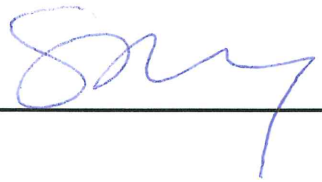
2018 QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION

Prepared on 3/8/2019

X 

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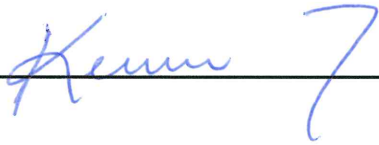
X 

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Quality Improvement Committee Chair
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1. INTRODUCTION

This program evaluation provides a comprehensive overview of quality improvement activities conducted in 2018.

The content of this evaluation includes:

- Descriptions of completed and ongoing QI activities
- Trending of QI measures to assess performance
- Analysis and evaluation of the overall effectiveness of the QI program.

2. HEDIS RESULTS

In 2018, HPSM was required to collect and report HEDIS measures for the Medi-Cal and CareAdvantage populations. The 2018 HEDIS results are an analysis of services provided in 2017. Individual HEDIS measures are selected by the Centers for Medicare and Medicaid Services (CMS) for CareAdvantage and the Department of Health Care Services Medi-Cal Managed Care Division (DHCS-MMCD) for Medi-Cal.

DHCS set a Minimum Performance Level (MPL) and a High Performance Level (HPL) for each required measure. Performance levels are based on prior year's HEDIS reporting from all National Committee of Quality Assurance (NCQA) national Medicaid plans. The MPL and HPL are the 25th and 90th percentiles respectively.

Results from each specific HEDIS measure can be found in the Quality of Clinical Care Activities Section of this evaluation to align with associated interventions. Included are the results for each of HPSM's key areas of focus for quality improvement interventions compared over the last five years, with the exception of the asthma medication ratio (AMR) measure which was new in 2018. *See Appendix A for the full set of 2018 HEDIS results for Medi-Cal and CareAdvantage Cal MediConnect lines of business.*

It should be noted that based on the HEDIS data collection and reporting schedule, HEDIS results discussed for reporting year 2018 are of services provided in 2017.

2018 MEDI-CAL SUMMARY:

For Reporting Year (RY) 2018, there were no measures below MPL and seven measures above HPL. The measures that preformed above the HPL in 2018 include the following:

- Childhood Immunization Status –Combo 3 (CIS-3)
- Immunizations for Adolescents – combination 2 (IMA-2)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
- Use of Imaging Studies for Low Back Pain (LBP)
- Weight Assessment and Counseling for Physical Activity (WCC-PA)
- Comprehensive Diabetes Care – Eye Exam (retinal) (CDC-E)
- Timeliness of Postpartum Care (PPC-Pst)

CAREADVANTAGE/CAL-MEDICONNECT (CA-CMC) SUMMARY:

In 2018, HPSM successfully reported on all 45 measures required by CMS for Medicare-Medicaid Plans. In addition, all CMS Core Quality Withhold HEDIS Measures were above withhold benchmarks which include the following measures:

- Controlling High Blood Pressure (CBP)
- Plan All-Cause Readmissions (PCR)
- Follow-up after Hospitalization for Mental Illness (FUH)
- Annual Flu Vaccine (CAHPS)

2019 ACTION PLAN

The following areas represent opportunities for improvement and key areas of focus for 2019:

- Cancer Screening
  - Cervical Cancer Screening (CCS)
  - Breast Cancer Screening (BCS)
  - Colorectal Cancer Screening (COL)
- Asthma Medication Ratio (AMR)
- Timeliness of Prenatal Care (PPC)
- Plan All Cause Readmissions (PCR)
- Diabetes Measures (CDC) and Medication Adherence – New!

2019 QI Department Goals:

For 201, three department goals were set based on 2018 HEDIS results. Specific action plan items related to improvement activities are included in the action plan section under Quality of Clinical Care Activities for these three measures and 2019 goals.

- Increase **timely prenatal care (PPC)** (within 42 days of enrollment or during the first trimester) from 83.88% (HEDIS 2018) to 87.06% (75th percentile).
- Increase the Medi-Cal **Asthma Medication Ratio (AMR)** rate of 58.15% (HEDIS 2018) to 62.3% (50th percentile).
- Increase the **Cervical Cancer Screening (CCS)** rate from 59.95% (HEDIS) to 60.1% (50th percentile).

3. QUALITY OF CLINICAL CARE ACTIVITIES

3.1 ASTHMA MEDICATION RATIO (AMR)

AMR HEDIS RESULTS

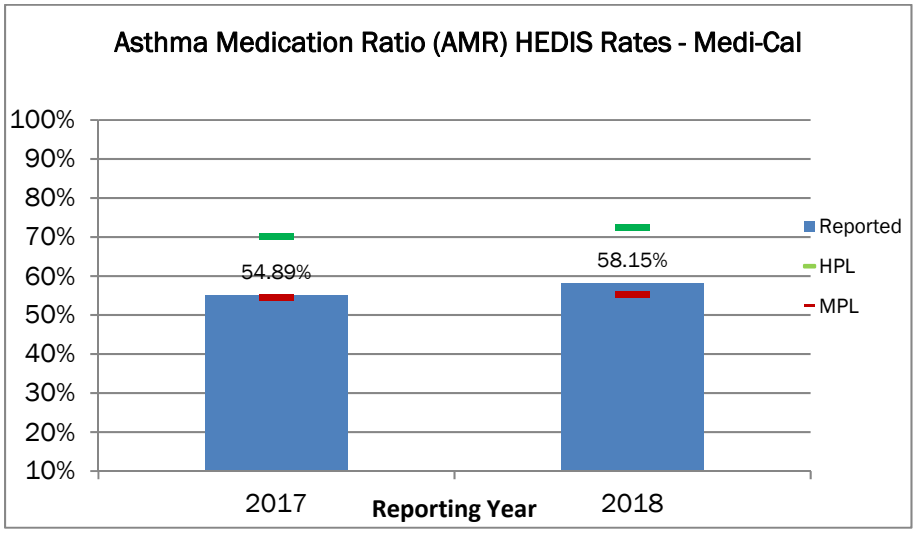


TABLE. Reporting Year 2018 Asthma Medication Ratio (AMR) HEDIS Rates

Asthma Medication Ratio (AMR)					
Data Element	**5-11 Years**	**12-18 Years**	**19-50 Years**	**51-64 Years**	**Total**

Eligible population	346	215	312	207	1,080
Numerator events by administrative data	213	134	164	117	628
Reported rate	61.56%	62.33%	52.56%	56.52%	58.15%

AMR PEFORMANCE IMPROVEMENT PROJECT (PIP)

HPSM has a current Performance Improvement Project (PIP) focused on improving the AMR rate titled Improving Asthma Medication Ratio for Medi-Cal Member ages 19-50 years olds.

AMR PIP PROCESS AND NARROWED FOCUS POPULATION SELECTION:

Due to the low AMR rates from HEDIS reporting year (RY) 2018, AMR was selected as a PIP topic to focus on in 2018. HEDIS RY 2018 AMR Rates indicated the 54.89% of HPSM members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. This rate is slightly above the 2017 MPL of 54.5%. HPSM's 2017 RY AMR HEDIS data was also analyzed by race/ethnicity, age, and language to assess for disparities among the member population with asthma (Table 2) as part of the planning process for the PIP. RY 2017 data was used because at the time of this analysis which was conducted in the spring of 2018, RY 2018 data was not yet available.

TABLE. RY 2017 Count of Compliant and Non-Compliant Members for Asthma Medication Ratio <.50

AMR	Total Count	Rate
Compliant	550	**54.89%**
Non-Compliant	452	45.11%
Total	**1002**	

TABLE. HEDIS 2017 AMR Rates by Age, Ethnicity, and Language

	Medication Ratio ≥ 0.50 Compliant (Numerator)	Medication Ratio ≥ 0.50 Non-Compliant	Total (Denominator)	AMR Compliant Rate %
AGE				
Age 5-11	205	139	344	59.6%
Age 12-18	101	77	178	56.7%
Age 19-50	140	145	285	49.1%
Age 51-64	104	91	195	53.3%
RACE/ETHNICITY				
HISPANIC	228	204	432	52.8%
ASIAN/ PACIFIC ISLANDER	103	80	183	56.3%
CAUCASIAN	94	70	164	57.3%
LANGUAGE				
ENGLISH	354	299	653	54.2%
SPANISH	173	137	310	55.8%

The AMR compliant rates are higher in children compared to the adult population. Only 49.1% of the adult members between the ages of 19-50 years were compliant with their asthma medication use, which is the lowest compliant rate of all age groups. This coincides with CDPH literature that indicates the number of Adult Medi-Cal members with asthma is expected to continue to rise significantly as environmental triggers worsen and are linked to high asthma rates. These findings continue to suggest that any interventions to improve this HEDIS measure should focus on the adult population between the ages of 19-50.

AMR PIP DESCRIPTION

Due to the smaller than 1% margin from performing below the 2017 MPL, HPSM chose to focus on this topic as part of the Performance Improvement Project (PIP) process with the state. Through this PIP, interventions aimed at increasing HPSM's performance on this measure to a more acceptable level above the MPL. The PIP targets adults between the ages 19-50 enrolled in HPSM Medi-Cal. The focus is to increase the percentage of adult members who have a .50 or greater asthma medication ratio.

Our intervention for this measure was developed by ascertaining the reason for the low compliance amongst this age group. Some of the reasons identified included, lack of reminders on medication pick-ups and limited understanding of the relationship between controller and rescue medications. Therefore, the intervention developed was aimed at the member level, which we believe would have the highest impact, and consists of outreach calls targeting those members with and AMR rate less than 0.50. The members were risk stratified into two groups where the first, lower risk group would be contacted by the Quality Improvement Coordinator. A call script was developed which asked members for the main reasons behind their inability to pick up medication as well as provide education on the importance of controller medication adherence. Further, members were encouraged to pick up their medications and in some cases, if required, asked to visit their PCP. A second group of higher risk members was also developed. The high risk group was defined as members who had an AMR of less than 0.50 and one or more of the following criteria over 12 month look-back period: 2+ ED visits, 1+ In-Patient Stays, difference between controller and rescue fills is 3+ (overuse of reliever), OR 10+ rescue fills. These higher risk members were contacted by the HPSM Care Coordination team and provided more focused assistance, such as warm transfers to their PCPs if required. Education on the importance of regular controller use, discussion of the asthma action plan and discussion of member's barriers to asthma medication adherence was also discussed.

AMR PIP GOAL

By Dec 31, 2018, increase the Medi-Cal rate of 54.89% (HEDIS 2017) to 62.19% (50th percentile).

ASTHMA OUTREACH METRICS

HPSM's Quality Improvement Coordinator began outreach calls to low risk members in October 2018 and calls were conducted in both Spanish and English. A total of 223 members received outreach attempts of which 62 calls were considered successful or completed calls between October and December of 2018, for a successful contact rate of 27.8%. In December 2018, HPSM's Care Coordinators began outreach to high risk members and a total of 20 members were contacted of which 5 calls were considered successful or complete. This intervention includes members beyond just the narrowed focus population selected for the PIP of the 19-50 year olds to also include adults in the 51+ age group as well, though the 19-50 year old members are prioritized in the process.

ASTHMA OUTREACH UPDATES AND PROGRAM BARRIERS/ISSUES

Asthma outreach calls are being conducted on a monthly basis. At the beginning of every month, the QI Specialist provides both the QI team and Care Coordination team with a list of non-compliant members in low risk and high risk groups respectively. Outreach is considered a success if the member is contacted, education is provided, reasons for barriers to asthma medication adherence has been identified, and the member is encouraged either to pick up medication or visit their PCP. Thus far, the biggest barrier has been the inability to reach some members due to call screening or due to wrong phone numbers associated with those members.

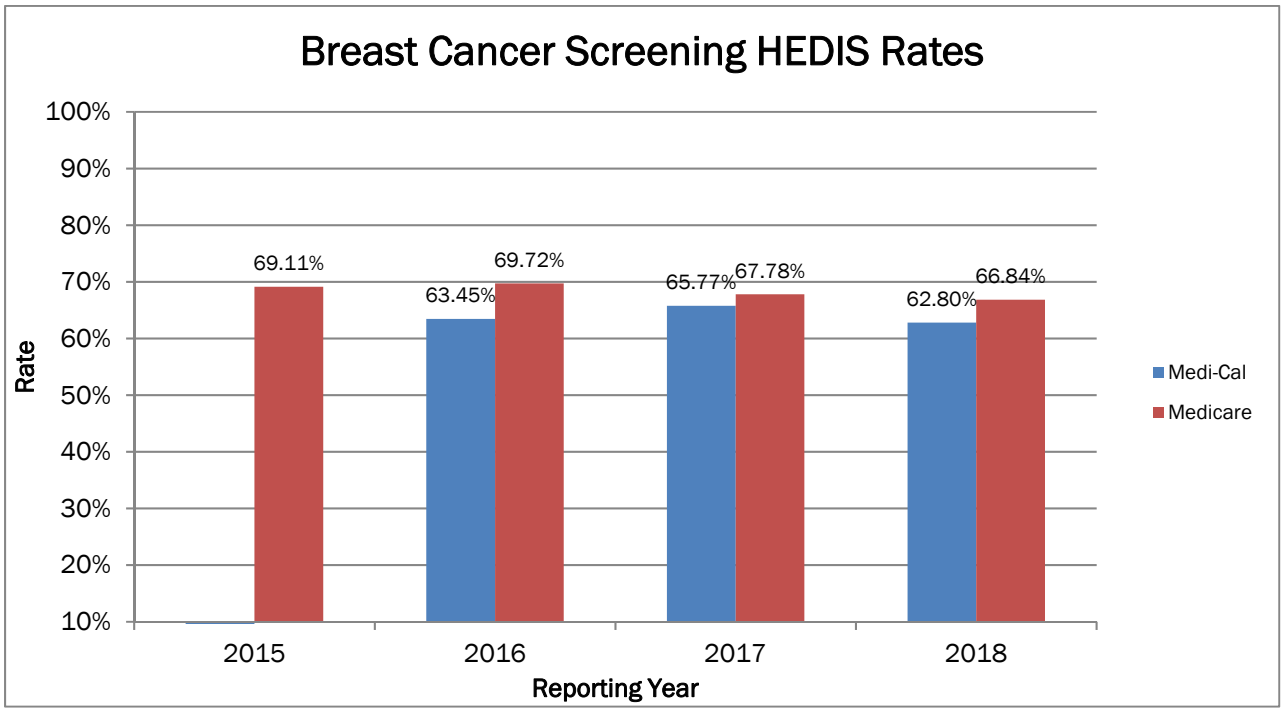
Another issue we faced was in obtaining the correct AMR data on each of our members. Early on in the process, we realized that our data required further revisions due to a discrepancy in measurement of package sizes, which was a key element in determining the total medication units dispensed at the pharmacy. However, through a truly collaborative effort involving Quality, Informatics and the Pharmacy department, we were able to correct this discrepancy and continue with outreach calls to members.

2019 ACTION PLAN

In 2019, HPSM will proceed with this intervention, monitor results and conduct and continue to evaluate the effectiveness of these efforts.

3.2 BREAST CANCER SCREENING (BCS)

BCS HEDIS RESULTS



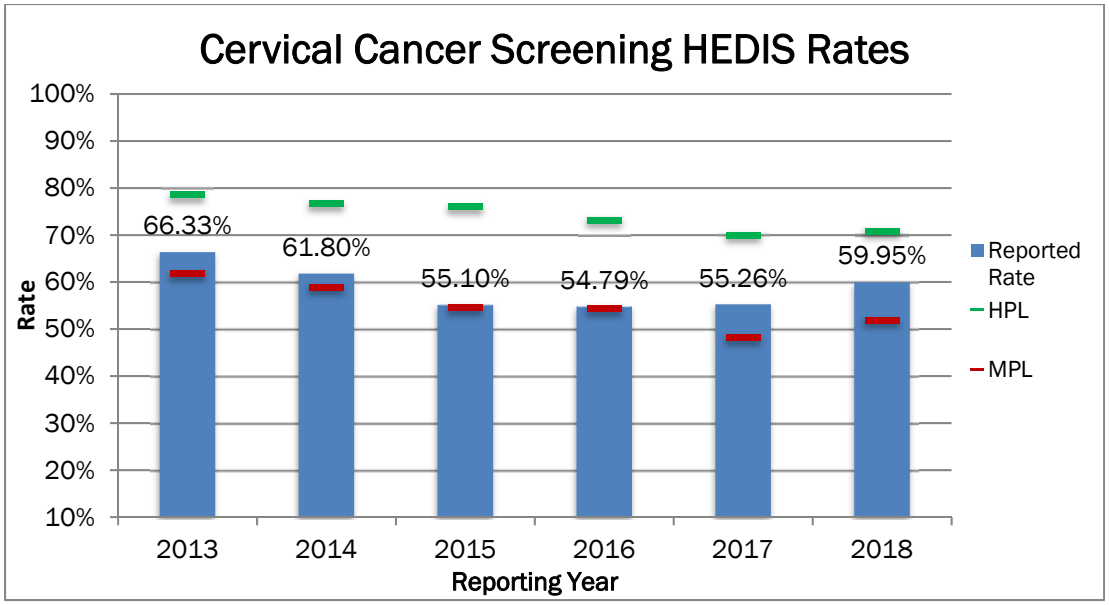
There was a slight decrease in rate for breast cancer screenings for Medicare line of business from 67.78% in 2017 to 66.84% in 2018. A similar decrease was seen in the Medi-Cal line of business from 65.77% in 2017 to 62.80% in 2018. Improvement planning for this measure began in 2018 with a focus on gathering information related to current processes related to members obtaining a mammogram, recall systems and referral practices for PCPs. Efforts to improve breast cancer screenings are described below.

BCS RECOMMENDED ACTION PLAN FOR 2019

In 2019, HPSM Quality will continue implementation of the BCS provider outreach plan presented to the QIC on September 19, 2018, and initiated in November. The ongoing objectives for 2019 will include completing site visits with solo PCPs with low BCS rates to establish relationships that facilitate sharing member data and gather information on PCP process for mammography referrals. Another key objective will be to identify appropriate opportunities for Quality to support PCPs in reaching out to members due for BCS to refer them to mammography services.

3.3 CERVICAL CANCER SCREENING (CCS)

CCS HEDIS RESULTS



The CCS HEDIS reported rate increased from 55.26% in 2017 to **59.95%** in 2018, which further moved HPSM's rate above the MPL. A progress update for 2018 on efforts to improve the cervical cancer screening rate is described below.

CCS OUTREACH PROGRAM DESCRIPTION

In 2018, HPSM's CCS Outreach Program aimed to align provider and member outreach plans with HPSM's new P4P Payment Model for the CCS Benchmark Metric. Planning for targeting member cohorts and assigned PCPs began in Q2, when Provider Services released its first summary of PCP measure selection for the new P4P payment model. Quality used this summary to identify PCPs that selected the CCS metric and review their CCS rates. Based on the August P4P Benchmark Reports, Quality identified an initial group of 6 solo PCPs with the lowest CCS rates. In September, Quality presented an outreach plan to Provider Services and to the Quality Improvement Committee at their respective meetings, to reach out to these PCPs to schedule site visits to review their CCS benchmark rate and discuss collaborative improvement opportunities that would be led and supported by Quality staff. Implementation of the outreach began in November with the completion of site visits with two of the six identified PCPs.

CCS OUTREACH PROGRAM GOAL

Improve the CCS screening rate among women, age 21 to 64, who are due for CCS and continuously enrolled in Medi-Cal from baseline rate of 55.26% to 58.44%

CCS OUTREACH PLANNING PROCESS

- Schedule and complete site visits with initial group of 6 solo practice PCPs with lowest CCS rates, per P4P Benchmark Report or CCS internal reports.
- Obtain PCP agreement to use HPSM CCS report of assigned patients due for CCS to target for collaborative member outreach and follow up.
- HPSM members due for CCS and assigned to PCPs with completed HSPM site visits are scheduled for an appointment.

CCS Outreach PROGRAM UPDATE

HPSM's Quality Improvement team began implementation of the provider outreach plan in November 2018. Site visits were scheduled and completed with two PCPs identified in the initial group of six solo practice PCPs: Pacific Family Medicine Clinic and Mission Neighborhood Health Center. The Quality Improvement Specialist gathered information on current processes for identifying assigned members due for their preventive CCS, and reaching out to them. Both

PCPs agreed to collaborate with Quality in using HPSM's member report to focus on for HPSM phone outreach to facilitate warm transfer to PCP office for scheduling an appointment.

CCS OUTREACH PROGRAM BARRIERS/ISSUES

Site visits completed with two PCPs in 2018 revealed the following challenges:

- Some PCPs exclude members on their assigned panel due for CCS from their clinic CCS outreach if they are not "active patients." These are members who do not have an existing medical record number, or if they have medical record number they do not have a documented clinic visit in the prior 12 months.
- Some PCPs who cannot offer female clinician on staff to do Pap may not have referral process in place to advise HPSM members on how to access female gynecologists in HPSM network.
- Smaller PCPs with limited staff resources may not be motivated to invest staff time to engage "inactive" patients on their HPSM panel, who are due for CCS.

CCS OUTREACH PROGRAM ACTION PLAN FOR 2019

- **Continue implementation of provider outreach plan with solo PCPs that have lower CCS rates.** Quality Improvement team will continue to schedule site visits throughout 2019 with PCPs with lower CCS rates. Completed site visits offer useful information on common issues/barriers at the PCP level that impact their CCS rates. Document barriers to CCS outreach with assigned members that are common to solo PCPs.
- **Develop HPSM gynecologist referral protocol for PCPs without availability of female staff for CCS.** Quality Improvement team will facilitate an internal HPSM workgroup to develop a protocol for PCPs to use forassigned members due for CCS who prefer to receive Pap test from outside female provider.
- **Pilot text message campaign to promote CCS:** Quality will pursue piloting the use of text messages as a method to reach members due for CCS. This will also be proposed as a potential intervention to use in partnership with low performing clinics.

DISPARITY - CCS PERFORMANCE IMPROVEMENT PROJECT (PIP)

In 2018, HPSM's Quality Improvement team selected cervical cancer screening (CCS) among Medi-Cal members with English Language Preference for the required Disparity PIP topic. The selection was based after a thorough analytical search for a statistically significant disparity for a Medi-Cal member subgroup across HEDIS measures. The project focuses on increasing the CCS rate for members with English language preference assigned to North East Medical Services (NEMS) clinic, through a collaborative data collection process and focused clinic outreach effort that targets members assigned to NEMS's panel who are due for CCS and have indicated English as their preferred language per Medi-Cal enrollment data.

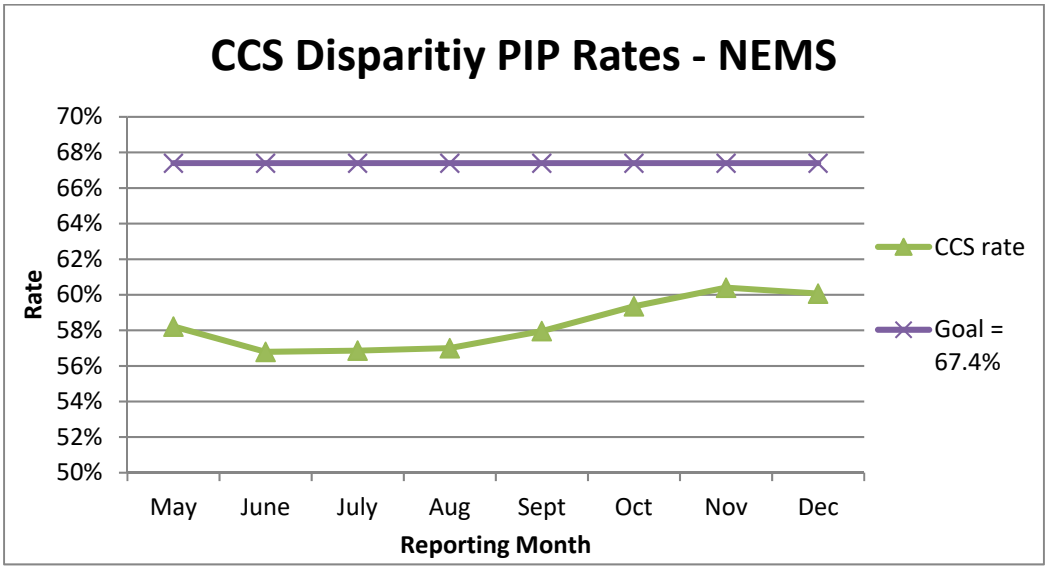
DISPARITY CCS PIP METRICS

SMART Aim Goal: Increase the CCS rate for Medi-Cal members with English language preference, ages 24 to 64, assigned to North East Medical Services (NEMS) for primary care, from baseline rate 56.7% to goal of 67.4%.

Intervention Metric: Track rate of assigned members at NEMS due for CCS and with English language preference, and are identified as "inactive patients", who are successfully contacted and scheduled for a primary care visit.

Intervention Objective: To successfully reach members identified as "inactive patients" to schedule a PCP or Pap test appointment at NEMS.

DISPARITY PIP PROJECT UPDATE – TRACKING SMART AIM GOAL



Pull date for Claims Data	Reporting Month	Numerator	Denominator	CCS rate
5/1/2018	May	163	280	58.21%
6/1/2018	June	163	287	56.79%
7/1/2018	July	174	306	56.86%
8/1/2018	Aug	175	307	57.00%
9/1/2018	Sept	182	314	57.96%
10/1/2018	Oct	184	310	59.35%
11/1/2018	Nov	180	298	60.40%
12/1/2018	Dec	179	298	60.07%

Pull date for Claims Data	Reporting Month	Numerator	Denominator	CCS rate
5/1/2018	May	163	280	58.21%
6/1/2018	June	163	287	56.79%
7/1/2018	July	174	306	56.86%
8/1/2018	Aug	175	307	57.00%
9/1/2018	Sept	182	314	57.96%
10/1/2018	Oct	184	310	59.35%
11/1/2018	Nov	180	298	60.40%
12/1/2018	Dec	179	298	60.07%

Rolling 12-month timeframe	Claims Pull date	Reporting Month	Numerator	Denominator	CCS rate
2/1/2017 - 1/31/2018	5/1/2018	May	163	280	58.21%

3/1/2017 - 2/28/2018	6/1/2018	June	163	287	56.79%
4/1/2017 - 3/31/2018	7/1/2018	July	174	306	56.86%
5/1/2017 - 4/31/2018	8/1/2018	Aug	175	307	57.00%
6/1/2017 - 5/31/2018	9/1/2018	Sept	182	314	57.96%
7/1/2017 - 6/31/2018	10/1/2018	Oct	184	310	59.35%
8/1/2017 - 7/31/2018	11/1/2018	Nov	180	298	60.40%
9/1/2017 - 8/31/2018	12/1/2018	Dec	179	298	60.07%

DISPARITY PIP PROJECT BARRIERS/ISSUES

Following are the project's barriers and issues which have made it challenging to begin implementing the project's activities in 2018.

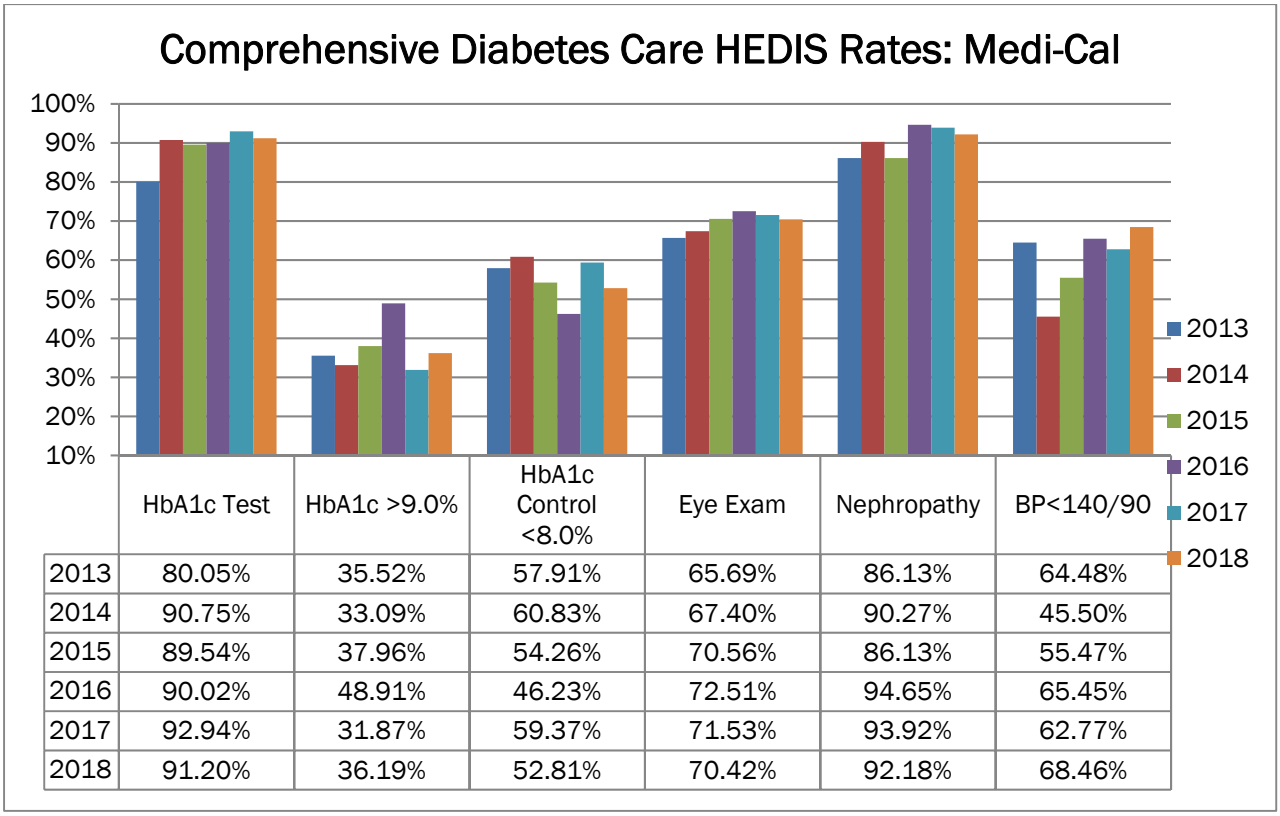
- **Temporary setback with NEMS participation**: Following HSAG approval in September to begin implementation of HPSM's proposed intervention at NEMS, HPSM's Quality Improvement Specialist met with the Clinic Manager from NEMS to discuss implementation. The Clinic Manager expressed concern with dedicating staff time to reaching out to assigned inactive members with prior documentation of having other health coverage or preferring an outside PCP. Previous experience with attempting to successfully reach assigned HPSM members that have remained inactive at NEMS for at least 12-months, has indicated that many "inactive" patients do not respond to NEMS outreach for CCS because of unfamiliarity with NEMS or because of a connection to a different PCP through other health coverage (OHC). To mitigate this, the HPSM Quality Improvement Specialist met with HPSM's Member Services to determine the best process to handle cases like this. It was determined that NEMS should warm transfer any members preferring to see a different PCP directly to HPSM's Member Services Department to follow through on the members PCP change request. This was added as a step to the member outreach process for the PIP and led NEMS to agree to continue on with the project.
- **Overall CCS rate for NEMS surpasses HPSM's P4P goal.** NEMS' current CCS rate overall, has surpassed the new P4P benchmark for the CCS metric which follows the HEDIS goal. The NEMS Clinic Manager may have decreased motivation to dedicate staff time to reaching out to assigned HPSM members due for CCS, that have not willfully engaged with NEMS for their primary care.

DISPARITY PIP ACTION PLAN FOR 2019

- **Provide HSAG with updates and changes for testing intervention at NEMS.** Begin implementing approved intervention with NEMS in January, 2019. Describe updates and changes to intervention timeline and data collection details submitted in Modules 2, 3, and 4, as needed, when submitting updates to HSAG in 2019.
- **Continue the partnership with Member Services to meet NEMS request to follow up with members that indicate preference for different PCP.** Track NEMS's documentation of inactive assigned members that report preference for outside PCP, and documentation of assigned members with other health coverage.

3.4 COMPREHENSIVE DIABETES CARE (CDC)

CDC HEDIS RESULTS

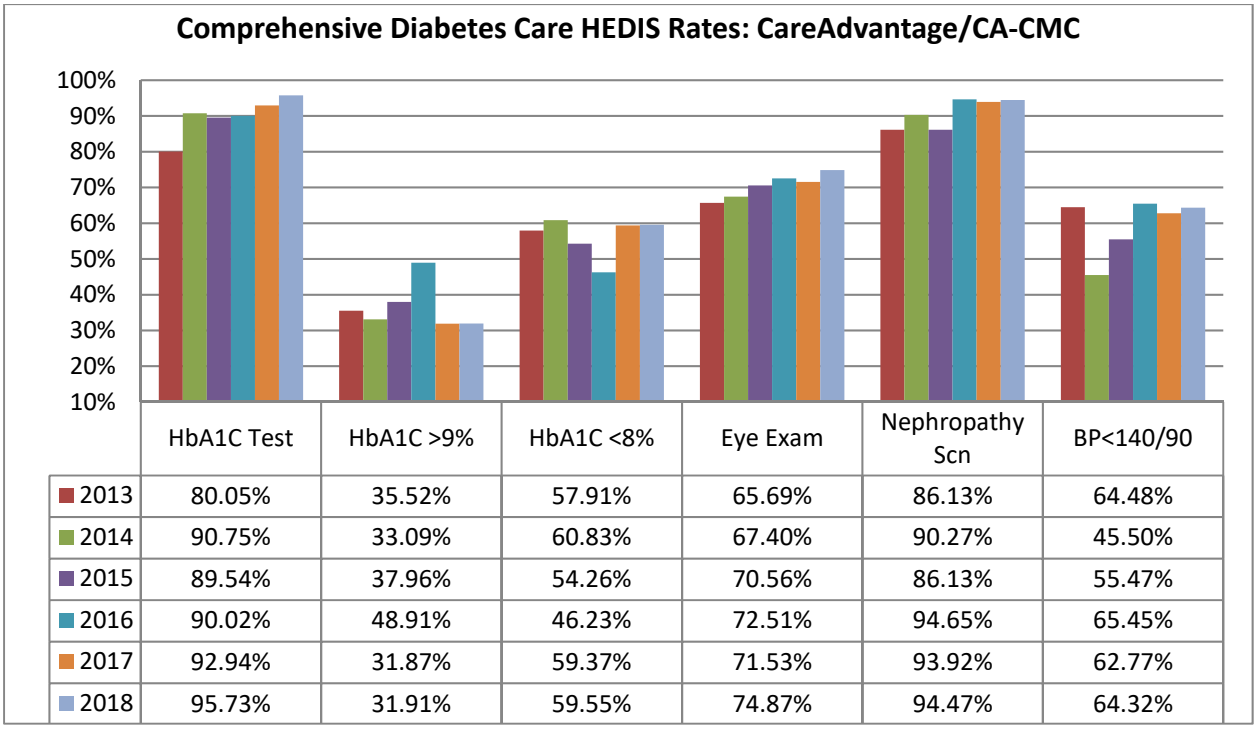


	HbA1c Test	HbA1c >9.0%	HbA1c Control <8.0%	Eye Exam	Nephropathy	BP<140/90
2013	80.05%	35.52%	57.91%	65.69%	86.13%	64.48%
2014	90.75%	33.09%	60.83%	67.40%	90.27%	45.50%
2015	89.54%	37.96%	54.26%	70.56%	86.13%	55.47%
2016	90.02%	48.91%	46.23%	72.51%	94.65%	65.45%
2017	92.94%	31.87%	59.37%	71.53%	93.92%	62.77%
2018	91.20%	36.19%	52.81%	70.42%	92.18%	68.46%

Comprehensive Diabetes Care (6 indicators) 2018 MPLs & HPLs:

HEDIS Measure	Medicaid 25th Percentile*	Medicaid 90th Percentile*
Eye Exam (Retinal) Performed	47.57	68.33
HbA1c Testing	84.25	92.82
HbA1c Poor Control (>9.0%)	48.57	29.07
HbA1c Control (<8.0%)	41.94	59.12
Medical Attn. for Nephropathy	88.56	93.27
Blood Pressure Control (<140/90 mm Hg)	52.70	75.91

The Comprehensive Diabetes Care (CDC) A1c testing, A1c Control <8, Eye Exams, and Medical Attention for Nephropathy all decreased slightly for the Medi-Cal lines of business in 2018. The A1c Poor Control Measure increased from 31.87% in 2017 to 36.19% in 2018, which is also concerning since a lower rate is better for this measure though HPSM still performs better than the MPL of 48.57%. Of the CDC measures, the Blood Pressure Control measure is the only one that increased from 62.77% to 68.46%.



	HbA1C Test	HbA1C >9%	HbA1C <8%	Eye Exam	Nephropathy Scn	BP<140/90
2013	80.05%	35.52%	57.91%	65.69%	86.13%	64.48%
2014	90.75%	33.09%	60.83%	67.40%	90.27%	45.50%
2015	89.54%	37.96%	54.26%	70.56%	86.13%	55.47%
2016	90.02%	48.91%	46.23%	72.51%	94.65%	65.45%
2017	92.94%	31.87%	59.37%	71.53%	93.92%	62.77%
2018	95.73%	31.91%	59.55%	74.87%	94.47%	64.32%

For the CareAdvantage line of business, the A1c testing, eye exam, monitoring for nephropathy and BP <140/90 all increased for the CDC measure set. There were little changes in the A1c control measures.

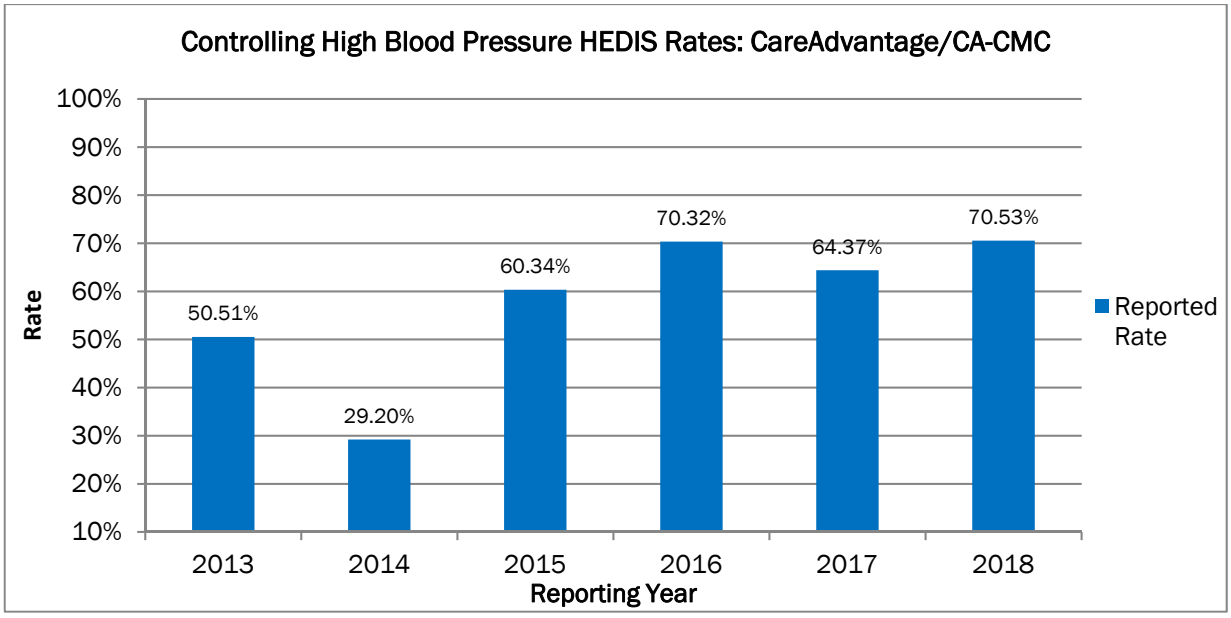
2019 ACTION PLAN

HPSM continues to provide P4P incentives to providers for their patients who had at least one HbA1c test and result submitted to HPSM, an eye exam, blood pressure reading, and medical attention for nephropathy or screening in the current program (calendar) year.

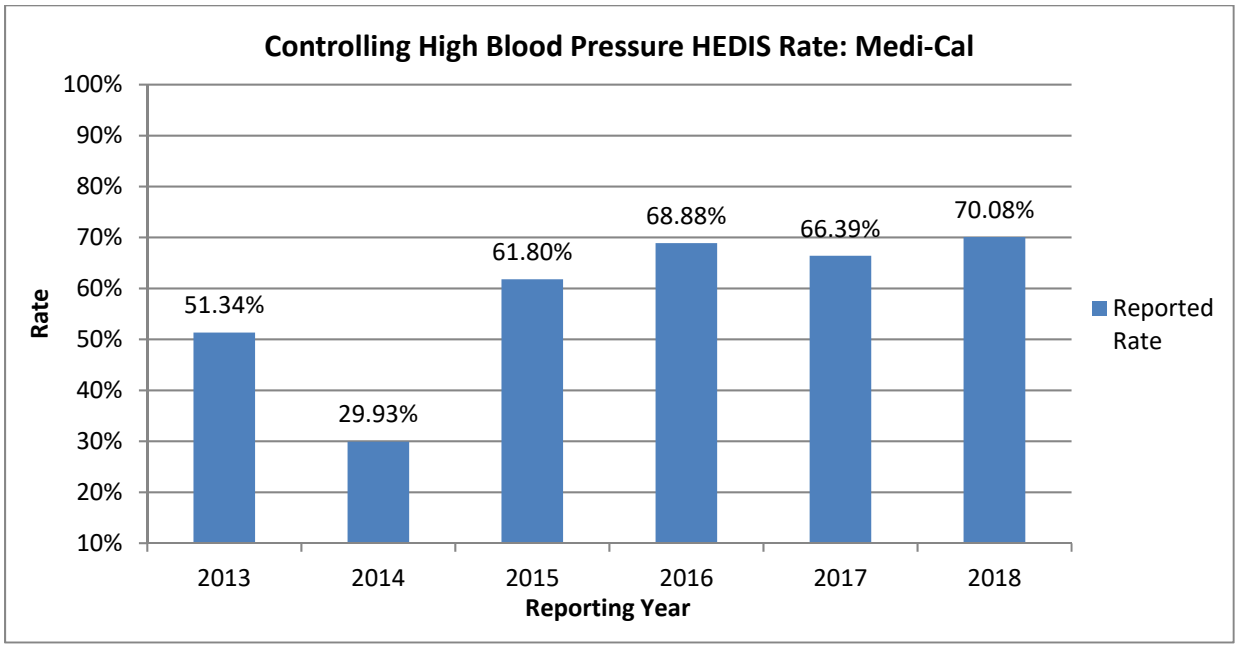
In addition to the CDC measures, *Medication Adherence for Diabetes Medications* is a new CMC Quality Withhold Measure for 2019 and a new area of focus for HPSM. The Quality Improvement Team has started the planning phase of identifying potential interventions aimed at improving the diabetes related HEDIS measures and connecting members with diabetes with high quality care and services. The Health Promotion Coordinator has started to update our community resource /health education classes guide to better connect members to appropriate resources or health education classes. The planning phase will continue into 2019 and a new cross departmental workgroup will be created to begin to identify opportunities for improvement and potential interventions and partnerships related to diabetes care, self-management and resources.

3.5 CONTROLLING HIGH BLOOD PRESSURE (CBP)

CBP HEDIS RESULTS



For HPSM's CareAdvantage/CA-CMC population, the controlling blood pressure rates went up from 64.37% to 70.53%, well above the quality withhold measure benchmark of 56%.



For HPSM's Medi-Cal population the controlling blood pressure rates went up from 66.39% to 70.08%, increasing closer to the HPL of 71.69%.

CBP PILOT PROGRAM DESCRIPTION

HPSM has partnered with a FQHC, North East Medical Services (NEMS), on a pilot program to provide smart blood pressure monitors to HPSM members with uncontrolled hypertension. Through this pilot, smart blood pressure monitors are provided to members served at their primary care provider's office. The smart monitors are provided by a vendor and have the capability of uploading BP reading data to a platform for use in clinical care and reporting. The members who enroll sign a contract verifying acceptance of blood pressure monitor and are taught how to take blood pressure in accordance to each individual's specific needs. The assigned clinician also educates members on signs and symptoms of hypertension, diet, proper medication adherence and use of the blood pressure monitor. The blood pressure monitors need to be connected to a gateway "cloud" device to upload the pressure readings via the internet. Using the

blood pressure monitor to upload blood pressure readings provides the primary care physician a way to view the patient's medical records along with readings from home to make treatment adjustments as necessary.

The lead physician of the clinic and the clinic's health educator are responsible for training all front and back office staff on the procedures. Clinic staff notify the health educator and physician when members in the pilot program are in the clinic for an appointment to better coordinate care. The health educator continues to reach out to all identified members with a hypertension diagnosis and who were seen in the clinic in the last year. When a member has an appointment to be seen by a physician, staff notify the physician and the health educator to market the benefits of joining the pilot to the member. When the member agrees to participating in the pilot, the health educator provides a BP monitor, records baseline BP, review medications and lifestyles with physician present and inform the member how to use and upload BP readings.

The QI Specialist pulls data from the platform to analyze on a quarterly basis to measure the number of members in pilot that are participating. The information collected also shows percentage of how many abnormal blood pressure readings the participant had. Blood pressure readings are collected from the member when they visit their health coach and clinician. Members who have out of control blood pressure have a visit with their health coach and clinician scheduled every 6 weeks. Members who have their blood pressure in control see their clinician and health coach every 3 months.

TARGET POPULATION

HPSM member's aged18 -85 years of age with a diagnosis of hypertension and Blood Pressure that does not meet the adequately controlled criteria which is defined as:

- Members 18-59 years of age whose BP was <140/90 mm Hg
- Members 60-85 year of age with a diagnosis of diabetes whose BP was <140/90 mm HG
- Members 60-85 years of age without a diagnosis of diabetes who BP was <150/90 mm HG

CBP PILOT OBJECTIVES:

- Enable patients to have accountability and responsibility for their own care.
- Inform and educate members about how to use blood pressures and understand how their medications and diet affect their blood pressure rates.
- A home blood pressure monitoring system helps an individual/patient to track their condition providing information to the patient in between visits to their provider. This will enhance communication and care between patients and providers.
- Decrease in health care costs by decreasing the number of visits a patient needs to visit their primary care provider occurs.

CBP PILOT PROGRAM UPDATES

In 2018, HPSM Quality Improvement team began the planning phase to expand its CBP pilot program by partnering with a Clinical Pharmacist champion located at the San Mateo Medical Center (SMMC)'s 39th Avenue Primary Care Clinic. In 2019, the clinic is set to receive 50 blood pressure monitors to officially begin the pilot at the clinic. Currently, the pilot with SMMC is in the early stages, with confirmed plans for training with ForaCare.

CBP PILOT PROGRAM BARRIERS & LESSONS LEARNED

- **Data Collection/Monitoring:** Evaluating the accuracy of the blood pressure readings has proven difficult, since members either are not being properly educated on how to measure their blood pressure. Additionally, members that are in the program have been found to take multiple readings throughout the day and only record the reading they feel satisfactory with, thus clouding the accuracy of their data. Though, the pilot has proven difficult to analyze quantitatively, anecdotal feedback from the NEMS team that has been participating

in the pilot indicate that the program meets the overarching objectives by providing additional member level data to support clinical discussions and discussions regarding self-management with the member.

- **Implementation Process:** To implement the blood pressure monitor pilot one person is needed to coordinate the program and another as a backup. This coordinator must be able to take the blood pressure machine and print out the results, look up the member's eligibility. The ideal coordinator needs to be an employee that does not follow a physician preferably an LVN or RN.
- **Clinic Engagement:** A physician champion is also needed to educate providers on the pilot. The best place for the pilot to be implemented is in a location where the patient visits occur.

CBP PILOT PROGRAM ACTION PLAN FOR 2019

- **SMMC Pilot:** The QI Specialist will implement the CBP pilot at the SMMC site. The implementation will involve working with the site champion for the project to determine how outreach will be done, and which patient population will qualify for the program.
- **NEMS Pilot:** The QI Specialist will continue to work with NEMS on evaluating the pilot and identifying opportunities for improvement.
- **Data Collection/Monitoring:** Reporting enhancements have been requested of the vendor that provides the Smart BP meetings and online platform. The QI Specialist will continue working with the vendor to fix data reporting issues so that collecting data from NEMS and SMMC can continue. The data will include the number of members that are participating in the pilot, length of time (in weeks) for a member to achieve the controlled blood pressure, if the member was seen at least once by the health educator quarterly, if member is on hypertensive medications and if member is compliant with the medications.

The QI Specialist will also look at what other clinics have the highest amount of members diagnosed with hypertension to identify potential partnerships aimed at increasing the amount of members with controlled hypertension as measured by the HEDIS CBP Measure specifications.

3.6 INITIAL HEALTH ASSESSMENT (IHA)

IHA OUTREACH PROGRAM DESCRIPTION

The Initial Health Assessment (IHA) has become an increasingly higher priority in health plans across California. Focus has also increased on primary care and preventative services as the Medi-Cal population has a higher incidence of chronic and/or preventable illnesses, many of which could be modified through appropriate health behavior change and early detection to promote lifestyle changes. The purpose of the IHA is to enable a provider to comprehensively assess the member's chronic, acute and preventative needs and to identify patients whose needs require coordination with additional resources. The All Plan Letter (APL 08-003) requires all primary care providers to administer an IHA to all Medi-Cal managed care patients as part of their initial and well care visits. DHCS audits of November 2014 and November 2015 have found that the plan did not ensure that IHAs for new members were completed within 120 calendar days of enrollment. It is required that health plan's reach a 100% compliance rate ensuring every member enrolled is seen by their primary care physician. The Quality Improvement team will continue to work on implementing a text messaging campaign to further market awareness of seeking early primary care services. The potential to reach more members through text messaging versus mail has evidence of success as studies have shown that more of the health plan's membership has access to a cell phone and messaging services.

IHA OUTREACH PROGRAM UPDATES

A letter is sent out to new HPSM members on a monthly basis in conjunction with a letter in their welcome packet, urging members to set an appointment with their provider as soon as they are able. A training manual for HPSM's provider network was created to educate providers on the requirement and benefit to outreach to their new members to get them in to be seen. Continued effort to increase compliance through text messaging is being explored as another option to reach new members.

The overall goals for increasing IHA compliance in 2018 included the following:

1) To increase provider's awareness of their panel assignments to initiate care and establish a medical home for HPSM members.
2) To increase members' awareness of the importance of having a visit with their PCP within first 120 days of enrollment.

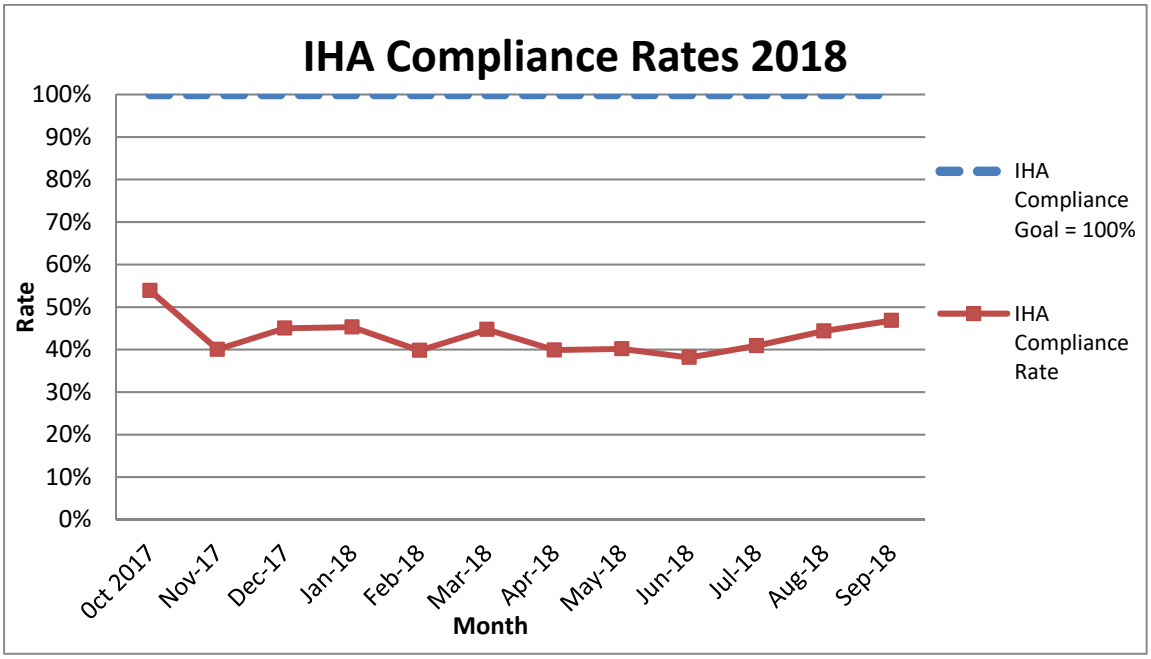
IHA OUTREACH PROGRAM METRICS

2018 PROGRAM OBJECTIVE: By December 31, 2018, increase compliance rate to 50% in Q4 2018 from Q1 2017 average rate of 41.7%.

The compliance rates have remained steady at an average of 42.2% from January through September 2018. This is a slight decrease in the compliance rate compared to the 2017 average of 42.7%. The rates for October to December 2018 are not accurate at this point in time as claims are not complete for the last quarter of the year. A more accurate portrayal of compliance will be provided in the first half of 2018. Based on the current rates, Q1 compliance was off to a slow start at 43.3%, the compliance rates continued to trend down in Q2 to 39.4%, however in Q3 the rates picked up to 44%.

A barrier to improving IHA compliance is related to incorrect physician assignment for members. The member may be assigned to one provider but has no encounters with that provider in the clinical system when audited.

MONTHLY IHA COMPLIANCE RATES 2018



IHA OUTREACH PROGRAM MAJOR ACCOMPLISHMENTS & PROGRESS

There were six areas of focus for 2018 to help increase awareness to members and train providers. They are listed below:

1. ***Reminder Letter:*** Targeted messages continued to be sent to HPSM patients identified in month as newly enrolled to promote healthy behaviors and encourage members to seek out primary care physician for their well visits upon joining HPSM. These messages encourage the member to initiate discussion, establish relationships with their identified medical home.
2. ***Provider Training*:** A toolkit was developed in 2016 for providers and office staff to be dispersed and trained by QI staff in partnership with the Provider Services team and continued to be distributed to providers in 2018. The

Provider Toolkit includes a FAQ sheet on all the components necessary to train the provider network on all components of what constitutes an IHA. A fax blast reminder was sent out to all primary care providers by the Provider Services department detailing/refreshing billing requirements for the IHA and the requirements for Pay for Performance Incentive Program attached with the completion of the IHA.

3. ***Provider Website:*** The complete Provider Toolkit continued to be available in the provider resources section of the website. This is another avenue HPSM's uses to streamline information to our provider network on any changes or regulations that they need to be aware of.
4. ***Provider Newslette***r: An article was included in the Summer 2018 edition of Health Matters MD, to educate providers about the importance of outreaching to their members. The purpose was to encouraged providers to use the opportunity of outreaching to members as a method for establishing care, seeking resources from HPSM for establishing their e-reports and receiving their monthly case management lists.
5. ***Text Messaging Campaign***: The pilot text messaging campaign continued with two on HPSM's largest clinics, San Mateo Medical Center and Northeast Medical Services. Based on the rates, the text messaging campaign has not shown any significant improvement from 2017, despite an increase in the number of participants.

IHA OUTREACH PROGRAM METRICS

2018 IHA Text Messaging Campaign Metrics:

	# received text messages	# received IHA	IHA compliance rate
SMMC	2267	588	25.93%
NEMS	35	8	22.85%
Combined	2302	596	25.89%
Overall rates (No text message)	12070	5100	42.2%

2018 Facility Site Review Results

Medical records of 171 members were reviewed for IHA completion in the first 120 days of enrollment with the Health Plan of San Mateo. These members were collected through the DHCS Facility Site Review.

Results

Level of Compliance	Number of members	Percent of total audited
IHA with SHA/IHEBA	69	40%
IHA without SHA/IHEBA	92	54%
No IHA and no SHA/IHEBA	8	5%
SHA/IHEBA without IHA	2	1%

IHA PROVIDER EDUCATION

The Health Plan of San Mateo makes the providers aware of the requirement of the SHA/IHEBA through three programs.

1. **Provider Services Outreach:** Periodic visits updating changes to existing programs, introducing new programs, and reinforcing on-going programs by provider service personnel.
2. **Pay for Performance Program:** Monthly reports sent to the provider detailing level of participation. Including Provider Services Pay for Performance promotion visits.
3. **Medical Record Review as part of the FSR audit process:** Any deficient IHA and SHA/IHEBA documentation is addressed at the time of the Facility Site Review by site review nurses. Providers noncompliant or mostly noncompliant with consistent IHA completion will be asked to complete a Corrective Action Plan. Providers are given copies of the Staying Healthy Assessments for all age groups and appropriate languages for the practice population.

IHA BARRIERS

The SHA continues to be the greatest hurdle to higher compliance rates. With the increased emphasis on use of Electronic Health Records, the paper based SHA has become more cumbersome for the provider and the office staff. Providers consistently ask about the availability of an electronic version of the SHA. Providers have asked for acceptable alternatives to the SHA. One provider recently purchased an EHR with an Ages & Stages Questionnaire module and wanted to know if this would qualify as an IHEBA. ASQ is a developmental assessment and the IHEBA is a behavioral assessment. The lack of a recognized alternative has limited IHA compliance as well.
The Quality Improvement Department continues to review new avenues to increase IHA compliance.

IHA OUTREACH PROGRAM ACTION PLAN FOR 2019

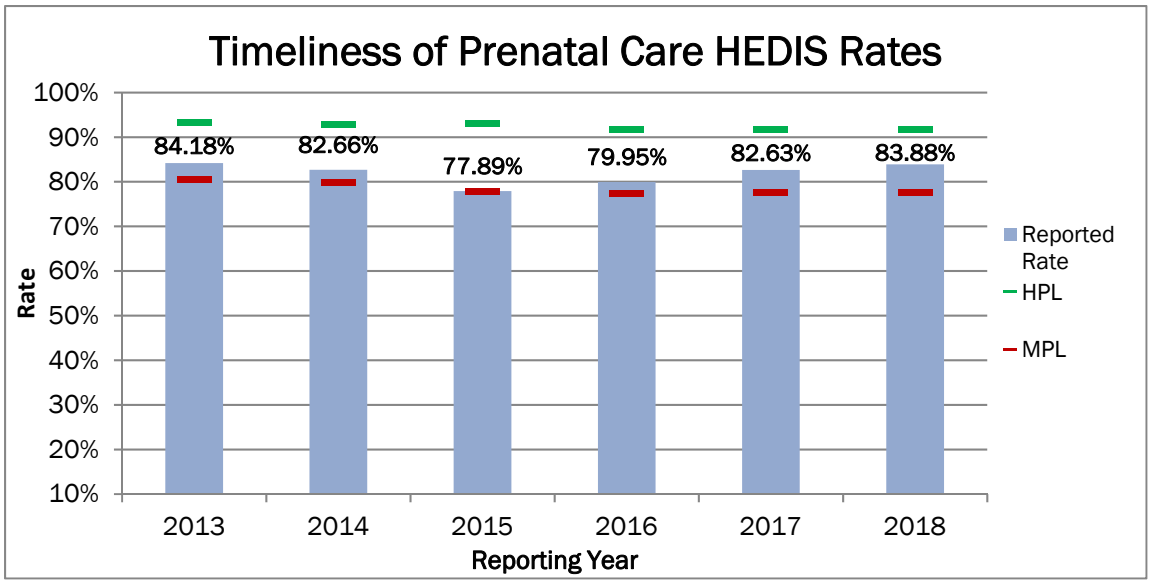
The SHA proves to be a significant area for providers to comply with. Training has been developed to address this, but the additional component of a questionnaire in busy practices is a barrier to fully completing the IHA. Providers have relayed the want to modify the questionnaire along with the difficulty in adding the questionnaire into their electronic health records. California Department of Health Care Services (DHCS) is aware of the issues. Until a modification from DHCS has been made aware to the health plan, training from all touch points to the providers and/or office staff will remain a focus. The Quality Improvement and Provider Services departments continue to provide training to providers through 2019.

PCP assignment continues to play a significant factor in crediting the correct providers with completing the initial health assessment of members assigned to them. Processes need to be developed to actively update PCP assignments of members when they decide to switch providers. Providers are also not actively outreaching to new members through their case management lists.

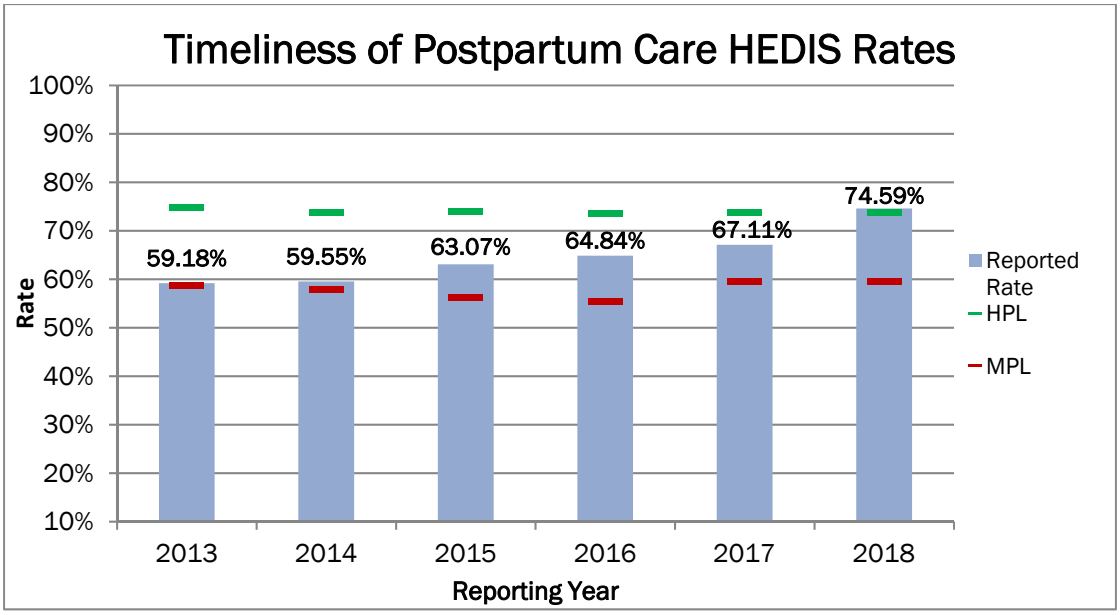
The IHA text messaging campaign will need to be revaluated for 2019. Currently, the QI specialist is working in conjunction with our vendor to streamline the outreach campaign. Additionally, we are considering altering the content of the text messages to see if it will enhance the rates.

3.7 PRENATAL AND POSTPARTUM CARE (PPC)

PPC HEDIS RESULTS



There was a slight rate increase from 82.63% in 2017 to 83.88% in 2018 continuing to raise the timeliness of prenatal care visits above the MPL of 74.21%. Efforts to improve timely prenatal care are described below (PPC Outreach Program Description).



The timely postpartum care rate increased considerably from 67.11% in 2017 to 74.59% in 2018 and is now higher than the HPL of 73.67%. We attribute this to our Prenatal and Postpartum Care Program described below (3.7.1 PPC Outreach Program Description).

PPC OUTREACH PROGRAM DESCRIPTION

In 2018, HPSM's Quality Improvement Department continued outreaching to pregnant Medi-Cal members and women that recently delivered. The program focuses on promoting timely entry into prenatal care and timely postpartum care by providing gift card incentives and education on the importance of timely care. Members are identified by the following data sources: prenatal ultrasound visits, first prenatal visit, prenatal vitamins, pregnancy diagnosis codes, or a recent delivery. Members are also identified through P4P Provider Referral Forms, OB Providers, County of San Mateo Family Health Services, and Self-Referral. Once the member is identified as pregnant through the different data sources, the Health Promotion Coordinator conducts outbound calls to members. If the member chooses to participate, the Health Promotion Coordinator enrolls and follows-up with the member throughout her pregnancy. In addition, the Health Promotion Coordinator links the member to community resources or programs including WIC, Nurse Family Partnership or Black Infant Health.

PPC OUTREACH PROGRAM GOAL

The objective of the program is to increase the rate of eligible women receiving timely prenatal and postpartum care. Timely prenatal care is defined as care received within 42 days of enrollment or during the first trimester. Timely postpartum care is defined as care received between 21-56 days post-delivery. The 2018 prenatal goal was to increase from 82.63% (HEDIS 2017) to 83.56% (Medicaid 50th %tile) and postpartum from 67.11% (HEDIS 2017) to 69.44% (Medicaid 75th %tile).

PPC OUTREACH PROGRAM METRICS

- As of December 31, 2018, 110 members enrolled in HPSM's Prenatal Care Program in 2018 and 99 (90%) attended their first trimester appointment.

- As of December 31, 2018, 1036 members enrolled in HPSM's Postpartum Care Program 675 (67.0%) attended their postpartum appointment.

PPC OUTREACH PROGRAM MAJOR ACCOMPLISHMENTS

- HPSM's HEDIS Timeliness of Prenatal Care rate increased by 1.51% over the previous year from 82.63% to 83.88%, surpassing the program goal by 0.38%.
- HPSM's HEDIS Postpartum Care rate increased by 2.27% over the previous year from 67.11 to 74.59% in 2018, surpassing the program goal by 7.42%.

PPC OUTREACH PROGRAM UPDATES

MEMBER INCENTIVE

In 2018, HPSM continued with the Prenatal and Postpartum Care Member Incentive Program. To improve pregnant women's early utilization of prenatal care, members can receive a $50 Target gift card for attending a prenatal visit during their first trimester (i.e., the initial 12 weeks of pregnancy) and an additional $50 Target gift card for visiting their doctor for their postpartum appointment (3-8 weeks post-delivery).

HPSM-FHS PARTNERSHIP

In 2018, continued partnering with the County of San Mateo Family Health Services (FHS) by providing a monthly file of pregnant HPSM Medi-Cal members living in San Mateo County. Pregnant members are then connected to one of FHS's home visiting programs or other resources such as Nurse Family Partnership or Black Infant Health. FHS Program Staff then reaches out to pregnant African American members and teens under 20 years of age, encouraging timely prenatal and postpartum care. Such data sharing enables HPSM and FHS to work collaboratively on improving outcomes for specific populations of expectant mothers and their babies.

PROGRAM PARTICIPANT SURVEY

From January 2018 to December 31, 2018, HPSM surveyed 273 members enrolled in the Prenatal and Postpartum Care Program about their experience with the incentive program. A total of 60 (22%) members responded to the survey. Key findings include:

- 73.12% respondents said that gift cards encouraged them to see their provider in a timely way.
- 78.26% respondents said they had no problems attending prenatal or postpartum appointments, but 10.9% said childcare was a barrier to attend to their health care appointments.
- 70.65% respondents said they would be very likely to tell a friend to enroll into the Prenatal and Postpartum Care Program.
- 18.9% respondents said they heard about the program through their OB/GYN providers.

2019 ACTION PLAN

In response to these results, we plan to take the following actions:

- Explore options to expand the HPSM OBGYN provider network and educate providers about HSPM PPP.
- Send text messaging surveys through CareMessage to increase the number of respondents.

PROVIDER SECRET SHOPPER CALLS

Annually, the Quality Improvement (QI) Department conducts "secret shopper" telephone surveys of Health Plan of San Mateo (HPSM) obstetric (OB) providers who are accepting new patients for the Medi-Cal line of business. The "Secret Shopper" survey strives to achieve the following:

- Monitor timely access on first prenatal appointment. Timely access defined as no more than 10 business days or two weeks from the time appointment is requested to the appointment date and within the first trimester.

- Ensure accuracy of printed and electronic member materials about HPSM OB provider network.

SECRET SHOPPER SURVEY RESULTS

In May 2018, using a call script guide, QI staff made "secret shopper" calls to 13 OB providers identified as accepting new members. The script instructs staff to act as a newly pregnant (8-10 weeks) patient seeking an initial prenatal appointment. To check for interpretation services utilization, four calls were made in Spanish by bilingual staff. All four OB providers had staff available to communicate in Spanish.

OB providers identified as accepting new members:

Providers identified from HPSM Member Handbook with provider type, language call was made and exclusion reason.

OB Provider	Provider Type	Language	Exclusion Reason
39th Avenue Clinic - OB/Gyn	County Clinic	Spanish	
Bay Area Obstetrics & Gynecology	Group	English	
Bay Obstetrics & Gynecology Group	Group	English	
Coastside Clinic	County Clinic	English	
De La Cruz, Zelda	Solo Provider	English	
Fair Oaks Health Center	County Clinic	Spanish	
Khilnani, Rubina	Solo Provider	English	
North East Medical Services (NEMs)	FQHC	English	
Ravenswood Family Health Center	FQHC	Spanish	
St. Luke's Women's Center	Clinic	Spanish	
Stodgel, Thomas	Solo Provider	English	
Ying Joy Zhou, MD	Solo Provider	English	Needs Insurance Verification
Zarate-Navarro, Sonia	Solo Provider	English	

Out of the 13 OB providers called to schedule an initial appointment, 12 (92%) were able to schedule a timely appointment of no more than ten business days or two weeks from the time the appointment was requested to the appointment date and within the first trimester. The other 1 (8%) OB provider needed to verify insurance coverage before scheduling an appointment.

Providers able to make an appointment:

OB Provider	Appointment Scheduled	Appointment Date	# of business days between scheduled & appointment date	Before 12 weeks of pregnancy?
39th Avenue Clinic - OB/Gyn	5/24/2018	5/29/2018	3	Yes
Bay Area Obstetrics & Gynecology	5/24/2018	6/1/2018	6	Yes
Bay Obstetrics & Gynecology Group	5/24/2018	6/4/2018	7	Yes
Coastside Clinic	5/24/2018	5/25/2018	1	Yes
De La Cruz, Zelda	5/24/2018	6/5/2018	8	Yes
Fair Oaks Health Center	5/24/2018	6/7/2018	10	Yes
Khilnani, Rubina	5/30/2018	6/4/2018	3	Yes
North East Medical Services (NEMs)	5/30/2018	6/1/2018	2	Yes
Ravenswood Family Health Center	5/30/2018	6/8/2018	7	Yes
St. Luke's Women's Center	5/30/2018	6/8/2018	7	Yes
Stodgel, Thomas	5/30/2018	6/6/2018	5	Yes
Zarate-Navarro, Sonia	5/30/2018	6/1/2018	2	Yes

Providers unable to make an appointment with information provided by QI staff:

OB Provider
Ying Joy Zhou, MD

Additionally, we compared wait times by geographical location to see if one part of the county had greater access over the other.

Timely access for initial appointment by geographical location:

Geographical Location	10 business days and before 12 weeks of pregnancy	>10 business days and >12 weeks of pregnancy	Unable to make appointment
North County (3)	3	0	0
Central County (7)	6	0	1
South County (2)	2	0	0
San Francisco (1)	1	0	0

CONCLUSION

The 2018 secret shopper calls highlight the increased number of OB providers available to HPSM- Medi-Cal members across the county. This year, 13 providers were accepting new members for OB services in comparison to 10 providers at the time the survey was done last year. Further, the clinics were more willing to share their availability of appointments, despite not having all necessary information from the member. This allowed us to capture accurate timely access from 12 out of 13 (92%) providers vs 4 out of 10 (40%) in 2017.

In 2017, two locations were unable to schedule a timely appointment before 10 business dates, 39th Avenue Clinic and Dr. Stodgel's practice. This was not the case this year. After last year's report, timely and overall OB access became top priority for HPSM and resulted in the creation of a committee made up of the Quality Improvement Department, Provider Services Department, the HPSM Senior Medical Director, and executive leadership to strategize methods to reduce overall wait time for members and expand its OB provider network. In addition to the HPSM Provider Services Department placing emphasis on retaining and improving the current network of OB providers by reviewing increased reimbursement reports of 175% Medi-Cal for claims and meeting 1:1 to address concerns and payment structures. Additionally, the Quality Improvement staff visited the two offices to stress the importance of timely care and Dr. Stodgel's office moved from San Mateo to Burlingame, which may have played a role in timely access. HPSM plans to continue these efforts in hopes of *recruiting 2-3 more providers in 2018 and continuing to strengthen the relationships with our current OB network.*

POSTPARTUM TEXT MESSAGE REMINDER PROGRAM

In May of 2017 HPSM concluded with the postpartum text messaging pilot. The intervention focused on testing if text messaging is an effective communication tool to encourage members to make a postpartum appointment in a timely mater. The text messaging intervention was implemented with SMMC during a one year intervention period, July 1, 2016 through May 31, 2017. The SMART Aim goal was 75% and the reported baseline was 64.9%. At the end of the intervention period, the calculated monthly average SMMC postpartum care compliance rate was 77.50%. Due to the success of the pilot, the text message campaign was expanded to all members participating in the Postpartum Outreach program in 2018.

For 2018, of the total of 1036 of HPSMs postpartum members who were part of our outreach program 836 were enrolled in our text messaging program, which represents more than 80 per cent of the members. Of those, 836 that were enrolled in the text messaging outreach, 21 opted out of the program and 19 did not return the complete text message, which implies that approximately 40 members were not interested in receiving text messages. Although the response rate from text messaging was low (25.6%), of the women who received at least one of the 3 text messages, 57.4% were compliant with their postpartum visit.

OB PROVIDER PAY-FOR-PERFORMANCE (P4P) PROGRAM

HPSM continued to offer performance bonus payments through the fee for service Pay for Performance (FFS P4P) program to Medi-Cal contracted OB providers that provide timely prenatal care to pregnant women early in their

pregnancy (first 12 weeks) and after delivery during the postpartum period (3-8 weeks after delivery). The performance payment specifications are aligned with HEDIS technical specifications for prenatal and postpartum care measures.

The program guidelines are:

Postpartum Exam (OB/GYN)
Patient Eligibility: Women who gave birth in the last 21 to 56 days
Payment Rate: $50 up to once per patient per pregnancy
Measure Definition: Postpartum exam performed within 21 to 56 days after delivery
Billing Guidelines: Procedure code 0503F
Line of Business: MC

Prenatal Visit (OB/GYN)
Patient Eligibility: Women in their first trimester of pregnancy
Payment Rate: $100 up to once per patient per pregnancy
Measure Definition: Prenatal visit with OB/GYN within first trimester of pregnancy
Billing Guidelines: Procedure code **0500F**
Line of Business: MC

The following information summarizes the total performance payments from in 2018 made to OB providers.

Incentive	Total
OB Visit by OB physician $100	192
Referrals by PCP to OB physicians $50	38
Postpartum exam by OB/GYN physician $50	757

PPC PROGRAM BARRIERS/ISSUES

The challenges to achieving the objectives of this intervention are the following:

- Identifying pregnant HPSM members early in their pregnancy due to claims lag.
- Members enroll with HPSM late during their pregnancy.
- Members not knowing they are pregnant until the second trimester.
- Timely identification of pregnant women and those women who have just delivered.
- Members have low perceived benefit for postpartum care check-up.
- 1st Prenatal appointment happens after the first twelve weeks or 42 days from enrollment.
- Postpartum care happens before or after the 21-56 days recommendation.
- Shortage of OB providers accepting new HPSM Medi-Cal members.

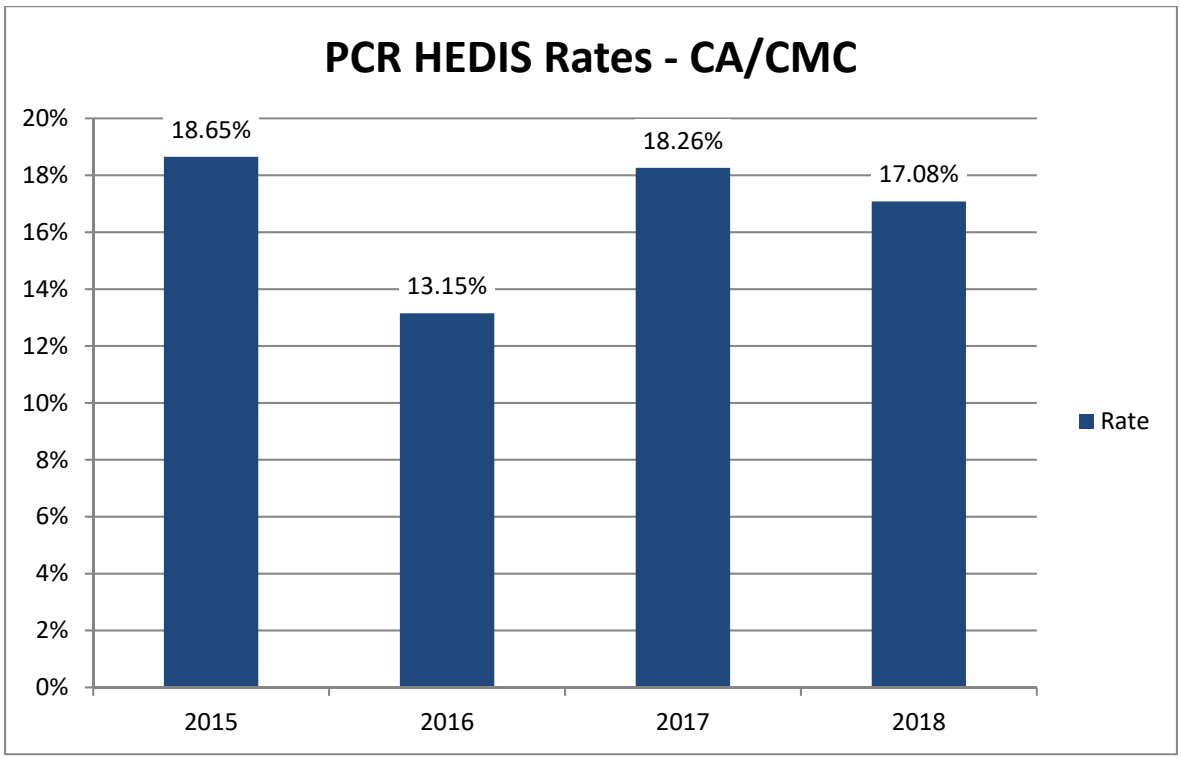
PPC PROGRAM ACTION PLAN FOR 2019

- Continue to identify members who are pregnant early in their pregnancy before their first trimester from the weekly claims report following the criteria of a positive pregnancy test result, or Rx for prenatal vitamins
- Continue working with the Provider Services department to address access issues in OB Provider network.
- Work with PCP offices that offer pregnancy tests to send a referral list of members who are pregnant.
- Continue receiving a report of recently delivered HPSM Medi-Cal members
- Continue to conduct postpartum weekly reminder calls to members who are enrolled in the Prenatal and Postpartum Care program.
- Strive to survey all members who completed the prenatal and postpartum program to learn about their experience and ways to improve the program.
- Continue to offer gift card incentives to members that attend timely prenatal and postpartum care visits.
- Include information that explains the importance of the first trimester prenatal and postpartum visits in the member and provider newsletters.

- Continue to promote the Prenatal and Postpartum member incentive program, a free program that provides gift care incentives for timely prenatal and postpartum care.

3.8 PLAN ALL-CAUSE READMISSIONS (PCR)

PCR HEDIS RESULTS - CAREADVANTAGE/CMC



CARE TRANSITIONS PROGRAM/QIP

POPULATION TARGETED: The Care Transition program is available to all HPSM members that are discharged from an in-patient hospital stay. Care Transitions Coaches introduce members to the program at bedside during their hospital, or conducts telephone outreach for engagement into the Care Transition Program for member that are discharged before the coaches are able to contact them.

REDUCING PCR REATES QIP

The initial goal of this QIP was to decreasing the PCR rate by 2% from the baseline rate 15.53% (HEDIS 2014 QIP baseline rate) by improving transitions of care across health care settings and practitioners. Currently HPSM has two interventions aimed at reducing a readmission within thirty days.

INTERVENTION DESCRIPTION

The primary objective of the Care Transitions program is to strengthen the continuity of care between HPSM's members from an inpatient visit stay through subsequent settings in order to reduce the risk of avoidable readmissions within 30 days. HPSM currently has three intervention arms aimed at reducing a readmission within 30 days of discharge:

1) **Care Transitions (CT):** A transition program where the member works directly with a HPSM Care Transitions coach. Members may be enrolled in BOTH intervention arms depending on their clinical needs
2) **Landmark(LM)/HomeAdvantage:** A home based medical care program for members with higher care needs
3) **Both CT&LM:** Some members may receive both services depending on their care needs.

The **Care Transitions (CT) Team** provides discharge support to HPSM members. Care Transition Coaches are located at high volume hospitals and follow up with the member at set intervals during the first 30 days post discharge. CT Coaches ensure a smooth transition to home by providing the following services to better support members during their transition from a hospital in-patient stay:

- Bedside visits for members during their hospitalization to offer information and follow up with the In-Patient Utilization Review nurse to report any identified needs post discharge.
- Collaborate with case manager and social worker while in hospital depending on the members needs at discharge in order to avoid additional days in the hospital.
- Participate in weekly IDT Interdisciplinary Team meeting to identify and discuss complex cases and complications with discharges.
- Arrange follow up visits with PCPs.
- Make referrals to other HPSM programs/services for ongoing needs.
- Provide linkage to applicable community resources.

HomeAdvantage /Landmark Program Description: Provides home-based medical care at no cost to HPSM members with complex care needs. Care teams comprised of doctors, nurses and other specialists make scheduled "house calls" to members' homes for check-ups and treatment. Some of its key benefits include:

- **Urgent care:** Team members are available by phone 24/7. Depending on the situation, they can send a clinician to the member's house or instruct them to visit the nearest emergency room. Knowing that a trusted medical professional is always just a phone call away helps members and their caretakers rest easier.
- **Reduced hospitalizations:** HomeAdvantage helps keep people healthy at home – where they want to be – and out of emergency rooms, hospitals and long-term care facilities, where stress and contagion can make them sicker.
- **Post-hospitalization visits:** The first few weeks after returning home from the hospital is when people are statistically most vulnerable to relapse. During this time, the HomeAdvantage care team provides enhanced support to speed the recovery process and prevent unnecessary rehospitalization.
- **A professional team:** In addition to doctors and nurses, HomeAdvantage's care team may also include pharmacists, social workers, behavioral health specialists, dieticians and other wellness professionals.
- **Care Coordination:** The HomeAdvantage team works with the member's PCP and other doctors, as well as family and caregivers, to ensure that all treatments complement one another. HomeAdvantage does not replace the member's other doctors – members continue seeing all of their regular care providers.

Barriers
Transportation Issues
Communication Issues
Non-compliance
Decline in Condition
Technology Issues
Medication Issues
Knowledge Deficit
Support Systems Issue(s)

MITIGATION STRATEGIES TO ADDRESS BARRIERS:

- **Case Management/Care Coordination:** In 2018, the CT Program implemented a standard process to better link members to Case Management Services. To further support members during transitions of care and improve

their overall experience with Care Coordination Services, the Care Transitions Team was integrated into the Care Coordination Department and now is part of the same unit that also includes the In-Patient Utilization Review team, and Complex Case Management. This reorganization strategy has helped to foster stronger communication between the various units involved with members care during their hospital stay, during discharge, throughout transitions of care and through ongoing case management services.

- **Provider Outreach:** In 2018, the Care Transitions Coaches made connecting members back to primary care services a top priority of the services they provide. It is now part of their standard workflow to connect members to their PCP, assist members in obtaining a PCP if needed, and ensure that members attend follow-up appointments. The CT Coaches also encourage members to complete the "My Personal Health" booklet and bring it to their PCP follow-up visit. In addition, the In-Patient Utilization Review team now notifies PCP's of all in-patient stays for their assigned members by sending a list of admissions and discharges in a PCP notification letter.
- **Culturally appropriate materials:** The My Personal Health Record is available to members in English, Spanish, Chinese, Tagalog, and Russian. This serves as a tool to support provider-member communication regarding care needs and medication adherence post discharge.
- **Increase Enrollee Family Engagement:** Family members or care givers are an essential component of the Care Transitions program as they facilitate addressing support system issues and communications when the client cannot speak for themselves. Increasing family engagement will reduce the chance of a hospital readmission by ensuring that a support system is in place to improve the member's health. In 2018, new AOR forms were implemented to address barriers to working with family members or care givers after the member leaves the hospital. Before this improvement change to the AOR forms, when the member was in the hospital, the CT coaches could abide by hospital information regarding authorized reps. In some cases when the hospital identifies a family member as the representative but HPSM doesn't have them listed on file, the health plan has to revert back to only working with the member once the member leaves the hospital. This would limit the CT Coaches ability to work with the family member to determine care needs for the member once the member goes home.

  In addition, in an effort to increase enrollee family engagement, the CT Coaches now attempt 100% of bedside visits and try to limit telephone outreach as much as possible. This also provides the opportunity to promote case management services to family members in-person to increase awareness about programs and services available to the member once they leave the hospital.
- **Information Technology Solutions:** In an effort to improve communications through the use of technology, CT Coaches now carry iPhones with them when they are out in the field seeing members at hospital facilities. This improves both communications with the hospital care team managing the patient's inpatient needs as well as communications back to HPSM's own Care Coordination team.
- **Improve Communication:** The Care Transitions Coaches continue to work closely with the Case Management unit to make sure that the member's care needs are addressed. The coaches also work with facility discharge planners to communicate any issues related to the member's transition. The department reorganization that moved the Care Transitions team into the Care Coordination Unit has also led to improved communications with HPSM In-patient Utilization Review Nurses providing a more member-centered approach to Care Coordination services.
- **Post Hospital Discharge Care:** The CT Coaches role has expanded to further facilitate post hospital discharge care and connecting members to additional services that will support their transition back to home and primary care after a hospital stay. The CT Coaches prioritize connecting members to a PCP, non-emergency health care related transportation services that increases the member's ability to access pharmacies to obtain medications, as well as assess for other home health follow-up needs such as access equipment (e.g. shower chairs) through the DME process.
- **Link to Community Service:** Changes to the Care Transitions Program now include more emphasis on the CT Coaches tracking the referral accepting process to support services to better identify any gaps and close the referral loop for members. By linking a member to support services or community resources, a more comprehensive approach is used to address the member's needs related to activities of daily living. Available

programs/resources that CT Coaches facilitate referrals to include IHSS, IOA, housing services, Mom's meals, MSSP, Care Coordination services, and other appropriate benefits.

RESULTS & FINDINGS

As of December 2018, there were 9,085 members enrolled in HPSM's Care Advantage line of business. There are three facilities selected as target sites for the Care Transitions program where CT Coaches currently see HPSM members which include Mills Peninsula Health Center, Seton Medical Center and San Mateo Medical Center. These sites were selected as they represent the largest volume of inpatient stays for our members across our network. In 2018, there were 1,166 unique discharges (Table 1) representing 867 unique members that had an inpatient stay that resulted in a discharge from one of three facilities to a lower level of care making them eligible for the Care Transitions Program or HomeAdvantage/Landmark services. Of those, there were 864 unique discharges representing 645 unique members that participated in the Care Transitions program or HomeAdvantage/Landmark after a stay at one of the three target facilities during this timeframe. The readmission rate for the intervention population was 15.16%.

Eligible Population for Intervention by Unique Members & Unique Discharges	
Metric	**Count**
Unique Members	
Total Unique CMC Members	9,085
Eligible Population (unique members with d/c from Mills, Seton, or SMMC)	867
Intervention Population (enrolled in CT +LM, CT Only or LM Only)	645
Unique Discharges	
Total CMC Discharges	2613
Eligible Population (unique d/c from Mills, Seton, or SMMC)	1166
Intervention Population	864
Exclusions - d/c to SNF	485
Exclusions - d/c to LTC	32

PCR Rates for Eligible Population (d/c from Mills, Seton or SMMC) & Intervention Population (enrolled in CT+LM, CT Only or LM Only) by Unique Discharges			
Metric	**Numerator**	**Denominator**	**Rate**
PCR for all CMC Discharges across all facilities	436	2613	16.69%
PCR for all facilities (excluding d/c to SNF or LTC)	306	1891	16.18%
PCR for eligible pop (d/c from Mills, Seton, SMMC)	168	1167	14.40%
Intervention Population (enrolled in CT + LM, LM only or CT Only)			
PCR for Intervention Population	131	864	15.16%
CT+ LM w Readmission/total CT+LM	12	112	10.71%
CT Only w readmission/total CT Only	96	557	17.24%
LM Only w readmission/total LM only	23	195	11.79%
PCP Visit w/30 Days for intervention population	791	864	91.55%
CT+ LM w PCP visit/total CT+LM	109	112	97.32%
CT Only w PCP visit/total CT Only	492	557	88.33%
LM Only w PCP visit/total LM Only	190	195	97.44%
PCP Visit w/30 Days for intervention pop	791	864	91.55%

HPSM measures Readmissions within 30 days of discharge by unique discharges to align with specifications for the HEDIS Plan All Cause Readmissions (PCR) measure. Using the PCR measure specifications accounts for the fact that unique members may have multiple hospitalizations and subsequent discharges throughout the year. In 2018, there were 1,166 unique discharges (Table 1) from the three high volume facilities where the Care Transitions Program is currently provided to members. This represents total discharges of CMC members from Mills Peninsula Health Center, San Mateo Medical Center, or Seton Medical Center between 1/1/2018-12/31/2018 timeframe. In 2018, the total PCR rate across all facilities where CMC members were hospitalized was 16.69%, representing all CMC discharges that

occurred between 1/1/2018-12/31/2018. The PCR rate for the population eligible for the intervention, meaning CMC members discharged from Mills Peninsula Medical Center, Seton Medical Center or San Mateo Medical Center, was 14.40%. The PCR rate was 15.16% (B1c) for the actual population of members that received an intervention of either Care Transitions only (CT Only), HomeAdvantage/Landmark (LM Only) only or both (CT+LM).

SUMMARY OF RESULTS

To determine effectiveness of this intervention, the PCR rate for the entire population of 16.69% is compared to that the intervention group of 15.16%. Though the goal of decreasing the overall PCR rate by two percent from the 2014 HEDIS baseline of 15.53% to a goal of 13.53% was not reached, it should be noted that, the PCR rate for members that actually received the intervention of 15.16% is also lower than the current overall PCR rate for all facilities (excluding those that were discharged to a SNF or LTC) of 16.18% indicating improvements in the right direction and some success of the intervention at the current sites. Another area of success due to this intervention is the high rate of PCP visits within 30 days for intervention participants (Table 2) with a 91.55% rate for the total intervention population, 97.32% for CT+LM arm, 88.33% for the CT Only arm and 97.44% for the LM Only arm. Transition across care settings continues to be a high area of focus for HPSM and the CT Program continues to evolve. Many changes were made to the Care Transitions program structure and process in 2018 so we expect to see further improvements in these rates continue into 2019.

The total Plan All Cause (PCR) rate for Medicare members is 16.69%, representing a total of 2,613 unique discharges from 01/01/2018-10/31/2018 and 436 that resulted in a readmission within 30 days. The total number of unique CMC members represented in the total number of unique discharges is 1,625. There were 676 unique discharges to a SNF and of those, 124 resulted in a readmission for a PCR rate of 18.34%. This rate is higher than the rate for the overall PCR rate and though the SNF population may represent members at higher risk, it also indicates that there may be some opportunity for improvement in PCR rates among members that are discharged to a SNF facility.

The current intervention did not meet the goal of the QIP. The aim of this QIP was to decrease the PCR rate by two percent from the 2014 HEDIS baseline of 15.53% to a goal of 13.53%. The PCR rate from the intervention population for this QIP is 15.16% which is higher than the 2014 goal of 13.53% and did not achieve the goal of this QIP. Though the goal of the QIP was not met, the PCR rate of the intervention population of 15.16% is lower when compared to the total population PCR rate of 16.69%.

BEST PRACTICES

Best Practices Integrated into HPSM Care Transitions Program:

- **Prompt follow-up visit with an outpatient provider after discharge:** Proactive follow-up to ensure member attends PCP visit and close the loop increases % of members in intervention with a PCP visit within 30 days of discharge. Follow-up visits with PCPs are scheduled for all Care Transitions participants. During the visits, PCPs provide follow-up care, ongoing symptom and medication management, and answer any clinical care or self-management questions.
- **Health Services Integration:** The reorganization of the Care Coordination department to include the Care Transitions Program promotes member centered care, increase efficiencies and improve communications.
- **Use of technology to improve communications**: Upgrading the cell phones used by CT Coaches when they are out in the field from flip phones to iPhones improved communications between CT coaches and other HPSM teams.
- **Continuous monitoring of intervention data**: Ensures quality assurance on data entry into the Case Management system and assess effectiveness in more real time.
- **In-person visits:** In person visits versus phone outreach (previous method used) allow the CT coaches to promote CT program, other care coordination services and community resources increase member and family member/care giver engagement.
- **Create medication management system**: Utilizing My Personal Health Record booklet allows for the CT coach to help members gather medication information that services as a communication tool to use during their PCP follow-up visit.

Industry Best Practices (to be explored further in 2019):

- **Complete and timely communication of information:** Facilitate communication handoff at time of discharge with PCP is an industry best practice for improving Transitions of care by providing health information related to the inpatient stay to better inform PCPs about appropriate follow-up care needs and increase their ability to provide comprehensive assessments of their patients.
- **Comprehensive discharge planning:** Prior to discharge, hospital staff organize follow-up services and address patients' financial and psychosocial barriers to receiving needed care, drawing on community resources as needed. Hospital staff call patients one to three days after discharge to address patients' questions, assess symptoms and medications, and reinforce patient/caregiver education. Discharge planning can be conducted by physicians, care managers, nurses, or pharmacists.
- **Patient/caregiver education using the "teach back" method:** In this method, patients are asked to restate instructions or concepts in their own words. Education can be supplemented by illustrations and written materials at appropriate reading levels. Education focuses on major diagnoses, medication changes, time of follow-up appointments, self-care, warning signs, and what to do if problems arise. Physicians, nurses, care managers, or discharge planners provide education before and after discharge.
- **Open communication between providers.** Communication occurs between care settings and among multidisciplinary teams within each setting. Responsibilities are clearly defined for the discharging provider and the subsequent provider. The discharging provider confirms that the subsequent provider received the discharge summary and pertinent test results, and responds to questions promptly. Information transfer involves physicians, nurses, care managers, office personnel, and information technology staff.

LESSONS LEARNED

- **Need for Program Expansion:** In order to impact the overall PCR rates, HPSM should consider expanding to additional facilities where there are large volumes of inpatient stays and discharges for HPSM members. HPSM is currently considering a rollout to Stanford Medical Center as the next potential implementation site.
- **SNF Focused Interventions:** Currently, members discharged to SNF facilities are eligible for Home Advantage/Landmark services but are excluded from the general CT Program Services. HPSM should continue to evaluate HomeAdvantage/Landmark's impact on PCR rates for members discharged to a SNF. In addition, exploring potential opportunities for improvement with the high volume SNFs is a strategy to consider in an effort to impact overall PCR rates since members that are discharged to SNFs have a higher readmission rate and represent a large volume of overall discharges.
- **The Value of Ongoing Collaboration:** Ongoing work group meetings focused on reducing readmissions and improving transitions of care facilitate monitoring and identification of opportunities for improvement.
- **Narrowed Focus on Higher Risk Populations:** Additional attention should be focused on members utilizing the ED to link them back to primary care as they are at higher risk for admission and subsequent readmissions. HPSM has implemented a new system, PreManage ED, to better monitor active ED utilization for certain facilities.

2019 ACTION PLAN

- **Technology Solutions**: The use of iPhones was recently implemented to improve overall communications and the CT team will continue identify other potential technology solutions to further improve efficiencies of the program.
- **Increase Reach of services aimed at reducing readmissions**:
    - In 2019, the workgroup will explore opportunities to spread the Care Transitions intervention to additional facilities including Stanford in an effort to reach more CMC members that would benefit from transitions of Care Services provided by HPSM.
    - The workgroup will also explore CT program options for SNF or LTC population. A new Post-Acute care program was implemented in June 2018 utilizing Landmark providers and will continue into 2019. The program was implemented to effectively manage members during their SNF stays and throughout the

subsequent discharge to home when appropriate. HPSM will continue to evaluate effectiveness of this new program in reducing 30 day readmissions for the population discharged to a SNF.

- **Data Reporting/Monitoring:** Ongoing and regular monitoring of PCR data is essential to determine additional sites or opportunities for improvement. In 2019, the workgroup will review program related data as well as implement more process measures into our CT intervention evaluation to ensure CT program components/workflows are happening as intended. Monthly PCR rates will also be added to the Quality improvement dashboard to better disseminate monitoring data organization wide in real time.
- **Health Services Integration**: The reorganization of the Health Services Department that led to the Care Transitions Program residing within the Care Coordination Department allows for restructuring of the CT Program to include risk stratification of members and the services they receive. Members will now be categorized into three populations:

Risk Level	Intervention
Low Risk	No intervention
High risk with no previous case management services	CT coaches follow for 7 days and connect member to PCP, ensure DME needs, and any other follow-up services such as home health or linkage to community resources. After the 7 days then hand off to Nurse Case Manager for the remainder of the 30 days post discharge to continue to address any further clinical care needs.
High risk with previous HPSM case management services w/in previous 90 days	Immediate handoff to reconnect with previously assigned Nurse Case Manager for continuity of care and increased member experience.

- **Incorporate Industry Best Practices into CT Program Structure:** In 2019, HPSM will conduct an assessment of the current intervention to determine if it includes components of industry best practices (*see list in best practices section below*) to identify any gaps or opportunities for improvement.

Reducing readmission continues to be a high priority area of focus for HPSM. These improvement efforts have continued to evolve and many lessons learned and best practice strategies have been identified. HPSM will continue will continue to evaluate the current efforts across the organization aimed at reducing readmissions and work to apply industry best practices to the services provided to HPSM members. HPSM has an interdepartmental work group that will continue to focus on identifying and implementing ways to improve data collection and identify strategies to reduce the readmission rates.

4. SAFETY OF CARE & QUALITY OF SERVICES

4.1 CLINICAL GUIDELINES ANNUAL REVIEW

HPSM's Quality department leads an annual review of the clinical guidelines posted on the HPSM website. The review process ensures the posted guidelines are evidenced-based, current, and relevant to the plan's member population. A Quality Improvement Specialist checks online for the most recent date of a published update for each guideline, posted by the source organizations. The QI Specialist prepares an annual summary of the posted guidelines for presentation to the Quality Improvement Committee (QIC). The summary provides the last published date of each guideline, and includes progress notes on the update status for any guideline that has not been updated within the last 5 years.

Clinical Guideline s listed by Topic:

Health Condition	Guidelines and Tools
Asthma and COPD	• National Asthma Education and Prevention Guidelines • Asthma Care Quick Reference Guide • Diagnosis and Management of Asthma • Diagnosis and Management of Chronic Obstructive Disease
Cardiovascular and Circulatory Guidelines	• Guidelines for Management of Heart Failure • Hypertension Diagnosis and Treatment Algorithm • Hypertension Treatment Algorithm

	• Lipid Management in Adults
Diabetes	• Standards of Care in Diabetes (American Diabetes Association)
Cancer Screening	• Screening for Lung Cancer • Primary Screening for Breast Cancer • Primary Screening for Cervical Cancer • Primary Screening for Colorectal Cancer
Obesity in Adults	• Weight Loss to Prevent Obesity-related Morbidity and Mortality in Adults • Adult BMI Calculator • Adult Body Mass Index Table
Obesity in Children & Teens	• Screening for Obesity in Children and Adolescents
Immunization Schedules	• Birth to age 18 schedule • Catch-up schedule: 4 months to 18 years • Adult schedule • Combination Vaccines
Sexually Transmitted Infections	• CDC Sexually Transmitted Guidelines • San Mateo County Disease Reporting Form • HPV Vaccine for Child/Teen • HPV Vaccine Information for Parents
Behavioral Health	• Practice Guideline for Treatment of Patients with Substance Use Disorders • Attention Deficit Hyperactivity Disorder • Practice Parameters for Child Mental Health • ADHD Medication Guide

Source organization and websites for evidence-based guidelines posted on HPSM's website.
• Institute for Clinical Systems Improvement (algorithms)
• National Heart Lung and Blood Institute
• Joint National Committee Evidence-Based Guidelines
• Centers for Disease Control
• American Academy of Child and Adolescent Psychiatry (AACAP)
• American Academy of Pediatrics (AAP)
• American College of Cardiology Foundation (ACCF)
• American Diabetes Association (ADA)
• American Psychiatry Association (APA)
• U.S. Preventive Services Task Force

CLINICAL GUIDELINES 2018 ANNUAL REVIEW UPDATE

Annual review and approval by Quality Improvement Committee (QIC)
The Quality department presented the annual summary of the posted guidelines to the Quality Improvement Committee at its quarterly meeting in September 2018. A follow up to the summary was subsequently presented at its December meeting. Updates presented in September featured the addition of the following three preventive cancer screening guidelines to the website in 2018: **Primary Screening for Breast Cancer, Primary Screening for Cervical Cancer, and Primary Screening for Colorectal Cancer**. Status updates for the following two guidelines, which have recent publication dates older than 5 years, were also presented. The American Psychiatric Association's (APA) behavioral health guideline for Treatment of Patients with Substance Use Disorders, was last updated in 2010. QIC member and behavioral health specialist, Dr. Chu, confirmed that the 2010 guideline is the most current evidence-based version and commented on the extensive publication turnaround for APA guidelines. The National Asthma Education and Prevention Guideline (NAEP) was lasted updated in 2007. The NAEP website states that the updating process for its guideline has been initiated (in 2014) and would be completed in 2019. The summary follow up presented in December focused on the addition of the **Lung Cancer Screening** guideline. The QIC reviewed and approved the addition of the four cancer screening guidelines and extended its approval of the currently posted guidelines.

CLINICAL GUIDELINES ACTION PLAN FOR 2019

HPSM Quality will continue to check source websites for updates or changes to the guidelines posted on the HPSM website in preparation for the annual review by QIC. Provider Services will ensure the provider newsletter features an article in at least one of its quarterly newsletters that promotes awareness of the clinical guidelines posted on the HPSM website.

4.3 FACILITY SITE REVIEW (FSR) AND MEDICAL RECORD REVIEW

Credentialing is part of the comprehensive quality improvement system included in all Medi-Cal managed care contracts as mandated by the California Code of Regulations (CCR) Title 22, sections 53100 and 53280 and Title 10 of the California Administrative Code, beginning with section 1300.43. As one element of the QI process, credentialing ensures that physician and non-physician medical practitioners are licensed and certified in accordance with State and Federal requirements. Full scope site reviews are conducted initially during the pre-credentialing period and triennially thereafter for primary care providers, including pediatricians, and obstetricians. These reviews are done as a requirement of participation in the California State Medi-Cal Managed Care Program, regardless of the status of other accreditation and/or certifications to assure providers are in compliance with applicable local, state, federal and HPSM standards.

HPSM conducts full scope reviews utilizing the criteria and guidelines of California Department of Health Care Services Medi-Cal Managed Care (MMCD Policy Letter 02-002 Dated May16, 2002 or any superseding Policy Letter). HPSM may also address additional requirements as appropriate for quality studies. A passing Site Review Survey shall be considered "current" if it is dated within the last 3 years, and need not be repeated until the due date of the next scheduled site review survey or when determined necessary through monitoring activities by the plan.

The schedule for performing facility site review is determined by Quality Management staff and the prospective provider. It is based on the prospective credentialing date, as well as provider availability and preference. Site reviews for continuing providers are scheduled and performed within three years of the provider's last site review in compliance with criteria and guidelines of a full scope review is conducted utilizing the criteria and guidelines of California Department of Health Care Services Medi-Cal Managed Care (MMCD Policy Letter 02-002 Dated May 16, 2002, or superseding Policy Letter) Full Scope Site Review Survey 2014 and Medical Record Survey Tool 2014.

Providers who move to a new site must undergo a full scope site review unless the site has been reviewed with a passing score within the last three years (MMCD PL 14-014). The site review must be completed as soon as possible after the provider's move to the site or the provider's notice to HPSM (whichever is later), and not later than 30 calendar days after the date the new site was opened for business or HPSM's notification date. A minimum passing score of 80% on both the Site Review Survey and Medical Record Review Survey is required for a provider to continue as an HPSM provider in good standing. If critical elements of deficiencies are identified, a score in any section of the site or medical record review scores below 90%, or there is a deficiency in Pharmacy or Infection Control, or an overall score below 90%, then a Corrective Action Plan (CAP) is requested to be completed by the provider and must be completed as part of compliance with the provider's HPSM contract.

HPSM reviews sites more frequently when determined necessary based on monitoring, evaluation or Corrective Action Plan (CAP) follow-up needs. Additional site reviews may be performed at the discretion of the Medical Director, using input from the Quality Site Review nurses, if patient safety or compliance with applicable standards is in question. The same audit criteria applicable for Initial Full Scope Site Reviews are applicable for subsequent site reviews.

When providers are required to correct deficiencies identified during the survey. Corrective Action Plans (CAPs) are monitored by the QAI Nurses. Provider Review issues are reviewed by the Medical Director and may be referred to the PR for action or follow up.

- Of the 17 Facility Site Reviews completed in 2018, the average score was 95%.
- Of the 13 Medical Record Reviews completed in 2018, the average score was 88%.

- In collaboration with San Francisco Health Plan, we received 9 review surveys.

Common Deficiencies identified in Facility Site Review:

- Evacuation Routes are not posted in visible locations
- Written policies of documenting medication expiration are not available
- Documentation of cleaning schedule for janitorial services including a list of cleaning products used
- Lab Supplies are accessible to unauthorized personnel
- Documentation of Employee Trainings are often incomplete
- Specialized Equipment such as Scales, EKG's are not always calibrated
- All stored and dispensed prescription drugs are not always labeled appropriately

Critical Elements in the Facility Site Review identified were the following:

- Emergency Equipment for certain practices are not always appropriate
- Personal Protective Equipment is not readily available to staff
- Medical Assistance were not verifying medications with a licensed person prior to administrations
- Needle stick safety precautions are not practiced on site

Common Deficiencies identified in Adult Medical Record Review

- Primary language and linguistic needs not documented.
- Staying Healthy Assessments as well as subsequent Staying Health Assessments are not completed.
- TB risk assessments are not always documented.
- Advance Care Directives
- Adult Immunizations
- VIS documentation
- Completion of IHA within 120 days of enrollment

Common Deficiencies identified in Pediatric Medical Record Review

- Staying Healthy Assessments as well as subsequent Staying Healthy Assessments are not completed.
- TB risk assessments are not always documented
- VIS documentations are not completed

FSR ACTION PLAN FOR 2019

- Continue with our processes with completing FSR/MRRs.
- Make educational materials, guidelines and tools available HPSM's website. Direct our providers towards obtaining information about FSR/MRRs and completing Corrective Action Plans from the resources on our HPSM Website. This will help reduce deficiencies in future FSRs and MRRs and help providers to maintain full compliance.
- We will continue to collaborate with other MC Health Plans to obtain results of site reviews as to not duplicate site reviews of the same provider.

4.4 NURSE ADVICE LINE (NAL) PROGRAM DESCRIPTION

HPSM provides its entire membership (all LOBs) access to a free nurse advice line (NAL) 24 hours/7 days a week. HPSM contracts a vendor (medical call center) for its provision of NAL triage services and delegates oversight to the Quality department. Members are encouraged to call the NAL when they cannot reach their PCP for advice on what to do about an urgent health concern. HPSM informs members of the availability of the NAL and its phone number, through its website. Newly enrolled Medi-Cal members receive information about the NAL in the Medi-Cal guide, which is included in their new member packet.

2018 NAL PROGRAM UPDATES

• **New NAL vendor**: In Q1 of 2018, HPSM changed its vendor for the nurse advice line and implemented a member postcard mailing to announce a new toll-free phone number for the NAL. Its new vendor, TeamHealth Medical Call Center, began providing phone triage service on February 1 to members who dialed the new phone number. The previous vendor, Envolve People Care, continued to provide phone triage service to members who dialed the original toll-free number up until the end of its HPSM contract, on March 31, 2018. Starting in April, members who dialed the old NAL number were redirected to dial the new NAL number.

• **Implementation of new protocol facilitates warm transfer of member calls with certain dispositions to PCPs, during clinic hours:** HPSM and TeamHealth agreed on a protocol for NAL warm transfers to a member's PCP for calls with triage outcomes to see their PCP for care of their medical symptoms.

• **Custom Report prepared for San Mateo Medical Center (SMMC):** HPSM's Quality Improvement Specialist worked with the TeamHealth account manager to collect Q2 data for calls from members assigned to the 7 SMMC county clinics. Reports for Q2 were prepared that provided analysis of call counts of triage calls during clinic hours and after hours; call counts by final dispositions; daytime warm transfers by disposition; and summary report of monthly breakdown of warm transfer counts by disposition.

• **NAL member utilization reports:** Below are summaries of member calls to the NAL. In 2018, the SQIC did not request presentation of analysis of NAL member use data at SQIC quarterly meetings.

MEMBER CALLS TO NAL

Summaries of calls to the NAL in Q1 reflect calls received by Envolve PeopleCare and TeamHealth, during the contract overlap period of February and March .

TRIAGE CALLS BY LOB

Triage Call Volume	**Q1** (contract overlap period)		**Q2**	**Q3**	**Q4**
LOB	Envolve	TeamHealth	TeamHealth	TeamHealth	TeamHealth
CareAdvantage	70	13	37	35	31
Medi-Cal	438	522	1024	986	873
ACE	84	43	103	77	96
Healthy Kids	6	12	16	16	25
HealthWorx	4	5	10	8	10
Total	**602**	**595**	**1,190**	**1,122**	**1,035**

CALLS TO TEAMHEALTH BY CALL TYPE: (TRIAGE, HEALTH INFO, GENERAL)

Call Type	Q1	Q2	Q3	Q4
Triage/symptoms	595	1190	1122	1035
Health Info/no symptoms	73	176	151	166
Admin type (general info)	144	240	202	416

Outbound Model used by New Vendor: TeamHealth uses a clinical outbound model for managing incoming calls to the NAL. Incoming member calls are screened for the acuity level of their medical need. Calls that meet high acuity criteria are transferred immediately to a nurse. Lower acuity clinical calls receive a callback from a nurse within 10 to 45 minutes, depending on the caller's symptoms or health information needs. A description of acuity ranking levels is provided below.

Description of Acuity Ranking Levels
Level 1– Urgent Call transferred immediately to Nurse
Level 2 – Nurse callback within 10 minutes

Level 3 – Nurse callback within 20 minutes
Level 4 – Nurse callback within 30 minutes
Level 5 – Non-symptomatic caller; health question

Number of Calls by Acuity Ranking

2018	Acuity Level 1 (urgent)	Acuity Level 2	Acuity Level 3	Acuity Level 4	Acuity Level 5
Q1	119	44	205	347	26
Q2	233	99	407	624	78
Q3	223	87	386	555	96
Q4	266	86	381	592	115

SUMMARY OF TRIAGE OUTCOMES

	Q1	Q2	Q3	Q4
CALL 911 NOW	2%	6%	5%	4%
GO TO ED/ **OR PCP TRIAGE**	11%/9%	15%/8%	14%/12%	15%/11%
SEE PHYSICIAN W/IN 4HOURS OR PCP TRIAGE	10%	14%	**15%**	14%
SEE PHYSICIAN W/IN 24 HOURS	22%	29%	**22%**	20%
SEE PHYSICIAN W/IN 3 DAYS TO2 WEEKS	11%	11%	13%	14%
HOME CARE	14%	14%	17%	18%

NAL ACTION PLAN FOR 2019

- **Track TeamHealth triage referrals to HPSM's newly contracted urgent care clinics:** In 2018, HPSM contracted five urgent care clinics in San Mateo County to provide members access to urgent care services during weeknights and weekends, when they're unable to see their PCP. Four of these clinics were contracted late in the year, in November. TeamHealth triage nurses were advised to begin referring HPSM callers with final urgent dispositions to these clinics located in San Mateo, Daly City, San Bruno, Redwood City, and Foster City.
- **Decrease urgent triage referrals to ER by increasing referrals to contracted Urgent Care clinics.** The availability of a HPSM contracted urgent care clinic in five San Mateo County cities, enables TeamHealth triage nurses to facilitate member access to urgent care in an appropriate setting, when needed. Referrals to a local emergency room for urgent care should decrease over time with the availability of five HPSM contracted urgent care clinics throughout San Mateo County.

4.5 PHYSICAL ACCESSIBILITY REVIEW (PAR)

Department of Health Care Services Policy Letter 12-006 and All Plan Letter 15-023 requires Medi-Cal managed care health plans to use FSR Attachment C, D and E appropriate to their provider type in line with the three year cycle requirement of FSR Attachment A and B. Attachment C is for provider sites that serves a high volume of Senior and Person with Disabilities (SPD). Attachment D is for Ancillary Services. Ancillary Services refers to Diagnostic and Therapeutic services but not limited to Radiology, Imaging, Cardiac Testing, Kidney dialysis, Physical Therapy, Occupational Therapy, Speech therapy, Speech Therapy, Cardiac rehabilitation and Pulmonary Testing. Lastly, Attachment E is for Community Based Adult Services (CBAS) and includes all facilities that provide bundle CBAS services and do not include Licensed Only Adult Daly Health Care Center and Programs.

Attachment C, D and E has accessibility indicator symbols that determine the level of accessibility. If a provider's office or site meets all critical elements (CE), they will have "Basic Access". If they miss one or more CE then they will have "Limited Access". If they meet all medical equipment guidelines then they will have "Medical Equipment Access". Accessibility Indicator Symbols are the following:

Accessibility Indicator Symbols

P= Parking
EB= Exterior Building
IB= Interior Building
R= Restroom
E= Exam Table
T=Medical Equipment
PD=Patient Diagnostic and Treatment Use
PA= Participant Areas

A total of 25 Physical Accessibility Reviews (PAR) was done for 2018. PAR included 20 PCP Facilities, 1 CBAS and 6 Ancillary Center .

Below is the break down for 2018:

Level of Access:	# of PCP/Hospital
Basic Access	3
Basic Access/ Medical Equipment	5
Limited Access	18
Limited Access/Medical Equipment	1
No Access	0

Three facilities meet all CE receiving "Basic Access". 5 sites meet all CE in addition they also have "Medical Equipment". 18 sites received" Limited Access". One site received "Limited Access" and has "Medical Equipment". No sites did not meet any of the critical elements and have no level of access.

The plan does not encounter barriers or issues meeting the PAR Policy objectives. No correction action plan is required for providers/facilities that do not meet the level of access. Recommendation may be made to meet the highest level of accessibility but it is not required.

The goal is to continue to provide the PAR results of Access Level and the Accessibility Indicators so that our SPD members can identify a facility to obtain healthcare services in the Provider Directory that will best fit their physical needs. The focus will be to continue to keep all providers' sites, ancillary and CBAS up to date with any physical changes to the Parking, Exterior Building, Interior Building, Restroom, Exam Room, Medical Equipment, Participant Areas, Patient Diagnostic and Treatment Use.

4.6 POTENTIAL QUALITY ISSUE (PQI) MONITORING

A Potential Quality Issue (PQI) is a suspected deviation from expected provider performance, clinical care, or outcome of care, which requires further investigation to determine whether an actual quality issue or opportunity for improvement exists. The purpose is to provide a systematic method for the identification, reporting, and processing of a potential quality issue (PQI) to determine opportunities for improvement in the provision of care and services to HPSM members, and to direct appropriate actions for improvement based on outcome, risk, frequency and severity.

Prior to 2015, HPSM did not have a comprehensive PQI process which was identified during the previous year's DHCS survey. Referrals for quality of care concerns originated solely from member grievances that were forwarded to the Associate Medical Director for review. On April 2015, a Grievance and Appeals (G&A) Nurse was hired to assist the Associate Medical Director to assist in processing quality of care reviews and member appeals. The G & A Nurse, Chief Medical Officer (CMO), and Associate Medical Directors started to collaborate to make amendments to the QAI-03 policy and procedure which was completed in June 2015. The aforementioned policy continues to serve as a framework for the PQI process.

Starting May 2015, all Quality of care reviews were forwarded to the Quality Improvement Department for record keeping for secure and access limited record keeping. Soon afterwards, PQI case leveling started based on a standardized PQI Case Leveling Grid. PQI training then was conducted by the CMO and G&A Nurse to the Health Services Department on the PQI process. Collaboration followed with Project Specialist for Health Services, Senior Health Data Analyst and G&A Nurse to transition PQI information into the Everest database and to develop work flow. In September 2015, Everest training was done for QI admin and use of Everest to house PQI information was initiated.

We conducted additional PQI training to the Compliance Dept and MSSP team in November. Review of M14 (member/family does not want to pursue a grievance) daily reports by G&A Nurse was initiated. In January 2016, the Project Specialist for Health Services and G&A Nurse revised G&A QOC work flow due to MedHok implementation for G&A Dept. PQI overall work flow process also revised and uploaded to C360. In 2016, information regarding the PQI process was sent to HPSM providers via the newsletter and continued education regarding the PQI process to HPSM providers is currently being done through the QI Provider Toolkit.

We have completed 127 PQI/Quality of Care Reviews from 1/1/2018 to 12/31/2018.

5.0 MEMBER EXPERIENCE & HEALTH OUTCOMES

5.1 HEALTH OUTCOMES SURVEY (HOS)

HPSM participates in the Medicare Health Outcomes Survey (HOS) to gather valid, reliable, and clinically meaningful health status data from the CareAdvantage/CA-CMC program to use in quality improvement activities, pay for performance, program oversight, public reporting, and to improve health (https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HOS/).

This self-report survey of plan members is conducted in English, Spanish, & Chinese. Baseline results of HOS are intended to help plans identify potential areas for improvement and evaluate the physical and mental health of members . The reporting is done within specific cohorts with a follow-up 2 years later. The following topics are covered

- Health Status Measures*
  - Physical (PCS) & Mental (MCS)Component Summary Scores
- Chronic medical conditions
- Functional status (ADLs)
- Clinical measures
- Effectiveness of Care (HEDIS) measures*
  - Fall Risk Management (FRM)
  - Osteoporosis Testing in Older Adults (OTO)
  - Physical Activity in Older Adults (PAO)
  - Management of Urinary Incontinence in Older Adults (MUI)

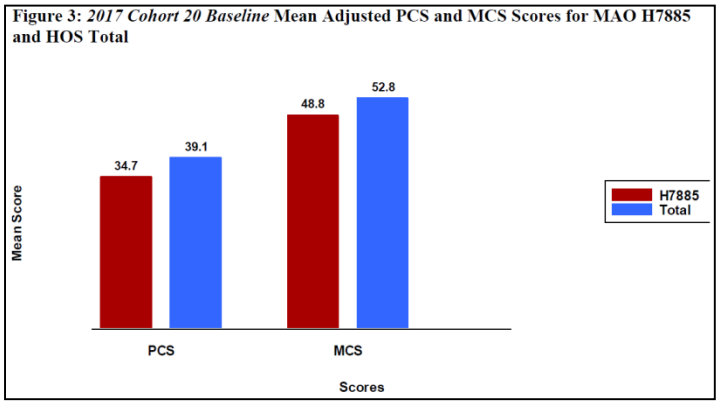
Requirements and Timeframes:
In 2017, MAOs with Medicare contracts in effect on or before 1/1/2015 participated in the survey. Plans must also have a minimum enrollment of 500 with 6 months of continuous enrollment to participate. Since HPSM's D-SNP members rolled into CMC in 2015, no prior cohort data is available. Surveys are fielded annually from April – June and summary reports are available the following May. The baseline was conducted for HPSM's Cohort 19 and the follow-up survey for that population was collected in 2018 and the merged results will be available in spring of 2019 in a report provided by CMS. For the Cohort 20 baseline survey, HPSM had an N of 422 with a response rate of 36.6%. Cohort 20 follow-up survey will be conducted in 2019 and final report will be available in 2020. Since beneficiary level data is distributed only for completed cohorts, HPSM does not have data for 2014-2016 Cohort 17.

Cohort				Follow-up Survey	Final Report
	Year	N	Response Rate		
19	2016	484	44.10%	2018	2019

20	2017	422	36.60%	2019	2020

*D-SNP members rolled into CMC in 2015 so no prior cohort data available

HOS Cohort 20 Baseline Results:



PCS is the physical (or functional) composite score and MCS is the mental health composite score. The chart above shows the PCS and MCS scores for Cohort 20 for HPSM, CA and HOS total. The adjusted score for HPSM is 34.7, compared to the CA score of 38.5 and total HOS score of 39.1. **The adjusted MCS score for HPSM is 48.8 and total HOS score of 52.8.** In general, functional health status, as measured by the PCS score, is expected to decline over time in older age groups, while mental health status, as measured by the MCS score, may decline at a slower rate. The baseline PCS and MCS scores are case-mix adjusted to allow for equitable comparisons across all MAOs.

PAO is an effectiveness of care measure that includes two components – discussing and advising physical activity. The details of this are as follows:

Physical Activity in Older Adults (PAO):

- **Discussing Physical Activity:** Spoke with doctor/health provider about their level of exercise or physical activity.
- **Advising Physical Activity:** Received advice to start, increase or maintain their level of exercise or physical activity.

Measure	HPSM Cohort 19	HPSM Cohort 20	CA	CMS - 9	HOS Total
Discussing Physical Activity	63.09%	61.72%	57.55%	57.27%	55.70%
Advising Physical Activity	65.50%	61.11%	56.55%	54.58%	51.74%

As shown in the table above, HPSM's score decreased slightly for both PAO measures though still remain above the scores for CA, CMS-9, and HOS total.

The Fall Risk Management (FRM) measure is another effectiveness of care measure with two parts which are as follows:

- **Discussing Fall Risk:** This is the reporting from members 75 years or older (or 65-74 w/balance or walking problem or fall in past 12 months) who discussed falls or problems with balance or walking with their current practitioner.
- **Managing Fall Risk:** This is the reporting from members 65 years or older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner is past 12 months and who received a recommendation for how to prevent falls or treat problems with balance or walking.

Measure	HPSM Cohort 19	HPSM Cohort 20	CA	CMS - 9	HOS Total

Discussing Fall Risk	40.82%	41.04%	36.60%	36.92%	36.50%
Managing Fall Risk	76.27%	74.52%	63.04%	61.65%	58.62%

For our members, discussing fall risk increased slightly (40.82% to 41.04%) and managing fall risk decreased (74.52% to 76.27%) slightly though both remain well above the CA, CMS-9, and HOS totals.

Another effectiveness of care measure from the HOS survey is the osteoporosis testing in older woman and consists of those women who report ever having received a bone density test to check for osteoporosis.

Measure	Cohort 19	Cohort 20	CA	CMS - 9	HOS Total
OTO	55.61%	63.16%	66.20%%	69.41%	74.24%

As shown in the table above, the rate for HPSM increased from Cohort 19 to Cohort 20 (from 55.61% to 63.16%), however, this is still below rates for CA, CMS-9 and the HOS Total.

Therefore, based on our survey results, we have identified the following areas of strengths and improvements.

Strengths	Opportunities for Improvement
• Fall Risk Management (FRM) • Physical Activity in Older Adults (PAO)	• Response Rate (HPSM saw a decline in response rates from 44.1% to 36.6% between the two cohorts) • Osteoporosis testing in older women (OTO)

5.2 CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS) SURVEY

The CAHPS survey is a member experience survey conducted annually for CMC and is conducted in the first half of the year and measures member experiences in the previous 6 months. The surveys are mailed in English and Spanish with a follow up telephone call. For HPSM, in 2018 there was a 33.1% response rate which was higher than the 27.8% average for other MMPs in California. The total number of respondents was 265, however, the responses differ for each questions as not all members answer every question. Most questions are answered using a 0 (worst) to 10 (best) scale **or** a "never, sometimes, usually, always" scale. The table below shows the sample size summary for 2018 for HPSM.

2018 CAHPS SURVEY SUMMARY

2018 CAHPS Data	*2017*	*2018*	*State MMP*	*National MMP*
Sample Size (includes oversampling)	*798*			
Patient Level Records Used: Complete & Valid	*292*	*265*		
Total Response Rate: Complete/(Sample-Ineligible) *	***36.59%***	***33.1%***	***27.7%***	***29.5%***

** "Completed" indicates that at least one question was answered. "Ineligible" indicates that member met at least one of the following criteria: they were deceased, were invalid (did not meet eligible population criteria, were mentally or physically incapacitated (adult population only), or had a language barrier.*

CAHPS MEDICARE SURVEY RESULTS

Health Plan Composite Measures Results:

Responses to individual survey questions were combined to form five composite (summary) measures of members' experiences with their health plans. For each measure, the table below shows the national average for all MA contracts, the national average for all MMP contracts, the plan's case-mix adjusted mean score on a 1-4 scale, and whether the plan's score was significantly greater than, less than, or equal to the national MA average.

CAHPS Health Plan Composite Measure Questions

Composite Measure	Survey Items Included
Getting Needed Care	• In the last 6 months, how often was it easy to get appointments with specialists? • In the last 6 months, how often was it easy to get the care, tests or treatment you thought you needed through your health plan?
Getting Appointments and Care Quickly	• In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? • Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?
Doctors Who Communicate Well	• In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand? • In the last 6 months, how often did your personal doctor listen carefully to you? • In the last 6 months, how often did your personal doctor show respect for what you had to say? • In the last 6 months, how often did your personal doctor spend enough time with you?
Customer Service	• In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect? • In the last 6 months, how often were the forms for your health plan easy to fill out?

Medicare Health Plan Composite Measure Trended Results

Health Plan Composite Measures	National MA	National MMP	HPSM 2016	HPSM 2017	HPSM 2018	↑↓
Getting Needed Care	3.51	3.43	3.47	3.37	3.36	↓
Getting Appointment and Care Quickly	3.35	3.30	3.12	3.24	3.22	↓
Doctors Who Communicate Well	3.74	3.71	3.74	3.74	N/A	
Customer Service	3.71	3.68	3.65	N/A	3.61	↓
Care Coordination	3.60	3.56	3.54	3.59	3.57	

Note: An up arrow (↑) indicates that your contract scored significantly better than the national average, a down arrow (↓) that it scored significantly worse than the national average, and the absence of an arrow means that it was not significantly different from the national average.

For the Medicare population, the results for the Doctors Who Communicate Well measure was NA indicating that not enough people answered the question to provide statically significant results. HPSM's score for both the Getting Needed Care and Getting Appointments and Care Quickly measures were slightly below the national average.

Health Plan Overall Ratings Measure Results:
For this survey measure, respondents used a 0-10 scale to rate their health plan, care received from their plan overall, their personal doctor, and the specialist (if any) they had seen most frequently in the past 6 months. The questions for each of the items are as follows:

Overall Ratings	Survey Item
Rating of Health Plan	Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
Rating of Health Care Quality	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?
Rating of Personal Doctor	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?
Rating of Specialist	We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

For each measure, the table below shows the national average for all MA contracts, the national average for all MMP contracts. This provides HPSM's case-mix adjusted mean score, over time, on a 0-10 scale. The arrows indicate whether the rating was significantly greater, less than or equal to the national MA average. As illustrated below, the ratings for HPSM in 2018 were in line with the national average but have been decreasing over time.

Overall Health Plan Ratings	National MA	National MMP	HPSM 2016	HPSM 2017	HPSM 2018	↑↓
Rating of Health Plan	8.7	8.6	8.8	8.7	8.6	
Rating of Health Care Quality	8.6	8.5	8.5	8.5	8.5	
Personal Doctor	9.1	9.0	9.3	9.2	N/A	
Specialist	9.0	8.9	N/A		N/A	

The table below highlights some of the Prescription drug related composite measures. These are described and detailed as follows:

Prescription Drug Composite Measure Results:
Responses to individual survey questions about prescription drugs were combined to form a composite (summary) measure of members' experiences. The table shows the national average for all MA-PD contracts, the national average for all MMP contracts, the plan's case-mix adjusted mean score on a 1-4 scale, and whether the plan's score was significantly greater than, less than, or equal to the national MA-PD average. For HPSM, this was in line with the national average.

Overall Rating of Drug Plan – Survey respondents were asked for an overall rating of their plan's drug coverage on a 0-10 scale. The table below shows the national average for all MA-PD contracts, the plan's case-mix adjusted mean score, and whether the plan's score was significantly greater than, less than, or equal to the national MA-PD average. For HPSM, this measure was in line with the national average.

Contact from Doctor's office, Pharmacy, or Drug Plan – Survey respondents in all MA-PD contracts, including MMPs, were asked whether their doctor's office, pharmacy, or health plan contacted them about making sure they filled prescriptions and were taking medications as directed. The table below shows HPSM's percentage of "yes" responses for these two questions and the national average for all MA-PD and MMP contracts. The table also shows whether the plan's percentage was significantly greater than, less than, or equal to the national MA-PD average. These items are not adjusted for case mix. For HPSM, these percentages were above the state and national averages.

Prescription Drug Composite Measure Results

Prescription Drug Measures	National MA-PD	National MMP	HPSM 2016	HPSM 2017	HPSM 2018	↑↓
Getting Needed Prescription Drugs	3.72	3.68	3.61	3.63	3.69	
Rating of Drug Plan	8.5	8.6	8.4	8.5	8.5	
Contact from Doctor's office, Pharmacy, or Drug Plan	**National MA-PD**	**National MMP**	**HPSM 2016**	**HPSM 2017**	**HPSM 2018**	**↑↓**
Reminders to fill prescriptions	50%	58%	46%	65%	64%	↑
Reminders to take medications	31%	48%	30%	53%	52%	↑

Medicare-Specific and HEDIS Measure Results:

For this response, survey participants were asked whether they received a flu vaccination recently and whether they had ever received a pneumonia vaccination (yes or no). The table below shows HPSM's percentage of "yes" responses for these two items, the national average for all MA contracts, the national average for all MMP contracts, and whether the score was significantly greater than, less than, or equal to the national MA average. These items are not adjusted for case mix. HPSM scored well on the flu vaccine measure, and has been on a steady increase, but falls below the national MA percentages for this measure for the pneumonia vaccination between 2017 and 2018.

Medicare-Specific and HEDIS Measures	National MA	National MMP	HPSM 2016	HPSM 2017	HPSM 2018	↑↓
Annual Flu Vaccine	73%	65%	73%	77%	78%	
Pneumonia Vaccination	73%	56%	64%	70%	68%	↓

2018 CAHPS SUMMARY OF RESULTS

Overall, *HPSM did not perform above the national average on any measure*. There are opportunities for improvement in two main areas, as identified by the surveys, Getting Appointments and Care Quickly and Customer Service measures. There is also some room for improvement for the Medicare-specific and HEDIS measure of pneumonia vaccination.

HPSM HOS & CAHPS IMPROVEMENT EFFORTS IN 2018

In 2018, HPSM will take on the following initiatives to improve overall member experience.

- Hired new QI Specialist with dedicated time for member experience & outcomes improvement initiatives
- CAHPS, HOS & program specific member experience/satisfaction data collection
- Testing new formats for program specific satisfaction surveys (e.g. PPC survey via text)
- Piloting warm transfers to clinics for appointment scheduling (Jan 2019)
- Starting a new Member Experience Workgroup
- Surveyed other plans
- Generated list of potential interventions
- Exploring a member experience survey that covers organization wide topics
- Internal HPSM staff education (2019) – Basic overview of surveys and specific questions

Potential Interventions for 2019

Topic	Potential Interventions
Response Rate	• General communication campaign regarding member surveys • Explore other survey formats (e.g. online)

Preventive Health Care
• *Case Management/Care Coordination*
• *Patient Education/ Resources*
• *Quality Improvement*
	• Health promotion campaigns, targeted reminders and partner with Care Coordination:
	  • Flu and Pneumonia Vaccine (CAHPS)
	  • Osteoporosis testing for women (HOS)

Understanding of Questions	• Align member communications to reflect CAHPS questions (e.g. marketing materials and outreach scripts, etc.) • Help members understand what we mean in each question. For example: understanding of "personal doctor" as the person you see most often for the majority of your care

5.3 GRIEVANCES AND APPEALS

The Grievances & Appeals Report representing data from 2018, was presented to the HPSM Consumer Advisory Committee on March 7, 2019. The report provided Health Plan of San Mateo's (HPSM) Consumer Advisory Committee with an overview of the volume and type of complaints received from HPSM members, as well as whether the Grievance and Appeals (G&A) Unit is addressing these complaints in a timely manner. Throughout this report, the term "complaints" refers to both grievances and appeals. Specifics regarding the following areas can be found in the attached report:

- Methodology
- Rates of Complaints per 1,000 Members
- Timeliness of Complaint Resolution
- Results, Analysis, Barriers and Proposed Actions by LOB
    - CareAdvantage/Cal-Mediconnect (CA-CMC)
    - Medi-Cal (MC)
    - Healthy Kids, HealthWorx, ACE & CCS
- Primary Care Provider (PCP Changes by Provider

See Appendix B. HPSM Consumer Advisory Committee Grievance & Appeals Report

5.4 TIMELY ACCESS TO CARE SURVEY

Health Plan of San Mateo, in compliance with state requirements, has contracts with DSS Research to assess their members' experiences with their health plan. By examining the accessibility of health services, Health Plan of San Mateo can proactively address issues to improve overall satisfaction.

This project is designed to achieve the following objectives:

1) Measure access to health care using questions from the Medicaid CAHPS survey and other questions
2) Identify differences in access between adult and child members and between members who speak English, Spanish or other languages.

TIMELY ACCESS SURVEY ADMINISTRATION

HPSM collaborated with DSS to develop a survey instrument designed for mail and telephone administration. The survey was offered in English, Spanish, Chinese and Tagalog. All data were collected by DSS using a combined approach of mail and CATI (computer-assisted telephone interviewing). The surveys were mailed on July 25, 2018, and calls were placed from August 15 through September 7, 2018. The sample, selected randomly from our membership,

Health Plan of San Mateo provided the sample that included 4,490 members (2,258 adult and 2,232 child). 649 surveys were completed (330 adult and 319 child). The overall response rate was 14.5%.

2018 TIMELY ACCESS SURVEY KEY FINDINGS

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2018 TIMELY ACCESS SURVEY KEY FINDINGS

Most members found it easy to get care.
According to this survey, 72% of those who sought care, tests or treatment through the plan indicated that it was always or usually easy to get what they needed, but this was lower than previous years.

The most common obstacle noted was inconvenient appointment times.

Most found it easy to get an appointment.

•Doctor's office or clinic:

–A slightly lower percentage than in 2017, (64%) made an appointment at a doctor's office or clinic (68% in 2016 vs. 62% in 2017).
–64% always or usually got an appointment as soon as needed, with an average wait of six days.
63 per cent of all members were always or usually seen within 30 minutes of their appointment times.
–As in 2017, most callers received a call back within two hours (72% during regular office hours and 59% after office hours).

•Specialist appointments:

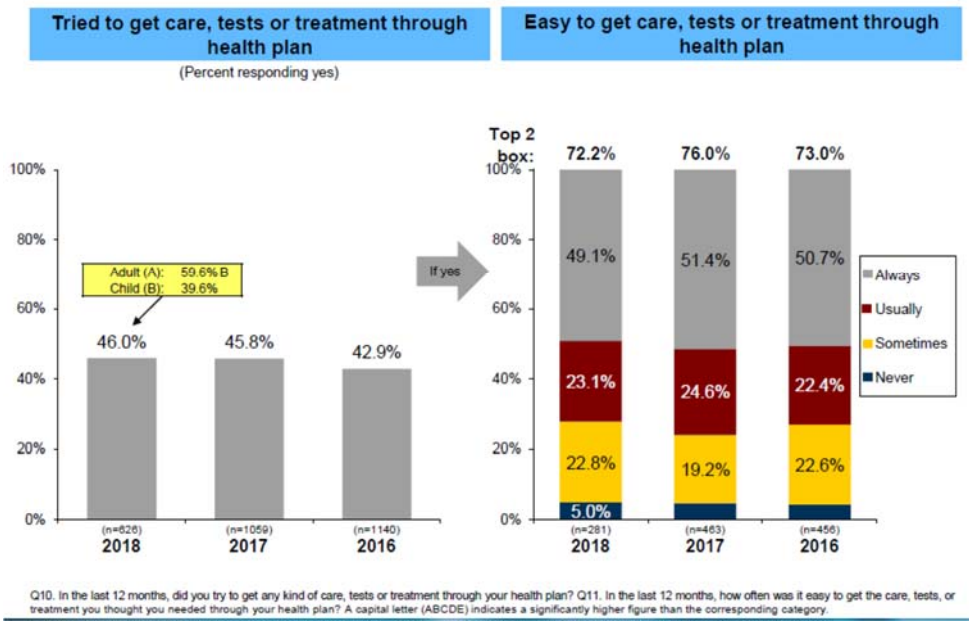
–A significantly higher percentage than in the past tried to make an appointment to see a specialist (34% in 2018 vs. 28% in 2017) and, among those, 61% indicated that it was always or usually easy to get care with an average wait for 25 days.
–Inconvenient appointment times remain the most common obstacle to seeing a specialist.

•Urgent care appointments. 71% said they always or usually got an appointment for urgent care as soon as they needed it with an average wait time of 25 days.

HEALTH PLAN

More than 25% of individuals tried to gain access through their health plan. Among those who did, a slightly lower percentage than in 2017 stated that it was always or usually easy to get the care they needed.

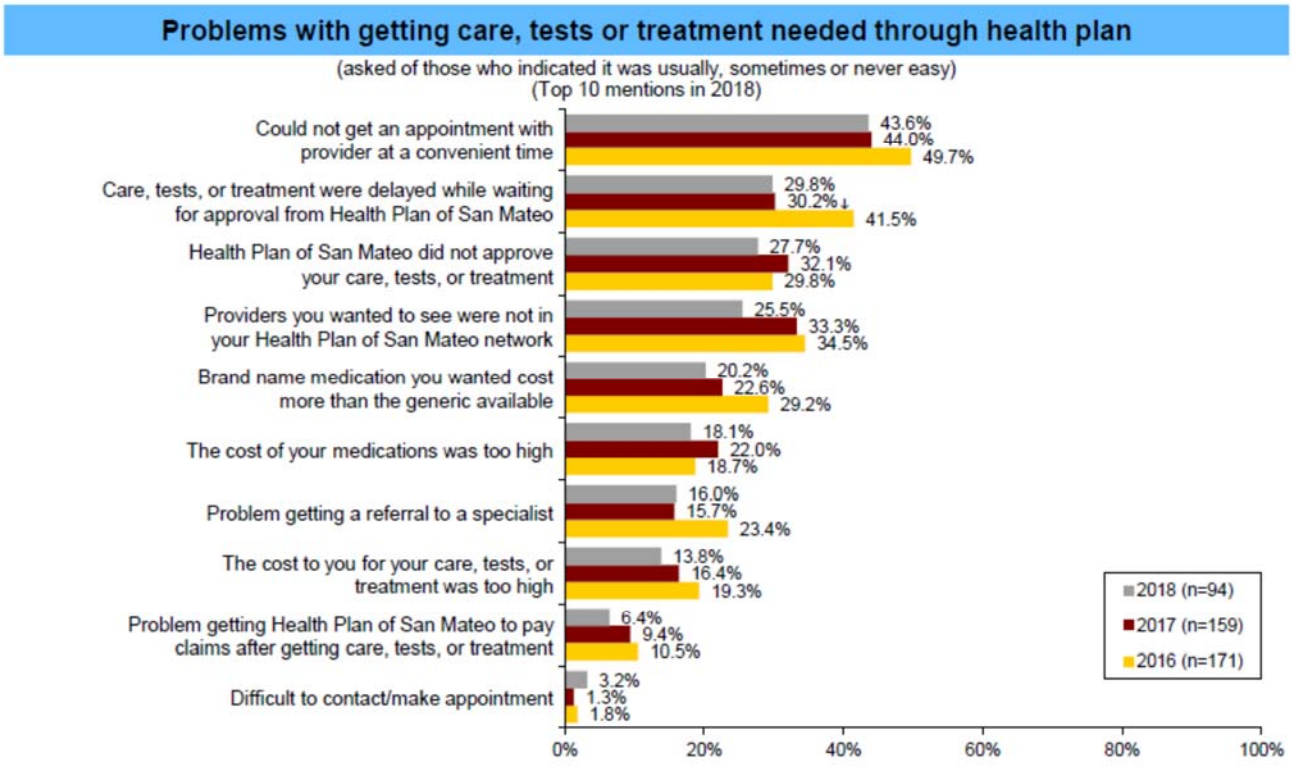
More than four in 10 tried to access care using their health plan. Among those who did, a slightly lower percentage than in 2017 indicated that it was always or usually easy to get the care they needed.



Q10. In the last 12 months, did you try to get any kind of care, tests or treatment through your health plan? Q11. In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan? A capital letter (ABCDE) indicates a significantly higher figure than the corresponding category.

BARRIERS/OBSTACLES

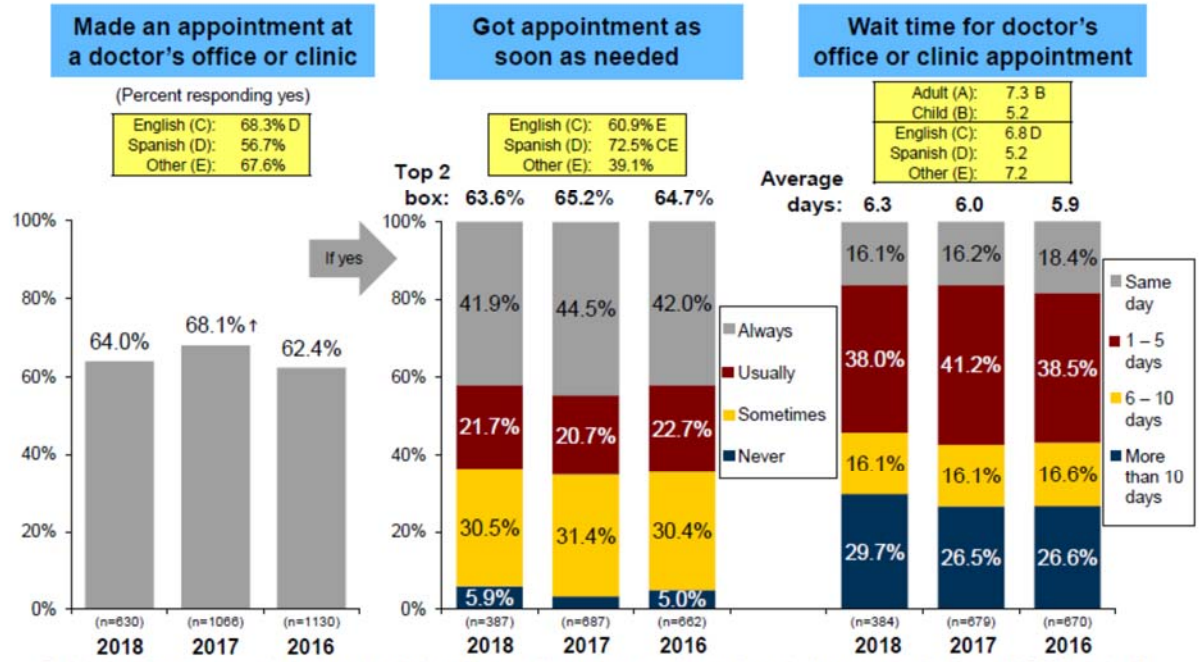
The most common obstacle remains inconvenient appointment times.



Q12. In the last 12 months, if you had a problem getting the care, test or treatment you needed through your health plan, what was the main problem you had? An arrow (↑↓) indicates a significantly higher or lower result than the previous year's result.

NON-URGENT CARE (DOCTOR'S OFFICE OR CLINIC)

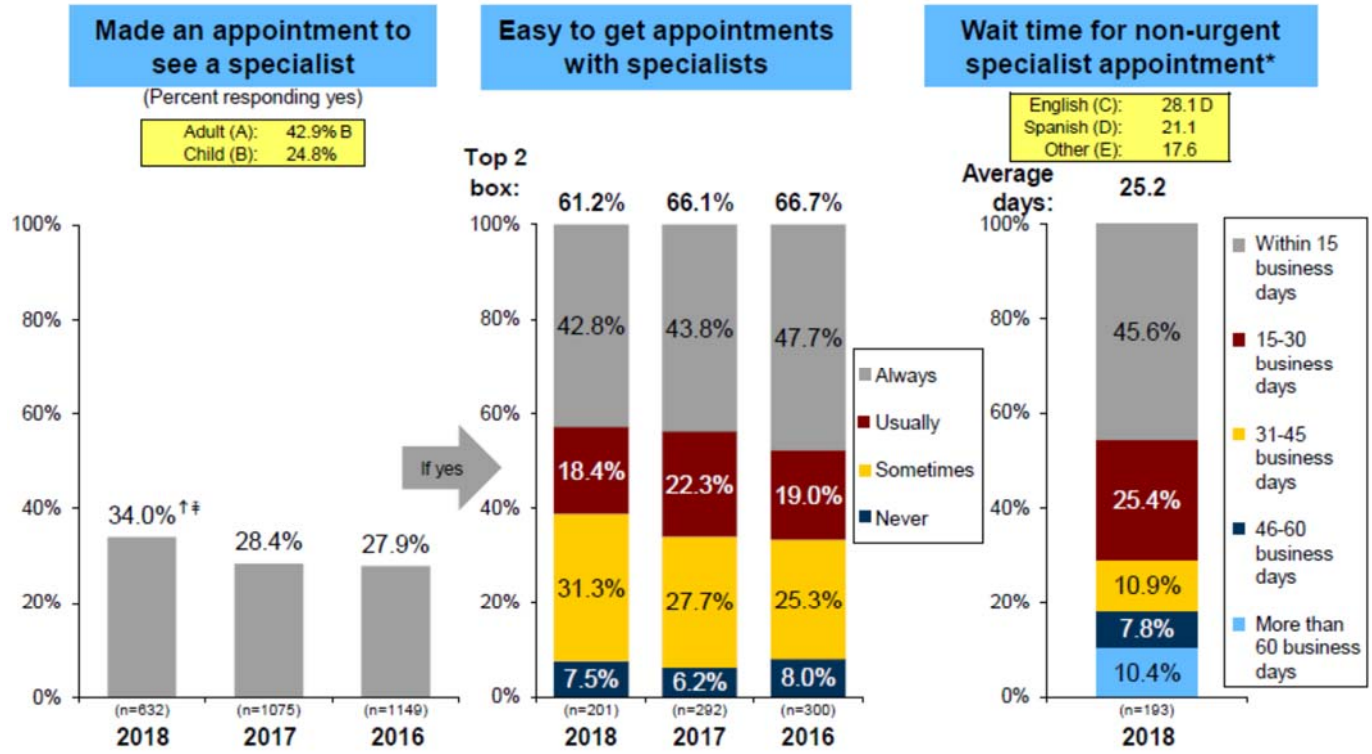
A slightly lower percentage than in 2017 made an appointment at a doctor's office or clinic. Appointment availability and wait times are stable.



Q4. In the last 12 months, not counting the times you needed care right away, did you make any appointments for your health care at a doctor's office or clinic? Q5. In the last 12 months, not counting the times you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought your needed? Q6. In the last 12 months, when you called to make an appointment for care you did not need right away, how long did you usually have to wait for the appointment? An arrow (↑↓) indicates a significantly higher or lower result than the previous year's result. A capital letter (ABCDE) indicates a significantly higher figure than the corresponding category.

SPECIALITY CARE

A significantly higher percentage than in 2017 and 2016 tried to make an appointment to see a specialist. Among those, a slightly lower percentage than in 2017 indicated that it was always or usually easy to do so. The average wait time for non-urgent specialist appointments is 25 days.

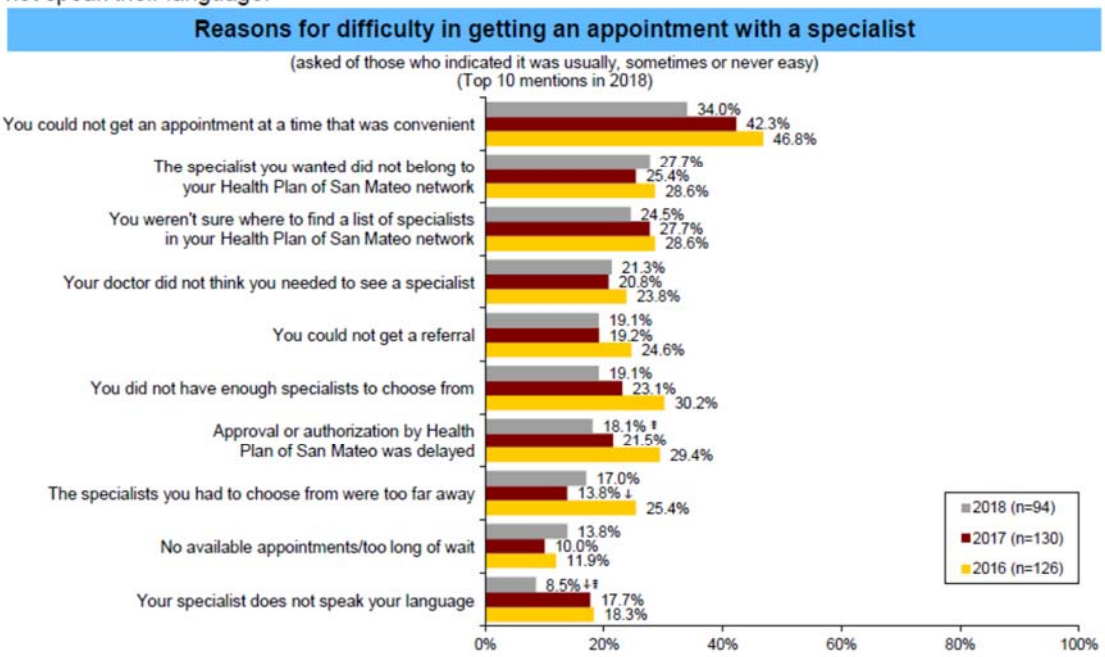


Q7. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors and other doctors who specialize in one area of health care. In the last 12 months, did you try to make any appointments to see a specialist? Q8. In the last 12 months, how often was it easy to get appointments with specialists? An arrow (↑↓) indicates a significantly higher or lower result than the previous year's result. A fishbone arrow (‡‡) indicates that the 2018 result is significantly higher or lower than the 2016 result. A capital letter (ABCDE) indicates a significantly higher figure than the corresponding category. An asterisk (*) indicates a new question in 2018.

BARRIERS/OBSTACLES

Inconvenient appointment times remain the most common obstacle to seeing a specialist. Additionally, significantly higher percentages than in 2014 had issues with the network or a language barrier.

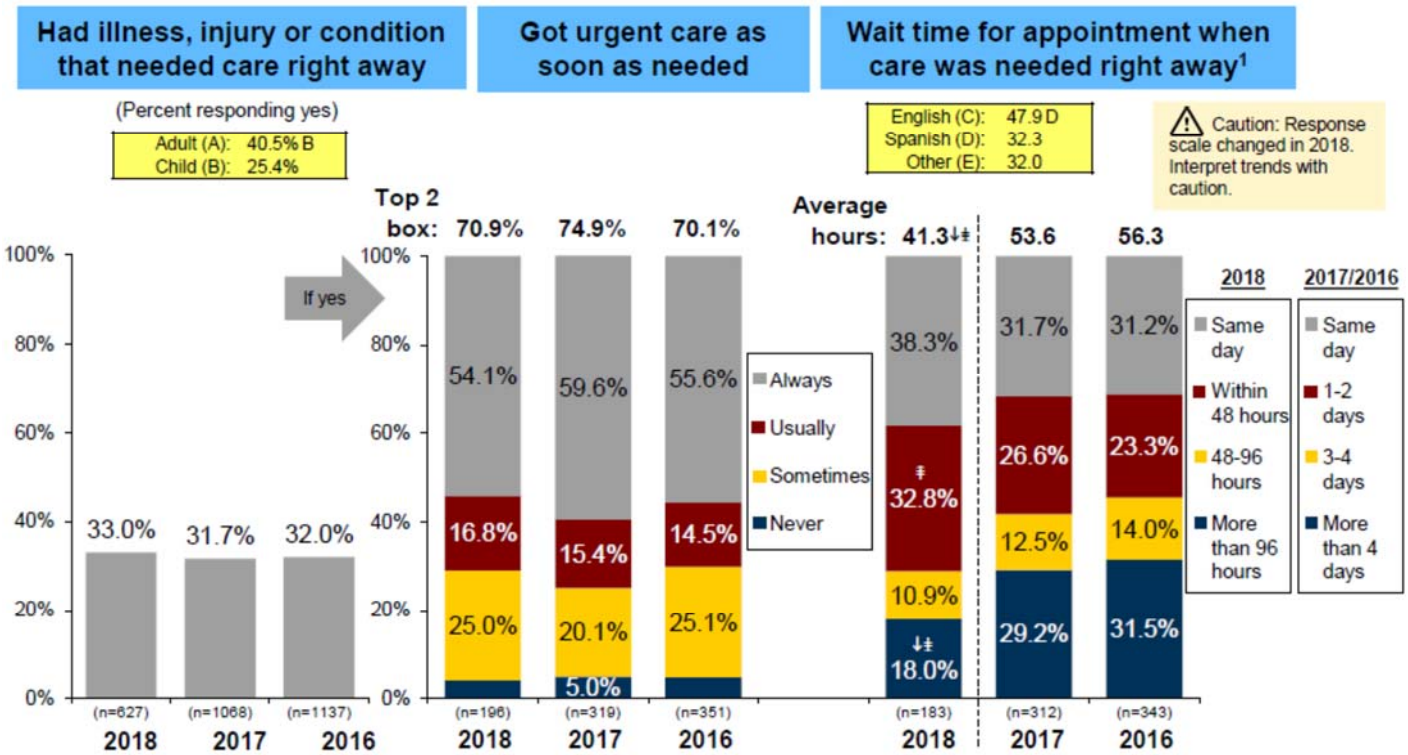
Inconvenient appointment times remain the most common obstacle to seeing a specialist. A significantly lower percentage than in 2016 mentioned that approval or authorization by Health Plan of San Mateo was delayed and a significantly lower percentage than in 2017 and 2016 mentioned that their specialist does not speak their language.



Q9. Were any of the following a reason it was difficult to get an appointment with a specialist? An arrow (↑↓) indicates a significantly higher or lower result than the previous year's result. A fishbone arrow (⇵) indicates that the 2018 result is significantly higher or lower than the 2016 result.

URGENT CARE

One-third required urgent care and, among them, a slightly lower percentage than in 2017 indicated that they always or usually received it as soon as needed. The average wait time for urgent care appointments is 41 hours.

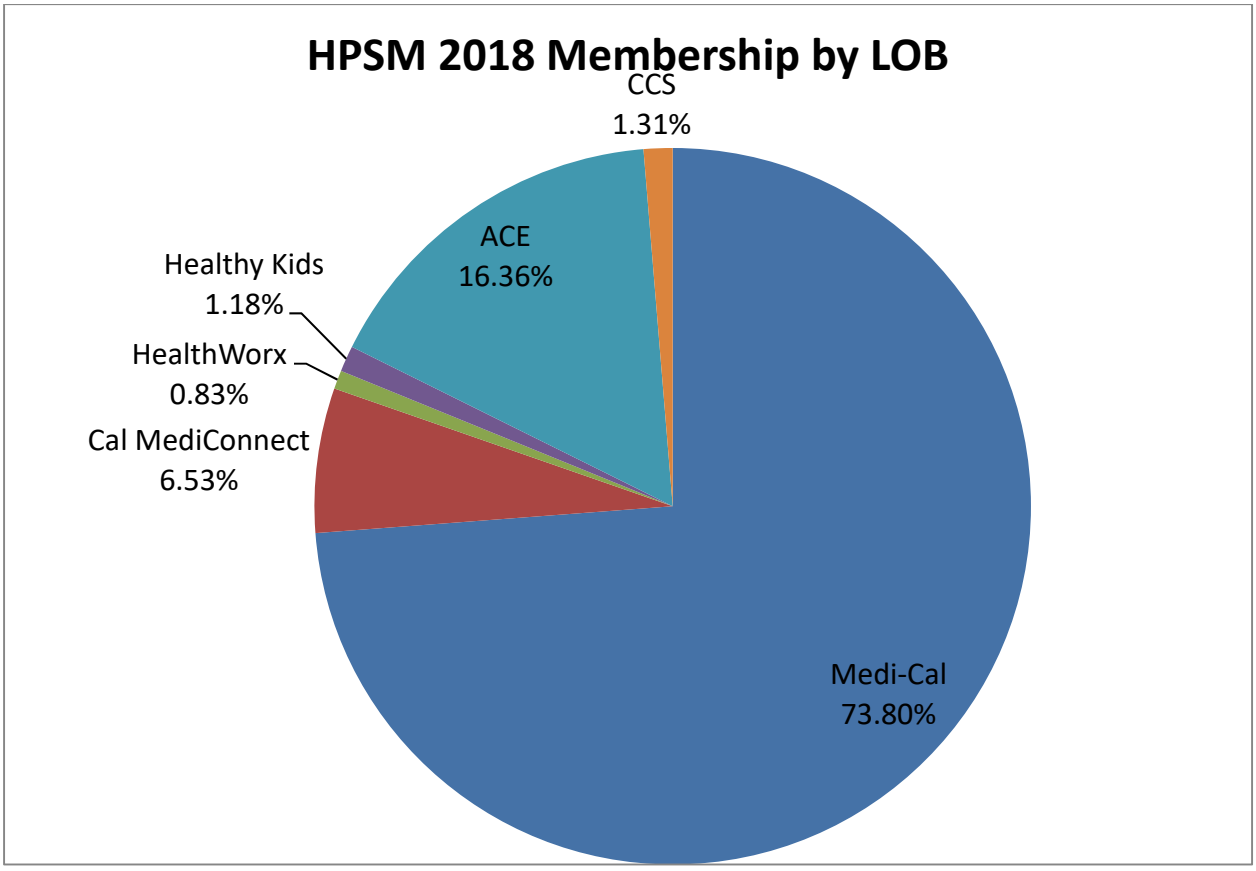


Q1. In the last 12 months, did you have an illness, injury or condition that needed care right away in a clinic, emergency room or doctor's office? Q2. In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed? Q3. In the last 12 months, when you called to make an appointment when you needed care right away, how long did you usually have to wait for the appointment? An arrow (↑↓) indicates a significantly higher or lower result than the previous year's result. A fishbone arrow (‡ ‡) indicates that the 2018 result is significantly higher or lower than the 2016 result. A capital letter (ABCDE) indicates a significantly higher figure than the corresponding category.
Note[1]: The scale was converted from days in 2016 and 2017 to hours in 2018. Interpret trends with caution.

6. SERVING A DIVERSE POPULATION

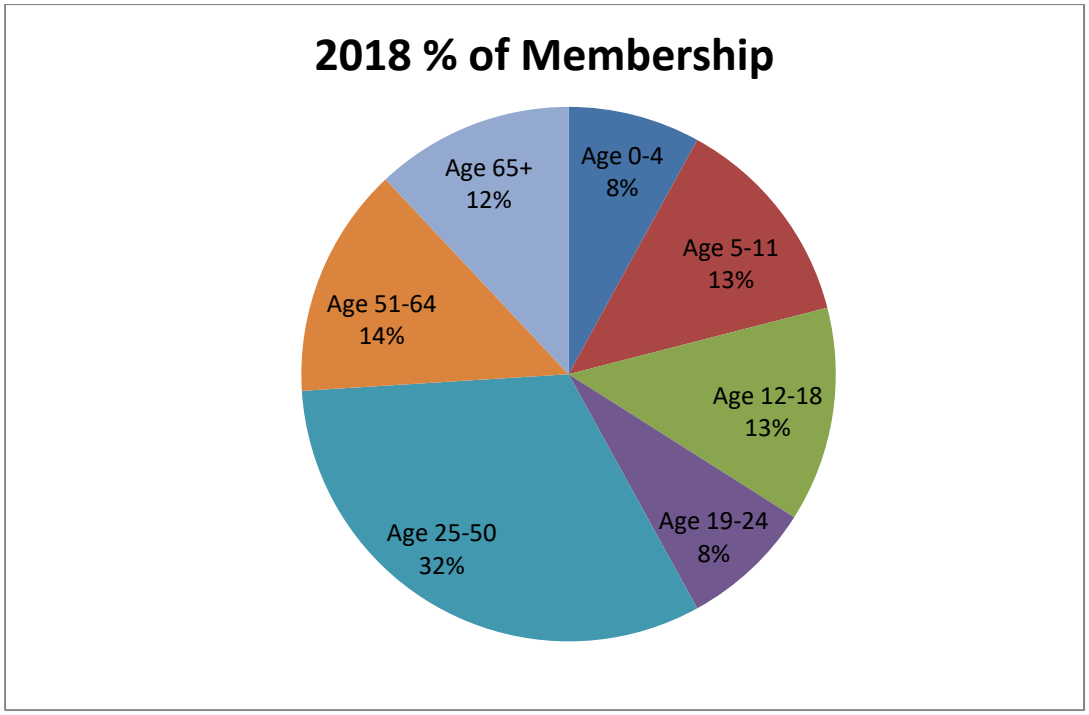
6.1 MEMBER POPULATION DEMOGRAPHICS

The following section summarizes HPSM's membership profile by age, gender, language, and ethnicity as of December 2017.



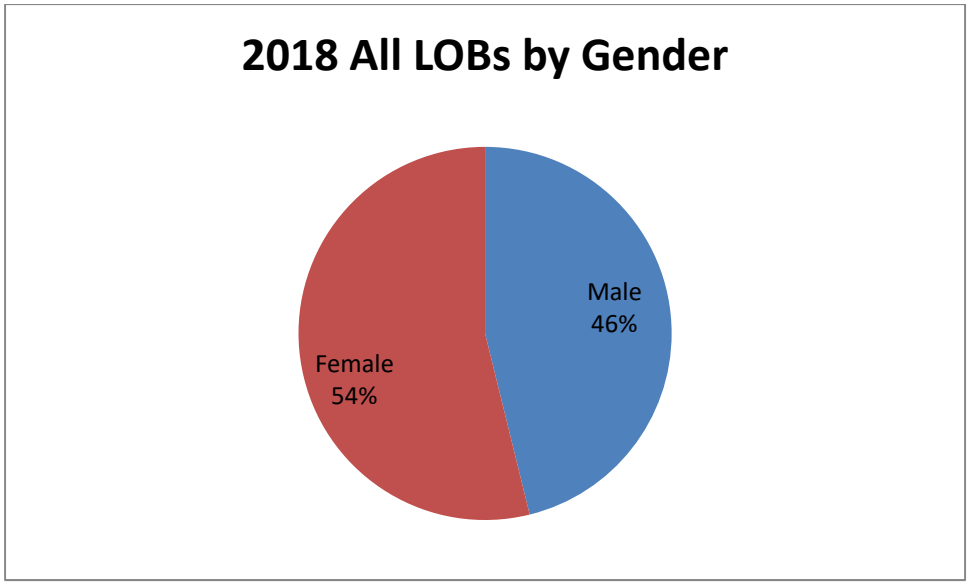
Year	Medi-Cal	Cal MediConnect	HealthWorx	Healthy Kids	ACE	CCS	Total
2017	120,270	9,153	1,056	1,380	21,218		153,078
2016	124,554	9404	1050	836	21,269		157,513
2018	102,770	9,086	1,159	1,639	22,776	1,818	139,248

HPSM Membership by Age:



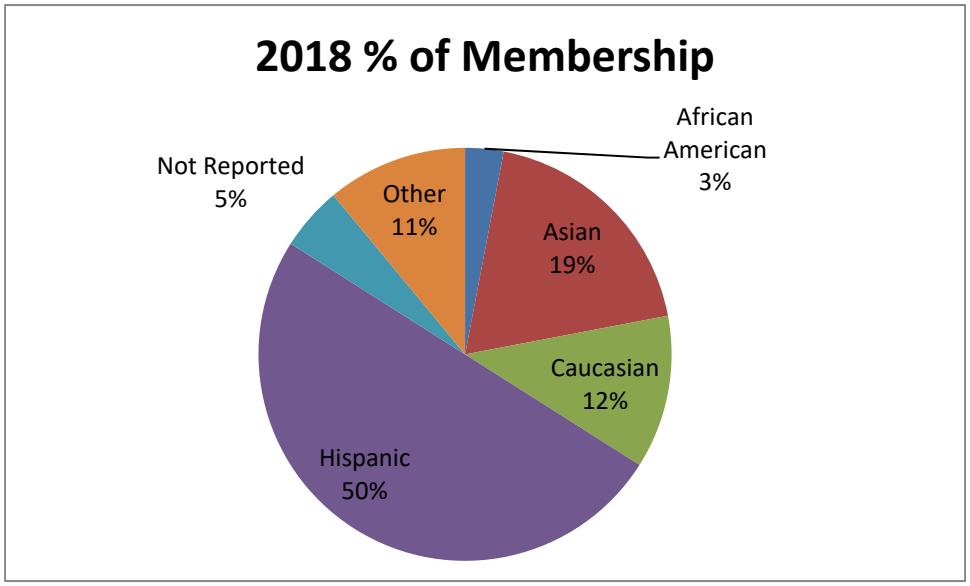
	Medi-Cal		CareAdvantage		All LOBs	
	Count	% of Membership	Count	% of Membership	Count	% of Membership
Age 0-4	10,546	10%			11197	8%
Age 5-11	16,863	16%			18078	13%
Age 12-18	16,769	16%			18188	13%
Age 19-24	8,698	8%	10	0%	10666	8%
Age 25-50	27,011	26%	720	8%	44553	32%
Age 51-64	13,841	13%	1300	14%	19182	14%
Age 65+	9,042	9%	7056	78%	17384	12%
Total	102,770	100%	9086	100%	139248	100%

Membership by Gender



	Medi-Cal		CareAdvantage		All LOBs	
Gender	**Count**	**% of Membership**	**Count**	**% of Membership**	**Count**	**% of Membership**
Male	48450	47%	3419	38%	64272	46%
Female	54320	53%	5667	62%	74976	54%

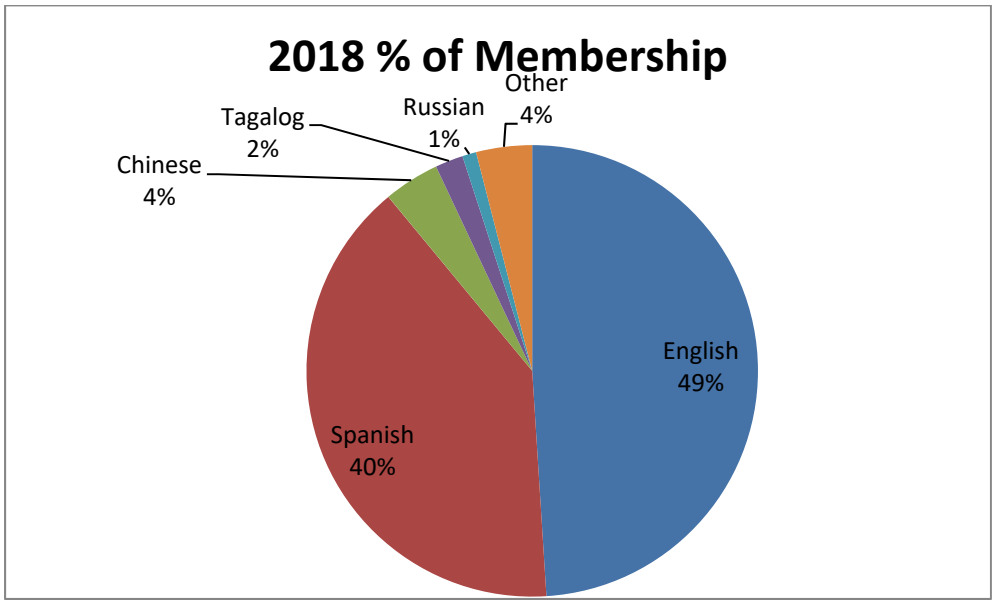
Membership by Race/Ethnicity:



	Medi-Cal		CareAdvantage		All LOBs	
Race/Ethnicity	Count	% of Membership	Count	% of Membership	Count	% of Membership
African American	3297	3%	410	5%	3828	3%
Asian	20844	20%	3114	34%	26198	19%
Caucasian	14201	14%	2107	23%	17216	12%
Hispanic	46123	45%	1756	19%	69566	50%
Not Reported	4270	4%	1059	12%	6470	5%
Other	14035	14%	640	7%	15970	11%

Total	102770	100%	9086	100%	139248	100%

Language:



Based on our analysis of HPSM membership for 2018, the predominate languages spoken by HPSM members are English at 49%, followed by Spanish at 40%, Chinese at 4%, and Tagalog at 2%. These four languages are HPSM threshold languages. HPSM strives to make available easy-to-read, well translated health education material, and continuously increase the availability of material in other formats (audio, Braille, large formats).

Medi-Cal 2018 Language Breakdown:

Language	Count	% of Membership
English	58338	57%
Spanish	33773	33%
Chinese	4463	4%
Tagalog	1914	2%
Russian	444	0%
Other	3838	4%
Total	102770	100%

CareAdvantage 2018 Language Breakdown:

Language	Count	% of Membership
English	5211	57%
Spanish	1525	17%
Chinese	1068	12%
Tagalog	637	7%
Russian	233	3%
Other	412	5%
Total	9086	100%

6.2 CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) PROGRAM

The Health Plan of San Mateo (HPSM) recognizes that its members represent a diverse mix of languages, ethnicities, cultures, and countries of origin, each of which may be accompanied by a variety of attitudes, beliefs and behaviors regarding their health and well-being. Having a better understanding of our members' cultures and their preferences are key principles driving our quality improvement activities. When making decisions about quality improvement interventions, HPSM examines yearly the demographic characteristics of its member population to ensure the inventions are culturally appropriate.

Organizationally, HPSM's CLAS activities are imbedded into the daily work of all the departments. Structurally, the CLAS Program is integrated into the Quality Improvement Program. Weekly updates at the Quality Department's Team Meeting are provided as a standing agenda item by the Culturally and Linguistically Appropriate Services (CLAS) staff member.

6.2.1 CLAS COMMITTEE

HPSM's CLAS Committee reports to the Service Quality Committee, Clinical Quality Committee, Consumer Advisory Committee and Quality Improvement Committee. The CLAS Committee is a multidisciplinary team that is comprised of Managers and Supervisors, as well as key staff throughout the organization that interact directly with members. The committee meets quarterly to review and assess cultural and linguistic services activities and interventions throughout departments within HPSM. Annually, the CLAS committee reviews the CLAS Program Description, work plan, and annual evaluations in regards to state requirements and makes revisions to address any updates or quality/process improvements when necessary.

6.2.2 CLAS TRAINING FOR HPSM STAFF

HPSM trained all new hires on HPSM cultural and linguistic assistance services through the on-boarding process. In addition, training with an increased focus on staff who have daily direct contact with members was provided to reinforce the language assistance program process.

HPSM provides on-going education on CLAS rights, requirements, services, resources, and cultural competencies. Each year, HPSM conducts a Cultural Awareness Training for all HPSM staff on various topics. In 2018, the in-person training course was titled "Introduction to Disability Awareness" and was designed to help staff better understand how to interact and work with people with disabilities. Though we strive for 100% participation in our annual staff trainings, this is difficult to achieve for the in-person sessions due to staff being out for vacation, leave or sick time at the time of the training. In addition to the annual all staff trainings, HPSM provides a CLAS training module for all new hires that is available through Litmos, our general online training platform. This new CLAS training module for new hires was launched in 7/1/2018. Low participation rate highlights the need for more regular review of participation results and will be an area of focus for 2019.

Training	Participant Count	Expected Participants	Participation Rate
All Staff Annual Cultural Awareness Training - Disability 101	224	260	86%
New Hire Training - CLAS Training Module (Litmos Platform)	55	84	65.4%

ALL STAFF TRAINING EVALUATION

A total of 223 employees completed the in-person training and evaluation form. According to the survey results, staff increased their confidence, knowledge and skills when working with people with disabilities.

1) The training increased my confidence in working with people with disabilities?

Disagree	2	.1%
Somewhat disagree	5	2.2%
Neutral	23	10.2%
Somewhat agree	48	21.4%
Agree	146	65.1%
Total Surveyed	224	100.0%

2) The training provided me with practical communication strategies for working with people with disabilities?

Disagree	0	0%
Somewhat disagree	1	.5%
Neutral	7	6.1%
Somewhat agree	52	23.3%
Agree	156	69.9%
Total surveyed	216	100%

3) The training increased my awareness of the potential misperceptions that society has regarding people with disabilities?

Disagree	1	.5%
Somewhat disagree	4	1.7%
Neutral	19	8.5%
Somewhat agree	40	18.0%
Agree	159	71.3%
Total surveyed	223	100%

4) How satisfied are you with this training?

Disagree	1	.7%
Somewhat disagree	3	1.3%
Neutral	12	5.4%
Somewhat agree	78	35%
Agree	128	57.6%
Total surveyed	222	100%

Overall the staff felt that the training met their expectations and would be able to use the information learned going forward.

6.2.3 CLAS PROVIDER EDUCATION

HPSM conducts regular trainings regarding various CLAS topics for HPSM's network providers through the following mechanisms:

- New provider orientation that covers HPSM's CLAS policies and procedures, specifically addressing provider's responsibility for providing CLAS and utilization of interpreter services.
- One-on-one training for providers and provider's office staff on CLAS issues when a need is identified that will improve provider effectiveness in meeting members' C&L needs.
- Senior and Persons with Disabilities (SPD) competency and sensitivity training is provided to providers, their staff and health plan staff utilizing the training developed by Medi-Cal Managed Care Division (MMCD).
- 2018 Provider newsletters had articles about communicating with limited English proficient patients and tips for communicating with patients with disabilities.

- HPSM sent fax blast to all of HPSM contracted provides informing them that language assistance services are free of charge.

The provider toolkit which includes information on cultural and linguistic services requirements, tips for communicating across language barriers and how to work with interpreters is available as both a hard copy and on the HPSM website.

6.3.4 CLAS MEMBER EDUCATION

Health Plan of San Mateo provides members with information on their right to language assistance services through several routes including:

- HPSM Member Handbook/Evidence of Coverage (EOC) mailed with New Member Packet.
- Disclosure Forms
- Notices in Provider Offices-Signs are provided in threshold languages during new provider visits and annually thereafter by Provider Services staff.
- HPSM website includes information about interpreter services that is provided in both the member and provider section of HPSM's website.
- Informative articles in HPSM's member newsletters
- One-on-one interactions between members and Member Service Representatives CareAdvantage Navigators, Grievance Coordinator, Health Educators, and other staff in contact with members.
- Information is published in the provider directory.

6.3 LANGUAGE ASSISTANCE PROGRAM

6.3.1 AVAILABILITY OF TRANSLATED MATERIALS

HPSM translates member materials into four threshold languages: English, Spanish, Chinese and Tagalog.

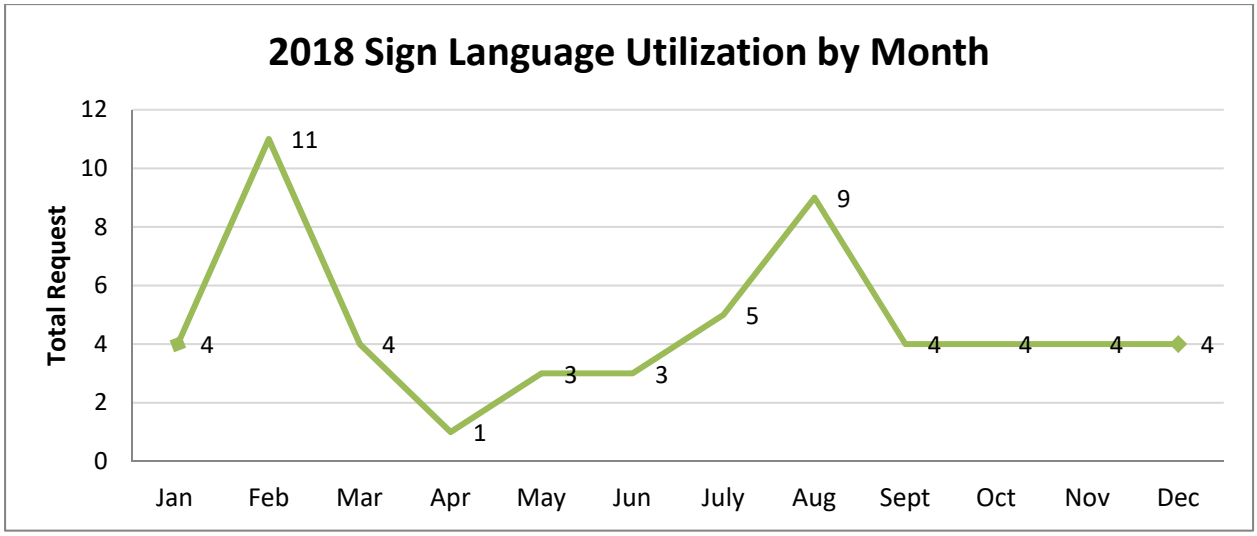
6.3.2 ACCESS TO INTERPRETER SERVICES

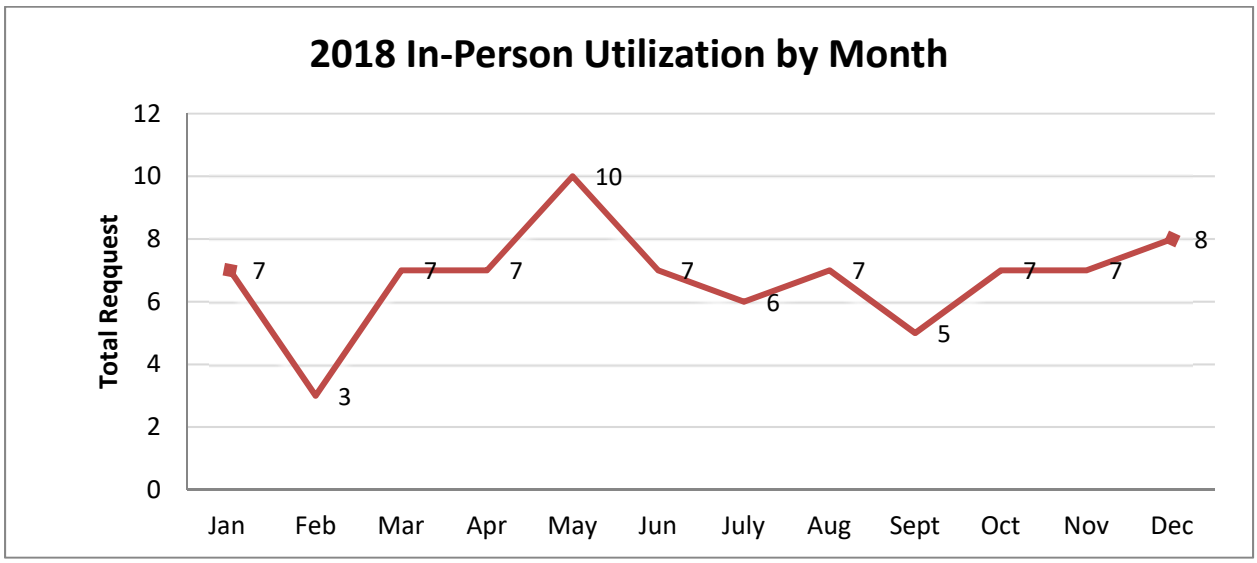
HPSM provides its entire limited English Proficient (LEP) membership access to free interpreter services to reduce any language barriers. Telephonic interpreter services are available for all medical and non-medical points of contact 24 hours/7 days a week. In addition, face-to-face and sign language interpretation are available upon request. HPSM informs its Members and Providers of the availability and their right to interpreter services through the Member and Provider Newsletter, the Member Handbook/Evidence of Coverage, and the Provider Directory.

The following summarizes utilization of the interpreter service utilization services for January to September 2018.

Interpreter Service Utilization January – December 2018

Interpreter Services	**Total Requests**
Sign Language	56
In-Person	81
Telephonic Services	
HPSM	8539
Provider Group	10,256





Telephonic Utilization by Top 5 Languages (January - December 2018)

Provider Network		HPSM	
By Language	**Call volume**	**By Language**	**Call volume**
Spanish	6800	Spanish	4240
Chinese Mandarin	669	Chinese Cantonese	853
Chinese Cantonese	614	Chinese Mandarin	817
Russian	486	Russian	675
Tagalog	379	Tagalog	548

6.3.3 LINGUISTIC CAPABILITY OF PLAN STAFF

HPSM's goal is to maintain staff that is reflective of the cultural and linguistic diversity of HPSM membership, with bilingual or bilingual/bicultural staff. All staff that provides interpreter services to HPSM members must be assessed to demonstrate proficiency in other languages.

6.3.4 LINGUISTIC CAPABILITY OF PROVIDER NETWORK

New and re-credentialing providers to HPSM's network are required to document their language capabilities on their initial application to become contracted providers. At least annually, HPSM conducts a self-reporting survey of the language capabilities available at each provider location through the Provider Change Request tool on the HPSM website. If there are any language changes, the Provider Directory is updated to reflect new information. HPSM publishes provider language information both on-line through HPSM website and via a hard copy of the Provider Directory to help members select a provider by language capabilities.

6.3.5 PROVIDER NETWORK

The following summarizes language spoken by HPSM's Provider network.

Arabic	French	Italian	Spanish
Bengali	French	Japanese	Tagalog
Burmese	Galician	Kapampangan	Taiwan
Cantonese	German	Korean	Taiwanese
Cantonese (Yue Chinese)	Greek	Mandarin	Tamil
Chinese	Gujarati	Persian	Turkish
Croatian	Hebrew	Portuguese	Ukrainian
Czech	Hindi	Romanian	Urdu
English	Ilocano	Russian	Vietnamese
Farsi	Indian	Serbian	

The language capabilities provided by HPSM Provider network align with the top threshold languages spoken by HPSM membership. HPSM will continue to monitor the language capabilities of its provider network to ensure there are sufficient numbers of providers with different language capabilities.

6.3.5 PROVIDER COMPLIANCE WITH LANGUAGE ASSISTANCE PROGRAM

HPSM continuously monitors issues related to provider interpreter capabilities through member complaint and grievance logs. Corrective Action Plan is developed with provider sites if issues are identified. For 2018, HPSM members filed two grievances against providers for not offering an interpreter on site.

6.4 MONITORING AND ADHERENCE

To ensure that HPSM's employees, providers, pharmacies and subcontractors adhere to its cultural and linguistic services policies and procedures, HPSM conducts regular monitoring activities that include , but not limited to, consumer satisfaction surveys, review of member grievances, annual provider language assessments, and provider site-reviews. Corrective action plans are developed if deficiencies are identified.

6.4.1 CLAS RELATED GRIEVANCES & APPEALS

Complaints and Grievances related to Cultural and Linguistic issues are reviewed quarterly. In 2018, there were a total of two grievances related to language assistance; due to the low number in grievances no trends were noted.

6.5 CONCLUSION AND NEXT STEPS

HPSM will continue exploring ways to improve services and measure performance for CLAS services by monitoring and reviewing the work plan goals and actions plans for the upcoming year with the CLAS Committee.

HPSM is committed to offering innovative training to meet the growing needs of HPSM Staff.

7. HEALTH EDUCATION

7.1 HEALTH EDUCATION MATERIALS

All health education materials are available in the sixth grade reading level that is culturally and linguistically appropriate for our members. A total of four health education materials were due for their 3 year review this year. All materials were evaluated using the Health Literacy Advisor software and the Readability and Suitability checklist. Both a hard copy and electronic copy are available for review if requested for all health education materials.

To provide the most current information, a community resource binder was compiled that includes a list of classes and other free community resources to maintain a healthy lifestyle. Thus far, a community resource binder has information on diabetes, asthma, physical activity, weight loss and smoking cessation. This information is provided to members who call in for referrals and distributed internally.

7.2 HEALTH EDUCATION RESOURCES

All health education materials are available in the sixth grade reading level that is culturally and linguistically appropriate for our members. All health education materials are evaluated using the Health Literacy Advisor software and the Readability and Suitability checklist. Both a hard copy and electronic copy are available for review if requested for all health education materials.

To provide the most current information, a community resource binder was compiled that includes a list of classes and other free community resources to maintain a healthy lifestyle. Thus far, the community resource binder includes information on diabetes, asthma, physical activity, weight loss and smoking cessation. This information is provided to members who call in for referrals and distributed internally.

7.3 HEALTH EDUCATION CLASSES

HPSM observed and evaluated selected health education classes and resources to ensure high quality and appropriate referrals are provided. In 2018, HPSM's Health Educator evaluated 3 classes which included Healthy Living with Diabetes in Spanish at the Fair Oaks Health Center, Diabetes Essentials in English at the San Mateo Medical Center and Diabetes Essentials in Spanish at San Mateo Medical Center. All classes were presented by experienced and knowledgeable speakers who appropriately tailored their presentations to their intended audience.

7.4 HPSM WEBSITE

The Health Information section on the HPSM website is undergoing a review and is expected to be updated on an as needed basis. This year HPSM launched a new website that provided an opportunity to reorganize the health topics to be more accessible to members.

7.5 WEIGHT WATCHERS

Weight Watchers is a weight loss program available to adult Medi-Cal members with a BMI over 30. The objective of this program were 1) By December 2018, 25 adult members with a BMI > 30 will participate in at least 10 Weight Watchers meetings; 2) by December 2018, 15 adult members with a BMI >30 participating in Weight Watchers will lose 10% of their body weight.

When a fax referral from a provider is received, the Quality Department staff is responsible for enrolling members into the program. The staff completes the initial data entry, discusses the program requirements, assists the member in finding a convenient meeting location, completes the pre-program survey and requests they attend a first class as a trial. If the member attends a Weight Watchers class and decides that they want to continue they can request a set of 5 vouchers. A provider referral is not required, and the staff may enroll the member into the program through the Health

Education line. Members must send in their weigh in logs after each set of 5 visits and can receive up to 4 sets of vouchers (a total of 20).

A total of 20 members were enrolled in the Weight Watchers program in 2018 and 15 members participated in at least 10 classes or more. Of these 15 members who attended 10 classes or more, 8 members lost less than 5% of their overall weight, 3 members lost 5-10% of their body weight and 4 members lost more than 10% of their overall weight. Those who lost more than 10% of their overall weight attended the 20 classes allotted to them. Four Target gift cards and certificates were awarded to those members who lost 10% or more of their overall body weight.

One of the challenges of this program is that attending group support classes is not always a preferred intervention for our members. In addition, the classes are only available in English. Although this program did not have significant outcomes, it is an appreciated benefit for our members who lack access to any other type of weight loss program. This program has filled an important gap to our membership where, according to the 2013 Community Needs Assessment Report for San Mateo County, 55% of adults are overweight and 22% are obese, many of these residents are our members. This program will continue to be offered to our members next year to assess other opportunities to build more interest in the program.

7.6 SMOKING CESSATION

HPSM continues to conduct direct flyer mailings to promote the use of the California Smoker's Helpline. Smokers are identified by ICD-10 codes and prescriptions of tobacco cessation medication on a monthly basis. From January to November 2018, HPSM mailed out 2,649 tobacco cessation promotional flyers in English, Spanish, Korean and Chinese. Currently, the California Smoker's Helpline does not include services in Tagalog or Russian. According to data provided from the California Smoker's Helpline for January to June 2018, there were a total of 76 San Mateo County callers to the Helpline. A total of 47.37% were Caucasian, 18.42% were Asian or Pacific Islander, 18.42% were Latino and 9.2% were African American. Of these, 82.89% spoke English, 9.21% spoke Spanish, 3.95% spoke Chinese and 3.95% spoke Korean.

However, to encourage the use of smoking cessation services throughout the year, a new flyer to promote the California Smoker's Helpline was developed to respond to the tradition of making it a New Year's resolution to quit smoking. The flyers were translated into English, Spanish and Chinese. Again, since the CA Smoker's Helpline does not have services in Tagalog, a Tagalog version was not created.

9. SUMMARY OF EFFECTIVENESS

SUMMARY OF 2018 GOALS

Through this annual evaluation process, HPSM assesses performance in all aspects of the QI program to determine the overall effectiveness of the QI Program and its progress in meeting safe clinical practice goals. Below is a summary of QI department goals that were set for 2018 and associated outcomes.

Goal	Outcome
#1: Meet 2018 targets for all QIPs and PIPs (CCS, PPC, AMR, BCS) (measures that were previously low or close to MPL)	• All measures above the minimum performance level (MPL) • All priority measures increased except BCS • Exceeded the MPL for Postpartum care! • ICP PIP/Care Coordination exceeded the project goal by Q2
#2: CLAS Program: 100% of HPSM staff complete annual Cultural Awareness Training by December 31, 2018.	Accomplished this goal through our Disability awareness training for all staff last year. Participation rate was not 100% but it is important to note that the format for the training changes from an online module to an in-person training so the decline in participation was expected.
#3: QW Measures: Pass 100% of CMS core measures quality withhold targets/benchmarks for CMC/MMP .	• Met the benchmarks for all CW measures • Strengths: Flu, Fall Risk, CBP

Benchmarks include CW6 (PCR) 11%, CW7(FLU) 69%, CW8 (FUH) 56%, CW10 (FRM) 55%, CW11 (CBP) 53%)"	• Opportunities - FUH

Priority areas selected to work on in 2018 included CCS, PPC, AMR and BCS (QI Department Goal #1) as they were low performing measures from the previous year. Below is a summary of the specific goals and results for each of these areas.

Measure	2018 Goal	2018 Result	Goal Met?
Cervical Cancer Screening	**HEDIS - Cervical Cancer Screening (CCS):** By Dec 31, 2018, increase the Medi-Cal CCS rate from 55. 26% (HEDIS) to 61.12% (statistically significant improvement).	59.95%	No, but increased from 55.26%-->59.95%
	Disparity CCS PIP: By June 2019, increase the CCS rate among Medi-Cal Expansion (MCE) members with English language Preference assigned to NEMS, from baseline measurement of 52.6% to 62.4% (statistically significant improvement).	NA	PIP in progress - implementation in 1/2019 so evaluation results not available.
Timeliness of Prenatal & Postpartum Care (PPC)	By 12/31/2018, improve timely prenatal care (within 42 days of enrollment or during the first trimester) from 82.63% (HEDIS 2016) to 87.12% (statistically significant improvement).	83.88%	No, still below goal but increased from 82.63% →83.88%
	By 12/31/2018, increase timely (21-56 day post-delivery) postpartum care from to 64.84% (HEDIS 2016) to 72.6% (statistically significant improvement).	74.59%	YES. Increased from 64.84% → 74.59% (over HPL of 72.38%)
Asthma Medication Ratio (AMR)	By Dec 31, 2018, increase the Medi-Cal rate of 54.89% (HEDIS 2017) to 58.58% (statistically significant improvement) (72.38% HPL).	58.18%	No, increased from 54.89% (2017) to 58.15% (2018), rate is above MPL of 55.33% (2018).
Breast Cancer Screening (BCS)	By 12/31/2018, increase BCS Medi-Cal rate from 65.77% to 67.18% (statistically significant improvement).	62.80%	No, no interventions implemented. Rate 65.77%-->62.80%
	By 12/31/2018, increase BCS Medicare rate from 67.78% to 70.25% (statistically significant improvement).	66.84%	No, no interventions implemented. Rate 67.78%-->66.84%

2018 QI BARRIERS TO IMPROVEMENT ACTIVITIES

Data accuracy is an important aspect of any improvement activity and in 2018, we focused efforts on ensuring that data was reliable. This process of validation, has been time consuming and at times, had an effect on project start times. However, taking the time to improve and validate this process has been ultimately valuable in ensuring that our programs are taking into account the most accurate sources, and has provided the team with a great deal of learning.

For some of our provider engagement interventions, we have learned that any program processes and requirements have to be adapted to the needs of our various providers. For example, strategies that work for our larger FQHCs cannot be applied to our smaller, solo practice providers. Therefore, many of these interventions have to be adjusted to fit the needs of provider which can be time consuming. During our improvement processes, we have also had to deal with competing priorities that can come from internal and external sources. For example, providers may have differing priorities from the health plan due to varied focus areas or changes in leadership which can lead to low provider/clinic engagement and ultimately may impact our project timelines and delivery. Additionally, in 2018, HPSMs staff time was focused on the NCQA accreditation process which also impacted the timely execution on projects and we had to make adjustments accordingly by focusing our remaining resources on high priority projects.

Finally, during interactions with some providers, we have found that due to various needs within the health plan for information from providers, such as medical record collection process from provider sites (due to HEDIS or Risk Adjustment purposes), providers are sometimes fatigued and frustrated by additional data requests that are critical to our improvement activities. As all these data requests are necessary, we are assessing options to ensure that in the future, providers are made aware of possible asks as soon as possible to help prepare them for in advance.

2018 QI FACILITATORS/SUCCESSES

In 2018, our QI projects have seen a great number of successes too. First, our current priority projects have made excellent use of cross departmental collaborations. For example, for the development of our AMR intervention, the Quality Improvement team has worked closely with Care Coordination, Provider Services, Pharmacy and Pediatrics in order to ensure development of the right interventions for the target groups. Further, for the ICP/HRA PIP, we have worked closely with Care Coordination and our Behavioral Health Units to better understand our population and develop processes that will improve our processes. We have also found our P4P platform a successful means to gain buy-in from providers for interventions.

For this year, we have also been able to use innovative approaches to technology. For example, our CBP pilot utilizes smart BP meters so that our members are able to capture BP values at home and providers are able to view and collect their readings. Further, we have been piloting our text messaging programs to ensure that members receive reminders on the various quality improvement interventions.

In 2018, we have also used our continuous improvement PDSA cycles to make some of our processes more efficient. In our postpartum care improvement program, for example, we have streamlined the communications we send to members, including reevaluating our text messaging reminders. We have also focused on cleaning up our PPC data, to ensure more frequent and timely reporting from monthly to weekly as well as establishing more frequent and timely reporting from monthly to weekly. As part of this continuous improvement, we have also increased our ties within the community, engaging out community partners such as NFP, BIH and WIC.

Our QI Working Meetings have also been a very successful part of our improvement process. Through these meetings, the teams have been able to come together to brainstorm and think through certain ideas as well as review project plans and provide status updates.. Team members also bring forward any challenges or barriers that they face in particular projects and the team works together to help determine the best courses of action which provides support to the entire project team. Establishing these meetings also provides each team member with a view on each project and its current status and highlights learnings that can be applied to other interventions.

Finally, we have found our intranet an excellent source of disseminating information throughout the organization and we regularly update the organization on some of our priority projects, such as CCS and AMR. These updates usually require a simple data pull from our monthly dashboard updates for both these projects and help keep the rest of the organization updated on some of these very important measures.

2018 SUMMARY OF EFFECTIVENESS

Adequacy of QI Program Resources	Securing adequate resources to support QI activities continued to be a challenge tin 2018. In 2018, there was staff turnover that left vacant positions while we worked to hire replacements for those roles. This left us spread thin at times and we had to assess priorities and shift responsibilities around remaining department staff to ensure coverage of high priority projects. Employee retention and recruitment itself continues to pose a challenge for our organization in general as the high cost housing market and the saturation of healthcare organizations in the area impacts staff recruitment as well as retention. This continues to be a high priority focus area for our Human Resources department and they have several initiatives in place to address recruitment strategies as well as employee satisfaction and retention.

	In 2018, HPSM participated in the in the Interim Survey phase of the NQCA Plan Accreditation process. Ultimately, this process helped to guide us to improve overall efficiency and effectiveness of our programs though it also identifies additional work and reporting which poses a challenge given current QI staff workloads are at or near capacity.
QI Committee Structure	In 2018, the role of the QIC chair changed from being held by an internal HPSM Medical Director to an external PCP representing one of HPSM's larger FQHC clinics. The committee still provides a forum for QI to report out of program activities. The committee continues to serve as an advisory role in our QI programming and actively participate in discussions regarding opportunities for improvement, data analysis, intervention planning and evaluation. Though there will be some membership changes in 2018, the QI Committee Structure itself has been successful at achieving its purpose and will continue.
Practitioner Participation and Leadership Involvement	In 2018, HPSM hired a new Chief Medical Officer (CMO) to oversee operations of the Health Services department which includes the Quality Improvement Unit. In addition to the practitioners that sit on the QI Committee and HPSM's CMO, HPSM has two medical directors with differing areas of expertise including Obstetrics & Gynecology and Geriatrics. Our CMO and Medical Directors are heavily involved with QI Program activities and provide their clinical expertise throughout our intervention planning and evaluation process. They also provide very valuable feedback and suggestions for improvement from the provider prospective on various initiatives. This is done both through their individual participation in various project meetings as well as the Clinical Quality Committee. Similarly, leadership involvement in the QI Program happens both from individual's participation in various QI activities as well as through the QI Committees including the Quality Improvement Committee (QIC), Clinical Quality Committee (CQC), Service Quality Committee (SQIC) and the CLAS Committee. HPSM's CEO sits on the QIC and actively participates in the meeting discussions. Management participation from several HPSM Departments participate in these committees and include representation from the following departments: • Claims • Health Services • Grievances & Appeals • Member Services • Provider Services • Quality Improvement This current structure supports practitioner participation and leadership involvement in QI Program Activities and will continue in 2018.

2019 QUALITY IMPROVEMENT DEPARTMENT GOALS

The QI Department sets annual goal to align with HPSM's strategic plan and organizational goals. QI department goals for 2019 include the following:

ACCESS TO HIGH QUALITY CARE & SERVICES

- By 12/31/19, improve timely prenatal care (within 42 days of enrollment or during the first trimester) from 83.88% (HEDIS 2018) to 87.06% (75th percentile)
- By 12/31/19, increase the Medi-Cal Asthma Medication Ratio rate of 58.15% (HEDIS 2018) to 62.3% (50th percentile)
- By 12/31/19, increase the Cervical Cancer Screening rate from 59.95% (HEDIS) to 60.1% (50th percentile)

- And for those combined efforts to further improve DHCS Aggregated Quality Factor Score (AQFS) two percentage points above the 2018 score of 81%.

STRONG INTERNAL OPERATIONS

- Spread knowledge and increase visibility of QI activities across HPSM business units to identify potential partnerships and align efforts.
- Review, update and upload QI P&Ps to C360.
- Optimize technology solutions to support our members and providers

FINANCIAL STABILITY

- Pass 100% of CMS core measures quality withhold targets/benchmarks for CMC/MMP (benchmarks include CW6 Ratio of < 1.0, CW7 69%, CW8 56% , CW11 56%, CW12 73%).

Updates to CMC QW Measure Set and Benchmarks for 2019:

CW Measure	Benchmark
CW6 – Plan All-Cause Readmissions	Ratio of < 1.0
CW7 – Annual Flu Vaccine	69%
CW8 – Follow-Up After Hospitalization for Mental Illness	56%
CW9 – Screening for Clinical Depression and Follow-Up Care	Retired
CW10 – Reducing the Risk of Falling	Retired
CW11 – Controlling Blood Pressure	56%
CW12 – Medication Adherence for Diabetes Medications	73%

QI PROGRAM MAJOR INITIATIVES FOR 2019

- Participate in cross-departmental staff meetings in order to facilitate collaboration and align efforts to improve member health outcomes and provider engagement.
- Implement Facility Site Review tracking system by 12/31/2019.
- Implement monthly HEDIS reporting to support the P4P program and other QI initiatives.
- Dissemination of results/findings from QI activities through quarterly summary reports and dashboards on the intranet.
- Improve documentation and organization of overall work flows/processes by developing DTPs, QI project plans, technical specifications for both quantitative and qualitative analyses, as well as legacy submissions to external/governing bodies.

2019 ACTION PLAN FOR QI INTERVENTIONS

The table below summarizes changes to the QI interventions for 2019 as a result of the 2018 QI Program Evaluation findings including assessment of the efficacy of the program.

Topic	2019 Plan
Asthma Medication Ratio (AMR)	In 2019, HPSM will proceed with this intervention, monitor results and conduct and continue to evaluate the effectiveness of these efforts.
Breast Cancer Screening (BCS)	• Continue implementation of the BCS provider outreach plan • Complete site visits with solo PCPs with low BCS rates to establish relationships that facilitate sharing member data and gather information on PCP process for mammography referrals • Identify appropriate opportunities for Quality to support PCPs in reaching out to members due for BCS to refer them to mammography services.
Cervical Cancer Screening (CCS)	• **Continue implementation of provider outreach plan with solo PCPs that have lower CCS rates.** Quality Improvement team will continue to schedule site visits throughout 2019 with PCPs with lower CCS rates. Completed site visits offer useful information on common issues/barriers at

	the PCP level that impact their CCS rates. Document barriers to CCS outreach with assigned members that are common to solo PCPs. • **Develop HPSM gynecologist referral protocol for PCPs without availability of female staff for CCS.** Quality Improvement team will facilitate an internal HPSM workgroup to develop a protocol for PCPs to use for assigned members due for CCS who prefer to receive Pap test from outside female provider. • **Pilot text message campaign to promote CCS:** Quality will pursue piloting the use of text messages as a method to reach members due for CCS. This will also be proposed as a potential intervention to use in partnership with low performing clinics.
CCS Disparities PIP	• **Provide HSAG with updates and changes for testing intervention at NEMS.** Begin implementing approved intervention with NEMS in January, 2019. Describe updates and changes to intervention timeline and data collection details submitted in Modules 2, 3, and 4, as needed, when submitting updates to HSAG in 2019. • **Continue the partnership with Member Services to meet NEMS request to follow up with members that indicate preference for different PCP.** Track NEMS's documentation of inactive assigned members that report preference for outside PCP, and documentation of assigned members with other health coverage.
Comprehensive Diabetes Care (CDC) & Medication Adherence for Diabetes Medications	• HPSM continues to provide P4P incentives HbA1c testing, eye exams, blood pressure reading, and medical attention for nephropathy or screening in the current program (calendar) year. • QI team has started the planning phase of identifying potential interventions aimed at improving the diabetes related HEDIS measures and connecting members with diabetes with high quality care and services. The planning phase will continue into 2019 and a new cross departmental workgroup will be created to begin to identify opportunities for improvement and potential interventions and partnerships related to diabetes care, self-management and resources. The Health Promotion Coordinator will continue to update our community resource /health education classes guide to better connect members to appropriate resources or health education classes.
Controlling High Blood Pressure (CBP)	• **SMMC Pilot:** The QI Specialist will implement the CBP pilot at the SMMC site. The implementation will involve working with the site champion for the project to determine how outreach will be done, and which patient population will qualify for the program. • **NEMS Pilot:** The QI Specialist will continue to work with NEMS on evaluating the pilot and identifying opportunities for improvement. • **Data Collection/Monitoring:** Reporting enhancements have been requested of the vendor that provides the Smart BP meetings and online platform. The QI Specialist will continue working with the vendor to fix data reporting issues so that collecting data from NEMS and SMMC can continue. The data will include the number of members that are participating in the pilot, length of time (in weeks) for a member to achieve the controlled blood pressure, if the member was seen at least once by the health educator quarterly, if member is on hypertensive medications and if member is compliant with the medications. The QI Specialist will also look at what other clinics have the highest amount of members diagnosed with hypertension to identify potential partnerships aimed at

	increasing the amount of members with controlled hypertension as measured by the HEDIS CBP Measure specifications.
Individual Care Plans (ICP)	Continue participating in PIP process to identify new intervention for Cal MediConnect members in 2019.
Initial Health Assessment (IHA)	• IHA Outreach Program will continue in 2019. • The Quality Improvement and Provider Services departments continue to provide training to providers through 2019. • The IHA text messaging campaign will need to be revaluated for 2019. Currently, the QI specialist is working in conjunction with our vendor to streamline the outreach campaign. • Considering altering the content of the text messages to see if it will enhance the rates.
Prenatal/Postpartum Care (PPC)	• Continue to identify members who are pregnant early in their pregnancy before their first trimester from the weekly claims report following the criteria of a positive pregnancy test result, or Rx for prenatal vitamins • Continue working with the Provider Services department to address access issues in OB Provider network. • Work with PCP offices that offer pregnancy tests to send a referral list of members who are pregnant. • Continue receiving a report of recently delivered HPSM Medi-Cal members • Continue to conduct postpartum weekly reminder calls to members who are enrolled in the Prenatal and Postpartum Care program. • Strive to survey all members who completed the prenatal and postpartum program to learn about their experience and ways to improve the program. • Continue to offer gift card incentives to members that attend timely prenatal and postpartum care visits. • Include information that explains the importance of the first trimester prenatal and postpartum visits in the member and provider newsletters.
Plan All-Cause Readmissions (PCR)	• **Technology Solutions**: The use of iPhones was recently implemented to improve overall communications and the CT team will continue identify other potential technology solutions to further improve efficiencies of the program. • **Increase Reach of services aimed at reducing readmissions**: o In 2019, the workgroup will explore opportunities to spread the Care Transitions intervention to additional facilities including Stanford in an effort to reach more CMC members that would benefit from transitions of Care Services provided by HPSM. o The workgroup will also explore CT program options for SNF or LTC population. A new Post-Acute care program was implemented in June 2018 utilizing Landmark providers and will continue into 2019. The program was implemented to effectively manage members during their SNF stays and throughout the subsequent discharge to home when appropriate. HPSM will continue to evaluate effectiveness of this new program in reducing 30 day readmissions for the population discharged to a SNF. • **Data Reporting/Monitoring:** Ongoing and regular monitoring of PCR data is essential to determine additional sites or opportunities for improvement. In 2019, the workgroup will review program related data as well as implement more process measures into our CT intervention evaluation to ensure CT program components/workflows are happening as intended. Monthly PCR rates will also be added to the Quality improvement

	dashboard to better disseminate monitoring data organization wide in real time. • **Incorporate Industry Best Practices into CT Program Structure:** In 2019, HPSM will conduct an assessment of the current intervention to determine if it includes components of industry best practices (*see list in best practices section below*) to identify any gaps or opportunities for improvement. • HPSM will continue will continue to evaluate the current efforts across the organization aimed at reducing readmissions and work to apply industry best practices to the services provided to HPSM members. HPSM has an interdepartmental work group that will continue to focus on identifying and implementing ways to improve data collection and identify strategies to reduce the readmission rates.

APPENDIX A. 2018 HEDIS RESULTS

HEDIS 2018 Results									
		CareAdvantage Cal Mediconnect			Medi-Cal				
HEDIS Abrv.	Name & Description	2017 rate	2018 rate	change ↕	2017 rate	2018 rate	change ↕	MPL	HPL
Pediatric Preventative Care									
CIS-3*	Childhood Immunization Status - Combo 3	NR	NR		82.99%	**80.80%**	-2.19%	65.25%	79.32%
	Percentage of children 2 years of age who receive a series of vaccines (# of injections) by their second birthday:								
	Dtap (4), Hep B (3), PCV (4), IPV (3), HiB (3), MMR (1), VZV (1)								
IMA - Combo2*	Immunizations for Adolescents	NR	NR		38.93%	**55.47%**	16.54%	15.87%	30.39%
	Percentage of adolescents 13 years of age who had:								
	▪*1 Meningococcal vaccine (MCV) injection between 11-13 years old*	NR	NR		84.91%	87.59%	2.68%		
	▪*1 Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one TD between 10-13 years old*	NR	NR		83.70%	91.48%	7.78%		
	▪*At least 3 HPV vaccines between 9-13 years old OR at least 2 does at least 146 days apart*	NR	NR		46.23%	58.88%	12.65%		
W-34*	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NR	NR		76.61%	74.43%	-2.18%	66.18%	82.77%
	Percentage of members 3-6 years of age who had one or more well child visits with a PCP during the MY.								
CAP	Children & Adolescents' Access to Primary Care Practitioners								
	Percentage of members 12 months - 19 years of age who had a visit with a PCP:								
CAP-1224	▪ *12-24 months*	NR	NR		93.74%	94.46%	0.72%	93.27%	97.89%
CAP-256	▪ *25 months - 6 years*	NR	NR		85.91%	85.95%	0.04%	84.94%	93.16%

CAP-711	▪ *7-11 years*	NR	NR		89.52%	89.82%	0.30%	87.58%	96.09%
CAP-1219	▪ *12-19 years*	NR	NR		86.17%	86.97%	0.80%	85.65%	94.72%
WCC*	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents								
	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 MY:								
WCC-N	▪ *Counseling for nutrition*	NR	NR		77.22%	80.85%	3.63%	58.56%	82.53%
WCC-PA	▪ *Counseling for physical activity*	NR	NR		65.00%	**78.19%**	13.19%	49.06%	75.40%
Adult Preventive Care & Screening									
ABA*	Adult BMI Assessment	86.22%	91.79%	5.57%	NR	NR		NA	NA
	Percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the MY or the year prior to the MY.								
BCS	Breast Cancer Screening	67.78%	66.84%	-0.94%	65.77%	62.80%	-2.97%	52.70%	70.29%
	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.								
COL*	Colorectal Cancer Screening	59.44%	60.30%	0.86%	NR	NR		NA	NA
	Percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.								
COA*	Care for Older Adults								
	Percentage of adults 66 years and older who had each of the following during the MY:								
	▪ *Advance Care Planning*	29.20%	45.99%	16.79%	NR	NR		NA	NA
	▪ *Medication Review*	72.26%	79.08%	6.82%	NR	NR		NA	NA
	▪ *Functional Status Assessment*	42.58%	54.01%	11.43%	NR	NR		NA	NA
	▪ *Pain Assessment*	71.78%	79.56%	7.78%	NR	NR		NA	NA
CCS*	Cervical Cancer Screening	NR	NR		55.26%	59.95%	4.69%	51.82%	70.80%
	Percentage of women 21-64 years of age who were screened for cervical cancer:								

	▪ *21-64 years: Cervical Cytology within the last 3 years*								
	▪ *30-64 years: Cervical Cytology/HPV co-testing within the last 5 years*								
	▪ *Or evidence of a hysterectomy*								
PSA	PSA Screening	28.77%	31.25%	2.48%	NR	NR		NA	NA
	The percentage of men 70 years and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening. Note: A lower rate indicates better performance.								
OMW	Osteoporosis Management in Women Who Had a Fracture	13.85%	11.27%	-2.58%	NR	NR		NA	NA
	Percentage of women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.								
LBP	Use of Imaging Studies for Low Back Pain	NR	NR		78.93%	**81.64%**	2.71%	66.23%	78.29%
	Percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.								
AAP	Adults' Access to Preventive/ Ambulatory Health Services								
	Percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.								
	▪ *Rate: 20 - 44 Years*	92.67%	94.91%	2.24%	NQ	NR		NA	NA
	▪ *Rate: 45 - 64 Years*	96.08%	96.50%	0.42%	NQ	NR		NA	NA
	▪ *Rate: 65+ Years*	94.86%	96.11%	1.25%	NQ	NR		NA	NA
	▪ *Total Rate*	94.97%	96.12%	1.15%	NQ	NR		NA	NA

SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	20.00%	22.09%	2.09%	NQ	NR		NA	NA
	Percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.								
Prenatal & Post Partum Care									
PPC*	Prenatal & Postpartum Care (2 indicators)								
	Percentage of deliveries of live births between November 6 of the year prior to the MY and November 5 of the measurement year. The measure assesses the following:								
PPC - Pre	▪ *Timeliness of Prenatal Care*	NR	NR		82.63%	83.88%	1.25%	77.66%	91.67%
PPC - Pst	▪ *Postpartum Care*	NR	NR		67.11%	**74.59%**	7.48%	59.59%	73.67%
Chronic Disease Management & Treatment									
CBP*	Controlling High Blood Pressure	64.73%	70.53%	5.80%	66.39%	70.08%	3.69%	47.69%	71.69%
	Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled:								
SPC	Statin Therapy for Patients with Cardiovascular Disease								
	Percentage of males 21-75 years of age and females 40-75 years of age during the MY who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:								
	▪ *Received Statin Therapy: 21-75 Years (Male)*	86.31%	86.58%	0.27%	NR	NR		NA	NA
	▪ *Statin Adherence 80%: 21-75 Years (Male)*	75.86%	85.27%	9.41%	NR	NR		NA	NA
	▪ *Received Statin Therapy: 40-75 Years (Female)*	80.87%	79.81%	-1.06%	NR	NR		NA	NA

	▪ *Statin Adherence 80%: 40-75 Years (Female)*	82.80%	77.11%	-5.69%	NR	NR		NA	NA
	▪ *Received Statin Therapy: Total*	84.10%	83.79%	-0.31%	NR	NR		NA	NA
	▪ *Statin Adherence 80%: Total*	78.57%	82.08%	3.51%	NR	NR		NA	NA
CDC*	Comprehensive Diabetes Care **(6 indicators)**								
	Percentage of members 18-75 years of age with diabetes (type 1 and 2) who had each of the indicators:								
CDC-E	▪ *Eye Exam (Retinal) Performed*	71.53%	74.87%	3.34%	64.84%	**70.42%**	5.58%	47.57%	68.33%
CDC-HT	▪ *HbA1c Testing*	92.94%	95.73%	2.79%	85.40%	91.20%	5.80%	84.25%	92.82%
CDC-H9	▪ *HbA1c Poor Control (>9.0%)- lower is better*	31.87%	31.91%	0.04%	36.01%	36.19%	0.18%	48.57%	29.07%
CDC-H8	▪ *HbA1c Control (<8.0%)*	59.37%	59.55%	0.18%	54.26%	52.81%	-1.45%	41.94%	59.12%
CDC-N	▪ *Medical Attention for Nephropathy*	93.92%	94.47%	0.55%	89.78%	92.18%	2.40%	88.56%	93.27%
CDC-BP	▪ *Blood pressure control (<140/90mmHg)*	62.77%	64.32%	1.55%	61.80%	68.46%	6.66%	52.70%	75.91%
SPD	Statin Therapy for Patients with Diabetes								
	Percentage of members 40-75 years of age during the MY with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:								
	▪ *Received Statin Therapy*	77.73%	80.32%	2.59%	NR	NR		NA	NA
	▪ *Statin Adherence: 80%*	76.40%	79.86%	3.46%	NR	NR		NA	NA
AMR	Asthma Medication Ratio								
	Percentage of members 5-85 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the MY.								
	▪ *5 - 11 Years*	NR	NR		59.59%	61.56%	1.97%		
	▪ *12 - 18 Years*	NR	NR		56.74%	62.33%	5.59%		
	▪ *19 - 50 Years*	50.00%	NR		49.12%	52.56%	3.44%		

	▪ *51 - 64 Years*	50.00%	NR		53.33%	56.52%	3.19%		
	▪ *65 - 85 Years*	68.69%	NR		NR	NR			
	▪ *Total*	61.94%	NR		54.89%	58.15%	3.26%	55.33%	72.38%
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	93.94%	82.86%	-11.08%	NR	NR		NA	NA
	Percentage of members 18 years of age and older during the MY who were hospitalized and discharged from July 1 of the year prior to the MY to June 30 of the MY with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.								
ART	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	82.67%	82.93%	0.26%	NR	NR		NA	NA
	Percentage of members who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug.								
PCE	Pharmacotherapy Management of COPD Exacerbation								
	▪ *Systemic Corticosteroid*	57.45%	63.39%	5.94%	NR	NR		NA	NA
	▪ *Bronchodilator*	90.96%	92.35%	1.39%	NR	NR		NA	NA
Pharmacy									
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	NR	NR		48.67%	**62.88%**	14.21%	24.91%	39.53%
	Percentage of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.								
MPM	Annual Monitoring for Patients on Persistent Medications (without anticonvulsant, 3 indicators)								

	Percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and at least one therapeutic monitoring event for the therapeutic agent.								
MPM - ACE	▪ *ACE inhibitors or ARBs*	92.57%	NR		90.90%	90.46%	-0.44%	85.93%	92.79%
MPM - Dig	▪ *Diuretics*	92.95%	NR		90.54%	91.35%	0.81%	NA	NA
MPM - Diu	▪ *Digoxin*	39.29%	NR		NR	NR		85.52%	92.47%
MRP	Medication Reconciliation Post-Discharge	36.01%	46.96%	10.95%	NR	NR		NA	NA
	Percentage of discharges from January 1 - December 1 of the MY for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge.								
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly								
	Percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition or health concern and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis.								
	▪ *Falls + Tricyclic Antidepressants or Antipsychotics*	42.86%	43.99%	1.13%	NR	NR		NA	NA
	▪ *Dementia + Tricyclic Antidepressants or Anticholinergic Agents*	53.50%	54.81%	1.31%	NR	NR		NA	NA
	▪ *Chronic Renal Failure + Non-aspirin NSAIDs or Cox - 2 Selective NSAIDs*	9.90%	9.72%	-0.18%	NR	NR		NA	NA
	▪ *Total rate*	39.26%	40.62%	1.36%	NR	NR		NA	NA
DAE	Use of High Risk Medications in the Elderly								

	▪ *Percentage of Medicare members 66 years of age and older who received at least one high-risk medication*	23.97%	28.28%	4.31%	NR	NR		NA	NA
	▪ *Percentage of Medicare members 66 years of age and older who received at least two different high-risk medications*	16.02%	17.67%	1.65%	NR	NR		NA	NA
UOD	Use of Opioids at High Dose	NR	81.75%		NR	NR		NA	NA
	For members 18 years and older, the rate per 1000 receiving prescriptions opioids for ≥ 15 days during the measurement year at a high dosage (average morphine equivalent dose [MED] > 120mg).								
UOP	Use of Opioids From Multiple Providers								
	For members 18 years and older, the rate per 1000 receiving prescriptions opioids for ≥ 15 days during the measurement year who received opioids from multiple providers. Three rates are reported:								
	▪ *Multiple Prescribers*	NR	126.75		NR	NR		NA	NA
	▪ *Multiple Pharmacies*	NR	27.16		NR	NR		NA	NA
	▪ *Multiple Prescribers and Multiple Pharmacies*	NR	7.41		NR	NR		NA	NA
AMM	Antidepressant Medication Management								

	Percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported:								
	▪ *Effective Acute Phase Treatment*	62.56%	70.91%	8.35%	NR	NR		NA	NA
	▪ *Effective Continuation Phase Treatment*	46.70%	51.82%	5.12%	NR	NR		NA	NA
Behavioral Health									
FUH	Follow-Up After Hospitalization for Mental Illness								
	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health provider. Two rates were reported:								
	▪ *30-Day Follow-Up*	64.84%	68.50%	3.66%	NR	NR		NA	NA
	▪ *7-Day Follow-Up*	42.97%	35.43%	-7.54%	NR	NR		NA	NA
FUM	Follow-Up After Emergency Department Visit for Mental Illness								
	Percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates were reported:								
	▪ *30-Day Follow-Up*	72.89%	56.45%	-16.44%	NR	NR		NA	NA
	▪ *7-Day Follow-Up*	48.80%	39.52%	-9.28%	NR	NR		NA	NA
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence								

	Percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol and other drug dependence (AOD), who had a follow-up visit for AOD.								
	▪ *30-Day Follow-Up*	39.78%	14.71%	-25.07%	NR	NR		NA	NA
	▪ *7-Day Follow-Up*	34.41%	11.76%	-22.65%	NR	NR		NA	NA
MPT	Mental health Utilization								
	Percentage of members receiving the following mental health services during the measurement year:								
	▪ *Any Service*	17.46%	18.27%	0.81%	NR	NR		NA	NA
	▪ *Inpatient service*	1.35%	0.44%	-0.91%	NR	NR		NA	NA
	▪ *Outpatient service*	17.29%	17.73%	0.44%	NR	NR		NA	NA
	▪ *Emergency Department*	17.29%	0.84%	-16.45%	NR	NR		NA	NA
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment								
	Percentage of adolescent and adult members with a new episode of alcohol and other drug (AOD) dependence who received the following treatment:								
	▪ *Initiation of AOD Treatment*	36.89%	26.86%	-10.03%	NR	NR		NA	NA
	▪ *Engagement of AOD Treatment*	3.17%	5.02%	1.85%	NR	NR		NA	NA
IAD	Identification of Alcohol and Other Drug Services								
	Summary of the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the MY.								
	▪ *Any Service % for Male*	9.05%	10.37%	1.32%	NR	NR		NA	NA
	▪ *Any Service % for Female*	4.39%	6.84%	2.45%	NR	NR		NA	NA
	▪ *Any Service % Total*	6.12%	8.17%	2.05%	NR	NR		NA	NA
	▪ *Inpatient Service % for Male*	3.13%	1.30%	-1.83%	NR	NR		NA	NA
	▪ *Inpatient Service % for Female*	1.24%	0.77%	-0.47%	NR	NR		NA	NA
	▪ *Inpatient Service % Total*	1.94%	0.97%	-0.97%	NR	NR		NA	NA
	▪ *Intensive Service % for Male*	0.00%	0.00%	0.00%	NR	NR		NA	NA

	▪ *Intensive Service % for Female*	0.00%	0.00%	0.00%	NR	NR		NA	NA
	▪ *Intensive Service % Total*	0.00%	0.00%	0.00%	NR	NR		NA	NA
	▪ *ED Service % for Male*	7.81%	2.11%	-5.70%	NR	NR		NA	NA
	▪ *ED Service % for Female*	4.00%	0.77%	-3.23%	NR	NR		NA	NA
	▪ *ED Service % Total*	5.41%	1.27%	-4.14%	NR	NR		NA	NA
Care Coordination									
TRC	Transition of Care								
	Percentage of discharges for members 18 years of age and older who had each of the following during the measurement year. Four rates are reported:								
	▪ *Notification of Inpatient Admission*	NR	5.84%		NR	NR		NA	NA
	▪ *Receipt of Discharge Information*	NR	0.73%		NR	NR		NA	NA
	▪ *Patient Engagement After Inpatient Discharge*	NR	81.75%		NR	NR		NA	NA
	▪ *Medication Reconciliation Post-Discharge*	NR	46.96%		NR	NR		NA	NA
FMC	Follow-Up After Emergency Department Visit for People With High-Risk Multiple Conditions								
	Percentage of emergency department (ED) visits for members 18 years and older who have high-risk multiple chronic conditions who had a follow-up service within 7 days of the ED visit.								
	▪ *7 day follow-after the ED visit: 18-64 years*	NR	56.46%		NR	NR		NA	NA
	▪ *7 day follow-after the ED visit: 65+ years*	NR	54.09%		NR	NR		NA	NA
	▪ *7-day follow-after the ED visit: Total*	NR	54.77%		NR	NR		NA	NA
Utilization									
PCR	Plan All-Cause Readmissions								

	For members 18 years of age and older, the number of acute inpatient stays during the MY that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Lower rate is better.								
	▪ *Age: 18 - 44*	20.54%	18.97%	-1.57%	NR	NR		NA	NA
	▪ *Age: 45 - 54*	22.76%	18.83%	-3.93%	NR	NR		NA	NA
	▪ *Age: 55 - 64*	15.12%	15.14%	0.02%	NR	NR		NA	NA
	▪ *Total*	18.26%	17.08%	-1.18%	NR	NR		NA	NA
	Ambulatory Care								
	Summarized utilization of ambulatory care.								
AMB- OB	▪ *Outpatient Total Visit/1000 member mbr year*	12534.04	12966.10	432	NR	406.17		303.58	473.73
AMB-ER	▪ *Emergency Department Visits*	683.48	694.13	11	NR	46.53		52.27	86.43
IPU	Inpatient Utilization - General Hospital/Acute Care								
	Summary of utilization of acute inpatient care and services in the following categories: total inpatient, maternity, surgery, medicine.								
	▪ *Total Inpatient Ds/1000 MM Total*	271.64	263.16	-8	NR	NR		NA	NA
	▪ *Medicine Total Ds/1000*	187.32	200.79	13	NR	NR		NA	NA
	▪ *Surgery Total Ds/1000*	85.30	61.71	-24	NR	NR		NA	NA
	▪ *Maternity Total Ds/1000*	NR	2.70		NR	NR		NA	NA
*	Hybrid Measure (medical records can be used in data collection)								
	DHCS does not hold plans to MPL								
NQ	Not Required								
NR	Not Reported								
UN	Un-audited								

HPSM CONSUMER ADVISORY COMMITTEE

GRIEVANCE & APPEALS REPORT

REPORTING PERIOD: Q4 2018 (OCT. – DEC. 2018)

PRESENTED 03/07/2019

Table of Contents

Overview

Purpose

This report provides Health Plan of San Mateo's (HPSM) Consumer Advisory Committee with an overview of the volume and type of complaints received from HPSM members, as well as whether the Grievance and Appeals (G&A) Unit is addressing these complaints in a timely manner. Throughout this report, the term "complaints" refers to both grievances and appeals.

Methodology

The data for this report comes from two databases:

1. MedHOK: system of record for appeals and grievances
2. HEALTHSuite: system of record for authorizations, claims, and member eligibility

All complaints received during the reporting period were analyzed by line of business and type of complaint. For Medi-Cal and CCS, additional information is included in accordance with guidelines from the National Committee for Quality Assurance (NCQA).

Please note that members assigned to Kaiser Permanente file their complaints directly with Kaiser, not with HPSM, since Kaiser is delegated for all grievance and appeals functions.

Case data is pulled from MedHOK based on the date HPSM received the case. If it is filed by a member's representative (e.g. family member, friend, attorney), the receive date is based on the date the member authorized that person to represent them. Complaint timeliness is calculated using this receive date as the start date of the complaint.

By tracking and trending complaints filed with HPSM, the Grievance and Appeals (G&A) Unit hopes to identify and address the root causes leading to member dissatisfaction.

Rate of Complaints per 1,000 Members

Enrollment Averages for Q4 2018

The rate of complaints per 1,000 members allows the G&A Unit to compare complaint rates while accounting for the differences in enrollment numbers across different lines of business. The rate of complaints per 1,000 members is based on the average enrollment numbers for Q4 2018.

Line of Business	Average Enrollment for Q4
CareAdvantage CMC	9,079
Medi-Cal Only (Excluding CCS)	103,278
Healthy Kids	1,616
HealthWorx	1,154
ACE	24,607
CCS	1,834
TOTAL	**141,568**

Goal Rate, by Line of Business

The complaint rates differ significantly by line of business in large part because each line of business serves a different population. For example, CareAdvantage CMC (CA CMC) members are older and/or have at least one disabling condition, which leads them to interact more frequently with the healthcare system. HPSM's assumption is that increased interaction leads to increased opportunity for member dissatisfaction. In contrast, Medi-Cal members, many of whom are healthy children or young adults, have a lower rate of complaints in part because these members do not need as many services and therefore have fewer interactions with HPSM and its providers.

Please note that HPSM is unable to quantify how much of the difference in complaint rates can be attributed to differences in members' level of interaction with the healthcare system versus other factors, such as differences in the way members are treated by providers or differences in access to care.

The G&A Unit reviewed the rate of complaints for each quarter in 2017 and 2018. From this historical review, the G&A Unit identified the minimum and maximum rate of complaints per 1,000 members in the past 18 months and set a goal for each line of business. Below is a table of the minimum, maximum, and resulting goal rate for each program:

Line of Business	Min	Max	Goal
CareAdvantage CMC	19	23.6	21.3

Medi-Cal Only (Excluding CCS)	2.5	3	2.75
Healthy Kids	1.3	6.6	3.95
HealthWorx	1.9	11.4	6.65
ACE	0.3	1.2	0.75
CCS	4.3	6.9	5.6
TOTAL	**3.4**	**3.8**	**3.6**

Rate of Complaints per 1,000 members for Q4 2018

Line of Business	Q1	Q2	Q3	Q4	Goal
CareAdvantage CMC	21.5	21.6	16.8	16.2	21.3
Medi-Cal Only (Excluding CCS)	2.9	2.5	2.5	2.5	2.75
Healthy Kids	4.0	1.3	8.8	4.3	3.95
HealthWorx	1.9	10.4	4.5	7.4	6.65
ACE	0.6	0.3	0.4	0.7	0.75
CCS	6.4	5.8	12.7	6.5	5.6
TOTAL	**3.8**	**3.4**	**3.3**	**3.2**	**3.6**

* Note: In the Q1 report, the rate for CCS members was mistakenly reported as 7. It has been re-calculated to be 6.4. The total rate for the quarter across all lines of business was not significantly affected.

Analysis

In Q4 2018 Healthy Kids, HealthWorx and CCS were not within the goal rate of complaints per 1,000 members. Given the small number of members enrolled in Healthy Kids and CCS, these programs are susceptible to large changes in calculated rates, which often do not indicate a significant change in member experience. CMC, Medi-Cal, and ACE, which all have larger member populations, were within their established goals indicating that no corrective action is needed.

Barriers and Proposed Actions

Finding: The rate of complaints per 1,000 members was higher than the goal rate for three lines of business (Healthy Kids, HealthWorx and CCS). All other lines of business were within the goal.

Barriers & Proposed Action: There is no identified need for action at this time.

Timeliness of Complaint Resolution

Timeliness Rates for Complaint Resolution

The G&A Unit's goal, as mandated by the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC), is to resolve at least 95% of grievances and appeals within the required regulatory timeframe. Below are the timeliness rates across all lines of business. This table excludes cases resolved within 24 hours of receipt.

The G&A Unit failed to meet its goal of 95% timeliness for during 2018 in processing grievances and appeals. In contrast, the Pharmacy Unit, which processes pharmacy appeals, met their goal of 95% timeliness.

Type of Complaint	# Received (all LOBs)	# Resolved Timely	% Resolved Timely (Q3 2018)	% Resolved Timely (Q4 2018)
Grievances	306	231	88%	75.5%
Medical Appeals	70	61	88.6%	87.1%
Pharmacy Appeals	76	75	97.1%	98.7%

Barriers and Root Causes

The G&A Unit attributes their failure to meet the timeliness goal to the following barriers:

1) **Staffing Shortage and Case Review Timeliness**:
   While the G&A Unit continued to struggle with case timeliness in Q3 and Q4, changes to the case review process are expected to have a positive effect in 2019.

Proposed Actions/ Solutions

2) **Solutions to Staffing Shortages:** The G&A Unit is currently fully staffed in terms of its non-clinical positions. A G&A Coordinator was hired in late September 2018 and began working cases in mid-November, and a new G&A Manager was hired in mid-November. (The Clinical Review Nurse position remains open and we are actively recruiting for this position).

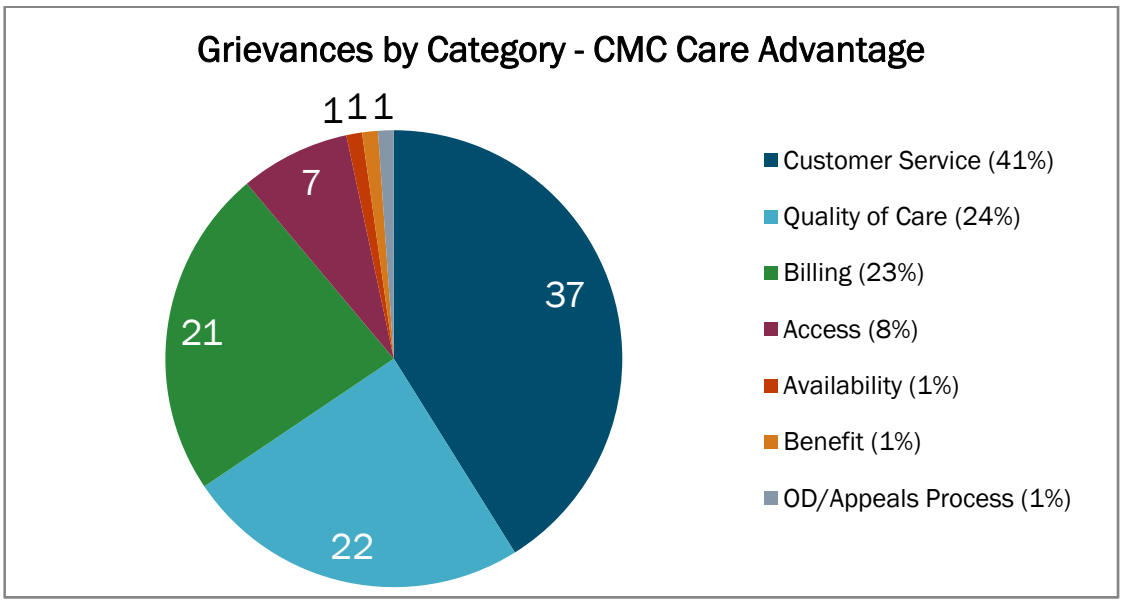
3) **Solutions to Changes in Case Review Process**: Many delays in case timeliness are the result of untimely case reviews. In response, the Unit restructured its process and promoted two Coordinators to take on responsibility for performing case reviews. As of February 2019, the team has four staff conducting case reviews where it only had one staff performing this function in 2018. We expect that these additional case review resources will reduce care turn-around time and improve timeliness.

CareAdvantage Cal-MediConnect (CA CMC)

Number of Appeals and Grievances (Complaints) Received

LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTAL
CareAdvantage CMC							
Appeals	**Part C**	**Expedited**	3	3	3	3	12
		Standard	37	24	25	29	115
	Part D	**Expedited**	1	8	4	7	20
		Standard	15	25	11	18	69
	Total Appeals		**56**	**60**	**43**	**57**	**216**
Grievances	**Part C**	**Expedited**	1	1	1	1	4
		Standard	125	122	93	82	422
	Part D	**Expedited**	0	1	0	0	1
		Standard	14	12	15	7	48
	Total Grievances		**140**	**136**	**109**	**90**	**475**
CareAdvantage CMC Total			**196**	**196**	**152**	**237**	**691**

Types of Grievances Received, by Category



Type of Grievances Received, by Sub-Category

Category	Sub-Category	# Received
Access	No MRF or Rx on File	1
	No TAR or Prescription on File	1
	Provider Not Dispensing Drug	1
	Provider Not Dispensing Item	2
	Other	2

Category	Sub-Category	# Received
Access total		7
Availability	Excessive Wait Time for Appointment	1
Availability total		1
Benefit	Drug not a Benefit	1
Benefit total		1
Billing	Balance Bill Not in Collections	1
	Balance Bill in Collections	19
	Other	1
Billing Total		21
Customer Service	Comm - Disrespect/Rudeness/Discrimination	8
	Comm - Incorrect Info Given to Mbr	5
	Comm - Other Issue with Staff	2
	Taxi - Driver no-show	8
	Taxi - Driver rude/disrespectful	3
	Taxi - Incorrect Info Given	1
	Taxi - Late pick-up/ drop off	2
	Time - No return call	4
	Time - Long hold time on phone	1
	Taxi - Other	3
Customer Service Total		37
OD/Appeals Process	Appeals Process Too Long	1
OD/Appeals Process Total		1
Quality of Care	Relationship - Provider Not Listening to Concerns	3
	Relat - Provider is Rude/Mean/Etc	1
	Treatment - Drug Not Prescribed	3
	Treatment - Incorrect Prescription	1
	Treatment - Poor Treatment	13
	Other	1
Quality of Care Total		22
Total		**90**

Resolutions Within 24 Hours of Receipt

The following reflect complaints that were resolved by HPSM staff within 24 hours of the member informing HPSM of the complaint. These complaints are not included in the count of grievances in the tables above and do not enter the formal grievance process.

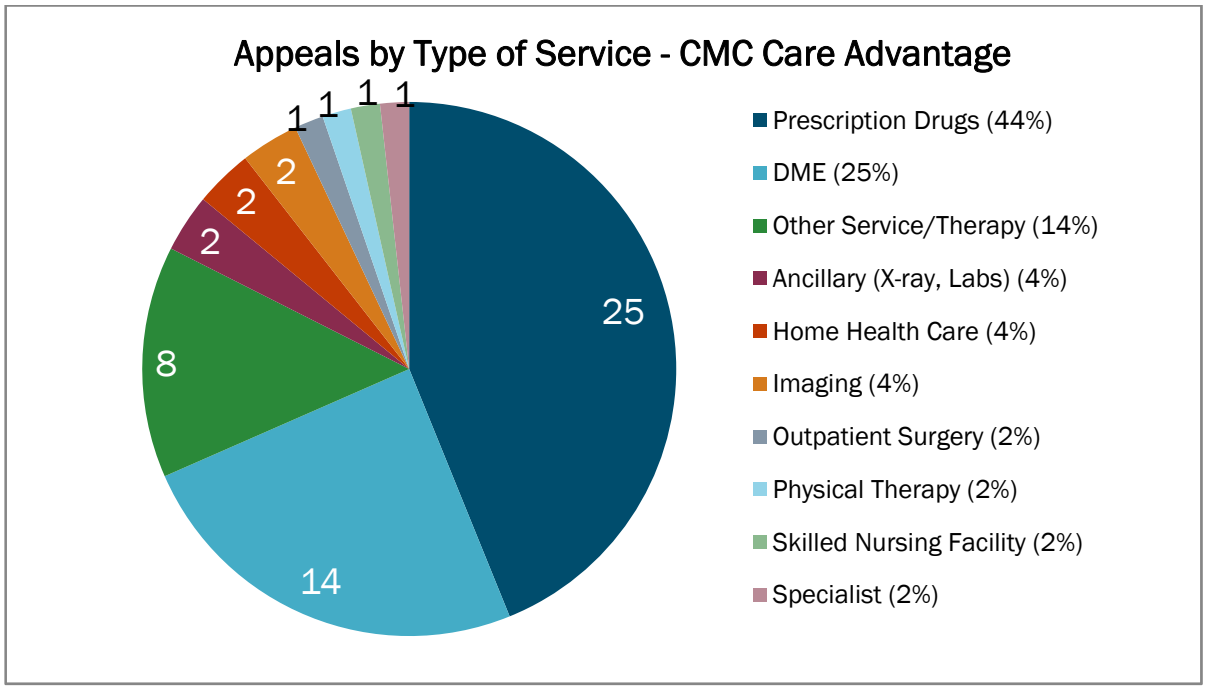
- **24 - Hour Resolutions, by Type of Service**

Types of Service	Q1	Q2	Q3	Q4	Total
Medical Services/Supplies	75	43	25	9	152
Prescription Drugs	69	62	49	60	240
Total	**144**	**105**	**74**	**69**	**392**

- **24 - Hour Resolutions, by Category**

Category	Part C Grievance	Part D Grievance
Access	4	54
Billing	0	3
Customer Service	5	2
Enrollment/Disenrollment	0	1
Grand Total	**9**	**60**

Types of Appeals Received



Rate of Overturned Appeals

The table below includes appeal resolutions and the percentage of appeals that result in an overturned denial decision (i.e. an approved medical service/item or prescription drug).

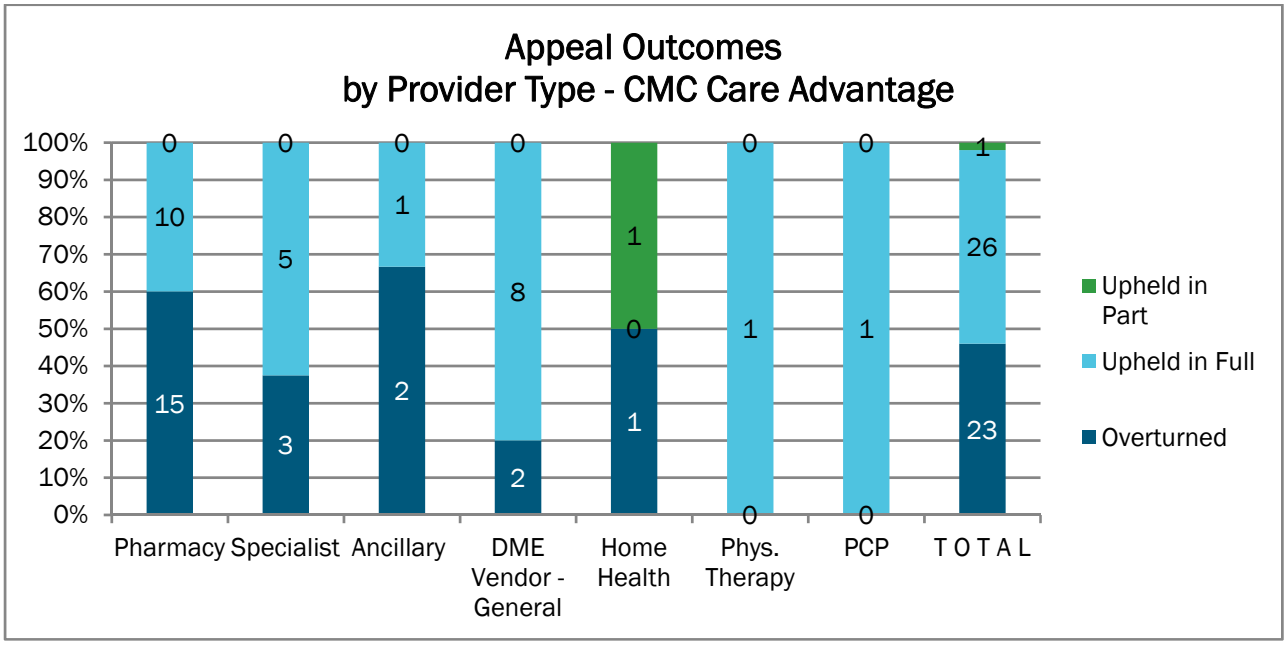
Type of Denial	Total Appeals	Upheld in Full	Upheld in Part	Overturned	Withdrawn or Dismissed	% Overturned on Appeal
Part C- Medical	32	16	1	8	7	25%
Part D - Prescription	25	10	0	15	0	67%

Appeal Outcome by Provider Type

For the fifty appeals that were neither withdrawn nor dismissed, the outcome is further broken down by Provider type in the table below:

Provider Type	Overturned	Upheld in Full	Upheld in Part
Pharmacy	15	10	0
Specialist	3	5	0
Ancillary	2	1	0
DME Vendor - General	2	8	0
Home Health	1	0	1
Physical Therapy	0	1	0
PCP	0	1	0
Total	**23**	**26**	**1**

The frequency of each outcome is charted below as a percentage within each provider type:



As seen in the chart above, there are higher overturn rates for pharmacy appeals and appeals related to ancillary services and home health. Appeals related to specialist services, physical therapy, and primary care tended to be upheld on appeal.

Analysis, Barriers, and Proposed Actions/Solutions (CA CMC)

- **Grievances:**

  The volume of grievances decreased significantly throughout the year, from 140 grievances in Q1 to 90 grievances in Q4 2018. The percentage of grievances related to Customer Service

decreased from 51% in Q1 2018 to 41% in Q4 2018. The percentage of grievances related to Quality of Care and Billing rose by 5-7 percentage points from Q1, however the volume of these grievances remained the same. The increase in percentage is therefore a result of the significant decrease in Customer Service grievances (from 71 grievances in Q1 to only 37 grievances in Q4). Grievances related to Access and Availability decreased slightly from Q1.

- **Appeals:**
  - The percentage of appeals related to prescription drugs increased from 29% (16 appeals) in Q1 2018 to 55% (33 appeals) in Q2 2018. In Q3, the volume of pharmacy-related appeals decreased back down to 35% (15 appeals), and then increased to 44% (25 appeals) in Q4.
  - Appeals related to Durable Medical Equipment (DME) remained constant.

- **Rate of Overturned Appeals:** The rate of overturned appeals for medical services increased from 30% in Q1 to 43% in Q3, but has dropped to 25% in Q4. The overturn rate for pharmacy appeals had decreased from 63% in Q1 to 45% in Q2, but rose again to 67% in Q3 and Q4.

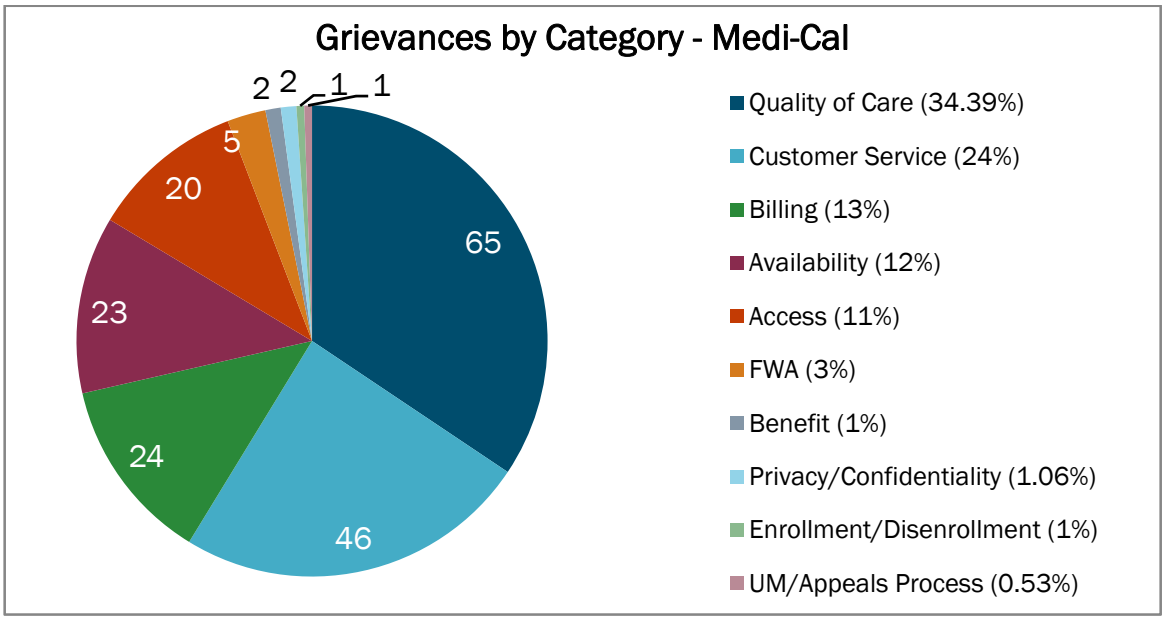
  - **Proposed Action:** The Overturned Appeals Workgroup (a collaboration between the G&A Unit, Utilization Management Department, HPSM Medical Directors, and the Compliance Department) continues its monthly review of the reason for overturned medical appeals and identify opportunities for improvement.

Medi-Cal (MC)

Number of Appeals and Grievances (Complaints) Received

LINE OF BUSINESS			Q1	Q2	Q3	Q4	TOTAL
Medi-Cal							
Appeals	**Medical Services**	**Expedited**	7	9	3	1	20
		Standard	76	45	40	28	189
	Drugs	**Expedited**	9	13	16	10	48
		Standard	45	41	34	32	152
	Total Appeals		**137**	**108**	**93**	**71**	**409**
Grievances	**Medical**	**Expedited**	0	0	0	0	0
		Standard	168	149	168	174	659
	Drugs	**Expedited**	0	2	1	2	5
		Standard	160	8	7	13	188
	Total Grievances		**184**	**159**	**176**	**189**	**708**
		Medi-Cal Total	**321**	**267**	**269**	**360**	**1,217**

Types of Grievances Received, by Category



Type of Grievances Received, by Sub-Category

Category	Sub_Category	# Received
Access	Interpretation Srvc Not Used	2
	Location too far	1
	Network - PCP	1
	Network - Specialist	3
	No TAR or Prescription on File	3
	Provider Not Dispensing Drug	5
	Provider Not Dispensing Item	3
	Other	2
Access Total		20
Availability	Excessive Wait Time for Appointment	15
	Unable to Schedule Appointment	4
	Other	4
Availability Total		23
Benefit	Service Not a Benefit	1
	Other	1
Benefit Total		2
Billing	Balance Bill Not in Collections	3
	Balance Bill in Collections	9
	Full Bill Direct to Member	11
	Other	1
Billing Total		24
Customer Service	Comm - Disrespect/Rudeness/Discrimination	12

Category	Sub_Category	# Received
	Comm - Incorrect Info Given to Mbr	6
	Comm - Other Issue with Staff	14
	Taxi - Late pick-up/ drop off	2
	Time - Long wait time during appt	3
	Time - No return call	7
	Time - Other	2
Customer Service Total		46
FWA	Fraud - Prov Billed w/o Rendering Srvc	1
	Fraud - Other	4
FWA Total		5
Enrollment/Disenrollment	Delay in Enrollment Process	1
Enrollment/Disenrollment Total		1
Privacy/Confidentiality	Inappropriate Sharing Member PHI	1
	Other	1
Privacy/Confidentiality Total		2
Quality of Care	Fac - Inadequate/Unsafe Equipment	1
	Ref - Delay in referral	1
	Ref - Provider did not refer	3
	Relat - Provider Not Listening to Concerns	1
	Relat - Provider is Rude/Mean/Etc	3
	Tx - Drug Not Prescribed	4
	Tx - Incorrect Prescription	1
	Tx - Poor Diagnosis	3
	Tx - Poor Treatment	36
	Tx - Prescription Reduction	1
	Tx - Services Not Rendered	8
	Other	3
Quality of Care Total	Category total	65
UM/Appeals Process	Appeal Process Too Long	1
UM/Appeals Process Total		1
Total		**189**

Resolutions Within 24 Hours of Receipt

The following reflect complaints that were resolved by HPSM staff within 24 hours of the member informing HPSM of the complaint. These complaints are not included in the count of grievances in the tables above, and do not enter the formal grievance process.

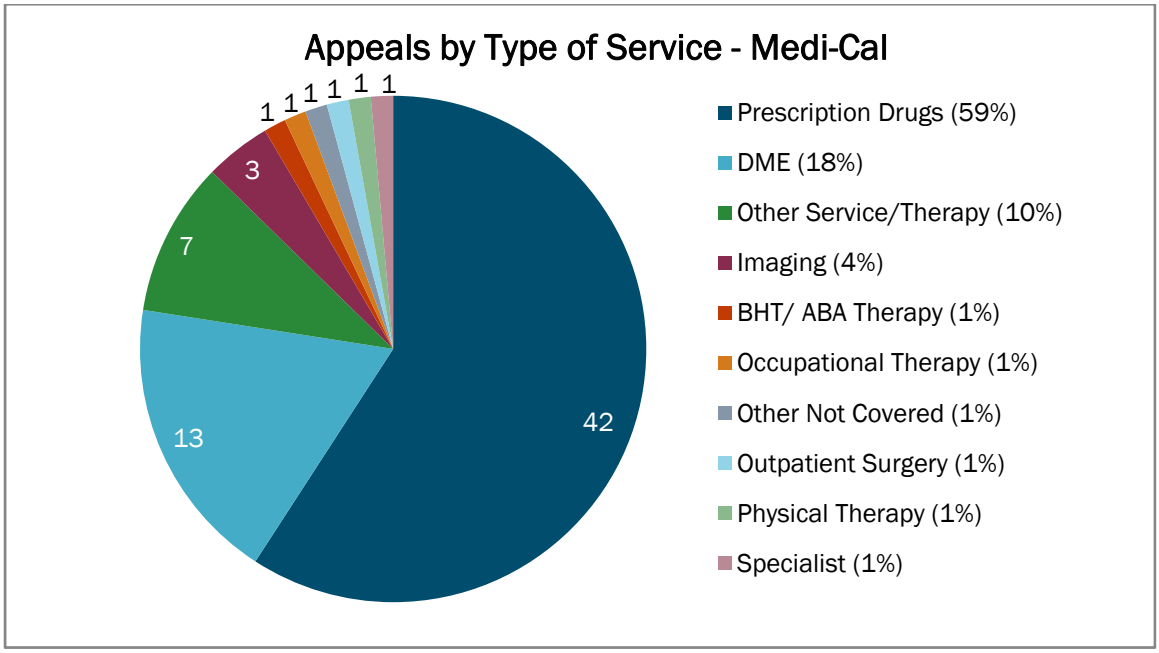
- **24 - Hour Resolutions, by Type of Service**

Types of Service	Q1	Q2	Q3	Q4	Total
Medical Services/Supplies	67	82	109	133	391
Prescription Drugs	129	142	131	110	512
Total	**196**	**224**	**240**	**243**	**903**

- **24 - Hour Resolutions, by Category**

Category	Medical Grievance	Pharmacy/Drug Grievance
Access	21	103
Availability	35	0
Benefit	3	0
Billing	3	4
Customer Service	71	0
Enrollment/Disenrollment	0	3
Grand Total	**133**	**110**

Type of Appeals Received



Rate of Overturned Appeals

The table below includes appeal resolutions and the percentage of appeals that result in an overturned denial decision (i.e. an approved medical service/item or prescription drug).

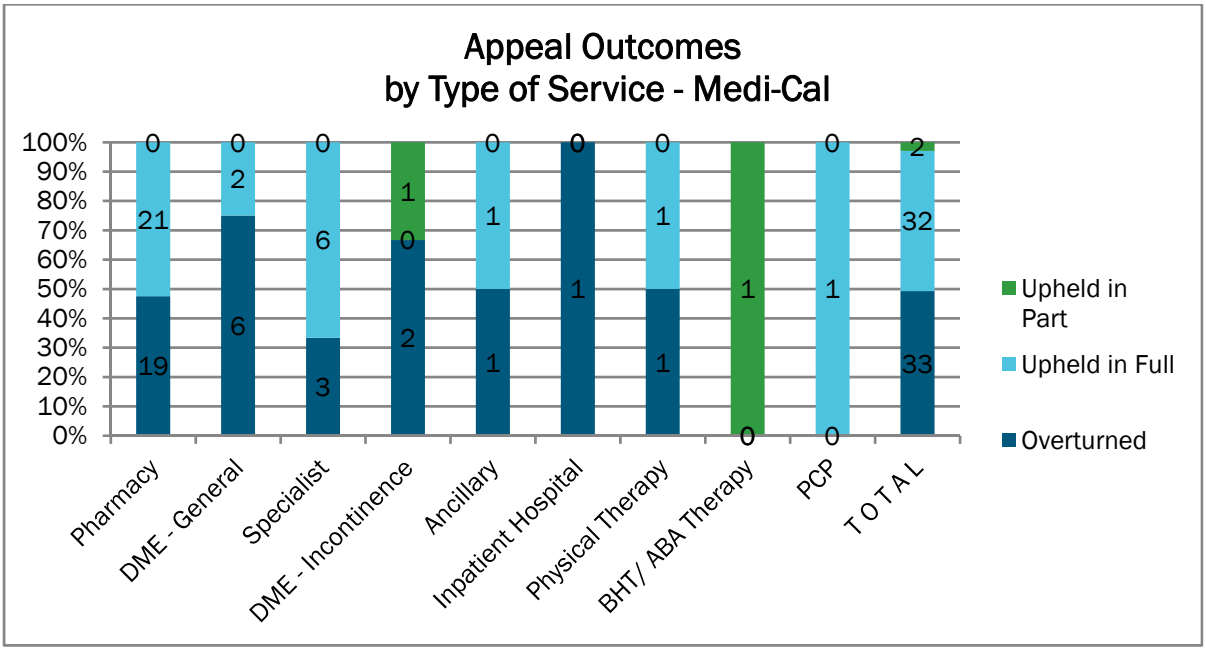
Type of Denial	Total Appeals	Upheld in Full	Upheld in Part	Overturned	Withdrawn or Dismissed	% Overturned on Appeal
Medical Services/Supplies	29	11	2	14	2	48.28%
Prescription Drugs	42	21	0	19	2	45.24%

Appeal Outcome by Provider Type

For the 67 appeals that were neither withdrawn nor dismissed, the outcome is further broken down by Provider type in the table below:

Provider Type	Overturned	Upheld in Full	Upheld in Part
Pharmacy	19	21	0
DME - General	6	2	0
Specialist	3	6	0
DME - Incontinence	2	0	1
Ancillary	1	1	0
Inpatient Hospital	1	0	0
Physical Therapy	1	1	0
BHT/ ABA Therapy	0	0	1
PCP	0	1	0
Total	**33**	**32**	**2**

The frequency of each outcome is charted below as a percentage within each provider type:



Analysis, Barriers, and Proposed Actions/Solutions (MC)

- **Grievances:** The volume of grievances remained relatively constant throughout 2018; grievances dipped slightly in Q2 (from 184 in Q1 to 159 in Q2) but increased back to 189 in Q4. Grievances related to Quality of Care increased from 48 grievances (26%) in Q1 to 65 grievances (43%) in Q4.

Other than Quality of Care, no other categories had significant changes. The increase in Quality of Care grievances has not been attributed to a particular issue or provider.

- **Appeals:** The volume of both medical and pharmacy appeals decreased throughout the year. Interestingly, although the volume of pharmacy appeals decreased from 54 appeals in Q1 to 42 appeals in Q4, the percentage of pharmacy appeals (compared to other services) increased from 39% in Q1 to 59% in Q4. This is likely a result of the significant decrease in other types of appeals. For example, the second-largest category of appeals, Durable Medical Equipment, decreased from 27 appeals (20%) in Q1 to only 13 appeals (18%) in Q4.

- **Rate of Overturned Appeals:** The rate of overturned appeals related to medical services has remained relatively constant; it increased from 43% in Q1 to 52% in Q2 but decreased back to 47% in Q3 and 48% in Q4. The rate for pharmacy appeals followed as similar pattern, increasing from 50% in Q1 to 61% in Q2, but decreasing to 54% in Q3 and 45% in Q4. As stated in the section regarding the overturned appeal rate for CareAdvantage CMC, HPSM meets monthly to conduct an interdisciplinary retrospective review of each case in order to identify trends and areas for improvement.

NCQA Data Collection and Grouping

Data Methodology

- For all Medi-Cal members, including those covered under CCS, the National Committee for Quality Assurance (NCQA) requires specific data collection and grouping standards, which we are including for Medi-Cal and CCS members only.
- In the tables below, grievances and appeals are separated based on whether they are related to Behavioral Health services, and further broken down in the categories NCQA requires. Behavioral Health includes services provided by San Mateo County Behavioral Health and Recovery Services (BHRS) to treat mild-moderate mental health diagnoses as well as services provided by Magellan Health to treat members with autism spectrum disorder and related diagnoses
    - *Note:* For the Q2 2018 report, the rate per 1,000 members was calculated using the number of members enrolled in Medi-Cal or CCS, not all of whom received behavioral health or other healthcare services. However, for this report we have calculated the rate of complaints per 1,000 members using the number of members who received services from BHRS or Magellan as the denominator. In this way, members who are not utilizing behavioral health services are not included in the rate and it is therefore a more accurate reflection of member experience.
    - The limitation in the data is that the BHT component could potentially include members covered by Healthy Kids. However, the number of Healthy Kids members utilizing such services is small, and there is no expected impact on the rate of complaints.

Goal Rates

In general, the goal rate of complaints per 1,000 Medi-Cal members is set at 2.75 and the goal rate per 1,000 CCS members is set at 5.6. These goal rates include all grievances and appeals for all services, not only those related to behavioral health; they are also calculated based on enrollment, not utilization of services.

In separating out behavioral versus non-behavioral health complaints, the G&A Unit has established separate goal rates in order to account for the more limited denominators in each of the data sets below.

Based on the data gathered for Q1 and Q2 2018, the G&A Unit has set the following goal rates for all non-behavioral health grievances and appeals. The goal for non-behavioral health services is set closer to the overall goal by line of business (2.75 complaints per 1,000 members for Medi-Cal and 5.6 per 1,000 for CCS).

	Goal Rate per 1,000 Members	Rate in Q1 and Q2 of 2018, based on enrollment
Non-Behavioral Health: Grievances	4	3.2
Non-Behavioral Health: Appeals	2	2.3

For behavioral health services, the rate of complaints during 2017 was calculated taking utilization into account:

	Goal Rate per 1,000 Members	Rate in 2017, per utilization
Behavioral Health: Grievances	1.5	1.97
Behavioral Health: Appeals	1	0.09

In 2017 HPSM received 1.97 behavioral health grievances for every 1,000 members using behavioral health services. Based on this baseline, we have increased the goal rate to 1.5 grievances.

Note: BHRS has initiated changes to their utilization management process, intended to bring BHRS further into compliance with state regulation. These changes are expected to result in an increase in denials for behavioral health services, which will result in an increase in appeals, at least in the short term. In 2017, BHRS and Magellan only received 0.09 appeals per 1,000 members utilizing behavioral health services. This is expected to increase in 2018 and 2019. The rate of appeals is not expected to change for non-behavioral health services.

Medi-Cal and CCS Behavioral Health Grievances

	Q3		Q4		Goal
	Complaints, Total	Complaints per 1000 members	Complaints, Total	Complaints per 1000 members	
Access	5	0.33	0	0	n/a
Attitude and Service	1	0.07	1	0.07	n/a

Billing and Financial Issues	0	0	0	0	n/a
Quality of Care	3	0.20	6	0.42	n/a
Quality of Practitioner Office Site	0	0	0	0	n/a
Total Complaints	**9**	**0.59**	**7**	**0.49**	**1**

These rates are based on members utilizing these services, not enrollment.

Medi-Cal and CCS Behavioral Health Appeals

	Q3		Q4		Goal
	Complaints, Total	**Complaints per 1000 members**	**Complaints, Total**	**Complaints per 1000 members**	
Access	8	0.53	2	0.14	n/a
Attitude and Service	0	0	0	0	0
Billing and Financial Issues	0	0	0	0	0
Quality of Care	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0
Total Appeals	**8**	**0.53**	**2**	**0.14**	**1**

These rates are based on members utilizing these services, not enrollment.

Note: HPSM does not receive appeals on any of the NCQA categories except "Access."

Medi-Cal and CCS Non-Behavioral Health Grievances

	Q3		Q4		Goal
	Complaints, Total	**Complaints per 1000 members**	**Complaints, Total**	**Complaints per 1000 members**	
Access	211	1.96	213	2.03	n/a
Attitude and Service	111	1.03	121	1.15	n/a
Billing and Financial Issues	49	0.46	31	0.29	n/a
Quality of Care	38	0.35	56	0.53	n/a
Quality of Practitioner Office Site	0	0	1	0.01	n/a
Total Complaints	**409**	**3.8**	**422**	**4.01**	**4**

Medi-Cal and CCS Non-Behavioral Health Appeals

	Q3		Q4		Goal
	Complaints, Total	Complaints per 1000 members	Complaints, Total	Complaints per 1000 members	
Access	85	0.79	70	0.67	n/a
Attitude and Service	0	0	0	0	0
Billing and Financial Issues	0	0	0		0
Quality of Care	0	0	0	0	0
Quality of Practitioner Office Site	0	0	0	0	0
Total Appeals	**85**	**0.79**	**70**	**0.67**	**2**

Note: HPSM does not receive appeals on any of the NCQA categories except "Access."

Analysis, Barriers, and Proposed Action:

Across all categories, the rate of grievances and the rate of appeals fall within the established goal rates. Therefore, no corrective action is needed at this time.

Healthy Kids, HealthWorx, ACE, and CCS

Number of Appeals and Grievances (Complaints) Received for Other Lines of Business

LINE OF BUSINESS		Q1	Q2	Q3	Q4	TOTAL
HEALTHY KIDS						
Appeals	**Expedited**	0	0	0	0	0
	Standard	1	0	0	1	2
Grievances	**Expedited**	0	0	0	0	0
	Standard	5	2	10	4	21
Healthy Kids Subtotal		**6**	**2**	**10**	**5**	**23**
HEALTHWORX						
Appeals	**Expedited**	0	0	0	0	0
	Standard	0	8	2	8	18
Grievances	**Expedited**	0	0	5	0	5
	Standard	2	3	0	4	9
HealthWorx Subtotal		**2**	**11**	**7**	**12**	**32**
ACE						
Appeals	**Expedited**	1	0	1	0	2
	Standard	4	1	0	4	9
Grievances	**Expedited**	0	0	0	0	0
	Standard	7	5	10	12	34
ACE Subtotal		**12**	**6**	**11**	**16**	**45**
CCS						
Appeals	**Expedited**	1	3	3	0	7
	Standard	5	3	6	5	19
Grievances	**Expedited**	0	0	0	0	0
	Standard	5	3	14	7	29
CCS Subtotal		**11**	**9**	**23**	**12**	**55**

Types of Grievances for Healthy Kids, HealthWorx, ACE, and California Children's Services (CCS)

CATEGORY	HK	HW	ACE	CCS	TOTAL
Access	0	0	0	2	2
Availability	0	0	1	0	1
Billing	1	1	6	2	10

Customer Service	2	2	1	1	6
Quality of Care	1	1	4	2	8
TOTAL	**4**	**4**	**12**	**7**	**27**

Resolutions Within 24 Hours of Receipt

The following reflect complaints that were resolved by HPSM staff within 24 hours of the member informing HPSM of the complaint. These complaints are not included in the count of grievances in the tables above, and do not enter the formal grievance process.

- **24 - Hour Resolutions, by Type of Service**

Types of Service	Q1	Q2	Q3	Q4	Total
Medical Services/Supplies	7	10	10	10	37
Prescription Drugs	15	14	18	17	64
Total	**196**	**224**	**28**	**27**	**475**

- **24 - Hour Resolutions, by Category**

Category	Medical Grievance	Pharmacy/Drug Grievance
Access	4	15
Availability	3	0
Billing	2	2
Customer Service	1	0
Grand Total	**10**	**17**

Primary Care Provider (PCP) Changes by Provider

Reason for PCP Change	Number of Changes in Q4 2018
Difficulty In Obtaining An Appointment.	26
Poor Service	43
Provider And Patient Incompatible	3
Provider's Attitude/Atmosphere	3
Total	**75**

A total of 75 members requested to change their assigned PCP during Quarter 4 due to dissatisfaction. Members switched away from a total of 30 different PCPs. Of those, 15 were clinics and 15 were individual providers. For 5 providers, 5 or more members requested to switch away from their practice. All of them were clinics, as opposed to individual physicians.