIP budget requests and spend. 3) The DHCS MOU template was sent to OCDE for legal review; the template will be used for the coordination of care and data sharing with the school districts. 4) Internal departments SMEs identified for the Carelon interim payment process; waiting for DHCS to finalize Carelon MOU. 5) 8 of 10 SBHIP-funded Well Spaces were installed in 2024; the remaining two are scheduled for completion in late January/early February 2025. 6) Hazel Health has launched its telehealth platform in 19 out of the 29 school districts.	The incentive earning of the SBHIP initiative ended 12/31/24; all required DHCS reporting is completed; CalOptima Health awaits approval from DHCS for the project outcome reports; the announcement is expected in Q1 2025. SBHIP partners will continue to meet throughout the upcoming months.	
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2024 QI Work Plan – Q4 Update

Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendors to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Chief Medical Officer	Sr. Manager of Medical Management	Medical Management	1) Held the grantees' kickoff meeting on October 2, 2024. 2) Hosted a virtual webinar to provide reporting instructions on November 8, 2024 3) Met with individual grantees (ACS, TFG) to provide support. 4) Submitted SMS content(s) to DHCS for approval. 5) Worked on an RFP for a research and evaluation initiative. Barriers/challenges: Due to a change in project management leadership, several critical operational requirements were overlooked (e.g., BAA, data exchange approval process, grant amendment, etc.).Also, senior leadership recommended canceling the bid exception for the Research & Evaluation contract. Focus has shifted to releasing an RFP, which may delay the Research & Eval initiative.	1) Host the 2nd quarterly grantee meeting 2) Establish a robust grant management process 3) Launch the Research & Evaluation RFP 4) Develop more concrete plans for the OC3 Collaborative and Member Journey Interventions initiatives.	
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2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	1. Member Health Reward: CCS (MC) - xxx; BCS (MC) - xxx; BCS (OC) - xxx; COL (OC) - xx  2. Mailings: COL (MC)- 21239; COL (OC)- 3908  3. Text Message: CCS (MC)- 73309; BCS (MC)- 21499  4. CareNet Live Call from October to December: CCS (MC)- 13711 ; BCS (MC)- 3839; BCS (OC)- 200; COL (OC)- 463  5. Continuation of CCN OC and MC COL GI outreach pilot program plus elimination of prior authorization for GI screening consult for the OC population  6. CCN Cologuard launched November: Mailing- MC Kits 25746 OC Kits 865; Kits returned by December: MC 2482 OC 119  7. September 2024 Prospective Rate Data: CCS (MC) - 43.16%; BCS (MC) - 49.07%; BCS (OC) - 62%; COL (OC) - 58%	Continue with plan as listed and implement additional initiatives outlined in QA's 2025 strategic project list	
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## 2024 QI Work Plan – Q4 Update

Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collaboratively with the Communications department to Fax blast non-compliant providers letter activity ( approx. 200 providers) by second quarter. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/14/2025) 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS RATES Q4 (September): Initiation Phase- 47.03% Continuation and Maintenance Phase- 52.08%  1) Monthly text messaging outreach to 125 members.(October, November, December). 2) Member Health Reward flyers mailed to 209 eligible members on 11/14/2024. 3) A new text message script for member Health reward will be launched in Q1 2025. 4) Monthly Health Network Communication BH Updates. 5) Collaborated with Communications to disseminate Best Practice Letter and Tip Sheet via automated process with ITs to 127 non-compliant providers on 12/12/2024.	1) Continue to send letters to providers via automated process with ITs who are not meeting the ADD requirements. 2) Continue to work with text messaging vendor to send text messages to members for follow-up visits. 3) Coordinate text message campaign of the Member Health Rewards flyer to eligible members.	
Quality of Clinical Care	Health Equity/Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/14/2025) 01/14/2025)	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	1) Attended collaborative meetings between teams to identify best practices to implement. 2) Attended provider and member education. 3) Continued to review the quarterly ACES report.	Goal Met	

2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primary Care Providers (PCP) for members in need of metabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to the next top 50 prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs) 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/14/2025) 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS RATES Q4 (September) : Blood Glucose all ages: 44.81%, Cholesterol all ages: 27.04%, Glucose & Cholesterol Combined all ages: 26.05% 1) Barrier: Data report unavailable for the end of the quarter due to new HEDIS software implementation for the Quality Analytics team. 2) The following materials have been disseminated to Providers (October 52 letters, November 110 letters): a) Provider Best Practices Letter. b) APM Provider Tip Sheet. 3) Collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis (October, November). 4) Mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis (October, November). 5) Text Messaging Campaign (October 440 texts, November 428 texts, December texts). 6) Monthly Health Network Communication BH Updates.	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue data pull from Tableau for text messaging campaign. 3) Continue mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to providers on a monthly basis. 4) Continue collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 5) Schedule listening sessions with Providers to educate/train on how to obtain BH data using the CalOptima Health Provider Portal.	
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## 2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/14/2025)	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	PR HEDIS RATES Q4 (September) :Effective Acute Phase Treatment: 64.74%, Effective Continuation Phase Treatment: 45.45% 1) Barrier: Data report unavailable for the end of the quarter due to new HEDIS software implementation for the Quality Analytics team. 2) Data report received monthly. 3) AMM Provider Tip Sheet letter completed. 4) The following materials have been disseminated to Providers (October 540 letters, November 962 letters): a) Provider Best Practices Letter. 5) Text Messaging Campaign (October 6,887 texts, November 6,885 texts, December 6, 885 texts). 6) AMM data available through Provider Portal 7) Monthly Health Network Communication BH Updates	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue Text Messaging campaign. 3) Continue mailings to providers (letter). 4) Schedule listening sessions with Providers to educate/train on how to obtain BH data using the CalOptima Health Provider Portal.	
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/14/2025)	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	PR HEDIS Rates Q4 (September): M/C:68.28% OC: N/A 1) We are currently monitoring this measure. 2) SMD data now available through Provider Portal. 3) Monthly Health Network Communication BH Updates.	1) Continue to monitor prospective rates on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement. 3) Schedule listening sessions with Providers to educate/train on how to obtain BH data using the CalOptima Health Provider Portal.	

2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare-Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/14/2025) <del>10/08/2024</del>	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q4 (September): 30 day- 26.98%, 7 day- 14.76%  1) The main barrier has been not having the bandwidth for outreach to members from daily vendor ED report. 2) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis as well as weekly reminder in HN communication. 3) Bi-weekly Member text messaging. 4) Finalize IVR calls for ED follow-up. 5) Monthly Health Network Communication BH Updates. 6) BH Telehealth vendor began test calls to follow up with FUM members starting in Mid-November. Phase one of outreach began 12/3/2024.	1) Starting January 2025- will begin weekly FUM text messages based on real time ED data. 2) Continue sharing ED data with HN's via sFTP and weekly HN Communication. 3) Collaborate with NAMI to share real-time ED data for member outreach/NAMI by Your Side. 4) BH Telehealth vendor will outreach to members based on daily ED data feed to assist with scheduling Follow up appointments.. 5) IVR calls for members who meet FUM criteria to remind them of the importance of scheduling a follow up appointment after an ED visit.	
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2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaboratively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward Program.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q4 (September): M/C:68.67% OC: N/A  1) Barrier: Data report unavailable for the end of the quarter due to new HEDIS software implementation for the Quality Analytics team. 2) Conducted a text message campaign to reach out to 1,528 members regarding getting their glucose lab screening (October, November, December). 3) Mailed out Member Health reward flyer to 971 eligible members on 11/14/2024, and mailed to 186 providers on 11/14/2024. 4) Continue to collaborate with Quality Analytics Team to retrieve data sourcing automation for Tableau on a monthly basis, confirmed that 729 Member Health rewards were mailed to members on 10/29/2024 and on 12/3/24, 337 members were mailed the Member Health rewards. 5) Monthly Health Network Communication BH Update completed.	1) Continue tracking members in need of glucose screening test as soon as we are able to receive HEDIS data. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Continue to follow up on data pull for text messaging campaign. 4) Mail out member health rewards flyer to eligible members. 5) Mail out to all prescribing provider offices with the following: a.) Medical Director Letter b.) List of members/patients in need of screening c.) Provider Tool Tip Sheet 6) Schedule listening sessions with Providers to educate/train on how to obtain BH data using the CalOptima Health Provider Portal.	
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## 2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP: Improve the percentage of members enrolled into care management, CalOptima Health community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/14/2025) 01/14/2025	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration/ Quality Analytics	Conduct Annual oversight of MC Non Clinical PIPs (Jan 2023 - Dec 2025) Improve the percentage of members enrolled: Baseline Measurement Period: Submitted to DHCS 09/09/2024. Remeasurement 1 Period : 01/01/24 -12/31/24 Remeasurement 2 Period : 01/01/25-12/31/25	1) Receiving daily report from vendor which contains Real-Time ED data for CCN and COD members. 2) Internal report developed that identifies members enrolled in CCM and ECM for CCN who meet FUM/FUA criteria for the duration of each measurement period. 3) Collaborate with telehealth provider, Telemed2U, and internal ITS team to develop implementation plan for Member Outreach. Vendor to provide information about case management including ECM and referrals	
Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	Assess and report the following activities: 1) Share real-time ED data with our health networks on a secured FTP site. 2) Participate in provider educational events related to follow-up visits. 3) Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/14/2025) 01/14/2025	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q4 (September): 30-Day- 21.12%, 7-Day-11.33%  1) Secured FTP folders have been established and BH ED data is being sent to Health Networks daily as well as weekly reminder in HN communication. 2) Bi-weekly member text messaging. 3) Finalize IVR calls for ED follow-up. 4) Monthly Health Network Communication BH Update completed.	1) IVR calls to members who fall under the FUA measure. 2) BH Telehealth vendor will outreach members from the daily ED data feed. 3) Continue weekly member text messaging in 2025. 4) Member outreach with NAMI By Your Side (NBYS).	



2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: EED (MC) - xxx; EED (OC) - xx  2. EED VSP mailing from October to December: MC - 4521; OC - 1030  3. CareNet Live Call from October to December: OC- 160  4. VSP data sharing to Health Network partners; multiple Health Networks are now receiving Production data and the remaining ones are completing testing  5. September 2024 Prospective Rate Data: EED (MC) - 40.70%; EED (OC) - 59%	Continue with plan as listed and implement additional initiatives outlined in QA's 2025 strategic project list	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control- lower rate is better) MY2024 Goals: MC: 29.44%; OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: HBD (MC) - xxx; HBD (OC) - xxx  2. CareNet Live Call fromOctober to December: OC- 233  3. August 2024 Prospective Rate Data: HBD (MC) - 58.8%; HBD (OC) - 53%	Continue with plan as listed and implement additional initiatives outlined in QA's 2025 strategic project list	

2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Equity and Community Health/ Quality Analytics	Member initiatives: 1) Bright Steps Program: prenatal and postpartum education to participating members.  2) Ongoing: Postpartum Health Reward for members that complete postpartum care between 1-12 weeks after delivery.  1) August 2024: Maternal Health workgroup meeting to discuss member journey. QA will develop a prenatal and postpartum care journey to support member messaging.  2) Community Clinic Forum presentation to support compliance for providers and clinics that utilized bundled coding practices.  Per August 2024 prospective rates, Timeliness of Prenatal Care is performing slightly lower than this time last year with a rate of 67.26% and Postpartum Cre is performing slightly higher than this time time last year with a rate of 65.83%.	Continue with plan as listed and implement additional initiatives outlined in QA's 2025 strategic project list	
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2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Maternal and Adolescent Depression Screening	Medi-Cal Only - Meet the following goals For MY2024 HEDIS: DSF-E Depression Screening and Follow-up for Adolescent and Adults - Screening: 2.97% PND-E Prenatal Depression Screening and Follow-up - Screening: 8.81% PDS-E Postpartum Depression Screening and Follow-up: 27.77%	1) Identification and distribution of best practices to health network and provider partners. 2) Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion. 3) Targeted member engagement and outreach campaigns in coordination with health network partners. 4) Provider education (CE/CME) in Q3.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Operations Management / Director of Behavioral Health Integration	Manager of Quality Analytics / Manager of Behavioral Health Integration	Operations Management/ Behavioral Health Integration	DSF-E PR HEDIS Rates Q4 (September): Screening Total 0.02%; Follow Up Total 40.00% 1) Data collection is still the main barrier. Currently capturing information by supplemental data. The Behavioral Health Quality Improvement Workgroup exploring ways to obtain additional supplemental data to better capture completed screenings and follow up visits. 2) Monthly Health Network Communication BH Update completed. 3) The following materials have been disseminated to Providers (October 540 letters, November 962 letters): a) Provider Best Practices Letter.	1) Distribute best practice guidelines for follow-up visits to providers and health network. 2) Schedule listening sessions with Providers to educate/train on how to obtain BH data using the CalOptima Health Provider Portal.	
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2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Blood Lead Screening	<p>HEDIS MY2024 Goal: 67.12%;</p> <p>Improve Lead Screening in Children (LSC) HEDIS measure.</p>	<p>Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of:</p> <p>1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts</p> <p>2) Partnership with key local stakeholders</p> <p>2024 Member Quality Initiatives will consist of the following but not limited to:</p> <ul style="list-style-type: none"><li>- Member health reward and monitoring of impact on LSC HEDIS rate</li><li>- IVR campaign to</li><li>- Texting campaign</li><li>- Mailing campaign</li><li>- Lead texting campaign for members</li><li>- Medi-Cal member newsletter article(s)</li></ul> <p>In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.</p>	<p>By December 2024 Report progress to QIHEC</p> <p>Q1 2024 Update (05/14/2024)</p> <p>Q2 2024 Update (08/13/2024)</p> <p>Q3 2024 Update (11/05/2024)</p> <p>Q4 2024 Update (02/11/2025)</p>	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	<p>Member Initiatives:</p> <p>1) Ongoing: Blood Lead Health Rewards for testing at 12 and 24 months of age.</p> <p>2) 2-way SMS campaign via Ushur and in alignment with AAP periodicity schedule for well-child visits. Campaign included reminders for lead testing.</p> <p>3) Live call campaign via vendor CareNet to educate and encourage lead testing.</p> <p>Monitoring Initiatives:</p> <p>1) In progress: Development of medical record review process to monitor CalOptima Health providers and the adherence to lead requirements (e.g., testing, follow-up, anticipatory guidance)</p> <p>Provider Initiatives:</p> <p>1) July 2024: Provider fax campaign to providers assigned to children ages 0-6. Fax campaign provided focus on providing resources related to lead requirements such as anticipatory guidance, patient educational materials, etc.</p> <p>2) July 2024: Posting of Stay Compliant with State-Issued Lead Requirements on CalOptima Health website.</p> <p>Per August 2024 prospective rates, Lead Screening in Children measure is 65.03% and is on track to meet the 50th percentile.</p>	Continue with plan as listed	
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## 2024 QI Work Plan – Q4 Update

Quality of Clinical Care	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS <b>MY2024</b> Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Member Initiatives: 1) 2-way SMS via Ushur for multiple pediatric age groups in place. 2) Ongoing telephonic outreach to pediatric members for multiple measures via Carenet. Provider/HN Initiatives: 1) Detailed W30 reports continue to be distributed regularly. CIS performance continues to trend lower than same point-in-time last year; as such, Carenet was provided with a Q4 focus report of members due for CIS that are still actionable (haven't reached their 2nd birthday yet).	Continue with plan as listed.	
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits.  Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Member Initiatives: 1) 2-way SMS via Ushur for multiple pediatric age groups in place. 2) Ongoing telephonic outreach to pediatric members for multiple measures via Carenet. Provider/HN Initiatives: 1) Detailed W30 reports continue to be distributed regularly. CIS performance continues to trend lower than same point-in-time last year; as such, Carenet was provided with a Q4 focus report of members due for CIS that are still actionable (haven't reached their 2nd birthday yet).	Continue with plan as listed.	
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data submitted by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 04/09/2024 Q4: 10/08/2024 postponed to 11/5/2024	Director of Finance	Manager of Finance	Finance	No efforts in Q4 2024.	Continue to monitor health networks	

2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025  Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	<b>FSR/MRR/PARS, Community-based Adult Services (CBAS), and Nursing Facilities (NF) Oversight:</b> <b>A. FSR:</b> Initial FSRs=13; Initial MRRs=14; Periodic FSRs=54; Periodic MRRs=56; On-Site Interims=9; Failed FSRs=3; Failed MRRs=19; CAPs: CE=44; FSR=60; MRR=55 <b>B. PARS:</b> Completed PARS=82 Basic Access=26 Limited Access=56 <b>C. CBAS Oversight:</b> Critical Incidents=2 (2 COVID cases); Non-Critical=17; Falls=14; Audits Completed=12; CAPs Issued:9; Unannounced Visits=0 <b>D. NF Oversight:</b> Critical Incidents=23; On-Site Visits=14; Unannounced Visits=0	<b>FSR/MRR:</b> In order to avoid third subsequent failed audits and removal from the CalOptima Health Provider Network, FSR nurses are completing annual audits, extensive education, and additional resources for sites with 2 failed audit scores. <b>PARS:</b> Continue with plan, as listed. <b>CBAS:</b> Continue with plan, as listed. <b>NF:</b> Continue with plan, as listed.	
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2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. a) HRA collections at volume to satisfy a 3-star HEDIS rating b) Q3 HRA1 Members reached, willing and completed HRA within 90 days of enrollment 100% c) Q3 ICP1 Member reached, willing and completed ICP within 90 days of enrollment 98% d) Off-cycle MOC submitted in Q4 2024 with minor updates for 2025 approved by CMS pending DHCS approval 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. a) Ongoing monthly communication with Health Networks for ICP1 development b) Monthly communication with Health Netowrks for annual ICP development and missing face-to-face interactions. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring a) Audit tool revision.	Continue to reduce the overall number of open PQIs. Further develop the Provider Action Workgroup.	
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	Initial BH Credentialing Q4 = 108; Initial CCN Credentialing Q4 = 43	Initial credentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial credentialling.	

2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Quality Improvement	Manager Quality Improvement	Quality Improvement	BH Recredentialing - Q4 = 31; CCN Recredentialing Q4 = 138. For Q4 we did not have any recredentialing files out of compliance	Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the recredentialing of providers. This will ensure that we continue with compliance and timeliness of the recredentialing files.	
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025):  CCIP Study - Comprehensive Diabetes Monitoring and Management  Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: EED (OC) - xx; HBD (OC) - xxx  2. EED VSP mailing from October to December: OC - 1030  3. CareNet Live Call from October to December: EED (OC)- 160 HBD (OC)- 233  4. Emerging Risk (telephonic outreach via Equity and Community Health department staff)  5. September 2024 Prospective Rate Data: EED (OC) - 59%; KED (OC)- 51%; HBD PC (OC)- 53%; MAD (OC)- 92%; SUPD (OC)- 85%	Continue with plan as listed.	



## 2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1) Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025) 01/14/2025	Director Medical Management/Case Management	QI Nurse Specialist	Case Management	Assess and report the following activities: 1) Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. a) HRA collections at volume to satisfy a 3-star HEDIS rating b) Q3 HRA1 Members reached, willing and completed HRA within 90 days of enrollment 100% c) Q3 ICP1 Member reached, willing and completed ICP within 90 days of enrollment 98% d) Off-cycle MOC submitted in Q4 2024 with minor updates for 2025 approved by CMS pending DHCS approval 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. a) Ongoing monthly communication with Health Networks for ICP1 development b) Monthly communication with Health Networks for annual ICP development and missing face-to-face interactions. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring a) Audit tool revision.	Assess and report the following activities which are revised for 2025. 1) Monthly communication process with Networks on ICP development 2) DHCS HRA1 and ICP1 quarterly reporting Q4 2024 available after 2/2025; 3) HRA Star status updates 4) MOC Updates 5) Face to Face interactions	
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	1) Director of Provider Network 2) Director of Contracting	Analyst of Quality Analytics	Contracting/Provider Data Operations	The Network Adequacy Workgroup met to discuss gaps and ideate solutions for implementation. Provider Data Ops curated and provided provider target leads lists to PR and Contracting to close plan level NCQA Provider to Member ratio gaps in LMFT, Orthopedic Surgery and Gastroenterology, which were identified in Q3. CalOptima Health closed out the 2023 SNC via approval of AAS for AMVI and UCMG.	1. PDO to review provider data and curate target lists as needed for rheumatology, neurology, urology to address access issues 2. PR and contracting to provide update on contracting efforts continue expand provider network for the above and LMFT, gastroenterology and orthopedic surgery, as well as to close CCN time and distance gaps.	

2024 QI Work Plan – Q4 Update

Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely access. 3) Continue to educate providers on timely access standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	<ul style="list-style-type: none"><li>• 2024 Timely Access Survey fielding started October 15th and concluded December 6, 2024.</li><li>• Held a Timely Access Q&amp;A Call for providers to discuss access standards, and changes for 2024 and 2025. Call provided an opportunity for providers to ask questions and collaborate on challenges they may be experiencing and discuss best practices.</li><li>• Scheduled two peer to peer collaborative calls with network providers and CalOptima Health Medical Director to discuss corrective action plan submission and ways to improve access.</li><li>• Issued Corrective Action Plan to nine HNs in December based on 2023 Timely Access Survey results for not meeting the minimum performance level of 80%.</li><li>• Access workgroup continues to review provider CAP responses to close out.<ul style="list-style-type: none"><li>o Mailed follow-up letters to several providers who did not submit a response to the original CAP issued in late June.</li></ul></li></ul>	QC survey reports and data as they come from vendor in Q1  Continue to schedule peer review meetings with select providers and CalOptima Medical Director for CAP review  Continue to review CAP submissions  Post Timely Access Survey RFP	
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2024 QI Work Plan – Q4 Update

Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for Improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024  Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst	Network Operations Provider Data Operations/Quality Analytics	Submitted Q4 2023 Quarterly CAP status update to DHCS - closed remaining 2023 time and distance CAP open (AMVI, UCMG) - Completed 2024 SNC submission to DHCS using Q4 network adequacy data analysis as follows:N54 -Time/Distance: all HN did not meet. Top 5 gaps were Phys Med/Rehab, Endocrinology, Dermatology, Neurology and HIV/AIDS Specialist/Infectious Diseases. South County remains as the general area where the gaps are occurring. Health Networks in general showed minor improvement in closing gaps from Q3 to Q4. - Network Capacity/Ratio (FTE): HNs met standards -PMR: 8 HNs now meet PMR, up 1 (AMVI) from Q3; ongoing gaps are in Orthopedic Surgery, Ophthalmology, and Gastroenterology. - PCP: 1new closures - WCM: Plan level met all specialties. All HNs confirmed met Timely Access: All eleven HN CAPs issued in December 2023 (2022	1. Issue 2024 SNC time and distance CAPs 2. Q1 network adequacy quarterly analysis 3. QC HNs update on closing issued CAPs 4. PR/Contracting to expand provider network to address access issues	
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2024 QI Work Plan – Q4 Update

Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, training, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	1) Increase health network and provider communications, training, and resources a. Communication: Most HN updates have been moved over to HN Quality Update Meeting (bimonthly); IHA updates provided to all HNs in November b. Presentations and Trainings HNs/Providers: 1 HN Forum, 7 HN Quality Update Meetings, 1 QIHEC, 1 CHCN Virtual, 1 PHMC Meetings, 1 QIHEC Meetings, 1 DOC Meeting c. Provider Toolkit Resource: The document was placed on hold due to the website redesign; Components of the Provider Toolkit document are linked on the website. d. Provider Portal: Promoting IHA Report and Member Roster at HN/Provider trainings and presentations. 2) Expand oversight of provider IHA completion a. IHA Chart Review Audits: Encountered barriers with communication and responsiveness from PCP offices; escalated communication to Medical Director for Clinic Leadership outreach, office direct calls, and provider office visits b. Provider Office Visits: 11 Provider office site visits in addition to Teams meetings with all providers selected for chart review audits c. KPI Metric Expectation for HNs: Worked with DO to send new Delegation Oversight Dashboard Response Forms to fill out to report back on what actions they are taking to increase rates and track their performance d. KPI Metric Tracking: Tracking HN performance in alignment with the DOC Dashboard and sharing at HN Quality Update Meetings and during individual HN meetings 3) Increase member outreach efforts	Continue the plan listed with the addition of starting the process of implementing Corrective Action Plans for HNs/Providers in 2025. New member text campaign scheduled to launch Q1 2025 as an outreach attempt for IHA completion.	
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2024 QI Work Plan – Q4 Update

								<p>a. Text Message campaign for new members + IHA: DHCS approval, translation, and COMMS text message request process completed. Current step: Working with the vendor to finalize the campaign. Expected to launch in quarter 1, 2025.</p> <p>b. Ongoing IVR Campaign: Sent out twice monthly to new members</p>		
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024  Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst for Quality Analytics/ Manager of Provider Data Management Services	Provider Data Operations Management Services	1. Per Q4 Network Adequacy Report, the plan meets DHCS requirements for MPT, capacity/ratio (FTE) and time/distance 2. DHCS approved AAS	1. Work on materials and get approvals to post AAS on COH's website. 2. Review last year's ANC filing to prepare for 2024 filing 3. Quarterly monitoring of ANC requirements and gap analysis	

## 2024 QI Work Plan – Q4 Update

Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	QA Project Manager	Quality Analytics	1. Closed 2. Closed 3. HNQR were sent to all health networks and results discussed at health network Quality meetings.	Convened a smaller workgroup dedicated to member experience improvement. This group meets multiple times per month and works with various impacted business owners in trying to improve member experience.  Launched member listening post campaigns that target members based on specific criteria and solicits feedback about the event/process/benefit to improve outcomes	
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of GARS	Manager of GARS	GARS	Q3 GARS Committee was held on 11/13/2024. Q2 committee meeting minutes were approved. Discussions were had around HN delays in authorizations and appointment availability. Grievance trends related to transportation were also presented and discussed.	Continue with plan.	
Quality of Service	Customer Service	Implement customer service process and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Director of Customer Services	Manager of Customer Service	Customer Service	Customer Service ran KPI data and reported results to QIHEC. DHCS' average speed of answer of not exceeding 10 minutes: Goal was met (1 min and 35 sec). Internal business goal of abandonment rate not exceeding 5% met: Goal was met (4.3%). Accomplishments: Hired additional staff, various departments staggered member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	Continue with plan	

## 2024 QI Work Plan – Q4 Update

Quality of Service	Medi-Cal Customer Service Performance Improvement Project	To meet Medi-Cal Customer Service KPIs by December 31, 2024: Internal call abandonment rate of 5% or lower, DHCS' 10 minutes average speed of answer	1) Partnering with HR to onboard more permanent and temporary staff to service inbound calls. 2) Interacting with various departments involved with member engagement campaigns and determine if they're able to update instructions for targeted members (i.e., instead of calling customer service, have them utilize the member portal).	Report progress to QIHEC quarterly: <del>Q2 2024 Update</del> (08/13/2024) <del>Q3 2024 Update</del> (11/05/2024) Q3 2024 Update (07/09/2024) <del>Q4 2024 Update</del> (02/11/2025) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Director of Customer Services	Manager of Customer Service	Customer Service	Customer Service ran KPI data and reported results to QIHEC. DHCS' average speed of answer of not exceeding 10 minutes: Goal was met (1 min and 35 sec). Internal business goal of abandonment rate not exceeding 5% met: Goal was met (4.3%). Accomplishments: Hired additional staff, various departments staggered member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	Medi-Cal KPI's were achieved by December 31, 2024. Please retire/close out.	
Safety of Clinical Care	Coordination of Care: Member movement across practitioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement: 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025) 01/14/2025)	Director of Case Management	TBD	Medical Management	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement: No meetings Q4, metric is in implementation. 2) Provider and member education a) All health networks are receiving monthly files from VSP except for Heritage-Regal. Heritage-Regal has internal barrier to receipt of file that they are working on. b) Ongoing monthly communication to members from VSP for those in need of eye exam.	Internal call abandonment rate of 5% or lower,	
Safety of Clinical Care	Emergency Department Member Support	Emergency Department Diversion Pilot has been implemented. In 2024 plan to expand a virtual program to additional hospital partners starting with UCI.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of LTSS	Manager of LTSS	LTSS	No metrics to report in Q4 2024. The program is still in development and implementation. The two staff, RN & MSW, have completed training and will start being embedded in the UCI ED the beginning of January 2024.	DHCS' 10 minutes average speed of answer	

## 2024 QI Work Plan – Q4 Update

Safety of Clinical Care	Coordination of Care: Member movement across settings - Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% from Q4 2023 by end of December 31,2024.	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High-Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Sr. Director of UM	Project Manager III, Medical Management	Utilization Management Case Management Long Term Care	Usher texting campaign continues to Medi-Cal CCN members admitted to the hospital based on our ADT data. TCS support line new report for call volume: 31 inbound calls handled. Ongoing audits for completion of outreach for high-risk members in need of TCS- 100% compliance for completed audits.	Further develop Usher texting opportunities through TCS and highrisk workgroups. Further refine NICE phone line reporting to drill down TCS support line specificity for further opportunities. Revision of goal for 2025 based on 2024 data.	
Cultural and Linguistic Appropriate Services	Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from 41.90% to 55.78% by 12/31/2024.	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	Findings: As part of the parental/guardian reminders, call also assessed for barriers and facilitators to well child visits. Challenges included limitations with successfully being able to outreach to parents/guardians of child members. Out of 85 members, was only able to successfully reach 24 members. Key highlights: • Parental knowledge- CalOptima Health assessed for knowledge as it relates to the importance of well-child visits and what should be expected at these visits. 21.18% expressed having knowledge of the importance of the visits and 18.82% did not express having any understanding. Some parents drew on the knowledge from their previous experiences with other children. • Scheduling- When inquired about the scheduling of the next well-child visit, 67.65% (n=23) responded not having a visit scheduled, or being unsure, followed by 32.35% reporting that they had the next well-visit scheduled with the PCP. When attempting to assess for barriers and facilitators, 6 of the 34 parents declined to proceed with the call. The following	Working with ECH department to identify CBOs which could assist with increasing performance  Continue with calls to gain understanding and educate members  Work more closely with HNs to target these members for HN based initiatives	



2024 QI Work Plan – Q4 Update

								<p>narrative is based on 28 successful parental interactions.</p> <ul style="list-style-type: none"><li>• Barriers to well-child visits- 35.29% (n=12) of parents reported experiencing challenges that impact their ability to attend well-child visits. Factors included: family law where custody for the child varied, scheduling conflicts with parental work schedules or PCP schedule that did not align with the parent's needs, lack of childcare, and lack of transportation.</li><li>• Facilitators to well-child visits- 32.35% (n=11) reported on various facilitators to attending these visits. PCP availability was mentioned the most, followed by transportation benefit, office reminders to attend, knowing who the child's PCP is.</li></ul> <p>PIP Steps 1-8 submitted</p>		
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2024 QI Work Plan – Q4 Update

Cultural and Linguistic Appropriate Services	Cultural and Linguistics and Language Accessibility	Enhance interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Initiate Request for Proposal (RFP) to add and/or replace the translation and interpreter services vendors to improve the member experience.	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	<p>During quarter 4, interpreter and translation services utilization data was analyzed, tracked and trends were identified and adjusted when necessary to ensure members received timely and adequate interpreter and translation services.</p> <p>Throughout Q4, all Member Material were translated accurately and on time to comply with regulatory standards.</p> <p>In lieu of a Request for Proposal (RFP), the vendor contracts for all five (5) vendors were extended. During Q4 two out of five contract extensions were completed.</p>	<p>During quarter 4, interpreter and translation services utilization data was analyzed, tracked and trends were identified and adjusted when necessary to ensure members received timely and adequate interpreter and translation services.</p> <p>In Quarters 4 from 2023 and 2024 we processed the following translation requests:</p> <ul style="list-style-type: none"><li>• 2023 – 11,889 Translations</li><li>• 2024 – 19,280 Translations</li></ul> <p>In Quarters 4 from 2023 and 2024 we processed the following Telephonic and Face-to-Face interpreter requests:</p> <ul style="list-style-type: none"><li>• 2023 – 255,442 Telephonic interpreter requests</li><li>• 2024 – 517,623 Telephonic interpreter requests</li><li>• 2023 – 6,944 Face-to-Face interpreter requests</li><li>• 2024 – 9,691 Face-to-Face interpreter requests</li></ul> <p>Barriers identified for interpreter services were the shortage/lack of interpreters in various languages such as Khmer/Cambodian.</p> <p>Throughout Q4, all Member Material were translated accurately and on time to comply with regulatory standards.</p> <p>In lieu of a Request for Proposal (RFP), the vendor contracts for all five (5) vendors were extended. During Q4 two out of five contract extensions were completed.</p>	
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## 2024 QI Work Plan – Q4 Update

Cultural and Linguistic Appropriate Services	Maternity Care for Black and Native American Persons	<p>1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima's Black members from 67.48% to 74.74% and Native Americans from 44.44 to 63.22% by 12/31/24.</p> <p>2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima's Black members from 53.77 to 72.37% and Native Americans from 27.78% to 59.43% by 12/31/24.</p>	<p>Assess and report the following activities:</p> <p>1) Determine the primary drivers to noncompliance via member outreach and literature review</p> <p>2) Targeted member engagement and outreach campaigns in coordination with health network partners</p> <p>3) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.</p> <p>4) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events</p> <p>5) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners</p> <p>6) Expand member engagement through direct services such as the Doula benefit and educational classes</p>	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Manager Equity and Community Health/ Director of Operations Management	Program Manager of Quality Analytics/ Manager of Quality Analytics	Equity and Community Health	<p>ECH piloted outreach efforts focused on Black and Native members using the Birth Equity population of focus list. Phone calls and mailings to promote BIH, ECM, and Doula services were provided to 183 members. 13% of members accepted referrals when contacted by phone, 92% of members were mailed materials about the services.</p> <p>Development of member messaging for prenatal and postpartum care is still taking place to support the goal of multimodal outreach and targeted engagement.</p>	<p>Working with ITS to develop reporting that identifies pregnant members earlier to allow for timely prenatal care</p> <p>Identify CBOs which could assist with increased performance and develop enhanced referral systems for ensuring care coordination.</p>	
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2024 QI Work Plan – Q4 Update

Cultural and Linguistic Appropriate Services	Data Collection on Member Demographic Information	Implement a process to collect member SOGI data by December 1st, 2024.	1) Develop and implement a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 3) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 4) Develop and implement a survey via the Member Portal, mail to new members and other methods. 5) Share member demographic information with practitioners.	Report progress to QIHEC quarterly: <del>Q2 2024 Update (08/13/2024)</del> Q2 2024 Update (07/09/2024) <del>Q3 2024 Update (11/05/2024)</del> Q3 2024 Update (10/08/2024) <del>Q4 2024 Update (02/11/2025)</del> Q4 2024 Update 01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	1) The Member's Sexual Orientation and Gender Identity (SOGI) survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age) was sent to members in September 2024.  2) The CalOptima Health's Core eligibility system to store SOGI data is continually being updated.  3) Member demographic information is being shared with practitioners.	1) Member's (SOGI) surveys will continue to be sent to members (18+ years of age) throughout Q1 and Q2 of 2025, to collect the Member's Sexual Orientation and Gender Identity (SOGI) information.  2) The CalOptima Health's Core eligibility system to store SOGI data will continue to be updated, as necessary.  3) Member demographic information will continue to be shared with practitioners.	
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## 2024 QI Work Plan – Q4 Update

Cultural and Linguistic Appropriate Services	Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.	1) Develop and implement a survey to collect practitioner REL data 2) Enter REL data into provider data system and ensure ability to retrieve and utilize for CLAS improvement. 3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership. 4) Assess the provider network's capacity to meeting CalOptima Health's culturally diverse member needs. 5) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Provider Data Management Services	Manger Provider Data Management System	Provider Data Management Services	Collecting REL data from healthcare providers was met, as the primary objective was to establish a process for REL data collection, rather than to achieve a specific response rate. The Provider Satisfaction Survey was successfully conducted in mid September 2024 to mid November 2024, and the data was processed and entered inot the database as planned. The Provider Satisfaction Survey was distributed to 2,272 healthcare providers, with 30 responses received, resulting in a response rate of 1.32%.  Challenges: The low response rate might be influenced by factors such survey fatigue at the end of the year, the lack of incentives, and the high volume of email communications likely contributed to low engagement and overlooked reminders, impacting the overall response rate.	In 2025, REL questions will be integrated into routine forms such as credentialing and provider demographic forms, instead of being included in the Provider Satisfaction Survey. This adjustment will shift visibility to the beginning of the year, rather than at the end, ensuring higher engagement and more timely responses.	
Cultural and Linguistic Appropriate Services	Experience with Language Services	Evaluate language services experience from member and staff	1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC quarterly: Q2-2024 Update (08/13/2024) Q2 2024 Update (07/09/2024) Q3-2024 Update (11/05/2024) Q3 2024 Update (10/08/2024) Q4-2024 Update (02/11/2025) Q4 2024 Update 01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	Cultural and Linguistic Services have developed a Staff and Member survey to evaluate the effectiveness of language services provided by cultural and linguistic services and vendors. The surveys will be launched in early February 2025.  Survey updates will be provided to QIHEC at the Quarterly Update on 02/11/2025.	Staff and Member surveys to evaluate the effectiveness of language services provided by cultural and linguistic services and vendors will continue to be sent to members in 2025.  Survey result updates will be provided to QIHEC at the Quarterly Update on 02/11/2025.	



## 2024 CalOptima Health Membership Risk Stratification

Interventions and Risk Levels	Targeted Intervention	Number of Members	Percentage of Membership
<b>Basic Population Health Management:</b> All members	An array of services that include care coordination, comprehensive wellness programs, and prevention initiatives, all requiring a strong connection to primary care.	916,989	100%
<b>Chronic Condition Management:</b> Medium Risk	Programs focused on conditions such as asthma, congestive heart failure, and diabetes. These interventions promote self-management skills, enabling members to manage their health daily and actively engage in their care.	45,166*	4.93%
<b>Complex Care Management:</b> High Risk	Care for high-risk patients with complex medical, behavioral, or social needs, including comprehensive assessments, care coordination, and advocacy to ensure effective health management and prevention of poor outcomes.	806	0.09%
<b>Enhanced Care Management:</b> Highest Risk	Enhanced Care Management (ECM) is a Medi-Cal benefit offering intensive, person-centered care for individuals with complex health and social needs. A dedicated "Lead Care Manager" coordinates care across providers and services, addressing unique needs like housing and social determinants of health. It represents the highest level of care management in Medi-Cal.	47,416**	5.17%

\*Chronic Care Management numbers based on CalOptima Health members potentially eligible for services from 01/01/24 to 12/01/24.

\*\*Enhanced Care Management numbers based on CalOptima Health members potentially eligible for services from 01/01/24 to 06/30/24.

**Medi-Cal Membership** = 916,989 (Membership Data as of January 2024)



# CalOptima Health

## **2024 Population Health Management Impact Report**

Report Date: January 2025

Data Date Range: January–December 2024



## 2024 Population Health Management Signature Page

Population Health Management Committee Chairperson:

A handwritten signature in black ink, reading "Shilpa Jindani", is written over a horizontal line.

Shilpa Jindani, M.D., FAAFP  
Medical Director, Equity and Community Health

A handwritten date "04/10/2025" in black ink is written over a horizontal line.

Date

Responsible Staff:

Shilpa Jindani, M.D., FAAFP  
Medical Director, Equity and Community Health

Katie Balderas, MPH  
Director, Equity and Community Health



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2024 Population Health Management Work Plan



## Section 1: CalOptima Health Overview

### CalOptima Health Overview

CalOptima Health has had the privilege of caring for Orange County residents since 1995. We believe that all our members deserve access to quality care and service throughout the health care continuum. As a county organized health system, CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision.

### Our Mission

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

### Our Vision

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

### Our Values

CalOptima Health honors its "Better. Together." motto by working with members, providers and community stakeholders so we can make things better — for our members and community. We believe that to best serve the people of Orange County, we must continue to lead with Collaboration, Accountability, Respect, Excellence and Stewardship. These are our CARES values, which guide how we build and maintain trust as a public agency, as well as with our members and providers.

## Section 2: Introduction

CalOptima Health's annual Population Health Management (PHM) Impact Report measures the effectiveness of the agency's PHM Strategy and Work Plan to address member care needs in the areas of:

- Keeping members healthy
- Managing members with emerging risks
- Increasing patient safety
- Managing multiple chronic conditions

Through this evaluation, CalOptima Health also identifies and addresses opportunities for improvement.

### Summary of Results

In 2024, all but one of the programs and initiatives within the 2024 PHM Strategy and Work Plan are on pace to meet established goals pending final rates for measurement year (MY) 2024. One of the three subgoals under the Street Medicine Program is at risk of not being met based on the lack of affordable housing opportunities for unhoused residents of Orange County.

### 2024 Population Health Management Strategy

Details of CalOptima Health's PHM impact evaluation are captured in this report and the 2024 PHM Work Plan can be found in the report Appendix on page 88.

## Section 3: Keeping Members Healthy

CalOptima Health designs programs and initiatives to keep our members healthy by focusing on promoting early detection, fostering healthy habits and supporting preventive care. CalOptima Health offers a range of screenings, wellness assessments and educational resources to empower members to take control of their health. With a focus on prevention, CalOptima Health aims to reduce the risk of chronic conditions and improve long-term well-being among members. The following section evaluates selected programs and initiatives designed to keep members healthy, including child preventive services, maternal health, nutrition and physical activity.

3.1 Blood Lead Testing in Children (12-24 Months)	
<b>Business Owner:</b> Mike Wilson	<b>Department:</b> Quality Analytics
<b>Support Staff:</b> Kelli Glynn/Leslie Vasquez	
<b>Products:</b> <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	<b>New Activity:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Work Plan Goal/Objective:</b> HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure: 63.99%	
<b>Goal Met:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
<b>Work Plan Planned Activities:</b> <ul style="list-style-type: none"> <li>A multi-modal, targeted member approach as well as provider and health network collaborative efforts. Activities will include but not be limited to: IVR calls, texting, mailing, newsletter articles</li> <li>Partnership with key local stakeholders (e.g., HCA)</li> </ul>	
<b>Status:</b> <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<b>Background:</b> Lead exposure can cause serious health issues, including brain and nervous system damage, and intellectual and behavioral problems. Since children often show no symptoms, lead poisoning may go unrecognized. According to the CDC, there is no safe blood lead level, and screening is the best way to detect exposure. If not caught early, the effects can be permanent.  California regulations recommend that Medi-Cal children be tested for lead at 12 and 24 months and receive catch-up tests if missed. Lead Screening in Children (LSC) is a key quality performance measure for HEDIS and part of the DHCS MCAS, reported annually by Medi-Cal MCPs. Starting in MY2022, MCPs are held to the NCQA Quality Compass Medicaid 50th percentile for LSC. DHCS also issued requirements for MCPs to ensure timely screenings in line with California regulations.  LSC is a hybrid HEDIS and MCAS measure that evaluates the percentage of children who receive a lead test by their second birthday. LSC is a proxy for how well children are being tested for lead in accordance with state regulations.	
<b>Methodology:</b> CalOptima Health follows the HEDIS data collection methodology to assess LSC performance. The methodology for the MY2024 goal is based on the MY2022 reported performance results compared to the MY2022 NCQA Quality Compass national percentile benchmark. If the performance rate meets the NCQA Quality Compass benchmark, CalOptima Health will set its goal to the next NCQA percentile to encourage	

continued performance improvement. However, if the measure rate falls below the 50th percentile, then CalOptima Health sets the 50th percentile as the organizational goal.

CalOptima Health stratified race and ethnicity for the LSC measure in MY2024 to assess potential disparities. However, this methodology differs from NCQA's approach to race and ethnicity stratification, meaning the identified groups may not align with those in NCQA's stratified data. It's important to note that NCQA does not require race and ethnicity stratification for the LSC measure.

Please note 2024 PHM Work Plan goal for Blood Lead Testing in Children was revised. Currently, blood lead testing rates are not available by 12 and 24 months. Therefore, the blood lead screening goals could not be evaluated by 12 and 24 months separately. Instead, the LSC MCAS measure of 50<sup>th</sup> percentile was used to evaluate performance.

#### Medi-Cal Results:

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met / Not Met
LSC	Lead Screening in Children	64.00%	63.00%	63.8%	63.99%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

#### Actions/Interventions Implemented in 2024:

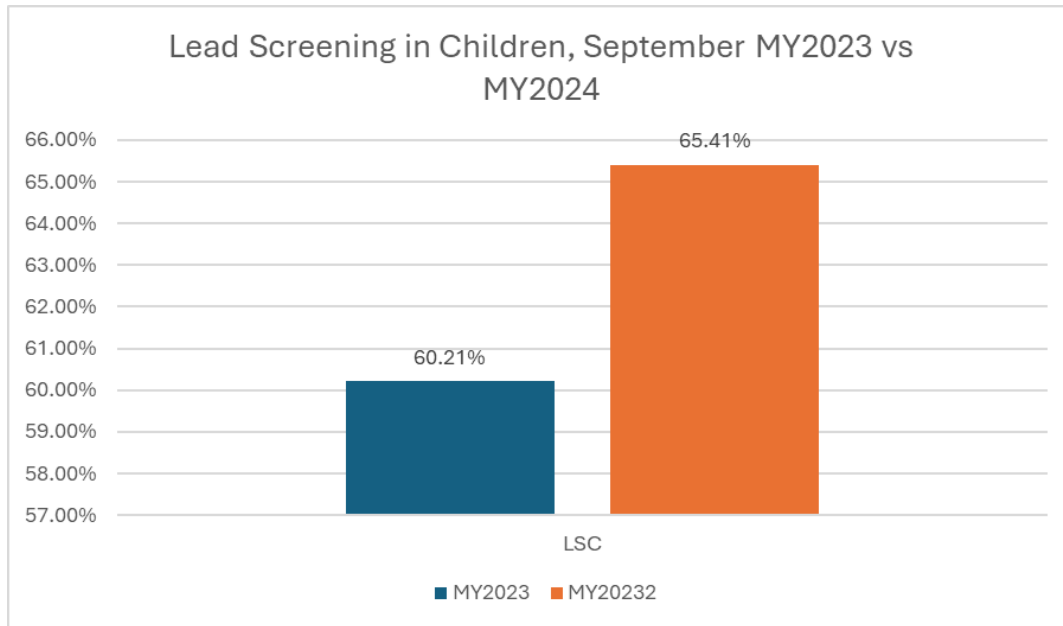
Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Member health reward for blood lead testing at 12 and 24 months of age	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	LSC
2. Texting campaigns — Members are issued general pediatric wellness texts along with blood lead-specific texts.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	LSC
3. Telephonic outreach	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	LSC
4. Blood Lead Screening Reports — Highlights members who are overdue for lead tests at 12 and 24 months of age. Highlights members that will be due for lead testing.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	LSC
5. Provider education: Various efforts, including presentations, provider continuing education and the Blood Lead Testing Guide. Education offered via fax, email, provider monthly update and provider newsletter.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	LSC
6. Targeted Paid Ads: Digital, social media, radio	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input checked="" type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	LSC
7. Community partnerships with local health care agency and Childhood Lead Poisoning Prevention Program focused on increasing blood lead testing	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input checked="" type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	LSC
8. Planned: Medical record review process to support monitoring of lead requirements.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input type="checkbox"/> Ongoing <input checked="" type="checkbox"/> Incomplete	LSC

9. Planned: Point-of-Care Lead Pilot	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input type="checkbox"/> Ongoing <input checked="" type="checkbox"/> Incomplete	LSC
10. P4V program	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	LSC

MC = Medi-Cal; OC= OneCare

## Results:

Chart A. MY2023 and MY2024 September Prospective Rates for LSC



Prospective rate methodology includes continuous enrollment criteria. LSC is a hybrid measure. Prospective rates showcased in Chart A are solely based on administrative data and are not final.

Chart A compares prospective rates; claims/encounters processed through September. LSC performance in September 2024 was much higher than the rate in September 2023 and trending 5% higher. LSC MY2024 rates are not final, however the measure is on pace to meet the established NCQA Quality Compass benchmark.

**Table A. MY2024 LSC Administrative Rates by Race/Ethnicity**

Admin	Race/Ethnicity									
HEDIS MY2024	Hispanic	No Response	Other	White	Vietnamese	Black	Chinese	Korean	Filipino	Asian or Pacific Islander
Numerator	4456	1112	810	405	367	61	46	48	35	36
Denominator	6260	1949	1307	885	496	114	81	80	63	52
Rate	71.18%	57.05%	61.97%	45.76%	73.99%	53.51%	56.79%	60.00%	55.56%	69.23%

Table A displays LSC administrative rates by race/ethnicity. Table A showcases the top 10 race/ethnic groups based on denominator, moving from the highest denominator (right) to lowest (far left).

**Quantitative Analysis:**

- LSC performance in September 2024 was much higher than the rate in September 2023 and trending 5% higher. LSC MY2024 rates are not final, however, the measure is on pace to meet the established NCQA Quality Compass benchmark.
- When assessing final rates (hybrid) for LSC from MY2021–MY2023, there has been no significant improvement in performance. In MY2022, the performance rate was decreased by 1% when compared to MY2021. In MY2023, the performance rate increased slightly (0.8%) from MY2022. Refer to Medi-Cal Results and Chart A.
- CalOptima Health set its organizational goal based on the MY2022 NCQA Quality Compass benchmark of 63.99%. MY2023 benchmarks were released subsequently, and the 50th percentile was set to 62.79%. CalOptima Health kept the 63.99% goal, which it did not meet. However, it should be noted that CalOptima Health did meet the 50th percentile of 62.79% for MY2023, with a final rate of 63.80%. See Medi-Cal rates above.
- Table A showcases MY2024 data by race and ethnicity data. Hispanic members account for the largest portion of the LSC denominator. When assessing for lead testing by race/ethnicity, the three groups with the lowest performance are as follows: White (45.76%), Black (53.51%) and Filipino (55.56%). Final rates are pending, but based on these trends, these groups may benefit from targeted interventions to support lead testing.

**Identified Barriers:**

- Lack of parent/guardian awareness related to the importance of lead testing for the identification of lead exposure and potential lead poisoning.
- Limited point-of-care lead testing practices
- Providers report that there are high costs associated with obtaining point-of-care lead testing machines and lead testing supplies

**Identified Opportunities for Improvement:**

- Ongoing need to support parental education on lead testing and reducing barriers to care.
- CalOptima Health to support a pilot to implement point-of-care testing in select provider offices.

**Conclusion:**

The latest September 2024 prospective rates showcase a slightly more than 5% increase in lead testing based on the same time last year. This indicates that the combined efforts for lead testing have made a positive impact on LSC performance. Additional activities, such as the medical record review and implementation of the point-of-care lead testing pilot, aim to support further increased rates in LSC performance. Results for these efforts are pending.

**Activities/Interventions to continue/add next year:**

- Continue the member health reward to encourage lead testing completion amongst members.
- Targeted member outreach via various modalities: mailing, text, IVR calls
- Complete the point-of-care lead testing pilot to support increased lead testing rates and reduce barriers for providers seeking to offer point-of-care testing in the office.
- Initiate medical record review to assess and monitor provider and health networks for state-issued lead requirements.



## 3.2 Pediatric and Adolescent Wellness (CIS-Combo 10, W30 First 15 and 15-30, IMA-Combo 2, and WCV-Total)

**Business Owner:** Mike Wilson

**Department:** Quality Analytics

**Support Staff:** Kelli Glynn/Leslie Vasquez

**Products:** ☒ Medi-Cal ☐ OneCare

**New Activity:** ☐ Yes ☒ No

### Work Plan Goal/Objective:

HEDIS MY2024 Goal

CIS-Combo 10: 45.26%, IMA-Combo 2: 48.80%, W30-First 15 Months: 58.38%, W30-15 to 30 Months: 71.35%, WCV (Total): 51.78%

**Goal Met:** ☐ Yes ☐ No ☒ Partial

### Work Plan Planned Activities:

- Targeted member engagement and outreach campaigns in coordination with health network partners.
- Quality Initiatives Intervention Plan — Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.
- Early identification and data gap bridging remediation for early intervention

**Status:** ☐ Completed ☒ Ongoing

### Background:

According to the CDC, well-child visits and recommended vaccinations are essential for good health. Well-child visits are essential for tracking growth and development milestones, discussing any concerns about a child's health, and is the time for children to receive scheduled vaccinations to prevent illnesses and receive recommended screenings (e.g., blood lead testing, developmental screenings). CalOptima Health focused on the following measures

- Childhood Immunization Status — Combination 10 (CIS-Combo10)
- Well-Child Visits in the First 30 Months of Life (W30), two key components:
  - Well-Child Visits in the First 15 Months (W30-First 15 Months)
  - Well-Child Visits for Age 15 Months–30 Months (W30–15 to 30 Months)
- Immunizations for Adolescents-Combination 2 (IMA-Combo2)
- Child and Adolescent Well-Care Visits (WCV-Total)

These measures are aligned with the DHCS Medi-Cal MCAS and held to the benchmarks established by the NCQA Quality Compass.

### Methodology:

CalOptima Health follows HEDIS data collection methodology to assess performance with prenatal and postpartum care. The methodology for MY2024 goal is based on the MY2022 reported performance results compared to the MY2022 NCQA Quality Compass national percentile benchmark. If the performance rate meets the NCQA Quality Compass benchmark, CalOptima Health will set its goal to the next NCQA percentile to encourage continued performance improvement. However, if the measure rate falls below the 50th percentile, then CalOptima Health sets the 50th percentile as the organizational goal.

For health disparity analysis, the data is pulled from the member enrollment file. The data is uploaded to the NCQA certified HEDIS software for rate calculation. The stratified rates are rolled up by denominator and numerator based on the rate/ethnicity, language or gender information uploaded.

## Medi-Cal Results:

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met / Not Met
CIS-Combo 10 (hybrid)	Childhood Immunization Status	47.4%	39.4%	36.50%	49.76%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
IMA-Combo 2 (hybrid)	Immunizations for Adolescents-Combo 2	50.7%	51.8%	47.5%	48.42%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
W30-First 15 Months (admin)	Well-Child Visits in the First 30 Months of Life	49.3%	55.8%	55.8%	55.72%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
W30-15 to 30 Months (admin)	Well-Child Visits in the First 30 Months of Life	67.3%	71.2%	72.4%	69.84%	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
WCV-Total (admin)	Child and Adolescent Well-Care Visits	54.0%	51.5%	53.0%	57.44%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

The following analysis pertains to the final rate trends from MY2021–MY2023.

- CIS-Combo 10 has steadily declined in performance. While the measure did not meet its organizational goal of 49.7%, it did meet the national benchmark of 30.9%.
- IMA-Combo 2 has a slight increase in MY2022 from MY2021, but rates declined in MY2023 compared to MY2022. While the measure did not meet the organizational goal for MY2023, it surpassed the national benchmark of 34.31% by more than 10%.
- W30-First 15 Months' performance has remained the same between MY2022 and MY2023. For MY2023, the measure met its organizational goal as well as the national benchmark goal of 58.38%.
- W30-15 to 30 Months' performance improved slightly in MY2023, up 1.2% from MY2022. However, this slight increase is not statistically significant. The measure met its organizational goal as well as the national benchmark goal of 66.76% for MY2023.
- WCV-Total rate performance improved slightly in MY2023, up 1.5% from MY2022. The change is not statistically significant. The measure did not meet the organizational goal for MY2023; however, it met the national benchmark goal of 48.07%.

## Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Member mailings (e.g., first and second birthday cards, member newsletters)	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	CIS, IMA, W30 WCV
2. Telephonic outreach (vendor-supported pediatric call campaign)	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	CIS IMA W30 WCV
3. Provider education (e.g., pediatric quality measures guide for HEDIS)	<input type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	CIS IMA W30 WCV
4. Targeted paid ads: digital, social media, radio, TV  Ads were available in English, Spanish, and Vietnamese member languages and targeted zip codes that were performing lower than the overall measure rate.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	CIS IMA W30 WCV
5. Well-Child Visits in the First 30 Months of Life Member Detail Report (monthly) — Reports outline the total number of visits completed along with visit dates.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	W30
6. Well Child Visit in the First 30 Months of Life Report — Identifying members with one or two visits pending.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	W30
7. Pediatric text campaigns — Issued to remind members of various period health assessment recommendations.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	CIS IMA W30 WCV
8. P4V Program	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	CIS IMA W30

		<input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Incomplete	WCV
<p>9. W30 Performance Improvement Project (PIP) to improve W30 well child visits in the first 15 months for Black children.</p> <p>Please refer to 4.7.1 Performance Improvement Project (PIP) in this evaluation and section 9.1 Evaluate the PIP of the 2024 Culturally and Linguistic Appropriate Services Program Evaluation for more information about this initiative.</p>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	W30

MC = Medi-Cal  
OC= OneCare

## Results:

### Disparity Analysis:

Methodology: Prospective rates with claims/encounters processed through September 2024 were analyzed for current performance by race/ethnicity. CalOptima Health viewed race/ethnic groups with more than 30 members in the denominator and identified the groups with the lowest performance for pediatric immunizations and pediatric well-care visits. For adolescent well-care performance, CalOptima Health analyzed race/ethnic groups with more than 400 members in the denominator and identified the groups with the lowest performance.

Chart A. Pediatric Immunization Rates by Race/Ethnicity, September 2024

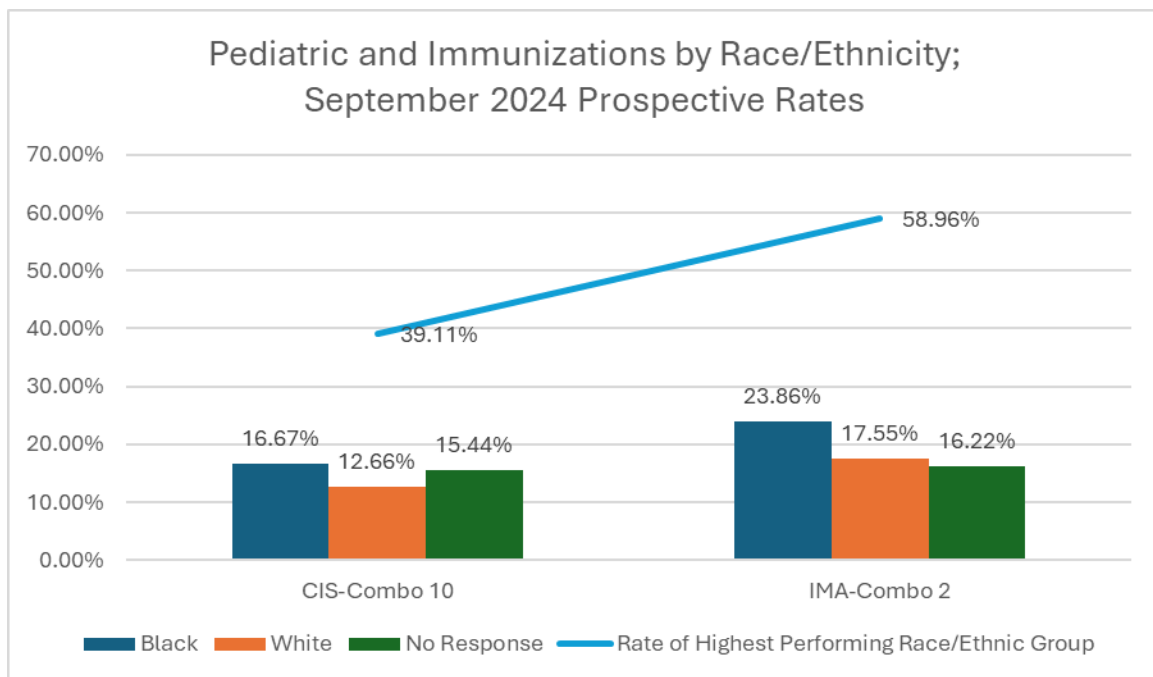


Chart A shows the CIS-Combo 10 and IMA-Combo 2 rates by race/ethnicity for prospective rates through September 2024. For both measures, Black, White and members that identified as “No Response” are performing the lowest across both measures. Vietnamese members are the highest-performing group in both pediatric and adolescent immunizations.

Chart B. Pediatric Well-Child Visits by Race/Ethnicity, September 2024

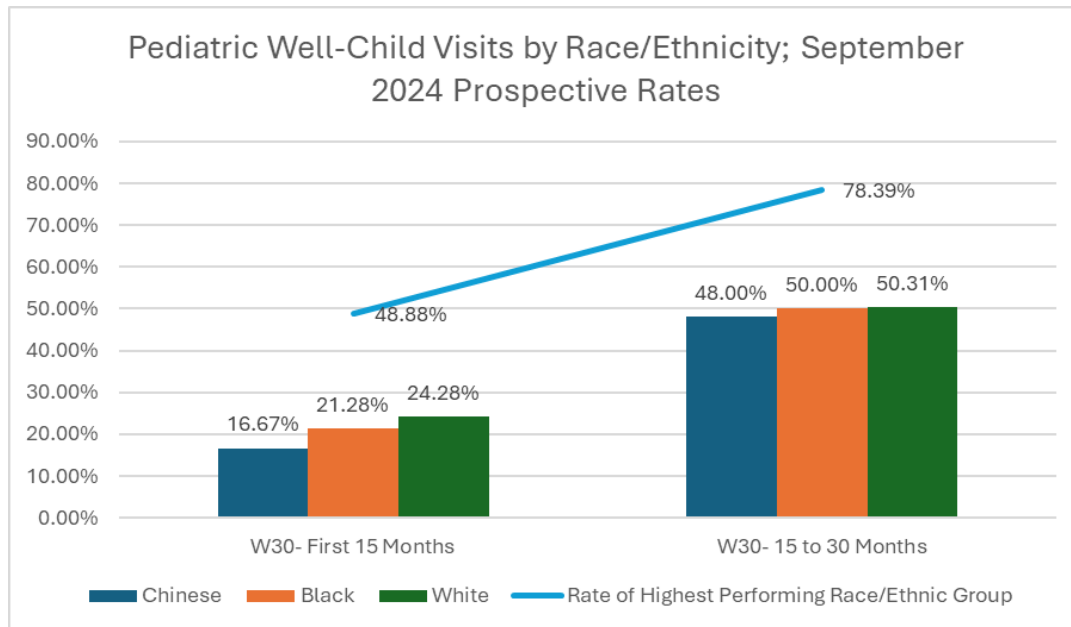


Chart B shows the rates for W30-First 15 Months and W30-15-30 Months by race/ethnicity for prospective rates through September 2024. For both measures, Chinese, Black and white members are performing the lowest across both measures. Vietnamese members are the highest-performing group for pediatric well-child visits.

Chart C. Pediatric Well-Care Visits by Race/Ethnicity, September 2024

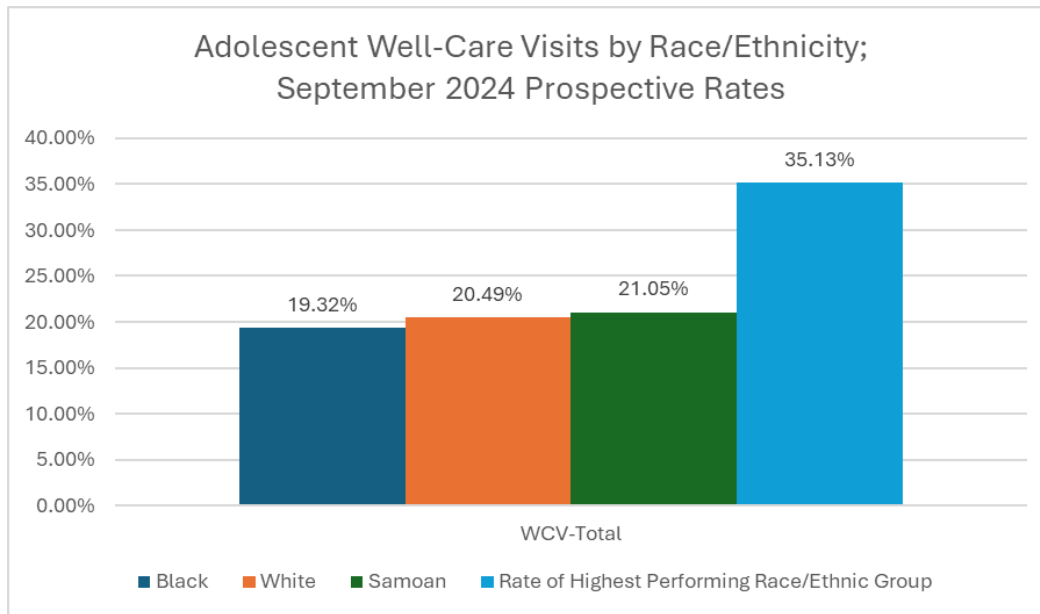


Chart C shows the rates for WCV-Total by race/ethnicity for prospective rates through September 2024. For both measures, Chinese, Black and white members are performing the lowest across both measures. Vietnamese members are the highest-performing group for pediatric well-child visits.

Chart D: MY2023 and MY2024 Pediatric and Adolescent Immunizations

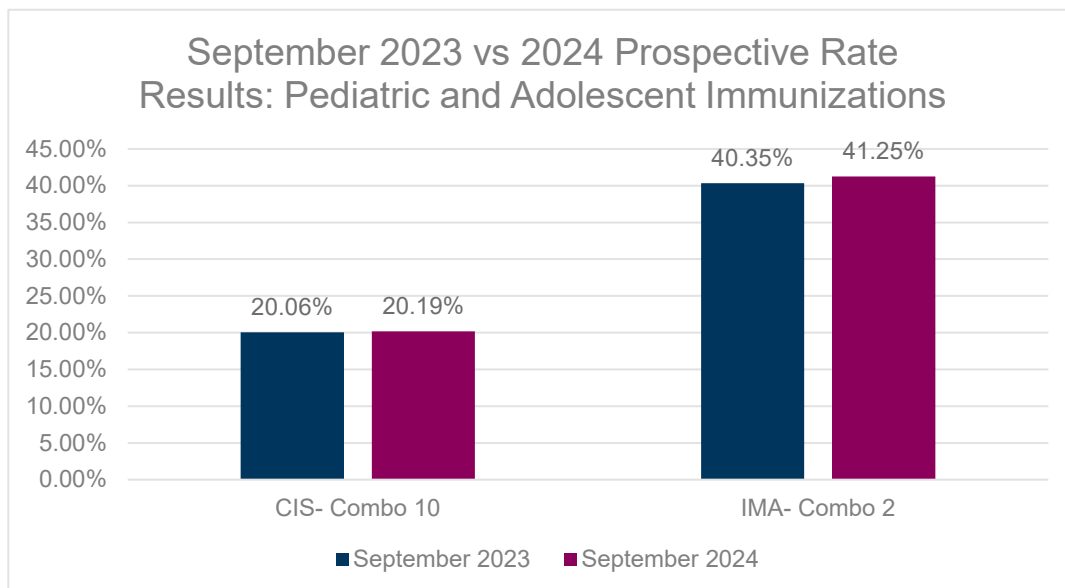
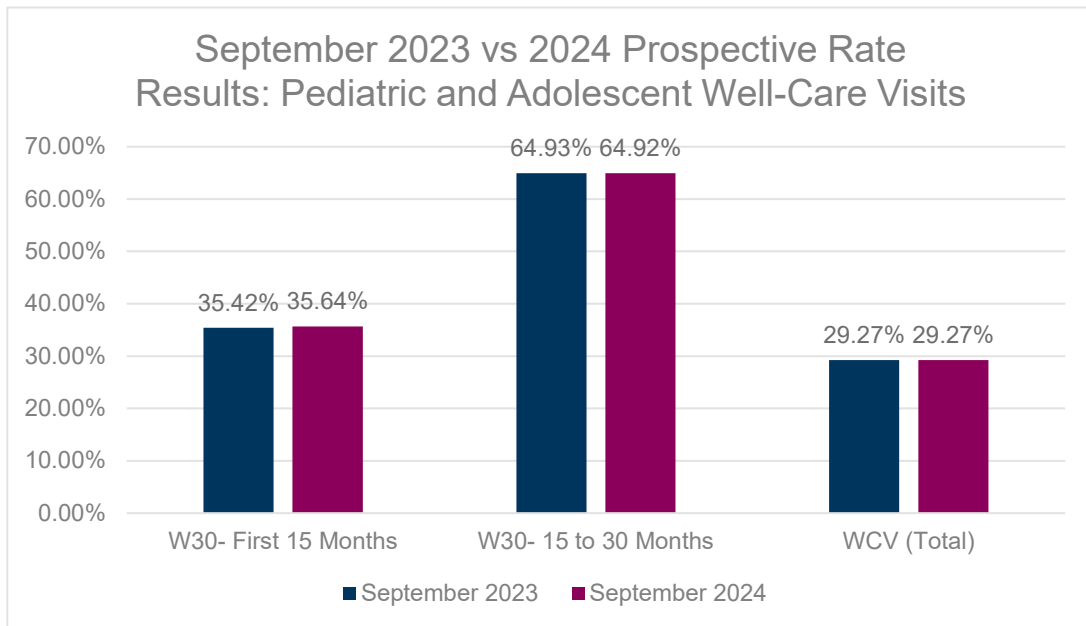


Chart E: MY2023 and MY2024 Pediatric and Adolescent Well-Care Visit Measures



Prospective rate methodology includes continuous enrollment criteria. CIS-Combo 10 and IMA-Combo 2 are hybrid measures, while W30 and WCV are administrative. Prospective rates are based on claims/encounters processed through September. Prospective rates in Chart A and Chart B are solely based on administrative data and are not final. Charts D and E compare September prospective rates for 2024 to the prospective rate in the previous year.

- Chart D: CIS-Combo 10 performance remains relatively similar to 2023 with no statistically significant improvement. IMA-Combo 2's performance increased slightly from 2023.
- Chart E: W30-First 15 Months of Life and W30-15–30 Months, as well as WCV Total, have not demonstrated any significant improvement in performance, thus indicating opportunities to continue implementing initiatives aimed at improving rates.



Table A

Submeasure	Denominator	Numerator	Administrative Numerator	Supplemental Numerator	Required Exclusions	Rate
Native Hawaiian and Other Pacific Islander Direct	704	247	226	21	0	35.09%
American Indian and Alaska Native Direct	213	75	69	6	0	35.21%
White Direct	32,312	12,419	11,420	999	10	38.43%
Black or African American Direct	4,616	1,872	1,739	133	2	40.55%
Unknown (Ethnicity)	109,890	53,501	50,601	2,900	21	48.69%
Some Other Race Direct	21,381	11,088	10,438	650	1	51.86%
Unknown Race	206,381	112,932	106,327	6,605	24	54.72%
Hispanic or Latino Direct	194,200	107,744	101,541	6,203	23	55.48%
Asian Direct	38,483	22,612	21,923	689	7	58.76%

### Quantitative Analysis:

As noted in the Results section above, there has been no significant increase in performance amongst all pediatric and adolescent immunization and well-child/well-care visit rates. CalOptima Health began targeted pediatric text campaigns in 2024 that allow for widespread outreach at the various timeframes for which a periodic health assessment is recommended. CalOptima Health has also refined its methodology with pediatric call campaigns to move away from general vaccination information to now sharing with parents/guardians what specific vaccinations are pending for the members. In addition, the plan has refined its messaging in text messages to speak to more than just vaccines. Often, parents/guardians may attribute well-child visits to just vaccines. However, there are other important screenings and care that are delivered at well-child visits.

### Disparity Analysis:

As shown in Table A, the overall total rate for the Child and Adolescent Well-Care Visits (WCV) measure in MY2023 was 53.03%. Using the total rate as a reference point, all ethnic groups except for Hispanic or Latino and Asian performed lower than 53.03%. The compliance rate for all ethnic groups except for Hispanic or Latino and Asian did not meet or exceed the MPL of 48.07%. The highest-performing ethnic group was Asian at 58.76%; the lowest-performing ethnic group was Native Hawaiian and Other Pacific Islander at 35.09%. In conclusion, CalOptima Health will continue to implement initiatives aimed at improving WCV performance across all ethnic groups.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Providers/health networks report that, since COVID-19, they have noted an increased hesitancy with vaccinations.</li> <li>Telephonic and text campaigns are dependent on having the correct contact information, and often, members opt not to pick up telephonic calls.</li> <li>Staffing shortages impact appointment availability making it difficult to complete well-child visits and important care (e.g., vaccinations).</li> </ul>	<ul style="list-style-type: none"> <li>Promote the messaging of HPV vaccination recommendation at an earlier timeframe to support dosage completion.</li> <li>Limited outreach success with text/calls indicates an opportunity to improve on rapport building with members, tailoring messages so that they meet different parental needs or concerns (e.g., vaccine safety), and leverage data on optimal call times.</li> </ul>
<b>Conclusion:</b> <ul style="list-style-type: none"> <li>Perceptions are changing around the importance of well-child visits and vaccinations after COVID-19. There is a need to augment messaging in communities about the importance of these visits and address vaccination hesitancy. Messages need to occur through various modalities.</li> <li>There is a need to continue to connect with health networks, clinics and provider offices to understand their challenges, successes and current process with well-care visits and vaccinations.</li> <li>Across all pediatric measures, both Black and White race/ethnic groups are the two performing the lowest. CalOptima Health should continue to work with providers and health networks to understand the contributing factors to this performance and tailor initiative to address the varying challenges/concerns with each population.</li> </ul>	
<b>Activities/Interventions to continue/add next year:</b>	
<p>CalOptima Health to continue the following efforts:</p> <ul style="list-style-type: none"> <li>Connect with health networks, clinics and provider offices to understand their challenges, successes and current process with well-care visits and vaccinations.</li> <li>Work with providers and health networks to understand best practices that are working to improve the delivery of well-care visits/vaccinations and share these best practices with others.</li> <li>Promote the CalOptima Health Pediatric HEDIS Guide to support performance and gap closure.</li> <li>Targeted member engagement and outreach campaigns in coordination with health network partners. <ul style="list-style-type: none"> <li>Multi-modal efforts: Mail, text, IVR calls, etc.</li> </ul> </li> <li>Early identification and data gap bridging remediation for early intervention and promotion of well-child visits as well as data capture in support of gap closure.</li> <li>Enhance the promotion of the CalOptima Health Pediatric HEDIS Guide to support performance and gap closure.</li> <li>Assess the effectiveness of the text campaigns newly implemented in 2024 and revise the member communication strategy as needed.</li> <li>Continue to leverage race and ethnicity performance data to drive initiatives aimed at reducing disparities in 2023.</li> </ul>	

3.2.1 Health Disparity Remediation for Well-Child Visits	
<b>Business Owner:</b> Mike Wilson	<b>Department:</b> Quality Analytics
<b>Support Staff:</b> Leslie Vasquez/Kelly Glynn	
<b>Products:</b> <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	<b>New Activity:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Work Plan Goal/Objective:</b> Meet and exceed goals set forth on all improvement projects. Increase well-child visit appointments for African American members (0–15 months) from 41.90% to 55.78% by December 31, 2024. This target was set for MY2024, however, the PIP timeframe spans from 2023 to 2026.	
<b>Goal Met:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
<b>Work Plan Planned Activities:</b> Action: Improve well-child visit rates in the first 30 months of life for African American child members.  MY2024 PIP activities consisted of a telephonic outreach campaign to the parents/guardians of African American child members turning 15 months of age in the measurement year. The telephonic outreach campaign aimed to provide the following: <ol style="list-style-type: none"> <li>1. Education on well-child visits</li> <li>2. Reminders to complete well-child visits</li> <li>3. Appointment coordination for well-child visits</li> <li>4. Data gathering on barriers and facilitators to well-child visits</li> </ol>	
<b>Status:</b> <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<b>Background:</b> The California 2020 Health Disparities Report identified disparities for most of the indicators of the Children's Health domain. Per this report, the African American group fared lower than other groups across all six key indicators.  The PIP aims to reduce the racial/ethnic disparities in W30-6 visits in support of the statewide goals. In alignment with the recommendations in the Health Equity Framework, this PIP will involve the African American population, the group most affected by health care disparities, through a survey call campaign to understand firsthand the experiences with well-child visits and the barriers to and facilitators for attending well-child visits.  Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate has the potential to improve member health status among these key indicators. Insight into the barriers to attending well-child visits has the potential to identify key areas that may improve member satisfaction across health care services.  PIP intends to address the following barriers to well-child visits: <ul style="list-style-type: none"> <li>• Parent/guardian gaps in knowledge as it relates to the purpose and value of well-child visits.</li> <li>• Lack of reminders for parents/guardians to complete well-child visits.</li> <li>• Lack of available resources for health networks to coordinate well-child visit appointments with a primary care provider for African American child members</li> </ul>	

## Methodology:

CalOptima Health followed HEDIS data collection methodology for the W30 — First 15 Months (noncontinuous enrollment). CalOptima Health then identified child members identified as African American to monitor for rates.

## Medi-Cal Results:

Chart A. Rates for W30 — First 15 Months

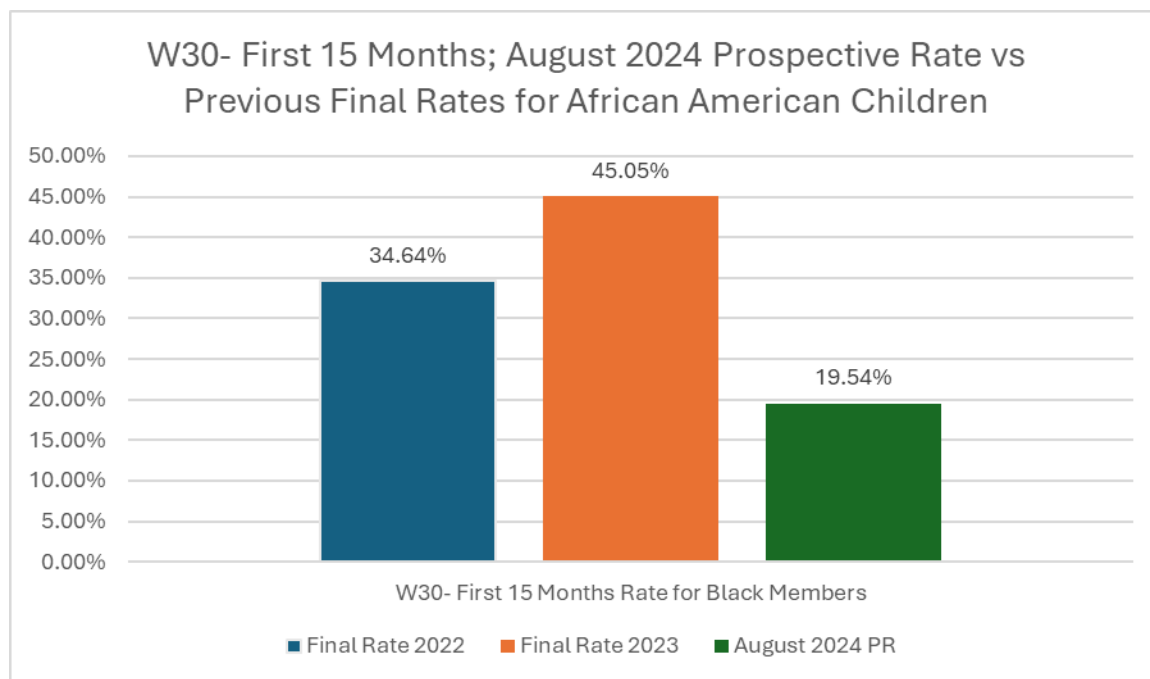


Chart A shows the final MY2022 and MY2023 W30 — First 15 Months rates for African American child members compared to the most recent 2024 prospective rate. The performance improvement project is set for 2023 to 2026. As part of the process, the MY2022 rate (34.64%) was used to confirm the population of interest — African American children — that would be targeted for the project. The chart demonstrates an increase in rates for MY2023 compared to MY2022. Final MY2024 rates are pending; however, the rate (19.54%) of claims/encounters processed through August 2024 is shown.

## Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Status	Measure(s) (Acronym)
1. Telephonic outreach campaign — Two calls were provided to each of the 85 members.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	W30 (First 15 Months)
2. Email campaign — To members with an email who were not successfully outreached via the telephonic campaign.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	W30 (First 15 Months)
3. Pediatric text campaign	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	W30 (First 15 Months)

MC = Medi-Cal; OC= OneCare

## Quantitative Analysis:

- For the 2024 calendar year, 85 African American members were identified as needing to complete six or more well-child visits by 15 months of age. Staff successfully contacted 34 (40%) of parents/guardians, providing reminders to complete well-child visits and addressing gaps in knowledge related to the importance and value of well-child visits.
- As part of the attempt to increase contact with members, letters were issued to the 51 parents/guardians who could not be contacted telephonically.
- Appointment coordination was offered to all 34 parents/guardians of child members who were successfully outreached. All 34 parents/guardians declined appointment coordination and refused support with appointment coordination for future well-child visits. This refusal may be driven by many reasons, including long call wait times, lack of urgency and competing priorities at the time in which the parent was called. based on feedback gained from the call campaign.

## Identified Barriers:

- Member contact information — Member contact lists contain outdated or incorrect information, contributing to a high rate of unsuccessful outreach. Other issues included the inability to leave voicemails or parent/guardian refusal to take the call.
- As part of an attempt to increase contact with members, letters were issued to the 51 parents/guardians who could not be contacted telephonically.

## Identified Opportunities for Improvement:

- Opportunities to improve member contact information to maximize outreach.
- Opportunities to partner with health networks to support care coordination for child members.

<p>Parents or guardians did not respond to the letter.</p>	
<p><b>Conclusion:</b></p> <ul style="list-style-type: none"> <li>• There is an opportunity to continue to inform members about the importance and cadence of well-child visits and what makes each of these visits unique to support adherence. Education about these visits should begin as early as possible including prenatal and postpartum timeframe.</li> <li>• There is an opportunity for PCPs to revise their workflows to allow for the scheduling of the next visit prior to the family leaving the existing visit.</li> <li>• Members feel that they benefit when their child's assigned PCP has appointment availability that fits the parents' schedules. PCP offices should continue to implement reminders for these visits.</li> <li>• There are opportunities to increase awareness of the Medi-Cal transportation benefit as well as inform parents of who the child's PCP is.</li> </ul>	
<p><b>Activities/Interventions to continue/add next year:</b></p> <ul style="list-style-type: none"> <li>• Efforts to include improved coordination with health networks to delivery care for African American child members.</li> </ul>	

### 3.3 Comprehensive Community Cancer Screening and Support Program (Breast Cancer Pilot)

**Business Owner:** Mike Wilson

**Department:** Quality Analytics

**Support Staff:** Melissa Morales/ Kelli Glynn

**Products:** ☒ Medi-Cal ☒ OneCare

**New Activity:** ☐ Yes ☒ No

**Work Plan Goal/Objective:** BCS-E: MC 62.67%

**Goal Met:** ☐ Yes ☒ No ☐ Partial

**Work Plan Planned Activities:**

Assess and report the following activities:

- Targeted member engagement and outreach campaigns in coordination with health network partners.
- Strategic Quality Initiatives Intervention Plan — Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.

**Status:** ☐ Completed ☒ Ongoing

**Background:**

According to the American Cancer Society, one in two men and one in three women will be diagnosed with cancer in their lifetime. Breast cancer is the second most common cancer for American women.

U.S. Preventive Services Task Force (USPSTF) has recommended screening for breast cancer. Cancer screening tests can help find cancer at an early stage before symptoms appear. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower health care costs.

The following is an evaluation of the cancer screening performance measures for HEDIS. Breast Cancer Screening are part of DHCS' MCAS for annual reporting by Medi-Cal managed care health plans. These measures are held to the MPL established by NCQA Quality Compass Medicaid 50th percentile.

**Methodology:** Followed the HEDIS data collection methodology.

Goal methodology for MY2023 is based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2023 is based on the MY2021 reported performance results compared to the national percentile from the MY2021 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile.

Goal methodology for MY2024 is set based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2024 is based on the MY2022 reported performance results compared to the national percentile from the MY2022 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile.

For health disparity analysis, the data is pulled from the member enrollment file. The data is uploaded to the NCQA certified HEDIS software for rate calculation. The stratified rates are rolled up by denominator and numerator based on the rate/ethnicity, language or gender information uploaded. Disparity analysis was conducted for BCS measures based on the HEDIS September MY2024 top 10 race/ethnicity administrative data by denominator.



## Medi-Cal Results:

### Table A

Table below reviews the Medi-Cal final rates for HEDIS MY2023 and goals for MY2023.

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Me/Not Met
BCS	Breast Cancer Screening	57.64%	57.81%	58.39%	61.27%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

### Table B

Table below reviews the Medi-Cal rates for September HEDIS MY2023-MY2024 and goals for MY2024.

Acronym	Measure	MY 2023 Sept Medi-Cal Rate	MY 2024 Sept Medi-Cal Rate	MY 2024 Medi- Cal Goal	MY 2024 Goal Me/Not Met
BCS	Breast Cancer Screening	51.72%	53.44%	62.67%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

### Table C

Table below reviews September MY2024 Breast Cancer Screening by Race/Ethnicity Based on Administrative Data.

Admin	Race/Ethnicity									
HEDIS Sept MY2024	Hispanic	Vietnamese	White	Other	No response, client declined to state	Korean	Filipino	Chinese	Asian or Pacific Islander	Black
Numerator	16591	8162	4948	3418	2381	921	785	562	466	353
Denominator	30979	13784	12480	6706	5942	2106	1566	1476	1012	917
Rate	53.56 %	59.21 %	39.65 %	50.97 %	40.07 %	43.73 %	50.13 %	38.08 %	46.05 %	38.50 %

Table caption: Table displays the top 10 ethnicities with the highest denominator based on total HEDIS Medi-Cal and OneCare population combined.



## Actions/Interventions Implemented in 2024:

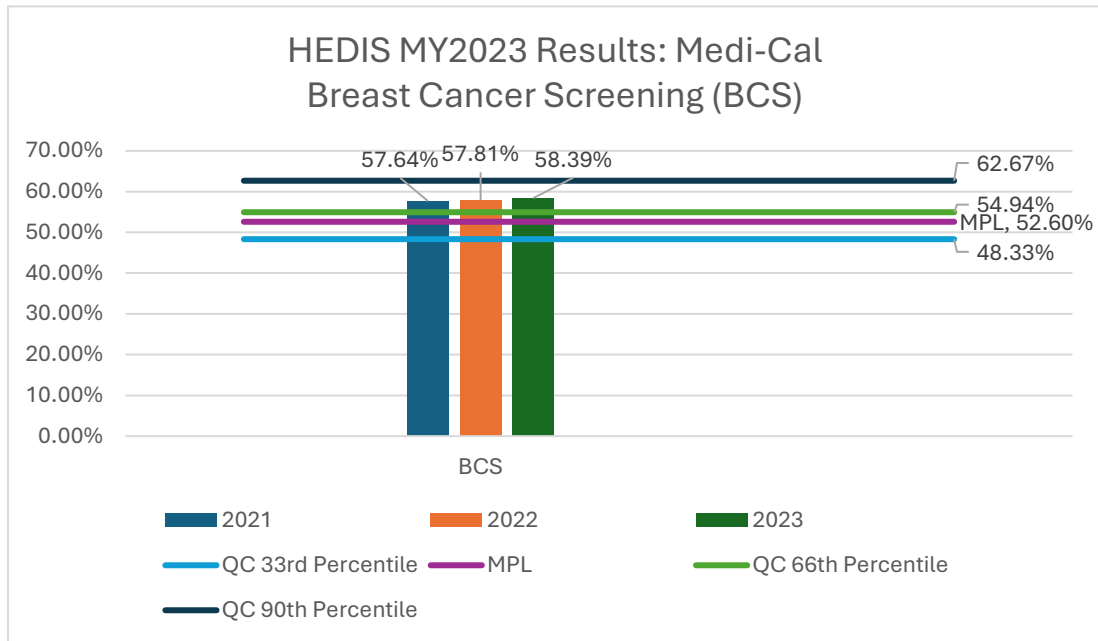
Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
• Member Health Reward	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	BCS
• Member Mailing	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	BCS
• IVR	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	BCS
• Text Messaging	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	BCS
• Telephonic Outreach	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	BCS
• Standing Orders Program	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	BCS
• Gap-in-Care Reporting	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete	BCS

MC = Medi-Cal; OC= OneCare

## Results:

### Chart A

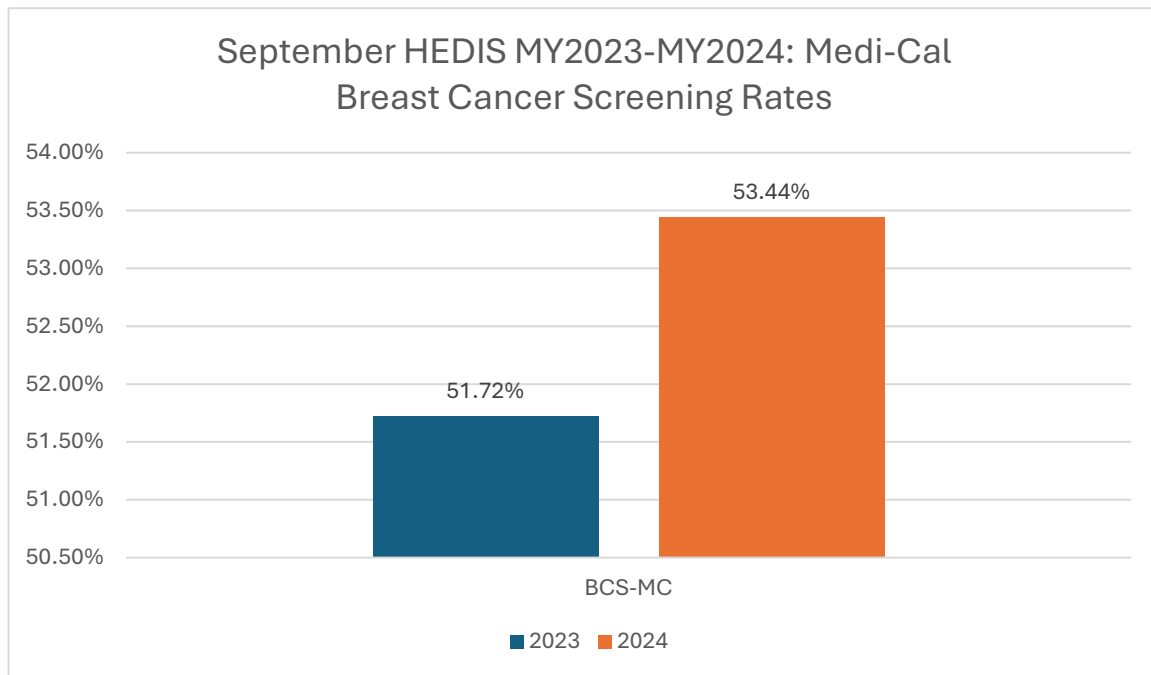
- CalOptima Health HEDIS MY2023 BCS rate for Medi-Cal was 58.39% and met the MPL of 52.60% but did not meet the MY2023 internal goal of 61.27%.



*Per HEDIS 2022 Quality Compass Percentile*

## Chart E

- CalOptima Health BCS rates for September HEDIS MY2023–2024 for Medi-Cal.



*Claims/encounters processed through September 2024*

### Quantitative Analysis:

Comparing CalOptima Health Medi-Cal BCS prospective rates for September HEDIS MY2023-MY2024. The rates are based on the administrative data and represent the claims/encounters process through the month of September for each respective year.

- Breast Cancer Screening (BCS-MC): As of September 2024, the BCS prospective rate was 53.44%, which is higher than the September 2023 prospective rate of 51.72% by 1.72 percentage points.

### Disparity Analysis:

BCS-MC, OC: When looking at the top three race/ethnicity groups by denominator count, the Vietnamese group had the highest rate at 53.56%. While the group identified as White had the lowest rate at 39.65%.

### Identified Barriers:

- Members did not visit their PCP during MY2024, so they were not educated or reminded of the cancer screenings they were due for.
- Members may not complete their cancer screening because of discomfort associated with the procedure and/or fear of knowing the test results.

### Identified Opportunities for Improvement:

- Data optimization
- Provider and health network quality committee meetings provide input on quality-related opportunities, helping identify barriers, develop and implement effective approaches

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>Members may not be aware of the importance of cancer screening and/or frequency of screening, especially after having a previous screening with a negative result.</li> <li>Appointment access could be limited due to scheduling limitations and/or staff shortages, resulting in long wait times.</li> <li>Due to data lag of approximately 90 days, the September 2024 prospective rate may not provide the most accurate rate of completion of cancer screening measures.</li> <li>Hybrid measures like Cervical Cancer Screening for Medi-Cal require medical record review; therefore, the actual final rate for MY2024 may be higher.</li> </ul> | <ul style="list-style-type: none"> <li>Develop member journey campaigns with new text messaging vendor to diminish member outreach abrasion.</li> <li>Member outreach specific to factors such as age.</li> <li>Internal member-facing departments will remind members of gaps in care during calls.</li> <li>Educate eligible members of direct access to imaging centers and gastroenterology specialists that no referral is needed.</li> <li>Engagement with specialists, such as OB/GYNs</li> </ul> |
|--|--|

## Conclusion:

Although we did not meet the internal CalOptima Health goal, we did reach MPL for Medi-Cal measures and 3-Star for OneCare Measures. On October 2024, the 2025 Star ratings were published, and for OneCare, BCS and COL reached 3-Star. CalOptima Health will retain CCS, BCS and COL measures on the 2025 Q1 Work Plan and continue to focus on preventative care screenings to address expected dips in utilization by conducting multicomponent interventions (mailers, automated calls and text messaging, e-mail) to increase demand for cancer screenings.

## Activities/interventions to continue/add next year:

- Continue health rewards for eligible CalOptima Health members for CCS, BCS and COL measures. In anticipation of the COL measure possibly being held to the MPL for MCAS, CalOptima Health expanded health reward offering to include COL member health reward for eligible Medi-Cal members. Will continue to increase participation in the program and motivate members to schedule and complete cancer screenings.
- The hybrid CCS measure reached MPL in MY2023 by a small margin. The new national benchmark was released in September 2024 and the MPL has increased from 57.11% to 57.18%. Opportunity remains to increase the CCS measure. MCAS announced that they are removing the hybrid reporting method for CCS and transitioning to Electronic Clinical Data Systems (ECDS) reporting in MY2025, which may have an impact on MCAS reporting in 2026. Accordingly, in MY2025, CalOptima Health will explore EMR integration with high-volume providers.
- In MY2024, CalOptima Health removed the prior authorization for OneCare colorectal cancer screening. Will expand removal of prior authorization for breast cancer screening.
- In MY2024, CalOptima Health awarded ~\$2.1 million dollars in quality improvement grants to health network partners and CHCN providers. Many of the grant programs will focus on the CCS, BCS and COL measures.
- In MY2024, CareNet conducted live agent calls to members with multiple gaps in care. In MY2025, internal member-facing staff will have access to Decision Point to remind members of cancer screenings that they are due for at the point of member contact.
- Cancer screening measures are part of the CalOptima Health Comprehensive Community Cancer Screening Program and grant funding has been dispersed to organizations to work towards increasing awareness and access to cancer screening.



- In MY2025, CalOptima Health will increase breast cancer screening access by offering mobile mammography.
- Staff will use disparity analysis to develop interventions to target higher-risk members with health inequities caused by race/ethnicity.

3.4 Maternal Health (TOPC and PPC)	
<b>Business Owner:</b> Mike Wilson	<b>Department:</b> Quality Analytics
<b>Support Staff:</b> Kelli Glynn/Leslie Vasquez	
<b>Products:</b> <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	<b>New Activity:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Work Plan Goal/Objective:</b> TOPC: 91.89%, PPC: 84.18%	
<b>Goal Met:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
<b>Work Plan Planned Activities:</b> <ol style="list-style-type: none"> <li>1. Targeted member engagement and outreach campaigns via collaboration with health networks and utilizing multiple communication channels</li> <li>2. Expansion of Bright Steps</li> <li>3. Collaborative member engagement events with community-based partners</li> <li>4. Expansion of member engagement through direct services such as the doula benefit and educational classes</li> </ol>	
The planned activities/initiatives outlined in the section below are reflective of the Work Plan's activities.	
<b>Status:</b> <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<b>Background:</b> <p>Joint guidelines published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) recommend a prenatal visit in the first trimester for all birthing persons. ACOG also recommends that all birthing persons have a comprehensive postpartum visit which provides an opportunity to address physical, mental and emotional health early on, followed by ongoing care as needed</p> <p>Prenatal and Postpartum Care (PPC) is a hybrid quality performance measure for HEDIS and is part of the DHCS MCAS that is held to a minimum performance level established by NCQA. HEDIS plays a critical role in supporting maternal health by assessing the quality and timeliness of care provided to birthing persons before and after childbirth.</p> <p>PPC has two components that assess the following for deliveries on or between October 8 of the year prior to October 7 of the current measurement year:</p> <ol style="list-style-type: none"> <li>1. Timeliness of Prenatal Care (TOPC): The percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization</li> <li>2. PPC: The percentage of deliveries that received a postpartum care visit on or between seven and 84 days (one–12 weeks) after delivery.</li> </ol>	
<b>Methodology:</b> <p>CalOptima Health follows the HEDIS data collection methodology to assess performance with prenatal and postpartum care. The methodology for the MY2023 goal is based on the MY2021 reported performance results compared to the MY2021 NCQA Quality Compass national percentile (benchmark). If the performance rate meets the NCQA Quality Compass benchmark, CalOptima Health will set its goal to the next NCQA percentile to encourage continued performance improvement. However, if the measure rate falls below the 50th percentile, then CalOptima Health sets the 50th percentile as the organizational goal.</p> <p>NCQA stratified select measures like PPC for race and ethnicity to support the identification of disparities amongst the patient population. Race and ethnicity data for MY2023 reflect these stratification requirements. PPC data was stratified by race and ethnicity and compared to the overall PCC rate to identify any disparities.</p>	

**Medi-Cal Results:** The table below indicates the final Medi-Cal rates for HEDIS MY2023 and how the rate fares against the goal set for MY2023.

Acronym	Measure	MY 2021 Medi- Cal Rate	MY 2022 Medi- Cal Rate	MY 2023 Medi- Cal Rate	MY 2023 Medi- Cal Goal	MY 2023 Goal Met/Not Met
TOPC (hybrid)	PPC: Timeliness of Prenatal Care	91.0%	88.10%	88.10%	91.89%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
PPC (hybrid)	PPC: Postpartum Care	81.60%	81.2%	80.00%	84.18%	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

In MY2023, TOPC did not meet the MY2023 organizational goal; however, TOPC met the NQCA Quality Compass benchmark of 84.23%. Similarly, PPC did not meet the desired MY2023 organizational goal. PPC did meet the NQCA Quality Compass benchmark of 78.1% for MY2023.

**Actions/Interventions Implemented in 2024:**

Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Postpartum health reward	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	PPC
2. Bright Steps Program — CalOptima Health’s maternal health program provides nutrition, health education, psychosocial support and resource referrals to members during and for one year post-pregnancy.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	TOPC PPC
3. Paid Digital and Social Media Ads — Provide education regarding the importance of prenatal and postpartum care  Ads were in English, Spanish, and Vietnamese and targeted lower performing zip codes across those member languages.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	TOPC PPC
4. PBS TV ad for maternal health	<input type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input checked="" type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	TOPC PPC
5. Member newsletter	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	TOPC PPC
6. Provider education — Provider education efforts include presenting on the PPC measure and coding requirements.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input checked="" type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	TOPC PPC

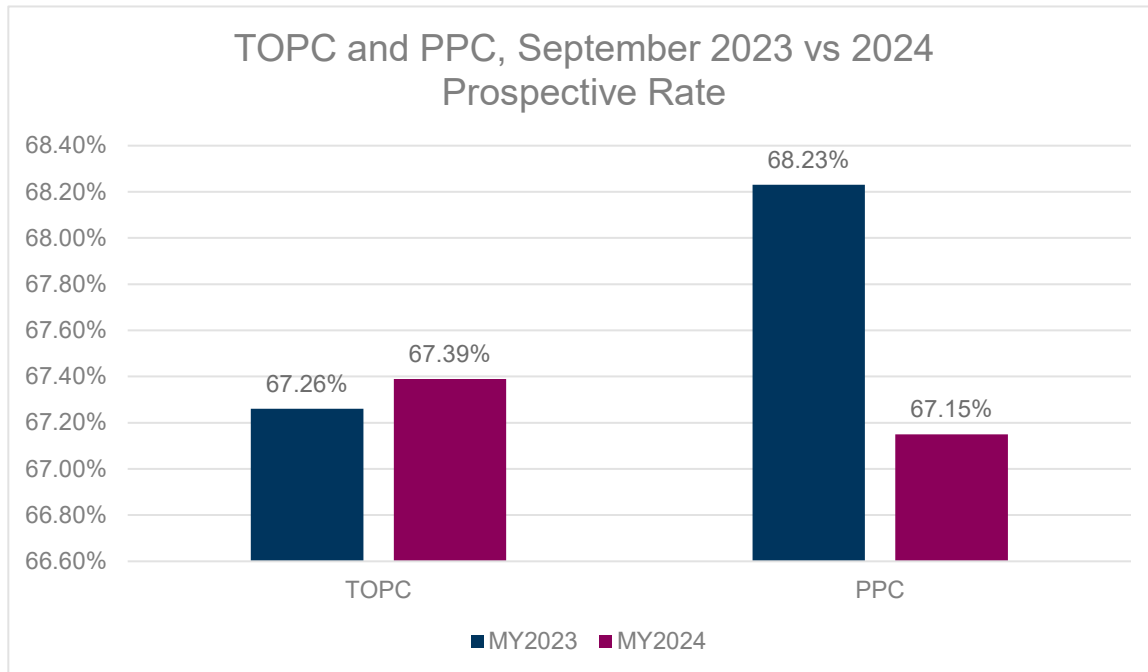


7. Postpartum care reminder call campaign	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> On-going <input type="checkbox"/> Incomplete	PPC
8. Planned: Provider education  The development of a coding guide to support practitioners who conduct bundled coding is planned for Q4 to support increased data capture for the PPC measure.	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input type="checkbox"/> On-going <input checked="" type="checkbox"/> Incomplete	TOPC PPC
9. P4V program	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	TOPC PPC
10. Planned: Report development utilizing available admit, discharge transfer (ADT) data to support the early identification of members that delivered for postpartum education	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input checked="" type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> On-going <input type="checkbox"/> Incomplete	PPC

MC = Medi-Cal  
OC= OneCare

## Results:

Chart A. MY2023 and MY2024 September Prospective Rate for TOPC and PPC



*Prospective rate (PR) methodology includes continuous enrollment criteria. PPC and TOPC are hybrid measures. Prospective rates are solely based on administrative data and are not final.*

- TOPC performance in September 2024 is performing relatively similar to September 2023. The increase in the rate for 2024 is not statistically significant.
- PPC is performing 1.08% lower in September 2024 compared to September 2023.

Table A. MY2023 Timeliness of Prenatal Care Rates by NCQA Ethnicity

NCQA Ethnicity	Hispanic/Latino	Unknown	Total
Numerator	4,256	2,500	6,756
Denominator	5,190	3,214	8,404
Rate	82.00%	77.78%	80.39%

*Table A displays timeliness of prenatal care rates per NCQA ethnicity specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. Comparisons were made against the total rate of 80.39%. Members that identify as Hispanic/Latino have a higher compliance rate (82.00%) than members whose ethnicity is unknown (77.78%).*

**Table B. MY2023 Timeliness of Prenatal Care Rates by NCQA Race**

NCQA Race	Unknown	Other	White	Asian	Black	Native Hawaiian and Other Pacific Islander	American Indian and Alaskan Native	Total
Numerator	4,713	718	621	575	106	13	10	6,756
Denominator	5,762	890	827	754	140	21	10	8,404
Rate	81.79%	80.67%	75.09%	76.26%	75.71%	61.90%	100%	80.39%

*Table B displays Timeliness of Prenatal Care rates per NCQA race specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. See Quantitative Analysis.*

**Table C. MY2023 Postpartum Care Rates by NCQA Ethnicity**

NCQA Ethnicity	Hispanic/Latino	Unknown	Total
Numerator	3,928	2,311	6,239
Denominator	5,190	3,214	8,404
Rate	75.68%	71.90%	74.24%

*Table C displays postpartum care rates per NCQA ethnicity specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. Comparisons were made against the total rate 74.24%. Similar to TOPC, the group with the unknown ethnicity performed lower than both the Hispanic/Latino group and the overall total rate.*

**Table D. MY2023 Postpartum Care Rates by NCQA Race**

NCQA Race	Unknown	Other	White	Asian	Black	Native Hawaiian and Other Pacific Islander	American Indian and Alaskan Native	Total
Numerator	4,338	664	549	572	100	10	6	6,239
Denominator	5,762	890	827	754	140	21	10	8,404
Rate	75.29%	74.61%	66.38%	75.86%	71.43%	47.62%	60%	74.24%

*Table D displays Postpartum Care rates per NCQA race specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. See Quantitative Analysis.*

## Quantitative Analysis:

- When assessing final rates (hybrid) for both TOPC and PPC, there has been no significant improvement in performance between MY2021 and MY2023.
- Tables A and B showcase race and ethnicity data, respectively, per NCQA specifications for TOPC. When assessing for race, a large portion of the population was identified as Unknown. Native Hawaiian and Other Pacific Islander represent the smallest ethnic group, however their TOPC rate was the lowest at 61.90% when compared to the overall total rate of 80.39%.
- Timeliness of Prenatal Care performance was assessed among racial groups with 100 or more members. Data stratified by racial groups were then compared to the overall rate for PPC Two additional racial groups that performed lower than the total rate (overall population) were White and Black, 75.09% and 75.71%, respectively, indicating an opportunity for targeted initiatives.
- Tables C and D showcase race and ethnicity data, respectively, per NCQA specifications for PPC. When assessing for race, a large portion of the population was identified as Unknown. The following three racial groups performed the lowest for PPC: White (66.38%), American Indian and Alaskan Native (60%) followed by Native Hawaiian and Other Pacific Islander (47.62%), American Indian and Alaskan Native (60%), followed by White (66.38%) when compared to the overall rate of 74.24%. This represents opportunities for targeted initiatives for these three groups.
- Across all racial groups, performance with postpartum care was lower compared to prenatal care. This represents opportunities for the health plan to explore the implementation of culturally appropriate messages in the prenatal period to support postpartum care as well as logistical issues (e.g., transportation) that may impede timely postpartum care.

## Identified Barriers:

- Delays of claims and encounter data present challenges for the timely identification of a delivery, which impacts the modalities in which CalOptima Health can leverage communication to outreach to members, support care coordination and reminders for care.
- Prenatal and postpartum care have varying coding practices. Bundled billing practices, in particular, can present challenges when the appropriate codes are not utilized, thus affecting the identification of care issued to members.
- CalOptima Health serves a diverse population. Cultural factors may contribute to gaps related to prenatal and postpartum care. Cultural factors may impact the timeline for which members seek timely prenatal care. Cultural practices and observations after delivery may impact the timeliness in which members seek the completion of a postpartum visit. Member perception as it relates to the value and importance of timely prenatal and postpartum care may impact member practices.

## Identified Opportunities for Improvement:

- Report development utilizing ADT data to support early identification for postpartum care.
- Development of a guide for practitioners practicing bundled billing for maternal care.
- Continue a multi-modal approach for members when issuing education about the importance of timely care. Outreach efforts should be representative of the various groups.

**Conclusion:**

A comprehensive strategy is needed to address the following:

- Proactive member outreach — Leverage data (e.g., claims, prescriptions) to trigger early member identification and engagement
- Provider education and training — Ongoing messaging and support to reduce disparities in maternal care, education on coding practices and cultural sensitivity
- Culturally tailored approach — Design campaigns that acknowledge cultural practices surrounding pregnancy and postpartum care
- Enhanced partnerships — CBOs can provide insight into barriers or facilitators of health that managed care plans may not have insight on.

**Activities/interventions to continue/add next year:**

- Continue the postpartum health reward and implement a broader promotion strategy
- Continue to promote postpartum care during the prenatal period and assess for barriers prior to delivery
- Targeted member outreach via various modalities: mailing, text, IVR calls
- Enhanced partnership with CBOs
- Continue to partner with health networks to identify providers to partner with for efforts that improve care delivery or reduce member barriers to care
- Develop initiatives (e.g., culturally appropriate material) aimed at reducing disparities amongst lower performing racial groups for improved TOPC and PPC performance.

## 3.5 Shape Your Life (SYL)

**Business Owner:** Thanh Mai Dinh

**Department:** Equity and Community Health

**Support Staff:** Michael Molina

**Work Plan Element:** Keeping Members Healthy

**Products:** ☒ Medi-Cal ☐ OneCare

**New Activity:** ☐ Yes ☒ No

**Work Plan Goal/Objective:** By December 31, 2024, at least 40% of the SYL participants who completed the pre- and post-assessment will increase their knowledge of basic nutrition and healthy lifestyles.

**Goal Met:** ☒ Yes ☐ No ☐ Partial

### Work Plan Planned Activities (From the QI Work Plan):

- Increase class locations with new community partners.
- Increase the number of class attendees by 50% from Q2 to Q4.
- Increase the number of classes offered.

**Status:** ☐ Completed ☒ Ongoing

### Background:

CalOptima Health's Equity and Community Health department offers the no-cost Shape Your Life (SYL) weight management program designed for children ages 5–18 years old and their families. Educational classes are open to the community, offered virtually and in person throughout Orange County at partner community centers and schools. Classes are customizable by location and audience needs. Along with the goal of achieving overall health, the program educates participants about healthy food choices, exercise, and how to attain or maintain a healthy weight by balancing healthy habits.

SYL includes six classes available in English, Spanish and Vietnamese. Classes are provided as a weekly series, for six consecutive weeks per location. When a class is not offered in the member's primary spoken language, language interpretation is provided as needed.

**Methodology:**

SYL measures participants' knowledge on class topics using multiple-choice assessments before and after the lesson. The assessments are implemented in the participant's primary language. SYL program goal calculation was updated in Q2 2024 and current results reflect the revised calculation.

- Numerator = SYL participant who completed the pre- and post-assessment with an increase in knowledge about nutrition and healthy lifestyle.
- Denominator = SYL participant who completed the pre- and post-assessment with the exclusion of those who scored 100% on both pre- and post-assessment.

After each class, participants had the opportunity to voluntarily fill out the SYL class qualitative feedback form about their experience, including the usefulness of class materials, feeling safe asking questions in class, staff knowledge of the topic, the importance of the topic, plans to use something learned in class and feeling connected with others.

**Actions/Interventions Implemented in 2024:**

Planned Activities/Interventions	Product	Quarter	Type	Status
<ul style="list-style-type: none"> <li>Implemented in-person and virtual SYL classes for members and families.</li> <li>Formative evaluation included monthly facilitator meetings to provide feedback and improve member experience in the program, which led to improving and revising lesson plans based on facilitator and member feedback.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input checked="" type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete
<ul style="list-style-type: none"> <li>SYL program goal calculation was updated in Q2 and its current results are reflected in the updated calculation. Numerator = SYL participant who completed the pre- and post-assessment with a gain in class topic knowledge. Denominator = SYL participant who completed the pre- and post- assessment with the exclusion of those who scored 100% on both pre- and post- assessment.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input checked="" type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete
<ul style="list-style-type: none"> <li>Expanded SYL program to at least four new schools and community partners in Orange County by attending and promoting the program at networking meetings such as Nutrition and Physical Activity Collaborative led by Orange County Health Care Agency and Family and Community Partnership with Orange County Department of Education.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input checked="" type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete
<ul style="list-style-type: none"> <li>Promoting SYL through Health Network Provider Relations department monthly emails to contracted providers and provider networks.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete



MC = Medi-Cal

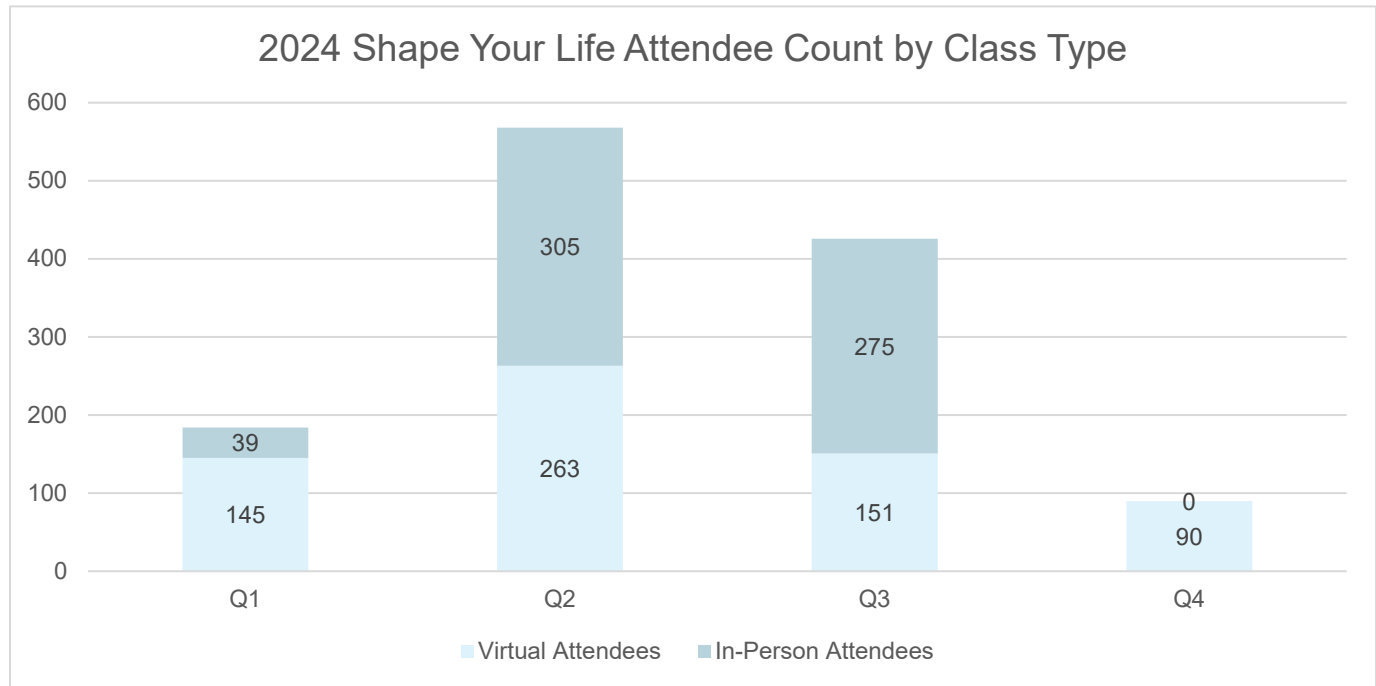
OC = OneCare

## Quantitative Results:

### 2024 SYL Pre- and Post-Assessment Results by Quarter

	Child Assessment	Adult Assessment	Combined	Goal Met
<b>Q1</b>	20% (1 out of 5)	64.8% (46 out of 71)	61.8% (47 out of 76)	Yes
<b>Q2</b>	50.9% (56 out of 110)	54.7% (93 out of 170)	53.2% (149 out of 280)	Yes
<b>Q3</b>	29.7% (19 out of 64)	39.4% (63 out of 160)	34.2% (82 out of 240)	No
<b>Q4</b>	0% (0 out of 3)	62.1% (23 out of 37)	57.5% (23 out of 40)	Yes
<b>Total (Q1–Q4)</b>	41.7% (76 out of 182)	51.3% (225 out of 438)	<b>47.3%</b> (301 out of 636)	<b>Yes</b>

The table above shows the evaluation of the cumulative pre- and post-assessment results by target group for each quarter. The last row represents the overall annual pre- and post-assessment evaluation of the SYL program.



	Q1	Q2	Q3	Q4
Virtual classes	60	33	24	14
In-person classes	8	34	24	0
Total class count	68	67	48	14

### Qualitative Results:

Below are the qualitative results from 472 responses collected from the SYL class feedback form in 2024.

In the form of Yes, No or Maybe responses:

- 96% of participants found the materials in class useful.
- 93% of participants felt safe asking questions and sharing ideas.
- 97% of participants believed the staff knew the topics well.
- 95% of participants believed the topics covered in class were important.
- 94% of participants plan to use something learned in the class.
- 79% of participants felt the classes helped them connect with their peers; 15% reported "Maybe."

## Quantitative Analysis:

In 2024, 47% of SYL participants who completed the pre- and post-assessment increased their knowledge of basic nutrition and healthy lifestyle. Results exceeded the goal (i.e., By December 31, 2024, at least 40% of the SYL participants who completed the pre- and post-assessment will increase their knowledge of basic nutrition and healthy lifestyle).

- Although the cumulative results for 2024 by Q3 were above the program goal rate, Q3 results alone during July, August and September decreased. Continuous process improvement was conducted with class facilitators in biweekly meetings to discuss implementation changes.

The SYL program well exceeded the goal of a 50% increase in participation from Q2 to Q4 due to the pilot of virtual class options. Attendance increased by 209% from Q1 to Q2. Looking only at in-person classes, this goal was also met, with the highest participation in Q3.

New partnerships for class locations were achieved, increasing from two community partners in 2023 to six community partners in 2024.

## Identified Barriers:

- Possible reasons for the lower rate of knowledge gain during Q3:
  - Increase of in-person attendees missing part of the assessment due to arriving late or leaving early from class.
  - Virtual participants had difficulty navigating and completing the assessment due to limited digital literacy skills.
- Translation of class materials, based on staff and attendee feedback, was identified as a minor challenge in gathering correct pre- and post-assessment responses.

## Identified Opportunities for Improvement:

- Improvement areas for the assessment included:
  - 1) Emphasizing information from the assessment during class.
  - 2) Providing pre-assessment after the group check in to allow more time for completion.
  - 3) Dedicating time to explicitly instruct members how to navigate the poll questions and encourage them to submit their responses.
- Offer more classes in Vietnamese to additional locations or more often. The first in-person series was very well attended weekly, and more classes were requested by attendees and the community partner who hosted the site.

## Conclusion:

The data conveys that the program curriculum and components address relevant issues that match attendee priorities. Also, the delivery of these educational sessions is conducted in a manner that is conducive to increasing knowledge on basic nutrition and healthy lifestyle strategies. The use of formative evaluation among class facilitators and support staff was an important process step used to quickly address barriers to meeting program goals.

The first Vietnamese in-person SYL class was implemented at a community center in Westminster. Classes were well attended for six consecutive weeks and more classes were requested by attendees and the community partner organization.

Virtual SYL classes were piloted in Q1 two times a day on Tuesday, Wednesday and Thursday in English and Spanish. Based on SYL virtual class pilot results, in Q2 virtual class options were reduced to two evening classes once a week in English and Spanish. By doing so, attendees seemed more willing to engage with each other or the facilitator, and to share their own experiences, successes and challenges. In addition, virtual classes had a higher attendance compared with in-person classes, which is likely due to the many families facing challenges with transportation and childcare.

## Activities/Interventions to continue/add next year:

- SYL in-person class locations increased from six in 2024 to 10 locations planned in 2025.
- Implement a plan to document class participation in the care management system (Jiva).
- Based on attendee and staff feedback, lesson plans were revised to enhance common terms and activities, creating a better connection with pre- and post-assessments.
- Implement a weight management presentation for general adult audiences emphasizing chronic condition prevention.

## Section 4: Emerging Risk

CalOptima Health's emerging risks programs and initiatives are designed to identify, assess and mitigate serious health risks among our members. These programs and initiatives focus on continuous monitoring, cross-disciplinary collaboration and adaptive strategies. Through these efforts, CalOptima Health aims to reduce the risk of chronic condition complications and improve long-term well-being among members. The following section evaluates select programs and initiatives designed to address emerging risks, including the chronic condition and self-management program and behavioral health services.

4.1 Chronic Condition Care and Self- Management Program (HbA1c <8.0%)	
<b>Business Owner:</b> Michael Wilson	<b>Department:</b> Quality Analytics
<b>Support Staff:</b> Melissa Morales/Kelly Glynn	
<b>Products:</b> <input type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	<b>New Activity:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Work Plan Goal/Objective:</b> Meet and exceed goals set forth on all improvement projects. By December 31, 2024, 5% of members identified as emerging risk* and who participated in the program will lower their HbA1C to less than 8.0%.	
<b>Goal Met:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
<b>Work Plan Planned Activities:</b> Conduct quarterly/annual oversight of specific goals for OneCare CCIP (January 2023–December 2025): CCIP Study — Comprehensive Diabetes Monitoring and Management	
<b>Status:</b> <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<b>Background:</b> CMS requires all Medicare Advantage (MA) and Special Needs Plans (SNP) to conduct a CCIP as part of their required QI Program over a three-year period. The purpose of the CCIP is to promote effective chronic disease management and the improvement of care and health outcomes for members with chronic conditions. For this three-year CCIP program beginning in 2023 and ending in December 2025, CalOptima Health has chosen to focus on diabetes as the target condition with a focus on increasing diabetes management. The target population for the CCIP interventions is OneCare members identified with diabetes (type 1 and 2). CalOptima Health chose to focus on members who fall in the category of “emerging risk” (A1C levels 8.0%–9.0%) as the target condition for this CCIP. Emerging risk is defined by members that were previously controlled <8.0% A1C level but had a recent A1C level result of 8.0% to 9.0%. These members were selected due to a higher chance of improving A1C results when targeting members with A1C results between 8.0% and 9.0% than members with an A1C >9.0% result.	
<b>Methodology:</b> <ul style="list-style-type: none"> <li>Two-year look back period for member’s A1C results (2022–2023) and current measurement years.</li> <li>Quality Analytics generated A1C report and identified members that were below 8.0%, 8.0% to 9.0% and above 9.0%. Also included was whether the A1C result decreased, increased, remained the same or no prior result was available.</li> <li>Quality improvement specialist filtered list for target population: Members between 8.0% and 9.0% with an increase in A1C result.</li> <li>Worked with Diabetes Management Program to finalize outreach list. Outreach included members who were part of the “emerging risk” category and the Diabetes Management stratification to keep outreach list manageable.</li> <li>Health coaches outreached to “emerging risk” members.</li> <li>Track outreach completion by using Jiva activity report.</li> <li>Data refresh occurs on a quarterly basis.</li> </ul>	
Actions/Interventions Implemented in 2024:	
<b>Quarter 1:</b>	<ul style="list-style-type: none"> <li>Finalize “emerging risk” report.</li> </ul>
<b>Quarter 2:</b>	<ul style="list-style-type: none"> <li>Telephonic outreach by health educators</li> </ul>
<b>Quarter 3:</b>	<ul style="list-style-type: none"> <li>Telephonic outreach by health educators</li> </ul>
<b>Quarter 4:</b>	<ul style="list-style-type: none"> <li>Telephonic outreach by health educators</li> </ul>

## Program Results:

### OneCare Outreach Results

Date	Emerging Risk List OneCare Members	Outreach Members	Outreach Rate
June 2024	28	3	10.7%
September 2024	97	113	85.8%

Table caption: Members that were outreached were those identified as “emerging risk” and were part of the Diabetes Management Program stratification-n.

**Quantitative Analysis:** For data report created in June 2024, health coaches attempted to call 10.7% of call list. For data report created in September 2024, health coaches attempted to call 85.8% of the call list. The CCIP goal has not been met since the program has an end date of December 31, 2025. CalOptima Health will evaluate whether the member was reached and accepted help for diabetes management. Also, will continue to track A1C values for members identified as “emerging risk” and participated in health coaching.

#### Identified Barriers:

- Delay due to the transition to CalOptima Health’s new managed care system (Jiva), which created the need to update emerging risk methodology.
- Data issue A1C values were missing, which may have affected emerging risk assignment.
- Outreach list included members that were already assigned to case management, so they were not outreached.
- Unable to contact “emerging risk” category members.

#### Identified Opportunities for Improvement:

- Work with Case Management department on members who are outreached by case managers but have been identified as emerging risk.
- Update emerging risk report with Diabetes Management Program report to make identification and assignment more efficient.

**Conclusion:** Will need additional time to obtain more recent A1C results and health coaching activity.

#### Activities/Interventions to continue/add next year:

- Identify barriers at the end of the intervention period for telephonic outreach by health educators and case managers.
- Evaluate member outreach and A1C trend.

## 4.2 Chronic Condition Program Member Satisfaction

**Business Owner:** Elisa Mora **Department:** Equity and Community Health

**Support Staff:** Joanna Hoffnagle

**Work Plan Element:** Member Satisfaction

**Products:** ☒ Medi-Cal ☒ OneCare **New Activity:** ☐ Yes ☒ No

**Work Plan Goal/Objective:** CalOptima Health established the goal of 85% member satisfaction with Disease Management (DM) services.

**Goal Met:** ☒ Yes ☐ No ☐ Partial

**Work Plan Planned Activities:**

**Status:** ☐ Completed ☒ Ongoing

### Background:

CalOptima Health annually evaluates the experiences of members who participate in disease management (DM) services. The Equity and Community Health (ECH) department analyzes data from the DM Member Satisfaction Survey and member complaints to identify opportunities to enhance the member experience.

In 2024, CalOptima Health set a goal of achieving 85% member satisfaction with DM services.

### Methodology:

The 2024 DM Satisfaction Survey focused on English and Spanish-speaking members enrolled in a DM program who had completed an initial health coach assessment between February 1, 2024, and September 15, 2024. The survey was sent to 767 members via two-way text message and 33 responses were received, resulting in a response rate of 3.69%.

The survey tool was developed to obtain feedback from members regarding their experience with DM programs including:

1. Overall program satisfaction
2. Helpfulness of program staff
3. Usefulness of the information disseminated
4. Members' ability to adhere to treatment plans
5. Members indicating that the program helped them achieve health goals

This year, a new question was added to obtain feedback from members on their preferred method(s) of receiving health coaching.

## Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
<ul style="list-style-type: none"> <li>Ongoing member enrollment to the program and health coaching interventions.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete
<ul style="list-style-type: none"> <li>Launched the two-way text message survey.</li> <li>Identify members for the survey.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input checked="" type="checkbox"/> Data <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Completed <input type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete
<ul style="list-style-type: none"> <li>Planned to mail 500 additional surveys.</li> <li>Explored other methods for obtaining timely feedback from members.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input checked="" type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete



## Program Results:

**Table A: Overall Member Satisfaction With CalOptima Health's DM Programs**

Question	Satisfaction	Neutral	Dissatisfaction	Goal Met
<b>Q.1 The information I received from my health coach while participating in the program helped me to better manage my health.</b>	97%	3%	0%	Yes
<b>Q.2 My health coach helped me follow my doctor's recommendations.</b>	91%	6%	3%	Yes
<b>Q.3 I was included when making decisions about my care plan.</b>	91%	6%	3%	Yes
<b>Q.4 The information and resources I have received from my health coach have been useful.</b>	97%	0%	3%	Yes
<b>Q.5 My health coach helped me manage my health needs and concerns.</b>	100%	0%	0%	Yes
<b>Q.6 My health coach helped me meet my care plan goals.</b>	100%	0%	0%	Yes
<b>Q.7 I am satisfied with CalOptima's Health Management program.</b>	96%	4%	0%	Yes

### Quantitative Analysis:

As indicated in Table A, the goal of 85% satisfaction was met in all categories. The data suggests that positive interactions with health coaches played a significant role in members' overall satisfaction with CalOptima Health's DM program. Numerous positive member comments further support this finding.

Survey results also indicate that 100% of members felt that their health coach effectively helped them manage their health needs, address concerns and achieve care plan goals. This data suggests strong effectiveness of health coach involvement, contributing to positive health outcomes and member satisfaction.

This year, a new question was added to assess member preferences for engaging with health coaches. The results revealed the following preferences:

- **76%** of participants prefer phone calls as their primary method of communication.
- **20%** of participants prefer in-person interactions.
- **4%** of participants favor video sessions.
- **0%** of participants prefer group classes.

These results suggest a strong preference for phone calls, which will be used to inform future program delivery strategies.

### Qualitative Analysis:

As previously mentioned, the DM satisfaction goal of 85% was successfully met across all areas, reflecting overall positive program performance. Additionally, 15 qualitative responses were received, with **100% positive comments** and no negative feedback.

Of the 15 responses, **three were in English (20%)** and **12 were in Spanish (80%)**. This distribution suggests that Spanish-speaking members are more likely to provide qualitative feedback, and it may be beneficial to consider strategies to increase response rates from English-speaking members as well.

The response rate to the DM Satisfaction Survey this year was 3.69%, **which is lower** than in previous years, which may limit the representativeness of the feedback. In response, we plan to mail **500 additional surveys** to a diverse group of members, which will help us increase the response rate and obtain more data to evaluate the program.

<p><b>Identified Barriers:</b></p> <ul style="list-style-type: none"> <li>• Low response rate when using only two-way text message to collect feedback from members.</li> <li>• Lengthy process for requesting changes to the survey.</li> </ul>	<p><b>Identified Opportunities for Improvement:</b></p> <ul style="list-style-type: none"> <li>• <b>Use multiple feedback collection methods:</b> Offer various options for collecting feedback from members, including text messaging (two-way), mail and QR codes.</li> <li>• <b>Expand language options:</b> Provide additional language options to ensure broader accessibility and inclusivity.</li> <li>• <b>Survey timing improvement:</b> Explore the possibility of launching the survey immediately after an intervention, instead of conducting it once a year.</li> </ul>
<p><b>Conclusion:</b></p> <p>While the data shows that members are highly satisfied with the DM program, a higher response rate would provide more comprehensive data, allowing for a better evaluation of the program.</p>	
<p><b>Activities/Interventions to continue/add next year:</b></p> <ul style="list-style-type: none"> <li>• Mail an additional 500 surveys to help increase the response rate.</li> <li>• Translate the survey into all CalOptima Health threshold languages.</li> <li>• Develop a platform that allows staff to launch the survey to members after intervention.</li> </ul>	

## 4.3 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA 7-days and 30-days)

<b>Business Owner:</b> Valerie Venegas	<b>Department:</b> Behavioral Health Integration (BHI)
<b>Support Staff:</b> Diane Ramos, Natalie Zavala, Carmen Katsarov	
<b>Products:</b> <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	<b>New Activity:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Work Plan Goal/Objective:</b> MC: 30-days: 36.34%; 7-days: 20.0% To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	
<b>Goal Met:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Partial	
<b>Work Plan Planned Activities:</b> <ul style="list-style-type: none"> <li>• Share real-time ED data with our health networks on an SFTP site.</li> <li>• Participate in provider educational events related to follow-up visits.</li> <li>• Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members with a follow-up after ED visit.</li> <li>• Implement new behavioral health virtual provider visits to increase access to follow-up appointments.</li> <li>• Bi-weekly member text messaging (approximately 500 members).</li> <li>• Member newsletter (Spring).</li> </ul>	
<b>Status:</b> <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<b>Background:</b> CalOptima Health's program assesses the percentage of ED visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose for which there was follow-up.	
<b>Methodology:</b> Two rates are reported in this program, the percentage of ED visits for which the member received follow-up within 30 days, as well as the percentage of ED visits for which the member received follow-up within seven days. Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends.	
<b>Actions/Interventions Implemented in 2024:</b>	
Quarter 1:	<ul style="list-style-type: none"> <li>• Shared real-time ED data with our health networks on an SFTP Site.</li> <li>• Met with ITS to discuss data sourcing automation for the provider portal information sharing monthly.</li> <li>• Bi-weekly member text messaging.</li> <li>• Drafted article for Spring member newsletter.</li> <li>• Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Health Centers and Medical Provider Forum on March 15, 2024, regarding the importance of quality measure.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Shared real-time ED data with our health networks on an SFTP site.</li> <li>• Bi-weekly member text messaging.</li> <li>• Spring member newsletter (April 2024).</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• SFTP folders have been established, and BH ED data was sent to health networks daily, as well as weekly reminders in HN communication.</li> <li>• Bi-weekly member text messaging.</li> </ul>

	<ul style="list-style-type: none"> <li>Article promoting Telemed2U and telehealth services will be included in Fall member newsletter. The article will help with possible provider access issues and increase the likelihood of ED follow-up visits.</li> <li>Developed IVR calls for ED follow-up.</li> <li>FUA data became available through provider portal.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>SFTP folders have been established and BH ED data is being sent to health networks daily, as well as weekly reminders in HN communication.</li> <li>Bi-weekly member text messaging.</li> <li>Finalized IVR script calls for ED follow-up.</li> </ul>

### Program Results:

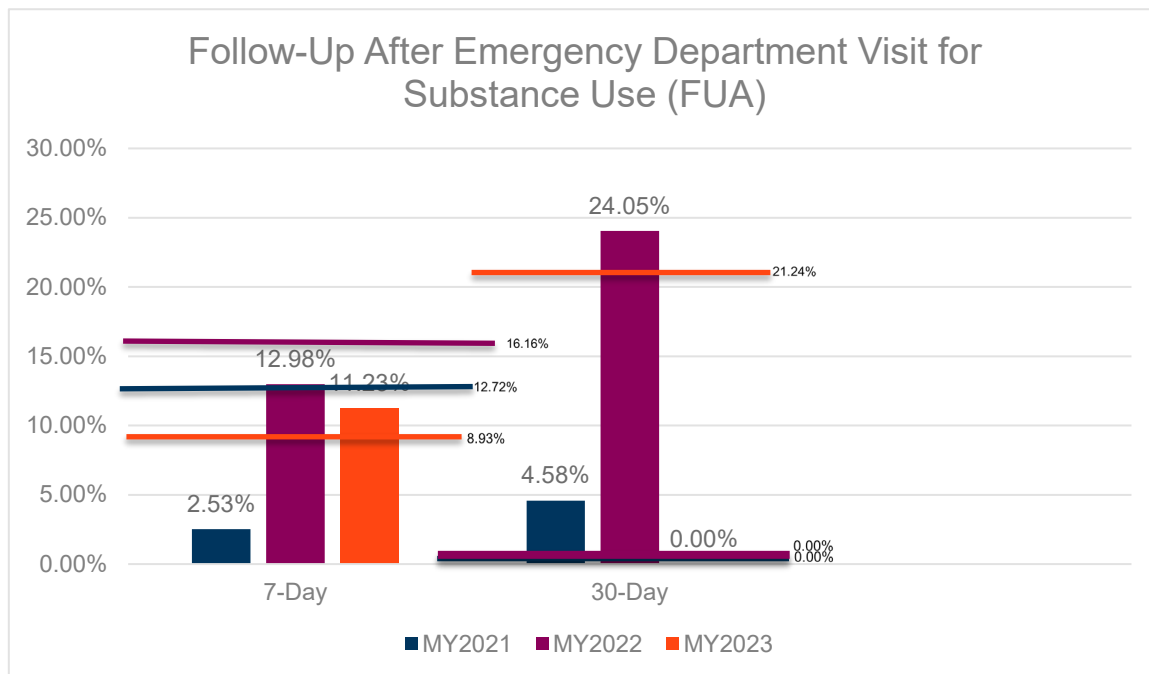


Chart caption: HEDIS Final Rates Trend Analysis

### Quantitative Analysis:

CalOptima Health's MY2023 HEDIS final seven-day rate was 11.23% which met the intended goal of 8.93%. The final 30-day rate was 21.41%, which also met the intended goal of 21.24%. The data demonstrates a slight increase in members attending follow-up visits post-ED visits. The pattern appears to be continuing into MY2024.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>Not having the bandwidth to outreach to members who fall into the FUA measure daily.</li> <li>Data collection and data sharing with the HCA has been difficult.</li> </ul>	<ul style="list-style-type: none"> <li>Use of available technology such as texting and telehealth services may allow better access to follow-up appointments for members as well as new forms of member outreach via IVR and telehealth providers.</li> </ul>

**Conclusion:**

Due to the measure not meeting the intended goal, we plan to continue to engage with both providers and members to achieve the desired outcome for FUA and improve data accessibility.

**Activities/Interventions to continue/add next year:**

- IVR calls to members who fall under the FUA measure
- BH Telehealth vendor will outreach to members from the daily ED data feed
- Continue bi-weekly member text messaging
- Member outreach with NAMI By Your Side (NBYS)

## Section 5: Patient Safety

CalOptima Health's patient safety programs and initiatives are designed to prevent harm and ensure the well-being of patients within health care settings. These programs and initiatives focus on identifying potential risks, fostering a culture of safety and implementing evidence-based practices. Through these efforts, CalOptima Health aims to reduce errors, improve quality of care across settings and enhance patient outcomes. The following section evaluates select programs and initiatives designed to ensure patient safety, including CalAIM Community Supports and Street Medicine.

5.1 CalAIM Community Supports	
<b>Business Owner:</b> Mia Arias	<b>Department:</b> CalAIM
<b>Support:</b> N/A	
<b>Work Plan Element:</b> Patient Safety	
<b>Products:</b> <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	<b>New Activity:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Work Plan Goal/Objective:</b> 90% of members referred to CalAIM Community Supports between July 1–December 31, 2024, will have received at least one Community Support.	
<b>Goal Met:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
<b>Work Plan Planned Activities:</b> Implement CalAIM Community Supports: 1. Recuperative care (medical respite) 2. Housing transition navigation services 3. Housing deposits 4. Housing tenancy and sustaining services 5. Short-term post-hospitalization housing 6. Day habilitation programs 7. Sobering centers 8. Medically tailored meals/medically supportive food 9. Personal care and homemaker services 10. Respite services 11. Nursing facility transition/diversion to assisted living facilities 12. Community transition services/nursing facility transition to a home 13. Environmental accessibility adaptations (home modifications) 14. Asthma remediation	
<b>Status:</b> <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<b>Background:</b> California Advancing and Innovating Medi-Cal (CalAIM) is a five-year initiative by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by addressing social drivers of health and breaking down barriers to access care. Community Supports are a core component of CalAIM.	
<b>Methodology:</b> Population of focus includes eligible CalOptima Health members referred to CalAIM Community Supports. <ul style="list-style-type: none"> <li>Numerator: Eligible CalOptima Health members who qualify for CalAIM Community Supports (CCS) between July 1–December 31, 2024, and received at least one CCS.</li> <li>Denominator: Eligible CalOptima Health members referred to CCS* between July 1– December 31, 2024.</li> </ul> To qualify for CalAIM Community Supports the member must be an eligible CalOptima Health member and referred or self-referred to CCS. Eligibility criteria for each CCS varies and are listed on the referral form.	

## Results:

Measure	MY 2024 Q1 Rate	MY 2024 Q2 Rate	MY 2024 Q3 Rate	MY 2024 Q4 Rate	MY 2024 Goal Met/ Not Met
Percentage of members who were referred to CalAIM Community Supports and received at least one Community Support.	90%	92%	94%	Pending	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Rationale for Trending: This is a new measure, and there is no trending data available.

## Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
<ul style="list-style-type: none"> <li>• Recuperative care (medical respite)</li> <li>• Housing transition navigation services</li> <li>• Housing deposits</li> <li>• Housing tenancy and sustaining services</li> <li>• Short-term post-hospitalization housing</li> <li>• Day habilitation programs</li> <li>• Sobering centers</li> <li>• Medically tailored meals/medically supportive food</li> <li>• Personal care and homemaker services</li> <li>• Respite services</li> <li>• Nursing facility transition/diversion to assisted living facilities</li> <li>• Community transition services/nursing facility transition to a home</li> <li>• Environmental accessibility adaptations (home modifications)</li> <li>• Asthma remediation</li> </ul>	<input checked="" type="checkbox"/> MC <input checked="" type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete

MC = Medi-Cal

OC = OneCare



## Quantitative Analysis:

The CalAIM Community Supports goal (i.e., 90% of members who were referred to CalAIM Community Supports between July 1–December 31, 2024, will have received at least one Community Support) is on track to meet set goal, as indicated in the results section. The data shows that the rate of members receiving at least one CalAIM Community Support has steadily increased over the first three quarters of 2024. Please note that the implementation of CalAIM Community Support Services is still in progress and final results will be available in the first quarter of 2025.

## Identified Barriers:

- None. CalAIM Community Supports continue to be successful in reaching this goal. One critical reason for this success is the diverse network of community-based organizations contracted to provide services in the communities where members live. Currently, there are more than 120 organizations providing one or more Community Supports to eligible CalOptima Health members.

## Identified Opportunities for Improvement:

- None.

## Conclusion:

Based on the data above, the CalAIM Community Supports goal is on track to be met. Furthermore, the data conveys that the program interventions are addressing social drivers of health, which can help reduce barriers to health care access.

## Activities/Interventions to continue/add next year:

- CalOptima Health will continue to support our contracted providers by offering ongoing training via the CalAIM Academy, which provides an annual schedule of monthly training.
- CalOptima Health will continue to reach out to community-based providers to educate them on the Community Supports available to members to help facilitate connection to services.

## 5.2 Street Medicine (Active PCP)

**Business Owner:** Nicole Garcia

**Department:** CalAIM

**Support Staff:** McKenzie Rodriguez

**Work Plan Element:** Patient Safety

**Products:** ☒ Medi-Cal ☐ OneCare

**New Activity:** ☐ Yes ☒ No

**Work Plan Goal/Objective:** By December 2024, connect 80% of unhoused participating members to an active Primary Care Physician (PCP).

**Goal Met:** ☒ Yes ☐ No ☐ Partial

### Work Plan Planned Activity (From the PHM Work Plan):

- Utilize a scheduling system for planning service delivery.
- Complete care scheduling and delivery.
- Utilize releases of information when a member has an active primary care provider (PCP) to increase collaboration and communication.
- Offer all members the opportunity to utilize the Street Medicine Provider as their PCP.

**Status:** ☐ Completed ☒ Ongoing

### Background:

CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's unhoused individuals and families through whole-person care approaches and addressing social drivers of health.

The service delivery process is efficiently managed through a well-organized scheduling system, ensuring timely care scheduling and consistent service delivery. All enrolled members are presented with the opportunity to select the Street Medicine Provider as their PCP, offering a flexible and accessible option for ongoing health care management. This approach promotes streamlined services and improved health outcomes. Enrolled members also have the option to select their own PCP, separate from the Street Medicine Provider. In this case, to enhance collaboration and communication, releases of information are utilized to facilitate better coordination of care.

## Methodology:

The population of focus includes members who are experiencing homelessness.

Numerator: Eligible CalOptima Health members who are experiencing homelessness, opted into the Street Medicine program, and are not assigned to a PCP.

Denominator: Members who are eligible for CalOptima Health services self-report experiencing homelessness to Street Medicine Team that is canvassing in designated geographic locations within Orange County during the measurement period (January 1–December 31, 2024).

## Results:

Measure	Q1 2024 Medi- Cal Rate	Q2 2024 Medi- Cal Rate	Q3 2024 Medi- Cal Rate	Q4 2024 Medi- Cal Rate	MY 2024 Goal Me/Not Met
Unhoused participating members were connected to an active Primary Care Physician (PCP).	84%	93%	83%	Pending	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Rationale for Trending: This is a new measure, and there is no trending data available.

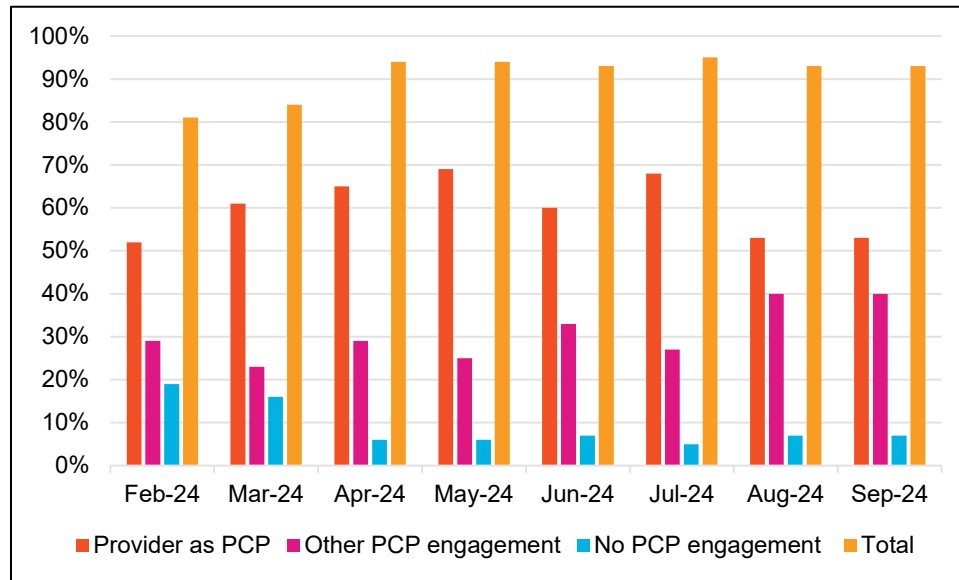
## Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
<ul style="list-style-type: none"> <li>Utilize a scheduling system for planning service delivery.</li> <li>Complete care scheduling and delivery.</li> <li>Utilize releases of information when member has an active PCP to increase collaboration and communication.</li> <li>Offer all members the opportunity to utilize the Street Medicine Provider as their PCP.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health <input type="checkbox"/> Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete

MC = Medi-Cal

OC = OneCare

## 2024 Unhoused Member Connected to a Medical Home



Source: Street Medicine Providers, Accessed November 2024

**Quantitative Analysis:** From Q1 to Q3, there was a steady increase in connecting members to a medical home. Members were successfully linked to a PCP to address and manage their health care needs.

### Identified Barriers:

- None. The Street Medicine providers are building a rapport with members and ensuring active PCP engagement.

### Identified Opportunities for Improvement:

- None.

### Conclusion:

The Street Medicine Active PCP goal (i.e., By December 2024, connect 80% of unhoused participating members to an active PCP) is on track to be met, as indicated in the results section. Furthermore, the data above indicates that the program effectively connects members to a PCP. Please note that the implementation of Street Medicine Program interventions is still in progress, and final results will be available in the first quarter of 2025.

### Activities/Interventions to continue/add next year:

- Continue to offer members who are unhoused a Street Medicine PCP.

## 5.2.1 Street Medicine (CalAIM ECM and Housing Navigation)

**Business Owner:** Nicole Garcia

**Department:** CalAIM

**Support Staff:** McKenzie Rodriguez

**Work Plan Element:** Patient Safety

**Products:** ☒ Medi-Cal ☐ OneCare

**New Activity:** ☐ Yes ☒ No

**Work Plan Goal/Objective:** By December 2024, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation.

**Goal Met:** ☒ Yes ☐ No ☐ Partial

### Work Plan Planned Activities (From the QI Work Plan):

- Making attempts to engage with members weekly.
- Providing Enhanced Care Management (ECM) and/or Housing Navigation and face-to-face appointments every other week.
- Completing care scheduling and delivery.
- Documenting all encounters.
- Connecting and providing supportive services.

**Status:** ☐ Completed ☒ Ongoing

### Background:

CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's unhoused individuals and families through whole-person care approaches and addressing social drivers of health.

Efforts are made to engage with members on a weekly basis, ensuring consistent communication and support. Every other week, face-to-face appointments are provided for ECM and Housing Navigation, addressing members' immediate needs and fostering stronger relationships. Care scheduling and delivery are carefully coordinated to ensure timely and efficient services, with all encounters thoroughly documented to maintain accurate records. Additionally, members are connected to a wide range of supportive services, reinforcing the overall care plan that contributes to long-term well-being.

## Methodology:

The population of focus includes members who are experiencing homelessness.

Numerator: Eligible CalOptima Health members who are experiencing homelessness, opted into the Street Medicine Program, and are not enrolled in CalAIM ECM or Housing Navigation.

Denominator: Members who are eligible for CalOptima Health services self-report experiencing homelessness to the Street Medicine Team that is canvassing in designated geographic locations within Orange County during the measurement period (January 1–December 31, 2024).

## Results:

Measure	Q1 2024 Medi- Cal Rate	Q2 2024 Medi- Cal Rate	Q3 2024 Medi- Cal Rate	Q4 2024 Medi- Cal Goal	MY 2024 Goal Me/Not Met
Unhoused participating members who were connected with CalAIM ECM and Housing Navigation.	93%	93%	95%	Pending	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

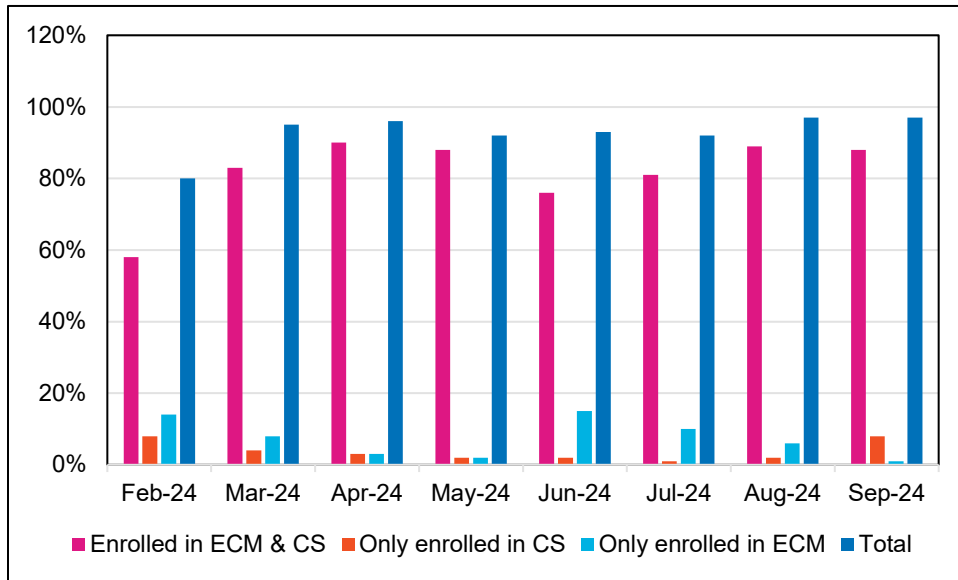
## Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
<ul style="list-style-type: none"> <li>Making attempts to engage with members weekly.</li> <li>Providing ECM and/or Housing Navigation appointments face to face at least every other week.</li> <li>Completing care scheduling and delivery.</li> <li>Documenting all encounters.</li> <li>Connecting and providing supportive services.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete

MC = Medi-Cal

OC = OneCare

## 2024 Unhoused Members Enrolled in ECM and/or Community Supports



Source: Street Medicine Providers, Accessed November 2024

### Quantitative Analysis:

From Q1 to Q3, there was a steady increase in enrolling members to CalAIM services. Members were successfully enrolled in CalAIM services to address and manage their medical and social needs.

### Conclusion:

The Street Medicine Program (CalAIM ECM and Housing Navigation) goal (i.e., By December 2024, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation) is on track to be met, as indicated in the results section. Furthermore, the data shows that the program has been successful in enrolling members into CalAIM ECM and Housing Navigation services, as the enrollment trend steadily increased over the course of the year. Please note that the implementation of the Street Medicine Program interventions is still in progress, and final results will be available in the first quarter of 2025.

### Identified Barriers:

- None. Street Medicine providers enrolled members into CalAIM services quickly and consistently.

### Identified Opportunities for Improvement:

- None.

### Activities/Interventions to continue/add next year:

- Street Medicine providers will continue to offer CalAIM ECM and Housing Navigation services to all enrolled members.

## 5.2.2 Street Medicine (Shelter or Housing Options)

**Business Owner:** Nicole Garcia

**Department:** CalAIM

**Support Staff:** McKenzie Rodriguez

**Work Plan Element:** Patient Safety

**Products:** ☒ Medi-Cal ☐ OneCare

**New Activity:** ☐ Yes ☒ No

**Work Plan Goal/Objective:** By December 2024, connect 20% of unhoused participating members to a shelter or other housing option.

**Goal Met:** ☐ Yes ☒ No ☐ Partial

### Work Plan Planned Activities (From the PHM Work Plan):

- Outreach to and engage unsheltered individuals.
- Provide Enhanced Care Management (ECM) and/or Housing Navigation services.
- Enter members into the Coordinated Entry System.
- Connect individuals to local shelters.
- Work with members on completing housing documentation.

**Status:** ☐ Completed ☒ Ongoing

### Background:

CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's unhoused individuals and families through whole-person care approaches and addressing social drivers of health.

Providing crucial support through ECM and Housing Navigation, the Street Medicine Coordination Care Teams focus on housing their unsheltered members. After individualized assessment, housing plans are completed, and interventions are carried out. This could include entering members into the Bed Reservation System, making direct links to shelter and/or entering members into the Coordinated Entry System to streamline access to housing resources. Additionally, services include assisting individuals in completing necessary housing documentation, helping to remove barriers and moving them closer to securing stable, permanent housing. This comprehensive approach aims to address both the immediate and long-term needs of unsheltered individuals, fostering a pathway to stability, safety and well-being.



## Methodology:

The population of focus includes members who are experiencing homelessness.

Numerator: Eligible CalOptima Health members who are experiencing homelessness, opted into the Street Medicine Program, and are not connected to a shelter or other housing option.

Denominator: Members who are eligible for CalOptima Health services self-report experiencing homelessness to the Street Medicine Team that is canvassing in designated geographic locations within Orange County during the measurement period (January 1–December 31, 2024).

## Results:

Measure	Q1 2024 Medi- Cal Rate	Q2 2024 Medi- Cal Rate	Q3 2024 Medi- Cal Rate	Q4 2024 Medi- Cal Goal	MY 2024 Goal Me/Not Met
Unhoused participating members were connected to a shelter or another housing option.	8%	9%	10%	Pending	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

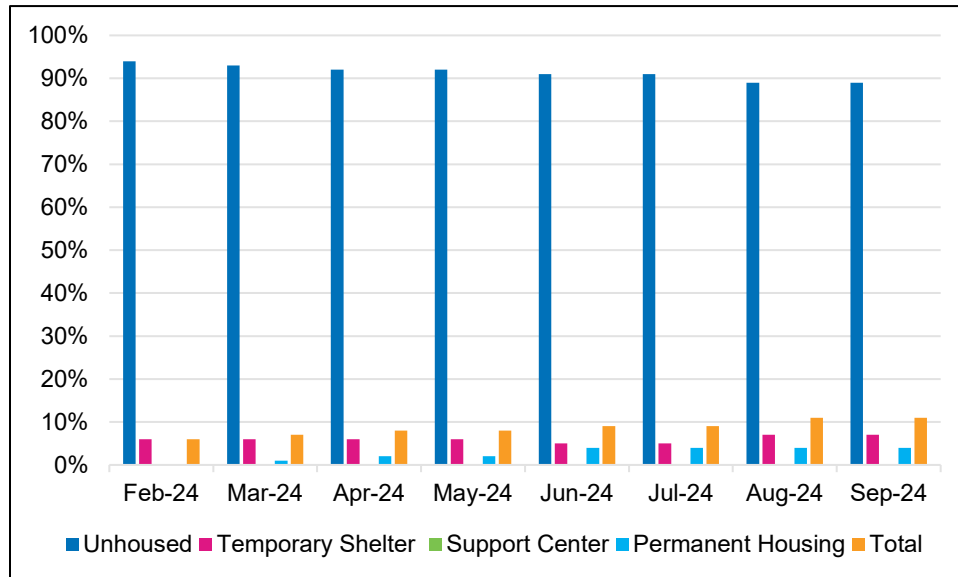
## Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
<ul style="list-style-type: none"> <li>Outreach to and engage unsheltered individuals.</li> <li>Provide ECM and/or Housing Navigation.</li> <li>Enter members into the Coordinated Entry System.</li> <li>Connect individuals to local shelters.</li> <li>Work with members on completing housing documentation.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input checked="" type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete

MC = Medi-Cal

OC = OneCare

## 2024 Housing Status



Source: Street Medicine Providers, Accessed November 2024

### Quantitative Analysis:

From Q1 to Q3 there was a slight increase in the number of members who were linked to housing over time.

### Conclusion:

The Street Medicine Program (Shelter/Housing) goal (i.e., By December 2024, connect 20% of unhoused participating members to a shelter or other housing option) is not on track to be met, as indicated in the results section. The data highlights a significant barrier in securing housing placements for members. However, there was a slight increase in the number of members who were successfully connected to housing. Please note that the implementation of Street Medicine Program interventions are still in progress, and final results will be available in the first quarter of 2025.

### Identified Barriers:

- There are simply not enough housing opportunities for the unsheltered residents of Orange County.
- Additionally, while members may be in the Coordinated Entry System (CES) or Shelter Bed Reservation System, there is no guarantee of a match.

### Identified Opportunities for Improvement:

- Street Medicine providers will continue to use and stay educated on CES and the Bed Reservation System.
- Street Medicine providers will stay up to date on housing opportunities in their geographic locations.

### Activities/Interventions to continue/add next year:

- Street Medicine providers will continue to offer and provide Housing Navigation to all members.
- Street Medicine providers will continue to use the CES and Bed Reservation System.

- Lastly, Street Medicine providers will work directly with CalOptima Health and the cities in which they operate to be aware of all housing opportunities.

## **Section 6: Managing Multiple Chronic Conditions**

CalOptima Health's program for managing members' multiple chronic conditions provides coordinated, comprehensive care for members living with more than one long-term health issue. The program aims to improve quality of life, reduce complications and prevent hospitalizations by integrating care across medical, behavioral and social domains. By tailoring treatment plans to each patient's unique needs and promoting proactive health management, this program helps members better manage chronic conditions, enhance overall well-being and navigate the complexities of living with multiple health challenges. Effective condition management relies on a collaborative approach, involving health care providers, patients and caregivers to optimize outcomes. The following section evaluates CalOptima Health's Complex Case Management (CCM) program.

## 6.1 Complex Case Management (Monthly Auditing)

**Business Owner:** Hannah Kim

**Department:** Case Management

**Support Staff:** Diana Tep

**Work Plan Element:** Managing Members with Multiple Chronic Conditions

**Products:** ☒ Medi-Cal ☐ OneCare

**New Activity:** ☐ Yes ☒ No

**Work Plan Goal/Objective:** Ensure provision of Complex Case Management (CCM) services resulting in optimal care coordination as evidenced through monthly auditing of five files or 5% of files for each health network resulting in a minimum score of 90% through December 31, 2024.

**Goal Met:** ☐ Yes ☐ No ☒ Partial

### Work Plan Planned Activiti (From the PHM Work Plan):

Conduct quarterly/annual oversight:

- Provided CCM updates to Population Health Management Committee (PHMC) on a quarterly basis.
- Provide ongoing training on CCM topics for new and current staff, including the CalOptima Health Community Network (CHCN) and other health networks.
- Review the National Committee for Quality Assurance (NCQA) standards with the health networks during the Clinical Operations biweekly meeting and encourage questions to ensure understanding and promote compliance with the standards.
- Train and educate individual case managers as requested.
- Meet with Quality Improvement (QI) nurses and Case Management (CM) leadership to review NCQA audit feedback to enhance NCQA CCM trainings.
- Participate in a mock audit with consultants to ensure compliance with the NCQA standards.
- Developed and refined training materials based on identified needs.
- Provide Motivational Interviewing (MI) training to Medi-Cal teams to promote member engagement and improve outcomes.

**Status:** ☐ Completed ☒ Ongoing

### Background:

CCM is the coordination of care and services provided to a member who has experienced a critical event or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

## Methodology:

The population of focus includes members with the most complex health care needs. The most frequently managed conditions, diseases or high-risk groups include but are not limited to: spinal injuries, transplants, cancer (with additional complex conditions), serious trauma, AIDS, multiple chronic illnesses, chronic illnesses that result in high utilization, children and adolescents with special health care needs, serious and persistent mental illness with complex medical illness, and/or members with a medical condition and complex social situation that affects the medical management of the members' care and requires extensive use of resources.

Case Management reviews five files or 5% of members for each health network that is enrolled in CCM for 60 days or longer.

Numerator: Total score achieved for PHM5 D (Initial Assessment) and E (Ongoing Case Management) by each health network with files to audit.

Denominator: Overall possible score achievable for PHM5 Elements D and E for each health network with files to audit.

## Results: Results:

Measure	Q1 2024 Medi-Cal Rate	Q2 2024 Medi-Cal Rate	Q3 2024 Medi-Cal Rate	Q4 2024 Medi-Cal Goal	MY 2024 Goal Me/Not Met
Review of five files or 5% of files for each health network resulting in a minimum score of 90%.	2 health networks received a score of 90%	4 health networks received a score of 90%	6 health networks received a score of 90%	Pending	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Planned Activities/Interventions	Product	Quarter	Type	Status
<ul style="list-style-type: none"> <li>Ongoing training of new and current staff including health networks.</li> <li>Reviewed NCQA standards with the health networks during the Clinical Ops biweekly meeting and encouraged questions to ensure understanding and promote compliance with the standards on 1/25/2024, 2/8/2024, and 3/7/2024.</li> <li>Training and education were provided to individual case managers as requested.</li> <li>Results provided for informational purposes to the PHMC in February 2024.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete
<ul style="list-style-type: none"> <li>Training and education were provided to individual case managers as requested.</li> <li>Training for CHCN was completed in April and May 2024.</li> <li>Training and education on member-centric care plans were provided to individual case managers as requested.</li> <li>Results provided for informational purposes to the PHMC in May 2024.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete
<ul style="list-style-type: none"> <li>Training and education were provided to individual case managers as requested.</li> <li>Meeting was held with QI nurses and CM leadership to review NCQA audit feedback from the consultant/auditors on 8/23/2024 to enhance NCQA CCM trainings.</li> <li>In-person training provided to Medi-Cal CHCN Case Management team on 9/17/2024.</li> <li>MI training provided to Medi-Cal teams on 7/9/2024, 7/10/2024 and 8/21/2024 to promote member engagement and improve outcomes.</li> <li>Scheduled training on NCQA PHM5 D and E in November 2024.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete

<ul style="list-style-type: none"> <li>Scheduled mock audit with Health Management Associate consultants on 11/20/2024.</li> <li>Results provided for informational purposes to the PHMC in August 2024.</li> </ul>				
<ul style="list-style-type: none"> <li>Results are provided on a quarterly basis for informational purposes to the PHMC in November 2024.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input checked="" type="checkbox"/> Provider <input type="checkbox"/> Health Network <input checked="" type="checkbox"/> Community <input type="checkbox"/> Data <input checked="" type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete

MC = Medi-Cal

OC = OneCare

Results:

**Chart A: Complex Case Management Scores for 2024**

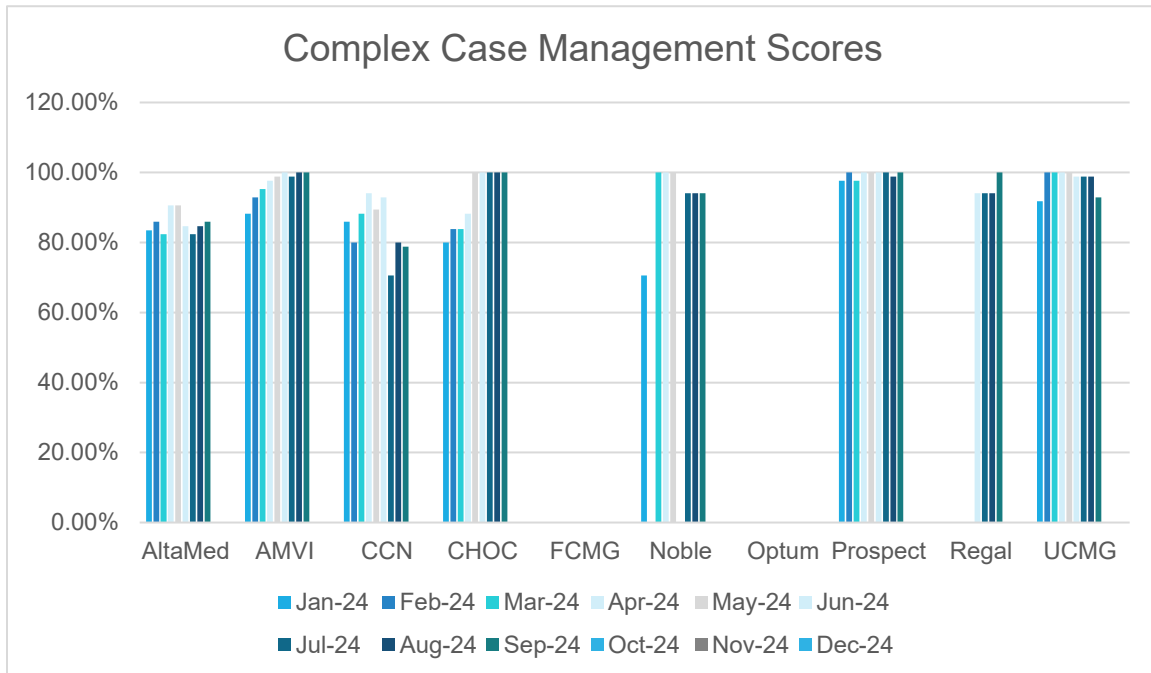


Chart A displays the average audited score for each health network that reported files during the given month. Note that Optum and Family Choice Medical Group (FCMG) did not identify any cases during this period.

**Table A: Complex Case Management Scores for Each Health Network in 2024**



	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
<b>AltaMed</b>	84%	86%	82%	91%	91%	85%	82%	85%	86%			
<b>AMVI</b>	88%	93%	95%	98%	99%	100%	99%	100%	100%			
<b>CHCN</b>	86%	80%	88%	94%	89%	93%	71%	80%	79%			
<b>CHOC</b>	80%	84%	84%	88%	100%	100%	100%	100%	100%			
<b>FCMG</b>	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			
<b>Noble</b>	71%	n/a	100%	100%	100%	n/a	94%	94%	94%			
<b>Optum</b>	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			
<b>Prospect</b>	98%	100%	98%	100%	100%	100%	100%	99%	100%			
<b>Regal</b>	n/a	n/a	n/a	n/a	n/a	94%	94%	94%	100%			
<b>UCMG</b>	92%	100%	100%	100%	100%	99%	99%	99%	93%			

Table A displays the score for each health network for each month. N/A indicates the health network did not have files available for review.

Cases are reviewed monthly for CalOptima Health members who are open to CCM for 60 days or longer. Five or 5% of cases are reviewed from each health network. There are a total of 10 health networks.

Q1: The files reviewed did not meet a minimum score of 90%. Eight out of 10 health networks had files to review. FCMG and Optum did not participate as they did not identify any CCM cases. Out of the 8 health networks, only Prospect and UCMG scored 90% and above through Q1.

Q2: Eight out of 10 health networks had files to review. FCMG and Optum did not participate as they did not identify any CCM cases. AltaMed, CHOC and CHCN did not meet the benchmark of 90%.

Q3: Eight out of 10 health networks had files to review. FCMG and Optum did not participate as they did not identify any CCM cases. AltaMed and CHCN did not meet the benchmark of 90%.

## Quantitative Analysis:

The goal of 90% for each health network was not met for Q1–Q3 2024.

## Qualitative Analysis:

The benchmark minimum of 90% for each health network was not met due to the challenges associated with training needs for managing CCM members. This led to lower scores at the beginning of the year as staff adapted to the updated processes. With ongoing training and support, consistent progress has been seen. By Q3, the majority of the health networks achieved the benchmark, with only two health networks falling short.

### Identified Barriers:

- Staff turnover led to the need for more training.
- Fortwo health networks, training and adjustment time were needed for staff to transition to the new medical management system. The new assessment is significantly longer and more complex, making it challenging for staff to navigate and adapt efficiently.
- Implementing consultants' guidance enhanced the process, and staff had a short period of time to adapt to the new process.

### Identified Opportunities for Improvement:

- Increase engagement with complex cases.
- Provide training in groups and individualized settings to reinforce learning.
- Offer ongoing training and support for new and existing staff.
- Regularly track performance.

## Conclusion:

Based on the data, six of the eight health networks that participated in CCM met the goal and achieved a minimum score of 90%. Please note that the implementation of CCM program interventions is still in progress, and final results will be available in the first quarter of 2025.

## Activities/Interventions to continue/add next year:

- Continue training and educational opportunities for staff on the 2025 PHM5 Element D and E and complex conditions and situations.

### 6.1.1 Complex Case Management (Member Satisfaction)

**Business Owner:** Hannah Kim

**Department:** Case Management

**Support Staff:** Diana Tep

**Work Plan Element:** Managing Members with Multiple Chronic Conditions

<b>Products:</b> <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	<b>New Activity:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Work Plan Goal/Objective:</b> Obtain 85% member satisfaction in the Complex Case Management (CCM) program by December 31, 2024.	
<b>Goal Met:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
<b>Work Plan Planned Activities (From the PHM Work Plan):</b> Conduct quarterly/annual oversight: <ul style="list-style-type: none"> <li>• Provide CCM updates to PHMC on a quarterly basis.</li> <li>• Host member satisfaction meetings with QI nurse and CM leadership team to improve member participation/engagement in survey.</li> <li>• Provide Member Satisfaction Survey outreach training for staff to curate details regarding scoring reasons.</li> <li>• Share Member Satisfaction Survey results at CM department Clinical Operations meetings to identify areas for improvement and highlight successes.</li> <li>• Share Member Satisfaction scores with the CHCN and delegates to help identify strengths and areas for improvement to enhance the quality of care and member outcomes.</li> <li>• Provide MI training to Medi-Cal teams to promote member engagement and improve outcomes.</li> </ul>	
<b>Status:</b> <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<b>Background:</b> CCM is the coordination of care and services provided to a member who has experienced a critical event or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.	

## Methodology:

The population of focus includes members with the most complex health care needs. The most frequently managed conditions, diseases or high-risk groups include but are not limited to: Spinal injuries, transplants, cancer (with additional complex conditions), serious trauma, AIDS, multiple chronic illnesses, chronic illnesses that result in high utilization, children and adolescents with special health care needs, serious and persistent mental illness with complex medical illness, and/or members with a medical condition and complex social situation that affects the medical management of the members' care and requires extensive use of resources.

▪**Numerator:** Members enrolled for 60 days or longer, completed satisfaction survey, and whose results show satisfaction\* with the program.

*\*The survey tool utilizes a rating scale of options for six questions. For five of the six questions, satisfaction is defined by selecting one of the following responses, Very Helpful, Helpful, Very Beneficial, Beneficial. For the sixth question, a response of "yes" defines satisfaction.*

▪**Denominator:** Members eligible with Medi-Cal line of business, enrolled in CCM for 60 days who successfully completed a satisfaction survey after the case is opened, annually and upon case closure during the measurement year. The denominator excludes blanks or "not applicable" responses.

## Results:

Measure	Q1 2024 Medi- Cal Rate	Q2 2024 Medi- Cal Rate	Q3 2024 Medi- Cal Rate	Q4 2024 Medi-Cal Goal	MY 2024 Goal Me/Not Met
85% member satisfaction in CCM program.	83%	91%	91%	Pending	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Planned Activities/Interventions	Product	Quarter	Type	Status
<ul style="list-style-type: none"> <li>Additional Member Satisfaction Survey outreach training for staff to curate details regarding scoring reasons.</li> <li>Member Satisfaction Survey scores shared with the CHCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care and member outcomes.</li> <li>Member satisfaction meeting held with QI nurse and CM leadership team on 1/9/2024 and 2/8/2024.</li> <li>Results are provided for informational purposes to the PHMC in February 2024.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete
<ul style="list-style-type: none"> <li>Member satisfaction meeting held with QI nurse and CM leadership on 5/12/2024 to review results and improve member participation/engagement in survey.</li> <li>Member Satisfaction Survey scores shared with the CHCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care and member outcomes.</li> <li>Results are provided for informational purposes to the PHMC in May 2024.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete

<ul style="list-style-type: none"> <li>Member Satisfaction Survey results shared during CM department meeting on 7/25/2024 and at the Clinical Operations meeting on 8/8/2024 to identify areas for improvement and highlight successes.</li> <li>Member satisfaction meeting held with QI nurse and CM leadership team on 07/3/2024 and 9/3/2024 to review results and improve member participation/engagement in survey.</li> <li>Motivational Interviewing (MI) training provided to Medi-Cal teams on 7/9/2024, 7/10/2024 and 8/21/2024 to promote member engagement and improve outcomes.</li> <li>Results are provided for informational purposes to the PHMC in August 2024.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete
<ul style="list-style-type: none"> <li>Results are provided on a quarterly basis for informational purposes to the PHMC in November 2024.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete

**Chart A: Member Experience Satisfaction Survey Average Results January–September 2024**

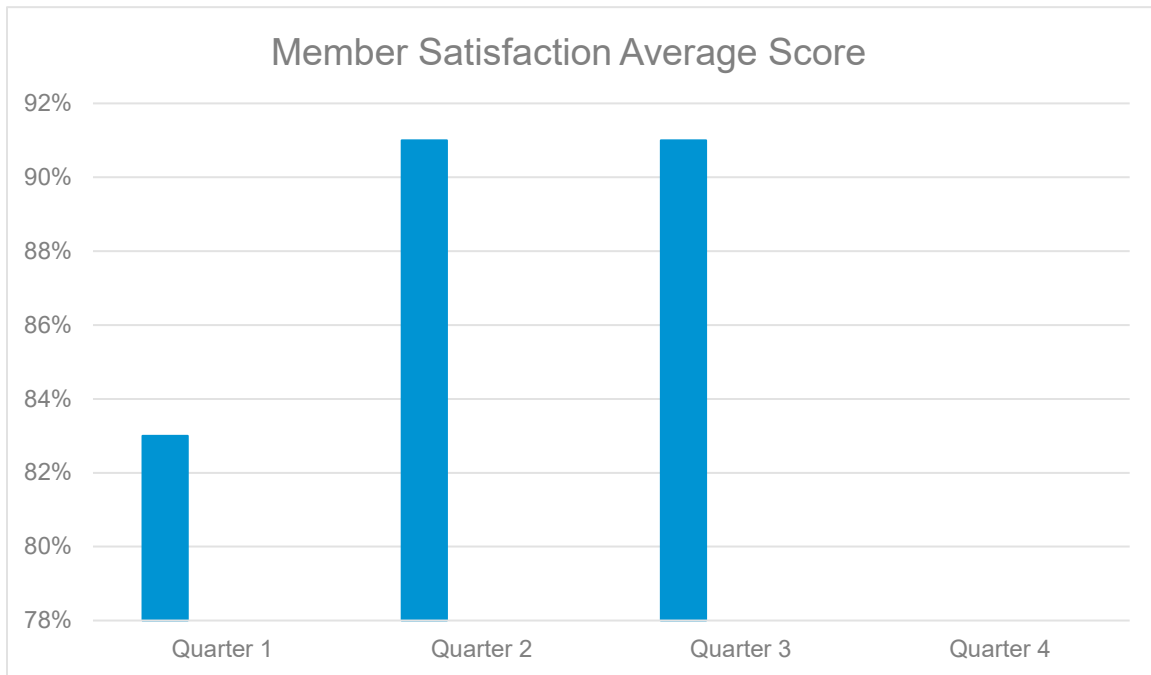


Chart A is the average total score for the member satisfaction survey. Q1 did not meet the 85% benchmark at 83%, Q2 and Q3 met at 91%.

**Table A: Member Experience Satisfaction Survey Results January–March 2024**

Q1 2024	Member Satisfaction Surveys Completed	Q1. Case Management was Beneficial	Q2. Educational Materials were Helpful	Q3. CM was helpful with Medical Questions	Q4. Community Resources were Helpful	Q5. Questions were answered to Satisfaction	Q6. Overall Satisfaction with CM
	3	3	2	2	2	3	3
		100%	67%	67%	67%	100%	100%

In Q1, three members were surveyed regarding their satisfaction with the CCM program, which had an impact on the overall score due to a smaller denominator. CM supports members with medical questions, educational materials and community resources, but did not meet the benchmark of 85% contributing to an average satisfaction score of 83%.

**Table B: Member Experience Satisfaction Survey Results April–June 2024**

<b>Q2 2024</b>	<b>Member Satisfaction Surveys Completed</b>	<b>Q1. Case Management was Beneficial</b>	<b>Q2. Educational Materials were Helpful</b>	<b>Q3. CM was helpful with Medical Questions</b>	<b>Q4. Community Resources were Helpful</b>	<b>Q5. Questions were answered to Satisfaction</b>	<b>Q6. Overall Satisfaction with CM</b>
	<b>22</b>	20	20	19	20	21	20
		91%	91%	86%	91%	95%	91%

In Q2, there was a significant improvement in the number of members who participated in the survey. A total of 22 members were surveyed, and all questions met the 85% benchmark contributing to an average score of 91%.

**Table C: Member Experience Satisfaction Survey Results July–September 2024**

<b>Q3 2024</b>	<b>Member Satisfaction Surveys Completed</b>	<b>Q1. Case Management was Beneficial</b>	<b>Q2. Educational Materials were Helpful</b>	<b>Q3. CM was helpful with Medical Questions</b>	<b>Q4. Community Resources were Helpful</b>	<b>Q5. Questions were answered to Satisfaction</b>	<b>Q6. Overall Satisfaction with CM</b>
	<b>34</b>	29	34	30	33	29	30
		85%	100%	88%	97%	85%	88%

In Q3, more member satisfaction surveys were completed showing increased engagement in the cCCM program. All surveyed questions met the 85% benchmark, leading to an average score of 91%.

### **Quantitative Analysis:**

The goal of 85% was not met in Q1. However, it was met in Q2 and Q3.

### **Qualitative Analysis:**

In Q1, we did not achieve the 85% member satisfaction benchmark. The feedback indicated gaps in the effectiveness of educational materials, helpfulness of the case manager with medical questions, and community resources. In Q2 and Q3, the benchmark was successfully met, demonstrating significant improvement. Progress shows that the training, sharing the satisfaction scores and meetings to improve outcomes were effective. Please note that the implementation of CCM program interventions is still in progress, and final results will be available in the first quarter of 2025.

### **Identified Barriers:**

Staff turnover led to the need for more training.

### **Identified Opportunities for Improvement:**

- Improve case manager engagement with members regarding understanding of mailed resources.
- Provide ongoing training and support for new and existing staff.



	<ul style="list-style-type: none"> <li>Regularly track performance.</li> </ul>
<b>Conclusion:</b> Based on the data, this goal is projected to met.	
<b>Activities/Interventions to continue/add next year:</b> <ul style="list-style-type: none"> <li>Member satisfaction scores will be shared with the CHCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care and member outcomes.</li> <li>Continue to gather member feedback to improve outcomes.</li> </ul>	

6.1.2 Complex Case Management (Care Plans)	
<b>Business Owner:</b> Hannah Kim	<b>Department:</b> Case Management
<b>Support Staff:</b> Diana Tep	
<b>Work Plan Element:</b> Managing Members with Multiple Chronic Conditions	

<b>Products:</b> <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	<b>New Activity:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Work Plan Goal/Objective:</b> 85% of members surveyed who participated in Complex Case Management (CCM) between January 1–December 31, 2024, will report that the case management process helped them meet their care plan goals.	
<b>Goal Met:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
<b>Work Plan Planned Activities (From the PHM Work Plan):</b> Conduct quarterly/annual oversight: <ul style="list-style-type: none"> <li>• Provided CCM updates to PHMC on a quarterly basis.</li> <li>• Provide training and educational materials on member-centric care plans to CHCN CM teams, health network CM teams, and individual case managers as requested.</li> <li>• Provide MI training to Medi-Cal teams to promote member engagement and improve outcomes.</li> </ul>	
<b>Status:</b> <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<b>Background:</b> CCM is the coordination of care and services provided to a member who has experienced a critical event or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.	
<b>Methodology:</b> The population of focus includes members with the most complex health care needs. The most frequently managed conditions, diseases or high-risk groups include but are not limited to: Spinal injuries, transplants, cancer (with additional complex conditions), serious trauma, AIDS, multiple chronic illnesses, chronic illnesses that result in high utilization, children and adolescents with special health care needs, serious and persistent mental illness with complex medical illness, and/or members with a medical condition and complex social situation that affects the medical management of the members' care and requires extensive use of resources. <p>•Numerator: Members enrolled for 60 days or longer, completed question 13 (How helpful was the case management process in helping you to meet your care plan goals?) in the satisfaction survey, and whose results show satisfaction* with the program.</p> <p><i>* The survey tool utilizes a rating scale of options for questions related to developing and helping with care plan goals. Satisfaction is defined by selecting one of the following responses, Very Helpful, Helpful.</i></p> <p>•Denominator: Members eligible with Medi-Cal line of business, enrolled in CCM for 60 days who successfully completed a satisfaction survey after the case is opened, annually or upon case closure during the measurement year. The denominator excludes blanks or "not applicable" responses.</p>	

## Results:

Measure	Q1 2024 Medi- Cal Rate	Q2 2024 Medi- Cal Rate	Q3 2024 Medi- Cal Rate	Q4 2024 Medi-Cal Goal	MY 2024 Goal Me/Not Met
85% of members will report that the case management process helped them meet their care plan goals.	67%	95%	91%	Pending	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
<ul style="list-style-type: none"> <li>Training and education on member-centric care plans provided to individual case managers as requested.</li> <li>Training and educational materials on member-centric care plans provided to CHCN CM teams, health network CM teams, and individual case managers as requested.</li> <li>Results are provided for informational purposes to the PHMC in February and May 2024.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input checked="" type="checkbox"/> Q1 <input checked="" type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete
<ul style="list-style-type: none"> <li>MI training provided to Medi-Cal teams on 7/9/2024, 7/10/2024, 8/21/2024 and 10/30/2024 to promote member engagement and improve outcomes.</li> <li>Results are provided for informational purposes to the PHMC in August 2024.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input checked="" type="checkbox"/> Q3 <input type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete
<ul style="list-style-type: none"> <li>Results are provided for informational purposes to the PHMC in November 2024.</li> </ul>	<input checked="" type="checkbox"/> MC <input type="checkbox"/> OC	<input type="checkbox"/> Q1 <input type="checkbox"/> Q2 <input type="checkbox"/> Q3 <input checked="" type="checkbox"/> Q4	<input type="checkbox"/> Member <input type="checkbox"/> Provider <input checked="" type="checkbox"/> Health Network <input type="checkbox"/> Community <input type="checkbox"/> Data <input type="checkbox"/> Other	<input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing <input type="checkbox"/> Incomplete

MC = Medi-Cal

OC = OneCare

**Quantitative Analysis:**

The goal of 85% was met in Q2 and Q3; however, the goal was not met in Q1.

**Qualitative Analysis:**

In Q1, we did not meet the 85% benchmark for members reporting that the case management process helped with their care plans. However, scores improved in Q2 and Q3, meeting the benchmark in both quarters. This increase demonstrates progress in addressing the members' needs and improving their outcomes with care plans. Please note that the implementation of CCM program interventions is still in progress, and final results will be available in the first quarter of 2025.

**Identified Barriers:**

- Staff turnover led to the need for more training.

**Identified Opportunities for Improvement:**

- Provide ongoing training and support for new and existing staff.
- Regularly track performance.

**Conclusion:**

Based on the data this goal is projected to meet.

**Activities/Interventions to continue/add next year:**

- Training and educational opportunities to work collaboratively with members.
- Continue to gather member feedback to improve outcomes.

Section 6: Appendix - 2024 Population Health Management Work Plan

Area of Focus	Program/ Initiative	Department	Description	Population of Focus	SMART Objective(s)	Red - At Risk Yellow - Concern Green - On Target
Keeping Members Healthy	Blood Lead Testing in Children	Quality Analytics	In babies and young children, whose brains are still developing, even a small amount of lead can cause learning disabilities and behavioral problems. CalOptima Health works with providers and members to ensure that all young children are tested for lead at appropriate age intervals.	Members that are 12 and 24 months and due for a blood lead test.  <b>Blood Lead Testing at 12 Months of Age:</b> - Numerator: Medi-Cal members who completed a one lead capillary or venous blood test within 6 months (before or after) their first birthday. - Denominator: Medi-Cal members who turn 12 months old during the measurement year. Child member must be continuously enrolled for 12 months (6 months before and 6 months after the first birthday with no more than one gap in enrollment during the 12-month period where the gap is no longer than one month.  <b>Blood Lead Testing at 24 Months of Age:</b> - Numerator: Medi-Cal members who complete one lead capillary or venous blood test within 6 months (before or after) their second birthday. - Denominator: Medi-Cal members who turn 24 months old during the measurement year. Child member must be continuously enrolled for 12 months (6 months before and 6 months after the 2nd birthday with no more than one gap in enrollment during the 12-month period where the gap is no longer than one month.	1. Increase the rate for blood lead testing in children (12 Months) from 56.03% to 59.03% by December 31st, 2024. 2. Increase the rate for blood lead testing in children (24 Months) from 47.44% to 52.44% by December 31st, 2024.	ON TARGET
	Health Disparity Remediation for Well- Child Visits	Quality Analytics	CalOptima Health aims to reduce the racial/ethnic disparities in well child visits in support of the statewide goals. Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate among African American child members has the potential to improve their overall health status.	African American child members who are turning 15 months old during the measurement year, between January 1 and December 31.  - Numerator: African American Medi-Cal members who complete six or more well-child visits (Well-Care Value Set) on different dates of service on or before their 15-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.  - Denominator: African American Medi-Cal members who turn 15 months old during the measurement year.	4-PIP-AIM-Statement: Do targeted interventions increase the percentage of African American children 16 months of age that had six or more well-child visits during the measurement year. <b>REVISED:</b> 1. Increase well-child visit appointments for Black/African American members (0-15 months) from 41.90% to 55.78% by December 31st, 2024.	ON TARGET
	Well-Child Visits	Quality Analytics	Well-child visits are important during the early months of a child's life to assess growth, development and identify and address any concerns early. CalOptima Health promotes preventive care for its youngest members to help them live long, happy and healthy lives.	Members 0-14 months and members 15-30 months due for a well-child visit.  <b>W30 (First 15 Months)</b> - Numerator: Medi-Cal members who complete six or more well-child visits (Well-Care Value Set) on different dates of service on or before their 15-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. - Denominator: Medi-Cal members who turn 15 months old during the measurement year.  <b>W30 (15-30 Months)</b> - Numerator: Medi-Cal members who complete two or more well-child visits (Well-Care Value Set) on different dates of service between their 15-month birthday plus 1 day and their 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. - Denominator: Medi-Cal members who turn 30 months old during the measurement year.	1. Increase the rate for well-child visits (W30 - 0 to 14 Months) to meet the 50th percentile benchmark of 58.38% by December 31st, 2024. 2. Increase the rate for well-child visits (W30 - 15 to 30 Months) to meet the 75th percentile benchmark of 71.35% by December 31st, 2024.	ON TARGET
	Childhood Immunizations	Quality Analytics	Childhood vaccinations are a safe and effective way to protect children from a variety of serious or potentially fatal diseases. CalOptima Health works to promote immunizations and ensure that children are healthy, growing and ready to learn.	Child members due for Combo 10 and adolescent members due Combo 2.  <b>CIS (Combo-10)</b> - Numerator: Medi-Cal members who completed 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. - Denominator: Medi-Cal members who turn 2 years of age during the measurement year.  <b>IMA (Combo-2)</b> - Numerator: Medi-Cal members who completed 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. - Denominator: Medi-Cal members who turn 13 years of age during the measurement year.	1. Increase the CIS-Combo 10 rate to meet the 90th percentile benchmark of 45.26% by December 31st, 2024. 2. Maintain the IMA-Combo 2 rate at quality compass 90% benchmark for MY 2024.	ON TARGET
	Comprehensive Community Cancer Screening and Support Program	Medical Management & Quality Analytics	CalOptima Health partnered with external stakeholders in the fight against cancer to launch this program. Together, we aim to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses through early screening.	Members between the ages of 50–74 due for mammogram.  - Numerator: Medi-Cal members who are women 50-74 years of age who complete at least one mammogram (Mammography Value Set) during the measurement period. - Denominator: Medi-Cal members who are women 52–74 years of age by the end of the measurement period.  Measurement period: anytime on or between October 1 two years prior to the measurement year and December 31 of the measurement year.	1. Increase the BCS rate from 57.81% to 61.27% by December 31st, 2023.	ON TARGET
	Maternal Health	Equity and Community Health & Quality Analytics	CalOptima Health's prenatal and postpartum care program aims to inform and provide resources to pregnant members to help them have a healthy pregnancy, delivery and baby.	Members who are expecting or recently delivered.  - Numerator: - PPC-Prenatal - Medi-Cal member who had a prenatal visit during the first trimester or 42 days within enrollment. - PPC-Postnatal - Medi-Cal member who had a postpartum visit on or between 7 and 84 days after delivery. - Denominator: Medi-Cal members who delivered a live birth within the measurement year.	1. Increase the Prenatal Care Services (PPC-Pre) rate from 88.08% to 91.89% by December 31st, 2024. 2. Increase the Postpartum Care Services (PPC-Post) rate from 81.15% to 84.18% by December 31st, 2024.	ON TARGET

Section 6: Appendix - 2024 Population Health Management Work Plan

Area of Focus	Program/Initiative	Department	Description	Population of Focus	SMART Objective(s)	Red - At Risk Yellow - Concern Green - On Target
	Shape Your Life	Equity and Community Health	CalOptima Health offers no-cost, in-person and virtual group classes for children ages 5 to 18 and their families. Topics include healthy eating, physical activity and other ways to build healthy habits.	Children ages 5-18 and/or their families.  - <b>Numerator:</b> The number of SYL participants who completed the pre and post assessments on basic nutrition and healthy lifestyle topics and showed an increase in knowledge on these topics during the measurement year.  *Basic nutrition and healthy lifestyle knowledge are assessed via in-class survey. The survey tool used contains multiple choice and open-ended questions on basic nutrition and healthy lifestyle topics taught during SYL classes. Correct responses are an indicator of basic nutrition and healthy lifestyle knowledge.  - <b>Denominator:</b> The number of SYL participants that completed the SYL pre and post assessments during the measurement year.	1. By December 31st, 2024, at least 40% of the SYL participants who completed the pre and post assessment will increase their knowledge on basic nutrition and healthy lifestyle.	ON TARGET
Emerging Risk	Chronic Condition Care and Self-Management Program	Equity and Community Health & Quality Analytics	CalOptima Health's programs promotes self-management skills for people with chronic conditions to enable them to manage their health on a day-to-day basis and to take an active role in their health care.	Members with diabetes that are at risk of HbA1c poor control.  - <b>Numerator:</b> Medi-Cal Members 18-75 years of age with diabetes (types 1 and 2) who participated in the Chronic Conditions Care and Self-Management Program and lowered their HbA1c to less than 8% during the measurement year. - <b>Denominator:</b> Medi-Cal Members 18-75 years of age with diabetes (types 1 and 2) with a result of HbA1c 8.0% to HbA1c 9.0% who were previously in good control (HbA1c less than 8.0%) in previous 12 months.	1. By December 31st, 2024, 5% of members identified as emerging risk* and who participated in program will lower HbA1c to less than 8.0%. *Emerging risk is defined as members with a result of A1C 8.0% to A1C 9.0% who were previously in good control A1C less than 8.0% in previous 12 months. 2. Maintain the HbD-HbA1c Poor Control (>9.0%)** at 75th percentile (33.45%) by December 31st, 2023. **Lower rates is better	ON TARGET
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Behavioral Health Integration	CalOptima Health's program assesses the percentage of emergency department (ED) visits for members aged 13 and older with a principal diagnosis of alcohol and other drug abuse or dependence to ensure our members receive appropriate follow-up care.	Members 13 years and older as of the ED visit for substance use.  - <b>Numerators:</b> -7-Day Follow-Up - A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit. -30-Day Follow-Up - A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.  - <b>Denominator:</b> Medi-Cal members ages 13 and older who had emergency department (ED) visits with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up during the measurement period.	1. Increase the FUA (7-days) rates from 11.47% to 20.0% by December 31st, 2024. 2. Increase the FUA (30-days) rates from 17.90% to 36.34% by December 31st, 2024.	ON TARGET
Patient Safety	CalAIM Community Supports	CalAIM	California Advancing and Innovating Medi-Cal (CalAIM) is a five-year initiative by the DHCS to improve the quality of life and health outcomes of the Medi-Cal population by addressing social drivers of health and breaking down barriers in accessing care. Community Supports are a core component of CalAIM.	Eligible CalOptima Health Members that are referred to CalAIM Community Supports.  - <b>Numerator:</b> Eligible CalOptima Health members who qualify for CalAIM Community Supports (CCS) between January 1st - December 31st, 2024 and received at least one CCS. - <b>Denominator:</b> Eligible CalOptima Health members referred to CCS* between January 1st - December 31st, 2024.  To qualify for CalAIM Community the member must be eligible for CalOptima Health and referred or self-referred to CCS. Eligibility criteria for each CSS varies and listed on the referral form.	1. 90% of members that were referred to CalAIM Community Supports between July 1st - December 31st, 2024 will have received at least one Community Support.	ON TARGET
	Street Medicine Program	CalAIM	CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's un-housed individuals and families through whole person care approaches and addressing social drivers of health.	Members that are experiencing homelessness.  - <b>Numerator:</b> Eligible CalOptima Health members who are experiencing homelessness*, opted into the Street Medicine program, and: - assigned to a Medical Home. - received CalAIM ECM or at least one Community Support; OR - referred to a shelter or other housing option. - <b>Denominator:</b> Members eligible for CalOptima Health who are experiencing homelessness* during the measurement period.  *Members that are eligible for CalOptima Health services self-report experiencing homelessness to Street Medicine Team canvassing in designated geographic locations within Orange County during the measurement period.	1. By December 2024, connect 80% of unhoused participating members to an active Primary Care Physician (PCP). 2. By December 2024, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation. 3. By December 2024, connect 20% of unhoused participating members to a shelter or other housing option.	CONCERN (Specific to Goal #3)

Section 6: Appendix - 2024 Population Health Management Work Plan

Area of Focus	Program/ Initiative	Department	Description	Population of Focus	SMART Objective(s)	Red - At Risk Yellow - Concern Green - On Target
Managing Multiple Chronic Conditions	Complex Case Management Program	Case Management	Complex Case Management is the coordination of care and services provided to a Member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.	<p>Members with the most complex health care needs. Most frequently managed conditions, diseases or high-risk groups (including, but not limited to): Spinal injuries, transplants, cancer (with additional complex condition, serious trauma, AIDS, multiple chronic illnesses, chronic illnesses that result in high utilization, children and adolescents with special health care needs, serious and persistent mental illness with complex medical illness, and/or members with a medical condition and complex social situation that affects the medical management of the members' care and requires extensive use of resources.</p> <p><i><b>Numerator:</b> Members enrolled for 60 days or longer, complete satisfaction survey, and who's results show satisfaction* with the program.</i></p> <p><i>* The survey tool utilizes a rating scale of options for six questions. For five of the six questions, satisfaction is defined by selecting one of the following responses, Very Helpful, Helpful, Very Beneficial, Beneficial. For the sixth question a response of "yes" defines satisfaction.</i></p> <p><i><b>Denominator:</b> Members eligible with Medi-Cal line of business, enrolled in CCM for 60 days who successfully completed a satisfaction survey after the case is opened, annually and upon case closure during the measurement year. The denominator excludes blanks or "not applicable" responses.</i></p>	<p>1. Ensure provision of CCM services resulting in optimal care coordination as evidenced through monthly auditing of 5 files or 5% of files for each health network resulting in a minimum score of 90% through December 31, 2024.</p> <p>2. Obtain 85% member satisfaction in CCM program by December 31st, 2024.</p> <p>3. 85% of members surveyed who participated in CCM between January 1, 2024-December 31, 2024, will report that the case management process helped them meet their care plan goals.</p>	ON TARGET





# **2024 CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) PROGRAM EVALUATION**





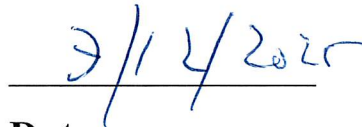
CalOptima Health

2024 CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)  
PROGRAM EVALUATION SIGNATURE PAGE

***Quality Improvement Health Equity Committee Chair:***

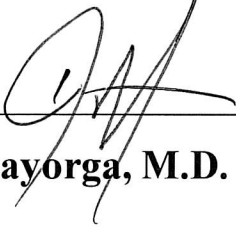


**Richard Pitts, D.O., Ph.D.**  
**CalOptima Health Chief Medical Officer**

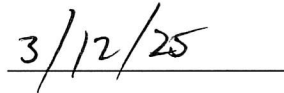


**Date**

***Board of Directors' Quality Assurance Committee Chair:***



**Jose Mayorga, M.D.**

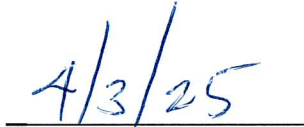


**Date**

***Board of Directors Chair:***



**Isabel Becerra**



**Date**

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Our Values

Who We Serve

Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

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## Section 1: CalOptima Health Overview

### Our Mission

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

### Our Values

**Collaboration. Accountability. Respect. Excellence. Stewardship.** CalOptima Health abides by our core values (CARES) in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

### Who We Serve

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

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

### Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

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

## Section 2: Executive Summary

### 2.1 2024 Achievements

Authors: Albert Cardenas and Carlos Soto

#### Summary of 2024 Achievements

In 2024, the following achievements were accomplished by Cultural & Linguistic Services (C&L):

#### CLAS Goals:

- Implemented a process to collect, store and retrieve member Race, Ethnicity and Language/Sexual Orientation Gender Identity (REL/SOGI) data.
- Implemented a process to collect, store and retrieve practitioner race/ethnicity/languages (REL) data.
- Created surveys to evaluate the language services experience of CalOptima Health members and staff (Implementation set for Q1 2025).
- Increased well-child visit appointments for Black/African American members (0–15 months).
- Increased timely postpartum appointments for CalOptima Health Black and Native American members.
- Improved practitioner support in providing language services.

#### C&L Department:

- Added a department supervisor to assist with the oversight of the daily operations of all C&L department activities, based on the increased utilization of translation and interpreter services and health equity deliverables.
- Streamlined the Pharmacy Care Plan process to reduce the translation turnaround times from 40 days to 10 days. This previously involved an extensive timeframe, approximately 40-day turnaround (20 days for the translation phase and 20 days for the review). As a result, the Care Plan timeline was reduced to a 10-day turnaround time.
- Created a new SharePoint worklog for the Spanish team. Spanish translations represent 67% of all translations. The new SharePoint worklog enhances the routine and expedited assignment process. This tool enables translators to receive their assignments more efficiently and provides clear guidance on task ownership. In addition, this new log helps the team quickly identify unassigned work to ensure timely deliveries to our internal clients.
- Streamlined the Alternative Format Selection (AFS) process for the Notice of Action (NOA) AFS requests. AFS materials include Braille, Audio/Data files and Large Print materials. This improved the production process of AFS (related NOAs), reducing it from 5 to 10 business days per request to 2 to 3 business days per request.

## 2.2 Review of 2024 CLAS Goals

Authors: Albert Cardenas and Carlos Soto

2024 CLAS goals and achievements:

1. Implement a process to collect, store and retrieve member REL/SOGI data.
  - Developed member surveys
  - Updated systems to support the collection of REL/SOGI data
  - Added member survey to the Member Portal
  - Developed member mailing packets
  - Launched mailing of surveys in September 2024 to new members 18+ years of age
  - Launched survey in the Member Portal in December 2024
2. Implement a process to collect, store and retrieve practitioner race/ethnicity/languages.
  - Developed provider satisfaction survey
  - Launched survey in September 2024
  - Store provider responses in CalOptima Health care system
3. Implement a process to survey and evaluate the language services experiences of CalOptima Health members and staff.
  - Developed member and staff surveys
  - Launch of surveys targeted for Q1 2025
4. Increase well-child visit appointments for Black/African American members (0–15 months).
  - Conducted focused outreach and assessed parental knowledge of the importance of well-child visits and what should be expected at these visits
  - CalOptima Health staff provided education, assisted with scheduling well-child visits and offered care coordination
  - CalOptima Health staff identified barriers and will use findings to develop new interventions for 2025
5. Increase in timely prenatal and postpartum appointments for CalOptima Health Black and Native American members.
  - Conducted focused outreach to offer doula, Enhanced Care Management and black infant health services
6. Improve practitioner support in providing language services.
  - Made members' language preference available to providers in the CalOptima Health Provider Portal
  - Informed providers of members' language preferences during customer service interactions
  - Evaluated CalOptima Health's contracted health networks Cultural and Linguistics process to ensure members' language needs are being met

## 2.3 Recommendations for 2025

Authors: Albert Cardenas and Carlos Soto

Recommendations for 2025 CLAS goals:

1. Expand the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).
2. Evaluate language services experience by collecting feedback from CalOptima Health members and staff using surveys. Analyze the results to identify potential improvements to language services.
3. Increase the collection of race/ethnicity/languages (REL) data by 10% through focused outreach and education, ensuring better representation and inclusion of providers.
4. Increase the collection of SOGI data through focused outreach and education.
5. Implement and train CalOptima Health and health network staff on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016.

## 2.4 Recommended Priority Areas and Goals for 2025

Authors: Albert Cardenas and Carlos Soto

### Recommended goals for 2025:

1. Expand the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).
2. Launch a language services experience survey for members and staff and aim to collect feedback from at least 10% of members and 80% of staff using surveys. Analyze the results to identify improvements to language services.
3. Increase the collection race/ethnicity/language (REL) data by 10% through focused outreach and education, ensuring better representation and inclusion of providers.
4. Increase the collection of sexual orientation gender identity (SOGI) data by 10% through focused outreach and education, ensuring better representation and inclusion of members.
5. Implement and train 90% of staff, health networks and providers on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016, by December 31, 2025.

### Section 3: Program Structure

#### 3.1 CLAS Program Documents

Authors: Albert Cardenas and Carlos Soto		Department: Customer Service/Cultural and Linguistic Services	
Responsible Party(ies): Albert Cardenas/Carlos Soto			
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare		New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Work Plan Goal/Objective: Complete documents and obtain Board of Directors Approval of 2024 Program and Work Plan			
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial			
Work Plan Planned Activities: CLAS Program Description and Work Plan will be completed, reviewed and approved by the following committees in Q1 2024, and by their appropriate subcommittee, where applicable. <ul style="list-style-type: none"><li>o QIHEC: 02/13/2024</li><li>o QAC: 03/13/2024</li><li>o Annual BOD Adoption by April 2024</li></ul>			
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing			
<p>Background:</p> <p>To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a CLAS Program, which is part of the Quality Improvement and Health Equity Transformation Program (QIHETP) that integrates culturally and linguistically appropriate services at all levels of the operation. Objectives for culturally and linguistically diverse membership include:</p> <ul style="list-style-type: none"><li>• Reduce health care disparities in clinical areas.</li><li>• Improve cultural competency in materials and communications.</li><li>• Improve network adequacy to meet the needs of underserved groups.</li><li>• Improve other areas of need as appropriate.</li></ul>			
<p>Methodology:</p> <p>The CLAS Program guides the development and implementation of an annual CLAS Work Plan, which includes but is not limited to documentation for the following:</p> <ul style="list-style-type: none"><li>• Network cultural responsiveness</li><li>• Language services</li><li>• Program scope</li><li>• Yearly objectives</li><li>• Yearly planned activities</li><li>• Time frame for each activity's completion</li><li>• Staff member responsible for each activity</li><li>• Monitoring of previously identified issues</li></ul>			
Actions/Interventions Implemented in 2024:			
Quarter 1:	<ul style="list-style-type: none"><li>• None</li></ul>		
Quarter 2:	<ul style="list-style-type: none"><li>• Staff worked with other departments to draft the CLAS Program Description and identify CLAS items to be included in the overall QIHETP Work Plan</li></ul>		
Quarter 3:	<ul style="list-style-type: none"><li>• The revised 2024 CalOptima Health QIHETP Program and Work Plan to include CLAS and the documents were approved by BOD on 8/1/2024 and a copy was posted on CalOptima Health's public website.</li></ul>		
Quarter 4:	<ul style="list-style-type: none"><li>• Staff developed a draft of the 2024 CLAS Evaluation, and the 2025 QIHETP and Work Plan, including CLAS, will be approved in Q1 2025.</li></ul>		
Program Results: Overall, the CLAS Program successfully yielded positive results.			
Identified Barriers:		Identified Opportunities for Improvement:	
<ul style="list-style-type: none"><li>• These are new documents for CalOptima Health, so it took staff time to draft the materials</li></ul>		<ul style="list-style-type: none"><li>• Schedule a meeting earlier in the year to review the goals and priorities for the next year.</li></ul>	



<ul style="list-style-type: none"> <li>As there were new elements added to the overall work plan, it took some time to identify the lead or main business owners for each element.</li> </ul>	
<p>Conclusion:</p> <ul style="list-style-type: none"> <li>The CLAS Program was drafted, presented and approved.</li> </ul>	
<p>Activities/Interventions to continue/add next year:</p>	
<ul style="list-style-type: none"> <li>C&amp;L staff to collaborate with staff in Quality Analytics and other business areas in September to begin developing goals and priorities for the next year.</li> </ul>	

### 3.2 CLAS Reporting Structure and Community and Member Engagement

Author: Albert Cardenas		Department: Customer Service/Cultural & Linguistic Services	
Support Staff: Carlos Soto			
<p>Background:</p> <p>CalOptima Health is committed to member-focused care through member and community engagement. C&amp;L seeks guidance from the Member Advisory Committee (MAC), the Provider Advisory Committee (PAC) and the Quality Improvement Health Equity Committee (QIHEC).</p> <p>Activities from the CLAS Program and Work Plan are reported quarterly to the QIHEC. Staff will present CLAS activities implemented for the quarter, findings, barriers and any need to conduct corrective action or remediation.</p> <p>CalOptima Health engages members through MAC to seek input, advice and guidance related to Cultural and Linguistic and Health Equity goals. 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 to ensure that the CLAS Program meets the needs of the population.</p> <p>The PAC provides advice and recommendations to the Board about CalOptima Health programs and services as a liaison on items of interest to the provider community. The PAC meets along with the MAC on a bimonthly basis and reports directly to the CalOptima Health Board of Directors, MAC/PAC meetings are open to the public.</p> <p>In addition to the MAC and PAC, CalOptima Health also seeks input, advice and guidance related to Cultural and Linguistic and Health Equity goals from the QIHEC. The QIHEC provides advice and recommendations regarding CalOptima Health programs and services. The QIHEC reports annually directly to CalOptima Health's Board of Directors.</p>			
Actions/Interventions Implemented in 2024:			
Quarter 1:	<ul style="list-style-type: none"><li>• None</li></ul>		
Quarter 2:	<ul style="list-style-type: none"><li>• None</li></ul>		
Quarter 3:	<ul style="list-style-type: none"><li>• CLAS activities were reported to QIHEC each quarter</li></ul>		
Quarter 4:	<ul style="list-style-type: none"><li>• A summary of the 2024 CLAS Program goals was presented at the December MAC and PAC meeting, and committee members provided feedback</li><li>• Requested MAC/PAC standing agenda items to ensure CLAS and quality items are presented to our advisory boards for feedback.</li></ul>		
<p>Analysis:</p> <p>The reporting structure was successful. Staff were able to report to QIHEC quarterly on all CLAS activities and obtained feedback and guidance from the QIHEC. The QIHEC was able to provide guidance on the following activities:</p> <ul style="list-style-type: none"><li>• DEI survey to staff and committee members.</li></ul>			

<ul style="list-style-type: none"> <li>Language to include in the surveys to encourage a response to providing SOGI data.</li> </ul>	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li>MAC and PAC meetings have a full agenda. It is difficult to obtain dedicated time on the agenda to have a deeper discussion and solicit feedback at these meetings.</li> </ul>	<ul style="list-style-type: none"> <li>Quality Improvement reserved space in the MAC and PAC meeting agenda for C&amp;L and Customer Service to present.</li> <li>Going forward C&amp;L and/or Customer Service will ensure they are added to the MAC and PAC agenda.</li> </ul>
<p>Conclusion:</p> <p>CalOptima Health staff presented the CLAS Program updates at the December MAC/PAC meeting. Staff noted that 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. Staff informed the committees of the 2024 CLAS Program and Work Plan Goals and provided an update on each goal and the challenges faced with each goal, with the most common challenge being a low member/provider response rate on surveys and outreach efforts.</p> <p>Staff asked the committees for feedback and recommendations to increase response rates. Committee members provided valuable feedback, including working with First 5 Orange County, which has a Black infant health program, and UCI's Black Pearl Program, which is focused on increasing the number of Black, Indigenous, and People of Color (BIPOC) doulas in the community. Committee members also suggested CalOptima Health, partner with FQHCs as they also collect the same member demographic data CalOptima Health is attempting to collect.</p>	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>CalOptima Health will continue to engage members and providers through the MAC and PAC to seek input, advice and guidance related to CLAS goals and objectives.</li> </ul>	

### 3.3 CLAS Monitoring Progress

Author: Albert Cardenas

Department: Customer Service/Cultural & Linguistic Services

Support Staff: Carlos Soto

#### Background:

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

#### Methodology:

CalOptima Health staff followed the 2024 Health Equity Standards and Guidelines when implementing the CLAS Program goals and monitored progress against CLAS goals. Quarterly, dedicated staff from C&L, in collaboration with multidisciplinary work teams throughout the agency, collect and track indicators and activities specific to CLAS goals, outcomes and outputs.

#### Actions/Interventions Implemented in 2024:

Quarter 1:	<ul style="list-style-type: none"><li>• Work began on the development of the CLAS Program and goals.</li></ul>
Quarter 2:	<ul style="list-style-type: none"><li>• Monitored the completion of surveys for the collection of member REL/SOGI data and collection of practitioner REL data.</li><li>• Monitored the updates to CalOptima Health systems to ensure the capacity to store member REL/SOGI.</li><li>• Reported progress to the QIHEC.</li></ul>
Quarter 3:	<ul style="list-style-type: none"><li>• Monitored the implementation of the mailing of the REL/SOGI surveys to new members 18 years of age and older.</li><li>• Quality Analytics team worked on CLAS goal: Increase well-child visit appointments for Black/African American members (0–15 months).</li><li>• Provider Data Management team implemented the collection of practitioner race/ethnicity/languages (REL) data.</li><li>• Equity and Community Health worked on CLAS goal: Maternity Care of Black and Native American Persons.</li><li>• Reported progress to the QIHEC.</li></ul>
Quarter 4:	<ul style="list-style-type: none"><li>• Created the survey to be used to evaluate the effectiveness related to cultural and linguistic services.</li><li>• Implemented the process of collecting REL/SOGI data via the Member Portal.</li><li>• Reported progress to the QIHEC.</li></ul>

#### Program Results:

#### Analysis:

CalOptima Health will continue to monitor progress against CLAS goals. Quarterly, dedicated staff from C&L, in collaboration with multidisciplinary work teams throughout the agency, collect and track indicators and activities specific to CLAS goals, outcomes and outputs.

#### Identified Barriers:

- SOGI surveys have a 5% return rate. Practitioner REL surveys had only a 1% return rate.
- The member and staff surveys are being reviewed and designed.
- During the outreach efforts conducted by CalOptima staff, parents provided feedback on barriers to well-child visits which included conflicts

#### Identified Opportunities for Improvement:

- Explore other methods of collecting member SOGI data, including community events, collaborating with contracted providers and direct member interaction. Also, explore other methods of collecting practitioner race/ethnicity data, including during new provider onboarding.

<p>with parental work schedules, PCP schedules not aligning with parents' needs, lack of childcare and lack of transportation.</p>	<ul style="list-style-type: none"> <li>• From the results of the survey, enhance interpreter and translation services by tracking and trending the utilization.</li> <li>• Utilize well-child visit findings to develop new interventions for 2025.</li> </ul>
<p><b>Conclusion:</b> Overall, the monitoring of CLAS was successful as all but one goal was completed. CalOptima Health will continue to monitor progress against the CLAS goals to ensure timely progress and completion.</p>	
<p><b>Activities/Interventions to continue/add next year:</b></p>	
<p>In 2025, C&amp;L will continue to monitor progress against CLAS goals by:</p> <ul style="list-style-type: none"> <li>• Continuing to send surveys to collect the members' SOGI information to members 18 years of age and older.</li> <li>• Implement a language services experience survey for members and staff and aim to collect feedback, analyze the results and identify improvement opportunities to language services.</li> </ul>	

### 3.4 Assessment of CLAS Staff and Resources

Author: Albert Cardenas

Department: Customer Service/Cultural & Linguistic Services

Support Staff: Carlos Soto

#### Background:

CalOptima Health has dedicated resources and staffing to meet the needs of the CLAS Program throughout the organization including C&L staff and contracted vendors that support translations, interpreter and alternative format services. Throughout 2024, CalOptima Health's Human Resources department worked with the business areas to fill vacant and needed positions to support the CLAS Program, including adding a C&L supervisor, a Sr. Director of Equity and Community Health and Director of Customer Service.

In addition to supporting CLAS, CalOptima Health has developed workgroups to focus on different CLAS priorities. Each workstream is comprised of staff from different functional departments to ensure the items listed on the CLAS work plan are implemented.

Workstream 1: Organizational Readiness

Workstream 2: REL/SOGI Data

Workstream 3: Access and Availability of Language Services

Workstream 4: Practitioner Network Cultural Responsiveness

Workstream 5: Reducing Health Care Disparities with CLAS

#### Actions/Interventions Implemented in 2024:

Quarter 1:	<ul style="list-style-type: none"><li>• None</li></ul>
Quarter 2:	<ul style="list-style-type: none"><li>• Recruited one (1) temp staff position to support C&amp;L staff.</li></ul>
Quarter 3:	<ul style="list-style-type: none"><li>• Hired a C&amp;L Supervisor.</li></ul>
Quarter 4:	<ul style="list-style-type: none"><li>• Hired a Sr. Director of Equity and Community Health.</li><li>• Renewed the contracts of CalOptima Health's translations and interpreter services vendors.</li></ul>

#### Analysis:

CalOptima Health added several positions that support CLAS throughout the organization, providing adequate staffing and resources to meet members' needs.

#### Identified Barriers:

- Ensuring we had adequate staffing to provide effective communication for LEP members.
- Needed a department supervisor to assist the department manager with the oversight of the department.
- C&L needed a coordinator to help coordinate translation and interpreter requests.

#### Identified Opportunities for Improvement:

- The C&L manager, supervisor and staff continue to ensure effective communication is conveyed to members, in their language, as part of the CalOptima Health CLAS Program.
- Hired a department supervisor.
- Hired a full-time coordinator to assist with the coordination and vending of incoming translation and interpreter requests.
- Cross-trained several members of the C&L staff to process interpreter requests and help with the influx of interpreter requests.

#### Conclusion:

This goal has been met, as CalOptima Health ensures sufficient CLAS staff and resources are available to effectively provide culturally and linguistically appropriate services to members.

#### Activities/Interventions to continue/add next year:

- Ensure CalOptima Health continues to provide culturally and linguistically appropriate services to members, with effective communication regarding treatment, medical history and health education.
- Continue to evaluate staffing resources to ensure there is adequate support for the CLAS Program.

### 3.5 Review of System Resources

Author: Albert Cardenas

Department: Customer Service/Cultural & Linguistic Services

Support Staff: Carlos Soto

#### Background:

To ensure effective communication regarding treatment and to try and avoid language barriers, CalOptima Health has resources to ensure there are adequate systems in place to support the CLAS Program. While most of CalOptima Health systems support CLAS, systems that directly support CLAS are:

- Customer Services core system (Facets) houses member eligibility, demographic, claims and member call records/logs.
- K2 Smart Forms support the intake and processing of member translations and interpreter services requests.
- Trados translation memory aids C&L translators in the translation of member-facing documents.
- The NICE CXone (NICE) Contact Center phone system was implemented in Q4 2024. The system includes telephone interactions and call routing, Interactive Voice Response, callback option, Workforce Management (planning, scheduling, productivity), Quality Management Assurance (recording, evaluations) and Feedback Management (member surveys).
- Jiva Healthcare Enterprise Platform is a comprehensive set of AI-powered solutions that integrate data, apply advanced analytics, automate workflows, and optimize team efficiency and effectiveness with clinical content-driven care pathways. Jiva also developed a module to support potential quality issues (PQIs).

These systems play a crucial role in staff providing culturally and linguistically appropriate services to CalOptima Health members and contracted providers.

In addition, in Q4 2024, CalOptima Health started implementing a Customer Relationship Management (CRM) System. This system will seamlessly integrate with existing systems (NICE CXone, Facets, Jiva, Salesforce Provider Network Management) to enable efficient data management, automate processes, and provide CalOptima Health staff with the tools and resources to deliver exceptional customer service to both members and providers. The anticipated launch date for the CRM system is Q3 2025.

#### Actions/Interventions Implemented in 2024:

Quarter 1:	<ul style="list-style-type: none"><li>• CalOptima Health transitioned to a new care management platform, Jiva Healthcare Enterprise Platform. Jiva represents a comprehensive set of AI-powered solutions that integrate data, apply advanced analytics, automate workflows, and optimize team efficiency and effectiveness with clinical content-driven care pathways. Jiva also developed a module to support potential quality issues (PQIs).</li></ul>
Quarter 2:	<ul style="list-style-type: none"><li>• Enhanced Facets to support the collection and storage of REL/SOGI data.</li></ul>
Quarter 3:	<ul style="list-style-type: none"><li>• Submitted request to ITS to enhance the Member Portal to implement the SOGI survey.</li></ul>
Quarter 4:	<ul style="list-style-type: none"><li>• Transitioned from Avaya phone system to NICE CXone Contact Center system.</li><li>• Implemented the SOGI surveys in the Member Portal.</li><li>• Began CRM implementation project.</li></ul>

#### Analysis:

CalOptima Health has sufficient system resources to support the CLAS Program.

#### Identified Barriers:

- Jiva reports still needed to be developed after go-live to produce appropriately formatted member documents for translations.
- Jiva required updates to store member pronouns (HE2 requirement).
- Facets had limitations in storing SOGI data.

#### Identified Opportunities for Improvement:

- Collaborated with the Jiva team and Utilization Management/Case Management to develop workarounds until the formatting issue with Jiva is corrected.
- Collaborated with ITS and Jiva team to update Jiva to store member pronouns.

<ul style="list-style-type: none"> <li>• The member portal required an update to upload the member SOGI survey.</li> </ul>	<ul style="list-style-type: none"> <li>• Collaborate with ITS to enhance Facets to store SOGI data.</li> <li>• Collaborated with ITS to update the Member Portal to make the SOGI survey available to members.</li> </ul>
<p>Conclusion: With the system updates completed in 2024 and updates scheduled for 2025, CalOptima Health has the necessary system resources to support the CLAS Program.</p>	
<p>Activities/Interventions to continue/add next year:</p>	
<ul style="list-style-type: none"> <li>• Continue to work with vendors and ITS to improve the current process.</li> <li>• Continue to work with the CRM implementation team to ensure the successful launch of the CRM system in Q3 2025.</li> </ul>	

### 3.6 Overall Assessment of CLAS Program Structure

Author: Albert Cardenas

Department: Customer Service/Cultural & Linguistic Services

#### Program Results:

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, medical history and health education, CalOptima Health developed a Cultural and Linguistic Services Program, a program that is a part of the Quality Improvement and Health Equity Transformation Program (QIHETP) that integrates culturally and linguistically appropriate services at all levels of the operation. Objectives for 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.

CalOptima Health is committed to member-focused care through member and community engagement. CalOptima Health intends to engage members through the Member Advisory Committee (MAC) and seek input and advice related to the Cultural and Linguistic and Health Equity goals.

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

Along with the MAC, QIHEC provides advice and recommendations regarding CalOptima Health programs and services. The QIHEC reports annually directly to CalOptima Health's Board of Directors.

The following are the goals of the QIHEC/CLAS Program:

1. Implement a process to collect, store and retrieve member SOGI data.
2. Evaluate the language services experience of members and staff.
3. Implement a process to collect, store and retrieve practitioner REL data.
4. Improve practitioner support in providing language services.

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

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

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



of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.

- An evaluation of the effectiveness of CLAS activities, including QIPs, PIPs and PDSAs.
- An evaluation of the effectiveness of member experience surveys related to cultural and linguistic services.
- A report to the QIHEC and QAC summarizing all CLAS measures and identifying significant trends.
- A critical review of the organizational resources involved in the CLAS Program through the CalOptima Health strategic planning process.
- Recommended changes included in the revised CLAS Program Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

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

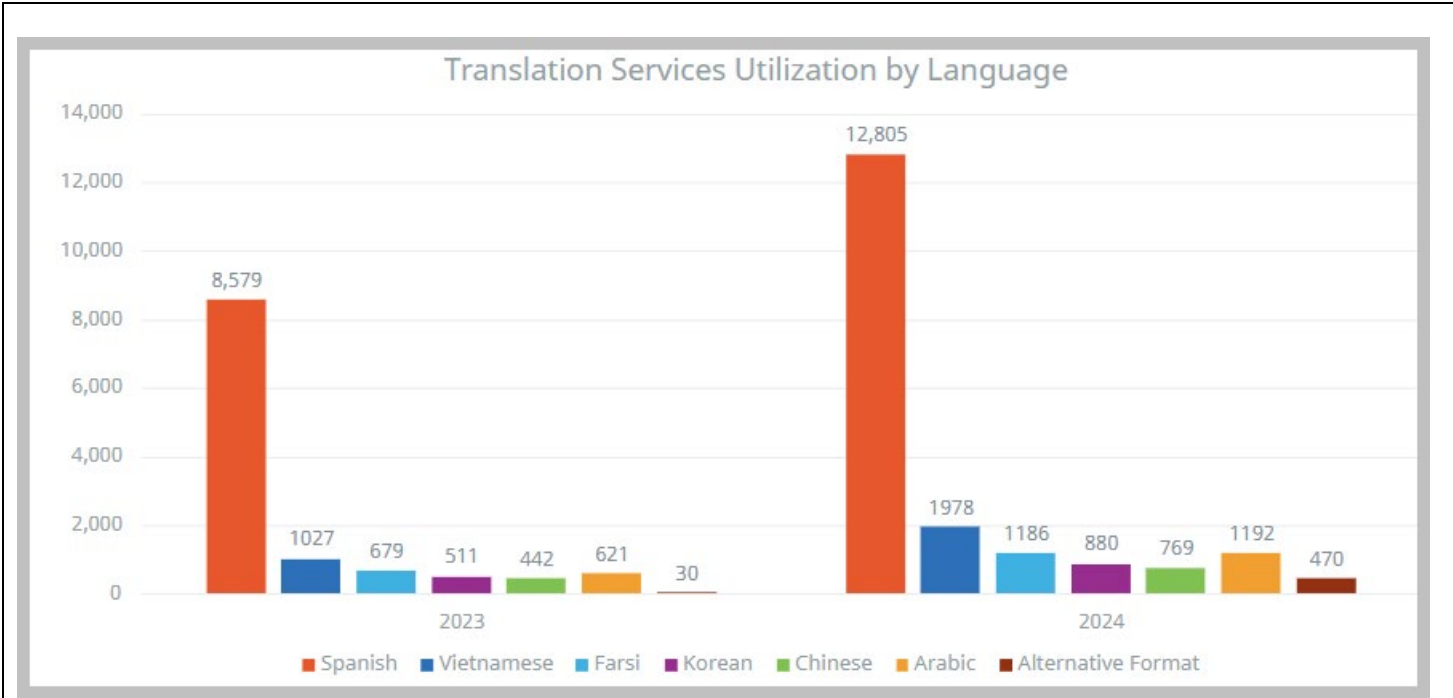
- Communications
  - Contracting
  - Customer Service
  - Equity and Community Health
  - Human Resources
  - Network Management
  - Provider Relations
  - Quality Analytics
- 
- CalOptima Health will continue to ensure we provide culturally and linguistically appropriate services to members, with effective communication.
  - CalOptima Health added staff and system resources during 2024 and implemented several surveys as part of the program. At the end of 2024, the CLAS program was appropriate and there is no plan to further restructure it in 2025.

## Section 4: Language Services

4.1 Translation Services	
Author: Carlos Soto/Albert Cardenas	Department: Cultural & Linguistic Services
Support Staff: Angelica Acosta (Dept. Sup.); C&L Translation Staff	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Work Plan Goal/Objective: Monitor translation services utilization	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: <ul style="list-style-type: none"> <li>• Track and trend interpreter and translation services utilization data and analysis for language needs</li> <li>• Comply with regulatory standards, including Member Material requirements</li> <li>• Maintain business for current programs</li> <li>• Improve the process for handling these services</li> </ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
Background: As a health care organization in the diverse community of Orange County, CalOptima Health recognizes that language misunderstandings and a lack of cultural awareness can sometimes negatively affect clear communication during care delivery. CalOptima Health's C&L department ensures that all members have access to translation services in CalOptima Health's threshold languages.	
Methodology: CalOptima Health's Cultural and Linguistics (C&L) department receives translation requests from members via CalOptima Health staff through an internal intake system named K2. C&L staff process the requests and translates member-facing materials in CalOptima Health's threshold languages, which are Arabic, Chinese, Farsi, Korean, Spanish and Vietnamese.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>• C&amp;L reviewed more than 1,500 pages of translated templates for the Jiva implementation throughout February 2024.</li> <li>• As a result of the new format, C&amp;L extended the previous 5-day Care Plans turnaround timeline to a 10-day turnaround timeline for all Care Plan translations. The new timeline helped with the translation schedule.</li> <li>• C&amp;L streamlined the Alternative Format Selection (Braille, Audio/Data files &amp; Large Print materials) for the Notice of Action (NOA) process.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Staff have been cross trained to process NOA translations to help cover the coordination process of NOAs to support the C&amp;L coordinator.</li> <li>• A new SharePoint work log was created for the Spanish team to distribute the workload among the Spanish translators.</li> <li>• A temporary staff member was hired to assist with the coordination and processing of NOA translations.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• The C&amp;L Coordinator was promoted to supervisor to help with the department oversight.</li> <li>• C&amp;L leaders opened recruitment for a full-time coordinator.</li> <li>• C&amp;L staff updated all Annual Notice of Change (ANOC) materials that were mailed to members.</li> <li>• C&amp;L management established a workflow for the C&amp;L team to vend out all overflow translation requests in order to accommodate the translations of all ANOC materials in-house.</li> <li>• A process was established for the C&amp;L staff to assist with coordination and vending of NOA translations and other translation requests.</li> </ul>

Quarter 4:	<ul style="list-style-type: none"> <li>A full-time coordinator was hired to assist with the translation coordination and vending of NOA and other incoming translation requests.</li> <li>C&amp;L streamlined the process with Pharmacy Management team to translate Care Plans.</li> <li>C&amp;L is processing a translated answer key for Case Management for HRA surveys.</li> <li>C&amp;L staff translated approximately five documents for Liberty Dental, in CalOptima Health threshold languages.</li> </ul>
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Program Results:



This slide shows a 2023–24 comparison of pages translated into CalOptima Health threshold languages, Arabic, Chinese, Farsi, Korean, Spanish and Vietnamese. Spanish and Vietnamese have the highest utilization.

Analysis:

- All goals and objectives were met in 2024.
- Spanish had the highest increase in utilization followed by Vietnamese.
- All other languages also show an increase in utilization.
- There was a 38% increase in utilization in 2024 compared with 2023.

Identified Barriers: Although C&L encountered the following challenges, all goals and/or objectives were met.

- C&L reviewed more than 1,500 pages of translated templates for the Jiva implementation, which caused delays in the translation process.
- Once JIVA went live, Case Management and Pharmacy Management Care Plans had a new format, which caused delays with translation.
- C&L assisted CalOptima Health’s contracted vendor with the review of member facing translated documents processed by the contracted vendor’s translation vendor.
- C&L experienced an influx of translation requests, which consequently led to hiring a department

Identified Opportunities for Improvement:

- Hired a department supervisor.
- Hired a full-time coordinator to assist with coordination and vending of NOA and other incoming translation requests.
- Streamlined the process with Pharmacy Management team to translate Care Plans.
- C&L is processing a translated answer key for Case Management for HRA surveys
- With Case Management’s approval, C&L extended the 5-day Care Plans turnaround timeline to a 10-day turnaround timeline for all Care Plan translations. The new timeline helped with translation schedule.

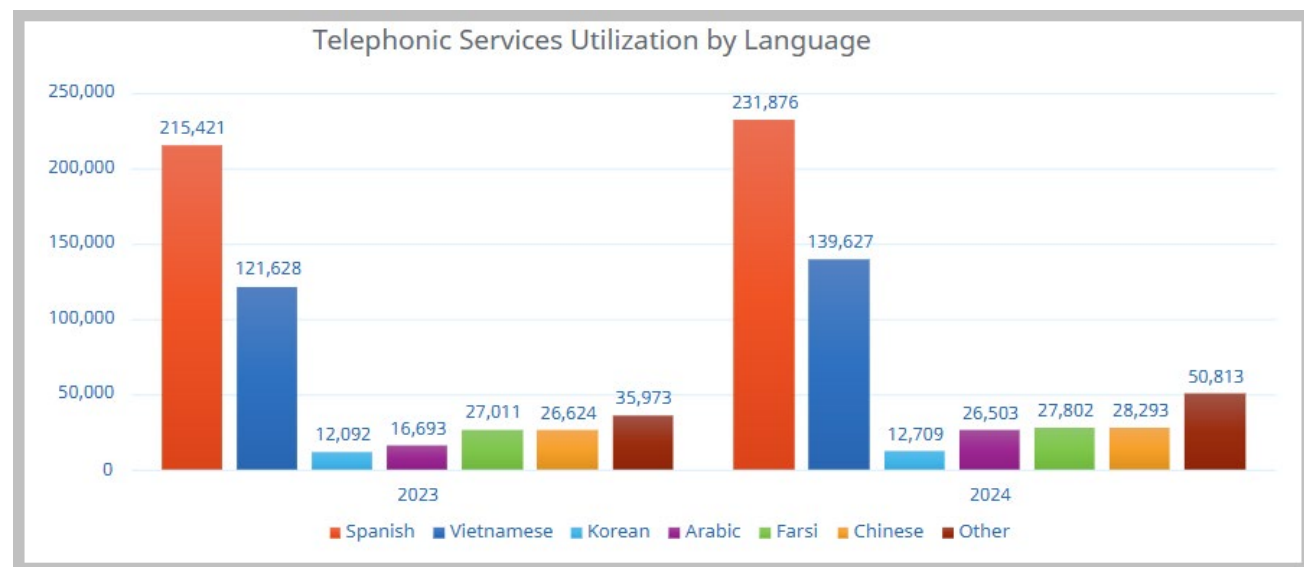
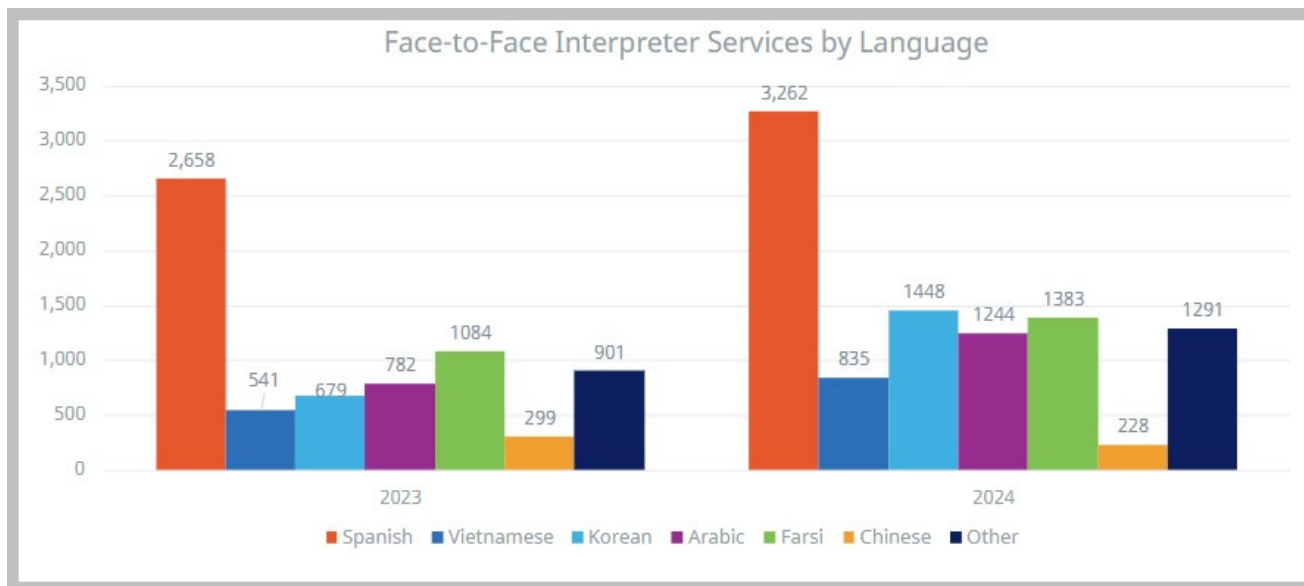
supervisor and a full-time coordinator to assist with the coordination and vending of the incoming translation workload.	<ul style="list-style-type: none"> <li>• A new SharePoint work log was created for the Spanish team to distribute the workload amongst the Spanish translators.</li> <li>• Streamlined the Alternative Format Selection (Braille, Audio/Data files &amp; Large Print materials) for the NOA process.</li> <li>• In 2025, C&amp;L will establish a process to assist the Medicare Program Development department with a transcreation process.</li> </ul>
Conclusion: The increase in utilization indicates there is increased member awareness of the availability of translations/interpreter services. CalOptima Health's C&L department will continue to ensure all members have access to translation services related to health care in CalOptima Health's threshold languages.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>• Continue to provide accessibility to translation services.</li> <li>• Implement new processes to make improvements and assist with the translation workflow for C&amp;L.</li> </ul>	

## 4.2 Interpreter Services

Author: Carlos Soto/Albert Cardenas		Department: Cultural & Linguistic Services	
Support Staff: Angelica Acosta (Dept. Sup.); C&L Interpreter Coordination Staff			
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare		New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Work Plan Goal/Objective: Monitor interpreter services utilization			
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial			
Work Plan Planned Activities: <ul style="list-style-type: none"> <li>• Track and trend interpreter and translation services utilization data and analysis for language needs.</li> <li>• Comply with regulatory standards, including Member Material requirements.</li> <li>• Maintain business for current programs.</li> <li>• Improve the process for handling these services.</li> </ul>			
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing			
Background: CalOptima Health recognizes that language misunderstandings and lack of cultural awareness can sometimes negatively affect communication during the process of receiving care. CalOptima Health's C&L services ensure that members can communicate clearly with CalOptima Health and health care providers in their preferred language. CalOptima Health's C&L department ensures all members have access to interpretation services related to receiving health care in any language and American Sign Language.			
Methodology: To ensure members communicate clearly with CalOptima Health and health care providers in their preferred language, CalOptima Health's C&L staff assist members in obtaining an interpreter in their preferred language for their health care-related appointments. Interpreter requests from members via CalOptima Health staff are submitted through internal intake systems, K2 and Facets. CalOptima Health's C&L services staff book interpreters for members in any language, including American Sign Language.			
Actions/Interventions Implemented in 2024:			
Quarter 1:	<ul style="list-style-type: none"> <li>• Created a new vendor process for TeleMed2U, who will be submitting interpreter requests via email.</li> <li>• Beginning January 2025, C&amp;L will begin booking interpreter requests for OC Liberty Dental members for face-to-face appointments.</li> </ul>		
Quarter 2:	<ul style="list-style-type: none"> <li>• The C&amp;L team received access to the interpreting vendor portals and began using the vendor for the overflow telephonic, face-to-face and VRI interpreter requests.</li> </ul>		

Quarter 3:	<ul style="list-style-type: none"> <li>Due to the influx of interpreter requests, existing C&amp;L staff were cross trained to assist with the coordination of interpreter request processing.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Created an internal process for C&amp;L staff to submit issue notifications on behalf of members when grievances are brought to our attention.</li> <li>Developed new Health Equity-related surveys to request feedback from members and CalOptima Health staff regarding their satisfaction with language access. The surveys will be launched in 2025.</li> </ul>

#### Program Results:



The charts show the 2023–24 comparison of face-to-face (in-person) and telephonic utilization interpreter services. CalOptima Health threshold languages, Arabic, Chinese, Farsi, Korean, Spanish and Vietnamese, are the most used languages. Spanish and Vietnamese have the highest utilization.

<b>Analysis:</b> <ul style="list-style-type: none"> <li>• All goals and objectives were met in 2024.</li> <li>• Spanish had the highest increase in utilization followed by Vietnamese.</li> <li>• All other languages also show an increase in utilization.</li> <li>• There was a 28% increase in face-to-face interpreter services in 2024 compared with 2023.</li> <li>• There was a 12% increase in telephonic interpreter services in 2024 compared with 2023.</li> </ul>	
<b>Identified Barriers:</b> <ul style="list-style-type: none"> <li>• Ensuring we were able to provide language interpreters in any language.</li> <li>• On occasion, we had trouble accessing Cambodian interpreters.</li> </ul>	<b>Identified Opportunities for Improvement:</b> <ul style="list-style-type: none"> <li>• We had discussions with our contracted vendors to ensure they can provide language interpreters in any language.</li> <li>• A couple of our contracted vendors onboarded more Cambodian interpreters to ensure this language will be properly covered going forward.</li> </ul>
<b>Conclusion:</b> The increase in utilization indicates there is increased awareness of the availability of interpreter services. CalOptima Health's C&L department will continue to ensure all members have access to interpreter services related to health care in CalOptima Health's threshold languages.	
<b>Activities/Interventions to continue/add next year:</b> <ul style="list-style-type: none"> <li>• Continue to provide accessibility to different language interpreters for interpreter service requests.</li> <li>• Implement new cross-training processes for C&amp;L staff to coordinate interpreter requests.</li> <li>• Hire an interpreter request coordinator to assist C&amp;L staff in coordinating and booking interpreter requests.</li> </ul> Monitor utilization and resources to ensure members are provided with timely language services.	

4.3 Experience with Language Services Survey	
Author: Albert Cardenas	Department: Cultural & Linguistic Services
Support Staff: Carlos Soto	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>Work Plan Goal/Objective:</b> <ul style="list-style-type: none"> <li>• Evaluate the language services experience of members and staff</li> </ul>	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
<b>Work Plan Planned Activities:</b> <ol style="list-style-type: none"> <li>1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services.</li> <li>2) Analyze data and identify opportunities for improvement.</li> </ol>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<b>Background:</b> The CLAS surveys were drafted and will be administered to CalOptima Health members and staff. <ul style="list-style-type: none"> <li>• A member survey will be mailed to all CalOptima Health members to assess members' satisfaction with language access.</li> <li>• CalOptima Health staff will receive a staff survey to evaluate members' satisfaction with language access.</li> </ul>	
<b>Methodology:</b> The CLAS surveys will be conducted with CalOptima Health members and staff, as per the following: <ul style="list-style-type: none"> <li>• A member survey will be mailed to all CalOptima Health members.</li> <li>• A staff survey will be sent to CalOptima Health staff through an internal process or email.</li> </ul>	
<b>Actions/Interventions Implemented in 2024:</b>	
Quarter 1:	• None
Quarter 2:	• None
Quarter 3:	• Surveys drafted, reviewed and approved by contracted consultants.

Quarter 4:	<ul style="list-style-type: none"><li>• The staff survey is currently being reviewed through the Member Material Approval Process (MMA) and DHCS. Once approved, it will be sent to the Communications department to be designed by CalOptima Health graphic designers.</li><li>• The member survey is currently being designed by CalOptima Health designers in the Communications department.</li><li>• Both surveys will be sent out in early 2025.</li></ul>
Program Results:	
Analysis: <ul style="list-style-type: none"><li>• This goal was not completed in 2024 and will carry over to the 2025 goals. Once the surveys are launched in Q1 2025, analysis will be conducted.</li></ul>	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"><li>• No barriers identified</li></ul>	<ul style="list-style-type: none"><li>• To be determined</li></ul>
Conclusion: The conclusion will be summarized and added to this section once the survey responses are received.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"><li>• Implement surveys in Q1 2025.</li><li>• Collect and analyze data.</li></ul>	

## Section 5: Data Collection and Analysis

### 5.1 Collecting CLAS Member Data

Author: Albert Cardenas		Department: Cultural & Linguistic Services	
Support Staff: Anita Garcia			
Work Plan Element: Data Collection on Member Demographic Information			
Products: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare		New Activity: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Plan Goal/Objective: Implement a process to collect member SOGI data by December 1, 2024.			
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial			
Work Plan Planned Activities: 1) Develop and implement a survey to collect the member's SOGI information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 4) Develop and implement a survey via the Member Portal, mail to new members and other methods. 5) Collect (REL data 6) Share member demographic information with practitioners.			
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing			
Background: The collection of SOGI data is a National Committee for Quality Assurance (NCQA) Health Equity Accreditation requirement and was implemented in Q3 2024.			
Methodology: CalOptima Health staff followed the 2024 NCQA Health Equity Accreditation Standards and Guidelines when implementing the CLAS Program goals and monitored progress against CLAS goals. Quarterly, dedicated staff from C&L, in collaboration with multidisciplinary work teams throughout the organization, collect and track indicators and activities specific to CLAS goals, outcomes and outputs.			
Actions/Interventions Implemented in 2024:			
Quarter 1:	• The HE2 workgroup began the development of a survey to collect SOGI data.		
Quarter 2:	• Received approval of SOGI survey from DHCS. • Updated CalOptima Health's Core eligibility system to store SOGI data. • Developed member mailing (survey) packets.		
Quarter 3:	• Implemented the mailing of the SOGI survey to new CalOptima Health members (18+ years of age).		
Quarter 4:	• Implemented the SOGI survey in the Member Portal.		
Program Results:			
Successfully implemented the process of collecting SOGI data.			
Analysis: CalOptima Health collects REL data via the state daily/monthly eligibility files, through member surveys, and member interaction with CalOptima Health staff. CalOptima Health meets the NCQA Health Equity requirement of 80% for REL data. CalOptima Health shares REL data with practitioners via the Provider Portal and the daily eligibility files sent to the contracted health networks.  There is currently no NCQA Health Equity Accreditation percentage requirement for SOGI data. Analysis is pending.			
Identified Barriers:		Identified Opportunities for Improvement:	



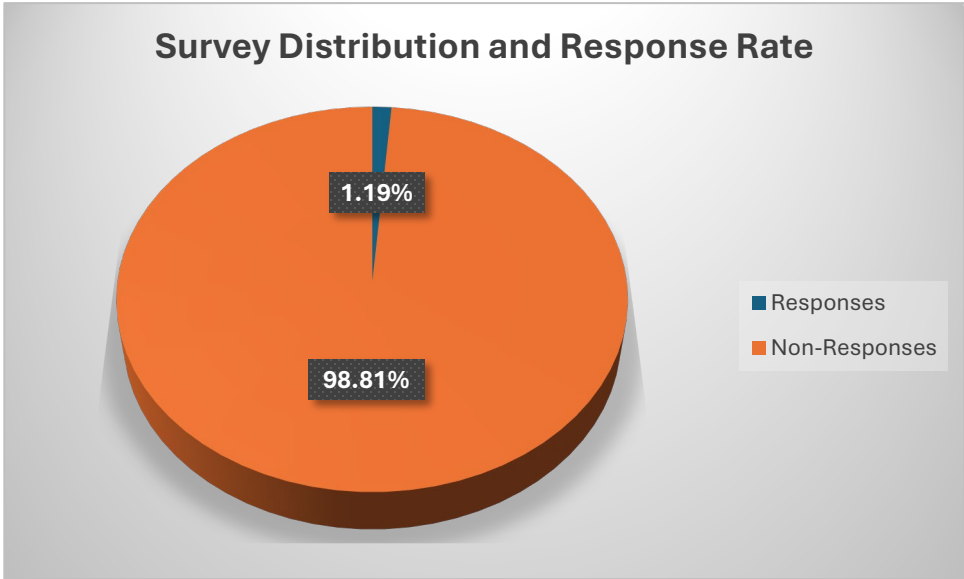
<ul style="list-style-type: none"> <li>Low response rate from members (5%).</li> </ul>	<ul style="list-style-type: none"> <li>Expand the survey collection efforts by including existing members.</li> <li>Adding additional methods such as texting campaigns and through customer service member interactions.</li> </ul>
<p>Conclusion: Although the implementation of collecting SOGI data was successful, the return rate is low, so additional efforts will be made in 2025 to increase it.</p>	
<p>Activities/Interventions to continue/add next year:</p>	
<ul style="list-style-type: none"> <li>Expand the collection efforts of SOGI data.</li> <li>Explore other methods of collecting SOGI data.</li> </ul>	

## 5.2 Collecting CLAS Provider Data

Author: Quynh Nguyen	Department: Provider Data Operations
Support Staff: Linda Huynh	
Work Plan Element: Data Collection on Practitioner Demographic Information	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Work Plan Goal/Objective: Implement a process to collect practitioner REL data by December 31, 2024.	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
<p>Work Plan Planned Activities:</p> <ol style="list-style-type: none"> <li>1) Develop and implement a survey to collect practitioner REL data.</li> <li>2) Enter REL data into the provider data system and ensure the ability to retrieve and utilize it for CLAS improvement.</li> <li>3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership.</li> <li>4) Assess the provider network's capacity to meet CalOptima Health's culturally diverse member needs.</li> <li>5) Collaborate with other participating CalOptima Health departments to share SOGI data with the health networks.</li> </ol>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>The initiative seeks to enhance CalOptima Health's ability to address the cultural and linguistic needs of its diverse membership by the collection efforts of race/ethnicity and language data from providers. Implementation will occur through ongoing updates to provider forms, including the Provider Satisfaction Survey.</p>	
<p>Methodology:</p> <p>CalOptima Health conducted a Provider Satisfaction Survey to assess provider experiences, including questions related to REL. The survey was distributed to 2,272 health care providers via e-mail. A total of 30 responses were received, 27 responded to the REL questions resulting in a response rate of 1.19%. The survey was designed to gather feedback on various aspects of provider satisfaction, including the REL questions. Once the data was gathered, Provider Relations sent it to Provider Data Operations, where the information was added to the system (Facets).</p>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>N/A</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li></li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Provider Satisfaction Survey questions to include REL questions.</li> <li>The survey was sent to providers via email. Reminders were sent every two weeks. A Provider Relations Representative reached out to providers to administer the survey through email/telephone interactions and during office visits. Additional efforts were made to collect survey responses during CCN Lunch &amp; Learn in September. Provider Data Management Service coordinators entered REL data into the provider data system (Facets).</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Email reminders were sent to providers every two weeks. Provider Relations Representatives reminded providers about the survey through email/telephone interactions</li> </ul>

and during office visits. Additional efforts were made during CCN Lunch & Learn in October and November Provider Update alerts. Provider Data Management Service coordinators entered REL data into the provider data system (Facets). Provider Satisfaction Survey initiative completed 11/15/2024.

Program Results:



*Provider Satisfaction Survey: 98.81% Non-Responses and 1.19% Responses*

**Quantitative Analysis:**  
Since the survey focuses on provider satisfaction and includes REL-related questions, satisfaction levels or metrics would typically be compared to past surveys. However, no historical data or baseline is provided, so only the response rate of 1.19% can be evaluated. Given that this is generally considered very low, it's likely that the response rate has decreased compared with previous efforts with higher engagement. While the data was collected and processed, the low response rate raises concerns about its representativeness and actionability, potentially limiting its value for drawing meaningful conclusions.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"><li>• Providers' offices likely had competing priorities during the survey period, which may have impacted on their capacity and willingness to participate in non-urgent surveys.</li><li>• The survey included over 20 questions, which may have been seen as time-consuming or burdensome.</li><li>• Providers' offices may have been overwhelmed by multiple feedback requests from various organizations, leading to fatigue and lower response rates.</li><li>• Lack of Incentive for survey completion.</li></ul>	<ul style="list-style-type: none"><li>• Offering a shorter, more focused survey could lead to better engagement, especially if it's framed as quick and easy to complete.</li><li>• Offering incentives, such as professional development credits or public recognition, may encourage providers to take the time to participate.</li><li>• To increase provider participation, incorporate key questions into standard forms or other mandatory reporting documents. This integration could be done as part of regular credentialing or quality reporting processes, ensuring higher response rates with minimal disruption to providers' workflow.</li></ul>

**Conclusion:**  
The Provider Satisfaction Survey conducted by CalOptima Health, with a response rate of 1.19%, highlights key challenges, such as survey length and competing demands on providers' time. These challenges offer clear opportunities to improve data collection efforts in the future. By shortening the survey, and using multiple communication channels, CalOptima Health can increase participation rates. Additionally, integrating REL

questions into annual forms or other reporting processes can streamline data collection and reduce provider burden.

**Activities/Interventions to continue/add next year:**

- **Adjust Timing:** Conduct the survey earlier in the year, avoiding the busy end-of-year period, to reduce provider fatigue and ensure more timely responses.
- **Shorten Survey Length:** Streamline the survey to focus on key areas only, such as REL, to make it more manageable and less time-consuming for providers.
- **Incentives and Recognition:** Introduce incentives such as gift cards, professional development credits or public recognition to motivate providers to complete the survey. Clear communication about how feedback will be used to make improvements could also encourage participation.
- **Integrate Questions into Forms:** Include key survey questions, especially those related to REL, within required attestation forms or other routine reporting processes as an example. This will streamline data collection and reduce provider burden.

## Section 6: Trainings

6.1 Cultural Competency and Training	
Author: Carlos Soto	Department: Cultural & Linguistic Services
Support Staff: Carlos Soto	
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Goal/Objective: <ul style="list-style-type: none"><li>Conduct a cultural competency training</li></ul>	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: <ul style="list-style-type: none"><li>Conduct cultural competency training in 2024</li></ul>	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>Cultural Competency: The NET1A Report C&amp;L outlines Cultural Competency details.</p> <p>Training: C&amp;L currently presents a cultural and linguistic overview during the monthly Bootcamp training. C&amp;L also provides in-service training to staff at different CalOptima Health departments. Cultural competency training is conducted annually and during the onboarding of new employees by CalOptima Health's Human Resources department and provider office staff by CalOptima Health's Provider Relations department.</p>	
<p>Methodology:</p> <p>HR conducts cultural competency training for the entire CalOptima Health staff. Provider Relations department conducts provider office staff training.</p> <p>Training: Bootcamp training is done monthly, as requested by Human Resources. The Bootcamp presentations are rotated among the C&amp;L manager and C&amp;L staff. C&amp;L conducts in-service training for CalOptima Health staff with different CalOptima Health departments, as requested.</p>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"><li>Held three Bootcamp presentations and two in-service trainings.</li><li>Cultural Competency training for CalOptima Health staff and provider office staff</li></ul>
Quarter 2:	<ul style="list-style-type: none"><li>Held three Bootcamp presentations.</li><li>Cultural Competency training for CalOptima Health staff and provider office staff</li></ul>
Quarter 3:	<ul style="list-style-type: none"><li>Held three Bootcamp presentations.</li><li>Cultural Competency training for CalOptima Health staff and provider office staff</li></ul>
Quarter 4:	<ul style="list-style-type: none"><li>Held two Bootcamp presentations.</li><li>Cultural Competency training for CalOptima Health staff and provider office staff</li></ul>
Program Results:	
<p>Quantitative Analysis:</p> <ul style="list-style-type: none"><li>The NET1A Report includes information on Cultural Competency trainings completed in 2024 by CalOptima Health staff and providers.</li><li>Bootcamp training courses were completed every quarter in 2024, as scheduled by Human Resources.</li><li>The C&amp;L manager lead two in-service training courses for CalOptima Health Customer Service staff at the beginning of 2024.</li><li>Cultural Competency training completed in 2024:<ul style="list-style-type: none"><li>CalOptima Health Employees: 1,742</li><li>Provider Office Staff: 9,724</li></ul></li></ul>	
Identified Barriers:	Identified Opportunities for Improvement:

<ul style="list-style-type: none"> <li>None.</li> </ul>	<ul style="list-style-type: none"> <li>Continue C&amp;L services bootcamp trainings..</li> <li>Continue in-service trainings for CalOptima Health Customer Service staff and other departments</li> </ul>
<p>Conclusion:</p> <ul style="list-style-type: none"> <li>Monthly Bootcamp training courses and in-service training courses for CalOptima Health Customer Service staff were completed in 2024.</li> <li>Cultural Competency training throughout the year for new and existing CalOptima Health staff and provider office staff.</li> </ul>	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"> <li>Continue to present at Bootcamp training courses and in-service training courses for CalOptima Health Customer Service staff in 2025.</li> <li>Diversity Equity and Inclusion (DEI) training.</li> <li>Cultural Competency Training for CalOptima Health staff and office provider staff.</li> </ul>	

## 6.2 Diversity, Equity and Inclusion Training

Author: Dr. Michael Rose		Department: Equity and Community Health	
Support Staff: Greta Rice; Adriana Ramos			
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare		New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Work Plan Goal/Objective: <i>DHCS mandated training from APL24-016</i>			
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial			
Work Plan Planned Activities: Creation of staff and provider DEI training and submission to DHCS.			
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing			
<p>Background: DHCS has a vision to advance health equity for Medi-Cal members. The managed care plan (MCP) DEI training program will support creating a better relationship and connectivity with diverse MCP members across populations disadvantaged by the system. Additionally, trainings can create an inclusive environment within the MCP organization and externally with health network providers and other community-based contractors and staff, thereby improving members' outcomes by enhancing access to care, reducing health disparities and improving overall quality of care.</p>			
<p>Methodology:</p> <p>Medi-Cal MCPs are required to develop a DEI training program encompassing the requirements in APL 24-016 that will be launched to staff and providers in 2025.</p> <p>Chief Health Equity Officer created a DEI Training policy based on the APL requirements that was approved at the December 2024 Board meeting..</p>			
Actions/Interventions Implemented in 2024:			
Quarter 1:	<ul style="list-style-type: none"> <li>Released RFP for a vendor to develop the DEI Training Program.</li> </ul>		
Quarter 2:	<ul style="list-style-type: none"> <li>Contracted with vendor; gathered staff, provider and community feedback.</li> </ul>		
Quarter 3:	<ul style="list-style-type: none"> <li>Developed the DEI Training Program.</li> </ul>		
Quarter 4:	<ul style="list-style-type: none"> <li>Finalized the DEI Training Program and submitted to DHCS.</li> </ul>		
Program Results:			
<ul style="list-style-type: none"> <li>No data since the DEI Training Program will be launched to staff and providers in 2025.</li> </ul>			
Identified Barriers:		Identified Opportunities for Improvement:	
<ul style="list-style-type: none"> <li>None</li> </ul>		<ul style="list-style-type: none"> <li>None</li> </ul>	
<p>Conclusion</p> <p>No data is available at this time.</p>			
Activities/Interventions to continue/add next year:			
<ul style="list-style-type: none"> <li>Incorporate DHCS feedback, pilot DEI Training Program and launch official training.</li> </ul>			

## Section 7: Promotion of Diversity

7.1 Staff, Leadership and Committee Hiring and Recruiting Practices	
Author: Michael Coringrato/Marsha Choo	Department: Human Resources/Quality Improvement
Support Staff: Ravi Hayashida/Glora Garcia	
Products: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Goal/Objective: To assess staff and committee experience with DEI at CalOptima Health and utilize the data to identify areas of opportunity for DEI improvement	
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	
Work Plan Planned Activities: Develop and launch surveys of all CalOptima Health staff and QIHEC participants to determine perceptions of current DEI support environment within the organization. Surveys will be sent to more than 1,600 people. The expected response rate is unknown. Subsequently, data will be used to determine the effectiveness of activities developed to improve identified opportunities.	
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing	
<p>Background:</p> <p>CalOptima Health is seeking NCQA Health Plan Accreditation, as required by DHCS. The organization also recognizes the opportunity to identify where the DEI environment in the workplace is healthy and where it can be improved. The HE1 workgroup has met since May 2024 to identify current policies and procedures relating to overall Hiring and Recruiting practices that support the DEI work environment. Further, the workgroup is developing surveys to gather data from internal staff and leadership, as well as participants within CalOptima Health's QIHEC committees and sub-committees. This is a first-of-its-kind survey that is scheduled to launch in Q4 2024. The HE1 workgroup plans to collect and analyze the data in January 2025 to determine areas of opportunity and develop action plans to seek improvement where applicable.</p>	
<p>Methodology:</p> <ol style="list-style-type: none"> <li>1) The workgroup analyzed statements and results from the 2024 Great Places to Work Survey. Initial analysis and feedback from a consultant for NCQA Health Equity Accreditation determined the statements were too broad to create actionable items to address perceptions relating to the DEI environment.</li> <li>2) The consultant provided example questions that the workgroup customized for CalOptima Health staff and committee participants.</li> <li>3) The survey was split into two sections: Perceptions of DEI environment and Demographics.</li> <li>4) The survey was hosted on HR Survey Monkey and the team is using Survey Monkey analytics to collect data and reports.</li> <li>5) Communication plan includes Chief-level review, announcements via All Staff meeting, email and internal meeting announcements</li> <li>6) Staff/Leadership survey was sent to about 1,600 employees; Committee survey was sent to 149 participants</li> <li>7) The Survey period was between Monday December 16, 2024, and Friday January 10<sup>th</sup>, 2025. Holidays were considered while setting this response period.</li> <li>8) NCQA target response rate is not specified, but the best practice is to seek at least 15%. Staff/Leadership Survey response reached about a 38% Response Rate; Committee Survey attained 34% Response Rate.</li> </ol>	
Actions/Interventions Implemented in 2024:	
Quarter 1:	<ul style="list-style-type: none"> <li>• Organization identified stakeholders for executing the project to achieve NCQA Health Equity Accreditation.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>• Workgroups held kickoff meetings.</li> <li>• HE1 workgroup met to identify relevant policies and available data.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>• HE1 workgroup analyzed Best Places to Work survey statements and results.</li> <li>• Obtained survey question examples from the consultant.</li> <li>• Drafted surveys and conducted multiple reviews.</li> <li>• Surveys focused on staff/leadership and committees. Determined Governance Body survey may be subject to exemption.</li> </ul>

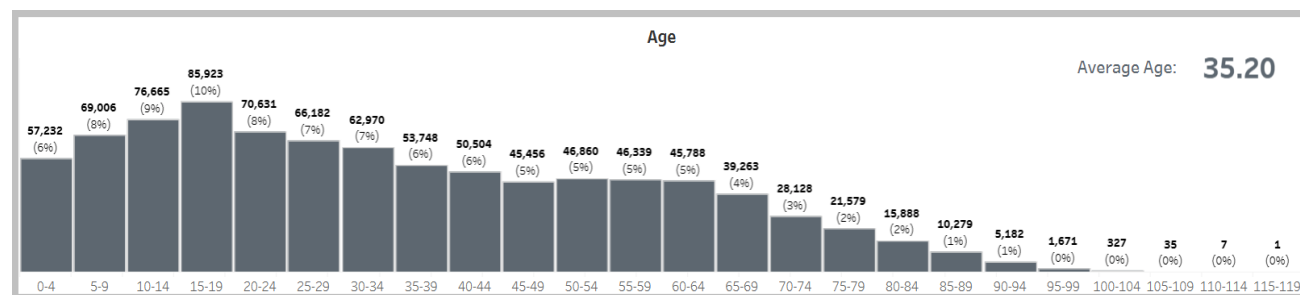
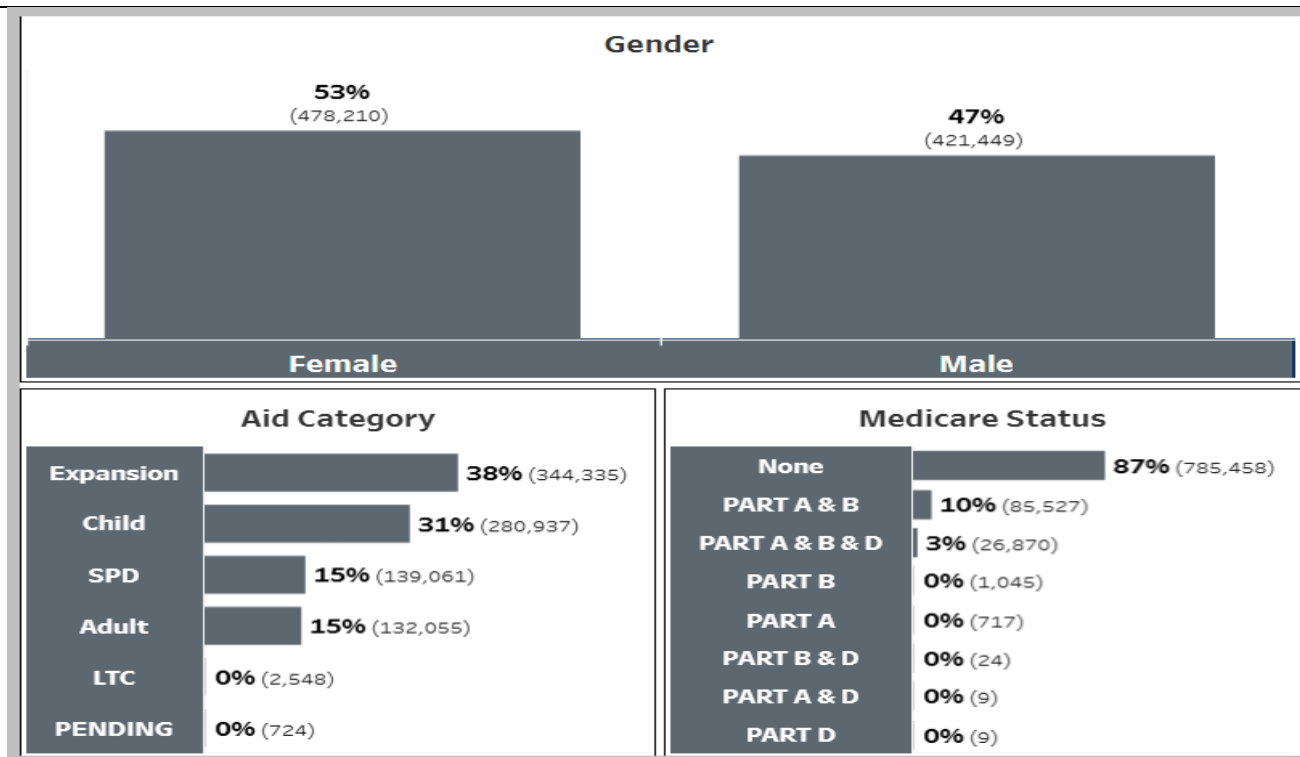
Quarter 4:	<ul style="list-style-type: none"><li>• Legal review</li><li>• Chief-level review and feedback</li><li>• Communications review completed December 12, 2024</li><li>• Communication to Committees of the upcoming survey</li><li>• Surveys were launched December 16, 2024.</li></ul>
Program Results:	
Quantitative Analysis: <ul style="list-style-type: none"><li>• 621 Staff / Leadership responses; 50 Committee responses.</li><li>• Analysis completion not expected until February 2025</li></ul>	
Identified Barriers: <ul style="list-style-type: none"><li>• </li><li>• None at this time.</li></ul>	Identified Opportunities for Improvement: <ul style="list-style-type: none"><li>• Final results and analysis not expected until February 2025</li><li>• Preliminary analysis indicates possible communications opportunities</li><li>• Maintain roster of committee participants</li><li>• Establish and maintain annual process</li></ul>
Conclusion: Staff were successful in fielding the survey. Response rate is encouraging. Further data analysis is needed to clearly identify opportunities for improvement.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"><li>• Data analysis of survey data collected.</li><li>• Identify opportunities for DEI improvement.</li></ul>	

Section 8: Practitioner Network Cultural Responsiveness

8.1 Member Demographics

Author: Carlos Soto, Albert Cardenas	Department: Customer Service/Cultural & Linguistic Services																																																												
Support Staff:																																																													
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																																												
Work Plan Goal/Objective: <ul style="list-style-type: none"><li>Implement a process to collect member SOGI data by December 31, 2024.</li></ul>																																																													
Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial																																																													
Work Plan Planned Activities: <ol style="list-style-type: none"><li>Develop and implement a survey to collect the member’s SOGI information from members (18+ years of age).</li><li>Update CalOptima Health’s Core eligibility system to store SOGI data.</li><li>Collaborate with other participating CalOptima Health departments to share SOGI data with the health networks.</li><li>Develop and implement a survey to distribute during the monthly New Member Orientation sessions.</li><li>Collect REL data.</li><li>Share member demographic information with practitioners.</li></ol>																																																													
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing																																																													
<p>Background:</p> <p>CalOptima Health staff followed the 2024 Health Equity Standards and Guidelines when implementing the CLAS Program goals and monitored progress against CLAS goals. Quarterly, dedicated staff from C&amp;L, in collaboration with multidisciplinary work teams throughout the organization, collect and track indicators and activities specific to CLAS goals, outcomes and outputs.</p> <p><b>Member Demographics (as January 2025)</b></p> <div><div><p>Ethnicity (Top 10)</p><table><tr><td>Hispanic</td><td>48%</td><td>(431,863)</td></tr><tr><td>White</td><td>14%</td><td>(129,451)</td></tr><tr><td>Vietnamese</td><td>12%</td><td>(104,422)</td></tr><tr><td>No response, client declined to state</td><td>9%</td><td>(85,283)</td></tr><tr><td>Other</td><td>7%</td><td>(63,413)</td></tr><tr><td>Korean</td><td>2%</td><td>(21,671)</td></tr><tr><td>Black</td><td>2%</td><td>(14,077)</td></tr><tr><td>Chinese</td><td>2%</td><td>(13,931)</td></tr><tr><td>Filipino</td><td>1%</td><td>(12,136)</td></tr><tr><td>Asian or Pacific Islander</td><td>1%</td><td>(10,189)</td></tr></table></div><div><p>Spoken Language (Top 10)</p><table><tr><td>English</td><td>48%</td><td>(431,223)</td></tr><tr><td>Spanish</td><td>26%</td><td>(231,806)</td></tr><tr><td>Unknown</td><td>13%</td><td>(114,038)</td></tr><tr><td>Vietnamese</td><td>9%</td><td>(77,141)</td></tr><tr><td>Korean</td><td>1%</td><td>(11,324)</td></tr><tr><td>Farsi</td><td>1%</td><td>(9,858)</td></tr><tr><td>Arabic</td><td>1%</td><td>(5,661)</td></tr><tr><td>Mandarin</td><td>0%</td><td>(4,175)</td></tr><tr><td>Russian</td><td>0%</td><td>(2,393)</td></tr><tr><td>Chinese</td><td>0%</td><td>(1,632)</td></tr></table></div></div>		Hispanic	48%	(431,863)	White	14%	(129,451)	Vietnamese	12%	(104,422)	No response, client declined to state	9%	(85,283)	Other	7%	(63,413)	Korean	2%	(21,671)	Black	2%	(14,077)	Chinese	2%	(13,931)	Filipino	1%	(12,136)	Asian or Pacific Islander	1%	(10,189)	English	48%	(431,223)	Spanish	26%	(231,806)	Unknown	13%	(114,038)	Vietnamese	9%	(77,141)	Korean	1%	(11,324)	Farsi	1%	(9,858)	Arabic	1%	(5,661)	Mandarin	0%	(4,175)	Russian	0%	(2,393)	Chinese	0%	(1,632)
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#### Actions/Interventions Implemented in 2024:

Quarter 1:	<ul style="list-style-type: none"> <li>HE2 workgroup began development of survey to collect SOGI data.</li> <li>Collection of REL data via the state daily/monthly eligibility files, through member surveys and member interaction with CalOptima Health staff.</li> </ul>
Quarter 2:	<ul style="list-style-type: none"> <li>Received approval of SOGI survey from DHCS.</li> <li>Updated CalOptima Health's Core eligibility system to store SOGI data.</li> <li>Developed member mailing (survey) packets.</li> </ul>
Quarter 3:	<ul style="list-style-type: none"> <li>Implemented the mailing of the SOGI survey to new CalOptima Health members (18+ years of age).</li> <li>Collection of REL data via the state daily/monthly eligibility files, through member surveys and member interaction with CalOptima Health staff.</li> </ul>
Quarter 4:	<ul style="list-style-type: none"> <li>Implemented the SOGI survey in the Member Portal.</li> <li>Collection of REL data via the state daily/monthly eligibility files, through member surveys, and member interaction with CalOptima Health staff.</li> </ul>

#### Analysis:

CalOptima Health collects REL information via the state daily/monthly eligibility files, through member surveys and member interaction with CalOptima Health staff. CalOptima Health meets the Health Equity requirement of 80% for REL data.

CalOptima shares REL data with practitioners via the Provider Portal and the daily eligibility files sent to the contracted health networks.

There is currently no Health Equity percentage requirement for SOGI data.

Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"> <li><u>Low response rate from members (5%).</u></li> </ul>	<ul style="list-style-type: none"> <li><u>Expand the survey collection efforts by including existing members.</u></li> <li><u>Adding additional methods such as texting campaigns and through customer service member interactions.</u></li> </ul>
<p>Conclusion:</p> <p><u>Although the implementation of collecting SOGI data was successful, the return rate is low, so additional efforts will be made in 2025 to increase member response.</u></p>	
<p>Activities/Interventions to continue/add next year:</p> <ul style="list-style-type: none"> <li><u>Expand the collection efforts of SOGI data.</u></li> <li><u>Explore other methods of collecting SOGI data.</u></li> </ul>	

## 8.2 Enhancing Network Responsiveness

Author: Carlos Soto	Department: Cultural & Linguistic Services				
Support Staff: Carlos Soto					
Products: <input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> OneCare	New Activity: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
<p>Work Plan Goal/Objective:</p> <ul style="list-style-type: none"> <li>Analyze CalOptima Health's provider network and its ability to address members' cultural and linguistic needs.</li> </ul>					
<p>Goal Met: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial</p>					
<p>Work Plan Planned Activities:</p> <ul style="list-style-type: none"> <li>Conduct an analysis on CalOptima Health's provider network and their ability to address members' cultural and linguistic needs.</li> </ul>					
<p>Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing</p>					
<p>Background:</p> <p>As a public agency and Orange County's single largest health insurer, CalOptima Health offers health insurance coverage through three major programs:</p> <ul style="list-style-type: none"> <li><b>Medi-Cal</b> – California's Medicaid Program for low-income children, adults, seniors and people with disabilities, offering comprehensive health care coverage.</li> <li><b>OneCare (HMO D-SNP)</b> – Medicare Advantage Special Needs Plan for seniors and people with disabilities who qualify for both Medicare and Medi-Cal.</li> <li><b>Program of All-Inclusive Care for the Elderly (PACE)</b> – PACE for frail older adults, providing a full range of health and social services so seniors can remain living in the community.</li> </ul>					
<p><b>Membership Data (as of January 2025)</b></p> <table border="1"> <tr> <td><b>899,659</b> (All)</td> <td><b>881,877</b> (Medi-Cal)</td> <td><b>17,280</b> (OneCare)</td> <td><b>502</b> (PACE)</td> </tr> </table>		<b>899,659</b> (All)	<b>881,877</b> (Medi-Cal)	<b>17,280</b> (OneCare)	<b>502</b> (PACE)
<b>899,659</b> (All)	<b>881,877</b> (Medi-Cal)	<b>17,280</b> (OneCare)	<b>502</b> (PACE)		
<p>Methodology:</p> <p>CalOptima Health provides the Medi-Cal, OneCare and PACE programs and collaborates with partnering Orange County providers who assist in delivering access to quality care, treatment, diagnoses and medical history in the member's language.</p>					
<p>Actions/Interventions Implemented in 2024:</p>					

Quarter 1:	<ul style="list-style-type: none"><li>CalOptima Health continues to collaborate with partnering Orange County providers in assisting and delivering access to quality care, treatment, diagnoses and medical history for members in the member's language.</li></ul>
Quarter 2:	<ul style="list-style-type: none"><li>CalOptima Health continues to collaborate with partnering Orange County providers in assisting and delivering access to quality care, treatment, diagnoses and medical history for members in the member's language.</li><li>C&amp;L staff held meetings with health networks' Cultural &amp; Linguistics departments to review their process to ensure the health networks have the staff and resources to address members' cultural and linguistic needs.</li><li>Provider Relations staff developed a provider satisfaction survey to collect practitioner REL data.</li></ul>
Quarter 3:	<ul style="list-style-type: none"><li>CalOptima Health continues to collaborate with partnering Orange County providers in assisting and delivering access to quality care, treatment, diagnoses and medical history for members in the member's language.</li><li>C&amp;L staff held meetings with health networks' Cultural &amp; Linguistics departments to review their process to ensure the health networks have the staff and resources to address members' cultural and linguistic needs.</li><li>Provider Relations staff launched the provider satisfaction survey.</li></ul>
Quarter 4:	<ul style="list-style-type: none"><li>CalOptima Health continues to collaborate with partnering Orange County providers in assisting and delivering access to quality care, treatment, diagnoses and medical history for members in the member's language.</li></ul>
Analysis:	
The C&L review of the health networks' C&L policies shows the networks have an established C&L process to address members' cultural and linguistic needs.	
Identified Barriers:	Identified Opportunities for Improvement:
<ul style="list-style-type: none"><li>Ensuring members had access to their health networks.</li><li>Ensure provider availability.</li><li>Ensure language interpreters assisted members in their language.</li><li>Low practitioner response rate to the provider satisfaction survey</li></ul>	<ul style="list-style-type: none"><li>Continue to ensure providers are available for members.</li><li>Continue to ensure language interpreters are booked and attend members' appointments to help members in their language.</li></ul>
Conclusion:	
The program appears to be successful, according to actions and interventions Implemented.	
Activities/Interventions to continue/add next year:	
<ul style="list-style-type: none"><li>Continue to ensure members have access to their providers.</li><li>Continue to ensure providers are available for members.</li><li>Continue to ensure language interpreters are booked and attend members' appointments to help members in their language.</li><li>Explore other methods to increase provider response rate.</li></ul>	

## Section 9: CLAS Improvement and Reduction in Health Care Inequities

### 9.1 Evaluate the PIP

Author: Leslie Vasquez

Department: Quality Analytics

Support Staff: Kelli Glynn

Work Plan Element: Performance Improvement Projects (PIPs) Medi-Cal

Products: ☒ Medi-Cal ☐ OneCare

New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective: Increase well-child visit appointments for African American members (0–15 months) from 41.90% to 55.78% by 12/31/2024.

Goal Met: ☐ Yes ☐ No ☒ Partial- 2024 final rates are still pending to confirm if goal was met

Work Plan Planned Activities (From the QI Work Plan):

Conduct quarterly/annual oversight of Medi-Cal PIPs (January 2023–December 2025):

1) Clinical PIP – Increasing W30 6+ measure rate among African American Population

Status: ☐ Completed ☒ Ongoing

Background:

The California 2020 Health Disparities Report identified disparities for most of the indicators of the Children's Health domain. Per this report, the Black/African American group fared lower than other groups across all six key indicators.

The PIP aims to reduce the racial/ethnic disparities in W30-6+ visits in support of the statewide goals. In alignment with the recommendations in the Health Equity Framework, this PIP will involve the African American population, the group most affected by health care disparities, through a survey call campaign to understand firsthand the experiences with well-child visits, the barriers and facilitators to attending well-child visits.

Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate has the potential to improve member health status among these key indicators. Insight into the barriers to attending well-child visits has the potential to identify key areas that may improve member satisfaction across health care services.

PIP intends to address the following barriers to well-child visits:

- Parent/guardian gaps in knowledge about the purpose and value of well-child visits.
- Lack of reminders for parents/guardians to complete the well-child visits.
- Limited resources for health networks to coordinate well-child visit appointments with a primary care provider for African American child members

Methodology:

CalOptima Health followed HEDIS data collection methodology for the W30 – First 15 Months (non-continuous enrollment). CalOptima Health then identified child members identified as African American to monitor for rates.

Medi-Cal Results:

Chart A. Rates for W30- First 15 Months

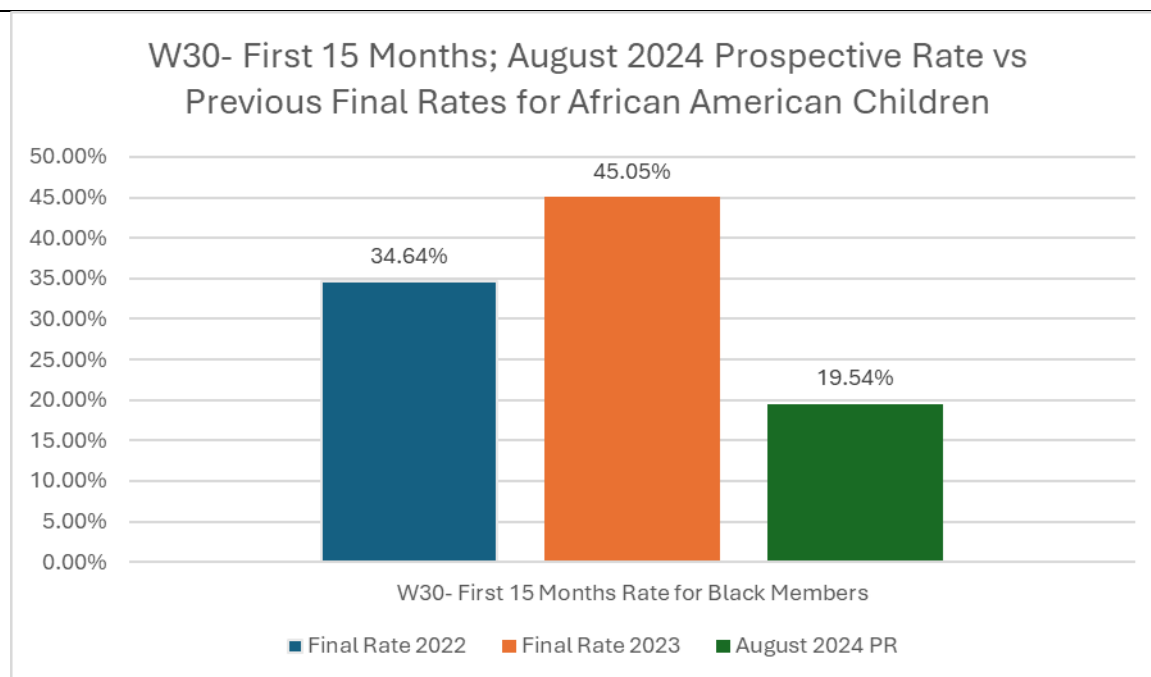


Chart A shows the final MY 2022 and MY 2023 W30-First 15 Months rates for African American child members compared with the most recent 2024 prospective rate. The performance improvement project is set for 2023–2026. As part of the process, the MY 2022 rate (34.64%) was used to confirm the population of interest — African American children — that would be targeted for the project. The chart demonstrates an increase in rates for MY 2023 compared with MY 2022. Final MY 2024 rates are pending; however, the rate (19.54%) of claims/encounters processed through August 2024 is shown.

#### Actions/Interventions Implemented in 2024:

#### Results:

- Final MY 2024 rates are pending; however, the rate (19.54%) of claims/encounters processed through August 2024 is shown in Chart A. Chart A depicts an increase in the W30 rate in MY2023, up from MY2022.

#### Quantitative Analysis:

- For the 2024 calendar year, 85 African American members were identified as needing to complete six or more well-child visits by 15 months of age. Staff successfully contacted 34 (40%) of parents/guardians, providing reminders to complete well-child visits and addressed gaps in knowledge about the importance and value of well-child visits.
- In an attempt to increase contact with members, letters were issued to the 51 parents/guardians who were unsuccessfully contacted telephonically.
- Appointment coordination was offered to all 34 parents/guardians of child members who were successfully reached. All 34 parents/guardians declined appointment coordination and refused support with appointment coordination for future well-child visits. This refusal may be driven by many reasons, including long call wait times, lack of urgency and competing priorities at the time the parent was called.
- 2024 rates have not been finalized; therefore, CalOptima cannot fully assess for the goal met.

#### Identified Barriers:

- Member Contact Information:** Member contact lists contain outdated or incorrect information, contributing to a high rate of unsuccessful outreach. Other issues include

#### Identified Opportunities for Improvement:

- Opportunities to improve member contact information to maximize outreach.
- Opportunities to partner with health networks to support care coordination for child members.

<p>the inability to leave voicemails or parent/guardian refusal to take calls.</p> <ul style="list-style-type: none"> <li>• <b>Refusal or Low Parental Engagement:</b> As part of an attempt to increase contact with members, letters were issued to the 51 parents/guardians who were unsuccessfully contacted telephonically. Parents/guardians did not respond to the letter that was issued after unsuccessful telephonic outreach. This may be due to the plan's business hours that do not align with the parent's needs, privacy concerns, lack of time, demanding jobs, responsibilities or other commitments, lack of urgency, previous negative experiences or lack of trust between the plan and the child's family.</li> </ul>	
<p>Conclusion:</p> <ul style="list-style-type: none"> <li>• There is an opportunity to continue to inform members about the importance and cadence of well-child visits and what makes each of these visits unique to support adherence. Education about these visits should begin as early as possible during the prenatal and postpartum timeframe.</li> <li>• There is an opportunity for PCPs to revise their workflows to allow for the scheduling of the next well-child visit prior to the family leaving the existing visit.</li> <li>• Members feel that they benefit when their child's assigned PCP has appointment availability that fits the parent's schedules. PCP offices should continue to implement reminders for these visits.</li> <li>• There are opportunities to increase awareness of the Medi-Cal transportation benefit as well as inform parents of who the child's PCP is.</li> </ul>	
<p>Activities/Interventions to continue/add next year:</p> <ul style="list-style-type: none"> <li>• Efforts to include improved coordination with health networks to deliver care for African American child members.</li> </ul>	

## 9.2 PPC for Black and Native American

Author: Leslie Vasquez/Katie Balderas	Department: Quality Analytics
Support Staff: Kelli Glynn	
Work Plan Element: Maternity Care for Black and Native American Persons	
Products: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> OneCare	New Activity: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>Work Plan Goal/Objective:</p> <p>1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima Health's Black members from 67.48% to 74.74% and Native Americans from 44.44% to 63.22% by 12/31/24.</p> <p>2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima Health's Black members from 53.77% to 72.37% and Native Americans from 27.78% to 59.43% by 12/31/24.</p>	
Goal Met: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Partial	
<p>Work Plan Planned Activities (From the QI Work Plan):</p> <p>Assess and report on the following activities:</p> <p>1) Determine the primary drivers of noncompliance via member outreach and literature review.</p> <p>2) Targeted member engagement and outreach campaigns in coordination with health network partners.</p> <p>3) Strategic Quality Initiatives Intervention Plan: Multimodal, omni-channel targeted member, provider and health network engagement and collaborative efforts.</p> <p>4) Continue expansion of Bright Steps comprehensive maternal health program through community partnerships, provider/health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events</p> <p>5) Implement Collaborative Member Engagement Event with CAP OC Diaper Bank and other community-based partners.</p>	

6) Expand member engagement through direct services such as the doula benefit and educational classes.													
Status: <input type="checkbox"/> Completed <input checked="" type="checkbox"/> Ongoing													
<p>Background:</p> <p>In alignment with DHCS' 2025 Bold Goals for maternal health, this focus area aims to improve timely prenatal and postpartum care for CalOptima Health's Black and Native American members. The initiative seeks to increase prenatal and postpartum care appointment adherence through targeted outreach, member engagement and enhanced provider partnerships. Key strategies include identifying barriers to care, implementing data-driven interventions, expanding community-based programs such as the Bright Steps maternal health program, and leveraging benefits like doulas and educational services. Collaborative efforts with community organizations, including WIC and diaper bank events, are central to achieving equitable maternal health outcomes.</p>													
<p>Methodology:</p> <p>CalOptima Health follows the HEDIS data collection methodology to identify members that are part of the prenatal and postpartum care measure denominator. CalOptima Health proceeds to stratify the data by race/ethnicity to identify performance for Black and Native American members.</p>													
<p>Actions/Interventions Implemented in 2024:</p> <p>Given that this was a new goal for the CLAS Program in 2024, many of the efforts were focused on laying the foundation for collaboration and process improvements. Activities completed in 2024 include:</p> <ul style="list-style-type: none"> <li>- Review and analysis of Birth Equity Population of Focus, which includes Black and Native American Pregnant Persons</li> <li>- Collaboration and relationship-building with local partners and providers, including the Orange County Health Care Agency, First Five Orange County, Orange County's new Black Infant Health (BIH) Program (led by Breastfeed LA), Black PEARL (Promoting Equity, Anti-Racism, and Love), Model for Systemic Integration of Community Maternal Support Services (COMSS), MOMS Orange County, and others.</li> <li>- Piloted a focused outreach call and mailing campaign to promote Enhanced Care Management (ECM), doula and BIH services (as appropriate) to members in the population of focus.</li> </ul>													
<p style="text-align: center;">Results:</p> <p>The outreach campaign piloted in Q4 2024 focused on Black and Native American members identified in the ECM Birth Equity Population of Focus. Members were called and offered information about ECM, doula services and the BIH program.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #005596; color: white;">Intervention</th> <th style="background-color: #005596; color: white;">Numerator</th> <th style="background-color: #005596; color: white;">Denominator</th> <th style="background-color: #005596; color: white;">Percent</th> </tr> </thead> <tbody> <tr> <td>Telephonic outreach to promote ECM, doula and BIH</td> <td>24</td> <td>183</td> <td>13%</td> </tr> <tr> <td>Member mailed materials on ECM, doula and BIH</td> <td>169</td> <td>183</td> <td>92%</td> </tr> </tbody> </table>		Intervention	Numerator	Denominator	Percent	Telephonic outreach to promote ECM, doula and BIH	24	183	13%	Member mailed materials on ECM, doula and BIH	169	183	92%
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Member mailed materials on ECM, doula and BIH	169	183	92%										
<p>Identified Barriers:</p> <ul style="list-style-type: none"> <li>• Many members cannot be contacted over the phone or by mail due to a lack of updated contact information/addresses in the system or because they are not available to answer the phone.</li> <li>• Many services that are culturally tailored for Black and Native members, including doula, ECM and BIH, are newer. The provider network and programming are still in the process of being developed.</li> </ul>	<p>Identified Opportunities for Improvement:</p> <ul style="list-style-type: none"> <li>• Develop multimodal outreach strategies for the population(s) of focus, including text, email, community events, group classes and social media.</li> <li>• Continue to participate in the Orange County Perinatal Council's workgroup on health equity to engage with partners around program enhancements and foster stronger relationships and coordination for members.</li> </ul>												
<p>Conclusion: Because efforts to pilot interventions were started in Q4 2024, additional work is needed to determine the success of various outreach efforts.</p>													
<p>Activities/Interventions to continue/add next year:</p>													

- Ensure a strong continuum of culturally relevant care for Black and Native members through continued collaboration with CalAIM providers to support provision of ECM, and Doulas and referrals to community organizations such as BIH
- Focused maternal health community events to meet members where they are and foster connection