Quality Improvement Program
All Lines of Business
2015

Quality Oversight Committee approval on	***02/23/15***
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L.A. Care
HEALTH PLAN

Quality Improvement All Lines of Business Program and Work Plan
2015

Review and approval of the attached 2015 Quality Improvement Program All Lines of Business and Work Plan performed by:

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MISSION

L.A. Care Health Plan's mission is 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 this 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.

PROGRAM STRUCTURE

L.A. Care's Quality Improvement Program describes the QI program structure, a formal decision- making arrangement where L.A. Care's goals and objectives are put into an operational framework. Tasks to meet the goals and objectives are identified, grouped and coordinated in the activities described in the accompanying QI work plan. The QI program description defines how the organization uses its resources to achieve its goals and includes how the QI program is organized to meet program objectives, functional areas that support the program and their responsibilities and reporting relationships for the QI Department staff and QI Committees. These are described in detail in the program.

In addition to Medi-Cal, the following product lines have been added and will be covered by the QI program description: Medi-Cal Expansion, L.A. Care Covered™ (On-Exchange), L.A. Care Covered Direct™ (Off-Exchange), Healthy Kids, PASC-SEIU Plan, and L.A. Care Cal MediConnect Medicare-Medicaid Plan (MMP). The program also supports the integration of Behavioral Health, Substance Use, and Managed Long-Term Services and Supports (MLTSS).

Medi-Cal Expansion

Under the Affordable Care Act (ACA), Medi-Cal coverage expanded in 2014 to include adults without children, ages 19-64. For all Medi-Cal applicants, there are new, simplified procedures for Medi-Cal eligibility. Eligibility is based upon income, as required by the ACA. To verify income and other eligibility data, DHCS relies on faster, more convenient electronic methods whenever possible. Medi-Cal will still accept applications and enroll individuals who qualify using previous eligibility procedures. Periodic redetermination of eligibility for those who are enrolled will also be much simpler and will be done electronically whenever possible. Once enrolled, beneficiaries will need to renew their coverage annually.

As of December 2014, L.A. Care's Medi-Cal expansion membership was over 200,000 members and growing.

L.A. Care Covered™ (On-Exchange) and L.A. Care Covered Direct™ (Off-Exchange)

In 2013, L.A. Care was one of eleven (11) health plans statewide selected by Covered California, the Health Benefit Exchange, to serve as a Qualified Health Plan (QHP) beginning January 1, 2014. Enrollment for this product, branded L.A. Care Covered™ (LACC), started on October 1, 2013 and was extended through April 15, 2014. Locally, L.A. Care competed against five (5) other QHPs selected by Covered California to serve Los Angeles County. Despite the intense completion, LACC captured 9.5% of the market share in Los Angeles, nearly doubling the estimated projection of 5.0%. At its peak, LACC enrollment reached nearly 28,000 members, and ended the 2014 benefit year with about 21,500, representing a retention rate of nearly 77%.

L.A. Care successfully bid to re-certify its QHP contract with Covered California in 2015, the second year of the Exchange. The 2015 Open Enrollment Period started on November 15, 2014 and continued through February 15, 2015. L.A. Care's renewal rate for 2015 was just over 90.1%, although this number skewed low due to a significant number of 2014 LACC members being transitioned to Medi-Cal due to fluctuations in family income. A seamless transition from product-to-product as families experience income fluctuations is one of the reasons L.A. Care opted to participate in Covered California, so this transition of populations achieved one of L.A. Care's strategic objectives.

The Accountable Care Act (ACA) requires that participating QHPs "that offers health insurance coverage in the individual or group market in a state accept every employer and individual in the state that applies for such coverage." To meet this ACA requirement, L.A. Care launched "Mirror Products" off the Exchange in 2015. The products are branded L.A. Care Covered Direct™ (LACC Direct) and include all levels (Platinum, Gold, Silver, and Bronze) and a Minimum Coverage Plan. As Mirror Products, these plans are offered at the same rates and with the same benefits as their counterparts on the Exchange.

The Centers for Medicare and Medicaid Services (CMS) developed the Quality Rating System (QRS) to inform consumers of qualified health plans offered in the Marketplace. The QRS requires all participating plans to submit measures to National Committee for Quality Assurance (NCQA), on behalf of CMS, on June 15, 2015. Results will not be publicly reported in 2015 as it is a beta test year.

PASC-SEIU Plan

The PASC-SEIU Homecare Workers Health Care Plan (PASC-SEIU Plan) transitioned from CHP to L.A. Care in February 2012. The Personal Assistance Services Council (PASC) and the Service Employees International Union (SEIU) developed the plan for In-Home Supportive Services (IHSS) Workers. PASC is the employer of record and contracts with L.A. Care to provide member services, claims processing, COBRA/Cal-COBRA billing, and other health plan services. L.A. Care contracts with the L.A. County Department of Health Services and Citrus Valley Physicians Group, which comprise the PASC-SEIU Plan network. Effective January 1, 2014, L.A. Care updated its internal systems and processes to identify the product as the PASC-SEIU Plan, instead of the IHSS Plan, to avoid confusion with the IHSS benefit under Medi-Cal/Long-Term Services and Supports. The projected membership for Fiscal Year 2014-15 is 46,203.

L.A. Care Duals Special Needs Plan (D-SNP)

Since 2008, LA Care had offered a Medicare Advantage Special Needs Plan (D-SNP) for members with both Medicare and Medicaid coverage. In 2014, the plan had about 8000 members. Late in 2014, L.A. Care opted to close its D-SNP product effective December 31, 2014. Members were notified of the DSNP closure and provided with options according to their eligibility for other products. On January 1, 2015 about 5000 D-SNP members were transitioned into L.A. Care's MMP product.

The Medicare Operations department provides functions that are focused on implementation of Medicare products. The functions contained within Medicare Operations include: enrollment processing and verification, risk adjustment using the HCC model, stars program monitoring and improvement, and regulatory and contract management. The department also provides training and education to staff, contracted providers and stakeholders on Medicare products, the MMP, and the Model of Care.

L.A. Care Cal MediConnect Medicare-Medicaid Plan (MMP)

Cal MediConnect program aims to improve care coordination for dual eligible beneficiaries through the provision of high quality care that helps people stay healthy and in their homes for as long as possible. Additionally, shifting services out of institutional settings and into the home and community will help create a person-centered health care system that is also sustainable.

L.A. Care's Cal MediConnect program aims to integrate medical care, long-term care, behavioral health care and social services for people who are dually eligible for Medicare and Medi-Cal in Los Angeles County. The program launched in April 2014, the program strives to provide a seamless service delivery experience with the ultimate goals of improving care quality, better health and a more efficient delivery system. L.A. Care anticipates Cal MediConnect will provide coverage to approximately 60,000 members through our direct product.

Managed Long Term Services and Supports (MLTSS)

L.A. Care's Managed Long Term Services and Supports (MLTSS) Department provides services that help individuals remain living independently in the community and oversees extended long-

term care provided in a skilled nursing or intermediate care facility. MLTSS serves L.A. Care's members enrolled in the California Coordinated Care Initiative (CCI)/Cal MediConnect (CMC) and Medi-Cal. In 2014 the California Department of Health Care Services (DHCS) began the transition of the MLTSS benefit to L.A. Care.

Conceptual Framework

The conceptual framework for the QI Program aligns with the National Quality Strategy. The National Quality Strategy presents three aims originally by the Institute for Healthcare Improvement (IHI) for the health care system, known as the Triple Aim. As a partner with CMS and the state of California on numerous programs, L.A. Care must align its quality program and initiatives with the Triple Aim. The Triple Aim is defined as:

Population Health: Improve the overall quality of care, by making health care more patient-centered, reliable, accessible, and safe. Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.

Patient Experience: Improve overall satisfaction with care and services through safe and effective patient-centered delivery.

Per Capita Cost: Reduce the cost of quality health care for individuals, families, employers, and government. [1]

Furthermore, in order to achieve these aims, the strategy established five priorities, to help focus efforts by public and private partners including L.A. Care Health Plan. Those priorities are:

1) Improve medical care by increasing quality and the responsiveness of care networks.
2) Improve member and provider satisfaction with L.A. Care.
3) Impalement an operational excellence strategy to excel at the full range of product lines offered by L.A. Care.
4) Improve financial sustainability of direct product lines.
5) Ensure access to care for low income and vulnerable populations through supporting the safety net and demonstrating value of the Local Initiative under the Medi-Cal Two-Plan model.

As the QI program aligns with the Triple Aim, there is increased integration of Medical Management and Quality Improvement in the QI program structure.

GOALS AND OBJECTIVES

The L.A. Care Quality Improvement Program, consistent with the L.A. Care mission, strives to improve clinical care, safety and service through the following goals and objectives:

[1] (http://www.healthcare.gov/news/factsheets/2012/04/national-quality-strategy04302012a.html)

Goal – Improve Quality of Care:
Improve and maintain the health and wellness of its members through the provision of coordinated, comprehensive, quality care for each member including those with complex health needs, such as, the Seniors and People with Disabilities (SPD) population.

Objectives:

- Improve HEDIS scores per work plan targets.
- Improve Medicare Star ratings.
- Improve provider encounter data reporting.
- Improve our provider network strategy to alleviate access to care issues.
- Confirm that the quality improvement structure and processes maintained by L.A. Care comply with provisions of the L.A. Care Quality Improvement Program and meet state, federal, NCQA and other applicable professionally recognized standards.
- Coordinate relevant sources of information available to L.A. Care including quality of care performance review (e.g. QI activities reports, utilization management, member services, pharmacy, and other data).
- Collect and analyze data related to the goals and objectives and establish performance goals to monitor improvement including Managed Long-Term Services and Supports (MLTSS) [Community Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and In-Home Support Services (IHSS) and Long-Term Care (LTC)/Skilled Nursing Facility (SNF) and other facilities through an organized committee structure.
- Identify opportunities for the improvement of L.A. Care processes to provide quality patient care and service by utilizing performance data to drive the QI process. Implement, monitor, and evaluate interventions to ensure members receive the highest quality healthcare available and exemplary patient experience.
- Communicate the quality improvement process to practitioners/providers and members through appropriate persons and venues (e.g. meetings, print media, electronic media, and L.A. Care's website).
- Evaluate the Quality Improvement Program annually and modify the program as necessary to improve program effectiveness.
- Develop, monitor and operationalize a QI work plan that addresses quality and safety of clinical care and service, program scope, yearly objectives, planned activities, timeframe for each activity, responsible staff, monitoring previously identified issues, and conducting an annual evaluation of the program.

Goal – Monitor and Improve Patient Safety:
Promote, monitor, evaluate and improve quality healthcare services through a system of collaboration between L.A. Care and its providers and practitioners by promoting processes that ensure timely, safe, effective, medically necessary, and appropriate care is available. In addition, L.A. Care monitors whether the provision and utilization of services meets professionally recognized standards of practice.

Objectives:

- Identify, monitor, and address known or potential quality of care issues (PQIs) and trends that affect the health care and safety of members and implement corrective action plans as needed.
- Ensure that mechanisms are in place to support and facilitate continuity of care within the health care network and to review the effectiveness of such mechanisms.
- Establish, maintain, and enforce a policy regarding peer review activities including conflict of interest policy.
- Establish standards of medical and behavioral health care (as required by product line) which reflect current medical literature and national benchmarks; design and implement strategies to improve compliance; and develop objective criteria and processes to evaluate and continually monitor performance and adherence to the clinical and preventive health guidelines.
- Foster a supportive environment to assist practitioners and providers to improve safety within their practices (e.g., member education information specific to clinical safety related to overuse of antibiotics or provider notifications of polypharmacy, etc.)

Goal – Improve Member Satisfaction:
Improve member satisfaction with the care and services provided by L.A. Care's network of providers and identify potential areas for improvement through review of multiple sources of data including evaluation of member complaints, grievances, and appeals as well as data collected from the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Streamline and coordinate all communications with members.

Objectives:

- Improve overall rating of the health plan on the CAHPS Survey.
- Identify key drivers that affect CAHPS scores of the health plan.
- Prioritize areas that impact rating of the health plan.
- Periodic review of key service-related reports that measure the quality of services members receive, for example, complaints and appeals report, access to care report, CAHPS, etc.
- Identify key areas for improvement, develop and monitor interventions based on the findings in the key service-related reports. Monitor results of the interventions.
- Consolidate multiple data sources in developing the analysis.
- Collaborate with delegates.

Goal – Provide Culturally and Linguistically Appropriate Services:
Ensure medically necessary covered services are available and accessible to members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and provided in a culturally and linguistically appropriate manner by qualified, competent practitioners and providers committed to L.A. Care's mission. Promote health education and disease management that is age-defined, culturally and linguistically appropriate, condition-specific, and designed to promote life-long wellness by encouraging and empowering the member to adopt and maintain optimal health behaviors.

Objectives:

- Analyze existence of significant health care disparities in clinical areas.
- Assess the cultural, ethnic and linguistic needs of member.
- Identify and reduce specific health care disparities.
- Promote preventive health measures, health awareness programs, education programs, patient safety, health care disparities, and cultural and linguistic programs that complement quality improvement interventions.
- Provide culturally appropriate health education services in order to enhance members' health status.
- Ensure the availability and accessibility of cultural and linguistic services such as 24/7 interpreting services including American Sign Language (ASL) as well as materials translated and in alternative formats.
- Conduct member focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risk.
- Maintain Multicultural Healthcare Distinction Certification.

Goal – Improve the Delivery of Care for Persons with Complex Health Care Needs:
Ensure the delivery and coordination of care of members with complex health needs through case management, complex case management, and effective liaisonship with services that are linked or carved out, such as, the Regional Centers (Disabilities) and the Department of Mental Health (DMH) and Department of Public Health (DPH).

Objectives:

- Provide case management to those with complex health care needs, such as seniors and people with disabilities.
- Improve access to primary and specialty care ensuring that members with complex health conditions receive appropriate service through audits, medical record reviews, and other oversight activities.
- Use care coordinators and case managers for members who receive multiple services.
- Identify and reduce barriers to services for members with complex conditions.
- Sponsor the delivery of educational information to practitioners to enhance the diagnosis and treatment of medical/health conditions, those with Complex Health Care Needs.
- Address and resolve patient-specific issues including those with complex health needs, such as, SPDs.

Goal – Provide a Network of High Quality Providers and Practitioners:
Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards and cultural/linguistic needs of members. Provide continuous quality improvement oversight to the provision of health care within the L.A. Care system network by monitoring and documenting the performance of L.A. Care's contracted network through facility site reviews, medical record reviews, HEDIS scores, and other focused studies.

Objectives:

- Establish and maintain policies, procedures, criteria, and standards for the monitoring of credentialing and recredentialing of plan practitioners.

- Educate practitioners regarding L.A. Care's performance expectations and provide feedback about compliance with those expectations.
- Monitor and document the performance of network practitioners in providing access and availability to quality care through the use of health-related indicators, member satisfaction surveys, provider satisfaction surveys, access and availability surveys, focused studies, facility inspections, medical record audits, and analysis of administrative data.

Goal – Monitor and Improve Behavioral Healthcare:
Monitor and improve behavioral healthcare and coordination between medical and behavioral health care.

Objectives:
- Collaborate with behavioral health practitioners and entities to ensure appropriate utilization of behavioral health services and continuity and coordination of mental and behavioral healthcare.
- Improve communication (exchange of information) between primary care practitioners and behavioral health practitioners.
- Monitor the appropriate diagnosis, treatment and referral of behavioral health care disorders commonly seen in primary care.
- Monitor appropriate use of psychopharmacological medications.
- Manage treatment access and follow-up for members with coexisting medical and behavioral disorders.
- Screening for depression members with chronic diseases and ensuring appropriate follow-up.
- Identification and management of Substance Use Disorders.

Goal – Meet Regulatory and Other Health Plan Requirements:
Consistently meet quality standards as required by contract, regulatory agencies, recognized care guidelines, industry and community standards, and this Quality Improvement Program.

Objectives:
- Monitor L.A. Care and network compliance with the contractual and regulatory requirements of appropriate state and federal agencies and other professional recognized standards, such as, NCQA and Joint Commission.
- Maintain grievance and appeal procedures and mechanisms and assure that members can achieve resolution to problems or perceived problems relating to access or other quality issues.
- Establish, maintain, and enforce confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations.
- Protect member identifiable health information by ensuring members' protected health information (PHI) is only released in accordance with federal, state, and all other regulatory agencies.

- L.A. Care does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience.

Goal – Monitor Quality of Care in Long Term Care Nursing Facilities
L.A. Care monitors its contracted Long Term Care (LTC) Nursing Facilities to ensure quality and coordination of long term care services for members.

Objectives:

- Review state and federal requirements for health plan oversight of contracted LTC Nursing Facilities.
- Develop a written quality monitoring program, including policy and procedures, for L.A. Care-contracted LTC Nursing Facilities.
- Establish LTC Nursing Facility quality indicators, standards and a reporting methodology.
- Monitor and provide feedback to contracted LTC Nursing Facilities on quality performance.
- Establish procedures for process improvement in the event that a LTC Nursing Facility falls below established standards.
- Collaborate with LTC Nursing Facilities on *Quality Improvement Projects* designed to improve the overall quality of care delivered to L.A. Care members.

Goal – Provide an Evidence Based Model of Care:
L.A. Care must implement an evidence-based Model of Care and evaluate the effectiveness of the care management process which includes the quality improvement activities designed for these individuals that have measureable outcomes

Objectives:

- Improve access to essential services such as medical, mental health and social services
- Improve access to affordable care
- Assuring appropriate utilization of services
- Improve coordination of care through an identified point of contact
- Improve seamless transition of care across healthcare setting, providers, and health services
- Improve access to preventive health services
- Improve beneficiary health outcomes.

AUTHORITY AND ACCOUNTABILITY

The Board of Governors (BoG) has ultimate accountability for L.A. Care's Quality Improvement Program. The Board of Governors approves the QI Program Description. L.A. Care Health Plan's Governing Body is the thirteen (13) member stakeholder Board of Governors (BoG). As a public entity, all meetings of the BoG and its subcommittees are conducted within the rules and regulations of the Brown Act (California Open Meeting Law). Officers are elected annually.

The members represent the following Los Angeles County stakeholder groups including but not limited to Free and Community Clinics, Private Disproportionate Share Hospitals (DSH), Federally Qualified Health Centers (FQHC), Knox Keene Licensed Pre-Paid Health Plans (California Association of Health Plans), Los Angeles County (Department of Health Services, Board of Supervisors), Children's Health Care Providers, Private Non-Disproportionate Share Hospitals, L.A. Care Member Advocates, L.A. Care Members and Physicians (L.A. County Medical Association).

The Board has assigned oversight of the QI Program to the Compliance and Quality Committee (C&QC), a subcommittee of the Board.

The Compliance and Quality Committee (C&QC) has final approval of the QI Program Description and the Quality Improvement Annual Evaluation annually. The C&QC monitors all quality activities and reports its findings to the Board of Governors. The Chief Medical Officer and the Medical Director, Quality Improvement & Health Assessment provide regular reports to the C&QC from the Quality Oversight Committee. Discussions, conclusions, recommendations, and approval of these reports are maintained in the minutes of the C&QC and BoG meetings.

Meeting Schedule
The BoG has scheduled ten (10) meetings per year. All draft meeting agendas are publicly posted 72 hours prior to the meeting. The final agenda is approved at the time of the meeting in accordance with the Brown Act.

QI PROGRAM PHYSICIAN LEADERSHIP

Chief Medical Officer

L.A. Care's Chief Medical Officer (CMO) is a physician, Board Certified in his or her primary care specialty, holding a valid, unrestricted California Physician and Surgeon License. The CMO is an ex-officio member of the BoG and reports to the Chief Executive Officer (CEO). The CMO is the senior healthcare clinician and has the ultimate responsibility for the QI Program and assigns authority for aspects of the program to the Medical Director, Quality Improvement & Health Assessment.

Medical Director, Quality Improvement & Health Assessment (QIHA)

The L.A. Care Medical Director (QIHA) has been designated to provide clinical direction to the QI program. He/she is a physician, Board Certified in his or her primary care specialty, holding a valid, current, unrestricted California Physician and Surgeon License to practice medicine. The Medical Director (QIHA) reports to the Chief Medical Officer and is substantially involved in QI Program operations as evidenced by providing clinical oversight and guidance/leadership to staff within the Quality Improvement Program. The Medical Director (QIHA) leads staff in achieving performance goals and meeting requirements of the accrediting and regulatory agencies. The Medical Director (QIHA) has considerable time commitment to the QI program operations as evidenced by:

- At the request of the CMO, chairs the Quality Oversight Committee, Joint Performance Improvement Collaborative Committee and Physician Quality Committee, Credentialing Committee, and Peer Review Committee.
- Participates in other committees and task forces as appropriate to assure appropriate management and accountability for all QI activities.
- Develops medical standards/medical affairs processes and facilitates adoption of medical policies and procedures.
- Encourages providers to participate in CMS and Health and Human Services (HHS) QI initiatives.
- Provides medical direction for the oversight of L.A. Care's delegated activities, facility site review process, and the potential quality issues process including ensuring that appropriate actions are taken and tracked, including peer review process if needed.

Medical Management (MM) Medical Director

The L.A. Care MM Medical Director is a physician, Board Certified in his or her primary care specialty, holding a valid, unrestricted California Physician and Surgeon License. The MM Medical Director is accountable for all operations of the Medical Management Department and reports to the Medical Director of Medical Management. The MM Medical Director is responsible for supporting the core functions of MM, including Utilization Management (UM), and Care Management (CM). The MM Medical Director also participates in case review for Appeals and Grievances (A&G) and those brought forth by regulatory bodies. The MM Medical Director also provides clinical contribution to special projects and cross departmental projects in the organization as needed.

The MM Medical Director:

- Participates in the UM Committee.
- Participates in and/or chairs medical staff committees as assigned by the CMO.
- Acts as a liaison in the resolution of UM issues with practicing physicians.
- Serves as a contact for providers with medical decisions related to authorization and denial of services that need to be escalated
- Provides recommendations and final determinations in review of member and provider grievances and appeals.
- Conducts and/or coordinates clinical case reviews for appeals, grievances, and other activities
- Functions as a resource to the UM staff when evaluating cases, including review of denials of delegated groups.
- Participates in yearly audit of Plan Partners and subcontracted plans as needed and as appropriate

The L.A. Care Utilization Management and Care Management Program Descriptions have additional information pertaining to the MM Medical Director's responsibilities.

Utilization Management (UM) Medical Director

The L.A. Care MM Medical Director is a physician, Board Certified in his or her primary care specialty, holding a valid, unrestricted California Physician and Surgeon License. The MM Medical Director is accountable for all operations of the Medical Management Department and

reports to the CMO. The MM Medical Director is responsible for the management of L.A. Care's Utilization Management Program. The MM Medical Director:

- At the request of the CMO, chairs the UM Committee and other medical staff committees.
- Acts as a liaison in the resolution of UM issues with practicing physicians.
- Serves as primary contact for medical decisions related to authorization and denial of services.
- Provides assistance and direction in review of member and provider grievances and appeals.
- Conducts and/or coordinates clinical case reviews for appeals, grievances, and other activities as directed by the CMO.
- Functions as a resource to the UM staff when evaluating cases, including review of denials of delegated groups.

The L.A. Care Utilization Management Program Description has additional information pertaining to the MM Medical Director's responsibilities and the UM program.

Medicare Medical Director

The L.A. Care Medicare Medical Director is a physician, Board Certified in his or her primary care specialty, holding a valid, current, unrestricted California Physician and Surgeon License to practice medicine. The Medcal Directror is responsible for leading medical performance in quality and utilization management for the Medicare programs, including the Special Needs Plan, as well as the Duals Demonstration. The Medical Director works with all stakeholders touching L.A. Care Medicare members. The Medical Director works most closely with the Preferred Provider Groups. The Medical Director role is to improve quality and enhance member satisfaction. Ensures service delivery to high risk fragile members managed directly by L.A. Care. In this role he or she is Medical Director for Managed Long Term Services and Supports (MLTSS). The Medical Director works in a team environment supporting Medicare Operations, MLTSS, and Health Services. The Medicare Medical Director reports to the Chief Medical Officer (CMO).

Behavioral Health Medical Director

The Medical Director of L.A. Care's behavioral health is a physician, completed residency training in his or her specialty, holding a valid, unrestricted California Physician and Surgeon License. Medical Director is the designated behavioral health practitioner involved in the behavioral health care aspects of the QI Program. Medical Director is a member of L.A. Care's Behavioral Health Collaborative Committee and provides input on behavioral health topics such as program implementation, quality improvement, and care integration. Medical Director also maintains responsibility for providing quarterly reports and updates to the Behavioral Health Collaborative Committee regarding delegated behavioral health activities and is responsible for overseeing the behavioral health delegate's operations to ensure L.A. Care meets all regulatory guidelines and standards. The Medical Director reports to the Chief Medical Officer.

QI PROGRAM RESOURCES

The Quality Improvement Director and the Quality Improvement Manager have responsibility for implementation of the Quality Improvement Program and its day-to-day activities. The Quality Improvement (QI) Department has multidisciplinary staff to address all aspects of the department functions.

The QI Department works closely with other departments to achieve targeted outcomes and to facilitate and accomplish quality initiatives within the quality program. The QI Department works closely with the Healthcare Outcomes and Analysis Department and collaborates with areas such as, but not limited to: Medical Management, Provider Network Operations, Member Services, Credentialing, Pharmacy and Formulary, Facility Site Review, and Health Education, Cultural and Linguistic Services to achieve outcome goals. In addition, Quality Improvement and Research Consultants are available to the program. A full organizational chart is attached to this program description (see attachment 1).

Compliance Officer

The Compliance Officer ensures that L.A. Care meets all state contract requirements, while providing oversight for the delivery of health care services via subcontracts with the extensive provider network. Compliance Officer serves as a reference and coordinates the organization's activities to conform to federal and state statutes, regulations, policies and other contractual requirements as well as overall corporate compliance. Compliance Officer also assists departments of L.A. Care in proactively addressing issues of compliance and maximizing effectiveness. The compliance Officer chairs the Internal Compliance Committee (ICC) and presents recommended actions to the Compliance & Quality Committee (C&QC) of the Board.

Executive Director Health Services

The Executive Director of Health Services is responsible for overseeing the planning, organization, direction, staffing, and development of L.A. Care's Utilization Management, Pharmacy, Appeals and Grievances departments including but not limited to various activities with each individual area mentioned above. Responsibility includes ensuring regulatory compliance, operations for direct lines of business and/or management services agreement functions, and interfacing with external agencies including other Local Initiatives, Plan Partners and external organizations. The Executive Director is further responsible to assure all functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership. The Executive Director works collaboratively with the Medical Directors for Utilization Management and the Medical Director for QI. The Executive Director reports to the Chief Medical Officer.

Senior Director, Quality Improvement & Health Assessment (QIHA)

The L.A. Care Senior Director of Quality Improvement & Health Assessment is directly responsible for the planning, organization, direction, staffing and development of L.A. Care's Quality function(s) including but not limited to Credentialing including Facility Site Review, HEDIS, CAHPS, NCQA, Incentive Programs, Health Education, Cultural & Linguistic Services,

Disease Management, and Quality Improvement Programs. Responsibility includes regulatory compliance, accreditation compliance, oversight of quality management vendor's related functions, quality for direct lines of business and/or management services agreement functions, and interfacing with external agencies including other Local Initiatives, Plan Partners and external organizations. The Senior Director is further responsible to assure all functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership. This Senior Director reports to the Chief Medical Officer.

Senior Director, Clinical Assurance

The Senior Director Clinical Assurance is directly responsible for the planning, organization, direction, staffing and development for the Health Services related compliance, auditing and monitoring function(s) including but not limited to Utilization Management, Case Management, Quality Improvement, Disease Management, Appeals & Grievance, Behavioral Health, Health Promotions & Education, Cultural & Linguistics, Pharmacy (limited) and Managed Long Term Services and Supports. Responsibility includes regulatory compliance, accreditation compliance, oversight of Plan Partners' and Delegated Provider Groups related operations, oversight of specialty health plans and the administrative service vendor related delegated functions, operations for direct lines of business and/or management delegation agreement functions, and interfacing with external agencies including regulatory agencies, other Local Initiatives, Plan Partners and external organizations. The Senior Director Clinical Assurance further responsible to assure all functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership. The Senior Director reports to the Chief Medical Officer.

Senior Director, Medicare and Cal MediConnect Operations

The Senior Director of Medicare and Cal MediConnect Operations serves as a subject matter expert on federal rules and statues specific to Medicare. The Senior Director is responsible for developing and overseeing the implementation of a comprehensive business and operational plan that ensures a smooth transition of dual membership into managed care. The Senior Director will preserve and enhance high quality care while improving health outcomes and satisfaction with care, coordination of care, and timely access to care. The Senior Director develops ensures seamless coordination of services for In-Home Support Services (IHSS), Community based Adult Services (CBAS), Long Term custodial care in nursing facilitates, and the Multipurpose Senior Services (MPSS) Program. The Senior Director develops and monitors tools and matrix to measure program success through select measures. The Senior Director reports to the Chief Operations Officer.

Senior Director Managed Long Term Services and Supports (MLTSS)

The MLTSS Senior Director manages all aspects of the MLTSS program and ensures compliance with Medicare and Medi-Cal guidelines. Managed Long Term Services and Supports refer to a wide range of services that support people living independently in the community. As defined by the Coordinated Care Initiative (CCI), MLTSS includes In Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community Based Adult Services (CBAS), and Long Term Care Nursing Facility services. MLTSS also provides Care Plan

Options to high risk Cal Medi-Connect members. The MLTSS Senior Director is responsible for program design, strategic planning, management, budgeting, and vendor oversight with a focus on program growth, fiscal viability, quality assurance, relationships with L.A. Care's Medical Management, Provider Network Operations, Clinical Assurance and Quality Improvement Departments, and positive member and staff experience. The MLTSS Senior Director reports to the Chief Medical Officer.

Senior Director, Pharmacy and Formulary Services

The Senior Director of Pharmacy and Formulary Services is directly responsible for the planning, organizing, directing, staffing and developing L.A. Care's Pharmacy and Formulary by having oversight of the contracted Pharmacy Benefit Management (PBM) for its direct line of business. Furthermore, this Senior Director works collaboratively with the Plan Partners to ensure access to the pharmacy benefit for L.A. Care members. This Senior Director is also responsible for all pharmacy operations in accordance with the organization's mission, values and strategic goals that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership. This Senior Director reports to the Executive Director of Health Services.

Position Requirements include: a graduate of accredited pharmacy school with Bachelors Degree or Doctorate of Pharmacy degree, a CA pharmacist license, a minimum of 10 years relevant Health Care experience, a minimum of 5 years relevant managed care experience, and a minimum of 5 years management/supervisory experience in a related capacity.

The Senior Director dedicates 25% of the time to quality improvement. The Senior Director is responsible for reporting Pharmacy Quality Oversight Committee (PQOC) results to the Quality Oversight Committee (QOC). In this role, the Senior Director is instrumental in the organizational QI process for pharmacy and continually contributes innovative QI projects to meet organizational goals.

Senior Director, Member and Medi-Cal Operations

The Senior Director of Member and Medi-Cal Operations Operations is responsible for the management and development of all aspects of the Member Services Department including membership information processing, and call center operations. The Senior Director develops a customer-oriented culture within Member Services with emphasis on dedication to the customer, service goals, respect for individuals, highest standards of quality, innovation, and implementing policies and procedures that reflect the vision of L.A. Care. The Senior Director manages the operation of the member service center, which provides one-stop service for members needing information regarding service/benefits, assistance with problems/complaints, and access to other business-related services, and is responsible to develop and manage a team that is customer-focused and empowered to resolve problems.

The Member and Medi-Cal Operations Senior Director is the primary liaison with the Department of Health Care Services, other local initiatives, the commercial plan, and the Department of Public Social Services regarding membership and eligibility issues.

Senior Director, Provider Network

The Senior Director of Provider Network is the senior leader in the organization that is charged with direct oversight of Provider Network Operations. The Senior Director reports to the Chief Operating Officer and works closely with the Chief Financial Officer and other members of L.A. Care's leadership team. The Senior Director ensures alignment of L.A. Care's contracting strategies, provider development and outcomes management in a way that results in better quality and value and is responsible for evolving the organizations collection, analysis, and use of data to better align with L.A. Care's contracting strategies. The Senior Director works closely with leadership of the following operating units: Quality Improvement, Finance, and Information Services and oversees the following functions: provider contracting, provider data base management, and provider relations. The Senior Director is responsible to ensure members have a complete and comprehensive network of providers.

Senior Director, Healthcare Outcomes and Analysis

The Senior Director of the Healthcare Outcomes and Analysis (HO&A) department must possess a graduate degree in public health, epidemiology, biostatistics, nursing or other relevant health field. The HO&A Senior Director dedicates 100% time to the HO&A department and reports directly to the Chief Medical Officer.

The HO&A department is the analytic unit for the Health Services service area. Duties and responsibilities include departmental decision-making, data analysis, ad hoc reporting, encounter data quality, project management, project coordination for HEDIS and CAHPS. The Senior Director works closely with the Quality Improvement department and other clinical areas such as Medical Management and Pharmacy.

The Senior Director also ensures that L.A. Care contracts with an appropriate Medicare CAHPS® vendor to conduct the Medicare CAHPS® satisfaction survey of Medicare enrollees. The Senior Director also ensures that all CMS required HEDIS data is submitted on time usually in June. The Senior Director reports to the Chief Medical Officer.

Director, Quality Improvement

The Director of Quality Improvement dedicates 100% of his or her time to QI program activities and is responsible and accountable for all operations conducted in the Quality Improvement Department. The QI Director reports to Medical Director (QIHA) for Clinical Operations and the Senior Director (QIHA) for all administrative operations. The QI Director is a Registered Nurse with at least 5 years clinical experience and 5 years in managed care environment with extensive experience in Quality Management.

The QI Director develops, coordinates, maintains, and updates the QI program and its related activities including the work plan. The QI Director leads staff in the performance of health plan provider quality reviews, establishes and monitors quality improvement goals, organizes outcome research, assures that L.A. Care meets regulatory and accrediting standards for quality improvement and oversees the QI department staff. The Director ensures providers and members receive information concerning the QI program. The Director reports directly to the Senior Director Quality Improvement & Health Assessment.

Director, Disease Management

The Disease Management Director directs the oversight of all assigned disease management programs and all related activities, including but not limited to, monitoring all stratification levels and associated interventions, leading the disease management teams, the condition specific managers, and other QI and Health Education staff. The Director is responsible for assigning member quarterly monitoring calls to the teams and providing documentation of ongoing compliance with NCQA, CMS, and DMHC requirements. This position is responsible for the overall strategic development and implementation of the programs including but not limited to budget management, CBO/vendor contracts and relationships, and daily activities such as monitoring inpatient census for disease management members, integration with utilization management and case management activities, and monitoring stratification levels and level changes. The Director must also be able to help other team members communicate with difficult disease management members and problem solve findings in the quarterly monitoring. This position reports directly to the Senior Director Quality Improvement & Health Assessment.

Director, Behavioral Health Clinical Services

The Director for Behavioral Health Clinical Services serves on the Management Team, responsible for the behavioral health clinically related issues, and attends agency committee meetings related to all services aspects for L.A. Care members. He or she provides the behavioral health clinical perspective at management team discussions and committee meetings to bring about positive outcomes in all area of quality of care, service utilization and data management. He or she represents L.A. Care and interacts with the County Department of Mental Health (DMH), County Department of Public Health/Substance Abuse Prevention & Control (SAPC), contracted organizations and providers, PPGs, and other stakeholders in a manner that promotes collaborative working relationships. The Director undertakes special projects in conjunction with the Behavioral Health Management Team, as assigned.

Director, Medicare Part D Business Operations

The Director of Medicare Part D Operations is responsible for ensuring that the Plan is compliant with established non-clinical regulatory requirements, timelines, reporting and procedures for all Medicare products, including the Medicare-Medicaid Plan (known as Cal MediConnect). Additionally, the Director is responsible for working with Pharmacy and leadership and staff, as well as the staff of other impacted business units, the Pharmacy Benefits Management (PBM), and other vendors or entities, as required, to support the implantation and administration and operational requirements, including the establishment of standardized operation processes and procedures.

Director, Health Education, Cultural and Linguistic Services

The Director of the Health Education, Cultural and Linguistic Services Department oversees all health education and cultural and linguistic program planning, implementation and evaluation. This includes, but is not limited to strategies to develop, implement and evaluate health promotion and education interventions, cultural competency training and education, translation and interpretation services, and interventions to reduce health disparities for L.A. Care members. The Director ensures that L.A. Care is compliant with health education and cultural and

linguistic regulatory requirements, and serves as the primary liaison with the Department of Health Care Services, Centers for Medicare and Medicaid Services (CMS) and Covered California on health education and cultural and linguistic issues.

Specific position duties and responsibilities include but are not limited to: maintaining policies, procedures, developing, implementing, and evaluating health education programs and services; reviewing and distributing health education materials and resources to members; participating in quality improvement planning, implementation, and evaluation; developing and/or acquiring health education services and resources for members; ensuring availability and accessibility of language assistance programs such as 24/7 interpreting including ASL and materials translated and in alternative formats; developing, implementing, and evaluating cultural sensitivity training for health plan staff and network providers; and conducting oversight of all subcontracted providers to ensure they are in compliance with the state and federal requirements. Position requirements include a master's degree in public health, with emphasis in health education, community and/or public health. Research and evaluation skills and experience working with underserved populations in managed healthcare systems are also required.

Director, Provider Relations

The Provider Relations Director is responsible for provider network services/relations for all lines of business. The Director manages complex and problematic provider-related issues, grievances and concerns. The Director acts as a team builder and leader of the provider relations Team and to multiple internal operational functional areas, and external providers. The Director ensures providers are educated on new products at time of implementation, ongoing provider training/education and works with internal departments to deliver their message for the Company to providers. The Director is involved in Plan Partner and provider audits, pre-contractual reviews and assessments. Additionally, the Director is responsible for day-to-day management, administration and operations of Provider Relations unit within Provider Network Operations (PNO). The Director interprets policies and procedures, and researches, analyzes, and resolves complex problems dealing with claims, appeals, grievances, and eligibility. The Director provides training, designs metrics, sets direction/priorities and leadership for staff.

Director, Provider Contracting

The Director of Provider Contracting is responsible for developing, negotiating, and managing financially sound contracts with participating physician groups (PPGs), Management Service Organizations (MSOs), hospitals, ancillary providers, and other healthcare providers and maintain a comprehensive and compliant network of healthcare providers ensuring provision of covered services to L.A. Care's members. The Director leads the Provider Contracting Team and manages the daily functions of the provider contracting team including, but not limited to, hiring and training staff, and successfully implements contracting documents to include network-wide strategic, legislative, and operational changes, including but not limited to, contract administration, and identifies opportunities to support safety net providers. The Director also manages the use of various analytical resources and financial data to conduct and manage complex analyses, prepare and interpret impact reports and recommend contracting strategies and alternatives. The Director ensures alignment of L.A. Care's contracting strategies, provider development and outcomes management in a way that results in better quality and value.

Director, Credentialing

The Credentialing Director oversees the operations and personnel in the Credentialing Department, Facility Site Review Department, and quality issues, including the planning and development of activities/procedures to ensure compliance with National Committee for Quality Assurance (NCQA), Department of Health Services (DHCS), Center for Medicare and Medicaid Services (CMS). He or she oversees delegated credentialing and facility site review to ensure compliance with state and federal regulatory standards and L.A. Care standards and ensures accuracy of practitioner data in internal databases and directories.

Director HEDIS Operations

The Director HEDIS Operations is responsible for directing and managing the performance of the HEDIS project staff which includes overseeing the HEDIS Manager, Manager Exchange HEDIS, Manager Medicare HEDIS, Project Managers, nurse abstractors, clinical specialist, HEDIS Analyst, and schedulers, and clerical staff. The Director is responsible for creating procedures and policies relevant to the HEDIS project, setting up a project management plan, setting time lines and overseeing the activities required to complete the HEDIS cycle. The Director takes a leadership role in activities related to the external NCQA HEDIS audit, quality control, project completion, and data submission. The Director oversees staff that is responsible for work flow functions, supervises the clerical staff/schedulers, directs the HEDIS abstractors, creates strategies for medical record and electronic data procurement and scheduling, and develops training curriculum. In addition to these responsibilities, the Director works with product evaluation, develops and manages the budget and accounts for variations, works with legal advisor on contract review, interviews vendors who provide technical services, compliance auditors, provider groups. The Director Initiates and champions quality improvement projects and committee meetings related to overall HEDIS performance.

The Director works closely with the technical, clinical, and compliance personnel to assure accurate and timely submission of the HEDIS data to the proper authorities. During the off-season, the Director evaluates the HEDIS results and strategizes how to optimize data procurement, and develops improvement processes for the next HEDIS cycle.

Director, Medicare Performance Management

This position is responsible for providing strategic direction and leadership for quality improvement activities across the organization for L.A. Care's Medicare program Cal MediConnect. The Director's projects include, but are not limited to implementing and providing oversight over quality management functions specific to the Medicare lines of business to ensure that activities are aligned with overall strategic direction and appropriately coordinated with Medi-Cal quality management functions, assure ongoing operational compliance with state and federal quality improvement/assurance requirements (i.e., CMS QIP, CCIP requirements, Chapter 5, etc.) and provide direction and support to other L.A. Care staff in the development and execution of activities related to Medicare quality. These activities include provider or other training programs, development of member and/or provider educational and information materials. The Director reports to the Senior Director, Medicare Programs, but works closely with the Chief Medical Officer and Medical Management staff.

Director, Appeals and Grievances

The Appeals and Grievances Director is responsible for the strategic Management and Oversight of the Appeals and Grievances Department. The Director oversees the resolution of member appeals and grievances for all product lines, including State Fair Hearings in a manner consistent with regulatory requirements from the Department of Managed Health Care, Department of Health Care Services, Centers for Medicare and Medicaid Services, as well as requirements from the National Committee on Quality Assurance (NCQA) and L.A. Care policies and procedures, ensuring the proper handling of member and provider complaints whether presented by members, their authorized representative, the Ombudsman office, state contractors, member advocates, L.A. Care Board Members, providers, etc. The Director reports to the Executive Director of Health Services.

Manager, Accreditation and Oversight

The Manager, Quality Improvement Accreditation is an experienced healthcare professional responsible for managing activities associated with Accreditation, the use of ongoing monitoring and analysis of plan performance, to facilitate the design and implementation of clinical and service related quality improvement studies and activities in support of the Quality Improvement Plan and strategic objectives of the organization. Position activities involve frequent day to day interface with Plan Partners, regulatory agencies and internal L.A. Care departments in support of established accreditation standards, quality improvement activities including budgetary and other resource components associated with annual HEDIS studies, and ongoing development of policies and procedures. Serves as the departmental point of contact in the absence of the Director. Possesses a strong quality improvement background that includes clinical experience in the acute and ambulatory settings as well as managed care and NCQA, specifically within the Medicaid and government sponsored programs environments.

Manager, Disease Management Asthma Program

The Asthma Disease Management Manager is responsible for oversight of the Asthma Disease Management Program and all related activities, including but not limited to, monitoring all stratifications levels and associated interventions, managing the asthma disease management team including other QI and Health Education staff, oversight of assigning member monitoring calls to the team. The Manager is responsible for providing documentation of ongoing compliance with NCQA, CMS, Covered California, and DMHC requirements. The Manager is responsible for the overall implementation of the program, including but not limited to, clinical workflow and clinical issues with CBO/vendor contracts and relationships, and daily activities such as oversight of monitoring inpatient census for disease management members, integration with utilization management and case management activates, and monitoring stratification levels and level changes. The Manager helps other team members communicate with difficult disease management members and problem solve findings in the phone condition monitoring. The Manager conducts staff development coaching and has discretion of personnel issues and escalates staffing concerns to upper-management appropriately. The Manager oversees program metrics and staff metrics. The Asthma Disease Management Manager reports directly to the Disease Management Director.

Manager, Disease Management Diabetes/CVD Program

The Diabetes/CVD Disease Management Manager is responsible for oversight of the Diabetes/CVD Disease Management Program and all related activities, including but not limited to, monitoring all stratification levels and associated interventions, managing the diabetes/CVD disease management team including other QI and Health Education staff, oversight of assigning member monitoring calls to the team. The Manager is responsible for providing documentation of ongoing compliance with NCQA, CMS, Covered California, and DMHC requirements. Additionally, the Manager is responsible for the overall implementation of the program, including but not limited to, clinical workflow and clinical issues with CBO/vendor contracts and relationships, and daily activities such as oversight of monitoring inpatient census for disease management members, integration with utilization management and case management activities, and monitoring stratification levels and level changes. The Manager helps other team members communicate with difficult disease management members and problem solve findings in the phone condition monitoring. The Manager conducts staff development coaching and has discretion of personnel issues and escalates staffing concerns to upper-management appropriately. The Manager oversees program metrics and staff metrics. The Diabetes/CVD Disease Management Manager reports directly to the Disease Management Director.

Manager, Incentives Program

The Manager of Incentives Program is responsible for strategic oversight of the company's portfolio of pay for performance and incentive programs, and value based reimbursement programs. The Manager will provide leadership direction to a project and analytic staff tasked with designing, building, operating and evaluating programs for all product lines, including Medi-Cal, Cal MediConnect and Covered California. The Manager will lead the development of reward-based incentive programs for consumers to promote evidence-based, optimal care for enrollees, a wide variety of initiatives to reward physicians, provider groups and hospitals for improved performance in health care delivery; and value based reimbursement programs for providers that promote adherence to clinical guidelines and link payment to performance. The Manager is further responsible to assure all functions are operating in accordance with the organization’s mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care’s culturally diverse membership.

Manager, Quality Improvement

The QI Manager dedicates 100% of his or her time to the QI program and reports to the QI Director. The QI Manager is responsible for coordinating activities associated with improving performance at the PPG & member level, annual review and update of the quality improvement program descriptions and ensures that all quality improvement committees are facilitated and documented in a concise timely manner and reflects all discussions that occur during the committee. Additional responsibilities include ongoing monitoring and analysis of plan performance, to assist in the design and implementation of quality improvement initiatives in support of the Quality Improvement Plan and strategic objectives of the organization. He or she is involved in frequent day to day interface with PPGs, Plan Partners, regulatory agencies and internal L.A. Care departments in support of established accreditation standards, quality improvement activities including budgetary and other resource components associated with

annual HEDIS studies, and ongoing development of policies and procedures. Serves as the departmental point of contact in the absence of the Director.

Manager, HEDIS

The Manager of HEDIS is responsible for managing the performance of the HEDIS project staff which includes overseeing the HEDIS abstractors, clinical specialist, HEDIS Analyst, schedulers and clerical staff. The Manager is responsible for creating procedures and policies relevant to the HEDIS project, setting up a project management plan, setting time lines and overseeing the activities required to complete the HEDIS project. The Manager oversees activities related to the external NCQA HEDIS audit, quality control, project completion, and data submission. The Manager oversees staff that is responsible for work flow functions, creates strategies for medical record and electronic data procurement and scheduling, and conducts training. In addition, to these responsibilities, the Manager works with product evaluation, reviews and manages the budget and accounts for variations, works with the legal advisor on contract review, interviews vendors who provide technical services, compliance auditors, and provider groups. The Manager initiates and participates in quality improvement projects and committee meetings.

Manager, Facility Site Review

The Manager of Facility Site Review is responsible for the management of daily operations of the Facility Site Review (FSR) Department, including development, implementation, administration and evaluation of goals and strategies. The Manager recruits and manages staff, including performance management, talent development, cross-training and coaching and counseling as appropriate. The Manager proposes process improvement activities to ensure cost effective and efficient operations. The Manager prepares, reviews, and updates policies and procedures for the FSR Department. The Manager develops, monitors, and reports metrics designed to evaluate effectiveness of assigned programs. He or she creates operational and capital budgets. The Manager ensures operational goals and objectives are met through expense management and within approved budget.

Manager, Appeals and Grievances

The Appeals and Grievances Department Manager is responsible for the centralized intake, logging and triage process for all member appeal and grievances. The Manager oversees the resolution of member appeals and grievances for all product lines including State Fair Hearings (SFH) in a manner consistent with regulatory requirements from the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), and Centers for Medicare and Medicaid Services (CMS), as well as requirements from the National Committee on Quality Assurance (NCQA) and L.A. Care policies and procedures, ensuring the proper handling of member complaints whether presented by members, their authorized representative, the Ombudsman office, state contractors, member advocates, L.A. Care Board Members, providers, etc. The Manager is responsible for establishing and monitoring processes to oversee and coordinate the identification, documentation, reporting, investigation, and resolution of all member appeal and grievances and SFH in a timely and culturally-appropriate manner. The Manager works with internal committees (i.e., Quality Oversight Committee (QOC), Member Quality Service Committee (MQSC), etc.) to review and analyze appeal and grievance trends and recommends corrective action as necessary. The Manager coordinates, tracks, and trends

internal and external appeal and grievance reports and oversees the complaint systems for L.A. Care Plan Partners, including identifying opportunities for improvement. The Manager ensures timely appeal and grievance reporting to regulatory agencies, Internal Regulatory Affairs and Compliance Department, internal Quality Oversight Committee, etc. The Manager collaborates with internal Departments to ensure the use of appropriate appeal and grievance issue codes, timely resolution, and refers to community partners as appropriate. Additionally, the Manager is responsible for leading internal and external audits, coordinating the collection of deliverables and responding to corrective action plans as necessary.

Manager, Clinical Appeals and Grievances

The Manager of Clinical Appeals and Grievances is responsible for managing the clinical work activities of the Appeals and Grievances Department, ensure that service standards are met and ensure adherence to established policies and procedures regarding the appeals and grievance process. The Manager supervises the Appeals and Grievances Nurse staff. The Manager meets regularly with the medical management staff with close interface with program Medical Directors in clarifying and resolving Clinical Appeals and Grievances cases, and works closely with the Director of Appeals and Grievances in communicating with executive staff, as well as other internal department contacts. The Manger maintains external contact with regulatory agencies, health networks, community based organizations, and medical groups

COLLABORATION THROUGH WORK GROUPS

L.A. Care collaborates with its delegated health plans to coordinate QI activities for all lines of business.

Facility Site Review (FSR) Task Force

The FSR Task Force reviews issues related to facility site review and medical record review processes. The Task Force is the forum to discuss facility site review activities including identification of non-compliant provider sites and formulation of interventions to improve processes and scores.

PPG/Plan Partner Collaboration

In the fall of 2014, L.A. Care began regularly scheduled meetings with high-volume PPGs, Plan Partners and the Department of Healthcare Services (DHS). The goal of these meetings is to show a united force in engaging our members, as well as improvement outcomes measured by HEDIS scores. We are focusing on Medicare STAR and DHCS auto assignment measures. For 2015, we will add to our focus the measures relative for the Quality Rating System (QRS) for our Marketplace product, or L.A. Care Covered, membership. Meetings will occur, at a minimum, quarterly with an increased frequency during early 2015. Example agenda items will include prioritization of measures, interventions to improve performance and data capture/transmission.

BEHAVIORAL HEALTH COLLABORATION

For Medi-Cal members, specialty mental health and substance use disorder treatment services are carved out to the Los Angeles County Department of Mental Health (DMH) and the Los Angeles County Substance Abuse Prevention & Control Program under Department of Public Health (DPH) respectively. L.A. Care collaborates with these entities to conduct activities to improve the coordination of behavioral healthcare and general medical care including collaborating with their provider networks. Beginning January 1, 2014, L.A. Care has a new set of carved-in behavioral health services which is managed by our contracted Managed Behavioral Health Organization (MBHO.)

The behavioral health aspects of the QI program are described in a separate QI program description developed by the delegated MBHO and approved by L.A. Care.

In addition, L.A. Care works closely with the MBHO, DMH, and DPH to annually collect data about the following areas that could identify potential opportunities for collaboration between medical and behavioral health:

- Exchange of information between PCPs and Behavioral Health Specialists.
- Appropriate diagnosis, treatment and referral of behavioral health disorders to all appropriate levels of care.
- Appropriate uses of psychopharmacological medications.
- Management of treatment access and follow-up for members with coexisting medical and behavioral disorders.
- Screening, Brief Intervention and Referral to Treatment (SBIRT) for alcohol misuse condition in primary care setting.
- Primary or secondary preventive health program implementation.

COMMITTEE STRUCTURE

L.A. Care's quality committees oversee various functions of the QI program (see attachment 2). The activities of the quality committees are formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and follow-up required. Draft minutes of the prior meeting are reviewed and approved at the next meeting. Minutes are then signed and dated. Minutes are also reported to their respective Committee as required under "Role and Reporting Relationships". All activities and associated discussion and documentation by the committee participants are considered confidential and shall abide with L.A. Care policies and procedures for written, verbal, and electronic communications.

Oversight of delegated activities occurs in the following committees (See Committee Section of this program for full description of committee):

- 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 and Peer Review Committee for Potential Quality of Care Issues (PQIs)
- Disease Management: Quality Oversight Committee (QOC)

The following section describes the role, reporting relationships, meeting frequency and functions of L.A. Care's quality committees. The committees serve as the major mechanism for intradepartmental collaboration for the Quality Program.

Compliance and Quality Committee

Role and Reporting Relationships: The Compliance and Quality Committee (C&QC) is a subcommittee of the Board of Governors. The C&QC monitors quality activities and reports its findings to the BoG. The C&QC reports to the BoG. The Compliance and Quality Committee is charged with reviewing the overall performance of L.A. Care and providing direction for action based upon findings to the BoG.

Structure: The C&QC's membership is comprised of no more than six (6) sitting members of the BoG, including at least one (1) physician. The Chair is elected annually. A quorum is established in accordance with the by-laws established for the conduct of such committees by the BoG. L.A. Care's CMO or designee reports to the C&QC at least quarterly and more often as needed. All draft agendas are publicly posted at least 72 hours prior to the meeting with the final agenda being approved at the time of the meeting in accordance with the Brown Act.

Frequency: The C&QC is scheduled to meet monthly.

Functions: The C&QC is responsible for reviewing, evaluating, and making recommendations to the BoG regarding all QI Activities and final approval of the QI Program Description and QI Annual Evaluations.

Internal Compliance Committee

Role and Reporting Relationships: The Internal Compliance Committee (ICC) provides oversight, advice, and general guidance to L.A. Care Health Plan senior management on all matters relating to L.A. Care and its subcontractors compliance with mandated and non-mandated performance standards. The Committee shall ensure that L.A. Care adopts and monitors the implementation of policies and procedures that require L.A. Care and its employees, the Plan Partners, and the providers to act in full compliance with all applicable laws, regulations, contractual requirements and policies

Structure: The ICC's membership is comprised of L.A. Care staff involved in Compliance oversight and accountability activities for the organization. A quorum is established when a minimum of 50% of the membership is in attendance. The committee is chaired by the Compliance Officer or designee. All members can vote on all other committee actions/activities.

Membership includes, but is not limited to the Compliance Officer (chair), Senior Director Provider Network Operations, Senior Director Member and Medi-Cal Operations, Chief Medical Officer, Executive Director Health Services, Senior Director Quality Improvement & Health Assessment, Director of Financial Compliance, Assistant Managing Counsel, Associate Counsel, and Privacy Officer.

Frequency: The ICC meets every other month but as frequently as necessary to act upon any important matters, findings or required actions.

Functions: The functions of the ICC include, but are not limited to the following:

- Monitors and oversees the compliance of L.A. Care member and provider grievance process for opportunities for improvement.
- Ensure that appropriate clinical issues are forwarded to the Quality Improvement Department when required.
- Monitor the claims payment timeliness and encounter data process of L.A. Care.
- Make recommendations to senior management to include, but not limited to, imposing appropriate sanctions, extending or renewing provider contracts, the establishing of policies, procedures, and standards, imposing additional conditions of participation, and reviewing corrective action plans for any organization that is either directly or indirectly contracted with L.A. Care.

Quality Oversight Committee

Role and Reporting Relationships: The Quality Oversight Committee (QOC) is an internal 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 quality improvement infrastructure.

Structure: The QOC membership is comprised of L.A. Care staff who are involved in improvement activities. A quorum is established when a minimum of 50% of the membership is in attendance. The Committee is chaired by the Chief Medical Officer or physician designee. Voting members are managers and above.

Membership includes, but is not limited to Medical Director of Quality Improvement & Health Assessment, Chief Medical Officer, Executive Director Health Services, Senior Director Quality Improvement & Health Assessment, Senior Director Medical Management, Senior Director Clinical Assurance, Quality Improvement Director, QI Manager, Senior Director Pharmacy and Formulary, Senior Director Medical Management, Medical Directors, Senior Director Healthcare Outcomes and Analysis, Senior Director Member and Medi-Cal Operations, Manager Facility Site Review, Director Health Education, Cultural and Linguistic Services, Director Provider Network Operations, Compliance Officer, Director Marketing and Communications, Director Credentialing, and ad hoc members – (members from other departments are invited to attend when input on topics require their participation).

Frequency: The QOC meets at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The meeting dates are established annually.

Functions: The functions of the Quality Oversight Committee include, but are not limited to the following:

- Analyzes and evaluates the results of QI activities, identifies needed actions, and ensures follow up as appropriate.

- Review current quality improvement projects and performance improvement activities to ensure appropriate collaboration and minimize duplication of efforts.
- Formulate organization-wide improvement activities and gain support from appropriate departments.
- Review performance requirements of strategic projects and performance improvement activities to enhance effectiveness and make corrections as appropriate.
- Ensure all departments have the opportunity to align project goals and map out responsibilities and deadlines prior to project implementation.
- Analyze and evaluate findings including first-level, quantitative data analysis that incorporates aggregate results and trends over time and compares results against goals and benchmarks.
- Conduct root causes analysis/barrier analysis to identify the reasons for the results especially if results do not meet goals. Analysis will include organization staff who understand the processes that may present barriers to improve.
- Identify opportunities for improvement based on analysis of performance data and prioritize these opportunities.
- Review and evaluate, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services.
- Identify actions to improve quality and prioritize based on analysis and significance; and indicate how actions are chosen.
- Review and evaluate actions taken to determine if actions are effective in improving quality and what revisions, if any, need to be made to the actions.
- Review, evaluate, and make recommendations regarding oversight of delegated activities, such as, audit findings and reports.
- Review and provide thoughtful consideration of changes in its QI and other policies and procedures and work plan and make changes to policies/work plan as needed.
- Review and modify the QI and UM program descriptions, annual QI and UM Work Plans, quarterly work plan reports and annual evaluation of the QI and UM programs.
- Provide and/or review and approve recommended changes to the QI and UM Programs and QI and UM Work Plans' activities based on updates and information sources available.
- Review and monitor effectiveness of Cultural and Linguistic services including the Language Assistance Program.

Executive Community Advisory Committee & Regional Advisory Community Committee

Executive Community Advisory Committee

The Executive Community Advisory Committee (ECAC) is a subcommittee of the Board of Governors of L.A. Care that serves as one of the public advisory committees.

Quorum and Voting: A majority of that month's official ECAC membership must be present in person to have an official ECAC meeting. All official acts of the ECAC require a majority vote of the members present. No vote or election shall be by secret ballot.

Membership The Executive Community Advisory Committee (ECAC) is made up of the eleven (11) elected Regional Community Advisory Committee's (RCAC) Chairpersons and two (2) At-Large Members. The ECAC elects a volunteer ECAC Chairperson and Vice-Chairperson.

Frequency: ECAC meets every month.

Function and Role: At ECAC meetings, matters such as those related to governance, programming, membership, and recommendations on healthcare services and policy are considered and forwarded to the Board of Governors for consideration and action in the form of motions. The Quality Improvement Program is a quarterly agenda item giving members opportunity to hear about Quality Improvement activities and provide feedback for program development.

Regional Advisory Community Committee

The Regional Community Advisory Committee (RCAC) is made up of eleven (11) consumer groups across Los Angeles County to ensure that the communities served by L.A. Care would be involved in the design and delivery of the Medi-Cal Managed Care program throughout Los Angeles County. RCACs were established to comply with state laws and regulations governing L.A. Care. The organizational structure and procedures for the RCACs are subject to the Bylaws of L.A. Care. Membership in a RCAC is based on a set of criteria approved by the Board of Governors, and all RCAC members serve at the pleasure of the Board and can be removed or replaced at any time.

Quorum and Voting: A majority of that month's official RCAC membership must be present in person to have an official RCAC meeting. All official acts of the RCAC require a majority vote of the members present. No vote or election shall be by secret ballot.

Membership: Composition of the RCAC and criteria for membership shall be approved by the Board of Governors of L.A. Care, and shall be in accordance with applicable law, regulations, and L.A. Care Bylaws. All participants in the RCACs serve on a voluntary basis, regardless of category. RCAC membership is not a form of employment with L.A. Care, nor is any permanent relationship or right to serve implies or established by such membership.

There are three categories of RCAC members: consumer members including SPDs who get healthcare from L.A. Care or care for someone who does; provider members who work at clinics, hospitals and medical offices where L.A. Care members get healthcare; and consumer advocates who represent community based organizations interested in improving access and the quality of healthcare. The RCAC's membership shall seek to be representative of ethnic, cultural, linguistic, age, sexual orientation, disability and special medical needs of the member population in the designated region.

Each RCAC meets every other month and shall have at least eight (8) members and no more than thirty-five (35) members with a target membership of twenty (20) members, and at one-third of who shall be Members as defined above. If a RCAC falls below the minimum membership of eight (8) members, the RCAC will be encouraged to make new member recruitment its top

priority. RCACs with less than eight (8) members should delay implementing any large projects, until a sufficient number of new members are attained.

RACs elect two volunteer leaders, a RCAC Chairperson and a Vice-Chairperson. In partnership with the staff of the Community Outreach and Education (CO&E) Department of L.A. Care, the elected RCAC leaders lead discussions, preside over business meetings and represent the RCAC at meetings of the ECAC. The RCAC membership elects two voting members to L.A. Care's Board of Governors a consumer member and an advocate.

Frequency: RCACs meet every other month on a schedule and location to be determined jointly by L.A. Care staff and the RCAC members. With guidance from the assigned CO&E staff person, RCAC members shall set the date and time of each meeting.

Function and Role: RCACs shall serve in an advisory capacity and may be given opportunities by the Board of Governors and/or the management of L.A. Care to have input into and evaluate the operation of Medi-Cal managed care in Los Angeles County. Areas where community and especially L.A. Care member input on the Quality Improvement Program may be requested include:

1. Improving member satisfaction with L.A. Care's provision of services;
2. Improving access to care;
3. Ensuring the provision of culturally and linguistically appropriate services and programs;
4. Identifying emerging needs in the community and establish programmatic responses;
5. Determining and prioritize health education and outreach programs: and
6. Addressing community health concerns collaboratively.
7. Support the gathering of information about issues and concerns that are pertinent to the health and well-being of L.A. Care members in the region. This information will be used by the RCACs, the ECAC, and L.A. Care to plan, implement, and evaluate activities to address identified concerns.

See RCAC Member Handbook & Guidelines for further detail.

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

Role and Reporting Relationship: The Joint Performance and Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC) primary objective is to ensure practitioner participation in the QI program through planning, design, and review of programs, quality improvement activities, interventions, and evidence based clinical practice guidelines designed to improve performance. The committee will provide an opportunity to dialogue with the provider community and gather feedback on clinical and administrative initiatives. The committee reports through the Medical Director (QIHA) or designee, to the Quality Oversight Committee.

Structure: The Joint Performance and Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC) serves as an advisory group to L.A. Care's Quality Improvement infrastructure for the delivery of health services to all lines of business in Los Angeles County. The committee reports to the QOC on findings and matters within its scope of

responsibility which are presented to the QOC by the Medical Director (QIHA) or the CMO. A quorum is established with a simple majority of voting members. The Committee is chaired by the Chief Medical Officer or physician designee. Voting members are Physicians, L.A. Care staff that are managers and above, Network Physicians, Plan Partners three (3) votes each and Provider Groups 2 votes each.

Membership includes, but is not limited to, Chief Medical Officer (chair), Medical Director (QIHA), Medical Director Medicare, Behavioral Health Medical Director, Senior Director Quality Improvement & Health Assessment, Quality Improvement Director, QI Manager, Senior Director Pharmacy and Formulary, Director Medical Management, Senior Director Healthcare Outcomes and Analysis, Director Health Education, Cultural and Linguistic Services, Senior Director Provider Network Operations, Senior Director Member and Medi-Cal Operations. Members from other departments are invited to attend when input on topics require their participation. Delegated Plan Partner UM, A&G, and QI Directors or designees, Delegated Provider Group representatives are also members of this committee. Other staff may attend on an ad hoc basis.

Network Physicians represents a broad spectrum of appropriate network primary care physicians and specialists, including behavioral health physicians serving L.A. Care members. These physicians include but not limited to practitioners who provide health care services to Seniors and People with Disabilities and chronic conditions (such as asthma, diabetes, congestive heart failure, etc.) and/or members receiving Managed Long-Term Services and Supports (MLTSS). Physician members of the community are appointed for three year terms with an option to serve for another 3 years or a total of 6 years. Committee members may be recommended for inclusion by current committee members. Appointments will be made by the Chief Medical Officer or Medical Director, Quality Improvement and Health Assessment.

Frequency: The Joint Performance and Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC) meets at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions.

Functions: The responsibilities of the Joint PICC & PQC include but not limited to:

- Review of quarterly Over/Underutilization UM stats such as inpatient bed days, ER, IHAs, etc.
- Review of quarterly Appeals and Grievances Report.
- Review and discuss quarterly delegated activity reports including audit trends.
- Review and discuss linked and carved out services for persons with complex health needs.
- Review of mandated improvement plans with the state.
- Make recommendations to L.A Care about issues relating to quality improvement activities and administrative initiatives.
- Promote initiatives and innovations offered to the provider community.
- Provide input and make recommendations to L.A. Care's Quality Oversight Committee (QOC) on policy decisions, as well as quality and service improvements.
- Provide a forum for dialogue to enhance the efficiency of practitioner business services including incentive programs and clinical information technology adoption.

- Review and discuss barriers to improvement of HEDIS and CAHPS and other QI measures.
- Review quality improvement project development and opportunities presented by L.A. Care and offer advisory feedback and recommendations as appropriate.
- Provide input and feedback on services provided to our members.
- Select, evaluate, and adopt evidence based clinical practice and preventive guidelines.
- Review and analyze member and provider satisfaction survey results and access to care results and make recommendations for improvement as appropriate.
- Other issues as they arise.

Utilization Management Committee

Role and Reporting Relationship: The Utilization Management Committee (UMC) is a subcommittee of the QOC and focuses on the UM activities.

Structure: The UM Committee supports the Quality Oversight Committee in the area of appropriate provision of medical services and provides recommendations for UM activities.

The CMO or designated Medical Management Medical Director serves as the Chairperson. A quorum is established when fifty one percent (51%) of voting members are present. Only physician members and L.A. Care Executive Director, Senior Director, and Director level members of the UM committees may vote. Findings and recommendations are presented to the Quality Oversight Committee.

UM Committee Membership includes, but is not limited to, CMO, Medical Directors Medical Management, Behavioral Health Medical Director, Medical Director (QIHA), , Medical Director Medicare, Medical Directors or permanent MD Designees of Participating Physician Groups, , Executive Director, Senior Director Health Services, Senior Director Clinical Assurance, Senior Director (QIHA), Senior Director Pharmacy & Formulary, Senior Director Managed Long Term Services & Supports (MLTSS), Senior Director Provider Network Operations (PNO), UM Director, Care Management (CM) Director, Grievance and Appeals (G&A) Director, MLTSS Director, Behavioral Health Director, Provider Group Directors, Lead Delegation Oversight Specialist, UM Oversight and Compliance Specialist, and Medical Management Project Manager. Ad hoc members include Director Credentialing and Senior Director Health Outcomes and Analysis.

Frequency: The Committee meets at least quarterly.

Functions: The UM Committee is responsible for overall direction and development of strategies to manage the UM Program.

The responsibilities of the UM Committee include but are not limited to:

- Participate in the Utilization Management/continuing care programs aligned with the Program's quality agenda.
- Monitoring for potential areas of over and under utilization and recommend appropriate actions when indicated.
- Receive and review utilization data.

- Annual review and approval of the UM Program Evaluation and Description, UM Policies/Procedures, UM Criteria, and other pertinent UM documents, such as, the UM Delegation Oversight Plan, UM Notice of Action Templates, CM Management Program Evaluations and Descriptions, CM Policies/Procedures, and Model of Care Program.
- Recommend actions to the Quality Oversight Committee when opportunities for improvement are identified from review of utilization data including, but not limited to, Ambulatory Visits, Emergency Visits, Hospital Utilization rates, Hospital Admission rates, Average Length of Stay rates, and Discharge rates.
- Review New Medical Technologies including new applications of existing technologies at least annually for potential addition as a new medical benefit for members.
- Review and make recommendations regarding oversight of delegated activities, such as, audit finding and reports.

The L.A. Care Utilization Management program document contains more detailed information pertaining to UMC responsibilities. There is also a separate Model of Care description.

Credentialing Committee

Role and Reporting Relationship: The Credentialing Committee is a subcommittee of the Quality Oversight Committee.; however, in accordance with state law, minutes will not be submitted but rather a summary of the meeting.

Structure: The Credentialing Committee addresses the credentialing and recredentialing activities for all lines of business. The Credentialing Committee serves as a peer review body and retains the right to approve or deny providers at all times and is the final approval of credentialing activities. The Chief Medical Officer (CMO) or physician designee serves as the Committee Chairperson and is responsible for all credentialing activities. A quorum is established when a minimum of three (3) physicians are present.

Membership includes, but is not limited to:
Voting Members are the L.A. Care Chief Medical Officer, L.A. Care Medical Director (QIHA), *L.A. Care* Medical Management Medical Directors, network physicians or designees, and one (1) nurse practitioner (NP) (may vote on NP cases only).

Non-Voting Members are L.A. Care Credentialing Director, Senior Director (QIHA), , Credentialing Specialists, Senior Director Medical Management, Clinical Grievance Specialist, and other board certified medical specialists invited on an ad hoc basis.

Frequency: The Committee meets at least quarterly but as frequently as necessary. The meeting dates are established and published each year.

Functions: The Credentialing Committee has the following functions:
- Credentialing and recredentialing of practitioners [MD, DO, DPM, DC, DDS/DMD, and Mid-Level disciplines, such as, Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS) and Physician Assistants (PA)] as outlined in Policy CR-004.

- Conditions for altering a practitioner's relationship with L.A. Care including suspension or termination of practitioners from the network
- Pre-contractual and annual delegated oversight activities for credentialing and recredentialing.
- Provide feedback on specific practitioner credentials that do not meet required standards and recommendation(s) for handling such cases.
- Review and approve facilities including Hospitals, Free Standing Surgical-Centers, Home Health agencies, Skilled Nursing facilities and mental health and substance abuse facilities providing care in inpatient, residential and ambulatory settings. For Center for Medicaid and Medicare Services (CMS), facilities include the following:
  - Hospice
  - Clinical Laboratory
  - Comprehensive Outpatient Rehabilitation Facility
  - Outpatient Physical Therapy and Speech Pathology Provider
  - Ambulatory Surgery Centers
  - End-Stage Renal Disease Provider (Dialysis Unit)
  - Outpatient Diabetes Self-Management Training Provider
  - Portable X-Ray Supplier
  - Rural Health Clinic (RHC)
  - Federally Qualified Health Center (FQHC)
  - Community-Based Adult Services (CBAS) Centers
- Ensure compliance with state and federal regulatory agencies and accrediting bodies concerning credentialing and recredentialing activities.
- Approve all delegation oversight activities, all Corrective Action Plans (CAPs) and de-delegation and recommendations.

Peer Review Committee

Role and Reporting Relationship: The Peer Review Committee (PRC) is a subcommittee of the Quality Oversight Committee; however, in accordance with state law, minutes will not be submitted but rather a summary of the meeting. The minutes are confidential information protected under California Evidence Code 1157.
Structure: The Peer Review Committee addresses peer review activities for all lines of business in order to assess and improve the quality of care rendered. The Chief Medical Officer or physician designee serves as the Committee Chairperson and is responsible for all peer review activities. A quorum is established when a minimum of three (3) physicians are present.

Membership includes, but is not limited to:
Voting Members are the L.A. Care Chief Medical Officer, L.A. Care Medical Director (QIHA), Chair, L.A. Care Medical Management Medical Directors, network physicians or designees, nurse practitioners (NPs) (may vote on NP cases only).

Non-Voting Members are the QI Director, QI Nurse Specialists, and other board certified medical specialists invited on an ad hoc basis.

Frequency: The Committee meets at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions.

Functions: The PRC addresses Peer Review activities for all lines of business in order to assess and improve the quality of care rendered. It is responsible for overseeing quality of the medical care rendered 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 or PQIs:

- Review, evaluate, and make recommendations regarding Potential Quality of Care Issues (PQIs)
- Recommend additional investigation and/or reporting as indicated or as appropriate
- Determine clinical appropriateness, quality of care and assigns the severity level to the case. PRC members may be requested to review the PQI case prior to the PRC meeting.
- Provide oversight of level 0, 1 and 2 cases that have been closed with no need for committee review.
- Provide oversight of delegated peer review and ongoing monitoring as needed.

Pharmacy Quality Oversight Committee

Role and Reporting Relationship: The Pharmacy Quality Oversight Committee (PQOC) is responsible for oversight of the Pharmacy and Therapeutics process administered by the existing Pharmacy Benefit Manager (PBM) and review new medical technologies or new applications of existing technologies. 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.

Structure: Medical Director of Medical Management serves as the Chairperson for the PQOC. Only physicians and pharmacist members have voting privileges. For decisions regarding new medical technologies or new applications of existing technologies, the PQOC will forward recommendations to the UM Committee for approval and implementation.

Membership: Voting membership includes physicians exclusively, with the L.A. Care Senior Director Pharmacy and Formulary, community pharmacists, and L.A. Care non-physicians as observers. Additional health care professionals may be invited on an ad hoc basis as members when additional medical or pharmacotherapy expertise is required for medical or drug evaluations.

Frequency: The PQOC meets at least quarterly.

Functions: The PQOC has the following functions:

Education/Communication:

- Forum to discuss clinical decision making process and concerns (TAT, G&A, etc.)
- Determine clinical communications goals for PPGs/PCPs/Plan Partners
- Identify the need for medical education programs for physician and pharmacy providers that will support and enhance the health care outcomes goals for L.A Care members.

Oversight/Advisory of PBM Vendor:

- Review newly marketed drugs for potential placement on the formulary.

- Provides input on new drug products to Navitus P&T
- Develop protocols and procedures for the use, of and access to, non-formulary drug products.

L.A. Care Strategic and Administrative Operations

- Specialty pharmaceutical patient management and distribution strategies.
- Pharmaceutical care program selection and evaluation.
- Develop, implement and review policies and procedures that will advance the goals of improving pharmaceutical care and care outcomes.
- Serve the health plan in an advisory capacity in matters of medication therapy.
- Recommend disease state management or treatment guidelines for specific diseases or conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions.
- Make recommendations to UM Committee after reviewing new medical technology and/or new applications of existing technology for benefit coverage after medical necessity review.
- Report metrics, policy and procedure updates and changes, program evaluation and other regulatory and contractual reporting to the UM Committee.

Behavioral Health Quality Improvement Committee

Role and Reporting Relationship: The Behavioral Health Quality Improvement Committee is responsible for collecting and reviewing data, and developing, implementing, and monitoring interventions based on the analysis of data to improve continuity and coordination of medical and behavioral care. L.A. Care delegates Behavioral Health services for Medi-Cal, Medicare, PASC-SEIU, and Healthy Kids to an MBHO. L.A. Care works closely with the MBHO in order to collaborate with behavioral health practitioners (BHPs) and use information collected to coordinate medical and behavioral health care. This committee reports to the Quality Oversight Committee.

Structure: Committee members from L.A. Care include: Medical Director Behavioral Health (chair), Clinical Director Behavioral Health Services, Manager Strategic Initiative Behavioral Health Services, Medical Director Quality Improvement & Health Assessment (QIHA), Medical Director Medicare, Senior Director Health Services/Medical Management, Medical Directors Medical Management, Senior Director Pharmacy Formulary, Senior Director Quality Improvement & Health Assessment, Quality Improvement Director, Senior Director Medical Management, and Quality Improvement and UM/CM Staff. Members from the MBHO include: Medical Director, Program Director, QI and UM Staff. Members from DMH and DPH include Medical Directors.

Frequency: The Behavioral Health Quality Improvement Committee meets quarterly.

Functions: The functions of the Behavioral Health Quality Improvement Committee include:

- Assess exchange of information between BHPs, medical/surgical specialists, organization providers or other relevant medical delivery systems.

- Assess appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care settings.
- Assess appropriate use of psychopharmacological medications and consistent guidelines for prescribing by behavioral and medical practitioners.
- Assess the screening and managing of patients with coexisting medical and behavioral health conditions.
- Collaboratively develop and adopt primary or secondary prevention programs for behavioral health and evaluate effectiveness of program through process or outcomes data.
- Using quantitative data and causal analysis, identify and take action on at least one area of opportunity annually collaborating with BHPs.

Member Quality Service Committee

Role and Reporting Relationship: The Member Quality Service Committee (MQSC) is responsible for improving and maintaining the L.A. Care member experience for all product lines. The scope of the committee includes, but is not limited to; analysis of 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, Appeals & Grievances Data, and Interface of Provider Satisfaction with Member Satisfaction. The committee will also act as a Steering Committee for member quality service issues. The Member Quality Service Committee reports its findings and recommendations to the Quality Oversight Committee.

Structure: Committee members include leadership from key internal departments required to participate in this committee are as follows: Provider Networks Operations (PNO), Member Services (MS), Appeals and Grievances, Medical Management/Case Management, Medicare Operations, Member Outreach, Pharmacy, Sales/Marketing, Communications (C), Healthcare Outcomes and Analysis (HO&A), Health Education, Cultural and Linguistic Services Department (HECLS), Quality Improvement (QI), Information Technology (IT), Regulatory Affairs and Compliance (RAC), and Managed Long Term Services & Support.

Frequency: The Member Quality Service Committee meets at least at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The meeting dates are established annually.

Functions: The functions of the Member Quality Service Committee include:
- Create and maintain a member-centered culture for the organization.
- Review aggregate performance data on L.A. Care's network.
- Measure, report, and improve member satisfaction
    - Define measurement.
    - Define reporting.
    - Set goals.
- Implement focused, measureable interventions. Provide input and make recommendations to L.A. Care's Quality Oversight Committee (QOC) on the state of member satisfaction on a quarterly basis.

- The committee may choose to invite representatives of subcontracted health plans or provider groups, as needed.

Continuing Medical Education Committee

Role and Reporting Relationship: The Continuing Medical Education (CME) Committee reports to the Quality Oversight Committee.

Structure: The Behavioral Health Department Medical Director serves as the Chairperson for the committee. A quorum is established when a minimum of three (3) physicians are present. Only physician members of the committee may vote.

Membership includes, but is not limited to Chief Medical Officer, Behavioral Health Department Medical Director, MM Medical Director, network physicians, Director of Health Education, Cultural and Linguistic Services or designee, CME Coordinator, QI Director, and up to five (5) outside physicians representing different specialties.

Frequency: The Continuing Medical Education Committee meets on an as needed basis, but as frequently as necessary, to address the CME needs of all lines of business and to demonstrate follow-up on all findings and recommendations.

Functions: The Continuing Medical Education Committee has the following functions:

- Develop, implement, and evaluate L.A. Care's CME program.
- Complete and analyze results of an annual professional medical education needs assessment.
- Plan the annual CME calendar.
- Review and approve all components of each educational offering including objectives, content, budget, faculty, and evaluation.
- Provide an annual program and report including findings and recommendations to the QOC and the Board of Governors.
- Oversee the (re)application process for maintaining CME accreditation status.

Long Term Care Quality Improvement Committee (LTC QIC)

The Long Term Care Quality Improvement Committee is in development with a projected implementation date of June 2015.

Role and Reporting Relationship: The Long Term Care Quality Improvement Committee will serve as expert advisor to the L.A. Care Quality Oversight Committee (QOC) on Long Term Care (LTC) Nursing Facilities' performance. The committee's primary responsibility is oversight of QI program activities related to LTC Nursing Facilities to ensure quality of care to institutionalized members. The committee will be an active partner with L.A. Care on clinical initiatives and performance measurement. The committee provides a mechanism for integrating, coordinating, and assessing LTC Nursing Facility quality activities with overall quality and improvement activities at L.A. Care.

Structure: The Medicare Medical Director or designee serves as the Chairperson for the committee. A quorum is established with a minimum of 51% members in attendance.

Membership includes, but is not limited to contracted Nursing Facility LTC Administrators, QI Directors, and Medical Directors. Membership also includes key L.A. Care leadership staff such as Chief Medical Officer, QI Director, and other members, as required.

Frequency: The Long Term Care Quality Improvement Committee meets at least quarterly, but as frequently as necessary, to demonstrate follow-up on all findings and required actions.

Functions: The Long Term Care Quality Improvement Committee has the following functions:

- Develop a section of the L.A. Care Quality Plan on LTC Nursing Facility quality, which:
  - Receives annual review and approval from the L.A. Care QI Program.
  - Identifies areas to improve delivery of LTC services through focused review and ad hoc studies.
  - Evaluates outcome of LTC Nursing Facility care as measured by standards and key quality indicators.
  - Implements plans of action to improve quality of care to members residing in LTC Nursing Facilities.
- Develop a dashboard of quality indicators.
- Address member and family satisfaction.
- Provide recommendations to L.A. Care's QI Program on quality improvements in LTC Nursing Facilities.
- Provide training for LTC Nursing Facility providers and staff who work with L.A. Care.
- Share LTC Nursing Facilities' best practices with L.A. Care's QI Program.
- Review aggregate performance data on L.A. Care's LTC Nursing Facility network.

SCOPE OF PROGRAM

The scope of the QI Program is reflective of the health care delivery system and provides for a systematic approach to continuous improvement, encompassing the quality of both clinical care and service. The processes and procedures are designed to ensure that all covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

The Quality Improvement Program is implemented through the multidisciplinary cooperation of departments across the entire organization. The program includes establishment of performance indicators and measurement methodologies, measurement of performance, quantitative and qualitative analysis of performance data and results, identification of improvement opportunities, prioritization of opportunities, timely implementation of strong interventions to improve performance and re-measurement to assess effectiveness of interventions.

As provided under 42 CFR §422.152© and §422.152(d), QI programs must include a CCIP and Quality Improvement Project (QIP) that measures and demonstrates improvement in health outcomes and beneficiary satisfaction.

CMS has reframed the QI program as a continuous performance improvement program that includes collection, reporting, and analysis of data that:

1. Assists beneficiaries in selecting plans that meet acceptable performance levels
2. Assists CMS in monitoring plan performance; and
3. Sets minimum requirements for MA plans to assess their own performance through a robust internal performance improvement program.

Quality of Care

Members with Complex Health Conditions, Seniors and People with Disabilities and Culturally and Linguistically Diverse Membership

L.A. Care seeks to improve the health and overall well being of all its members, including seniors and people with disabilities as well as focusing on health disparities. L.A. Care specifically develops programs that target and accommodate members who are at higher risk for health disparities including those related to race and ethnicity, language, disabilities and chronic conditions.

L.A. Care has undertaken a significant effort to improve services for seniors and people with disabilities. This population is one that often has complex health needs. This effort has involved review of L.A. Care's departments for the ability to appropriately serve and communicate with disabled members including the availability of L.A. Care member materials in alternative formats (large print, Braille, and audio recording) and to assure the availability of sign-language interpretation as requested. L.A. Care is also developing an enhanced care coordination process to include screening mechanisms to identify the need for more intensive case management and coordination of specialty referral including referrals for linked and carved out services.

HEDIS

L.A. Care measures clinical performance related to Healthcare Effectiveness Data and Information Set (HEDIS) and External Accountability Set (EAS) indicators. HEDIS data is audited by an NCQA – approved external auditor.

On an annual basis, L.A. Care completes an on-site EAS Compliance Audit (also referred to as the HEDIS Compliance Audit) to assess L.A. Care's information and reporting systems, as well as L.A. Care's methodologies for calculating performance measure rates. L.A. Care uses the DHCS-selected contractor for performance measures that constitute the EAS. Compliance Audits are performed by an External Quality Review Organization (EQRO). L.A. Care calculates and reports all EAS and selected Use of Service performance measures. HEDIS rates are calculated by L.A. Care and verified by the DHCS-selected EQRO. Rates for DHCS-developed performance measures are calculated by the EQRO. L.A. Care reports audited results on the EAS performance measures to DHCS no later than June 15 of each year or such date as established by DHCS. DHCS will notify L.A. Care of the HEDIS measures selected for inclusion in the following years' utilization monitoring measure set.

The following table outlines specific Quality of Care measures and activities that are the subject of ongoing monitoring and evaluation specific to line of business:

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H)	Covered CA Measure	DHCS Auto Assignment Measure	DHCS Required Measure (EAS)	NCQA Accreditation Measure - Medi-Cal	Star (Cal MediConnect)	Medicare Accreditation Measures
PPC-PST	Prenatal and Postpartum Care - Postpartum Care	H	X		X	X		
CBP	Controlling High Blood Pressure - Total (new DHCS 2014)	H	X	X	X	X	X	X
MPM-ACE	Annual Monitoring for Patients on Persistent Medications -ACE/ARB	A	X		X			
MPM-DIG	Annual Monitoring for Patients on Persistent Medications -Digoxin	A	X		X			
MPM-DIU	Annual Monitoring for Patients on Persistent Medications -Diuretics	A	X		X			
CCS	Cervical Cancer Screening	H	X	X	X	X		
CDC-N	Comprehensive Diabetes Care - Medical Attention for Nephropathy	H	X		X	X	X	X
PPC-Pre	Prenatal and Postpartum Care - Timeliness of Prenatal Care	H	X	X	X	X		
ABA	Adult BMI Assessment	H	X			X	X	X
BCS	Breast Cancer Screening - Total	A	X			X	X	X
CDC-BP	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	H			X	X	X	X
CDC-E	Comprehensive Diabetes Care - Eye Exams	H	X		X	X		X
CDC-H9	Comprehensive Diabetes Care - Poor HbA1c Control >9%	H			X	X	X	X
CDC-HT	Comprehensive Diabetes Care – HbA1c Testing	H	X	X	X			
CIS-3	Childhood Immunization Status - Combo 3	H	X	X	X			
W-34	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	H	X	X	X			
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	A	X		X	X		
ACR	All Cause Readmission		X		X			

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H)	Covered CA Measure	DHCS Auto Assignment Measure	DHCS Required Measure (EAS)	NCQA Accreditation Measure - Medi-Cal	Star (Cal MediConnect)	Medicare Accreditation Measures
AMM	Antidepressant Medication Management - Acute Phase	A	X			X		X
AMM	Antidepressant Medication Management-continuation phase	A	X			X		X
COL	Colorectal Cancer Screening	H	X				X	X
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement		X			X		X
IMA	Immunizations for Adolescents	H	X		X	X		
LBP	Use of Imaging Studies for Low Back Pain	A	X		X	X		
MMA-75	Medication Management for People with Asthma-75% Compliance Total	A	X		X	X		
WCC-BMI	Weight Assessment & Counseling for Nutrition& Physical for Children and Adolescents	H	X		X	X		
WCC--N	Weight Assessment & Counseling for Nutrition& Physical for Children and Adolescents	H	X		X	X		
WCC-PA	Weight Assessment & Counseling for Nutrition& Physical for Children and Adolescents	H	X		X	X		
ADD	Follow-Up for Children Prescribed ADHD Medication-initiation	A	X			X		
ADD	Follow-Up for Children Prescribed ADHD Medication - Continuation and Maintenance	A	X			X		
ART	Rheumatoid Arthritis Management						X	X
CDC-H8	Comprehensive Diabetes Care - HbA1c Control <8%	H	X		X			
CHL	Chlamydia Screening in Women-Total	A	X			X		
FUH	Follow-Up After Hospitalization for Mental Illness - 7 day	A	X			X		
HPV	HPV Vaccine for Female Adolescents		X			X		

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H)	Covered CA Measure	DHCS Auto Assignment Measure	DHCS Required Measure (EAS)	NCQA Accreditation Measure - Medi-Cal	Star (Cal MediConnect)	Medicare Accreditation Measures
OMW	Osteoporosis Management in Women with a Fracture						X	X
PCE	Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroid	A				X		X
PCE	Pharmacotherapy Management of COPD Exacerbation Bronchodilator	A				X		X
AMB-ED	Ambulatory Care ED Visits				X			
AMB-OP	Ambulatory Care Outpatient Visits				X			
ASM	Use of Appropriate Medication for People with Asthma (total rate)	A				X		
AMM	Antidepressant Medication Management - Acute Phase		X					
AMM	Antidepressant Medication Management- continuation phase		X					
CAP-12-19	Children & Adolescents' Access to Primary Care - 12-19 years	A			X			
CAP-12-24	Children & Adolescents' Access to Primary Care - 12-24 months	A			X			
CAP-25-6	Children & Adolescents' Access to Primary Care - 25 months-6yrs	A			X			
CAP-7-11	Children & Adolescents' Access to Primary Care - 7-11 years	A			X			
CIS-2	Childhood Immunization Status - Combo 2	H				X		
CIS-0	Childhood Immunization Status - Combo - 0					X		
CWP	Appropriate Testing for Children with Pharyngitis	A	X			X		
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - initiation		X					
MMA-50	Medication Management for People with Asthma-50% Compliance Total	A			X			
PBH	Persistence of Beta Blocker Treatment After Heart Attack	A						X

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H)	Covered CA Measure	DHCS Auto Assignment Measure	DHCS Required Measure (EAS)	NCQA Accreditation Measure - Medi-Cal	Star (Cal MediConnect)	Medicare Accreditation Measures
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	A						X
URI	Appropriate Treatment for Children with Upper Respiratory Infections	A	X			X		

Star Program

The Centers for Medicare and Medicaid Services (CMS) has implemented a program to rate Medicare Managed Care Plans on the quality of clinical and service experiences of beneficiaries. This one to five star rating system also provides consumers with information on how a particular plan compares to other plans when choosing a plan during open enrollment. For health plans, the Star rating system provides quality bonus payments for plans that score 4 stars and above. Star measures can vary from year to year and covers aspects of both Medicare Part C and Part D. Star measures are noted on the QI work plan. CMS updates star ratings for health plans each October on the Medicare Plan Finder, to assist members with making an informed decision when choosing a Medicare Advantage Plan.

Chronic Care Improvement Programs (CCIP) - Medicare

The objective of L.A. Care's Chronic Care Improvement Program (CCIP) is to improve the health status of its eligible members with multiple or severe chronic conditions. The programs achieve their objective by educating the member and by enhancing the member's ability to self-manage his or her condition or illness. CCIPs are developed from evidenced-based clinical practice guidelines and support the practitioner–patient relationship, the plan of care as well as foster patient empowerment. CCIPs were selected based on an analysis of internal data relating to disease prevalence in the L.A. Care population. In addition, the CCIP targets the appropriate Medicare population with a clearly defined numerator, denominator and exclusion criteria.

At a minimum, the CCIP addresses the following components:

- CCIP is relevant, important, and developed with a strong QI process, based on evidence. Strong rationale for targeting condition is given.
- Multiple sources and QI processes are used to identify need for CCIP. Data sources are valid and reliable.
- Identifying enrollees with multiple or sufficiently chronic conditions who meet the criteria for participation in the program. Criteria for participation are thoroughly identified. Method of identifying eligible enrollees is designed for high, meaningful participation.
- The CCIP demonstrates a rigorous enrollment method that reaches a significant segment of the targeted population while exhibiting robust participation in the program. Participation in the program is measured annually by member participation rates.

- Condition monitoring, patient adherence to the program's treatment plans, consideration of other health conditions and lifestyle issues as indicated by practice guidelines. Interventions reach a significant segment of the targeted population, impact multiple aspects of problem, and address health literacy/cultural needs of members.
- Use of nationally recognized guidelines that are reviewed at a minimum of every two years unless the guidelines change earlier.
- Systematic identification of members who qualify for programs monthly.
- Provision for eligible members to receive written program information regarding how to use the services, how members become eligible to participate, and how to opt in or opt out.
- Member interventions are based on stratification.
- A documented process for providing practitioners with written program information including instructions on how to use the disease management program services and how L.A. Care works with a practitioner's members in the program.
- Systematic program monitoring is integrated into the program; program progress of enrollee is reviewed at least annually and opportunities for improvement are addressed. At least one performance measures for each program is tracked. Specific, appropriate outcome/performance measures are provided. Each measurement addresses a relevant process or outcome, produces a quantitative result, is population based, uses data and methodology that are valid for the process or outcome measured, and is analyzed in comparison to a benchmark or goal. These results are reported in the annual QI program evaluation.

Topic	Product Line
Cardiovascular Care	Cal MediConnect

Quality Improvement Projects (QIPs)

L.A. Care conducts Quality Improvement Projects (QIPs) as mandated by DHCS and CMS. The EQRO and CMS Quality Improvement Activity forms are used to propose initiation of the project and for subsequent periodic reporting. QIPs are multi-year projects that may include small group or state wide collaboratives. DHCS requires health plans to always maintain two active QIP projects. CMS requires that Medicare Advantage Organizations maintain one active QIP project.

L.A. Care conducts CMS and DHCS quality improvement projects that achieve, through ongoing measurement and intervention, demonstrable improvement defined as "significant improvement sustained over time" in aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. L.A. Care continuously monitors its performance on a variety of dimensions of care and services for enrollees, identify areas for potential improvement, carry out individual projects to undertake system interventions to improve care, and monitor the effectiveness of those interventions.

An individual QI project developed in support of DHCS or CMS requirements involves the following:

1. An aspect of clinical care or non-clinical services is identified and the members who would benefit from participation in the QIP. Target population is appropriate to the topic and is clearly defined, with clear numerator, denominator, and exclusion criteria. Topic is relevant, important, and developed with a strong QI process, based on evidence with a clinical or non-clinical focus.
2. The QIP outlines robust indicators that are objective, clearly and unambiguously defined, based on current clinical knowledge, and measurable. Data sources and collection methodology is valid and reliable. Specification of clearly defined objectives and quality indicators to measure performance are selected and capable of measuring outcomes including, but not limited to, changes in health status, functional status, enrollees satisfaction, and valid processes for these and/or other outcomes.
3. Collection of baseline data.
4. Identification and implementation of appropriate system interventions to improve performance. Intervention reaches a significant segment of the targeted population and beneficiary participation is robust. Strong, realistic interventions address multiple aspects of the problem, based on root cause analysis.
5. Repeated data collection to assess the immediate and continuing effect of the interventions and determine the need for further action.
6. Significant improvement sustained over time. Results show demonstrable improvement.

Because the key QI project components are interdependent, failure on any one of them affects the overall project. Documentation of a completed project will provide evidence of compliance with each component.

L.A. Care takes timely action to correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanism. For instance, if internal surveillance discovers a systemic problem pertaining to an aspect of care delivery as a result of performing oversight activities, the problem is addressed promptly.

In addition, CMS may require a particular QIP that is specific to the organization. There may be instances in which CMS believes that some aspects of care require greater emphasis, either because of the organization's relationship to populations with special health care needs or because the organization's performance is in need of greater improvement in some areas than in others. In such an instance, CMS may require the organization to conduct a particular project.

This type of project may be required in response to a remedial or corrective action request or if a previous QIP did not meet CMS' expectations.

Topic	Product Line
Quality Improvement Project (QIP)	
All cause readmissions	Cal MediConnect
All cause readmissions	Medi-Cal
Diabetes	Medi-Cal

Topic	Product Line
Improvement Project (IP)	
Annual Monitoring for Patients on Persistent Medications (MPM)	Medi-Cal
Postpartum Care	Medi-Cal

Patient Safety

L.A. Care is committed to improving patient safety and promoting a supportive environment for network practitioners and other providers to improve patient safety. Information about safety issues is received from multiple sources including member and practitioner grievances, adverse issues, pharmacy data such as polypharmacy, facility site reviews, continuity of care activities, and member satisfaction survey results. Many of the ongoing QI Program measurement activities, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation include safety components. When performance is analyzed for these measures, patient safety is considered, opportunities are identified and prioritized and actions taken to improve safety.

L.A. Care collects and tracks critical incidents by enrollee and makes referrals to appropriate agencies for follow up. L.A. Care also makes referrals to local Adult Protective Services (APS) agencies or, when appropriate, law enforcement, and tracks the number of cases referred for enrollees, including those receiving Managed Long-Term Services and Supports (MLTSS). A "critical incident" is an incident in which the enrollee is exposed to abuse, neglect or exploitation, a serious, life threatening, medical event for the enrollee that requires immediate emergency evaluation by medical professional(s), the disappearance of the enrollee, a suicide attempt by the enrollee, unexpected death of the enrollee, and restraint or seclusion of the enrollee.

L.A. Care follows state laws to report suspected child or adult abuse, neglect, or domestic violence and makes referrals to appropriate agencies as appropriate. L.A. Care has a policy on reporting suspected cases and tracks referred cases.

Potential Quality Issue (PQI) cases are referred to the Quality Improvement (QI) Department for clinical evaluation, investigation, resolution, and tracking. The QI nurse conducts the initial clinical review of all PQI referrals. Level 0/no quality of care, level 1/appropriate quality of care, and/or quality of service cases are closed, tracked, and presented to the Peer Review Committee monthly by QI nurse. All other quality of care issues with severity level 2/borderline quality of care and above are reviewed by QI Medical Director. PQI cases with severity 3/moderate quality of care or 4/serious and/or significant quality of care are subsequently presented to the Peer Review Committee for review, assignment of final severity level, action, and resolution as needed. Closed PQI cases are tracked and trended on a quarterly basis for timeliness of acknowledgement and resolution, issue type, provider type, and severity level assignment. The committee will identify potential interventions and measure(s) to address opportunities for improvement.

Pharmacy safety measures include edits at the point of service. Each prescription filled is subject to a prospective drug utilization review. This review includes a search for possible drug

interactions and previous known allergies to reduce the risk of dispensing medications with potential adverse consequences.

L.A. Care has established medical record standards to facilitate communication, coordination and continuity of care, and to promote safe, efficient and effective treatment. L.A. Care monitors PCP medical record documentation. A medical record review is completed every three years for each practice site to evaluate compliance with medical record standards. A follow up audit can be conducted for those PCP sites that do not meet acceptable standards as determined by the certified site reviewer.

Guidelines for Care

Preventive Health Care Guidelines

L.A. Care's preventive care guidelines are reviewed and approved annually by the Joint Performance Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC). Adult preventive services are provided in accordance with the most recent guidelines based on the U.S. Preventive Health Task Force Guidelines. Pediatric preventive health services are provided to members 21 years of age and younger in accordance with the most recent recommendations of the American Academy of Pediatrics (AAP) "Recommendations for Preventive Health Care." Periodicity schedules for health assessment and dental referrals by age are provided by the California Department of Health Care Services for members aged 20 years and younger.

Immunizations are provided according to the most recent Recommended Childhood and Adult Immunization Schedule approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), and the American College of Obstetricians and Gynecologists (ACOG). Prenatal guidelines are based on theACOG Guidelines for Prenatal Care. Revisions and updates are presented to the Joint PICC & PQC prior to approval and adoption. L.A. Care ensures dissemination of information through member and provider newsletters, meetings, mailings, and via the web to providers, members, and staff as appropriate.

Medicare approves and publishes preventive health guidelines for members and providers on the CMS website. For the most part, Medicare provides preventive services in accordance with the most recent guidelines based on the U.S. Preventive Health Task Force Guidelines.

Clinical Practice Guidelines for Acute and Chronic Medical Care

L.A. Care adopts clinical practice guidelines promulgated by recognized regional and national entities based on reasonable medical evidence for selected conditions identified as relevant for its membership. Clinical practice guidelines are adopted for each of L.A. Care's health management programs which are Asthma, Diabetes, and Cardiovascular Risk Reduction. Clinical practice guidelines are adopted for L.A. Care's chronic care improvement program. Performance against guidelines is measured through HEDIS and other measures. Clinical practice guidelines are formally adopted by the Joint PICC & PQC.

Clinical Practice Guidelines for Behavioral Health Care

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, Cal MediConnect (non-specialty behavioral health: mild to moderate impairment), and Medi-Cal lines of business. Specialty behavioral health, inpatient and substance use benefits are carved out for the Medi-Cal line of business; specialty behavioral health such as severe impairment is carved out for the Cal MediConnect line of business.

Clinical practice guidelines are reviewed at least every two years. The guidelines are reviewed more frequently when new scientific evidence or national standards are published or changed. Behavioral health clinical practice guidelines are available for all practitioners through L.A. Care's and the MBHO's website and paper copies are available upon request.

Disease Management Programs

The objective of each of L.A. Care's Disease Management Programs is to improve the health status of its eligible members with chronic conditions. The programs achieve this objective by educating the member and by enhancing the member's ability to self-manage his or her condition or illness. Disease management programs are developed from evidenced-based clinical practice guidelines and support the practitioner–patient relationship, plan of care and foster patient empowerment. L.A. Care's Disease Management Programs include: Asthma, Diabetes, and Cardiovascular Risk Reduction. These conditions were selected based on common chronic conditions experienced by L.A. Care members and the success of disease management programs in helping patients with chronic illness improve their health status over the course of the disease. At a minimum each disease management program addresses the following components:

- Systematic identification and stratification of members who qualify for programs monthly.
- Integration of member information from disease management, case management, utilization management and wellness programs to facilitate access to member health information for continuity of care.
- Improve patient self-management/activation of disease through education, empowerment, monitoring, and communication.
- Condition monitoring, patient adherence to the program's treatment plans, consideration of other health conditions, co-morbidity, psychosocial, and lifestyle issues as indicated by practice guidelines.
- Provide culturally and linguistically appropriate health education materials.
- Communicate information about the member's condition to caregivers with member's consent.
- Improve practitioner performance of condition treatment through adoption of evidence-based clinical guidelines and practitioner and member feedback.
- Expand program services and resources through community collaboration.
- Provision for eligible members to receive written program information regarding how to use the services, how members become eligible to participate, and how to opt in or opt out.
- Annual measurement and analysis of member satisfaction and knowledge, as well as participation rates.

- A documented process for providing practitioners with written program information including instructions on how to use the disease management program services and how L.A. Care works with a practitioner's members in the program.
- Tracking of at least one performance measure for each disease management program. Each measurement addresses a relevant process or outcome, produces a quantitative result, is population based, uses data and methodology that are valid for the process or outcome measured, and is analyzed in comparison to a benchmark or goal. These results are reported in the annual QI program evaluation.

Utilization Management (UM) (Serving members with complex health needs)

L.A. Care's Utilization Management activities are outlined in the Utilization Management Program Description which includes persons with complex health conditions. The UM Program Description defines how UM decisions are made in a fair and consistent manner. There is also a Case Management Program Description and a Complex Case Management Program Description. These programs address serving members with complex health needs, such as, seniors and people with physical or developmental disabilities (SPDs) and/or multiple chronic conditions. There is one staff person dedicated to working with "linked and carved out services" such as the Regional Centers, California Children Services (for children with complex health care needs) and the Department of Mental Health. The UM Program Description is approved by the UMC and QOC. For additional information, refer to the UM Program Description.

Model of Care (MOC)

The Model of Care will be updated and submitted to the Centers of Medicare and Medicaid Services (CMS) February 2015.

Medical Management's Case Management Department identifies and monitors the most vulnerable members of the population by implementing the model of care program which includes the quality improvement activities designed for these individuals. The program includes a description of how L.A Care evaluates the effectiveness of it model of care program including methodology and specific performance outcomes that demonstrate improvements. L.A. Care maintains documentation on the evaluation and makes it available to CMS as requested and during onsite audits. The Care Management department determines what actions to take based on the results of the model of care evaluation. For additional information, see the MOC program description.

The MOC details activities related to the following categories, background and description of specific target population, measurable goals and objectives, staff structure and care management roles, Interdisciplinary Care Team (ICT), Provider Network's Specialized Expertise and Use of Clinical Practice Guidelines and Protocols, Model of Care training for L.A. Care personnel and provider network, Health Risk Assessment (HRA), Individualized Care Plan, Communication Network, Case Management of the most vulnerable subpopulations, performance and health outcome measurements, beneficiary protections, and health information technology.

Pharmacy Management

Pharmacy and formulary utilization is monitored regularly with reports and updates to the Quality Oversight Committee (QOC). The Pharmacy Quality Oversight Committee (PQOC) performs regular reviews and updates to the formulary, utilization edits/guidelines and policies and procedures based on clinical evidence available at the time of consideration. Since the management of the Medicare Part D Formulary is delegated to a contracted Pharmacy Benefit Manager (PBM), Navitus, the Pharmacy staff performs oversight to ensure compliance with CMS requirements. With the PBM, L.A. Care collects prescription drug quality measures, consistent with Medicare Part D requirements and has established quality assurance measures and systems to reduce medication errors, adverse drug interactions and improve medication use. (See also Patient Safety section of this program.)

Additionally, L.A. Care participates in the Part D MTM program, which examines multi-drug therapy for specific chronic conditions. The MTM program can be used to satisfy the requirements under Medicare and Medicaid that pertain to assessing the quality and appropriateness of care and services, as outlined in 42 CFR §438.204, §438.208, §438.240, and §422.152.

The Medication Therapy Management (MTM) program is contracted out to Navitus to perform medication reviews with the following services: Comprehensive Medication Review to identify any duplications or conflicts with their medications; prescriber consult to resolve any problems found with the medications; over-the-counter consult to resolve minor ailments; and drug information on any new medication. L.A. Care collects data from Navitus, analyzes the data and reports MTM measures to CMS and ensures the accuracy of the MTM Measures and determines what actions to take based on the results of the MTM measurements.

Contracting

L.A. Care requires that its contracted network cooperate with L.A. Care's quality improvement activities, as well as provide L.A. Care access to medical records and that member information be kept confidential according to applicable laws.

L.A. Care requires that all provider network contracts contain an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

L.A. Care does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience.

Credentialing/Recredentialing

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 initially assesses health delivery organizations (HDOs) and reassess every three years thereafter to assure compliance with regulatory standards.

Quality of Services

Member Satisfaction

L.A. Care monitors member satisfaction with care and service and identifies potential areas for improvement. To assess member satisfaction, L.A. Care reviews multiple sources of data including evaluation of member complaints, grievances, and appeals as well as data collected from the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Opportunities for improvement are identified; priorities are set; and interventions are selected, implemented, and monitored and evaluated through various internal committees. Results are presented to the Member Quality Service Committee, the Joint PICC & PQC, the QOC, and Compliance and Quality Committee.

Provider Satisfaction

L.A. Care monitors provider satisfaction with L.A. Care on relevant health programs, services, and processes. The annual provider satisfaction survey also includes open-ended questions related to service improvements. The survey questions focus on L.A. Care's practitioner service areas, such as, overall satisfaction, access to specialists, utilization management, credentialing, contracting processes, and coordination of care between PCPs and hospitals, home health, and free standing surgical facilities. The survey is fielded annually for all lines of business and includes primary care physicians, specialty care physicians, community clinics, hospitals, and Provider Groups. Results are presented to the Member Quality Service Committee, the Joint PICC & PQC, the QOC, and Compliance and Quality Committee.

Complaints and Appeals

Complaints including those related to Cultural and Linguistic issues and appeals are tracked and trended on a quarterly basis for timeliness of acknowledgement and resolution, issue types, and by provider type. The quarterly report is presented and reviewed by the Member Quality Service Committee, the Credentialing Committee, and the QOC. Committees will identify potential interventions and measure(s) to address opportunities for improvement.

L.A. Care Health Plan collaborates with a Quality Improvement Organization (QIO) appointed by CMS in the state of California. QIOs are organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. The following types of issues would be referred to QIOs for their review:

- Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers.
- Continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

- Quality of Care Issue: A quality of care complaint may be filed through the L.A. Care's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Availability of Practitioners

Availability of practitioners is assessed through the Provider Network Operations Department using quantifiable standards for both geographic distribution and numbers (ratio of providers to members) of PCPs, and high volume specialists, including high volume behavioral health practitioners L.A. Care standards and contractual requirements define the geographic standards and ratios for PCPs and SCPs. L.A. Care assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts the availability of providers if necessary.

Accessibility of Services

L.A. Care has established standards for the accessibility of primary care and behavioral health care. These include standards to address:

- Appointments for regular and routine primary care.
- Urgent primary care appointments.
- After hours access to primary care.
- Wait times for appointments.
- Preventive health appointments.
- Telephone service.
- Routine, urgent, and non-life-threatening emergent behavioral health care.
- Behavioral health telephone access.
- Language assistance services.

L.A. Care collects and performs an annual analysis of data to measure its performance against its access standards. The data sources include but are not limited to: CAHPS survey, access to care studies, and L.A. Care's Behavioral Health Partner.

An access to care study is conducted annually to measure the compliance of contracted physicians in rendering medical care within timeframes established by the Department of Managed Healthcare (DMHC), CMS, and other regulatory agencies. The study measures in "wait-days" the length of time it takes for a patient to receive various types of primary care appointments and routine appointments in targeted areas of specialty care.

Member Services

L.A. Care has established standards for access to member services by telephone. These standards include call abandonment rate, wait time, and service level. Performance data are provided to the QOC on a regular basis.

Member, Provider, and Practitioner Communication

Member Communication

Member communication occurs in a variety of ways. The member evidence of coverage booklet provides members with a written description of health plan benefits and other subscriber issues. Member newsletters disseminate information regarding changes to benefit coverage and services, preventive health care guidelines, special events and services, legislative changes, health management programs, enrollment information, health education, access to interpreter services, and issues related to patient safety. Targeted mailings are used to promote L.A. Care disease management programs, chronic care improvement programs, health education opportunities, and Regional Community Advisory Committee events. Educational materials are available through the Health Education, Cultural and Linguistic Services Department. Materials are developed to address the cultural and linguistic needs of L.A. Care's diverse population. QI program updates and improvements in care management resulting from its overall quality improvement program are also posted for all stakeholders on the website. Members are notified of the information that is available on the L.A. Care website and may use this site and/or call member services to request paper copies of information available on the website. The Regional Community Advisory Committees also provide a means to facilitate member participation in the Quality Improvement program.

Effective July 1, 2015 L.A. Care will offer the availability of telephonic and /or digital access to the following services for all product lines.

- Electronic Health Appraisal
- Self-Management Tools
- Functionality of Claims Processing
- Pharmacy Benefit Information
- Personalized Information on Health Plan Services
- Member Support through Innovative Technologies (eConsult, prescribing, scheduling, etc.)
- 24 Hour Health Information Line including Interpreter Services
- Encouraging Wellness and Prevention

The following table lists key measures captured for all lines of business as a component of annual CAHPS:

Quality Rating System (QRS)

Measure	
Data Source: CAHPS	
Access to Care (getting needed care, getting care quickly)	Plan Administration (Customer Service)
Access to information (plan information on costs)	Rating of All Health Care
Aspiring Use and Discussion	Rating of Health Plan

Measure	
Care Coordination (coordination of members' health care services)	Rating of Personal Doctor
Cultural Competency	Rating of Specialist (specialist seen most often)
Medical Assistance with Smoking and Tobacco Use	

Provider and Practitioner Communication

A provider/practitioner newsletter communicates updates on all aspects of the health plan including pharmacy procedure, health management programs, provider and patient education opportunities, cultural and linguistic training opportunities, Language Assistance Program services, Utilization Management program changes, and patient safety issues. The newsletter is published at least three times a year. Providers are kept abreast of the information that is available on the L.A. Care website and on the provider portal. They may use these resources to stay updated and/or call to request paper copies.

Provider Incentive Programs

L.A. Care's Quality Improvement department operates pay-for-performance incentive programs for providers to improve HEDIS, CAHPS, auto-assignment, and member care. Incentive programs provide a highly visible platform to engage providers in quality improvement; 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 where possible so that all providers can pursue common performance improvement priorities.

2015 marks the fifth 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, as well as financial rewards for practices serving L.A. Care Medi-Cal and L.A. Care Covered members. It 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.LA P4P, now in its sixth year, is a pay-for-performance program for 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. In addition to clinical quality, LA P4P now measures, reports, and rewards provider group performance 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.

L.A. Care's redesigned incentive program for health plan partners enters its second year in 2015. Participating plan partners are rewarded for performance improvement in essential HEDIS

measures. The program also rewards health plans whose largest PPGs meet their encounter data targets in LA P4P.

Patient Centered Medical Home

In 2010, L.A. Care recognized the need to strengthen the capacity of L.A. Care providers to care for members with complex medical and social needs and launched a program to help 10 practices transform into patient centered medical homes and achieve NCQA PCMH Recognition. In 2012, a second cohort was launched with 7 practices. In 2013, all 17 practices completed training with an external consultant. Fifteen of the 17 participating clinics submitted NCQA applications. Twelve practices achieved NCQA PCMH Recognition, reaching at least a level 2 recognition.

SALES AND MARKETING

L.A. Care makes a good-faith effort to submit and use complete marketing materials approved by CMS and File and Use certification for eligible marketing materials. At least 90% of quality materials have been submitted via File and Use certification. L.A. Care makes appropriate changes to marketing materials based on new regulatory or policy requirements. L.A. Care demonstrates that marketing resources are allocated to the disabled Medicare population as well as members ages 65 and over.

L.A. Care provides to members information on advance directives, emergency services and policies on plan counseling or referral services that L.A. Care will not provide due to a "conscience" objection in accordance with (IAW) CMS requirements.

At the time of enrollment and annually thereafter, L.A. Care discloses to each member in a clear, accurate, and consistent form, the information required by regulatory agencies including CMS, DHCS, DMHC, and the Department of Insurance (DOI). L.A. Care also provides the information upon the request of a member. In addition, L.A. Care has an established system for confirming that enrolled members are enrolled in the plan and they understand the rules applicable under the plan. If L.A. Care intends to change its rules, it will give notice to all members at least 30 days before the intended effective date of the change.

L.A. Care does not engage in activities which materially mislead, confuse, or misrepresent L.A. Care. Where a significant non-English speaking population exists, L.A. Care provides materials in the language of these individuals.

L.A. Care makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PCP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.

QUALITY IMPROVEMENT PROCESS AND HEALTH INFORMATION SYSTEMS

L.A. Care maintains and operates a Quality Improvement Program that is designed to monitor performance in key areas and identify opportunities to improve clinical care, care delivery, service, and member safety. L.A. Care formally adopts and maintains goals against which performance is measured, assessed, and evaluated. L.A. Care has effective procedures to

develop, compile, evaluate, and report certain measures and other information to CMS, its enrollees, and the general public. In doing so, L.A. Care safeguards the confidentiality of the doctor-patient relationship. Health Information data and documentation of the overall quality improvement program is maintained and made available for CMS as requested and during onsite audits.

L.A. Care's Quality Improvement infrastructure includes a comprehensive array of clinical and service performance measurement activities that provide information about the processes and outcomes of clinical care and service delivery. The performance measurement activities are coordinated with other organizational activities. Staff throughout the organization participate in these activities and are educated as to their role and responsibility to make every effort in improving performance.

When identifying critical performance measures, the demographic characteristics and health risks of the covered population are considered. Key indicators are identified. These indicators are related to structure, process, or outcome of care or service delivery. A sound rigorous measurement methodology is developed and followed for all indicators. Performance is measured and tracked overtime. Most indicators are rate-based indicators or scalar measures. Rate-based indicators describe the percentage or ratio at which a subgroup is evident among a larger group. Scalar measures use a scale such as satisfaction rating scale. Some indicators are sentinel event indicators and require analysis of each and every occurrence.

L.A. Care uses many different sources to obtain performance data. The data sources include but are not limited to HEDIS results, quality report cards, complaints, grievances, appeals, member and provider satisfaction survey results, network access and availability reports, encounter data, utilization data, medical record review results and facility site review results.

Performance goals are established for each indicator. Performance goals may be based on historical performance, normative data, standards, goals, or benchmarks. Benchmarks are the best of the best, that is, the best real level of performance obtained by another organization. The initial performance goal for an indicator is often to "obtain baseline data." Some indicators, although they have acceptable sustained performance with acceptable variation, will always be measured because of the importance of knowing that performance is maintained or because of reporting requirements. Efforts to further improve performance may require systemic changes that are not considered feasible. The performance goal in these instances may be to sustain the same level in subsequent measurement cycles. Other indicators may be deleted from the process because they provide data considered less valuable than alternative uses of the resources involved.

The Quality Improvement program ensures that information from all parts of the organization are routinely collected and interpreted to identify issues in the areas of clinical services, access to care and member services. Types of information to be reviewed include:

- Population Information – data on enrollee characteristic relevant to health risks or utilization of clinical and non-clinical services, including age, sex race, ethnicity, language and disability or functional status.

- Performance Measures – data on the organization's performance as reflected in standardized measures, including when possible Local, State or National information on performance of comparable organizations.
- Other utilization, diagnosis and outcome information - Data on utilization of services, cost of operations, procedures, medications, and devices; admitting and encounter diagnoses, adverse incidents (such as death, avoidable admission or readmission and patterns of referrals or authorizations requests).
- Information demonstrating L.A. Care has a fiscally sound operation.
- Data from results of HEDIS measures. .
- External data sources – data from outside organization, including Medicare or Medicaid fee-for-service data, data from other managed care organizations and local national public health reports on condition or risks for specified populations.
- Enrollee Information on their experiences with care to the extent possible, to developments in their health status. Data from surveys (such as, Health Outcomes Survey (HOS), the Consumer Assessment of Health Plans and Provider Systems or CAHPS), information from the grievance and appeals processes, and information on disenrollments and requests to change providers. (Note that general population surveys may under represent populations who may have special needs, such as linguistic minorities or the disabled. Assessment of satisfaction for these groups may require over sampling or other methods, such as focus groups or enrollee interviews). In addition to information generated with the organization, the QI Program assesses information supplied by purchasers, such as data on complaints.
- Availability, accessibility, and acceptability of Medicare approved and covered services.
- Measures related to behavioral health, care coordination/transitions, and MLTSS, as required.
- Data elements from CMS Part C & D reporting.
- Other information CMS may require.

L.A. Care (Provider Network Operations Department) ensures that information and data received from providers are accurate, reliable, timely, and complete. All HEDIS measures are audited by an external auditor to ensure accuracy.

Performance data for the key indicators are collected, aggregated, integrated, and analyzed on a rolling schedule. Multiple data points are displayed together on graphs to show historical performance and facilitate data analysis and trending. Each review includes quantitative and qualitative (causal) analysis. Evaluating the effectiveness of previous interventions is included and influences the next step in planning.

Action is triggered when undesirable sentinel events, patterns and/or trends are identified; comparison with established benchmarking reflects an undesirable level of performance and/or undesirable variance from recognized and accepted standards; improvement is desired, even in the absence of a performance variance; or compliance falls beneath the standard or goal set by L.A. Care and/or regulatory body.

Interventions are planned and implemented based on the data analysis. When areas for improvement are identified, efforts to develop improvement strategies are prioritized. An in-

depth review is conducted on the areas identified as having the greatest potential for improving care, safety, and health status outcomes of members. Continuous quality improvement is realized when data are collected and analyzed, interventions are planned and implemented, measurement is repeated and performance continually improved. The cycle is continuous and maintained on a schedule that is not limited by the end of the calendar year. Quality improvement is accomplished by using the improvement model described. This process embraces the Plan, Do, Study, and Act (PDSA) model of improvement and rapid-cycle tests of change.

The L.A. Care QI Department works with other departments to address opportunities to improve the delivery of care through the selection, design, and implementation of interventions. Wherever possible, these interventions are designed to achieve systemic or procedural improvements affecting multiple members, providers, or services.

Interventions to improve performance include health promotion and health education programs, to inform members of ways to improve their health or their use of the health care delivery system, modifications to administrative processes, to improve quality of care, accessibility and service and modifications to the provider network, such as, additions to improve accessibility and availability. These processes may include customer services, utilization and case management activities, model of care, preventive services and health education. Interventions to improve provider performance may include presentation of provider education programs, individual provider feedback on individual and aggregate performance and distribution of best practice material.

Performance Target

The terms benchmark and performance targets are not necessarily one and the same. Recognized benchmark may be a performance target, but sometimes there is not an established or available benchmark for a particular indicator. If this is the case, L.A. Care may create an internal performance target based on a clear rationale. The target should be something that an organization strives for, but may not necessarily reach.

Significant Improvement

L.A. Care's interventions in its *QI* project result in significant improvement in its performance as evidenced in repeat measurements of the quality indicators specified for each performance improvement project undertaken by the organization. It is not expected that a *QI* project initiated in a given year will achieve improvement in that same year. The CMS assumes a 3-year cycle for most MA organizations to reach demonstrable improvement.
L.A. Care demonstrates, through repeated measurement of the quality indicators selected for the project, significant change in performance relative to the performance observed during baseline measurement. This significant change may not be statistical significance although statistical significance may be used.

Significant improvement may be defined either as reaching a prospectively set benchmark or as improving performance and sustaining that improvement. Whenever possible L.A. Care should select indicators for which data are available on the performance or other comparable

organizations (or other components of the same organization), or for which there exist local or national data for a similar population in the fee-for-service sector.

It is important that the measures of performance before and after interventions be comparable in order to measure improvement accurately. The same methods or identifying the target population and or selecting individual cases for review methods for identifying the target population and for selecting individual cases for review must be used for both measurements. For example, in a project to improve care of diabetes patients, it would be acceptable to draw the baseline sample from a population identified on the basis of diagnoses reported in ambulatory encounter data and draw the following-up sample from a population identified on the basis of pharmacy data. In a project to address follow-up after hospitalization for mental illness, it would not be acceptable to shift from a sampling method under which an individual with multiple admissions could be chosen more than once to a method under which the individual could be chosen only once.

The repeat measurement should use the same methodology and time frames as the baseline measurement, except that, when baseline data was collected for the entire population at risk, the repeat measurement may use a reliable sample instead.

MEMBER CONFIDENTIALITY

L.A. Care keeps confidential information secure and makes it available only to L.A. Care employees, contractors, and affiliates who have a need to know in order to do their job functions and signed a confidentiality statement. L.A. Care ensures that all individuals or agencies who participate in the use, creation, maintenance, or disclosure of protected health information limit the use and disclosure only to the minimum necessary to complete the task. Without a signed authorization, disclosure of protected health information is limited to the purposes of treatment, payment, or health care operations. These purposes include the use of protected health information for quality of care activities, disease management service referrals, statistical evaluation, claims payment processes, medical payment determinations, practitioner credentialing, peer review activities, and the grievance and appeals process.

Network practitioners and providers are obligated to maintain the confidentiality of member information and information contained in a member's medical record and may only release such information as permitted by applicable laws and regulation, including Health Insurance Portability & Accountability Act (HIPAA).

L.A. Care maintains confidentiality in written, verbal, and electronic communications. L.A. Care has specific policies that outline appropriate storage and disposal of electronic and hard copy materials so that confidentiality is maintained within the plan and network.

CONFIDENTIALITY

To the extent permitted by law, QI Committee proceedings and records of proceedings are protected and kept confidential pursuant to applicable law, including but not limited to California Evidence Code Section 1157 (a) of the California Evidence Code and California Welfare and

Institutions Code Section 14087.38 Subsections (n)-(q) and are thereby confidential and may not be discoverable.

All member/patient information available at any of the L.A. Care locations is confidential and protected from unauthorized dissemination by L.A. Care, its employees and agents.

DISEASE REPORTING STATEMENT

L.A. Care complies with disease reporting standards as cited by the California Code of Regulations, Title 17 (Section 2500), which states that public health professionals, medical providers and others are mandated to report approximately 85 diseases or conditions to their local health department. The primary objective of disease reporting and surveillance is to protect the health of the public, determine the extent of morbidity within the community, evaluate risk of transmission, and intervene rapidly when appropriate. Forms to report diseases can be found at www.lapublichealth.org/acd/cdrs.htm and via a link on the L.A. Care website at www.lacare.org.

QI DELEGATION

L.A. Care has written service agreements with delegated Plan Partners and Provider Groups to provide specific health care services and perform other delegated functions. L.A. Care requires and ensures that each delegate maintain adequate processes, is appropriately and adequately staffed and complies with applicable standards and regulatory requirements. Specific elements of the QI program may be delegated. However, L.A. Care retains accountability and ultimate responsibility for all components of the QI Program. All components of the QI process, maintained by delegates, will be made available to L.A. Care at the time of scheduled oversight audits. Oversight audit results are reviewed, opportunities for performance improvement are identified and reported to the delegate and corrective action plans are required to address deficiencies. As appropriate, follow up to assess compliance occurs approximately six (6) months following the evaluation. In addition, L.A. Care provides ongoing monitoring through substantive review and analysis of delegate reports and collaboration with delegate to continually assess compliance with standards and requirements.

CMMI Funding Opportunity: Transforming Clinical Practice Initiatives (TCPI) Practice Transformation network (PTN)

The Centers for Medicare Services (CMS) Innovation Center released a Funding Opportunity Announcement (FOA):

- Up to $670 million available nationally for 35 cooperative agreements between $2 million and $50 million. ($4,467 per clinician, max network of 11,000 clinicians)
- Proposal due February 2, 2015. LOI due November 20, 2014.
- Award period May 1, 2015 – April 30, 2019 (4 years)

CMS Goals

- Assist 150,000 clinicians to achieve triple-aim practice transformation.
- Improve health outcomes and reduce unnecessary hospitalizations and over-utilization for 5 million Medicare, Medicaid, and CHIP beneficiaries.

- Sustain efficient care delivery by moving 75% of clinicians into incentive programs and practice models that reward value.
- Generate savings to the federal government over a period of 4 years through reduced Medicare, Medicaid, and CHIP expenditures.

CMS Program Approach
Test approaches to scaling practice transformation by funding data-driven networks incorporating practice assessments, peer-to-peer networks, coaching and other forms of assistance and training. TCIP intends to provide a national Change Package and national expert faculty.

ANNUAL QI PROGRAM EVALUATION

Annually, L.A. Care reviews data, reports, and other performance measures regarding program activities to assess the effectiveness of its QI Program. This evaluation includes a review of completed and continuing program activities and audit results; trending of performance data; analysis of the results of QI initiatives including barriers, successes, and challenges; an assessment of the effectiveness of monitoring activities and identifying and acting upon quality and safety of clinical care and service issues; an evaluation of the overall effectiveness of the QI program including progress toward influencing network-wide safe clinical practices; and the goals and plans for the next year. The annual QI Program Evaluation is presented to the Quality Oversight Committee for review and approval and available to CMS if requested.

ANNUAL QI WORK PLAN (SEE Attachment 3)

The annual QI Work Plan is developed in collaboration with staff and is based, in part, upon the results of the prior year's QI Program evaluation.

The QI Work Plan includes a description of:

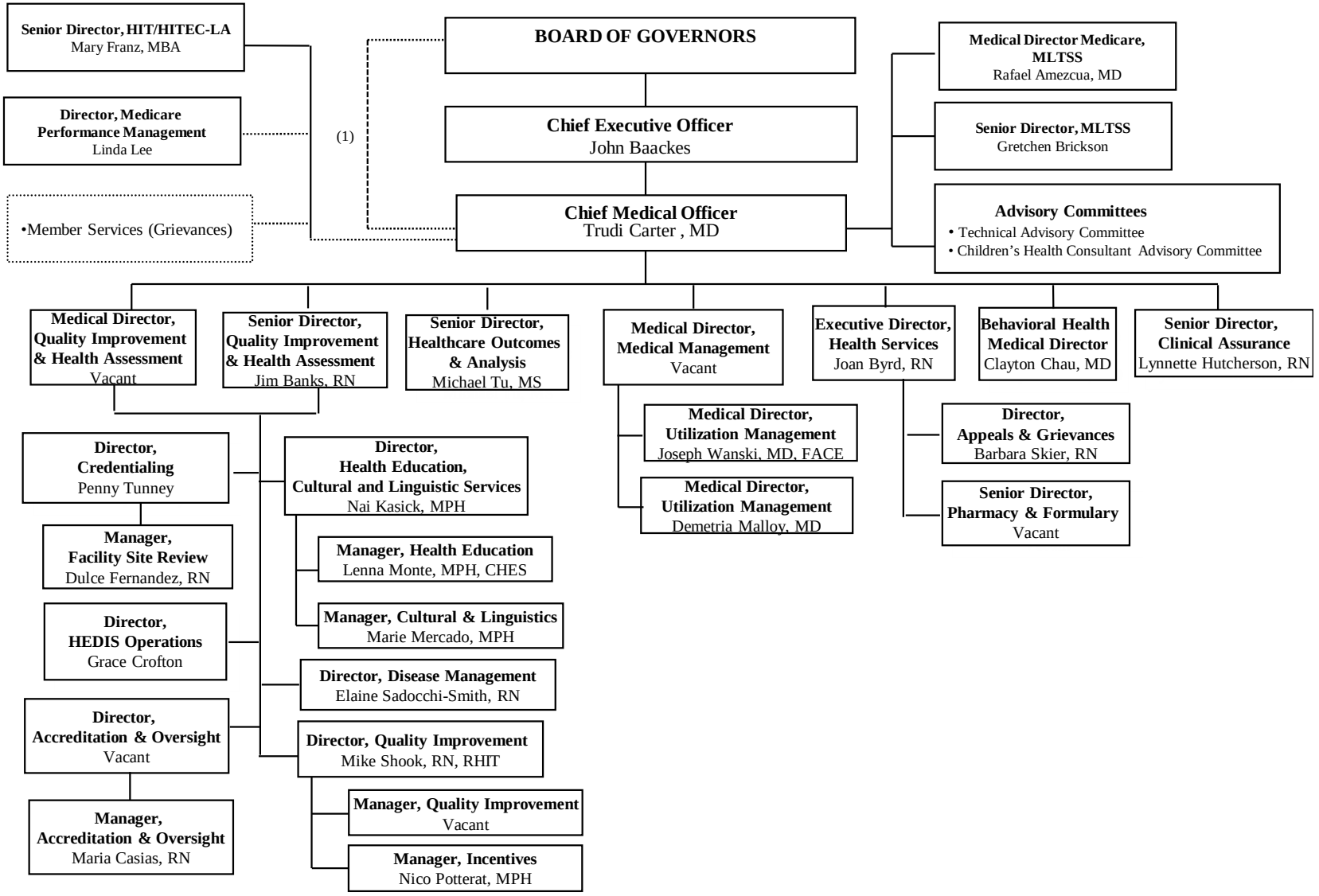
- The QI program scope including quality of clinical care, service, and safety of clinical care.
- Planned activities and measureable goals and/or benchmarks that encompass a comprehensive program scope, including the quality and safety of clinical care and quality of service, to be undertaken in the ensuing year.
- Staff member(s) responsible for each activity.
- The time frame within which each activity is to be achieved.
- Key findings, interventions, analysis of findings/progress and monitoring of previously identified issues.
- Planned evaluation of the QI program.

Each of the elements identified on the Work Plan has activities defined, responsibility assigned, and the date by which completion is expected. The QI Work Plan and Quality Improvement Program description are presented to the Quality Oversight Committee for review and approval. Quarterly updates to the Work Plan are documented and reported to the Quality Oversight Committee. Quarterly work plan updates are available to CMS if requested.

Endnotes: Source: Medicare Managed Care Manual Chapter 5- Quality Assessment Rev. 100, 08-05-11

Attachment 1	Health Services Organization
Attachment 2	Quality Program Committee Structure
Attachment 3	2015 QI Work Plan including Medicare

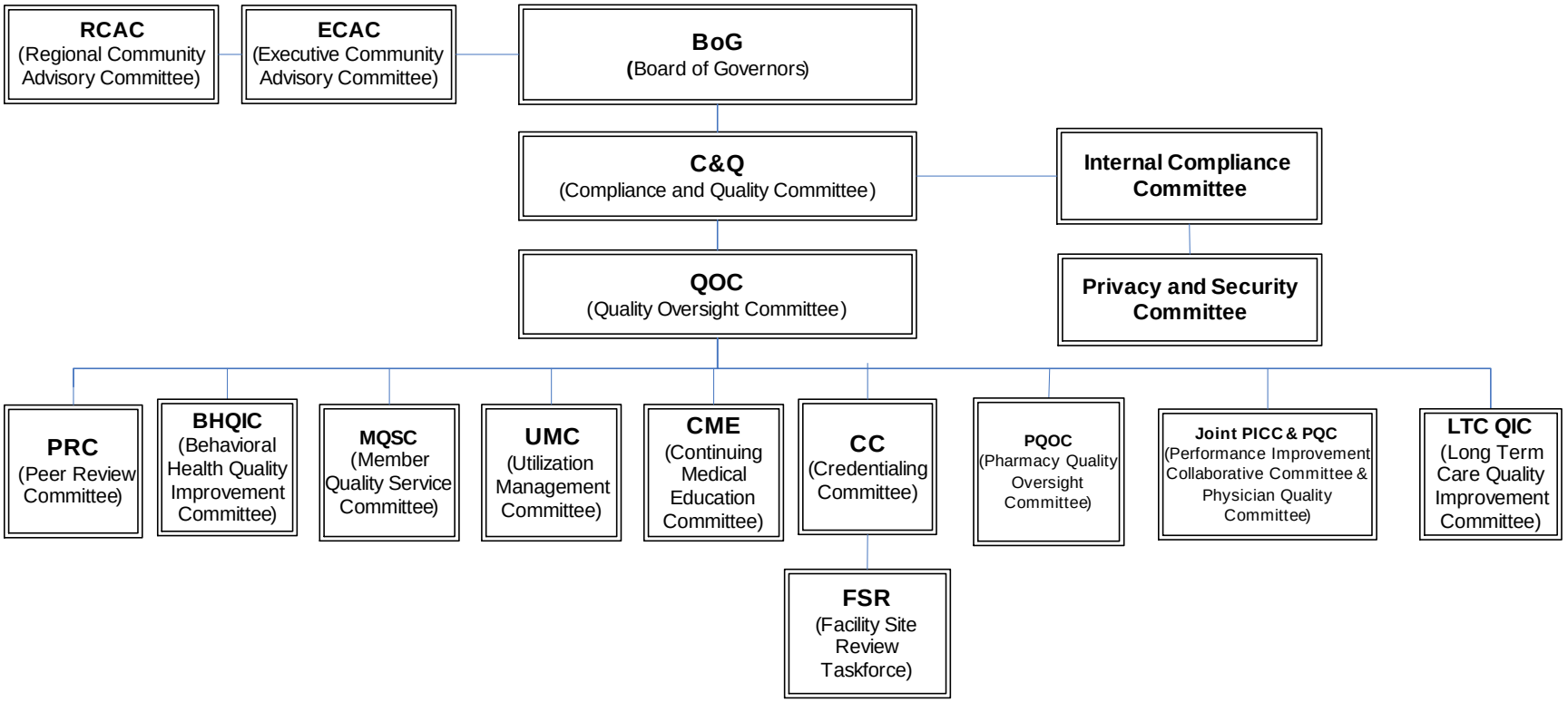
ATTACHMENT 1
L.A. Care Health Plan
Health Services Organization



ATTACHMENT 2

L.A. Care Health Plan

Quality Improvement Committees



ATTACHMENT 3

2015 QI Work Plan including Medicare

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Service - *Access*								
Member Services Department Telephone Abandonment Rate		Total incoming calls abandoned ≤ 5%	Maribel Ferrer	Quarterly	**Member Quality Service Committee (MQSC):** March 10, June 09, Sept 1, Nov 2			
Member Services Department Telephone Wait Time- Service Level		90% of total incoming calls answered ≤ 30 seconds	Maribel Ferrer	Quarterly	**MQSC:** March 10, June 09, Sept 1, Nov 2			
Non-Emergent Ancillary Services		Within 15 business days of request, for appointment	Maria Casias/ Liz Tran	Annually: Sept '15	**MQSC:** Sept 1			
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 '15	**MQSC:** Sept 1			
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 '15	**MQSC:** Sept 1			
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 '15	**MQSC:** Sept 1			
Urgent Care **MOC**		98% of urgent care appointments available within 48 hours	Maria Casias/ Liz Tran	Annually: Sept '15	**MQSC:** Sept 1			
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 '15	**MQSC:** Sept 1			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
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 '15	**MQSC:** Sept 1			
Ratio - PCP (excludes mid-level providers) **MOC**		1: 2000 members	Gwen Cathey	Annually: Sept '15	**MQSC:** Sept 1			
Ratio - High Volume Specialist (Note the top 5 specialists can vary year to year) **MOC**		**Medi-Cal:** OBG: 1:3000 CARDIOVAS: 1:5000 GASTROENTEROLOGY: 1:5000 OPHTHO: 1:5000 ORTHO: 1:5000 **Medicare:** Top 5 High Volumes as noted in 2013 report: CARDIOVAS: 1:5000 GASTROENTEROLOGY: 1:5000 PULMONOLOGY 1:5000 mbrs OPHTHO: 1:5000 UROLOGY: 1:5000 mbrs	Gwen Cathey	Annually: Sept '15	**MQSC:** Sept 1			
Service Improvements	Benchmarks reflect the 90th percentile of the NCQA Quality Compass for Medicaid results. Where Benchmarks are noted, CAHPS measures are used.							
Service - *Member Satisfaction ADULT*								
ADULT - Rating of Health Plan (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '14: 81% LACC:TBD	**77%** **LACC:TBD**	Rae Starr/ Maribel Ferrer/ All Departments	Annually: Sept '15	**MQSC:** Sept 1			
ADULT - Rating of Health Care (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '14: 77% LACC:TBD	**75%** **LACC:TBD**	Rae Starr/ Maribel Ferrer/ All Departments	Annually: Sept '15	**MQSC:** Sept 1			
ADULT - Rating of Personal Doctor Plan (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '14: 83% LACC:TBD	**80%** **LACC:TBD**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
ADULT - Rating of Specialist Seen Most Often (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '14: 85% LACC:TBD	**80%** **LACC:TBD**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
ADULT - Getting Care Quickly (CAHPS)	Benchmark '14: 86%	**79%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
Q4: Usually or always got needed care as soon as you thought you needed (routine)?		**82%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
Q6: Usually or always got an appointment for care as soon as you thought you needed (urgent)?		**75%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
ADULT - Getting Needed Care (CAHPS)	Benchmark '14: 86%	**79%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
Q25: In the last 6 months, how often was it easy to get appointments with specialist?		**80%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
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?		**78%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
ADULT - Customer Service (CAHPS)	Benchmark '14: 90%	**89%**	Rae Starr/ Maribel Ferrer	Annually: Sept '15	**MQSC:** Sept 1			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
ADULT - How Well Doctors Communicate (CAHPS)	Benchmark '14: 92%	**88%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
Service - *Member Satisfaction CHILD*								
CHILD - Rating of Health Plan (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '14: 86%	**86%**	Rae Starr/ Maribel Ferrer/	Annually: Sept '15	**MQSC:** Sept 1			
CHILD - Rating of Health Care (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '14: 87%	**87%**	Rae Starr/ Maribel Ferrer	Annually: Sept '15	**MQSC:** Sept 1			
CHILD - Rating of Personal Doctor Plan (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '14: 89%	**88%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
CHILD - Rating of Specialist Seen Most Often (Rating of 8, 9, or 10 of 10) (CAHPS)	Benchmark '14: 88%	**88%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
CHILD - Getting Care Quickly (CAHPS)	Benchmark '14: 95%	**84%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
Q4: Usually or always got needed care as soon as you thought you needed (routine)?		**85%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
Q6: Usually or always got an appointment for care as soon as you thought you needed (urgent)?		**83%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
CHILD - Getting Needed Care (CAHPS)	Benchmark '14: 91%	**81%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Q46: In the last 6 months, how often was it easy to get appointments with specialist?		**70%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
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?		**86%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
CHILD - Customer Service (CAHPS)	Benchmark '14: 92%	**88%**	Rae Starr/ Maribel Ferrer	Annually: Sept '15	**MQSC:** Sept 1			
CHILD - How Well Doctors Communicate (CAHPS)	Benchmark '14: 96%	**90%**	Rae Starr/ Mike Shook	Annually: Sept '15	**MQSC:** Sept 1			
Service - *Complaints and Appeals*								
Appeals Resolution		100% appeal resolution within 30 days.	Barbara Skier	Quarterly Reports	**MQSC:** March 10, June 09, Sept 1, Nov 2			
Complaint Resolution **MOC**		100% complaint resolution within 30 days	Barbara Skier	Quarterly Reports	**MQSC:** March 10, June 09, Sept 1, Nov 2			
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.	Barbara Skier	Quarterly Reports	**MQSC:** March 10, June 09, Sept 1, Nov 2			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 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 '15	**UMC:** Mar '15			
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 '15	**UMC:** Mar '15			
SCP satisfaction with UM process		80% of SCPs will be overall satisfied with timely decisions for pre-auths.	Halima Bascus/ Earl Leonard	Annually: Sept '15	**UMC:** Mar '15			
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 '15	**UMC:** Mar '15			
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 '15	Quality Oversight Committee (QOC) Oct 26 and Joint PICC & PQC Feb 2016			
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 '15	Quality Oversight Committee (QOC) Oct 26 and Joint PICC & PQC Feb 2016			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Clinical - *Continuity and Coordination of Medical and Behavioral Care*								
Exchange of Information between PCPs and Behavioral Health Providers (BHPs) **MOC**		80% of providers will be always/usually satisfied with the exchange of information between PCPs and BHPs	Bettsy Santana/ Beacon	Annual: Due Oct '15	**Behavioral Health Quaility Improvement Committee (BHQIC):** Dec 17			
Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care: Appropriate Treatment of Depression	Baseline	**AMM (Acute Phase):** Medi-Cal: 65% Medicare: 62% **AMM (Continuation Phase):** Medi-Cal: 52% Medicare: 53%	Mike Tu Clayton Chau/ Beacon	Annual: Due Oct '15	**BHQIC:** Dec 17			
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	**BHQIC:** Dec 17			
Management of treatment access and follow-up for members with coexisting medical and behavioral disorders **MOC**	NA	100% of providers will be notified of members on diabetes and antipsychotic medication	Gayle Butler/ Clayton Chau	Quarterly reporting	**BHQIC:** March 12, June 18, Sept 16, Dec 17			
Primary or secondary preventive behavioral health program	NA	100% of members that screen positive on the PHQ-2 with receive a behavioral health consultation	Clayton Chau	Quarterly	**BHQIC:** March 12, June 18, Sept 16, Dec 17			
Primary or secondary preventive behavioral health programs at Family Resource Centers (FRCs)	NA	100% of members can attend a stress or anxiety class at the FRCs	Christina Delgado	Quarterly	**BHQIC:** March 12, June 18, Sept 16, Dec 17			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Special needs of members with severe and persistent mental illness	Baseline	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Baseline	Michael Tu/ Clayton Chau	Annual	**BHQIC:** March 12, June 18, Sept 16, Dec 17			
Clinical Improvements Note that for HEDIS measures goals are set ensuring that MPLs are met. *Italicized measures are also auto-assignment measure.* **Bolded measures are also NCQA Accreditation measures.** * Are measures used by NCQA to report the top health plans.	Benchmarks reflect the 90th percentile of the NCQA Quality Compass. Where Benchmarks are noted, HEDIS measures are used.	**Goal Methodology: Next highest percentile.**						
Well Visits								
Well Child Visits 3-6 yrs of age (Physician P4P and LA P4P)	Benchmark '14: 82.69% LACC: TBD	**Medi-Cal: 72% LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Adolescent Well Care (Physician P4P and LA P4P)	Benchmark '14: 65.56%	**Medi-Cal: 59%**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents	**Benchmark 14:** 82.46% for BMI; 77.47% for Nutrition; 69.76% for Physical Activity LACC: TBD	**BMI: 80% Nutrition; 77% Physical Activity: 70% LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Childhood Immunizations- Combo 3	Benchmark '14: 80.86% LACC: TBD	**Medi-Cal: 78% LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Children and Adolescents Access to PCP for (ages 7-11)*	Benchmark '14: 95.19 %	**Medi-Cal: 88%**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Immunization for Adolescents	Benchmark 14: 86.46% LACC: TBD	**Medi-Cal: 81% LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Children's Health								
Appropriate Testing for Children w/ Pharyngitis (Physician P4P & LA P4P)	Benchmark 14: 83.66% LACC: TBD	**Medi-Cal: 58% LACC: TBD**	Mike Shook/ Michael Tu/ Esther Bae	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Appropriate Rx for Children w/ URI (Physician P4P)	Benchmark 14: 94.39% LACC: TBD	**Medi-Cal: 91% LACC: TBD**	Mike Shook/ Michael Tu/ Esther Bae	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Perinatal Program								
Prenatal Visits (LA P4P)	Benchmark 14: 93.10% LACC: TBD	**Medi-Cal: 90% LACC: TBD**	Nai Kasick/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Postpartum Care (LA P4P)	Benchmark 14: 74.03% LACC: TBD	**Medi-Cal: 63% LACC: TBD**	Nai Kasick/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6		**Postpartum IP**	

This work plan addresses QI program scope as defined by the 2015 QIPD and is consistent with QIPD objectives.

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Women's Health Initiatives								
Breast Cancer Screenings (Physician Incentive and LA P4P)	Benchmark 14: 71.35% LACC: TBD	**Medi-Cal: 57%** **LACC: TBD**	Mike Shook/ Michael Tu/ Lenna Monte/ Esther Bae	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Cervical Cancer Screenings (Physician Incentive and LA P4P)	Benchmark 14: not available - due to spec changes LACC: TBD	**Medi-Cal: 66%** **LACC: TBD**	Mike Shook/ Michael Tu/ Lenna Monte	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Chlamydia Screening In Women (Physician Incentive and LA P4P)	Benchmark 14: 67.19% LACC: TBD	**Medi-Cal: 63%** **LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Chronic Disease Plan wide								
Appropriate Use of Asthma Medications (LA P4P)	Benchmark 14: 91.47%	**Medi-Cal: 81%**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Medication Management for People with Asthma (MMA)	**Benchmark 14:** 50% compliance: N/A% 75% compliance: 42.79% LACC: TBD	**Medi-Cal:** **50% compliance: 67%** **75% compliance: 46%** **LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Diabetes: Eye Exam (retinal) performed (Physician P4P and LA P4P)	Benchmark 14: 68.04% LACC: TBD	**Medi-Cal: 54%** **LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Diabetes: A1C Screening (Physician P4P and LA P4P)	Benchmark 14: 91.73% LACC: TBD	**Medi-Cal: 84%** **LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Diabetes: A1C Poor Control (>9.0%) (The lower the results the less members in poor control.)	Benchmark 14: 30.28%	**Medi-Cal: 60%**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Diabetes: A1C Good Control (<8.0%)	Benchmark 14: 59.37% LACC: TBD	**Medi-Cal: 46%** **LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Diabetes: Medical attention for nephropathy (Physician Incentive and LA P4P)	Benchmark 14: 86.86% LACC: TBD	**Medi-Cal: 87%** **LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Diabetes: Blood Pressure Control (<140/90 mm Hg)	Benchmark 14: 75.18%	**Medi-Cal: 61%**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Other Chronic Conditions Measures								
Controlling High Blood Pressure	Benchmark 14: 69.79% LACC: TBD	**Medi-Cal: 64%** **LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Use of Imaging Studies for Low Back Pain	Benchmark 14: 84.03% LACC: TBD	**Medi-Cal: 84%** **LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Benchmark 14: 42.37%	**Medi-Cal: 26%**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Pharmacotherapy Management of COPD Exacerbation (dispensed a systemic corticosteroid within 14 days of the event)	Benchmark 14: 78.20%	**Medi-Cal: 61%**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Pharmacotherapy Management of COPD Exacerbation (dispensed a bronchodilator within 30 days of the event)	Benchmark 14: 90.32%	**Medi-Cal: 84%**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Other Measures								
Quality and Accuracy of Pharmacy Benefit information via the Telephone (NCQA - MEM 4)	NA	100% of members can obtain pharmacy benefit information via the phone in one attempt or contact	Amanda Wolarik/ Maribel Ferrar	Quarterly: Annual Analysis	**MQSC:** March 10, June 09, Sept 1, Nov 2 **QOC:** January (Annual Analysis)		**Measure will be effective July 1, 2015. 1st reporting 3rd Q 2015.**	
Quality and Accuracy of Pharmacy Benefit information via the Web (NCQA - MEM 4)	NA	100% of members can obtain pharmacy benefit information on the web in one attempt or contact	Mike Sax/ Gayle Butler	Quarterly: Annual Analysis	**MQSC:** March 10, June 09, Sept 1, Nov 2 **QOC:** January (Annual Analysis)		**Measure will be effective July 1, 2015. 1st reporting 3rd Q 2015.**	
Quality and Accuracy of the Benefit information on the Web (NCQA - MEM 5)	NA	100% of members can obtain personalized health information on the Web site in one attempt or contact	Amanda Wolarik/ Maribel Ferrar	Quarterly: Annual Analysis	**MQSC:** March 10, June 09, Sept 1, Nov 2 **QOC:** January (Annual Analysis)		**Measure will be effective July 1, 2015. 1st reporting 3rd Q 2015.**	
Quality and Accuracy of the Benefit information via the Telephone (NCQA - MEM 5)	NA	100% of members can obtain personalized health information via the phone in one attempt or contact	Amanda Wolarik/ Maribel Ferrar	Quarterly: Annual Analysis	**MQSC:** March 10, June 09, Sept 1, Nov 2 **QOC:** January (Annual Analysis)		**Measure will be effective July 1, 2015. 1st reporting 3rd Q 2015.**	
Quality of email response (NCQA - MEM 5)	NA	100% of member email inquires will be responded to wihtin one business day of submission	Amanda Wolarik/ Maribel Ferrar	Quarterly: Annual Analysis	**MQSC:** March 10, June 09, Sept 1, Nov 2 **QOC:** January (Annual Analysis)		**Measure will be effective July 1, 2015. 1st reporting 3rd Q 2015.**	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (Physician Incentive and LA P4P)	Benchmark 14: 38.66% LACC: TBD	**Medi-Cal: 31% LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers to Quit)* (CAHPS)	Benchmark 14: 81.42% LACC: TBD	**Medi-Cal: 74%** **LACC: TBD**	Michael Tu/ Rae Srarr	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Medical Assistance With Smoking and Tobacco Use Cessation (Discussing Cessation Medications)*	Benchmark 14: 57.11% LACC: TBD	**Medi-Cal: 41%** **LACC: TBD**	Michael Tu/ Rae Srarr	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Medical Assistance With Smoking and Tobacco Use Cessation (Discussing Cessation Strategies)*	Benchmark 14: 50.89% LACC: TBD	**Medi-Cal: 42%** **LACC: TBD**	Michael Tu/ Rae Srarr	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Adult BMI Assessment	Benchmark 14: 90.82% LACC: TBD	**Medi-Cal: 85%** **LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Annual Monitoring for Patients on Persistent Medications- ACE inhibitors or ARBs	Benchmark 14: 92.01% LACC: TBD	**Medi-Cal: 86%** **LACC: TBD**	Michael Tu/ Bettsy Santana/ Michael Sax	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6		**MPM IP**	
Annual Monitoring for Patients on Persistent Medications-Digoxin	Benchmark 14: 95.65% LACC: TBD	**Medi-Cal: 89%** **LACC: TBD**	Michael Tu/ Bettsy Santana/ Michael Sax/ Gayle Butler	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6		**MPM IP**	
Annual Monitoring for Patients on Persistent Medications-Diuretics	Benchmark 14: 92.11% LACC: TBD	**Medi-Cal: 86%** **LACC: TBD**	Michael Tu/ Bettsy Santana/ Michael Sax/ Gayle Butler	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6		**MPM IP**	
Topical Fluoride Varnish Utilization	Benchmark not available		Michael Tu/ Bettsy Santana/ Michael Sax/ Gayle Butler	Annual: By June '15	**QOC:** June 22			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Other Measures for NCQA Rankings								
Well Child Visits in the First 15 Months of Life*	Benchmark 14: 76.92% LACC: TBD	**Medi-Cal: 55%** **LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Lead Screening in Children*	Benchmark 14: 85.84%	**Medi-Cal: 71%**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Annual Monitoring for Patients on Persistent Medications **Total** (Monitoring Key Long-term Medications) (note state measure excludes anticonvulsant)	Benchmark 14: 89.81% LACC: TBD	**Medi-Cal: 84%** **LACC: TBD**	Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6		**Same as indiviudal measures**	
Disease Management Programs- Asthma								
Appropriate Use of Asthma Medications	Benchmark 14: 91.47%	**MCLA: 83%**	Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Medication Management for People with Asthma 50% compliance.	Benchmark 14: not available	**MCLA: 70%**	Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Medication Management for People with Asthma 75% compliance.	Benchmark 14: 42.8%	**MCLA 49%**	Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
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 '15	**QOC:** 4/27/15, 7/27/15, 10/226/15 4th Qtr. Attached to QI Eval		**Continue Quarterly DUE program to identify members for letter submission to providers. Implement referrals to Case Management**	**Y**
% of members who have Asthma Action Plan		75%	Elaine Sadocchi-Smith	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
% of members who had Flu shot between Sept 2014 and March 2015		65%	Elaine Sadocchi-Smith	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Asthma Disease Management Program Membership		N/A	Elaine Sadocchi-Smith	Identified Monthly; reported quarterly	**QOC:** Jan 26, June 22, July 27, Oct 26			
Member Satisfaction with Disease Management Programs- Asthma		90% of the members in Asthma program will be overall satisfied	Elaine Sadocchi-Smith	Annual: Due Dec 31	**QOC**: Sept 28			
Inquiries re: Asthma		N/A	Maribel Ferrer/ Elaine Sadocchi-Smith	Quarterly	**QOC:** Jan 26, June 22, July 27, Oct 26			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Complaints re: Asthma		0	Maribel Ferrer/ Elaine Sadocchi-Smith	Quarterly	**QOC:** Jan 26, June 22, July 27, Oct 26			
Disease Management Programs- Diabetes								
Diabetes: Eye Exam (retinal) performed	Benchmark 14: 68.04%	**MCLA: 45%**	Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Diabetes: A1C	Benchmark 14: 91.73%	**MCLA: 82%**	Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Diabetes: A1C Poor Control (>9.0%) (Note the lower the results the less members that are in poor control.)	Benchmark 14: 30.28%	**MCLA: 47%**	Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Diabetes: A1C Good Control (<8.0%)	Benchmark 14: 59.37%	**MCLA: 37%**	Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Diabetes: Medical attention for nephropathy	Benchmark 14: 86.86%	**MCLA: 87%**	Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Diabetes Disease Management Program Membership		N/A	Elaine Sadocchi-Smith	Identified monthly; reported quarterly	**QOC:** Jan 26, June 22, July 27, Oct 26			
Member Satisfaction with Disease Management Programs- Diabetes		90%	Elaine Sadocchi-Smith	Annual: Due Dec 31	**QOC:** Jan 26			
Inquiries		N/A	Elaine Sadocchi-Smith/ Maribel Ferrer	Quarterly	**QOC:** Jan 26, June 22, July 27, Oct 26			
Complaints		0	Elaine Sadocchi-Smith/ Maribel Ferrer	Quarterly	**QOC:** Jan 26, June 22, July 27, Oct 26			
State Quality Improvement Projects								
All-Cause Readmissions - Statewide Collaborative QIP measure		**14.78%**	Bettsy Santana/ Halima Bascus/ Demitira Malloy/ Michael Tu	Due to State: Sept. 30, 2015	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Diabetes QIP		**A1c Screening** Medi-Cal: 84.% **DRE** Medi-Cal: 56%	Mike Shook/ Bettsy Santana	Annual: By Aug. 29, 2015	**QOC:** Sept 28 **PICC & PQC:** Oct 6			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
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 23, Sept 28			
FSR- needlestick safety		75%	Dulce Fernandez	Annual	**QOC:** March 23			
FSR- spore testing of autoclave/sterilizer		85%	Dulce Fernandez	Annual	**QOC:** March 23			
Medical Record Documentation		95% of sites reviewed achieve ≥ 80% compliance	Dulce Fernandez	Annual	**QOC:** Nov 23			
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:** 4/27/15, 7/27/15, 10/226/15 4th Qtr. Attached to QI Eval			
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:** 4/27/15, 7/27/15, 10/226/15 4th Qtr. Attached to QI Eval			
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:** 4/27/15, 7/27/15, 10/226/15 4th Qtr. Attached to QI Eval			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 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:** 4/27/15, 7/27/15, 10/226/15 4th Qtr. Attached to QI Eval			
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:** 4/27/15, 7/27/15, 10/226/15 4th Qtr. Attached to QI Eval			
Medication Therapy Management (MTM) program		MTM program with Outcomes for 2015: Comprehensive Medication Review (CMR)--in person or phone intervention by pharmacist	Michael Sax/ Gayle Butler/ Agavni Aslanyan	Quarterly	**QOC:** 4/27/15, 7/27/15, 10/226/15 4th Qtr. Attached to QI Eval			
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:** May 7			
Clinical Practice Guidelines		100% of at least 2 aspects of 4 guidelines will be measured.	Mike Shook/ Esther Bae	Annual: By Dec '15	**PICC & PQC:** May 7			
Preventive Health Guidelines (PHGs)		Review, update, approve, & distribute Preventive Health Guidelines	Mike Shook/ Esther Bae	Annual	**PICC & PQC:** May 7			
Medical Record Documentation MOC/CPG		95% of sites reviewed achieve ≥ 80% compliance	Dulce Fernandez	Annual	**QOC:** Nov 23			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
★**Star Measures** **MOC = Model of Care Measures** **MOC/CPG = Model of Care/Clinical Practice Guideline**	**For Star measures benchmarks are 5 Star Rating for 2015. Other benchmarks reflect the 90th percentile of the NCQA Quality Compass.**	**Goal Methodology: Move rate to next star level** **NA = new measure or not enough data to report in previous year.**						
Breast Cancer Screening	Benchmark '14: 82.86%	**66%**	Linda Lee/ Esther Bae/ Michael Tu	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C01 - Colorectal Cancer Screening ★	5 Stars: ≥ 65%	**5 Stars: ≥ 65%**	Linda Lee/ Bettsy Santana/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C02 - Cholesterol Management for Patient with Cardiovascular Disease (LDL Screening) ★	5 Stars: ≥ 89%	**5 Stars: ≥ 89%**	Linda Lee/ Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6		**CCIP - Reducing Cardiovascular Risk**	
Measure #1 **C03** - Diabetes: LDL Screening ★	5 Stars: ≥ 91%	**5 Stars: ≥ 91%**	Linda Lee/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6		**3rd Project QIP: Improving Management of Cholesterol in Diabetes**	
C04- Anual Flu Vaccine ★ **(CAHPS)**	5 Stars: ≥ 79%	**5 Stars: ≥ 79%**	Linda Lee/ Mike Shook/ Michael Tu/ Nai Kasick	Annually: Sept '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C05- Improving or Maintaining Physical Health ★**(HOS)**	5 Stars: ≥ 68%	**5 Stars: ≥ 68%**	Linda Lee/ Mike Shook/ Michael Tu	Annually: Sept '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
C06- Improving or Maintaining Mental Health ★ **(HOS)**	5 Stars: ≥ 89%	**2 Stars: ≥ 76% to <80%**	Linda Lee/ Mike Shook/ Michael Tu	Annually: Sept '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C07 - Monitoring Physical Activity ★ **(HOS)**	5 Stars: ≥ 63%	**5 Stars: ≥ 63%**	Linda Lee/ Mike Shook/ Michael Tu	Annually: Sept '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C08 - Adult BMI Assessment ★	5 Stars: ≥ 93%	**5 Stars: ≥ 93%**	Linda Lee/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C10- Care for Older Adults- Medication review ★	5 Stars: ≥ 87%	**5 Stars: ≥ 87%**	Linda Lee/ Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C11 - Care for Older Adults- Functional Status Assessment ★	5 Stars: ≥ 83%	**3 Stars: ≥ 59% to <73%**	Linda Lee/ Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C12 - Care for Older Adults- Pain Screening ★	5 Stars: ≥ 88%	**5 Stars: ≥ 88%**	Linda Lee/ Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C13 - Osteoporosis Management in Older Women ★	5 Stars: ≥ 76%	**3 Stars: ≥ 29% to <60%**	Linda Lee/ Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C14 - Diabetes : Eye Exam (retinal) performed ★ **MOC/CPG**	5 Stars: ≥ 77 %	**5 Stars: ≥ 77 %**	Linda Lee/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C15 - Diabetes : Medical attention for nephropathy ★ **MOC/CPG**	5 Stars: ≥ 94%	**5 Stars: ≥ 94%**	Linda Lee/ Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C16 - Diabetes: A1C (>9.0%) (Poor Control) ★	5 Stars: ≥ 86%	**3 Stars: ≥ 70% to <80%**	Linda Lee/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Measure #2 **C17-** Diabetes: LDL control (<100 mg/dL) ★	5 Stars: ≥ 62%	**3 Stars: ≥ 49% to <53%**	Linda Lee/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Measure #1 (CCIP) **C18** - Controlling High Blood Pressure ★	5 Stars: ≥ 75%	**5 Stars: ≥ 75%**	Linda Lee/ Elaine Sadocchi-Smith/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6		**CCIP - Reducing Cardiovascular Risk**	
C19 - Disease - Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis ★	5 Stars: ≥ 88%	**3 Stars: ≥ 71% to <78%**	Linda Lee/ Mike Shook/ Michael Tu	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C20 - Improving Bladder Control ★ **(HOS)**	5 Stars: ≥ 71%	**3 Stars: ≥ 40% to <60%**	Linda Lee/ Mike Shook/ Michael Tu/ Rae Starr	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C21 - Reducing the Risk of Falling ★ **(HOS)**	5 Stars: ≥ 73%	**5 Stars: ≥ 73%**	Linda Lee/ Mike Shook/ Michael Tu/ Rae Starr	Annual: By June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
C22 - All Cause Readmission Rate ★ **(Note lower rate = better performance)**	5 Stars: ≤ 2%	**2 Stars: >11% to ≤13%**	Linda Lee/ Michael Tu/ Halima Bascus/ Demitria Mallory/ Mike Shook	Annual: Due June '15	**QOC:** Sept. 28		**QIP due Fall 2014**	
C23- Getting Needed Care ★ **(See 2 questions below) (MAPD CAHPS)**	5 Stars: ≥ 87%	**3 Stars: ≥ 83% to <85%**	Rae Starr	Annually: Sept '15	**MQSC:** Sept 1			
C24 - Getting Care Quickly ★ **(MAPD CAHPS)**	5 Stars: ≥ 80%	**3 Stars: ≥ 74% to <75%**	Rae Starr	Annually: Sept '15	**MQSC:** Sept 1			
C25 - Customer Service ★	5 Stars: ≥ 91%	**2 Stars: ≥ 84% to <86%**	Rae Starr	Annually: Sept '15	**MQSC:** Sept 1			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
C26- Rating of Health Care (Rating of 7, 8, 9 or 10 of 10) ★	5 Stars: ≥ 88%	**5 Stars: ≥ 88%**	Rae Starr	Annually: Sept '15	**MQSC:** Sept 1			
C27- Rating of Health Plan (Rating of 7, 8, 9 or 10 of 10) ★	5 Stars: ≥ 88%	**4 Stars: ≥ 85% to <88%**	Rae Starr	Annually: Sept '15	**MQSC:** Sept 1			
C28- Care Coordination ★	5 Stars: ≥ 87%	**3 Stars: ≥ 84% to <86%**	Linda Lee/ Maribel Ferrer/ Halima Bascus/ Anna Edwards	Annually: Sept '15	**MQSC:** Sept 1			
C29 - Complaints about the Health Plan ★ (lower is better)	5 Stars: ≤ 0.17%	**5 Stars: ≤ 0.17%**	Barbara Skier/ Linda Lee	Annual	**MQSC:** Nov 2			
C30- Members Choosing to Leave the Health Plan ★ (lower is better)	5 Stars: ≤ 9%	**4Stars: >9% to ≤16%**	Linda Lee/ Maribel Ferrer	Annual	**MQSC:** Nov 2			
C33- Appeals Resolution ★	5 Stars: ≥ 95%	**4 Stars: ≥ 87% to <95%**	Barbara Skier/ Linda Lee	Annual	**MQSC:** Nov 2			
Adult Access to Primary/Ambulatory Health Services (HEDIS) **MOC (moved to display measures)**	N/A	**87%**	Linda Lee/ Earl Lenard/ Michael Tu	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
D06-Overall Rating of Drug Plan (Rating 7, 8, 9 or 10, out of 10) ★	5 Stars: ≥ 87%	**5 Stars: ≥ 87%**	Agavni Aslanyan/ Linda Lee	Annual: Sept '15	**MQSC:** Nov 2		**Continue MPM initiative, Clinical Programs, IVR, Choice 90, member outreach**	
D07- Getting Needed Drugs (RX) ★	5 Stars: ≥ 92%	**3 Stars: ≥ 90% to <91%**	Agavni Aslanyan/ Linda Lee	Annual: Sept '15	**MQSC:** Nov 2		**Continue MPM initiative, Clinical Programs, IVR, Choice 90, member outreach**	

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
D11- Medication Adherence for Diabetes Medications ★	5 Stars: ≥ 81%	**3 Stars: ≥ 73% to <77%**	Agavni Aslanyan/ Linda Lee	Annual: Sept '15	**MQSC:** Nov 2		**Continue MPM initiative, Clinical Programs, IVR, Choice 90, member outreach**	
Getting Information About RX Coverage/Costs (moved to display measures)		**94%**	Agavni Aslanyan/ Linda Lee/ Maribel Ferrer	Annual: Sept '15	**MQSC:** Nov 2		**Incorporate education in member newsletters, website, handbook and mailings**	
CMC Required Measures								
Pharmacotherapy of COPD Exacerbation-Bronchodilator **MOC/CPG**	Benchmark '14: 89.25 %	**82%**	Mike Shook/ Michael Tu	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Pharmacotherapy of COPD Exacerbation-systemic corticosteroid **MOC/CPG**	Benchmark '14: 80.00%	**67%**	Mike Shook/ Michael Tu	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Persistence of Beta-Blocker Treatment After a Heart Attack	Benchmark '14: 96.49%	**N/A**	Mike Shook/ Michael Tu	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Antidepressant Medication Management (Acute Phase) MOC/CPG	Benchmark '14: 79.20%	**62%**	Michael Tu	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Antidepressant Medication Management (Continuation Phase) MOC/CPG	Benchmark '14: 67.92%	**47%**	Michael Tu	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Use of Spirometry Testing in the Assessment and Diagnosis of COPD **MOC/CPG**	Benchmark '14: 52.86%	**27%**	Mike Shook/ Michael Tu	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Follow-Up After Hospitalization for Mental Illness (in 7 days)	Benchmark '14: 56.76%	**23%**	Michael Tu/ Beacon	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Follow-Up After Hospitalization for Mental Illness (in 30 days)	Benchmark '14: 75.00%	**41%**	Michael Tu/ Beacon	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
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 '14: 96.38%	**86%**	Michael Tu/ Agavni Aslanyan/ Michael Sax/ Gayle Butler/ Bettsy Santana	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Annual Monitoring for Patients on Persistent Medications-Digoxin	Benchmark '14: 98.09%	**89%**	Michael Tu/ Agavni Aslanyan/ Michael Sax/ Gayle Butler/ Bettsy Santana	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Annual Monitoring for Patients on Persistent Medications-Diuretics	Benchmark '14: 96.52%	**86%**	Michael Tu/ Agavni Aslanyan/ Michael Sax/ Gayle Butler/ Bettsy Santana	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Potentially Harmful Drug-Disease Interactions-Falls + tricyclic antidepressants, antipsychotics or sleep agents (Note lower rates signify better performance)	Benchmark not available	**45%**	Michael Tu/ Agavni Aslanyan/	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Potentially Harmful Drug-Disease Interactions- Dementia + tricyclic antidepressants, anticholinergic agents (Note lower rates signify better performance)	Benchmark not available	**58%**	Michael Tu/ Agavni Aslanyan/	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Potentially Harmful Drug-Disease Interactions- Chronic Renal Failure + NSAIDS (Note lower rates signify better performance)	Benchmark not available	**23%**	Michael Tu/ Agavni Aslanyan	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Potentially Harmful Drug-Disease Interactions- Combination Rate (Note lower rates signify better performance)	Benchmark not available	**47%**	Michael Tu/ Agavni Aslanyan/	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Use of High Risk Medication in the Elderly- one drug (Note lower rates signify better performance)	Benchmark '14: 11.57%	**22%**	Michael Tu/ Agavni Aslanyan/	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Use of High Risk Medication in the Elderly- two drugs (Note lower rates signify better performance)	Benchmark '14: 1.10%	**4%**	Michael Tu/ Agavni Aslanyan	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Care for Older Adults- Advance care planning	Benchmark not available	**51%**	Michael Tu/ Agavni Aslanyan	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Medication Reconciliation Post Discharge	Benchmark not available	**17%**	Michael Tu/ Agavni Aslanyan	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
Board Certification	N/A	**Fam Med: 46%** **IM: 77%** **Geriatrics: 70%** **Other: 73%**	Mike Shook/ Michael Tu	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Other Measures								
Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers to Quit only) (Always, Usually, and Sometimes) **(CAHPS - Medicare)**		**86%**	Michael Tu/ Rae Starr	Annual: Due Sept. '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6			
CCIP - Reducing Cardiovascular Risk								
Measure #1 (CCIP) **C18** - Controlling High Blood Pressure ★	5 Stars: ≥ 75%	**5 Stars: ≥ 75%**	Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6		**CCIP - Reducing Cardiovascular Risk**	
Measure #2 (CCIP) **C08**- Adult BMI assessment ★	5 Stars: ≥ 93%	**5 Stars: ≥ 93%**	Elaine Sadocchi-Smith/ Michael Tu	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6		**CCIP - Preventing Cardiovascular disease**	
Measure #3 (CCIP) **D12** - Medication Adherence for Hypertension (RAS antagonists) ★	5 Stars: ≥ 85%	**2 Stars: ≥ 72% to <76%**	Elaine Sadocchi-Smith/ Michael Tu/ Agavni Aslanyan	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6		**CCIP - Preventing Cardiovascular disease**	

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Measure #4 (CCIP) **D13** - Medication Adherence for Cholesterol (Statins) ★	5 Stars: ≥ 83%	**3 Stars: ≥ 68% to <76%**	Elaine Sadocchi-Smith/ Michael Tu/ Agavni Aslanyan	Annual: Due June '15	**QOC:** Sept 28 **PICC & PQC:** Oct 6		**CCIP - Preventing Cardiovascular disease**	
Model of Care (MOC) Measures								
Improving access to preventive health services: Increase the percentage of members vaccinated annually against seasonal influenza								
Quality of Life Survey - SF12 Mental Component Score **(HOS)**	**Target - 95%**	**6%/3 years or 2% change per year**	Jim Banks	Annually				
Quality of Life Survey - SF12 Physical Component Score **(HOS)**	**Target - 95%**	**6%/3 years or 2% change per year**	Jim Banks	Annually				
Medication compliance	**Target - 80%**	**Improvement of 2 percentage points per year**	Jim Banks	Annually				
Patient satisfaction		**90% of members will be satisfied with care management activities**	Jim Banks	Annually				
Avoidance of hospital admissions for ambulatory care sensitive conditions (ACSC)	**Target - 20%**	**10% reduction in total beddays/K for ACSC**	Jim Banks	Annually				

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Hospital Utilization (MOC)								
Hospital Bed Days	**Target - 1400K**	**10% reduction in total beddays/K**	Jim Banks	Quarterly				
Hospital Admissions	**Target - 220**	**10% reduction in admissions**	Jim Banks	Quarterly				
Hospital Average Length of Stay	**Target - 4.2 Days**	**10% reduction in length of stay**	Jim Banks	Quarterly				
Readmissions rates	**Target - <20%**	**2 percentage point reduction from previous year**	Jim Banks	Quarterly				
Ambulatory Services (MOC)								
Emergency Room Visits	**Dec. 2013 - 1338.62**	**10% reduction from the previous year**	Jim Banks	Quarterly				
Ambulatory Care Visits	**Dec. 2013 - 5024.13**	**10% reduction from the previous year**	Jim Banks	Quarterly				
Grievance	**4th Qtr. 2013** **Part C: 72** **Part D: 15**	**Monitor in QI Program**	Jim Banks	Quarterly				
HRA Completion Rate		**100% of all Medicare enrollees within 90 days**	Jim Banks	Quarterly				
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 26, Feb 23, March 23, Apr 27, May 25, Jun 22, July 27, Sept 28, Oct 26, Nov 23			

This work plan addresses QI program scope as defined by the 2015 QIPD and is consistent with QIPD objectives.

Performance Measures for Planned Activities for Objectives	2015 Benchmark	2015 Goal	Responsible Staff	Timeframe for completion	Reports to: (Dates are 2015 unless otherwise noted)	Updates	Comments	Recommend for '16 Work Plan
Departmental Oversight reporting requirements		100% submission of timely delegate oversight reporting for each department	QI: Mike Shook MS: Maribel Ferrer A&G: Barbara Skier RX: Michael Sax	QOC quarterly	**QOC:** April 27, Jun 22, Sept 28, Nov 23			
QI Program Description & Work Plan		2015 QI Program Description & Work Plan approval	Mike Shook	**QOC**:2/23/15 **C & Q**: 3/19/15	**QOC**:2/23/15 **C & Q**: 3/19/15			
QI Evaluation		2014 QI Evaluation approval	Mike Shook	**QOC**:2/23/15 **C & Q**: 3/19/15	**QOC**:2/23/15 **C & Q**: 3/19/15			
QI Work Plan Updates		Review and Update of QI Work Plan	Marla Lubert/ Mike Shook	Biannually/ Final attached to QI eval	**QOC:** 7/27/15, 10/26/15			
QI Reports to Board		Update Board (C&Q) on QI activities	Trudi Carter	At least quarterly	**C & Q:** 1/15/15, 3/19/15, 5/21/15, 7/16/15, 9/17/15, 11/19/15			
UM Program Documents		Annual UM Program Description, UM Work Plan, & UM Evaluation	Halima Bascus/ Anna Edwards	**QOC**:2/23/15 **C & Q**: 3/19/15	**QOC**:2/23/15 **C & Q**: 3/19/15			
MMP Core Reporting		Reports submitted monthly	Christine Babu/ Adrianne Govan	**QOC** Quarterly, Bi-annually & Annually	**QOC:** April 27, Jun 22, Sept 28, Nov 23			
CA State Reporting		Reports submitted monthly to the state	Christine Babu/ Adrianne Govan	**QOC** Quarterly, Bi-annually & Annually	**QOC:** April 27, Jun 22, Sept 28, Nov 23			
Part C & D CMS Reporting		Complete and accurate collection, analysis, and reports of Part C & D data elements	Christine Babu/ Adrianne Govan	**QOC** Quarterly, Bi-annually & Annually	**QOC:** April 27, Jun 22, Sept 28, Nov 23			

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