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

WEDNESDAY, FEBRUARY 19, 2020
3:00 P.M.

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

BOARD OF DIRECTORS' QUALITY ASSURANCE COMMITTEE
Paul Yost, M.D., Chair
Dr. Nikan Khatibi
Alexander Nguyen, M.D.

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	INTERIM CLERK OF THE BOARD
Michael Schrader	Gary Crockett	Sharon Dwiers

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

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

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

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

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

CONSENT CALENDAR
1. Approve Minutes of the December 13, 2019 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee

REPORTS
2. Receive and File 2019 CalOptima Quality Improvement Program Evaluation

3. Consider Recommending Board of Directors' Approval of the CalOptima 2020 Quality Improvement Program and 2020 Quality Improvement Work Plan

4. Receive and File 2019 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement (QAPI) Plan Evaluation

5. Consider Recommending Board of Directors' Approval of the 2020 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement (QAPI) Plan

6. Consider Recommending Board of Directors' Approval of Calendar Years 2020 and 2021 Health Network Medi-Cal Pay for Value Program Payment Methodology Incorporating the Health Network Quality Rating Methodology

7. Consider Recommending Board of Directors Approval of Calendar Years 2020 and 2021 Health Network OneCare Connect Pay for Value Program Payment Methodology

8. Consider Recommending Board of Directors' Allocation of Intergovernmental Transfer (IGT) 9 Funds

INFORMATION ITEMS
9. Improving Transitions of Care for Members Experiencing Homelessness

10. PACE Member Advisory Committee Update

11. Quarterly Reports to the Quality Assurance Committee
    a. Quality Improvement Committee Report
    b. Program for All-Inclusive Care for the Elderly (PACE) Report
    c. Member Trend Report

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

December 13, 2019

A Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on December 13, 2019, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Paul Yost called the meeting to order at 3:38 p.m. and led the Pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Alexander Nguyen, M.D.

Members Absent: Dr. Nikan Khatibi

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Betsy Ha, Executive Director, Quality and Population Health Management; Nancy Huang, Chief Financial Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez M.D., Chief Medical Officer; Sharon Dwiers, Interim Clerk of the Board

PUBLIC COMMENTS
There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the October 17, 2019 Special Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Director Nguyen, seconded and carried, the Committee approved the Minutes of the October 17, 2019 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 2-0-0; Director Khatibi absent)***

REPORTS

2. Consider Recommending Board of Directors; Approval of Calendar Year 2020 Health Network Medi-Cal Pay for Value Performance Program Incorporating the Quality Rating Methodology

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Betsy Ha, Executive Director, Quality and Population Health Management, presented a brief overview of the item noting that staff is recommending that we align with industry standards and the National Committee for Quality Assurance (NCQA).

Chair Yost noted that many of CalOptima's Board Members have expressed an interest in seeing more homogeneity among the health networks in their ratings, wanting to consistently see performance at a higher level across all health networks.

Action: ***On motion of Chair Yost, seconded and carried, the Committee recommended Board of Directors' approval of the Calendar Year 2020 Health Network Medi-Cal Pay for Value Performance Program incorporating the Quality Rating Methodology, for Measurement Period effective January 1, 2020 through December 31, 2020. (Motion carried 2-0-0; Director Khatibi absent)***

3. Consider Recommending Board of Directors Approval of Unbudgeted Expenditures to Support Community Education Efforts to Increase Medi-Cal Provider Awareness of Trauma-Informed Care and Adverse Childhood Experiences (ACE) Screening

Ms. Ha presented a brief overview of this item and reviewed the statistics of the effects of trauma on children and adults.

Director Nguyen commented that better results might be achieved if providers receive incentives to conduct the ACE screenings.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' authorize unbudgeted expenditures of up to $80,000 from existing reserves for outreach and education efforts to increase Medi-Cal provider awareness of evidence-based ACE screening and Trauma-Informed Care. (Motion carried 2-0-0; Director Khatibi absent)***

INFORMATION ITEMS

4. Member Experience Initiative: Improving Access and Availability

Marsha Choo, Manager, Quality Analytics, presented an overview of CalOptima's member experience performance. Ms. Choo reviewed some of the methods CalOptima uses to measure member experience, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is conducted in English and Spanish. In addition, Ms. Choo reviewed the key measures that the Department of Health Care Services (DHCS) monitors. Ms. Choo noted that there are opportunities for improvement, and staff has identified several strategies to improve member experience. These include expanding access to specialty care, coaching provider offices on customer service, and extending hours of provider offices.

Director Nguyen mentioned that there are organizations that provide specialty care that could supplement CalOptima's provider network, such as Rubicon M.D., which may be an effective strategy to minimize low ratings in accessing care by members. Director Nguyen also suggested that CalOptima consider conducting the CAHPS surveys in other threshold languages for a clearer picture of CalOptima's member experience performance.

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5. Intergovernmental Transfer (IGT) 9 Update

Candice Gomez, Executive Director, Program Implementation, and David Ramirez, M.D., Chief Medical Officer, presented an update on IGT 9. Ms. Gomez provided general background on IGTs 1 through 7, noting that the funds received from these IGTs must be used to deliver enhanced services for the Medi-Cal population, and that these funds are accounted for outside of operating income and expenses. However, with IGTs 8 and 9, the funds must be used for Medi-Cal covered services for the Medi-Cal population, and are part of operating income and expenses. Ms. Gomez also mentioned that there is no guarantee of future availability of IGT funds, which is why the IGT funds are better suited to one-time investments or as start-up funding for new services or initiatives for the benefit of Medi-Cal beneficiaries. To date, CalOptima's share of funding from IGTs 1 through 8 is $121.31 million.

Dr. Ramirez added that $45 million is CalOptima's estimated share of IGT 9 funding and staff will provide recommendations on possible usage of funds for Medi-Cal members.

Ms. Gomez noted that the next steps include meetings with the Board's advisory committees and stakeholders to solicit feedback. Staff plans to present initial recommendations for the Board to consider at its February meeting. Final recommendations will be presented for approval at the March or April CalOptima Board meeting.

6. Quality Measures and Health Condition Attestation Program for OneCare Connect and CalOptima Community Network Members

Dr. Ramirez presented an overview the Medicare Attestation Program staff will be proposing noting that this information item focuses on members that are in the CalOptima Community Network (CCN) and the OneCare Connect (OCC) program. Dr. Ramirez stated that Medicare Attestation Programs are a common industry practice for Medicare plans and are intended to facilitate proper coding, accurate data reporting, and correct payments. Dr. Ramirez noted that CCN does not currently have a Medicare Attestation Program. Dr. Ramirez provided background on how CalOptima monitors diagnosis codes and utilization data submitted by providers and submits regular diagnosis data to the Centers for Medicare & Medicaid Services (CMS). CMS uses the diagnosis data to assess program quality and calculate expected health care costs, which ties into risk adjustment factors (RAF) scores and affects the revenue CalOptima receives from CMS. In reviewing the RAF scores, CCN's average score is 18% below the health network average. Dr. Ramirez mentioned that the lower score may be due to diagnosis codes being reported incorrectly. Staff recommends developing a policy for review and approval at the policy review committee and if approved, bringing a recommendation to the Board that would authorize including CCN members in a Medicare Attestation Program to ensure accurate data reporting and RAF scores, which will ensure that CalOptima receives appropriate payments for CCN OCC members.

7. OneCare and OneCare Connect Behavioral Health Implementation Update

Edwin Poon, Ph.D., Director, Behavioral Health Services, presented an update on the OneCare (OC) and OneCare Connect (OCC) behavioral health (BH) transition activities. Dr. Poon noted that currently, the BH services benefit is administered by Magellan, CalOptima's Managed Behavioral Health Organization for OC and OCC members. On May 2, 2019, the CalOptima Board approved the integration of OC and OCC covered BH services within CalOptima internal operations effective January 1, 2020. Since the Board's May 2, 2019 action, staff has been working on credentialing and contracting with as many Magellan OC/OCC BH providers as possible to ensure that network

adequacy levels continue to be met. CalOptima has identified approximately 320 members who have received services from non-contracted providers and staff is reaching out to work with those members on transitioning to contracted providers. Dr. Poon added that CalOptima has recruited additional staff and is working to continue to contract with additional BH providers.

8. PACE Member Advisory Committee Update

Elizabeth Lee, Director of PACE, provided an update on the CalOptima PACE Member Advisory Committee meeting held on September 11, 2019, highlighting discussions on program enhancements, including: 1.) Activities: special entertainment and BINGO for morning and afternoon shifts; 2.) Nursing: diabetes education class for participants; 3.) Social Work: reminiscence group; and 4.) Rehabilitation Therapy: 'Boxing Champs' group, life skills education, and therapeutic dance. Ms. Lee also reported that feedback is being sought from participants about potentially extending PACE center hours and adding Saturday hours. Ms. Lee noted that most participants do not want pickups before 7:00 a.m. and do not want to be dropped off at home later than 6:00 p.m. in the evening. Ms. Lee added that Saturday hours elicited mixed reactions, with most participants conceptually supportive of the idea of Saturday hours, but not for themselves.

9. Quarterly Reports to the Quality Assurance Committee

The following Quarterly Report was accepted as presented:

a. Quality Improvement Report

COMMITTEE MEMBER COMMENTS

Committee members thanked staff for their work and wished everyone a happy holiday.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:51 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Interim Clerk of the Board

Approved: February 19, 2020

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QUALITY IMPROVEMENT EVALUATION

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2019 QUALITY IMPROVEMENT EVALUATION

SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

David Ramirez, M.D. **Date**

Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

Paul Yost, M.D. **Date**

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2019 Quality Improvement Evaluation of Overall Program Effectiveness

EXECUTIVE SUMMARY

The 2019 Annual Quality Improvement (QI) Program Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved its key performance goals during the year. This evaluation focuses on quality activities undertaken during the first three quarters of the 2019 calendar year to improve health care and services available to CalOptima members.

The final 2019 QI Work Plan with the full calendar year results will be presented as a separate document in Q1 2020 to the Quality Improvement Committee (QIC). The 2019 QI Evaluation also identifies key areas that offer opportunities for improvement to be implemented or continued as part of the 2020 QI Program and its Work Plan.

CalOptima achieved many of its organizational objectives in 2019:

- Continued to be one of the highest ranked Medicaid plans in the state.
- All Department of Health Care Services (DHCS) measures required to achieve a Minimum Performance Level (MPL) were met in 2019 (based on the latest plan level HEDIS results for measurement year 2018).
- Performed well on several HEDIS measures in comparison to the national thresholds. Out of the 62 reportable measures, CalOptima performed better on 42 measures in 2019, compared to 2018. And 69% of measures are at the National Medicaid 50th percentile or higher.
- Performed successful incentive outreach to members to obtain preventive care. In 2019, there were outreach programs for W15 well child visits, postpartum care, breast and cervical cancer screening.
- Expanded and continued initiatives to address access to care and member satisfaction, such as:
  - Provider Coaching to evaluate and improve services provided at point of care.
  - CalOptima Days to improve access and promote preventive health screenings were conducted and 27 were completed in 2019
  - Active recruitment of new providers (both primary and specialty care).
- Implemented CalOptima's comprehensive health network (HN) Pay for Value (P4V) Performance Measurement Program to recognize outstanding performance and support ongoing improvement that aimed to strengthen CalOptima's mission of providing quality health care.
  - In 2019, the program proved to be a success as CalOptima was able to improve rates for several P4V measures.
- Implemented a quality incentive for Community Health Centers that participate in the Homeless Clinical Access Program (HCAP). CalOptima coordinates with Community Health Centers through our HCAP to bring primary care services via mobile clinics at designated shelters and hot spots. This program started in late 2019 and will continue in 2020.
- Post-acute Infection Prevention Quality Incentive (PIPQI) was implemented on 10/1/2019 to reduce post-acute infections at 25 nursing facilities of which 12 were already participating with University California Irvine (UCI) since Q2 2017 in the SHIELD study.
- Implementation of opioid cumulative MME point-of-sale (POS) pharmacy edits such that members with claims exceeding a cumulative MME threshold of 90mg will trigger a soft rejection and exceeding 400mg will trigger a hard rejection. POS soft drug utilization review (DUR) rejections for concomitant opioids and benzodiazepines.

- Pharmacy Home Program Policy: Members filling prescriptions at four (4) or more pharmacies in a two-month period are restricted to a single pharmacy for a period of one year.
- Prescriber Restriction Program Policy: Pharmacy claims utilization reports indicate the Members filling controlled substance prescriptions from four (4) or more Prescribers in a two (2) month period are restricted to designated prescribers.
- In 2019, CalOptima facilitated weekly Be Safe rounds to identify members at risk of opioid misuse and provide personalized outreach and assistance to members with high Morphine Milligram Equivalent (MME).

For 2019, CalOptima had adequate staffing, resources, and a well-defined quality committee structure in place to meet the required needs of the QI program. This included the new Whole-Child Model Clinical Quality Committee which provided clinical guidance for the Whole-Child Model program that went live on July 1, 2019. There was exceptional participation from external and internal practitioners as well as staff. CalOptima also adopted a very strong "Plan-Do-Study-Act" (PDSA) cycle approach to develop initiatives in 2019 that will continue into 2020. These initiatives are focused on long-term improvement efforts for selected high priority measures. In 2020, CalOptima will continue to evaluate the needs of the program through the QI Work Plan on a quarterly basis and add staffing, as needed, to supplement the QI department.

In 2020, CalOptima will also implement a robust population-based health management program that will focus on different conditions ranging from cancer screening to managing patients with multiple complex conditions. This program will have strong member and provider engagement components and will be monitored on a quarterly basis. Activities will include providing practitioners with lists of members who showed gaps in care, along with incentives to encourage provider offices to contact those members to obtain the needed screenings or other assessments. In conjunction with provider incentives, CalOptima will also have member incentives to encourage the members to see their providers for care.

SECTION 1: QI PROGRAM STRUCTURE

Activities in the 2019 QI Program and associated Work Plan activities focused on refining the structure and process of care delivery, with the emphasis on member centric activity and consistency with regulatory and accreditation standards. All activities were undertaken in direct support of the Mission, Vision, Values and Strategic Initiatives of CalOptima's Board of Directors.

Components of the QI Program and Structure

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

QI Program Documents:

- **Annual Evaluation** — Completed a comprehensive evaluation of the QI program at the end of the fiscal year that assesses the performance of measures/indicators that are part of the QI program.
- **Program Description** — Developed and implemented a robust written QI program description that focuses on improving standards of care and addressing gaps in care identified in prior year's evaluation. The organization will enhance the QI program by

including “new initiatives” in the QI program description that will outline measurable goals and objectives that the organization is going to focus on in subsequent years.

- **Work Plan** — Created a work plan to monitor and evaluate performance of QI measures and interventions on an ongoing basis. This is a dynamic document that may change throughout the year dependent on priorities and opportunities.
- **Policies and Procedures** — Ensure that the organization has developed and implemented appropriate policies and procedures that are needed to provide care to the members.

Reviews of QI Documents:

- CalOptima successfully completed review of all the above documents with the QI committees during 2019. The documents were reviewed and approved by the CalOptima Board of Directors.
- Feedback from the practitioners that participated in the QI committee meetings were included in program documents (i.e. Program Description, Work Olan and Annual Evaluation).

Quality Improvement Committee (QIC) — Provides critical feedback and guidance to the QI department on key initiatives. The QIC also reviewed and approved all the key documents in a timely manner.

- The QIC is the primary committee that is responsible for the QI Program and reports to the Quality Assurance Committee (QAC) of the Board. The committee also recommends policy decisions.
- The committee provided oversight and direction to the QI Program, Work Plan and Evaluation in the first quarter of 2019. This gave the QI department a framework on how to start implementing the QI program throughout 2019. For the remainder of the year, the QI staff updated the committee on the progress of the program through regular reports. In addition to reviewing and approving the reports, the QIC (which included participating practitioners) provided valuable insight on barriers and potential interventions. These recommendations focused on improving performance improvement activities directed towards clinical quality, quality of service, patient safety, as well as quality cultural and ethnic accessible services. Upon evaluation of the QI activities, the QIC recommended needed actions or improvements to the activities and ensured follow-up, as appropriate.
- In 2019, the QIC reviewed and provided feedback on key clinical and other coordination of care initiatives like member outreach, provider education and outreach, incentives, educational materials, etc.
- The committee also reviewed and approved the policies and procedures as they were presented to the committee throughout 2019.
- The committee reviewed and provided feedback on key reports: annual analysis of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS); access to care; complaints and appeals; etc. Part of the feedback included specific actions that CalOptima could take to improve performance.
- The committee also received quarterly reports from the Credentialing Peer Review, Utilization Management Committee, Member Experience Committee, Grievance and Appeal Committee, Behavioral Health QIC and LTSS-QISC. At the end of 2019, to fully integrate BHI and LTSS into the existing QIC, it was recommended to sunset the BHQIC and LTSS-QISC in 2020 and incorporate reporting directly to QIC.
- The QIC established the Whole-Child Model Clinical Advisory Committee (WCM CAC) at the end of 2018 and met eight times in 2019. The committee’s purpose is to provide

clinical guidance to the Whole-Child Model program which services children with CCS eligible conditions. The WCM program at CalOptima operates in collaboration with the County CCS, Family Advisory Committee, and Health Network CCS providers and had a successful launch on 7/1/2019. The committee has initiated review of quality measures related to the WCM program and will monitor performance measures in 2020.

Assessment of QI Staff and Resources:
CalOptima continues to dedicate significant resources and staffing to meet the needs of the QI program. The QI department also has support from other key departments within the organization including, but not limited to, the following:

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

Review of System Resources:
CalOptima has dedicated significant resources to ensuring they have adequate systems in place to monitor and evaluate performance of QI programs on an ongoing basis. The resources include HEDIS Analysts for reporting plus extensive analytic staff support. Additional support and collaboration were provided by Provider Relations, Network Management, Grievance and Appeals, and Customer Service departments.

CalOptima has the capability to generate quality reports, gaps in care reports, physician feedback reports, and other relevant reports needed in the QI program. There is a robust data integration flow in place that allows the organization to utilize data from different sources and identify improvement opportunities. The team also has an adequate number of business analysts that can support the reporting needs of the organization.

Overall Assessment of Program Structure:

At the current time, CalOptima has adequate staffing and resources required to meet the needs of the QI program in addition to organizational program requirements. CalOptima will continue to evaluate the needs of the program through the work plan on a quarterly basis and add staffing and additional resources, as needed to supplement the QI department. The organization receives adequate feedback from its community practitioners in the development and implementation of the QI initiatives and programs through the different committees.

SECTION 2: QUALITY & SAFETY OF CLINICAL CARE

HEDIS Overview

CalOptima monitors several external and internally developed clinical quality measures measure and track the quality of health care services provided by the Plan and its network of contracted providers. In order to calculate these rates for these measures, CalOptima collects data for a number of different sources that include, but are not limited, to the following:

- Annual HEDIS submission
- Claims and encounter data from contracted primary and specialty care providers

- Claims and encounters from ancillary care providers (e.g. hospitals, labs, radiology centers, etc.)

Measuring and reporting these measures helps CalOptima assess the effectiveness of the care members are receiving. These clinical quality measures are used to evaluate multiple aspects of patient care including preventive care, coordination of care, patient safety, and management of chronic conditions.

Overall Performance Highlights:

- Medi-Cal
  - All DHCS measures required to achieve a MPL were met in 2019 (based on the latest plan level HEDIS results for measurement year 2018)
  - 42 out of 62 (68%) measures performed better than the prior year.
  - 69% of measures are at the National Medicaid 50th percentile or higher.
  - However, the goal is to improve all the State required measures to above the 50th percentile as it is the new requirement by the State.
  - Pay for Value program measures showed improvement but several still below the 50th percentile.
  - Based on the review of rates, several measures were identified as an opportunity for improvement. The following measures performed at a lower percentile in comparison to prior year. CalOptima is going to monitor these measures in the 2020 QI Work Plan.

Key Measures for Medi-Cal:

Focus on new MCAS measure set required by DHCS

Measures in red indicate a decrease from HEDIS 2018 performance

easure	Quality Compass Percentiles Met	
	HEDIS 2018	HEDIS 2019
Comprehensive Diabetes Care (HbA1c Testing)*	75th	50th
Comprehensive Diabetes Care (Eye Exam)* (not a MCAS measure)	75th	50th
Cervical Cancer Screening	50th	50th
Breast Cancer Screening	50th	50th
Prenatal and Postpartum Care (Prenatal Care)	50th	50th
Prenatal and Postpartum Care (Postpartum Care)	75th	50th
Well Child Visits in the First 15 Months of Life	<10th	<10th
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	75th	50th

* Drop in rate may be due to change in specification from prior year. NCQA issued guidance to trend this measure with caution.

Key Measures for OneCare (OCC) Connect LOB:

Measure	Quality Compass Percentiles Met	
	HEDIS 2018	HEDIS 2019
Breast Cancer Screening	3 Star	2 Star
Plan All-Cause Readmissions (OCC Quality Withhold)	1 Star	2 Star
Antidepressant Medications Management (Acute Phase Treatment)	<=10th	25th
Follow-up After Hospitalization for Mental Illness (OCC Quality Withhold)	<10th	25th
Adults' Access to Preventive/Ambulatory Health Services (age 20–44) +C	<=10th	25th

Key Measures for OneCare LOB:

Measure	Quality Compass Percentiles Met	
	HEDIS 2018	HEDIS 2019
Breast Cancer Screening (C01)	2 Star	3 Star
Colorectal Cancer Screening (C02) +C	3 Star	3 Star
Plan All-Cause readmissions	3 Star	2 Star
Adults' Access to Preventive/Ambulatory Health Services (Total) +C	50th	25th

Evaluation of 2019 Priority Initiatives

CalOptima Homeless Health Initiative

The CalOptima Homeless Health Initiative (HHI) was launched on April 1, 2019, to bridge the gap for the homeless population between existing care delivery systems and the needs of a transient and transitioning membership.

The program objectives were to provide care to homeless CalOptima members in more nontraditional settings through Clinical Field Teams (CFTs), mobile clinics and clinics in shelters. In addition, preventive services for the homeless were established through a quality incentive-based Homeless Clinical Access Program (HCAP). Attention for putting recuperative care and a medical respite program for homeless CalOptima members are in progress.

Next steps include helping transition members back to their primary care provider (PCP). Evaluation of this initiative will be ongoing in 2020, and strategy will be adjusted accordingly.

CalOptima Days

In 2019 CalOptima collaborated with our health network partners and community clinics to co-host 27 health and wellness events called “CalOptima Day.” Our provider partners designated a day to prioritize appointments for CalOptima members. Of the 27 CalOptima Day events there were five piloted to target the adult population. These events were to outreach to CalOptima members who were due for either a well-care visit and/or immunizations. CalOptima successfully provided well-care checkups and immunizations to more than 1,250 Medi-Cal

members through these CalOptima Day events. The aim was to increase the HEDIS rates for pediatric measures and to achieve the performance goals as defined by the 2019 QI Work Plan.

Member Participation:

- 1250 members attended CalOptima Day events in 2019
- The average attendance rate per event was 68.72%

Targeted Pediatric HEDIS Measures:

1. Childhood Immunization Status (CIS)
2. Immunizations for Adolescents (IMA)
3. Well-Child Visits in the First 15 Months of Life (W15)
4. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
5. Adolescent Well-Care Visits (AWC)

Potential Impact (based on dates of service through June 2019):

- Based on the July 2019 Prospective Rates:
  - The following are potential HEDIS numerator hits: (based on member attendance at CalOptima Day)
    - 34 W15, 21 CIS, 39 IMA, 158 W34 and 373 AWC hits
    - The 18 pediatric events yielded a total potential of 625 HEDIS hits across the 5 measures
    - These are "potential" HEDIS hits because CIS-Combo 10, IMA-Combo 2 and W15 requires the completion of a combination of vaccinations or a series of well-care visits.

Discussion: Although evaluation of CalOptima Days (based on July Prospective Rates for pediatric measures) shows no significant impact to plan or HN level HEDIS rates, it was due to the low volume of members seen versus the overall denominator. The five CalOptima Days targeting the adult population showed similar impact as the pediatric populations.

- Many Benefits:
  - Improved data sharing and collaboration with provider offices
  - Increased interest from provider offices due to provider incentive
  - Positive member experience
- Challenges for CalOptima Days:
  - Resource intensive
  - Little impact on plan and HN HEDIS measures
  - Due to data lag, identification of those members needing services was challenging

Next Steps:

- Based on the review of results, CalOptima Days will focus on more targeted measures with smaller denominators.
- CalOptima Days will focus partnership will those providers willing to take on more responsibility to mine their own practice data to mitigate the issues related to data lag and to reduce the CalOptima resources needed. This will allow for the expansion of CalOptima Days and subsequent increased member participation without an increase in CalOptima staff resources.

P4V Program

CalOptima implemented a comprehensive HN P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting ongoing improvement that aimed to strengthen CalOptima's mission of providing quality health care. The comprehensive P4V Performance Measurement Program is based on a customized methodology developed by CalOptima staff and approved by the CalOptima Board. Annually, the CalOptima staff conducts a review of the current measures and their performance over time. Based on a 2018 retrospective longitudinal QI performance review, although CalOptima consistently met the MPL, overall quality performance trends have been flat over the past five years.

This trend is very consistent with California Health Care Foundation's recently published quality report entitled: *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade.* From 2009–2018, quality of care in Medi-Cal managed care was stagnant at best on most measures. Among 41 quality measures collected in two or more years, 59 percent remained unchanged or declined. CalOptima's HNs provided feedback including, concerns with difficulty of improving selected measure due to the size of the eligible population and/or difficulty in gathering data. Based on the feedback, a proposed new methodology aims for greater transparency, consistency and administrative simplification. Finally, the proposed methodology aligns with changes to the measures that are important to CalOptima's National Committee for Quality Assurance (NCQA) Accreditation status, Centers for Medicare and Medicaid Services (CMS) Star Rating Status, newly required DHCS managed care accountability set (MCAS) and/or overall NCQA Health Plan Rating. This new methodology will be presented to our QAC in February 2020.

Provider Incentive Programs:

In addition to our comprehensive P4V Program, CalOptima also extended provider incentives for several Performance Improvement Plans (PIPs), and quality initiatives. Areas of focus included, Improving Adult Access to Primary Care Services, Screening for Clinical Depression, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, and Well-Child Measures. Preliminary data suggest the provider incentives added value for all initiatives except for Improving Adult Access to Primary Care Services.

Member Incentive Programs

CalOptima Days were targeted events, where identified child, adolescent and adult members were given a $25 gift card to come in for a well-care or immunization visit. The total member incentives distributed for CalOptima Day events was approximately $25,000 for 2019. CalOptima also had other Medi-Cal member incentive programs in 2018 that were continued in 2019. These include: diabetic eye exam, diabetic A1C test, Shape your Life (weight control), breast and cervical cancer screening.

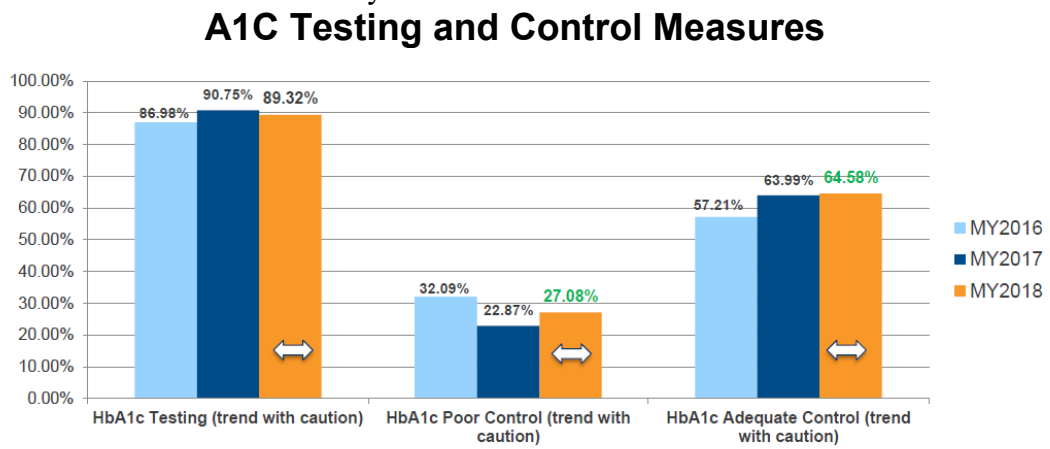
In 2019, new Medi-Cal member incentives were launched, including those for the postpartum care and W15 measures. CalOptima will continue existing member incentives in 2020, but will be adding member incentives for adolescent well-care visits for Medi-Cal, colorectal cancer screening for OC and OCC, and expand the current breast cancer screening incentive to OC and OCC.

Evaluation of Interventions for Specific HEDIS Measures

Comprehensive Diabetes Care (CDC)

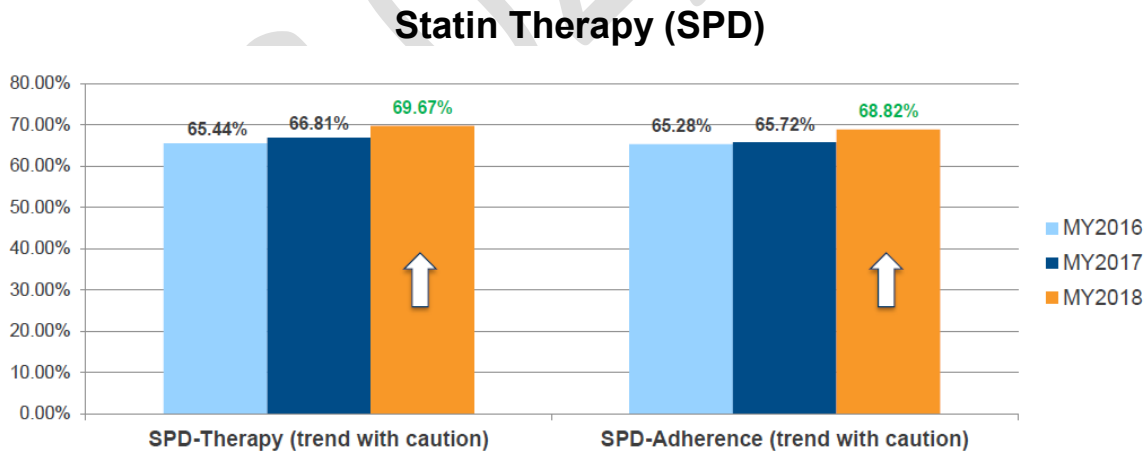
Eye Exam and A1C Testing and Statin Therapy for Patients with Diabetes (SPD)

The tables below show the trend analysis for Medi-Cal CDC and SPD measures for the last 3 years.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
HbA1c Testing	87.83%	90.45%	92.7%	91.58%	MPL
HbA1c Poor Control (>9.0%) (Lower is better)	38.2%	33.09%	29.68%	29.68%	MPL
HbA1c Adequate Control (<8.0%) ++	51.34%	55.47%	59.49%	59.49%	ACC, P4V, MPL, RS

*Red = less 50th percentile, Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings
↑ ↓ statistically higher or lower ↔ statistically no difference
*RS=Health Plan Rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Statin Therapy for Patients with Diabetes (SPD) - therapy	62.7%	65.6%	68.78%	67.19%	ACC, RS
Statin Therapy for Patients with Diabetes (SPD) - adherence	59.11%	64.62%	72.03%	68.33%	ACC, RS

*Red = less than 50th percentile, Green= met goal, MPL met
↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

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Completed Activities in 2019:

- IVR campaign with A1C testing and statin medicine messaging for diabetics ran in November 2019 in conjunction with Diabetes Awareness month.
- Direct mail of separate diabetic eye exam and A1C testing member incentive to members who were still outstanding for an annual exam or test.
- Incentivize Diabetic Eye Exams through P4V program.
- Member newsletter article on the importance of Diabetic yearly eye exams, and statin use after a heart attack.
- Collaboration with various HNs on promoting incentive via their call campaign outreach efforts.
- Targeted round-robin identification of high-risk members with diabetes for telephonic health coaching on outstanding exams and tests needed.
- Targeted call campaign intervention launched in Oct./Nov. identified emerging risk population of diabetics who were well controlled, but now have an A1C between ≥8.0% and ≤9.0%.
- Provider fax reports of diabetic members NOT on a statin.
- Complementary member quarterly mailings to educate members with diabetes NOT on a statin on the benefits of statin-use in preventing cardiovascular risk and the importance of having the discussion with their provider.
- Social media message in November 2019 emphasizing the increased for heart disease with diabetes, encouraging members to talk to their doctor about whether a statin may be right for them.

Existing Barriers:

- Members were confused about their benefits related to eye exams. Members who are diabetic are covered to see a vision specialist once every 12 months, but this may not have been communicated clearly to members. CalOptima obtained approval for members to get the service every 12 months with one vendor but this was not translated into the vendor's daily operations for identifying eligible members with diabetes.
- Sharing information between specialists and PCPs sometimes does not occur, thus the PCP may not be aware of previous diabetic eye exam results or the need for an annual diabetic eye exam.
- Limitations in obtaining lab and test data from electronic health records as well as from non-contracted lab vendors.
- Reconciliation of provider data with CalOptima, as some providers use point of care and are not submitting through normal channels.
- Members are not aware of the increased risk of cardiovascular complications with diabetes.

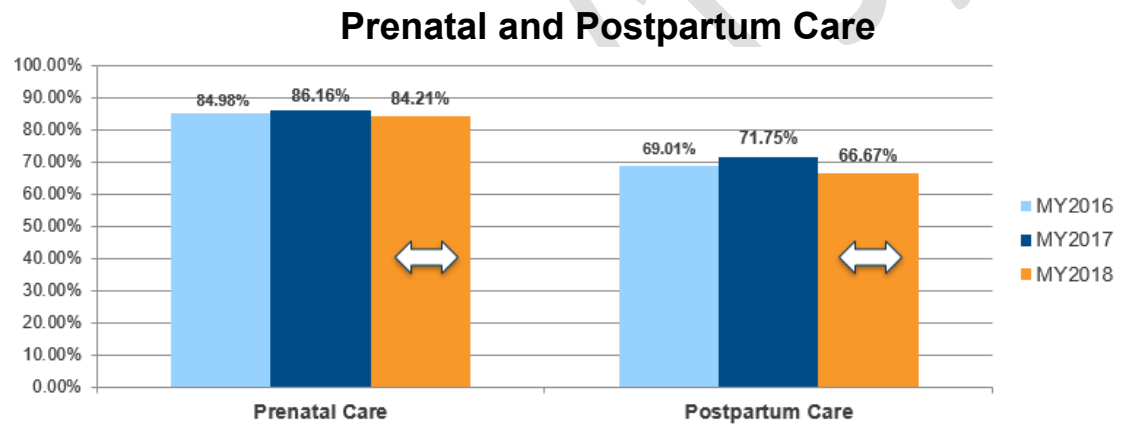
Next Steps for 2020:

- Add A1C testing and good control of A1C levels to 2020 P4V program.
- Promote more widely the $25 member incentive program for completion of diabetic eye exams and A1C testing to providers through various provider communication modes such as fax blasts, provider portal, HN and provider meetings and through provider relations representatives.
- Offer member incentives to all diabetic members, instead of targeted mailing to only those who are non-compliant.
- Promote the member incentive on the CalOptima updated website as well as through social media and various health guides and newsletters.

- Strategize promotion of member incentives through website, newsletters and other avenues.
- Collaborate with Office Ally and other electronic health records to improve lab data
- CalOptima website and social media platforms will have educational message banner rotating with diabetes awareness messaging in November.
- Continue targeted call campaign and health coaching intervention for CDC identified members at risk.
- Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes.
- Implement integration of EMR data from Office Ally.
- Continue quarterly faxes to providers of their diabetic members who are not compliant or not on a statin.
- Continue quarterly member mailings to newly identified diabetic members who are not currently on a statin.
- Newsletter articles on the importance of diabetic labs and exams, and diabetes and heart health on statin-use.

Prenatal/Postpartum Screenings (PPC)

The table below shows the trend analysis for Medi-Cal PPC measures for the last 3 years.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Prenatal Care	83.21%	87.06%	90.75%	87.06%	ACC, MPL, RS
Postpartum Care	65.21%	69.34%	73.97%	73.97%	ACC, MPL, RS

*Red = less than 50th percentile, Green= met goal, MPL met
↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

Completed Activities in 2019:

- The postpartum care member incentive dollar amount increased Sept. 1, 2019 from $25 to $50.
- Collaborated with engaged HNs with their call campaign outreach efforts.
- Strategized promotion of member incentives through website and monthly quality meetings with HNs.

- Member newsletter Spring and Fall 2019 promoted Health Management Programs, including Bright Steps Maternity Health Program and emphasized the importance of the postpartum visit.

Existing Barriers:

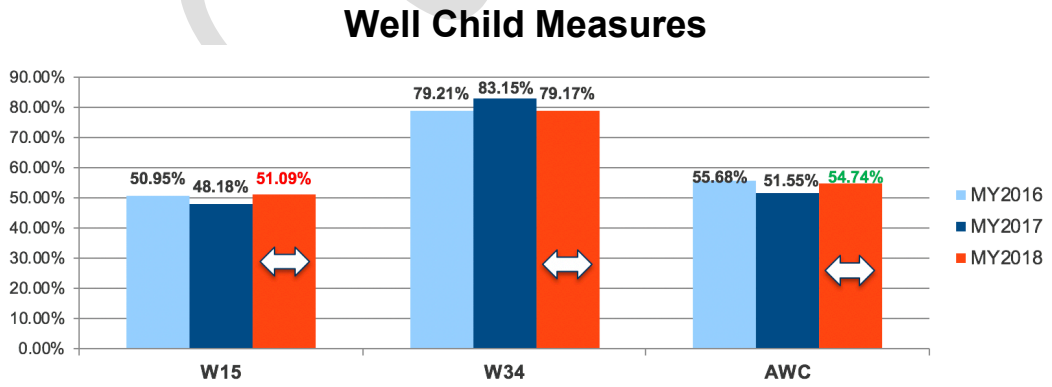
- A significant number of members have been going in for the wound check visit within the first two weeks and not returning for a postpartum visit between days 21–56 days of delivery.

Next Steps for 2020:

- Promote the $50 member incentive program for completing a postpartum visit within the required timeframes.
- CalOptima website and social media platforms will have an educational message banner rotating with women's health and maternal mental health awareness messaging in May 2020.
- HEDIS Postpartum Care technical specifications have been relaxed to promote a visit between 1–12 weeks and will likely have a large impact on compliance.
- Conduct Bright Step postpartum assessment in a timely manner.
- Improve collaboration with HNs and CalOptima's Community Network (CCN) providers to promote prenatal and postpartum visits.
- Prenatal and postpartum care measures will be incentivized in the 2020 P4V program.
- Member newsletter articles in 2020 emphasizing prenatal and postpartum care and the member incentive.

Well-Child Visits 0-15 Months (W15)

The rates for the W15, W34 and AWC measures are presented below. W15 measure performed below the 50th percentile and is at risk for being below the new MPL in 2019.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Well-Child Visits in the First 15 Months of Life — 6 Well-Child Visits (W15)	66.23%	71.29%	75.43%	58.54%	P4V
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	73.89%	79.33%	83.7%	83.70%	MPL, P4V
Adolescent Well-Care Visits (AWC)	54.57%	61.99%	66.8%	54.57%	P4V

*Red = less than 50th percentile, Green = met goal, MPL met, ↑ ↓ statistically higher or lower, ↔ statistically no difference
**RS = Health plan rating, MPL = DHCS Minimum Performance Level, ACC = NCQA Accreditation, P4V = Pay for Value

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Completed Activities in 2019:

- W15 member incentive of $50 gift card was sent to targeted members due with missing well-child visits 4–6 with ample time to complete before the 15th month birthday deadline to impact HEDIS MY 2019.
- W15 provider incentive of $50 for each completed incentive form for eligible members.
- Health Guides with immunization and well-child schedules were mailed to all members Ages 0–6 in Q2 of 2019.
- Medi-Cal member newsletter Spring 2019 highlighted articles promoting scheduling first health exam for new members, well child visits and immunizations.
- Targeted W15 call campaign to promote the 5 and/or 6 visits for members in HEDIS 2020 by health educators (Sept–Oct).
- This measure was incentivized in the 2019 P4V program.
- CalOptima Day events for child measures also included targeted W15 at high-volume provider offices.
- Root cause analysis via survey to new mothers asking them where they took their children for their first two well-child visits and when. Final confirmation of survey responses pending cross-check with claims and encounter data.
- Provider fax blast to all PCPS of members with outstanding W15 visits.

Existing Barriers:

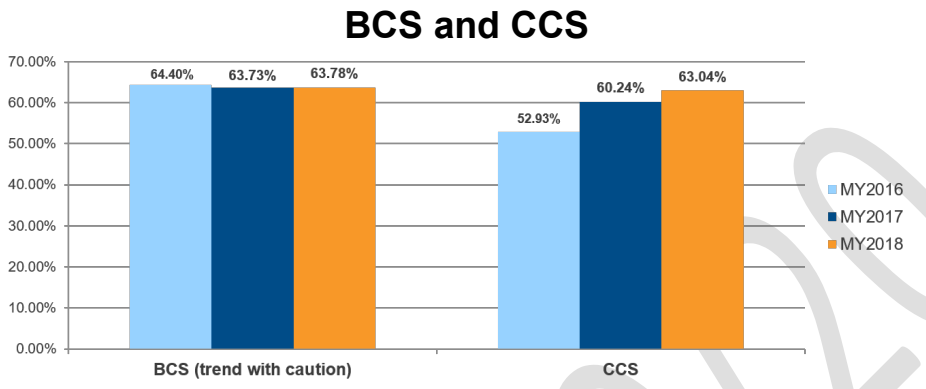
- One of the major barriers is identifying the visits which occur in the first two months of life as they frequently occur under the mother's name and ID/medical record/CIN. It is partly related to the way the baby is covered by Medi-Cal after delivery and this can cause a lot of confusion when the data does come into the plan.
- Also, providers do not always use the right CPT code, so it seems like a regular office visit that occurred for the mother rather than a well-child visit that occurred for a newborn baby.
- Members are not completing the full requirement of 6 visits in a timely manner or are not aware that they need to get 6 visits before the 15 month birthday.

Next Steps in 2020:

- Evaluation shows there are members who have completed well-care visits in the first two months of life for which we have no data. Additional assessment of data gaps in process.
- Implement CalOptima Days targeting the W15 population only at high volume provider offices.
- Promote incentive program for completing 1–3 and 4–6 well-child visits in the first 15 months of life to members and providers alike through various modes of communication, including the website and portals.
- Targeted outreach campaigns (IVR, call campaigns, etc.) throughout the year. At least five to six touch points during the year are necessary for the member to change their behavior.
- Medi-Cal member newsletter Spring 2020 will have articles highlighting immunization schedules for children returning to school, well-care visits and scheduling first health exam for new members.
- Promotion of W15 member incentive through Bright Steps prenatal and postpartum calls with PCCs.
- Well child visits for 15 month, 3-6 years and adolescents, will be incentivized in the 2020 P4V program.

Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS)

In 2019, CalOptima had initiatives for breast (BCS) and cervical (CCS) cancer screenings. The table below shows a trend analysis for Medi-Cal BCS and CCS for the last three years. The rates have been steady for BCS but show improvement for CCS.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Breast Cancer Screening (BCS)	58.04%	64.12%	68.94%	65.30%	ACC, MPL, P4V, RS
Cervical Cancer Screening (CCS)	60.1%	66.01%	70.68%	63.26%	ACC,MPL, P4V, RS

*Red = less than 50th percentile, Green= met goal, MPL met
↑↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

Completed Activities in 2019:

- Continued monitoring and tracking incentive for both screening measures.
- Collaborated with willing HNs with their call campaign outreach efforts.
- Promoted member incentives through website and other avenues.
- CCS and BCS member incentives were increased to $25 starting September 1, 2019. This incentive was shared with HNs to promote at point of service and aligned with HN campaigns.
- Facets reminder message campaign prompting Customer Service representatives to convey to members if they are eligible for breast cancer screening Sept. 30–Dec. 31, 2019.
- BCS IVR campaign targeting Medi-Cal population in October 2019 was completed.
- Breast and Cervical Cancer Screenings were incentivized in the 2019 P4V program.

Existing Barriers:

- Members do not go to their doctor in a timely manner even when they are referred for their screening tests.
- Members are afraid to know the result of the test and avoid getting screened because of that fear.
- Members may not be discussing the reasons for their fear and how to overcome it with their providers.
- The providers may not be spending enough time with their patients at the time of the referral to explain to them the importance of the screening and how early detection can improve outcomes.

Next Steps for 2020:
As a part of the quality initiative, CalOptima will focus on the following initiatives to improve screening for cancer:

- Continue and widely promote the $25 incentives for the BCS and CCS screenings.
- Implement a $50 OC/OCC member incentive for colorectal cancer screening to launch January 2020.
- Targeted outreach campaigns to promote BCS, CCS, and colorectal cancer screening (i.e. IVR, calls, etc.)
- CalOptima website will have educational message banner rotating with cervical, breast and colorectal cancer awareness messages in their corresponding awareness months in 2020.
- BCS and CCS screenings will continue to be incentivized in the 2020 P4V program.
- Member newsletter articles emphasizing adult preventive health screenings and wellness exams including BCS and CCS.

Follow-Up After Hospitalization for Mental Illness (FUH)

This is a quality initiative and HEDIS measure that the Behavioral Health Integration department has been monitoring since its inception. The intent of this measure is to ensure that a member has a follow-up care visit with a clinical provider within 7–30 days of discharge from the hospital. The behavioral health clinical team discusses strategy and interventions with the Managed Behavioral Health Organization (MBHO) on a bi-weekly basis. Some of the barriers identified by the MBHO include unable to contact members post discharge, members do not consider the follow-up appointment as a priority, and facilities not engaging members in discharge planning. The current MBHO is managing interventions (i.e., some outreach/coordination) until 12/31/19. CalOptima has offered additional interventions (e.g., flagging returning members to prompt call center staff to offer additional support when member calls in).

In 2020, CalOptima will stop working with the MBHO and bring BH services in house. CalOptima will be directly managing BH on 1/1/2020 and is currently looking at ways to improve follow-up after hospitalization. As a part of its quality initiative, CalOptima will continue to focus on improving rate for this measure by doing the following activities:

- Visit top three hospitals in the first quarter.
- Follow-up with facilities during regular joint operation meetings.
- Outreach to members post discharge to coordinate follow-up appointments.

Safety of Clinical Care

Plan All-Cause Readmission (PCR)

Completed activities in 2019:

- Updated Transition of Care post-discharge program, all diagnosis for all LOB (focused on Anaheim and Fountain Valley hospitals)
- New project proposal to identify ER visits in near real time versus claim based to reduce readmissions.
- CMS: CCN OCC Members with CHF and hospital admission. Health coaches contacted members to prevent unplanned readmission within 30 days (all hospitals excluding Anaheim and Fountain Valley).

Existing Barriers:
One of the main reasons that the all cause readmission rate is high is because there is a lack of communication between PCPs and inpatient facilities once the patient is discharged from the facilities. CalOptima identified the following as the key barriers that impacted this measure:

Facility Level Barriers:

- Practitioners often are not notified by hospitals when their member is hospitalized.

Plan Level Barriers:

- CalOptima does not have access to the electronic medical records (EMR) or health information exchange (HIE) systems at most inpatient facilities, which prevents it from playing a more proactive role in improving coordination of care between hospitals and PCPs. If CalOptima had access to the EMR systems and HIEs, it could ensure that the clinical notes were sent to the PCPs in a timely manner once the patient is discharged.
- CalOptima realizes that it needs to play a larger role in transitioning and coordinating care and is working on establishing more robust data sharing agreements with facilities. TOC is resource intensive for the low volume of member therefore strategy will be pivoted to allow greater impact on All Cause Readmissions.

Next Step for 2020s:

- Identification for ER visits in Data Warehouse through a new vendor.
- CMS: CCN OCC members with CHF and hospital admission. Health Coaches contact member to prevent unplanned readmission within 30 days
- Work with Office Ally to incorporate their EMR into CalOptima data warehouse for offices that are contracted with both entities.

Opioid Utilization

Opioid Utilization Data 2018-2019 Results

CalOptima Medi-Cal Opioid Analgesic Utilization	2018-Q3	2018-Q4	2019-Q1	2019-Q2	2019-Q3	% Change 3Q18 to 3Q19
Opioid Analgesic Rxs	44,697	41,335	38,819	38,585	38,426	-14.0%
% Members Utilizing Opioid Analgesic Rxs	1.23%	1.15%	1.10%	1.08%	1.09%	-11.6%
Opioid Analgesic Rxs PMPQ	0.0236	0.0222	0.0210	0.0206	0.0208	-11.5%
Members Receiving > 80mg Avg MME	793	716	647	638	604	-23.8%
% Utilizing Members Receiving > 80mg Avg MME	3.39%	3.34%	3.18%	3.16%	3.01%	-11.3%
Average Quantity/Rx for Short-Acting Opioid Analgesics	53.9	54.5	53.7	52.4	51.7	-4.1%

CalOptima Organization-Wide Opioid Utilization Goals Fiscal Year 18/19	2018-Q1	2018-Q2	2018-Q3	2018-Q4	2019-Q1
Average Morphine Milligram Equivalent (MME)/Member Goal = 10% Decrease (<17.5)	19.5	18.6	17.9	17.2	15.6
Number of Members Receiving Concomitant Benzodiazepines and Opioid Analgesics Goal = 5% Decrease (<4,295)	4,522	3,880	3,819	3,521	3,251

CMS Medicare Star Display Measures

Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D): Multi-provider and/or high dosage opioid use among individuals 18 years and older without cancer and not in hospice care.

- Measure 1: Use of Opioids at High Dosage (OHD): Members receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer.
- Measure 2: Use of Opioids from Multiple Providers (OMP): Members receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.
- Measure 3: Use of Opioids at High Dosage and from Multiple Providers (OHDMP): Members receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.

Patient Safety Measure	Plan	2019 Rate	MAPD Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids at High Dosage in Persons without Cancer	OneCare	6%	7%	Equal or Better
Use of Opioids at High Dosage in Persons without Cancer	OneCare Connect	6%	7%	Equal or Better

Patient Safety Measure	Plan	2019 Rate	MAPD Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids from Multiple Providers	OneCare	0%	0.52%	Equal or Better
Use of Opioids from Multiple Providers	OneCare Connect	0%	0.19%	Equal or Better

Patient Safety Measure	Plan	2019 Rate	MAPD Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids at High Dosage and from Multiple Providers	OneCare	0%	0.04%	Equal or Better
Use of Opioids at High Dosage and from Multiple Providers	OneCare Connect	0%	0.04%	Equal or Better

Completed Pharmacy Management Interventions in 2019:

Prescriber:

- Quarterly prescriber report card: Intervention provided to providers whose average Milligram Morphine Equivalent (MME) dose per prescription fell above their practice specialty average.
- Prescriber Newsletters:
    - Deprescribing Benzodiazepines in Patients Receiving Opioids
    - Safe Medication Disposal in the Community
    - Co-prescribing Naloxone with Opioids
- Monthly Medicare Opioid Overutilization Intervention: Member opioid and benzodiazepine medication list faxed to most recent prescriber of members who meet CMS Opioid Monitoring System (OMS) Criteria.

Pharmacy:

- Implementation of opioid cumulative MME point-of-sale (POS) pharmacy edits such that members with claims exceeding a cumulative MME threshold of 90mg will trigger a soft rejection (overridable by the pharmacist) and exceeding 400mg will trigger a hard rejection (authorization required).
- Point of service soft drug utilization review (DUR) rejections for concomitant opioids and benzodiazepines.

Member:

- Retrospective identification of members meeting criteria for opioid overutilization for Medical Director Review and referral to Compliance, QI or Case management.
- Pharmacy Home Program Policy: Members filling prescriptions at four (4) or more pharmacies in a two-month period are restricted to a single pharmacy for a period of one year.
- Prescriber Restriction Program Policy: Pharmacy claims utilization reports indicate the Members filling controlled substance prescriptions from four (4) or more Prescribers in a two (2) month period are restricted to designated prescribers.

Formulary:

Medi-Cal

- Implementation of point-of-sale (POS) pharmacy edits triggering a soft rejection for opioid pharmacy claims attempted to be filled within 30 calendar days of a fill for buprenorphine-containing products.
- Require prior authorization for new starts for methadone doses above 30mg/day.
- Require prior authorization for new starts for all long-acting opioids.
- Stricter quantity limits for short-acting opioid analgesics.
- Concurrent use of opioids and benzodiazepines formulary safety edits that may be overridden at the pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

Medicare:

- Hard safety edit to limit initial opioid prescription fills to no more than a seven (7)-day supply.
- Pharmacist-driven care-coordination formulary safety edit for duplicative long-acting opioid therapy (excluding buprenorphine) with a prescriber count of at least two (2)

prescribers that may be overridden at the pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.
- Pharmacist-driven opioid care coordination formulary safety edit would trigger when a member's cumulative MME per day across all opioid prescriptions reaches or exceeds 90 MME.
- Concurrent use of opioids and benzodiazepines formulary safety edits that may be overridden at the pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

Existing Barriers:
- Lack of timely data from DHCS for Medication Assisted Therapy (MAT) medication carve out claims for Medi-Cal members.
- No access to data for medications dispensed by Opioid Treatment Programs (OTP).

New Opioid Interventions in 2020:
- Effective October 1, 2019, CalOptima's Medi-Cal DUR program complies with section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, and applicable guidance issued by DHCS: opioid pharmacy claims for members shall not exceed a cumulative morphine milligram equivalent (MME) of 500 MME/day without prior authorization.
- Promote Medication Assisted Therapy (MAT): The use of FDA- approved medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.
- Contract with OTP for Medicare members effective January 1, 2020.

Be Safe Pilot Program
In addition to the pharmacy management interventions, CalOptima launched the Be Safe pilot program at the end of 2018 with the goals of decreasing opioid misuse, promoting appropriate prescribing, and decreasing adverse events related to opioid misuse.

Completed Activities in 2019:
- In 2019, CalOptima facilitated weekly Be Safe rounds to identify members at risk of opioid misuse and provide personalized outreach and assistance to members with high Morphine Milligram Equivalent (MME).
  - Each discipline had specific, timed interventions that approach and support each member's unique situation from their respective specialties.
  - Staff participants included Registered Nurse Case Managers, Behavioral Health clinician, Medical Director, and Clinical Pharmacist.
- The Be Safe rounds provided valuable information regarding the challenges of managing opioid use.

Existing Barriers:
- Resources for the Be Safe Program.

Next Steps for 2020:
- In 2020, Be Safe will take the lessons learned from the rounds and update the program to meet our objectives.

Post-Acute Infection Prevention Quality Incentive (PIPQI)

CalOptima engaged in a project with Nursing Facilities to reduce post-acute infections. At CalOptima we refer to this project as Shared Healthcare Intervention to Eliminate Life-threatening Dissemination (SHIELD) OC, and with Board approval began implementation on 10/1/2019. There are 25 Nursing Facilities participating, and of those, 12 were already participating with UCI since Q2 2017 in the SHIELD study. Participating facilities are required to use a solution of Chlorhexidine (CHG) soap to bathe all residents and administer Idophor (nasal swabs). CalOptima nurses are monitoring each facility monthly for CHG utilization and Hospital Acquired Infection (HAI) scores. Quality performance measures will be monitored in 2020. This program will be made available to additional facilities in 2020, with a kick-off mandatory training in Q1.

Facility Site Review (FSR)

Per DHCS, all PCP sites must have the capacity to support the safe and effective provision of primary care clinical services to Medi-Cal managed care health plans (MCP) members (Title 22, California Code of Regulations [CCR], Section 56230). The Site Review Process is part of a MCP's QI Program that focuses on the capacity of each PCP site to ensure and support the safe and effective provision of clinical services. In order to verify that PCP sites comply with all applicable local, state, and federal standards, CalOptima is required to conduct a Full Scope Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review Survey (PARS) for all PCP sites as part of the initial credentialing process and at least every 36 months thereafter.

In 2019, CalOptima continued to maintain safety standards and practices to their members by completing FSR/MRR/PARS at all contracted PCP offices, as well as PARS at high volume specialist offices. With a staff of three nurses, 64 Initial Facility Site Reviews, 282 Full Scope Reviews, and 462 PARS were conducted in 2019. There were 10 failed audits (3.5%) which increased from 2.4% in 2018. The number of CAPS issued in 2019 were 364, which increased from 285 in 2018. In April, DHCS proposed new criteria and scoring to the FSR/MRR tools. The changes to the MRR tool were significant and added additional criteria and guidelines to ensure member safety at provider offices. In December, DHCS issued a draft APL to supersede PL 14-004. The new tools are currently being field tested and evaluated with the intent to fully implement by 7/1/2020. Due to the volume of changes to the tools, additional resources and staffing will be required to meet the new DHCS requirements.

2019 Improvement Projects

The following are a summary of all Quality Improvement Projects (QIP), Chronic Care Improvement Programs (CCIP), Performance Improvement Projects (PIP) and PDSA projects for 2019 by each improvement project type.

Quality Improvement Projects (QIPs)

OCC QIP — Improving Statins Use for Patients with Diabetes (SPD) 2019–2020

- **Goal:** To increase statin use among members with diabetes by 5%.
- **Target Population:** All CalOptima Medi-Cal members with diabetes.

- **Interventions:** In tandem with an existing provider focused program to promote assessment of members with diabetes who might benefit from statin use in preventing cardiovascular risk, a member-focused multi-modal promotion campaign is in place to urge members with diabetes to have the discussion with their providers about whether a statin is right for them.
- **Activities:** Interactive Voice Recordings (IVR) messaging, quarterly member mailing campaign and newsletter articles promoting the discussion with their providers have been put into place to urge members to consider the potential benefits of preventing cardiovascular complications.
- **Summary of Results:** Program implemented in quarter 4, 2019. Data collection is in ongoing and in process.

Performance Improvement Projects (PIPs)

OCC PIP: Members with Individualized Care Plan Completed/Members with Documented Discussions of Care Goals 2018–2019

- **Goals:**
  1. CA 1.5 – Members with an Individualized Care Plan Completed. Year 1 Goal: High Risk: 79.9%; Low Risk: 71%
  2. CA 1.6 – Members with Documented Discussions of Care Goals. Year 1 Goal: 77.91%
- **Interventions:**
  1. Change language with Health Risk Assessment (implemented 1/3/18)
  2. Initiate Initial Care Plan (ICP) discussion goals at the first contact with member
- **Summary of Results:**

Study Indicator 1	
Study Indicator 1 Title	CA 1.5 High Risk with an ICP completed. (77.43%)
Measurement Year Goal	81.20%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 4) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 5) Quarter 3: 07/01/2019 to 09/30/2019 Quarter 4: 10/01/2019 to 12/31/2019
Results	High Risk (B/A) Quarter 1: (2019) 82.46% (PDSA cycle 4) Quarter 2: (2019) 82.79% (PDSA cycle 5) Quarter 3: (2019) 54.97% Quarter 4: (2019)
Study Indicator 2	
Study Indicator 2 Title	CA 1.5 Low Risk with an ICP completed. (68.48%) – 90 days continuous enrollment
Measurement Year Goal	73.48%

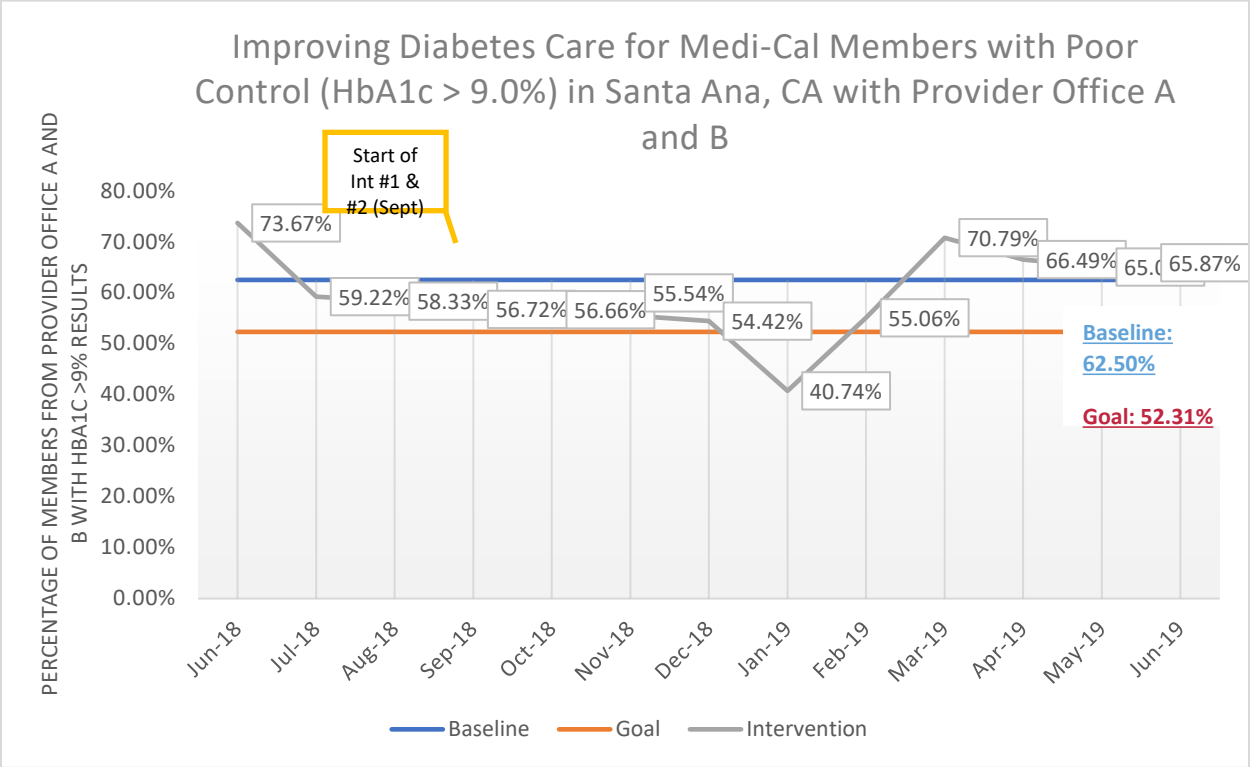
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 4) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 5) Quarter 3: 07/01/2019 to 09/30/2019 Quarter 4: 10/01/2019 to 12/31/2019
Results	Low Risk (D/C) Quarter 1: (2019) 74.51% Quarter 2: (2019) 75.42% Quarter 3: (2019) 43.28% Quarter 4: (2019)
Study Indicator 3	
Study Indicator 3 Title	CA 1.6 OCC Members with Documented Discussion of Care Goals (74.81%)
Measurement Year Goal	81.57%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 3) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 4) Quarter 3: 07/01/2019 to 09/30/2019 (PDSA cycle 5) Quarter 4: 10/01/2019 to 12/31/2019
Results	Quarter 1: (2019) 93.01% (PDSA cycle 3) Quarter 2: (2019) 90.21% (PDSA cycle 4) Quarter 3: (2019) 91.02% (PDSA cycle 5) Cumulative Rate (up to end of each cycle/quarter): 1/1/18–3/31/19: 93.01% 1/1/18–6/30/19: 91.55%

For study indicators 1 and 2, changes made to our data collection process in response to regulatory guidance to only count care plans that had proof of member involvement resulted in a change to our data collection process. Our prior process did not have a positive review question that addressed member involvement. When we made the change, it allowed us to collect data specifically aimed at that question for each quarter going forward. However, since this is a cumulative measure, and the target criteria have been modified, when we applied the same logic, we lost the ability to count many care plans that were created prior to the question being implemented. We anticipate that our numbers will show improvement as we add new care plans with the new logic in upcoming quarters and we will see a decrease in the dilutional effect of the earlier care plans as the denominator increases.

For study indicator 3, results continue to show strong improvement, with Q3 results indicating that 91.02% of members had discussions of care goals. This intervention is proving to be effective and will be continued.

Medi-Cal PIP — Improving Diabetes Care for Medi-Cal Members with Poor Control (A1C >9%) residing in Santa Ana, CA — 2018–2019 COMPLETED

- **Goal:** By June 30, 2019, reduce the rate of poor or uncontrolled blood glucose levels (HbA1c >9) among diabetic CalOptima Medi-Cal members who are 18–75 years of age during the measurement period and enrolled in CCN at the two targeted provider offices from 62.5% to 52.31% in Santa Ana, CA.
- **Interventions:**
  1. Provider outreach — CalOptima provides targeted member registry list for providers to schedule health visit with member. Assess their diabetes status and provide appropriate health care services and referrals.
  2. Health coach targeted outreach — Health coach team will call members on the targeted member registry list to offer health coaching services. Follows the current health coaching process.
- **Summary of Results**:

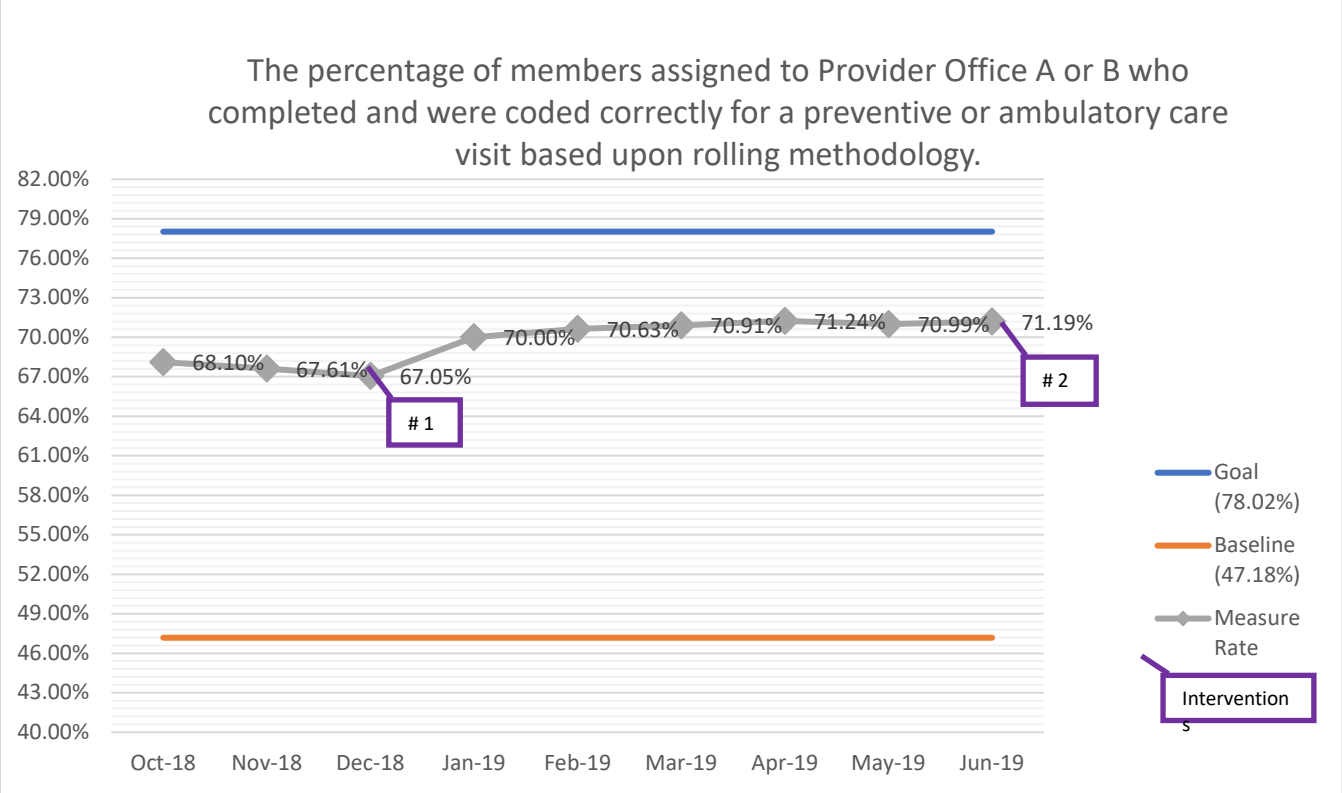


Intervention 1: Provider Outreach Start Date — September 2019
Intervention 2: Health Coaching Start Date — September 2019

CalOptima met our SMART Aim goal in January 2019, with the lowest rate of 40.74% in January 2019. We believe that the data reconciliation between CalOptima and Provider Office A and Provider Office B helped contribute to this decrease. The rate spiked up to 55.06% on February 2019, and 70.79% in March 2019, and the rate trended downward again before settling on 65.87% in June 2019. The increase in some of the denominators was due to the new HEDIS year and new diabetic members. For example, some of the diabetic members in 2019 were not part of the 2018 diabetic denominator since they were not eligible until 1/1/2019. Ultimately, we did not achieve our SMART Aim goal of 52.31% (lower than 52.31% is better). However, there were some good improvements from baseline for majority of the intervention period.

Medi-Cal PIP — Improving Adult's Access to Preventive/Ambulatory Health Services: Ages 45–65 years — 20018–2019 COMPLETED

- **Goal:** By 06/30/2019, increase the rate of adults' access to preventive/ambulatory health services among Medi-Cal members 45–64 years in CCN, from 78.02% to 82.49%.
- **Interventions:**
  1. Provider Office Staff Incentive — based on improvement from baseline.
  2. Member incentive ($25 for completing an adult well-care visit)
- **Summary of Results**:



Intervention 1: Launch of Provider Office Staff Incentive — December 2018
Intervention 2: Launch of Member Incentive — June 2019

From December 1, 2018 through June 30, 2019, Provider Office A and Provider Office B participated in outreach efforts to increase the number of preventive or ambulatory health care visits among CalOptima members between 45-64 years of age assigned to the CalOptima Community Network. The rate of completed preventive or ambulatory health visits in the target population at Provider Office A and Provider Office B increased from 47.18% to 71.19%. The SMART AIM goal of 78.02% was not achieved with this Performance Improvement Project. However, positive and incremental improvement was seen over the course of the intervention period. Specifically, the data illustrates that there was a rate increase in six out of the seven months of the intervention period. The exception was December 2019.

Chronic Care Improvement Programs (CCIPs)

OC CCIP — Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2021

- **Goal:** Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to OneCare members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab

results. The goal is to move 5% of OC members identified and who participate back to an A1C <8% within one year.

- **Target Population:** OC members at risk for poor control >8% who were previously in good control <8% based on recent labs.
    - These members have been enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.
    - Exclusion Criteria:
        - Ineligible CalOptima members
        - Members identified for long-term Care (LTC) or dementia
        - Members delegated to Kaiser
- **Interventions:** This intervention targets OC members with diabetes with A1C results trending upward from <8% to >8%. OC members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.
- **Summary of Results:**
  Program implemented in quarter 4, 2019. Data collection is in process. Preliminary results will be available quarter 1, 2020.

OCC CCIP — Emerging Risk – Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2020

- **Goal:** Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to OCC members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab results. The goal is to move 5% of OCC members identified and who participate back to an A1C <8% within one year.
- **Target Population:** OneCare Connect members at risk for poor control >8% who were previously in good control <8% based on recent labs.
    - These members have been enrolled by December 31st of the measurement year and be within 18-75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications. Exclusion Criteria:
    - Ineligible CalOptima Members
    - Members Identified for LTC or Dementia
    - Members Delegated to Kaiser
- **Interventions:** This intervention targets OCC members with diabetes with A1C results trending upward from <8% to >8%. OCC Members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.
- **Summary of Results:**
  Program implemented in quarter 4, 2019. Data collection is in process. Preliminary results will be available quarter 1, 2020.

PDSA Initiatives

OCC PDSA — Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents LTC

- **Project:** Increasing post-hospitalization coordination and support among OCC LTC members in CNN to decrease acute readmission rates.
- **Reporting Period:** Cycle 6 (July 1, 2019–September 30, 2019)
- **Target Population:** OCC LTC members in CCN.
- **Goal:**
    - **Smart Objective 1:** By 6/30/2018, CalOptima will offer enhanced care coordination to all OCC CCN LTC members with ≥ two (2) acute admissions within the last rolling 12 months.
    - **Smart Objective 2:** By 12/31/2018, the rolling 12-month average acute admissions represented by OCC CCN LTC members with multiple admissions, 2.76 admissions per member per year at 2017 baseline, will decrease to ≤2.45 admissions per member per year.
    - **Smart Objective 3:** By 6/30/2019, the overall rolling 12-month average ratio of acute admissions represented by all OCC CCN LTC members, 0.88 admissions per member at 2017 baseline, will decrease to ≤0.79 admissions per member per year.
- **Interventions:** During the first phase of the new project, CalOptima will focus on providing enhanced care management strategies outlined below, for OCC CCN LTC members with ≥2 acute admissions within a rolling 12-month period, through assigned CalOptima Nurse Case Manager NCM's. These interventions will be initiated between 4/01/2018 through 6/30/2018. During the second or third phase of the project —pending feedback and outcomes from the initial implementation — CalOptima will extend the enhanced care management strategies to all OCC CCN LTC members with new acute admissions.

  Enhanced care management strategies for the targeted OCC CCN LTC members can involve the following interventions, as appropriate:
  1. Field visits with members
  2. Increased contact with member/family members
  3. Increased coordination with facility staff
  4. Increased participation with ICT meetings at the facility
  5. Pharmacy consult post-discharge
  6. Education and training with member/family member(s)
  7. Support in completing an advance directive
  8. Structured motivational interviewing/goal setting with members
  9. Additional coordination with ICT meetings, including PCP

  The assigned CalOptima NCM will be primarily responsible for either directly completing or supporting the facility staff's completion of the interventions outlined above, as appropriate. If a need for any of these interventions is identified, the NCM will attempt to ensure it is initiated within 30 days of making contact with the member/family member. While the assigned NCM will provide their availability to the member/family member and facility staff, the CalOptima PCC's, with their consistent availability in the office, will also act as additional contact points for the member/family members. The PCC can also follow-up on referrals and meetings, as needed.

  Summary of Results: (Cycle 6) — During 3Q2019, 22 hospital admissions by 17 OCC CCN LTC members were reported at the time of this update. Of these hospital admissions, 12 were a readmission within a 12 months period. That is, 12 of the members

have at least one other hospital admission during the preceding 12 months. During this cycle, all OCC CCN LTC members with a hospital admission in 3Q2019, regardless of whether they had a hospital admission in the preceding 12 months, were eligible for the project interventions. The assigned CalOptima NCM continued to follow-up with all identified members to complete the enhanced care coordination interventions previously outlined. For comparison, there were two readmissions within the same quarter during 2Q2019 compared to five readmissions within the same quarter during 3Q2019. There was an increase of 9 hospital admissions in Q32019, compared to Q22019.

During Cycle 6, CalOptima continued with one designated medical case manager (MCM) to follow-up with all acute admissions. The MCM spoke with members, facility staff and/or member's authorized representative, attended Interdisciplinary Care Team meetings, and developed interventions. Members and facility staff are beginning to recognize the MCM and understand her purpose. Many of the members are happy to see the MCM, they appreciate her "organizing their charts;" others appear indifferent to her, they answer her questions but don't engage in goal setting. Due to other assignments, it has been challenging to monitor the implementation of the interventions.

While some improvement in rapport building has been achieved, the advantage of a dedicated case manager to follow-up on acute admissions has not been clearly demonstrated by Cycle 6's outcomes. CalOptima will continue with this configuration for another cycle to gather additional results and feedback.

As of October 2019, there were 76 OCC CCN LTC members compared to the 115 OCC CCN LTC members at the end 2017 when this project started. For the 12-month period from 10/01/2018 through 9/30/2019, there were 90 acute admissions reported for all OCC CCN LTC members. The average ratio, based on the October 2019 OCC CCN LTC membership, was 0.84 admissions per member per year. SMART Objective 3 was not met.

SECTION 3: QUALITY OF SERVICE

Member Experience

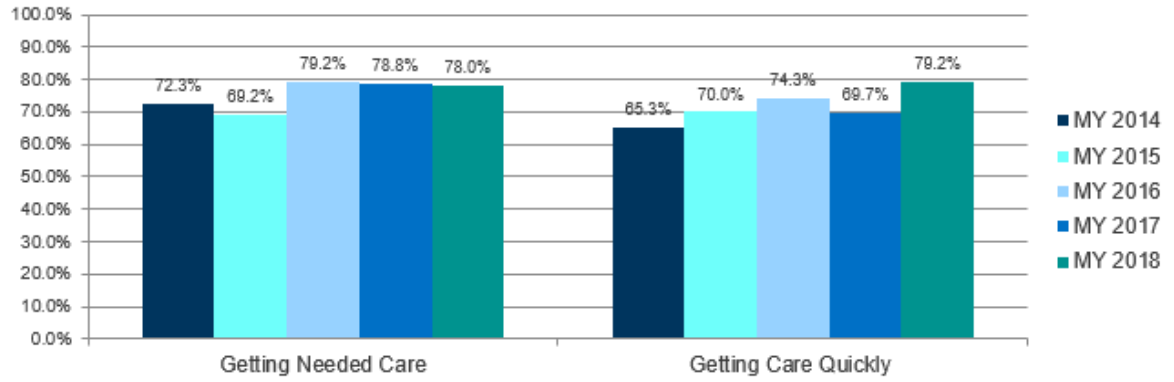
CalOptima annually monitors member satisfaction and identifies areas for improvement for all lines of business. CalOptima assesses member satisfaction by identifying the appropriate population and collecting valid data from the affected population about various areas of their health care experience. Opportunities for improvement are identified from this information and specific evidence-based interventions are implemented. The goal is to improve the overall member experience by better meeting our members' needs.

CalOptima monitors the CAHPS results, particularly the achievement score at various levels including plan and HN. The achievement score is the calculation of positive responses, typically identified as "Usually" or "Always" or rated top scores of "8, 9 or 10."

CAHPS Trend Analysis:
CalOptima identified that the "Getting Needed Care and Getting Care Quickly" measures were consistently performing below goal. The following tables includes the plan level survey achievement scores for the adult and child surveys for two key measures (i.e. getting needed care and getting care quickly).

Goal:
To meet the 50th percentile when compared to National Medicaid Benchmarks.

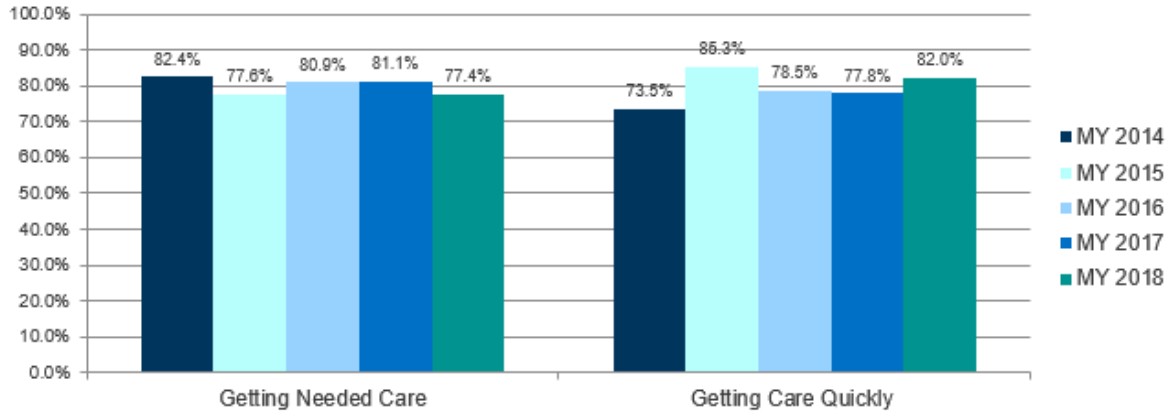
Medi-Cal Adult CAHPS Survey Results



National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	78.0%	<25th	<25th	80.53%	83.06%	85.47%	86.84%
Getting Care Quickly	79.2%	<25th	<25th	80.02%	82.34%	85.08%	86.74%

Red = less than 25th percentile

Medi-Cal Child CAHPS Survey Results



National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	77.4%	<25th	<25th	81.49%	84.85%	88.01%	89.98%
Getting Care Quickly	82.0%	<25th	<25th	87.01%	89.98%	92.43%	94.17%

Red = less than 25th percentile

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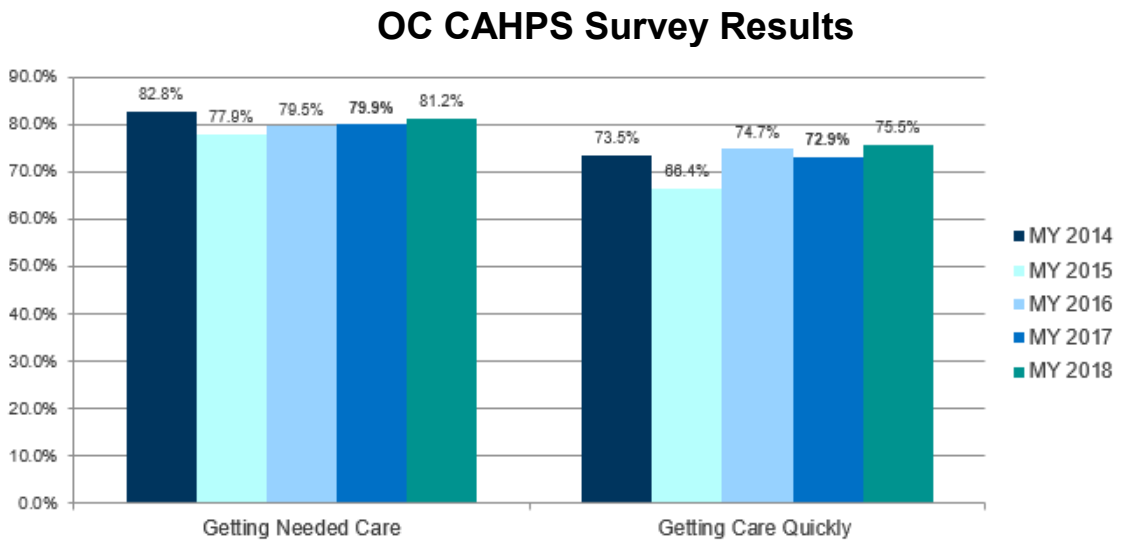
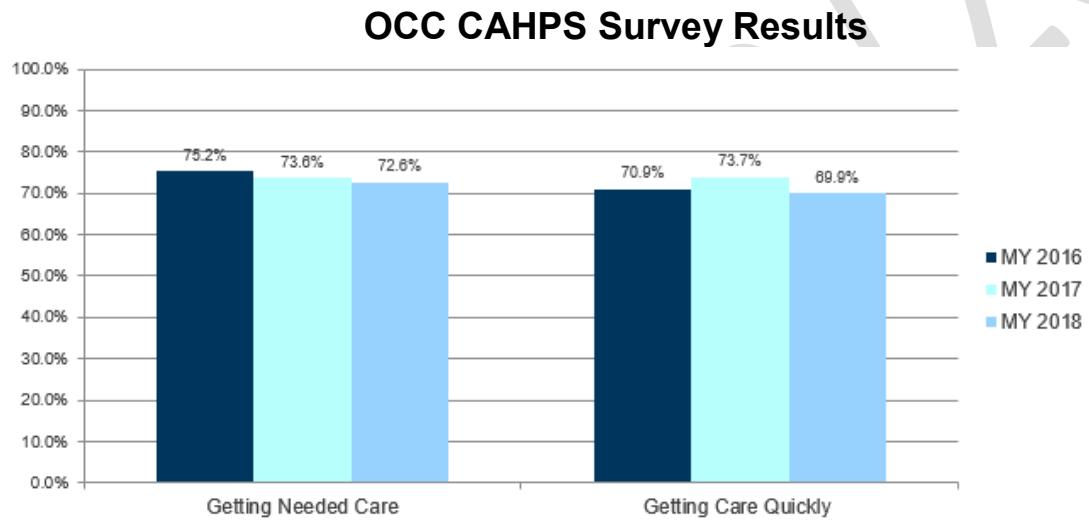




In 2019, CalOptima reviewed all the CAHPS rates in detail and compared them to the benchmarks and found getting needed care and getting care quickly to be high priority for the organization.

Access to Care

Timely Access Study:
CalOptima monitors appointment availability and accessibility on an annual basis. The evidence is clear that timely access to health care services results in better health outcomes, reduced health disparities, and lower spending, including avoidable emergency room visits and hospital care. CalOptima fields a survey to collect appointment wait times and compares them to standards from DHCS and CMS. A compliance rate is calculated by appointment type for each provider type.

Methodology Change:
In 2019, CalOptima adopted the mystery shopper methodology to monitor appointment availability performance for all primary care providers and identified provider specialty types. This allowed CalOptima and its HNs to determine exactly which providers are non-compliant

with the access standards, and provider outreach and education can be targeted. In addition, the data collected will be more accurate, since it will no longer be provider self-reported. As there was a major change in data collection methodology, it is not possible to trend data for access to care in 2019.

Goal:
To meet internal goal of 80% for each individual measure and practitioner types

Key Findings by LOB, (preliminary results):
Medi-Cal:

- The only providers that met the goal of 80% were:
  - Follow-up appointments met for BH specialists
  - Non urgent appointments met for Family Medicine and Pediatrics
  - Non urgent appointments met for physical medicine and rehabilitation providers
  - Appointments for regular physicals were met for all PCP types.
- None of the provider types met the goal for urgent appointment wait times.
- All providers specialty types did not meet the non-urgent appointment wait times goal. Only one did.

OCC

- The only providers that met the goal of 80% were:
  - Non urgent appointments met for (licensed clinical social worker (LCSW) for BH appointments
  - Non urgent appointments met Family Medicine and General Practice
  - Non urgent appointments met for Orthopedic and Podiatry
  - Appointments for regular physicals were met for all PCP types
- None of the provider types met the goal for urgent appointment wait times.
- 14 of 16 providers specialty types did not meet the non-urgent appointment wait times goal.

OC

- The only providers that met the goal of 80% were:
  - Urgent care appointment met for only one provider type (Family Medicine)
  - Non urgent appointments met for Family Medicine, General Practice and Pediatrics
  - Non urgent appointments met for Ear, Nose & Throat, Midwife, Orthopedic and Podiatry
  - Appointments for regular physicals were met for all PCP types
- All but one of the provider types met the goal for urgent appointment wait times.
- 12 of 16 providers specialty types did not meet the non-urgent appointment wait times goal.

Based on the review of timely access study results, appointment access is an area of concern. The data shows that of all the appointment types, urgent care, non-urgent care visits are areas where there are opportunities for improvement for almost all provider types, primary care and specialty care.

Network Adequacy - Time and Distance Analysis:
CalOptima monitors network adequacy on a quarterly basis by running reports to evaluate whether the Plan meets the time and distance standards established by CMS and DHCS. For all lines of business, the Plan has met the time and distance standards with the exception OB-GYN/PCPs in a few zip codes in South County where we have an approved alternative access standard with DHCS at the Plan level. When evaluating network adequacy for each of CalOptima's delegated HNs, the HNs did not meet all the time and distance standards.

Comparison to Complaints/Appeals:
When the CAHPS results were compared to the Access grievances, CalOptima found that access grievances make up about 10% of all grievances in 2019. Delays in service was a top reason for the HN and CCN. Although the Access related grievances have decreased, appointment availability continues to be a pain point for members.

The top 3 sub-categories of access grievances are specialty care, appointment availability, and telephone accessibility. The members complained that referrals were not made to a provider who is able to treat the member or to a provider that the member wants to see. These required referral modifications which resulted in delays. Another key finding was that providers are not submitting complete and timely referral to the Utilization Management (UM department). The providers also had long wait times and the authorizations expired by the time the member went in for the referral. Members also had challenges with providers when scheduling and obtaining appointments, particularly BH provider since many of these providers tend to have a solo practice. Some of these findings mirror the barriers the team identified in its discussions.

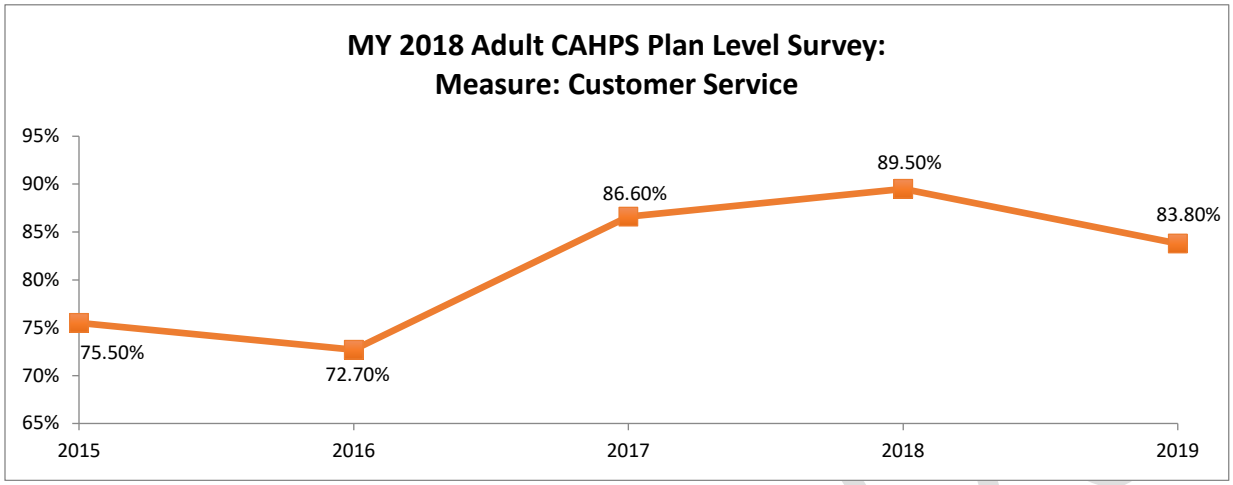
Member Experience Activities Completed in 2019

Homeless Clinical Access Program
In late 2019, CalOptima implemented a quality incentive for Community Health Centers participating in the Homeless Clinical Access Program (HCAP). HCAP is a means for CalOptima to coordinate with Community Health Centers to bring primary care services via mobile clinics at designated shelters and hot spots. Community Health Centers are incentivized for time spent at shelter and/or hot spot in addition to providing primary care services to CalOptima homeless population. At the close of 2019, CalOptima had three Community Centers identified to participate in the HCAP program.

In 2020, CalOptima intends to expand Community Health Center participation in HCAP, including identification of more shelters and hot spots where services via mobile clinic can be supported.

Provider Coaching
In 2018, CalOptima contracted with SullivanLuallin Group, a customer service improvement health care consultant, to conduct provider shadow coaching and to hold workshops on customer service for office staff, office managers/supervisors and physicians to improve overall patient experience. In 2019, there were 21 providers who participated in the shadow coaching. And 6 workshops (3 for staff and 3 for supervisor/management) were held on how to improve customer service. The feedback from these sessions has been very positive and CalOptima will be continuing this activity in 2020. The trend graph related to customer service for data collect from the plan level CAHPS survey for the adult population shows that there has been a decline in customer service from 2018 to 2019 but it does not reflect the work that is being conducted by the SullivanLuallin Group as the group only started work late in 2018. The 2020 CAHPS survey

results will be a clearer indicator of their performance as they were working with the large provider groups for the entire duration of 2019. This program will continue in 2020 as well.



*Scores are based upon the 2019 Adult Plan CAHPS Survey Report developed by DataStat.

The Member Experience Subcommittee identified referrals and authorizations and coordination of care as the areas of focus for 2019. A workgroup was formed to focus on mapping out the referral and authorization process from the members' perspective and identifying opportunities for improvement. Some of the other initiatives CalOptima considered were :

- Validating provider information prior to UM referral (e.g. accepting new patients, area of focus, sees children)
- Planning to call members who hit threshold of denials/grievances
- Auto approve referrals for selected specialists

A special Member Experience Subcommittee was held, and the committee determined that there were not enough resources to implement interventions listed above. However, in 2019 CalOptima was able to implement the following:

- CalOptima focused their efforts on improving access by making 'urgent care' services easily searchable in the online provider directory.
- CalOptima presented the HN Quality Rating program to the Board of Director's November Finance and Audit Committee and December Quality Assurance Committee. The HN Quality Rating is proposed to drive future P4V payments with a significant portion of the HN quality rating dependent upon excellent member experience scores.
- CalOptima developed and launched the CCN PCP report card and has started posting the results to the provider portal for CCN PCPs. The CCN report card includes information for each provider regarding over-capacity member assignments.
- Approximately 34 providers were sent a notification letter in September 2019 to address PCP member panel overcapacity with panel closures and member reassignment.
- The Member Portal was soft launched in April 2019 for members in all LOBs.
    - Average weekly member registrations: 275
    - Registered users as of 10/26/19: 6,756
    - Top five activities by members on portal:
        1. Update new address/e-email
        2. ID card mailing/download requests
        3. General inquiries to customer service
        4. Change of HN requests
        5. Telephone number updates

- CalOptima also reviewed the current auto-authorization rules. There was a total of 107 Auto Authorization rules in Cerecons. In March 2019, the UM team started reviewing these rules to ensure accuracy and to evaluate if they were working as anticipated.

Overall Assessment of Member Experience and Access to Care

Based on the review of CAHPS, Timely Access study, Time and Distance Analysis and complaints data, the general theme that stands out is that appointment access is an area of concern. The data shows that of all the appointment types, urgent care, non-urgent care visits are areas where there are opportunities for improvement for almost all provider types, primary care and specialty care. This has a significant impact on how members respond on the member CAHPS survey for questions related to getting care quickly and getting needed care. In 2020, CalOptima will continue focusing on the key initiatives that were implemented in 2019 and develop additional initiatives to improve timely access to care. The section below describes the barriers that continue to exist that maybe impacting timely access to care.

Existing Barriers: Based on the CAHPS and member complaints data, CalOptima has identified that getting needed care and getting care quickly are the most critical measures, and therefore are the highest priority in terms of making improvements.

A group of subject matter experts from across the organization completed a detailed barrier analysis:

1. **Prior Authorization Process**
    a. Timeliness of submission by PCP and specialist is an issue. Provider office staff wait to submit the authorization request and then submit the request as an urgent authorization when it truly doesn't meet the criteria for urgent.
    b. Providers also do not always send all the information needed to make a decision at the time of the initial submission. Resubmission is sometime required and may cause delay in obtaining services.
    c. Since a contracted hospital provides a tertiary level of care, all referrals need to be reviewed and cannot go through an auto authorization process. With this process, members may feel that it takes a long time to obtain an approval for the authorization.
2. **Provider Data Quality**
    a. Members are referred to and approvals are sent to specialists who cannot see the patient.
        - Specialists/subspecialties/area focus is not clear, or information is not captured.
    b. Open/close panel is not up-to-date
        - No real-time process to collect correct information about which specialists have open panels and available appointments to see patients.
    c. System issue: FACETS shows no longer accepting patients, but GC shows as participating without any restrictions.
3. **Network and Contract Issues**
    a. Some PCP and specialty groups are not open to see all members in their contracted HN.
        - CalOptima is a delegated model and members are only able to see a provider in their HN.

        - A particular PCP and specialist group will not see members that are not in their system.
    b. Not enough specialists are willing to contract with CalOptima
        - Low reimbursement rates in comparison to other types of health insurance providers (e.g., commercial plans) operating in these counties or cash paying patients.
    c. Not enough urgent care centers listed in the provider directory
        - Some HNs indicate no urgent centers in their network.
4. **Appointment Timeliness and Availability**
    a. Lack of extended office hours for urgent appointments can be a significant barrier.
    b. PCPs have too many members in their panel.
    c. There may be an adequate number of practitioners in CalOptima's panel but not all of them have open panels or are available to see CalOptima new patients.
    d. Certain geographic areas in the Orange County, particularly South Orange County, do not have an adequate number of specialists for a particular type of specialty (i.e. pediatric subspecialties, oncologists, rheumatologists, etc.).

Next Steps for Member Experience in 2020

The Member Experience Subcommittee identified access to care as the areas of focus for 2020. CalOptima has established the goal of improving member experience for getting needed care and getting care quickly from 25th to 50th percentile.

In order to accomplish this goal, CalOptima is developing several interventions that include, but are not limited, to the following:

- Continue to monitor PCPs to determine if their panel size is too large to provide care for our members. Ensure quarterly provider overcapacity notification letters are sent in a timely manner. Close panels for providers that are not meeting the capacity.
- Develop incentives for hard to access PCPs/specialists in challenged areas who have the capacity to open their panels and see CalOptima members.
- Increase payment rates to encourage hard to access specialists in challenged areas to contract with CalOptima and expand the network.
- Explore implementing telehealth services for members and primary care providers to access hard to access and in-demand specialty providers.
- Develop incentives for providers to expand after-hours care.
- Monitor Time and Distance Standards by HN. While DHCS is requiring all plans to certify their delegated networks on network adequacy access performance by July 1, 2021, CalOptima will begin monitoring adequacy of network at the HNs level and developing implementation plans, as needed, in 2020 to ensure that each HN meets time and distance standards.
- Expand the network of urgent care centers. Enhance contracting efforts with urgent care centers for CCN and work with the HNs to contract with more urgent care centers.

SUMMARY

CalOptima developed and implemented programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care management, disease management and complex care management. Ongoing data analysis across multiple areas provides the basis for identifying over/under utilization of services. Our approach also uses support systems for our members with vulnerabilities, disabilities and chronic illnesses. Although individual measures may vary in their level of accomplishment, our overall effort has been a considerable success. As we continue to monitor our performance and refine our methods, we are confident that our QI efforts will continue to make a positive impact.

CalOptima
A Public Agency
Better. Together.

2019 Quality Improvement Program Evaluation

Board of Directors' Quality Assurance Committee Meeting
February 19, 2020

Betsy Ha
Executive Director, Quality and Population Health Management

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2019 Quality Improvement (QI) Accomplishments

- Continued to be one of the highest rated Medicaid plans in the state.
- Maintained “Commendable” accreditation status from the National Committee for Quality Assurance (NCQA).
  - Standards based on Healthcare Effectiveness Data and Information Set (HEDIS) and Healthcare Providers and Systems (CAHPS).
- Performed well on several HEDIS measures in comparison to national thresholds.
  - Out of the 62 reportable measures, CalOptima performed better on 42 measures in 2019, compared to 2018.
- Implemented CalOptima’s comprehensive health network (HN) Pay for Value (P4V) Performance Measurement Program to recognize outstanding performance and support ongoing improvement.

2019 QI Accomplishments (cont.)

- Performed successful incentive outreach to members to obtain preventive care for Well-Care Visits in first 15 months of life (W15), postpartum care, and breast and cervical cancer screening.
- Expanded and continued initiatives to address access to care and member satisfaction, such as:
  - Provider coaching to evaluate and improve services provided at point of care
  - CalOptima Days to improve access and promote preventive health screenings
  - Active recruitment of new providers (both primary and specialty care)
- Implemented a quality incentive for Community Health Centers that participate in the Homeless Clinical Access Program (HCAP).

2019 QI Accomplishments (cont.)

- Implemented several prescriber, pharmacy, member and formulary interventions to reduce opioid utilization.
- Implemented Post-Acute Infection Prevention Quality Incentive (PIPQI) which included 25 nursing facilities of which 12 were already participating with UCI.
- Implemented six quality initiatives and several required Quality Improvement Projects (QIP), Performance Improvement Projects (PIP), Chronic Care Improvement Programs (CCIP), and Plan-Do-Study-Act (PDSA) to improve chronic condition measures
- Viable QI committee structure with subcommittees reporting of QI activities to QI Committee through the QI Work Plan.

2019 QI Evaluation Summary

- QI Program Structure
  - Components of QI Program and Structure
  - Overall Assessment

- Quality of Clinical Care
  - HEDIS — Performance Highlights

HEDIS Overview

- Key Measures for Medi-Cal:

Measure	Quality Compass Percentiles Met	
	HEDIS 2018	HEDIS 2019
Comprehensive Diabetes Care (HbA1c Testing)*	75th	50th
Comprehensive Diabetes Care (Eye Exam)* (not a MCAS measure)	75th	50th
Cervical Cancer Screening	50th	50th
Breast Cancer Screening	50th	50th
Prenatal and Postpartum Care (Prenatal Care)	50th	50th
Prenatal and Postpartum Care (Postpartum Care)	75th	50th
Well-Child Visits in the First 15 Months of Life	<10th	<10th
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	75th	50th

* *Drop-in rate may be due to change in specification from prior year. NCQA issued guidance to trend this measure with caution.*

HEDIS Overview (cont.)

- Key Measures for OneCare Connect Cal MediConnect Plan (Medicaid-Medicare Plan) (OCC)

Measure	Quality Compass Percentiles Met	
	HEDIS 2018	HEDIS 2019
Breast Cancer Screening	3 Star	2 Star
Plan All-Cause Readmissions (OCC Quality Withhold)	1 Star	2 Star
Antidepressant Medications Management (Acute Phase Treatment)	<=10th	25th
Follow-up After Hospitalization for Mental Illness (OCC Quality Withhold)	<10th	25th
Adults' Access to Preventive/Ambulatory Health Services (age 20–44) +C	<=10th	25th

HEDIS Overview (cont.)

- Key Measures for OneCare (HMO SNP) (OC):

Measure	Quality Compass Percentiles Met	
	HEDIS 2018	HEDIS 2019
Breast Cancer Screening (C01)	2 Star	3 Star
Colorectal Cancer Screening (C02) +C	3 Star	3 Star
Plan All-Cause readmissions — O/E Ratio 65+ (C21) +C	3 Star	2 Star
Adults' Access to Preventive/Ambulatory Health Services (Total) +C	50th	25th

2019 QI Evaluation Summary

- Quality of Clinical Care (cont.)
  - Evaluation of Priority Initiatives
    - Homeless Health Initiative
    - CalOptima Days
    - P4V
  - Evaluation of Interventions for:
    - Comprehensive Diabetes Care (CDC)
    - Prenatal/Postpartum Screenings (PPC)
    - Well-Child Visits 0-15 Months (W15)
    - Preventive Health Screenings (BCS/CCS)
      - Breast Cancer Screening and Cervical Cancer Screening
    - Follow-up After Hospitalization for Mental Illness (FUH)
- Safety of Clinical Care
  - Plan All-Cause Readmissions (PCR)
  - Opioid Utilization

Opioid Utilization Data 2018–2019

CalOptima Medi-Cal Opioid Analgesic Utilization	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	% Change 3Q18 to 3Q19
Opioid Analgesic Rxs	44,697	41,335	38,819	38,585	38,426	**-14.0%**
% Members Utilizing Opioid Analgesic Rxs	1.23%	1.15%	1.10%	1.08%	1.09%	**-11.6%**
Opioid Analgesic Rxs PMPQ	0.0236	0.0222	0.0210	0.0206	0.0208	**-11.5%**
Members Receiving > 80mg Avg MME	793	716	647	638	604	**-23.8%**
% Utilizing Members Receiving > 80mg Avg MME	3.39%	3.34%	3.18%	3.16%	3.01%	**-11.3%**
Average Quantity/Rx for Short-Acting Opioid Analgesics	53.9	54.5	53.7	52.4	51.7	**-4.1%**

Opioid Utilization Data 2018–2019 (cont.)

CalOptima Organization-Wide Opioid Utilization Goals Fiscal Year 18/19	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1
Average Morphine Milligram Equivalent (MME)/Member Goal = 10% Decrease (<17.5)	19.5	18.6	17.9	17.2	15.6
Number of Members Receiving Concomitant Benzodiazepines and Opioid Analgesics Goal = 5% Decrease (<4,295)	4,522	3,880	3,819	3,521	3,251

2019 QI Evaluation Summary (cont.)

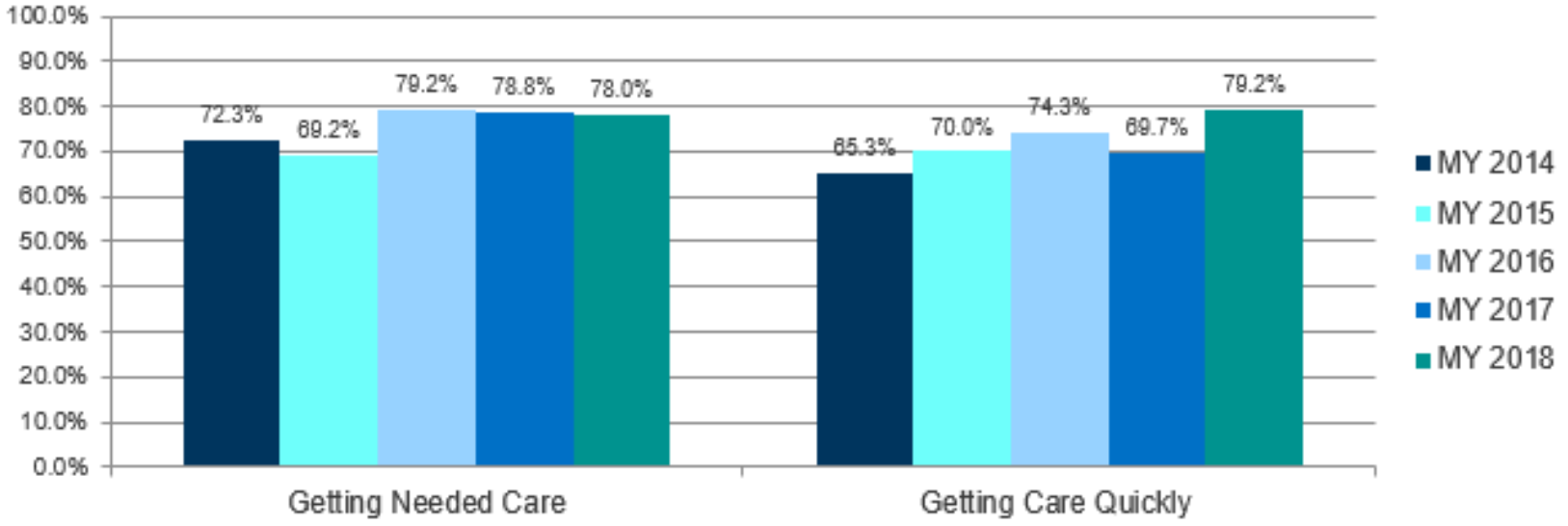
- Safety of Clinical Care (Cont.)
  - Post-Acute Infection Prevention Quality Incentive (PIPQI)
  - Facility Site Review (FSR)
  - Medical Record Review (MRR)
  - Physical Accessibility Review Survey (PARS)

- 2019 Improvement Projects
  - QIPs
  - PIPs
  - CCIPs
  - PDSA Initiatives

2019 QI Evaluation Summary (cont.)

- Quality of Service — Member Experience
  - Medi-Cal CAHPS (Adult and Child)
  - OC CAHPS
  - OCC CAHPS

2019 Medi-Cal Adult CAHPS Survey



National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	78.0%	<25th	<25th	80.53%	83.06%	85.47%	86.84%
Getting Care Quickly	79.2%	<25th	<25th	80.02%	82.34%	85.08%	86.74%

Red = less than 25th percentile

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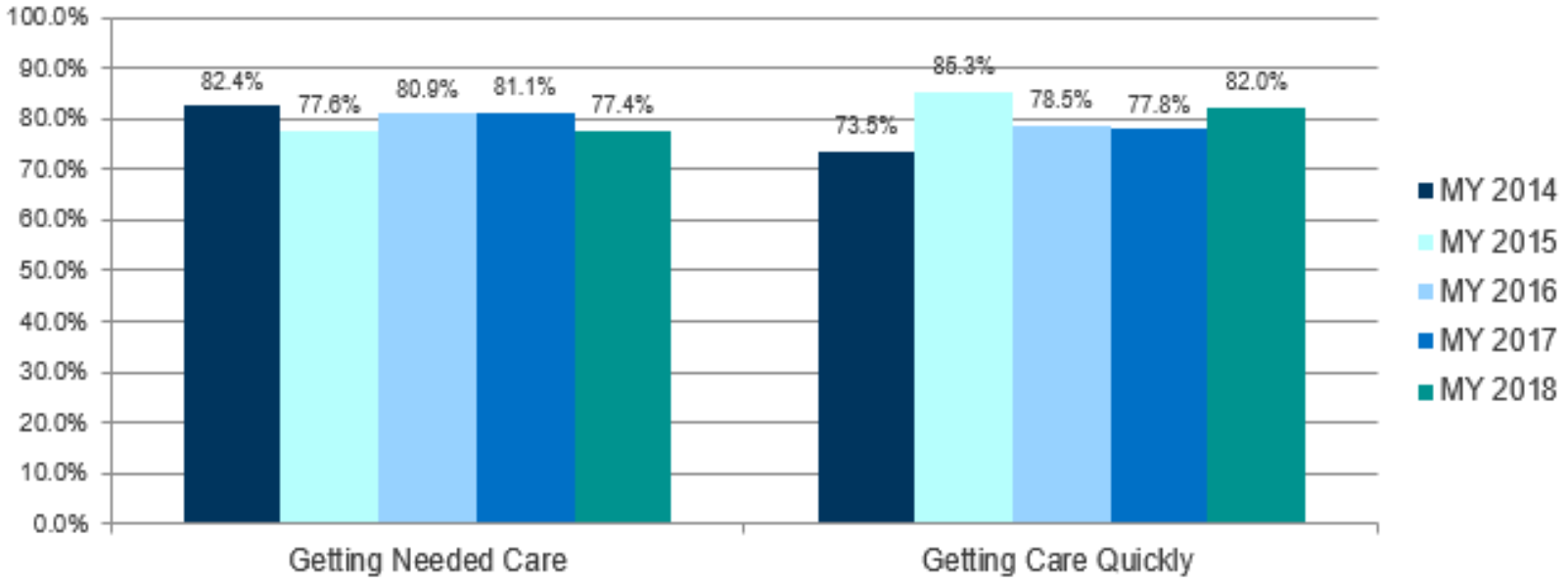
2019 Medi-Cal Child CAHPS Survey



National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	77.4%	<25th	<25th	81.49%	84.85%	88.01%	89.98%
Getting Care Quickly	82.0%	<25th	<25th	87.01%	89.98%	92.43%	94.17%

Red = less than 25th percentile

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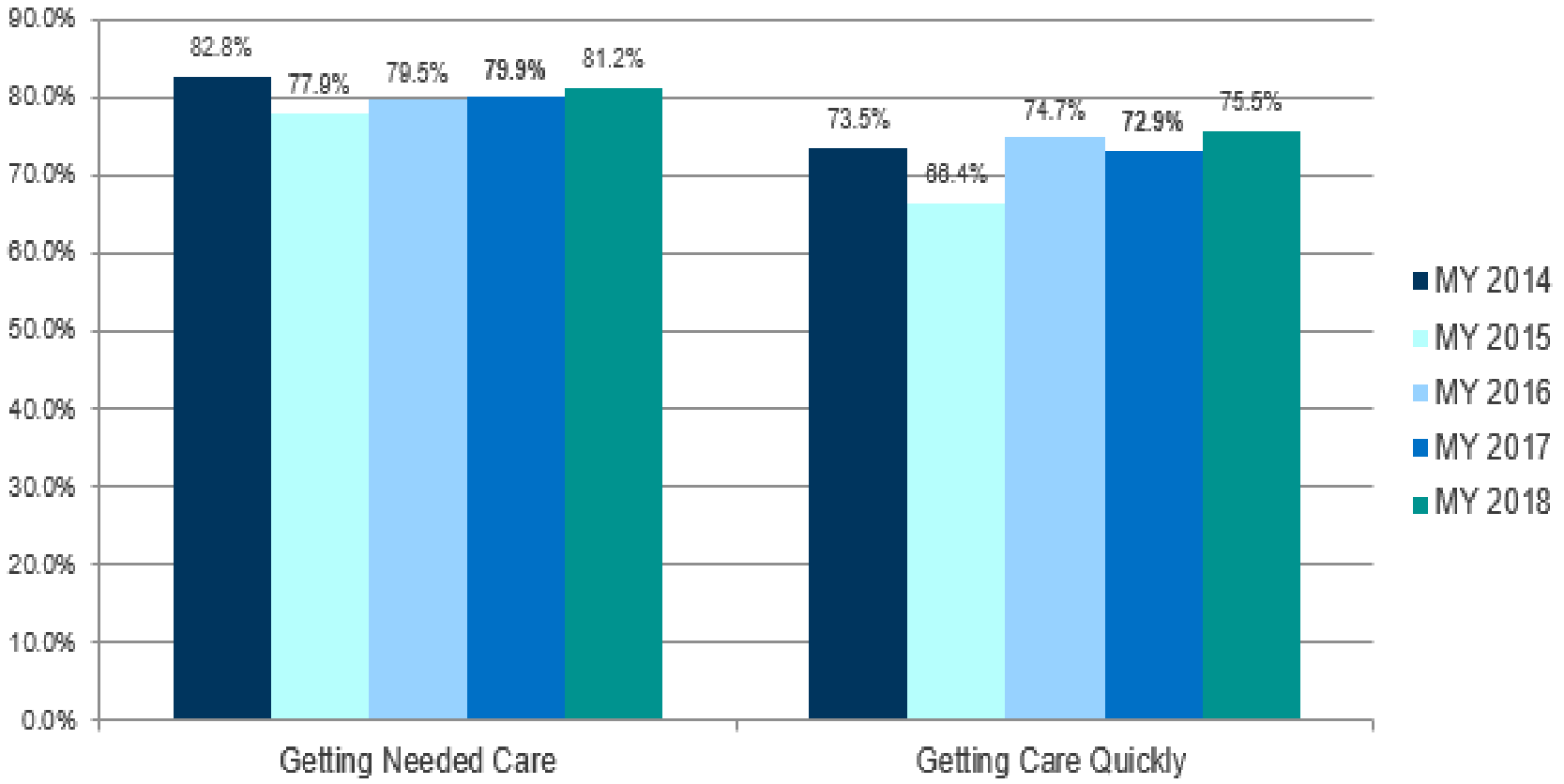
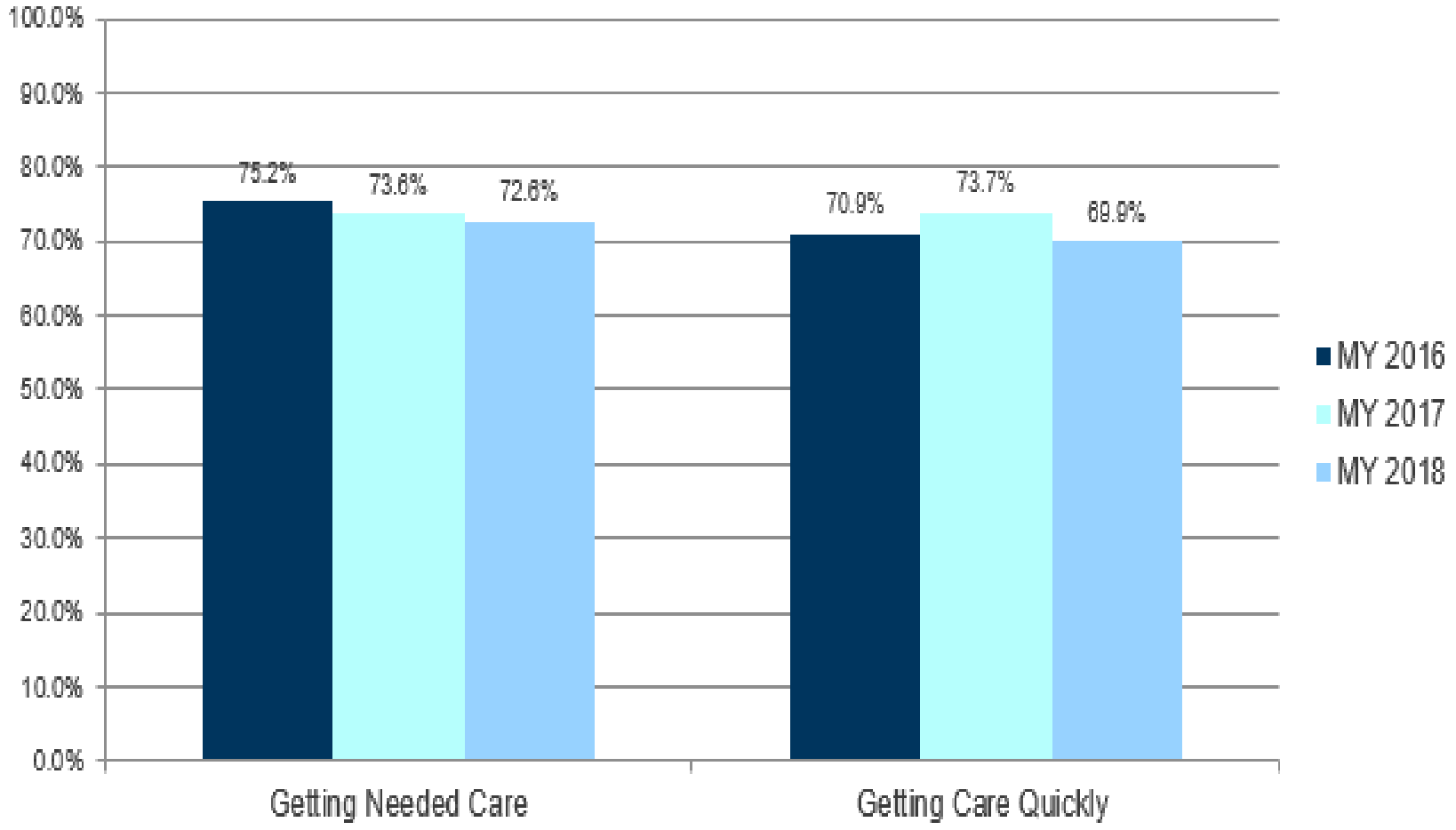
OC CAHPS Survey Results



OCC CAHPS Survey Results



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2019 QI Evaluation Summary (cont.)

- Quality of Service — Access to Care
  - Timely Access Study — Key Findings
    - The only providers that met the goal of 80% were:
      - Follow-up appointments met for BH specialists
      - Non urgent appointments met for Family Medicine and Pediatrics
      - Non urgent appointments met for physical medicine and rehabilitation providers
      - Appointments for regular physicals were met for all PCP types.
    - None of the provider types met the goal for urgent appointment wait times.
    - All provider specialty types did not meet the non-urgent appointment wait times goal. Only one did.
  - Network Adequacy
  - Comparison to Complaints/Appeals

QI Opportunities for 2020

- Maintain “Commendable” accreditation status and meet managed care accountability set (MCAS) measures (minimum performance level) MPL
- Achieve 4.5 for overall NCQA Health Plan rating
- Streamline QI Committee structure
- Perform targeted initiatives to improve performance on clinical HEDIS metrics specifically those MCAS measures at risk to fall below the MPL
- Utilize CalOptima Days for more targeted measures with smaller denominators
- Implement new P4V program with HN rating

QI Opportunities for 2020 (cont.)

- Implement member and provider incentives for specific quality measures, and evaluate effectiveness with HEDIS 2020
- Improve exchange of hospital data through new vendor to revamp Transition of Care program
- Reduce opioid utilization through various planned interventions in 2020
- Develop Quality Measures for PIPQI
- Develop Quality Measures for Whole-Child Model (WCM)
- Implement new DHCS tools and All Plan Letter (APL) for Facility Site Review
- Implement 2020 planned improvement projects

QI Opportunities for 2020 (cont.)

- Improve member experience CAHPS results for access related measures
- Increase appointment access to timely (routine and urgent) primary and specialty care

Questions?

CalOptima's Mission

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

CalOptima

Better. Together.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 19, 2020
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

3. Consider Recommending Board of Directors' Approval of the CalOptima 2020 Quality Improvement Program and 2020 Quality Improvement Work Plan

Contact

Betsy Ha, Executive Director of Quality and Population Health Management 714-246-8400

Recommended Action(s)

Recommend Board of Directors' approval of the recommended revisions to the 2020 Quality Improvement Program and 2020 Quality Improvement Work Plan.

Background

As part of existing regulatory and accreditation mandated oversight processes, CalOptima's Quality Improvement ("QI Program") and Quality Improvement Work Plan ("QI Work Plan") must be reviewed, evaluated and approved annually by the Board of Directors.

The QI Program defines the structure within which quality improvement activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima members. It is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks. The QI Program guides the development and implementation of the annual QI Work Plan.

The QI Work Plan is the operational and functional component of the QI Program and outlines the key activities for the upcoming year. The QI Work Plan provides the detailed objectives, scope, timeline, monitoring, and accountable persons for each activity. Progress against the QI Work Plan is monitoring throughout the year and reported to QI Committee quarterly.

CalOptima staff has updated the 2020 QI Program Description and Work Plan with revisions to ensure that it is aligned to reflect the changes regarding the health networks and strategic organizational changes. This will ensure that all regulatory requirements and National Committee of Quality Assurance (NCQA) accreditation standards are met in a consistent manner across all lines of business.

Discussion

The 2020 QI Program is based on the Board-approved 2019 Quality Improvement Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all programs to ensure they are consistent with regulatory requirements, NCQA standards and CalOptima's strategic initiatives.

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The revisions are summarized as follows:

1. Updated signature page to replace Chief Medical Officer to David Ramirez, M.D.).
2. Updated 2019 to 2020 dates throughout program, including up-to-date demographics on membership
3. Updated Values section to reflect accurate accountability to various committees
4. Updated Strategic Plan to reflect 2020–2022 Strategic Priorities and Objectives
5. Updated What We Offer sections to reflect 2020 scope of services by line of business
6. Updated Program Initiatives section to initiatives for 2020:
    a. Whole Person Care
    b. Health Homes Program
    c. Homeless Health Initiative
    d. Behavioral Health for OC/OCC
7. Updated Role of CalOptima Officers for QI Program to reflect current organizational responsibilities
8. Updated QI Committee structure to streamline practitioner engagement and reporting efforts to the QIC
9. Updated 2020 QI Goals and Objectives:
    a. Increase NCQA Overall Rating from 4.0 to 4.5
    b. Improve Member Experience CAHPS Performance from 25th to 50th percentile focusing on Getting Needed Care and Getting Care Quickly
    c. Improve member access to schedule urgent and routine appointments for PCP's and Specialist
10. Updated QI Program Resources to reflect current organizational structure
11. Updated term for Health Care Delivery Organizations to industry term, Organizational Providers
12. Updated section on Population Health Management area, in line with the PHM strategy. Included reference to statewide efforts to reduce Adverse Childhood Experiences (ACE) in adult Medi-Cal members by promoting awareness
13. Updated Cultural & Linguistic Services section including description and approach for serving diverse membership
14. Updated 2020 Delegation Grid to include NCQA consistent with 2020 NCQA Standards

The recommended changes are designed to better review, analyze, implement and evaluate components of the QI Program and Work Plan. In addition, the changes are necessary to meet the requirements specified by the Centers for Medicare and Medicaid services, California Department of Health Care Services, and NCQA accreditation standards.

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Fiscal Impact

The recommended action to approve the 2020 QI Program and QI Work Plan has no additional fiscal impact for Fiscal Year (FY) 2019-20. To the extent there is any fiscal impact due to increases in Quality Improvement Program resources and incentives from July 1, 2020, through December 31, 2020, Staff will address the impact in separate Board actions or the CalOptima FY 2020-21 Operating Budget.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Proposed 2020 Quality Improvement Program (Redline)
2. Proposed 2020 Quality Improvement Program (Clean)
3. Quality Improvement Work Plan
4. 2020 Delegation Grid
5. PowerPoint Presentation: 2020 Quality Improvement Program and Work Plan

/s/ Michael Schrader *02/12/2020*
Authorized Signature **Date**

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~~2019~~2020

QUALITY IMPROVEMENT PROGRAM

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~~2019~~2020 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

David Ramirez, M.D. Date
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

Paul Yost, M.D. Date

Board of Directors Chair:

_____ _____

Paul Yost, M.D. Date

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members is in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason ~~why~~ CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

Our Values — CalOptima CARES

Collaboration: We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability: We were created by the community, for the community, and are accountable to the community. Committee mMeetings are open to the public are: Our Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, Quality Assurance Committee and Whole-Child Model Family Advisory Committee., Provider Advisory Committee, Investment Advisory Committee, Quality Assurance Committee and Finance and Audit Committee meetings are open to the public.

Respect: We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.
- We speak to our members in their languages.
- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

~~E~~**Excellence:** We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

S~~s~~tewardship: We recognize that public funds are limited, so we use our time, talent and funding wisely~~,~~ and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."
We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, ~~S~~state and ~~F~~federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan
~~CalOptima's 2017–19~~new 2020–2023 ~~Strategic Plan honors our long-standing mission focused on members while recognizing that the future holds some unknowns given possible changes for Medicaid plans serving low-income people through the Affordable Care Act. Still, any future environment will demand attention to the priorities of more innovation and increased value, as well as enhanced partnerships and engagement. Additionally, CalOptima must focus on workforce performance and financial strength as building blocks so we can achieve our strategic goals. Below are the key elements in our Strategic Plan framework.~~

~~Strategic Priorities:~~
~~Innovation: Pursue innovative programs and services to optimize member access to care.~~
~~• Value: Maximize the value of care for members by ensuring quality in a cost-effective way.~~
~~• Partnerships and Engagement: Engage providers and community partners in improving the health status and experience of members.~~
~~•~~
~~Building Blocks:~~
~~Workforce Performance: Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes.~~
~~Financial Strength: Provide effective financial management and planning to ensure long-term financial strength.~~
In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:
- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery

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- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure ~~optional~~ optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input
- Be accountable for the decisions we make.

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. ~~In~~Year 2020 marks CalOptima's 25th year of service to~~For more than 20 years, CalOptima has been serving~~ Orange County's Medi-Cal population ~~for 25 years~~. ~~Due to the implementation of the Affordable Care Act — as more low-income children and adults qualified for Medi-Cal — membership in CalOptima grew by an unprecedented 49% between 2014 and 2016!~~

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

Scope of Services
Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program~~,~~ that went into effect~~ive~~ in ~~7/1/~~2019.

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

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California's Denti-Cal program.

- ~~Eligible conditions under California Children's Services (CCS). Effective July 1, 2019, or such later date as the program becomes effective, this program will be managed by CalOptima through the Whole Child Model (WCM) program.~~

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

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services ~~through CalOptima's member liaisons and~~ through specific Memoranda of Understanding (MOU) with certain community agencies, including Orange County Health Care Agency (OC HCA)~~,~~ and the Regional Center of Orange County (RCOC).~~,~~ ~~CCS (through June 30, 2019, or such later date as the Whole Child Model becomes effective) and the Regional Center of Orange County (RCOC).~~

Medi-Cal Managed Long-Term Services and Supports
Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:
- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)
Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal**.** OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for ~~the~~ dual eligible members~~,~~ enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County~~,~~ and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services
In addition to the comprehensive scope of acute~~,~~ ~~and~~ preventive care~~,~~ and behavioral health services covered under Medi-Cal and Medi-~~C~~care benefits, CalOptima OC members are eligible for enhanced services~~,~~ such as transportation to medical services and gym membership~~s~~.

OneCare Connect

The OneCare Connect ~~is a~~ Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members ~~often~~ frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home~~-~~ and community-based settings.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results i~~s~~n a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services
OCC simplifies and improves health care for low-income seniors and people with disabilities~~.~~, while ensuring timely access to the comprehensive scope of acute, ~~and~~ preventive care~~,~~ and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care, ~~and~~ gym benefits, over-the-counter benefits and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

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

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services
PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dieti~~e~~tians, physical therapists, occupational therapists, home-care staff, activity staff, and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to participants. PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

PROGRAM INITIATIVES

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal ~~2020~~ 2017–2019 ~~s~~Strategic ~~p~~Plan ~~that is effective between January 1 2016 and December 31, 2020~~. In Orange County, the pilot is being led by the OC HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC ~~Connect~~ information sharing platform was launched in November 2018. For ~~2019~~ 2020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. ~~Currently, CCS services are carved out (separated) from most Medi-Cal managed care plans, including CalOptima. In Orange County, OC HCA manages the local CCS program. OC HCA provides case management, eligibility determination, service authorization and direct therapy under the Medical Therapy Program.~~

As of July 1, 2019, t~~T~~hrough SB 586, the ~~S~~state ~~has~~ required CCS services to become a CalOptima Medi-Cal managed care plan benefit ~~in select counties~~. The goal ~~-~~of this transition was~~is~~ to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. ~~This approach is known as the~~ The Whole-Child Model (WCM) ~~was~~ successfully transitioned to CalOptima in 2019 ~~and will continue through 2020~~. ~~,~~ Under this program~~model,~~ in Orange County, medical eligibility determination processes, ~~and~~ the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with OC HCA~~, while other CCS program components are transferred to CalOptima. CalOptima had originally expected to launch WCM effective January 1, 2019, but recently DHCS delayed the WCM implementation in Orange County, and the new implementation date is now no sooner than July 1, 2019.~~

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima plans to implement HHP in the following two phases: ~~July~~ January 1, ~~2019~~ 2020, for members with chronic physical conditions or substance use disorders (SUD), and ~~January~~ July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). ~~Serious Emotional Disturbance (SMI).~~

~~DHCS~~ CalOptima's goal is to target~~ing~~ the highest-risk 3–5~~%~~ percent of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes.

~~DHCS will send a targeted engagement list of members to CalOptima for review and outreach, as appropriate.~~ To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions~~;~~ and
2. Meet specified acuity/complexity criteria~~.~~

Members eligible for HHP must consent to participate and receive HHP services. CalOptima ~~will be the Lead Administrative Entity and~~ is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP ~~health home~~ providers. In addition to CalOptima's Community Network, ~~some~~ all health networks (HN)~~s~~ ~~may~~ will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima ~~is also contracting with a vendor to~~will provide housing related and accompaniment services to further support HHP members.~~-~~ Following implementation, CalOptima will consider opportunities for other entities to participate. ~~provide HHP related services.~~

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years ~~because of increased housing costs and stagnant wages~~. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health~~,~~; health care~~,~~; housing~~,~~ support services; community corrections~~,~~; and ~~housing, benefits and support services~~public social services.~~i~~ The county's WPC~~P~~ program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care –– As part of the Whole Person Care program, services provide post-acute care for up~~date~~ to 90-days ~~stay~~ for homeless CalOptima ~~M~~members.
- Medical Respite Care –– As an extension to the recuperative care program, CalOptima provides additional respite care beyond the 90 days of recuperative care under the Whole Person Care program.
- Clinical Field Teams –– In collaboration with Federally Qualified ~~Community~~ Health Centers (FQHC), Orange County Health Care Agency's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima ~~M~~members.

- Homeless Clinical Access Program —– The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventative care services at Orange County homeless shelters.
- Hospital Discharge Process for Members Experiencing Homelessness —– Support is designedprovided to assist hospitals with the increased cost associated with discharge planning under the new sState Llegislative requirements.
-

Behavioral Health for OC/OCC

CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective 1/1January 1,/2020, OC/OCC behavioral health will be fully integrated within CalOptima internal operations. CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. -Members will be connected to a CalOptima representative for behavioral health assistance.

Population Health Management (PHM)

CalOptima has developed a comprehensive PHM Strategy for 2019. The 2019 PHM Strategy including plan of action for addressing our culturally diverse member needs across the continuum of care based on the National Quality Assurance Committee (NCQA) Population Health Management standards released in July 2018. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The 2019 PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and C&L needs, health disparities, and gaps in services related to these issues.

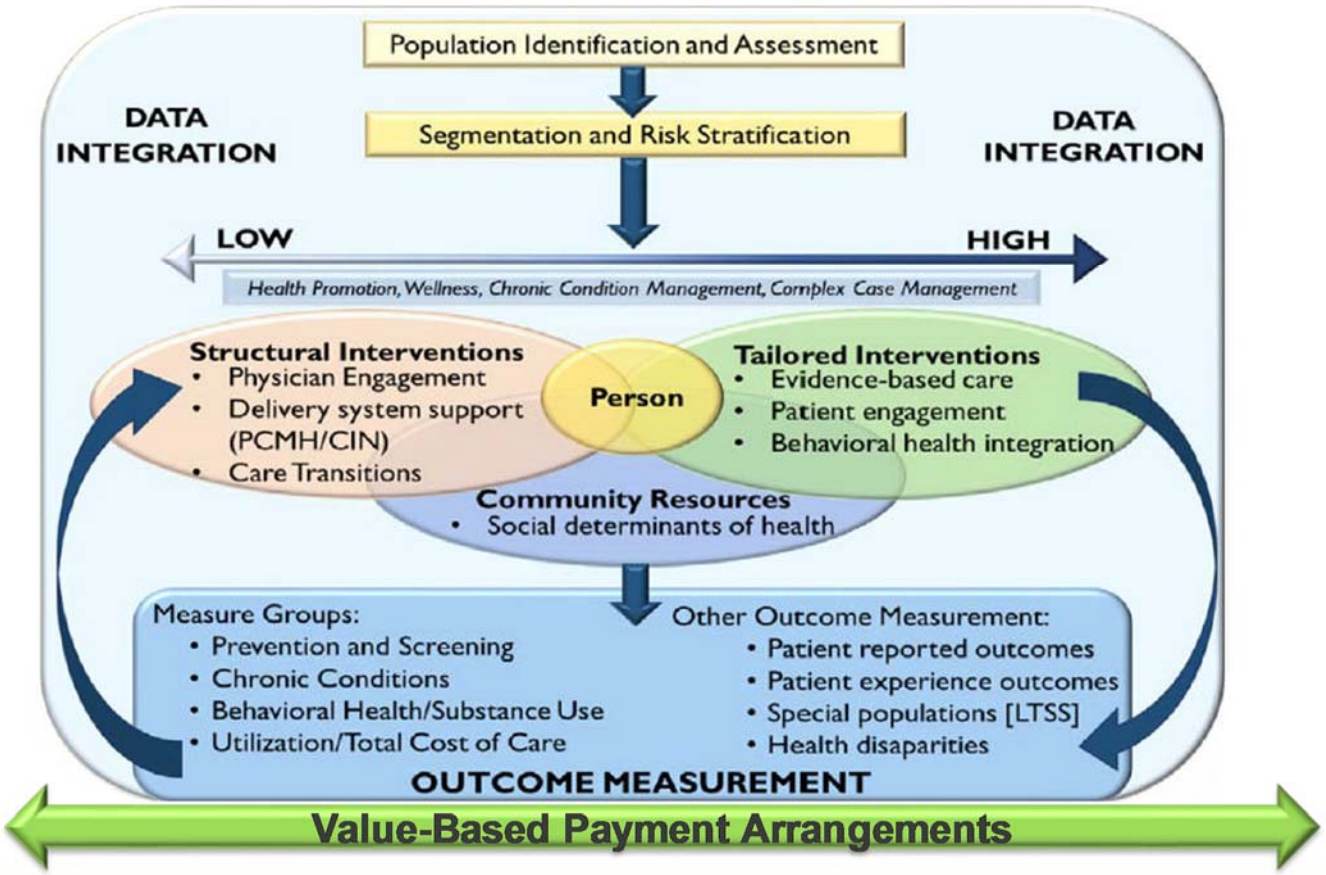
The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual, and environmental stressors, to improve health outcomes. CalOptima will conduct Quality Initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and Member satisfaction. Initiatives that are conducted to improve quality of

~~care and health services delivery to members may include Quality Improvement Projects (QIP), Performance Improvement Projects (PIP) and Chronic Care Improvement Programs (CCIP), which leverage the rapid cycle improvement process (i.e., Plan-Do-Study-Act (PDSA) cycle).~~

~~In the first year, the PHM Strategy will be focused on expanding the Model of Care while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus, with an integrated model as illustrated below in Figure 1. The PHM Conceptual Model is adapted from the model created by the Association of Community Affiliated Plans. CalOptima added the PHM Value Based Payment Arrangement as the foundation to align the future Pay for Value program methodology.~~

~~See Appendix C — 2019 PHM Strategy~~

Figure 1.PHM Conceptual Model



With [1] ~~http://ochmis.org/wp-content/uploads/2019/08/2019-PIT-FINAL-REPORT-7.30.2019.pdf~~

~~WITH~~ WHOM WE WORK ~~WITH~~

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct-Administrative and/or CalOptima Community Network (CCN) and/or contract with a CalOptima Health Network (HN). ~~, and/or participate through CalOptima Direct-Administrative, and/or the CalOptima Community Network.~~ CalOptima members can choose CCN or one of 134 HNs ~~,~~ representing more than 8,4500 practitioners.

~~**Health Networks**~~
~~CalOptima contracts with through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:~~

- ~~Health Maintenance Organizations (HMOs)~~
- ~~Physician/Hospital Consortia (PHCs)~~
- ~~Shared Risk Medical Groups (SRGs)~~

~~Through these HNs, CalOptima members have access to nearly 1,600 Pprimary Ccare Pproviders (PCPs), more than 6,800 specialists, 23 40 hospitals, and 23 35 clinics and 100 long-term care facilities.~~

CalOptima Direct (COD)
CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)
CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members~~,~~ and members residing outside of Orange County. Members enrolled in CalOptima Direct-Administrative are not HN eligible.

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered internally by CalOptima and ~~is the 14th network~~ available for members to select, supplementing the existing HN delivery model and creating additional capacity for growth.

CalOptima Contracted Health Networks
CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

~~Currently,~~ CalOptima contracts with the following 13 Heath Networks:~~Ns for Medi-Cal. CCN is administered internally by CalOptima and is the 14th network available for members to select, supplementing the existing HN delivery model and creating additional capacity for growth.~~

~~The following are CalOptima's contracted HNs:~~

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	SRG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	SRG	HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Medical Group	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

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

- Utilization Management (UM)
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities
-

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2019

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

Membership Data as of November 30, 2018

Total CalOptima Membership
769,216

Program	Members
Medi-Cal	752,888
OneCare Connect	14,610
OneCare (HMO SNP)	1,423
Program of All-Inclusive Care for the Elderly (PACE)	295

Note: The Fiscal Year 2018-19 Membership Data started on July 1, 2018.

Member Age (All Programs)

11%	0 to 5
30%	6 to 18
29%	19 to 44
18%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
28%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

43%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care

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CalOptima
A Public Agency
Better. Together.

Fast Facts: December 2019

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

Membership Data as of October 31, 2019

Total CalOptima Membership
743,465

Program	Members
Medi-Cal*	727,437
OneCare Connect	14,093
OneCare (HMO SNP)	1,567
Program of All-Inclusive Care for the Elderly (PACE)	368

Note: The Fiscal Year 2019-20 Membership Data began on July 1, 2019.
*Includes prior year adjustment

Member Age (All Programs)

11%	0 to 5
29%	6 to 18
29%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
27%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

QUALITY IMPROVEMENT PROGRAM

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

CalOptima ~~has~~ developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and sub-acute care, long-term care~~,~~ and end of life care.~~preventive care, closing gaps in care, care coordination, PHM, complex case management, behavioral health integration, and palliative care.~~ Our comprehensive person-centered approach integrates physical and behavioral health, leverag~~es~~inges the care delivery systems and community partners for our members with vulnerabilities, disabilities and chronic illnesses.

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

Since 2010, the "Triple Aim" has been at the heart of the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage and Prescription Drug Plan (Medicare Parts C and D) quality improvement strategy. The Triple Aim focuses on patient-centered improvements to the health care system including improving the care experience and population health and decreasing the cost of care. The Quadruple Aim adds a fourth element focused on provider satisfaction~~,~~ on the theory that providers who find satisfaction in their work will provide better service to patients. CalOptima's quality strategy embraces the Quadruple Aim as a foundation for its quality improvement strategy.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD-A, as well as our contracted ~~provider~~ health networks. Through the QI Program~~,~~ — and in collaboration with its providers and community partners~~,~~ — ~~-~~CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system to serve our members.

The CalOptima QI Program incorporates continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.
- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.
- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality of care issues to ensure safe patient care and experiences.
- Maintain agency-wide practices that support accreditation by ~~NCQA, and~~NCQA and meet DHCS/CMS quality requirements and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- Sets expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes.
- Supports the provision of a consistent level of high quality of care and service for members throughout the contracted provider networks, as well as monitors utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.
- Provides oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensures certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — OC HCA — which may include, but are not limited to, methicillin resistant *Staphylococcus aureus* (MRSA), scabies, tuberculosis, etc., as reported by the HNs.
- Promotes patient safety and minimizes risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and works with appropriate committees, departments, staff, practitioners, provider medical

groups, and other related ~~health care delivery organizations (HDOs)~~Oorganizational ~~P~~providers (O~~ps~~PS) to assure that steps are taken to resolve and prevent recurrences.
- Educates the workforce and promotes a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Internal and External Oversight departments, the QI Program ensures the following standards or outcomes apply to populations served by CalOptima's contracted HNs, including CCN and/or COD-A ~~N~~network ~~P~~providers, to:

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

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which

oversees the functions of the QI Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

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

The QI Program is based on ongoing systematic collection, integration, and analysis of clinical and administrative data ~~analysis~~ to identify the ~~clinical~~ member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member~~,~~ and promotes health equity among specific population segments, ~~-~~while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with Federal and State regulations, contractual obligations and fiscal parameters.

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

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the Quality Assurance Committee (QAC) to review and make recommendations to the Board regarding accepting the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC ~~shall~~ also makes recommendations for annual modifications of the QI Program and actions to achieve the Institute for Healthcare Improvement's Quadruple Aim moving upstream from the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee
The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventative services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers
- Family support
- Foster children

- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons
- OC HCA
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by OC HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee
The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
  - OC SSA
  - OC Community Resources Agency, Office on Aging
  - OC HCA, Behavioral Health
  - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee
The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent a broad provider community that serves CalOptima members. The PAC is comprised of 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of OC HCA, which maintains a standing seat. PAC meets at least quarterly and ~~The meetings~~ are open to the public. The 15 seats include:

- HN
- Hospitals
- Physicians (3 seats)
- Nurse
- Allied health services
- Community health centers
- OC HCA (1 standing seat)
- LTSS (LTC facilities and CBAS) (2 seats)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee
In 2018~~8~~, CalOptima's Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC), as required by the state as part of California Children's Services (CCS) becoming a Medi-Cal managed care plan benefit. The WCM FAC ~~will~~ provides advice and recommendations to the Board and staff on issues concerning WCM, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima WCM. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: 7 ~~to~~ 9 seats
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
  - CalOptima members age 18–21 who are a current recipient of CCS services; or
  - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: 2 to 4 seats
  - Community-based organizations; or
  - Consumer advocates

Members of the Committee shall serve staggered two-year terms. Of the above seats, five members serve an initial one-year term (after which representatives for those seats will be appointed to a full two-year term), and six will serve an initial two-year term. WCM FAC meets at least quarterly and meetings are open to the public.

Role of CalOptima Officers for Quality Improvement Program

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the State and Federal Contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims

Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) — ~~or physician designee — chairs the QIC~~oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI program ~~, which oversees and provides direction to CalOptima's QI activities,~~ and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

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

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

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met. The medical director is also the chair of the Credentialing Peer Review Committee (CPRC).

Medical Director (~~,~~ Behavioral Health) is the designated behavioral healthcare practitioner in the QI program, and serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC), and CPRC~~redentialing Peer Review Committee~~. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T).

Executive Director, Quality & Population Health Management (ED of Q&PHM) is responsible for facilitating the company-wide QI Program deployment, driving performance results~~improvements~~ in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining ~~commendable~~ accreditation standing as a high performing health plan with NCQA. The ED of Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED of Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. ~~programs throughout the company and makes certain that quality initiatives are aligned with Clinical Operations within Medical Affairs.~~ Reporting to the ED of Q&PHM are the: Director, Quality Analytics; ~~Director,~~ Director, ~~of~~ Quality Improvement~~,~~; Director, ~~of~~ Population Health Management; Director, Behavioral Health Services (Clinical Operations); and Director, ~~of~~ Behavioral Health Integration.~~Quality Improvement.~~

Executive Director, Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including: UM, Care Coordination, Complex Case Management, LTSS and MSSP Services, along with new program

implementation related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO/DCMO and ED of Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, ~~Public Affairs~~Program Implementation (ED of PI~~A~~) ~~serves as the State Liaison; and is responsible for the management, development and implementation of CalOptima's Communication plan, Issues Management and Legislative Advocacy. This position~~is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED of PI: Director, Process Excellence; and Director, ~~ also oversees~~ Strategic Development. ~~and the integration of activities for the Community Relations Program.~~

Executive Director, Compliance (ED of C) is responsible for monitoring and driving interventions so that CalOptima and its ~~HMOs, PHCs, SRGs~~HNs~~,~~ and other FDRs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight departments (external and internal) to refer any potential sustained noncompliance issues or trends encountered during audits of HNs, and other functional areas. The ED of C serves as the State Liaison and is responsible for legislative advocacy. ~~a~~Also, the ED of C oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements.

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

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

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI program and is accountable to the QAC. The QIC assists the CMO in overseeing, maintaining~~,~~ and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated~~,~~ and communicated internally and to the contracted delegated health networks ~~HMOs, PHCs, and SRGs , and MBHOs~~ to achieve the result of improved care and services for members. The QIC oversees the performance of delegated functions by its delegated health networks ~~HMOs, PHCs, and SRGs, and MBHOs~~ and their contracted provider and practitioner partners.

The composition of the QIC includes a participating ~~B~~behavioral ~~H~~health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of

recognized criteria, development of policies and procedures, case review as needed, and identification of opportunities to improve care.

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

Responsibilities of the QI Committee include the following:

- Recommends policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives~~.~~
- Oversees the analysis and evaluation of QI activities~~.~~
- Makes certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI program activities~~.~~
- Identifies and prioritizes needed actions and interventions to improve quality~~.~~
- Makes certain that there is follow~~-~~ up as necessary to determine the effectiveness of quality~~-~~ improvement-related actions and interventions.

Practice patterns of providers, practitioners and~~,~~ ~~HMOs, PHCs, and SRGs, and MBHOs~~ delegated health networks are evaluated, and recommendations are made to promote practices that all members receive medical care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, ~~HMOs, PHCs, and SRGs, and MBHOs~~and delegated health networks.

The QI Program adopts the classic Continuous Quality Improvement cycle with 4 basic steps:

- **Plan** Goals with d~~D~~etailed description of an implementation plan~~and goals~~
- **Do** Implementation of the plan
- **Study** Data and collection
- **Act** Analyze data and develop conclusions

The composition of the QIC is defined in the QIC Charter, and includes, but may not be limited to, the following:

Voting Members

- Four ~~(4)~~ physicians or practitioners, with at least two ~~(2)~~ practicing physicians or practitioners
- County Behavioral Health ~~County~~ Representative
- CalOptima CMO (Chair or Designee)

- CalOptima Medical Directors
- CalOptima BH Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- ~~Executive Director, Quality & Population Health Management~~
- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six ~~(6)~~ voting members of which at least four ~~(4)~~ are physicians or practitioners. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

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

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

Minutes of the Quality Improvement Committee and Subcommittees

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

Minutes of the QIC meeting include, but are not limited to:

- Goals and objectives outlined in the QI Charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of work plan activities

All agendas, minutes, reports~~,~~ and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only ~~not reproduced~~ for committee approval. ~~All other quality documentation is not reproduced in order to (except for Quality Profile documentation) in order to maintain confidentiality, privilege and protection.~~

Credentialing Peer Review Committee (CPRC)
The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process~~,~~ ; and determines corrective actions as necessary to ensure that all practitioners and providers ~~that~~ who serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC reviews, investigates~~,~~ and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee~~internal CalOptima medical staff for membership, and~~ maintains a continuing review of the qualifications and performance of all practitioners every three years.~~external medical staff.~~ In addition, the CPRC reviews and monitors sentinel events, quality of care issues~~,~~ and identified ~~services~~ trends across the entire continuum of CalOptima's contracted providers~~:~~ — ~~HMOs, PHCs, SRGs~~delegated health networks~~,~~ and ~~health care delivery organizations~~OPs to ensure patient safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

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

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

The UMC monitors the utilization of ~~physical health~~medi~~d~~cal,~~health care~~, behavioral health and Long-Term Services and Support (LTSS) services ~~by CalOptima Direct~~for the CalOptima Care Network (CCN) and through the delegated ~~HMOs, PHCs, and SRGs, and MBHOs~~health networks to identify areas of under or over-utilization that may adversely impact member care. The UMC oversees Inter-R~~r~~ater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of e~~E~~vidence-b~~B~~ased c~~C~~linical p~~P~~ractice g~~G~~uidelines, and completes an annual review and updates ~~updates approves~~ the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a

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~~B~~behavioral ~~H~~health practitioner*) and the quorum requirements of the UMC are defined in its charter.

** Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.*

Pharmacy & Therapeutics Committee (P&T)
The P&T committee is a forum for an evidence-based formulary review process. The P&T committee promotes clinically sound and cost-effective pharmaceutical care for all CalOptima members, and reviews anticipated and actual drug utilization trends, parameters~~,~~ and results ~~on the basis of~~based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T committee includes practicing physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T committee provides written decisions regarding all formulary development decisions and revisions. The P&T committee meets at least quarterly, and reports to the UMC. The voting member composition and quorum requirements of the P&T committee are defined in its charter.

Benefit Management Subcommittee (BMSC)
The purpose of the BMSC is to oversee, coordinate, and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its program lines of business benefits, prior authorization~~,~~ and financial responsibility requirements for the administration of benefits. The subcommittee reports to the UMC~~, and also~~and ensures that benefit updates are implemented~~,~~ and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs, and SRGs~~, and MBHOs~~. The Regulatory Affairs department provides technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

~~**Long-Term Services and Supports QI Subcommittee (LTSS-QISC)**~~
~~The LTSS subcommittee is composed of representatives from the LTC, CBAS, and MSSP communities, which may include administrators, directors of nursing, facility Medical Directors, and pharmacy consultants, along with appropriate CalOptima staff. LTSS subcommittee members serve as specialists to assist CalOptima in the development, implementation, and evaluation of criteria and methodologies to measure and report quality and access standards with HCBS and in LTC facilities where CalOptima members reside. The LTSS subcommittee also serves to identify best practices, monitor over and underutilization patterns, and partner with facilities to share the information as it is identified. The LTSS subcommittee meets quarterly and reports through the Clinical Operations subcommittee, and through the QIC. The voting member composition and quorum requirements of the LTSS-QISC are defined in its charter.~~

~~**Behavioral Health Quality Improvement Committee (BHQIC)**~~
~~The BHQIC ensures members receive timely and satisfactory behavioral health care services, through enhancing integration and coordination between physical health and behavioral health care providers, monitoring key areas of services to members and providers, identifying areas of improvement, and guiding CalOptima towards the vision of bi-directional behavioral health care~~

~~integration. The designated chairman of the BHQIC is the Medical Director, Behavioral Health, who is responsible for chairing the committee and reporting through the QIC. The BHQIC meets, at a minimum, on a quarterly basis, or more often as needed. The voting member composition and quorum requirements of the BHQIC are defined in its charter.~~

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-011. The WCM CAC ~~will~~ advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuringe they are integrated into the design, implementation, operation~~,~~ and evaluation of the CalOptima WCM program in collaboration with county CCS, the WCM Family Advisory Committee~~,~~ and HN CCS providers. The WCM CAC meets ~~4~~four times a year and reports to the QIC. -The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee ~~Subcommittee~~ (MEMX)
Improving member experience is a top priority of CalOptima. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC~~,~~ and OCC. NCQA's Health Insurance Plan Ratings ~~Medicaid Plan Ratings~~ measure three dimensions ~~—~~ ~~—~~ ~~P~~prevention, ~~T~~treatment and c~~C~~ustomer ~~S~~satisfaction. ~~CalOptima's QI Program focuses on the performance in each of these areas.~~ The MEMX committee is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network, including access and availability (CCN and 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. In 2020~~2019~~, the MEMX committee, which includes the Access ~~&~~and Availability workgroup, will ~~be~~ continue to meet at least bi-monthly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the 2020 and 2021 CAHPS survey results. ~~This subcommittee meets at least bi-monthly and is reported through the QIC. The voting member composition and quorum requirements of the MEMX are defined in its charter.~~

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

Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC)
The PQIC committee provides oversight for the overall administrative and clinical operations of CalOptima PACE. The PQIC assures compliance to all state and federal regulatory bodies. The PQIC may create new ad-hoc committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. The PQIC meets, at a minimum, quarterly and is chaired by the PACE Medical Director. A summary of the PQIC meetings are submitted to the CalOptima Quality Improvement Committee (QIC) which are then included in the QIC summary submitted to the CalOptima Board of Directors Quality Assurance Committee (QAC). Annually, the PQIC will assess all PACE quality improvement initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. Potential areas for improvement will be identified through analysis of the data and through root cause analysis.

~~**Whole-Child Model Clinical Advisory Committee (WCM CAC)**~~
~~The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-011. The WCM CAC will advise on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensure they are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with county~~

~~CCS, the WCM Family Advisory Committee, and HN CCS providers. The WCM CAC meets 4 times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.~~

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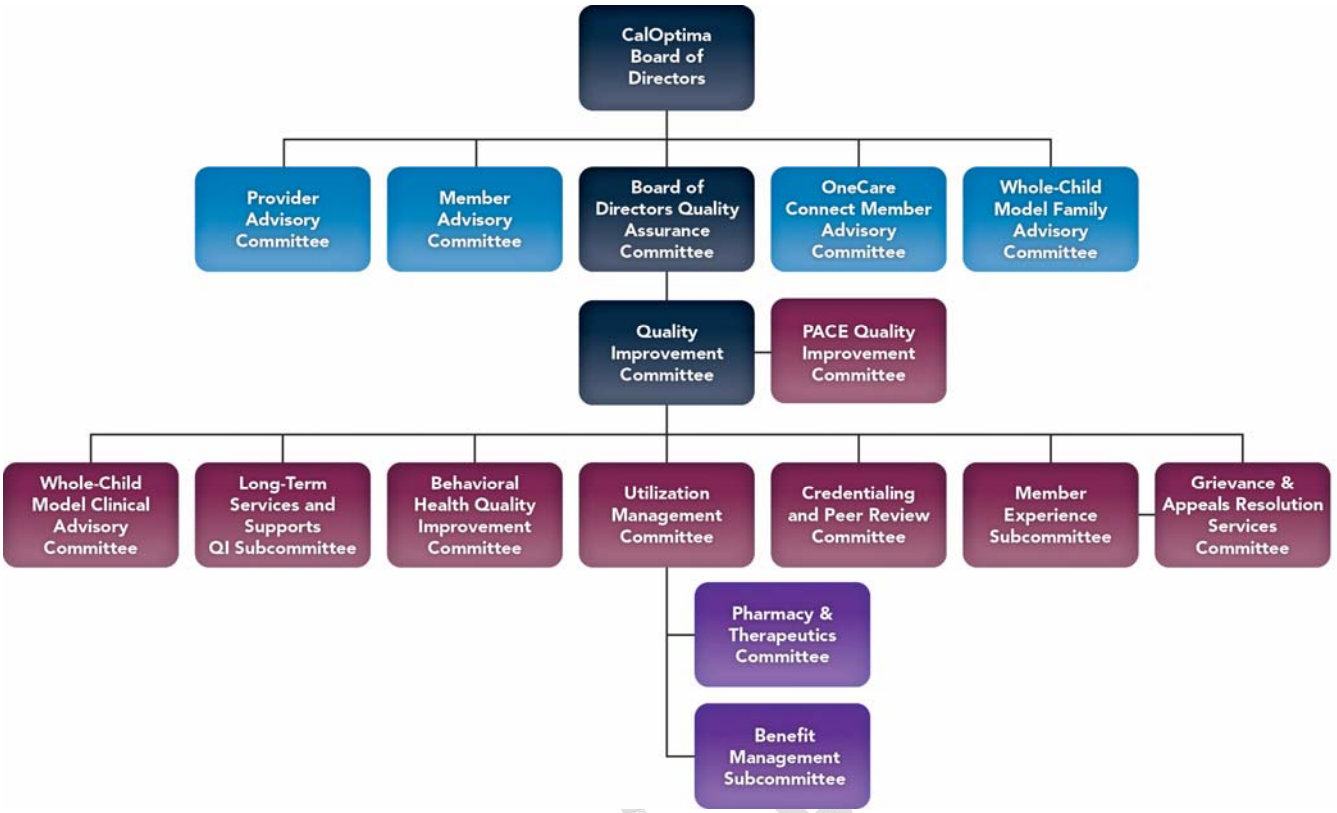
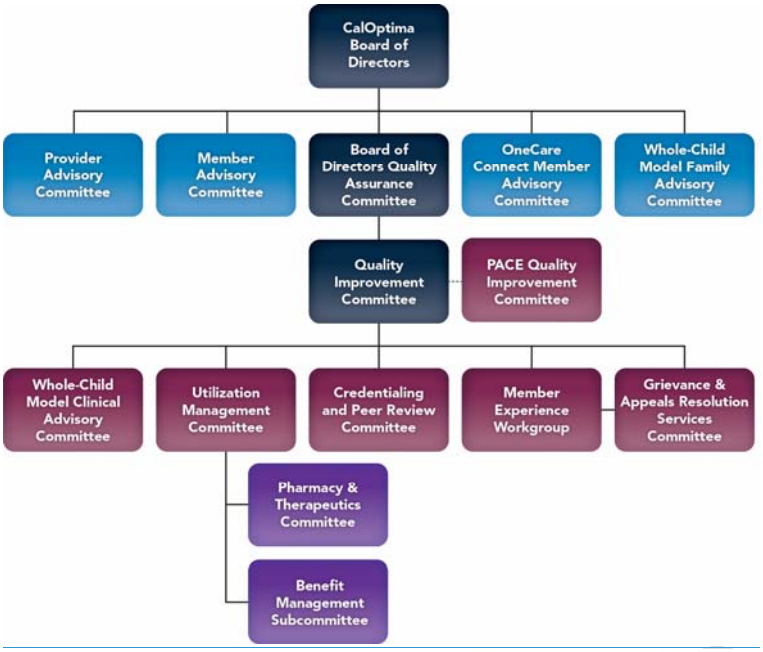
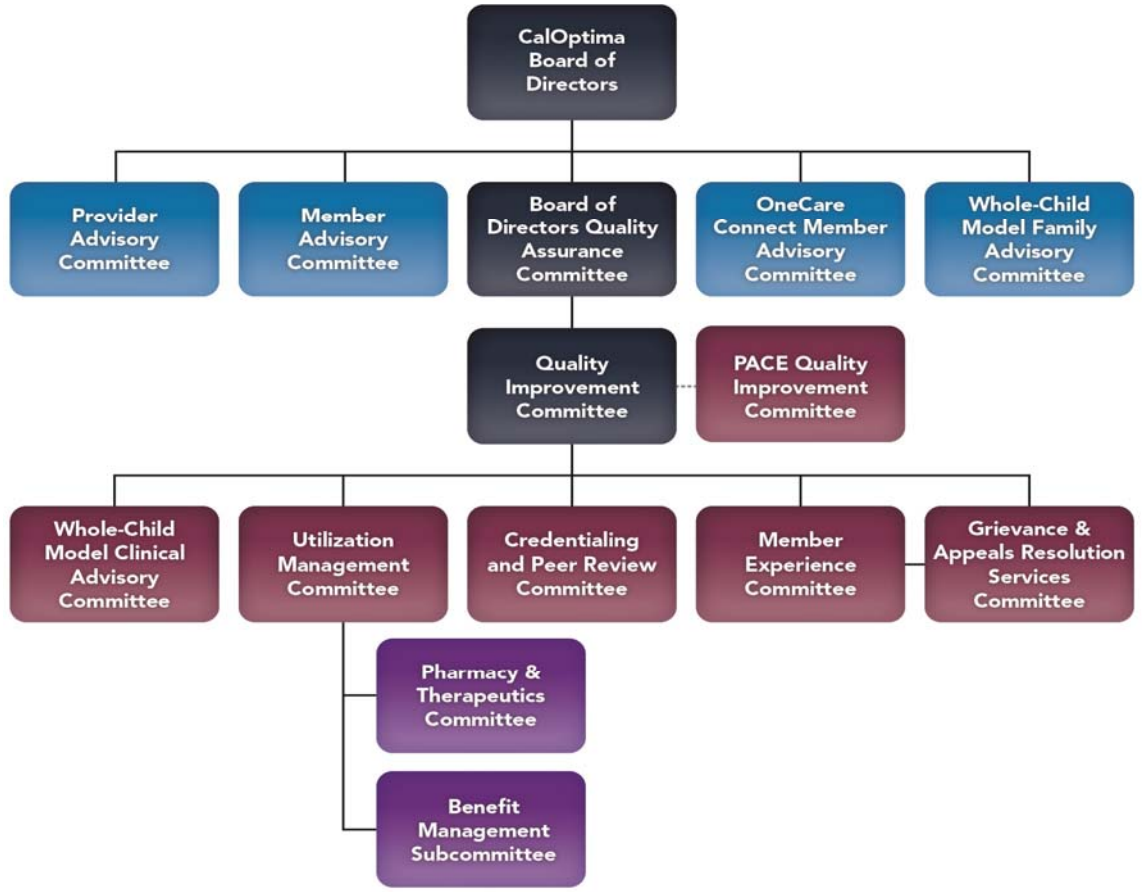
~~2019~~2020 Committee Organization Structure — Diagram







Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information —

sign a written statement delineating responsibility for maintaining confidentiality. In addition, all ~~C~~committee members of each entity are required to sign a ~~C~~confidentiality ~~A~~agreement on an annual basis. Invited guests must sign a ~~C~~confidentiality ~~A~~agreement at the time of ~~C~~committee attendance.

All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The ~~HMOs, PHCs, and SRGs~~delegated networks ~~and MBHOs~~ hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a c~~C~~onfidentiality a~~A~~greement. This a~~A~~greement requires the member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the ~~S~~state ~~C~~contract.

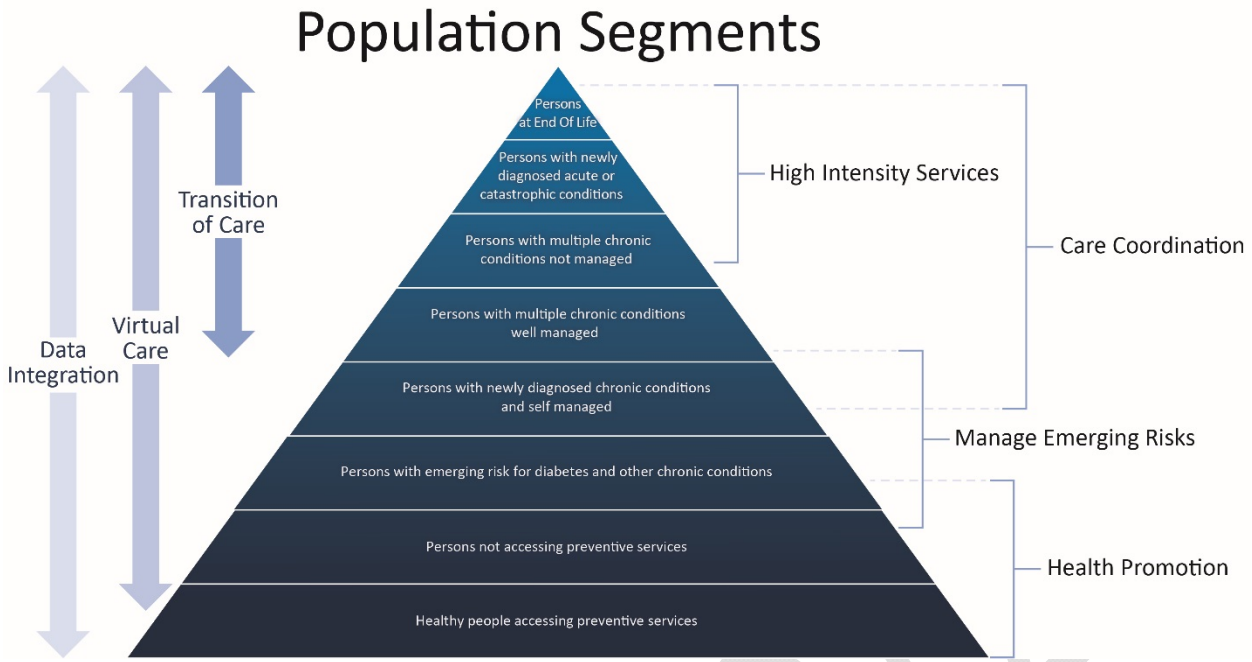
Conflict of Interest

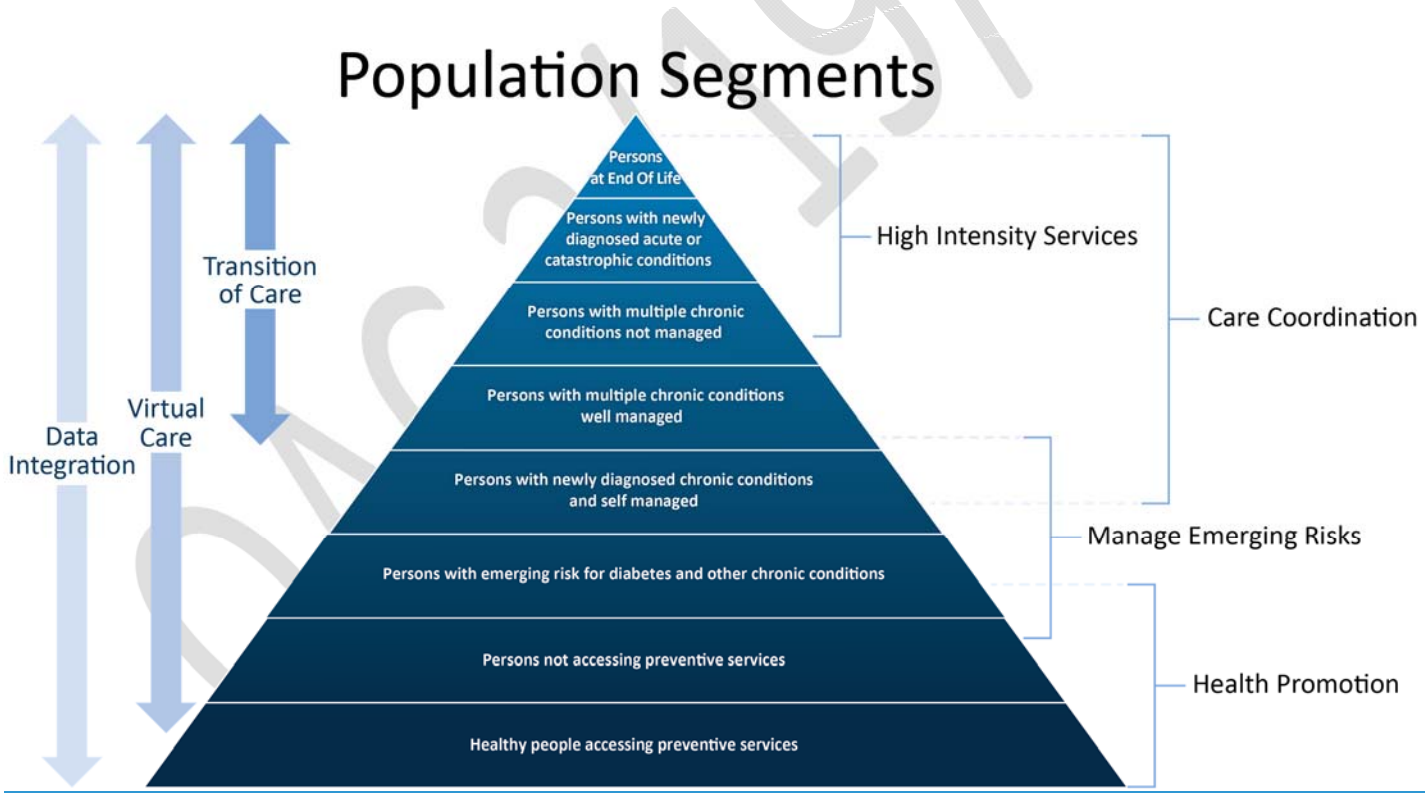
CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and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

QUALITY IMPROVEMENT STRATEGIC GOALS

The QI Program supports a Population Health Management (PHM) approach, stratifying our population based on their health needs, conditions~~,~~ and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care (MOC), the ~~2019~~2020 QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.

~~The Population Segments and Homeless Population Segments with an integrated intervention hierarchy, is are shown below:~~





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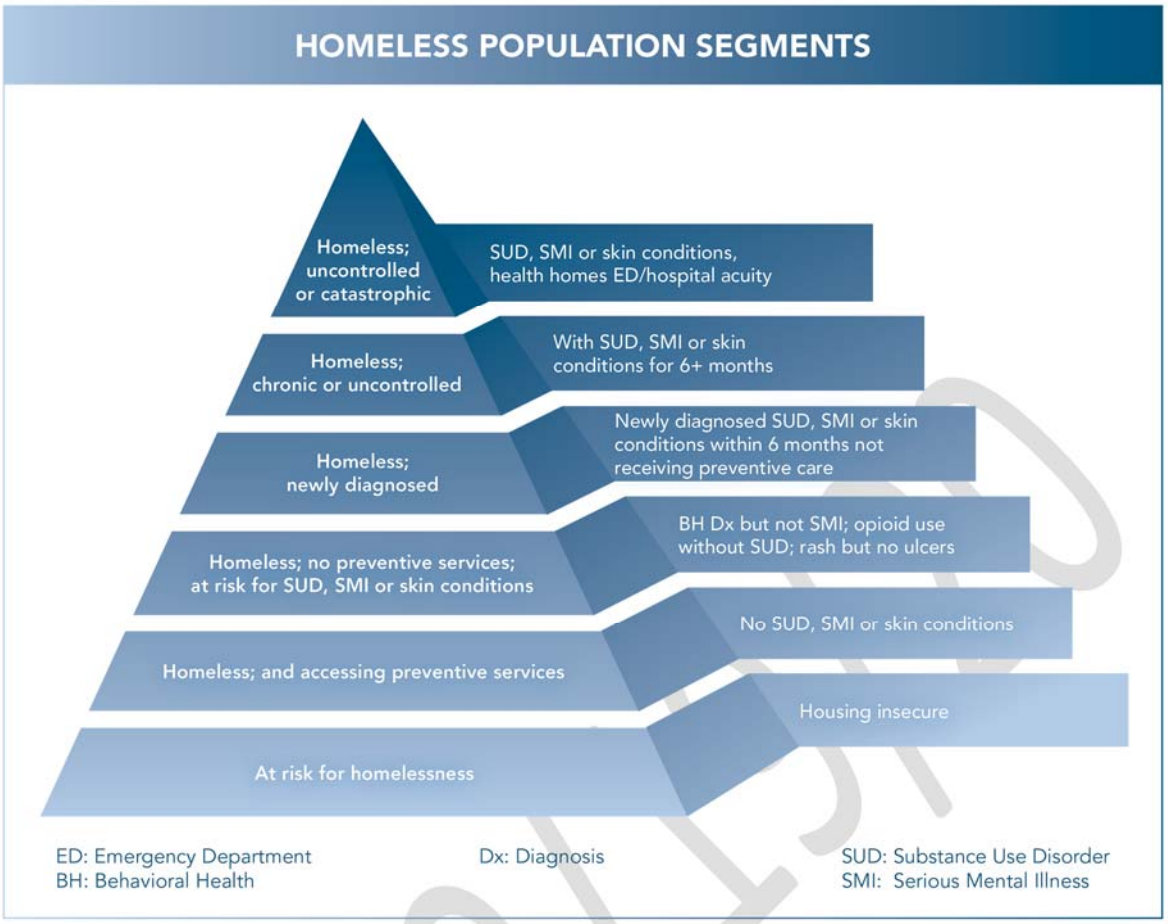

CalOptima's ~~Model of Care (~~MOC~~)~~ recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists~~,~~ and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is very effective in managing the health care needs of ~~the~~ high-risk members one-by-one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

~~2019~~2020 QI Goals and Objectives

CalOptima's QI Goals and objectives are aligned with CalOptima's 2020–2021 ~~2017–2019~~ strategic goals.

1. ~~Goal:~~ Increase~~Achieve~~ NCQA overall rating ~~of~~ from 4.0 to 4.5~~.~~ ~~as the #1 Medi-Cal Health Plan in California by:~~

~~1.1. Improving NCQA ratings in Member Experience from 1.5 to 3.0~~
~~1.2. Improving NCQA ratings in Treatment from 3.5 to 4.0~~

~~2. Goal: Improve overall Health Networks, including CCN, quality performance rankings by:~~

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~~2.1. Implementing practice transformation technical assistance in 5 high volume CCN practices by December 2019.~~2020

~~2.2. Expanding provider coaching and customer services training to include all health networks and all PQI providers and office staff in CCN by December 2019~~2020~~.~~

2. ~~Goal:~~ Improve Member Experience CAHPS performance from 25th to 50th percentile, focusing on Getting Needed Care and Getting Care Quickly~~from 25th percentile to exceed 50th percentile~~

~~**3.** thththth by:~~

~~3.1. Increasing the number of providers who have a high rate of grievances and PQIs who will participate in provider coaching and customer services training by December 2019.~~2020

~~3.2. Expanding provider coaching and customer services training to all health networks providers and office staff on the PQI list by December 2019.~~2020

3. Improve member's ability to access primary and specialty care timely, for urgent and routine appointments, from 2019 baseline to goal of 80% ~~.~~

Detailed strategies for achieving ~~2019~~2020 Goals and Objectives are measured and monitored in the QI Work Plan, reported to QIC quarterly~~,~~ and evaluated annually.

QI Measurable Goals for the Model of Care

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

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of Social Determinants of Health (SDOC)
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services~~,pbhcmo~~
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

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

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and CalOptima's Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. A ~~QI Work Plan~~

~~addenda~~QI Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

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

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

- Quality of ~~C~~clinical ~~C~~care
- Safety of ~~C~~clinical ~~C~~care
- Quality of ~~S~~service
- Member ~~E~~experience
- ~~Compliance~~
- QI Program ~~O~~oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program

Priorities for QI activities based on ~~the specific needs of~~ CalOptima's organizational needs and specific needs of Cal-Optima's populations for key areas or issues identified as opportunities for improvement. In addition, o~~O~~ngoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified.

- These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are ~~and~~ reflected in the QI Work Plan.
- ~~Priorities for QI activities based on the specific needs of CalOptima's populations, and on areas identified as key opportunities for improvement~~
- ~~Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified~~

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

See Appendix A — ~~2019~~2020 QI Work Plan

Methodology

QI Project Selections and Focus Areas

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

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to, (a) potential quality ~~concern~~ issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) ~~satisfaction~~ member experience surveys, (f) HEDIS results, and (g) other opportunities for improvement as identified by subcommittee's data analysis~~.~~
- Measures required by regulators such as DHCS and CMS~~.~~

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

- Access to and availability of services, including appointment availability~~, as described in the UM Program and in policy and procedure~~
- Coordination and continuity of care for SPD
- Provisions of chronic, complex case management and case management services
- Access to and provision of preventive services

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

- Staff, administration, and physicians provide vital information necessary to support continuous performance improvement, and is occurring at all levels of the organization
- Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
- Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes
- Project coordination occurs through the various leadership structures: Board of Directors, Management, QIC, UMC, etc., based upon the scope of work and impact of the effort
- These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

QI Project Quality measures

Quality measures may be process measures (lead quality measures) or outcome measures (lag quality measures) where there is strong clinical evidence of the correlation between the process and member outcomes. This evidence and the rationale for selection of the lead quality measure must be cited in the project description, when appropriate.

Each QI Project will have at least one (and frequently more) lead measure(s) that are actionable in real time. The selected lead measures should be levers, drivers, or predictors of the desired outcome measures or lag quality measure such as HEDIS and STARS measures. While at least one lead measure must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Since quality measures will measure changes in health status, functional status, member satisfaction, and provider/staff, ~~HMO, PHC, and SRG, and MBHO~~delegated HNs, or system performance, quality measures will be clearly defined and objectively measurable.

QI Project Measurement Methodology

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

For outcomes studies or measures that require data from sources other than administrative data (e.g. medical records), sample sizes will be a minimum of 411 (with 5 to 10% percent over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30 or 100 %percent of the sample size when sample target population is less than 30, can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies dependent on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

Communication of QI Activities

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QI work plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Quality Assurance Committee of the Board of Directors, and/or the QAC, through the CMO or designee, on a quarterly basis. QIC participants are responsible for communicating pertinent, non-confidential QI issues to all members of CalOptima staff. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- HN Forums, Medical Directors meetings, Quality Forum and other ongoing ad-hoc meetings

- Annual synopsized QI report ~~(both web-site and hardcopy availability for both practitioners and members) shall be~~ posted on CalOptima's website (both web-site and hardcopy are available for both practitioners and members)~~., in addition to the annual article in both practitioner and member newsletter.~~ The information includes a QI Program Executive Summary ~~or outline~~and ~~of~~ highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service. Notification on how to obtain a paper~~paper~~ copy of QI Program information is posted on the web, and is made available upon request
- MAC, OCC MAC, WCM FAC and PAC.

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, IS resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

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

In addition to CalOptima CMO and ED of Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management (QM) functions ~~I department~~, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED of Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

- The following positions report to the Director, Quality Improvement:
  - Manager, Quality Improvement
  - Supervisor, Quality Improvement (PQI)
  - ~~Supervisor, Quality Improvement (Credentialing)~~
  - Supervisor, Quality Improvement, and Master Trainer (FSR)
  - Supervisor, Credentialing
  - ~~QI Program Specialists~~
  - QI Nurse Specialists
  - ~~o~~
  - Program Policy Analyst ~~and Data Analyst~~
  - Credentialing Coordinators
  - Program Specialists
  - Program Assistants
  - Outreach Specialists
  -

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing and coordinating QI activities and projects, aligned with the

QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

- The following positions report to the Director, Quality Analytics:
  - Quality Analytics HEDIS Manager
  - Quality Analytics Pay for Value Manager
  - Quality Analytics ~~QI Initiatives~~ Network Adequacy Manager
  - Quality Analytics Analysts
  - Quality Analytics Project Managers
  - Quality Analytics Program Coordinators
  - Quality Analytics Program Specialists

Director, Population Health Management
Provides direction for program development and implementation for agency-wide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to ~~health and~~ health care with Case Management, UM, Pharmacy and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

- The following positions report to the Director, Population Health Management:
  - Population Health Management Manager (Program Design)
  - Population Health Management Manager (Operations)
  - Population Health Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Population Health Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dieticians
  - Data Analyst
  - Program Manager
  - Program Specialists
  - Program Assistant

Director, Behavioral Health ~~Services~~ (~~Integration~~) provides program development and leadership to the implementation, expansion, and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. ~~operational oversight for behavioral health benefits and services provided to members.~~ The director is responsible for the management and strategic direction of the Behavioral Health Integration Department efforts in integrated care, quality initiatives, and community partnerships. ~~monitoring, analyzing, and reporting on changes in the health care delivery environment and identifying program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services.~~ The Director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Services (Clinical Operation) provides operational oversights of the Behavioral Health Integration Dd~~d~~epartment clinical services. ~~-~~The Director leads a team that provides behavioral health telephonic clinical triage, care coordination~~,~~ and utilization management for members in all lines of business.

In addition to the direct QI resources described above, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our members' health status.

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

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

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

Director, Long-Term Services and Supports is responsible for LTSS programs, which include CBAS, LTC, and MSSP. The position supports a "Member-Centric" approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures, and processes related to LTSS program operations and quality measures.

Director, Enterprise Analytics provides leadership across CalOptima in the development and distribution of analytical capabilities. The director drives the development of the strategy and roadmap for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the roadmap. Working with departments that supply data, the team is responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the enterprise analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

Staff Orientation, Training and Education

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

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

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable department program training, policies ~~&~~ and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency and Trauma~~-~~-Informed Care training
- QI Lean training curriculum ~~will be~~ (added to CalOptima University in 2019)
-

MOC-related employees, contracted providers and practitioner networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

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

~~***MOC-related employees, contracted providers and practitioner networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.***~~

Annual Program Evaluation

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

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement~~.~~
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization~~.~~
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions~~.~~
- An evaluation of ~~each~~ QI a~~A~~ctivities~~y~~, including QIPs, PIPs, PDSAs, and CCIPs. ~~QI Projects (QIPs), Programs (s~~

- ~~with any area showing improvements in care or service as a result of QI activities receiving continued interventions to sustain improvement.~~
- An evaluation of member satisfaction surveys and initiatives.
- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends.
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process.
- Recommended changes included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors review and approval.

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

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

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

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

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

- Clinical ~~C~~care and ~~S~~service
- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care and treatment of acute and chronic conditions
- Complex ~~C~~case ~~M~~management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management departments, which details this process in its UM/CM Program and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/under-utilization
- Disease management

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities

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- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

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

QUALITY IMPROVEMENT

The QI department is responsible for ~~the execution and coordination of quality assurance and improvement activities. It also supports the specific focus of~~ monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

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

Peer Review Process f~~F~~or Potential Quality Issues

Peer Review is coordinated through the QI department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors, and trends PQI cases, in order to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and

tracking and trending of service and access issues are reported to the CPRC and are also reviewed at the time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or GARS.

Comprehensive Credentialing Program Standards

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

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to: non-physician behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and re-credentialing activities for CCN are performed at CalOptima, and ~~also~~ delegated to ~~Health Networks~~HNs and other sub-delegates for their providers.~~are delegated to the HNs and performed by CalOptima for CCN.~~

~~Health Care Delivery Organizations~~Organizational Providers
CalOptima performs credentialing and re-credentialing of ~~Health Care Delivery Organizations (HDOs), also known as O~~organizational ~~P~~providers (OPs) ~~for providers~~ such as, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies.

Use of QI Activities in the Re-credentialing Process
Findings from QI activities and other performance monitoring are included in the re-credentialing process.

Monitoring for Sanctions and Complaints
CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, State or Federal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns and member complaints between re-credentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate ~~P~~primary ~~C~~care ~~P~~practitioner (PCP) site and medical records review to its contracted HMOs, PHCs~~,~~ and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by Medi-Cal Managed

Care Division (MMCD) Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates fFacility Ssite Rreview (FSR) and Mmedical Rrecord Rreview (MRR) for the non-delegated HNs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs.

Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full-scope site review performed by another health plan in the lpast three years, in accordance with MMCD Policy Letter 14-004 and CalOptima policies. Medical records of new providers shall be reviewed within ninety 90 calendar days of the date on whichthat members are first assigned to the provider. An additional extension of ninety 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)
CalOptima conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

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

Medical Record Documentation Standards
CalOptima requires that its contracted HMOs, PHCs, and SRGsdelegated HNs make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.

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

The medical record should be protected to ensure that medical information is released only in accordance with applicable Federal and State law.

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

When monitoring by either CalOptima's QI department, or Audit & Oversight department or other functional areas identifiessd as an opportunity for improvement, the delegated orappropriate functional areas will determine the appropriate action(s) to be taken to correct the

problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the QI department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools (i.e., quality improvement plans or Plan-Do-Study-Act) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a mMedical Ddirector.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- Prescribed continuing education or office training
- De-delegation
- De-Ccredentialing
- Contract termination
-

Performance Improvement Evaluation Criteria for Effectiveness

The effectiveness of actions taken, and documentation of improvements made are reviewed through the monitoring and evaluation process. Additional analysis and action will be required when the desired state of performance is not achieved. Analysis will include use of the statistical control process, use of comparative data, and benchmarking when appropriate.

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

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

- Report, monitor and trend outcomes.
- Drive solutions and interventions to improve quality of care, access to preventive care, and management of chronic conditions to clinical guidelines.
- Support efforts to improve internal and external customer satisfaction.
- Improve organizational quality improvement functions and processes to both internal and external customers.
- Collect clear, accurate and appropriate data used to analyze problems performance of specific quality metrics and measure improvement.
- Coordinate and communicate organizational, health networkHN- and provider specific performance on quality metrics, as requiredinformation, both division and department specific, and agency-wide.

- Participate in various reviews through the QI Program such as, but not limited to, ~~the All Cause Readmission monitoring,~~ network adequacy, access to care, and availability of practitioners ~~and other reviews.~~
- Facilitate satisfaction surveys for members and practitioners.
- Provide agency-wide oversight of monitoring activities that are:

Balanced:	Measures clinical quality of care and customer service
Comprehensive:	Monitors all aspects of the delivery system
Positive:	Provides incentive to continuously improve

In addition to working directly with the contracted HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case Management reports
- Pharmacy data
- Lab data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Population Needs Assessment~~Group Needs Assessments~~
- Results of ~~R~~risk s~~S~~tratification
- HEDIS p~~P~~erformance
- Member and ~~P~~provider satisfaction surveys
- QIPs, PIPs, PDSAs, and CCIPs
  - ~~QI Projects: Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement CCIP)~~
  - ~~Health Risk Assessment (HRA) data~~

By analyzing data that CalOptima currently receives (i.e., claims data, pharmacy data, and encounter data), the data warehouse can identify ~~the~~ members for quality improvement and access to care interventions, which will allow us to improve our HEDIS, STARS and HOS measures. This information will guide CalOptima and our delegated ~~networks~~HNs in identifying gaps in care and metrics requiring improvement. ~~not only targeting the members, but also the HMOs, PHCs, and SRGs, and MBHOs, and providers who need additional assistance.~~

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality measures. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality measure) is accompanied by clear guidelines for interpretation.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the ~~Population Health Management~~PHM program. ~~.~~Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines

- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

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

Improvement Standards

A. Demonstrated Improvement

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

B. Sustained Improvement

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

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

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

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

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping Members Healthy
2. Managing Members with Emerging Risks
3. Patient Safety or Outcomes ~~a~~Across ~~s~~Settings
4. Managing Multiple Chronic Conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, ~~ and~~ Behavioral Health Services~~,~~ and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019. The 2019 PHM Strategy will continue in 2020 including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and C&L needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual~~,~~ and environmental stressors, to improve health outcomes. CalOptima will conduct Quality Initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and ~~M~~member satisfaction. Quality Initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 2020 are tracked~~ing~~ in the QI Workplan and reported to the QIC.

In 2020, the PHM Strategy will be focused on expanding the ~~Model of Care~~MOC while integrating CalOptima's existing services, such as care coordination, case management~~,~~, health promotion, preventive services and new programs with broader population health focus~~,~~ with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epi~~c~~

genetic effect of ACE, improve population health outcomes, and promote affordable health care for the next generation. -Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member -focused trauma informed care which isto be consistent with NCQA 2020 Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma- Informed Care Plan of Action aims to promote awareness and reduce the impact of Adverse Childhood ExperiencesACE.– The Board approved Trauma-Informed Care Plan of Action is attachedin Appendix C.

Health Promotion

Health Education provides program development and implementation for agency-wide population health programs**.** PHM programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics include Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, Shape Your Life/Weight Management and Tobacco Cessation.

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

PHM supports CalOptima members with customized interventions, which that may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- Execution and coordination of programs with Case Management, QA and our HN providers.

Managing Members with Emerging Risk

CalOptima staff provides a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner and CalOptima. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members across locales and providing services, resources, and support to members as they learn to care for themselves and their condition. The PHM program supports the CA-OSG Office of Surgeon General and Prop 56 requirements for ACE screening, as well as identification of Social Determinants of Health (SDOH).– It

proactively also identifies those members in need of closer management, coordination and intervention. CalOptima assumes responsibility for the PHM program for all ofall its lines of business, however members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

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

- Standardized mechanisms for member identification through use of data including Health Risk Assessment (HRA) data
- .
  - Documented process to assess the needs of member population.
  - Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory.
  - Ability of member to opt- out.
  - Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs.
  - Use of evidenced--based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD).
  - Development of individualized care plans that include input from the member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary.
  - Coordinationg of services for members for appropriate levels of care and resources.
  - Documentingation of all findings.
  - Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services.
  - Ongoing assessment of outcomes.

CalOptima's case management program includes three care management levels that reflect the health risk status of members. SPD, OCC and OC members are stratified using a plan-developed tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. This stratification results in the categorizing members as "high" or "low" risk. The case management levels (CML) of complex, care coordination and basic are specific to SPD, OCC and OC members who have either completed an HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status. The ICT always includes the member

(and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, such as a ~~M~~medical ~~D~~director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dieti~~e~~tian~~,~~ and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

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

- ICT for Moderate to High-Risk Members — ICT occurs at the HN, or ~~h~~Health ~~P~~plan CalOptima for CCN ~~Community Network~~ Members
  - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, HN UM staff, behavioral health specialist and social worker
    - Roles and responsibilities of this team:
      - Identification and management of planned transitions
      - Case management of high-risk members
      - Coordination of ICPs for high-~~-~~risk members
      - Facilitating member, PCP and specialists, and vendor communication
      - Meets as frequent as is necessary to coordinate ~~and~~ care and stabilize member's medical condition

Dual Eligible Special Needs Plan (SNP)/OC and OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation~~,~~ and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help ~~patients~~ members regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow~~-~~up.

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

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services.
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of rehospitalization.
- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at high-risk individuals.
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning.

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

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

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

Home- and Community-~~-~~Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive home and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

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

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

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting to members 18 and older who may misuse alcohol.~~–~~ Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

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

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occur~~s~~ as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

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

OC and OCC

CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective ~~1/1/2020~~January 1, 2020, OC/OCC behavioral health will be fully integrated ~~and operationalized~~ within CalOptima internal operations. ~~CalOptima internal operations.~~ OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line.~~-~~ Members will be connected to a CalOptima representative for behavioral health assistance.~~Functions delegated to Magellan include provider network, UM, credentialing, and customer service.~~

~~CalOptima OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a Magellan representative for behavioral health assistance. If office-based services are appropriate, the member is registered and given referrals to an appropriate provider. If ambulatory Specialty Mental Health needs are identified, services may be rendered through the Orange County Mental Health Plan.~~

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the PCP setting to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral

counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those which that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 20202018 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff reviews and approves requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 20192020 UM Program Description, and related Work Plan.

Enterprise Analytics

Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA drives the development of the strategy and roadmap for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the road map. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services and Medical Affairs, the EA team develops or extends the data architecture and data definitions which expresses a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider preventable conditions, trimester-specific member mailing lists, high-impact specialists, PDSA on LTC inpatient admissions, and under-utilization information. As QI needs evolve, so will the EA contribution.

Safety Program

Member safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care ~~delivery, and~~delivery and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally and include strategic efforts specific to member safety.

This safety program is based on a needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Health education and promotion
- Over/Under utilization monitoring
- ~~Group needs assessment~~
- Medication management
- PHM
- Operational aspects of care and service

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

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

Collaborating with HNs and practitioners in performing the following activities:

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

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

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training

    - Preventative maintenance contracts to promote keeping equipment in good working order
    - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings including CBAS, SNF, and MSSP settings
    - Falls and other prevention programs
    - Identification and corrective action implemented to address post-operative complications
    - Sentinel events, critical incident identification, appropriate investigation and remedial action
    - Administration of flu and pneumonia vaccines
- Administrative offices
    - Fire, disaster, and evacuation plan, testing and annual training

Cultural & Linguistic Services

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

Since CalOptima serves a large and culturally diverse population, t~~. T~~he seven most common languages spoken for all CalOptima programs are: English 56~~%~~ percent, Spanish 28~~%~~ percent, Vietnamese 11~~%~~percent, Farsi 1~~%~~percent, Korean 1~~%~~ percent, Chinese 1 percent~~%~~, Arabic 1~~%~~ percent and all others at 3~~%~~ percent, combined. CalOptima provides member materials ~~in~~as follows:

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

CalOptima is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation. ~~See CalOptima Policy DD. 2002 – Cultural and Linguistic Services for a detailed description of the program.~~

Objectives for serving a culturally and linguistically diverse membership include:

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

The approach for serving a culturally and linguistically diverse membership include:

- Analyzing significant health care disparities in clinical areas to ensure health equity.
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved.
- Considering outcomes of member grievances and complaints.
- Conducting memberpatient-focused interventions with culturally competent outreach materials that focus on race-/ethnicity-/language- or gender-specific risks.
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group. Providing information, training and toiols to staff and practitioners to support culturally competent communication
- ~~Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group.~~
- ~~**Providing information, training and tools to staff and practitioners to support culturally competent communication.**~~

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to ~~HMO, PHC, and SRG, and MBHO~~delegated HNs ~~contractors~~ ~~who~~ that are required to meet all contractual, statutory~~,~~ and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

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

NON-DELEGATED ACTIVITIES

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services.
- QI program for all lines of business, ~~HMOs, PHCs, and SRGs, and MBHOs~~delegated HNs must comply with all quality-related operational, regulatory and accreditation standards.
- ~~Medi-Cal~~ Behavioral Health for MC, OC~~,~~ and OCC ~~L~~lines of ~~b~~business.
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program.
- Health Education (as applicable).
- Grievance and Appeals process for all lines of business, peer review process on specific, referred cases.

- Development of system-wide measures, thresholds and standards.
- Satisfaction surveys of members, practitioners and providers.
- Survey for Annual Access and Availability.
- Access and availability oversight and monitoring.
- Second level review of provider grievances.
- Development of credentialing and re-credentialing standards for both practitioners and health care delivery organizations ~~(~~OP~~HDOs).~~
- Credentialing and re-credentialing of OP~~HDO~~s.
- Development of UM and Case Management standards.
- Development of QI standards.
- Management of Perinatal Support Services (PSS).
- Risk management.
- Pharmacy and drug utilization review as it relates to quality of care.
- Interfacing with ~~S~~state and ~~F~~federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations.

Further details of the delegated and non-delegated activities can be found in the 202018 Delegation Grid.

See Appendix B — 20192020 Delegation Grid

IN SUMMARY

As stated ~~earlier~~previously, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, s~~S~~tate and ~~F~~federal agencies and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better~~,~~ Together."

APPENDIX A — 20192020 QI WORK PLAN

APPENDIX B — 20192020 DELEGATION GRID

~~APPENDIX C — 20192020 PHM STRATEGY~~ACE CHIP ~~APPENDIX C~~

~~The CalOptima Health Improvement Project to reduce the impact of Adverse Childhood Experiences (The ACE CHIP)~~

[i] ~~http://ochmis.org/wp-content/uploads/2019/08/2019-PIT-FINAL-REPORT-7.30.2019.pdf~~

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2020

QUALITY IMPROVEMENT PROGRAM

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2020 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

David Ramirez, M.D. Date
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

Paul Yost, M.D. Date

Board of Directors Chair:

_____ _____

Paul Yost, M.D. Date

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. Our 25th anniversary serving our members is in 2020. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members

Our Values — CalOptima CARES

Collaboration: We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability: We were created by the community, for the community and are accountable to the community. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

Respect: We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.
- We speak to our members in their languages.
- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence: We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome

differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship: We recognize that public funds are limited, so we use our time, talent and funding wisely and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."
We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan
In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input
- Be accountable for the decisions we make.

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population.

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

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

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

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California's Denti-Cal program.

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

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including Orange County Health Care Agency (OC HCA) and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports
Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

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

disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services
In addition to the comprehensive scope of acute, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits, CalOptima OC members are eligible for enhanced services, such as transportation to medical services and gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

Scope of Services
OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter benefits and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

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

In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

Scope of Services
PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff, and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to participants. PACE participants must receive all needed services — other than emergency care — from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

PROGRAM INITIATIVES

Whole-Person Care
Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the OC HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information sharing platform was launched in November 2018. For 2020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.

Whole-Child Model
California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned to CalOptima in 2019. Under this program in Orange County, medical eligibility determination processes, the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with OC HCA.

Health Homes Program
The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima plans to implement HHP in the following two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD), and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED).

CalOptima's goal is to target the highest-risk 3–5 percent of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing related and accompaniment services to further support HHP members. Following implementation, CalOptima will consider opportunities for other entities to participate.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health; health care; housing support services; community corrections; and public social services. The county's WPC program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care — As part of the Whole Person Care program, services provide post-acute care for up to 90-days for homeless CalOptima members.
- Medical Respite Care — As an extension to the recuperative care program, CalOptima provides additional respite care beyond the 90 days of recuperative care under the Whole Person Care program.
- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), Orange County Health Care Agency's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members.

- Homeless Clinical Access Program — The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventive care services at Orange County homeless shelters.
- Hospital Discharge Process for Members Experiencing Homelessness — Support is provided to assist hospitals with the increased cost associated with discharge planning under new state requirements.

Behavioral Health for OC/OCC

CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective January 1,2020, OC/OCC behavioral health will be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

With Whom We Work

Contracted Health Networks/Contracted Network Providers
Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can participate through CalOptima Direct-Administrative and/or CalOptima Community Network (CCN) and/or contract with a CalOptima Health Network (HN). CalOptima members can choose CCN or one of 13 HNs representing more than 8,500 practitioners.

CalOptima Direct (COD)
CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)
CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's OneCare Connect or OneCare programs), share of cost members and members residing outside of Orange County. Members enrolled in CalOptima Direct-Administrative are not HN eligible.

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered internally by CalOptima and available for members to select, supplementing the existing HN delivery model and creating additional capacity for growth.

CalOptima Contracted Health Networks
CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:
- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

CalOptima contracts with the following 13 Heath Networks:

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	SRG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	SRG	HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Medical Group	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	SRG	SRG

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

- Utilization Management (UM)
- Case Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: December 2019

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

Membership Data as of October 31, 2019

Total CalOptima Membership
743,465

Program	Members
Medi-Cal*	727,437
OneCare Connect	14,093
OneCare (HMO SNP)	1,567
Program of All-Inclusive Care for the Elderly (PACE)	368

Note: The Fiscal Year 2019-20 Membership Data began on July 1, 2019.
*Includes prior year adjustment

Member Age (All Programs)

11%	0 to 5
29%	6 to 18
29%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

56%	English
27%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

QUALITY IMPROVEMENT PROGRAM

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

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

CalOptima's QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual

orientation, gender identity, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

Since 2010, the "Triple Aim" has been at the heart of the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage and Prescription Drug Plan (Medicare Parts C and D) quality improvement strategy. The Triple Aim focuses on patient-centered improvements to the health care system including improving the care experience and population health and decreasing the cost of care. The Quadruple Aim adds a fourth element focused on provider satisfaction on the theory that providers who find satisfaction in their work will provide better service to patients. CalOptima's quality strategy embraces the Quadruple Aim as a foundation for its quality improvement strategy.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD-A, as well as our contracted health networks. Through the QI Program — and in collaboration with its providers and community partners — CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system to serve our members.

The CalOptima QI Program incorporates continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.
- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.
- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality of care issues to ensure safe patient care and experiences.
- Maintain agency-wide practices that support accreditation by NCQA and meet DHCS/CMS quality requirements and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- Sets expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes.
- Supports the provision of a consistent level of high quality of care and service for members throughout the contracted provider networks, as well as monitors utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.
- Provides oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensures certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — OC HCA — which may include, but are not limited to, methicillin resistant *Staphylococcus aureus* (MRSA), scabies, tuberculosis, etc., as reported by the HNs.

- Promotes patient safety and minimizes risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and works with appropriate committees, departments, staff, practitioners, provider medical groups, and other related organizational providers (OPS) to assure that steps are taken to resolve and prevent recurrences.
- Educates the workforce and promotes a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Internal and External Oversight departments, the QI Program ensures the following standards or outcomes apply to populations served by CalOptima's contracted HNs, including CCN and/or COD-A network providers, to:

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

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

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

The QI Program is based on ongoing systematic collection, integration, and analysis of clinical and administrative data to identify the member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with Federal and State regulations, contractual obligations and fiscal parameters.

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

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the Quality Assurance Committee (QAC) to review and make recommendations to the Board regarding accepting the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC also makes recommendations for annual modifications of the QI Program and actions to achieve the Institute for Healthcare Improvement's Quadruple Aim moving upstream from the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee
The Member Advisory Committee (MAC) is comprised of 15 voting members, each seat represents a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventative services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumers

- Family support
- Foster children
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons
- OC HCA
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by OC HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee
The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and is comprised of 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - OC HCA, Behavioral Health
    - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The meetings are held at least quarterly and are open to the public.

Provider Advisory Committee
The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent a broad provider community that serves CalOptima members. The PAC is comprised of 15 members, 14 of whom serve three-year terms with two

consecutive term limits, along with a representative of OC HCA, which maintains a standing seat. PAC meets at least quarterly and are open to the public. The 15 seats include:

- HN
- Hospitals
- Physicians (3 seats)
- Nurse
- Allied health services
- Community health centers
- OC HCA (1 standing seat)
- LTSS (LTC facilities and CBAS) (2 seats)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee
In 2018, CalOptima's Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC), as required by the state as part of California Children's Services (CCS) becoming a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning WCM, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima WCM. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC is composed of the following 11 voting seats:

- Family representatives: 7–9 seats
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
    - CalOptima members age 18–21 who are a current recipient of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: 2 to 4 seats
    - Community-based organizations; or
    - Consumer advocates

Members of the Committee shall serve staggered two-year terms. Of the above seats, five members serve an initial one-year term (after which representatives for those seats will be appointed to a full two-year term), and six will serve an initial two-year term. WCM FAC meets at least quarterly and meetings are open to the public.

Role of CalOptima Officers for Quality Improvement Program

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the State and Federal Contracts.

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

Chief Medical Officer (CMO) — oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI program and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

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

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met. The medical director is also the chair of the Credentialing Peer Review Committee (CPRC).

Medical Director (Behavioral Health) is the designated behavioral healthcare practitioner in the QI program, and serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC), and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T).

Executive Director, Quality & Population Health Management (ED of Q&PHM) is responsible for facilitating the company-wide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED of Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ED of Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrating behavioral health across the health care delivery system and populations served. Reporting to the ED of Q&PHM are the: Director, Quality Analytics; Director, Quality Improvement; Director, Population Health Management; Director, Behavioral Health Services (Clinical Operations); and Director, Behavioral Health Integration.

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

Executive Director, Program Implementation (ED of PI) is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational

process improvement activities and community relations. Reporting to ED of PI: Director, Process Excellence; and Director, Strategic Development.

Executive Director, Compliance (ED of C) is responsible for monitoring and driving interventions so that CalOptima and its HNs and other FDRs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight departments (external and internal) to refer any potential sustained noncompliance issues or trends encountered during audits of HNs, and other functional areas. The ED of C serves as the State Liaison and is responsible for legislative advocacy. Also, the ED of C oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements.

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

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

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI program and is accountable to the QAC. The QIC assists the CMO in overseeing, maintaining and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members. The QIC oversees the performance of delegated functions by its delegated health networks and their contracted provider and practitioner partners.

The composition of the QIC includes a participating behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, case review as needed, and identification of opportunities to improve care.

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

Responsibilities of the QI Committee include the following:

- Recommends policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives
- Oversees the analysis and evaluation of QI activities
- Makes certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI program activities
- Identifies and prioritizes needed actions and interventions to improve quality
- Makes certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions.

Practice patterns of providers, practitioners and delegated health networks are evaluated, and recommendations are made to promote practices that all members receive medical care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, and delegated health networks.

The QI Program adopts the classic Continuous Quality Improvement cycle with 4 basic steps:

- **Plan** Goals with detailed description of an implementation plan
- **Do** Implementation of the plan
- **Study** Data and collection
- **Act** Analyze data and develop conclusions

The composition of the QIC is defined in the QIC Charter, and includes, but may not be limited to, the following:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- County Behavioral Health Representative
- CalOptima CMO (Chair or Designee)
- CalOptima Medical Directors
- CalOptima BH Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Committee Recorder as assigned

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

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

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

Minutes of the Quality Improvement Committee and Subcommittees
Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the Committee Chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- Goals and objectives outlined in the QI Charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of work plan activities

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

Credentialing Peer Review Committee (CPRC)
The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process; and determines corrective actions as necessary to ensure that all practitioners and providers who serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC reviews, investigates and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima's contracted providers — delegated health networks and OPs to ensure patient safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

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

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

** Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.*

Pharmacy & Therapeutics Committee (P&T)
The P&T committee is a forum for an evidence-based formulary review process. The P&T committee promotes clinically sound and cost-effective pharmaceutical care for all CalOptima members, and reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T committee includes practicing physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T committee provides written decisions regarding all formulary development decisions and revisions. The P&T committee meets at least quarterly, and reports to the UMC. The voting member composition and quorum requirements of the P&T committee are defined in its charter.

Benefit Management Subcommittee (BMSC)
The purpose of the BMSC is to oversee, coordinate, and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its program lines of business benefits, prior authorization and financial responsibility requirements for the administration of benefits. The subcommittee reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs, and SRGs. The Regulatory Affairs department provides technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and

guidance that impacts the benefit sets and CalOptima's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

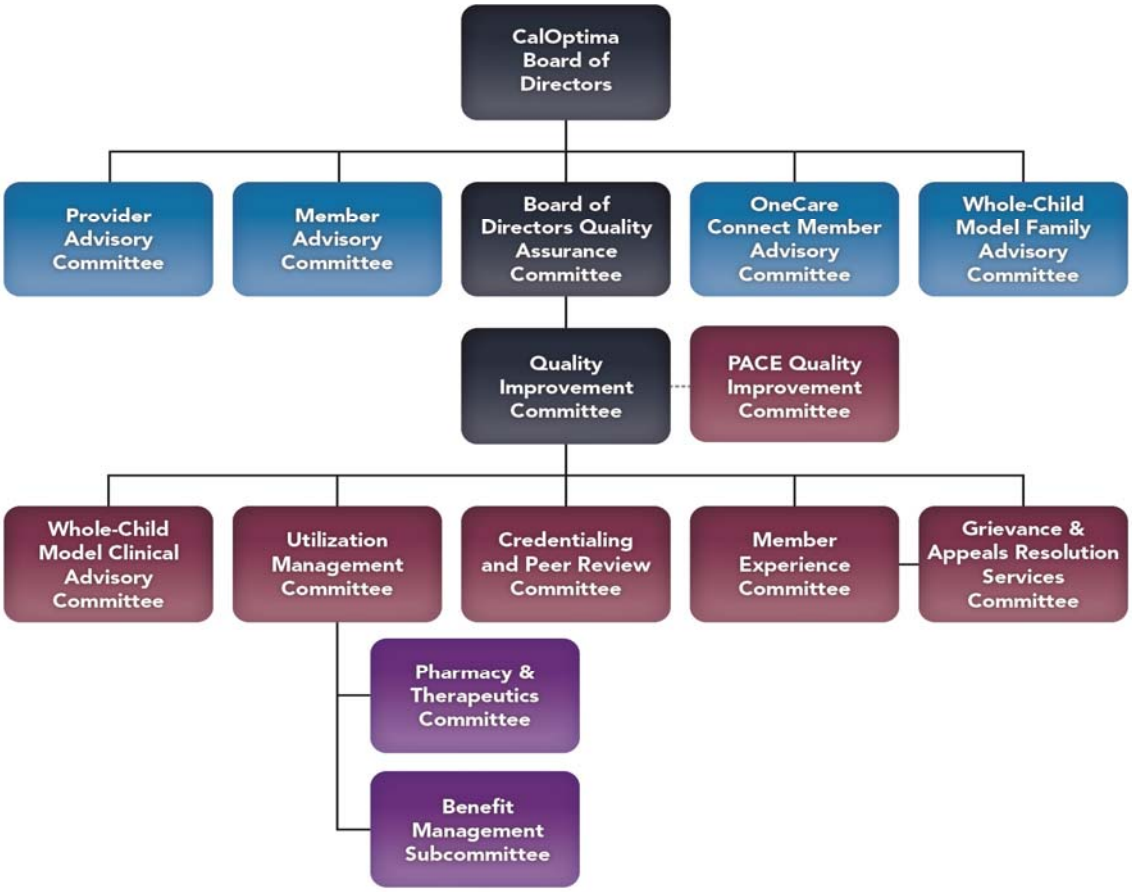
Whole-Child Model Clinical Advisory Committee (WCM CAC)
The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-011. The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima WCM program in collaboration with county CCS, the WCM Family Advisory Committee and HN CCS providers. The WCM CAC meets four times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)
Improving member experience is a top priority of CalOptima. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC and OCC. NCQA's Health Insurance Plan Ratings measure three dimensions — prevention, treatment and customer satisfaction. The MEMX committee is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network, including access and availability (CCN and 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. In 2020, the MEMX committee, which includes the Access and Availability workgroup, will continue to meet at least bi-monthly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the 2020 and 2021 CAHPS survey results.

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

Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC)
The PQIC committee provides oversight for the overall administrative and clinical operations of CalOptima PACE. The PQIC assures compliance to all state and federal regulatory bodies. The PQIC may create new ad-hoc committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. The PQIC meets, at a minimum, quarterly and is chaired by the PACE Medical Director. A summary of the PQIC meetings are submitted to the CalOptima Quality Improvement Committee (QIC) which are then included in the QIC summary submitted to the CalOptima Board of Directors Quality Assurance Committee (QAC). Annually, the PQIC will assess all PACE quality improvement initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. Potential areas for improvement will be identified through analysis of the data and through root cause analysis.

2020 Committee Organization Structure — Diagram



Confidentiality

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

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

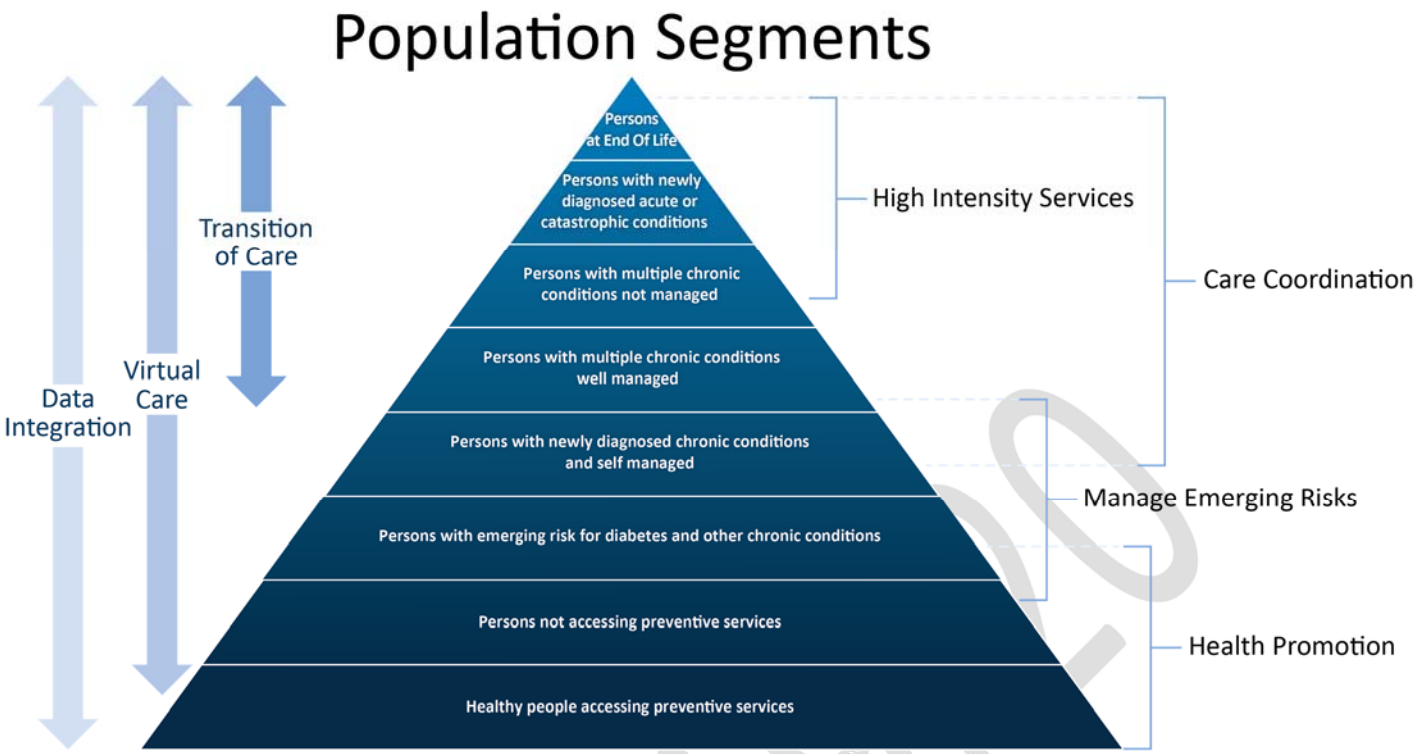
applicable laws regarding confidentiality, issues any QI reports required by law or by the state contract.

Conflict of Interest

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

Quality Improvement Strategic Goals

The QI Program supports a Population Health Management (PHM) approach, stratifying our population based on their health needs, conditions and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care (MOC), the 2020 QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.



CalOptima's MOC recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is very effective in managing the health care needs of high-risk members one-by-one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

2020 QI Goals and Objectives

CalOptima's QI Goals and objectives are aligned with CalOptima's 2020–2021 strategic goals.

1. Increase NCQA overall rating from 4.0 to 4.5
2. Improve Member Experience CAHPS performance from 25th to 50th percentile, focusing on Getting Needed Care and Getting Care Quickly
3. Improve member's ability to access primary and specialty care timely, for urgent and routine appointments, from 2019 baseline to goal of 80%

Detailed strategies for achieving 2020 Goals and Objectives are measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

QI Measurable Goals for the Model of Care

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

The MOC goals are:

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

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

QI Work Plan

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

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

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

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program

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

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

See Appendix A — 2020 QI Work Plan

Methodology

QI Project Selections and Focus Areas
Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to, (a) potential quality issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) member experience surveys, (f) HEDIS results, and (g) other opportunities for improvement as identified by subcommittee's data analysis
- Measures required by regulators such as DHCS and CMS

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

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

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

- Staff, administration, and physicians provide vital information necessary to support continuous performance improvement, and is occurring at all levels of the organization
- Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
- Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes
- Project coordination occurs through the various leadership structures: Board of Directors, Management, QIC, UMC, etc., based upon the scope of work and impact of the effort
- These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

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QI Project Quality measures

Quality measures may be process measures (lead quality measures) or outcome measures (lag quality measures) where there is strong clinical evidence of the correlation between the process and member outcomes. This evidence and the rationale for selection of the lead quality measure must be cited in the project description, when appropriate.

Each QI Project will have at least one (and frequently more) lead measure(s) that are actionable in real time. The selected lead measures should be levers, drivers, or predictors of the desired outcome measures or lag quality measure such as HEDIS and STARS measures. While at least one lead measure must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Since quality measures will measure changes in health status, functional status, member satisfaction, and provider/staff, delegated HNs, or system performance, quality measures will be clearly defined and objectively measurable.

QI Project Measurement Methodology

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

For outcomes studies or measures that require data from sources other than administrative data (e.g. medical records), sample sizes will be a minimum of 411 (with 5–10 percent over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30 or 100 percent of the sample size when target population is less than 30, can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies dependent on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

Communication of QI Activities

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

- Practitioner participation in the QIC and its subcommittees
- HN Forums, Medical Directors meetings, Quality Forum and other ongoing ad-hoc meetings
- Annual synopsized QI report posted on CalOptima's website (both web-site and hardcopy are available for both practitioners and members). The information includes a QI Program Executive Summary and highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
- MAC, OCC MAC, WCM FAC and PAC.

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, IS resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

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

In addition to CalOptima CMO and ED of Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management (QM) functions , including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED of Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

- The following positions report to the Director, Quality Improvement:
  - Manager, Quality Improvement
  - Supervisor, Quality Improvement (PQI)
  - Supervisor, Quality Improvement, and Master Trainer (FSR)
  - Supervisor, Credentialing
  - QI Nurse Specialists
  - Program Policy Analyst
  - Credentialing Coordinators

- Program Specialists
- Program Assistants
- Outreach Specialists

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agency-wide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

- The following positions report to the Director, Quality Analytics:
  - Quality Analytics HEDIS Manager
  - Quality Analytics Pay for Value Manager
  - Quality Analytics Network Adequacy Manager
  - Quality Analytics Analysts
  - Quality Analytics Project Managers
  - Quality Analytics Program Coordinators
  - Quality Analytics Program Specialists

Director, Population Health Management
Provides direction for program development and implementation for agency-wide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with Case Management, UM, Pharmacy and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

- The following positions report to the Director, Population Health Management:
  - Population Health Management Manager (Program Design)
  - Population Health Management Manager (Operations)
  - Population Health Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Population Health Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dieticians
  - Data Analyst
  - Program Manager
  - Program Specialists
  - Program Assistant

Director, Behavioral Health Integration provides program development and leadership to the implementation, expansion, and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. The director is responsible for the management and strategic direction of the Behavioral Health Integration Department efforts in integrated care, quality initiatives, and community partnerships. The Director ensures departmental compliance with all local, state and

federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Services (Clinical Operation) provides operational oversights of the Behavioral Health Integration Department clinical services. The Director leads a team that provides behavioral health telephonic clinical triage, care coordination and utilization management for members in all lines of business.

In addition to the direct QI resources described above, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our members' health status.

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

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

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

Director, Long-Term Services and Supports is responsible for LTSS programs, which include CBAS, LTC, and MSSP. The position supports a "Member-Centric" approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures, and processes related to LTSS program operations and quality measures.

Director, Enterprise Analytics provides leadership across CalOptima in the development and distribution of analytical capabilities. The director drives the development of the strategy and roadmap for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the roadmap. Working with departments that supply data, the team is responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the enterprise analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

Staff Orientation, Training and Education

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

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

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency and Trauma-Informed Care training
- QI Lean training curriculum (added to CalOptima University in 2019)

MOC-related employees, contracted providers and practitioner networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

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

Annual Program Evaluation

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

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions
- An evaluation of QI activities, including QIPs, PIPs, PDSAs, and CCIPs.
- An evaluation of member satisfaction surveys and initiatives
- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends

- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process
- Recommended changes included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors review and approval

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

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

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

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

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

- Clinical care and service
- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care and treatment of acute and chronic conditions
- Complex case management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management departments, which details this process in its UM/CM Program and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources

- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

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

QUALITY IMPROVEMENT

The QI department is responsible for monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

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

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors, and trends PQI cases, in order to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues are reported to the CPRC and are also reviewed at the time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or GARS.

Comprehensive Credentialing Program Standards

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

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to: non-physician behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and re-credentialing activities for CCN are performed at CalOptima, and delegated to HNs and other sub-delegates for their providers.

Organizational Providers
CalOptima performs credentialing and re-credentialing of organizational providers (OPs) such as, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies.

Use of QI Activities in the Re-credentialing Process
Findings from QI activities and other performance monitoring are included in the re-credentialing process.

Monitoring for Sanctions and Complaints
CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, State or Federal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns and member complaints between re-credentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate primary care practitioner (PCP) site and medical records review to its contracted HMOs, PHCs and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full-scope site review performed by another health plan in the past three years, in accordance with MMCD Policy Letter 14-004 and CalOptima policies. Medical records of new providers shall be reviewed within 90 calendar days of the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)
CalOptima conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

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

Medical Record Documentation Standards
CalOptima requires that its contracted delegated HNs make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.

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

The medical record should be protected to ensure that medical information is released only in accordance with applicable Federal and State law.

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

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

- Development of cross-departmental teams utilizing continuous improvement tools (i.e., quality improvement plans or Plan-Do-Study-Act) to identify root causes, develop and implement solutions and develop quality control mechanisms to maintain improvements.

- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a medical director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- Prescribed continuing education or office training
- De-delegation
- De-credentialing
- Contract termination

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

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

- Report, monitor and trend outcomes.
- Support efforts to improve internal and external customer satisfaction.
- Improve organizational quality improvement functions and processes to both internal and external customers.
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement.
- Coordinate and communicate organizational, HN and provider specific performance on quality metrics, as required
- Participate in various reviews through the QI Program such as, but not limited to, network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members and practitioners.
- Provide agency-wide oversight of monitoring activities that are:
  - Balanced: Measures clinical quality of care and customer service
  - Comprehensive: Monitors all aspects of the delivery system
  - Positive: Provides incentive to continuously improve

In addition to working directly with the contracted HNs, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case Management reports
- Pharmacy data
- Lab data

- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Population Needs Assessment
- Results of risk stratification
- HEDIS performance
- Member and provider satisfaction surveys
- QIPs, PIPs, PDSAs, and CCIPs

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

Medical Record Review
Wherever possible, administrative data is utilized to obtain measurement for some or all project quality measures. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality measure) is accompanied by clear guidelines for interpretation.

Interventions
For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

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

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

Improvement Standards

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

B. Sustained Improvement
Sustained improvement is documented through the continued re-measurement of quality measures for at least one year after the improved performance has been achieved.

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

Documentation of QI Projects
Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

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

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping Members Healthy
2. Managing Members with Emerging Risks
3. Patient Safety or Outcomes Across Settings
4. Managing Multiple Chronic Conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019. The 2019 PHM Strategy will continue in 2020 including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement

for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and C&L needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual and environmental stressors, to improve health outcomes. CalOptima will conduct Quality Initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality Initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 2020 are tracked in the QI Workplan and reported to the QIC.

In 2020, the PHM Strategy will be focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member -focused trauma informed care to be consistent with NCQA 2020 Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma- Informed Care Plan of Action aims to promote awareness and reduce the impact of ACE.

Health Promotion

Health Education provides program development and implementation for agency-wide population health programs. PHM programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics include Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, Shape Your Life/Weight Management and Tobacco Cessation.

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

PHM supports CalOptima members with customized interventions, that may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- Execution and coordination of programs with Case Management, QA and our HN providers.

Managing Members with Emerging Risk

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

These interventions include coordinating care for members across locales and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the CA-OSG and Prop 56 requirements for ACE screening, as well as identification of SDOH. It proactively identifies those members in need of closer management, coordination and intervention. CalOptima assumes responsibility for the PHM program for all its lines of business, however members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

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

- Standardized mechanisms for member identification through use of data including Health Risk Assessment (HRA) data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs
- Use of evidenced-based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)

- Development of individualized care plans that include input from the member, care giver, primary care provider, specialists, social worker and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Documentation of all findings
- Monitoring, reassessing and modifying the plan of care to drive appropriate quality, timeliness and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. SPD, OCC and OC members are stratified using a plan-developed tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. This stratification results in the categorizing members as "high" or "low" risk. The case management levels (CML) of complex, care coordination and basic are specific to SPD, OCC and OC members who have either completed an HRA or have been identified by or referred to case management.

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

The Interdisciplinary Care Teams process includes:

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

- ICT for Moderate to High-Risk Members — ICT occurs at the HN, or CalOptima for CCN Members
  - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, HN Medical Director, PCP and/or specialist, ambulatory case manager

(CM), hospitalist, hospital CM and/or discharge planners, HN UM staff, behavioral health specialist and social worker

- Roles and responsibilities of this team:
  - Identification and management of planned transitions
  - Case management of high-risk members
  - Coordination of ICPs for high-risk members
  - Facilitating member, PCP and specialists, and vendor communication
  - Meets as frequent as is necessary to coordinate care and stabilize member's medical condition

Dual Eligible Special Needs Plan (SNP)/OC and OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help members regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow up.

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

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of rehospitalization
- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at high-risk individuals
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning

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

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing

Facility Level B, and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive home and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

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

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

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting to members 18 and older who may misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

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

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occur as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

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

OC and OCC
CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective January 1, 2020, OC/OCC behavioral health will be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the PCP setting to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or refer to mental health and/or alcohol use disorder services as medically necessary.

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2020 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 2020 UM Program Description and related Work Plan.

Enterprise Analytics

Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA drives the development of the strategy and roadmap for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the road map. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services and Medical Affairs, the EA team develops or extends the data architecture and data definitions which express a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider

preventable conditions, trimester-specific member mailing lists, high-impact specialists, PDSA on LTC inpatient admissions and under-utilization information. As QI needs evolve, so will the EA contribution.

SAFETY PROGRAM

Member safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally and include strategic efforts specific to member safety.

This safety program is based on a needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Health education and promotion
- Over/Under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service

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

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

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results; addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to ensure the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication

- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA and SPD site review audits into the general facility site review process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

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

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings including CBAS, SNF, and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address post-operative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of flu and pneumonia vaccines
- Administrative offices
  - Fire, disaster, and evacuation plan, testing and annual training

Cultural & Linguistic Services

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

Since CalOptima serves a large and culturally diverse population, the seven most common languages spoken for all CalOptima programs are: English 56 percent, Spanish 28 percent, Vietnamese 11percent, Farsi 1percent, Korean 1 percent, Chinese 1 percent, Arabic 1 percent and all others at 3 percent, combined. CalOptima provides member materials as follows:

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

- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

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

The approach for serving a culturally and linguistically diverse membership include:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-/ethnicity-/language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group. Providing information, training and tools to staff and practitioners to support culturally competent communication

Delegated And Non-Delegated Activities

CalOptima delegates certain functions and/or processes to delegated HNs that are required to meet all contractual, statutory and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

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

Non-Delegated Activities

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services
- QI program for all lines of business, delegated HNs must comply with all quality-related operational, regulatory and accreditation standards.
- Behavioral Health for MC, OC and OCC lines of business

- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, peer review process on specific, referred cases
- Development of system-wide measures, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and health care delivery organizations OP
- Credentialing and re-credentialing of OPs
- Development of UM and Case Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations.

Further details of the delegated and non-delegated activities can be found in the 2020 Delegation Grid.

See Appendix B — 2020 Delegation Grid

IN SUMMARY

As stated previously, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better, Together."

APPENDIX A — 2020 QI WORK PLAN

APPENDIX B — 2020 DELEGATION GRID

I. PROGRAM OVERSIGHT

A. 2020 QI Annual Oversight of Program and Work Plan
B. 2019 QI Program Evaluation
C. 2020 UM Program
D. 2019 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Utilization Management Committee (UMC) Oversight
H. Member Experience (MEMX) Committee Oversight
I. Whole Child Model - Clinical Advisory Committee (WCM CAC)
J. Grievance and Appeals Resolution Services (GARS) Committee
K. PACE QIC - Quarterly review and update of PACE QIC activities
L. Quality Withold for OCC
M. Quality Program updates (Health Network Quality Rating, MCAS, P4V)
N. Improvement Projects (All LOB)
PPME and SNP-MOC Monitoring (OC)
QIPE Monitoring (OCC)

II. QUALITY OF CLINICAL CARE- ADULT WELLNESS

A. Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)
B. Cervical Cancer Screening (CCS)
C. Colorectal Cancer Screening (COL)
D. Breast Cancer Screening (BCS)

III. QUALITY OF CLINICAL CARE - BEHAVIORAL HEALTH

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).
B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase.
- Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC: Date:
Submitted and approved by QAC: Date:
Submitted and approved by Board of Director's Date:

Quality Improvement Committee Chairperson:

David Ramirez, MD Date:

Board of Directors' Quality Assurance Committee Chairperson:

Paul Yost, MD Date:

IV. QUALITY OF CLINICAL CARE - CHRONIC CONDITIONS

A. Statin Therapy for People with Cardiovascular Disease (SPC) and Statin Therapy for People with Diabetes (SPD)
B. Persistence of Beta Blocker Treatment after a Heart Attack (PBH)
C. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Good Control (<8.0%)
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam

V. QUALITY OF CLINICAL CARE - MATERNAL CHILD HEALTH

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care

VI. QUALITY OF CLINICAL CARE - PEDIATRIC /ADOLESCENT WELLNESS

A. Antidepressant Medication Management (AMM): Continuation Phase Treatment.
- Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.

B. Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)
C. Well-Care Visits in first 15 months of life (W15)
D. Adolescent Well-Care Visits (AWC)
E. Children and Adolescents' Access to Primary Care Practitioners (CAP)

VII. QUALITY OF SERVICE

A. Review of Member Experience (CAHPS)
-Increase CAHPS score on Getting Needed Care
B. Review of Timely Access
- Increase appointment availability

VIII. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR)

B. Opiods Utlization
C. Post-Acute Infection Prevention Quality Incentive (PIPQI),aka as SHIELD OC

2020 QI Work Plan

2020 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	**Results/Metrics: Assessments, Findings, Monitoring of Previous Issues**	**Next Steps Interventions / Follow-up Actions**
Program Oversight						
2020 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2020 QI Program and Workplan by March 2020	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Descritpion-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption	Betsy Ha		
2019 QI Program Evaluation	Complete Evaluation 2019 QI Program by January 2020	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation	Betsy Ha		
2020 UM Program	Obtain Board Approval of 2020 UM Program by June 2020	UM Program will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Annual Adoption	Mike Shook		
2019 UM Program Evaluation	Complete Evaluation of 2019 UM Program by March 2020	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Annual Evaluation	Mike Shook		
Population Health Management Strategy	Review and implement strategy in 2020	Review and adopt on an annual basis	Annual Adoption	Pshyra Jones		
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	Quarterly Adoption of Report	Miles Masastugu, MD/ Esther Okajima		
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook		
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo		
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quaterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD		
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievance Appeals and Resolution of complaints by members for CalOptima's network. Results are presented to committee quarterly	Quarterly Adoption of Report	Ana Aranda		
PACE QIC - Quarterly review and update of PACE QIC activities		The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC, and summarized quarterly at QIC	Quarterly Adoption of Report	Miles Masatsugu, MD		

2020 QI Work Plan

2020 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	**Results/Metrics: Assessments, Findings, Monitoring of Previous Issues**	**Next Steps Interventions / Follow-up Actions**
Quality Withold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2020	Monitor and report to QIC	Annual Assessment	Kelly Rex-Kimmet/ Sandeep Mital		
Quality Program updates (Health Network Quality Rating, MCAS, P4V)	Achieve 50th percentile on all MCAS measures in 2020	**Varies per measure**. Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Adoption of Report	Kelly Rex-Kimmet/ Paul Jiang		
Improvement Projects (All LOB) PPME and SNP-MOC Monitoring (OC) QIPE Monitoring (OCC)	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) and SNP-MOC goals.	Conduct quarterly oversight of specific goals on QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **PPME (OC):** Emerging Risk (A1C), HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC):** HRA's, ICP High/Low Risk, ICP Completed within 90 days, Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents, Statins, Emerging Risk (A1C), HN MOC Oversight (Review of MOC ICP/ICT bundles)	Quarterly/Annual Assessment	Helen Syn/ Mimi Cheung/Sloane Petrillo		
Quality of Clinical Care						
Antidepressant Medication Management (AMM): Continuation Phase Treatment. - Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal:** MC 44.82%; OC 58.82%; OCC 50.39%	Educate providers and members on importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. Track number of educational events on depression screening and treatment.	12/31/2020	Edwin Poon		
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS 2020 Goal:** 30-Days: OC: NA; OCC: 56% 7-Days: OC: NA; OCC: 18.20%	1) Visit top 3 hospitals in the first quarter. 2) Follow up with facilities during regular joint operation meetings. 3) Outreach to members post discharge to coordinate follow-up appointments. 4) Track the number of members that have a follow up appointment at discharge.	12/31/2020	Edwin Poon		
Statin Therapy for People with Cardiovascular Disease (SPC) and Statin Therapy for People with Diabetes (SPD)	**HEDIS 2020 Goal:** SPC - Therapy MC 77.57%; OC 79%; OCC 79% SPD - Therapy MC 70.19%; OC 74.13%; OCC 74.13%	1) Quarterly faxes to Provider offices with lists of members missing an appopriate statin (SPD: any potency statin; SPC: moderate to high potency statin) or members who fall below adherence thresholds (PDC< 80%). (Rx) 2) SPD targeted mailings to members based on list provided from Pharmacy Provider outreach. (PHM) 3) Conduct IVR outreach calls to targeted members. (PHM) 4) Track the number of new members starting appropriate statins medications from targeted outreach list. 5) Track the number of members who were adherent to appropriate statins using calculated PDC rates.	12/31/2020	Nicki Ghazanfarpour/ Helen Syn		

2020 QI Work Plan

2020 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	**Results/Metrics: Assessments, Findings, Monitoring of Previous Issues**	**Next Steps Interventions / Follow-up Actions**
Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	**HEDIS 2020 Goal:** MC 77.93%; OC N/A; OCC N/A	1) Quarterly faxes to Provider offices for members missing persistent beta blocker use for a total of 6 months post-ASCVD date. 2) Track the number of members who are persistently using beta blockers 6 months post-ASCVD date.	12/31/2020	Nicki Ghazanfarpour		
Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	**HEDIS 2020 Goal:** MC 76.07%; OC 95.66%; OCC 93.70%	1) Continue Homeless Clinical Access Program (HCAP) program. This program started in late 2019 and will be available for members in 2020 2) Support health networks and provider offices with targeted outreach (i.e. CalOptima Day activities) 3) Implement the Health Equity PIP to improve access to acute/preventive care services for homeless members. 4) Track the number of homeless members accessing preventive care services at Homeless clinic events, and help transition members back to PCP	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Cervical Cancer Screening (CCS)	**HEDIS 2020 Goal:** MC 63.99%	1) Implement $25 member incentive program for completing a CCS. 2) Targeted outreach campaigns to promote cervical cancer screenings 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach (IVR, call campaigns, etc.)	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Colorectal Cancer Screening (COL)	**HEDIS 2020 Goal:** OC 73%; OCC 73%	1) Implement new member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy)	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Breast Cancer Screening (BCS)	**HEDIS 2020 Goal:** MC 63.98%; OC 76%; OCC 66%	1) Implement $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted outreach campaigns to promote breast cancer screenings. Track the number of calls listened to from targeted outreach campaigns (i.e. IVR or direct phone outreach) 5) Track the number of mammograms scheduled through targeted call campaigns.	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		

2020 QI Work Plan

2020 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	**Results/Metrics: Assessments, Findings, Monitoring of Previous Issues**	**Next Steps Interventions / Follow-up Actions**
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. - Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS 2020 Goal:** MC 55.50%	1) Develop CORE report and track the numbers of members that filled Rx and their providers. 2) Coordination for members and providers through outreach and assistance with appointment setting and reminders. 2)Track the number of members that have a follow up appointment scheduled.	12/31/2020	Edwin Poon		
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	DHCS required, for MC, no external benchmarks **HEDIS 2020 Goal:** **MC: NA**	1) Develop way to load PHQ scores from Guiding Care to HEDIS software. Develop way to capture information (i.e., PHQ scores and scheduled f/u appt.s) from provider offices. 2) Educate providers on depression screening tools and importance of screening. 3) Educate providers and members on importance of follow up appointments via newsletters/ outreach. 4) Track depression screening scores completed by internal staff in GC. 5) Track number of eduational events for depression screening and treatment, and increase # compared to last year.	12/31/2020	Edwin Poon		
Well-Care Visits in first 15 months of life (W15)	**HEDIS 2020 Goal:** MC 65.83%	1) Implement CalOptima Days targeting the W15 population only and track the number of members who engaged in W15 CalOptima Day events. 2) Implement **Member** incentive program for completing 1-3 and 4-6 well-child visits in the first 15 months of life and Track the number of W15 incentives paid out to members 3) Implement **Provider** incentive program for the W15 measures; members must complete 1-3 and 4-6 visits. Track the number of W15 incentives paid out to providers.	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Adolescent Well-Care Visits (AWC)	**HEDIS 2020 Goal:** MC 60.34%	1) Implement $25 member incentive program for adolescents 12-17 years old and Track the number of AWC incentives paid out to members. 2) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents and Track the number of participants for targeted adolescent "back-to-school" events.	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Children and Adolescents' Access to Primary Care Practitioners (CAP)	**HEDIS 2020 Goal:** **MC:** 12-24 Months 95.62% 25 months-6 years: 87.87% 7-11 years: 92.33% 12-19 years: 90.21%	1) Targeted outreach campaigns (IVR, call campaigns, etc.) 2) Also see other measure activities: [W15, AWC, IMA, CIS activities] 3) Track number of members who have an office visit after targeted outreach campaigns (i.e. IVR/Text messaging) 4) CAP measures is impacted by the following measures: W15, AWC, IMA, CIS and it's activities.	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		

2020 QI Work Plan

2020 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	**Results/Metrics: Assessments, Findings, Monitoring of Previous Issues**	**Next Steps Interventions / Follow-up Actions**
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing	**HEDIS 2020 Goal:** MC: HbA1c Testing: 89.78% OC: HbA1c Testing: 93% OCC: HbA1c Testing: 93%	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Good Control (<8.0%)	**HEDIS 2020 Goal:** MC: HbA1c Control (<8.0%): 60.77% OC: HbA1c Control (<8.0%): 71.97% OCC: HbA1c Control (<8.0%): 71.97%	1) Targeted outreach to members in "emerging risk" category (8.0-9.0) 2) Track the number of completed calls to emerging risk members identified	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	**HEDIS 2020 Goal:** MC: Eye Exam: 64.72% OC: Eye Exam: 78% OCC: Eye Exam: 78%	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care	**HEDIS 2020 Goal:** Prenatal MC 86.37% Postpartum MC 68.36%	1) Implement $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments	12/31/2020	Ann Mino		
Quality of Service						
Review of Member Experience (CAHPS) -Increase CAHPS score on Getting Needed Care	Improve Member Experience for **Getting Needed Care** from 25th to 50th percentile AND Improve Member Experience for **Getting Care Quickly** from 25th to 50th percentile	1) Continue Provider Data Initiative 2) Update the CalOptima Website (Provider Directory) so that providers and services are easily accessible to members 3) To have HN meet Time and Distance Standards 4) To have HN have at least 1 urgent care enter int he provider directory. 5)Provider Coaching and Workshops, report on # of Physician Shadow Coaching and Customer Service Improvement Workshops	12/31/2020	Marsha Choo		

2020 QI Work Plan

2020 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	**Results/Metrics: Assessments, Findings, Monitoring of Previous Issues**	**Next Steps Interventions / Follow-up Actions**
Review of Timely Access - Increase appointment availability	Improve Timely Access for **Compliance with Routine/Urgent Appointment Wait Times for PCPs/Specialists** from current rate to 80%	1) Increase payment rates for hard to access specialists 2) Contract with Telehealth vendor and initiate telehealth services for identified specialities. 3) Incentive for hard to access PCPs/Specialists to open their panels 4) PCP Overcapacity Monitoring and closing of panels 5) Offer After Hours Incentive	12/31/2020	Marsha Choo		
Safety Of Clinical Care						
Plan All-Cause Readmissions (PCR)	**HEDIS 2020 Goal:** OC 8%; OCC 8%	1) Complete RFP and select vendor to collect ER data, and reinstate ER discharge program 2) Track # of Members receiving health coaching 3) Track # of member with a hospital admission versus unplanned readmission	12/31/2020	Sloane Petrillo Helen Syn/ Jocelyn Johnson		
Opioids Utilization	Optimal utilization of opioid analgesics.	Formulary Management quarterly meetings a. Quantity limits b. Duration limits c. Prior Authorization criteria d. Prescriber Report Cards e. Pharmacy Home f. Prescriber Restriction	Quarterly	Kris Gericke		
Post-Acute Infection Prevention Quality Incentive (PIPQI), aka as SHIELD OC	1. To reduce the number of nosocomial infections for LTC members. 2. To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer Iodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	12/31/2020	Cathy Osborn		

2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
QI1A: QI Program Structure	X		X		CO responsibility S&P component, even if delegated
QI1B: Annual Work Plan	X				CO responsibility S&P component, even if delegated
QI1C: Annual Evaluation	X		X		CO responsibility S&P component, even if delegated
QI1D: QI Committee Responsibilities	X		X		CO responsibility S&P component, even if delegated
QI2A: Practitioner Contracts	X		X		CO responsibility S&P component, even if delegated
QI2B: Provider Contracts	X		X		CO responsibility S&P component, **this element is not required for renewal surveys.**
QI3A: Identifying Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X		
QI3B: Acting on Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X		
QI3C: Measuring Effectiveness-Continuity & Coordination of Care of Medical Care (C&C)	X		X		
QI3D: Transition to other Care-Continuity & Coordination of Care of Medical Care (C&C)	X		X		
QI4A: Data Collection- C&C Between Medical Care and Behavioral Health	X		X		
QI4B: Collaborative Activities- C&C Between Medical Care and Behavioral Health	X		X		

NCQA Standards Abbreviations: QI = Quality Improvement; PHM – Population Health Management; NET – Network Management; UM – Utilization Management; CR – Credentialing; ME –Statement of Members' Rights and Responsibilities; Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

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"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
QI4C: Measuring Effectiveness- C&C Between Medical Care and Behavioral Health	X		X		
PHM1A: Strategy Description-PHM	X		X		CO responsibility S&P component
PHM1B: Informing Members-PHM	X		X		
PHM2A: Data Integration-PHM	X		X		
PHM2B: Population Assessment-PHM	X		X		
PHM2C: Activities and Resources-PHM	X		X		
PHM2D: Segmentation-PHM	X		X		
PHM3A: Practitioner or Provider Support	X		X		
PHM3B: Value-Based Payment Arrangement	X		X		
PHM4A: Frequency of HA Completion	X		X		
PHM4B: Topics of Self- Management Tools	X		X		
PHM5A: Access to Case Management-CCM	X	X	X		
PHM5B: Case Management Systems-CCM	X	X	X		

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"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
PHM5C: Case Management Process-CCM	X	X	X		CO responsibility S&P component, **this element will not be reviewed for Renewal Surveys.**
PHM5D: Initial Assessment-CCM	X	X	X		
PHM5E: Case Management- Ongoing Management-CCM	X	X	X		
PHM6A: Measuring Effectiveness-PHM	X		X		CO responsibility S&P component, even if delegated
PHM6B: Improvement and Action -PHM	X		X		CO responsibility S&P component, even if delegated
NET1A: Cultural Needs and Preferences	X		X		
NET1B: Practitioners Providing Primary Care	X				CO responsibility S&P component Factors 1&2, even if delegated
NET1C: Practitioners Providing Specialty Care	X				CO responsibility S&P component Factors 1-4, even if delegated
NET1D: Practitioners Providing Behavioral Health (BH)	X		X		CO responsibility S&P component Factors 1-3, even if delegated. Factor 4 Kaiser
NET2A: Access to Primary Care	X		X		CO responsibility S&P component, even if delegated
NET2B: Access to BH	X		X		CO responsibility S&P component, even if delegated
NET2C: Access to Specialty Care	X		X		
NET3A: Assessment of Member Experience Accessing the Network	X		X		Kaiser Factors 1-3

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"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X		Kaiser Factors 1-3
NET3C: Opportunities to Improve Access to BH Services	X		X		Kaiser Factors 1-3
NET4A: Notification of Termination	X	X	X		
NET4B: Continued Access to Practitioners	X	X	X		
NET5A: Physician Directory Data	X		X		
NET5B: Physician Directory Updates	X		X		
NET5C: Assessment of Physician Directory Accuracy	X		X		
NET5D: Identifying and Acting on Opportunities	X		X		
NET5E: Searchable Physician Web-Based Directory	X		X		
NET5F: Hospital Directory Data	X		X		
NET5G: Hospital Directory Updates	X		X		
NET5H: Searchable Hospital Web-Based Directory	X		X		
NET5I: Usability Testing	X		X		

NCQA Standards Abbreviations: QI = Quality Improvement; PHM – Population Health Management; NET – Network Management; UM – Utilization Management; CR – Credentialing; ME –Statement of Members' Rights and Responsibilities; Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

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2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
NET5J: Availability of Directories	X		X		
UM1A: Written Program Description	X		X		CO responsibility S&P component, even if delegated
UM1B: Annual Evaluation	X				CO responsibility S&P component, even if delegated
UM2A: UM Criteria	X	X	X		CO responsibility S&P component, even if delegated
UM2B: Availability of Criteria	X	X	X		CO responsibility S&P component, **this element is not required for Renewal surveys.**
UM2C: Consistency in Applying Criteria	X	X	X	X	
UM3A: Access to Staff	X	X	X		
UM4A: Licensed Health Professionals	X	X	X	X	CO responsibility S&P component, even if delegated
UM4B: Use of Practitioners for UM Decisions	X	X	X	X	CO responsibility S&P component, even if delegated
UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X		
UM4D: Practitioner Review of BH Denials	X		X		
UM4E: Practitioner Review of Pharmacy Denials	X		X		
UM4F: Use of Board-Certified Consultants	X	X	X		

NCQA Standards Abbreviations: QI = Quality Improvement; PHM – Population Health Management; NET – Network Management; UM – Utilization Management; CR – Credentialing; ME –Statement of Members' Rights and Responsibilities; Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

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"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM5A: Notification of Non-Behavioral Decisions	X	X	X		
UM5B: Notification of Behavioral Healthcare Decisions	X		X		
UM5C: Notification of Pharmacy Decisions	X		X	X	
UM5D: UM Timeliness Report	X		X	X	
UM5E: Interim- Policies and Procedures	X				
UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X		
UM6B: Relevant Information for BH Decisions	X		X		
UM6C: Relevant Information for Pharmacy Decisions	X		X		
UM7A: Discussing a Denial with a Reviewer	X	X	X		
UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X		
UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X		
UM7D: Discussing a BH Denial with a Reviewer	X		X		
UM7E: Written Notification of BH Denials	X		X		

NCQA Standards Abbreviations: QI = Quality Improvement; PHM – Population Health Management; NET – Network Management; UM – Utilization Management; CR – Credentialing; ME –Statement of Members' Rights and Responsibilities; Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

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2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM7F: BH Notice of Appeal Rights/Process	X		X		
UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X		
UM7H: Written Notification of Pharmacy Denials	X		X	X	
UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	X	
UM8A: Internal Appeals (Policies and Procedures)	X		X		CO responsibility S&P component, even if delegated
UM9A: Pre-service and Post-service Appeals	X		X		
UM9B: Timeliness of the Appeal Process	X		X		
UM9C: Appeal Reviewers	X		X		
UM9D: Notification of Appeal Decision/Rights	X		X		
UM11A: Pharmaceutical Management Procedures (Policies and Procedures)	X		X		
UM11B: Pharmaceutical Restrictions/Preferences	X		X		
UM11C: Pharmaceutical Patient Safety Issues	X		X		
UM11D: Reviewing and Updating Procedures	X		X		

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2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM11E: Considering Exceptions	X		X		
UM12A: UM Denial System Controls	X	X	X		
UM12B: UM Appeal System Controls	X		X		
CR1A: Practitioner Credentialing Guidelines	X	X	X		CO responsibility S&P component, even if delegated
CR1B: Practitioner Rights	X	X	X		CO responsibility S&P component, even if delegated
CR1C: Credentialing System Controls	X	X	X		
CR2A: Credentialing Committee	X	X	X		
CR3A: Verification of Credentials	X	X	X		
CR3B: Sanction Information	X	X	X		
CR3C: Credentialing Application	X	X	X		
CR4A: Recredentialing Cycle Length	X	X	X		
CR5A: Ongoing Monitoring and Interventions	X	X	X		
CR6A: Actions Against Practitioners	X	X	X		CO responsibility S&P component, **this element is not required for Renewal Surveys.**

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2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
CR7A: Review and Approval of Provider	X	X	X		**This element is not required for Renewal Surveys.**
CR7B: Medical Providers	X	X	X		**This element is not required for Renewal Surveys.**
CR7D: Assessing Medical Providers	X	X	X		
ME1A: Rights and Responsibility Statement	X				
ME1B: Distribution of Rights Statement	X				
ME2A: Subscriber Information	X				
ME2B: Interpreter Services	X				
ME4A: Functionality: Website	X				**This element is not required for Renewal Surveys**
ME4B: Functionality: Telephone Requests	X	X	X		**This element is not required for Renewal Surveys**
ME5A: Pharmacy Benefit Information: Website	X		X	X	PBM delegate possibility for Factors 6-8, **this element is not required for Renewal Surveys.**
ME5B: Pharmacy Benefit Information: Telephone	X		X		**This element is not required for Renewal Surveys.**
ME5C: QI Process on Accuracy of Information	X		X		
ME5D: Pharmacy Benefit Updates	X		X		

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2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
ME6A: Functionality: Web Site	X		X		CO: Factors 1-3; Kaiser Factors 1,2,3; Factor4 NA
ME6B: Functionality: Telephone	X	X	X		
ME6C: Quality and Accuracy of Information	X		X		
ME6D: E-Mail Response Evaluation	X		X		
ME7A: Policies and Procedures for Complaints	X		X		CO responsibility S&P component, even if delegated
ME7B: Policies and Procedures for Appeals	X		X		CO responsibility S&P component, even if delegated
ME7C: Annual Assessment-Member Experience	X				CO fields CAHPS, Kaiser complaint data included
ME7D: Opportunities for Improvement-Member Experience	X				
ME7E: Annual Assessment of BH and Services-Member Experience	X		X		Kaiser: Factor1 & Factor2
ME7F: BH Opportunities for Improvement-Member Experience	X				
Additional CMS/DHCS					
Contracts Opt-Out Provisions (CMS)	*X*	*X*	*X*		*CMS Requirement*
Medicare-Exclusions/Sanctions (CMS)	*X*	*X*	*X*		*CMS Requirement*

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2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
Preclusion List (CMS)	*X*	*X*	*X*		*CMS Requirement*
Hospital Admitting Privileges (CMS/DHCS)	*X*	*X*	*X*		*CMS/DHCS Requirement*
Facility Site Review DHCS)	*X*		*X*		*DHCS Requirement*
Enrollment & Screening (DHCS APL 19-004)	*X*	*X*	*X*		*DHCS Requirement*
Review of Performance Information -Recred (CMS/DHCS)	*X*	*X*	*X*		*CMS/DHCS Requirement*
Monitoring Medicare opt Out (CMS)	*X*	*X*	*X*		*CMS Requirement*
Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)	*X*	*X*	*X*		*DHCS Requirement*
Appeals Process for Termination/Suspension (CMS)	*X*	*X*	*X*		*CMS Requirement*
ID of HIV/AIDS Specialists: Written Process	*X*	*X*	*X*		*DHCS Requirement*
ID of HIV/AIDS Specialists: Evidence of Implementation	*X*	*X*	*X*		*DHCS Requirement*
ID of HIV/AIDS Specialists: Distribution of Findings	*X*	*X*	*X*		*DHCS Requirement*

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CalOptima
A Public Agency
Better. Together.

2020 Quality Improvement Program and Work Plan

Board of Directors' Quality Assurance Committee Meeting
February 19, 2020

Betsy Ha
Executive Director, Quality and Population Health Management

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2019 Quality Improvement (QI) Accomplishments

- Continued to be one of the highest rated Medicaid plans in the state.
- Maintained “Commendable” accreditation status from the National Committee for Quality Assurance (NCQA).
  - Standards based on Healthcare Effectiveness Data and Information Set (HEDIS) and Healthcare Providers and Systems (CAHPS).
- Performed well on several HEDIS measures in comparison to national thresholds.
  - Out of the 62 reportable measures, CalOptima performed better on 42 measures in 2019, compared to 2018.
- Implemented CalOptima’s comprehensive health network (HN) Pay for Value (P4V) Performance Measurement Program to recognize outstanding performance and support ongoing improvement.

2019 QI Accomplishments (cont.)

- Performed successful incentive outreach to members to obtain preventive care for Well-Care Visits in first 15 months of life (W15), postpartum care, and breast and cervical cancer screening.
- Expanded and continued initiatives to address access to care and member satisfaction, such as:
  - Provider coaching to evaluate and improve services provided at point of care
  - CalOptima Days to improve access and promote preventive health screenings
  - Active recruitment of new providers (both primary and specialty care)
- Implemented a quality incentive for Community Health Centers that participate in the Homeless Clinical Access Program (HCAP).

2019 QI Accomplishments (cont.)

- Implemented several prescriber, pharmacy, member and formulary interventions to reduce opioid utilization.
- Implemented Post-Acute Infection Prevention Quality Incentive (PIPQI) which included 25 nursing facilities of which 12 were already participating with UCI.
- Implemented six quality initiatives and several required Quality Improvement Projects (QIP), Performance Improvement Projects (PIP), Chronic Care Improvement Programs (CCIP), and Plan-Do-Study-Act (PDSA) to improve chronic condition measures
- Viable QI committee structure with subcommittees reporting of QI activities to QI Committee through the QI Work Plan.

QI Opportunities for 2020

- Maintain “Commendable” accreditation status and meet managed care accountability set (MCAS) measures (minimum performance level) MPL
- Achieve 4.5 for overall NCQA Health Plan rating
- Streamline QI Committee structure
- Perform targeted initiatives to improve performance on clinical HEDIS metrics specifically those MCAS measures at risk to fall below the MPL
- Utilize CalOptima Days for more targeted measures with smaller denominators
- Implement new P4V program with HN rating

QI Opportunities for 2020 (cont.)

- Implement member and provider incentives for specific quality measures, and evaluate effectiveness with HEDIS 2020
- Improve exchange of hospital data through new vendor to revamp Transition of Care program
- Reduce opioid utilization through various planned interventions in 2020
- Develop Quality Measures for PIPQI
- Develop Quality Measures for Whole-Child Model (WCM)
- Implement new DHCS tools and All Plan Letter (APL) for Facility Site Review
- Implement 2020 planned improvement projects

QI Opportunities for 2020 (cont.)

- Improve member experience CAHPS results for access related measures
- Increase appointment access to timely (routine and urgent) primary and specialty care

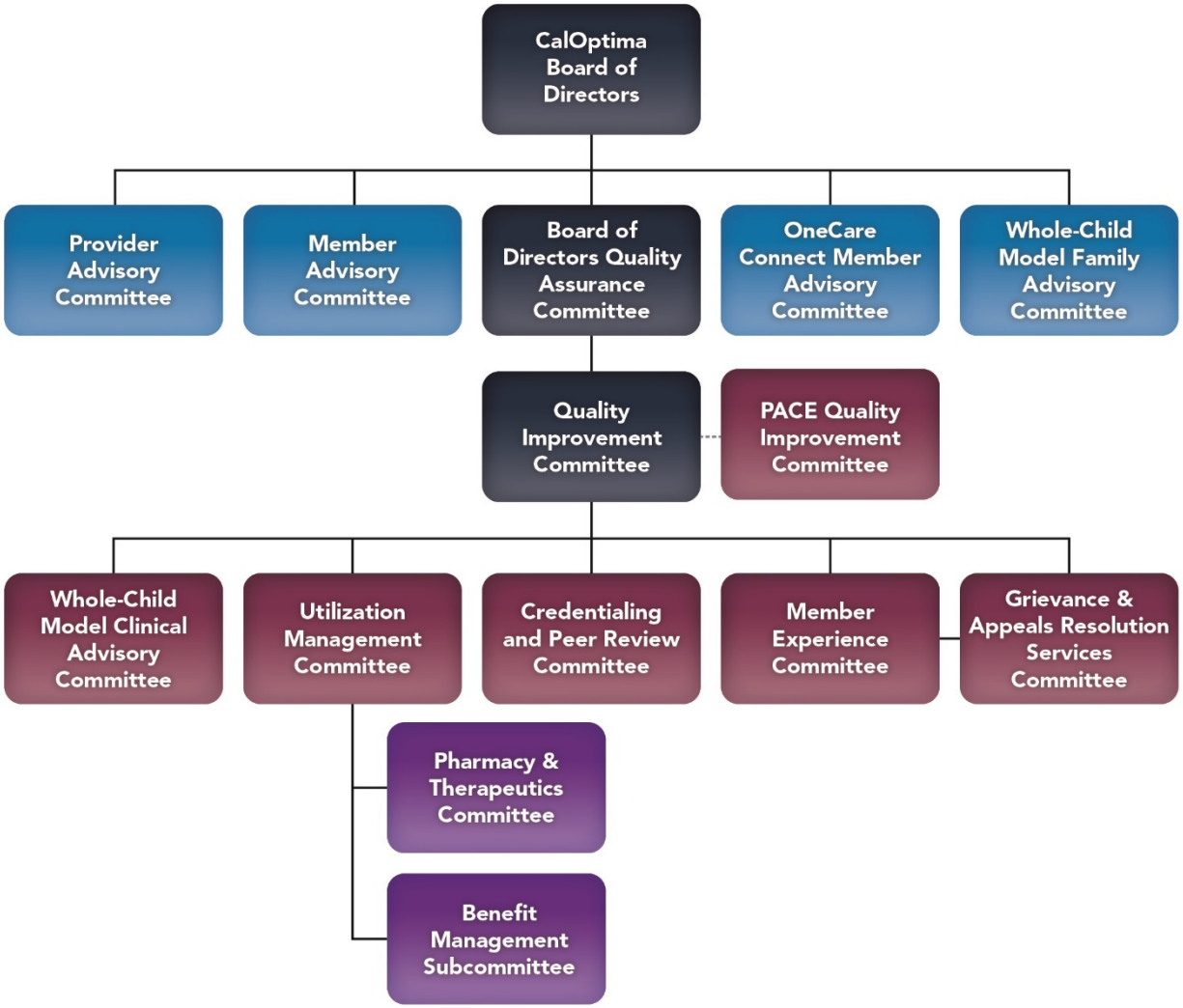
2020 QI Program Description

- Describes the quality and safety of clinical care, and organizational services provided to our members
- Aligns with the CalOptima's 2020–2022 strategic priorities:
  - Innovate and Be Proactive
  - Expand CalOptima's Member-Centric Focus
  - Strengthen Community Partnerships
  - Increase Value and Improve Care Delivery
  - Enhance Operational Excellence and Efficiency

2020 QI Program Description Revisions

- Description of scope of services for each line of business
- Updated the new program initiatives
  - Whole Person Care
  - Health Homes Program
  - Homeless Health Initiative
  - Behavioral Health for OC/OCC
- Updated QI Committee Structure

2020 QI Program Description Revisions (cont.)



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2020 QI Program Description Revisions (cont.)

- Established 2020 QI Goals and Objectives
  - Goal 1 — Improve NCQA overall rating 4.0 to 4.5 rating by 2021
  - Goal 2 — Improve Member Experience CAHPS performance from 25th percentile to 50th percentile focusing on Getting Needed Care and Getting Care Quickly
  - Goal 3 — Improve member's ability to access primary and specialty care timely, for urgent and routine appointments, from 2019 baseline to goal of 80%

2020 QI Program Description Revisions (cont.)

- Other revisions:
  - Updated program dates throughout document to reflect 2020
  - Updated values section to reflect accurate accountability to various committees
  - Updated Strategic Plan to reflect 2020–2022 strategic priorities and objectives
  - Updated what we offer sections to reflect 2020 scope of services
  - Updated Program Initiatives to include:
    - Whole Person Care
    - Health Homes Program
    - Homeless Health Initiative
    - Behavioral Health for OC/OCC

2020 QI Program Description Revisions (cont.)

- Other revisions (cont.):
  - Updated QI Program resources to reflect current organizational structure
  - Updated term for Health Care Delivery Organizations to industry term, Organizational Providers
  - Updated section on Population Health Management, in line with the PHM strategy. Included reference to statewide efforts to reduce Adverse Childhood Experiences (ACE) in adult Medi-Cal members by promoting awareness
  - Updated Cultural & Linguistic Services section including description and approach for serving diverse membership

2020 QI Program Description Revisions (cont.)

- Updated 2020 QI Work Plan (Appendix A)
- Updated delegated and non-delegated activities (Appendix B)
  - Changed pre-delegation review to Readiness Assessment
  - Population Health Management program renamed from Disease Management or Chronic Care Improvement Program
  - Renumbered based on 2018 Standards

2020 QI Work Plan (Appendix A)

- QI Work Plan measures aligned with 2020 QI Goals and Objectives
- Retired LTSS-QISC Committee from Work Plan. LTSS metrics are being reported as part of UMC Committee, BHQI Committee became part of QIC, and all respective measures will be reported to
  - Utilization Management Committee (UMC)
  - Member Experience Committee (MEMX)
  - Credentialing and Peer Review Committee (CPRC)
  - Grievance & Appeals Resolution Services Committee (GARS)
- Carried over measures that did not meet goals in 2019, and included measures requiring extra focus and attention

2020 QI Work Plan (Appendix A) (cont.)

- Removed maintenance of business goals on the Work Plan, measures tracked in other areas, and measures that are performing well.
  - Use of imaging studies for Lower Back Pain (LBP)
  - Appropriate testing for Children with Pharyngitis (CWP)
  - Antidepressant Medication Management (AMM): Acute Phase Treatment

2020 Delegation Grid (Appendix B)

- QI2 Element B: Informing members, this element was moved to MED 8 Element.
- QI3 Element B: Affirmative Statement.
  - In 2020 removed affirmative statement and incorporated the text into the policies and procedures Section 2: Accreditation Scoring and Status requirements
- The following elements were retired in the 2020 HP Standards:
  - QI4 Element A: Member Services Telephone Access
  - QI4 Element B: BH Telephone Access Standards
  - QI4 Element G: Assessing Experience with UM Process Member Experience

2020 Delegation Grid (Appendix B) (cont.)

- The following elements were retired in the 2020 HP Standards (cont.):
  - PHM4 Elements A–E: Health Appraisal
  - PHM4 Element G: Health Appraisal Review and Update Process
  - PHM4 Element I: Usability Testing of Self-Management Tools
  - PHM4 Element J: Review and Update Process for Self-Management Tools.
  - PHM4 Element K: Self-Management Tool Formats
  - PHM5 Element F: Experience with Case Management
  - MEM4 Element A: Supportive Technology

2020 Delegation Grid (Appendix B) (cont.)

- The following elements were retired in the 2020 HP Standards (cont.):
  - NET6 Element E: Physician Information Transparency
  - NET6 Element I: Hospital Information Transparency
  - UM5 Element A: Timeliness of Nonbehavioral UM Decision Making
  - UM5 Element C: Timeliness of Behavioral Health Care UM Decision Making.
  - UM5 Element E: Timeliness of Pharmacy UM Decision Making

2020 Delegation Grid

- New Requirements
  - **UM12 Element A:** UM Denial System Controls
    - Requires the organization to have policies and procedures describing how UM denial notification information is stored, modified and secured.
  - **UM12 Element B:** UM Appeal System Controls
    - Requires the organization to have policies and procedures describing how UM appeal information is stored, modified and secured.
  - **CR1 Element C:** Credentialing System Controls
    - Requires the organization to have policies and procedures describing how credentialing information is stored, modified and secured.

2020 Delegation Grid (cont.)

- Elements not Reviewed for Renewal Survey called out on the delegation grid
  - QI2 Element B: Provider Contracts
  - PHM5 Element C: Case Management Process
  - UM2 Element B: Availability of Criteria
  - CR7 Element A: Review and Approval of Provider
  - CR7 Element B: Medical Providers
  - CR7 Element C: Behavioral Health Providers

- Renumbered standards to account for standards and elements that were incorporated into other categories or eliminated from the Standards.

Questions?

CalOptima's Mission

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

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CALOPTIMA PACE

2019 CALOPTIMA PACE QUALITY IMPROVEMENT (QI) PLAN ANNUAL EVALUATION

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SIGNATURE PAGE

Quality Improvement Subcommittee Chairperson:

_____ _____

David Ramirez, M.D. **Date:**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson

_____ _____

Paul Yost, M.D. **Date:**

Board of Directors Chairperson

_____ _____

Paul Yost, M.D. **Date:**

TABLE OF CONTENTS

2019 CalOptima PACE Quality Improvement (QI) Plan Annual Evaluation

Executive Summary

CalOptima PACE opened for operations on October 1st, 2013. We have seen steady growth over the years with 13 participants at the end of 2013, and 393 participants at the end of 2019. Our participant represents six different social groups per the definition of the U.S. Census Bureau. Currently, 10 different languages are spoken by our participants with 82% of the participants speaking English as their second language. Out of our 393 participants, 58% use Spanish as their preferred language, followed by 18% using English as their preferred language and 16% citing Vietnamese as their preferred language. Other languages spoken include Korean, Tagalog, Chinese, Hindu, Urdu and Telugu. The multi-cultural and the diversity of our participant population provides a very vibrant and engaging environment.

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

The goals of the CalOptima PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff. The 2019 PACE QI Evaluation helps to identify key areas that offer opportunities for improvement that will be incorporated into the 2020 PACE QI Plan.

Section 1: Program Structure

The CalOptima's PACE QI Plan is developed by the PACE QI Committee (PQIC). It is then reviewed and approved by the CalOptima Board of Directors Quality Assurance Committee (QAC) and then approved by the CalOptima Board of Directors annually. The 2019 PACE QI Plan was reviewed and approved by the CalOptima Board of Directors on February 20, 2019.

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

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

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

SECTION 2: PACE QAPI PROGRAM

Major Accomplishments

In 2019, CalOptima PACE accomplishments include:

1. Successful Department of Health Care Services (DHCS) Level of Care (LOC) Audits.
2. Program growth to 393 participants, of which 63 receive services at Alternative Care Setting (ACS) sites.
3. Solidifying partnerships with five ACS sites, thereby meeting our expansion goals and improving access for participants into the PACE program.
4. Completion of three Quality Initiatives (Program Growth, Participant Care Plans and Participant Triage).
5. Met 20 out of 25 Work Plan goals.
6. Of participants enrolled in PACE for 6 months, 100% completed Physician's Orders for Life-Sustaining Treatment (POLST).
7. 97% of participants received their annual influenza vaccine.
8. 95% of participants received the Pneumococcal vaccine.
9. Respiratory infection rates in the elderly were lower than national benchmarks.
10. 95% of participants that had their medications reconciled within 30 days of hospital discharge.
11. The rate of day center falls fell by over 10% compared to 2018.
12. Quality of Diabetes Care
    a. 94% of participants with diabetes completed an annual eye exam.
    b. 97% of participants with diabetes went through nephropathy monitoring.
    c. 84% of participants with diabetes had their blood pressure controlled.
13. Utilization:
    a. Only 1.3% participants were placed in Long-Term Care in 2019.
    b. Refined the PACE Emergency Room (ER) Diversion program.
    d. Brought specialists in-house including podiatry, dental, and optometry for improved access and coordination of care.
14. Transportation:
    a. Over 60,000 one-way trips with an on-time performance of 94%.
15. Participant Satisfaction
    a. Overall satisfaction with care received of 96% compared to the national average of 94.7%
    b. 96% of participants would recommend the program to a close friend compared to the national average of 93.2%
    c. Of the 10 participant satisfaction domains:
        i. We scored higher than the national average in all 10 domains
        ii. Overall satisfaction composite score of 92% compared to the national average of 88.8%.
        iii. Improvement was seen in 7 of the 10 domains.
14. 100% of staff competency assessments were completed. Year-round staff trainings covering a broad area of topics included coding, infection control, wound care, emergency responses, grievances, appeals, service delivery requests and rights.

SECTION 3: STRATEGIC GOALS AND OBJECTIVES

Accomplishments

1. The QI program is organized to identify and analyze significant opportunities for improvement in clinical services, care and utilization.

    a. Accomplished as evidenced by the ongoing Health Plan Management System (HPMS) and QI individual metric data collection and analysis.
    b. Accomplished as evidenced by the ongoing PACE QI activities and initiatives.
2. The quality of clinical care and services and patient safety provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
    a. Accomplished as evidenced by the ongoing HPMS and QI individual metric data collection and analysis.
    b. Accomplished as evidenced by the ongoing PACE QI initiatives.
    c. Accomplished as evidenced by monitoring of member grievances and complaints, and regular review of delegated entities.
    d. Accomplished by the monthly meeting with the transportation vendor.
    e. Accomplished as evidenced by the daily morning inpatient and nursing facility clinical reviews.
    f. Accomplish by the ongoing infection control activities.
    g. Collaborated with the Compliance Department for identification of potential quality issues that may involve fraud, waste, abuse, confidentiality, security, etc.
    h. Accomplished as evidenced by the annual approval of Up-to-date Clinical Practice Guidelines and the National PACE Association Preventative Guidelines.
    i. Redesigned the PACE Clinic Workflow/Triage to efficiently address participant population growth and the increase in same-day appointment requests.
3. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners.
    a. Accomplished as evidenced by the daily Interdisciplinary Care Team (IDT) meetings at CalOptima PACE.
    b. Accomplished by adding the hospital and nursing home attending physicians to the IDT.
    c. Accomplished by the addition of preferred specialists who agree to participate in IDT.
    d. Accomplished by the coordination of care found in the ER Diversion Program.
4. The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population.
    a. Accomplished as evidenced by the number of grievances that have been tracked and trended.
    b. Accomplished by the Podiatrist, Optometrist and Dentist coming to the PACE center to see and treat the PACE participants.
    c. Accomplished by the Podiatrist, Psychiatrist, Nephrologist and Dentist participating in the IDT meetings.
5. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service.
    a. Accomplished as evidenced by the credentialing and peer review process.
    b. Accomplished as evidenced by annual evaluations of all CalOptima PACE employees.
6. Member and provider satisfaction, including the timely resolution of complaints and grievances.
    a. Accomplished as evidenced by the improvements in the PACE Participant Satisfaction Survey.
    b. Accomplished as evidenced by the summary of GARs activities.
    c. Accomplished through the ongoing PACE Member Advisory Committee meetings.
7. Risk prevention and risk management processes.
    a. Accomplished as evidenced by the QI activities which occur around all Unusual Incidents.
    b. Accomplished as evidenced by physical therapy driven groups such as Fall Prevention Group, Fall Committee, Fallers Anonymous and Matter of Balance groups.
    c. Accomplished as evidenced by root cause analysis done on Unusual Quality Incidences.

8. Compliance with regulatory agencies and accreditation standards.
    a. Accomplished as evidenced by the two successful DHCS Level of Care Audits.
9. Compliance with clinical practice guidelines and evidence-based medicine.
    a. Accomplished as evidenced by the adoption of the National PACE Association Preventative Guidelines
    b. Accomplished as evidenced by the adoption of Uptodate.com clinical practice standards.
    c. Accomplished as evidenced by on-going staff training.
10. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently.
    a. Accomplished as evidenced by tracking, trending and analyzing utilization management (UM) data monthly.
    b. Accomplished by the provider incentive program.
    c. Accomplished by the coordination of care found in the ER Diversion Program.
    d. Accomplished by the weekly PACE management team meetings.
    e. Accomplished by the participation in the CalOptima QI, UM, and Credentialing and Peer Review Committee meetings.
    f. Accomplished by the participation in the CalOptima Board of Directors and the Board of Directors Quality Assurance Committee meetings.
    g. Accomplished by the completion of the PACE 2.0 quality initiative which focused on program growth and employee engagement. PACE 2.0 was a collaborative partner with other PACE entities in California under CalPACE. In 2020, we will monitor improvements and interventions.

SECTION 4: SUMMARY OF ACCOMPLISHMENTS, BARRIERS AND ACTIONS

2019 Quality Improvement Work Plan — Elements by Category:

Quality of Care and Services

QAPI19.01 PACE QAPI Plan and Work Plan will be evaluated annually

Received and filed by the CalOptima Board of Directors on February 7, 2019.

QAPI19.02 PACE QAPI Plan and Work Plan will be reviewed and updated annually

Approved by the CalOptima Board of Directors on February 7, 2019.

QAPI19.03 Increase Influenza immunization rates for all eligible PACE participants

Goal: Greater than or equal to 90% of eligible participants will have their annual influenza vaccination by December 31, 2019.

Goal: Met

Data/Analysis: 97% percent of participants received the influenza vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

In order to meet our goal of vaccinating 90% or more of the participants by year end, we employed an effective strategy of a robust flu vaccine campaign for the 2019/2020 influenza season. By the

end of 2019, 97% of the participants had received the influenza vaccine. This was a slight decrease from the 98% who met this metric in 2018. We dedicated staff on multiple occasions to host a "Flu Booth" where participants received their flu vaccine from the PACE Clinic Nurse and received an acknowledgement button. PACE staff also received their vaccines through employee health services, expanding the scope and engagement of the flu vaccine campaign. We plan to implement this campaign again for the 2020/2021 flu season. As a highlight, CalOptima PACE reported no influenza outbreaks among our participants or staff in 2019. It is important to note that enrollees in the month of December were part of the statistical data and may not have had the vaccine due to their short involvement in the PACE program.

One of our challenges was in receiving the flu vaccine promptly from our vaccine vendor. Although we placed our order as soon as the vaccine was released, we did encounter a delay in one of our expected shipments, however we still met our goal.

QAPI19.04 Increase Pneumococcal immunization rates for all eligible PACE participants

Goal: Greater than or equal to 90% of eligible participants will have their pneumococcal vaccination by December 31, 2019.

Goal: Met

Data/Analysis: 95% of participants received the pneumococcal vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2019, 95% of our participants had received the pneumococcal vaccine, exceeding our goal. This was an improvement from the 90% who met this metric in 2018. Much of our success is attributed to the implementation of the following protocols:

a. Standing orders and standardized procedures in vaccine administration. This eliminates the need to wait for a physician order by delegating this responsibility to a registered nurse who has demonstrated the required competency.

b. Utilizing the EMR's quality analytics for tracking of missed opportunities for immunization.

The PACE QI department provided detailed monthly reports which specified which participants still needed the vaccination. One of the main barriers in vaccinating our participant population was the difficulty in obtaining previous medical records with prior vaccination documentation for new participants. An additional challenge was the complex interval periodicity between the Pneumococcal 13 and Pneumococcal 23 vaccines.

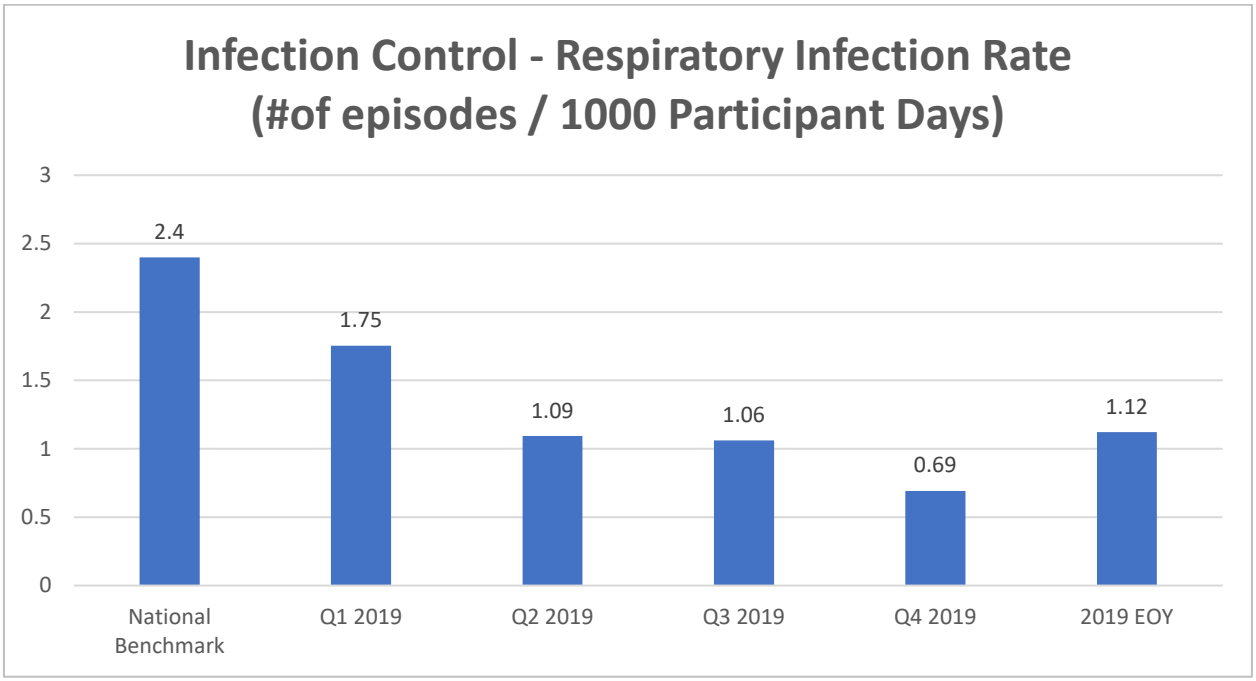
Looking forward into 2020, we plan to integrate the administration of the pneumococcal vaccines concurrently with the flu vaccine campaign for those participants who still require the vaccination. This will mitigate missed opportunities. It is important to note that enrollees in the month of December were part of the statistical data and may not have had the vaccine due to their short involvement in the PACE program.

QAPI19.05 Reduce common infectious in PACE participants (Respiratory Infection)

Goal: Maintain common respiratory infection rate less than the following national benchmarks: Respiratory Tract 0.1–2.4 episodes/1000 participant days.

Goal: Met

Data/Analysis: The 2019 rate is 1.12 episodes per 1000 participant days.



Summary and Key Findings/Opportunities for Improvement: Overall, rates were consistently below benchmarks.

As in previous years, we focused heavily on infection control in 2019. As an example, we began our influenza vaccination program as soon as the vaccine was released. This assured a high number of vaccinated individuals early in the flu season thereby reducing potential influenza outbreaks among our participants. In June 2019, our staff participated in a robust infection control training facilitated by the associate medical director of epidemiology at UCI Medical Center. Concepts such as universal precautions, droplet precautions and airborne precautions were discussed, highlighting the significant roles of health care workers in managing preventable infections. Additionally, CalOptima PACE's contracted after-hours on-call providers were instrumental in addressing participant's concerns regarding potential illnesses by responding to calls by using either a physician or a registered nurse. Often a medical provider would visit the patient in the home, providing immediate interventions and averting serious consequences.

In October 2019, we encountered our first case of infectious tuberculosis. Swift action was taken, and our infection control plan was enacted, initiating collaboration with the County of Orange Health Care Agency. The PACE QI team identified 256 PACE participants and 30 staff members as having potential exposure with the source contact. All participants were screened and tested for tuberculosis. Weekly TB status meetings were convened with the PACE Infection Control sub-committee, apprising all members of actions taken and pending actions. The activation of our exposure control plan was a smooth process, demonstrating an effective partnership between CalOptima PACE and the County of Orange Health Care Agency.

QAPI19.06 Increase Physician Orders for Life-Sustaining Treatment (POLST) utilization for PACE participants

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

Goal: Met

Data/Analysis: 100% of participants who have been enrolled in the PACE program for 6 months had PLOST by the end of 2019.

Quarter 2019	Completion Rate
Q1	100%
Q2	100%
Q3	100%
Q4	100%

Summary and Key Findings/Opportunities for Improvement: At the end of 2019, 100% of PACE participants had a completed POLST on file. This had been one of the program's key initiatives to ensure that we understood and delivered the end-of-life care which is consistent with the participants wishes. End-of-life and palliative care discussions have now been integrated into our Interdisciplinary Team meetings (IDT) and are documented in the participant's care plan.

QAPI19.07 Increase the number of PACE participants who have a designated emergency, family decision maker documented on the POLST

Goal: Greater than or equal to 90% of participants who a completed POLST will have the designated family member make decisions in emergency situations identified and documented on the POLST by December 31, 2019.

Goal: Not Met

Data/Analysis: 19% participants had POLST by the end of 2019. See table below:

Quarter 2019	Completion Rate
Q1	19%
Q2	20%
Q3	19%
Q4	19%

Summary and Key Findings/Opportunities for Improvement:

Designation of a family member as a decision maker has been a challenge for us. This may be a result of several factors. First, end-of-life discussions are difficult for many participants and their families, particularly in our diverse participant population where cultural traditions and practices influence such conversations. Second, we frequently experience a lack of family involvement in the care of many of our participants. To increase family involvement and identify the decision-maker, we will be moving in the direction of having participants, together with their family member, complete an Advance Health Care Directive at the time of enrollment. The Advance Health Care Directive will contain three components: (1) Designation of an Agent and (2) Instructions for Health Care (end-of-life decisions, relief from pain); and (3) organ donation. The

conversation concerning Advance Health Care Directive will begin early in the enrollment process, beginning with the initial nursing Level of Care assessment during the pre-enrollment process. This element will be retired next year and will be replaced by an Advanced Health Care Directive quality initiative.

QAPI19.08 Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS

Goal: 100% of participants have functional status assessment completed every 6 months by the disciplines required by CMS.

Goal: Met

Data/Analysis:

Functional Status Assessment	Q1 2019	Q2 2019	Q3 2019	Q4 2019	EOY
Charts with All Assessments	319	324	354	391	1388
Census at End of Quarter	319	326	356	393	1394
Rate	100%	99.4%	99.4%	100%	100%

Care for Older Adults: Functional Status Assessment				
	2019 Star Rating Measure Cut Points			
MY 2019 PACE	2 Stars	3 Stars	4 Stars	5 Stars
100%	27% to 68%	68% to 77%	77% to 90%	≥ 90%

Summary and Key Findings/Opportunities for Improvement:

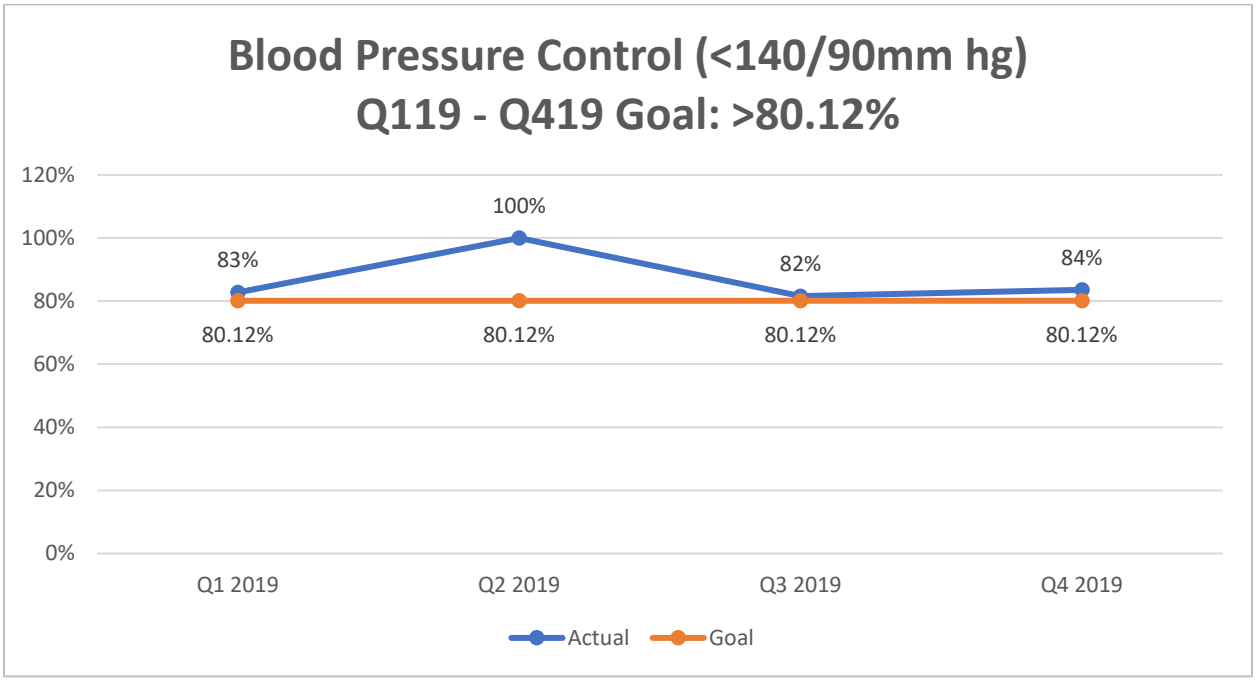
A key factor in achieving this has been the monthly reports generated by the QI department and sent to the PACE clinical team, specifying which participants required the functional assessment. This prompts the clinical team to schedule the appointment, communicate with the family/caregiver regarding the appointment and coordinating transportation for the participant. The result is comparable to a 5-Star Medicare rating based on the 2019 Star Rating Measure Cut Points.

QAPI19.09 Increase the percentage of PACE participants with diabetes who have controlled blood pressured (<140/90 mm hg)

Goal: > 80.12% of Diabetics will have a Blood Pressure of <140/90

Goal: Met

Data/Analysis: The 2019 final rate is 84%.



Diabetics with Controlled Blood Pressure				
	Medicare Quality Compass 2019 HEDIS Percentiles			
MY 2019 PACE	50th Percentile	75th Percentile	90th Percentile	95th Percentile
84%	69.53%	76.56%	81.50%	84.91%

Summary and Key Findings/Opportunities for Improvement:

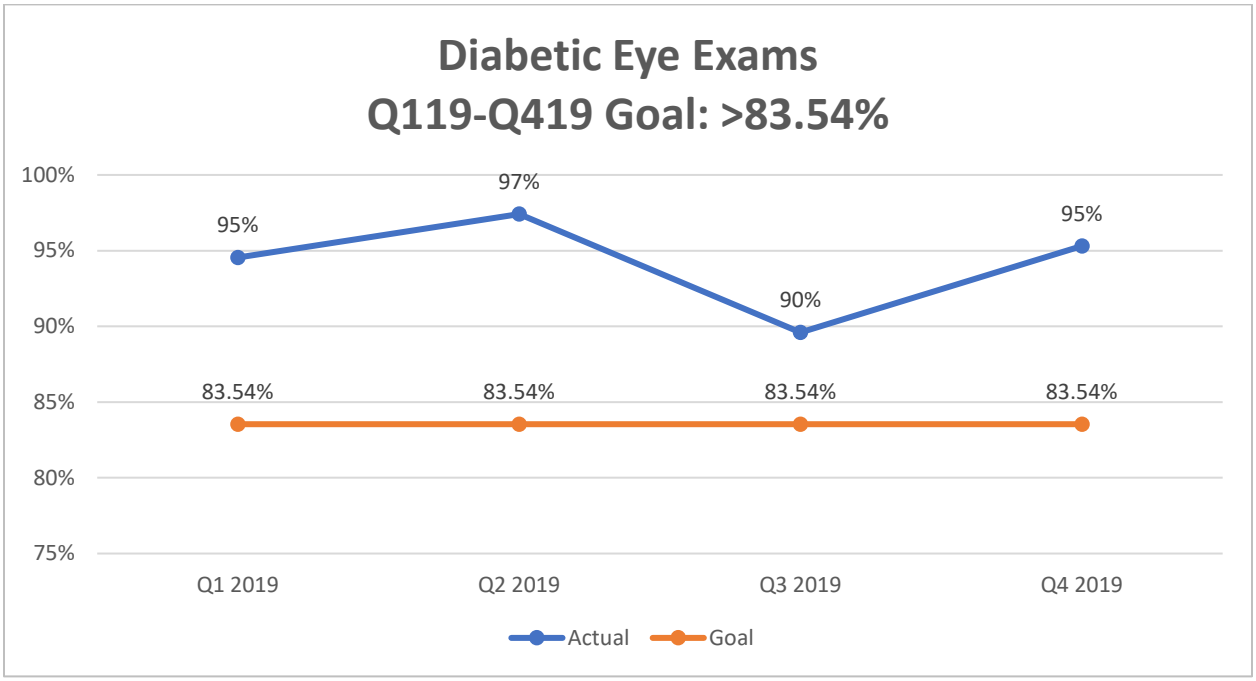
We exceeded our goals in this element due to the prompt identification of participants with poor control of their blood pressure, although a decrease from the 100% of participants who met this metric in 2018. The PACE QI department remits a monthly report to the PACE clinical team, specifying which participants have poorly controlled blood pressure. These identified participants are monitored with out-of-range numbers leading to direct intervention. Close supervision on the day center floor of those participants who may be symptomatic or have had a change-of-condition adds an extra layer of oversight with appropriate immediate intervention. Interventions include in-house pharmacist consults as well as adjustments by the medical provider. These results would have put us in the 90th percentile based on the 2019 Medicare HEDIS Quality Compass.

QAPI19.09 Increase the percentage of PACE participants with diabetes who have had their annual diabetic eye exam completed

Goal: Greater than or equal to 83.54% of Diabetics will have an Annual Eye Exam

Goal: Met

Data/Analysis: The 2019 final rate is 95%.



Comprehensive Diabetes Care: Annual Diabetic Eye Exam				
	Medicare Quality Compass 2019 HEDIS Percentiles			
MY 2019 PACE	50th Percentile	75th Percentile	90th Percentile	95th Percentile
95%	75.28%	82%	85.33%	87.10%

Diabetes Care: Eye Exam					
	2019 Star Cut Points				
MY 2019 PACE	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
95%	<56%	56% to 64%	64% to 73%	73% to 80%	>/= 80%

Summary and Key Findings/Opportunities for Improvement:

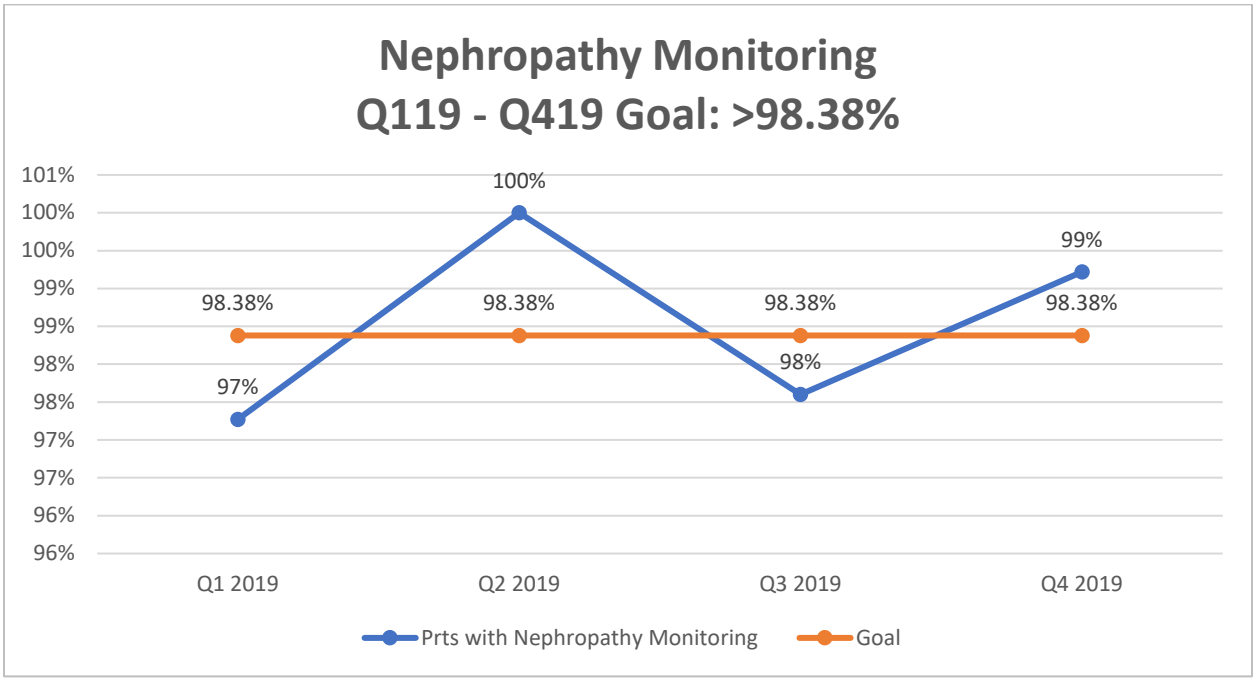
We exceeded our target goal with 95% of diabetic participants receiving an annual eye exam in 2019. This was an improvement from the 90% who met this metric in 2018. In late 2019, PACE purchased Optometry equipment and contracted with an optometrist to conduct on-site eye exams for our participants. The optometrist comes on-site at the PACE clinic twice per month and provides eye exams for approximately 15 participants on a monthly basis. This assures prompt access to eye exams as well as any immediate interventions. These results are comparable to a 5-Star Medicare rating based on the 2019 Star Cut Points and would have put us in the 95th percentile based on the 2019 Medicare HEDIS Quality Compass.

QAPI19.09 Increase the percentage of PACE participants with diabetes who receive nephropathy monitoring

Goal: Greater than 98.38% of Diabetics will have Nephropathy Monitoring

Goal: Met

Data/Analysis: The 2019 final rate is 99%.



Comprehensive Diabetes Care: Medical Attention for Nephropathy				
	Medicare Quality Compass 2019 HEDIS Percentiles			
MY 2019 PACE	50th Percentile	75th Percentile	90th Percentile	95th Percentile
99%	95.95%	97.08%	98.30%	98.78%

Comprehensive Diabetes Care: Nephropathy Monitoring				
	2019 Star Rating Measure Cut Points			
MY 2019 PACE	2 Stars	3 Stars	4 Stars	5 Stars
99%	NA	87% to 95%	95% to 97%	≥ 97%

Summary Key Findings/Opportunities for Improvement: In 2019, 99% of our participants had received nephropathy monitoring. This was an improvement from the 96% who met this metric in 2018. The PACE QI department provided the PACE clinical team with monthly reports specifying which participants required nephropathy screening/monitoring. Compliance to screening/monitoring includes meeting one of the criteria: (1) labs as indicated; (2) medications as indicated, and (3) a follow-up with a nephrologist. Looking ahead into 2020, we will have our clinical pharmacist review the diabetic regimen as it correlates to nephropathy screening. These results are comparable to a 5-Star Medicare rating based on the 2019 Star Cut Points and would have put us in the 95th percentile based on the 2019 Medicare HEDIS Quality Compass.

QAPI19.10 Decrease the rate of participant falls occurring at the PACE day centers

Goal: <10% (6.65 Falls per 1000 member months)

Goal: Met

Data/Analysis: The 2019 rate is 6.34 falls per 1000 member months.

Quarter 2019	# falls	Member Months	# falls per 1000 members months
Q1	10	932	10.73
Q2	4	976	4.10
Q3	5	1037	4.82
Q4	7	1155	6.06
EOY	26	4100	6.34

Summary Key Findings/Opportunities for Improvement:

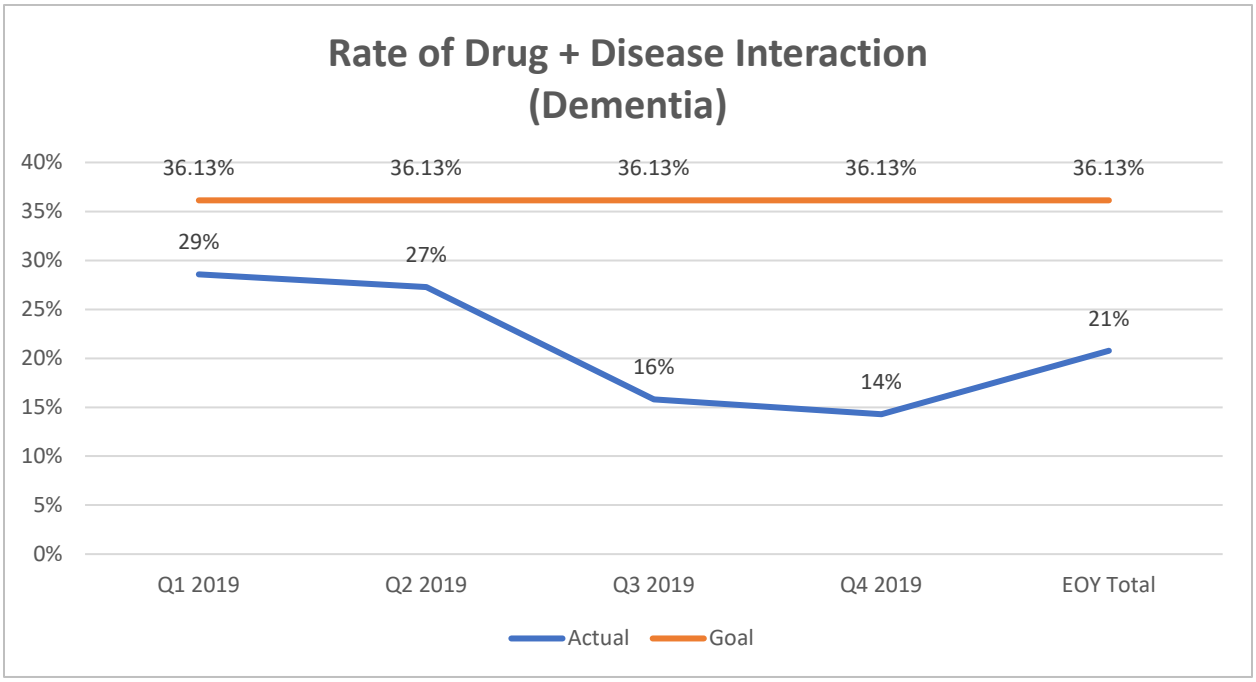
This was the first year of this measurement and the goal was met. Our success in the low fall rate in the day center is attributable to our preventive efforts. The day center floor is adequately staffed with personal care attendants who provide supervision and support. Aside from working on a 1:1 basis with our participants, the PACE rehabilitation team identifies those participants who are fall-risks and provides numerous fall prevention programs such as "Fallers Anonymous," a Fall Recovery Workshop and a Fall Prevention Committee. The day center is free of obstacles which may hinder safe ambulation and mobility of our participants. This is one of the measures we are using to ensure the quality of care delivered across the Alternative Care Setting (ACS) sites. There were no falls of any participants at any of the ACS sites.

QAPI19.11 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents

Goal: <36.13%

Goal: Met

Data/Analysis: The 2019 rate is 21% (23 out of 96 participants).



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DDE: Dementia + tricyclic antidepressant or anticholinergic agents				
	Medicare Quality Compass 2019 HEDIS Percentiles			
MY 2019 PACE	50th Percentile	75th Percentile	90th Percentile	95th Percentile
21%	44.44 %	40%	35.73%	33.96%

Summary and Key Findings/Opportunities for Improvement:

In 2019, we had 21% of participants with dementia who took a tricyclic antidepressant or anticholinergic agent which is a decrease from the 24% in 2018. We added a clinical medical director who receives monthly reports from our QI department of potential drug/disease interactions for a frail population. In collaborating with PACE staff medical providers, specific participants are identified and changes in medication regimen may be implemented, preventing adverse outcomes. Our on-site clinical pharmacist also reviews medication for appropriate use and dosing. These results would have put us in the 95th percentile based on the 2019 Medicare HEDIS Quality Compass.

QAPI19.12 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs

Goal: <3.85%

Goal: Met

Data/Analysis: The 2019 rate is 0%.

DDE: CKD+ Nonaspirin NSAIDS or Cox2 Selective NSAIDs				
	Medicare Quality Compass 2019 HEDIS Percentiles			
MY 2019 PACE	50th Percentile	75th Percentile	90th Percentile	95th Percentile
0%	9.31%	6.36%	3.90%	2.47%

Summary and Key Findings/Opportunities for Improvement:

In 2019, we had no participants with Chronic Kidney Disease (CKD) who took a NSAID or Cox2 Selective NSAID. This is a decrease from the 1% of CKD participants who were on a NSAID or Cox2 Selective NSAID in 2018. The coordinated efforts of the PACE medical providers and the PACE clinical pharmacist will assure optimal scrutiny in the use of NSAIDs among our participants with chronic kidney disease. These results would have put us in the 95th percentile based on the 2019 Medicare HEDIS Quality Compass.

QAPI19.13 Monitor participants who are receiving prescription opioids for 15 days or more days at an average milligram morphine equivalent (MME) dose of 120mg

Goal: 100% of participants receiving opioids for 15 or more days at an average milligram morphine doses (MME) 120mg will be reevaluated monthly by their treating provider.

Goal: Not Met

Data/Analysis: The 2019 rate is 70% (7 out of 10 participants were reevaluated monthly)

Quarter 2019	# Participants with high dosage of opioids
Q1	0 out of 2 participants were reevaluated (0%)
Q2	1 out of 2 participants were reevaluated (50%)
Q3	4 out of 4 participants were reevaluated (100%)
Q4	2 out of 2 participants were reevaluated (100%)

Summary and Key Findings/Opportunities for Improvement:

This was the first year of this metric. It steadily improved over the course of the year as the quarterly rate increased from 0% to 50% to 100%. We had challenges with keeping these monthly appointments for some participants who were in skilled nursing facilities and or who were in hospitals for extended periods of time as we had not created any exemption criteria which we will look to add in 2020. Although the number of participants receiving high dosages of opioids is small, it nevertheless requires attentive management.

QAPI19.14 Increase the percentage of participants for whom medications were reconciled within 30 days of hospital discharge

Goal: ≥ 90% of participants will have their medications reconciled within 30 days of hospital discharge in 2019

Goal: Met

Data/Analysis: 95% percent of participants had medications reconciled within 30 days post discharge in 2019.

Medication Reconciliation Post-Discharge	Q1 2019	Q2 2019	Q3 2019	Q4 2019	EOY
Total # of Discharges	40	29	45	52	166
Received Reconciliation	39	28	43	49	157
Rate	98%	97%	91%	96%	95%
Goal	90%	90%	90%	90%	90%

Medication Reconciliation Post-Discharge				
	Medicare Quality Compass 2019 HEDIS Percentiles			
MY 2019 PACE	50th Percentile	75th Percentile	90th Percentile	95th Percentile
95%	59.40%	74.45%	84.91%	88.08%

Medication Reconciliation Post-Discharge					
	2019 Star Rating Measure Cut Points				
MY 2019 PACE	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
95%	<37%	37% to 54%	54% to 66%	66% to 79%	≥ 79%

Summary and Key Findings/Opportunities for Improvement:

Medication reconciliation post hospital discharge remains one of our top priorities. In 2018, we contracted with House Calls Medical Associates which serves as our after-hours call center and provides our hospitalists and nursing home physicians. In 2019, the contract with House Calls Medical Associates extended to the provision of primary care providers within the PACE clinic. Through this partnership, our providers maintain a close relationship with our participants and can take care of our participants across all levels of care thereby improving continuity of care. This allows for prompt medication reconciliation. These results are comparable to a 5-Star Medicare rating based on the 2019 Star Cut Points and would have put us in the 95th percentile based on the 2019 Medicare HEDIS Quality Compass.

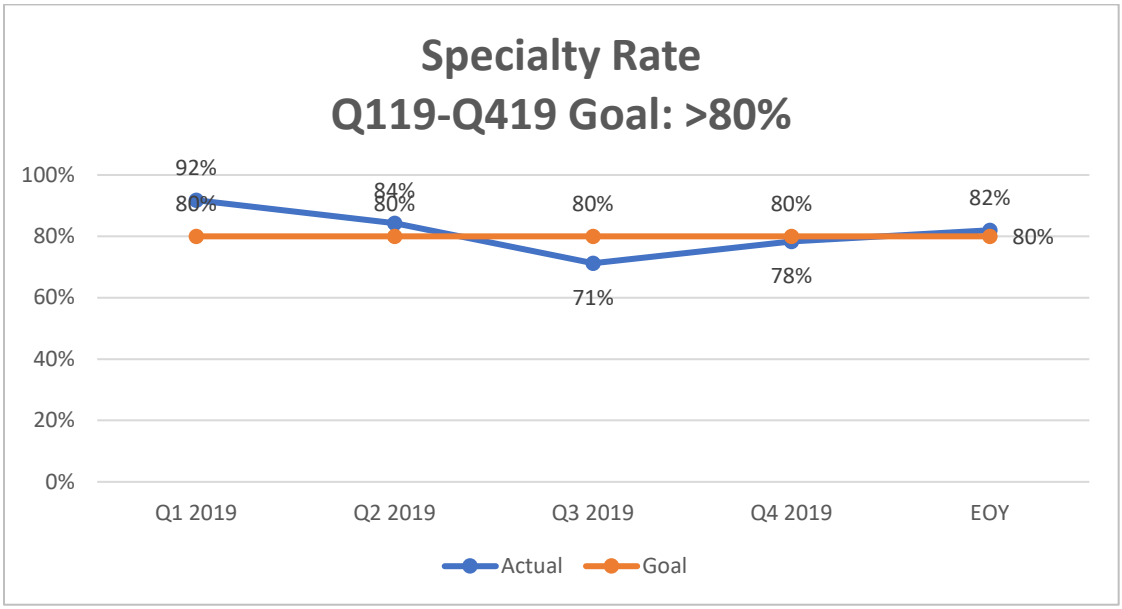
Access and Availability

QAPI19.15 Improve access to specialty practitioners

Goal: ≥ 80% of specialty care authorizations will be scheduled within 10 days

Goal: Met

Data/Analysis: The 2019 rate was 82%.



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Summary and Key Findings/Opportunities for Improvement:

Over the past years, we have concentrated efforts on scheduling specialty care authorized visits in a timely manner. As the PACE population grows, so do the number of specialty referrals. To improve our outcome in this measure, we recently implemented the following:

1. Addition of two scheduling staff members for a total of three scheduling assistants. Not only do they schedule appointments and coordinate transportation needs, they also remind participants, coordinate with participant's family, provide interpreters or escorts (if needed), send relevant medical records to the authorized specialist and follow-up on specialty consult notes.
2. Contracting additional specialists, thereby enlarging our specialty pool and permitting timely access.
3. Bringing specialist in-house (podiatry, dental, and optometry).

We currently work with two nephrologists, a podiatrist, a psychiatrist, an ophthalmologist and an optometrist who work closely with the program. In addition to their private practice, the podiatrist, dentist and optometrist offer care and services to our participants on-site at the PACE clinic. Looking forward into 2020, we are looking to identify additional core specialists who understand the PACE model of care and are willing to work closely with the program. This will improve scheduling access as well as care coordination through prompt consult notes and real-time dialogue between the specialist and the PACE medical provider.

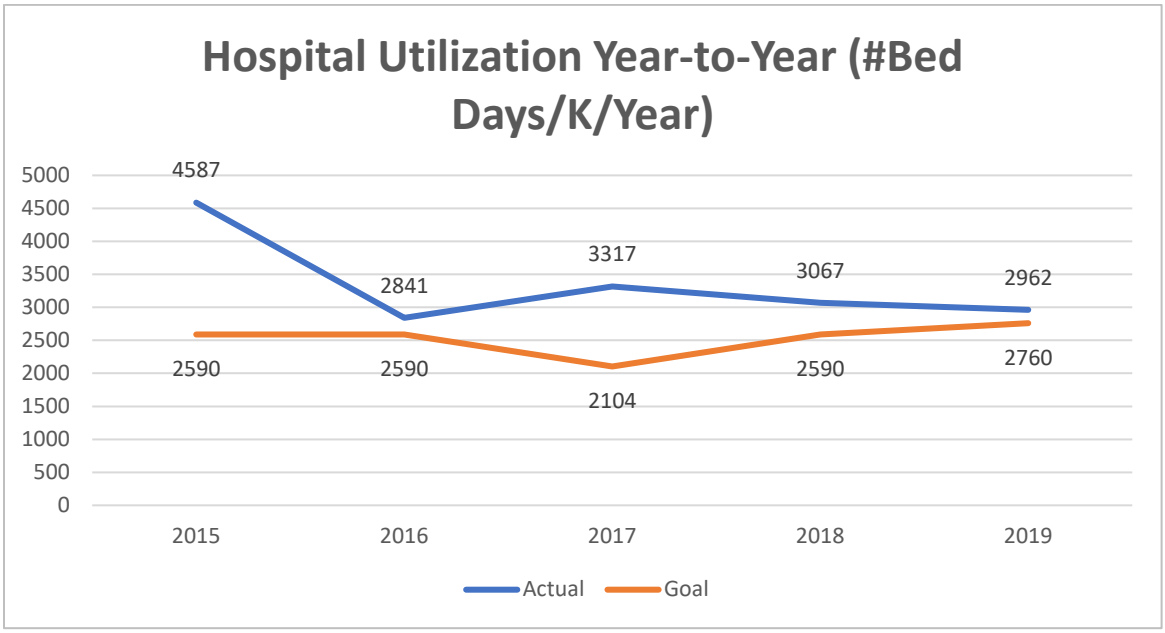
Utilization Management

QAPI19.16 Reduce the rate of acute hospital days by PACE participants

Goal: < 2,670 hospital days per 1000 per year

Goal: Not Met

Data/Analysis: The 2019 rate was 2,962 bed days per 1000 per year.



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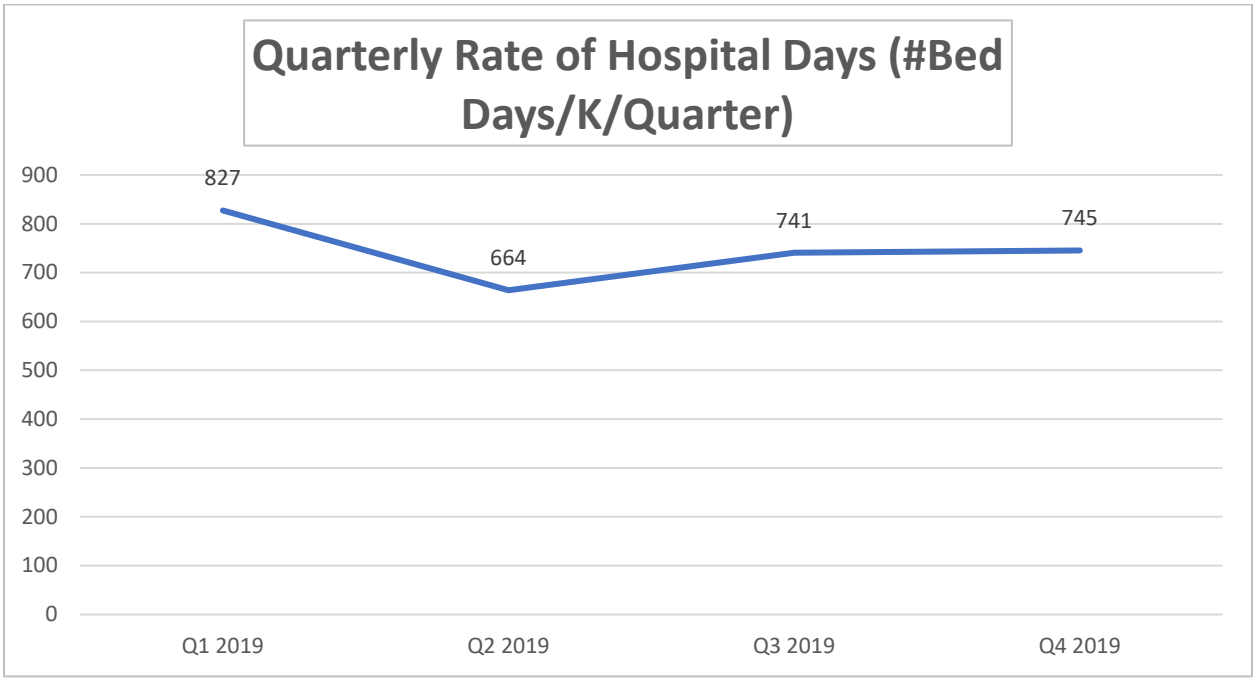
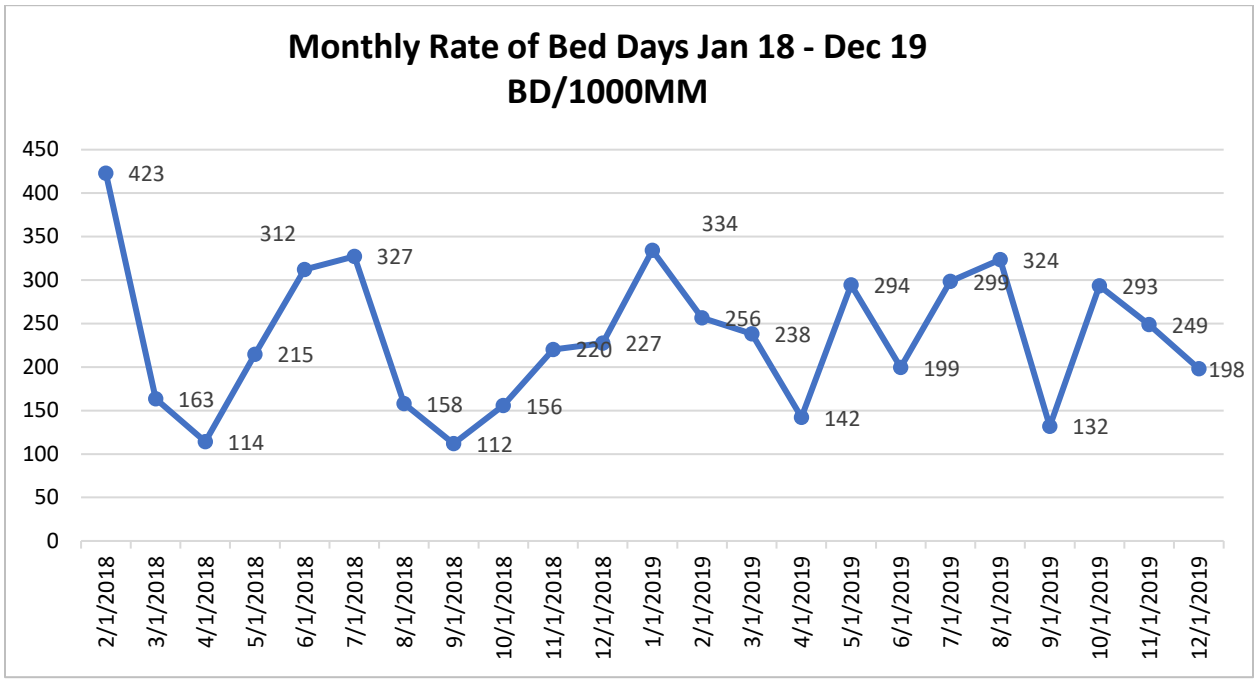




Summary/Key Findings/Opportunities for Improvement

Over the last 12 months, the monthly rate of bed days has had an overall slightly improving trend line, but inpatient hospital utilization remains a challenge. The 2018–2019 flu season was particularly severe resulting in a very high Q1 rate which increased the overall 2019 rate. Outside of the 2018–2019 flu season, we found that most of the visits came from a small subset of participants. One of the largest subsets were participants on dialysis. We have found two trends which we will be working on closely to change. First, there is a group of dialysis participants who were often sent directly to the ER from the dialysis center, many for minor issues. We have begun to work more closely with two specific nephrologists/dialysis centers to help improve coordination

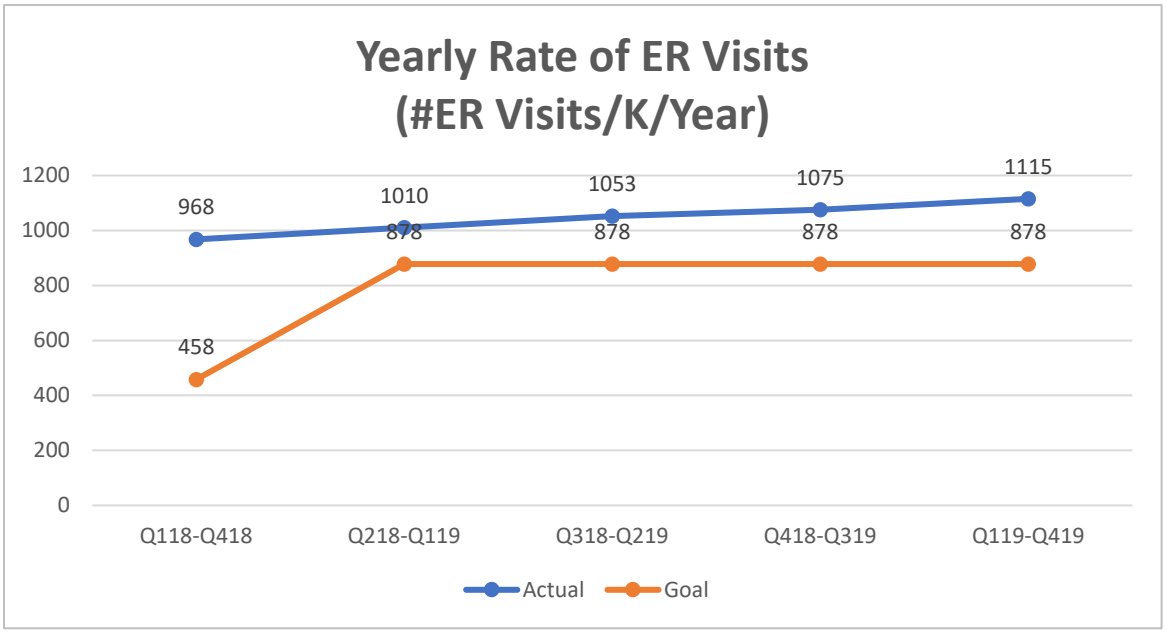
and remedy this situation. Second, another small group of the same dialysis participants occasionally miss their dialysis appointments which often lead directly to an admission. We are looking to add a new nurse case manager who will focus part of their time providing enhanced case management to these dialysis participants. In addition, in 2020, we will continue to refine our ER Diversion program. Not only will they provide direct participant after-hours home visits, but they will also take into consideration the admission of a participant into a skilled nursing facility or custodial care as opposed to an inpatient hospitalization.

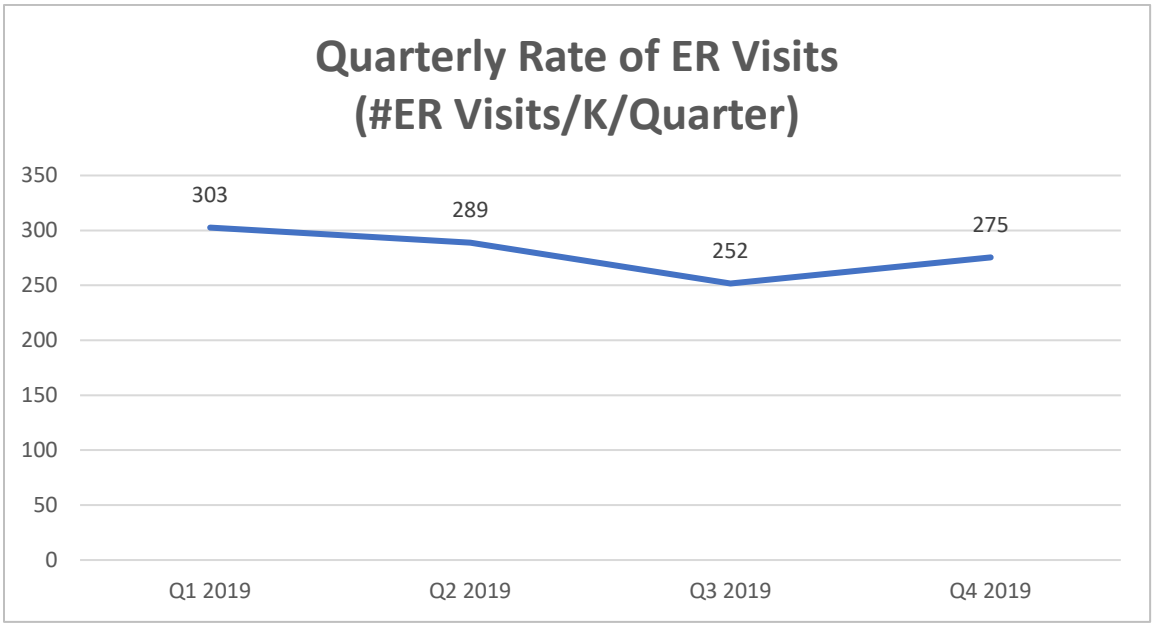
QAPI19.17 Reduce the rate of ER utilization by PACE participants

Goal: < 878 emergency room visits per 1000 per year

Goal: Not Met

Data/Analysis: The 2019 rate was 1,115 emergency room only visits per 1000 per year.





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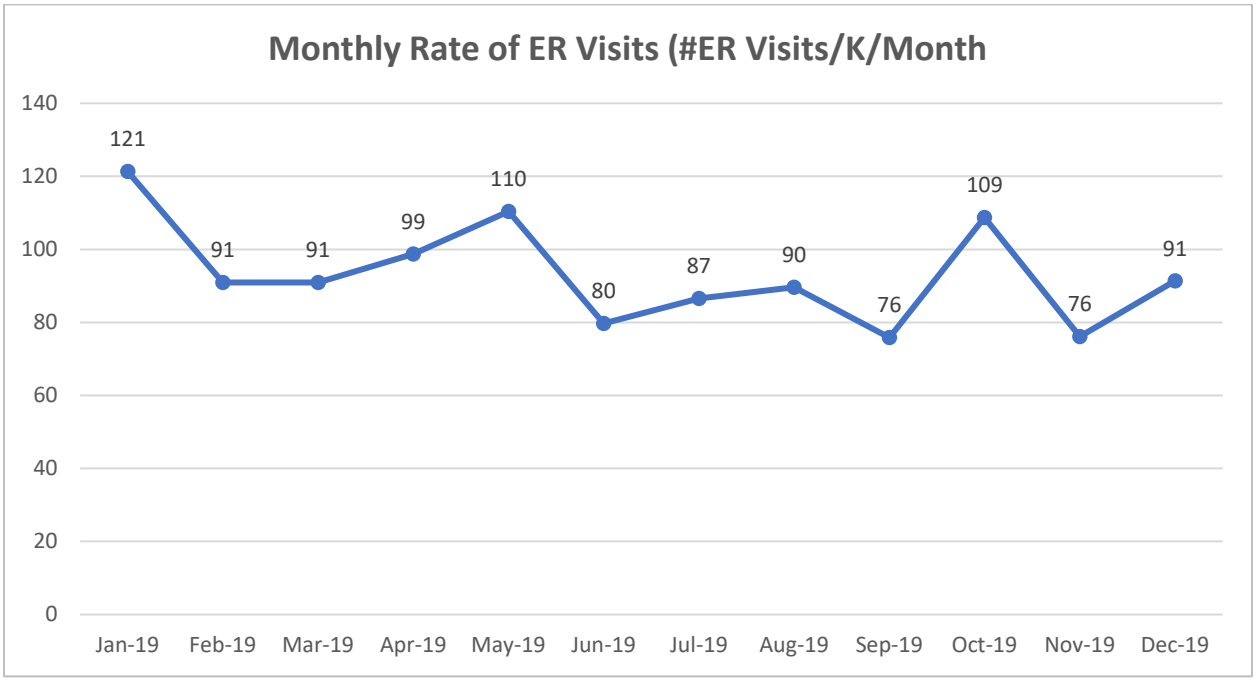


Summary and Key Findings/Opportunities for Improvement:

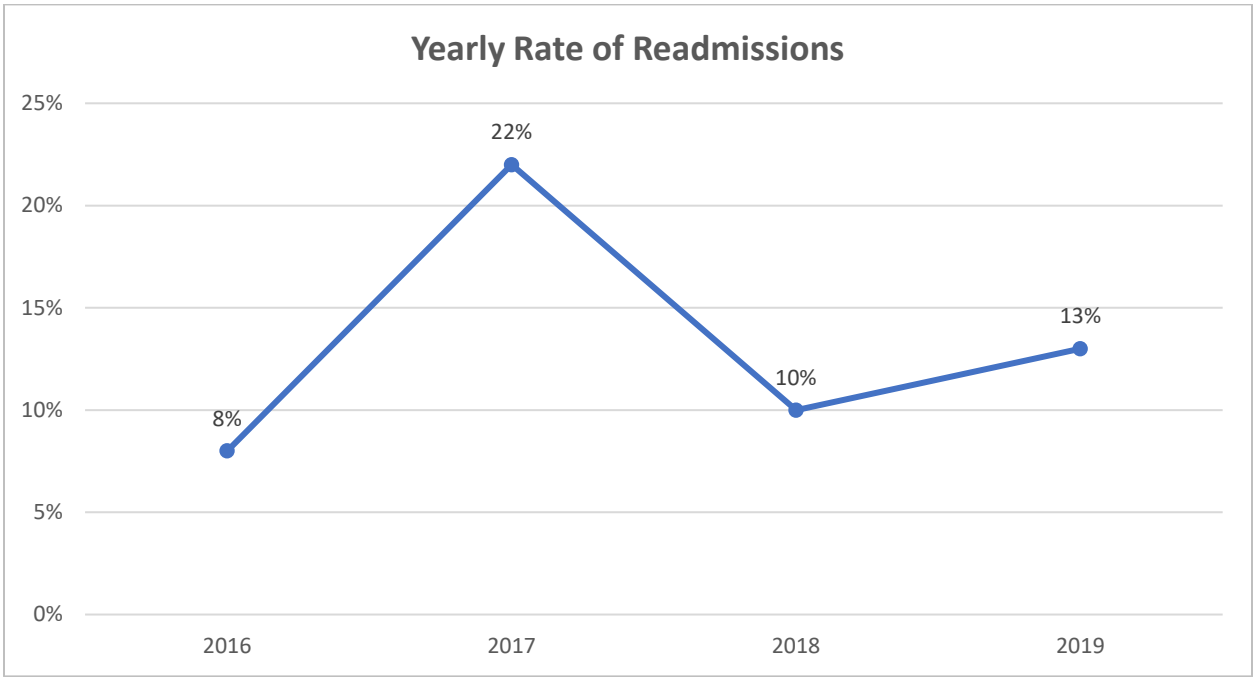
Similar to our inpatient bed days, the ER visits have been trending down over the course of 2019. However, the overall ER rate did slightly increase year over year due to the challenging 2018–2019 flu season. The ER diversion program continued to expand this year which correlates with the slightly decreasing rates. This is where the on-call physicians can employ triage strategies (i.e. send a RN to the participant home, divert to a nursing facility or do a home visit) and eliminate the need for an ER visit. As with the previous measure, our new RN case manager will focus on working with on our frequent ER utilizers. Additionally, this nurse will start to work closely with the vendors (Board and Care and Assisted Living Facilities) who are frequently sending our participants to the ER. Vendor education regarding our after-hours service will play an important role in over-utilization of emergency room visits. The strategy implemented regarding the missed dialysis appointments should also favorably impact the number of ER visits. Finally, in 2020, we will also focus on providing greater family engagement for our high-risk participants in hopes that they will offer greater support and guidance to the participant.

QAPI19.18 Reduce the 30-day all cause readmission rates by PACE participants

Goal: Less than 15% 30-day all cause readmissions

Goal: Met

Data/Analysis: The 2019 rate was 13%.



Summary and Key Findings/Opportunities for Improvement:

The readmission rates tend to have a great deal of variance year over year due to the small total number of participants and readmissions. We ended 2019 with a 13% 30-day readmission rate which is a slight increase over last year. Our major challenges in readmissions are the medical complexity of our participants, non-compliance on the part of the participant and lack of family support. In 2020, the new RN case manager will focus more specifically on these participants. Additionally, we have begun incorporating the morning clinical huddles into the IDT meetings this year. This concept was piloted in Q4 of 2019 with one IDT with great success and will be adopted program wide in 2020.

QAPI19.19 Decrease the percentage of participants who are placed in a long-term care facility

Goal: < 3% of participants will reside in long-term care (LTC)

Goal: Met

Data/Analysis: We had 5 participants who were in LTC in 2019, which was 1.27% of the PACE enrollment

Summary and Key Findings/Opportunities for Improvement:

This is one of our key elements, as the goal of PACE is to help nursing home eligible participants to live safety at home as long as possible. Although the number of participants residing in LTC facilities is approximately 1%, we recognize that as our program matures, we will see an increase in the percentage of participants who are placed in a LTC facility.

Enrollment

QAPI19.20 Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment.

Goal: Reduce the percentage of participants who disenroll for controllable reasons within the first 90 days of enrollment in 2019 by 10%

Goal: Met

Data/Analysis:

Disenrollment Data in the First 90 Days

	Total Disenrollment	Uncontrollable Disenrollment	Controllable Disenrollment	% Controllable Disenrollment
2018	8	1	7	88%
2019	14	5	9	64%

Summary and Key Findings/Opportunities for Improvement:

In 2019, nine participants disenrolled for controllable reasons with the dominant reason of wanting to keep their pre-enrollment PCP. This information was shared with the enrollment team throughout the year to ensure we are communicating effectively with participants prior to enrollment. Overall, this resulted in a 24% improvement in controllable disenrollment compared to 2018. In 2020, we will continue to monitor and share this information with staff to ensure continuous improvement.

QAPI19.21 Increase the Inquiry to enrollment conversion rate to 7%

Goal: Increase the Inquiry to enrollment conversion rate to 7% (Baseline of 5% in the last 6 months of 2018)

Goal: Not Met

Data/Analysis: Final rate was 5%.

Quarter 2019	Rate
Q1	5%
Q2	4%
Q3	6%
Q4	8%
EOY	5%

Summary and Key Findings/Opportunities for Improvement:

In 2020, we are changing the description of this quality indicator to “Qualified Leads to Enrollment.” Inquiry to Enrollment as in the 2019 quality indicator description, encompasses a broad spectrum of potential enrollees including those who actually had no interest in joining PACE after an inquiry and those who were too high-functioning and would not be eligible per State certification although they initiated an inquiry. By changing the description from inquiry to qualified lead, we have a more accurate assessment of enrollment rates.

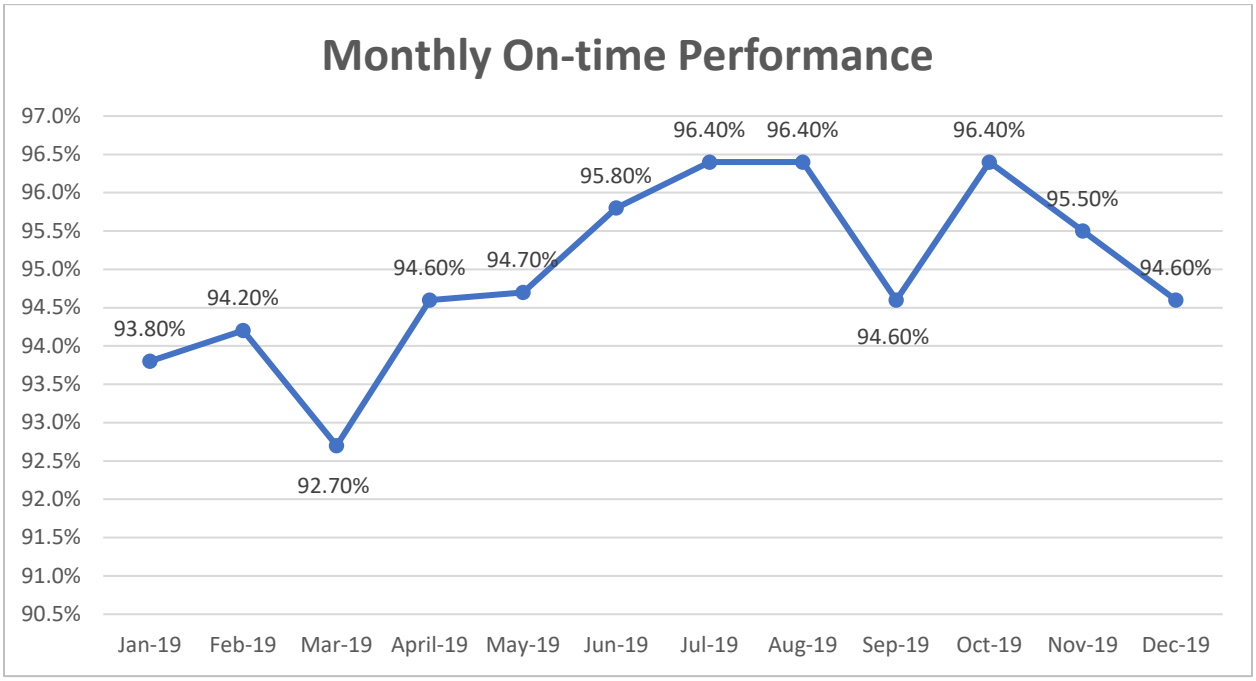
Transportation

QAPI19.22 and QAPI19.23: Transportation

Goal: Ensure PACE transportation ride times are less than 60 minutes per trip with a goal: 0 trips > 60 minutes in duration and improve participant experience by providing timely transportation services with a goal of ≥ 90% on-time performance.

Goal: Less than 60 minutes in ride duration: **Goal Met**
On-time performance: **Goal Met**

Data/Analysis:



Summary and Key Findings/Opportunities for Improvement:

Towards the end of 2019, our Transportation department provided approximately 60,000 one-way trips for our participants as a result of a substantial growth in enrollment. Nevertheless, we met our goal of providing timely transportation services with a greater than 94% on-time performance. With over 60,000 one-way trips, we only had four one-hour violations (Q4) which were in large part due to major street repairs. Looking ahead into 2020, we plan to streamline the transportation workflow to assure that we remain compliant with no one-hour violations. This involves restructuring our Transportation Department and designing workflow to assure efficiency and participant satisfaction.

Meals

QAPI19.24 Improve the overall satisfaction of participants with meals within the PACE program

Goal: ≥ 64% on Satisfaction with Meals summary score on the 2019 PACE Satisfaction Survey

Goal: Met

Data/Analysis: 75% overall weighted participant satisfaction summary score.

2019 Participant Survey Satisfaction with Meals Domains

Domain	2018	2019	2019 National Average
Do the lunches look good?	62%	75%	70.3%
Do the lunches taste good?	52%	72%	62.8%
Do you get a variety of foods here?	61%	85%	81.2%
Meal satisfaction composite score	55%	77%	71.3%
Overall, would you rate the lunches as excellent, very good and/or good.	74%	81%	79.4%

Summary and Key Findings/Opportunities for Improvement:

In 2018, 59% of the participants were satisfied with meals served at PACE. As a result, meal satisfaction was added as one of our 2019 quality indicators and meals became an area of focus. We worked with different vendors who would be able to provide a variety of meal options which would be consistent with our multi-cultural population. We formed a food committee whereby participants could express their food likes and dislikes. We added "food enhancements" such as guacamole and sour cream and added ethnic specialties such as porridge. Finally, we surveyed participants regularly throughout the year and responded quickly to the feedback. As a result of these efforts, our meal satisfaction domain increased by 18% and is nearly 6% above the national average.

Overall Satisfaction

QAPI19.25 Improve the overall satisfaction of participants and their families with the CalOptima PACE program

Goal: Greater than or equal to 88% on the Overall Satisfaction Weighted Average on the 2019 PACE Satisfaction Survey.

Goal: Met

Data/Analysis: 92% overall weighted participant satisfaction summary score.

Participant Survey Overall Satisfaction Domains

Domain	2018	2019	2019 National Average
Would you recommend the program to a close friend or relative?	93%	96%	93.2%
Overall satisfaction with the care received	97%	96%	94.7%

2019 Participant Survey Domains

Domain	2018	2019	2019 National Averages
Transportation	93%	96%	94.3%
Center Aids	92%	94%	91%
Home Care	91%	89%	86.8%
Medical Care	88%	93%	91.1%
Health Care Specialist	90%	98%	90.1%
Social Worker	97%	96%	94.9%
Meals	59%	77%	71.3%
Rehabilitation Therapy and Exercise	98%	98%	94.4%
Recreational Therapy	77%	91%	80.9%
Environment and Safety	92%	93%	88.2%
Weighted Summary Score	87%	92%	88.8%

Summary and Key Findings/Opportunities for Improvement:

In the fall of 2019, CalOptima PACE contracted with Vital Research to conduct the Participant Satisfaction Survey. Vital Research interviewed 116 participants to gauge the participant's satisfaction with CalOptima PACE services. This is a standardized survey taken by most of the PACE programs in the country.

The overall satisfaction score was 96%, and also 96% would recommend PACE to a close friend or relative.

Overall, 7 of the 10 satisfaction domains increased from 2018 along with the weighted summary score. All 10 participant satisfaction domains were above the national average.

SECTION 5: 2019 HEALTH PLAN MANAGEMENT SYSTEM (HMPS)

2019 HPMS Updates: In 2018, CMS implemented changes to the Level I event and Level II reporting structure. Level I and Level II events are now referred to as Unusual Quality Incidents and are reported to CMS on a quarterly basis via the Health Plan Management System (HPMS). The following elements are reported:

1. Grievances
2. Appeals
3. Unusual Quality Incidents
4. Medication Errors

5. Immunizations (evaluated in the Quality of Care section of this report)
6. Falls without Injury
7. ER Visits (evaluated in the Utilization Management section of this report)
8. Denials of Prospective Enrollees

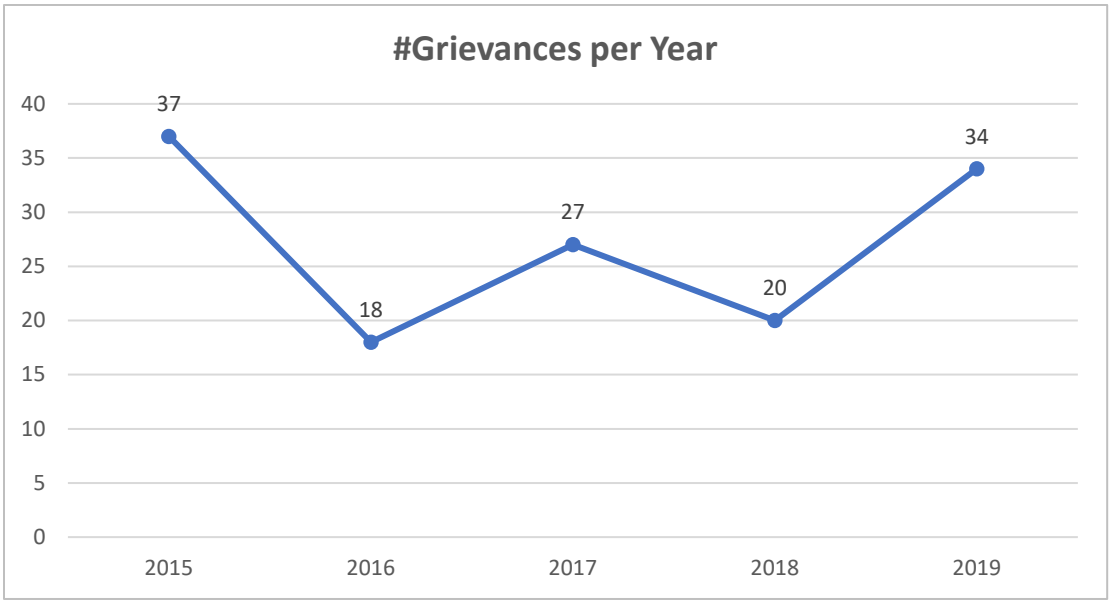
Grievances

Data Analysis:

Quarterly Grievances Q4 2014–Q4 2019

	CENTER							CLINIC			
					Transportation			Clinical Care/			
	# Grievance	Other	Food	Home Car	Timelines	Prt-Driver	Escort	Dissatisfaction	Timeliness	Comm-unication about care	Scheduling/ Communication
Q4 2014	2	0									
Q1 2015	0	0									
Q2 2015	7	0	1	1	1	0	0	1	1	1	1
Q3 2015	17	0	0	0	4	1	2	3	4	1	1
Q4 2015	13	0	0	0	1	1	1	8	1	0	1
Q1 2016	1	0	0	0	0	0	0	0	0	0	1
Q2 2016	7	0	0	0	4	0	0	2	0	0	1
Q3 2016	6	0	0	0	2	1	0	1	0	0	2
Q4 2016	4	0	0	0	0	2	0	0	2	0	0
Q1 2017	9	0	0	1	0	0	0	3	1	1	3
Q2 2017	2	0	0	0	2	0	0	0	0	0	0
Q3 2017	10	0	0	0	7	0	0	2	1	0	0
Q4 2017	6	1	0	0	2	1	0	1	0	0	1
Q1 2018	10	1	0	0	2	1	0	2	2	0	2
Q2 2018	4	0	1	0	0	0	0	2	0	1	0
Q3 2018	5	0	0	0	1	0	0	3	0	1	0
Q4 2018	1	1	0	0	0	0	0	0	0	0	0
Q1 2019	2	0	0	0	1	0	0	0	0	1	0
Q2 2019	9	0	0	0	8	0	0	0	0	1	0
Q3 2019	14	7	0	0	4	0	1	0	0	0	2
Q4 2019	9	0	0	2	4	0	0	1	0	1	1

Grievances Per Year 2015–2019



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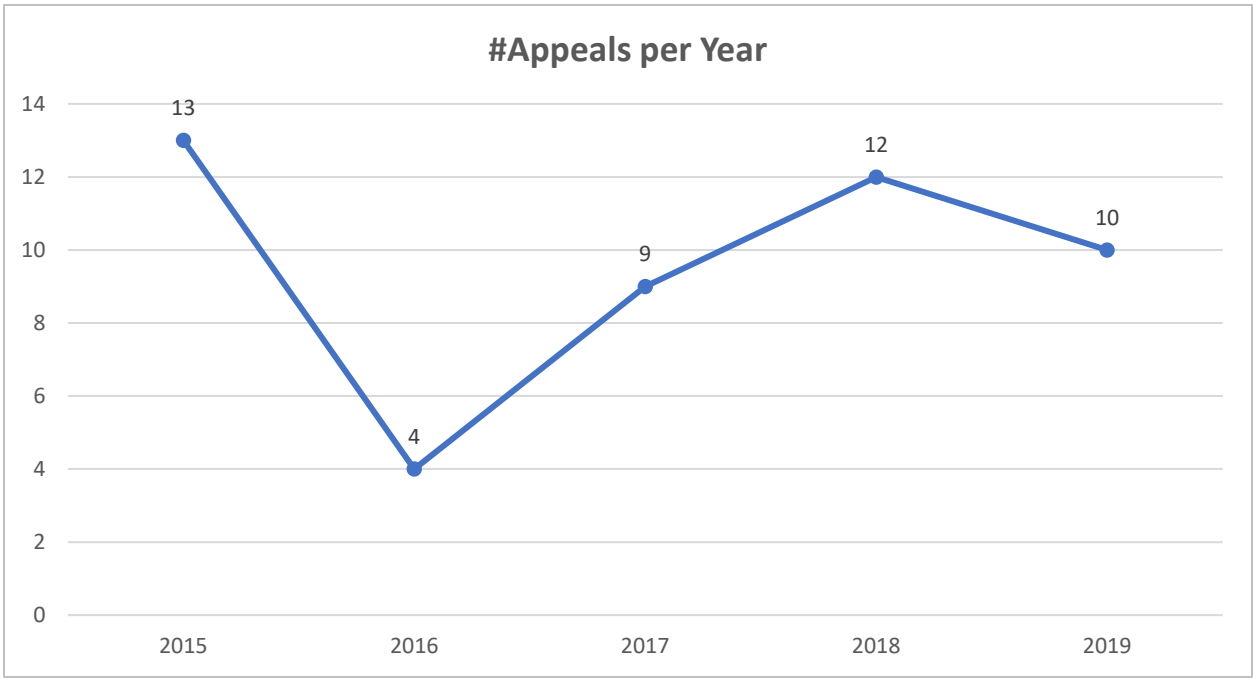
In proportion to our overall growth in enrollment, we did see an increase in the number of participant grievances. Although transportation related issues were the most the most common type of grievance, the overall transportation participant satisfaction score increased from 93% in 2018 to 96% in 2019 which is higher than the PACE national average of 94.3%. The transportation department averages approximately 6,000 one-way trips per month, transporting participants to and from PACE as well as specialty appointments including dialysis. In 2019, we received 34 grievances with the majority centered around issues with transportation services. In response, we initiated a corrective action plan which led to positive feedback from participants. Additionally, the transportation vendor has agreed to add additional on-site transportation staff supervision due to our increasing participant enrollment.

Appeals

Data Analysis:

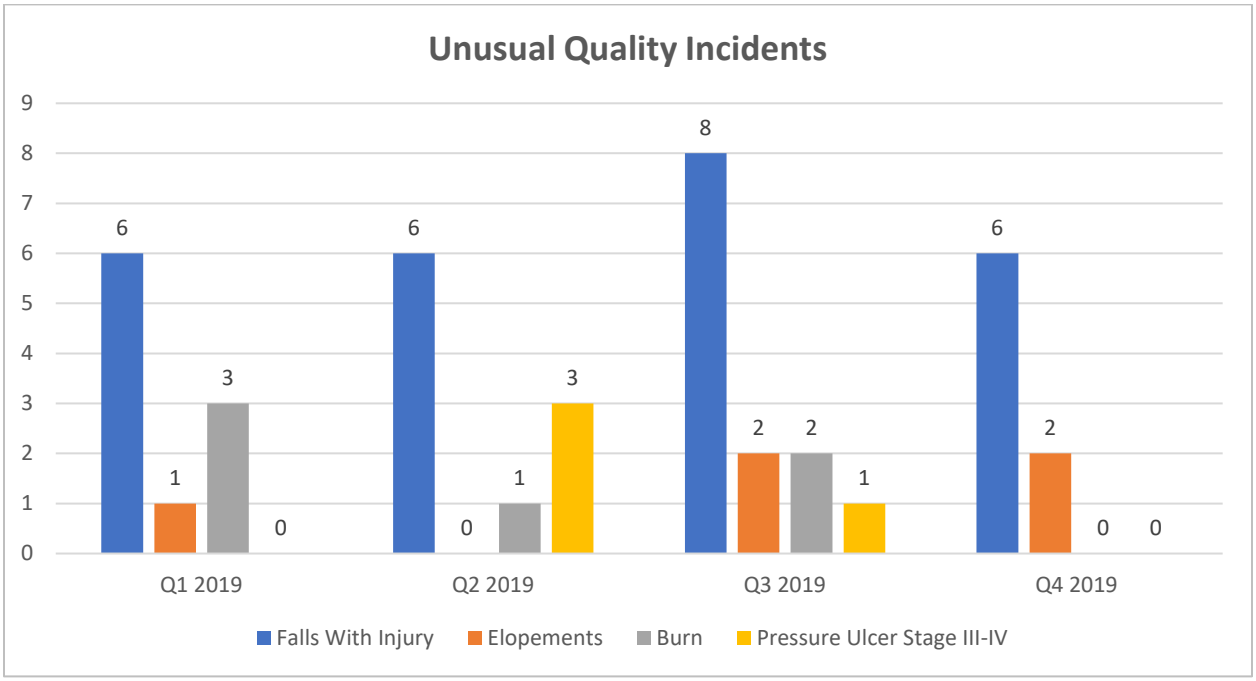
Appeals Per Year 2015–2019



Appeals by participants continue to be minimal in 2019. A total of 10 appeals were submitted in 2019, the majority concerning requests for either increased center day attendance or home care hours. Of the 10 appeals, 3 were overturned. No trends were identified in these 3 cases. PACE QI closely monitors appeals from a quality and compliance standpoint.

Level II Events/Unusual Quality Incidents

Data Analysis:



System Changes

Resulting From Unusual Quality Incidents Root Cause Analyses

Category	Issue	System Change
Participant Safety on PACE Day Center Floor	Participant sustained burn to hand while ambulating with a cup of coffee	1. Changed way that coffee is dispensed on Day Center floor 2. Purchased a new coffee machine which maintains appropriate temperature 3. Sought feedback from participants regarding new process Evaluation: No further burns have been cited. Participant Satisfaction increased.

Falls with injury are the most prevalent event followed by burns and elopements. The majority of falls occur in the home and are either a result of non-use of durable medical equipment or lack of family supervision. A root cause analysis is conducted after each unusual quality incident which involves discussion from the appropriate disciplines (i.e. rehabilitation, home care, etc.) and identifies any potential systemic or operational concerns. Remediation is initiated as appropriate. Although no significant trends were found in the Unusual Quality Incidences, a systemic change to the way coffee was dispended was made based on the findings of a root cause analysis as listed above.

Medication Errors

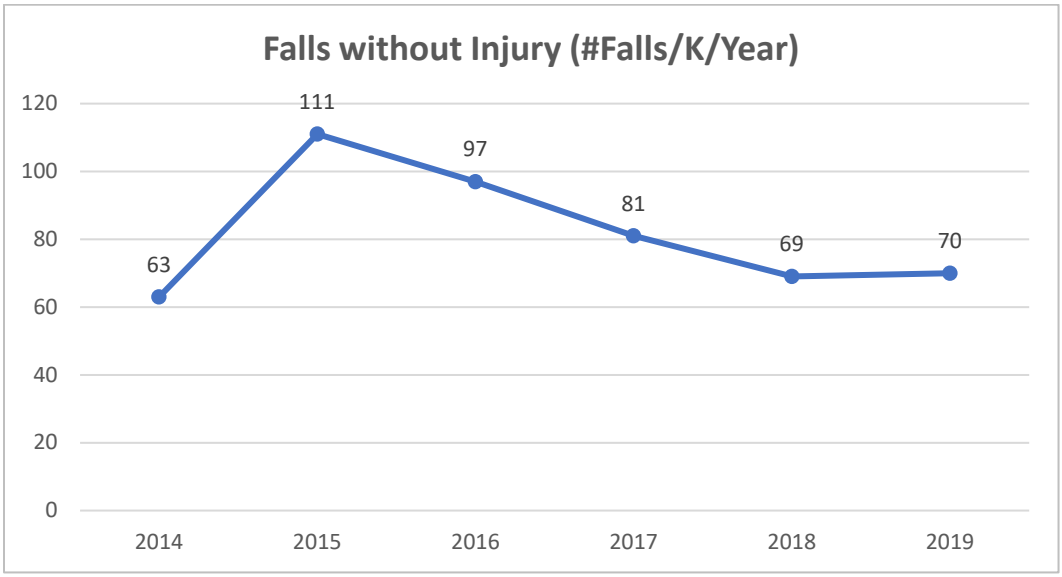
A total of 6 medication errors were reported in 2019 which reflects a 50% decrease from the previous year. Most errors were attributable to either staff errors or errors in transcription. In

response, internal corrective action plans were implemented which involved staff training and a performance improvement plan.

Falls Without Injury

Data Analysis**:**

Falls without Injury 2014–2019



We have continued to maintain the low rate of falls accomplished in 2018. Most falls are continuing to occur in the community, specifically in the participant's home environment. CalOptima PACE has spearheaded fall prevention groups among the high fall risk participants, with the goal to decrease in the numbers of falls in 2019 and continuing into 2020. Ongoing falls prevention groups include:

1. *PACE Fall Committee*: Comprised of PACE rehabilitation staff which reviews those participants who have incurred a fall.
2. *PACE Fall Prevention*: Comprised of PACE participants who are educated by the rehabilitation staff in fall recovery mechanisms.
3. *Fallers Anonymous*: Comprised of PACE participants who meet quarterly with the rehabilitation team to discuss safety in the home and environment.
4. *Matter of Balance*: Targets those participants with cognitive impairment. Discusses the many misconceptions surrounding falls.

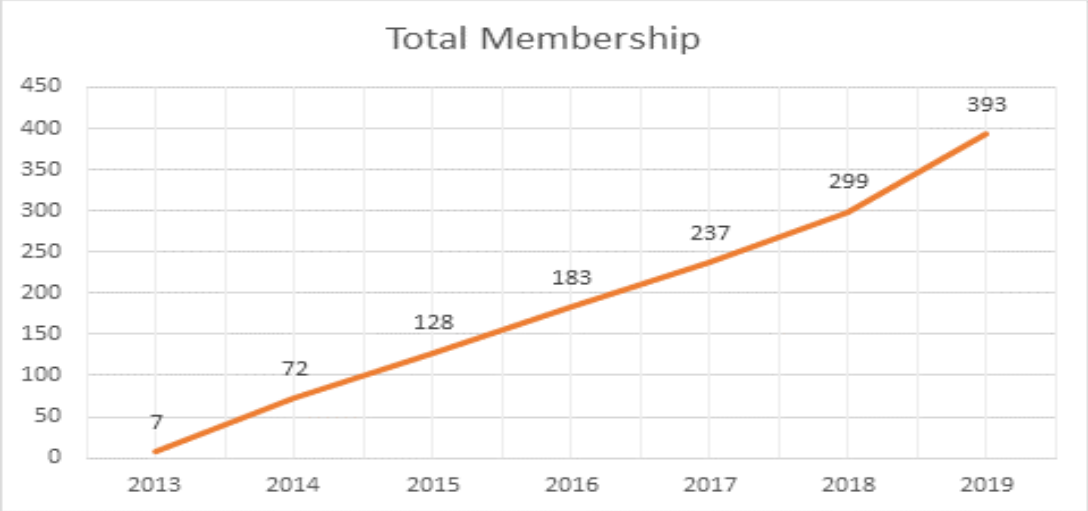
Denials of Prospective Enrollees

Three prospective enrollees were denied enrollment by the State.

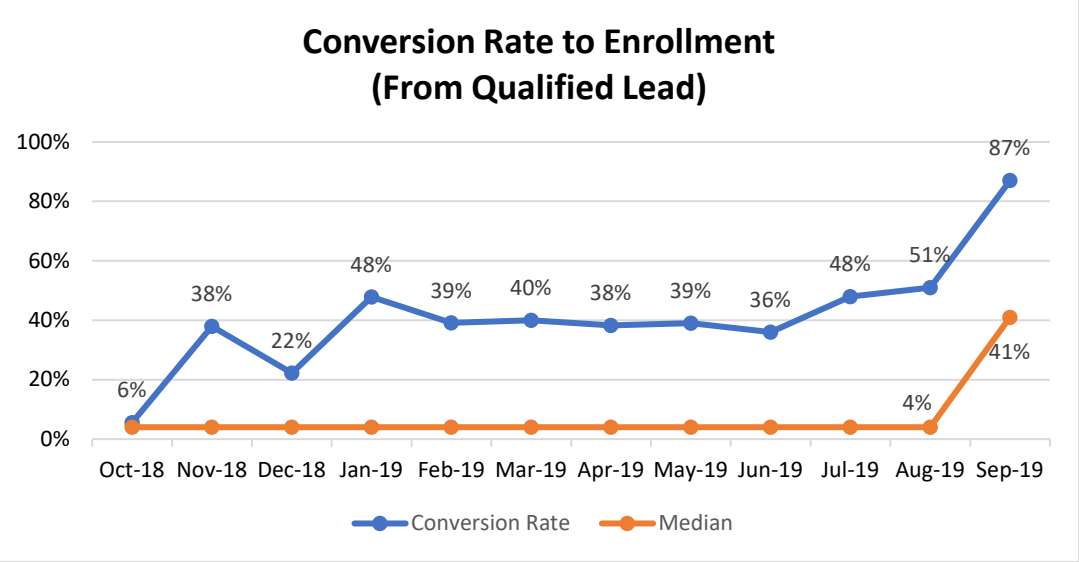
Quality Initiatives

In 2019, we focused on our Quality Initiatives to improve the participant experience and assure optimal clinical outcomes:

(1) PACE 2.0 Initiative: Focused on PACE program growth including outreach strategies, streamlining the enrollment process and capacity building. Since the initiation of this initiative in October 2018, we have seen as significant enrollment growth from 293 participants to 393 participants and more importantly an increase in the rate of growth. We have also seen a significant increase in the conversion rate to enrollment from a qualified lead. We have streamlined the enrollment process, reducing the time from a participant's inquiry into PACE services, and adding a RN to conduct the level of care assessments required for eligibility. We have aggressively hired new staff to accommodate the growth and have re-designed workspaces to accommodate the staff. As a result of the positive outcome of the PACE 2.0 Initiative, we will continue with this initiative into 2020, renaming it to PACE 2.1.



This graph illustrates the increase in the rate of membership in 2019.

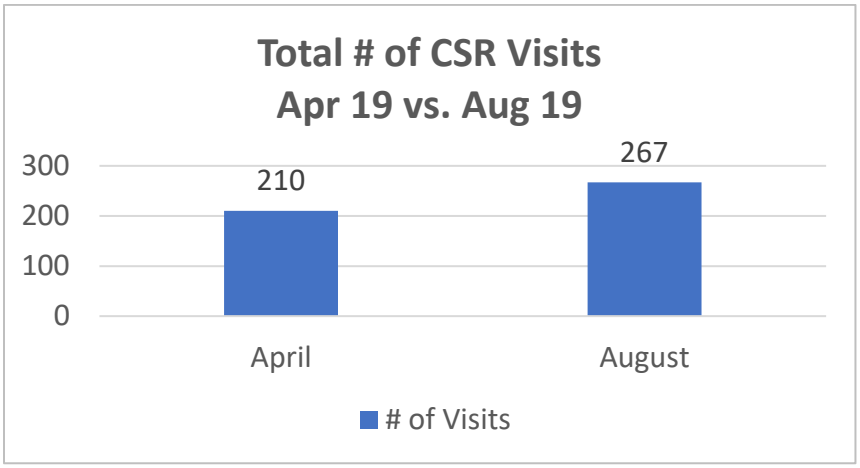


This graph illustrates the dramatic increase in the conversion rate from qualified inquiry to enrollment.

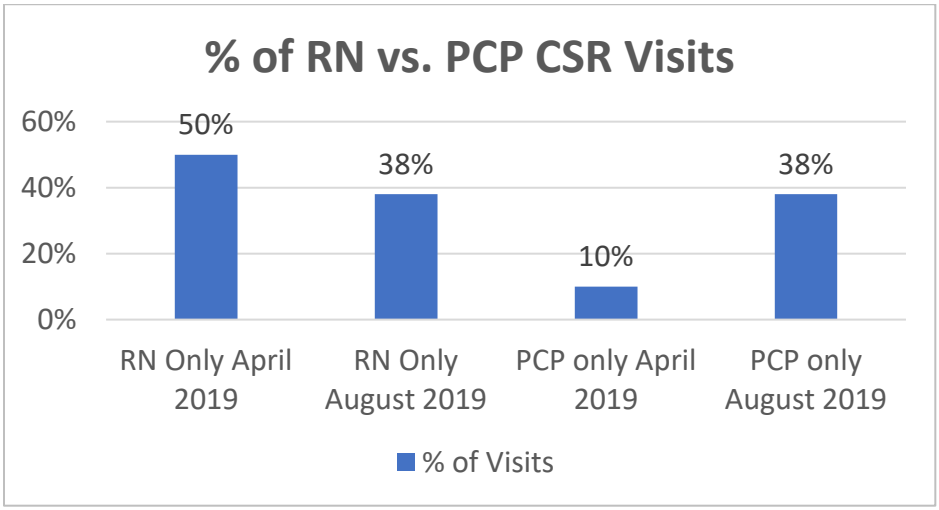
(2) Care Plan Initiative: Focused on consistent and accurate documentation of a participant's care plan which included elements such as identifying a participant's problem with noted specificity, assuring that the problem is addressed by the appropriate discipline, documenting interventions, assuring that interventions were measurable with an end-date, and coding the problem. At the end of 2019, internal PACE chart audits revealed that we achieved compliance

in the 95th percentile in 3 of the 5 elements. Proper notation of the measurable interventions with an end-date was in the 7th percentile upon internal PACE audit.

(3) Triage Workflow: Focused on revising the triage workflow within the PACE Clinic. This was to address and accommodate the large volume of participants seeking same-day appointment requests. After a thorough analysis of the triage workflow, we implemented a new system — Clinic Service Requests (CSR). Same-day appointment requests (CSR's), were categorized by conditions which were within the scope of the RN to address and those which required a PCP intervention. A new scheduling system was designed where same-day appointment requests were built into the PCP's schedule. This initiative has led to an increase in the timeliness of appointment requests, a reduction in the wait-time for participants to be seen, greater overall clinic efficiency and ultimately, an increase in participant satisfaction.



The growth in enrollment correlated to the number of same day walk-in requests (27% increase in walk-in requests). This necessitated a change in the workflow where appointment slots were built-in to the PCP's schedule. This allowed the PCP to see their paneled participants, improving not only continuity of care, but also participant satisfaction.



This graph illustrates the result of the implementation of the new workflow process (CSR). The new workflow, where same-day request appointments are integrated into the PCP schedule, show that many visits which had been previously delegated to the RN, are now being assigned to the

PCP. This allowed the PCP to see their paneled participants, improving not only continuity of care, but also participant satisfaction.

SECTION 5: OPPORTUNITIES FOR IMPROVEMENT IN 2020

1. Improve the Quality of Care (QOC) for Participants
    a. Implement enhanced care coordination program for participants with dialysis.
    b. Further develop the operational/utilization dashboard to reflect the oversight needed as PACE expands ACS partners.
    c. A new advanced health care directive quality improvement initiative will be started in 2020.
2. Ensure the Safety of Clinical Care
    a. Increase the percentage of specialty medications ordered by outside specialists which are reviewed in real time by the pharmacist.
    b. Participants receiving more than an average milligram morphine equivalent (MME) dose of 120mg will continued to be closely monitored.
    c. The QI team will focus on strengthening oversight activities of external providers and vendors specifically related to home care, skilled nursing facilities, board and care facilities and transportation.
    d. The grievances and potential quality issues involving downstream vendors will be track and trended to assure no service or clinical trend is emerges.
3. Ensure the Appropriate Use of Resources
    a. Inpatient/ER Utilization
        i. The morning clinical huddles will be incorporated into the IDT meetings for all teams.
        ii. Further expansion of our complex case management program with individualized interventions with a focus on high-risk dialysis participants.
        iii. Continue to refine the ER Diversion program.
    b. Specialty Care
        i. Increase the number of core PACE specialists who are willing to work closely with the PACE program, receive training in the PACE Model of Care and will attend some IDT meetings.
        ii. PACE will leverage CalOptima's Provider Relations department to ensure that the specialist network meets the needs of PACE.
    c. Pharmacy
        i. Retrospective quarter reviews of medication utilization will be analyzed and shared with IDT and the PACE PCPs.
        ii. Increase the percentage of specialty medications ordered by outside specialists which are reviewed in real time by the pharmacist.
4. Improve Participant Experience
    a. Participants will be updated on the satisfaction survey process.
    b. The PACE QI team will survey a sample of participants semi-annually and use the metrics as a lead indicator and help find opportunities for improvement.
    c. Grievances and potential quality issues will be monitored and analyzed to find opportunities for improvement.
    d. We will continue the monthly meal satisfaction surveys and make refinements to our meal program based on the feedback.
5. Ensure Appropriate Access and Availability

a. Full implementation of the PACE 2.1 initiative, promoting program growth and employee engagement.
b. Update the inquiry to enrollment conversion rate element to qualified lead to enrollment conversion rate.
c. Expanding the number of ACS sites will be considered in 2020
d. Trail expansion of the Garden Grove PACE Center clinic to weekday evenings and Saturdays.
e. Expanded us of the Community Based Physicians.
f. Expansion of PACE at Home program.
g. Continued development of our list of preferred specialists who are willing to work closely with PACE, be trained in the PACE model of care and attend occasional interdisciplinary care team meetings.

SUMMARY

CalOptima PACE developed and implemented systems using evidence-based guidelines that incorporate data and best practices tailored to the frail and elderly participants within our community. Our focus is to prevent institutionalization of these participants and enable them to live safely in our community with the support of PACE services. To accomplish our goals, we target many aspects of the health care continuum, such as preventive care, care management and disease management, closing any potential gaps in care. Through our ongoing data analysis, we are positioned to identify opportunities for improvement resulting in optimal clinical outcomes and participant satisfaction. Although individual measures may vary in their level of accomplishment, our overall effort has been a considerable success. As we continue to monitor our performance and refine our methods, we are confident that our QI efforts will continue to make a positive impact amongst our participants.

2019 CalOptima PACE Quality Improvement (QI) Work Plan

QI Item#	Goal	Description	Objective	Sub-Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI19.01	Improve the Quality of Care for Participants	2018 PACE QI Plan and Work Plan Annual Evaluation	2018 PACE QI Plan will be evaluated by March 1st, 2019	N/A	PACE QI Plan and QI Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2019	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met
QI19.02	Improve the Quality of Care for Participants	2019 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be reviewed and updated by March 1st, 2019	N/A	PACE QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2019	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met
QI19.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	>/= 90% of eligible participants will have their annual influenza vaccination by December 31st, 2019	N/A	Improve compliance with influenza immunization recommendations	Quarterly	12/31/2019	PACE Clinical Operations Manager	92%	Met	N/A	N/A	N/A	N/A	97%	Met	97%	Met
QI19.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	>/= 90% of eligible participants will have had their pneumococcal vaccination by December 31st, 2019	N/A	Improve compliance with pneumococcal immunization recommendations.	Quarterly	12/31/2019	PACE Clinical Operations Manager	95%	Met	94%	Met	99%	Met	95%	Met	95%	Met
QI19.05	Improve the Quality of Care for Participants	Infection Control	In 2019, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days	N/A	Monitor and analyze the incidence of respiratory infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Quarterly	12/31/2019	PACE Clinical Operations Manager	1.75	Met	1.09	Met	1.06	Met	0.69	Met	1.12	Met
QI19.06	Improve the Quality of Care for Participants	Care for Older Adults (COA): Advance Directive Planning	>/=95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2019	N/A	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2019	PACE Center Manager	98%	Met	99%	Met	96%	Met	100%	Met	100%	Met
QI9.07	Improve the Quality of Care for Participants	Care for Older Adults (COA): Advance Directive Planning	>/=90% of participants who a completed POLST will have the designated family member who will make decisions in emergency situations identified and documented on the POLST by December 31st, 2019	N/A	Increase the number of PACE participants who have a designated emergency, family decision maker documented on the POLST.	Quarterly	12/31/2019	PACE Center Manager	18%	Not Met	19%	Not Met	20%	Not Met	19%	Not Met	19%	Not Met
QI19.08	Improve the Quality of Care for Participants	Care for Older Adults (COA): Functional Status Assessment	Ensure that 100% of PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS	N/A	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months.	Quarterly	12/31/2019	PACE Center Manager	100%	Met	99%	Not Met	99%	Not Met	100%	Met	100%	Met
QI19.09	Improve the Quality of Care for Participants	Comprehensive Diabetes Care (CDC)	100% of CDC Sub Objectives will be met in 2019	>80.12% of Diabetics will have a Blood Pressure of <140/90 (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2019	PACE Clinical Medical Director	83%	Met	100%	Met	82%	Met	84%	Met	84%	Met
				> 83.54% of Diabetics will have an Annual Eye Exam (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)		Quarterly	12/31/2019		95%	Met	97%	Met	90%	Met	95%	Met	95%	Met
				>98.38% of Diabetics will have Nephropathy Monitoring (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)		Quarterly	12/31/2019		97%	Not Met	100%	Met	98%	Not Met	99%	Met	99%	Met
QI19.10	Ensure the Safety of Clinical Care	Reduce the Rate of Day Center Falls	Decrease the rate of participate falls occurring at the PACE day centers (ACS and Garden Grove PACE) by 10% (<6.65 Falls per 1000 member months) in 2019	N/A	Falls occurring at the PACE or ACS centers will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement.	Quarterly	12/31/2019	PACE Center Manager	1%	Met	0.41%	Met	0%	Met	0.61%	Met	0.63%	Met
QI19.11	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<36.13% (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	N/A	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2019	PACE Clinical Medical Director	29%	Met	27%	Met	16%	Met	14%	Met	21%	Met
QI19.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs	<3.85% (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	N/A	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2019	PACE Clinical Medical Director	0%	Met	0%	Met	0%	Met	0%	Met	0%	Met

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QI Item#	Goal	Description	Objective	Sub-Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI19.13	**Ensure the Safety of Clinical Care**	**Decrease the Use of Opioids at High Dosage (UOD)**	100% of members receiving opioids for 15 or more days at an average milligram morphine dose (MME) 120mg will be reevaluated monthly by their treating provider in 2019	N/A	The PACE QI Department will monitor any participant who is receiving prescription opioids for >/= 15 days at an average milligram morphine dose (MME) >120mg	Quarterly	12/31/2019	PACE Clinical Medical Director	0 out of 2 seen monthly (0%)	Not Met	1 out of 2 prts seen monthly (50%)	Not Met	4 out of 4 prts were seen monthly (100%)	Met	2 out of 2 prts were seen monthly (100%)	Met	7 out of 10 prts were seen monthly (70%)	Not Met
QI19.14	**Improve the Quality of Care for Participants**	**Medication Reconciliation Post Discharge (MRP)**	>/=90% of participants will have their medications reconciled within 30 days of hospital discharge in 2019	N/A	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2019	PACE Pharmacist	98%	Met	97%	Met	91%	Met	96%	Met	95%	Met
QI19.15	**Ensure Appropriate Access and Availability**	**Improve Access to Specialty Care**	>/= 80% of specialty care authorizations will be scheduled within 10 days in 2019	N/A	Appointments for specialty care will be scheduled within 10 days to improve access to specialty care for initial consultations	Quarterly	12/31/2019	PACE Clinical Operations Manager	92%	Met	84%	Met	71%	Not Met	78%	Not Met	82%	Met
QI19.16	**Ensure Appropriate Use of Resources**	**Reduce Acute Hospital Day Utilization**	< 2,760 hospital days per 1000 per year (10% decrease from 2018)	N/A	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2019	PACE Medical Director	2962	Not Met	2828	Not Met	2875	Not Met	2974	Not Met	2974	Not Met
QI19.17	**Ensure Appropriate Use of Resources**	**Reduce Emergency Room Utilization**	< 878 emergency room visits per 1000 per year (10% decrease from 2018)	N/A	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2019	PACE Medical Director	1017	Not Met	1053	Not Met	1075	Not Met	1115	Not Met	1115	Not Met
QI19.18	**Ensure Appropriate Use of Resources**	**30-Day All Cause Readmission Rates**	<15% 30-day all cause readmission (July 2018 CalPACE average)	N/A	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2019	PACE Medical Director	20%	Not Met	14%	Met	13%	Met	9%	Met	13%	Met
QI19.19	**Ensure Appropriate Use of Resources**	**Long Term Care Placement**	<3% of members (July 2018 CalPACE average) will reside in long term care	N/A	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2019	PACE Center Manager	0.3%	Met	0.3%	Met	0.6%	Met	0.5%	Met	0.5%	Met
QI19.20	**Improve Participant Experience**	**Enrollment/Disenrollment**	Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment in 2019 by 10% (<27 disenrollments/K/Y)	N/A	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Quarterly	12/31/2019	PACE Marketing and Enrollment Manager	2 out of 2 disenrollment are controllable	N/A	7 out of 11 disenrollment are controllable	N/A	0	N/A	0 out of 1 disenrollment is controllable	N/A	9 out of 14 disenrollment are controllable	Met
QI19.21	**Improve Participant Experience**	**Enrollment/Disenrollment**	Increase the Inquiry to enrollment conversion rate to 7% in 2019 (Baseline of 5% in the last 6 months of 2018)	N/A	Review and analyze the inquiry to enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2019	PACE Marketing and Enrollment Manager	5%	Not Met	4%	Not Met	6%	Not Met	8%	Met	5%	Not Met

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QI Item#	Goal	Description	Objective	Sub-Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI19.22	**Improve Participant Experience**	**Transportation**	I00% of transportation trips will be less than 60 minutes in 2019	N/A	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2019	PACE Center Manager	100%	Met	100%	Met	100%	Met	99.97%	Not Met	100%	Met
QI19.23	**Improve Participant Experience**	**Transportation**	>/= 90% of all transportation rides will be on-time in 2019	N/A	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports by sampling GPS records and monthly ride-along	Quarterly	12/31/2019	PACE Center Manager	93.57%	Met	95.03%	Met	95.80%	Met	95.50%	Met	94.98%	Met
QI19.24	**Improve Participant Experience**	**Increase Participant Satisfaction with Meals**	>/= 64% on Satisfaction with Meals summary score (2018 CalPACE average) on the 2019 PACE Satisfaction Survey	N/A	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Quarterly	12/31/2019	PACE Center Manager	68%	Not Met	89%	Met	N/A	N/A	N/A	N/A	77%	Met
QI19.25	**Improve Participant Experience**	**Increase Overall Participant Satisfaction**	>/=88% on the Overall Satisfaction Weighted Average (2018 CalPACE Average) on the 2019 PACE Satisfaction Survey	N/A	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2019	PACE Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	92%	Met

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken February 19, 2020
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

5. Recommend Board of Directors' Approval of the 2020 CalOptima Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Contact

David Ramirez, M.D.., Chief Medical Officer, (714) 246-8400

Recommended Action

Recommend Board of Directors' approval of the 2020 CalOptima PACE Quality Improvement (QI) Plan.

Background

The Board of Directors first authorized the Chief Executive Officer to submit CalOptima's application to become a PACE Provider on October 7, 2010. The CalOptima PACE program opened its doors for operation in October of 2013. PACE is viewed as a natural extension of CalOptima's commitment to integration of acute and long-term care services for its members. This program provides the link between our healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. PACE takes care of the frail elderly by integrating acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents and continues to grow. As of December 31st, 2019, CalOptima PACE had 393 members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes.

PACE organizations are required to have a written Quality Improvement (QI) Plan that is reviewed and approved annually by the PACE governing body and, if necessary, revised. The QI Plan reflects the full range of services furnished by CalOptima PACE. The goal of the QI Plan is to improve future performance through effective improvement activities driven by identifying key, objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff.

Discussion

The 2020 CalOptima PACE QI Plan is based on CalOptima's first six full years of data collection, review and analysis with specific data driven goals and objectives. The work plan elements were developed based on the opportunities for quality improvement that were revealed in the 2019 CalOptima PACE QI Plan Evaluation. In 2020, we will continue most of the new elements added in 2019 including those focused on reducing falls, increasing participant satisfaction with meals, and monitoring participants on high dosages of opioids. However, the "inquiry to enrollment conversion" element was modified to "qualified lead to enrollment conversion" to get a more accurate assessment of enrollment

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conversion rates. Additionally, a new advanced health care directive QI initiative will be added in place of the removed advanced care planning element which focused on identifying a family member who can make decisions in emergency situations. Finally, the diabetes element was unbundled into three separate elements. The target goals are based on national benchmarks, CalPACE data, or internal CalOptima PACE metrics.

Fiscal Impact

The recommended action to approve the 2020 CalOptima PACE QI Plan does not have a fiscal impact beyond what was incorporated in the Board-approved Fiscal Year (FY) 2019-20 Operating Budget. Staff will include updated expenditures for the period of July 1, 2020, through December 31, 2020, in the FY 2020-21 Operating Budget.

Rationale for Recommendation

PACE organizations are required to establish a Quality Improvement (QI) program. Through 42 CFR §460.132(b), the Centers for Medicare & Medicaid Services (CMS) requires PACE Organizations to have their QI plan reviewed annually by the PACE governing body and, if necessary, revised. As per 42 CFR §460.132(a) and (b), the PACE organization leadership presents their QI plan and any revisions to their governing body for annual approval to assure effective organizational oversight. CMS and the State will review the plan during subsequent monitoring visits.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Proposed 2020 CalOptima PACE Quality Improvement (QI) Plan Description
2. PowerPoint Presentation – 2020 PACE QI Plan Description
3. Appendix A - Proposed 2020 CalOptima PACE QI Work Plan

/s/ Michael Schrader *02/12/2020*
Authorized Signature **Date**

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CALOPTIMA PACE
QUALITY IMPROVEMENT PLAN DESCRIPTION
2020

Quality Improvement Subcommittee Chairperson:

David Ramirez, M.D. **Date**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

Paul Yost, M.D. **Date**

Board of Directors Chairperson:

Paul Yost, M.D. **Date**

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INTRODUCTION

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

Overview

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

Goals

- **Improve the quality of health care for participants.**
    - Ensure all QI activities fit into a well-integrated system that oversees quality of care and coordination of all services.
    - Ensure the QI program involves all providers of care within the PACE program.
    - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
    - Identify and address areas for improvement that arise from unusual incidents, and sentinel events.
    - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) in order to identify areas needing quality improvement.
    - Meet or exceeds minimum levels of performance on standardized quality measures as established by CMS and the state administering agencies (SAA) which includes achieving an immunization rate for both influenza and pneumococcal vaccinations of 90% for the appropriate participant population.
    - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the Board of Directors.
    - Share results of QI identified benchmarks with staff and contracted providers at least annually.
    - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. Professional standards of CalOptima PACE staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g. California Board of Nursing, etc.).
    - Ensure that all levels of care are consistent with professionally recognized standards of practice.
    - Assure compliance with regulatory requirements of all responsible agencies.

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

Organizational and Committee Structure

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

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

PACE Quality Improvement Committee

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

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

PACE Focused Review Committees

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

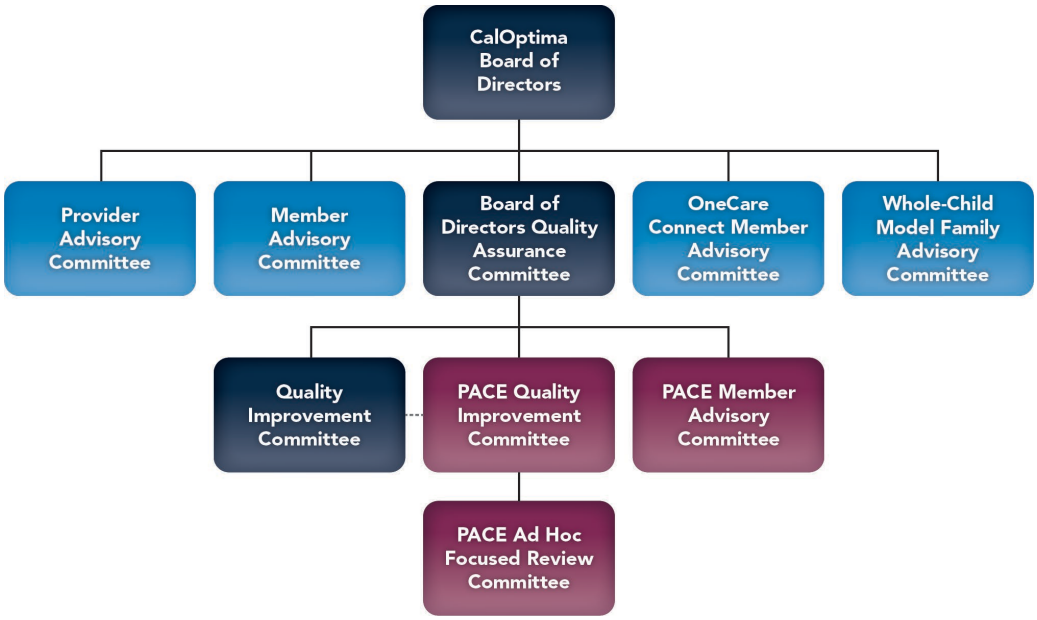
Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program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

PACE Member Advisory Committee

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

Membership
The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing chair and will facilitate for the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

2020 Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

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

Utilization of Services
- PACE will collect, analyze and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization including:

    - Hospital Bed Days
    - ER Visits
    - 30-Day All-Cause Readmissions
    - Participants residing in Long-Term Care
- Data analysis will allow for analyzing both overutilization and underutilization for areas of quality improvement.

Participant and Caregiver Satisfaction

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

Clinically Relevant HPMS Data

- Unusual Incidents
- Medication Errors
- Falls without Injury
- Clinical measures from the QI Work Plan elements which include:
    - Influenza and Pneumococcal Immunizations Rates (mandated by CMS)
    - Infection Control: Respiratory Infection Rates
    - Advanced Care Planning: POLST Completion
    - Functional Status Assessment Completion
    - Day Center Fall Rates
    - Opioids at High Dosage Monitoring
    - Medication Reconciliation Post Discharge
    - Diabetes Care: Annual Eye Exams
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Enrolled for at least six months during measurement year
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
                - Participants who are 76 years and older as of December 31, 2020
    - Diabetes Care: Nephropathy Monitoring and Blood Pressure Control
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Enrolled for at least six months during 2020
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
                - Participants who are 76 years and older as of December 31, 2020
                - Participants with End Stage Renal Disease
    - Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Continuous enrollment throughout year
                - Participants who are 66 years and older as of December 31, 2020

- Exclusion criteria:
    - Participants who are end of life (less than six months)
    - Participants with Schizophrenia or Bipolar Disorder
- Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Kidney Disease plus Nonaspirin NSAIDS or Cox2 Selective NSAIDs
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Continuous enrollment throughout year
            - Participants who are 66 years and older as of December 31, 2020
        - Exclusion criteria:
            - Participants who are end of life (less than six months)

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

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

Non-Clinical Areas

- The PACE PQIC has oversight to all activities offered by PACE.
- Member grievances will be forwarded to the QI Coordinator and QI Manager for investigation, tracking, trending and data gathering. These results will be forwarded to the PACE Director for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations, decisions and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
- Member appeals will be forwarded to the QI Coordinator and QI Manager for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be forwarded to a third-party with the appropriate licensure for review. The third-party reviewer's decision shall be reviewed by either the PACE Director or the PACE Medical Director and will be immediately shared with the IDT who will inform caregivers and participants of the decision and assist them with furtherment of the process as needed.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE QI department will monitor transportation services with periotic ride alongs. The times gathered during the ride alongs will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through regular participant meal satisfaction surveys as well as comments solicited by the PMAC.
- Life safety will be monitored internally via quarterly fire drills and annual mock code and mock

disaster drills, as well as regulatory agency inspections.

- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority Setting for Performance Improvement Initiatives

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

External Monitoring and Reporting

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

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

Unusual Quality Incidents

- When unusual incidents reach specified thresholds, PACE must notify CMS on a quarterly basis through HPMS. PACE must complete a Root Cause Analysis and present the results of the analysis on a conference call with both CMS and the Department of Health Care Services (DHCS) as well as internally at PQIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Unusual Quality Incidents include:
    - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
    - Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall.
    - Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame.
    - Pressure injuries acquired while enrolled in PACE.
    - Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.

    - Any elopement.
    - Adverse drug reactions
    - Foodborne outbreak
    - Burns 2nd degree or higher
- HOS-M
    - PACE will participate in the annual HOS-M to assess the frailty of the population in our center.
- Other external reporting requirements
    - Suspected elder abuse shall be reported to appropriate state agency.
    - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
    - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency.

Corrective Action Plans (CAP)

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

Urgent Corrective Measures

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

Re-Evaluation and Follow-Up

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

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies and measurable interventions to meet our goals. The status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis.
- In 2020, a new advanced health care directive quality initiative will be added.

ANNUAL REVIEW OF PACE QI PLAN

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

APPENDIX A (SEE ATTACHMENT)

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PACE

CalOptima

A Public Agency

Better. Together.

2020 PACE Quality Improvement (QI) Plan Description

Board of Directors' Quality Assurance Committee Meeting

February 19, 2020

Miles Masatsugu, M.D., Medical Director

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2020 PACE QI Program Description

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

2020 PACE QI Work Plan Goals

- Improve the Quality of Care for Participants
- Ensure the Safety of Clinical Care
- Ensure Appropriate Access and Availability
- Ensure Appropriate Use of Resources
- Improve Participant Experience

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2020 PACE QI Eliminated/Modified Work Plan Elements

- Eliminated one element
  - Advanced Care Planning: Designate decision maker on Physician's Orders for Life-Sustaining Treatment (POLST)
    - Adding an Advanced Health Care Directive QI Initiative in 2020
- Modify two elements
  - Qualified Lead to Enrollment Conversion
  - Added inclusion and exclusion criteria for diabetes and potentially harmful drug/disease interactions in the elderly
- Diabetes Care elements were unbundled into three separate elements
- Total of 26 QI Work Plan Elements in 2020

Recommended Action

- Recommend approval of the 2020 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Plan Description

CalOptima's Mission

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

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CalOptima's Mission

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

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Appendix A

2020 CalOptima PACE Quality Improvement (QI) Work Plan							
QAPI Item#	**Goal**	**Description**	**Objective**	**Activity**	**Reporting Frequency**	**Target completion**	**Responsible Person**
QI20.01	**Improve the Quality of Care for Participants**	**2019 PACE QAPI Plan and Work Plan Annual Evaluation**	2019 PACE QAPI Plan will be evaluated by March 1st, 2020	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2020	PACE Medical Director
QI20.02	**Improve the Quality of Care for Participants**	**2020 PACE QI Plan and Work Plan Annual Oversight**	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2020	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2020	PACE Medical Director
QI20.03	**Improve the Quality of Care for Participants**	**Influenza Immunization Rates**	≥ 94% of eligible participants will have their annual influenza vaccination by December 31st, 2020	Improve compliance with influenza immunization recommendations	Q3 and Q4 2020	12/31/2020	PACE Clinical Operations Manager
QI20.04	**Improve the Quality of Care for Participants**	**Pneumococcal Immunization Rates**	≥ 94% of eligible participants will have had their pneumococcal vaccination by December 31st, 2020	Improve compliance with pneumococcal immunization recommendations.	Quarterly	12/31/2020	PACE Clinical Operations Manager
QI20.05	**Improve the Quality of Care for Participants**	**Infection Control**	In 2020, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days	Monitor and analyze the incidence of respiratory infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Quarterly	12/31/2020	PACE Clinical Operations Manager
QI20.06	**Improve the Quality of Care for Participants**	**Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment**	≥ 95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2020	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2020	PACE Center Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI20.07	**Improve the Quality of Care for Participants**	**Care for Older Adults (COA): Functional Status Assessment**	Ensure that 100% of PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months.	Quarterly	12/31/2020	PACE Center Manager
QI20.08	**Improve the Quality of Care for Participants**	**Diabetes Care**	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)*	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director
QI20.09	**Improve the Quality of Care for Participants**	**Diabetes Care**	> 85.33% of Diabetics will have an Annual Eye Exam (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)*	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director
QI20.10	**Improve the Quality of Care for Participants**	**Diabetes Care**	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)*	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director
QI20.11	**Ensure the Safety of Clinical Care**	**Day Center Falls**	≤ 6.65 Falls per 1000 member months occurring at the PACE day centers (ACS and Garden Grove PACE)	Falls occurring at the Garden Grove PACE or ACS centers will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement.	Quarterly	12/31/2020	PACE Center Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI20.12	**Improve the Quality of Care for Participants**	**Reduce Potentially Harmful Drug/Disease Interactions in the Elderly: Dementia + tricyclic antidepressant or anticholinergic agents**	<35.73% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)*	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director
QI20.13	**Improve the Quality of Care for Participants**	**Reduce Potentially Harmful Drug/Disease Interactions in the Elderly: Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs**	<3.90% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)*	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director
QI20.14	**Ensure the Safety of Clinical Care**	**Decrease the Use of Opioids at High Dosage (UOD)**	100% of members receiving opioids for 15 or more days at an average milligram morphine dose (MME) 120mg will be reevaluated monthly by their treating provider in 2020	The PACE QI department will monitor any participant who is receiving prescription opioids for >/= 15 days at an average milligram morphine dose (MME) >120mg	Quarterly	12/31/2020	PACE Clinical Medical Director
QI20.15	**Improve the Quality of Care for Participants**	**Medication Reconciliation Post Discharge (MRP)**	≥ 90% of participants will have their medications reconciled within 30 days of hospital discharge in 2020	The PACE QI department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2020	PACE Pharmacist
QI20.16	**Ensure Appropriate Access and Availability**	**Improve Access to Specialty Care**	≥ 80% of specialty care authorizations will be scheduled within 10 business days	Appointments for specialty care will be scheduled within 10 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2020	PACE Clinical Operations Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI20.17	**Ensure Appropriate Use of Resources**	**Reduce Acute Hospital Day Utilization**	< 2,813 hospital days per 1000 per year (5% decrease from 2019)	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2020	PACE Medical Director
QI20.18	**Ensure Appropriate Use of Resources**	**Reduce Emergency Room Utilization**	< 1,004 emergency room visits per 1000 per year (10% decrease from 2019)	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2020	PACE Medical Director
QI20.19	**Ensure Appropriate Use of Resources**	**30-Day All Cause Readmission Rates**	<15% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2020	PACE Medical Director
QI20.20	**Ensure Appropriate Use of Resources**	**Long Term Care Placement**	<3% of members (July 2019 CalPACE average) will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2020	PACE Center Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI20.21	**Improve Participant Experience**	**Enrollment/Disenrollment**	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 4%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Quarterly	12/31/2020	PACE Marketing and Enrollment Manager
QI20.22	**Improve Participant Experience**	**Enrollment/Disenrollment**	Increase the Qualified Lead to Enrollment conversion rate to 50% in 2020	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2020	PACE Marketing and Enrollment Manager
QI20.23	**Improve Participant Experience**	**Transportation**	I00% of transportation trips will be less than 60 minutes in 2020	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2020	PACE Center Manager
QI20.24	**Improve Participant Experience**	**Transportation**	≥ 92% of all transportation rides will be on-time in 2019	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of ± 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2020	PACE Center Manager
QI20.25	**Improve Participant Experience**	**Increase Participant Satisfaction with Meals**	≥ 71% on Satisfaction with Meals summary score (2019 PACE National Average) on the 2020 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Quarterly	12/31/2020	PACE Center Manager
QI20.26	**Improve Participant Experience**	**Increase Overall Participant Satisfaction**	≥ 89% on the Overall Satisfaction Weighted Average (2019 PACE National Average) on the 2020 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2020	PACE Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person

*There is not a PACE-specific benchmark for these measures. Because of this, we utilize the 2019 Medicare Quality Compass HEDIS as a comparable benchmark, even though the metrics do not have identical inclusion/exclusion criteria.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken February 19, 2020
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Consent Calendar

6. Consider Recommending Board of Directors' Approval of Calendar Years 2020 and 2021 Health Network Medi-Cal Pay for Value Program Payment Methodology Incorporating the Health Network Quality Rating Methodology

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8400

Recommended Action

Consider Recommending Board of Directors' Approval of the CY 2020 and 2021 Health Network Medi-Cal Pay for Value (P4V) Program Payment Methodology incorporating the Health Network Quality Rating (HNQR) methodology for the Measurement Years effective January 1, 2020 through December 31, 2021.

Background

CalOptima has implemented a comprehensive Health Network Pay for Value (P4V) Performance Measurement Program consisting of recognizing outstanding performance and supporting ongoing improvement that aimed to strengthen CalOptima's mission of providing quality health care. The existing P4V Performance Measurement Program is based on a customized methodology developed by CalOptima staff and approved by the CalOptima Board. Annually, the CalOptima staff conducts a review of the current measures and their performance over time. Based on a 2018 retrospective longitudinal quality improvement performance review, although CalOptima consistently met the Minimum Performance Level, overall quality performance trends have been flat over the past five years.

This trend is very consistent with California Health Care Foundation's recently published quality report entitled: *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade.* From 2009 to 2018, quality of care in Medi-Cal managed care was stagnant at best on most measures. Among 41 quality measures collected in two or more years, more than half (59 percent) remained unchanged or declined. Based on feedback from CalOptima Health Networks, including concerns about the difficulty of improving selected measure due to the size of the eligible population and/or difficulty in gathering data, the proposed new methodology aims for greater transparency, consistency and administrative simplification. Finally, the proposed methodology aligns with changes to the measures that are important to CalOptima's National Committee for Quality Assurance (NCQA) Accreditation status, Centers for Medicare and Medicaid Services (CMS) Star Rating Status, newly required DHCS managed care accountability set (MCAS) and/or overall NCQA Health Plan Rating.

Discussion

For the Medi-Cal program, staff recommends adopting and incorporating a new "Quality Rating Methodology" consistent with NCQA validated methodology. Having a standard Quality Rating Methodology will provide CalOptima with one reliable methodology to establish an overall quality

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rating score for each Health Network. The quality rating score will be used to establish P4V payment methodology, or other future programs to improve quality health care for CalOptima members.

Measures

- All Managed Care Accountability Set (MCAS) measures that are required for Minimum Performance Level (MPL) by the Department of Health Care Services (DHCS) are used.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures are used for member experience.
- Measures with small denominators (HEDIS < 30; CAHPS < 100) are not used in the score calculation.

Data and Frequency

- Each Health Network's quality rating score will be calculated annually, including CCN.
- The Health Network quality rating score will be derived from the most recently available audited, plan level Healthcare Effectiveness Data and Information Set (HEDIS) results. The HEDIS results for Health Networks are based on the administrative methodology for measures that have a hybrid method option, the additional percentage from medical records collection (difference of CalOptima's hybrid and admin result) will be added to each Health Network's results.
- Health Network level Adult/Child CAHPS (member survey) results will be used for member experience scoring. The highest overall score results from either the Health Network's Adult or Child CAHPS survey results will be used.

Benchmarks

All measure results (clinical and Member Experience) will be benchmarked against the National Committee for Quality Assurance Quality Compass National Medicaid percentiles.

Score Calculation

- The CY2020 Health Network Medi-Cal P4V Program has a Measurement Period of January 1, 2020 through December 31, 2020.
- Overall Rating
  - The overall rating is the weighted average of a Health Network's HEDIS and CAHPS measure ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), rounded to the nearest half point displayed as stars (see below for rounding rules).
  - The overall rating is based on performance on dozens of measures of care and is calculated on a 0–5 (5 is highest) scale in half points.
- Measure point calculation
  - A measure result in the top decile (>= 90th percentile) receives 5 points
  - A measure result in the top 3rd but not in the ~~tip~~ top10th (>= 66th but < 90th percentile) receives 4 points
  - A measure result in the middle 3rd (>= 33rd but < 66th percentile) receives 3 points
  - A measure result in the bottom 3rd but not in the bottom 10th (>= 10th but < 33rd percentile) receives 2 points

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  - A measure result in the bottom 10th (< 10th percentile) receives 1 point
- Health Network's score = Σ (measure rating * measure weight) / Σ weights + Accreditation Bonus Points
- Health Network's Rating = round the score to the nearest half point
- Final scoring will result in an overall Health Network Quality Rating for each Health Network. Based on the final overall score, Health Networks will be assigned a score from 1-5 with 5.0 representing the best possible performance.
- NCQA Rounding Rules: The overall rating is calculated and truncated to 3 decimal places and round according to the rules below.

NCQA Rounding Rules	
Overall Rating	**Rating**
0.000 - 0.249	0.0
0.250 - 0.749	0.5
0.750 - 1.249	1.0
1.250 - 1.749	1.5
1.750 - 2.249	2.0
2.250 - 2.749	2.5
2.750 - 3.249	3.0
3.250 - 3.749	3.5
3.750 - 4.249	4.0
4.250 - 4.749	4.5
>= 4.750	5.0

Payment Methodology

- Health Network allocation for P4V payments will be increased from $2.00 PMPM to $5.00 PMPM maximum.

Health Network Quality Rating	**Percent of $5 PMPM Health Network Payment Received**
≥ 4.5	100%
≥ 4.0	80%
≥ 3.5	60%
≥ 3.0	40%
≥ 2.5	20%
< 2.5	0%

- A health network must achieve a minimum score of 2.5 to be eligible to receive P4V incentive dollars.
- Health Networks with a rating less than 2.5 will not be eligible to receive any P4V incentive award and may be asked to complete a Corrective Action Plan (CAP).

- MY 2020 (January 1 through December 31, 2020) Health Network Quality Rating will be used for the MY 2020 P4V program.
- MY 2021 (January 1 through December 31, 2021) Health Network Quality Rating will be used for the MY 2021 P4V program
- All P4V incentive payments will be performance based.
- No separate improvement incentive money is available during these periods (MY2020 and MY2021); however, a higher payment could be received in 2021 if a health network moves up a tier in the HNQR tiers (for example movement from 3.0 rating to 3.5 rating increases percent of payment earned from 40 to 60 percent.
- Health Networks must be "in good standing" at the time of payment as determined by the Audit and Oversight Committee.

Distribution of Incentive Dollars

- Performance allocations will be distributed upon final calculation and validation of each Health Network Quality Rating, based on NCQA final HEDIS and CAHPS scores for the health networks.
- A health network must be "in good standing" and achieve a minimum score of 2.5 to be eligible to receive P4V incentive dollars.

Fiscal Impact

The recommended action to approve the CY 2020 and 2021 Health Network Medi-Cal P4V Program Payment Methodology to incorporate the new Health Network Quality Rating Methodology has no additional fiscal impact to the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019. The current budget, which was based on CY 2019 Quality Rating Methodology, included Health Network Medi-Cal P4V program funding in an amount not to exceed $2.00 per member per month (PMPM) through June 30, 2020.

Management will include expenses in an amount not to exceed $5.00 PMPM related to the Health Network Medi-Cal P4V program for the period beginning July 1, 2020, and after in future operating budgets.

Rationale for Recommendation

CalOptima must pivot from stagnant performance trend to demonstrate breakthrough improvement in all measures in order to maintain its standing as one of the highest performing Medi-Cal Managed Care Plans. Having a consistent Health Network Quality Rating Methodology using NCQA methodology will provide CalOptima with one consistent quality measurement system to establish an overall quality rating score for each Health Network to reward performance and achieve CalOptima's strategic quality goals, which include member experience and clinical excellence.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Medi-Cal Health Network Payment Methodology (presentation)

/s/ Michael Schrader *02/12/2020*
Authorized Signature **Date**

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Proposed Health Network Quality Rating and Payment Methodology for MY2020

Board of Directors' Quality Assurance Committee Meeting
February 19, 2020

David Ramirez, M.D., Chief Medical Officer

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Guiding Principles for Proposed Changes

- Align with Department of Health Care Services (DHCS) changes in Managed Care Accountability Sets (MCAS).
- Shift from “ranking” winner and loser thinking to a tiered rating system.
- Raise the tide of quality performance across all health networks (HN) to promote win-win thinking.
- Align with industry National Committee for Quality Assurance (NCQA) methodology.
- External expert consultant validation
- Administrative simplification by using a consistent measurement system across programs
- Leverage behavioral economics.

MCAS

- Due to the governor's recent focus on increased accountability for managed care plan performance on select measures, CalOptima is proposing a HN rating methodology and measurement set for measurement year (MY) 2020.
- Effective immediately, DHCS will require Managed Care Plans to perform at least as well as 50 percent of Medicaid plans in the US.
  - We must achieve the 50th National Medicaid Benchmark for each measure to avoid sanctions.
  - To achieve the new minimum performance levels, we propose adopting a new HN rating methodology and MCAS measures to the Pay for Value (P4V) program to incentivize HNs for the additional quality metrics required by DHCS.

HN Rating Methodology

- NCQA Health Plan Rating method adopted for HN Rating:
  - Each HN is assessed a quality score between 1 and 5.
  - Score is based on HN performance on the list of DHCS Minimum Performance Level (MPL) Medicaid measures on 1–5 scale. The highest is 5.
  - Healthcare Effectiveness Data and Information Set (HEDIS) measures will be weighted 1.0.
  - Member Experience measures: Consumer Assessment of Healthcare Providers and Systems (CAHPS) will be weighted 1.5.
  - Hybrid measures: the additional percentage from medical records collection (difference of CalOptima's hybrid and admin result) will be added to each HN result.
  - Measures having small denominator (HEDIS < 30; CAHPS <100) will be assigned "NA," and the measure will not used in the calculation.

Proposed New Scoring

- Score calculation is based on HN Medicaid HEDIS/Member Experience results
- NCQA Quality Compass Medicaid national percentiles are used as benchmarks
- Score points
  - 5 > = 90th percentile
  - 4 > = 66th but <90th percentile
  - 3 > = 33rd but <66th percentile
  - 2 > = 10th but <33rd percentile
  - 1 < 10th percentile

Proposed Measures for MY 2020

- Children's Health
  - * **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — Body Mass Index (WCC BMI)**
  - * **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — Nutrition**
  - * **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — Physical Activity**
  - * Childhood Immunization Status — Combo 10 (CIS 10)
  - * Well Child Visits in the first 15 months of life (W15)
  - * Well Child Visits in the Third, Fourth, Fifth and Sixth years of life (W34)
  - * **Immunizations for Adolescents (IMA 2)**
  - * Adolescents Well-Care Visits (AWC)

** Measure rate may include findings from medical record review.*

Measures highlighted in bold are proposed new measures for P4V MY2020.

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Proposed Measures for MY 2020 (cont.)

- Behavioral Health
  - **Antidepressant Medication Management (AMM Acute phase)**
  - **Antidepressant Medication Management (AMM Continuation phase)**
  - **Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)**
  - **Metabolic Monitoring for Children and Adolescents (APC)**

** Measure rate may include findings from medical record review.*

Measures highlighted in bold are proposed new measures for P4V MY2020.

Proposed Measures for MY 2020 (cont.)

- Women's Health
  - *Cervical Cancer Screening (CCS)
  - **Chlamydia Screening in Women Ages 21–24 (CHL)**
  - Breast Cancer Screening (BCS)
  - ***Prenatal and Postpartum Care (PPC-Pre)**
  - ***Prenatal and Postpartum Care (PPC-Post)**
- Acute and Chronic Disease Management
  - ***Adult Body Mass Index Assessment (Adult BMI)**
  - ***Comprehensive Diabetes Care HbA1c Testing (CDC HT)**
  - ***Comprehensive Diabetes Care HbA1c Poor Control (CDC H9)**
  - **Asthma Medication Ratio Ages 19–64 (AMR)**

** Measure rate may include findings from medical record review.*

Measures highlighted in bold are proposed new measures for P4V MY2020.

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Member Satisfaction Measures

- Member Experience Performance remains an important metric (and required by DHCS).
- CAHPS measures
  - Rating of Health Care
  - Rating of Health Network
  - Rating of PCP
  - Rating of Specialist
  - Getting Needed Care
  - Getting Care Quickly
  - Care Coordination
  - Customer Service

Health Network Quality Rating Tiers Overall Rating

Based on 2018 Performance and Proposed Measures

HEDIS + CAHPS + Accreditation Bonus Rating	
Health Network Name (alphabetical order for tied tiers)	Stars
Kaiser Permanente	★ ★ ★ ★ ½
AltaMed Health Services	★ ★ ★ ★
AMVI Care Health Network Arta Western Health Network CalOptima Overall CHOC Health Alliance Monarch Family HealthCare Talbert Medical Group United Care Medical Group	★ ★ ★ ½
CCN Family Choice Health Network Noble Mid-Orange County Prospect Medical Group	★ ★ ★
Heritage – Regal Medical Group	★ ★ ½

Health Network Quality Rating

Based on 2018 Performance and Proposed Measures

Health Network Name	HEDIS	Member Experience	Overall Rating
AltaMed Health Services	★★★★	★★½	★★★★
AMVI Care Health Network	★★★★	★	★★★½
Arta Western Health Network	★★★½	★½	★★★½
CalOptima Overall	★★★★	★½	★★★½
CCN	★★★	★★	★★★
CHOC Health Alliance	★★★	★★	★★★½
Family Choice Health Network	★★★½	★	★★★
Heritage – Regal Medical Group	★★★	★½	★★½
Kaiser Permanente	★★★★½	★★★★	★★★★½
Monarch Family HealthCare	★★★½	★½	★★★½
Noble Mid-Orange County	★★½	★½	★★★
Prospect Medical Group	★★★½	★	★★★
Talbert Medical Group	★★★½	★★½	★★★½
United Care Medical Group	★★★½	★½	★★★½

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Payment Methodology for MY2020

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P4V Payments to HNs

- Tier-based payment based upon Health Network Quality Rating Score
- Rating ≥ 2.5 to be eligible to receive P4V incentive money.
- Health networks with a rating less than 2.5 will not be eligible to receive any P4V money and may be asked to complete a Corrective Action Plan (CAP).

P4V 2020 Program Payment Methodology

- $5 PMPM per HN allocated for MY 2020 and MY2021.
- Performance based $5 PMPM payment will be calculated at the end of each measurement period, based on the final HN quality rating achieved for the measurement period.

Rating	Percent of $5 PMPM Payment
≥ 4.5	100%
≥ 4.0	80%
≥ 3.5	60%
≥ 3.0	40%
≥ 2.5	20%
< 2.5	0%

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P4V Changes to MY2020

- Change to a new “Health Network Quality Rating Methodology” consistent with NCQA validated methodology for the Medi-Cal program.
- Performance based incentive dollars only — higher Health Network Quality Rating (HNQR) earns higher payment.
- Member Satisfaction (CAHPS) survey results will now use National NCQA Medicaid benchmarks.

Next Steps

- Present the final recommendations for QAC approval in February 2020 and CalOptima Board of Directors' approval in March 2020.
- OneCare Connect measures and methodology are proposed to remain unchanged.

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CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken February 19, 2020
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

7. Consider Recommending Board of Directors Approval of the Calendar Years 2020 and 2021 Health Network OneCare Connect Pay for Value Program Payment Methodology

Contact

David Ramirez, M.D., Chief Medical Officer (714) 246-8400
Betsy Ha, R.N. Executive Director, Quality & Population Health Management (714) 246-8400

Recommended Action

Consider Recommending Board of Directors approval of the Calendar Years 2020 and 2021 Pay for Value Program for OneCare Connect line of business, which defines measures and allocations for performance and improvement for the Measurement Years (MY) effective January 1, 2020 through December 31, 2021.

Background

On February 7, 2019 CalOptima Board of Directors approved a Pay for Value (P4V) COBAR for MY2019 for Medi-Cal and OneCare Connect (OCC) lines of businesses. CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care. Annually, the CalOptima staff conducts a review of the current measures and their performance over time. A part of this analysis included evaluating both the overall performance of the measure and the level of improvement left to achieve. In addition, the staff analyzed the difficulty of improving a measure due to the size of the eligible population or difficulty in data gathering. Finally, the staff evaluated any changes to the measures that are important to CalOptima's NCQA Accreditation status, CMS Star Rating Status and/or overall NCQA Health Plan Rating.

The purpose of CalOptima's P4V program for the Health Networks OCC line of business, including CalOptima Community Network (CCN) is consistent with the P4V programs of the prior years, which remains:

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

Discussion

For the OneCare Connect line of business, staff recommends no changes to the previously Board approved measures and scoring methodology for the OCC pay for value program. A separate COBAR has been submitted to the Quality Assurance Committee regarding the recommendation for proposed changes to the Medi-Cal Pay for Value Program for measurement years 2020 and 2021.

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Distribution of Incentive Dollars

There is no proposed change to the previously Board approved distribution strategy for earned pay for value dollars. The following P4V program requirements will remain:

- All health networks will continue to have clinical performance measures and member satisfaction measures.
- Performance and improvement allocations are distributed upon final calculation and validation of each measurement rate. Weighting of performance and improvement may be adjusted based on overall CalOptima performance.
- To qualify for payment for each of the Clinical and member satisfaction measures, the Health Network must have a minimum denominator in accordance with statistical principles.
- To qualify for payments, a health network or physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.
- Any separate OCC Quality Withhold incentive dollars earned will be distributed based upon Board of Directors previously approved methodology.
- Payments can be made annually or more frequently, at CalOptima's discretion.
- Distribution methodology to CCN providers for measurement year 2020 and 2021 payout will remain the same as approved by Board of Directors.

Fiscal Impact

The fiscal impact of the OCC P4V program will not exceed $20.00 per member per month for MY 2020 (January 1, 2020, to December 31, 2020) and MY 2021 (January 1, 2021, to December 31, 2021). Management will include these expenses in the CalOptima Fiscal Year (FY) 2020-21 and FY 2021-22 Operating Budgets.

Rationale for Recommendation

This alignment leverages improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Attachment 1: MY2020 - 2021 OCC P4V Program Measurement Set
2. Attachment 2: February 2, 2019 Board Approved P4V COBAR for MY2019 for Medi-Cal and OneCare Connect lines of businesses

/s/ Michael Schrader *2/12/2020*
Authorized Signature **Date**

Attachment 1: MY2020 - 2021 OCC P4V Program Measurement Set

OneCare Connect Measures	**2020 Measurement Year / HEDIS 2021 Specifications Anticipated Payment Date: Q4 2021**	**Measurement Assessment Methodology**
Clinical Domain – HEDIS Weight: 60.00% Each measure weighted equally	Measures: • Breast Cancer Screening (BCS) • Comprehensive Diabetes Care (CDC) – HbA1c poor control (> 9.0) • Plan All Cause Readmissions (PCR) • Part D Medication Adherence for Diabetes • Colorectal Cancer Screening	A relative point system by measure based on: • CMS STAR thresholds • Cut Point Level Improvement
Member Satisfaction Domain - CAHPS Weight: 40%	Adult Satisfaction Survey (Adult CAHPS): • Annual Flu Vaccine • Getting Appointments and Care Quickly • Getting Needed Care • Rating of Healthcare Quality	A relative point system by measure based on: • CMS CAHPS Cut Points • Cut Point Level Improvement
Display Measure	Comprehensive Diabetes Care (CDC) Nephropathy Monitoring	CMS Technical Specifications and Benchmarks for STAR measures

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OneCare Connect Measures	**2021 Measurement Year / HEDIS 2022 Specifications Anticipated Payment Date: Q4 2022**	**Measurement Assessment Methodology**
Clinical Domain – HEDIS Weight: 60.00% Each measure weighted equally	<u>Measures:</u> • Breast Cancer Screening (BCS) • Comprehensive Diabetes Care (CDC) – HbA1c poor control (> 9.0) • Plan All Cause Readmissions (PCR) • Part D Medication Adherence for Diabetes • Colorectal Cancer Screening	A relative point system by measure based on: • CMS STAR thresholds • Cut Point Level Improvement
Member Satisfaction Domain - CAHPS Weight: 40%	<u>Adult Satisfaction Survey (Adult CAHPS):</u> • Annual Flu Vaccine • Getting Appointments and Care Quickly • Getting Needed Care • Rating of Healthcare Quality	A relative point system by measure based on: • CMS CAHPS Cut Points • Cut Point Level Improvement
Display Measure	Comprehensive Diabetes Care (CDC) Nephropathy Monitoring	CMS Technical Specifications and Benchmarks for STAR measures

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken February 7, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Approval of the Proposed Pay for Value Program for Fiscal Year 2020 (Measurement Year 2019) for Medi-Cal and OneCare Connect Lines of Business

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality and Analytics, (714) 246-8400

Recommended Action

Approve Fiscal Year 2020 (Measurement Year 2019) "Pay for Value (P4V) Program" for Medi-Cal and OneCare Connect (OCC)," which defines measures and allocations for performance and improvement, as described in Attachment 1, subject to regulatory approval, as applicable.

Background

CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care. Annually, the CalOptima staff conducts a review of the current measures and their performance over time. A part of this analysis included evaluating both the overall performance of the measure and the level of improvement left to achieve. In addition, the staff analyzed the difficulty of improving a measure due to the size of the eligible population or difficulty in data gathering. Finally, the staff evaluated any changes to the measures that are important to CalOptima's NCQA Accreditation status, CMS Star Rating Status and/or overall NCQA Health Plan Rating.

The purpose of CalOptima's P4V program for the Health Networks, including CalOptima Community Network (CCN) is consistent with the P4V programs of the prior three years, which remains:

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

Discussion

For the Measurement Year 2019 programs, staff recommends maintaining the tenets from the prior year, with some modifications.

For the Medi-Cal line of business, staff recommends no changes to the incentivized Adult and Child clinical and member experience performance measures. Both Adult and Child measures remain in the measurement set and weighting by acuity (SPD vs. non-SPD) will carry forward in the proposed MY

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2019 P4V program. Staff propose one additional measure to be added to the Medi-Cal measurement set.

Measurement Year 2019 Medi-Cal P4V Display Measure Changes:

Recommendation: Addition of one new Display measure:

- Persistence of Beta Blocker treatment after a Heart attack

Clinical guidelines recommend prescribing a beta-blocker after a heart attack to prevent another heart attack from occurring. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes. Current CalOptima performance based on measurement year 2017 performance is at the National NCQA Medicaid 25th percentile which is well below the National Medicaid average at the 75th percentile.

Display measures are not eligible for P4V payments. The intent of including them in the data set is to raise awareness of the measure and provide time for the Health Networks to evaluate, educate, monitor and implement actions to improve the rates. The CalOptima P4V team will also monitor the performance of these display measures throughout the year and offer recommendations to potentially include them as payment measures for MY2020. For example, Colorectal Screening is now proposed to move from a Display measure to a Pay for Value clinical measure.

Measurement Year 2019 OneCare Connect P4V Measures Changes:
For the OneCare Connect line of business, staff recommends one change to the clinical performance measures and one addition to the clinical display measures.

Recommendation: Addition of one new Clinical measure:

- Colorectal Cancer Screening

Regular screening, beginning at age 50, is the key to preventing colorectal cancer. The U.S. Preventive Services Task Force (USPSTF) recommends that adults age 50 to 75 be screened for colorectal cancer. Current CalOptima performance based on measurement year 2017 performance is at the two-star CMS Rating. Our goal is to achieve three star or higher rating from CMS on all quality metrics in the Star Rating set.

Recommendation: Addition of one new Clinical Display measure:

- Comprehensive Diabetes Care Nephropathy Monitoring

Clinical guidelines recommend annual screening or monitoring test for diabetics for evidence of nephropathy. This includes urine protein tests, evidence of treatment for nephropathy, stage 4 chronic kidney disease, end stage renal disease, kidney transplant, or visit to a nephrologist or prescription for one ACE/ARB medication.

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Distribution of Incentive Dollars

There are no proposed changes to the previously-Board-approved distribution strategy for earned pay for value dollars. The following P4V program requirements will remain:

- All health networks will continue to have performance measures for both adult and child care.
- Performance and improvement allocations are distributed upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid proportional to acuity level, as determined by aid category. Weighting of performance and improvement may be adjusted based on overall CalOptima performance.
- To qualify for payment for each of the Clinical and CAHPS measures, the Health Network must have a minimum denominator in accordance with statistical principles.
- To qualify for payments, a health network or physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.
- Any separate OCC Quality Withhold incentive dollars earned will be distributed based upon the methodology previously approved by the Board of Directors.
- Payments can be made annually or more frequently, at CalOptima's discretion.
- Distribution methodology to CCN providers for measurement year 2019 payout will remain the same as previously approved by the Board of Directors.

Fiscal Impact

The fiscal impact of the Medi-Cal P4V program will not exceed $2.00 per member per month (PMPM) and the OCC P4V program will not exceed $20.00 PMPM for the MY of January 1, 2019, through December 31, 2019. Since the distribution of incentive dollars for the MY 2019 P4V programs for Medi-Cal and OneCare Connect will be made in Fiscal Year 2020-21, Management will include expenses related to the MY 2019 P4V program in a future operating budget.

Rationale for Recommendation

This alignment leverages improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

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Attachments

1. FY 2020 (MY 2019) Medi-Cal and OneCare Connect Pay for Value Program Measurement Set
2. PowerPoint Presentation to Board of Directors' Quality Assurance Committee: Measurement Year 2019 Pay for Value Program Proposed Changes

/s/ Michael Schrader — *1/30/2019*

Authorized Signature — **Date**

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Attachment 1: FY 2020 (MY 2019) Medi-Cal and OCC
Pay for Value Program Measurement Set

Adult Measures	**2019 Measurement Year / HEDIS 2020 Specifications** **Anticipated Payment Date: Q3 2020**	**Measurement Assessment Methodology**
Clinical Domain – HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	<u>Prevention:</u> • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) <u>Diabetes (CDC):</u> • HbA1c < 8.0 (adequate control) • Retinal Eye Exams <u>Access to Care</u>: • Adults Access to Preventive/Ambulatory Care (AAP) <u>Respiratory</u>: • Medication Management for People with Asthma (MMA) – 19-50 years 75% compliance • Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percentile Improvement
Adult Measures	**2019 Measurement Year / HEDIS 2020 Specifications** **Anticipated Payment Date: Q3 2020**	**Measurement Assessment Methodology**
Patient Experience Domain - CAHPS Weight: 40%	<u>Adult Satisfaction Survey (Adult CAHPS):</u> • Getting Needed Care • Getting Care Quickly • Rating of PCP • How well Doctors Communicate	A relative point system by measure based on: • NCQA CA CAHPS percentiles • Percentile Improvement
Display Measure	• Initial Health Assessment • Persistence of Beta Blocker treatment after a Heart Attack	• DHCS percentiles • NCQA National HEDIS percentiles

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Pediatric Measures	2019 Measurement Year / HEDIS 2020 Specifications Anticipated Payment Date: Q3 2020	Measurement Assessment Methodology
Clinical Domain - HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	Respiratory: • Medication Management for People with Asthma (MMA) - 5-11 years 75% Compliance • Appropriate Testing for Children with Pharyngitis (CWP) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) Prevention: • Childhood Immunization Status Combo 10 (CIS) • Well-Care Visits in the 3-6 Years of Life (W34) • Adolescent Well-Care Visits (AWC) • Well Child Visits in the First 15 months of Life –six well child visits (W15) Access to Care: • Children's Access to Primary Care Physician (CAP)	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percentile Improvement
Pediatric Measures	**2019 Measurement Year /HEDIS 2020 Specifications Anticipated Payment Date: Q3 2020**	**Measurement Assessment Methodology**
Patient Experience Domain - CAHPS Weight: 40%	Child Satisfaction Survey (Child CAHPS) • Getting Needed Care • Getting Care Quickly • Rating of PCP • How well Doctors Communicate	A relative point system by measure based on: • NCQA CA CAHPS percentiles • Percentile Improvement

OneCare Connect Measures	**2019 Measurement Year /HEDIS 2020 Specifications Anticipated Payment Date: Q3 2020**	**Measurement Assessment Methodology**
Clinical Domain – HEDIS Weight: 60.00% Each measure weighted equally	Measures: • Breast Cancer Screening (BCS) • Comprehensive Diabetes Care (CDC) – HbA1c poor control (> 9.0) • Plan All Cause Readmissions (PCR) • Part D Medication Adherence for Diabetes • Colorectal Cancer Screening	A relative point system by measure based on: • CMS STAR thresholds • Percentile Improvement
Patient Experience Domain - CAHPS Weight: 40%	Adult Satisfaction Survey (Adult CAHPS): • Annual Flu Vaccine • Getting Appointments and Care Quickly • Getting Needed Care • Rating of Healthcare Quality	A relative point system by measure based on: • CMS CAHPS Cut Points • Cut Point Level Improvement
Display Measure	Comprehensive Diabetes Care (CDC) Nephropathy Monitoring	CMS Technical Specifications and Benchmarks for STAR measures

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Measurement Year 2019 Pay for Value Program Proposed Changes

Special Board of Directors' Quality Assurance Committee Meeting

January 17, 2019

Betsy Ha, RN, MS, Lean Six Sigma Master Black Belt

Executive Director, Quality & Analytics

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Introduction

- Annually, staff conduct a review of CalOptima's performance on key quality performance metrics such as:
  - NCQA Accreditation
  - Pay4Value
  - Health Plan Ratings
  - Model of Care
  - CMS STARS
- This analysis includes evaluating the overall performance of the measure, improvement over time, and the level of improvement left to achieve.

P4V Measure Set Considerations

- The P4V measure sets include a diverse set of measures including:
  - Preventive screenings for children and adults
  - Chronic Care Measures
  - Outcomes based Measures
  - Member Experience
  - Utilization/Readmissions
- Measures must be actionable by PCP's:
  - Monthly, staff provide industry benchmarks and data-driven feedback to Health Networks on their performance on P4V measures.
- Reporting Administrative Data Only

Medi-Cal P4V Measures

P4V Recommendations:

- No changes to Medi-Cal Adult measures for MY 2019.
- No changes to Medi-Cal Child measures for MY 2019.
- No changes to CAHPS Survey measures but the CAHPS benchmarks were changed to California benchmarks from National benchmarks for MY 2018 and will remain in place for MY 2019.
- Prefer measures to remain in program for at least 2-3 years for health networks to adapt to changes.
- Based on recommendation from Chronic Care conditions team, adding “Persistence for Beta Blocker Treatment after a Heart Attack” as a Display Measure (< 25th percentile currently).

Medi-Cal P4V Clinical Measures - Adult

Measurement Year 2019 – NO CHANGES	
Adult	**Quality Strategy**
Adult Access to Preventive Care Services	Area of HEDIS auditor focus due to declining rates; at 10th percentile Nationally
Breast Cancer Screening	Accreditation and Health Plan Rating
Cervical Cancer Screening	Accreditation, DHCS, and Health Plan Rating
Diabetes Care: HbA1c <8.0% (adequate control)	Accreditation and Health Plan Rating
Diabetes Care: Retinal Eye Exams	Accreditation, DHCS, and Health Plan Rating
Medication Management for People with Asthma: Age 19 – 50 years 75% Compliance	Accreditation, Health Plan Rating
Avoidance of Antibiotic Treatment in Adults with Bronchitis	Accreditation

Medi-Cal P4V Clinical Measures - Child

Measurement Year 2019 – NO CHANGES	
Child	**Quality Strategy**
Adolescent Well-Care Visits	Health Plan Rating
Appropriate Testing for Children with Pharyngitis	Accreditation and Health Plan Rating
Appropriate Treatment for Children with URI	Accreditation and Health Plan Rating
Childhood Immunizations: Combo 10	Accreditation and Health Plan Rating
Children's Access to Primary Care Providers	Area of HEDIS Auditor focus; below 50th percentile
Medication Management for People with Asthma: Age 5 – 11 years 75% Compliant	Accreditation, DHCS, and Health Plan Rating
Well-Child Visits 3–6 Years	DHCS and Health Plan Rating
Well Child Visits in the first 15 Months of Life	Health Plan Rating

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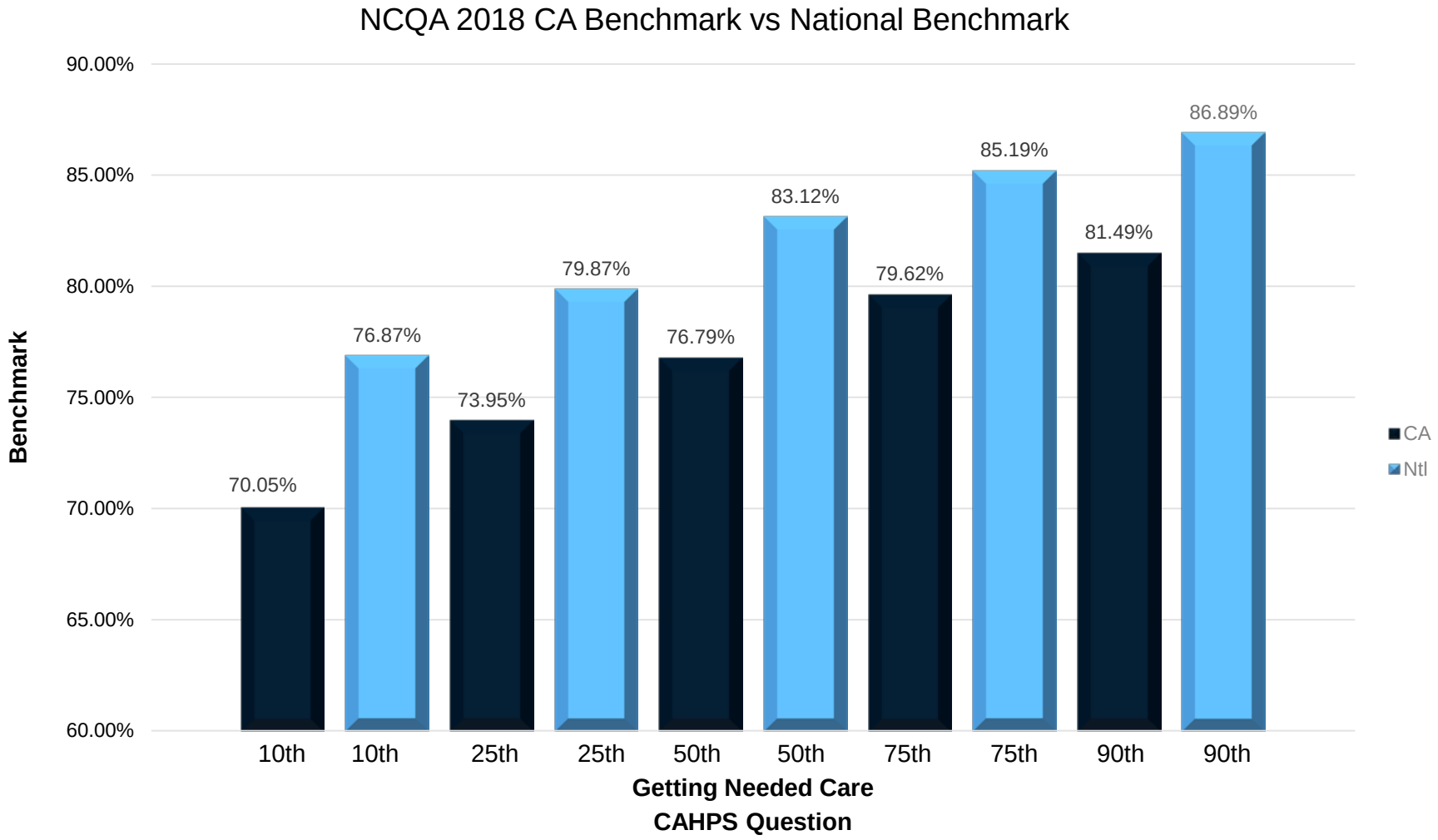
Medi-Cal P4V Display Measures

Measurement Year 2019	
Display	**Quality Strategy**
Initial Health Assessment	DHCS focus measure
NEW: Persistence for Beta Blocker Treatment after a Heart Attack	Health Plan Rating

Medi-Cal P4V CAHPS Measures

Measurement Year 2019 – NO CHANGES	
Adult and Child Measures	
Getting Needed Care	Accreditation and Health Plan Rating
Getting Care Quickly	Accreditation and Health Plan Rating
Rating of PCP	Accreditation and Health Plan Rating
How well Doctors Communicate	Accreditation

Adult CAHPS Benchmark Comparison



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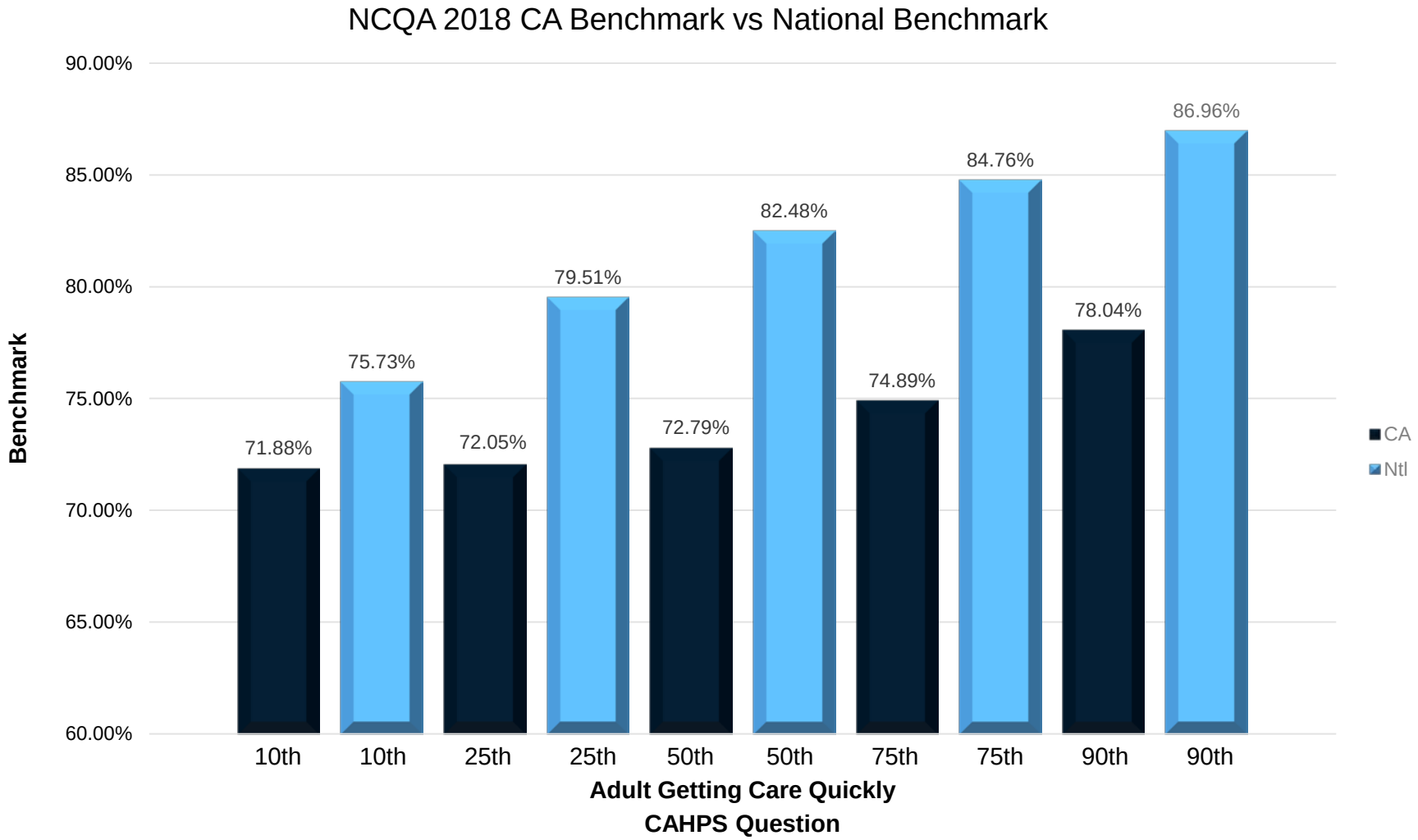
Adult CAHPS Benchmark Comparison



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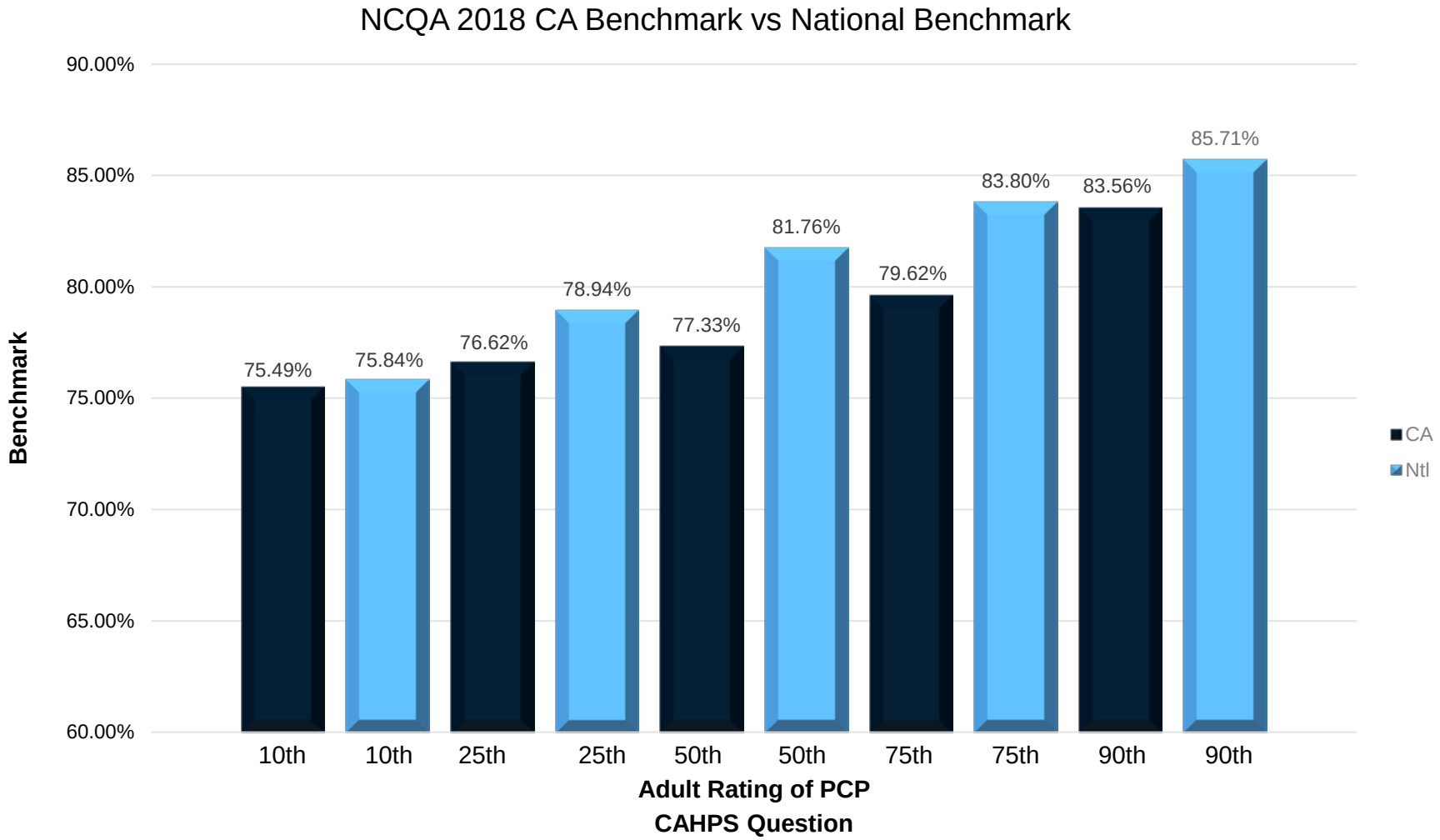
Adult CAHPS Benchmark Comparison



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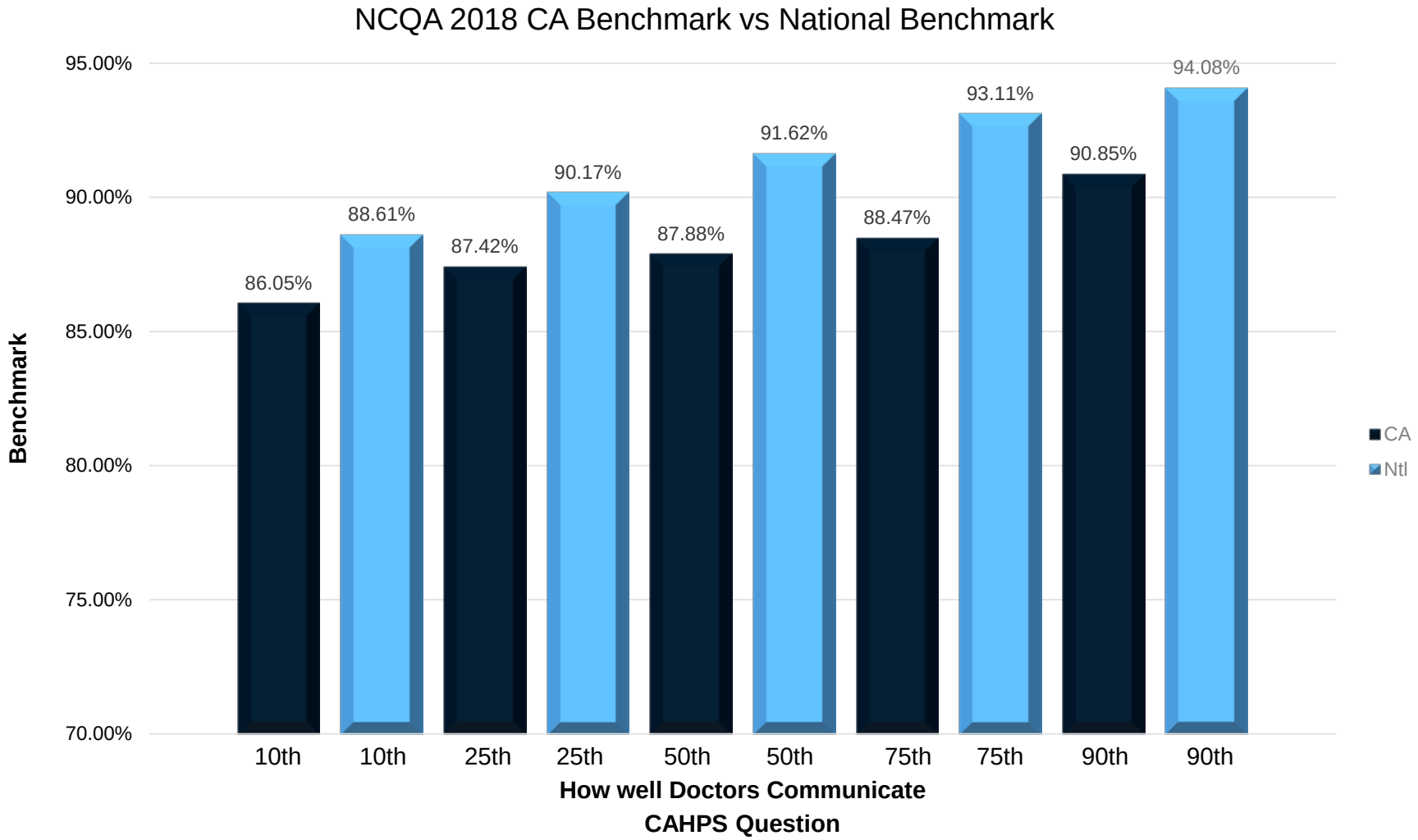
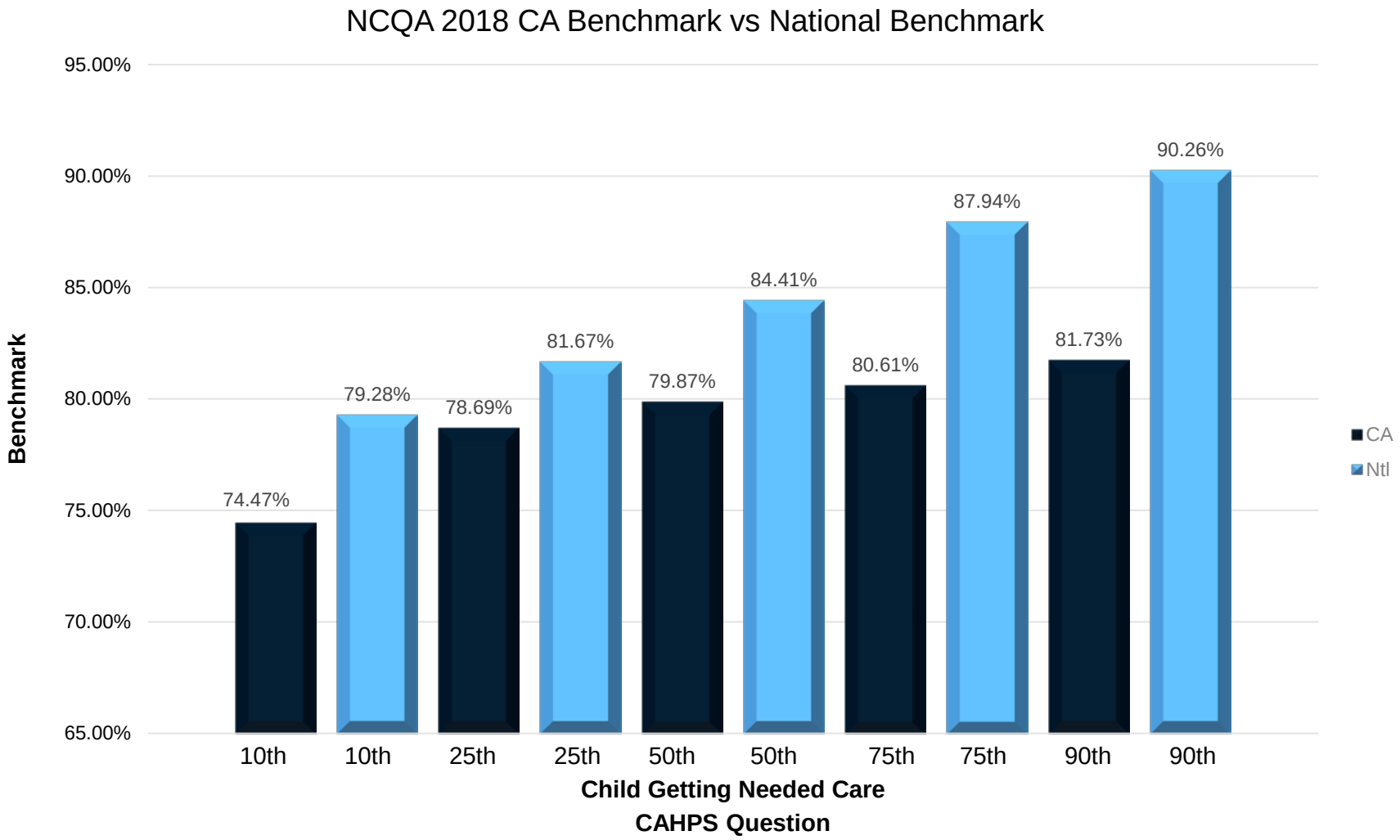
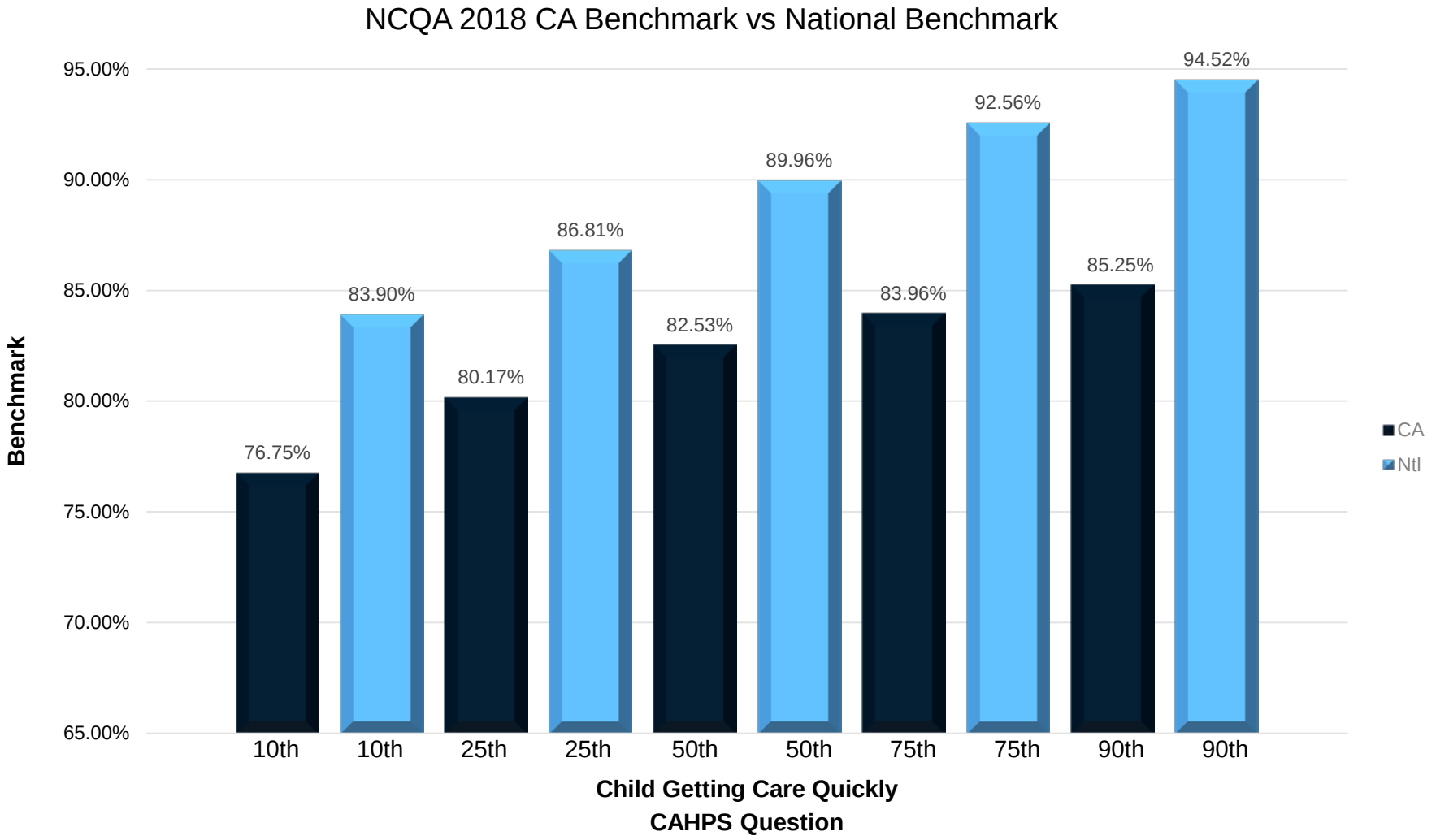
Adult CAHPS Benchmark Comparison



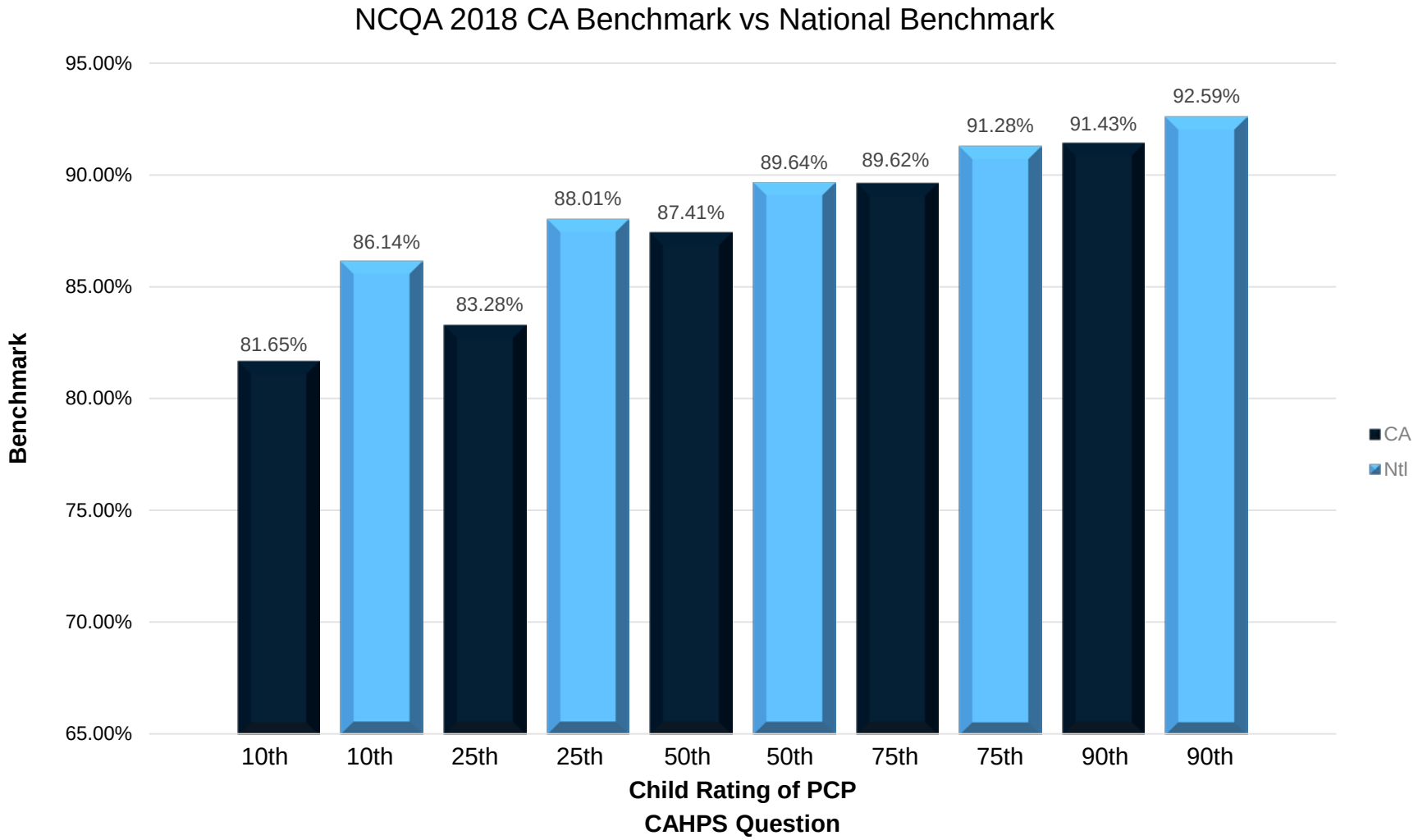
Child CAHPS Benchmark Comparison



Child CAHPS Benchmark Comparison



Child CAHPS Benchmark Comparison



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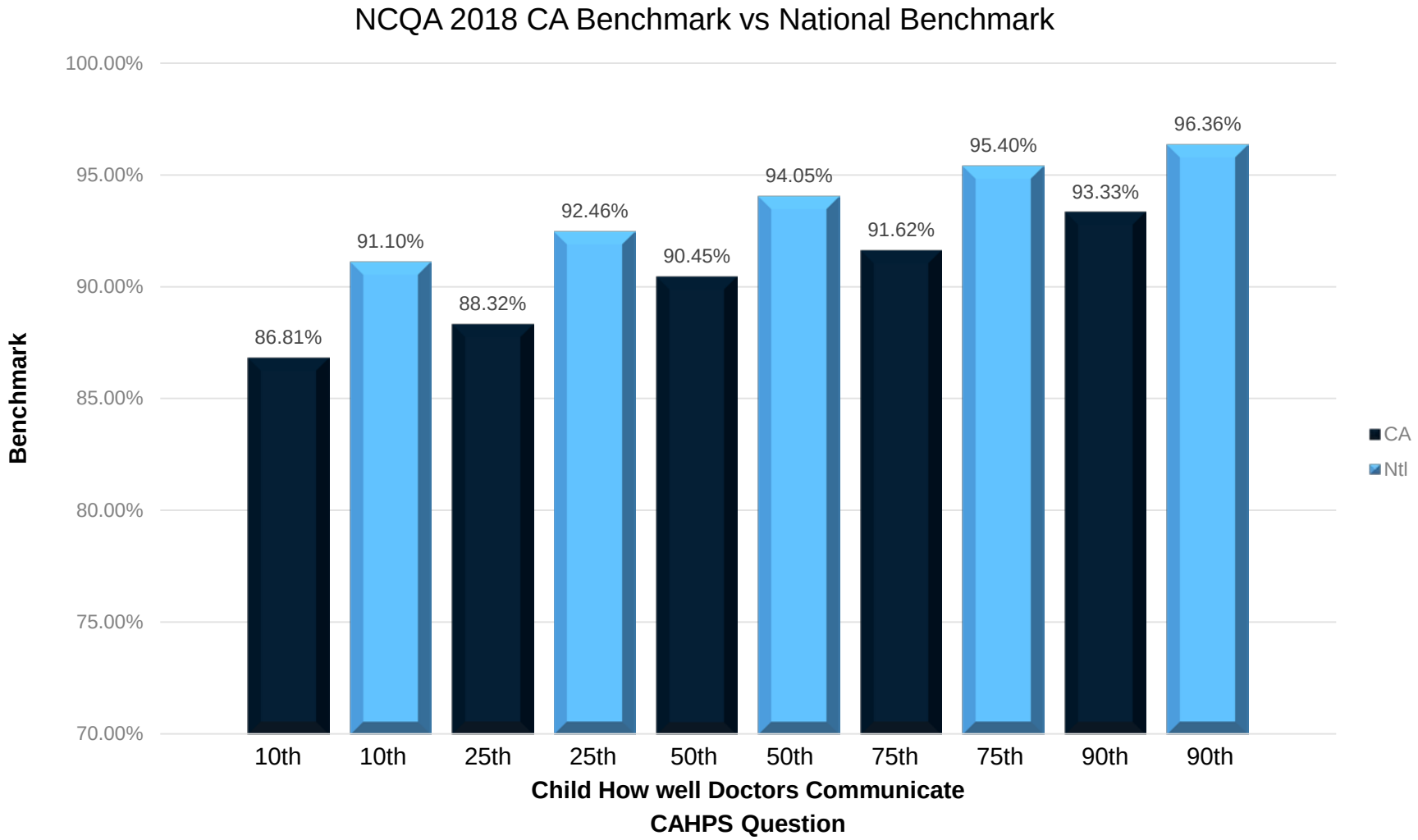
Child CAHPS Benchmark Comparison



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OneCare Connect P4V Measures – MY 2019

P4V Recommendations:

- One change to OneCare Connect measures for MY 2019.
- Colorectal Screening to be moved from a Display measure to a P4V measure.
- CDC Nephropathy Monitoring to be included as a Display Measure for MY2019.
- No changes to OneCare Connect CAHPS Survey measures.

OneCare Connect P4V Measures

Measurement Year 2019	
Breast Cancer Screening	Model of Care and STAR measure
Diabetes Care – HbA1c poor control (>9.0%)	STAR measure
Medication Adherence for Diabetes Medications (Part D measure)	Model of Care, STAR, and Quality Withhold
Plan All-Cause Readmissions	STAR and Quality Withhold measure
NEW: Colorectal Cancer Screening	Model of Care and STAR

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OneCare Connect P4V CAHPS Measures

Measurement Year 2019 – NO CHANGES	
Annual Flu Vaccine	STAR
Getting Appointments and Care Quickly	Model of Care and STAR
Getting Needed Care	Model of Care and STAR
Rating of Healthcare Quality	Model of Care and STAR

OneCare Connect P4V Display Measure

Measurement Year 2019	
NEW: Diabetes Care - Nephropathy Monitoring	STAR measure

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 19, 2020
Regular Meeting of the CalOptima Board of Directors'
Quality Assurance Committee

Report Item

8. Consider Recommending Board of Directors' Allocation of Intergovernmental Transfer (IGT) 9 Funds

Contact

David Ramirez, Chief Medical Officer (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400
Candice Gomez, Executive Director Program Implementation (714) 246-8400

Recommended Actions

Recommend that the Board of Directors:

1. Approve the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives for quality performance, access to care, data exchange and support and other priority areas; and,
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to take actions necessary to implement the proposed initiatives, subject to staff first returning to the Board for approval of:
    a. Additional initiative(s) related to member access and engagement; and
    b. New and/or modified policies and procedures, and contracts/contract amendments, as applicable.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in eight Rate Range IGT transactions. Funds from IGTs 1 through 8 have been received and IGT 9 funds are expected from the state in the first quarter of 2020. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2020-2011 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to CMS.

The IGT funds received under IGT 1 through 7 have supported special projects that address unmet healthcare needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds are incorporated into the contract between the California Department of Health Care Services (DHCS) and CalOptima for the current fiscal year. Funds must be used for CalOptima covered Medi-Cal services per DHCS requirements. Upon Board approval, funds may be allocated and used over multiple years. IGT 8

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funds have been allocated to the Homeless Health Initiative. In July 2018, CalOptima received notice from DHCS regarding the fiscal year 2018-19 Voluntary Rate Range IGT 9. While supporting documents were submitted to DHCS in August 2018, IGT 9 funds have not yet been received or allocated. Submission of documentation to participate in IGT 9 was ratified at the September 9, 2018 Board of Directors meeting. CalOptima is expected to receive funding from DHCS in calendar year 2020. CalOptima's estimated share is expected to be approximately $45 million.

Discussion

Beginning with IGT 8, the requirement is that IGT funds are to be used for Medi-Cal programs, services and operations. IGT funds are subject to all applicable requirements set forth in the CalOptima Medi-Cal contract with DHCS and are considered part of the capitation payments CalOptima receives from DHCS and are accounted for as either medical or administrative expenses, and factor into CalOptima's Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR). As indicated, per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

While IGT 9 funds have not yet been received, CalOptima staff has begun planning to support use of the funds. CalOptima staff has considered the DHCS requirements for use of IGT 9 funds and Board approved strategic priorities and objectives in identifying the following focus areas:

- Member access and engagement
- Quality performance
- Data exchange and support
- Other priority areas identified

CalOptima staff has and will continue to share information about the proposed focus areas with various stakeholders.

CalOptima staff anticipates receiving approximately $45 million in IGT 9 funding and proposes allocation of funds towards the following focus areas:

Focus Area	Amount Requested
Member access and engagement	$6.5 million
Quality performance	$3.4 million
Data exchange and support	$2.0 million
Other identified priority areas	$33.1 million

Within the IGT 9 focus areas, staff has identified initiatives targeted for $40.5 million of the anticipated $45 million. These initiatives include:

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	$3.4 million

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3. Hospital Data Exchange Incentive	Data exchange and support	One–year	$2.0 million
4. IGT Program Administration	Other priority areas	Five–years	$2.0 million
5. Whole Child Model (WCM) Program	Other priority areas	One–year	Up to $31.1 million

Prior to implementation, CalOptima staff will return to the Board with recommendations related the remaining estimated $4.5 million towards member access and engagement, as well as regarding new and/or modified policies and procedures, and contracts, as applicable.

Fiscal Impact

The recommended action has no net fiscal impact to CalOptima's operating budget over the proposed project terms. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures and initiatives recommended in this COBAR.

Rationale for Recommendation

CalOptima staff is considering and has considered proposals that are consistent with the identified focus areas and CalOptima's strategic priorities and objectives.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Power Point Presentation: Intergovernmental Transfer (IGT) 9 Update
2. CalOptima Board Action dated September 6, 2018, Consider and Authorize Activities to Secure Medi-Cal Funds through IGT 9
3. CalOptima Board Action dated June 6, 2019, Approve Post-Acute Infection Prevention Quality Initiative and Authorize Quality Incentive Payments
4. IGT Funding Proposals

/s/ Michael Schrader *02/12/2020*

Authorized Signature **Date**

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CalOptima
A Public Agency
Better. Together.

Intergovernmental Transfer (IGT) 9 Update

Board of Directors' Quality Assurance Committee Meeting
February 19, 2020

David Ramirez, M.D., Chief Medical Officer
Nancy Huang, Chief Financial Officer
Candice Gomez, Executive Director, Program Implementation

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IGT Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGT 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
    - Funds are outside of operating income and expenses
  - IGT 8–10: Funds must be used for Medi-Cal covered services for the Medi-Cal population
    - Funds are part of operating income and expenses

IGT Funding Process

High-Level Overview
1. CalOptima receives DHCS notice announcing IGT opportunity
2. CalOptima secures funding partnership commitments (e.g., UCI, Children and Families Commission, et al.)
3. CalOptima submits Letter of Interest to DHCS listing funding partners and their respective contribution amounts
4. Funding partners wire their contributions and an additional 20% fee to DHCS
5. CMS provides matching funds to DHCS
6. DHCS sends total amount to CalOptima
7. From the total amount, CalOptima returns each funding partner's original contribution
8. From the total amount, CalOptima also reimburses each funding partner's 20% fee and where applicable, retained amount for MCO tax (IGT 1–6 only)
9. Remaining balance of the total amount is split 50/50 between CalOptima and the funding partners or their designees

CalOptima Share Totals to Date

IGTs	CalOptima Share	Date Received
IGT 1	$12.43 million	September 2012
IGT 2	$8.70 million	June 2013
IGT 3	$4.88 million	September 2014
IGT 4	$6.97 million	October 2015 (Classic)/ March 2016 (MCE)
IGT 5	$14.42 million	December 2016
IGT 6	$15.24 million	September 2017
IGT 7	$15.91 million	May 2018
IGT 8	$42.76 million	April 2019
IGT 9*	TBD	TBD (Spring 2020)
IGT 10*	TBD	TBD
Total Received	**$121.31 million**	

** Pending DHCS guidance*

IGT 9 Status

- CalOptima's estimated share is approximately $45 million
  - Expect receipt of funding in calendar year 2020
  - Funds used for Medi-Cal programs, services and operations
  - Funds are part of operating income and expenses
    - Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR) apply
    - Managed through the fiscal year budget

- Stakeholder vetting on the following focus areas
  - Member access and engagement
  - Quality performance
  - Data exchange and support
  - Other identified priority areas

Proposed Allocation

Focus Area	Amount Requested
Member access and engagement	$6.5 million
Quality performance	$3.4 million
Data exchange and support	$2.0 million
Other identified priority areas	$33.1 million

- Staff has identified initiatives targeted $40.5 million of the anticipated $45 million
- Additional initiatives in development will be presented before the end of the fiscal year

1. Member Access and Engagement: Expanded Office Hours

- Description
  - Offer additional incentives to providers and/or clinics
    - Expand office hours in the evening and weekends
    - Expand primary care services to ensure timely access
- Guidelines
  - Primary care providers in community clinics serving members in high-demand/impacted areas are eligible
  - Per-visit access incentive awarded to providers and/or clinics for members seen during expanded hours
- Key Components
  - Two-year initiative
  - Budget request of $2.0 million ($500,000 in FY 2019–20)

2. Quality Performance: Post-Acute Infection Prevention Initiative (PIPQI)

- Description
  - Expand CalOptima's PIPQI to suppress multidrug-resistant organisms in contracted skilled nursing facilities (SNFs) and decrease inpatient admissions for infection
- Guidelines
  - Phase 1: Training for 41 CalOptima-contracted SNFs not currently participating in initiative
  - Phase 2: Compliance, quality measures and performance incentives for all participating facilities
  - Two FTE to support adoption, training and monitoring
- Key Components
  - Three-year initiative
  - Budget request of $3.4 million ($1 million in FY 2019–20)

3. Data Exchange: Hospital Data Exchange Incentive

- Description
  - Support data sharing among contracted and participating hospitals via use of CalOptima selected vendors
    - Other organizations within the delivery system may also be added
  - Enhance monitoring of hospital activities for CalOptima's members, aiming to improve care management and lower costs
- Guidelines
  - Participating organizations will:
    - Work with CalOptima and vendor to facilitate sharing of ADT (Admit, Discharge, Transfer) and Electronic Health Record data
    - Be eligible for an incentive once each file exchange is in place
- Key Components
  - One-year initiative
  - Budget request of $2.0 million (CY 2020)

4. Other: IGT Program Administration

- Definition
  - Administrative support for prior, current and future IGTs
    - Continue support for two existing staff positions to manage IGT transaction process, project and expenditure oversight
    - Fund Grant Management System license, public activities and other administrative costs
- Guidelines
  - Will be consistent with CalOptima policies and procedures
  - Will provide oversight of the entire IGT process and ensure funding investments are aligned with CalOptima strategic priorities and member needs
- Key Components
  - Five years of support
  - Budget request of $2.0 million

5. Other Priorities: Whole-Child Model (WCM) Program

- Definition
  - CalOptima launched WCM on July 1, 2019
  - Based on the initial analysis, CalOptima is projecting an overall loss of up to $31.1 million in FY 2019–20
- Challenges
  - Insufficient revenue from DHCS to cover WCM services
  - Complex operations and financial reconciliation
- Key Components
  - One year
  - Budget request of up to $31.1 million to fund the deficit from WCM program in FY 2019–20

Next Steps

- Present recommendations during the March 2020 Board of Directors meeting

- Return to the Board as needed regarding
  - New or modified policy and procedures
  - Contracts
  - Additional initiatives

CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Ratification of the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8400

Recommended Actions

Ratify and authorize the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program:

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9);
2. Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9), and;
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 9 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in seven Rate Range IGT transactions. Funds from IGTs 1 – 7 have been received and IGT 8 funds are expected in the first quarter of 2019. IGT 1 – 7 funds were retrospective payments for prior rate range years and have been used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. These funds have been best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

The IGT funds that have been received to date have supported special projects that address unmet needs for CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing unmet needs.

Discussion

Beginning with IGT 8, the IGT program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the current fiscal year. Unlike previous IGTs (1-7), IGT funds must now be used in the current rate year for CalOptima covered

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services per DHCS instructions. CalOptima may determine how to spend the IGT funds (net proceeds) as long as they are for CalOptima covered services for Medi-Cal beneficiaries.

On July 31, 2018, CalOptima received notification from DHCS regarding the State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Intergovernmental Transfer Program (IGT 9). CalOptima's proposal, along with the funding entities' supporting documents were due to DHCS on August 31, 2018.

The five eligible funding entities from the previous IGT transactions were contacted regarding their interest in participation. All five funding entities have submitted letters of interest regarding participation in the IGT program this year. These entities are:

1. University of California, Irvine,
2. Children and Families Commission of Orange County,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach.

Board approval is requested to ratify the submission of the proposal letter to DHCS for participation in the 2018-19 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with the five proposed funding entities or their designated providers for the purpose of securing available IGT funds. Consistent with the eight prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to your Board with more information regarding the IGT 9 transaction and an expenditure plan for CalOptima's share of the net proceeds at a later date. .

Fiscal Impact
The recommended action to ratify and authorize activities to secure Medi-Cal funds through IGT 9 will generate one-time IGT revenue that will be invested in Board-approved programs/initiatives. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. As such, there is no net fiscal impact on CalOptima's current or future operating budgets as IGT funds have been accounted for separately.

Rationale for Recommendation
Consistent with the previous eight IGT transactions, ratification of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2018-19 (IGT 9).

Concurrence
Gary Crockett, Chief Counsel

Attachment
Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader — **Authorized Signature**

8/29/2018 — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

July 31, 2018

Greg Hamblin
Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Mr. Hamblin:

The 2018-19 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of July 1, 2018 through June 30, 2019 (SFY 2018-19).

DHCS shall not direct the MCP's expenditure of payments received under the 2018-19 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the 2018-2019 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR SFY 2018-19:

MCPs should refer to the estimated SFY 2018-19 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the 2018-19 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. If an MCP elect to participate in the 2018-19 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the 2018-19 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.

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2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for SFY 2018-19. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the "supplemental attachment" described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** (using the format provided in Attachment A) from each governmental funding entity included in the MCP's proposal to DHCS. An individual authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest. Each letter of interest must specify:

  1. The governmental funding entity's name and Federal Tax Identification Number,
  2. The dollar amount or percentage of the total available rate range the governmental funding entity will contribute for each MCP and county/region, and
  3. The governmental funding entity's primary contact information (name, e-mail address, mailing address, phone number).

- The MCP must distribute to governmental funding entities and ensure submission to DHCS of the **SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Friday, August 31, 2018.

- The proposals and letters of interest are due to DHCS ***by 5pm on Friday, August 31, 2018***. Please send a PDF copy of the required documents by e-mail to Sandra.Dixon@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the SFY 2018-19 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their

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uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the 2018-19 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 345-8269 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

Jennifer Lopez
Division Chief
Capitated Rates Development Division

Attachments

cc: Michael Schrader, Chief Executive Officer
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Financial Management Section
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

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ATTACHMENT A – LETTER OF INTEREST TEMPLATE

Jennifer Lopez
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Lopez:

This letter confirms the interest of [Insert Participating Funding Entity Name], a governmental entity, federal I.D. Number [Insert Federal Tax I.D. Number], in working with [Managed Care Plan's Name] (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the period of July 1, 2018, to June 30, 2019. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

[Insert Participating Funding Entity Name] is willing to contribute up to $_____ for the SFY 2018-19 rating period as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,
Signature

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Attachment B

SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment

Provider Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by Friday, August 31, 2018.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2016 through June 30, 2017.

	Charges	Costs	Payments from Health Plan*	Uncompensated Chares (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$	$
Outpatient				$	$
All Other				$	$
Total	$	$	$	$	$

* Include payments received and anticipated to be received for service dates of July 1, 2016 through June 30, 2017.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. For any capitation payments to be funded by the IGT, please provide the following:

(i) The name of the entity transferring funds:

(ii) The operational nature of the entity (state, county, city, other):

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations.)

(iv) Does the transferring entity have general taxing authority? *(Yes / No)*

(v) Does the transferring entity receive appropriations from a state, county, city, or other local government jurisdiction? *(Yes / No)*

5. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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Orange County Organized Health System dba Cal Optima - Orange (HCP 506)
IGT - 2018/19 (July 2018 - June 2019)

	Total	50% FMAP (Non-MCHIP and OE)	88% FMAP (MCHIP)	Optional Expansion (93.5%)
Total Funds Available	$ 138,114,451	$ 68,412,249	$ 7,133,302	$ 62,568,900
Federal Match	$ 98,985,353	$ 34,206,125	$ 6,277,306	$ 58,501,922
Governmental Funding Entity's Portion	$ 39,129,098	$ 34,206,124	$ 855,996	$ 4,066,978
	28.3%	50.0%	12.0%	6.5%

Rate Categories[1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Dept. Usage[2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,474,781	$ 84.85	$ 89.93	$ 5.08	$ -	$ 5.08	$ 12,571,887
Child - MCHIP	1,273,587	$ 84.85	$ 89.93	$ 5.08	$ -	$ 5.08	$ 6,469,822
Adult - non MCHIP	1,082,406	$ 299.18	$ 316.64	$ 17.46	$ -	$ 17.46	$ 18,898,809
Adult - MCHIP	38,000	$ 299.18	$ 316.64	$ 17.46	$ -	$ 17.46	$ 663,480
SPD	466,754	$ 755.18	$ 798.48	$ 43.30	$ -	$ 43.30	$ 20,210,448
SPD/Full-Dual	22,704	$ 219.25	$ 229.52	$ 10.27	$ -	$ 10.27	$ 233,170
BCCTP	7,156	$ 1,225.69	$ 1,296.82	$ 71.13	$ -	$ 71.13	$ 509,006
LTC	14,686	$ 10,472.34	$ 10,858.28	$ 385.94	$ -	$ 385.94	$ 5,667,915
LTC/Full-Dual	0	$ 6,036.73	$ 6,235.58	$ 198.85	$ -	$ 198.85	$ -
OBRA	0	$ -	$ -	$ -	$ -	$ -	$ -
Whole Child Model	74,642	$ 1,824.65	$ 1,962.92	$ 138.27	$ -	$ 138.27	$ 10,321,014
Optional Expansion	2,853,119	$ 442.21	$ 471.45	$ 29.24	$ 7.31	$ 21.93	$ 62,568,900
	8,307,835	$ 309.49	$ 328.62	$ 19.14	$ 2.51	$ 16.62	$ 138,114,451

[1]The supplemental payments (Maternity, BHT and HEP C) are not included in the rate range calculation.
[2]Other Departmental Usages decreases available rate range funding.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

33. Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Emily Fonda, M.D., MMM, CHCQM, Medical Director, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
2. Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

Background

The Centers for Disease Control and Prevention (CDC) and the University of California-Irvine (UCI) recently collaborated on an extensive study in 2017 through 2019 to suppress the spread of Multi-Drug-Resistant Organisms (MDRO) in Skilled Nursing Facilities (SNFs) across Orange County. The ambitious study also garnered the support of the California Department of Public Health as well as the Orange County Health Care Agency. This regional collaborative established a structured "…decolonization strategy to reduce the transmission of MDROs both countywide and within healthcare facilities." The name of the collaborative is SHIELD OC.

SHIELD OC is comprised of intervention protocols for both hospitals and nursing homes. There were 16 Orange County SNFs contracted with CalOptima that participated through to the conclusion of the study.

The study was focused on MDRO decolonization through "…the use of topical products to reduce bacteria on the body that can produce harmful infections." In SNFs, the study protocol involved the implementation of two interventions: (1) the consistent use of Chlorhexidine (CHG) antiseptic soap for routine bathing and showering of residents, and (2) the scheduled use of povidone-iodine nasal swabs on residents.

The preliminary study outcomes were very promising and gained the close attention of CDC senior leadership, who have reached out to CalOptima regarding the project on more than one occasion. Long term care (LTC) residents in facilities following the study protocol showed markedly lower rates of MDRO colonization, which translated into lower rates of hospital admissions and lower utilization costs for CalOptima members. The implications of the study, as well as the innovative regional collaboration model, have also garnered the interest of the press. News regarding the collaborative recently aired on National Public Radio and appeared in *USA Today* articles. The lead author in the study, Dr. Susan Huang, was also recently interviewed in a local news radio segment on KNX 1070.

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The study concluded on May 2, 2019. At the SHIELD OC Wrap Up Event, concerns were expressed by facility participants as well as the CDC that the end of the project funding would prevent the SNFs in the study from continuing the study protocol efforts. Without continuation of the interventions, the momentum of the efforts by the participating SNFs would be interrupted, and the considerable gains made in regional decolonization could potentially be unraveled. While the responsibility of infection prevention in post-acute settings is not solely the responsibility of CalOptima, the extensive project has provided significant safety and health benefits to CalOptima members who reside in these facilities. After the conclusion of the study, the collaborative will face an absence of funding and direction. This presents an opportunity for CalOptima to take a leadership role in supporting the care delivery system by offering value-based quality incentives to facilities that follow evidence-based patient safety practices in the institutionalized population segment which are congruent with CalOptima's mission as well as the National Quality Assurance Committee (NCQA) Population Health Management Standards of Delivery System Support.

Discussion

As proposed, the Post-Acute Infection Prevention Quality Initiative will provide an avenue through which CalOptima can incentivize SNFs to provide the study protocol interventions. The study protocols have been recognized to meaningfully suppress the spread of MDROs and will support the safety and health of CalOptima members receiving skilled interventions at or residing in SNFs. Implementation of the quality initiative is in line with CalOptima's commitment to continuous quality improvement.

The initiative would be comprised of two separate phases. Summarily, in Phase I, CalOptima-contracted SNFs in Orange County could initiate a commitment to implementing the study protocol and CalOptima would respond by providing funding to the facility for setup and protocol training. For each participating SNF, Phase I would last for two quarters. In Phase II of the quality initiative, after the SNF has been trained and can demonstrate successful adoption of the protocol, each SNF would be required to demonstrate consistent adherence to the study protocol as well as meet defined quality measures in order to be eligible to continue receiving the quality initiative payments on a retrospective quarterly basis.

Phase I

CalOptima to provide quality initiative funding to SNFs demonstrating a commitment to implementing the SHIELD OC study protocol. The quality initiative is intended to support start up and training for implementation of the protocols not currently in standard use in SNFs but, as per the SHIELD OC study, have been demonstrated to effectively suppress the spread of MDROs.

Contracted SNFs in Orange County must complete an Intent to Implement MDRO Suppression form, signed by both its Administrator and Director of Nursing.

CalOptima will then initiate payment for the first quarter of setting up and training. Payment will be based on an average expected usage cost per resident, to be determined by CalOptima for application across all participating facilities, so the amount of payment for each facility will be dependent on its size. These payments are intended to incentivize the facilities to meet the protocol requirements. The facility must demonstrate use of the supplies and the appropriate

application of the study protocol to the assigned CalOptima staff to qualify for the second quarterly Phase I payment.

The following supplies are required of the facility:

- 4% Chlorohexidine Soap
- 10% Iodine Swab Sticks

The following activities will be required of the facility:

- Proof of appropriate product usage.
- Acceptance of training and monitoring of infection prevention protocol by CalOptima and/or CDC/UCI staff.
- Evidence the decolonization program handouts are in admission packets.
- Monitoring and documentation of compliance with CHG bathing.
- Monitoring and documentation of compliance with iodophor nasal swab.
- Documentation of three peer-to-peer bathing skills assessments per month.

Phase II

CalOptima will provide retrospective quality initiative payments on a quarterly basis for facilities that completed Phase I and meet Phase II criteria outlined below. The amount of each Phase II facility payment will reflect the methodology used in Phase I, accounting for facility size at the average expected usage cost. These payments are intended to support facilities in sustaining the quality practices they adopted during Phase I to suppress MDRO infections.

To qualify for Phase II quality initiative payments, the participating facility must continue demonstrating adherence to the study protocol through the requirements as outlined above for Phase I.

In addition, the facility must also meet minimum quality measures representative of effective decolonization and infection prevention efforts, to be further defined with the guidance of the UCI and CDC project leads. The facilities in Phase II of the initiative must meet these measures each quarter to be eligible for retrospective payment.

The 16 SNFs that participated in SHIELD OC would be eligible for Phase II of the quality initiative at implementation of this quality initiative since they have already been trained in the project and demonstrated adherence to the study protocol. Other contracted SNFs in Orange County not previously in SHILED OC and beginning participation in the quality initiative would be eligible for Phase I.

The proposed implementation of the quality initiative is Q3 2019.

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Fiscal Impact

The recommended action to implement a Post-Acute Infection Prevention Quality Initiative program and make payments to qualifying SMFs, beginning in FY 2019-20 to CalOptima-contracted SNFs in Orange County is projected to cost up to and not to exceed $2.3 million annually. Management plans to include projected expenses associated with the quality initiative in the upcoming CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

The quality initiative presents an avenue for CalOptima to actively support an innovative regional collaborative of high visibility that has been widely recognized to support the safety and health of individuals receiving care in SNFs.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. PowerPoint Presentation
2. SHIELD OC Flyer
3. Letter of Support

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

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Post-Acute Infection Prevention Quality Initiative

Regular Meeting of the Board of Directors

June 6, 2019

Dr. Emily Fonda, MD, MMM, CHCQM

Medical Director

Care Management, Long-Term Services and Supports and Senior Programs

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Background

- Efforts to lower hospitalization rates from long-term care (LTC) placed us in contact with Dr. Huang and her study
  - Through the Long-Term Services and Supports (LTSS) Quality Improvement Subcommittee
- Susan Huang, MD, MPH, Professor, Division of Infectious Diseases at U.C. Irvine — lead investigator for Project SHIELD Orange County (OC)
  - 36 facility decolonization intervention protocol supported by the Center for Disease Control and Prevention (CDC)
  - 16 of those facilities are CalOptima-contracted skilled nursing facilities
- Early results at wrap-up event on 1/30/19 ➔ overall 25 percent lower colonization rate of multidrug resistant organisms in OC skilled nursing facilities

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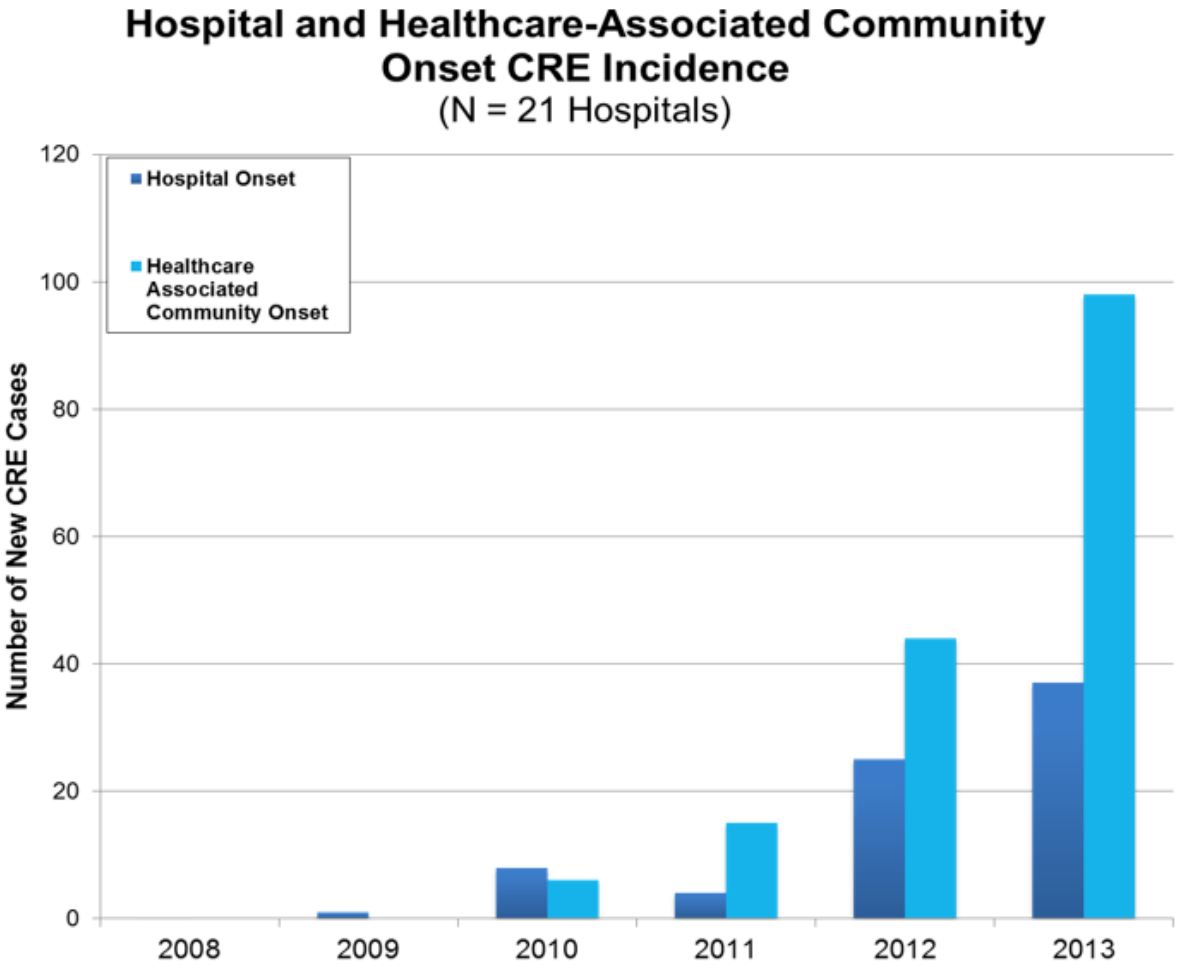
Background

- Rise of Multi-Drug Resistant Organisms (MDROs)
  - Methicillin Resistant *Staphylococcus aureus* (MRSA)
  - Vancomycin Resistant Enterococcus (VRE)
  - Multi-Drug Resistant Pseudomonas
  - Multi-Drug Resistant Acinetobacter
  - Extended Spectrum Beta Lactamase Producers (ESBLs)
  - Carbapenem Resistant Enterobacteriaceae (CRE)
  - Hypervirulent KPC (NDM)
  - *Candida auris*
- **10–15%of hospital patients harbor at least one of the above**
- **65% of nursing home residents harbor at least one of the above**

CRE Trends in Orange County, CA



Gohil S. AJIC 2017; 45:1177-82

CDC Interest

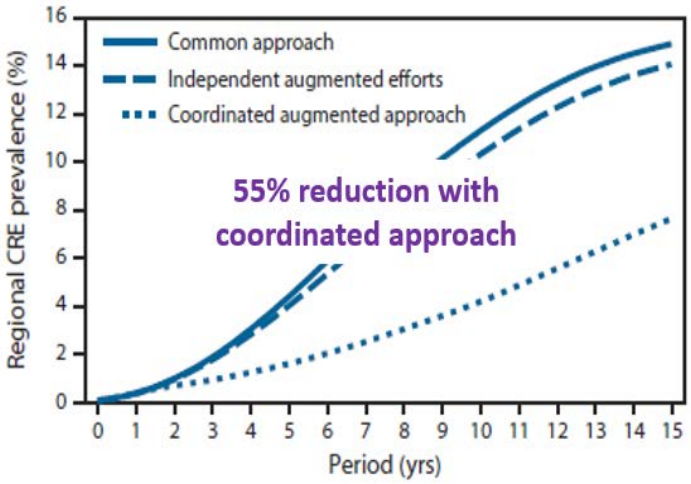
Orange County has historically had one of the highest carbapenem-resistant enterobacteriaceae (CRE) rates in California according to the OC Health Care Agency

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 64
August 4, 2015

Vital Signs: Estimated Effects of a Coordinated Approach for Action to Reduce Antibiotic-Resistant Infections in Health Care Facilities — United States

Rachel B. Slayton, PhD[1]; Damon Toth, PhD[2]; Bruce Y. Lee, MD[3]; Windy Tanner, PhD[2]; Sarah M. Bartsch, MPH[3]; Karim Khader, PhD[2]; Kim Wong, PhD[4]; Kevin Brown, PhD[2]; James A. McKinnell, MD[5]; William Ray[2]; Loren G. Miller, MD[6]; Michael Rubin, MD, PhD[2]; Diane S. Kim[7]; Fred Adler, PhD[8]; Chenghua Cao, MPH[7]; Lacey Avery, MA[1]; Nathan T.B. Stone, PhD[9]; Alexander Kallen, MD[1]; Matthew Samore, MD[2]; Susan S. Huang, MD[7]; Scott Fridkin, MD[1]; John A. Jernigan, MD[1]

FIGURE 3. Projected countywide prevalence of carbapenem-resistant *Enterobacteriaceae* (CRE) over a 15-year period under three different intervention scenarios — 102-facility model, Orange County, California*



* Additional information available at http://www.cdc.gov/drugresistance/resources/publications.html.

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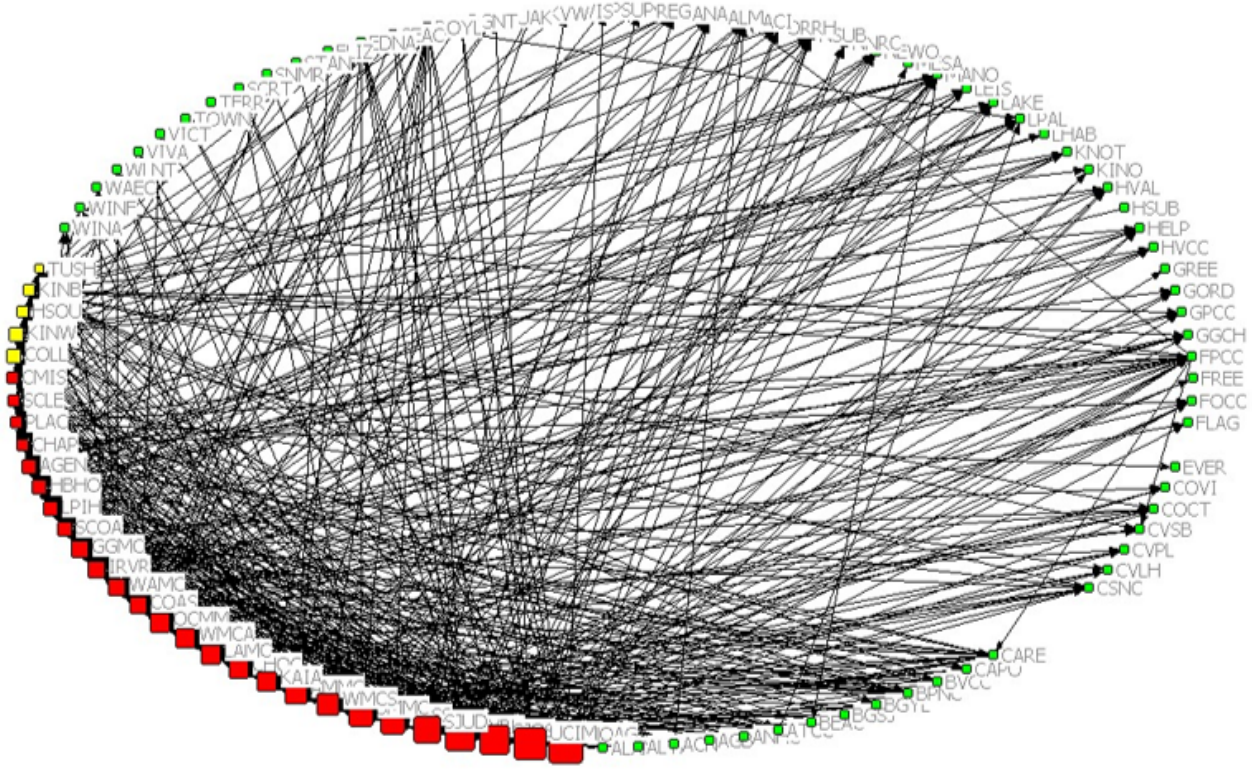
Extent of the Problem

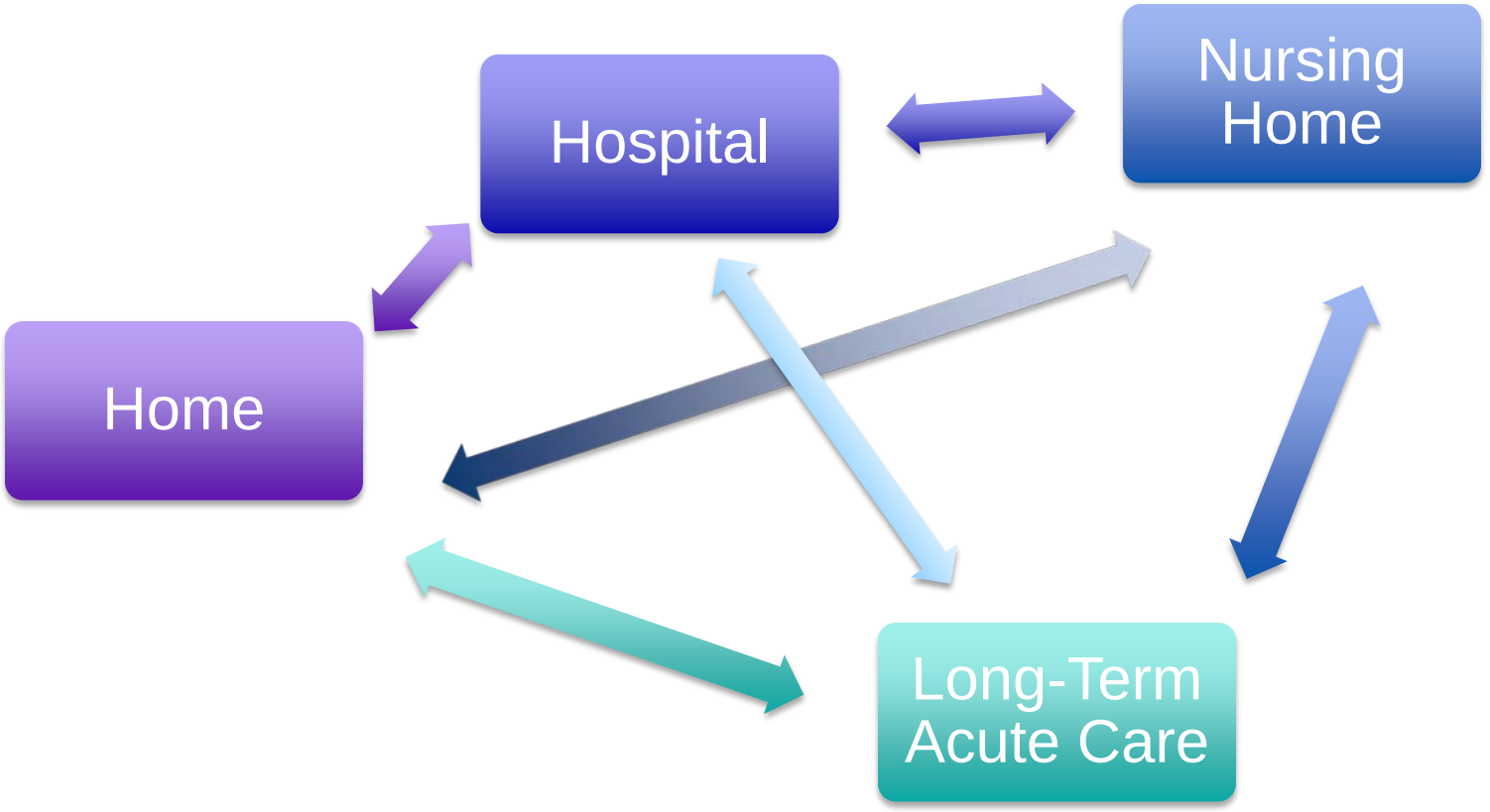
OC Hospitals and Nursing Homes

10 patients shared



Lee BY et al. Plos ONE. 2011;6(12):e29342

Extent of the Problem



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Baseline MDRO Prevalence — 16 Nursing Homes

	N	Any MDRO	MRSA	VRE	ESBL	CRE
Nares	900	28%	28%	-	-	-
Axilla/Groin	900	47%	30%	10%	22%	1%
Peri-Rectal	900	52%	25%	15%	31%	1%
All Body Sites	**900**	**64%**	**42%**	**16%**	**34%**	**2%**

- 64% MDRO carriers, facility range 44–88%
- Among MDRO pathogens detected, only 14% known to facility
- Among all residents, 59% harbored ≥1 MDRO unknown to facility

Participating Health Care Facilities

16 Nursing Homes Contracted with CalOptima

- Alamitos West Health Care Center
- Anaheim Healthcare Center
- Beachside Nursing Center
- Crystal Cove Care Center
- French Park Care Center
- Garden Park Care Center
- Healthcare Center of Orange County
- Laguna Hills Health and Rehab Center
- Lake Forest Nursing Center
- Mesa Verde Post Acute Care Center
- New Orange Hills
- Orange Healthcare & Wellness Centre
- Regents Point – Windcrest
- Seal Beach Health and Rehab Center
- Town and Country Manor
- Victoria Healthcare and Rehab Center

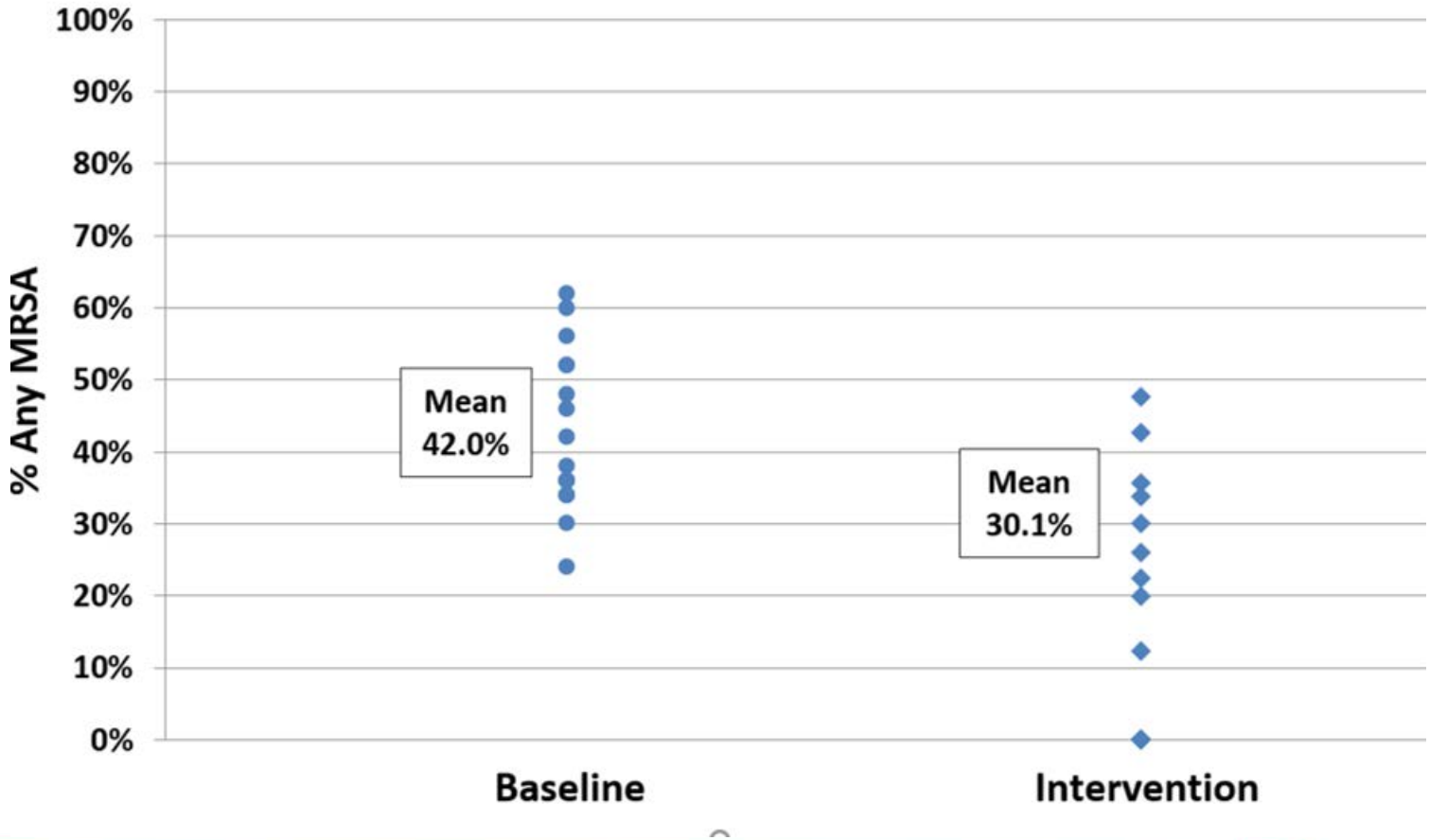
SHIELD OC Decolonization Protocol

- Nursing Homes: Decolonize All Patients
  - Replaced regular soap with chlorhexidine (CHG) antiseptic soap
  - CHG on admit and for all routine bathing/showering
  - Nasal iodophor on admit and every other week
    - https://www.cdc.gov/hai/research/cdc-mdro-project.html
- Following initial testing and training
  - Intervention timeline (22 months) July 1, 2017–May 2, 2019
- Outcome: MDRO Prevalence
  - MRSA, VRE, ESBL, CRE and any MDRO
  - By body site
    - Nasal product reduces MRSA
    - CHG bathing reduces skin carriage

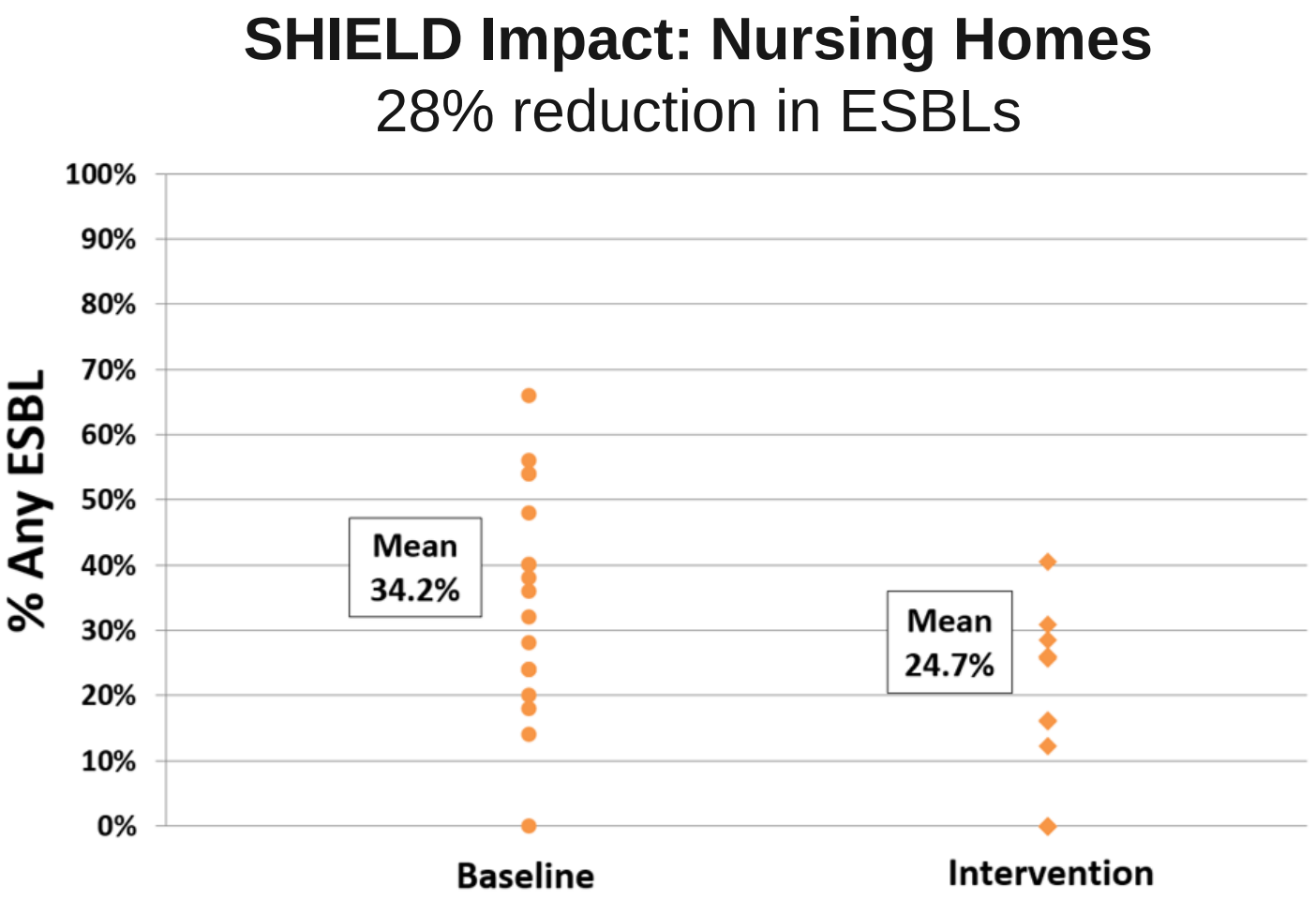
SHIELD Outcomes

SHIELD Impact: Nursing Homes

28% reduction in MRSA



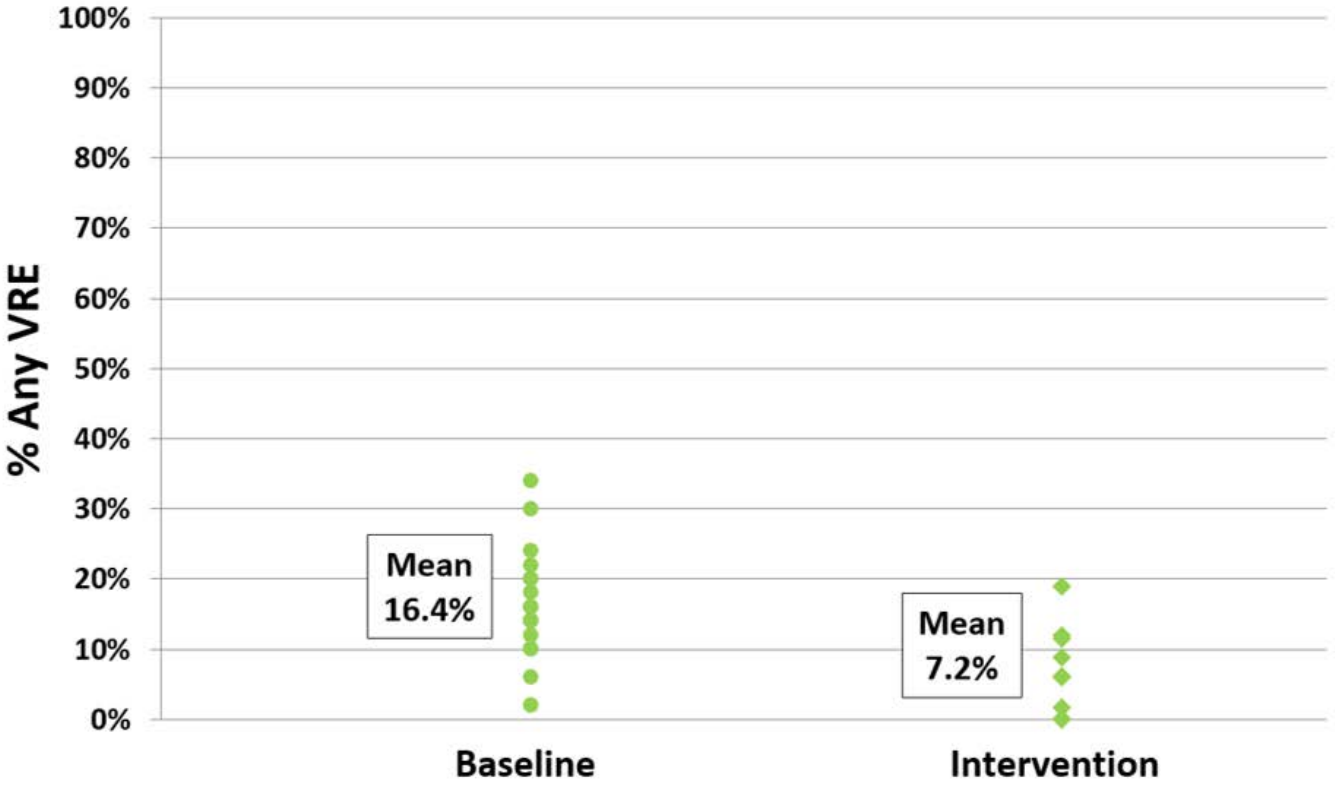
SHIELD Outcomes (cont)



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

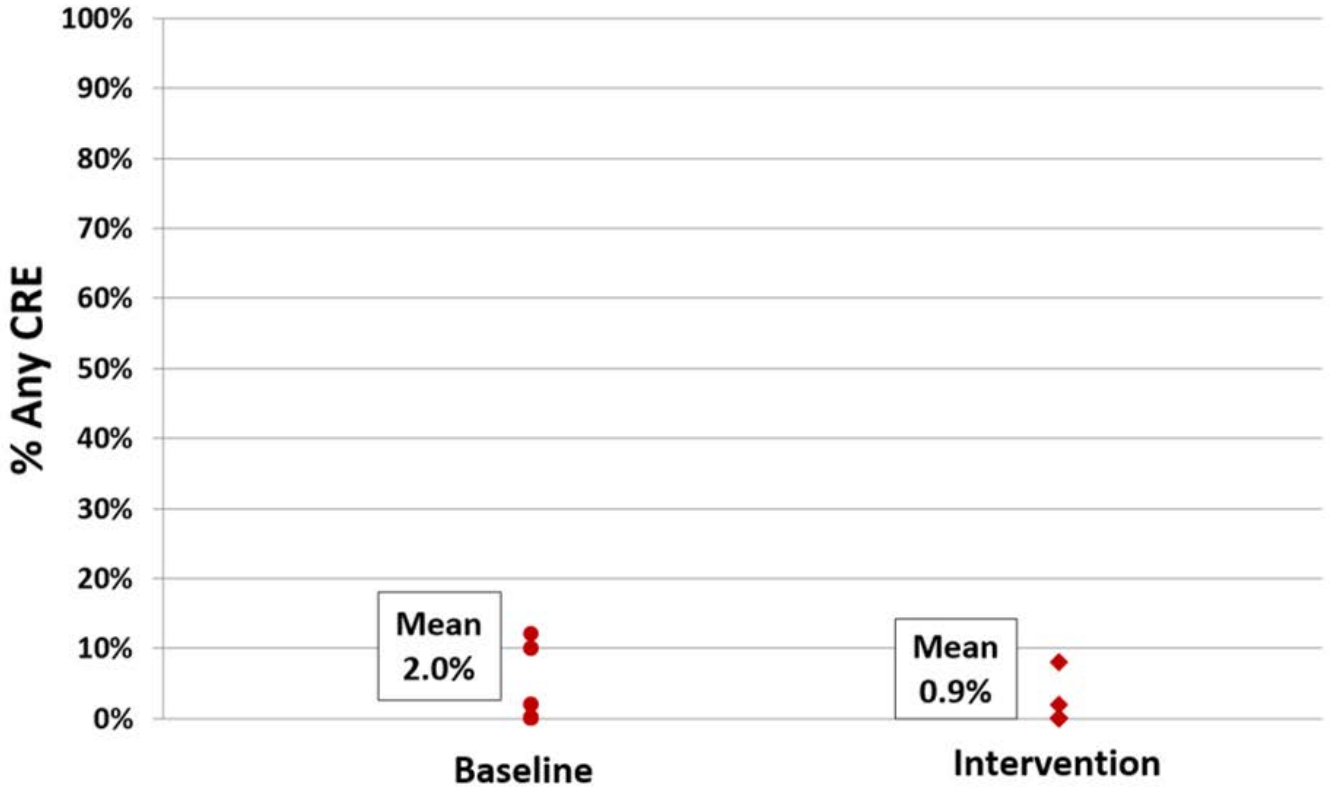
56% reduction in VRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

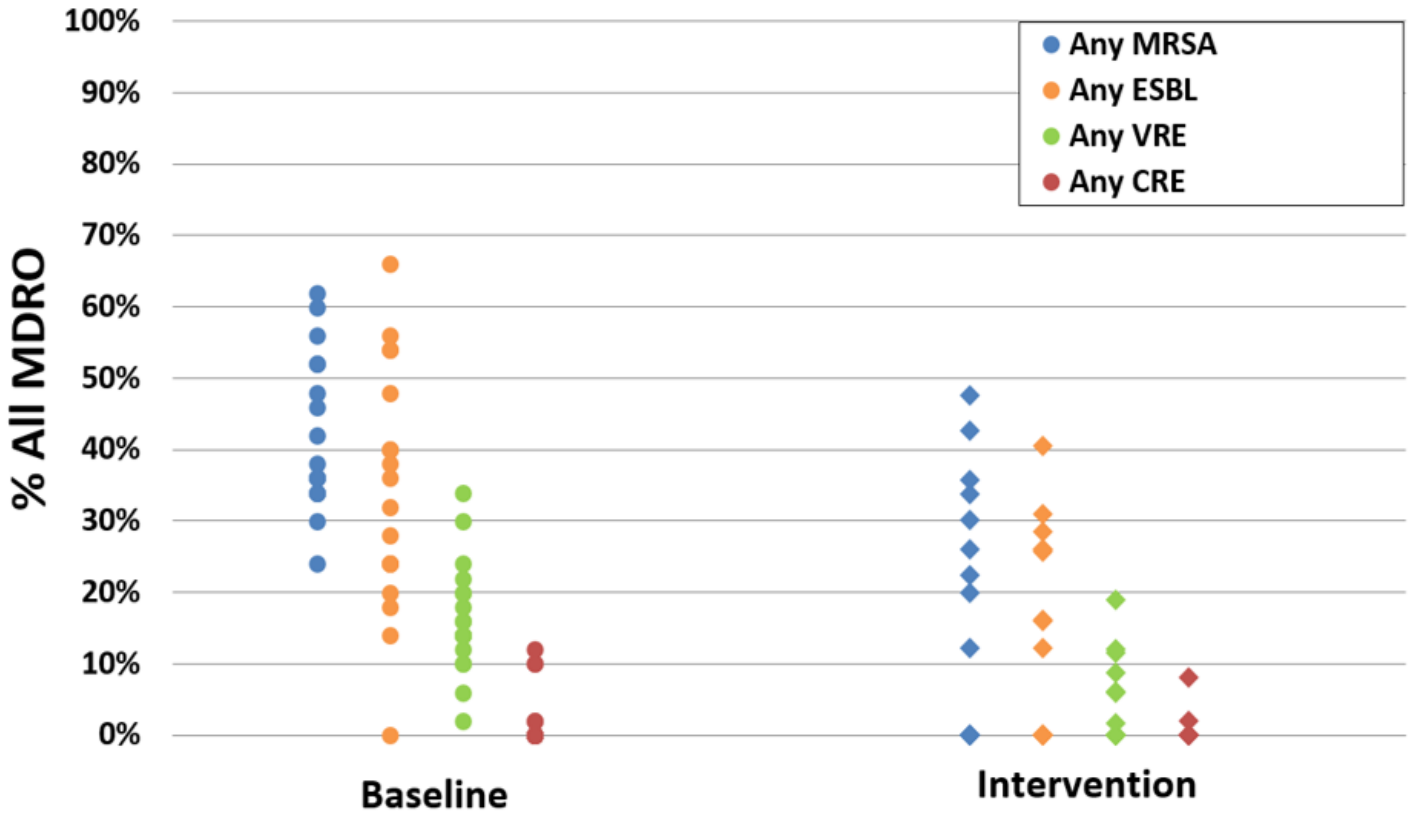
55% reduction in CRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

25% reduction in all MDROs



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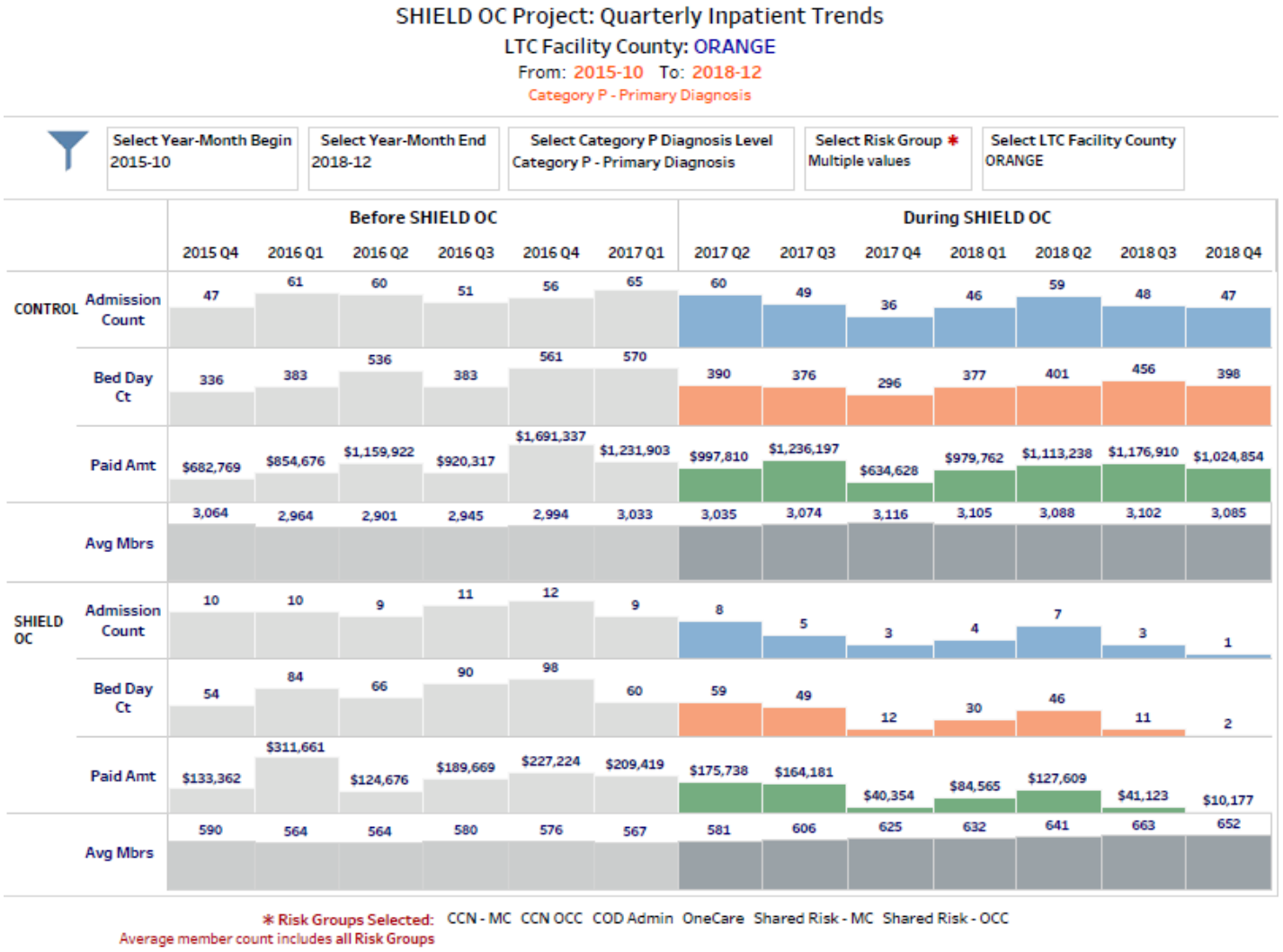
Quarterly Inpatient Trends



SHIELD OC Project: Quarterly Inpatient Trends

LTC Facility County: ORANGE

From: 2015-10 To: 2018-12

Category P - Primary Diagnosis

Select Year-Month Begin	Select Year-Month End	Select Category P Diagnosis Level	Select Risk Group *	Select LTC Facility County
2015-10	2018-12	Category P - Primary Diagnosis	Multiple values	ORANGE

		Before SHIELD OC						During SHIELD OC						
		2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4
CONTROL	Admission Count	47	61	60	51	56	65	60	49	36	46	59	48	47
	Bed Day Ct	336	383	536	383	561	570	390	376	296	377	401	456	398
	Paid Amt	$682,769	$854,676	$1,159,922	$920,317	$1,691,337	$1,231,903	$997,810	$1,236,197	$634,628	$979,762	$1,113,238	$1,176,910	$1,024,854
	Avg Mbrs	3,064	2,964	2,901	2,945	2,994	3,033	3,035	3,074	3,116	3,105	3,088	3,102	3,085
SHIELD OC	Admission Count	10	10	9	11	12	9	8	5	3	4	7	3	1
	Bed Day Ct	54	84	66	90	98	60	59	49	12	30	46	11	2
	Paid Amt	$133,362	$311,661	$124,676	$189,669	$227,224	$209,419	$175,738	$164,181	$40,354	$84,565	$127,609	$41,123	$10,177
	Avg Mbrs	590	564	564	580	576	567	581	606	625	632	641	663	652

* Risk Groups Selected: CCN - MC CCN OCC COD Admin OneCare Shared Risk - MC Shared Risk - OCC

Average member count includes all Risk Groups

Admission counts and costs significantly lower in the SHIELD OC group

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Quarterly Inpatient Trends

- 16 contracted facilities utilizing the CHG program:
  - Inpatient costs for infection for 6 quarters prior to the Chlorhexidine protocol = $1,196,011
  - Inpatient costs for the last 6 quarters following training and use of CHG protocol = $468,009
    - $728,002 lowered inpatient expenditure (61%) for infection in the participating facilities

- 51 contracted facilities not utilizing the CHG program:
  - Inpatient costs for the last 6 quarters =$6,165,589
  - Potential 61% lowered inpatient expenditure for infection = $3,761,009 if the CHG protocol had been expanded

SHIELD Impact on CalOptima

- Adoption of the SHIELD protocol is well-supported by the Center for Disease Control
  - Plan for extended use of an existing trainer in OC for one year
  - Plan for extended monitoring of Orange County MDROs for one year
- 25% decrease in MDRO prevalence translates to the following for CalOptima's LTC population of 3,800 members as of December 2018:
  - Decreased infection-related hospitalizations
  - An opportunity for a significant advancement in population health management
  - Practice transformation for skilled nursing facilities in fulfillment of National Committee for Quality Assurance (NCQA) requirements
  - Continuation of cost savings

CalOptima Post-Acute Infection Prevention Quality Initiative

- Adoption of the SHIELD protocol in all 67 CalOptima post-acute contracted facilities (long-term care and subacute facilities) will:
  - Support the continuation of care in the 16 participating facilities as Phase 2 without loss of momentum
  - Initiate the chlorhexidine bathing protocol in the remaining facilities as Phase 1 utilizing the CDC-supported trainer
  - Require quarterly reporting and fulfillment of quality measures with payments proportional to compliance
  - Include a trainer provided by the CDC for one year
  - Train current CalOptima LTSS nurses to quantify best practices and oversee compliance
  - Provide consideration around adding this patient safety initiative as a Pay 4 Value (P4V) opportunity to the next quality plan

Recommended Actions

- Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
- Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

CalOptima's Mission

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

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Shared Healthcare Intervention to Eliminate Life-threatening Dissemination of MDROs in Orange County

SHIELD Orange County – *Together We Can Make a Difference!*

What is SHIELD Orange County?

SHIELD OC is a public health collaborative initiated by the Centers for Disease Control and Prevention (CDC) to combat the spread of endemic and emerging multi-drug resistant organisms (MDROs) across healthcare facilities in Orange County. This effort is supported by the California Department of Public Health (CDPH) and the Orange County Health Care Agency (OCHCA). This regional collaborative will implement a decolonization strategy to reduce transmission of MDROs both countywide and within healthcare facilities.

Visit our CDC webpage here!
https://www.cdc.gov/hai/research/cdc-mdro-project.html

SHIELD OC Goals:

- Reduce MDRO carriage
- Reduce countywide MDRO clinical cultures
- Assess impact in participants and non-participants

SHIELD OC is coordinated by the University of California Irvine and LA BioMed at Harbor-UCLA.

Who is participating?

38 healthcare facilities are participating in SHIELD OC. These facilities were invited to participate based on their inter-connectedness by patient sharing statistics. In total, participants include 17 hospitals, 3 long-term acute care hospitals (LTACHs), and 18 nursing homes.

What is the decolonization intervention?

In the SHIELD OC collaborative, decolonization refers to the use of topical products to reduce bacteria on the body that can produce harmful infections.

- **Hospitals (for adult patients on contact precautions)**
  - Chlorhexidine (CHG) antiseptic soap for daily bathing or showering
  - Nasal decolonization with 10% povidone-iodine
  - Continue CHG bathing for adult patients in ICU units
- **Nursing homes and LTACHs**
  - Chlorhexidine (CHG) antiseptic soap for routine bathing and showering
  - Nasal decolonization with 10% povidone-iodine on admission and every other week

All treatments used for decolonization are topical and their safety profile is excellent.

With questions, please contact the SHIELD OC Coordinating Team

(949) 824-7806 or SHIELDOrangeCounty@gmail.com

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CalOptima Checklist

Nursing Home Name: _____

Month Audited (Month/year): _____/_____

Today's Date: _____/_____/_____

Completed by: _____

- ☐ Proof of product purchase
- ☐ Evidence the decolonization program handout is in admission packet
- ☐ Monitor and document compliance with bathing one day each week
- ☐ Monitor and document compliance with iodophor one day each week iodophor is used
- ☐ Conduct three peer-to-peer bathing skills assessments per month

Product Usage

PRODUCT DESCRIPTION	RECEIPT PROVIDED	QUANTITY DELIVERED	ESTIMATED MONTHLY USAGE
4% CHG Gallons	☐	_____ gallons	_____ gallons
10% Iodine Swabsticks	☐	_____ boxes	_____ boxes
		_____ swabs per box	

INTERNAL USE ONLY –APPROVAL:

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Facility Name: _____Unit: _____ Date: _____

STAFF Skills Assessment:
CHG Bed Bath Observation Checklist

Individual Giving CHG Bath

Please indicate who performed the CHG bath.

☐ **Nursing Assistant (CNA)** ☐ **Nurse** ☐ **LVN** ☐ **Other: _____**

Observed CHG Bathing Practices

Please check the appropriate response for each observation.

☐ **Y** ☐ **N** **Resident received CHG bathing handout**
☐ **Y** ☐ **N** **Resident told that no rinse bath provides protection from germs**
☐ **Y** ☐ **N** **Provided rationale to the resident for not using soap at any time while in unit**
☐ **Y** ☐ **N** **Massaged skin *firmly* with CHG cloth to ensure adequate cleansing**
☐ **Y** ☐ **N** **Cleaned face and neck well**
☐ **Y** ☐ **N** **Cleaned between fingers and toes**
☐ **Y** ☐ **N** **Cleaned between all folds**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned occlusive and semi-permeable dressings with CHG cloth**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned 6 inches of all tubes, central lines, and drains closest to body**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on superficial wounds, rash, and stage 1 & 2 decubitus ulcers**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on surgical wounds (unless primary dressing or packed)**
☐ **Y** ☐ **N** **Allowed CHG to air-dry / does not wipe off CHG**
☐ **Y** ☐ **N** **Disposed of used cloths in trash /does not flush**

Query to Bathing Assistant/Nurse

1. How many cloths were used for the bath?

_____

2. If more than 6 cloths was used, provide reason.

_____

3. Are you comfortable applying CHG to superficial wounds, including surgical wounds?

_____

4. Are you comfortable applying CHG to lines, tubes, drains and non-gauze dressings?

_____

5. Do you ever wipe off the CHG after bathing?

_____

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ORIGINAL ARTICLE

Decolonization to Reduce Postdischarge Infection Risk among MRSA Carriers

S.S. Huang, R. Singh, J.A. McKinnell, S. Park, A. Gombosev, S.J. Eells, D.L. Gillen, D. Kim, S. Rashid, R. Macias-Gil, M.A. Bolaris, T. Tjoa, C. Cao, S.S. Hong, J. Lequieu, E. Cui, J. Chang, J. He, K. Evans, E. Peterson, G. Simpson, P. Robinson, C. Choi, C.C. Bailey, Jr., J.D. Leo, A. Amin, D. Goldmann, J.A. Jernigan, R. Platt, E. Septimus, R.A. Weinstein, M.K. Hayden, and L.G. Miller, for the Project CLEAR Trial

ABSTRACT

BACKGROUND

Hospitalized patients who are colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) are at high risk for infection after discharge.

METHODS

We conducted a multicenter, randomized, controlled trial of postdischarge hygiene education, as compared with education plus decolonization, in patients colonized with MRSA (carriers). Decolonization involved chlorhexidine mouthwash, baths or showers with chlorhexidine, and nasal mupirocin for 5 days twice per month for 6 months. Participants were followed for 1 year. The primary outcome was MRSA infection as defined according to Centers for Disease Control and Prevention (CDC) criteria. Secondary outcomes included MRSA infection determined on the basis of clinical judgment, infection from any cause, and infection-related hospitalization. All analyses were performed with the use of proportional-hazards models in the per-protocol population (all participants who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization) and as-treated population (participants stratified according to adherence).

RESULTS

In the per-protocol population, MRSA infection occurred in 98 of 1063 participants (9.2%) in the education group and in 67 of 1058 (6.3%) in the decolonization group; 84.8% of the MRSA infections led to hospitalization. Infection from any cause occurred in 23.7% of the participants in the education group and 19.6% of those in the decolonization group; 85.8% of the infections led to hospitalization. The hazard of MRSA infection was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03; number needed to treat to prevent one infection, 30; 95% CI, 18 to 230); this lower hazard led to a lower risk of hospitalization due to MRSA infection (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The decolonization group had lower likelihoods of clinically judged infection from any cause (hazard ratio, 0.83; 95% CI, 0.70 to 0.99) and infection-related hospitalization (hazard ratio, 0.76; 95% CI, 0.62 to 0.93); treatment effects for secondary outcomes should be interpreted with caution owing to a lack of prespecified adjustment for multiple comparisons. In as-treated analyses, participants in the decolonization group who adhered fully to the regimen had 44% fewer MRSA infections than the education group (hazard ratio, 0.56; 95% CI, 0.36 to 0.86) and had 40% fewer infections from any cause (hazard ratio, 0.60; 95% CI, 0.46 to 0.78). Side effects (all mild) occurred in 4.2% of the participants.

CONCLUSIONS

Postdischarge MRSA decolonization with chlorhexidine and mupirocin led to a 30% lower risk of MRSA infection than education alone. (Funded by the AHRQ Healthcare-Associated Infections Program and others; ClinicalTrials.gov number, NCT01209234.)

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. Huang at the University of California Irvine School of Medicine, Division of Infectious Diseases, 100 Theory, Suite 120, Irvine, CA 92617, or at sshuang@uci.edu.

N Engl J Med 2019;380:638-50.
DOI: 10.1056/NEJMoa1716771

Methicillin-resistant *Staphylococcus aureus* (MRSA) causes more than 80,000 invasive infections in the United States annually.[1] It is the most common cause of skin, soft-tissue, and procedure-related infections.[2] Rates of invasive MRSA infection are highest within 6 months after hospital discharge and do not normalize for 1 year.[1,3,4]

Approaches to MRSA have included education about both hygiene and environmental cleaning as well as decolonization with nasal mupirocin and chlorhexidine antiseptic baths to reduce carriage and prevent infection.[5,6] Decolonization has reduced the risks of surgical-site infection, recurrent skin infection, and infection in the intensive care unit (ICU).[7-10] Our goal was to evaluate whether, after hospital discharge, decolonization plus hygiene education was superior to education alone in reducing the likelihood of MRSA infection among patients colonized with MRSA (carriers).

Methods

Trial Design and Intervention

We conducted the Project CLEAR (Changing Lives by Eradicating Antibiotic Resistance) Trial as a multicenter, two-group, unblinded, randomized, controlled trial to compare the effect of hygiene education with that of education plus decolonization on the likelihood of postdischarge infection among MRSA carriers. This trial was approved by the institutional review board of the University of California Irvine. The authors vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol, available with the full text of this article at NEJM.org.

Participants were randomly assigned, in a 1:1 ratio, to the education group or the decolonization group. Randomization was performed with a randomized block design stratified according to Hispanic ethnic group and nursing home residence. In the education group, participants received and reviewed an educational binder (provided in English and Spanish) about MRSA and how it is spread and about recommendations for personal hygiene, laundry, and household cleaning (Appendix A in the Supplementary Appendix, available at NEJM.org). In the decolonization group, participants received and reviewed the identical educational binder and also underwent decolonization for 5 days twice monthly for a period of 6 months after hospital discharge (Appendix B in the Supplementary Appendix). The decolonization intervention involved the use of 4% rinse-off chlorhexidine for daily bathing or showering, 0.12% chlorhexidine mouthwash twice daily, and 2% nasal mupirocin twice daily. All products were purchased with grant funds and were provided free of charge to the participants.

Recruitment and Eligibility Criteria

Recruitment involved written informed consent provided between January 10, 2011, and January 2, 2014, during inpatient admissions in 17 hospitals and 7 nursing homes in Southern California (Table S1 in the Supplementary Appendix). Eligibility requirements included an age of 18 years or older, hospitalization within the previous 30 days, positive testing for MRSA during the enrollment hospitalization or within the 30 days before or afterward, and the ability to bathe or shower (alone or assisted by a caregiver). Key exclusion criteria were hospice care and allergy to the decolonization products at recruitment. California mandates MRSA screening at hospital admission in high-risk patients: those undergoing hemodialysis, those who had a recent hospitalization (within the preceding 30 days), those who were undergoing imminent surgery, those who were admitted to the ICU, and those who were transferred from a nursing home.

Follow-up

Participants were followed for 12 months after discharge. In-person visits at home or in a research clinic occurred at recruitment and at months 1, 3, 6, and 9. An exit interview was conducted at 12 months. The trial had a fixed end date of June 30, 2014. Participants who were enrolled after July 1, 2013, had a truncated follow-up and had their data administratively censored at that time. Loss to follow-up was defined as the inability of trial staff to contact participants for 3 months, at which point the participant was removed from the trial as of the date of last contact. Participants received escalating compensation for completing follow-up visits ($25, $30, $35, and $50).

All participants were contacted monthly and requested to report any hospitalizations or clinic visits for infection. After trial closure, medical records from reported visits were requested, double-redacted for protected health information and trial-group assignment, and reviewed for trial outcomes. Records from enrollment hospi-

talizations were requested and reviewed for characteristics of the participants and the presence or absence of MRSA infection at the enrollment hospitalization. Records were requested up to five times, with five additional attempts to address incomplete records.

TRIAL OUTCOMES

Redacted medical records from enrollment hospitalizations and all reported subsequent medical visits were reviewed in a blinded fashion, with the use of standardized forms, by two physicians with expertise in infectious diseases (five of the authors) for coexisting conditions, antibiotic agents, and infection outcomes. If consensus was not reached, discordant outcomes were adjudicated by a third physician with expertise in infectious diseases.

The primary outcome was MRSA infection according to medical-record documentation of disease-specific infection criteria (according to 2013 guidelines) from the Centers for Disease Control and Prevention (CDC) in a time-to-event analysis.[11] A priori secondary outcomes included MRSA infection defined in a time-to-event analysis according to the clinical judgment of two reviewers with expertise in infectious diseases who were unaware of the trial-group assignments, infection from any cause according to disease-specific CDC criteria in a time-to-event analysis, infection from any cause according to infectious disease clinical judgment in a time-to-event analysis, hospitalization due to infection, and new carriage of a MRSA strain that was resistant to mupirocin (evaluated by Etest, bioMérieux)[12] or that had an elevated minimum inhibitory concentration (MIC) of chlorhexidine (≥8 μg per milliliter) on microbroth dilution.[13,14] All outcomes were assessed on the basis of the first event per participant.

DATA COLLECTION

Surveys of health conditions, health care utilization, and household cleaning and bathing habits were administered during recruitment and all follow-up visits. Swabs of both nares, the throat, skin (axilla and groin), and any wounds were taken, but the results are not reported here. At each visit, participants in the decolonization group reported adherence to the intervention, and staff assessed the remaining product. Potential discrepancies were broached with the participant to obtain affirmation of actual adherence. Adherence was assessed as full (no missed doses), partial (some missed doses), and nonadherence (no doses used).

STATISTICAL ANALYSIS

The characteristics of the participants and outcomes were described by frequency and type according to trial group. Outcomes were summarized with the use of Kaplan–Meier estimates of infection-free distributions across the follow-up period and analyzed with the use of unadjusted Cox proportional-hazard models (per-protocol primary analysis) for the postdischarge trial population (all the participants who underwent randomization, met inclusion criteria, and survived beyond the recruitment hospitalization); outcomes were also analyzed according to the as-treated adherence strata (fully adherent, partially adherent, and nonadherent participant-time). In the as-treated analyses, information about participant adherence during at-risk periods before each visit was updated with the use of the adherence assessment at that visit.

The assumption of proportional hazards was assessed by means of residual diagnostic tests and formal hypothesis tests. P values are provided only for the primary outcome. Because the statistical analysis plan did not include a provision for correction for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, those results are reported as point estimates with 95% confidence intervals. The widths of the confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

In post hoc exploratory analyses, we used adjusted Cox proportional-hazard models to address potential residual imbalances in the characteristics of the participants between the two groups after randomization. The characteristics of the participants were entered into the model if they were associated with outcomes at a P value of less than 0.20 in bivariate analyses. Characteristics included demographic data; educational level; insurance type; presence of coexisting conditions, devices, or wounds at enrollment; hospitalization or residence in a nursing home in the year before enrollment; ICU admission or surgery during enrollment hospitalization; need

for assistance with bathing; frequency of bathing; and randomization strata. Adjusted models also accounted for two time-dependent covariates: receipt of anti-MRSA antibiotics and adherence to the intervention. The number needed to treat was calculated with the use of rates that accounted for participant-time that incorporated censoring due to loss to follow-up, withdrawal from the trial, or the end of the trial.[15] Full details of the trial design and analytic approach are provided in the protocol and in the Supplementary Appendix.

RESULTS

PARTICIPANTS

Figure 1 shows the randomization and follow-up of 2140 participants, of whom 19 were excluded after randomization because they did not meet inclusion criteria (6 participants did not have a positive MRSA test, and 13 died during the enrollment hospitalization). The characteristics of the final 2121 enrolled participants (per-protocol population) are provided in Table 1, and in Tables S2 through S4 in the Supplementary Appendix.

According to the randomization strata, Hispanic participants made up 31.9% of the education group (339 participants) and 32.0% of the decolonization group (339), and nursing home residents made up 11.3% of the education group (120) and 11.0% of the decolonization group (116). In a comparison of the education group with the decolonization group across the 1-year follow-up, early exit from the trial occurred in 34.9% of the participants (371 participants) and 37.0% (391), respectively ($P=0.32$); withdrawal from the trial in 6.8% (72) and 11.6% (123), respectively ($P<0.001$); loss to follow-up in 17.4% (185) and 16.1% (170), respectively ($P=0.41$); and death in 10.7% (114) and 9.3% (98), respectively ($P=0.26$). The characteristics of the participants who withdrew from the trial or were lost to follow-up and of the participants in the decolonization group according to adherence category are shown in Table S5 in the Supplementary Appendix.

OUTCOMES

A total of 8395 full-text medical records were requested, and 8067 (96.1%) were received and redacted. Charts underwent duplicate blinded review (16,134 reviews) by physicians with expertise in infectious diseases at a rate of approximately 800 charts per month for 20 months. Of the 2121 enrollment admission records, 2100 (99.0%) were received. Of the 6271 subsequent inpatient and outpatient records, 5967 (95.2%) were received for outcome assessment. The overall rate of reported hospitalizations per 365 days of follow-up was 1.97 in the education group and 1.75 in the decolonization group.

Regarding the primary outcome in the per-protocol analysis, 98 participants (9.2%) in the education group had a MRSA infection, as compared with 67 (6.3%) in the decolonization group (Table 2). This corresponded to an estimated MRSA infection rate in the education group of 0.139 infections per participant-year, as compared with 0.098 infections per participant-year in the decolonization group. Among first MRSA infections per participant, skin and soft-tissue infections and pneumonia were common. Across both groups, 84.8% (140 of 165) of the MRSA infections resulted in hospitalization, at a rate of 0.117 hospitalizations per participant-year in the education group and 0.083 per participant-year in the decolonization group. Bacteremia occurred in 28.5% (47 of 165) of all MRSA infections; the MRSA bacteremia rate was 0.040 events per participant-year in the education group and 0.028 per participant-year in the decolonization group. Findings were similar when MRSA infection was determined according to the clinical judgment of physicians with expertise in infectious diseases and according to CDC criteria (Table 2). All the MRSA infections were treated with an antibiotic, but the receipt of an antibiotic was not sufficient to render a decision of a MRSA infection.

In the analysis of infection from any cause according to CDC criteria, 23.7% of the participants in the education group (252 participants) had an infection, as compared with 19.6% of those in the decolonization group (207), which corresponded to an estimated rate of 0.407 infections per participant-year in the education group and 0.338 per participant-year in the decolonization group (Table 2). Skin and soft-tissue infections and pneumonia remained the most common infection types.

Pathogens were identified in 67.7% of the infections (Table S6 in the Supplementary Appendix). Participants in the decolonization intervention had a lower rate of infections due to gram-positive pathogens or without cultured pathogens than those in the education group. There was a

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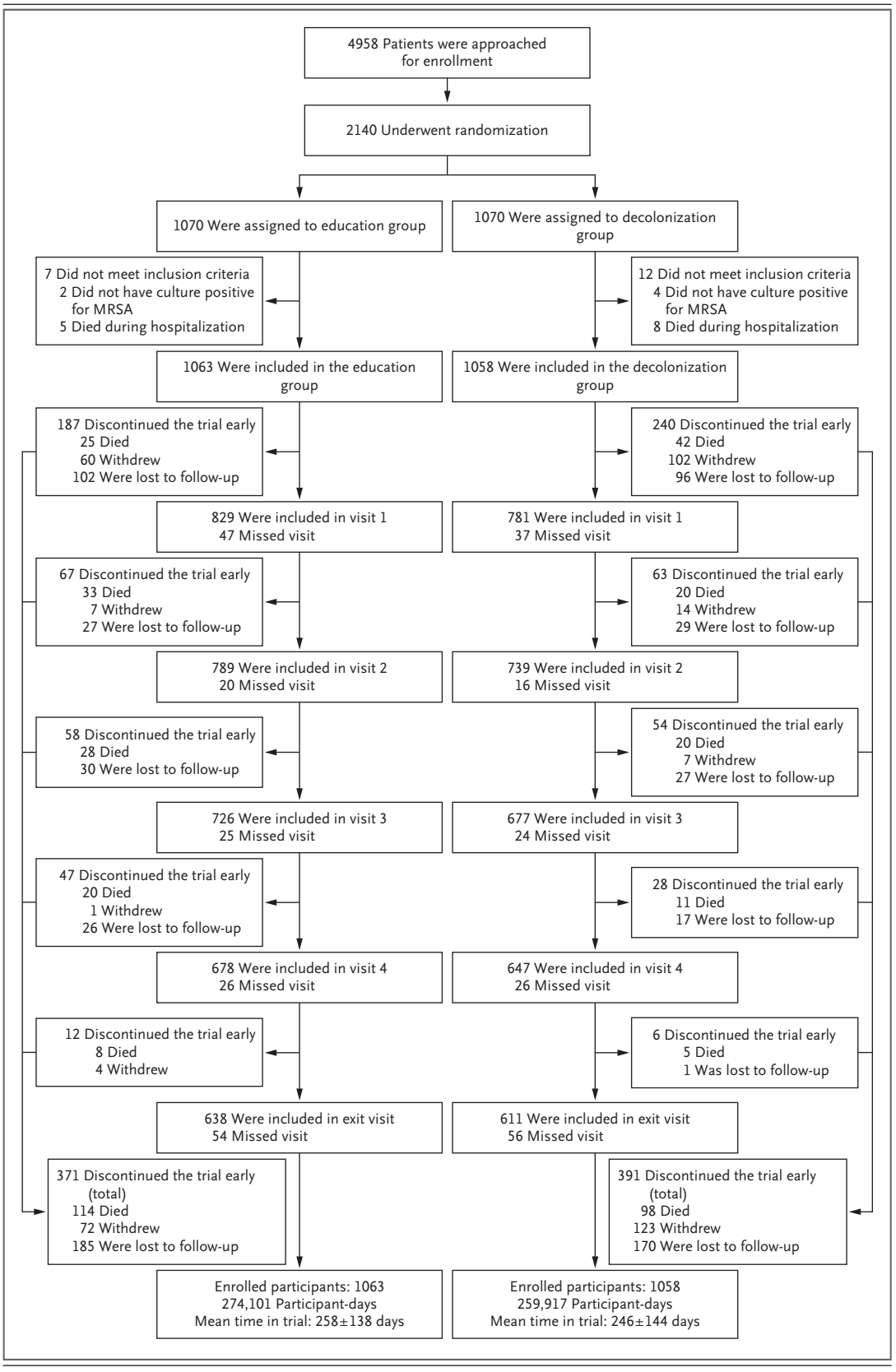

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Figure 1 (facing page). Randomization and Follow-up of the Participants.

This flow chart describes the recruitment and the four follow-up visits (at 1, 3, 6, and 9 months) for the 1-year period after hospital discharge. Recruitment occurred during hospitalization, and 19 participants were excluded from the postdischarge trial population because they did not meet inclusion criteria, leaving 2121 participants in the per-protocol population (1063 participants in the education group and 1058 in the decolonization group). Early exit from the trial was provided between each visit and included active withdrawal from the trial, loss to follow-up, and death. Active withdrawal represented situations in which participants indicated their desire to withdraw from the trial. Loss to follow-up was defined as the inability to contact the participant for 3 months, at which point the participant was removed from the trial at the time of last contact. Visits indicate both participants who successfully completed the visit and those who remained in the trial but missed that visit. The mean (±SD) time in the trial (in days) is shown for each group. All deaths were considered by the investigators to be unrelated to side effects from decolonization products. Summary boxes are provided at the bottom of the figure. MRSA denotes methicillin-resistant *Staphylococcus aureus*.

higher rate of gram-negative infection among the CDC-defined all-cause infections when participants in the decolonization intervention were compared with those in the education group, but this was not seen among clinically defined infections.

Across the two trial groups, infection from any cause led to hospitalization in 85.8% of the participants (394 of 459), and bacteremia occurred in 18.1% (83 of 459). The observed rate of hospitalization due to infection from any cause was 0.356 events per participant-year in the education group and 0.269 per participant-year in the decolonization group. The rate of bacteremia among participants with infection from any cause was 0.074 events per participant-year in the education group and 0.060 per participant-year in the decolonization group. Findings were similar when infection from any cause was determined according to clinical judgment (Table 2).

Estimates of the per-protocol treatment effects are shown in Table 3. No significant departures from proportional hazards were observed. In the main unadjusted analysis, the hazard of MRSA infection according to the CDC criteria (the primary outcome) was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03). This lower hazard of MRSA infection led to a 29% lower risk of hospitalization due to CDC-defined MRSA infection in the decolonization group than in the education group (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The effect was nearly identical for cases and hospitalizations involving clinically defined MRSA infection. Kaplan–Meier curves showing the infection-free time for the primary outcome of CDC-defined MRSA infection and the secondary outcome of infection from any cause show that the curves remained separated even after the intervention ended in month 6 (Fig. 2, and Table S7 in the Supplementary Appendix). Adjusted models showed greater MRSA infection effects that were significant (Table 3). A total of 10 participants (0.9%) in the education group and in 3 (0.3%) in the decolonization group died from MRSA infection. Results of sensitivity analyses conducted regarding death and early withdrawal from the trial are provided in Table S8 in the Supplementary Appendix.

The hazard of infection from any cause according to clinical judgment was lower in the decolonization group than in the education group (hazard ratio, 0.83; 95% CI, 0.70 to 0.99); similarly, the hazard of infection from any cause according to CDC criteria was lower in the decolonization group (hazard ratio, 0.84; 95% CI, 0.70 to 1.01) (Fig. 2B and Table 3). The risk of hospitalization due to infection from any cause was lower in the decolonization group than in the education group (hazard ratio, 0.76; 95% CI, 0.62 to 0.93). The results of the adjusted analyses were similar to those of the unadjusted analyses (Table 3). Deaths due to any infection occurred in 25 participants (2.3%) in the education group and 17 (1.6%) in the decolonization group.

EFFECT OF ADHERENCE

In as-treated analyses, 65.6% of the participant-time in the decolonization group involved full adherence; 19.6%, partial adherence; and 14.8%, nonadherence. Participants were highly consistent in adherence across the follow-up time. Increasing adherence was associated with increasingly lower rates of infection in both the adjusted and unadjusted models (Table 3). In comparisons of the adherence-category subgroups in the decolonization group with the education group overall, the likelihood of CDC-defined MRSA infection decreased 36% and 44%, respectively, as adher-

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Table 1. Characteristics of the Participants at Recruitment Hospitalization.*

Characteristic	Education Group (N=1063)	Decolonization Group (N=1058)	P Value†
Age — yr	56±17	56±17	0.78
Male sex — no. (%)	583 (54.8)	565 (53.4)	0.51
Coexisting conditions‡			
Diabetes — no./total no. (%)	424/1062 (39.9)	462/1056 (43.8)	0.08
Chronic obstructive pulmonary disease — no./total no. (%)	212/1055 (20.1)	203/1045 (19.4)	0.70
Congestive heart failure — no./total no. (%)	145/1055 (13.7)	149/1045 (14.3)	0.73
Cancer — no./total no. (%)	153/1055 (14.5)	161/1045 (15.4)	0.56
Renal disease — no./total no. (%)	140/1062 (13.2)	134/1056 (12.7)	0.74
Charlson Comorbidity Index score§	1.7±1.6	1.7±1.6	0.49
Bathe daily or every other day — no./total no. (%)¶	926/1037 (89.3)	927/1034 (89.7)	0.73
Bathing assistance needed — no./total no. (%)¶	200/1025 (19.5)	224/1013 (22.1)	0.15
MRSA source at enrollment — no. (%)			0.79
Nares‖	580 (54.6)	602 (56.9)	
Wound	320 (30.1)	305 (28.8)	
Respiratory	44 (4.1)	45 (4.3)	
Blood	43 (4.0)	31 (2.9)	
Other	76 (7.1)	75 (7.1)	
Recruitment hospitalization**			
Hospitalized in previous yr — no./total no. (%)‡	595/1046 (56.9)	598/1041 (57.4)	0.80
Nursing home stay in previous yr — no./total no. (%)‡	165/1043 (15.8)	168/1040 (16.2)	0.84
ICU stay — no./total no. (%)	188/1055 (17.8)	206/1045 (19.7)	0.27
Surgery — no./total no. (%)	392/1055 (37.2)	399/1045 (38.2)	0.63
MRSA infection — no./total no. (%)††	447/1055 (42.4)	438/1045 (41.9)	0.83
Wound at hospital discharge — no./total no. (%)	587/1055 (55.6)	588/1045 (56.3)	0.77
Medical device at hospital discharge — no./total no. (%)‡‡	320/1055 (30.3)	307/1045 (29.4)	0.63
Discharged to nursing home — no. (%)	120 (11.3)	116 (11.0)	0.81

* Plus–minus values are means ±SD. There were no significant differences between the two groups. Selected descriptive data are shown. For a full descriptive list of characteristics, see Table S2 in the Supplementary Appendix. ICU denotes intensive care unit.
† Student's t-test was performed for continuous variables, chi-square test for proportions, and Fisher's exact test for proportions if the numerator was 5 or less.
‡ Data reflect a positive response to either a survey question or chart review. Not all participants responded to every question, and not all enrollment charts were received from recruiting hospitals despite a signed release request, so data were missing for 21 participants.
§ Scores on the Charlson Comorbidity Index range from 0 to 10, with higher scores indicating more coexisting illness.
¶ Data reflect respondents to the survey question among all the participants. Not all the participants responded to every question.
‖ By law, California requires hospitals to screen five groups of patients for MRSA on hospital admission (patients who are transferred from a nursing home, who have been hospitalized in the past 30 days, who are undergoing hemodialysis, who are undergoing imminent surgery, and who are admitted to an ICU).
** Data reflect chart review from the received medical records. Not all recruiting hospitals released participants' medical records to the trial despite a signed release request, so records were missing for 21 participants.
†† Assessment of infection was based on criteria of the Centers for Disease Control and Prevention (CDC). Information regarding infection types is provided in Table S3 in the Supplementary Appendix.
‡‡ Information about medical device types is provided in Table S4 in the Supplementary Appendix.

ence increased from partial adherence (hazard ratio, 0.64; 95% CI, 0.40 to 1.00) to full adherence (hazard ratio, 0.56; 95% CI, 0.36 to 0.86). Similar effects were seen with regard to CDC-defined infection from any cause, which was 40% lower among fully adherent participants than among the participants in the education group (hazard ratio, 0.60; 95% CI, 0.46 to 0.78).

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Table 2. MRSA Infection Outcomes (First Infection per Person) per 365 Days of Follow-up, According to Trial Group.*

Variable	MRSA Infection, According to CDC Criteria†		MRSA Infection, According to Clinical Criteria		Any Infection, According to CDC Criteria		Any Infection, According to Clinical Criteria	
	Education	Decolonization	Education	Decolonization	Education	Decolonization	Education	Decolonization
All Participants								
Infection — no. of participants (no. of events/participant-yr)								
Any infection	98 (0.139)	67 (0.098)	98 (0.139)	68 (0.100)	252 (0.407)	207 (0.338)	298 (0.498)	246 (0.414)
Skin or soft-tissue infection	34 (0.048)	32 (0.047)	35 (0.050)	32 (0.047)	80 (0.129)	59 (0.096)	97 (0.162)	82 (0.138)
Pneumonia	18 (0.026)	9 (0.013)	20 (0.028)	10 (0.015)	39 (0.063)	25 (0.041)	45 (0.075)	34 (0.057)
Primary bloodstream or vascular infection	11 (0.016)	10 (0.015)	12 (0.017)	11 (0.016)	20 (0.032)	14 (0.023)	20 (0.033)	14 (0.024)
Bone or joint infection	13 (0.019)	9 (0.013)	12 (0.017)	8 (0.012)	20 (0.032)	22 (0.036)	0.18 (0.030)	17 (0.029)
Surgical-site infection	13 (0.019)	2 (0.003)	13 (0.018)	2 (0.003)	20 (0.032)	8 (0.013)	22 (0.037)	9 (0.015)
Urinary tract infection	3 (0.004)	2 (0.003)	1 (0.001)	1 (0.002)	38 (0.061)	46 (0.075)	52 (0.087)	56 (0.094)
Abdominal infection	1 (0.001)	2 (0.003)	1 (0.001)	2 (0.003)	20 (0.032)	21 (0.034)	26 (0.044)	18 (0.030)
Other infection	5 (0.007)	1 (0.002)	4 (0.006)	2 (0.003)	15 (0.024)	12 (0.020)	18 (0.030)	16 (0.027)
Infection involving bacteremia	28 (0.040)	19 (0.028)	27 (0.038)	18 (0.026)	46 (0.074)	37 (0.060)	46 (0.077)	33 (0.056)
Infection leading in hospitalization	83 (0.117)	57 (0.083)	82 (0.115)	56 (0.082)	225 (0.356)	169 (0.269)	259 (0.420)	199 (0.325)
Time to infection — days	111±91	117±93	116±94	117±95	103±87	110±91	107±91	113±94
Adherent Participants in Decolonization Group‡								
Infection — no. of participants (no. of events/participant-yr)								
Any infection		42 (0.085)		42 (0.088)		118 (0.272)		142 (0.338)
Skin or soft-tissue infection		22 (0.045)		22 (0.046)		40 (0.092)		54 (0.129)
Pneumonia		5 (0.010)		5 (0.011)		11 (0.025)		16 (0.038)
Primary bloodstream or vascular infection		5 (0.010)		6 (0.013)		8 (0.019)		8 (0.019)
Bone or joint infection		5 (0.010)		4 (0.008)		14 (0.032)		11 (0.026)
Surgical-site infection		2 (0.004)		2 (0.004)		6 (0.014)		7 (0.017)
Urinary tract infection		0		0		22 (0.051)		27 (0.064)
Abdominal infection		2 (0.004)		2 (0.004)		12 (0.028)		11 (0.026)
Other infection		1 (0.002)		1 (0.002)		5 (0.012)		8 (0.019)
Infection involving bacteremia		9 (0.019)		8 (0.017)		19 (0.045)		16 (0.039)
Infection leading to hospitalization		36 (0.075)		34 (0.071)		98 (0.226)		115 (0.274)
Time to infection — days		122±93		125±96		119±89		123±94

* Participant-day denominators were censored by the specified outcome. Dates of infection onset based on CDC criteria may differ from those based on clinical judgment.
† This was the primary outcome.
‡ A total of 546 participants were considered to have adhered fully to the decolonization intervention.

Table 3. Effect of Decolonization Plus Education, as Compared with Education Alone, According to Cox Proportional-Hazard Models.*

Variable	MRSA Infection, According to CDC Criteria	MRSA Infection, According to Clinical Criteria	Any Infection, According to CDC Criteria	Any Infection, According to Clinical Criteria
Per-protocol analysis				
Unadjusted hazard ratio (95% CI)	0.70 (0.52–0.96)†	0.71 (0.52–0.97)	0.84 (0.70–1.01)	0.83 (0.70–0.99)
Adjusted hazard ratio (95% CI)‡	0.61 (0.44–0.85)	0.61 (0.43–0.84)	0.80 (0.66–0.98)	0.81 (0.68–0.97)
As-treated analysis§				
Unadjusted hazard ratio (95% CI)				
Nonadherent	1.31 (0.72–2.38)	1.09 (0.57–2.10)	1.68 (1.19–2.36)	1.53 (1.11–2.13)
Partially adherent	0.64 (0.40–1.00)	0.72 (0.47–1.11)	0.86 (0.67–1.11)	0.92 (0.74–1.16)
Fully adherent	0.56 (0.36–0.86)	0.53 (0.34–0.83)	0.60 (0.46–0.78)	0.58 (0.45–0.74)
Adjusted hazard ratio (95% CI)¶				
Nonadherent	0.78 (0.36–1.71)	0.72 (0.37–1.41)	0.780 (0.51–1.26)	0.76 (0.40–1.45)
Partially adherent	0.75 (0.59–0.95)	0.69 (0.54–0.88)	0.78 (0.64–0.97)	0.76 (0.63–0.92)
Fully adherent	0.72 (0.57–0.92)	0.66 (0.51–0.84)	0.75 (0.60–0.94)	0.72 (0.58–0.88)

* The per-protocol population included all the participants (2121) who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization. The unadjusted analyses included all these participants. The adjusted models included the 1901 participants who provided data for all the baseline characteristics shown in Table S2 in the Supplementary Appendix.

† A P value is provided only for the primary outcome (P=0.03). Because the statistical analysis plan did not include a provision for correcting for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, these results are reported as point estimates with 95% confidence intervals. The widths of these confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

‡ Models evaluating the outcomes of MRSA infection according to CDC criteria and any infection according to clinical criteria were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, cancer, cerebrovascular disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, need for bathing assistance, and anti-MRSA antibiotics as time-varying covariates on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses. Models evaluating the outcome of MRSA infection according to clinical criteria and any infection according to CDC criteria were adjusted for the same variables with the addition of age. Resistance to mupirocin did not significantly modify the effect of the trial group.

§ The as-treated analysis assessed the effect on trial outcomes on the basis of the participant's level of adherence to the use of decolonization products as compared with the education group. Among the participants in the decolonization group, 65.6% of the participant-time involved full adherence (no missed doses); 19.6%, partial adherence (some missed doses); and 14.8%, nonadherence (no doses used). The comparator for each adherence subgroup was the overall education group.

¶ As-treated models for all outcomes were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, and need for bathing assistance on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses.

Nonadherence was associated with a higher likelihood of infection from any cause than was observed among participants in the education group.

NUMBER NEEDED TO TREAT

Overall, the estimated number needed to treat to prevent a MRSA infection was 30 (95% CI, 18 to 230) and to prevent an associated hospitalization, 34 (95% CI, 20 to 336). The number needed to treat to prevent any infection was 26 (95% CI, 13 to 212) and to prevent an associated hospitalization, 28 (95% CI, 21 to 270). Among the participants who adhered fully to the intervention (all of whom were in the decolonization group), the number needed to treat to prevent a MRSA infection was 26 (95% CI, 18 to 83) and to prevent an associated hospitalization, 27 (95% CI, 20 to 46). The number needed to treat to prevent any infection was 11 (95% CI, 8 to 21) and to prevent an associated hospitalization, 12 (95% CI, 8 to 23).

ADVERSE EVENTS

Adverse events that were associated with the topical decolonization intervention were mild and uncommon, occurring in 44 participants (4.2%) (Table S9 in the Supplementary Appendix). Local irritation occurred with mupirocin in 1.1% of the participants (12 of 1058), with chlorhexidine bathing in 2.3% (24), and with chlorhexidine mouthwash in 1.1% (12). In those respective

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categories, 33% (4 of 12), 29% (7 of 24), and 50% (6 of 12) of the participants chose to continue using the product (overall, 39% of the participants with side effects).

A total of 12.6% of the 1591 participants with postrecruitment MRSA strains had high-level resistance to mupirocin (9.4% [150 participants]) or low-level resistance to mupirocin (3.1% [50]). A total of 1.9% of the participants were newly found to have a mupirocin-resistant strain at subsequent visits (1.9% [16 of 826 participants] in the education group and 2.0% [15 of 765] in the decolonization group, P=0.97). A total of 1.5% of the participants in each group were newly found to have high-level mupirocin-resistant strains (1.6% [13 of 826 participants] in the education group and 1.4% [11 of 765] in the decolonization group, P=0.82) when only sensitive strains were detected at recruitment. Chlorhexidine MICs of 8 μg or more per milliliter were rare (occurring in 2 participants overall [0.1%]). Both patients were in the intervention group, and both isolates had an MIC of 8 μg per milliliter and were negative for the *qac A/B* gene).

DISCUSSION

Infection-prevention campaigns have reduced the risks of health care–associated infections in hospitals, leaving the majority of preventable infections to the postdischarge setting.[16] MRSA carriers are an appealing population target because of their higher risks of infection and postdischarge rehospitalization and the common practice of screening selected inpatients for MRSA colonization.[1,17-19] In the CLEAR trial, topical decolonization led to lower risks of infections and readmissions than hygiene education alone among patients after the transition from hospital to home and other care settings. With a number needed to treat between 25 and 30 to prevent infection and hospitalization, this intervention is relevant to 1.8 million MRSA carriers (5% of inpatients) who are discharged from hospitals each year.[16]

Although decolonization has successfully prevented disease during temporary high-risk circumstances (e.g., recurrent skin infections, ICU care, and arthroplasty and cardiac surgery),[6-10,19-22] a single 5-day decolonization regimen produced short-lived MRSA clearance in half the carriers.[23-26] In contrast, twice-monthly decolonization provided protection for many months after discharge. The protective benefit continued after decolonization. In addition, this regimen was effective despite the greater variability in application with home bathing and showering than has occurred in previous inpatient trials that evaluated nursing-assisted chlorhexidine bath-

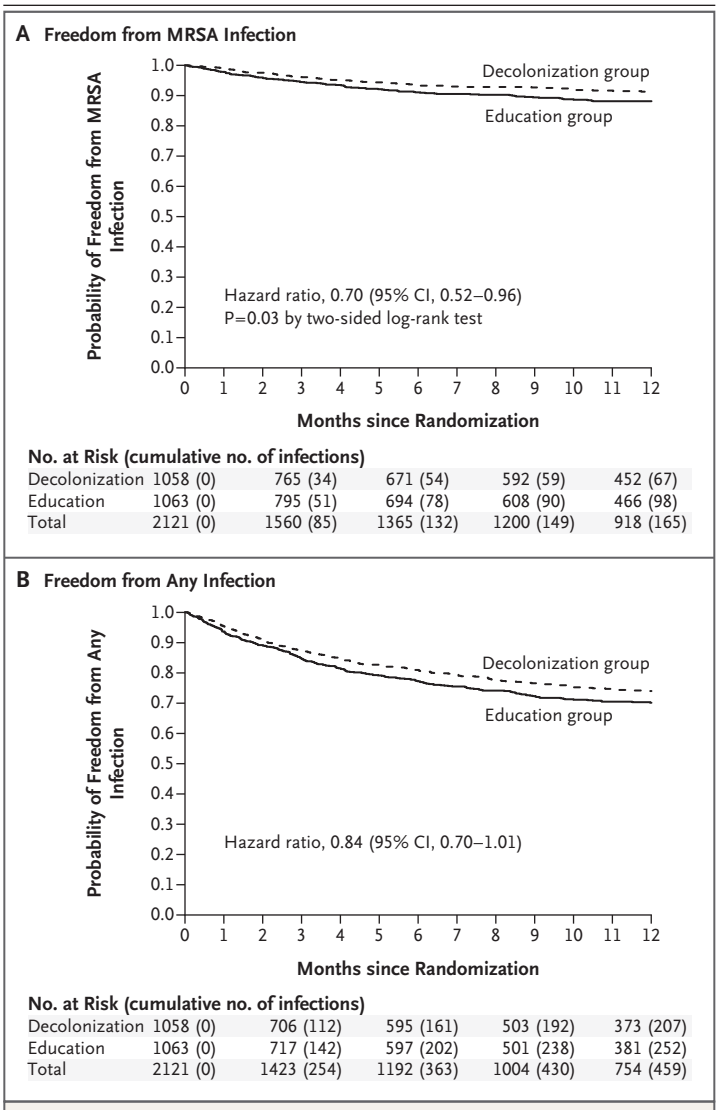

Figure 2. Kaplan–Meier Curves for Freedom from MRSA Infection and Infection from Any Cause, Assessed According to CDC Criteria.

Cases of MRSA infection and infection from any cause were assessed according to criteria of the Centers for Disease Control and Prevention (CDC). The probability of being free from MRSA infection (primary outcome) was significantly greater in the decolonization group than in the education group. The curves remained separated even though decolonization stopped at 6 months. Details regarding the numbers of patients at risk for infection and those with infection at the specific time points are provided in Table S7 in the Supplementary Appendix.

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ing and mupirocin application.[8,9,22] This trial also showed that 4% rinse-off chlorhexidine was effective in a postdischarge population that typically takes showers or baths and is unlikely to use a 2% leave-on chlorhexidine product.[8,9,22]

Not surprisingly, participants who adhered fully to the decolonization intervention had rates of MRSA infection and infection from any cause that were at least 40% lower than the rates among participants in the education group, with a number needed to treat of 12 to prevent infection-related hospitalization. This finding probably is attributable to both the decolonization effect and the likelihood that these participants were more adherent to other prescribed treatments and health-promotion behavior than participants in the education group. Participants who fully adhered to the intervention had fewer coexisting conditions, had fewer devices, required less bathing assistance, and were more likely to have MRSA infection (rather than asymptomatic colonization) at the time of enrollment than either participants in the education group or participants in the decolonization group who had lower levels of adherence. These differences represent an important practical distinction. To the extent that physicians can identify patients who are able to adhere to an intervention, those patients would derive greater benefit from the recommendation to decolonize. Nonadherence was common among nursing home residents, which raises questions about research barriers in that care setting.

Decolonization appeared to affect the risks of skin and soft-tissue infections, surgical-site infections, pneumonia, and bacteremia, although sample-size constraints necessitate cautious speculation. Decolonization also appeared to reduce the rate of gram-positive pathogens and infections without a cultured pathogen. The higher rate of gram-negative pathogens in the decolonization group than in the education group was seen among the CDC-defined all-cause infections but not among the clinically defined infections and requires further substantiation. These observations are based on relatively small numbers; larger studies have shown that chlorhexidine can reduce the incidence of gram-negative infections and bacteriuria.[27-30]

The design of this trial did not permit us to determine the effect of hygiene education alone. Both trial groups received in-person visits and reminders about the importance of MRSA-prevention activities. In addition, the free product overcame financial disparities that could become evident with post-trial adoption of the decolonization intervention.

Some participants (<5%) in the decolonization group had mild side effects; among those participants, nearly 40% opted to continue using the agent. Resistance to chlorhexidine and mupirocin was not differentially engendered in the two groups. We defined an elevated chlorhexidine MIC as at least 8 μg per milliliter, although 4% chlorhexidine applies 40,000 μg per milliliter to the skin.

This trial is likely to be generalizable because it was inclusive. For example, the enrollment of participants with late-stage cancer contributed to the 10% anticipated mortality and the approximate 25% rate of withdrawal and loss to follow-up. These rates are similar to other postdischarge trials with shorter durations of follow-up than the durations in our trial.[31-33] It is unknown whether the participants who withdrew or were lost to follow-up had different infection rates or intervention benefits. They were more educated and less likely to be Hispanic than those who did not withdraw or were not lost to follow-up, but the percentages of participants with coexisting conditions were similar.

Limitations of this trial include the unblinded intervention, although outcomes were assessed in a blinded fashion. The trial also had substantial attrition over the 1-year follow-up, and adherence was based on reports by the participants, with spot checks of remaining product, both of which may not reflect actual use. In addition, nearly all infections led to hospitalization, which suggests that milder infections escaped detection. Most outpatient and nursing home records had insufficient documentation for the event to be deemed infection according to the CDC or clinical criteria. Thus, it remains unknown whether the observed 30% lower risk of MRSA infection or the observed 17% lower risk of infection from any cause with decolonization than with education alone would apply to less severe infections that did not lead to hospitalization. Finally, although resistance to chlorhexidine and mupirocin did not emerge during the trial, the development of resistance may take time, beyond the follow-up period of this trial.

In conclusion, inpatients with MRSA-positive

cultures who had been randomly assigned to undergo decolonization with topical chlorhexidine and mupirocin for 6 months after discharge had lower risks of MRSA infection, infection from any cause, and hospitalization over the 1 year after discharge than those who had been randomly assigned to receive hygiene education only.

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), or the Agency for Healthcare Research and Quality (AHRQ).

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APPENDIX

The authors' full names and academic degrees are as follows: Susan S. Huang, M.D., M.P.H, Raveena Singh, M.A., James A. McKinnell, M.D., Steven Park, M.D., Ph.D., Adrijana Gombosev, M.S., Samantha J. Eells, M.P.H., Daniel L. Gillen, Ph.D., Diane Kim, B.S., Syma Rashid, M.D., Raul Macias-Gil, M.D., Michael A. Bolaris, M.D., Thomas Tjoa, M.P.H., M.S., Chenghua Cao, M.P.H., Suzie S. Hong, M.S., Jennifer Lequieu, B.S., Eric Cui, B.S., Justin Chang, B.S., Jiayi He, M.S., Kaye Evans, B.A., Ellena Peterson, Ph.D., Gail Simpson, M.D., Philip Robinson, M.D., Chester Choi, M.D., Charles C. Bailey, Jr., M.D., James D. Leo, M.D., Alpesh Amin, M.D., Donald Goldmann, M.D., John A. Jernigan, M.D., Richard Platt, M.D., Edward Septimus, M.D., Robert A. Weinstein, M.D., Mary K. Hayden, M.D., and Loren G. Miller, M.D., M.P.H.

The authors' affiliations are as follows: the Division of Infectious Diseases (S.S. Huang, R.S., S.P., D.K., S.R., T.T., C. Cao, S.S. Hong, J.L., E.C., J.C., J.H.), the Health Policy Research Institute (S.S. Huang), and the Department of Medicine (A.A.), University of California Irvine School of Medicine, and the Institute for Clinical and Translational Science (A.G.) and the Department of Statistics (D.L.G.), University of California Irvine, Irvine, the Infectious Disease Clinical Outcomes Research Unit, Division of Infectious Diseases, Los Angeles Biomedical Research Institute at Harbor–UCLA Medical Center, Torrance (J.A.M., S.J.E., R.M.-G., M.A.B., L.G.M.), the Department of Pathology and Laboratory Medicine, University of California Irvine School of Medicine, Orange (K.E., E.P.), Ventura County Medical Center, Ventura (G.S.), the Division of Infectious Disease, Hoag Hospital, Newport Beach (P.R.), the Division of Infectious Disease, St. Mary Medical Center (C. Choi), and MemorialCare Health System (J.D.L.), Long Beach, and the Division of Infectious Disease, Mission Hospital, Mission Viejo (C.C.B.) — all in California; the Institute of Healthcare Improvement, Cambridge (D.G.), and the Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care, Boston (R.P.) — both in Massachusetts; the Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta (J.A.J.); Texas A&M Health Science Center, Houston (E.S.); and Cook County Health and Hospitals System (R.A.W.) and the Division of Infectious Diseases, Rush University Medical Center (R.A.W., M.K.H.), Chicago.

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PUBLIC HEALTH

Hospitals Look To Nursing Homes To Help Stop Drug-Resistant Infections

April 2, 20195:00 AM ET

ANNA GORMAN

A certified nursing assistant wipes Neva Shinkle's face with chlorhexidine, an antimicrobial wash. Shinkle is a patient at Coventry Court Health Center, a nursing home in Anaheim, Calif., that is part of a multicenter research project aimed at stopping the spread of MRSA and CRE — two types of bacteria resistant to most antibiotics. *Heidi de Marco/KHN*

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy to stop the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government's Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel collaboration recognizes that superbugs don't remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC's office on health care-acquired infection research.

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"No health care facility is an island," Jernigan says. "We all are in this complicated network."

At least 2 million people in the U.S. become infected with some type of antibiotic-resistant bacteria each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15 percent of hospital patients and 65 percent of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, says Dr. Susan Huang, who specializes in infectious diseases at the University of California, Irvine.
"Superbugs are scary and they are unabated," Huang says. "They don't go away."

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant *Enterobacteriaceae*, or CRE, often called "nightmare bacteria." *E.Coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CRE have "basically spread widely" among health care facilities in the Chicago region, says Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. "If MRSA is a superbug, this is the extreme — the super superbug."
Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it.

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The Centers for Disease Control and Prevention funds the project in California, based in Orange County, in which 36 hospitals and nursing homes are using an antiseptic wash, along with an iodine-based nose swab, on patients to stop the spread of deadly superbugs.
Heidi de Marco/KHN

Though hospital intensive care units frequently rely on chlorhexidine in preventing infections, it is used less commonly for bathing in nursing homes. Chlorhexidine also is sold over the counter; the FDA noted in 2017 it has caused rare but severe allergic reactions.
In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote hand-washing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control protocol was new to many nursing homes, which don't have the same resources as hospitals, Lin says.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a Kaiser Health News analysis, and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.
In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, says Dr. Matthew Zahn, medical director of epidemiology at the Orange County Health Care Agency
"We don't have an infinite amount of time," Zahn says. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, says Huang, who is leading the project.

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Licensed vocational nurse Joana Bartolome swabs Shinkle's nose with an antibacterial, iodine-based solution at Anaheim's Coventry Court Health Center. Studies find patients can harbor drug-resistant strains in the nose that haven't yet made them sick.
Heidi de Marco/KHN

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County — she discovered they do so far more than previously thought. That prompted a key question, she says: "What can we do to not just protect our patients but to protect them when they start to move all over the place?"

Her previous research showed that patients who were carriers of MRSA bacteria on their skin or in their nose, for example, who, for six months, used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic were able to reduce their risk of developing a MRSA infection by 30 percent. But all the patients in that study, published in February in the *New England Journal of Medicine*, already had been discharged from hospitals.

Now the goal is to target patients still in hospitals or nursing homes and extend the work to CRE. The traditional hospitals participating in the new project are focusing on patients in intensive care units and those who already carry drug-resistant bacteria, while the nursing homes and the long-term acute care hospitals perform the cleaning — also called "decolonizing" — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

"It kills germs," Shinkle responded.

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"That's right. It protects you from infection."

In a nearby room, senior project coordinator Raveena Singh from UCI talked with Caridad Coca, 71, who had recently arrived at the facility. She explained that Coca would bathe with the chlorhexidine rather than regular soap. "If you have some kind of open wound or cut, it helps protect you from getting an infection," Singh said. "And we are not just protecting you, one person. We protect everybody in the nursing home."

Coca said she had a cousin who had spent months in the hospital after getting MRSA. "Luckily, I've never had it," she said.

Coventry Court administrator Shaun Dahl says he was eager to participate because people were arriving at the nursing home carrying MRSA or other bugs. "They were sick there and they are sick here," Dahl says.
Results from the Chicago project are pending. Preliminary results of the Orange County project, which ends in May, show that it seems to be working, Huang says. After 18 months, researchers saw a 25 percent decline in drug-resistant organisms in nursing home residents, 34 percent in patients of long-term acute care hospitals and 9 percent in traditional hospital patients. The most dramatic drops were in CRE, though the number of patients with that type of bacteria was smaller.

The preliminary data also show a promising ripple effect in facilities that aren't part of the effort, a sign that the project may be starting to make a difference in the county, says Zahn of the Orange County Health Care Agency.

"In our community, we have seen an increase in antimicrobial-resistant infections," he says. "This offers an opportunity to intervene and bend the curve in the right direction."

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USA TODAY

How to fight ‘scary’ superbugs that kill thousands each year? Cooperation — and a special soap

Anna Gorman, Kaiser Health News Published 9:27 a.m. ET April 12, 2019 | **Updated 1:47 p.m. ET April 12, 201**

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy against the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government’s Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel approach recognizes that superbugs don’t remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC’s office on health care-acquired infection research.

“No health care facility is an island,” Jernigan said. “We all are in this complicated network.”

At least 2 million people in the U.S. become infected with an antibiotic-resistant bacterium each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15% of hospital patients and 65% of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, said Dr. Susan Huang, who specializes in infectious diseases at the University of California-Irvine.

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USA TODAY

Certified nursing assistant Cristina Zainos prepares a special wash using antimicrobial soap. *(Photo: Heidi de Marco, Kaiser Health News)*

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Some of the most common bacteria in health care facilities are methicillin-resistant Staphylococcus aureus, or MRSA, and carbapenem-resistant Enterobacteriaceae, or CRE, often called “nightmare bacteria.” E. coli and Klebsiella pneumoniae are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

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Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it. Though chlorhexidine is frequently used for bathing in hospital intensive care units and as a mouthwash for dental infections, it is used less commonly for bathing in nursing homes.

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Kaiser Health News is a national health policy news service that is part of the nonpartisan Henry J. Kaiser Family Foundation.

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DEPARTMENT OF HEALTH & HUMAN SERVICES **Public Health Service**

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30341-3724

May 14, 2019

CalOptima Board of Directors
505 City Parkway West
Orange, CA 92868

Dear CalOptima Board of Directors:

As the Director of the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC), I want to relay that CDC is very encouraged by your proposed Post-Acute Infection Prevention Quality Initiative (PIPQI). We hope that this type of insurer initiative will help protect nursing home residents from infections and hospitalization.

To combat antibiotic resistant – an important global threat – CDC has activities to prevent infections, improve antibiotic use, and detect and contain the spread of new and emerging resistant bacteria. The nursing home population is at particular risk for acquiring these bacteria and developing infections that require antibiotics and hospital admission because of their age, complex health status, frequency of wounds, and need for medical devices. Surveillance data have shown that the majority of nursing home residents currently have one of these highly antibiotic resistant bacteria on their body, and often these bacteria are spread between residents, within the nursing home, and to other healthcare facilities.

There is a need for public health agencies, insurers, and healthcare providers to forge coordinated efforts to promote evidence-based infection prevention strategies to prevent infections and save lives. We see great synergy in linking CDC's role in providing surveillance and infection prevention guidance to CalOptima's ability to protect its members by supporting patient safety initiatives to reduce infections and the hospitalizations they cause.

CDC funded the Orange County regional decolonization collaborative (SHIELD) as a demonstration project to inform broader national infection prevention guidance. The ability to maintain its resounding success in reducing antibiotic resistant bacteria and infections is critical and Orange County will benefit on initiatives such as PIPQI that provide incentives to enable its adoption into operational best practices.

CDC plans to continue transitional support for this initiative, including training support for the 16 nursing homes currently in the SHIELD collaborative for at least one year. We hope that this training effort can complement and synergize the efforts of CalOptima's education and liaison nurses. In addition, we are providing transitional support to the Orange County Health Department to continue their ongoing surveillance efforts in order that the ongoing benefits of the intervention can be captured.

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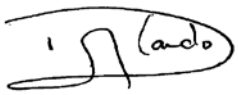
We look forward to collaborating with you. We believe this partnership is a valuable opportunity to protect highly vulnerable patients and to set an example of how insurers and public health can work together to improve healthcare quality.

Sincerely,



Denise Cardo, MD
Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

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Attachment 4: IGT Funding Proposals

Proposal 1: Expanded Office Hours

Initiative Description: The Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) is a two-year program to incentivize primary care providers and/or clinics for providing after-hour primary care services to CalOptima members in highly demanded and highly impacted areas. The Expanded Office Hours aims to improve member experience, timely access to needed care, and achieve positive population health outcomes.

Target Population(s): Primary care providers serving CalOptima's Medi-Cal members in highly demanded/impacted areas

Plan of Action/Key Milestones:
High level actions of how CalOptima will invest financial and staff resources to support the Expanded Office Hours initiative, such as:

1. Provider Data Gathering and Internal System Configuration
    - Identify primary care providers in community clinics who serve members in highly demanded and impacted areas
    - Configure the internal system (using codes 99050 and 99051) so claims can be adjudicated, and providers can receive expanded office hour incentives.
        - CPT code descriptions:
            - 99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
            - 99051: Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
2. Provider Outreach
    - Collaborate with Provider Relations and Health Network Relations to promote the opportunity and encourage providers to provide these services.
    - $125 per member per visit incentive
3. Announce the Expanded Office Hours initiative to impacted Members
    - Call Center and frontline staff training
4. Monitor utilization of the expanded office hour services
    - Monitor and report claims and encounter for identification and linkage to primary care providers providing expanded office hour services

5. Evaluation
    - Conduct evaluation after pilot to see if member access has improved and depending on the outcome, consider expanding the initiative.

Estimated Budget: Total $2 million (up to $500,000 for FY2019/20, remaining amounts from FY2019/20 and $750,000 for FY2020/21, $750,000 FY2021/22)

Project Timeframe: April 2020 – March 2022

IGT 9 Focus Area: Member access and engagement

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus

- Focus on Population Health
- Strengthen Provider Network and Access to Care
- Enhance Member Experience and Customer Service

Participating/Collaborating Partners/Vendors/Covered Entities: Participating providers

Proposal 2: Post-Acute Infection Prevention Initiative (PIPQI)

Initiative Description: Expand CalOptima's program to suppress Multi Drug Resistant Organisms (MDROs) in CalOptima's contracted nursing facilities and decrease inpatient admissions due to infection. The pilot program was approved by CalOptima's Board of Directors on June 6, 2019.

Benefits of the Initiative:

- Member-centric focus: avoid MDRO colonization and inpatient admissions
- Potential cost savings from decreased antibiotic utilization
- Decreased demand for antibiotic-related c. difficile isolation beds
- Decreased Healthcare Acquired Infection rates (HAI):
    - Potential improved Star ratings
    - Strengthens community and national partnerships:
        - UCI (Professor Susan Huang -Department of Infectious Diseases)
        - Matthew Zahn, MD, Orange County Health Care Agency-Division of Epidemiology, CDC
        - (John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention)
        - contracted nursing facilities
        - members/families
- Increased value and improved care delivery
- Enhanced operational excellence and efficiency

*Please note that there is currently an outbreak of a fungal infection called C. auris in Orange County LTACHs and NFs. It's a costly and virulent infection and the Public Health Department is involved. There are currently 160 cases in OC (need updated numbers). Chlorhexidine eradicates and protects against this fungus as well as Multi Drug Resistant Organisms (MDROs)

Target Member Population(s): CalOptima Members receiving services at contracted nursing facilities

Plan of Action/Key Milestones:

A. Teleconference requested by the CDC scheduled for April 2, 2020, as CalOptima is the only County in the U.S. that is an early adopter of CHG/Iodophor in NFs to lower MDRO colonization rates

B. Dedicate two Long Term Support Services Nurses to:

1) Provide training for newly participating facilities,
2) Provide ongoing support and compliance monitoring* at all participating facilities,
3) Develop additional informing, training and monitoring materials.

C. Promote the expansion of the Post-Acute of Infection Prevention Program and engage nursing facility administration and staff at the March 20, 202 LTSS Workshop.

*Monitoring includes monthly random testing (five patients per facility confirming presence of Chlorhexidine, invoices /delivery receipt for Chlorhexidine and Iodophor). Additional metrics: acute inpatient admission rates due to infection, Hospital Acquired Infection (HAI) rates.

Estimated Budget: Total budgeted amount $3.4 million over 3 fiscal years ($1 million for FY2019/20, $1.2 million for FY 2020/21 and $1.2 million for FY 2021/22)

Project Timeframe: Three years FY 2019/20– 2021/22

IGT 9 Focus Area: Quality performance and data exchange and support

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Expand CalOptima's Member-Centric Focus, Strengthen Community Partnerships, Increase Value and Improve Care Delivery, Enhance Operational Excellence and Efficiency.

Participating/Collaborating Partners/Vendors/Covered Entities: University of California Irvine Medical Center, Department of Infectious Disease, Dr. Susan Huang; Orange County Health Care Agency-Division of Epidemiology, Centers for Disease Control (CDC); John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention; CalOptima contracted nursing facilities.

Proposal 3: Hospital Data Sharing Initiative

Initiative Description: Establish incentives for implementation of a data sharing solution for Admit, Discharge, Transfer (ADT) and Electronic Health Record data to support alerting of hospital activities for CalOptima members for the purposes of improving care management. Participating entity will be eligible for incentive once each file exchange is in place. The overall goal is to improve costs, quality, care, and satisfaction.

Target Population(s): Contracted and participating Orange County hospitals serving CalOptima members and, potentially, other Community Based Organizations within the delivery system

Plan of Action/Key Milestones: Staff will obtain Board of Directors approval, contract with selected vendors, implement the solutions, establish an incentive plan and details, and work with the vendors and the hospitals to establish the means of sharing data.

Estimated Budget: $2 million to be exhausted by end of FY 2020-2021

Project Timeframe: Until end of FY 2020-2021

IGT 9 Focus Area: Data exchange and support

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus and Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: Hospitals providing the requested data

Proposal 4: Intergovernmental Transfer (IGT) Program Administration

Initiative Description: Administrative support activities related to prior, current and future IGTs opportunities, grants, internal initiatives. This will continue support for management of the IGT transaction process, project and expenditure oversight related to prior IGTs (outstanding grants and internal projects), as well as current IGTs in progress (i.e., IGTs 9 and 10) and oversight. Administration will be consistent with CalOptima standard policies, procedures and practices and will ensure funding investments are aligned with CalOptima's strategic priorities and member needs. Two staff positions, the Grant Management System license, public activities and other administrative costs are included.

Target Member Population(s): NA

Plan of Action/Key Milestones: NA

Estimated Budget: $2,000,000

Project Timeframe: Five–years

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Strengthen Community Partnerships, Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: NA

Proposal 5: Whole Child Model (WCM) Program

Initiative Description: To fund WCM program deficit in year one

Target Member Population(s): WCM eligible members (12,000 to 13,000)

Plan of Action/Key Milestones: N/A

Estimated Budget: Total $31.1 million for FY 2019-20

Project Timeframe: FY 2019-20 (July 1, 2019 to June 30, 2020)

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives:
To Support care delivery for WCM population in FY 2019-20

1) Insufficient revenue from DHCS
2) Complexity in operation and financial reconciliation

Participating/Collaborating Partners/Vendors/Covered Entities: N/A

Board of Directors' Quality Assurance Committee Meeting
February 19, 2020

Improving Transitions of Care for Members Experiencing Homelessness

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During the summer, CalOptima established a Homeless Health – Outreach & Navigation Workgroup in partnership with the health networks. Over the past several months, hospitals and Orange County Health Care Agency Whole Person Care have joined the workgroup. The focus of the workgroup has been to better understand the challenges encountered coordinating services for CalOptima members who are experiencing homelessness and identify opportunities to address these challenges. Through these collaborative meetings, it was identified that transitions of care from inpatient (IP) to skilled nursing facilities (SNFs) and recuperative care settings are particularly challenging. Based on these discussions, the workgroup is recommending a pilot to reduce avoidable admission delays from IP to SNF for SNF-eligible CalOptima members experiencing homelessness. This will provide pathways to recuperative care and housing supportive services.

The proposed pilot leverages current requirements and planned care coordination efforts included in California Health and Safety Code (HSC) §1262.5 as amended by SB 1152, the Whole Person Care pilot and the Health Homes Program. Nothing in this pilot would replace or reduce existing responsibilities or requirements. In addition, participating SNFs would receive an incentive to provide increased member support and for coordination with others involved in member's care including hospitals, health networks, Whole Person Care and Recuperative Care sites.

A SNF stay following discharge from an inpatient hospital admission may be covered under this pilot for a CalOptima managed care member who is:

- Enrolled in Medi-Cal, OneCare or OneCare Connect. Members enrolled in Medi-Cal and another Medicare plan or Medicare Fee-For-Service is not eligible
- Admitted as an inpatient to a hospital contracted with CalOptima or member's assigned health network, as applicable
- A "homeless patient"[1] under HCS §1262.5

[1] HSC § 1262.5 ascribes to "homeless patient" the same meaning as provided in HCS §1262.4, which states at §(b):

> For purposes of this section, "homeless patient" means an individual who lacks a fixed and regular nighttime residence, or who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations, or who is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.

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- Anticipated to meet the SNF medical necessity criteria, is not anticipated to require a long-term care stay and expresses willingness to transfer to a SNF at discharge from the IP stay
- Anticipated to meet recuperative care criteria at discharge from the SNF and expresses a willingness to enroll in Whole Person Care for recuperative care

Next steps include:

- Finalizing draft requirements for SNF participation, documentation requirements and incentive payment methodology for vetting purposes
- Vetting with stakeholders including current and/or former Provider Advisory Committee SNF representatives
- Finalizing the proposal, processes and informing materials based on feedback from stakeholders
- Finalizing list of targeted SNFs; the list will be informed by feedback received from health networks, hospitals and CalOptima Utilization Management and Long-Term Services and Supports departments
- Requesting consideration by the CalOptima Board of Directors to implement the pilot
- Implementing pilot, if approved by the Board of Directors

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Board of Directors' Quality Assurance Committee Meeting
February 19, 2020

PACE Member Advisory Committee (PMAC) Update

PMAC Meeting January 22, 2020

- Updates from the Director
  Director Elizabeth Lee thanked PMAC members for their patience and being available for this rescheduled meeting date. Members were reminded that the original meeting was cancelled December 11, 2019 on short notice due to emergency personnel activity on Garden Grove Boulevard. The next meeting will be March 2020 and will resume quarterly thereafter. Members were thanked for their service in 2019.

- Items Discussed
  PACE Transportation: Transportation Coordinator Oscar Ocampos provided an overview on PACE transportation services, including:
  - PACE transportation services are provided by a contracted vendor, Secure Transportation. Secure has a nationwide fleet of vehicles specializing in the transport of individuals with special needs. As Transportation Coordinator assigned to CalOptima PACE, Mr. Ocampos is responsible for coordinating 15 drivers, a dispatcher and a transportation assistant. Mr. Ocampos shared that the fleet is continuing to grow, and two more drivers are being hired. Secure uses an affiliate partner to provide transportation to non-routine outpatient specialist visits.
  - Mr. Ocampos explained driver background checks, experience, training, orientation and general scheduling systems. Each vehicle typically has three morning and two afternoon round trips to the PACE center in Garden Grove, plus non-routine and Alternative Care Setting trips. There are over 5,000 trips made per month.
  - PMAC members asked Mr. Ocampos about challenges with missed appointments and late pick-ups. A participant asked that clinic schedulers make reminder calls when the appointment is made and the day prior to the appointment. Another participant expressed concern over the drivers working long hours.

- PMAC Member Forum
  - One participant shared the PACE center is getting more crowded. He suggested that employees have an alternative place to park, as the lot next door has many open spots. He also recommended CalOptima open another PACE center to allow participants to 'spread out'. He suggested CalOptima hire all of the new staff for the PACE center because he feels that a good job has been done in the past.
  - A participant requested the next meeting include information on how CalOptima recruits, screens and trains the PACE staff.

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Board of Director's Quality Assurance Committee Meeting
February 19, 2020

Quality Improvement Committee (QIC) Quarter 4 2019 Update

- Summary
  - QIC met on October 8th, and November 12th, and was dark in December.
  - The following sub-committees reported to QIC in Q4:
    - Behavioral Health Integration (BHI)
    - Utilization Management (UM)
    - Credentialing and Peer Review Committee (CPRC)
    - Member Experience (MEMX)
    - Whole-Child Model Clinical Advisory Committee (WCM CAC)
  - GARS subcommittee was scheduled to present in December and was postponed until in January 2020.
  - Accepted minutes from the following committees and subcommittees:
    - Utilization Management Committee (UMC): May 23, 2019
    - Behavioral Health QI Committee (BHQIC): August 07, 2019
    - Member Experience Subcommittee (MEMX): September 24, 2019
    - PACE Quality Improvement Committee (PACE QIC): September 10, 2019
    - Whole-Child Model Clinical Advisory Committee (WCM CAC): July 15, 2019; August 20, 2019
- QIC Highlights
    - **UMC** provided an update of its Q2 (April - June) metrics, which included membership summary and operational performance. Medical, pharmacy and LTSS inquiry authorization goals were met. Unused Authorization performance is low however UM is refining the unused authorization reporting process to determine goal or baseline.
    - **WCM CAC** provided updates from its two meetings that met in July and August. The committee updates included the successful report of Go-Live activities that took place July 1, 2019, as well as HN and provider training that was completed prior to Go-Live. There were discussions around transplant criteria, and care delivery issues for peds regarding children with ESRD versus being on dialysis. Also, there was discussion regarding CCS therapy, and the opportunity centralize and coordinate to improve the process.
    - **BHQIC** continues to meet call center metrics, however call handle time continues to increase in Q2 due to increased ASO referrals and a period of reduced staffing. Collaboration between BHI Customer service and BHI Clinical continue to ensure minimal impact to quality of service. BH grievances as reported through GARS had a slight increase while appeals decreased. The increase in GARS was due to increase of PQIs being referred to GARS in Q2. BHI has focused on analyzing utilization versus authorization for BHT related services. Specifically, BHI has begun regular monitoring of utilization for approved ABA services to ensure underutilization does not indicate barrier to access of ABA services. As BHQIC moves toward full integration

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into the QIC, there was a recommendation to add County provider to QIC participants in 2020. The charter will be updated and presented at the November QIC.

- **CPRC** updates include Credentialing, PQI, and Facility Site Review updates. For Credentialing, there were no medical disciplinary action taken in Q3. Monthly ongoing monitoring was reported and yielded about 46 contracted and non-contracted providers for which CPRC reviews for potential action. CPRC continues to review and act on issues related to medical disciplinary cause or reason, however, actions related to non-medical disciplinary cause or reason may be more appropriately handled outside the committee. Hence an ad-hoc cross-department committee has been formed to meet and discuss contractual or quality of service issues related to specific providers. As the group is formalized, additional reports will be made to the QIC. PQI trend reports were presented to QIC. There were several providers with very high PQI and GARS rates. Details of these providers will be reviewed by the ad-hoc committee, with recommended actions. CPRC also reports FSR/MRR/PARS activities which include providers with failed FSR/MRR. In August, one provider failed both the FSR/MRR which resulted in CAPS and member panel closure until CAPS are completed and verified.
- **MEMX** updates included a presentation for OC/OCC CAHPS survey score, as well as DHCS Q3 monitoring report on timely access. The DHCS monitoring report revealed issues with provider data (i.e. unable to reach the provider), and unreachable sites (i.e. long hold, answering machines or no answer). For those providers that were reachable, the survey revealed appointments could only be scheduled approximately 60% of the time. These results were consistent with preliminary results from Timely Access survey. The MEMX committee also presented a deep dive of grievances related to Access which produced high level themes that will be used to focus efforts for the Access Availability workgroup in 2020. MEMX issued Quality Improvement Plans to health networks for low CAHPS performance and overcapacity notifications with closing of panels.
- **Pay for Value (P4V)** team proposed new incentive and methodology for 2020 to QIC. The proposed incentive included new HN rating methodology and Managed Care Accountability Sets (MCAS) for Measurement Year 2020. Feedback and discussion were received from the QIC, and a presentation was made to QAC in November. OCC P4V measures and methodology remains unchanged.
- **Population Health Management** presented measures and incentives priorities for CalOptima's quality improvement programs. Priorities included member incentives for preventative screenings such as Breast Cancer, Cervical Cancer, and Colorectal Cancer. Additional focus on Chronic Care interventions for Diabetes and Cardiovascular, as well as Well-child, and Maternal Health activities.
- **QI Work Plan Dashboard Q3 2019** – 49 elements on the workplan. Most are on-target with planned activities and completion dates. There were 8 elements with concerns, and 2 elements at risk for meeting goal, as measured by HEDIS prospective rates. There are QI teams working on interventions, which were setup at the end of 2019, and will be included in 2020 QI Workplan.

Attachments

1. 2019 Quality Improvement Work Plan 3Q

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2019 Quality Improvement Work Plan 3Q

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT							
2019 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2019 QI Program and Workplan by February 2019	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption	Betsy Ha	Approved at **QIC** 2/14/19; **QAC** 2/20/19; **BOD** on 3/7/19	None	
2018 QI Program Evaluation	Complete Evaluation 2018 QI Program by January 2019	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation	Betsy Ha	Approved at **QIC** 2/14/19;**BOD** 2/20/19	None	
2019 UM Program	Obtain Board Approval of 2019 UM Program by Q1 2019	UM Program will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Annual Adoption	Tracy Hitzeman	Approved at **UMC** 2/14/19; **QAC** 2/20/19; **BOD** 3/7/2019	None	
2018 UM Program Evaluation	Complete Evaluation of 2018 UM Program by Q1 2019	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Annual Evaluation	Tracy Hitzeman	Approved at QIC 2/14/19; **QAC** 2/20/19	None	
Population Health Management Strategy	Obtain Board Approval of 2019 Population Health Management Strategy and start implementation by July 1, 2019	Implement PHM Strategy. Review and adopt on an annual basis	Annual Adoption	Betsy Ha	Approved as attachment C to the 2019 QI Program **QIC** 2/14/19; **QAC** 2/20/19; **BOD** 3/7/19.	None	
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network per regulatory and contract requirement	Peer Review of Credentialing and Re-credentialing files, and Quality of Care and Quality of Service cases related to CalOptima's provider network.	Review of initial and recredentialing applications, related quality of care issues, approvals, denials, and reported to QIC; Delegation oversight reported by A&O quarterly to CPRC.	Quarterly Adoption of Report	Miles Masastugu, MD/ Esther Okajima	CPRC reported 2Q to QIC Aug 13, 2019. Updates on credentialing activity, FSR/MRR/PARS, and PQI summary. There were 3 failed site reviews in Q1 and Q2, plus an increase in CAP activity. DHCS conducted an audit on 16 sites in Q2. CAPS were issued and resolved. PQI team saw significant increase in number of referrals, and # of new cases opened, which is impacting TAT to close cases.	CPRC due to report Q3 in Nov 2019	

2019 Quality Improvement Work Plan 3Q

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Behavioral Health Quality Improvement Committee (BHQIC) Oversight - Conduct Internal and External oversight of BHI QI Activities per regulatory and contract requirement	Ensure member's have access to quality behavioral health services, while enhancing continuity and coordination between physical health and behavioral health providers.	BHQI meets quarterly to: monitor and identify improvement areas of member and provider services, ensure access to quality BH care, and enhance continuity and coordination between behavioral health and physical health care providers.	Quarterly Adoption of Report	Donald Sharps MD/ Edwin Poon	BHQIC reported 1Q to QIC July 9, 2019 update on Access & Member Experience, GARS - BH Grievances and Appeals for all LOB. Following up on CAP from DHCS to look at ABA Utilization and Authorization. Updated policy and process flow.	Ensure BH CS staff have access to Provider contract status to help identify providers in network. Continue improvement to LOA process workflows; Continue to monitor BHT services hours and utilization patterns. Complete steps to carry out DSF/AMM and ADD interventions. Final report on IGT Depression Screening at next BHQI	
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities per regulatory and contract requirement	Monitors the utilization of health care services of CalOptima Direct and delegated HMO's, PHCS, SRGs to area identifies over and under utilization that may adversely impact the member's care.	UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results	Quarterly Adoption of Report	Frank Federico MD/ Tracy Hitzeman	UMC reported 1Q to QIC 7/9/2019 update on 2019 Operational Performance; 2019 Utilization Outcomes for MC/OC/OCC Measures	Review immature vs mature data at next UMC. Ensure tracking and reporting of WCM-specific performance and outcomes data. Continue analysis of Over and Under Utilization and bring to UMC. Strengthen transitions-related reporting.	

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Member Experience (MEMX) Subcommittee Oversight - Oversight of Member Experience activities to improve member experience to achieve the 2019 QI Goal	Improve member experience to meet 2019 strategic objectives. Increase CAHP performance from 25th percentile to exceed 50th percentile.	The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet	MEMX reported 2Q to QIC September 10, 2019. Reported Adult Survey Results, CAHPS Child Member Survey Results (Parents Satisfaction with Their Child's Care). PCP overcapacity notificatoin letters sent in Sept. Notified provider network on DHCS Survey and telephone access standards. Provider Data is a challenge for CalOptima and they continue to work on improving it. Beginning July 1, 2019, CalOptima started quarterly monitoring the health networks for Whole Child Model network adequacy (Will share reports with the health networks quarterly).	Outreach to providers identified as not answering their phone during business hours for BH and DHCS identified providers; Explore Telehealth options; Schedule Provider Coaching and Customer Services Improvement workshops with SullivanLuallin; Continue efforts to improve provider data quality.	

2019 Quality Improvement Work Plan 3Q

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM per regulatory and contract requirement	Provide clinical advice for issues related to Whole Child Model.	Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	Tracy Hitzeman	The WCM CAC met on June 18, 2019. Physician training and education was performed in preparation to the WCM transitioned on July 1, 2019. Daily huddles were being held with County CCS and health networks to work through issues. Frequency of the huddles have decreased to weekly.	WCM due to report their Q3 update to QIC in November 2019. Future topics include, Continuity of Care, Emergency/Urgent Care, Transaction of care for members with CCS conditions and other SPD's that transition out of pediatric.	
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals per regulatory and contract requirement	Resolve provider complaints and appeals expeditiously for all CalOptima providers in a timely manner.	The GARS Committee oversees the Grievance Appeals and Resolution of complaints by members for CalOptima's network. Results are presented to committee quarterly	Quarterly Adoption of Report	Ana Aranda	GARS reported their Q2 update to QIC 9/10/2019 on Medi-cal Complaints, Medi-Cal, OC, OCC, Grievances by Category, and discussed Outliers/Trends. Grievances related to inappropriate referrals caused by incorrect provider data have been trending down as the Provider Data Initiative continues to improve the collection of provider information.	CalOptima continues to review all grievances and appeals for: Trends, Improvements, Correction. GARS to report 3Q to QIC Jan 2020.	
PACE QIC - Quarterly submission PACE QIC minutes	Provide all the acute and long-term care services covered by Medicare and Medi-Cal.	The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC, and submitted quarterly at QIC	Quarterly Adoption of Report	Miles Masatsugu, MD	PACE QIC presented their 2Q minutes to QIC September 10, 2019	Q3 PACE minutes will be submitted to the November QIC.	
Quality Program Oversight - Quality Withhold	Earn 100% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2019	Quarterly monitoring and reporting to OCC Steering Committee and QIC	Annual Assessment	Kelly Rex-Kimmet/ Sandeep Mital	For MY2017, CalOptima received 100% of the OneCare Connect Quality Withhold funds because of extreme and uncontrollable circumstances. The withhold fund checks were mailed out to participating health networks in August 2019	Monitor progress on Quality Withhold measures for MY2018 and MY2019.	

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Quality Program Oversight - QIPE/PPME Monitoring	Meet and exceed goals set forth on the QIPE/PPE dashboard for OC/OCC measures.	Conduct quarterly oversight of specific goals on QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals	Annual Assessment	Esther Okajima/Mimi Cheung	Completed Table 2 entries for 2018, Received feedback from Compliance on clarifications needed for the 2019 Submission. Will make necessary changes to the table.	Finish Table 2 for 2019, in preparation for CMS audit next year.	
II. QUALITY OF CLINICAL CARE							
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	OC OCC 30 day: 56% 33rd percentile OC: N/A OCC: 7 day: 28.97% 50th percentile	CalOptima to manage mental health services for OC/OCC Develop transition of care process for post-discharge Outreach to members post discharge to coordinate follow-up appointments Add ADT and/or EDIE Reporting Incentives for urgent appointments for providers	12/31/2019	Edwin Poon	OC PR HEDIS Rates Q3: 7 day: 30.77% / Gap 75 is 1 30 day: 61.54% / Gap 75 is 1 OCC PR HEDIS Rates Q3: 7 day: 13.11% /Gap 50 is 19 30 day: 28.69% / Gap 50 is 27 MBHO managing interventions (i.e., some outreach/coordination) until 12/31/19. CalOptima has offered additional interventions (e.g., flagging returning members to prompt call center staff to offer additional support when member calls in).	CalOptima will be directly managing LOB beginning 1/1/2020 and is currently looking at ways to improve follow-up after hospitalization.	
Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	MC: 79.67% 50th percentile OC: N/A OCC: 90.23% 50th percentile	Targeted outreach of CCN	12/31/2019	Pshyra Jones/ Nicki Ghazanfarpour	September 2019 Prospective Rates for PBH MC PBH 73.44%; MC CCN PBH 81.43%; OC PBH 100%; OCC PBH 81.48% PBH Faxes: 86; Successful: 79; Failed: 7 (faxes); 8 (members); Total Mbr count: 122 MCAL: 108, OCC: 14, OC: 0	1) Continue Provider fax campaign quarterly. 2) CalOptima Website will have educational message banner rotating with American Heart Month awareness messaging in February 2020.	
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	MC; Continuation Phase: 45% 50th percentile	Targeted outreach of CCN Develop a process for member outreach and/or coordination	12/31/2019	Edwin Poon	PR HEDIS Rates Q3: Initiation Phase: 41.94% / Gap 50 is 40 Continuation and Maintenance Phase: 43.85% / Gap 50 is 32 Pharmacy implemented 30-day limit on refill of Rx in order for member to attend a follow-up with provider past 30 days for a refill.	Plan to address members and providers through outreach and assistance with appointment setting and reminders is pending due to limited resources. The IS CORE report to identify members and their providers is on hold until December due to limited resources as well.	

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2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Improve HEDIS measures related to Asthma: Asthma Medication Ratio (AMR)	MC: 65.30% 66th percentile	CCIP/QIP for AMR Targeted outreach of CCN	12/31/2019	Pshyra Jones/Helen Syn	1) After HEDIS rates were released, AMR was not seen as an area where intervention was currently needed since the national threshold was met/exceeded. 2) Medi-Cal member newsletter Spring 2019 highlighted Child and Adult Asthma Health program services available to members. September Prospective Rate (PR): Total (5-64 years) = 95.90% @ 90th percentile	1) No special AMR outreach or interventions currently planned. 2) CalOptima Website will have educational message banner rotating with Asthma awareness messaging in May 2020. 3) Medi-Cal member newsletter Fall 2019 promotes Health Management Programs, including Child and Adult Asthma Health Program.	
Plan All-Cause Readmissions (PCR)	MC: N/A OC: 8% 50th percentile OCC: 10%	Update Transition of Care post-discharge program, all diagnosis for all LOB (Focus on Anaheim and Fountain Valley hospitals) New means of identification for ER visits in Data Warehouse. CMS: CCN OCC Members with CHF and hospital admission. Health Coaches contact member to prevent unplanned readmission within 30 days (all hospitals excluding Anaheim and Fountain Valley)	12/31/2019	Sloane Petrillo/ Pam Neale Joanne/Melanie Helen Syn/ Jocelyn Johnson	CHF OCC Unplanned Readmission Program: 10 referrals for TOC CHF program in Q3: 6 out 10 referrals were referred to us in previous quarters 1 member deceased 1 member worked with Regina and had no re-admission in 30 days Other Members were discharged to SNF or LTC	Continue OCC CHF Unplanned Readmission Program. Starting RFP process to select a vendor to assist with improving ER data to assist program.	
Improving the quality performance of all HNs, including CalOptima Community Network (CCN).	Implement practice transformation technical assistance in 5 high volume CCN practices by December 2019 Expand provider coaching and customer service training to include all health networks, and PQI Providers and CCN office staff by December 2019	Pay for Value Provider Report Card Provider Incentive targeting measures not in P4V Practice Transformation Initiative in partnership with California Quality Coalition Expand provider coaching and customer service training	12/31/2019	Kelly Rex-Kimmet / Esther Okajima	Pay for Value (P4V) program has generated quarterly CCN Provider Report Cards for all P4V clinical measures and made the reports available to all CCN providers through the CalOptima Provider Portal. P4V team has participated in several meetings hosted by the Provider Relations program to provide an overview to CCN providers and their staff on how to access the Report Cards from the Provider Portal, as well as to interpret their performance for each clinical measure. CalOptima is working to extend the contract with SullivanLuillan to provider provider coaching and customer service trainings.	Pay for Value team will continue to generate the Provider Report Cards and work with the CCN providers to improve their performance on each clinical measure and thereby, improve the overall performance and ranking of CCN as a health network. Upon execution of the amended with SullivanLuillan, QA will promote services to physicians and provider offices.	

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	MC: 75.84% 25th percentile	CalOptima Days targeting adults and children Continue implementing MC PIP activities through 6/30/2019	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) AAP PIP submission (Module 4 and 5) completed and approved by HSAG. September Prospective Rate (PR): MC: - (20-44): 54.40% - (45-64: 72.30% - 65+: 81.91% - All: 63.19% All submeasures are better compared to same time last year.	Develop homeless clinical access health equity PIP to focus on increase overall PCP visits inluding AAP visits.	
Cervical Cancer Screening (CCS)	MC: 63.26% 66th percentile	CalOptima Days targeting adults and children Continue existing incentives	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) CCS Member incentive was increased to $25 starting September 1, 2019. Incentive shared with health networks to promote at point of service and aligned with HN campaigns. **# of CCS member incentives paid out as of 10/29/2019: 680** The incentive is gaining awareness and being more actively promoted to Health Networks directly. **September Prospective Rate (PR): MC** 55.80%Measure is performing better than same time last year.	1) Continue monitoring and tracking incentive. 2) Collaborate with willing Health Networks with their call campaign outreach efforts. 3) Strategize promotion of member incentives through website and other avenues. 4) CalOptima Website will have educational message banner rotating with cervical cancer awareness messaging in January 2020.	
Colorectal Cancer Screening (COL)	OC: 4 STAR OCC: 3 STAR	$50 per screening incentive for OC/OCC	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	**September Prospective Rate (PR)**: OC: 54.28% OCC: 51.50% Measure is performing better than same time last year.	1) $50 OC/OCC Member Incentive for colorectal cancer screening to launch January 2020. 2) Collaborate with willing Health Networks with their call campaign outreach efforts. 3) Strategize promotion of member incentives through website and other avenues. 4) CalOptima Website will have educational message banner rotating with colorectal cancer awareness messaging in March 2020.	

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Breast Cancer Screening (BCS)	MC: 65.30% 75th percentile	CalOptima Days targeting adults and children Continue existing incentives	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) BCS Member incentive was increased to $25 starting September 1, 2019. **# of BCS member incentives paid out as of 10/29/2019: 561** The incentive is gaining awareness and being more actively promoted to Health Networks directly. September Prospective Rate (PR): MC 57.55% OC 66.26% OCC 61.03% Measures are performing better than same time last year.	1) Facets reminder message campaign prompting Customer Service representatives to convey to members if they are eligible Sept 30 - December 31, 2019. 2) BCS IVR campaign targeting Medi-Cal population in October 2019 was completed. 3) Collaborating with various Health Networks to promote incentive in their call campaign outreach efforts. 4) Strategize promotion of member incentives through website and other avenues.	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	MC; 27.63% 25th percentile	Urgent Care Center Provider Incentives, $10 per hit	12/31/2019	Pshyra Jones/Mimi Cheung	1) On hold until further notice. AAB is no longer a MPL measure for DHCS. AAB is still a NCQA measure. **September Prospective Rate (PR): MC** 28.40% Measure is performing better when compared to same time last year. **Goal: 31.97%**	1) Discussion on purchase and distribution of Pharyngitis Kits to providers. This is a NCQA measure.	

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Statin Therapy for People with Cardiovascular Disease (SPC) and Statin Therapy for People with Diabetes (SPD)	Therapy OC:74% 66th percentile OCC:74% 66th percentile Adherence OC: 80.75% 75th percentile OCC: 74.56% 50th percentile	Chronic Disease Bundle, $100 for getting tests done and screenings	12/31/2019		September Prospective (PR): MC SPD19 Therapy Total: 67.37%; MC SPD19 Adherence Total: 29.13%; MC SPC19 Therapy Total: 74.60%; MC SPC19 Adherence Total: 32.17% OC SPC19 Therapy Total: 76.60%; OC SPC19 Adherence Total: 55.56%; OC SPD19 Therapy Total: 70.87%; OC SPD19 Adherence Total: 38.04% OCC SPC Therapy Total: 73.23% ; OCC SPC Adherence Total: 47.67%; OCC SPD Therapy Total: 72.44% ; OCC SPD Adherence Total: 49.68% 4) Provider fax interventions completed by Pharmacy Dept for SPD: **SPD** Faxes: 561; Successful: 518; Failed: 44 (faxes); 2,527 (members) Total Mbr Count: 7,360; MCAL: 6,429; OCC: 816; OC: 115 5) Provider fax interventions completed by Pharmacy Dept for SPC: **SPC** Faxes: 250; Successful: 235; Failed: 15 (faxes); 31 (members); Total Mbr Count: 567; MCAL: 460; OCC: 94; OC: 13	1) Continue Provider fax campaign on a quarterly basis. 2) Targeted member mailings to the same identified members from provider SPD provider faxes are scheduled to begin in September 2019. 3) IVR campaign with statin medicine messaging for diabetics will be run in November 2019. 4) CalOptima website and social media platforms will have educational message banner rotating with diabetes awareness messaging highlighting statin use in November in conjunction with Diabetes Awareness month and American Heart Month awareness messaging in February 2020.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention for Nephrology	A1c Testing: MC: 91.58% 75th percentile OC: 92.15% 25th percentile OCC: 92.15% 25th percentile	Chronic Disease Bundle, $100 for getting tests done and screenings PIP - CDC	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	**# of Diabetes A1C Testing member incentives paid out from June to Oct 2019: 425** The incentive is gaining awareness and being more actively promoted to Health Networks directly. September Prospective Rates (PR): MC CDC A1C Testing - 80.83% Measure is performing better when compared to same time last year. OC CDC A1C Testing - 84.89% OCC CDC A1C Testing - 84.68%	1) IVR campaign with A1C testing messaging for diabetics will be run in November 2019 in conjunction with Diabetes Awareness month. 2) Continue monitoring and tracking incentive. 3) Collaborating with various Health Networks on promoting incentive via their call campaign outreach efforts. 4) Strategize promotion of member incentives through website and other avenues. 5) CalOptima website and social media platforms will have educational message banner rotating with diabetes awareness messaging in November.	

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention for Nephrology	A1c (<8%): MC: 59.49% 90th percentile OC: 77.26% 66th percentile OCC: 71.29% 66th percentile	Chronic Disease Bundle, $100 for getting tests done and screenings Expand annual access to VSP to MC Diabetic members PIP - CDC	12/31/2019	Pshyra Jones/ Dr. Dajee/ Helen Syn/ Mimi Cheung	1) PIP Project - final Module 4 and 5 submitted in September 2019. September Prospective Rates (PR): MC CDC - HbA1c Poor Control (>9%) 62.78% MC CDC - HbA1c Adequate Control (<8%) 30.48% OC CDC - HbA1c Poor Control (>9%) 48.87% OC CDC - HbA1c Adequate Control (<8%) 44.05% Measure is performing better when compared to the same time last year. OCC CDC - HbA1c Poor Control (>9%) 51.82% OCC CDC - HbA1c Adequate Control (<8%) 40.89% Measure is performing better when compared to the same time last year.	1) Ongoing identification lists will be provided to participating provider offices until December 2019 2) Targeted call campaign intervention will launch in Oct/Nov to identified emerging risk population of diabetics who were well controlled, but now have an A1C >8% and <9%. 3) CalOptima website and social media platforms will have educational message banner rotating with diabetes awareness messaging in November. 4) Collaborating with various Health Networks on promoting incentive via their call campaign outreach efforts.	
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention for Nephrology	Eye Exams: MC: 66.42% 75th percentile OC: 80% 66th percentile OCC: 80% 66th percentile	Chronic Disease Bundle, $100 for getting tests done and screenings PIP - CDC	12/31/2019	Pshyra Jones/Helen Syn	**# of Diabetes Eye Exam member incentives paid out from June to Oct 2019: 128** The incentive is gaining awareness and being more actively promoted to Health Networks directly. September Prospective Rates (PR): MC CDC Eye Exams - 50.97% Measure is performing better when compared to same time last year. OC CDC Eye Exams - 55.63% OCC CDC Eye Exams - 64.16%	1) Continue monitoring and tracking incentive. 2) Collaborating with various Health Networks on promoting incentive via their call campaign outreach efforts. 3) CalOptima website and social media platforms will have educational message banner rotating with diabetes awareness messaging in November.	

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing; HbA1c Good Control (<8.0%); Eye Exam; Medical Attention for Nephrology	Nephropathy: MC: 92.05% 75th percentile OC: 95% 25th percentile OCC 97% 66th percentile	Chronic Disease Bundle, $100 for getting tests done and screenings PIP - CDC	12/31/2019	Pshyra Jones/Helen Syn	September Prospective Rates (PR): MC CDC Nephropathy 87.65% OC CDC Nephropathy 91.00% OCC CDC Nephropathy 93.32%	1) Monitor HEDIS prospective rates as it is estimated the CDC Nephropathy measure will exceed MPL similar to HEDIS 2019 final rate.	
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care	Prenatal: 87.06% 75th percentile Postpartum: 73.97% 90th percentile	Increase PPC from existing $25 to $50 Conduct Bright Step post partum assessment	12/31/2019	Pshyra Jones/ Ann Mino	1) Postpartum Care (PPC) Member incentive: **# of PPC member incentives paid out in Q1-Q3 2019: 100** The incentive is gaining awareness and being more actively promoted to Health Networks directly. Postpartum Care (PPC) September Prospective Rate: 52.18%	1) The PPC member incentive dollar amount increases from Sept 1, 2019 from $25 to $50. 2) Collaborate with willing Health Networks with their call campaign outreach efforts. 3) Strategize promotion of member incentives through website and other avenues. 4) CalOptima website and social media platforms will have educational message banner rotating with Women's health and maternal mental health awareness messaging in May 2020. 5) Medi-Cal member newsletter Fall 2019 promotes Health Management Programs, including Bright Steps Maternity Health Program.	

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2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Antidepressant Medication Management (AMM): Continuation Phase Treatment. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	Continuation Phase: MC: 42.31% 75th Percentile OC: 67.87% 90th percentile OCC: 49% 25th percentile	Proposed Incentive for 2 follow-up incentives within 6 months: AMM $75	12/31/2019	Edwin Poon	PR HEDIS Rates Q3: Medi-Cal Initiation Phase: 59.23%/ Gap to 90 is 387 Continuation and Maintenance Phase: 42.06%/ Gap to 75 is 18; OC Initiation Phase: 73.91%/ Gap to 75 is 1; Continuation and Maintenance Phase: 56.52%/ Gap to 75 is 1; OCC Initiation Phase: 72.57%/ Gap to 75 is 7; Continuation and Maintenance Phase: 55.14%/ Gap to 75 is 17 All Rx measure have component of real time data missing w/ exception of having Rx Core reports available to actively manage and assist mbrs with reminders to follow up w/ appts.	No active intervention, however trend continues to maintain above 50%. Will look at potential impact from DSF as well as depression screening initiative through new IGT project (currently, conceptualizing provider incentive for screening and f/u appointments).	
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)	New in 2019, DHCS required, for MC, no external benchmarks	Proposed Incentive f/u visit within 30 days for those who screen positive: DSF $25	5/31/2019	Edwin Poon	HEDIS specifications changed this year. No data available for this measure at this time. Meetings occurring to look at capturing HNA PHQ scores from Guiding Care for WCM population.	Develop way to load data to HEDIS software. Explore expanding process of gathering data from other populations.	
Childhood Immunization Status (CIS): Combo 10	MC: Combo 10: 48.42% 90th percentile Last year final rate 45.01 75%, our goal is to move from 75% to 90%	CalOptima Days targeting adults and children W15 Incentive, $100 completed 6 visits in 12 month or $50 for first month, and $100 for completing	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) W15 incentive will impact CIS measure as IZ are administered during well-care visits. September Prospective Rate (PR): MC 31.05% Measure is performing better than same time last year. According to the Sept. PR report, we are close to achieving the 50th percentile (<100 members to go).	1) CalOptima website and social media platforms will have educational message banner rotating with Back to School Well Care visit and immunization awareness messaging in July 2020.	

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)	MC: 83.70% 90th percentile	CalOptima Days targeting adults and children	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Medi-Cal member newsletter Spring 2020 has articles highlighting immunization schedules for children returning to school, well care visits and scheduling first health exam for new members. 2) CalOptima website and social media platforms will have educational message banner rotating with Back to School Well Care visit and immunization awareness messaging in July 2020. Continue to monitor as this a new MCAS measure; MPL September Prospective Rate (PR): 52.74% MC Measure is performing better than same time last year.	CalOptima website and social media platforms will have educational message banner rotating with Back to School Well Care visit and immunization awareness messaging in July 2020.	
Well-Care Visits in first 15 months of life (W15)	MC: 58.54% 25th percentile	CalOptima Days targeting adults and children W15 Incentive, $100 completed 6 visits in 12 month or $50 for first month, and $100 for completing	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	**1)** Completed 23 CalOptima Day events in Q2. Eighteen (18) events were Pediatric focused; 2 of the 18 events targeted teens for the AWC measure. There were 12 Full Day and 6 Half Day events completed for the Pediatric CalOptima Day events. September Prospective Rate (PR): 35.92% Measure is performing better than same time last year. However, currently below the 10th percentile for 2019 HEDIS final rate. Measure is at risk for falling below the MPL. **GOAL:** 66.23% (50th percentile)	1) CalOptima is moving forward with CalOptima Day targeted events to impact HEDIS 2020. 2) W15 incentive program (visits 4-6) launched in Sept. Incentive for visits 1-3 will launch in January, 2020 3) Health guides dropped in Q2, 2019. 4) Medi-Cal member newsletter Spring 2020 will have articles highlighting immunization schedules for children returning to school, well care visits and scheduling first health exam for new members. 5) Health educators completed outreach. Evaluation of targeted outreach will be validated next year. 6) Evaluation shows members have completed well-care visists in the first 2 months of life. Additional assessment of data gaps in process.	

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Adolescent Well-Care Visits (AWC)	MC: 54.57% 50th percentile	CalOptima Days targeting adults and children AWC incentive, $25/visit targeting 12-15 year olds	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Completed at total of 23 CalOptima Day events in Q2. Eighteen (18) events were Pediatric focused; 2 of the 18 events targeted teens for the AWC measure. There were 12 Full Day and 6 Half Day events completed for the Pediatric CalOptima Day events. 2)AWC member incentive planning in process. Slated to launch next year. 3) Medi-Cal member newsletter Spring 2019 highlighted articles promoting scheduling first health exam for new members, well child visits and immunizations. September Prospective Rate (PR)**:** 31.68% Measure is performing better when compared to the same time last year. This is a DHCS MPL measure. May not meet the 50th precentile goal of 54.57%.	1) Recommendation for CalOptima Day - Impact measures that require only 1 visit to complete. AWC is one of the recommended measures for future CalOptima Day events in 2020. 2) AWC incentive program will launch in January, 2020. Health guide 12-17 will drop with the incentive mailing. 3) Medi-Cal member newsletter Spring 2020, will have articles highlighting immunization schedules for children returning to school, well care visits and scheduling first health exam for new members.	
Appropriate Testing for Children with Pharyngitis (CWP)	MC: 72.52% 25th percentile	Urgent Care Center Provider Incentives, $10 per hit	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) On hold until further notice. CWP is a NCQA measure 2) Medi-Cal member newsletter Spring 2019 highlighted articles warning against the overuse of antibiotics. September Prospective Rate (PR): 61.93% Measure is performing better when compared to same time last year and has already surpassed the 2019 HEDIS final rate. HEDIS 2019 Final Rate = 61.05%. **Goal** is the 25th percentile: 72.52%	Need to discuss next steps with leadership team. This is a NCQA measure. We could continue with the urgent care educational outreach. Recommendation - purchase Rapid Strep A Test kits for urgent care centers and high volume providers offices.	

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Children and Adolescents' Access to Primary Care Practitioners (CAP)	MC 12-24 Months 93.64% 25-6 years: 89.26% 7-11 years: 90.69% 12-19 years: 89.56% 50th percentile	CalOptima Days targeting adults and children AWC incentive, $25/visit targeting 12-15 year olds W15 Incentive, $100 completed 6 visits in 12 month or $50 for first month, and $100 for completing	12/31/2019	Pshyra Jones/ Helen Syn/ Mimi Cheung	1) Completed at total of 23 CalOptima Day events in Q2. Five (5) events were Adults events and 18 were children and teens. 2) AWC member incentive in process 3) W15 incentive is launching 9/1/19 to targeted members who are due for well-care visits and likely to be compliant based on HEDIS specifications. 4)Health Guides with immunization and well child schedules were mailed to all members Ages 0 - 6 in Q2 of 2019. 5) Promote well-care using other social media platforms and web site. 6) Medi-Cal member newsletter Spring 2019 highlighted scheduling first health exam for new members. **September Prospective Rate (PR):** - 12-24 months: 92.20* - 25-6 years: 77.82% * - 7-11 years: 88.86% **- 12-19 years (P4V):** 86.01%	1) CalOptima is moving forward with CalOptima Day targeted events to impact HEDIS 2020. 2) AWC incentive program will launch in January, 2020. Health guide 12-17 will drop with the incentive mailing. 3) W15 incentive program (visits 4-6) launched in Sept. Incentive for visits 1-3 will launch in January, 2020 4) Health guides and Medi-Cal member newsletter Spring 2020 will have articles highlighting immunization schedules for children returning to school, well care visits and scheduling first health exam for new members. 5) CalOptima website and social media platforms will have educational message banner rotating with Back to School Well Care visit and immunization awareness messaging in July 2020. 6) Medi-Cal member newsletter Spring 2020 will have articles highlighting immunization schedules for children returning to school, well care visits and scheduling first health exam for new members.	
III. QUALITY OF SERVICE							
Review and Report GARS for all Lines of Business, Include review of quality issues (QOC, QOS, Access) related to member "pain points" and provide recommendation to assure appropriate actions are taken to improve member experience.	Address quality issues related to (Quality of Service, Access, and Quality of Care).	Provider Data Initiative to address accuracy issues with on-line provider directory which may impact member experience Provider Coaching Initiative	12/31/2019	Marsha Choo	Working with SullivanLuallin to amendent the contract to extend services for Provider Coaching and customer service workshops. Amendment to be fully executed mid-November.	Work with QI to identify providers to target and outreach for these services. Promote these services to provider.	

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IV. SAFETY OF CLINICAL CARE							
Pharmacy Utilization Performance: Opioid Analgesics	Promote optimal utilization of opioid analgesics.	Formulary Management quarterly meetings a. Quantity limits b. Duration limits c. Prior Authorization criteria d. Prescriber Report Cards	12/31/2019	Kris Gericke	QTR 1: 15.6 QTR 2: 15.1 QTR 3: 14.8	Goal met. Continue interventions and monitoring.	
Follow-up on Potential Quality Of Care Complaints	To assure patient safety and enhance patient experience by timeliness of clinical care reviews	Provider Report Card Expand Provider Coaching	12/31/2019	Laura Guest	The 6 month trend report of grievances and PQIs will be presented at CPRC on 10/24/19. Seventy providers with grievances > 25 in 2 years. Of those, 12 providers also had PQIs > 10 in 3 years. Twenty-five providers will be removed for a variety of reasons. The actions determined by the committee are: 1) Two will be trended again in 6 months, and 2) forty-three will be referred for additional action. In Q3, the number of PQIs referred has continued to remain high. In Q1 was 292, Q2 was 427 and Q3 was 441. This totals more cases in 3 quarters of 2019, then in all of 2018. However the cases that are identified as quality of care after investigation, remain to be less than 5% of all PQIs.	I. Forty-three providers requiring additional action will be presented to the appropriate committee, i.e. Access & Availability for action. PQI will continue to monitor the two providers. II. We will continue to monitor for reasons for the increased volume and ways to reduce the number of QOS cases. The next 6 month trend report is scheduled to presented to CPRC in march 2020.	

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
V. MEMBER EXPERIENCE							
Review of Member Experience (CAHPS) -Increase CAHPS score on Getting Needed Care	Improve Member Experience for **Getting Needed Care** from 25th to 50th percentile AND Improve Member Experience for **Getting Care Quickly** from 25th to 50th percentile	Update and redesign P4V CalOptima Days for Specialists as well as PCPs Create Access incentives for hard to access specialties to accept new referrals Member Portal Implementation Streamline CCN Prior Auth Process: i.e. change feed from COLA to GC, update auto auth, Provider Directory Initiative, notification to members of approved auths, unused auth reporting, UCI specialist referrals etc.	12/31/2019	Marsha Choo	HN Quality Rating Methodology has been developed, vetted with the health networks and presented to QIC and QAC. The HN Quality rating methodology is proposed to be utilized in the 2020 Value Based payment program which includes member experience. CCN Report card has been developed and has been posted to provider portal for CCN PCPs. 34 providers were sent a notification letter in September 2019. Panels were closed for 9 providers. 22 providers panel closure are on hold to determine if there is a non-physician medical practitioner available to increase capacity and/or if the PCP wants to work to reassign members. Member Portal was soft launched in April 2019. Accessible by all LOBs. Avg Weekly member registrations: 275 Registered users as of 10/26/19: 6,756	Present HN Quality Rating and proposed 2020 Value Based payment program to November finance and audit and quality assurance committees. Follow-up with providers who were sent panel closure and overcapacity letters.	

2019 QI Work Plan Element Description	Objectives/Lag Measures	Planned Activities	Target Date(s) for Completion	Person(s) Responsible	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Red - At Risk Yellow - Concern Green - On Target
VI. COMPLIANCE							
Delegation Oversight of HN Compliance (UM, CR, Claims)	Delegation Oversight of Health Networks to assess compliance of **UM, CR, Claims**	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as Prior Authorizations; Credentialing, Claims etc. **Report from AOC	12/31/2019	Solange Marvin	Reported to AOC	Please refer to AOC for corrective actions issued	
HN Compliance with CCM NCQA Standards	Delegation Oversight of Health Networks to assess compliance of **CCM**	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as CCM; **Report from AOC	12/31/2019	Sloane Petrillo	Reported to AOC	Please refer to AOC for corrective actions issued	

PACE Quality Improvement Committee (PQIC)
Quarter 3, 2019 Update

PQIC Meeting Date: September 10, 2019

Highlights:

- Membership
  - Enrollment trends moving in a positive direction
- Immunizations
  - 94% of participants have received the pneumococcal vaccine, surpassing our goal of 90%
  - 43% of the participants have received the influenza vaccine
- Infection Control
  - Our respiratory infection rates continue to be lower than the national benchmark.
  - Will work on a collaborative project with University of California, Irvine (UCI) Medical Center which addresses hospital readmissions related to methicillin-resistant staphylococcus aureus (MRSA)
- Provider orders for life-sustaining treatment (POLST)
  - 99% of participants have completed the POLST
- Decrease of opioid use
  - One participant did not have their monthly follow-up visit
- Access to Specialty Care
  - Above goal with 84% scheduled within 10 days
- 30-Day Readmissions
  - Interdisciplinary Team (IDT) to discuss high utilizers
- Long-Term Care
  - Below national and state benchmarks
- Transportation
  - On-time performance at 96%

Summary, Priorities and Resource Allocation:

- Ongoing hiring and training of new providers
- Clinic
  - Continue implementation of new clinical workflows to improve clinical efficiencies
  - Develop new clinical operations metrics to be reported to upcoming Quarter 4 PQIC meeting
- Utilization Management (UM)
  - Completed Emergency Room (ER) and Inpatient Visit Analysis
  - Developed targeted interventions
- Completed implementation of new Primary Care Provider (PCP)/Registered Nurse (RN) role in IDT
- Completed Advanced Directive Review workflow
- Implemented a new Quality Initiative: *Project Clear Trial*

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CalOptima
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Member Trend Report: Third Quarter 2019

Board of Directors' Quality Assurance Committee Meeting
February 19, 2020

Ana Aranda
Director, Grievance and Appeals Resolution Services

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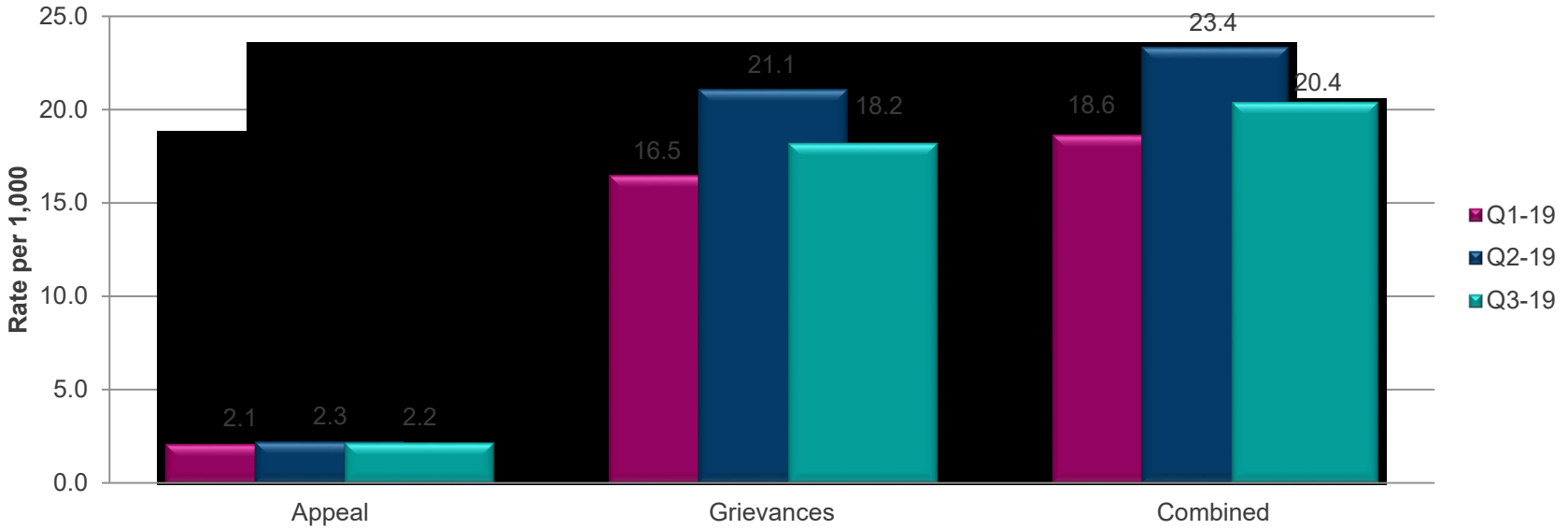
Overview

- Breakdown of complaints by category
- Second quarter trends in rate of complaints (appeals/grievances) per 1,000 members for all CalOptima programs
- Interventions based on trends, as appropriate

Definitions

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

Medi-Cal Complaints



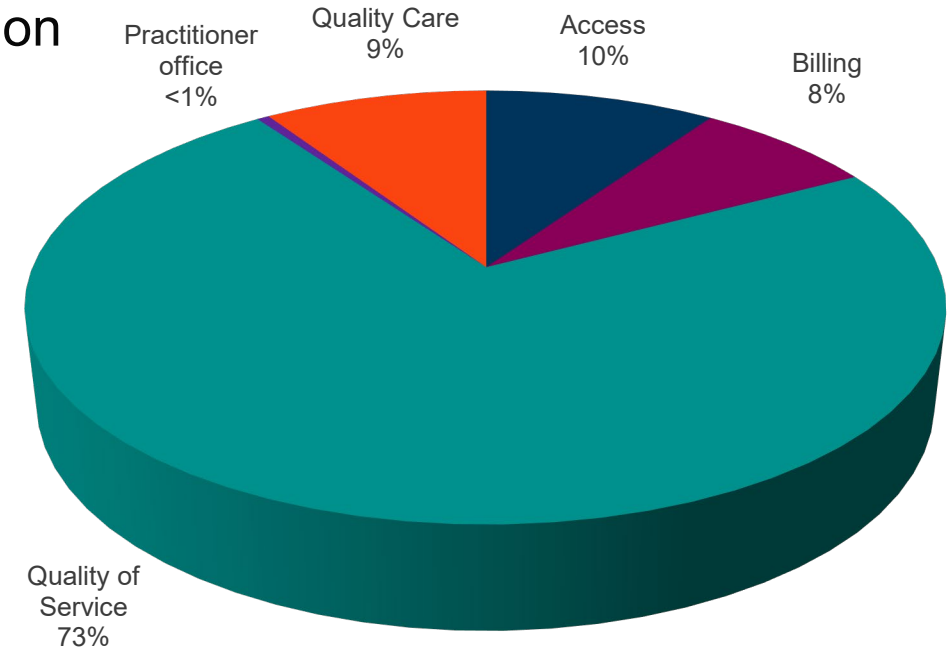
	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2019	3,476	393	3,083	741,963
Q2-2019	4,302	416	3,886	738,880
Q3-2019	3,744	398	3,346	732,115

Medi-Cal Complaints (Cont.)

- There was a 13 percent decrease in total complaints (appeals and grievances) compared to the prior quarter
- There was a 4 percent decrease in appeals
- There was a 14 percent decrease in grievances
- Access related grievances have decreased by 22% from Q2, 2019

Medi-Cal Grievances by Category

- Top grievance types
  - Question treatment
  - Delays in service
  - Non-Medical Transportation
  - Member billing
  - Provider/staff services



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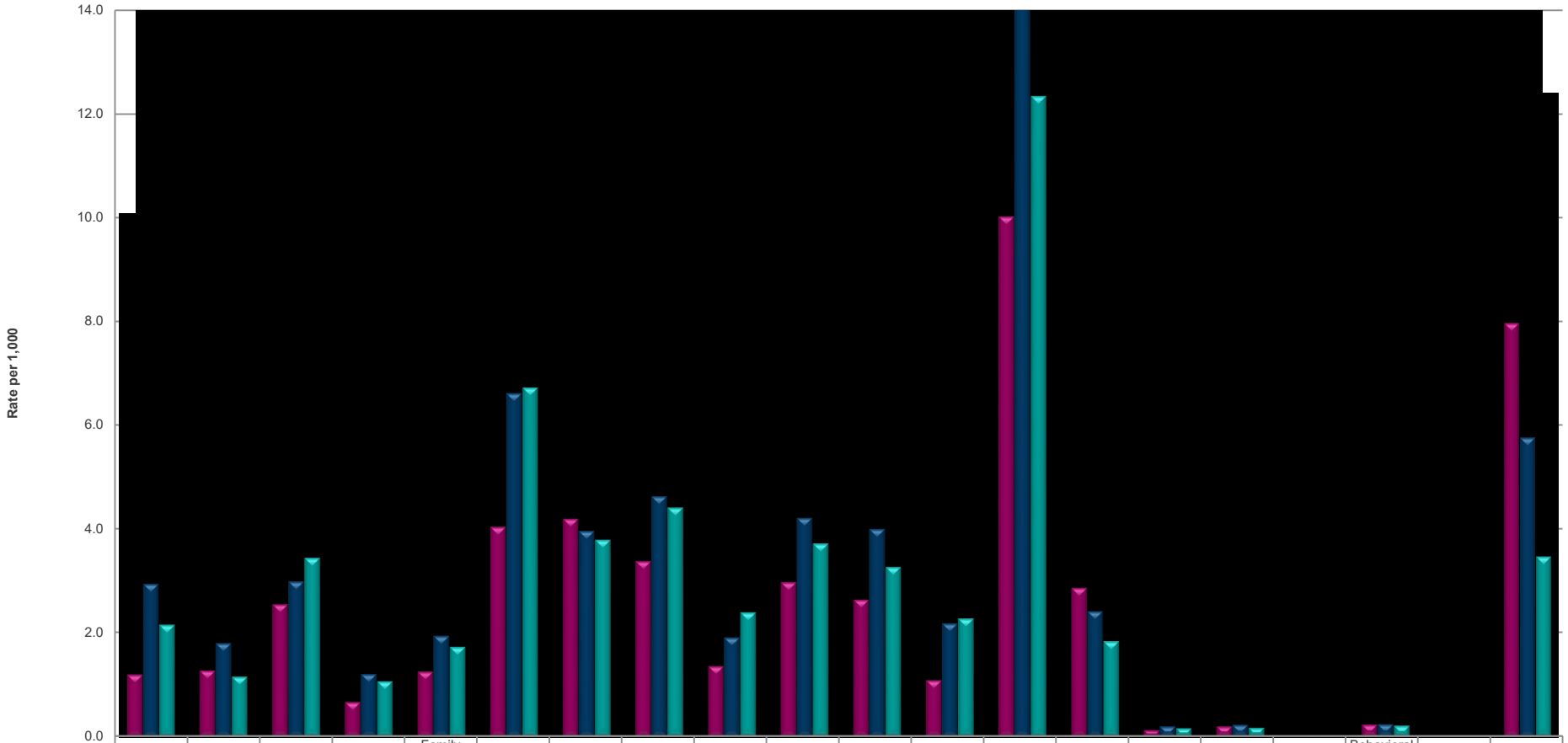
Medi-Cal Grievances by Category (Cont.)

- Quality of Service grievances (2,439) continue to be the highest category followed by Access (323) and Quality of Care (313)

- The top grievance types are consistent with previous quarters; Question Treatment (502), Delay in Service (391), Transportation (316), Member Billing (151), Provider/Staff Services (294)

- Transportation grievances decreased by 26%, while the number of rides increased by 23% from Q2 to Q3, 2019

Medi-Cal Member Grievances Quarterly Rate/1,000



	AltaMed (46,959)	AMVI (21,703)	Arta (61,283)	CHA (144,377)	Family Choice (44,642)	Heritage (6,690)	Kaiser (44,339)	Monarch (78,009)	Noble (21,318)	Prospect (33,902)	Talbert (24,213)	UCMG (33,052)	*CCN (78,989)	COD (92,640)	CO Prog (732,115)	CO Pharm (687,776)	MLTSS (687,776)	Behavioral Health (732,115)	VSP (687,776)	Veyo, LLC (97,456)
Q1-19 (3083)	1.19	1.27	2.54	0.66	1.24	4.04	4.19	3.38	1.35	2.97	2.63	1.08	10.02	2.86	0.12	0.20	0.00	0.23	0.02	7.96
Q2-19 (3886)	2.97	1.83	3.02	1.23	1.97	6.64	3.99	4.65	1.94	4.24	4.02	2.21	14.24	2.44	0.20	0.23	0.00	0.24	0.02	5.78
Q3-19 (3346)	2.15	1.15	3.44	1.07	1.72	6.73	3.79	4.41	2.39	3.72	3.26	2.27	12.34	1.84	0.16	0.17	0.01	0.21	0.02	3.47

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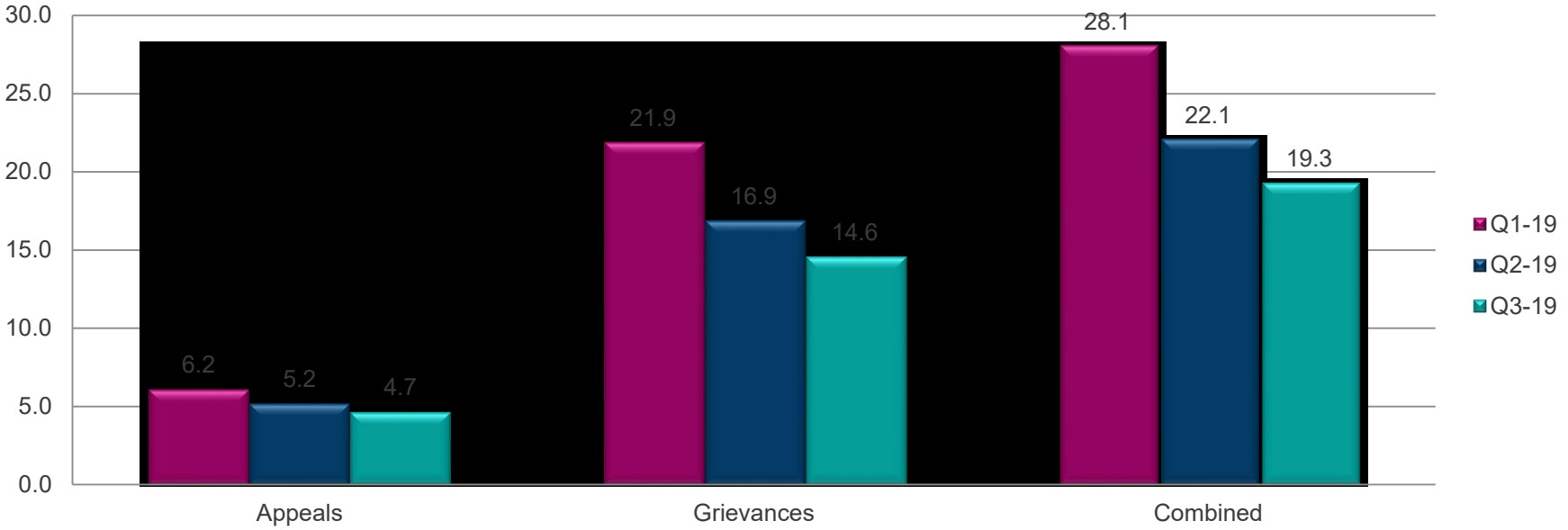
Medi-Cal Summary

- Although Access related grievances have decreased by 22 percent, appointment availability continues to be a pain point for members. GARS is working with the QI team in identifying these trends for further recommendations and actions.
- There was an overall 14 percent decrease in grievances, with 20 percent decrease in billing issues and 22 percent decrease in Access related issues.
  - ✓ The updated billing process implemented in January 2019 has continued to decrease billing concerns.
  - ✓ The Provider Data Initiative has improved the provider directory providing accurate referrals to specialists and improving access related issues.

Medi-Cal Summary (Cont.)

- CCN continues to represent the highest number of grievances due to CalOptima's broader categorization of grievances.
- The CalOptima Health Networks (HNs) were provided additional training in November 2019 on identifying potential grievances, which may not be directly expressed by members. This additional training may result in an increase of the grievance rates across all HNs and provide a more balanced comparison across all Health Networks.

OneCare Connect Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2019	402	88	314	14,293
Q2-2019	314	74	240	14,207
Q3-2019	275	67	208	14,205

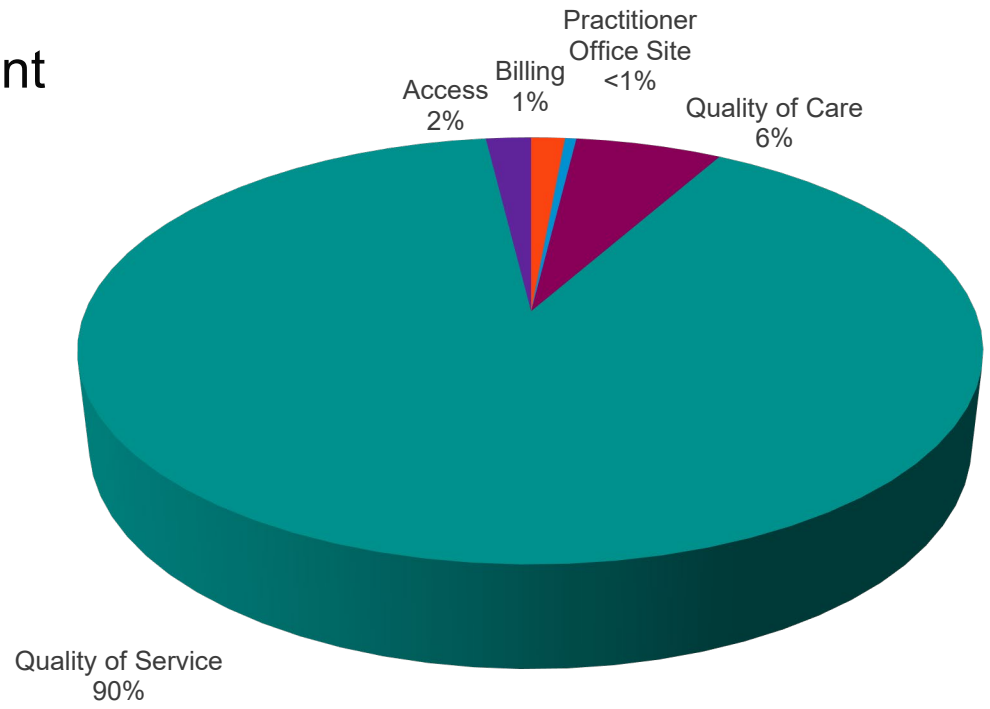
OneCare Connect Complaints Cont.

- There was a 12 percent decrease in total complaints (appeals and grievances) compared to the prior quarter
- There was a 10 percent decrease in the number of appeals
- There was a 13 percent decrease in grievances

Overall 50 percent of Grievances were for Non-Medical Transportation services (104 of 208). Complaints include dissatisfaction with the vendor's customer service, the drivers, late pick ups and no shows.

OneCare Connect Grievances by Category

- Top grievance types
  - Non-Medical Transportation (NMT) services
  - Provider services
  - Question treatment



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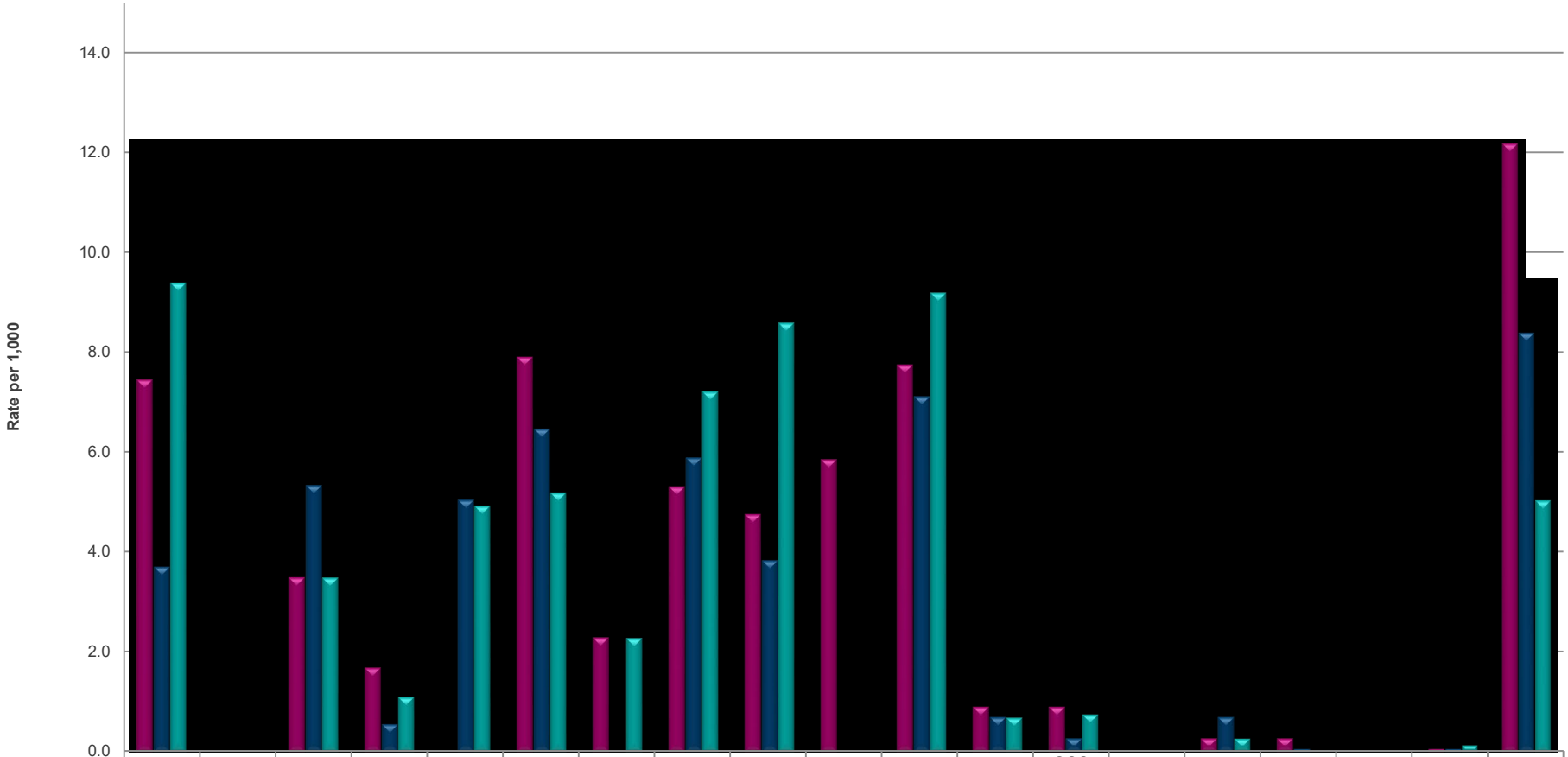
OneCare Connect Grievances (Cont.)

- Quality of Service grievances continue to be the top grievance type.

- The overall breakdown of the top three grievances is as follows:
  - Non-Medical Transportation (NMT) services (104)
  - Provider services (16)
  - Question Treatment (7)

OneCare Connect Member Grievances Quarterly Rate/1,000



	Alta Med Health (533)	AMVI Care (428)	Arta (568)	Family Choice (1,771)	Heritage (202)	Monarch (4,605)	Noble (431)	Prospect (2,355)	Talbert (1,048)	UCMG (525)	CCN (1,741)	OCC Prog (14,205)	OCC Pharmacy (14,205)	MLTSS (14,205)	Behavioral Health (14,205)	Liberty Dental (14,205)	Silver and Fit (14,205)	VSP (14,205)	Veyo (20,576)
Q1-19 (314)	7.5	0.0	3.5	1.7	0.0	7.9	2.3	5.3	4.8	5.9	7.8	0.9	0.9	0.0	0.3	0.3	0.0	0.1	12.2
Q2-19 (240)	3.7	0.0	5.3	0.6	5.0	6.5	0.0	5.9	3.8	0.0	7.1	0.7	0.3	0.0	0.7	0.1	0.0	0.1	8.4
Q3-19 (208)	9.4	0.0	3.5	1.1	5.0	5.2	2.3	7.2	8.6	0.0	9.2	0.7	0.8	0.0	0.3	0.0	0.0	0.1	5.1

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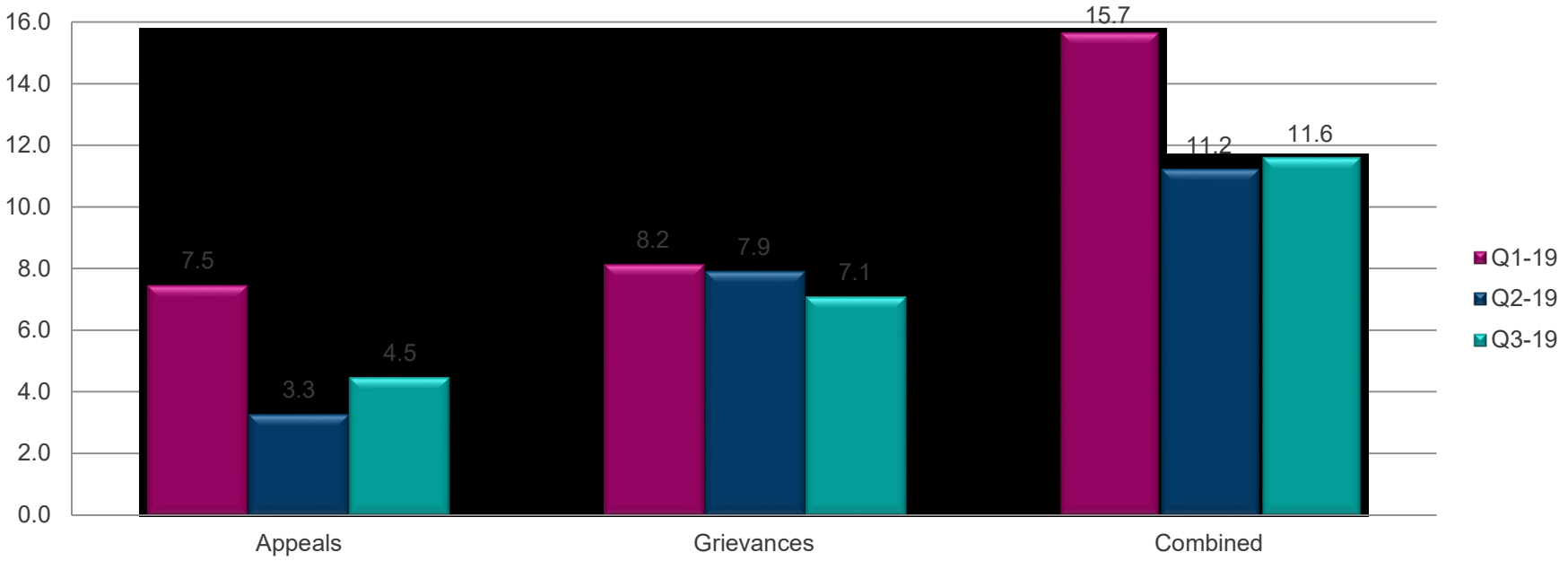
OneCare Connect Summary

- Grievances decreased by 13 percent from Q2-2019 to Q3-2019.
- Non-Medical Transportation grievances had a decrease of 29 percent, even though utilization increased by 15 percent.
- No other significant trends by specific providers were identified.

OneCare Complaints



	Total Complaints	Member Appeals	Member Grievances	Membership
Q1-2019	23	11	12	1,468
Q2-2019	17	5	12	1,514
Q3-2019	18	7	11	1,546

OneCare Member Grievances Quarterly Rate/1,00

	Alta Med Health (85)	AMVI/ Prospect (287)	Arta Western (121)	Family Choice (91)	Monarch (737)	Noble (32)	Talbert (141)	UCMG (52)	OC Operations (1,546)	OC Pharm (1,546)	Behavioral Health (1,546)	Liberty Dental (1,546)	VSP (1,546)	Veyo (40)
Q1-19 (12)	0.0	3.5	0.0	11.0	4.3	0.0	0.0	0.0	0.7	0.0	0.0	0.7	0.0	227.3
Q2-19 (12)	0.0	0.0	8.4	0.0	5.6	0.0	0.0	0.0	0.0	1.3	0.0	0.0	0.0	416.7
Q3-19 (11)	23.4	0.0	0.0	0.0	4.1	0.0	0.0	0.0	0.6	0.0	0.0	0.0	0.0	125.0

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OneCare Summary

- Grievances remain consistently low. An increase or decrease of one or two grievances can impact the percentage anywhere from 6 to 40 percent.

- Grievances were mostly service-related.
  - Dissatisfaction with PCP and staff services
  - Service delays
  - Non-Medical Transportation

- Almost half the grievances (5 out of 11) were regarding NMT services. No other trends with specific issues or providers were identified.

Overall Interventions

- Grievance trends continue to be reviewed by the Quality Improvement and shared with Provider Relations leadership for further action.

- Provider Relations staff continue to outreach to providers with high grievance count to provide awareness and education.

CalOptima's Mission

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

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