



L.A. Care
HEALTH PLAN®

Quality Improvement Program Annual Report and Evaluation 2014

Quality Oversight Committee approval on _____ 2/23/15
Compliance and Quality Committee approval on _____ 3/19/15



Quality Improvement Program
Annual Report and Evaluation
2014

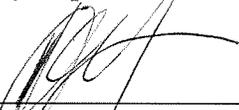
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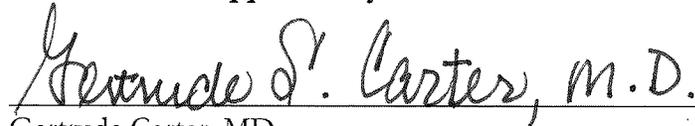
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Mission

To provide access to quality health care for Los Angeles County's vulnerable and low income communities and residents and to support the safety net required to achieve that purpose.

Vision

A healthy community in which all have access to the health care they need.

Values

We are committed to the promotion of accessible, high quality health care that:

- Is accountable and responsive to the communities we serve and focuses on making a difference;
- Fosters and honors strong relationships with our health care providers and the safety net;
- Is driven by continuous improvement and innovation and aims for excellence and integrity;
- Reflects a commitment to cultural diversity and the knowledge necessary to serve our members with respect and competence;
- Empowers our members, by providing health care choices and education and by encouraging their input as partners in improving their health;
- Demonstrates L.A. Care's leadership by active engagement in community, statewide and national collaborations and initiatives aimed at improving the lives of vulnerable low income individuals and families; and
- Puts people first, recognizing the centrality of our members and the staff who serve them.

EXECUTIVE SUMMARY

L.A. Care Health Plan continues its efforts to improve the quality of care and services to members. The Quality Improvement Program describes the infrastructure L.A. Care uses to coordinate quality improvement activities with quantifiable goals. The 2014 Quality Improvement Work Plan was the vehicle for reporting quarterly updates of quality activities and progress toward measureable goals. This 2014 Annual Report and Evaluation summarizes and highlights the key accomplishments in the area of quality improvement for the period of January 1, 2014 through December 31, 2014. This Annual Report evaluates activities for L.A. Care's lines of business: Medi-Cal, Healthy Kids, PASC-SEIU Homecare Workers Health Care for In-Home Supportive Services Workers, Covered California, Cal MediConnect, and Medicare HMO Special Needs Plan (SNP).

Under the leadership and strategic direction established by the L.A. Care Health Plan Board of Governors through the Compliance and Quality Committee (C&Q) and senior management, the 2014 Quality Improvement Plan was implemented. This report provides a detailed discussion of quality improvement activities and significant accomplishments during the past year, in the areas of clinical care, patient safety, model of care, member experience/satisfaction, and access to care. The evaluation documents activities undertaken to achieve work plan goals and establishes the groundwork for future quality improvement activities.

The development and execution of the Quality Improvement Program is a process which relies on input from a number of committees, public and member advisory groups and task forces, as well as dedicated organizational staff. The input and work of these committees and of L.A. Care staff are directed at appropriate initiatives, activities, deliverables, and policies and procedures that support the mission and direction established by the Board of Governors.

Staff throughout L.A. Care contributes to activities to support the execution of the Quality Improvement Program. Most activities are coordinated and/or carried out by staff in two main service areas: Health Services and Managed Care Operations. The Quality Improvement (QI) Department takes the lead in compiling this Annual Report, with support from staff in the following departments: Healthcare Outcomes and Analysis (HO&A), Member Services, Provider Network Operations (PNO), Pharmacy, Community Outreach and Education (CO&E), Medicare Operations (Med Ops), Managed Long Term Services and Supports (MLTSS), Behavioral Health, Health Education, Cultural and Linguistic Services (HECL), Medical Management, Facility Site Review (Medical Record Review), and Credentialing.

L.A. Care Health Plan has successfully undergone evaluation by regulators and accrediting bodies in 2014, with particular emphasis on quality of care, coordination and integration of services, and provision of effectiveness and efficacy of processes.

The assessments in 2014 included:

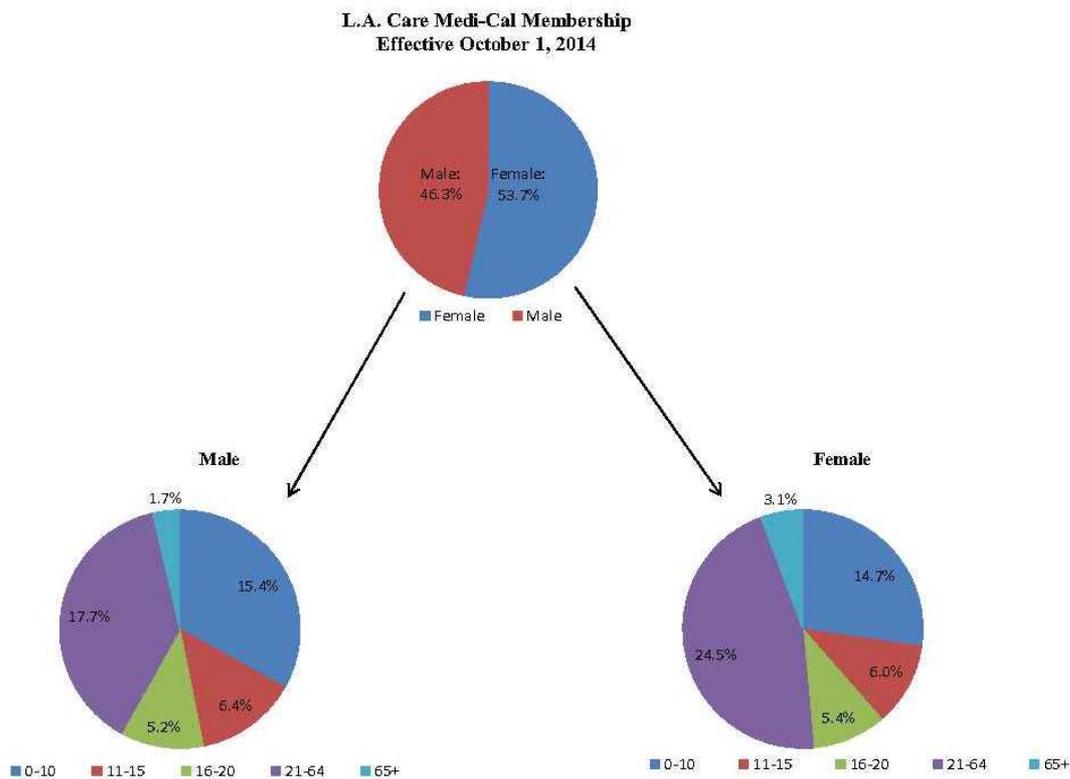
- March 10-20: CMS review of D-SNP, which identified multiple issues requiring immediate corrective action response (ICAR) and corrective action responses (CAR).
- June 16-17: NCQA reaccreditation of Medi-Cal and Covered California product lines, resulting in an overall "accredited" status.
- June 25 – July 9: DHCS audit of Medi-Cal. Results pending at this time.

In 2014, L.A. Care's D-SNP achieved a solid 3.0 Star rating. We earned 3.0 Star rating for Part C and improved to a Part D rating of 3.5 Stars. This allows us to obtain passive enrollment for our Cal MediConnect line of business, effective 1/1/2015.

Membership

The Quality Improvement Program is designed to meet the unique and specific needs of L.A. Care members. The following information provides a high level summary of L.A. Care's membership.

As of October 1, 2014, L.A. Care had 1,556,172 Medi-Cal members of those 203,641 members in senior and disability categories (an increase from 172,451 at the end of 2013), 857 Healthy Kids members, and 41,983 IHSS members as of October 1, 2014. L.A. Care's Medi-Cal membership profile is shown below:



Three ethnic groups make up 82.3% of L.A. Care's Medi-Cal membership as seen in the table below:

Ethnicity	Number of Members	% of Membership
Hispanic/Latino	895,124	57.5%
Caucasian/White	196,888	12.6%
African American/Black	189,114	12.2%

91.0% of all L.A. Care Medi-Cal members speak one of two languages as seen in the table below:

Language	Number of Members	% of Membership
English	897,249	57.66%
Spanish	518,254	33.30%

Approximately 53% of L.A. Care members across all lines of business are under 21 years of age. The rate of members 65 and over increased from 1% in 2010 to 4.8% in 2014. Of the adult membership, approximately 58.7% are female and 41.3% are male. Approximately 57.5% of L.A. Care Med-Cal members are Hispanic/Latino, but the main preferred languages spoken are divided between English and Spanish. L.A. Care strives to make available easy-to-read, well translated health education material, and continuously increases the availability of material in alternative formats (audio, Braille, large format).

MEDI-CAL

Medi-Cal		
The Top 10 Diagnosis for Outpatient Visits (other than for well visits and pregnancy) (Oct. 1, 2013 – Sept. 30, 2014)		
	2013	2014
1	Unspecified Respiratory Abnormality	Symptoms Involving Respiratory Systems and Other Chest Symptoms
2	General Symptoms	Symptoms Involving Abdomen and Pelvis
3	Symptoms Involving Abdomen and Pelvis	Disorders of Refraction and Accommodation
4	Complications Mainly Related to Pregnancy	General Symptoms
5	Acute Upper Respiratory Infections of Multiple or Unspecified Sites	Diabetes Mellitus
6	Symptoms Involving Digestive System	Acute Respiratory Infections of Multiple or Unspecified Sites
7	Symptoms Involving Head and Neck	Asthma
8	Unspecified Disorders of back	Suppurative and Unspecified Otitis Media
9	Suppurative and Unspecified Otitis Media	Unspecified Disorders of the Joint
10	Injury, Other and Unspecified	Symptoms Involving Digestive System

Medi-Cal		
The Top 10 Diagnosis for Inpatient Visits (other than those related to labor and delivery) (Oct. 1, 2013 – Sept. 30, 2014)		
	2013	2014
1	Unspecified Respiratory Abnormality	Septicemia
2	General Symptoms	Symptoms Involving Respiratory Systems and Other Chest Symptoms
3	Symptoms Involving Abdomen and Pelvis	Diabetes Mellitus
4	Septicemia	Asthma
5	Nonspecific Abnormal Findings	Cellulites and Abscess
6	Diabetes Mellitus	Heart Failure
7	Congestive Heart Failure	Pneumonia, Organism Unspecified
8	Pneumonia	Acute Appendicitis
9	Extrinsic Asthma	Cholelithiasis
10	Cellulites and Abscess	Chronic Bronchitis

The top three outpatient diagnoses for 2014 were Symptoms Involving Respiratory Systems and Other Chest Symptoms, Symptoms Involving Abdomen and Pelvis, and Disorders of Refraction and Accommodation. In terms of top three diagnoses for Inpatient, they were Septicemia, Symptoms Involving Respiratory Systems and Other Chest Symptoms, and Diabetes Mellitus.

IHSS

PASC-SEIU		
The Top 10 Diagnosis for Outpatient Visits (other than for well visits and pregnancy) (Oct. 1, 2013 – Sept. 30, 2014)		
	2013	2014
1	Unspecified Respiratory Abnormality	Symptoms Involving Respiratory Systems and Other Chest Symptoms
2	Symptoms Involving Abdomen and Pelvis	Symptoms Involving Abdomen and Pelvis
3	Unspecified Disorders of Back	General Symptoms
4	General Symptoms	Diseases of the Lung
5	Symptoms Involving Head and Neck	Symptoms Involving Head and Neck
6	Effusion of Joint	Unspecified Disorders of the Joint
7	Cellulites and Abscess	Injury, Other and Unspecified
8	Disorders of Soft Tissue	Disorders of Soft Tissue
9	Disorders of Urethra and Urinary Tract	Unspecified Disorders of Back
10	Involving Cardiovascular System	Spondylosis and Allied Disorders

PASC-SEIU		
The Top 10 Diagnosis for Inpatient Visits (other than for well visits and pregnancy) (Oct. 1, 2013 – Sept. 30, 2014)		
	2013	2014
1	Unspecified Respiratory Abnormality	Symptoms Involving Respiratory Systems and Other Chest Symptoms
2	Symptoms Involving Abdomen and Pelvis	Cholelithiasis
3	General Symptoms	Septicemia
4	Cholelithiasis	Episodic Mood Disorders
5	Septicemia	Asthma
6	Cardiac Dysrhythmias	Cellulites and Abscess
7	Calculus of Kidney and Ureter	Diseases of Pancreas
8	Cellulites and Abscess	Acute Myocardial Infarction
9	Diabetes Mellitus	Heart Failure
10	Acute Myocardial Infarction	Diabetes Mellitus

The top three outpatient diagnoses for 2014 were Symptoms Involving Respiratory Systems and Other Chest Symptoms, Symptoms Involving Abdomen and Pelvis, and General Symptoms. In terms of top three diagnoses for Inpatient, they were Symptoms Involving Respiratory Systems and Other Chest Symptoms, Cholelithiasis, and Septicemia. This is the third year for this product line.

The Centers for Medicare and Medicaid Services (CMS) approved the California Section 1115 Medicaid Waiver. The 1115 Waiver mandated the transition of Medi-Cal fee-for service Seniors and People with Disabilities (SPDs) to managed care Medi-Cal health plans across the state of California. The 1115 Medicaid Waiver transition began on June 1, 2011 and continued throughout 2012. L.A. Care continues to develop strong relationships with community-based organizations and specialty provider groups serving seniors and people with disabilities.

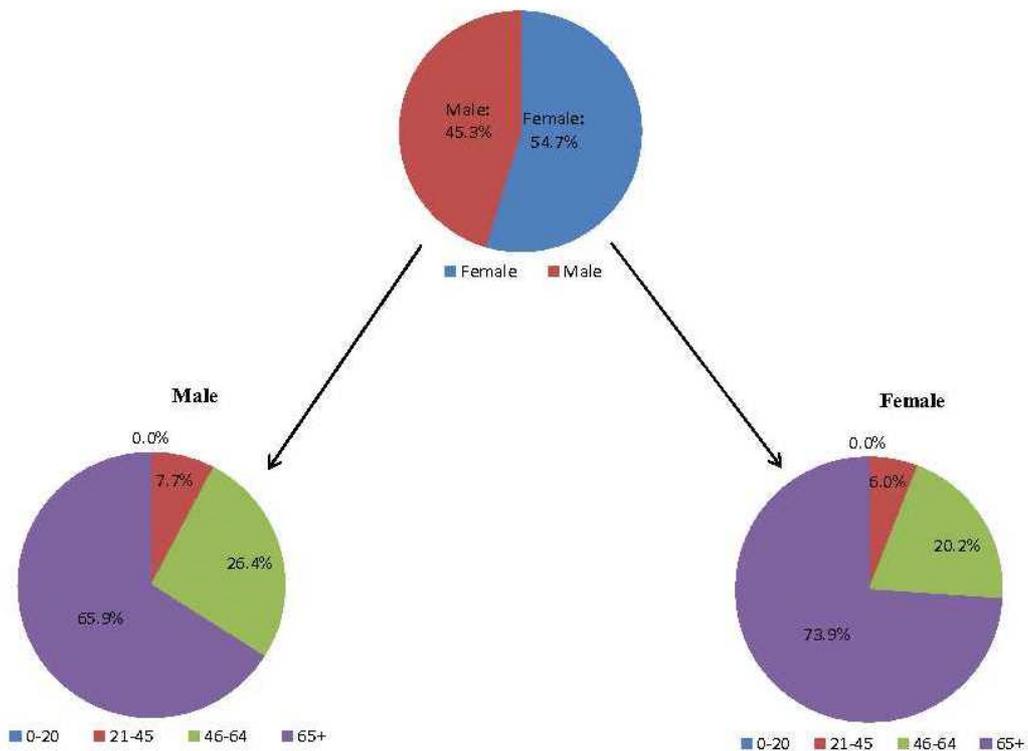
Medicare-SNP Membership

L.A Care’s Medicare SNP membership grew from 84 members in December 2008 to 9,177 members as of October 2014. The detail of L.A. Care’s Medicare membership profile is shown below:

Age	Number of Members	% of Membership
0-20	0	0.0%
21-45	621	6.8%
46-64	2,109	23.0%
65+	6,447	70.3%
Total	9,177	100%

Gender	Number of Members	% of Membership
Female	5,017	54.7%
Male	4,160	45.3%

L.A. Care Medicare Membership
Effective October 1, 2014



L.A. Care’s Medicare-SNP membership based on ethnicity can be seen in the table below: *Note: The majority of the SNP-members’ ethnicity (63.1%) is either unknown/blank or decline to state.*

Ethnicity	Number of Members	% of Membership
Hispanic/Latino	2,088	22.8%
Black/African American	680	7.4%
White/Caucasian	341	3.7%
Filipino	91	1.0%
Asian Pacific Islander	85	0.9%

Approximately 94.8% of the SNP members speak one of two languages as seen in the table below:

Language	Number of Members	% of Membership
Spanish	5,423	59.1%
English	3,276	35.7%

Seventy percent (70%) of L.A. Care Medicare SNP members are 65 years and over. Of adult membership, 55% are female and 45% are male. The main preferred languages spoken are divided between Spanish and English with Spanish being the predominant preferred language. L.A. Care strives to make available easy-to-read, well translated health education material, and continuously increases the availability of material in alternative formats (audio, Braille, large format).

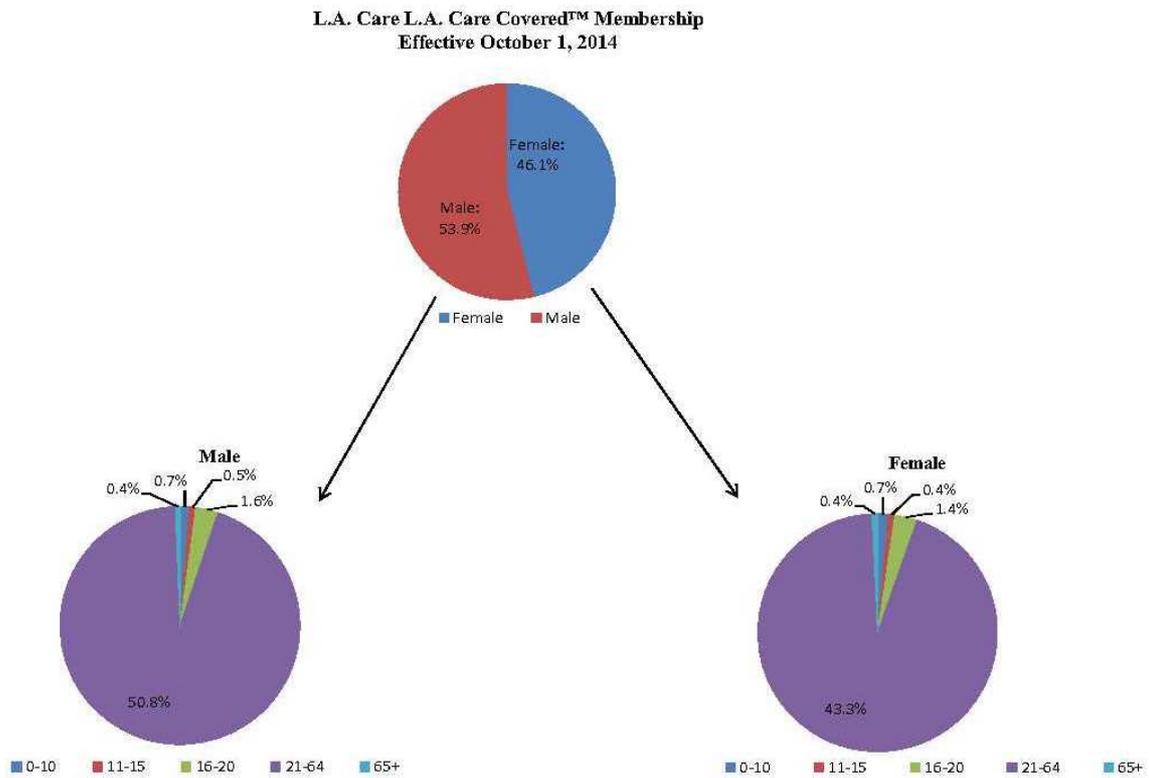
The Top 10 Diagnosis for Outpatient Visits (other than for well visits and pregnancy) (Oct. 1, 2013 – Sept. 30, 2014)		
	2013	2014
1	Unspecified Respiratory Abnormality	Symptoms Involving Respiratory Systems and Other Chest Symptoms
2	Symptoms Involving Abdomen and Pelvis	Diseases of the Lung
3	General Symptoms	Cardiac Dysrhythmias
4	Unspecified Disorders of Back	Acute Kidney Failure
5	Unspecified Disorders of Joint	General Symptoms
6	Disorders of Soft Tissues	Heart Failure
7	Symptoms Involving Head and Neck	Diabetes Mellitus
8	Disorders of Urethra and Urinary Tract	Symptoms Involving Abdomen and Pelvis
9	Diabetes Mellitus	Chronic Kidney Disease
10	Cataract	Schizophrenic Disorders

The Top 10 Diagnosis for Inpatient Visits (Oct. 1, 2013 – Sept. 30, 2014)		
2013		2014
1	Unspecified Respiratory Abnormality	Septicemia
2	General Symptoms	Symptoms Involving Respiratory Systems and Other Chest Symptoms
3	Congestive Heart Failure	Diabetes Mellitus
4	Symptoms Involving Abdomen and Pelvis	Schizophrenic Disorders
5	Septicemia	Heart Failure
6	Diabetes Mellitus	Acute Kidney Failure
7	Diseases of Lung	Cardiac Dysrhythmias
8	Cardiac Dysthymias	Osteoarthritis and Allied Disorders
9	Pneumonia	Chronic Bronchitis
10	Chronic Bronchitis	Pneumonia, Organism Unspecified

The top three outpatient diagnoses for 2014 were Symptoms Involving Respiratory Systems and Other Chest Symptoms, Diseases of the Lung, and Cardiac Dysrhythmias. In terms of top three diagnoses for Inpatient, they were Septicemia, Symptoms Involving Respiratory Systems and Other Chest Symptoms, and Diabetes Mellitus.

L.A. Care Covered™ Membership

As of October 1, 2014, L.A. Care had 23,751 L.A. Care Covered™ members. The detail of L.A. Care Covered™ membership profile is shown below:



Three ethnic groups make up 34.4% of L.A. Care's L.A. Care Covered™ membership as seen in the table below:

Ethnicity*	Number of Members	% of Membership
Caucasian/White	6,255	26.3%
Chinese	1,035	4.4%
Black/African American	887	3.7%

* 55.14% are unknown

89.2% of all L.A. Care L.A. Care Covered™ members speaks one of two languages as seen in the table below:

Language	Number of Members	% of Membership
English	15,300	64.4%
Spanish	5,887	24.8%

Approximately 5.3% of L.A. Care Covered™ members are under 21 years of age. Of the adult membership, approximately 43.6% are female and 51.1% are male. L.A. Care strives to make available easy-to-read, well translated health education material, and continuously increases the availability of material in alternative formats (audio, Braille, large format).

L.A. Care Covered™	
The Top 10 Diagnosis for Outpatient Visits (other than for well visits and pregnancy) (Oct. 1, 2013 – Sept. 30, 2014)	
2014	
1	Unspecified Essential Hypertension
2	Bacteremia
3	Abdominal Pain, Unspecified Site
4	Diabetes Mellitus Without Mention of Complication, Type II or Unspecified Type, Not Stated As Uncontrolled
5	Unspecified Anemia
6	Unspecified Cerebral Artery Occlusion With Cerebral Infarction
7	Acute Respiratory Failure
8	Chest Pain, Unspecified
9	Intracranial Abscess
10	Unspecified Hemiplegia Affecting Unspecified Side

L.A. Care Covered™	
The Top 10 Diagnosis for Inpatient Visits (other than those related to labor and delivery) (Oct. 1, 2013 – Sept. 30, 2014)	
2014	
1	Unspecified Essential Hypertension
2	Diabetes Mellitus Without Mention of Complication, Type II or Unspecified Type, Not Stated as Uncontrolled
3	Unspecified Anemia
4	Other And Unspecified Hyperlipidemia
5	Nondependent Tobacco Use Disorder
6	Acute Kidney Failure, Unspecified
7	Outcome Of Delivery, Single Liveborn
8	Urinary Tract Infection, Site Not Specified
9	Leukocytosis, Unspecified
10	Hypopotassemia

The top three outpatient diagnoses for 2014 were Unspecified Essential Hypertension, Bacteremia, and Abdominal Pain, Unspecified Site. In terms of top three diagnoses for Inpatient, they were Unspecified Essential Hypertension, Diabetes Mellitus without Mention of Complication, Type II or Unspecified Type, Not Stated as Uncontrolled, and Unspecified Anemia.

Clinical Care

L.A. Care targets four main areas for clinical care improvement: *health promotion and prevention, management of chronic conditions, management of episodic conditions, and monitoring the network for compliance with guidelines.* In the area of *health promotion and prevention*, L.A. Care sought to increase

the number of members who received breast and cervical cancer screenings, well child and adolescent visits, prenatal and postpartum care and other services to maintain women's health.

L.A. Care demonstrated significant improvement in three (3) HEDIS measures: Breast Cancer Screening, Chlamydia Screening in Women, and All-Cause Readmissions. There was significant decline in five (5) indicators: Timeliness of Prenatal Care, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis, Lead Screening in Children, Persistence of Beta Blocker Treatment after a Heart Attack, and HbA1c Poor Control (>9.0%).

Another Quality Improvement Project focused on chronic hypercholesterolemia. This chronic condition offers significant opportunity to improve practitioner practice and patient management. Depression was also identified as a prevalent condition. L.A. Care provided two chronic care improvement programs one for Diabetes and one on Reducing Cardiovascular Risk.

Throughout 2014, L.A. Care's NCQA accredited Managed Behavioral Health Organization (MBHO) provided specialty behavioral health services for members. L.A. Care worked with its MBHO to improve coordination of medical and behavioral care.

In order to monitor the network for compliance with guidelines, L.A. Care conducted medical record reviews that focus on various aspects of the guidelines. This process gives providers feedback and educates them at the same time. Healthcare Effectiveness and Data Information Set (HEDIS) measures are also used to monitor the network for compliance. Medical records reviewed by the FSR team indicate 88% compliance rate with "child" preventive guidelines and 96% compliance rate with "adult" preventive health guidelines (sample size 3,354).

L.A. Care's asthma, diabetes, and cardiovascular disease management programs continue to grow to provide education and support to empower members to manage their chronic conditions. The program has bilingual nurses who make outbound condition monitoring calls to members and has bilingual staff to answer the telephone resource lines. L.A. Care has expanded the phone coaching components of the asthma, diabetes, and cardiovascular programs to include bi-annual condition monitoring calls to level two members, in addition to continuing the quarterly condition monitoring calls to level three and four members. These changes resulted in increased outreach and engagement of members with chronic conditions.

In 2012 L.A. Care Health Plan CME Program was reaccredited for another four (4) years by The Institute for Medical Quality. The following are activities offered in the 2014 calendar year: A webinar discussing a new behavioral health screening tool, entitled "Screening, Brief Intervention and Referral to Treatment" was conducted by UCLA, The California Department of Health Care Services and L.A. Care, Feb.28, March 10, 24 and April 3, An activity for primary care providers entitled "Lesbian, Gay, Bisexual, Transgender/Questioning (LGBT/Q) Sensitivity Training. What Your LGBT/Q Patients Would Like You To Know" was offered on February 20, 2014 in joint providership with Care1st Health Plan. In addition, L.A. Care sponsored 5 additional CME events during 4th quarter 2014: Sept 30 "Keeping Children Healthy", October 6 "Women's Health Guidelines", December 3 & 11 "Applied Behavior Analysis", and December 10 "Substance Abuse Disorder".

The Cultural & Linguistic (C&L) Services Unit provides language access services, including translation, telephonic interpreting, and face-to-face interpreting, cultural competency trainings for L.A. Care staff and providers, and language proficiency assessment of L.A. Care staff. In 2014, the C&L Services Unit received and processed 1,543 translation requests totaling over two million words (2,161,427), an increase of 47% over the previous year's total. This increase was due to a large number of member letters, such as grievance acknowledgement letters and resolution letters, which accounted for

approximately 30% of translation requests. Spanish was the top requested language, followed distantly by Armenian, Traditional Chinese, and Khmer.

The C&L Services Unit provides face-to-face interpreters upon request at medical appointments, meetings, and health education classes. In 2014, a total of 1,917 face-to-face interpreting requests were processed, 1,681 for medical appointments, and 236 for administrative meetings and events, an increase of 71% over the previous year. The increase was due to an increased number of requests for interpreters at medical appointments resulting from the overall growth in membership. Top languages for medical appointments were American Sign Language and Spanish. Spanish was the top language for administrative appointments followed distantly by Khmer.

Telephonic interpreting services are offered to L.A. Care staff, network providers, pharmacies, and medical groups when communicating with members over the phone or when face-to-face interpreters are not available. In 2014, the C&L Services Unit's contracted telephonic interpreting services vendor provided services for 49,042 calls and 596,235 minutes. Utilization of telephonic interpreting services increased 67% over the previous year due to an increase in L.A. Care members as a result of Medi-Cal expansion and the initiation of L.A. Care Covered. Telephonic interpreting services were provided in a total of 79 languages.

Working collaboratively with the Human Resources Department, the C&L Services Unit ensures the success of the existing language assessment program for L.A. Care employees. Employees routinely using oral and/or written skills in a language other than English in their job position are assessed at the time of hire and reassessed every three years. In 2014, C&L Services Unit staff coordinated the assessment of language proficiency for 251 individuals and three-year renewal assessments for 81 employees.

The C&L Services Unit provides on-going education on C&L rights, requirements, services and resources, and cultural competency. Trainings are conducted for L.A. Care staff and network providers. The C&L Services Unit conducted a total of 50 trainings on C&L related topics in 2014, with a total of 795 attendees. The C&L Services Unit will continue to expand cultural competency curricula and educational trainings, with an increased focus on the special needs for the incoming Cal MediConnect population.

In 2014, the C&L Services Unit also worked with the Myers Group to administer the Enhancing Network Responsiveness Survey to network providers. A mixed methodology was employed (one wave mail with an option to fill out the surveys online, two email blasts, and a fax blast) to gather survey data for the Enhancing Network Responsiveness Analysis and Action Plan. The survey was sent to 1,000 eligible providers; a total of 104 providers completed the survey (68 by mail and 36 via internet). Some of the major findings of the report include:

- Surveyed providers had used the following resources to provide interpreting services in the three months prior to the survey: 72.5% had utilized bilingual staff, 10.8% had utilized other certified/trained medical interpreters, 9.8% had utilized L.A. Care's face-to-face interpreting services, 9.8% had utilized L.A. Care's telephonic interpreting services, and 19.6% had not utilized interpreting services.
- Findings indicate that 80% of the surveyed providers who were aware of L.A. Care's face-to-face interpreting services had used bilingual staff in the past three months to provide interpreting services compared to 20% of providers who had used L.A. Care's face-to-face interpreting services. Findings also show that that 73% of surveyed providers who were aware of L.A. Care's telephonic interpreting services had used bilingual staff in the past three months to provide telephonic interpreting services vs. 11% of providers who had used L.A. Care's telephonic interpreting services.

- In the three months prior to the survey, 88.3% of the providers had taken into account such factors as the patients' language, health literacy, cultural beliefs, etc. to help the patients make informed decisions and actively participate in their care.
- In the three months prior to the survey, 32.6% providers and providers' office staff had received training on cultural competency. The top 3 training modalities and times which surveyed providers were interested in attending trainings are: Lunch hour (noon-1pm) (50.5%), In-person (39.6%) and Webinar (with live presenter) (38.6%).

The Health Education Unit's *Health In Motion*[™] program delivers health education services to all direct line of business L.A. Care members via telephonic consultations and in-person group appointments by certified Health Coaches, Registered Dietitians, and Master's Level Health Educators. In 2014, Health Education conducted 1,253 encounters to members, 889 via phone and 364 via in-person group appointments and wellness workshops. Medical Nutrition Therapy and Diabetes Self-Management Education were the most requested services, with 265 and 232 phone encounters, respectively. Health Education workshops and group appointments are offered in provider offices and other community locations. Topics included Asthma Basics, Diabetes, Pre-Diabetes, Heart Health, and Healthier Living. Healthier Living is based on Stanford University's evidence-based chronic disease self-management program. Additionally, Health Education's Diabetes Self-Management Education and Support program received recognition from the American Diabetes Association in 2014. Finally, L.A. Care makes Weight Watchers coupons available for direct line of business members, except SNP, and provides up to 20 free weekly meeting coupons for eligible L.A. Care members. In 2014, a total of 177 members were sent weekly meeting coupons compared to 85 in 2013.

L.A. Care's *Healthy Lifestyle Program* aims to reduce rates of overweight and obesity and decrease weight-related chronic conditions among L.A. Care Covered members. The program improves member health status through identification of members who are overweight or obese and provision of member interventions. Members in the *Healthy Lifestyle Program* are identified via the Health Risk Assessment, provider referral, L.A. Care staff referral, or member self-referral. Upon identification, members receive a phone call from an L.A. Care Health Educator to complete an initial assessment. Members are then stratified into four risk levels based on their (self-reported) BMI. Levels are as follows: Level 1 = BMI < 25, Level 2 = BMI 25 – 29.9, Level 3 = BMI 30 – 34.9, Level 4: BMI ≥ 35. Services offered include written health education materials, an on-line weight management program, in-person Weight Watchers meetings, telephonic consultations with a Health Coach, and telephonic Medical Nutrition Therapy with a Registered Dietitian. The Health Education Unit launched the *Healthy Lifestyle Program* in January of 2014. In 2014, 318 members were identified as overweight or obese. Of those, 123 completed an initial assessment and enrolled in the program.

L.A. Care's *Smoke Free Program* is a tobacco cessation program for L.A. Care Covered members to help them live smoke free one day at a time. Members are identified as smokers via the Health Risk Assessment, pharmacy utilization data, provider referral, L.A. Care staff referral, or member self-referral. Once identified, participants are contacted by a trained L.A. Care health coach, who assesses the member for readiness to change, presence of children in the home, and high risk co-morbid conditions. Based on the assessment, the health coach determines the member's risk level and offers appropriate stop smoking services. Services range from health education materials and resources, to warm transfers to the California Smokers' Helpline, to coordination with their PCP and/or to L.A. Care's disease management program. Members in the program receive on-going follow up and support from a qualified health educator/health coach and/or disease management nurse. The Health Education Unit launched the *Smoke Free Program* in January of 2014. In 2014, 275 members were identified as eligible for the program. Of those, 34 completed the initial assessment and enrolled in the program.

To improve HEDIS postpartum screening rates, the Health Education Unit launched the “Healthy Mom” Postpartum Program in November 2012. This program provides assistance and support to members to schedule their postpartum visit including transportation coordination upon request and provision of an in-person interpreter if needed. Member outreach efforts include telephone calls to women who have recently delivered a baby to provide education on the importance of the postpartum visit, assistance with scheduling the visit – including assistance with transportation and interpreters if needed – and a \$40 incentive for attending the postpartum appointment. In September 2013, the incentive amount was increased to \$40 from a previous \$10 to more closely match incentives offered by Plan Partners. In fiscal year 2013-2014, a total of 2,688 members were called for postpartum appointment scheduling assistance, an increase of 128% over the previous fiscal year’s total of 1,179. Of these, 37% were successfully contacted. Additionally, Health Education unit staff visited 46 new mothers in-person at Antelope Valley Hospital, confirmed postpartum visits and sent gift cards to 757 women, an increase in 235% over last year’s total of 226. Health Education staff, together with Health Outcomes and Analysis, determined that in-person hospital visits were not effective, and discontinued visits in April 2014. The program continues to outreach to women telephonically.

To assist health plan staff in providing appropriate services and resources to L.A. Care members, the Health Education unit offers several training including Motivational Interviewing and Writing in Plain Language. Motivational Interviewing is a nine hour, two-session training which provides tools and guidance for L.A. Care staff about how to help members set their own health behavior goals. The *Writing in Plain Language* training provides tools and guidance on how to write easy-to-read materials for members. In 2014, six sessions of Motivational Interviewing consisting of two one-day session and four half-day refresher sessions were conducted with a total of 56 staff attending. Five sessions of *Writing in Plain Language* were conducted with 50 attendees. *Writing in Plain Language* is also available as an e-learning module for staff to access and view at their leisure. During 2014, 4 L.A. Care employees completed the Language module.

Patient Safety

Recognizing the role of health information technology in delivering safe, effective patient care, L.A. Care started offering an incentive program in 2007 to encourage physicians to adopt and use electronic health records (EHRs) in a meaningful way. The program helps practices select, implement, and achieve meaningful use with certified EHRs by offsetting upfront costs, complementing federal incentives available to many providers. Eligible physicians could receive up to \$6,000 for enrolling in HITEC-LA (\$500), adopting or upgrading to a certified EHR system (\$3,500), and achieving meaningful use Stage 1 (\$2,000). The program paid out \$4,245,000.

Pharmaceutical safety has been another area of focus for patient safety efforts. There are four pharmaceutical safety programs in place: Retrospective Drug Use Evaluation (DUE), Potentially Inappropriate Medication (PIM) and Level 1 (highest) severity drug-drug interactions.

Another patient safety monitoring effort is accomplished through the Potential Quality Issue (PQI) investigation and peer review process. In 2014, the investigation and referral processes continued to be enhanced. The Quality Improvement (QI) Department conducts departmental training to raise L.A. Care staffs as well as network providers’ awareness in identification of PQIs. The QI department conducts a thorough internal investigation on all PQIs. In 2014 there were 269 cases reviewed as compared 104 in 2013. This is a 158% increase. The increase is attributable to better identification and increased training regarding the process.

Critical Incident Reporting is another patient safety monitoring effort added in 2014. All L.A. Care staff and network providers are trained to identify and report on all Critical Incidents (abuse, exploitation, neglect, disappearance/missing member, a serious life threatening event, restraints or seclusion, suicide

attempt or unexpected death) by member when identified. The program is put in place to promote the health, safety and welfare of L.A. Care's Cal MediConnect members.

L.A. Care also enhanced patient safety through the facility site review (FSR) process by monitoring elements related to patient health and safety. The two measures monitored were: (a) Needle stick safety precautions practiced on site, and (b) Spore testing of autoclave/steam sterilizer with documented results (at least monthly). Compliance with needle stick precautions dropped from 67% in 2013 to 63% in 2014. Spore testing dropped from 87% in 2013 to 83% in 2014. Neither was statistically significant.

Addressing Disparities

Each year the QI program evaluation noted analysis of HEDIS data to identify and address any ethnic disparities. The HO&A Department completed this analysis by measure in 2014. This year's evaluation contains a separate analysis for each HEDIS measure by SPD or non SPD, race, ethnicity, gender, age, and RCAC (Regional Community Advisory Committee) region. Highlights from the analysis shows culture, ethnicity, and geography can change perception and participation in seeking and attaining preventive healthcare.

Member Experiences, Satisfaction, and Access to Care

L.A. Care has a TTY software called ipTTY to help staff communicate more efficiently with Deaf and hard of hearing members. L.A. Care has a total of 3 toll free 800 numbers that ring into three different groups who had the software installed. The ipTTY software allows for internal staff and after hours vendor, AnsaFone, to receive and dial out calls to and from members at any time of day. L.A. Care has a process implemented for daily testing of the ipTTY software. ipTTY has worked properly every time meeting all company requirements.

All users of the software attended a mandatory training class which provided a brief history on TTY as well as how to actively use the new software. For Fiscal Year 2013-2014 one in-person and one webinar training sessions on "How to Communicate with the Deaf and Hard of Hearing using TTY" were conducted by the Interpreting Services Specialist and Senior Telecommunication Administrator. This course provided basic information about: 1) Deaf culture, 2) History and characteristics of American Sign Language, 3) Literacy of the deaf and hard of hearing, 4) Regulations that mandate L.A. Care to provide TTY services, 5) TTY devices, 6) Etiquette and communication style of TTY, 7) Glossary of commonly used TTY abbreviations, and 8) Software demonstration.

Member Participation, Community Outreach and Education

L.A. Care continues to support its Regional Community Advisory Committees (11) throughout Los Angeles County by working collaboratively to address health disparities that impact vulnerable and low income residents and communities.

In its continuing effort to address the systemic issue of obesity in low income and vulnerable communities, L.A. Care's Community Outreach and Engagement (CO&E) Departments Active Steps Program (ASP) were strategically provided in 6 RCAC regions found to have the highest rates of health disparities (obesity, diabetes, and hypertension) where community residents can experience a program where they are able to come together with their peers and experience the first step to bettering not only their health but their families as well with free nutrition education and physical activity classes. This year, a partnership was formed with the Los Angeles Trust and their Wellness Centers in providing the program. 194 community members participated in the ASP with a 68% retention rate that completed the 16 session effort, knowledge increased by an average of 16% (pre-test 72%, post-test 87%), significant reductions ($p < 0.05$) were also shown in their Body Mass Index (BMI) scores, weight loss, waist circumference, reduction of fried food consumption as well as any soda or sugary beverage consumption.

Furthermore, significant improvements ($p < 0.05$) were found in their perception of their health status as 31.5% reported a healthier status, increase in the levels of physical activity (low, moderate, high) were seen, consumption of fruits, vegetables, and water intake were found, self-efficacy towards reading food labels and getting their families to be more involved in a healthier lifestyle. Community Wellness Champions were also identified, trained, and certified in Zumba Basic in order to keep the program sustainable for years to come.

Health Promoter's (HP) Program: In July 2014, 23 community members graduated from the health promoter's 10-week training program. Together with the 2012 health promoter (HP) graduates, they initiated over 250 outreach efforts reaching thousands of L.A. County residents from lower socio-economic backgrounds by teaching community workshops, hosting resource tables at community health fairs, wellness expos, and participating in other events. Topics included access to health care, health care reform, nutrition, asthma, women's health, and other health related wellness classes. In 2014, the health promoters worked closely with our USC MPH graduate students in developing new educational theater show and created a preventive health care series. Topics vary from women's health, mental health, dental health, routine check-ups, diabetes, fitness, nutrition, and the flu. HPs also continued teaching the RCACs on preventive care, urgent care, emergency care, nurse advice line, pre-diabetes, grievances, and continued the updates on health care reform. HPs also continued in the Active Steps by increasing their involvement by co-teaching 3 classes (Personal Goal Setting, My Plate Nutrition, and Rethink Your Drink). They continued helping with data collection: body measurements, surveys, 1:1 follow-up phone sessions implementing the motivational interviewing technique, and reporting. Continuing the CO&E presence at the America Public Health Association's annual conference, select staff members hosted a roundtable session to explain the benefits of partnerships between community and academic in public health research, programs and interventions. Discussed was the role of community health workers in public health interventions and research and described various methods for effective collaboration between community and academic partners.

Marketing and Activities:

L.A. Care provides support to multiple initiatives throughout the organization utilizing the services of the in-house Marketing Department, Health Plan Field Representatives, Community Outreach and Education Representatives, Health Educators and the Family Resource Centers. Marketing staff participates in workgroups to collaborate and develop collateral materials in formats, languages and reading levels to support member and consumer understanding of their benefits, programs and services that they are eligible for. Marketing staff are aligned by product lines; health plan initiatives and the recently expanded Family Resource Centers. Centers are now open and operating in Lynwood, Inglewood, Boyle Heights and Pacoima. Centers provide free health education and healthy living services in underserved communities. Community and member awareness messaging and campaigns are developed and implemented throughout L.A. County in the form of marketing, educational events and advertising on health and insurance programs specifically targeted to communities where access to quality health care is limited.

The Health Plan Field and Community Outreach and Education Representatives and Health Educators conduct outreach educational and marketing events to extend the opportunity for consumers and members to learn more about Medi-Cal, Healthy Kids, Medicare, Cal MediConnect, and the Covered California Marketplace. Community based educational events, health fairs and open house events are prescheduled and are posted on L.A. Care's web site and promoted through social media to provide members and non-members with information on the conveniently located events that are conducted throughout L.A. County.

Additional education outreach is provided to Enrollment Entities & their down-line Certified Application Assistants (CAAs) and Certified Enrollment Counselors (CECs) to educate and update them on the programs that L.A. Care members receive as well as eligibility for L.A. Care's product lines including

Medi-Cal, Healthy Kids, Cal MediConnect and Covered California. L.A. Care continually seeks opportunities to improve provider awareness and secure their commitment to L.A. Care through participation in joint operational meetings, physician quality improvement programs, incentive programs, health educational events and building and maintaining effective relationships. The target focus of the provider outreach is for providers who serve low-income seniors and people with disabilities.

Member-focused newsletters are distributed to our members four times a year (including our health plan partners' Medi-Cal enrollment) that focuses on (a) helping members navigate the managed Medi-Cal system to obtain care; (b) understanding the benefits and services available. Two newsletters are utilized to better focus the content based on the need to communicate to young and building families as well as the aging and disabled members that we serve. *Be Well* addresses the interests of young and building families and *Live Well* is designed to address the interests of aging and disabled members.

Required CMS Reporting for Part C and D

The Compliance department gathered and submitted all required reporting for Part C and D to CMS on time in 2014. Reports were reviewed by their respective areas for accuracy and completeness.

QI Work Plan

The organization's quality improvement work plan effectively monitors and reports on the numerous quality-related efforts underway throughout the organization. The work plan was updated and reviewed by the Quality Oversight Committee (QOC) on a quarterly basis. Highlights from the work plan continue to be reported to the Compliance and Quality Committee (C&Q) by the CMO and key departmental representatives.

Physician Incentive Programs:

L.A. Care's Quality Improvement (QI) department operates pay-for-performance (P4P) incentive programs for providers to improve HEDIS, CAHPS, auto-assignment, and member satisfaction. Incentive programs provide a highly visible platform to engage providers in quality improvement; increase provider accountability for performance; provide peer-group benchmarking and actionable performance reporting; and deliver performance-based revenue above capitation. Incentives for physicians, community clinics, PPGs, and health plan partners are aligned wherever possible so that L.A. Care's partners share performance improvement priorities. These programs are additionally designed to incorporate best practices of organizations that provide leadership at the state and national levels, including the Integrated Healthcare Organization (IHA) and CMS.

Physician Pay-for-Performance (P4P) Program

2014 marked the fourth year of L.A. Care's Physician P4P Program, which targets high-volume solo and small group physicians and community clinics. The Physician P4P Program provides performance reporting and financial rewards for practices serving L.A. Care Medi-Cal and L.A. Care Covered members, and represents an opportunity to receive significant revenue above capitation. Eligible physicians receive annual incentive payments for outstanding performance and year-over-year improvement on multiple HEDIS measures—16 were included in 2014, and auto-assignment measures were double-weighted (these have a greater role in determining physician and clinic performance scores and incentive payments).

Final performance reports and incentive payments for the 2014 Physician P4P Program are scheduled for the 4th quarter of 2015. Additionally, \$10.8 million in incentive payments were made for the 2013 Physician P4P Program in the 4th quarter of 2014.

LA P4P for PPGs

2014 marked the fifth year of L.A. Care's LA P4P pay-for-performance program, which targets PPGs serving members in Medi-Cal and L.A. Care Covered. When it was introduced in 2010, LA P4P measured and rewarded provider groups primarily for encounter data submission. Beginning in year 2, the program expanded to include additional performance domains, including a HEDIS clinical quality domain that mirrors the Physician P4P Program, and that rewards provider groups for both high performance and year-over-year improvement. In addition to clinical quality, LA P4P now measures, reports, and rewards provider group performance and improvement in appropriate resource use (utilization) and patient experience (based on the CG-CAHPS survey instrument). In 2014 a new encounter data gating methodology was introduced into the program. Incentive payments to provider groups across all payment domains are now adjusted to reflect the volume of encounter data received by L.A. Care, which reinforces the organization's efforts to improve administrative data capture. Incentives staff created and distributed a new report for PPGs in 2014 to show progress on encounter data reporting and to help guide improvement. Final P4P performance reports and incentive payments for the 2014 program are scheduled for the 4th quarter of 2015. Additionally, \$9 million in incentive payments were made for the 2013 LA P4P program in the 4th quarter of 2014.

Plan Partner Incentive Program

The QI incentives team re-designed plan partner performance incentives for 2014. This new program aligns the efforts of L.A. Care with those of its strategic partners as a critical point for improving the outcomes and satisfaction of members. L.A. Care's restructured program combines several older programs into one unified program that promotes improvement on L.A. Care's core metrics and improvements in encounter data submission. Participating health plan partners receive incentive payment for defined improvement in L.A. Care's auto-assignment measures based on both administrative data and hybrid chart review. A portion of each plan's incentive is tied to the encounter data submission performance of its largest PPGs, as measured in the LA P4P program—this is an important example of the interconnectedness of L.A. Care's provider incentive programs. Incentives staff created and distributed a new report for participating health plans in 2014 to show mid-year progress on the program's HEDIS measures. Final performance reports and incentive payments for the 2014 program are scheduled for the 4th quarter of 2015. Additionally, \$8.25 million in incentive payments were made for the 2013 plan partner incentive programs in the 4th quarter of 2014.

Member Incentives:

The QI incentives team operated several member incentives in 2014 to improve member utilization of critical clinical services. The following member incentives operated in QI in 2014:

Well-Child 3-6 Member Incentive

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (HEDIS W34) measures the proportion of eligible members who receive one or more well-child visits with a PCP during the measurement year. To encourage members to receive this important primary care service, L.A. Care offered an incentive to MCLA members beginning in August. Eligible members were those who had not yet received needed service in 2014. This program provided eligible members and their legal guardians an incentive offer (a \$20 Target gift card to parents, and a gift set to the child for completion of a well care visit), as well as valuable education about the importance of an annual well care visit. A total of 1,789 gift cards were awarded.

Cervical Cancer Screening Member Incentive

Cervical Cancer Screening (HEDIS CCS) measures the proportion of female members 21-64 years of age who received at least one pap test in the measurement year or in the 2 prior years. To encourage members

to receive this vital service, L.A. Care offered an incentive to MCLA members beginning in August. This program provided eligible members a \$50 Target gift card offer, as well as valuable education about the importance of cervical cancer screening. A total of 3,307 gift cards were awarded.

Health Risk Assessment (HRA) Member Incentive

The HRA member incentive accompanied the launch of L.A. Care's new L.A. Care Covered product line in 2014. New members receive a health risk assessment form as part of their new member welcome kit, and are asked to complete and return the survey within 120 days of enrollment. To underscore the value of this assessment, members were offered a \$25 gift card offer. A total of 2,081 gift cards were awarded

L.A. Care Covered Wellness Incentive

The QI incentives team launched a time-limited incentive in late 2014 to encourage members to receive a preventive care visit in the measurement year. Members in the L.A. Care Covered line of business were sent an incentive offer for a \$25 gift card, as well as valuable education about the importance of an annual well care visit. A total of 248 gift cards were awarded.

Effectiveness of these incentives will be established once HEDIS 2015 results are released in June 2015. We will then be able to compare HEDIS 2014 results to HEDIS 2015 to determine if an improvement is noted.

Patient Centered Medical Home

The Patient Centered Medical Home (PCMH) Initiative aligned with L.A. Care's mission to provide access to quality health care for Los Angeles County's vulnerable and low income communities and to support the safety net required to achieve this purpose. This project upheld L.A. Care's organizational objectives of enhanced provider systems and performance while increasing provider and patient satisfaction. The initiative also prepared, developed and sustained a provider network to serve additional seniors and people with disabilities as part of the State of California's 1115 Waiver process, and prepared for Medi-Cal expansion through the health care reform.

The PCMH model reduced health system costs by decreasing emergency department visits and increasing office visits among clinics with a small SPD population. L.A. Care's PCMH helped transform 17 practices to meet the NCQA Patient-Centered Medical Home Recognition. The first cohort of 10 practices, which began in October, 2010, consisted of over 90 primary care providers who served approximately 30,000 L.A. Care members. Six of the selected practices were community clinics, two were private practices, and two were residency training programs. The second cohort, which began in May 2012, consisted of 7 community clinic practices serving approximately 16,000 L.A. Care members. The goals and objectives of this project included building capacity in L.A. Care's provider network, preparing for new payment and care models to help support robust PCMH practices, improving outcomes and reducing costs. L.A. Care hired a nationally recognized PCMH consultant, Qualis Health, to provide workshops and help the practices become NCQA PCMH Recognized.

Status of Practices Achieving NCQA PCMH Recognition

The Initiative formally ended Oct. 31, 2014. To date, twelve practices achieved NCQA PCMH Recognition, one is awaiting a decision, two were declined recognition, one decided not to apply, and one decided to apply for The Joint Commission certification.

An external evaluator will complete the final report of the practices' patient and leadership surveys by March 2015. An article will be submitted for publication by Health Outcomes and Analysis on quality outcomes.

QI COMMITTEE SUMMARY

L.A. Care's quality committees oversee various functions of the QI program. The activities of the quality committees were formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and follow-up required. Draft minutes of the prior meeting were reviewed and approved at the next meeting. Minutes were then signed and dated. Minutes were also reported to their respective Committee as required. All activities and associated discussion and documentation by the committee participants were considered confidential and shall abide with L.A. Care policies and procedures for written, verbal, and electronic communications. The committees serve as the primary mechanism for intradepartmental collaboration for the Quality Program.

Compliance and Quality Committee (C&Q)

The Compliance and Quality Committee (C&Q) is a subcommittee of the Board of Governors (BoG). The C&Q monitors quality activities and reports its findings to the BoG. The Compliance and Quality Committee is charged with reviewing the overall performance of L.A. Care's quality program and providing direction for action based upon findings to the BoG. The C&Q met six (6) times in 2014. The Compliance and Quality Committee reviewed and approved the 2014 QI and UM program descriptions, 2014 QI and UM work plans, quarterly QI work plan reports, and 2013 evaluations of the QI and UM programs. The Committee also reviewed periodic reports on quality activities.

Quality Oversight Committee

The Quality Oversight Committee (QOC) is a cross functional staff committee of L.A. Care which reports to the Board of Governors through the Compliance and Quality Committee. The QOC is charged with aligning organization-wide quality improvement goals and efforts prior to program implementation and monitoring the overall performance of L.A. Care's quality improvement infrastructure. The QOC met five (5) times in 2014. The Quality Oversight Committee conducted the following activities:

- Reviewed current projects and performance improvement activities to ensure appropriate collaboration and minimize duplication of efforts.
- Conducted as well as reviewed quantitative and qualitative analysis of performance data of reports and subcommittee reports.
- Identified opportunities for improvement based on analysis of performance data.
- Tracked and trended quality measures through quarterly updates of the QI work plan and other reports.
- Reviewed and made recommendations regarding quality delegated oversight activities such as reporting requirements on a quarterly basis.
- Reviewed, modified, and approved policies and procedures.
- Reviewed and approved the 2014 QI and UM program descriptions, 2014 QI and UM work plans, quarterly QI work plan reports, and 2013 evaluations of the QI and UM programs.

Joint Performance improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC)

The Joint Performance and Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC) membership includes Plan Partners, Provider Groups, and practitioner participation in the QI program through planning, design, and review of programs, quality improvement activities and interventions designed to improve performance. The committee provides an opportunity to dialogue with the provider community and gather feedback on clinical and administrative initiatives. The committee also provides an opportunity to improve collaboration between L.A. Care and delegated Plan Partners/Provider Groups and practitioners by providing a platform to discuss reports, assess current interventions in place, and propose new interventions to improve HEDIS and CAHPS results and other measures as defined. The Joint Performance and Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC) reports to the Quality Oversight Committee.

The Joint PICC and PQC met four (4) times in 2014. The Joint PICC and PQC contributions in 2014 included:

- Made recommendations to L.A. Care about barriers and causal analysis relating to quality improvement activities and administrative initiatives.
- Reviewed and approved updated clinical practice and preventive health guidelines.
- Provided input and made recommendations to L.A. Care's Quality Oversight Committee (QOC) on policy decisions, as well as quality and service improvements.
- Discussed clinical report results and how to improve results based on their practice and experience with L.A. Care membership.
- Provided feedback and recommendations regarding the Behavioral Health program.

Utilization Management Committee

The Utilization Management Committee (UMC) is responsible for overall direction and development of strategies to manage the UM Program. The Committee met five (5) times in 2014. The UM Committee assessed the utilization of medical services, reviewed and made recommendations regarding utilization management or case management, reviewed and made recommendations regarding UM delegated oversight activities. The UMC was also responsible for the review, revision and approval of all UM policies and procedures, the Model of Care Program Description, 2013 UM program evaluation, 2014 UM program description and the 2014 UM Program Work Plan.

Credentialing Committee

The Credentialing Committee addressed credentialing, recredentialing activities and demonstrated follow-up on all findings and required actions. The Committee met 10 times in 2014. The Credentialing Committee reviewed L.A. Care's credentialing and recredentialing activities, policies and procedures, made recommendations for each practitioner regarding credentialing delegated oversight activities, made recommendations regarding credentialing and recredentialing for each practitioner, and coordinated peer review activities.

Peer Review Committee

The Peer Review Committee (PRC) addressed peer review activities to assess and improve the quality of care and demonstrated follow-up on all findings and required actions. The Committee met nine (9) times in 2014. The Peer Review Committee is responsible for overseeing the quality of medical care in order to determine whether accepted standards of care have been met by investigating and resolving potential problems brought to the PRC as potential quality of care issues (PQI) or PQIs. The Committee also provided oversight of all closed and delegated PQI cases.

Pharmacy, Therapeutics, and New Technology Committee

The Pharmacy, Therapeutics, and New Technology (PT&T) Committee is responsible for evaluating drugs and drug therapies for the following direct lines of businesses: Medi-Cal, PASC-SEIU (aka IHSS), and Health Kids and making formulary coverage determinations on these drugs. The PT&T Committee is also responsible for reviewing new medical technologies or new applications of existing technologies and provided recommendations for benefit coverage based on medical necessity.

The Committee met five (5) times in 2014 and conducted the following reviews: newly marketed drugs for potential placement on the formulary, current formulary status of drugs for appropriateness and possible deletion with the replacement of newer, safer, or more cost-effective drugs. The Committee also served as an advisory capacity on medication therapy, the development and implementation of pharmacy policies and procedures, the identification of the need for medical education programs for physician and pharmacy providers to support and enhance the health care outcomes goals for L.A Care members, the approval of generic substitution, prior authorization, therapeutic interchange, and step therapy written guidelines and protocols, and the development of protocols/procedures to access non-formulary drugs. If a new medical technology or new application of existing technologies is considered as a medical benefit, the recommendation(s) from PT&T will be forwarded to Utilization Management Committee for benefit coverage based medical necessity.

The role of the PT&T meeting changed in November 2014, due to the Pharmacy Benefits (PBM) transition from MedImpact to Navitus to take place on 1/1/2015. The PT&T committee functions were delegated to Navitus as of 1/1/2015 and the PT&T Committee at L.A. Care was restructured to the Pharmacy Quality Oversight Committee (PQOC). The PQOC Committee is responsible for oversight of the P&T process administered by the existing Pharmacy Benefit Manager (PBM) and review new medical technologies or new applications of existing technologies. This is for all L.A. Care direct lines of business. The PQOC's role is to review and evaluate drugs and drug therapies to be added to, or deleted from, the formulary and to review new medical technologies or new applications of existing technologies and recommend for benefit coverage, based on medical necessity.

Member Quality Service Committee (MQSC)

The Member Quality Service Committee (MQSC) is responsible for improving and maintaining the L.A. Care member experience for all product lines. This Committee met four (4) times in 2014. The committee reviewed analysis the following sources to identify opportunities for improvement in member satisfaction as identified in the following: Member Satisfaction Surveys, Member Retention Reports, Access & Availability Surveys, Grievances & Appeals Data, and Interface of Provider Satisfaction with Member Satisfaction. The committee also acts as a Steering Committee for member quality service issues.

L.A. Care Behavioral Health Collaborative Committee

The L.A. Care Behavioral Health Collaborative Committee is responsible for developing, implementing and monitoring interventions based on the analysis of collected data that result in an improvement in continuity and coordination of medical and behavioral health care (mental health and substance abuse). L.A. Care delegated specialty behavioral health services for Healthy Kids, and PASC-SEIU Home Workers, Medicare SNP, and Medi-Cal members to an NCQA accredited Managed Behavioral Health Organization (MBHO). L.A. Care worked closely with its MBHOs in order to collaborate with behavioral health practitioners (BHPs) and use information collected to improve and coordinate medical and behavioral health care. This committee met four (4) times in 2014. The Committee performed substantive review and analysis of quarterly reports from the MBHO; assessed exchange of information between BHPs and PCPs, assessed appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care settings, assessed appropriate use of psychopharmacological

medications and consistent guidelines for prescribing by behavioral and medical practitioners, collaboratively monitored the secondary prevention behavioral health program (postpartum depression screenings for Healthy Kids, and Medicare SNP members) and evaluated the effectiveness of the program. Using quantitative data and causal analysis, L.A. Care and MBHO identified and took action on areas of opportunity annually.

L.A. Care is collaboratively working with Beacon to conduct activities to improve coordination of behavioral healthcare and general medical care including collaborating with their behavioral health and substance abuse practitioners. With bringing on a new MBHO, L.A. Care identified an opportunity to improve the Behavioral Health Collaborative Committee; therefore, enhanced the committee membership to include practitioners from the Los Angeles County Department of Mental Health (DMH), Los Angeles County Alcohol and Drug Treatment Services Program under Department of Public Health (DPH), and Participating Provider Groups (PPGs). Additionally, L.A. Care secured a new Behavioral Health Medical Director, who will chair the committee. With the restructure of the committee members, the committee will focus on improving quality improvement initiatives related to behavioral health aspects, avoiding duplication of efforts, improving coordination of services to members, prioritizing initiatives, and increasing collaborative efforts to include new committee members.

Continuing Medical Education Committee

The Continuing Medical Education (CME) Committee develops, implements, and evaluates L.A. Care's CME program and oversees the (re)application process for maintaining CME accreditation status. The Continuing Medical Education Committee convenes on an as needed basis through either email or teleconference communication. Reports of these communications are provided to the QOC and Board of Governors. There has been 1 email communication in CY 2014. The Continuing Medical Education Committee reviews CME applications, policies and procedures, and receives pertinent updates from the Institute for Medical Quality.

A. CLINICAL CARE AND SAFETY

A.1 PREVENTIVE SERVICES/WELL CARE VISITS

2014 WORK PLAN GOALS:

HEDIS Measure	2014 Medi-Cal Goal	2014 Medicare-SNP Goal
Well-Child Visits 3-6 Years (W34)	75%	
Adolescent Well-Care Visits (AWC)	57%	
Childhood Immunization Status Combination 3 (CIS-3)	82%	
Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	BMI: 74% NUTRITION: 77% PHYSICAL ACTIVITY: 70%	
Adult Body Mass Index Assessment (ABA)	77%	85%

BACKGROUND

Preventive services and well-care visits play an important role in preventing disease and managing health across the age spectrum. For children, clinical guidelines recommend periodic well-care visits to monitor growth, assess development, and identify potential problems. The Healthcare Effectiveness Data and Information Set (HEDIS) measures health plan performance on several important dimensions of care and services including annual well-care visits for children 3-6 years of age (W34) and adolescents 12-21 years of age (AWC); a number of childhood immunizations (CIS); weight assessment and counseling for nutrition and physical activity for children and adolescents (WCC); and adult body mass index assessment (ABA). Providers must use codes specified by HEDIS when completing encounter forms as well as provide medical record documentation. For example, during a Well Child or Adolescent Well Care visit, the provider must document all five mandatory visit components were completed in the medical record: health history; physical developmental history; mental developmental history; physical exam; and health education/anticipatory guidance.

Maintaining a healthy weight is vital in reducing the risk of many chronic diseases such as diabetes, hypertension, and certain cancers, thus L.A. Care works to address the obesity epidemic by increasing awareness of strategies to prevent and treat obesity, such as promoting body mass index (BMI) assessment in children (WCC) and adults (ABA). Additionally, L.A. Care works to enhance community-driven and patient centered disease prevention and health promotion efforts through activities and programs offered through several L.A. Care departments, including Health Education, Community Outreach and Engagement (CO&E), and Family Resource Centers (FRCs).

MAJOR ACCOMPLISHMENTS

- L.A. Care's Medi-Cal 2014 HEDIS rate and Medicare Star rate for Adult BMI Assessment both exceeded their respective 2014 goals.
- L.A. Care led a CME-approved event for physicians entitled, "Preventive Health Guidelines: Keeping Children Healthy" on September 30, 2014; there were 42 attendees.

- L.A. Care addressed several preventive services/well care measures through a continued and expanded QI Incentives strategy which engages providers, physician groups, and plan partners in the QI process through the use of benchmarking, performance reporting, and incentive payments. Below are some 2014 highlights of various QI Incentive programs (with included preventive services/well care measures noted in parentheses):
 - For the LA Pay-for-Performance (LAP4P) provider group incentive program (W34, CIS-3, AWC) and the Physician Pay-for-Performance (P4P) provider incentive program (W34, CIS-3, AWC), the W34 and CIS-3 measures were doubly weighted in calculating LAP4P payments in 2014.
 - A restructured Plan Partner Incentive Program (W34, CIS-3) was launched for measurement year 2014.
- Additionally, member and physician specific incentives in 2014, included:
 - A limited time August 1- December 31, 2014 incentive for MCLA Medi-Cal members 3-6 years of age who completed an annual well-child visit during this timeframe. The incentive included a gift package for the child and a \$20 gift card for the guardian.
 - A continuation of a \$350 physician incentive for the completion and submission of Medicare members' Annual Wellness form, which includes BMI assessment among other important preventive services and tests.
- In January 2014, the Health Education Unit launched the *Healthy Lifestyle Program* which aims to reduce rates of overweight and obesity and decrease weight-related chronic conditions among L.A. Care Covered members.
- In 2014, the Community Outreach and Engagement Department, implement the *Active Steps Program* in 6 RCAC regions and saw significant change ($p < 0.5$) in BMI among participants.
- In 2014, L.A. Care mailed updated Preventive Health Guidelines to all households.
- In 2014, L.A. Care developed Preventive Health Guideline posters, which were mailed out to all L.A. Care network physicians. In addition, the Preventive Health Guidelines were made available for physicians on the L.A. Care website.

Description of measures:

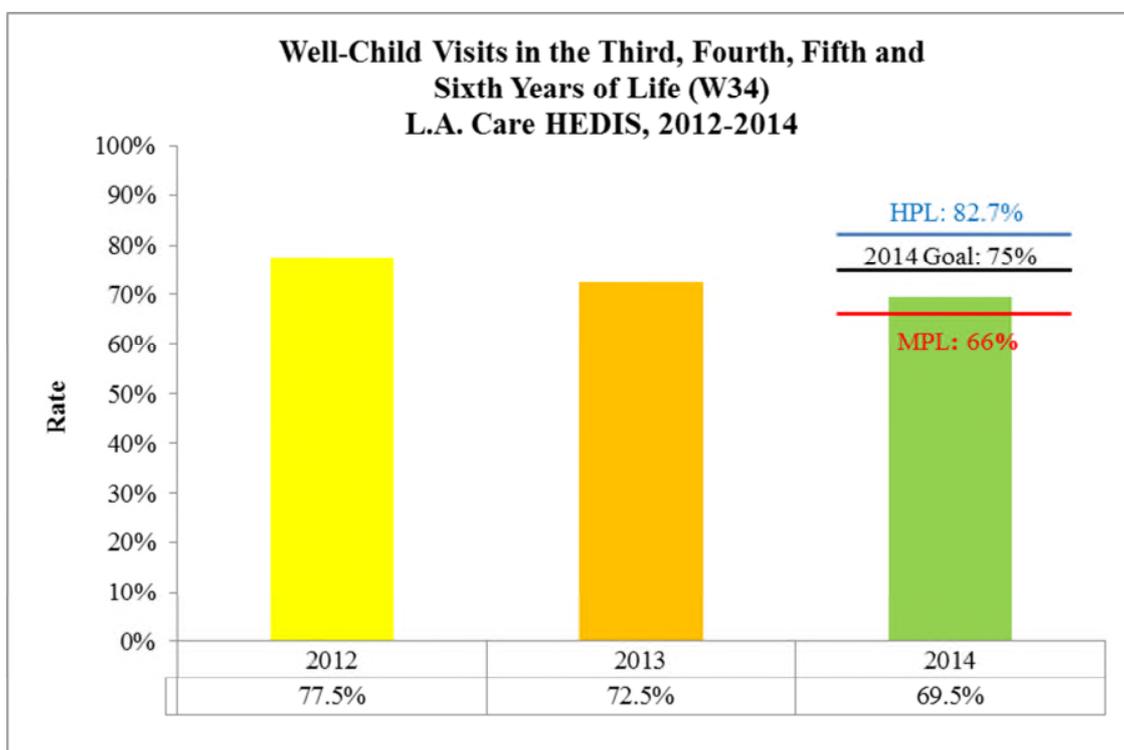
HEDIS Measure	Specific Indicator(s)	Measure Type
Well-Child Visits 3-6 Years (W34)	The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	Hybrid
Adolescent Well-Care Visits (AWC)	The percentage of members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Hybrid
Childhood Immunizations Combination 3 (CIS-3)	The percentage of children 2 years of age who had: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday.	Hybrid
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – BMI	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> • BMI percentile documentation* • Counseling for nutrition • Counseling for physical activity <p>*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed</p>	Hybrid

HEDIS Measure	Specific Indicator(s)	Measure Type
	rather than an absolute BMI value (note that for those 16-17 years of age, BMI value can meet criteria).	
Adult BMI Assessment (ABA)	The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) (or for those <19 years of age, a BMI percentile) was documented during the measurement year or the year prior to the measurement year.	Hybrid

RESULTS

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

The following graph compares L.A. Care’s Medi-Cal W34 HEDIS rate from 2012, 2013, and 2014 to L.A. Care’s 2014 goal.



ANALYSIS

Quantitative Analysis

In 2014, the well child visits rate for children between three and six years of age was 69.5%. This was a decrease of 3.0 percentage points from the 2013 rate of 72.5%. The 2014 rate of 69.5% did not reach L.A. Care’s 2014 Goal of 75%; however, exceeded the Minimum Performance Level (MPL) 66%. Overall, the rate has decreased 8.0 percentage points from 2012 to 2014.

Disparity Analysis

L.A. Care also conducted an analysis based on gender, ethnicity, language, age group, and RCAC regions to examine whether disparities exist in getting well care visits for children between three and six years of

age. Age group and ethnicity were the only major disparities found for the W34 measure. Six year-old children had the lowest rate among the age groups. Hispanic children had the highest rate (72.5%) while black children had the lowest rate (50.0%). There were no statistically significant disparities noted.

Qualitative Analysis

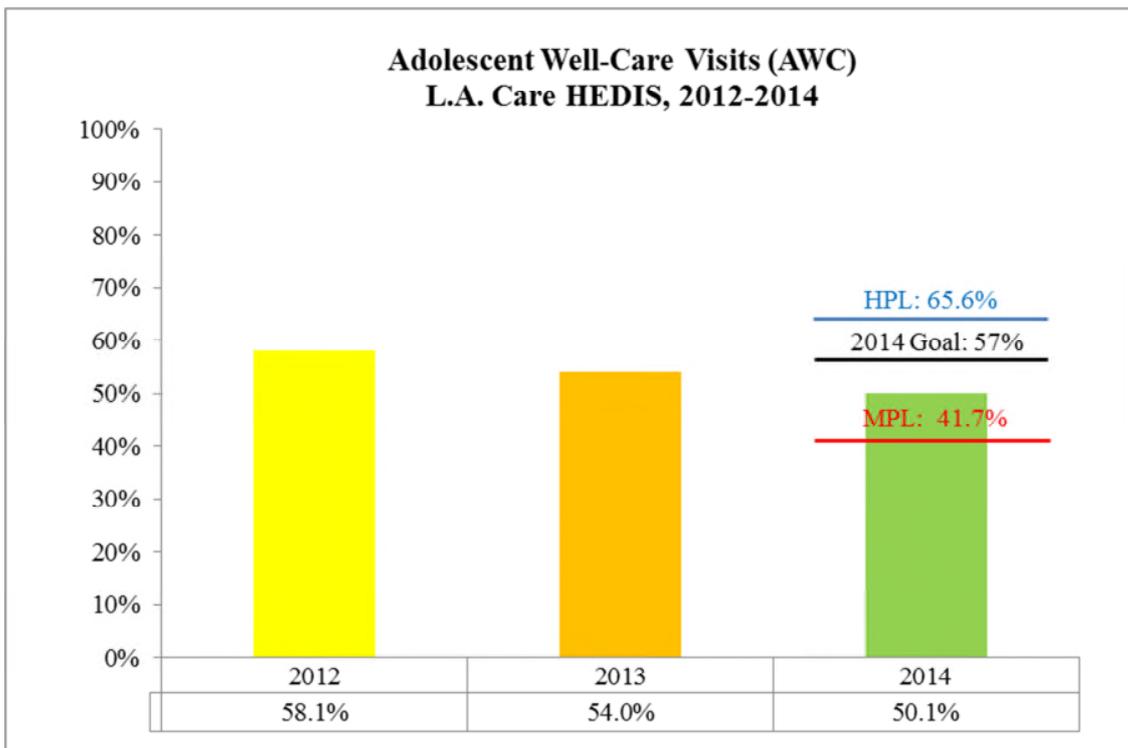
The W34 Medi-Cal HEDIS rate has presented a downward trend for the past three years. If the current trend for the W34 measure continues, L.A. Care may be at risk of falling below the MPL in 2015. L.A. Care recognized the need for additional efforts to increase the rates; therefore, implemented and reinforced several provider and member interventions in 2014.

One of the major barriers identified in achieving a better rate is the difference in well-care visit schedules between the Child Health and Disability Prevention (CHDP) and the American Academy of Pediatrics (AAP). The CHDP periodicity table does not require annual well-care visits, while AAP does. In addressing this issue, L.A. Care annually provides HEDIS-based well-care visit schedules to providers and provider opportunity reports that lists patients needing care to encourage outreach to these patients missing services. Additionally, in 2014, a CME-approved event was held to educate providers on Preventive Health Guidelines for children.

RESULTS

Adolescent Well-Care Visits (AWC)

The following graph compares L.A. Care’s Medi-Cal AWC HEDIS rate from 2012, 2013, and 2014 to L.A. Care’s 2014 goal.



ANALYSIS

Quantitative Analysis

L.A. Care's Adolescent Well-Care (AWC) visit rate in 2014 was 50.1%; this was a 3.9 percentage point decrease from the 2013 rate of 54.0%. L.A. Care did not meet its 2014 goal of 57%; however, it did meet the MPL of 41.7%. Overall the rate has decreased 8.0 percentage points from 2012 to 2014.

Disparity Analysis

L.A. Care conducted an analysis based on gender, ethnicity, language, age group, and RCAC regions to examine whether disparities exist in getting well care visits for adolescents. The only major disparity found was within age groups. The older age group (ages 17-21) had a significantly lower AWC rate compared to the younger group (ages 12-16).

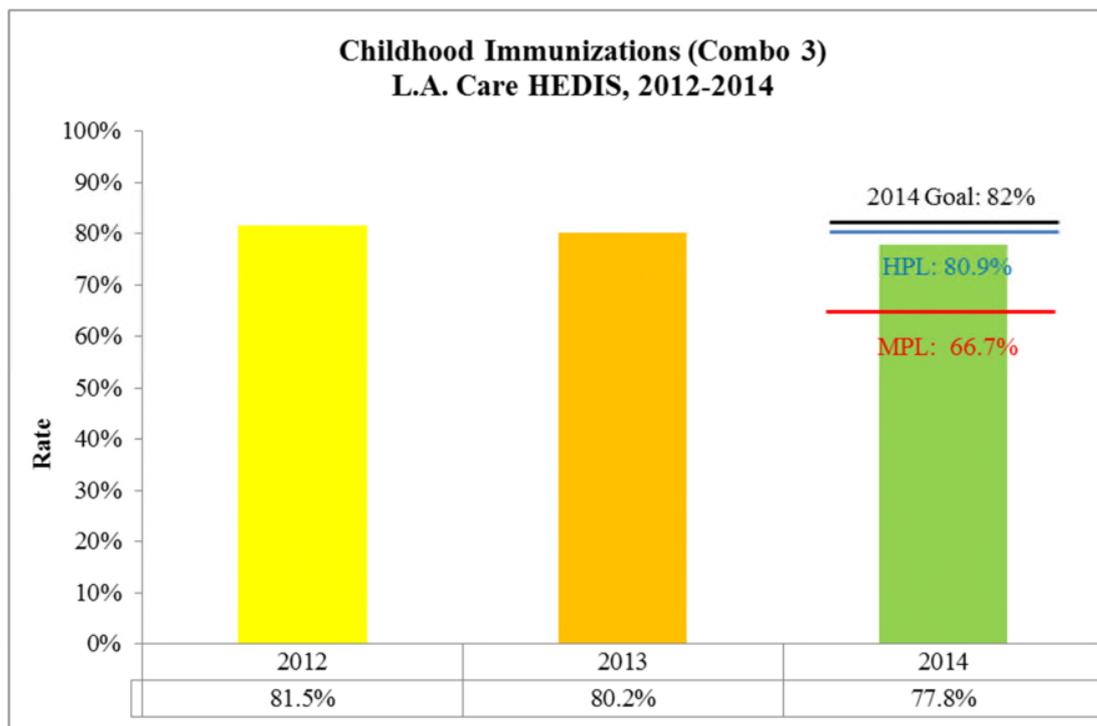
Qualitative Analysis

Encouraging adolescents to get a well-care visit has been an ongoing challenge. L.A. Care's Adolescent Well-Care Visits HEDIS rate improved in 2012 and 2013 from the 2011 rate, however in 2014 the AWC rate is nearly back to the 2011 rate of 49.2. L.A. Care has taken on a multi-disciplinary approach to address adolescent well-care, including incentives for provider groups and physicians and provider education. The AWC measure was included in year 2 and remains part of the Physician Pay-for-Performance program for Medi-Cal.

RESULTS

Childhood Immunization Status, Combination 3 (CIS-3)

The following graph compares L.A. Care's Medi-Cal CIS-3 HEDIS rate from 2012, 2013, and 2014 to L.A. Care's 2014 goal.



ANALYSIS

Quantitative Analysis

L.A. Care's Childhood Immunization Status, Combination 3 rate in 2014 was 77.8%; this was a 2.4 percentage point decrease from the 2013 rate of 80.2%. L.A. Care did not meet its 2014 goal of 82%; however, it did exceed the MPL of 66.7%. Overall the rate has decreased 3.7 percentage points from 2012 to 2014.

Disparity Analysis

L.A. Care conducted an analysis based on gender, ethnicity, language, age group, and RCAC regions to examine whether disparities exist in childhood immunization status. Two statistically significant disparities were found. Black children had the lowest rate at 58.3%, which was significantly lower than other populations. Additionally, there was a language disparity found where the Spanish speaking population showed a significantly higher CIS-3 rate than the English speaking population (86.4% vs. 71.5% respectively).

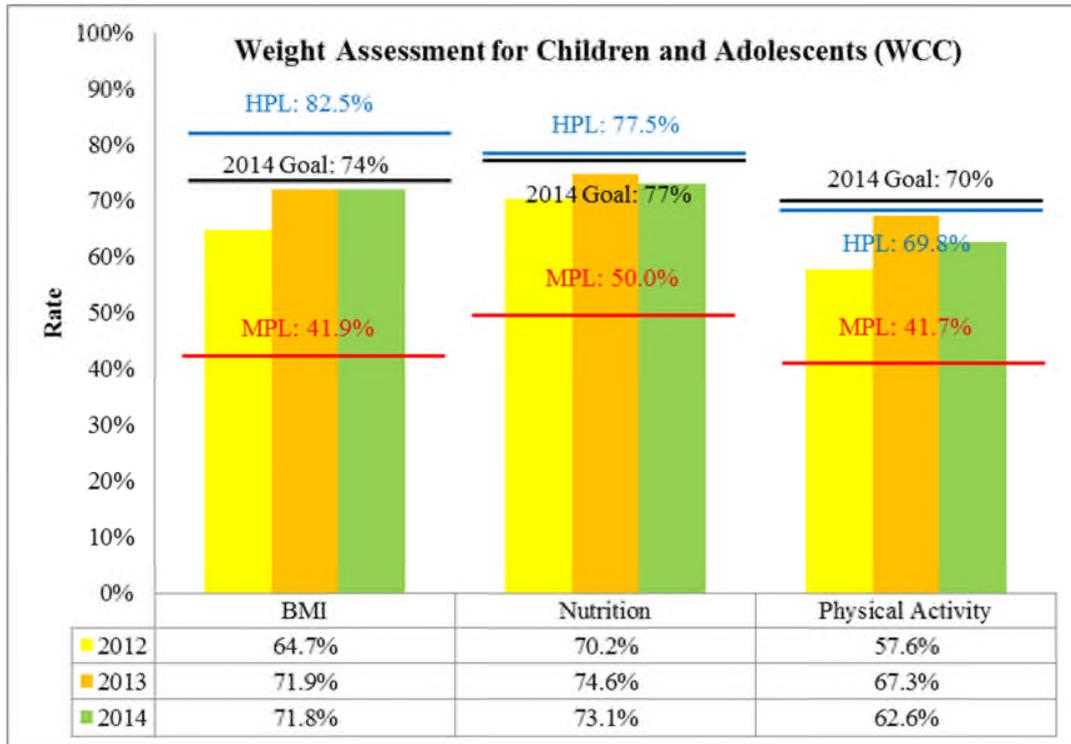
Qualitative Analysis

The HEDIS rate for CIS-3 demonstrates a slowly declining three year trend. The complexity of the immunization schedule and lack of education about the importance of basic vaccination series to members' guardian(s) may be some of the factors why members are not getting immunized as recommended. L.A. Care has addressed this issue by providing members with an immunization schedule and reminders through various means, such as distributing the revised Preventive Health Guidelines and posting it on the L.A. Care website. L.A. Care also sent out provider opportunity reports and made the member detail report available at the L.A. Care provider portal. Physicians can identify members in his/her panel needing immunizations from the posted list and perform outreach to those patients needing care.

RESULTS

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

The following graph compares L.A. Care's Medi-Cal WCC HEDIS rate in 2012, 2013, and 2014 to L.A. Care's 2014 goal.



Quantitative Analysis

L.A. Care’s 2014 rate for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) is composed of three components: BMI assessment (WCC – BMI), counseling for nutrition (WCC – Nutrition), and counseling for physical activity (WCC – PA).

The rate for BMI assessment remained relatively stable from the previous year – 71.8% in 2014 compared to 71.9% in 2013. L.A. Care’s 2014 goal of 74% was not met; however the MPL of 41.9% was exceeded. Overall, from 2012 to 2014, the WCC – BMI rate has increased 7.1 percentage points.

The 2014 rate for counseling for nutrition was 73.1%; this was a decrease of 1.5 percentage points from the 2013 rate of 74.6%. The goal of 77% was not met, though the MPL of 50% was exceeded. Overall, from 2012 to 2014, the WCC – Nutrition rate increased 2.9 percentage points.

The 2014 rate for counseling for physical activity was 62.6%; this was a decrease of 4.7 percentage points from the 2013 rate of 67.3%. The goal of 70% was not met; however the MPL of 41.7% was exceeded. Overall, from 2012 to 2014, the WCC – PA rate increased 5 percentage points.

Disparity Analysis

L.A. Care conducted an analysis based on gender, ethnicity, language, age group, and RCAC regions to examine whether disparities exists in Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescent for BMI.

- *BMI Assessment* – There were statistically significant disparities noted with gender, where females had a higher rate than males, 77.8% compared to 67.0% respectively.
- *Counseling for Nutrition* – No significant disparities were found for this component of the measure.

- *Counseling for Physical Activity* –There was a statistically significant difference in age group, where the older adolescent age group (12-17 years of age) had a higher rate compared to the younger age group (3-11 years of age).

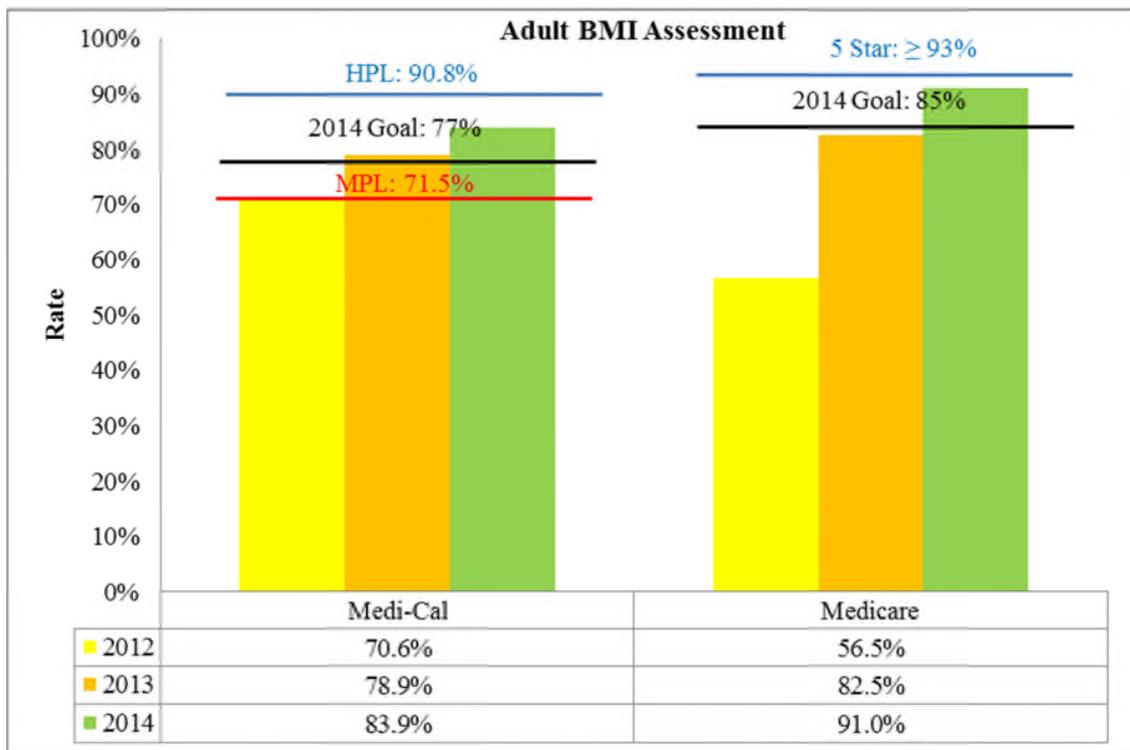
Qualitative Analysis

With an understanding of the socio-ecological model, L.A. Care realizes that a multi-pronged approach is needed to address the multitude of factors that can potentially impact weight status in childhood into adulthood. L.A. Care works to address the obesity epidemic by increasing awareness of strategies that can prevent and treat obesity, including the promotion of BMI assessment and nutrition and physical activity counseling in children (WCC) – something that can initiate a conversation between the provider and the member and/or guardian.

RESULTS

Adult BMI Assessment (ABA)

The following graph compares L.A. Care’s Medi-Cal ABA HEDIS and L.A. Care’s Medicare Star ABA rates in 2012, 2013, and 2014 to their respective L.A. Care 2014 goals.



ANALYSIS

Quantitative Analysis

L.A. Care’s Medi-Cal 2014 rate for Adult BMI Assessment (ABA) was 83.8%; an increase of 4.9 percentage points from the 2013 rate of 78.9%. L.A. Care’s goal of 77% was met; however, L.A. Care fell below the Quality Compass 90th percentile of 90.8%.

L.A. Care’s Medicare 2014 rate for ABA was 91.0%, which was an increase of 8.5 percentage points from the 2013 rate of 82.5%. L.A. Care’s goal of 85% was met however did not reach the 2015 5-Star threshold of 93%.

Disparity Analysis

L.A. Care conducted an analysis within the Medi-Cal population based on gender, ethnicity, language, age group, and RCAC regions to examine whether disparities exists in Adult BMI rates. There were no significant disparities for this ABA measure.

Qualitative Analysis

Both Medi-Cal and Medicare rates for the ABA measurement have seen continued improvement from 2012 to 2014. Many factors could be influencing this positive trend, including but not limited to, increased provider utilization of BMI as a clinical indicator, a greater number of providers using EMR with the benefit of BMI being automatically calculated with the entry of member height and weight during encounters, as well as improved provider record abstraction. In 2014, HEDIS nurses addressed and educated selected providers on the importance of proper documentation and member follow-up for needed services, which encompassed the ABA measure. With an increase awareness of their weight status, members may take a next step towards utilizing community-driven and patient centered disease prevention and health promotion resources and programs offered to members. Additionally, L.A. Care’s Health Education unit is increasing the capacity of its staff to effectively communicate with and enhance positive behavior change in members through the offering of several trainings - Motivational Interviewing and Writing in Plain Language.

The table below summarizes the barrier analysis with the actions for each measure:

HEDIS Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
Well-Child visits 3 to 6 years	<ul style="list-style-type: none"> • Providers continue to follow the CHDP periodicity table (rather than the AAP schedule), which does not require annual Well-Care visits. • Conflicting information for providers from AAP and CHDP as to the recommended Well-Care visit schedules. • Missing documentation of key elements. • Large eligible population. • Members/Caregivers do not perceive the importance of Well-Child visits. 	<ul style="list-style-type: none"> • L.A. Care continued the LA Pay-for-Performance (LAP4P) provider group incentive program and the Physician Pay-for-Performance (P4P) provider incentive program for Medi-Cal, which includes the W34 HEDIS measure. The W34 measure was doubly weighted in calculating LAP4P payments in 2014. • Provider Opportunity Reports were provided (July and October 2014) to inform groups and providers of their year to date performance to encourage outreach to members in need of the service. • In 2014, L.A. Care developed a new (limited time August 1- December 31, 2014) incentive for Medi-Cal members 3-6 years of age to complete an annual well-child visit. The incentive included a gift package for the child and a \$20 gift card for the guardian. • In 2014, L.A. Care distributed updated Preventive Health Guideline posters to physicians for use in their offices. • In September 2014, L.A. Care led a CME-approved event for physicians entitled, “Preventive Health 	See results above

HEDIS Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		<p>Guidelines: Keeping Children Healthy”; there were 42 attendees.</p> <ul style="list-style-type: none"> • In November 2014, two “Well-Care Visit Checklist” stamps were distributed to 526 provider offices not currently using EMR to assist with documentation of the 5 required visit components. • L.A. Care distributed updated Preventive Health Guidelines to members. The PHG are member-friendly, easy to understand, and useful to members. • Preventive health guidelines which include well-child visit schedule are available at L.A. Care website for both providers and members. 	
Adolescent Well-Care visit	<ul style="list-style-type: none"> • Adolescent members do not want to attend a clinic that caters to young children. • Providers indicate that it’s very difficult to get teens into the office. 	<ul style="list-style-type: none"> • In 2014, Provider Opportunity Reports were provided (July and October) to inform groups and provider of their year to date performance to encourage outreach to members in need of the service. • A list of members needing care was also provided at the L.A. Care provider portal where providers can identify the noncompliant members and conduct outreach. • This measure was included in both LAP4P and Physician P4P Programs for incentives at the provider group and physician levels for Medi-Cal. • In 2014, L.A. Care developed and distributed updated Preventive Health Guideline posters to physicians for use in their offices. • In September 2014, L.A. Care led a CME-approved event for physicians entitled, “Preventive Health Guidelines: Keeping Children Healthy”; there were 42 attendees. • In November 2014, two “Well-Care Visit Checklist” stamps were distributed to 526 provider offices not currently using EMR to assist with documentation of the 5 required visit components. • In 2014, L.A. Care distributed updated Preventive Health Guidelines to members that are member-friendly, easy to understand, and useful to members. • Preventive health guidelines, which include well-care visit schedule for both providers and members, are available at L.A. Care website. 	<p>See results above</p>

HEDIS Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
Childhood Immunization Combo 3	<ul style="list-style-type: none"> • Due to the complexity of the immunization schedule, parents may not fully understand the recommended immunization schedule for their children. • Lack of education about the importance of basic vaccination series to parents of members. • Parents may perceive taking time off from work to get immunizations, sometimes without pay. • Missed opportunities - physicians should take advantage of all appropriate patient contacts, including acute office visits for minor illnesses, to keep children's immunizations current. • Incomplete coding of immunizations result in chart requests. • Language and RCAC region disparity. 	<ul style="list-style-type: none"> • In 2014, LAP4P and P4P programs changed the program incentive calculations to double weight the CIS-3 measure. • In 2014, L.A. Care distributed updated Preventive Health Guideline posters to physicians for use in their offices. • In 2014, L.A. Care distributed updated Preventive Health Guidelines that included an immunization schedule. • Preventive health guidelines and current immunization schedule for both providers and members are available on the L.A. Care website. • CIS measure information was shared at PPG, County, and Plan Partner meetings to increase awareness and encourage strategic improvement. • In October 2014, L.A. Care's Health Outcomes and Analysis (HO&A) team worked with the California Immunization Registry (CAIR) to improve their member matching algorithm. 	See results above
Weight Assessment and Counseling for Nutrition and Physical Activity for Children / Adolescents	<ul style="list-style-type: none"> • Providers are not aware of the WCC measure. • Providers do not know how to properly document BMI in a patient's record. • Providers do not always know how to properly diagnose/measure and or treat obesity (using BMI). • Members may not be aware of need or value of physical activity counseling • Members may not be motivated to obtain physical activity counseling. • Members may not be aware of physical activity counseling resources. • Ethnicity and sex disparity. • Health plan staff may not be interacting with members using the most effective means of goal setting and communication. 	<ul style="list-style-type: none"> • L.A. Care's HEDIS nurses conducted office visits to provider offices to educate office staff on proper documentation of BMI and counseling for nutrition. • In 2014, Family Resource Centers (FRCs) continued to offer a variety of fitness and health classes and educational materials to members. • In 2014, L.A. Care's Health Education department sent eligible direct LOB members up to 20 free weekly meeting coupons for Weight Watchers. • In 2012 and 2013, nutrition and fitness presentations were conducted for each RCAC. • In 2014, the Health Education unit offered several trainings including Motivational Interviewing and Writing in Plain Language to staff including Certified Health Coaches, Registered Dietitians, and Master's Level Health Educators. 	See results above
Adult BMI Assessment (ABA)	<ul style="list-style-type: none"> • Providers are not aware of the ABA measure. • Providers do not know how to properly document BMI in a patient's record. • Providers do not always know how to properly diagnose/measure/treat obesity (using BMI). • Members may not be aware of the need or value of achieving a healthy 	<ul style="list-style-type: none"> • L.A. Care's HEDIS nurses conducted office visits to provider offices to educate office staff on proper documentation of BMI and counseling for nutrition. • In 2014, Family Resource Centers (FRCs) continued to offer a variety of fitness and health classes and educational materials to members. • In 2014, the Health Education Unit's 	See results above

HEDIS Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
	<p>weight to prevent/manage chronic disease and maintain QOL/ADLs as one ages.</p> <ul style="list-style-type: none"> Members may not be aware of and/or motivated to obtain nutrition and/or physical activity counseling. Members may not be aware of resources available around physical activity, nutrition, and disease management. Health plan staff may not be interacting with members using the most effective means of goal setting and communication. 	<p><i>Health In Motion</i>TM program conducted 1,253 encounters to members, 889 via phone and 364 via in-person group appointments and wellness workshops.</p> <ul style="list-style-type: none"> In 2014, L.A. Care's Health Education department sent eligible direct LOB members up to 20 free weekly meeting coupons for Weight Watchers. In 2012 and 2013, nutrition and fitness presentations were conducted for each RCAC. L.A. Care has continued a Medicare incentive for Physicians who accurately complete and submit the members' Annual Wellness form. Physicians are given \$350 per calendar year for each form. The form includes preventive services like BMI assessment as well as tests for diabetes and other important services. In 2014, the Health Education unit offered several trainings including Motivational Interviewing and Writing in Plain Language to staff including Certified Health Coaches, Registered Dietitians, and Master's Level Health Educators. 	

LOOKING FORWARD

L.A. Care will continue to work on improving current successful interventions for these HEDIS measures as well as the following for 2015:

- Continue to collaborate with plan partners on updating Preventive Health Guidelines to create a widely distributed common version that is easy to understand and more appealing to members – included in distribution are Medi-Cal, Medicare, and LACC membership.
L.A. Care will continue to share updated Preventive Health Guidelines with providers so they can discuss with their members.
- L.A. Care will produce and distribute provider group and physician level opportunity and performance reports which include preventive/well-care measures of W34, AWC, and CIS. This performance reporting will be expanded to include LACC membership.
- Member level incentives will be considered to motivate members accessing care to receive preventive services.
- L.A. Care will continue to offer provider education training packets, specific to the Medicare population, including preventive guidelines, clinical guidelines, coding references, a BMI wheel, and other useful tools.
- Priority HEDIS measure information, including these preventive/well-care measures, will be shared at PPG, County, and Plan Partner meetings to increase awareness and encourage collaborative and strategic improvement for the benefit of all our members.

2015 WORK PLAN GOALS:

HEDIS Measure	2015 MEDI-CAL GOAL	2015 CAL-MEDICONNECT GOAL	2015 L.A. CARE COVERED GOAL
Well-Child Visits 3-6 Years (W34)	72%		
Adolescent Well-Care Visits (AWC)	59%		
Childhood Immunizations Combination 3 (CIS-3)	78%		
Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	BMI: 74% Nutrition: 77% Physical Activity: 70%		
Adult Body Mass Index Assessment (ABA)	85%	93%	*

*New LOB, goal TBD based on year 1 HEDIS data when it becomes available

IMPROVING RATES OF ADULTS’ ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES (MEDICARE)

2014 WORK PLAN GOAL:

HEDIS MEASURE	2014 GOAL
Adults’ Access to Preventive/Ambulatory Health Services (AAP)	85%

BACKGROUND

A visit to the primary care provider (PCP) offers patients an opportunity to discuss their health issues/concerns with their PCP, obtain preventive screenings and help detect and monitor chronic health conditions. This is especially relevant to the adult and senior populations. Given the importance of such visits, access to primary care visits is designated as one of L.A. Care work plan initiatives.

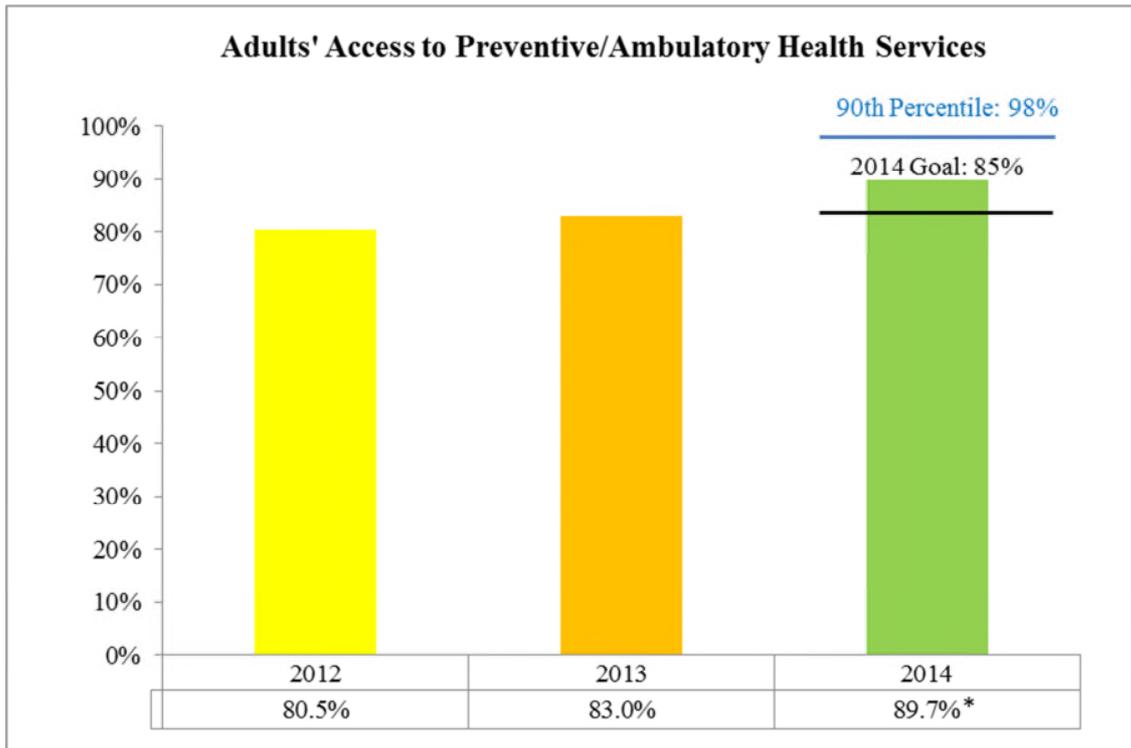
MAJOR ACCOMPLISHMENTS

- L.A. Care improved this HEDIS measure by 6.7 percentage points compared to last year and by 9.2 percentage points compared to baseline. L.A. Care developed and mailed a Preventive Health Guideline poster to all providers to be placed in exam rooms
- SNP members received a Preventive Health Guideline (PHG) brochure to educate members about required health services such as getting a wellness visit every year
- L.A. Care distributed provider education training packet which included resources for SNP providers such as the latest preventive guidelines, clinical guidelines, coding references, etc.
- L.A. Care continued physician-level incentives for Annual Wellness Exam (AWE) Physician incentive program.
- Physicians conducted home visits to SNP members who had not already received an annual wellness exam. Members with care gaps and those identified as being home-bound were prioritized.

Description of measures:

HEDIS Measure	Specific Indicator(s)	Measure Type
Adults' Access to Preventive/Ambulatory Health Services (AAP)	The percentage of members 20 years and older who had an ambulatory or preventive care visits.	Administrative

RESULTS



*Statistically significant

Quantitative Analysis

In HEDIS 2014, the rate for Adults' Access to Preventive/Ambulatory Health Services was 89.7%, which was a statistically significant increase of 6.7 percentage points from the HEDIS 2013 rate of 83.0%. Starting from HEDIS 2013, this measure was no longer a star measure; therefore, the rate was compared to L.A. Care's 2014 goal of 85%. L.A. Care has met its goal in HEDIS 2012-2014.

INTERVENTIONS

HEDIS Measure	Barriers	Actions
Adults' Access to Preventive/Ambulatory Health Services (AAP)	<ul style="list-style-type: none"> Members may not have the time, transportation available or physical capability to visit their primary care provider. Members may not realize the importance of visiting their primary care provider. 	<ul style="list-style-type: none"> L.A. Care's Quality Improvement (QI) Department developed a new Preventive Health Guidelines (PHG) poster for physicians to place in their offices. The poster was mailed to all physicians. L.A. Care's Quality Improvement (QI) Department developed the new

HEDIS Measure	Barriers	Actions
		<p>Preventive Health Guidelines (PHG) brochure that are member friendly and target SNP members and their requirements.</p> <ul style="list-style-type: none"> • L.A. Care developed a provider education training packet which included resources for SNP providers such as the latest preventive guidelines, clinical guidelines, coding references, etc. • January-July 2014, annual wellness exams were offered to SNP members by their PCPs. Starting from August 2014, home assessments by a PCP or a nurse practitioner were offered to SNP members (members with gaps in care and members that are home-bound were prioritized) who had not already received an annual wellness exam • L.A. Care mailed physician level Provider Opportunity Reports as produced by the Health Outcomes and Analysis (HO&A) Department. The reports targeted SNP providers and included preventative health screening measures. • L.A. Care continued physician-level incentives for Annual Wellness Exam (AWE) Physician incentive program, for physicians who conduct annual wellness exam for eligible SNP members; \$350 incentive per visit with completion of AWE form

LOOKING FORWARD

- Since the AAP measure is no longer a STAR measure, L.A. Care will not report the measure in the 2015 QI Evaluation, but will continue to monitor it via the CMS webpage.

A.2 PERINATAL SERVICES

2014 WORK PLAN GOALS:

HEDIS Measure	2014 Medi-Cal GOAL
Timeliness of Prenatal Care	87%
Postpartum Care	59%

BACKGROUND

Perinatal services which include “timeliness of prenatal visits” and “postpartum care” are an important component of maternal and child health. Inadequate prenatal care may result in pregnancy-related complications and may lead to potentially serious consequences for both the mother and the baby¹.

MAJOR ACCOMPLISHMENTS

- L.A. Care’s “Healthy Mom” postpartum program, which provides assistance and support to women to schedule their postpartum visit, reached 1,087 women of which 74% completed their postpartum visit.
- L.A. Care’s MCLA HEDIS rate improved 4.2% over the previous year, from 45% to 49.2%.
- L.A. Care’s Health Education and Cultural Linguistic Department sends out women’s health postcards targeting L.A. Care’s MCLA members between the age of 18 and 75 years old. These postcards reminded women about the following health screenings: 1) Pap test; 2) Mammogram; 3) Pregnancy doctor's visits; and 4) Children's immunizations.
- L.A. Care’s LA P4P provider group incentive program includes timeliness of prenatal care as one of the clinical measures. The LA P4P program also distributes provider group report cards that inform groups of their performance on these measures.
- L.A. Care mailed the Preventive Health Guidelines to members. In addition, the Preventive Health Guidelines were made available for physicians on the L.A. Care website.
- L.A. Care promoted Text4Baby, a free program that provides education about prenatal and postpartum care to members via text messaging. Text4Baby was promoted throughout the network: in publications, on the website, and through Provider Quality Improvement Liaison (PQIL) outreach.
- L.A. Care offers prenatal classes for parents at the Lynwood Family Resource Center. The class includes education on how to breastfeed, physical postpartum changes, stress baby blues and postpartum depression.
- L.A. Care formed a women’s health HEDIS work team with members from across the organization to help develop and implement different health initiatives.
- L.A. Care also formed a Plan Partner Quality Improvement Collaborative meeting to help collaborative and develop best practices among the health plans. Prenatal and postpartum are areas of priority.

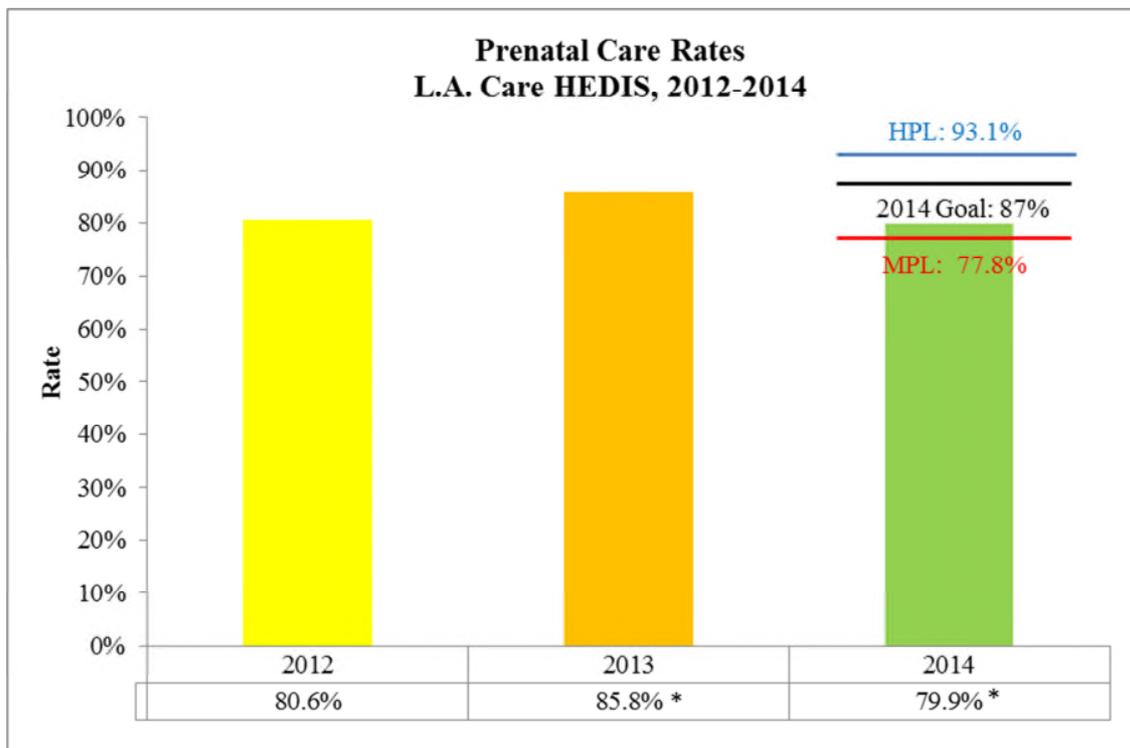
¹ http://kidshealth.org/parent/pregnancy_newborn/pregnancy/medical_care_pregnancy.html

RESULTS

PRENATAL CARE

Description of measures:

HEDIS Measure	Specific Indicator(s)	Measure Type
Timeliness of Prenatal Care	Percentage of eligible members who received a prenatal care visit in the first trimester or within 42 days of enrollment if the member was pregnant at the time of enrollment. Qualifying visits must be made with an obstetrician, family practitioner, general internist, or certified nurse practitioner.	Hybrid
Postpartum Care	Percentage of eligible members who received a postpartum visit on or between 21 days and 56 days after delivery during the measurement year.	Hybrid



* Statistically significant

ANALYSIS

Quantitative Analysis

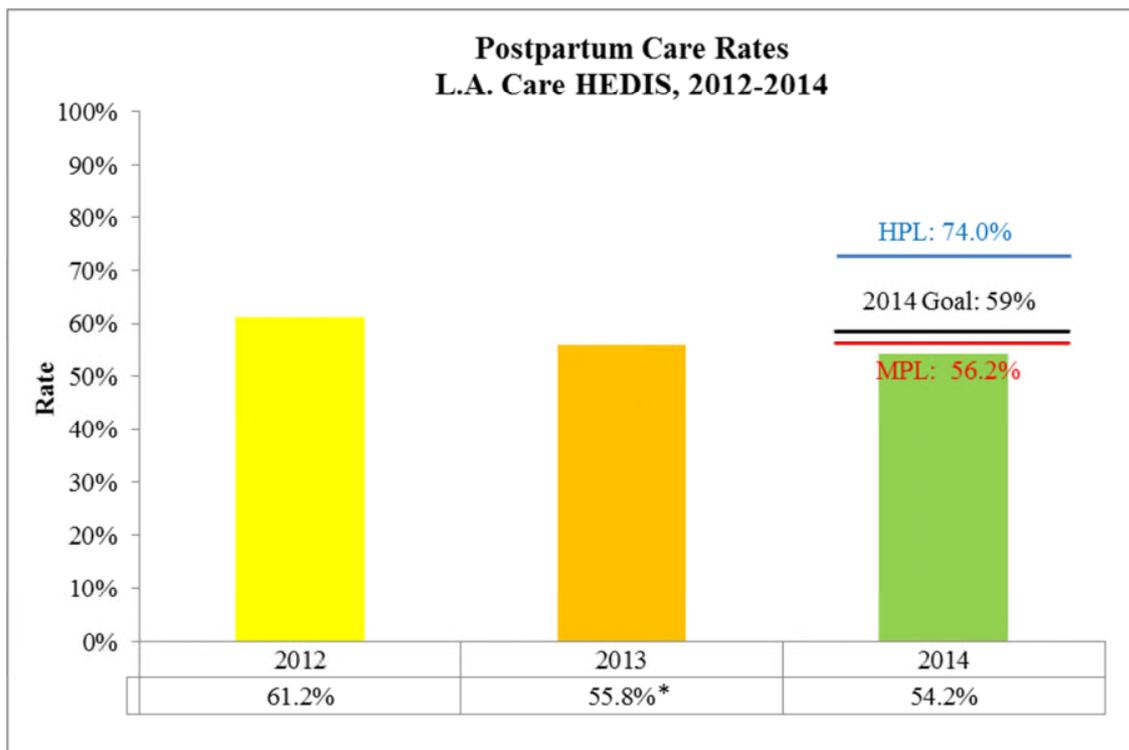
The timeliness of prenatal care rate decreased by 5.9 percentage points; from 85.8% in 2013 to 79.9% in 2014. This difference is statistically significant ($p < 0.05$). The 2014 rate exceeded the MPL of 77.8% by 2.1%. The timeliness of prenatal care rate did not meet the 2014 goal of 87.0%.

Disparity Analysis

L.A. Care also conducted an analysis based on Plan Partner, age, gender, ethnicity, region, and language to examine whether disparities exist in getting timely prenatal care. The HEDIS 2014 results indicate that Africa-American women had significantly lower rates (66.7%) than other ethnic groups. MCLA's performance (69.5%) is also significantly lower than all other plan partners.

POSTPARTUM CARE

RESULTS



* Statistically significant

ANALYSIS

Quantitative Analysis

L.A. Care's 2014 postpartum rate of 54.2 % decreased by 1.6 percentage points in comparison to the 2013 rate of 55.8%. The 2014 rate did not meet the MPL of 56.2% nor did the rate meet the 2014 goal of 59.0%. The difference between the 2013 and 2014 postpartum rates is not statistically significant.

Disparity Analysis

L.A. Care also conducted an analysis based on Plan Partner, age, gender, ethnicity, region, and language to examine whether disparities exist in women receiving postpartum care. The HEDIS 2014 results found no significant disparities. Care 1st Health Plan had a significant decline from the previous year (16.5%)

Qualitative Analysis

The rates for Prenatal and Postpartum care have dropped from HEDIS 2013. The prenatal rate increased in 2013 but fell back to the 2012 rate as a result of the 11.3% drop in the MCLA rate. Despite some

annual fluctuations in the rate, the prenatal visit rate has remained at a similar level over the past three years. This may be due to the difficulty in getting an appointment within the first trimester or within 42 days of enrolling in the health plan. In fact, a review of the hybrid HEDIS sample showed that 65% of the records that were non-compliant were due to the visit happening outside of the required timeframe and was the main reason for non-compliance. The MCLA rate may also be lower since it is the default health plan for those who do not elect a health plan, which may mean that members in this health plan are less engaged and may not be scheduling appointments in a timely manner. Additionally, it is difficult to identify a pregnant member within 42 days of enrollment or within the first trimester due to lags in claims and information.

The postpartum rate has been on a significant downward trend for the last three years. However, last year's rate may have been affected by Care 1st Health Plan's significantly lower postpartum rate (-16.5%) which was a result of several members' medical records in the hybrid sample being lost due to a leak at a physician's office. All other health plan rates did not have any statistically significant changes. For the postpartum rate, there is significant disparity among members in Care 1st compared to the other health plans. A review of the hybrid records showed the main reason for non-compliance was due to the visit not occurring as opposed to the visit occurring out of timeframe. This may be due to the member's perception of insignificance of the postpartum visits, transportation, and child care issues.

In addressing these barriers for prenatal and postpartum care, L.A. Care distributed several educational materials to members, notified providers of members needing these services and contacted postpartum women. L.A. Care mailed out perinatal health education packages to MCLA newly pregnant women 18 years and older and sent out women's health postcards to all women age 21-64 that reminded members to keep their appointments with their doctors specifically related to pregnancy, offered appointment assistance to pregnant members, and revised the Preventive Health Guidelines. In 2014, L.A. Care continued to send out provider opportunity reports (gaps in care reports) that included perinatal care measures. The list of members who did not receive care is also available at the L.A. Care provider portal. While this information may be too late for the physician to act on, it nevertheless brings the issue to the attention of the physician in order to change behavior and to comply with guidelines in the future. In September of 2014, L.A. Care contacted all network OB/Gyns and asked them to submit the names of all L.A. Care women who were in their third trimester of pregnancy. These women were then contacted by the Healthy Mom program and offered appointment assistance and a \$40 incentive. In addition, the Healthy Mom program rates were evaluated in 2014 and it was found that women in the program had statistically higher rates of compliance than those they were unable to reach. However, it was also noted that too few women participated in program to have a significant impact in the overall rate. Currently, efforts are being made to improve the identification of pregnant women to improve these rates. The table below summarizes the barrier analysis with the actions for each measure:

HEDIS Measure	Barriers	Actions
Timeliness of prenatal care	<ul style="list-style-type: none"> • Identification of pregnant women. • Members do not understand what prenatal visits are or why they are important. • Members do not perceive the urgency for prenatal care, especially multi-gravida women. • Cultural issues/traditions. • Potential transportation and child care issues. • Late acceptance to the managed Medi-Cal program during pregnancy. 	<ul style="list-style-type: none"> • The fall issue of the member newsletter had an article explain the importance of the first prenatal visit • The LA P4P provider group incentive program includes timeliness of prenatal care as one of the clinical measures. • L.A. Care continued to promote Text4Baby, a free program that provides education about prenatal and postpartum care to members via text messaging. • L.A. Care continued to distribute

HEDIS Measure	Barriers	Actions
		<p>Preventive Health Guidelines that are member-friendly, easy to understand, and useful to members.</p> <ul style="list-style-type: none"> • Providers were mailed progress reports, known as, Provider Opportunity Reports, that included the prenatal care measure. • A list of members who did not receive care is also provided at the L.A. Care provider portal where providers can identify the non-compliant members. • L.A. Care distributes trimester-specific perinatal health education packages to identified MCLA pregnant women.
Postpartum care	<ul style="list-style-type: none"> • Identification of pregnant and those women who have just delivered. • Cultural issues/traditions. • Members do not perceive the urgency for a postpartum check-up. • Potential transportation and child care issues. • Postpartum care occurs before or after the 21-56 day recommendation. • Multi-gravida postpartum women may not perceive the importance of the postpartum visit. • Postpartum women are difficult to identify in a timely fashion. 	<ul style="list-style-type: none"> • The fall issue of the member newsletter had an article explain the importance of the postpartum visit • L.A. Care continued to promote Text4Baby, a free program that provides education about prenatal and postpartum care to members via text messaging. • L.A. Care continued to distribute Preventive Health Guidelines that are member-friendly, easy to understand, and useful recommendations regarding tests and screenings for members. • L.A. Care distributes trimester-specific perinatal health education packages to identified MCLA pregnant women. • L.A. Care's "Healthy Mom" postpartum program, which provides assistance and support to women to schedule their postpartum visit. Members also receive a gift card for attending the postpartum visit. In 2014, L.A. Care called 2,667 women, reached 1,087 women and provided appointment assistance to 195 members. The program reported that 804 women completed their postpartum visit as of December 12, 2014. • L.A. Care contacted all contracted OB/Gyns and requested member information for all women in their third trimester. Seventeen women that were identified by this campaign met HEDIS criteria for 2014. • L.A. Care screened all face sheets and authorization to identify deliveries.

LOOKING FORWARD

In addition to continuing the above interventions, L.A. Care also plans the following:

- L.A. Care is planning county-wide prenatal social campaign in collaboration with community partners.
- L.A. Care will conduct a telephone survey of OB/GYNs to learn more about their scheduling problems and perceived barriers.
- L.A. Care will continue the “Healthy Mom” postpartum program, which will provide assistance and support to women to schedule their postpartum visits for MCLA and L.A. Care Covered members.
- L.A. Care will work with the L.A. County Department of Health Services and the top volume PPGs to design and implement interventions.
- L.A. Care will continue to distribute Preventive Health Guidelines that are member-friendly, easy to understand, and useful to members.
- L.A. Care will continue to distribute perinatal health education packages to MCLA newly pregnant women.
- The LA P4P provider group incentive program will continue to include timeliness of prenatal care as one of the clinical measures.

2015 WORK PLAN GOALS:

HEDIS Measure	2015 Medi-Cal GOAL	2015 Medicare Goal	2015 L.A. Care Covered Goals*
Timeliness of Prenatal Care	82%	NA	NR**
Postpartum Care	57%	NA	NR**

*New LOB, goal TBD based on year 1 HEDIS data when it becomes available

**NR: Not reportable

A.3 OTHER WOMEN’S HEALTH INITIATIVES

2014 WORK PLAN GOALS:

HEDIS Measure	2014 Goal for Medi-Cal	2014 Goal for Medicare SNP
Breast Cancer Screening	52%	58%
Cervical Cancer Screening	69%	N/A
Chlamydia Screening	58%	N/A

BACKGROUND

Breast cancer affects American women more than any other type of cancer, except skin cancer,² and is estimated to affect 12.3% of women at some point during their lifetime.³ Cervical cancer, on the other hand, was once the leading cause of cancer death for women in the United States; but during the past four decades, the incidence and mortality from cervical cancer have declined significantly, primarily due to early detection through cervical cancer screening. Early detection of both breast and cervical cancer through regular screenings is a key step for prompt and more effective treatments for these diseases; thus reducing women’s mortality rates.

Chlamydia remains to be the most commonly reported infectious disease in the United States. Data between 1994 and 2008 showed that Chlamydia comprised the largest proportion of all sexual transmitted diseases (STDs) reported to Centers for Disease Control and Prevention (CDC).⁴ Chlamydia infections are usually asymptomatic and, in women, can cause infertility, ectopic pregnancy, and chronic pelvic pain. Because of the large burden of disease and risks associated with infection, CDC recommends annual Chlamydia screening of all sexually active women younger than 26 years of age.

MAJOR ACCOMPLISHMENTS

- Breast cancer screening (BCS) focus groups were conducted in July 2014 to learn about the factors that influence a women’s decision to receive mammograms and the barriers that limit participation.
- Direct access letters sent to imaging centers to educate that prior authorization for mammograms are not needed.
- BCS myths and facts flyer to Medi-Cal and Medicare SNP members sent in October 2014.
- \$75 BCS incentive awarded to physicians with Medicare SNP members that were non-compliant for BCS (August-December 2014).
- L.A. Care launched a cervical cancer screening incentive program in July of 2014. The goal was to increase compliance rates for the screening and provided members with a \$50 Target gift card for receiving the screening by December 31, 2014.
- L.A. Care continued to distribute provider group report cards through the LA P4P incentive program, which includes BCS, CCS, and Chlamydia Screening measures. These report cards inform groups of their performance on these measures.
- In 2014, L.A. Care also continued the Physician P4P provider incentive program, which includes BCS, CCS, and Chlamydia Screening measures.

² <http://www.lbl.gov/Education/ELSI/screening-main.html>

³ <http://seer.cancer.gov/statfacts/html/breast.html>

⁴ <http://www.cdc.gov/std/stats08/chlamydia.htm>

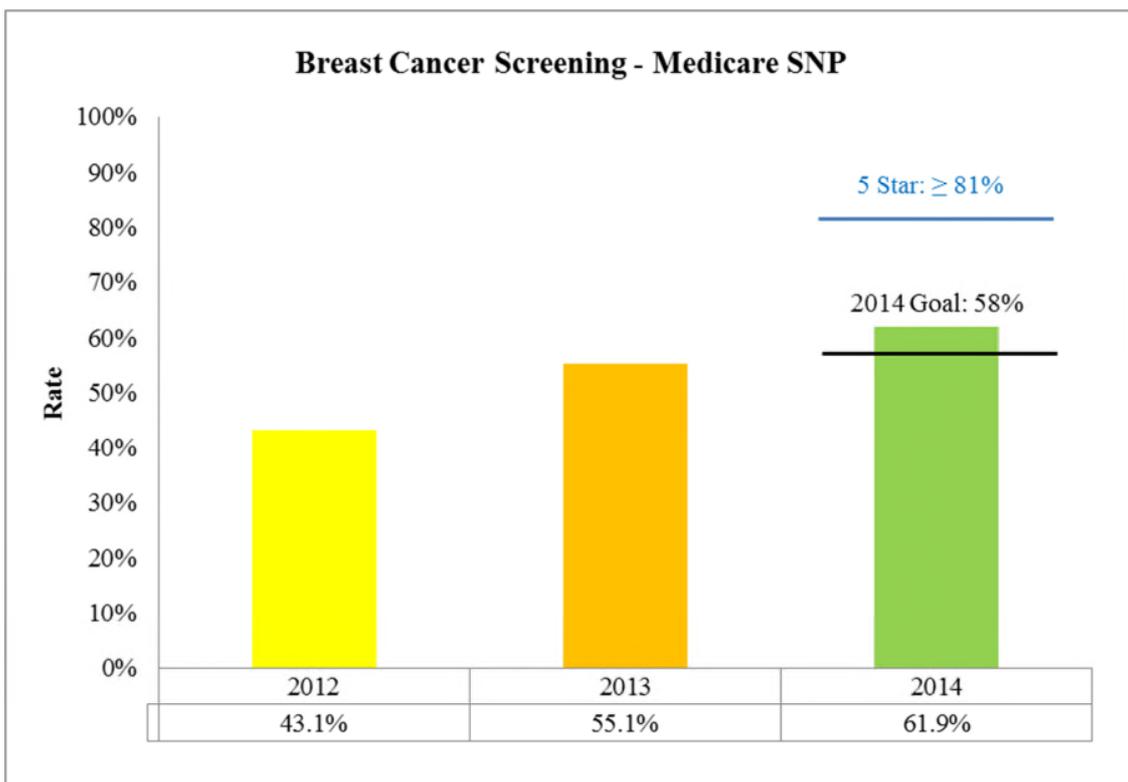
- L.A. Care formed a women’s health HEDIS work team with members from across the organization to help develop and implement different health initiative.
- L.A. Care also formed a Plan Partner Quality Improvement Collaborative to help collaborative and develop best practices among the health plan. Cervical cancer and breast cancer are areas of priority.

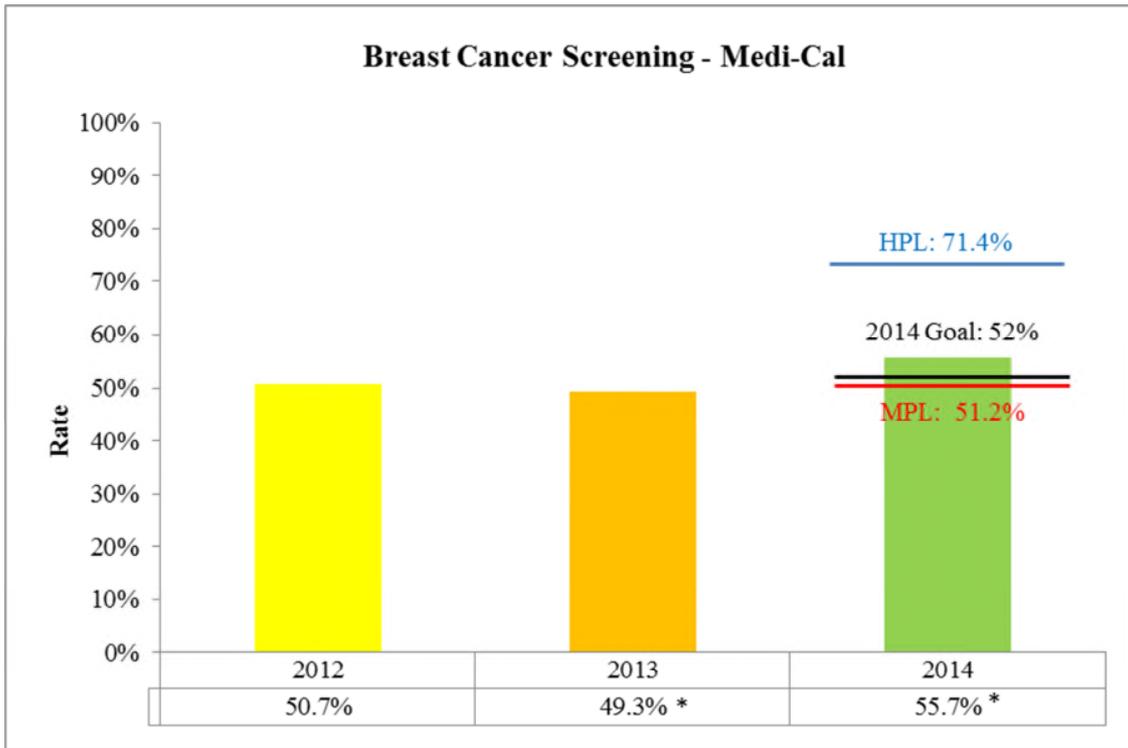
Description of measures:

HEDIS Measure	Specific Indicator(s)	Measure Type
Breast Cancer Screening	The percentage of members who are women aged 52-74 years and have received one or more mammograms on or between October 1 two years prior to the measurement year and December 31 of the measurement year.	Administrative
Cervical Cancer Screening	Percentage of women aged 21-64 years who received one or more screening tests for cervical cancer during or within the two years prior to the measurement year.	Hybrid
Chlamydia Screening in Women	Percentage of women aged 16-24 years who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.	Administrative

BREAST CANCER SCREENING

RESULTS





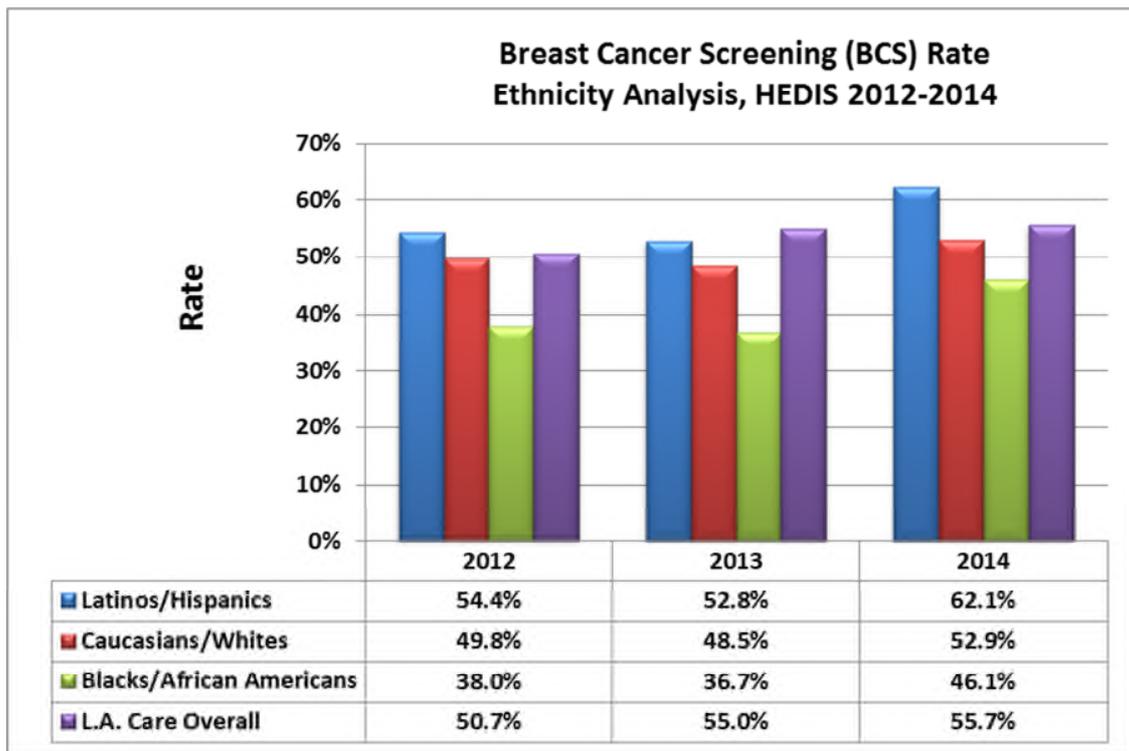
*Statistically significant

ANALYSIS

Quantitative Analysis

L.A. Care’s breast cancer screening (BCS) rate for Medicare SNP members improved from 55.1% in HEDIS 2013 to 61.9% in HEDIS 2014. BCS rates for Medicare SNP members have increased in the past three years. It exceeded the 58% goal rate but did not reach the 81% five star level. Similarly, the BCS rate for Medi-Cal members in HEDIS 2014 significantly increased by more than six percentage points from 49.3% in HEDIS 2013 to 55.7% in HEDIS 2014. The 52% goal rate was met, although the high performing level was not.

Disparity Analysis



HEDIS 2014 results show that Medi-Cal Latinos/Hispanics, Caucasians/Whites, Blacks/African Americans improved BCS rates in the past three years. Among Latinos/Hispanics, the BCS rate increased by nearly ten percentage points from 52.8% in HEDIS 2013 to 62.1% in HEDIS 2014. Latinos/Hispanics was the only ethnic group that surpassed the overall L.A. Care Medi-Cal BCS rate of 55.7%. Caucasians/Whites increased more than four percentage points from 48.5% in HEDIS 2013 to 52.9% in HEDIS 2014. Similarly, the BCS rate among Blacks/African Americans increased nearly ten percentage points from 36.7% in HEDIS 2013 to 46.1% in HEDIS 2014. However, Caucasians/Whites and Blacks/Africans had lower BCS rates than the overall L.A. Care Medi-Cal rate.

Qualitative Analysis

A focus group series was conducted in July 2014 among Medicare and Medi-Cal members aged 50-74 years in Westchester and Sherman Oaks. The objective of the study was to identify factors that influence a woman’s decision to receive mammograms and barriers curbing participation. Findings from the study will be used to strategize future interventions aimed at increasing breast cancer screening rates among eligible L.A. Care members.

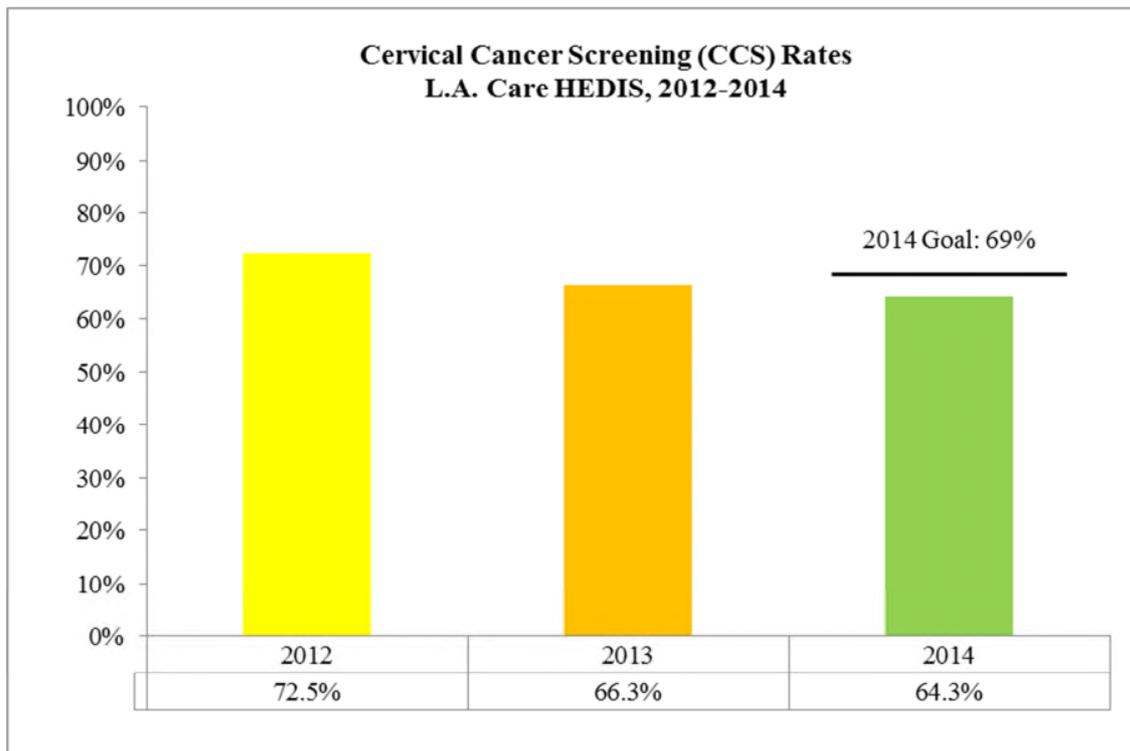
Results from the 2014 focus group show that the majority of L.A. Care members interviewed in the study were familiar with mammograms and their purpose in detecting breast cancer. However, only a handful of women were convinced that mammograms were more effective than self-breast exams. Moreover, a common barrier among participants who had previously had received a mammogram cited pain as a reason for not getting another mammogram. The most prevalent reason for getting a mammogram was the member getting a referral from her primary care physician, followed by the member’s concerns over the health of an adult daughter(s).

Results from a focus group conducted in 2009 revealed that travel distance to an imaging center, the discomfort associated with the screening exam, and the fear of test and test results are some of the main barriers for members. Various interventions were conducted in the years since then to address these barriers. Examples include, but are not limited to, sending reminder postcards for mammography screening, making automated phone calls to members, encouraging members to get a mammogram through L.A. Care’s member newsletter, informing members through the Community Health Improvement Project (CHIP), distributing and posting the Preventive Health Guidelines on the L.A. Care website, holding a Mobile Mammography event in 2012, and sending out provider group report cards. The list of members needing care is available at the L.A. Care provider portal so physicians can identify their members who still need a mammography screening.

CERVICAL CANCER SCREENING

RESULTS

The following graph compares L.A. Care in 2012, 2013, and 2014:



*MPL & HPL is not applicable for 2014 HEDIS because the measure specification was changed considerably

ANALYSIS

Quantitative Analysis

L.A. Care’s cervical cancer screening rate declined slightly for the third year. In 2014 this rate decreased from the 2013 rate by 2.1% to 64.3%. The difference was not statistically significant ($p < 0.05$) from the previous year. L.A. Care exceeded the MPL of 58.2%, but the rate did not meet the 2014 goal of 69.0%.

Disparity Analysis

L.A. Care also conducted an analysis based on Plan Partner, ethnicity, language, and RCAC regions to examine whether disparities exist in getting cervical cancer screenings. There is a major disparity among different plan partners. Similar to last year's performance, MCLA had a significantly lower rate (58.3%) while Kaiser had a significantly higher rate (84.4%). Spanish speaking members had a higher rate than the English-speaking population (71.1% vs 62%), and the SPD population had lower rates than the non-SPD population (51.5% vs 68.3%).

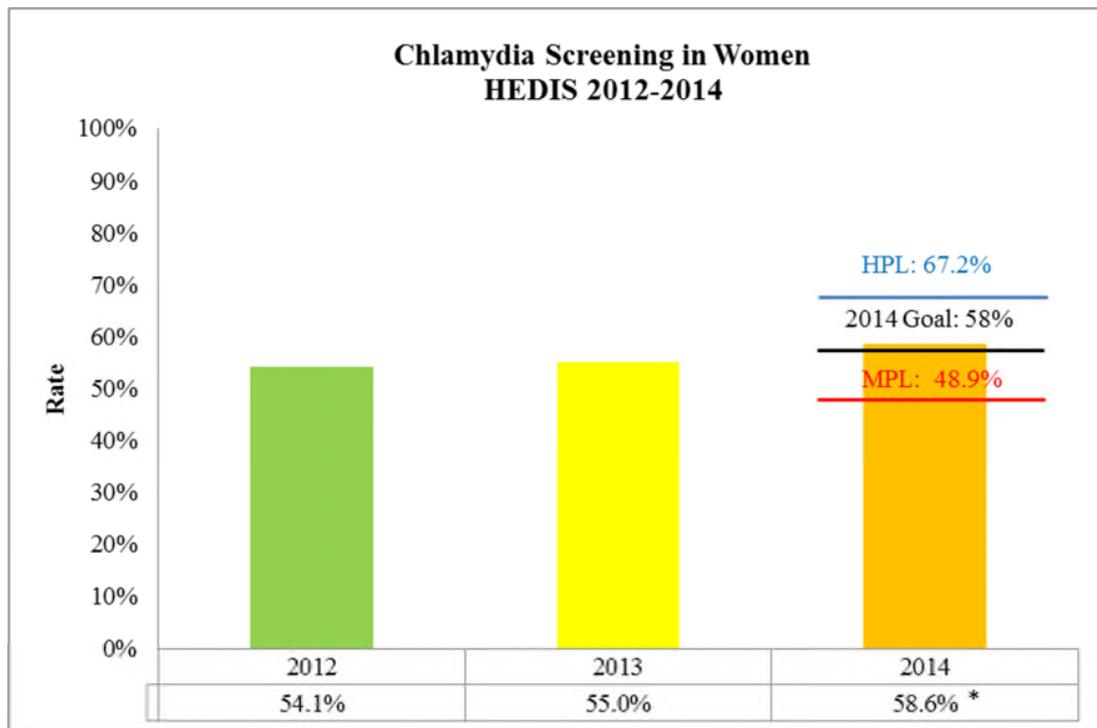
Qualitative Analysis

At 64.3%, the rate is the lowest throughout the last five HEDIS seasons. Results from a focus group conducted in 2009 revealed that the fear of test and test results, cultural inhibition, personal modesty/embarrassment, and lack of understanding on the importance of getting the screening are some of the main deterrents for members in getting a cervical cancer screening. Various interventions have been in place to address this issue in the years since such as: encouraging members to get a cervical cancer screening through L.A. Care's member incentive, member newsletter articles, and sending out provider group report cards, and a \$50 member incentive.

CHLAMYDIA SCREENING

RESULTS

The following graph compares L.A. Care in 2012, 2013, and 2014:



*Statistically significant

ANALYSIS

Quantitative Analysis

L.A. Care’s Chlamydia screening rate increased by 3.6 % percentage points from 55% in 2013 to 58.6% in 2014. The difference was statistically significant (p<.05) and the rate met 2014 goal of 58%.

Disparity Analysis

L.A. Care also conducted an analysis based on Plan Partner, ethnicity, language, and RCAC regions to examine whether disparities existed in getting Chlamydia screenings. Kaiser out performs among the other plan partners at 77.2% which is significantly greater than MCLA at 53.3% Similar to last year’s result, members between the ages of 16-20 years had a lower screening rate (54.6%) when compared to women between ages 21-24 (64.5%). The difference between the rates of these two groups is considered statistically significant. Unlike last year, there were no differences between those who are English-speaking vs. Spanish-speaking and no other disparities exist.

Qualitative Analysis

Multiple barriers still exist in members receiving Chlamydia screening, including a lack of knowledge of the benefit of testing, inhibitions about discussing sexual health, fear about discovery of a sexually transmitted disease (STD), and physicians’ non-adherence to recommended guidelines. In 2013, L.A. Care revised the Chlamydia toolkit and presented it to the Physician Quality Committee (PQC) for review and feedback before distributing the toolkits to providers through PQIL nurses and posting at L.A. Care’s website. The toolkit includes a cover letter, member educational materials, information on partner therapy, clinical practice guidelines, a public health form, and online resources such as “Don’t Think, Know” which provides home testing kits. Additionally provided as an online resource, “SPOTLA” can be used by patients to anonymously notify partners of testing positive for various sexually transmitted diseases. SPOTLA was specifically recommended by the PQC. A physician stated that both the member and partner need to be treated or they will re-infect each other. In 2014, Preventive Health Guidelines posters, which include recommendations for Chlamydia screening, were distributed to provider offices to be placed in exam rooms. We anticipate that members will read these while waiting to see the doctor and be reminded of the need for screening if applicable and also be empowered to bring the topic up with their primary care physician.

The table below summarizes the barrier analysis with the actions for each measure.

HEDIS Measure	Barriers	Actions	Effectiveness of Intervention/ Outcome
Breast cancer screening	<ul style="list-style-type: none"> • Issues with travel distance. • Members do not perceive the need for biennial exams after having undergone one screening with a negative result. • Discomfort associated with the mammography screening process. • Fear of the test and the test results. • Members unaware of direct access to imaging centers and receiving preventive services. • Member refusal for personal reasons. 	<ul style="list-style-type: none"> • BCS focus groups conducted in July 2014 to learn about the factors that influence a women’s decision to receive mammograms and the barriers that limit participation • Direct access letters sent to imaging centers to educate that prior authorization for mammograms are not needed • Signed agreement received from PPG’s attesting to education of imaging centers regarding open access for BCS • Survey of imaging centers to identify adherence to open access policy • BCS myths and facts flyer to Medi-Cal and Medicare SNP members sent in October 2014 	See results above

HEDIS Measure	Barriers	Actions	Effectiveness of Intervention/ Outcome
	<ul style="list-style-type: none"> • Unable to contact members. • Imaging centers continue to ask members for a prior authorization, when screening mammograms do not require, as there is open access for these. 	<ul style="list-style-type: none"> • \$75 BCS incentive awarded to physicians with Medicare SNP members that were non-compliant for BCS (August-December 2014) • L.A. Care includes breast cancer screening as one of the clinical measures for both the LA P4P provider group incentive and the Physician P4P incentive programs. • L.A. Care distributed Preventive Health Guidelines brochures to members to serve as a reminder of recommended tests and screenings. • L.A. Care offers women health classes which includes breast cancer as a topic on an ongoing basis at its Family Resources centers. • On October 6, 2014, L.A. Care held a Women’s Health educational session that offered free CME/CEUs to educate providers on the screening guidelines for breast and cervical cancer screening. There were 52 providers were in attendance. 	
Cervical cancer screening	<ul style="list-style-type: none"> • Fear of the test and the test results. • Doctor insensitivity. • Cultural inhibitions. • Personal modesty/ embarrassment. • Discomfort associated with screening. • Lack of knowledge on the test itself. • Members may not understand the importance of getting the screening. • Long wait times for appointment. 	<ul style="list-style-type: none"> • L.A. Care relaunched a cervical cancer screening incentive program in August of 2014. The goal was to increase compliance rates for the screening and provided members with a \$50 Target gift card for receiving the screening by December 31, 2014. • L.A. Care distributed 135,559 reminder postcards to direct line of business female women who are age 18 and over • L.A. Care offers women health classes which include cervical cancer as a topic on an ongoing basis at its Family Resources centers. • L.A. Care includes cervical cancer screening as one of the clinical measures for both the LA P4P provider group incentive and the Physician P4P incentive programs. • L.A. Care distributed Preventive Health Guidelines brochures to members to serve as a reminder of recommended tests and screenings. • On October 6, 2014, L.A. Care held a Women’s Health educational session that offered free CME/CEUs to educate providers on the screening guidelines for breast and cervical cancer screening. There were 52 providers were in attendance. 	<ul style="list-style-type: none"> • The rate decreased by 2.1 percentage points from 2013 and did not meet the 2014 goal.

HEDIS Measure	Barriers	Actions	Effectiveness of Intervention/ Outcome
Chlamydia screening	<ul style="list-style-type: none"> Physicians do not adhere to recommended Chlamydia screening practices because they believe that the prevalence of Chlamydia is low. Members' lack of knowledge of the benefits of testing, worries about discussing sexual health, were unsure of the consequences of Chlamydia infection, and lack of guidance. Members' concern that someone will know if they were tested or tested positive. Fear about discovering they have a sexually transmitted disease (STD), and fear of acquired immunodeficiency syndrome. 	<ul style="list-style-type: none"> L.A. Care includes Chlamydia screening as one of the clinical measures for both the LA P4P provider group incentive and the Physician P4P incentive programs. L.A. Care's PQIL nurses continued to distribute Chlamydia toolkits to physicians during their visits and they are also available on the provider portal. L.A. Care distributed Preventive Health Guidelines brochures to members to serve as a reminder of recommended tests and screenings. 	<ul style="list-style-type: none"> The rate increased by 3.6 percentage points from 2013 and did meet the 2014 goal.

LOOKING FORWARD

L.A. Care will continue the above interventions to improve cervical cancer and Chlamydia screening rates as well as the following for 2015 for both Medi-Cal and LACC while Breast cancer screening will be applied to all direct lines of business:

- L.A. Care, in collaboration with the American Cancer Society, will have an on-line Cervical Cancer educational campaign in 2015.
- L.A. Care plans to offer mobile mammograms through a partnership with the Susan G Komen organization for all eligible women in L.A. Care's direct lines of business.
- L.A. Care will continue to include breast cancer and cervical cancer screenings as two of the clinical measures for both the LA P4P provider group incentive and the Physician P4P incentive programs.

2015 WORK PLAN GOALS:

HEDIS Measure	2015 Goal for Medi-Cal	2015 Goal for CMC	2015 Goal for LACC*
Breast Cancer Screening	57%	66%	NR
Cervical Cancer Screening	67%	N/A	NR
Chlamydia Screening	62%	N/A	NR

*New LOB, goal TBD based on year 1 HEDIS data when it becomes available

A.4 OLDER ADULTS AND CHRONIC CONDITION MANAGEMENT

A.4.a IMPROVING RATE OF CARE FOR OLDER ADULTS (COA)

2014 WORK PLAN GOAL:

HEDIS Sub-Measure	2014 GOAL
Medication Review	80%
Functional Status Assessment	55%
Pain Screening	43%

BACKGROUND

There are over 39 million people age 65 and over in the United States, and this population is expected to grow over the next two decades.⁵ In addition, an estimated 9 million low-income seniors and adults under the age of 65 with disabilities are eligible for Cal MediConnect and have a range of complex physical and mental health conditions. As this population grows older, daily functions may become more difficult, aches and pains increase, and medication regimens become much more complex.⁶ Medication review, functional status assessment, and pain screening are therefore important measures in ensuring that older adults receive comprehensive care.

MAJOR ACCOMPLISHMENTS

- L.A. Care continued with the in-home assessment program in which physicians conduct home visits to members who have not completed the annual visit. The annual visit addresses preventive health services and screenings, including pain screening.
- L.A. Care offered a \$350 provider incentive per member for completing the Annual Wellness examination (AWE) form which includes care of older adult measures.

Description of sub-measures

HEDIS Sub-Measure	Specific Indicator(s)	Measure Type
Medication Review	Percentage of adults 66 years and older who had at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year, and the presence of a medication list in the medical record.	Hybrid
Functional Status Assessment	Percentage of adults 66 years and older who had at least one functional status assessment during the measurement year.	Hybrid
Pain Screening	Percentage of adults 66 years and older who had at least one pain screening or pain management plan during the measurement year.	Hybrid

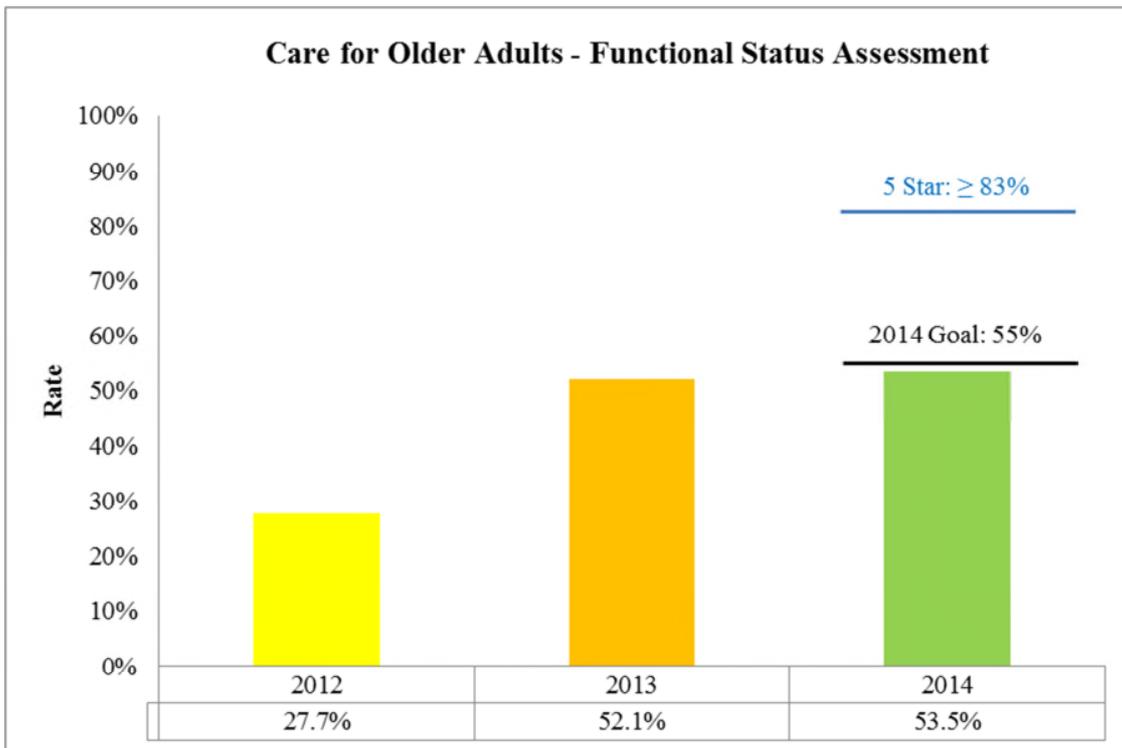
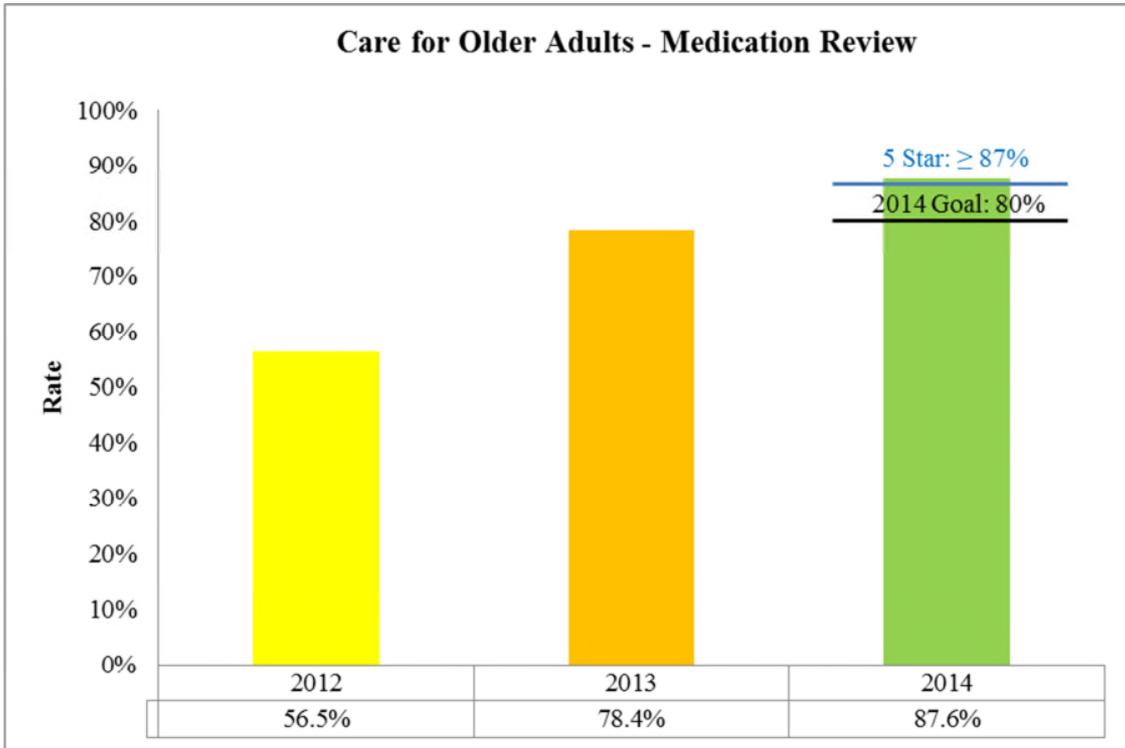
⁵ Older Americans 2010. Federal Interagency Forum on Aging-Related Statistics.

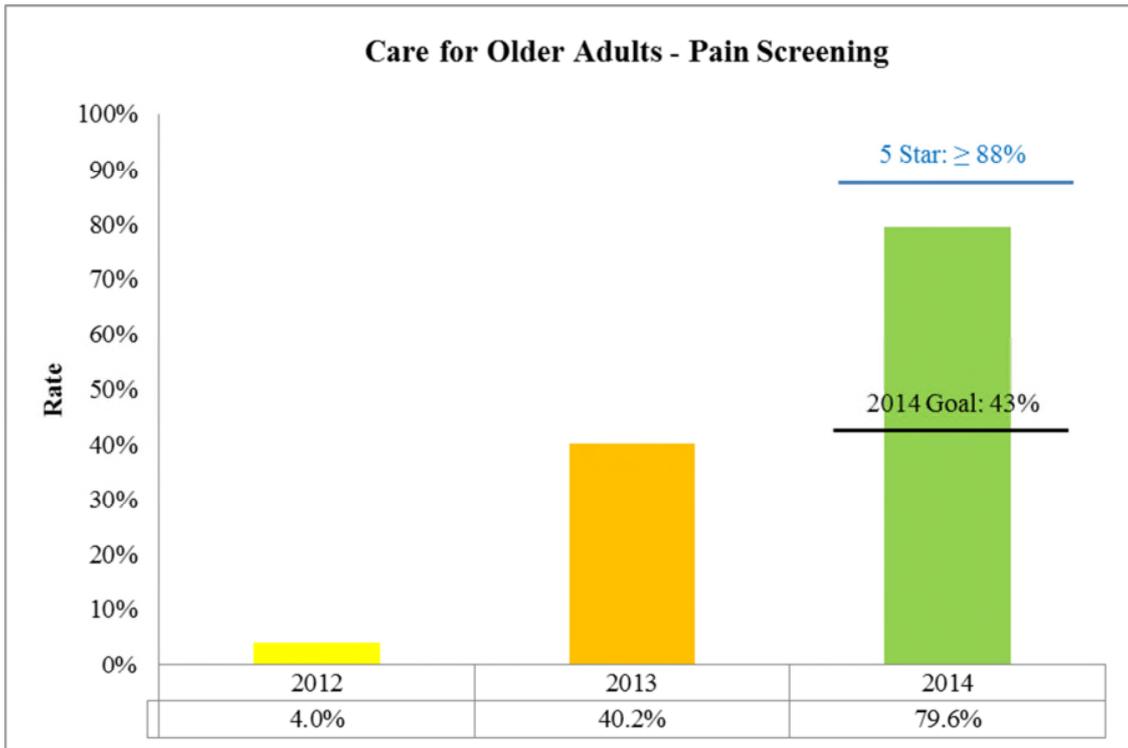
http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2010_Documents/Docs/OA_2010.pdf

⁶ Care for Older Adults. U.S. Department of Health & Human Services Agency for Healthcare Research and Quality.

<http://www.qualitymeasures.ahrq.gov/content.aspx?id=32470>

RESULTS





Quantitative Analysis

L.A. Care’s Medicare rates for Care for Older Adults (Medication Review, Functional Status Assessment, and Pain Screening) are 87.6%, 53.5%, and 79.6%.

Qualitative Analysis

L.A. Care’s rates for Care for Older Adults Functional Status Assessment and Pain Screening were well below the Medicare 5 star rates, while Medication Review improved to 5 stars. One of the explanations for the low rates for functional status assessment and pain screening is that providers are not completely documenting for these measures. For example, if a member is not experiencing chronic pain, many providers are not notating this as the rationale for the lack of a pain management plan. Another common issue is that many providers assess pain and functional status related to acute or single conditions/events, which does not meet the criteria for a comprehensive assessment.

INTERVENTIONS

HEDIS Measure	Barriers	Actions
Care for Older Adults (Medication Review, Functional Status Assessment, and Pain Screening)	<ul style="list-style-type: none"> • Providers and staff may not properly document these services. • Providers may be unaware of clinical requirements for the Medicare population. • Members’ personal reasons such as culture for not outwardly expressing chronic pain • Members’ inefficient education on what chronic pain is 	<ul style="list-style-type: none"> • Nurses regularly review medical records to see if providers are compliant with specific HEDIS measures, including medication review, pain screening, and functional status assessment. • L.A. Care continued to distribute provider education training packets which include resources specific to the Medicare population, such as preventive health guidelines, clinical

HEDIS Measure	Barriers	Actions
		<p>guidelines, coding references, pain screening tool, and other tools. L.A. Care implemented an in-home assessment program in which practitioners conduct home visits to members who had not seen their PCP in 2013. During these visits, member educational handouts on care of older adult measures were distributed.</p> <ul style="list-style-type: none"> L.A. Care offered a \$350 provider incentive per member for completing the Annual Wellness examination (AWE) form which includes care of older adult measures.

LOOKING FORWARD

In 2015, L.A. Care will conduct following interventions to improve the care for older adults rate:

- Facility site reviewers will continue to conduct medical record review. In addition, any member's chart that does not indicate screening will be noted.
- L.A. Care will continue to distribute a provider education training packet specific to the Medicare population, including preventive guidelines, clinical guidelines, coding references, a pain screening tool, and other useful tools.
- L.A. Care will distribute member educational materials for providers to distribute during Annual Wellness Exams.

2015 WORK PLAN GOAL:

HEDIS SUB-MEASURE	2015 GOAL
Medication Review	87%
Functional Status Assessment	59%
Pain Screening	88%

A.4.b ANNUAL MONITORING OF PATIENTS ON PERSISTENT MEDICATIONS (MPM)

2014 WORK PLAN GOALS:

HEDIS Measure	2014 Medi-Cal GOAL	2014 Medicare-SNP	2014 LACC
Annual Monitoring of Patients on Persistent Medication- ACE Inhibitors/ARBs	84.6%	78%	NA
Annual Monitoring of Patients on Persistent Medication- Digoxin	87%.5	87%	NA
Annual Monitoring of Patients on Persistent Medication- Diuretics	83.8%	77%	NA

NA – Not applicable

BACKGROUND

Adverse drug events contribute to patient injury and increased health care costs. For patients on persistent medications, appropriate monitoring can reduce the occurrence of preventable adverse drug events.⁷ Annual monitoring of these medications allows the providers to assess for side-effects and adjust drug dosage. The costs of annual monitoring are offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications.⁸

The MPM measures began with HEDIS 2012 although the first official reporting year was HEDIS 2013. For these three measures, an annual monitoring event is one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in 2013. In 2014, the anti-convulsant measure was retired and therefore is not included in this report.

MAJOR ACCOMPLISHMENTS

- In March, L.A. Care mailed all PCPs information on the HEDIS measure and the need regarding the need for monitoring patients on these medications.
- L.A. Care mailed a postcard to 19002 Medi-Cal and 760 Medicare members informing them of the importance of having an annual monitoring event while on these medications.
- L.A. Care called 45 high volume physicians and provided them with member missing an annual monitoring event.

RESULTS

ANNUAL MONITORING OF PATIENTS ON PERSISTENT MEDICATION (MPM)

Description of measures:

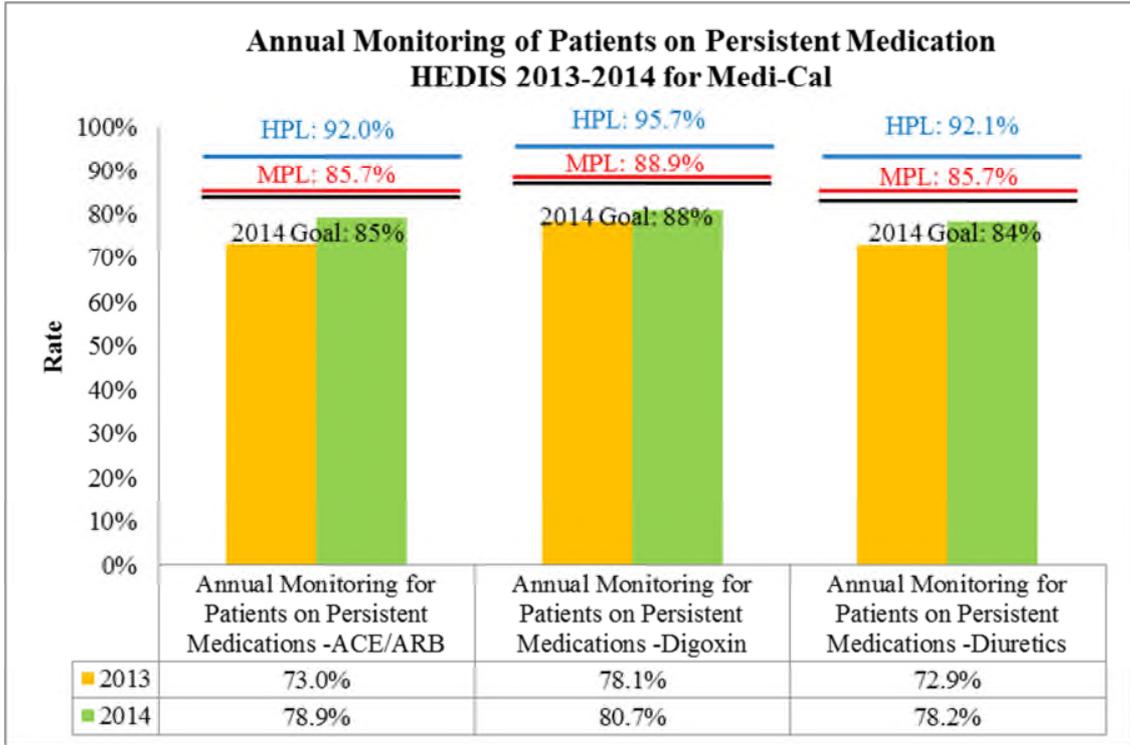
HEDIS Measure	Specific Indicator(s)	Measure Type
Annual Monitoring of Patients on Persistent Medication- ACE Inhibitors/ARBs	The percentage of members 18 years and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year, and received at least one therapeutic monitoring event for the therapeutic agent in the measurement year. A therapeutic monitoring event is at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in 2013.	Admin
Annual Monitoring of Patients on Persistent Medication- Digoxin		Admin
Annual Monitoring of Patients on Persistent Medication- Diuretics		Admin

⁷ NCQA. Annual Monitoring of patients on persistent medication.

<http://www.ncqa.org/ReportCards/HealthPlans/StateofHealthCareQuality/2014TableofContents/PersistentMedications.aspx>

⁸ National Quality Measures Clearing House. AHRQ. 2014. Measure Summary.

<http://www.qualitymeasures.ahrq.gov/content.aspx?id=47201>. Accessed on January 20, 2015.



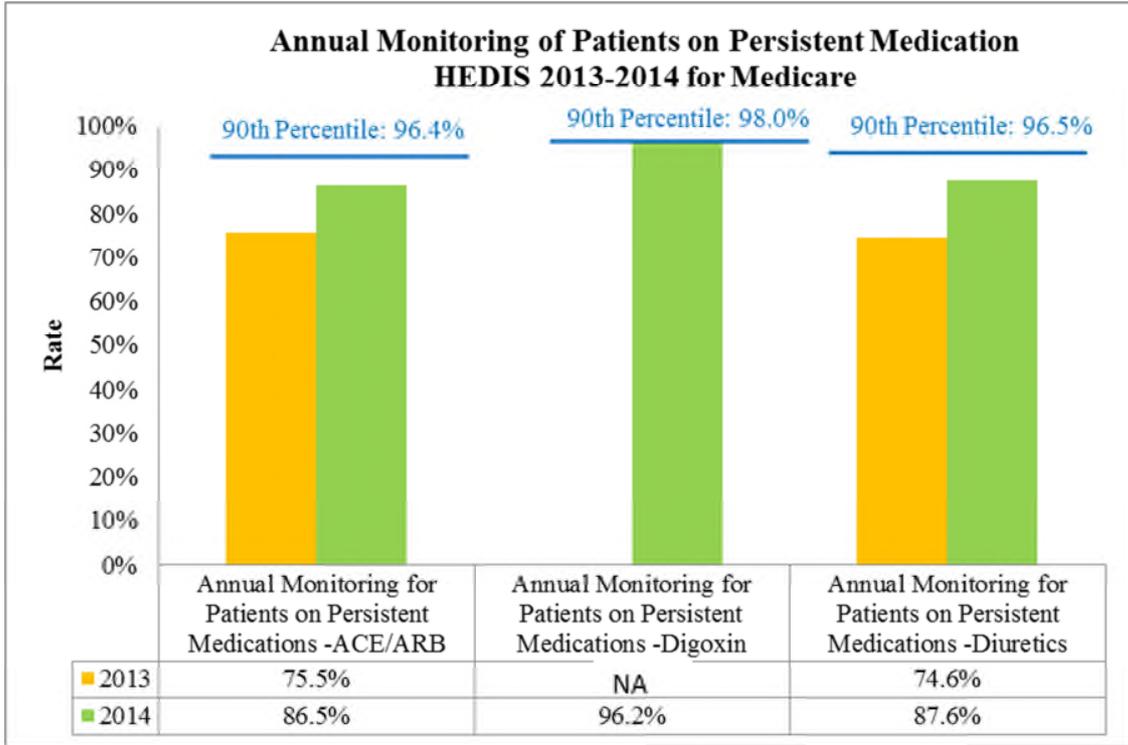
ANALYSIS

Quantitative Analysis (Medi-Cal)

The rates for all three measures were below the minimum performance level in 2014. The rate for ACE inhibitors or ARBs was 6.8% below the minimum performance level (MPL). The rate for Digoxin was 8.2% below the MPL. The rate for Diuretics was 7.5% below MPL. However, the rate compared to the prior year for ACE inhibitors of ARBs improved by 5.9%. The rate for Digoxin improved by 2.6% and the rate of for Diuretics improved by 5.3% compared to the prior year.

Disparity Analysis (Medi-Cal)

L.A. Care also conducted an analysis based on Plan Partner, age, gender, ethnicity, region, and language to examine whether disparities exist in receiving these tests. The HEDIS 2014 results indicate that there is a Plan Partner disparity with those in Kaiser Health Plan outperforming all other health plans for all three measures. No other disparities exist.



Quantitative Analysis (Medicare)

The rates for all three measures were below the minimum performance level in 2014. The rate for ACE inhibitors or ARBs was 6.8% below the minimum performance level (MPL). The rate for Digoxin was 8.2% below the MPL. The rate for Diuretics was 7.5% below MPL. However, the rate compared to the prior year for ACE inhibitors of ARBs improved by 5.9%. The rate for Digoxin improved by 2.62% and the rate of for Diuretics improved by 5.3% compared to the prior year.

Qualitative Analysis

From 2013 to 2014, all three rates have shown an improvement for both Medi-Cal and Medicare. However, L.A. Care rates are still below the 25th percentile. In 2014, The Department of Health Care Services asked that L.A. Care submit an Improvement Plan to address the plan’s low performance. The Improvement Plan led to a barrier analysis and an investigation into low and high performing providers. PCPs were called to find out if members that appeared non-compliant for the prior year had in fact received the test or were accurately captured as non-compliant. Of the 30 physicians that responded, 29% reported that they had completed the test in the year. Approximately 48% had not conducted the test. The remainder were either unfamiliar with the member or the member had discontinued the use of the medication. Some of the physicians stated that they were unfamiliar with the length of time the member was on the medication, that the member had not shown up for their lab appointments after repeated scheduling, and that the member did not feel the need to be tested based on their history with the medication. Based on these results, the interventions in 2014 focused on providing PCPs with lists of non-compliant members and educating them on the importance of monitoring their patients. Additional data analysis showed that certain PPG performed better than other PPGs. This led to the development of quarterly meeting with our high volume PPGs to review high priority HEDIS measures such as MPM. In meeting with PPGs, L.A. Care discovered that many PPGs were unfamiliar with this measure and did not have any interventions in place. L.A. Care requested that MPM be a part of their quality improvement plan for the year. L.A. Care also discussed the health plan’s Opportunity Reports with PPG staff in

addition to placing it on the provider portal to make sure staff received this information and passed it on to their providers. In 2015, efforts will focus on getting needed labs easier for the member and improving data capture from labs especially those members that are part of the L.A. County Department of Health Services (DHS).

INTERVENTIONS

HEDIS Measure	Barriers	Actions
Annual Monitoring Of Patients On Persistent Medication (MPM)	<ul style="list-style-type: none"> • Providers may be unfamiliar with members medication history • Providers do not know the member is part of their panel • Providers are unaware of need for lab tests. • Member does not view the need for test based on their history with these medication • Members may not know that these drugs need annual monitoring. • Lab data errors may be contributing to lower rates 	<ul style="list-style-type: none"> • Provider Opportunity Reports added the MPM measures in 2014 and were distributed to all providers • 45 high volume PCPS were called and asked to call in members for MPM labs • In March of 2014 all providers (excluding Kaiser) were sent information about the MPM measure. • The provider newsletter included an article about MPM in the summer. • In September members were sent a mailer explaining the need for lab test and to contact their doctor to schedule a screening. • The fall issue of the member newsletter included an article on the importance of blood test while on certain medication • Meetings with PPGs addressed low performance and data management. • High Volume PCPs were asked to submit lab data if they had already performed test

LOOKING FORWARD

In addition to continuing the above interventions, L.A. Care also plans the following:

- L.A. Care is planning to add MPM total rate to the LA P4P program and P4P program.
- L.A. Care plans to send Provider Opportunity Reports on a monthly basis.
- L.A. Care plans to send member MPM reminders on a quarterly basis.

2015 WORK PLAN GOALS:

HEDIS Measure	2015 Medi-Cal GOAL	2015 CMC Goal*	2015 L.A. Care Covered Goals*
Annual Monitoring Of Patients On Persistent Medication (MPM)-Ace	86%	NA	NA
Annual Monitoring Of Patients On Persistent Medication (MPM)-Dig	89%	NA	NA
Annual Monitoring Of Patients On Persistent Medication (MPM)-Diu	86%	NA	NA

*New LOB, goal TBD based on year 1 HEDIS data when it becomes available.

A.5 DISEASE MANAGEMENT

A. 5.a ASTHMA DISEASE MANAGEMENT PROGRAM

2014 WORK PLAN GOALS:

Measures	Specific Indicators	2014 Goals	Measure Type
Appropriate Use of Medications for People with Asthma. <ul style="list-style-type: none"> MCLA 	Percentage of eligible members with persistent asthma prescribed acceptable medications for long-term control of asthma during measurement year.	83%	Administrative
Medication Management for People with Asthma 50% compliance. (New) <ul style="list-style-type: none"> MCLA 	Percentage of eligible members with persistent asthma who remained on an asthma controller medication for at least 50% of their treatment period	66%	Administrative
Medication Management for People with Asthma 75% compliance. (New) <ul style="list-style-type: none"> MCLA 	Percentage of eligible members with persistent asthma who remained on an asthma controller medication for at least 75% of their treatment period	42%	Administrative
Asthma Action Plan	Percentage of members with an asthma action plan.	79%	Survey
Flu shot	Percentage of members who had a flu shot between September 1, 2013 and March 31, 2014.	66%	Survey
Overall Member Satisfaction	Percentage of members who are overall satisfied with the program (strongly agree or agree)	92%	Survey

BACKGROUND

Asthma is one of the most common chronic conditions experienced by L.A. Care members. *Symptoms involving respiratory system and other chest systems* was ranked as the top inpatient and outpatient diagnosis in FY 13 for MCLA, while *Asthma* was ranked as the 12th inpatient diagnosis and 13th outpatient diagnosis. L.A. Care's Asthma Disease Management Program addresses a range of interventions, including condition monitoring, monitoring patient adherence to the program's treatment plans, medical and behavioral health co-morbidities, health behaviors, psychosocial issues, and depression screenings. Members with asthma are identified on a monthly basis and are stratified into one of three risk levels (1, 2, and 3, with 3 being highest risk) based on medical utilization and pharmacy claims. Each member's stratification determines the type and intensity of program intervention he or she receives.

Practitioner interventions focus on education and adherence to clinical practice guidelines to improve the assessment and treatment of members with asthma, as well as care coordination communication to practitioners. The asthma toolkit (revised annually) emphasizes that practitioners can play an active role in empowering patients to effectively manage their asthma. L.A. Care informs practitioners annually, through the practitioner newsletter, website, and mailings, about the availability of the most up to date clinical practice guidelines from the National Institutes of Health, National Heart, Lung and Blood

Institute on the management and treatment of asthma. See the asthma program description for further details on this program.

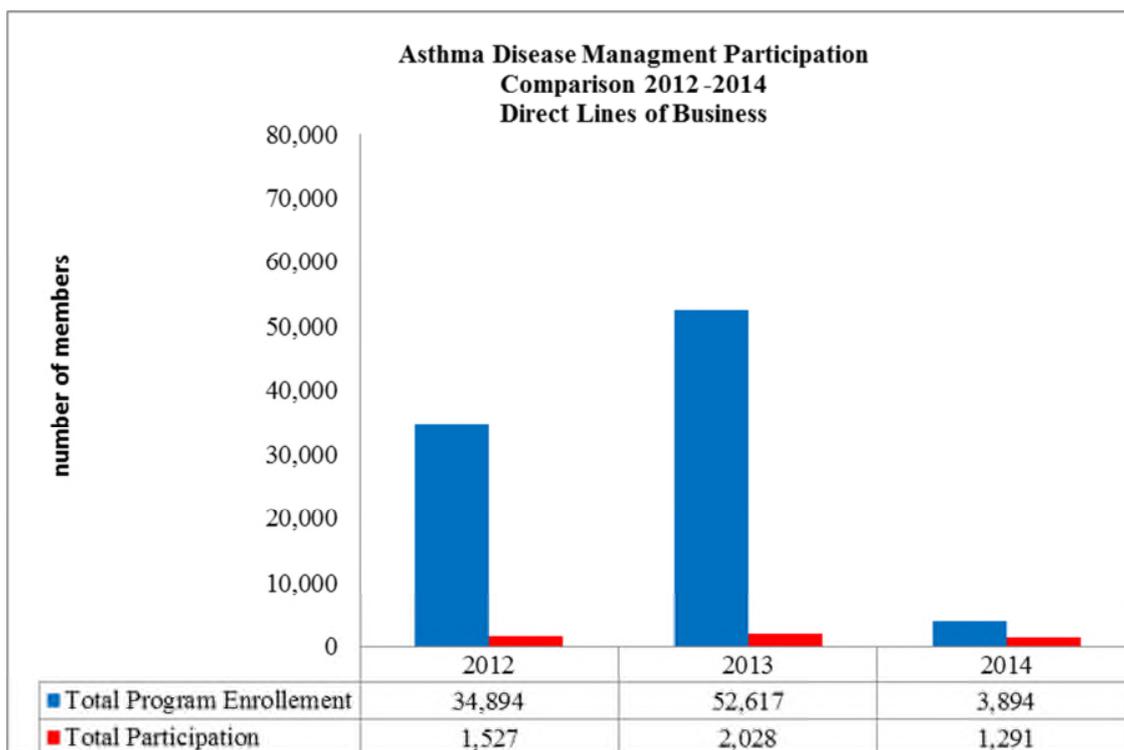
MAJOR ACCOMPLISHMENTS

- *L.A. Cares About Asthma*® grew from 58,658 members at the end of 2013 to 83,306 members at the end of 2014, an increase of 42.0%.
- L.A. Care produced a variety of new asthma education materials and mailings on the subjects of asthma triggers, asthma and allergies, bedbugs, asthma in the workplace/school, staying active with asthma, and asthma in pregnancy. Most new material was developed based on interest expressed by members in the 2013 satisfaction survey.
- The asthma Clinical Health Improvement Nurses conducted six visits to high volume practitioners. The nurses reviewed the asthma program, referral process, practitioner reports of their assigned members, practitioner barriers to asthma management, and available asthma educational materials that L.A. Care sends the members.
- The *L.A. Cares About Asthma*® staff increased from five (5) to seven (7) members in 2014.
- In 2014, *L.A. Cares About Asthma*® expanded the condition monitoring calls to include newly identified level 2 members. The Clinical Health Improvement Nurses call these members two times per year and complete a condensed assessment, also utilizing the validated ACT (Asthma Control Test) tool.
- Level 3 members (level 2 members as available and needed) who live in selected zip codes may be referred to a Community Based Organization (CBO) for a home visit (with consent). Home visits with a Community Health Worker (CHW) include: review of medical history; asthma education; home environment assessment, review and reinforcement of asthma treatment plan, identification of triggers, and counseling member on how to talk with PC.

Participation Rate

In 2014, L.A. Care identified eligible members monthly and stratified them based on their risk level. The tables below show L.A. Care eligible asthma members for MCLA and SNP lines of business. L.A. Care's asthma disease management program utilizes an opt-out enrollment method, which means that eligible members are enrolled unless they actively opt out. In 2014, 27 members with an active asthma diagnosis opted out of the program. In order to reflect the percentage of members that are actively engaged in the program, the denominator represents the average number of eligible members in level 2 and 3 per month over 2014,⁹ and the numerator represents the number of eligible members in level 2 and 3 with at least one interactive contact. The average monthly membership of level 2 and 3 members throughout 2014 was 3,894; of these eligible members, 1291 actively participated in the ADM program through either condition monitoring, use of the Asthma Resource Line, mail-based communication, email, attendance at an Asthma 101 class, or participation in the mail-based member knowledge assessment sent along with the annual satisfaction survey. Thus, the active participation rate for 2014 is approximately 33.2%, compared to a 3.9% in 2013. The 2013 participation rate included all level 1 mail-only members in the denominator, but these members are not eligible for most opportunities for interactive contact. We have changed the methodology for 2014 to accurately reflect only those members who are eligible for nurse outreach. Thus, Level 1 (low severity asthma members) are identified and enrolled in a registry and receive mail based education throughout the year and are not considered active participants in the program.

⁹ Similar to 2013, the *average monthly membership* is used as the denominator for the calculation, since interactions occur throughout the entire course of the year and are not limited to December. Just as the numerator accounts for all unique interactions throughout the year, the denominator must account for the fact that membership fluctuates throughout the year. An average is the most reliable means of reporting overall 2014 membership.



*The 2012 and 2013 participation rate included mail-only members. We have changed the methodology for 2014 to accurately reflect only those members who are eligible for nurse outreach (level 2 and 3).

	Total Program Enrollment	Total Participation	Percentage of Active Participation
2012	34,894	1,527	4.4%
2013	52,617	2,028	3.9%
2014	3,894	1,291	33.2%

2014 Year-End Membership by Line of Business	
MCLA	80,669
SNP	0*
Total	80,669

*SNP line of business terminated as of 12/31/2014

Member Satisfaction

METHODOLOGY

Satisfaction of participants in the asthma disease management program is assessed by 1) analysis of complaints and inquiries, and 2) a formal satisfaction survey. In June 2014, L.A. Care conducted a mail-in survey to active MCLA and SNP members in the asthma disease management program. Only members identified in January 2014 who were still active L.A. Care members in March 2014 were surveyed. With consultation from the Health Outcomes and Analysis (HO&A) department, all Level 2 and 3 MCLA and SNP members were surveyed, as well as a statistically significant sample of our Level 1 members. A total of 14,715 surveys were mailed with 537 returned, or a 3.6% response rate. This was a marked decrease from the 6.5% response rate for the 2013 satisfaction survey. Possible reasons for the decline in response rate are discussed in the Qualitative Analysis section below. As an incentive for members to return the surveys to L.A. Care, all eligible members who returned the survey by July 15,

2014 were entered in a drawing to win a \$15 Target® gift card. We awarded 100 gift cards to randomly selected eligible respondents.

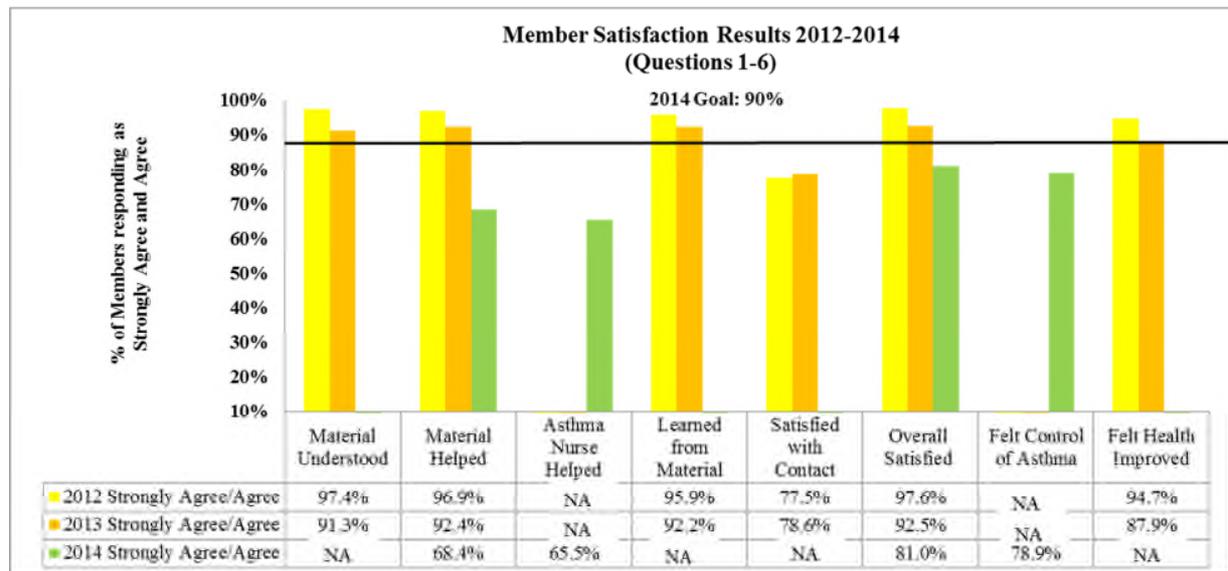
The composition of the surveyed population was 73.5% Asthma Disease Management (ADM) severity Level 1-intermittent, 23.7% ADM severity Level 2-mild persistent, and 2.8% ADM severity Level 3-moderate-to-severe persistent. The composition of respondents was 64.4% Level 1-intermittent, 28.7% Level 2-mild persistent, and 6.9% Level 3-moderate-to-severe persistent. The higher the ADM severity level, the more likely the member was to return the survey. Level 3-moderate-to-severe persistent members had a 9.1% response rate, compared to 4.4% for Level 2-mild persistent and 3.2% for Level 1-intermittent members.

The Healthcare Outcomes and Analysis department provided a representative sample of our Level 1 MCLA members that took into account the proportion of members who indicated Spanish as their preferred written language. 62.7% of members surveyed received English surveys and 37.3% received Spanish. In 2013, 58.9% of members surveyed received English surveys and 50.6% in 2012. All ADM Level 2-mild persistent and Level 3-moderate-to-severe-persistent members were surveyed. English-speaking members also had a higher rate of response (4.2%) compared to Spanish-Speaking members (2.8%).

RESULTS

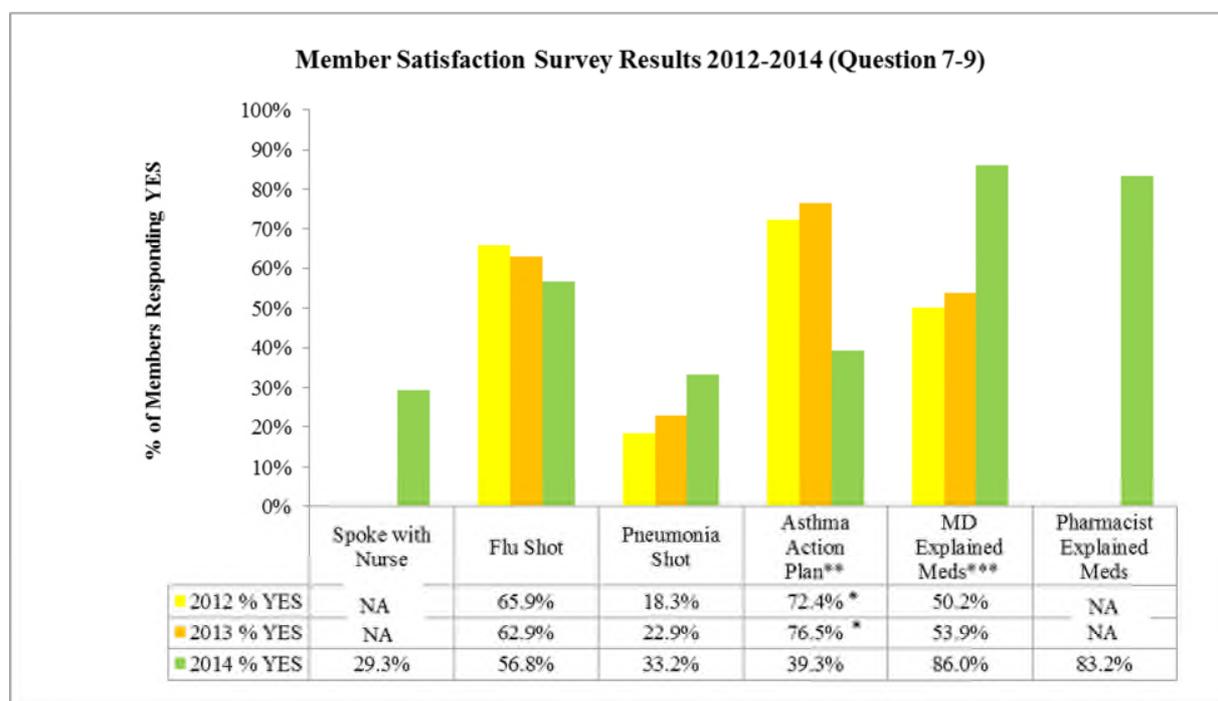
The format and content of the 2014 survey differed from previous years such that a direct comparison of results compared to previous years would not be valid or appropriate. As such, we have detailed the previous years' results for reference, but have not included trend analysis.

On the 2014 survey, respondents were asked to rate their level of satisfaction with various aspects of the program for four questions, based on a Likert scale ranging from Strongly Agree to Strongly Disagree. This differs from the previous years' surveys, which contained six Likert scale satisfaction questions.



	Material Understood	Material Helped	Asthma Nurse Helped	Learned From Material	Satisfied with Contact	Overall Satisfied	Feel in Control of Asthma	Felt Health Improved
2012 % Strongly Agree or Agree	97.4%	96.9%	N/A	95.9%	77.5%	97.6%	N/A	94.7%
2013 % Strongly Agree or Agree	91.3%	92.4%	N/A	92.2%	78.6%	92.5%	N/A	87.9%
2014 % Strongly Agree or Agree	N/A	68.4%	65.5%	N/A	N/A	81.0%	78.9%	N/A

For question 2 and questions 6-10, survey respondents were asked Yes/No questions related to asthma management.



*Statistically significant

	Spoke with Nurse	Flu Shot	Pneumonia Shot	Asthma Action Plan**	MD Explained Meds***	Pharmacist Explained Meds
2012 % YES	N/A	65.9%	18.3%	72.4%	50.2%	N/A
2013 % YES	N/A	62.9%	22.9%	76.5%	53.9%	N/A
2014 % YES	29.3%	56.8%	33.2%	39.3%	86.0%	83.2%

**In 2012 and 2013 this question asked only, "I have an Asthma Action Plan," and all responses other than "I do not have an Asthma Action Plan" were counted as positive responses. In 2014, the question was changed to "I have a completed Asthma Action Plan signed by my doctor," and only "Yes" responses were counted as positive responses.

***In 2012 and 2013 this question asked "My doctor explained my Asthma Action Plan." On the 2014 survey, this question was changed to, "My doctor explained to me how to use my asthma medicines."

Quantitative Analysis

Member satisfaction goals and baselines based on the survey for 2014 cannot be accurately determined because of modifications in the survey format and content. With 81.0% of respondents satisfied with the program, L.A. Care did not meet the 2014 goal of 93% overall member satisfaction. 68.4% of respondents found the program's educational materials helpful in managing their asthma, as compared to 92.4% in 2013. New questions on the 2014 survey asked whether members felt in control of their asthma (78.9% positive response) and whether respondents found contact with a program nurse helpful in controlling their asthma. Of the 147 respondents who reported speaking with an asthma nurse in the past 12 months, 126 agreed or strongly agreed that the nurse contact was helpful in managing their asthma (85.7% positive response), while only 1 disagreed (0.7% negative response).

Respondents who reported receiving a pneumonia shot increased from 22.9% in 2013 to 33.2% in 2014. Respondents who reported receiving a flu shot in the past year decreased from 62.9% in 2013 to 56.8% in 2014.

The questions regarding the Asthma Action Plan (AAP) were modified to ask respondents whether they have an AAP completed by their doctor, rather than asking whether the respondents just have an AAP. In 2012 and 2013 this question asked only, "I have an Asthma Action Plan," and all responses other than "I do not have an Asthma Action Plan" were counted as positive responses. For the 2014 survey, only "Yes" responses to "I have An Asthma Action Plan signed by my doctor" were counted as positive responses. As such, we cannot effectively compare the 2013 76.5% positive response rate to the 2014 39.3% positive response rate. Similarly, the 2013 question "My doctor explained my Asthma Action Plan" was changed to "My doctor explained to me how to use my asthma medications" in 2014. The 53.9% positive response to the 2013 question cannot be accurately compared to the 86.0% positive response rate in 2014 as the question emphasis shifted away from the AAP to medication instruction.

Qualitative Analysis

The appearance, format, content, and timeframe of the 2014 survey differed from the 2013 survey in such a way that direct comparison between the results of previous years and 2014 is not appropriate. While overall program satisfaction and member satisfaction with various aspects of the program were still measured, the intent of the questions may have been interpreted differently as the wording was changed. Further, for the respondents to be eligible for the incentive, surveys were required to be returned by a set date in 2014 (6 weeks from the mailing date), which may have negatively impacted the response rate. The decrease in reported overall satisfaction with the program may be correlated with response rate from members who are less actively engaged in the program (members who receive mailings only and do not receive contact from an asthma nurse). Of the 147 respondents who reported speaking with an asthma nurse in the past 12 months, 85.7% found their nurse contact to be helpful in managing their asthma. Tailoring surveys to be more applicable to the various levels of involvement in the asthma program and disease severity level may serve to provide a more accurate measure of overall member satisfaction, and will be addressed in the development of the 2015 satisfaction survey.

By asking members in 2014 if they have a completed and signed AAP rather than simply having an AAP, positive response decreased markedly (from 72% to 39%). However, the high positive response (83%) to doctors having explained asthma medications may indicate a barrier in practitioners' use of the AAP. To address this situation, we are currently working to address practitioner education on the AAP in addition to providing education to our members. Currently, all program members receive educational mailings on how to speak with their doctors about asthma both in annual mailings and upon being enrolled into the program. Higher-severity Level 2 and Level 3 members also receive condition monitoring telephone calls from asthma nurses during which the importance of the AAP is discussed. Addressing the importance of the Asthma Action Plan on the PPG and provider level will continue to be a high priority for the program in 2015.

As the goal for 66% of respondents receiving a flu shot in the past year was not met, all asthma program members received flu shot reminders in the fall of 2014 that may be reflected in the 2015 response. Program members of all severity levels were mailed a flu shot reminder postcard in addition to the enterprise-wide IVR flu shot reminders. Flu shots are also addressed during telephonic monitoring of Level 2 and 3 members.

KNOWLEDGE ASSESSMENT

BACKGROUND

L.A. Cares About Asthma® members received an asthma knowledge assessment in addition to the satisfaction survey. The knowledge assessment included ten (10) questions. Seven (7) questions were true/false questions and three (3) were multiple choice questions. All of the questions were based off of health education materials sent to all asthma members to assess what members have learned about asthma management through *L.A. Cares About Asthma*® mail and phone-based interventions.

This information will help *L.A. Cares About Asthma*® identify areas that members with asthma could benefit from more education and/or interventions. There were a total of 527 completed knowledge assessments for a response rate of 3.6%, which is a decrease from the 6.1% response rate from 2013. 72.3% of completed assessments were in English and 27.7% were in Spanish. Below are the seven true/false questions and correct response results:

- Asthma is a lifelong disease that can be controlled – **TRUE**
- The red zone on your Asthma Action Plan means your breathing is good – **FALSE**
- I should continue to use my controller medication when I feel good – **TRUE**
- Asthma controller medicines and quick relief medicines do the same thing – **FALSE**
- A peak flow meter can be used to find out if your airways are getting tight – **TRUE**
- People with asthma should have a flu shot every year – **TRUE**
- I can play sports and be active even though I have asthma – **TRUE**

	LIFELONG	AAP-RED	CONROLLER	MED TYPES	PEAKFLOW	FLU	EXERCISE
CORRECT	90%	78%	67%	63%	77%	82%	88%
INCORRECT	8%	16%	31%	34%	17%	15%	11%
BLANK	2%	6%	2%	3%	6%	2%	1%

Quantitative Analysis

The average score on the knowledge assessment was 75.2%, down from 83.7% in 2013. Respondents performed well on questions regarding chronic disease and flu shots. The weakest topic area for members was the proper use of asthma long term controller and quick-relief medicines, particularly question 10 (below):

“Controller medicine:”

- A) Is for quick relief
- B) Is taken each day, even when you feel good and have no asthma signs (**CORRECT ANSWER**)
- C) Should be taken sometimes
- D) Opens the airways quick

52% of respondents answered this question correctly, compared to 68% in 2013.

OPPORTUNITIES

Member education on long-term controller and quick-relief medicines remains a priority for 2015. In addition to educational materials developed with the Health Education/Cultural & Linguistics department, the department will work to develop a convenient and accessible mailer explaining how to use the Asthma Action Plan to our members to be included in new member welcome letters.

Not only was the English-speaking response rate higher than the Spanish-speaking response rate, but average score for English-speaking members was higher as well. The mean score for English-speaking respondents was 77%, while the median score for Spanish-speaking respondents was 69%. Accordingly, accessibility and readability of the Spanish translation of the knowledge assessment questions will be re-assessed in the development of the 2015 survey.

COMPLAINTS AND INQUIRIES

Member complaints and inquiries are evaluated to identify opportunities to improve satisfaction with the disease management process. Complaints related to the disease management program are identified through L.A. Care's grievance process. The Member Services staff keeps a log of all member complaints and inquiries related to disease management. The log is searched monthly for key words related to asthma disease management. In addition, all inquiries and complaints made by asthma disease management program participants are aggregated annually and analyzed. The asthma resource telephone line also receives inquiries and complaints.

In 2011, 2012, 2013, and 2014 there were no complaints related to asthma disease management program. In 2014, there were 368 inquires made on the asthma member telephone resource line compared to 494 in 2013.

Asthma Resource Line Call Analysis								
Complaints	2011		2012		2013		2014	
Number of complaints received	0		0		0		0	
Inquiry Reason	Number of Calls	Percentage of all Calls	Number of Calls	Percentage of all Calls	Number of Calls	Percentage of all Calls	Number of calls	% of all calls
Opt out/no asthma	164	76%	439	67%	334	68	237	64%
Requested Asthma Information	39	18%	158	24%	58	12	63	17%
Disenrolled	1	0%	3	<1%	3	<1%	2	<1%
Misc	13	6%	54	8.3%	99	20%	66	18%
TOTAL	217	100%	654	100%	494	100%	368	100%

OPPORTUNITIES

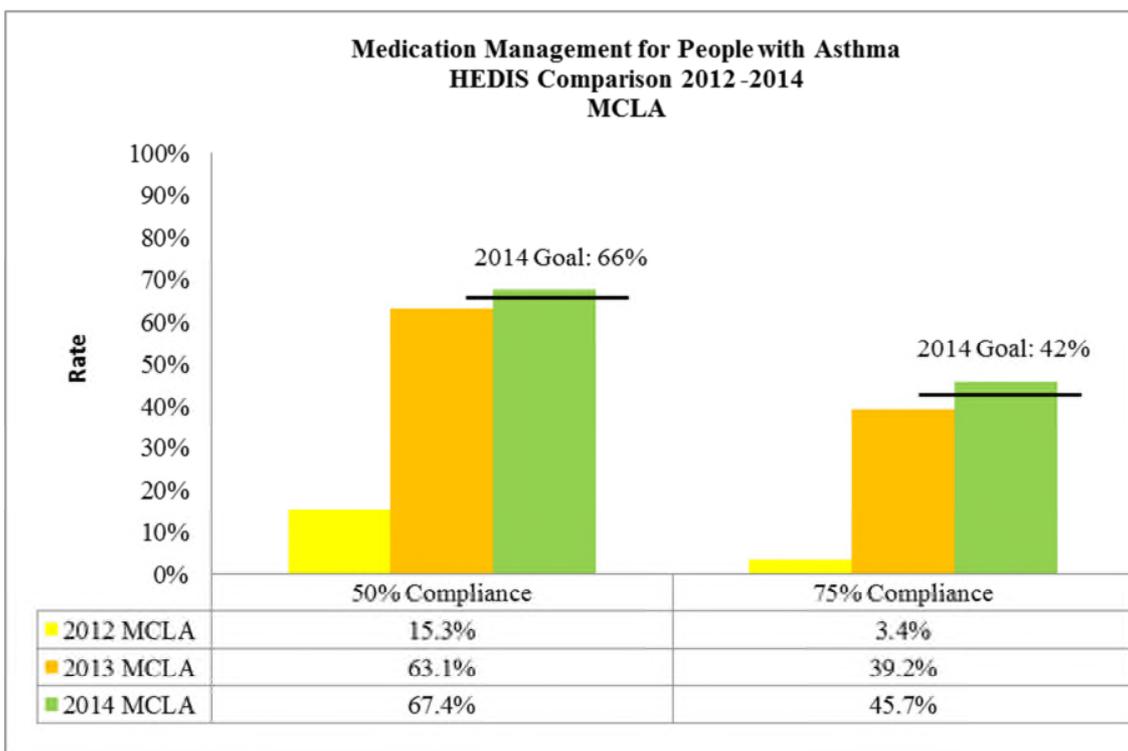
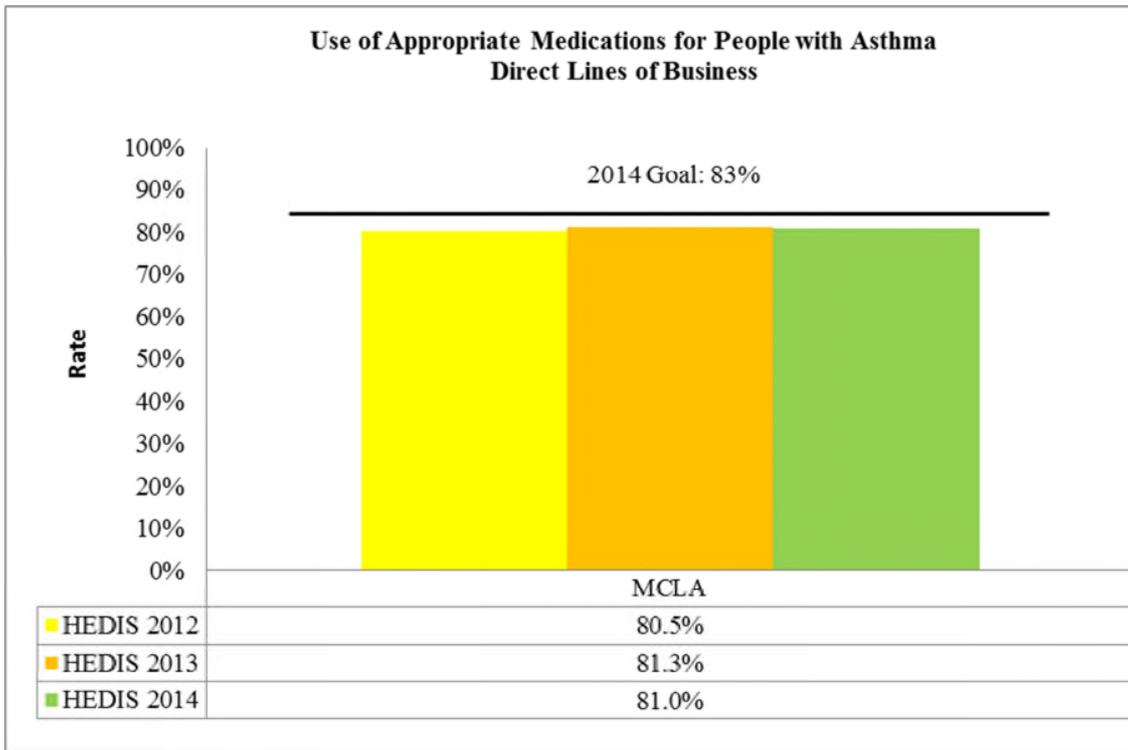
There may be opportunities for better data collection regarding complaints and inquires. To date, no complaints related to the asthma program have been filed, however some inquires have been missed due to data collection challenges.

Measuring Effectiveness:

Measure	Methodology	
	Calculation	Data Collection
Use of Appropriate Medications for People with Asthma (HEDIS)	Refer to 2014 HEDIS Technical Specification Vol.2 specifically on Use of Appropriate Medications for People with Asthma Measure	
Asthma Action Plan	<p>Calculation of Minimum Sample Size Required:</p> <p>Margin of Error = 10 % Confidence Level = 95 % Response Distribution = 50 % Population: =35,181 (average membership in 2012)* *Because of large increase in membership due to the transition of CHP members in January, 2012, the 2012 survey was sent to the current asthma members identified in December, 2011 or before. = 52,617 (average membership in 2013)** =76,593 (average membership in 2014) **Survey was sent to current asthma members identified in January who remained members through March</p> <p><i>Minimum Recommended Sample Size :</i> = 96 (in 2012) =96 (in 2013) =96 (in 2014)</p> <p><i>Actual Completed Survey:</i> = 473 (in 2012) =763 (in 2013) =537 (in 2014)</p>	<p>Data Collection:</p> <p>L.A. Care conducted a mail-in survey targeting a representative sample of Level 1 and all Level 2 and 3 ADM members/parents of members.</p>

Measure	Methodology	
	Calculation	Data Collection
Flu Shot	<p>Calculation of Minimum Sample Size Required:</p> <p>Margin of Error = 10 % Confidence Level = 95 % Response Distribution = 50 %</p> <p>Population: =35,181 (average membership in 2012)* *Because of large increase in membership due to the transition of CHP members in January, 2012, the 2012 survey was sent to the current asthma members identified in December, 2011 or before. = 52,617 (average membership in 2013)** =76,593 (average membership in 2014) **Survey was sent to current asthma members identified in January who remained members through March</p> <p><i>Minimum Recommended Sample Size :</i> = 96 (in 2012) =96 (in 2013) =96 (in 2014)</p> <p><i>Actual Completed Survey:</i> = 473 (in 2012) =763 (in 2013) =537 (in 2014))</p>	<p>Data Collection:</p> <p>L.A. Care conducted a mail-in survey targeting a representative sample of Level1 and all Level 2 and 3 ADM members/parents of members.</p>

RESULTS



Quantitative Analysis

MCLA

In 2014, the MCLA HEDIS rate was 81.0%, a decrease of 0.3% in comparison to 2013's rate of 81.3%. This year's rate did not meet the 2014 goal of 83%.

In 2014, the MCLA HEDIS rate for medication management for people with asthma (MMA) was 67.4% with 50% medication compliance and 45.7% with 75% medication compliance. Both measures exceeded the 2013 goals of 66% and 42%, respectively. In 2013, the MMA rate was 63.1% with 50% medication compliance and 39.2% with 75% medication compliance. MMA 50% compliance increased 6.8% from 2013 and MMA 75% compliance increased 16.6%.

Healthy Kids

In 2014 Healthy Kids represented only 0.02% of the asthma member population, so the program is using solely MCLA goals and measures.

PASC-SEIU Homecare Workers Health Care Plan (Formerly called IHSS)

In 2014 PASC-SEIU represents only 3.1% of the asthma member population, so the program is using solely MCLA goals and measures.

Qualitative Analysis

The MCLA HEDIS rate results suggest opportunities for improvement for the asthma disease management program. Some barriers to medication compliance are discussed below:

- Asthma medication samples received by patients and prescriptions received during an emergency room visit or hospital stay do not appear in the pharmacy data collected by L.A. Care
- Some medications require prior authorization forms. While L.A. Care provides this information to practitioners, this extra step can be a barrier for members in following through to receive and comply with the proper asthma medication treatment.
- Members with multiple prescriptions for asthma inhalers may also affect the accuracy of the controller/reliever ratio.
- Low-severity members who do not comply with asthma medication and have opted out of the program can affect compliance rates as they are still counted in the denominator.

Low practitioner adherence to clinical practice guidelines can also affect member compliance. To address the barrier of practitioner adherence to clinical practice guidelines, L.A. Care has taken the following measures:

- Practitioners annually receive the EPR-3 Guidelines for the diagnosis and management of asthma that emphasizes best practices, including use of the Asthma Action Plan, as well as a bi-monthly report with the HEDIS asthma medication rate for review and follow-up.
- Practitioners received asthma toolkits that were updated in November 2014 and updated toolkit is available on the practitioner section of the L.A. Care website.
- Practitioner Quality Improvement Liaisons (PQILs) distribute the asthma guidelines, Asthma Practitioner Toolkits, and a copy of the pharmacy formulary during their visits with practitioner practices.
- *L.A. Cares About Asthma*® developed practitioner reports for the Asthma Clinical Health Improvement Nurses (CHINs) to bring out to practitioners to highlight their patients not adhering to a proper asthma treatment plan. In 2014 the CHINs visited six practitioners to review their patients' treatment plans and to review asthma clinical guidelines.

Another continual barrier to high compliance is lack of patient education regarding asthma care, self-management, and decreased medication compliance in adults. To address this barrier, L.A. Care provides multiple educational materials regarding asthma, allergies, and flu shots including postcards and newsletters addressing asthma and allergy triggers and medications, reminders in the annual fall newsletter to receive a flu shot, and reminders and education to Level 2 and 3 members discussed during monitoring calls. To address member education and engagement, mobile health and SMS programs are being explored in order to engage members effectively with health education. SMS messaging and remote condition monitoring for higher severity members are also being explored.

Other Considerations: (Cultural, Linguistic, and Seniors and People with Disabilities (SPD)

Materials are culturally and linguistically appropriate, and continue to be mailed in English and Spanish. The mailings include an attachment to the cover letter indicating that the information is available in ten (10) different languages, larger print, Braille, audio or TTY as requested.

However, L.A. Care Health Plan’s inability to reach members who require more education and monitoring, by phone or by mail due to incorrect addresses or no address (transient and homeless populations) contributes to the member barriers. The *L.A. Cares About Asthma®* staff tracks the members without an address listed (homeless/transient members) and return mail. With the higher severity level members the CHINs call the member to attempt to identify an address to reach the member, but often these members officially enrolled in the program are not receiving the benefits of the program. To better engage a greater percentage of the member population, options for SMS messaging in addition to phone and mail outreach are being explored.

Other Opportunities

There remain opportunities to improve the use of appropriate medications for people with asthma, especially in the adult population. The Disease Management department has recommended that the frequency of the quarterly mailings to practitioners regarding members who received four or more prescriptions for asthma medications over the previous 12 months to mailings every other month. As of 2013, the MMA HEDIS measure has been used to monitor effectiveness of this intervention.

The *L.A. Cares About Asthma®* program staff will also review program materials and continually revise and expand the asthma health education library to ensure that the materials are as appropriate for adults as they are for children. Additional materials on medication usage may be need in alternative formats. L.A. Care will continue to promote the asthma toolkit and CME offering to assist practitioners in the understanding of and compliance with clinical practice guidelines.

INTERVENTIONS (EFFECTIVENESS)

Measure	Barrier	Action	Effectiveness of Intervention/Outcome
HEDIS Appropriate Use of Asthma Medication (AMA) measure	<ol style="list-style-type: none"> 1. Member lack of knowledge of controller and reliever medication. 2. Practitioners’ lack of implementation of the Clinical Practice Guidelines. 	<ul style="list-style-type: none"> • Quarterly mailings on asthma symptoms and medication • Telephonic contact with Level 2 and 3 members • Level 3 members are assessed during quarterly monitoring and if needed, are coached on controller and reliever medications. • Level 3 members (level 2 members as available and needed) who live in selected zip codes may be referred to a Community Based Organization (CBO) for a home visit (with consent). Home visits with a 	<p><u>MCLA</u> Did not meet the goal.</p>

Measure	Barrier	Action	Effectiveness of Intervention/Outcome
		<p>Community Health Worker (CHW) include: review of medical history; asthma education; home environment assessment, review and reinforcement of asthma treatment plan, identification of triggers, and counseling member on how to talk with PC.</p> <ul style="list-style-type: none"> Practitioners are informed quarterly on those members who were identified as having received four or more prescriptions for asthma medications who did not receive recommended medication therapy and are asked to evaluate the member's medications and asked to consider inhaled corticosteroids or an alternative controller. Asthma Formulary Coverage and the Asthma Provider Toolkits are distributed by the Practitioner Quality Improvement Liaisons (PQILs) during site visits. Asthma toolkits are available on the L.A. Care website or upon request by phone. 	
<ul style="list-style-type: none"> Flu shot Asthma Action Plan 	<ol style="list-style-type: none"> Lack of information on asthma Lack of knowledge regarding asthma action plans 	<ul style="list-style-type: none"> New member & annual mailing includes the following information: All about Asthma, Talking to Your Doctor About Asthma, Using an Action Plan, My Action Plan Seasonal mailings to all program members include information on asthma triggers at work and school, exercise and asthma, flu shot reminders, and asthma medications at school and home Level 2 and 3 members are telephonic monitoring, and asthma educational materials are sent to the member, as needed. Asthma action plans sent to providers as needed 	<p>Flu shot: Goal not met; difference not statistically significant</p> <p>Action Plan: Did not meet goal. Question for measurement changed in 2014, so 2014 will serve as baseline.</p>

LOOKING FORWARD

- With Medi-Cal expansion and the L.A. Care Covered Exchange line of business under the Affordable Care Act (ACA), the population served by L.A. Care, and subsequently *L.A. Cares About Asthma*®, will increase. Accordingly, monitoring, measures, and goals will need to be adjusted to represent this larger population.
- With the D-SNP product termination as of 12/31/2014, it is projected that a large percentage of D-SNP members will enroll into the CMC product line of business. Data will reflect CMC membership in Q1 2015.
- The Clinical Health Improvement Nurses and/or Pharmacist will continue attending and assisting with Asthma 101 Health Education classes when available to review members' asthma medications.
- The Asthma Disease Management staff department will continue increased interventions for Level 2 members, including bi-annual condition monitoring calls.
- Practitioner education visits from the Clinical Health Improvement Nurses and partnering with Provider Network Operations will continue in 2015.
- L.A. Care is exploring mobile health technology to further target and reach members. These possible interventions include an asthma text-messaging program to send asthma education and medication adherence reminders to members who opt-in to the program. Another intervention

involves a pilot project with several clinics for remote monitoring of asthma medication use with reporting and monitoring by L.A. Care's CHINs and practitioners.

- The 2015 satisfaction survey is being modified to further reflect and gauge the interest of our members in order to develop effective interventions. The 2015 will include questions regarding member interest in and capability for mobile health interventions.

2015 WORK PLAN GOALS:

Measures	2015 Goals
Appropriate Use of Medications for People with Asthma. <ul style="list-style-type: none"> • MCLA 	83%
Medication Management for People with Asthma 50% compliance. <ul style="list-style-type: none"> • MCLA 	70%
Medication Management for People with Asthma 75% compliance. <ul style="list-style-type: none"> • MCLA 	49%
Asthma Action Plan	75%
Flu shot	65%
Overall Member Satisfaction	90%

OTHER 2015 SURVEY MEASURE GOALS*:

Measures	2015 Goals
Material Helped	75%
Satisfied with Contact	90%
Feel In Control of Asthma	85%

* 2014 survey results are serving as baseline measurements for 2015 goals.

A.5.b DIABETES DISEASE MANAGEMENT PROGRAM

2014 WORK PLAN GOALS:

- Members in the Diabetes Disease Management Program will be satisfied with the program. Goal 8 (scale of 1-10 with 10 being the highest).
- Members diagnosed with diabetes will receive the recommended tests: 2014 HEDIS reporting data.

MEASURE	2013 GOAL MCLA (Hybrid)
A1c screening	86%
A1c good control (< 8%)	50%
A1c poor control (> 9%)*	37%
LDL screening	77%
LDL control (< 100mg/dl)	37%
Retinal eye exam	46%
Nephropathy screening	83%

**This is an inverse measure; a lower number is better.*

BACKGROUND

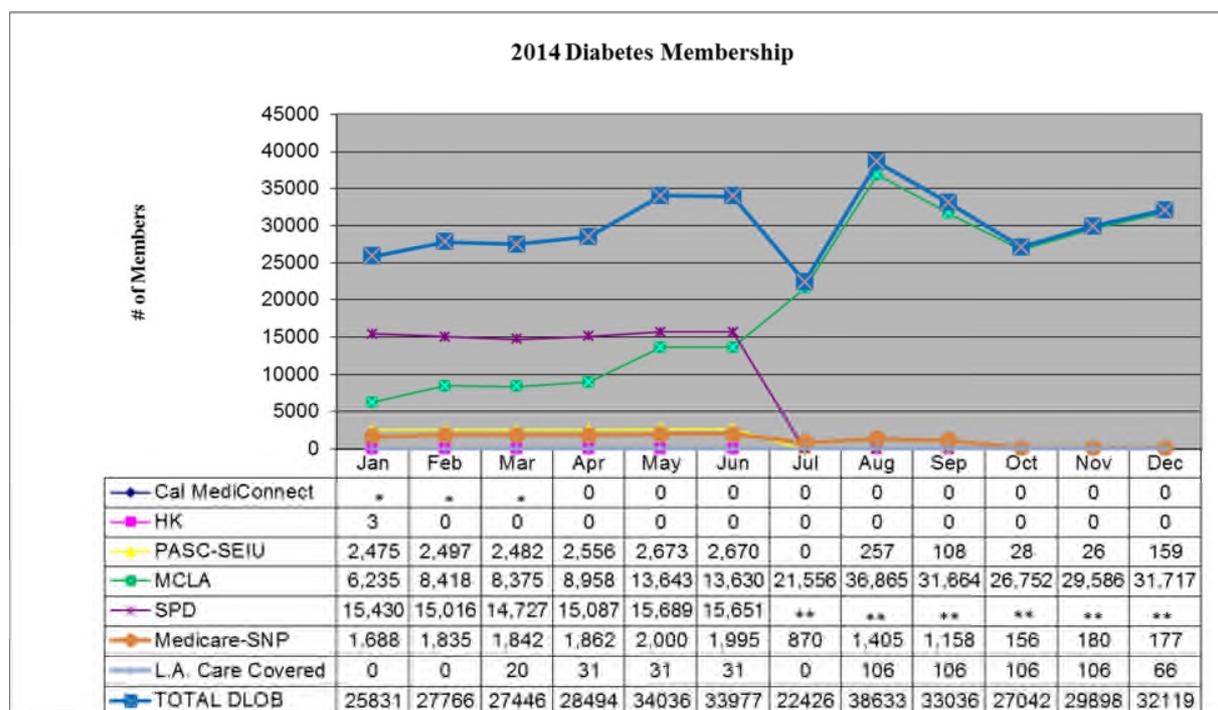
The 15.50% prevalence of diabetes among L.A. Care's Medi-Cal 2014 membership has remained similar to the 2013 prevalence of 16.30%. This is higher than the Los Angeles County rate of 9.9% among adults only. The difference is primarily due to the high number of seniors and people with disability enrolled in L.A. Care's Medi-Cal program, which brings the overall prevalence rate up. *L.A. Cares About Diabetes®*, L.A. Care's diabetes disease management program, was implemented through the delegated NCQA accredited vendor, American Healthways, from January 1, 2008 to June 30, 2014. Starting July 1, 2014, L.A. Care's diabetes disease management program was implemented in-house. *LA Cares About Diabetes®* focuses on a collaborative, team-based approach for improving health outcomes of members with diabetes. The program considers the Social-Ecological model in planning all interventions. This model encompasses all of the inter-related areas that affect health behavior, including the individual, interpersonal relationships, organizational impacts, the community and societal norms and public policies (Bronfenbrenner, 1979).

Program interventions are based on the Relationship-Based Care (RBC) delivery model, a conceptual framework, which places the member, member's caregiver, and the member's family at the center, impacted by the relationships and collaboration and delivery of care of an integrated interdisciplinary care team. The model emphasizes the measurement of clinical and health behavior outcomes resulting from team-based, member-focused interventions (Koloroutis, 2004). *LA Cares About Diabetes®* program content addresses condition monitoring, self-management, adherence to treatment plans, consideration of other health conditions/medical and behavioral health co-morbidities and other health conditions, health behaviors, psychosocial issues, depression screening, information about the member's condition provided to caregivers who have the member's consent, encouraging members to communicate with their practitioners about their health conditions and treatment, lifestyle issues, and use of available external resources. The program focuses on the development, implementation, and evaluation of a system of coordinated health care interventions and communications for patients with diabetes and the practitioners who care for them. L.A. Care's multidisciplinary program team uses their expertise in specific areas to develop and implement multi-faceted intervention programs that are culturally-sensitive, linguistically appropriate, and meet the unique needs of the target population and practitioner community. L.A. Care also considers the level of health literacy in developing interventions. All written health education materials and resources adhere to regulatory guidelines as applicable to the product line. All materials are

tested for reading level and are written at 6th grade level or below and are easy-to-read and cognitively accessible.

L.A. Cares About Diabetes® is based on evidence-based clinical guidelines and utilizes recognized sources (e.g. American Diabetes Association (ADA)) for its clinical content. On an annual basis an evidenced based review is conducted on the guidelines to identify any significant changes that would require an update to the program. Members with diabetes are identified on a monthly basis and are stratified into one of five risk levels (0, 1, 2, 3, and 4 with 4 being highest risk) based on medical utilization and pharmacy claims. The member's stratification determines the type and intensity of program intervention he or she receives.

The graphs and tables below show L.A. Care eligible diabetes members for each direct line of business: Cal MediConnect, Healthy Kids, PASC-SEIU Homecare Workers, L.A. Care Medi-Cal Direct (MCLA), L.A. Care Medi-Cal Direct SPD, Medicare-SNP, and L.A. Care Covered.



Practitioner interventions focus on education and adherence to clinical practice guidelines to improve the assessment and treatment of members with diabetes. Disease management clinicians emphasize that practitioners play an active role in teaching patients to effectively manage their diabetes.

MAJOR ACCOMPLISHMENTS

- The 2014 HEDIS rate for LDL screening, LDL control <100mg/dL and nephropathy improved and exceeded the work plan goal.
- In October and November 2014, L.A. Care conducted reminder calls to 41,645 members who had not had their diabetes screenings (A1C, LDL, and DRE). There were 7,729 members reached. Of those reached, 4,927 (63.8%) had already completed the tests/exams in 2014. Additional outreach calls were made to 496 members, and 179 (36.1%) members confirmed they had already had the tests/exams in 2014.

RESULTS

Participation Rate

Member participation rates are measured annually. The active participation rate is the number of members who are Level 3 or 4 and who have received at least one interactive contact in an intervention, divided by the number of members in level 3 or 4 who are identified as eligible for the program from July through December 2014. In 2014, the active participation rate was 12.7%, which was a decrease compared to the 2012 rate of 31%. The decrease is a result of changes to the program moving in-house and using membership from July – December of 2014 interventions. Total enrollment in the diabetes program as of December 2014 was 31,717.

The 2013 Participation rate included low-severity members, who receive mailing-only interventions. We have changed the methodology for 2014 to accurately reflect only those members who are eligible for nurse outreach. Level 1 and 2 members (low-severity diabetes members) are identified and enrolled in a registry and receive mail based education throughout the year. As such, they are not considered active participants in the program.

Member Satisfaction

To assess participant satisfaction with the diabetes disease management program, Healthways uses a Satisfaction Survey developed by the Care Continuum Alliance. Annually, Healthways conducts a telephonic satisfaction survey. The survey questions are designed to provide feedback in five general categories: Global Satisfaction, Program/Staffing, Information/Communication, Lifestyle Changes (Information on behavior change), and Productivity.

Qualitative Analysis

Healthways' benchmark is 6.88 and the Care Continuum benchmark is 7.09. In 2014, L.A. Care exceeded both benchmarks with an overall satisfaction mean of 8.56 (with 1-unacceptable and 10 outstanding), which was an increase of 0.34 compared to the 2013 mean of 8.22. The goal of 8.0 was met. In 2011, there was a delay in fielding the survey; therefore, results were not available. The sample size has not been large enough to be statistically significant. The *L.A. Care's About Diabetes*® members' responses were positive, indicating that L.A. Care members are highly satisfied with the Healthways diabetes disease management program. Although members are satisfied with the overall disease management program, barriers affecting member satisfaction rates include: ability to connect with the member on the telephone, member perception of inability to manage chronic disease, and the member's health concerns and/or other priorities. Strategies to increase connectivity include: call members in the early morning versus in the evening since connectivity is shown to be better in the morning and increase initial engagement (welcome calls) by calling at least once a month. In 2015, *L.A. Care's About Diabetes*® will conduct a member satisfaction and knowledge assessment survey.

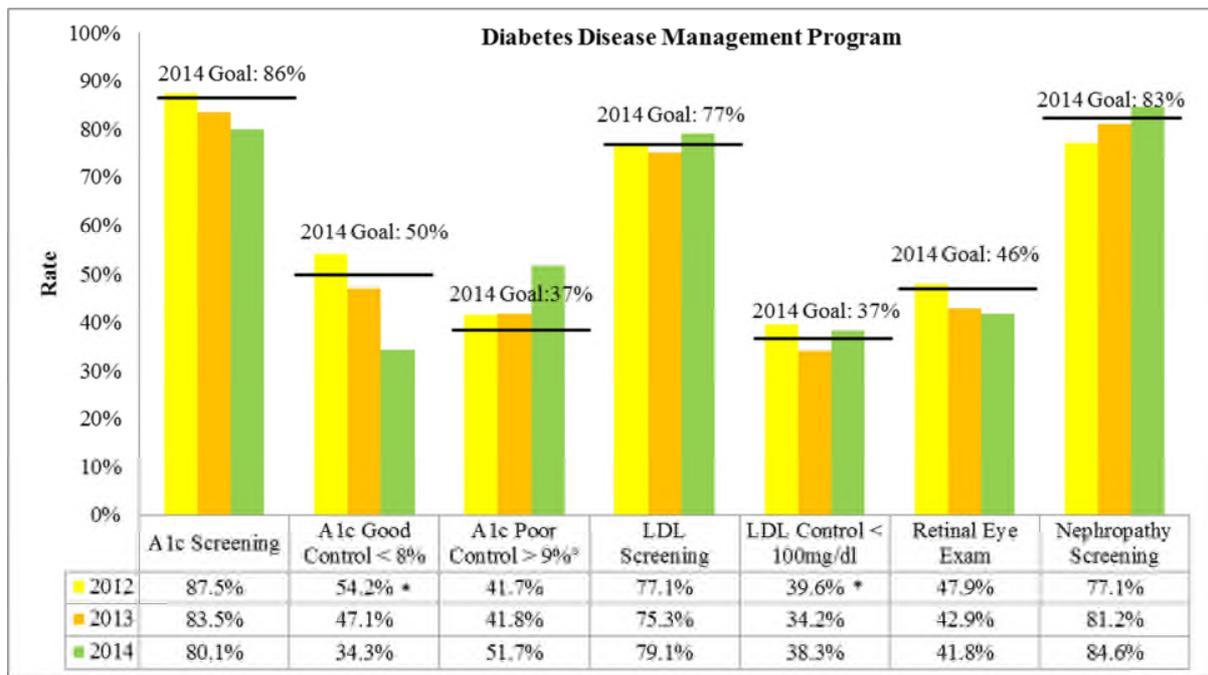
Member complaints and inquiries are evaluated annually to identify opportunities to improve satisfaction with the disease management process. Complaints related to the disease management program are identified via Healthways and L.A. Care grievances. Members Services staff keep a log of all member complaints and inquiries. In 2014 there was zero complaints related to the diabetes disease management program. This supports that members are satisfied with the disease management program.

HEDIS RESULTS

MEASURE	2012* Measurement year 2011	2013* Measurement year 2012	2014* Measurement year 2013
Hybrid MCLA data			
A1c screening	87.5%	83.5%	80.1%
A1c good control < 8%	54.2%**	47.1%	34.3%
A1c poor control > 9% <i>Note: this is an inverse measure; lower number better</i>	41.7%	41.8%	51.7%
LDL screening	77.1%	75.3%	79.1%
LDL control < 100mg/dL	39.6%**	34.2%	38.3%
Retinal eye exam	47.9%	42.9%	41.8%
Nephropathy screening	77.1%	81.2%	84.6%

* HEDIS Reporting Year. 2013 denominator was 157. 2012 denominator was 48. 2011 denominator was 33.

** Statistically significant difference



*Statistically Significant Difference °Inverse measure (lower number better)

Quantitative Analysis

In 2014, A1c screening was 80.1 percent, which was a 4.1 percent decline compared to the 2013 rate of 83.5 percent. The 2014 goal of 86.0 percent was not met. In 2014, A1c good control (<8%) was 34.3 percent, which was a 27.2 percent decline compared to the 2013 rate of 47.1 percent. The 2014 goal of 50 percent was not met. In 2014, A1c poor control (>9%) was 51.7 percent, which was a 23.7 percent improvement compared to the 2013 rate of 41.8 percent. (*Note, this is an inverse measure; lower number is better*). The 2014 goal of 37.0 percent was not met. In 2014, LDL screening was 79.1 percent, which was a 5.0 percent improvement compared to the 2013 rate of 75.3 percent. The 2014 goal of 77.0 percent was met. In 2014, LDL control (<100mg/dl) was 38.3 percent, which was a 12.0 percent improvement compared to the 2013 rate of 34.2 percent. The 2014 goal of 37.0 percent was met. In 2014, retinal eye exam was 41.8 percent, which was a 2.6 percent decline compared to the 2013 rate of 42.9 percent. The 2014, goal of 46.0 percent was not met. In 2014 nephropathy testing was 84.6 percent, which was a 4.2 percent improvement compared to the 2013 rate of 81.2 percent. The 2014 goal of 83.0 percent was met.

Qualitative Analysis

In 2014, of the seven measures there was improvement in three measures: LDL screening, LDL control <100mg/dL, and nephropathy screening. There was no improvement noted in A1C screening, A1c good (<8%) control, A1c poor control (>9%), and retinal eye exam. In 2013, of the seven measures, there was improvement in one measure, nephropathy. There were six measures that did not show improvement (A1C screening, A1C good control <8%, A1C poor control >9%, LDL screening, LDL control <100mg/dL, and retinal eye exam). The diabetes membership continues to grow. In 2013 there were 21,984 members in the program. As of December 2014 there were 31,717 members in the program. This change is not comparable since membership criteria were changed when the program was transitioned in-house in July 2104.

Some identified member barriers include, but are not limited to: ability to connect with members on the telephone, need to use translation services for some members, diversity of cultures, financial barriers regarding transportation and access to care, multiple co-morbidities, lack of knowledge regarding how to navigate through the healthcare system to help themselves, and difficulty building a working relationship with a primary care practitioner. There are also challenges with building relationships telephonically with the members, the member's motivation and self-efficacy to change behavior, and the lack of basic health education on diabetes. Education is needed to assist members in self-management. To address this, the *L.A. Care's About Diabetes®* program developed a workflow that refers members identified as needing further education to L.A. Care's Health Education department, who will provide the needed education to the members in a variety of modalities to meet the member's specific needs.

Programs offered include, "Healthier Living" which teaches skills to help individuals manage chronic conditions and "Weight Watchers" which helps individuals with weight management. In 2012, L.A. Care added a Medical Nutrition Therapy (MNT) program. The MNT program uses specific nutrition interventions to treat an illness, injury or condition. The program objectives are to optimize blood glucose levels, lipids and/or blood pressure, prevent and treat chronic complications such as retinopathy and nephropathy, adapt dietary intake to individual's differences (culture and willingness to change), and integrate insulin regimens into usual eating and physical activity habits. In 2013, a new Diabetes Self-Management Education (DSME) program was added. The DSME program is a series of four interactive workshops to help individuals manage diabetes. Members learn about how diabetes affects their body, how to check and manage blood sugar, how to prevent or delay complications from diabetes, how to eat well while managing diabetes, and how different medications work. The program is also offered telephonically. In 2014, L.A. Care's Health Education department developed a Pre-Diabetes program for the level 0 membership that includes a mailing to members on preventing or delaying onset of diabetes, and offers telephonic or group education and services on nutrition, hypertension, weight management and resources to quit smoking.

The *L.A. Care's About Diabetes*® program is continuously striving to improve results and has taken actions to learn about members' priorities, to acknowledge barriers, to identify which barriers are most problematic for the members, to empower the members to take action, to summarize the call with the member and ask, "Have I answered all of your questions," and to ask the member before the end of the call if the call has been valuable.

An additional barrier which has been identified is practitioners not adhering to clinical practice guidelines. L.A. Care recognizes this barrier and has implemented various methods for guideline dissemination for practitioners. Practitioners receive clinical practice guidelines in numerous ways throughout the year. For example, they also receive information on updated guidelines and diabetes care reminders via L.A. Care's practitioner newsletter. Additionally, practitioners receive an annual opportunity report with the HEDIS diabetes rates for review and follow-up and in a separate mailing they receive the most current diabetes clinical practice guidelines and reference tools. These materials are also available on the practitioner section of L.A. Care's website.

Performance metrics for The *L.A. Care's About Diabetes*® program have been set to include process measures such as the number of members identified and enrolled, number of mail and phone contacts, and outcome measures such as HEDIS rates and member satisfaction. Evaluation of the diabetes disease management program is conducted annually.

LOOKING FORWARD

- The *L.A. Care's About Diabetes*® program will continue to explore ways to best provide diabetes disease management.
- The *L.A. Care's About Diabetes*® program will conduct a 2015 member satisfaction and knowledge assessment survey.
- L.A. Care and The *L.A. Care's About Diabetes*® program will work collaboratively at improving our HEDIS diabetes care measurement scores.

2015 WORK PLAN GOALS:

MEASURE	2015 GOAL MCLA (Hybrid)
A1c screening	82%
A1c good control (< 8%)	37%
*A1c poor control (> 9%)	47%
LDL screening	Measure retired in 2015
LDL control (< 100mg/dl)	Measure retired in 2015
Retinal eye exam	45%
Nephropathy screening	87%

* This is an inverse measure; a lower number is better.

DIABETES MANAGEMENT - MEDICARE

2014 WORK PLAN GOALS:

- Members in the Chronic Care Improvement program will be satisfied with the program. Goal 8 (scale of 1-10 with 10 being the highest).
- Members diagnosed with diabetes will receive the recommended tests: 2014 HEDIS reporting data.

HEDIS MEASURE	2014 GOAL
A1c screening	95%
A1c good control (< 8%)	65%
A1c poor control (> 9%)*	23%
LDL screening	92%
LDL control (< 100mg/dl)	56%
Retinal Eye Exam	67%
Nephropathy screening	94%

**Note: this is an inverse measure; a lower number is better.*

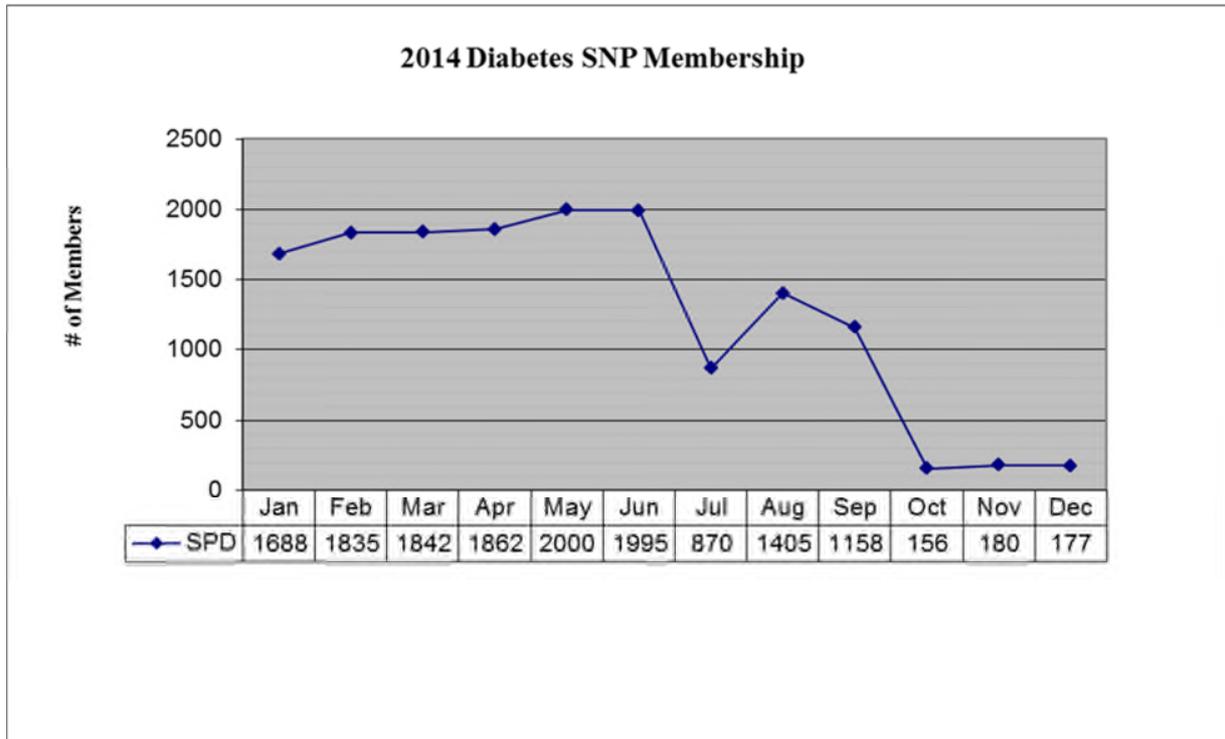
BACKGROUND

The prevalence of diabetes among L.A. Care's Medicare membership as of July, 2014 was approximately 25%. This is higher than the Los Angeles County rate of 9.9% among adults only. The difference may be due to the high number of older members (65 and above) enrolled in L.A. Care's Medicare SNP program, which brings the overall prevalence rate higher. *LA Cares About Diabetes*®, the L.A. Care chronic care improvement program was implemented through the delegated NCQA accredited vendor, American Healthways from January 2008 to June 2014. Starting July 1, 2014 the *LA Cares About Diabetes*®, L.A. Care's diabetes disease management program was implemented in-house. *LA Cares About Diabetes*® focuses on a collaborative, team-based approach for improving health outcomes of members with diabetes. The program considers the Social-Ecological model in planning all interventions. This model encompasses all of the inter-related areas that affect health behavior, including the individual, interpersonal relationships, organizational impacts, the community and societal norms and public policies (Bronfenbrenner, 1979)

Program interventions are based on the Relationship-Based Care (RBC) delivery model, a conceptual framework, which places the member, member's caregiver, and the member's family at the center, impacted by the relationships and collaboration and delivery of care of an integrated interdisciplinary care team. The model emphasizes the measurement of clinical and health behavior outcomes resulting from team-based, member-focused interventions (Koloroutis, 2004). *LA Cares About Diabetes*® program content addresses condition monitoring, self- management, adherence to treatment plans, consideration of other health conditions/medical and behavioral health co-morbidities and other health conditions, health behaviors, psychosocial issues, depression screening, information about the member's condition provided to caregivers who have the member's consent, encouraging members to communicate with their practitioners about their health conditions and treatment, lifestyle issues, and use of available external resources. The program focuses on the development, implementation, and evaluation of a system of coordinated health care interventions and communications for patients with diabetes and the practitioners who care for them. L.A. Care's multidisciplinary program team uses their expertise in specific areas to develop and implement multi-faceted intervention programs that are culturally-sensitive, linguistically appropriate, and meet the unique needs of the target population and practitioner community. L.A. Care also considers the level of health literacy in developing interventions. All written health education materials and resources adhere to regulatory guidelines as applicable to the product line. All materials are

tested for reading level and are written at 6th grade level or below and are easy-to-read and cognitively accessible.

The graphs and tables below show L.A. Care eligible diabetes members for the Medicare SNP population for 2014. As of 12/31/2014 the Medicare SNP line of business was terminated by L.A. Care.



MAJOR ACCOMPLISHMENTS

- 2014 HEDIS showed improvement in two of the seven measures. Nephropathy screening and retinal eye exam measures improved in 2014.
- In October and November 2014, L.A. Care conducted reminder calls to 41,645 members who had not had their diabetes screenings (A1C, LDL, and DRE). There were 7,729 members reached. Of those reached, 4,927 (63.8%) had already completed the testes/exams in 2014. Additional outreach calls were made to 496 members and 179 (36.1%) members confirmed they had already had the tests/exams in 2014.
- In July, 2014 L.A. Care mailed out a diabetes educational booklet to all members identified with diabetes.

RESULTS

Participation Rate

Member participation rates are measured annually. The active participation rate is the number of members level 3 and 4 who have received at least one interactive contact in an intervention (13), divided by the number of members level 3 and 4 who are identified as eligible for the program (147) from July through December 2014. In 2014, the active participation rate was 8.8%. Total enrollment in the diabetes chronic care improvement program as of December 2014 was 177. By January 1, 2015 total enrollment was 0.

The 2013 Participation rate included level 1 and 2 members which receive mailing only interventions. We have changed the methodology for 2014 to accurately reflect only those members who are eligible for nurse outreach. Level 1 and 2 (low severity diabetes members) are identified and enrolled in a registry and receive mail based education throughout the year. As such, they are not considered active participants in the program.

Member Satisfaction

To assess participant satisfaction with the diabetes disease management program, Healthways uses a Satisfaction Survey developed by the Care Continuum Alliance. Healthways conducts an annual telephonic satisfaction survey. The survey questions are designed to provide feedback in five general categories: Global Satisfaction, Program/Staffing, Information/Communication, Lifestyle Changes (Information on behavior change), and Productivity.

Qualitative Analysis

Healthways’ benchmark is 6.88 and the Care Continuum benchmark is 7.09. In 2014, L.A. Care exceeded both benchmarks with an overall satisfaction mean of 8.56 (with 1-unacceptable and 10 outstanding), which was an increase of 0.34 compared to the 2013 mean of 8.22. The goal of 8.0 was met. In 2011, there was a delay in fielding the survey; therefore, results were not available. The sample size has not been large enough to be statistically significant. Members’ responses were positive, indicating that L.A. Care members are highly satisfied with the Healthways diabetes disease management program. Although members are satisfied with the overall disease management program, barriers affecting member satisfaction rates include: ability to connect with the member on the telephone, member perception of inability to manage chronic disease, and the member’s health concerns and/or other priorities. Strategies to increase connectivity include: call members in the early morning versus in the evening since connectivity is shown to be better in the morning and increase initial engagement (welcome calls) by calling at least once a month.

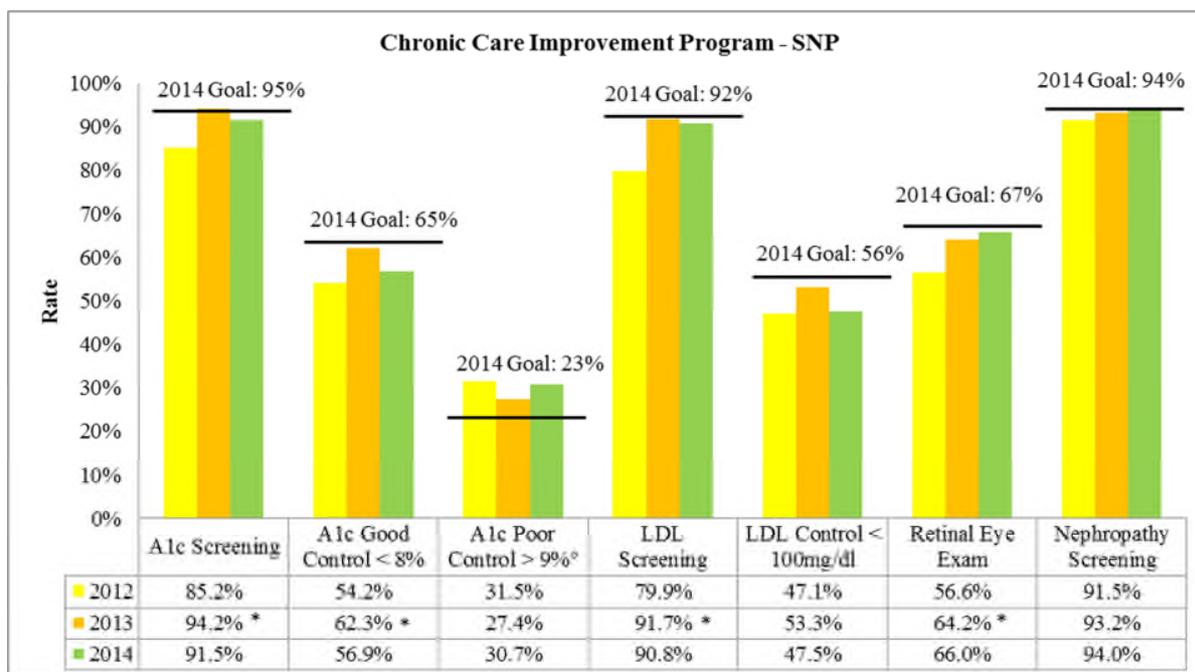
Member complaints and inquiries are evaluated annually to identify opportunities to improve satisfaction with the chronic care management process. Complaints related to the chronic care improvement program are identified via Healthways and L.A. Care grievances. Members Services staff keep a log of all member complaints and inquiries. In 2012, 2013, and 2014 there were no complaints related to the chronic care improvement program. This supports that members are satisfied with the chronic care improvement program.

HEDIS Results

HEDIS MEASURE	2012* MEASUREMENT YEAR 2011	2013* MEASUREMENT YEAR 2012	2014* MEASUREMENT YEAR 2013
A1c screening	85.2% **	94.2% **	91.5%
A1c good control < 8%	54.2% **	62.3% **	56.9%
A1c poor control > 9% <i>Note: this is an inverse measure; lower number better</i>	31.5% **	27.4%	30.7%
LDL screening	79.9% **	91.7% **	90.8%
LDL control < 100mg/dl	47.1% **	53.3%	47.5%
Retinal Eye Exam	56.6% **	64.2% **	66.0%
Nephropathy screening	91.5%	93.2%	94.0%

**HEDIS Reporting Year*

***statistically significant difference*



*Statistically Significant Difference ^oInverse measure (lower number better)

Quantitative Analysis

In 2014, A1c screening was 91.5 percent, which was a 2.9 percent decline compared to the 2013 rate of 94.2 percent. In 2014, A1c good control (<8%) was 56.9 percent, which was a 39.7 percent decline compared to the 2013 rate of 94.3 percent. In 2014 A1c poor control (>9%) was 30.7 percent, which was a 12.0 percent improvement compared to the 2013 rate of 27.4 percent. In 2014, LDL screening was 90.8 percent, which was a 1.1 percent decline compared to the 2013 rate of 91.8 percent. In 2014, LDL control (<100mg/dL) was 47.5 percent, which was a 10.9 percent decline compared to the 2013 rate of 53.3 percent. In 2014, retinal eye exam was 66.0 percent, which was a 2.8 percent improvement compared to the 2013 rate of 64.2 percent. In 2014, nephropathy testing was 94.0 percent, which was a .8 percent improvement compared to the 2013 rate of 93.2 percent. The 2014 goal of 94 percent was met.

Qualitative Analysis

In 2014, two of the seven measures improved. The Medicare diabetes membership as of December was 177 and of January 1, 2015 was 0.

Some of the identified member barriers include, but are not limited to: SNP line of business was terminated as of 12/31/2014, ability to connect with members on the telephone, need to use translation services for some members, diversity of cultures, financial barriers regarding transportation and access to care, multiple co-morbidities, lack of knowledge regarding how to navigate through the healthcare system to help themselves, and little or no members have working relationships with a primary care provider. There are also challenges with building relationships telephonically with the members, the member’s willingness to change behavior, and the lack of basic information on their condition. Education is needed to assist members in self-management.

Programs offered include “Healthier Living” which teaches skills to help patients manage chronic conditions. In 2012, L.A. Care added a Medical Nutrition Therapy (MNT) program. The MNT program uses specific nutrition interventions to treat an illness, injury or condition. The program objectives are to optimize blood glucose levels, lipids and/or blood pressure, prevent and treat chronic complications such

as retinopathy and nephropathy, adapt dietary intake to individual’s differences (culture and willingness to change), and integrate insulin regimens into usual eating and physical activity habits. In 2014, a new Diabetes Self-Management Education (DSME) program was added. The DSME program is a series of four interactive workshops to help individuals manage diabetes. Members learn about how diabetes affects their body, how to check and manage blood sugar, how to prevent or delay complications from diabetes, how to eat well while managing diabetes, and how different medications work. The program is also offered telephonically.

Members with multiple issues may also be referred to Complex Case Management Program.

An additional barrier which has been identified is providers not adhering to guidelines. L.A. Care recognizes this barrier and has implemented various methods for guideline dissemination for providers. Providers receive guidelines in numerous ways throughout the year. For example, they receive information on updated guidelines and diabetes care reminders via L.A. Care’s provider newsletter. Additionally, all providers receive an annual mid-year report with the HEDIS diabetes rates for review and follow-up and in a separate mailing they receive the most current diabetes guidelines and reference tools. These materials are also available on the provider section of L.A. Care’s website.

LOOKING FORWARD

- As of January 1, 2015 the Medicare SNP population will enroll in the Medicare CMC line of business and will be eligible for the *L.A. Care’s About Diabetes®* disease management program.

A.5.c REDUCING CARDIOVASCULAR RISK

2014 WORK PLAN GOALS:

- A. Improve health outcomes, quality of care, and disease self-management for members with cardiovascular risk by ensuring efficient and appropriate utilization of resources and treatment plans.

Administrative Measures (2013 Benchmarks)	Specific Indicators	2014 Results
Cholesterol Management for Patients with Cardiovascular Conditions (CMC, HEDIS) Screening (≥95.56%) Control (≥71.45%)	Percent of adult members who received an LDL-C Screening in the past year	LDL-C Screening: 95.6% LDL-C control (<100 mg/dL): 61.5 %
Controlling High Blood Pressure (CBP, HEDIS) (Star Measure 5*≥79.87%)	Percent of adult members who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled(<140/90) during the measurement year	65.9%
Adult BMI Assessment (ABA, HEDIS) (Star Measure 5*≥97.81%)	Percent of adult members who had their body mass index (BMI) and weight documented during an outpatient visit either by a claim or as a medical record entry during the measurement year or year prior	91%

Administrative Measures (2013 Benchmarks)	Specific Indicators	2014 Results
Medication Adherence for Hypertension (ACEI, ARB) (STAR Measure 5* \geq 79%)	Percent of adult Medicare Part D members who adhere to their prescribed drug therapy for angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medications.	69%
Medication Adherence for Cholesterol (Statins) (STAR Measure 5* \geq 75%)	Percent of adult Medicare Part D members who adhere to their prescribed drug therapy for statin cholesterol medications	63%
Annual Flu Shot (CAHPS) (\geq 78%)	Percentage of Medicare members 65 years of age and older who received an influenza vaccination between September 1, 2012 and the date on which the Medicare CAHPS® survey was completed	74.1%
Pneumonia Shot (CAHPS) (71.1%)	Percentage of Medicare members 65 years of age and older who have ever received a pneumococcal vaccine.	61.9%

B. Reduce further deterioration of cardiac disease as manifested in heart attacks and strokes.

- Reduce hospitalizations by 5%, over 5 years, for members with a CVD event or a diagnosis of hypercholesterolemia (ICD-9 codes: 272.0-.5) or hypertension (ICD-9 codes: 401.0-.1, 401.9).

BACKGROUND

Reducing cardiovascular risk was selected as a Chronic Care Improvement Program (CCIP) focus based on multiple factors. Heart disease is the leading cause of death in both men and women, (National Vital Statistics Reports, Deaths, 2008) for all racial/ethnic groups, and persons 45 years and older (Mortality in Los Angeles County, 2003). While heart disease can lead to death, disability, or a reduced quality of life, national clinical treatment guidelines, such as the National Cholesterol Education Program, provide guidance on how risk factors for heart disease can be managed and controlled with patient self-management, lifestyle changes and pharmaceutical treatment (Source: CDC Million Hearts®). Additionally, the high adult prevalence estimates in Los Angeles County for heart disease and its risk factors (heart disease-5.6%, high cholesterol 24.2%, hypertension 23.6%, cigarette smoking 15.2%, being overweight 34.6%, being obese 20.6% sedentary lifestyle/no physical inactivity 10.9%) influenced L.A. Care's decision to implement a cardiovascular risk reduction program (Source: California Health Interview Survey 2005-2011).

According to claims, encounter, and pharmacy data, the prevalence of hypertension and hypercholesterolemia, diabetes and other cardiovascular disease co-morbidities identified among L.A. Care's SNP membership is approximately 72%. The program includes these hypertensive and hypercholesterolemic members as well as members identified with other cardiovascular risk factors, such as chronic kidney disease and obesity. In 2014, L. A. Care added two new lines of business to the CVD program. These are LA Care Covered Exchange (LACC) and Cal MediConnect (Duals or CMC). While the membership is currently low, claims and encounters are beginning to come in. In August, the CVD program enrolled 609 new LACC members and 1011 new CMC members. We expect the membership will continue to grow as our program expands.

MAJOR ACCOMPLISHMENTS

- *L.A. Cares About Your Heart*® developed a disease management website landing page with program and referral information for members and providers on the L.A. Care website. CVD educational videos for our members were included on the CVD program webpage.
- The algorithm used to identify members for the program was expanded to include members with diabetes, so that members stratified at a low severity level into the diabetes disease management program can now receive coordinated interventions from both programs.
- *L.A. Cares About Your Heart*® worked with the Health Education, Communications and Marketing departments to develop a series of seasonal “*For a Healthy Heart*” postcards. All four postcards have been mailed to members throughout the year. The L.A. Care disease management brochure for providers was revised to include the *L.A. Cares About Your Heart*® program and referral information and sent to providers.
- *L.A. Cares About Your Heart*® developed a CVD formulary, which was mailed to providers.
- Disease Management Department created an internal DM brochure educating other departments of the 3 programs we offer and was distributed to department heads.
- Program membership increased from 4319 members at the beginning of 2014 to 8,573 members at the end of the year.
- The pharmacy department has three incentive programs running to increase medication compliance. These include the member refill reminder call (IVR Program), the Member CHOICE 90 program (90 day refill) and the Practitioner DUE mailings.
- The monthly CVD report format was updated to include lab results (when available), utilizing LOINC codes to identify this data element.
- The CVD program began enrollment of Cal MediConnect (CMC) members into the program.
- The CVD program began enrollment of L.A. Care Connect (LACC) members into the program.
- The CVD Toolkit was updated with new 2014 AHA guidelines and educational materials were updated for our providers and members. The toolkit is on the CVD webpage for provider access.

Membership and Participation Rate

In 2014, L.A. Care identified eligible members using an algorithm to identify hypertensive and hypercholesterolemic members as well as members with other cardiovascular risk factors, such as chronic kidney disease and obesity. *L.A. Cares About Your Heart*® utilizes an opt-out enrollment method, which means that eligible members are enrolled unless they actively opt out. One member opted out of the program in 2014. The average monthly membership through September 2014 was 5,086.

COMPLAINTS AND INQUIRIES

Member complaints and inquiries are evaluated to identify opportunities to improve satisfaction with the disease management process. Complaints related to the disease management program are identified through L.A. Care’s grievance process. Member services staff keep a log of all member complaints and inquiries related to disease management. In 2014, there were 0 complaints related to *L.A. Cares About Your Heart*® and 23 inquiries about the program.

ANALYSIS

Intervention Effectiveness:

2013 was the inaugural year for *L.A. Cares About Your Heart*®. As such, 2013 results for effectiveness measures will serve as baseline, and measurement of program effectiveness will begin in 2014.

Measure	Barrier	Action/Intervention	Effectiveness of Intervention/ Outcome
ICD-9 to ICD-10 transition	<ul style="list-style-type: none"> Federal law requires providers to change to new system by October 2014 		Federal government has postponed use of ICD-10 until October 2015

Quantitative Analysis

As 2013 was the inaugural year for *L.A. Cares About Your Heart®*, 2013 performance measures will be used as a baseline for 2014 goals and evaluation of program effectiveness. In 2013, program performance measure results were as follows:

Administrative Measures	2013 Results
Cholesterol Management for Patients with Cardiovascular Conditions (CMC, HEDIS)	LDL-C Screening: 97% LDL-C control (<100 mg/dL): 71%
Controlling High Blood Pressure (CBP, HEDIS)	73%
Adult BMI Assessment (ABA, HEDIS)	82.5%
Medication Adherence for Hypertension (ACEI, ARB) (STAR Measure)	67.0%
Medication Adherence for Cholesterol (Statins) (STAR Measure)	57.0%
Annual Flu Shot (CAHPS)	72.4%
Pneumonia Shot (CAHPS)	57.5%

ANALYSIS OF 2014 RESULTS OR FINDINGS:

- Annual Flu Shot rate of **74.55%** was **3.45 percentage points below the 5 Star rate of greater than or equal to 78%**
- The Pneumonia Shot measure is no longer a 5 star rating; therefore, it was compared to the Medicare national average. L.A. Care's rate of **61.86%** was **9.24 percentage points below the national average of 71.1**
- Cholesterol Management for Patients with Cardiovascular Conditions LDL-C Screening was **95.60%** which was **0.04 percentage points above the 5 Star rate of greater than or equal to 95.56%**.
- The Cholesterol Management for Patients with Cardiovascular Conditions measure is not a 5 star measure; therefore, it was compared against the 90th percentile from the Quality Compass. LDL-C Control less than 100mg/dL was **61.54%** which was **9.91 percentage points below the 90th percentile from the Quality Compass of 71.45%**
- Medication Adherence for Cholesterol (Statins) rate was **63%** which was **12 percentage points below the 5 Star rate of greater than or equal to 75%**.
- Medication Adherence for Hypertension (ACEI, ARB) rate was **69%** which was **10 percentage points below the 5 Star rate of greater than or equal to 79%**.

- Controlling High Blood Pressure was **65.94% which was 13.93 percentage points below the 5 Star rate of greater than or equal to 79.87%.**
- Adult BMI Assessment (ABA, HEDIS) was **91% which was 6.81 percentage points above the 5 Star rate of greater than or equal to 97.81%.**

Based on these results, we have set goals for 2015 performance measures and will use these to evaluate intervention effectiveness.

Qualitative Analysis

Over the course of 2014, several barriers to achieving high performance measures were noted. As a result, *L.A. Cares About Your Heart®* took several actions to mitigate these barriers. One of the major issues in achieving high performance for all measures was provider compliance with guidelines for CVD management. As such, several resources were made available to providers to review these guidelines, including updated guidelines mailed to providers, online guidelines available on the program website, an updated disease management pamphlet including *L.A. Cares About Your Heart®* information mailed to providers, and a newly-developed medication formulary mailed to providers.

Another continuing barrier is patient information and education regarding cardiovascular health and disease management. Accordingly, in 2014 four educational postcards were mailed to members and a flu shot postcard was developed. *L.A. Cares About Your Heart®* also continued quarterly monitoring telephone monitoring calls to members in order to both inquire about member health status and questions as well as provide education and resources to members. Also, in order effectively contact more members, the program began tracking of members' current phone numbers and addresses to create an improved member contact database.

L.A. Cares About Your Heart® will continue to develop new materials and interventions to address these issues in 2015.

LOOKING FORWARD

- *L.A. Cares About Your Heart®* will continue to review the member identification and stratification process to incorporate members at risk in addition to members identified through cardiovascular related ICD-9 claims and pharmacy medication noncompliance reports.
- *L.A. Cares About Your Heart®* will be able to provide members with resource referrals to an L.A. Care in-house tobacco cessation program offered through health education, so members will be able to receive disease management assistance from a central source.
- The cardiovascular toolkit distributed to providers will continue to be updated with the latest clinical best practice guidelines.
- The CVD disease management website will be updated with a list of educational videos for members, pending CMS approval.
- In 2015, *L.A. Cares About Your Heart®* membership may grow substantially with the inclusion of L.A. Care Covered members as well as Cal MediConnect members.

2015 WORK PLAN GOALS:

Measures	2015 Goal
Controlling High Blood Pressure (CBP, HEDIS)	75%
Adult BMI Assessment (ABA, HEDIS)	93%
Medication Adherence for Hypertension (ACEI, ARB)	72%
Medication Adherence for Cholesterol (Statins)	68%
Annual Flu Shot (CAHPS)	77%

A.6 CLINICAL PRACTICE GUIDELINES COMPLIANCE

2014 WORK PLAN GOAL:

- Measure clinical practice guidelines for at least two medical conditions and at least two behavioral conditions with at least one behavioral guideline addressing children and adolescents.

BACKGROUND

As part of the Model of Care Program, L.A. Care Health Plan adopts evidence-based clinical practice guidelines and preventive health guidelines known to be effective in improving health outcomes promulgated by recognized sources for selected conditions identified as relevant to its membership for the provision of preventive health, non-preventive health, acute and chronic medical conditions, and for preventive and non-preventive behavioral health services. L.A. Care monitors the network compliance with specific clinical and preventive health guidelines through annual medical record review as well as HEDIS and other measures.

Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines (PHGs) are presented for review and approval to the Joint Performance Improvement Collaborative Committee (PICC) and the Physician Quality Committee (PQC) in an effort to improve health care quality and reduce unnecessary variation in care. The CPGs and PHGs are reviewed at least every two (2) years and updated as needed. L.A. Care gets regular clinical and preventive health guideline updates from the Agency for Healthcare Research and Quality, which are published by the National Guidelines Clearinghouse and the U.S. Preventive Services Task Force. L.A. Care disseminates CPGs and PHGs to the practitioners via the L.A. Care website and sends PHG posters to practitioner offices. Practitioners are informed through the provider newsletter (published twice a year) that the CPGs and PHGs are available on the website and that hard copies are available upon request.

Two (2) of L.A. Care's clinical practice guidelines, Diabetes and Cardiovascular Risk provide the clinical basis for L.A. Care's Chronic Care Improvement Programs and are used to guide the program interventions. L.A. Care delegates behavioral health services to an NCQA accredited Managed Behavioral Health Organization (MBHO) for its Healthy Kids Programs, PASC-SEIU Homecare Workers, L.A. Care Covered, Medicare SNP (inpatient only), and Medi-Cal lines of business. Specialty behavioral health, inpatient and substance use benefits are carved out for the Medi-Cal line of business.

Clinical Practice Guidelines

Condition	Clinical Practice Guideline	Source	Reviewed Approved by PICC/PQC	Notification to Practitioners
Diabetes	American Diabetes Association: Clinical Practice Guidelines and Algorithms 2014 Standards of Medical Care in Diabetes (subset of above)	American Diabetes Association www.diabetes.org	9/2/14 4/4/14 2/28/13 2/23/12	Practitioner Newsletter Fall 2014 Summer 2014 Summer 2013 Spring 2013
Cardiovascular Risk	Cardiovascular Risk Reduction/Primordial and Primary Prevention for CVD/Secondary Prevention and Risk Reduction Therapy	American Heart Association	9/2/214 4/4/14 2/28/13 2/23/12	Practitioner Newsletter Fall 2014 Summer 2014 Summer 2013 Spring 2013

Condition	Clinical Practice Guideline	Source	Reviewed Approved by PICC/PQC	Notification to Practitioners
Asthma	NAEPP Expert Panel Report Guidelines for the Diagnosis and Management of Asthma Update on Selected Topics 2007	National Heart, Lung, and Blood Institute	9/2/14 4/4/14 2/28/13 2/23/12	Practitioner Newsletter Fall 2014 Summer 2014 Summer 2013 Spring 2013
COPD	Diagnosis and Management of Stable Chronic Obstructive Pulmonary Disease	American College of Physicians http://www.acponline.org/	9/2/14 4/4/14 2/28/13 2/23/12	Practitioner Newsletter Fall 2014 Summer 2014 Summer 2013 Spring 2013

Behavioral Guidelines

Condition	Behavioral Guideline	Source	Reviewed Approved by PICC/PQC	Notification to Practitioners
Depression	Treating Major Depressive Disorder (2010)	American Psychiatric Association www.psych.org	9/2/14 4/4/14 2/28/13 2/23/12	Practitioner Newsletter Fall 2014 Summer 2014 Summer 2013 Spring 2013
Attention Deficit Hyperactivity Disorder	Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents (2011)	American Academy of Pediatrics www.aap.org	9/2/214 4/4/14 2/28/13 2/23/12	Practitioner Newsletter Fall 2014 Summer 2014 Summer 2013 Spring 2013

Preventive Health Guidelines

Preventive Service	Preventive Health Guideline	Source	Reviewed Approved by PICC/PQC	Notification to Practitioners
Preventive Screenings				
Adult BMI	Obesity in Adults	U. S. Preventive Task Force http://www.uspreventiveservicestaskforce.org/adultrec.htm	9/2/14 4/4/14 2/28/13 2/23/12	Practitioner Newsletter Fall 2014 Fall 2013 Summer 2013 Summer 2012

Preventive Service	Preventive Health Guideline	Source	Reviewed Approved by PICC/PQC	Notification to Practitioners
Preventive Screenings				
Cervical Cancer Screening	Cervical Cancer	U. S. Preventive Task Force http://www.uspreventiveservicestaskforce.org/adultrec.htm	9/2/14 4/4/14 12/9/13 2/28/13	Practitioner Newsletter Fall 2014 Fall 2013 Summer 2013 Summer 2012
Colorectal Cancer Screening	Colorectal Cancer	U. S. Preventive Task Force http://www.uspreventiveservicestaskforce.org/adultrec.htm	9/2/14 4/4/14 12/9/13 2/28/13	Practitioner Newsletter Fall 2014 Fall 2013 Summer 2013 Summer 2012
Vaccinations				
Influenza Vaccination	Immunization	CDC Immunization Schedules http://www.cdc.gov/vaccines/schedules/index.html	9/2/14 4/4/14 12/9/13 2/28/13	Practitioner Newsletter Fall 2014 Fall 2013 Summer 2013 Summer 2012
Pneumococcal Vaccination	Immunization	CDC Immunization Schedules http://www.cdc.gov/vaccines/schedules/index.html	9/2/14 4/4/14 12/9/13 2/28/13	Practitioner Newsletter Fall 2014 Fall 2013 Summer 2013 Summer 2012

Compliance with the Clinical and Preventive Health guidelines is measured using annual HEDIS and CAHPS rates and other measures. L.A. Care annually measures performance of at least two important aspects for each of its clinical and preventive health guidelines. The performance is compared to goals and/or benchmarks which can be from Quality Compass, Centers for Medicare and Medicaid Services (CMS) Star rating technical specification or the Medicare National HMO Averages from The State of Health Care Quality. Interventions implemented in the last three years (2012-2104) will be presented.

- **DIABETES GUIDELINES RECOMMEND ANNUAL TESTING FOR DIABETIC RETINOPATHY (DRE), NEPHROPATHY, AND QUARTERLY A1C TESTING.**

L.A. Care selected A1c testing, A1c good control < 8%, DRE, and nephropathy to measure performance, because as stated in the 2014 Standards of Medical Care in Diabetes, pages S21-24 glucose monitoring and glycemic control have shown to significantly reduce microvascular and neuropathic complication of diabetes. Also, as stated on page S42-S43 of the guideline, annual nephropathy screening is essential in assessing the progression of nephropathy. Moreover, on pages S44-S46 the guidelines note annual retinal screening is crucial to identify any level of retinopathy in order to delay and/or prevent retinopathy progression.

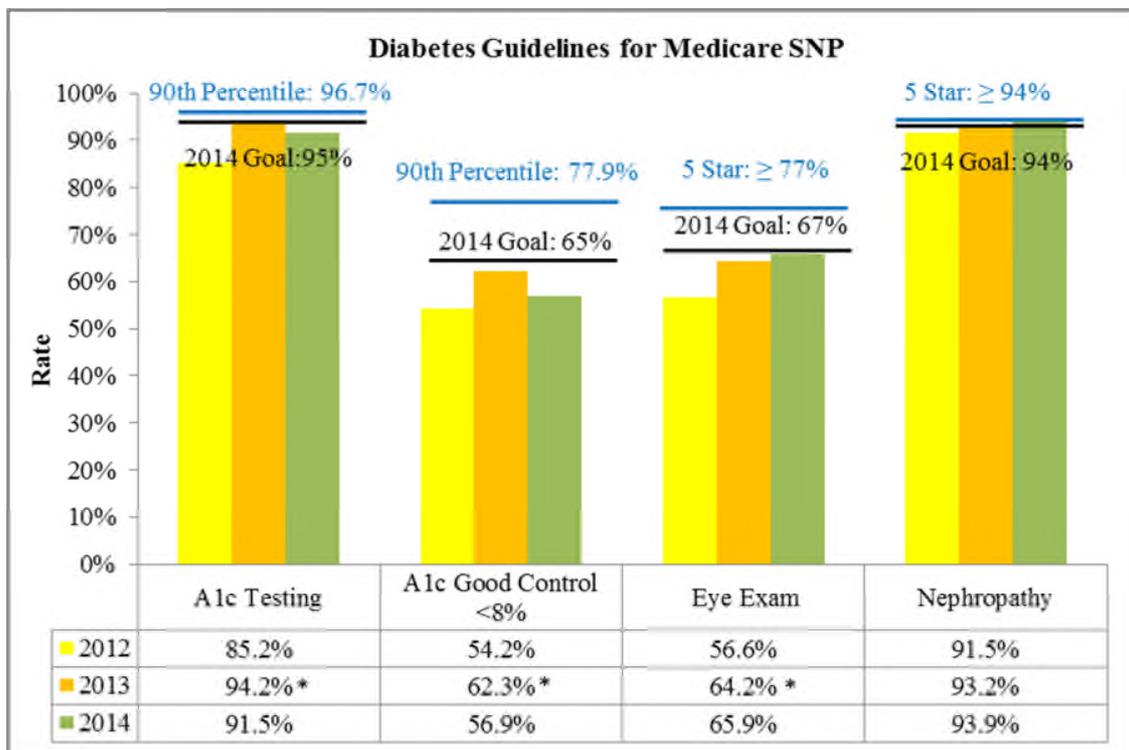
RESULTS

The tables below show compliance to guidelines using annual HEDIS rates and Medical Record Adherence to Guideline Criteria for members.

CDC HEDIS 2014 Rates for Medicare SNP

Measure	2012	2013	2014
A1c Testing (annual)	85.2%	94.2%*	91.5%
A1c Good Control (<8%)	54.2%	62.3%*	56.9%
Retinal Eye Exam (annual)	56.6%	64.2%*	65.9%
Nephropathy	91.5%	93.2%	93.9%

* Statistically Significant ($p < 0.05$)



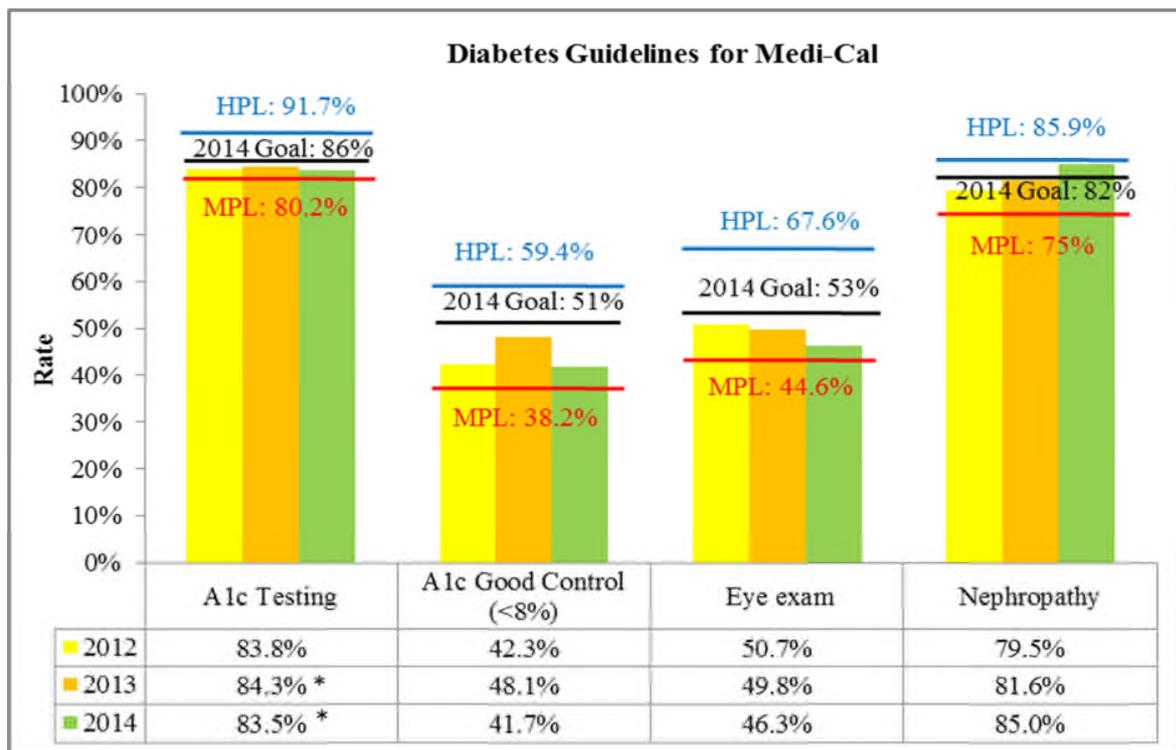
90th percentile from Quality Compass

* Statistically Significant ($p < 0.05$)

CDC HEDIS 2014 Rates for Medi-Cal

Measure	2012	2013	2014
A1c Testing (annual)	83.8%	84.3%*	83.5%*
A1c Good Control (<8%)	42.3%	48.1%	41.7%
Retinal Eye Exam (annual)	50.7%	49.8%	46.3%
Nephropathy	79.5%	81.6%	85.0%

* Statistically Significant ($p < 0.05$)



* Statistically Significant ($p < 0.05$)

Quantitative Analysis

Medicare SNP

In HEDIS 2014, the rate for HbA1c testing was 91.5%, which was a 2.7 percentage point decrease compared to the HEDIS 2013 rate of 94.2%, and did not meet the 2014 goal of 95%. The difference between the rates was not statistically significant. Similarly, HbA1c good control (<8%) decreased from 62.3% in HEDIS 2013 to 56.9% in HEDIS 2014, and did not meet the 2014 goal of 65%. Retinal eye exam rates increased 1.7% (64.2% in HEDIS 2013 to 65.9% in HEDIS 2014), but the 2014 goal of 67% was not met. There was a 0.7% rate increase in nephropathy screenings in HEDIS 2014; the goal of 94% was almost met.

Medi-Cal

In HEDIS 2014, the rates of HbA1c testing, HbA1c good control (<8%), and eye exam decreased from HEDIS 2013 and the respective goals were not met, except for the nephropathy measure. The 0.8% drop in HbA1c testing was statistically significant at the $p < 0.05$ level. The HEDIS 2014 rate (83.5%) did not meet the 2014 goal of 86%. Similarly, the HbA1c good control (<8%) rate decreased by 6.4% to 41.7% in HEDIS 2014 and eye exam rates decreased 3.5% to 46.3% in the same year. There were no statistically significant differences between the measures' rates from the previous years. Nephropathy was the only measure that improved with an increase of 3.4% to 85% in HEDIS 2014 and was the only measure that exceeded the 2014 goal of 82%.

L.A. Care Covered

Data for L.A. Care Covered is not available for 2014; 2015 rates will be reported in the 2015 QI Evaluation.

Qualitative Analysis

L.A. Care is actively involved in many efforts to assist practitioners to meet the guidelines. At the April 4, 2014 Joint PICC/PQC meeting, the 2014 Clinical Practice Guidelines Source Matrix was approved by the committee, which includes a section on the 2014 Standards of Medical Care in Diabetes from the American Diabetes Association.

At the June 27, 2013 Physician Quality Committee, L.A. Care's Director of Healthcare Outcome and Analysis, informed the committee that there was a significant increase in the 2013 HEDIS diabetes eye exam, LDL control (<100), and cholesterol screening rates. Noting that in 2013, a new initiative was to create a continuing medical education (CME) session to educate providers on diabetes care, and enhance the live reminder calls to members to obtain their needed diabetes services.

At the February 28, 2013 Physician Quality Committee, L.A. Care's Medical Director, an endocrinologist, provided the committee with highlights from the updated diabetes guidelines. Stating that hypertension/blood pressure control has been revised to suggest that the systolic blood pressure goal for many people with diabetes and hypertension should be <140 mmHg, but that lower systolic targets (such as <130 mmHg) may be appropriate for certain individuals, such as younger patients, if it can be achieved without undue treatment burden. Additionally, noting that dyslipidemia/lipid management have been revised to emphasize the importance of statin therapy over particular LDL cholesterol goals in high-risk patients, and everyone over 40 should be on a statin unless contraindicated. Lastly, the guidelines eliminated "micro" and "macro" from the terms micro-albuminuria and macro-albuminuria to now be referred to as just albuminuria. L.A. Care also mailed the guidelines that were presented. L.A. Care's Medical Director asked the physicians how they manage guidelines in their office. A physician noted that he has the guidelines on his iPad to refer to when seeing patients. Another physician shared that at her practice they discuss the guidelines and come to a consensus. The guidelines are then summarized in their EMR. She also mentioned that Netscape emails news alerts, which get her attention.

At the April 26, 2012 Physician Quality Committee, L.A. Care discussed their diabetes incentive program for physicians designed to improve the management of patients with diabetes. The program began in November 2011 and has not been well utilized with only 7 family practice physicians completing the module and no Internal Medicine or General Practice physicians finishing the module. Physicians can earn a \$1,000 incentive while also earning maintenance of certification credit in Internal Medicine and Family Medicine. General Practice physicians earn \$1,000 after completing a free online diabetes module. In addition, physicians can earn 20 continuing medical education hours while learning new diabetes management tools that teach performance improvement in diabetes care.

At the August 30, 2012 Performance Improvement Collaborative Committee, L.A. Care discussed that the mandatory SPD population will increase the number of eligible members for the Comprehensive Diabetes measure. Ms. Young L.A. Care's Director of Health Outcomes and Analysis department noted that with the growth in mandatory SPD population, it's expected that the SPD members will make up 60% of the diabetic population in the coming year which may prove to make it a challenging year for the measurement of diabetes.

At the June 21, 2012 Performance Improvement Collaborative Committee, L.A. Care discussed that the HEDIS measures for Medicare were submitted on June 15, 2012. There was improvement in the Medicare population; eight (8) of the measures showed improvement including all the comprehensive diabetes measures. Two moves made to achieve those improvements were Health Outcomes Analysis chart reviews and data collection and provider education and outreach and member information, education and outreach to improve performance in those domains.

INTERVENTIONS

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
<ul style="list-style-type: none"> • A1c Testing • A1c Good Control (<8%) • Retinal Eye Exam • Nephropathy 	<ul style="list-style-type: none"> • It is difficult for patients to make doctors' appointments. • Patients are less likely to see their physician for chronic conditions and are more likely to for acute visits. • Patients are non-compliant not taking their medications, not following the recommended diet etc. • There is no system in place for physicians to identify which patients need a retinal eye exam or HbA1c. • Physician offices do not all perform phlebotomy services. • Physicians do not use checklists (flow sheets) or disease registries to indicate what has been done or what is needed. • Physicians don't always receive reports from ophthalmologist/optometrist for DRE performed on their members. • Physicians don't have time to fully educate patients • When patients are referred out for DRE either the office staff and/or the patient don't follow up • Physicians may believe they are following the guidelines; however, they may be overstating their familiarity 	<ul style="list-style-type: none"> • In October 2014, Provider HEDIS tip sheets created by the Quality Improvement department were distributed to select PPGs. The tip sheets offer general tips educating physicians on HEDIS guidelines, standards of care, most common billing codes to get credit for HEDIS services, and ways to improve HEDIS scores. A section on the Comprehensive Diabetes Care (CDC) measure such as blood pressure control, retinal eye exams, HbA1c testing, HbA1c poor control (>9%), and nephropathy monitoring are included. • In September 2014, an outreach was targeted to members that were in the CDC denominator but did not have evidence of HbA1c testing and/or eye exam. The calls were also conducted in summer 2013, with follow up calls in October 2013. The calls were also conducted in October 2012. This outreach will be continued in 2015. • In August 2014, the Diabetes Quality Improvement Project (QIP) for Medi-Cal was submitted and approved in November 2014. The goal of the Diabetes QIP is to increase HbA1c testing and retinal eye exam rates. • In July 2014, the diabetes program became an in-house disease management program with L.A. Care's disease management nurses directly managing diabetic members. • In May 2014 the Preventive Health Guideline brochure was sent to Medi-Cal and Medicare SNP members about ways to stay healthy, including a guideline about pre-diabetes and diabetes screening (blood pressure greater than 135/80 or as recommended by the doctor). In August, the Preventive Health poster was sent to providers with a section on diabetic screening. • In winter 2014, a newsletter to L.A. Care's providers was distributed with an updated 	<p>See results above</p>

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		<p>section on Clinical Practice and Preventative Health Guidelines with diabetes as one of the CPGs listed. This lists the most up to date standard of care practice that physicians should follow. In summer 2013, L.A. Care’s provider newsletter included a section entitled “Do You Know L.A. Care’s Clinical Practice & Preventive Health Guidelines? The section informed physicians that L.A. Care’s Clinical Practice and Preventive Health Guidelines are posted on L.A. Care’s website and that the guidelines may be helpful in managing care in common areas of the physicians’ medical practice. Additionally, listing the availability of the 2013 Immunization Schedule for Adults and 0-18, as well as the 2013 Clinical Practice Guidelines Source Matrix and 2013 Preventive Health Guideline Source Matrix. Further, encouraging physicians to visit the website which has new and updated guidelines for 2014 and that hard copies are available upon request. The summer 2012 provider newsletter also included a CPH/PHG article and a newsletter reminding physicians of L.A. Care’s Diabetes Disease Management program.</p> <ul style="list-style-type: none"> • In 2014, provider opportunity reports (PORs) were mailed to all physicians (excluding Kaiser) that detail members with remaining HEDIS gaps, including those for the CDC measure. Medi-Cal PORs were distributed in June and October 2014; Medicare SNP PORs were distributed in July and September 2014. September 2013, September 21, 2012 and May 25, 2012, L.A. Care mailed Medicare PORs to physicians. • In January 2014, L.A. Care mailed 3,288 high volume providers physician reference tools to help meet the guidelines. The tools included “Summary of Revisions for the 2014: Clinical Practice Recommendations,” “Executive Summary: Standards of Medical Care in Diabetes – 2014,” “Diabetes Care 	

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		<p>Guidelines/Flow Sheet,” Diabetes Health Educational Material: “Important Tests to Remember” and “2014 HEDIS criteria: Comprehensive Diabetes Care.” The cover letter referred physicians to L.A. Care’s website for clinical and preventive health guidelines and toolkits. This mailing was also conducted in years 2012 and 2013 with the pertinent tools.</p> <ul style="list-style-type: none"> • L.A. Care continued the incentive for Physicians since 2012 to those who accurately complete and submit the members’ Annual Wellness form. Physicians will be given \$350 per calendar year for each form. The form includes preventive services and tests for diabetes as well as other important services to be performed. • L. A. Care has posted to its provider section of the website a combined Diabetes and Cardiovascular toolkit, which contains guidelines, tools, and resources for providers. • L.A. Care updates its provider section of the website to include the most updated Clinical Practice & Preventive Health Guideline Source Matrix’s and toolkits easily accessible to physicians. 	

• **CARDIOVASCULAR RISK REDUCTION GUIDELINES RECOMMEND RISK REDUCTION THERAPIES IN THE MANAGEMENT AND TREATMENT OF PATIENTS WITH CARDIOVASCULAR RISKS.**

Reducing cardiovascular risk was selected as a Chronic Care Improvement Project (CCIP) for Medicare SNP members. L.A. Care selected Medication Adherence for Hypertension (ACEI, ARB), Medication Adherence for Cholesterol (Statins) and Blood Pressure control (<140/90) to measure performance, because the guidelines provide strong clinical evidence that assessment for CVD can guide providers in making decisions about a member’s lifestyle, medication interventions, and the selection of appropriate screenings to define risk status to reduce the risk of CVD. Page two of the guidelines provide the evidence-based recommendations for medication adherence for hypertension (ACEI, ARB), medication adherence for cholesterol (Statins) and blood pressure control (<140/90). The guidelines support preventive services, CVD risk identification and reduction, improved health outcomes through promotion of healthy lifestyles, screening for hypertension, obesity and instituting early interventions including but not limited to: medication, diet, physical activity, tobacco counseling for patients with hyperlipidemia and other risk factors for CVD.

RESULTS

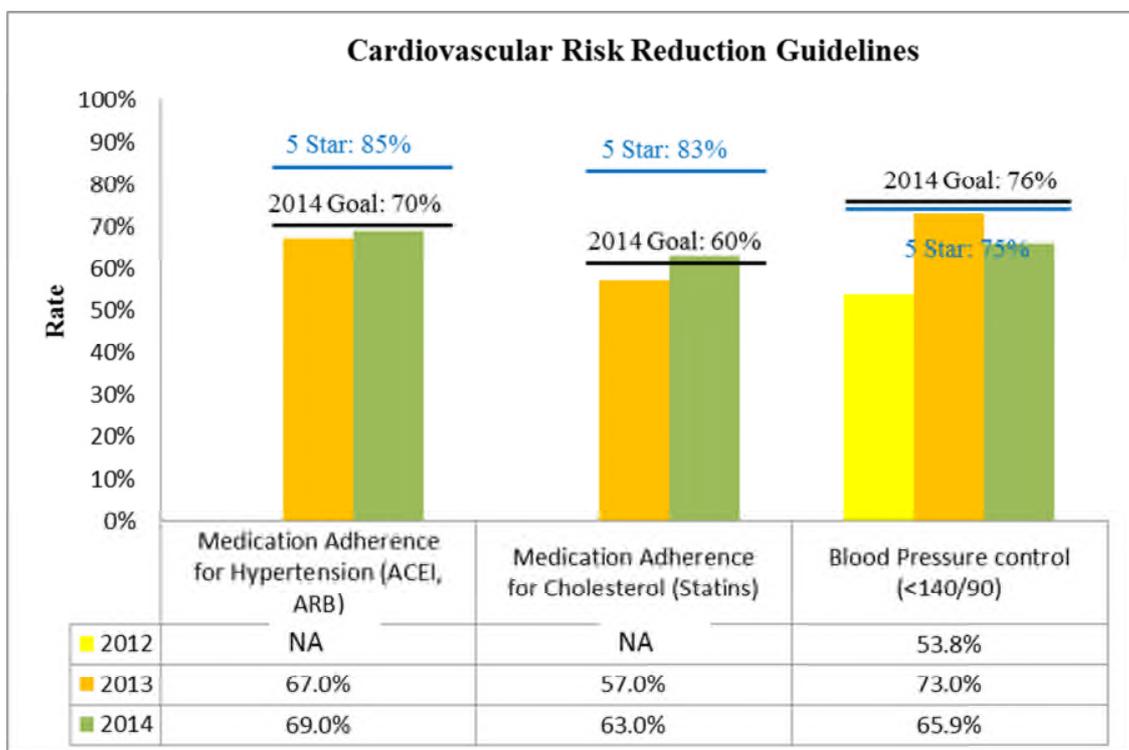
The table below shows guideline compliance using HEDIS data. The HEDIS rates for 2013 (2012 measurement year) will be used as baseline for Medication Adherence for Hypertension (ACEI, ARB) and Medication Adherence for Cholesterol (Statins). The HEDIS 2012 rate (2011 measurement year) for Blood Pressure control (<140/90) will be used as baseline.

Cardiovascular Risk Reduction Rates

Measure	2012*	2013*	2014*
Medication Adherence for Hypertension (ACEI, ARB)	N/A	67%	69%
Medication Adherence for Cholesterol (Statins)	N/A	57%	63%
Blood Pressure control (<140/90)	53.8%	73.0%	65.94%

N/A – Not applicable

*HEDIS reporting year for Controlling High Blood Pressure



Quantitative Analysis

In HEDIS 2014, the medication adherence for hypertension (ACEI, ARB) rate was 69.0%, which was two percentage points higher compared to the previous year. It did not meet the 2014 goal of 70%. The medication adherence for cholesterol (statins) was 63.0%, exceeding the 2014 goal of 60% and improving by six percentage point from the previous year. Controlling high blood pressure, however, decreased seven percentage points to 65.9% in HEDIS 2014. The 2014 goal of 76% and 5 Star rate of 75% were not met. There were no statistically significant difference between the rates of the measures compared to the previous year.

Qualitative Analysis

At the April 4, 2014 Joint PICC/PQC meeting, the Chair of the committee informed about updates to the Cardiovascular Risk Clinical Practice Guideline. The committee reviewed and approved updates to the 2013 ACC/AHH Guideline on the Assessment of Cardiovascular Risk, the 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, the 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk, and the 2014 Guideline for Management of High Blood Pressure (JNC-8).

At the June 27, 2013 Physician Quality Committee, L.A. Care’s Director of Healthcare Outcome and Analysis, informed the committee that there was a significant increase in the 2013 HEDIS cardiovascular care cholesterol screening and controlling high blood pressure.

At the April 26, 2012 Physician Quality Committee, the committee was given a presentation entitled “Chronic Care Improvement Program for SNP.” The presentation outlined the CMS mandated Chronic Care Improvement program (CCIP) for preventing cardiovascular risk. The purpose is to align with the Million Hearts Campaign and prevent incidence of further deterioration of heart disease. Proposed measures are controlling high blood pressure, LDL management, flu, and pneumonia. L.A. Care’s director of quality asked the committee for additional ideas for the program. Physicians suggested stress reduction, smoking cessation, and checking vitamin D levels because a slightly low vitamin D level increases the risk of heart attack in middle aged men. The following guidelines were reviewed and approved to provide additional clinical basis for the CCIP to reduce cardiovascular risk: Circulation – AHA/ACCF Secondary Prevention and Risk Reducing Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2011 Update: A Guideline from the American Heart Association and American College of Cardiology Foundation.

At the February 23, 2012 Physician Quality Committee, the committee was informed of CMS’ new requirement to have a Chronic Care Improvement program (CCIP) for preventing cardiovascular risk. The committee was requested to review guidelines to be used as the clinical basis for the cardiovascular CCIP. The following guidelines were reviewed and approved: 2010 ACCF/AHA Guideline for Assessment of Cardiovascular Risk in Asymptomatic Adults: A Report of the American and the College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and Value of Primordial. The committee approved the 2012 Clinical Practice Guidelines source matrix with links to all guidelines and applicable toolkits.

INTERVENTIONS

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
<ul style="list-style-type: none"> Medication adherence for hypertension (ACE/ARB) Medication adherence for cholesterol (Statins) Blood Pressure Control (<140/90) 	<ul style="list-style-type: none"> Providers lack familiarity with the constantly changing guidelines Guidelines are extensive and complicated Providers lack time to follow the guidelines Providers lack of agreement with the guidelines Member fail to follow treatment/counseling regimes There is a lack of community educational 	<ul style="list-style-type: none"> Physician outreach was conducted in November 2014 that consisted of calling and faxing gaps in care list (MPM, SPR, ART, and CBP) to clinics and solo physicians. The list consisted of members that had more than one gap in care. The measure description and requirements for 2014 were included in the fax In October 2014, Provider HEDIS tip sheets created by the Quality Improvement department were distributed to select PPGs. The tip sheets offer general tips educating physicians 	See results above

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
	<p>resources</p> <ul style="list-style-type: none"> • It is difficult for patients to make doctors' appointments. • Providers don't have time to fully educate patients • Patients are less likely to see their physician for chronic conditions and are more likely to for acute visits. • Patients are non-compliant not taking their medications, not following the recommended diet etc. • Contacting members is impeded by out-of-date state database and incorrect phone number. • Members have difficulty making an appointment with PCP. 	<p>on HEDIS guidelines, standards of care, most common billing codes to get credit for HEDIS services, and ways to improve HEDIS scores. A section on the controlling high blood pressure measure was included.</p> <ul style="list-style-type: none"> • July and September 2014, September 2013, September 21, 2012 and May 25, 2012, L.A. Care mailed Medicare Provider Opportunity reports to physicians. The report contains the PCP's list of members in need of preventive services • 2014 AHA updated guidelines are included in the revised toolbox for providers and published online • <i>L.A. Cares About Your Heart®</i> developed a disease management website landing page with program and referral information for members and providers on the L.A. Care website • L.A. Care disease management pamphlet was updated to include <i>L.A. Cares About Your Heart®</i> and referral information • In 2013, a formulary was developed and sent to providers. • Continued quarterly telephone monitoring of members was used to educate members and inquire about status • Four educational postcards were sent to members, and a seasonal flu postcard was developed and sent to members • Online educational material was updated and made available for members and providers CCIP began tracking of members current phone numbers and addresses to improve patient contact database • The CVD program included additional two lines of business (CMC & LACC) in 2014 • ICD-10 codes were reviewed and adopted to reflect current ICD-9 codes used by CVD program • In 2013, L.A. Care enhanced its retrospective drug use evaluation program (DUE) to include outreach calls (by pharmacist, disease management and case management nurses) to members who are non-adherent to 3 or more medications. The calls are to promote medication adherence. The DUE was started in December 2012 in an effort to assist physicians with monitoring patients' adherence. L.A. Care implemented the DUE program to promote medication adherence and 	

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		<p>monitoring for members with CVD. The DUEs: ACE/ARBs and cholesterol (statins) medications. The cover letters outlines cardiovascular clinical practice guideline recommendations for the respective DUE program. The DUE program is to promote medication adherence and monitor for members who are 70-79% compliant with antihypertensive (ACE/ARBs) and cholesterol (statins) medications. Physicians are sent a medication profile for members who met the criteria and are asked to provide feedback via a questionnaire.</p> <ul style="list-style-type: none"> <li data-bbox="735 779 1173 1339">• In 2013, L.A. Care’s provider newsletter included a section entitled “Do You Know L.A. Care’s Clinical Practice & Preventive Health Guidelines?” The section informed physicians that L.A. Care’s Clinical Practice and Preventive Health Guidelines are posted on L.A. Care’s website and that the guidelines may be helpful in managing care in common areas of the physicians’ medical practice. Additionally, listing the availability of the 2013 Immunization Schedule for Adults and 0-18, as well as the 2013 Clinical Practice Guidelines Source Matrix and 2013 Preventive Health Guideline Source Matrix. Further, encouraging physicians to visit the website which has new and updated guidelines for 2013 and that hard copies are available upon request. <li data-bbox="735 1346 1173 1608">• Additionally, the newsletter included an article entitled, “Help Patients Quit Smoking with [Medi-Cal Incentives to Quit Smoking] MIQS,” the article informed physicians that the program seeks to motivate smoking cessation by offering a \$20 gift card to members who call the California Smokers’ Helpline and enroll in its free telephone-based support services. <li data-bbox="735 1615 1173 1928">• In 2013, L.A. Care began its Cardiovascular (CVD) Disease Management program. A letter was sent to physicians introducing them to the new CVD Disease Management Program and asking them to review the enclosed CVD guidelines. The letter discussed how risk factors can be prevented and controlled with the ABCS (Appropriate aspirin therapy, Blood pressure control, Cholesterol control, and Smoking cessation. The following materials were 	

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		<p>enclosed: ATP III At-A-Glance Quick Desk Reference, JNC-7 Reference Card, and Tobacco Cessation guidelines. Additionally, L.A. Care updated its provider section of the website to further notify physicians to review clinical practice guidelines to improve assessment and treatment of CVD disease, and that the CVD program content uses evidence-based practice guidelines. There is also a link for providers to assess CVD clinical practice guidelines, the CVD Toolkit, and health education resources for members. The member section of the website was updated to notify members of the new CVD program and providing a link to the Health Education page where members can find information on heart disease.</p> <ul style="list-style-type: none"> • In the spring 2013, L.A. Care’s Provider Newsletter announces its new cardiovascular disease management program called “L.A. Care’s About Your Heart” for Medicare Advantage (HMO SNP) members. • May 2013, January 31, 2012 and February 10, 2011 L.A. Care mailed physicians cardiovascular guideline reference tools to assist them with meeting the guidelines and notified them that guidelines and toolkits can be found on L.A. Care’s website. • L.A. Care developed a “Cardiovascular Toolkit” to assist physician in meeting the guidelines. In 2013, member material was updated and new piece was added called “Live Smoke Free.” In 2012, L.A. Care enhanced the toolkit to include Cardiovascular Risk guidelines. • The toolkit contains a letter to physicians which notes that appropriate screening and effective control of blood pressure, cholesterol levels, and use of B-blockers post myocardial infarction can reduce the risk of developing heart disease and its associated complications. The letter further urges physicians to utilize the resources and information provided. The content of the toolkit contains the ATP III Cholesterol Guidelines, JNC 7 Blood Pressure Guidelines, and patient education materials to assist physicians in the care of their patients. • In summer 2012, L.A. Care’s provider newsletter article entitled “Risk Factor Management Helps Cardiovascular Disease,” reminded physicians that many of L.A. Care’s members, especially seniors, have some form of 	

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		<p>cardiovascular disease and recent evidence confirms that aggressive, comprehensive risk factor management improves survival and quality of life. The article further notes that every effort should be made to ensure patients are treated in accordance with evidenced-based guideline recommendations, and that Clinical Preventive Health Guidelines as well as Provider Toolkits can be found on L.A. Care’s website and that hard copies are available upon request.</p> <ul style="list-style-type: none"> • In summer of 2012, L.A. Care developed a comprehensive provider training education packet, which contains various toolkits and clinical practice guidelines as well as other resources for physicians use. The materials are hand delivered to physician offices. • On July 10 & 19, 2012, L.A. Care held a CME entitled, “HCCs and Star Quality Measures for SNP Plan Members.” The workshop reviewed the importance of Medicare coding and its requirements for new, established, acute and chronic diagnoses, how to avoid missed opportunities in documentation. The training discussed HEDIS and Medicare’s Star Program’s measures. • On June 7, 2012, in an effort to assist physicians with improving patient adherence, L.A. Care held a physician CME entitled, “Three Easy Tips to Improve Patient Adherence in Diverse Populations.” • In February 2012, in an effort to mitigate physician barriers, L.A. Care launched a new health education program that included a mailing to all Medicare members. The program, called Passport to Health, educates members on the importance of scheduling their annual health screenings and lab assessments. Members are encouraged to schedule an appointment with their PCP to receive needed services and to maintain a record of services they’ve received. • L.A. Care updates its provider section of the website to include the most updated Clinical Practice & Preventive Health Guideline Source Matrix’s and toolkits easily accessible to physicians. • L.A. Care’s matrix of Clinical Practice Guidelines is distributed on an ongoing basis 	

- **A PRACTICAL GUIDE FOR THE DIAGNOSIS AND MANAGEMENT OF ASTHMA GUIDELINES RECOMMEND THE USE OF AN ASTHMA ACTION PLAN, PHARMACOTHERAPY TO PREVENT AND CONTROL ASTHMA, AND ANNUAL INFLUENZA VACCINATION.**

L.A. Care selected members who had the flu shot, members that have an asthma action plan, and use of pharmacotherapy as measures, because as stated in the guideline on pages 15-21, periodic assessment and ongoing monitoring of asthma control are recommended; one method of doing this is to provide patients a written asthma action plan. The guideline recommends on page 215, pharmacotherapy to prevent and control asthma symptoms. Patients who have persistent asthma require both classes of medication. Furthermore, pages 66 & 182 state physicians should consider the flu vaccine for patients with asthma as they may be at risk for complications of the flu and at risk of asthma exacerbation.

RESULTS

The tables below show the percentage of members who had a flu shot, the percentage of members who have an asthma action plan, and the percentage of members who received four or more prescriptions for asthma reliever medications over the previous 12 months and did not receive any asthma controller medications. This information was obtained from quarterly medical record review and pharmacy data. The 2012 *pharmacy* data will be used as baseline for the percentage of members who received four or more prescriptions for asthma reliever medications over the previous 12 months and did not receive any asthma controller medications.

2014 Rates for Medicare SNP

Measure	2012	2013	2014
Percentage of Members who had the Flu Shot*	66.0%	72.4%	74.6%
Percentage of Members that have a completed Asthma Action Plan signed by the doctor**	N/A	N/A	35.7%

*CAHPS measure

**Denominator includes Medicare SNP members in the Asthma DM program and who completed the Annual Satisfaction Survey

Pharmacy Drug Program Data for Medicare SNP

Measure	2012	2013	2014
Number of members who received 4 or more prescriptions for asthma reliever medications over the previous 12 months and did not receive any asthma controller medications	98	177	95

2014 Rates for Medi-Cal

Measure	2012	2013	2014
Percentage of Members who had the Flu Shot*	N/A	N/A	35.6%
Percentage of Members that have a completed Asthma Action Plan signed by the doctor**	N/A	N/A	39.4%

*CAHPS measure

**Denominator includes MCLA members in the Asthma DM program and who completed the Annual Satisfaction Survey

Pharmacy Drug Program Data for Medi-Cal

Measure	2012	2013	2014
Number of MCLA members who received 4 or more prescriptions for asthma reliever medications over the previous 12 months and did not receive any asthma controller medications	1,427	N/A	2,378

Quantitative Analysis

Medicare SNP

In 2014, the percentage of members who had the flu shot increased 2.2 percentage points from the previous year. The 2014 rate fell short of the goal of 75%. Since 2012, the percentage of members who had the flu shot has increased. Among members in the Asthma DM program and who had completed the Asthma Satisfaction Survey, 35.7% stated that they had a completed Asthma Action Plan signed by their doctor. In 2014, two survey questions (have an asthma action plan and MD explained the asthma action plan) were combined into one question in order to reflect the true number of respondents who are using their asthma action plan as directed. Hence, this may explain why the rate may be low. Lastly, there were 95 SNP members who received 4 or more prescriptions for asthma reliever medications over the previous 12 months and did not receive any asthma controller medications. Compared to 177 members in 2013 and 98 members in 2012, there was a decrease in members that were in this measure in 2014.

Medi-Cal

In 2014, the percentage of members who had the flu shot was 35.6%. The 2014 rate will be used as baseline since previous years' data is not available. Among members in the Asthma DM program and who had completed the Asthma Satisfaction Survey, 39.4% stated that they had a completed Asthma Action Plan signed by their doctor. Once again, the survey question in 2014 was a combination of two questions, which may explain for the low percentage. Lastly, there were 2,378 MCLA members who received 4 or more prescriptions for asthma reliever medications over the previous 12 months and did not receive any asthma controller medications. Compared to 1,427 members in 2012, there was an increase in members that were in this measure in 2014.

L.A. Care Covered

Data for L.A. Care Covered is not available for 2014; 2015 rates will be reported in the 2015 QI Evaluation.

Qualitative Analysis

At the November 11, 2014 Joint PICC/PQC meeting, the Senior Director of Quality Improvement and Health Assessment explained that the National Committee for Quality Assurance requires L.A. Care to review guidelines every two years or as they are updated. There were no changes to the Guidelines for the Diagnosis and Management of Asthma from the National Institutes of Health/National Heart, Lung, and Blood Institute.

At the February 28, 2013 Physician Quality Committee, L.A. Care's Medical Director, informed the committee of an update for the asthma guidelines, noting the National Heart, Lung, and Blood Institute has created a new reference guide entitled "Asthma Care Quick Reference Diagnosing and Managing Asthma. Stating the goal of the asthma care quick guide reference is to help clinicians provide quality care to people who have asthma. The quick reference outlines that asthma control focuses on two domains: *reducing impairment* – the frequency and intensity of symptoms and functional limitations experienced by the patient and *reducing risk* – the likelihood of future asthma attacks, progressive decline in lung function, or medication side effects. L.A. Care also mailed the guidelines that were presented. L.A. Care's Medical Director asked the physicians how they manage guidelines in their office. A physician noted that he has the guidelines on his iPad to refer to when seeing patients. Another physician shared that at her practice they discuss the guidelines and come to a consensus. The guidelines are then summarized in their EMR. She also mentioned that Netscape emails news alerts, which get her attention.

At the September 27, 2012 Physician Quality Committee, guideline compliance results were presented and discussed. L.A. Care's Medical Director asked if the physicians had any particular strategies or ideas

they found successful to improve guideline compliance. One physician noted there is clear evidence that a strong provider recommendation increases uptake. He addresses the reasons the patient does not want to get the flu vaccine. Another physician mentioned that she commonly hears patients say that the vaccine causes the flu. She explains to them that the vaccine does not cause the flu but rather prevents the flu. Another physician stated that the allergist at her practice thinks that getting the flu vaccine consistently could help your immune system. L.A. Care's Quality Director noted that one way L.A. Care educates member on the flu is through articles in the member newsletter. She also mentioned that AWARE has literature on how to talk to patients regarding the flu vaccine.

On July 17, 2012, the Quality Oversight Committee discussed that use of spirometry testing. L.A. Care's Senior Director of Medical Management noted that spirometry testing is not routinely performed by PCPs. It is difficult for PCPs to have the equipment in their offices. The testing is usually performed in the Pulmonologist office. L.A. Health Outcomes and Analysis Director explained that this particular measure is based solely on encounter data and mentioned that when speaking with one of L.A. Care's Medical Directors, she was informed that spirometry testing is not often used since physicians are trained to treat clinically rather than relying on spirometry testing. It was suggested that an option would be to have the PCPs trained or retrained. L.A. Care's Medical Director noted that not a lot of PCPs are willing to go through that process.

INTERVENTIONS

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
<ul style="list-style-type: none"> • % Of Members that have an Asthma Action Plan • % Of Members who had the flu shot • % of Members who received 4 or more prescriptions for asthma reliever medications over the previous 12 months and did not receive any asthma controller medications 	<ul style="list-style-type: none"> • Providers lack familiarity with the constantly changing guidelines • Guidelines are extensive and complicated • Providers lack time to follow the guidelines • Providers lack of agreement with the guidelines • Providers feel it is difficult to communicate with members who have a low health literacy level • There is a lack of community educational resources • Providers lack tracking systems • It is difficult for patients to make doctor appointments • Patients are less likely to see their physician for chronic conditions and are more likely to for acute visits • Patients are non-compliant not taking their medications, not following the recommended diet etc. • Providers feel there are too many guidelines that conflict with each other 	<ul style="list-style-type: none"> • Asthma CME/CE on February 4, 2015 on Pediatric Asthma: Diagnosis, Assessment & Cultural Competency Updates • The Asthma Satisfaction Survey will be sent to L.A. Care Covered members in 2015 • In June 2014, the Asthma Satisfaction Survey was sent to MCLA and Medicare SNP members • In fall 2014, L.A. Care's provider newsletter included articles on Clinical Practice Guidelines and Disease Management programs such as L.A. cares About Asthma, a program available for the Medi-Cal, Medicare SNP, LACC, Healthy Kids, and PASC-SEIU lines of business. In fall 2013, L.A. Care's provider newsletter included a section entitled, "When Your Patient Needs a Nebulizer." L.A. Care physicians sometimes face challenges with obtaining nebulizers for members and/or don't understand the process for obtaining a nebulizer. The article outlines the process for obtaining and/or replacing nebulizers which physicians may need in following the guidelines to manage member's 	See results above

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
	<ul style="list-style-type: none"> • Providers feel the guidelines don't apply to their patients • Providers feel there is lack of appropriate patient education materials that speak to diverse audiences in their language, and at their educational level. • Clinicians' may believe they are following the guidelines; however, they may be overstating their familiarity 	<p>asthma.</p> <ul style="list-style-type: none"> • In 2014, the asthma survey was conducted with questions on whether the member had a flu shot between 9/2013 and 3/2014 • In February 2014, a postcard as sent to members of an incentives reward for receiving the flu shot. A mailer with a magnifying glass promoting the flu shot was sent for Medicare SNP and an automated call reminder was made to MCLA members as a reminder to get the flu shot. A follow-up Thank You postcard will be sent out in early 2015. October 2013, November 12, 2012 and February 21, 2012, in an effort to assist physicians, L.A. Care sent members a flu educational mailing. • In 2012-2014, L.A. Care's provider newsletter included a section on L.A. Care's Clinical Practice & Preventive Health Guidelines. The section informed physicians that L.A. Care's Clinical Practice and Preventive Health Guidelines are posted on L.A. Care's website and that the guidelines may be helpful in managing care in common areas of the physicians' medical practice. • L.A. Care Facility Site Review department conducts annual medical record review to assess provider adherence to guideline criteria, and the findings are reviewed with providers. • The asthma toolkit is distributed via various methods: mailed to high volume asthma providers, distributed at the Physician Quality Committee, on an on-going basis delivered by the Physician Quality Liaison Nurses to PCP offices, availability and ordering communicated via the L.A. Care Providers newsletter, and posted on L.A. Care's website and that hard copies are available upon request. • Primary care physicians (PCP) receive a monthly letter regarding new members identified as having severe asthma. The PCP is asked to review the member's medical record and appropriately classify their asthma based on the NHLBI Asthma Guidelines. The letter contains the classification criteria 	

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		<p>for asthma based on the asthma guidelines.</p> <ul style="list-style-type: none"> • In 2014, Disease Management nurses conducted provider office visits targeting providers with two or more Level 3 asthma members and/or six or more Level 2 members. Visits include reviewing available asthma reports, resources (asthma CME flyer & Asthma Quick Reference Guide) and the asthma toolkit, which include the asthma clinical practice guidelines. There were six providers that were visited in 2014. The office visits were a continuation from December 2012 and continued in 2013.. • Member materials including asthma action plans are given free to providers for distribution in their practices. • L.A. Care updates its provider section of the website to include the most updated Clinical Practice & Preventive Health Guideline Source Matrix's and toolkits are easily accessible to physicians. 	

• **DIAGNOSIS AND MANAGEMENT OF STABLE CHRONIC OBSTRUCTIVE PULMONARY DISEASE GUIDELINES RECOMMEND USE OF SPIROMETRY, AND PHARMACOTHERAPY IN DIAGNOSES AND MANAGEMENT.**

L.A. Care selected appropriate spirometry testing in the assessment and diagnosis of COPD, members who were dispensed a systemic corticosteroid, and members who were dispensed a bronchodilator to measure performance, because as stated in the guideline on page 187, patients with respiratory symptoms, particularly dyspnea, spirometry testing should be performed to diagnose airflow obstruction. Also on page 181 the guideline recommends adding spirometry to clinical examination for individuals with respiratory symptoms, has demonstrated benefits. The guideline also recommends on page 186, that clinicians should prescribe maintenance monotherapies, such as long-acting inhaled beta agonists and long-acting inhaled anticholinergics for symptomatic patients with COPD to reduce exacerbations. Further, on page 183, the guideline notes that monotherapy with long-acting inhaled corticosteroids, long-acting anticholinergic, or long-acting inhaled beta-agonist are more effective in reducing exacerbations than are short-acting anticholinergics.

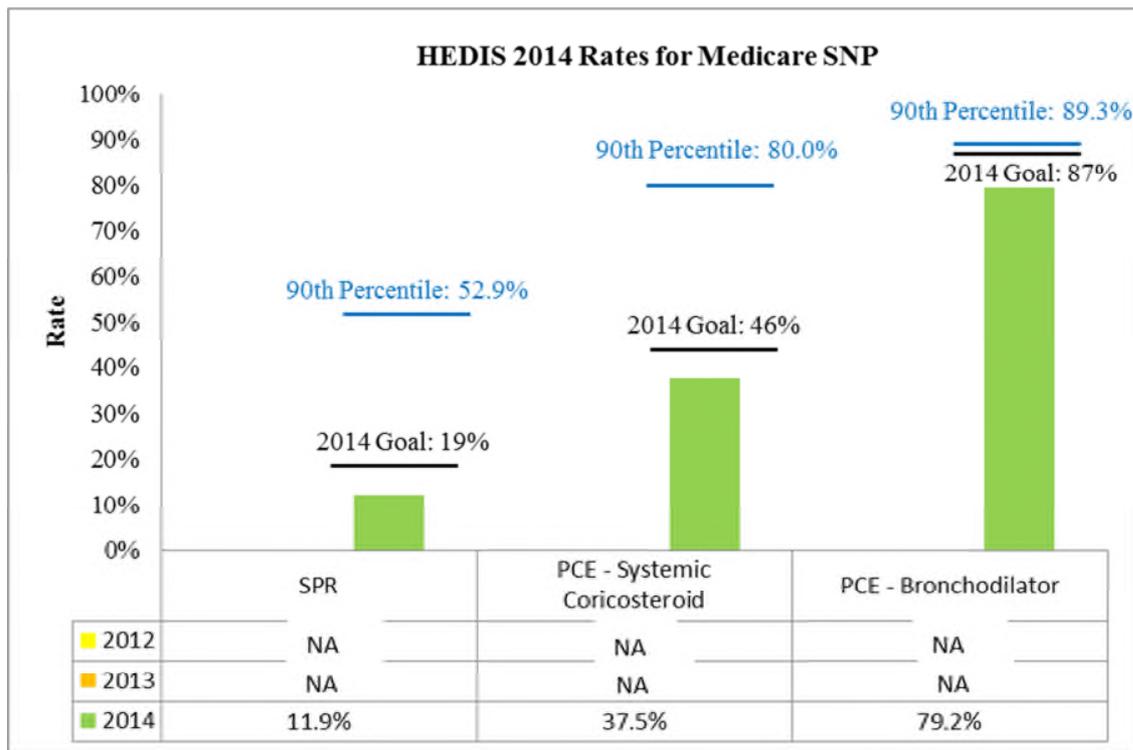
RESULTS

The tables below show guidelines using annual HEDIS rates to the Guideline Criteria. For Medicare SNP members, the HEDIS rates for 2014 (2013 measurement year) will used as baseline data since there has been a low eligible population for the measures.

HEDIS 2014 Rates for Medicare SNP

Measure	2012	2013	2014
The percentage of members 40 years and older with a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis (SPR)	N/A	N/A	11.9%
The percentage of members dispensed a systemic corticosteroid within 14 days of the event (PCE-systemic corticosteroid)**	N/A	N/A	37.5%
The percentage of members dispensed a bronchodilator within 30 days of the event (PCE-bronchodilator)**	N/A	N/A	79.2%

**Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1-November 30 of the measurement year and who were dispensed appropriate medications
N/A due to low eligible population



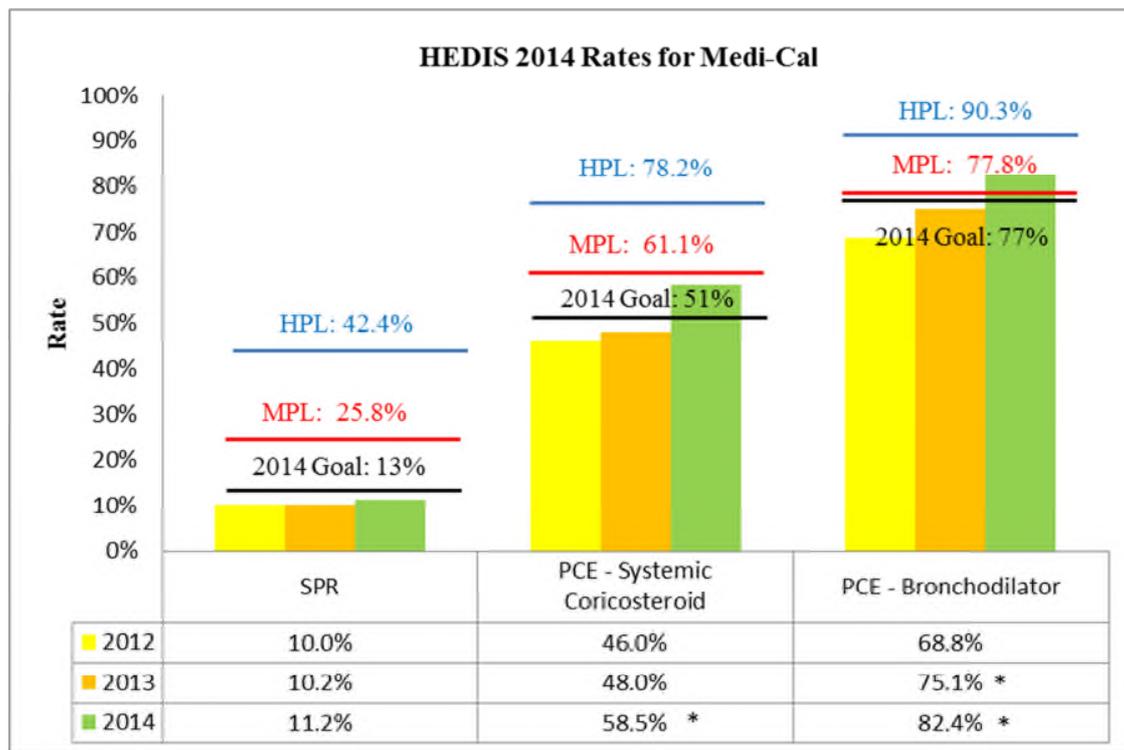
90th percentile from Quality Compass

HEDIS 2014 Rates for Medi-Cal

Measure	2012	2013	2014
The percentage of members 40 years and older with a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis (SPR)	10.0%	10.2%	11.2%
The percentage of members dispensed a systemic corticosteroid within 14 days of the event (PCE-systemic corticosteroid)**	46.0%	48.0%	58.5%*
The percentage of members dispensed a bronchodilator within 30 days of the event (PCE-bronchodilator)**	68.8%	75.1%*	82.4%*

* Statistically Significant Difference

**Percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1-November 30 of the measurement year and who were dispensed appropriate medications



*Statistically significant difference

Quantitative Analysis

Medicare SNP

HEDIS 2013 and 2012 rates were N/A due to the low eligible population for the Medicare SNP LOB; therefore, there were no HEDIS results to analyze. HEDIS 2014 rates will be used as baseline data: the percentage of members 40 years and older with a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis (11.9%), the percentage of members dispensed a systemic corticosteroid within 14 days of the event (37.5%), and the percentage of members dispensed a systemic bronchodilator within 30 days of the event (79.2%). None of the measures met the 2014 goal rates, as well as the 25th percentile and 90th percentiles from Quality Compass.

Medi-Cal

The rate (11.2%) of the members aged 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis was below the 2014 goal of 13% and did not reach the minimum performance level of 25.8%. However, the rate increased in the past three years, with a 1% increase in HEDIS 2014 from 10.2% in HEDIS 2013. Similarly, the rate (58.5%) of members who were dispensed a systemic corticosteroid within 14 days of the event among members aged 40 years and older with COPD exacerbations who had an acute inpatient discharge or ED visit on or between January 1-November 30 of the measurement year rose in the past three years. There was a statistically significant 10.5% increase in HEDIS 2014 compared to HEDIS 2013, and the 2014 goal of 51% was exceeded. Also, the rate (82.4%) of members who were dispensed a bronchodilator within 30 days of the event among members aged 40 years and older with COPD exacerbations who had an acute inpatient discharge or ED visit on or between January 1-November 30 of the measurement year

rose in the past three years rose in the past three years and exceeded the 77% 2014 goal and 77.8% MPL. The rates were statistically significant at the p<0.05 level for HEDIS 2013 and 2014 rates.

L.A. Care Covered

Data for L.A. Care Covered is not available for 2014; 2015 rates will be reported in the 2015 QI Evaluation

Qualitative Analysis

At the September 2, 2014 Joint PICC/PQC meeting, the Senior Director of Quality Improvement and Health Assessment reported the recalculated based on HEDIS 2014 results. The Senior Director stated that areas of focus will be measures that did not meet the MPL, such as the spirometry and the PCE-Systemic Corticosteroid measures.

On July 17, 2012, the Quality Oversight Committee discussed that “Use of Spirometry Testing in the Assessment and Diagnosis of COPD.” L.A. Care’s Senior Director of Medical Management noted that spirometry testing is not routinely performed by PCPs. It is difficult for PCPs to have the equipment in their offices. The testing is usually performed in the Pulmonologist office. L.A. Health Outcomes and Analysis Director explained that this particular measure is based solely on encounter data and mentioned that when speaking with one of L.A. Care’s Medical Directors, she was informed that spirometry testing is not often used since physicians are trained to treat clinically rather than relying on spirometry testing. It was suggested that an option would be to have the PCPs trained or retrained. L.A. Care’s Medical Director noted that not a lot of PCPs are willing to go through that process.

On February 2, 2011, L.A. Care held a COPD CME for provider entitled COPD: Making Diagnosis and Identifying Treatment Strategies. Several of the physicians raised questions, resulting in a discussion on antibiotic choice and use. The speaker noted zithromycin as the antibiotic of choice; however, stating each case should be individualized and highly recommended the physicians familiarize themselves with the COPD guidelines. Other physician questions involved medication use in persons with episodes of exacerbation; again the speaker encouraged physicians to review guidelines, though providing examples of how to use different medications and explained the use of prednisone with individuals who have frequent exacerbations. In discussing spirometry testing, he referenced the guidelines and stated that all patients suspected of lung disease should have spirometry testing. During open discussion many physicians described challenges with following the guidelines including: patients don’t take their medications as directed, they don’t use and/or don’t know how to use their aero chamber.

INTERVENTIONS

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
<ul style="list-style-type: none"> • Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) • COPD Exacerbation – Systemic Corticosteroid Dispensed • Use of Spirometry Testing Performed in Assessment and Diagnosis of COPD 	<ul style="list-style-type: none"> • Providers are not aware of the need to conduct spirometry testing in the assessment and diagnosis of COPD. • PPGs pay capitation for spirometry testing • Prior authorization may be required to conduct spirometry testing • Lack of spirometry equipment in provider offices 	<ul style="list-style-type: none"> • Physician outreach was conducted in November 2014 that consisted of calling and faxing gaps in care list (MPM, SPR, ART, and CBP) to clinics and solo physicians. The list consisted of members that had more than one gap in care. The measure description and requirements for 2014 were included in the fax. • In October 2014, Provider HEDIS tip sheets created by the Quality Improvement department were distributed to select PPGs. The tip 	<p>See results above</p>

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
	<ul style="list-style-type: none"> • Providers don't want to have to calibrate and maintain spirometry equipment • Providers lack familiarity with the constantly changing guidelines • Guidelines are extensive and complicated • Providers lack time to follow the guidelines • Providers lack of agreement with the guidelines • Member fail to follow treatment/counseling regimes • There is a lack of community educational resources • If a spirometry test was performed in the hospital there is no claim for it • Clinicians' may believe they are following the guidelines; however, they may be overstating their familiarity 	<p>sheets offer general tips educating physicians on HEDIS guidelines, standards of care, most common billing codes to get credit for HEDIS services, and ways to improve HEDIS scores. A section on the spirometry measure was included</p> <ul style="list-style-type: none"> • In 2012-2014, L.A. Care's provider newsletter included a section on L.A. Care's Clinical Practice & Preventive Health Guidelines. The section informed physicians that L.A. Care's Clinical Practice and Preventive Health Guidelines are posted on L.A. Care's website and that the guidelines may be helpful in managing care in common areas of the physicians' medical practice. Further, encouraging physicians to visit the website which has new and updated guidelines for 2014 and that hard copies are available upon request. • In July 2014, September 2013, and November 2012, L.A. Care sent out a COPD guideline mailing to PCPs. The mailing explained how physicians could make a difference by adopting COPD guidelines in their practice. • L.A. Care is actively involved in a statewide collaboration with the California Medical Association (CMA) Foundation. CMA Foundation initiated a long-term, statewide effort to promote the appropriate use of antibiotics called, Alliance Working for Antibiotic Resistance Education, (AWARE). AWARE is a partnership that includes physician organizations, healthcare practitioners, health systems, health plans, public health agencies, consumer, and community based health organizations, federal, state and local government representatives, and the pharmaceutical industry. AWARE sends annual COPD materials to their toolkit, which is distributed to physicians. Updated materials included COPD Management Tool, a 3-in-1 personal tool that helps the patient talk with their doctor to make a plan that is best for them. With a plan, the patient will know how and when to take their medicines, when to call the healthcare provider and when to get emergency 	

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		<p>care and a COPD Essentials for Health Professionals Reference Card containing COPD essentials and listing risk factors and diagnosis and treatment options, which are based on COPD guidelines.</p> <ul style="list-style-type: none"> • L.A. Care’s COPD provider toolkit to assist physicians with meeting the guidelines is posted on the L.A. Care website. The toolkit includes a cover letter, provider and member educational materials, and recommended clinical practice guidelines. Availability and ordering is communicated via the L.A. Care Providers newsletter, and posted on L.A. Care’s website and that hard copies are available upon request. • L.A. Care updates its provider section of the website to include the most updated Clinical Practice & Preventive Health Guideline Source Matrix’s and toolkits easily accessible to physicians. 	

• **BEHAVIORAL CONDITIONS: DEPRESSION AND ATTENTION DEFICIT HYPERACTIVITY DISORDER**

L.A. Care delegates behavioral health services to an NCQA accredited Managed Behavioral Health Organization (MBHO) for L.A. Care Covered, Medicare SNP (inpatient only), and Medi-Cal lines of business. Specialty behavioral health, inpatient and substance use benefits are carved out for the Medi-Cal line of business. L.A. Care selected depression and attention deficit hyperactivity disorder (ADHD) as behavioral health conditions to measure performance. More than nine percent of U.S. adults are currently depressed (major depression or other depression)¹, which is linked with decreased productivity and increased work absenteeism and short-term disability. Attention deficit hyperactivity disorder is one of the most prevalent childhood disorders² and affects five percent of children in the United States³.

¹http://www.cdc.gov/mentalhealth/data_stats/depression.htm

²<http://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml>

³<http://www.cdc.gov/ncbddd/adhd/data.html>

RESULTS

The table below shows behavioral health compliance using depression measures evaluated by the MBHO. The rates for 2013 will be used as baseline for the depression and ADHD measures.

Behavioral Rates for Medicare SNP

Depression	2013	2014*
Two or more visits within 12 weeks of initial diagnostic visit	60.9%	47.5%
One or more medication visits within 12 weeks of diagnosis	43.5%	18.6%

*QUARTERS 1-3 IN 2014

Behavioral Rates for Medi-Cal

Depression	2013	2014*
Two or more visits within 12 weeks of initial diagnostic visit**	N/A	37.5%
One or more medication visits within 12 weeks of diagnosis**	N/A	24.2%
Attention Deficit Hyperactivity Disorder		
The percentage of members aged 6-12 years with a diagnosis of ADHD, who participated in 3 or more family treatment visits within 180 days of being diagnosed with ADHD (Claims)	N/A	11.5%
The percentage of members aged 6-12 years with a diagnosis of ADHD, who had an outpatient psychopharmacology visit within 30-90 days following the initial diagnostic visit (Claims)	N/A	0%

*QUARTERS 1-3 IN 2014

**POPULATION CONSISTS OF MEMBERS AGES 18 YEARS AND OLDER WITH DEPRESSIVE DIAGNOSIS

Behavioral Rates for L.A. Care Covered

Depression	2013	2014*
Two or more visits within 12 weeks of initial diagnostic visit**	59.4%	57.9%
One or more medication visits within 12 weeks of diagnosis**	29.2%	29.7%
Attention Deficit Hyperactivity Disorder		
The percentage of members aged 6-12 years with a diagnosis of ADHD, who participated in 3 or more family treatment visits within 180 days of being diagnosed with ADHD (Claims)	N/A	N/A
The percentage of members aged 6-12 years with a diagnosis of ADHD, who had an outpatient psychopharmacology visit within 30-90 days following the initial diagnostic visit (Claims)	N/A	N/A

*QUARTERS 1-3 IN 2014

**POPULATION CONSISTS OF MEMBERS AGES 18 YEARS AND OLDER WITH DEPRESSIVE DIAGNOSIS

Quantitative Analysis

The aggregate rate of Medicare members ages 18 and older with depressive diagnosis who received two or more visits within 12 weeks of initial diagnostic visit during the first three quarters of 2014 was 47.5%, which was a 13.4% decrease compared to 2013. The drop in the 2014 rate may be attributed to incomplete data in 2014 (only quarters 1-3 were represented and quarter 3 did not account for claims lag); hence, the percentage of members that received two or more visits within 12 weeks of initial diagnostic visit may increase once full data is represented. In 2014, 18.6% of members ages 18 years and older with depressive diagnosis received one or more medication visits within 12 weeks of diagnosis, compared to 43.5% in 2013. Once again, the low 2014 rate may be attributed to the lack of a full data set of claims. The goals for both of the depression measures was 50%, which was not met in 2014.

The 2014 rates of the depression and attention deficit hyperactivity disorder (ADHD) measures for the Medi-Cal line of business will be used as baseline figures since 2013 data is not available. Among Medi-Cal members ages 18 and older with depressive diagnosis, 37.5% received two or more visits within 12 weeks of initial diagnostic visit during the first three quarters of 2014. Almost a quarter (24.2%) of members in the same population received one or more medication visits within 12 weeks of diagnosis. The 50% goal for the depression measures were not met; rates may increase once the full data set for 2014 is available. Two measures for ADHD were measured in 2014 among members aged 6-12 years with a diagnosis of ADHD: the percentage of members who participated in 3 or more family treatment visits within 180 days of being diagnosed with ADHD (11.5%), and the percentage of members who had an outpatient psychopharmacology visit within 30-90 days following the initial diagnostic visit (0%). The goals for both measures (20% for members that participated in 3 or more family treatment visits within 180 days of being diagnosed, 30% for members that had an outpatient psychopharmacology visit within 30-90 days following the initial diagnostic visit) were not met.

Among L.A. Care Covered members aged 18 years and older with depressive diagnosis, 57.9% had two or more visits within 12 weeks of initial diagnostic visit. The 50% goal was met for this measure. In the same population, 29.7% had one or more medication visits within 12 weeks of diagnosis; the 50% goal was not met for this measure. The 2014 rates only represent quarters 1-3, with quarter 3 not accounting for claims lag; hence rates may increase once the full data set is available. ADHD measure data for L.A. Care Covered was not available for 2013 and 2014.

Qualitative Analysis

L.A. Care continues to be actively involved in many efforts to assist practitioners to meet the guidelines. The MBHO continued to review, approve, and disseminate the American Psychiatric Association CPG (provider education on importance of two or more outpatient visits and one or more medication visits within three months of diagnosis) on depression when necessary via website and Provider Advisory Council. In the November 2014 Joint PICC/PQC meeting, L.A. Care’s Medical Director of Behavioral Health mentioned that an individual should be referred to the MBHO if they are found to be positive for depression and anxiety, following a USPSTF recommendation referring overweight/obese adults that have cardiovascular disease risk factor to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
<ul style="list-style-type: none"> • Depression • Attention Deficit Hyperactivity Disorder 	<ul style="list-style-type: none"> • Members resistant to depression treatment due to social stigma or cultural barriers • Members do not adhere to instructions for treating depression and the provider may have a poor follow up plan • Members may not be aware that it takes time for the medication to take effect and may discontinue if they don’t see changes immediately and experience side effects • Members may 	<ul style="list-style-type: none"> • L.A. Care will host a CME/CE on Depression in Primary Care on January 27, 2015 on understanding how to screen patients for depression, identifying treatment strategies in treating patients with depression, and understanding treatment options for special populations • MBHO will collaborate with L.A. Care on exchange of information and data in 2015 • MBHO will outreach to members by sending educational materials to members that are in the AMM HEDIS denominator and outreach to their prescribers (depending on availability of pharmacy and 	<p>See results above</p>

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
	<p>discontinue medication when they start feeling better</p> <ul style="list-style-type: none"> • Members may stop their therapy sessions if they don't feel better immediately • Members may have chronic comorbid medical conditions that could make accessing outpatient care for depression more difficult • Member may have follow up appointments with a PCP, which may not be tracked by BHS claims 	<p>medical data) in 2015</p> <ul style="list-style-type: none"> • MBHO will outreach to providers (BH providers and PCPs) with educational materials on the AMM measure and survey their knowledge of the measure and their prescribing habits in 2015 • MBHO will continue to seek ways to promote best practices for treatment of members with chronic medical and behavioral conditions (complex care management models and initiatives for members with dual eligibility) in 2015 • MBHO will continue to schedule quarterly Provider Advisory Council meetings to receive feedback and suggestions on Quality Improvement efforts, outcome measures, satisfaction surveys, performance standards, and clinical practice guidelines in 2015 • MBHO will identify newly prescribed ADHD members via pharmacy and medical claims and outreach to them through letters reminding them of the importance of follow up visits in 2015 • MBHO will identify newly diagnosed ADHD members and their BH providers via behavioral claims (if pharmacy claims are not available) and mail educational materials to members • Provider outreach (BH providers and PCPs) with educational materials and survey about knowledge of Antidepressant Medication Management (AMM) HEDIS measures, prescribing habits, frequency of directing patients to MBHO website for depression educational resources (October 2014) • Member mailing as part of hospitalization post-discharge aftercare activity: brochures about depression or substance abuse • Monitor provider adherence to CPGs through chart audits of high volume outpatient providers (i.e. 19 charts from three high volume providers in Q3 of 2014); follow up with providers that perform poorly by providing resources about the CPG measure and recommendations for best practices • Annually inform providers about 	

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		<p>information and updates to Depression Management tools available on BHS website through postcard mailing (1,645 providers in LA County), newsletter articles, and provider site visits.</p> <ul style="list-style-type: none"> • Formed NCQA Steering Committee and sub-committees in Q3 2013: utilization of PHQ-9 tool to monitor treatment progress of members with depression among BH providers & PCP. • Provider education on MBHO's Depression Screening Program through website postings and discussion at MBHO Provider Advisory Council meetings • Created educational articles for members, and for providers to share with members about depression; available online; updated Depression treatment tool to help members track appointments with providers, medications • Self-management tools on website to encourage members to take control of their health using tools to help them identify health-related issue, stay on track with wellness goals, and stay healthy; shared with providers through website and Provider Advisory Council • Mailed PCP toolkit (identification of BH conditions in members and provide next steps in treatment of BH conditions) to health plan providers and PCPS in Q4 2014 • Published provider article on provider newsletter regarding best practices for treatment adherence to facilitate effective outcomes and on the Follow-Up Care for Children Prescribed ADHD Medication (ADD) HEDIS measure • Monitor provider adherence to CPG through chart audits of high volume providers and follow up with poor performing providers by providing resources regarding ADHD and recommendations for best practice 	

- **PREVENTIVE HEALTH GUIDELINES RECOMMEND PREVENTIVE SERVICES AND SCREENINGS TO PREVENT, DETECT, CONTROL, MANAGE ILLNESS AND DISEASE, AND IMPROVE HEALTH OUTCOMES.**

L.A. Care selected adult body mass index (BMI) assessment, cervical cancer screening, and colorectal cancer screening to measure performance, because clinical preventive health guidelines when followed can identify diseases at earlier stages when they are more treatable or reduce a person’s risk of developing a disease. The U.S. Preventive Task Force comprehensively assesses evidence for the effectiveness of clinical preventive services including screenings, and found that clinical preventive services can have a tremendous health importance as the potential benefits include early identification of diseases leading to earlier treatment and ultimately improved health outcomes such as quality and length of life. L.A. Care also chose influenza (flu) and pneumococcal vaccinations; the Centers for Disease Control (CDC) in collaboration with the Advisory Committee on Immunization Practices (ACIP) maintain that vaccines are responsible for the control of many infectious diseases and save lives through vaccination efforts.

RESULTS

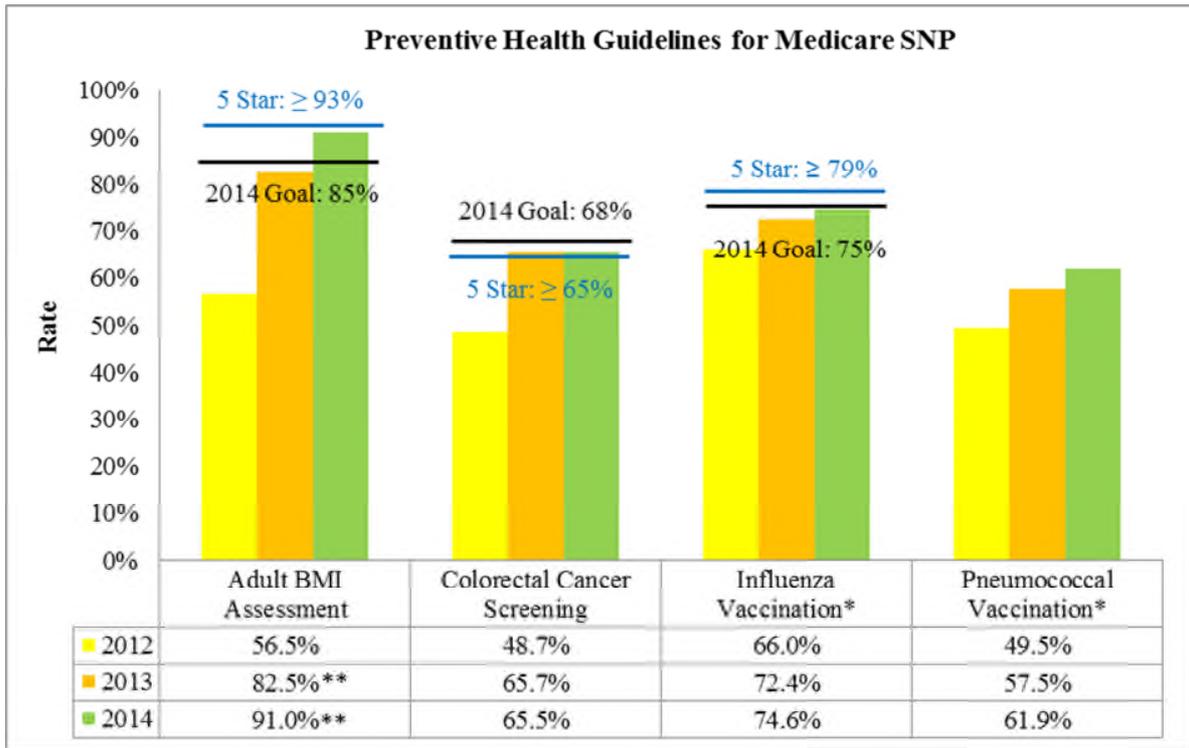
The table below shows preventive health guideline compliance using HEDIS and CAHPS data. The HEDIS rates for 2012 (2011 measurement year) will be used as baseline for adult BMI, cervical cancer screening, and colorectal cancer screening. 2012 CAHPS rates will be used as baseline for the flu and pneumococcal vaccination measures.

2014 Preventive Health Guidelines for Medicare SNP

Measure	2012	2013	2014
Preventive Screenings			
Adult BMI Assessment	56.5%	82.5%**	91.0%**
Colorectal Cancer Screening	48.7%	65.7%**	65.5%
Vaccinations			
Influenza Vaccination*	66%	72.4%	74.6%
Pneumococcal Vaccination* Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroid	49.5%	57.5%	61.9%

* CAHPS Measure

** Statistically Significant Difference ($p < 0.05$)



*CAHPS

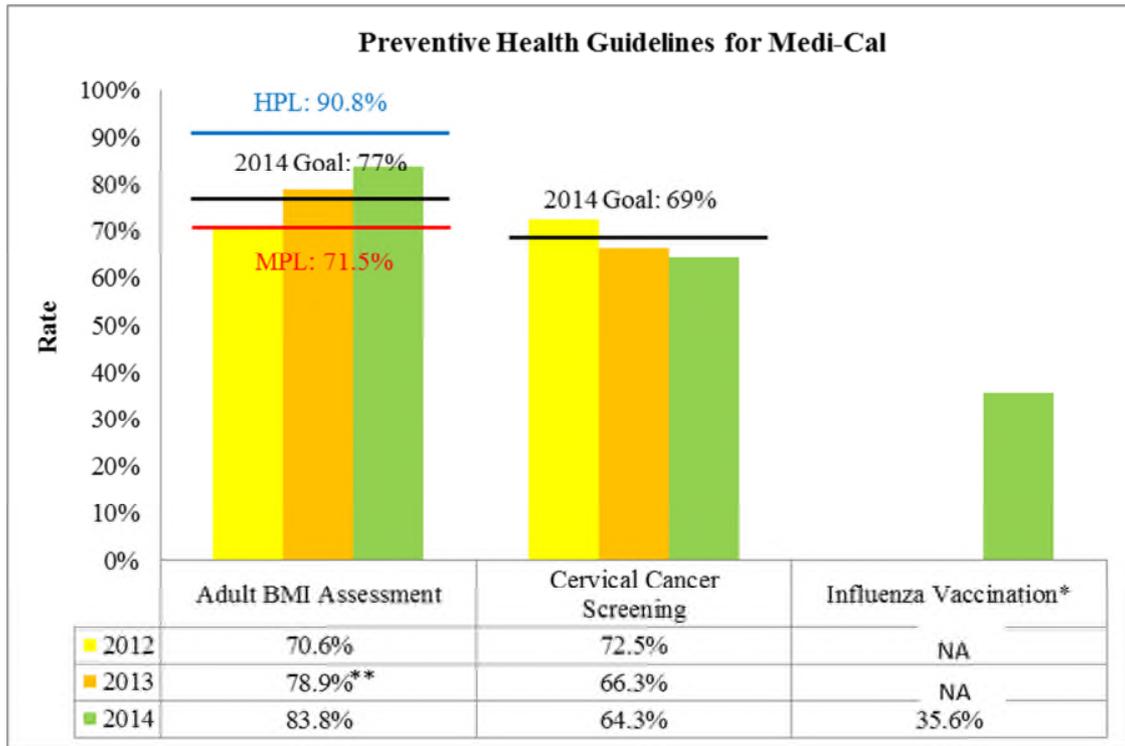
**Statistically significant

2014 Preventive Health Guidelines for Medi-Cal

Measure	2012	2013	2014
Preventive Screenings			
Adult BMI Assessment	70.6%	78.9%**	83.8%
Cervical Cancer Screening	72.5%	66.3%	64.3%
Vaccinations			
Influenza Vaccination*	N/A	N/A	35.6%
Pneumococcal Vaccination*	N/A	N/A	N/A

* CAHPS Measure

** Statistically Significant Difference ($p < 0.05$)



*CAHPS

** Statistically significant

NOTE: MPL & HPL are not applicable for 2014 HEDIS because the measure specification was changed considerably.

Quantitative Analysis

Medicare SNP

The 2012 HEDIS rates (2011 measurement year) were used as baseline rates for adult BMI and colorectal cancer screening. In HEDIS 2014, the rate for adult BMI was 91.0%, which was a 8.5 percentage point increase compared to the HEDIS 2013 rate of 82.5%. This difference was statistically significant. The goal of 85% was exceeded but fell short of the 5 Star 93% rate. Throughout the past three years, the adult BMI measure has increased drastically from 56.5% in HEDIS 2012 to 91.0% in HEDIS 2014. The colorectal cancer screening rate was 65.5%, which was slightly lower than the HEDIS 2013 rate of 65.7%. This difference was not statistically significant. The goal of 68% was not met; however, the 5 Star rate of 65% was met. The 2012 CAHPS rates were used as baseline results for the flu and pneumococcal measures. In 2014, the rate for flu was 74.6%, which was a 2.2% increase from HEDIS 2013. The flu vaccination rate fell short of the goal rate of 75%. The HEDIS 2014 pneumococcal vaccination rate increased 4.4% to 61.9%. The difference was not statistically significant.

Medi-Cal

The HEDIS 2014 rate for adult BMI Assessment was 83.8%, which was a 4.9% increase compared to the previous year. The difference was not statistically significant. The rate surpassed the 2014 goal of 77% and the minimum performance level of 71.5%. Cervical cancer screening rate in HEDIS 2014 dropped 2% to 64.3%. It did not meet the 2014 goal of 69%.

The 2014 CAHPS rate for the flu measure was used as the baseline result. There were 35.6% of Medi-Cal members that received the flu vaccination in 2014.

L.A. Care Covered

Data for L.A. Care Covered is not available for 2014; 2015 rates will be reported in the 2015 QI Evaluation.

Qualitative Analysis

L.A. Care continues to be actively involved in many efforts to assist practitioners to meet the guidelines. In the September 2, 2014 Joint PICC/PQC meeting, the Senior Director of Quality Improvement and Health Assessment presented the summary of changes made to the 2014 AAP Recommendations for Preventive Pediatric Health Care, which includes immunization schedules. Also, the preventive health guideline posters were approved and sent to Medi-Cal (adult and child) and Medicare SNP members.

In the July 16, 2014 Joint PICC/PQC meeting, the Director of Quality Improvement discussed a quality strategy that focused on L.A. Care's priorities, current and planned interventions, and collaborative opportunities to impact measures. One of the interventions mentioned in the meeting was the Fecal Occult Blood Test (FOBT) mailing and member incentive for cervical cancer screening. At the April 4, 2014 Joint PICC/PQC meeting, the 2014 Recommended Adult Immunization Schedule was approved by the Committee as part of the Preventive Health Guidelines.

At the December 9, 2013 Joint Performance Improvement Collaborative and Physician Quality Committee, L.A. Care's Medical Director presented the 2013 Clinical Practice and Preventive Health Guideline Updates noting the Preventive Health Guideline resource page is available on the L.A. Care Website. Slight changes were made to the age ranges to encompass older adults. The guidelines are now broken out by age group, zero to eighteen, and nineteen and older.

The U.S. Preventive Services Task Force (USPSTF) list of Grade A and B recommendations from the USPSTF website were presented to the committee for review and approval. L.A. Care's Medical Director noted Grade A and B recommendations are of increasing importance and highlighted in the Affordable Care Act. The services must be accessed under that context.

L.A. Care's Medical Director reported that there is an updated recommendations related to tobacco use. The recommendation is for school age children and adolescents and requires interventions to prevent initiation of tobacco use with a Grade B recommendation. The USPSTF found adequate evidence that behavioral counseling interventions, such as face-to-face or phone interaction with a health care provider, printed materials, and computer applications, can reduce the risk for smoking initiation in school-aged children and adolescents. L.A. Care is currently exploring ways to utilize texting in 2014 as an added method for communicating health education in this area.

L.A. Care's Medical Director reviewed the Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women Clinical Summary of U.S. Preventive Services Task Force Recommendation. The committee was given the Guide for Clinicians "Helping Smokers Quit" which contains the 5 "As" Ask (about tobacco use), Advise (all tobacco users to quit), Assess (readiness to quit), Assist (tobacco users with a quit plan), and Arrange (follow up visits).

L.A. Care's Medical Director mentioned that the Health Education department has been working on enhancing tobacco cessation programs at L.A. Care. L.A. Care reported actively focusing efforts in a structured manner regarding member assessment and identification of co-morbid conditions. Identified members are placed in various levels and receive interventions according to their level. Interventions include educational information by trained health educators, counseling, motivation, referrals to the California Help Line, along with the components included in the guidelines such as pharmacotherapy and intense case management from disease management nurses. The program deadline is January 1, 2014 and

will included Covered California and Medi-Cal. Additional product lines will be included if the program is successful.

At the June 27, 2013 Physician Quality Committee, L.A. Care’s Director of Healthcare Outcome and Analysis, informed the committee that there was a significant increase in the 2013 HEDIS colorectal screening, adult BMI, and glaucoma testing.

At the February 28, 2013 Physician Quality Committee, L.A. Care’s Medical Director explained that the 2013 Preventive Health Guidelines (PHG) source matrix have been updated and will be posted on L.A. Care’s website upon committee review and approval; further noting that the PHG source matrix contains links to all of the guidelines making them easy to access. The following updated PHG were presented to the committee: *Screening and Behavioral Counseling Interventions In Primary Care To Reduce Alcohol Misuse*: Adults aged 18 years or older recommendation Grade B, *Screening for Hepatitis C Virus Infection in Adults*: Persons at high risk for infection and adults born between 1945 and 1965 recommendation Grade: B, *Screening For HIV Clinical*: Adolescents and adults aged 15 to 65 years, younger adolescents and older adults at increased risk for infection, and pregnant women recommendation Grade: A. L.A. Care’s Medical Director was interested in knowing if any of the physicians were doing routine HIV or within the target populations Hep C screenings, particularly at point of care. A physician from Watts Health Care noted they do routine HIV screenings. L.A. Care’s Medical Director asked if they do rapid testing, since the levels of sensitivity specificity are over 99% with the rapid test. The physician indicated that they are doing rapid testing in their clinic. They also go out into the community.

At the February 23, 2012 Physician Quality Committee, the committee reviewed and approved the 2012 Preventive Health Guidelines source matrix. The matrix was updated to include the Center for Medicaid and Medicare Prevention-General Information. The matrix was posted on L.A. Care’s website.

At the April 26, 2012 Physician Quality Committee, the 2012 member Preventive Health Guidelines were presented. The preventive health guidelines were mailed to members and will be available on the provider website. One physician suggested having a poster of the preventive health guidelines that could be posted in provider offices. The committee was provided a presentation entitled “Medicate Star Rating,” the presentation outlined CMS’ star rating system and the 53 quality measures including success in providing preventive services and managing chronic illnesses.

At the February 24, 2011 Physician Quality Committee, the 2011 Preventive Health Guidelines source matrix was presented and approved. The committee was informed that the 2011 immunizations schedules were available on L.A. Care’s website. One provider suggested L.A. Care staff conducting provider office visits place an icon (i.e., shortcut) on the providers’ computer desktop for easy access to the website and guidelines.

INTERVENTIONS

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
<ul style="list-style-type: none"> Adult BMI assessment Cervical Cancer Screening Colorectal Cancer Screening Flu vaccination 	<ul style="list-style-type: none"> Providers do not know how to properly document BMI in a patient’s record. Providers do not always know how to properly diagnose/measure and or 	<ul style="list-style-type: none"> Medicare SNP Provider Opportunity Reports (PORs) were distributed in July and September 2014; Medi-Cal PORs were distributed in June and October 2014; the PORs contain member lists of those with gaps in care, such as colorectal cancer 	See results above

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
<ul style="list-style-type: none"> Pneumococcal vaccination 	<p>treat obesity (using BMI).</p> <ul style="list-style-type: none"> Providers don't have tracking system to remind patients about the vaccinations. Providers may not be aware of the latest clinical and preventive health guidelines for adults. Providers lack of agreement with the preventive health guidelines. Members may not be aware of physical activity counseling and or the need and value. Members may not be motivated to obtain physical activity counseling. Members may not be aware of physical activity counseling resources. Members are not aware of need for this screening. Members don't have the time or capability to go to their provider's office to obtain the necessary screening. There is insufficient education effort to members about the importance and benefits of the vaccinations. 	<p>screening and flu vaccination</p> <ul style="list-style-type: none"> In October 2014, Provider HEDIS tip sheets created by the Quality Improvement department were distributed to select PPGs. The tip sheets offer general tips educating physicians on HEDIS guidelines, standards of care, most common billing codes to get credit for HEDIS services, and ways to improve HEDIS scores. A section on the adult BMI, cervical cancer screening, and colorectal cancer screening measures were included L.A. Care launched a cervical cancer screening incentive program in July of 2014. The goal was to increase compliance rates for the screening and provided members with a \$50 Target gift card for receiving the screening by December 31, 2014 In 2013, L.A. Care's Fall Provider Newsletter included information on the "New Preventive Health Guidelines." Noting that PHG booklets were mailed to members annually as well as monthly to new members. The PHGs serve as a reminder of what immunizations or tests they need and the frequency for which they need them. Further noting that the guidelines are in compliance with the United State Preventive Services Task Force (USPFT) and are annually updated. Additionally, informing providers that there are several additions which should be particularly noted for the 2013 PHGs: <i>Adults born between 1945-1965 receive one-time Hepatitis C test as well as others at risk; HIV screening at least once for those ages 15-65, those at risk, and all pregnant women as well as those who present in labor with unknown HIV status.</i> September 2013, September 21, 2012 and May 25, 2012, L.A. Care mailed Medicare Provider Opportunity reports to physicians. The report contains the PCP's list of members in need of preventive services. The September 2012 Opportunity reports were hand delivered to the top 60 high volume Medicare PCPs and the remainders were mailed. The September 	

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		<p>reports were also enhanced to include individual member reports. The goal of the report is to provide PCPs with information to focus their clinical outreach effort and to include the information in the member's medical record.</p> <ul style="list-style-type: none"> • In 2013 L.A. Care's Health Education Department initiated a flu campaign targeting all SNP members. The campaign consists of sending out a mailer in mid-October to all SNP members that includes a trifold with information on the flu and in January sending out a postcard reminder to get the flu shot. The postcard will also be sent to all SNP members. In August 2012, L.A. Care mailed an annual wellness postcard that included information on the flu. • September 2013, fecal occult blood test kits were mailed to 658 SNP members in need of their screening, and the results were shared with the members' PCP. In October 2012 there were 587 fecal occult kits sent out. • In 2013, L.A. Care's provider newsletter included a section entitled "Do You Know L.A. Care's Clinical Practice & Preventive Health Guidelines?" The section informed physicians that L.A. Care's Clinical Practice and Preventive Health Guidelines are posted on L.A. Care's website and that the guidelines may be helpful in managing care in common areas of the physicians' medical practice. Additionally, listing the availability of the 2013 Immunization Schedule for Adults and 0-18, as well as the 2013 Clinical Practice Guidelines Source Matrix and 2013 Preventive Health Guideline Source Matrix. Further, encouraging physicians to visit the website which has new and updated guidelines for 2013 and that hard copies are available upon request. • In 2013 and in February 2012, in an effort to mitigate physician barriers, L.A. Care launched a new health education program that included a mailing to all Medicare members. The program, called Passport to Health, educates members on the 	

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		<p>importance of scheduling their annual health screenings and lab assessments. Members are encouraged to schedule an appointment with their PCP to receive needed services and to maintain a record of services they've received.</p> <ul style="list-style-type: none"> • In November 2012, L.A. Care called 400 members in need of a glaucoma test. Members were assisted with appointments as needed. • In spring 2012, L.A. Care' Provider Newsletter informs PCPs about L.A. Care's recent mailing to members called "Passport to Good Health," which encourages member to bring their personalized report of 11 health measures to their next PCP visit to ensure appropriate lab tests, screening or vaccinations. • On July 10 & 19, 2012, L.A. Care held a CME entitled, "HCCs and Star Quality Measures for SNP Plan Members." The workshop reviewed the importance of Medicare coding and its requirements for new, established, acute and chronic diagnoses, how to avoid missed opportunities in documentation. The training discussed HEDIS and Medicare's Star Program's measures. • On June 7, 2012, in an effort to assist physicians with improving patient adherence, L.A. Care held a physician CME entitled, "Three Easy Tips to Improve Patient Adherence in Diverse Populations." • In summer 2012, L.A. Care provider newsletter notified physicians that Clinical and Preventive Health Guidelines can be found on L.A. Care's website and that hard copies are available upon request. The newsletter also reminds physicians that health education services are available to patients and to refer members. • In summer of 2012, L.A. Care developed a comprehensive provider training education packet, which contains various toolkits and clinical practice guidelines as well as other resources for physicians use. The materials are hand delivered to physician offices. • L.A. Care updates its provider 	

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		<p>section of the website to include the most updated Clinical Practice & Preventive Health Guideline Source Matrix's and toolkits easily accessible to physicians.</p> <ul style="list-style-type: none"> • L.A. Care's matrix of Clinical Practice Guidelines is distributed on an ongoing basis 	

A.7 CONTINUITY AND COORDINATION OF MEDICAL CARE

2014 WORK PLAN GOALS:

MEASURE	2014 Medi-Cal Goals	2014 Medicare – SNP Goals	2014 L.A. Care Covered (LACC) Goals
Avoidable ER Visits (AER), a non-HEDIS Measure, is the rate of members over the age of 1 year seen in the Emergency Room with designated avoidable diagnoses set by the Department of Health Care Services (DHCS).	A 10% reduction in the AER visit	N/A	N/A
The percentage of physicians who receive poly-pharmacy reports regarding their members	100%	100%	100%
The number of physicians who receive reports from Nurse Advice Line (NAL) on members directed to ER	100%	100%	100%
Percentage of Primary Care Practitioners (PCPs) reporting that they <i>always/often</i> receive adequate clinical information from Specialists (SCPs).	80%	80%	80%
Percentage of SCPs reporting that they <i>always/often</i> receive adequate clinical information from PCPs.	80%	80%	80%

BACKGROUND

L.A. Care Health Plan monitors performance areas affecting and reflecting coordination of care on an annual basis. L.A. Care acknowledges that continuity of care is important to ensure that members receive the highest quality of care possible. Continuity of care is an important factor that impacts patient safety and satisfaction with care. Although studies show that in most instances, practitioners are able to detect and bridge gaps in continuity of care, incidents can result from breakdowns in communication. Thus, L.A. Care uses information at its disposal and continues to build its network's ability to communicate in order to facilitate continuity and coordination of medical care across its delivery system.

L.A. Care has prioritized several efforts that aim to bridge gaps in communication, improve continuity of care, and engage providers, specialists, and members in development and execution of a comprehensive care plan. For example, the Patient Centered Medical Home (PCMH) Initiative, the Blue Button Pilot Program, the eConnect Pilot Program, and the eConsult Program all include efforts to systematically improve continuity and coordination of care, and subsequently patient outcomes and patient satisfaction with care. L.A. Care collects data from different settings, such as: hospital emergency rooms, pharmacies, and transitions in care -including changes in management of care between specialists and primary care practitioners. This report provides an overview and analysis of available data collected to assess coordination of care across two different healthcare settings with four measures:

- Hospital (ER) – Avoidable ER visits and Nurse Advice Line (NAL) (eConnect Pilot Program)
- Ambulatory – Primary Care Practitioners/Specialists communication (eConsult Program) and Polypharmacy reports to PCPs (Blue Button Pilot Program)

MAJOR ACCOMPLISHMENTS

- L.A. Care noted a significant increase in polypharmacy members identified.
- In 2014, L.A. Care continued and expanded the e-Consult Program with the purpose to leverage the specialist base and facilitate PCP and SCP electronic communication and collaboration regarding patients' care.
- In 2014, L.A. Care successfully handed over ownership of the e-Consult Pilot Program with the L.A. Department of Health Services (DHS) to be fully implemented and monitored by DHS – a strong sign of the program's sustainability.
- In 2014, L.A. Care continued the Patient Centered Medical Home (PCMH) initiative. The project requires the PCP and PCP's medical team to provide coordinated, continuous and comprehensive primary care. The PCP and PCP's medical team are responsible for delivering coordinated patient-centered care across settings and utilizing health information technology to improve patient outcomes.
- In 2014, L.A. Care began the e-Connect Pilot Program with five hospitals. This program allows L.A. Care to receive notification when a member is admitted to the ER which is then shared via the IPA/PPG portal so that providers are aware and can follow-up appropriately.

A.7.a AVOIDING UNNECESSARY ER VISITS

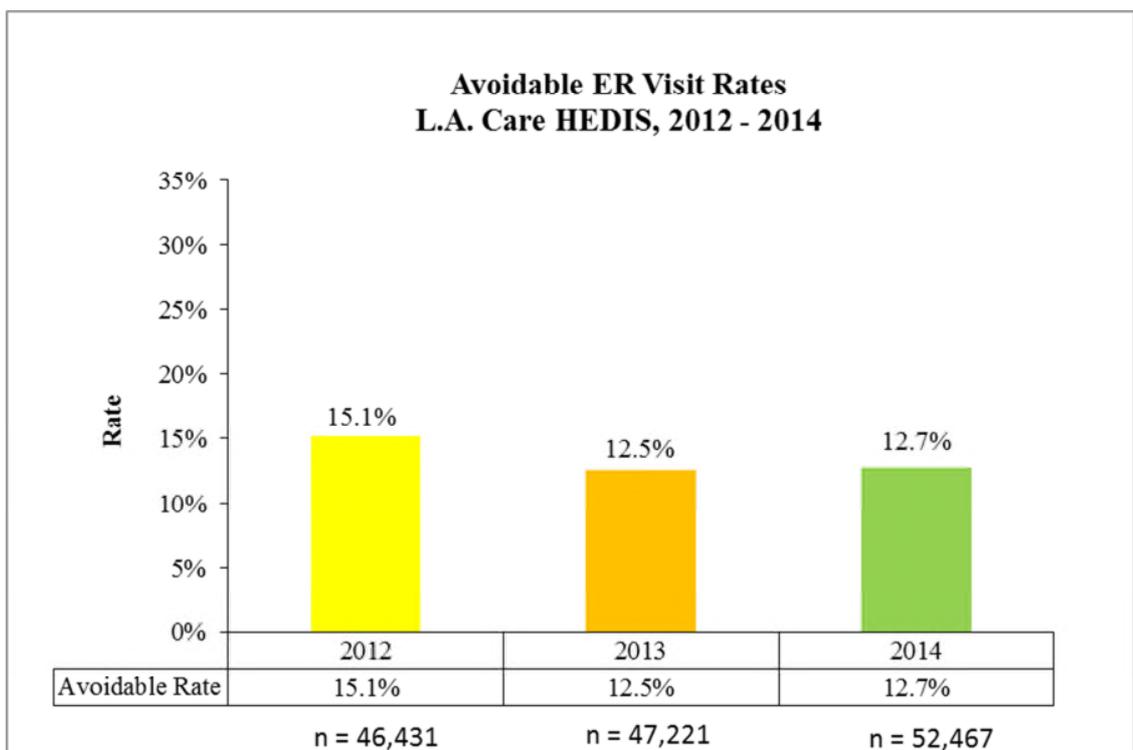
REDUCING AVOIDABLE ER VISITS (AER)

METHODOLOGY

L.A. Care collected the ER data per HEDIS 2014 specifications and applied a filter of statewide Medicaid recognized avoidable ER diagnoses to calculate the avoidable ER (AER) rate.

RESULTS

AVOIDABLE ER VISIT RATES



Quantitative Analysis

There was a statistically significant decrease in the Avoidable ER (AER) rate from 2012 to 2013 ($p < 0.05$); an improvement which has remained relatively stable in 2014 with a rate of 12.7%. Note: AER codes per DHCS list and have been consistent since 2008.

Qualitative & Causal Analysis

It should be noted that most of the member interventions started in the latter part of 2008. Starting in 2008, L.A. Care provided health education materials with a prompt for the member to follow-up with the PCP. Later, L.A. Care had expanded the intervention to primary care physicians (PCPs) in October 2010 and provider groups in March 2011. As a result, it may have taken these additional years to see a significant drop in the rate, which we saw in HEDIS 2012 and HEDIS 2013. In 2014, the HEDIS rate remains similar to the year prior. The collaboration with CHLA continues in 2014.

Throughout the study period, L.A. Care had identified several barriers that may prevent members from properly utilizing the ER. These barriers include parents are worried when their child is sick and do not know what to do, members perceive that they get better care in the ER, member's lack of confidence in his/her PCP, and members do not utilize the Nurse Advice Line (NAL). In some cases, members may face access to care barriers such as not being able to visit their PCP or urgent care after normal business hours including weekends. In other instances, providers are not aware of their members who recently visited the ER in order to provide a timely follow-up visit, appropriate assessment, and education to members on aftercare instructions or how to deal with potential risk factors for existing conditions. Some of the other barriers identified are:

- There is no timely exchange of information from the ER to the Health Plan. Health Plans rely on claims or encounter data which typically can take up to 6 months to obtain.
- Most hospitals are not incentivized to work with health plans to decrease ER usage and thus the revenue stream. Many tell the patient to return to the ER for a follow up visit rather than contact their own PCP.

It was difficult for L.A. Care to act timely since ER claims were so late and members could have already been seen in the ER again. Often, the data stream from CHLA is still delayed and efforts to reduce avoidable ER admissions remain difficult without more resources put into improving the infrastructure in which communication between the health plan and hospitals takes place. ER and AER visits still occur at CHLA but also many other hospitals; therefore, expanding the L.A. Care's ability to receive ER notification from hospitals for more than children admitted to CHLA will be necessary to improve ER/PCP continuity of care for all members (adults and children).

Given this lack of infrastructure to support communication of member admissions to the ER, L.A. Care has developed a pilot program called eConnect. In 2014, eConnect began working to enhance the networks infrastructure to electronically receive member ER admission data from hospitals and then share (via an online portal) with IPAs when their patients have been admitted to the ER. Thus, this program directly impacts coordination and continuity of care for all lines of business (Medi-Cal, CMC, and LACC) since it offers IPAs and PCPs daily knowledge of when their patients have been admitted to the ER – not just CHLA child admissions. Through the eConnect Pilot Program's interface, five hospitals are now able to electronically notify L.A. Care upon member admission to the ER. Looking forward, eConnect has goals to expand to more hospitals as well as track utilization of the information shared within the PPGs' online portal.

This improved communication network will also provide L.A. Care's medical management department with more timely access to member data for identifying members that would benefit from complex case management services and transition of care programs.

Opportunity for Improvement

There was an opportunity identified to decrease the avoidable ER rate if ER visit data could be received in a timely, systematic manner.

Action Taken

INTERVENTION

Measure	Barriers	Actions	Effectiveness of Intervention/ Outcome
Avoidable ER Visits	<ul style="list-style-type: none"> • Parents worry when their child is sick and do not know what to do. • Members are not utilizing the NAL. • Members do not know where to find help except the ER. • Members/parents perceive their / their children's conditions are more serious than it actually is. • Some of the providers have poor phone access after-hours and for urgent care. • Inconvenient for providers/provider offices to provide extended hours or weekend hours. • Capitation reimbursement model combined with low reimbursement rate for physicians disincentivizes providers to provide extended hours and/or weekend hours. 	<ul style="list-style-type: none"> • In 2014, L.A. Care generated and distributed individual physician reports that include a list of physicians' assigned members who have recently visited Children's Hospital Los Angeles (CHLA) ER along with their diagnosis information. The cover letter encourages the PCP to make a follow up appointment as needed. Members who have been seen in the CHLA ER have been receiving educational packets prompting them to follow up with their PCP. • Since March 2011, L.A. Care sends Provider Group level reports that consist of a list of the PG's contracted physicians along with their assigned members who were seen in the ER for avoidable conditions. • Since June 2009, on a periodic basis CHLA began sending L.A. Care a list of its members seen in the ER. All members identified as having an avoidable visit are sent member information packets within 14 days of the ER visit and a letter to prompt the member to follow up with their PCP. • L.A. Care continues to promote the availability and use of the NAL along with its Plan Partners through various sources such as new member mailings, member newsletters, website, and etc. • In 2014, L.A. Care expanded its ability to identify members admitted to the ER through the eConnect Pilot Program. 	See above.

A.7.b POLYPHARMACY

METHODOLOGY

In order to minimize the concurrent use of multiple medications in the same patient and reinforce compliance in patients with complex medication regimens, L.A. Care collects members' quarterly pharmacy data from a 3-month period with the following parameters:

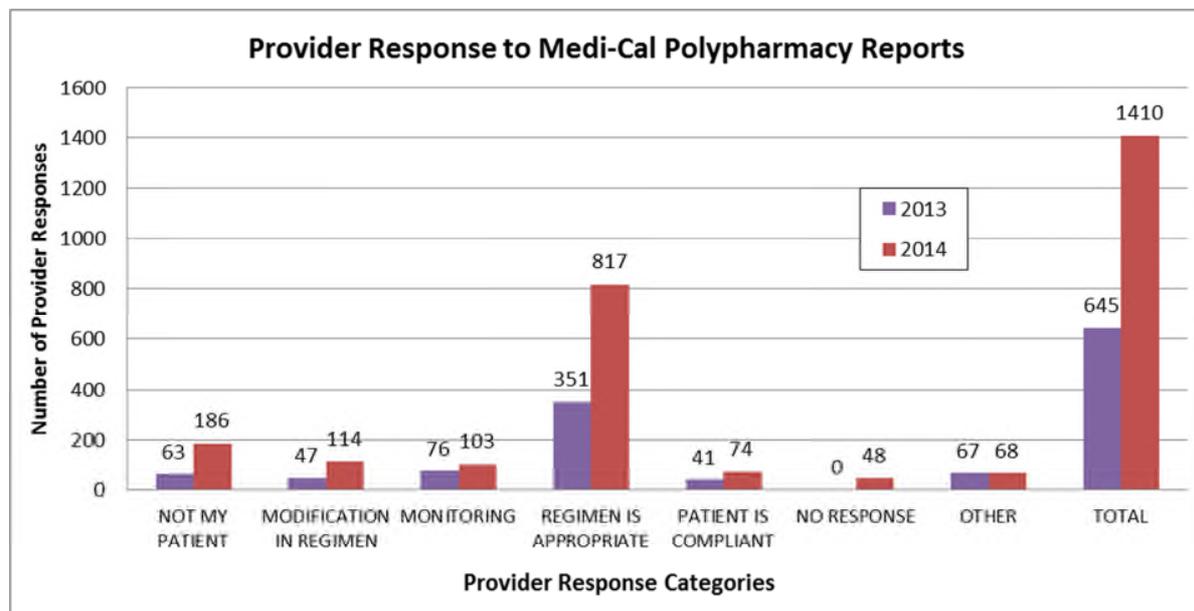
- More than 10 unique, chronic medications
- From 3 or more prescribers (coordination between prescribing settings)

Each identified member's prescription drug history has been formatted for effective drug regimen review and placement in the medical chart. The primary care provider is most familiar with their patients' medical conditions and can evaluate these medication profiles specifically looking for the occurrence of inappropriate polypharmacy and simplification of drug therapy.

RESULTS

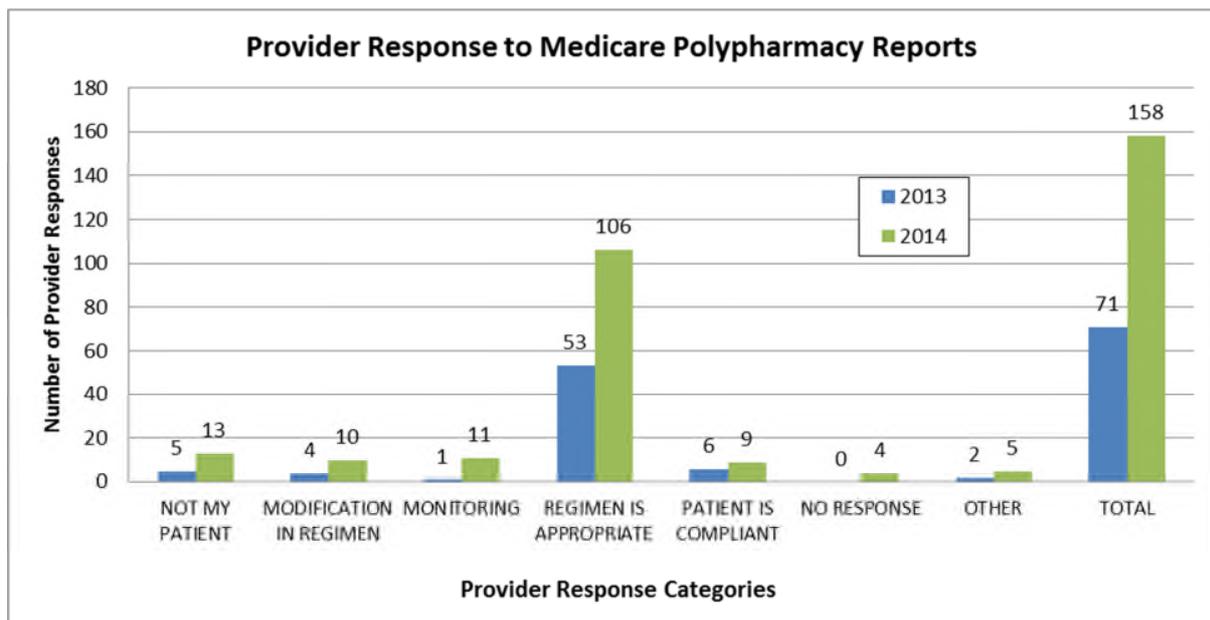
Medi-Cal Polypharmacy:

	Number of Medi-Cal Members Identified	Number of Medi-Cal Provider Mailings	Percent of Provider Mailings that Provider Responded
2012	6068	3710	N/A
2013	7074	4331	14.9%
2014	10829	5469	25.8%



Medicare Polypharmacy:

	Number of Medicare Members Identified	Number of Medicare Provider Mailings	Percent of Provider Mailings that Provider Responded
2012	447	340	N/A
2013	835	641	11.1%
2014	1332	997	15.8%



ANALYSIS

Quantitative Analysis

Medi-Cal

The Medi-Cal 2014 goal was met; 100% of prescribers were notified of members with polypharmacy. Based on the data above, the number of members identified with polypharmacy instances has increased; between 2013 and 2014, there was a 53.1% increase among Medi-Cal members (7074 vs. 10829). There was a subsequent increase in the number of providers notified as well as the number of provider responses to the polypharmacy reports sent back to L.A. Care. There was an increase in the percent of providers who acknowledged receipt of the report and responded in 2013 (14.9%) compared to 2014 (25.8%). Though the predominant provider response was that the patient's regimen is appropriate, 217 (15.4%) responded that they would monitor or modify the medication regimen.

Medicare

The Medicare 2014 goal was met; 100% of prescribers were notified of members with polypharmacy. Based on the data above, the number of members identified with polypharmacy instances has increased; between 2013 and 2014, there was a 59.5% increase among Medicare members (835 vs. 1332). There was a subsequent increase in the number of providers notified as well as the number of provider responses to the polypharmacy reports sent back to L.A. Care. There was an increase in the percent of providers who

acknowledged receipt of the report and responded in 2013 (11.1%) compared to 2014 (15.8%). Though the predominant provider response was that the patient's regimen is appropriate, 22 (13.9%) responded that they would monitor or modify the medication regimen.

Qualitative & Causal Analysis

Between 2012 and 2014, L.A. Care's membership has increased consistently. This growth may be in part due to the continual enrollment of Seniors and People with Disabilities (SPDs), increased enrollment of Medi-Cal members, and the expansion of the Cal MediConnect (CMC) line of business. While the increase in polypharmacy cases may simply be due to a corresponding increase in the overall membership, there are some other factors that may be contributing to the increase, such as:

- Providers may not be aware of other practitioner prescriptions, such as those from specialists or ER physicians.
- Members do not communicate, whether intentionally or unintentionally, with their PCPs about all the medications they are taking which they obtain from many practitioners, including the mid-level prescribers (nurse practitioners and physician assistants).

As the growth of utilization of services occurs, there exists a potential increased risk of polypharmacy. In 2014, the LACC line of business was not included in the PBM's polypharmacy reporting and thus not included in this year's quantitative and qualitative analyses. In 2015, L.A. Care's new PBM will notify PCPs of members with polypharmacy in LACC line of business, in addition to Medi-Cal and CMC.

Opportunity for Improvement

There was an opportunity to decrease polypharmacy by addressing the two potential contributing factors mentioned above:

- First, to increase PCP awareness of polypharmacy by providing physicians with reports on members with 10 or more unique chronic medications from three or more prescribers, and
- secondly, by empowering members to communicate with their PCPs about all medications they are currently prescribed and by making knowledge regarding prescription history more readily accessible to the member and subsequently, the PCP and SCP(s).

Both opportunities will require enhancement L.A. Care's network and infrastructure ability to communicate member's prescription history to the PCP, SCP(s), and the member themselves. L.A. Care's Blue Button Pilot Program supports improved prescription history data exchange and thus, continuity and coordination of care. The program provides an electronic platform on the member portal such that members can have online access to download and/or share their prescription information for enhanced PCP/SCP-member communication and improved patient safety. The current reach of the program is limited given that the program is in an early implementation phase. In 2015, there are goals to expand the program's reach as well as collect process/utilization measures of the member portal application.

Action Taken

INTERVENTION

Measure	Barriers	Actions	Effectiveness of Intervention/ Outcome
Pharmacy data showing members with more than 10 unique, chronic medications from 3 or more prescribers from a 3 month period.	Practitioners are not aware their patients are getting drugs from multiple prescribers.	Notify practitioners about patients with prescriptions from multiple practitioners.	100% of practitioners were notified of polypharmacy members for Medi-Cal and Medicare D-SNP. The goal for LACC was not met as the PBM did not generate polypharmacy reports for members in this line of business.

A.7.c NURSE ADVICE LINE (NAL) DIRECTS TO ER

METHODOLOGY

Annually, L.A. Care assesses the NAL member redirection report. The report tracks: 1) the total number of calls made to NAL with a specific intention across different levels of care, ranging from the intention to seek care at the ER to self-care; and 2) the outcome of the call, i.e. the total number of members being directed to a particular level of care based on the NAL nurse's recommendation.

In the below table, data reflects responses to queries made of callers by nursing staff upon completion of the encounter. Questions asked are:

- "If you had not called this service, what would you have done?" and
- "Do you agree with the Nurse's recommendation?"

All records are gathered from symptom based encounters. Percentages are based on Caller Pre-Intent totals.

When a member calls the NAL and a NAL nurse directs the member to the ER, the NAL vendor provides reports to L.A. Care about these members. L.A. Care then notifies the IPAs about patients who have been directed to the ER by the NAL and why they were directed so as to improve coordination and continuity of care for the members.

RESULTS

I. MEDI-CAL NAL SUMMARY, 2012-2014

Medi-Cal* Member Redirection/Outcomes (January 1, 2014 – December 31, 2014)

Caller Pre-Intent		Nurse Recommendation					
Level of Care		Seek Care ER	Seek Urgent Care	Call for Advice	Make an Appt.	Self Care	Other/Not Asked
Seek Care ER	4,259 34.39%	637 14.96%	537 12.61%	1451 34.07%	359 8.43%	1275 29.94%	0 0.00%
Seek Urgent Care	1,295 10.46%	103 7.95%	180 13.90%	396 30.58%	153 11.81%	463 35.75%	0 0.00%
Call for professional advice	3,492 28.20%	368 10.54%	347 9.94%	1214 34.77%	486 13.92%	1077 30.84%	0 0.00%
Make an appointment with Health Professional	1,784 14.41%	117 6.56%	172 9.64%	548 30.72%	386 21.64%	561 31.45%	0 0.00%
Self Care	1,223 9.88%	103 8.42%	125 10.22%	368 30.09%	165 13.49%	462 37.78%	0 0.00%
Other/Not asked	331 2.67%	34 10.27%	17 5.14%	135 40.79%	21 6.34%	124 37.46%	0 0.00%
Total	12,384 100.00%	1,362 11.00%	1,378 11.13%	4,112 33.20%	1,570 12.68%	3,962 31.99%	0 0.00%
Post-Intent	Agrees with Nurse	1,307 95.96%	1339 97.17%	3979 96.77%	1524 97.07%	3888 98.13%	0 0.00%
	Disagrees with Nurse	55 4.04%	39 2.83%	133 3.23%	46 2.93%	74 1.87%	0 0.00%

*Combined data for Medi-Cal and COMM

Medi-Cal Member Redirection/Outcomes (January 1, 2013 – December 31, 2013)

Caller Pre-Intent		Nurse Recommendation					
Level of Care		Seek Care ER	Seek Urgent Care	Call for Advice	Make an Appt.	Self Care	Other /Not Asked
Seek Care ER	2,935 40.97%	363 12.37%	328 11.18%	995 33.90%	175 5.96%	1,074 36.59%	0 0.00%
Seek Urgent Care	665 9.28%	41 6.17%	79 11.88%	228 34.29%	43 6.47%	274 41.20%	0 0.00%
Call for professional advice	1,874 26.16%	157 8.38%	158 8.43%	705 37.62%	166 8.86%	688 36.71%	0 0.00%
Make an appointment with Health Professional	888 12.40%	42 4.73%	83 9.35%	280 31.53%	138 15.54%	345 38.85%	0 0.00%
Self Care	534 7.45%	41 7.68%	41 7.68%	159 29.78%	39 7.30%	254 47.57%	0 0.00%
Other/Not asked	267 3.73%	28 10.49%	13 4.87%	89 33.33%	10 3.75%	127 47.57%	0 0.00%
Total	7,163 100.00%	672 9.38%	702 9.80%	2,456 34.29%	571 7.97%	2,762 38.56%	0 0.00%
Post-Intent	Agrees with Nurse	613 91.22%	688 98.01%	2,397 97.60%	562 98.42%	2,737 99.09%	0 0.00%
	Disagrees with Nurse	59 8.78%	14 1.99%	59 2.40%	9 1.58%	25 0.91%	0 0.00%

Medi-Cal Member Redirection/Outcomes (January 1, 2012 – December 31, 2012)

Caller Pre-Intent		Nurse Recommendation					
Level of Care		Seek Care ER	Seek Urgent Care	Call for Advice	Make an Appt.	Self Care	Other /Not Asked
Seek Care ER	3,080 42.24%	426 13.83%	322 10.45%	1,099 35.68%	202 6.56%	1,031 33.47%	0 0.00%
Seek Urgent Care	587 8.05%	43 7.33%	61 10.39%	199 33.90%	59 10.05%	225 38.33%	0 0.00%
Call for professional advice	1,743 23.90%	189 10.84%	138 7.92%	590 33.85%	204 11.70%	622 35.69%	0 0.00%
Make an appointment with Health Professional	954 13.08%	55 5.77%	80 8.39%	276 28.93%	172 18.03%	371 38.89%	0 0.00%
Self Care	634 8.69%	61 9.62%	50 7.89%	202 31.86%	66 10.41%	255 40.22%	0 0.00%
Other/Not asked	294 4.03%	28 9.52%	11 3.74%	112 38.10%	19 6.46%	124 42.18%	0 0.00%
Total	7,292 100.00%	802 11.00%	662 9.08%	2,478 33.98%	722 9.90%	2,628 36.04%	0 0.00%
Post-Intent	Agrees with Nurse	754 94.01%	651 98.34%	2,412 97.34%	694 96.12%	2,595 98.74%	0 0.00%
	Disagrees with Nurse	48 5.99%	11 1.66%	66 2.66%	28 3.88%	33 1.26%	0 0.00%

II. MEDICARE NAL SUMMARY, 2012-2014

Medicare Member Redirection/Outcomes (January 1, 2014 – December 31, 2014)

Caller Pre-Intent		Nurse Recommendation					
Level of Care		Seek Care ER	Seek Urgent Care	Call for Advice	Make an Appt.	Self Care	Other/Not Asked
Seek Care ER	31 24.22%	6 19.35%	5 16.13%	12 38.71%	3 9.68%	5 16.13%	0 0.00%
Seek Urgent Care	7 5.47%	4 57.14%	0 0.00%	2 28.57%	0 0.00%	1 14.29%	0 0.00%
Call for professional advice	53 41.41%	6 11.32%	5 9.43%	28 52.83%	3 5.66%	11 20.75%	0 0.00%
Make an appointment with Health Professional	16 12.50%	1 6.25%	2 12.50%	7 43.75%	2 12.50%	4 25.00%	0 0.00%
Self Care	14 10.94%	2 14.29%	1 7.14%	4 28.57%	2 14.29%	5 35.71%	0 0.00%
Other/Not asked	7 5.47%	0 0.00%	0 0.00%	4 57.14%	0 0.00%	3 42.86%	0 0.00%
Total	128 100.00%	19 14.84%	13 10.16%	57 44.53%	10 7.81%	29 22.66%	0 0.00%
Post-Intent	Agrees with Nurse	18 94.74%	13 100.00%	53 92.98%	10 100.00%	28 96.55%	0 0.00%
	Disagrees with Nurse	1 5.26%	0 0.00%	4 7.02%	0 0.00%	1 3.45%	0 0.00%

*Combined data for CalMediConnect and SNP lines of business

Medicare (SNP) Member Redirection/Outcomes (January 1, 2013 – December 31, 2013)

Caller Pre-Intent		Nurse Recommendation					
Level of Care		Seek Care ER	Seek Urgent Care	Call for Advice	Make an Appt.	Self Care	Other /Not Asked
Seek Care ER	34 28.57%	6 17.65%	4 11.76%	16 47.06%	4 11.76%	4 11.76%	0 0.00%
Seek Urgent Care	5 4.20%	0 0.00%	2 40.00%	1 20.00%	1 20.00%	1 20.00%	0 0.00%
Call for professional advice	46 38.66%	6 13.04%	7 15.22%	25 54.35%	2 4.35%	6 13.04%	0 0.00%
Make an appointment with Health Professional	18 15.13%	3 6.67%	2 11.11%	5 27.78%	3 16.67%	5 27.78%	0 0.00%
Self Care	10 8.40%	1 10.00%	1 10.00%	5 50.00%	0 0.00%	3 30.00%	0 0.00%
Other/Not asked	6 5.04%	0 0.00%	0 0.00%	4 66.67%	1 16.67%	1 16.67%	0 0.00%
Total	119 100.00%	16 13.45%	16 13.45%	56 47.06%	11 9.24%	20 16.81%	0 0.00%
Post-Intent	Agrees with Nurse	13 81.25%	16 100.00%	55 98.21%	10 90.91%	18 90.00%	0 0.00%
	Disagrees with Nurse	3 18.75%	0 0.00%	1 1.79%	1 9.09%	2 10.00%	0 0.00%

Medicare (SNP) Member Redirection/Outcomes (January 1, 2012 – December 31, 2012)

Caller Pre-Intent		Nurse Recommendation					
Level of Care		Seek Care ER	Seek Urgent Care	Call for Advice	Make an Appt.	Self Care	Other /Not Asked
Seek Care ER	22 30.56%	6 27.27%	0 0.00%	13 59.09%	1 4.55%	2 9.09%	0 0.00%
Seek Urgent Care	3 4.17%	0 0.00%	1 33.33%	2 66.67%	0 0.00%	0 0.00%	0 0.00%
Call for professional advice	19 26.39%	4 21.05%	2 10.53%	9 47.37%	1 5.26%	3 15.79%	0 0.00%
Make an appointment with Health Professional	12 16.67%	1 8.33%	2 16.67%	4 33.33%	5 41.67%	0 0.00%	0 0.00%
Self Care	9 12.50%	1 11.11%	3 33.33%	4 44.44%	0 0.00%	1 11.11%	0 0.00%
Other/Not asked	7 9.72%	0 0.00%	0 0.00%	4 57.14%	0 0.00%	3 42.86%	0 0.00%
Total	72 100.00%	12 16.67%	8 11.11%	36 50.00%	7 9.72%	9 12.50%	0 0.00%
Post-Intent	Agrees with Nurse	11 91.67%	8 100.00%	36 100.00%	7 100.00%	9 100.00%	0 0.00%
	Disagrees with Nurse	1 8.33%	0 0.00%	0 0.00%	0 0.00%	0 0.00%	0 0.00%

III. LA CARE COVERED (LACC) NAL SUMMARY, 2014 (BASELINE YEAR)

LACC Member Redirection/Outcomes (January 1, 2014 – December 31, 2014)

Caller Pre-Intent		Nurse Recommendation					
Level of Care		Seek Care ER	Seek Urgent Care	Call for Advice	Make an Appt.	Self Care	Other /Not Asked
Seek Care ER	59 18.21%	6 10.17%	10 16.95%	23 38.98%	7 11.86%	13 22.03%	0 0.00%
Seek Urgent Care	77 23.77%	11 14.29%	12 15.58%	23 29.87%	7 9.09%	24 31.17%	0 0.00%
Call for professional advice	85 26.23%	8 9.41%	15 17.65%	30 35.29%	14 16.47%	18 21.18%	0 0.00%
Make an appointment with Health Professional	57 17.59%	2 3.51%	5 8.77%	25 43.86%	12 21.05%	13 22.81%	0 0.00%
Self Care	40 12.35%	4 10.00%	1 2.50%	11 27.50%	5 12.50%	19 47.50%	0 0.00%
Other/Not asked	6 1.85%	0 0.00%	0 0.00%	2 33.33%	1 16.67%	3 50.00%	0 0.00%
Total	324 100.00%	31 9.57%	43 13.27%	114 35.19%	46 14.20%	90 27.78%	0 0.00%
Post-Intent	Agrees with Nurse	30 96.77%	43 100.00%	112 98.25%	46 100.00%	86 95.56%	0 0.00%
	Disagrees with Nurse	1 3.23%	0 0.00%	2 1.75%	0 0.00%	4 4.44%	0 0.00%

ANALYSIS

Quantitative Analysis

Medi-Cal

In 2014, there were a total of 12,384 calls made to the NAL, a significant increase of 5,221 (72.9%) more calls than in 2013. Depending on the NAL nurses' assessment and triaging algorithm, members are advised a particular level of care. In 2014, the majority of callers had a pre-intent of seeking ER care (34.4% or 4,259), followed by 28.2% (or 3,492) calling for a professional advice, and 14.4% (or 1,784) calling to make an appointment with a health professional. The remainder of caller pre-intent categories were received in lower percentages. Of those callers with the pre-intent of seeking ER care, 15.0% (or 637) were directed to the ER by the NAL nurses. Often the NAL nurses were able to triage and work with the member to determine the appropriate level of care the member required; post-encounter, members agreed with the NAL nurse 97.2% of the time, similar to patient agreement with the NAL nurse in 2013 at 97.7%.

Medicare

Given the transition of SNP membership to the newly formed CMC Medicare line of business, data from CMC and SNP membership was combined for 2014. In 2014, there were a total of 128 calls made to the NAL, 9 more calls than in 2013. Depending on the NAL nurses' assessment and triaging algorithm, members are advised a particular level of care. In 2014, the majority of callers had a pre-intent of calling for professional advice (41.4% or 53), followed by 24.2% (or 31) seeking ER care, and 12.5% (or 16) calling to make an appointment with a health professional. Of the 31 callers with the pre-intent of seeking ER care, 19.4% (or 6) were directed to the ER by the NAL nurses. Often the NAL nurses were able to triage and work with the member to determine the appropriate level of care the member required; post-encounter, members agreed with the NAL nurse 95.3% of the time, a slight increase from 2013 at 94.1%.

LACC

For LACC's baseline year of 2014, there were a total of 324 calls made to the NAL. Depending on the NAL nurses' assessment and triaging algorithm, members are advised a particular level of care. In 2014, the majority of callers had a pre-intent of calling for professional advice (26.2% or 85), closely followed by 23.8% (or 77) seeking urgent care, 18.2% (or 59) seeking ER care, and 17.6% (or 57) calling to make an appointment with a health professional. Of the 59 callers with the pre-intent of seeking ER care, 10.2% (or 6) were directed to the ER by the NAL nurses. Often the NAL nurses were able to triage and work with the member to determine the appropriate level of care the member required; post-encounter, members agreed with the NAL nurse 97.8% of the time.

Overall Causal Analysis

Communication around ER admissions remains a barrier; PCPs have very limited means of learning when their patients are directed and/or admitted to the ER. L.A. Care receives reports of members who have been directed to the ER by the NAL and then shares this information with the IPA 100% of the time.

Timely communication regarding these members from L.A. Care to the IPA and then the IPA to their PCPs is crucial so that appropriate follow-up with the member can occur. Enhancing the networks ability to alert L.A. Care promptly and accurately when a member is admitted to the ER and then to share this information directly with the IPAs and PCPs would improve coordination of care and allow for better utilization of PCP/staff's efforts to follow-up with patients who recently had an ER visit.

Opportunity for Improvement

There is an opportunity to enhance L.A. Care's network and infrastructure ability to communicate with the IPAs and PCPs what members are directed to the ER by the NAL and more specifically, admitted to the ER. Timely exchange of this information can prompt the member's PCP/staff to make a follow-up call and schedule an appointment with the member post-ER discharge.

L.A. Care plans to continue to learn more about how the IPAs and PCPs utilize the NAL information to guide improvements of the current process. For example, callers who are directed by the NAL nurse to seek ER care are expected to result in an ER visit since the patients' conditions may require emergency care; however, this assumption is not always true. Based on 2013 NAL Redirection/Outcomes reports (all L.A. Care LOBs) and ER claims data, L.A. Care conducted analysis of whether or not a member directed to the ER by the NAL resulted in an actual ER visit. The analysis found that of those callers directed by the NAL to seek ER care (947), only 13.2% (125) had an ER visit. Each notification from L.A. Care to the IPA when a member is directed to the ER by the NAL was only associated with an ER visit about 1 in 10 times.

Related to ER admissions, continuing to analyze NAL and claims data will be important to determine how our growing membership acts on health information and direction from the NAL; trends which may elucidate more targeted/tailored interventions to improve coordination and continuity of care.

In 2014, L.A. Care's pilot program called eConnect began working to enhance the networks infrastructure to electronically receive member ER admission data from hospitals and then share (via an online portal) with IPAs when their patients have been admitted to the ER. Thus, this program directly impacts coordination and continuity of care since it offers IPAs and PCPs daily knowledge of when their patients have been admitted to the ER. Through the eConnect Pilot Program's interface, five hospitals are now able to electronically notify L.A. Care upon member admission to the ER which is then shared with the IPAs and PCPs. This improved communication network will also provide L.A. Care's medical management department with more timely access to member data for identifying members that would benefit from complex case management services and transition of care programs. Looking forward, eConnect has goals to expand to more hospitals as well as track utilization of the information shared within the PPGs' online portal.

Action Taken

INTERVENTION

Measure	Barriers	Actions	Effectiveness of Intervention/ Outcome
Number of Nurse Advice line calls from which members were directed to the ER	Practitioners do not know when their patients have been directed to the ER	Notify the IPAs about patients who have been directed to the ER by the NAL and why they were directed. Request that the IPAs notify the PCPs.	100% of IPAs were notified when their patients were directed to the ER.

A.7.d SPECIALIST AND PCP COMMUNICATION

METHODOLOGY

L.A. Care is able to measure Specialty Care Provider/Specialist (SCP) and primary care provider (PCP) communication through a yearly coordination of care survey as well as by monitoring the utilization of the eConsult Program's electronic communication platform.

It is the purpose of the coordination of care survey to measure communication between PCPs and SCPs. Practitioners were asked to respond to the following questions:

Questions Measuring Continuity of Care
1. How frequently do you receive adequate clinical feedback from specialists to whom you have referred a patient? – <i>Question was specifically asked to PCPs.</i>
2. How frequently do you receive adequate clinical information from Primary Care Physicians who refer a patient to you? -- <i>Question was specifically asked to SCPs.</i>

In 2014, due to a delay in fielding by the vendor, the survey was not completed until mid-January 2015; therefore no 2014 survey data is available for analysis in this report. However, L.A. Care's survey results from 2012 and 2013 are shared below as they are historical indicators of PCP/SCP communication and have supported the need for additional systemic efforts to improve PCP/SCP communication.

The eConsult Program addresses the need to improve PCP/SCP communication, coordination, and continuity of care for our members by providing a web-based system that allows PCPs and specialists to securely share health information and discuss patient needs. Developing a more efficient platform for PCP/SCP communication enables PCP and specialist collaboration allows for co-management of complicated patients, leverages the available specialist base, can optimize quality of first specialist visit, and reduce avoidable specialist visits – overall, this patient-centered approach can improve patient safety and satisfaction with care. SCPs available to PCPs through the e-Consult platform include an array of adult and pediatric specialty areas.

In 2014, L.A. Care successfully handed over ownership of the e-Consult Pilot Program with DHS to be fully implemented and monitored by the DHS – a signal of program effectiveness and sustainability. At the end of 2014, DHS reported the following highlights of their DHS eConsult Program:

- Successfully implemented the eConsult tool at more than 2700 submitting providers, 210 clinic sites, and also used at the Department of Public Health clinics and the Sheriff's Department of Medical Services Bureau clinics
- There are currently 35 specialty services available on eConsult with the remaining specialties expected to be onboard in the coming year.
- DHS has received more than 147,000 specialty requests via eConsult; averaging about 9,000-10,000 specialty requests processed per month and with an average response rate to new eConsult requests of less than 3 days.

Given this success, L.A. Care is working to expand the eConsult Program and implement within other IPA networks. Currently, the Health Care LA (HCLA) IPA is partnering with L.A. Care to make the eConsult Program available to their network of physicians. A summary of HCLA's key utilization indicators of the eConsult Program are shared in the results section below.

RESULTS

I. COORDINATION OF CARE SURVEY

Note that weighted data is used for each table below. Providers responding as “always” or “often” are grouped as “regularly exchanging adequate clinical information for their members” during a visit.

- A. PCP: How frequently do you receive adequate clinical feedback from specialists to whom you have referred a patient?

Medi-Cal PCP Responses		
	2012	2013
Always or Often	39.8%	48.4%
Sometimes	47.5%	37.5%
Rarely or Never	12.8%	14.1%

Medicare PCP Responses		
	2012	2013
Always or Often	19.2%	47.5%
Sometimes	43%	39.2%
Rarely or Never	37.9%	13.2%

- B. SCP: How frequently do you receive adequate clinical information from Primary Care Physicians who refer a patient to you?

Medi-Cal SCP Responses		
	2012	2013
Always or Often	54.6%	67.4%
Sometimes	28.9%	25.0%
Rarely or Never	16.6%	7.5%

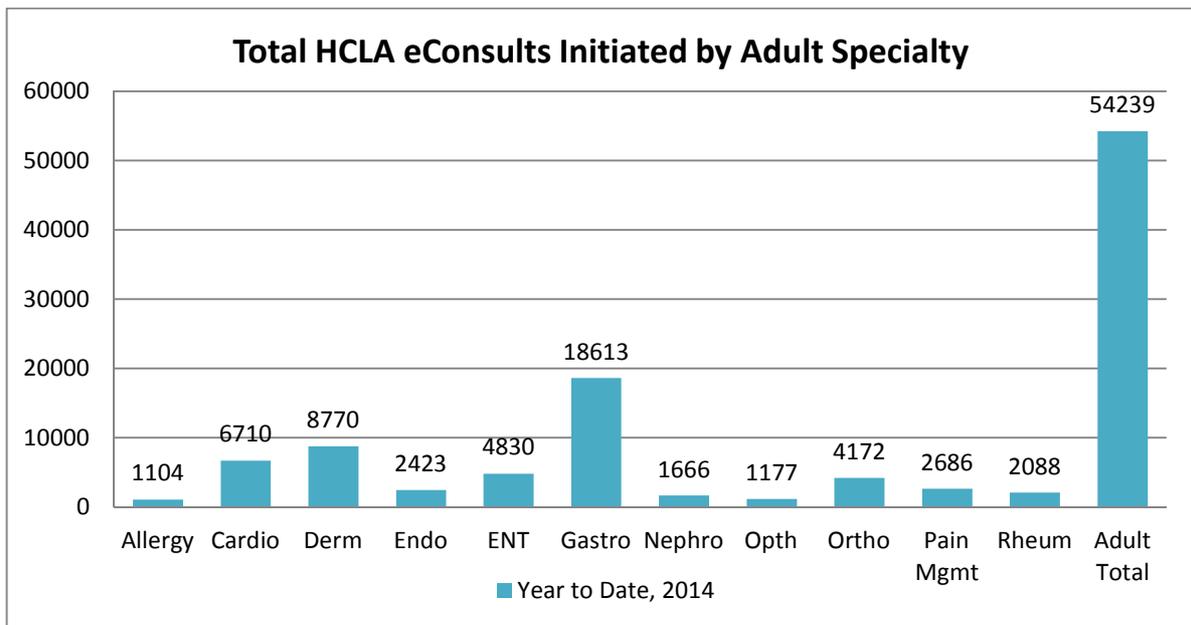
Medicare SCP Responses		
	2012	2013
Always or Often	94.8%	59.7%
Sometimes	4.4%	25.7%
Rarely or Never	0.8%	14.6%

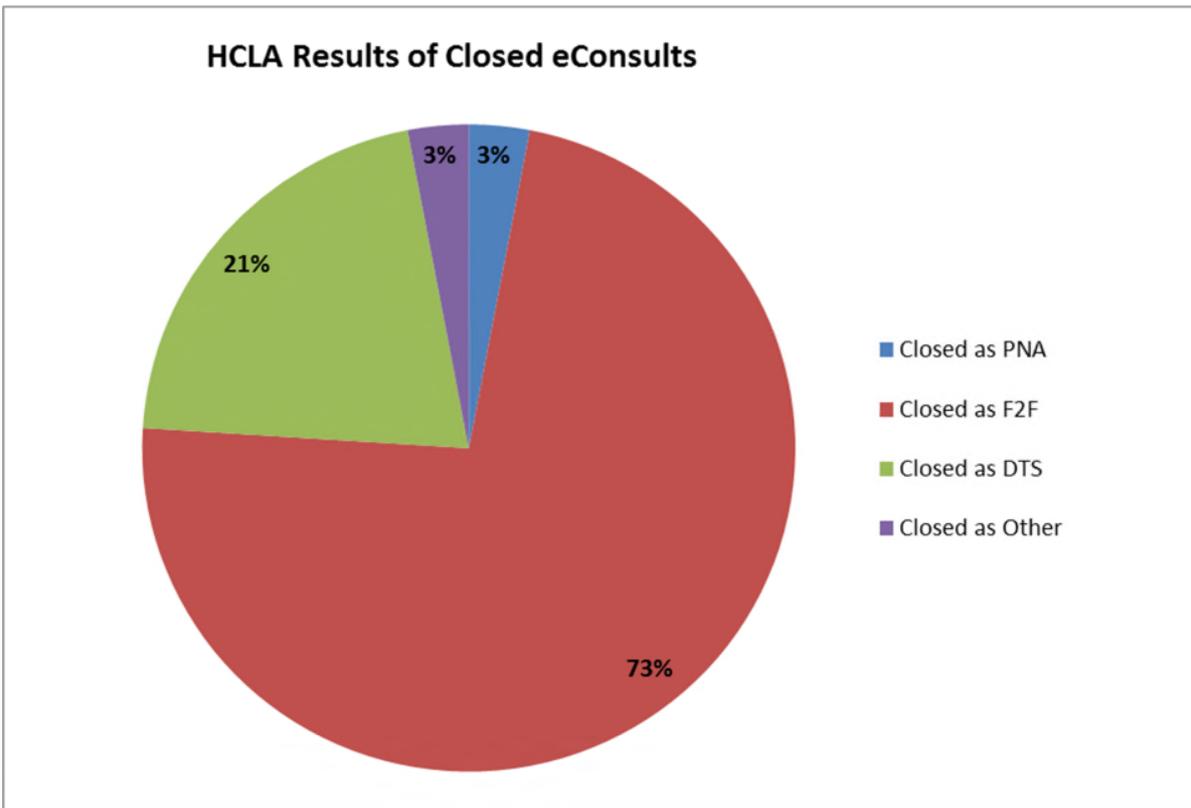
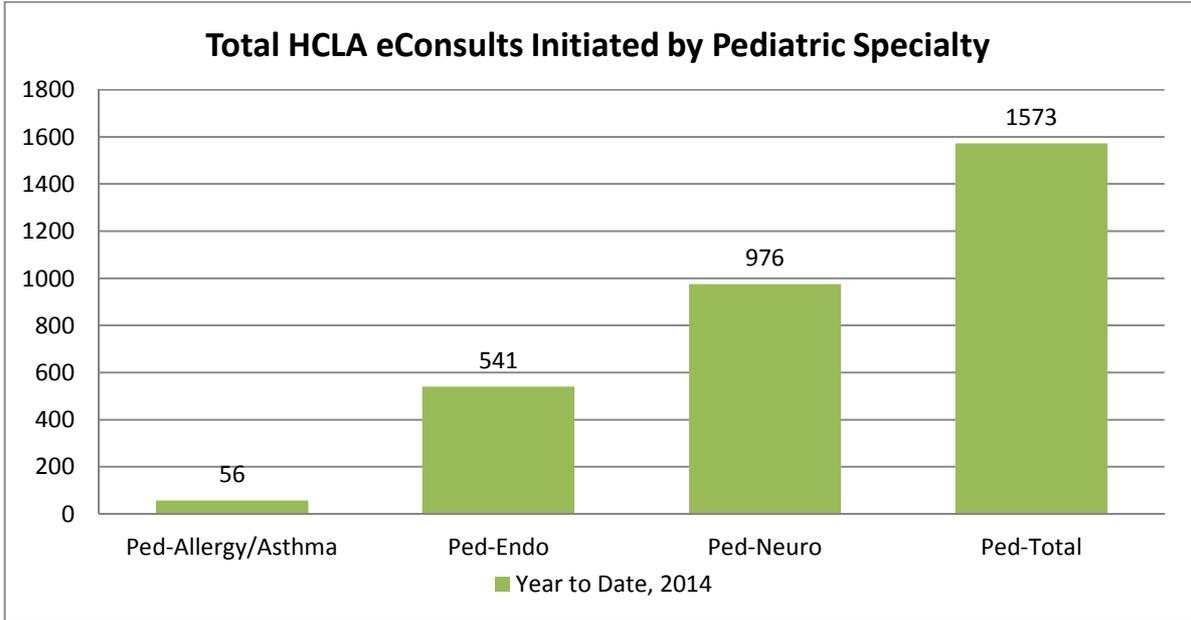
II. HCLA eCONSULT UTILIZATION INDICATORS

HCLA Member Counts by L.A. Care Product Line	
	2014 Member Counts
Medi-Cal	202,770
Medicare (CMC)	2,678
LACC	1,203
Other	107
Total	206,758

HCLA Site and User Totals	
	2014
Sites Live	112
PCP Users	1013
Total Users	1912

*Total Users includes PCPs, Staff, and HCLA Senior Level





* Results of closed eConsults depicted in above pie-chart is for 2014. PNA: Patient Needs Addressed, F2F: Face to Face, DTS: Direct to Schedule

QUANTITATIVE AND CAUSAL ANALYSIS

Quantitative Analysis

I. COORDINATION OF CARE SURVEY

Medi-Cal

In 2013, 48.4% of PCPs reported that they regularly received adequate information from SCPs and this rate did not meet the 2013 goal of 80.0%. For the SCPs, 67.4% reported that they regularly received adequate clinical information from PCPs in 2013 and this rate did not meet the 2013 goal of 80.0%. There are no available 2014 data to report and analyze.

Medicare

In 2013, 47.5% of PCPs reported that they regularly received adequate information from SCPs and this rate did not meet the 2013 goal of 80.0%. For the SCPs, 59.7% reported that they regularly received adequate clinical information from PCPs in 2013 and this rate did not meet the 2013 goal of 80.0%. There are no available 2014 data to report and analyze.

There are no data for LACC due to delayed 2014 fielding of the Coordination of Care Survey; the survey fielded in January 2015 will include providers serving the LACC line of business.

II. HCLA ECONSULT UTILIZATION INDICATORS

In 2014, the expansion of the eConsult Program to partnering with HCLA has led to increase continuity and coordination of care activities among participating providers and staff to improve member care. At the end of 2014, L.A. Care members that are part of the HCLA IPA account for 12.3% (206,758) of L.A. Care's total membership (1,679,737).

As of December 31, 2014, 1013 HCLA providers and 112 HCLA sites were using the eConsult Program, which resulted in a total of 54,239 adult eConsult initiated and 1,573 pediatric eConsults initiated. Gastroenterology SCPs were the most utilized eConsult adult specialty at 34.3% (18,613) of all initiated eConsults. For pediatric specialties, neurology SCPs were the most utilized at 62.0% (976) of all initiated pediatric eConsults. Upon closing of the PCP/SCP communication within the eConsult platform, 73% patients were recommended for a face to face specialist visit; followed by 21% being directly scheduled with the SCP; and 3% of patients needs addressed at the patient's medical home.

Qualitative & Causal Analysis

Adequate communication between PCPs and SCPs is the key to ensure that these providers receive sufficient clinical information regarding their patients in order to maintain continuity and improve coordination of medical care. Staff turnover, no standardized forms, and lack of staffing prohibit the likelihood of adequate information exchange between PCPs and SCPs. Providers may not have the resources to commit staff in an effort to improve continuity of care, as available resources (staff, money, and/or time) may be limited. All of these factors affect the continuity and coordination of medical care.

As HCLA builds its eConsult network, more specialties will likely be added. Additionally, as staff and providers will become more acquainted with the eConsult platform, it is expected that the number of initiated consults will increase and more patients will be able to have their needs addressed without having to schedule an additional SCP visit, as was seen over time during implementation of the eConsult Program with DHS.

Keeping a patient's care within the patient's medical home can improve continuity and coordination of care. In 2014, L.A. Care's Patient Centered Medical Home Initiative continued with its second cohort consisting of seven practices serving approximately 16,000 L.A. Care members. The 17 practices from the first and second cohorts of the PCMH initiative are located in a wide range of areas in Los Angeles County.

Opportunities for Improvement

There was an opportunity to improve communication between PCPs and Specialists.

Action Taken

Measure	Barriers	Actions	Effectiveness of Intervention/Outcome
<p>PCPs reporting that they <i>always/often</i> receive adequate clinical information from SCPs.</p> <p>SCPs reporting that they <i>always/often</i> receive adequate clinical information from PCPs.</p>	<p>Providers (PCPs and SCPs) have a high staff turnover making it difficult to keep staff trained in the process.</p>	<ul style="list-style-type: none"> • L.A. Care will continue the e-Consult Project, expanding its reach by partnering with HCLA. • In 2014, L.A. Care's eConsult Pilot project with DHS was fully implemented and subsequently taken over by DHS to deliver going forward; basic updates will be requested regarding yearly progress. L.A. Care will remain available for technical assistance as needed. • The Medical Management oversight team monitors the specialty referral tracking systems of L.A. Care's delegates. • L.A. Care continued the PCMH initiative to improve coordination of patient care and services. • L.A. Care continues the Patient Centered Medical Home (PCMH) initiative to improve coordination of patient care and services. • L.A. Care incentivizes utilization of an electronic health record and provides support to reach meaningful use standards through the HITECLA program and HIT programs. The continued adoption of EHRs improves coordination of care. 	<p>No 2014 survey data available for analysis. Goal of 80% not met.</p>

LOOKING FORWARD

- L.A. Care will continue the polypharmacy reports to practitioners and monitoring of provider responses regarding the reports in order to review for potential fraud, waste, and abuse.
- L.A. Care will enhance its ability to inform providers about patients who have been admitted to the ER through the eConnect Pilot Program.
- L.A. Care will continue the e-Consult Project with HCLA to improve communication between PCPs to SCPs
- L.A. Care will expand available specialties on the e-Consult platform to Behavioral Health providers who can be accessed by PCPs to seek advice and coordination members' behavioral health needs.
- L.A. Care will complete the coordination of care survey to measure communication between PCPs and SCPs, including PCPs and SCPs who serve Medi-Cal, CMC, and LACC members.
- L.A. Care will continue to perform provider group level audits annually regarding specialty referral.

- L.A. Care will continue the PCMH initiative.
- L.A. Care will explore opportunities to collaborate with the L.A. County healthcare delivery system to improve continuity and coordination of medical care.

2015 WORK PLAN GOALS:

MEASURE	Medi-Cal 2015 Goal	Medicare 2015 Goal	LACC 2015 Goal
Avoidable ER Visits (AER), a non-HEDIS Measure, is the rate of members over the age of 1 year seen in the Emergency Room with designated avoidable diagnoses set by the Department of Health Care Services (DHCS).	A 10% reduction in the AER visit	N/A	N/A
The percentage of physicians who receive poly-pharmacy reports regarding their members	100%	100%	100%
The number of physicians who receive reports from Nurse Advice Line (NAL) on members directed to ER	100%	100%	100%
Percentage of Primary Care Practitioners (PCPs) reporting that they <i>always/often</i> receive adequate clinical information from Specialists (SCPs).	80%	80%	80%
Percentage of SCPs reporting that they <i>always/often</i> receive adequate clinical information from PCPs.	80%	80%	80%

N/A – Not applicable

A.8 CONTINUITY AND COORDINATION BETWEEN MEDICAL AND BEHAVIORAL HEALTHCARE

2014 WORK PLAN GOALS:

Measure	2014 Medi-Cal GOALS	2014 Medicare-SNP GOALS	2014 LACC GOALS
Exchange of information	80% of providers will be always/usually satisfied with the exchange of information between PCP and Behavioral Health Practitioners (BHPs)	80% of providers will be always/usually satisfied with the exchange of information between PCP and BHPs	80% of providers will be always/usually satisfied with the exchange of information between PCP and BHPs
Appropriate Diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care:	Antidepressant Medication Management Baseline year	Antidepressant Medication Management (Acute Phase) 53% Antidepressant Medication Management (Continuation Phase) 48%	50% of providers will meet clinical practice guidelines for members with depression: Percent of members (18+) newly diagnosed with depressive disorder who received two or more outpatient Behavioral Health (BH) visits within 84 days (12 weeks) of initial diagnostic visit and who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit
Appropriate uses of Psychopharmacological medications	100% of providers will be notified of members with ≥ 10 or more controlled substances	100% of providers will be notified of members with ≥ 10 or more controlled substances	90% of members aged 6-12 years that screened positive for ADHD and are receiving psychopharmacological treatment.
Management of treatment access and follow up for member with coexisting medical and behavioral disorders	100% of members with diabetes and depression will be identified	100% of members with diabetes and depression will be identified	100% of members with diabetes and depression will be identified
Primary or secondary prevention behavioral health program	Behavioral Health Consultations program to reduce hospital readmission	Behavioral Health Consultations program to reduce hospital readmission	Behavioral Health Consultations program to reduce hospital readmission

Measure	2014 Medi-Cal GOALS	2014 Medicare-SNP GOALS	2014 LACC GOALS
Special needs of members with severe and persistent mental illness	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) NR*	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) NR*	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) NR*

*NR –Rate was not reported in 2014

BACKGROUND

The Behavioral Health Services Department aims to ensure behavioral health and physical health care integration for members with a range of mental health and substance use conditions. Since January 2014, a new set of behavioral health benefits were added to the Medi-Cal program administered by the health plan. The new set of benefits provides treatments for members who meet the level of functioning impairments ranging from mild to moderate. Beacon Health Strategies (Beacon) is the Behavioral Specialty Care vendor that is responsible for administering these new benefits for members with mild to moderate mental health conditions. In California, Medi-Cal specialty mental health services is carved out to the Los Angeles County Department of Mental Health (DMH) and Drug Medi-Cal services is carved out to the LA County Department of Public Health/Substance Abuse Prevention and Control (DPH). Individuals must meet a set of medical necessity criteria in order to receive services in the carved out specialty mental health services. L.A. Care has a Memorandum of Understanding (MOU) with both entities to provide this level of care services for our members with Severe Persistent Mental Illness with severe functional impairments.

In 2014, L.A. Care identified an opportunity to improve the Behavioral Health Collaborative Committee by enhancing the committee membership to include practitioners from DMH, DPH, the Community Clinic Association of LA County and UCLA/Integrated Substance Abuse Program to strengthen our intention for system wide intervention as it relates to behavioral health (BH) quality measures. With the restructuring of the committee members, the committee focused on improvement initiatives related to behavioral health, avoiding duplication of efforts, improving coordination of services to members, prioritizing initiatives, and increase collaborative efforts to include new committee members. The committee was also renamed the Behavioral Health Quality Improvement Committee.

MAJOR ACCOMPLISHMENTS

- L.A. Care established a Behavioral Health HEDIS work group to address measure performance on the following HEDIS measures: Anti-depressant Medication Management (Effective Acute Phase and Effectiveness Continuation Phase), Follow up after Mental Health Hospitalization and Follow-up Care for Children Prescribed ADHD Medication.
- The behavioral health department conducted 15 training session to health care providers on the referral process between PCP, Beacon, DMH, and DPH.
- The Behavioral Health Quality Improvement Committee established processes that allow for expedited behavioral health referrals.
- In September of 2014, L.A. Care developed a behavioral health toolkit for providers that contain tools and resources for both providers and members.

- The Behavioral Health Services Department received accreditation to provide continuing education credits (CEUs/CMEs) for Psychologist, Licensed Social Worker, Licensed Marriage & Family Therapist, Licensed Educational Psychologist, and Licensed Professional Clinical Counselors.
- L.A. Care hosted eight Behavioral Health Stakeholder meetings to educate providers on various behavioral health topics.
- L.A. Care’s Behavioral Health Department hosted three behavioral health educational sessions that offered CME/CEU for L.A. Care providers at no cost.

I. EXCHANGE OF INFORMATION

L.A. Care measures in-network providers’ satisfaction with continuity and coordination of care they have experienced with behavioral health specialists. L.A. Care acknowledges that continuity of care is important to ensure that members receive the highest quality of care possible.

RESULTS

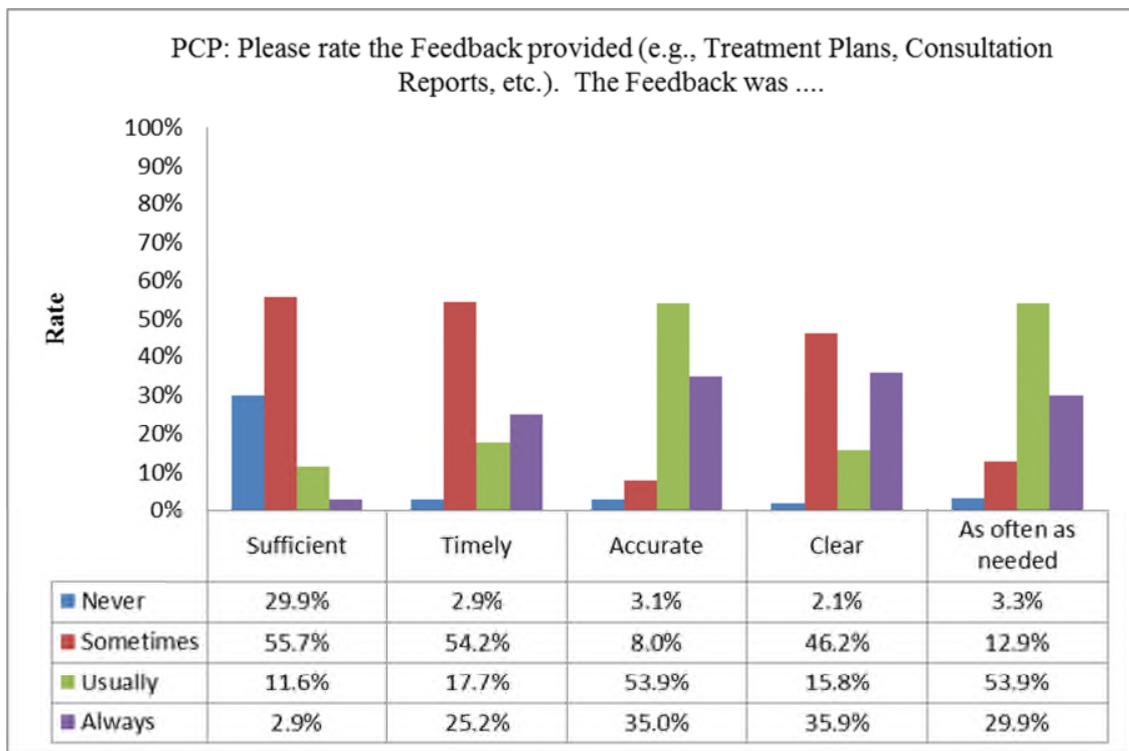
METHODOLOGY

L.A. Care conducts an annual telephone survey (see Attachment A) of all PCPs offices, only Kaiser PCPs are excluded for the sample. The survey was fielded in December of 2013. The sample size was 2,350 PCP’s sites. Of those contacted, 63.6% (1,494) completed the survey. The survey consisted of eight questions using a combination of a Likert scale and open ended questions. In 2013, the survey asked about satisfaction with the Los Angeles Department of Mental Health. In 2012, the survey asked PCPs about their satisfaction with CompCare® the prior Behavioral Specialty Care vendor. Therefore, 2013 rates were not compared to the prior year’s survey.

DESCRIPTION OF MEASURE

Measure	Specific Indicator(s)	Measure Type
Exchange of Information	Percentage of PCPs in L.A. Care’s network that responded to the question, “Please Rate the Feedback Provided (E.G. Treatment Plans, Consultation Reports, Etc.). The Feedback Was Sufficient: Always, Usually, Sometimes, Never.”	Survey Question

SURVEY



ANALYSIS

Quantitative Analysis

The survey found that out of 1,494 respondents only 2.9 % found the information was “Always” sufficient and only 11.6% said it was “Usually” sufficient. The percentage of providers that were “Usually” or “Always” found the information sufficient was 14.5%. When PCPs were asked about the timeliness of the feedback provided, 42.9 % of respondents were “Always” or “Usually” satisfied. Only 51.7% of members were “Usually” or “Always” satisfied with the clarity of the feedback provided. The survey found that 88.9% of PCPs were “Usually” or “Always” satisfied, while 83.8% of PCPs were “Usually” or “Always” satisfied with receiving the information “As often as needed.” The goal was met for “Accurate” and “As often as needed” but not for “Sufficient,” “Timely,” or “Clear.” The goal of 80% satisfaction on all five measures was not met.

Qualitative Analysis

It’s important to know that this survey differed significantly from the previous survey. This year’s survey asked PCPs to rate the feedback provided by the Department of Mental Health due to a vendor transition from CompCare® to Beacon. Since 2011 the survey had focused on CompCare® exclusively. In addition, this year’s survey was conducted by phone. The response rate to this survey was significantly greater than the prior years. In 2011 and 2012 there were fewer than 200 respondents. Therefore, it was anticipated that the results of the survey would be significantly different than the prior surveys conducted. The survey questions, however, did not change significantly.

This year’s survey asked the same questions about quality and about the amount of knowledge the PCP has of the current referral system as well as allowing for comments. The results of the survey showed that

there is a significant room for improvement. Timeliness and sufficient feedback were well below 80% satisfaction. Most participants (>80%) were “Usually” or “Always” satisfied with the accuracy and frequency of the feedback was given. It was also noted that of those surveyed, only 50% had referred a patient to a behavioral health specialist in the last six months. The respondents also provided a great deal of detail comments about the issues of feedback, communication and the difficulty in getting their patients in to see provider with the Department of Mental Health. When asked if the PCP had experienced any other issues using the Department of Mental Health, only 5.8% of the respondents provided comments. However, their comments detailed how difficult it was to get an appointment to see a specialist. In fact, 44.2% stated that it was very difficult to get an appointment, while 5.8% were on a long waiting list of several months and would give up. This represented about half of the respondent’s comments. There was an additional 22.1% that stated that they were provided no feedback and that the communication was not sufficient. The participants also responded that they were on hold for a long time. This was true for 3.5% of the respondents. However, 16.3% of the respondents stated that they saw no issues with regard to the Department of Mental Health.

The survey results were presented at the February Behavioral Quality Improvement Committee meeting. Based on the results and some of these open ended comments from the survey, L.A. Care worked with the Department of Mental Health to redesign their referral form and include a reminder to send the PCP information on the patient. DMH and L.A. Care staff felt that satisfaction rates were low because PCPs were unaware that patients must authorize the release of information before DMH can send information back to the PCP. As a result, L.A. Care provided 24 educational sessions for providers on how to refer patients to Beacon, DMH, and DPH and information about the patient release forms that are needed in order for information to be exchanged appropriately. L.A. Care also created a behavioral health hotline line for providers to help answer any questions they may have about the various services and benefits. Furthermore, L.A. Care DMH, DPH, and Beacon are also collaborating on a universal referral form to help make referrals easier for PCPs and prevent confusion among all parties.

The next survey will contain some revision based on the feedback from the Behavioral Quality Improvement Committee. The 2014 survey asks PCPs about both Beacon and DMH separately to avoid confusion and accurately measure DMH’s progress. The previous version did not ask about Beacon and it was not clear that all of the responses could be directly attributed to DMH. Result of survey will be available in February of 2015.

INTERVENTIONS:

Measure	Opportunities for Improvement	Actions	Effectiveness of Intervention/ Outcome
Coordination of Care/Exchange of Information between PCPs and Behavioral Health Providers	<ul style="list-style-type: none"> Feedback from DMH to PCPs is less than acceptable. PCPs lack knowledge on how to refer members and what information can be shared between providers. PCP referrals to BH providers are at 50%. PCPs state that DMH appointments are difficult to make. PCPs are unaware there is a process for exchanging information for BH services due to the sensitive PCPs are unaware of the 	<ul style="list-style-type: none"> DMH, at L.A. Care’s request, added a section to the referral that reminds them to provide feedback to PCP. L.A. Care has conducted 24 webinars to educate providers on the referral process and benefits with DMH, DPH, and Beacon. Participating Provider Groups (PPGs) are required to attend. L.A. Care in collaboration with the Behavior quality committee members (e.g. DMH and Beacon) has developed an expedited referral process to improve timeliness of service. DMH created one central number to 	<ul style="list-style-type: none"> Effectiveness will be measured in 2015.

Measure	Opportunities for Improvement	Actions	Effectiveness of Intervention/ Outcome
	<p>availability of services that the BHS provide to L.A. Care members.</p> <ul style="list-style-type: none"> Behavioral Health Specialist lack time and resources to send information to the PCP. 	<p>give urgent appointments for LA Care members in need of services.</p> <ul style="list-style-type: none"> L.A. Care posted information on its provider website on how to exchange information with the BH provider and the forms that are needed. Beacon surveyed its practitioners on coordination of care in Q3 to help facilitate information exchange. Results will be available in 2015 Beacon review provider charts for evidence of at least one Release of Information, Authorization, or Consent was obtained to speak with at least one other outpatient (OP) mental health or OP substance abuse treatment provider Beacon held Provider Advisory Council meetings where the importance of communicating and coordinating with PCP were discussed (quarterly) 	

II. APPROPRIATE DIAGNOSIS, TREATMENT, AND REFERRAL OF BEHAVIORAL HEALTH DISORDERS COMMONLY SEEN IN PRIMARY CARE

Beacon tracks claims data to monitor provider adherence of Clinical Practice Guidelines (CPG). L.A. Care uses the HEDIS measure Antidepressant Medication Management to monitor member medication use. In 2014, HEDIS data was not available for L.A. Care Covered (LACC) and therefore Beacon claims rates are also included in this report.

RESULTS

BEACON: DEPRESSIONS GUIDELINE MEASURES (2014)

MEASURE	GOAL	L.A. CARE COVERED
Clinical Practice Guideline Measure Depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient BH visits within 84 days (12 weeks) of initial diagnostic visit	50%	58.7%
Clinical Practice Guideline Measure Depression: percent Of members(18+) newly diagnosed with depressive disorder who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit	50%	30.7%

ANALYSIS

Quantitative Analysis

The L.A. Care Covered (LACC) rate for percent of members (18+) newly diagnosed with depressive disorder who received two or more visits within 12 weeks of initial diagnostic visit was 58.7% and met the goal of 50%. The percent of members ages 18 years and older with depressive diagnosis who received one or more medication visits within 12 weeks of diagnosis was 30.7% and did not meet the goal for 2014.

Qualitative Analysis

The 2014 rate is a baseline rate, since it is Beacons' first full year as L.A. Care's behavioral health vendor. It is important to note that the data is based on available claims data and Q4 data does not account for claims lag. Similarly, as measures look for events that happen up to 12 weeks from diagnostic visit, data for Q4 may be incomplete and underrepresentation of the visits. The medication rate may also be low since pharmacy data is captured by the health plan and not Beacon. Members may also have follow up appointments with a PCP and that might not be tracked by Beacon claims. In 2015, L.A. will work with Beacon to improve data exchange of pharmacy and claims data to improve rates and member care.

INTERVENTIONS

Measures	Barrier	Actions	Effectiveness of Intervention/ Outcome
<p>Clinical Practice Guideline Measure Depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more OP BH visits within 84 days (12 weeks) of initial diagnostic visit</p> <p>Percent Of members(18+) newly diagnosed with depressive disorder who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit</p>	<ul style="list-style-type: none"> Providers are unaware of the clinical practice guidelines for depression. Members may be resistant to treatment due to social stigma or cultural barriers. Members may not adhere to instructions for treating depression and the provider may have a poor follow up plan. Members may not be aware that it takes time for the medication to take effect. They may discontinue if they do not see changes immediately and see side effects. Members may also discontinue medication when they start feeling better. Members may also stop their therapy sessions if they do not feel better immediately Members with depression may have 	<ul style="list-style-type: none"> Beacon continued to monitor provider adherence to CPGs through chart audits of high volume outpatient providers. Followed up with providers who perform poorly on this measure by providing resources regarding the CPG measure and recommendations for best practices. In collaboration with Beacon's provider partnership team, develop and disseminate PCP toolkit to health plan providers and PCPs. The toolkit will help with identification of BH conditions in members, as well as provide next steps in treatment of BH conditions (Q4, 2014). L.A. Care posted a BH Provider Toolkit on its website that included Clinical Practice Guidelines as well as educational materials for members. 	<ul style="list-style-type: none"> Effectiveness will be measured in 2015.

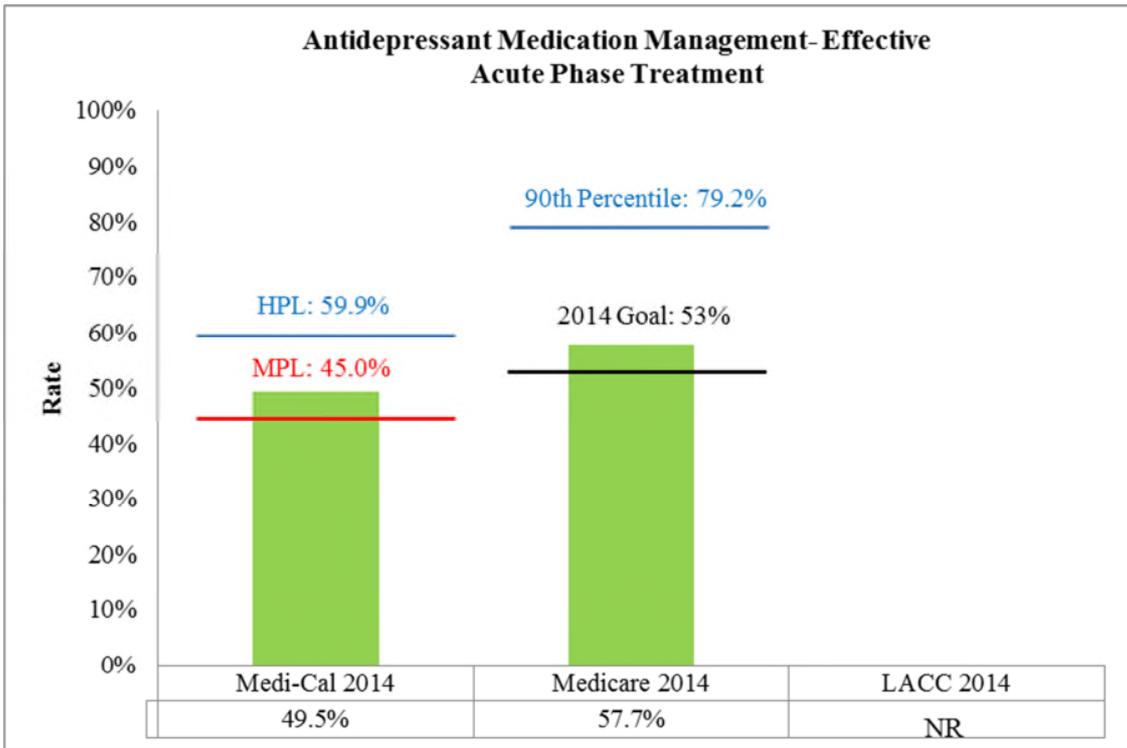
Measures	Barrier	Actions	Effectiveness of Intervention/ Outcome
	chronic co-morbid medical conditions that could make accessing outpatient care for depression more difficult.		

RESULTS

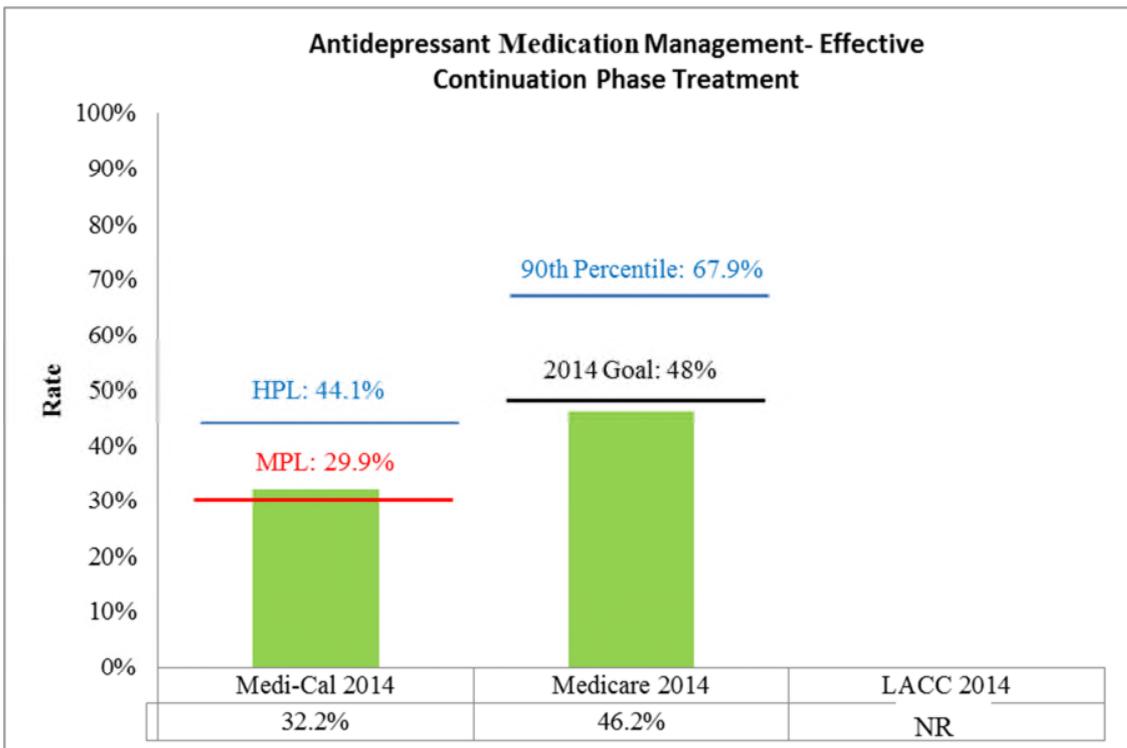
HEDIS RESULTS FOR MEDI-CAL AND MEDICARE

DESCRIPTION OF MEASURE

HEDIS Measure	Specific Indicator(s)	Measure Type
Antidepressant Medication Management-Effective Acute Phase Treatment	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Effective Acute Phase Treatment-The percentage of newly diagnosed and treated members who remained on and antidepressant medication for at least 84 days (12 weeks).	Admin
Antidepressant Medication Management-Effective Continuation Phase Treatment	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Effective Continuation Phase Treatment-The percentage of newly diagnosed and treated members who remained on and antidepressant medication for at least 180 days (6 months).	Admin



NR – Not reportable



NR – Not reportable

ANALYSIS

Quantitative Analysis

Medi-Cal

The Medi-Cal Antidepressant Medication Management- Effective Acute Phase Treatment rate is 49.5% 4.5% above the minimum performance level. The minimum performance level is defined as the NCQA 25th percentile. The Antidepressant Medication Management-Effective Continuation Phase Treatment is 32.2% and 2.3% above the minimum performance level.

Medicare-SNP

The Medicare Antidepressant Medication Management- Effective Acute Phase Treatment rate is 57.7% and exceeded the goal of 53%. The Medicare-SNP Antidepressant Medication Management-Effective Continuation Phase Treatment rate is 46.2% and was 1.8% below the 2014 goal of 48%.

Qualitative Analysis

Medi-Cal and Medicare-SNP

The Medi-Cal rates were above the goal in 2015 will be to reach the 50th percentile for both measures. To improve performance, L.A. Care established a HEDIS Behavioral Health workgroup to investigate barriers, improve data management and collaborate with key behavioral health stakeholders such as PCPs and specialist.

In 2015, L.A. Care plans to share pharmacy data and gaps in care reports with Beacon to help improve rates. The Medicare –SNP rate line closed at the end of 2014 and these members will be rolled into the Cal Medi Connect (CMC). Due to this significant change, the HEDIS 2015 rate will have to be used as a baseline year for this product line.

INTERVENTIONS:

Measure	Barrier	Actions	Effectiveness of Intervention/ Outcome
Antidepressant Medication Management	<ul style="list-style-type: none"> Members may be resistant to treatment due to social stigma or cultural barriers. Members may not adhere to instructions for treating depression and the provider may have a poor follow up plan. Members may not be aware that it takes time for the medication to take effect. They may discontinue if they do not see changes immediately and see side effects. Members may also discontinue medication when they start feeling better. 	<ul style="list-style-type: none"> L.A. Care has developed a member mailing to remind member to fill their prescription for members on antidepressant. L.A. Care has developed a PCP mailing to notify them of patients non-compliant for this measure and to remind them of Beacon services and referrals available to their patients. Beacon continued to review, approve and disseminate the American Psychiatric Association Clinical Practice Guideline (CPG) on depression when necessary, which educates providers on the importance of 2 or more outpatient visits and 1 or more medication visit within 3 months of diagnosis via website and through Provider Advisory Council (PAC) held in Q1, Q2 and Q3 of 	Effectiveness will be measured in 2015.

Measure	Barrier	Actions	Effectiveness of Intervention/ Outcome
	<ul style="list-style-type: none"> Member might have follow up appointments with a PCP and that might not be tracked by Beacon claims. 	2014. <ul style="list-style-type: none"> Beacon continued to monitor provider adherence to CPGs through chart audits of high volume outpatient providers. Followed up with providers who perform poorly on this measure by providing resources regarding the CPG measure and recommendations for best practices. Beacon developed educational article for members, and for providers to share with their members around depression and made available through website. Beacon updated the Depression treatment tool to help members track their appointments with providers, medications and other supports. 	

III. APPROPRIATE USE OF PSYCHOPHARMACOLOGICAL MEDICATIONS

L.A. Care analyzes pharmaceutical utilization data for appropriateness of psychopharmacological medication. The pharmacy benefits manager, MedImpact, mails letter to providers with members on ten or more prescriptions for controlled substances for Medi-Cal and Medicare patients. The letter identifies the member and asks the physician to evaluate the member’s medication use. In 2015, there will be a new PBM, Navitus, which will be managing these reports and will include L.A. Care Covered members/providers.

In addition, Beacon monitors practitioner medical record documentation for its high volume providers to ensure providers are appropriately using psychopharmacological medications. The charts are reviewed on core indicators to assess compliance with:

1. Continuity and coordination activities
2. Screening activities
3. Member rights and responsibilities
4. Treatment planning and intervention, and
5. Level of care criteria per policy and procedures regarding treatment record standards

One of the measures reviewed in the charts is the initiation of medication for members diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).

RESULTS

CONTROLLED SUBSTANCES DRUG UTILIZATION EVALUATION (DUE)

L.A. Care has a Controlled Substance Drug Utilization Evaluation (DUE) program pulls data quarterly each year. Medication profiles of patients are pulled by MedImpact that contain prescription claims for receiving the following drugs over a 3 month period:

- 10 or more prescriptions for DEA schedule II, III, IV or V controlled substances (excluding steroid hormones and drugs used treat attention deficit hyperactivity disorder) OR

- Tramadol containing agents OR
- Carisoprodol containing agents (Note: effective January 1, 2012, carisoprodol is a schedule IV controlled substance under the Controlled Substances Act of 1970.

The goal is to have the patient’s physician evaluate the controlled substance patterns for these patients and consider additional follow-up where medically appropriate.

Measure		Medi-Cal Providers	Medical Members	Medicare-SNP Providers	Medicare-SNP Members
Providers with members on 10 or more prescriptions for controlled substances (including tramadol or carisoprodol)	Q1	719	1275	48	84
	Q2	841	1529	NA	NA
	Q3	884	1619	NA	NA
	Q4	735	1279	NA	NA

ANALYSIS

Quantitative Analysis

Medi-Cal

In 2014, 3,179 letters were sent out to providers notifying them of the medication their patients were on. The number of members ranged from 1275 to 1616. The goal of reaching 100% of identified providers was met.

Medicare

For Medicare, 48 providers were sent letters in the first quarter. The program was discontinued in the second quarter and was replaced by a new drug utilization evaluation measure and the goal was not met.

Qualitative Analysis

Medi-Cal

The drug utilization evaluation program was successful in identifying members on 10 or more controlled substances and in notifying providers of these members. While 100% of providers were sent letters, tracking the responses from the providers has been a challenge due to a lack in systems to capture this type of data from the providers.

Medicare

The goal in 2014 was not met due to a change in reporting. In the second quarter of 2014, L.A. Care started to monitor Opioid and acetaminophen drug utilization in lieu of the controlled substances in the Medicare line of business due to L.A. Care's participation on a national collaborative. The goal of the Opioid and Acetaminophen report is to identify members and implement an early intervention in preventing opioid abuse in non-cancer patients. L.A. Care is collaborating with the Association for Community Affiliated Plans and with two LA County Department of Health Services (DHS) health centers to implement this pilot program. For the remainder of the year there were no members identified in the Opioid Acetaminophen report. Based on these results, L.A. Care will continue to modify their pharmacy report and work closely with the pilot sites to establish a process for reporting the members in treatment. In 2015, Opioid use and Acetaminophen will replace this measure in the CMC product line.

RESULTS

BEACON

METHODOLOGY

As of Q2, 2014, Beacon conducts quarterly medical record reviews of the high volume provider sites and practitioners for L.A. Care. Every quarter, high volume providers (defined as providers seeing a high volume of unique members) are identified. Criteria for selection of high volume providers include:

1. Provider sites treating 100 or more unique members per calendar year
2. Practitioners treating 50 or more unique members per calendar year

For health plans with practitioners or providers that do not meet the threshold of treating 50 or 100 unique members/year respectively, top 10% of the providers are selected.

In 2014, Beacon identified 7 providers for desktop review for Attention Deficit Hyperactivity Disorder (ADHD) psychopharmacological compliance. A total of 26 charts were reviewed.

ATTENTION DEFICIT HYPERACTIVITY DISORDER CHART REVIEW RESULTS (2014)

MEASURE	GOAL	RATE
Members aged 6-12 years that screened positive for ADHD and are receiving psychopharmacological treatment.	90%	NA

ANALYSIS

Quantitative Analysis

In 2014, there were no members that fit the criteria for the measure.

Qualitative Analysis

The sample in 2014 may have been too low to identify members who meet the criteria. Reviewing claims and pharmacy data may be more meaningful since the sample size would be greater than those from quarterly chart reviews.

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
Providers with members on 10 or more prescriptions for controlled substances (including tramadol or carisoprodol)	<ul style="list-style-type: none"> PCPs may be unaware that members are getting multiple prescriptions from different providers. Lack of PCP's knowledge on how to refer and what information can be shared between providers. 	<ul style="list-style-type: none"> L.A. Care Controlled Substance DUE program notifies provider of all members on 10 or more prescription. L.A. Care's pharmacy department forwards Controlled Substances reports to Medical Management for review and potential enrollment in case management. L.A. Care's Pharmacy Department will review the results for potential fraud, waste and abuse and forward responses to RA&C if the prescribing provider indicated that it is not his/her patient. L.A. Care will provide members with a referral to see a BH specialist when they are on 10 or more controlled substances. Beacon will continue provider chart audits to review provider's compliance with APA Clinical Practice Guideline for the Treatment of Patients with Substance Abuse Disorder. Provide feedback, education and assistance to those providers that perform "poorly" (score of <65%) on questions related to Substance abuse (Quarterly). 	100% of providers were notified. Goal was met.
Members aged 6-12 years that screened positive for ADHD and are receiving psychopharmacological treatment.	<ul style="list-style-type: none"> New providers may not be aware of Beacon's expectation in terms of documentation standards. Providers may be providing members with necessary care and consultation, but may fail to document on the member's chart due to lack of time or habit. 	<ul style="list-style-type: none"> Beacon continued to monitor provider adherence to CPGs through chart audits of high volume providers throughout the year. Followed up with providers who perform poorly on this measure by providing resources regarding the CPG measure and recommendations for best practices Beacon will ensure members between the ages of 13-18 included during chart selection (Quarterly) 	NA

IV. MANAGEMENT OF TREATMENT ACCESS AND FOLLOW-UP FOR MEMBERS WITH COEXISTING MEDICAL AND BEHAVIORAL DISORDERS

L.A. Care uses pharmacy data to identify members with coexisting medical and behavioral disorder. The pharmacy data is used to refer members to the diabetes disease management program, *L.A. Cares About Diabetes*®, the L.A. Care chronic care improvement program was implemented through the delegated NCQA accredited vendor, American Healthways. The program empowers members and gives them the necessary tools to better partner with their health care practitioners in the management of their condition and to improve their overall health. The report did not include L.A. Care Covered in 2014 but it will be a part of the report in 2015.

RESULTS

Measure	January-June 2014
Number of Medi-Cal, and Medicare members identified as taking diabetic oral medication and antidepressants and or antipsychotics	40317
Total Members in Healthways	14253
Total Members not in Healthways	6367
Total members excluded	19697

Quantitative Analysis

In 2014, 40,317 members were identified for the first half of the year. The report was discontinued in July and therefore the goal was not met.

Qualitative Analysis

L.A. Care's diabetes chronic care improvement and asthma disease management programs use pharmacy data monthly to identify members with diabetes and a behavioral health disorder. Members who may not have been identified through other means, (e.g. referrals, claims, etc.) and included in the programs are referred to the appropriate program for inclusion. In July of 2014, the contract with Healthways expired and the diabetes disease management program was transferred to L.A. Care and the fledgling program did not have the capacity to manage referrals and data analytics. In October of 2014, the Behavioral Health Services department began to work with the pharmacy department in redesigning the pharmacy report to better capture those in need of a behavioral health specialist that may only be receiving care in the primary care setting.

INTERVENTIONS

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
Members with co-existing medical and behavioral health disorders	<p>PCPs lack of training and are uncomfortable on how to appropriately treat patients with mental health conditions commonly seen in the PCP office.</p> <p>Lack of PCP's knowledge on how to refer and what information can be shared between providers.</p> <p>PCPs lack resources for educating members with coexisting medical and behavioral health disorders.</p> <p>PCPs are uncomfortable in managing patients with</p>	<ul style="list-style-type: none"> • L.A. Care hosted a CME sessions "Alcohol Screening and Intervention: What Clinicians Need To Know" on December 10, 2014. • Beacon in collaboration with the provider partnership team, developed and disseminated PCP toolkit to health plan providers and PCPs. The toolkit will help with identification of BH conditions in members, as well as provide next steps in treatment of BH conditions. • L.A. Care has conducted 24 webinars to educate providers on the referral process and benefits with DMH, DPH, and Beacon. PCPs are required to attend. • L.A. Care posted and continued to update resources and tools on the L.A. Care website for providers as well as members. Topics include but not limited to: <ul style="list-style-type: none"> ○ Understanding ICD-10-CM and 	Goal not met.

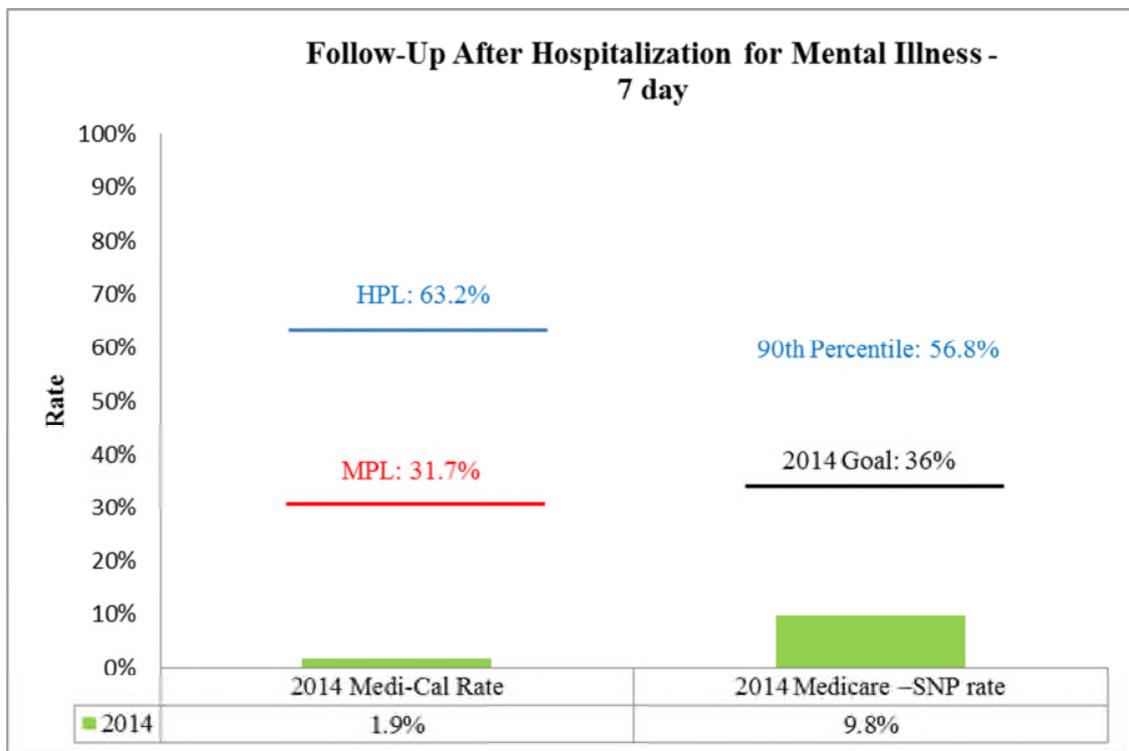
Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
	<p>mental health conditions.</p> <p>PCPs are not aware of the latest guidelines in treating behavioral health conditions.</p>	<p>DSM-5</p> <ul style="list-style-type: none"> ○ Drug Interaction Checker ○ Screening, Brief Interventions, and Referral to Treatment (SBIRT) ○ Improving Pain Treatment Through Education ○ Patient Health Questionnaire (PHQ) Screeners 	

V. SECONDARY PREVENTIVE BEHAVIORAL HEALTHCARE PROGRAM IMPLEMENTATION PROVIDING BEHAVIORAL HEALTH CONSULTATIONS TO REDUCE HOSPITAL READMISSION

It is important to provide regular follow-up to patients after they have been hospitalized for mental illness to help reduce relapses and improve management of chronic conditions. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the member's transition to the home or work environment is supported. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care.¹⁰ Appropriate follow-up care also helps reduce hospital readmissions. In 2014, L.A. Care implemented a program to reduce readmissions from medical hospitals and psychiatric facilities. The follow-up after mental health hospitalization-7-day rate was used to assess the need for behavioral health consultations and improve transition from hospital to home. The rates below were not reported to NCQA as these services were carved out for half of the measurement year for Medi-Cal.

¹⁰ AHRQ. Measure Summary. <http://www.qualitymeasures.ahrq.gov/content.aspx?id=47196>. Accessed on January 24, 2015.

RESULTS



Quantitative Analysis

The Medi-Cal HEDIS rate was 29.8% below the 25th percentile. The Medicare rate was 9.8% and was 26.2% below the goal.

Qualitative Analysis

Both the rates for Medicare and Medi-Cal are low. Medi-Cal rates are most likely low due to the carved out services with DMH, since there is little information received from the DMH regarding the follow up visits that members receive. However, the Medicare rates are also low, which indicates that there is a need to improve coordination of care across all product lines. This led the Behavioral Health Service Department at L.A. Care to work with the Medical Management Department on the Transition of Care (TOC) program to reduce hospital readmissions and create a process that would capture members with a possible behavioral health condition that are hospitalized with a medical condition for Medi-Cal and Medicare-SNP members members that have a medical conditions.

Furthermore, the data demonstrated the need to improve follow-up care for those with mental illness and improve the exchange of information with DMH. In the December Behavioral Health Quality Improvement meeting, L.A. Care requested data from DMH on the follow up care received by L.A. Care members after mental health hospitalization.

INTERVENTION

L.A. Care launched the Transition of Care (TOC) program in December of 2013 to improve health outcomes and lower 30-day all cause readmission rates by identifying patients at risk for readmission during concurrent review and provide targeted case management and care coordination for members while they are in the hospital through 30 days post-discharge from a hospital. Upon admission, members

in standard delegation for L.A. Care concurrent review are stratified according to risk of admission and level of need in order to receive customized follow-up after discharge. The risk assessment screening tool assigns each member a risk score based on functional status, recent medical events, age, social history, and co-morbidities. The hospital readmission workgroup identified the need to capture and referral members to behavioral health services to prevent. Starting in Q3, anyone that is high risk and has a behavioral health condition is referred to L.A. Care’s behavioral health department for further evaluation. In 2014, there were nine (9) behavioral health consultations provided by the Behavioral Health Service Department for members recently discharge from the hospital.

In addition, Beacon has a Post Mental Health Hospitalization Aftercare Program in place for members in LACC and Medicare-SNP receiving in-patient psychiatric care to improve follow-up after mental health hospitalization and reduce psychiatric readmissions. Members receive appointment assistants after they are discharge as well as appointment reminder calls and reminder cards, follow-up letters to members, and aftercare educational letters and brochures to all members who do not keep their appointments. Members that cannot be reached by phone are mailed a letter to notify them that Beacon is trying to contact them.

In 2015, L.A. Care’s delegation model will change for Medi-Cal, CMC, and LACC. As a result, fewer members will be participating in Transition of Care program and L.A. Care will work on developing a depression screening program for its members to enhance its preventive programs.

INTERVENTIONS

Measure	Barrier	Action	Outcome
Develop a referral program for members hospitalized with a medical and behavioral health needs.	<ul style="list-style-type: none"> • Members with co-existing medical and behavioral health issues do not receive behavioral health services • Members are difficult to reach after a hospitalization • Hospital face sheets may not contained details on BH diagnosis or evaluation 	<ul style="list-style-type: none"> • L.A. Care launched the Transition of Care (TOC) program identifies anyone that is high risk and has a behavioral health condition and refers them to L.A. Care’s behavioral health department for further evaluation • An electronic form has been built into the existing software that captures project data medical and behavioral diagnosis is captured on the form • Members that cannot be reached by phone are sent a letter explain the support services available to them • The TOC program calls member prior to discharge and uses a screening tool to help identify the member’s needs, including psychosocial needs 	Goal was met.
Prevent psychiatric hospital readmissions	<ul style="list-style-type: none"> • Members are difficult to reach to help schedule appointments • Providers do not consistently inform Beacon that the members have kept their appointment. • Members may not feel the need to see an outpatient provider if they are feeling better. 	<ul style="list-style-type: none"> • Beacon offers after appointment assistance to member recently discharged from the hospital. • Beacon conducts appointment reminder calls • Follow-up letters to members • Sending appointment reminder cards to members • Sending aftercare educational letters and brochures to all members who do not keep appointments 	Beacon FUH rates will not be available until 2015.

Measure	Barrier	Action	Outcome
		<ul style="list-style-type: none"> • Sending "We are trying to reach you" slips when unable to reach members • Beacon uses "Preferred Office Designation (POD): providers that serve as multi-disciplinary groups with central scheduling and expedited appointments. • Made self-management tools available on their website to encourage members to identify a health related issue and stay on track with wellness goals 	

VI. SEVERE AND PERSISTENT MENTAL ILLNESS: NR

L.A. Care will use Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications HEDIS 2015 data to evaluate severe and persistent mental illness. Services were carved out in 2013 for Medi-Cal and therefore, there are no rates available. Medicare D-SNP did not have any members that met the HEDIS criteria and L.A. Care Covered did not report any data in 2014 since there were no services in 2013.

LOOKING FORWARD:

- L.A. Care will evaluate its exchange of information between PCPs and BH specialists with another telephonic survey. Results will be available in early 2015.
- L.A. Care and Beacon will work on exchanging pharmacy information to address gaps in care.
- L.A. Care and Beacon will work on sending member prescription reminders to newly diagnosed patients.
- L.A. Care will evaluate the referral program and track provider responses to the letter.
- L.A. Care will continue to monitor the co-morbidity reports to identify members for the chronic care program and disease management programs.
- L.A. Care will continue its physician survey to assess exchange of information with behavioral health providers.
- L.A. Care and DMH will work on improving data exchange for those member in Specialty Mental Health.
- L.A. Care plans to launch Behavioral Health eManagement project. This project aims to utilize behavioral health specialist reviewer to support PCPs in making clinical decision as it relates to behavioral health symptoms/issues in real time. The PCP and reviewer will be able to exchange patient symptomatology/conditions over a secured site and optimize appropriate targeted treatment goals.
- L.A. Care BH department is participating in the Healthy Neighborhoods and Homeless Projects to develop a Behavioral Health Model of care for individuals that are homeless.

2015 WORK PLAN GOALS:

Measure	2015 Medi-Cal GOALS	2015 CMC GOALS	2015 L.A. Care Covered GOALS
Exchange of information	80% of providers will be always/usually satisfied with the exchange of information between PCP and Behavioral Health Practitioners (BHPs)	80% of providers will be always/usually satisfied with the exchange of information between PCP and BHPs	80% of providers will be always/usually satisfied with the exchange of information between PCP and BHPs
Appropriate Diagnosis, treatment, and referral of behavioral health disorders commonly see in primary care	AMM (Acute Phase): Medi-Cal: 65% AMM (Continuation Phase): Medi-Cal: 52%	Antidepressant Medication Management Baseline year	Antidepressant Medication Management Baseline year
Appropriate uses of Psychopharmacological medications	100% of providers will be notified of members with ≥ 10 or more Controlled Substances	100% of providers will be notified of members with potential opioid or acetaminophen overutilization	100% of providers will be notified of members with ≥ 10 or more Controlled Substances
Management of treatment access and follow up for member with coexisting medical and behavioral disorders	100% of providers will be notified of members on diabetes and antipsychotic medication	100% of providers will be notified of members on diabetes and antipsychotic medication	100% of providers will be notified of members on diabetes and antipsychotic medication
Primary or secondary prevention behavioral health program	Develop and implement a depression screening program	Develop and implement a depression screening program	Develop and implement a depression screening program
Special needs of members with severe and persistent mental illness	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Baseline	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Baseline	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Baseline

ATTACHMENT A



Complete this section to receive a chance at a gift card!

Your Name: _____

Title (Check one): Physician P.A./ N.P. Office Staff

Practice Name: _____

Address: _____

Phone: _____

Email: _____

L.A. Care Exchange of Information Survey
For PCPs Working with the Department of Mental Health

	Questions	Answer
1.	<p>Are you aware that a FREE behavioral health specialty network is available to assist in the care of your patients?</p> <p>If No, the Department of Mental Health is L.A. Care’s behavioral health specialty provider for Medi-Cal Managed Care members that meet the following criteria: The member must be diagnosed with one or more of the following conditions: Pervasive Developmental Disorders, except Autistic Disorders, Disruptive Behavior and Attention Deficit Disorders, Feeding and Eating Disorders of Infancy and Early Childhood, Elimination Disorders, Other Disorders of Infancy, Childhood, or Adolescence, Schizophrenia and other Psychotic Disorders, Mood Disorders, Anxiety Disorders, Somatoform disorders, Dissociative Disorders, Paraphilias, Gender Identity Disorder, Eating Disorders, Impulse Control Disorders Not Elsewhere Classified, Adjustment Disorders, Personality Disorders, excluding Antisocial Personality Disorder, Medication-Induced Movement Disorders related to other included diagnoses. <i>In addition to the above diagnoses member must have a significant impairment in an important area of life functioning or a probability of significant deterioration in an important area of life functioning.</i></p>	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	<p>Do you know how patients are referred to the Department of Mental Health?</p> <p>If No, Medi-Cal members may self-refer by calling:</p> <ul style="list-style-type: none"> • 1-800-854-7771 	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	<p>Have you referred any Medi-Cal members to a Behavioral Health Specialist in the last 6 months?</p> <p>If No, please state the reason(s):</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.	<p>Have you been notified by your IPA that you can obtain information regarding SPD members who are receiving DMH services?</p> <p>_____</p> <p>_____</p>	

Please answer questions 5 – 8 on the back side **ONLY IF YOU HAVE REFERRED** at least one member to a Department of Mental Health Specialist in the last 6 months.

Please answer the following questions based on your experience using the Department of Mental Health:

5. Please rate the feedback provided (e.g. treatment plans, consultation reports, etc.) by the behavioral health specialist to whom you referred members most often:

The feedback was...	Rating Scale			
Sufficient	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Usually	<input type="checkbox"/> Always
Timely	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Usually	<input type="checkbox"/> Always
Accurate	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Usually	<input type="checkbox"/> Always
Clear (Easy to understand)	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Usually	<input type="checkbox"/> Always
As often as needed	<input type="checkbox"/> Never	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Usually	<input type="checkbox"/> Always

6. If you did not receive **ANY** feedback when you referred a member to the Department of Mental Health, please tell us about it:

7. Have you experienced any other issues using the Department of Mental Health? Please explain:

8. Please provide your suggestions to improve the communication you receive from Department of Mental Health Specialists and what L.A. Care can do to help you refer members to the Department of Mental Health:

**If you have any questions regarding the Department of Mental Health, the direct contact number is:
1-800-854-7771**

THANK YOU FOR YOUR FEEDBACK!

A.9 EVALUATION OF EFFECTIVENESS OF MODEL OF CARE

2014 WORK PLAN GOALS:

MEASURES	2014 GOAL
Quality of Life Survey - SF12 Mental Component Score (HOS)	6%/3 years or 2% change per year
Quality of Life Survey - SF12 Physical Component Score (HOS)	6%/3 years or 2% change per year
Medication compliance	Improvement of 2 percentage points per year
Patient satisfaction	90% of members will be satisfied with care management activities
Avoidance of hospital admissions for ambulatory care sensitive conditions (ACSC)	10% reduction in total beddays/K for ACSC
Hospital Utilization (MOC)	
Hospital Bed Days	10% reduction in total beddays/K
Hospital Admissions	10% reduction in admissions
Hospital Average Length of Stay	10% reduction in length of stay
Readmissions rates	2 percentage point reduction from previous year
Ambulatory Services (MOC)	
Emergency Room Visits	10% reduction from the previous year
Ambulatory Care Visits	10% reduction from the previous year
Grievance	Monitor in QI Program
HRA Completion Rate	100% of all Medicare enrollees within 90 days

BACKGROUND

The Model of Care (MOC) provides the structure for care management processes that enable the provision of coordinated care for special needs individuals. L.A. Care has designed its Model of Care to meet the special needs of the population. The MOC has goals and objectives for the targeted population, include a specialized provider network, uses nationally-recognized clinical practice guidelines, conducts health risk assessment to identify the special needs of members and adds services for the most vulnerable member including, but not limited to those who are frail, disabled, or near the end-of-life. In 2011, L.A. Care's Model of Care received a passing score of 85% or higher on NCQA's evaluation of their MOC and was granted SNP approval for three years. In this QI evaluation, the following components of Model of Care are evaluated: Clinical Practice Guideline compliance, continuity and coordination of medical care, continuity and coordination of medical and behavioral care, access and availability and Credentialing. Other components of the Model of Care evaluation are found in the utilization management/case management evaluation.

RESULTS

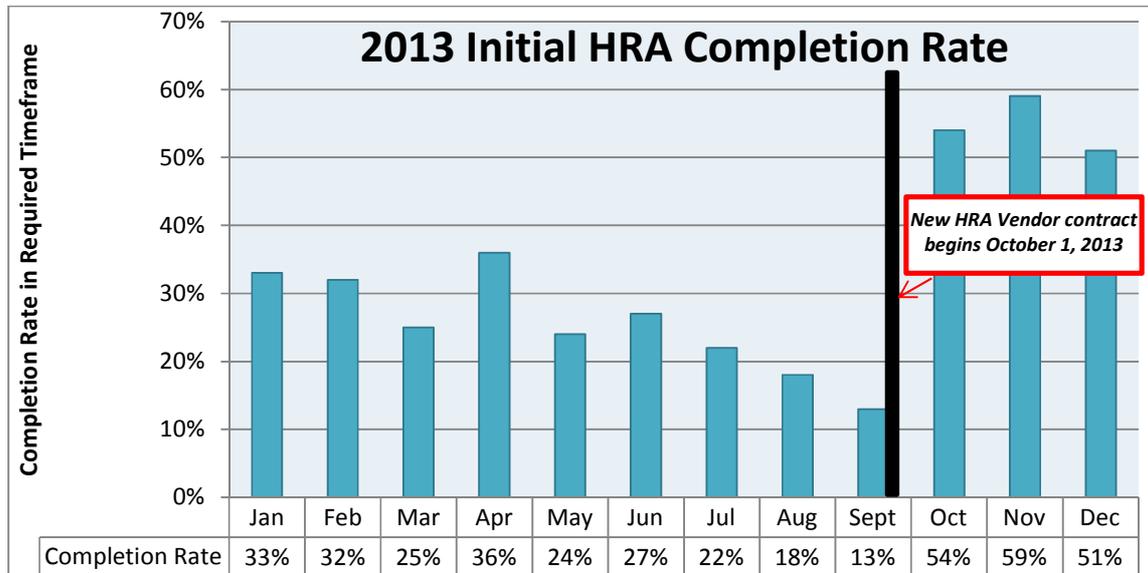
During the first quarter of 2014, CMS performed a comprehensive audit of the SNP LOB. The measurement time period was from 1/1/2013-2/28/2014. The Care Management audit focus was on the Health Risk Assessment (HRA), Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT) and Performance Monitoring of the MOC measures.

The audit findings revealed that areas of improvement were required in all three (3) measures, resulting in specific Corrective Action Responses (CARs) from the Care Management Department. The following

paragraphs presents a summary of the CARs needed for each area and the details of the interventions that were put in place in response. All CARs were 100% complete by 11/3/14.

HEALTH RISK ASSESSMENT (HRA)

HRA data presented to CMS on 3/14/14 is captured in the table below:



ANNUAL HRA COMPLETION RATES 11/12/2013:

L.A. Care D-SNP

Reporting Period: October, 2013

Report Run Date : 11/12/2013

Monthly Report		HRA Results **					Total
		High	Moderate	Low	Not Categorized	Unable to Reach *	
New Members	HRA Completed by Mail	0	0	0	0		0
	HRA Completed by Phone	8	56	167	0		231
	Unable to Reach*					6	6
	Total New D-SNP Members (for October)	0	0	0	396		396
	Number of Initial Assessment Performed on New Members	8	56	167	0		231

Monthly Report		High	Moderate	Low	Not Categorized	Unable to Reach *	Total
Annual Reassessments	HRA Completed by Mail	0	0	0	0		0
	HRA Completed by Phone	1	12	19	0		32
	Unable to Reach*					0	0
	Number of D-SNP Members Eligible for an Annual Reassessment (for October)	0	0	0	73		73
	Number of Annual Reassessments Performed on D-SNP Members Eligible for Reassessment	1	12	19	0		32

1) **Condition:** Sponsor did not provide evidence that it administered the annual HRA to the beneficiary.

Corrective Action Required: Sponsor must conduct a comprehensive annual health risk assessment of the individual's physical, psychosocial, and functional needs.

Root Cause Analysis: After a thorough assessment of all factors involved in the deficiency, the following Correction Action Plan interventions were instituted.

L.A. Care Corrective Action Plan:

- Review and revise the P&P 406, Interdisciplinary Care Team (ICT) to ensure alignment with MOC and CMS requirements to use an ICT to coordinate the delivery of services and benefits and manage the beneficiary's care.
- Train staff and associates on roles and responsibilities in ICT
- Develop an ICT documentation tool to ensure consistency with CMS requirements
- Train staff and associates on documentation of ICT and use of ICT tool
- Build report for internal case management system that enables management to verify that ICT was conducted
- Audit protocol of staff and associates to ensure compliance developed and implemented
- Monthly monitoring, reporting, and review for compliance

2) **Condition:** Sponsor did not administer the comprehensive annual reassessment within 12 months of the last risk assessment.

Corrective Action Required: Sponsor must administer the annual reassessment to the beneficiary within 12 months of the last risk assessment, or as often as the health of the beneficiary requires.

Root Cause Analysis: After a thorough assessment of all factors involved in the deficiency, the following Correction Action Plan interventions were instituted.

L.A. Care Corrective Action Plan:

- Review and revise the P&P HRA 031
- Trained staff on revised outreach plan and process
- Built system indicator to alert staff of a member's upcoming or outstanding HRA
- Developed an outreach plan for members who remain without a completed HRA after required attempts by the HRA vendor

- Developed and launched an incentive plan to encourage members to complete the annual HRA
 - Conducted cross-departmental training on new HRA system indicator
 - Developed process to enable associates to facilitate referral for HRA
 - Audit protocol for compliance developed and implemented
 - Monthly monitoring, reporting, and review for compliance
- 3) **Condition:** Sponsor administered the initial health risk assessment to a beneficiary more than 90 days after their enrollment.
Corrective Action Required: Sponsor must administer the initial HRA to the beneficiary within 90 days of a beneficiary's enrollment.
Root Cause Analysis: After a thorough assessment of all factors involved in the deficiency, the following Correction Action Plan interventions were instituted.

L.A. Care Corrective Action Plan:

- Review and revise the P&P HRA 031
- Train staff on revised outreach plan and process
- Build system indicator to alert staff of a member's upcoming or outstanding HRA
- Develop an outreach plan for members who remain without a completed HRA after required attempts by the HRA vendor
- Develop and launch an incentive plan to encourage members to complete the initial HRA
- Conduct cross-departmental training on new HRA system indicator
- Develop process to enable associates to facilitate referral for HRA
- Audit protocol for compliance
- Monthly monitoring, reporting, and review for compliance

Monitoring results of intervention impact on HRA Performance presented in 2014 SNP HRA Data Table:

Enrollment Date	Newly Enrolled Members	Total Completed HRAs	Overall Completion Rate	Completed HRAs within 90 Days	% of Completion within 90 days	Re-assessment*	% of Re-assessment
Jan-14	312	245	79%	136	44%	191	61%
Feb-14	330	264	80%	159	48%	162	49%
Mar-14	362	272	75%	178	49%	95	26%
Apr-14	433	348	80%	269	62%	83	19%
May-14	468	349	75%	295	63%	57	12%
Jun-14	464	375	81%	308	66%	67	14%
Jul-14	534	410	77%	361	68%	49	9%
Aug-14	597	488	82%	483	81%	8	1%
Total	3500	2751	79%	2189	62.5%		

The plan is to continue monitoring the HRA CAR areas in 2015 with the Cal MediConnect LOB.

Individualized Care Plan (ICP)

- 1) **Condition:** The beneficiary's ICP did not include measurable outcomes.
Corrective Action Required: Sponsor must ensure that it develops and implements a comprehensive individualized plan of care through an interdisciplinary care team in consultation with the beneficiary, as feasible, identifying goals and objectives including measurable outcomes as well as specific services and benefits to be provided.
Root Cause Analysis: After a thorough assessment of all factors involved in the deficiency, the following Correction Action Plan interventions were instituted.

L.A. Care Corrective Action Plan:

- Review and revise P&P 409, Individualized Care Plan to ensure alignment with CMS requirement that ICP will be developed and implemented with the beneficiary, as feasible, identifying goals and objective including measurable outcomes as well as specific services and benefits to be provided
- Train staff and associates on ICP requirements and documentation
- Develop a process to individualize the preliminary ICP per CMS requirements
- Audit protocol for compliance developed and implemented
- Monthly monitoring, reporting and review

- 2) **Condition:** Sponsor did not provide evidence of individualized care plan (ICP) implementation through care or case management notes and/or the ICP did not address issues identified in the health risk assessment (HRA).
Corrective Action Required: Sponsor must ensure it provides evidence of implementation of the ICP and that the beneficiary's ICP addresses the issues identified within their HRA.
Root Cause Analysis: After a thorough assessment of all factors involved in the deficiency, the following Correction Action Plan interventions were instituted.

L.A. Care Corrective Action Plan:

- Reviewed and revised ICP P&P 409 and included process to ensure the individualized ICP reflects needs identified in the HRA
- Trained staff and associates on appropriate documentation including the process to ensure the individualized ICP reflects needs identified in the HRA
- Created a report in case management system to verify that all members have an ICP reviewed and updated at least annually
- Developed a process that ensures the individualized ICP is reflective of the HRA elements
- Audit protocol for compliance developed and implemented
- Monthly monitoring, reporting, and review for compliance

LOOKING FORWARD:

L.A. Care will continue to work with IT on automating the ICP monitoring reports. The reports will monitor the performance of internal and contracted PPG staff. At the time of this evaluation, the automated reporting was not available.

- 3) **Condition:** Sponsor did not provide evidence that it had an individualized care plan (ICP) for the beneficiary.
Corrective Action Required: Sponsor must maintain a comprehensive ICP for each beneficiary enrolled in a SNP.
Root Cause Analysis: After a thorough assessment of all factors involved in the deficiency, the following Correction Action Plan interventions were instituted.

L.A. Care Corrective Action Plan:

- Reviewed and revised ICP P&P 409
- Trained staff and associates on the roles and responsibilities and CMS requirements related to ICP
- Developed a protocol to ensure that all members have a documented individualized ICP
- Audit protocol for compliance developed and implemented
- Monthly monitoring, reporting, and review for compliance

INTERDISCIPLINARY CARE TEAM (ICT)

- 1) **Condition:** Sponsor failed to have and/or use an interdisciplinary care team (ICT) to coordinate and manage the beneficiary's care.

Corrective Action Required: Sponsor must have and use an ICT to coordinate the delivery of services and benefits and manage the beneficiary's care.

Root Cause Analysis: After a thorough assessment of all factors involved in the deficiency, the following Correction Action Plan interventions were instituted.

L.A. Care Corrective Action Plan:

- Reviewed and revised the P&P 406, Interdisciplinary Care Team (ICT) to ensure alignment with MOC and CMS requirements to use an ICT to coordinate the delivery of services and benefits and manage the beneficiary's care.
- Trained staff and associates on roles and responsibilities in ICT.
- Developed an ICT documentation tool to ensure consistency with CMS requirements.
- Trained staff and associates on documentation of ICT and use of ICT tool.
- Built report for internal case management system that enables management to verify that ICT was conducted.
- Audit protocol of staff and associates to ensure compliance.
- Monthly monitoring, reporting, and review for compliance.

LOOKING FORWARD:

L.A. Care will continue to work with IT on automating the ICT monitoring reports. The reports will monitor the performance of internal and contracted PPG staff. At the time of this evaluation, the automated reporting was not available.

PLAN PERFORMANCE MONITORING AND EVALUATION OF THE MOC

- 1) **Condition:** Sponsor displayed evidence that corrective action was needed based on results of monitoring and evaluation of the MOC, however the corrective action was not implemented.

Corrective Action Required: Sponsor must ensure that when monitoring and evaluation of the MOC indicate a need for corrective action, that the necessary corrective actions are implemented.

Root Cause Analysis: After a thorough assessment of all factors involved in the deficiency, the following Correction Action Plan interventions were instituted.

L.A. Care Corrective Action Plan:

- Revised RA&C P&P 019 to include MOC
- Trained staff and associates on updated policy
- Developed process to ensure CAP is implemented per policy
- Audited the process
- Monitor, report and review

Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Updates
Model of Care (MOC) Measures*			
Hospital Utilization (MOC)			
Hospital Bed Days	Target - 1400K	10% reduction in total beddays/K Target - 1400K	Jan.: 1030 April: 918 June: 869
Hospital Admissions	Target - 220	10% reduction in admissions Target - 220	Jan.: 335 April: 213 June: 197
Hospital Average Length of Stay	Target - 4.2 Days	10% reduction in length of stay Target - 4.2 Days	Jan.: 4.38 April: 4.30 June: 4.41
Readmissions rates	Target - <20%	2 percentage point reduction from previous year Target - <20%	Jan.: 18.00 April: 14.18 June: Not available
Ambulatory Services (MOC)			
Emergency Room Visits	Dec. 2013 - 1338.62	10% reduction from the previous year	Jan.: 483.21 April: 346.09 June: 100.8
Ambulatory Care Visits	Dec. 2013 - 5024.13	10% reduction from the previous year	Jan.: 5510.68 April: 4219.41 June: 1605.96
Grievance	4th Qtr. 2013 Part C: 72 Part D: 15	Monitor in QI Program	Part C: 1st Qtr.: 73 2nd Qtr.: 93 3rd Qtr.: 76 Part D: 1st Qtr.: 4 2nd Qtr.: 9 3rd Qtr.: 5
HRA Completion Rate		100% of all Medicare enrollees within 90 days	Jan.: 41% April: 56% Sept.: 56%
* Only 3 quarters of data available			

2015 WORK PLAN GOALS:

MEASURES	2014 GOAL
Quality of Life Survey - SF12 Mental Component Score (HOS)	6%/3 years or 2% change per year
Quality of Life Survey - SF12 Physical Component Score (HOS)	6%/3 years or 2% change per year
Medication compliance	Improvement of 2 percentage points per year
Patient satisfaction	90% of members will be satisfied with care management activities
Avoidance of hospital admissions for ambulatory care sensitive conditions (ACSC)	10% reduction in total beddays/K for ACSC
Hospital Utilization (MOC)	
Hospital Bed Days	10% reduction in total beddays/K
Hospital Admissions	10% reduction in admissions
Hospital Average Length of Stay	10% reduction in length of stay

MEASURES	2014 GOAL
Readmissions rates	2 percentage point reduction from previous year
Ambulatory Services (MOC)	
Emergency Room Visits	10% reduction from the previous year
Ambulatory Care Visits	10% reduction from the previous year
Grievance	Monitor in QI Program
HRA Completion Rate	100% of all Medicare enrollees within 90 days

A. 10 QUALITY IMPROVEMENT PROJECTS (QIPS)

A.10.a REDUCING READMISSIONS- MEDI-CAL

2014 WORK PLAN GOAL:

DHCS Modified HEDIS Measure*	2014 Goal
All-Cause Readmissions (ACR)	16.1%

*Note lower rate = better performance

BACKGROUND

Data from the 2007 Healthcare Cost and Utilization Project (HCUP) on all-cause readmissions among non-elderly Medicaid patients revealed that Medicaid readmission rates were higher than commercially insured patients. Discharge from a hospital is a critical transition point in a patient's care. The Medi-Cal population is uniquely vulnerable to poor outcomes in the transition from hospital to home due to poor health literacy, language barriers, and primary care access difficulties. Medi-Cal patients may have poor understanding of red flags (when to ask for help) or how to manage medication changes. Dr. Eric Coleman's research¹¹ shows that 40 percent of older patients experience a medication discrepancy at the time of discharge. Organizations across the country are focused on hospital discharges as a high-yield opportunity to improve outcomes and reduce costs, with interventions focusing on improving care coordination between hospital, specialist and PCP, improving patient/family understanding of their conditions and how to manage predictable symptoms, ensuring accurate medication reconciliation, and assisting patients with accessing needed follow-up services.

In 2012, DHCS mandated that each health plan participate in the statewide collaborative and evaluate the readmission rate for its Medi-Cal members and address any disparities identified through barrier analysis with targeted interventions. The statewide readmission collaborative provides an opportunity to collect data, share knowledge and best practices, and implement changes that will help reduce readmission rates for the Medi-Cal population.

In late 2013, L.A. Care's Medical Management Department developed a Transition of Care program (TOC) based on the Coleman model of Care transitions⁶. The intervention takes a member-centered approach to identifying barriers and coordinating post-discharge care, and brings together an interdisciplinary team which (for at risk patients) includes TOC nurses, care coordinators, social workers, primary care providers, disease management nurses and coordinators, behavioral health specialists, pharmacists and long-term support and service specialists.

MAJOR ACCOMPLISHMENTS

- L.A. Care's ACR rate improved significantly from the previous year.
- L.A. Care launched an electronic form that would capture data for the project from the existing case management software.

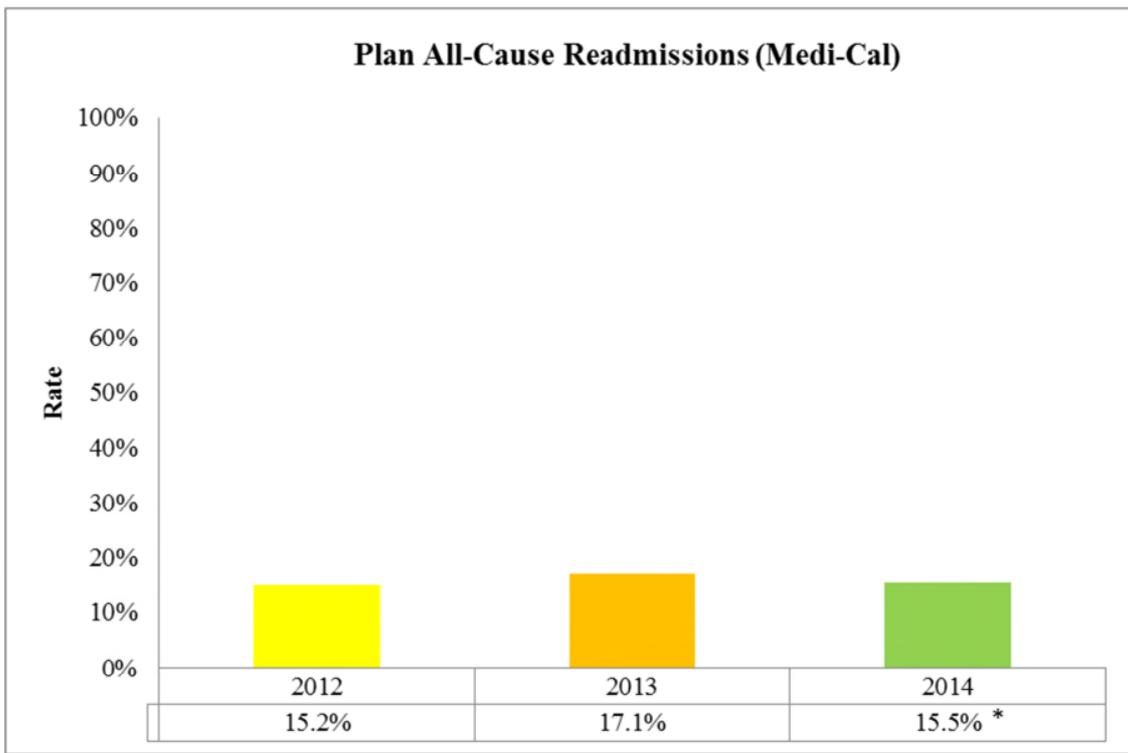
¹¹ <http://www.caretransitions.org/documents/Coleman%20Senate%20Aging%20Testimony%20July%202008.pdf>

⁶ Coleman, Eric. *The Care Transitions Program*. Eric A Coleman, 1 Jan. 2007. Web. 14 Jan. 2015.
<http://www.caretransitions.org/>.

Description of measures:

DHCS Modified HEDIS Measure	Specific Indicator(s)	Measure Type
All-Cause Readmissions (ACR)	For members 21 years of age older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days. This measure specification was created by CA Department of Health Care Services and deviates from HEDIS specification slightly by taking members who are 21 years of age or older and the member must also be enrolled continuously 120 days prior to the initial inpatient stay through 30 days after the discharge date.	Administrative

RESULTS



* Statistically significant

Quantitative Analysis

In 2014, the all-cause readmission rate was 15.5%, which is a significant decrease from the 2013 rate of 17.1%. This difference is statistically significant (p<0.05).

Qualitative Analysis

The intervention was launched in December of 2013, too late to impact the HEDIS 2014 rate. It is unclear what affect the post-discharge calls had on that rate or if other interventions by hospitals or IPAs had an effect on the HEDIS rate. It is very possible that hospitals have been working to improve readmission rates due to penalties imposed by CMS. Only a rate decrease in the target group, of those who participate

in the TOC program would demonstrate a causal relationship. Tracking data and using the PDSA improvement strategy will help determine if the intervention had an impact on the rate.

While the program is largely the same in 2014, there were some revisions to address some of the major barriers of the interventions. There is an addition of a member mailing for those members that cannot be reached by phone to participate in the TOC program. TOC staff has also been trained on using the pharmacy database so they can provide information to the member’s PCP for appropriate follow up discussions and care. Lastly, one of the major barriers is the difficulty in electronically capturing data and determining if the cohorts in the intervention are having lower rates of readmission. Until the fall of 2014, TOC staff were tracking on lengthy spreadsheets in addition to their case notes in the case management software, leading to significant data errors or incomplete fields.

INTERVENTIONS

HEDIS Measure	Barriers	Actions
All-Cause Readmissions (ACR)	<ul style="list-style-type: none"> • Both L.A. Care concurrent review nurses and member’s PCP have difficulty receiving discharge and medication reconciliation information from the hospital within one week of discharge. With inconsistent data, it is difficult to schedule follow-up visits for member to see their PCP. • PCP do not know patient have been discharged and have limited time to schedule appointments for follow-up with patients. • Member may not perceive that he or she is at risk of having any medication related problem(s) and may refuse medication reconciliation or follow-up with PCP. • Hospital staff have limited follow-up post discharge. They rely on PCP or plan case managers for follow up care. • Members may not have adequate transportation to PCP offices for follow up care • Intervention/program data is difficult to capture in the existing software. • Members are difficult to reach by phone after discharge 	<ul style="list-style-type: none"> • L.A. Care launched the revised Transition of Care (TOC) program in December of 2013 to address barriers and improve health outcomes and lower 30-day all cause readmission rates through identifying patients at risk for readmission during concurrent review, and providing targeted case management and care coordination for members while they are in the hospital through 30 days post-discharge from a facility. Upon admission, members in standard delegation for L.A. Care concurrent review are stratified according to risk of admission and level of need in order to receive customized follow-up after discharge. The risk assessment screening tool assigns each member a risk score based on functional status, recent medical events, age, social history, and comorbidities. • An electronic form has been built into the existing software (Essette) that captures project data. • Members that cannot be reached are sent a letter that explains the TOC program and offers assistance.

LOOKING FORWARD

- L.A. Care will continue the Transition of Care program to reduce hospital readmissions in 2015 for those at high risk for readmissions and in standard delegation.
- L.A. Care will conduct Plan-Do- Study-Act (PDSA) cycles on a monthly basis at a minimum to help identify barriers quickly.
- The QIP is being retired by DHCS in 2015.

2015 WORK PLAN GOAL:

HEDIS Measure	2015 Goal*
All-Cause Readmissions (ACR)	14.8%

*Goal based on statistical improvement from the previous year based on the same denominator size.

PLAN ALL CAUSE READMISSIONS (MEDICARE-SNP)

2014 WORK PLAN GOAL:

HEDIS MEASURE	2013 GOAL
Plan All-Cause Readmissions (PCR)	12%*

*Note lower rate = better performance

BACKGROUND

Hospital readmissions are common, costly and negatively impact health outcomes. Nearly one in five Medicare patients were readmitted within 30 days of discharge from a hospital stay and estimates of the cost of these potentially preventable readmissions equates to \$12 billion dollars annually.¹² Medication reconciliation plays a critical role in helping to reduce hospital readmissions due to preventable adverse drug events. Research has found that the rate of hospitalization is lower for those who receive a pharmacist intervention (1%) as opposed to those who do not receive the intervention (8%).¹³ One study found a bundled intervention, including pharmacist medication review, was associated with a lower rate of preventable adverse drug events 30 days after hospital discharge. Reducing readmissions with pharmacist led medication reconciliation is a cost effective way to provide better care to members and improve health outcomes.

In 2013, L.A. Care began a medication reconciliation intervention to improve readmissions. Due to low member participation, L.A. Care developed an action plan to enhance efforts to reduce hospital readmission rates. In late 2013, L.A. Care's Medical Management Department developed a Transition of Care program (TOC) based on the Coleman model of Care transitions. The intervention takes a member-centered approach to identifying barriers and coordinating post-discharge care, and brings together an interdisciplinary team which (for at risk patients) includes TOC nurses, care coordinators, social workers, primary care providers, disease management nurses and coordinators, behavioral health specialists, pharmacists and long-term supports and services specialists.

The Medicare-SNP QIP closed in 2014 due to the termination of this product line. The QIP topic and intervention will be transition to the Cal Medi Connect plan but with some modifications.

MAJOR ACCOMPLISHMENTS

- L.A. Care's PCR rate improved by 4% from the previous year.
- L.A. Care launched an electronic form that would capture data for the project from the existing case management software.

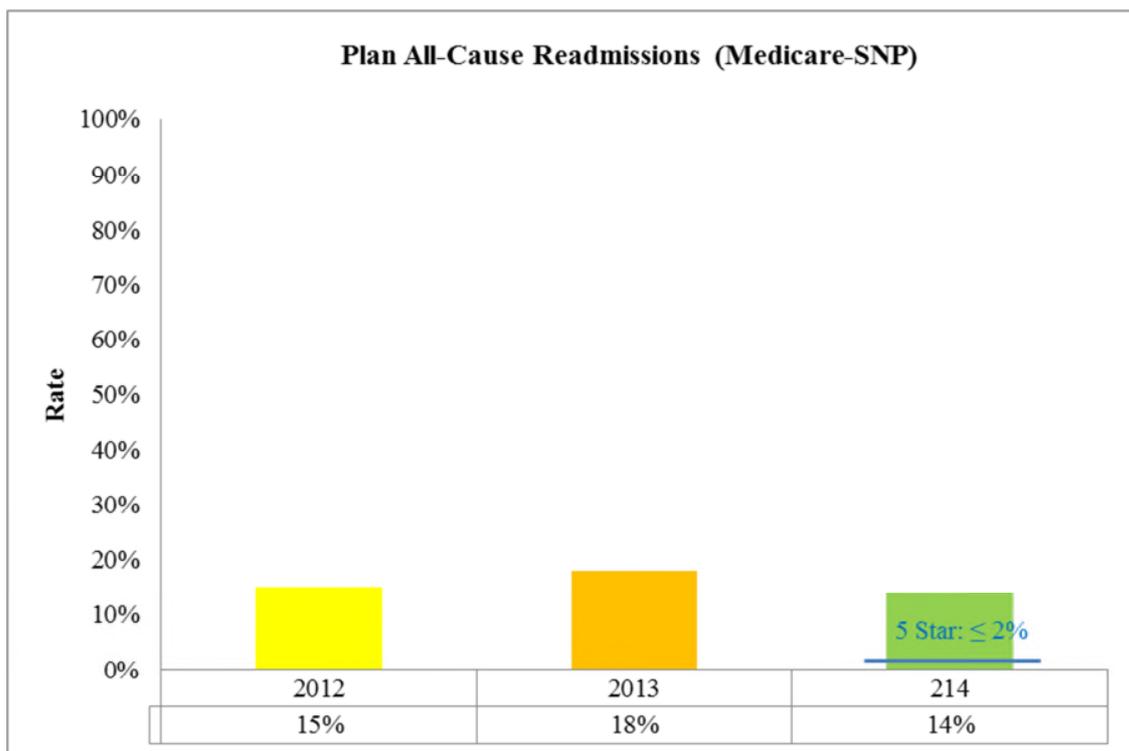
1 MedPAC. Report to Congress: Promoting Greater Efficiency in Medicare. June 2007.
<http://www.medpac.gov/documents/Jun2007>.

¹³ Boutwell, AE, et al. An early look at a four-State initiative to reduce avoidable hospital readmissions. (2011). Health Affairs, 30(7), 1272-80

Description of measures:

HEDIS Measure	Specific Indicator(s)	Measure Type
Plan All-Cause Readmissions (PCR)	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.	Administrative

RESULTS



Quantitative Analysis

In 2014 the plan all-cause readmissions CMS Case Mix Adjusted rate was 14%, which is a 1 star rating for the Medicare Star Program, falling short 2 percentage points below the QIP goal and 3% percentage points below the three star rating of 11% or less. L.A. Care did not meet the goal of 12%. Statistical significance could not be calculated because CMS used a different algorithm for calculating the rate the previous year.

Qualitative Analysis

L.A. Care’s Transition of Care (TOC) intervention began in December of 2013 and as a result, the 2013 calendar year rate could not be greatly impacted by the program. While medication reconciliation was the intervention in the first half of the year, only seven (7) of 113 members in the cohort received the intervention. It is unclear what affect the post-discharge calls had on that rate or if other interventions by hospitals or IPAs had an effect on the HEDIS rate. It is very possible that hospitals have been working to improve readmission rates due to penalties imposed by CMS. Only a rate decrease in the target group of those who participate in the TOC program would demonstrate a causal relationship. Tracking data and using the PDSA improvement strategy will help determine if the intervention had an impact on the rate.

While the program is largely the same in 2014, there were some revisions to address some of the major barriers of the interventions. There is an addition of a member mailing for those members that cannot be reached by phone to participate in the TOC program. TOC staff has also been trained on using the pharmacy database so they can provide information to the member's PCP for appropriate follow up discussions and care. Upcoming months will focus on improving data capture in order to evaluate the outcomes of the members that participate in the program and make data driven changes to the intervention. Lastly, L.A. Care is exploring the option of delegating the TOC program, or certain levels of the TOC program to provider groups to enhance care coordination and have the most optimal outcomes for members.

INTERVENTIONS

HEDIS Measure	Barriers	Actions
Plan All-Cause Readmissions (PCR)	<ul style="list-style-type: none"> Both L.A. Care concurrent review nurses and member's PCP have difficulty receiving discharge and medication reconciliation information from the hospital within one week of discharge. With inconsistent data, it is difficult to schedule follow-up visits for member to see their PCP. PCP do not know patient have been discharged and have limited time to schedule appointments for follow-up with patients. Member may not perceive that he or she is at risk of having any medication related problem(s) and may refuse medication reconciliation or follow-up with PCP. Hospital staff have limited follow-up post discharge. They rely on PCP or plan case managers for follow up care. Members may not have adequate transportation to PCP offices for follow up care Intervention/program data is difficult to capture in the existing software. Members are difficult to reach by phone after discharge 	<ul style="list-style-type: none"> L.A. Care launched the revised Transition of Care (TOC) program in December of 2013 to address barriers and improve health outcomes and lower 30-day all cause readmission rates through identifying patients at risk for readmission during concurrent review, and providing targeted case management and care coordination for members while they are in the hospital through 30 days post-discharge from a facility. Upon admission, members in standard delegation for L.A. Care concurrent review are stratified according to risk of admission and level of need in order to receive customized follow-up after discharge. The risk assessment screening tool assigns each member a risk score based on functional status, recent medical events, age, social history, and co-morbidities. An electronic form has been built into the existing software (CCA) that captures project data. Members that cannot be reached are sent a letter that explains the TOC program and offers assistance.

LOOKING FORWARD

- L.A. Care will transition this QIP to the Cal-Medi-Connect plan but with some modifications.

2015 WORK PLAN GOAL: N/A

IMPROVING FLU SHOTS AND PNEUMONIA IMMUNIZATION RATES FOR OLDER ADULTS

This QIP was retired in 2013. The Chronic Care improvement Project replaced this QIP. Please see the CCIP section for more details on these rates.

IMPROVING RATES OF CHOLESTEROL MANAGEMENT FOR PATIENTS WITH DIABETES

This QIP was retired in 2013. The Chronic Care improvement Project replaced this QIP. Please see the CCIP section for more details on these rates.

A.10.b IMPROVING DIABETES SCREENINGS

2014 WORK PLAN GOALS:

HEDIS MEASURE	2014 GOAL
Eye Exam	53%
A1c Testing	86%
A1c good control < 8%	51%
LDL screening	82%
LDL control < 100mg/dL	41%

BACKGROUND

Diabetes has been increasing in prevalence globally and is now considered a worldwide pandemic. Results of the 2011 California Health Interview Survey (CHIS) revealed that the prevalence of adults (ages 18 and above) with diabetes in L.A. County was 9.9%. The prevalence of diabetes among L.A. Care's Medi-Cal membership for calendar year 2014 is approximately 4.0%¹⁴, which is significantly lower than the CHIS rate that is self-reported and limited to the adult population.

While the Quality Improvement Plan (QIP) focuses on eye exams and A1c screening, this section will evaluate other plan-wide diabetes rates: A1c good control <8%, LDL screening, and LDL control < 100mg/dL. (See A.4 for other plan-wide diabetes measures)

MAJOR ACCOMPLISHMENTS

- L.A. Care met the state Minimum Performance Level (MPL) for all the state required diabetes measures.
- On February 13, 2014 L.A. Care mailed out the updated 2014 Diabetes Clinical Practice Guidelines to 3,288 high volume providers.
- In October 2014, L.A. Care staff called members missing their A1c test, dilated eye exam, and LDL-C screening to encourage them to see their physicians and get tested.
- In 2014 L. A. Care launched Year 4 of the Physician P4P Program. The program offers performance reporting and performance-based incentive payments to high volume solo and small group physicians and community clinics. HbA1c Screening, HbA1c Control ($\leq 9.0\%$), Eye Exams, and Nephropathy Screening are 4 of the 16 HEDIS measures included.
- In 2014 L.A. Care launched Year 5 of the LA P4P pay-for-performance program, which targets high volume PPGs. HbA1c Screening, HbA1c Control ($\leq 9.0\%$), Eye Exams, and Nephropathy Screening are 4 of the 16 HEDIS measures included.

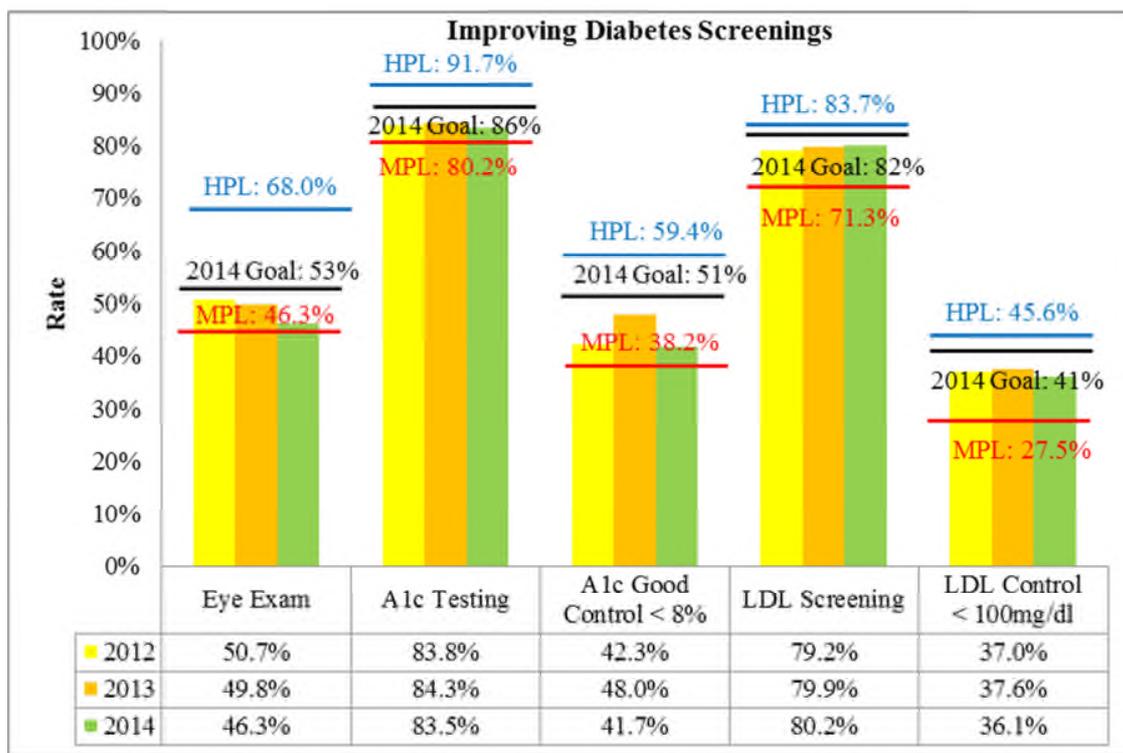
¹⁴ The L.A. Care diabetes prevalence was derived by Internal KPI report showing the LA Cares about diabetes prevalence by line of business, December membership.

- In 2014 L.A. Care launched its new Plan Partner Incentive Program. This new program aligns the efforts of L.A. Care with those of its strategic partners as a critical point for improving the outcomes and satisfaction of members. Care 1st and Anthem Blue Cross are eligible for the Plan Partner Incentive Program, which includes HbA1c Screening.

Description of Measure:

HEDIS Measure	Specific Indicator(s)	Measure Type
Comprehensive Diabetes Care(CDC)	Percentage of diabetics aged 18-75 who had each of the following during the measurement year: <ul style="list-style-type: none"> ○ A1c Screening ○ A1c poor control (>9.0%) ○ A1c good control (<7.0%) ○ Retinal eye exam performed ○ LDL-C (cholesterol) screening ○ LDL-C control (< 100mg/dL) ○ Medical attention for nephropathy (micro albumin) 	Hybrid

RESULTS



Quantitative Analysis

In 2014, the rate for *Retinal Eye Exam* was 46.3%, this was a decrease of 3.5 percentage points from the 2013 rates, which were 49.8%. Overall, the rate has been stagnant. The 2014 goal of 53% was not met; however, L.A. Care exceeded the MPL of 45.0% by 4.8 percentage points. In 2014, the rate for *A1c screening* was 83.5%, which was a decrease of 0.8 percentage point from the 2013 rate of 84.3%. The 2014 goal of 86% was not met; however, L.A. Care exceeded the MPL of 78.5% by 5.8 percentage points. In 2014, the rate for *A1c-Good Control (<8%)* was 41.7% which is a 603 percentage point

decrease from the 2013 rate of 48.0%. The 2014 goal of 51% was not met, and the MPL of 42.1% was exceeded by 5.9 percentage points. In 2014 the rate for *LDL screening* was 80.2%, which was a 0.3 percentage point increase from the 2014 rate of 79.9%. Overall the rate has remained essentially the same. The 2014 goal of 82.0% was not met; however, L.A. Care exceeded the MPL of 70.3% by 9.6 percentage points. In 2014, the rate for *LDL Control (<100mg/dL)* was 36.1%, which was a 1.5 percentage point decrease from the 2013 rate of 37.6%. The rate has been relatively steady. The 2014 goal of 41.0% was not met; however, L.A. Care exceeded the MPL of 28.5% by 9.1 percentage points.

Disparity Analysis Eye Exam

For *Eye Exam* there are major disparities among language groups English speaking group rate and Spanish speaking group rate are not significantly different. However, there is a significant difference found between other language speaking group rate and English/Spanish speaking group rate. For *A1c testing*, there was a disparity between Age Group: 65 - 75 group had significantly higher rate than that of 18-35 group and non-significantly higher rate the 36-64 group. There was also a disparity between SPD vs Non-SPD group: SPD group had a significantly higher rate than non-SPD group. A1c control <8% showed a disparity between RCAC Region: The highest rate (from region 9) differs significantly from other regions' rates starting from the region1 whose rate is 3rd lowest from all 11 regions. LDL screening showed disparity between Age Group: 65-75 group had the highest rate, which is significantly different from the lowest rate from the 18-65 group. LDL control <100 mg/dL showed disparity between Age Group: Age group 65-75 had the highest rate, which was significantly different from that of both 18- 35 & 36-64 age groups. There was also a disparity between SPD vs. Non-SPD: SPD group had significantly higher rate than the non-SPD group.

Qualitative Analysis

HEDIS results for the 2014 measures for improving diabetes screenings showed L.A. Care met the goal for one of the five CDC measures (LDL Screening; however, did not meet the goal for other four measures (retinal eye exam, A1c screening , LDL, and LDL control <100mg/dL). Although four of the five measures did not meet the 2014 goals, the state MPLs for all measures were exceeded. Overall, results have remained stagnant for the last three years and require further efforts to sustain and improve rates. In an effort to improve the rates for improving diabetes screening measures, various interventions were implemented in 2011 and continued through 2013. In 2014, new interventions, such as a member incentive, were developed and implemented and existing interventions were evaluated and enhanced.

L.A. has a number of activities to improve member knowledge about diabetes. There are diabetes self-management classes available at the Family Resource Centers as well as health education classes at other community sites. In 2014, 2013 and 2012, L.A. Care staff made calls to members to encourage them to get their needed test and/or exams. From the call campaigns, L.A. Care learned that many of the members were unaware about the required screenings and/or how well they were doing. However, number of contacted members reported already having had the test or had an appointment scheduled. This may translate that we do not receive a significant portion of claims and encounter forms and it may be negatively affecting our rates.

To support physicians in mitigating barriers, L.A. Care developed and mailed a diabetes member incentive booklet to motivate members to get the necessary screenings to manage their disease. The booklet entitled “10 Ways to Keep Diabetes in Check” serves as the program announcement as well as an education tool for managing diabetes.

To encourage providers to complete diabetes screenings, L.A. Care has a performance improvement program that is designed to reward provider groups for performance in clinical outcomes. L.A. Care is in its third year of operation. The first year was focused on collecting data and reporting baseline performance to provider groups. The second and third years of LA P4P will reward and recognize groups

that strive to provide high quality, efficient care through financial incentives and public reporting based on a broad set of performance metrics. The measures include: A1c screening, retinal eye exam, LDL-C screening, and nephropathy screening. Encounter data submission goals are also part of this program. In 2014, diabetes control measures are being tested (A1c control \leq 9.0% and LDL-control ($<$ 100 mg/L) and would replace corresponding screening measures.

L.A. Care also continues to be actively involved in many efforts to assist practitioners to meet the guidelines. L.A. Care mails Provider Opportunity Reports to physicians that notify which members have not received their screenings.

(Note that there are diabetes improvement activities across all of L.A. Care’s membership with ongoing interventions. L.A. Care’s interventions are in addition to these efforts).

HEDIS Measure	Barriers	Actions	Effectiveness of Intervention/Outcome
Comprehensive Diabetes Care (CDC) <ul style="list-style-type: none"> • Eye Exam • A1c Screening • A1c good control $<$8% • LDL Screening • LDL control $<$ 100 mg/dL 	<p>Member</p> <ul style="list-style-type: none"> • Diabetic members do not recognize the critical need for an annual screenings and/or tests • Lack of member knowledge regarding appropriate diabetic management • Member too busy; does not follow through or has difficulty scheduling an appointment with a qualified eye care provider • Members are non-compliant with taking their medications and following provider recommendations <p>Provider</p> <ul style="list-style-type: none"> • Lack of incentive to follow up on exams under capitated payment system • Providers are not aware of all of the members with diabetes on their panels and which tests they need • Providers lack of compliance with clinical practice guidelines • PCPs do not use checklists (flow sheets) or disease registries to indicate what has been done or what is needed • Physicians don’t have time to fully educate members 	<ul style="list-style-type: none"> • Diabetes Reminder Calls: In October 2014 and November 2014, L.A. Care conducted reminder calls with appointment assistance to members who had not had their required screenings. • Physician P4P program In 2014, L.A. Care launched Year 4 of the <i>Physicians Pay-for-Performance Program</i>. This program offers performance reporting and performance-based incentive payments to high volume solo and small group physicians and community clinics. CDC (HbA1c Screening, A1c control \leq 9.0% Eye Exams, and Nephropathy Screening are 4 of the 16 HEDIS measures included. • LAP4P: In 2014, L.A. Care launched Year 5 of the <i>Provider Group Pay-for-Performance Program</i>. 2011 was the baseline data collection phase of the L.A. Care Provider Group Improvement Program (LA P4P) which measures, reports, and rewards contracted provider group performance in an effort to engage provider groups (e.g. IPAs) to improve clinical quality, medical cost management and member satisfaction. A1C, DRE and other diabetes related measures are included in this program. The program is to be implemented in phases over the next 3 years. • Annual Provider Opportunity Report: In June 2014 and October of 2014, L.A. Care sent to high volume physicians an annual provider opportunity report, which contains the providers’ individual 	See results above

HEDIS Measure	Barriers	Actions	Effectiveness of Intervention/Outcome
		<p>performance on A1c, nephropathy, LDL and retinal screenings in their diabetic population as well as the names of the members who required the exams.</p> <ul style="list-style-type: none"> Clinical Practice Guidelines Mailing: In February 2014, L.A. Care mailed to physicians the Summary of current Revisions for the Clinical Practice Recommendations and “Executive Summary: Standards of Medical Care in Diabetes.” Also notifying physicians that guidelines and toolkits can be found on L.A. Care’s website. Diabetes and Cardiovascular Toolkit: In August 2014 L.A. Care posted to its provider section of the website a new combined Diabetes and Cardiovascular toolkit, which contains guidelines, tools, and resources for providers 	

LOOKING FORWARD

- L.A. will continue reminder calls and postcards to diabetic members.
- L.A. Care will continue the member incentive for diabetic members that receive appropriate screenings.
- L.A. Care will continue to send physicians its annual provider opportunity reports on their progress on various diabetes measures with lists of members who need the services.
- L.A. Care will continue the provider group and physician incentive programs.
- L.A. Care will continue to educate physicians on use of diabetes guidelines.

2015 WORK PLAN GOALS:

HEDIS MEASURE	2015 GOAL
Eye Exam	54%
A1c Testing	84%
A1c good control < 8%	46%
LDL screening	Measure retired in 2015
LDL control < 100mg/dL	Measure retired in 2015

A.11 POTENTIAL QUALITY ISSUES

2014 WORK PLAN GOAL:

- 100% of Potential Quality of Care Issues (PQIs) will be closed within 6 months.

BACKGROUND

Investigation of PQIs is a fundamental, but extremely valuable way to monitor patient safety in the network. A Potential Quality Issue is defined as an individual occurrence or occurrences with a potential or suspected deviation from accepted standards or care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review. A potential quality of care issue may include, but is not limited to, a physician's medical knowledge, clinical skill, judgment, appropriate record documentation, medication management, appropriate diagnosis, continuity and coordination of care, and medical errors-all of which impact patient safety. Sources of PQIs include, but are not limited to, UM staff, care management staff, disease management staff, member services staff, other physicians, and clinical grievances. The Quality Improvement Department (QI) conducts a thorough internal investigation on all potential quality issues. The QI department may use the peer review process to present cases which are under review for potential quality issues. The peer review committee conducts a thorough and objective evaluation of the case to determine whether care was appropriate. Upon the peer review committee's determination that care was not appropriate, remedial measures including, but not limited to education, may be recommended. Cases under review may also be sent for external review. Upon the committee's final determination of clinical appropriateness, the case is assigned a severity level. All cases must be closed within 6 months.

MAJOR ACCOMPLISHMENTS

- Continue to enhance the PQI investigation process requiring the QI nurse to conduct initial clinical review for all PQI referrals. The QI nurse would close the case if no QOC (level 0) or appropriate QOC (level 1) was determined. The QI nurse would also evaluate the case for quality of service issue as appropriate. For any clinical QOC case with severity level 2 or above, the case would be forwarded to a medical director review. The medical director would review all information collected by the QI nurse and close the case with appropriate actions or refer the case for Peer Review Committee (PRC) review (level 3 and 4).
- Update all four PQI P&Ps (QI-001/ Potential Quality of Care Issues (PQI), QI-021/ PQI-Plan Partner, QI-022/ Peer Review Committee & QI-024/ PQI-Provider Group/IPA) to reflect the current PQI process.
- Processed PQIs timely, despite of the significant increase of caseload from 104 cases in 2013 to 269 cases in 2014.

RESULTS

The following table shows the PQIs handled by L.A. Care directly or delegated to the appropriate plan partner for thorough investigation and closure.

	Total PQI Cases (Jan – Dec 2012)	Total PQI Cases (Jan – Dec 2013)	Total PQI Cases (Jan – Dec 2014)	Closed Within 6 Months
L.A. Care*	66	104	269	No
Care 1st	508	281	969	No
Kaiser	150	201	242	No
Anthem Blue Cross	175	74	87	Yes

*Includes all lines of business (Medi-Cal, Medicare, PASC-SEIU and L.A. Care Covered)

ANALYSIS

In 2014, all closed PQI cases were completed within 6 months except one. The PQI case was opened on March 4, 2014 with a due date for closure on September 4, 2014, but instead closed September 5, 2014 due to the delayed in physician's response beyond standard timeline. The case was closed one business day late. There were 23 PQI cases opened in 2014, but remained open with a 6-month due date in 2015. All PQI cases, except the 23 cases, were closed with severity levels and action codes upon completion of PQI investigation.

Anthem Blue Cross met the goal of 100% closure within the six (6) month timeframe.

In 2013, Care 1st Health Plan submitted a full corrective action plan addressing delayed in PQI closure in July 2012. In first quarter 2014, Care 1st hired additional staffs to ensure full compliance with 6-months closure. Though Care 1st reported 2 cases closed beyond 6-months timeframe in 3rd quarter, Care 1st met the goal of 100% closure within the six month timeframe by closing of year 2014.

Kaiser reported 1 case closed beyond 180 days/ 6-months timeframe. The case was not processed timely after it was received in their Quality Improvement Department. The issue had been raised to their QI Director. Expectations were clarified and intake process was reinforced.

A.12 FACILITY SITE REVIEW/MEDICAL RECORDS INITIATIVES

2013 WORK PLAN GOALS:

- Needlestick safety precaution – 75%
- Spore testing of autoclave/sterilizer – 84%

BACKGROUND

L.A. Care is committed to developing and implementing activities to enhance patient safety. L.A. Care also enhanced patient safety through the facility site review (FSR) process by monitoring elements on patient health/safety. In the FSR process, the two (2) measures that did not meet the 80% standard in 2010 included: (a) Needlestick safety precautions practiced on site, and (b) Spore testing of autoclave/steam sterilizer with documented results (at least monthly).

RESULTS

Needlestick Safety Precaution

2012 Results	2013 Results	2014 Results	Goal Met	2014 Goal
68.00%	67.00%	63.00%	No	75%

ANALYSIS

Quantitative Analysis

The 2014 goal for needlestick safety precaution was not met. The compliance score for needlestick safety dropped by 4.00 percentage points from 2013. The difference in rates was not statistically significant (p value = 0.2740) compared to 2013 results, and there has been no improvements in regards to the compliance to this criteria since 2012.

Spore Testing of Autoclave/Sterilizer

2012 Results	2013 Results	2014 Results	Goal Met	2014 Goal
83.00%	87.00%	83.00%	No	84%

Quantitative Analysis

The provider offices reviewed did meet the 2014 goal for spore testing of autoclave/sterilizer spore testing. The compliance score decreased by 4.00 percentage points from 2013. The 2014 results dropped from previous years; however, the difference between 2013 and 2014 was not statistically significant (p value = 0.4611).

Qualitative Analysis

It is a continuous challenge to meet the goals and to change provider office behavior. The following reasons contribute to this:

- Reverting back to previous behaviors after an audit has been completed.
- Cost of purchasing needlestick safety devices causes a financial burden to provider offices/facilities.

- Staff, due to high office staff turnover, do not know the requirements for needlestick safety precautions.
- Staff, due to high office staff turnover, do not know the requirements for spore testing of autoclave/sterilizer.
- Staff are not properly trained upon hire to inform them of the requirements for needlestick safety precautions and spore testing of autoclave/sterilizer.
- Durable medical equipment (DME) suppliers still have non-safety needles/syringes available for purchase. This may cost less than the safety devices.
- New provider sites participated in our network are not knowledgeable of the requirements.

Upon in-depth review of data, it was noted that new provider offices that received an additional educational visit were compliant and most providers were slowly transitioning out of utilizing autoclave/steam sterilization equipment.

LOOKING FORWARD

Certified Site Reviewer (CSR) Nurses will continue to monitor and educate provider offices regarding Local, State, and Federal regulations, and provide educational material and information every 18 months or sooner to assist in compliance with these patient safety measures.

2015 WORK PLAN GOALS:

- Needlestick: 75%
- Spore Testing: 85%

MEDICAL RECORDS INITIATIVES

2014 WORK PLAN GOAL:

Aggregate network PCP sites should score at least 80% in the following key areas:

- Ease of retrieving medical records (FSR G1 &2)
- Confidentiality of Medical Records (records are stored securely; only authorized staff have access to records, etc. (FSR H4)

Aggregate network PCP sites should score at least 80% in the following key documentation areas:

- Allergies and adverse reactions (2A)
- Problem list (2B)
- Current continuous medications are listed (2C)
- History and Physical (3A)
- Unresolved or continuing problems are addressed in subsequent visits (3E)
- Documentation of clinical finding and evaluation for each visit:
 - Working diagnosis consistent with findings (3B)
 - Treatment plans consistent with diagnosis (3C)
 - Instruction for follow-up care is documented (3D)
- Preventive services or risk screening (4 & 5C)

BACKGROUND

L.A. Care Health Plan has established medical record standards to facilitate communication, coordination and continuity of care and to promote safe, efficient, and effective treatment. L.A. Care requires practitioners to maintain medical records in a manner that is current, detailed, and organized. L.A. Care assesses the site's compliance with regulations and L.A. Care policies by utilizing the *mandated*

Department of Health Care Services (DHCS) survey tools. This report provides an annual analysis of medical record keeping standards for the time period of October 1, 2011 – September 30, 2014, of primary care practitioner (PCP) sites (practitioner’s office or clinic) to measure compliance with appropriate medical record documentation requirements. This analysis allows L.A. Care to measure site’s compliance with current documentation standards and develop interventions to make improvements. The use of electronic health record (EHR) improves documentation, coordination of care, and therefore, has a great impact on improving patient safety.

MAJOR ACCOMPLISHMENTS

- All standards met and/or exceeded the 2014 goal of 80%. Practitioners continued to be educated on site during the Facility Site Review (FSR), Medical Record Review, or Physician Quality Improvement Liaison (PQIL) Nurses visits.

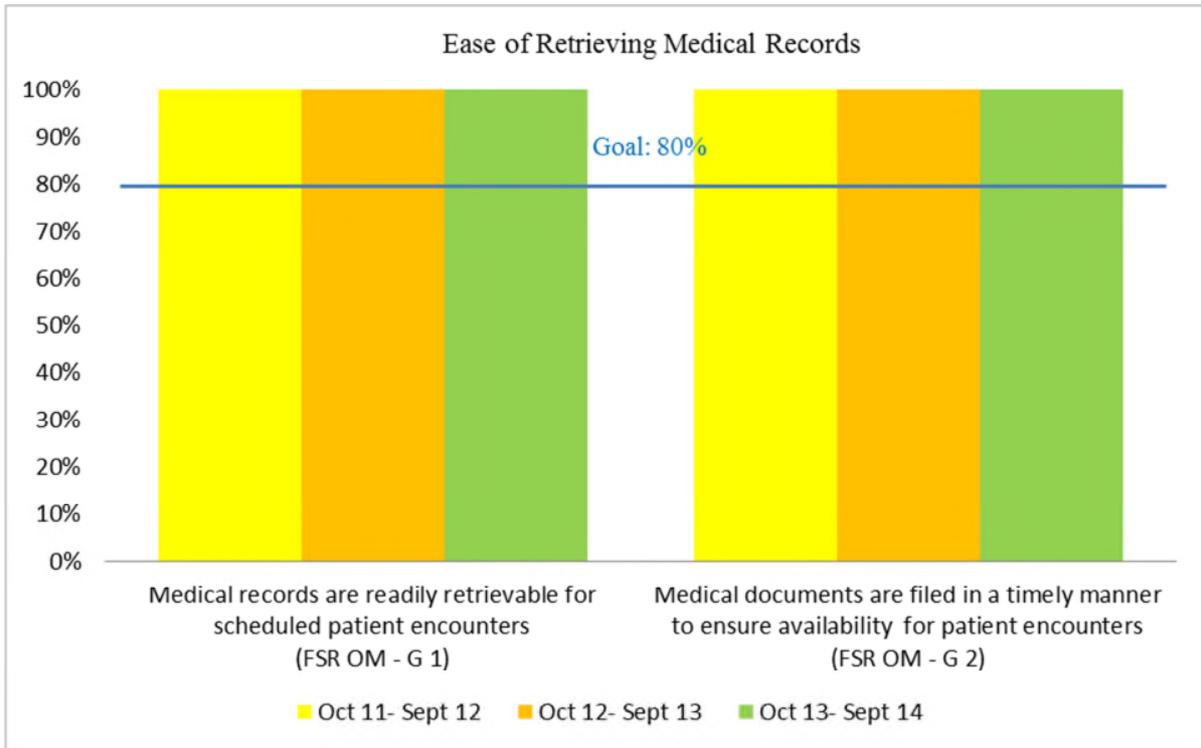
RESULTS

Year	Site #	Sample Size
2012	431	3772
2013	529	4427
2014	454	3,354

The following tables and graphs show the results of the FY 2011–2014 review of practitioner’s sites and medical records. These FY 2013–2014 results are compared to the previous two years.

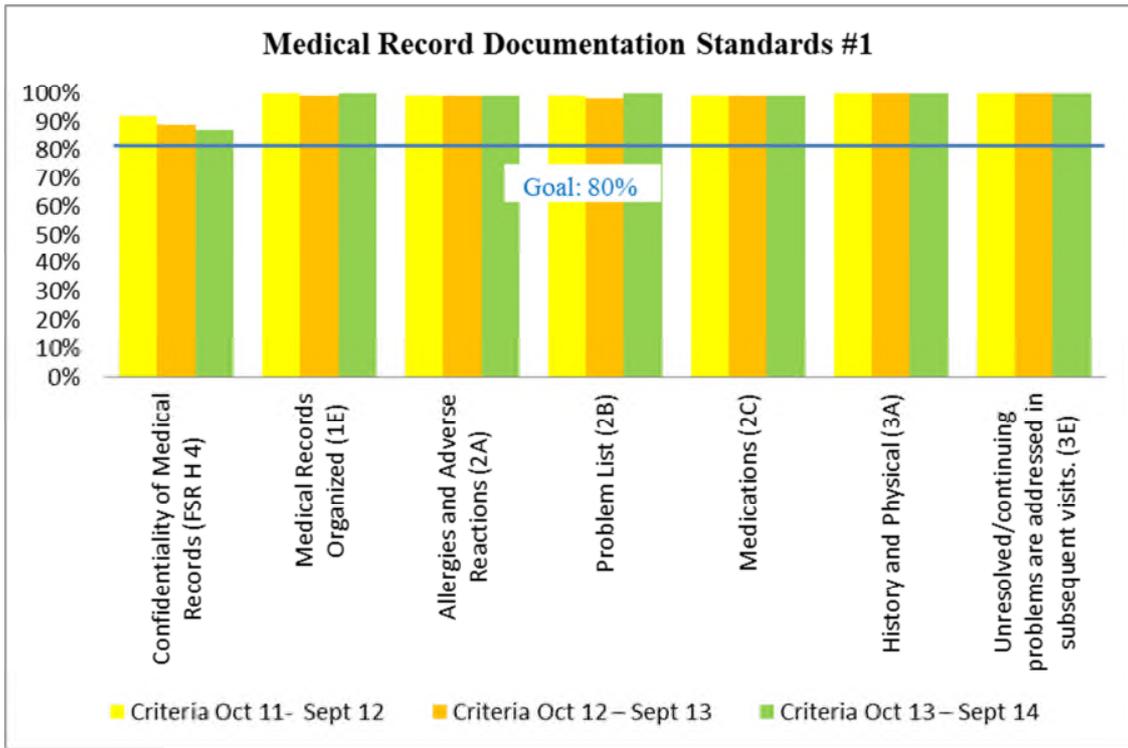
Ease of Retrieving Medical Records

Criteria	Oct 11 – Sept 12	Oct 12 – Sept 13	Oct 13 – Sept 14	% change from Oct 11 to Sept 13	% from 80% Goal
Medical records are readily retrievable for scheduled patient encounters (FSR OM - G 1)	100%	100%	100%	0%	20%
Medical documents are filed in a timely manner to ensure availability for patient encounters. (FSR OM - G 2)	100%	100%	100%	0%	20%



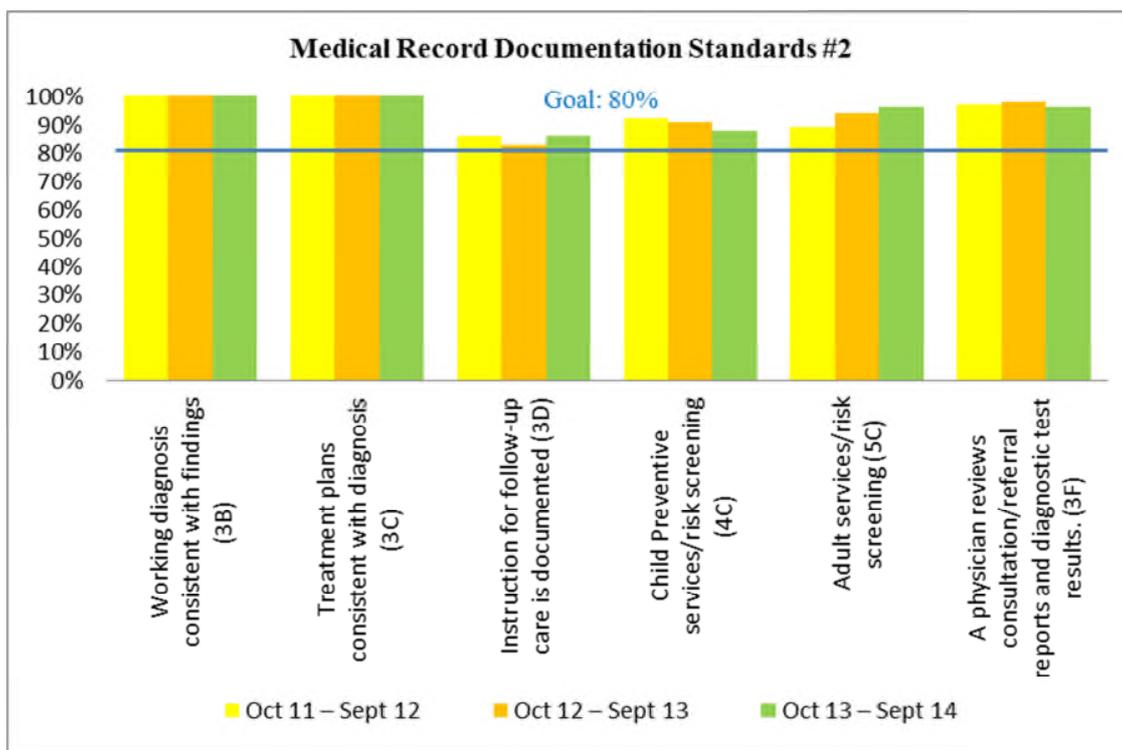
Medical Record Documentation Standards #1

Criteria	Oct 11 – Sept 12	Oct 12 – Sept 13	Oct 13 – Sept 14	% change from Oct 12 to Sept 14	% from 80% Goal
Confidentiality of Medical Records (FSR H 4)	92%	89%	87%	-2.00%	7%
Medical Records Organized (1E)	100%	99%	100%	1.0%	20%
Allergies and Adverse Reactions (2A)	99%	99%	99%	0.0%	19%
Problem List (2B)	99%	98%	100%	2.00%	20%
Medications (2C)	99%	99%	99%	0.00%	19%
History and Physical (3A)	100%	100%	100%	0.00%	20%
Unresolved/continuing problems are addressed in subsequent visits. (3E)	100%	100%	100%	0.00%	20%



Medical Record Documentation Standards #2

Criteria	Oct 11 – Sept 12	Oct 12 – Sept 13	Oct 13 – Sept 14	% change from Oct 12 to Sept 14	% from 80% Goal
Working diagnosis consistent with findings (3B)	100%	100%	100%	0.00%	20%
Treatment plans consistent with diagnosis (3C)	100%	100%	100%	0.00%	20%
Instruction for follow-up care is documented (3D)	86%	83%	86%	3.0%	6%
Child Preventive services/risk screening (4C)	92%	91%	88%	-3.00%	8%
Adult services/risk screening (5C)	89%	94%	96%	2.00%	16%
A physician reviews consultation/referral reports and diagnostic test results. (3F)	97%	98%	96%	-2.00%	16%



ANALYSIS

Quantitative Analysis

The 2014 audits achieved the 80% goal in all criteria selected for this study.

Qualitative Analysis

Although the 2014 goals have been achieved, ongoing monitoring will be needed to address the following ongoing barriers:

- Practitioner confusion regarding when to follow Child Health and Disability Prevention Program (CHDP) versus American Academy of Pediatrics (AAP) guidelines for preventive services periodicity requirements.
- Perceived reimbursement issues leading physicians to believe they will not be reimbursed for AAP periodicity.
- Medical record forms require time to complete and may not include all required elements. Forms vary among Physician Provider Groups, practitioner offices and state mandated forms.
- There is an increase number of sites transitioning or have implemented an electronic health record (EHR) system. There are many choices of EHR vendors making the decision complex and puzzling for physicians. In addition, adding additional fields to accommodate medical record documentation standards may incur increase costs to physician offices.
- Time needed to document patient services and care rendered may be limited depending on patient volume.
- There are inconsistent or no processes in place to document care rendered to patients.

INTERVENTIONS

Based on the barrier analysis and feedback from physicians, L.A. Care will continue the interventions to maintain or improve medical record keeping.

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
All measures	<ul style="list-style-type: none"> • Medical record elements to the DHCS MRR tool have been unbundled into separate criteria. • Elements within a standard are not completed resulting in no credit for that record. • Medical record forms require time to complete and may not include all required elements. Forms vary among Physician Provider Groups, practitioner offices and state mandated forms. • There is an increase number of sites transitioning or have implemented an electronic health record (EHR). There are many choices of EHR vendors making the decision complex and puzzling for physicians. In addition, adding additional fields to accommodate medical record documentation standards may incur increase costs to physician offices. • Time needed to document patient services and care rendered may be limited depending on patient volume. • There are inconsistent or no processes in place to document care rendered to patients. 	<ul style="list-style-type: none"> • As of December 31, 2014, HITEC-LA has enrolled 64 clinics and 5,598 providers. HITEC-LA is charged with assisting physician adoption of EHR systems thru federal stimulus funding. • Medical Record Reviews are ongoing. • An established corrective action plan (CAP) process for provider offices that need to address deficiencies noted during a site review survey. 	All measures met goal.

LOOKING FORWARD

Medical record review will continue in 2015. During the review process, practitioner and office staff continue to be educated, and sample medical record documents and policies are distributed. If the provider falls below the California state requirement score of 80% for any section of the medical record review survey regardless of score, a corrective action plan is requested. 2015 goal is to meet or exceed 80% compliance goal.

2015 WORK PLAN GOAL:

Aggregate network PCP sites should score at least 80% in the following key areas:

- Ease of retrieving medical records and timely filing of documents (FSR G1 &2)
- Confidentiality of Medical Records (records are stored securely; only authorized staff have access to records, etc. (FSR H4)

Aggregate network PCP sites should score at least 80% in the following key documentation areas:

- Allergies and adverse reactions (2A)
- Problem list (2B)
- Current continuous medications are listed (2C)
- History and Physical (3A)
- Unresolved or continuing problems are addressed in subsequent visits (3E)
- Documentation of clinical finding and evaluation for each visit
 - Working diagnosis consistent with findings (3B)
 - Treatment plans consistent with diagnosis (3C)
 - Instruction for follow-up care is documented (3D)
- Preventive services or risk screening (4 & 5C)

B. SERVICE IMPROVEMENTS

B.1 MEMBER SATISFACTION (CAHPS) AND GRIEVANCES AND APPEALS

BACKGROUND

L.A. Care Health Plan demonstrates its commitment to improving member satisfaction through an annual assessment of all complaints and appeals, as well as the results from the 2014 Medicaid Adult and Child CAHPS 5.0 Member Survey. Results are trended over a three year period. This report contains a quantitative analysis, followed by a qualitative analysis; selection of the top priorities among opportunities identified for improvement and measured effectiveness, where available. The CAHPS survey is conducted by DSS Research, an NCQA certified vendor. DSS Research conducts key driver statistical modeling to assist L.A. Care in selecting priority measures to target improvements.

The Member Quality Service Committee (MQSC) is the cross-departmental multidisciplinary committee responsible for identifying quality improvement needs, and reports its findings and recommendations to the Quality Oversight Committee (QOC). The MQSC is comprised of representatives from Quality Improvement, Member Services, Utilization Management, Health Education, Cultural and Linguistic, Health Outcomes and Analysis, Product Operations, Provider Network Operations and other departments, as required. Information in this report is based on the analysis of available data and survey, as well as discussions at the Quality Oversight and Physician Quality (PQC) Committees.

ACCOMPLISHMENTS

- Evaluated all registered member complaints and appeals
- Evaluated the 2014 Medicaid Adult & Child CAHPS 5.0 survey results
- Conducted a quantitative and qualitative analysis from combined complaints, appeals and CAHPS data.
- Prioritized areas for improvement based on findings.
- Measured effectiveness of priority interventions.

SECTION 1: QUANTITATIVE ANALYSES

COMPLAINTS:

METHODOLOGY

L.A. Care Health Plan conducted an analysis of all registered complaints and appeals for the 12 month period October 1, 2013 – September 30, 2014. The complaint data in this report will be reflected as 2014 data. No sampling of data was used. L.A. Care can capture up to three complaint codes per call as often members often have more than one reason to call. The following provides a breakdown and summary of all complaint codes reported for the current year and a comparison against the prior 2 years data by count, rate per thousand members and percentage of total complaint/appeals codes.

GOAL

In 2014, lower and upper control limits were established using 2 years of complaint and appeals data (October 1, 2013 through September 30, 2014). The upper and lower thresholds were determined to be two standard deviations above and below the average complaint rate.

Complaints - 2014		
Low End	Average	High End
.0356	.4969	.5634

Appeals – based on data in 2014 data for indicate the following lower and upper limits:

Appeals - 2014		
Low End	Average	High End
.0074	.0659	.0093

COMPLAINT AND APPEALS RESULTS

Complaints and appeals data are assessed periodically to ensure they stay within established limits. Levels above the high end will be analyzed to determine reasons for these increases. From there, the development of action plans will attempt to bring levels closer to the average. If levels fall below the threshold, analysis will be done to assess if there are corresponding improvements to connect to as a measure of success. There are no outliers identified for 2014.

Complaints	2012			2013			2014		
	Count	Rate*	%	Count	Rate*	%	Count	Rate*	%
Attitude & Service	2815	0.30	42%	3263	0.25	40%	2560	0.16	23.3%
Access to Care	3512	0.24	33%	2468	0.19	30%	3723	0.24	33.8%
Billing & Finance	639	0.07	8%	868	0.07	11%	1278	0.08	11.6%
Benefits	117	0.01	1%	140	0.01	2%	1308	0.08	11.9%
Quality of Care	1233	0.11	15%	1379	0.11	17%	2049	0.13	18.6%
Quality of Practitioner Office	129	0.01	2%	80	0.01	1%	89	0.001	0.8%
Grand Total	8445	0.73	100%	8198	0.64	100%	11007	0.70	100%

* Rate per thousand members is calculated based on total member months for the measurement period (October 1, 2013 – September 30, 2014 (2012=11,603,333 member mos.; 2013=12,844,283 member mos.; and 2014=15,771,358 member mos.)

- Registered complaints have increased since 2012; however, the rate per thousand members has declined from 2012 so the increase is reflective of member growth.
- The rate of access to care complaints decreased in fiscal year 2013, but has again increased in fiscal year 2014. Approximately 50% of the Access to Care complaints are regarding delays in service, delays in authorization, and specialty access/availability.
- Attitude and Service complaints have decreased from previous years.

- Billing and Finance complaints, where members called with concerns regarding balance billing or charge discrepancy, has increased. This is due mainly to the LACC Premium Billing issues members have experienced.
- Quality of Care (QOC) issues, where members called with concerns regarding refusal of care or prescription, or perceived inappropriate care, have increased in volume since 2011 due to membership growth but the rate of calls has not changed since 2012. QOC complaints remain a small percentage of overall complaints.
- Quality of a Practitioner’s Office complaints has decreased over the past two years and is the lowest percentage of overall complaints. All complaints were reviewed and did not result in a need to conduct a facility site review.

The following provides a breakdown and summary of total appeals reported by all SNP members for 2012, 2013, and 2014 expressed in count and appeal rate per thousand members:

Appeals	2012			2013			2014		
	Count	Rate*	%	Count	Rate*	%	Count	Rate*	%
Access To Care	463	0.06	57%	791	0.06	61%	968	0.06	69%
Attitude & Service	0	0.00	0%	0	0.00	0%	0	0.00	0%
Billing & Finance	17	0.00	2%	13	0.00	1%	0	0.00	0%
Benefits	0	0.00	0%	208	0.02	16%	212	0.01	15%
Quality of Care	333	0.04	41%	285	0.02	22%	308	0.02	22%
Quality of Practitioner Office	0	0.00	0%	0	0.00	0%	0	0	0%
Grand Total	813	0.10	100%	1297	0.10	100%	1410	0.09	100%

* Rate per thousand members is calculated based on total member months for the measurement period October 1, 2013 – September 30, 2014 (2012=11,603,333 member mos.; and 2013=12,844,283 member mos.; and 2014=15,771,358 member mos.)

- The rate of registered appeals increased slightly from Fiscal Year 2013; this may be reflective of the increase in membership.
- Access to Care appeals remain the highest rate per thousand and percentage as in the previous 2 years.
- Quality of Care appeals have remained the same from Fiscal Year 2013.
- Benefit appeals account for 15% of overall complaints. There were no registered benefit appeals in 2012; however, this may be due to how appeals were coded in the system.
- The rate of appeals is typically low due to the all-inclusive benefit package that is provided to the membership.
- There are no trends identified for the overall rates of appeals.

CHILD MEDICAID CAHPS 5.0 RESULTS

METHODOLOGY

This report summarizes findings of the 2014 Child Medicaid CAHPS 5.0 survey and compares the results to the 2012 and 2013 scores as well as our performance relative to the 2014 National Medicaid Average (NMA) and California Medicaid HMO Average (CMHA), as published by Quality Compass. Members were surveyed in English and Spanish.

The CAHPS Survey targeted potential respondents who are parents of those 17 years and younger as of the anchor date of December 31, 2013, who were continuously enrolled in Medi-Cal for at least five of the last six months of the measurement year and who were still enrolled at the time of the survey. A total of 2,145 surveys were mailed and a total of 691 or 33.53% were completed.

GOAL

L.A. Care met goals for Overall Rating: Care Received and Personal Doctor, as well as composite ratings of Getting Needed Care, Getting Care Quickly and Doctors who communicate well. L.A. Care did not meet the goals for Overall Rating of Health Plan and Composite rating for Health Plan Customer Service. Overall Rating: Specialist Seen Most Often is marked N/A, as there were not enough respondents to the question on the survey. Goals are determined using the NCQA sliding scale for Improvement, as well as analysis of historical performance.

Overall Ratings	Score	Goal	Met
Overall Rating: Health Plan	84.2%	87%	N
Overall Rating: Care Received	84.5%	81%	Y
Overall Rating: Personal Doctor	85.9%	85%	Y
Overall Rating: Specialist Seen Most Often	NA	88%	NA
Composite Ratings	Score	Goal	Met
Health Plan Customer Service	86%	87%	N
Getting Needed Care	79.9%	79%	Y
Getting Care Quickly	82.1%	75%	Y
Doctors Who Communicate Well	88.3%	85%	Y

OVERALL SCORES

The CAHPS survey includes the following five general overall rating questions designed to distinguish among important aspects of care. These questions ask enrollees to rate their experience in the past 6 months. Response options for rating satisfaction ranged from 0 (worst) to 10 (best). The NCQA scoring for overall ratings used in the table below, ratings of 8, 9 or 10 are considered favorable, and the achievement score is presented as a percentage of members whose response was favorable.

Child CAHPS Overall Ratings	Score 2012	Score 2013	Score 2014	2014 vs. 2013	NMA 2014	CMHA 2014
Health Plan	82.0%	84.0%	84.2%	0.2	84.5%	84.5%
All Health Care	76.0%	79.2%	84.5%	5.3	84.7%	82.0%
Personal Doctor	83.0%	84.2%	85.9%	1.7	87.6%	86.2%
Specialist Seen Most Often	NA	NA	NA	NA	84.5%	ND

- Health Plan Overall: The 2014 overall ratings shows slight improvement from 2013 but remain fairly flat over the three-year period from 2012 to 2014. The 2014 Health Plan rating is slightly below the National Medicaid Average (NMA) and California Medicaid HMO Average (CMHA)
- All Health Care Rating: The All Health Care score showed a 5.3 point improvement between 2013 to 2014. This rating is slightly below the NMA, but improved over the CMHA.
- Personal Doctor: The Personal Doctor score has showed slight improvement over the past three years, however the improvements are not significant. This falls below both the NMA and CMHA.

- Specialist Seen Most Often: The response rate was insufficient to score.

Composite Scores

The CAHPS survey asks respondents about their experience with various aspects of their care. Survey questions are combined into “composites”. Questions within each composite ask members how often a positive service experience occurred in the past six months. Respondents have the option to select from “never”, “sometimes”, “usually” and “always”. The scores for composite scores and survey questions throughout this report reflect the percent of responses indicating “usually” or “always”.

Child CAHPS Composites	Score 2012	Score 2013	Score 2014	2014 vs. 2013	NMA 2014	CMHA 2014
Getting Needed Care	NA	77.1%	79.9%	2.8	85.0%	79.1%
Getting Care Quickly	77.5%	81.3%	82.1%	0.8	89.5%	80.2%
How Well Doctors Communicate	84.1%	84.1%	83.3%	-0.8	93.0%	88.4%
Customer Service	NA	85.8%	86%	0.2	87.9%	84.8%

- Getting Needed Care: L.A. Care scored below the NMA and slightly above the CMHA. Comparative scores were not available in 2012 due to low response rate.
- Getting Care Quickly: L.A. Care showed slight improvement from 2013. The 2014 score is below the NMA but above the CMHA.
- How Well Doctors Communicate: L.A. Care’s score showed a slight decrease from 2013 and remains below the NMA and CMHA.
- Customer Service: L.A. Care’s score fell below the NMA and is higher than CMHA. Comparative scores are not available for 2012 due to low response rate.

SECTION 2: IDENTIFYING PRIORITY AREAS FOR IMPROVEMENT

Based on the quantitative analysis of complaints and CAHPS results, as well as DSS key driver statistical modeling, the following items have been identified as the priority areas on which L.A. Care will focus to improve the overall member satisfaction.

- Access to Care
 - Access to Specialty Care Complaints
- Getting Needed Care
 - Q15: Always or usually easy to get care, tests or treatment
- Provider Attitude Complaints/How Well Doctors Communicate
 - Q32: Always or usually explains things, easy to understand
 - Q33: Always or usually listens carefully to you
- Customer Service
 - Q50: Always or usually get help from health plan customer service
 - Q51: Customer service staff always or usually treat you with courtesy and respect

SECTION 3: QUALITATIVE ANALYSES AND KEY DRIVERS

The following provides a qualitative analysis of member satisfaction derived from the quantitative analysis of combined complaints and CAHPS data, as well as feedback from, but not limited to, committee discussion and focus groups.

ACCESS TO CARE

Access to Care remains the top reason for member complaints. Approximately 50% of all Access to Care complaints (Adult and Child combined) are regarding delays in service, delays in authorization, and specialty access/availability. Medicaid Child CAHPS results indicate that 84.1% of members find it easy to get care, tests or treatment, which is an improvement from the 2013 score of 81.5%.

Through discussion and feedback, the following have been identified as possible contributing factors to the members' ratings of access to care:

- An inherent shortage of specialists, especially at the provider group level. L.A. Care does meet the provider to member ratio for the overall network but opportunity for improvement has been identified at the delegate level.
- Actual delays in timeliness of processing authorizations.
- Delays with the authorization process due to practitioners submitting incomplete or incorrect requests to the authorizing party resulting in delays and multiple calls for clarification of the request for additional information.
- Limited oversight of delegate's authorization processes.
- Member perception of timeliness.
- Transportation issues traveling to provider offices.

Provider Network Operations examines the individual specialty networks of contracted provider groups quarterly and informs them of any deficiencies in their network. Furthermore, individual attention is paid to referrals to out of network specialists on an as-needed basis in order to ensure member s' needs are continually met.

Future implementation of health information technology at participating clinics might help alleviate some of these problems. In addition, L.A. Care continually provides education for members to help guide their expectations regarding speed-of-access to routine care, help them understand when to use urgent care and remind them L.A. Care can assist them with making appointment if needed. Education is conducted through member orientation, new member welcome calls, member newsletters, the Family Resource Center, and the L.A. Care website.

L.A. Care's UM team does work closely with the contracted provider groups to encourage usage and promotion of improved programs, such as a direct referral process or auto authorizations. Delegates are monitored through the quarterly utilization management reports where trends are identified and reported to the QOC for advisement.

HEALTH PLAN CUSTOMER SERVICE INFORMATION/HELP

Based on key driver statistical modeling conducted by DSS, the most important areas to focus for improvement in health plan customer services are in getting needed care and courtesy and respect.

The following have been identified as contributing factors to ratings of member satisfaction with health plan customer service:

- Member feedback indicates inconsistency of information; long hold times, multiple transfers, communication and customer service treatment at various touch points of the organization.

- Internal customer service training is limited to the Member Services Department. Other areas such as Utilization Management, Claims and Pharmacy handle customer calls but do not have the benefit of the ongoing customer service training.
- Quality oversight of customer service is only in place in the Member Services Department.
- Multiple touch points through transfer of calls and call back can cause member confusion and dissatisfaction.
- L.A. Care's expansion over the past several years has provided a challenge to staff of keeping pace with membership growth.

L.A. Care continues to hire additional staff for the call center to support the increased call volume. Member Services also performs an internal Quality Review Audits for calls in the unit.

L.A. Care's Member Services Department also has Member Service Specialist/Navigators who are responsible for resolving member coordination of care for complex cases which may involve benefit coordination, continuity of care, access to care, quality of care issues, member eligibility, assignment and disenrollment issues. The specialist/navigator ensures proper and timely handling of member issues.

February 2014, the Member Outreach, Retention and Engagement (M.O.R.E) unit was formed and their mission is to inform, educate, engage, and empower members and create a positive member experience that translates to increased member satisfaction. QI has leveraged the M.O.R.E unit expertise in member call campaigns to improve HEDIS rates.

Member retention committee formed early 2014 as part of the L.A. Care & member strategy:

- One of the focus of the committee, areas is to improve the member experience, as evidenced through CAHPS survey results
- The multi-disciplinary committee is led by Medicare ops, with participation from member services, quality, HO&A, MORE, G&A, Med Ops and other pertinent departments across the organization.

Actions underway & being considered

- A drill down survey for CMC members is to be conducted by an external vendor in February 2015 in order to allow us to understand member specific information regarding access to care, care coordination and customer service – all designed to help us obtain actionable information to improve CAHPS performance on the focus areas for the org (Customer service & access).
- Customer service week education across the organization in November 2014.
- Considering an initiative related to CAHPS awareness, so all L.A. Care employees know when the survey is fielded and ensure exemplary customer service.
- Considering in person customer service training for high volume providers and their staff
- Continue analysis of CAHPS, disenrollment and other data to help us obtain actionable data to improve the overall member experience.

PROVIDER COMMUNICATION AND COORDINATION OF CARE

Provider Attitude and Service is the second largest area of member complaints, however, there was a significant drop in the number of these complaints from 40% of overall complaints in 2013 to 23.3% in 2014. The 2014 overall rating of personal doctor showed 1.7%age point improvement from 2013.

The Cultural and Linguistic Department reported that literacy, language and cultural barriers are inherent in the L.A. Care populations and which often causes frustration, especially when combined with complex medical conditions.

- Focus studies show that members with complex medical needs are frustrated with their experiences and believe they are receiving low-quality medical coverage.
- Member feedback indicates dissatisfaction is often due to their interaction with provider staff.

In March 2013, L.A. Care became one of only 11 health plans in the nation to receive the National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction: (MHC). NCQA ensures excellence in health care and sets the industry benchmark for assessing and improving health quality. It created the MHC to encourage and recognize health care organizations that provide excellent care to diverse and minority populations. This distinction recognizes L.A. Care as an organization that not only meets, but exceeds, NCQA’s rigorous requirements for multicultural health care, while also being a leader in providing culturally and linguistically sensitive services and reducing health care disparities. We will be going through the recertification process for MHC in 2015.

L.A. Care continually provides education for providers regarding cultural sensitivity and the importance of quality customer service. Education is conducted through on-site training, webinars provided by L.A. Care Medical Directors, provider newsletters and the L.A. Care website. Additionally, provider relations conducted customer service training to provider offices in early 2014.

SECTION 4: ADULT MEDICAID CAHPS SURVEY RESULTS AND ANALYSES

METHODOLOGY

The Medicaid Adult CAHPS 5.0H Survey was conducted by DSS Research (DSS), an NCQA-certified vendor contracted by L.A. Care Health Plan (L.A. Care). Results were submitted to NCQA and reported in NCQA’s Quality Compass database. This report summarizes these findings and results are compared to our 2012 and 2013 CAHPS scores, as well as our performance relative to the 2014 National Medicaid HMO (NMA) and California Medicaid HMO Averages (CMA) published by Quality Compass. While this current report focuses on L.A. Care’s response to the Adult CAHPS 5.0H survey findings, L.A. Care also conducted a Child Medicaid CAHPS 5.0H survey in 2014. The findings of both the adult and child surveys are considered in L.A. Care’s assessment of their quality improvement process.

The CAHPS 5.0H Survey targeted potential respondents who are adult members ages 18 and above on the anchor date of December 31, 2013, who were continuously enrolled in L.A. Care Health Plan for at least 6 months as of the anchor date with no more than one enrollment gap of 45 days or less, and who remained members on the anchor date and the date they were actually surveyed. The sample included an NCQA based sample of members assigned to L.A. Care and its sub-contracted health plans, as well as an oversample of 30% to increase the total number of responses available for measures where reporting is sparse. Respondents were surveyed in English and Spanish.

2014 WORK PLAN GOAL:

Overall Ratings	2014 GOAL
Overall Rating: Health Plan Rating	78%
Overall Rating: Health Care Rating	74%
Overall Rating: Personal Doctor Rating	80%
Overall Rating: Specialist Seen Most Often Rating	80%

Composite Scores	2014 GOAL
Composite: Customer Service	79%
Composite: Getting Needed Care	71%
Composite: Getting Care Quickly	75%
Composite: How Well Doctors Communicate	86%

RESULTS

The CAHPS survey includes the following four general overall rating questions designed to distinguish among important aspects of care. Overall ratings are single-question measures rating services on a scale from 0 (worst) to 10 (best) services possible. Response options for rating satisfaction ranged from 0 (worst) to 10 (best). Thus, in the NCQA scoring for overall ratings used in the table below, only ratings of 8, 9 or 10 are considered favorable, and the achievement score is presented as a percentage of members whose response was favorable. NA indicates those measures with insufficient eligible respondents to report.

Overall Rating	Adult Score 2012	Adult Score 2013	Adult Score 2014	NMA 2014	CMA 2014
Health Plan	65.3%	71.1%	75.2%	74.67%	72.33%
All Health Care	64.3%	68.5%	72.7%	71.26%	65.85%
Personal Doctor	73.2%	78.2%	78.8%	78.75%	75.37%
Specialist Seen Most Often	73.8%	78.5%	77.7%	80.42%	77.28%

Composites are indices calculated from multiple CAHPS questions. Questions within each composite ask members how often a positive service experience occurred in the past six months. Respondents have the option to select from “never”, “sometimes”, “usually” and “always”. The scores for composite scores and survey questions throughout this report reflect the percent of responses indicating “usually” or “always”.

Customer Service scores from 2012 were unavailable due to a low response rate, additionally NMA & CMA for customer service composite are not available. NA indicates those measures with insufficient eligible respondents to report.

Composite Scores	Adult Score 2012	Adult Score 2013	Adult Score 2014	NMA** 2013	CMA** 2013
Getting Needed Care	65.9%*	72.0%	77.4%	80.6%	70.8%
Getting Care Quickly	70.9%*	76.0%	76.6%	81.2%	73.5%
How Well Doctors Communicate	84.2%*	85.7%	86.4%	89.3%	84.8%
Customer Service	NA	85.2%	87.3%	NA	NA

*Scores indicate scores that fell below the NCQA Medicaid 25th percentile.

**2014 NMA & CMA not available on Quality Compass, 2013 composite rates used

Quantitative Analysis

L.A. Care scored above the 2014 NMA in all of the Adult Overall Ratings and Composites, except for specialist seen most often, which is lower than the NMA & CMA. Although composite scores have shown year-over-year improvement, they are still below the NMA & CMA. Outside of how well doctors communicate, the 2014 Child CAHPS scores are higher than the adult.

Qualitative Analysis

In 2014, L.A. Care maintained the gains from the 2013 survey, as scores remained relatively flat from 2013 to 2014. There was statistically significant improvement noted for overall rating of health plan and the getting needed care composite.

Getting Needed Care has one of the highest correlations with overall health plan satisfaction and health care they receive. This remains a priority area and evidence that opportunities for improvement exist.

Health Outcomes and Analysis reported that member ratings for getting an appointment with a specialist can be perceived as either an evaluation of the authorization process within the health plan, availability of the specialist in the network, or the time it takes to get an appointment with the specialist.

In 2014, CAHPS' demonstrated that wait times for an appointment with a specialist remained relatively flat from 2013 to 2014, reporting 11.8 days on the average wait days for urgent care and 11.9 average wait days for routine care.

Provider Network Operations reported that the practitioner to member ratio is increasing year over year. This is partly due to membership growth, especially the addition of members in January 2014 due to the Medicaid expansion

L.A. Care forecasts that membership will continue to increase at a faster pace than the addition of provider groups which results in the specialist network not keeping pace with the membership growth. L.A. Care continually strives to maintain and expand its network of contracted specialists and ancillary providers with particular emphasis on contracting with specialists identified in the top utilized specialties for each line of business.

L.A. Care's Utilization Management Department reported that delays in care or treatment are often actual delays with the authorization process, compounded by the members' perception of delay in service. Practitioners often submit incomplete or incorrect requests to the authorizing party. In these instances, requests may be deferred resulting in delays and multiple calls for clarification of the request for additional information. Modifications or denials may be made based on the lack of clinical information or inadequate information submitted by practitioners. These factors do result in delayed service for members. The Utilization Management Department also recognizes there is opportunity for improvement at the delegate level. Utilization Management is diligent in consistently monitoring delegate performance against L.A. Care and regulatory standards. They work closely with the provider groups to encourage usage and promotion of improved programs, such as a direct referral process or auto authorizations.

L.A. Care encourages provider groups/physicians to adopt electronic health records recognizing that the implementation of health information technology at participating clinics might help alleviate some of these problems. In addition, L.A. Care continually provides education for members to help guide their expectations regarding speed-of-access to care, help them understand when to use urgent care and remind them L.A. Care can assist them with making appointment if needed. Education is conducted through member orientation, new member welcome calls, member newsletters, the Family Resource Center, and the L.A. Care website.

L.A. Care's Family Resource Centers continually encourage members to participate in orientation classes to learn how to navigate the health care system and further educate members regarding access to care standards and our overall compliance with those standards. L.A. Care also educates members through the new member benefits package, the L.A. Care website, and the member newsletter.

Getting Care Quickly has a high correlation to member satisfaction. CAHPS results show improvement on satisfaction for accessing appointments for routine and urgent care from 2013 to 2014. Results for Getting Care Quickly evidences this is a priority area where opportunities for improvement exist. Recent focus studies indicate that members are dissatisfied due to delays in getting an appointment with their provider and are often dissatisfied when they are seen by providers other than their regular provider. 2014 CAHPS results show that when members request a routine appointment with their provider the average number of days to wait are 7.6, which is an improvement over 8.7 days average wait in 2014.

Members of the Joint Performance Improvement Collaborative and Physician Quality Committee noted that member dissatisfaction with wait time is often due to members' perception of timeliness. A physician on the committee noted that some members complain that clinics double book; however, this is necessary due to the high no show rate that many clinics experience. The P Joint Performance Improvement Collaborative and Physician Quality Committee agreed that clear communication with the member, along with member education, can help manage member expectations. Another physician noted that the adoption of electronic health records is helpful in tracking wait times to identify reasons for delays and areas for improving member satisfaction.

L.A. Care publishes Member Newsletters biannually that contain educational materials for members including, but not limited to, access to care issues. Provider Newsletters are also published three times a year and include educational materials and tips on accessing care. Members of Executive Community Advisory Committee recommend that L.A. Care members call the doctor's offices in advance to find out if their provider is on time or is running behind schedule. This way, members will know what to expect when they arrive at the provider's office.

How Well Doctors Communicate impacts members' overall satisfaction and has remained consistent over the three year period from 2012 to 2014 with slight upward movement. The Cultural and Linguistic Department reported that literacy; language and cultural barriers are inherent in the L.A. Care populations and cause frustration often resulting in member dissatisfaction surrounding access to care and/or the customer service they receive from their provider. Focus studies show that members with complex medical needs are frustrated with their experiences and believe they are receiving low-quality medical coverage. Members have reported frustration and suggest that office staff receive training on how to treat and communicate with people of different cultures and ethnicities. Members report that they are unaware of free interpreting services although this is highly promoted to the L.A. Care members. The Cultural and Linguistic Department does provide various courses which are designed to facilitate provider/staff and member communication as well as courses specifically for cultural competence and the importance of quality customer service.

The Member Quality Service Committee (MQSC) noted that the CAHPS Adult Medicaid 5.0H survey instrument only rates the "personal doctor" rather than the "personal doctor's staff". Often the members' first point of contact in the provider office is with the staff, and it is not uncommon for members to be treated by the physician extenders, with whom they have their primary relationship. The implementation of a clinical and group survey will provide L.A. Care with a further insight into the members' relationship with the physician office staff.

OPPORTUNITIES

Findings and conclusions in this report are based on our analysis of available data, survey and focus group findings and discussions at the various quality committees, such as the Member Quality Service, Joint Performance Improvement Collaborative/Physician Quality and , Quality Oversight Committees. These committees include an internal cross-departmental representation from departments, such as Quality Improvement, Medical Management, Health Education, C&L, Behavioral Health, Clinical Assurance, Grievances and Appeals, Provider Network Operations, Marketing and Communications and Leadership. There is also external representation from the Joint Performance Improvement Collaborative/Physician Quality Committee, delegated health plans and provider groups. Opportunities for improvement are determined based on conclusions drawn from these meetings. Overall findings include:

- Based on review of the combined complaints data, along with the CAHPS Getting Needed Care and Getting Care Quickly Composites and Access to Care Survey results, Access to Care was identified as the priority area to focus opportunities for improvement.
- Approximately 50% of Access to Care complaints are regarding delays in service, delays in authorizations, and delays in getting appointments with specialists. These delays in service can be reflected in the member's overall CAHPS scores in rating the health plan who authorizes services, the PCP who submits authorizations and the treating specialists.
- There is further evidence in the increasing practitioner to member ratio reported increasing year over year. This is partly due to rapid membership growth and the specialist network not keeping pace with this growth rate. This membership growth is projected to continue to increase at a faster pace than the addition of provider groups.
- It is also recognized that member perception of timeliness can result in complaints and lower results on the CAHPS survey. The Access to Care Survey indicates that L.A. Care, in most instances, does comply with the appointment timeliness and provider availability standards.
- There are common themes in both CAHPS results and the grievance data that indicate that the Getting Needed Care and Getting Care Quickly CAHPS results align with the Access to Care complaints. The CAHPS findings for How Well Doctors Communicate align with complaints regarding Attitude and Service, including language barriers. Improvement in the overall CAHPS scores is reliant upon improvements in all of these areas.

MEMBER SATISFACTION (CAHPS) AND GRIEVANCES AND APPEALS (MEDICARE)

BACKGROUND

L.A. Care Health Plan demonstrates its commitment to improving member satisfaction through an annual assessment of all complaints and appeals, as well as the results from the 2013 Medicare CAHPS 5.0 Member Survey. Results are trended over a three year period. This report contains a quantitative analysis, followed by a qualitative analysis; selection of the top priorities among opportunities identified for improvement and measured effectiveness, where available. The survey is conducted by DSS Research, an NCQA certified vendor. DSS Research conducts key driver statistical modeling to assist L.A. Care in selecting priority measures to target improvements.

The Member Quality Service Committee (MQSC) is the cross-departmental multidisciplinary committee responsible for identifying quality improvement needs, and reports its findings and recommendations to the Quality Oversight Committee (QOC). Information in this report is based on the analysis of available data and survey, as well as discussions at the Quality Oversight and Physician Quality (PQC) Committees.

OBJECTIVE

- Evaluate all registered SNP member complaints and appeals for the Medicare Advantage SNP product.
- Evaluate the 2014 Medicare CAHPS 5.0 survey results
- Conduct a quantitative and qualitative analysis from combined complaints, appeals and CAHPS data.
- Prioritize areas for improvement based on findings.
- Measured effectiveness of priority interventions.

ACCOMPLISHMENTS:

- Received approval to implement a customer service telephone survey

SECTION 1: CLINICAL AND ADMINISTRATIVE COMPLAINTS AND APPEALS

Complaints

METHODOLOGY

L.A. Care Health Plan conducted an analysis of all registered complaints and appeals for the 12 month period October 1, 2013 to September 30, 2014. The complaint data in this report will be reflected as 2014 data. No sampling of data was used. L.A. Care can capture up to three complaint codes per call as often members often have more than one reason to call.

Complaint and Appeals Results

Complaints	2012			2013			2014		
	Count	Rate*	%	Count	Rate*	%	Count	Rate*	%
Attitude & Service	35	1.20	22%	73	1.43	28%	133	1.48	32%
Access to Care	76	2.60	48%	121	2.37	47%	168	1.87	40%
Billing & Finance	28	0.96	18%	24	0.47	9%	11	0.12	3%
Benefits	1	0.03	1%	2	0.04	1%	32	0.36	7%
Quality of Care	16	0.55	10%	34	0.67	13%	70	0.78	17%
Quality of Practitioner Office	3	0.10	2%	4	0.08	2%	1	0.01	.02%
Grand Total	159	5.44	100%	258	5.05	100%	415	4.61	100%

* Rate per thousand members is calculated based on total member months for the measurement period (2012=29,234 member mos.; 2013=51,009 member mos.; and 2014=89,983 member mos.)

- Registered complaints have increased over the three year period; however, the rate per thousand members has remained fairly stable.
- The rate of access to care complaints has increased slightly over the three year period and remains the highest percentage of registered complaints. Approximately 50% of the Access to Care complaints are regarding delays in service, delays in authorization, and specialty access/availability.
- Attitude and Service complaints comprised 32% of overall complaints in 2014 and have gradually increased in rate per thousand since 2012.

- Billing and Finance complaints, where members called with concerns regarding balance billing or charge discrepancy, has decreased over the three year period.
- Quality of Care issues, where members called with concerns regarding refusal of care or prescription, or perceived inappropriate care, have increased since 2012 but remain a small percentage of overall complaints.
- Qualities of a Practitioner’s Office complaints are fairly flat over the past two years and are the lowest percentage of overall complaints.

The following provides a breakdown and summary of total appeals reported by all SNP members for 2012, 2013 and 2014 expressed in count and appeal rate per thousand members:

Appeals	2012			2013			2014		
	Count	Rate*	%	Count	Rate*	%	Count	Rate*	%
Attitude & Service	0	0.00	0%	0	0.00	0%	0	0.00	0%
Access	13	0.44	37%	18	0.35	25%	66	0.73	64%
Billing & Finance	19	0.65	54%	22	0.43	31%	4	0.04	4%
Benefits	3	0.10	9%	30	0.59	42%	12	0.13	12%
Quality of Care	0	0.00	0%	1	0.02	1%	21	0.23	20%
Quality of Practitioner Office	0	0.00	0%	0	0.00	0%	0	0.00	0%
Grand Total	35	1.20	100%	71	1.39	100%	103	1.14	100%

* Rate per thousand members is calculated based on total member months for the measurement period (2012=29,234 member mos.; 2013=51,009 member mos.; and 2014=89,983 member mos.)

- The rate of registered appeals has steadily increased over the three year period; although the rate per thousand members is down in 2014.
- Appeals due to benefit coverage disputes have decreased in volume, rate and percentage followed by Billing/Finance and Access.
- Total appeals for L.A. Care member are typically low due to the all-inclusive benefit package that is provided to the membership.
- There are no trends identified for the overall rates of appeals.

MAPD CAHPS 5.0 RESULTS

METHODOLOGY

This report summarizes findings of the 2014 MAPD CAHPS 5.0 survey and compares the results to the 2012 and 2013 scores as well as our performance relative to the 2014 National Average (NA) from Centers for Medicare and Medicaid Services (CMS).

The MAPD CAHPS Survey targeted potential respondents who are adult SNP members ages 18 and above on the anchor date of December 31, 2013, who were continuously enrolled in L.A. Care Health Plan Medicare Advantage (MA) for at least 6 months as of the anchor date with no more than one enrollment gap of 45 days or less, and who remained members on the anchor date and the date they were actually surveyed. A total of 1,250 surveys were mailed and a total of 373 were completed for a 31.58% response rate, which is a decrease from 46.29% response rate in 2013.

GOAL

L.A. Care met goals for Overall Rating of Personal Doctor. Goals are determined using the NCQA sliding scale for Improvement, as well as analysis of historical performance. L.A. Care did not meet the goals for remaining overall or Composite Scores.

Overall Ratings	Score	Goal	Met
Overall Rating: Health Plan	87.4%	86%	Y
Overall Rating: Care Received	83.6%	87%	N
Overall Rating: Personal Doctor	90.8%	88%	Y
Overall Rating: Specialist Seen Most Often	89.7%	89%	Y
Overall Rating: Rx Drug Coverage	91.9%	92%	Y
Composite Ratings	Score	Goal	Met
Health Plan Customer Service	83.2%	87%	N
Getting Needed Care	74.6%	78%	N
Getting Care Quickly	72.5%	72%	Y
Doctors Who Communicate Well	87.7%	88%	Y
Getting Needed Prescription Drugs	90.4%	89%	Y
Getting Information from the Plan about Rx Drug Coverage	80.6%	80%	Y

OVERALL SCORES

The CAHPS survey includes the following five general overall rating questions designed to distinguish among important aspects of care. These questions ask SNP enrollees to rate their experience in the past 6 months. Response options for rating satisfaction ranged from 0 (worst) to 10 (best). The NCQA scoring for overall ratings used in the table below, ratings of 7, 8, 9 or 10 are considered favorable, and the achievement score is presented as a percentage of members whose response was favorable.

CAHPS Overall Ratings	2012 Score	2013 Score	2014 Score	2014 vs. 2013	2013 CMS Nat'l Avg.
Overall Rating: Health Plan	87.38%	83.67%	87.2%	3.5	88.7%
Overall Rating: Health Care	79.39%	80.44%	83.6%	3.2	87.9%
Overall Rating: Personal Doctor	86.52%	92.35%	90.8%	-1.5	93.6%
Overall Rating: Specialist Seen Most Often	86.67%	83.87%	89.8%	5.9	91.9%
Overall Rating: Rx Drug Coverage	90.94%	88.58%	91.9%	3.3	86.8%

- The 2014 overall health plan score improved from 2013 and is in line with the 2012 score, since a decrease was noted for the 2013 scoring.
 - Approximately 64.2% of respondents scored their health plan 9 or 10 out of a 0 to 10 scale, which is higher than 2013 and significantly higher than 2012.
- The 2013 overall rating of personal doctor increased significantly from 2012; however, in 2014 a slight drop in performance has been noted.
- The 2014 overall rating of Specialist Seen Most Often shows significant improvement from the past two surveys.
- The 2014 overall rating of Rx Drug Coverage shows significant improvement from 2013 and is the only measure that is above the 2012 CMS national average.

COMPOSITE SCORES

The CAHPS survey asks respondents about their experience with various aspects of their care. Survey questions are combined into “composites”. Questions within each composite ask members how often a positive service experience occurred in the past six months. Respondents have the option to select from

“never”, “sometimes”, “usually” and “always”. The scores for composite scores and survey questions throughout this report reflect the percent of responses indicating “usually” or “always”. Composite ratings analyzed include Health Plan Customer Service, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Health Care Services and Getting Needed Prescription Drugs.

Composite Scores	2012 Score	2013 Score	2014 Score	2014 vs. 2013	2013 CMS Nat'l Avg.
Health Plan Customer Service Information/Help	84.71%	84.61%	83.2%	-1.4	90.9%
Getting Needed Care	74.05%	72.87%	74.6%	1.8	90.6%
Getting Care Quickly	65.81%	67.27%	72.5%	5.2	83.4%
Doctors Who Communicate Well	86.75%	87.49%	87.7%	0.2	94.9%
Coordination of Health Care Services	87.09%	84.77%	86.5%	1.7	91.2%
Ease of Getting Prescriptions Filled	90.87%	86.96%	90.4%	3.5	95.9%
Getting Info from Plan/Rx Drug Coverage	77.89%	72.21%	80.6%	8.4	84.7%

- Health plan Customer Service scores have remained fairly flat over the past 3 years.
- Getting Needed Care scores have shown slight improvement since 2013.
- Getting Care Quickly has shown a significant increase from 2014, but Doctors Who Communicate Well scores have remained fairly flat since 2012.
- The 2014 score for Coordination of Health Care Services has shown a slight improvement from 2013.
- Ease of Getting Prescriptions Filled scores have reveals a significant improvement from 2013 to 2014.
- The 2014 composite score for Getting Information about Rx Drug Coverage from the Plan demonstrates significant improvement from the 2013 score.

SECTION II: IDENTIFYING PRIORITY AREAS FOR IMPROVEMENT

Based on the quantitative analysis of complaints and CAHPS results, as well as DSS key driver statistical modeling, the following items have been identified as the priority areas on which to drive the overall health plan rating.

- Access to Care
 - Routine
 - Specialty
- Health Plan Customer Service
 - Courtesy and respect
 - Information/help needed
- Provider/Member Communication
 - Shows respect
 - Spends Time
 - Clearly explains

- Listens carefully
- Has medical records and patient history
- Medicare Part D
 - Gets information from plan/Rx drug coverage
 - Ease of getting prescriptions filled

SECTION III: QUALITATIVE ANALYSES AND KEY DRIVERS

The following provides a qualitative analysis of member satisfaction derived from the quantitative analysis of combined complaints and CAHPS data, as well as feedback from, but not limited to, committee discussion and focus groups.

Health Plan Customer Service Information/Help

Although member complaints do not evidence member dissatisfaction with the health plan customer service, CAHPS scores indicate that there is opportunity for improvement. Based on key driver statistical modeling conducted by DSS, the most important areas to focus for improvement in health plan customer services are in getting needed care and courtesy and respect.

The following have been identified as contributing factors to ratings of member satisfaction with health plan customer service:

- Supplemental data provided from CAHPS respondents indicates that the two top reasons for their rating is that the customer service agent listened but did not help solve the problem, followed by the agent provided suggestions rather than resolution for how to resolve their issue.
- Member feedback indicates inconsistency of information; long hold times, multiple transfers, communication and customer service treatment at various touch points of the organization.
- Internal customer service training is limited to the Member Services Department. Other areas such as Utilization Management, Claims and Pharmacy handle customer calls but do not have the benefit of the ongoing customer service training.
- Quality oversight of customer service is only in place in the Member Services Department.
- Multiple touch points through transfer of calls and call back can cause member confusion and dissatisfaction.
- L.A. Care's expansion over the past several years has provided a challenge to staff of keeping pace with membership growth.

L.A. Care continues to hire additional staff for the call center to support the increased call volume. Member Services performs an internal Quality Review Audit for 100% of the Medicare calls in the unit. Quarterly refresher trainings are in place for Coverage Determination (Part D), Grievance and Appeals for Coverage Determination (Part D), Organizational Determination (Part C), Grievance and Appeals for Organizational Determination (Part C), and Disenrollment and Sales Allegations.

L.A. Care's Member Services Department has Member Service Specialist/Navigators who are responsible for resolving member coordination of care for complex cases which may involve benefit coordination, continuity of care, access to care, quality of care issues, member eligibility, assignment and disenrollment issues. The specialist/navigator ensures proper and timely handling of member issues.

Access to Care

Approximately 50% of the Access to Care complaints are regarding delays in service, delays in authorization, and specialty access/availability. An analysis of CAHPS composite scores for Getting Needed Care and Getting Care Quickly was conducted to further understand the causes of member dissatisfaction complaints. Based on key driver statistical modeling conducted by DSS, the most

important areas to focus for improvement in access to care are in getting routine care, getting seen within 15 minutes of appointment, and getting an appointment with a specialist.

Through discussion and feedback, the following have been identified as possible contributing factors to the members' ratings of access to care:

- An inherent shortage of specialists, especially at the provider group level. L.A. Care does meet the provider to member ratio for the overall network but perhaps there is opportunity for improvement at the delegate level.
- Actual delays in timeliness of processing authorizations.
- Delays with the authorization process due to practitioners submitting incomplete or incorrect requests to the authorizing party resulting in delays and multiple calls for clarification of the request for additional information.
- Limited oversight of delegate's authorization processes.
- Member perception of timeliness.
- Transportation issues traveling to provider offices.

Provider Network Operations examines the individual specialty networks of contracted provider groups quarterly and informs them of any deficiencies in their network. Furthermore, individual attention is paid to referrals to out of network specialists on an as-needed basis in order to ensure member s' needs are continually met.

Future implementation of health information technology at participating clinics might help alleviate some of these problems. In addition, L.A. Care continually provides education for members to help guide their expectations regarding speed-of-access to routine care, help them understand when to use urgent care and remind them L.A. Care can assist them with making appointment if needed. Education is conducted through member orientation, new member welcome calls, member newsletters, the Family Resource Center, and the L.A. Care website.

L.A. Care's UM team does work closely with the contracted provider groups to encourage usage and promotion of improved programs, such as a direct referral process or auto authorizations. Delegates are monitored through the quarterly utilization management reports where trends are identified and reported to the QOC for advisement.

Provider Communication and Coordination of Care

Provider Attitude and Service is the second largest area of member complaints. Approximately one half of the complaints data indicates a complaint with the service provided by provider office staff rather than their physician. The 2014 overall rating of personal doctor showed a slight decrease from 2013. CAHPS respondents reported that 98% of the time, their doctor had medical records/information during their appointment.

The Cultural and Linguistic Department reported that literacy, language and cultural barriers are inherent in the L.A. Care populations and which often causes frustration, especially when combined with complex medical conditions.

- Focus studies show that members with complex medical needs are frustrated with their experiences and believe they are receiving low-quality medical coverage.
- Member feedback indicates dissatisfaction is often due to their interaction with provider staff.

In March 2013, L.A. Care became one of only 11 health plans in the nation to receive the National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction: (MHC). NCQA ensures excellence in health care and sets the industry benchmark for assessing and improving health

quality. It created the MHC to encourage and recognize health care organizations that provide excellent care to diverse and minority populations. This distinction recognizes L.A. Care as an organization that not only meets, but exceeds, NCQA's rigorous requirements for multicultural health care, while also being a leader in providing culturally and linguistically sensitive services and reducing health care disparities.

L.A. Care continually provides education for providers regarding cultural sensitivity and the importance of quality customer service. Education is conducted through on-site training, webinars provided by L.A. Care Medical Directors, provider newsletters and the L.A. Care website.

Medicare Part D

Complaints data evidences billing issues and denial of prescriptions as the source of member complaints regarding their Rx coverage. The CAHPS questions comprising the Medicare Part D CAHPS results provided below provides a clearer indication of issues surrounding members' assessment of pharmacy services.

Based on key driver statistical modeling conducted by DSS, the most important areas to focus for improvement in pharmacy services are in getting information about Rx Drugs from the plan, being treated with courtesy/respect from health plan, understanding which prescriptions are covered, ease of using the plan to get Rx and ease of filling Rx at Pharmacy.

Through discussion and feedback, the following have been identified as contributing factors to the CAHPS results for Medicare Part D:

- CAHPS respondents reported that customer service agents listen and are courteous but do not help solve the problem when calling the plan about a denial of Rx medications, followed by the agents providing suggestions for how to resolve the complaint rather than solve it. This is consistent with the customer service health plan score.
- Members report satisfaction with the plan's drug coverage but they are unclear about what prescriptions are covered. CAHPS respondents reported that the number one reason they have problems getting their prescriptions is that the Rx their doctor prescribes is not covered by the health plan.
- Calls regarding pharmacy issues that are not easily resolved are closed out by the Member Services Department and sent to the Pharmacy Department who, in turn, has to call the member resulting in delay in resolution.
- Pharmacy customer services calls are not handled by trained customer service staff.
- Pharmacy staff not keeping pace with membership growth to handle calls timely.
- CAHPS members report prescriptions not covered, wait time for prescriptions and transportation are the three top issues with pharmacies. Members do report that they prefer to get prescriptions by mail. The CAHPS question Q73 for ease of filling Rx by mail shows a slight increase from 76.19% in 2013 to 76.47% in 2014.

L.A. Care has a step therapy program that takes members through a 90 day transition period. L.A. Care also has pharmacy representatives available 24 hours per day, 7 days per week to address any questions or concerns members may have about their drug plan.

The Member Services Department has implemented an internal Quality Review Audit for 100% of the Medicare calls in the unit. Quarterly refresher trainings started at the same time on Coverage Determination (Part D), Grievance and Appeals for Coverage Determination (Part D).

SECTION 5: CONCLUSIONS AND MEASURING EFFECTIVENESS

L.A. Care Health Plan serves Los Angeles County’s low-income and vulnerable residents. Access to quality healthcare is a challenge for everyone and even more so for individuals with limited English proficiency and low literacy levels combined with complex medical conditions. L.A. Care seeks to provide the highest quality service and access to quality healthcare for this traditionally underserved population.

Problems often have more than one cause, and solutions often have limited scopes of effectiveness. Therefore, mixed solutions work best. So L.A. Care departments design and launch multiple interventions. Focusing on a few feasible targets and launching several interventions over longer, more workable periods of time is a proven strategy under these conditions. This is also the best strategy to increase the likelihood that some combination of these interventions will significantly improve satisfaction scores, and hence improve the quality of services that L.A. Care staff and providers give to our members.

The Member Quality Service Committee (MQSC) is tasked with analyzing and identifying action initiatives for improving member satisfaction.

Based on careful analysis of all themes of results, the following action steps and ongoing improvements are established.

Opportunity	New and/or Ongoing	Action(s) Taken	Measurement of Effectiveness
<u>PRIORITY #1</u>	Improve member’s access to care through stronger collaboration with delegated PPGs		
	<ul style="list-style-type: none"> • Access to specialty care • Care, tests and treatment 		
Collaborate with delegated provider groups to improve Access to Care	New	In 2014, L.A. Care will be visiting with targeted provider groups to discuss outcomes of the Access to Care Study and opportunities for collaborative interventions for improvement.	<ul style="list-style-type: none"> • Improved CAHPS Scores for getting needed care and getting care quickly • Decreased complaints regarding access to care
<u>PRIORITY #2</u>	Improve member’s access to care through stronger collaboration with delegated plans		
	<ul style="list-style-type: none"> • Access to specialty care • Care, tests and treatment 		
Collaborate with sub-contracted health plans, provider groups and select network physicians to improve Access to Care	New	In 2013, L.A. Care did a restructure of committees to develop the Performance Improvement Collaborative Committee, comprised of L.A. Care’s network of sub-contracted health plans, provider groups and select physicians. A focus in 2014 will be to strategize on collaborative initiatives to improve access to care to members.	<ul style="list-style-type: none"> • Improved CAHPS Scores for getting needed care and getting care quickly • Decreased complaints regarding access to care

Opportunity	New and/or Ongoing	Action(s) Taken	Measurement of Effectiveness
<u>PRIORITY #3</u>	Improve member satisfaction with customer service <ul style="list-style-type: none"> • Help needed from customer service • Courtesy and respect 		
Improve Health Plan Customer Service Project	New	<p>A call survey option was developed on October 2013 and began testing in December 2013 where members are asked when contacting L.A. Care’s call center if they will take a short survey. The goal is to affect:</p> <ul style="list-style-type: none"> • Improved service: Knowing that services are being evaluated by members may result in behavioral change. • Added member service: Providing the members an opportunity to have someone call them back provides better service and provides us an opportunity to resolve any open issues the member may have. • Data collection: Survey results provide us information on why members feel they are not getting information they need or not treated 	<ul style="list-style-type: none"> • Results of CAHPS surveys in Spring 2014 • Results from survey to measure improvement month over month
<u>PRIORITY #4</u>	Improve member’s access to specialty care through educating members about the referral/authorization process <ul style="list-style-type: none"> a. Getting care, tests and treatment b. Access to specialty care 		
Getting Needed Care Project	New	<p>In September 2013 a workgroup developed an easy to read educational material that informs members about L.A. Care’s specialty care referral process. The intervention was designed with direct line of business members in mind. The education sheet, in English and Spanish, was distributed to members, providers, and PPGs through</p>	<p>Improved member satisfaction and CAHPS scores in the following Questions:</p> <ul style="list-style-type: none"> • Q25: Always or usually easy to get an appointment with a specialist • Q14: Always or usually get care, tests, or treatments

Opportunity	New and/or Ongoing	Action(s) Taken	Measurement of Effectiveness
		multiple modalities between Octobers to November 2013 and beyond.	<ul style="list-style-type: none"> Decreased complaints regarding access to care
<u>PRIORITY #5</u>	Improve member experience with office visit <ul style="list-style-type: none"> Doctor explains in easy/understandable way Courtesy and respect 		
Letter to members from their assigned PCPs	New	In early 2014, a letter is being sent to Medi-Cal households from their PCP office explaining how they can work as a team to enhance the office visit with the goal of better preparing the member for their visit, improving communication.	Improved member satisfaction and CAHPS scores in provider communication: <ul style="list-style-type: none"> Q32: Always or usually explains things, easy to understand Q33: Always or usually listens carefully to you
<p>Improve access to specialty care</p> <p>Improve efficiency by decreasing unnecessary specialist visits</p>	Ongoing	<p>In January 2013 launched Phase II of an eConsult program allowing PCPs to send, via electronic communication, specific data on their patients to a specialist.</p> <p>Using eConsult, a primary care physician can discuss a patient's condition with a specialist via a referral exchange available through the internet. Treatment instructions can be relayed to the primary care physician eliminating the need to schedule a specialist appointment.</p> <p>The program has produced very positive results for improving member access and provider collaboration</p> <p>In Phase III, eConsult will be rolled out to 65 clinics with a goal of 15,000 eConsults by the end of the phase in July 2013.</p>	<p>In 2013, complaints and appeals data nor CAHPS results reflected measurable improvement. Results of the program, however, are as follows:</p> <p>As of August 2013, 132 sites are live with 1,700 providers, and 29,000 eConsults have been initiated. Between 14% and 17% are closed with the patients' needs having been addressed in the eConsult.</p> <p>The program goal of implementing eConsult at 180 sites by December 31, 2013 is on track. Discussions are underway for the next phase of the program on expanding service to additional L.A. Care members.</p>

Opportunity	New and/or Ongoing	Action(s) Taken	Measurement of Effectiveness
Educate providers/offices on improving customer services	Ongoing	<ul style="list-style-type: none"> • An ongoing program offering in-office Customer Service training provided by Provider Network Operations. • Newsletter articles in Progress Notes about effective communication and educating providers/staff about • Distribute timely access standards to providers annually 	

B.2 ACCESS TO CARE

BACKGROUND

L.A. Care Health Plan monitors its practitioner network accessibility annually to ensure all members have adequate access to primary care, specialty care, behavioral healthcare (where appropriate) and member services. An annual access to care assessment is conducted by The Meyers Group (TMG), an NCQA Certified survey vendor, to measure how well practitioners are adhering to L.A. Care's established access to care standards. Opportunities for improvement are identified and acted upon on an annual basis. Each section of this report contains specific quantifiable goals. The annual behavioral health accessibility analysis is conducted by L.A. Care's contracted NCQA accredited Managed Behavioral Health Organization (MBHO).

Information obtained from the provider access to care assessment allows plans to measure how well their practitioners are adhering to the access standards put in place by the health plan. The Myers Group (TMG) was selected by L.A. Care Health Plan to analyze the results from its 2014 access to care provider assessment survey. This analysis allows L.A. Care Health Plan to assess its PCP and Specialists appointment availability in further detail. L.A. Care's network of providers covers all product lines.

2014 WORK PLAN GOALS: Each section of this report contains specific quantifiable goals.

SECTION 1: APPOINTMENT WAIT TIMES

METHODOLOGY AND RESPONSE RATES

Results were collected using a phone-only survey methodology from November through December of 2014. PCP and high volume specialist offices were contacted to assess many aspects of practitioner accessibility, including the next available appointment dates. This study provides a combination of L.A. Care Covered (Health Benefit Exchange), Medicare and Medi-Cal (includes PASC-SEIU Homecare Workers and Healthy Kids) active PCPs and high volume specialty practitioners, identified by encounters submitted over a 12 month period from **September 01, 2013 thru August 31, 2014**. High volume specialties and those required by regulatory agencies identified for the 2014 survey include Allergy, Cardiology, Dermatology, Endocrinology, Gastroenterology, General Surgery, Hematology, Infectious Disease, Nephrology, Neurology, OB/GYN, OB/Oncology, Ophthalmology, Orthopedic Surgery, ENT, Rhinology, Perinatology, Physical Medicine, Podiatry, Pulmonary Diseases, Radiation/Oncology and Urology.

Appointment types measured include the following:

PCP:

- Urgent (no authorization required)
- Urgent (authorization required)
- Non-urgent (routine primary care) appointments
- Routine well care physical exam
- Initial Health Assessment (IHA)
- First prenatal appointment
- Emergency visits
- After Hours Care

SCP:

- Urgent (no authorization required)
- Urgent (authorization required)
- Non-urgent (routine specialist) visit
- Emergency Visits
- First prenatal appointments
- After Hours Care

L.A. Care submitted two databases to the survey vendor (TMG), one each for PCPs and the high volume specialists. The databases were deduplicated based on provider's full name. Using phone numbers, practitioners were rolled up into one record. The overall response rate and the proportion of respondents who fall into each respondent/non-respondent category are shown in the Table 1 below.

Table 1. Overall Response Rate

Response Breakdown	2014 MEDI-CAL				2014 MEDICARE				2014 LA CARE COVERED			
	PCP		SCP		PCP		SCP		PCP		SCP	
	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Complete call	1823	59	782	39.9	1715	59.5	615	42.5	1626	60.3	585	47.1
Non-complete*	1049	34	741	37.8	524	18.2	469	32.4	871	32.3	434	35
Wrong phone number	12	0.4	73	3.7	206	7.1	198	13.7	12	0.4	40	3.2
Refusal to participate	2	0.1	4	0.2	153	5.3	10	0.7	2	0.1	3	0.2
Ineligible**	202	6.5	359	18.3	285	9.9	155	10.7	184	6.8	179	14.4
TOTAL	3088	100	1959	100	2883	100	1447	100	2695	100	1241	100

*Non-complete is defined as three call attempts (busy, dropped call, no answer or no call back)

**Ineligible includes bad phone number, deceased provider, and language barrier, no longer with plan, on national DO NOT CALL registry, technical phone problems and no eligible respondent.

STATISTICAL SIGNIFICANCE TESTING

Significance testing, which determines if an observed difference is too large to have occurred by chance alone, is provided, where applicable. Focus should be given to those appointment types that show significant changes in compliance rate. *Not significant* denotes that there was insufficient support to conclude that there was a significant difference between compliance percentages, when compared to prior years. *Unable to Test* denotes that there is an insufficient sample size to conduct statistical testing. All significance testing was performed at the 99% confidence level.

RESULTS

Table 2 below provides the compliance rate by type of call, along with year over year comparison. Performance goals are established for each standard. Compliance rate trend data in some measures (indicated by NA) are unavailable due to changes in the survey tool and survey administration methodology in 2014, or the inclusion of a new line of business.

Table 2a. Appointment Type Year-Over-Year Comparison

Access to Care Study	Medi-Cal						Medicare					
PCP Appointment Type	Standard	Work Plan Performance Goal	Compliance Rate			Met Goal	Standard	Work Plan Performance Goal	Compliance Rate			Met Goal
			2014 (n= 1823)	2013 (n=761)	2012 (n=42)				2014 (n= 1715)	2013 (n=172)	2012 (n=42)	
Urgent (no prior auth)	≤ 48 hrs	98.0%	70.4%	93.0%	82.0%	N	≤ 48 hrs	98.0%	71.0%	96.0%	90.0%	N
Urgent (prior auth)	≤ 96 hrs	100.0%	76.0%	N/A	N/A	N	≤ 96 hrs	100.0%	76.7%	N/A	N/A	N
Non-urgent (routine primary care)	≤ 10 bus days	95.0%	89.5%	94.0%	88.0%	N	≤ 10 bus days	95.0%	90.6%	94.0%	100.0%	N
Routine well care physician exam	≤ 10 bus days	95.0%	81.6%	88.1%	91.0%	N	≤ 30 bus days	95.0%	93.4%	98.0%	92.0%	N
Initial Health Assessment (<18 mos)	≤ 60 cal days/elig	100.0%	99.0%	99.2%	N/A	N	N/A	N/A	N/A	N/A	N/A	N/A
Initial Health Assessment (>18 mos)	≤ 120 cal days/elig	100.0%	99.9%	N/A	N/A	Y	≤ 90 cal days/elig	100.0%	99.7%	100.0%	N/A	Y
First prenatal visit	≤ 14 cal days	100.0%	80.0%	100.0%	N/A	N	N/A	N/A	N/A	N/A	N/A	N/A
Specialist Appointment Type	Standard	Work Plan Performance Goal	2014 (n=782)	2013 (n=346)	2012 (n=835)	Met Goal	Standard	Work Plan Performance Goal	2014 (n= 615)	2013 (n= 119)	2012 (n= 567)	Met Goal
Urgent (no auth required)	≤ 48 hrs	100.0%	59.4%	63.0%	N/A	N	≤ 48 hrs	100.0%	60.0%	60.0%	N/A	N
Urgent (auth required)	≤ 96 hrs	100.0%	62.1%	73.0%	N/A	N	≤ 96 hrs	100.0%	61.2%	72.0%	N/A	N
Non-urgent (routine specialty exam)	≤ 15 bus days	95.0%	86.8%	92.0%	85.0%	N	≤ 30 cal days	95.0%	86.8%	92.0%	90.0%	N

The valid n provides the number of respondents who chose to answer the questions.

The Compliance Rate is the sum of the proportion of respondents who meet the appointment availability standards as defined by L.A. Care.

Table 2b. Appointment Availability Year-Over-Year Comparison

Access to Care Study	LA Care Covered					
PCP Appointment Type	Standard	Work Plan Performance Goal	Compliance Rate 2014 2013 2012 (n=1626)			Met Goal
Urgent (no prior auth)	≤ 48 hrs	98.0%	76.4%	N/A	N/A	N
Urgent (prior auth)	≤ 96 hrs	100.0%	70.9%	N/A	N/A	N
Non-urgent (routine primary care)	≤ 10 bus days	95.0%	90.3%	N/A	N/A	N
Routine well care physician exam	≤ 10 bus days	95.0%	82.9%	N/A	N/A	N
Initial Health Assessment (<18 mos)	N/A	N/A	N/A	N/A	N/A	N/A
Initial Health Assessment (>18 mos)	≤ 120 cal days/elig	100.0%	99.9%	N/A	N/A	Y
First prenatal visit	≤ 14 cal days	100.0%	75.0%	N/A	N/A	N
Specialist Appointment Type	Standard	Work Plan Performance Goal	2014 (n=585)	2013	2012	Met Goal
Urgent (no auth required)	≤ 48 hrs	100.0%	60.5%	N/A	N/A	N
Urgent (auth required)	≤ 96 hrs	100.0%	61.9%	N/A	N/A	N
Non-urgent (routine specialty exam)	≤ 15 bus days	95.0%	86.8%	N/A	N/A	N

The valid n provides the number of respondents who chose to answer the questions.

The Compliance Rate is the sum of the proportion of respondents who meet the appointment availability standards as defined by L.A. Care.

Quantitative Analysis

Due to modifications made to the Appointment Availability survey tools for the 2014 study, the survey vendor was unable to provide significance testing. In addition, it is recommended that caution is used when interpreting trend results, because several questions incurred changes in gating, question text, response option text, available response options, etc.

- For the Medi-Cal product, L.A. Care **did not** meet performance goals for:
 - PCP urgent, routine, well care, initial health assessment (<18 mos.) or first prenatal visits
 - SCP urgent or routine care
- For the Medicare product, L.A. Care **did not** meet performance goals for:
 - PCP urgent, routine, well care, initial health assessment (<18 mos.) or first prenatal visits
 - SCP urgent or routine care
- For the the Marketplace (L.A. Care Covered) product, L.A. Care **did not** meet performance goals for:
 - PCP urgent, routine, well care, initial health assessment (<18 mos.) or first prenatal visits
 - SCP urgent or routine care

- Although the performance goal was not met for SCP urgent (no auth. required), the compliance rate for Medicare remained steady from 2013 to 2014.
- Routine specialty care did evidence a slight improvement in both Medi-Cal and Medicare.
- For L.A. Care Covered, the data is baseline for comparison moving forward, as this is a new product line.
- L.A. Care *met* the performance goal for all lines of business for:
 - PCP initial health assessment (>18 mos.)

Qualitative Analysis

L.A. Care did not meet its performance goals for any of the appointment availability measures except Initial Health Assessment (>18 mos.). In addition, it is noted that compliance rates have decreased over the last 2 years.

L.A. Care has identified appointment availability as an opportunity for improvement. It is recognized that non-availability of a member's personal doctor can result in poor customer service, increased emergency room visits and lower satisfaction scores.

Upon receipt of the 2014 survey results, L.A. Care conducted an immediate review at the practice/provider group level (see Tables 3a & b, 4 and 5 below). To address non-compliance, all non-compliant provider groups were issued a Corrective Action Plan (CAP) to determine root-causes for non-compliance, identify actions to bring practice/provider groups into immediate compliance. Provider group Correction Action Plans and root-cause analyses at the practice/provider group level revealed two major themes for causes of non-compliance with the appointment availability standards. These themes are: (1) lack of knowledge of appointment availability requirements at the practice locations; (2) lack of ongoing oversight and monitoring of practice locations.

TABLE 3a: MEDI-CAL RESULTS BY PPG		MEDI-CAL PCP			MEDI-CAL SCP		
PPG Code	PPG	UC (no auth - 98% w/in 48 hrs)	UC (auth - 100% w/in 96 hrs)	ROUTINE (95% w/in 10 bus days)	UC (no auth - 98% w/in 48 hrs)	UC (auth - 100% w/in 96 hrs)	ROUTINE (95% w/in 15 bus days)
ACI	ACCESS IPA	100.0%	100.0%	100.0%	0.0%	100.0%	NA
ACCT	ACCOUNTABLE HEALTH PLAN IPA	77.1%	85.7%	91.9%	75.0%	72.4%	90.0%
AHN	ADVANTAGE HEALTH NETWORK, INC	66.7%	100.0%	100.0%	0.0%	100.0%	100.0%
AHF	AIDS HEALTHCARE FOUNDATION	0.0%	0.0%	66.7%	NA	NA	NA
AKM	AKM MEDICAL GROUP (CAP MGMT)	83.3%	0.0%	100.0%	50.0%	76.5%	94.1%
ACMG	ALL CARE MEDICAL GROUP	57.1%	66.7%	100.0%	NA	100.0%	100.0%
AP	ALLIED PHYSICIANS IPA (NETWORK MED. MGMT)	76.9%	81.0%	89.8%	76.7%	72.5%	86.1%
ALCM	ALPHA CARE MEDICAL GROUP	83.3%	100.0%	100.0%	NA	NA	NA
AMHS	ALTAMED HEALTH SERVICES CORPORATION	73.4%	77.4%	89.5%	75.0%	61.5%	86.7%
AIPA	ANGELES IPA, A MEDICAL CORPORATION	80.6%	76.2%	93.4%	62.5%	70.0%	86.4%
AVMA	ANTELOPE VALLEY MEDICAL ASSOCIATES, INC	NA	NA	100.0%	50.0%	60.0%	100.0%
BCSC	ANTHEM BLUE CROSS	80.6%	87.5%	94.3%	66.7%	68.2%	88.9%
AHI	APOLLO HEALTHCARE INC	90.0%	50.0%	90.0%	NA	NA	NA
APPL	APPLECARE MEDICAL GROUP (DOWNEY, WHITTIER AND SELECT REGION)	75.0%	77.1%	95.3%	44.4%	70.0%	78.1%
AMGS	APPLECARE MEDICAL GROUP ST FRANCIS	73.9%	83.9%	96.6%	55.6%	68.0%	88.9%
ADMG	ARDMORE MED GRP	66.7%	100.0%	100.0%	NA	NA	NA
AVFH	ARROYO VISTA FAM HLTH CTR	100.0%	100.0%	100.0%	NA	NA	NA
AC	ASIAN COMMUNITY MEDICAL GROUP, INC	75.0%	50.0%	100.0%	0.0%	100.0%	100.0%
AHP	ASSOCIATED HISPANIC PHYSICIANS OF SOUTHERN CALIFORNIA	72.1%	90.0%	92.7%	NA	100.0%	100.0%
AXMG	AXMINSTER MEDICAL GROUP	60.0%	NA	80.0%	NA	75.0%	80.0%
BVMG	BELLA VISTA IPA (MEDPOINT MGMT)	81.1%	92.9%	95.5%	60.0%	81.8%	94.6%
CCI	CAL CARE IPA	67.3%	84.2%	97.0%	NA	NA	NA
CFST	CARE 1ST HEALTH PLAN	67.3%	60.0%	95.3%	50.0%	61.5%	90.0%
AMCL	CATALINA ISLAND MEDICAL GROUP	0.0%	0.0%	0.0%	NA	NA	NA
CSMG	CEDARS-SINAI MEDICAL GROUP	NA	NA	NA	NA	NA	NA
CVPG	CITRUS VALLEY PHYSICIANS GROUP	76.0%	77.3%	97.3%	77.8%	58.3%	87.0%
SMI	CLINICA MEDICA SAN MIGUEL IPA, A MEDICAL GROUP, INC	88.9%	100.0%	92.3%	NA	NA	NA
CFC	COMMUNITY FAMILY CARE (CAP MANAGEMENT)	71.1%	80.0%	93.6%	100.0%	61.5%	92.3%
County	County of L.A Dept of Health Services	52.6%	75.0%	56.6%	20.0%	55.6%	46.2%

*NA - Non-eligible due to insufficient response to measure

TABLE 3b: MEDI-CAL RESULTS BY PPG		MEDI-CAL PCP			MEDI-CAL SCP		
PPG Code	PPG	UC (no auth - 98% w/in 48 hrs)	UC (auth - 100% w/in 96 hrs)	ROUTINE (95% w/in 10 bus days)	UC (no auth - 98% w/in 48 hrs)	UC (auth - 100% w/in 96 hrs)	ROUTINE (95% w/in 15 bus days)
CRCM	CROWN CITY MEDICAL GROUP	72.7%	50.0%	92.3%	50.0%	72.2%	81.0%
EMG	EASTLAND MEDICAL GROUP	93.3%	66.7%	95.5%	NA	NA	NA
EPDB	EL PROYECTO DEL BARRIO INC	NA	NA	NA	40.0%	54.2%	76.9%
EHSG	EMPLOYEE HEALTH SYSTEMS MEDICAL GROUP	74.2%	71.9%	92.7%	80.0%	71.9%	90.8%
ECMG	EXCEPTIONAL CARE MEDICAL GROUP	84.6%	82.1%	94.2%	64.3%	63.2%	85.1%
FCS	FAMILY CARE SPECIALISTS MEDICAL GROUP	93.3%	100.0%	95.5%	33.3%	59.1%	95.5%
FHA	FAMILY HEALTH ALLIANCE MEDICAL GROUP	90.9%	62.5%	100.0%	NA	NA	NA
GCMG	GLOBAL CARE IPA (MEDPOINT MGMT)	70.0%	84.6%	91.2%	74.1%	67.5%	86.6%
HCLA	HEALTH CARE LA, IPA (MEDPOINT MGMT)	73.0%	71.4%	80.5%	68.0%	61.3%	82.6%
HCPM	HEALTHCARE PARTNERS MEDICAL GROUP	70.1%	71.2%	90.0%	68.4%	59.0%	86.8%
HNLM	HEALTHY NEW LIFE MEDICAL CORPORATION	57.1%	100.0%	100.0%	NA	NA	NA
HMG	HERITAGE MEDICAL GROUP	77.0%	80.8%	92.9%	61.3%	59.9%	85.9%
HD	HIGH DESERT MEDICAL GROUP	60.0%	100.0%	75.0%	NA	NA	NA
HPIP	HISPANIC PHYSICIAN IPA	84.2%	42.9%	96.3%	NA	NA	NA
KPMG	KARING PHYSICIANS MEDICAL GROUP, INC	75.0%	66.7%	100.0%	NA	100.0%	100.0%
LMG	LA SALLE MEDICAL GROUP	75.0%	66.7%	71.4%	NA	75.0%	100.0%
LAKE	LAKESIDE MEDICAL GROUP	69.7%	69.0%	90.1%	40.0%	34.6%	78.8%
LAMC	LOS ANGELES MEDICAL CENTER IPA	78.4%	60.0%	95.7%	NA	NA	NA
MCMG	MISSION IPA	63.6%	83.3%	78.6%	NA	NA	NA
NWHC	NEW WATTS HEALTH CENTER	NA	NA	100.0%	62.6%	65.3%	88.4%
NCMA	NOBLE COMMUNITY MEDICAL ASSOCIATES	75.0%	66.7%	93.3%	66.7%	33.3%	100.0%
OMNI	OMNICARE MEDICAL GROUP	84.3%	70.0%	95.1%	87.5%	76.0%	89.7%
PH	PHYSICIANS HEALTHWAYS MEDICAL GROUP, INC	81.6%	82.5%	94.2%	NA	100.0%	87.5%
PPN	PIONEER PROVIDER NETWORK, A MEDICAL GROUP, INC	66.7%	NA	100.0%	NA	NA	NA
PVMG	POMONA VALLEY MEDICAL GROUP	69.4%	100.0%	96.7%	75.0%	50.0%	80.0%
PIPA	PREFERRED IPA OF CALIFORNIA	76.4%	72.4%	95.1%	63.2%	76.5%	87.1%
FRMG	PREMIER PHYSICIAN NETWORK	84.4%	100.0%	95.6%	NA	NA	NA
PROV	PROSPECT MEDICAL GROUP	77.5%	89.6%	90.6%	54.3%	61.5%	87.5%
REMG	REGAL MEDICAL GROUP	72.9%	78.9%	92.4%	NA	NA	NA
RMG	REGENT MEDICAL GROUP (HEALTHSMART MSO)	100.0%	100.0%	100.0%	50.0%	70.8%	86.2%
SJMG	SAN JUDAS MEDICAL GROUP	100.0%	NA	100.0%	NA	NA	100.0%
SEA	SEASIDE HEALTH PLAN	68.6%	100.0%	97.6%	NA	NA	NA
SLMG	SEOUL MEDICAL GROUP	85.7%	100.0%	100.0%	100.0%	66.7%	100.0%
SCMC	SERRA COMMUNITY MEDICAL CLINIC	100.0%	0.0%	100.0%	66.7%	66.7%	100.0%
SIMG	SIERRA MEDICAL GROUP	50.0%	100.0%	100.0%	NA	NA	NA
SCCH	SO CAL CHILDRENS	89.5%	75.0%	91.7%	NA	100.0%	100.0%
SAMG	SOUTH ATLANTIC MEDICAL GROUP	75.0%	66.7%	94.7%	NA	NA	100.0%
SSG	SOUTHLAND SAN GABRIEL VALLEY MEDICAL GROUP, INC	94.7%	100.0%	96.0%	NA	0.0%	100.0%
SVIP	ST VINCENT IPA	81.8%	78.9%	93.3%	66.7%	93.8%	100.0%
SPMG	ST. PETER MEDICAL GROUP, INC. (HEALTHSMART MSO)	50.0%	100.0%	100.0%	NA	NA	100.0%
SC	SUPERIOR CHOICE MEDICAL GROUP, INC	NA	NA	NA	66.7%	76.9%	83.3%
TMG	TALBERT MEDICAL GROUP	58.1%	82.4%	80.4%	33.3%	25.0%	66.7%
UCLA	UCLA MEDICAL GROUP	100.0%	NA	0.0%	38.9%	34.8%	68.1%
UCMG	UNIVERSAL CARE MEDICAL GROUP	0.0%	NA	100.0%	NA	50.0%	100.0%

*NA - Non-eligible due to insufficient response to measure

TABLE 4: MEDICARE RESULTS BY PPG		MEDICARE PCP			MEDICARE SCP		
PPGCode	PPG	UC: No Auth 48 hrs (100%)	UC: Auth 96 hrs (100%)	Routine: 15 Days (95%)	UC: No Auth 48 hrs (100%)	UC: Auth 96 hrs (100%)	Routine: 15 Days (95%)
ACCT	ACCOUNTABLE HEALTH PLAN IPA	82.6%	80.0%	89.3%	100.0%	100.0%	100.0%
AHF	AIDS HEALTHCARE FOUNDATION	0.0%	0.0%	66.7%	NA	NA	NA
AIPA	ANGELES IPA, A MEDICAL CORPORATION	81.1%	74.3%	93.9%	71.4%	68.8%	91.7%
AKM	AKM MEDICAL GROUP (CAP MGMT)	83.3%	0.0%	100.0%	33.3%	75.0%	93.8%
AMGS	APPLECARE MEDICAL GROUP ST FRANCIS	73.3%	83.3%	96.6%	55.6%	68.0%	88.9%
AMHS	ALTAMED HEALTH SERVICES CORPORATION	76.3%	80.8%	87.6%	72.7%	60.5%	86.4%
AP	ALLIED PHYSICIANS IPA	74.8%	80.4%	88.2%	76.0%	69.2%	83.1%
APPL	APPLECARE MEDICAL GROUP (DOWNEY, WHITTIER AND SELECT REGION)	74.3%	78.1%	95.2%	44.4%	71.0%	78.8%
AVMA	ANTELOPE VALLEY MEDICAL ASSOCIATES, INC	NA	NA	NA	NA	50.0%	100.0%
AXMG	AXMINSTER MEDICAL GROUP	60.0%	NA	80.0%	NA	75.0%	75.0%
BVMG	BELLA VISTA IPA (MEDPOINT MGMT)	82.9%	92.3%	95.1%	60.0%	85.2%	93.5%
CFC	COMMUNITY FAMILY CARE (CAP MANAGEMENT)	71.2%	76.5%	92.8%	100.0%	66.7%	91.7%
CRCM	CROWN CITY MEDICAL GROUP	66.7%	100.0%	85.7%	50.0%	70.6%	80.0%
CVPG	CITRUS VALLEY PHYSICIANS GROUP	75.0%	77.3%	97.3%	73.7%	61.1%	84.4%
ECMG	EXCEPTIONAL CARE MEDICAL GROUP	87.5%	93.8%	92.7%	63.0%	64.3%	84.4%
EHSG	EMPLOYEE HEALTH SYSTEMS MEDICAL GROUP	74.2%	73.0%	92.6%	92.9%	74.3%	93.8%
EPDB	EL PROYECTO DEL BARRIO INC	NA	NA	0.0%	40.0%	59.1%	75.0%
FCS	FAMILY CARE SPECIALISTS MEDICAL GROUP	93.3%	100.0%	95.5%	33.3%	60.0%	95.0%
GCMG	GLOBAL CARE IPA (MEDPOINT MGMT)	70.5%	83.3%	90.9%	70.8%	64.7%	84.0%
HCLA	HEALTH CARE LA, IPA (MEDPOINT MGMT)	73.6%	73.2%	80.2%	83.3%	59.2%	83.7%
HCPM	HEALTHCARE PARTNERS MEDICAL GROUP	70.1%	72.5%	90.3%	65.0%	59.7%	86.8%
HD	HIGH DESERT MEDICAL GROUP	60.0%	100.0%	75.0%	72.7%	50.0%	90.6%
HMG	HERITAGE MEDICAL GROUP	76.7%	80.4%	92.6%	60.0%	60.2%	86.5%
LAKE	LAKESIDE MEDICAL GROUP	69.9%	69.0%	90.2%	25.0%	36.8%	85.7%
OMNI	OMNICARE MEDICAL GROUP	86.4%	70.0%	94.3%	58.9%	56.2%	81.6%
PH	PHYSICIANS HEALTHWAYS MEDICAL GROUP, INC	81.7%	80.4%	94.2%	87.5%	76.0%	90.0%
PIPA	PREFERRED IPA OF CALIFORNIA	74.4%	69.7%	95.8%	NA	100.0%	83.3%
PPN	PIONEER PROVIDER NETWORK, A MEDICAL GROUP, INC	66.7%	NA	100.0%	68.8%	73.7%	84.0%
PROV	PROSPECT MEDICAL GROUP	78.0%	91.5%	91.0%	54.5%	61.8%	81.0%
PVMG	POMONA VALLEY MEDICAL GROUP	70.8%	100.0%	96.7%	75.0%	54.5%	81.3%
REMG	REGAL MEDICAL GROUP	72.8%	78.8%	92.2%	60.7%	59.7%	86.8%
SAMG	SOUTH ATLANTIC MEDICAL GROUP	75.0%	72.4%	95.2%	NA	NA	100.0%
SEA	SEASIDE HEALTH PLAN	57.1%	100.0%	100.0%	50.0%	50.0%	100.0%
SIMG	SIERRA MEDICAL GROUP	66.7%	100.0%	100.0%	44.4%	43.8%	94.7%
SLMG	SEOUL MEDICAL GROUP	58.7%	100.0%	100.0%	100.0%	66.7%	100.0%
SVIP	ST VINCENT IPA	81.5%	78.9%	93.4%	66.7%	93.8%	100.0%
TMG	TALBERT MEDICAL GROUP	58.1%	82.4%	80.4%	33.3%	25.0%	66.7%
UCMG	UNIVERSAL CARE MEDICAL GROUP	50.0%	NA	100.0%	NA	66.7%	100.0%

NA - Non-eligible due to insufficient responses to measure

TABLE 5: L.A. Care Covered RESULTS BY PPG		L.A. Care Covered PCP			L.A. Care Covered SCP		
PPGCode	PPG	UC: No Auth 48 hrs (100%)	UC: Auth 96 hrs (100%)	Routine: 15 Days (95%)	UC: No Auth 48 hrs (100%)	UC: Auth 96 hrs (100%)	Routine: 15 Days (95%)
AMGS	APPLECARE MEDICAL GROUP ST FRANCIS	74.7%	83.9%	96.6%	55.6%	66.7%	88.5%
AMHS	ALTAMED HEALTH SERVICES CORPORATION	75.6%	80.8%	87.9%	75.0%	61.5%	86.7%
AP	ALLIED PHYSICIANS IPA (NETWORK MED. MGMT)	74.4%	80.4%	88.2%	79.2%	69.8%	84.3%
APPL	APPLECARE MEDICAL GROUP (DOWNEY, WHITTIER AND	74.3%	78.1%	95.2%	44.4%	70.0%	78.1%
AXMG	AXMINSTER MEDICAL GROUP	80.0%	NA	80.0%	NA	75.0%	75.0%
BVMG	BELLA VISTA IPA (MEDPOINT MGMT)	100.0%	100.0%	100.0%	NA	NA	NA
CVPG	CITRUS VALLEY PHYSICIANS GROUP	76.0%	77.3%	97.3%	77.8%	60.0%	84.4%
FCS	FAMILY CARE SPECIALISTS MEDICAL GROUP	93.3%	100.0%	95.5%	25.0%	62.5%	93.8%
GCMG	GLOBAL CARE IPA (MEDPOINT MGMT)	72.4%	83.3%	90.7%	72.0%	65.2%	85.4%
HCLA	HEALTH CARE LA, IPA (MEDPOINT MGMT)	72.6%	73.2%	80.3%	78.9%	59.0%	84.0%
HCPM	HEALTHCARE PARTNERS MEDICAL GROUP	70.2%	72.7%	90.3%	68.4%	59.0%	86.8%
HD	HIGH DESERT MEDICAL GROUP	60.0%	100.0%	75.0%	72.7%	50.0%	90.6%
HMG	HERITAGE MEDICAL GROUP	71.6%	76.1%	91.8%	60.4%	60.5%	86.7%
LAKE	LAKESIDE MEDICAL GROUP	69.9%	69.0%	90.2%	NA	NA	NA
OMNI	OMNICARE MEDICAL GROUP	85.7%	66.7%	94.1%	60.3%	56.3%	81.1%
PH	PHYSICIANS HEALTHWAYS MEDICAL GROUP, INC	82.2%	80.4%	93.8%	NA	100.0%	87.5%
PIPA	PREFERRED IPA OF CALIFORNIA	78.0%	70.0%	96.6%	70.6%	74.4%	86.0%
PROV	PROSPECT MEDICAL GROUP	78.0%	91.3%	90.9%	54.5%	61.8%	81.0%
PVMG	POMONA VALLEY MEDICAL GROUP	71.1%	100.0%	98.2%	75.0%	50.0%	80.0%
REMG	REGAL MEDICAL GROUP	72.9%	78.3%	92.1%	61.6%	59.8%	86.4%
SIMG	SIERRA MEDICAL GROUP	66.7%	100.0%	100.0%	44.4%	43.8%	94.7%
SLMG	SEOUL MEDICAL GROUP	83.3%	100.0%	100.0%	100.0%	66.7%	100.0%
TMG	TALBERT MEDICAL GROUP	57.1%	82.4%	80.4%	33.3%	25.0%	66.7%

NA - Non-eligible due to insufficient responses to measure

In order to further validate and understand the Member experience in relation to appointment availability, L.A. Care conducted an assessment comparing the 2014 Access to Care Survey results with specific CAHPS (member satisfaction) questions addressing urgent and routine appointments, as outlined in Table 6 below.

Table 6. CAHPS

CAHPS (% of Answers "Usually or Always")	Performance Goal	CHILD CAHPS			ADULT CAHPS			MEDICARE CAHPS		
		2014	2013	2012	2014	2013	2012	2014	2013	2012
PCP Routine Appointment	85%	81.3%*	75.6%	NA	72.9%	72%	69%	79.43%	80%	77%
PCP Urgent Care	83%	82.9%	87%	80%	80.3%	80%	73%	89.83%*	76%	76%
Specialist Routine Appointment	82%	75.7%	72.6%	74%	78.4%	75%	61%	72.73%	67%	74%

NA indicates there were too few responses to report.

* Significant decrease or increase over 2013 score.

Member satisfaction with getting timely urgent appointments showed improvement in Medicare from 2014. Timely access for urgent care dropped back toward baseline for Child Medi-Cal CAHPS, but remained improved for Adult Medi-Cal CAHPS. Timeliness of access for urgent Medicare improved significantly over 2014. Access time for routine appointments improved significantly for children, but remained flat for Medicaid and Medicare adults. Access to specialist appointments was flat for children, but continues to improve for Medicaid adults from a low score in 2012, although this improvement remains non-significant.

Supplemental questions on the Medi-Cal Adult and Child CAHPS asked members to state the typical number of days between making an appointment and seeing their physician for routine and urgent appointments. Table 7 below provides the average days reported. Equivalent data is not available for the Medicare product due to CMS limits on the number of questions that L.A. Care can add to the Medicare CAHPS tool (see table below).

Table 7. Average Days Between Making Appointments for Specialists

Average days between making appointment and seeing specialist	MEDI-CAL											
	PCP						SCP					
	Adult CAHPS			Child CAHPS			Adult CAHPS			Child CAHPS		
	2014	2013	2012	2014	2013	2012	2014	2013	2012	2014	2013	2012
Routine Appointment	7.61	8.7	7.8	2.87	3.9	2.5	11.98	12.2	13.3	5.98	7.6	3.9
Urgent Appointment	5.28	6.3	4.6	1.45	1.6	1.9	11.85	12.8	13.8	5.4	7.4	4.9

Average wait days for routine appointments is within established standards for both product lines, as is urgent care for PCP child. Average SCP appointments are within established standards for both Adult and Child. Urgent care; however, for PCP adult and SCP adult and child do not meet established standards, indicating an opportunity for improvement.

Complaint data for both Medicare and Medi-Cal evidence that approximately 45% of complaints pertain to access to care, with approximately 50% of those access to care complaints resulting from delays in service, delays in authorization, and specialty access/availability. This again evidences opportunities for improvement, especially for specialist appointments.

SECTION 2: PCP AND SPECIALISTS AFTER HOURS STUDY

BACKGROUND

Information obtained from the practitioner after-hours access to care assessment measures how well practitioners are adhering to the L.A. Care’s established after hours access standards. Based on the response to each survey questions and the access standard set, the provider is categorized as being either compliant or non-compliant. L.A. Care’s primary network serves L.A. Care Covered (The Marketplace), Medicare and Medi-Cal (PASC-SEIU Homecare Workers and Healthy Kids) product lines and established standards are consistent. All PCPs and high volume SCPs were surveyed.

METHODOLOGY AND RESPONSE RATES

Results were collected using a phone-only survey methodology from November through December of 2014. Provider offices were surveyed during closed office hours (early morning, evening or weekend hours).

L.A. Care Health Plan requires that primary care physicians, or designated on-call licensed practitioners, be available to coordinate patient care beyond normal business hours. To achieve after hours compliance, PCPs/ high volume SCPs must utilize one of the following systems and meet the requirements as outlined:

- A. Automated systems
 - Must provide emergency instructions
 - Offer a reasonable process to contact the PCP, covering practitioner or other "live" party
 - If process does not enable the caller to contact the PCP or covering practitioner directly, the "live" party must have access to a practitioner for both urgent and non-urgent calls.
- B. Professional exchange staff
 - Must provide process for emergency calls
 - Must have access to practitioner for both urgent and non-urgent calls.
- C. To achieve after hours timeliness compliance, PCPs/ high volume SCPs must return a member's call within 30 minutes

L.A. Care submitted a complete database of L.A. Care's network of primary care and high volume specialty care practitioners. The database was de-duplicated based on provider full name and address. Using address and phone number, up to five practitioners were rolled up into one record. The overall response rate and the proportion of respondents who fall into each respondent/non-respondent category are shown in the tables below.

Table 8a. Medi-Cal Overall Response Rate

Response Breakdown	2014 MEDI-CAL				2013 MEDI-CAL			
	PCP		SCP		PCP		SCP	
	Count	%	Count	%	Count	%	Count	%
Complete call	2745	85.1%	1573	76.4%	777	39%	366	30%
Non-complete*	379	11.7%	357	17.3%	1066	53%	503	41%
Wrong phone number	49	1.5%	63	3.1%	107	5%	266	22%
Refusal to participate	4	0.1%	2	0.1%	0	0%	0	0%
Ineligible**	50	1.5%	64	3.1%	54	3%	97	8%
TOTAL	3227	100%	2059	100%	2004	100%	1232	100%

Table 8b. Medicare Overall Response Rate

Response Breakdown	2014 MEDICARE				2013 MEDICARE			
	PCP		SCP		PCP		SCP	
	Count	%	Count	%	Count	%	Count	%
Complete call	1715	59.5	615	42.5	177	34%	120	34%
Non-complete*	524	18.2	469	32.4	277	53%	132	38%
Wrong phone number	206	7.1	198	13.7	23	4%	57	16%
Refusal to participate	153	5.3	10	0.7	0	0%	0	0%
Ineligible**	285	9.9	155	10.7	44	8%	43	12%
TOTAL	2883	100	1447	100	521	100%	352	100%

Table 8c. The Marketplace (LA Care Covered) Overall Response Rate

Response Breakdown	2014 LA CARE COVERED			
	PCP		SCP	
	Count	%	Count	%
Complete call	2413	86.2	964	77.6
Non-complete*	301	10.8	201	16.2
Wrong phone number	47	1.7	38	3.1
Refusal to participate	4	0.1	0	0
Ineligible**	35	1.3	40	3.2
TOTAL	2800	100	1243	100

*Non-complete is defined as three call attempts (busy, dropped call, no answer or no call back)

**Ineligible includes bad phone number, deceased provider, and language barrier, no longer with plan; on national DO NOT CALL registry, technical phone problems and no eligible respondent.

- Based on the provider’s response to each survey question and the established access standard, the provider is categorized as being either compliant or non-compliant.

RESULTS

The following tables provides the after hours compliance rate along with year over year comparison. Performance goals are established for each standard. Compliance rate trend data in some measures (indicated by NA) are unavailable due to the inclusion of a new line of business.

Table 9a. PCP/SCP After Hours Access Year-Over-Year Comparison

PCP/SCP After Hours Access to Care Results to Goal Comparison					
Year	Medi-Cal Rate	Medicare Rate	LA Care Covered	Goal	Goal Met
2012	82%	82%	N/A	92%	No
2013	70%	70%	N/A	92%	No
2014	64.3%	65.5%	65.5%	92%	No

Table 9b. PCP/SCP After Hours Timeliness Year-Over-Year Comparison

PCP/SCP After Hours Access to Care Timeliness Results to Goal Comparison					
Year	Medi-Cal Rate	Medicare Rate	LA Care Covered	Goal	Goal Met
2012	82%	82%	N/A	92%	No
2013	70%	70%	N/A	92%	No
2014	48.2%	51.4%	51.2%	92%	No

Individual scores are calculated for the number of provider offices that offer compliant emergency instructions to callers and the number/percentage of offices with adequate means of reaching the on-call practitioner. In addition, provider offices are measured for compliance with the after hours timeliness standard, which measures whether the PCPs/ high volume SCPs returned a member's call within 30 minutes. A score is provided to all provider groups.

Quantitative Analysis

Access

Medi-Cal

- A compliance rate of **64.3%** for after-hours access to physicians utilizing either an automated system or professional exchange staff for measurement year 2014.
 - **Goal not met for 3 consecutive years.**
- It is noted that compliance rates have decreased over the last 3 years.

Medicare

- A compliance rate of **65.5%** for after-hours access to physicians utilizing either an automated system or professional exchange staff for measurement year 2014.
 - **Goal not met for 3 consecutive years.**
- It is noted that compliance rates have decreased over the last 3 years.

The Marketplace (L.A. Care Covered)

- A compliance rate of **65.5%** for after-hours access to physicians utilizing either an automated system or professional exchange staff for measurement year 2014.
 - **Baseline data for comparison moving forward.**
- No trending data available due to new product line.

Timeliness

Medi-Cal

- A compliance rate of **48.2%** for after-hours timeliness of physician response within 30 minutes for measurement year 2014.
 - **Goal not met for 3 consecutive years.**
- It is noted that compliance rates have decreased over the last 3 years.

Medicare

- A compliance rate of **51.4%** for after-hours timeliness of physician response within 30 minutes for measurement year 2014.
 - **Goal not met for 3 consecutive years.**
- It is noted that compliance rates have decreased over the last 3 years.

The Marketplace (L.A. Care Covered)

- A compliance rate of **51.2%** for after-hours timeliness of physician response within 30 minutes for measurement year 2014.
 - **Baseline data for comparison moving forward.**
- No trending data available due to new product line.

For the Medi-Cal and Medicare lines of business, it is noted that compliance rates are consistent across both lines of business. This is most likely due to most Medicare members also being Medi-Cal members due to the crossover of providers serving both populations.

Qualitative Analysis

L.A. Care did not meet its performance goals for After Hours access and timeliness. In addition, it is noted that compliance rates have decreased over the last 3 years. Upon receipt of the 2014 survey results, L.A. Care conducted an immediate review at the practice/provider group level (see Table 4 below). All non-compliant provider groups were issued an Immediate Corrective Action Response (ICAR) to address deficiencies, determine root-causes for non-compliance, and provide actions to bring providers into immediate compliance. Provider group Immediate Correction Action Responses and root-cause analyses at the practice/provider group level revealed five (5) major themes for causes of non-compliance with the appointment availability (after hours) standards. These themes are as follows:

- **Lack of Provider Education:** Practitioners do not realize that their exchange services or automated systems are non-compliant with L.A. Care's standard.
- **Poor Exchange Staff Training:** Staff at exchange services lacks adequate information on the practitioners they represent, or they lack the ability to adequately search these data.
- **Misunderstanding of Provider Responsibility:** Practitioners don't believe that they are responsible for access to care beyond normal business hours.
- **Lack of Provider Resources:** Practitioners do not have sufficient staff or financial resources to provide compliant after hours systems.
- **Lack of continuous oversight & monitoring measures to ensure compliance**

L.A. Care has identified after-hours access as an opportunity for improvement. It is recognized that non-availability of a member's personal doctor can result in poor customer service, increased emergency room visits and lower satisfaction scores.

Table 4a: Provider Group After Hours Compliance Results - Mcal

PPG Name	Total PCPs	Total PCPs Surveyed	Response Rate	Total Compliant Access	Total Compliant Timeliness	Overall Access Compliance	Overall Timeliness Compliance
CATALINA ISLAND MEDICAL GROUP	3	3	100.0%	100	0	100.0%	0.0%
SEOUL MEDICAL GROUP	15	12	80.0%	11	8	90.5%	66.7%
APOLLO HEALTHCARE INC	52	47	90.4%	41	36	87.2%	76.6%
AIDS HEALTHCARE FOUNDATION	9	7	77.8%	6	0	85.7%	0.0%
HIGH DESERT MEDICAL GROUP	29	27	93.1%	23	18	85.2%	66.7%
KARING PHYSICIANS MEDICAL GROUP, INC	22	20	90.9%	18	13	83.3%	58.3%
LA SALLE MEDICAL GROUP	56	47	83.9%	37	32	83.1%	64.4%
AKM MEDICAL GROUP (CAP MGMT)	28	14	50.0%	12	11	82.5%	52.5%
SERRA COMMUNITY MEDICAL CLINIC	9	9	100.0%	9	9	81.3%	75.0%
CAL CARE IPA	96	85	88.5%	69	49	81.2%	57.6%
APPLECARE MEDICAL GROUP ST FRANCIS	165	140	84.8%	114	85	81.0%	60.9%
APPLECARE MEDICAL GROUP (DOWNEY, WHITTIER AND SELECT	239	199	83.3%	163	116	80.9%	59.9%
ASIAN COMMUNITY MEDICAL GROUP, INC. (HEALTHSMART	19	17	89.5%	14	8	78.3%	39.1%
TALBERT MEDICAL GROUP	120	84	70.0%	67	41	77.5%	55.9%
ANGELES IPA, A MEDICAL CORPORATION	470	222	47.2%	179	115	76.0%	51.0%
EASTLAND MEDICAL GROUP	61	53	86.9%	40	34	75.5%	64.2%
LOS ANGELES MEDICAL CENTER IPA	65	49	75.4%	37	27	75.5%	55.1%
PREMIER PHYSICIAN NETWORK	80	69	86.3%	52	34	75.4%	49.9%
ACCESS IPA	17	14	82.4%	10	7	75.0%	43.8%
HISPANIC PHYSICIAN IPA	37	32	86.5%	24	20	75.0%	62.5%
MISSION IPA	16	15	93.8%	11	6	75.0%	37.5%
SAN JUDAS MEDICAL GROUP	4	3	75.0%	3	3	75.0%	75.0%
ST. PETER MEDICAL GROUP, INC. (HEALTHSMART MSO)	9	6	66.7%	5	2	75.0%	37.5%
PHYSICIANS HEALTHWAYS MEDICAL GROUP, INC	371	312	84.1%	235	164	74.9%	52.6%
ACCOUNTABLE HEALTH PLAN IPA	480	393	81.9%	300	190	74.7%	48.4%
LAKESIDE MEDICAL GROUP	332	279	84.0%	208	135	74.6%	48.4%
FAMILY HEALTH ALLIANCE MEDICAL GROUP	24	21	87.5%	15	11	73.9%	56.5%
REGAL MEDICAL GROUP	926	766	82.7%	559	375	73.0%	49.0%
EMPLOYEE HEALTH SYSTEMS MEDICAL GROUP	844	383	45.4%	291	192	72.9%	48.9%
ALL CARE MEDICAL GROUP	10	10	100.0%	8	5	72.7%	45.5%
<i>N/A - Non-eligible due to insufficient responses to measure</i>							

Table 4b: Provider Group After Hours Compliance Results - Mcal

PPG Name	Total PCPs	Total PCPs Surveyed	Response Rate	Total Compliant Access	Total Compliant Timeliness	Overall Access Compliance	Overall Timeliness Compliance
UNIVERSAL CARE MEDICAL GROUP	1	1	100.0%	0	1	72.7%	54.5%
POMONA VALLEY MEDICAL GROUP	101	92	91.1%	64	55	72.2%	61.7%
PREFERRED IPA OF CALIFORNIA	795	346	43.5%	248	179	71.8%	49.9%
CITRUS VALLEY PHYSICIANS GROUP	209	92	44.0%	69	52	71.6%	57.4%
CLINICA MEDICA SAN MIGUEL IPA, A MEDICAL GROUP, INC	23	14	60.9%	10	8	71.4%	57.1%
ST VINCENT IPA	133	114	85.7%	77	56	71.1%	47.4%
SO CAL CHILDRENS	35	28	80.0%	19	13	70.0%	43.3%
ANTHEM BLUE CROSS	137	114	83.2%	91	59	69.5%	48.5%
NOBLE COMMUNITY MEDICAL ASSOCIATES	20	15	75.0%	13	5	69.4%	33.3%
ASSOCIATED HISPANIC PHYSICIANS OF SOUTHERN CALIFOR	76	66	86.8%	45	33	69.1%	50.0%
ALLIED PHYSICIANS IPA (NETWORK MED. MGMT)	607	288	47.4%	207	156	69.0%	50.8%
SOUTH ATLANTIC MEDICAL GROUP	106	88	83.0%	61	49	68.5%	55.1%
PROSPECT MEDICAL GROUP	267	231	86.5%	162	111	68.4%	50.3%
OMNICARE MEDICAL GROUP	87	74	85.1%	55	45	68.0%	59.0%
EXCEPTIONAL CARE MEDICAL GROUP	134	113	84.3%	89	57	67.7%	47.0%
CARE 1ST HEALTH PLAN	105	86	81.9%	62	50	67.5%	54.8%
HERITAGE MEDICAL GROUP	632	530	83.9%	393	273	67.1%	49.1%
ARROYO VISTA FAM HLTH CTR	3	3	100.0%	2	1	66.7%	33.3%
HEALTHY NEW LIFE MEDICAL CORPORATION (HEALTHSMA	10	9	90.0%	6	3	66.7%	33.3%
SUPERIOR CHOICE MEDICAL GROUP, INC	6	3	50.0%	3	3	66.7%	25.9%
SOUTHLAND SAN GABRIEL VALLEY MEDICAL GROUP, INC	39	32	82.1%	21	9	66.7%	27.3%
BELLA VISTA IPA (MEDPOINT MGMT)	106	48	45.3%	37	31	65.5%	47.8%
GLOBAL CARE IPA (MEDPOINT MGMT)	303	132	43.6%	104	57	65.2%	38.6%
COMMUNITY FAMILY CARE (CAP MANAGEMENT)	192	139	72.4%	93	69	64.8%	49.4%
SIERRA MEDICAL GROUP	16	11	68.8%	7	5	63.6%	45.5%
HEALTHCARE PARTNERS MEDICAL GROUP	1018	912	89.6%	590	513	63.4%	54.6%
UCLA MEDICAL GROUP	4	3	75.0%	3	1	60.1%	19.3%
NEW WATTS HEALTH CENTER	13	10	76.9%	9	9	59.9%	48.5%
CROWN CITY MEDICAL GROUP	21	14	66.7%	11	12	59.1%	50.0%
HEALTH CARE LA, IPA (MEDPOINT MGMT)	588	212	36.1%	115	127	58.9%	52.5%
ALTAMED HEALTH SERVICES CORPORATION	421	189	44.9%	112	94	58.4%	47.9%
FAMILY CARE SPECIALISTS MEDICAL GROUP	63	32	50.8%	20	31	56.8%	68.9%
PIONEER PROVIDER NETWORK, A MEDICAL GROUP, INC (r	24	18	75.0%	10	17	55.6%	94.4%
LA CARE DIRECT (new)	NA	NA	NA	NA	NA	54.8%	58.1%
County of LA Dept of Health Services	371	164	44.2%	89	52	52.4%	34.8%
EL PROYECTO DEL BARRIO INC	24	12	50.0%	2	10	51.8%	37.5%
SEASIDE HEALTH PLAN (new)	72	58	80.6%	30	25	50.8%	44.1%
ARDMORE MED GRP (new)	4	2	50.0%	1	2	50.0%	100.0%
ADVANTAGE HEALTH NETWORK, INC	5	3	60.0%	1	3	50.0%	50.0%
ALPHA CARE MEDICAL GROUP	21	20	95.2%	10	16	50.0%	80.0%
ANTELOPE VALLEY MEDICAL ASSOCIATES, INC	6	3	50.0%	2	1	50.0%	33.3%
REGENT MEDICAL GROUP (HEALTHSMART MSO)	20	19	95.0%	11	14	47.4%	52.6%
AXMINSTER MEDICAL GROUP	14	14	100.0%	5	14	25.0%	62.5%

N/A - Non-eligible due to insufficient responses to measure

Table 4c: Provider Group After Hours Compliance Results - LACC

PPG Name	Total PCPs	Total PCPs Surveyed	Response Rate	Total Compliant Access	Total Compliant Timeliness	Overall Access Compliance	Overall Timeliness Compliance
APPLECARE MEDICAL GROUP ST. FRANCIS	164	139	84.8%	113	83	81.3%	59.7%
ALTAMED HEALTH SERVICES	190	157	82.6%	93	83	59.2%	52.9%
ALLIED PHYSICIANS IPA	261	220	84.3%	155	118	70.5%	53.6%
APPLECARE MEDICAL GROUP DOWNEY REGION	201	168	83.6%	137	101	81.5%	60.1%
AXMINSTER MEDICAL GROUP	14	14	100.0%	5	14	35.7%	100.0%
BELLA VISTA IPA	4	4	100.0%	3	2	75.0%	50.0%
CITRUS VALLEY PHYSICIANS GROUP	102	88	86.3%	65	50	73.9%	56.8%
FAMILY CARE SPECIALISTS MEDICAL GROUP	31	31	100.0%	19	30	61.3%	96.8%
GLOBAL CARE IPA	147	123	83.7%	100	55	81.3%	44.7%
HEALTH CARE LA IPA	292	206	70.5%	112	124	54.4%	60.2%
HEALTHCARE PARTNERS MEDICAL GROUP	1084	978	90.2%	618	547	63.2%	55.9%
HIGH DESERT MEDICAL GROUP	30	31	93.3%	27	21	85.7%	67.9%
HERITAGE MEDICAL GROUP	1110	926	83.4%	671	468	72.5%	50.5%
LAKESIDE MEDICAL GROUP	333	280	84.1%	208	135	74.3%	48.2%
OMNICARE MEDICAL GROUP	72	60	83.3%	44	35	73.3%	58.3%
PHYSICIANS HEALTHWAYS MEDICAL GROUP	297	252	84.8%	194	136	77.0%	54.0%
PREFERRED IPA OF CALIFORNIA	345	279	80.9%	204	148	73.1%	53.0%
PROSPECT MEDICAL GROUP	246	211	85.8%	145	98	68.7%	46.4%
POMONA VALLEY MEDICAL GROUP	95	88	92.6%	62	54	70.5%	61.4%
REGAL MEDICAL GROUP	988	817	82.7%	597	400	73.1%	49.0%
SIERRA MEDICAL GROUP	17	12	70.6%	7	5	58.3%	41.7%
SEOUL MEDICAL GROUP	15	12	80.0%	11	8	91.7%	66.7%
TALBERT MEDICAL GROUP	108	83	76.9%	66	40	79.5%	48.2%
<i>N/A - Non-eligible due to insufficient responses to measure</i>							

Table 4d: Provider Group After Hours Compliance Results - Medicare

PPG Name	Total PCPs	Total PCPs Surveyed	Response Rate	Total Compliant Access	Total Compliant Timeliness	Overall Access Compliance	Overall Timeliness Compliance
ACCOUNTABLE HEALTH PLAN	42	34	81.0%	25	12	73.5%	35.3%
AIDS HEALTHCARE FOUNDATION	8	6	75.0%	5	0	83.3%	0.0%
ANGELES IPA	204	168	82.4%	132	84	78.6%	50.0%
AKM MEDICAL GROUP	1	10	90.9%	10	9	100.0%	90.0%
APPLECARE MEDICAL GROUP ST FRANCIS	163	138	84.7%	111	83	80.4%	60.1%
ALTAMED HEALTH SERVICES	188	155	82.4%	92	82	59.4%	52.9%
ALLIED PHYSICIANS IPA	263	217	82.5%	152	117	70.0%	53.9%
APPLECARE MEDICAL GROUP DOWNEY REGION	202	169	83.7%	137	101	81.1%	59.8%
ANTELOPE VALLEY MEDICAL ASSOCIATES	3	2	66.7%	1	0	50.0%	0.0%
AXMINSTER MEDICAL GROUP	14	14	100.0%	5	14	35.7%	100.0%
BELLA VISTA IPA	50	43	86.0%	34	28	79.1%	65.1%
COMMUNITY FAMILY CARE	133	104	78.2%	71	52	68.3%	50.0%
CROWN CITY MEDICAL GROUP	12	8	66.7%	5	6	62.5%	75.0%
CITRUS VALLEY PHYSICIANS GROUP	103	89	86.4%	66	50	74.2%	56.2%
EXCEPTIONAL CARE MEDICAL GROUP	87	71	81.6%	52	35	73.2%	49.3%
EMPLOYEE HEALTH SYSTEMS MEDICAL GROUP	368	303	82.3%	229	151	75.6%	49.8%
EL PROYECTO DEL BARRIO INC	11	10	90.9%	1	8	10.0%	80.0%
FAMILY CARE SPECIALISTS MEDICAL GROUP	31	31	100.0%	19	30	61.3%	96.8%
GLOBAL CARE IPA	149	125	83.9%	101	56	80.8%	44.8%
HEALTH CARE LA	289	204	70.6%	111	123	54.4%	60.3%
HEALTHCARE PARTNERS MEDICAL GROUP	1081	975	90.2%	616	546	63.2%	56.0%
HIGH DESERT MEDICAL GROUP	30	28	93.3%	24	19	85.7%	67.9%
HERITAGE MEDICAL GROUP	630	530	84.1%	39	273	7.3%	51.5%
LA CARE DIRECT	NA	NA	NA	NA	NA	NA	NA
LAKESIDE MEDICAL GROUP	333	280	84.1%	208	135	74.3%	48.2%
OMNICARE MEDICAL GROUP	77	65	84.4%	48	39	73.8%	60.0%
PHYSICIANS HEALTHWAYS MEDICAL GROUP	292	246	84.2%	190	136	77.2%	55.3%
PREFERRED IPA OF CALIFORNIA	351	283	80.6%	203	149	71.7%	52.7%
PIONEER PROVIDER NETWORK	24	18	75.0%	10	17	55.6%	94.4%
PROSPECT MEDICAL GROUP	250	214	85.6%	148	101	69.2%	47.2%
POMONA VALLEY MEDICAL GROUP	98	89	90.8%	61	53	68.5%	59.6%
REGAL MEDIAL GROUP	982	811	82.6%	592	398	73.0%	49.1%
SOUTH ATLANTIC MEDICAL GROUP	85	69	81.2%	49	39	71.0%	56.5%
SERRA COMMUNTY MEDICAL CLINIC	NA	NA	NA	NA	NA	NA	NA
SEASIDE HEALTH PLAN	28	23	82.1%	11	9	47.8%	39.1%
SIERRA MEDICAL GROUP	17	12	70.6%	7	5	58.3%	41.7%
SEOUL MEDICAL GROUP	16	13	81.3%	12	9	92.3%	69.2%
ST. VINCENT IPA	134	114	85.1%	76	56	66.7%	49.1%
TALBERT MEDICAL GROUP	108	84	77.8%	67	41	79.8%	48.8%
UNIVERSAL CARE MEDICAL GROUP	2	2	100.0%	1	2	50.0%	100.0%

N/A - Non-eligible due to insufficient responses to measure

CONCLUSION AND PLAN OF ACTION

Findings and conclusions in this report are based on analysis of available data, survey findings and discussions at the various quality committees, such as the Member Quality Service, Performance Improvement Collaborative/Physician Quality Committee and Quality Oversight. These committees include an internal cross-departmental representation from departments, such as Quality Improvement, Medical Management, Health Education, Cultural & Linguistics, Health Education, Provider Network Operations, Marketing and Communications and Leadership. There is also external representation from delegated health plans and provider groups. Opportunities for improvement are determined based on conclusions drawn from these meetings.

To identify issues below the plan level, after hours data was segmented to the provider group level (See tables 4a). Results are distributed to each provider group. L.A. Care will be meeting with provider groups throughout 2015 to discuss targeted and collaborative efforts to improve appointment wait times.

L.A. Care analyzed the survey data and identified continuous non-compliance for After Hours Access. The following measures have been put into place for After Hours non-compliance.

CORRECTIVE ACTION:

In 2014, the 2013 After Hours survey results, in the form of a report card, were distributed to participating provider groups, along with detailed results at the provider level. For those provider groups that did not meet L.A. Care's After Hours performance goal, L.A. Care issued a request for a Corrective Action Plan (CAP). CAP submissions from the provider groups were review in 2014 and the majority were deemed by L.A. Care as not aggressive enough to ensure compliance with After Hours standards moving forward.

In September 2014, L.A. Care's Chief Medical Officer conducted a mandatory webinar with non-compliant provider groups, which included a review of After Hours regulatory standards and requirements and expectations for acceptable corrective actions steps. Provider groups were asked to resubmit their CAPs. The second round of provider group CAPs were accepted and the PPGs were notified that a re-survey would be conducted in the latter half of 2014 to measure provider group compliance.

L.A. Care's contracted vendor (TMG) conducted the 2014 Access to Care Survey in November and December of 2014. Final results of the 2014 After Hours survey were received in May of 2015. Survey results were validated and analyzed. Once again, a majority of provider groups did not meet the After Hours performance standards. L.A. Care requested an Immediate Corrective Action Response (ICAR) from those provider groups who were identified as not meeting the performance goal for two (2) consecutive years (2013, 2014). The request included copies of provider group's previous CAP, After Hours Auditing template, PPG specific performance results, Primary Care Provider (PCP) compliance detailed report, along with notice that disciplinary action will be taken. L.A. Care's Chief Medical Officer conducted a mandatory conference call with these identified non-compliant provider groups on May 19, 2015.

For provider groups new to the L.A. Care network in 2014 and found non-compliant with After Hours standards in the 2014 After Hours survey, and those groups who were compliant in 2013 and non-compliant in 2014, L.A. Care has requested a corrective action plan (CAP). L.A. Care's Chief Medical Officer conducted a mandatory conference call on May 18, 2015 with these identified non-compliant provider groups similar to the webinar conducted in 2014.

L.A. Care will conduct a re-survey of all non-compliant providers for after hours access within 6 months after the original 2014 survey. Delegates and provider groups that do not reach 92% compliance (L.A. Care's Work Plan goal) with the After Hours Access re-survey will be submitted to L.A. Care's

Regulatory Affairs and Compliance department to prepare formal notification of non-compliance and, where necessary, impose sanctions including, but not limited to, financial sanctions.

SUMMARY OF INTERVENTIONS

Based on data gathered from the Annual Access to Care Survey, grievance data and CAHPS Surveys, L.A. Care will continue and or develop the following interventions to continually improve member access to care:

Opportunity	New and/or Ongoing	Action(s) Taken	Measurement of Effectiveness
Collaborate with internal departments to ensure that Access to Care standards are distributed continuously	New	Working with internal teams to ensure that policies and procedures are reflective of the same actions. Channeling more touch points to Provider Network teams and other departments to ensure that the provider offices and MSO's have more communication and continuously monitoring their access to care requirements.	<ul style="list-style-type: none"> • ATC results
Collaborate with delegated provider groups to improve Access to Care	Ongoing	In 2015, L.A. Care will be visiting with targeted provider groups to discuss outcomes of the Access to Care Study and opportunities for collaborative interventions for improvement.	<ul style="list-style-type: none"> • Re-measurement of ATC Study
Collaborate with sub-contracted health plans, provider groups and select network physicians to improve Access to Care	Ongoing	In 2013, L.A. Care did a restructure of committees to develop the Performance Improvement Collaborative Committee, comprised of L.A. Care's network of sub-contracted health plans, provider groups and select physicians. In 2014 L.A. Care worked on methods to improve access to care standards. In 2015, the focus will be to strategize on collaborative initiatives with MSOs/PPGs to improve access to care to members.	<ul style="list-style-type: none"> • Re-measurement of ATC Study • Improved CAHPS Scores for getting needed care and getting care quickly • Decreased complaints regarding access to care
Develop a corrective action process to improve after hours access	Ongoing	Implementation of oversight & monitoring measures of the provider network, including but not limited to a re-survey of 2014 non-compliant providers six months after the original survey. Collection of root cause/barrier analyses from the delegates will help to identify and address cause of non-compliance and guide implementation of immediate and comprehensive measures to address issues and target changes.	<ul style="list-style-type: none"> • Re-measurement of after- hours study in 2015.
Educate providers on timely access standards	Ongoing	<ul style="list-style-type: none"> • An ongoing program offering in-office Customer Service training provided by Provider Network Operations. • Newsletter articles in every issue of Progress Notes educating providers on improving access to care • Distribute timely access standards to providers annually • Marketing materials "Quick Tips for Access to 	<ul style="list-style-type: none"> • ATC Results • Improved CAHPS scores for getting need care and getting care quickly. • Decreased complaints regarding access to care

Opportunity	New and/or Ongoing	Action(s) Taken	Measurement of Effectiveness
		Care Standards” distributed to Providers by different channels (FSR, PNO, website, Pharmacy)	

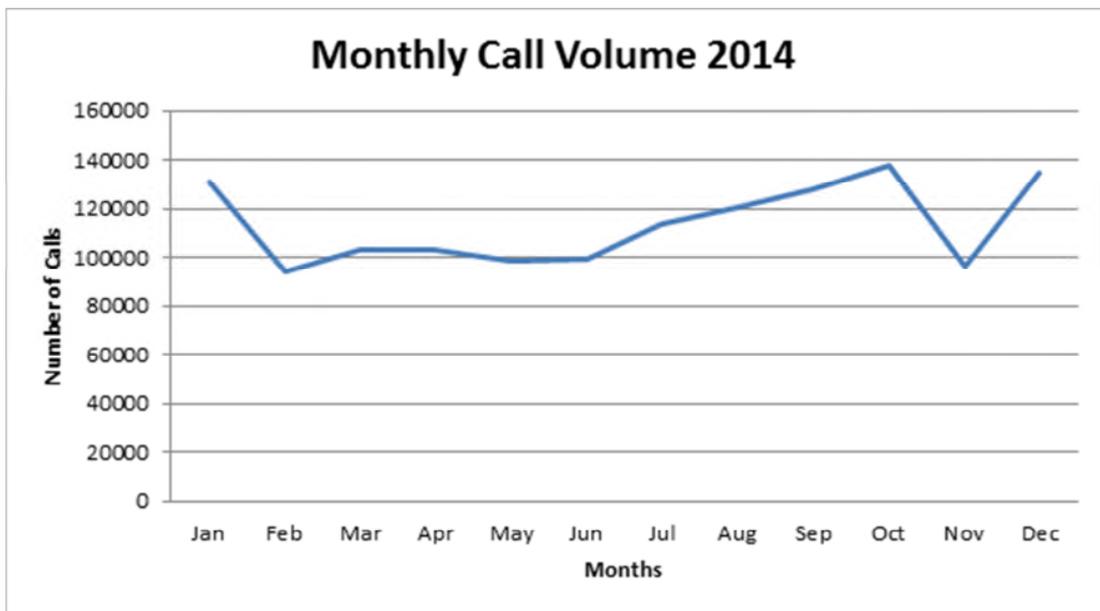
SECTION 3: MEMBER SERVICES TELEPHONE ACCESSIBILITY

RESULTS

In order to measure member services telephone accessibility across all lines of business (Medi-Cal, Medicare and the Marketplace), L.A. Care uses a telephone system called CISCO. The system collects and reports telephone statistics that the Member Services Department uses to create reports. The system counts all incoming calls as the denominator and all calls abandoned. The table and chart below compare L.A. Care’s telephone accessibility for 2012, 2013 and 2014 performance goals.

Table 11: Member Services Telephone Accessibility Compliance Results					
Measure	Goal	2012	2013	2014	Goal Met
Call Abandonment Rates	Below 5 %	1.94%	1.87%	3.05%	Yes
Percent of Calls Handled within 30 Seconds	85%	76%	67%	53%	No

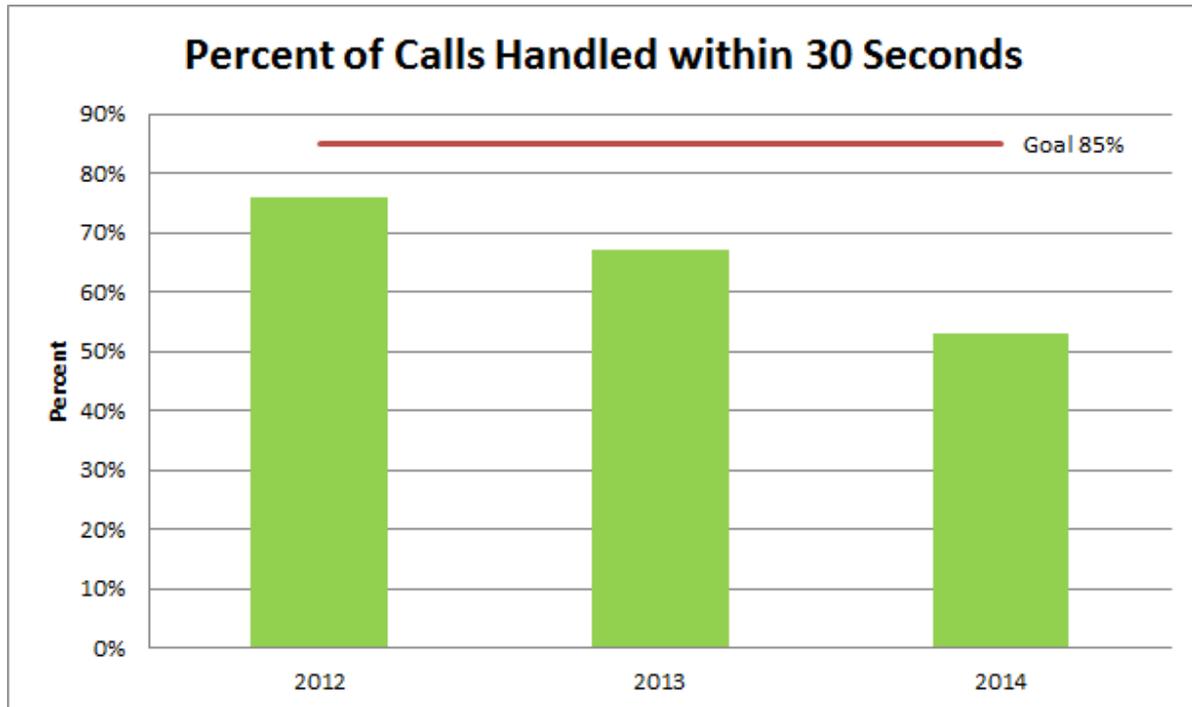
The chart below outlines an overview of member services monthly call volume:



As evidenced below, member complaints related to Member Services accessibility were analyzed. There were a total of 73 Access to Care grievances filed, comprising 2.23% of total Access to Care complaints.

Table 12: Call Center Accessibility Complaints		
Issue	Count	Percent Total
Accessibility By Telephone or Other (of Plan)	73	2.23%

The chart below outlines a compliance rate comparison of the call answer speed:



Quantitative Analysis

- The member services call center met the call abandonment goal of less than 5%.
- The goal of 85% of call handled within 30 seconds was not met in 2012, 2013 or 2014. The rate decreased from 75% in Q1 to 53% in Q4.

Qualitative Analysis

The Member Services Department experienced a significant growth overall in call volume from 2012 to 2013 by 25.04%. This can be attributed to an increase in approximately 165,000 Healthy Way LA members beginning in January 2014. This affected the overall call volume for Q4. The call volume from Q1 to Q4 increased by 12.03%. The provider calls that were taken by AnsaFone were transferred back to the Call Center in March 2013.

The Member Services Department continued to have a significant growth in overall call volume from 2013 to 2014 by 45.66%. This is due to an increase for overall memberships of about 500,000 members. In addition to the increase of membership due to the Exchange for Covered California and Medi-Cal Expansion on January 1, 2014, L.A. Care was also selected for Duals Demonstration Pilot program (Cal MediConnect). The Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) developed a three-year pilot program to integrate medical care, long-term care, behavioral health care and social services under a managed care health plan for people who are dually eligible for Medicare and Medi-Cal. The addition of Cal MediConnect resulted in an additional 30,000 members. The provider calls were also taken back by AnsaFone in January 2014.

In 2014, an additional 97 FTEs were hired to the Call Center and began taking calls after a 6 week training course. The Call Center also lost approximately 45 FTEs throughout the year.

LOOKING FORWARD

L.A. Care Health Plan experienced tremendous growth throughout 2014 as a result of the implementation of the Affordable Care Act, through such programs as Covered California and Medicaid Expansion. Cal MediConnect, California's Duals Demonstration Pilot program was also launched in 2014. Call volume increased substantially as individuals began accessing health care for the first time. To support the growth of the programs, L.A. Care held five 8-week training classes hiring a total of 123 new Member Service Representatives from March 2014 to March 2015. Additionally, the CISCO telephone/ACD system has been enhanced to improve call routing capabilities, NICE, a new recording software was also implemented to enhance existing quality review process and a new Work Force Management tool is scheduled for implementation before the end of the year. The Workforce Management tool will provide staff automated capability to monitor peak times and appropriately assign staff to meet call volume needs to achieve performance standards.

B.3 NETWORK ADEQUACY

BACKGROUND

L.A. Care Health Plan conducts an annual analysis of the Medi-Cal and Medicare networks of primary care and specialty care practitioners to ensure there are sufficient numbers and types of practitioners to effectively meet the needs and preferences of its membership. L.A. Care does not have a separate network for its Medi-Cal and Medicare Managed Care Programs. This network adequacy analysis includes practitioners and providers who accept members' Medicare and Medicaid coverage for care and services within defined geographic areas. Quantifiable and measureable standards for both the number and geographic distribution of practitioners are collected and assessed against these standards. Opportunities for improvement are identified and acted upon on an annual basis.

2014 WORK PLAN GOALS: Each section of this report contains specific quantifiable goals.

SECTION 1: MEDI-CAL PRACTITIONERS' NETWORK AVAILABILITY

METHODOLOGY

Primary care practitioners include Family Practice/General Medicine, Internal Medicine, Obstetrics/Gynecology and Pediatrics. Based on the number of encounters received for the 12-month period from January 1, 2014 through December 31, 2014 of the study year, the five most utilized areas of specialty care include Obstetrics/Gynecology, Cardiovascular Disease, Gastroenterology, Ophthalmology and Orthopedics. Analysis of L.A. Care's Behavioral Health provider network is excluded from this report. The provision of Behavioral Health services and analysis of provider availability is delegated to an NCQA accredited Managed Behavioral Health Organization (MBHO).

PERFORMANCE STANDARDS

Performance standards are based on regulatory requirements, external benchmarks, industry standards, and national and regional comparative data. Availability standards are established for:

- PCP to Member Ratio = Total number of PCPs/Total Membership
- SCP to Member Ratio = Total number of SCPs for the specific specialty type (e.g. total number of ophthalmologists)/Total Membership
- PCP and SCP Drive Distance: MapInfo software is used to measure performance.

PERFORMANCE ASSESSMENT

As of December 2014 the total number of Medi-Cal members was 1,462,549. The 136,166 members assigned to Kaiser are excluded from this analysis as this function is delegated to Kaiser. This report measures practitioner availability for 1,462,549 non-Kaiser members.

PCP and Top 5 Specialty	Providers	Members*	P:M Ratios	Standard	Standard Met
PCP	2,795	1,462,549	1:523	1:2000	Yes
FP/GP	1,005	658,455	1:655	1:2000	Yes
IM†	806	245,309	1:304	1:2000	Yes
PED††	820	484,190	1:590	1:2000	Yes
SCP					
OB/GYN (PCP & SCP)**	392	606,330	1:1547	1:3000	Yes
CARDIO	178	1,462,549	1:8217	1:5000	No
GASTRO	136	1,462,549	1:10754	1:5000	No
OPHTHO	248	1,462,549	1:5897	1:5000	No
ORTHO	193	1,462,549	1:7578	1:5000	No

*Analysis does not include Kaiser Membership.

** Only female and age ≥ 11 years as of December 31, 2014 included to calculate practitioner to member ratios for OB/GYN.

†Members 17 and up used to calculate ratio.

††Members 18 and under used to calculate ratio.

PCP and Top 5 Specialty	Average Distance			% of Members* with Access			Standard for Drive Distance	Standard for % of Members with Access	Standard met
	2012	2013	2014	2012	2013	2014			
PCP	0.7	1.0	0.6	100	100	99.8	10 miles	95%	Yes
FP/GP	0.7	0.7	0.7	100	99.9	99.8	10 miles	95%	Yes
IM†	1.1	1.0	0.9	100	99.5	99.7	10 miles	95%	Yes
PED††	1.0	1.0	1.0	100	99.6	99.5	10 miles	95%	Yes
SCP									
OB/GYN (PCP & SCP)**	1.5	1.5	1.4	100	100	99.8	15 miles	90%	Yes
CARDIO	2.7	2.7	2.5	98	99	99.4	15 miles	90%	Yes
GASTRO	3.7	2.5	2.4	95	99	99.4	15 miles	90%	Yes
OPHTHO	2.4	2.2	2.3	99	100	99.8	15 miles	90%	Yes
ORTHO	2.3	2.2	2.2	98	99	99.3	15 miles	90%	Yes

*Analysis does not include Kaiser Membership.

** Only female and age ≥ 11 years as of December 31, 2014 included to calculate practitioner to member ratios for OB/GYN.

†Members 17 and up used to calculate ratio.

††Members 18 and under used to calculate ratio.

Quantitative Analysis

- L.A. Care met the standards for drive distances for all PCP types.
- L.A. Care met the standards for drive distances for high volume SCPs.

Qualitative Analysis

While L.A. Care met all ratio and drive distance standards and goals for primary care, Medi-Cal ratio standards were not met for Cardiovascular Disease, Gastroenterology, Ophthalmology and Orthopedic specialties.

L.A. Care monitors its specialty care network closely and produces quarterly reporting to identify deficiencies within its Medi-Cal network. The organization is committed to the ongoing development of a sufficient network of contracted specialists and places particular emphasis on contracting with specialists identified as highly utilized. Although strategies are firmly in place to continually expand the specialty network, it remains challenging to meet the access demands brought about by the significant increase in the number of Medi-Cal enrollees. The number of Medi-Cal enrollees increased by 10% in 2012, by 11% in 2013 and by 27% in 2014. It should also be noted that there is an industry wide shortage of practitioners in specific areas of specialty care who are willing to serve Medi-Cal beneficiaries due to low reimbursement rates. Nonetheless, L.A. Care contractually requires its Participating Physician Groups to provide access to needed specialty care by referring patients to out-of-network providers when a specialist is not available within its contracted network.

INTERVENTIONS

eConsult

With eConsult, PCPs can securely send patient-specific clinical information and care questions to specialists through a HIPAA compliant email. Specialists use the system to review the clinical information and provide “electronic consultations” back to the primary care physicians. eConsult started in 2009 when L.A. Care launched a pilot to test the effectiveness of the electronic consultation system. An evaluation found that using eConsult improved information sharing and dialogue among physicians, shortened the time to resolve clinical issues, and reduced the need for face-to-face specialty visits, which declined by 25 to 48 percent depending on the specialty, while developing capacities at the primary care level and improving overall specialty care access. Patients benefited from faster resolution of clinical issues and elimination of unnecessary specialist visits. In 2012, L.A. Care extended eConsult to Health Care L.A. IPA (HCLA) and to its network of community clinic safety net providers and to the L.A. County Department of Health Services. To date, this second project has over 70,000 primary care/specialty consultations initiated, involving 112 sites and 12 specialties with a potential member/patient base of over 500,000. Results of FY2013 are shown in the table below, including 19,995 eConsults with Gastroenterologists and 4,172 eConsults with Orthopedic Surgeons, specialties not meeting the P:M standard for the study period.

SPECIALTY	Total
Allergy	1,104
Cardiology	6,710
Dermatology	8,770
Endocrinology	2,423
ENT	4,830
Gastroenterology*	18,613
Nephrology	1,666
Ophthalmology	1,177
Orthopedic Surgery*	4,172
Pain Management	2,686
Ped-Allergy/Asthma	56
Ped-Endocrinology	541
Ped- Nephrology	976
Rheumatology	2,088
Total	55,812

**Specialties not compliant to P:M standard*

SECTION 2: CULTURAL AND LINGUISTIC NEEDS AND PREFERENCES

L.A. Care's Cultural and Linguistic (C&L) Services Unit provides face-to-face interpreters upon request at medical appointments, meetings, health education classes and community events. A total of 1,917 interpreting requests were processed in FY 2013-2014 (1,681 for medical appointments and 236 for health education classes and health care information meetings), which is an increase of 71% when compared to the previous year. A satisfaction survey is administered upon fulfillment of an interpreting services request. Members received a mail-based survey for interpreting services provided at medical appointments. Internal staff received a written survey for interpreting services provided at administrative events. Results of the survey show a high level of satisfaction with 100% of respondents being "very satisfied" or "satisfied."

The C&L Services Unit provides on-going education on C&L rights, requirements, services and resources. Educational strategies target staff, members, and network providers. The Provider Toolkit for Serving Diverse Populations was made available for providers on L.A. Care's website. This toolkit was developed to assist providers in providing high quality, effective, and compassionate care to their patients and ensure they meet the changing service requirements of state and federal regulatory agencies.

In addition to education, the C&L Services Unit conducts cultural competency trainings that target staff and network providers. Training topics include: Cultural Competency, Disability Awareness, How to Communicate with LEP Members Using Interpreters, Communicating Effectively Using TTY, Introduction to Telephonic Interpreting Services, Translation Process, Communicating Through Healthcare Interpreters (CME), and LGBT/Q Sensitivity Training (CME). In March 2014, C&L Services Unit, in collaboration with Human Resources, has launched Cultural Competency as an electronic training module in Learning Management System for both L.A. Care staff and providers to increase training availability. In addition, How to Communicate with LEP Members Using Interpreters, Introduction to Telephonic Interpreting Services and Translation Process were made available on-line to L.A. Care staff. A total of 50 educational and cultural competency trainings on C&L related topics were offered in FY 2013-2014 and 416 L.A. Care staff and 379 providers have attended these trainings in-person and on-line.

Based on information provided, the five racial and ethnic groups that make up 85.98% of L.A. Care's total membership are shown below.

Race	Number of Members	% of Membership	Number of PCPs	% of PCPs	P:M Ratio
Hispanic/Latino	829,908	56.74%	29	1.04%	1:2861
African American/Black	169,958	11.62%	9	0.32%	1:1884
Caucasian/White	199,321	13.63%	50	1.79%	1:3986
Chinese	35,811	2.45%	21	0.75%	1:1705
Filipino	22,496	1.54%	16	0.57%	1:1406

Based on information provided, the top five languages comprising 95.96% of languages spoken by L.A. Care members are depicted below.

Language	Number of Members	% of Membership	Number of PCPs¹⁵	% of PCPs	P:M Ratio
English	822,744	56.25%	2,795	100.00%	1:294
Spanish	493,256	33.73%	2,454	87.80%	1:201
Armenian	40,579	2.77%	664	23.76%	1:61
Chinese	32,026	2.19%	435	15.56%	1:74
Korean	14,917	1.02%	727	26.01%	1:21

QUANTITATIVE ANALYSIS

- Race/Ethnicity of practitioners ratios are low due to extremely limited self-reported ethnicity data. L.A. Care requests practitioner race/ethnicity information from all contracted network practitioners on a voluntary basis during the application process. As a result, the practitioners to member ratios are unreliable.
- Data on practitioner self-reported languages is more robust and provides a more accurate view of the L.A. Care practitioner network.
- Spanish speaking members comprise 33.7% of overall membership. Spanish speaking practitioners comprise 87.8% of contracted PCPs.
- The average distance that Spanish-speaking members have to travel to a Spanish-speaking PCP is 0.5 miles.
- 99.9 percent of these members have at least one Spanish-speaking PCP within 10 miles of their residence.

Qualitative Analysis

L.A. Care requests practitioner race/ethnicity information from all contracted network practitioners directly on a voluntary basis during the application process. The response rate remains low and does not adequately reflect the race/ethnicity of the L.A. Care practitioner network.

L.A. Care initially requests practitioner language information from all contracted network practitioners on a voluntary basis and identifies languages in which a practitioner is fluent when communicating about medical care, during the L.A. Care application process. The language categories for practitioner language on the application are the same as those used to collect member language. Any subsequent changes or updates to practitioner spoken language information are voluntarily self-reported to the Provider Network Operations Department (PNO) on a monthly basis.

L.A. Care reviews community data every two years to determine the languages spoken by one percent of the population or 200 eligible individuals, whichever is less. Languages spoken by one percent of Los Angeles county residents include Spanish, Arabic, Armenian, Chinese, English, Farsi, Hebrew, Japanese, Khmer, Korean, Russian, Vietnamese, Tagalog and Thai. All languages but Hebrew, Japanese and Thai are Los Angeles County threshold languages as determined by DHCS.

¹⁵ The total number of unique PCPs across L.A. Care’s network is 2,795 (Medi-Cal excluding KAIS); while, the subtotal number of PCPs broken down by languages represents an aggregate number. This means that if one PCP speaks two languages, then the PCP is counted twice based on the language he/she speaks. This also results in the total percentage of PCPs such that it exceeds 100%.

Table 6: Cultural and Linguistics Complaints			
Issue	Count of complaints	% of ATC Complaints	Rate/1000/Quarter
Cultural Issues	30	0%	0.002
Linguistic Issues	9	0%	0.001

L.A. Care continually monitors complaints and grievances related to cultural and linguistic issues. The rate of complaints related to culture and language are low and do not present any trends for the study period.

L.A. Care publishes practitioner language information both on-line through L.A. Care’s website and via a hard copy Provider Directory to facilitate member selection of practitioners. L.A. Care’s hard copy Provider Directory is mailed annually to all L.A. Care members and contains an index of practitioners by language. The on-line version of L.A. Care’s Provider Directory is searchable by practitioner and office staff language capabilities.

Over the study period, L.A. Care added the following practitioners broken out by language spoken:

Table 7: New Practitioners Added to Network in 2014 by Language Spoken	
Language	Number of Physicians
English	299
Spanish	221
Korean	57
Mandarin	48
Cantonese	37
Tagalog	35
Armenian	35
Farsi	26
Vietnamese	25
Arabic	19
Russian	18
Other Chinese	15

Based on the cultural and linguistic findings, L.A. Care concluded that the practitioner network does not need to be adjusted at this time. In order to remain proactive, the C&L Services Unit plans and executes activities to improve Culturally and Linguistically Appropriate Services (CLAS), reduce disparities, and increase operational efficiency:

- In March 2014, the Language Access DVDs in Cantonese, Mandarin, Khmer, Korean, Tagalog, Thai and Vietnamese were sent to members as a part of the annual member mailing package to increase low Asian-language face-to-face interpreting services utilization rates. All Asian languages appear to have experienced a modest increase in face-to-face interpreting services rate since the inclusion of the Asian language access DVDs in new member welcome packets, with Khmer experiencing the largest increase overall.
- From April to June 2014, the Enhancing Network Responsiveness Survey took place to measure the level of cultural and linguistic competency among L.A. Care network providers. The results were used to improve the C&L Provider Toolkit and enhance future provider trainings to better serve members. Some of the major findings included:
 - In the past 3 months, 32.6% providers and providers' office staff had received training on cultural competency.
 - The top 3 cultural competency trainings which surveyed providers were interested in attending in 2014 are: Beliefs about Illness and Health (51.1%), Servicing Patients with Mental Health Conditions (47.9%) and Introduction to Cultural Competency (44.7%).
 - The top 3 training modalities and times which surveyed providers were interested in attending trainings are: Lunch hour (noon-1pm) (50.5%), In-person (39.6%) and Webinar (with live presenter) (38.6%).
- In August 2014, the Language Poster, which informs members of the availability of interpreting services in all Los Angeles threshold languages, was updated to include two additional languages that were identified as spoken by one percent of the eligible individuals in Los Angeles County residents (Hebrew and Japanese). The posters were mailed to all the L.A. Care network providers in September 2014.

SUMMARY

Through quarterly and annual quantitative monitoring and analysis, L.A. Care ensures that its network has sufficient numbers and types of practitioners who provide primary care, behavioral healthcare and specialty care. This analysis is supplemented by an evaluation of member complaints. Through this process, only slight adjustments to the network were indicated. Ongoing monitoring of Participating Physician Groups' provider networks will continue in 2015. L.A. Care will engage in collaborative efforts to ensure additional provider contracting opportunities are pursued which will enable the provider network to meet the needs of the organization's rapidly growing membership.

The results of this analysis are presented at the Quality of Care Committee.

NETWORK ADEQUACY (MEDICARE)

SECTION 1: MEDICARE PRACTITIONERS' NETWORK AVAILABILITY

METHODOLOGY

PCP to Member Ratio = Total number of PCPs/Total SNP Membership

SCP to Member Ratio = Total number of SCPs for the specific specialty type (e.g. total number of ophthalmologists)/Total SNP Membership

Provider to Member Ratio = Total number of Providers for each specific facility type (e.g. total number of skilled nursing facilities)/Total SNP Membership

PCP, SCP and Provider Drive Distance: GeoMap software is used to measure performance.

Specific Membership counts vary as the reports will reflect membership for the day they were generated.

Table 1: 2014 Performance Standards and Results										
Specialty	STANDARD	Providers	Members	P:M Ratio	Standard Met?	STANDARD Driving Distance (Mile)	STANDARD % Members with Access	Average Distance (Mile)	% Members with Access	Standard Met?
P-M Ratio										
<i>Primary Care Practitioner</i>										
Internal Medicine	1:2000	640	9176	1:14	Yes	5	95%	1.0	99.20%	Yes
Family Practice	1:2000	722	9176	1:13	Yes	5	95%	0.9	99.60%	Yes
General Practice	1:2000	438	9176	1:21	Yes	5	95%	0.9	99.80%	Yes
Hospitals	1:5000	56	9176	1:164	Yes	10	90%	3.1	98.70%	Yes
Skilled Nursing Facilities	1:5000	188	9176	1:49	Yes	10	90%	1.7	99.50%	Yes
Home Health Agencies	1:5000	126	9176	1:73	Yes	10	90%	2.9	99.10%	Yes
Ambulatory Surgery Centers	1:5000	18	9176	1:510	Yes	10	90%	5.7	85.30%	No
Radiology Centers	1:5000	15	9176	1:612	Yes	10	90%	6.2	87.90%	No
Dialysis Centers	1:5000	122	9176	1:75	Yes	10	90%	2.0	99.70%	Yes
Cardiology*	1:5000	62	9176	1:148	Yes	10	90%	3.6	95.70%	Yes
Gastroenterology*	1:5000	87	9176	1:105	Yes	10	90%	2.1	98.80%	Yes
Ophthalmology*	1:5000	171	9176	1:54	Yes	10	90%	2.5	99.60%	Yes
Pulmonology*	1:5000	72	9176	1:127	Yes	10	90%	2.7	98.80%	Yes
Urology*	1:5000	68	9176	1:135	Yes	10	90%	2.7	98.80%	Yes
Allergy and Immunology	1:5000	28	9176	1:328	Yes	15	90%	3.6	98.30%	Yes
Cardiac Surgery	1:5000	17	9176	1:540	Yes	15	90%	5.3	96.90%	Yes
Dermatology	1:5000	41	9176	1:224	Yes	10	90%	3.4	99.80%	Yes
Endocrinology	1:5000	31	9176	1:296	Yes	15	90%	4.3	99.20%	Yes
ENT/	1:5000	32	9176	1:287	Yes	15	90%	3.0	98.10%	Yes
Otolaryngology	1:5000	32	9176	1:287	Yes	15	90%	5.3	96.20%	Yes
General Surgery	1:5000	111	9176	1:83	Yes	10	90%	2.1	99.00%	Yes
Gynecology, OB/GYN, SCP	1:5000	231	9176	1:40	Yes	15	90%	1.6	98.90%	Yes
Infectious Diseases	1:5000	32	9176	1:287	Yes	15	90%	4.1	99.70%	Yes
Nephrology	1:5000	123	9176	1:75	Yes	15	90%	2.3	99.40%	Yes
Neurology	1:5000	56	9176	1:164	Yes	10	90%	3.1	98.90%	Yes
Neurosurgery	1:5000	27	9176	1:340	Yes	15	90%	4.3	98.80%	Yes
Oncology - Medical, Surgical	1:5000	32	9176	1:287	Yes	10	90%	3.9	97.40%	Yes
Oncology - Radiation	1:5000	52	9176	1:176	Yes	15	90%	4.2	97.00%	Yes
Orthopedic Surgery	1:5000	107	9176	1:86	Yes	10	90%	2.5	99.60%	Yes
Physiatrist, Rehabilitative	1:5000	30	9176	1:306	Yes	15	90%	4.3	99.20%	Yes

Table 1: 2014 Performance Standards and Results										
Specialty	STANDARD	Providers	Members	P:M Ratio	Standard Met?	STANDARD Driving Distance (Mile)	STANDARD % Members with Access	Average Distance (Mile)	% Members with Access	Standard Met?
P-M Ratio										
Plastic Surgery	1:5000	22	9176	1:417	Yes	15	90%	5.2	97.80%	Yes
Podiatry	1:5000	31	9176	1:296	Yes	10	90%	3.5	97.90%	Yes
Rheumatology	1:5000	25	9176	1:367	Yes	15	90%	4.2	96.20%	Yes
Thoracic Surgery	1:5000	25	9176	1:367	Yes	15	90%	4.8	97.30%	Yes
Vascular Surgery	1:5000	12	9176	1:765	Yes	15	90%	5.7	96.40%	Yes

†Standards are based on baseline data, industry standards, facility size, occupancy and location, and are reviewed and subject to change on an annual basis.

*Top Specialty by encounter volume

Quantitative Analysis

L.A. Care met the standards for Medicare practitioner to member ratios for PCPs and all high volume specialties. L.A. Care also met the standards for drive distances for PCPs and all high volume specialties. With the exception of Ambulatory Surgery Centers and Radiology facilities, L.A. Care met the standards for patient drive distance to ancillary providers.

Qualitative Analysis

L.A. Care's provider and ancillary network is generally sufficient to meet the health care needs of Medicare enrollees. Geographical distribution of ancillary providers is appropriate for the patient population and is compliant with the vast majority of network adequacy standards.

PCPs

As of December 2014, L.A. Care had **9,170** active members enrolled in its SNP program which became effective on January 1, 2008. The ratio of PCP to members was well within the standard of 1:2000 for each PCP specialty type. The highest P:M ratio was for General Practice at 1:21 P:M. No adjustment to the PCP network is necessary for the SNP product line at this time.

Over 99% of members were within 1.0 mile of a PCP, which is within the standard for member drive distance.

SCP

L.A. Care met availability and drive standards for all specialty types.

High Volume Specialists

L.A. Care evaluates the sufficiency of its SNP specialist network on an annual basis. As of December 2014, high volume specialists, by encounter, for the previous 12 month period were: Cardiology, Gastroenterology, Pulmonology, Ophthalmology, and Urology. Practitioners to member ratios were all within the 1:5000 P:M standard established by L.A. Care. Each high volume specialty met the goal of ensuring that 95% of members are within ten miles of a SCP.

L.A. Care continually strives to maintain and expand its network of contracted specialists with particular emphasis on contracting with specialists practicing in areas identified as highly utilized. Provider Network Operations examines the individual specialty networks of contracted provider groups quarterly and informs them of any deficiencies in their network. L.A. Care's Participating Physician Groups (PPGs) are contractually required to ensure Medicare enrollees have adequate access to specialty care

when needed. This may require entering into “one-time” agreements with physicians outside of a PPGs provider network.

The following table shows the specialists added to the network over the 12 month period this study covers.

Table 1: Specialists Added June 2013- June 2014	
SPECIALTY	COUNT
Allergy	3
Anesthesiology	15
Cardiology	3
Cardiovascular Disease (Md Only)	13
Colon & Rectal Surgery	1
Dermatology	5
Emergency Medicine	5
Endocrinology	6
Gastroenterology (Md Only)	8
General Surgery	14
Geriatrics	1
Gynecology (Do Only)	2
Hand Surgery	1
Hematology	8
Hematology/Oncology (Mhc Nurse Anesthetist)	2
Infectious Diseases	3
Miscellaneous Medicine	18
Neonatology	1
Nephrology	13
Neurological Surgery	6
Neurology (Md Only)	7
Nuclear Medicine	1
Obstetrics - Gynecology (Md Only)	25
Oncology	7
Ophthalmology	14
Orthopedic Surgery	15
Other	2
Otology, Laryngology, Rhinology	3
Pediatric Cardiology (Md Only)	6
Pediatric Gastroenterology	2
Pediatric Neurology	1
Perinatology	1
Peripheral Vascular Disease Or Surgery (Do Only)	6
Physical Medicine And Rehabilitation	6
Plastic Surgery	3
Podiatry	4

SPECIALTY	COUNT
Psychiatry	9
Pulmonary Diseases (Md Only)	6
Radiation Oncology	1
Radiology	14
Rheumatology	3
Thoracic Surgery	2
Urology; Urological Surgery	3

ANCILLARY PROVIDERS

L.A. Care measures the adequacy of the SNP ancillary network on an annual basis. As of December 2014, Hospitals, Skilled Nursing Facilities, Home Health Agencies, Ambulatory Clinics, Radiology Centers and Dialysis Centers were all within the 1:5000 P:M standard established by L.A. Care. All provider facilities were within ten miles of 90% of membership with the exception for Ambulatory Surgery Centers and Radiology facilities. In 2014, 85.30% of members had an Ambulatory Surgery Center within 10 miles and 87.90% of members were within 10 miles of a Radiology facility. L.A. Care's Provider Contracts unit continues to bring additional surgery centers into the ancillary network and anticipates that the drive distance deficiency will be eliminated as a result of these contracting efforts. L.A. Care will continue to monitor the networks of its contracted PPGs to ensure that improvements are made in the number of members who have Radiology facilities within the 10 mile drive distance

REVIEW OF COMPLAINTS

A review of complaints over a 12-month period shows there were only 29 complaints (8.4%) regarding access to specialty care, and 5 complaints (1.5%) regarding access to PCP.

Complaint Description	Count	% Total
Specialty Access/Availability	29	8.38%
PCP Access/Availability	5	1.45%

ACCESS TO PUBLIC TRANSPORTATION

L.A. Care assessed public transportation from PCP, SCP, and total ancillaries to nearest bus stop. The graphs below show the result of the assessment. As the Los Angeles metro area is thoroughly covered by public transportation, producing a map of the locations from provider to bus stop would not be feasible.

There is no standard to evaluate this measurement against. All providers and ancillaries are within 1 mile of a bus stop. In addition, L.A. Care provides up to 28 non-emergent one-way transports for free to members through Logisticare to approved locations. Members are notified of this supplemental benefit through their EOC.

CULTURAL NEEDS AND PREFERENCES

L.A. Care assesses the cultural, racial, ethnic, and linguistic needs of its members and adjusts availability of practitioners within its network if necessary.

METHODOLOGY

- Language needs and cultural background of members, including prevalent languages and cultural groups, are collected using individuals' race/ethnicity data collected when they apply for coverage.
- Language preference data for members is validated telephonically from eligible individuals using a standardized script during inbound member calls.
- L.A. Care uses census data for Los Angeles County to examine the languages spoken in the service area.
- Language and race/ethnicity of practitioners in the provider network is reported voluntarily through the practitioner credentialing application.
- L.A. Care uses mapping software to assess availability of PCPs to members for the five largest language groups of members.

LANGUAGE	COUNT
Spanish	5423
English	3276
Not Valid	189
Tagalog	107
Armenian	34
Cantonese	32
	25
Mandarin	19
Other Non-English (Specify)	14
Vietnamese	13
Korean	11
Arabic	6
Farsi	6
Thai	5
Cambodian	4
Russian	3
Samoan	3
American Sign Language	2
Other Chinese	2
French	1
Japanese	1
Laotian	1
Total	9177

ETHNICITY	COUNT
	5188
Hispanic/Latino	2088
Black (African American)	680
No Valid Data Reported	600
White (Caucasian)	341
Filipino	91
Asian/Pacific Islander	85
Chinese	45
Other	23
Korean	9
American Indian/Alaskan	5
Asian Indian	5
Unknown	5
Vietnamese	5
Laotian	2
Samoan	2
Amerasian	1
Cambodian	1
Japanese	1
Total	9177

C. SYSTEMS OF CARE, ADMINISTRATIVE AND OTHER QI ACTIVITIES

C.1 PHARMACY INITIATIVES AND MANAGEMENT (MEDICARE AND MCLA)

C.1.a PHARMACY INITIATIVES (MEDICARE AND MCLA)

I. POLYPHARMACY

2014 WORK PLAN GOAL:

- 100% of prescribers will be notified of members for polypharmacy (more than 10 unique, chronic medications from 3 or more prescribers).

BACKGROUND

L.A. Care Health Plan uses Retrospective Drug Use Evaluation (DUE), which is administered by our Pharmacy Benefit Manager (PBM)—MedImpact, to minimize polypharmacy, increase continuity of care and reduce the potential for adverse drug reactions. Polypharmacy exists when a patient is taking multiple medications simultaneously. The definition of polypharmacy has varied widely in published studies, but one study has shown the number of adverse drug events (ADEs) per patient increases linearly with the number of drugs used; one unit increase in number of drugs yielded a 8.6% increase in ADEs (95% CI 1.07-1.10).¹⁶

Physicians are asked to review a patient's drug profile on a regular basis and simplification of drug therapy where appropriate can help prevent or minimize polypharmacy, along with reinforcing compliance in patients with complex medication regimens from a 3 month period with the following parameters: More than 10 unique, chronic medications from 3 or more prescribers.

Each identified member's prescription drug history has been formatted for effective drug regimen review and placement in the medical chart. The primary care provider is most familiar with their medical conditions and can evaluate these medication profiles specifically looking for the occurrence of inappropriate polypharmacy and simplification of drug therapy.

RESULTS (MEDICARE)

	Number of Medicare Members Identified	Number of Provider Mailings
2012	447	340
2013	716	760
2014	1,342	997

RESULTS (MCLA)

	Number of MCLA Members Identified	Number of Provider Mailings
2012	6,068	3,710
2013	5,215	6,190
2014	10,829	5,469

¹⁶ Viktil KK, Blix HS, Moger TA, Reikvam A. Polypharmacy as commonly defined is an indicator of limited value in the assessment of drug-related problems. Br J Clin Pharmacol 2006; 63: 187-195.

ANALYSIS

100% of prescribers were notified of members for polypharmacy (more than 10 unique, chronic medications from 3 or more prescribers).

LOOKING FORWARD

L.A. Care will continue to consistently monitor Polypharmacy (more than 10 unique, chronic medications from 3 or more prescribers) through the DUE program in 2015.

II. HIGH RISK MEDICATIONS IN THE ELDERLY

2014 WORK PLAN GOAL

- 100% of prescribers will be notified of members with 1 or more unique medications in a three-month period considered to be high risk in the elderly (Mbrs \geq 65 yo on \geq one HRME drug or meeting dosing thresholds for doxepin, digoxin, reserpine, nitrofurantoin in 3 months). Additionally, a list of safer formulary alternatives reference sheet will be created and utilized to intervene at the prior authorization level.

BACKGROUND

Appropriate use of medications in our members is a safety concern, especially among the elderly. Studies found that 12-40% of older patients receive drugs identified as inappropriate, such as sedating antihistamines, skeletal muscle relaxants and certain opioid analgesics.¹⁷ Additionally, nearly 3 percent of elderly patients received at least one medication that should be avoided in this population.¹⁸

L.A. Care reviewed the medication profiles of patients 65 years of age and older to determine whether their medication history contained 1 or more unique medication based on the NCQA-PQA/HEDIS criteria. Patients identified in a report sent to the providing prescriber may be candidates for the evaluation of alternative medications or consideration of discontinued use of these medications.

RESULTS (MEDICARE)

	Number of Medicare Members Identified	Number of Provider Mailings
2012	1044	701
2013	1,117	1,537
2014	1,722	1,082

RESULTS (MCLA)

	Number of MCLA Members Identified	Number of Provider Mailings
2012	5,404	3,111
2013	7,101	4,132
2014	9,408	4,572

¹⁷ Gallagher P, et al. Inappropriate prescribing in the elderly. [J Clin Pharm Ther.](#) 2007 Apr;32(2):113-21.

¹⁸ Zhan C, Sangl J, Bierman AS, et al. Potentially inappropriate medication use in the community-dwelling elderly. [JAMA](#) 2001; 22:2823-29.

ANALYSIS

100% of prescribers were notified of members with 1 or 2 or more unique potentially inappropriate medications (PIMs) based on NCQA/HEDIS drug list criteria.

LOOKING FORWARD

L.A. Care will continue to consistently monitor use of high-risk medications in the elderly through the Medication Therapy Management Program and the coverage determination process in 2015.

III. DRUG TO DRUG INTERACTION WORK PLAN GOAL:

- 100% of prescribers will be alerted by fax for members with select high risk medication concerns (level 1 drug-drug interaction).

BACKGROUND

Medication-related errors, occurring either in or out of the hospital, are estimated to account for over 7,000 deaths annually.¹⁹ Underuse, overuse and misuse of medications more frequently results in non-death related adverse drug events that are harmful as well as costly.

For the drug-to-drug interaction intervention, MedImpact identifies members who received at least one approved prescription drug claim where a Level 1 (highest) severity drug-drug interaction based on First Data Bank NDDF Plus™ documentation with a previously approved medication during the claims adjudication process. The prescribing provider is notified via fax daily Monday through Friday based upon the previous day(s) claims submission. Faxed materials will include:

- Patient specific identification of a Level 1 drug-drug interaction
- Request for a re-evaluation of therapy
- Report of outcomes from intervention

The identified patients may be candidates for the evaluation of alternative medications, increased monitoring or consideration of discontinued use of these medications.

RESULTS (MEDICARE)

	Number of Medicare Members Identified
2012	299
2013	615
2014	44

RESULTS (MCLA)

	Number of MCLA Members Identified
2012	2,420
2013	4,320
2014	512

¹⁹ Kohn, L; Corrigan, J; Donaldson, M; *To Err is Human: Building a safer Health System*. Washington D.C., Institute of Medicine, 1999.

ANALYSIS

100% of prescribers were alerted by fax for members with select high risk medication concerns (level 1 drug-drug interaction).

LOOKING FORWARD

L.A. Care will continue to consistently monitor drug to drug interactions with DUR edits that have been implemented at the point-of-sale and through the daily review of rejected DUR claims in 2015.

C.1.b PHARMACY MANAGEMENT

I. CONTROLLED SUBSTANCES

2014 WORK PLAN GOAL:

- 100% of prescribers will be notified of members for controlled substances. (10 or more prescriptions for DEA schedule II, III, IV, or V controlled substances [excluding drugs used to treat attention deficit hyperactivity disorder], tramadol containing agents, or carisoprodol containing products during a three-month period).

BACKGROUND

L.A. Care is committed to developing and implementing activities to identify overuse, dependence or drug seeking behavior. In the United States, an estimated 22.2 million persons (9.1 percent of all Americans aged 12 and older) are classified with substance dependence or abuse and 6.4 million persons aged 12 or older used prescription psychotropics including pain relievers, tranquilizers and sedative drugs non-medically in the past month.²⁰

L.A. Care has a Controlled Substance Drug Utilization Evaluation (DUE) program which pulls data quarterly each year. Medication profiles of patients are pulled by MedImpact that contain prescription claims for receiving the following drugs over a 3 month period:

- 10 or more prescriptions for DEA schedule II, III, IV or V controlled substances (excluding steroid hormones and drugs used treat attention deficit hyperactivity disorder) OR
- Tramadol containing agents OR
- Carisoprodol containing agents (Note: effective January 1, 2012, carisoprodol is a schedule IV controlled substance under the Controlled Substances Act of 1970).

The goal is to have the patient's physician evaluate the controlled substance patterns for these patients and consider additional follow-up where medically appropriate.

²⁰ Results from the 2005 National Survey on Drug Use and Health: National Findings. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. September 2006. Pages 6 and 15.

RESULTS (MEDICARE)

	Number of Members Identified	Number of Provider Mailings
2012	62	51
2013	132	137
2014	53	48

RESULTS (MCLA, HEALTHY KIDS AND PASC-SEIU)

	Number of MCLA Members Identified	Number of Provider Mailings for MCLA Members	Number of Healthy Kids Members Identified	Number of Provider Mailings for HK Members	Number of PASC-SEIU Members Identified	Number of Provider Mailings for PASC-SEIU Members
2012	3,527	2,188	0	0	104	84
2013	2,867	3,742	0	0	171	176
2014	5,702	3,179	0	0	167	142

ANALYSIS

100% of prescribers were notified of members for controlled substances (10 or more RXs for controlled substances or tramadol or carisoprodol).

LOOKING FORWARD

MCLA

L.A. Care will continue to enhance pharmacy management for MCLA members through the following interventions:

- Controlled Substances reports will continue to be forwarded to Medical Management for review and potential enrollment in case management.
- Pharmacy department will review the results for potential fraud, waste and abuse and forward responses to RA&C if the prescribing provider indicated that it is not his/her patient.

MEDICARE

L.A. Care will continue to enhance pharmacy management through for Medicare members the following interventions:

- Point-of-sale DUR edits will be implemented for high doses of opioids/acetaminophen/controlled substances. Depending on the level of severity, a prescriber may need to initiate a coverage determination to justify the dose being requested.
- L.A. Care will notify members where appropriate by mail of their high opioid utilization as being a safety issue followed by telephonic outreach by a Case Manager. In the event that a beneficiary's prescription drug claims for opioid analgesics cannot be established as medically necessary for the level of prescribing from the information or documentation received from prescribers, if any, during Case Management, L.A. Care will implement beneficiary-level edits at POS at all network pharmacies to reject claims or quantities in excess of plan established limits of opioid analgesics, for the beneficiary. L.A. Care case manager will notify the prescriber(s) and beneficiary in writing that the rejections will begin after a reasonable period of time despite multiple attempts to work with prescribers to adjust dosing.

II. ANTIBIOTICS (THIS PROGRAM DOES NOT PERTAIN TO MEDICARE MEMBERS)

2014 WORK PLAN GOAL:

- 100% of prescribers will be notified if prescribing 3 or more short-term antibiotics for 3 or more members in 3 months.

In 2010, L.A. Care modified the Antibiotic DUE program to enhance pharmacy management activity by targeting providers who have 3 or more patients who received 3 or more antibiotics over 3-month period to review utilization patterns.

Inappropriate antibiotic prescribing contributes to the problem of high bacterial resistance. Surveillance studies conducted in the United States over the last decade have revealed increasing resistance among community-acquired respiratory pathogens, especially Streptococcus Pneumonia that may limit future options for empirical therapy.^{21,22} The emergence of drug-resistant bacteria has implications not only for patients with documented resistance, but for all patients who might have such infections. Currently, the specter of drug-resistant Streptococcus Pneumonia and other resistant bacteria has led to recommended empiric treatment regimens for a variety of infections (such as community-acquired pneumonia that include antibiotics previously reserved for life-threatening infections).²³

Antibiotics are not indicated for treating adults with acute bronchitis who do *not* have a comorbidity or other infection for which antibiotics may be appropriate. Likewise, Pediatric clinical practice guidelines do not recommend antibiotics for a majority of upper respiratory tract infections due to viral etiology of these infections, including the common cold. The National Quality Measures Clearinghouse has a quality measure assessing whether antibiotics are inappropriately prescribed for healthy adults with bronchitis.²⁴ The measure is built on an existing HEDIS® measure that targets inappropriate antibiotic prescribing for children with upper respiratory infection (URI) (common cold).²⁵

The goal is to have these prescribers consider the use of palliative treatment instead of antibiotics for upper respiratory infections when members have no comorbidity.

RESULTS IN 2012-2014 (MCLA, HEALTHY KIDS, HEALTHY FAMILIES)

	Medi-Cal (MCLA)	Healthy Kids	Healthy Families
2012	1,050	18	16
2013	937	0	0
2014	127	0	0

²¹Critchley IA; Brown SD; Traczewski MM; Tillotson GS; Janjie N, National and regional assessment of antimicrobial resistance among community-acquired respiratory tract pathogens identified in a 2005-2006 U.S. Faropenem surveillance study. *Antimicrob Agents Chemother.* 2007;51(12):4382-9.

²²Linder JA; Stafford RS, Antibiotic treatment of adults with sore throat by community primary care physicians: a national survey, 1989-1999. *JAMA.* 2001; 286(10):1181-6.

²³<http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hstechrev&part=A21681>

²⁴National Committee for Quality Assurance (NCQA). HEDIS® 2009: Healthcare Effectiveness Data & Information Set. Vol.1, Narrative. Washington

(DC): National Committee for Quality Assurance (NCQA); 2008 Jul. 90p.

²⁵http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?ss=1&doc_id=13041&string=4226

ANALYSIS

100% of prescribers were notified if prescribing 3 or more antibiotics for 3 or more members in 3 months. The notifications to prescribing providers increased due to Medi-Cal expansion.

LOOKING FORWARD

L.A. Care will continue this modified Antibiotic DUE program on a quarterly basis in 2013 in the identification of providers who have 3 or more patients who received 3 or more antibiotics over 3-month period to review utilization patterns.

III. ASTHMA

2014 WORK PLAN GOAL:

- 100% of prescribers with members who received 4 or more prescriptions for asthma medications over the previous 12 months and did not receive recommended medication therapy will be notified and provided a medication profile. Mbrs \geq 6yo with 4 or more asthma medication dispensing events over a 12 month time period with no controller medication. Exclude members on syrups only.

BACKGROUND

In 2007, the National Heart, Lung, and Blood Institute (NHLBI) and the National Asthma Education and Prevention Program (NAEPP) updated the asthma treatment guidelines.²⁶ Key elements of the guidelines include:

- Symptom control is the chief therapeutic target in asthma management
- Anti-inflammatory agents are the most effective medications for long-term asthma therapy
- Use of short-acting beta agonists $>$ 2 times a week for symptom relief may indicate need to initiate or intensify long-term control therapy

The National Committee for Quality Assurance (NCQA) developed a Healthcare Effectiveness Data and Information Set (HEDIS) measure called, “Use of Appropriate Medications for People with Asthma” to measure conformity with the NHLBI guidelines. The measure:

- Reflects the rate of recommended therapy for patients with persistent asthma.
- Defines persistent asthma as patients who have filled 4 or more prescriptions for asthma medications during the measurement year, or those that have had at least one ER visit or hospitalization due to asthma as the primary diagnosis.

L.A. Care Health Plan evaluated and provided medication profiles of members who received 4 or more prescriptions for asthma medications over the previous 12 months and did not receive recommended medication therapy (i.e. an inhaled corticosteroid, oral leukotriene, theophylline, Xolair, or mast cell stabilizer in the same 12 month period) to the prescribing physicians.

²⁶ The National Asthma Education and Prevention Program. NAEPP Expert Panel Report 3 (EPR 3). Available at: <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm>.

RESULTS (MEDICARE)

Asthma	Number of Members Identified	Number of Provider Mailings
2012	98	74
2013	177	199
2014	379	302

RESULTS (MCLA)

	Medi-Cal (MCLA)	Healthy Kids	Healthy Families
2012	4,909	48	60
2013	4,591	14	18
2014	9,513	0	0

ANALYSIS

100% of the prescribing physicians were provided with medication profiles of members who received 4 or more prescriptions for asthma medications over the previous 12 months and did not receive recommended medication therapy (i.e. an inhaled corticosteroid, oral leukotriene, theophylline, Xolair, or mast cell stabilizer in the same 12 month period).

The increase in numbers in Medi-Cal may be due to continuous increase in membership, especially with the mandatory enrollment of Seniors and People with Disabilities (SPDs) starting June 2011. However, the asthma HEDIS measure is also decreasing demonstrating the need to continue this program.

LOOKING FORWARD

- L.A. Care will continue to consistently identify members who receive asthma reliever medications with no asthma controller medications. The exact specifications of the clinical program are pending with Navitus for 2015.
- Asthma Clinical Health Improvement Nurses will visit doctors with significant asthma membership and discuss asthma reports.

IV. ACETAMINOPHEN (APAP) (THIS PROGRAM DOES NOT PERTAIN TO NON-MEDICARE MEMBERS)

2014 WORK PLAN GOAL:

- Improved Use of Claim Edits (Safety Controls at POS) to prevent the dispensing of unsafe daily doses of APAP (greater than 4gm/day as recommended by the FDA) to any beneficiary, either in agreement with the prescribers to assist in managing the patient or when the prescribers are non-responsive to case management to help protect the beneficiary.

BACKGROUND

As detailed in Chapter 7 of the Prescription Drug Benefit Manual, the regulations at 42 CFR 423.153(c)(2) require that each Part D sponsor have concurrent DUR systems, policies, and procedures designed to ensure that a review of prescribed drug therapy is performed before each prescription is dispensed to an enrollee, typically at point of sale (POS) or point of distribution. The Part D sponsor's concurrent DUR program must include a number of checks each time a prescription is dispensed, including one for overutilization.

L.A. Care has a safety edit at POS to alert the dispensing of unsafe daily doses of APAP (greater than 4gm/day as recommended by the FDA). It is expected the pharmacists will exercise clinical review to minimize the risk of overutilization.

L.A. Care receives quarterly reports from CMS identifying beneficiaries with potential overutilization issues identified through Medicare Part D Prescription Drug Event (PDE) data based on CMS' methodology. L.A. Care investigates beneficiaries' potential overutilization issues identified in the Overutilization Monitoring System and will review, submit, and track responses to overutilization issues in Acumen.

The goal is to promote safe use (by not allowing dosages beyond maximum dose or unsafe dosages) and to decrease incidences of fraud, waste and abuse.

RESULTS (MEDICARE)

Overutilization Monitoring System Reports	Number of beneficiaries with Potential Overutilization Issue	Number of beneficiaries requiring Case Management
7/31/2013	15	0
10/31/2014	18	1

LOOKING FORWARD

L.A. Care will continue to investigate beneficiaries' potential overutilization issues identified in the Overutilization Monitoring System and will review, submit, and track responses to overutilization issues in Acumen.

V. MEDICATION THERAPY MANAGEMENT PROGRAM (THIS PROGRAM DOES NOT PERTAIN TO NON-MEDICARE MEMBERS)

BACKGROUND

Since Medicare Part D was launched in October 2006, Part D prescription drug plan sponsors are required to establish a medication therapy management program (MTMP) that is designed to optimize therapeutic outcomes for target beneficiaries by improving medication use and reducing adverse events. For each contract year since 2008, L.A. Care has been required to submit targeted criteria for eligibility in the MTMP.

For Contract Year 2010, CMS modified the MTM program. In order to meet the new CMS requirements, L.A. Care contracted with Outcomes Pharmaceuticals Health Care (Outcomes).

For Contract Year 2014, each beneficiary may receive MTM intervention based on the following criteria:

- 3 or more chronic diseases
- 8 or more covered Part D drugs
- Incurred quarterly costs of one-fourth of annual cost threshold of \$3,017
- Beneficiary is allowed to Opt-Out of the MTM program
- Both the beneficiary and prescriber will be the recipients of the MTM program
 - Beneficiary interventions include the following:

- Annual Comprehensive Medication Review performed face-to-face or telephonically by a local retail pharmacist
- Targeted medication reviews performed on a quarterly basis
- Patient Compliance Consultation performed face-to-face by the local retail pharmacist
- Patient Education and Monitoring performed face-to-face by the local retail pharmacist
- Prescriber interventions to resolve medication-related problems or optimize therapy by phone or fax consultations

NOTE: The local retail pharmacist is compensated for these face-to-face interventions by Outcomes.

RESULTS FOR 2012-2014 (MEDICARE)

Comprehensive Medication Review (CMR)

The member intervention includes face-to-face consultations with a local retail pharmacist for an Annual Comprehensive Medication Review (CMR). The member meets with a local pharmacist for an interactive review all medications including prescription and over-the-counter drugs.

The prescriber intervention includes a consultation by a local retail pharmacist on his patient's therapy. The Targeted Intervention Program (TIP) retroactively identifies potential gaps in care, non-adherence, high risk medication and cost savings opportunities and are sent to local pharmacists to intervene with the prescribers by phone or fax consultation.

RESULTS (MEDICARE)

	2012	2013	2014
Completed CMR	241	325	551
CMR Member Refusal	91	412	1,006
TIPs Sent	5,597	6,640	11,951
TIPs Returned	1,704	1,881	3,462
Member TIP Refusal	450	513	626
Prescriber TIP Refusal	322	270	315

VI. OTHER PHARMACY PROGRAMS

PRIOR AUTHORIZATION

L.A. Care has a prior authorization process in place to ensure that non-formulary and certain formulary medications are reviewed for medical necessity. Each prior authorization request is reviewed based on the individual member's need within 24 hours. All determinations are based on documentation of existing medical need. The goal of the prior authorization is to be used for medications that pose a potential efficacy, toxicity or utilization problems and which do not meet criteria for being included in a Step Therapy Protocol. L.A. Care and MedImpact reviews the top 10 list of drugs requiring prior authorization requests and approvals to make necessary adjustments to formulary status and/or prior authorization protocols on a monthly basis.

TOP 10 DRUGS RECEIVING PRIOR AUTHORIZATION REQUESTS FOR 2014

MEDICARE PART D: January to December 31, 2014

January to December 31, 2014	
1	Restasis
2	Ondansetron HCl
3	Metformin HCl
4	Nexium
5	Amlodipine besylate
6	Diovan
7	Zolpidem tartrate
8	Dexilant
9	Omeprazole
10	Losartan Potassium
# of Auths Requested	1,965
# of Auths Approved	1,589
Approval %	80.8%

CMC: JANUARY TO DECEMBER 31, 2014

January to December 31, 2014	
1	Prednisone
2	Restasis
3	Mycophenolate mofetil
4	Tacrolimus
5	Nexium
6	Celebrex
7	Methotrexate
8	Humira
9	Azathioprine
10	Dexilant
# of Auths Requested	603
# of Auths Approved	448
Approval %	74.3%

TOP 10 DRUGS RECEIVING PRIOR AUTHORIZATION REQUESTS FOR 2014

MEDI-CAL, HEALTHY KIDS, HEALTHY FAMILY AND PASC-SEIU: JANUARY TO DECEMBER 31, 2014

	MCLA	Healthy Kids	Healthy Families*	PASC-SEIU
1.	Duloxetine HCl (Cymbalta)	Zovirax (2 PAs)	-	Acyclovir
2.	Renagel	Lamotrigine (2 PAs)	-	Duloxetine HCl (Cymbalta)
3.	Pediasure	Tamiflu (1 PA)	-	Truvada
4.	Freestyle Lite Test Strips	Topiramate (1 PA)	-	Hydrocodone/APAP (Norco)
5.	Januvia	Focalin XR (1 PA)	-	Atorvastatin
6.	Lyrica	Nitrofurantoin (1 PA)	-	Atripla
7.	Similac Expert Care Neosure	-	-	Valacyclovir
8.	Sensipar	-	-	Invokana
9.	Lantus	-	-	Humalog
10.	Fluconazole	-	-	Clobetasol propionate
# of auths requested	42,673	8	-	1945
# of auths approved	30,247	5	-	1436
Approval %	70.9%	62.5%	-	73.8%

* No prior authorizations for Healthy Families submitted in 2014

STEP THERAPY

L.A. Care uses Step Therapy to promote cost-effective pharmaceutical management when there are multiple effective drugs to treat a condition. Medications that have a step therapy requirement will require one or more “prerequisite” first step drugs to be tried before progressing to the second step drug. When a prescription for a Step Therapy drug is filled at the dispensing pharmacy, the contracted PBM’s pharmacy claims system will search past claims for the first step drugs. If necessary, a Step Therapy drug can be obtained without first trying a first step drug by submitting a Prior Authorization request with documentation of existing medical need for consideration. Procedures and timeframes follow the Prior Authorization process.

QUANTITY LIMIT

L.A. Care has identified a select number of medications to be subjected to quantity limits. A quantity limit establishes the maximum amount of medication that L.A. Care will cover within a defined period of time. If a member has a medical condition that requires a quantity of medication that exceeds the limit, a written Prior Authorization request can be submitted with documentation of existing medical need for consideration. Procedures and timeframes follow the Prior Authorization process.

THERAPEUTIC INTERCHANGE

L.A. Care may use Therapeutic Interchange to promote rational pharmaceutical therapy when evidence suggests that outcomes can be improved by substituting a drug that is therapeutically equivalent but chemically different from the prescribed drug. Therapeutic Interchange protocols are never automatic; a dispensing provider may not substitute a therapeutically equivalent alternative drug for the prescribed drug without the knowledge and authorization of the prescribing provider.

PHARMACY UTILIZATION TRENDS IN 2014

L.A. Care also monitors pharmacy utilization trends on a monthly basis. List below are the overall pharmacy utilization results for each direct line of business for January to December 2014.

MEDICARE PART D

Top 10 Diseases by Prescription Volume for PART D in January to December 2013			Top 10 Diseases by Prescription Volume for PART D in January to December 2014	
Rank	Disease	Total Prescriptions	Disease	Total Prescriptions
1	Cardiovascular Disease- Hypertension	40,167	Cardiovascular Disease- Hypertension	74,205
2	Diabetes	23,680	Diabetes	45,330
3	Cardiovascular Disease - Lipid Irregularity	15,941	Cardiovascular Disease - Lipid Irregularity	27,712
4	Pain Management - Analgesics	12,223	Pain Management – Analgesics	25,207
5	Upper Gastrointestinal Disorders - Ulcer Disease	11,023	Upper Gastrointestinal Disorders - Ulcer Disease	22,821
6	Inflammatory Disease	8,475	Inflammatory Disease	19,657
7	Behavioral Health-Other	7,573	Asthma	15,359
8	Behavioral Health- Antidepressants	6,417	Behavioral Health-Other	14,880
9	Asthma	6,061	Seizure Disorder	12,686
10	Seizure Disorder	5,941	Behavioral Health – Antidepressants	12,186

Top 10 Diseases by Prescription Cost for PART D in January to December 2013			Top 10 Diseases by Prescription Cost for PART D in January to December 2014	
Rank	Disease	Total Plan Paid	Disease	Total Plan Paid
1	Diabetes	\$2,900,028	Diabetes	\$5,593,249.46
2	Asthma	\$1,041,295	Infectious Disease – Viral	\$2,372,343.47
3	Behavioral Health- Other	\$1,010,610	Asthma	\$1,766,830.21
4	Cardiovascular Disease- Hypertension	\$860,280	Behavioral Health-Other	\$1,563,652.82
5	Cardiovascular Disease-Lipid Irregularity	\$879,688	Cardiovascular Disease-Lipid Irregularity	\$1,359,380.56
6	Infectious Disease – Viral	\$657,535	Cardiovascular Disease – Hypertension	\$1,316,853.00
7	Neoplastic Disease	\$653,311	Inflammatory Disease	\$1,062,493.77
8	Inflammatory Disease	\$513,547	Neoplastic Disease	\$894,529.78
9	Urinary Tract - Functional Disorders	\$365,155	Seizure Disorder	\$630,604.46
10	Seizure Disorder	\$345,597	Urinary Tract - Functional Disorders	\$557,370.02

MEDICARE PART D

Top 10 Drugs by Prescription Volume for PART D in January to December 2013			Top 10 Drugs by Prescription Volume for PART D in January to December 2014	
Rank	Drug	Total Prescriptions	Drug	Total Prescriptions
1	Metformin HCL	9,411	Omeprazole	12,459
2	Omeprazole	9,329	Metformin HCL	12,165
3	Amlodipine Besylate	8,620	Amlodipine besylate	11,614
4	Simvastatin	7,502	Blood Sugar Diagnostics (all brands, volume being highest for Freestyle Lite)	9,622
5	Hydrocodone-Acetaminophen	6,074	Simvastatin	8,255
6	Benazepril HCL	5,763	Hydrocodone/Acetaminophen	8,053
7	Lisinopril	5,393	Atorvastatin calcium	7,697
8	Atorvastatin Calcium	5,109	Gabapentin	6,757
9	Hydrochlorothiazide	4,900	Aspirin	6,748
10	Ibuprofen	4,884	Ibuprofen	6,744

Top 10 Drugs by Prescription Cost for PART D in January to December 2013			Top 10 Drugs by Prescription Cost for PART D in January to December 2014	
Rank	Drug	Total Plan Paid	Drug	Total Plan Paid
1	Januvia	\$602,895	Insulin glargine (includes all formulations, spend being highest for Lantus vials)	\$1,194,723.13
2	Abilify	\$508,954	Januvia	\$1,183,249.80
3	Lantus	\$361,340	Sovaldi	\$1,114,904.86
4	Advair Diskus	\$345,197	Abilify	\$870,877.06
5	Revlimid	\$318,418	Blood Sugar Diagnostics (all brands, spend being highest for Freestyle Lite)	\$813,505.10
6	Crestor	\$246,294	Advair Diskus	\$564,231.25
7	Spiriva	\$193,673	Crestor	\$442,070.36
8	Gleevec	\$194,659	Diclofenac sodium (includes all formulations, spend being highest for Voltaren gel)	\$353,783.16
9	Diovan	\$188,619	Spiriva	\$297,793.34
10	Lantus Solostar	\$169,486	Albuterol sulfate (includes all formulations, spend being highest for ProAir HFA)	\$295,173.94

CAL MEDICONNECT(CMC)

Top 10 Diseases by Prescription Volume for CMC in January to December 2014		
Rank	Disease	Total Prescriptions
1	Cardiovascular Disease- Hypertension	18,872
2	Diabetes	9,477
3	Behavioral Health-Other	8,221
4	Pain Management - Analgesics	7,378
5	Cardiovascular Disease – Lipid Irregularity	7,123
6	Upper Gastrointestinal Disorders - Ulcer Disease	5,667
7	Behavioral Health- Antidepressants	4,909
8	Seizure Disorder	4,628
9	Inflammatory Disease	4,153
10	Asthma	3,522

Top 10 Diseases by Prescription Cost for CMC in January to December 2014		
Rank	Disease	Total Plan Paid
1	Behavioral Health- Other	\$1,568,347.06
2	Diabetes	\$1,221,664.01
3	Infectious Disease- Viral	\$878,071.02
4	Neoplastic Disease	\$555,944.49
5	Asthma	\$430,862.65
6	Cardiovascular Disease – Hypertension	\$391,429.92
7	Hematological Disorders	\$331,116.73
8	Inflammatory Disease	\$328,689.43
9	Cardiovascular Disease – Lipid Irregularity	\$323,378.19
10	Seizure Disorder	\$274,703.04

CAL MEDICONNECT(CMC)

Top 10 Drugs by Prescription Volume for CMC in January to December 2014		
Rank	Drug	Total Prescriptions
1	Aspirin	3,253
2	Amlodipine besylate	2,925
3	Metformin HCL	2,740
4	Omeprazole	2,556
5	Atorvastatin calcium	2,282
6	Simvastatin	2,253
7	Hydrocodone/acetaminophen	1,806
8	Lisinopril	1,678
9	Blood Sugar Diagnostics (all brands, volume being highest for FreeStyle Lite)	1,599
10	Levothyroxine sodium	1,584

Top 10 Drugs by Prescription Cost for CMC in January to December 2014		
Rank	Drug	Total Plan Paid
1	Abilify	\$711,389.64
2	Insulin glargine (all formulations, spending being highest for Lantus vials)	\$272,222.51
3	Januvia	\$206,495.73
4	Revlimid	\$196,326.07
5	Blood Sugar Diagnostics (all brands, spend being highest for FreeStyle Lite)	\$184,023.76
6	Clozapine	\$155,796.71
7	Humira	\$152,360.13
8	Namenda	\$150,922.16
9	Factor IX Human Recombinant	\$145,590.08
10	Truvada	\$144,686.23

MCLA

Top 10 Diseases by Prescription Volume for MCLA in January to December 2013			Top 10 Diseases by Prescription Volume for MCLA in January to December 2014	
Rank	Disease	Total Prescriptions	Disease	Total Prescriptions
1	Cardiovascular Disease - Hypertension	465,239	Antidiabetics	331,047
2	Pain Management - Analgesics	386,850	Antihypertensives	324,423
3	Diabetes	254,022	Antidepressants	306,879
4	Inflammatory Disease	253,115	Analgesics - Anti-Inflammatory	300,661
5	Infectious Disease - Bacterial	248,019	Analgesics – Opioid	265,880
6	Asthma	214,631	Analgesics – Non-narcotic	259,240
7	Behavioral Health - Antidepressants	188,228	Antiasthmatic And Bronchodilator Agents	257,537
8	Vitamin and/or Mineral Deficiency	184,228	Antihyperlipidemics	248,843
9	Allergy	183,426	Ulcer Drugs	221,368
10	Seizure Disorder	163,042	Dermatologicals	219,413

Top 10 Diseases by Prescription Cost for MCLA in January to December 2013			Top 10 Diseases by Prescription Cost for MCLA in January to December 2014	
Rank	Disease	Total Plan Paid	Disease	Total Plan Paid
1	Diabetes	\$23,485,188	Antidiabetics	\$40,678,542
2	Asthma	\$19,245,593	Antiasthmatic And Bronchodilator Agents	\$26,711,116
3	Cardiovascular Disease - Hypertension	\$12,234,870	Antivirals	\$15,970,404
4	Neoplastic Disease	\$9,646,878	Anticonvulsants	\$12,295,608
5	Seizure Disorder	\$8,487,632	Antihyperlipidemics	\$11,437,391
6	Cardiovascular Disease - Lipid Irregularity	\$6,749,010	Dermatologicals	\$11,007,099
7	Electrolyte Regulation	\$6,501,924	Antineoplastics And Adjunctive Therapies	\$10,936,981
8	Pain Management - Analgesics	\$4,510,622	Diagnostic Products	\$10,227,395
9	Upper Gastrointestinal Disorders - Ulcer Disease	\$4,509,129	Antihypertensives	\$7,703,264
10	Infectious Disease - Bacterial	\$4,478,636	Gastrointestinal Agents - Misc.	\$7,690,301

MCLA

Top 10 Drugs by Prescription Volume for MCLA in January to December 2013			Top 10 Drugs by Prescription Volume for MCLA in January to December 2014	
Rank	Drug	Total Prescriptions	Drug	Total Prescriptions
1	Ibuprofen	145,676	Ibuprofen	196,441
2	Hydrocodone-Acetaminophen	102,620	Hydrocodone/Acetaminophen	131,940
3	Aspirin EC	92,908	Metformin Hcl	131,609
4	Amoxicillin	89,350	Omeprazole	126,244
5	Ventolin HFA	88,854	Ventolin Hfa	114,448
6	Omeprazole	83,116	Amlodipine Besylate	106,452
7	Metformin HCL	69,311	Amoxicillin	98,266
8	Amlodipine Besylate	67,026	Simvastatin	90,515
9	Simvastatin	60,285	Lisinopril	89,707
10	Loratadine	56,599	Aspirin Ec Low Dose	88,843

Top 10 Drugs by Prescription Cost for MCLA in January to December 2013			Top 10 Drugs by Prescription Cost for MCLA in January to December 2014	
Rank	Disease	Total Plan Paid	Disease	Total Plan Paid
1	Renagel	\$4,729,865	Sovaldi	\$12,663,956
2	Ventolin Hfa	\$4,139,561	Freestyle Lite Test Strip	\$9,543,700
3	Lantus	\$3,743,374	Lantus	\$8,954,651
4	Qvar	\$3,130,702	Ventolin Hfa	\$5,680,610
5	Advair Diskus	\$2,718,700	Qvar	\$5,339,472
6	Omeprazole	\$2,679,987	Januvia	\$5,336,031
7	Januvia	\$2,512,160	Renagel	\$5,036,928
8	Atorvastatin Calcium	\$2,229,800	Omeprazole	\$4,562,136
9	Sensipar	\$2,149,480	Atorvastatin Calcium	\$4,420,358
10	Spiriva	\$2,144,190	Dulera	\$4,350,860

HEALTHY KIDS

Top 10 Diseases by Prescription Volume for HK in January to December 2013			Top 10 Diseases by Prescription Volume for HK in January to December 2014	
Rank	Disease	Total Prescriptions	Disease	Total Prescriptions
1	Infectious Disease - Bacterial	1,961	Antiasthmatic And Bronchodilator Agents	220
2	Asthma	1,264	Penicillins	200
3	Inflammatory Disease	941	Dermatologicals	86
4	Cough And Cold	754	Analgesics - Anti-Inflammatory	81
5	Allergy	666	Antihistamines	71
6	Eye - General Disorders	293	Macrolides	69
7	Dermatology - Antiinfective	267	Cough/Cold/Allergy	66
8	Dermatology - Antiinflammatory	238	Corticosteroids	63
9	Seizure Disorder	159	Cephalosporins	63
10	Upper Gastrointestinal Disorders - Ulcer Disease	136	Ophthalmic Agents	58

Top 10 Diseases by Prescription Cost for HK in January to December 2013			Top 10 Diseases by Prescription Cost for HK in January to December 2014	
Rank	Disease	Total Plan Paid	Disease	Total Plan Paid
1	Asthma	\$71,805	Antiasthmatic And Bronchodilator Agents	\$12,960
2	Infectious Disease - Bacterial	\$28,926	Anticonvulsants	\$5,477
3	Behavioral Health - Other	\$19,340	Dermatologicals	\$4,438
4	Infectious Disease - Viral	\$12,466	Urinary Anti-Infectives	\$3,520
5	Allergy	\$9,649	Corticosteroids	\$3,322
6	Dermatology - Antiinfective	\$11,442	Cephalosporins	\$2,195
7	Seizure Disorder	\$11,373	Macrolides	\$1,439
8	Inflammatory Disease	\$7,035	Penicillins	\$1,433
9	Dermatology - Acne	\$9,536	Vasopressors	\$1,301
10	Eye - General Disorders	\$6,631	Assorted Classes	\$1,057

HEALTHY KIDS

Top 10 Drugs by Prescription Volume for HK in January to December 2013			Top 10 Drugs by Prescription Volume for HK in January to December 2014	
Rank	Drug	Total Prescriptions	Drug	Total Prescriptions
1	Amoxicillin	914	Amoxicillin	175
2	Ibuprofen	680	Albuterol Sulfate	84
3	Promethazine-DM	655	Ibuprofen	81
4	Ventolin HFA	520	Azithromycin	69
5	Azithromycin	446	Ventolin Hfa	64
6	Albuterol Sulfate	254	Cephalexin	54
7	Cephalexin	254	Prednisolone	38
8	Fluticasone Propionate	208	Montelukast Sodium	33
9	Loratadine	200	Promethazine-Dm	31
10	Qvar	172	Amoxicillin/Clavulanate P	22

Top 10 Drugs by Prescription Cost for HK in January to December 2013			Top 10 Drugs by Prescription Cost for HK in January to December 2014	
Rank	Drug	Total Plan Paid	Drug	Total Plan Paid
1	Ventolin HFA	\$22,223	Budesonide	\$7,158
2	Qvar	\$22,093	Vimpat	\$3,653
3	Budesonide	\$8,347	Nitrofurantoin	\$3,484
4	Azithromycin	\$6,093	Ventolin Hfa	\$2,773
5	Tamiflu	\$7,782	Qvar	\$2,227
6	Amoxicillin	\$3,307	Cephalexin	\$1,566
7	Fluticasone Propionate	\$5,155	Azithromycin	\$1,439
8	Abilify	\$6,085	Nystatin/Triamcinolone	\$1,396
9	Montelukast Sodium	\$5,276	Epipen-Jr 2-Pak	\$1,301
10	Flovent Hfa	\$5,251	Montelukast Sodium	\$1,113

HEALTHY FAMILIES

Top 10 Diseases by Prescription Volume for HF in January to December 2013			Top 10 Diseases by Prescription Volume for HF in January to December 2014	
Rank	Disease	Total Prescriptions	Disease	Total Prescriptions
1	Infectious Disease - Bacterial	2,500	Ulcer Drugs	1
2	Asthma	1,349	-	-
3	Inflammatory Disease	1,078	-	-
4	Cough And Cold	871	-	-
5	Allergy	663	-	-
6	Dermatology - Antiinfective	269	-	-
7	Dermatology - Antiinflammatory	258	-	-
8	Eye - General Disorders	236	-	-
9	Behavioral Health - Other	148	-	-
10	Infectious Disease - Viral	148	-	-

HEALTHY FAMILIES

Top 10 Diseases by Prescription Cost for HF in January to December 2013			Top 10 Diseases by Prescription Cost for HF in January to December 2014	
Rank	Disease	Total Plan Paid	Disease	Total Plan Paid
1	Asthma	\$75,478	Ulcer Drugs	\$1.65
2	Infectious Disease - Bacterial	\$29,840	-	-
3	Behavioral Health - Other	\$21,217	-	-
4	Infectious Disease - Viral	\$15,033	-	-
5	Dermatology - Antiinfective	\$11,309	-	-
6	Allergy	\$7,769	-	-
7	Inflammatory Disease	\$2,815	-	-
8	Cough And Cold	\$1,270	-	-
9	Dermatology - Acne	\$6,985	-	-
10	Seizure Disorder	\$6,075	-	-

Top 10 Drugs by Prescription Volume for HF in January to December 2013			Top 10 Drugs by Prescription Volume for HF in January to December 2014	
Rank	Drug	Total Prescriptions	Drug	Total Prescriptions
1	Amoxicillin	1,135	Rantidine HCl	1
2	Ibuprofen	747	-	-
3	Promethazine-DM	740	-	-
4	Azithromycin	689	-	-
5	Ventolin HFA	552	-	-
6	Albuterol Sulfate	297	-	-
7	Cephalexin	261	-	-
8	Fluticasone Propionate	237	-	-
9	Loratadine	203	-	-
10	Amox TR-Potassium Clavulanate	188	-	-

Top 10 Drugs by Prescription Cost for HF in January to December 2013			Top 10 Drugs by Prescription Cost for HF in January to December 2014	
Rank	Drug	Total Plan Paid	Drug	Total Plan Paid
1	Ventolin HFA	\$21,726	Rantidine HCl	\$1.65
2	Qvar	\$19,084	-	-
3	Tamiflu	\$14,923	-	-
4	Budesonide	\$13,875	-	-
5	Azithromycin	\$8,291	-	-
6	Amoxicillin	\$2,464	-	-
7	Abilify	\$9,487	-	-
8	Flovent HFA	\$6,979	-	-
9	Fluticasone Propionate	\$5,436	-	-
10	Ibuprofen	\$1,603	-	-

PASC-SEIU

Top 10 Diseases by Prescription Volume for PASC-SEIU in January to December 2013			Top 10 Diseases by Prescription Volume for PASC-SEIU in January to December 2014	
Rank	Drug	Total Plan Paid	Drug	Total Plan Paid
1	Cardiovascular Disease - Hypertension	41,778	Antihypertensives	18,389
2	Diabetes	21,703	Antidiabetics	18,109
3	Cardiovascular Disease - Lipid Irregularity	16,868	Antihyperlipidemics	16,858
4	Infectious Disease - Bacterial	13,177	Ulcer Drugs	12,572
5	Pain Management - Analgesics	13,041	Antidepressants	10,432
6	Upper Gastrointestinal Disorders - Ulcer Disease	11,681	Analgesics – Opioid	10,359
7	Inflammatory Disease	10,997	Analgesics - Anti-Inflammatory	9,503
8	Behavioral Health - Antidepressants	9,305	Diuretics	7,989
9	Behavioral Health - Other	7,653	Beta Blockers	7,793
10	Endocrine Disorder - Thyroid	6,668	Thyroid Agents	7,351

Top 10 Diseases by Prescription Cost for PASC-SEIU in January to December 2013			Top 10 Diseases by Prescription Cost for PASC-SEIU in January to December 2014	
Rank	Drug	Total Plan Paid	Drug	Total Plan Paid
1	Diabetes	\$1,369,405	Antivirals	\$1,681,476
2	Infectious Disease - Viral	\$909,397	Antidiabetics	\$1,560,454
3	Cardiovascular Disease - Hypertension	\$523,040	Antihyperlipidemics	\$593,345
4	Cardiovascular Disease - Lipid Irregularity	\$621,132	Antiasthmatic And Bronchodilator Agents	\$521,469
5	Neoplastic Disease	\$489,466	Antineoplastics And Adjunctive Therapies	\$454,672
6	Asthma	\$372,013	Diagnostic Products	\$352,336
7	Pain Management - Analgesics	\$242,282	Dermatologicals	\$304,300
8	Behavioral Health - Other	\$246,372	Analgesics – Opioid	\$281,987
9	Upper Gastrointestinal Disorders - Ulcer Disease	\$190,599	Ulcer Drugs	\$201,562
10	Infectious Disease - Bacterial	\$164,105	Antihypertensives	\$199,693

PASC-SEIU

Top 10 Drugs by Prescription Volume for PASC-SEIU in January to December 2013			Top 10 Drugs by Prescription Volume for PASC-SEIU in January to December 2014	
Rank	Drug	Total Plan Paid	Drug	Total Plan Paid
1	Simvastatin	8,131	Simvastatin	7,908
2	Metformin HCL	7,650	Metformin Hcl	7,728
3	Omeprazole	7,007	Omeprazole	7,599
4	Hydrocodone-Acetaminophen	6,904	Levothyroxine Sodium	6,159
5	Amlodipine Besylate	6,029	Amlodipine Besylate	5,940
6	Levothyroxine Sodium	5,807	Ibuprofen	5,757
7	Ibuprofen	5,680	Losartan Potassium	5,382
8	Benazepril HCL	5,651	Hydrochlorothiazide	5,259
9	Hydrochlorothiazide	5,207	Benazepril Hcl	5,060
10	Losartan Potassium	4,796	Lisinopril	4,782

Top 10 Drugs by Prescription Cost for PASC-SEIU in January to December 2013			Top 10 Drugs by Prescription Cost for PASC-SEIU in January to December 2014	
Rank	Drug	Total Plan Paid	Drug	Total Plan Paid
1	Simvastatin	\$308,599	Sovaldi	\$670,688
2	Lantus	\$184,125	Freestyle Lite Test Strip	\$319,030
3	Truvada	\$173,508	Lantus	\$311,851
4	Metformin HCL	\$136,120	Simvastatin	\$276,517
5	Valacyclovir	\$171,463	Januvia	\$218,868
6	Amlodipine Besylate	\$108,628	Truvada	\$179,046
7	Januvia	\$130,933	Tasigna	\$165,835
8	Viread	\$121,239	Humalog	\$161,041
9	Humalog	\$114,576	Revlimid	\$139,935
10	Atripla	\$110,947	Lantus Solostar	\$137,106

C.2 DELEGATED OVERSIGHT

2014 WORK PLAN GOALS:

- 100% of all delegates who need an audit will receive an annual audit.
- 100% of all delegates will report quarterly as specified in contract.
- 100% submission of timely delegate oversight reporting for each department.

BACKGROUND

L.A. Care may delegate activities to entities with established quality improvement programs and policies consistent with regulatory and NCQA accreditation requirements and standards. L.A. Care has mutually agreed upon delegation agreements with delegated entities. Prior to contracting with the entity, L.A. Care performs a pre-delegation audit to assess compliance with L.A. Care, current NCQA standards and state and federal regulatory requirements. L.A. Care retains accountability and ultimate responsibility for all components of the Program. On an annual basis, L.A. Care evaluates the delegates' performance against NCQA and DMHC/DHCS standards for the delegated activities. L.A. Care analyzes audit results and reports, and identifies opportunities for performance improvement. A corrective action may be required to address deficiencies. In addition, L.A. Care provides ongoing monitoring through oversight reports, meetings, and collaboration to continually assess compliance with standards and requirements.

Delegate reports are reviewed in the following committees:

- Utilization and Complex Case Management: Utilization Management Committee
- Credentialing: Credentialing Committee
- Member Rights (grievance and appeals): Quality Oversight Committee
- Quality and PQIs: Quality Oversight Committee
- Behavioral Health: Quality Oversight Committee
- Disease Management: Quality Oversight Committee

MAJOR ACCOMPLISHMENTS

- Continued monitoring and delegated oversight of delivery of preventive health services by measuring Healthcare Effectiveness Data and Information Set (HEDIS) performance during annual audit. Delegates are required to submit a Corrective Action Plan (CAP)/Quality Improvement Plan (QIP) in 2013 for HEDIS rate falling below minimal performance level (MPL) for both clinical measures as well as preventive health measures.
- Conducted full scope oversight of Kaiser Foundation using NCQA 2014 QI standards for all delegated functions, without provision of auto-credit issued by NCQA.

RESULTS

- 100% of required delegate audits were completed in 2014.
- 100% of the delegate reports were reviewed by the respective committee.
- 100% of delegate oversight reports were submitted for each department for substantive review and analysis.

ANALYSIS

L.A. Care continues to assess delegated activities by conducting substantive review and analysis of delegate reports. Plan Partners that are NCQA accredited are not audited for certain standards and functions. Healthways, an NCQA accredited Disease Management Organization was delegated for Diabetes Disease Management for all lines of business Medi-Cal, Medicare (diabetes chronic care improvement), L.A. Care Covered, Healthy Families, Healthy Kids and PASC-SEIU Home Workers for the first part of 2014; therefore, no longer delegates disease management. Beacon Health Strategies (Beacon), an NCQA accredited Managed Behavioral Health Organization (MBHO) is delegated behavioral health services for Medi-Cal (except special mental health services), Medicare, L.A. Care Covered, Healthy Families, Healthy Kids and PASC-SEIU Home Workers is NCQA accredited. During Beacon's annual audit, a corrective action plan was requested. Plan Partners and vendors submitted regular reports as defined in the delegation agreement. Some reports are reviewed on-site. All three (3) Plan Partners (Anthem Blue Cross, Care 1st and Kaiser Foundation) were requested to submit CAPs, as well as QIPs for underachieving in select HEDIS measures during annual delegation oversight audit.

LOOKING FORWARD

- L.A. Care will continue to work with the Plan Partners and contracted vendors to provide monitoring and oversight by obtaining the requested reports quarterly and during the annual audit process as required.
- QI will continue to require Plan Partners to complete a CAP/QIP if their HEDIS scores on key clinical and preventive health measures do not meet minimum performance level (MPL).

C.3 CREDENTIALING

BACKGROUND

L.A. Care develops and adheres to credentialing and recredentialing policies and procedures, including a process to document the mechanism for the credentialing and recredentialing of licensed independent practitioners with whom it contracts. The Credentialing Department reports regularly to the Quality Oversight Committee with an update from the Credentialing Committee. L.A. Care evaluates and contracts with health delivery organizations (HDOs). L.A. Care initially assesses and reassesses every three years thereafter, network facilities to assure compliance with regulatory standards and conducts ongoing monitoring for the entire network.

MAJOR ACCOMPLISHMENTS

- The Credentialing Department credentialed approximately 130 Skilled Nursing Facilities and additional HDO types to meet the network requirements for Cal MediConnect along with our regular core business. We continue to enhance policies and procedures for the SNF credentialing process to ensure the most comprehensive policy available.
- The Credentialing Department has completely integrated the ACN process using the California online application through our CACTUS database. The process has gained efficiencies, tightened the integrity, and adds a continuous monitoring. We have incorporated the online application for all lines of business so we have now gained efficiencies across the board.
- The Credentialing Department was the auspice of L.A. Care purchasing a CACTUS module that performs the monthly audit of OIG for our vendors and employees. This allows L.A. Care to manage this process independently and not have to hire a vendor to perform this function. The Credentialing Department is also the lead on the implementation to develop their business rules and then IT will do a rollout.
- The Credentialing Department received a 100% on our NCQA audit and received no deficiencies for the CMS audit.
- The Credentialing Department acquired the Facility Site Review Department. Integration of both departments went very smoothly and is a positive collaboration.
- The Credentialing Department has been able to maintain structure and compliance during a major growth of many different lines of businesses, rules, and regulations, as demonstrated by our audits above.

RESULTS

	Goal	2012 Results	2013 Results	2014 Results	Goal Met?
Credentialed	100%	100%	100%	100%	Met
Recredentialed	100%	100%	100%	100%	Met
HDO Assessment	100%	100%	100%	100%	Met

ANALYSIS

Quantitative and Qualitative Analysis

Goals were met for all three measures. No barriers were identified in meeting these goals.

LOOKING FORWARD

The Credentialing Department is looking to partner with CAQH and hopes to gain efficiencies through this application process.

The Credentialing Department is looking into the direct credentialing of mental health providers as our business and health care changes.

We plan to purchase the CACTUS Import/Export module which will allow data to be shared with any database. The goal will be to reduce administrative costs by eliminating inputting data manually. We will be able to export data from CACTUS to L.A. Care's database through automation.

CONCLUSION

Overall Effectiveness and Opportunities

Overall, the 2014 Quality Improvement Program was effective in identifying opportunities for improvement and enhancing processes and outcomes. Sufficient and appropriate resources were committed to complete projects detailed in the work plan. Additional staff were added to the disease management programs. Leadership played an active role by participating in quality committee meetings, providing input on quality related opportunities, helping to identify barriers and develop and implement effective approaches to achieve improvements. The Chief Executive Officer, Chief Medical Officer and Medical Director Quality Improvement and Health Assessment participate in the Compliance and Quality Committee of the Board. The organization's quality improvement work plan effectively monitored and reported on the numerous quality-related efforts underway throughout the organization. The work plan was updated and reviewed by the Quality Oversight Committee on a quarterly basis.

L.A. Care Health Plan has successfully undergone evaluation by regulators and accrediting bodies in 2014, with particular emphasis on quality of care, coordination and integration of services, and provision of effectiveness and efficacy of processes.

The assessments in 2014 included:

- March 10-20: CMS review of D-SNP, which identified multiple issues requiring immediate corrective action response (ICAR) and corrective action responses (CAR).
- June 16-17: NCQA reaccreditation of Medi-Cal and Covered California product lines, resulting in an overall "accredited" status.
- June 25 – July 9: DHCS audit of Medi-Cal. Results pending at this time.

In 2014, L.A. Care's D-SNP achieved a solid 3.0 Star rating. We earned 3.0 Star rating for Part C and improved to a Part D rating of 3.5 Stars. This allows us to obtain passive enrollment for our Cal Mediconnect line of business, effective 1/1/2015.

Practicing physicians provided input through the Joint Performance Improvement Collaborative (PICC) and Physician Quality Committee (PQC). L.A. Care members and consumer advocates provided input through the eleven Regional Community Advisory Committees and the Executive Community Advisory Committee. Other external experts provided input through the Children's Health Consultant Advisory Committee and the Technical Advisory Committee.

In addition to demonstrating improvements in clinical care, staff made process improvements in the asthma program and programs that promote clinical practice guideline adherence, such as pharmacy notifications indicating controller and reliever medication use for members with asthma. Potential quality issues were monitored and tracked in the Peer Review Committee. Patient safety was addressed through the monitoring of potential quality issues, facility site reviews, and pharmacy management programs. Coordination and collaboration among departments supported more effective clinical and service improvements.

Improvements were made in several areas MY 2012 to 2013. Better provider record abstraction led to an increase from three stars to four stars for Adult BMI assessment. Monitoring physical activity also increased from four to five stars. Flu shots improved from three to a four star rating. In 2013, members received reminders for flu shots and Facility Site Review (FSR) nurses conducted medical record reviews to monitor Medicare SNP physicians' compliance with clinical guidelines. Diabetic members received calls from the disease management program to remind them of needed services. Providers also received

educational information (toolkits and faxes) and member information regarding gaps in service and medication adherence. These activities have continued in 2014.

There remain opportunities to improve management of hypercholesterolemia and diabetes. Several other clinical measures have been identified for improvement, such as, breast cancer screenings, colorectal cancer screenings, glaucoma screenings, annual assessment of ADLs and pain management, and diabetics with cholesterol under control. There were several member satisfaction measures as well in need of improvement: getting needed care, getting appointment and care quickly, customer service, overall rating of health care quality and overall rating of health plan.

The QI Program will continue to focus on opportunities to improve clinical care and service in the areas outlined in this report. Member satisfaction has remained flat over the last three years. Afterhours access studies continue to show the need for improvement. There are areas that still need improvement, such as, breast and cervical cancer screenings, use of spirometry testing in the assessment and diagnosis of COPD, appropriate medications for people with asthma, and appropriate testing for children with pharyngitis. These and other QI activities are detailed in the 2015 QI work plan and will be tracked through the QI committees.

L.A. Care Health Plan
2014 Q1 Work Plan
Q4

Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
<i>Service - Access</i>								
Member Services Department Telephone Abandonment Rate		Total incoming calls abandoned ≤ 5%	Maribel Ferrer	Quarterly	Member Quality Service Committee (MQSC): Feb 21, April 16, July 16, Oct 15	Medi-Cal, HF, HK, PASC, Potential, Prov, & IVR: 1st Qtr.: 3.45% 2nd Qtr.: 0.78% 3rd Qtr.: 2.77% 4th Qtr.: 2.69% Medicare/CMC: 1st Qtr.: 3.07% 2nd Qtr.: 2.09% 3rd Qtr.: 1.28% 4th Qtr.: 1.06% LACC: 1st Qtr.: 19.59% 2nd Qtr.: 18.32% 3rd Qtr.: 1.60% 4th Qtr.: 2.62%	There was a significant increase in call volume in Q1. 9.62% increase in call volume from Q1 to Q3. Call volume continued to increase in Q4.	Y
Member Services Department Telephone Wait Time- Service Level		90% of total incoming calls answered ≤ 30 seconds	Maribel Ferrer	Quarterly	MQSC: Jan 14, April 16, July 16, Oct 15	Medi-Cal, HF, HK, PASC, Potential, & Prov: 1st Qtr.: 38.77% 2nd Qtr.: 83.30% 3rd Qtr.: 37.30% 4th Qtr.: 37.08% Medicare/CMC: 1st Qtr.: 88.67% 2nd Qtr.: 89.95% 3rd Qtr.: 91.47% 4th Qtr.: 93.26% LACC: 1st Qtr.: 45.34% 2nd Qtr.: 53.94% 3rd Qtr.: 93.00% 4th Qtr.: 86.78%	Did not meet goal in Q1 due to a significant increase in calls received. They received over 30,000 more calls in January compared to any other month. Did not meet goal in Q2 due to staffing. They had about 30 seasoned representatives that were either separated or transferred and received about 40 new representatives that were still learning. There were 23 new MSR's hired in Q4. 6 seasoned MSR's transferred to QR, 5 transferred to LACC, 3 to Medicare/CMC, and 4 were separated.	Y
Non-Emergent Ancillary Services		Within 15 business days of request, for appointment	Maria Casias/ Liz Tran	Annually: Sept '14	MQSC: Oct 15	2014 results available 1st Q 2015. (Survey was delayed to due challenges with data. Started 1-5-15 ended 1-16-15)		Y
After Hour Care MOC		92% of practitioners surveyed have after hour care process such as exchange service, automated answering/paging system, or directly accessible, in order to respond to member call with live person within 30 minutes.	Maria Casias/ Liz Tran	Annually: Sept '14	MQSC: Oct 15	2014 results available 1st Q 2015. (Survey started 11-3-14 ended 12-30-14)	8-8-14, PPG after-hours CAP requested. 8-29-14, L.A. Care hosted a call with PPGs to discuss after-hours compliance. Requests PGG supporting documents for CAP follow up. 10-16-14 completed Random After-hours survey.	Y
Routine Primary Care (Non-Urgent) MOC		95% of practitioners surveyed have routine primary visits available within 10 business days	Maria Casias/ Liz Tran	Annually: Sept '14	MQSC: Oct 15	2014 results available 1st Q 2015. (Survey started 11-3-14 ended 12-30-14)		Y

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2014 QI Work Plan
Q4

Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Routine Specialty Care (Non-Urgent) MOC		95% of specialist practitioners surveyed have routine specialty care visits available within 15 business days of request not to exceed 30 calendar days	Maria Casias/ Liz Tran	Annually: Sept '14	MQSC: Oct 15	2014 results available 1st Q 2015. (Survey started 11-3-14 ended 12-30-14)		Y
Urgent Care MOC		98% of urgent care appointments available within 48 hours	Maria Casias/ Liz Tran	Annually: Sept '14	MQSC: Oct 15	2014 results available 1st Q 2015. (Survey started 11-3-14 ended 12-30-14)		Y
Service - Availability								
Drive Distance to PCP MOC		95% of members have access to a PCP within 10 miles radius of their primary residence	Gwen Cathey	Annually: Sept '14	MQSC: Oct 15	MEDI-CAL In the 4th Quarter, 99.8% of Medi-Cal members have access to a PCP within a 10 mile radius of their residence. MEDICARE - In the 4th Quarter, 99.5% of Medicare members have access to a PCP within 5 miles of their residence.		Y
Drive Distance to all SCP, including identified high volume SCP MOC		90% of members have access to specialty care practitioners within 15 miles radius of their primary residence	Gwen Cathey	Annually: Sept '14	MQSC: Oct 15	MEDI-CAL 99.5% of Medi-Cal members have access to the specialists identified as high volume in the 4th Quarter. This percentage is calculated using all sites at which a specialist practices. MEDICARE 98.34% of Medicare members have access to the specialists identified as high volume in the 4th Quarter. This percentage is calculated using all sites at which a specialist practices.		Y
Ratio - PCP (excludes mid-level providers) MOC		1:2000 members	Gwen Cathey	Annually: Sept '14	MQSC: Oct 15	MEDI-CAL : The average PCP to member ratio in the 4th Quarter is 1:523. MEDICARE : The average PCP to member ratio in the 4th Quarter is 1:5		Y
Ratio - High Volume Specialist (Note the top 5 specialists can vary year to year) MOC		Medi-Cal: OBG: 1:3000 CARDIOVASC: 1:5000 GASTROENTEROLOGY: 1:5000 OPHTHO: 1:5000 ORTHO: 1:5000 Medicare: Top 5 High Volumes as noted in 2013 report: OPHTHO: 1:5000 CARDIOVASC: 1:5000 GASTROENTEROLOGY: 1:5000 PULMONOLOGY 1:5000 mbrs UROLOGY: 1:5000 mbrs	Gwen Cathey	Annually: Sept '14	MQSC: Oct 15	MEDI-CAL : In the 4th Quarter, the average Specialist to member ratio for high volume specialties are as follows: OB/GYN - 1:547; Cardiovascular Disease - 1:8217; Gastroenterology 1:10754; Ophthalmology 1:5897; Orthopedics 1:7578 MEDICARE : In the 4th Quarter, the average Specialist to member ratio for high volume specialties are as follows: Cardiology 1:148; Gastroenterology 1:1105; Ophthalmology 1:54; Pulmonology 1:127; Urology 1:135		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
<i>Service Improvements</i>	Benchmarks reflect the 90th percentile of the NCQA Quality Compass for Medicaid results. Where Benchmarks are noted, CAHPS measures are used.							
<i>Service - Member Satisfaction ADULT</i>								
ADULT - Rating of Health Plan (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '11: 80% Benchmark '12: 81% Benchmark '13: 81%	78% (2012-2014)	Rae Starr/ Maribel Ferrer/ All Departments	Annually: Sept '14	MQSC: Oct 15	CAHPS: 75.2%		Y
ADULT - Rating of Health Care (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '11: 73% Benchmark '12: 76% Benchmark '13: 76%	74% (2012-2014)	Rae Starr/ Maribel Ferrer/ All Departments	Annually: Sept '14	MQSC: Oct 15	CAHPS: 72.7%		Y
ADULT - Rating of Personal Doctor Plan (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '11: 82% Benchmark '12: 83% Benchmark '13: 83%	80% (2012-2014)	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	CAHPS: 78.9%		Y
ADULT - Rating of Specialist Seen Most Often (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '11: 81% Benchmark '12: 83% Benchmark '13: 84%	80% (2012-2014)	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	CAHPS: 77.7%		Y
ADULT - Getting Care Quickly (CAHPS)	Benchmark '11: 86% Benchmark '12: 86% Benchmark '13: 85%	75% (2012-2014)	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	CAHPS: 76.6%		Y
Q4: Usually or always got needed care as soon as you thought you needed (routine)?		78%	Rae Starr/ Mike Shook	Annual: Sept '14	MQSC: Oct 15	CAHPS: 80.26%		Y
Q6: Usually or always got an appointment for care as soon as you thought you needed (urgent)?		82%	Rae Starr/ Mike Shook	Annual: Sept '14	MQSC: Oct 15	CAHPS: 72.91%		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
ADULT - Getting Needed Care (CAHPS)	Benchmark '11: 84% Benchmark '12: 85% Benchmark '13: 86%	71% (2012-2014)	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	CAHPS: 77.4%		Y
Q25: In the last 6 months, how often was it easy to get appointments with specialist?		70%	Rae Starr/ Mike Shook	Annual: Sept '14	MQSC: Oct 15	CAHPS: 78.42%		Y
Q14: In the last 6 months, how often was it easy to get care, tests or treatment you thought you needed through your health plan?		80%	Rae Starr/ Mike Shook	Annual: Sept '14	MQSC: Oct 15	CAHPS: 76.30%		Y
ADULT - Customer Service (CAHPS)	Benchmark '11: 85% Benchmark '12: 87% Benchmark '13: 87%	79% (2012-2014)	Rae Starr/ Maribel Ferrer	Annually: Sept '14	MQSC: Oct 15	CAHPS: 87.3%		Y
ADULT - How Well Doctors Communicate (CAHPS)	Benchmark '11: 91% Benchmark '12: 92% Benchmark '13: 93%	86% (2012-2014)	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	CAHPS: 86.4%		Y
Service - Member Satisfaction CHILD								
CHILD - Rating of Health Plan (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '12: 86% Benchmark '13: 87%	87% (2012-2014)	Rae Starr/ Maribel Ferrer/	Annually: Sept '14	MQSC: Oct 15	CAHPS: 84.2%		Y
CHILD - Rating of Health Care (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '12: 86% Benchmark '13: 87%	81% (2012-2014)	Rae Starr/ Maribel Ferrer	Annually: Sept '14	MQSC: Oct 15	CAHPS: 84.5%		Y
CHILD - Rating of Personal Doctor Plan (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '12: 90% Benchmark '13: 90%	85% (2012-2014)	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	CAHPS: 85.9%		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
CHILD - Rating of Specialist Seen Most Often (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '12: 88% Benchmark '13: 90%	88% (2012-2014)	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	NA: Too few members in denominator for NCQA reporting.		Y
CHILD - Getting Care Quickly (CAHPS)	Benchmark '12: 93% Benchmark '13: 94%	75% (2012-2014)	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	CAHPS: 82.1%		Y
Q4: Usually or always got needed care as soon as you thought you needed (routine)?		78%	Rae Starr/ Mike Shook	Annual: Sept '14	MQSC: Oct 15	CAHPS: 82.87%		Y
Q6: Usually or always got an appointment for care as soon as you thought you needed (urgent)?		82%	Rae Starr/ Mike Shook	Annual: Sept '14	MQSC: Oct 15	CAHPS: 81.32%		Y
CHILD - Getting Needed Care (CAHPS)	Benchmark '12: 87% Benchmark '13: 90%	79%	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	CAHPS: 79.9%		Y
Q46: In the last 6 months, how often was it easy to get appointments with specialist?		70%	Rae Starr/ Mike Shook	Annual: Sept '14	MQSC: Oct 15	NA: Too few members in denominator for NCQA reporting.		Y
Q15: In the last 6 months, how often was it easy to get care, tests, or treatment you thought you needed through your health plan?		80%	Rae Starr/ Mike Shook	Annual: Sept '14	MQSC: Oct 15	CAHPS: 84.14%		Y
CHILD - Customer Service (CAHPS)	Benchmark '12: 88% Benchmark '13: 91%	87%	Rae Starr/ Maribel Ferrer	Annually: Sept '14	MQSC: Oct 15	CAHPS: 86.0%		Y
CHILD - How Well Doctors Communicate (CAHPS)	Benchmark '12: 95% Benchmark '13: 95%	85% (2012-2014)	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	CAHPS: 88.3%		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
<i>Service Improvements (Medicare)</i>								
Rating of Personal Doctor (Rating of 7, 8, 9 or 10 of 10) (CAHPS)	Benchmark '13: 93.6% Benchmark '12: 93.3% Benchmark '13: 93.6%	Medicare: 92.9%	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	Rate: 90.81%		Y
Rating of Specialist Seen Most Often (Rating of 7, 8, 9 or 10 of 10) (CAHPS)	Benchmark '13: 92.1 % Benchmark '12: 91.9% Benchmark '13: 92.1%	Medicare: 86%	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	Rate: 89.76%		Y
How Well Doctors Communicate (CAHPS)	Benchmark '13: 94.9% Benchmark '12: 94.9% Benchmark '13: 94.9%	Medicare : 89%	Rae Starr/ Mike Shook	Annually: Sept '14	MQSC: Oct 15	Rate: 87.74% Display measure - CAP required		Y
<i>Service - Complaints and Appeals</i>								
Appeals Resolution		100% appeal resolution within 30 days.	Cindy Doorn	Quarterly Reports	MQSC: Feb 21, April 16, July 16, Oct 15	Medi-Cal: 1st Qtr.: 95% 2nd Qtr.: 82% 3rd Qtr.: 95% 4th Qtr.: 99% Medicare: 1st Qtr.: 100% 2nd Qtr.: 97% 3rd Qtr.: 100% 4th Qtr.: 100%		Y
Complaint Resolution MOC		100% complaint resolution within 30 days	Cindy Doorn	Quarterly Reports	MQSC: Feb 21, April 16, July 16, Oct 15	Medi-Cal: 1st Qtr.: 95% 2nd Qtr.: 92% 3rd Qtr.: 96% 4th Qtr.: 100% Medicare: 1st Qtr.: 97% 2nd Qtr.: 97% 3rd Qtr.: 100% 4th Qtr.: 100%		Y
Complaint & Appeals Analysis - Complaint categories based on the following categories: Quality of Care, Access, Attitude/Service, Billing/Financial, and Quality of Practitioner Office Site		100% of complaints & appeals will be analyzed quarterly to identify top 5 complaint categories.	Cindy Doorn	Quarterly Reports	MQSC: Feb 21, April 16, July 16, Oct 15	1st Qtr.: Reviewed Q3 2013 by OOC on Jan 27, 2014. 2nd Qtr.: Reviewed Q4 2013 & Q1 2014 by QOC on June 23 2014. 3rd Qtr.: Reviewed Q2 2014 by MQSC on Aug 4, 2014 and QOC on July 28, 2014. 4th Qtr.: Reviewed Q3 2014 by MQSC on Oct 15, 2014 and by QOC on Nov 24, 2014.		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Service - Provider Satisfaction								
PCP satisfaction with UM process		80% of PCPs will be overall satisfied with timely decisions for pre-auths.	Halima Bascus/ Earl Leonard	Annually: Sept '14	UMC: Mar '15	Field date was delayed due to vendor staffing changes.	2014 Provider satisfaction outcomes will become available during the latter part of Feb. 2015. Final report Mar. 13th.	Y
PCP satisfaction with UM process		80% of PCPs will be overall satisfied with clinically reasonable decisions for pre-auths.	Halima Bascus/ Earl Leonard	Annually: Sept '14	UMC: Mar '15	Field date was delayed due to vendor staffing changes.	2014 Provider satisfaction outcomes will become available during the latter part of Feb. 2015. Final report Mar. 13th.	Y
SCP satisfaction with UM process		80% of SCPs will be overall satisfied with timely decisions for pre-auths.	Halima Bascus/ Earl Leonard	Annually: Sept '14	UMC: Mar '15	Field date was delayed due to vendor staffing changes.	2014 Provider satisfaction outcomes will become available during the latter part of Feb. 2015. Final report Mar. 13th.	Y
SCP satisfaction with UM process		80% of SCPs will be overall satisfied with clinically reasonable decisions for pre-auths.	Halima Bascus/ Earl Leonard	Annually: Sept '14	UMC: Mar '15	Field date was delayed due to vendor staffing changes.	2014 Provider satisfaction outcomes will become available during the latter part of Feb. 2015. Final report Mar. 13th.	Y
Clinical Improvements and Initiatives								
Clinical - Continuity and Coordination of Medical Care								
Coordination of Care: PCP/SCP Communication MOC	NA	80% of PCPs will rate their communication with SCPs Always/Often	Mike Shook/ Earl Leonard	Annually: Sept '14	Quality Oversight Committee (QOC) Oct 27 and Joint PICC & PQC Feb 2015	Field date was delayed due to vendor staffing changes.	2014 Provider satisfaction outcomes will become available during the latter part of Feb. 2015. Final report Mar. 13th.	Y
Coordination of Care: SCP/PCP Communication MOC	NA	80% of SCPs will rate their communication with PCPs Always/Often	Mike Shook/ Earl Leonard	Annually: Sept '14	Quality Oversight Committee (QOC) Oct 27 and Joint PICC & PQC Feb 2015	Field date was delayed due to vendor staffing changes.	2014 Provider satisfaction outcomes will become available during the latter part of Feb. 2015. Final report Mar. 13th.	Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
<i>Clinical - Continuity and Coordination of Medical and Behavioral Care</i>								
Exchange of Information between PCPs and Behavioral Health Providers (BHPs)		80% of providers will be always/usually satisfied with the exchange of information between PCPs and BHPs	Betsy Santana	Annually: Oct '14	Behavioral Health Collaborative Committee (BHCC): Nov 17	The rate is 14.5% were always or usually satisfied based on the results from December 2014 that were reported in January of 2014.		Y
<i>Clinical - Continuity and Coordination of Medical and Behavioral Care for SNP members</i>								
Exchange of Information between PCPs and Behavioral Health Providers (BHPs) MOC	NA	80% of providers will be always/usually satisfied with the exchange of information between PCPs and BHPs	Betsy Santana/ Beacon	Annual: Due Oct '14	BHCC: Nov 17	14.5% of 1,494 PCPs were "usually" or "always" satisfied with the level of information from BHPs	Goal in 2014 was not met. New survey will be fielded in Nov. 2014. Results available Jan. 2015.	Y
Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care: Appropriate Treatment of Depression	NA	AMM (Acute Phase): Medi-Cal: Baseline year Medicare: 53% AMM (Continuation Phase): Medi-Cal: Baseline year Medicare: 48%	Mike Shook/ Michael Sax/ Gayle Butler/ Clayton Chau/ Beacon	Annual: Due Oct '14	BHCC: Nov 17	AMM (Acute Phase): Medi-Cal: 49.5% Medicare : 57.7% AMM (Continuation Phase): Medi-Cal: 32.2% Medicare - 46.2%	A CME event on Depression in the Primary Care Setting focuses on Screening, Diagnosis, and Treatment is scheduled for 01/27/15. A new BH screening form will be introduced at the CME event. A 6-month follow up survey will be conducted among the attendees to assess the usage.	Y
Appropriate uses of Psychopharmacological medications	NA	100% of providers will be notified of members with adherence of atypical antipsychotics of < 80%	Mike Shook/ Michael Sax/ Gayle Butler/ Clayton Chau/ Beacon	Annually	BHCC: Nov 17	Did not start interventions in 2014.		N

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Appropriate uses of Psychopharmacological medications	NA	100% of providers will be notified of members with ≥ 10 OR MORE CONTROLLED SUBSTANCES	Gayle Butler/ Clayton Chau	Quarterly	BHCC: Nov 17	<p>Medi-Cal: 1st Qtr: 719 providers identified, 1,275 members identified 2nd Qtr: 841 providers identified, 1,529 members identified 3rd Qtr: 884 providers identified and 1,619 members identified 4th Qtr: 735 providers identified, 1,279 members identified PASC-SEIU: 1st Qtr: 50 providers identified, 56 members identified 2nd Qtr: 30 providers identified, 36 members identified 3rd Qtr: 38 providers identified, 48 members identified 4th Qtr: 24 providers identified, 27 members identified Medicare: 1st Qtr: 48 providers identified, 53 members identified 2nd Qtr: N/A, Opiate/Acetaminophen overutilization program implemented for Medicare LOBs 3rd Qtr: 0 members and 0 providers identified 4th Qtr: 0 members and 0 providers identified</p>		Y
Management of treatment access and follow-up for members with coexisting medical and behavioral disorders MOC	NA	100% of members will be identified and referred to disease management	Elaine Sadocchi-Smith/ Johanna Kichaven	Quarterly reporting	BHCC: June 19, Aug 22, Nov 17	<p>September: Total membership Level 3-4 (All programs) = 15,942 Total referrals to Beacon = 5 (0.03% referral rate) Q4: 20</p>	New reporting method started 9/1/2014.	Y
Primary or secondary preventive behavioral health program	NA	80% of providers will receive consultation, support, and education on BH resources/system of care and referral process. 100% of members that score positive in PHQ-2 receives BH screening and referral to BH services. 100% of members with BH condition on HRA receives BH screening/referral and care coordination.	Clayton Chau	Quarterly	BHCC: June 19, Aug 22, Nov 17	<p>a) We provided education on the BH system of care and referral process at the Joint Operation Meetings with all PPGs in 2014. In addition, we also provided in-services trainings to different physician groups including the community clinics and DHS clinics. b) CM department staff evaluate individuals with positive PHQ-2 for depression and make referral to Beacon for treatment. c) We are in the process of developing a file transfer of those members responded positively to BH questions on the HRA to Beacon for outreach and assessment.</p>		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
<p>Clinical Improvements Note that for HEDIS measures goals are set ensuring that MPLs are met. <i>Italicized measures are also auto-assignment measure.</i> Bolded measures are also NCQA Accreditation measures. * Are measures used by NCQA to report the top health plans.</p>	Benchmarks reflect the 90th percentile of the NCQA Quality Compass. Where Benchmarks are noted, HEDIS measures are used.							
Well Visits								
<u>Well Child Visits 3-6 yrs of age</u> (Physician P4P and LA P4P)	Benchmark 11: 82.88% Benchmark 12: 82.94% Benchmark 13: 82.08%	Medi-Cal: 75%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 69.49% Member incentive (\$20) launch 07/01/2014		Y
<u>Adolescent Well Care</u> (Physician P4P and LA P4P)	Benchmark 11: 64.10% Benchmark 12: 64.33% Benchmark 13: 65.45%	Medi-Cal: 57%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 50.12%		Y
<u>Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents</u>	Benchmark 11: 69.83% for BMI; 72.02% for Nutrition; 60.56% for Physical Activity Benchmark 12: 77.13% for BMI; 77.61% for Nutrition; 64.87% for Physical Activity Benchmark 13: 80.24% for BMI; 75.18% for Nutrition; 64.72% for Physical Activity	BMI: 74% Nutrition: 77% Physical Activity: 70%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	BMI: 71.84%, Nutrition: 73.06% Physical Activity: 62.62%		Y
<u>Childhood Immunizations- Combo 3</u>	Benchmark 11: 82.60% Benchmark 12: 82.39% Benchmark 13: 83.12%	Medi-Cal: 82%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 77.78%		Y
Children and Adolescents Access to PCP for (ages 7-11)*	Benchmark 11: 94.72% Benchmark 12: 94.51% Benchmark 13: 95.23%	Medi-Cal: 89%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 83.89%		Y
Immunization for Adolescents	Benchmark 12: 80.91% Benchmark 13: 85.64%	Medi-Cal: 75%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 73.12%		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Children's Health								
Appropriate Testing for Children w/ Pharyngitis (Physician P4P & LA P4P)	Benchmark 11: 83.01% Benchmark 12: 83.65% Benchmark 13: 85.09%	Medi-Cal: 19%	Mike Shook/ Michael Tu/ Esther Bae	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 15.43% AWARE provider toolkits mailed in December		Y
Appropriate Rx for Children w/ URI (Physician P4P)	Benchmark 11: 94.81% Benchmark 12: 93.20% Benchmark 13: 92.99%	Medi-Cal: 88%	Mike Shook/ Michael Tu/ Esther Bae	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 86.11% AWARE provider toolkits mailed in December		Y
Perinatal Program								
Prenatal Visits (LA P4P)	Benchmark 11: 93.19% Benchmark 12: 93.33% Benchmark 13: 92.82%	Medi-Cal: 87%	Nai Kasick/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	<p>Rate: 79.90% A county-wide prenatal social campaign is being discussed.</p> <p>3rd Qtr.: L.A. Care's Medical Director of Quality Improvement and Health Assessment, with support from the HE Unit, has facilitated two collaborative meetings to date. The kickoff meeting focused on presenting data, identifying stakeholders, and determining group objectives. During the second meeting, a representative from Maternal Child Health Access shared a presentation about the Presumptive Eligibility process, a topic that was identified by the collaborative as an area of interest and potential barrier to prenatal care. Additionally, during this meeting, the collaborative brainstormed interventions to improve access to prenatal care. Interventions that were suggested included: launching a unified text messaging program (Text4Baby) for L.A. County residents, developing a county-wide toll-free phone number for pregnant women to call to receive information on how to obtain health insurance, training providers on the Presumptive Eligibility process, and developing an educational campaign with messaging about preconception care.</p> <p>4th Qtr.: HE staff provided an update to CHAC regarding social media campaign efforts. CHAC recommended that LAC prioritize focus on implementing Text4Baby, and that HE staff present a proposal to implement Text4Baby for LAC DLOB members to QOC. The proposal will be presented to QOC in Q1 2015.</p>		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Postpartum Care (LA P4P)	Benchmark 11: 75.22% Benchmark 12: 74.45% Benchmark 13: 73.83%	Medi-Cal: 59%	Nai Kasick/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 54.24% 1st Qtr.: Live calls are being made to members to schedule their postpartum visit within the 21 to 56 day window. An incentive is being offered to those that attend. In Q1, 535 members were called, 151 were reached, and 18 appointments were made (126 already had appointments). 124 of those members actually attended their appointment (86.1% of those with appointments). In RCAC 1 only, mothers were visited to encourage attendance to the visit. During Q1, 11 mothers were visited. 7 of those actually attended their appointment (63.6%). 2nd Qtr.: In Q2, 680 members were called, 207 were reached, and 31 appointments were made (161 already had appointments). 151 of those members actually attended their appointment (78.6% of those with appointments). During Q2, 10 mothers were visited. 3 of those actually attended their appointment (30%). The visits to RCAC 1 were discontinued in April 2014 when program evaluation results revealed the visits to not be significantly effective. 3rd Qtr.: In Q3, 730 members were called, 357 were reached, and 86 appointments were made (257 already had appointments). 250 of those members actually attended their appointment. 4th Qtr.: In Q4, 1,023 members were called, 456 were reached, and 68 appointments were made (370 already had appointments). 306 of those members actually attended their appointment.	Postpartum IP	Y
Women's Health Initiatives								
Breast Cancer Screenings (Physician Incentive and LA P4P)	Benchmark 11: 62.92% Benchmark 12: 62.76% Benchmark 13: 62.88%	Medi-Cal: 52%	Mike Shook/ Michael Tu/ Lenna Monte/ Esther Bae	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 55.71% <ul style="list-style-type: none"> BCS focus groups conducted in July 2014 to learn about the factors that influence a women's decision to receive mammograms and the barriers that limit participation Direct access letters sent to imaging centers to educate that prior authorization for mammograms are not needed BCS myths and facts flyer to Medi-Cal and Medicare SNP members sent in October 2014 \$75 BCS incentive awarded to physicians with Medicare SNP members that were non-compliant for BCS (August-December 2014) 		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
<u>Cervical Cancer Screenings</u> (Physician Incentive and LA P4P)	Benchmark 11: 78.65% Benchmark 12: 78.51% Benchmark 13: 76.64%	Medi-Cal: 69%	Mike Shook/ Michael Tu/ Lenna Monte	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 64.25% Member incentive (\$50) launched in July		Y
<u>Chlamydia Screening In Women</u> (Physician Incentive and LA P4P)	Benchmark 11: 69.06% Benchmark 12: 68.83% Benchmark 13: 68.81%	Medi-Cal: 58%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Total Rate: 58.62% Age: 16-20= 54.60% Age:21-24= 64.49%		Y
Chronic Disease Plan wide								
<u>Appropriate Use of Asthma Medications (LA P4P)</u>	Benchmark 11: 93.19% Benchmark 12: 90.59% Benchmark 13: 89.76%	Medi-Cal: 82%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 81.01%		Y
<u>Medication Management for People with Asthma (MMA)</u>	50% compliance: 62.39% 75% compliance: 40.17% Benchmark 13: 50% compliance: N/A% 75% compliance: 39.41%	Benchmark 12:	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Med Compliance 50%= 67.42% Med Compliance 75%= 45.71%		Y
<u>Diabetes: Eye Exam (retinal) performed</u> (Physician P4P and LA P4P)	Benchmark 11: 70.64% Benchmark 12: 69.72% Benchmark 13: 67.64%	Medi-Cal: 53%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 46.25%		Y
<u>Diabetes: A1C Screening</u> (Physician P4P and LA P4P)	Benchmark 11: 90.85% Benchmark 12: 91.13% Benchmark 13: 90.97%	Medi-Cal: 86%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 83.54%		Y
<u>Diabetes: A1C Poor Control (>9.0%) (The lower the results the less members in poor control.)</u>	Benchmark 11: 29.15 % Benchmark 12: 28.95 % Benchmark 13: 31.14%	Medi-Cal: 36%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 47.46%		Y
<u>Diabetes: A1C Good Control (<8.0%)</u>	Benchmark 11: 59.12% Benchmark 12: 59.37% Benchmark 13: 58.38%	Medi-Cal: 51%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 41.65%		Y
<u>Diabetes: LDL Screening</u> (Physician Incentive and LA P4P)	Benchmark 11: 84.18% Benchmark 12: 83.45% Benchmark 13: 83.52%	Medi-Cal: 82%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 80.15%	Measure retired for 2015	N

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
<u>Diabetes: LDL control (<100mg/dL)</u>	Benchmark 11: 45.90% Benchmark 12: 46.41% Benchmark 13: 43.80%	Medi-Cal: 41%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 36.08%	Measure retired for 2015	N
<u>Diabetes: Medical attention for nephropathy</u> (Physician Incentive and LA P4P)	Benchmark 11: 86.86% Benchmark 12: 86.93% Benchmark 13: 85.85%	Medi-Cal: 84%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 84.99%		Y
<u>Diabetes: Blood Pressure Control (<140/90 mm. Hg)</u>	Benchmark 11: 75.98% Benchmark 12: 75.44% Benchmark 13: 74.55%	Medi-Cal: 68%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 60.05%		Y
Other Chronic Conditions Measures								
Cholesterol Management for Patient with Cardiovascular Disease (LDL Screening)	Benchmark 11: 89.07% Benchmark 12: 88.83% Benchmark 13: 88.84%	Medi-Cal: 84%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 84.30%	Measure retired in 2015	N
Controlling High Blood Pressure	Benchmark 11: 67.64% Benchmark 12: 69.11% Benchmark 13: 69.41%	Medi-Cal: 64%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 61.59%		Y
<u>Use of Imaging Studies for Low Back Pain</u>	Benchmark 11: 82.26% Benchmark 12: 82.04% Benchmark 13: 82.29%	Medi-Cal: 82%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 80.40%		Y
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Benchmark 11: 47.15% Benchmark 12: 44.01% Benchmark 13: 42.80%	Medi-Cal: 13%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 11.20%		Y
Pharmacotherapy Management of COPD Exacerbation (dispensed a systemic corticosteroid within 14 days of the event)	Benchmark 11: 76.79 % Benchmark 12: 75.96% Benchmark 13: 77.06%	Medi-Cal: 51%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 58.53%		Y
Pharmacotherapy Management of COPD Exacerbation (dispensed a bronchodilator within 30 days of the event)	Benchmark 11: 89.29% Benchmark 12: 88.06% Benchmark 13: 90.20%	Medi-Cal: 77%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 82.36%		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Other Measures								
<u>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</u> (Physician Incentive and LA P4P)	Benchmark 11: 31.61% Benchmark 12: 33.33% Benchmark 13: 35.45%	Medi-Cal: 38%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 27.88%		Y
Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers to Quit)* (CAHPS)	Benchmark 11: 80.81% Benchmark 12: 81.36% Benchmark 13: 81.26%	Medi-Cal: 63%	Michael Tu/ Rae Starr	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 70.25%		Y
Medical Assistance With Smoking and Tobacco Use Cessation (Discussing Cessation Medications)*	Benchmark 11: 54.97% Benchmark 12: 56.62% Benchmark 13: 57.50%	Medi-Cal: 40%	Michael Tu/ Rae Starr	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 38.66%		Y
Medical Assistance With Smoking and Tobacco Use Cessation (Discussing Cessation Strategies)*	Benchmark 11: 48.45% Benchmark 12: 50.66% Benchmark 13: 50.69%	Medi-Cal: 41%	Michael Tu/ Rae Starr	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 40.00%		Y
Adult BMI Assessment	Benchmark 11: 70.47% Benchmark 12: 77.39% Benchmark 13: 85.77%	Medi-Cal 77%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 83.78%		Y
Annual Monitoring for Patients on Persistent Medications- ACE inhibitors or ARBs		MPL: 84.6%	Michael Tu/ Betsy Santana/ Michael Sax	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 78.93% Provider Mailing went out in March Member mailing scheduled for August Provider Call Campaign Schedule for September. Submission of MPM article in Progress Notes newsletter Summer 2014.	MPM IP	Y
Annual Monitoring for Patients on Persistent Medications- Anticonvulsants		MPL: 62%	Michael Tu/ Betsy Santana/ Michael Sax/ Gayle Butler	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 55.87% Submission of MPM article in Progress Notes newsletter Summer 2014.	Measure retired for 2015	N
Annual Monitoring for Patients on Persistent Medications-Digoxin		MPL: 87.5%	Michael Tu/ Betsy Santana/ Michael Sax/ Gayle Butler	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 80.72% Provider Mailing went out in March Member mailing scheduled for August Provider Call Campaign Schedule for September. Submission of MPM article in Progress Notes newsletter Summer 2014.	MPM IP	Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Annual Monitoring for Patients on Persistent Medications-Diuretics		MPL: 83.8%	Michael Tu/ Betsy Santana/ Michael Sax/ Gayle Butler	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 78.17% Provider Mailing went out in March Member mailing scheduled for August Provider Call Campaign Schedule for September. Submission of MPM article in Progress Notes newsletter Summer 2014.	MPM IP	Y
Topical Fluoride Varnish Utilization	Benchmark not available		Michael Tu/ Betsy Santana/ Michael Sax/ Gayle Butler	Annual: By June '14	QOC: June 23	14.99 PTPY individuals received fluoride treatment in 2013 compared to 4.09 PTPY in 2012 (<6 yrs).		Y
Other Measures for NCQA Rankings								
Well Child Visits in the First 15 Months of Life*	Benchmark 11: 77.13% Benchmark 12: 77.31% Benchmark 13: 77.44%	Medi-Cal: 28%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 17.28%		Y
Lead Screening in Children*	Benchmark 11: 87.58% Benchmark 12: 86.56% Benchmark 13: 86.96%	Medi-Cal: 66%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 61.60%		Y
Annual Monitoring for Patients on Persistent Medications Total (Monitoring Key Long-term Medications) (note state measure excludes anticonvulsant)	Benchmark 11: 88.15% Benchmark 12: 88.55% Benchmark 13: 89.00%	Medi-Cal: 73%	Mike Shook/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 76.41% Provider Mailing went out in March Member mailing scheduled for August Provider Call Campaign Schedule for September	Same as individual measures	Y
Disease Management Programs- Asthma								
Appropriate Use of Asthma Medications	Benchmark 11: 93.19% Benchmark 12: 90.59% Benchmark 13: 89.76%	MCLA: 83%	Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 81% *Asthma Medications postcard sent to al asthma members January, 2014 * Back to School Postcard sent to all asthma members August 2014. *New asthma booklet with medication info included sent to all members May, 2014 and monthly to new members thereafter. *Condition monitoring for level 2s and 3s to address medication adherence.		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Medication Management for People with Asthma 50% compliance.	Benchmark 12: 15.3% Benchmark 13: 63.1%	MCLA: 66%	Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 67.4% *Asthma Medications postcard sent to al asthma members January, 2014. * Back to school postcard sent to all asthma members August 2014. *New asthma booklet with medication info included sent to all members May, 2014 and monthly to new members there after. *Condition monitoring for level 2s and 3s to address medication adherence.		Y
Medication Management for People with Asthma 75% compliance.	Benchmark 12: 3.4% Benchmark 13: 31.2%	MCLA 42%	Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 45.7% *Asthma Medications postcard sent to al asthma members January, 2014. * Back to school postcard sent to all members August 2014. *New asthma booklet with medication info included sent to all members May, 2014 and monthly to new members thereafter. *Condition monitoring for level 2s and 3s to address medication adherence.		Y
Inappropriate Use of Asthma Relievers		100% of providers who had members who received 4 or more prescriptions for asthma medications over the previous 12 months	Michael Sax/ Gayle Butler	Annual: By June '14	QOC: 4/28/14, 7/28/14, 10/27/14 4th Qtr. Attached to QI Eval	Medi-Cal: 1st Qtr.: 1,136 identified providers, 1867 identified members 2nd Qtr.: 1,268 identified providers, 2,234 identified members 3rd Qtr.: 1,408 providers identified, 2,585 members identified 4th Qtr.: 1,502 providers identified, 2827 members identified PASC-SEIU: 1st Qtr.: 73 providers identified, 81 members identified 2nd Qtr.: 67 providers identified, 80 members identified 3rd Qtr.: 65 providers identified, 79 members identified 4th Qtr.: 54 providers identified, 62 members identified	Continue Quarterly DUE program to identify members for letter submission to providers. Implement referrals to Case Management - program may change DUE to implementation of a new PBM	Y
% of members who have Asthma Action Plan		79%	Elaine Sadocchi-Smith	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate 2014 survey results: 39% of members reported having an asthma action plan. Asthma Satisfaction Survey sent out 6/17/2014 to MCLA and SNP members. Results available in August.	Asthma response rate was low - only 4%. In 2015 asthma survey will be redesigned.	Y
% of members who had Flu shot between Sept 2013 and March 2014		66%	Elaine Sadocchi-Smith	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Medi-Cal: 35.6% Medicare: 75% DM materials discuss the importance of getting annual flu shots in member mailings. Flu postcards reminding member to get a flu shot mailed out 10/2013. Q4: Asthma survey results self-reported that 56.8% of members in asthma program had a flu shot between 9/2013 and 3/2014.		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Asthma Disease Management Program Membership		N/A	Elaine Sadocchi-Smith	Identified Monthly; reported to CIC quarterly	QOC: Jan 27, June 2, July 28, Oct 27	1st Qtr.: 67,033 DLOB 2nd Qtr.: 77,198 DLOB 3rd Qtr.: 83,110 DLOB 4th Qtr.: 88,163 DLOB		Y
Member Satisfaction with Disease Management Programs- Asthma		93% of the members in Asthma program will be overall satisfied	Elaine Sadocchi-Smith	Annual: Due Dec 31	QOC: Sept 22	14715 Mailed out 543 Respondents 4% Response Rate 81% of members reported being satisfied with the Asthma program. Barriers Identified: 1) In 2014, we included a due date by which surveys needed to be returned in order to qualify for an incentive. As a result, members may not have seen any reason to turn in the survey after that due date. 2) The 2014 survey was formatted as a bifold pamphlet rather than a single sheet front and back. As a result, this may have looked too complicated/time intensive to fill out for some members 3)We included letters, surveys, and asthma action plans instead of just the letter and survey (which was sent in 2013). This amount of materials may have been overwhelming for the member 4)As a result of the deadline we put on the surveys, members only had a full month to do and return surveys. We may need to allow a larger timeframe for next year.		Y
Inquiries re: Asthma		N/A	Maribel Ferrer/ Elaine Sadocchi-Smith	Quarterly	QOC: Jan 27, June 2, July 28, Oct 27	Medi-Cal: 1st Qtr.: 72 2nd Qtr.: 162 3rd Qtr.: 35 4th Qtr.: 3 Medicare: 1st Qtr.: 3 2nd Qtr.: 5 3rd Qtr.: 5 4th Qtr.: 27 All DLOB: 1st Qtr.: 88 2nd Qtr.: 202 3rd Qtr.: 45 4th Qtr.: 33	No co-management of members with CM and DM is responsible for decrease in referrals to DM from CM.	Y
Complaints re: Asthma		0	Maribel Ferrer/ Elaine Sadocchi-Smith	Quarterly	QOC: Jan 27, June 2, July 28, Oct 27	Medi-Cal: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: 0 Medicare: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: 0 All DLOB: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: 0		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Disease Management Programs- Diabetes								
Diabetes: Eye Exam (retinal) performed	Benchmark 11: 70.64% Benchmark 12: 69.72% Benchmark 13: 67.64%	MCLA: 46%	Healthways/ Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 41.79%	No data - Diabetes Program ramp up 7/1/2014	Y
Diabetes: A1C	Benchmark 11: 90.85% Benchmark 12: 91.13% Benchmark 13: 90.97%	MCLA: 86%	Healthways/ Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 80.10%	No data - Diabetes Program ramp up 7/1/2014	Y
Diabetes: A1C Poor Control (>9.0%) (Note the lower the results the less members that are in poor control.)	Benchmark 11: 29.15 % Benchmark 12: 28.95 % Benchmark 13: 31.14%	MCLA: 37%	Healthways/ Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 51.74%	No data - Diabetes Program ramp up 7/1/2014	Y
Diabetes: A1C Good Control (<8.0%)	Benchmark 11: 59.12% Benchmark 12: 59.37% Benchmark 13: 58.38%	MCLA: 50%	Healthways/ Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 34.33%	No data - Diabetes Program ramp up 7/1/2014	Y
Diabetes: LDL Screening	Benchmark 11: 84.18% Benchmark 12: 83.45% Benchmark 13: 83.52%	MCLA: 77%	Healthways/ Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 79.10%	No data - Diabetes Program ramp up 7/1/2014	Y
Diabetes: LDL control (<100mg/dL)	Benchmark 11: 45.90% Benchmark 12: 46.41% Benchmark 13: 43.80%	MCLA: 37%	Healthways/ Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 38.31%	No data - Diabetes Program ramp up 7/1/2014	Y
Diabetes: Medical attention for nephropathy	Benchmark 11: 86.86% Benchmark 12: 86.93% Benchmark 13: 85.85%	MCLA: 83%	Healthways/ Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 84.58%	No data - Diabetes Program ramp up 7/1/2014	Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Diabetes Disease Management Program Membership		N/A	Healthways/ Elaine Sadocchi-Smith	Identified monthly; reported quarterly	QOC: Jan 27, June 2, July 28, Oct 27	Medi-Cal: 1st Qtr.: 23,102 2nd Qtr.: 29,332 3rd Qtr.: 36,865 4th Qtr.: 31,717 Medicare: 1st Qtr.: 1,842 2nd Qtr.: 2,000 3rd Qtr.: 1,405 4th Qtr.: 106 DLOB: 1st Qtr.: 27,446 2nd Qtr.: 34,036 3rd Qtr.: 38,633 4th Qtr.: 32,159	No data - Diabetes Program ramp up 7/1/2014	Y
Member Satisfaction with Disease Management Programs- Diabetes		Overall satisfaction of members in the diabetes program on a scale of 1-10 with 10 the highest will be at least 8.0	Healthways/ Elaine Sadocchi-Smith	Annual: Due Dec 31	QOC: Jan 27	No change - 2015 satisfaction survey will be conducted for 2014.	2014 Healthways survey (for 2013 membership) was 95% overall satisfaction. Diabetes Healthways contract terminated 6/30/2014. Satisfaction survey will be completed in 2015 for 2014 membership.	Y
Inquiries		N/A	Healthways/ Elaine Sadocchi-Smith/ Maribel Ferrer	Quarterly	QOC: Jan 27, June 2, July 28, Oct 27	Medi-Cal: 1st Qtr.: 87 2nd Qtr.: 52 3rd Qtr.: 34 4th Qtr.: 31 Medicare: 1st Qtr.: 4 2nd Qtr.: 4 3rd Qtr.: 18 4th Qtr.: 17 DLOB: 1st Qtr.: 114 2nd Qtr.: 67 3rd Qtr.: 65 4th Qtr.: 52	No co-management of members with CM and DM is responsible for decrease in referrals to DM from CM.	Y
Complaints		0	Healthways/ Elaine Sadocchi-Smith/ Maribel Ferrer	Quarterly	QOC: Jan 27, June 2, July 28, Oct 27	Medi-Cal: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: 0 Medicare: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: 0 DLOB: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: 0		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan	
State Quality Improvement Projects									
<u>All-Cause Readmissions - Statewide Collaborative QIP measure</u>		16.10%	Betty Santana/ Halima Bascus/ Demetria Malloy/ Michael Tu	Due to State: Sept. 30, 2014	QOC: Sept 22 PICC & PQC: Nov 14		The All-Cause Readmission Rate for 2014 was 15.47% the rate met and exceeded the goal. The All-Cause Readmission QIP submitted September 30th, 2014. The new goal for 2015 is 14.78%.	Y	
Diabetes QIP	A1c Screening Benchmark 11: 90.85% Benchmark 12: 91.13% Benchmark 13: 90.97% DRE Benchmark 11: 70.64% Benchmark 12: 69.72% Benchmark 13: 67.64%	A1c Screening Medi-Cal: 86% DRE Medi-Cal: 53%	Mike Shook/ Betsey Santana	Annual: By Aug. 29, 2014	QOC: Sept 22 PICC & PQC: Nov 14		QIP submitted on August 29th 2014. It was approved on October 10th.	Y	
Clinical - Patient Safety									
Potential Quality Issues		100% of PQI investigation will be completed in 6 months	Christine Chueh	Biannually and end of year	QOC: Feb 24, Sept 22		<p>1st & 2nd Qtr.: Total 156 PQI cases were opened in the 1st and 2nd quarter for all line of business. 82 of those 156 cases were closed with PQI investigation. 100% of the 82 cases were closed within 6 months.</p> <p>3rd Qtr.: Total 67 PQI cases were opened in the 3rd quarter and 104 cases were closed with PQI investigation. All cases were closed except one case that was closed the day following the due date.</p> <p>4th Qtr.: Total 52 PQI cases were opened in the 4th quarter and 61 cases were closed with PQI investigation. All cases were closed in 6 months.</p> <p>Medi-Cal: 1st Qtr.: 26 2nd Qtr.: 41 3rd Qtr.: 85 4th Qtr.: 48</p> <p>PASC-SEIU 1st Qtr.: 2 2nd Qtr.: 6 3rd Qtr.: 12 4th Qtr.: 12</p> <p>L.A. Care Covered 1st Qtr.: 0 2nd Qtr.: 1 3rd Qtr.: 1 4th Qtr.: 0</p> <p>Medicare: 1st Qtr.: 4 2nd Qtr.: 2 3rd Qtr.: 6 4th Qtr.: 1</p>	One PQI case closed one day after the 6-month due date.	Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
FSR- needlestick safety		75%	Dulce Fernandez	Annual	QOC: March 24	Annual: For 2014, the compliance rate for needlestick safety was 62%. Did not meet the 2014 goal of 75%.		Y
FSR- spore testing of autoclave/sterilizer		85%	Dulce Fernandez	Annual	QOC: March 24	Annual: For 2014, the compliance rate for spore testing was 79%. Did not meet the 2014 goal of 79%		Y
Medical Record Documentation		95% of sites reviewed achieve ≥ 80% compliance	Dulce Fernandez	Annual	QOC: Nov 24	For 2014 Qtr. 1 and Qtr. 2, the rate of provider sites achieving a compliance rate of ≥ 80% is as follows: 1st & 2nd Qtr.: Medi-Cal LOB: 86% Medicare LOB: 82% 3rd Qtr.: Medi-Cal LOB: 91% Medicare LOB: 99% 4th Qtr.: Medi-Cal LOB: 86% Medicare LOB: 83%		Y
Appropriate uses of medications-Polypharmacy		100% of PCPs will be notified of members for polypharmacy (more than 10 unique, chronic medications from 3 or more prescribers)	Michael Sax/ Gayle Butler/ Agavni Aslanyan	Quarterly	QOC: 4/28/14, 7/28/14, 10/27/14 4th Qtr. Attached to QI Eval	Medi-Cal: 1st Qtr.: 1,236 identified providers, 2,397 identified members 2nd Qtr.: 1,331 identified providers, 2,629 identified members 3rd Qtr.: 1,443 providers identified, 2,916 members identified. 4th Qtr.: 1,459 identified providers, 2,887 identified members PASC-SEIU: 1st Qtr.: 36 providers identified and 49 members identified 2nd Qtr.: 35 identified providers, 46 identified members 3rd Qtr.: 42 identified providers, 48 identified members 4th Qtr.: 34 identified providers, 39 identified members Medicare: 1st Qtr.: 216 identified providers, 281 identified members 2nd Qtr.: 246 identified providers, 311 identified members 3rd Qtr.: 272 identified providers, 384 identified members 4th Qtr.: 263 identified providers, 356 identified members	Continue DUE Program to identify members for letter submission to providers. Additional follow up to top prescribers to be implemented	Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Appropriate uses of medications-Antibiotics		100% of MDs will be notified if prescribing 3 or more antibiotics for 3 or more members in 3 months	Michael Sax/ Gayle Butler/ Agavni Aslanyan	Quarterly	QOC: 4/28/14, 7/28/14, 10/27/14 4th Qtr. Attached to QI Eval	Medi-Cal: 1st Qtr.: 70 member identified, 380 members identified 2nd Qtr.: 50 provider identified, 264 members identified 3rd Qtr.: 59 providers identified, 287 members identified 4th Qtr.: 260 providers identified, 316 members identified PASC-SEIU: 1st Qtr.: 2 providers identified, 9 members identified 2nd Qtr.: 1 provider identified, 4 members identified 3rd Qtr.: 1 provider identified, 3 members identified 4th Qtr.: 2 providers identified, 4 members identified Medicare: 1st Qtr.: 0 members and 0 providers identified 2nd Qtr.: 1 provider and 4 members identified 3rd Qtr.: 0 members and 0 providers identified 4th Qtr.: 2 providers and 3 members identified	Continue DUE Program to identify members for letter submission to providers. Additional follow up to top prescribers to be implemented	Y
Appropriate uses of medications - Controlled substances		100% of PCPs will be notified of members for controlled substances (10 or more RXs for controlled substances or tramadol or carisoprodol)	Michael Sax/ Gayle Butler/ Agavni Aslanyan	Quarterly	QOC: 4/28/14, 7/28/14, 10/27/14 4th Qtr. Attached to QI Eval	Medi-Cal: 1st Qtr.: 719 providers identified, 1275 members identified 2nd Qtr.: 841 providers identified, 1,529 members identified 3rd Qtr.: 884 providers identified and 1,619 members identified 4th Qtr.: 735 providers identified, 1,279 members identified PASC-SEIU: 1st Qtr.: 50 providers identified, 56 members identified 2nd Qtr.: 30 providers identified, 36 members identified 3rd Qtr.: 38 providers identified, 48 members identified 4th Qtr.: 24 providers identified, 27 members identified Medicare: 1st Qtr.: 48 providers identified, 53 members identified 2nd Qtr.: N/A, Opiate/Acetaminophen overutilization program implemented for Medicare LOBs 3rd Qtr.: 0 members and 0 providers identified 4th Qtr.: 0 members and 0 providers identified	Continue DUE Program Continue substance abuse pilot with referral to intervention for identified members. Implementation of Pharmacy Home for over utilizers in progress.	Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Potentially inappropriate medication (PIM)		100% of PCPs will be notified of members with Potential opioid or acetaminophen overutilization	Michael Sax/ Gayle Butler/ Agavni Aslanyan	Quarterly	QOC: 4/28/14, 7/28/14, 10/27/14 4th Qtr. Attached to QI Eval	Medicare: New Program implemented 6/14	Continue DUE Program to identify members for letter submission to providers. Additional follow up to top prescribers to be implemented. Referral to case management if necessary.	Y
High Risk Safety Management		100% of prescribers will be alerted by fax for members with select high risk medication concerns (level 1 drug-drug interaction)	Michael Sax/ Gayle Butler/ Agavni Aslanyan	Quarterly	QOC: 4/28/14, 7/28/14, 10/27/14 4th Qtr. Attached to QI Eval	Medi-Cal: 1st Qtr.: 1,184 providers identified, 2,475 members identified 2nd Qtr.: 990 providers identified, 1,770 members identified 3rd Qtr.: 1,083 providers identified 1,971 members identified. 4th Qtr.: 1,315 providers identified, 3,192 members identified PASC-SEIU: 1st Qtr.: 106 providers identified, 116 members identified 2nd Qtr.: 76 providers identified, 83 members identified 3rd Qtr.: 70 providers identified, 76 members identified 4th Qtr.: 67 providers identified, 72 members identified Medicare: 1st Qtr.: 327 providers identified, 499 members identified 2nd Qtr.: 256 providers identified, 396 members identified 3rd Qtr.: 242 providers identified, 394 members identified 4th Qtr.: 257 providers identified, 433 members identified	Continue DUE Program to identify members for letter submission to providers. Additional follow up to top prescribers to be implemented. Referral to case management if necessary.	Y
Medication Therapy Management (MTM) program		MTM program with Outcomes for 2014: Comprehensive Medication Review (CMR)—in person or phone intervention by pharmacist	Michael Sax/ Gayle Butler/ Agavni Aslanyan	Quarterly	QOC: 4/28/14, 7/28/14, 10/27/14 4th Qtr. Attached to QI Eval	Medicare: 1st Qtr.: 146 CMRs completed 2nd Qtr.: 145 CMRs completed 3rd Qtr.: 77 CMRs completed 4th Qtr.: As of 1/7/15, CMRs completed up to November 2014 are 183	MTM is outsourced to Outcomes MTM Vendor, contracted by LAC pharmacy.	Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Clinical- Clinical Practice & Preventive Guidelines								
Clinical Practice Guidelines		100% review and approval at least every 2 years/updates as required.	Mike Shook/ Esther Bae	Annual and as needed for updates	PICC & PQC: April 4	CPG were reviewed and approved at the PICC/PQC mtg 9-2-14 (Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents (Updated May 2014)); mtg. 4-4-14 (Cardiovascular:2013 ACC/AHH Guideline on the Assessment of Cardiovascular Risk, 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk, & 2014 Guideline for Management of High Blood Pressure (JNC-8), & 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. <u>Obesity</u> : 2013 AHA/ACC/TOC Guideline for the Management of Overweight and Obesity in Adults		Y
Clinical Practice Guidelines		100% of at least 2 aspects of 4 guidelines will be measured.	Mike Shook/ Esther Bae	Annual: By Dec '14	PICC & PQC: April 4	Diabetes, Cardiovascular Risk, Asthma, COPD		Y
Preventive Health Guidelines (PHGs)		Review, update, approve, & distribute Preventive Health Guidelines	Mike Shook/ Esther Bae	Annual	PICC & PQC: April 4	1st Qtr.: PHG were reviewed and approved at the PICC/PQC mtg. 4-4-14 (Screening for Lung Cancer, Risk Assessment, Genetic Counseling, and Genetic Testing for BRCA-Related Cancer in Women, Screening for Gestational Diabetes Mellitus, 2014 Recommended Child & Adult Immunization Schedule). PHG brochures were updated and distributed to Members by mail by May 2014. 2nd Qtr.: Planning for upcoming mailing of posters to providers. 3rd Qtr.: Updated PHGs sent to providers.; PHGs sent to new SNP members enrolled from May-August 2014; reviewed and approved at 9/2/14 Joint PICC/PQC mtg (□ 2014 Recommendations for Pediatric Preventive Health Care (Periodicity Schedule) (updated February 2014) □ Screening for Hepatitis B Virus Infection in Non Pregnant Adolescents and Adults (Grade B/updated May 2014) □ Prevention of Dental Caries in Children from Birth Through Age 5 Years (Grade B/updated May 2014) □ Screening for Abdominal Aortic Aneurysm (Grade B/updated June 2014))		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Preventive Health Guidelines (PHGs)		Review, update, approve, & distribute Preventive Health Guidelines	Mike Shook/ Esther Bae	Annual	PICC & PQC: April 4	<p>4th Qtr.: Reviewed and approved at 11/11/14 Joint PICC/PQC mtg (Behavioral Counseling to Promote a Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: U.S. Preventive Services Task Force Recommendation Statement (Updated September 2014)</p> <ul style="list-style-type: none"> • Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality From Preeclampsia (Updated September 2014) • Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement (Updated September 2014) • Behavioral Counseling Interventions to Prevent Sexually Transmitted Infections: U.S. Preventive Services Task Force Recommendation Statement (Updated September 2014) 		Y
Medical Record Documentation MOC/CPG		95% of sites reviewed achieve ≥ 80% compliance	Dulce Fernandez	Biannually	QOC: Oct 27	<p>For 2014 Qtr. 1 and Qtr. 2, the rate of provider sites achieving a compliance rate of ≥ 80% is as follows:</p> <p>1st & 2nd Qtr.: Medi-Cal LOB: 86% Medicare LOB: 82%</p> <p>3rd Qtr.: Medi-Cal LOB: 91% Medicare LOB: 99%</p> <p>4th Qtr.: Medi-Cal LOB: 86% Medicare LOB: 83%</p>		Y
★Star Measures MOC = Model of Care Measures MOC/CPG = Model of Care/Clinical Practice Guideline	For Star measures benchmarks are 5 Star Rating for 2014. Other benchmarks reflect the 90th percentile of the NCQA Quality Compass.	NA = new measure or not enough data to report in previous year.						
C01 - Breast Cancer Screening ★	5 Stars: ≥ 81%	58%	Linda Lee/ Esther Bae/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	<p>Rate: 61.94%</p> <p>Distributing Opportunity Reports and possible development for a DNSP P4P program.</p> <p>4 focus groups in July to gain an understanding of values and barriers, in the discussion phase of partnership with Susan G. Komen organization for mobile mammography. Collaborating with PPGs to promote direct access to mammography at imaging centers. Planning stages of PCP incentive.</p> <p>3rd Qtr.: BCS myths and facts flyer sent to members; Direct access letters sent to imaging centers.</p>		N

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
C02 - Colorectal Cancer Screening ★	5 Stars: ≥ 65%	68%	Linda Lee/ Jasmine Mines/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 65.45% Re-engage GeriNet and House Call Doctors for AWE to include colorectal cancer screening. Fecal occult blood test mailing to eligible members in July.	14% of kits have been returned to date.	Y
C03 - Cholesterol Management for Patient with Cardiovascular Disease (LDL Screening) ★	5 Stars: ≥ 89%	96%	Linda Lee/ Mike Shook/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 95.60% Distribute Adult Preventive Guidelines with AWE	CCIP - Reducing Cardiovascular Risk	Y
Measure #1 C04 - Diabetes: LDL Screening ★	5 Stars: ≥ 93%	92%	Healthways/ Linda Lee/ Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 91.48% Diabetes Healthways contract terminated 6/30/2014. Internal program ramping up starting 7/1/2014. Medicare Ops: Distributing Adult Preventive Guidelines with AWE	CCIP - Diabetes 3rd Project QIP: Improving Management of Cholesterol in Diabetes Diabetes program ramp up 7/1/2014	Y
C05 - Glaucoma Screening in Older Adults ★	5 Stars: ≥ 77%	65%	Linda Lee/ Mike Shook/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 64.03% Promote screening as indicated by risk factors, distribute updated CPGs--include as possible tip sheet	Retired measure in 2015	N
C06- Annual Flu Vaccine ★ (CAHPS)	5 Stars: ≥ 78%	75%	Linda Lee/ Mike Shook/ Michael Tu/ Nai Kasick	Annually: Sept '14	QOC: Sept 22 PICC & PQC: Nov 14	1st Qtr.: In late January/early February, a second mailer (flashy postcard) was sent to inform members of an incentive reward for receiving the flu shot. Rewards were sent out prior to the CAHPS survey. 2nd Qtr.: Planning for the Flu Campaign this year is under discussion. Annual reminders & incentives beginning in July/August 2014. 3rd Qtr.: CAHPS: 75% 4th Qtr.: 13,910 members (DSNP and CMC) received a mailer with a magnifying glass promoting the flu shot, and 730,704 members (all DLOB) received an automated call reminding them to get their flu shot. A follow-up 'Thank You' postcard will be sent out early 2015.		Y
C07- Improving or Maintaining Physical Health ★ (HOS)	5 Stars: ≥ 67%	76%	Linda Lee/ Mike Shook/ Michael Tu	Annually: Sept '14	QOC: Sept 22 PICC & PQC: Nov 14	HOS: 73% Medicare Operations initiated a workgroup to collect and analyze HOS data that CMS has started sending to L.A. Care. The goal of the workgroup was to identify analyses needed to see what drives HOS measures. -Discussions to field an off-season HOS		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
C08 - Improving or Maintaining Mental Health ★ (HOS)	5 Stars: ≥ 86%	87%	Linda Lee/ Mike Shook/ Michael Tu	Annually: Sept '14	QOC: Sept 22 PICC & PQC: Nov 14	HOS: 73% -Screening tool on AWE Educational materials included with AWE visit for eligible members. - Medicare Operations initiated a workgroup to collect and analyze HOS data that CMS has started sending to L.A. Care. The goal of the workgroup was to identify analyses needed to see what drives HOS measures.		Y
C09 - Monitoring Physical Activity ★ (HOS)	5 Stars: ≥ 64%	64%	Linda Lee/ Mike Shook/ Michael Tu	Annually: Sept '14	QOC: Sept 22 PICC & PQC: Nov 14	HOS: 63% - Medicare Operations initiated a workgroup to collect and analyze HOS data that CMS has started sending to L.A. Care. The goal of the workgroup was to identify analyses needed to see what drives HOS measures.		Y
C10 - Adult BMI Assessment ★	5 Stars: ≥ 89%	85%	Linda Lee/ Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 91.00% Addressed in condition monitoring with level 2s and level 3s in CVD program		Y
C11 - Care for Older Adults- Medication review ★	5 Stars: ≥ 92%	80%	Linda Lee/ Mike Shook/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 87.59% Educational materials included with AWE visit for eligible members		Y
C12 - Care for Older Adults- Functional Status Assessment ★	5 Stars: ≥ 87%	55%	Linda Lee/ Mike Shook/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 53.53% Educational materials included with AWE visit for eligible members		Y
C13 - Care for Older Adults- Pain Screening ★	5 Stars: ≥ 91%	43%	Linda Lee/ Mike Shook/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 79.56% Educational materials included with AWE visit for eligible members		Y
C14 - Osteoporosis Management in Older Women ★	5 Stars: ≥ 70%	14%	Linda Lee/ Mike Shook/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 17.39% Educational materials included with AWE visit for eligible members Provider to Provider outreach		Y
C15 - Diabetes : Eye Exam (retinal) performed ★ MOC/CPG	5 Stars: ≥ 70%	67%	Healthways/ Linda Lee/ Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 65.94% Diabetes Healthways contract terminated 6/30/2014. Internal program ramping up starting 7/1/2014	CCIP - Diabetes program ramp up in 7/1/2014 Diabetes	Y
C16 - Diabetes : Medical attention for nephropathy ★ MOC/CPG	5 Stars: ≥ 89%	94%	Healthways/ Linda Lee/ Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 93.92% Diabetes Healthways contract terminated 6/30/2014. Internal program ramping up starting 7/1/2014	CCIP - Diabetes program ramp up in 7/1/2014 Diabetes	Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
C17 - Diabetes: A1C (>9.0%) (Poor Control) ★	5 Stars: ≥ 84%	72%	Healthways/ Linda Lee/ Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 30.66% Diabetes Healthways contract terminated 6/30/2014. Internal program ramping up starting 7/1/2015	CCIP - Diabetes Diabetes program ramp up in 7/1/2014	Y
Measure #2 C18- Diabetes: LDL control (<100 mg/dL) ★	5 Stars: ≥59%	56%	Healthways/ Linda Lee/ Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 47.45% Diabetes Healthways contract terminated 6/30/2014. Internal program ramping up starting 7/1/2016	CCIP - Diabetes Diabetes program ramp up in 7/1/2014	Y
Measure #1 (CCIP) C19 - Controlling High Blood Pressure ★	5 Stars: ≥ 77%	76%	Linda Lee/ Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 65.94% *New member letter series sent to all CVD members with call to action to contact their doctor for screenings for CVD. Sent June, 2014. Follow-up to be sent September, 2014 *Addressed in condition monitoring with level 2s and 3s	CCIP - Reducing Cardiovascular Risk	Y
C20 - Disease - Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis ★	5 Stars: ≥ 83%	55%	Linda Lee/ Mike Shook/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 65.22% Develop practice guidelines and treatment goals for selected HEDIS measure Provider to Provider outreach		Y
C21 - Improving Bladder Control ★ (HOS)	5 Stars: ≥ 71%	N/A	Linda Lee/ Mike Shook/ Michael Tu/ Rae Starr	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	HOS: 38% - Educational materials included with AWE visit for eligible members - Medicare Operations initiated a workgroup to collect and analyze HOS data that CMS has started sending to L.A. Care. The goal of the workgroup was to identify analyses needed to see what drives HOS measures.		Y
C22 - Reducing the Risk of Falling ★ (HOS)	5 Stars: ≥ 71%	71%	Linda Lee/ Mike Shook/ Michael Tu/ Rae Starr	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	HOS: 78% - Educational materials included with AWE visit for eligible members - Medicare Operations initiated a workgroup to collect and analyze HOS data that CMS has started sending to L.A. Care. The goal of the workgroup was to identify analyses needed to see what drives HOS measures.		Y
C23 - All Cause Readmission Rate ★ (Note lower rate = better performance)	5 Stars: ≤ 9%	14%	Linda Lee/ Michael Tu/ Halima Bascus/ Demetria Mallory/ Mike Shook	Annual: Due June '14	QOC: Sept. 22	Rate: 16.39% -Developed Transition of Care (TOC) program for DSNP modeled after Medi-Cal -Develop post discharge mailing	QIP due Fall 2014	Y
C24 - Getting Needed Care ★ (See 2 questions below) (MAPD CAHPS)	5 Stars: ≥ 88%	78%	Rae Starr	Annual: Sept '14	MQSC: Oct 15	MAPD CAHPS: 75% Developed member retention workgroups to address the low member retention ratings including members' accessing specialty care.		Y

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C25 - Getting Care Quickly ★ (MAPD CAHPS)	5 Stars: ≥ 79%	72%	Rae Starr	Annual: Sept '14	MQSC: Oct 15	MAPD CAHPS: 73% Developed member retention workgroups to address the low member retention rating. Analyzed disenrollment data to drill down to disenrollment reasons conduct disenrollment survey to determine disenrollment reasons		Y
C26 - Customer Service ★	5 Stars: ≥ 91%	87%	Rae Starr	Annual: Sept '14	MQSC: Oct 15	MAPD CAHPS: 87% M.O.R.E. Unit initiating Customer Service week in October 2014. M.O.R.E Unit conducted internal Customer Service training for targeted departments		Y
C27- Rating of Health Care (Rating of 7, 8, 9 or 10 of 10) ★	5 Stars: ≥ 88%	87%	Rae Starr	Annual: Sept '14	MQSC: Oct 15	MAPD CAHPS: 84% Developed member retention workgroup to monitor, track, and strategize interventions to improve rating.		Y
C28- Rating of Health Plan (Rating of 7, 8, 9 or 10 of 10) ★	5 Stars: ≥ 88%	86%	Rae Starr	Annual: Sept '14	MQSC: Oct 15	MAPD CAHPS: 84% Developed member retention workgroup to monitor, track, and strategize interventions to improve rating.		Y
C29- Care Coordination★	5 Stars: ≥ 87%	81%	Linda Lee/ Maribel Ferrer/ Halima Bascus/ Anna Edwards	Annual: Sept '14	MQSC: Oct 15	MAPD CAHPS: 83%		Y
C30 - Complaints about the Health Plan ★ (lower is better)	5 Stars: ≤ 0.10%	0.09%	Cindy Doorn/ Linda Lee	Annual	MQSC: Oct 15	Rate: 19% Developed member retention workgroup to monitor, track, and strategize interventions to improve rating.		Y
C32- Members Choosing to Leave the Health Plan ★ (lower is better)	5 Stars: ≤ 8%	19%	Linda Lee/ Maribel Ferrer	Annual	QOC: Oct 27	Rate: 100% -Developed workgroups to address the low member retention rating. -Analyzed disenrollment data to drill down to disenrollment reasons -Conduct disenrollment survey to determine disenrollment reasons		Y
C34 - Appeals Resolution ★	5 Stars: ≥ 92%	N/A	Cindy Doorn/ Linda Lee	Annual	QOC: Nov 24	-Defining and training pharmacy on coverage determination and timeframe -Process enhancement and trainings -Workgroup developed to include Pharmacy, Gorman, Med Ops, and Medical	Need from CMS.	Y

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Adult Access to Primary/Ambulatory Health Services (HEDIS) MOC (moved to display measures)	N/A	85%	Linda Lee/ Earl Lenard/ Michael Tu	Annual: Due June '13	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 70.12%		Y
D08- Overall Rating of Drug Plan (Rating 7, 8, 9 or 10)★	5 Stars: ≥ 87%	86%	Agavni Aslanyan/ Linda Lee	Annual: Sept '14	MQSC: Oct 15	MAPD CAHPS: 86% Developed member retention workgroup to monitor, track, and strategize interventions to improve rating.	Continue MPM initiative, Clinical Programs, IVR, Choice 90, member outreach	Y
D09- Getting Needed Drugs (RX) ★	5 Stars: ≥ 93%	89%	Agavni Aslanyan/ Linda Lee	Annual: Sept '14	MQSC: Oct 15	MAPD CAHPS: 88% -Developed member retention workgroup to monitor, track, and strategize interventions to improve rating. -Develop member "opt-in" program for mail order prescriptions. -Developed member educational materials about how to fill a prescription	Continue MPM initiative, Clinical Programs, IVR, Choice 90, member outreach	Y
D13 - Medication Adherence for Diabetes Medications ★	5 Stars: ≥ 77%	N/A	Agavni Aslanyan/ Linda Lee	Annual: Sept '14	MQSC: Oct 15	Rate: 63% -Leverage existing Health Plan/member relationship for CM, DM, UM, concurrent review. -Leverage MTM program . Develop incentive programs for community/chain pharmacies and PCPs to encourage 90-day fill. -Develop educational materials physicians and members regarding chronic conditions. -Distribute pill boxes or other automated dispensing tool to members Include a member medication list to AWE.	Continue MPM initiative, Clinical Programs, IVR, Choice 90, member outreach	Y
Getting Information About RX Coverage/Costs (moved to display measures)	5 Stars: ≥ 86%	93%	Agavni Aslanyan/ Linda Lee/ Maribel Ferrer	Annual: Sept '14	MQSC: Oct 15	Rate: NA - either too few beneficiaries answered the question to permit reporting or the score had very low reliability.	Incorporate education in member newsletters, website, handbook and mailings	Y
SNP Required Measures								
Use of Spirometry Testing in the Assessment and Diagnosis of COPD MOC/CPG	Benchmark '13: 50.35% Benchmark '12: 49.96%	19%	Mike Shook/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 11.20%		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Pharmacotherapy of COPD Exacerbation- Bronchodilator MOC/CPG	Benchmark '13: 88.64 % Benchmark '12: 87.05 %	87.0%	Mike Shook/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 82.36%		Y
Pharmacotherapy of COPD Exacerbation- systemic corticosteroid MOC/CPG	Benchmark '13: 78.17% Benchmark '12: 77.06%	46.0%	Mike Shook/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 58.53%		Y
Persistence of Beta-Blocker Treatment After a Heart Attack	Benchmark '13: 95.24% Benchmark '12: 94.24%	N/A	Mike Shook/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: (deno <30- None reportable)		Y
Antidepressant Medication Management (Acute Phase) MOC/CPG	Benchmark '13: 81.25 % Benchmark '12: 79.59%	53.0%	Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 57.69%		Y
Antidepressant Medication Management (Continuation Phase) MOC/CPG	Benchmark '13: 69.62 % Benchmark '12: 68.24%	48%	Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 46.15%		Y
Follow-Up After Hospitalization for Mental Illness (in 7 days)	Benchmark '13: 59.80% Benchmark '12: 61.96 %	36%	Michael Tu/ Beacon	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 9.76%		Y
Follow-Up After Hospitalization for Mental Illness (in 30 days)	Benchmark '13: 78.95% Benchmark '12: 79.57 %	36%	Michael Tu/ Beacon	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 24.39%		Y
Percentage of members taking long-term medications who have been monitored (See 4 measures below)								
Annual Monitoring for Patients on Persistent Medications- ACE inhibitors or ARBs	Benchmark '13: 95.83% Benchmark '12: 95.2%	78%	Michael Tu/ Agavni Aslanyan/ Michael Sax/ Gayle Butler/ Bettsy Santana	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 78.93% Provider Mailing went out in March Member mailing scheduled for August. Provider Call Campaign Schedule for October. Article submission for The Pulse Summer 2014.		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Annual Monitoring for Patients on Persistent Medications- Anticonvulsants	Benchmark '13: 78.13% Benchmark '12: 79.5%	57%	Michael Tu/ Agavni Aslanyan/ Michael Sax/ Gayle Butler/ Betsy Santana	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 55.87% Provider Mailing went out in March. Article submission for The Pulse Summer 2014.	Retired measure in 2015	N
Annual Monitoring for Patients on Persistent Medications-Digoxin	Benchmark '13: 97.75% Benchmark '12: 97.1%	87%	Michael Tu/ Agavni Aslanyan/ Michael Sax/ Gayle Butler/ Betsy Santana	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 80.72% Provider Mailing went out in March Member mailing scheduled for August Provider Call Campaign Schedule for October. Article submission for The Pulse Summer 2014.		Y
Annual Monitoring for Patients on Persistent Medications-Diuretics	Benchmark '13: 95.98 % Benchmark '12: 95.5%	77%	Michael Tu/ Agavni Aslanyan/ Michael Sax/ Gayle Butler/ Betsy Santana	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 78.17% Provider Mailing went out in March Member mailing scheduled for August. Provider Call Campaign Schedule for October. Article submission for The Pulse Summer 2014.		Y
Potentially Harmful Drug-Disease Interactions- Falls + tricyclic antidepressants, antipsychotics or sleep agents (Note lower rates signify better performance)	Benchmark '13: 10.86% Benchmark '12: 10.57%	N/A	Michael Tu/ Agavni Aslanyan/	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate:48.00% Consider Referrals to Case Management		Y
Potentially Harmful Drug-Disease Interactions- Dementia + tricyclic antidepressants, anticholinergic agents (Note lower rates signify better performance)	Benchmark '13: 16.40% Benchmark '12: 17.14%	52%	Michael Tu/ Agavni Aslanyan/	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 60.94% Consider Referrals to Case Management		Y
Potentially Harmful Drug-Disease Interactions- Chronic Renal Failure + NSAIDS (Note lower rates signify better performance)	Benchmark '13: 4.44% Benchmark '12: 4.17%	23%	Michael Tu/ Agavni Aslanyan	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 27.78% Consider Referrals to Case Management		Y
Potentially Harmful Drug-Disease Interactions- Combination Rate (Note lower rates signify better performance)	Benchmark '13: 13.94% Benchmark '12: 14.35%	44%	Michael Tu/ Agavni Aslanyan/	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 51.88% Consider Referrals to Case Management		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Use of High Risk Medication in the Elderly- one drug (Note lower rates signify better performance)	Benchmark '11: 13.2% Benchmark '12: 11.40% Benchmark '13 not available	29%	Michael Tu/ Agavni Aslanyan/	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 25.13% Consider Referrals to Case Management		Y
Use of High Risk Medication in the Elderly- two drugs (Note lower rates signify better performance)	Benchmark '11: 1.6% Benchmark '12: 1.22% Benchmark '13 not available	3%	Michael Tu/ Agavni Aslanyan	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 4.77% Consider Referrals to Case Management		Y
Care for Older Adults- Advance care planning	Benchmark not available	40%	Michael Tu/ Agavni Aslanyan	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 47.93% Consider Referrals to Case Management		Y
Medication Reconciliation Post Discharge	Benchmark not available	23%	Michael Tu/ Agavni Aslanyan	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 14.36% Consider Referrals to Case Management		Y
Board Certification	N/A	Fam Med: 43% IM: 74% Geriatrics: 67% Other: 70%	Mike Shook/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Fam Med: 41.36% IM: 73.16% Geriatrics: 63.00% Other: 63.63%		Y
Other Measures								
Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers to Quit only) (Always, Usually, and Sometimes) (CAHPS - Medicare)		90%	Michael Tu/ Rae Starr	Annual: Due Sept. '14	QOC: Sept 22 PICC & PQC: Nov 14	CAHPS: 84%		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Chronic Care Improvement Programs- Diabetes								
Diabetes Disease Management Program Membership - CCIP	N/A	Identify and place eligible members in CCIP	Healthways/ Elaine Sadocchi-Smith	Monthly identification of members for program; quarterly reporting	QOC: Jan 27, April 28, July 28, Oct 27	Medi-Cal: 1st Qtr.: 23,102 2nd Qtr.: 29,332 3rd Qtr.: 36,865 4th Qtr.: 31,717 Medicare: 1st Qtr.: 1,842 2nd Qtr.: 2,000 3rd Qtr.: 1,405 4th Qtr.: 106 DLOB: 1st Qtr.: 27,446 2nd Qtr.: 34,036 3rd Qtr.: 38,633 4th Qtr.: 32,159	CCIP - Diabetes Diabetes Healthways contract terminated 6/30/2014. 3rd quarter will be internal program membership. (NOTE: respective with line 129 because SNP, MCLA and all other DLOB LOBs receive same program)	N
Member Satisfaction with Chronic Care Improvement Programs- Diabetes	N/A	Overall satisfaction of members in the diabetes program on a scale of 1-10 with 10 the highest will be at least 8.0	Healthways/ Elaine Sadocchi-Smith	Annual: Due 4th Qtr.	QOC: Jan 27	2014 Healthways survey (for 2013 membership) was 95% overall satisfaction. Diabetes Healthways contract terminated 6/30/2014. Satisfaction survey will be completed in 2015 for 2014 membership.	Diabetes is no longer a CCIP.	N
Diabetes: HEDIS measures (see also Star measures section)								
Diabetes: A1C Testing MOC/CPG	Benchmark '13: 95.61% Benchmark '12: 95.61%	95%	Healthways/ Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 91.48% Diabetes Healthways contract terminated 6/30/2014. Internal program ramping up starting 7/1/2015	Recommend removing from 2015 work plan since this will be reported for ALOB under DM Diabetes program.	N
Diabetes: A1C Poor Control (>9.0%) (Note the lower the results the less members that are in poor control.) MOC/CPG	Benchmark '13: 13.33% Benchmark '12: 12.41%	23%	Healthways/ Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 30.66% Diabetes Healthways contract terminated 6/30/2014. Internal program ramping up starting 7/1/2015	Recommend removing from 2015 work plan since this will be reported for ALOB under DM Diabetes program.	N
Diabetes: A1C Good Control (<8.0%) MOC/CPG	Benchmark '13: 77.38% Benchmark '12: 79.08%	65%	Healthways/ Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 56.93% Diabetes Healthways contract terminated 6/30/2014. Internal program ramping up starting 7/1/2015	Recommend removing from 2015 work plan since this will be reported for ALOB under DM Diabetes program.	N

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CCIP - Reducing Cardiovascular Risk								
Measure #1 (CCIP) C19 - Controlling High Blood Pressure ★	5 Stars: ≥77%	76%	Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 65.94% *New member letter series sent to all CVD members with call to action to contact their doctor for screenings for CVD. Sent June, 2014. Follow-up to be sent September, 2014 *Addressed in condition monitoring with level 2s and 3s	CCIP - Reducing Cardiovascular Risk	Y
Measure #2 (CCIP) C10- Adult BMI assessment ★	5 Stars: ≥89%	85%	Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 91.00% *New member letter series sent to all CVD members with call to action to contact their doctor for screenings for CVD. Sent June, 2014. Follow-up to be sent September, 2014 *Addressed in condition monitoring with level 2s and 3s	CCIP - Preventing Cardiovascular disease	Y
Measure #3 (CCIP) Cholesterol Management for Patient with Cardiovascular Disease (LDL Control)	Benchmark '13: 69.59% Benchmark '12: 64.48%	74%	Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 61.54% *New member letter series sent to all CVD members with call to action to contact their doctor for screenings for CVD. Sent June, 2014. Follow-up to be sent September, 2014 *Addressed in condition monitoring with level 2s and 3s	CCIP - Preventing Cardiovascular disease	N
Measure #4 (CCIP) D14 - Medication Adherence for Hypertension (RAS antagonists) ★	5 Stars: ≥79%	70%	Elaine Sadocchi-Smith/ Michael Tu/ Agavni Aslanyan	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 66% *New member letter series sent to all CVD members with call to action to contact their doctor for screenings for CVD. Sent June, 2014. Follow-up to be sent September, 2014 *Addressed in condition monitoring with level 2s and 3s *Medication postcard sent to all CVD members 1/28/2014 *Pharmacy 90-day supply incentive for providers *Continue DUE Program. Implement additional follow up to providers. Consider referral to Case Management *Per 2015 tracking dashboard, the result is 66%.	CCIP - Preventing Cardiovascular disease	Y

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Measure #5 (CCIP) D15 - Medication Adherence for Cholesterol (Statins) ★	5 Stars: ≥75%	60%	Elaine Sadocchi-Smith/ Michael Tu/ Agavni Aslanyan	Annual: Due June '14	QOC: Sept 22 PICC & PQC: Nov 14	Rate: 60% *New member letter series sent to all CVD members with call to action to contact their doctor for screenings for CVD. Sent June, 2014. Follow-up to be sent September, 2014 *Addressed in condition monitoring with level 2s and 3s *Medication postcard sent to all CVD members 1/28/2014 *Pharmacy 90-day supply incentive for providers *Continue DUE Program. Implement additional follow up to providers. Consider referral to Case Management *Per 2015 tracking dashboard, the result is 60%	CCIP - Preventing Cardiovascular disease	Y
Model of Care (MOC) Measures								
Improving access to preventive health services: Increase the percentage of members vaccinated annually against seasonal influenza								Y
Quality of Life Survey - SF12 Mental Component Score (HOS)	Target - 95%	6%/3 years or 2% change per year Target - 95%	Jim Banks	Annually		-6% change	This was based on two individuals only who took both the pre and the post test- a very small sample size.	Y
Quality of Life Survey - SF12 Physical Component Score (HOS)	Target - 95%	6%/3 years or 2% change per year Target - 95%	Jim Banks	Annually		2% change	This was based on two individuals only who took both the pre and the post test- a very small sample size.	Y
Medication compliance	Target - 80%	Improvement of 2 percentage points per year Target - 80%	Jim Banks	Annually		89.21%		Y
Patient satisfaction		90% of members will be satisfied with care management activities	Jim Banks	Annually		84.60%		Y
Avoidance of hospital admissions for ambulatory care sensitive conditions (ACSC)	Target - 20%	10% reduction in total beddays/K for ACSC Target - 20%	Jim Banks	Annually		Results Pending		Y

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Hospital Utilization (MOC)								
Hospital Bed Days	Target - 1400K	10% reduction in total beddays/K Target - 1400K	Jim Banks	Quarterly		Jan.: 1030 April: 918 June: 869 3Q: 1132		Y
Hospital Admissions	Target - 220	10% reduction in admissions Target - 220	Jim Banks	Quarterly		Jan.: 335 April: 213 June: 197 3Q: 231		Y
Hospital Average Length of Stay	Target - 4.2 Days	10% reduction in length of stay Target - 4.2 Days	Jim Banks	Quarterly		Jan.: 4.38 April: 4.30 June: 4.41 3Q: 4.9 days		Y
Readmissions rates	Target - <20%	2 percentage point reduction from previous year Target - <20%	Jim Banks	Quarterly		Jan.: 18.00 April: 14.18 June: Not available 2Q: 17.51		Y
Ambulatory Services (MOC)								
Emergency Room Visits	Dec. 2013 - 1338.62	10% reduction from the previous year	Jim Banks	Quarterly		Jan.: 483.21 April: 346.09 June: 100.8 3Q: 679 PTPY		Y
Ambulatory Care Visits	Dec. 2013 - 5024.13	10% reduction from the previous year	Jim Banks	Quarterly		Jan.: 5510.68 April: 4219.41 June: 1605.96 3Q: 429 PTPY		Y
Grievance	4th Qtr. 2013 Part C: 72 Part D: 15	Monitor in QI Program	Jim Banks	Quarterly		Part C: 1st Qtr.: 73 2nd Qtr.: 93 3rd Qtr.: 76 Part D: 1st Qtr.: 4 2nd Qtr.: 9 3rd Qtr.: 5		Y
HRA Completion Rate		100% of all Medicare enrollees within 90 days	Jim Banks	Quarterly		Jan.: 41% April: 56% Sept.: 56%		Y

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Administrative								
Annual Review of Policies & Procedures		100% Annual Review of P&Ps	Each Department Head	Each QOC as needed and by specific committee reported to QOC	QOC: Jan 27, Feb 24, March 24, Apr 28, May 26, Jun 23, July 28, Sept 22, Oct 27, Nov 24	1st Qtr.: HECL policies approved at QOC March 24, 2014. 2nd Qtr.: QI policy approved at QOC June 23, 2014. 3rd Qtr.: QI policy approved at QOC Sept. 22, 2014. 4th Qtr.: No policies presented to QOC for approval.		Y
Departmental Oversight reporting requirements		100% submission of timely delegate oversight reporting for each department	QE: Mike Shook MS: Maribel Ferrer A&G: Cindy Doom RX: Michael Sax	QOC quarterly	QOC: April 28, Jun 23, Sept 22, Nov 24	1st Qtr.: 4th Q 2013 approved at QOC March 24, 2014. 2nd Qtr.: 1st Qtr. 2014 approved at QOC June 23, 2014. 3rd Qtr.: 2nd Qtr. 2014 approved at QOC Sept. 22, 2014. 4th Qtr.: 3rd Qtr. approved at QOC 11/24/14		Y
QI Program Description & Work Plan		2014 QI Program Description & Work Plan approval	Mike Shook	QOC: 1/27/14 C & Q: 3/20/14	QOC: 1/27/14 C & Q: 3/20/14	Approved: QOC - 1/27/14 Approved: C&Q - 3/20/14		Y
QI Evaluation		2013 QI Evaluation approval	Mike Shook	QOC: 1/27/14 C & Q: 3/20/14	QOC: 1/27/14 C & Q: 3/20/14	Approved: QOC - 1/27/14 Approved: C&Q - 3/20/14		Y
QI Work Plan Updates		Review and Update of QI Work Plan	Marla Lubert/ Mike Shook	Biannually/ Final attached to QI eval	QOC: 7/28/14, 10/27/14	1st & 2nd Qtr.: QOC - 7/28/14 3rd Qtr.: QOC - 10/27/14 4th Qtr.: QOC - 2/23/15		Y
QI Reports to Board		Update Board (C&Q) on QI activities	Trudi Carter	At least quarterly	C & Q: 1/16/14, 3/20/14, 5/15/14, 7/17/14, 9/18/14, 11/20/14	1st Qtr.: 1/16/13, 3/20/14 2nd Qtr.: 5/15/14 3rd Qtr.: 7/17/14, 9/18/14 4th Qtr.: 11/20/14		Y
UM Program Documents		Annual UM Program Description, UM Work Plan, & UM Evaluation	Halima Bascus/ Anna Edwards	QOC: 2/24/14 C & Q: 3/20/14	QOC: 2/24/14 C & Q: 3/20/14	Approved: QOC - 3/24/14 Approved: UM - 1/16/14 Approved: C&Q - 3/20/14		Y
SNP Structure and Process (S&P) Measures (NCQA)		SNP S&P 1-4 and 6 will be reported in ISS	Christine Babu	By Oct. 15, 2014	QOC: Nov. 25, 2014	CMS has discontinued this review. This is no longer applicable for 2014		N

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Performance Measures for Planned Activities for Objectives	2014 Benchmark	2014 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2014 unless otherwise noted)	Updates	Comments	Recommend for '15 Work Plan
Part C & D CMS Reporting		Complete and accurate collection, analysis, and reports of Part C & D data elements	Christine Babu/ Adrienne Govan	QOC Quarterly, Bi-annually & Annually	QOC: April 28, Jun 23, Sept 23, Nov 25	1st Qtr.: submitted by 2/28/2014 2nd Qtr: due 8/31/2014 3rd & 4th Qtr.: next submission due 2/28/2015	Since our DSNP will sunset in Dec 2014 reporting requirements and the necessity to report for DSNP may change.	Y