



L.A. Care
HEALTH PLAN®

Quality Improvement Program Annual Report and Evaluation

2015

Quality Oversight Committee approval on 2/22/16
Compliance and Quality Committee approval on 3/17/16



**Quality Improvement Program
Annual Report and Evaluation
2015**

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Mission

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

Vision

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

Values

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

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

EXECUTIVE SUMMARY

L.A. Care Health Plan continues its efforts to improve the quality of care and services to members. The Quality Improvement Program describes the infrastructure L.A. Care uses to coordinate quality improvement activities with quantifiable goals. The 2015 Quality Improvement Work Plan was the vehicle for reporting quarterly updates of quality activities and progress toward measureable goals. This 2015 Annual Report and Evaluation summarizes and highlights the key accomplishments in the area of quality improvement for the period of January 1, 2015 through December 31, 2015 except where annotated otherwise. This Annual Report evaluates activities for L.A. Care's lines of business: Medi-Cal, Healthy Kids, PASC-SEIU Homecare Workers Health Care for In-Home Supportive Services Workers, L.A. Care Covered™ (Marketplace), L.A. Care Covered Direct™, and Cal MediConnect [(CMC) Duals Demonstration Project].

Under the leadership and strategic direction established by the L.A. Care Health Plan Board of Governors through the Compliance and Quality Committee (C&Q) and senior management, the 2015 Quality Improvement Plan was implemented. This report provides a detailed discussion of quality improvement activities and significant accomplishments during the past year, in the areas of clinical care, patient safety, model of care implementation & monitoring, member experience/satisfaction, and access to care. The evaluation documents activities undertaken to achieve work plan goals and establishes the groundwork for future quality improvement activities.

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

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

L.A. Care Health Plan has successfully undergone evaluation by regulators and accrediting bodies in 2015, with particular emphasis on quality of care, coordination and integration of services, and provision of effectiveness and efficacy of processes.

The assessments in 2015 included:

- August 24: NCQA annual reevaluation based on HEDIS® and CAHPS® performance of Medi-Cal and Covered California product lines, resulting in an overall “accredited” status.
- July 20 – July 31: DHCS/DMHC audit of Medi-Cal. Results pending at this time.
- April 16: NCQA Distinction in Multicultural Healthcare achieved.

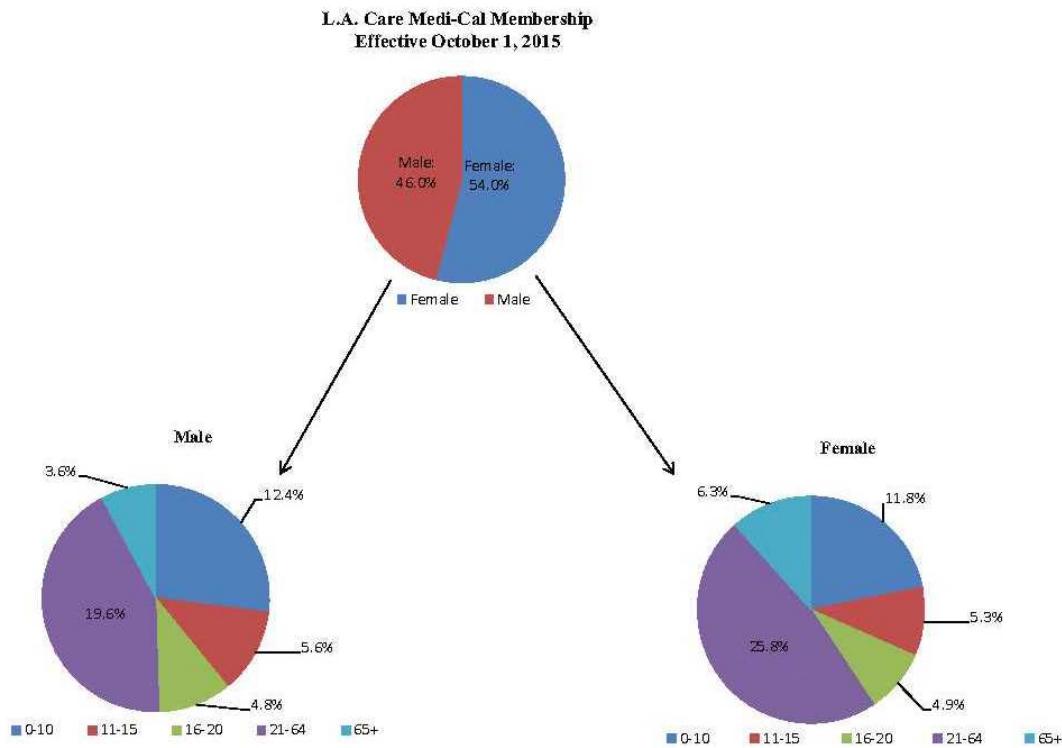
Membership

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

As of October 1, 2015, L.A Care had 1,798,818 Medi-Cal members of those 314,204members in the Senior and People with Disabilities (SPDs) categories (an increase from 110,563 at the end of 2014), 850 Healthy Kids members, and 46,067 IHSS members as of October 1, 2015. L.A. Care's Medi-Cal membership profile by age and gender is shown below:

Age	Number of Members	% of Membership
0-10	434,469	24.2%
11-15	195,249	10.9%
16-20	175,244	9.7%
21-64	815,640	45.3%
65+	178,216	9.9%
Total	1,798,818	100.0%

Gender	Number of Members	% of Membership
Female	971,607	54.0%
Male	827,211	46.0%



Three ethnic groups make up 79.5% of L.A. Care's Medi-Cal membership as seen in the table below:

Ethnicity	Number of Members	% of Membership
Hispanic/Latino	970,715	54.0%
Caucasian/White	261,239	14.5%
African American/Black	198,537	11.0%

89.7% of all L.A. Care Medi-Cal members speak one of two languages as seen in the table below:

Language	Number of Members	% of Membership
English	1,054,825	58.6%
Spanish	559,772	31.1%

Approximately 44.7% of Medi-Cal members are under 21 years of age. The rate of members 65 and over increased from 1% in 2010 to 9.9% in 2015. Of the adult membership, approximately 58.0% are female and 42.0% are male. Approximately 54.0% of L.A. Care Med-Cal members are Hispanic/Latino, but the main preferred languages spoken are divided between English and Spanish. L.A. Care strives to make available easy-to-read, well translated health education material, and continuously increases the availability of material in alternative formats (audio, Braille, large format).

THRESHOLD LANGUAGES FOR L.A. CARE'S PRODUCT LINES OF BUSINESS

Medi-Cal and Cal MediConnect	Healthy Kids	PASC-SEIU	L.A. Care Covered
English	English	English	English
Spanish	Spanish	Spanish	Spanish
Chinese	Korean	Chinese	
Armenian		Armenian	
Arabic			
Farsi			
Khmer			
Korean			
Russian			
Tagalog			
Vietnamese			

MEDI-CAL

Medi-Cal	
The Top 10 Diagnosis for Outpatient Visits (other than for well visits and pregnancy) (Oct. 1, 2014 – Sept. 30, 2015)	
2015	
1	Essential hypertension
2	Other upper respiratory infections
3	Spondylosis; intervertebral disc disorders; other back problems
4	Abdominal pain
5	Diabetes mellitus without complication
6	Other lower respiratory disease
7	Other non-traumatic joint disorders
8	Other connective tissue disease
9	Nonspecific chest pain
10	Chronic kidney disease

Medi-Cal	
The Top 10 Diagnosis for Inpatient Visits (other than those related to labor and delivery) (Oct. 1, 2014 – Sept. 30, 2015)	
2015	
1	Septicemia (except in labor)
2	Nonspecific chest pain
3	Congestive heart failure; nonhypertensive
4	Diabetes mellitus with complications
5	Pneumonia (except that caused by tuberculosis or sexually transmitted disease)
6	Skin and subcutaneous tissue infections
7	Asthma
8	Urinary tract infections
9	Biliary tract disease
10	Chronic obstructive pulmonary disease and bronchiectasis

The top 10 diagnoses, were identified using Clinical Classifications Software (CCS) Single Level Diagnosis categories by LOB and by In Patient and Out Patient setting (using primary diagnosis only), from October 1 2014 – September 30, 2015.

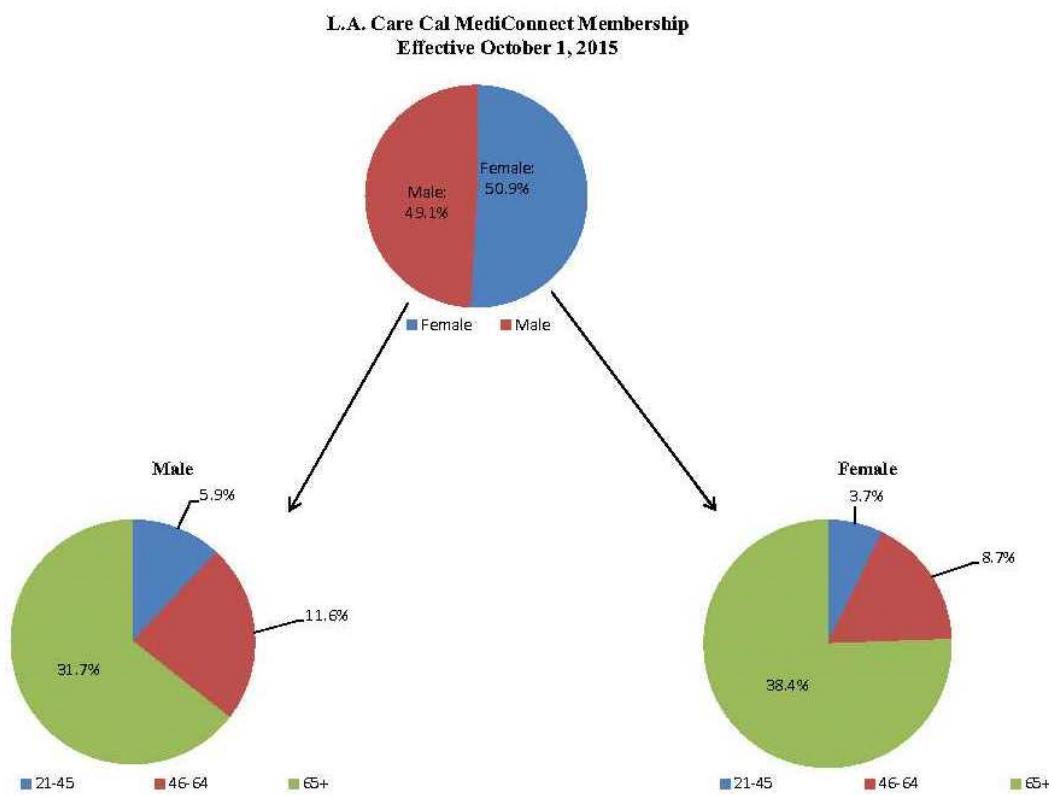
The top three outpatient diagnosis categories for 2015 were Essential Hypertension, Other Upper Respiratory Infections, and Spondylosis; Intervertebral Disc Disorders; Other Back Problems. In terms of top three diagnosis categories for Inpatient, they were Septicemia (except in labor), Nonspecific Chest Pain, and Congestive Heart Failure; Nonhypertensive.

Cal MediConnect Membership (Duals Demonstration Project)

As of October 1, 2015, L.A Care had 14,115 Cal MediConnect members. The population below 65 years of age qualifies for participation in the Duals Demonstration Project based on presence of a disabling condition and/or aid code designation. The detail of L.A. Care's Cal MediConnect membership profile is shown below:

Age	Number of Members	% of Membership
21-45	1,357	9.6%
46-64	2,863	20.3%
65+	9,895	70.1%
Total	14,115	100.0%

Gender	Number of Members	% of Membership
Female	7,178	50.9%
Male	6,937	49.1%



L.A. Care's Cal MediConnect membership based on ethnicity can be seen in the table below: *Note: The majority of the Cal MediConnect-members' ethnicity (80.2%) is either unknown/blank or decline to state.*

Ethnicity	Number of Members	% of Membership
Filipino	227	1.6%
Chinese	134	0.9%
Vietnamese	41	0.3%
Hispanic/Latino	39	0.3%
Korean	38	0.3%
Black/African American	33	0.2%

Ethnicity	Number of Members	% of Membership
White/Caucasian	28	0.2%
Asian Indian	28	0.2%
Japanese	20	0.1%
Asian Pacific Islander	9	0.1%

Approximately 82.4% of the Cal MediConnect members speak one of two languages as seen in the table below:

Language	Number of Members	% of Membership
English	6,371	45.1%
Spanish	5,263	37.3%

70.1% of L.A. Care Cal MediConnect members are 65 years and over. Of adult membership, 50.9% are female and 49.1% are male. The main preferred languages spoken are divided between Spanish and English with English being the predominant preferred language. L.A. Care strives to make available easy-to-read, well translated health education material, and continuously increases the availability of material in alternative formats (audio, Braille, large format).

Cal MediConnect	
The Top 10 Diagnosis for Outpatient Visits (other than for well visits and pregnancy)	
(Oct. 1, 2014 – Sept. 30, 2015)	
2015	
1	Essential hypertension
2	Diabetes mellitus without complication
3	Schizophrenia and other psychotic disorders
4	Diabetes mellitus with complications
5	Other lower respiratory disease
6	Spondylosis; intervertebral disc disorders; other back problems
7	Nonspecific chest pain
8	Mood disorders
9	Delirium, dementia, and amnesia and other cognitive disorders
10	Other non-traumatic joint disorders

Cal MediConnect	
The Top 10 Diagnosis for Inpatient Visits (other than those related to labor and delivery) (Oct. 1, 2014 – Sept. 30, 2015)	
2015	
1	Septicemia (except in labor)
2	Schizophrenia and other psychotic disorders
3	Congestive heart failure; nonhypertensive
4	Pneumonia (except that caused by tuberculosis or sexually transmitted disease)
5	Nonspecific chest pain
6	Acute and unspecified renal failure
7	Acute myocardial infarction
8	Acute cerebrovascular disease
9	Mood disorders
10	Chronic obstructive pulmonary disease and bronchiectasis

The top 10 diagnoses, were identified using CCS Single Level Diagnosis categories by LOB and by In Patient and Out Patient setting (using primary diagnosis only), from October 1 2014 – September 30, 2015.

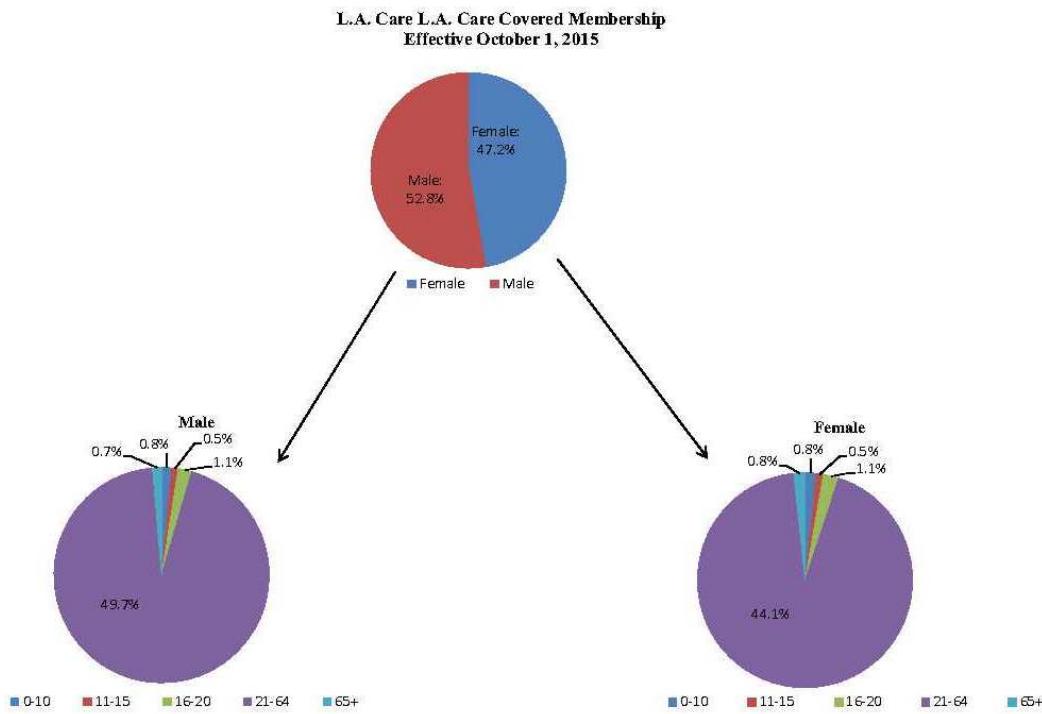
The top three outpatient diagnosis categories for 2015 were Essential Hypertension, Diabetes Mellitus Without Complication, and Schizophrenia and Other Psychotic Disorders. In terms of top three diagnosis categories for Inpatient, they were Septicemia (except in labor), Schizophrenia and Other Psychotic Disorders, and Congestive Heart Failure; Nonhypertensive.

L.A. Care Covered™ Membership (Marketplace)

As of October 1, 2015, L.A. Care had 14,752 L.A. Care Covered™ members. The detail of L.A. Care Covered™ membership profile is shown below:

Age	Number of Members	% of Membership
0-10	241	1.6%
11-15	139	0.9%
16-20	316	2.1%
21-64	13,837	93.8%
65+	219	1.5%
Total	14,752	100.0%

Gender	Number of Members	% of Membership
Female	6,965	47.2%
Male	7,787	52.8%



Six ethnic groups make up 48.0% of L.A. Care's L.A. Care Covered™ membership as seen in the table below:

Ethnicity*	Number of Members	% of Membership
Caucasian/White	3,872	26.2%
Hispanic/Latino	1,068	7.2%
Chinese	661	4.5%
Black/African American	512	3.5%
Korean	495	3.4%
Filipino	477	3.2%

*48.2% are unknown

88.5% of all L.A. Care L.A. Care Covered™ members speaks one of two languages as seen in the table below:

Language	Number of Members	% of Membership
English	9,587	65.0%
Spanish	3,466	23.5%

Approximately 4.7% of L.A. Care Covered™ members are under 21 years of age. Of the adult membership, approximately 47.1% are female and 52.9% are male. L.A. Care strives to make available easy-to-read, well translated health education material, and continuously increases the availability of material in alternative formats (audio, Braille, large format).

L.A. Care Covered™	
The Top 10 Diagnosis for Outpatient Visits (other than for well visits and pregnancy) (Oct. 1, 2014 – Sept. 30, 2015)	
2015	
1	Diabetes mellitus without complication
2	Essential hypertension
3	Spondylosis; intervertebral disc disorders; other back problems
4	Disorders of lipid metabolism
5	Abdominal pain
6	Other non-traumatic joint disorders
7	Other connective tissue disease
8	Diabetes mellitus with complications
9	Nonspecific chest pain
10	Other lower respiratory disease

L.A. Care Covered™	
The Top 10 Diagnosis for Inpatient Visits (other than those related to labor and delivery) (Oct. 1, 2014 – Sept. 30, 2015)	
2015	
1	Acute myocardial infarction
2	Biliary tract disease
3	Acute cerebrovascular disease
4	Septicemia (except in labor)
5	Prolonged pregnancy
6	Appendicitis and other appendiceal conditions
7	Complications of surgical procedures or medical care
8	Benign neoplasm of uterus
9	Pancreatic disorders (not diabetes)
10	Congestive heart failure; nonhypertensive

The top 10 diagnoses, were identified using CCS Single Level Diagnosis categories by LOB and by In Patient and Out Patient setting (using primary diagnosis only), from October 1 2014 – September 30, 2015.

The top three outpatient diagnosis categories for 2015 were Diabetes Mellitus Without Complication, Essential Hypertension, and Spondylosis; Intervertebral Disc Disorders; Other Back Problems. In terms of top three diagnosis categories for Inpatient, they were Acute Myocardial Infarction, Biliary Tract Disease, and Acute Cerebrovascular Disease.

Clinical Care

L.A. Care targets four main areas for clinical care improvement: *health promotion and prevention, management of chronic conditions, management of episodic conditions, and monitoring the network for compliance with guidelines*. In the area of *health promotion and prevention*, L.A. Care sought to increase the number of members who received breast, cervical, and colorectal cancer screenings, well child and adolescent visits, childhood and adolescent immunizations, prenatal and postpartum care and other services to maintain women's health.

L.A Care demonstrated significant improvement in 11 HEDIS measures: Adult BMI Assessment, Breast Cancer Screening, Controlling High Blood Pressure, Chlamydia Screening in Women, Appropriate Testing for Children with Pharyngitis, Annual Monitoring for People on Persistent Medications-ACE/ARB, Diuretics, and Diuretics, Appropriate Treatment for Children with Upper Respiratory Infection, and Weight Assessment and Counseling for Nutrition & Physical Activity for Children/Adolescents- BMI, Nutrition, and Physical. There was significant decline in three (3) indicators: Medication Management for People

with Asthma - Total Population 75% Covered, Medication Management for People with Asthma - Total Population 50% Covered, and Annual Monitoring for People on Persistent Medications - Digoxin

L.A. Care's asthma, diabetes, and cardiovascular disease management programs are available for all lines of business and continue to grow to provide education and support to empower members to manage these chronic conditions. The programs have bilingual English-Spanish nurses who make outbound condition monitoring calls to members who are stratified with higher severity and has bilingual English-Spanish staff to answer the telephone resource lines. L.A. Care developed targeted L.A. Care branded education materials for the three disease management programs to outreach and engage lower severity members as well as revising the clinical practice guidelines for all three programs to engage providers in evidence based practice of their patients with asthma, diabetes and cardiovascular disease.

Additionally, L.A. Care participates in a CMS mandated Chronic Care Improvement Program (CCIP) focused on reducing cardiovascular disease and a Quality Improvement Plan (QIP) focused on reducing all cause re-admissions.

Throughout 2015, L.A. Care's NCQA accredited Managed Behavioral Health Organization (MBHO) provided specialty behavioral health services for members. L.A. Care worked with its MBHO to improve coordination of medical and behavioral care.

In order to monitor the network for compliance with guidelines, L.A. Care conducted medical record reviews that focus on various aspects of the guidelines. This process gives providers feedback and educates them at the same time. Healthcare Effectiveness and Data Information Set (HEDIS) measures are also used to monitor the network for compliance. Medical records reviewed by the FSR team indicate 75% compliance rate with "child" preventive guidelines and 30% compliance rate with "adult" preventive health guidelines (sample size 5,570).

L.A. Care's Provider Continuing Education Program (PCEP) continues to be an accredited Continuing Medical Education (CME) provider by the Institute for Medical Quality and Continuing Education provider (CE) by the Board of Registered Nursing and Board of Behavioral Sciences. The program provides three levels of activities including direct sponsorship, co-sponsorship with other CME providers, or jointly-sponsorship with non CME accredited providers. In 2015, the PCEP hosted a total of 39 of CME evening training activities and weekend all-day Saturday conferences listed below:

Evenings/Day Activities:

- Behavioral Health Treatment: Autistic Spectrum Disorder Services in L.A. County (1/22/15)
- Depression in Primary Care (1/27/15)
- UCLA First 5 Los Angeles Oral Health Program, Quality Improvement Learning Collaborative, Learning Session 2 (2/2/15)
- UCLA First 5 Los Angeles Oral Health Program, Quality Improvement Learning Collaborative, Learning Session 2 (2/3/15)
- Pediatric Asthma Diagnosis, Assessment & Cultural Competency (2/4/15)
- Alcohol Screening and Intervention: What Clinicians Need to Know (2/25/15)
- Achieving Pediatric Wellness in the Primary Care Setting: A Closer Look at EPSDT, CHDP, & BHT Conference (3/21/15)
- Dementia in the Primary Care Setting (3/31/15)
- Psychotropic Medication Use (4/23/15)
- Diabetic Care: What Clinicians Need to Know (4/30/15)
- UCLA First 5 Los Angeles Oral Health Program Quality Improvement Learning Collaborative, Learning Session 3 (5/11/15)
- UCLA First 5 Los Angeles Oral Health Program, Quality Improvement Learning Collaborative, Learning Session 3 (5/12/15)

- CMC Improving Care for California's Medicare & Medi-Cal Consumers (5/14/15)
- Bringing a Trauma-Informed Lens to Primary Care and Behavioral Health (5/18/15)
- Voices: A Documentary on Human and Untold Stories of Mental Illness (5/27/15)
- CMC Improving Care for California's Medicare & Medi-Cal Consumers (6/4/15)
- Deaf Awareness and Sensitivity Training (6/11/15)
- Autism: A Medical Necessity Disorder (6/16/15)
- The Nuts and Bolts of Care Integration (7/1/15)
- Substance Abuse Prevention and Control SAPC Lecture: ASAM Criteria (7/31/15)
- Care Management Training (8/5/15)
- The POLST (Physician's Order for Life Sustaining Treatment) Conversation (8/12/15)
- Lesbian, Gay, Bisexual, Transgender/Questioning Sensitivity Training (8/13/15)
- The POLST (Physician's Order for Life Sustaining Treatment) Conversation (8/20/15)
- The POLST (Physician's Order for Life Sustaining Treatment) Conversation (8/25/15)
- LGBTQ Health at L.A. Care Health Plan (8/31/15)
- The POLST (Physician's Order for Life Sustaining Treatment) Conversation (9/9/15)
- UCLA First 5 Los Angeles Oral Health Program Quality Improvement Learning Collaborative - Phase II Learning Session 1 (9/23/15)
- UCLA First 5 Los Angeles Oral Health Program Quality Improvement Learning Collaborative - Phase II Learning Session 1 (9/24/15)
- Pediatric Asthma Diagnosis, Assessment and Cultural Competency (10/21/15)
- Substance Use Disorders (SUD) Conference (11/7/15)
- Being Mortal, Increasing Conversations about Advanced Care Planning (11/19/15)

Weekend Conferences

- EPSDT/Pediatric Wellness (3/21/15)
- Palliative Care Symposium (4/11/15)
- LGBTQ Health Conference (5/16/15)
- Men's Health Conference (8/1/15)
- Women's Health Conference (9/26/15)
- Care Management Conference (10/17/15)
- Buprenorphine Certification Training (11/6/15)
- Substance Use Disorders Conference (11/7/15)

Overall, year 2015 has been an extremely busy and productive year for L.A. Care's Provider Continuing Education Program, providing more than 110 CME/CE credits for the year. L.A. Care is up for re-accreditation as a CME provider and is currently in the process of completing the application, which is due in March 2016. We anticipate full accreditation.

The Cultural & Linguistic (C&L) Services Unit provides language access services, including translation, telephonic interpreting, and face-to-face interpreting, and cultural competency trainings for L.A. Care staff and providers. In 2015, the C&L Services Unit received and processed 2,769 translation requests totaling over four million words (4,223,100), an increase of 95% over the previous year's total. This increase was due to a large number of member letters, such as grievance acknowledgement letters and resolution letters, which accounted for approximately 57% of documents. Spanish was the top requested language, followed distantly by Khmer, Armenian, and Traditional Chinese.

The C&L Services Unit provides face-to-face interpreters upon request at medical appointments, meetings, and health education classes. In 2015, a total of 3,914 face-to-face interpreting requests were processed, 3,601 for medical appointments, and 313 for administrative meetings and events, an increase of 104% over the previous year. This growth was primarily due to an increase in the number of requests for interpreters at medical appointments resulting from the overall growth in membership. Top languages for medical

appointments were Spanish, American Sign Language and Farsi. Spanish was the top language for administrative appointments followed distantly by Khmer.

Telephonic interpreting services are offered to L.A. Care staff, network providers, pharmacies, and medical groups when communicating with members over the phone or when face-to-face interpreters are not available. In 2015, the C&L Services Unit's contracted telephonic interpreting services vendor provided services for 72,300 calls and 804,934 minutes. Utilization of telephonic interpreting services increased 35% over the previous year due to an increase in L.A. Care members as a result of the initiation of L.A. Care Covered and Cal MediConnect. Telephonic interpreting services were provided in a total of 82 languages.

The C&L Services Unit provides on-going education on C&L rights, requirements, services and resources, cultural competency, and disability sensitivity. Training topics include: C&L Overview, Cultural Competency, Disability Awareness, Interpreting Services, TTY, Translation Services, Communicating Through Healthcare Interpreters (CME), Deaf Awareness (CME), and LGBT/Q Sensitivity Training (CME). Trainings are conducted for L.A. Care staff and network providers, both in person and online through L.A. Care's Learning Management System. The C&L Services Unit conducted a total of 50 in person trainings on C&L related topics in 2015, with a total of 1,202 attendees (911 staff and 291 providers). An additional 379 staff and 589 providers completed C&L trainings online. The C&L Services Unit will continue to expand cultural competency curricula and educational trainings, with an increased focus on provider and vendor education and training, especially for those providing services to the cultural diverse populations across all product lines.

The C&L Services Unit also educates providers and staff through various other methods and activities:

- In May 2015, the C&L Services Unit partnered with Provider Relations as part of its ongoing efforts to educate providers. A letter and resource flyers were sent out to all network providers about available C&L resources and services and how to access them.
- In June 2015, the Interpreting Quick Guide was created for L.A. Care staff and subcontractors on how to easily access L.A. Care's interpreting services.
- In September 2015, the C&L Services Unit revised the C&L Provider Toolkit, "Better Communication, Better Care: A Provider toolkit for Serving Diverse Populations." This toolkit was developed to assist providers in providing high quality, effective, and compassionate care to their patients and ensure they meet the changing service requirements of state and federal regulatory agencies. In addition to being available on L.A. Care's website, this toolkit was also distributed by the C&L Services Unit at provider trainings and PPG meetings as well as by Facility Site Review nurses during their site reviews.
- In September 2015, the telephonic interpreting cards were updated to make them more user-friendly for PPGs and network providers.

The Health Education Unit's *Health In Motion*™ program delivers health education services to all direct line of business L.A. Care members via telephonic consultations and in-person group appointments by certified Health Coaches, Registered Dietitians, and Master's Level Health Educators. In fiscal year 2014-2015, Health Education conducted 1,873 encounters to members. An encounter is defined as delivery of health education services to an individual in person or over the phone. Of the 1,873 encounters, 1,394 were via phone and 503 were via in-person group appointments and wellness workshops. Medical Nutrition Therapy and Diabetes Self-Management Education were the most requested services, with 332 and 434 phone encounters, respectively. Health Education workshops and group appointments are offered in provider offices and other community locations. Topics included Asthma Basics, Diabetes, Pre-Diabetes, Heart Health, and Healthier Living. Healthier Living is based on Stanford University's evidence-based chronic disease self-management program. Additionally, Health Education's Diabetes Self-Management Education and Support program received recognition from the American Diabetes Association in 2014 and successfully completed an annual review in 2015. Finally, L.A. Care makes Weight Watchers coupons

available for direct line of business members, and provides up to 20 free weekly meeting coupons for eligible L.A. Care members. In 2015, a total of 267 members were sent weekly meeting coupons compared to 177 in 2014.

Targeting HEDIS postpartum screening rates, the Health Education Unit continued the “Healthy Mom” Postpartum Program in 2015. This program provides assistance and support to members to schedule their postpartum visit including transportation coordination upon request and provision of an in-person interpreter if needed. Member outreach efforts include telephone calls to women who have recently delivered a baby to provide education on the importance of the postpartum visit, assistance with scheduling the visit – including assistance with transportation and interpreters if needed – and a \$40 incentive for attending the postpartum appointment. In fiscal year 2014-2015, a total of 2,866 members were called for postpartum appointment scheduling assistance. Of these, 48% were successfully contacted, an increase of 30% over the previous fiscal year’s reach rate of 37%. Based on the success of the program it was expanded to include LACC and CMC members in July 2015.

To assist health plan staff in providing appropriate services and resources to L.A. Care members, the Health Education unit offers several training including Motivational Interviewing and Writing in Plain Language. Motivational Interviewing is a nine hour, two-session training which provides tools and guidance for L.A. Care staff about how to help members set their own health behavior goals. The *Writing in Plain Language* training provides tools and guidance on how to write easy-to-read materials for members. In fiscal year 2014-2015, eight sessions of Motivational Interviewing consisting of four one-day sessions and four half-day refresher sessions were conducted with a total of 64 staff attending. Attendees included staff from Case Management, Disease Management, Behavioral Health, and Managed Long Term Services and Supports. Two sessions of *Writing in Plain Language* were conducted with 52 attendees from departments including Marketing, MORE, Regulatory Affairs and Compliance, Case Management, Quality Improvement, and Appeals and Grievances, among others. *Writing in Plain Language* is also available as an e-learning module for staff to access and view at their leisure. During fiscal year 2014-2015, four L.A. Care employees completed the module.

In July 2015, the Health Education unit launched My *Health In Motion*™, an online health and wellness portal for L.A. Care Medi-Cal Direct (MCLA), LACC, LACC-D, and CMC members. Available through the member portal, members can complete the Health Appraisal with 72 questions, view a personalized report of their health risk and strengths, and utilize tailored wellness tools such as workshops, exercise how-to videos, meal plans, and biometric trackers. Members have access to a wealth of resources on health and wellness, including recipes, interactive decision tools, and a DHCS-approved comprehensive health and medical library. The site is intended to highlight members’ health risks, such as nutrition, tobacco use, and emotional health, and provide resources for self-management.

The Health Education unit contracted with Cerner, a NCQA HIP-certified vendor, to create My *Health In Motion* (My HIM) and customize it for L.A. Care members. By contracting with Cerner, L.A. Care will receive auto credit for NCQA Member Connections (MEM) 1 (Health Appraisal) and 2 (self-management tools). From June 24th through September 2015, a total of 172 members completed the Health Appraisal. Members can also communicate directly with Certified Health Coaches and registered dietitians and personal trainers via secure messaging. A total of 70 members signed up for health coaching from June 24th to September 2015. In order to increase utilization of My HIM and its associated tools several campaigns are planned for fiscal year 2015-2016.

Patient Safety

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

The patient safety monitoring effort is accomplished through the Potential Quality Issue (PQI) investigation and peer review process. In 2015, the investigation and referral processes continued to be enhanced. The Quality Improvement (QI) Department works collaboratively with Grievance and Appeals team and Medical Management team to better identify PQI issues. The Quality Improvement (QI) Department conducts departmental training to raise L.A. Care staffs as well as network providers' awareness in identification of PQIs. The QI department conducts a thorough internal investigation on all PQIs.

Critical Incident (CI) Reporting is another patient safety monitoring program in place to promote the health, safety and welfare of L.A. Care's Cal MediConnect members. In 2015, the QI department worked closely with Provider Network Operations (PNO) team and Managed Long-Term Services & Supports (MLTSS) team to better identify CI's as well as increase compliance with CI reporting from all contracted/delegated entities. All L.A. Care staff and network providers are trained to identify and report all Critical Incidents (abuse, exploitation, neglect, disappearance/missing member, a serious life threatening event, restraints or seclusion, suicide attempt or unexpected death) by member when identified. The Quality Improvement (QI) Department is responsible for tracking, trending, and appropriate reporting of all CI for all lines of business.

L.A. Care also enhanced patient safety through the facility site review (FSR) process by monitoring elements related to patient health and safety. The two measures monitored were: (a) Needle stick safety precautions practiced on site, and (b) Spore testing of autoclave/steam sterilizer with documented results (at least monthly). Compliance with needle stick precautions increased from 63% in 2014 to 65% in 2015. Spore testing dropped from 83% in 2014 to 82% in 2015. Neither was statistically significant.

Addressing Disparities

Each year the QI program evaluation noted analysis of HEDIS data to identify and address any ethnic disparities. The HO&A Department completed this analysis by measure in 2015. This year's evaluation contains a separate analysis for each HEDIS measures by SPD or non SPD, race, ethnicity, gender, age, and RCAC (Regional Community Advisory Committee) region. Highlights from the analysis shows culture, ethnicity, and geography can change perception and participation in seeking and attaining preventive healthcare.

In 2015, disparities were identified for Comprehensive Diabetes Care A1c Control among African Americans and Medication Management for People with Asthma among Latinos.

Member Experiences, Satisfaction, and Access to Care

In April 2015, L.A. Care began transitioning from a TTY software called ipTTY to utilizing California Relay (CRS) 711 Services to help staff communicate more effectively with Deaf and hard of hearing members. Staff received training to prepare them for the transition and instruct them on how to access 711. The CRS allows for internal staff and after hours vendor, Ansafone, to receive and dial out calls to and from members at any time of day from any phone without the use of any additional software.

All users, that will be making the transition from ipTTY to CRS and/or will need to use CRS, attended a mandatory training class which provided a brief history on CRS as well as how to actively use the service. For Fiscal Year 2014-2015 one in-person and one webinar training sessions on "How to communicate with the Deaf and Hard of Hearing using CRS" were conducted by the Interpreting Services Specialist and Senior Telecommunication Administrator. This course provided basic information about: 1) Deaf culture, 2) History and characteristics of American Sign Language, 3) Literacy of the Deaf and Hard of Hearing, 4) Regulations that mandate L.A. Care to provide CRS services, 5) From ipTTY to CRS transition (Why, How, When), 6) Etiquette and Tips, and 7) Scenarios/Demonstration.

Member Participation, Community Outreach and Engagement

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

In its continuing effort to address the systemic issue of obesity in low income and vulnerable communities, L.A. Care's Community Outreach and Engagement (CO&E) Departments Active Steps Program (ASP) were strategically provided in 3 RCAC regions found to have the highest rates of health disparities (obesity, diabetes, and hypertension). This year, continuing its partnership with the Los Angeles Trust and its Wellness Centers along with the Antelope Valley Partners for Health the program was provided to 87 community members. These 3 sites were revisited based on establishing a Community Wellness Champion who was identified, trained, and certified in Zumba Basic in order to keep the program sustainable for years to come. The program had a 70% retention rate, their knowledge increased by an average of 15% (pre-test 68%, post-test 83%), significant reductions ($p<0.05$) were also shown in their Body Mass Index (BMI) scores, weight loss, waist circumference, reduction of fried food consumption as well as any soda or sugary beverage consumption. Furthermore, significant improvements ($p<0.05$) were found in their perception of their health status as 55% reported a healthier status, increase in the levels of physical activity (low, moderate, high) were seen, consumption of fruits, vegetables, and water intake were found, self-efficacy towards reading food labels and getting their families to be more involved in a healthier lifestyle.

Health Promoter's Program (HPP): In the Fiscal Year 2014-2015, Health Promoters conducted over 315 outreach efforts reaching thousands of L.A. County residents from lower socio-economic backgrounds by teaching community workshops, hosting resource tables at community health fairs, wellness expos, and participating in other events. Topics included access to health care, health care reform, nutrition, asthma, women's health, and other health related wellness classes. In 2015, the health promoters worked closely with USC MPH graduate students in creating an interactive educational activity on "How a Bill Becomes a Law," which was presented at the 2015 Spring RCAC Conference to approximately 300 RCAC members, L.A. Care staff, and community partners. The USC MPH graduate students also educated RCAC members and Health Promoters on reviewing the CA legislature, SB4 Health For All Act, and SB 103 Soda Labeling Bill. The USC MPH graduate students also helped improve data collection for the Health Promoter community workshops and report the impact L.A. Care's Health Promoters have in the communities L.A. Care serves. During January – March 2015, over 390 pre-post tests and 390 satisfaction surveys were analyzed for various community workshops. The My Plate workshop showed the most improvement in overall knowledge change from 15% correct at the pre-test to 95% correct at the post-test. Types of Care and My Plate workshops had the highest satisfaction (very satisfied) in the community. Results for the rest of the Fiscal Year are still being processed. Health Promoters also continued assisting in the Active Steps Program by co-teaching 3 classes (Personal Goal Setting, My Plate Nutrition, and Rethink Your Drink). They continued helping with data collection: body measurements, surveys, 1:1 follow-up phone sessions implementing the motivational interviewing technique, and reporting. At the 2015 Fall RCAC Conference health promoters were acknowledged and recognized for their hard work, dedication, and leadership with several special awards.

Marketing and Activities:

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

L.A. County in the form of marketing, educational events and advertising on health and insurance programs specifically targeted to communities where access to quality health care is limited.

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

Additional education outreach is provided to Enrollment Entities & their down-line Certified Application Assistants (CAAs) and Certified Enrollment Counselors (CECs) to educate and update them on the programs that L.A. Care members receive as well as eligibility for L.A. Care's product lines including Medi-Cal, Healthy Kids, Cal MediConnect and L.A. Care Covered. L.A. Care continually seeks opportunities to improve provider awareness and secure their commitment to L.A. Care through participation in joint operational meetings, physician quality improvement programs, incentive programs, health educational events and building and maintaining effective relationships. The target focus of the provider outreach is for providers who serve low-income seniors and people with disabilities.

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

L.A. Care offers a variety of benefit and health education information on its primary website, www.lacare.org. Additionally, members can access personal health information and perform tasks such as changing a doctor, reprinting ID cards, paying a premium or checking a claim through L.A. Care Connect, our secure online member account.

Required CMS Reporting for Part C and D

The Compliance department gathered and submitted all required reporting for Part C and D to CMS on time in 2015. Reports were reviewed by their respective areas for accuracy and completeness.

QI Work Plan

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

Provider Incentive Programs:

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

Physician Pay-for-Performance (P4P) Program

2015 marked 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 and financial rewards for practices serving Medi-Cal and L.A. Care Covered members, and represents an opportunity to receive significant revenue above capitation. Eligible physicians receive annual incentive payments for outstanding performance and improvement on multiple HEDIS measures—16 were included in 2015, and auto-assignment measures were double-weighted (these have a greater role in determining physician and clinic performance scores and incentive payments).

Final performance reports and incentive payments for the 2015 Physician P4P Program are scheduled for the 4th quarter of 2016. Additionally, \$13.6 million in incentive payments were made for the 2014 Physician P4P Program in the 4th quarter of 2015.

LA P4P for PPGs

2015 marked the sixth year of L.A. Care's LA P4P pay-for-performance program, which targets PPGs serving members in Medi-Cal and L.A. Care Covered. When it was introduced in 2010, LA P4P rewarded provider groups primarily for encounter data submission. Beginning in Year 2, the program expanded to include additional performance domains, including a HEDIS clinical quality domain that mirrors the Physician P4P Program, and that rewards provider groups for both high performance and improvement. In addition to clinical quality, LA P4P measures, reports, and rewards provider group performance and improvement in appropriate resource use (utilization) and patient experience (based on the CG-CAHPS survey instrument). In 2014 a new encounter data gating methodology was introduced into the program. Incentive payments to provider groups across all payment domains are now adjusted to reflect the volume of encounter data received by L.A. Care, which reinforces the organization's efforts to increase administrative data capture.

Final P4P performance reports and incentive payments for the 2015 program are scheduled for the 4th quarter of 2016. Additionally, \$13.7 million in incentive payments were made for the 2014 LA P4P program in the 4th quarter of 2015.

Plan Partner Incentive Program

The QI incentives team re-designed plan partner performance incentives for 2014 and it continued with adjustments in 2015. The program aligns the efforts of L.A. Care with those of its strategic partners as a critical point for improving the outcomes and satisfaction of members. Participating health plan partners receive incentive payment for defined improvement in L.A. Care's auto-assignment measures based on both administrative data and hybrid chart review. A portion of each plan's incentive is tied to the encounter data submission performance of its largest PPGs, as measured in the LA P4P program an example of the interconnectedness of L.A. Care's provider incentive programs.

Final performance reports and incentive payments for the 2015 program are scheduled for the 4th quarter of 2016. Additionally, \$6.6 million in incentive payments were made for the 2014 plan partner incentive programs in the 4th quarter of 2015.

Member Incentives:

The QI incentives team operated several member incentives in 2015 to improve member utilization of critical clinical services. QI operated the following incentives in 2015:

Comprehensive Diabetes Care Member Incentive

The Comprehensive Diabetes Care Member Incentive seeks to increase member completion of essential diabetes eye exams, HbA1c screenings, and nephropathy screenings. Eligible members received a mailer with member education and an incentive offer (\$50 gift card award) for completion of all three exams. The 2015 program targeted L.A. Care Medi-Cal (direct) and L.A. Care Covered members with gaps in

nephropathy care and recent history of primary care utilization. Incentive payments through December 2015 totaled \$19,150 while additional awards for services in 2015 are pending.

Adolescent Immunization Member Incentive

The Adolescent Immunization Member Incentive seeks to increase member completion of meningococcal and Tdap vaccines. Incentive materials sent to eligible members and their parents underscored the importance of these vaccines, and members could receive a \$25 gift card award for timely completion of all shots. The incentive was offered in L.A. Care Medi-Cal (direct) and L.A. Care Covered to members with gaps in care in a specified age range. Incentive payments through December 2015 totaled \$5,625 while additional awards for services in 2015 are pending.

HPV Vaccine Member Incentive

The HPV Vaccine Member Incentive seeks to increase member completion of the HPV vaccine series. Incentive materials sent to eligible members and their parents underscored the importance of the vaccine, and members could receive a \$25 gift card award for timely completion of the series. The incentive was offered in L.A. Care Medi-Cal (direct) and L.A. Care Covered to members in a specified age range who were missing some or all immunizations. Incentive payments through December 2015 totaled \$3,750 while additional awards for services in 2015 are pending.

Childhood Immunization Member & Physician Incentives

This incentive seeks to increase member completion of vaccines in Childhood Immunization Status Combo 3. Incentive materials sent to parents/guardians of members underscored the importance of these vaccines, and offered a \$25 gift card award for their timely completion. The incentive was offered to L.A. Care Medi-Cal (direct) members in a specified age range who were missing some or all immunizations. The member incentive was paired with a physician-level incentive for submission of immunization records for eligible members. Physicians could receive \$25 per completed series for eligible members in Medi-Cal, including members with L.A. Care's health plan partners. Incentive payments through December 2015 totaled \$8,300 while additional awards for services in 2015 are pending.

National Committee for Quality Assurance (NCQA) Health Plan Accreditation Score

NCQA publicly reports an annual summarized plan performance for L.A. Care's Medi-Cal plan based on its latest score for Health Plan Standards and the current year's HEDIS and CAHPS reported rates. The following report lists the accreditation type, accreditation expiration date, date of next review and accreditation in a report card that is also available on the NCQA website. This report card provides a summary of overall plan performance on a number of standards and measures through an accreditation star rating comprised of five categories (access and service, qualified providers, staying healthy, getting better, and living with illness).

Accreditation Summary Report

Accreditation Summary Report

8/24/2015

Org Name: **Local Initiative Health Authority, dba L.A. Care Health Plan**
Accred Code: **CA052**

Last HEDIS® Review Based on HEDIS® 2015

Product Line : Medicaid HMO

Accreditation Status : Accredited

Last Survey Date : 4/30/2014

Effective Date : 7/10/2014

	Points	Number of Stars
Access & Service	87.1	3
Getting Better	57.9	1
Living with Illness	53.9	0
Quality Providers	87.9	3
Staying Healthy	76.8	2

* Standards Scores : 50.0000

*EOC Score : 20.3676

CAHPS Score : 5.8356

*Total HEDIS® Score : 26.2032

Total Score : 76.2032

Next HEDIS® Review Based on HEDIS® 2016

Standards Score Expiration : 7/10/2017

* Total scores may not appear to total as all numbers are truncated for display purposes only. All total scores and star calculations are based on actual, not truncated, numbers.

Standards Only Scoring	
Points	No. Of Stars
80 - 100	3
65 - 79.9999	2
55 - 64.9999	1
0 - 54.9999	0

Standards Plus HEDIS Scoring	
Points	No. Of Stars
90 - 100	4
80 - 89.9999	3
65 - 79.9999	2
55 - 64.9999	1
0 - 54.9999	0

The following tables are the 2014 and 2015 NCQA Accreditation Scores/Status for the Medi-Cal HMO plan. The total score is based on the combined allocated points for the Standards, HEDIS rates and CAHPS results (see the Scoring Chart below). The plan achieved a 79.63 score in the 2014 Accreditation cycle and a 76.20 score in the 2015 NCQA calculated score. The variance is the amount of points needed to achieve the total available points for that category.

2014 Scoring			2015 Scoring				
	Available Points	L.A. Care Score		Available Points	L.A. Care Score		
			Variance		Variance		
Standards	50.00	50.00	0.00	Standards	50.00	50.00	0.00
HEDIS	37.00	21.31	15.69	HEDIS	37.00	20.3676	16.63
CAHPS	13.00	8.32	4.68	CAHPS	13.00	5.8356	7.16
TOTAL	100.00	79.63	20.37	TOTAL	100.00	76.20	23.80
Accreditation Status:	Accredited			Accreditation Status:	Accredited		

The variance between the two accreditation scores is a decrease in 3.43 points from 2014 to 2015

Medi-Cal HMO Scores

2014 Score	2015 Score
79.63	76.20

NCQA Scoring Chart to determine health plan accreditation status Scoring Ranges	Stars
Excellent	90-100
Commendable	80-89.99
Accredited	65-79.99
Provisional	55-64.99
Denied	0-54.99

Medi-Cal HMO is currently at the Accredited Status. In order to achieve the next level up of “Commendable,” the plan needs to increase its current score of 76.20 by 3.80 points. In order to achieve “Excellent,” the plan needs to increase its current score by 13.80 points.

Points Needed to Achieve Next Level	
Level	Points
Commendable	3.7968
Excellent	13.7968

The current status is valid through July 2017. The next onsite review of the Medi-Cal HMO plan will be in April 2017. L.A. Care will also be submitting the Cal MediConnect (CMC) and L.A. Care Covered (LACC) health plans for NCQA Accreditation in April 2017.

The L.A. Care Covered plan was included in the 2014 NCQA submission as an add-on and was given “Accredited” status based on the standards alone. No CAHPS or HEDIS data for LACC was available for submission. The Cal MediConnect line of business will be submitted for its initial NCQA accreditation in 2017.

NCQA Distinction in Multicultural Health Care

Cultural competency is a necessary component of a high quality health care system. L.A. Care was awarded with the National Committee for Quality Assurance (NCQA) Multicultural Health Care (MHC) Distinction for our Medicaid, Medicare, and Commercial products with a score of 98 from a total of 100. The Distinction recognizes organizations as industry leaders that provide culturally and linguistically appropriate services while reducing health care disparities. This achievement is a testimony to L.A. Care’s commitment and dedication to providing accessible, high quality multicultural health care to our diverse membership. As a result of this distinction, Covered California publically acknowledged L.A. Care as a leader in this area.



QI COMMITTEE SUMMARY

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

Compliance and Quality Committee (C&Q)

The Compliance and Quality Committee (C&Q) is a subcommittee of the Board of Governors (BoG). The C&Q monitors quality activities and reports its findings to the BoG. The Compliance and Quality Committee is charged with reviewing the overall performance of L.A. Care's quality program and providing direction for action based upon findings to the BoG. The C&Q met six (6) times in 2015. The Compliance and Quality Committee reviewed and approved the 2015 QI and UM program descriptions, 2015 QI and UM work plans, quarterly QI work plan reports, and 2014 evaluations of the QI and UM programs. The Committee also reviewed periodic reports on quality activities.

Quality Oversight Committee

The Quality Oversight Committee (QOC) is a cross functional staff committee of L.A. Care which reports to the Board of Governors through the Compliance and Quality Committee. The QOC is charged with aligning organization-wide quality improvement goals and efforts prior to program implementation and monitoring the overall performance of L.A. Care's quality improvement infrastructure. The QOC met eight (8) times in 2015. The Quality Oversight Committee conducted the following activities:

- Reviewed current projects and performance improvement activities to ensure appropriate collaboration and minimize duplication of efforts.
- Conducted as well as reviewed quantitative and qualitative analysis of performance data of reports and subcommittee reports.
- Identified opportunities for improvement based on analysis of performance data.
- Tracked and trended quality measures though quarterly updates of the QI work plan and other reports.
- Reviewed and made recommendations regarding quality delegated oversight activities such as reporting requirements on a quarterly basis.
- Reviewed, modified, and approved policies and procedures.
- Reviewed and approved the 2015 QI and UM program descriptions, 2015 QI and UM work plans, quarterly QI work plan reports, and 2014 evaluations of the QI and UM programs.

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

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

The Joint PICC and PQC met four (4) times in 2015. The Joint PICC and PQC contributions in 2015 included:

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

Utilization Management Committee

The Utilization Management Committee (UMC) is responsible for overall direction and development of strategies to manage the UM Program. The Committee met five (5) times in 2015. The UM Committee assessed the utilization of medical services, reviewed and made recommendations regarding utilization management and case management, reviewed and made recommendations regarding UM program activities. The UMC was also responsible for the review, revision and approval of all 2015 UM policies and procedures, 2015 UM and Care Management (CM) program descriptions, the 2015 UM and CM Program Work Plans, and the 2015 UM and CM program evaluations.

Credentialing Committee

The Credentialing Committee addressed credentialing, recredentialing activities and demonstrated follow-up on all findings and required actions. The Committee met 10 times in 2015. The Credentialing Committee reviewed L.A. Care's credentialing and recredentialing activities, policies and procedures, made recommendations for each practitioner regarding credentialing delegated oversight activities, made recommendations regarding credentialing and recredentialing for each practitioner, and coordinated peer review activities.

Peer Review Committee

The Peer Review Committee (PRC) addressed peer review activities to assess and improve the quality of care and demonstrated follow-up on all findings and required actions. The Committee met seven (7) times in 2015. The Peer Review Committee is responsible for overseeing the quality of medical care in order to determine whether accepted standards of care have been met by investigating and resolving potential problems brought to the PRC as potential quality of care issues (PQI) or PQIs. The Committee also provided oversight of all closed and delegated PQI cases.

Pharmacy Quality Oversight Committee (PQOC)

The PQOC Committee is responsible for oversight of the P&T process administered by the existing Pharmacy Benefit Manager (PBM) and review new medical technologies or new applications of existing technologies. This is for all L.A. Care direct lines of business. The PQOC's role is to review and evaluate drugs and drug therapies to be added to, or deleted from, the formulary and to review new medical technologies or new applications of existing technologies and recommend for benefit coverage, based on medical necessity.

Additionally, the PQOC provides a peer review forum for L.A. Care's clinical policies, provider communication strategies, pharmaceutical quality programs/outcomes, and specialty drug distribution options.

This Committee met four (4) times in 2015 and conducted the following activities:

Oversight/Advisory of PBM Vendor

1. Review newly marketed drugs for potential placement on the formulary.
2. Provides input on new drug products to Navitus P&T.
 - a. L.A. Care has the ability to overrule a Navitus P&T formulary and/or utilization control decision when required by regulation or unique member characteristics in the health plan.
3. Develop protocols and procedures for the use, of and access to, non-formulary drug products.

L.A. Care Strategic and Administrative Operations

1. Specialty pharmaceutical patient management and distribution strategies.
2. Pharmaceutical care program selection and evaluation.
3. Develop, implement and review policies and procedures that will advance the goals of improving pharmaceutical care and care outcomes.
4. Serve the health plan in an advisory capacity in matters of medication therapy.
5. 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.

Member Quality Service Committee (MQSC)

The Member Quality Service Committee (MQSC) is responsible for improving and maintaining the L.A. Care member experience for all product lines. This Committee met four (4) times in 2015. The committee reviewed analysis the following sources to identify opportunities for improvement in member satisfaction as identified in the following: Member Satisfaction Surveys, Member Retention Reports, Access & Availability Surveys, Grievances & Appeals Data, and Interface of Provider Satisfaction with Member Satisfaction. The committee also acts as a Steering Committee for member quality service issues.

Behavioral Health Quality Improvement Committee

The Behavioral Health Quality Improvement Committee (BHQIC) is responsible for developing, implementing and monitoring interventions based on the analysis of collected data that result in an improvement in continuity and coordination of medical and behavioral health care (mental health and substance abuse). L.A. Care delegated specialty behavioral health services for Healthy Kids, and PASC-SEIU Home Workers, Cal MediConnect, and Medi-Cal members to an NCQA accredited Managed Behavioral Health Organization (MBHO). L.A. Care worked closely with its MBHOs in order to collaborate with behavioral health practitioners (BHPs) and use information collected to improve and coordinate medical and behavioral health care. This committee met four (4) times in 2015. The Committee performed substantive review and analysis of quarterly reports from the MBHO; assessed exchange of information between BHPs and PCPs, assessed appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care settings, assessed appropriate use of

psychopharmacological medications and consistent guidelines for prescribing by behavioral and medical practitioners. Using quantitative data and causal analysis, L.A. Care and MBHO identified and took action on areas of opportunity annually.

L.A. Care is collaboratively working with the MBHO as well as the County Department of Mental health (DMH) and Department of Public Health/Substance Abuse Prevention & Control (SAPC) to conduct activities to improve coordination of behavioral healthcare and physical health care providers such as Interdisciplinary Care Team and Clinical Management Team meetings. L.A. Care identified an opportunity to improve the Behavioral Health Quality Improvement Committee; therefore, enhanced the committee membership to include practitioners from the Los Angeles County DMH, SAPC, the UCLA Integrated Substance Abuse Program (UCLA ISAP), and Participating Provider Groups (PPGs). With the addition of the Autism Spectrum Disorder (ASD) Treatment Benefits to the health plans, L.A. Care has added a Manager for ASD to the Behavioral Health Department Leadership Team.

The restructure of the committee members, the committee will focus on improving quality improvement initiatives related to behavioral health aspects, avoiding duplication of efforts, improving coordination of services to members, prioritizing initiatives, and increasing collaborative efforts to include new committee members.

Continuing Medical Education Committee

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

A. CLINICAL CARE AND SAFETY

A.1 PREVENTIVE SERVICES/WELL CARE VISITS

2015 WORK PLAN GOALS*:

HEDIS Measure	2015 Medi-Cal Goal	2015 Cal MediConnect Goal
Well-Child Visits 3-6 Years (W34)	72%	
Adolescent Well-Care Visits (AWC)	59%	
Childhood Immunization Status Combination 3 (CIS-3)	78%	
Immunizations for Adolescents Combination 1 (IMA-1)	81%	
Human Papillomavirus Vaccine for Female Adolescents (HPV)		
Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	BMI: 80% Nutrition: 77% Physical Activity: 70%	
Adult Body Mass Index Assessment (ABA)	85%	
Colorectal Cancer Screening (COL)		
Flu Vaccinations for adults ages 18-64 (FVA)		
Flu Vaccination for adults ages 65 and older (FVO)		

*Please note that mammography and breast cancer screening are covered under Other Women's Health Initiatives.

HEDIS 2015 for LACC and CMC was considered a baseline year with only administrative measures collected.

Additional wellness-related care for older adults, including Annual Wellness Exam is addressed in A.2.a.

BACKGROUND

Preventive services and well-care visits play an important role in preventing disease and managing health across the age spectrum. For children, clinical guidelines recommend periodic well-care visits to monitor growth, assess development, and identify potential problems. The Healthcare Effectiveness Data and Information Set (HEDIS®) measures health plan performance on several important dimensions of care and services including annual well-care visits for children 3-6 years of age (W34) and adolescents 12-21 years of age (AWC); a number of childhood immunizations (CIS); immunizations for adolescents (IMA-1) which includes meningococcal and Td/Tdap, human papillomavirus vaccine for adolescents; and weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC); Adult body mass index assessment (ABA) was another HEDIS measure that focused on preventive health in the adult population. Providers must use codes specified by HEDIS when completing encounter forms as well as provide medical record documentation. For example, during a Well Child or Adolescent Well Care visit, the provider must document that all five mandatory visit components were completed in the medical record: health history; physical developmental history; mental developmental history; physical exam; and health education/anticipatory guidance.

Maintaining a healthy weight is vital in reducing the risk of many chronic diseases such as diabetes, hypertension, and certain cancers like colon cancer, thus L.A. Care works to address the obesity epidemic

by increasing awareness of strategies to prevent chronic diseases and treat obesity, such as promoting body mass index (BMI) assessment in children (WCC) and adults (ABA) and encouraging preventive services like colorectal cancer screening (COL) for adults. Additionally, L.A. Care works to enhance community-driven and patient centered disease prevention and health promotion efforts through activities and programs offered through several L.A. Care departments, including Health Education, Community Outreach and Engagement (CO&E), and Family Resource Centers (FRCs) and external partnerships with organizations such as the American Cancer Society.

MAJOR ACCOMPLISHMENTS

- L.A. Care's Medi-Cal 2015 HEDIS rate for Adult BMI Assessment exceeded the 2015 goal.
- In 2015, Childhood and Adolescent Wellness Flyers for Providers that detail recommended health services, such as the W34, CIS-3, AWC, and WCC HEDIS measures, for appropriate age groups, were sent to Medi-Cal and L.A. Care Covered providers.
- L.A. Care addressed several preventive services/well care measures through a continued and expanded QI Incentives strategy which engages providers, physician groups, and plan partners in the QI process through the use of benchmarking, performance reporting, and incentive payments. Below are some 2015 highlights of various QI Incentive programs (with included preventive services/well care measures noted in parentheses):
 - For the LA P4P Pay-for-Performance (LA P4P) provider group incentive program (W34, CIS-3, AWC) and the Physician Pay-for-Performance (P4P) provider incentive program (W34, CIS-3, AWC), the W34 and CIS-3 measures were doubly weighted in calculating payments in 2015. As part of the Plan Partner Incentive Program, clinical quality measures such as W34 and CIS-3 were targeted to improve the health outcomes of members.
- Additionally, member and physician specific incentives in 2015, included:
 - A limited October 17- December 31, 2015 incentive for MCLA Medi-Cal members turning two years that need to receive all CIS-3 vaccines; eligible members' guardians are able to receive a \$25 Target GiftCard if documentation from the physician shows that all CIS-3 vaccines have been administered.
 - A \$25 physician incentive for the completion and submission of eligible Medi-Cal members' CIS-3 vaccines.
 - A limited October 17-December 31, 2015 incentive for MCLA members aged 11-12 years (but under 13 years) for IMA-1 was launched; eligible members were able to receive a \$25 Target GiftCard for receiving meningococcal and Td/Tdap vaccines.
 - A limited October 17-December 31, 2015 incentive for MCLA members aged 11-12 years (but under 13 years) for HPV was launched; eligible members were able to receive a \$25 Target GiftCard for completing all three HPV vaccines. Members that were eligible for both IMA and HPV vaccines were able to receive up to \$50 in Target GiftCards for completing the targeted vaccines. The incentives were also available to LACC members only if they qualified for both IMA and HPV incentives.
- In 2015, L.A. Care showed our commitment to eliminating colorectal cancer as a major public health problem, by adding its name to the expanding list of health care organizations supporting the "80% by 2018" initiative – an initiative created by the National Colorectal Cancer Roundtable (co-founded by the American Cancer Society (ACS) and the Centers for Disease Control and Prevention (CDC) with the goal of increasing the percentage of adults 50 and older who are screened for colorectal cancer to 80 percent by 2018. A member mailer was sent to MCLA, CMC, and LACC members encouraging colorectal cancer screening by calling a number to order a stool test kit. Providers were sent a letter that explains the partnership between L.A. Care and the American Cancer Society and urges physicians to recommend the screening to their patients to meet the 80% by 2018 goal.
- In 2015, L.A. Care reminded all DLOB members to get their annual flu shot via two automated reminder calls and, for CMC members, a mailer with promotional magnifying ruler. Members in the Disease Management Programs (Asthma, Diabetes, CVD) were sent flu shot reminders to all members (except for CMC) in mid-September 2015.

- In January 2015, L.A. Care mailed a thank you card and magnet thermostat to CMC members who received the flu shot. The thank you cards were intended to enhance members' recollection of receiving the flu vaccine, thus increasing the likelihood of accurate reporting when completing the CAHPS member satisfaction survey.
- Throughout 2015, QI was involved in quarterly PPG meetings reviewing MY2014 results and discussing P4P, quality interventions, the POR and collection of supplemental data. Biweekly quality meetings with DHS were conducted to review interim QI measure results, QI interventions, and enhanced data collection.

Description of measures:

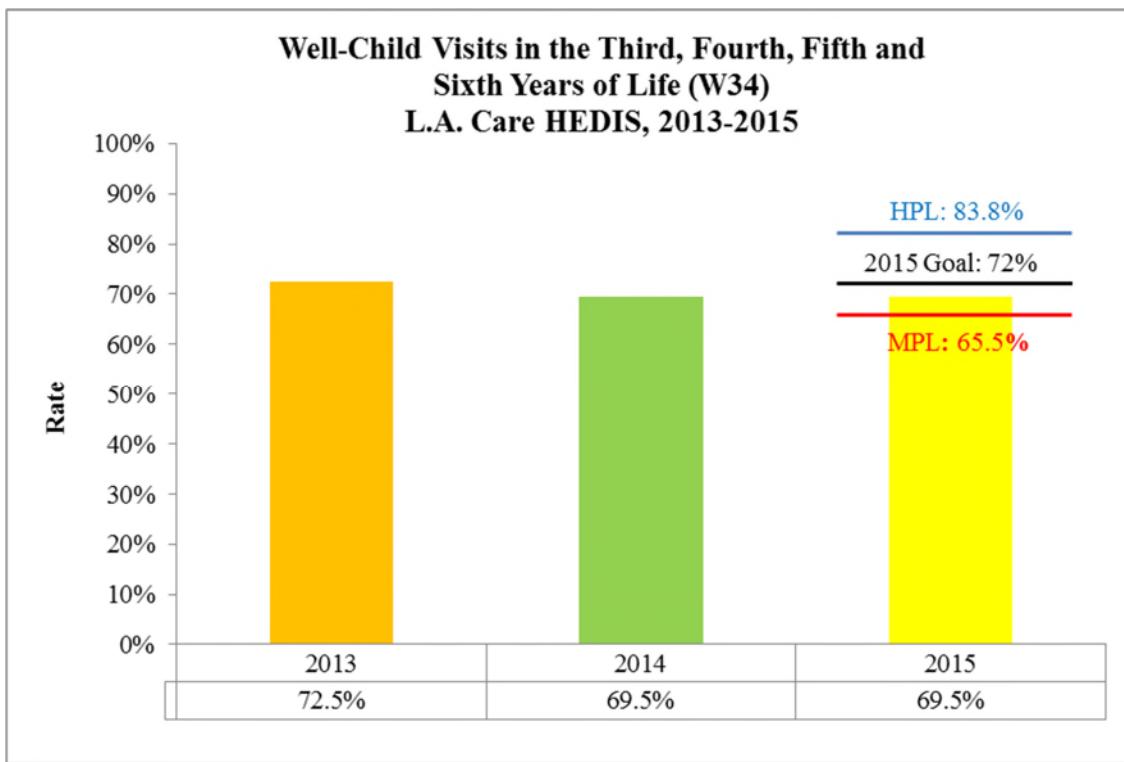
HEDIS Measure	Specific Indicator(s)	Measure Type
Well-Child Visits 3-6 Years (W34)	The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	Hybrid
Adolescent Well-Care Visits (AWC)	The percentage of members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Hybrid
Childhood Immunizations Combination 3 (CIS-3)	The percentage of children 2 years of age who had: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three Haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday.	Hybrid
Immunizations for Adolescents Combination 1 (IMA-1)	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13 th birthday.	Hybrid
Human Papillomavirus Vaccine for Female Adolescents (HPV)	The percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13 th birthday.	Hybrid
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> • BMI percentile documentation* • Counseling for nutrition • Counseling for physical activity *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value	Hybrid
Adult BMI Assessment (ABA)	The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) (or for those <19 years of age, a BMI percentile) was documented during the measurement year or the year prior to the measurement year.	Hybrid
Colorectal Cancer Screening (COL)	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer. Either FOBT during the measurement year, a flexible sigmoidoscopy during in the past 5 years, or a colonoscopy within the past 10 years.	Hybrid (for 2015, only administrative data available for reporting)
Flu Vaccinations for adults ages 18-64 (FVA)	Flu vaccinations for adults ages 18 to 64: percentage of members 18 to 64 years of age who received an influenza vaccination between July 1 of the measurement year and the date when the CAHPS 5.0H Adult Survey was completed.	CAHPS

HEDIS Measure	Specific Indicator(s)	Measure Type
Flu Vaccination for adults ages 65 and older (FVO)	The percentage of members 65 years of age and older who received an influenza vaccination between July 1 of the measurement year and the date when the CAHPS survey was completed.	CAHPS

RESULTS

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

The following graph compares L.A. Care's Medi-Cal W34 HEDIS rate from 2013, 2014, and 2015 to L.A. Care's 2015 goal.



ANALYSIS

Quantitative Analysis

In 2015, the well-child visits rate for children between three and six years of age was 69.5%, which was the same rate as the previous year. The 2015 rate of 69.5% did not reach L.A. Care's 2014 Goal of 72%; however, it exceeded the Minimum Performance Level (MPL) of 65.5%. Overall, the rate has decreased three percentage points from 2013 to 2015.

Disparity Analysis

L.A. Care also conducted an analysis (limited to the hybrid sample) based on gender, ethnicity, language, age group, SPD, and RCAC regions to examine whether disparities exist in getting well care visits for children between three and six years of age. Age group and ethnicity were the only major disparities found for the W34 measure. Six year-old children had the lowest rate (62.37%) among the age groups. Caucasian children had the highest rate (77.8%) while African American children had the lowest rate (64.7%). There were no statistically significant disparities noted.

Qualitative Analysis

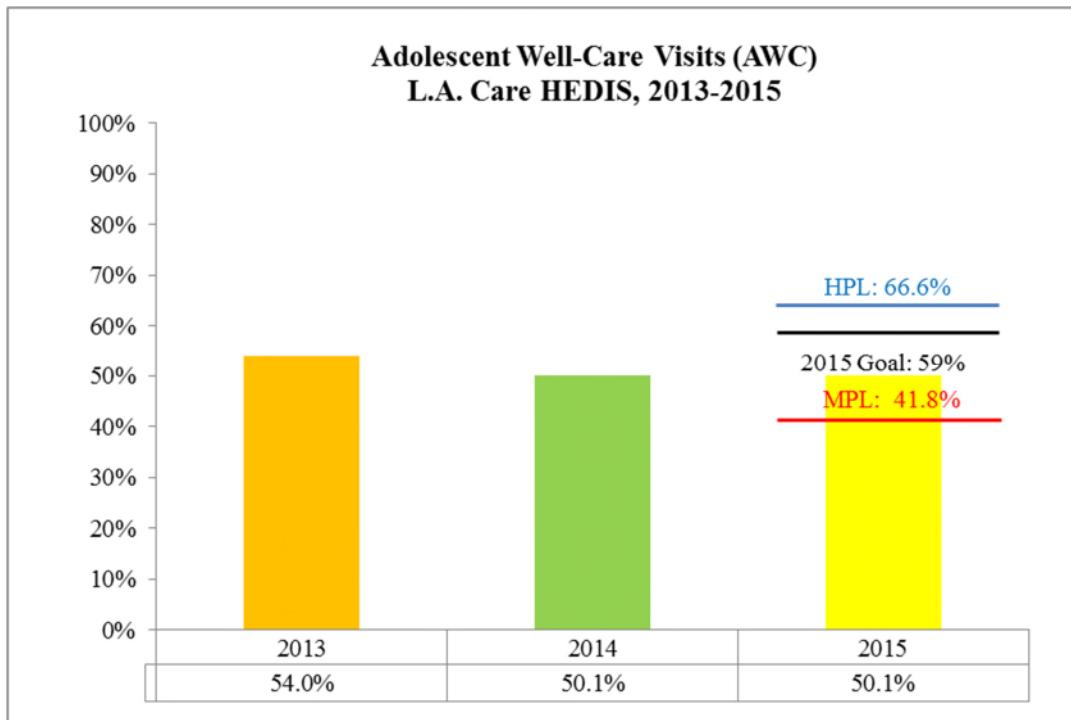
The W34 Medi-Cal HEDIS rate has presented a downward trend for the past three years. If the current trend for the W34 measure continues, L.A. Care may be at risk of falling below the MPL in 2016. L.A. Care recognized the need for additional efforts to increase the rates; therefore, implemented and reinforced several provider and member interventions in 2015.

One of the possible barriers identified in achieving a better rate is the difference in well-care visit schedules between the Child Health and Disability Prevention (CHDP) and the American Academy of Pediatrics (AAP). The CHDP periodicity table does not require annual well-care visits, while AAP does. In addressing this issue, L.A. Care provided childhood and adolescent wellness flyers to solo and small group providers that detail HEDIS-related health services that are recommended for age groups. Provider opportunity reports that lists patients needing care to encourage outreach to these patients missing services were also distributed. Lastly, W34 is a measure in the Physician P4P, LA P4P and Plan Partner P4P incentive programs.

RESULTS

Adolescent Well-Care Visits (AWC)

The following graph compares L.A. Care's Medi-Cal AWC HEDIS rate from 2013, 2014, and 2015 to L.A. Care's 2015 goal.



ANALYSIS

Quantitative Analysis

L.A. Care's Adolescent Well-Care (AWC) visit rate in 2015 was 50.1% due to measure rotation. Measure rotation is the use of audited and reportable hybrid method from the prior year's data collection in lieu of collecting the measure for the measurement year. This is a 3.9 percentage point decrease from the 2013 rate of 54.0%. L.A. Care did not meet its 2015 goal of 59%; however, it exceeded the MPL of 41.8%.

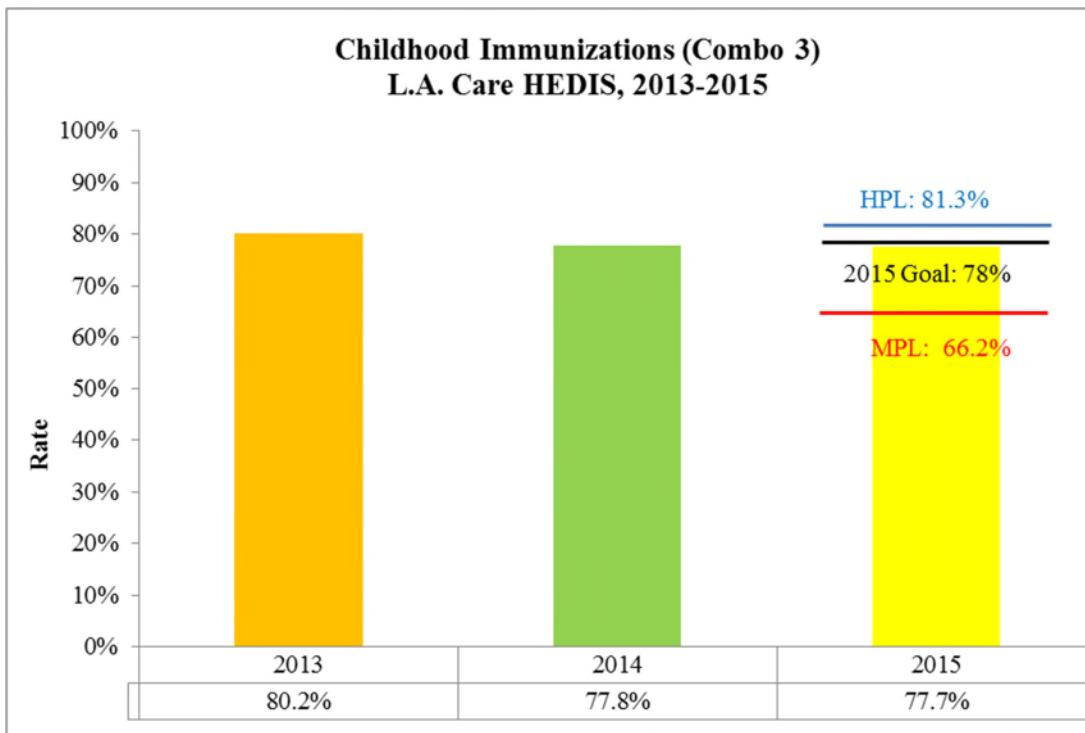
Qualitative Analysis

Encouraging adolescents to get a well-care visit has been an ongoing challenge. L.A. Care's Adolescent Well-Care Visits HEDIS rate improved in 2012 and 2013 from the 2011 rate, however in 2014/2015 the AWC rate is nearly back to the 2011 rate of 49.2. L.A. Care has taken on a multi-disciplinary approach to address adolescent well-care, including incentives for provider groups and physicians and provider education. The AWC measure was included in year 5 and remains part of the Physician Pay-for-Performance program for Medi-Cal and also the LA P4P Incentive program. The incentive programs targeting immunizations for adolescents (IMA-1) and/or Human Papillomavirus Vaccine for Female Adolescents (HPV) that were launched in October 2015 may have had a positive impact on AWC rates (the HPV incentive was expanded to include eligible adolescent boys). L.A. Care provided childhood and adolescent wellness flyers to 1,965 solo and small group Medi-Cal and LACC providers that detail HEDIS-related health services that are recommended for age groups.

RESULTS

Childhood Immunization Status, Combination 3 (CIS-3)

The following graph compares L.A. Care's Medi-Cal CIS-3 HEDIS rate from 2013, 2014, and 2015 to L.A. Care's 2015 goal.



ANALYSIS

Quantitative Analysis

L.A. Care's Childhood Immunization Status, Combination 3 rate in 2015 was 77.7%, showing little change compared to 2014 (77.8%). L.A. Care did not meet its 2015 goal of 78%; however, it exceeded the MPL of 66.2%. Overall the rate has decreased 2.5 percentage points from 2013 to 2015.

Disparity Analysis

L.A. Care also conducted an analysis (limited to the hybrid sample) based on gender, ethnicity, language, age group, SPD, and RCAC regions to examine whether disparities exist in getting childhood

immunizations for children two years of age. Male toddlers had a higher rate (80.2%) compared to 74.9% among female toddlers. Spanish-speakers had a statistically significantly higher CIS-3 rate (85.4%) compared with English speakers (73.5%).

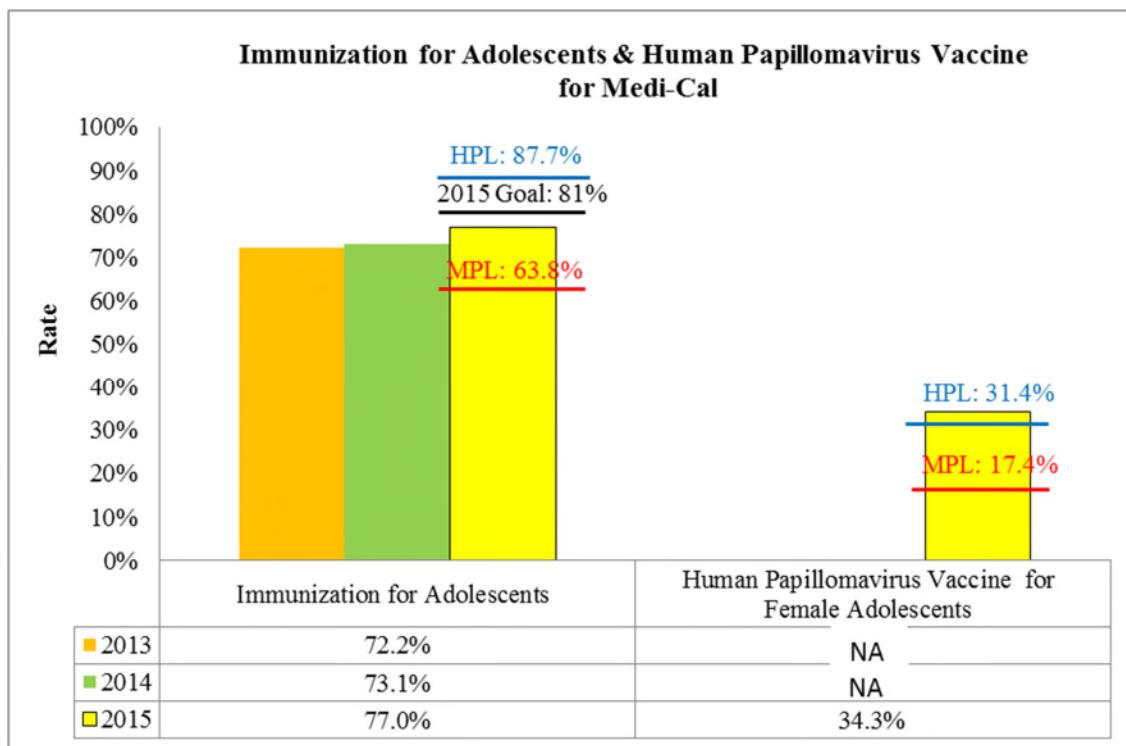
Qualitative Analysis

The HEDIS rate for CIS-3 demonstrates a slowly declining three year trend. The complexity of the immunization schedule and lack of education about the importance of basic vaccination series to members' guardian(s) may be some of the factors why members are not getting immunized as recommended. In order to address this, L.A. Care also sent out provider opportunity reports and made the member detail report available at the L.A. Care provider portal. The provider opportunity reports were sent out in July, September, and November 2015 that contain administrative data only. Physicians can identify members in his/her panel needing immunizations from the posted list and perform outreach to those patients needing care. However, due to the time-sensitive nature of the measure, it is better to use near real-time data from CAIR to outreach to children in receiving timely CIS-3 vaccines. L.A. Care provided childhood and adolescent wellness flyers to solo and small group providers that detail HEDIS-related health services that are recommended for age groups. CIS-3 is also a measure in the Physician, LA, and Plan Partner P4P programs. Additionally, member and physician incentive programs for CIS-3 were launched to eligible members; members' guardians were eligible to receive a \$25 Target GiftCard, while physicians were eligible to receive a \$25 check for sending in completed CIS-3 documentation.

RESULTS

Immunization for Adolescents (IMA-1) and Human Papillomavirus Vaccine for Female Adolescents (HPV)

The following graph compares L.A. Care's Medi-Cal IMA-1 HEDIS rate from 2013, 2014, and 2015 to L.A. Care's 2015 goal, and also looks at the 2015 HEDIS rate for HPV.



ANALYSIS

Quantitative Analysis

Over the past three years, the Immunization for Adolescents (IMA-1) rate for the Medi-Cal population has been increasing. Since 2013, the rate has risen 4.8 percentage points from 72.2% in 2013 to 77.0% in 2015. The 2015 rate exceeded the minimum performance level of 63.8%; however, the 2015 goal of 81% was not reached. In 2015, the HPV rate for Medi-Cal members was 34.3%, which exceeded the high performance level of 31.4%.

Disparity Analysis

L.A. Care also conducted an analysis (limited to the hybrid sample) based on gender, ethnicity, language, age group, SPD, and RCAC regions to examine whether disparities exist in getting immunizations for adolescents. The only disparity was found in ethnicity, where African-Americans adolescents had a lower rate (69.7%) compared to other groups, excluding the other/unknown category.

Qualitative Analysis

For both the IMA-1 and HPV measures, member incentives aimed at increasing immunization rates for the adolescent population were launched in October 2015. Targeted members included adolescents aged 11 and 12 years (but under 13 years) that had a gap for the IMA-1 and/or the HPV measure(s). For each incentive program, the member must have gotten the required vaccines by the 13th birthday, or by December 31, 2015 (whichever came first), and were rewarded with a \$25 Target GiftCard. Members could potentially earn up to \$50 in Target GiftCards if they were eligible for both programs and received all vaccinations.

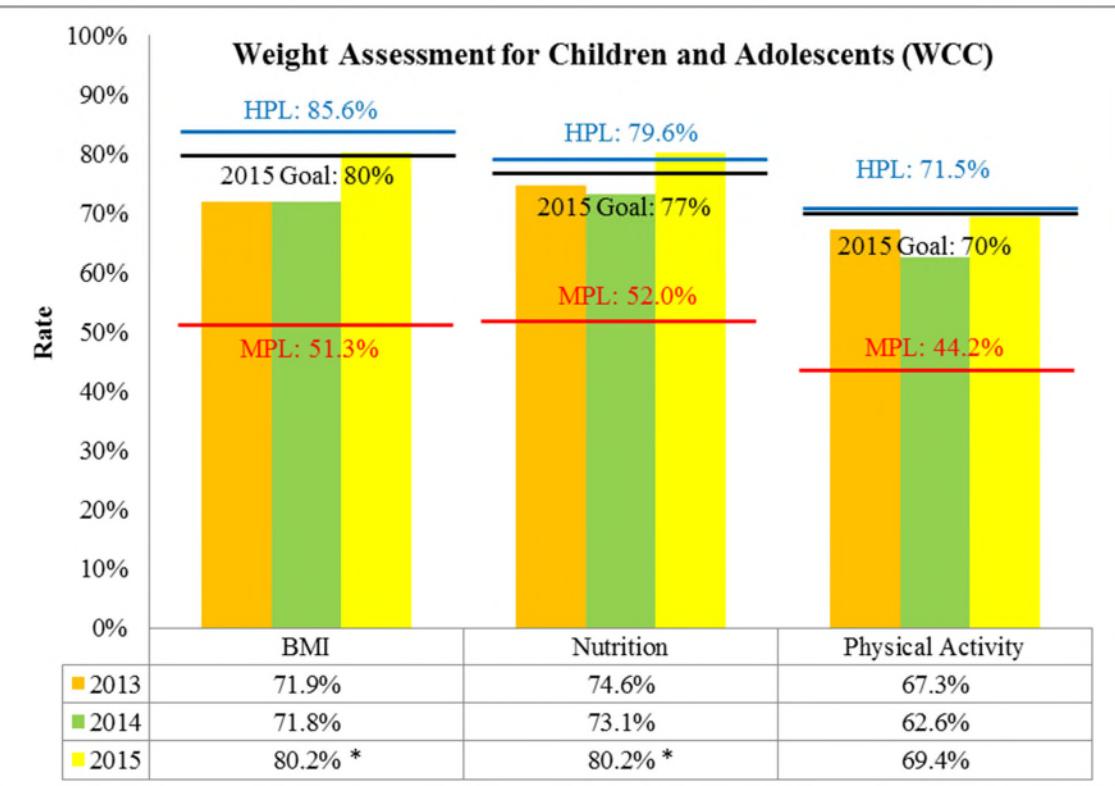
Although the HPV measure focuses solely on the female adolescent population, the HPV incentive program was expanded to include boys as the vaccine is also beneficial to them. Both measures were also included in the childhood and adolescent wellness flyers for providers, which were sent to solo and small group Medi-Cal and LACC providers. The measures were reflected specifically in the flyer targeting the 11-15 year old range.

Lastly, IMA continues to be a performance measure in the Physician and LA P4P programs.

RESULTS

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

The following graph compares L.A. Care's Medi-Cal WCC HEDIS rate in 2013, 2014, and 2015 to L.A. Care's 2015 goal.



*Statistically significant difference

Quantitative Analysis

L.A. Care's 2015 rate for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) is composed of three components: BMI assessment (WCC – BMI), counseling for nutrition (WCC – Nutrition), and counseling for physical activity (WCC – PA).

The rate for BMI assessment statistically significantly increased by 8.4 percentage points from the previous year – 80.2% in 2015 compared to 71.8% in 2014. L.A. Care's 2015 goal of 80% was met and the MPL of 51.3% was exceeded. Overall, from 2013 to 2015, the WCC – BMI rate has increased 8.3 percentage points.

The 2015 rate for counseling for nutrition was 80.2%; this was a statistically significant increase of 7.1 percentage points from the 2014 rate of 73.1%. The goal of 77% was met, and the MPL of 52% was exceeded. Overall, from 2013 to 2015, the WCC – Nutrition rate increased.

The 2015 rate for counseling for physical activity was 69.4%; this was an increase of 6.8 percentage points from the 2014 rate of 62.6%. The goal of 70% was not met; however the MPL of 44.2% was exceeded. Overall, from 2013 to 2015, the WCC – PA rate increased.

Disparity Analysis

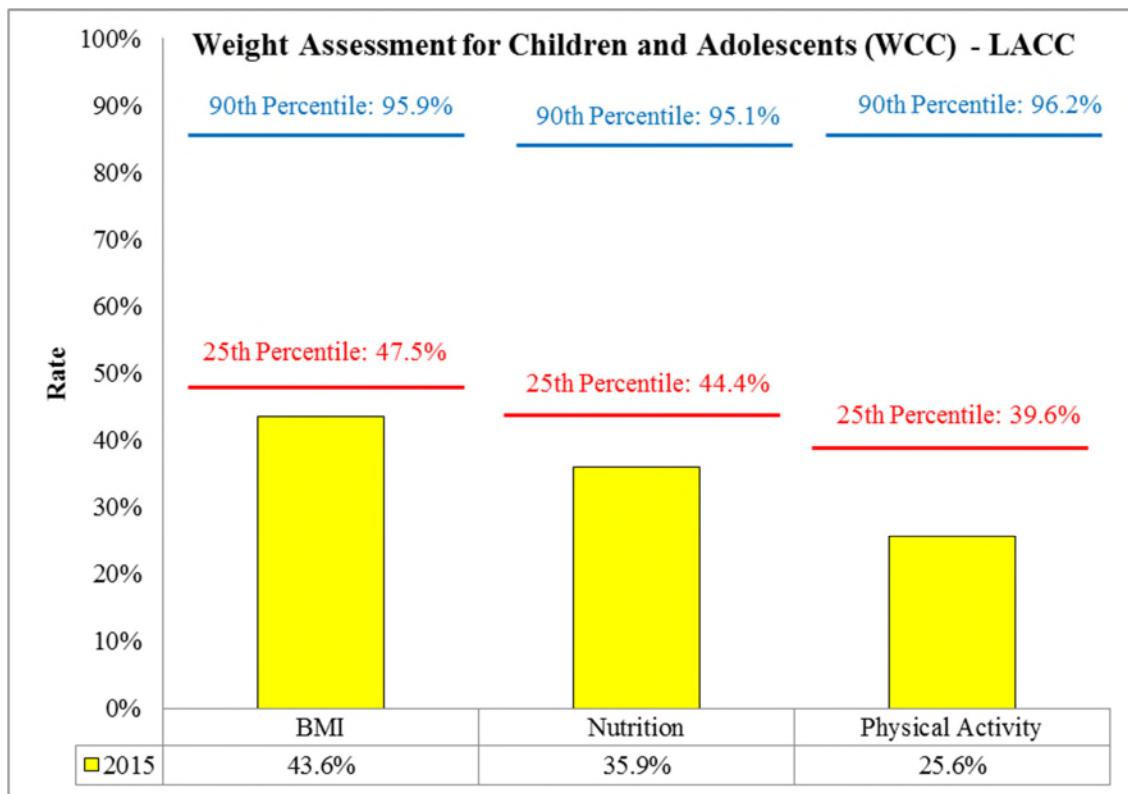
L.A. Care conducted an analysis based on gender, ethnicity, language, age group, SPD, and RCAC regions to examine whether disparities exists in Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescent for BMI.

- *BMI Assessment* – There were no statistically significant disparities found across the demographic factors.
- *Counseling for Nutrition* – No significant disparities were found for this component of the measure.
- *Counseling for Physical Activity* –There was a statistically significant difference in age group, where the older adolescent age group (12-17 years of age) had a higher rate (78%) compared to the younger age group (8-12 years of age) with a rate of 65.2%.

Qualitative Analysis

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

The following graph is a baseline WCC HEDIS rates for L.A. Care Covered.



Quantitative Analysis

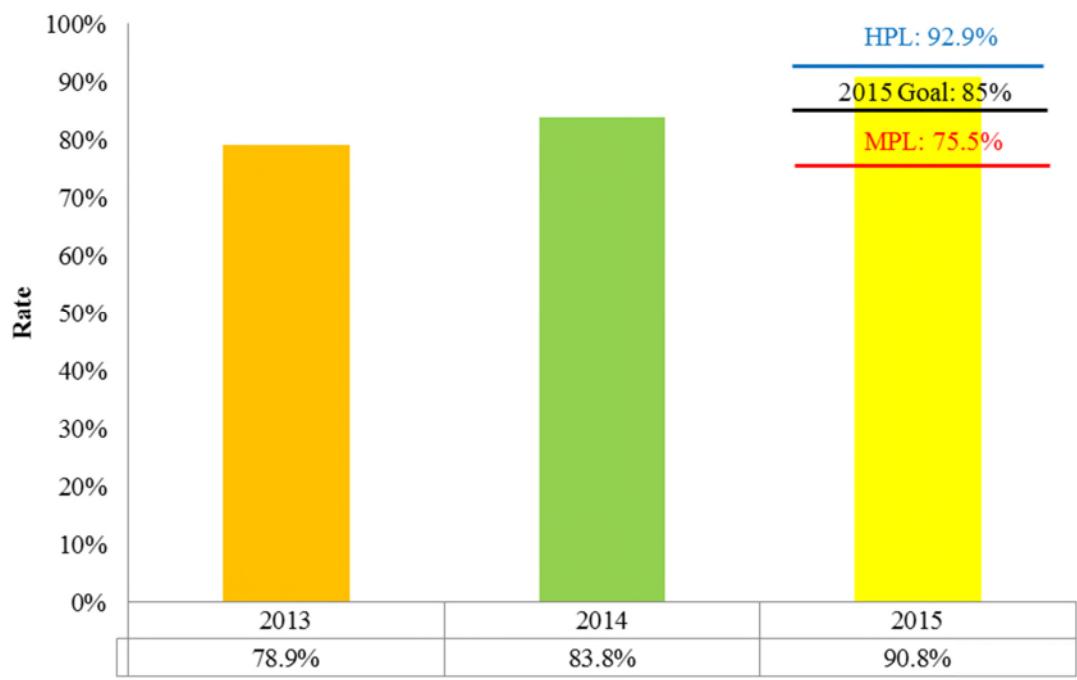
The baseline rates for WCC were 43.6%, 35.9%, and 25.6% for BMI, Nutrition, and Physical Activity, respectively. Unfortunately, the 25th percentiles for all three WCC submeasures were not met; underreporting for this measure may be explained by reporting of administrative data only. However, since 2015 was the first year for the L.A. Care Covered line of business, L.A. Care can work on increasing the rates by engaging in preventive health outreach to these new members in 2016.

RESULTS

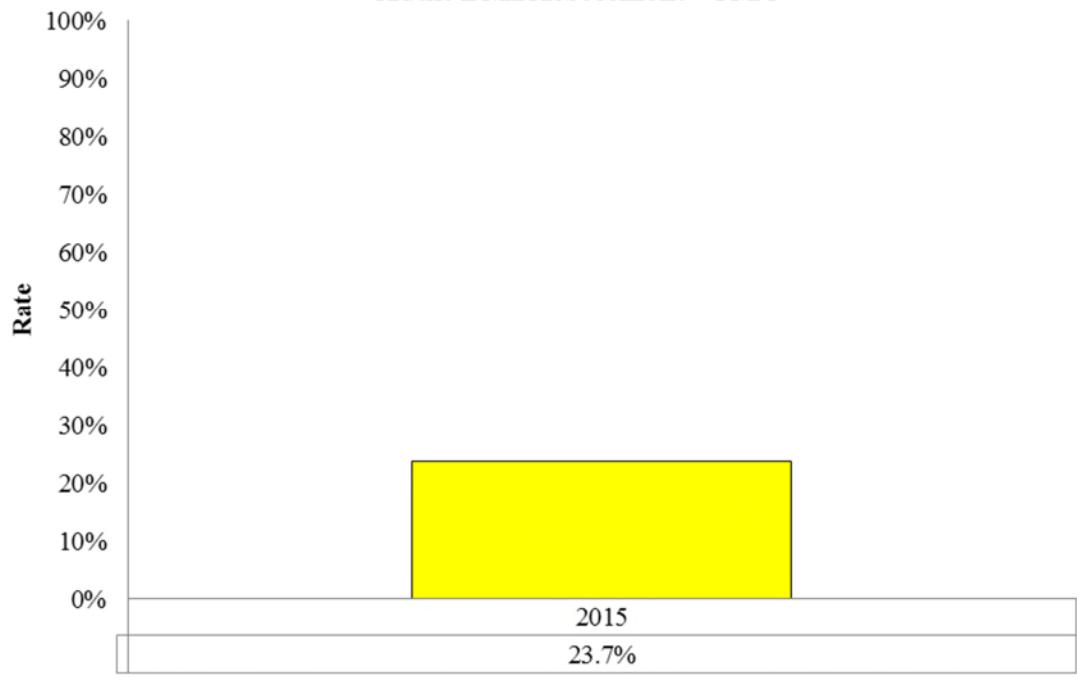
Adult BMI Assessment (ABA)

The following graph compares L.A. Care's Medi-Cal ABA HEDIS rates in 2013, 2014 and 2015 to their respective L.A. Care 2015 goals. L.A. Care's CMC ABA HEDIS baseline rate for 2015 is also depicted.

Adult BMI Assessment - Medi-Cal



Adult BMI Assessment - CMC



ANALYSIS

Quantitative Analysis

L.A. Care's Medi-Cal 2015 rate for Adult BMI Assessment (ABA) was 90.8%; an increase of 7.0 percentage points from the 2014 rate of 83.8%. L.A. Care's goal of 85% was met; however, L.A. Care fell 2.1 percentage points below the Quality Compass 90th percentile of 92.9%.

Since L.A. Care transitioned to CMC (dual demonstration) in mid-2014, rates were captured administratively on 33 measures, but HEDIS 2015 measures for Medicare were not reported. L.A. Care's CMC 2015 rate for ABA was administratively reported and came in at 23.7%. There are no previous years' data to trend and no benchmarks for comparison of the administrative ABA rate in the CMC population.

Note that in 2015, LACC was a pilot. LACC is now entering into the beta-test; therefore, the Plan rate will not be publicly reported. Our HEDIS Operations Team is working on setting up the tool to access the results from the vendor outsourced by CMS to collect this data. Once this becomes available, ABA rates for LACC we will be reported.

Disparity Analysis

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

Qualitative Analysis

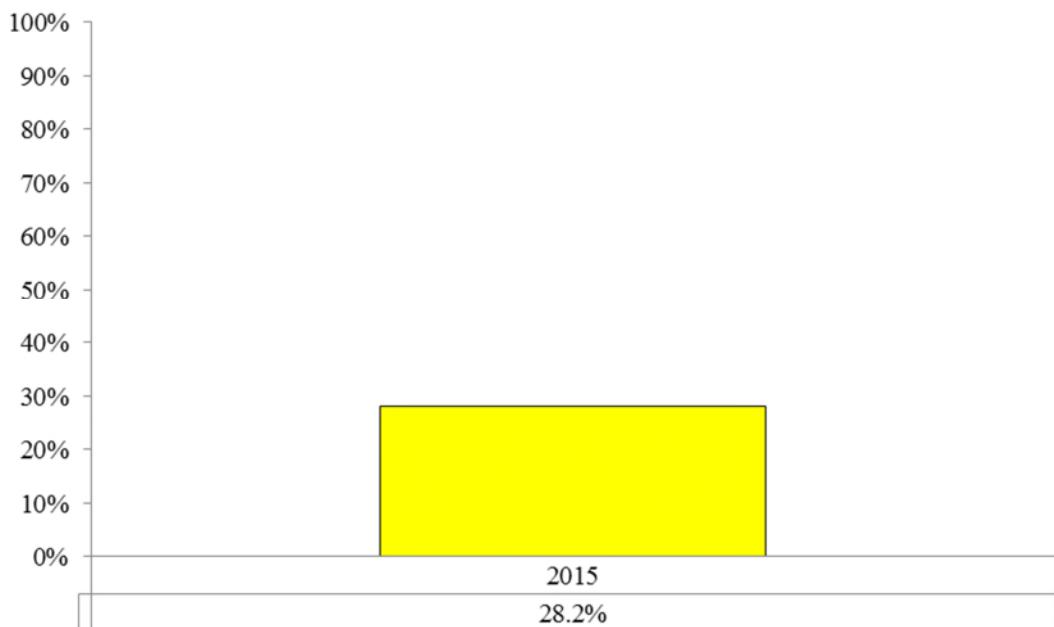
For Medi-Cal ABA rates, there has been a continued improvement from 2012 to 2015. Many factors could be influencing this positive trend, including but not limited to, increased provider utilization of BMI as a clinical indicator, a greater number of providers using EMR with the benefit of BMI being automatically calculated with the entry of member height and weight during encounters, as well as improved provider record abstraction. In 2015, HEDIS nurses addressed and educated selected providers (different from the selected providers in 2014) on the importance of proper documentation and member follow-up for needed services, which encompassed the ABA measure. With an increase awareness of their weight status, members may take a next step towards utilizing community-driven and patient centered disease prevention and health promotion resources and programs offered to members. A pilot program was implemented in partnership with AppleCare in which monthly Family Resource Center (FRC) calendars were mailed directly to L.A. Care/AppleCare members living nearby one of three participating FRCs with the goal of promoting available resources to members who may not be aware of the variety of free classes (exercise classes, nutrition, chronic disease self-management education, etc.) available at the FRCs.

RESULTS

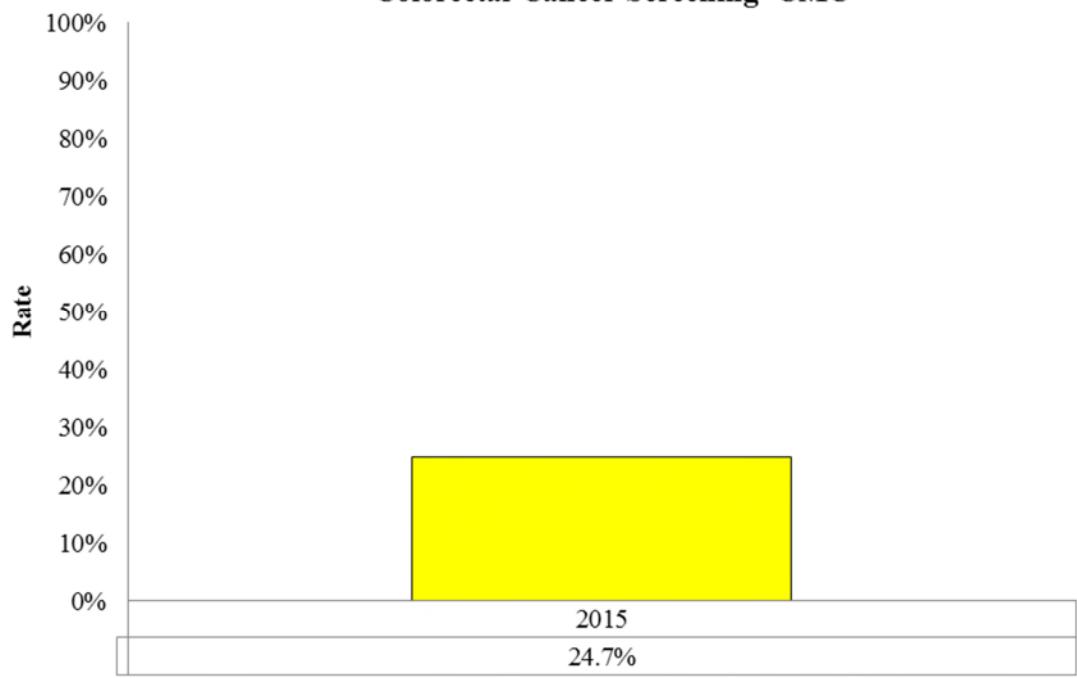
Colorectal Cancer Screening (COL)

The following graphs depicts L.A. Care's Medi-Cal and CMC COL HEDIS rate (administrative data only) for 2015.

Colorectal Cancer Screening -Medi-Cal



Colorectal Cancer Screening- CMC



ANALYSIS

Quantitative Analysis

Since L.A. Care transitioned to CMC (dual demonstration) in mid-2014, rates were captured administratively on 33 measures, but HEDIS 2015 measures for Medicare were not reported. L.A. Care's CMC 2015 rate for COL was administratively reported and came in at 24.7%. There are no previous years' data to trend and no benchmarks for comparison of the administrative COL rate in the CMC population.

The COL rate for the Medi-Cal population is not a standard reported rate, only administrative data is available to report for 2015. L.A. Care's Medi-Cal administrative rate for COL came in at 28.2%. There are no previous years' data to trend and no benchmarks for comparison of the administrative COL rate in this population.

Note that in 2015, LACC was a pilot. LACC is now entering into the beta-test, therefore the Plan rate will not be publicly reported. Our HEDIS Operations Team is working on setting up the tool to access the results from the vendor outsourced by CMS to collect this data. Once this becomes available, COL rates for LACC we will be reported.

Qualitative Analysis

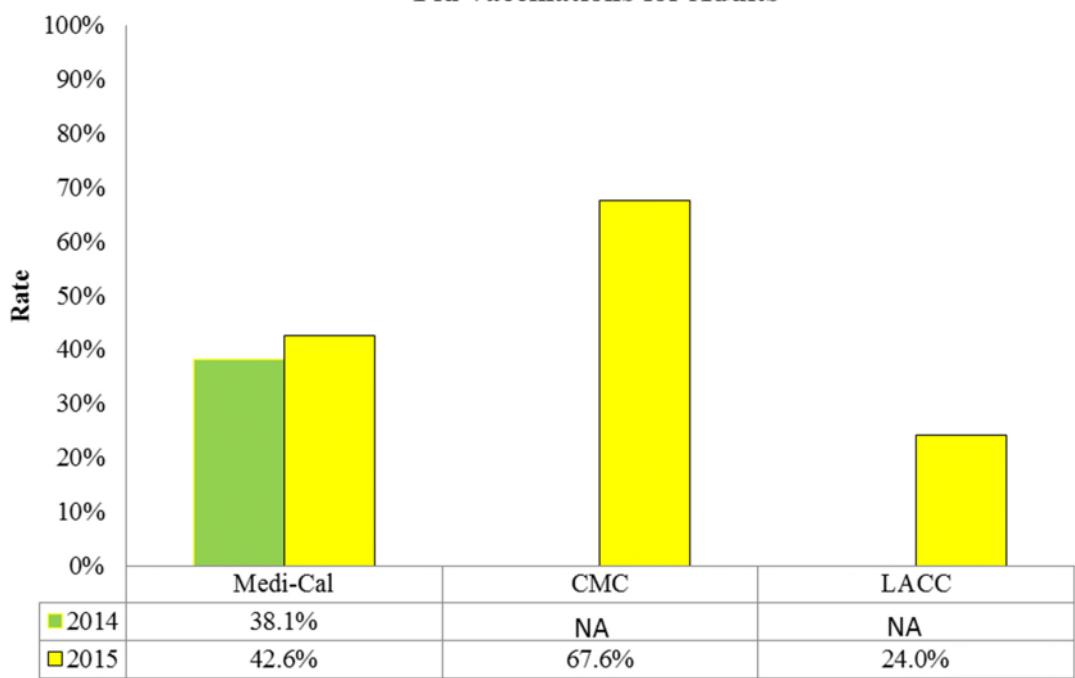
For CMC COL rate, given it was based on administrative data only, it is likely not capturing the full extent to which members have received colon cancer screening given the lengthy look-back period for this measure (up to 10 years for colonoscopy). For the D-SNP population from 2012-2014, there was a steady positive trend for the COL measure reaching the 4 STAR threshold (based on hybrid data), however this trend cannot be extrapolated to the CMC population. In 2015, initiatives to improve COL were put in place for adults 50-74 years old for all LOBs (CMC, LACC, and MCLA). L.A. Care partnered with the American Cancer Society to update educational materials and create a mailer promoting benefits of and options for colorectal cancer screening. The mailer gave the members an option to call and leave a message if they desired to get a Fit kit mailed to their residence.

RESULTS

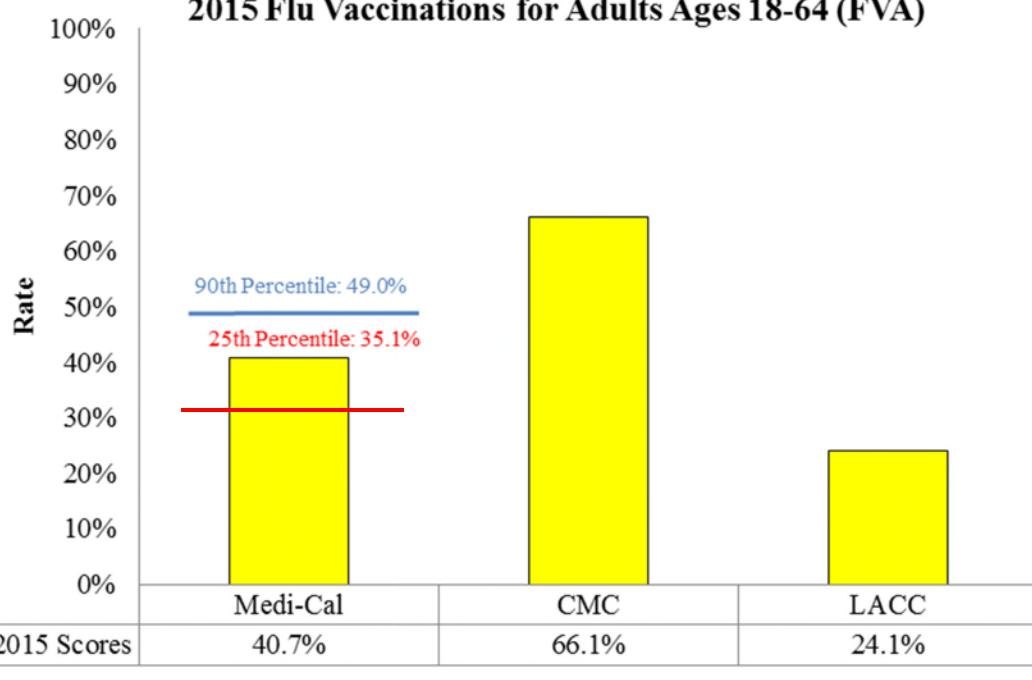
Flu Vaccinations for Adults (FVA & FVO)

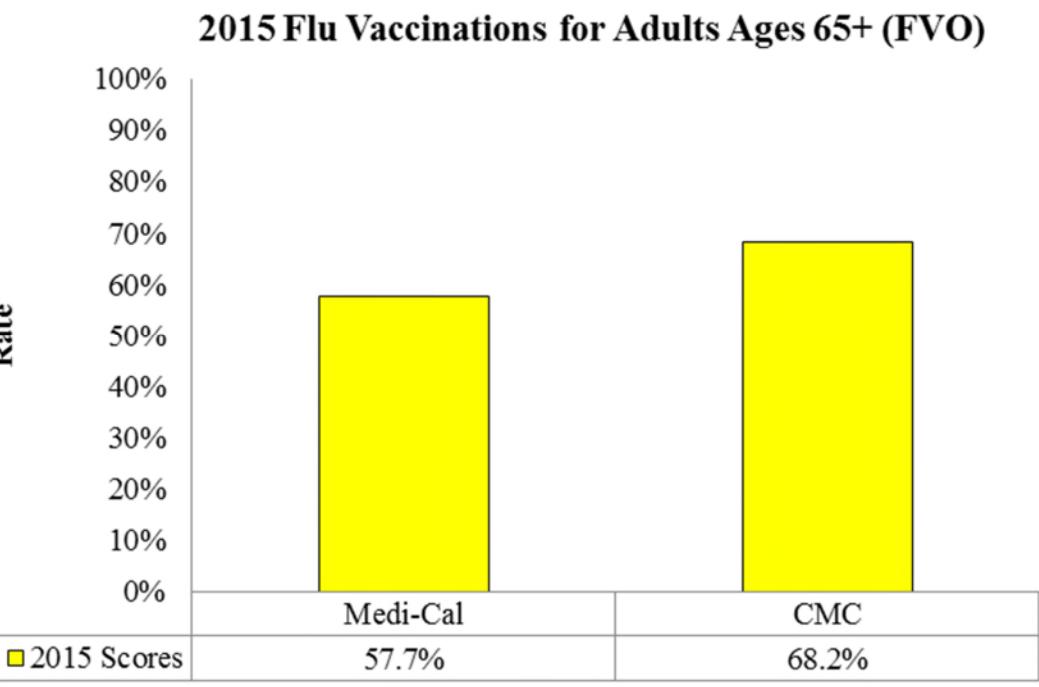
The following graph compares L.A. Care's Medi-Cal, Medicare, and LACC rates for flu vaccination in adults in 2014 and 2015. The subsequent graphs break down the rates into the two measures by age (FVA & FVO).

Flu Vaccinations for Adults



2015 Flu Vaccinations for Adults Ages 18-64 (FVA)





ANALYSIS

Quantitative Analysis

L.A. Care's Medi-Cal 2015 rate for Flu Vaccination for Adults (FVA & FVO) was 42.6%; an increase of 4.5 percentage points from the 2014 rate of 38.1%. This question was new in 2014, so no data is available for 2013. L.A. Care's Medi-Cal rate of Flu Vaccination for Adults Ages 18-64 fell below the Quality Compass 75th percentile of 44.83% by 4.1 percentage points. Formal goals were not set for 2015; however, a goal of 45% for Medi-Cal will be targeted for 2016.

L.A. Care's CMC 2015 rate for flu vaccination was 67.6%. This is a decrease of 7.0 percentage points from the 2014 DSNP rate; however, the two Medicare populations are not identical. L.A. Care fell below the FVO Base Group 3 threshold of 69% by a fraction of a percentage point, although Stars scores have not yet been reported.

L.A. Care's LACC 2015 rate for flu vaccination was 24.1%. This is the first year the data was collected.

Disparity Analysis

L.A. Care conducted an analysis within the Medi-Cal population based on gender, ethnicity, language, age group, and RCAC regions to examine whether disparities exists in flu vaccination rates.

For the Medi-Cal population (18-64), rates differed by race, with Black members reporting the lowest rate (25.5%, compared to 39.3% for White members and 48.4% for Hispanic members). Spanish speaking members were 5.6 percentage points more likely to receive the flu shot. Members in RCAC 8 were the least likely to receive the flu shot (difference of at least 8.9 percentage points).

For the CMC population, members ages 75 and older were 20.5 percentage points more likely to get the flu vaccine than members ages 65 to 74. Spanish speakers were 11.1 percentage points more likely to report receiving the flu vaccine than English speakers.

For the LACC population, members ages 18 to 34 and male members were less likely to report receiving the flu vaccine.

Qualitative Analysis

The flu vaccination measures are new questions for Medi-Cal and LACC (two and one years of scores, respectively). Because these are the baseline scores, it is difficult to evaluate the effectiveness of interventions. While the flu vaccination rate for CMC fell from historical DSNP rates, comparing the two scores should be avoided given that the populations differ. As data is collected for subsequent years, the impact of interventions will be analyzed.

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

HEDIS Measure	Barrier	Action	Effectiveness of Intervention/Outcome
Well-Child Visits 3 to 6 Years (W34)	<ul style="list-style-type: none"> • Providers continue to follow the CHDP periodicity table (rather than the AAP schedule), which does not require annual Well-Care visits. • Conflicting information for providers from AAP and CHDP as to the recommended Well-Care visit schedules. • Missing documentation of key elements. • Large eligible population. • Members/Caregivers do not perceive the importance of Well-Child visits. 	<ul style="list-style-type: none"> • Childhood and adolescent wellness flyers were sent in August 2015 to solo and small group providers that detail HEDIS-related health services that are recommended for different age groups; WC34 was one of the measures represented in the flyer • L.A. Care continued the Physician, LA, and Plan Partner P4P incentive programs for Medi-Cal, which includes the W34 HEDIS measure. The W34 measure was doubly weighted in calculating LAP4P payments in 2015. • Provider Opportunity Reports were provided (July, September, and November 2015) to inform groups and providers of their year to date performance to encourage outreach to members in need of the service. • Preventive health guidelines which include well-child visit schedule are available at L.A. Care website for both providers and members. 	See results above
Adolescent Well-Care Visit (AWC)	<ul style="list-style-type: none"> • Adolescent members do not want to attend a clinic that caters to young children. • Providers indicate that it's very difficult to get teens into the office. 	<ul style="list-style-type: none"> • Childhood and adolescent wellness flyers were sent in August 2015 to solo and small group providers that detail HEDIS-related health services that are recommended for different age groups; AWC was one of the measures represented in the flyer • Provider Opportunity Reports were provided (July, September, and November 2015) to inform groups and providers of their year to date performance to encourage outreach to members in need of the service • This measure was included in both LAP4P and Physician P4P Programs for incentives at the provider group and physician levels for Medi-Cal. • Preventive health guidelines, which include well-care visit 	See results above

HEDIS Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
		schedule for both providers and members, are available at L.A. Care website.	
Childhood Immunization Combo 3 (CIS-3)	<ul style="list-style-type: none"> Due to the complexity of the immunization schedule, parents may not fully understand the recommended immunization schedule for their children. Lack of education about the importance of basic vaccination series to parents of members. Parents may perceive taking time off from work to get immunizations, sometimes without pay. Missed opportunities - physicians should take advantage of all appropriate patient contacts, including acute office visits for minor illnesses, to keep children's immunizations current. Incomplete coding of immunizations result in chart requests. Language and RCAC region disparity. 	<ul style="list-style-type: none"> Childhood and adolescent wellness flyers were sent in August 2015 to solo and small group providers that detail HEDIS-related health services that are recommended for different age groups; CIS was one of the measures represented in the flyer Member and physician incentives for CIS-3 were launched for October-December 2015; targeted Medi-Cal members were eligible to receive a \$25 Target GiftCard, while physicians were eligible to receive a \$25 check after submitting complete CIS-3 documentation Provider Opportunity Reports were provided (July, September, and November 2015) to inform groups and providers of their year to date performance to encourage outreach to members in need of the service In the Plan Partner, LAP4P, and Physician P4P programs, CIS-3 continued to be a targeted measure. Preventive health guidelines and current immunization schedule for both providers and members are available on the L.A. Care website. CIS measure information and use of CAIR was shared at PPG, County, and Plan Partner meetings to increase awareness and encourage strategic improvement 	See results above
Immunizations for Adolescents (IMA-1)	<ul style="list-style-type: none"> Missed opportunities - physicians should take advantage of all appropriate patient contacts, including acute office visits for minor illnesses, to keep children's immunizations current. Lack of education on the importance of vaccinations during adolescence 	<ul style="list-style-type: none"> Childhood and adolescent wellness flyers were sent in August 2015 to solo and small group providers that detail HEDIS-related health services that are recommended for different age groups; IMA-1 was one of the measures represented in the flyer \$25 incentive program for Medi-Cal adolescents who were eligible and still had a gap for the IMA-1 measure; the incentive provided health education to the guardian and targeted adolescent; LACC members were eligible only if they had both IMA and HPV gaps in care 	See results above
Human Papillomavirus Vaccine for Female Adolescents (HPV)	<ul style="list-style-type: none"> Missed opportunities - physicians should take advantage of all appropriate patient contacts, including acute office visits for 	<ul style="list-style-type: none"> Childhood and adolescent wellness flyers were sent in August 2015 to solo and small group providers that detail HEDIS-related health services that are recommended for 	See results above

HEDIS Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
	<p>minor illnesses, to keep children's immunizations current.</p> <ul style="list-style-type: none"> Lack of education on the importance of vaccinations during adolescence Guardians/adolescents are sensitive to receiving vaccinations that are linked with preventing (sexual) diseases Rate of finishing the 3-dose vaccine schedule drops after the first dose 	<p>different age groups; HPV was one of the measures represented in the flyer</p> <ul style="list-style-type: none"> \$25 incentive program for Medi-Cal adolescents who were eligible and still had a gap for the HPV measure; the incentive provided health education to the guardian and targeted adolescent; LACC members were eligible only if they had both IMA and HPV gaps in care 	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	<ul style="list-style-type: none"> Providers are not aware of the WCC measure. Providers do not know how to properly document BMI in a patient's record. Providers do not always know how to properly diagnose/measure and or treat obesity (using BMI). Members may not be aware of need or value of physical activity counseling Members may not be motivated to obtain physical activity counseling. Members may not be aware of physical activity counseling resources. Ethnicity and sex disparity. Health plan staff may not be interacting with members using the most effective means of goal setting and communication. 	<ul style="list-style-type: none"> Childhood and adolescent wellness flyers were sent in August 2015 to solo and small group providers that detail HEDIS-related health services that are recommended for different age groups; WCC was one of the measures represented in the flyer L.A. Care's HEDIS nurses conducted office visits to provider offices to educate office staff on proper documentation of BMI and counseling for nutrition. In 2015, Family Resource Centers (FRCs) continued to offer a variety of fitness and health classes and educational materials to members. In 2015, L.A. Care's Health Education department offered consultations on Weight Watchers, obesity/weight management, and nutrition. 	See results above
Adult BMI Assessment (ABA)	<ul style="list-style-type: none"> Providers are not aware of the ABA measure. Providers do not know how to properly document BMI in a patient's record. Providers do not always know how to properly diagnose/measure/treat obesity (using BMI). Members may not be aware of the need or value of achieving a healthy weight to prevent/manage chronic disease and maintain QOL/ADLs as one ages. Members may not be aware of and/or motivated to obtain nutrition and/or physical activity counseling. Members may not be aware of L.A. Care and community resources available around physical activity, nutrition, and disease management. Health plan staff may not be interacting with members using 	<ul style="list-style-type: none"> L.A. Care's HEDIS nurses conducted visits to provider offices to educate office staff on proper documentation of BMI. In 2015, the Health Education Unit's <i>Health In Motion™</i> program conducted 1,897 health education encounters The Health Education unit launched a new on-line wellness site: "My Health In Motion™," for members Health In Motion™ conducted 72 group appointments in six Regional Community Advisory Committee (RCAC) regions, with 503 DLOB attendees. L.A. Care has continued a Medicare incentive for Physicians who accurately complete and submit the members' Annual Wellness form. Physicians are given \$350 per calendar year for each form. The form includes preventive services like BMI assessment as well as 	See results above

HEDIS Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
	the most effective means of goal setting and communication.	<p>tests for diabetes and other important services.</p> <ul style="list-style-type: none"> • L.A. Care also contracts with House Calls, which performs in-home AWEs for members that are home bound. • In 2015, the Health Education unit offered several trainings including Motivational Interviewing and Writing in Plain Language to staff including Certified Health Coaches, Registered Dietitians, and Master's Level Health Educators. • In 2015, Family Resource Centers (FRCs) continued to offer a variety of fitness and health classes and educational materials to members (and the greater community). • In 2015, QI conducted a pilot with our AppleCare PPG in which LA Care shared monthly FRC calendars for Inglewood, Boyle Heights, and Lynwood for AppleCare to mail to members living around those areas (September – December). There are plans for evaluation in 2016 to determine impact/reach. 	
Colorectal Cancer Screening (COL)	<ul style="list-style-type: none"> • Providers are not aware of the COL measure. • Providers do not know how to properly document past colon cancer screenings in a patient's record. • Providers do not always know how to best discuss the various colon cancer screening options • Providers may not know how to code previously completed colonoscopy • Lab supply of iFOBT/FIT kits to provider offices may not be adequate to meet demand. • Members may not be aware of the need or value of having regular colon cancer screenings. • Members may not be aware of and/or motivated to complete a colon cancer screening, be it a colonoscopy that requires more preparation or obtaining and returning an iFOBT/FIT kit. • Members may receive an iFOBT/FIT kit from their provider and/or lab but then not complete the test and return for analysis. 	<ul style="list-style-type: none"> • In 2015, L.A. Care took the 80% by 2018 pledge – an initiative was created by the National Colorectal Cancer Roundtable (co-founded by ACS and the CDC) with the goal of increasing the percentage of adults 50 and older who are screened for colorectal cancer to 80 percent by 2018 • L.A. Care's CME team included speakers at the Men's and Women's Health Conferences in 2015 to highlight and educate on the importance of colon cancer screening. • Members (all LOB) 50-74 years of age overdue for a colorectal cancer screening received a co-branded reminder mailer encouraging them to complete a colon cancer screening test and to talk to their primary care provider about options. There was also an option to call L.A. Care's inquiry phone line if they wanted an at-home FIT kit and then L.A. Care worked with PPGs/providers to fulfill the member's request. As of the end of 2015, a total of approximately 80 members called the inquiry 	See results above

HEDIS Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
	<ul style="list-style-type: none"> The long look back period (10 years for colonoscopy) results in difficulty of compiling complete administrative data for the COL measure. Hybrid data results in significantly greater COL rates. 	<ul style="list-style-type: none"> line. Evaluation of the intervention will take place in 2016. L.A. Care's QI team shared best practices among PPG QI contacts related to improving colon cancer screening rates. 	
Flu Vaccinations for Adults Ages 18-64 (FVA)	<ul style="list-style-type: none"> Members may not be aware of the importance of the flu vaccine. Members may not be aware of the availability of the flu vaccine at pharmacies. Missed opportunities - physicians should take advantage of all appropriate patient contacts, including acute office visits for minor illnesses, to vaccinate for the flu. 	<ul style="list-style-type: none"> In 2015, a mailing and two automated calls mentioned the availability of the flu shot at pharmacies for MCLA and CMC members. Outreach materials mentioned the importance of the flu shot. Disease Management sent all its non-CMC members flu shot reminders. 	See results above
Flu Vaccinations for Adults Ages 65 and Older (FVO)	<ul style="list-style-type: none"> Members may not be aware of the importance of the flu vaccine. Members may not be aware of the availability of the flu vaccine at pharmacies. Missed opportunities - physicians should take advantage of all appropriate patient contacts, including acute office visits for minor illnesses, to vaccinate for the flu. 	<ul style="list-style-type: none"> In 2015, a mailing and two automated calls mentioned the availability of the flu shot at pharmacies for MCLA and CMC members. Outreach materials mentioned the importance of the flu shot. 	See results above

LOOKING FORWARD

L.A. Care will continue to work on improving current successful interventions for these HEDIS measures as well as the following for 2016:

- L.A. Care will be conducting a rapid cycle performance improvement program for CIS in collaboration with DHCS and HSAG. The planned PIP will work in collaboration with a large clinic, will leverage CAIR and target members 0-8 months of age with a target of improving completion of three DTaP and PCV doses by 12 months.
- Continue to collaborate with plan partners on updating Preventive Health Guidelines to create a widely distributed common version that is easy to understand and more appealing to members – included in distribution are Medi-Cal, Medicare, and LACC membership.
- L.A. Care will share updated Preventive Health Guidelines with providers so they can discuss with their members.
- L.A. Care will produce and distribute provider group and physician level opportunity and performance reports which include preventive/well-care measures of W34, AWC, CIS, and COL. This performance reporting will be expanded to include LACC membership.
- Priority HEDIS measure information, including these preventive/well-care measures like colon cancer screening, will be shared at PPG, County, and Plan Partner meetings to increase awareness and encourage collaborative and strategic improvement for the benefit of all our members.

2016 WORK PLAN GOALS:

HEDIS Measure	2016 Medi-Cal Goal	2016 L.A. Care Covered Goal	2016 Cal MediConnect Goal
Well-Child Visits 3-6 Years (W34)	72%	63%	
Adolescent Well-Care Visits (AWC)	60%	33%	
Childhood Immunizations Combination 3 (CIS-3)	81%	72%	
Immunizations for Adolescents (IMA-1)	82%	63%	
Human Papillomavirus Vaccine for Female Adolescents (HPV)	31%	12%	
Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	BMI: 86% Nutrition: 80% Physical Activity: 72%	BMI: 47% Nutrition: 44% Physical Activity: 40%	
Adult Body Mass Index Assessment (ABA)	85%	*	90%
Colorectal Cancer Screening (COL)		*	71%
Flu Vaccinations for adults ages 18-64 (FVA)	45%	*	
Flu Vaccination for adults ages 65 and older (FVO)			75%

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

A.2 IMPROVING RATE OF CARE FOR OLDER ADULTS (COA)

2015 WORK PLAN GOALS:

HEDIS Sub-Measure	2015 Goal
Medication Review	87%
Functional Status Assessment	59%
Pain Screening	88%

BACKGROUND

There are over 39 million people age 65 and over in the United States, and this population is expected to grow over the next two decades.¹ In addition, an estimated 9 million low-income seniors and adults under the age of 65 with disabilities are eligible for Cal MediConnect and have a range of complex physical and mental health conditions. As this population grows older, daily functions may become more difficult, aches and pains increase, and medication regimens become much more complex.² Medication review, functional status assessment, and pain screening are therefore important measures in ensuring that older adults receive comprehensive care.

MAJOR ACCOMPLISHMENTS

- L.A. Care continued with the in-home assessment program in which physicians conduct home visits to members who have not completed the annual visit. The annual visit addresses preventive health services and screenings, including pain screening.
- L.A. Care offered a \$350 provider incentive per member for completing the Annual Wellness examination (AWE) form which includes care of older adult measures.
- Out of 2,320 members, 987 completed a CMR (Comprehensive Medication Review) during 2015. CMR completion rate of 42% was achieved with the collaboration of L.A. Care, SinfoniaRx and Navitus.
- The Campaign performance for STAR in 2015 is below:



proActive Management

Campaign Performance									
Program: 2015 LA Care - 5 Star			Campaign: Star Ratings						
Measure Name	Sub Measure Name	Num	Den	Stars	Distance From Target				
					1 Star	2 Star	3 Star	4 Star	5 Star
Cholesterol (Statins)	Reported Rate	3,663	5,386	3	0	0	0	269	592
High Risk Medication	Reported Rate	495	13,671	5	0	0	0	0	0
Hypertension (ACEI or ARB)	Reported Rate	4,507	6,289	2	0	0	84	336	588
Oral Diabetes Medications	Reported Rate	2,039	2,835	3	0	0	0	88	286

¹ Older Americans 2010. Federal Interagency Forum on Aging-Related Statistics.

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

² Care for Older Adults. U.S. Department of Health & Human Services Agency for Healthcare Research and Quality.

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

Description of sub-measures

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

RESULTS

Quantitative Analysis

Since Cal MediConnect membership commenced on April 1, 2014, L.A. Care was too new to be measured for any HEDIS 2015 measure including Care for Older Adults. Therefore, rates for this measure are not available at this time. Results will be reported for dates of service in 2015 as part of HEDIS 2016 reporting.

Qualitative Analysis

NOT APPLICABLE

LOOKING FORWARD

In 2016, L.A. Care will conduct following interventions to improve the care for older adults rate:

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

2016 WORK PLAN GOALS:

HEDIS Sub-Measure	2016 Goal
Medication Review	77%
Functional Status Assessment	67%
Pain Screening	78%

Note: goals set at 4-star threshold

A.3 PERINATAL SERVICES

2015 WORK PLAN GOALS:

HEDIS Measure	2015 Medi-Cal Goal
Timeliness of Prenatal Care	90%
Postpartum Care	63%

BACKGROUND

Perinatal services which include “timeliness of prenatal visits” and “postpartum care” are an important component of maternal and child health. Inadequate prenatal care may result in pregnancy-related complications and may lead to potentially serious consequences for both the mother and the baby³.

MAJOR ACCOMPLISHMENTS

- L.A. Care’s “Healthy Mom” postpartum program, which provides assistance and support to women to schedule their postpartum visit, reached 1,087 women of which 74% completed their postpartum visit.
- L.A. Care’s MCLA prenatal care HEDIS rate improved over 7 percentage points over the previous year, from 69.53% to 76.67%.
- L.A. Care’s Health Education Department sends out trimester-specific perinatal education packets to identified pregnant MCLA members. The packets include information on the importance of timely prenatal care, breastfeeding, WIC, and the “Healthy Mom” postpartum program.
- L.A. Care’s LA P4P provider group incentive program includes timeliness of prenatal care as one of the clinical measures. The LA P4P program also distributes provider group report cards that inform groups of their performance on these measures.
- L.A. Care mailed the Preventive Health Guidelines to members. In addition, the Preventive Health Guidelines were made available for physicians on the L.A. Care website.
- L.A. Care promoted Text4Baby, a free program that provides education about prenatal and postpartum care to members via text messaging. Text4Baby was promoted throughout the network: in publications, on the website, and through Provider Quality Improvement Liaison (PQIL) outreach.
- L.A. Care offers prenatal classes for parents at the Lynwood Family Resource Center. The class includes education on how to breastfeed, physical postpartum changes, stress baby blues and postpartum depression.
- L.A. Care also formed a Plan Partner Quality Improvement Collaborative meeting to help collaboration and develop best practices among the health plans. Prenatal and postpartum are areas of priority.

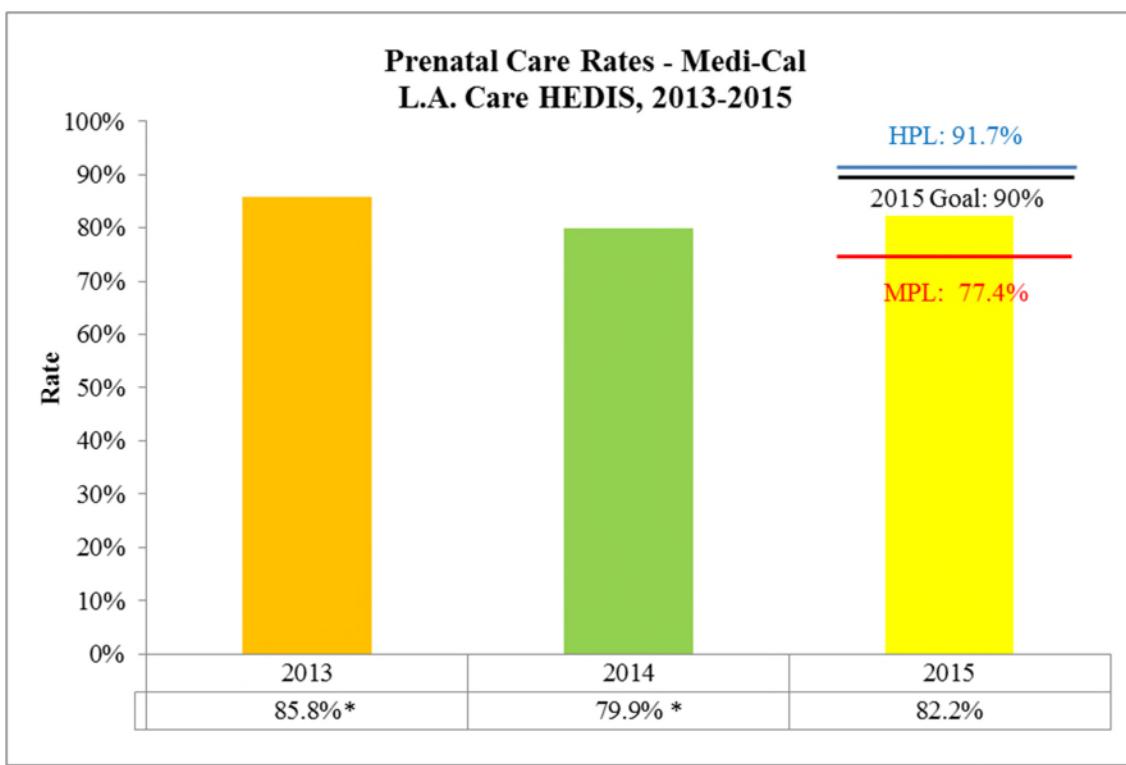
³ http://kidshealth.org/parent/pregnancy_newborn/pregnancy/medical_care_pregnancy.html

RESULTS

PREGNATAL CARE

Description of measures:

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



*Statistically significant difference

ANALYSIS

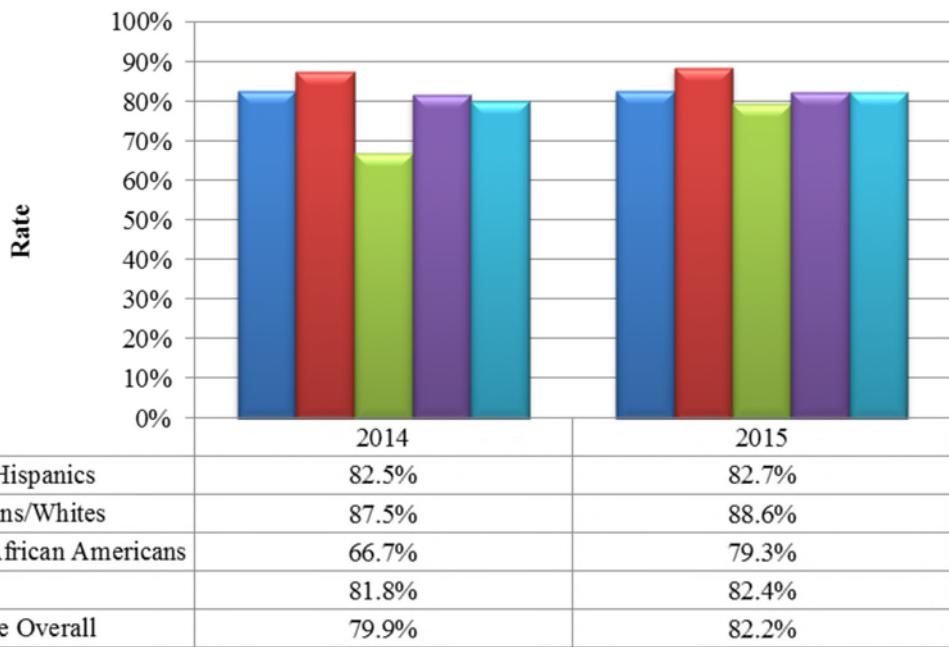
Quantitative Analysis

The timeliness of prenatal care rate increased by 2.3 percentage points; from 79.9% in 2014 to 82.2% in 2015. This difference is not statistically significant ($p < 0.05$). The 2015 rate exceeded the MPL of 77.4%. The timeliness of prenatal care rate did not meet the 2015 goal of 90.0%.

Disparity Analysis

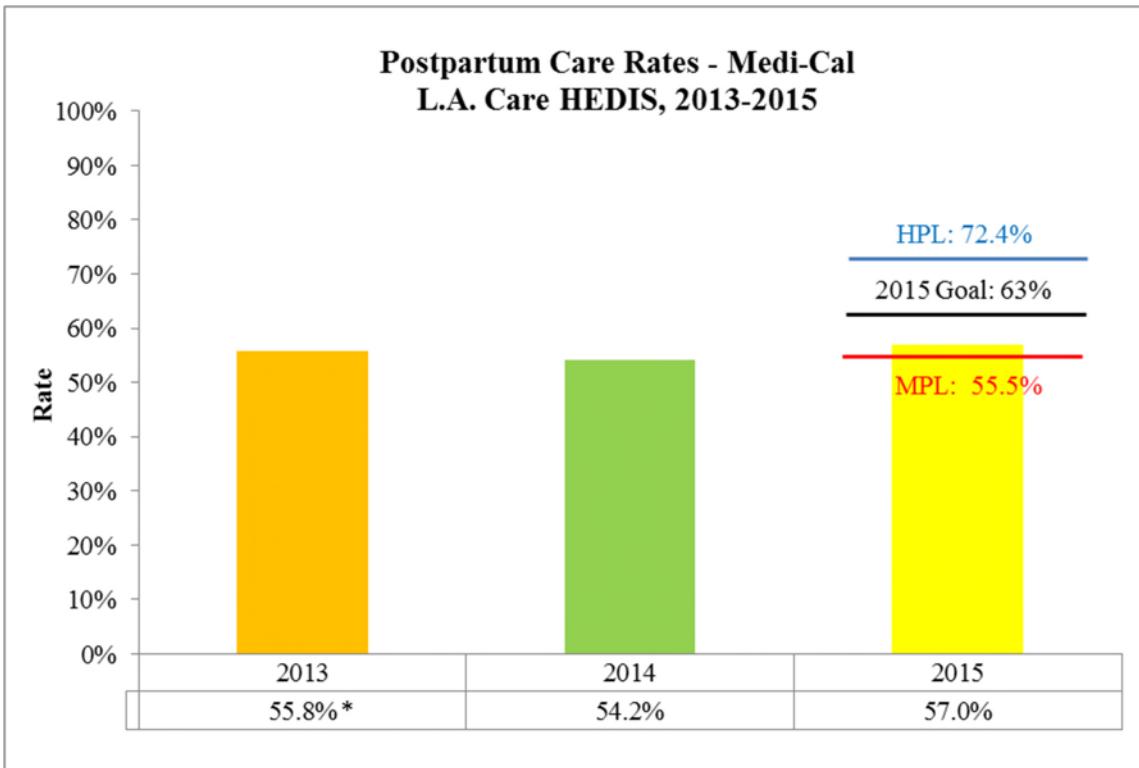
L.A. Care also conducted an analysis based on Plan Partner, age, gender, ethnicity, region, and language to examine whether disparities exist in getting timely prenatal care. The HEDIS 2015 results indicate that African-American women had lower rates (79.3%) than other ethnic groups. MCLA's performance (76.67%) is also significantly lower than all other plan partners.

Prenatal Rate Ethnicity Analysis, HEDIS 2014- 2015



POSTPARTUM CARE

RESULTS



ANALYSIS

Quantitative Analysis

L.A. Care's 2015 postpartum rate of 57.0 % increased by 2.8 percentage points in comparison to the 2014 rate of 54.2%. The 2015 rate met the MPL of 55.5% but did not meet the 2015 goal of 63.0%. The difference between the 2014 and 2015 postpartum rates is not statistically significant.

Disparity Analysis

L.A. Care also conducted an analysis based on Plan Partner, age, gender, ethnicity, region, and language to examine whether disparities exist in women receiving postpartum care. The HEDIS 2015 results found no significant disparities.

Qualitative Analysis

The rates for Prenatal and Postpartum care have increased from HEDIS 2014. The prenatal rate increased in 2015 due to an increase in rates for MCLA and Kaiser. Despite some annual fluctuations in the rate, the prenatal visit rate has remained at a similar level over the past three years. This may be due to the difficulty in getting an appointment within the first trimester or within 42 days of enrolling in the health plan. In fact, a review of the hybrid HEDIS sample in 2014 showed that 65% of the records that were non-compliant were due to the visit happening outside of the required timeframe and was the main reason for non-compliance. The MCLA rate may also be lower since it is the default health plan for those who do not elect a health plan, which may mean that members in this health plan are less engaged and may not be scheduling appointments in a timely manner. Additionally, it is difficult to identify a pregnant member within 42 days of enrollment or within the first trimester due to lags claims and information.

The postpartum rate increased in 2015, the first time in the past three years. The increase was due to a high rate for Kaiser (93.75%) and an increased rate for Care1st (up to 63.7% compared to 2014's rate of 51.7%). The MCLA rate dipped to 42.67% from 49.22% and the Anthem Blue Cross rate remained the same at 57%. A review of the hybrid records showed the main reason for non-compliance was due to the visit not occurring as opposed to the visit occurring out of timeframe. This may be due to the member's perception of insignificance of the postpartum visits, transportation, and child care issues.

In March 2015, L.A. Care Health Education staff conducted patient experience mapping interviews with three L.A. Care members who had recently delivered a baby to ascertain L.A. Care members' experiences with prenatal and postpartum care in an effort to identify barriers to accessing timely care. The patient interviews showed that members were highly motivated to seek care. Rather than patient engagement, one of the main barriers to accessing care that arose out of interviews was members' challenges with the DPSS system. Identified opportunities for improvement include, but are not limited to: working with DPSS and DHCS to improve access to DPSS services related to eligibility and availability of case workers and ensure computer systems are integrated and up-to-date, working with clinic staff to educate them on the importance of providing timely prenatal and postpartum appointments for patients, as well as assisting clinic staff in determining efficient methods for seeing patients and limiting wait times, providing additional health education services and resources to clinics for dissemination to patients, and continuing with L.A. Care's postpartum phone call.

In addressing perceived member barriers for prenatal and postpartum care, L.A. Care distributed several educational materials to members, notified providers of members needing these services and contacted postpartum women. In 2015, 1,464 pregnant members were identified and sent educational packets. In 2015, L.A. Care continued to send out provider opportunity reports (gaps in care reports) that included perinatal care measures. The list of members who did not receive care is also available at the L.A. Care provider portal. While this information may be too late for the physician to act on, it nevertheless brings the issue to the attention of the physician in order to change behavior and to comply with guidelines in the future. In addition, the Healthy Mom program rates were evaluated and it was found that women in the program had statistically higher rates of compliance than those they were unable to reach. However, it was

also noted that too few women participated in program to have a significant impact in the overall rate. Approximately 50% of members who deliver are identified in a timely fashion, and of those, approximately 50% are unable to contact. Currently, efforts are being made to improve the identification of pregnant women to improve these rates. The table below summarizes the barrier analysis with the actions for each measure:

HEDIS Measure	Barriers	Actions
Timeliness of prenatal care	<ul style="list-style-type: none"> • Identification of pregnant women. • Members do not understand what prenatal visits are or why they are important. • Members do not perceive the urgency for prenatal care, especially multi-gravida women. • Cultural issues/traditions. • Potential transportation and child care issues. • Late acceptance to the managed Medi-Cal program during pregnancy. • Challenges with the DPSS system and eligibility workers. 	<ul style="list-style-type: none"> • The fall issue of the member newsletter had an article explain the importance of the first prenatal visit. • The LA P4P provider group incentive program includes timeliness of prenatal care as one of the clinical measures. • L.A. Care continued to promote Text4Baby, a free program that provides education about prenatal and postpartum care to members via text messaging. • L.A. Care continued to distribute Preventive Health Guidelines that are member-friendly, easy to understand, and useful to members. • Providers were mailed progress reports, known as Provider Opportunity Reports, that included the prenatal care measure. • A list of members who did not receive care is also provided at the L.A. Care provider portal where providers can identify the non-compliant members. • L.A. Care distributes trimester-specific perinatal health education packages to identified MCLA pregnant women.
Postpartum care	<ul style="list-style-type: none"> • Identification of pregnant and those women who have just delivered. • Cultural issues/traditions. • Members do not perceive the urgency for a postpartum check-up. • Potential transportation and child care issues. • Postpartum care occurs before or after the 21-56 day recommendation. • Multi-gravida postpartum women may not perceive the importance of the postpartum visit. • Postpartum women are difficult to identify in a timely fashion. 	<ul style="list-style-type: none"> • The fall issue of the member newsletter had an article explain the importance of the postpartum visit. • L.A. Care continued to promote Text4Baby, a free program that provides education about prenatal and postpartum care to members via text messaging. • L.A. Care continued to distribute Preventive Health Guidelines that are member-friendly, easy to understand, and useful recommendations regarding tests and screenings for members. • L.A. Care distributes trimester-specific perinatal health education packages to identified MCLA pregnant women. • L.A. Care's "Healthy Mom" postpartum program, which provides assistance and support to women to schedule their postpartum visit. Members also receive a gift card for attending the postpartum visit. In 2015, L.A. Care called 2,532 women, reached 1,214 and provided appointment assistance to 132 of them. The program reported that 806 women completed their postpartum visit as of December 18, 2015.

LOOKING FORWARD

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

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

2016 WORK PLAN GOALS:

HEDIS Measure	2016 Medi-Cal Goal	2016 Cal MediConnect Goal	2016 L.A. Care Covered Goal
Timeliness of Prenatal Care	85%	NA	84%
Postpartum Care	63%	NA	69%

A.4 OTHER WOMEN'S HEALTH INITIATIVES

BACKGROUND

Breast Cancer affects American women more than any other type of cancer, except skin cancer,⁴ and is estimated to affect 12.3% of women at some point during their lifetime.⁵ Cervical Cancer, on the other hand, was once the leading cause of cancer death for women in the United States; but during the past four decades, the incidence and mortality from Cervical Cancer have declined significantly, primarily due to early detection through Cervical Cancer screening. Early detection of both Breast and Cervical Cancer through regular screenings is a key step for prompt and more effective treatments for these diseases; thus reducing women's mortality rates.

Chlamydia remains to be the most commonly reported infectious disease in the United States. Data between 1994 and 2008 showed that Chlamydia comprised the largest proportion of all sexual transmitted diseases (STDs) reported to Centers for Disease Control and Prevention (CDC).⁶ In Los Angeles County, Chlamydia rates have steadily increased since 2005 with reported rates in 2014 at 539.9 per 100,000; highest among females of African American or Latino race/ethnicity.⁷ Chlamydia infections are usually asymptomatic and, in women, can cause infertility, ectopic pregnancy, and chronic pelvic pain. Because of the large burden of disease and risks associated with infection, CDC recommends annual Chlamydia screening of all sexually active women younger than 25 years of age.

2015 WORK PLAN GOALS:

HEDIS Measure	2015 Goal for Medi-Cal	2015 Goal for Cal MediConnect*	L.A. Care Covered*
Breast Cancer Screening (BCS)	57%	N/A	N/A
Cervical Cancer Screening (CCS)	66%	N/A	N/A
Chlamydia Screening (CHL)	63%	N/A	N/A

*New product line in MY 2014. Official rates are unavailable.

MAJOR ACCOMPLISHMENTS

- In January of 2015, L.A. Care launched a Cervical Cancer Awareness Campaign via social media in collaboration with the American Cancer Society.
- L.A. Care formed a women's health HEDIS work team with members from across the organization to help develop and implement different health initiative.
- Breast Cancer Screening (BCS) reminders to Medi-Cal and Cal MediConnect members were sent in October 2015.
- In November of 2015, BCS reminder phone calls were also made to members that received the mailers.
- In August 2015, nearly 1,000 parents of 16 and 17 year old members in the denominator for the chlamydia screening measure received a letter stressing the importance of preventive screenings for teens. The letter also encourages parents to allow their daughter have a private, age-appropriate conversation with her provider about concerns like sexual and reproductive health.
- Members 18 to 24 identified for the Chlamydia screening measure received a mailing highlighting the importance of screening and how to obtain the test. The material, mailed to over 9,000 members, featured a message of empowerment.

⁴ <http://www.lbl.gov/Education/ELSI/screening-main.html>

⁵ <http://seer.cancer.gov/statfacts/html/breast.html>

⁶ <http://www.cdc.gov/std/tg2015screening-recommendations.htm>

⁷ <https://www.cdph.ca.gov/data/statistics/Documents/STD-Data-LHJ-LosAngeles.pdf>

- L.A. Care PCPs, OB/GYNs, and pediatricians received a blast fax in July 2015 and refaxed in October 2015 that noted the prevalence of Chlamydia infections amongst L.A. County youth, various screening options, and opportunities for screening.
- The Quality Improvement Department updated the Chlamydia Toolkit for providers. The Toolkit was posted on the L.A. Care website and distributed by PQIL nurses.

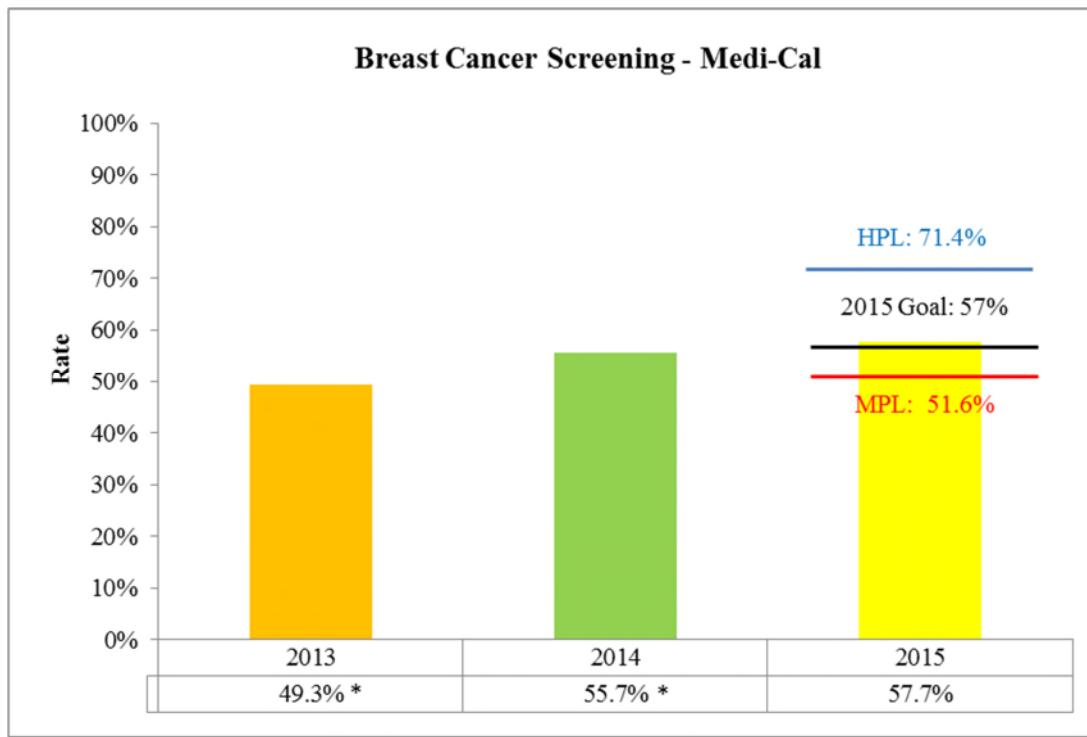
Description of measures:

HEDIS Measure	Specific Indicator(s)	Measure Type
Breast Cancer Screening	The percentage of members who are women aged 50-74 years and have received one or more mammograms on or between October 1 two years prior to the measurement year and December 31 of the measurement year.	Administrative
Cervical Cancer Screening	Percentage of women aged 21-64 years who received one or more screening tests for Cervical Cancer during or within the three years prior to the measurement year or 5 years for women 30-64 with HPV co-testing.	Hybrid
Chlamydia Screening in Women	Percentage of women aged 16-24 years who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.	Administrative

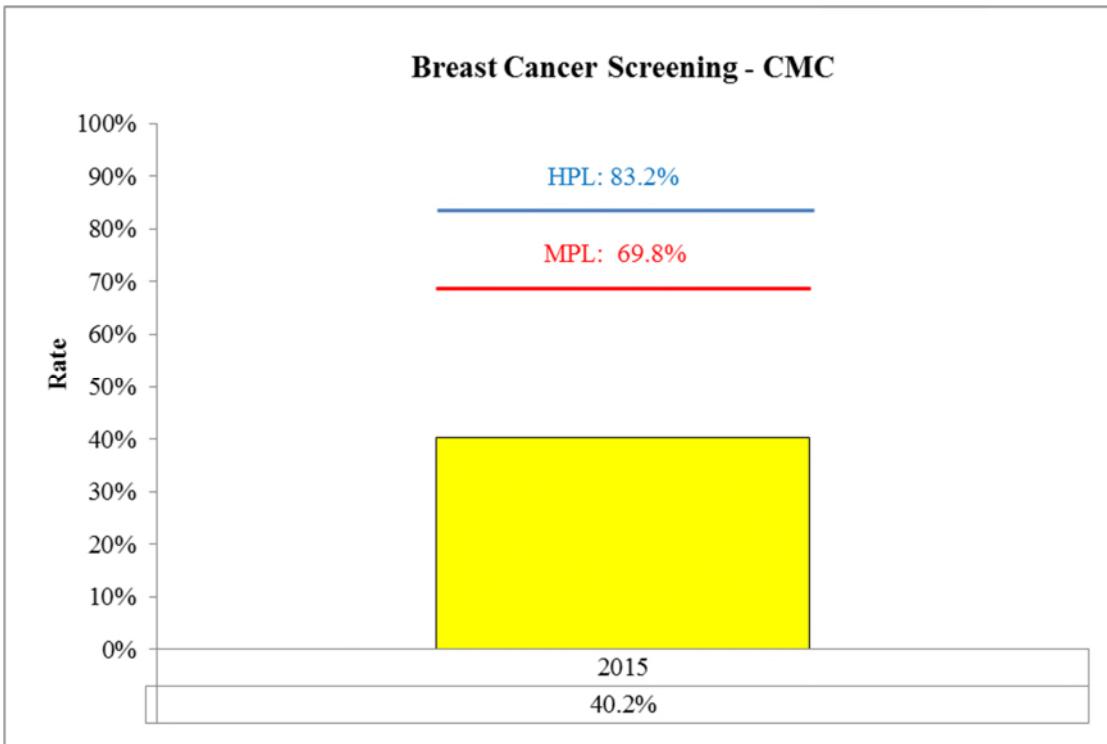
BREAST CANCER SCREENING

RESULTS

The following graph compares L.A. Care in 2013, 2014, and 2015:



*Statistically significant difference



ANALYSIS

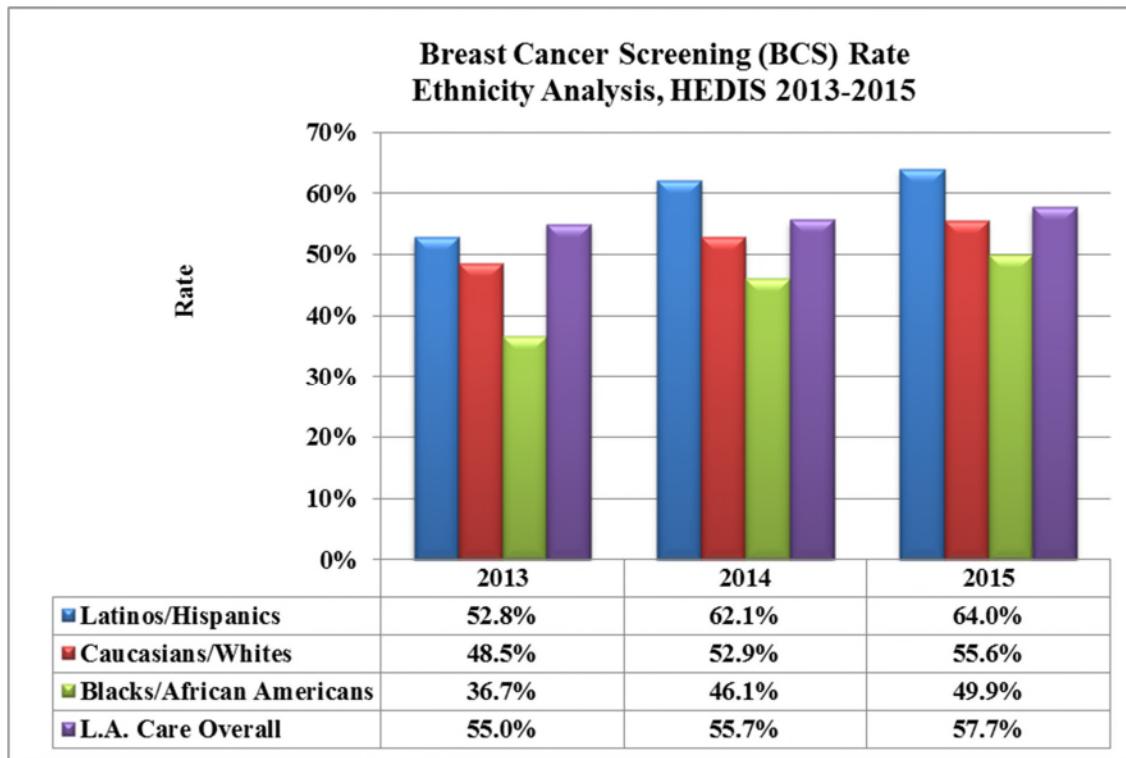
Quantitative Analysis

L.A. Care's Breast Cancer screening (BCS) rate for Medi-Cal was 57.7% and met the 2015 goal. The rate increased by 2 percentage points from the prior year and is on a three year upward trend. The rate however, was just below the national 50th percentile (58.8%).

Since L.A. Care transitioned to Cal MediConnect (CMC) in mid-2014, rates were captured administratively but were not reported. CMC members had an unofficial rate of 40.2%. This is a low rate compared to other HMO Medicare plans and is most likely due to the lack of data available for these members. The BCS measure has a two- year look back period and the product line began mid-year in 2014. Therefore, it is too early to analyze the data.

L.A. Care Covered (LACC) rates were also not reported for HEDIS 2015. In addition, no members met the denominator criteria and are not included in this year's evaluation.

Disparity Analysis



L.A. Care conducts a disparity analysis annually for its priority Medi-Cal HEDIS measures. HEDIS 2015 results show that Medi-Cal Latinos/Hispanics, Caucasians/Whites, Blacks/African Americans improved BCS rates in the past three years. Among Latinos/Hispanics members, the BCS rate increased by nearly 12 percentage points, from 52.8% in HEDIS 2013 to 64.0% in HEDIS 2015. Latinos/Hispanics were the only ethnic group that surpassed the overall L.A. Care Medi-Cal BCS rate of 57.7%. Caucasians/Whites increased more than seven percentage points from 48.5% in HEDIS 2013 to 55.6% in HEDIS 2015. Similarly, the BCS rate among Blacks/African Americans increased 13 percentage points from 36.7% in HEDIS 2013 to 49.9% in HEDIS 2015. Blacks/African Americans had significantly lower rates than all other ethnic groups.

Qualitative Analysis

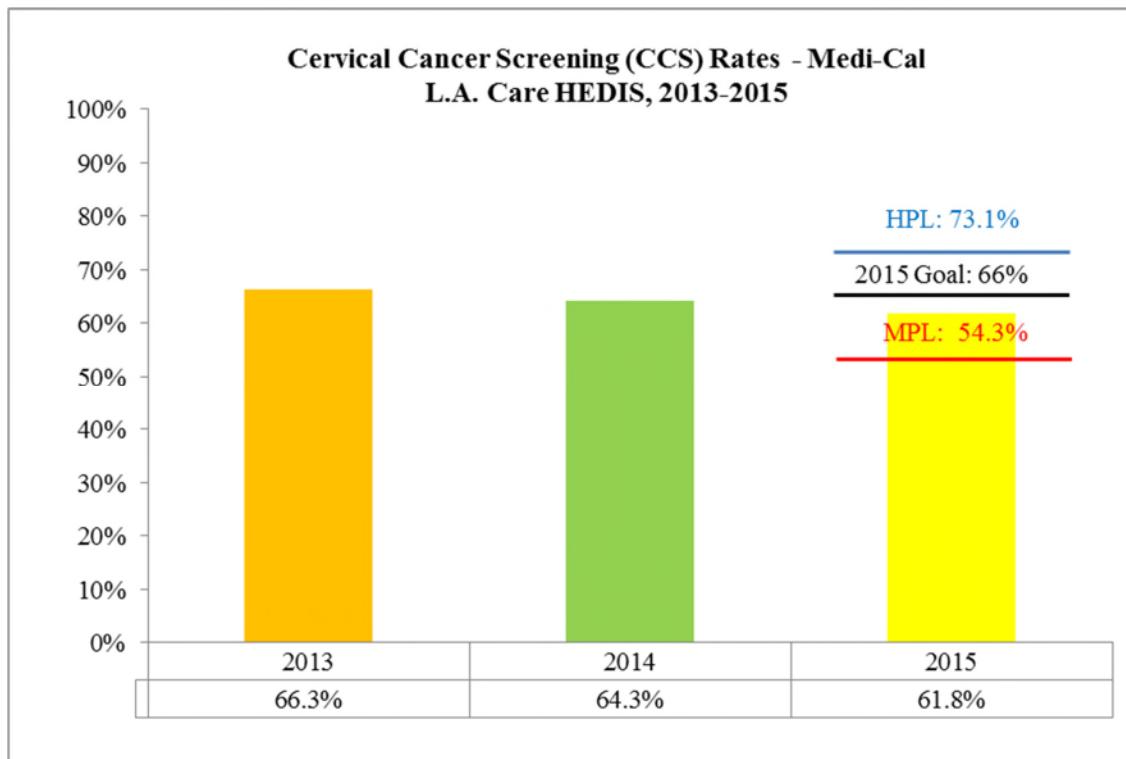
After a series of focus groups in Los Angeles, L.A. Care focused its 2014 interventions on member materials that addressed members concerns about mammography. In addition, a hotline was created to help answer members questions about mammography and to help schedule appointments. L.A. Care also asked PPGs to attest to training their contracted imaging centers on the ability of members to schedule directly with the imaging center, also known as “Open Access.” While each intervention was not individually evaluated, the MCLA HEDIS rate had a statistically significant increase of 6.4 percentage points than the prior year, in spite of the growth in membership due to Medi-Cal expansion population.

In 2015, L.A. Care mailed out member materials similar to the prior year and included the hotline again to address some of the member barriers from the prior year. In addition, L.A. Care followed up the member mailing with an automated phone call reminding members to follow up with their provider or they could also be redirected to an operator that could help them with scheduling an appointment or answering any questions they may have. Both these interventions targeted Medi-Cal and Medicare members. A number of PPGs partner with their respective contracting imaging centers in member outreach for mammography scheduling. An evaluation of these interventions will occur in 2016 when Q4 claims data is available.

CERVICAL CANCER SCREENING

RESULTS

The following graph compares L.A. Care in 2013, 2014, and 2015:



ANALYSIS

Quantitative Analysis

L.A. Care's Cervical Cancer screening rate was 61.8 % and decreased by 2.5 percentage points from the prior year. This is the lowest rate throughout the last five years. The 2015 rate met the MPL but did not meet the goal of 66%.

Cervical Cancer Screening is not a CMC measure and is not included in this report. The measure is also a hybrid measures and L.A. Care Covered rates were only captured administratively during its first year and are also not included in this report.

Disparity Analysis

L.A. Care also conducted an analysis based on Plan Partner, ethnicity, language, and RCAC regions to examine whether disparities exists in getting Cervical Cancer screenings. There is a major disparity among different plan partners. Similar to last year's performance, MCLA had a significantly lower rate (57.1%) while Kaiser had a significantly higher rate (92%). Spanish speaking members had a higher rate than the English-speaking population (76.6% vs 57.3%), and the SPD population had lower rates than the non-SPD population (48.0% vs 65.1%).

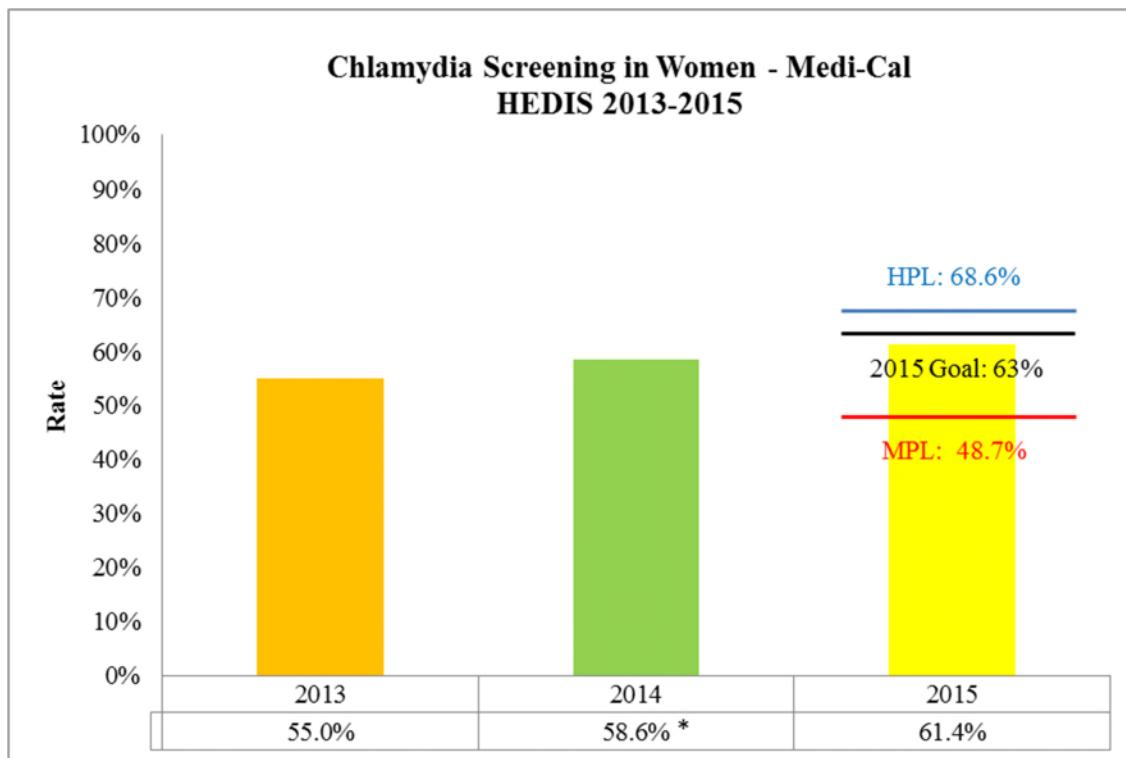
Qualitative Analysis

The rate in 2015 dropped and is the lowest throughout the last five HEDIS seasons despite having several interventions in place. In June of 2015, L.A. Care sent out a survey to PCPs to determine how many providers offer these services in their office and any other barriers they may be encountering. Results showed that 58% of PCPs offered the screening in their office. Most stated that their biggest barrier was scheduling the appointment during the patients preferred time. In addition, most providers (61%) did not receive L.A. Care's Provider Opportunity Reports which lists which members are in need of these services. The majority (60%) were also interested in receiving these reports quarterly. Surprisingly, 85% of PCPs have never participated in an outreach campaign. Based on these results, L.A. Care met with high volume PPGs and shared the importance of distributing the PORs list to PCPs. Since PORs are only distributed to PCPs, L.A. Care also sent Ob/Gyns that had previously rendered service to our members, a list of patients in need of screening. They were asked to reach out to these members and provide the screening if they were still providing care for these members. L.A. Care will be evaluating this new intervention in 2016 when claims data becomes available.

CHLAMYDIA SCREENING

RESULTS

The following graph compares L.A. Care in 2013, 2014, and 2015:



*Statistically significant difference

ANALYSIS

Quantitative Analysis

L.A. Care's Chlamydia screening rate increased by 2.76 percentage points from 58.62% in 2014 to 61.39% in 2015. However, the rate did not meet the 2015 goal of 63%.

Disparity Analysis

L.A. Care also conducted an analysis based on Plan Partner, ethnicity, language, and RCAC regions to examine whether disparities existed in getting Chlamydia screenings. Kaiser out performs among the other plan partners at 74.03% which is significantly greater than MCLA at 57.61%, although Kaiser was the only plan partner to experience a decrease from 2014 to 2015. Similar to last year's result, members between the ages of 16-20 years had a lower screening rate (58.0%) when compared to women between ages 21-24 (65.7%). A similar disparity existed between English and Spanish speakers (63.8% and 56.6%, respectively). White members were the least likely to be screened (51%, compared to 60.3% for Hispanic members and 69.9% for Black members). Rates were consistent across RCAC regions.

Qualitative Analysis

Multiple barriers still exist in members receiving Chlamydia screening, including a lack of knowledge of the benefit of testing, inhibitions about discussing sexual health, fear about discovery of a sexually transmitted disease (STD), and physicians' non-adherence to recommended guidelines. In 2015, L.A. Care reached out directly to both members and providers to increase awareness of the importance of Chlamydia screening and the screening guidelines. The Health Education Unit crafted age and culturally appropriate materials that were mailed to members. An informative one page flyer on screening guidelines and the prevalence of Chlamydia amongst youth in L.A. County was blast faxed to L.A. Care providers. QI also revised the Chlamydia toolkit and presented it to the Physician Quality Committee (PQC) for review and feedback before distributing the toolkits to providers through PQIL nurses and posting at L.A. Care's website. The toolkit includes a cover letter, member educational materials, information on partner therapy, and clinical practice guidelines. Additionally provided as an online resource, "SPOTLA" can be used by patients to anonymously notify partners of testing positive for various sexually transmitted diseases.

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

HEDIS Measure	Barriers	Actions	Effectiveness of Intervention/Outcome
Breast Cancer screening	<ul style="list-style-type: none">• Members do not perceive the need for biennial exams after having undergone one screening with a negative result.• Discomfort associated with the mammography screening process.• Fear of the test and the test results.• Members unaware of direct access to imaging centers and receiving preventive services.• Member refusal for personal reasons.• Unable to contact members.• Providers unsure of screening guidelines and recommendations• Providers are unaware of when a patient is due for services.	<ul style="list-style-type: none">• BCS reminder postcards sent to Medi-Cal and CMC members in October of 2015.• Automated calls were sent to members needing mammograms in November of 2015.• L.A. Care offers women health classes which includes Breast Cancer as a topic on an ongoing basis at its Family Resources centers.• L.A. Care distributed Preventive Health Guidelines brochures to CMC members to serve as a reminder of recommended tests and screenings.• In September of 2015, L.A. Care held a Women's Health Conference that offered free CME/CEUs to educate providers on the screening guidelines for breast and Cervical Cancer screening.• L.A. Care includes Breast Cancer screening as one of the clinical measures for both the LA P4P provider group incentive and the Physician P4P incentive programs.	<ul style="list-style-type: none">• The rate increased by 2 percentage points from 2014, and met the 2015 goal.

HEDIS Measure	Barriers	Actions	Effectiveness of Intervention/ Outcome
		Providers receive a list of members in need of services.	
Cervical Cancer screening	<ul style="list-style-type: none"> • Lack of knowledge on the test itself. • Fear of the test and the test results. • Doctor insensitivity. • Cultural inhibitions. • Personal modesty/ embarrassment. • Discomfort associated with screening. • Members may not understand the importance of getting the screening. • Long wait times for appointment. • Providers are unaware of who is in need of CCS screenings • Providers often refer to specialists for services. • Providers may not be familiar with the new guidelines on CCS screening 	<ul style="list-style-type: none"> • L.A. Care, in collaboration with the American Cancer Society, produced co-branded materials to distribute online via social media that addressed lack of knowledge and fear about testing. • L.A. Care offers women health classes which include Cervical Cancer as a topic on an ongoing basis at its Family Resources centers. • L.A. Care includes Cervical Cancer screening as one of the clinical measures for both the LA P4P provider group incentive and the Physician P4P incentive programs. • Specialists, Ob/Gyns were sent list of members needing CCS, if they had contact with the member in the last 18months. • In September of 2015, L.A. Care held a Women's Health Conference that offered free CME/CEUs to educate providers on the screening guidelines for Breast and Cervical Cancer screening. 	<ul style="list-style-type: none"> • Rate drop by 2.5% and did not meet goal
Chlamydia screening	<ul style="list-style-type: none"> • Physicians do not adhere to recommended Chlamydia screening practices because they believe that the prevalence of Chlamydia is low or are uncomfortable testing and talking to young members about sexually transmitted diseases. • Members' lack of knowledge of the benefits of testing, worries about discussing sexual health, were unsure of the consequences of Chlamydia infection, and lack of guidance. • Members' concern that someone will know if they were tested or tested positive. • Fear about discovering they have a sexually transmitted disease (STD), 	<ul style="list-style-type: none"> • L.A. Care includes Chlamydia screening as one of the clinical measures for both the LA P4P provider group incentive and the Physician P4P incentive programs. • L.A. Care blast faxed a flyer highlighting the importance of Chlamydia screening with tips for conducting screening to provider offices. • L.A. Care's PQIL nurses continued to distributed updated Chlamydia toolkits to physicians during their visits. The toolkits and they are also available on the provider portal and the provider section of lacare.org. • L.A. Care contacted members 18-24 to educate them on the importance and ease of screening. • L.A. Care encouraged parents of minor members to seek preventive screenings and allow private, age-appropriate discussions about sensitive topics with their child's provider. 	<ul style="list-style-type: none"> • The rate increased by 2.7 percentage points from 2014, and did not meet the 2015 goal.

HEDIS Measure	Barriers	Actions	Effectiveness of Intervention/ Outcome
	and fear of acquired immunodeficiency syndrome.	<ul style="list-style-type: none"> L.A. Care distributed Preventive Health Guidelines brochures to members to serve as a reminder of recommended tests and screenings. 	

LOOKING FORWARD

- L.A. Care plans to use social media to increase awareness of the importance of Chlamydia screening, due to the high rate of social media usage amongst the target population.
- L.A. Care plans to continue outreach to providers on the Chlamydia screening guidelines.
- L.A. Care plans to design an intervention targeting SPDs due to their lower rates of compliance.
- L.A. Care will continue to include Breast Cancer and Cervical Cancer screenings as two of the clinical measures for both the LA P4P provider group incentive and the Physician P4P incentive programs.

2016 WORK PLAN GOALS:

HEDIS Measure	2016 Goal for Medi-Cal	2016 Goal for CMC	2016 Goal for LACC
Breast Cancer Screening	58%	74%	70%
Cervical Cancer Screening	68%	N/A	72%
Chlamydia Screening	62%	N/A	58%

A.5 CHRONIC CONDITION MANAGEMENT

A. 5.a ASTHMA DISEASE MANAGEMENT PROGRAM

2015 WORK PLAN GOALS:

Measures	Specific Indicators	2015 Goals	Measure Type
Appropriate Use of Medications for People with Asthma.	Percentage of eligible members with persistent asthma prescribed acceptable medications for long-term control of asthma during measurement year.	MCLA: 83% LACC: Baseline year CMC: Baseline year	Administrative
Medication Management for People with Asthma 50% compliance.	Percentage of eligible members with persistent asthma who remained on an asthma controller medication for at least 50% of their treatment Period	MCLA: 70% LACC: Baseline year CMC: Baseline year	Administrative
Medication Management for People with Asthma 75% compliance.	Percentage of eligible members with persistent asthma who remained on an asthma controller medication for at least 75% of their treatment Period	MCLA: 49% LACC: Baseline year CMC: Baseline year	Administrative
Asthma Action Plan	Percentage of members with an asthma action plan.	MCLA: 75% LACC: Baseline year CMC: Baseline year	DM Survey
Flu shot	Percentage of members who had a flu shot between September 1, 2014 and March 31, 2015.	MCLA: 65% LACC: Baseline year CMC: Baseline year	DM Survey
Overall Member Satisfaction	Percentage of members who are overall satisfied with the program (strongly agree or agree)	MCLA: 90% LACC: 90% CMC: 90%	DM Survey

BACKGROUND

Asthma is one of the most common chronic conditions experienced by L.A. Care members. L.A. Care's Asthma Disease Management Program addresses a range of interventions, including condition monitoring, monitoring patient adherence to the treatment plans, medical and behavioral health co-morbidities, health behaviors, psychosocial issues, and depression screenings. Members with asthma are identified on a monthly basis and are stratified into one of three risk levels (1, 2, and 3, with 3 being highest risk) based on medical utilization and pharmacy claims. Each member's stratification determines the type and intensity of program intervention he or she receives.

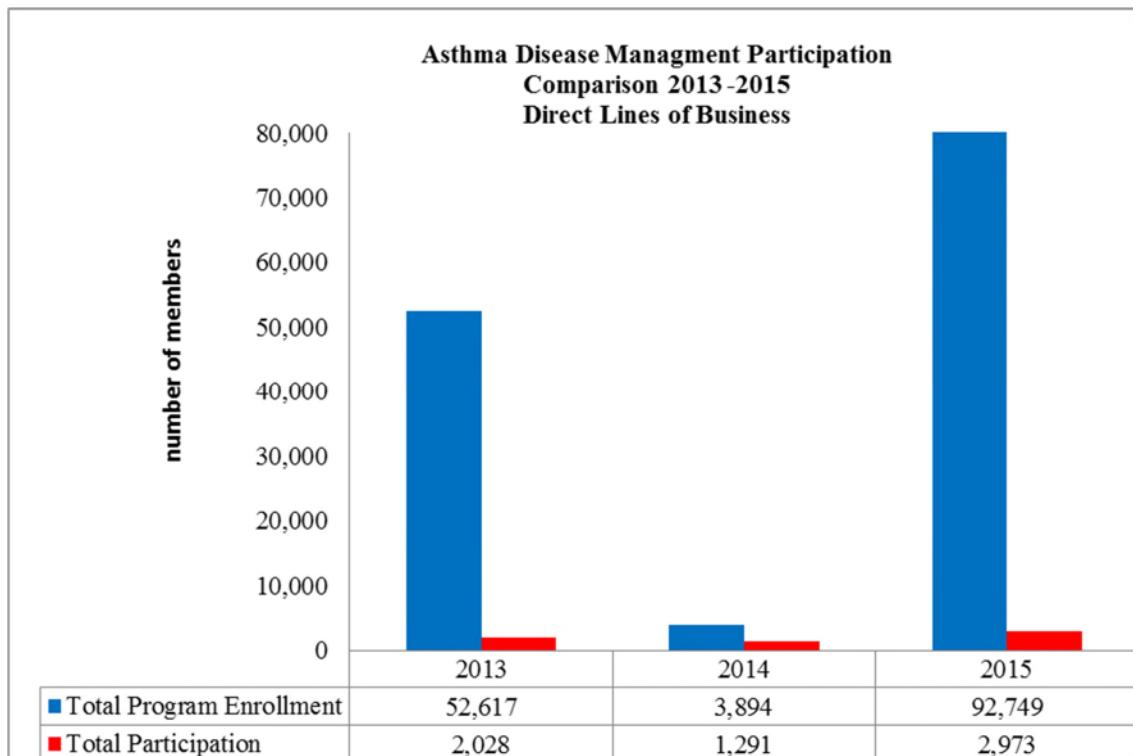
MAJOR ACCOMPLISHMENTS

- *L.A. Cares About Asthma®* grew from 83,306 members at the end of 2014 to 92,749 members at the end of December 2015, an increase of 11.3%.
- L.A. Care produced new asthma education materials and mailings on safe household cleaning solutions for people with asthma to minimize triggers caused by inhaling cleaning products and a frequently asked question flyer on the home visitation program.
- The *L.A. Cares About Asthma®* program had two staff members become Certified Asthma Educators (AE-Cs), for a total of three AE-Cs in the program.

- *L.A. Cares About Asthma®* is contracted with QueensCare Health Centers to provide high-touch in-home interventions for asthma members participating in the *L.A. Cares About Asthma®* Disease Management program. In the 2015 contract, the geographic area and age ranges expanded to better serve our members. QueensCare now serves members living in a 20 mile radius of the QueensCare Health Centers (expanding from coverage of two RCACs to ten RCACs) and this is open to adults as well as children with asthma.
- L.A. Care was recognized by the EPA and America's Health Insurance Plans (AHIP) as a national health plan leader in innovative strategies for asthma management. L.A. Care's Disease Management department was invited to lead a webinar for 242 participants from 66 health plans across the country on health plan strategies for managing asthma and reducing exposure to environmental triggers, in which our partnership with QueensCare was highlighted.
- The *L.A. Cares About Asthma®* nurses have all been trained in ongoing motivational interviewing to help improve communication with the diverse populations in which the program interacts.
- L.A. Care partnered with QueensCare Health Centers to provide a joint CME/CEU titled "Pediatric Asthma Diagnosis, Assessment & Cultural Competency" for MDs, DOs, PAs, & NPs.
- Telephonic condition monitoring was increased from quarterly outreach to at least monthly outreach for level 3 members.
- The *L.A. Cares About Asthma®* program added a manager position to oversee the Asthma Disease Management Program, conduct the day to day operations, manage clinical issues and to make sure the program is in compliance with NCQA, CMS and DMHC requirements.

Participation Rate

In 2015, L.A. Care identified eligible members monthly and stratified them based on their risk level. The tables below show L.A. Care eligible asthma members for Medi-Cal Direct (MCLA), L.A. Care Covered (LACC) and Cal MediConnect (CMC) lines of business. L.A. Care's asthma disease management program utilizes an opt-out enrollment method, which means that eligible members are enrolled unless they actively opt out. In 2015, 178 MCLA members, 2 LACC members and 2 CMC members with an active asthma diagnosis opted out of the program. In order to reflect the percentage of members that are actively engaged in the program, the denominator represents the number of eligible members in all levels at the end 2015, and the numerator represents the number of eligible members in levels 1, 2, or 3 with at least one interactive contact. The monthly membership of level 1, level 2 and 3 members at the end of December 2015 was 92,749; of these eligible members, 2,973 actively participated in the ADM program through either condition monitoring or use of the Asthma Resource Line, for a total participation rate of 3.2%. The rationale for change in participation rate is to reflect NCQA requirements for including full program member eligible population in the denominator.



	Total Program Enrollment	Total Participation	Percentage of Active Participation
2013	52,617	2,028	3.9%
2014*	3,894	1,291	33.2%
2015	92,749	2,973	3.2%

*The 2014 participation rate only reflected those members who were eligible for nurse outreach (level 2 and 3) and did not include the level 1 mail-only members.

2015 Year-End Membership by Line of Business	
MCLA	89,608
LACC	219
CMC	313
Other Lines of Business (Healthy Kids, PASC-SEIU)	2,609
Total	92,749

Member Satisfaction

METHODOLOGY

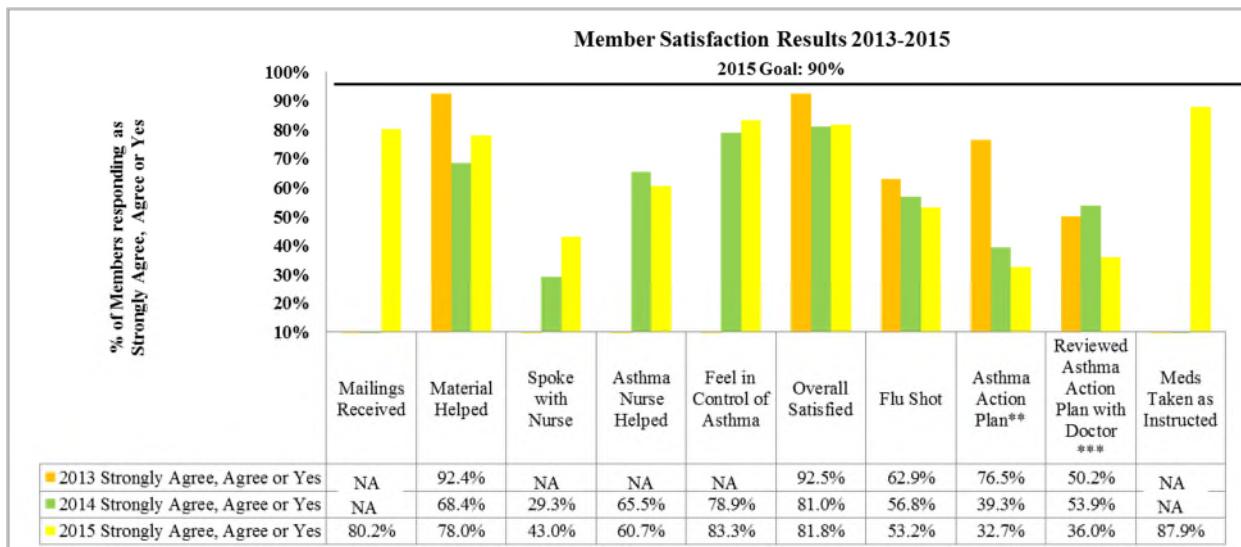
Satisfaction of participants in the asthma disease management program is assessed by 1) analysis of complaints and inquiries, and 2) a formal satisfaction survey. In July 2015, L.A. Care conducted a mail-in survey to active MCLA, LACC and CMC members in the asthma disease management program. Only members identified as active in the Asthma program from January 2014–February 2015 were surveyed. With consultation from the Health Outcomes and Analysis (HO&A) department, all Level 2 and 3 MCLA, LACC and CMC members were surveyed. A total of 2,998 surveys were mailed with 200 completed and returned, or a 6.67% response rate. This was a slight increase from the 6.5% response rate for the 2014 satisfaction survey. Possible reasons for the increase in response rate are discussed in the Qualitative Analysis section below.

The composition of the surveyed population was 89.2% Asthma Disease Management (ADM) severity Level 2-mild persistent, and 10.8% ADM severity Level 3-moderate-to-severe persistent.

RESULTS

The format and content of the 2015 survey differed from previous years such that a direct comparison of results compared to previous years would not be valid or appropriate. As such, we have detailed the previous years' results for reference, but have not included trend analysis.

On the 2015 survey, respondents were asked to rate their level of satisfaction with various aspects of the program with ten questions, based on a Likert scale ranging from Strongly Agree to Strongly Disagree.



	Mailings Received	Material Helped	Spoke with Nurse	Asthma Nurse Helped	Feel in Control of Asthma	Overall Satisfied	Flu Shot	Asthma Action Plan**	Reviewed Asthma Action Plan with Doctor ***	Meds Taken as Instructed
2013 % Strongly Agree, Agree or Yes	N/A	92.4%	N/A	N/A	N/A	92.5%	62.9%	76.5%	50.2%	N/A
2014 % Strongly Agree, Agree or Yes	N/A	68.4%	29.3%	65.5%	78.9%	81.0%	56.8%	39.3%	53.9%	N/A
2015 % Strongly Agree, Agree or Yes	80.2%	78.0%	43.0%	60.7%	83.3%	81.8%	53.2%	32.7%	36.0%	87.9%

**In 2013 this question asked only, "I have an Asthma Action Plan," and all responses other than "I do not have an Asthma Action Plan" were counted as positive responses. In 2014, the question was changed to "I have a completed Asthma Action Plan signed by my doctor," and only "Yes" responses were counted as positive responses. In 2015, the question was changed to "Have you filled out an Asthma Action Plan?" and only "Yes" responses were counted as positive responses.

***In 2013 this question asked "My doctor explained my Asthma Action Plan." On the 2014 survey, this question was changed to, "My doctor explained to me how to use my asthma medicines." On the 2015 survey, this question was changed to, "Have you reviewed your Asthma Action Plan with your doctor?"

Barriers to reviewing the Asthma Action Plan	Percentage	Barriers to taking medications as directed	Percentage
I did not have an Asthma Action Plan	36.0%	Cannot afford medications	2.8%
The doctor did not want to fill out the Asthma Action Plan	2.2%	Did not fill prescriptions	2.8%
The doctor did not know what an Asthma Action Plan is or how to fill it out	5.8%	Do not see need for medication	13.9%
I forgot to bring my Asthma Action Plan with me to my appointment	16.5%	Lack of knowledge about medication use	2.8%
The doctor said I did not need an Asthma Action Plan	7.2%	Forget to take them	5.6%
		Forget to bring the medications with me when traveling or leaving home	5.6%
		I feel better so I stopped taking them	11.1%
Blank	35.5%	Blank	84.7%
Other	32.40%	Other	55.5%

Quantitative Analysis

Member satisfaction goals and baselines based on the survey for 2015 cannot be accurately determined because of modifications in the survey format and content. With 81.8% of respondents satisfied with the program, L.A. Care did not meet the 2015 goal of 90% overall member satisfaction. 78.0% of respondents found the program's educational materials helpful in managing their asthma, as compared to 68.4% in 2014. New questions on the 2015 survey asked barrier questions to what stopped the members from reviewing their Asthma Action Plan with their doctor of those who responded, 36% stated they did not have an Asthma Action Plan. Another barrier question was what stopped the member from taking their medications of those who responded, 13.9% stated they did not see a need for the medication. Of the 86 respondents who reported speaking with an asthma nurse in the past 12 months, 60.7% agreed or strongly agreed that the nurse contact was helpful in managing their asthma , while only 0.72% strongly disagreed.

Respondents who reported receiving a flu shot in the past year decreased from 56.8% in 2014 to 53.2% in 2015.

The questions regarding the Asthma Action Plan (AAP) were modified to ask respondents whether they have an AAP that has been filled out and an additional question asking if the respondent reviewed the AAP with their doctor, rather than asking whether the respondents have a completed AAP signed by their doctor. In 2013 this question asked only, “I have an Asthma Action Plan,” and all responses other than “I do not have an Asthma Action Plan” were counted as positive responses. In 2014, the question was changed to “I have a completed Asthma Action Plan signed by my doctor,” and only “Yes” responses were counted as positive responses. The 2014 question “I have a completed Asthma Action Plan signed by my doctor.” was changed in 2015 to “Have you filled out an Asthma Action Plan?” and only “Yes” responses were counted as positive responses. As such, we cannot effectively compare the 2013 76.5% positive response rate to the 2014 39.3% and the 2015 32.7% positive response rate. Similarly, the 2013 question “My doctor explained my Asthma Action Plan” was changed in 2014 to “My doctor explained to me how to use my asthma medications” and again in 2015 to “Have you reviewed your Asthma Action Plan with your doctor?” The 50.2% positive response to the 2013 question cannot be accurately compared to the 53.9% positive response rate in 2014 as the question emphasis shifted away from the AAP to medication instruction. The response rates from the 2013 survey with the 2015 survey can be more accurately compared with the emphasis on reviewing the AAP with the doctor. The positive response rate of 50.2% in 2013 has decreased to a positive response rate of 36% in 2015.

Qualitative Analysis

The 2015 survey differed from the 2014 and 2013 survey in that there was a 3 tiered approach with getting the surveys completed by mailing out the survey, followed it up with a reminder postcard and for those members who did not complete the survey by mail, a phone campaign was conducted to complete the surveys over the phone. The 3-tiered approach could be the reason for the slight increase in response rate from 6.5% in 2014 to 6.67% response rate in 2015. This was the first year an incentive was not given for returning the survey which may have negatively impacted the response rate however, the other 2 Disease Management programs also did not have an incentive and they had higher response rates.

Of the respondents who reported speaking with an asthma nurse in the past 12 months, 60.7% (88 of the 145 responses) found their nurse contact to be helpful in managing their asthma. However, only 86 respondents reported speaking with an asthma nurse at all. This discrepancy could be due to how members completed the survey. Additionally, members may be reporting on other L.A. Care staff or provider office staff as their ‘asthma nurse.’ This year the survey was tailored to be more applicable to the level of involvement in the asthma program and disease severity level. The survey was only sent to level 2 and level 3 members in hopes to get a more accurate measure of overall member satisfaction.

By asking members in 2015 if they have a reviewed the AAP with their doctor rather than simply having a completed AAP, positive response decreased markedly (from 53.9% to 36%). However, 29.6% of

responses stated they did not have an AAP. To address this situation, we are currently working to address practitioner education on the AAP in addition to providing education to our members. Currently, all program members receive an annual mailing that includes the AAP and how to talk to their doctor. When a member is newly enrolled into the program they receive our asthma booklet which is a consolidation of educational materials. Higher-severity Level 2 and Level 3 members also receive condition monitoring telephone calls from asthma nurses during which the importance of the AAP is discussed. Addressing the importance of the Asthma Action Plan as well as medication compliance on the PPG and provider level will continue to be a high priority for the program in 2016.

As the goal for 65% of respondents receiving a flu shot in the past year was not met, all asthma program members received flu shot reminders in the fall of 2015 that may be reflected in the 2016 response. Program members of all severity levels were mailed a flu shot reminder postcard. Flu shots are also addressed during telephonic monitoring of Level 2 and 3 members.

OPPORTUNITIES IDENTIFIED FROM SURVEY

Member education on long-term controller and quick-relief medicines remains a priority for 2016. In addition to educational materials developed with the Health Education, Cultural & Linguistic Services department, the department will work to develop a convenient and accessible mailer explaining how to use the Asthma Action Plan as well as an educational piece regarding medication compliance to our members to be included in new member welcome letters. Due to the drop in reported flu vaccinations we will plan an intervention in 2016 to inform members with asthma on the importance of getting their annual flu vaccination.

COMPLAINTS AND INQUIRIES

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

In, 2013, 2014, and 2015 there were no complaints related to asthma disease management program. In 2015, there were 325 inquires made on the asthma member telephone resource line compared to 368 in 2014.

Asthma Resource Line Call Analysis						
Complaints	2013		2014		2015	
Number of complaints received	0		0		0	
Inquiry Reason	Number of Calls	Percentage of all Calls	Number of Calls	Percentage of all Calls	Number of calls	% of all calls
Opt out/no asthma	334	68%	237	64%	157	48%
Requested Asthma Information	58	12%	63	17%	57	17%
Other (member services and disenrolled)	99	20%	66	18%	111	34%
TOTAL	494	100%	368	100%	325	100%

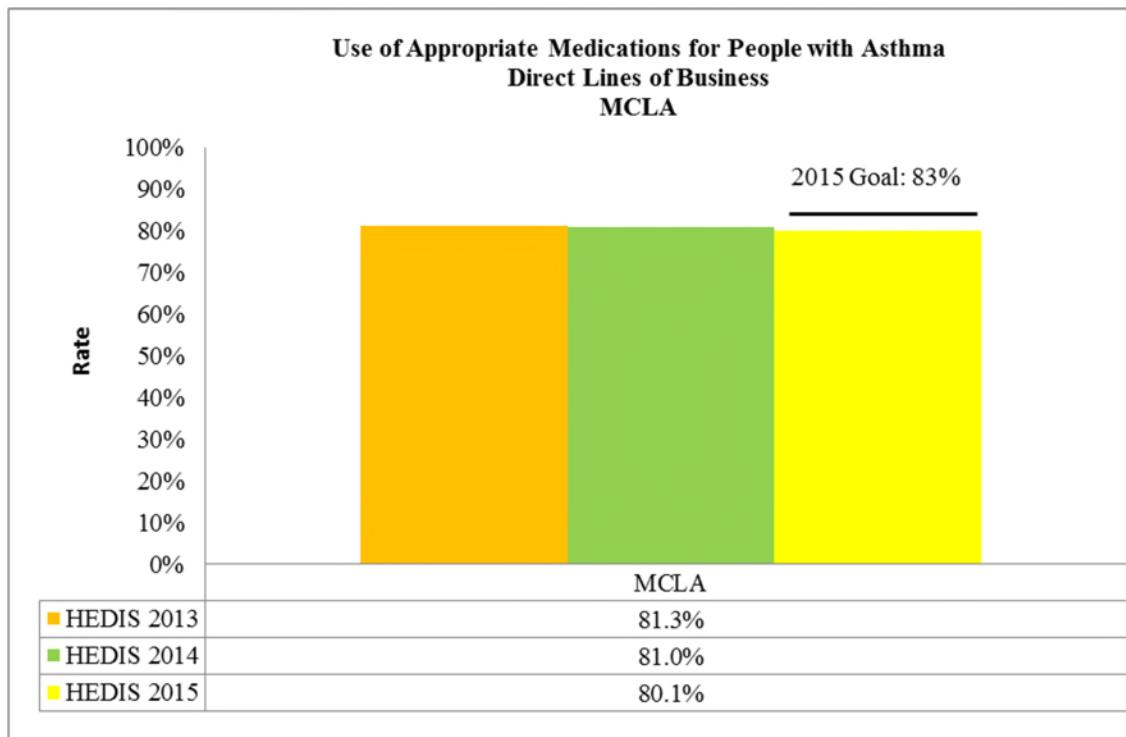
OPPORTUNITIES

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

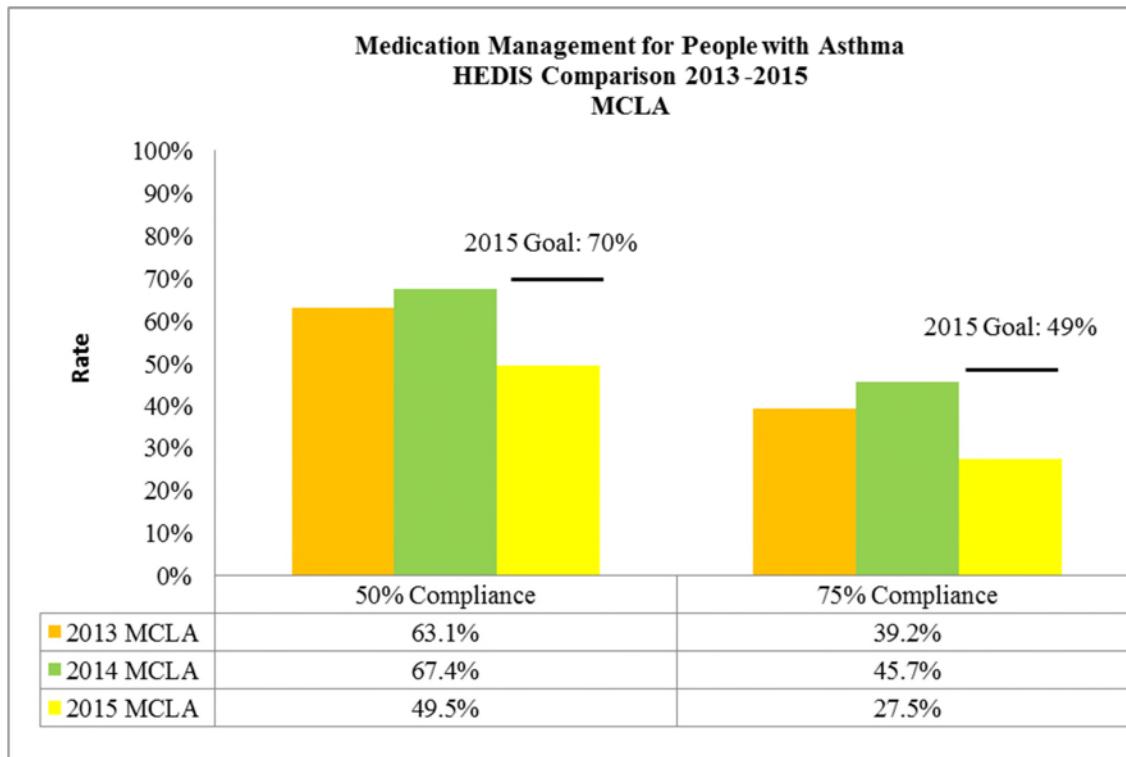
Measuring Effectiveness:

Measure	Methodology
Use of Appropriate Medications for People with Asthma (ASM)	Refer to 2015 HEDIS Technical Specification Vol.2 specifically on Use of Appropriate Medications for People with Asthma Measure (will be retired in 2016)
Medication Management for People with Asthma 50% compliance (MMA)	Refer to 2015 HEDIS Technical Specification Vol.2 specifically on Medication Management for People with Asthma
Medication Management for People with Asthma 75% compliance (MMA)	Refer to 2015 HEDIS Technical Specification Vol.2 specifically on Medication Management for People with Asthma
Proportion of Days Covered (PDC) for Asthma Controller Medications with 50% compliance	Refer to specifications in LACC and CMC Quantitative Analysis Section
Proportion of Days Covered (PDC) for Asthma Controller Medications with 75% compliance	Refer to specifications in LACC and CMC Quantitative Analysis Section
Average Proportion of Days Covered (PDC) for Asthma Controller Medications	Refer to specifications in LACC and CMC Quantitative Analysis Section
Asthma Action Plan	L.A. Care conducted a mail-in survey targeting all Level 2 and 3 members/parents of members.
Flu Shot	L.A. Care conducted a mail-in survey targeting all Level 2 and 3 members/parents of members.
Member Satisfaction	L.A. Care conducted a mail-in survey targeting all Level 2 and 3 members/parents of members.

RESULTS



*Appropriate Medications for People with Asthma (ASM) will retire in 2016



Note: 2015 goal was established based on 2015 HEDIS results. Evidence was found after the goal was established that the 2014 HEDIS data was incorrect, explaining the drop from 2014 to 2015. New goals were set for 2016.

Quantitative Analysis

L.A. Care Medi-Cal Direct (MCLA)

Analysis of 2015 results and findings:

- Use of appropriate medications for people with asthma (ASM) was 80.1%, a decrease of 0.9% in comparison to 2014's rate of 81.0%. This year's rate did not meet the 2015 goal of 83%. This measure will retire in 2016.
- Medication management for people with asthma with 50% medication compliance (MMA) was 49.5%. This year's rate did not meet the 2015 goal of 70%. MMA 50% compliance decreased 17.9% from 2014 which was 67.4%.
- Medication management for people with asthma with 75% medication compliance (MMA) was 27.5%. This year's rate did not meet the 2015 goal of 49%. MMA 75% compliance decreased 18.2% from 2014 which was 45.7%

L.A. Care Covered (LACC)

L.A. Care Covered (LACC) was a new line of business in 2014. In evaluating the HEDIS eligible population for MMA, there was insufficient membership in the HEDIS 2015 MMA denominator to measure effectiveness based on the HEDIS timeframes. Instead, L.A. Care defined a baseline measure modelled after Medication Management for People with Asthma (MMA) reflecting adherence to asthma controller medications. The denominator was defined as LACC members ages 5-85 from 7/1/14-6/30/15 with continuous enrollment of 12 months prior to 6/30/2015 with no more than one gap of up to 30 days.

Members were eligible if they had at least one of the following within the 24 months prior to 6/30/15 based on claims/encounters:

- One visit from ED Value Set with a principal diagnosis from the Asthma Value Set
- One visit from Acute Inpatient Value Set with a principal diagnosis from the Asthma Value Set
- At least 4 visits from the Outpatient Value Set with a primary or secondary diagnosis from the Asthma Value Set (ideally with at least two dispensing events from MMA-A)
- At least 4 dispensing events (per HEDIS MMA tech specs) from MMA-A table

Members were excluded if they had any of the following:

- A primary or secondary diagnosis within the prior 24 months from any of the following Value Sets:
 - Emphysema
 - Other Emphysema
 - COPD
 - Obstructive Chronic Bronchitis
 - Chronic Respiratory Conditions due to Fumes/Vapor
 - Cystic Fibrosis
 - Acute Respiratory Failure
 -
- Zero days covered for asthma controller medications (MMA-B table) in the measurement period.

To calculate the proportion of days covered (PDC) on controller medications for LACC members, L.A. Care used the HEDIS technical specifications based on the following modification of the HEDIS MMA technical specifications:

- Index Prescription Start Date (IPSD) – the earliest dispensing event for a medication in Table MMA-B starting 12 months prior to 6/30/15. If there was a surplus of covered days from 12-15 months prior, those were applied and PSD was imputed to the first day of the 12 month measurement period. PDC was calculated per the HEDIS specs for the PSD anchor.

For Measurement Period July 1, 2014-June 30, 2015, the Proportion of Days Covered (PDC) for:

- Asthma Controller Medications with 50% compliance was 45.1%.
- Asthma Controller Medications with 75% compliance was 35.3%.
- The average Proportion of Days Covered (PDC) for Asthma Controller Medications was 40.2%

Cal MediConnect (CMC)

Cal Medi-Connect (CMC) was a new line of business in 2014.

In evaluating the HEDIS eligible population for MMA, the rate was 100% with a denominator of two, which was not statistically significant to report.

Instead, for baseline, L.A. Care measured effectiveness of asthma controller medications with CMC members ages 18-85 from 7/1/14-6/30/15 with continuous enrollment of 12 months prior to 6/30/2015 with no more than one gap of up to 30 days. Members were eligible if they had at least one of the following within the 24 months prior to 6/30/15:

- One visit from ED Value Set with a principal diagnosis from the Asthma Value Set
- One visit from Acute Inpatient Value Set with a principal diagnosis from the Asthma Value Set
- At least 4 visits from the Outpatient Value Set with a primary or secondary diagnosis from the Asthma Value Set (ideally with at least two dispensing events from MMA-A)
- At least 4 dispensing events (per HEDIS MMA tech specs) from MMA-A table

Members were excluded if they had any of the following:

- A primary or secondary diagnosis within the prior 24 months from any of the following Value Sets:
 - Emphysema
 - Other Emphysema
 - COPD
 - Obstructive Chronic Bronchitis
 - Chronic Respiratory Conditions due to Fumes/Vapor
 - Cystic Fibrosis
 - Acute Respiratory Failure
- Zero days covered for asthma controller meds (MMA-B table) in the measurement period.

To calculate the proportion of days covered (PDC) on controller medications for LACC members, L.A. Care used the HEDIS technical specifications based on the following modification of the HEDIS MMA technical specifications:

- Index Prescription Start Date (IPSD) – the earliest dispensing event for a medication in Table MMA-B starting 12 months prior to 6/30/15. If there was a surplus of covered days from 12-15 months prior, those were applied and PSD was imputed to the first day of the 12 month measurement period. PDC was calculated per the HEDIS specs for the PSD anchor.

For Measurement Period July 1, 2014-June 30, 2015, the Proportion of Days Covered (PDC) for:

- Asthma Controller Medications with 50% compliance was 67.8%.
- Asthma Controller Medications with 75% compliance was 49.6%.
- The average Proportion of Days Covered (PDC) for Asthma Controller Medications was 58.7%

Qualitative Analysis

The MCLA, LACC, and CMC results suggest the following opportunities for improvement for the asthma disease management program. Some barriers to medication compliance are discussed below:

- Asthma medication samples received by patients and prescriptions received during an emergency room visit or hospital stay do not appear in the pharmacy data collected by L.A. Care.

- Some medications require prior authorization forms. While L.A. Care provides this information to practitioners, this extra step can be a barrier for members in following through to receive and comply with the proper asthma medication treatment.
- Members with multiple prescriptions for asthma inhalers may also affect the accuracy of the controller/reliever ratio.
- Low-severity members who do not comply with asthma medication and have opted out of the program can affect compliance rates as they are still counted in the denominator.
- Not all providers are using the Asthma Action Plan to help with members with their medication compliance.

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

- Practitioners annually receive the EPR-3 Guidelines for the diagnosis and management of asthma that emphasizes best practices, including use of the Asthma Action Plan.
- DM conducted a pilot study for a Provider intervention by contacting 20 high volume/low performing providers. Provider outreach was targeted to help increase compliance with controller medications with the use of Asthma Action Plans. The results of this pilot study will be available in January 2016.

Another continual barrier to high compliance is lack of patient education regarding asthma care, self-management, and decreased medication compliance. To address these barriers, L.A. Care provides multiple educational materials regarding asthma, allergies, flu shots, and annual preventative guidelines including mailings and a booklet that addressing asthma and allergy triggers and medications and reminders and education to Level 2 and 3 members discussed during monitoring calls. Level 2 and 3 members who live in selected zip codes may be referred to QueensCare for a home visit with a Community Health Worker. These visits include: a review of medical history; asthma education; home environmental assessment, review and reinforcement of asthma treatment plan, identification of triggers, and counseling members on how to talk with their provider.

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

Materials are culturally and linguistically appropriate, and continue to be mailed in English and Spanish. The mailings include an attachment to the cover letter indicating that the information is available in eleven (11) different languages, larger print, Braille, audio or TTY as requested.

However, L.A. Care Health Plan's inability to reach members who require more education and monitoring, by phone or by mail due to incorrect addresses or no address (transient and homeless populations) contributes to the member barriers. With the higher severity level members the Disease Management RNs call the member to attempt to identify an address to reach the member, but often these members officially enrolled in the program are not receiving the benefits of the program.

Opportunities

There remain opportunities to improve the use of appropriate medications for people with asthma, especially in the adult population. The Disease Management department is developing interventions to help improve controller medication compliance.

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

LOOKING FORWARD

- The Cal MediConnect (CMC) membership is expected to increase throughout 2016 as membership increases.
- The Disease Management leadership will develop, implement and evaluate a COPD program that will align with the asthma program.
- The Disease Management leadership, working in collaboration with IS, will evaluate the algorithm for identification and stratification of asthma members to reduce false positive identification.
- The Disease Management Nurses and/or Pharmacist will continue attending and assisting with Asthma 101 Health Education classes when available to review members' asthma medications.
- The Asthma Disease Management staff department will continue increased interventions for Level 2 members, increasing bi-annual condition monitoring calls to at least monthly outreach.
- Disease Management will be transitioning to our core system, Clinical Care Advance (CCA) to integrate member information across the organization to improve care coordination.
- As part of the CCA transition all members will have care plans to include personalized goals and interventions based on clinical practice guidelines. For example, care plans will include goals and interventions to improve medication compliance, the use of asthma action plans and the use of internal and community based asthma resources.
- L.A. Care is exploring mobile health technology to further target and reach members. These possible interventions include an asthma text-messaging program to send asthma education and medication adherence reminders to members who opt-in to the program.
- Medication Management for People with Asthma 75% compliance (MMA) will be added in 2016 to the P4P Incentive program.

2016 WORK PLAN GOALS:

MCLA Measures	2016 Goal
Medication Management for People with Asthma 50% compliance	Not reported
Medication Management for People with Asthma 75% compliance	30%
Asthma Action Plan	75%
Flu Shot	65%
Overall Member Satisfaction	90%

LACC Measures	2016 Goal
Medication Management for People with Asthma 50% compliance	Not reported
Medication Management for People with Asthma 75% compliance	37%
Asthma Action Plan	75%
Flu Shot	65%
Overall Member Satisfaction	90%

CMC Measures	2016 Goal
Medication Management for People with Asthma 50% compliance	Not available*
Medication Management for People with Asthma 75% compliance	Not available*
Asthma Action Plan	75%
Flu Shot	65%
Overall Member Satisfaction	90%

*There were no NCQA benchmarks available for this measure in Quality Compass

A. 5.b DIABETES DISEASE MANAGEMENT PROGRAM

2015 WORK PLAN GOALS:

Measures	Specific Indicators	2015 Goal (Hybrid)	Measure Type
Hemoglobin A1c screening (HbA1c)	Percentage of eligible members 18-75 years of age with diabetes (type 1 and type 2) who had A1c testing.	MCLA: 82% CMC: Baseline Year LACC: Baseline Year	Hybrid
A1c good control (< 8%)	Percentage of eligible members 18-75 years of age with diabetes (type 1 and type 2) who had A1c control (<8.0%).	MCLA: 37% CMC: Baseline Year LACC: Baseline Year	Hybrid
A1c poor control (> 9%)*	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had A1c poor control (>9.0%)	MCLA: 47% CMC: Baseline Year LACC: Baseline Year	Hybrid
Retinal eye exam	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had retinal eye exam performed.	MCLA: 46% CMC: Baseline Year LACC: Baseline Year	Hybrid
Medical Attention for Nephropathy	Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy.	MCLA: 87% CMC: Baseline Year LACC: Baseline Year	Hybrid
Overall Member Satisfaction	Percentage of members will be satisfied with the Diabetes Disease Management Program	90%	Survey

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

BACKGROUND

Diabetes is the world's most prevalent metabolic disease and it is the leading cause of adult blindness, renal failure, gangrene and the necessity for limb amputations. There are about 25.8 million children and adults (8.3 % of the total United States population) living with diabetes. This included 18.8 million people diagnosed and 7 million who were not diagnosed. Additionally, there are 79 million people diagnosed as pre-diabetic. The prevalence of diabetes among L.A. Care Covered (LACC), Cal MediConnect (CMC) and L.A. Care Medi-Cal Direct (MCLA) is 15.1%. This is higher than the Los Angeles County rate of 9.9% among adults only. The difference is primarily due to the high number of seniors and people with disability enrolled in L.A. Care's Health Plan.

LA Cares About Diabetes® focuses on a collaborative, team-based approach for improving health outcomes of members with diabetes. L.A. Care's Diabetes Disease Management Program is based on evidence-based clinical guidelines and utilizes recognized sources (e.g. American Diabetes Association (ADA) for its clinical content. On an annual basis an evidenced based review is conducted on the guidelines to identify

any significant changes that would require an update to the program. The program addresses a range of interventions, including condition monitoring, monitoring patient adherence to treatment plans, medical and behavioral health co-morbidities, health behaviors, psychosocial issues, and depression screenings. Members with diabetes are identified on a monthly basis and are stratified into one of five risk levels (0, 1, 2, 3, and 4 with 4 being highest risk) based on medical utilization, lab data and pharmacy claims. Level 0 are identified as Pre-Diabetic and referred to the Health Education department for member intervention and education. The member's stratification from Levels 1-4 determines the type and intensity of program intervention he or she receives.

MAJOR ACCOMPLISHMENTS

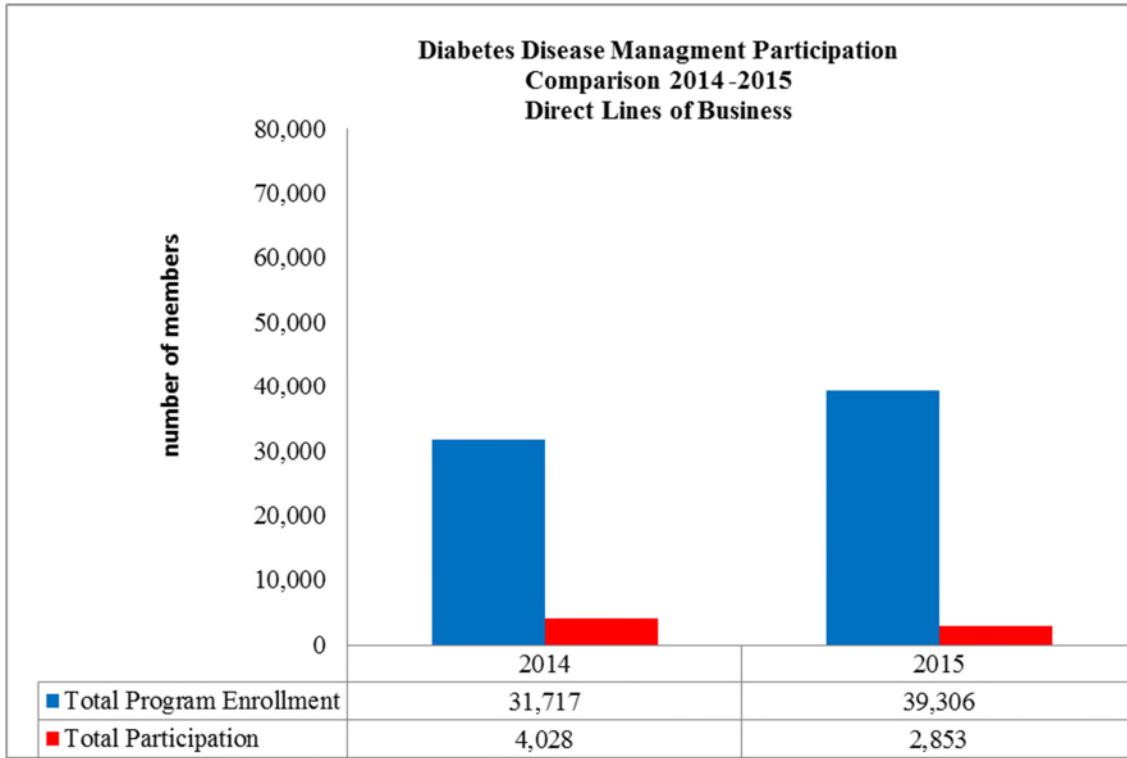
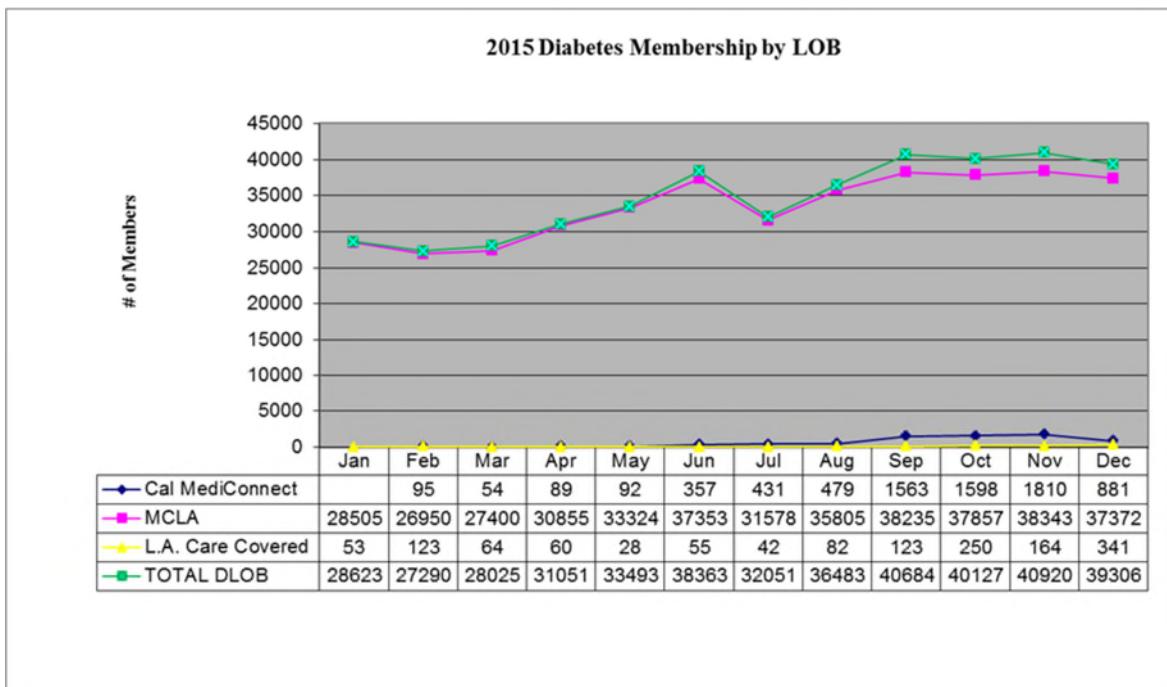
- *L.A. Cares About Diabetes®* grew from 32,119 members at the end of 2014 to 39,306 members at the end of November 2015, an increase of 22.0%
- The Disease Management Program completed the first internal satisfaction survey with a response rate of 10.54%.
- Development of L.A. Care branded Diabetes booklet that provides targeted education on Diabetes Disease Management to all new members upon identification and enrollment in the program.
- Providing ongoing Motivational Interviewing (MI) training to all Disease Management staff.
- Change in leadership with addition of Management position and addition of Disease Management Nurses for member outreach.

RESULTS

Participation Rate

In 2015, L.A. Care identified eligible members monthly and stratified them based on their risk level. The tables below show L.A. Care eligible diabetes members for MCLA, LACC and CMC lines of business. L.A. Care's diabetes disease management program utilizes an opt-out enrollment method, which means that eligible members are enrolled unless they actively opt out. In 2015, 95 MCLA members, 0 LACC members and 2 CMC members with an active diabetes diagnosis opted out of the program. In order to reflect the percentage of members that are actively engaged in the program, the denominator represents the number of eligible members in all levels at the end of 2015, and the numerator represents the number of eligible members in levels 1, 2, 3, or 4 with at least one interactive contact. The monthly membership of level 1, level 2, level 3 and level 4 members at the end of 2015 was 39,306; of these eligible members, 2,853 actively participated in the Diabetes program through either condition monitoring or use of the Diabetes Resource Line, which gives the program a total participation rate of 7.3%. The change in participation rate reflects NCQA requirements for including full program member eligible population in the denominator.

The graphs and tables below show L.A. Care eligible diabetes members for the following direct lines of business: Cal MediConnect (CMC), L.A. Care Medi-Cal Direct (MCLA), and L.A. Care Covered (LACC).



	Total Program Enrollment	Total Participation	Percentage of Active Participation
2014	31,717	4,028	12.7%
2015	39,306	2,853	7.3%*

*The change in participation rate reflects NCQA requirements for including full program member eligible population in the denominator.

2015 Year-End Membership by Line of Business	
MCLA	37,372
LACC	341
CMC	881
Total	39,306

Member Satisfaction

This is the first year L.A. Care's Disease Management conducted a survey for the in-house program, since moving from Healthways in July 2014.

METHODOLOGY

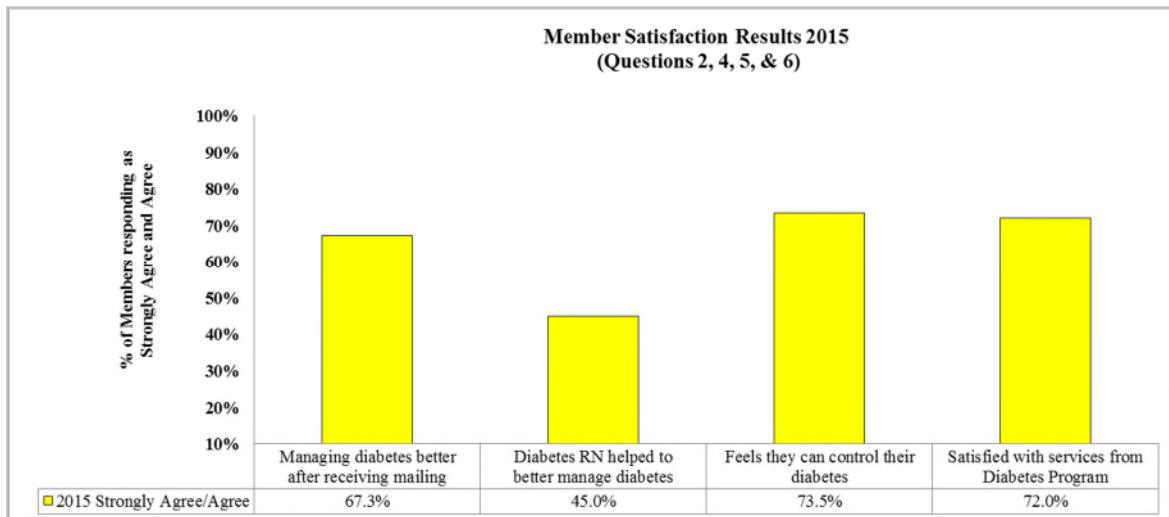
Satisfaction of participants in the diabetes disease management program is assessed by 1) analysis of complaints and inquiries, and 2) a formal satisfaction survey. In July 2015, L.A. Care conducted a mail-in survey to active MCLA, LACC and CMC members in the diabetes disease management program. Only members identified as active in the diabetes program from January 2014-February 2015 were surveyed. With consultation from the Health Outcomes and Analysis (HO&A) department, all Level 3 and 4 MCLA, LACC and CMC members were surveyed. A total of 11,156 surveys were mailed with 1,176 completed and returned, for a 10.54% response rate. This was the first year a survey was completed on the in-house program since the transition from Healthways.

The composition of the surveyed population was 78.83% Diabetes Disease Management severity Level 3 and 21.17% Level 4. English-speaking members also had a higher rate of response (56.80%) compared to Spanish-Speaking members (43.20 %).

RESULTS

On the 2015 survey, respondents were asked to rate their level of satisfaction with various aspects of the program for four questions, based on a Likert scale ranging from Strongly Agree to Strongly Disagree.

Quantitative Analysis



	Received Mailings	Spoke with DM RN	Had A1c test this year	Had Eye Exam this year	Had kidney (urine) test this year	Check blood sugars at home	Take medicine as directed
2015 Strongly Agree/Agree	71.7%	36.3%	80.3%	62.8%	69.5%	88.2%	95.6%

Barriers to getting tests completed (A1c, DRE, Kidney)	Percentage	Barriers to taking medications as directed	Percentage
I didn't know I needed these exams	24.2%	Forgot to take them	14.1%
Transportation to appointments/labs	12.1%	Cannot afford medications	12.5%
Forgot to schedule appointments/labs	16.1% %	Forgot to bring medication when leaving the home	12.5%
Blank	65.2%	Blank	90.1%
Other:	19.8%	Other: • Already scheduled appointment • Provider did not tell me to get tests • Scheduled appointment but forgot to go	20.7%
		• Didn't understand need for medications • Problems with side effects • Felt better so stopped taking medications	

Qualitative Analysis

The 2015 survey was developed to include barrier questions so the disease management staff can determine some of the barriers that the members are experiencing and how these barriers are impacting their healthcare. The survey had 14 questions for the member to answer on satisfaction with the program and services, test/exams completed in the last 12 months, barriers in getting those exams/tests and the method members would like to receive educational materials.

To increase response rates, two weeks after the survey was mailed to all Level 3 and 4 members, a reminder postcard was sent to the members. After 1 month, those members who did not respond to the mailed survey, a live agent called the member (145) to conduct the survey over the phone. The total response rate for 2015 was 10.54%.

With 72.0 % of respondents satisfied with the program, L.A. Care did not meet the 2015 goal of 90% overall member satisfaction. 67.3% of respondents found the program's educational materials helpful in managing their asthma. The 2015 survey asked barrier questions to what stopped the members from getting their A1c, dilated eye exam and kidney tests completed; 24.2% did not know they needed these exams, 12.1% did not have transportation to the appointment/lab and 16.1% forgot to schedule an appointment/lab. The survey asked what stopped the member from taking their medications; 14.1% forgot to take their medication, 12.5% answered that they could not afford their medication and forgot to take their medication with them when leaving the home, respectively. Other reasons for not taking their medications is; did not understand the need for medications, problem with side effects and felt better so stopped taking medications.

OPPORTUNITIES IDENTIFIED FROM SURVEY

Member education on basic diabetes care and self-management remains a priority for 2016. In September, 2015 a new L.A. Care branded diabetes booklet was developed and was sent to all enrolled members. In addition to educational materials developed with the Health Education, Cultural & Linguistics Services

department, the department will work to develop a convenient and accessible mailer reminding members to get their diabetes care exams/test and the importance of medication compliance.

In 2015, Level 3 members received condition monitoring calls every other month and Level 4 members received condition monitoring calls every month. This was not strongly adhered to due to limitations with the data systems and data collection. A higher intensity outreach is needed to improve satisfaction scores with the program and improve health outcomes for the members. Moving into 2016, the disease management programs will be migrating to the Clinical Care Advance (CCA) where RNs will complete the diabetes assessment, an individualized care plan with goals and target interventions and timeframes for follow-up. This will allow RNs to schedule call backs, intervention follow up and increase coaching to empower the member to take actions on their care.

COMPLAINTS AND INQUIRIES

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

In, 2013, 2014, and 2015 there were no complaints related to diabetes disease management program. In 2015, there were 448 inquiries made on the diabetes member telephone resource line compared to 433 in 2014.

Complaints	2013		2014		2015	
Number of complaints received	0		0		0	
Inquiry Reason	Number of Calls	Percentage of all Calls	Number of Calls	Percentage of all Calls	Number of calls	% of all calls
Opt out/no diabetes	36	20.5%	10	2.3%	25	5.6%
Requested diabetes Information	133	75.5%	368	85%	312	69.6%
Other	7	4.0%	55	12.7%	111	24.8%
TOTAL	176	100%	433	100%	448	100%

OPPORTUNITIES

There may be opportunities for better data collection regarding complaints and inquiries. To date, no complaints related to the diabetes program have been filed. A new process was developed in 2015 for routing any complaints received through the L.A. Care's Appeals & Grievance department.

MEASURING EFFECTIVENESS:

Since L.A. Care transitioned to CMC in mid- 2014, rates were captured administratively on 33 measures, but HEDIS 2015 measures for Medicare were not reported. 2015 results for measures will serve as a measurement of program effectiveness for 2016.

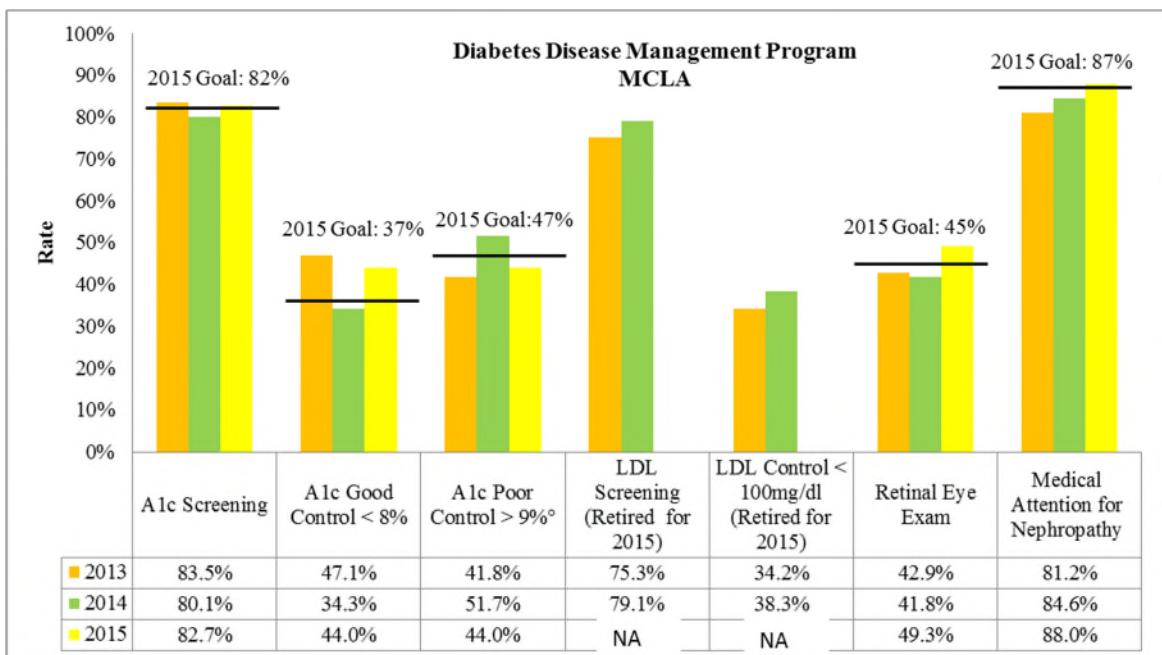
Measure	Methodology
A1C Screening	Refer to 2015 HEDIS Technical Specification Vol.2
A1C good control <8%	Refer to 2015 HEDIS Technical Specification Vol.2
A1C poor control >9%	Refer to 2015 HEDIS Technical Specification Vol.2
Retinal eye exam	Refer to 2015 HEDIS Technical Specification Vol.2
Medical Attention for Nephropathy	Refer to 2015 HEDIS Technical Specification Vol.2
Member satisfaction	Disease Management Satisfaction Survey

RESULTS

Quantitative Analysis

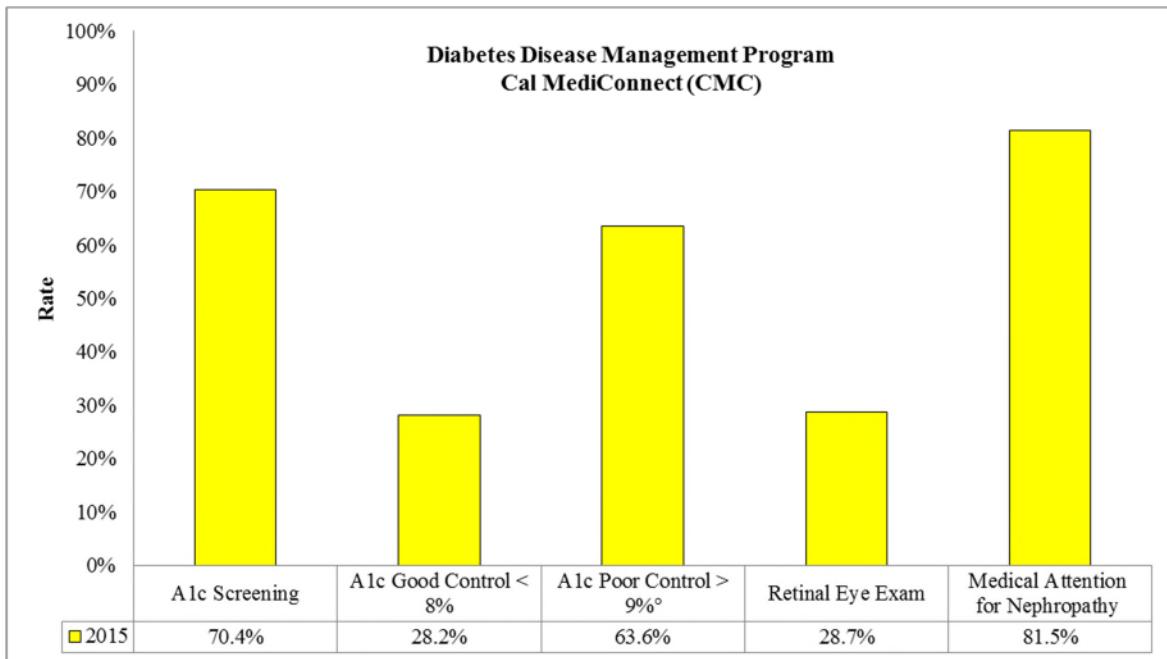
Administrative Measures	2015 Results
A1C screening	MCLA:82.7% CMC: 70.4% LACC: 87.3%
A1C good control <8%	MCLA:43.9% CMC: 28.2% LACC:30.4%
A1C poor control >9%	MCLA:43.9% CMC: 36.5% LACC: 58.6%
Retinal eye exam	MCLA:49.3% CMC: 28.7% LACC: 29.3%
Medical Attention for Nephropathy	MCLA:83.6% CMC: 81.5% LACC: 82.3%
Member satisfaction	MCLA: 71.3% CMC: Data Not Available LACC: 50.0%

Measure	2013 Results	2014 Results	2015 Results
Hybrid MCLA data			
A1c screening	85.5%	80.1%	82.7%
A1c good control < 8%	47.1%	34.3%	44.09%
A1c poor control > 9% <i>* Note: this is an inverse measure; lower number better</i>	41.8%	51.7%	44.09%
Retinal eye exam	42.9%	41.8%	49.3%
Medical Attention for Nephropathy	81.2%	84.6%	88.0%



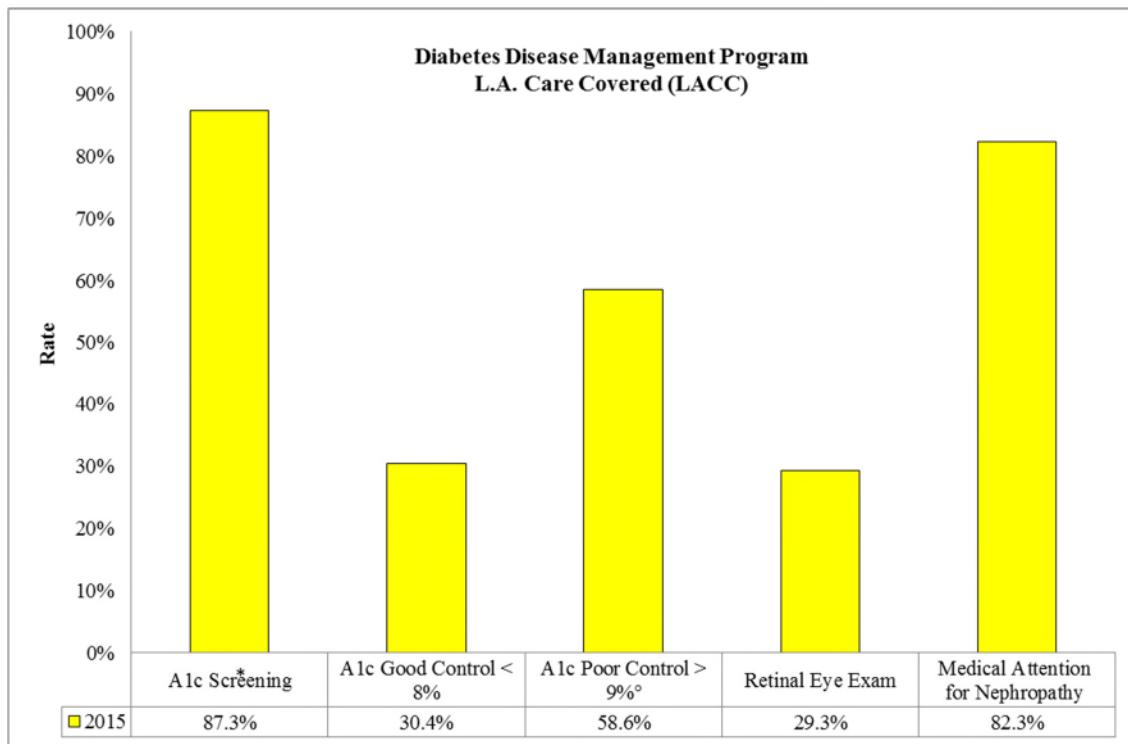
^oInverse measure (lower number better)

HEDIS CMC RESULTS



^oInverse measure (lower number better)

HEDIS LACC RESULTS



^oInverse measure (lower number better)

Quantitative Analysis

Medi-Cal Direct (MCLA)

Analysis of 2015 results or findings:

- Diabetes A1C screening of 82.7% is above the HEDIS measure goal of 82%, an increase of 2.6 percentage points from 2014.
- Diabetes A1C good control <8% of 44.0% is above the HEDIS measure goal of 37%, an increase of 9.7 percentage points from 2014.
- Diabetes A1C poor control >9% of 44.0% is below the HEDIS measure goal of 47%, a decrease of 7.7 percentage points from 2014. The goal was met, as this is an inverse measure.
- Retinal eye exam of 49.3% is above the HEDIS measure goal of 45%, an increase of 7.5percentage points from 2014.
- Medical Attention to Nephropathy of 88.0% is above the HEDIS measure goal of 87%, an increase of 3.4 percentage points from 2014.

Cal MediConnect (CMC)

Since L.A. Care transitioned to CMC in mid-2014, rates were captured only administratively for HEDIS 2015. Analysis of 2015 results or findings (Baseline year):

- Diabetes A1C screening of 70.4% is above the HEDIS measure goal.
- Diabetes A1C good control <8% of 28.2% met the HEDIS measure goal.
- Diabetes A1C poor control >9% goal of 36.5% is slightly below the HEDIS measure goal.
- Retinal eye exam goal of 28.7% is slightly below the HEDIS measure goal.
- Medical Attention to Nephropathy goal of 81.5% is slightly below the HEDIS measure goal.
- CMC Member Satisfaction rate data is not available due to 4 CMC member surveys were sent out and none returned.

L.A. Care Covered (LACC)

Analysis of 2015 results or findings:

- Diabetes A1C screening goal of 88% is slightly above the HEDIS measure goal.
- Diabetes A1C good control <8% of 22% is below the HEDIS measure goal.
- Diabetes A1C poor control >9% of 59% is slightly above the HEDIS measure goal.
- Retinal eye exam goal of 29% is aligned with the HEDIS measure goal.
- Medical Attention to Nephropathy goal of 82% is slightly above the HEDIS measure goal.

Qualitative Analysis

Over the course of 2015, several barriers to achieving high performance measures were noted. As a result, the *L.A. Cares About Diabetes®* program took several actions to mitigate these barriers. The MCLA, CMC and LACC 2015 HEDIS baseline rate results suggest opportunities for improvement for the diabetes disease management program. Some barriers to improving member interventions are discussed below:

- Ability to connect with members on the telephone, creating challenges in building relationships telephonically with members.
- Needing to use translation services for some members due to the diversity of cultures within L.A. Care's disease programs.
- Barriers to care (i.e. financial, transportation and access to care).
- Lack of knowledge regarding how to navigate through the healthcare system to help themselves, limiting the member's motivation and self-efficacy to change behavior.
- Lack of basic knowledge of diabetes.

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

- Change in pharmacy vendor impacted reporting on medication adherence, a full report on interventions not available until 2016.
- A 30 to 90 day supply conversion program, MMTP, a monthly refill reminder call program, and the high touch STARS adherence outreach program was implemented to increase medication adherence and address barriers to member access in getting provider prescribed drugs.
- Practitioner interventions focused on education and adherence to clinical practice guidelines to improve the assessment and treatment of members with diabetes, as well as care coordination communication to practitioners.
- L.A. Care informs practitioners annually, through the practitioner newsletter, website, and mailings, about the availability of the most up to date clinical practice guidelines on the management and treatment of diabetes.
- Through L.A. Care's provider portal, providers have access to the diabetes toolkit, which serves as another reference point for diabetes practice guidelines. (*See the diabetes program description for further details on this program*).
- L.A. Care offers various health education and program initiatives to address these barriers these include, "Healthier Living" which teaches skills to help individuals manage chronic conditions and "Weight Watchers" which helps individuals with weight management.
- The Medical Nutrition Therapy (MNT) program uses specific nutrition interventions to treat an illness, injury or condition. The program objectives are to optimize blood glucose levels, lipids and/or blood pressure, prevent and treat chronic complications such as retinopathy and medical attention to nephropathy, adapt dietary intake to individual's differences (culture and willingness to change), and integrate insulin regimens into usual eating and physical activity habits.

In 2013, a Diabetes Self-Management Education (DSME) program was added. The DSME program is a series of four interactive workshops to help individuals manage diabetes. Members learn about how diabetes affects their body, how to check and manage blood sugar, how to prevent or delay complications

from diabetes, how to eat well while managing diabetes, and how different medications work. The program is also offered telephonically. Below details the number of DSME participants during Fiscal Year 2015:

Health In Motion™ FY 2014-2015 Phone Consultation Encounters

Health Topic	Number of Encounters	% of Total of Phone Consultations
Diabetes Self-Management Education (DSME)	434	31%
Obesity/Weight Management	126	9%
Hypertension	64	5%
Smoking Cessation (referred to CA Smokers' Helpline)	8	1%
Cholesterol	3	0%

Health In Motion™ FY 2014-2015 Group Appointment Encounters

	No. of Group Appointments Implemented	No. of DLOB Member Encounters	Total No. of Participants
Diabetes			
DME-S	13	75	85

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

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

LOOKING FORWARD

- The Cal MediConnect (CMC) membership is expected to continue to increase throughout 2016, as the D-SNP product line was terminated at the end of 2014. The Diabetes Disease Management program will work collaboratively with the Health Disparities workgroup in developing interventions to address health disparities in the diabetes population at L.A. Care.
- The Diabetes Disease Management department will continue increased interventions for Level 3 and 4 members. The Diabetes disease management program has begun to increase frequency of outreach calls to these members to at least monthly.
- Disease Management will be transitioning to our core system, Clinical Care Advance (CCA) to integrate member information, including clinical data, across the organization to improve care coordination.
- As part of the CCA transition, all members will have care plans to include personalized goals and interventions based on clinical practice guidelines. For example, care plans will include goals and interventions to improve medication compliance, A1C and dilated eye exam testing and results, to improve self-management skills and the use internal and external diabetes resources.
- L.A. Care is exploring mobile health technology to further target and reach members. These possible interventions include a Diabetes text-messaging program to send Diabetes education and medication adherence reminders to members who opt-in to the program.

2016 WORK PLAN GOALS:

Measure	2016 Goal MCLA (Hybrid)
A1c screening	86%
A1c good control (< 8%)	48%
Retinal eye exam	55%
Medical Attention for Nephropathy	88%
Overall Satisfaction	90%

Measure	2016 Goal LACC
A1c screening	88%
A1c good control (< 8%)	51%
Retinal eye exam	49%
Medical Attention for Nephropathy	82%
Overall Satisfaction	90%

Measure	2016 Goal CMC
A1c screening	Baseline
A1c good control (< 8%)	Baseline
Retinal eye exam	75%
Medical Attention for Nephropathy	93%
Overall Satisfaction	90%

A. 5.c REDUCING CARDIOVASCULAR RISK

2015 WORK PLAN GOALS:

Administrative Measures (2014 Benchmarks)	Specific Indicators	2015 Goals	Measure Type
Controlling High Blood Pressure (CBP, HEDIS)	Percent of adult members who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled(<140/90) during the measurement year	CMC: Baseline Year LACC: Baseline Year	Hybrid
Adult BMI Assessment (ABA, HEDIS)	Percent of adult members who had their body mass index (BMI) and weight documented during an outpatient visit either by a claim or as a medical record entry during the measurement year or year prior	CMC: Baseline Year LACC: Baseline Year	Hybrid
Medication Adherence for Hypertension (ACEI, ARB, HEDIS)	Percent of adult Medicare Part D members who adhere to their prescribed drug therapy for angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medications.	CMC: Baseline Year LACC: Baseline Year	Admin
Overall Member Satisfaction	Percentage of members who are overall satisfied with the program (strongly agree or agree)	CMC: 90% LACC: 90%	DM Survey

BACKGROUND

Reducing cardiovascular risk was selected as a Chronic Care Improvement Program (CCIP) focus based on multiple factors. Heart disease is the leading cause of death in both men and women, (National Vital Statistics Reports, Deaths, 2008) for all racial/ethnic groups, and persons 45 years and older (Mortality in Los Angeles County, 2003). While heart disease can lead to death, disability, or a reduced quality of life, national clinical treatment guidelines, such as the National Cholesterol Education Program, provide guidance on how risk factors for heart disease can be managed and controlled with patient self-management, lifestyle changes and pharmaceutical treatment (Source: CDC Million Hearts®). The high adult prevalence estimates in Los Angeles County for heart disease and its risk factors (heart disease-5.6%, high cholesterol 24.2%, hypertension 24.8%, cigarette smoking 15.2%, being overweight 23.7%, being obese 36.7% sedentary lifestyle/no physical inactivity 27.1%) influenced L.A. Care's decision to implement a cardiovascular risk reduction program (Source: California Health Interview Survey 2005-2011). Cardiovascular conditions are key diagnoses for L.A. Care. Essential hypertension is the most common reason for outpatient visits for CMC and is the second most common reason for outpatient visits for LACC. L.A. Cares About Your Heart® disease management program identifies members with hypertension and hypercholesterolemia as well as members identified with other cardiovascular risk factors to be included in the program.

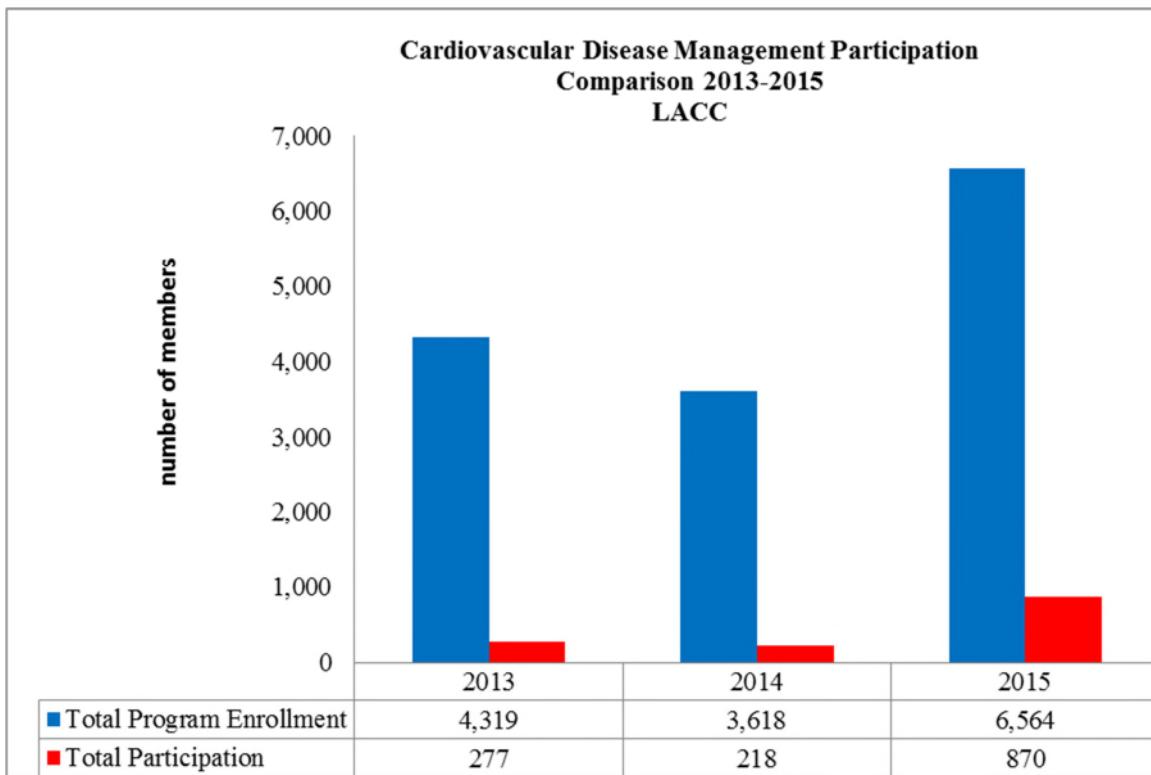
L.A. Care's About Your Heart® Program addresses a range of interventions, including condition monitoring by Registered Nurses, monitoring member's adherence to the treatment plans, addresses other medical and behavioral health co-morbidities, lifestyle modification, psychosocial issues and depression screenings. Members are identified on a monthly basis and are stratified into one of three risk levels (Levels 1, 2, and 3 being the highest acuity) based on claims, encounter, utilization and pharmacy data.

MAJOR ACCOMPLISHMENTS

- Program membership at the end of December 2015 was 6,564 members.
- The provider intervention was revised to expand on the stratification letter mailed to providers whose members are level three. In September, a mailing was sent to all providers with members enrolled in the CVD program regardless of stratification level (1, 2, and 3). The provider's call to action was to fax the clinical information form back to L.A. Care. The stratification letters and clinical information form are mailed out monthly for high acuity members.
- A new *L.A. Cares About Your Heart* ® booklet was developed and will be sent to all enrolled members.
- This was the first year a member satisfaction survey was mailed to 461 members stratified as Level 2 and 3 in July. Sixty surveys were returned, for a 13.9% response rate.
- Flu reminder postcards were sent to all enrolled members.
- The CVD program began enrollment of Cal MediConnect (CMC) members into the program.
- In November, 2015, 3,259 providers received a controlling blood pressure toolkit, including a patient education poster, hypertension treatment pocket card, and a recommended workflow with tips on consistent measurement and documentation of blood pressure.

Membership and Participation Rate

In 2015, L.A. Care identified eligible members using an algorithm to identify hypertensive and hypercholesterolemic members as well as members with other cardiovascular risk factors, such as chronic kidney disease and obesity. Eligible members are those LACC and CMC members over the age of 18 that have been identified with hypertension, hypercholesterolemia and other cardiovascular risk factors based on specific ICD 9/10 codes to meet eligibility criteria. Members are excluded if they are in the *L.A. Cares About Diabetes*® program, enrolled at Level 3 or Level 4 or identified with end stage renal disease or renal failure. *L.A. Cares About Your Heart*® utilizes an opt-out enrollment method, which means that eligible members are enrolled unless they actively opt out. Twenty-six members opted out of the program in 2015.



	Total Program Enrollment	Total Participation	Percentage of Active Participation
2013	4319	277	6.4%
2014	3618	218	6.0%
2015	6564	870	13.3%

2015 Year-End Membership by Line of Business	
LACC	1,089
CMC	5,475
Total	6,564

MEMBER SATISFACTION

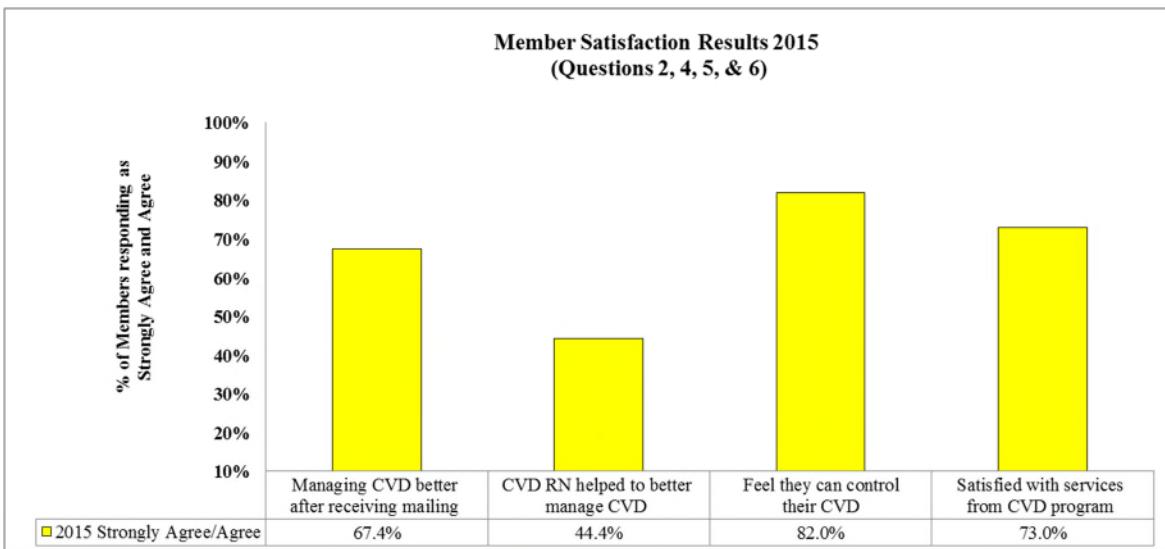
METHODOLOGY

Satisfaction of participants in the cardiovascular disease management program are assessed by 1) analysis of complaints and inquires, and 2) a formal satisfaction survey. In July 2015, L.A. care conducted a mail-in survey to active CMC and LACC members in the CVD program. Only members identified as active in the CVD program from January 2014-February 2015 were surveyed. A total of 461 surveys were mailed.

RESULTS

On the 2015 survey, respondents were asked to rate their level of satisfaction with various aspects of the program for four questions, based on a Likert scale ranging from Strongly Agree to Strongly Disagree.

Quantitative Analysis



	Received Mailings	Spoke with DM RN	Had Blood Pressure Checked this year	Had Cholesterol checked this year	Take medicine as directed
2015 Strongly Agree/Agree	65.1%	26.3%	95.2%	82.5%	88.9%

Barriers to getting tests completed (Blood Pressure and Cholesterol)	Percentage	Barriers to taking medications as directed	Percentage
I felt good and did not want to get the tests	22.2%	Lack of Knowledge about medications	40.0%
Transportation to appointments/labs	22.2%	Cannot afford medications	20.0%
Blank	14.1%	Blank	4.7%

Qualitative Analysis

This was the initial year a member satisfaction survey was conducted on the *L.A. Cares About Your Heart®* program. The 2015 survey was developed to include barrier questions so the disease management staff can determine some of the barriers that the members are experiencing and how these barriers are impacting their healthcare. The survey had 14 questions for the member to answer on satisfaction with the program and services, test/exams completed in the last 12 months, barriers in getting those exams/tests and the method members would like to receive educational materials.

On the 2015 survey, members were asked to rate their level of satisfaction with various aspects of the program. Out of the 461 surveys mailed, 64 surveys were completed and returned, or a 13.9% response rate. To increase response rates, two weeks after the survey was mailed to all Level 2 and 3 members, a reminder postcard was sent to the members. After 1 month, those members who did not respond to the mailed survey, a live agent called the member (28) to conduct the survey over the phone.

With 73.0 % of respondents satisfied with the program, L.A. Care did not meet the 2015 goal of 90% overall member satisfaction. 67.4% of respondents found the program's educational materials helpful in managing their asthma. The 2015 survey asked barrier questions to what stopped the members from getting their blood pressure and cholesterol tests; 22.2% felt good and did not want to get the tests and 22.2% did not have transportation to the appointment/lab. The survey asked what stopped the member from taking their medications; 40.0% had a lack of knowledge about medications and 20.0% answered that they could not afford their medication.

Opportunities Identified From Survey

Member education on basic heart health care and self-management remains a priority for 2016. In December, 2015 a new L.A. Care branded CVD booklet was developed and will be sent to all enrolled members on 2016. In addition to educational materials developed with the Health Education/Cultural & Linguistics department, the department will work to develop a convenient and accessible mailer reminding members to get their CVD care exams/test and the importance of medication compliance.

In 2015, Level 2 members received condition monitoring calls every six months and Level 3 members received condition monitoring calls every three months. A higher intensity outreach is needed to improve satisfaction scores with the program and improve health outcomes for the members. Level 2 members will receive telephonic condition monitoring at least every other month and the RN will generate a care plan with member specific goals. Level 3 members will receive telephonic condition monitoring at least every month and the RN will generate a care plan with member specific goals.

Moving into 2016, the disease management programs will be migrating to the Clinical Care Advance (CCA) where RNs will complete the CVD assessment, an individualized care plan with goals and target interventions and timeframes for follow-up. This will allow RNs to schedule call backs, intervention follow up and increase coaching to empower the member to take actions on their care.

COMPLAINTS AND INQUIRIES

Member complaints and inquiries are evaluated to identify opportunities to improve satisfaction with the disease management process. Complaints related to the disease management program are identified through L.A. Care's grievance process. Member services staff keep a log of all member complaints and inquiries related to disease management. In 2015, there were 0 complaints related to *L.A. Cares About Your Heart®* and 86 inquiries about the program.

Complaints	2013		2014		2015	
Number of complaints received	0		0		0	
Inquiry Reason	Number of Calls	Percentage of all Calls	Number of Calls	Percentage of all Calls	Number of calls	% of all calls
Opt out/no cardiovascular disease	4	6.25%	0	0	25	26.6%
Requested Cardiovascular Information	56	87.5%	94	85.5%	9	9.6%
Other	4	6.25%	16	14.5%	60	63.8%
TOTAL	64	100%	110	100%	94	100%

OPPORTUNITIES

There may be opportunities for better data collection regarding complaints and inquiries. To date, no complaints related to the cardiovascular disease management program have been files. A new process was developed in 2015 for routing complaints received through the L.A. Care's Appeals & Grievance department.

Measuring Effectiveness:

2015 results for effectiveness measures will serve as baseline, and measurement of program effectiveness will begin in 2016. Since L.A. Care transitioned to CMC in mid-2014, rates were captured administratively on 33 measures, but HEDIS 2015 measures for Medicare were not reported.

Measure	Methodology
Controlling High Blood Pressure (HEDIS)	Refer to 2015 HEDIS Technical Specification Vol.2
Adult BMI Assessment (ABA, HEDIS)	Refer to 2015 HEDIS Technical Specification Vol.2
Medication Adherence for Hypertension (ACEI or ARB)	Refer to 2015 HEDIS Technical Specification Vol.2
Member Satisfaction	L.A. Care conducted a mail survey targeting all Level 2 and 3 members.

RESULTS

Administrative Measures	2015 Results
Controlling High Blood Pressure (CBP, HEDIS)	CMC: Not Reported for 2015 LACC: 45.8%
Adult BMI Assessment (ABA, HEDIS)	CMC: 23.7% LACC: 44.0%
Medication Adherence for Hypertension (ACEI, ARB) (STAR Measure)	CMC: 87.9% LACC: 81.6%
Member Satisfaction	CMC: 73.2% LACC: 66.7%

Health Education - Health In Motion

The Health Education unit provides comprehensive health education programs, services, and resources to direct line of business (DLOB) members while simultaneously supporting and working collaboratively with other L.A. Care Health Plan departments including Quality Improvement, Case Management, Disease Management, the Family Resource Centers, Community Outreach & Engagement, Sales & Marketing, Pharmacy, Behavioral Health, Provider Network Operations, and Member Services.

Health In Motion™ aims to improve the well-being of L.A. Care Health Plan members, prospective members, and community members by providing innovative, culturally and linguistically appropriate health education services.

Health In Motion™ supports solo or small group practices with limited resources in delivering health education to L.A. Care patients in an effort to improve quality of care and health outcomes. Certified Health Coaches, Registered Dieticians, Master's Level Health Educators, and trained Health Promoters provide in-person group appointments or telephonic consultations upon physician referral, L.A. Care staff referral, targeted recruitment by member diagnosis, or self-referral. Services promote positive health behavior change in the areas of chronic disease self-management, wellness, and nutrition, to improve clinical outcomes. Group appointments are conducted in easily-accessible locations such as high-volume provider sites. Below details the number of participant encounters during Fiscal Year 2015.

Health In Motion™ FY 2014-2015 Group Appointment Encounters

	No. of Group Appointments Implemented	No. of DLOB Member Encounters	Total No. of Participants
Hypertension			
Love Your Heart	6	61	70

Health In Motion™ FY 2014-2015 Phone Consultation Encounters

Health Topic	Number of Encounters	% of Total of Phone Consults
Obesity/Weight Management	126	9%
Hypertension	64	5%
Smoking Cessation (referred to CA Smokers' Helpline)	8	1%
Cholesterol	3	0%

Controlling Blood Pressure Mailing to Providers

The Quality Improvement department led an intervention to collaborate with providers to support evidence based care guidelines for diagnosing and controlling blood pressure. In November, 2015, a controlling blood pressure toolkit, including a patient education poster, hypertension treatment pocket card, and a recommended workflow with tips on consistent measurement and documentation of blood pressure was mailed to 3,259 providers. A return postcard was included for providers to request additional copies of the toolkit materials. Below details the responses received in 2015:

Quarter Tally		Poster English	Poster Spanish	RCI-Pocket Card	BP Workflow	Envelope	Cover Letter
Q4 2015	Return Postcard Order totals	109	104	168	120	20	20
Q4 2015	Total Shared with Outside entities	145	140	601	156	22	21
Q4 2015	Total Distributed (Internally, externally)	195	190	751	206	62	71

Quantitative Analysis

Cal MediConnect (CMC)

Since L.A. Care transitioned to CMC in mid-2014, rates were captured administratively on 33 measures, but HEDIS 2015 measures for Medicare were not reported. 2015 performance measures will be used as a baseline for 2016 goals and evaluation of program effectiveness. Analysis of 2015 Results/Findings;

- Controlling High blood pressure not measured/not available
- Adult BMI measurement of 23.7% is below the HEDIS measure goal.

- Medication adherence for hypertension (ACEI/ARB) measures met 87.9% for the served population.

L.A Care Covered (LACC)

In 2015, LACC was a pilot. LACC is now entering the beta-test. The Plan preview period started October 5, 2015 and will go through October 16, 2016. Analysis of 2015 Results/Findings:

- Controlling high blood pressure of 45.8% is below the HEDIS measure.
- Adult BMI measurement of 44.0% is below the HEDIS measurement.
- Medication adherence for hypertension (ACEI/ARB) measurement met 81.6% for the served population.

Qualitative Analysis

Over the course of 2015, several barriers to achieving high performance measures were noted. As a result, *L.A. Cares About Your Heart®* took several actions to mitigate these barriers. The LACC and CMC 2015 HEDIS baseline rates results suggest the following opportunities for improvement for the cardiovascular disease management program. Some barriers to improving member interventions are discussed below:

- A delay in the Preventive Health Guidelines (PHG) led to a delay in the targeted follow-up letters. The PHG mailing was delayed to collaborate with plan partners for a coordinated mailing which led to the follow-up letters being held until marketing completed formatting,
- Inability to track the number of members that have been to the PCP due to delay in call to action mailing.

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

- Change in pharmacy vendor impacted report on ACEI/ARB and statin medication adherence. A 30 to 90 day supply conversion program, MMTP, a monthly refill reminder call program, and the high touch STARS adherence outreach program was implemented to increase medication adherence and address barriers to member access in getting provider prescribed drugs.
- Revised the expansion of the monthly stratification letter mailed to providers whose members are level 3 (highest severity) in the CVD program to include members of all stratification levels annually (1, 2, and 3).
- An in-house L.A. Care branded cardiovascular educational booklet has been developed to provide targeted education regarding cardiovascular health and disease management.
- *L.A. Cares About Your Heart®* continued telephonic nurse outreach condition monitoring to members to conduct a CVD assessment, inquire about member health status and questions as well as provide education and resources to members.
- Medication adherence was addressed through the Medication Therapy Management Program (MTMP) and high-touch STARS adherence program which members with poor medication adherence to ACEI/ARBs and statins are contacted to address barriers (access to providers, etc.)

LOOKING FORWARD

- *L.A. Cares About Your Heart®* will continue to review the member identification and stratification process to incorporate members at risk in addition to members identified through cardiovascular related ICD-10 claims and pharmacy medication noncompliance reports.
- *L.A. Cares About Your Heart®* will be able to provide members with resource referrals to an L.A. Care in-house tobacco cessation program offered through health education, so members will be able to receive disease management assistance from a central source.
- Members who are Level 2 and Level 3 will receive higher intensity outreach such as, Level 2 members will receive telephonic condition monitoring at least every other month and the RN will generate a care plan with member specific goals. Level 3 members will receive telephonic

- condition monitoring at least every month and the RN will generate a care plan with member specific goals
- Disease Management will upgrade Clinical Care Advance (CCA) to migrate all CVD members into a single electronic documentation system to coordinate referrals and care plans across the organization.
 - Cardiovascular Nurses will have the ability to set problems, goals and monitor interventions for members enrolled in the CVD program when the upgrade to CCA is completed by September 2016.
 - In 2016, *L.A. Cares About Your Heart®* membership is expected to substantially grow with the planned inclusion of MCLA line of business in CCA and in the *L.A. Cares About Your Heart®* program identification, stratification and interventions.
 - L.A. Care is exploring mobile health technology to further target and reach members. These possible interventions include a Heart Health text-messaging program to send Heart Health education and medication adherence reminders to members who are enrolled in the program.
 - Materials are culturally and linguistically appropriate, and continue to be mailed in English and Spanish. The mailings include an attachment to the cover letter indicating that the information is available in eleven (11) different languages, larger print, Braille, audio or TTY as requested.

2016 WORK PLAN GOALS:

CMC Measures	2016 Goal
Controlling High Blood Pressure (CBP, HEDIS)	75%
Adult BMI Assessment (ABA, HEDIS)	90%
Medication Adherence for Hypertension (ACEI, ARB)	77%
Overall Member Satisfaction	90%

LACC Measures	2016 Goal
Controlling High Blood Pressure (CBP, HEDIS)	62%
Adult BMI Assessment (ABA, HEDIS)	76%
Medication Adherence for Hypertension (ACEI, ARB)	82%
Overall Member Satisfaction	90%

A.5.d ANNUAL MONITORING OF PATIENTS ON PERSISTENT MEDICATIONS (MPM)

BACKGROUND

Adverse drug events contribute to patient injury and increased health care costs. For patients on persistent medications, appropriate monitoring can reduce the occurrence of preventable adverse drug events.⁸ Annual monitoring of these medications allows the providers to assess for side-effects and adjust drug dosage. The costs of annual monitoring are offset by the reduction in health care costs associated with complications arising from lack of monitoring and follow-up of patients on long-term medications.⁹

The MPM measures had significant changes in 2014 (HEDIS 2015). The measure no longer allows a blood urea nitrogen test to count as evidence of annual monitoring. In addition, digoxin requires three tests to be completed to count as evidence of appropriate monitoring. Digoxin requires a serum digoxin level in

⁸ NCQA. Annual Monitoring of patients on persistent medication.

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

⁹ National Quality Measures Clearing House. AHRQ. 2014. Measure Summary.

<http://www.qualitymeasures.ahrq.gov/content.aspx?id=47201>. Accessed on January 8, 2016.

addition to serum potassium and serum creatinine test. For diuretics and ACE/ARBs, an annual monitoring event is one serum potassium and a serum creatinine level.

2015 WORK PLAN GOALS:

HEDIS Measure	2015 Medi-Cal Goal	2015 Cal MediConnect Goal	2015 L.A. Care Covered Goal
Annual Monitoring of Patients on Persistent Medication- ACE Inhibitors (ACE)/ARBs	86%	NA	NA
Annual Monitoring of Patients on Persistent Medication- Digoxin	89%	NA	NA
Annual Monitoring of Patients on Persistent Medication- Diuretics	86%	NA	NA

*New product line in MY 2014. Official rates are unavailable.

MAJOR ACCOMPLISHMENTS

- L.A. Care improved lab data capture among its largest provider, the Los Angeles Department of Health Services (DHS), which led to an estimated 4.3 percentage point increase in the ACE/ARBs Medi-Cal rate and a 4.7 percentage point increase in the diuretic Medi-Cal rate.
- The LA P4P and P4P incentive program added the MPM total rate measure to their program. In August, L.A. Care mailed all specialists that had prescribed digoxin to our members and informed them of the need for monitoring patients on these medications.
- L.A. Care mailed a postcard to 12,842 Medi-Cal, 1,131 Cal MediConnect, and 194 L.A. Care Covered members informing them of the importance of having an annual monitoring event while on these medications.
- L.A. Care called 25 high volume clinics and provided them with a list of members missing an annual monitoring event.

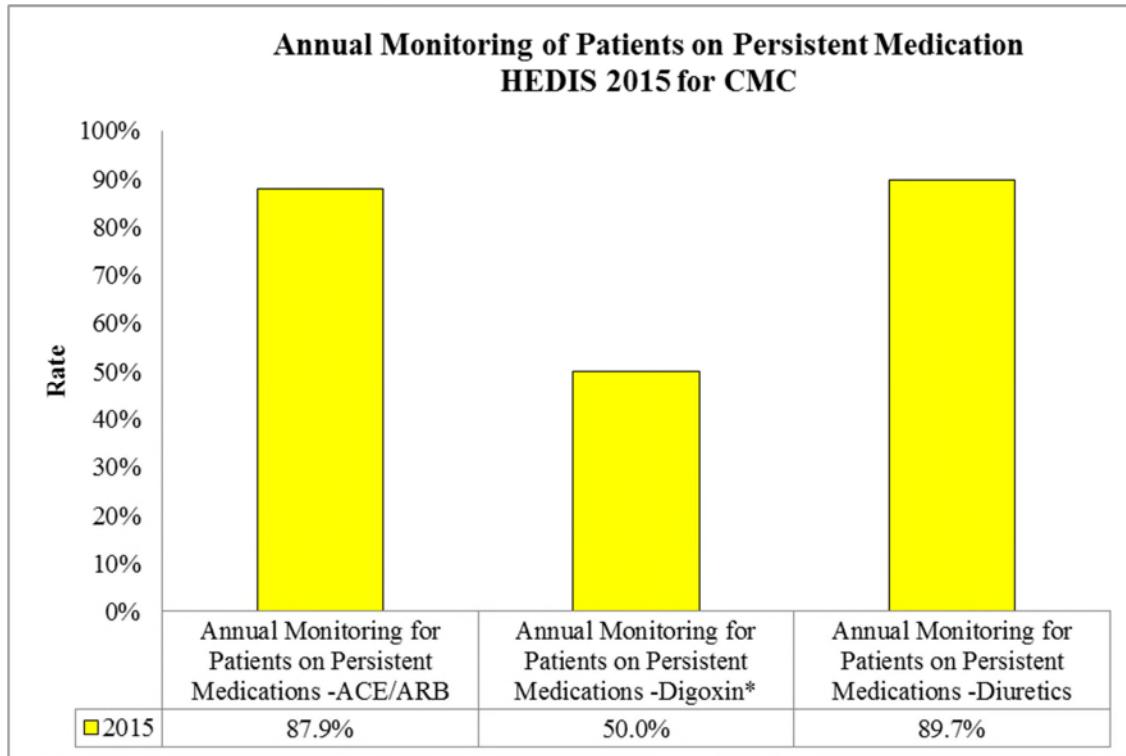
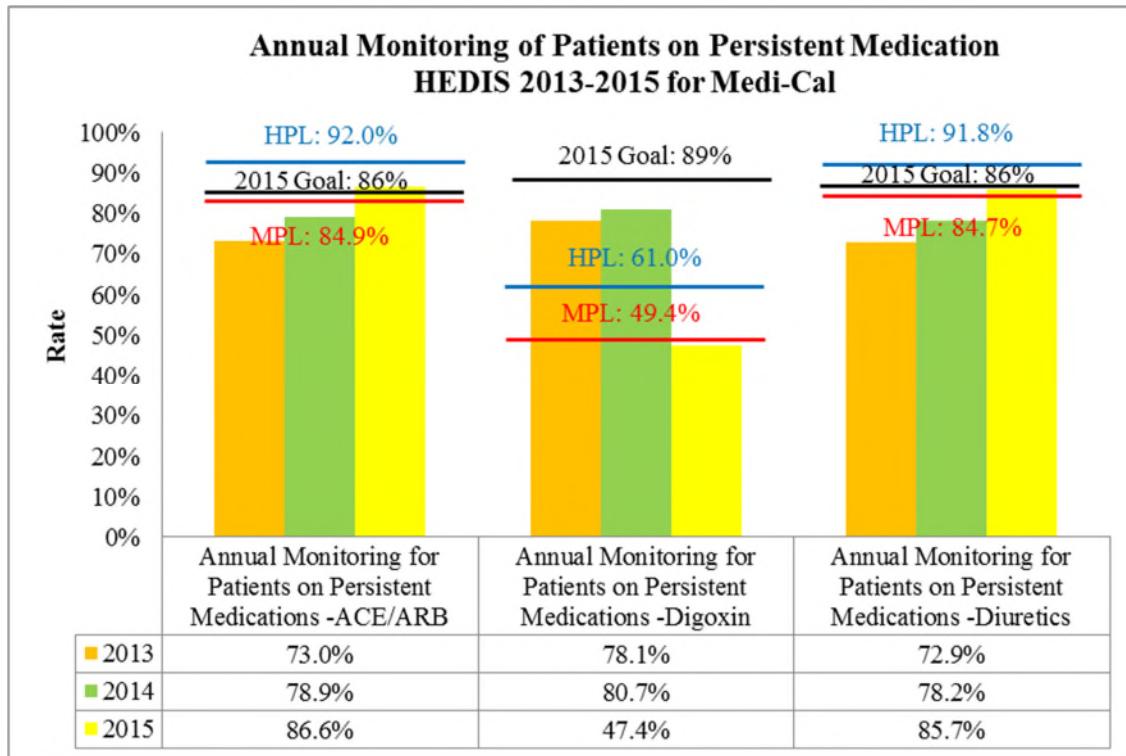
ANNUAL MONITORING OF PATIENTS ON PERSISTENT MEDICATION (MPM)

Description of measures:

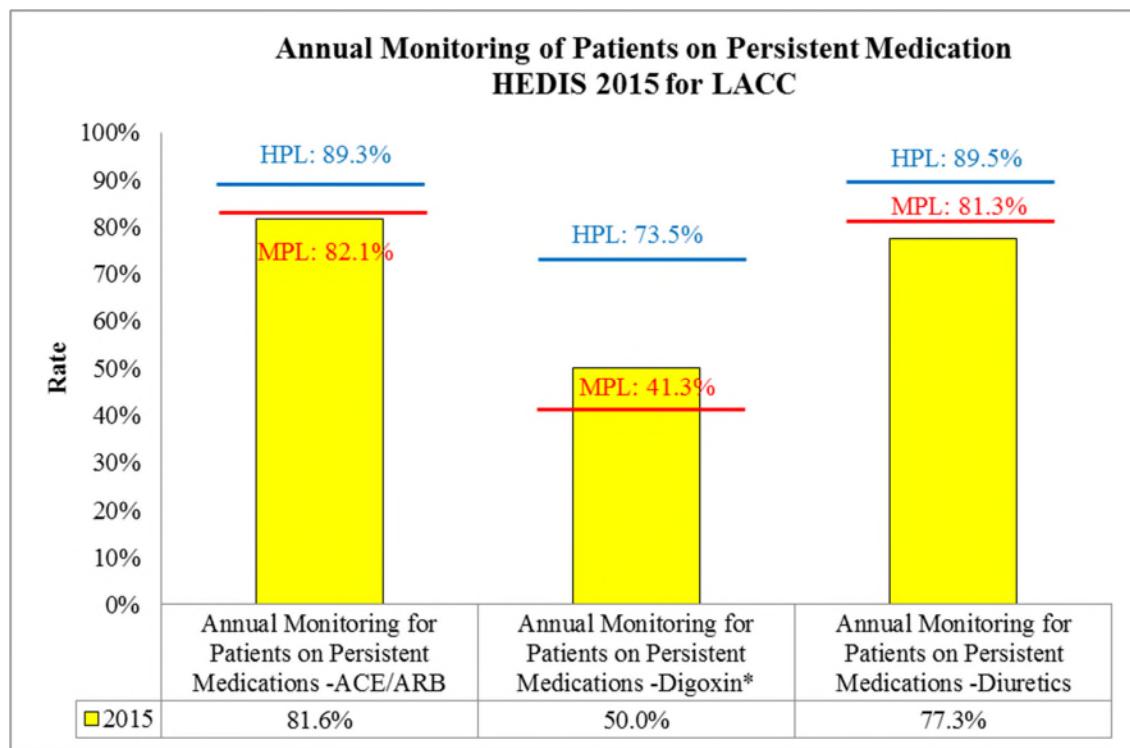
HEDIS Measure	Specific Indicator(s)	Measure Type
Annual Monitoring of Patients on Persistent Medication- ACE Inhibitors/ARBs	The percentage of members 18 years and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year,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

RESULTS

The following graph compares L.A. Care in 2013, 2014, and 2015:



*Denominator fewer than 30



*Denominator fewer than 30

ANALYSIS

Quantitative Analysis

The Medi-Cal rates for ACE/ARBs and diuretics showed statistically significant improvement from the prior year. The ACE/ARBs rate increased by 7.6% compared to the prior year and was above the minimum performance level (MPL) and met the goal. The diuretics rate increased by 7.5% from the prior year, however, this did not exceed the MPL (86.69%) by .02 % since DHCS does not allow for rounding off rates. It did meet the goal of 86%. The digoxin rate dropped significantly by 33.3% and did not meet the MPL or the goal. This was likely due to the change in specifications as the rate fell nationally as well.

Since L.A. Care transitioned to Cal MediConnect (CMC) in mid-2014, rates were captured administratively but were not reported. L.A. Care's CMC 2015 rate for MPM ACE/ARBS was 87.9%, and 89.7% for diuretics. The digoxin rate was 50%. There are no previous years' data to trend and no benchmarks for comparison of the administrative MPM rate in the CMC population.

Similarly, L.A. Care Covered (LACC) rates were also not reported for HEDIS 2015, but rates were captured even when the denominator fell below 30 members (see graph for details). The ACE/ARB rates were 81.6% and the digoxin rate was 50%. The diuretics rate was 77.3%. Both the ACE/ARB and diuretic rates were below the NCQA commercial plans MPL. The digoxin rate was 8.7% above the MPL; however, the denominator had fewer than 30 members and is not consider a reliable sample size.

Disparity Analysis (Medi-Cal only)

L.A. Care also conducted an analysis based on Plan Partner, age, gender, ethnicity, region, and language to examine whether disparities exist in receiving these tests. The HEDIS 2015 results indicate that there is a Plan Partner disparity with those in Kaiser Health Plan outperforming all other health plans for all three measures. The ACE/ARBs measure also shows a disparity among younger members, with those 18-25yrs of age having completed their labs at a rate of 75.4%, which is a lower rate than the other age groups. The digoxin rate among SPD members was also significantly higher (49.3%) than the non-SPD population (40.7%). For diuretics, the Spanish-speaking population, the SPD population, and older adults all had high rates compared to other groups.

Qualitative Analysis

From HEDIS 2014 to HEDIS 2015, the Medi-Cal ACE/ARBs and diuretics rate improved significantly. Beginning in 2014, L.A. Care met with high volume PPGs and stressed the importance of including all MPM measures in their member outreach campaigns. In late 2014, L.A. worked with its largest health care provider, DHS, to improve the capture of lab data. By requesting all in-house lab data, L.A. Care was able to locate an additional 2,030 labs/complaint members than the prior year for members on ACE/ARBs and an additional 1,263 compliant members on diuretics. These additional hits led to an increase of 4.3 percentage points in the Medi-Cal ACE/ARBs rate and 4.7 percentage point increase in the Medi-Cal diuretic rate.

The digoxin and the diuretic rates, however, are still below the MPL. The digoxin rate is likely low due to the additional digoxin lab test. Desk top audits from some of our largest providers, such as DHS, show that there is lack of digoxin screening among providers. In 2014 and 2015, primary care providers received list of members missing these labs as part of the Provider Opportunity Reports. In August 2015, L.A. Care also targeted specialists that prescribe digoxin to remind them of the importance of completing all three lab tests and to send lab results if they had already completed these test. This intervention was applied to Medi-Cal, CMC, and LACC members. In addition, all members on these medications received a mailer in October that encouraged them to get screened and to ask their doctor about the three labs that may be needed. This intervention was also sent to members in the three product lines, since they may face similar barriers to getting these services.

To improve the Medi-Cal diuretic rate, the Department of Health Care Services (DHCS) is requesting that L.A. Care conduct a HEDIS Plan-Do- Study-Act (PDSA) cycle, since performance was just below the MPL. L.A. Care has requested that high volume low performing clinics conduct outreach to members missing potassium, creatinine, and digoxin labs and report their progress to L.A. Care. The effectiveness of this intervention will be evaluated in the first quarter of 2016.

INTERVENTIONS

HEDIS Measure	Barriers	Actions	Effectiveness of Intervention/ Outcome
Annual Monitoring Of Patients On Persistent Medication (MPM)	<ul style="list-style-type: none">• Providers may be unfamiliar with members medication history• Providers do not know the member is part of their panel• Providers are unaware of need for lab tests.• Member does not view the need for test based on their	<ul style="list-style-type: none">• Provider Opportunity Reports included the MPM measures and were distributed to all PCPs.• In 2015, the LA P4P and the P4P program added the MPM total rate to their incentive program.• 25 high volume clinics asked to call in members for MPM labs	<ul style="list-style-type: none">• Improved data capture led to an increase in the rate. Goals met for ACE/ARBs and diuretics.

HEDIS Measure	Barriers	Actions	Effectiveness of Intervention/Outcome
	<p>history with these medication</p> <ul style="list-style-type: none"> • Members may not know that these drugs need annual monitoring. • Lab data errors may be contributing to lower rates 	<ul style="list-style-type: none"> • In August of 2015 prescribers of digoxin were sent list of patients needing labs and were asked to call in members for labs and/or submit lab results. • In October, members were sent a mailer explaining the need for lab test and to contact their doctor to schedule a screening. • Meetings with PPGs addressed low performance and data management. • L.A. Care worked with DHS to improve lab data capture. 	

LOOKING FORWARD

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

- L.A. Care plans to send member MPM reminders on a semi-annual basis starting in Q1.
- L.A. Care will continue working with high volume low performing providers to improve compliance rates.
- L.A. Care will continue working with PPGs on implementing interventions and improving data capture.

2016 WORK PLAN GOALS:

HEDIS Measure	2016 Medi-Cal Goal	2016 Cal MediConnect Goal*	2016 L.A. Care Covered Goal
Annual Monitoring Of Patients On Persistent Medication (MPM)- ACE Inhibitors/ARBs	88%	NA	82%
Annual Monitoring Of Patients On Persistent Medication (MPM)- Digoxin	49%	NA	41%
Annual Monitoring Of Patients On Persistent Medication (MPM)-Diuretics	87%	NA	81%

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

A.6 CLINICAL PRACTICE GUIDELINES

2015 WORK PLAN GOAL:

- Measure clinical practice guidelines for at least two medical conditions and at least two behavioral conditions with at least one behavioral guideline focused on improving health for children and adolescents.

BACKGROUND

As part of the Model of Care Program, L.A. Care Health Plan (L.A. Care) systematically reviews and adopts evidence-based clinical practice and preventive health guidelines promulgated from peer reviewed sources for diseases and health conditions identified as most salient to its membership for the provision of preventive, acute or chronic medical and behavioral health services known to be effective in improving health outcomes. L.A. Care monitors network compliance with specific clinical and preventive health guidelines through measures including: Healthcare Effectiveness Data Information Set (HEDIS®); Consumer Assessment of Healthcare Providers and Systems (CAHPS®); and other measures as appropriate. Performance is compared to goals and/or benchmarks which can be from the National Committee for Quality Assurance (NCQA) Quality Compass, Centers for Medicare and Medicaid Services (CMS) Star rating technical specification, or the Medicare National HMO Averages from The State of Health Care Quality.

L.A. Care receives regular clinical practice and preventive health guideline updates sponsored by government and non-government organizations including, but not limited to, the Agency for Healthcare Research and Quality, which are published by the National Guidelines Clearinghouse and the U.S. Preventive Services Task Force. New and revised clinical practice and preventive health guidelines are presented annually, and/or as necessary, to L.A. Care's Joint Performance Improvement Collaborative Committee and Physician Quality Committee (PICC/PQC) for review and adoption in an effort to help improve the delivery of primary and preventative health care services to our members and reduce unnecessary variation in care. L.A. Care's provider newsletter is used to inform physician partners of where they can locate the latest clinical practice and preventative health guidelines adopted by L.A. Care; these guidelines are disseminated via L.A. Care's website. At least two of the non-preventative guidelines provide the clinical basis for L.A. Care's chronic care improvement and disease management programs for diabetes, cardiovascular risk, and asthma. L.A. Care annually measures performance of at least two important aspects for each of its clinical and preventive health guidelines. The guidelines may be used for quality-of-care reviews, member and provider education and/or incentive programs, and to assure appropriate benefit coverage.

For selected lines of business, L.A. Care delegates behavioral health services to a National Committee for Quality Assurance (NCQA) Accredited Managed Behavioral Health Organization (MBHO). For enrollees in those plans, the MBHO collaborates with L.A. Care on the approval and monitoring of the selected Clinical Practice Guidelines for behavioral health with input and approval at the Behavioral Health Quality Improvement Committee quarterly meetings. For Medi-Cal members, L.A. Care is responsible for the delivery of behavioral health services to members with mild to moderate levels of behavioral health conditions and L.A. Care collaborates with the primary care physician network to equip them to diagnose and treat behavioral health conditions with mild to moderate levels of functional impairment. The L.A. County Department of Mental Health (LACDMH) is responsible for providing services to Medi-Cal members with severe and persistent mental illness and moderate to severe levels of functional impairment. For its overall insured population, L.A. Care shall adopt at least two behavioral health guidelines, one of which addresses children and adolescents. L.A. Care selected Adult Depression and Attention Deficit Hyperactivity Disorder (ADHD) in children.

CLINICAL PRACTICE AND PREVENTATIVE HEALTH GUIDELINES

In September, 2015, L.A. Care's 'Progress Notes' newsletter for physician partners was used to inform practitioners of where they can locate the latest clinical practice and preventative health guidelines adopted by L.A. Care; these guidelines include those listed below and are disseminated via L.A. Care's website.

Clinical Practice Guidelines

Medical Conditions	Clinical Practice Guideline	PICC/PQC Review Dates
Diabetes	American Diabetes Association 2015 Standards of Medical Care in Diabetes. http://care.diabetesjournals.org	10/06/15 09/02/14 04/04/14
Cardio-vascular Risk	2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. American Heart Association – http://content.onlinejacc.org/article.aspx?articleid=1879710	10/06/15 09/02/14 04/04/14
	2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the 8 th Joint National Committee http://jama.jamanetwork.com/article.aspx?articleid=179149720	10/06/15 09/02/14 04/04/14
Asthma	Guidelines for the Diagnosis and Management of Asthma (EPR-3). National Heart Lung and Blood Institute National Heart, Lung, and Blood Institute. http://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/full-report	10/06/15 09/02/14 04/04/14
Behavioral Health	Clinical Practice Guideline	PICC/PQC Review Date
Depression	Practice Guideline for the Treatment of Patients with Major Depressive Disorder. Third Edition. Gelenberg, A. J., Freeman, M. P., Markowitz, J. C., Rosenbaum, J. F., Thase, M. E., Trivedi, M. H., & Silbersweig, D. A. (2010). The American Journal of Psychiatry, 167(10), 1. http://psychiatryonline.org/guidelines	10/06/15 09/02/14 04/04/14
Attention Deficit Hyper-activity Disorder	ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention Deficit Hyperactivity Disorder in Children and Adolescents. Subcommittee on Attention-Deficit. Pediatrics, 2011. http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-26544	10/06/15 09/02/14 04/04/14

Preventative Health Guidelines

Preventive Screenings	Guidelines	PICC/PQC Review Date
Obesity in Children HEDIS Measure: Weight Assessment for Children and Adolescents (WCC-BMI). Ages 3-17 yrs.	U. S. Preventive Task Force uspreventiveservicestaskforce.org	10/06/15 09/02/14 04/04/14
Obesity in Adults HEDIS Measure: Adult BMI Assessment (ABA). Ages 18-74 yrs.	U. S. Preventive Task Force uspreventiveservicestaskforce.org	10/06/15 09/02/14 04/04/14
Colorectal Cancer Screening HEDIS Measure: Colorectal Cancer Screening (COL). Ages 50-75 yrs.	U. S. Preventive Task Force uspreventiveservicestaskforce.org	10/06/15 09/02/14 04/04/14
Immunizations		
Childhood Immunization Status HEDIS Measure: Childhood Immunization Status Combination 3 (CIS-3). Ages Birth - 2 yrs.	CDC Immunization Schedules cdc.gov/vaccines/	10/06/15 09/02/14 04/04/14
Influenza Vaccinations CAHPS Measure: Flu Vaccinations for adults (FVA) and older adults (FVO). Ages 18 - 64 yrs, and ≥ 65 yrs.	CDC Immunization Schedules cdc.gov/vaccines/	10/06/15 09/02/14 04/04/14

I. DIABETES GUIDELINES RECOMMEND QUARTERLY HBA1C TESTING AND ANNUAL TESTING FOR DIABETIC RETINOPATHY AND NEPHROPATHY

NB: A full report on Diabetes Management can be found in Section A.5.b.

The American Diabetes Association's 'Standards of Medical Care in Diabetes – 2015' state that glucose monitoring and glycemic control have been shown to significantly reduce microvascular and neuropathic complications associated with diabetes. Furthermore, the guidelines state annual retinal screening is crucial to identifying levels of retinopathy in order to delay and/or prevent retinopathy progression and that medical attention for nephropathy, at least once a year, is essential in detecting the disease and delaying progression. To measure performance associated with these guidelines, L.A. Care Health Plan uses the following NCQA HEDIS indicators: HbA1c testing, control <8%, and poor control >9%; and diabetic retinal eye exams and nephropathy testing.

Clinical Practice Guidelines for Diabetes Care:

L.A. Care is actively involved in several initiatives to help practitioners achieve high standards of diabetes care as described in the American Diabetes Association's (ADA) 2015 guidelines and the NCQA HEDIS performance indicators for comprehensive diabetes care. L.A. Care's Joint Performance Improvement

Collaborative Committee and Physician Quality Committee (PICC/PQC) meet on a quarterly basis and systematically reviews and adopts evidence based clinical practice and preventative health guidelines promulgated from peer reviewed sources for diseases and health conditions identified as most salient to its membership for the provision of preventative, acute and chronic conditions like diabetes. On March 2, 2015, the committee reviewed and adopted the ADA 'Standards of Medical Care in Diabetes – 2015'. These guidelines were discussed at the Joint PICC/PQC meeting and changes were identified and highlighted for consideration. The changes include the BMI cutoff point for pre-diabetes screening and Type 2 Diabetes; in particular for Asian Americans where the cutoff point was changed from 25 to 23. This acknowledges the increased risk of diabetes at lower BMI levels for the Asian American population. In addition, the ADA now recommends a pre-meal blood glucose target of 80-130mg/dL, instead of the previous 70-130mg/dL, and is attempting to not include people who have hypo-glycemic episodes. The guidelines also recommended goals for diastolic blood pressure be changed from 80mmHg to 90mmHg for people with diabetes and hypertension to better reflect evidence from randomized clinical trials on best practices for disease risk management. Sedentary time identified with causing a higher risk factor of diabetes was also discussed at the Joint PICC/PQC; the guidelines recommend decreasing extended times spent sitting. Furthermore, the guidelines now recommend a target HbA1C of <7.5% for all pediatric age groups. However, individualization is still encouraged.

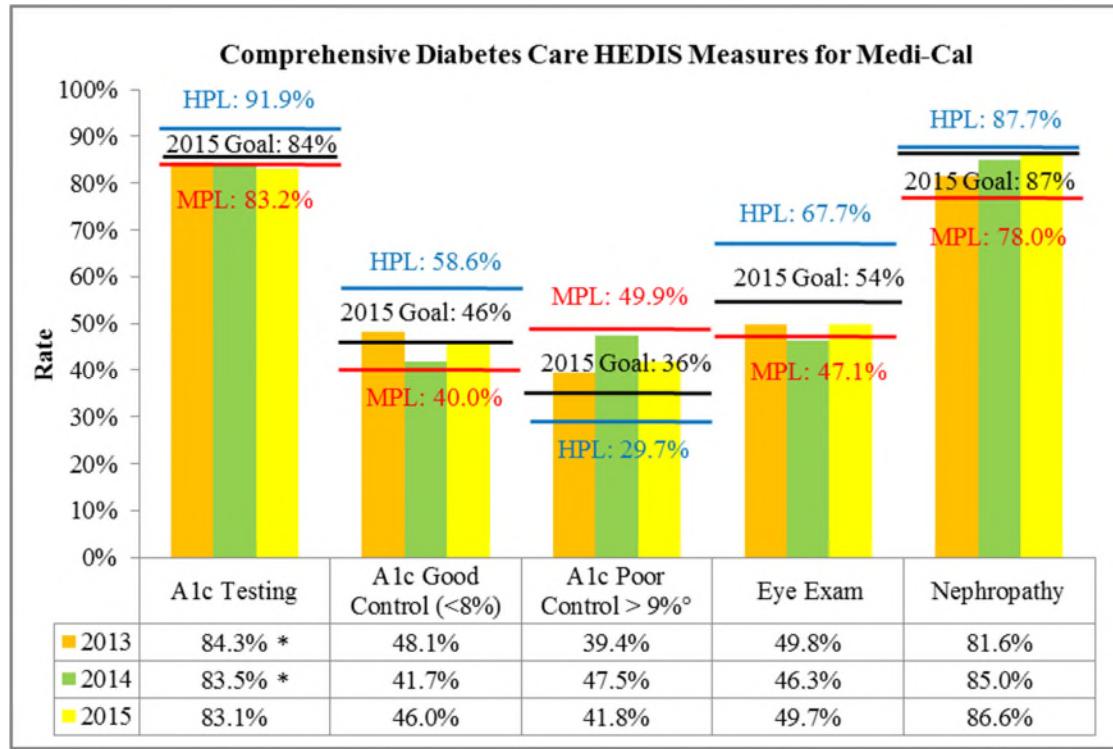
RESULTS

Comprehensive Diabetes Care HEDIS 2015 Rates (Hybrid) for Medi-Cal			
Measure	2013	2014	2015
HbA1c Testing (annual)	84.3%*	83.5%*	83.1%
HbA1c Control (<8%)	48.1%	41.7%	46.0%
HbA1c Poor Control (>9%)	39.4%*	47.5%*•	41.8%*
Retinal Eye Exam (annual)	49.8%	46.3%	49.7%
Nephropathy	81.6%	85.0%	86.6%

Rates above show performance for measures using hybrid data from claims, encounters and medical records.

*Statistically significant difference

°Inverse measure (lower number indicates better performance)



* Statistically significant difference

°Inverse measure (lower number indicates better performance)

Comprehensive Diabetes Care HEDIS 2015 Rates (Admin) for Cal MediConnect			
Measure	2013	2014	2015
HbA1c Testing (annual)	N/A	N/A	70.4%
HbA1c Control (<8%)	N/A	N/A	28.2%
HbA1c Poor Control (>9%)	N/A	N/A	63.6%*
Retinal Eye Exam (annual)	N/A	N/A	28.7%
Nephropathy	N/A	N/A	81.5%

Rates above show performance for measures using administrative data from claims and encounters. Since L.A. Care transitioned to Cal MediConnect (CMC) in mid-2014, the rates above do not represent annual performance over a 12 month period and were not reported.

^o Inverse measure (lower number indicates better performance)

Comprehensive Diabetes Care HEDIS 2015 Rates (Hybrid) for L.A. Care Covered			
Measure	2013	2014	2015
HbA1c Testing (annual)	N/A	N/A	87.9%
HbA1c Control (<8%)	N/A	N/A	30.4%
HbA1c Poor Control (>9%)	N/A	N/A	58.6%*
Retinal Eye Exam (annual)	N/A	N/A	29.3%
Nephropathy	N/A	N/A	82.3%

Rates above show performance for measures using hybrid data from claims, encounters and medical records. In 2015, LACC was a pilot. LACC is now entering into the beta-test, therefore the Plan rate will not be publicly reported and star results will only be released to the health plan.

^o Inverse measure (lower number indicates better performance)

Quantitative Analysis

A full report on Diabetes Management can be found in Section A.5.b

Medi-Cal: For HEDIS 2015, performance rates for HbA1c Control <8%, and Poor Control >9%, Eye Exams, and Nephropathy Tests improved compared with rates reported in HEDIS 2014. HbA1c control <8% increased by 4.3% to 46%; HbA1c poor control >9% decreased by 5.7% to 41.8%, eye exams increased by 3.4% to 49.7%; and nephropathy tests increased by 1.6% to 86.6%. However, despite these improvements, HbA1c Control (<8%) was the only measure that met the 2015 work plan goal set at 46%. For HEDIS 2015, performance rates for HbA1c Testing decreased by 0.4% to 83.1%. HbA1c Testing did not meet the 2015 goal of 84% and narrowly missed the minimum performance level (MPL) of 83.2%. Statistical significance at the p<0.05 level was not determined for any of the aforementioned 2015 rates compared with rates reported in 2014.

Cal MediConnect: L.A. Care transitioned to Cal MediConnect (CMC) in mid-2014. Therefore, rates were captured administratively and do not represent performance over a full 12 months

L.A. Care Covered: Launched in 2013, L.A. Care Covered (LACC) is a new line of business for L.A. Care Health Plan. The data shown for this line of business represents the first full year of data captured. LACC is currently in beta-test, therefore the Plan rate will not be publicly reported and star results will only be released to the health plan.

SUMMARY OF INTERVENTIONS

HEDIS Tip Sheets: HEDIS tip sheets were developed and tested among physicians in 2015. The tip sheets aim to help ensure services rendered to members are captured and reflected in the data by educating providers on the correct billing codes to use for diabetic care services rendered. The tip sheets educate physicians on HEDIS guidelines, standards of care that are salient to HEDIS, and the most common billing codes submitted to receive credit for services rendered. The tip sheets include a section on Comprehensive

Diabetes Care (CDC) for HEDIS indicators including HbA1c testing, HbA1c poor control (>9%), diabetic retinal eye exams, and nephropathy testing.

Dissemination of Preventative Health Guidelines: Preventive Health Guideline (PHG) member brochures highlighting health services that can help members stay healthy, including diabetes screening for adults who are overweight, or who have a family history of diabetes, or who have a persistent blood pressure reading greater than 135/80, were mailed to over 14,500 CMC members in October, 2015. PHG member brochures for Medi-Cal and LACC members were revised in 2015 and will be mailed to members in Q1 2016.

L.A. Care's Disease Management Program: Since July 2014, L.A. Care has conducted its own in-house diabetes disease management program with L.A. Care's disease management nurses directly managing diabetic members who are identified and stratified according to diabetes risk level on a monthly basis to help determine the type and intensity of program intervention delivered. The disease management program entitled '*L.A. Cares About Diabetes®*' grew from 32,119 members at the end of 2014 to 36,399 members at the end of October 2015, an increase of approximately 27%. In August 2015, the *L.A. Cares About Diabetes®* member hand book was published. The book provides targeted education on diabetes disease management and is sent to all new diabetic members upon identification and enrollment into the disease management program. In 2015, diabetes magnet white boards were developed to promote diabetes control awareness among members. Approximately 50,000 magnet whiteboards were ordered. The magnet white boards will be sent to all members in the disease management program.

Member Call Outreach: In September 2014, a call outreach was conducted to members whose records showed that at least one of the diabetic tests, including HbA1c testing and the eye exam, were missing. In 2015, the call outreach continued with an estimated 34,550 calls made to members. Approximately 16% of calls to members were completed; 9% of members declined to participate, and 80% were not contactable during normal business hours. An after-hours call campaign began in November, 2015, with the aim of reaching out to those members that were not previously contacted.

Provider Opportunity Reports: In 2015, quarterly Medi-Cal Provider Opportunity Reports (PORs) were mailed to physicians (excluding those with Kaiser) highlighting physician performance levels for HEDIS measures including those related to diabetes. Reports showing individual members with gaps-in-care were made available on the provider portal. Medi-Cal PORs were mailed in July, September and November, 2015. CMC PORs were mailed in December, 2015.

Member Incentives: In October, 2015, the Disease Management and Quality Improvement Departments created a member incentive program for those members enrolled in L.A. Care's direct line of business for Medi-Cal (MCLA), and non-Medi-Cal members enrolled in L.A. Covered Connect (LACC). The incentive was mailed to members who were missing their eye exam but who had seen a provider in last 15 months. The incentive required members to obtain provider confirmation that they had received three diabetic health tests in order to qualify for a \$50 target gift card. The three tests included HbA1c testing, a retinal eye exam, and nephropathy test. A total of 25,679 mailers were sent out to MCLA/LACC members.

Provider Incentives: On April 4, 2014, the Joint PICC/PQC committee learned that comprehensive diabetes care performance indicators were to become part of L.A. Care's Physician 'Pay-for-Performance' (P4P) Program which rewards physicians with annual incentive payments above capitation for delivering high quality care. Comprehensive Diabetes Care is among one of 16 NCQA HEDIS measures rewarded in the P4P program. By 2015, the indicators included in the P4P program included HbA1c testing, HbA1c control ($\leq 9.0\%$), diabetic retinal eye exams, and nephropathy testing. Eligible physicians are automatically enrolled and need to submit timely, complete and accurate encounter data through their normal reporting channels on diabetic services rendered.

L.A. Care also continued its Medicare incentive for Physicians who accurately complete and submit their patients' Annual Wellness forms where physicians are given \$350 per calendar year for each form. The form includes preventive services and tests for diabetes as well as other important services to be performed.

II. CARDIOVASCULAR GUIDELINES RECOMMEND RISK REDUCTION THERAPIES IN THE MANAGEMENT AND TREATMENT OF CARDIOVASCULAR DISEASE

NB: A full report on reducing cardiovascular risk can be found in Section A.5.c.

Evidence based clinical practice guidelines are used by clinicians to help prevent cardiovascular disease, and reduce risks associated with having the disease by improving disease management. Several professional organizations including the American College of Cardiologists (ACC), American Heart Association (AHA), National Heart, Lung and Blood Institute (NHLBI), and Eighth Joint National Committee (JNC 8) develop guidelines, standards, and policies that promote screening to assess personal risk factors and reduce modifiable risks known to increase cardiovascular disease. Modifiable risk factors include smoking, high blood pressure, diabetes, physical inactivity, being overweight and having high blood cholesterol. Smoking cessation, following a healthy diet, keeping a healthy weight, and adhering to medications for a healthy heart can help reduce risks for cardiovascular disease. Reducing these risks provides the focus for one of L.A. Care's Chronic Care Improvement Projects (CCIP) for the Cal MediConnect and L.A. Care Covered lines of business. To measure performance associated with these guidelines, L.A. Care Health Plan uses the following NCQA HEDIS indicators: medication adherence for hypertension and cholesterol, and blood pressure control. Hypertension medications include angiotensin-converting enzyme (ACE) inhibitors and angiotensin-receptor blockers (ARBs); and cholesterol medications include statins. Blood pressure control is defined as having a blood pressure <140/90mmHg.

Clinical Practice Guidelines for Cardiovascular Risk Reduction Therapies

L.A. Care is actively involved in several initiatives to help practitioners achieve high standards in reducing cardiovascular risk as described in the 2013 American College of Cardiology and American Heart Association's (ACC/AHA) Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults; and in the report '2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults' by the Panel Members Appointed to the Eighth Joint National Committee (JNC 8). On April 4, 2014, L.A. Care's Joint PICC/PQC committee reviewed and approved updates to the aforementioned cardiovascular risk clinical practice guidelines where it was discussed that four major statin benefit groups were identified as requiring intense therapy: those with clinical ASCVD; primary elevations of LDL-C >190 mg/dL; diabetes aged 40 to 75 years with LDL-C 70 to 189 mg/dL and without clinical ASCVD; or without clinical ASCVD or diabetes with LDL-C 70 to 189 mg/dL and estimated 10-year ASCVD risk >7.5%. No changes to the guidelines were noted when they were reviewed by the committee on 10/06/15.

RESULTS

Cardiovascular Risk Reduction HEDIS 2015 Rates for Medi-Cal			
Measure	2013	2014	2015
Annual Monitoring for People on Persistent Medications (ACE/ARB) ^A	73.0%	78.9%	86.6%
Medication Adherence for Cholesterol (Statins) ^A	N/A	N/A	N/A
Blood Pressure control (<140/90) ^H	61.6%	57.1%	66.8%

Rates above show performance for measures using administrative data (A) from claims and encounters, and hybrid data (H) which also includes data from medical records.

Cardiovascular Risk Reduction HEDIS 2015 Rates for Cal MediConnect			
Measure	2013	2014	2015
Annual Monitoring for People on Persistent Medications (ACE/ARB) ^A	N/A	N/A	87.9%
Medication Adherence for Cholesterol (Statins) ^A	N/A	N/A	N/A
Blood Pressure control (<140/90) ^H	N/A	N/A	N/A

Rates above show performance for measures using administrative data (A) from claims and encounters, and hybrid data (H) which also includes data from medical records. Since L.A. Care transitioned to Cal MediConnect (CMC) in mid-2014, the rates above do not represent annual performance over a 12 month period and were not reported.

Cardiovascular Risk Reduction HEDIS 2015 Rates for L.A. Care Covered			
Measure	2013	2014	2015
Annual Monitoring for People on Persistent Medications (ACE/ARB) ^A	N/A	N/A	81.6%
Medication Adherence for Cholesterol (Statins) ^A	N/A	N/A	N/A
Blood Pressure control (<140/90) ^H	N/A	N/A	45.76

Rates above show performance for measures using administrative data (A) from claims and encounters, and hybrid data (H) which also includes data from medical records. LACC is currently in beta-test, therefore the Plan rate will not be publicly reported and star results will only be released to the health plan.

Quantitative Analysis

Medi-Cal: For HEDIS 2015, rates for the Annual Monitoring for Patients on Persistent Medications (MPM), that includes angiotensin converting enzyme (ACE) Inhibitors and angiotensin receptor blockers (ARB's), increased for the third consecutive year to 86.6%. This exceeded the work plan goal of 86% and the DHCS minimum performance level (MPL) of 85.76%. The HEDIS 2015 rate for Controlling High Blood Pressure (CBP) increased by 9.7% to 66.8% and exceeded the work plan goal of 64% and DHCS MPL of 48.53%. Rates for Medication Adherence for Cholesterol were not collected in 2014. Statistical significance at the p<0.05 level was not determined for any of the aforementioned 2015 rates compared with rates reported in 2014.

Cal MediConnect: L.A. Care transitioned to Cal MediConnect (CMC) in mid-2014. Therefore, rates were captured administratively and do not represent performance over a full 12 months

L.A. Care Covered: Launched in 2013, L.A. Care Covered (LACC) is a new line of business for L.A. Care Health Plan. The data shown for this line of business represents the first full year of data captured. LACC is currently in beta-test, therefore the Plan rate will not be publicly reported and star results will only be released to the health plan.

SUMMARY OF INTERVENTIONS

Provider Opportunity Reports: In 2015, quarterly Medi-Cal provider opportunity reports (PORs) were mailed to physicians (excluding those with Kaiser) highlighting physician performance levels for HEDIS indicators including MPM (ACE/ARBs). Reports showing individual members with gaps-in-care were made available on request. Medi-Cal PORs were mailed in July, September and November, 2015. CMC PORs were mailed in December, 2015

HEDIS Tip Sheets: HEDIS tip sheets were developed and tested among physicians in 2015. The tip sheets aim to help ensure services rendered to members are captured and reflected in the data by educating providers on the correct billing codes to use for lab panels that help to monitor members on persistent medications like ACE/ARBs and Digoxin, and controlling blood pressure. The tip sheets educate physicians on HEDIS guidelines, standards of care that salient to HEDIS, and the most common billing codes submitted to receive credit for services rendered.

Member Health Education Materials: L.A. Cares About Your Heart® member booklet was developed in 2015 and is due to be published and mailed to members in 2016. In addition, the Health In Motion™ program continued to support clinics with limited resources with the delivery of health education by health coaches and registered dieticians with focus on lifestyle and behavior change.

L.A. Care's Disease Management Program: In 2015, 1,366 LACC members and 4,440 CMC members who were diagnosed with hypertension, hypercholesterolemia, or other cardiovascular risk factors like chronic kidney disease and obesity, were enrolled in L.A. Care's disease management program '*L.A. Cares About Your Heart®*'.

Member Call Outreach: In 2015, members identified as high risk of CVD received quarterly telephone calls to monitor their health condition; members identified as moderate risk received telephone calls every 6 months.

Provider Initiative: In 2015, QI led and intervention to support the dissemination of clinical guidelines for diagnosing and controlling high blood pressure. A toolkit was sent to 3,259 providers which included a poster to educate patients on what they can do to help the clinician obtain the most accurate blood pressure measurement; a hypertension treatment algorithm pocket card; and a blood pressure reading procedural workflow chart.

CVD Provider Toolkit: L.A. Care's cardiovascular provider toolkit continued to be disseminated to providers in 2015 through the clinical practice guidelines directory and online provider portal. The toolkits included clinical guidelines for the assessment and treatment of cardiovascular conditions and risk factors including ACC/AHA Guidelines on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, and on the Assessment of Cardiovascular Risk; in addition to member health education resources on risk reduction factors like diet, smoking cessation, exercise, and medication adherence.

III. GUIDELINES FOR THE DIAGNOSIS AND MANAGEMENT OF ASTHMA RECOMMEND THE USE OF ASTHMA ACTION PLANS, PHARMACOTHERAPY, AND ANNUAL INFLUENZA IMMUNIZATIONS

NB: A full report including qualitative analysis on Asthma Management can be found in Section A.5.a.

The National Heart Lung and Blood Institute's (NHLBI) 'Guidelines for the Diagnosis and Management of Asthma' continue to be adopted by L.A. Care as indicated at the Joint PICC/PQC meeting on October 10, 2015. The guidelines state that periodic assessment and ongoing monitoring of asthma control using a written asthma action plan (AAP) may help facilitate patient involvement in disease self-management and preventing or managing acute exacerbations. The guidelines also advocate that optimal pharmacotherapy with minimal or no adverse effects be used to maintain control of persistent asthma and treat acute symptoms and exacerbations and that patients diagnosed with persistent asthma take both long-term control medications and quick-relief medications for acute symptoms and exacerbations. In addition, the guidelines recommend clinicians consider inactivated influenza vaccination for patients who have asthma due to the potential increased risk for complications from influenza. To measure performance associated with the NHLBI guidelines, L.A. Care uses the following NCQA HEDIS/CAHPS indicators: Use or Appropriate Medications for People with Asthma (ASM); Medication Management for People with Asthma (MMA) Compliance 50% and 75%; Flu Vaccinations for Adults age 18-64, and ≥65 years.

RESULTS

Asthma Management HEDIS/CAHPS 2015 Rates for Medi-Cal			
Measure	2013	2014	2015
Appropriate Medications for People with Asthma (ASM) ^A	80.2%	81%	80.2%
Medication Management for People with Asthma (MMA) 50% ^A	79.8%	67.4%	46.7%*
Medication Management for People with Asthma (MMA) 75% ^A	57.7%	45.7%	24.9%*
Flu Vaccinations for Adults 18-64 Years (FVA) ^{CAHPS}	N/A	35.6%	40.7%
Flu Vaccinations for Adults ≥65 Years (FVO) ^{CAHPS}	N/A	N/A	57.7%
Rates above show performance for measures using administrative data (A) from claims and encounters.			

*Statistically significant difference

Asthma Management HEDIS/CAHPS 2015 Rates for Cal MediConnect			
Measure	2013	2014	2015
Medication Management for People with Asthma (MMA) 50% ^A	N/A	N/A	N/A
Medication Management for People with Asthma (MMA) 75% ^A	N/A	N/A	N/A
Flu Vaccinations for Adults 18-64 Years (FVA) ^{CAHPS}	N/A	N/A	66.1%
Flu Vaccinations for Adults ≥65 Years (FVO) ^{CAHPS}	N/A	N/A	68.2%
Since L.A. Care transitioned to Cal MediConnect (CMC) in mid-2014, the rates above do not represent annual performance over a 12 month period and were not reported. Rates above show performance for measures using administrative data (A) from claims and encounters.			

Asthma Management HEDIS/CAHPS 2015 Rates for LACC			
Measure	2013	2014	2015
Medication Management for People with Asthma (MMA) 50% ^A	N/A	N/A	N/A
Medication Management for People with Asthma (MMA) 75% ^A	N/A	N/A	N/A
Flu Vaccinations for Adults 18-64 Years (FVA) ^{CAHPS}	N/A	N/A	24.1%
In 2015, LACC was a pilot. LACC is now entering into the beta-test, therefore the Plan rate will not be publicly reported and star results will only be released to the health plan. Rates above show performance for measures using administrative data (A) from claims and encounters.			

Quantitative Analysis

A full report including qualitative analysis on Asthma Management can be found in Section A.5.a.

Medi-Cal: For HEDIS 2015, rates for the Appropriate Medications for People with Asthma (ASM) decreased by 0.8%. The ASM measure will be retired in 2016. The 2015 rate for Medication Management for People with Asthma (MMA) 50% Compliance was 1.2% below the MPL set at 47.88%, and the rate for 'MMA 75% Compliance' was 2.4% above the MPL set at 22.55%. Rates for MMA have been in decline since 2013; most notably both MMA compliance rates decreased by nearly 21% compared with 2014 rates. CAHPS rates for Flu Vaccinations for Adults 18-64 Years (FVA) increased by 5.1% to 40.7%; this rate was above the Quality Compass 50th Percentile and 8.2% below the 90th Percentile set at 49.63%.

Cal MediConnect: L.A. Care transitioned to Cal MediConnect (CMC) in mid-2014. Therefore, rates were captured administratively and do not represent performance over a full 12 months

L.A. Care Covered: Launched in 2013, L.A. Care Covered (LACC) is a new line of business for L.A. Care Health Plan. The data shown for this line of business represents the first full year of data captured. LACC is currently in beta-test, therefore the Plan rate will not be publicly reported and star results will only be released to the health plan.

SUMMARY OF INTERVENTIONS

HEDIS Tip Sheets: The HEDIS tip sheets include a section on Respiratory Conditions including Use of Appropriate Medication for People with Asthma (ASM) which was part of L.A. Care's Pay for Performance program.

L.A. Care's Disease Management Program: The '*L.A. Cares About Asthma*'® disease management program grew 9.8% by November, 2015, compared with membership in 2014, and now includes 91,453 members. Disease management nurses receive ongoing motivational training to promote member engagement and self-management of asthma. The program is contracted with QueenCare Health Centers to provide members living within a 20 mile radius of the centers with high-touch in-home interventions.

Provider Opportunity Reports: In 2015, quarterly Medi-Cal provider opportunity reports (PORs) were mailed to physicians (excluding those with Kaiser) highlighting physician performance levels for HEDIS indicators including MMA 50%. Reports showing individual members with gaps-in-care were made available on the provider portal. Medi-Cal PORs were mailed in July, September and November, 2015. CMC PORs were mailed in December, 2015.

Provider Initiatives: In 2015, L.A. Care's Disease Management Department mailed hard copies of the latest adopted clinical guidelines for asthma to its physician partners. In addition, primary care physicians (PCP) receive a monthly letter regarding new members identified as having severe asthma. The PCP is asked to review the member's medical record and appropriately classify their asthma based on the NHLBI Asthma Guidelines. The letter contains the classification criteria for asthma based on the asthma guidelines.

Member Outreach: In 2015, members enrolled in the '*L.A. Cares About Asthma*'® disease management program were mailed an Asthma booklet developed by the Disease Management Department which includes an Asthma Action Plan and supporting educational materials. In addition, members identified as being at higher risk for the disease, were telephoned and offered support by disease management nurses.

Quality Improvement Projects: In 2015, L.A. Care began a state mandated improvement plan (IP) to increase medication compliance among members diagnosed with persistent asthma; the IP was submitted in the format of a Plan-Do-Study-Act (PDSA) worksheet.

In August, 2015, L.A. Care telephoned 59 Primary Care Providers (PCPs) and conducted 39 surveys to gather data on members who did not remain on asthma controller medication for at least 50% of their treatment period in measurement year 2014, and who continued to be identified as having this gap-in-care in 2015. The survey evaluation showed all 39 members with gaps-in-care in 2014 visited a PCP in 2015 but only 25% (10/39) of PCPs referenced asthma as one of the main reasons for the member's visit. Furthermore, of those PCPs who answered, 56% (14/25) of members were prescribed asthma controller medications in the last 12 months but only 16% (4/25) of these members had an asthma action plan. A review of the literature indicates that regular follow-up appointments and action plans created and reviewed in partnership by physicians and members can be useful tools in facilitating medication adherence and, therefore, provides the rationale for our objective and intervention.

L.A. Care's objective for the PDSA was to increase the percentage of eligible members with an asthma action plan by 10% by 12/31/15 in at least one high-volume, low-performing primary care provider site by implementing an L.A. Care Disease Management Nurse outreach initiative advising providers contact members with gaps-in-care and create or review an asthma action plan with the member to help facilitate medication adherence. L.A. Care conducted an outreach to 20 high-volume, low-performing providers with members who have gaps-in-care for the MMA measure in MY 2015. The nurses highlighted the benefits of creating and regularly reviewing asthma action plans with members as a tool for facilitating medication adherence. The nurses requested providers perform outreach to members with gaps-in-care to schedule

appointments with the member to create or review their asthma action plan. Asthma action plan forms created by L.A. Care's Disease Management Department were disseminated to providers. The results of the PDSA will be available in January, 2016, and submitted to DHCS.

Asthma Provider Toolkits: L.A. Care's Asthma Provider Toolkits continued to be disseminated to providers in 2015 through the clinical practice guidelines directory and online provider portal as well as during physician site visits conducted by L.A. Care nurses. The toolkits included clinical guidelines for the assessment and treatment and management of Asthma alongside patient education materials.

IV. BEHAVIORAL CONDITIONS: DEPRESSION AND ATTENTION DEFICIT HYPERACTIVITY DISORDER

NB: A full report including qualitative analysis on Continuity and Coordination of Medical and Behavioral Health can be found in Section A.8.

For selected lines of business, L.A. Care delegates behavioral health services to a National Committee for Quality Assurance (NCQA) Accredited Managed Behavioral Health Organization (MBHO). For enrollees in those plans, the MBHO collaborates with L.A. Care on the approval and monitoring of the selected Clinical Practice Guidelines for behavioral health with input and approval at the Behavioral Health Quality Improvement Committee quarterly meetings. For Medi-Cal members, L.A. Care is responsible for the delivery of behavioral health services to members with mild to moderate levels of behavioral health conditions and L.A. Care collaborates with the primary care physician network to equip them to diagnose and treat behavioral health conditions with mild to moderate levels of functional impairment. The L.A. County Department of Mental Health (LACDMH) is responsible for providing services to Med-Cal members with severe and persistent mental illness and moderate to severe levels of functional impairment. For its overall insured population, L.A. Care adopts at least two behavioral health guidelines, one of which addresses children and adolescents. L.A. Care selected depression and attention deficit hyperactivity disorder (ADHD) as behavioral health conditions to measure performance.

L.A. Care continues to be actively involved in many efforts to assist practitioners to meet the guidelines. The MBHO continued to review, approve, and disseminate the American Psychiatric Association CPG (provider education on importance of two or more outpatient visits and one or more medication visits within three months of diagnosis) on depression when necessary via their website and Provider Advisory Council.

At the March, 2015, Joint PICC/PQC meeting, L.A. Care's behavioral health team reported current efforts around increasing exchange of information between medical and behavioral health providers for 2015 and explained that there is a PCP to BH provider exchange of information form located on the provider portal which is available for use. Efforts also continue regarding prevention of site inpatient re-admits as well as cases with multiple emergency room visits for patients that have BH issues.

At the May, 2015, Joint PICC/PQC meeting, L.A. Care's Director of Behavioral Health Clinical Services presented the Behavioral Health Screening Tool form for the committees review. The tool screens for Generalized Anxiety Disorder (GAD-2), Patient Health Questionnaire (PHQ-2) for depression and Staying Healthy Assessment (SHA) questions for alcohol and includes a referral phone number. The Director of Behavioral Health also discussed follow-up care for children who are prescribed ADHD medication. The Behavioral Health team aimed to identify members that have missed visits and mail letters to providers listing members that need follow up care and ask to practice: 1) appointment reminders; 2) appointment scheduling during visit; 3) following up with missed appointments. Other interventions discussed included identifying low performers from the Provider Opportunity Reports, assess root causes and develop an ADHD brochure for providers to use and discuss treatment adherence. L.A. Care's QI Director discussed the initiatives to help improved antidepressant medication management including member refill reminders,

provider mailings reminding them to schedule follow up visits with members diagnosed with depression, encourage medication adherence, and provide L.A. Care resources.

TREATMENT FOR DEPRESSION

The practice guideline for the 'Treatment of Patients with Major Depressive Disorder' by Gelenberg et. al. and published by The American Journal of Psychiatry, recommends establishing and maintaining a therapeutic alliance with the patient to help facilitate collaborative decision making where the patients preferences and concerns about treatment are addressed. The guideline also recommends that during the acute phase of treatment, patient need to be monitored on a regular basis to assess their response to pharmacotherapy, including any side effects, co-occurring disorders, treatment compliance, and availability of social support. These two guideline recommendations are reflected in the measures selected by the MBHO and presented below:

RESULTS

Beacon Depression Measures – 2015 Rates for Medi-Cal

Measure	2014	Q1, 2015	Q2, 2015	Q3, 2015
Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient BH visits within 84 days (12 weeks) of initial diagnostic visit	38.2%	47.5%	47.1%	28.8%
Percent of members (18+) newly diagnosed with depressive disorder who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit.	21.3%	19.6%	18.5%	14.0%

Beacon Depression Measures – 2015 Rates for Cal MediConnect

Measure	2014	Q1, 2015	Q2, 2015	Q3, 2015
Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient BH visits within 84 days (12 weeks) of initial diagnostic visit	52.6%	N/A	N/A	N/A
Percent of members (18+) newly diagnosed with depressive disorder who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit.	17.1%	N/A	N/A	N/A
Since L.A. Care transitioned to Cal MediConnect (CMC) in mid-2014, the rates above do not represent annual performance over a 12 month period and were not reported.				

Beacon Depression Measures – 2015 Rates for LACC

Measure	2014	Q1, 2015	Q2, 2015	Q3, 2015
Percent of members (18+) newly diagnosed with depressive disorder who received two or more outpatient BH visits within 84 days (12 weeks) of initial diagnostic visit.	61.5%	64.1%	48.1%	37.5%
Percent of members (18+) newly diagnosed with depressive disorder who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit.	32.7%	25.6%	38.5%	16.7%*
In 2015, LACC was a pilot. LACC is now entering into the beta-test, therefore the Plan rate will not be publicly reported and star results will only be released to the health plan.				

*Statistically significant change from the previous reporting period using z-test for proportions at p<0.05

Quantitative Analysis

Medi-Cal: The rates for both measures declined throughout Q1-Q3, 2015, and neither measure met the work plan goal of 50% in Q3. Rates for Q4 were not available at the time of writing.

Cal MediConnect: There were no CMC members for this measure in 2015.

L.A. Care Covered: Rates for ‘*outpatient visits*’ in Q1, 2015, showed a strong start to the year. However, by Q3 rates fell by 24% and did not meet the goal of 50%. Rates for ‘*medication visits*’ were strong at 38.5% in Q2 but by Q3 had dropped to 16.7% and did not reach the work plan goal of 50%. Rates for Q4 were not available at the time of writing.

N.B. Q3 data doesn’t account for claims lag and may be an underrepresentation of actual results.

SUMMARY OF INTERVENTIONS

Member Outreach: Members newly diagnosed with depression and who qualified for the HEDIS measure ‘Antidepressant Medication Management’ (AMM) received educational materials on the common side effects of medications for depression and the importance of follow-up appointments.

Provider Outreach: Behavioral Health and PCP prescribers received letters and notifications highlighting the adopted clinical practice guidelines for depression, toolkits used for depression management, and information on the criteria set for HEDIS measure AMM. In addition providers were educated on Beacon’s quality program.

Data Exchange: Medical, behavioral and prescription claims data on members newly diagnosed with depression continued to be sent to Beacon to help identify those patients prescribed medications by both medical and behavioral health clinicians.

TREATMENT FOR ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

The American Academy of Pediatrics’ ‘Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit Hyperactivity Disorder in Children and Adolescents’ recommends elementary school age children be prescribed FDA approved medications for ADHD and/or evidence based parent administered behavioral therapy as treatment for ADHD, preferably both. These two guideline recommendations are reflected in the measures selected by the MBHO and presented below:

RESULTS

Beacon ADHD Measures – 2015 Rates for Medi-Cal				
Measure	2014	Q1, 2015	Q2, 2015	Q3, 2015
Percentage of members aged 6-12 years with a diagnosis of ADHD, who participated in 3 or more family treatment visits within 180 days of being diagnosed with ADHD.*	0%	0%	0%	0%
Percent of members aged 6-12 years with a diagnosis of ADHD, who had an outpatient psychopharmacology visit within 30-90 days following the initial diagnostic visit.*	14.3%	37.5%	43.8%	0%

*Claims data

Quantitative Analysis

Medi-Cal: The rates for '*family treatment visits*' did not meet the target of 20% in Q1, Q2, and Q3 of 2015. The rates for '*psychopharmacology visits*' met the workplan goal of 30% in Q1 and Q2, but did not meet the goal in Q3. Rates for Q4 were not available at the time of writing.

N.B. Q3 data doesn't account for claims lag and may be an underrepresentation of actual results. There were no LACC members who met the criteria for ADHD claims data.

SUMMARY OF INTERVENTIONS

Provider Audits: The MBHO conducted chart audits of high volume providers and disseminated resources and recommendations for best practices to those providers who performed poorly.

Guideline Dissemination: The MBHO distributed a 'Follow-up Care Guidelines' article regarding children prescribed ADHD medication in their September, 2015, Provider Bulletin.

QI Workgroup: The MBHO developed an ongoing quality improvement activity workgroup in Q3 of 2015 to help identify initiatives to increase performance.

V. PREVENTIVE HEALTH GUIDELINES RECOMMEND HEALTH SERVICES THAT HELP PREVENT, DETECT, AND MANAGE ILLNESS AND DISEASE

NB: A full report and qualitative analysis on Preventative Services can be found in Section A.1.

Preventative health services like screenings can help to detect diseases early when they may be easier to treat, helping to improve quality and length of life; immunization are responsible for the control of many infectious diseases and can prevent illness, disease and disability from initially occurring. The U.S. Preventive Task Force (USPSTF) works to improve health by reviewing existing peer-reviewed evidence based recommendations about clinical preventative services including screenings, counseling, and preventative medications. Those recommendations which are adopted by USPSTF are disseminated on the USPSTF website. L.A. Care reviews and adopts USPSTF guidelines in addition to guidelines disseminated by the Centers for Disease Control (CDC) and the Advisory Committee on Immunization Practices (ACIP). L.A. Care promotes several preventative health guidelines (PHGs) through its clinical initiatives which include, but are not limited to, reducing obesity in adults and children, screening for colorectal cancer, and immunizing against illness, disease and disability.

L.A. Care continues to be actively involved in many efforts to assist practitioners to meet the guidelines. L.A. Care's medical director presented the changes to ACIP's child immunization guidelines at the March, 2015, Joint PICC/PQC meeting. These changes included those relating to the influenza vaccination whereby 1 or 2 doses was extended from 2 through 8 years; and 1 dose was extended from 9 to 18 years. Clarity was also given as to the validity of the 4th dose of DTaP: if the 4th dose DTaP vaccine was administered four months or more after the 3rd dose, at an appropriate age, it can be counted as a valid dose, and need not be repeated after the recommended six month interval between doses three and four. L.A. Care's preventative health guideline directory was also presented at the meeting with information on both child and adult immunizations and preventative health services. In addition, L.A. Care's QI Director reported that a partnership with American Cancer Society (ACS) was established in an effort to bolster colorectal cancer screening rates as well as leverage their expertise and learning materials. The American Cancer Society is spearheading a national campaign which was launched on Friday, March 13, 2015, regarding a pledge to commit to reaching an 80% screening rate for colorectal cancer by 2018.

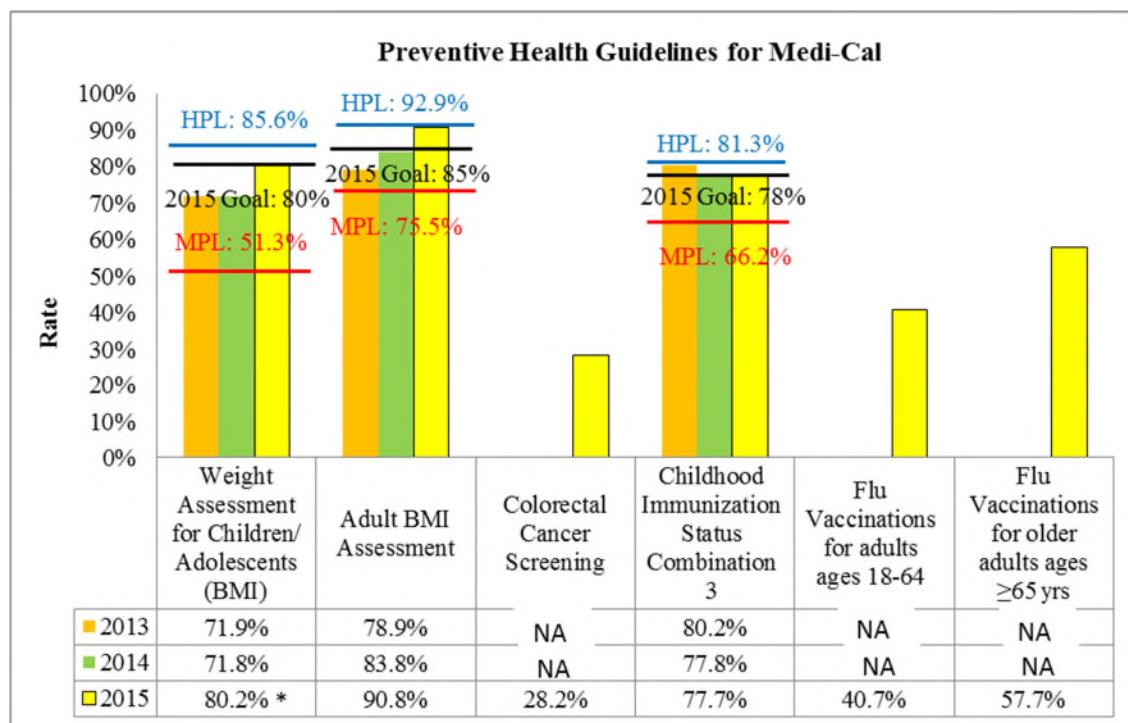
At the March, 2015, Joint PICC/PQC meeting, the QI Director gave a report on the colorectal cancer screening campaign in which L.A. Care will work with members' PPGs/Providers to get colorectal cancer screening kits sent to those members expressing interest and enhance knowledge of effectiveness and access these kits within MD offices, and work to supply MD offices with kits so they can distribute them to members at point of care.

RESULTS

Preventative Health Screening Rates for 2015 - Medi-Cal			
Measure	2013	2014	2015
Weight Assessment for Children/Adolescents (WCC-BMI) ^H	71.9%	71.8%	80.2%*
Adult BMI Assessment (ABA) ^H	78.9%	83.8%	90.8%
Colorectal Cancer Screening (COL) ^A	N/A	N/A	28.2%
Childhood Immunization Status Combination 3 (CIS-3).	80.2%	77.8%	77.7%
Flu Vaccinations for adults ages 18-64 (FVA) ^{CAHPS}	N/A	N/A	40.7%
Flu Vaccinations for older adults ages ≥65 yrs (FVO) ^{CAHPS}	N/A	N/A	57.7%

Rates above show performance for measures using administrative data (A) from claims and encounters, and hybrid data (H) which also includes data from medical records, except where CAHPS is indicated.

*Statistically significant difference



Preventative Health Screening Rates for 2015 - Cal MediConnect			
Measure	2013	2014	2015
Adult BMI Assessment (ABA) ^H	N/A	N/A	23.7%
Colorectal Cancer Screening (COL) ^A	N/A	N/A	24.7%
Flu Vaccinations for adults ages 18-64 (FVA) ^{CAHPS}	N/A	N/A	66.1%
Flu Vaccinations for older adults ages ≥65 yrs (FVO) ^{CAHPS}	N/A	N/A	68.2%

Rates above show performance for measures using administrative data (A) from claims and encounters, and hybrid data (H) which also includes data from medical records, except where CAHPS is indicated. L.A. Care transitioned to Cal MediConnect (CMC) in mid-2014, the rates above do not represent annual performance over a 12 month period and were not reported.

Preventative Health Screening Rates for 2015 - L.A. Care Covered			
Measure	2013	2014	2015
Weight Assessment for Children/Adolescents (WCC-BMI) ^H	N/A	N/A	43.6%
Flu Vaccinations for adults ages 18-64 (FVA) ^{CAHPS}	N/A	N/A	24.1%
Rates above show performance for measures using administrative data (A) from claims and encounters, and hybrid data (H) which also includes data from medical records, except where CAHPS is indicated. In 2015, LACC was a pilot. LACC is now entering into the beta-test, therefore the Plan rate will not be publicly reported.			

Quantitative Analysis

Weight Assessment - Body Mass Index

- **Medi-Cal:** For HEDIS 2015, the rate for BMI assessment among children aged 3-17 years, statistically significantly increased by 8.4 percentage points from the previous year – 80.2% in 2015 compared to 71.8% in 2014. For adults aged 18-74 years the rate for BMI assessment increased by 7% to 90.8%, reaching L.A. Care's goal set at 85%.
- **Cal-MediConnect:** For HEDIS 2015, the rate for BMI assessment among adults aged 18-74 years was 23.7%.
- **L.A. Care Covered:** Launched in 2013, L.A. Care Covered (LACC) is a new line of business for L.A. Care Health Plan. For HEDIS 2015, the baseline rate for BMI assessment is 43.6%, 3.9% below the 25th Percentile.

Colorectal Cancer Screening

- **Medi-Cal:** The HEDIS 2015 Admin rate for colorectal cancer screening among Medi-Cal members was 28.2%; there are no previous years' data to trend and no benchmarks for comparison.
- **Cal MediConnect:** L.A. Care's CMC 2015 HEDIS rate for colorectal cancer screening (COL) the rate was 24.7%; there are no previous years' data to trend, and no benchmarks for comparison.

Flu Vaccines for Adults

- **Medi-Cal:** For HEDIS 2015, the rate of Flu Vaccinations for Adults Aged 18-64 years fell below the Quality Compass 75th percentile of 44.83% by 4.1 percentage points. Formal goals were not set for 2015; however a goal of 45% for Medi-Cal will be targeted for 2016.
- **Cal-MediConnect:** For HEDIS 2015, the rate for flu vaccination for adult aged 18-64 years was 61.1%; the rate for adults aged ≥65 years was 68.2%.
- **L.A. Care Covered:** For HEDIS 2015, the rate of Flu Vaccination for Adults Aged 18-64 years was 24.1%.

Childhood Immunization Status, Combination 3 (CIS-3)

- **Medi-Cal:** For HEDIS 2015, the rate for CIS-3 decreased by 0.1% to 77.7%. The rate exceeded the MPL but fell short of reaching the work plan goal of 78% and HPL of 81.3%.

NB: Data limitations - L.A. Care transitioned to Cal MediConnect (CMC) in mid-2014, the rates above do not represent annual performance over a 12 month period and were not reported. In 2015, LACC was a pilot. LACC is now entering into the beta-test. Therefore, the Plan rate will not be publicly reported.

SUMMARY OF INTERVENTIONS

General Provider Incentives: L.A. Care's Pay-for-Performance (P4P) program incentivized performance on the CIS-3 and AWC measures, with CIS-3 being double weighted in calculating payments in 2015. Provider Opportunity Reports were mailed to providers in July, September, and November, 2015,

informing providers of their year to date performance and encouraging outreach to members with gaps-in-care.

Provider Initiatives: In August 2015, Child and adolescent wellness flyers were mailed to solo and small group providers detailing HEDIS-related health services recommended for different age groups; WCC and CIS-3 measures were represented in the flyer.

CIS-3 Incentive: From October 17 – December 31, 2015, parents/guardians of eligible Medi-Cal child members qualified to receive a \$25 Target gift card for having their child vaccinated according to the HEDIS CIS-3 measure based on ACIP guidelines. Furthermore, physicians received a \$25 incentive for each child who completed the immunization schedule by age 2 years.

Colorectal Cancer Screening: In 2015, L.A. Care committed to the National Colorectal Cancer Roundtable's goal to increase the percentage of adults age 50 years and older who are screened for colorectal cancer to 80% by 2018. Members aged 50-74 years and who were overdue for colorectal cancer screening received a reminder mailer encouraging them to complete a colon cancer screening test and to talk to their primary care provider about available screening options. A dedicated colorectal cancer screening inquiry phone line was set up with L.A. Care working with PPGs/providers to fulfill the member's request. As of the end of 2015, a total of approximately 80 members called the inquiry line.

Flu Vaccinations: In January 2015, L.A. Care mailed a thank you card and magnet thermostat to CMC members who received the flu shot. In Fall, 2015, L.A. Care reminded all Direct Line of Business members to get their annual flu shot using automated reminder calls; CMC members also received a promotional magnifying ruler.

BMI Initiatives: L.A. Care's HEDIS nurses visited providers to educate office staff on how to correctly document BMI and counseling for nutrition according to HEDIS criteria. L.A. Care continued a Medicare incentive for Physicians who accurately complete and submit members' Annual Wellness form. Physicians are given \$350 per calendar year for each form. The form includes preventive services like BMI assessment as well as tests for diabetes and other important services. L.A. Care's Health Education Department launched a new on-line wellness site: "My Health In Motion™", and conducted 72 group appointments with 503 DLOB attendees. The Health Education department also offered training on Motivational Interviewing to staff including Certified Health Coaches, Registered Dietitians, and Master's Level Health Educators. In 2015, Family Resource Centers (FRCs) continued to offer a variety of fitness and health classes and educational materials to the public.

A.7 CONTINUITY AND COORDINATION OF MEDICAL CARE

BACKGROUND

L.A. Care Health Plan monitors performance areas affecting and reflecting coordination of care on an annual basis. L.A. Care acknowledges that continuity of care is important to ensure that members receive the highest quality of care possible. Continuity of care is an important factor that impacts patient safety. Although studies show that in most instances, practitioners are able to detect and bridge gaps in continuity of care, incidents can result from breakdowns in communication. L.A. Care uses information at its disposal and continues to build its network's ability to communicate effectively so as to facilitate continuity and coordination of medical care across its delivery system. This report provides an overview and analysis of several key initiatives aimed at improving coordination of care across transitions in management and inpatient and outpatient settings.

SECTION I. CONTINUITY AND COORDINATION OF CARE - TRANSITIONS IN MANAGEMENT

A. TRANSITIONS IN MANAGEMENT: SPECIALIST AND PRIMARY CARE PROVIDER COMMUNICATION

1. Data Collection – PCP/SCP Communication

L.A. Care measures Specialty Care Provider/Specialist (SCP) and Primary Care Provider (PCP) communication through a yearly Provider Satisfaction Survey (PSS). Providers are asked to respond to the following questions measuring continuity of care:

- (a) How frequently do you receive adequate clinical feedback from specialists to whom you have referred a patient? – Question specifically asked to PCPs.
- (b) How frequently do you receive adequate clinical information from Primary Care Physicians who refer a patient to you? – Question specifically asked to SCPs.

For all lines of business, L.A. Care has set a goal of having 80% of both PCPs and SCJs reporting that they “always” or “often” receive adequate clinical information as this would be an indicator of more consistent and effective communication and coordination of care.

2. Provider Satisfaction Survey Responses (2012-2015)

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

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

Percent of PCPs Responding Always or Often				
	2012	2013	2014	2015
Medi-Cal	39.8%	48.4%	37.4%	43.0%
CMC/SNP	19.2% (SNP)	47.5% (SNP)	20.5% (CMC), 14.3% (SNP)	42.7%
LACC	N/A	N/A	50.6%	41.3%

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

Percent of SCPs Responding Always or Often				
	2012	2013	2014	2015
Medi-Cal	54.6%	67.4%	53.1%	53.7%
CMC/SNP	94.8% (SNP)	59.7% (SNP)	42.4% (CMC), 47.5% (SNP)	39.3%
LACC	N/A	N/A	46.3%	49.0%

3. Quantitative and Causal Analysis – PCP/SCP Communication

Analysis by Line of Business:

Medi-Cal:

The percent of PCPs reported that they regularly received adequate information from SCPs increased by 5.6 percentage points in 2015 to 43.0% from its 2014 level of 37.4% but did not meet the goal of 80%. The percent of SCPs reported that they regularly received adequate clinical information from PCPs increased by 0.6 percentage points in 2015 to 53.7% from its 2014 level of 53.1% but did not meet the goal of 80%.

Cal MediConnect/SNP

In 2015, CMC had its first full year of PSS data so this will serve as baseline. The percent of PCPs that reported they regularly received adequate information from SCPs was 42.7% and this rate did not meet the 2015 goal of 80.0%. For the SCPs, 39.3% reported that they regularly received adequate clinical information from PCPs in 2015 and this rate did not meet the 2015 goal of 80.0%.

L.A. Care Covered

The percent of PCPs reported that they regularly received adequate information from SCPs decreased by 9.3 percentage points in 2015 to 41.3% from its 2014 level but did not meet the goal of 80%. The percent of SCPs reported that they regularly received adequate clinical information from PCPs increased by 2.7 percentage points in 2015 to 49.0% from its 2014 level but did not meet the goal of 80%.

Analysis by Specific Participating Provider Group:

The 2015 Provider Satisfaction Survey Report includes a segmentation analysis showing the responses by LOB (in tables above) as well as Participating Physician Group (PPG). Some PPGs had significantly lower always/often responses than others; notably one of L.A. Care's largest PPGs – Health Care LA (HCLA) which serves approximately 11.7% (216,120 members) of L.A. Care's total membership, reported that only 42.6% of PCPs reported that they always/often receive adequate clinical information from specialists. For L.A. County (DHS) on the other hand, which serves 13.1% (241,687 members) of L.A. Care's total membership, 44.1% of PCPs reported that they always/often receive adequate clinical information from specialists in 2015.

Below are examples of Quantitative Analysis:

HCLA Member Counts by L.A. Care Product Line		
	Sept 2014 Member Counts	Sept 2015 Member Counts
Medi-Cal	213,748	213,568
Medicare (CMC)	1,767	1,439
LACC	1,344	949
Other	95	164
Total (% of total membership)	216,954 (12.9%)	216,120 (11.7%)
Total L.A. Care membership	1,685,354	1,845,627

DHS Member Counts by L.A. Care Product Line		
	Sept 2014 Member Counts	Sept 2015 Member Counts
Medi-Cal	228,461	203,887
Medicare (CMC)	0	0
LACC	0	0
Other	37,228	37,800
Total (% of total membership)	265,689 (15.8%)	241,687 (13.1%)
Total L.A. Care membership	1,685,354	1,845,627

Adequate communication between PCPs and SCPs is the key to ensure that providers receive sufficient clinical information regarding their patients to maintain continuity and improve coordination of medical care. Staff turnover, no standardized forms, and limitations on staffing prohibit adequate information exchange between PCPs and SCPs. Also, providers may not have the system capabilities to communicate and exchange information in a timely manner nor resources to commit staff in an effort to improve continuity of care.

Opportunities for Improvement

In fielding these questions to providers (and when available, reviewing the segmentation analyses), L.A. Care has identified an opportunity to put interventions in place to enhance PCP and SCP communication/coordination/continuity around member care.

4. Intervention to act on Opportunity: HIT eConsult

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

In general, a PCP will determine if assistance from a specialist is needed and will initiate an eConsult with a specialist reviewer (SR). Upon review by the SR, the SR will communicate with the PCP giving patient care advice/education resulting in the PCP being able to meet the patient's specialty care needs (coded as patient needs addressed (PNA)) or the SR will suggest that the patient have a face to face with a specialist (coded as face to face (F2F)) and clinic staff will assist the patient in making the appointment. There are also other less frequently used codes that can be used to close an eConsult, such as patient deceased, PCP

determines different type of specialist should be engaged, etc. Alternatively, if a provider answers “Yes” to any of the mandatory Clarifying Questions (vary by specialty) within the consult submission process, the PCP can bypass the SR communication portion of the eConsult platform and directly submit a specialist referral request into the PPG’s authorization system (coded as direct to schedule (DTS)).

In 2009, the eConsult program was piloted. In 2011, the program expanded to DHS and Health Care LA (HCLA) clinics. L.A. Care began a gradual roll-out of the eConsult Program with HCLA in 2011. It began by offering one specialty (cardiology) and incrementally added specialties. In August 2013, a policy making eConsult mandatory was put into place, though clinics continued becoming users of the platform after this date, in practice. In 2014, L.A. Care successfully handed over ownership of the eConsult Program to be fully implemented and monitored by DHS – a signal of program effectiveness and sustainability.

Currently, HCLA remains in partnership with L.A. Care to make the eConsult Program available and more effective in meeting the needs of their network of physicians. This is of priority as HCLA serves a large portion of L.A. Care’s membership and in 2015, HCLA reevaluated and began discussing how to better utilize this interface which resulted in a 2016 action plan.

5. Measuring Intervention Effectiveness: HIT eConsult

Regarding SCP/PCP communication, targeting those provider groups that represent a large portion of the L.A. Care provider network and who serve a high volume of L.A. Care membership will have the greatest potential for impact. Thus, targeting the eConsult Program to improve PCP/SCP communication within the Los Angeles Department of Health Services (DHS) (241,687 members) and Health Care LA (HCLA) (216,120 members) will reach approximately 24.8% of L.A. Care’s total membership.

(a) DHS eConsult Summary Indicators

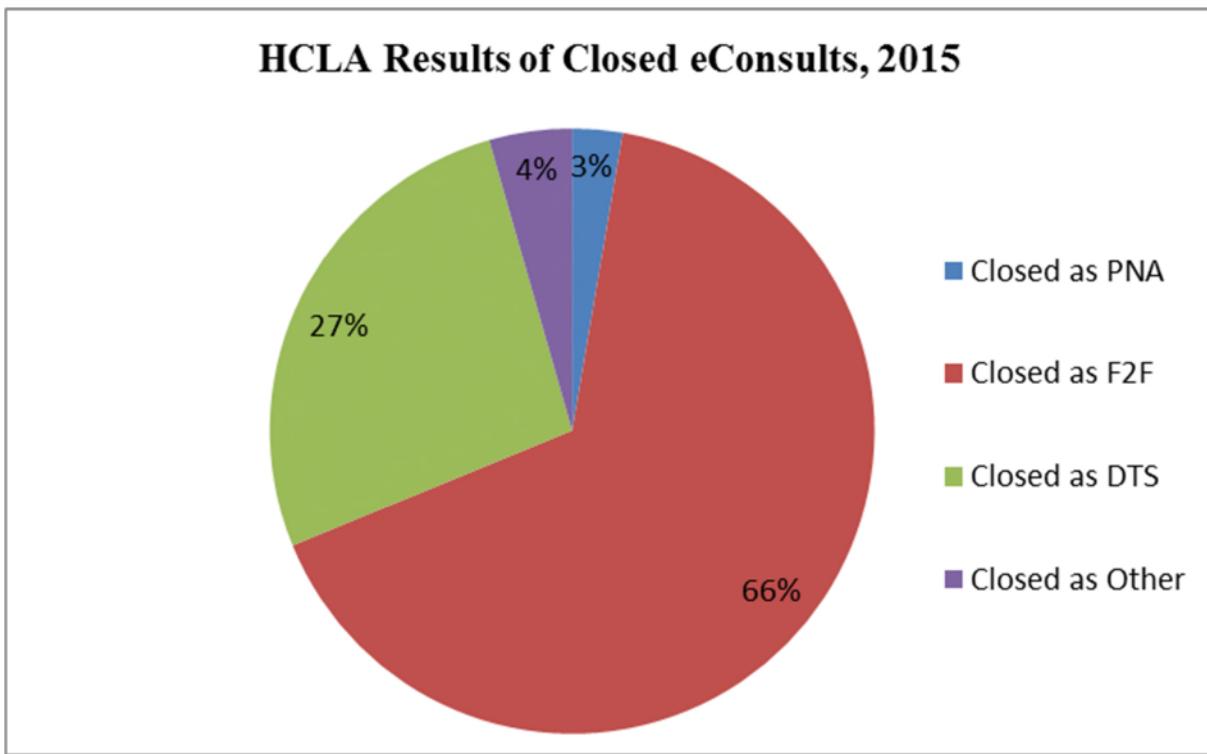
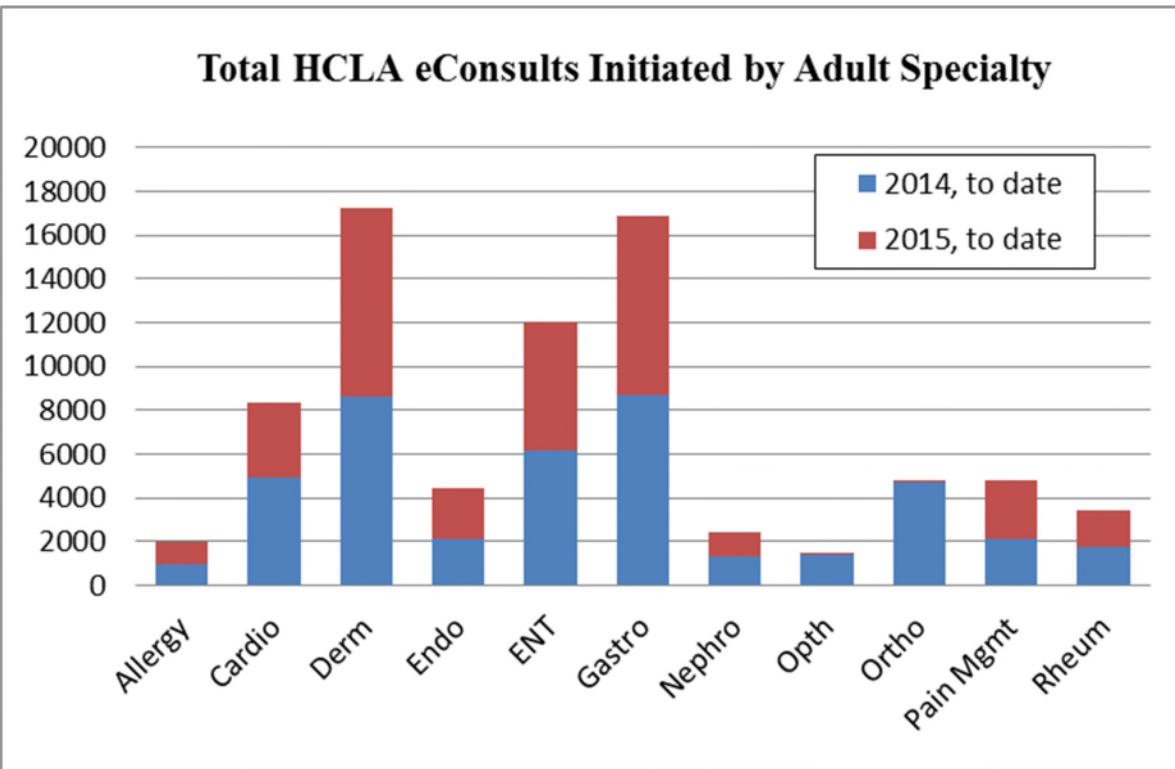
L.A. Care is no longer an active partner in DHS’s eConsult Program; however DHS continues to leverage the eConsult platform to improve PCP/SCP communication, specialty access, and coordination/continuity of care for their patients. DHS reported the following 2014 highlights of their fully implemented DHS eConsult Program (no 2015 highlights were available at time of submission):

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

(b) HCLA eConsult Summary Indicators

HCLA Site and User Totals		
	2014	2015
Sites Live	112	114
PCP Users	1,013	1,178
Total Users	1,912	2,189

*Total Users includes PCPs, Staff, and Senior Level



*Results of closed eConsult consultations depicted in above pie-chart are for 2015. PNA: Patient Needs Addressed, F2F: Face to Face, DTS: Direct to Schedule

The four (4) primary eConsult close codes and their description are as follows:

- (i) Patient Needs Addressed (PNA): Closed by the PCP when the specialty reviewer (SR) has provided information that would assist the PCP to treat the patient without the need of a specialty visit
- (ii) Refer for Face to Face visit (F2F): Closed by the SR when he/she determines that a face to face visit is necessary
- (iii) Direct to Schedule (DTS): eConsult sent directly for authorization for face to face visit with no dialogue between PCP and SR required
- (iv) Closed as Other: this is a combination of eight (8) additional close codes used less frequently including Specialty Change, Pending Diagnostics, Pending Therapeutic Trial, Cancelled, Out of Network, Expired, Patient Declined Care, and Patient Out of County

6. Intervention Effectiveness: Discussion – PCP/SCP Communication and eConsult

Together in 2015, HCLA and DHS serve nearly 25% of L.A. Care's total membership and thus the impact of the eConsult platform on continuity and coordination of care has potential significance.

Though L.A. Care is no longer an active partner in this implementation, DHS continues to implement the eConsult platform within the county network with success (DHS contracts directly with the eConsult vendor). Note there is no L.A. Care Provider Satisfaction Survey Report segmentation data available for 2015 at time of submission.

Specifically looking at HCLA, as of December 31, 2015, 1178 HCLA providers and 114 HCLA sites were using the eConsult Program, which resulted in a total of 34,660 adult eConsult consultations submitted and 1,117 pediatric eConsult consultations. Dermatologist SCPs were the most utilized eConsult consultation adult specialty at 24.8% (8,598) of all initiated eConsult consultations. For pediatric specialties, neurology SCPs were the most utilized at 53.6% (599) of all initiated pediatric eConsult consultations.

Upon closing of the PCP/SCP communication within the eConsult platform, 66% patients were recommended for a face to face specialist visit and 3% of patients needs addressed at the patient's medical home. For 27%, there was no PCP communication with a SR in the platform interface and the member was directly referred out and scheduled with a SCP. Over time, the goal is that the portion of eConsults closed as "PNA" (patient needs addressed) will increase so that the members' care remains coordinated at the PCP-level and benefits the patient by not adding the burden of scheduling and attending a specialist appointment(s).

Reviewing trends in these process codes also gives L.A. Care a better sense of how the eConsult tool is (isn't) being utilized to its fullest potential. L.A. Care has developed web-based and webinar re-trainings since staff and specialist reviewer turnover can be high and thus, keeping staff up-to-date on how to utilize this resource is important. In 2015, HCLA worked to improve the quality of the consults initiated through this platform. Too often, eConsults were closed as the patient needing a face-to-face with the specialist without meaningful discussion between the PCP and specialist reviewer. Beginning on January 1, 2016, HCLA will be utilizing the services of specialist reviewers from Telemed 2 U or TM2U. These new reviewers will be replacing the existing ENT and GI specialists that were used previously. The new specialist reviewers understand the importance of engaging in dialogue with the PCPs to coordinate care without pushing everything through as a face to face. As lessons are learned from the eConsult Program, L.A. Care plans to utilize these learnings to adapt to better meet the needs of end-users and strategically implement eConsult or similar programs so that L.A. Care can continue to expand its infrastructure to support PCP/SCP communication and thus, continuity and coordination of care.

B. TRANSITIONS IN MANAGEMENT: EMERGENCY DEPARTMENT TO PRIMARY CARE PRACTITIONER

1. Data Collection – Emergency Department Use

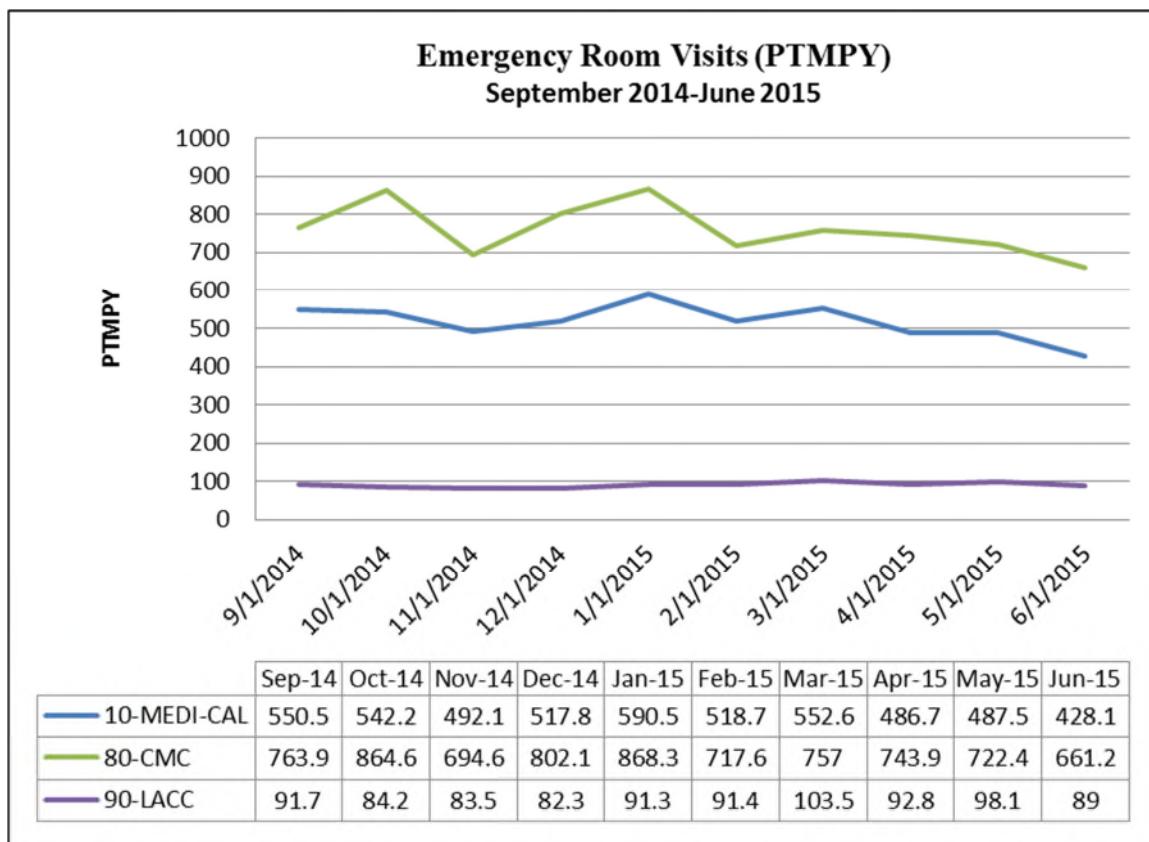
Within a network that has strong and effective continuity and coordination of care, ED visits can be reduced as members are more likely to receive care in the appropriate setting (PCP, urgent care, self-care) and have participatory guidance from their care team so as to reduce reliance on emergency care service.

L.A. Care monitors emergency department use through several data sources. The Key Performance Indicator (KPI) Reports tracks Emergency Room Visits per 1000 members per year (PTPY) for Medi-Cal and Medicare. LACC will be included in future reporting. Yearly HEDIS reporting also includes compilation of ER visit rates by line of business. And for Medi-Cal, a report of risk-adjusted ER visit rates was prepared comparing MCLA to the Plan Partners using 3M Clinical Risk Groups..

In general, L.A. Care's goal is a 10% reduction in emergency room visits from the previous year.

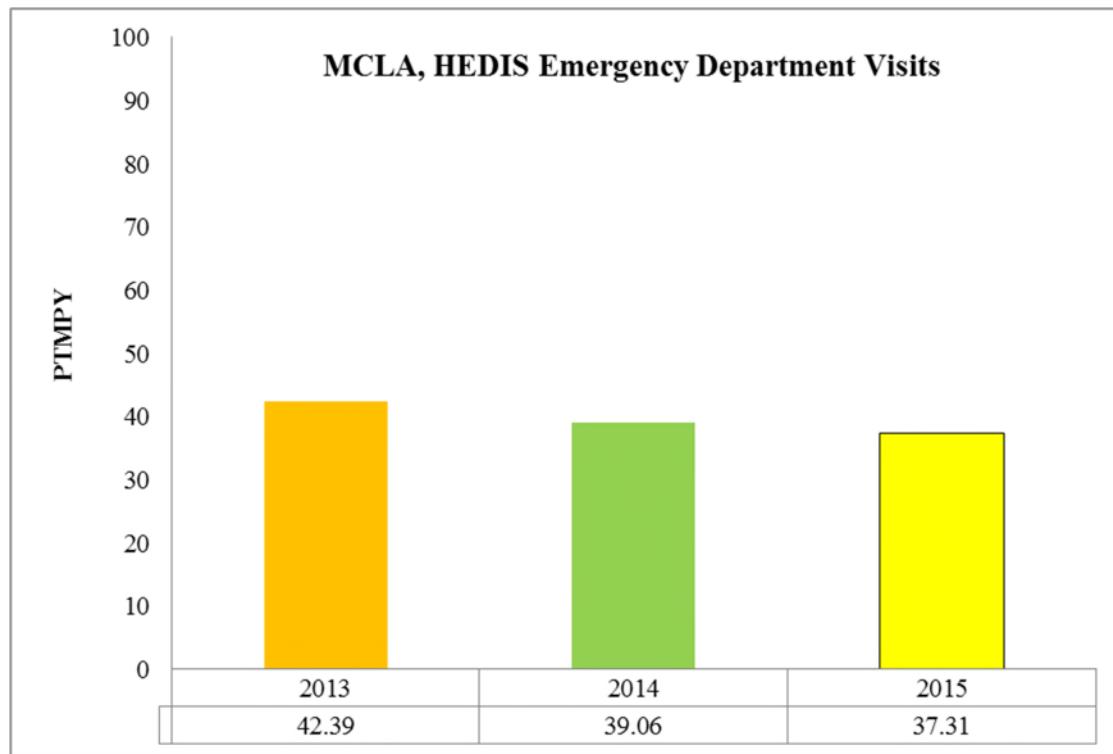
2. ED Visit Data Monitoring

(a) KPI Reports - Emergency Room Visits per 1000 members per year (PTMPY) for Medi-Cal (SPD and non-SPD), CMC, and LACC

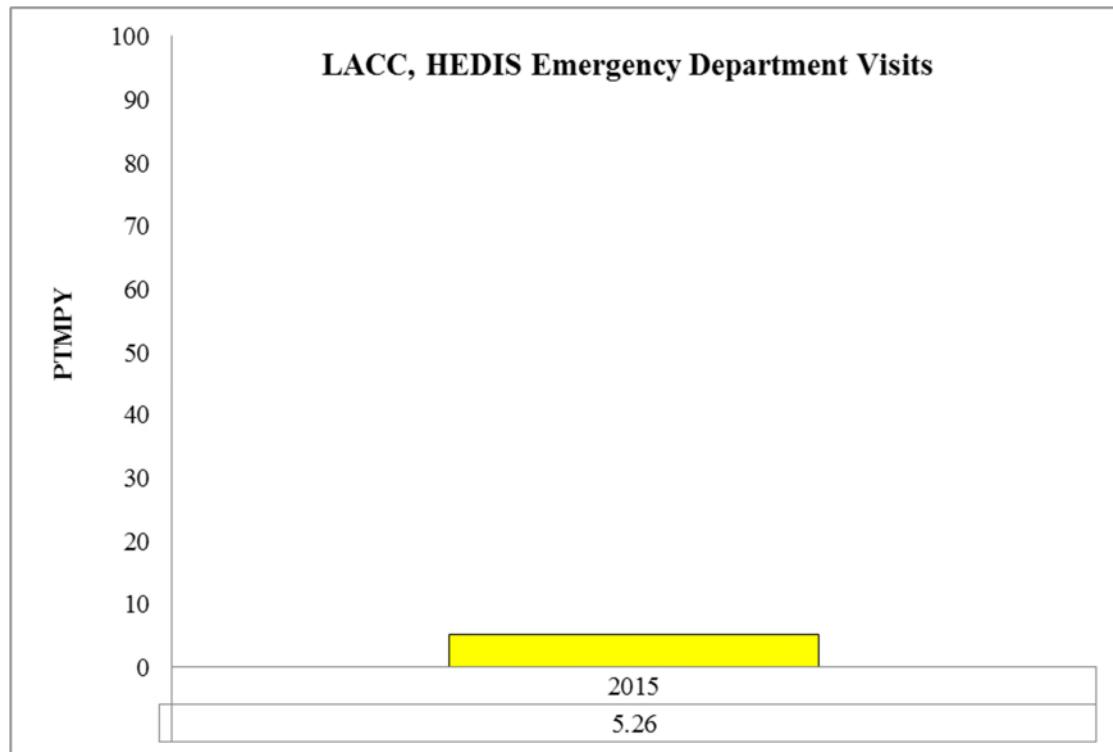


(b) HEDIS - ED Visit Rates

- i. Medi-Cal HEDIS – ED Visits/1,000 Member Months

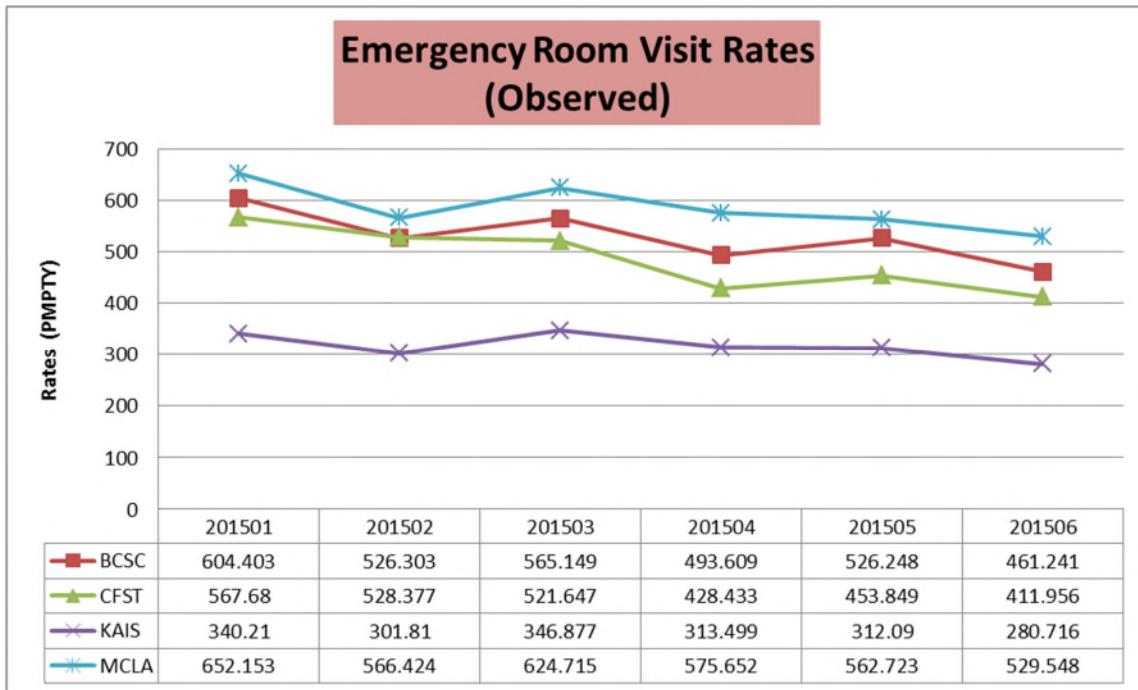


- ii. LACC HEDIS – ED Visits/1,000 Member Months

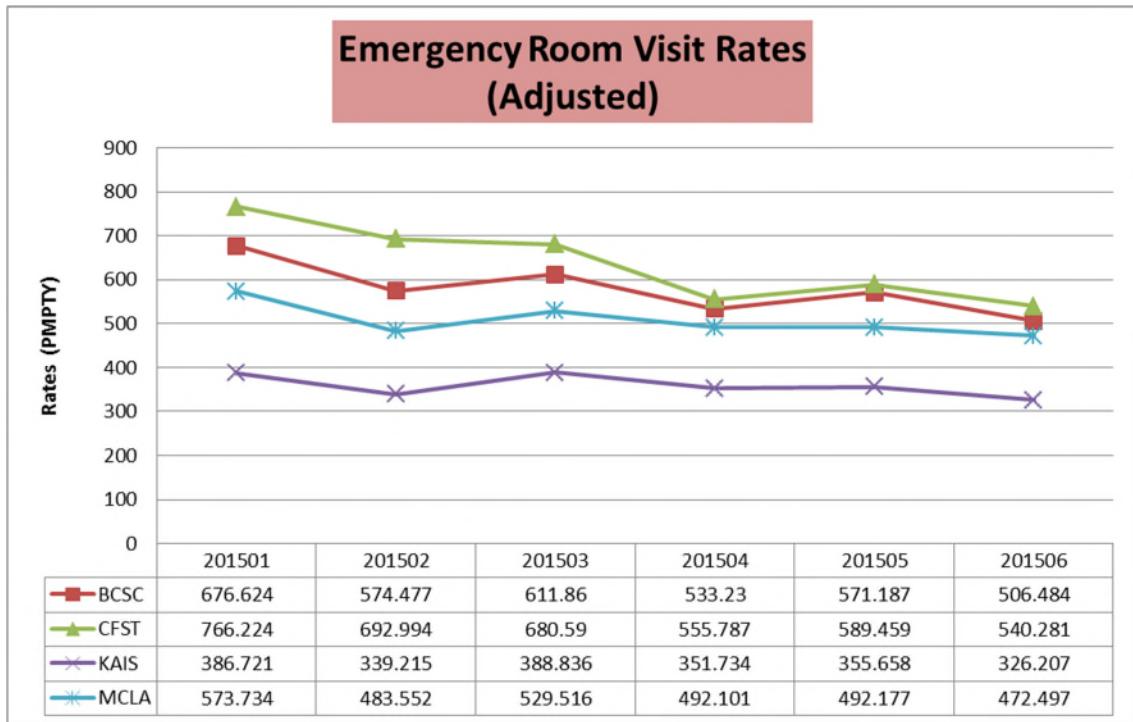


(c) ER visit rates for Medi-Cal (comparing MCLA to the Plan Partners)

i. Observed ER visit rates



ii. Risk-adjusted ER visit rates for Medi-Cal using 3M Clinical Risk Groups



3. Quantitative and Causal Analysis – Emergency Department Use

For Medi-Cal from September 2014 to June 2015, the average Emergency Room Visits per thousand members per year (PTMPY), was 516.7 PTMPY, with a downward trend (fewer using the ED) over the time frame depicted. HEDIS ER visit rate for Medi-Cal was 37.31 Visits/1,000 Member Months in 2015; a 1.75% decrease from 2014 and 5.08% decrease from 2013. In the report of risk-adjusted ER visit rates for Medi-Cal comparing MCLA to the Plan Partners, with the exception of Kaiser, the adjusted case-mix index using 3M Clinical Risk Groups ER visit rates for MCLA was lower than CFST and Anthem.

For Medicare-CMC from September 2014 to June 2015, the average Emergency Room Visits per Year (PTMPY) was 759.6 PTMPY, with a downward trend (fewer using the ED) over the time frame depicted. No HEDIS 2015 data is available for CMC since L.A. Care transitioned to CMC (dual demonstration) in mid-2014, rates were captured administratively on 33 measures, but HEDIS 2015 measures for Medicare were not reported.

For LACC, the HEDIS ER visit rate was 5.25 Visits/1,000 Member Months in 2015; 2015 is the baseline year for LACC.

Through the use of tracking and trending ER utilization patterns, L.A. Care has identified several barriers around use of emergency services:

- Members may perceive that they get better care in the ER, related to member's lack of confidence in his/her PCP
- Members may face access to care barriers such as not being able to visit their PCP or urgent care after normal business hours including weekends
- Providers are not aware of their members who recently visited the ER in order to provide a timely follow-up visit, appropriate assessment, and education to members on aftercare instructions or how to deal with potential risk factors for existing conditions.
- There is no timely exchange of information from the ER to the Health Plan. Health Plans rely on claims or encounter data which typically can take up to 6 months to obtain.
- Most hospitals are not incentivized to work with health plans to decrease ER usage and thus the revenue stream. Many tell the patient to return to the ER for a follow up visit rather than contact their own PCP.

Discharge from a hospital is a critical transition point in a patient's care and organizations across the country are focused on hospital discharges as a high-yield opportunity to improve outcomes and reduce costs. However, knowledge of patients being admitted and discharged from hospitals is a barrier for L.A. Care's network. PCPs do not consistently know when patients have been discharged which has a significant impact on patients accessing time-sensitive follow-up services.

Regarding L.A. Care members admitted for emergency services, timely communication to the IPA and then the IPA to their PCPs is crucial so that appropriate follow-up with the member can occur. Enhancing the networks ability to alert L.A. Care promptly and accurately when a member is admitted to the ER and then to share this information directly with the IPAs and PCPs would allow for more efficient utilization of PCP/staff's efforts to follow-up with patients who recently had an ER visit.

Opportunities for Improvement

There is opportunity to increase timeliness of data sharing to care managers and providers for ER admissions. Improving the timeliness of data sharing between the hospital, L.A. Care, and the IPAs/PCPs will have a positive impact on coordination and continuity of care for L.A. Care members.

4. Intervention to act on Opportunity: HIT eConnect

To increase timeliness of data sharing related to ED admissions, L.A. Care is taking action to enhance its network's ability and infrastructure to communicate (share data) with L.A. Care's Utilization and Care Management departments, IPAs and PCPs about which members are admitted to the ED. Timely exchange of this information can prompt the member's PCP/staff to make follow-up calls and schedule appointments with members post-ED discharge leading to a potential reduction of ER services.

Currently, L.A. Care receives hospital face sheets, clinical notes, and discharge summaries by fax. Given this lack of infrastructure to support efficient and timely communication of member admissions to the ER, L.A. Care has developed a pilot program called eConnect. In 2014, L.A. Care's eConnect pilot program began working to enhance the networks infrastructure to electronically receive member ED admission data from hospitals by establishing an ADT (admission, discharge, transfer) feed from hospitals as well as establishing access by L.A. Care's Care Management team to Hospital EHRs. ADT information is shared (via an online portal) with L.A. Care's Utilization and Care Management department when members have been admitted to the ED; information that can then be shared with IPAs and subsequently PCPs. Thus, this pilot program directly impacts coordination and continuity of care for all lines of business (Medi-Cal, CMC, and LACC) since it offers care managers, IPAs and PCPs "real-time" knowledge of when their patients have been admitted to the emergency setting. This improved communication network will also provide L.A. Care's Utilization and Care Management departments with more timely access for concurrent review, discharge planning, and care coordination via read-only hospital EHR access. Looking forward, the eConnect Pilot Program will increase the number of participating hospitals with a goal to expand to more hospitals as well as initiate and track utilization of the information shared within the IPAs' online portal.

5. Measuring Intervention Effectiveness: HIT eConnect

Through the eConnect Pilot Program's interface, as of 2014 eight hospitals were able to electronically notify L.A. Care upon member ER admission which is then shared with the IPAs and PCPs. This increased to 10 hospitals in 2015, with an additional 8 hospitals having set systems in place and in the process of testing the eConnect ADT interface (expected "go-live" in February 2016).

(a) 2015 eConnect Process Data on ER Admissions/Visits

Estimated ER Visits Captured by Participating L.A. Care eConnect Hospitals		
Hospital Group	Hospital Site	Estimated ER Visits that will be captured
Alta	Alta – Los Angeles	926
Alta	Alta - Hollywood	3,066
Alta	Alta – Culver City	85
Alta	Alta - Norwalk	1,296
Citrus	Citrus – Queen of the Valley	14,102
Citrus	Citrus – Foothill Presbyterians Hospital	2,666
Citrus	Citrus – Inter Community	1,903
Memorial Care Systems	Long Beach Memorial	19,037
Memorial Care Systems	Miller Children's Hospital	N/A

Estimated ER Visits Captured by Participating L.A. Care eConnect Hospitals		
Hospital Group	Hospital Site	Estimated ER Visits that will be captured
Valley Presbyterian Hospital	Valley Presbyterian Hospital	18,428
Estimated ED visits for active ADT eConnect Hospitals (% of total ER visits/year)		61,509(9.0%)
End Goal: Total ER Visits for ALL participating Hospitals (% of total ER visits/ year)		284,455 (41.9%)
Total L.A. Care ER visits/year for all Hospitals		679,172

6. Intervention Effectiveness: Discussion – Emergency Department Use and eConnect

As of 2015, among those 10 participating hospitals the ADT (admission, discharge, transfer) feed, L.A. Care is able to capture 9.0% of estimated ER admissions, up from 6.3% in 2014. **Specifically for 2015, among participating hospitals 22,266 ER visits were processed via eConnect;** noting that Valley Presbyterian Hospital went live in December 2015. By the end of the 3 year implementation process, L.A. Care will receive ADT data for approximately 42% of all ER admissions. L.A. Care has also established care manager access to 14 hospital EHRS as of the end of 2015 – usage of this access is tracked monthly. Over time, as the timeliness of ADT data exchange improves for the network, it is expected that avoidable ER rates will improve as a reflection of more timely coordination and continuity of care. Additionally, this timely data can also inform L.A. Care's development of more targeted interventions that can reduce reliance on the ER for health issues more effectively addressed within the continuum of care by the PCP and/or urgent care. In 2015, the Avoidable ED Utilization Measure Workgroup tested avoidable ED measure options with a goal of finding a measure that will be used for tracking/trending purposes by Utilization Management and potentially in the calculation of L.A. Care Incentive payments. There is an opportunity to leverage the eConnect data in the future to inform timely targeted interventions to reduce unnecessary use of the ED.

C. TRANSITIONS IN MANAGEMENT: INPATIENT FACILITY TO PRIMARY CARE PRACTITIONER

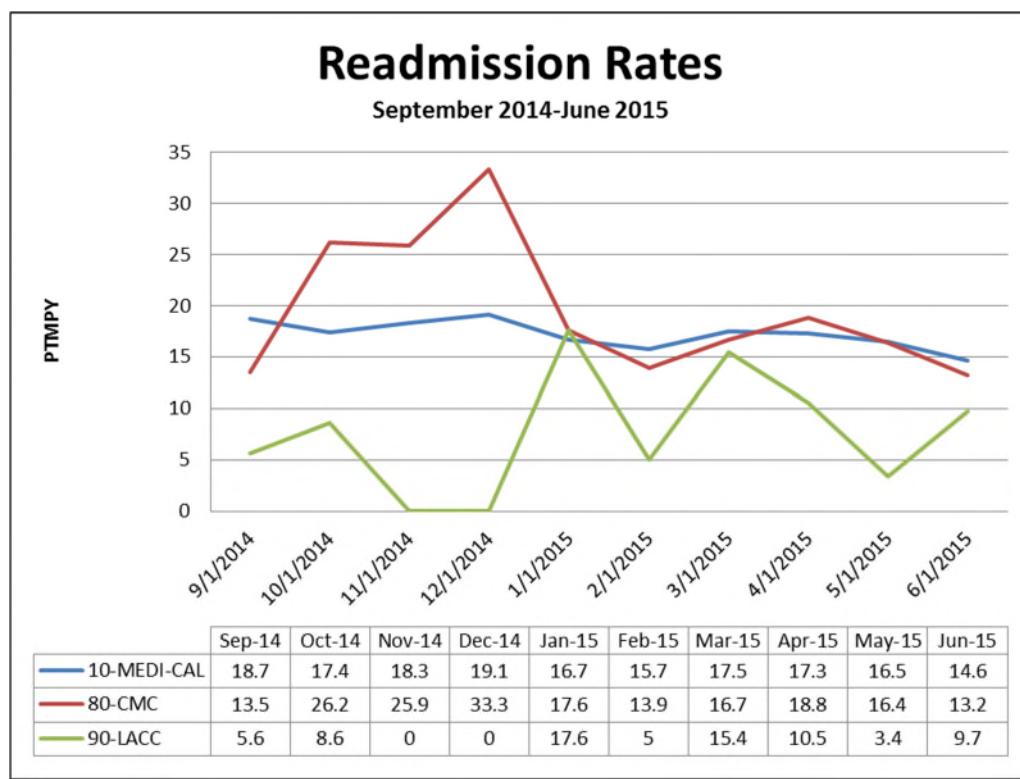
1. Data Collection – Readmissions

Hospital readmissions are common, costly and negatively impact health outcomes. Data from the 2007 Healthcare Cost and Utilization Project (HCUP) on all-cause readmissions among non-elderly Medicaid patients revealed that Medicaid readmission rates were higher than commercially insured patients. For Medicare patients, nearly one in five were readmitted within 30 days of discharge from a hospital stay and estimates of the cost of these potentially preventable readmissions equates to \$12 billion dollars annually.¹⁰ Readmission rates can be indicators of continuity and coordination of care.

L.A. Care monitors admissions and readmissions use through several data sources. The Key Performance Indicator (KPI) Reports tracks Inpatient Readmission Rates per 1000 members per year (PTMPY) for Medi-Cal and Medicare. LACC will be included in future reporting. And for Medi-Cal, a report of risk-adjusted hospital admissions rates was prepared comparing MCLA to the Plan Partners using 3M Clinical Risk Groups.

2. Readmission Data Monitoring

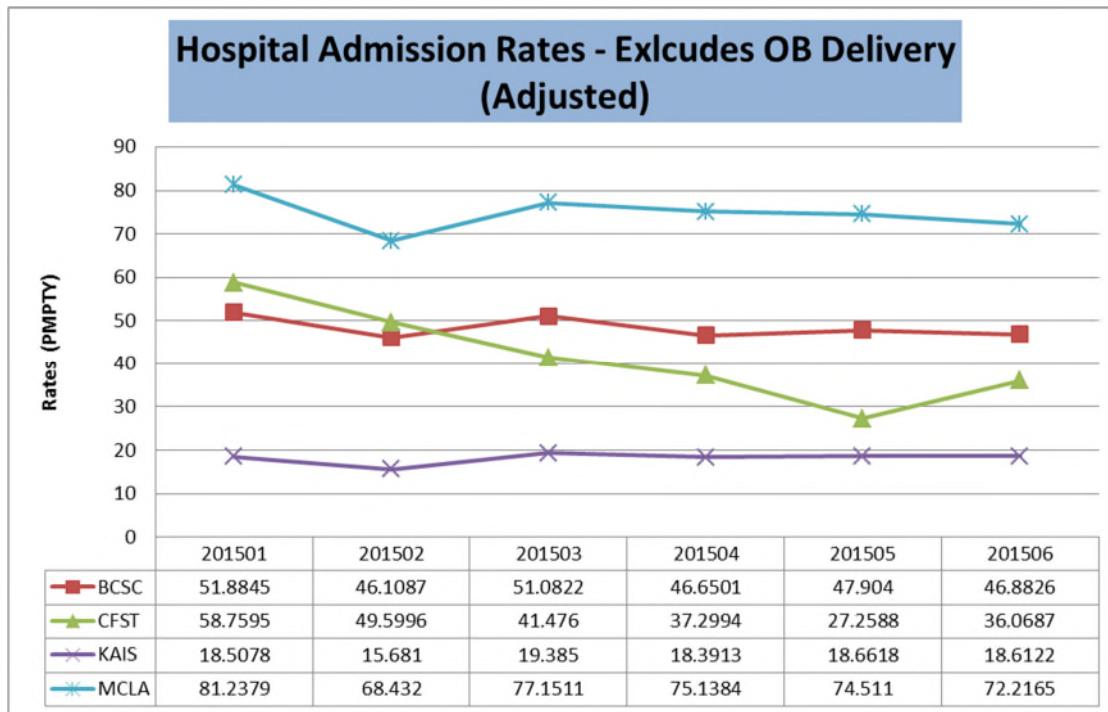
- (a) **KPI Reports – Inpatient 30-day Readmission Rates per 1000 members per year (PTMPY) for Medi-Cal (SPD and non-SPD), CMC, and LACC**



*Note 30-day inpatient readmission rates

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

(b) Risk-adjusted Hospital Admission rates for Medi-Cal (comparing MCLA to the Plan Partners) using 3M Clinical Risk Groups



3. Quantitative and Causal Analysis – Admissions and Readmissions

For Medi-Cal from September 2014 to June 2015, the average Readmission Rate per thousand members per year (PTMPY) was 17.2%, with a slight downward trend (fewer readmissions) towards the end of the time frame depicted. Of note, the hospital admission rates are higher for MCLA compared to our Plan Partners but this may be linked to the finding that generally speaking, the severity of illness in MCLA population is about 14-18% higher than the average Medi-Cal population managed in L.A. Care based on 3M Clinical Risk Groups. With a greater number of admissions, there will likely be a subsequent increase in number of readmissions, thus monitoring both of these utilization measures is important for tracking/trending and care coordination purposes.

For Medicare-CMC from September 2014 to June 2015, the average Readmission Rate per thousand members per year (PTMPY) was 19.6%, with a downward trend (fewer readmissions) over the time frame depicted.

For LACC, there was more variability month to month in readmissions likely due to the smaller membership size. The average Readmission Rate per thousand members per year (PTMPY) was 7.6% over the time frame depicted.

Discharge from a hospital is a critical transition point in a patient's care and organizations across the country are focused on hospital discharges as a high-yield opportunity to improve outcomes and reduce costs. However, knowledge of patients being admitted and discharged from hospitals is a barrier for L.A. Care's network. PCPs do not know when patients have been discharged which has a significant impact on patients accessing time-sensitive follow-up services.

Opportunities for Improvement

There is opportunity to increase timeliness of data sharing to care managers and providers for inpatient admissions, specifically targeting hospitals with a high volume of inpatient admissions. Improving the timeliness of data sharing between the hospital, L.A. Care, and the IPAs/PCPs will have a positive impact on coordination and continuity of care for L.A. Care members.

4. Intervention to act on Opportunity: HIT eConnect

To increase timeliness of data sharing related to inpatient admissions, L.A. Care is taking action to enhance its network's ability and infrastructure to communicate (share data) with L.A. Care's Utilization and Care Management departments, IPAs and PCPs about which members are admitted inpatient. Timely exchange of this information can prompt the member's PCP/staff to make follow-up calls and schedule appointments with members post-inpatient discharge leading to a potential reduction of readmissions.

Currently, L.A. Care receives hospital face sheets, clinical notes, and discharge summaries by fax. Given this lack of infrastructure to support efficient and timely communication of member admissions to the inpatient setting, L.A. Care has developed a pilot program called eConnect. In 2014, L.A. Care's eConnect pilot program began working to enhance the networks infrastructure to electronically receive member inpatient admission data from hospitals by establishing an ADT (admission, discharge, transfer) feed from hospitals as well as establishing access by L.A. Care's Care Management team to Hospital EHRs. ADT information is shared (via an online portal) with L.A. Care's Utilization and Care Management department when members have been admitted to the inpatient setting; information that can then be shared with IPAs and subsequently PCPs. Thus, this pilot program directly impacts coordination and continuity of care for all lines of business (Medi-Cal, CMC, and LACC) since it offers care managers, IPAs and PCPs "real-time" knowledge of when their patients have been admitted to the inpatient setting. This improved communication network will also provide L.A. Care's Utilization and Care Management departments with more timely access for concurrent review, discharge planning, and care coordination via read-only hospital EHR access. Looking forward, the eConnect Pilot Program will increase the number of participating hospitals with a goal to expand to more hospitals as well as initiate and track utilization of the information shared within the IPAs' online portal.

5. Measuring Intervention Effectiveness: HIT eConnect

Through the eConnect Pilot Program's interface, 10 hospitals are now able to electronically notify L.A. Care upon member admission, with an additional 8 hospitals having set systems in place and in the process of testing the eConnect ADT interface (expected "go-live" in February 2016).

(a) 2015 eConnect Process Data on Inpatient Admission and Readmissions

Estimated Capture of Inpatient Admissions and Readmissions among Active ADT eConnect Hospitals			
Hospital Group	Hospital Site	Estimated Admissions captured	Estimated Readmissions captured
Alta	Alta – Los Angeles	1,250	310
Alta	Alta - Hollywood	1,121	271
Alta	Alta – Culver City	587	154
Alta	Alta - Norwalk	593	136
Citrus	Citrus – Queen of the Valley	891	163

Estimated Capture of Inpatient Admissions and Readmissions among Active ADT eConnect Hospitals			
Hospital Group	Hospital Site	Estimated Admissions captured	Estimated Readmissions captured
Citrus	Citrus – Foothill Presbyterians Hospital	195	35
Citrus	Citrus – Inter Community	591	108
Memorial Care Systems	Long Beach Memorial	1,488	354
Memorial Care Systems	Miller Children's Hospital	N/A	N/A
Valley Presbyterian Hospital	Valley Presbyterian Hospital	1,005	192
Total Admissions/Readmissions for active ADT eConnect Hospitals (% of total Admissions or Readmissions/year)		7727 (18.7%)	1725 (21.8%)
End Goal: Total Admissions/Readmissions for ALL participating eConnect Hospitals (% of total ER visits/year)		End goal: 28,959 (69.9%)	End Goal: 5,757 (72.6%)
Total L.A. Care Admissions/Readmissions visits/year for all Hospitals		41,422	7,929

6. Intervention Effectiveness: Discussion – Readmissions and eConnect

As of 2015, among those 10 participating hospitals the ADT (admission, discharge, transfer) feed, L.A. Care is able to capture 18.7% of admissions and 21.8% of readmissions, up from 16.2% and 19.3%, respectively, in 2014. **Specifically for 2015, among participating hospitals 8,177 inpatient admissions were processed via eConnect;** noting that Valley Presbyterian Hospital went live in December 2015. By the end of the 3 year implementation process, L.A. Care will receive ADT data for approximately 69.9% of all admissions. L.A. Care has also established care manager access to 14 hospital EHRS as of the end of 2015 – usage of this access is tracked monthly. Over time, as the timeliness of ADT data exchange improves for the network, it is expected that readmission rates will improve as a reflection of more timely coordination and continuity of care.

SECTION II. CONTINUITY AND COORDINATION OF CARE – OUTPATIENT SETTING

A. OUTPATIENT SETTING: PHYSICIAN'S OFFICE, POLYPHARMACY

1. Data Collection - Polypharmacy

L.A. Care collects and utilizes pharmacy claims data in partnership with L.A. Care's contracted Pharmacy Benefits Manager (PBM). From the health plan perspective, administrative pharmacy claims data is utilized to support polypharmacy interventions as the data includes member, provider, and medication specific details that are vital to the intervention process.

2. Identification of Polypharmacy

Although the term polypharmacy has no single-source consensus definition, polypharmacy may be described as potentially inappropriate/excessive utilization of medication therapy within the context of population health management. On January 1st, 2015, L.A. Care switched PBMs to Navitus Health Solutions (Navitus) and the methodology towards identification of polypharmacy as well as the intervention has subsequently changed.

As multiple aspects of drug utilization contribute to the pattern of polypharmacy, identification of polypharmacy in 2015 is based upon one or more of the following observations:

- **Multi-Prescriber** – Patients who have received prescriptions from 7 or more unique prescribers for at least 2 months during a 4 month period.
 - *The Multi-Prescriber Program identifies patients that have utilized multiple prescribers to obtain prescription medications during the last four months. Patients who seek prescriptions from multiple prescribers are at a higher risk for duplicate therapy and/or drug-to-drug interactions.*
- **Multi-Prescription** – Patients who have received 13 or more prescriptions per month for at least 3 months during a 4 month period.
 - *The Multi-Prescription Program identifies patients with a higher number of medications and that have demonstrated a consistent pattern of utilization during the last four months. Research has shown that as the number of medications used by a patient increases, the potential for adverse drug events increases exponentially.*
- **Duplicate Therapy** – Patients who have received 2 or more prescriptions in the same drug class for at least 3 months during a 4 month period.
 - *The Duplicate Therapy program identifies patients using multiple drugs in the same therapeutic class consistently during the last four months. Duplicate therapy has the potential for additive toxicity, adverse effects and may cause therapeutic redundancy without increased benefit to the patient. Additionally, simplifying the patient's drug regimen to one drug may save the patient money and lead to greater adherence.*

3. Quantitative and Causal Analysis - Polypharmacy

The following table highlights the number of members that were identified with pharmacy claims data as having met patterns of potentially inappropriate polypharmacy as described above (having multiple prescribers, multiple prescriptions, and/or duplication of therapy). Members were identified during 3

separate periods throughout 2015 (March, July, and November) with 4 month look back periods to identify polypharmacy patterns.

The number of members identified for intervention in March was low due to the PBM transition switch to Navitus and a lack of data that was readily available to be utilized in the polypharmacy interventions (described in the next section).

Members Identified

LOB	Intervention	March 2015 Look back period: 11/1/14 - 2/28/15	July 2015 Look back period: 3/1/15 - 6/30/15	November 2015 Look back period: 7/1/15 - 10/31/15
Medi-Cal	Multi-Prescriber	42	140	162
	Multi-Prescription	-	2,007	2,093
	Duplicate Therapy	-	227	392
Cal MediConnect	Multi-Prescriber	2	4	6
	Multi-Prescription	-	184	193
	Duplicate Therapy	-	16	21
L.A. Care Covered	Multi-Prescriber	-	-	-
	Multi-Prescription	-	1	1
	Duplicate Therapy	-	1	1

Opportunities for Improvement

Better understanding processes and behaviors that impact rates of polypharmacy, L.A. Care has identified an opportunity to improve exchange of L.A. Care's pharmacy data to providers so that providers are aware of which of their members meet the parameters for polypharmacy.

4. Intervention to act on Opportunity: Polypharmacy Provider Outreach

The intervention for identified members is a prescriber mailing campaign administered by Navitus on behalf of L.A. Care, known as the Retrospective Drug Utilization Review (RDUR) Safety Program. For each identified member, Navitus sends out mailings to all prescribers that have played a role in the member's identification for having multiple prescribers, multiple prescriptions, and/or duplication of therapy. The mailing to prescribers includes details on the history of prescriptions filled (fill date, drug name, prescriber information, pharmacy information, etc.). The mailings occur in conjunction with the identification periods described in the previous section.

The purpose of the prescriber mailing intervention is to inform a prescriber of patient medication utilization that the prescriber may not be aware of. Although mailings are sent for all members identified with potential polypharmacy concerns, it is important to note that the prescriber must determine whether or not members truly have polypharmacy issues that need to be addressed. Certain identified members may be appropriately utilizing pharmacy services depending on factors such as the number of co-morbidities and complexity of their overall health status. The mailing also includes a brief recommendation on steps to be taken, which is intended to aid prescribers in addressing polypharmacy issues, when applicable.

The following table highlights the number of prescriber mailings sent in 2015 on behalf of members with potential polypharmacy issues.

Prescribers Mailed

LOB	Intervention	March 2015 Look back period: 11/1/14 - 2/28/15	July 2015 Look back period: 3/1/15 - 6/30/15	November 2015 Look back period: 7/1/15 - 10/31/15
Medi-Cal	Multi-Prescriber	412	1,355	1,463
	Multi-Prescription	-	3,768	3,843
	Duplicate Therapy	-	321	475
Cal MediConnect	Multi-Prescriber	19	44	70
	Multi-Prescription	-	507	559
	Duplicate Therapy	-	23	34
L.A. Care Covered	Multi-Prescriber	1	-	-
	Multi-Prescription	-	4	7
	Duplicate Therapy	-	2	1

5. Measuring Intervention Effectiveness: Change in Polypharmacy Drug Utilization Patterns

For the purposes of this evaluation, the prescriber mailing intervention is considered to have contributed to an improved outcome under the following circumstance:

- Member is identified for one or more interventions (Multi-Prescriber, Multi-Prescription, and/or Duplicate Therapy) during a given intervention period.
- Member no longer qualifies for the same intervention(s) during the next intervention mailing period.
- Example: Member has 8 different prescribers and meets criteria for Multi-Prescriber mailings in March. From March to June, the number of different prescribers for the member has decreased to four (4) and member no longer meets the criteria for Multi-Prescriber mailings in July.

Intervention Outcome – Change in Drug Utilization Patterns

		March - July			July - November		
LOB	Intervention	Identified in March	No longer meet criteria in July	% with Improved Outcomes	Identified in July	No longer meet criteria in November	% with Improved Outcomes
Medi-Cal	Multi-Prescriber	42	22	52.38%	140	84	60.00%
	Multi-Prescription	-	-	-	2,007	817	40.71%
	Duplicate Therapy	-	-	-	227	151	66.52%
Cal MediConnect	Multi-Prescriber	2	1	50.00%	4	2	50.00%
	Multi-Prescription	-	-	-	184	71	38.59%
	Duplicate Therapy	-	-	-	16	11	68.75%
L.A. Care Covered	Multi-Prescriber	-	-	-	-	-	-
	Multi-Prescription	-	-	-	1	0	0.00%
	Duplicate Therapy	-	-	-	1	1	100.00%

6. Intervention Effectiveness: Discussion – Polypharmacy Provider Outreach

In contrast to previous methods used to measure intervention effectiveness (monitoring provider response rates to mailings), the intervention effectiveness of the prescriber mailing campaign implemented in 2015 is based upon actual changes in drug utilization patterns related to polypharmacy. A prescriber mailing intervention is considered to have made a contribution towards a positive outcome when members previously identified as having a polypharmacy issue no longer meet criteria in subsequent mailing periods.

For the Medi-Cal and Cal MediConnect populations, interventions may have contributed to improved outcomes in 38.59% to 68.75% of identified members. There are several limitations to the above measured effectiveness of the intervention including the following: exclusion of disenrolled members during subsequent mailing periods was not incorporated and difficulty in concluding the exact cause of decrease in drug utilization patterns. However, based upon currently available observations of the prescriber mailing interventions in 2015, it does appear that the RDUR Safety Program is making a positive impact towards reduction of drug utilization with potential polypharmacy concerns. More data will be available next year including the impact of November mailings when members are identified for mailing interventions in March of 2016.

B. OUTPATIENT SETTING: PHYSICIAN'S OFFICE, MEDICATIONS AND NEEDED LABS

1. Data Collection - Annual Monitoring of Patients on Persistent Medications (MPM)

For patients on persistent medications, appropriate monitoring can reduce the occurrence of preventable adverse drug events.¹¹ For the three MPM measures (outlined in table below), an annual monitoring event is one serum potassium and a serum creatinine level. Digoxin requires a serum digoxin level in addition to serum potassium and serum creatinine test.

Annual monitoring of these medications allows providers to assess for side-effects and adjust drug dosage however, there are multiple barriers including that often members are taking medication from multiple prescribers. Thus, enhancing coordination and continuity of care is vital for improving the MPM measure and patient safety – PCPs must be aware of all the medications their members are taking, even those prescribed by specialists, so that appropriate testing can occur annually.

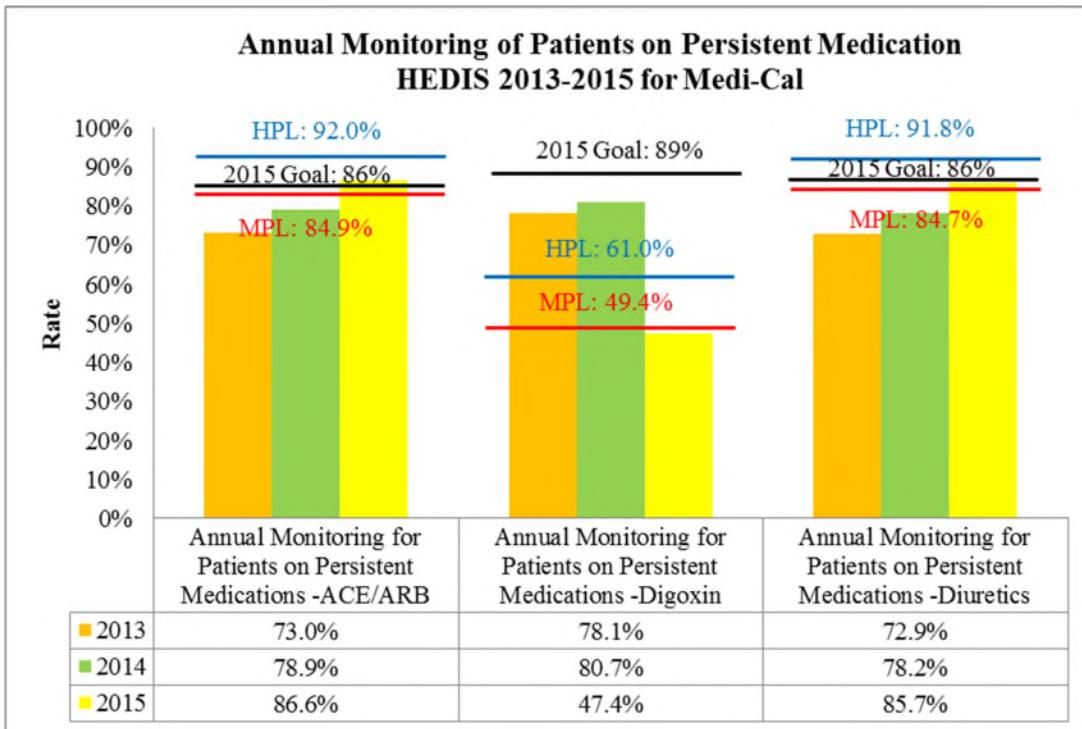
HEDIS Measure	Specific Indicator(s)	Measure Type
Annual Monitoring of Patients on Persistent Medication- ACE Inhibitors/ARBs	The percentage of members 18 years and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year,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

¹¹ NCQA. Annual Monitoring of patients on persistent medication.

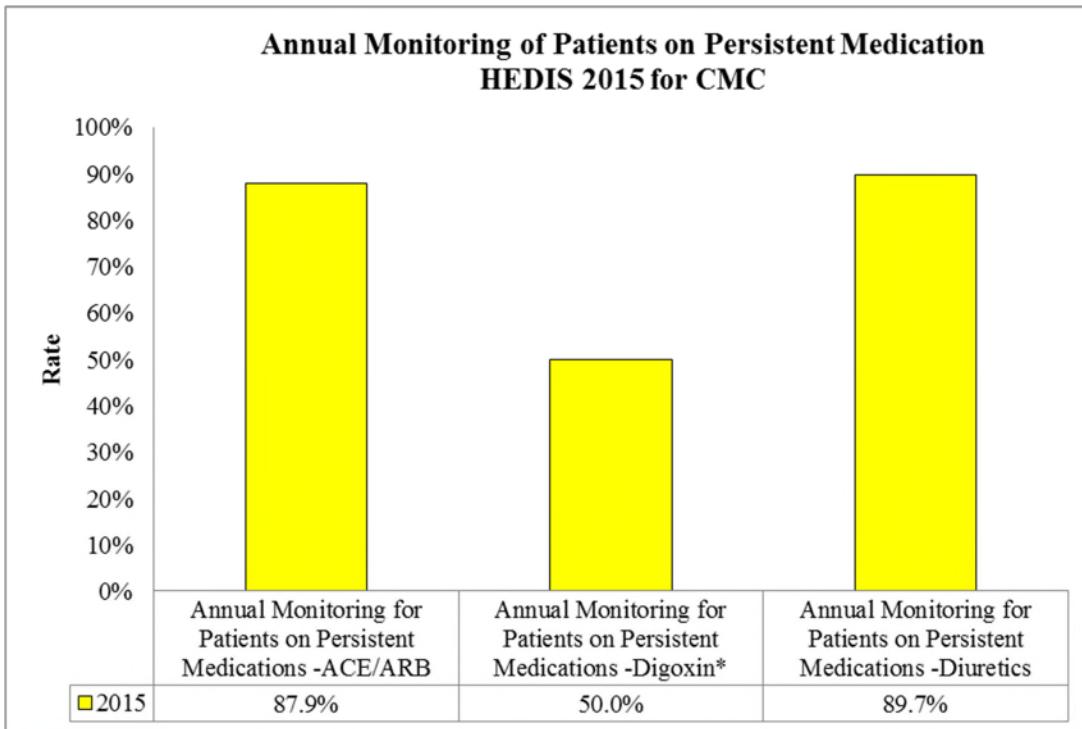
<http://www.ncqa.org/ReportCards/HealthPlans/StateofHealthCareQuality/2014TableofContents/PersistentMedications.aspx>

2. HEDIS - MPM Rates

(a) Medi-Cal

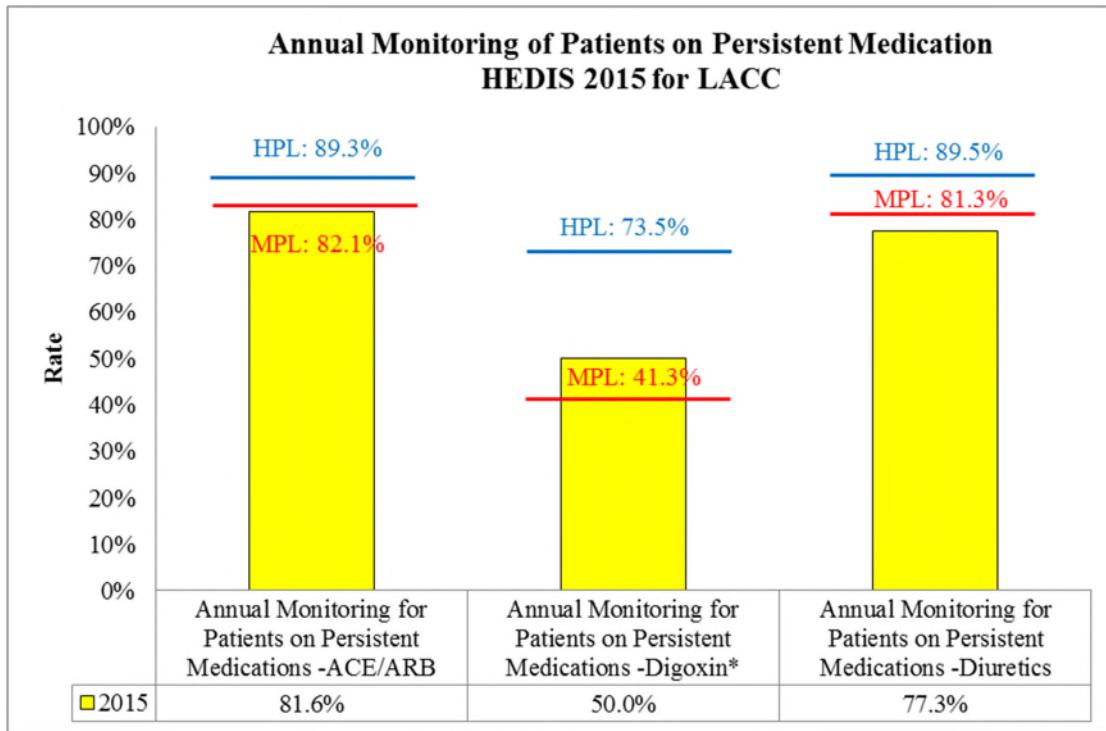


(b) Medicare – CalMediConnect (CMC)



*Denominator fewer than 30

(c) L.A. Care Covered (LACC)



*Denominator fewer than 30

3. Quantitative and Causal Analysis - MPM

The Medi-Cal rates for ACE/ARBs and diuretics showed statistically significant improvement from the prior year. The ACE/ARBs rate increased by 7.6% compared to the prior year and was above the minimum performance level (MPL) and met the goal. The diuretics rate increased by 7.5% from the prior year, however, this did not exceed the MPL (86.69%) by .02 % since DHCS does not allow for rounding of rates. It did meet the goal of 86%. The digoxin rate dropped significantly by 33.3% and did not meet the MPL or the goal.

Since L.A. Care transitioned to Cal MediConnect (CMC) in mid-2014, rates were captured administratively but were not reported. L.A. Care's CMC 2015 rate for MPM ACE/ARBS was 87.9%, and for diuretics 89.7%. The digoxin rate was 50%. There are no previous years' data to trend and no benchmarks for comparison of the administrative MPM rate in the CMC population.

Similarly, L.A. Care Covered (LACC) rates were also not reported for HEDIS 2015, but rates were captured even when the denominator fell below 30 members (see graph for details). The ACE/ARB rates were 81.6% and the digoxin rate was 50%. The diuretics rate was 77.3%. Both the ACE/ARB and diuretic rates were below the NCQA commercial plans MPL. The digoxin rate was 8.7% above the MPL; however the denominator had fewer than 30 members and is not consider a reliable sample size.

Disparity Analysis (Medi-Cal only)

L.A. Care also conducted an analysis based on Plan Partner, age, gender, ethnicity, region, and language to examine whether disparities exist in receiving these tests. The HEDIS 2015 results indicate that there is a Plan Partner disparity with those in Kaiser Health Plan outperforming all other health plans for all three measures. The ACE/ARBs measure also shows a disparity among younger members, with those 18-25yrs

of age having completed their labs at a rate of 75.4%. The digoxin rate among SPD members was also significantly higher (49.3%) than the non-SPD population (40.7%). For diuretics, the Spanish-speaking population, the SPD population, and older adults all had high rates compared to other groups.

Qualitative Analysis

From HEDIS 2014 to HEDIS 2015, the Medi-Cal ACE/ARBs and diuretics rate improved significantly. Beginning in 2014, L.A. Care met with high volume PPGs and stressed the importance of including all MPM measures in their member outreach campaigns. In late 2014, L. A. Care worked with its largest health care provider, DHS, to improve the capture of lab data. By requesting all in-house lab data, L.A. Care was able to locate an additional 2,030 labs/complaint members than the prior year for members on ACE/ARBs and an additional 1,263 compliant members on diuretics. This improved data sharing/communication between L.A. Care and DHS led to an increase of 4.3 percentage points in the Medi-Cal ACE/ARBs rate and 4.7 percentage point increase in the Medi-Cal diuretic rate.

The digoxin and the diuretic rates, however, are still below the MPL. The digoxin rate is likely low due to the additional digoxin lab test. Desk top audits from some of our largest providers, such as DHS, show that there is lack of digoxin screening among providers.

To improve the Medi-Cal diuretic rate, the Department of Health Care services is requesting that L.A. Care conduct a HEDIS Plan-Do- Study-Act (PDSA) cycle, since performance was just below the MPL. L.A. Care has requested that high volume low performing clinics conduct outreach to members missing potassium, creatinine, and digoxin labs and report their progress to L.A. Care. The effectiveness of this intervention will be evaluated in the first quarter of 2016.

Through the use of tracking and trending the MPM measure and understanding processes and behaviors that impact these rates, L.A. Care has identified several barriers around obtaining necessary labs to meet the MPM HEDIS specification:

- Providers may be unfamiliar with members medication history
- Providers do not know the member is part of their panel
- Providers are unaware of need for lab tests.
- Members are taking medication from multiple prescribers and their PCP is not informed of full medication regimen
- Member does not view the need for test based on their history with these medication
- Members may not know that these drugs need annual monitoring.
- Lab data errors may be contributing to lower rates

Opportunities for Improvement

There is opportunity to improve exchange of L.A. Care's pharmacy and lab data to providers so that providers are aware of which of their members require annual monitoring tests for ACE/ARBs, diuretics, and/or digoxin. Improving the data exchange process to make it more clinically actionable (timeliness, frequency, accuracy) by providers and care teams will have a positive impact on coordination and continuity of care for L.A. Care members.

4. Intervention to act on Opportunity: MPM Outreach Initiative

Based on the identified barriers and data, L.A. Care has prioritized provider level interventions to improve continuity and coordination of care as it relates to members getting needed tests annually (MPM HEDIS measure).

L.A. Care continued its MPM Outreach initiative at the provider level to include:

- Continuing to regularly distribute Provider Opportunity Reports (Gaps in Care reports) to all PCPs.

- Adding the MPM total rate to the LA P4P and the P4P incentive programs in 2015.
- L.A. Care staff calling 25 high volume clinics and providing them with information on member missing an annual monitoring event and asking them to call members in to get MPM labs
- Sending specialist prescribers of Digoxin a list of patients needing labs and asking them to call in members for labs and/or submit lab results (August 2015). **This intervention was applied to Medi-Cal, CMC, and LACC members.**
- Engaging PPGs in discussion around low performance and data management
- Working specifically with DHS to improve lab data capture.

At the member level, L.A. Care also promoted awareness of needed annual monitoring labs:

- In October of 2015, all members on these medications received a mailer that encouraged them to get screened and to ask their doctor about the three labs that may be needed. This intervention was also sent to members in the three product lines, since they may face similar barriers to getting these services.

This provider, PPG and member approach was taken to promote activities and behaviors that will enhance adherence to the MPM specifications across the continuum of care. Specifically, actions to improve data sharing with providers will have a positive influence on coordination and continuity of care, as providers will more likely take action if aware of a gap in care. The inclusion of the MPM measure on the Provider Opportunity Reports provided data to support the need for action at the provider/care team level.

5. Measuring Intervention Effectiveness: MPM Outreach Initiative

At this time, effectiveness of the MPM Initiative can be measured only by comparing yearly HEDIS rates. From 2014 to 2015, MPM rates have shown improvement in ACE/ARBs and diuretics but remains underperforming for the digoxin rate as seen in Section 2, MPM HEDIS rates above.

6. Intervention Effectiveness: Discussion – MPM

Improved data capture led to an increase in the rate. Goals met for ACE/ARBs and diuretics.

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

- L.A. Care plans to send member MPM reminders on a semi-annual basis starting in Q1.
- L.A. Care will continue working with high volume low performing providers to improve compliance rates.
- L.A. Care will continue working with PPGs on implementing interventions and improving data capture.

By better coordinating and communicating information related to medications prescribed and those patients needing labs to PCPs and specialist, L.A. Care hopes to see continued performance improvement for the MPM measures.

A.8 CONTINUITY AND COORDINATION BETWEEN MEDICAL AND BEHAVIORAL HEALTHCARE

BACKGROUND

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

In 2015, L.A. Care continued to collaborate with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare. To drive collaboration, L.A. Care collects data in 6 areas: Exchange of information between PCPs and Behavioral Health Practitioners (BHPs), Appropriate diagnosis and treatment, and referral of behavioral health disorders commonly seen in primary care, Appropriate uses of Psychopharmacological medications, Management of treatment access and follow up for member with coexisting medical and behavioral disorders, Prevention programs for behavioral health, and Special needs of members with severe and persistent mental illness.

2015 WORK PLAN GOALS:

Measure	2015 Medi-Cal Goals	2015 Cal MediConnect Goals	2015 L.A. Care Covered Goals
Exchange of information	80% of providers will be always/usually satisfied with the exchange of information between PCP and Behavioral Health Practitioners (BHPs)	80% of providers will be always/usually satisfied with the exchange of information between PCP and BHPs	80% of providers will be always/usually satisfied with the exchange of information between PCP and BHPs
Appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care	50% of providers will meet clinical practice guidelines for members with depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient Behavioral Health (BH) visits within 84 days (12 weeks) of initial diagnostic visit and who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit	50% of providers will meet clinical practice guidelines for members with depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient Behavioral Health (BH) visits within 84 days (12 weeks) of initial diagnostic visit and who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit	50% of providers will meet clinical practice guidelines for members with depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient Behavioral Health (BH) visits within 84 days (12 weeks) of initial diagnostic visit and who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit

Measure	2015 Medi-Cal Goals	2015 Cal MediConnect Goals	2015 L.A. Care Covered Goals
Appropriate uses of Psychopharmacological medications	100% of providers will be notified of members with ≥ 9 or more controlled substances	100% of providers will be notified of members with ≥ 9 or more controlled substances	100% of providers will be notified of members with ≥ 9 or more controlled substances
Management of treatment access and follow up for member with coexisting medical and behavioral disorders	100% of providers will be notified of members on diabetes and antipsychotic medication	100% of providers will be notified of members on diabetes and antipsychotic medication	100% of providers will be notified of members on diabetes and antipsychotic medication
Primary prevention behavioral health program implementation	Provide stress and anxiety management classes at L.A. Care's Family Resource Centers	Provide stress and anxiety management classes at L.A. Care's Family Resource Centers	Provide stress and anxiety management classes at L.A. Care's Family Resource Centers
Secondary prevention behavioral health program implementation	Conduct provider education to improve substance abuse screening	Conduct provider education to improve substance abuse screening	Conduct provider education to improve substance abuse screening
Special needs of members with severe and persistent mental illness	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

MAJOR ACCOMPLISHMENTS

- In September 2015, together with the HITECH-LA, the BH Department was awarded a 4-year CMS Innovation Grant to support a Practice Transformation Network (PTN) of 3100 PCPs in transforming their practice to improve the quality of care and care integration for individuals with the diagnosis of Diabetes and/or Depression.
- In September 2015, the BH Department was selected to join ACAP (Association of Community Affiliated Health Plans) nationwide Learning Collaborative on Health Integration.
- In October of 2015, together with various local entities, L.A. Care was awarded a regional planning grant from the California Health Care Foundation to form a broad coalition with the goal of identifying and implementing collective actions that will help reduce prescription drug abuse and overdose death epidemic in LA County.
- In October of 2015, together with the Safety Net Initiative Department, the BH Department was awarded a second phase BlueShield Foundation grant to plan a Health Neighborhood in a specific targeted region/area in LA County based on the frame work of year one funding in 2014.
- In December of 2015, together with the HITECH-LA, the BH Department was awarded a one year grant from the California Health Care Foundation and the BlueShield Foundation to study the outcome of a pilot eManagement for behavioral health which is set to be implemented in April 2016.
- A total of 30 BH related CME/CE activities were offered in 2015, including evening events and Saturday all-day conferences for a total of more than 120 credits for physicians, nurses, and behavioral health clinicians.

I. EXCHANGE OF INFORMATION

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

RESULTS

METHODOLOGY

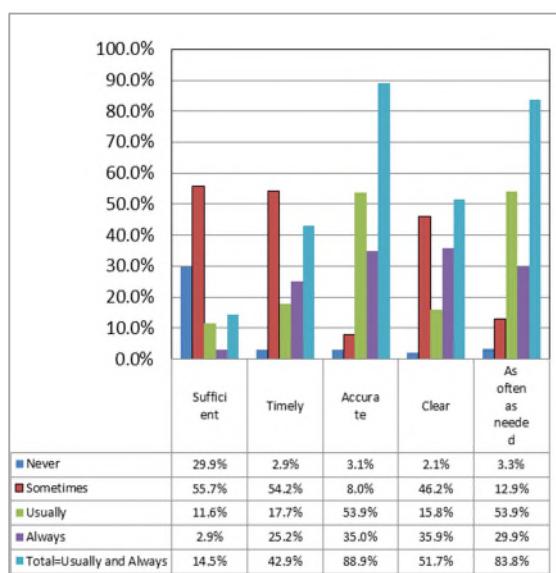
L.A. Care conducts an annual telephone survey of all PCPs offices, only Kaiser PCPs are excluded from the sample. The survey was fielded in November of 2015 and results became available in January of 2016. The sample size was 1907 PCP's sites. Of those contacted, 72.2% (1377) completed the survey. The survey consisted of eight questions using a combination of a Likert scale and open ended questions. In 2015, the survey asked about satisfaction with the Los Angeles Department of Mental Health (DMH) and about their satisfaction with Beacon Health Strategies (Beacon). This was the first year that PCPs were asked about both mental health providers.

DESCRIPTION OF MEASURE

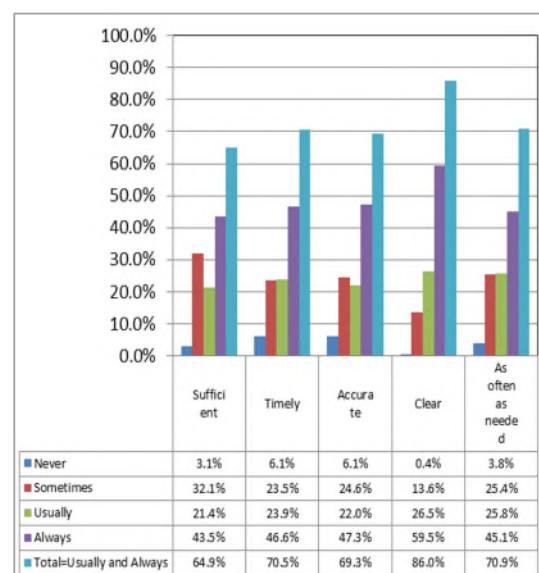
Measure	Specific Indicator(s)	Measure Type
Exchange of Information	Percentage of PCPs in L.A. Care's network that responded to the question, "Please Rate the Feedback Provided to the Behavioral Health Specialist to whom you refer most often (e.g. Treatment Plans, Consultation Reports, etc.)." The Feedback Was Sufficient, Timely, Accurate, Clear, And As often as needed: Always, Usually, Sometimes, Never."	Survey Question

DMH SURVEY RESULTS

2014



2015



ANALYSIS

Quantitative Analysis

The survey showed significant improvement for DMH over the previous year. ‘Sufficient’, ‘Timely’ and ‘Clear,’ had significant improvements over the prior year. While ‘Accurate’ and ‘As often as needed’ declined. The rate for the top box responses (‘Always’ or ‘Usually’) for ‘Sufficient’ was 64.9% compared to 14.5% in the prior year. When PCPs were asked about the timeliness of the feedback provided, 70.5% of respondents were ‘Always’ or ‘Usually’ satisfied compared to 42.9 % in 2014. In 2015, fewer providers (69.3%) were satisfied with the accuracy of the information, a drop of 14.5%. ‘Clear’ or clarity of the feedback provided increased to 86% from 51.7% in the prior year. The survey found that 70.9% of PCPs were ‘Usually’ or ‘Always’ satisfied with receiving the information ‘As often as needed.’ The goal of 80% satisfaction on all five measures was not met. The goal was only met for ‘Clear’ but overall DMH rates were higher in three out of five areas in 2015.

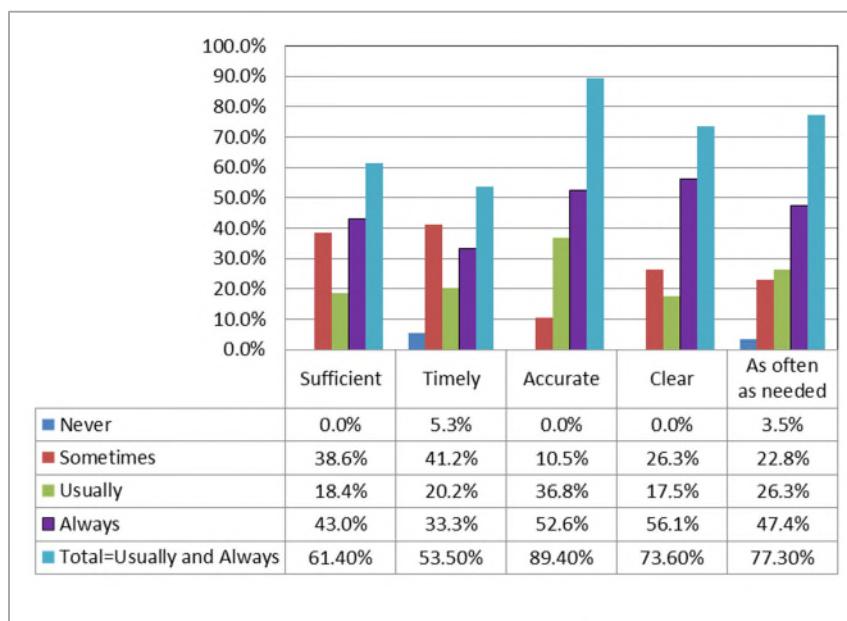
Qualitative Analysis

It is important to know that this survey differed significantly from the previous survey. This survey asked PCPs to rate the feedback provided by the Department of Mental Health and Beacon separately as it was believed that some of the respondents may have rated DMH based on interactions with Beacon. Therefore this survey is believed to be more representative of DMH’s performance.

The interventions that were implemented in 2015 may have led to improvement in the rates. The combination of educational sessions, combined with the redesign of the DMH referral form that included a reminder to send the PCP information about the patient, may have led to the rate increases in ‘sufficient’ and ‘timely’ information. The effects of the behavioral health hotline line for providers to help answer any questions they may have about the various services and benefits, may have also led to these improvements. At the March Behavioral Health Quality Improvement Committee meeting, DMH was advised that ‘Sufficient’ and ‘Accurate’ were two areas still in need of improvement.

BEACON SURVEY RESULTS

2015



ANALYSIS

Quantitative Analysis

Beacon's first survey showed that a majority of providers were 'Usually' or 'Always' satisfied with the information they received from Beacon. The rate for the top box responses ('Always' or 'Usually') for 'Sufficient' was 61.4% and 53.5% for 'Timely.' The rate of providers that found the information 'Accurate' was 89.4%, which exceed the goal of 80%. 'Clear' and 'As often as needed,' did not meet the goal but had rates of 73.6% and 77.3% respectively. The goal of 80% satisfaction on all five measures was not met.

Qualitative Analysis

The survey results represent Beacon's baseline rate. Beacon had lower rates than DMH in three areas: 'Sufficient,' 'Timely' and 'Clear.' Beacon had higher rates than DMH for 'Accurate' and 'As often as needed.' 'Timely' and 'Sufficient' were two areas that were identified as needing improvement at the Behavioral Health Quality Committee meeting in March. One of the physicians on the committee stated that he would like to see more information about the patient's diagnosis and medications to address the issue of if sufficient information is received from the behavioral health specialists. L.A. Care will work with DMH and Beacon in educating providers on completing the appropriate forms needed to release member information.

INTERVENTIONS:

Measure	Barriers	Opportunities for Improvement	Actions	Effectiveness of Intervention/ Outcome
Coordination of Care/Exchange of Information between PCPs and Behavioral Health Providers	<ul style="list-style-type: none">• PCPs lack knowledge on how to refer members and what information can be shared between providers.• PCPs state that DMH appointments are difficult to make.	<ul style="list-style-type: none">• Feedback from DMH to PCPs is below goal.• PCPs are unaware there is a process for exchanging information for BH services due to the sensitive nature of the information• PCPs are unaware of the availability of services that the BH department provides to L.A. Care members.• Behavioral Health Specialist lack time and resources to send information to the PCP.	<ul style="list-style-type: none">• L.A. Care will work with DMH and Beacon in educating providers on completing the appropriate forms needed to release member information.• L.A. Care will target offices that stated they had no awareness regarding referrals to DMH or Beacon for educational sessions.• DMH, at L.A. Care's request, added a section to the referral that reminds them to provide feedback to PCP.• L.A. Care in collaboration with the Behavior quality committee members (e.g. DMH and Beacon) has developed an expedited referral process to improve timeliness of service.• DMH created one central number to give urgent appointments for LA Care members in need of services.• L.A. Care posted information on its provider website on how to exchange information with the BH provider and the forms that are needed.	<ul style="list-style-type: none">• Rates had a statistically significant increase for DMH on 3 out of five measures.

Measure	Barriers	Opportunities for Improvement	Actions	Effectiveness of Intervention/ Outcome
			<ul style="list-style-type: none"> Beacon held Provider Advisory Council meetings where the importance of communicating and coordinating with PCP were discussed (quarterly) 	

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

Beacon tracks claims data to monitor provider adherence of Clinical Practice Guidelines (CPG) across all three product lines.

RESULTS

BEACON: DEPRESSIONS GUIDELINE MEASURES (2015)

MEDI-CAL

Measure	Goal	2014	2015
Clinical Practice Guideline Measure Depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient BH visits within 84 days (12 weeks) of initial diagnostic visit	50%	38.2% (287/751)	45.2% (913/2020)
Clinical Practice Guideline Measure Depression: percent Of members(18+) newly diagnosed with depressive disorder who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit	50%	21.3% (160/751)	19.4% (392/2020)

CAL MEDICONNECT

Measure	Goal	2014	2015
Clinical Practice Guideline Measure Depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient BH visits within 84 days (12 weeks) of initial diagnostic visit	50%	52.6% (40/76)	44.0% (37/84)
Clinical Practice Guideline Measure Depression: percent Of members(18+) newly diagnosed with depressive disorder who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit	50%	17.1% (13/16)	19.0% (16/84)

L.A. CARE COVERED

Measure	Goal	2014	2015
Clinical Practice Guideline Measure Depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient BH visits within 84 days (12 weeks) of initial diagnostic visit	50%	61.5% (126/205)	51.9% (82/158)
Clinical Practice Guideline Measure Depression: percent Of members(18+) newly diagnosed with depressive disorder who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit	50%	32.7% (67/205)	28.5% (45/158)

ANALYSIS

Quantitative Analysis

Medi-Cal: The percent of members ages 18 years and older with depressive diagnosis who received two or more visits within 12 weeks of initial diagnostic visit increased by seven percentage points in 2015 to 45.2% from its 2014 level but did not meet the goal (50%). The measure on medication visits within 12 weeks of diagnosis, however, decreased to 19.4% from its 2014 level and also did not meet the goal (50%).

Cal MediConnect: The percent of members ages 18 years and older with depressive diagnosis who received two or more visits within 12 weeks of initial diagnostic visit decreased to 44.0% from its 2014 rate and did not meet the goal (50%). The percent of member ages 18 years and older with depressive diagnosis who received one or more medication visits within 12 weeks of diagnosis improved slightly to 19.0% from its 2014 rate but did not meet the goal (50%).

L.A. Care Covered: The percent of members ages 18 years and older with depressive diagnosis who received two or more visits within 12 weeks of initial diagnostic visit decreased by almost 10% points in 2015 to 51.9% from its 2014 level but still meeting the goal (50%). The percent of member ages 18 years and older with depressive diagnosis who received one or more medication visits within 12 weeks of diagnosis decreased by 4.2% points in 2015 to 28.5% failing to meet the goal.

Qualitative Analysis

The 2015 rates are based on available claims data. Data from Quarter 4 and possibly Quarter 3 of 2015 do not account for claims lag and may need adjustment in future report. Similarly, as measures look for events that happen up to 12 weeks from diagnostic visit, data for Quarter 4 may be incomplete and underrepresent the visits. Thus, the percent of member ages 18 years and older with depressive diagnosis who received two or more visits within 12 weeks of initial diagnostic visit for Medi-Cal and Cal MediConnect could meet the goal of 50% once all the data are accounted for. Therefore, a true measure of effectiveness may not be available until the end of first quarter of 2016.

INTERVENTIONS

Measures	Barriers	Opportunities for Improvement	Actions	Effectiveness of Intervention/ Outcome
<p>Clinical Practice Guideline Measure Depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more OP BH visits within 84 days (12 weeks) of initial diagnostic visit</p> <p>Percent Of members(18+) newly diagnosed with depressive disorder who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit</p>	<ul style="list-style-type: none"> Members with depression may have chronic co-morbid medical conditions that could make accessing outpatient care for depression more difficult. Members may be resistant to treatment due to social stigma or cultural barriers. Q3 data doesn't account for claims lag and may be an underrepresentation of actual results. 	<ul style="list-style-type: none"> Members may not adhere to instructions for treating depression and the provider may have a poor follow up plan. Members may not be aware that it takes time for the medication to take effect. They may discontinue if they do not see changes immediately and see side effects. Members may also discontinue medication when they start feeling better. Members may also stop their therapy sessions if they do not feel better immediately Member might have follow up appointments with a PCP and that might not be tracked by Beacon claims. 	<ul style="list-style-type: none"> Collaborate with health plan to identify and outreach to newly prescribed members that qualify for HEDIS AMM measure with educational materials around common side effects and the importance of follow-up appointments. Similarly, outreach and educate the prescribers (BH and PCP) around HEDIS AMM measure and best practice. L.A. Care sent members letters to remind them to stay on their medication and keep appointments. L.A. Care sent Primary Care Physicians (PCP) a letter to educate them about the clinical practice guidelines regarding depression and included the phone numbers to L.A. Care and Beacon resources. Ensure that PCPs are informed about the information and updates to all Depression Management tools that are available on the website through sharing of PCP toolkit with health plans. Educate providers (behavioral health and PCP) on Beacon's Quality Program through distribution of "Quality Packets". Continue to collaborate with the health plan on exchange of information and data. The availability of medical, behavioral and prescription claims will allow Beacon to identify members that are newly diagnosed and prescribed in both medical and behavioral health care. Continue scheduling quarterly Provider Advisory Council (PAC) 	<ul style="list-style-type: none"> Members who were sent letters had a 30- day refill rate of 53% vs. the baseline rate of 56%.

Measures	Barriers	Opportunities for Improvement	Actions	Effectiveness of Intervention/ Outcome
			<p>to receive feedback and suggestions regarding the Quality Improvement efforts (including practitioner based interventions), outcome measures, satisfaction surveys, performance standards and clinical practice guideline.</p> <ul style="list-style-type: none"> • Encourage the utilization of the PCP toolkit by health plan providers and PCPs. The toolkit will help with identification of BH conditions in members, as well as provide next steps in treatment of BH conditions (On-going) • Utilize the Depressions QIA as an avenue to develop creative and innovative interventions to improve HEDIS AMM scores. 	

III. APPROPRIATE USE OF PSYCHOPHARMACOLOGICAL MEDICATIONS

L.A. Care analyzes pharmaceutical utilization data for appropriateness of psychopharmacological medication. The pharmacy benefits manager, Navitus, mails letter to providers with members on nine or more prescriptions for controlled substances for Medi-Cal, L.A. Care Covered, and Cal MediConnect patients. The letter identifies the members and asks the physician to evaluate the member's medication use.

RESULTS

CONTROLLED SUBSTANCES DRUG UTILIZATION EVALUATION (DUE)

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

- 9 or more prescriptions for DEA schedule II, III, IV or V controlled substances (excluding steroid hormones and drugs used treat attention deficit hyperactivity disorder) and
- A high number of unique prescribers
- Unique pharmacies in two out of four months

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

RESULTS

CONTROLLED SUBSTANCES RETROSPECTIVE DRUG UTILIZATION REVIEW (RDUR)

Product line	March Look-back period: 11/1/2014-2/28/2015			July Look-back period: 03/1/2015-6/30/2015	
	Members Identified	Prescribers Mailed	Outcomes improved	Members Identified	Prescribers Mailed
Medi-Cal	181	619	34.3%	477	1,580
Cal MediConnect	10	34	40%	20	67
L.A. Care Covered	1	3	0%	2	13
Total	192	656	74.3%	499	1,660

ANALYSIS

Quantitative Analysis

Medi-Cal, Cal MediConnect, and L.A. Care Covered

In 2015, there were 2,199 Medi-Cal providers received notification of the medication their patients were on. The number of members ranged from 181 to 477. The goal of reaching 100% of identified providers was met. In addition, 34.3% of members showed improvement, meaning they did not show up on the list during the next time period.

For Cal MediConnect, 101 providers were sent letters. The program saw a 40% improvement in the number of members that were no longer on the list the subsequent quarter. The goal of reaching 100% of providers was met.

L.A. Care Covered had much smaller numbers due to the population size, but still met the goal of reaching 100% of identified providers. In 2015, there were 16 providers received notification of the medication their patients were taking. The number of members ranged from 1 to 3. There was no improvement in the outcome for this population.

Qualitative Analysis

Medi-Cal, Medicare, and L.A. Care Covered

The drug utilization evaluation program was successful in identifying members on nine or more controlled substances and in notifying providers of these members. Navitus not only sends letters but tracks members that have been on the list four or more times in the last two years and includes a repeat alert system for the provider. In addition, Navitus tracks improvement of how many members are no longer on the list the subsequent quarter. This enables to track the performance of the intervention. Since this is the first year that Navitus has tracked performance, the rates in the table will be baseline rates. At this time, L.A. Care Covered population is too small to draw any conclusions regarding the effectiveness of the intervention. In 2016, L.A. Care will use this information to further screen members and refer them to the “Pharmacy Home” program that limits members to the use of one pharmacy. This intervention should help reduce over utilization of controlled substances in 2016 for Medi-Cal members.

Measure	Barriers	Opportunities for Improvement	Action	Effectiveness of Intervention/Outcome
Providers with members on 9 or more prescriptions for controlled substances (including tramadol or carisoprodol)	<ul style="list-style-type: none"> • Too many providers in the Medi-Cal line of business who were identified on unique providers list. • Limited exchange of information between different providers for the same member. 	<ul style="list-style-type: none"> • PCPs may be unaware that members are getting multiple prescriptions from different providers. • Lack of PCP's knowledge on how to refer and what information can be shared between providers. • Implementation of a medication reconciliation process and protocol. 	<ul style="list-style-type: none"> • Navitus's Controlled Substance RDUR program notifies provider of all members on 9 or more prescription. • L.A. Care's pharmacy department forwards Controlled Substances reports to Medical Management for review and potential enrollment in case management. • L.A. Care's Pharmacy Department will review the results for potential fraud, waste and abuse and forward responses to RA&C if the prescribing provider indicated that it is not his/her patient. • Beacon will continue provider chart audits to review provider's compliance with APA Clinical Practice Guideline for the Treatment of Patients with Substance Abuse Disorder. Provide feedback, education and assistance to those providers that perform "poorly" (score of <65%) on questions related to Substance abuse (Quarterly). 	100% of providers were notified. Goal was met.

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

L.A. Care uses pharmacy data to identify members with coexisting medical and behavioral disorders. The pharmacy data is used to identify members on antipsychotics and anti-diabetics. L.A. Care notifies the PCPs of their members that are on antipsychotics or antipsychotics and anti-diabetics. The letter provides PCPs with information they may not receive from the behavioral health specialist(s) and it encourages them to conduct metabolic screening. Antipsychotic medication is paid for by the state and this data is available twice a year (July/December) for Medi-Cal members as a result mailing are semi-annual. In 2015, we received the first data feed from the state in July and therefore only one mailing was possible. L.A. Care also shares the list with the diabetes disease management program, L.A *Cares About Diabetes®*, so their staff is aware of which members are on antipsychotics and may need closer monitoring.

RESULTS

Product Line	November Look-back period: 1/1/2015-7/15/2015		
	Members Identified on Both Antipsychotics and Anti- diabetics	Members Identified on Antipsychotics	PCPs Mailed
Medi-Cal	2,576	31,672	1,363
Cal MediConnect	448	1,752	541
L.A. Care Covered	3	42	25
Total	3,027	33,466	1,929

Quantitative Analysis

Medi-Cal, Cal MediConnect, and L.A. Care Covered

In 2015, a total of 1,929 PCPs received notification about which of their patients were on antipsychotics and anti-diabetics. Most were from those that treat Medi-Cal members (1363), followed by those that treat Cal Medi-Connect members (541). Lastly, 25 L.A. Care Covered PCPs received the letter. The mailings cover 36,493 members. As of December 31, 2015, only three letters for CMC providers have been returned. The reach rate is currently at 99.8%. The goal of notifying 100% of providers was met for Medi-Cal and L.A. Care Covered.

Qualitative Analysis

The mailing went out in November of 2015 and we notified doctors based on our internal data and that of the State. This was the first year that the State data file was available and we could provide our primary care physicians with information about member receiving antipsychotics. This is especially important because members with severe mental illness are carved out to L.A. County's Department of Mental Health which historically has not had the ability to share that type of data. The next step is to evaluate the impact of the mailing. L.A. Care plans to look at HEDIS measure 'Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications,' to track glucose monitoring among this population. The next report in February, will allow us to see if the rate improved.

INTERVENTIONS

Measure	Barriers	Opportunities for Improvement	Action	Effectiveness of Intervention/ Outcome
Management of treatment access and follow up for member with coexisting medical and behavioral disorders	<ul style="list-style-type: none"> Antipsychotic is a carve out drug to the State. Carve out drug information receiving from the State has a 6-month lag. No medication reconciliation between different providers due to fear of HIPAA violation without member consent 	<ul style="list-style-type: none"> PCPs lack information on what type of medication their patients are receiving from behavioral health specialists. Members lack knowledge of how medications can affect their glucose levels 	<ul style="list-style-type: none"> L.A. Care sent PCPs list of members on Antipsychotics and Antidiabetics. L.A Cares About Diabetes® staff receive list of members on both antipsychotics and anti-diabetics to better educate patients on the impact of those medications. Develop a countywide universal consent form. 	Goal was met for Medi-Cal and L.A. Care Covered. Medicare rate was very close with a 99.8% reach rate.

V. PREVENTIVE BEHAVIORAL HEALTHCARE PROGRAM IMPLEMENTATION

SUBSTANCE ABUSE SCREENING IN PRIMARY CARE SETTINGS

Studies show that alcohol and drug use are associated with detrimental physical, social, and psychological consequences. In addition, Adults with alcohol and drug use disorders are overrepresented in primary care and emergency department (ED) settings. Therefore, it is important that these setting screening for substance abuse. In 2015, L.A. Care began collecting encounter data on the need for substance abuse screening in the primary care setting to improve patient care.

RESULTS

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) RATES AMONG PRIMARY CARE PROVIDERS (PCPs)

Measure	1/1/2014-6/30/2014	1/1/2015-6/30/2015
Number of Unique PCPs Using SBIRT (Numerator)	73	94
Number of Total Unique La Care PCPs (Denominator)	8,145	8,400
% Numerator/Denominator*100	0.90%	1.10%

Quantitative Analysis

There are very few providers screening members using the SBIRT Tools, 0.9% in 2014 and 1.1% in 2015. The rates have not changed comparing the first two quarters of 2014 and 2015. After analyzing the rates using a Chi-square with a Yates correction, no statistical difference was found in the rates between the two years.

Qualitative Analysis

The rates are very low but consistent with national data. The rates may also be low due to lack of knowledge about how to code for these services and because many providers do not normally bill for these services which may lead to the low rates as well.

INTERVENTION

L.A. Care has been hosting a series of trainings on SBIRT Screening for its providers to help improve the screening rates and address some of the common barriers in screening for substance abuse. During calendar year 2015, there were three CME events which offered training on SBIRT to 385 attendees (2/25/2015 34 attendees; 10/17/2015 227 attendees; 11/07/2015 124 attendees).

STRESS, ANXIETY, AND DEPRESSION MANAGEMENT PROGRAMS FOR ADULTS

L.A. Care offers various health education and community classes to help members address stress, anxiety, and depression. In September of 2015, pharmacy data showed that there were 7,172 Medi-Cal L.A. Care Direct (MCLA) members were on antidepressant medication. Approximately 526 members in the Cal MediConnect and 116 members of the L.A. Care Covered product line were on anti-depressant. While not all of these members maybe on this medication for depression, it does provide an estimate on the need for services, especially since many people may still be undiagnosed or treated. Based on this data and input from members, L.A. Care offers classes free of charge to all its members and community members at four of its Family Resource Centers throughout the County of Los Angeles.

INTERVENTION

The Family Resources Centers (FRCs) are open to the community and provide an array of classes to help manage stress, anxiety and depression. The four resources are located in the cities/neighborhoods of Boyle Heights, Pacoima, Lynwood, and Inglewood. Some of the session's titles include: Wellness Circle, Stress and Anxiety Management, Fighting Stress through Art, Healing through Art, Depression, and Meditation. All recently enrolled members receive an invitation and calendars to their local FRC.

SESSIONS IN 2015

Facility	Sessions for 2015	Members attended
BOYLE HEIGHTS	3	7
INGLEWOOD	11	66
LYNWOOD	27	142
PACOIMA	36	176

INTERVENTIONS SUMMARY

Measure	Barriers	Opportunities for Improvement	Action	Effectiveness of Intervention/Outcome
Stress, anxiety, and depression management programs	<ul style="list-style-type: none"> Pharmacy data does not include indication for antidepressant. No real time encounter data to ensure early psychoeducational intervention. 	<ul style="list-style-type: none"> Members may have few resources to manage stress and anxiety which may lead to depression. Members may not know how to identify symptoms of depression. 	<ul style="list-style-type: none"> L.A. Care has several free health education sessions at its FRC sites during the year that help manage stress, anxiety, and depression. L.A. Care will increase recruitment efforts by targeting provider offices and PPGs to promote sessions to members. 	Goal was met.
Substance abuse (SA) screening in primary care settings	<ul style="list-style-type: none"> PCP reluctant to screen for substance use. Limited substance use disorder treatment providers 	<ul style="list-style-type: none"> Members are not adequately screened in the primary care setting Providers are not familiar with what tools to use to screen members for SA Providers are not familiar with how to code/bill for SA screening 	<ul style="list-style-type: none"> L.A. Care provides sessions on who to conduct SBIRT screening for providers. 	Rates remain the same.

VI. SEVERE AND PERSISTENT MENTAL ILLNESS:

L.A. Care uses the ‘Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications’ HEDIS 2016 unofficial data to evaluate continuity and coordination of care for members with severe and persistent mental illness. Unofficial HEDIS 2016 rates (MY 2015) are reported below because HEDIS 2015 rates are unavailable for both the Cal MediConnect and the L.A. Care Covered product line. Medi-Cal was the only product line that reported an official HEDIS 2015 rate of 78.4% for this measure.

RESULTS

DIABETES SCREENING FOR PEOPLE WITH SCHIZOPHRENIA OR BIPOLAR DISORDER WHO ARE USING ANTIPSYCHOTIC MEDICATIONS

Product Line	June Rate	September Rate	November Rate
Medi-Cal	38.9%	52.0%	67.8%
Cal MediConnect	40.5%	56.7%	57.78%
L.A. Care Covered	25.0%	25.0%	16.7%

Quantitative Analysis

Both Medi-Cal and Medicare are rates are increasing and on track to reach the Medi-Cal NCQA Minimum Performance Level (MPL) of 75.7%. Currently there are no benchmarks for the Cal Medi-Connect or L.A.

Care Covered line of business. The L.A. Care Covered rates have decreased by 8.3% but this may be due to the low denominator (6) for this measure.

Qualitative Analysis

L.A. Care is using these year-to-date rates to measure if the current intervention of notifying providers of the need for metabolic monitoring significantly improves the rate. This is the first year that L.A. Care is able to notify Medi-Cal providers due to the carved out services for members with severe and persistent mental illness. This is significant barrier because often members may not disclose their medication history with their PCP or they may not see the prescriber of the medication regularly and metabolic screening may be missed. In September 2015, the Behavioral Health Quality Improvement Committee reported the Medi-Cal rates and asked both DMH and Beacon to remind their providers to screen patients annually to help address this issue with both primary care providers and behavioral health specialists.

INTERVENTIONS

Measure	Barriers	Opportunities for Improvement	Action	Outcome
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	<ul style="list-style-type: none">• PCPs might not be aware that members are on high risk antipsychotic medication• No medication reconciliation between different providers due to fear of HIPAA violation without member consent.	<ul style="list-style-type: none">• Members with severe and persistent mental illness receive care from specialist and the PCP is unaware of what medications the member is taking.• Member may have complex comorbidities.• Members may not seek care due to their mental illness.	<ul style="list-style-type: none">• L.A. Care sent PCPs a letter with information about which members were on antipsychotics and antidiabetics.• DMH also provided education to their behavioral health providers about appropriate monitoring of their patients based on recommendations by the L.A. Care Behavioral Health Quality Improvement Committee.• Develop a countywide universal consent form.	L.A. Care mailed 100% of PCPs with members on Antipsychotics.

LOOKING FORWARD:

- L.A. Care will continue to evaluate its exchange of information between PCPs and BH specialists with another telephonic survey.
- L.A. Care will start the ‘Pharmacy Home’ program to reduce the overutilization of controlled substances
- L.A. Care will continue to send member prescription reminders and resources to newly diagnosed patients.
- L.A. Care will create a member educational brochure about depression that primary care providers can distribute in their offices.
- L.A. Care will start work on a grant to support a Practice Transformation Network (PTN) of 3100 PCPs in transforming their practice to improve the quality of care and care integration for individuals with the diagnosis of Diabetes and/or Depression.
- L.A. Care and DMH will work on improving data exchange for those members in Specialty Mental Health.

- L.A. Care will continue to conduct practice and physician trainings on the Screening, Brief Intervention, and Referral to Treatment (SBIRT) method.
- L.A. Care plans to launch Behavioral Health eManagement project. This project aims to utilize behavioral health specialist reviewer to support PCPs in making clinical decision as it relates to behavioral health symptoms/issues in real time. The PCP and reviewer will be able to exchange patient symptomatology/conditions over a secured site and optimize appropriate targeted treatment goals.
- L.A. Care BH department is participating in the Healthy Neighborhoods and Homeless Projects to develop a Behavioral Health Model of care for individuals that are homeless.

2016 WORK PLAN GOALS:

Measure	2016 Medi-Cal Goals	2016 Cal MediConnect Goals	2016 L.A. Care Covered Goals
Exchange of information	80% of providers will be always/usually satisfied with the exchange of information between PCP and Behavioral Health Practitioners (BHPs)	80% of providers will be always/usually satisfied with the exchange of information between PCP and BHPs	80% of providers will be always/usually satisfied with the exchange of information between PCP and BHPs
Appropriate Diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care	50% of providers will meet clinical practice guidelines for members with depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient Behavioral Health (BH) visits within 84 days (12 weeks) of initial diagnostic visit and who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit	50% of providers will meet clinical practice guidelines for members with depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient Behavioral Health (BH) visits within 84 days (12 weeks) of initial diagnostic visit and who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit	50% of providers will meet clinical practice guidelines for members with depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient Behavioral Health (BH) visits within 84 days (12 weeks) of initial diagnostic visit and who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit
Appropriate uses of Psychopharmacological medications	100% of providers will be notified of members with ≥9 or more Controlled Substances	100% of providers will be notified of members with potential opioid or acetaminophen overutilization	100% of providers will be notified of members with ≥9 or more Controlled Substances

Measure	2016 Medi-Cal Goals	2016 Cal MediConnect Goals	2016 L.A. Care Covered Goals
Management of treatment access and follow up for member with coexisting medical and behavioral disorders	100% of providers will be notified of members on diabetes and antipsychotic medication	100% of providers will be notified of members on diabetes and antipsychotic medication	100% of providers will be notified of members on diabetes and antipsychotic medication
Primary or secondary prevention behavioral health program	Provide stress and anxiety management classes at L.A. Care's Family Resource Centers Continue to conduct provider education to improve substance abuse screening	Provide stress and anxiety management classes at L.A. Care's Family Resource Centers Continue to conduct provider education to improve substance abuse screening	Provide stress and anxiety management classes at L.A. Care's Family Resource Centers Continue to conduct provider education to improve substance abuse screening
Special needs of members with severe and persistent mental illness	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) 80.16%	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) MPL	HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) MPL

A.9 EVALUATION OF EFFECTIVENESS OF MODEL OF CARE

2015 WORK PLAN GOALS:

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

BACKGROUND

The Model of Care (MOC) provides the structure for care management processes that enable the provision of coordinated care for our DUAL Eligible population (Cal MediConnect). L.A. Care has designed its Model of Care to meet the individualized needs of the population. The MOC has goals and objectives for the targeted population, include a specialized provider network, uses nationally-recognized clinical practice guidelines, conducts health risk assessment to identify the needs of members and adds services for the most vulnerable member including, but not limited to those who are frail, disabled, or near the end-of-life. The initial Model of Care developed as part of the CMC readiness review process was approved for the length of the demonstration (through 12/31/17). In this QI evaluation, the following components of Model of Care are evaluated: Clinical Practice Guideline compliance, continuity and coordination of medical care, continuity and coordination of medical and behavioral care, access and availability and Credentialing. Other components of the Model of Care evaluation are found in the utilization management/case management evaluation.

RESULTS

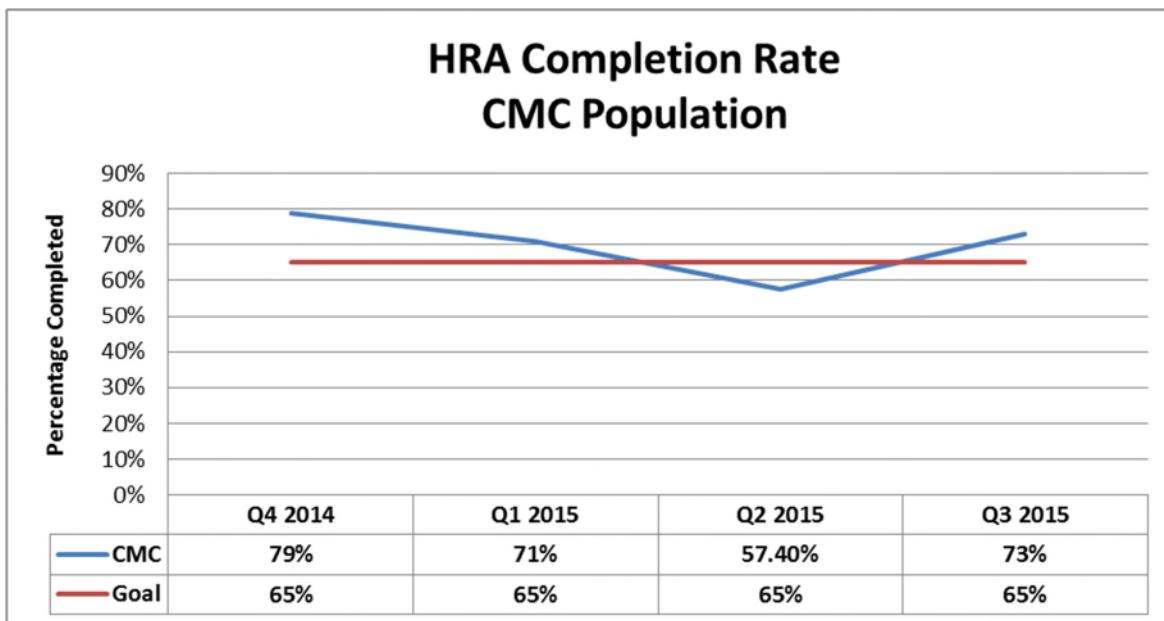
The Cal MediConnect program commenced in April 2014 and received first voluntary enrollment of members in May 2014. This will be the first time that the CMC program's Model of Care is being evaluated using the available three (3) quarters of data for 2015. This essentially provides baseline data to base improvement activities upon. The performance of the Care Management/Care Coordination measures; Health Risk Assessment, Individualized Care Plan and Interdisciplinary Care Team, are monitored on a monthly basis, compiled on a quarterly basis and reported through regulatory reporting requirements to CMS and DHCS and shared with internal governing committees (Regulatory, Utilization, Quality). The following information was reported to the

HEALTH RISK ASSESSMENT (HRA) COMPLETION RATES:

The HRA completion rates for CMC were set as a part of the CM Work Plan goals. The table below reports Q1-3 results and the status of the goal and recommendations for 2016 based on the 2015 results.

2015 Goal	CM- 2015 Updates	CM- 2015 Updates	CM- 2015 Updates	R=Did Not Meet Goal Y=At Risk G=On Target	Recommend for 2016 Work plan
	Q1	Q2	Q3		
Maintain the 2014 average completion rate of sixty-five percent (65%) HRA for Cal MediConnect members	71%	57.40%	73.00%	Green	Maintain the goal of 65% or greater

Figure: Cal MediConnect HRA Completion Rate Q1-3 2015



ANALYSIS-2015 HRA RATES:

The CMC HRA average completion rates met goal for Q1-3.

INTERVENTION AND LOOKING FORWARD

The CM leadership and HO&A leadership continued to meet with the contracted HRA vendor on a weekly basis to address HRA related issues. In addition, the HO&A department assumed the primary responsibility of the relationship with the vendor and put into place controls and work flows to improve the monitoring and reporting process. Looking forward, the CM department will continue to be an active participant in the HRA meetings and will continue to report on HRA completion rates in 2016.

CMC MOC PERFORMANCE GOALS:

A CM Work Plan goal was set to Meet or Exceed the revised, 2015 CMC Model of Care Performance target. The care management department focus was on HRA/ICT/ICP completion rates. In alignment with CMS' expectations, the goals for HRA/ICT/ICP were set at 100%.

RESULTS

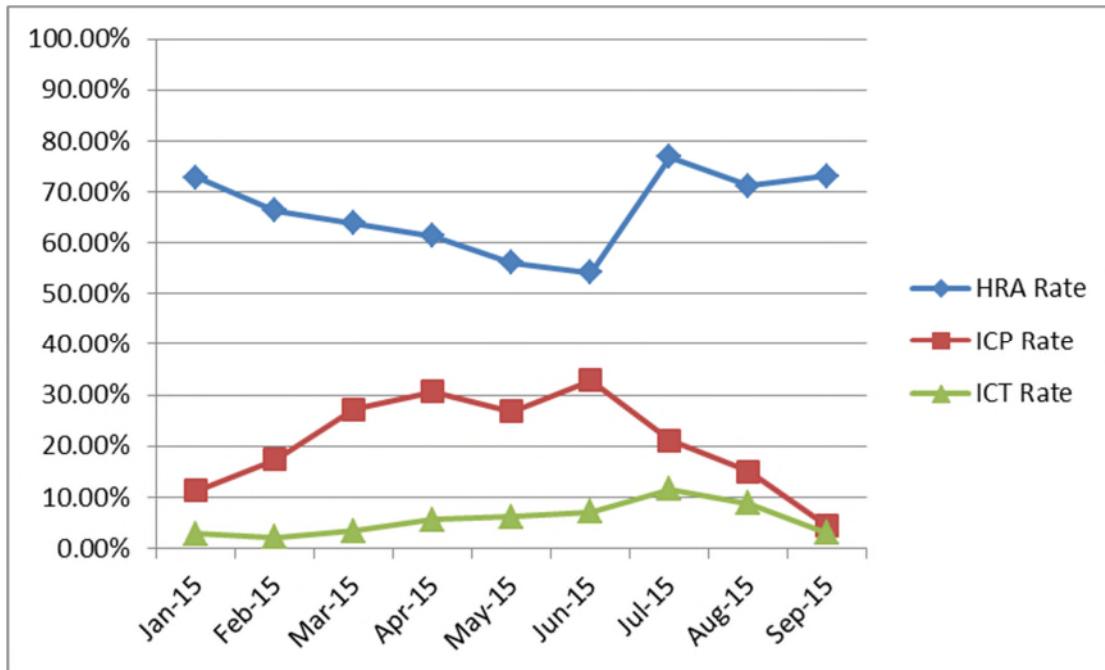
The table below illustrates the outcome reporting on the universe (entire membership) of CMC members' completion of the MOC measures. The outcome results for the High Risk members were reported in the CMC section of the evaluation.

RESULTS - 2015 CMC- MOC MEASURE % COMPLETION BY MONTH (HIGH, MODERATE & LOW RISK):

Universe of CMC Members-MOC Measure % Completion by Month (High, Moderate & Low Risk Levels)

	Newly Enrolled Members	HRA Count	ICP Count	ICT Count	HRA Rate	ICP Rate	ICT Rate
Jan-15	10,677	7,783	1,200	299	72.90%	11.24%	2.80%
Feb-15	2,195	1,456	380	48	66.33%	17.31%	2.19%
Mar-15	2,064	1,318	561	71	63.86%	27.18%	3.44%
Apr-15	1,768	1,086	543	99	61.43%	30.71%	5.60%
May-15	1,805	1,013	482	110	56.12%	26.70%	6.09%
Jun-15	1,728	937	567	123	54.22%	32.81%	7.12%
Jul-15	95	73	20	11	76.84%	21.05%	11.58%
Aug-15	80	57	12	7	71.25%	15.00%	8.75%
Sep-15	205	150	9	6	73.17%	4.39%	2.93%

TREND LINE: CMC MOC MEASURES-COMPLETION % BY MONTH (HIGH, MODERATE & LOW RISK)



There is a need for overall improvement in the completion rates of the MOC measures for all risk levels. Of note, there was a change in the ICP/ICT requirement communicated from DHCS via DPL 15-001 in Q2 of 2015 (3/9/2015). In summary, the new guidance indicated that an ICP/ICT was required if a member requested this or if a need for an ICP/ICT is demonstrated. L.A. Care's senior leadership further defined this for care management staff as presented in the table below:

ICP& ICT Completion Requirements Post-DPL 15-001

Risk Level	ICP Requirement	ICT Requirement
Low	If PCP/PPG identifies a care coordination need- ICP Required (PPG CM must review HRA and other data such as multiple authorization requests which would demonstrate a need for an ICP).	If a need for an ICT is demonstrated during clinical review, or if the member requests one, an ICT is required.
Moderate	ICP is required	If a need for an ICT is demonstrated during clinical review, or if the member requests one, ICT is required.
High/Complex	ICP required	ICT required
*Default High= No claims received, assigned as High Risk initially, not able to complete HRA, remains High	Assign to L.A. Care CM team to monitor daily to weekly for encounter data, pharmacy activities, PCP activities, clinical notes, etc. Once any information is obtained, Coordinator will submit to clinical staff for review and determination risk level and follow algorithm above based on risk level.	Required to offer an ICT "when a need is demonstrated" or if the member requests one.

INTERVENTION

In addition to updating the ICP and ICT policy and procedures, this information was formally communicated to all internal and contracted PPG CM staff during the June 25, 2015 MOC training.

The Clinical Assurance department monitors the internal and PPG CM staff performance around these MOC measures.

LOOKING FORWARD

The CMC management staff will continue to monitor and oversee the performance of internal staff on a weekly basis as a part of the audit process. In addition to this, an ICT Workgroup was started Q3 to address improving ICT completion rates and participation and will continue in 2016.

2014-2015 Model of Care Performance and Outcome Measures

L.A. Care formally adopts and maintains goals against which performance is measured and assessed. Specific goals and health outcomes are included in the QI Program and are monitored quarterly via the QI work plan. On an annual basis, a comprehensive review and analysis is conducted via the QI Program Annual Report and Evaluation. The Annual Report and Evaluation summarizes and highlights the key accomplishments of the quality improvement program for each calendar year specifically for the Cal MediConnect. The report provides a detailed discussion of quality improvement activities in the priority areas of clinical care, patient safety, Model of Care, member experience/satisfaction and access to care. The

evaluation documents activities undertaken to achieve work plan goals and establishes the groundwork for future quality improvement activities.

Note: Year 1 for Cal MediConnect is the period from April 1, 2014 to December 31, 2015. Depending on the data source, measures are based on calendar year or Y1 CMC reporting periods.

Model of Care Measures	Timeframe	Benchmark	Data Source	2014 Rate	2015 Rate
Quality of Life Survey– SF12 Mental Component Score – HOS	Annual	6%/3 years or 2% change per year Target – 95%	HOS	Plan too new to be measured	Plan too new to be measured
Quality of Life Survey– SF12 Physical Component Score – HOS	Annual	6%/3 years or 2% change per year Target – 95%	HOS	Plan too new to be measured	Plan too new to be measured
Medication compliance	Annual	Improvement of 2 percentage points per year Target - 80%	Pharmacy Data Stars Measures D13-D15	Plan too new to be measured	Plan too new to be measured
Patient satisfaction	Annual	90% of members will be satisfied with care management activities	CAHPS	85% (as reported in 2014 CM Annual Evaluation) Goal was not met.	79% (as reported in 2015 CM Annual Evaluation) Goal was not met.

Model of Care Measures	Timeframe	Benchmark	Data Source	2014 Rate	2015 Rate
Hospital Utilization					
Hospital Bed Days	Monitor bi- monthly; measure annually	10% reduction in total bed days/K Target: 1400/K	Claims/ Encounter Data	1948.9 bed days/1000 Rate exceeded target.	Q1: 1837.9 Q2.:1549.6 Q3: 920.1 Q4: Data N/A
Hospital Admissions	Monitor bi- monthly; measure annually	10% reduction in admissions Target – 220	Claims/ Encounter Data	336.9 admits/1000 Rate exceeded target.	Q1: 363.8 Q2: 332.9 Q3: 221.4 Q4: Data N/A
Hospital Average Length of Stay	Monitor bi- monthly; measure annually	10% reduction in length of stay Target – 4.2	Claims/ Encounter Data	5.8 days Rate exceeded target.	Q1: 5.1 Q2: 4.7 Q3: 4.2 Q4: Data N/A
Readmissions rates	Monitor bi- monthly; measure annually	2 percentage point reduction from previous year Target: < 20%	HEDIS PCR	Plan too new to be measured	Q1: 20.5% Q2: 19.7% Q3: 13.5% Q4: Data N/A
Ambulatory Services					
Emergency Room Visits	Monitor bi- monthly; measure annually	10% reduction from the previous year	Claims Encounter	826.6 visits/1000	Q1: 802.9 Q2: 748.2 Q3: 648.0 Q4.: Data N/A
Ambulatory Care Visits	Monitor bi- monthly; measure annually	10% reduction from the previous year	Claims/ Encounter	3545.2 visits/1000	Q1: 5281.0 Q2: 5520.3 Q3: 4557.7 Q4: Data N/A
Grievance (standard grievances/1000)	Quarterly	Monitored in QI Program	Grievance Data	1.17 grievances/1000 Q4 2014	Q1: 4 Q2.: 34 Q3: 34 Q4: 39

N/A: Not available

2016 WORK PLAN GOALS:

Measures	2016 Goal
Quality of Life Survey - SF12 Mental Component Score (HOS)	80%
Quality of Life Survey - SF12 Physical Component Score (HOS)	69%
Medication compliance	75%
Patient satisfaction	Significant improvement over baseline
Hospital Utilization (MOC)	
Hospital Bed Days	10% reduction in total beddays/K, 665/PTPY
Hospital Admissions	10% reduction in admissions, 140
Hospital Average Length of Stay	10% reduction in length of stay, 4.2
Readmissions rates	9%
Ambulatory Services (MOC)	
Emergency Room Visits	10% reduction from the previous year
Ambulatory Care Visits	10% reduction from the previous year
Grievance	Monitor in QI Program
HRA Completion Rate	100% of all Medicare enrollees within 90 days

A. 10 QUALITY IMPROVEMENT PROJECTS (QIPs)

A.10.A REDUCING READMISSIONS- MEDICARE

2015 WORK PLAN GOAL:

HEDIS Measure	2015 Goal (Q3 2014-Q2 2015)
Plan All-Cause Readmissions (PCR)	14%*

*Note lower rate = better performance

BACKGROUND

Hospital readmissions are common, costly and negatively impact health outcomes. Nearly one in five Medicare patients were readmitted within 30 days of discharge from a hospital stay and estimates of the cost of these potentially preventable readmissions equates to \$12 billion dollars annually.¹² The Medicare-SNP QIP closed in 2014 due to the termination of this product line. The QIP topic and intervention transitioned to the Medicare-Medicaid plan, Cal MediConnect (CMC) plan, but with some modifications. For CMC, discharge planning and management of care transitions were delegated to L.A. Care (LAC) participating provider groups (PPGs).

Due to the variable nature of how each PPG decided to approach managing care transitions, it was difficult to characterize, monitor, and evaluate which intervention components were driving changes in outcomes. Over the year, work was done to ensure PPGs were aware of Provider Manual requirements and semi-structured inquiry calls were conducted with each PPG having greater than 30 admissions in a year. With CMC being a new plan and claims/encounter lag, there was limited HEDIS 2015 (MY 2014) data to establish baselines specific to the CMC duals population; thus data shared below is from Q3 2014 through Q2 2015 and for Plan All-Cause Readmission (PCR) rates, this rate has not been risk-adjusted.

MAJOR ACCOMPLISHMENTS

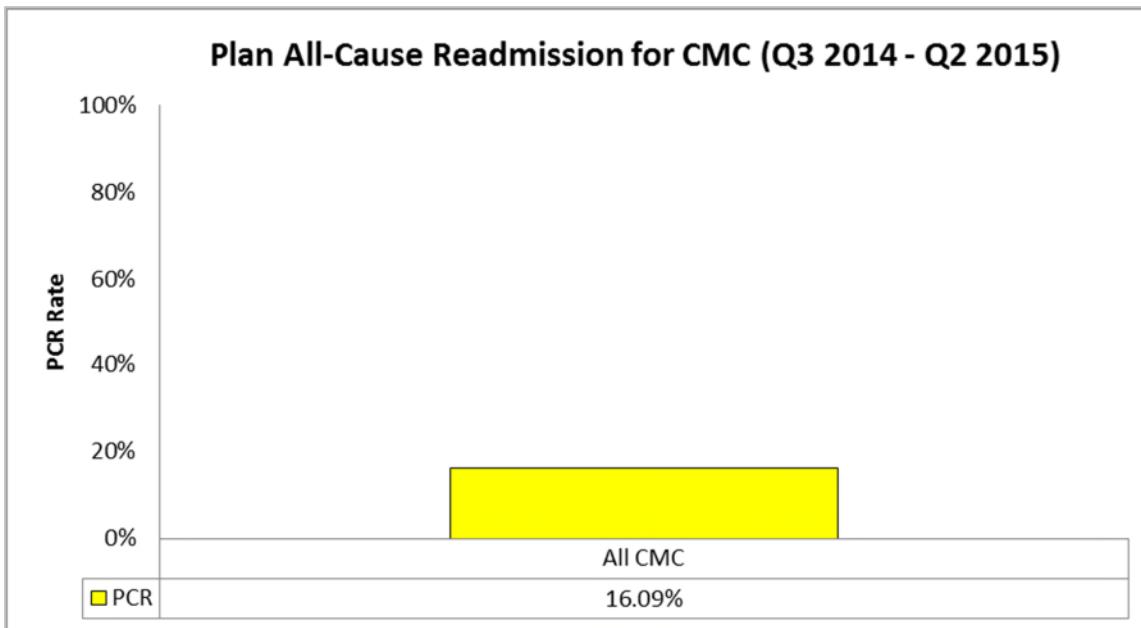
- L.A. Care conducted in-depth TOC inquiry calls with all PPGs having greater than 30 admissions in a year period (Q3 2014 through Q2 2015).
- L.A. Care developed and created a PPG TOC assessment tool with the goal of capturing best practices and identifying gaps/barriers each PPG is encountering as far as their TOC processes – L.A. Care is planning to disseminate/implement use of this tool in 2016.

Description of measures:

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

¹² MedPAC. Report to Congress: Promoting Greater Efficiency in Medicare. June 2007.
<http://www.medpac.gov/documents/Jun2007>.

RESULTS



Being a new plan and given the continuous enrollment criteria (12-month pre-discharge) based on PCR HEDIS specs, the denominators (index admissions) are smaller in HEDIS 2015 (service dates 2014) so the readmission rates may not be stable. Thus, we opted to make the measurement year from July 1, 2014 through June 30, 2015 (Q3 2014 through Q2 2015) for our baseline measurements. The PCR rate (not risk adjusted) baseline analysis of the CMC population from July 1, 2014 through June 30, 2015 (Q3 2014 through Q2 2015) includes (a) the overall PCR HEDIS rate for all of CMC and then segmented analysis of the HEDIS PCR rate by (b) those members within one of the three top PPGs (representing 70% of the CMC population) and (c) those members in the remaining PPGs (each PPG with membership no greater than 5% of total CMC population but combined representing 30% of CMC population): these PCR rates are as follows: (a) 16.09%, (b) 13.72%, (c) 19.34%.

Quantitative Analysis

The PCR rate for CMC was 16.09% and did not meet the goal of 14% for this baseline year for CMC. When examined at the PPG level, at baseline, the Top 3 PPGs have an average PCR rate of 13.72% which is 2.37 percentage points lower than the overall CMC and 5.62 percentage points lower than the PCR rates for the grouping of PPGs representing 30% of CMC membership. PPG level analysis identified low performing PPGs with at least 30 index admissions that are targeted for LAC intervention/support given that the PCR rates among these PPGs are pulling down LAC's overall CMC PCR rate significantly.

LAC is tracking two additional TOC metrics-sharing of transition records between settings within 24 hours of discharge and ambulatory follow-up after discharge.

- The PPG reported rates of transition record shared within 24 hours of discharge was 79.7% for all of CMC in Q1 of 2015. Of note, the rate was greater than 98% for two of the Top 3 PPGs, though more variable among the PPGs with less CMC membership. Among those PPGs not in the Top 3 PPGs with greater than 30 instances of reported shared transition records, the rate dropped to an average of 56.4%.
- Using claims and encounter data, analysis of the days from discharge to receipt of ambulatory care follow-up occurred (ambulatory health services based on state report criteria). From Q3 2014 through Q2 2015, the percent of CMC members who received follow-up care within 30-days of

discharge was 44.17% for all of CMC. Of those who received follow-up care after discharge, the median days to follow-up was 11 days with an average of 25.87 days, standard deviation of 38.55.

Among all the PPGs, the median days to follow-up were similar at 10 to 11 days; however, the Top 3 PPGs have significantly better rates of sharing transition records within 24 hours which may be contributing to lower PCR rates in this grouping.

Qualitative Analysis

In 2015, LAC conducted extensive inquiry meetings with each PPGs with at least 30 index admissions in the past year (Q3 2014 – Q2 2015) (n of 10 PPGs) to better understand the details of how they conduct discharge planning and manage TOC. Qualitative summaries of each meeting were documented and component commonalities identified among their various programs and initiatives.

INTERVENTIONS

HEDIS Measure	Barriers	Actions
Plan All-Cause Readmissions (PCR)	<ul style="list-style-type: none">• Due to the variable nature of how each PPG decided to approach managing care transitions, it was difficult to characterize, monitor, and evaluate which intervention components were driving changes in outcomes.• The three PPGs with the majority of our CMC membership represent 70% of CMC membership and were most engaged with L.A. Care regarding the QIP. The remaining PPGs represent 30% of CMC membership but each have less than 5% of total CMC membership - with such small numbers, it was difficult to engage and assess individual PPG performance.• PPGs do not always receive hospital information for admitted and/or discharged patients in a timely and complete manner.• PCP do not know patient have been discharged and have limited time to schedule appointments for follow-up with patients.• Hospital staff have limited follow-up post discharge. They rely on PCP or plan case managers for follow up care.• Members may not have adequate transportation to PCP offices for follow up care• Members are difficult to reach by phone after discharge	<ul style="list-style-type: none">• L.A. Care outlines PPG responsibilities for management of transitions of care (TOC) in the provider manual including seven minimum requirements.• L.A. Care began requiring PPGs to report data on the sharing of transition records within 24 hours of discharge and members getting follow-up care within 30 days.• L.A. Care conducted in-depth TOC inquiry calls with all PPGs having greater than 30 admissions in a year period (Q3 2014 through Q2 2015).• With assistance from Clinical Assurance and using both PPG reported metrics and LAC claims/encounter data, LAC is able to track and trend certain shared outcomes despite variability in PPGs' TOC programs.• PPGs reported streamlining the sharing of discharge summaries process by identifying key points of contact at hospitals and outpatient facilities to retrieve and share discharge information.• LAC is exploring potential health information exchange (HIE) initiatives to share more real-time admission/discharge/transfer data.• Each PPG has a protocol that involves multiple attempts to reach members- some require multiple numbers be shared so there can be alternative means of contact; some PPGs meet members in-person at the hospital so that they are more likely to engage in TOC processes post-discharge.

LOOKING FORWARD

- L.A. Care's UM and QI departments will continue the Readmissions QIP with the Cal MediConnect plan and begin implementing the TOC assessment tool with CMC contracted PPGs.
- After TOC assessments are completed, L.A. Care's UM and QI departments will address and engage those who are low performing or have gaps/barriers in processes necessary to improve care transitions and reduce readmissions.
- L.A. Care's QI department will work with the Clinical Assurance department to analyze data they receive from PPGs and collaborate to ensure PPGs are meeting minimum TOC requirements as outlined in the CMC provider manual.

A.10.b ROBERT E. TRANQUADA, M.D. SAFETY NET AWARD V – HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS) INITIATIVE

BACKGROUND

In 2000, L.A. Care created the Community Health Investment Fund (CHIF) to support community health care initiatives, which led to the establishment of a safety net infrastructure initiative in 2005 named after founding L.A. Care Board member and former Board Chair, Robert E. Tranquada, M.D. The initiative provided funding opportunities to safety net providers throughout the Los Angeles County to improve core infrastructure capabilities and to support projects that have a long-term and systemic impact.

The Robert E. Tranquada, M.D. Safety Net Award V – Healthcare Effectiveness Data and Information Set (HEDIS) Initiative, hereafter referred to as Tranquada V, is a two-year initiative that involves several parties/entities:

- L.A. Care Health Plan
 - Community Benefit Programs
 - Quality Improvement
- Safety Net Clinics
 - Arroyo Vista Family Health Center
 - Eisner Pediatric and Family Medical Center
 - JWCH Institute Inc.
 - Northeast Valley Health Corporation
 - St. John's Well Child and Family Center
 - Valley Community Clinic
 - Venice Family Clinic
- Object Health-technology consultant
- Health Management Associates-evaluator of initiative

The initiative targets seven HEDIS measures—Childhood Immunization Status Combination 3 (CIS-3), Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34), Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), Prenatal and Postpartum Care (PPC), and Comprehensive Diabetes Care Hemoglobin A1c testing (CDC HbA1c). The objective of the initiative is for each clinic to choose four HEDIS measures and improve their rates by a minimum of four percentage points by March 2016. However, due to Medi-Cal expansion in 2014, the denominator for some measures, particularly, W34, BCS, and CCS, have doubled or even tripled. To take this into account, a hybrid approach—looking at both the change in rates and the projected number served by end of the grant—will be used to evaluate the clinics' goal attainment. Each clinic is awarded up to \$150,000 in grant money to reach the goal. In general, the funds are used to hire personnel (IT, Quality Improvement), purchase technological applications, and outreach to members via reminder letters and calls.

Object Health, the technology consultant, works with the health centers in improving HEDIS scores for select populations. They assess the overall clinic capabilities for improving HEDIS scores and identify

barriers and pose solutions to those barriers, especially regarding the data flow and HEDIS reporting at the clinic level.

As the evaluator of the Tranquada V Initiative, Health Management Associates looks at the progress of the clinics in improving HEDIS scores and assessing work plan activity completion. They are also involved in assessing the key process elements in the Object Health scope of work.

CHILDHOOD IMMUNIZATION STATUS COMBINATION 3 (CIS-3)

Clinic	Baseline CIS-3 Rate	CIS-3 Goal Rate
Arroyo Vista Family Health Center	26.0%	40%
Eisner Pediatric and Family Medical Center	43.4%	52%
Northeast Valley Health Corporation	24.5%	28.5%
St. John's Well Child and Family Center	23.1%	33%
Valley Community Clinic	15.0%	38%

Arroyo Vista organized a Back to School Children's Health Fair in August 2015 that included education on the importance of well child exams, vaccinations for children, diabetic and women's health. The fair provided free immunizations and also set up an L.A. Care tent where appointments for well-child exams and immunizations were scheduled. Valley Community Clinic was able to identify patients that were due/overdue for immunizations and were able to keep 1,174 appointments out of 1,194 appointments made: a 98% success rate. Eisner collaborated with the Baby Buggy organization, which provides strollers to moms whose babies received all the immunizations. Currently, Arroyo Vista, Northeast Valley Health Corporation, and St. John's use the CAIR interface to upload immunizations from their electronic health record (EHR) systems. However, there are many issues using the CAIR interface, such as difficulty matching the correct member in the database and the inability to download data from CAIR to the EHR.

WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS OF LIFE (W34)

Clinic	Baseline W34 Rate	W34 Goal Rate
Arroyo Vista Family Health Center	53.3%	56.3%
Eisner Pediatric and Family Medical Center	58%	65%
Northeast Valley Health Corporation	70.4%	74.4%
St. John's Well Child and Family Center	65.2%	69%
Valley Community Clinic	62.1%	68%
Venice Family Clinic	51%	55%

Arroyo Vista addressed the importance of well-child visits and helped guardians schedule them during its Back to School Children's Health Fair in August 2015. Northeast Valley outreached to parents of children that need a well-child visit by sending recall letters. Out of the 2,178 letters sent, 735 (33.7%) patients received the exam. At Valley Clinic, the pediatric triage nurse identified children that were due/overdue for well-child visits, reaching 1,194 children and providing well-child exams to 1,171 members (a 98% success rate).

BREAST CANCER SCREENING (BCS)

Clinic	Baseline BCS Rate	BCS Goal Rate
Northeast Valley Health Corporation	63.3%	79%
St. John's Well Child and Family Center	38.8%	68%
Valley Community Clinic	61.8%	99%
JWCH Institute Inc.	36.5%	66%
Venice Family Clinic	52.1%	74%

Venice Family Clinic's Azara DRVS, a population management system, was used to identify specific populations, such as L.A. Care members, and members that are due for health services. A challenge for the BCS measure is that clinics oftentimes have difficulty receiving mammogram reports from the imaging centers. At JWCH, the LVN Process Improvement Champion schedules members that are due for a mammogram via the alert reminder system, which allows staff to identify which patients are due for health services. Valley Community Clinic also took a similar approach—a medical assistant scheduled breast cancer appointments by calling members. Also, posters about female cancer screenings were placed in all General Medicine exam rooms so that members can be educated while waiting in the rooms. At Northeast Valley, women that were in need of a cervical cancer screening were also identified for breast cancer screening. At St. John's, English/Spanish flyers that address common myths/concerns about mammograms were distributed. Moreover, staff prints patient reports for every provider of patients that will be seen, which includes a list of due/overdue health services. Lastly, St. John's purchased a screening unit and is recruiting an X-ray technician to improve breast cancer screening rates.

CERVICAL CANCER SCREENING (CCS)

Clinic	Baseline CCS Rate	CCS Goal Rate
Arroyo Vista Family Health Center	47.3%	51%
Northeast Valley Health Corporation	63.2%	67.2%
St. John's Well Child and Family Center	45.8%	50%
Valley Community Clinic	54.4%	59%
JWCH Institute Inc.	32.7%	62%
Venice Family Clinic	21.9%	27%

At Northeast Valley, members that did not have a Papanicolaou test (Pap test) were identified and were called to schedule appointments. Due to limited access for Pap test, Northeast Valley changed the templates into "single visit" types, allowing any type of visit to be scheduled. Additionally, the clinic is working to create additional sessions that are Pap test only appointments. At Valley Community Clinic, a medical assistant made calls to members to schedule appointments (22 out of 34 appointments were kept) and posters on female cancer screenings were posted in all General Medicine exam rooms to educate patients.

PREGNATAL AND POSTPARTUM CARE (PPC)

Clinic	Baseline PPC (prenatal) Rate	PPC (prenatal) Goal Rate	Baseline PPC (postpartum) Rate	PPC (postpartum) Goal Rate
Eisner Pediatric and Family Medical Center	47.1%	63%	39.9%	56%
JWCH Institute Inc.	22.2%	78%	28.9%	84%

Eisner clinic has a comprehensive prenatal health worker that works with prenatal and postpartum patients. The worker manages scheduling appropriate appointments for expecting and recently delivered mothers.

At JWCH, medical assistants check appointments for pregnant and recently delivered patients to make sure that they receive a first trimester visit or a postpartum care visit.

COMPREHENSIVE DIABETES CARE HEMOGLOBIN A1C TESTING (CDC HbA1c)

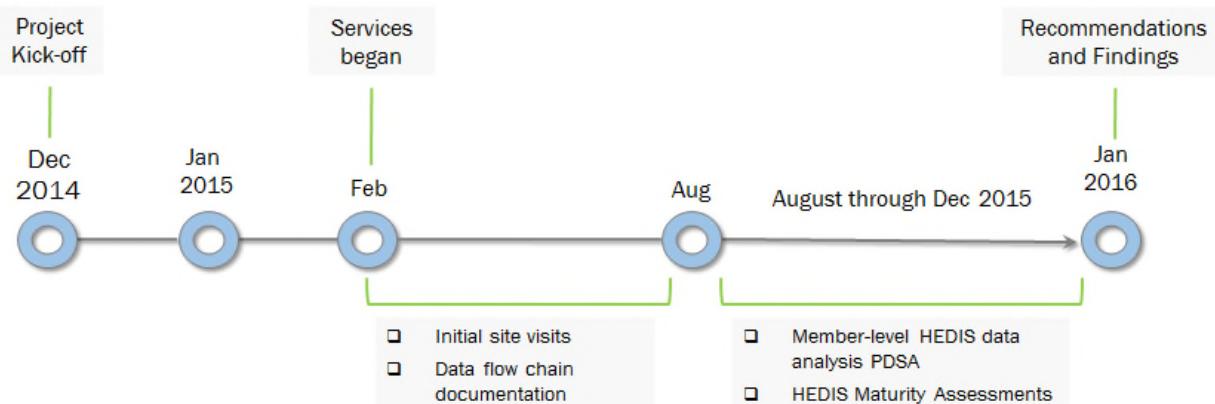
Clinic	Baseline CDC HbA1c Rate	CDC HbA1c Goal Rate
Arroyo Vista Family Health Center	47.1%	63%
Venice Family Clinic	22.2%	78%

During the August Health Fair, patients at Arroyo Vista were educated on the importance of diabetic health management and were encouraged to visit the diabetes management nurse who was able to check HbA1c and cholesterol levels for free using a droplet blood analyzer. Patients with abnormal results were provided with a follow-up appointment with a primary care provider. Many patients commented that the analyzer was a great way to see their diabetes status quickly and said it was a wake-up call to stay on track with their diabetic plan. Venice Clinic uses its population management system to produce the Patient Visit Planning Document, which lists all the outstanding gaps in care the patient has, before the visit.

OBJECT HEALTH

Object Health is a technology consultant vendor that assists providers and staff at the seven participating clinics to enhance the quality and efficiency of primary and preventive care at health centers through the effective use of health IT and quality improvement reporting systems. Object Health provides technical assistance and program support to clinics, educates clinics on best practices and correct HEDIS coding, and reviews the integrity and flow of data at the clinic, MSO/PPG, and health plan levels. Object Health is able to measure HEDIS maturity at the clinics with its HEDIS Maturity assessment tool, which evaluates maturity of HEDIS billing, provider and staff HEDIS education, and EHR maturity.

Timeline of Object Health's activities in 2015



HEALTH MANAGEMENT ASSOCIATES (HMA)

Health Management Associates is the initiative evaluator that evaluates the seven clinics on the progression of the goals proposed in the work plans, and evaluates Object Health's activities in assisting the clinics to enhance the quality and efficiency of primary and preventive care through the effective use of health IT and quality improvement reporting systems.

A.11 POTENTIAL QUALITY ISSUES

2015 WORK PLAN GOAL:

- 100% of Potential Quality of Care Issues (PQIs) will be closed within 6 months.

BACKGROUND

Investigation of PQIs is a fundamental, but extremely valuable way to monitor patient safety in the network. A Potential Quality Issue is defined as an individual occurrence or occurrences with a potential or suspected deviation from accepted standards or care, including diagnostic or therapeutic actions or behaviors that are considered the most favorable in affecting the patient's health outcome, which cannot be affirmed without additional review. A potential quality of care issue may include, but is not limited to, a physician's medical knowledge, clinical skill, judgment, appropriate record documentation, medication management, appropriate diagnosis, continuity and coordination of care, and medical errors-all of which impact patient safety. Sources of PQIs include, but are not limited to, UM staff, care management staff, disease management staff, member services staff, other physicians, and clinical grievances. The Quality Improvement Department (QI) conducts a thorough internal investigation on all potential quality issues. The QI department may use the peer review process to present cases which are under review for potential quality issues. The peer review committee conducts a thorough and objective evaluation of the case to determine whether care was appropriate. Upon the peer review committee's determination that care was not appropriate, remedial measures including, but not limited to education, may be recommended. Cases under review may also be sent for external review. Upon the committee's final determination of clinical appropriateness, the case is assigned a severity level. All cases must be closed within 6 months. If a PQI investigation cannot be completed within six months, a one-month extension maybe granted with a medical director's approval. The approved extension shall be documented in the case summary.

MAJOR ACCOMPLISHMENTS

- Continued to enhance the PQI investigation process requiring the QI nurse to conduct initial clinical review for all PQI referrals. The QI nurse would close the case if no QOC (level 0) or appropriate QOC (level 1) was determined. The QI nurse would also evaluate the case for quality of service issue as appropriate. For any clinical QOC case with severity level 2 or above, the case would be forwarded to a medical director review. The medical director would review all information collected by the QI nurse and close the case with appropriate actions or refer the case for Peer Review Committee (PRC) review (level 3 and 4).
- Implemented Inter Rater Reliability Testing of PQI cases closed by nurses in two folds:
 - In March 2015, PQI nurses completed Inter Rater Reliability Testing by randomly pulling 10 PQI cases reviewed by a registered nurse. PQI nurses agreed on how cases were coded and leveled on all 10 cases.
 - At the end of the year, the QI Medical Director randomly selected 12 PQI cases closed by a registered nurse. QI Medical Director identified 2 cases that would have been categorized or leveled differently. Though there were not gross deviations from how cases were coded and leveled, the QI Medical Director used the findings for teaching and discussion and will continue focused reviews and feedback on at least a quarterly basis to improve the consistence of PQI reviews
- Consolidated three PQI policy and procedures (*QI-001*, *QI-021*, and *QI 024*) into one document, *QI-001/Potential Quality of Care Issues* to reflect the current PQI process.
- Identified three new PQI issue codes: *Communication/Conduct*, *Physical Environment*, and *Medical Record/Documentation*, to further distinguish and encompass PQI investigation.
- Created new PQI issue codes nomenclature (*PQ*) to differentiate from the coding system used for PQI Severity leveling.
- In Mid-Year 2015 PQI Track and Trend Analysis, 2 categories related to potential underutilization and potential access issues were introduced. PQI cases which included denial of ER visit, denial

of service, refusal of care/prescription by provider, and refusal of referral issue codes were aggregated under potential underutilization; and PQI cases which included delay in service and delay in authorization were aggregated under potential access issues. Review of these 2 categories by participating provider groups will help identify potential issues and can be correlated with other measures including Grievances and Appeals as well as appointment availability and after hours survey results.

RESULTS

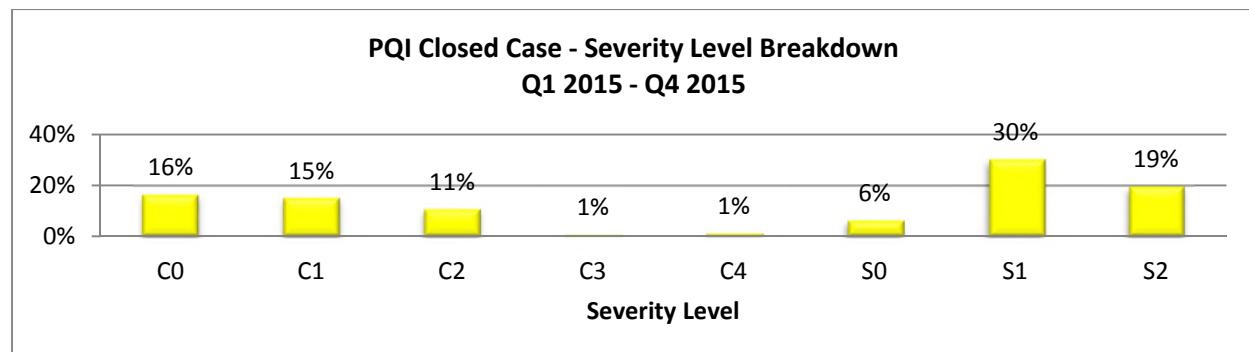
The following table shows the PQIs handled by L.A. Care directly or delegated to the appropriate plan partner for thorough investigation and closure.

	Total PQI Cases (Jan – Dec 2013)	Total PQI Cases (Jan – Dec 2014)	Total PQI Cases (Jan – Dec 2015)	Closed Within 6 Months
L.A. Care*	104	269	184	No
Care 1st	281	969	1187	Yes
Kaiser	201	242	545	Yes
Anthem Blue Cross	74	87	47	Yes

*Includes all lines of business (Medi-Cal, Medicare, PASC-SEIU and L.A. Care Covered)

ANALYSIS

In 2015, L.A. Care Health Plan closed 159 PQI cases, which included cases that were opened in 2014, with severity level breakdown as followed:



PQI Severity Level Assigned	Total	
C0/No Quality of Care concern	26	16.4%
C1/Appropriate Quality of Care	24	15.1%
C2/Borderline Quality of Care concern	17	10.7%
C3/Moderate Quality of Care concern	1	0.6%
C4/Serious Quality of Care concern	2	1.3%
S0/No Quality of Service concern	10	6.3%
S1/Quality of Service identified	48	30.2%
S2/Quality of Service identified, member change provider or disenrolled	31	19.5%
Total	159	100.0%

The analysis showed a total of 31.5% cases leveled as no quality of care concern (C0) and appropriate quality of care (C1); total of 12.5% cases leveled as borderline quality of care (C2), moderate quality of care (C3) and serious/significant quality of care (C4); 6.3% of cases leveled as no quality of service (S0);

49.7% of cases leveled with Quality of Service (QOS) issues level S1 and S2. More analysis would be done in 2016 by participating provider groups for cases identified with QOS issues, in addition to analysis of Quality of Care (QOC) issues.

In 2015, Anthem Blue Cross, Care 1st Health Plan and Kaiser completed PQI investigation timely within 6 months; L.A. Care Health Plan completed PQI investigation for all closed cases within 6 months except one. The PQI case was opened on March 19, 2015 with a due date for closure on September 19, 2015, but instead closed on November 11, 2015 due to unplanned cancellation of Peer Review Committee meetings in September and October. The case was closed after an ad-hoc Peer Review meeting with 3 physicians from Peer Review Committee. The 2015 PQI track and trend analysis including cases reviewed by Anthem Blue Cross and Care 1st Health Plan will be conducted in first quarter of 2016.

There were 45 PQI cases remained opened in 2015, but remained open with a 6-month due date in 2016. All PQI cases, except the 45 cases, were closed with severity levels and action codes upon completion of PQI investigation.

A.12 FACILITY SITE REVIEW/MEDICAL RECORDS INITIATIVES

2015 WORK PLAN GOALS:

- Needlestic safety precaution – 75%
- Spore testing of autoclave/sterilizer – 84%

BACKGROUND

L.A. Care is committed to developing and implementing activities to enhance patient safety. L.A. Care also enhanced patient safety through the facility site review (FSR) process by monitoring elements on patient health/safety. In the FSR process, the two (2) measures that did not meet the 80% standard in 2010 included: (a) Needlestic safety precautions practiced on site, and (b) Spore testing of autoclave/steam sterilizer with documented results (at least monthly).

RESULTS

Needlestic Safety Precaution

2013 Results	2014 Results	2015 Results	Goal Met	2015 Goal
67.0%	63.0%	65.0%	No	75%

ANALYSIS

Quantitative Analysis

The 2015 goal for needlestic safety precaution was not met. The compliance score for needlestic safety increased by 2.00 percentage points from 2014. The difference in rates was not statistically significant (p value = 0.5685) compared to 2014 results, and there has been no improvements in regards to the compliance to this criteria since 2012.

Spore Testing of Autoclave/Sterilizer

2013 Results	2014 Results	2015 Results	Goal Met	2015 Goal
87.0%	83.0%	82.0%	No	84%

Quantitative Analysis

The provider offices reviewed did not meet the 2015 goal for spore testing of autoclave/sterilizer spore testing. The compliance score decreased by 1.00 percentage point from 2014. The 2015 results dropped from previous years; however, the difference between 2014 and 2015 was not statistically significant (p value = 0.9784).

Qualitative Analysis

It is a continuous challenge to meet the goals and to change provider office behavior. The following reasons contribute to this:

- Reverting back to previous behaviors after an audit has been completed.
- Cost of purchasing needlestic safety devices may cause a financial burden to provider offices/facilities.
- Staff, due to high office staff turnover, do not know the requirements for needlestic safety precautions.

- Staff, due to high office staff turnover, do not know the requirements for spore testing of autoclave/sterilizer.
- Staff are not properly trained upon hire to inform them of the requirements for needlestick safety precautions and spore testing of autoclave/sterilizer.
- Durable medical equipment (DME) suppliers still have non-safety needles/syringes available for purchase. This may cost less than the safety devices.
- New provider sites participated in our network are not knowledgeable of the requirements.

Upon in-depth review of the available data, it was noted that new provider offices that received an additional educational visit were compliant and most providers were slowly transitioning out of utilizing autoclave/steam sterilization equipment.

LOOKING FORWARD

Certified Site Reviewer (CSR) Nurses will continue to monitor and educate provider offices regarding Local, State, and Federal regulations, and provide educational material and information every 18 months or sooner to assist in compliance with these patient safety measures.

2016 WORK PLAN GOALS:

- Needlestick: 70%
- Spore Testing: 85%

MEDICAL RECORDS INITIATIVES

2015 WORK PLAN GOAL:

Aggregate network PCP sites should score at least 80% in the following key areas:

- Ease of retrieving medical records (FSR G1 &2)
- Confidentiality of Medical Records (records are stored securely; only authorized staff have access to records, etc. (FSR H4)

Aggregate network PCP sites should score at least 80% in the following key documentation areas:

- Allergies and adverse reactions (2A)
- Problem list (2B)
- Current continuous medications are listed (2C)
- History and Physical (3A)
- Unresolved or continuing problems are addressed in subsequent visits (3E)
- Documentation of clinical finding and evaluation for each visit:
 - Working diagnosis consistent with findings (3B)
 - Treatment plans consistent with diagnosis (3C)
 - Instruction for follow-up care is documented (3D)
- Preventive services or risk screening (4 & 5C)

BACKGROUND

L.A. Care Health Plan has established medical record standards to facilitate communication, coordination and continuity of care and to promote safe, efficient, and effective treatment. L.A. Care requires practitioners to maintain medical records in a manner that is current, detailed, and organized. L.A. Care assesses the site's compliance with regulations and L.A. Care policies by utilizing the **mandated** Department of Health Care Services (DHCS) survey tools. This report provides an annual analysis of medical record keeping standards for the time period of October 1, 2012 – September 30, 2015, of primary care practitioner (PCP) sites (practitioner's office or clinic) to measure compliance with appropriate medical record documentation requirements. This analysis allows L.A. Care to measure site's compliance with

current documentation standards and develop interventions to make improvements. The use of electronic health record (EHR) improves documentation, coordination of care, and therefore, has a great impact on improving patient safety. In addition, conducting medical record reviews also provides L.A. Care the ability to identify potential quality of care concerns. In the calendar year 2015 there were a total of three (3) potential quality of care concerns identified and referred for further review.

MAJOR ACCOMPLISHMENTS

- All standards met and/or exceeded the 2015 goal of 80%. Practitioners continued to be educated on site during the Facility Site Review (FSR), Medical Record Review, or Physician Quality Improvement Liaison (PQIL) Nurses visits.

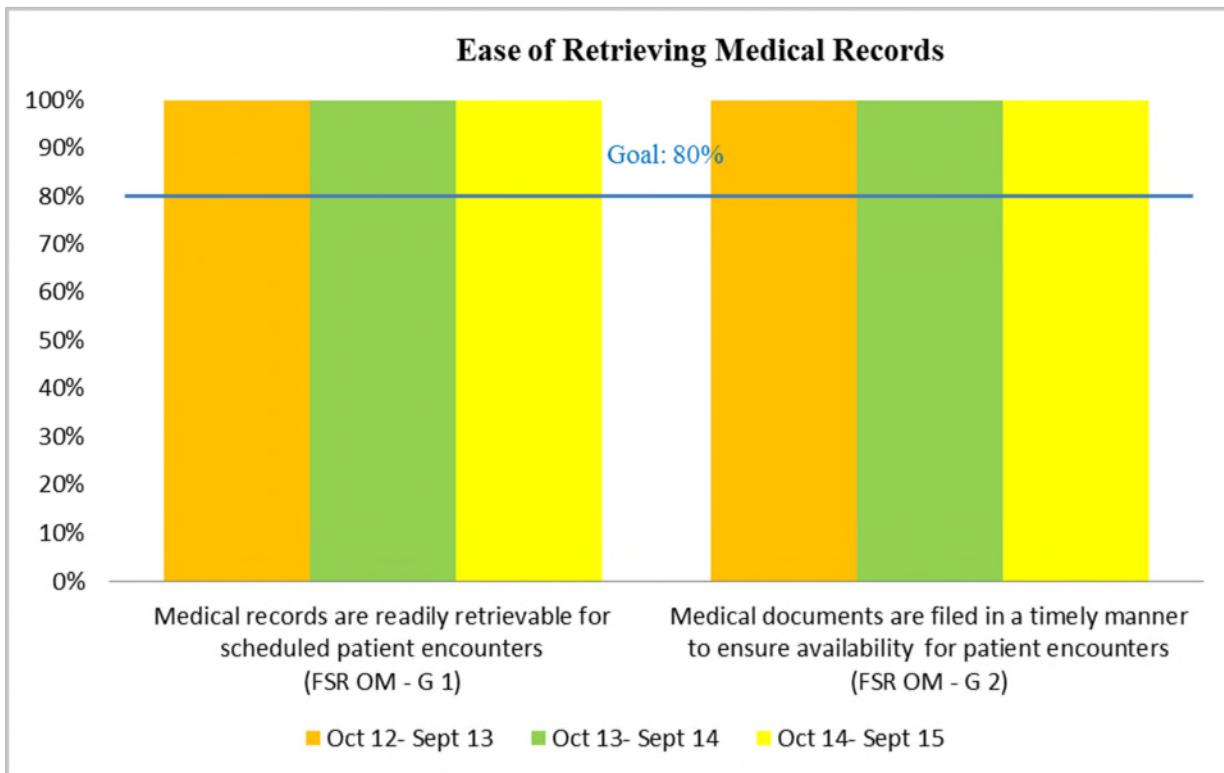
RESULTS

Year	Site #	Sample Size
2013	529	4,427
2014	454	3,354
2015	705	5,570

The following tables and graphs show the results of the FY 2012–2015 review of practitioner's sites and medical records. These FY 2014–2015 results are compared to the previous two years.

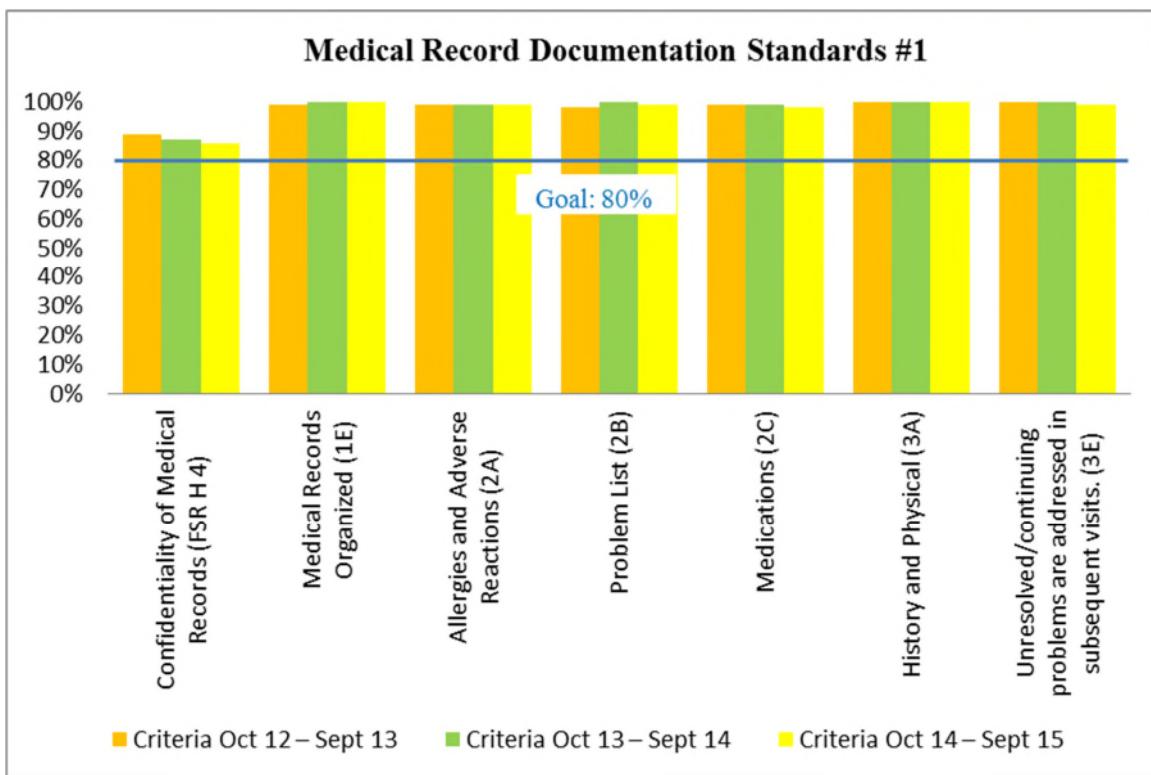
Ease of Retrieving Medical Records

Criteria	Oct 12 – Sept 13	Oct 13 – Sept 13	Oct 14 – Sept 15	% change from Oct 13 to Sept 15	% from 80% Goal
Medical records are readily retrievable for scheduled patient encounters (FSR OM - G 1)	100%	100%	100%	0%	20%
Medical documents are filed in a timely manner to ensure availability for patient encounters. (FSR OM - G 2)	100%	100%	100%	0%	20%



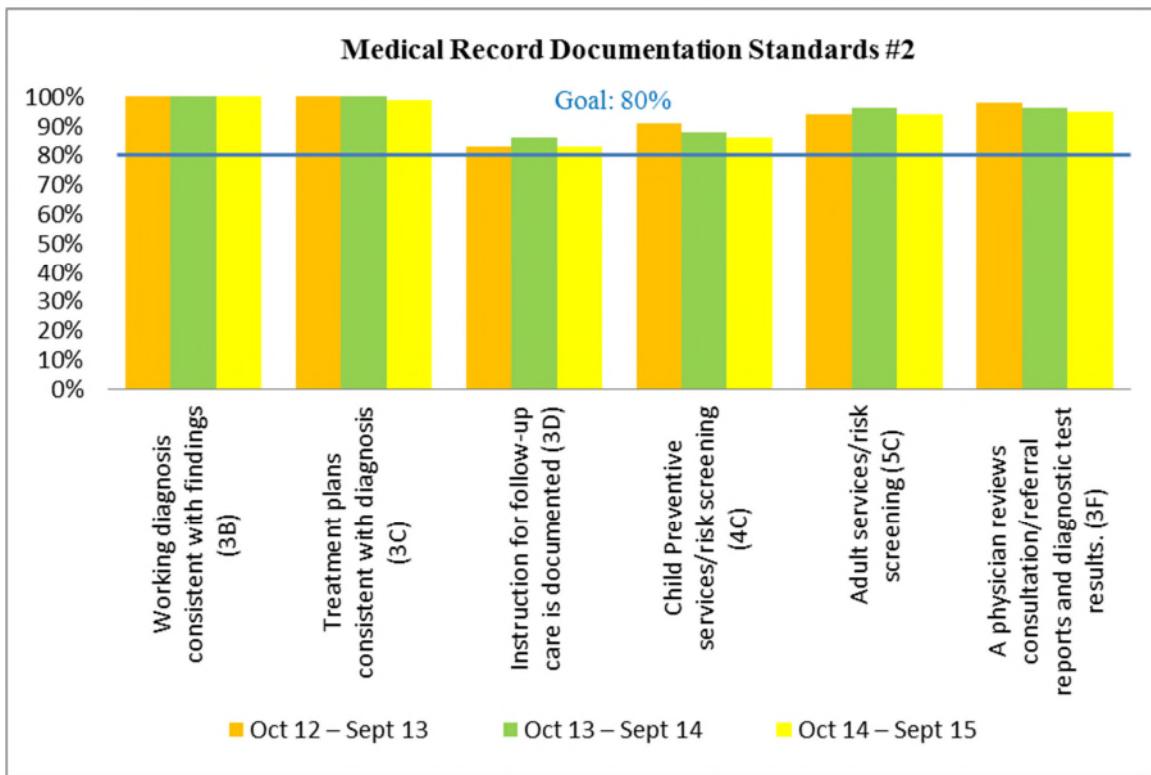
Medical Record Documentation Standards #1

Criteria	Oct 12 – Sept 13	Oct 13 – Sept 14	Oct 14 – Sept 15	% change from Oct 13 to Sept 15	% from 80% Goal
Confidentiality of Medical Records (FSR H 4)	89%	87%	86%	-1.00%	6%
Medical Records Organized (1E)	99%	100%	100%	0.00%	20%
Allergies and Adverse Reactions (2A)	99%	99%	99%	0.00%	19%
Problem List (2B)	98%	100%	99%	-1.00%	19%
Medications (2C)	99%	99%	98%	-1.00%	18%
History and Physical (3A)	100%	100%	100%	0.00%	20%
Unresolved/continuing problems are addressed in subsequent visits. (3E)	100%	100%	99%	-1.00%	19%



Medical Record Documentation Standards #2

Criteria	Oct 12 – Sept 13	Oct 13 – Sept 14	Oct 14 – Sept 15	% change from Oct 14 to Sept 15	% from 80% Goal
Working diagnosis consistent with findings (3B)	100%	100%	100%	0.00%	20%
Treatment plans consistent with diagnosis (3C)	100%	100%	99%	-1.00%	19%
Instruction for follow-up care is documented (3D)	83%	86%	83%	-3.00%	3%
Child Preventive services/risk screening (4C)	91%	88%	86%	-2.00%	6%
Adult services/risk screening (5C)	94%	96%	94%	-2.00%	14%
A physician reviews consultation/referral reports and diagnostic test results. (3F)	98%	96%	95%	-1.00%	15%



ANALYSIS

Quantitative Analysis

The 2015 audits achieved the 80% goal in all criteria selected for this study.

Qualitative Analysis

Although the 2015 goals have been achieved, some compliance rates had dropped slightly therefore ongoing monitoring will be needed and the following ongoing barriers need to be addressed:

- Practitioner confusion regarding when to follow Child Health and Disability Prevention Program (CHDP) versus American Academy of Pediatrics (AAP) guidelines for preventive services periodicity requirements.
- Perceived reimbursement issues leading physicians to believe they will not be reimbursed for AAP periodicity.
- Medical record forms require time to complete and may not include all required elements. Forms vary among Physician Provider Groups, practitioner offices and state mandated forms.
- There is an increase number of sites transitioning or have implemented an electronic health record (EHR) system. There are many choices of EHR vendors making the decision complex and puzzling for physicians. In addition, adding additional fields to accommodate medical record documentation standards may incur increase costs to physician offices.
- Time needed to document patient services and care rendered may be limited depending on patient volume.
- There are inconsistent or no processes in place to document care rendered to patients.

INTERVENTIONS

Based on the barrier analysis and feedback from physicians, L.A. Care will continue the interventions to maintain or improve medical record keeping.

Measure	Barrier	Action	Effectiveness of Intervention/ Outcome
All measures	<ul style="list-style-type: none"> • Medical record elements to the DHCS MRR tool have been unbundled into separate criteria. • Elements within a standard are not completed resulting in no credit for that record. • Medical record forms require time to complete and may not include all required elements. Forms vary among Physician Provider Groups, practitioner offices and state mandated forms. • There is an increase number of sites transitioning or have implemented an electronic health record (EHR). There are many choices of EHR vendors making the decision complex and puzzling for physicians. In addition, adding additional fields to accommodate medical record documentation standards may incur increase costs to physician offices. • Time needed to document patient services and care rendered may be limited depending on patient volume. • There are inconsistent or no processes in place to document care rendered to patients. 	<ul style="list-style-type: none"> • Medical Record Reviews are ongoing. • An established corrective action plan (CAP) process for provider offices that need to address deficiencies noted during a site review survey. • Provide technical assistance as appropriate and necessary. 	All measures met goal.

LOOKING FORWARD

Medical record review will continue in 2016. During the review process, practitioner and office staff continue to be educated, and sample medical record documents and policies are distributed. If the provider falls below the California state requirement score of 80% for any section of the medical record review survey regardless of score, a corrective action plan is requested. 2016 goal is to meet or exceed 80% compliance goal.

2016 WORK PLAN GOAL:

Aggregate network PCP sites should score at least 80% in the following key areas:

- Ease of retrieving medical records and timely filing of documents (FSR G1 &2)
- Confidentiality of Medical Records (records are stored securely; only authorized staff have access to records, etc. (FSR H4)

Aggregate network PCP sites should score at least 80% in the following key documentation areas:

- Allergies and adverse reactions (2A)
- Problem list (2B)
- Current continuous medications are listed (2C)
- History and Physical (3A)
- Unresolved or continuing problems are addressed in subsequent visits (3E)
- Documentation of clinical finding and evaluation for each visit
 - Working diagnosis consistent with findings (3B)
 - Treatment plans consistent with diagnosis (3C)
 - Instruction for follow-up care is documented (3D)
- Preventive services or risk screening (4 & 5C)

B. SERVICE IMPROVEMENTS

B.1 GRIEVANCES AND APPEALS, MEMBER SATISFACTION (CAHPS), AND TELEPHONE ACCESS

BACKGROUND

L.A. Care Health Plan demonstrates its commitment to improving member satisfaction through an annual assessment of all complaints and appeals, as well as the results from the 2015 Medicaid Adult and Child CAHPS 5.0 Member Survey. Results are trended over a three year period. This report contains a quantitative analysis, followed by a qualitative analysis; selection of the top priorities among opportunities identified for improvement and measured effectiveness, where available. The CAHPS survey is conducted by DSS Research, an NCQA certified vendor. DSS Research conducts key driver statistical modeling to assist L.A. Care in selecting priority measures to target improvements. The 2015 survey was a baseline year for L.A. Care Covered™ (LACC) and Cal MediConnect (CMC) lines of business.

The Member Quality Service Committee (MQSC) is the cross-departmental multidisciplinary committee responsible for identifying quality improvement needs, and reports its findings and recommendations to the Quality Oversight Committee (QOC). The MQSC is comprised of representatives from Quality Improvement, Member Services, Utilization Management, Health Education, Cultural and Linguistic, Health Outcomes and Analysis, Product Operations, Provider Network Operations and other departments, as required. Information in this report is based on the analysis of available data and survey, as well as discussions at the Quality Oversight and Joint Performance Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC) Committees.

ACCOMPLISHMENTS

- Evaluated all registered member complaints and appeals
- Evaluated the 2015 Medicaid Adult & Child CAHPS 5.0 survey results
- Conducted a quantitative and qualitative analysis from combined complaints, appeals and CAHPS data.
- Prioritized areas for improvement based on findings.
- Measured effectiveness of priority interventions.
- Reported baseline rates for L.A. Care Covered and Cal MediConnect product lines.

SECTION 1: QUANTITATIVE ANALYSES

GRIEVANCES/COMPLAINTS AND APPEALS

L.A. Care Health Plan demonstrates its commitment to providing access to member-centric quality services. Complaints and Appeals works diligently with departments in L.A. Care to identify, document, manage, resolve, and track & trend both member and provider concerns. The report contains priorities followed by opportunities identified for improvement and measured effectiveness.

ACCOMPLISHMENTS:

- Revision of complaint protocols in Member Services and Appeals/Grievance Departments.
- Implementation of a robust reporting process to analyze and report trends to Quality Improvement (QI).
- Revision of grievance categories to be consistent with regulatory and accreditation requirements.
- Implementation of an internal auditing program designed to improve the quality of documentation and to ensure all concerns are addressed for the member.
- Implementation of training program for staff responsible for the identification and management of complaints to ensure timeliness, regulatory compliance and high quality service to our members.

CLINICAL AND ADMINISTRATIVE COMPLAINTS AND APPEALS

METHODOLOGY

L.A. Care Health Plan conducts an analysis of complaints and appeals for the 12 month period of October 1, 2014 – September 30, 2015. Analysis of the data and reporting requirements resulted in the department revising grievance categories. These revisions resulted in several categories being eliminated, redefined, or combined. The new categories have resulted in significant changes which will be highlighted in the analysis. Below is the newly revised category grid:

	Quality of Care	Access	Attitude & Service	Billing & Finance	Benefit	Other
NCQA	X	X	X	X	X	Quality of Practitioner Office/Site
CMS	X	X	X		X	Enrollment Marketing CMS Issues Organizational Determination
DHCS	X	X	X	X	X	Regulatory Member Rights Cultural & Linguistics
DMHC	X	X	X	X	X	

The data provided below is reported in terms of rates defining the number of complaints by membership and terms of actual complaint counts by product by category to allow for a drill down into the issues.

Grievance/Complaints

Medi-Cal

Complaints	2013			2014			2015		
	Count	Rate*	%	Count	Rate*	%	Count	Rate*	%
Attitude & Service	3,263	0.25	40%	2,560	0.16	23.3%	2,498	0.13	16%
Access to Care	2,468	0.19	30%	3,723	0.24	33.8%	2,369	0.12	15%
Billing & Finance	868	0.07	11%	1,278	0.08	11.6%	4,956	0.24	32%
Quality of Care	1,379	0.11	17%	2,049	0.13	18.6%	5,623	0.28	36%
Quality of Practitioner Office	80	0.01	1%	89	0.001	0.8%	270	0.01	2%
Grand Total	8,198	0.64	1%	11,007	0.70	100%	15,716	0.16	100%

*Rate per thousand members is calculated based on total member months for the measurement period (October 1, 2014 – September 30, 2015 (2015=1,654,372 member mos.)

Quantitative Analysis

An analysis of the Medi-Cal complaint data reveals the following:

- Overall rate of complaints per 1000 members continues to decline;

- Attitude & Service and Access to Care decreased from 2014 to 2015;
- However, Billing & Finance and Quality of Care increased significantly with balance billing contributing to the 200% increase in Billing and Finance.

Cal MediConnect (CMC)

Complaints	2014			2015		
	Count	Rate*	%	Count	Rate*	%
Attitude & Service	13	0.39	54%	147	0.90	16%
Access to Care	4	0.14	17%	110	0.77	12%
Billing & Finance	5	0.66	21%	524	2.78	58%
Quality of Care	2	0.06	8%	117	0.66	13%
Quality of Practitioner Office	0	0.00	0%	3	0.03	0%
Grand Total	24	0.25	100%	901	1.03	100%

*Rate per thousand members is calculated based on total member months for the measurement period (October 1, 2014 – September 30, 2015 (2015=12,852 member mos.)

Quantitative Analysis

- 2015 represents the first full year of operations for CMC product.
- January 1, 2015 to June 30, 2015 was the period of passive enrollment with significant opt out rate ranging from 50% to 75% per month.
- All categories showed significant increase. This period also represented considerable confusion surrounding the program by embers and providers which resulted in the increased complaints.

L.A. Care Covered (LACC)

Complaints	2014			2015		
	Count	Rate*	%	Count	Rate*	%
Attitude & Service	84	0.45	31%	133	0.64	7%
Access to Care	31	0.19	12%	61	0.27	3%
Billing & Finance	118	0.55	44%	1500	7.62	83%
Quality of Care	16	0.09	6%	79	0.39	4%
Quality of Practitioner Office	19	0.10	7%	26	0.11	1%
Grand Total	268	0.28	100%	1799	1.81	100%

*Rate per thousand members is calculated based on total member months for the measurement period (October 1, 2014 – September 30, 2015 (2015=17,862 member mos.)

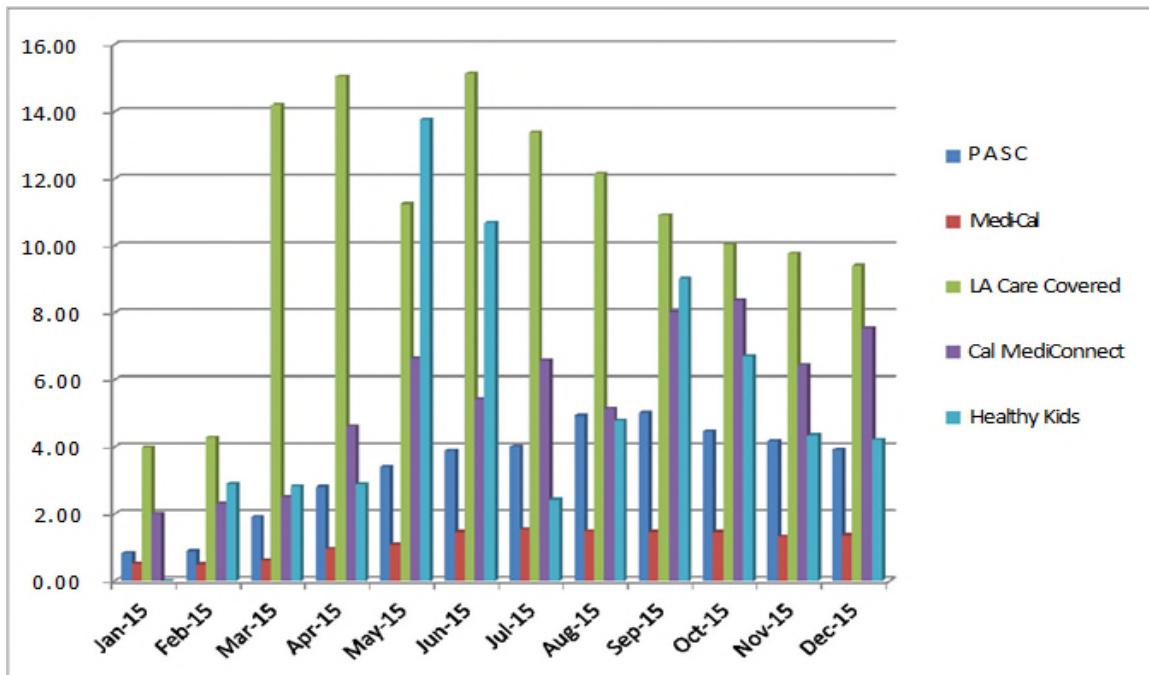
Quantitative Analysis

- This is the second year of operation of the L.A. Care Covered;
- All categories of L.A. Care Covered complaints increased;
- Significant increase is reflected in the Billing & Finance category where premium billing continued to be a serious issue.

GRIEVANCES/COMPLAINTS

The Grievances/Complaints data in this report is reflective of calendar year 2015.

FIGURE 1: GRIEVANCES PER 1000 MEMBERS BY LOB



- Represent a comparison of grievance rates across all lines of business. Of note, while L.A. Care Covered saw a peak in the 2nd Quarter, there is a steady decline in the remainder of the year.
- Line of business with the highest grievance rate was L.A. Care Covered;
- CMC grievance rates progressively increase across the year with a peak in the 4th Quarter.
- Significant increases are seen in Healthy Kids between May and June 2015 which is thought to be due to the confusion around the program termination scheduled for August 2015 and the membership decrease. Of note, the program was due to terminate in August but this action was suspended which can be seen by the steady decrease through the end year.
- All five lines of business show an increase in grievances due to Billing and Finance issues which are primarily balance billing issues.

The data below represents specific grievance by specific categories based on the line of business as seen in the last 2 Quarters of 2015 and supports the fact that Billing and Finance and Quality of Care were significant issues for most lines of business.

FIGURE 2: MEDI-CAL GRIEVANCES NCQA CATEGORIES

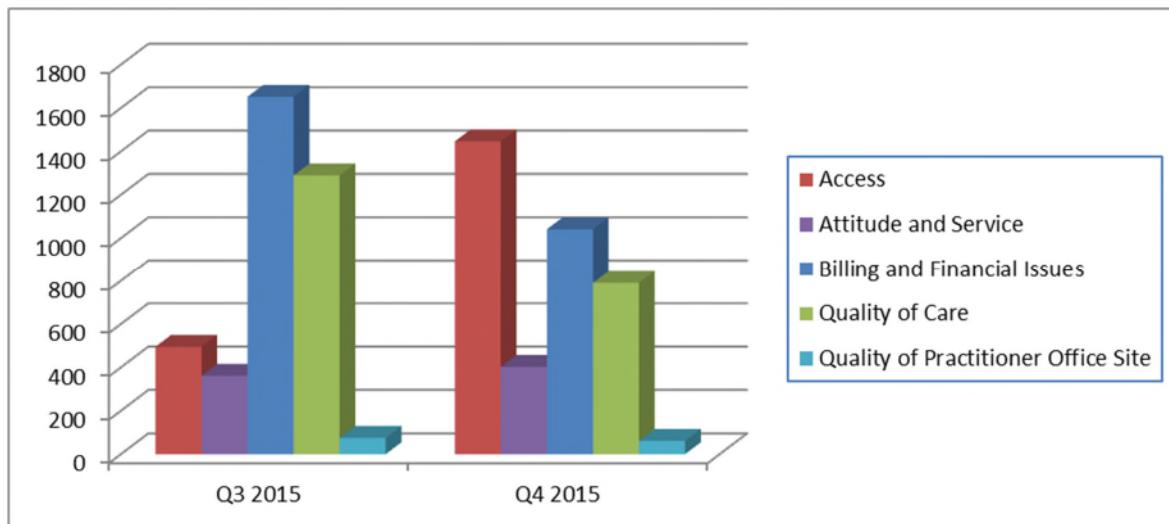


FIGURE 3: CAL MEDICONNECT GRIEVANCES CMC CATEGORIES

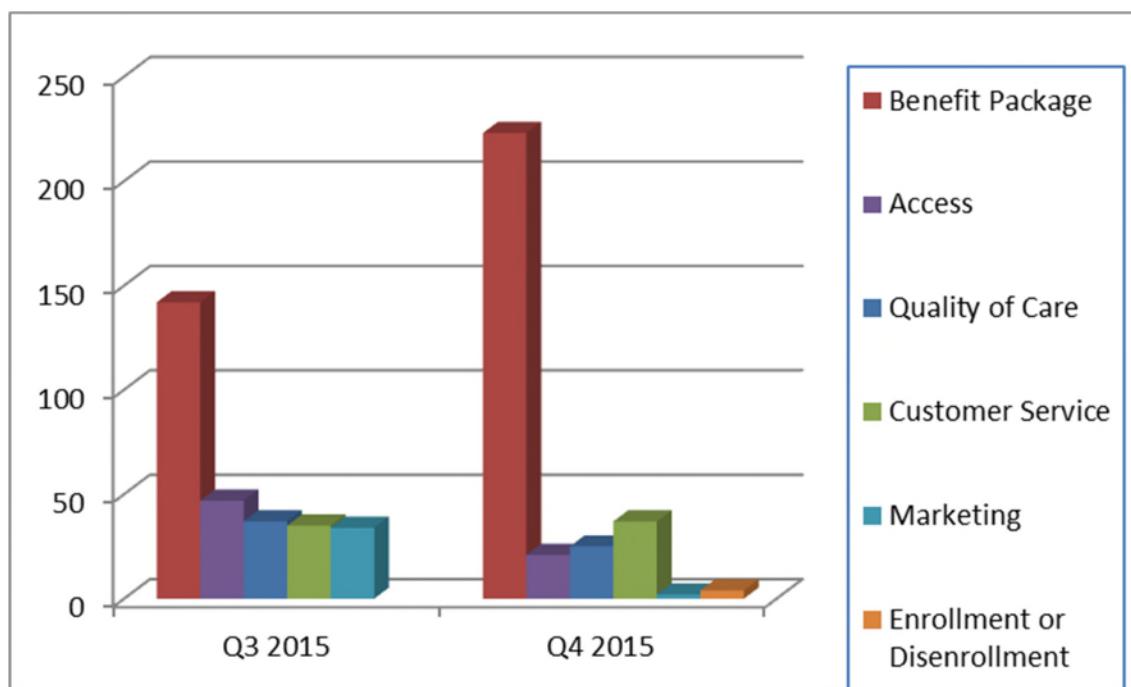


FIGURE 4: L.A. CARE COVERED GRIEVANCES NCQA CATEGORIES

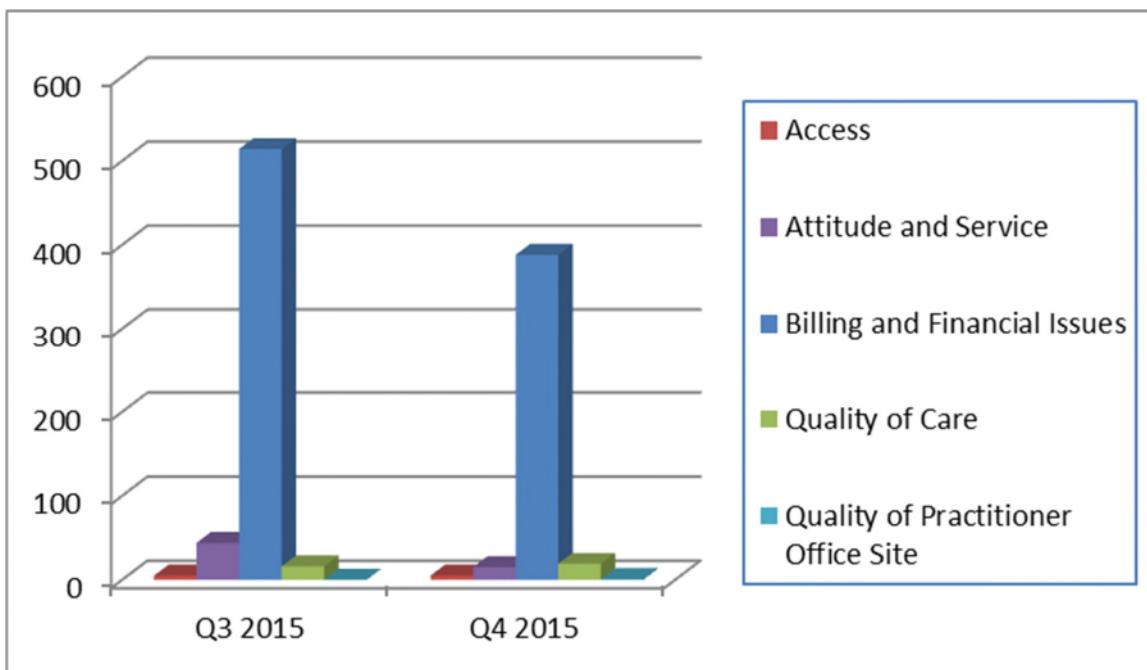


FIGURE 5: PASC-SEIU GRIEVANCES NCQA CATEGORIES

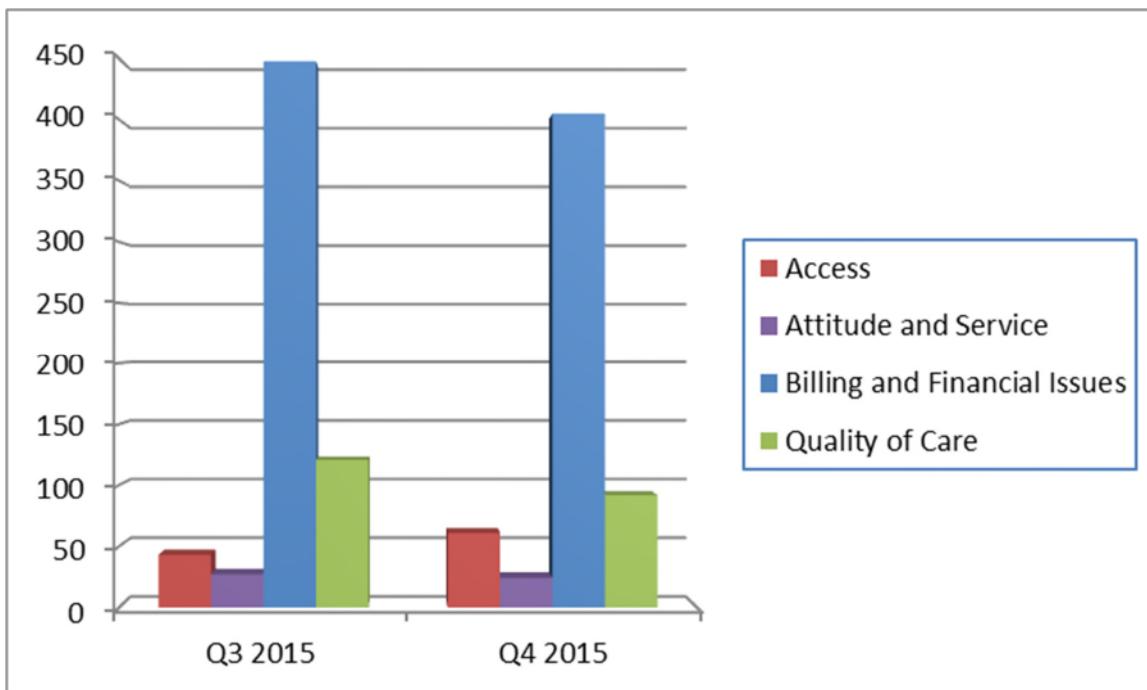
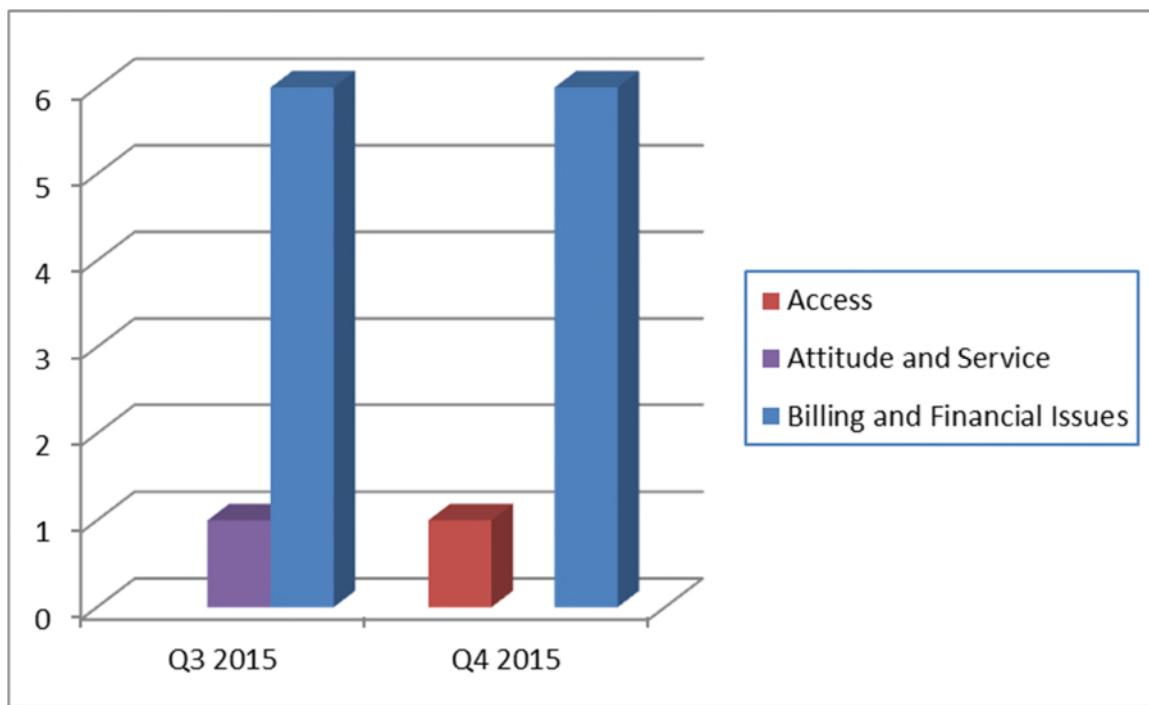


FIGURE 6: HEALTHY KIDS GRIEVANCES NCQA CATEGORIES



Qualitative Analysis

2015 saw an emergence of significant billing and finance issues across all lines of business. A root cause analysis of the issues found:

- There was confusion in the market place on new products being introduced, i.e. Cal MediConnect with passive and voluntary enrollment, L.A. Care Covered and termination of Healthy Kids;
- Lack of understanding in billing and finance by members, providers and vendors resulted in members being billed for covered services.

SUMMARY/OPPORTUNITIES FOR IMPROVEMENT

During 2015 L.A. Care undertook several activities to address the issues of balance billing and finance. These included:

- Performing a detailed analysis to identify specific providers, conditions and services that resulted in the increased rates.
- Education of Participating Physician Groups and Primary Care Providers as well as specialist and specialty providers.
- Focused education was developed for providers with more than 2 balance billing episodes (repeat offenders).
- Education on reimbursement and billing issues was developed for provider and member newsletters.
- Added tracking and monitoring systems to see if there is improvement with the activities

Another area of concern was an increase in access to care seen in the Medi-Cal line of business. The root cause analysis found the significant influx of members who were new to the Medi-Cal program. These members had difficulty in negotiation of the system.

Activities to address this issue include:

- Educate members on how to access health plan services
- Review of the access to care audits to recognize services and rectify geographic access in areas

APPEALS

Medi-Cal

Appeals	2013			2014			2015		
	Count	Rate*	%	Count	Rate*	%	Count	Rate*	%
Attitude & Service	791	0.06	61%	968	0.06	69%	0	0.000	0%
Access to Care	0	0.00	0%	0	0.00	0%	88	0.00	7%
Billing & Finance	13	0.000	1%	0	0.00	0%	1	0.00	0%
Benefits	208	0.02	16%	212	0.01	15%	*	*	*
Quality of Care	285	0.02	22%	308	0.02	22%	1,098	0.06	93%
Quality of Practitioner Office	0	0.00	0%	0	0	0%	0	0.00	0%
Grand Total	1,297	0.10	100%	1,410	0.09	100%	1,187	0.01	100%

*Due to remapping

Quantitative Analysis

An analysis of the Medi-Cal appeals data reveals the following:

- Quality of Care appeals account for the majority of appeals issues. This may be due to the remapping done for NCQA Categories for appeals coded in the system.
- Access to care appeals increased for 2015 fiscal year.

CMC

Appeals	2014			2015		
	Count	Rate*	%	Count	Rate*	%
Attitude & Service	0	0.00	0%	0	0	0%
Access to Care	0	0.00	0%	85	0.46	79%
Billing & Finance	***	***	***	13	0.07	12%
Benefits	3	0.11	100%	**	**	**
Quality of Care	0	0.00	0%	9	0.12	8%
Quality of Practitioner Office	3	0.00	0%	0	0	0%
Grand Total	0	0.00	0%	107	0.13	100%

*Rate per thousand members is calculated based on total member months for the measurement period (October 1, 2014 – September 30, 2015 (2015=12,852 member mos.)

**Due to remapping

***CMC program did not start until April 2015

Quantitative Analysis

- Access to Care and Billing/Finance appeals account for the majority of appeal issues. This may be due to the remapping done for NCQA Categories for appeals coded in the system.
- Quality of Care appeals increased during the year.

LACC

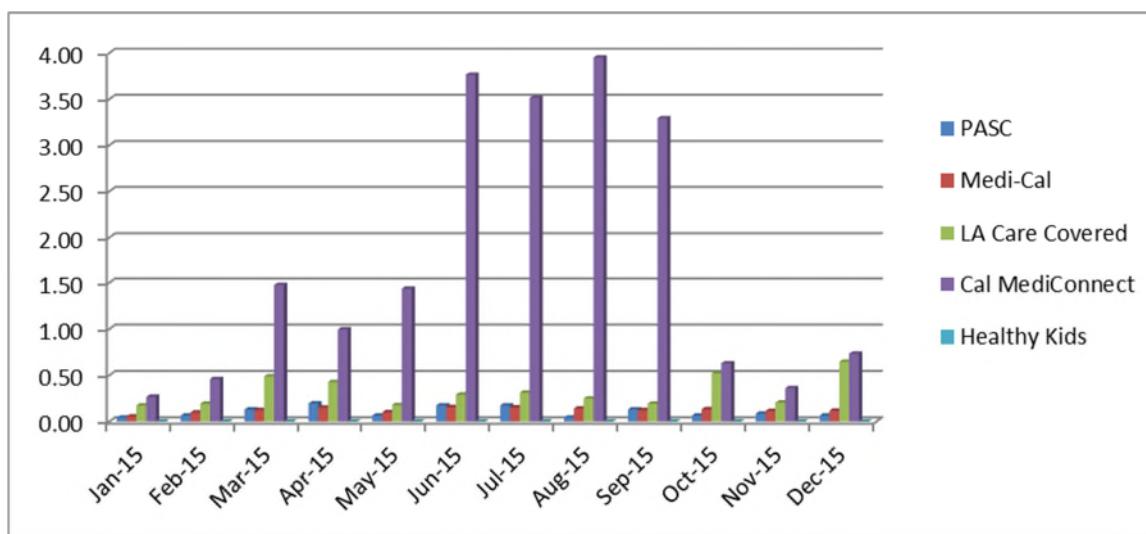
Appeals	2014			2015		
	Count	Rate*	%	Count	Rate*	%
Attitude & Service	0	0.00	8%	0	0	0%
Access to Care	2	0.00	0%	37	0.19	82%
Billing & Finance	0	0.00	0%	2	0.01	4%
Benefits	0	0.00	0%	0	0.00	0%
Quality of Care	22	0.19	92%	6	0.03	13%
Quality of Practitioner Office	0	0.00	0%	0	0.00	0%
Grand Total	24	0.04	0%	45	0.05	100%

*Rate per thousand members is calculated based on total member months for the measurement period (October 1, 2014 – September 30, 2015 (2015=17,862 member mos.)

Quantitative Analysis

- Access to Care appeals account for the majority of appeal issues. This may be due to the remapping done for NCQA Categories for appeals coded in the system;
- Billing and Finance saw an increase;
- Quality of Care appeal decreased during the year.

FIGURE 7: APPEALS PER 1000 MEMBERS BY LOB



Cal MediConnect saw a significant spike in 3rd Quarter with a significant decrease in 4th Quarter. A review of the data showed the spike was due to the billing and finance or balance billing issues. The next series of graphs show the categories by LOB and category for the last two Quarters of 2015.

FIGURE 8: MEDI-CAL APPEALS NCQA CATEGORIES

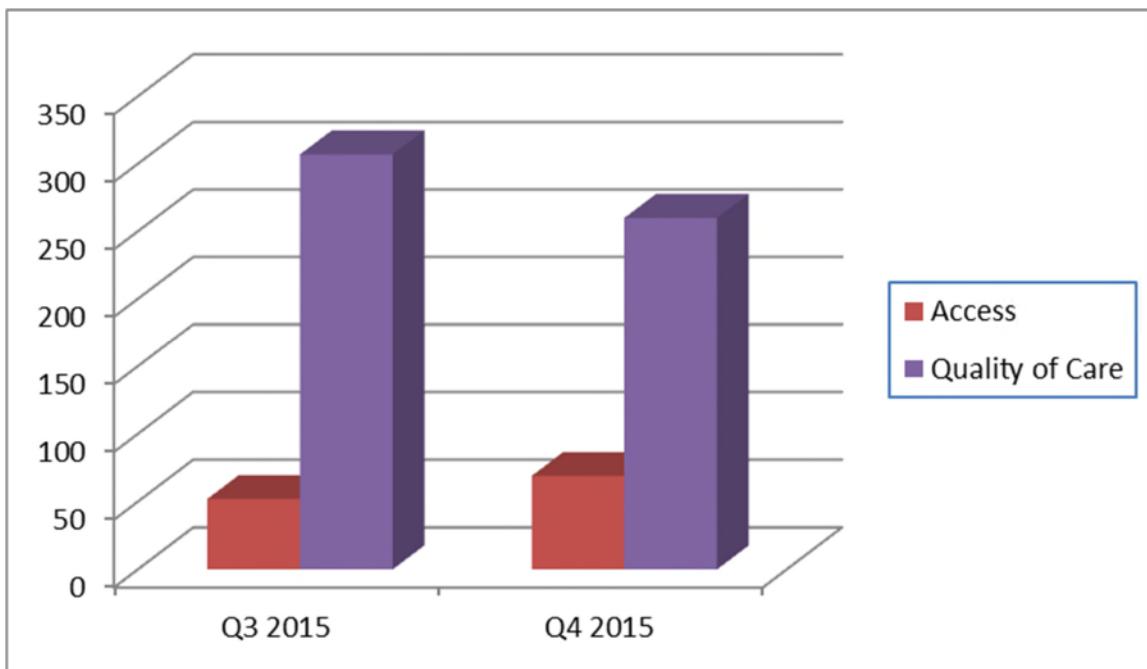


FIGURE 9: CAL MEDICONNECT APPEALS CMC CATEGORIES

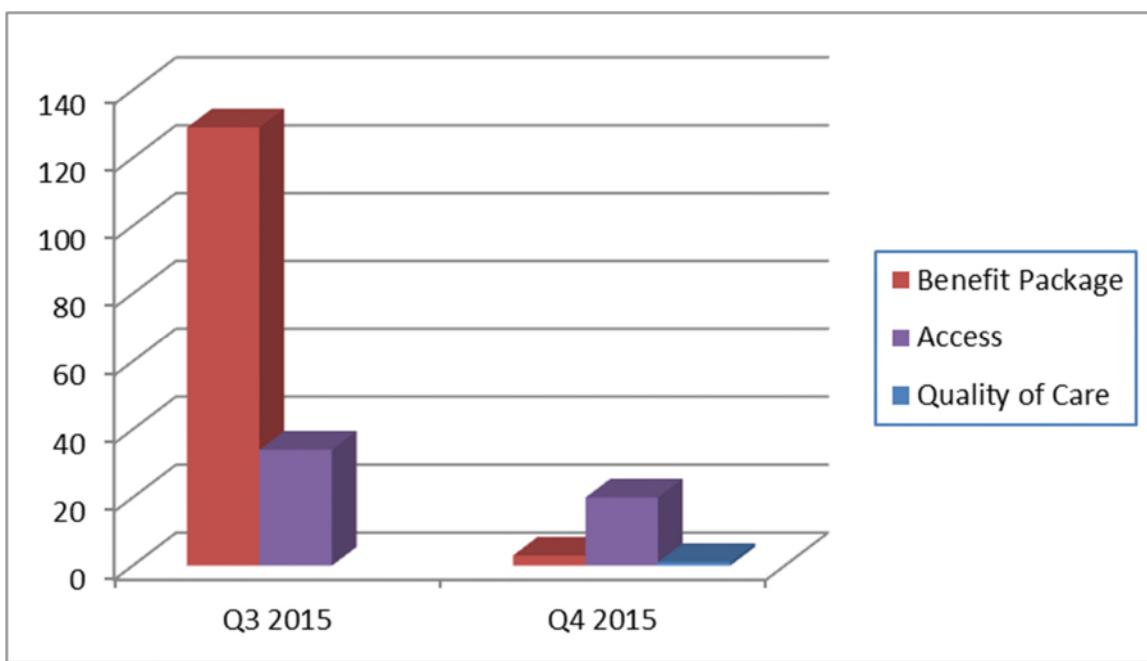


FIGURE 10: L.A. CARE COVERED APPEALS NCQA CATEGORIES

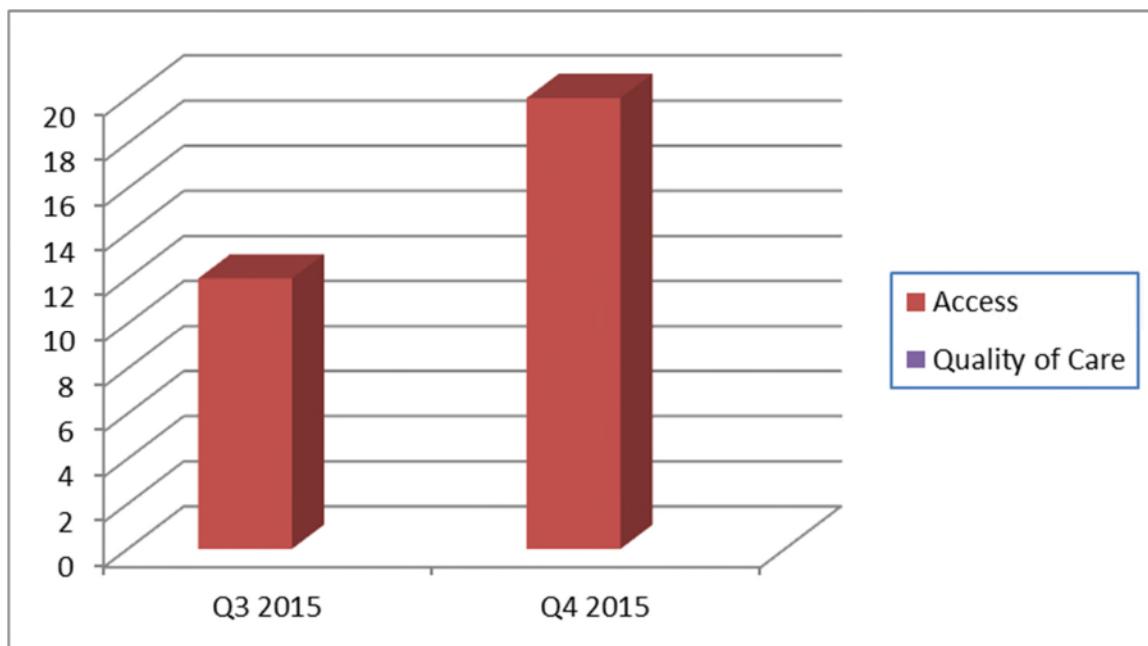
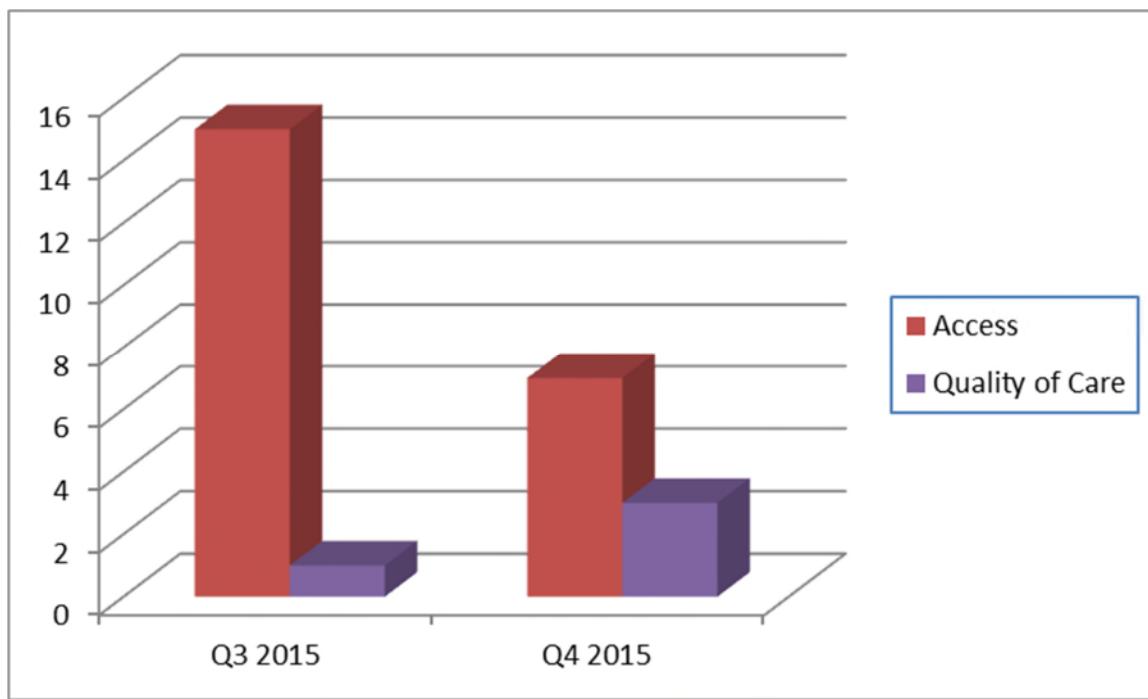


FIGURE 11: PASC-SEIU APPEALS NCQA CATEGORIES



Qualitative Analysis

For all lines of business except Medi-Cal, access to care was the issue. Only in Medi-Cal was quality of care identified as an issue. A root cause analysis of the issues found:

- Lack of understanding by members enrolled in the new products on how to negotiate the health care system;

- Lack of understanding in billing and finance by Cal MediConnect members, providers and vendors resulted in members being billed for covered services;
- Quality of care categories includes delays in accessing service and care which may be driving the spike and linked to the category mapping;
- Geographic access to primary and specialty care was a reported issue, particularly in Antelope Valley.

SUMMARY/OPPORTUNITIES FOR IMPROVEMENT

During 2015 L.A. Care undertook several activities to address the issues of access to care:

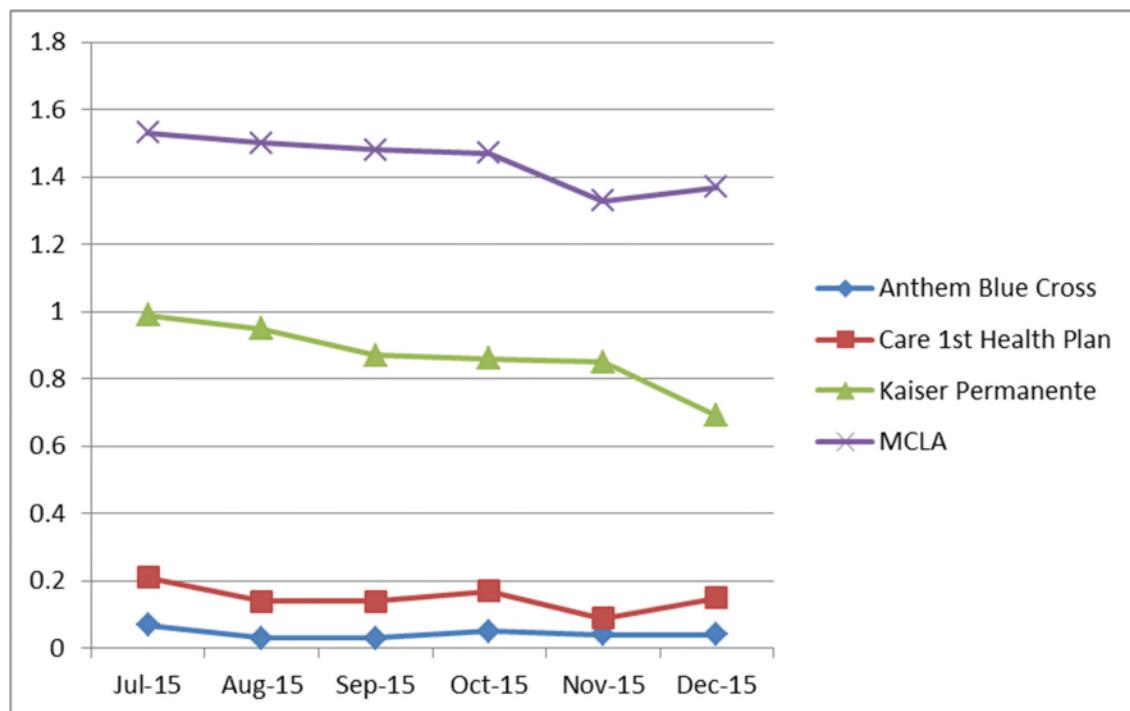
- L.A. Care introduced the Community Access Network to help in the geographic access as most of the reported access issues seen in the access audits were related to Antelope Valley.
- Continued to explore unique ways to add specialist services, which include telehealth, new relationship with providers from academic centers (e.g. UCLA and Cedars) and alternative care delivery sites (e.g. urgent care centers, retail medical clinics).
- Educate members on how to access health plan services.
- Review of the access to care audits recognize services and rectify geographic areas with limited access.
- Added tracking and monitoring systems to see if there is improvement with the activities.

PLAN PARTNERS

L.A. Care reviews Medi-Cal grievance and appeals data submitted by from the Plan Partners to identify trends in services or access across the network. As each Plan Partner has independent coding categories, this report is unable to identify complaints by categories. The data below reflects grievance and appeal rates per 1000/members for 3rd and 4th Quarter 2015.

2015 3RD AND 4TH QUARTER APPEALS AND GRIEVANCES

GRIEVANCES/COMPLAINTS



Quantitative Analysis

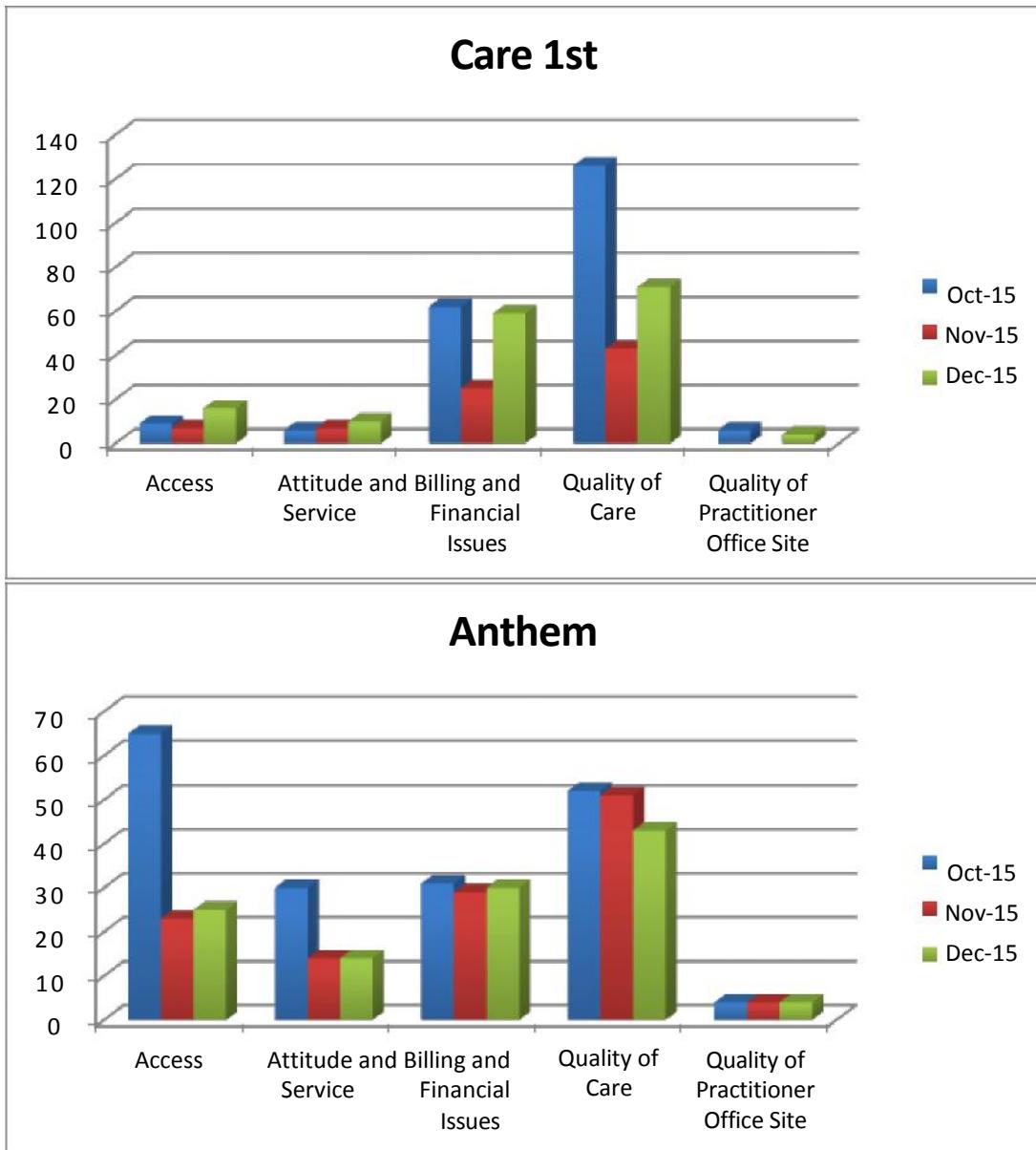
Of the three Plan Partners:

- Anthem grievance rates are the lowest;
- Care 1st had a significant drop during November;
- While MCLA is the highest, both MCLA and Kaiser grievance rates are trending downward for the past six months.

PLAN PARTNER GRIEVANCES BY NCQA CATEGORIES

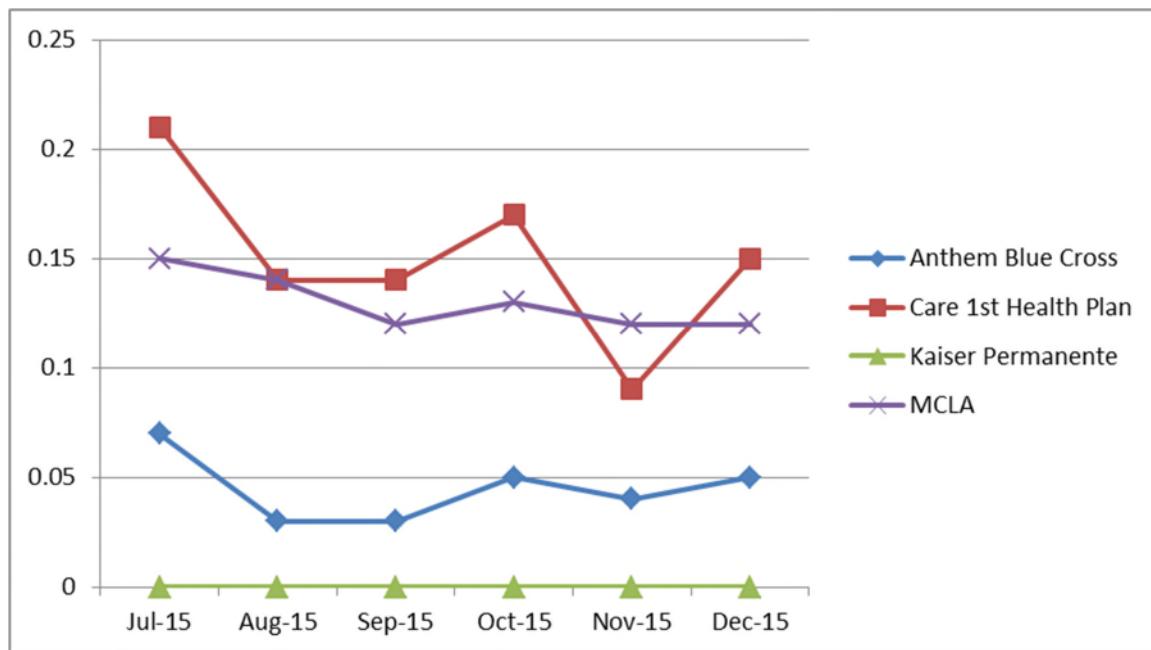
L.A Care began efforts to ensure data reported by Plan Partners is categorized using the standardized NCQA categories. Below are graphs for 4th Quarter 2015 identifying how categories will allow staff to compare complaints across the Medi-Cal network. As the data is limited, no interventions are planned. Appeals and Grievance will continue to work with the Plan Partners on standardized reporting.

Plan Partner Grievances by NCQA Categories – 4th Quarter 2015



APPEALS

FIGURE 14: PLAN PARTNERS 2015 3RD AND 4TH QUARTERS APPEALS



Quantitative Analysis

Of the three Plan Partners:

- Care 1st appeal rates are the highest;
- Care 1st had a significant drop during November;
- Kaiser did not have or report any appeal activity.

SUMMARY/OPPORTUNITIES FOR IMPROVEMENT

In review of the issues found:

- Lack of consistent data for aggregate reporting between the Plan Partners and L.A. Care.
- Lack of similar categorizations of complaints.
- At the time of this report, lack of sufficient data and data elements to trend.

During 2015 L.A. Care undertook several activities to address the Medi-Cal network data issues:

- Standardized grievance and appeals categories based on regulatory and accreditation requirements.
- Began planning meetings with Plan Partners to standardize category coding between Plan Partners.
- Developing standardized reporting across Plan Partners to report data to the level of common providers.

Opportunity	New and/or Ongoing	Action(s) Taken	Measurement of Effectiveness
PRIORITY #1	Improve understanding of billing and finance by members, providers and vendors • Billing and Finance		
Educate members, providers, and vendors on billing and finance	New	In 2016, L.A. Care performed detailed analysis to identify specific providers, conditions and services for which members were inappropriately billed. Educational were developed for inclusion in Member and Provider Newsletters. Focused education of Participating Physician Groups and Primary Care Providers as well as specialists and specialty providers were conducted. A tracking and monitoring system has been developed and implemented,	<ul style="list-style-type: none"> Decreased grievances and appeals related to Billing and Finance
PRIORITY #2	Improve member's understanding and ability to navigate the health care system. • Access to care		
Collaborate with sub-contracted health plans, provider groups and select network physicians to better educate members on benefits, referral processes, and how to access care.	Ongoing	In 2016, L.A. Care will continue to explore unique ways to expand access to services. Co-branded marketing and member informing materials will be utilized to increase understanding and access to care.	<ul style="list-style-type: none"> Decreased grievances regarding access to care

Please see Section 9 and associated table of CAHPS related Priorities and Opportunities also related to satisfaction.

SECTION 2: CHILD MEDICAID CAHPS 5.0 RESULTS

METHODOLOGY

This report summarizes findings of the 2015 Child Medicaid CAHPS 5.0 survey and compares the results to the 2013 and 2014 scores as well as our performance relative to the 2015 National Medicaid Average (NMA) and California Medicaid HMO Average (CMHA), as published by Quality Compass. Members were surveyed in English and Spanish.

The CAHPS Survey targeted potential respondents who are parents of those 17.9 years and younger as of the anchor date of December 31, 2014, who were continuously enrolled in Medi-Cal (i.e., present for at least five of the last six months of the measurement year and who were still enrolled at the time of the survey). A total of 2,597 surveys were mailed and a total of 596 or 30.6% were completed.

GOAL

L.A. Care did not meet the goals for Overall Rating of Health Plan, Care Received, Personal Doctor, and Composite Rating for Health Plan Customer Service, Getting Needed Care, Getting Care Quickly, and Doctors Who Communicate Well. Overall rating Specialist Seen Most Often is marked N/A, as there were

not enough respondents to the question on the survey. Goals are determined using the NCQA sliding scale for Improvement, as well as analysis of historical performance.

Overall Ratings	Score	Goal	Met
Health Plan	84.5%	86%	N
Care Received	81.4%	87%	N
Personal Doctor	85.8%	88%	N
Specialist Seen Most Often	NA	88%	NA
Composite Ratings	Score	Goal	Met
Health Plan Customer Service	81.7%	88%	N
Getting Needed Care	77.2%	81%	N
Getting Care Quickly	81.1%	84%	N
Doctors Who Communicate Well	86.3%	90%	N

OVERALL SCORES

The CAHPS survey includes the following five general overall rating questions designed to distinguish among important aspects of care. These questions ask enrollees to rate their experience in the past 6 months. Response options for rating satisfaction ranged from 0 (worst) to 10 (best). The NCQA scoring for overall ratings used in the table below, ratings of 8, 9 or 10 are considered favorable, and the achievement score is presented as a percentage of members whose response was favorable.

Child CAHPS Overall Ratings	Score 2013	Score 2014	Score 2015	2015 vs. 2014	NMA 2015	CMHA 2015
Health Plan	84.0%	84.2%	84.5%	0.3%	84.4%	83.4%
All Health Care	79.2%	84.5%	81.4%*	-3.1%	85.1%	80.9%
Personal Doctor	84.2%	85.9%	85.8%*	-0.1%	88.2%	85.7%
Specialist Seen Most Often	NA	NA	NA	NA	85.0%	ND

*Scores indicate scores that fell below the NCQA Medicaid 25th percentile.

Quantitative Analysis

- **Health Plan Overall:** The 2015 overall ratings shows slight improvement from 2013 but remain fairly flat over the three-year period from 2013 to 2015. The 2015 Health Plan rating is slightly above the National Medicaid Average (NMA) and the California Medicaid HMO Average (CMHA)
- **All Health Care Rating:** The All Health Care score showed a 5.3 point improvement between 2013 to 2014 but dropped significantly (3.1 points) in 2015. This rating is below the NMA, but slightly above the CMHA.
- **Personal Doctor:** The Personal Doctor score has showed slight improvement over the past three years; however, the improvements are not significant. This falls below the NMA and slightly above the CMHA.

- Specialist Seen Most Often: The response rate was insufficient to score.

Composite Scores

The CAHPS survey asks respondents about their experience with various aspects of their care. Survey questions are combined into “composites”. Questions within each composite ask members how often a positive service experience occurred in the past six months. Respondents have the option to select from “never”, “sometimes”, “usually” and “always”. The scores for composite scores and survey questions throughout this report reflect the percent of responses indicating “usually” or “always”.

Child CAHPS Composites	Score 2013	Score 2014	Score 2015	2015 vs. 2014	NMA 2015	CMHA 2015
Getting Needed Care	77.1%	79.9%	77.2%*	-2.7	84.3%	77.6%
Getting Care Quickly	81.3%	82.1%	81.1%*	-1.0	88.6%	78.1%
How Well Doctors Communicate	84.1%	83.3%	86.3%*	3.0	93.1%	88.5%
Customer Service	85.8%	86%	81.7%*	-4.3	87.5%	85.8%

*Scores indicate scores that fell below the NCQA Medicaid 25th percentile.

Quantitative Analysis

- Getting Needed Care: L.A. Care scored below the NMA and slightly below the CMHA. L.A. Care dropped in score to 2013 level.
- Getting Care Quickly: L.A. Care showed a drop from 2014. The 2015 score is below the NMA but above the CMHA.
- How Well Doctors Communicate: L.A. Care’s score showed a 3 percentage point increase from 2014 and remains below the NMA and CMHA.
- Customer Service: L.A. Care’s score fell below the NMA and CMHA.

SECTION 3: QUALITATIVE ANALYSES AND KEY DRIVERS

ACCESS TO CARE

Access to Care remains a reason for member complaints. Approximately 50% of all Access to Care complaints (Adult and Child combined) are regarding delays in service, delays in authorization, and specialty access/availability. Although the overall score has improved it is still viewed as a contributor to Quality of Care.

Through discussion and feedback, the following have been identified as possible contributing factors to the members’ ratings of access to care:

- An inherent shortage of specialists, especially at the provider group level. L.A. Care does meet the provider to member ratio for the overall network but opportunity for improvement has been identified at the delegate level.
- Actual delays in timeliness of processing authorizations.
- Delays with the authorization process due to practitioners submitting incomplete or incorrect requests to the authorizing party resulting in delays and multiple calls for clarification of the request for additional information.
- Limited oversight of delegate’s authorization processes.
- Member perception of timeliness.
- Transportation issues traveling to provider offices.

Provider Network Operations examines the individual specialty networks of contracted provider groups quarterly and informs them of any deficiencies in their network. Furthermore, individual attention is paid to referrals to out of network specialists on an as-needed basis in order to ensure member's needs are continually met.

The table below is a summary report of out of network specialists requests processed during the period of April 2015 – January 2016 for all lines of business. The summary report includes major categories of out of network specialists' requests for both delegated and direct lines of business.

Type of Service	Approved	Denied	Grand Total
SNF	3,052	11	3,068
Hospital (Inpatient)	333	21	354
Ancillary	144	10	154
Surgery Center	114	7	121
Specialist (Direct)	88	4	92
PPG (Specialty)	12	0	12
Sub-Acute	4	0	4
Home Health (Infusion)	3	0	3
Hospice	3	0	3
DME	2	0	2
Grand Total	3,755	53	3,813

Initial analysis of the data indicates that 80% of the out of network specialists are requests for Skilled Nursing Facility services which may include both short-term and long-term care requirements. The top four categories or 3,697 requests account for 96% of all requests. This is indicative of a potential shortfall in the availability of beds and services within the categories represented.

Opportunities Identified

Further drill down of this aggregate information to identify program specific gaps in access are warranted. Geographic analysis should be contemplated to focus on locals where services are limited or not available and new contracting strategies need to be considered. Standardization of reporting should be developed and implemented.

A break-down of out of network specialists requests for the LACC line of business for the period of April 2015 – January 2016 was completed and the chart below is a reflection of that activity.

Type of Service	Approved	Denied	Grand Total
Surgery Center	19	0	19
Hospital (Inpatient)	6	0	6
Specialist	3	0	3
DME	1	0	1
Grand Total	29	0	29

Analysis of the data indicates for the period covered there were a total of 29 out of network specialists requested and 100% of the requests were approved. Of the total 65% of the requests were related to services provided in an outpatient surgery center. Inpatient services at a non-contracted facility equates to 20% of the requests submitted.

Opportunities Identified

In addition to those stated related to the aggregate results a focus for the LACC line of business should target strategies to improve availability of contracted inpatient and outpatient surgery centers.

L.A. Care continually provides education for members to help guide their expectations regarding speed-of-access to routine care, help them understand when to use urgent care and remind them L.A. Care can assist them with making appointment if needed. Education is conducted through member orientation, new member welcome calls, member newsletters, the Family Resource Center, and the L.A. Care website.

L.A. Care's UM team does work closely with the contracted provider groups to encourage usage and promotion of improved programs, such as a direct referral process or auto authorizations. Delegates are monitored through the quarterly utilization management reports where trends are identified and reported to the QOC for advisement.

HEALTH PLAN CUSTOMER SERVICE INFORMATION/HELP

Based on key driver statistical modeling conducted by DSS, the most important areas to focus for improvement in health plan customer services are in getting needed care and courtesy and respect.

The following have been identified as contributing factors to ratings of member satisfaction with health plan customer service:

- Member feedback indicates inconsistency of information; long hold times, multiple transfers, communication and customer service treatment at various touch points of the organization.
- Internal customer service training is limited to the Member Services Department. Other areas such as Utilization Management, Claims and Pharmacy handle customer calls but do not have the benefit of the ongoing customer service training.
- Quality oversight of customer service is only in place in the Member Services Department.
- Multiple touch points through transfer of calls and call back can cause member confusion and dissatisfaction.
- L.A. Care's expansion over the past several years has provided a challenge to staff of keeping pace with membership growth.

L.A. Care continues to hire additional staff for the call center to support the increased call volume. Member Services also performs an internal Quality Review Audits for calls in the unit.

In 2015 L.A. Care's Member Services Department has Member Service Specialist/Navigators who are responsible for resolving member coordination of care for complex cases which may involve benefit coordination, continuity of care, access to care, quality of care issues, member eligibility, assignment and disenrollment issues. The specialist/navigator ensures proper and timely handling of member issues.

Member Outreach, Retention and Engagement (M.O.R.E) unit continues their mission to inform, educate, engage, and empower members and create a positive member experience that translates to increased member satisfaction. QI has leveraged the M.O.R.E unit expertise in member call campaigns to improve HEDIS rates.

Member retention committee formed in 2014 continues as part of the L.A. Care & member strategy:

- One of the focus of the committee, areas is to improve the member experience, as evidenced through CAHPS survey results
- The multi-disciplinary committee is led by Medicare Ops, with participation from member services, quality, HO&A, MORE, A&G, and other pertinent departments across the organization.

Actions underway & being considered:

- A drill down survey for CMC members is to be conducted by an external vendor in February 2016 in order to allow us to understand member specific information regarding access to care, care coordination and customer service – all designed to help us obtain actionable information to improve CAHPS performance on the focus areas for the org (Customer service & access).
- Customer service week education across the organization in November 2015.
- Considering an initiative related to CAHPS awareness, so all L.A. Care employees know when the survey is fielded and ensure exemplary customer service.
- Considering in person customer service training for high volume providers and their staff
- Continue analysis of CAHPS, disenrollment and other data to help us obtain actionable data to improve the overall member experience.

PROVIDER COMMUNICATION AND COORDINATION OF CARE

Provider Attitude and Service is an area of member complaints, however, there was a significant drop in the number of these complaints from 40% of overall complaints in 2013 to 16% in 2015. The 2015 overall rating of personal doctor showed -0.1% point decrease from 2014.

The Cultural and Linguistic Department reported that literacy, language and cultural barriers are inherent in the L.A. Care populations and which often causes frustration, especially when combined with complex medical conditions.

- Focus studies show that members with complex medical needs are frustrated with their experiences and believe they are receiving low-quality medical coverage.
- Member feedback indicates dissatisfaction is often due to their interaction with provider staff.

In March 2015, L.A. Care was recertified by the National Committee for Quality Assurance (NCQA) Multicultural Health Care Distinction: (MHC). NCQA ensures excellence in health care and sets the industry benchmark for assessing and improving health quality. It created the MHC to encourage and recognize health care organizations that provide excellent care to diverse and minority populations. This distinction recognizes L.A. Care as an organization that not only meets, but exceeds, NCQA's rigorous requirements for multicultural health care, while also being a leader in providing culturally and linguistically sensitive services and reducing health care disparities.

L.A. Care continually provides education for providers regarding cultural sensitivity and the importance of quality customer service. Education is conducted through on-site training, webinars provided by L.A. Care Medical Directors, provider newsletters and the L.A. Care website. Additionally, provider relations conducted customer service training to provider offices in early 2014.

SECTION 4: ADULT MEDICAID CAHPS SURVEY RESULTS AND ANALYSES

METHODOLOGY

The Medicaid Adult CAHPS 5.0H Survey was conducted by DSS Research (DSS), an NCQA-certified vendor contracted by L.A. Care Health Plan (L.A. Care). Results were submitted to NCQA and reported in NCQA's Quality Compass database. This report summarizes these findings and results are compared to our 2013 and 2014 CAHPS scores, as well as our performance relative to the 2015 National Medicaid HMO (NMA) and California Medicaid HMO Averages (CMA) published by Quality Compass. While this current report focuses on L.A. Care's response to the Adult CAHPS 5.0H survey findings, L.A. Care also conducted a Child Medicaid CAHPS 5.0H survey in 2015. The findings of both the adult and child surveys are considered in L.A. Care's assessment of their quality improvement process.

The CAHPS 5.0H Survey targeted potential respondents who are adult members ages 18 and above on the anchor date of December 31, 2014, who were continuously enrolled in L.A. Care Health Plan for at least 6 months as of the anchor date with no more than one enrollment gap of 45 days or less, and who remained members on the anchor date and the date they were actually surveyed. The sample included an NCQA based sample of members assigned to L.A. Care and its sub-contracted health plans, as well as an oversample of 30% to increase the total number of responses available for measures where reporting is sparse. Respondents were surveyed in English and Spanish.

The CAHPS Adult 2015 Survey targeted potential respondents who are 18 years and older as of the anchor date of December 31, 2014, who were continuously enrolled in Medi-Cal (i.e. present for at least five of the last six months of the measurement year and who were still enrolled at the time of the survey). A total of 1,755 surveys were mailed and a total of 439 or 27.1% were completed.

2015 WORK PLAN GOAL:

Overall Ratings	Score	2015 Goal	Met
Health Plan Rating	73.2%	77%	N
Health Care Rating	73.9%	75%	N
Personal Doctor Rating	79.7%	80%	N
Specialist Seen Most Often Rating	76.4%*	80%	N

Composite Scores		2015 Goal	
Customer Service	84.7%*	89%	N
Getting Needed Care	73.4%*	79%	N
Getting Care Quickly	74.0%*	79%	N
How Well Doctors Communicate	88.6%*	88%	N

*Scores indicate scores that fell below the NCQA Medicaid 25th percentile.

RESULTS

The CAHPS survey includes the following four general overall rating questions designed to distinguish among important aspects of care. Overall ratings are single-question measures rating services on a scale from 0 (worst) to 10 (best) services possible. Response options for rating satisfaction ranged from 0 (worst) to 10 (best). Thus, in the NCQA scoring for overall ratings used in the table below, only ratings of 8, 9 or 10 are considered favorable, and the achievement score is presented as a percentage of members whose response was favorable. NA indicates those measures with insufficient eligible respondents to report.

Overall Rating	Adult Score 2013	Adult Score 2014	Adult Score 2015	NMA 2015	CMHA 2015
Health Plan	71.1%	75.2%	73.2%	75.0%	70.7%
All Health Care	68.5%	72.7%	73.9%	72.5%	67.7%
Personal Doctor	78.2%	78.8%	79.7%	79.8%	75.6%
Specialist Seen Most Often	78.5%	77.7%	76.4%*	80.5%	75.9%

*Scores indicate scores that fell below the NCQA Medicaid 25th percentile.

Composites are indices calculated from multiple CAHPS questions. Questions within each composite ask members how often a positive service experience occurred in the past six months. Respondents have the

option to select from “never”, “sometimes”, “usually” and “always”. The scores for composite scores and survey questions throughout this report reflect the percent of responses indicating “usually” or “always”.

Composite Scores	Adult Score 2013	Adult Score 2014	Adult Score 2015	NMA 2015	CMHA 2015
Getting Needed Care	72.0%	77.4%	73.4%*	80.8%	71.9%
Getting Care Quickly	76.0%	76.6%	74.0%*	80.7%	71.6%
How Well Doctors Communicate	85.7%	86.4%	88.6%*	90.7%	86.3%
Customer Service	85.2%	87.3%	84.7%*	87.1%	83.9%

*Scores indicate scores that fell below the NCQA Medicaid 25th percentile.

Quantitative Analysis

L.A. Care scored above the 2015 CMHA in all of the Adult Overall Ratings and Composites. Although composite scores have shown year-over-year improvement, they are still below the NMA. The overall rating for All Health Care exceeded both the NMA and CMHA ratings.

Overall:

- Health Plan: 2015 score up from 2013 but decreased by 2% from 2014. Scored below NMA but above CHMA.
- All Health Care: Scored above the 2013 & 2014 rates and exceeded both the NMA and CHMA targets.
- Personal Doctor: Slight drop in score compared to 2013 and 2014. Scored below the NMA by 0.1% and exceeded the CHMA.
- Specialist Seen Most Often: 2015 score shows steady decline as compared to 2013 and 2014. Scored lower than the NMA but slightly higher than the CHMA.

Composite:

- Getting Needed Care: 2015 showed 4% point drop in rate from 2014. Did not meet the NMA rate but exceeded the CHMA rate.
- Getting Care Quickly: Greater than 2% point drop in scoring; fell below the NMA and above the CHMA.
- How Well Doctors Communicate: 2015 score demonstrates an upward trend over 2014 & 2014 scores. Score slightly under the NMA and exceeded the CHMA.
- Customer Service: 2015 score below both 2013 & 2014. Did not meet NMA but slightly exceeded CHMA.

Qualitative Analysis

In 2015, L.A. Care maintained the gains from the 2013 survey, with the exception of Specialist Seen Most Often, as scores remained relatively flat from 2013 to 2015.

Billing and Finance: Balance billing or charging a member for services is the number one reason for member complaints. Balance billing contributed to a 200% increase in this category of complaints in 2015. Uncertainty regarding benefits and confusion by members and providers led to the increased complaints.

Through discussion and feedback the following have been identified as possible contributing factors resulting in member dissatisfaction:

- Confusion in the marketplace on new products being introduced with passive and involuntary enrollment confusing to both members and providers.
- Lack of understanding in billing and finance by all parties resulted in members being billed for covered services.

In 2015 L.A. Care undertook several activities to establish the root cause and implemented interventions to remedy the issues. The detailed analysis, not only complaint data but claims and authorization data were used to identify specific providers, conditions and services that were contributing to this issue. Based on this analysis focused education was developed targeting those providers who had two or more occurrence, as well as sharing the education with Physician Groups and Primary Care Providers. Additionally a newsletter education piece targeting reimbursement and billing issues was developed for both provider and member newsletter articles. Finally, a tracking and monitoring system has been instituted to document improvement.

Getting Needed Care has one of the highest correlations with overall health plan satisfaction and health care they receive. This remains a priority area and evidence that opportunities for improvement exist.

Provider Network Operations reported that the practitioner to member ratio is increasing year over year. This is partly due to membership growth.

L.A. Care forecasts that membership will continue to increase at a faster pace than the addition of provider groups which results in the specialist network not keeping pace with the membership growth. L.A. Care continually strives to maintain and expand its network of contracted specialists and ancillary providers with particular emphasis on contracting with specialists identified in the top utilized specialties for each line of business.

L.A. Care's Utilization Management Department reported that delays in care or treatment are often actual delays with the authorization process, compounded by the members' perception of delay in service. Practitioners often submit incomplete or incorrect requests to the authorizing party. In these instances, requests may be deferred resulting in delays and multiple calls for clarification of the request for additional information. Modifications or denials may be made based on the lack of clinical information or inadequate information submitted by practitioners. These factors do result in delayed service for members. The Utilization Management Department also recognizes there is opportunity for improvement at the delegate level. Utilization Management is diligent in consistently monitoring delegate performance against L.A. Care and regulatory standards. They work closely with the provider groups to encourage usage and promotion of improved programs, such as a direct referral process or auto authorizations.

L.A. Care encourages provider groups/physicians to adopt electronic health records recognizing that the implementation of health information technology at participating clinics might help alleviate some of these problems. In addition, L.A. Care continually provides education for members to help guide their expectations regarding speed-of-access to care, help them understand when to use urgent care and remind them L.A. Care can assist them with making appointment if needed. Education is conducted through member orientation, new member welcome calls, member newsletters, the Family Resource Center, and the L.A. Care website.

L.A. Care's Family Resource Centers continually encourage members to participate in orientation classes to learn how to navigate the health care system and further educate members regarding access to care

standards and our overall compliance with those standards. L.A. Care also educates members through the new member benefits package, the L.A. Care website, and the member newsletter.

Getting Care Quickly has a high correlation to member satisfaction. CAHPS results showed relatively flat performance on satisfaction for accessing appointments for routine and urgent care from 2013 to 2015. Results for Getting Care Quickly evidences this is a priority area where opportunities for improvement exist. Recent focus studies indicate that members are dissatisfied due to delays in getting an appointment with their provider and are often dissatisfied when they are seen by providers other than their regular provider.

Members of the Joint Performance Improvement Collaborative and Physician Quality Committee noted that member dissatisfaction with wait time is often due to members' perception of timeliness. The Joint Performance Improvement Collaborative and Physician Quality Committee agreed that clear communication with the member, along with member education, can help manage member expectations. Another physician noted that the adoption of electronic health records is helpful in tracking wait times to identify reasons for delays and areas for improving member satisfaction.

L.A. Care publishes Member Newsletters biannually that contain educational materials for members including, but not limited to, access to care issues. Provider Newsletters are also published three times a year and include educational materials and tips on accessing care. Members of Executive Community Advisory Committee recommend that L.A. Care members call the doctor's offices in advance to find out if their provider is on time or is running behind schedule. This way, members will know what to expect when they arrive at the provider's office.

How Well Doctors Communicate impacts members' overall satisfaction and has remained consistent over the three year period from 2013 to 2015 with slight upward movement. The Cultural and Linguistic Department reported that literacy; language and cultural barriers are inherent in the L.A. Care populations and cause frustration often resulting in member dissatisfaction surrounding access to care and/or the customer service they receive from their provider. Focus studies show that members with complex medical needs are frustrated with their experiences and believe they are receiving low-quality medical coverage. Members have reported frustration and suggest that office staff receive training on how to treat and communicate with people of different cultures and ethnicities. Members report that they are unaware of free interpreting services although this is highly promoted to the L.A. Care members. The Cultural and Linguistic Department does provide various courses which are designed to facilitate provider/staff and member communication as well as courses specifically for cultural competence and the importance of quality customer service.

The Member Quality Service Committee (MQSC) noted that the CAHPS Adult Medicaid 5.0H survey instrument only rates the "personal doctor" rather than the "personal doctor's staff". Often the members' first point of contact in the provider office is with the staff, and it is not uncommon for members to be treated by the physician extenders, with whom they have their primary relationship. The implementation of a clinical and group survey will provide L.A. Care with a further insight into the members' relationship with the physician office staff.

OPPORTUNITIES

Findings and conclusions in this report are based on our analysis of available data, survey and focus group findings and discussions at the various quality committees, such as the Member Quality Service, Joint Performance Improvement Collaborative/Physician Quality and , Quality Oversight Committees. These committees include an internal cross-departmental representation from departments, such as Quality Improvement, Medical Management, Health Education, C&L, Behavioral Health, Clinical Assurance,

Grievances and Appeals, Provider Network Operations, Marketing and Communications and Leadership. There is also external representation from the Joint Performance Improvement Collaborative/Physician Quality Committee, delegated health plans and provider groups. Opportunities for improvement are determined based on conclusions drawn from these meetings. Overall findings include:

- Based on review of the combined complaints data, along with the CAHPS Getting Needed Care and Getting Care Quickly Composites and Access to Care Survey results, Access to Care was identified as the priority area to focus opportunities for improvement.
- Approximately 50% of Access to Care complaints are regarding delays in service, delays in authorizations, and delays in getting appointments with specialists. These delays in service can be reflected in the member's overall CAHPS scores in rating the health plan who authorizes services, the PCP who submits authorizations and the treating specialists.
- There is further evidence in the increasing practitioner to member ratio reported increasing year over year. This is partly due to rapid membership growth and the specialist network not keeping pace with this growth rate. This membership growth is projected to continue to increase at a faster pace than the addition of provider groups.
- It is also recognized that member perception of timeliness can result in complaints and lower results on the CAHPS survey. The Access to Care Survey indicates that L.A. Care, in most instances, does comply with the appointment timeliness and provider availability standards.
- There are common themes in both CAHPS results and the grievance data that indicate that the Getting Needed Care and Getting Care Quickly CAHPS results align with the Access to Care complaints. The CAHPS findings for How Well Doctors Communicate align with complaints regarding Attitude and Service, including language barriers. Improvement in the overall CAHPS scores is reliant upon improvements in all of these areas.

SECTION 5: L.A. CARE COVERED™ CAHPS SURVEY RESULTS AND ANALYSES

BACKGROUND

METHODOLOGY

The 2015 Qualified Health Plans (QHP) Enrollee Experience Survey was conducted by DSS Research (DSS), an NCQA-certified vendor contracted by L.A. Care Health Plan (L.A. Care).

The 2015 Qualified Health Plans (QHP) Enrollee Experience Survey targeted potential respondents who are 18 years and older as of the anchor date of December 31, 2014, who were continuously enrolled in L.A. Care Covered™ (LACC) for at least five of the last six months of the measurement year and who were still enrolled at the time of the survey. A total of 1,000 surveys were mailed and a total of 242 or 31.8% were completed.

RESULTS

The QHP Enrollee Experience survey includes the following four general overall rating questions designed to distinguish among important aspects of care. Overall ratings are single-question measures rating services on a scale from 0 (worst) to 10 (best) services possible. Response options for rating satisfaction ranged from 0 (worst) to 10 (best). Thus, in the NCQA scoring for overall ratings used in the table below, only ratings of 8, 9 or 10 are considered favorable, and the achievement score is presented as a percentage of members whose response was favorable. NA indicates those measures with insufficient eligible respondents to report.

Overall Rating	LACC Score 2015	DDS Average	Bronze Average
Health Plan	47.3%	52.0%	43.2%
All Health Care	60.8%	72.3%	57.3%
Personal Doctor	74.4%	85.7%	70.7%
Specialist Seen Most Often	83.9%	83.0%	NR*

*NR-Not reported

Quantitative Analysis

- Health Plan Overall: L.A. Care's score was lower than the DSS Average but above the Bronze Average.
- All Health Care Rating: L.A. Care's score was greater than 10 percentage points below the DSS Average but exceeded the reported Bronze Average.
- Personal Doctor: L.A. Care's score was greater than 10 percentage points below the DSS Average but exceeded the reported Bronze Average.
- Specialist Seen Most Often: L.A. Care's score was slightly higher than the DSS Average and rating for the Bronze Average was NR.

Composites are indices calculated from multiple QHP Enrollee Experience survey questions. Questions within each composite ask members how often a positive service experience occurred in the past six months. Respondents have the option to select from “never”, “sometimes”, “usually” and “always”. The scores for composite scores and survey questions throughout this report reflect the percent of responses indicating “usually” or “always”.

Composite Scores	LACC Score 2015	DDS Average	Bronze Average
Access to Care	62.3%	79.7%	54.2%
Access to Information	41.9%	56.2%	47.1%
Cultural Competence	56.3%	71.4%	57.2%
Care Coordination	55.4%	87.6%	48.2%
Plan Administration	68.1%	79.0%	67.0%
How Well Doctors Communicate	89.0%	94.5%	88.2%

Quantitative Analysis

- Access to Care: L.A. Care's score was lower than the DSS Average and exceeded the Bronze Average.
- Access to Information: L.A. Care's initial score was lower than the DSS and Bronze level averages.

- Cultural Competence: L.A. Care's score was 15 percentage points lower than the DSS Average and just slightly below the Bronze Average.
- Care Coordination: L.A. Care's score is significantly lower than the DSS Average but exceeded the Bronze Average.
- Plan Administration: L.A. Care's score is lower than the DSS Average but slightly exceeded the Bronze Average.
- How Well Doctors Communicate: L.A. Care's score is lower than the DSS Average and slightly exceeded the Bronze Average.

Qualitative Analysis

The following provides a qualitative analysis of member satisfaction derived from the quantitative analysis of combined complaints and CAHPS data, as well as feedback from, but not limited to, committee discussion and focus groups.

Billing and Finance: Balance billing or charging a member for services is the number one reason for member complaints. Balance billing contributed to a 200% increase in this category of complaints in 2015. Uncertainty regarding benefits and confusion by members and providers led to the increased complaints. Premium billing continues to be a serious issue for the LACC members.

Through discussion and feedback the following have been identified as possible contributing factors resulting in member dissatisfaction:

- Confusion in the marketplace on new products being introduced with passive and involuntary enrollment confusing to both members and providers.
- Lack of understanding in billing and finance by all parties resulted in members being billed for covered services.

In 2015 L.A. Care undertook several activities to establish the root cause and implemented interventions to remedy the issues. The detailed analysis, not only complaint data but claims and authorization data were used to identify specific providers, conditions and services that were contributing to this issue. Based on this analysis focused education was developed targeting those providers who had two or more occurrence, as well as sharing the education with Physician Groups and Primary Care Providers. Additionally a newsletter education piece targeting reimbursement and billing issues was developed for both provider and member newsletter articles. Finally, a tracking and monitoring system has been instituted to document improvement.

SECTION 6: MEMBER SATISFACTION (CAHPS) (CAL MEDICONNECT)

BACKGROUND

L.A. Care Health Plan demonstrates its commitment to improving member satisfaction through an annual assessment of all complaints and appeals, as well as the results from the 2015 Medicare CAHPS 5.0 Member Survey. Results are trended over a three year period. This report contains a quantitative analysis, followed by a qualitative analysis; selection of the top priorities among opportunities identified for improvement and measured effectiveness, where available. The survey is conducted by DSS Research, an NCQA certified vendor. DSS Research conducts key driver statistical modeling to assist L.A. Care in selecting priority measures to target improvements.

The Member Quality Service Committee (MQSC) is the cross-departmental multidisciplinary committee responsible for identifying quality improvement needs, and reports its findings and recommendations to the Quality Oversight Committee (QOC). Information in this report is based on the analysis of available data

and survey, as well as discussions at the Quality Oversight and Joint Performance Improvement Collaborative (PICC) and Physician Quality (PQC) Committees.

OBJECTIVE

- Evaluate all registered SNP member complaints and appeals for the Medicare Advantage SNP product.
- Evaluate the 2015 Medicare CAHPS 5.0 survey results
- Conduct a quantitative and qualitative analysis from combined complaints, appeals and CAHPS data.
- Prioritize areas for improvement based on findings.
- Measured effectiveness of priority interventions.

ACCOMPLISHMENTS:

Received approval to implement a customer service telephone survey.

MAPD CAHPS 5.0 RESULTS

METHODOLOGY

This report summarizes findings of the 2015 MAPD CAHPS 5.0 survey. The MAPD CAHPS Survey targeted potential respondents who are Cal MediConnect (CMC) members ages 18 and above on the anchor date of December 31, 2014, who were continuously enrolled in L.A. Care Health Plan Medicare Advantage (MA) for at least 6 months as of the anchor date with no more than one enrollment gap of 45 days or less, and who remained members on the anchor date and the date they were actually surveyed. A total of 1,410 surveys were mailed and a total of 274 were completed for a 20.9% response rate.

GOAL

L.A. Care met goals for Overall Rating of Personal Doctor. Goals are determined using the NCQA sliding scale for Improvement, as well as analysis of historical performance. L.A. Care did not meet the goals for remaining overall or Composite Scores.

Overall Ratings	Score	Goal	Met
Health Plan	79%	80%	N
Health Care Received	80%	82%	N
Personal Doctor	NA	91%	NA
Specialist Seen Most Often	NA	89%	NA
Rx Drug Coverage	82%	82%	Y

Composite Ratings	Score	Goal	Met
Health Plan Customer Service	82.7%	86%	N
Getting Needed Care	NA	82%	NA
Getting Care Quickly	68%	74%	N
Doctors Who Communicate Well	NA	93%	NA
Getting Needed Prescription Drugs	NA	92%	NA
Getting Information from the Plan about Rx Drug Coverage	NA	79%	NA

OVERALL SCORES

The CAHPS survey includes the following five general overall rating questions designed to distinguish among important aspects of care. These questions ask CMC enrollees to rate their experience in the past 6 months. Response options for rating satisfaction ranged from 0 (worst) to 10 (best). The NCQA scoring for overall ratings used in the table below, ratings of 7, 8, 9 or 10 are considered favorable, and the achievement score is presented as a percentage of members whose response was favorable.

Overall Ratings	2015 Score
Health Plan	79%
Health Care	80%
Personal Doctor	NA
Specialist Seen Most Often	NA
Rx Drug Coverage	82%

*NA low responses or low reliability

- For the 2015 overall ratings, the goal was not met for Rating of the Drug Plan with a rate of 82%, which equaled the goal. The goal was also not met for Rating of Health Care Received.

COMPOSITE SCORES

The CAHPS survey asks respondents about their experience with various aspects of their care. Survey questions are combined into “composites”. Questions within each composite ask members how often a positive service experience occurred in the past six months. Respondents have the option to select from “never”, “sometimes”, “usually” and “always”. The scores for composite scores and survey questions throughout this report reflect the percent of responses indicating “usually” or “always”. Composite ratings analyzed include Health Plan Customer Service, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Health Care Services and Getting Needed Prescription Drugs.

Composite Scores	2015 Score
Health Plan Customer Service Information/Help	82.7%
Getting Needed Care	NA
Getting Appointments and Care Quickly	68%
Doctors Who Communicate Well	NA
Getting Needed Prescription Drugs	NA
Getting Information from the Plan about Rx Drug Coverage	NA

*NA low responses or low reliability

- For 2015 composite ratings goals were not met for Customer Service and Getting Appointments and Care Quickly. Other composite categories could not be analyzed due to ratings of NA low responses or low reliability.

IDENTIFYING PRIORITY AREAS FOR IMPROVEMENT

Based on the quantitative analysis of complaints and CAHPS results, as well as DSS key driver statistical modeling, the following items have been identified as the priority areas on which to drive the overall health plan rating.

- Overall ratings
 - Health Care
 - Personal Doctor
 - Specialist
 - Prescription Plan
- Customer Service
 - Gave Information/Help Needed
 - Treated with Courtesy/Respect
- Getting Needed Care
 - Easy to See Specialist
 - Got Needed Care, Tests or Treatment
- Additional questions
 - Got Dr. you are happy with
 - Pharmacist explained how to take medications
- Doctors Who Communicate Well
 - Provides clear explanations
 - Listens carefully
 - Shows respect
 - Spends enough time
- Getting Appointments and Care Quickly
 - Urgent care
- Technology
 - Use of computer/handheld device made it easier to talk to doctor

SECTION 7: QUALITATIVE ANALYSES AND KEY DRIVERS

The following provides a qualitative analysis of member satisfaction derived from the quantitative analysis of combined complaints and CAHPS data, as well as feedback from, but not limited to, committee discussion and focus groups.

Health Plan Customer Service Information/Help

Although member complaints do not evidence member dissatisfaction with the health plan customer service, CAHPS scores indicate that there is opportunity for improvement. Based on key driver statistical modeling conducted by DSS, the most important areas to focus for improvement in health plan customer services are in getting needed care and courtesy and respect.

The following have been identified as contributing factors to ratings of member satisfaction with health plan customer service:

- Supplemental data provided from CAHPS respondents indicates that the two top reasons for their rating is that the customer service agent listened but did not help solve the problem, followed by the agent provided suggestions rather than resolution for how to resolve their issue.
- Member feedback indicates inconsistency of information; long hold times, multiple transfers, communication and customer service treatment at various touch points of the organization.
- Internal customer service training is limited to the Member Services Department. Other areas such as Utilization Management, Claims and Pharmacy handle customer calls but do not have the benefit of the ongoing customer service training.
- Quality oversight of customer service is only in place in the Member Services Department.
- Multiple touch points through transfer of calls and call back can cause member confusion and dissatisfaction.
- L.A. Care's expansion over the past several years has provided a challenge to staff of keeping pace with membership growth.

L.A. Care continues to hire additional staff for the call center to support the increased call volume. Member Services performs an internal Quality Review Audit for 100% of the Medicare calls in the unit. Quarterly refresher trainings are in place for Coverage Determination (Part D), Grievance and Appeals for Coverage Determination (Part D), Organizational Determination (Part C), Grievance and Appeals for Organizational Determination (Part C), and Disenrollment and Sales Allegations.

L.A. Care's Member Services Department has Member Service Specialist/Navigators who are responsible for resolving member coordination of care for complex cases which may involve benefit coordination, continuity of care, access to care, quality of care issues, member eligibility, assignment and disenrollment issues. The specialist/navigator ensures proper and timely handling of member issues.

Access to Care

Approximately 50% of the Access to Care complaints are regarding delays in service, delays in authorization, and specialty access/availability. An analysis of CAHPS composite scores for Getting Needed Care and Getting Care Quickly was conducted to further understand the causes of member dissatisfaction complaints. Based on key driver statistical modeling conducted by DSS, the most important areas to focus for improvement in access to care are in getting routine care, getting seen within 15 minutes of appointment, and getting an appointment with a specialist.

Through discussion and feedback, the following have been identified as possible contributing factors to the members' ratings of access to care:

- An inherent shortage of specialists, especially at the provider group level. L.A. Care does meet the provider to member ratio for the overall network but perhaps there is opportunity for improvement at the delegate level.
- Actual delays in timeliness of processing authorizations.
- Delays with the authorization process due to practitioners submitting incomplete or incorrect requests to the authorizing party resulting in delays and multiple calls for clarification of the request for additional information.
- Limited oversight of delegate's authorization processes.
- Member perception of timeliness.
- Transportation issues traveling to provider offices.

Provider Network Operations examines the individual specialty networks of contracted provider groups quarterly and informs them of any deficiencies in their network. Furthermore, individual attention is paid to referrals to out of network specialists on an as-needed basis in order to ensure member s' needs are continually met.

L.A. Care continually provides education for members to help guide their expectations regarding speed-of-access to routine care, help them understand when to use urgent care and remind them L.A. Care can assist them with making appointment if needed. Education is conducted through member orientation, new member welcome calls, member newsletters, the Family Resource Center, and the L.A. Care website.

L.A. Care's UM team does work closely with the contracted provider groups to encourage usage and promotion of improved programs, such as a direct referral process or auto authorizations. Delegates are monitored through the quarterly utilization management reports where trends are identified and reported to the QOC for advisement.

Medicare Part D

Complaints data evidences billing issues and denial of prescriptions as the source of member complaints regarding their Rx coverage. The CAHPS questions comprising the Medicare Part D CAHPS results provided below provides a clearer indication of issues surrounding members' assessment of pharmacy services.

Based on key driver statistical modeling conducted by DSS, the most important areas to focus for improvement in pharmacy services are in getting information about Rx Drugs from the plan, being treated with courtesy/respect from health plan, understanding which prescriptions are covered, ease of using the plan to get Rx and ease of filling Rx at Pharmacy.

Through discussion and feedback, the following have been identified as contributing factors to the CAHPS results for Medicare Part D:

- CAHPS respondents reported that customer service agents listen and are courteous but do not help solve the problem when calling the plan about a denial of Rx medications, followed by the agents providing suggestions for how to resolve the complaint rather than solve it. This is consistent with the customer service health plan score.
- Members report satisfaction with the plan's drug coverage but they are unclear about what prescriptions are covered. CAHPS respondents reported that the number one reason they have problems getting their prescriptions is that the Rx their doctor prescribes is not covered by the health plan.
- Calls regarding pharmacy issues that are not easily resolved are closed out by the Member Services Department and sent to the Pharmacy Department who, in turn, has to call the member resulting in delay in resolution.
- Pharmacy customer services calls are not handled by trained customer service staff.
- Pharmacy staff not keeping pace with membership growth to handle calls timely.
- CAHPS members report prescriptions not covered, wait time for prescriptions and transportation are the three top issues with pharmacies. Members do report that they prefer to get prescriptions by mail.

L.A. Care has a step therapy program that takes members through a 90 day transition period. L.A. Care also has pharmacy representatives available 24 hours per day, 7 days per week to address any questions or concerns members may have about their drug plan.

The Member Services Department has implemented an internal Quality Review Audit for 100% of the Medicare calls in the unit. Quarterly refresher trainings started at the same time on Coverage Determination (Part D), Grievance and Appeals for Coverage Determination (Part D).

SECTION 8: MEMBER SERVICES TELEPHONE ACCESSIBILITY

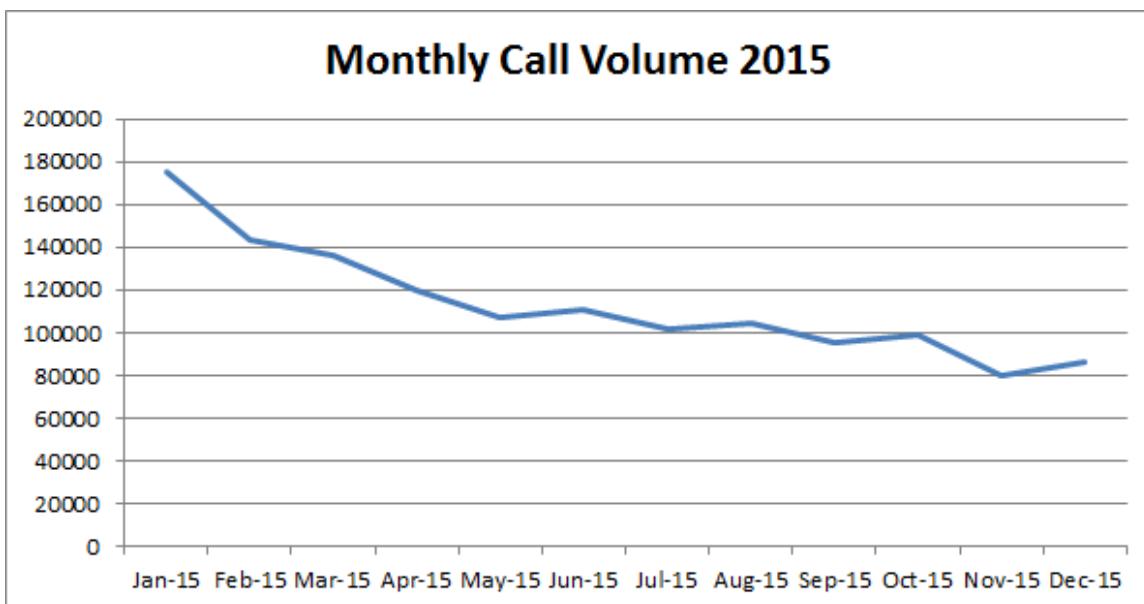
METHODOLOGY

In order to measure member services telephone accessibility across all lines of business (Medi-Cal, Medicare and the Marketplace), L.A. Care uses a telephone system called CISCO. The system collects and reports telephone statistics that the Member Services Department uses to create reports. The system counts all incoming calls as the denominator and all calls abandoned. The table and chart below compare L.A. Care's telephone accessibility for 2013, 2014, and 2015 performance goals.

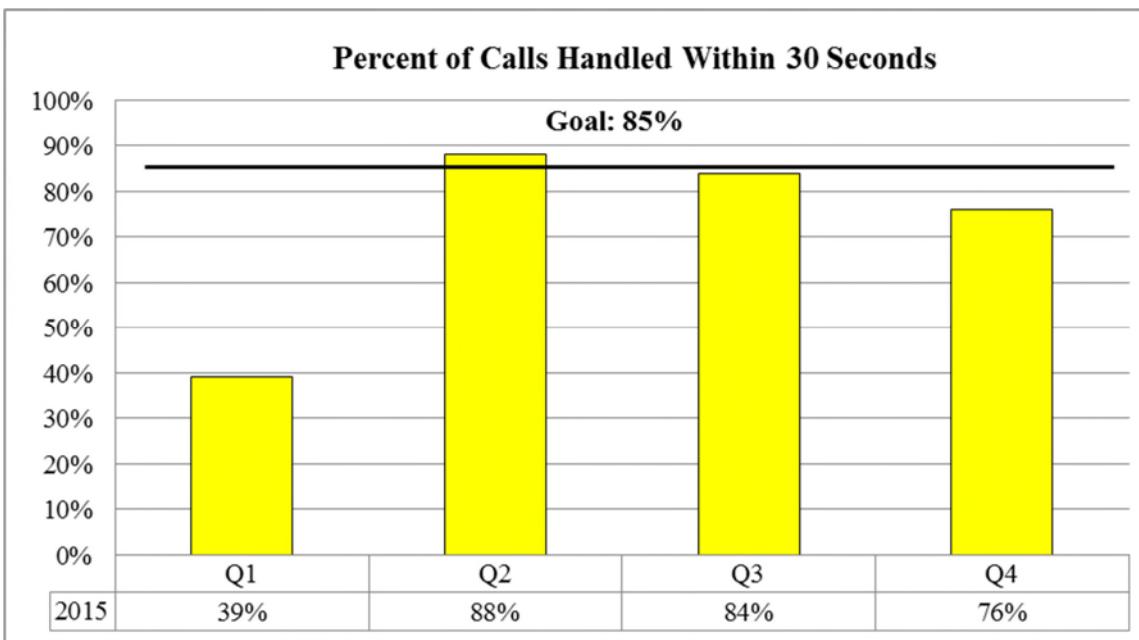
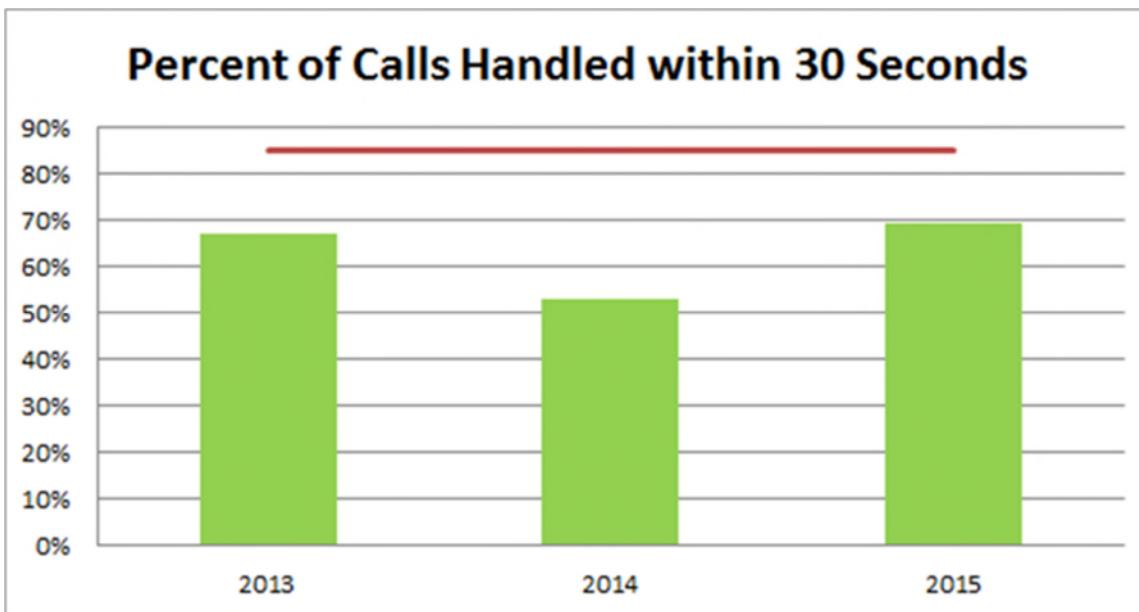
RESULTS

Member Services Telephone Accessibility Compliance Results					
Measure	Goal	2013	2014	2015	Goal Met
Call Abandonment Rates	Below 5 %	1.87%	3.05%	3.12%	Yes
Percent of Calls Handled within 30 Seconds	85%	67%	53%	69%	No

The chart below outlines an overview of member services monthly call volume:



The charts below outline a compliance rate comparison of the calls answered within 30 seconds:



Quantitative Analysis

- The member services call center met the call abandonment goal of less than 5%.
- The goal of 85% of call handled within 30 seconds was not met in 2013, 2014 or 2015. The rate increased from 53% in 2014 to 69% in 2015.

Qualitative Analysis

L.A. Care experienced tremendous growth throughout 2015 as a result of the implementation of the Affordable Care Act and Medicaid Expansion; membership grew by 13.6% in 2015 compared to 2014. There has already been an increase of over 100,000 members since the beginning of 2015. Call volume

increased substantially as individuals began accessing health care for the first time. Compared to 2014's 1st and 2nd quarter, call volume has increased from an average of approximately 4,800 calls per day to 7,500 calls per day during the 1st quarter and an average of 3,800 calls per day to 5,300 calls per day during the 2nd quarter. Calls answered \leq 30 seconds goals were not met in Q1 and Q2 for Medi-Cal only. Only LACC Q2 goal was met and for CMC, goal was met for Q2, Q3, and Q4. In addition, Ansafone continues to provide support by handling the Provider Line during business hours with the exception of LACC. Call Center Management worked closely with Appeals and Grievances, to revamp the Grievance intake and call handling processing as of June of 2015 in order to comply with deficiencies found in the DMHC/DHCS audit. As a result, the Member Service Representative time off the telephones increased. To support the growth of the programs, L.A. Care hired a total of 62 Member Services Representative in 2015 that went through an 8 week training course. However, the Call Center also lost a total of 41 Member Services Representatives, and had an increase in staff utilizing personal leaves; approximately 30 in total.

LOOKING FORWARD

Because of L.A. Care's continuous growth, L.A. Care continues to hold new hire training classes, and in 2015 worked closely with Human Resources to launch a pilot program in January 2016 that introduces Cohort students to L.A. Care Health Plan. This pilot is designed to fulfill Call Center staffing as needed to help meet daily goals.

Additionally, the CISCO telephone/ACD system has been enhanced to improve call routing and reporting capabilities. The NICE new recording software was also implemented to enhance existing quality review process and the new Work Force Management tool that was scheduled to launch early 2016, is now scheduled for implementation before the end of the year. The Workforce Management tool will provide staff automated capability to monitor peak times and appropriately assign staff to meet call volume needs to achieve performance standards. These system and staffing updates, will aid the Call Center in increasing and meeting stats. In addition, a goal for 2016 is to also reroute the Provider Line back to L.A. Care so that these calls are handled in L.A. Care's Call Center.

SECTION 9: CONCLUSIONS AND MEASURING EFFECTIVENESS

L.A. Care Health Plan serves Los Angeles County's low-income and vulnerable residents. Access to quality healthcare is a challenge for everyone and even more so for individuals with limited English proficiency and low literacy levels combined with complex medical conditions. L.A. Care seeks to provide the highest quality service and access to quality healthcare for this traditionally underserved population.

Problems often have more than one cause, and solutions often have limited scopes of effectiveness. Therefore, mixed solutions work best. So L.A. Care departments design and launch multiple interventions. Focusing on a few feasible targets and launching several interventions over longer, more workable periods of time is a proven strategy under these conditions. This is also the best strategy to increase the likelihood that some combination of these interventions will significantly improve satisfaction scores, and hence improve the quality of services that L.A. Care staff and providers give to our members.

The Member Quality Service Committee (MQSC) is tasked with analyzing and identifying action initiatives for improving member satisfaction.

Based on careful analysis of all themes of results, the following action steps and ongoing improvements are established.

Opportunity	New and/or Ongoing	Action(s) Taken	Measurement of Effectiveness
PRIORITY #1	Improve member's access to care through stronger collaboration with delegated PPGs <ul style="list-style-type: none"> • Access to specialty care • Care, tests and treatment 		
Collaborate with delegated provider groups to improve Access to Care	Ongoing	In 2016, L.A. Care will be visiting with targeted provider groups to discuss outcomes of the Access to Care Study and opportunities for collaborative interventions for improvement.	<ul style="list-style-type: none"> • Improved CAHPS Scores for getting needed care and getting care quickly • Decreased complaints regarding access to care
PRIORITY #2	Improve member's access to care through stronger collaboration with delegated plans <ul style="list-style-type: none"> • Access to specialty care • Care, tests and treatment 		
Collaborate with sub-contracted health plans, provider groups and select network physicians to improve Access to Care	Ongoing	In 2016, L.A. Care will continue restructure of committees to develop the Performance Improvement Collaborative Committee, comprised of L.A. Care's network of sub-contracted health plans, provider groups and select physicians. A focus in 2016 will be to strategize on collaborative initiatives to improve access to care to members.	<ul style="list-style-type: none"> • Improved CAHPS Scores for getting needed care and getting care quickly • Decreased complaints regarding access to care
PRIORITY #3	Improve member satisfaction with customer service <ul style="list-style-type: none"> • Help needed from customer service • Courtesy and respect 		
Improve Health Plan Customer Service Project	New	<p>In 2015 Member Services Specialists/Navigators are responsible for resolving member coordination of care for complex casers which may involve benefit coordination, continuity of care, access to care, quality of care issues, member eligibility, assignment and disenrollment issues:</p> <ul style="list-style-type: none"> • Improved service: Knowing that services are being evaluated by members may result in behavioral change. • Added member service: Providing the members an opportunity to have someone call them back provides better service and provides us an opportunity to resolve any open issues the member may have. • Data collection: Survey results provide us information on why members feel they are not 	<ul style="list-style-type: none"> • Results of CAHPS surveys in Spring 2016 • Results from survey to measure improvement month over month

Opportunity	New and/or Ongoing	Action(s) Taken	Measurement of Effectiveness
		getting information they need or not treated.	
PRIORITY #4	Improve member's access to specialty care through educating members about the referral/authorization process <ul style="list-style-type: none"> a. Getting care, tests and treatment b. Access to specialty care 		
Getting Needed Care Project	New	In September 2015 a workgroup developed an easy to read educational material that informs members about L.A. Care's specialty care referral process. The intervention was designed with direct line of business members in mind. The education sheet, in English and Spanish, will be distributed to members, providers, and PPGs through multiple modalities.	Improved member satisfaction and CAHPS scores in the following Questions: <ul style="list-style-type: none"> • Q25: Always or usually easy to get an appointment with a specialist • Q14: Always or usually get care, tests, or treatments • Decreased complaints regarding access to care
PRIORITY #5	Improve member experience with office visit <ul style="list-style-type: none"> • Doctor explains in easy/understandable way • Courtesy and respect 		
Letter to members from their assigned PCPs	New	In early 2016, a letter is being sent to Medi-Cal households from their PCP office explaining how they can work as a team to enhance the office visit with the goal of better preparing the member for their visit, improving communication.	Improved member satisfaction and CAHPS scores in provider communication: <ul style="list-style-type: none"> • Q32: Always or usually explains things, easy to understand • Q33: Always or usually listens carefully to you
Improve access to specialty care Improve efficiency by decreasing unnecessary specialist visits	New	In April 2016 will launch eManagement program allowing PCPs to send, via electronic communication, specific data on their patients to a Psychiatrist. Using eManagement, a primary care physician can discuss a patient's condition with a specialist via a referral exchange available through the internet. Treatment instructions can be relayed to the primary care physician eliminating the need to schedule a specialist appointment.	The program goal of implementing eConsult at 180 sites by December 31, 2013 is on track. Discussions are underway for the next phase of the program on expanding service to additional L.A. Care members.
Educate providers/offices on improving customer services	Ongoing	<ul style="list-style-type: none"> • An ongoing program offering in-office Customer Service training provided by Provider Network Operations. 	

Opportunity	New and/or Ongoing	Action(s) Taken	Measurement of Effectiveness
		<ul style="list-style-type: none"> • Newsletter articles in Progress Notes about effective communication and educating providers/staff about • Distribute timely access standards to providers annually 	

B.2 ACCESS TO CARE

BACKGROUND

L.A. Care Health Plan monitors its practitioner network accessibility annually to ensure all members have adequate access to primary care, specialty care, and behavioral health care (where appropriate). An annual access to care assessment is conducted, which measures member Appointment Availability and After Hours Care. The Appointment Availability portion of the 2015 survey was conducted by Call Logic as part of the Health Industry Collaboration Effort, Inc. (ICE). SPH Analytics (formerly The Meyers Group), an independent NCQA-certified research firm, conducted the 2015 After Hours portion of the survey. L.A. Care contracted with both 3rd party survey vendors to measure how well practitioners are adhering to L.A. Care's established access to care standards. Opportunities for improvement are identified, prioritized and acted upon on an annual basis. The annual behavioral health accessibility analysis is conducted by L.A. Care's contracted NCQA accredited Managed Behavioral Health Organization (MBHO).

SECTION 1: APPOINTMENT WAIT TIMES

METHODOLOGY

Results are collected using a phone-only survey methodology from August through December of 2015. Primary Care Physicians (PCPs) and DMHC required specialty type offices are contacted to assess many aspects of practitioner accessibility, including the next available appointment dates.

The following Appointment types are measured in the 2015 survey:

PCP:

- Urgent (no authorization required)
- Urgent (authorization required)
- Non-urgent (routine primary care) appointments
- Routine well care physical exam
- First prenatal appointment
- In-office Wait Times

SCP:

- Urgent (no authorization required)
- Urgent (authorization required)
- Non-urgent (routine specialist) visit
- First prenatal appointments
- In-office Wait Times

L.A. Care submitted a complete database of L.A. Care's network of primary care and specialty care practitioners to the survey vendor. The database was de-duplicated based on provider's full name and address. Using address and phone number, up to five practitioners will be rolled up into one record.

Results from the Appointment Availability Survey will be received in March 2016.

SECTION 2: PCP AFTER HOURS STUDY

BACKGROUND

Information obtained from the practitioner After-hours Access to Care assessment measures how well practitioners are adhering to L.A. Care's established access standards. Based on the response to each survey question and the access standard set, the provider is categorized as being either compliant or non-compliant. L.A. Care's provider network serves L.A. Care Covered (The Marketplace), Cal MediConnect (Duals Demonstration Pilot) and Medi-Cal, including PASC-SEIU Homecare Workers and Healthy Kids, product lines and established standards are consistent among all three product lines. All PCPs and DMHC specified and high volume designated specialists are surveyed.

METHODOLOGY

Results are collected using a phone-only survey methodology. The 2015 annual After Hours Survey was fielded in December of 2015. Provider offices are surveyed during closed office hours (early morning, evening, weekend or holiday hours).

L.A. Care Health Plan requires that PCP and specialists (SCPs), or their designated on-call licensed practitioners, be available to coordinate patient care beyond normal hours. To achieve after hours compliance, PCPs and SCPs must utilize one of the following systems and meet the requirements as outlined below:

A. Automated systems

- Must provide emergency instructions
- Offer a reasonable process to contact the PCP, SCP, covering practitioner or offer a call-back from the PCP, SCP covering practitioner, or triage/screening clinician* within 30 minutes
- If the process does not enable the caller to contact the PCP or covering practitioner directly, the “live” party must have access to a practitioner or triage/screening clinician for both urgent and non-urgent calls.

B. Professional exchange staff

- Must provide process for emergency calls
- Must have access to practitioner or triage/screening clinician* for both urgent and non-urgent calls.

**Clinical advice can only be provided by appropriately qualified staff, e.g. physician, physician assistant, nurse practitioner or registered nurse.*

L.A. Care submitted a complete database of L.A. Care’s network of primary care and specialty care practitioners to the survey vendor. The database was de-duplicated based on provider’s full name and address. Using address and phone number, up to five practitioners will be rolled up into one record.

The results of the 2015 annual survey will be delivered by March 2016.

UPDATE TO MY 2014 AFTER HOURS STUDY

L.A. Care conducted a re-survey of all providers found non-compliant for after-hours access in the MY 2014 survey. The survey was conducted to measure whether the interventions implemented by L.A. Care’s delegated Participating Physician Groups (PPGs) and captured in their Immediate Corrective Action Responses (ICARs) or Corrective Action Plans (CAPs) in response to the 2014 annual After Hours Survey were successful in improving practitioner compliance with L.A. Care’s After Hours standards.

The following table outlines the L.A. Care’s Overall After Hours (PCPs & SCPs) Access and Timeliness survey results for 2013 and 2014 (annual surveys):

Medi-Cal

PCP/SCP After Hours Access to Care Results to Goal Comparison			
Year	Medi-Cal Rate	Goal	Goal Met
MY 2013 Annual	70%	92%	No
MY 2014 Annual	66.3%	92%	No

PCP/SCP After Hours Access to Care Timeliness Results to Goal Comparison			
Year	Medi-Cal Rate	Goal	Goal Met
MY 2013 Annual	70%	92%	No
MY 2014 Annual	52.6%	92%	No

L.A. Care Covered

PCP/SCP After Hours Access to Care Results to Goal Comparison			
Year	LACC Rate	Goal	Goal Met
MY 2014 Annual (Baseline)	67.8%	92%	No

PCP/SCP After Hours Access to Care Timeliness Results to Goal Comparison			
Year	LACC Rate	Goal	Goal Met
MY 2014 Annual (Baseline)	53.9%	92%	No

Figure 1 below outlines results from the annual MY 2014 survey and MY 2014 resurvey (adjusted rates) for those PPG directly contracted with L.A. Care, along with the percentage of change since ICARs and CAPs were issued to the PPGs by L.A. Care in response to the MY 2014 annual survey results.

Figure 1

MEDI-CAL PPGs			MY 2014 After Hours PCP and SCP Final Survey Results (11/01/2014 - 9/16/2015)								
			Access			Timeliness Compliance			Overall Access Timeliness		
PPG Code	PPG Name	Providers (n)	Re-calculated Compliance Score (%)	Annual Compliance Score (%)	Variance (%)	Re-calculated Compliance Score (%)	Annual Compliance Score (%)	Variance (%)	Re-calculated Compliance Score (%)	Annual Compliance Score (%)	Variance (%)
AKM	AKM Medical Group (Cap Mgmt)	40	77.5	82.5	-5.0	75	52.5	22.5	60	40.0	20
AP	Allied Physicians IPA (Network Med. Mgmt)	413	78.93	68.0	10.9	70.7	50.9	19.9	58.84	37.3	21.55
AMHS	Altamed Health Services Corporation	257	67.32	57.6	9.7	70.04	47.9	22.2	53.31	32.7	20.63
AIPA	Angeles IPA, A Medical Corporation	312	83.97	75.0	9.0	73.72	51.0	22.8	66.03	43.9	22.12
AMGS	Applecare Medical Group St Francis	184	89.13	81.0	8.1	79.35	60.9	18.5	72.83	50.5	22.29
AXMG	Axminster Medical Group	24	91.67	25.0	66.7	83.33	62.5	20.8	79.17	20.8	58.34
BVMG	Bella Vista IPA (Medpoint Mgmt)	113	79.65	65.5	14.2	67.26	47.8	19.5	61.06	42.5	18.58
CVPG	Citrus Valley Physicians Group	162	83.95	71.0	13.0	72.84	57.4	15.4	69.14	46.9	22.23
CFC	Community Family Care	162	81.48	63.6	17.9	70.99	49.4	21.6	64.2	33.3	30.87
County	County Of L.A. Dept of Health Services	273	78.02	52.4	25.6	60.07	34.8	25.3	59.71	31.9	27.84
CRCM	Crown City Medical Group	44	70.45	59.1	11.4	68.18	50.0	18.2	56.82	34.1	22.73
EPDE	El Proyecto Del Barrio Inc	56	62.5	50.0	12.5	51.79	37.5	14.3	33.93	19.6	14.29
EHSG	Employee Health Systems Medical Group	505	83.17	71.1	12.1	71.49	48.9	22.6	64.75	39.0	25.74
ECMG	Exceptional Care Medical Group	217	83.87	67.3	16.6	65.9	47.0	18.9	59.91	36.9	23.04
FCS	Family Care Specialists Medical Group	74	71.62	56.8	14.9	78.38	68.9	9.5	60.81	39.2	21.62
GCMG	Global Care IPA (Medpoint Mgmt)	290	77.93	64.1	13.8	64.14	38.6	25.5	55.86	31.7	24.14
HCLA	Health Care LA, IPA (Medpoint Mgmt)	387	72.09	58.9	13.2	71.06	52.5	18.6	55.81	36.4	19.38
OMNI	Omnicare Medical Group	122	86.07	68.0	18.1	76.23	59.0	17.2	70.49	41.8	28.69
PVMG	Pomona Valley Medical Group	115	90.43	72.2	18.2	80	61.7	18.3	76.52	47.0	29.56
PIPA	Preferred IPA Of California	439	84.97	70.8	14.1	75.85	49.9	26.0	67.88	39.0	28.93
PROV	Prospect Medical Group	386	81.61	67.9	13.7	69.69	50.3	19.4	61.92	39.6	22.28
PH	Physicians Healthways Medical Group, Inc	327	90.52	74.0	16.5	76.76	52.6	24.2	71.87	40.7	31.2
SLMG	Seoul Medical Group	21	85.71	90.5	-4.8	85.71	66.7	19.0	76.19	61.9	14.29
SAMG	South Atlantic Medical Group	89	82.02	68.5	13.5	83.15	55.1	28.1	71.91	41.6	30.34
SC	Superior Choice Medical Group, Inc	27	77.78	66.7	11.1	51.85	25.9	25.9	44.44	25.9	18.51
APPL	Applecare Medical Group (Downey, Whittier and Select Region)	257	87.94	80.2	7.8	78.21	59.9	18.3	71.6	51.8	19.85
PPN	Pioneer Provider Network, A Medical Group, Inc	18	100	55.6	44.4	100	94.4	5.6	100	55.6	44.44
SEA	Seaside Health Plan	59	86.44	50.8	35.6	84.75	44.1	40.7	83.05	39.0	44.07
TMG	Talbert Medical Group	102	84.31	77.5	6.9	65.69	55.9	9.8	60.78	46.1	14.7
UCMG	Universal Care Medical Group	11	81.82	72.7	9.1	63.64	54.6	9.1	63.64	27.3	36.37
Total	Final Survey MCAL Direct LOB PPGs	3,981	81.85	66.30	15.6	72.43	52.62	19.8	65.10	39.1	26.04
L.A. CARE COVERED PPGs			Access			Timeliness			Overall Access Timeliness		
PPG Code	PPG Name	Providers	Re-calculated Compliance Score (%)	Annual Compliance Score (%)	Variance (%)	Re-calculated Compliance Score (%)	Annual Compliance Score (%)	Variance (%)	Re-calculated Compliance Score (%)	Annual Compliance Score (%)	Variance (%)
HCPM	Healthcare Partners Medical Group	1,111	74.44	62.2	12.2	72.37	54.5	17.91	55.72	35.4	20.35
HD	High Desert Medical Group	72	80.56	75.0	5.6	79.17	65.3	13.89	68.06	55.6	12.5
LAKE	Lakeside Medical Group	598	79.1	68.1	11.0	62.21	45.3	16.89	52.51	31.8	20.74
SIMG	Sierra Medical Group	46	69.57	65.2	4.3	69.57	56.5	13.05	58.7	43.5	15.22
REMG	Regal Medical Group	1,310	79.85	68.5	11.4	65.8	47.9	17.94	56.95	35.0	21.91
Total	Final Survey LACC Direct LOB PPGs	3,137	76.70	67.80	8.9	69.82	53.89	15.9	58.39	40.2	18.14

*CAP Only PPGs

*Some providers have multiple PPG affiliations. Providers may be counted more than once.

Although some improvement has been made in the Access and Timeliness measures as illustrated by improvements in the Medi-Cal and L.A. Care Covered (LACC) results outlined above, significant improvement is needed to meet L.A. Care's Overall Access to Care performance standards (92%)

compliance rate). The L.A. Care Covered product line was launched in late 2014, therefore, MY 2014 Annual Survey results will serve as baseline performance for those PPGs participating in the LACC line of business. The Cal MediConnect (CMC) product line began in 2014. There is a 100% crossover of participating provider networks between Medi-Cal and CMC; therefore, the Medi-Cal results are reflective of CMC product line. In MY 2015, L.A. Care will submit reporting for the CMC product line separately.

To support and facilitate continued improvement in After Hours access performance of L.A. Care's provider network, L.A. Care's Quality Improvement department has instituted a PPG Oversight and Monitoring process to measure PPG's provider network compliance with L.A. Care's After Hours standards on an ongoing basis. The process requires that all L.A. Care contracted PPGs audit practitioners found noncompliant in the MY 2014 After Hours Resurvey until they are compliant with the After Hours measures. PPG are required to submit to L.A. Care their audit results on a quarterly basis beginning January 2016 for 4th Q 2015. Once the MY 2015 After Hours Survey results are received in 2016, PPGs will be required to monitor practitioners found noncompliant in that survey until they are compliant using the same audit process.

In addition to the newly established Oversight and Monitoring process, L.A. Care has created and shared with the PPGs several resources to support their efforts to bring their networks into compliance. These resources include: *L.A. Care's Access to Care Quick Tips* document that can be distributed directly to practitioner offices; *Best Practices, Noncompliance Suggested Interventions* and *Access to Care FAQs* documents; along with working with PPG representatives to ensure their understanding of Access to Care regulatory requirements and L.A. Care's Access to Care performance standards.

B.3 NETWORK ADEQUACY

BACKGROUND

L.A. Care Health Plan (L.A. Care) conducts an annual analysis of its primary care and specialty care practitioner networks to ensure there are sufficient numbers and types of practitioners to effectively meet the needs and preferences of its membership. This network adequacy analysis includes practitioners and providers who participate in L.A. Care's Medi-Cal, L.A. Care Covered, and Cal MediConnect lines of business, providing services to members enrolled in these programs within defined geographic areas. L.A. Care has established quantifiable and measureable standards for both the number and geographic distribution of practitioners. Data that determines providers' compliance with these standards is collected and assessed and opportunities for improvement are identified and acted upon on an annual basis.

2015 WORK PLAN GOALS: Each section of this report contains specific quantifiable goals.

SECTION 1: MEDI-CAL PRACTITIONERS' NETWORK AVAILABILITY

METHODOLOGY

Primary care practitioners include Family Practice/General Medicine, Internal Medicine, Obstetrics/Gynecology and Pediatrics. High volume areas of specialty care are determined by the number of encounters within a specific timeframe. Based on the number of encounters received for the 12-month period from January 1, 2015 through December 31, 2015 of the study year, the five most utilized areas of specialty care include Obstetrics/Gynecology, Cardiovascular Disease, Gastroenterology, Ophthalmology and Orthopedics. Analysis of L.A. Care's Behavioral Health provider network is excluded from this report. The provision of Behavioral Health services and analysis of provider availability is delegated to an NCQA accredited Managed Behavioral Health Organization (MBHO).

PERFORMANCE STANDARDS

Performance standards are based on regulatory requirements, external benchmarks, industry standards, and national and regional comparative data. Availability standards are established for:

- PCP to Member Ratio = Total number of PCPs/Total Membership
- SCP to Member Ratio = Total number of SCPs for the specific specialty type (e.g., total number of ophthalmologists)/Total Membership
- PCP and SCP Drive Distance: MapInfo software is used to measure performance.

PERFORMANCE ASSESSMENT

As of December 2015 the total number of Medi-Cal members was 1,602,559. The 179,140 members assigned to Kaiser are excluded from this analysis as this function is delegated to Kaiser. This report measures Medi-Cal practitioner and provider availability for 1,423,419 non-Kaiser members. The report also measures practitioner and provider availability for 11,552 L.A. Care Covered members and 17,805 Cal MediConnect members.

Provider To Member Ratio Standards

Medi-Cal

Medi-Cal: Provider to Member Ratio Standard and Results					
PCP and Top 5 Specialty	Providers	Members*	P:M Ratios	Standard	Standard Met
PCP	3,453	1,602,559	1:486	1:2000	Yes
FP/GP	1,344	701,209	1:522	1:2000	Yes
IM†	1,186	323,851	1:273	1:2000	Yes
PED††	878	641,000	1:730	1:2000	Yes
SCP					
OB/GYN (PCP & SCP)**	370	883,088	1:2387	1:5000	Yes
CARDIOVASCULAR DISEASE	345	1,602,559	1:4645	1:5000	Yes
OTOLARYNGOLOGY	350	1,602,559	1:4578	1:5000	Yes
OPHTHALMOLOGY	340	1,602,559	1:4713	1:5000	Yes
ORTHOPEDICS	321	1,602,559	1:4993	1:5000	Yes

*Analysis does not include Kaiser Membership.

** Only female and age ≥ 11 years as of December 31, 2015 included to calculate practitioner to member ratios for OB/GYN.

†Members 17 and up used to calculate ratio.

††Members 18 and under used to calculate ratio.

L.A. Care Covered (LACC)

LACC: Provider to Member Ratio Standard and Results					
PCP and Top 5 Specialty	Providers	Members*	P:M Ratios	Standard	Standard Met
PCP	2,970	11,552	1:4	1:2000	Yes
FP/GP	1,267	6,613	1:3	1:2000	Yes
IM†	986	4,689	1:5	1:2000	Yes
PED††	707	370	1:1	1:2000	Yes
SCP					
OB/GYN (PCP & SCP)**	271	5,437	1:20	1:5000	Yes
CARDIOVASCULAR DISEASE	234	11,552	1:50	1:5000	Yes
GASTROENTEROLOGY	135	11,552	1:85	1:5000	Yes
OPHTHALMOLOGY	249	11,552	1:46	1:5000	Yes
OTOLARYNGOLOGY	69	11,552	1:167	1:5000	Yes

** Only female and age ≥ 11 years as of December 31, 2015 included to calculate practitioner to member ratios for OB/GYN.

†Members 17 and up used to calculate ratio.

††Members 18 and under used to calculate ratio.

Cal Medi-Connect (CMC)

CMC: Provider to Member Ratio Standard and Results					
PCP and Top 5 Specialty	Providers	Members*	P:M Ratios	Standard	Standard Met
PCP	2,503	17,805	1:8	1:2000	Yes
FP/GP	1,283	10,796	1:9	1:2000	Yes
IM†	1,054	6,842	1:7	1:2000	Yes
PED††	163	165	1:1	1:2000	Yes
SCP					
NEPHROLOGY	156	17,805	1:114	1:5000	Yes
CARDIOVASCULAR DISEASE	261	17,805	1:68	1:5000	Yes
GASTROENTEROLOGY	143	17,805	1:125	1:5000	Yes
OB/GYN	313	4,858	1:19	1:3000	Yes
OPHTHALMOLOGY	249	17,805	1:72	1:5000	Yes
PODIATRY	28	17,805	1:636	1:5000	Yes

** Only female and age ≥ 11 years as of December 31, 2015 included to calculate practitioner to member ratios for OB/GYN.

†Members 17 and up used to calculate ratio.

††Members 18 and under used to calculate ratio.

Provider to Member Geographical Distribution Standards

Medi-Cal

Medi-Cal: Provider to Member Geographical Distribution Standard and Results									
PCP and Top 5 Specialty	Average Distance			% of Members* with Access			Standard for Drive Distance	Standard for % of Members with Access	Standard Met
	2013	2014	2015	2013	2014	2015			
PCP	1	0.6	0.6	100	99.8	99.8	10 miles	95%	Yes
FP/GP	0.7	0.7	0.7	99.9	99.8	99.8	10 miles	95%	Yes
IM†	1	0.9	0.9	99.5	99.7	99.7	10 miles	95%	Yes
PED††	1	1	1	99.6	99.5	99.5	10 miles	95%	Yes
SCP									
OB/GYN (PCP & SCP)**	1.5	1.4	2.6	100	99.8	99.3	15 miles	90%	Yes
CARDIOVASCULAR DISEASE	2.7	2.5	2.7	99.0	99.4	99.6	15 miles	90%	Yes
OTOLARYNGOLOGY	3.5	2.87	2.9	99.2	99.6	99.19	15 miles	90%	Yes
OPHTHALMOLOGY	2.2	2.3	2.9	100	99.8	99.8	15 miles	90%	Yes
ORTHOPEDICS	2.2	2.2	3.0	99.0	99.3	99.3	15 miles	90%	Yes

*Analysis does not include Kaiser Membership.

** Only female and age ≥ 11 years as of December 31, 2014 included to calculate practitioner to member ratios for OB/GYN.

†Members 17 and up used to calculate ratio.

L.A. Care Covered (LACC)

LACC: Provider to Member Geographical Distribution Standard and Results									
PCP and Top 5 Specialty	Average Distance			% of Members* with Access			Standard for Drive Distance	Standard for % of Members with Access	Standard Met
	2013	2014	2015	2013	2014	2015			
PCP	N/A	N/A	2.10	N/A	N/A	99.8	10 miles	95%	Yes
FP/GP	N/A	N/A	2.34	N/A	N/A	99.8	10 miles	95%	Yes
IM†	N/A	N/A	2.45	N/A	N/A	99.7	10 miles	95%	Yes
PED††	N/A	N/A	2.35	N/A	N/A	99.5	10 miles	95%	Yes
SCP									
OB/GYN (PCP & SCP)**	N/A	N/A	2.9	N/A	N/A	99.9	15 miles	90%	Yes
CARDIOVASCULAR DISEASE	N/A	N/A	2.7	N/A	N/A	99.7	15 miles	90%	Yes
GASTROENTEROLOGY	N/A	N/A	3.3	N/A	N/A	99.6	15 miles	90%	Yes
OPHTHALMOLOGY	N/A	N/A	2.9	N/A	N/A	99.6	15 miles	90%	Yes
OTOLARYNGOLOGY	N/A	N/A	3.4	N/A	N/A	99.2	15 miles	90%	Yes

** Only female and age ≥ 11 years as of December 31, 2014 included to calculate practitioner to member ratios for OB/GYN.

†Members 17 and up used to calculate ratio.

Cal MediConnect

CMC: Provider to Member Geographical Distribution Standard and Results									
PCP and Top 5 Specialty	Average Distance			% of Members* with Access			Standard for Drive Distance	Standard for % of Members with Access	Standard met
	2013	2014	2015	2013	2014	2015			
PCP	N/A	N/A	0.6	N/A		99.8	10 miles	95%	Yes
FP/GP	N/A	N/A	0.7	N/A	N/A	99.8	10 miles	95%	Yes
IM†	N/A	N/A	0.9	N/A	N/A	99.7	10 miles	95%	Yes
PED††	N/A	N/A	1.0	N/A	N/A	99.5	10 miles	95%	Yes
SCP									
GASTROENTEROLOGY	N/A	N/A	1.4	N/A	N/A	99.8	10 miles	90%	Yes
CARDIOVASCULAR DISEASE	N/A	N/A	3.4	N/A	N/A	99.8	10 miles	90%	Yes
NEPHROLOGY	N/A	N/A	3.06	N/A	N/A	99.98	15 miles	90%	Yes
OB/GYN	N/A	N/A	2.1	N/A	N/A	99.8	15 miles	90%	Yes
OPHTHALMOLOGY	N/A	N/A	2.3	N/A	N/A	99.8	15 miles	90%	Yes
PODIATRY	N/A	N/A	2.2	N/A	N/A	99.8	10 miles	90%	Yes

** Only female and age ≥ 11 years as of December 31, 2014 included to calculate practitioner to member ratios for OB/GYN.

†Members 17 and up used to calculate ratio.

Quantitative Analysis

Provider To Member Ratios:

All PCP and high volume specialist ratio standards were met for the Medi-Cal, L.A. Care Covered and Cal MediConnect lines of business.

Member Drive Distance:

- L.A. Care met the standards for drive distances for all PCP types for its Medi-Cal, L.A. Care Covered and Cal Medi-Connect lines of business.
- L.A. Care also met the standards for drive distances for high volume SCPs for each of the three lines of business.

Qualitative Analysis

L.A. Care performs systematic monitoring of its primary and specialty care network and produces quarterly reporting to identify deficiencies within its Medi-Cal, L.A. Care Covered (LACC) and Cal MediConnect (CMC) networks. The organization continues to focus on strategies to ensure a robust network sufficient to provide primary and specialty care services across all managed care programs. L.A. Care places particular emphasis on monitoring its PPGs' specialty networks for the inclusion of highly utilized specialties.. Although the organization continues to expand its specialty network, it remains challenging to meet the access demands so clearly impacted by the significant increase in the number of Medi-Cal enrollees over the last few years. The number of Medi-Cal enrollees increased by 11% in 2013, by 27% in 2014, and by 8% in 2015. Although the 2015 Medi-Cal membership increase is not as dramatic as in previous years, physician shortages in specific areas of specialty care continue to affect specialist to member ratios. In addition, portions of our network are in areas designated as Health Professional Shortage Areas (HPSA), including sections of South Los Angeles. This is further impacted by the fact that not all physician practices will accept Medi-Cal insurance. Anecdotal information suggests that fewer new physicians are entering the field of Gastroenterology even as long practicing physicians are retiring. Despite these challenges, L.A. Care contractually requires its Participating Physician Groups (PPGs) to provide access to needed specialty care by referring patients to out-of-network providers when a specialist is not available within its contracted network. Quarterly PPG Specialty Access reports are generated which show the number of specialists, by type, within each PPG's network. This allows the organization to identify those PPGs whose networks are deficient in specific areas of specialty care.

L.A. Care also performs annual onsite audits of its PPGs which includes reviews of their contracted specialty networks. The audit process requires PPGs to produce documentation that out-of-network access to needed specialty care has been available to enrollees when an in-network specialist did not exist.

INTERVENTIONS

Antelope Valley Direct Network: L.A. Care is in the final stages of developing a direct network of physicians in the Antelope Valley. This contracting strategy was in direct response to a recognized need to improve access to care in this region. It was determined that this access need could not be met through the networks of the organization's contracted PPGs. This Antelope Valley network will be comprised of approximately 93 specialists and 24 PCPs and will significantly increase access in this geographical region. The organization anticipates future implementation of direct network contracting strategies in other geographical locations across all product lines.

Enhanced Data Verification Process: L.A. Care's Provider Network Operations department requires its contracted Participating Physician Groups (PPGs) to submit accurate and timely specialist data and has

developed an enhanced data verification process to ensure all contracted specialists are captured in L.A. Care's databases. Complete PPG specialist data submission is key to the organization's ability to analyze network compliance with adequacy standards, therefore, on a quarterly basis, L.A. Care requires its PPGs to verify the accuracy and completeness of their PCP and Specialty networks.

eConsult

With eConsult, PCPs can securely send patient-specific clinical information and care questions to specialists through a HIPAA compliant email. Specialists use the system to review the clinical information and provide "electronic consultations" back to the primary care physicians. eConsult started in 2009 when L.A. Care launched a pilot to test the effectiveness of the electronic consultation system. An evaluation found that using eConsult improved information sharing and dialogue among physicians, shortened the time to resolve clinical issues, and reduced the need for face-to-face specialty visits, which declined by 25 to 48 percent depending on the specialty, while developing capacities at the primary care level and improving overall specialty care access. Patients benefited from faster resolution of clinical issues and elimination of unnecessary specialist visits. In 2012, L.A. Care extended eConsult to Health Care L.A. IPA (HCLA) and to its network of community clinic safety net providers and to the L.A. County Department of Health Services. To date, this second project has over 100,000, primary care/specialty consultations submitted, involving 114 sites and 12 specialties with a potential member/patient base of over 500,000. Results of FY2015 are shown in the table below, including 36,300 eConsults with Gastroenterologists and 5,130 eConsults with Orthopedic Surgeons, specialties not meeting the P:M standard for the study period.

eConsult Encounter Count by Specialty	
SPECIALTY	Total
Allergy	2241
Cardiology	11,085
Dermatology	17,250
Endocrinology (Adult)	4946
ENT	13,406
Gastroenterology*	36,300
Nephrology	2,958
Ophthalmology (specialty no longer live in eConsult)	1,176
Orthopedic Surgery* (specialty no longer live in eConsult)	5,130
Pain Management	6,139
Ped-Allergy/Asthma	87
Ped-Endocrinology	1,025
Ped- Neurology	1,671
Rheumatology (Adults/Peds)	4,088
Total	106,765

*Specialties not compliant to P:M standard

SECTION 2: CULTURAL AND LINGUISTIC NEEDS AND PREFERENCES

L.A. Care's Cultural and Linguistic (C&L) Services Unit provides face-to-face interpreters upon request at medical appointments, meetings, health education classes and community events. A total of 3,914 interpreting requests were processed in FY 2014-2015 (3,601 for medical appointments and 313 for health education classes and administrative meetings), which is an increase of 104% when compared to the previous year. A satisfaction survey is administered upon fulfillment of an interpreting services request. Members received a mail-based survey for interpreting services provided at medical appointments. Internal staff received a written survey for interpreting services provided at administrative events. Results of the survey show a high level of satisfaction with 100% of respondents being "very satisfied" or "satisfied."

The C&L Services Unit provides on-going education on C&L rights, requirements, services and resources. Educational strategies target staff, members, and network providers. The Provider Toolkit for Serving Diverse Populations is available for providers on L.A. Care's website. This toolkit was developed to assist providers in providing high quality, effective, and compassionate care to their patients and ensure they meet the changing service requirements of state and federal regulatory agencies.

In addition to education, the C&L Services Unit conducts trainings that target staff and network providers. Training topics include: C&L Overview, Cultural Competency, Disability Awareness, Interpreting Services, TTY, Translation Services, Communicating Through Healthcare Interpreters (CME), Deaf Awareness (CME), and LGBT/Q Sensitivity Training (CME). Trainings are conducted for L.A. Care staff and network providers, both in person and online through L.A. Care's Learning Management System. The C&L Services Unit conducted a total of 50 in person trainings on C&L related topics in 2015, with a total of 1,202 attendees (911 staff and 291 providers). An additional 379 staff and 589 providers completed C&L trainings online.

L.A. Care assesses the cultural, racial, ethnic, and linguistic needs of its members and adjusts availability of practitioners within its network if necessary.

METHODOLOGY

- Language needs and cultural background of members, including prevalent languages and cultural groups, are collected using individuals' race/ethnicity data collected when they apply for coverage.
- Language preference data for members is validated telephonically from eligible individuals using a standardized script during inbound member calls.
- L.A. Care uses census data for Los Angeles County to examine the languages spoken in the service area.
- Language and race/ethnicity of practitioners in the provider network is reported voluntarily through the practitioner credentialing application.
- L.A. Care uses mapping software to assess availability of PCPs to members for the five largest language groups of members.

Med-Cal

Medi-Cal: Member Professed Written Language		Medi-Cal: Member Ethnicity	
LANGUAGE	COUNT	ETHNICITY	COUNT
English	1,054,825	Hispanic/Latino	970,715
Spanish	559,772	White (Caucasian)	261,239
Armenian	45,960	Black (African American)	198,537
Not Valid	29,715	No Valid Data Reported	145,268
Korean	18,898	Chinese	45,409
Cantonese	18,382	Other	33,697
Mandarin	17,968	Filipino	31,384
Vietnamese	12,329	Asian/Pacific Islander	24,608
Farsi	8,919	Korean	22,988
Other Non-English (Specify)	6,553	Unknown	19,340
Tagalog	5,686	Vietnamese	17,572
Russian	5,322	Asian Indian	8,059
Cambodian	3,725	Cambodian	6,196
Arabic	3,705	Blank	3,849
Other Chinese	3,326	Japanese	3,430
Blank	1,155	American Indian/Alaskan	2,405
Thai	888	Samoan	1,924
American Sign Language	435	Amerasian	1,177
Japanese	364	Hawaiian	529
Samoan	230	Laotian	292
Hebrew	203	Guamanian	198
French	92	No Response - Client Declined To State	2
Laotian	86	Total:	1,798,818
Other Sign Language	83		
Turkish	46		
Portuguese	40		
Ilocano	33		
Polish	29		
Italian	25		
Hmong	22		
Mien	2		
Total:	1,798,818		

Cal MediConnect

CMC: Member Professed Written Language	
LANGUAGE	COUNT
English	6,371
Spanish	5,263
Not Valid	1,589
Tagalog	225
Armenian	107
Cantonese	99
Mandarin	89
Farsi	84
Vietnamese	79
Korean	76
Cambodian	41
Blank	33
Arabic	30
Russian	22
Other Non-English (Specify)	4
Other Chinese	2
Japanese	1
Total	14,115

CMC: Member Ethnicity	
ETHNICITY	COUNT
Unknown	11,324
Blank	2,185
Filipino	227
Chinese	134
Vietnamese	41
Hispanic/Latino	39
Korean	38
Black (African American)	33
White (Caucasian)	28
Asian Indian	28
Japanese	20
Asian/Pacific Islander	9
Samoan	5
No Valid Data Reported	2
American Indian/Alaskan	1
No Response - Client Declined To State	1
Total	14,115

L.A. Care Covered

LACC: Member Professed Written Language	
LANGUAGE	COUNT
English	9,587
Spanish	3,466
Not Valid	1,169
Korean	351
Vietnamese	98
Armenian	19
Farsi	17
Cambodian	13
Tagalog	12
Russian	10
Arabic	7
Hmong	1
Cantonese	1
Mandarin	1
Total	14,752

LACC: Member Ethnicity	
ETHNICITY	COUNT
Unknown	7,106
White (Caucasian)	3,872
Hispanic/Latino	1,068
Chinese	661
Black (African American)	512
Korean	495
Filipino	477
Vietnamese	220
Japanese	145
Asian Indian	114
American Indian/Alaskan	49
Asian/Pacific Islander	21
Guamanian	6
Samoan	6
Total	14,752

Practitioner to Member Ratios By Race/Ethnicity:

The five most prevalent racial and ethnic groups that comprise L.A. Care's Medi-Cal, L.A. Care Covered and Cal MediConnect membership are illustrated below.

The top 5 ethnic groups within the Medi-Cal line of business represent 92.18% of all Medi-Cal membership. Based on reported data, only 40.4% of the L.A. Care Covered membership is comprised of the top 5 ethnic/racial groups. This relatively low percentage is a result of the number of members who do not report their ethnicity and, quite possibly, a more varied ethnic composition across the program. The top 5 ethnicities within the CalMediConnect program represent 75.67% of all members in the program.

Medi-Cal

Medi-Cal: Top 4 Practitioner to Member Ratio by Race/Ethnicity					
Race	Number of Members	% of Membership	Number of PCPs	% of PCPs	P:M Ratio
Hispanic/Latino	997,842	54.40%	29	1.04%	1:34408
African American/Black	205,005	11.18%	9	0.32%	1:22778
Caucasian/White	274,492	22.17%	50	1.79%	1:5489
Chinese	48,022	2.62%	21	0.75%	1:2286
Filipino	33,187	1.81%	16	0.57%	1:2074

L.A. Care Covered

LACC: Top 5 Practitioner to Member Ratio by Race/Ethnicity					
Race	Number of Members	% of Membership	Number of PCPs	% of PCPs	P:M Ratio
Hispanic/Latino	556	4.49%	35	1.17%	1:16
African American/Black	416	3.36%	7	0.23%	1:59
Caucasian/White	3,213	25.95%	79	2.65%	1:41
Chinese	445	3.59%	28	0.94%	1:16
Korean	376	3.04%	16	0.53%	1:24

Cal MediConnect

CMC: Top 5 Practitioner to Member Ratio by Race/Ethnicity					
Race	Number of Members	% of Membership	Number of PCPs	% of PCPs	P:M Ratio
Hispanic/Latino	5525	41.66%	17	0.07%	1:132
African American/Black	1933	14.58%	6	0.01%	1:322
Caucasian/White	1806	13.62%	38	1.50%	1:48
Asian/Pacific Islander	478	3.60%	15	0.06%	1:3
Filipino	293	2.21%	10	1.00%	1:29

Practitioner to Member Ratios by Language

The top five languages spoken by L.A. Care's Medi-Cal, L.A. Care Covered, and Cal MediConnect members are shown in the tables below.

The top five languages spoken by Medi-Cal members represent 96.11% of all languages spoken by members participating in the program. English and Spanish speaking Medi-Cal members have the highest percentage of PCPs who speak their respective languages while Korean speaking members have the lowest percentage of PCPs speaking their language.

Medi-Cal: Practitioner to Member Ratio by Top 5 Languages Spoken					
Language	Number of Members	% of Membership	Number of PCPs	% of PCPs	P:M Ratio
English	1,087,226	59.28%	3,448	99.85%	1:315
Spanish	565,357	30.83%	2,492	72.16%	1:227
Armenian	48,671	2.65%	303	8.77%	1:161
Chinese	41,377	2.26%	677	19.60%	1:61
Korean	19,956	1.09%	164	4.74%	1:122

L.A. Care Covered: The top five languages spoken by L.A. Care Covered members comprise 89.93% of all languages spoken. As in the Medi-Cal program, members who speak English and Spanish have the highest percentage of network PCPs speaking their language. Korean speaking members have the lowest number of PCPs able to speak their language.

LACC: L.A. Care Practitioner to Member Ratio by Top 5 Languages Spoken					
Language	Number of Members	% of Membership	Number of PCPs	% of PCPs	P:M Ratio
English	7,369	63.79%	2,965	99.83%	1:2
Spanish	2,656	22.99%	2,133	71.18%	1:1
Tagalog	17	0.15%	408	13.78%	1:24
Korean	230	2.00%	147	4.95%	1:2
Vietnamese	112	1.00%	285	9.59%	1:3

Cal MediConnect: The top five languages spoken by Cal MediConnect members represent 87.17% of the program's membership. Consistent with Medi-Cal and L.A. Care Covered, the majority of Cal MediConnect members speak English and Spanish, with these two member groups having the highest percentage of PCPs who speak their language. Of the top five languages spoken by this population, members who speak Chinese have the lowest percentage of PCPs who speak their language.

CMC: L.A. Care Practitioner to Member Ratio by Top 5 Languages Spoken					
Language	Number of Members	% of Membership	Number of PCPs	% of PCPs	P:M Ratio
English	6,055	45.66%	2,502	99.99%	1:7
Spanish	4,986	37.60%	1,719	68.67%	1:8
Tagalog	243	1.83%	330	13.18%	1:2

CMC: L.A. Care Practitioner to Member Ratio by Top 5 Languages Spoken					
Language	Number of Members	% of Membership	Number of PCPs	% of PCPs	P:M Ratio
Chinese	181	1.36%	120	4.79%	1:2
Armenian	96	0.72%	334	13.33%	1:1

Quantitative Analysis

- Race/Ethnicity of practitioners ratios are low due to extremely limited self-reported ethnicity data. L.A. Care requests practitioner race/ethnicity information from all contracted network practitioners on a voluntary basis during the application process. As a result, the practitioners to member ratios are unreliable.
- Data on practitioner self-reported languages is more robust and provides a more accurate view of the L.A. Care practitioner network.
- Spanish speaking members comprise 30.83% of overall Medi-Cal membership, 22.99% of LACC membership, and 37.60% % of CMC membership.
- Spanish speaking practitioners comprise 72.16% of contracted PCPs in the Medi-Cal program, 71.18% of L.A. Care Covered PCPs , and 68.67% of Cal MediConnect PCPs
- The average distance that Spanish-speaking Medi-Cal members must travel to a Spanish-speaking PCP is 2.07 miles; L.A. Care Covered and Cal MediConnect members who speak Spanish travel an average of 2.01miles to a Spanish speaking PCP. All travel distances meet established standards.
- 99.98 percent of Spanish speaking members across all three programs have at least one Spanish-speaking PCP within 10 miles of their residence.

Qualitative Analysis

L.A. Care requests practitioner race/ethnicity information from all contracted network practitioners directly on a voluntary basis during the application process. The response rate remains low and does not adequately reflect the race/ethnicity of the L.A. Care practitioner network.

During the application process, L.A. Care requests practitioner language information from all potential network practitioners on a voluntary basis and identifies languages in which a practitioner is fluent when communicating about medical care. Physicians' language fluency is self-reported and is not validated by L.A. Care. The language categories for practitioner language on the application are the same as those used to collect member language. Any subsequent changes or updates to practitioner spoken language information are voluntarily self-reported to the Provider Network Operations department for updating in the provider database.

L.A. Care reviews community data every two years to determine the languages spoken by one percent of the population or 200 eligible individuals, whichever is less. Languages spoken by one percent of Los Angeles county residents include Spanish, Arabic, Armenian, Chinese, English, Farsi, Hebrew, Japanese, Khmer, Korean, Russian, Vietnamese, Tagalog and Thai. All languages but Hebrew, Japanese and Thai are Los Angeles County threshold languages as determined by DHCS.

Medi-Cal

Medi-Cal: Cultural and Linguistics Complaints			
Issue	Count of complaints	% of ATC Complaints	Rate/1000/Quarter
Cultural Issues	11	0%	0.01
Linguistic Issues	31	0%	0.04

Cal MediConnect

CMC: Cultural and Linguistics Complaints			
Issue	Count of complaints	% of ATC Complaints	Rate/1000/Quarter
Cultural Issues	0	0%	0.00
Linguistic Issues	2	0%	0.16

L.A. Care Covered

LACC: Cultural and Linguistics Complaints			
Issue	Count of complaints	% of ATC Complaints	Rate/1000/Quarter
Cultural Issues	1	0%	0.06
Linguistic Issues	0	0%	0.00

PASC-SEIU

PASC-SEIU: Cultural and Linguistics Complaints			
Issue	Count of complaints	% of ATC Complaints	Rate/1000/Quarter
Cultural Issues	2	0%	0.04
Linguistic Issues	0	0%	0.00

L.A. Care continually monitors complaints and grievances related to cultural and linguistic issues. The rate of complaints related to culture and language are low and do not present any trends for the study period.

L.A. Care publishes practitioner language information both on-line through L.A. Care's website and via a hard copy Provider Directory to facilitate member selection of practitioners. L.A. Care's hard copy Provider Directory is mailed annually to all L.A. Care members and contains an index of practitioners by language. The on-line version of L.A. Care's Provider Directory is searchable by practitioner and office staff language capabilities.

New Practitioners Added to the Networks by Language Spoken

Over the study period, L.A. Care added the following practitioners to the Medi-Cal, L.A. Care Covered and Cal MediConnect lines of business. These additions are calculated by practitioner languages spoken. Across all three lines of business, English and Spanish speaking practitioners represented the majority of additions during the December 2014-December 2015 timeframe. This is consistent with the languages most prevalent among the member population across all lines of business.

Medi-Cal

Medi-Cal: New Practitioners Added to Network in 2015 by Language Spoken	
Language	Number of Physicians
English	231
Spanish	184
Farsi	34
Tagalog	32
Armenian	30
Mandarin	29
Arabic	25
Russian	19
Cantonese	19
Other Chinese	18
French	18
Korean	16

L.A. Care Covered

LACC: New Practitioners Added to Network in 2015 by Language Spoken	
Language	Number of Physicians
English	62
Spanish	28
Mandarin	7
Farsi	6
Armenian	4
Cantonese	4
Tagalog	4
Arabic	3
Russian	3
Burmese	2
Thai	2
Other Chinese	2

Cal MediConnect

CMC: New Practitioners Added to Network in 2015 by Language Spoken	
Language	Number of Physicians
English	133
Spanish	114
Armenian	27
Farsi	26
Tagalog	19
Arabic	18
Thai	16
Mandarin	15
Russian	15
Other Chinese	13
French	13
Cantonese	11

Based on the cultural and linguistic findings, L.A. Care concluded that the practitioner network does not need to be adjusted at this time. In order to remain proactive, the C&L Services Unit plans and executes activities to improve Culturally and Linguistically Appropriate Services (CLAS), reduce disparities, and increase operational efficiency:

- In October 2014, the C&L Services Unit made updates to the Interpreting Satisfaction Survey. Surveys were not disseminated for 10 months, while revisions were made to the survey's protocols and mechanisms for distribution and frequency. In August 2015, the C&L Services Unit began mailing the interpreting satisfaction surveys to members on a weekly basis. Feedback from these surveys is used to evaluate services and identify opportunities for improvement.
- In May 2015, the C&L Services Unit partnered with Provider Relations as part of its ongoing efforts to educate providers. A letter and resource flyers were sent out to all network providers about C&L resources and services and how to access them.
- In June 2015, the Interpreting Quick Guide was created for L.A. Care staff and subcontractors on how to easily access L.A. Care's interpreting services.
- In July 2015, the C&L Services Unit created the Translation Satisfaction Survey for members. Feedback from these surveys is used to evaluate services and identify opportunities for improvement.
- In September 2015, the C&L Services Unit revised the C&L Provider Toolkit, "Better Communication, Better Care: A Provider toolkit for Serving Diverse Populations." In addition to being available on L.A. Care's website, this toolkit was also distributed by the C&L Services Unit at provider trainings and PPG meetings as well as by Facility Site Review staff during their site visits.
- In September 2015, the telephonic interpreting cards were updated to make them more user-friendly for PPGs and network providers.

SUMMARY

Through quarterly and annual quantitative monitoring and analysis, L.A. Care monitors its network to determine if it has sufficient numbers and types of practitioners who provide primary care, behavioral healthcare and specialty care. This analysis is supplemented by an evaluation of member complaints.

Through this process, only slight adjustments to the network were indicated. Ongoing monitoring of Participating Physician Groups' provider networks will continue in 2016. In addition to the development of its directly contracted provider network in the Antelope Valley region, L.A. Care continues engage in collaborative efforts to ensure additional provider contracting opportunities are pursued in other geographical locations to enable the provider network to meet the access needs of the organization's rapidly growing membership.

The results of this analysis are presented at the Quality of Care Committee.

Specialists Added to the Network

The following table shows the specialists added to the Medi-Cal, L.A. Care Covered and Cal MediConnect networks from December 2014 through December, 2015. Specialists identified as high volume were added to the networks of all three programs.

Medi-Cal

Medi-Cal: Specialists Added December 2014- December 2015	
SPECIALTY	COUNT
Allergy	4
Anesthesiology	14
Cardiology	3
Cardiovascular Disease	34
Colon & Rectal Surgery	3
Dermatology	12
Diagnostic Radiology	15
Endocrinology	10
Gastroenterology (Md Only)	21
General	26
Geriatric Medicine	1
Hematology	11
Infectious Disease	8
Nephrology	27
Neurological	11
Neurology	9
Gynecology (Do Only)	67
Oncology	5
Ophthalmology	52
Orthopedic	31
Other	72
Otolaryngology	8
Pathology	2
Pediatric Cardiology	8
Pediatric Gastroenterology	5
Pediatric Neurology	1
Physical Medicine and Rehabilitation	10

Medi-Cal: Specialists Added December 2014- December 2015	
SPECIALTY	COUNT
Plastic	3
Podiatry	13
Psychiatry	15
Pulmonology	14
Radiation Oncology	10
Rheumatology	7
Thoracic	4
Urology	18
Vascular	7

L.A. Care Covered

LACC: Specialists Added December 2014- December 2015	
SPECIALTY	COUNT
Allergy	14
Anesthesiology	24
Cardiology	3
Cardiovascular Disease	122
Colon & Rectal Surgery	0
Dermatology	22
Diagnostic Radiology	171
Endocrinology	29
Gastroenterology (Md Only)	75
General Surgery	80
Geriatric Medicine	2
Hematology	17
Infectious Disease	37
Nephrology	97
Neurological	31
Neurology	48
Gynecology (Do Only)	118
Oncology	38
Ophthalmology	96
Orthopedic	67
Other	55
Otolaryngology	32
Pathology	4
Pediatric Cardiology	14
Pediatric Gastroenterology	1

LACC: Specialists Added December 2014- December 2015	
SPECIALTY	COUNT
Pediatric Neurology	1
Physical Medicine and Rehabilitation	28
Plastic	15
Podiatry	7
Psychiatry	48
Pulmonology	50
Radiation Oncology	30
Rheumatology	22
Thoracic	21
Urology	55
Vascular	12

Cal MediConnect

CMC: Specialists Added December 2014 - December 2015	
SPECIALTY	COUNT
Allergy	11
Anesthesiology	26
Cardiology	6
Cardiovascular Disease	88
Colon & Rectal Surgery	6
Dermatology	22
Diagnostic Radiology	30
Endocrinology	21
Gastroenterology (Md Only)	32
General Surgery	79
Geriatric Medicine	2
Hematology	16
Infectious Disease	27
Nephrology	52
Neurological	11
Neurology	27
Gynecology (Do Only)	102
Oncology	21
Ophthalmology	81
Orthopedic	31
Other	130
Otolaryngology	25
Pathology	5

CMC: Specialists Added December 2014 - December 2015	
SPECIALTY	COUNT
Pediatric Cardiology	14
Pediatric Gastroenterology	4
Pediatric Neurology	4
Physical Medicine and Rehabilitation	23
Plastic	15
Podiatry	14
Psychiatry	17
Pulmonology	27
Radiation Oncology	29
Rheumatology	16
Thoracic	24
Urology	31
Vascular	14

ANCILLARY PROVIDERS

L.A. Care measures ancillary providers' compliance with established geographical distribution and ratio standards. The top 5 ancillary provider types in 2015 were Skilled Nursing Facilities, Home Health Agencies, Ambulatory Surgery Centers, Radiology Facilities and Dialysis Centers. As shown in the tables below. All travel distance standards and ratio standards were met for the top 5 ancillary types, across the Medi-Cal, L.A. Care Covered and Cal MediConnect lines of business. L.A. Care evaluates the sufficiency of its ancillary network on a monthly basis to determine additional contracting needs.

Ancillary Provider to Member Geographical Distribution Standard and Results			
	Medi-Cal	LACC	CMC
	% within 15 miles	% within 15 miles	% within 10 miles
Skilled Nursing Facilities	94.18%	95.82%	91.61%
Home Health Agencies	93.41%	93.95%	94.48%
Ambulatory Surgery Centers	94.49%	97.25%	95.12%
Radiology Facilities	95.86%	97.23%	97.98%
Dialysis Centers	95.61%	98.35%	96.14%

Ancillary Provider to Member Ratio Standard and Results			
	Medi-Cal	LACC	CMC
	Ratio	Ratio	Ratio
Skilled Nursing Facilities	1:3130	1:118	1:103
Home Health Agencies	1:4827	1:41	1:34
Ambulatory Surgery Centers	1:4993	1:62	1:53
Radiology Facilities	1:3129	1:27	1:22
Dialysis Centers	1:3545	1:30	1:25

REVIEW OF COMPLAINTS

A review of complaints over a 12-month period shows there were only 29 complaints (8.4%) regarding access to specialty care, and 5 complaints (1.5%) regarding access to PCP.

Access to Care Complaints by Complaint Description		
Complaint Description	Count	% Total
Specialty Access/Availability	29	8.38%
PCP Access/Availability	5	1.45%

ACCESS TO PUBLIC TRANSPORTATION

L.A. Care assessed public transportation from PCP, SCP, and total ancillaries to nearest bus stop. As the Los Angeles metro area is thoroughly covered by public transportation, producing a map of the locations from provider to bus stop would not be feasible.

There is no standard to evaluate this measurement against. All providers and ancillaries are within 1 mile of a bus stop. In addition, L.A. Care provides up to 28 non-emergent one-way transports for free to members through Logisticare to approved locations. Members are notified of this supplemental benefit through their Evidence of Coverage (EOC) document.

C. SYSTEMS OF CARE, ADMINISTRATIVE AND OTHER QI ACTIVITIES

C.1 PHARMACY INITIATIVES AND MANAGEMENT

BACKGROUND

Starting 1/1/2015, L.A. Care has transitioned to a new Pharmacy Benefit Management (PBM) group, Navitus Health Solutions. Functions delegated to Navitus include: Coverage Determinations, Formulary administration, Clinical Programs, etc. As such, 2015 is considered a baseline year.

Through their contracted vendor, SinfoniaRx, clinical programs and MTM are administered for L.A. Care CMC members.

CONCURRENT DUR (info from Navitus)

Administered by Navitus, this program (applies to all LOBs) helps pharmacists in protecting member health and safety by ensuring they receive the appropriate medications through hard and soft electronic rejects.

Drug-Drug Interactions (DDI)	<i>Claim history indicates fills of two or more drugs that; when taken together, can cause unpredictable or undesirable effects</i>
High Dose Alert (HD)	<i>Dose prescribed is considered excessive or dangerous when compared to the recommended dosing</i>
Low Dose Alert (LD)	<i>Dose prescribed is considered low or ineffective when compared to the recommended dosing</i>
Underuse (LR)	<i>Member has not followed the expected refill schedule to ensure the recommended therapy duration</i>
Insufficient Duration (MN)	<i>The duration of the prescription may not able to fulfill the adequate therapeutic effect</i>
Excessive Duration (MX)	<i>The period of time for the prescription is considered excessive or dangerous when compared to the recommended dosing</i>
Patient Age (PA)	<i>Medication is contraindicated, unintended, or untested for use by patients of this age</i>
Drug-Sex (SX)	<i>Medication is contraindicated, unintended, or untested for use by patients of this sex</i>
Therapeutic Duplication (TD)	<i>This service identifies prescriptions that provide the same therapeutic effect.</i>
Dose Range (DR)	<i>Identifies a member whose acetaminophen use was greater than 4 grams (4,000 mg) per day</i>
Morphine Equivalent Dose (ER)	<i>Detects members that have greater than 120 Morphine Equivalent Doses, more than two pharmacies or two doctors for active opioid claims</i>

CDUR Edits	Number of rejects fired			
	Q1 2015	Q2 2015	Q3 2015	Q4 2015
DDI (<i>Drug-Drug Interaction</i>)	37,278	45,769	41,059	-
<i>DDI Stayed Rejected</i>	368	364	348	-
HD (<i>High Dose</i>)	3,029	2,785	2,296	-
<i>HD Stayed Rejected</i>	200	155	93	-
LD (<i>Low Dose</i>)	5,839	6,154	5,171	-
LR (<i>Underuse</i>)	7,523	14,606	16,574	-
MN (<i>Insufficient Duration</i>)	956	1,126	870	-
MX (<i>Excessive Duration</i>)	1,337	1,438	1,357	-
PA (<i>Patient-Age</i>)	22,122	21,354	15,965	-
SX (<i>Drug-Sex</i>)	34	35	35	-
TD (<i>Therapeutic Duplication</i>)	14,456	17,287	15,104	-
DR (<i>Dose Range</i>)	57	59	46	-
<i>DR Stayed Rejected</i>	53	58	41	-
ER (<i>Morphine Equivalent Dose</i>)	30	41	24	-
<i>ER Stayed Rejected</i>	2	2	1	-
Totals	93,284	111,233	98,984	-

RETROSPECTIVE DUR (info from Navitus)

Administered by Navitus, the following are safety measures in place for L.A. Care members in all LOBs.

Product Name	Prescriber Message	Value for Member Identification / Inclusion
<i>Multi-Prescriber</i>	The Multi-Prescriber Program identifies patients that have utilized multiple prescribers to obtain prescription medications during the last four months. Patients who seek prescriptions from multiple prescribers are at a higher risk for duplicate therapy and/or drug-to-drug interactions.	Patient received Rx's from 7 or more <i>unique</i> prescribers per month in 2 of 4 months
<i>Controlled Substance Monitoring (CSM)</i>	The Controlled Substance Monitoring (CSM) Program highlights patients with potential overuse of controlled medications (schedules II through V). The profiles identified contain an unusually high number of prescribers, pharmacies and prescriptions for controlled medications during the last four months.	Patient had 9 or more controlled substance Rx's + Prescribers + Pharmacies in 2 of 4 months
<i>CSM Repeat Alert</i>	CSM Repeat Alert is an extension of our CSM program for patients with regular, high utilization of controlled medications. CSM Repeat Alert identifies patients who have been included in the CSM program at least four times in the last two years.	Patient identified in original CSM product mailing 4 or more times over 2-year period
<i>Duplicate Therapy</i>	The Duplicate Therapy program identifies patients using multiple drugs in the same therapeutic class consistently during the last four months. Duplicate therapy has the potential for additive toxicity, adverse effects and may cause therapeutic redundancy without increased benefit to the patient. Additionally, simplifying the patient's drug regimen to one drug may save the patient money and lead to greater adherence.	Patient had 2 or more Rx's in the same drug class in 3 of 4 months during look-back period
<i>Multi-Prescription</i>	The Multi-Prescription Program identifies patients with a high number of medications, and that have demonstrated a consistent pattern of utilization during the last four months. Research has shown that as the number of medications used by a patient increases, the potential for adverse drug events increases exponentially.	Patient received 13 or more prescriptions per month in previous 3 of 4 months
<i>Expanded Fraud, Waste & Abuse</i>	The Expanded Fraud, Waste and Abuse Program identify patients whose last four months of claims include medications with potential for overuse or abuse. Continued abuse of these drugs over time could result in unfavorable health outcomes.	Patient had 7 or more <i>non-controlled</i> Rx's with abuse potential + Prescribers + Pharmacies per month for 2 out of 4 months

Current Intervention Period:	11/1/2014		2/28/2015	
RDUR Safety Intervention Name	Prescribers Mailed	Members Identified	Client Name	Line of Business
Controlled Substance Monitoring	34	10	Cal Medi-Connect	MMP
Multi-Prescriber	19	2		
Totals	53	12		
Controlled Substance Monitoring	3	1	LA Care -Covered	Exchange
Controlled Substance Monitoring	619	181	Medi-Cal	Medicaid
Multi-Prescriber	412	42		
Totals	1,031	223		
Controlled Substance Monitoring	13	3	PASC SEIU	Commercial
3/2015 RDUR Safety Totals	1,100	239	LA Care Groups	

Current Intervention Period:	3/1/2015	through	6/30/2015	
RDUR Safety Intervention Name				
Controlled Substance Monitoring	Prescribers Mailed	Members Identified	Client Name	Line of Business
Duplicate Therapy				
Multi-Prescription				
Multi-Prescriber				
Controlled Substance Monitoring				
Duplicate Therapy				
Multi-Prescription				
Controlled Substance Monitoring				
Duplicate Therapy				
Multi-Prescription				
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Duplicate Therapy				
Multi-Prescription				
Controlled Substance Monitoring				
Duplicate Therapy				
Multi-Prescription				
7/2015 RDUR Safety Totals	3,092	7,745	L.A. CARE	

Current Intervention Period:	7/1/2015		through	10/31/2015
RDUR Safety Intervention Name	Prescribers Mailed	Members Identified	Client Name	Line of Business
Controlled Substance Monitoring	61	13	CAL MEDICONNECT	MMD
Duplicate Therapy	34	21		
Multi-Prescription	559	193		
Multi-Prescriber	70	6		
Duplicate Therapy	1	1	L.A. CARE - COVERED	EXCHANGE
Multi-Prescription	7	1		
Controlled Substance Monitoring	1,614	486	MEDI-CAL	MEDICAID
Duplicate Therapy	475	392		
Multi-Prescription	3,843	2,093		
Multi-Prescriber	1,463	162		
Expanded Fraud, Waste & Abuse	4	1		
Controlled Substance Monitoring	37	8	PASC SEIU	COMMERCIAL
Duplicate Therapy	14	10		
Multi-Prescription	71	22		
11/2015 RDUR Safety Totals	8,253	3,409	L.A. CARE	

COVERAGE DETERMINATIONS

Starting 01/01/2015, L.A. Care has delegated coverage determination process for all LOBs to the new PBM, Navitus Health Solutions. L.A. Care's Pharmacy and Formulary Department has been monitoring Navitus' coverage determination processes to assure they meet state and federal regulations.

APPEALS

Starting 04/01/2015, pharmacists from Pharmacy and Formulary Department have been providing clinical consulting services to Appeals and Grievances (A & G) department on reviewing appeal cases.

The pharmacist assists the A & G team in outreach process for obtaining additional necessary medical information, and provides a complete report on member's appeal request and medical conditions to the medical director in order for the medical director to review and decide to overturn or uphold the appeal request.

CLINICAL PROGRAMS FOR MEDICARE (STAR)

The following programs have been in place for 2015 through Navitus and SinfoniaRx. These programs involve quarterly interventions, which entail mailings to the members and providers.

- High-Risk Medications in the Elderly
- Cholesterol adherence
- RAS antagonist adherence
- Diabetes medication adherence
- 30-90 day program – Provider mailings that educate the provider regarding 90 day fills. >10,000 letters mailed.

L.A. Care pharmacy department has also implemented a new in-house adherence program, which involves a high touch approach to ensuring adherence is achieved and maintained for CMC members. Technicians in the pharmacy department make outbound calls to members, pharmacies and prescribers to inquire about barriers to adherence the members are facing and to remedy the situation when appropriate.

During a short period of time, an estimated success rate of 30% has been achieved with this program.

The pharmacy department has also partnered with Medicare Operations to implement IVRR, which is an automated call members receive prior to their refills to ensure they are compliant with their chronic medications. This program has also yielded a 30% success rate.

The pharmacy department has also partnered with Disease Management and Case Management to streamline existing processes, to minimize the calls to the members, while achieving the same results.

The pharmacy department has also created educational materials for providers regarding clinical programs. These materials include tips on how to help improve member health and STAR ratings. Through Joint Operations Meetings (JOMs), educational material has been presented to PPGs on a regular basis in 2015.

The combined efforts above have yielded the following STAR ratings as of December 2015.

NAVI-GATE Star Ratings Program		proActive Management								
Campaign Performance										
Program: 2015 LA Care - 5 Star			Campaign: Star Ratings							
Measure Name	Sub Measure Name	Num	Den	Stars	1 Star	2 Star	3 Star	4 Star	5 Star	Distance From Target
Cholesterol (Statins)	Reported Rate	3,646	5,256	3	0	0	0	191	507	
High Risk Medication	Reported Rate	485	13,461	5	0	0	0	0	0	
Hypertension (ACEI or ARB)	Reported Rate	4,465	6,155	2	0	0	29	275	521	
Oral Diabetes Medications	Reported Rate	2,049	2,799	3	0	0	0	51	247	

LOOKING FORWARD

The goal for 2016 is to continue existing clinical programs with SinfoniaRx and within the L.A. Care Pharmacy department.

MEDICATION THERAPY MANAGEMENT (MTM)

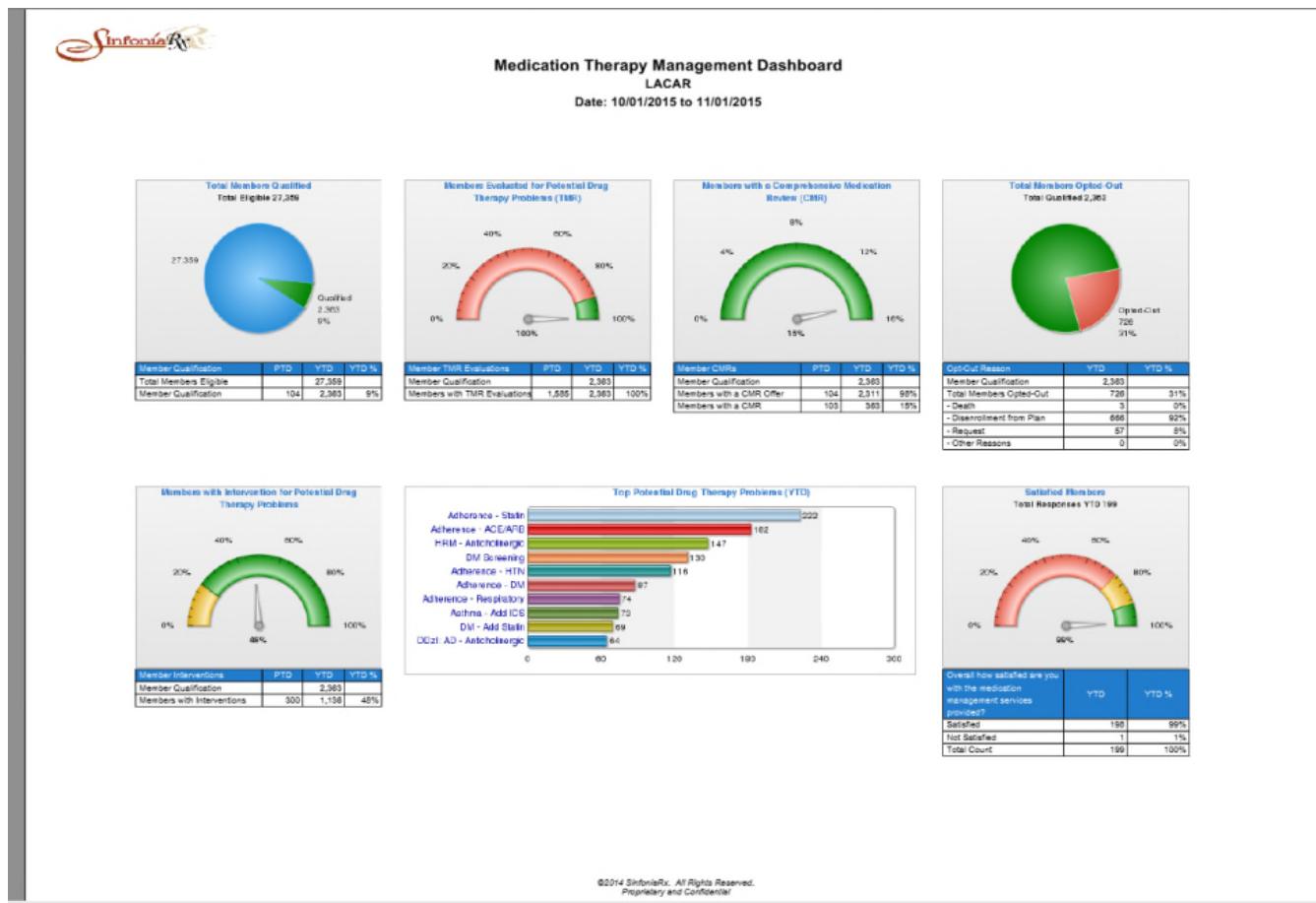
Since Medicare Part D was launched in October 2006, Part D prescription drug plan sponsors are required to establish a medication therapy management program (MTMP) that is designed to optimize therapeutic outcomes for target beneficiaries by improving medication use and reducing adverse events. For each contract year since 2008, L.A. Care has been required to submit targeted criteria for eligibility in the MTMP.

SinfoniaRx currently administers MTM for L.A. Care CMC members. Telephonic Comprehensive Medication Reviews (CMRs) are conducted by SinfoniaRx personnel.

For Contract Year 2015, each beneficiary may receive MTM intervention based on the following criteria:

- 3 or more chronic diseases
- 8 or more covered Part D drugs
- Incurred quarterly costs of \$784.50 in covered Part D drugs.
- Beneficiary is allowed to Opt-Out of the MTM program

Due to recent cut point changes by CMS, L.A. Care signed on with the MTM vendor to achieve higher percentage of completion of CMRs. As of December 2015, The CMR rate has increased to 26%. The latest SinfoniaRx report below is from October 2015.



LOOKING FORWARD

Currently, Navitus and the pharmacy department are working together to finalize the 2016 work plan for clinical programs and MTM.

C.2 DELEGATED OVERSIGHT

2015 WORK PLAN GOALS:

- 100% of all delegates who need an audit will receive an annual audit.
- 100% of all delegates will report quarterly as specified in contract.
- 100% submission of timely delegate oversight reporting for each department.

BACKGROUND

L.A. Care may delegate activities to entities with established quality improvement programs and policies consistent with regulatory and NCQA accreditation requirements and standards. L.A. Care has mutually agreed upon delegation agreements with delegated entities. Prior to contracting with the entity, L.A. Care performs a pre-delegation audit to assess compliance with L.A. Care, current NCQA standards and state and federal regulatory requirements. L.A. Care retains accountability and ultimate responsibility for all components of the Program. On an annual basis, L.A. Care evaluates the delegates' performance against NCQA, DMHC/DHCS, and CMS standards for the delegated activities. L.A. Care analyzes audit results and reports, and identifies opportunities for performance improvement. A corrective action may be required to address deficiencies. In addition, L.A. Care provides ongoing monitoring through oversight reports, meetings, and collaboration to continually assess compliance with standards and requirements.

Delegate reports are reviewed in the following committees:

- Utilization and Complex Case Management: Utilization Management Committee
- Credentialing: Credentialing Committee
- Member Rights (grievance and appeals): Quality Oversight Committee
- Quality and PQIs: Quality Oversight Committee
- Behavioral Health: Behavioral Health Quality Improvement Committee
- Pharmacy: Pharmacy Quality Oversight Committee
- Disease Management: Quality Oversight Committee

MAJOR ACCOMPLISHMENTS

- Continued monitoring and delegated oversight of delivery of preventive health services by measuring selected Healthcare Effectiveness Data and Information Set (HEDIS) performance during annual audit. Delegates are required to submit a Corrective Action Plan (CAP)/Performance Improvement Plan (PIP) in 2015 for HEDIS rate falling below minimal performance level (MPL) for both clinical measures as well as preventive health measures.
- Conducted full scope oversight of Kaiser Foundation using NCQA 2015 QI standards for all delegated functions, without provision of auto-credit issued by NCQA.
- Conducted annual delegated oversight audit of Beacon Health Strategies; a contracted behavioral health specialty plan.
- Conducted annual oversight audits of contracted Physician Provider Groups and Specialty Health Plans with Cal MediConnect members.

RESULTS

- 100% of required delegate audits were completed in 2015.
- 100% of the delegate reports were reviewed by the respective committee.
- 100% of delegate oversight reports were submitted for each department for substantive review and analysis.

ANALYSIS

L.A. Care continues to assess delegated activities by conducting substantive review and analysis of delegate reports. Plan Partners that are NCQA accredited are not audited for certain standards and functions. Beacon Health Strategies (Beacon), an NCQA accredited Managed Behavioral Health Organization (MBHO) is delegated behavioral health services for Medi-Cal (except special mental health services), Cal MediConnect, L.A. Care Covered, and PASC-SEIU Home Workers.

Plan Partners and vendors submitted regular reports as defined in the delegation agreement. Some reports are reviewed on-site. All three (3) Plan Partners (Anthem Blue Cross, Care 1st and Kaiser Foundation) were requested to submit CAPs, as well as PIPs for underachieving in select HEDIS measures during annual delegation oversight audit.

- Anthem Blue Cross:
 - o HEDIS Improvement Plan for HEDIS CDC HbA1c and DRE measures
 - o Evidence of organization uses, supports or facilitates use of at least 4 innovative technologies per NCQA MEM 6 standard
- Care 1st Health Plan:
 - o HEDIS Improvement Plan for HEDIS Adolescent Well Care measure
 - o CAP to correct service level performance for Nurse Advice Line first quarter 2015.
- Kaiser Foundation:
 - o CAP to ensure compliance of annual analysis of member complaints and grievance in the NCQA required 5 categories for L.A. Care Health Plan Medi-Cal members
 - o HEDIS Improvement Plan for Well Child Care for age 3, 4, 5 and 6 years old.

LOOKING FORWARD

- L.A. Care will continue to work with the Plan Partners and contracted vendors to provide monitoring and oversight by obtaining the requested reports quarterly and during the annual audit process as required.
- QI will continue to require Plan Partners to complete a CAP/PIP if their HEDIS scores on key clinical and preventive health measures do not meet minimum performance level (MPL).

C.3 CREDENTIALING

BACKGROUND

L.A. Care develops and adheres to credentialing and recredentialing policies and procedures, including a process to document the mechanism for the credentialing and recredentialing of licensed independent practitioners with whom it contracts. The Credentialing Department reports regularly to the Quality Oversight Committee with an update from the Credentialing Committee. L.A. Care evaluates and contracts with health delivery organizations (HDOs). L.A. Care initially assesses and reassesses every three years thereafter, network facilities to assure compliance with regulatory standards and conducts ongoing monitoring for the entire network.

MAJOR ACCOMPLISHMENTS

- The Credentialing Department credentialed approximately 412 HDOs which includes 89 Skilled Nursing Facilities to meet the network requirements for Cal MediConnect along with our regular core business. We continue to enhance policies and procedures for the SNF credentialing process to ensure the most comprehensive policy available.
- There were 49 Hot Sheets identified in addition to other ongoing monitoring activities.
- The Credentialing Department collaborated with PNO to credential the Antelope Valley direct network. 91 practitioners have been credentialed and we will continue to credential more in the year to come.
- The Credentialing Department integrated the behavioral health professionals into our scope of credentialing. To date, we have credentialed 312 professionals and 55 paraprofessionals. We will continue to ensure all our practitioners are credentialed.
- The Credentialing Department programmed an electronic version of our NCQA HDO tracking log. This will be used for the upcoming audit.
- The integration of the Credentialing and FSR departments continues to operate smoothly and is a positive collaboration.
- The Credentialing Department has been able to maintain structure and compliance during a major growth of many different lines of businesses, rules, and regulations, as demonstrated by our audits above.

RESULTS

	Goal	2013 Results	2014 Results	2015 Results	Goal Met?
Credentialed	100%	100%	100%	100%	Met
Recredentialed	100%	100%	100%	100%	Met
HDO Assessment	100%	100%	100%	100%	Met

ANALYSIS

Quantitative and Qualitative Analysis

Goals were met for established measures. No barriers were identified in meeting these goals.

LOOKING FORWARD

The Credentialing Department is looking to partner with CAQH and hopes to gain efficiencies through this application process.

We plan to purchase the CACTUS Import/Export module which will allow data to be shared with any database. The goal will be to reduce administrative costs by eliminating inputting data manually. We will be able to export data from CACTUS to L.A. Care's database through automation.

The Credentialing Department is bringing the credentialing functions of Beacon Health Strategies in house. There are approximately 700 practitioners to be credentialed.

CONCLUSION

Overall Effectiveness and Opportunities

Overall, the 2015 Quality Improvement Program was effective in identifying opportunities for improvement and enhancing processes and outcomes. Sufficient and appropriate resources were committed to complete projects detailed in the work plan. Additional staff were added to the disease management programs. Leadership played an active role by participating in quality committee meetings, providing input on quality related opportunities, helping to identify barriers and develop and implement effective approaches to achieve improvements. The Chief Executive Officer, Chief Medical Officer and Medical Director Quality Improvement and Health Assessment participate in the Compliance and Quality Committee of the Board. The organization's quality improvement work plan effectively monitored and reported on the numerous quality-related efforts underway throughout the organization. The work plan was updated and reviewed by the Quality Oversight Committee on a quarterly basis.

In line with the strategic direction undertaken by the Leadership Team and the Board of Governors the Chief Executive Officer unveiled the reorganization of L.A. Care. The intent of the reorganization was to align the business processes to foster accountability internally and externally; eliminate duplicate functions; to clarify communication with internal and external stakeholders; and add new functions in internal auditing, enterprise risk assessment, and single source for data management and analytics. A second component of the restructuring was to clearly organize the population served into segments based on risk, reimbursement, and enrollment challenges.

L.A. Care Health Plan has successfully undergone evaluation by regulators and accrediting bodies in 2015, with particular emphasis on quality of care, coordination and integration of services, and provision of effectiveness and efficacy of processes.

The assessments in 2015 included:

- August 24: NCQA annual reevaluation based on HEDIS® and CAHPS® performance of Medi-Cal and Covered California product lines, resulting in an overall “accredited” status.
- July 20 – July 31: DHCS/DMHC audit of Medi-Cal. Results pending at this time.
- April 16: NCQA Distinction in Multicultural Healthcare achieved.

The Chief Medical Officer, as the senior physician or designee serves as the Chairperson of all standing committees. The assignment of a subject matter physician to each committee and subcommittee is dependent on the scope and role of the committee.

Practicing physicians provided input through the Joint Performance Improvement Collaborative (PICC) and Physician Quality Committee (PQC). L.A. Care members and consumer advocates provided input through the eleven Regional Community Advisory Committees and the Executive Community Advisory Committee. Other external experts provided input through the Children's Health Consultant Advisory Committee and the Technical Advisory Committee.

Critical to the successful integration of physician leadership in the activities and structure of the quality improvement program was the hiring of a Medical Director, Quality Improvement & Health Assessment which occurred in 2015.

Review of the scope, composition and business of the individual committee has led to management taking a second look at the existing committee structure and has resulted in consolidation of committees as well

as redesign of subcommittees to be working committees recommending actions to the Quality Oversight Committee.

The refinement of the committee structure and reporting is an ongoing performance improvement initiative and is expected to continue in 2016. The overall goal of improving the effectiveness and efficiency of the committees is critical in improving the overall quality of care.

In addition to demonstrating improvements in clinical care, staff made process improvements in the asthma program and programs that promote clinical practice guideline adherence, such as pharmacy notifications indicating controller and reliever medication use for members with asthma. Potential quality issues were monitored and tracked in the Peer Review Committee. Patient safety was addressed through the monitoring of potential quality issues, facility site reviews, and pharmacy management programs. Coordination and collaboration among departments supported more effective clinical and service improvements.

Improvements were made in several areas MY 2013 to 2014. Better provider record abstraction and encounter data capture led to improved scores. Diabetic members received calls from the disease management program to remind them of needed services. Providers also received educational information (toolkits and faxes) and member information regarding gaps in service and medication adherence. These activities have continued in 2015.

There remain opportunities to improve management of hypercholesterolemia and diabetes. Several other clinical measures have been identified for improvement, such as, breast cancer screenings, colorectal cancer screenings, glaucoma screenings, annual assessment of ADLs and pain management, and diabetics with cholesterol under control. There were several member satisfaction measures as well in need of improvement: getting needed care, getting appointment and care quickly, customer service, overall rating of health care quality and overall rating of health plan.

The QI Program will continue to focus on opportunities to improve clinical care and service in the areas outlined in this report. Member satisfaction has remained flat over the last three years. Afterhours access studies continue to show the need for improvement. There are areas that still need improvement, such as, breast and cervical cancer screenings, use of spirometry testing in the assessment and diagnosis of COPD, appropriate medications for people with asthma, and immunization among pediatric and adolescents. These and other QI activities are detailed in the 2016 QI work plan and will be tracked through the QI committees.



L.A. Care
HEALTH PLAN

**Quality Improvement Program
Annual Report and Evaluation
2015**

Review and approval of the attached Quality Improvement Program Annual Report and Evaluation 2015 performed by:

Submitted by:

Jim Banks

Date: 2/22/16

Jim Banks, RN
Senior Director,
Quality Improvement & Health Assessment

M. Emons

Date: 2/22/16

Matthew Emons, MD, MBA
Medical Director,
Quality Improvement & Health Assessment

Reviewed and Approved by Chief Medical Officer

Gertrude S. Carter, M.D.

Date: 3/22/16

Gertrude Carter, MD
Chief Medical Officer

Reviewed and approval at Compliance & Quality Committee

G. Michael Roybal, MD, MPH
G. Michael Roybal, MD, MPH
Compliance & Quality Committee - Chair

Date: 3/17/16

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	<u>Medi-Cal, HK, PASC, Potential, Prov, & IVR:</u> 1st Qtr.: 3.15% 2nd Qtr.: 0.49% 3rd Qtr.: 0.60% 4th Qtr.: 0.85% <u>CMC:</u> 1st Qtr.: 3.04% 2nd Qtr.: 1.54% 3rd Qtr.: 0.49% 4th Qtr.: 0.32% <u>LACC:</u> 1st Qtr.: 3.23% 2nd Qtr.: 1.11% 3rd Qtr.: 1.01% 4th Qtr.: 4.42%	Abandonment Rate Goals were met in Q1, Q2, and Q3.	Y
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	<u>Medi-Cal, HK, PASC, Potential, Prov, & IVR:</u> 1st Qtr.: 32.78% 2nd Qtr.: 86.34% 3rd Qtr.: 82.02% 4th Qtr.: 73.11% <u>CMC:</u> 1st Qtr.: 73.38% 2nd Qtr.: 87.59% 3rd Qtr.: 98.59% 4th Qtr.: 98.93% <u>LACC:</u> 1st Qtr.: 85.80% 2nd Qtr.: 98.50% 3rd Qtr.: 98.18% 4th Qtr.: 88.09%	Calls answered ≤ 30 seconds goals were not met in Q1 and Q2. Only LACC Q2 goal was met. L.A. Care Health Plan experienced tremendous growth throughout 2015 as a result of the implementation of the Affordable Care Act and Medicaid Expansion. There has already been an increase of over 100,000 members since the beginning of 2015. Call volume increased substantially as individuals began accessing health care for the first time. Compared to 2014's 1st and 2nd quarter, call volume has increased from an average of approximately 4,800 calls per day to 7,500 calls per day during the 1st quarter and an average of 3,800 calls per day to 5,300 calls per day during the 2nd quarter. To support the growth of the programs, L.A. Care held two 6-week training classes hiring a total of 43 new Member Service Representatives from January 2015 to June 2015. Additionally, the CISCO telephone/ACD system has been enhanced to improve call routing capabilities. NICE new recording software was also implemented to enhance existing quality review process and a new Work Force Management tool is scheduled for implementation before the end of the year. The Workforce Management tool will provide staff automated capability to monitor peak times and appropriately assign staff to meet call volume needs to achieve performance standards. During Q3, there were some phone issues. Due to a power outage, phones were down on 07/22 from 7am-2pm. Phones also had issues on 08/28, which was the first day after we had cutover to the new IVR servers. On 09/21, there was a fire evacuation for about 15 minutes.	Y
Member Services Department Telephone Wait Time- Service Level cont.)							IT did not route the calls during that time over to ansafone so there were many calls left on hold in the queue and some for over 15 minutes. In Q4, call center lost a total of 22 member service representatives. In addition, we had an increases in FMLA cases and LOA. Approximately 30 has FMLA cases and there are around 10 who are on LOA at a time. We held another 6-week training classes mid November and 17 new representatives has started taking calls as of January 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
Non-Emergent Ancillary Services		Within 15 business days of request, for appointment	Maria Casias/ Deborah Manders	Annually: Sept '15	MQSC: Sept 1 QOC: June 22	Ancillary - There were 7 Ancillary services (Radiology 100%, Clinical lab 98.4%, Dialysis 98.9%, Orthotic Device 92.1%, Prosthetic Devise 66.7%, Durable Medical Equipment 95.6%, and Home Health Services 97.5%) survey in MY 2014. Only Prosthetic Devise was below 90%.	Although only 1 of the 7 Ancillary services was 100% (within 15 business days of the request for appointment), there was a total of 6 Ancillary services that reached 92% and greater. 2015 Survey has been fielded. Final results expected in 1st Q 2016.	Y
After Hour Care MOC		92% of practitioners surveyed have after-hour care process such as exchange service, automated answering/paging system, or directly accessible, in order to respond to member call with live person within 30 minutes.	Maria Casias/ Deborah Manders	Annually: Sept '15	MQSC: Sept 1 QOC: June 22	MY 2014 results L. A. Care After Hours overall compliance rate: Medi-Cal Access - 66.3% & Timeliness - 52.6% MY 2014 RE-SURVEY results L.A. Care Adjusted compliance rate: Access - 81.9% & Timeliness - 72.4% L.A. Care Covered Access - 67.8% & Timeliness - 53.9% MY 2014 RE-SURVEY results L.A. Care Adjusted compliance rate: Access - 76.7% & Timeliness - 69.8% Cal MediConnect Access - 66.6% & Timeliness - 50.4%	The goal was not met for the 3 lines of business. For Provider Groups not compliant for a second consecutive year, an Immediate Corrective Action Required (ICAR) was requested. For Provider Groups not compliant for the first time, a Corrective Action Plan was requested. A re-survey of all non compliant PCPs/SCPs will be fielded in August 2015. Medi-Cal & L.A. Care Covered -L.A. Care conducted a re-survey of all providers found non-compliant for after-hours access in the MY 2014 survey. CMC-The Cal MediConnect (CMC) product line began in 2014. There is a 100% crossover of participating provider networks between Medi-Cal and CMC, therefore the Medi-Cal results are reflective of CMC product line.	Y
Routine Primary Care (Non-Urgent) MOC		95% of practitioners surveyed have routine primary visits available within 10 business days	Maria Casias/ Deborah Manders	Annually: Sept '15	MQSC: Sept 1	May 2015 MY 2014 results received. L. A. Care Appointment Availability overall compliance rate: Medi-Cal 89.5% L.A. Care Covered 90.3% Cal MediConnect 89.9%	The goal was not met for the 3 lines of business. A Corrective Action Plan was requested of all non compliant Provider Groups. Working with PPGs to improve overall Timely Access to Care. MY 2015 survey completed pending results in 1st Q 2016	Y
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/ Deborah Manders	Annually: Sept '15	MQSC: Sept 1 QOC: June 22	May 2015 MY 2014 results received. L. A. Care Appointment Availability overall compliance: Medi-Cal 86.8% L.A. Care Covered 86.8% Cal MediConnect 86.8%	The goal was not met for the 3 lines of business. A Corrective Action Plan was requested of all non compliant Provider Groups. Working with PPGs to improve overall Timely Access to Care. MY 2015 survey completed pending results in 1st Q 2016	Y

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
Urgent Care (PCP) MOC		98% of urgent care appointments available within 48 hours	Maria Casias/ Deborah Manders	Annually: Sept '15	MQSC: Sept 1 QOC: June 22	May 2015 MY 2014 results received. L. A. Care Appointment Availability overall compliance: <u>Medi-Cal</u> 70.4% <u>L.A. Care Covered</u> 70.9% <u>Cal MediConnect</u> 70.7%	The goal was not met for the 3 lines of business. A Corrective Action Plan was requested of all non compliant Provider Groups. Working with PPGs to improve overall Timely Access to Care. MY 2015 survey completed pending results in 1st Q 2016	Y
Service - Availability								
Drive Distance to PCP MOC		95% of members have access to a PCP within 10 miles radius of their primary residence	Gwen Cathey	Annually: Sept '15	MQSC: Sept 1	Compliance with drive distance standards to receive primary care are as follows: <u>Medi-Cal</u> - 99.8% <u>LACC</u> : 99.8% <u>CMC</u> : 99.8%		Y
Drive Distance to all SCP, including identified high volume SCP MOC		90% of members have access to specialty care practitioners within 15 miles radius of their primary residence	Gwen Cathey	Annually: Sept '15	MQSC: Sept 1	Compliance with drive distance standards to receive specialty care is as follows: <u>Medi-Cal</u> - 99.4% <u>LACC</u> : 99.6% <u>CMC</u> : 99.8%		Y
Ratio - PCP (excludes mid-level providers) MOC		1: 2000 members	Gwen Cathey	Annually: Sept '15	MQSC: Sept 1	The PCP to member ratio across all primary care types is as follows: <u>Medi-Cal</u> - 1:486 <u>LACC</u> : 1:4 <u>CMC</u> : 1:8		Y

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
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 OPHTHHO: 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 OPHTHHO: 1:5000 UROLOGY: 1:5000 mbrs	Gwen Cathey	Annually: Sept '15	MQSC: Sept 1	The specialist to member ratios for high volume specialists are as follows: Medi-Cal: OB/GYN 1:2387 Cardiovascular Disease 1: 5785 Otolaryngology 1:11697 Ophthalmology 1:6335 Orthopedics 1:8069 LACC: OB/GYN 1:20 Cardiovascular Disease: 1:50 Gastroenterology 1:85 Ophthalmology 1:46 Otolaryngology 1:167 CMC: Nephrology 1:114 Cardiovascular Disease 1:68 Gastroenterology: 1:125 Ophthalmology 1:72 Podiatry 1:636		Y
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	Medi-Cal Rate: 73.81% CMC: Rate: 77.73% LACC: Rate: 47.27%		Y
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	Medi-Cal Rate: 73.91% CMC: Rate: 75.00% LACC: Rate: 60.82%		Y
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	Medi-Cal Rate: 79.70% CMC: Rate: 85.71% LACC: Rate: 74.36%		Y

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	<u>Medi-Cal</u> Rate: 76.38% <u>CMC:</u> Rate: 88.14% <u>LACC:</u> Rate: 83.87%		Y
ADULT - Getting Care Quickly (CAHPS)	Benchmark '14: 86%	79%	Rae Starr/ Mike Shook	Annually: Sept '15	MQSC: Sept 1	<u>Medi-Cal</u> Rate: 73.99% <u>CMC:</u> Rate: 62.66% <u>LACC:</u> Rate: 62.34%		Y
Q4: 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	<u>Medi-Cal</u> Rate: 75.00% <u>CMC:</u> Rate: 70.93% <u>LACC:</u> Rate: 60.53%		Y
Q6: 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	<u>Medi-Cal</u> Rate: 72.98% <u>CMC:</u> Rate: 72.29% <u>LACC:</u> Rate: 56.18%		Y
ADULT - Getting Needed Care (CAHPS)	Benchmark '14: 86%	79%	Rae Starr/ Mike Shook	Annually: Sept '15	MQSC: Sept 1	<u>Medi-Cal</u> Rate: 73.44% <u>CMC:</u> Rate: 71.71% <u>LACC:</u> Rate: 62.34%		Y
Q25: How often was it easy to get appointments with specialist?		80%	Rae Starr/ Mike Shook	Annually: Sept '15	MQSC: Sept 1	<u>Medi-Cal</u> Rate: 71.01% <u>CMC:</u> Rate: 67.00% <u>LACC:</u> Rate: 80.00%		Y
Q14: 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	<u>Medi-Cal</u> Rate: 75.88% <u>Medicare:</u> Rate: 76.42% <u>LACC:</u> Rate: 65.00%		Y

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 - Customer Service (CAHPS)	Benchmark '14: 90%	89%	Rae Starr/ Maribel Ferrer	Annually: Sept '15	MQSC: Sept 1	<u>Medi-Cal</u> Rate: 84.71% <u>CMC</u> : Rate: 82.72% <u>LACC</u> : Rate: 68.07%		Y
ADULT - How Well Doctors Communicate (CAHPS)	Benchmark '14: 92%	88%	Rae Starr/ Mike Shook	Annually: Sept '15	MQSC: Sept 1	<u>Medi-Cal</u> Rate: 88.62% <u>CMC</u> : Rate: 87.99% <u>LACC</u> : Rate: 89.01%		Y
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	<u>Medi-Cal</u> Rate: 84.50%		Y
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	<u>Medi-Cal</u> Rate: 81.36%		Y
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	<u>Medi-Cal</u> Rate: 85.82%		Y
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	<u>Medi-Cal</u> Rate: NA%		Y
CHILD - Getting Care Quickly (CAHPS)	Benchmark '14: 95%	84%	Rae Starr/ Mike Shook	Annually: Sept '15	MQSC: Sept 1	<u>Medi-Cal</u> Rate: 81.10%		Y
Q4: 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	<u>Medi-Cal</u> Rate: 82.50%		Y

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
Q6: 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	<u>Medi-Cal</u> Rate: 79.71%		Y
CHILD - Getting Needed Care (CAHPS)	Benchmark '14: 91%	81%	Rae Starr/ Mike Shook	Annually: Sept '15	MQSC: Sept 1	<u>Medi-Cal</u> Rate: 77.18%		Y
Q46: How often was it easy to get appointments with specialist?		70%	Rae Starr/ Mike Shook	Annually: Sept '15	MQSC: Sept 1	<u>Medi-Cal</u> Rate: NA%		Y
Q15: 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	<u>Medi-Cal</u> Rate: 81.02%		Y
CHILD - Customer Service (CAHPS)	Benchmark '14: 92%	88%	Rae Starr/ Maribel Ferrer	Annually: Sept '15	MQSC: Sept 1	<u>Medi-Cal</u> Rate: 81.72%		Y
CHILD - How Well Doctors Communicate (CAHPS)	Benchmark '14: 96%	90%	Rae Starr/ Mike Shook	Annually: Sept '15	MQSC: Sept 1	<u>Medi-Cal</u> Rate: 86.25%		Y
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	<u>Medi-Cal:</u> 1st Qtr.: 97.2% 2nd Qtr.: 97.71% 3rd Qtr.: 97.12% 4th Qtr.: 98.87% <u>CMC:</u> 1st Qtr.: 82.97% 2nd Qtr.: 67.36% 3rd Qtr.: 59.69% 4th Qtr.: 100% <u>LACC:</u> 1st Qtr.: 100% 2nd Qtr.: 95.24% 3rd Qtr.: 100% 4th Qtr.: 100%		Y

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
Complaint Resolution MOC		100% complaint resolution within 30 days	Barbara Skier	Quarterly Reports	MQSC: March 10, June 09, Sept 1, Nov 2	Medi-Cal: 1st Qtr.: 99.49% 2nd Qtr.: 99.57% 3rd Qtr.: 97.85% 4th Qtr.: 98.24% CMC: 1st Qtr.: 100% 2nd Qtr.: 99.55% 3rd Qtr.: 99.52% 4th Qtr.: 96.07% LACC: 1st Qtr.: 98.20% 2nd Qtr.: 99.47% 3rd Qtr.: 94.19% 4th Qtr.: 98.58%		Y
Complaint & Appeals Analysis - Complaint categories based on the following categories: Quality of Care, Access, Attitude/Service, Billing/Financial, and Quality of Practitioner Office Site		100% of complaints & appeals will be analyzed quarterly to identify top 5 complaint categories.	Barbara Skier	Quarterly Reports	MQSC: March 10, June 09, Sept 1, Nov 2	Medi-Cal: 1st Qtr.: 1,486 2nd Qtr.: 3,225 3rd Qtr.: 4,231 4th Qtr.: 4,072 CMC: 1st Qtr.: 134 2nd Qtr.: 314 3rd Qtr.: 462 4th Qtr.: 468 LACC: 1st Qtr.: 352 2nd Qtr.: 711 3rd Qtr.: 591 4th Qtr.: 525		Y
Service - Provider Satisfaction								
PCP satisfaction with UM process		80% of PCPs will be overall satisfied with timely decisions for pre-auths.	Earl Leonard	Annually: Sept '15	UMC: Mar '15	2014 Rate: 85.2% 2015 Provider Satisfaction Survey Results due Q1 2016.	Survey was fielded Oct. 2015. Eligible Population: 3,578 2,000 Samples Drawn:	Y
PCP satisfaction with UM process		80% of PCPs will be overall satisfied with clinically reasonable decisions for pre-auths.	Earl Leonard	Annually: Sept '15	UMC: Mar '15	2014 Rate: 82.6% 2015 Provider Satisfaction Survey Results due Q1 2016.	Survey was fielded Oct. 2015. Eligible Population: 3,578 2,000 Samples Drawn:	Y
SCP satisfaction with UM process		80% of SCPs will be overall satisfied with timely decisions for pre-auths.	Earl Leonard	Annually: Sept '15	UMC: Mar '15	2014 Rate: 72.9% 2015 Provider Satisfaction Survey Results due Q1 2016.	Respondents from 11 PPG's were less than 80% satisfied with timely decisions for pre-auths. They are ACCT, AMGS, AMHS, AP, BCBS, BVMG, EHSG, GCMG, HCLA, NWHC, OMNI, and PROV. Survey was fielded Oct. 2015. Eligible Population: 4,064 Samples Drawn: 1,000	Y

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
SCP satisfaction with UM process		80% of SCPs will be overall satisfied with clinically reasonable decisions for pre-auths.	Earl Leonard	Annually: Sept '15	UMC: Mar '15	2014 Rate: 67.9% 2015 Provider Satisfaction Survey Results due Q1 2016.	Respondents from only 2 PPG's were more than 80% satisfied with clinically reasonable decisions for pre-auths. Survey was fielded Oct. 2015. Eligible Population: 4,064 Samples Drawn: 1,000	Y
Clinical Improvements and Initiatives								
Clinical - Continuity and Coordination of Medical Care								
Coordination of Care: PCP/SCP Communication MOC	NA	80% of PCPs will rate their communication with SCPs Always/Often	Mike Shook/ Earl Leonard/ Whitney Franz	Annually: Sept '15	Quality Oversight Committee (QOC) Oct 26 and Joint PICC & PQC Feb 2016	2014 Rate: 37.3% 2015 Provider Satisfaction Survey Results due Q1 2016.	Goal in 2014 was not met. Result decreased from 48.4% in 2013 to 37.3% in 2014 (11.1% decrease). An intervention may be necessary to improve measure. Survey was fielded Oct. 2015. Eligible Population: 3,578 Samples Drawn: 2,000	Y
Coordination of Care: SCP/PCP Communication MOC	NA	80% of SCPs will rate their communication with PCPs Always/Often	Mike Shook/ Earl Leonard/ Whitney Franz	Annually: Sept '15	Quality Oversight Committee (QOC) Oct 26 and Joint PICC & PQC Feb 2016	2014 Rate: 53.2% 2015 Provider Satisfaction Survey Results due Q1 2016.	Goal in 2014 was not met. Result decreased from 60.2% in 2013 to 53.2% in 2014 (7% decrease). An intervention may be necessary to improve measure. Survey was fielded Oct. 2015. Eligible Population: 4,064 Samples Drawn: 1,000	Y
Coordination of Care: SCP/PCP Communication, eConsult reports	NA	Trend the portion of total eConsults closed as "Patient Needs Addressed" (PNA)	Whitney Franz/ Jennifer McCullough/ Shamika Mane	Quarterly Reports	4th Qtr. Attached to QI Eval; included in Coordination of Care Report Quality Oversight Committee (QOC) June 2016	Medi-Cal, CMC, LACC combined: 1st Qtr.: 1.9% (213/11,520) 2nd Qtr.: 1.2% (293/13,186) 3rd Qtr.: 1.8% (225/12,310) 4th Qtr.: 1.2% (141/11,448) Year: 1.8% (872/48,464)		Y
Coordination of Care: Transitions in Management, ED/Inpatient to PCP	NA	Trend proportion of ER admissions and inpatient admissions captured by eConnect Pilot Program	Whitney Franz/ Ali Modaresi	Annually: Sept '15	4th Qtr. Attached to QI Eval; included in Coordination of Care Report Quality Oversight Committee (QOC) June 2016	Citrus Valley Hospital: ER: 5,219 Inpatient: 2,762 Grand Total: 7,981 Foothill Presbyterian Hospital: ER: 2,286 Inpatient: 619 Grand Total: 2,905 Inter Community Medical Center: ER: 2,116 Inpatient: 663 Grand Total: 2,779 Memorial Health Services: ER: 10,280 Inpatient: 3,522 Grand Total: 13,802 Valley Presbyterian Hospital: ER: 2,365 Inpatient: 611 Grand Total: 2,976	Include breakdown of ER admissions and inpatient admissions by participating hospitals and associated PPGs	Y

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
Coordination of Care: Outpatient Setting, Pharmacy to PCP communication, Polypharmacy	NA	NA	NA	NA	4th Qtr. Attached to QI Eval; included in Coordination of Care Report QOC June 2016	NA	Included in "Clinical - Patient Safety" section	Y
Coordination of Care: Outpatient Setting, Pharmacy to PCP communication, Monitoring of Patients on Persistent Medications (MPM)	NA	NA	NA	NA	4th Qtr. Attached to QI Eval; included in Coordination of Care Report QOC June 2016	NA	Included in HEDIS "Other Measures"	Y
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	Betty Santana/ Beacon	Annual: Due Oct '15	Behavioral Health Quality Improvement Committee (BHQIC): Dec 17	Survey was fielded in Q4 of 2014. Results show County met the goal for 'Accurate' but not for the other four measures: sufficient, timely, clear, as often as needed. Beacon met the goal for 'Clear'.		Y
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	AMM (Acute Phase): Medi-Cal: 49.14% Medicare: NA AMM (Continuation Phase): Medi-Cal: 32.86% Medicare: NA	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016.	Y

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
Appropriate uses of Psychopharmacological medications	NA	100% of providers will be notified of members who meet criteria (9 or more of the following): RXs for controlled substances + unique prescribers + unique pharmacies in 2 of 4 months	Gayle Butler/ Clayton Chau	Quarterly	BHQIC: Dec 17	<p>Medi-Cal: March: 181 members identified, 619 prescribers mailed July: 463 members identified, 1,550 prescribers mailed November: 486 members identified, 1,614 prescribers mailed</p> <p>CMC: March: 10 members identified, 34 prescribers mailed July: 16 members identified, 58 prescribers mailed November: 13 members identified, 61 prescribers mailed</p> <p>LACC: March: 1 member identified, 3 prescribers mailed July: 2 members identified, 13 prescribers mailed November: 0 members identified, 0 prescribers mailed</p> <p>PASC-SEIU: March: 3 members identified, 13 prescribers mailed July: 9 members identified, 33 prescribers mailed November: 8 members identified, 37 prescribers mailed</p>	New as of 2015: Intervention mailings for Controlled Substance Monitoring through the RDUR Program occur 3x year (March, July, November). Outcomes monitoring to occur at a later time after November mailings.	Y
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	<p>Q1 & Q2: Pharmacy data for members on antidiabetics and antipsychotic medication provided to BH on 6/18/15 with updates on 7/5/15 and 7/18/15. Members on antipsychotics: 36,683 Members on antidiabetics and antipsychotics: 3,038</p> <p>Q3: Members on antipsychotics: 36,645 Members on antidiabetics and antipsychotics: 3,008. Update 10/21/15 - the provider antipsychotic letter is completed, approved by marketing and now pending approval from R&AC. Anticipated mail date of the letter provider is 10/30/15. Second target provider mailing date with updated member data is 12/30.</p> <p>Q4: A total of 1,929 PCPs received notification about which of their patients were on antipsychotics and antidiabetics. Most were from those that treat Medi-Cal members (1363), followed by those that treat Cal Medi-Connect members (541). Lastly, 25 L.A. Care Covered PCPs received the letter. The mailings cover 36,493 members. As of December 31, 2015, only three letters for CMC providers have been returned. The reach rate is currently at 99.8%. The goal of notifying 100% of providers was met for Medi-Cal and L. A. Care Covered.</p>	Medi-Cal: Letters will be sent Q3 for all MCLA, CMC, LACC.	Y

**L.A. Care Health Plan
2015 QI Work Plan
Q4**

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
Primary or secondary preventive behavioral health program	NA	100% of members that screen positive on the PHQ-2 will receive a behavioral health consultation	Clayton Chau	Quarterly	BHQIC: March 12, June 18, Sept 16, Dec 17	Medi-Cal: Q1 & Q2: total 47.4% 3rd Qtr.: 1.6% 4th Qtr.: 3.7% CMC: Q1 & Q2: total 17% 3rd Qtr.: 2.6% 4th Qtr.: 7.2% LACC: Q1 & Q2: Pending data 3rd Qtr.: unavailable 4th Qtr.: N/A	Our available data shows the combined numbers for 1st and 2nd quarters for Medical and CMC. Though the Medical data from DMH is not fully received due to IT issues, average 1/2 Medical members with PHQ2 positive receives BH service. LACC data is pending and will report soon.	Y
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	Pacoima FRC: Q1: Being Happy- 5 members Q2: Grief and Loss - 5 members; Benefits of Meditating - 9 members; What is Mental Illness - 11 members; What is Depression - 9 members; Anxiety and Coffee: Combining the two - 7 members; Learning to Relax - 15 members; Depression and Anxiety - 25 members; and Meditation - 12 members Q3: 8 sessions with 75members. Sessions included Anxiety Disorders, Depression, Meditation and Wellness Circle. Q4: Meditation-9 members; Wellness Circle-4 members; Depression or Sadness-3 members; Getting the most out of our relationships I & II-33members; Coping with Stress during the Holidays-10 members. Lynwood FRC: Q1 & Q2: Anxiety 25 participants/5 members/MCLA; Calming & Relaxing Techniques 23 participants/3 members/MCLA; Responding Better to Stress (coping tips) 18 participants/1 member/MCLA; Managing Stress 25 participants/3 members/MCLA Q3:14 Sessions with 26 members:sessions include Stress Management, Depression, Healing thru Art and Relaxing thru art. Q4: Healing thru Art with 12 members, Relaxing using Art with 8 members, Stress and Anxiety Management 18 members, Fighting Stress thru Art 8 members, Depression and Suicide in Adults 1 members	Inglewood FRC: Q2: Behavioral Health/ 4 MCLA members Q3: 6 sessions 39 members Q4: Behavioral Health: Anger Management, Stress Management, Building Healthy Relationships -16 members. Boyle Heights FRC: Data unavailable for Q1, Q2, Q3 Q4: Wellness Circle: Building Healthy Relationships/2MCLA members; Wellness Circle: Unhealthy Relationships/2 MCLA members; Wellness Circle: Anger Management/3 MCAL members	Y
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	Medi-Cal: Rate: 78.40% Num: 265 Den: 338		Y

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 Improvements Note that for HEDIS measures goals are set ensuring that MPLs are met. <i>Italicized measures are also auto-assignment measure.</i> Bolded measures are also NCQA Accreditation measures. * Are measures used by NCQA to report the top health plans.	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						LACC is entering into the beta-test; therefore, the Plan rate will not be publicly reported. LACC rate reported is an internal rate (15 measures).		
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/ Ester Bae	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	Medi-Cal: Rate: 69.52% Den: 374 Num: 260 LACC: Rate: 37.93% Den: 29 Num: 11 Provider child/adolescent wellness flyer (checklist) to be sent in 08/15.	Childhood & Adolescent Wellness flyers were mailed in August 2015 to solo and small group MediCal and LACC providers; it provides a guide of recommended health services that different age groups should receive.	Y
Adolescent Well Care (Physician P4P and LA P4P)	Benchmark '14: 65.56%	Medi-Cal: 59% LACC: TBD	Mike Shook/ Michael Tu/ Ester Bae	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	Medi-Cal 2014 Rate Rate: 50.12% Den: 209,119 Num: 411 Medi-Cal 2015 Rate: 50.12% (Rotated hybrid rate reported for H2015) Den: 285,376 Num: 111,444 2015 Admin only rate: 39.05% Provider child/adolescent wellness flyer (checklist) to be sent in 08/15. LACC: Rate: 15.82% Den: 196 Num: 31	2015 Rate (Measure Rotation- Measure rotation allows an organization to use the audited and reportable Hybrid Method from the prior year's data collection in lieu of collecting the measure for the measurement year). Childhood & Adolescent Wellness flyers were mailed in August 2015 to solo and small group MediCal and LACC providers; it provides a guide of recommended health services that different age groups should receive.	Y

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
<u>Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents</u>	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	Medi-Cal: BMI Rate: 80.15% Den: 398 Num: 319 Nutrition Rate: 80.15% Den: 398 Num: 319 Physical Activity Rate: 69.35% Den: 398 Num: 276 LACC: BMI Rate: 43.59% Den: 39 Num: 17 Nutrition Rate: 35.90% Den: 39 Num: 14 Physical Activity Rate: 25.64% Den: 39 Num: 10	Childhood & Adolescent Wellness flyers were mailed in August 2015 to solo and small group MediCal and LACC providers; it provides a guide of recommended health services that different age groups should receive.	Y
<u>Childhood Immunizations- Combo_3</u>	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	Medi-Cal: Rate: 77.65% Den: 434 Num: 337	Childhood & Adolescent Wellness flyers were mailed in August 2015 to solo and small group MediCal and LACC providers; it provides a guide of recommended health services that different age groups should receive; Joint member and provider CIS-3 incentives were launched in October 2015 that provides \$25 Target giftcard to members & \$25 check to providers if members turning 2 in Oct-Dec 2015 get all CIS-3 vaccines.	Y
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	Medi-Cal: Rate: 86.49% Den: 138,671 Num: 119,943		Y

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
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	<u>Medi-Cal:</u> <u>MCV</u> Rate: 80.75% Den: 348 Num: 281 <u>TDaP</u> Rate: 89.08% Den: 348 Num: 310 <u>Combo 1</u> Rate: 77.01% Den: 348 Num: 268	IMA incentive (\$25 Target GifstCard) launched in October 2015 that targets adolescents aged 11-12 years that will be turning 13 years in Oct-Dec 2015 that are eligible for IMA.	Y
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	<u>Medi-Cal:</u> Rate: 25.51% Den: 21,089 Num: 5,379		Y
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	<u>Medi-Cal:</u> Rate: 87.45% Den: 8,440 Num: 67,266		Y
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	<u>Medi-Cal:</u> Rate: 82.16% Den: 426 Num: 350 <u>LACC:</u> Rate: 47.62% Den: 21 Num: 10 Q1 & Q2: Working with Text4Baby to establish a data sharing agreement in which Text4Baby will help LAC identify pregnant members enrolled in the service. Q3: Developing plan to invite LAC members to joinText4Baby; Voxiva will inform LAC of members who enrolled and thus are pregnant or new moms. Q4:		Y

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
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	Medi-Cal: Rate: 57.04% Den: 426 Num: 243 Met MPL and NO IP plan is needed for this measure. LACC: Rate: 33.33% Den: 21 Num: 7	No Postpartum IP this year The number of members identified declined significantly from Q1 to Q2 due to extended delegation. It is unclear why the number of members identified increased from Q2 to Q3. Efforts are ongoing to improve identification of members.	Y
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	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	Medi-Cal: Rate: 57.69% Den: 31,219 Num: 18,011	Met goal and was a statistically significant rate. In Q3 and Q4 interventions will include member calls and mailers.	Y
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	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	Medi-Cal: Rate: 61.79% Den: 390 Num: 241 LACC: Rate: 24.82% Den: 427 Num: 106		Y

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
Chlamydia Screening In Women (Physician Incentive and LA P4P)	Benchmark 14: 67.19% LACC: TBD	Medi-Cal: 63% LACC: TBD	Mike Shook/ Michael Tu/ Nai Kasick	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	Medi-Cal: Rate: 61.39% Num: 19,955 Den: 32,507 LACC: Rate: 48.39% Den: 31 Num: 15 1st Qtr.: Intervention planning and evaluation of past interventions. 2nd Qtr.: LAC Providers received a blast fax on chlamydia screening guidelines, as well as an article on the importance of screening in Progress Notes. Worked with California Family Health Councils to draft effective messages for providers and members. 3rd Qtr.: 18-24 year old members in the denominator received a mailer on the importance of screening. The parents of 16-17 years old members in the denominator received a mailer on preventive screenings, including chlamydia. Both mailing went to MCLA & LACC members.	Mailing for 18-24 year old members in the denominator on the importance of screening will release to print in early August. Mailing to the parents of 16-17 years old members in the denominator on preventive screenings is under DHCS review. ON TRACK TO MEET GOAL. All interventions are for both MCLA & LACC. Additional provider interventions planned for Q4.	Y
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	Medi-Cal: Rate: 80.19% Num: 8,904 Den: 11,103		N
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	Medi-Cal: <u>Population 50% Covered</u> Rate: 46.69% Num: 4,123 Den: 8,830 <u>Population 75% Covered</u> Rate: 24.85% Num: 2,194 Den: 8,830		Y

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: 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	Medi-Cal: Rate: 49.65% Num: 215 Den: 433 LACC: Rate: 29.28% Den: 181 Num: 53		Y
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	Medi-Cal: Rate: 83.14% Num: 360 Den: 433 LACC: Rate: 87.85% Den: 181 Num: 159		Y
Diabetes: A1C Poor Control (>9.0%) (The lower the results the less members in poor control.)	Benchmark 14: 30.28%	Medi-Cal: 36%	Mike Shook/ Michael Tu	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	Medi-Cal: Rate: 41.80% Num: 181 Den: 433 LACC: Rate: 58.56% Den: 181 Num: 106		Y
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	Medi-Cal: Rate: 45.96% Num: 200 Den: 433 LACC: Rate: 30.39% Den: 181 Num: 55		Y
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	Medi-Cal: Rate: 86.61% Num: 375 Den: 433 LACC: Rate: 82.32% Den: 181 Num: 149		Y

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
<u>Diabetes: Blood Pressure Control (<140/90 mm Hg)</u>	Benchmark 14: 75.18%	Medi-Cal: 61%	Mike Shook/ Michael Tu	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	Medi-Cal: Rate: 65.13% Num: 282 Den: 433 LACC: Rate: 50.28% Den: 181 Num: 91		Y
Other Chronic Conditions Measures								
<u>Controlling High Blood Pressure</u>	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	Medi-Cal: Rate: 66.83% Num: 276 Den: 413 LACC: Rate: 45.76% Den: 177 Num: 81		Y
<u>Use of Imaging Studies for Low Back Pain</u>	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	Medi-Cal: Rate: 79.73% Num: 1,390 Den: 6,856 LACC: Rate: 63.64% Den: 22 Num: 8		Y
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	Medi-Cal: Rate: 10.82% Num: 211 Den: 1,950		Y
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	Medi-Cal: Rate: 60.39% Num: 1,183 Den: 1,959		Y
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	Medi-Cal: Rate: 82.59% Num: 1,618 Den: 1,959		Y

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								
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)	Q3: Quality and Accuracy score of 96% met for Q3 Q4: Quality and Accuracy score of 89% met for Q4.	Measure will be effective July 1, 2015. 1st reporting 3rd Q 2015.	Y
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	Yana Paulson/ Gayle Butler	Quarterly: Annual Analysis	MQSC: March 10, June 09, Sept 1, Nov 2 QOC: January (Annual Analysis)	Member single-sign on portal is active and available at https://members.lacare.org/ . Pharmacy formulary information (updated monthly) is also posted in the member section of the L.A. Care website. Website functionality with tester ID MCLA: 3rd Qtr: 100% 4th Qtr: 100% CMC: 3rd Qtr: 100% 4th Qtr: 100% LACC: 3rd Qtr: 100% 4th Qtr: 100%	Measure effective and process complete as of July 1, 2015. 1st reporting 3rd Q 2015	Y
Quality and Accuracy of the Benefit information on the Web (NCQA - MEM 5)	NA	Members can obtain personalized health information on the Web site in one attempt or contact 100% of the time	Marella Umali/ Amanda Wolarik	Quarterly: Annual Analysis	MQSC: March 10, June 09, Sept 1, Nov 2 QOC: January (Annual Analysis)	Q3: Quality and Accuracy score of 100% met for Q3 Q4: Quality and Accuracy score of 100% met for Q4.	Measure will be effective July 1, 2015. 1st reporting 3rd Q 2015.	Y
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)	Q3: Quality and Accuracy score of 92% met for the Q3 Q4: Quality and Accuracy score of 93% met for Q4.	Measure will be effective July 1, 2015. 1st reporting 3rd Q 2015.	Y
Quality of email response (NCQA - MEM 5)	NA	100% of member email inquiries will be responded to within 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)	Q3: Audit Result: 98% of member email inquiries were responded to within one business day for Q3 Q4: Audit Result: 94% of member email inquiries were responded to within one business day for Q4.	Measure will be effective July 1, 2015. 1st reporting 3rd Q 2015.	Y

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
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	Medi-Cal: Rate: 29.73 Num: 2,598 Den: 3,697		Y
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	Medi-Cal: Rate: 75.21%		Y
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	Medi-Cal: Rate: 41.88%		Y
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	Medi-Cal: Rate: 40.52%		Y
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	Medi-Cal: Rate: 90.48% Num: 228 Den: 251		Y
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	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	Medi-Cal: Rate: 86.55% Num: 40,467 Den: 46,753 Goal met. Rate met minimum performance due to improved data capture from DHS and an outreach to members and providers in 2014. NO IP plan is needed for this measure. LACC: Rate: 81.56% Den: 141 Num: 115	Included in Coordination of Care (Pharmacy-PCP) section	Y

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
Annual Monitoring for Patients on Persistent Medications-Digoxin	Benchmark 14: 95.65% LACC: TBD	Cal: 89% LACC: TBD	Medi-Cal: Michael Tu/ Bettsy Santana	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	Medi-Cal: Rate: 47.43% Num: 342 Den: 721 LACC: Rate: 50.00% Den: 2 Num: 1	Included in Coordination of Care (Pharmacy - PCP) section	Y
Annual Monitoring for Patients on Persistent Medications-Diuretics	Benchmark 14: 92.11% LACC: TBD	Medi-Cal: 86% LACC: TBD	Michael Tu/ Bettsy Santana	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	Medi-Cal: Rate: 85.67% Num: 23,157 Den: 27,029 LACC: Rate: 77.33% Den: 75 Num: 58	MPM IP Included in Coordination of Care (Pharmacy - PCP) section	Y
Adult Access to Primary/Ambulatory Health Services (HEDIS) MOC	N/A	87%	Linda Lee/ Earl Lenard/ Michael Tu	Annual: Due June '15	QOC: Sept 28 PICC & PQC: Oct 6	Medi-Cal: Members aged 20-44: Rate: 60.92% Den: 230,504 Num: 140,431 Members aged 45-64: Rate: 78.87 % Den: 188,763 Num: 148,875 Members aged 65 and older: Rate: 77.44% Den: 23,336 Num: 18,071 LACC: Members aged 20-44: Rate: 33.24% Den: 2,121 Num: 705 Members aged 45-64: Rate: 41.56% Den: 2,495 Num: 1,037 Members aged 65 and older: Rate: 46.94% Den: 49 Num: 23	-Analyzing enrollment and disenrollment trends -Analyzing Morpace member survey results for additional intervention efforts -Initiating Customer Service Standards sub-workgroup to strategize interventions to improve Customer satisfaction (CAHPS measure) -Streamlining member touch points by assessing/consolidating all communication to develop high value content	Y

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
Topical Fluoride Varnish Utilization	Benchmark not available		Michael Tu/ Betsy Santana	Annual: By June '15	QOC: June 22	16.62 PTPY individuals received fluoride treatment in 2014 compared to 4.48 PTPY in 2013 (<6 yrs).		Y
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/ Ester Bae	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	<u>Medi-Cal:</u> <u>0 Visits</u> Rate: 4.22% Num: 462 Den: 10,960 <u>1 Visit</u> Rate: 3.99% Num: 437 Den: 10,960 <u>2 Visits</u> Rate: 6.34% Num: 695 Den: 10,960 <u>3 Visits</u> Rate: 13.44% Num: 1,473 Den: 10,960 <u>4 Visits</u> Rate: 25.82% Num: 2,830 Den: 10,960 <u>5 Visits</u> Rate: 24.99% Num: 2,739 Den: 10,960 <u>6 or more Visits</u> Rate: 21.20% Num: 2,324 Den: 10,960 Provider child/adolescent wellness flyer (checklist) to be sent in Q3/15.	Childhood & Adolescent Wellness flyers were mailed in August 2015 to solo and small group MediCal and LACC providers; it provides a guide of recommended health services that different age groups should receive	Y
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	<u>Medi-Cal:</u> Rate: 65.66% Num: 22,687 Den: 34,550		Y
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	<u>Medi-Cal:</u> Rate: 30.99% Num: 533 Den: 1,720	Same as individual measures	Y

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
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	MCLA: 80.05% *Total eligible population: 3,444 *MCLA Numerator: 2,757 CMC Rate: 100% *CMC Numerator: 2 *CMC Denominator: 2	o Goal was not met. oTo improve rate/goal the following interventions are in place to improve outcomes: *Member Asthma Refill Reminder Letter *Provider Asthma Refill Reminder Letter *Member Asthma Refill Reminder Live Call Campaign *Member Asthma Refill Reminder IVR Call Campaign	N
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	MCLA Rate: 49.45% *Total eligible population: 2,730 *MCLA Numerator: 1,350 CMC Rate: 100% *CMC Numerator: 2 *CMC Denominator: 2	o Goal was not met. oTo improve rate/goal the following interventions are in place to improve outcomes: *Member Asthma Refill Reminder Letter *Provider Asthma Refill Reminder Letter *Member Asthma Refill Reminder Live Call Campaign *Member Asthma Refill Reminder IVR Call Campaign	Y
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	MCLA Rate: 27.47% *Total eligible population: 2,730 *MCLA Numerator: 750 CMC Rate: 100% *CMC Numerator: 2 *CMC Denominator: 2	o Goal was not met. oTo improve rate/goal the following interventions are in place to improve outcomes: *Member Asthma Refill Reminder Letter *Provider Asthma Refill Reminder Letter *Member Asthma Refill Reminder Live Call Campaign *Member Asthma Refill Reminder IVR Call Campaign	Y
Inappropriate Use of Asthma Relievers		100% of providers who had members who received 4 or more prescriptions for asthma medications over the previous 12 months	Yana Paulson/ Gayle Butler	Annual: By June '15	QOC: 4/27/15, 7/27/15, 10/22/15 4th Qtr. Attached to QI Eval	Discontinued as of January 2015. Pharmacy does not recommend this measure/intervention due to limited utility.	Continue Quarterly DUE program to identify members for letter submission to providers. Implement referrals to Case Management	N
% of members who have Asthma Action Plan		75%	Elaine Sadocchi-Smith	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	32.70%	36.00% reported reviewing Asthma Action Plan with their doctor	Y
% 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	53.30%		Y

**L.A. Care Health Plan
2015 QI Work Plan
Q4**

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
Asthma Disease Management Program Membership		N/A	Elaine Sadochi-Smith	Identified Monthly; reported quarterly	QOC: Jan 26, June 22, July 27, Oct 26	MCLA: 1st Qtr.: 80,363 2nd Qtr.: 84,387 3rd Qtr.: 85,259 4th Qtr.: 88,279 (as of November) CMC: 1st Qtr.: 62 2nd Qtr.: 165 3rd Qtr.: 259 4th Qtr.: 283 (as of November) LACC: 1st Qtr.: 199 2nd Qtr.: 244 3rd Qtr.: 252 4th Qtr.: 264 (as of November)	This includes all members with severity levels 1-3 enrolled in the Asthma Disease Management program.	Y
Member Satisfaction with Disease Management Programs- Asthma		90% of the members in Asthma program will be overall satisfied	Elaine Sadochi-Smith	Annual: Due Dec 31	QOC: Sept 28	81.80%		Y
Inquiries re: Asthma		N/A	Maribel Ferrer/ Elaine Sadochi-Smith	Quarterly	QOC: Jan 26, June 22, July 27, Oct 26	Medi-Cal: 1st Qtr.: 74 2nd Qtr.: 87 3rd Qtr.: 85 4th Qtr.: 28 CMC: 1st Qtr.: 1 2nd Qtr.: 0 3rd Qtr.: 2 4th Qtr.: 0 LACC: 1st Qtr.: 0 2nd Qtr.: 2 3rd Qtr.: 0 4th Qtr.: 0		Y
Complaints re: Asthma		0	Maribel Ferrer/ Elaine Sadochi-Smith	Quarterly	QOC: Jan 26, June 22, July 27, Oct 26	Medi-Cal: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: CMC: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: LACC: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.:	DM had staff training on complaint process so that all complaints are captured and sent to Grievances and Appeals.	Y

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
Disease Management Programs- Diabetes								
Diabetes: Eye Exam (retinal) performed	Benchmark 14: 68.04%	MCLA: 45%	Elaine Sadochi-Smith/ Michael Tu	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	MCLA Rate: 49.25% (hybrid) *Total eligible population: 29,320 *MCLA Numerator: 131 *MCLA Denominator: 266 LACC Rate: 29.28% *LACC Numerator: 53 *LACC Denominator: 181 CMC Rate: 28.73% *CMC Numerator: 160 *CMC Denominator: 557	oGoal was met for MCLA. oTo improve rate/goal the following interventions are in place to improve outcomes: -August call campaign for missing services -Development of DM Diabetes booklet including missing services -Development of magnet/whiteboard for diabetes services for members. -Development of member incentive	Y
Diabetes: A1C	Benchmark 14: 91.73%	MCLA: 82%	Elaine Sadochi-Smith/ Michael Tu	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	MCLA Rate: 82.71% (hybrid) *Total eligible population: 29,320 *MCLA Numerator: 220 *MCLA Denominator: 266 LACC Rate: 87.29% *LACC Numerator: 158 *LACC Denominator: 181 CMC Rate: 70.38% *CMC Numerator: 392 *CMC Denominator: 557	oGoal was met for MCLA. oTo improve rate/goal the following interventions are in place to improve outcomes: -August call campaign for missing services -Development of DM Diabetes booklet including missing services -Development of whiteboard for diabetes services for members. -Development of incentive	Y
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 Sadochi-Smith/ Michael Tu	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	MCLA Rate: 43.98% (hybrid) *Total eligible population: 29,320 *MCLA Numerator: 117 *MCLA Denominator: 266 LACC Rate: 58.56% *LACC Numerator: 106 *LACC Denominator: 181 CMC Rate: 63.55% *CMC Numerator: 354 *CMC Denominator: 557	oGoal was not met for MCLA. oTo improve rate/goal the following interventions are in place to improve outcomes: -August call campaign for missing services -Development of DM Diabetes booklet including missing services -Development of magnet/whiteboard for diabetes services for members. -Development of member incentive	Y
Diabetes: A1C Good Control (<8.0%)	Benchmark 14: 59.37%	MCLA: 37%	Elaine Sadochi-Smith/ Michael Tu	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	MCLA Rate: 43.98% (hybrid) *Total eligible population: 29,320 *MCLA Numerator: 117 *MCLA Denominator: 266 LACC Rate: 30.39% *LACC Numerator: 55 *LACC Denominator: 181 CMC Rate: 28.19% *CMC Numerator: 157 *CMC Denominator: 557	oGoal was met for MCLA. oTo improve rate/goal the following interventions are in place to improve outcomes: -August call campaign for missing services -Development of DM Diabetes booklet including missing services -Development of magnet/whiteboard for diabetes services for members. -Development of member incentive	Y

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: 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	MCLA Rate: 86.61% (hybrid) *Total eligible population: 29,320 *MCLA Numerator: 234 *MCLA Denominator: 266 LACC Rate: 82.32% *LACC Numerator: 149 *LACC Denominator: 181 CMC Rate: 81.51% *CMC Numerator: 454 *CMC Denominator: 557	oGoal was not met for MCLA. oTo improve rate/goal the following interventions are in place to improve outcomes: -August call campaign for missing services -Development of DM Diabetes booklet including missing services -Development of magnet/whiteboard for diabetes services for members. -Development of member incentive	Y
Diabetes Disease Management Program Membership		N/A	Elaine Sadocchi-Smith	Identified monthly; reported quarterly	QOC: Jan 26, June 22, July 27, Oct 26	MCLA: 1st Qtr.: 26,299 2nd Qtr.: 31,183 3rd Qtr.: 35,805 4th Qtr.: 38,343 (as of Nov) CMC: 1st Qtr.: 54 2nd Qtr.: 257 3rd Qtr.: 479 4th Qtr.: 1,810 (as of Nov) LACC: 1st Qtr.: 26 2nd Qtr.: 23 3rd Qtr.: 82 4th Qtr.: 164 (as of Nov)	This includes all members with severity levels 1-4 enrolled in the Diabetes Disease Management program.	Y
Member Satisfaction with Disease Management Programs- Diabetes		90%	Elaine Sadocchi-Smith	Annual: Due Dec 31	QOC: Jan 26	72.00%		Y
Inquiries		N/A	Elaine Sadocchi-Smith/ Maribel Ferrer	Quarterly	QOC: Jan 26, June 22, July 27, Oct 26	MCLA: 1st Qtr.: 74 2nd Qtr.: 46 3rd Qtr.: 129 4th Qtr.: 44 CMC: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 2 4th Qtr.: 0 LACC: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 2 4th Qtr.: 0		Y

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		0	Elaine Sadocchi-Smith/ Maribel Ferrer	Quarterly	QOC: Jan 26, June 22, July 27, Oct 26	Medi-Cal: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: 0 CMC: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: 0 LACC: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: 0	DM had staff training on complaint process so that all complaints are captured and sent to Grievances and Appeals.	Y
Disease Management Programs-Cardiovascular Disease (CVD)								
CVD Disease Management Program Membership		N/A	Elaine Sadocchi-Smith	Identified Monthly; reported quarterly	QOC: Jan 26, June 22, July 27, Oct 26	 CMC: 1st Qtr.: 4,902 2nd Qtr.: 5,101 3rd Qtr.: 5,238 4th Qtr.: 4,440 (as of Nov) LACC: 1st Qtr.: 1,697 2nd Qtr.: 1,830 3rd Qtr.: 1,942 4th Qtr.: 1,363 (as of Nov)	This includes all members with severity levels 1-3 enrolled in the CVD Disease Management program.	Y
Member Satisfaction with Disease Management Programs- CVD		90% of the members in CVD program will be overall satisfied	Elaine Sadocchi-Smith	Annual: Due Dec 31	QOC: Sept 28	73% of the members who responded to the 1st annual CVD satisfaction survey were satisfied with the services from the CVD program.	This question is on the 2015 survey that will be mailed 7/24/2015. Data available in Q4.	Y
Inquiries re: CVD		N/A	Maribel Ferrer/ Elaine Sadocchi-Smith	Quarterly	QOC: Jan 26, June 22, July 27, Oct 26	 CMC: 1st Qtr.: 5 2nd Qtr.: 15 3rd Qtr.: 9 4th Qtr.: 5 LACC: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: 0		Y

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: CVD		0	Maribel Ferrer/ Elaine Sadocchi-Smith	Quarterly	QOC: Jan 26, June 22, July 27, Oct 26	CMC: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: 0 LACC: 1st Qtr.: 0 2nd Qtr.: 0 3rd Qtr.: 0 4th Qtr.: 0	DM had staff training on complaint process so that all complaints are captured and sent to Grievances and Appeals.		Y
State Quality Improvement Projects									
All-Cause Readmissions - Statewide <u>Collaborative QIP measure</u>		14.78%	Betty Santana/ Demitira Malloy/ Michael Tu	Due to State: Sept. 30, 2015	QOC: Sept 28 PICC & PQC: Oct 6	QIP closed in April of 2015. HEDIS 2015 rate was 20.83%.	Consider removing from the work plan.	N	
Diabetes QIP		A1c Screening Medi-Cal: 84.% DRE Medi-Cal: 56%	Mike Shook/ Betty Santana	Annual: By Aug. 29, 2015	QOC: Sept 28 PICC & PQC: Oct 6	Goal for eye exam and A1c screening was not met. QIP submission date has not been established. A1c Screening Medi-Cal: 83% DRE Medi-Cal: 50%	The State is considering closing this QIP and may start a new QIP in the fall.	N	
Clinical - <i>Patient Safety</i>									
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	Q1 and Q2: All 70 PQI cases closed within 6 months. Q3: All 40 PQI cases closed within 6 months. Q4: 49 PQI cases closed within 6 months, 1 PQI case closed after 6-month due date after peer reviewed by 3 physicians.		Y	
FSR- needlestick safety		75%	Dulce Fernandez	Annual	QOC: March 23	Annual: For FY 2014- 2015, the compliance rate for needlestick safety was 65%. Did not meet the 2015 goal of 75%.		Y	
FSR- spore testing of autoclave/sterilizer		85%	Dulce Fernandez	Annual	QOC: March 23	Annual: For FY 2014-2015, the compliance rate for spore testing was 82%. Did not meet the 2015 goal of 84%		Y	

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 Record Documentation		95% of sites reviewed achieve \geq 80% compliance	Dulce Fernandez	Annual	QOC: Nov 23	<p>Annual: For FY 2014-2015, the rate of provider sites achieving a compliance rate of \geq 80% is as follows:</p> <p>Approximate numb of Sites with MRR completed- 852</p> <p>Number of sites Scored MRR audit \Rightarrow 80% - 778 or 91%</p>		Y
Appropriate uses of medications-Polypharmacy		100% of providers will be notified of members who meet criteria: (Multi-Rx: 13 or more prescriptions in 3 of 4 months, Multi-Prescriber: 7 or more unique prescribers in 2 of 4 months, Duplicate Therapy: 2 or more Rx's in same drug class consistently during 4 month period)	Yana Paulson/ Gayle Butler/ Agavni Aslanyan	Quarterly	<p>QOC: 4/27/15, 7/27/15, 10/22/15 4th Qtr. Attached to QI Eval</p>	<p>Medi-Cal: March: <i>Multi-Rx</i> - 42 members identified, 412 prescribers mailed July: <i>Multi-Rx</i> - 1 member identified, 4 prescribers mailed; <i>Duplicate Therapy</i> - 1 member identified, 2 prescribers mailed November: <i>Multi-Rx</i> - 1 member identified, 7 prescribers mailed ; <i>Duplicate Therapy</i> - 1 member identified, 1 prescriber mailed</p> <p>Duplicate Therapy - 227 members identified, 321 prescribers mailed</p> <p>PASC-SEIU: July: <i>Multi-Rx</i> - 18 members identified, 60 prescribers mailed; <i>Duplicate Therapy</i> - 4 members identified, 7 prescribers mailed November: <i>Multi-Rx</i> - 22 members identified, 71 prescribers mailed; <i>Duplicate Therapy</i> - 10 members identified, 14 prescribers mailed</p> <p>New as of 2015: Intervention mailings for polypharmacy with 3 initiatives through the RDUR Program (Multi-Rx, Multi-Prescriber, and Duplicate Therapy). Mailings occur 3x year (March, July, November). Outcomes monitoring to occur at a later time after November mailings.</p>	Y	
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	Yana Paulson/ Gayle Butler/ Agavni Aslanyan	Quarterly	<p>QOC: 4/27/15, 7/27/15, 10/22/15 4th Qtr. Attached to QI Eval</p>	Discontinued as of January 2015. Pharmacy does not recommend this measure/intervention due to limited utility.		N

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
Appropriate uses of medications - Controlled substances		100% of providers will be notified of members who meet criteria (9 or more of the following): RXs for controlled substances + unique prescribers + unique pharmacies in 2 of 4 months	Yana Paulson/ Gayle Butler/ Agavni Aslanyan	Quarterly	QOC: 4/27/15, 7/27/15, 10/22/15 4th Qtr. Attached to QI Eval	Medi-Cal: March: 181 members identified, 619 prescribers mailed July: 463 members identified, 1,550 prescribers mailed November: 486 members identified, 1,614 prescribers mailed CMC: March: 10 members identified, 34 prescribers mailed July: 16 members identified, 58 prescribers mailed November: 13 members identified, 61 prescribers mailed LACC: March: 1 member identified, 3 prescribers mailed July: 2 members identified, 13 prescribers mailed November: 0 members identified, 0 prescribers mailed PASC-SEIU: March: 3 members identified, 13 prescribers mailed July: 9 members identified, 33 prescribers mailed November: 8 members identified, 37 prescribers mailed	New as of 2015: Intervention mailings for Controlled Substance Monitoring through the RDUR Program occur 3x year (March, July, November). Outcomes monitoring to occur at a later time after November mailings.	Y
Potentially inappropriate medication (PIM)		Concurrent DUR edits in place for members with Potential opioid or acetaminophen overutilization	Yana Paulson/ Gayle Butler/ Agavni Aslanyan	Quarterly	QOC: 4/27/15, 7/27/15, 10/22/15 4th Qtr. Attached to QI Eval	Medi-Cal: 1st Qtr.: Data not available 2nd Qtr.: Data not available 3rd Qtr.: Data not available 4th Qtr.: Data not available CMC: 1st Qtr.: 30 claims with edit fired 2nd Qtr.: Data not available 3rd Qtr.: Data not available 4th Qtr.: Data not available	For Medi-Cal LOB, Opioid QL's to align with Medicare recommended limits have been voted on at PQOC (8/5/2015) to be implemented.	Y
High Risk Safety Management		100% of prescribers will be alerted by fax for members with select high risk medication concerns (level 1 drug-drug interaction)	Yana Paulson/ Gayle Butler/ Agavni Aslanyan	Quarterly	QOC: 4/27/15, 7/27/15, 10/22/15 4th Qtr. Attached to QI Eval	Medi-Cal: 1st Qtr.: Data not available 2nd Qtr.: Data not available 3rd Qtr.: Data not available 4th Qtr.: Data not available CMC: 1st Qtr.: Data not available 2nd Qtr.: Data not available 3rd Qtr.: Data not available 4th Qtr.: Data not available LACC: 1st Qtr.: Data not available 2nd Qtr.: Data not available 3rd Qtr.: Data not available 4th Qtr.: Data not available	Discontinue for 2016	N

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 Therapy Management (MTM) program		MTM program with SinfoniaRx for 2015: Comprehensive Medication Review (CMR)– phone intervention by pharmacist	Yana Paulson/ Gayle Butler/ Agavni Aslanyan	Quarterly	QOC: 4/27/15, 7/27/15, 10/22/15 4th Qtr. Attached to QI Eval	CMC: 1st Qtr.: 0% 2nd Qtr.: 5% 3rd Qtr.: 11.8% 4th Qtr.: 52%	Only for CMC	Y
Clinical- Clinical Practice & Preventive Guidelines								
Clinical Practice Guidelines		100% review and approval at least every 2 years/updates as required.	Mike Shook/ Callum James	Annual and as needed for updates	PICC & PQC: May 20	3/2/2015 Adopted: Recommended Immunization Schedules for Persons Aged 0 Through 18 Years - UNITED STATES 2015. CDC 2015. The Diagnosis and Management of Acute Otitis Media. Diabetes Care: Standards of Medical Care in Diabetes - 2015. Institute for Clinical Systems Improvement (ICSI) – Health Care Guideline, Assessment & Management of Chronic Pain Adult Acute and Subacute Low Back Pain Health Care Guideline. Recommended Adult Immunization Schedule – United States 2015. 5/20/2015 Adopted: Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. 7th Version. The World Professional Association for Transgender Health, 2015. ESRD-NKF, KDOQI, ESRD-UMHS, ESRD-RPA CPG for diabetes and CKD. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. Liver CPGs .	7/7/2015 Adopted: The ASM Nat'l Practice Guideline For the Use of Medications in the Treatment of Addiction Involving Opioid Use. 10/6/2015 Adopted: CDC STD Treatment Guidelines, 2015. Retired: Several ACC/AHA Guidelines were retired. Hepatology guidelines from AASL. Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. KDOQI Clinical Practice Guideline For Diabetes and CKD: Update 2012. Management of chronic kidney disease. Proposed QI-010 Policy presented to the committee. New format for CPGs uploaded to provider site.	Y
Clinical Practice Guidelines		100% of at least 2 aspects of 4 guidelines will be measured.	Mike Shook/ Callum James	Annual: By Dec '15	PICC & PQC: May 20	CPGs Annual Report Adopted at PICC/PQC on 5/20/2015. Measures used include: Asthma, Cardiovascular Risk, Diabetes, Attention Deficit Hyperactivity Disorder (ADHD) and Depression.		Y
Preventive Health Guidelines (PHGs)		Review, update, approve, & distribute Preventive Health Guidelines	Mike Shook/ Callum James	Annual	PICC & PQC: May 20	PHGs Adopted by PICC/PQC on 5/20/15 and retired on 10/06/2015 Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. Department of Health and Human Services, 2015.	New format for PHGs uploaded to provider site.	Y

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 (moved to display measure)	Benchmark '14: 82.86%	66%	Linda Lee/ Michael Tu	Annual: Due June '15	QOC: Sept 28 PICC & PQC: Oct 6	-Mailing for members who haven't seen PCP in the last 15 months - Live agent reminder calls for all women- set for October - Member messaging via social media has been completed (Evaluation: Track volume of shares, tweets, impressions and measure against prior campaign) - CME regarding Women's Health being set in September	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016.	Y
C01 - Colorectal Cancer Screening ★	5 Stars: ≥ 65%	5 Stars: ≥ 65%	Linda Lee/ Betty Santana/ Michael Tu	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	-Partner with American Cancer Society and participate in the 80% by 2018 Campaign - Enhancing knowledge of effectiveness and access to FIT kits within MD offices - 2 CME's regarding Men's health and Women's Health being held in September -PPG survey regarding QI activities around COL, end of May send out for response = 14/18 PPGs who responded shared that they have some initiatives around COL - Provide gaps-in-care for PPG/PCPs in order to remind them of who to distribute FIT Kits to - Share best practices with staff regarding the distribution of the kits, goals for screening/preventive care	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016.	Y
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	REMOVED AS STAR MEASURE	CCIP - Reducing Cardiovascular Risk Not a Star Measure in 2016.	N
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	-Eligible members enrolled in Diabetes Management program through DM (members stratified into 5 risk categories and given interventions according to their score) -Educational handouts	3rd Project QIP: Improving Management of Cholesterol in Diabetes Not a Star Measure in 2016.	N
C04- Annual 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	INTERVENTIONS: -Initiating 2 automated reminder calls (Oct/Nov & Jan) -Reminder mailing (Sept - complete) -Flu article in member newsletter (submitted) -Thank you postcard for members who received Flu shot (Jan) 2015 Rate = 68%	Workplan in progress. Mailing complete. Automated call campaigns planned for November and January. All approvals obtained. HECL:	Y

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
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	-Member educational hand-outs -Measure covered in Annual Wellness Exam (AWE)	CMC was too new to measure in 2015.	Y
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	-Member educational hand-outs -Measure covered in Annual Wellness Exam (AWE)	CMC was too new to measure in 2015.	Y
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	-Member educational hand-outs -Measure covered in Annual Wellness Exam (AWE)	CMC was too new to measure in 2015.	Y
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	-Member educational hand-outs -Measure covered in Annual Wellness Exam (AWE)	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016.	Y
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	-Member educational hand-outs -Measure covered in Annual Wellness Exam (AWE)	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016.	Y
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	-Member educational hand-outs -Measure covered in Annual Wellness Exam (AWE)	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016.	Y
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	-Member educational hand-outs -Measure covered in Annual Wellness Exam (AWE)	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016.	Y
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	-Member educational handouts -Summary of treatment guidelines	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016.	Y
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	-Eligible members enrolled in Diabetes Management program through DM' (members stratified into 5 risk categories and given interventions according to their score) -Educational handouts	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016.	Y

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
C15 - Diabetes : Medical attention for nephropathy ★ MOC/CPG	5 Stars: ≥ 94%	5 Stars: ≥ 94%	Linda Lee/ Elaine Sadoochi-Smith/ Michael Tu	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	-Eligible members enrolled in Diabetes Management program through DM' (members stratified into 5 risk categories and given interventions according to their score) -Educational handouts	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016.	Y
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	-Eligible members enrolled in Diabetes Management program through DM' (members stratified into 5 risk categories and given interventions according to their score) -Educational handouts	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016.	Y
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	-Eligible members enrolled in Diabetes Management program through DM' (members stratified into 5 risk categories and given interventions according to their score) -Educational handouts	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016. Not a Star Measure in 2016.	N
Measure #1 (CCIP) C18 - Controlling High Blood Pressure ★	5 Stars: ≥ 75%	5 Stars: ≥ 75%	Linda Lee/ Elaine Sadoochi-Smith/ Michael Tu	Annual: By June '15	QOC: Sept 28 PICC & PQC: Oct 6	-Member educational handout	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016. CCIP - Reducing Cardiovascular Risk	Y
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	-LAC Physician outreach -Member educational handout	CMC was too new to be measured in 2015. All Part C and D, HEDIS, CAHPS, and HOS will be reported in 2016.	Y
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	Member educational handout	CMC was too new to measure in 2015. Not a Star Measure in 2016.	N
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	CMC was too new to measure in 2015. Member educational handouts		Y
C22 - All Cause Readmission Rate ★ (Note lower rate = better performance)	5 Stars: ≤ 2%	2 Stars: >11% to ≤13%	Linda Lee/ Michael Tu/ Demitria Malloy/ Jim Banks	Annual: Due June '15	QOC: Sept. 28	Year 3 QIP report (CMC Transitions of Care (TOC) due Fall 2015)	Meetings scheduled with PPGs to discuss /collaborate TOC program	Y

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
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	CMC was too new to measure in 2015.		Y
C24 - Getting Care Quickly ★ (MAPD CAHPS)	5 Stars: ≥ 80%	3 Stars: ≥ 74% to <75%	Rae Starr	Annually: Sept '15	MQSC: Sept 1	CMC was too new to measure in 2015.		Y
C25 - Customer Service ★	5 Stars: ≥ 91%	2 Stars: ≥ 84% to <86%	Rae Starr	Annually: Sept '15	MQSC: Sept 1	CMC was too new to measure in 2015.		Y
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	CMC was too new to measure in 2015.		Y
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	CMC was too new to measure in 2015.		Y
C28- Care Coordination★	5 Stars: ≥ 87%	3 Stars: ≥ 84% to <86%	Linda Lee/ Maribel Ferrer/ Anna Edwards	Annually: Sept '15	MQSC: Sept 1	-Analyzing enrollment and disenrollment trends -Analyzing Morpace member survey results for additional intervention efforts -Initiating Customer Service Standards sub-workgroup to strategize interventions to improve customer satisfaction (CAHPS measure) -Streamlining member touch points by assessing/consolidating all communication to develop high value content 2015 rate = 87%	CMC was too new to measure in 2015.	Y
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	CMC was too new to measure in 2015.		Y

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
C30- Members Choosing to Leave the Health Plan ★ (lower is better)	5 Stars: ≤ 9%	4 Stars: >9% to ≤16%	Linda Lee/ Maribel Ferrer	Annual	MQSC: Nov 2	-Analyzing enrollment and disenrollment trends -Analyzing Morpace member survey results for additional intervention efforts -Initiating Customer Service Standards sub-workgroup to strategize interventions to improve customer satisfaction (CAHPS measure) -Streamlining member touch points by assessing/consolidating all communication to develop high value content	CMC was too new to measure in 2015.	Y
C33- Appeals Resolution ★	5 Stars: ≥ 95%	4 Stars: ≥ 87% to <95%	Barbara Skier/ Linda Lee	Annual	MQSC: Nov 2	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016.		Y
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		Y
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		Y
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		Y
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		Y
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	Medi-Cal: Rate: 82.59% Num: 1,618 Den: 1,959	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016.	Y

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 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	<u>Medi-Cal:</u> Rate: 60.39% Num: 1,183 Den: 1,959	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016.	Y
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	<u>Medi-Cal:</u> Rate: 77.57% Num: 325 Den: 419	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016.	Y
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	<u>Medi-Cal:</u> Rate: 49.14% Num: 2,509 Den: 5,106 <u>LACC:</u> Rate: 83.33% Den: 6 Num: 5	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016.	Y
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	<u>Medi-Cal:</u> Rate: 32.86% Num: 1,618 Den: 5,106 <u>LACC:</u> Rate: 83.33% Den: 6 Num: 5	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016.	Y
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	<u>Medi-Cal:</u> Rate: 10.82% Num: 211 Den: 1,950	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016.	Y
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	<u>Medi-Cal:</u> Rate: 4.89% Num: 32 Den: 655	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016.	Y
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	<u>Medi-Cal:</u> Rate: 7.63% Num: 50 Den: 655	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016.	Y

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
Percentage of members taking long-term medications who have been monitored (See 4 measures below)								
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	Medi-Cal: Rate: 40.56% Num: 290 Den: 715		Y
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	Medi-Cal: Rate: 56.49% Num: 809 Den: 1,360		Y
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	Medi-Cal: Rate: 22.99% Num: 97 Den: 422		Y
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	Data not available.		Y
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	Medi-Cal: Rate: 23.49% Num: 4,998 Den: 21,278		Y
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	Medi-Cal: Rate: 5.34% Num: 1,136 Den: 21,278		Y
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	Medi-Cal: Rate: 3.71% Num: 790 Den: 21,278		Y

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 Reconciliation Post Discharge	Benchmark not available	17%	Michael Tu/ Agavni Aslanyan	Annual: Due June '15	QOC: Sept 28 PICC & PQC: Oct 6	Medi-Cal: Rate: 1.10% Num: 33 Den: 2,993		Y
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	Fam Med: 54.7% IM: 66.1% Geriatrics: 82.3% Other: 73.0%		Y
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	CMC was too new to measure in 2015.		Y
CCIP - Reducing Cardiovascular Risk								
Measure #1 (CCIP) C18 - Controlling High Blood Pressure ★	5 Stars: ≥ 75%	5 Stars: ≥ 75%	Elaine Sadochi-Smith/ Michael Tu	Annual: Due June '15	QOC: Sept 28 PICC & PQC: Oct 6	Disease Management Interventions to improve rate/goal: -Development of DM CVD booklet including preventive tests and services -Targeted member letter campaign with call to action to visit PCP with individual member's PCP name and number and heart health tips.	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016. CCIP - Reducing Cardiovascular Risk	Y
Measure #2 (CCIP) C08- Adult BMI assessment ★	5 Stars: ≥ 93%	5 Stars: ≥ 93%	Elaine Sadochi-Smith/ Michael Tu	Annual: Due June '15	QOC: Sept 28 PICC & PQC: Oct 6	Disease Management Interventions to improve rate/goal: -Development of DM CVD booklet including preventive tests and services -Targeted member letter campaign with call to action to visit PCP with individual member's PCP name and number and heart health tips.	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016. CCIP - Preventing Cardiovascular disease	Y

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 #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	Pharmacy: Based on Acumen results from 7/2015, adherence rate of 79.3% is below MAPD average (88.5%). Disease Management Interventions to improve rate/goal: -Development of DM CVD booklet including preventive tests and services -Targeted member letter campaign with call to action to visit PCP with individual member's PCP name and number and heart health tips.	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016. CCIP - Preventing Cardiovascular disease	Y
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	Pharmacy: Based on Acumen results from 7/2015, adherence rate of 77.9% is below MAPD average (86.4%).	No public reporting of Star rating in 2015; however, all measures will be reported to CMS. Public reporting of star ratings will resume in 2016. CCIP - Preventing Cardiovascular disease	Y
Model of Care (MOC) Measures								
Improving access to preventive health services: Increase the percentage of members vaccinated annually against seasonal influenza								Y
Quality of Life Survey - SF12 Mental Component Score (HOS)	Target - 95%	6%/3 years or 2% change per year	Jim Banks	Annually		CMC was too new to measure in 2015.		Y
Quality of Life Survey - SF12 Physical Component Score (HOS)	Target - 95%	6%/3 years or 2% change per year	Jim Banks	Annually		CMC was too new to measure in 2015.		Y
Medication compliance	Target - 80%	Improvement of 2 percentage points per year	Jim Banks	Annually		CMC was too new to measure in 2015.		Y
Patient satisfaction		90% of members will be satisfied with care management activities	Jim Banks	Annually		79%		Y

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
Avoidance of hospital admissions for ambulatory care sensitive conditions (ACSC)	Target - 20%	10% reduction in total beddays/K for ACSC	Jim Banks	Annually		Removed from MOC for 2016		N
Hospital Utilization (MOC)								
Hospital Bed Days	Target - 1400K	10% reduction in total beddays/K	Jim Banks	Quarterly		CMC: 1st Qtr.: 1837.9 2nd Qtr.: 1549.6 3rd Qtr.: 920.1 4th Qtr.: Data N/A		Y
Hospital Admissions	Target - 220	10% reduction in admissions	Jim Banks	Quarterly		CMC: 1st Qtr.: 363.8 2nd Qtr.: 332.9 3rd Qtr.: 221.4 4th Qtr.: Data N/A		Y
Hospital Average Length of Stay	Target - 4.2 Days	10% reduction in length of stay	Jim Banks	Quarterly		CMC: 1st Qtr.: 5.1 2nd Qtr.: 4.7 3rd Qtr.: 4.2 4th Qtr.: Data N/A		Y
Readmissions rates	Target - <20%	2 percentage point reduction from previous year	Jim Banks	Quarterly		CMC: 1st Qtr: 20.5% 2nd Qtr: 19.7% 3rd Qtr: 13.5% 4th Qtr.: Data N/A		Y
Ambulatory Services (MOC)								
Emergency Room Visits	Dec. 2013 - 1338.62	10% reduction from the previous year	Jim Banks	Quarterly		CMC: 1st Qtr.: 802.9 2nd Qtr.: 748.2 3rd Qtr.: 648.0 4th Qtr.: Data N/A		Y
Ambulatory Care Visits	Dec. 2013 - 5024.13	10% reduction from the previous year	Jim Banks	Quarterly		CMC: 1st Qtr.: 5281.0 2nd Qtr.: 5520.3 3rd Qtr.: 4557.7 4th Qtr.: Data N/A		Y

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
Grievance	4th Qtr. 2013 Part C: 72 Part D: 15	Monitor in QI Program	Jim Banks	Quarterly	CMC: 1st Qtr.: 4 2nd Qtr.: 34 3rd Qtr.: 34 4th Qtr.: 39			Y
HRA Completion Rate		100% of all Medicare enrollees within 90 days	Jim Banks	Quarterly	CMC: 1st Qtr.: 73% 2nd Qtr.: 57% 3rd Qtr.: 73% 4th Qtr.: 69%			Y
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	1st Qtr.: QI policies approved at QOC Jan. 26, 2015. 2nd Qtr: QI & HE policy approved at QOC April 27, 2015. C&L policy approved at QOC June 22, 2015. 3rd Qtr.: No policies approved in 3rd quarter. 4th Qtr.: QI & HE policies approved at QOC Nov. 30, 2015.		Y
Departmental Oversight reporting requirements		100% submission of timely delegate oversight reporting for each department	QI: Jim Banks MS: Maribel Ferrer A&G: Barbara Skier RX: Yana Paulson	QOC quarterly	QOC: April 27, Jun 22, Sept 28, Nov 23	1st Qtr: 4th Q 2014 approved at QOC February 23, 2015. 2nd Qtr: 1st Qtr. 2015 approved at QOC June 22, 2015. 3rd Qtr.: 2nd Qtr. 2015 approved at QOC September 28, 2015. 4th Qtr.: 3rd Qtr. 2015 approved at QOC Nov. 30 2015.		Y
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	Approved: QOC - 2/23/15 Approved: C&Q - 3/19/15		Y
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	Approved: QOC - 2/23/15 Approved: C&Q - 3/19/15		Y
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	1st & 2nd Qtr.: QOC - 8/17/15 3rd Qtr.: QOC - 11/23/15 4th Qtr.: QOC - 2/22, 2016		Y
QI Reports to Board		Update Board (C&Q) on QI activities	Trudi Carter/ Jim Banks	At least quarterly	C & Q: 1/15/15, 3/19/15, 5/21/15, 7/16/15, 9/17/15, 11/19/15	1st Qtr: 1/15/15, 3/19/15 2nd Qtr: 5/21/15 3rd Qtr: 7/16/15, 9/17/15 4th Qtr: 11/19/15		Y
UM Program Documents		Annual UM Program Description, UM Work Plan, & UM Evaluation	Anna Edwards	QOC: 2/23/15 C & Q: 3/19/15	QOC: 2/23/15 C & Q: 3/19/15	Approved: QOC - 2/23/15 Approved: UMC - 1/15/15 Approved: C&Q - 3/19/15		Y

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
MMP Core Reporting		Reports submitted monthly	Christine Babu/ Adrienne Govan	QOC Quarterly, Bi-annually & Annually	QOC: April 27, Jun 22, Sept 28, Nov 23	CMC: 1st Qtr.: All "Core" reports submitted on time. 2nd Qtr.: All "Core" reports submitted on time. 3rd Qtr.: All "Core" reports submitted on time. 4th Qtr.: All "Core" reports were submitted on time.		Y
CA State Reporting		Reports submitted monthly to the state	Adrienne Govan/ Diana Ramirez	QOC Quarterly, Bi-annually & Annually	QOC: April 27, Jun 22, Sept 28, Nov 23	Medi-Cal: 1st Qtr.: QOC Minutes for 1st Quarter submitted to DHCS 4.30.15 2nd Qtr.: QOC Minutes for 2nd Quarter submitted to DHCS 7.30.15 3rd Qtr.: QOC Minutes for 3rd Quarter submitted to DHCS 10.30.15 4th Qtr.: QOC Minutes for 4th Quarter submitted to DHCS 1.30.16 CMC: 1st Qtr.: All "CA State" reports submitted on time. 2nd Qtr.: All "CA State" reports submitted on time. 3rd Qtr.: All "CA State" reports submitted on time. 4th Qtr.: All "CA State" reports were submitted on time. (please see below for more details)		Y
Part C & D CMS Reporting		Complete and accurate collection, analysis, and reports of Part C & D data elements	Adrienne Govan/ Diana Ramirez	QOC Quarterly, Bi-annually & Annually	QOC: April 27, Jun 22, Sept 28, Nov 23	 Part C: 1st Qtr.: Grievances (Annually) - Submitted on 02/28/15; Organization Determinations / Reconsiderations (Annually) - Submitted on 02/28/15 2nd Qtr.: 3rd Qtr.: There were no Part C reports due to CMS for Q3 2015. 4th Qtr.: There were no Part C reports due to CMS for Q4 2015. Part D: 1st Qtr.: Medication Therapy Management Programs (Annually) - Submitted on 02/23/15 Grievances (Annually) - Submitted on 02/28/15 Coverage Determinations and Redeterminations (Annually) - Submitted on 02/28/15 Long-Term Care (LTC) Utilization (Bi-annually) - Submitted on 02/23/15 2nd Qtr.: Retail, Home Infusion, and Long-Term Care Pharmacy Access (Quarter 1) - Submitted on 05/14/15 3rd Qtr.: There were no Part D reports due to CMS for Q3 2015. 4th Qtr.: There were no Part D reports due to CMS for Q4 2015.		Y