2016 Quality Awards Winners

- Methodology (PDF)
- Innovation Award Proposal Summaries (PDF)

Outstanding Performance Award 2016

Small Scale Medi-Cal Plan – San Francisco Health Plan
Medium Scale Medi-Cal Plan - Central California Alliance for Health
Large Scale Medi-Cal Plan - CalOptima

Most Improved Award 2016

Greatest Improvement in Quality Strategy Focus Areas
Molina, Imperial County

Most Improved Award 2016

Greatest Improvement in One Year
Molina, Imperial County

Innovation Award 2016

Health Plan of San Mateo
Community Care Setting Pilot

Innovation Award 2016 - Runner Up

CareMore Health Plan
Non-emergency Medical Transportation: Delivering Care in the Era of Digital Transportation Companies
Quality Awards Criteria and Methodology
HEDIS Reporting Year 2016

Introduction

In 2015, the California Department of Health Care Services (DHCS) significantly changed the structure of the quality awards methodology for the Medi-Cal Managed Care program to recognize a broader array of achievements and to highlight quality improvement efforts among its Medi-Cal managed care health plans (MCPs). The following quality award categories have been adopted for the 2016 award year based on performance rates for the 2015 Healthcare Effectiveness Data and Information Set (HEDIS) measures, and are intended to highlight MCPs that have excelled in improving health care quality for the now over 10.5 million managed care beneficiaries receiving services.

Goals

- To promote excellence in the provision of health care services by recognizing MCPs for outstanding achievements in the improvement of health care quality and population health.
- To broaden the criteria used for evaluation to reflect changes due to expansion of managed care into all 58 counties of California, and the addition of new populations to the Medi-Cal Managed Care program.
- To encourage the sharing of best practices among MCPs by highlighting achievements in quality improvement.
- To encourage innovative interventions that advance health quality, and recognize efforts that advance health equity.

Minimum Award Eligibility Criteria

1) MCP must have submitted HEDIS data on time for auditing purposes during the specified reporting period.
2) MCP must have three or fewer measures below the MPL to be eligible for the Outstanding Performance Award.
3) MCP must have no entries of Not Reported (NR) on any External Accountability Set (EAS) measure.
4) MCPs that have been found to be in violation of federal or State laws, regulations, or other requirements set forth in guidance such as All Plan Letters, or are under a DHCS Quality Corrective Action Plan (CAP) during the measurement year and have not met the established milestones, may not be eligible. MCPs under a newly issued Quality CAP may not be eligible.
Quality Awards Categories

1) Outstanding Performance Award 2016
   (3 awards based on enrollment clusters)
   ➢ Award the MCP with the best overall HEDIS performance in each cluster. DHCS grouped MCPs into three clusters (small, medium and large) by enrollment size as reported for the end of calendar year 2015. Clusters were determined using Statistical Analysis System (SAS) software.
   ➢ DHCS applied a point system similar to the Aggregated Quality Factor Score as the basis for determining the MCPs with the highest scores based on HEDIS performance.
     • Points for each indicator are computed from the 22 distinct EAS indicators for which DHCS holds MCPs to the Minimum Performance Levels (MPLs) to calculate an overall score for each reporting unit.
     • Scores at the reporting unit level are aggregated to calculate the total score for the MCP.
     • Calculation is repeated for all three clusters.

2) Most Improved Awards 2016
   (2 awards)
   ➢ Greatest Improvement in Quality Strategy Focus Areas
     Award the MCP Reporting Unit with the most significant improvement from the prior year based on performance in four Quality Strategy Focus Areas:
     1. Comprehensive Diabetes Care (an average of 6 indicators)
     2. Controlling High Blood Pressure
     3. Childhood Immunizations Status – Combination 3
     4. Prenatal and Postpartum Care – Postpartum Care
     • Plan reporting unit level scores for the QSFAs are aggregated for a total MCP score.
   ➢ Greatest Overall Improvement in One Year
     Award the MCP Reporting Unit with the most significant improvement from the prior year based on performance across all EAS Indicators for which DHCS holds MCPs to the MPLs.
3) **Innovation Award**  
*(2 awards)*

- **Innovation Award 2016**
- **Innovation Award 2016—Runner Up**

  Innovation Awards are aimed at highlighting innovative interventions by the MCPs intended to improve the quality of health care for Medi-Cal beneficiaries.

  - MCPs submitted brief descriptions of the intervention(s) to DHCS.
  - DHCS released all submissions to the MCPs for a vote using SurveyMonkey.
  - DHCS staff voted to resolve any ties between submissions.
  - A winner and runner up were selected based on total MCP and DHCS votes.
Second Annual Innovation Award for Medi-Cal Managed Health Care Plans

January 2017
2016
Award Winner
Health Plan of San Mateo
Community Care Settings Pilot
(CCSP)

Runner-up
CareMore Health Plan
Non-emergency Medical Transportation: Delivering Care in the Era of Digital Transportation Companies
The intent of the Innovation Award is to highlight the innovative interventions developed by our Medi-Cal Managed Care Health Plans (MCPs) that strive to improve the quality of health care for Medi-Cal beneficiaries. By highlighting these interventions DHCS hopes to facilitate and encourage the sharing of best practices.

MCPs were allowed to submit two nominations for the Innovation Award. The nominations needed to include a description of the target population, the scope of the problem, a description of why the intervention was innovative, and any outcomes or results of the intervention if available.

MCQMD reviewed all of the submitted nominations and provided the summaries of the nomination to MCPs for voting. MCPs were asked to submit one vote, but were not allowed to vote for their own MCP.

DHCS received fourteen nominations from ten MCPs.
**AWARD NOMINATION SUMMARIES**

### Anthem Blue Cross

1. **Management of Persistent Medications (MPM) utilizing “standing orders**

   With the need to manage patients who are on persistent medication in order to reduce the risk of adverse medication events from long-term medication use, hospitalization, and emergency room visits, Anthem identified a solution which required partnering with a Federally Qualified Health Center (FQHC), Primary Care Provider (PCP), and Pharmacist, to develop a clinical pathway to create an innovative solution to meet care needs of the patients. The pathway consists of the PCP identifying and flagging the patients requiring lab studies. Utilizing a “standing order” by the PCP, the Pharmacist then implements the lab order when the patient picks up their prescription for ACE, ARB, or Diuretic. The patient then immediately has lab studies done, and the results go directly to the PCP for evaluation and medication management. This approach provides opportunity for patient education and compliance for lab monitoring. The intervention removes the barriers that affect patients not accessing care by reducing multiple locations for care. As of July 2016, results have shown there is an 88% success rate. The intervention is ongoing into 2017 and the FQHC will implement this intervention at two of its other clinic sites.

### Care 1st Health Plan

**Home Pilot & Long Term Care (LTC) Community Transitions**

A key goal of the Coordinated Care Initiative (CCI) is to shift care delivery from institutional settings to the community, to ensure that beneficiaries are getting the right care at the right time and in the right place. Care 1st began conducting LTC facility visits to meet with its approximately 3,000 institutionalized members in Los Angeles (LA) and San Diego (SD) counties in July 2015 to verify admissions and readmissions, and to identify members who could potentially safely transition to the community. In April 2016, Care 1st launched the Care 1st at Home Pilot, which is an enhanced version of the California Community Transition program, for Cal MediConnect (CMC) members. Since that time, Care 1st has transitioned 10 CMC members, for a total of 115 transitioned to the community. Care 1st developed a partnership with the LA LTC Ombudsman program (LTCOP) and, in the Home Pilot, we have enhanced the California Community Transitions program, and utilized a State-approved Preference Interview Tool (PIT) to screen members for potential repatriation to the community, and work closely with transition vendors. Claims data was used to calculate 105 Managed Long Term Services and Supports (MLTSS) members and 10 CMC members (115 total) six months prior to transition and six months after transition. The average cost for MLTSS members was $17,699 PMPM and post-transition was $6,283 PMPM. As for the CMC members the average cost PMPM pre-transition was $39,252 and post-transition was $200.
CareMore Health Plan

Nonemergency Medical Transportation (NEMT): Delivering Care in the Era of Digital Transportation Companies

The federal government spends approximately $2.7 billion annually on NEMT yet long wait times are the norm and 3.6 million people annually miss care due to transportation barriers. CareMore focused on areas of the highest chronically ill Medi-Cal or Dual Medi-Cal/Medicare patients. CareMore partnered with Lyft, and has introduced better results at lower costs. The innovative application of the Lyft technology and business model to healthcare transportation is a new and sensible approach. As published in JAMA, patient wait times have decreased by 30%, costs by 32% and satisfaction is at 80% and improving.

CenCal Health

1. Co-branded Cervical Cancer Screening Reminder Mailing

Statewide health plans have seen an overall decrease in HEDIS performance for the Cervical Cancer Screening measure in recent years. Due to the Affordable Care Act Medi-Cal expansion, in particular, CenCal Health has had a 97% increase in members who are newly enrolled since 2013. Newly enrolled members likely have not completed recommended preventive healthcare visits or screenings, such as cervical cancer screening. In the fall of 2015, CenCal Health partnered with the American Cancer Society (ACS) to create a co-branded mailing regarding the importance of cervical cancer screening. Partnering with a non-profit nationwide advocacy group such as ACS is a unique approach because the ACS is the most trusted source for cancer information (Harris Interactive, 2008). CenCal Health targeted female members aged 21 to 65 who have not had a cervical cancer screening in the last three years. The total sample was 22,340 households; 378 members were included from the 2016 HEDIS sample for Cervical Cancer Screening. Of those 378 members, 106 completed their cervical cancer screening prior to the end of 2015, which is a 28% success rate. As a result, CenCal Health achieved a performance rate above the nationally established HEDIS minimum performance level, thereby improving the quality of healthcare services delivered to members.

2. Heart SMART Congestive Heart Failure Disease Management Program

According to the Center for Disease Control and Prevention, heart failure accounts for 5.7 million deaths annually in the US and 50% of people die within 5 years of diagnosis. Heart failure is associated with high medical costs due to emergency department visits, hospital readmissions, medications and medical treatments and procedures. In the Fall of 2015, CenCal Health created a Heart SMART program to assess its member’s needs and provide customized health and monitoring education. Additionally, CenCal Health provided care management and arranged healthcare services with local agencies. CenCal also partnered with a tele-monitoring program, in which CenCal Health refers eligible members for in home telephonic monitoring of essential vital signs (weight, blood pressure, and pulse oximetry). The Heart SMART program focused on members aged 21 and older who were identified with a cardiovascular condition (members aged 20 and under with a cardiovascular condition were referred to the state’s CCS program). Heart SMART is innovative because an experienced clinical Nurse Practitioner (NP) oversees the development of the program. The NP works directly with our network providers and members in order to improve the quality of care in accordance with AHA clinical practice guidelines for Congestive Heart Failure (CHF) and Coronary Artery Disease. Furthermore, CenCal Health developed a CHF toolkit, provided motivational interviewing, and the teach back method to assure members understood their medical condition and treatment to decrease emergency and hospital readmission. Outcome data is not currently available but a combination of ED/hospital data will be reviewed along with other tools that evaluate a patients perceived health status and satisfaction with their medical care prior and subsequent to the interventions of the Heart SMART Program.
Central California Alliance for Health

Bridging the Gaps for Patients with Complex Needs

Central California Alliance for Health ("Alliance") designed a collaborative care model with the following entities: Primary Care Provider (PCP), Hospital, and Health Plan to meet the needs for complex Medi-Cal patients by focusing on shared care goals, prioritizing needed resources, and preventing future costs (i.e. emergency department (ED) visits, inpatient visits). Based on the Institute for Healthcare Improvement (IHI) Triple Aim, the goal of the innovation was to develop a program to better coordinate care and address the multiple medical and social needs in an efficient way. Within three months of engagement, participants reduced their Emergency Department visit utilization by 57% and received the appropriate services to address their current needs. For the patients enrolled in the program (34), 79% (27) decreased their ED visits 3 months after enrollment. The average number of ED visits was 4.08 visits, reduced to 1.75 visits (3 months post-enrollment). For inpatient visits, the average number was 1.67 visits, reduced to 0.67 visits (3 months post-enrollment). For those who did not enroll, ED visits averaged 3.63 visits, and increased to 5.46 visits. In addition, referrals to health programs, such as the Alliance Healthy Breathing for Life, had an effect on decreased ED visits (48% - 13 out of 27 patients referred).

Health Net Community Solutions (HNCS)

1. Childhood Immunization Status (CIS) Health Disparity Project

In 2014, HNCS observed statistically significantly lower rates of vaccination coverage for HEDIS Childhood Immunization Combo-3 among Medi-Cal's Russian-speaking Sacramento County membership with, only 0.88% of the population compliant (compared to 37.2% of the English speaking population). In response to this disparity, Health Net’s Cultural and Linguistics Team developed a disparity workgroup, inviting Health Education, Quality Improvement, Public Programs, and Provider Relations, to collaborate on a multi-pronged approach. Through collaborative efforts a community advisory group was formed to support intervention development. This led to HNCS, schools and providers hosting parent workshops at charter schools, developing a Russian-language media campaign (print, public service announcements and radio interviews) and conducting targeted interventions to Russian-speaking children who were not up-to-date on their vaccines. Moreover, HNCS was able to provide multiple educational materials and brochures in Russian on vaccine safety throughout the targeted provider clinics. Findings from 84 surveys administered at 2 parent workshops showed: 1) a decrease in the belief that vaccines are bad for children (15% to 13% between the 2 workshops); and 2) an increase in call to action of 13% (compared to 17% at the 1st workshop) of parents reported they would not vaccinate their children. Results from the tailored educational live outreach calls showed that 59% (of 33) of parents reported their kids were up to date, or that they were scheduling or would schedule immunization appointments. Among those, 28% (2/7) of parents who reported they would schedule or have already scheduled an appointment were confirmed to have appointments scheduled.

2. Perinatal Notification Incentive Program (PNIP)

HNCS identified issues with prenatal and postpartum care including: poor encounter submissions from the Participating Provider Groups (PPGs), limited provider engagement and out of timeframe visits. PNIP is a provider form and faxing initiative that works with the PPGs and their practitioners (OBs/PCPs). This form captures the data for the prenatal visit and postpartum visit and was approved by auditors as administrative HEDIS data, thereby reducing the need for chart review during HEDIS season. The initial prenatal visit form is also used as a notification of pregnancy so that the women are included in prenatal and postpartum care outreach efforts, including high risk OB case management. The PPGs decide how to participate in PNIP by tailoring the program to fit their needs. The incentive payment is made directly to the PPG or directly to the Provider. This incentive is different in that specialists are often not included in health plan incentive programs. PNIP uses a team to promote PNIP and educate the Providers about prenatal and postpartum care HEDIS. Results have shown that the PPGs are more engaged in prenatal and postpartum care;
that correctly coded encounter submissions have increased; and year over year administrative perinatal HEDIS results are improved. The initial prenatal visit forms captured about 32% of the HNCS 2016 delivery volume and the postpartum forms captured about 13%. Since inception, over 1,000 referrals have been submitted to high risk OB case management; this is a much higher volume than prior to PNIP.

Health Plan of San Mateo (HPSM)

Community Care Setting Pilot (CCSP)

HPSM research showed that 10-30% of long term care (LTC) facility residents could live more independently in the community with appropriate medical and social service supports. HPSM also has many members at high risk for nursing facility institutionalization struggling to stay in the community. Shortages of nursing facility beds in this community exacerbated long term care placement issues for hospitals and the MCP. However, expensive housing in the Bay Area makes it difficult to find alternatives for people who may have lost their homes during a long nursing facility stay. HPSM has found alternative housing for participants in assisted living, affordable housing developments, other housing in the community, or helped members stay in their homes. HPSM has created a strong partnership with a range of county and community-based organizations, including: a community based non-profit that provides home and community based services; a non-profit that provides housing location and retention services; County Behavioral Health, Aging and Adult Services, and the Housing Authority; non-profit housing developers; local residential care facilities; and nursing facilities. HPSM has transitioned or diverted 121 members from long term care (59% transitioned from a LTC Facility and 41% have been diverted from a stay in a LTC facility). CCSP has demonstrated substantial cost savings, success in helping members remain in the community, and high levels of member satisfaction. Overall costs for participants were reduced by an average of 54%, or $29,425 per member, measuring all costs in six months post intervention compared to six months prior, and of those members with at least six months experience post intervention, 97% have remained in place.

Inland Empire Health Plan

Desert Clinic Pain Institute-Center for Excellence for Pain Management

In partnership with IEHP, Dr. Tobias Moeller-Bertram and colleagues have established an innovative Center for Excellence in pain management based on a Whole Person Care model. The goal is to treat high risk patients that have failed other treatment, in a comprehensive, holistic and integrative manner to obtain improved function and quality of life. The Desert Clinic offers a three Phase, 12 month evidence-based program involving an integrated and multidisciplinary approach to chronic pain. There are four pillars of this program: Medical Treatment, Behavioral Therapy, Physical Reconditioning and Education. Multiple modalities are utilized based on the patient’s specific needs and individualized treatment plan. These include a spectrum of evidence based interventions delivered on site, ranging from individual and group cognitive therapy, to restorative medicine and conditioning, to alternative therapies such as yoga, mindfulness, medication, massage, acupuncture and other treatment modalities. The patients work with the practitioners, and support staff as well as their peers to develop a community dedicated to their success. This contributes to the high participation rate and member satisfaction. What makes this program exceptional is the unique algorithm developed by Dr. Moeller-Bertram, which stratifies risk by utilizing specific and individual outcome data gathered at intervals throughout the program to diagnose, engage and treat patients with precision. The initial program outcomes at 6 months include a statistically significant decrease in patient’s perception of pain intensity and interference, a significant improvement in their Pain Disability Index, and a decrease in depression symptoms as measured by PHQ-9 scores. Utilization and cost analysis will be forthcoming.

Kaiser Foundation Health Plan

1. Sacramento Geographic Managed Care (GMC) Care Coordination Program

Kaiser’s Sacramento GMC Care Coordination program optimizes total health and patient well-being by coordinating high-quality services for Medi-Cal members. Medi-Cal members often face multiple
complex medical, behavioral, and non-medical, social needs. They often lack the understanding needed to navigate the health care system and as a result, often seek emergency care. This is not only costly to the organization, it is also an ineffective and inefficient way to receive the quality care they desperately need. A multidisciplinary team comprised of member outreach specialists, social workers and RNs (Health Care Coordinators) completes a medical and/or psychosocial assessment, develops and implements individualized plans of care, monitors service delivery, and evaluates outcomes. This team is supported by an in-house pharmacist, physicians, and a data analysis leader. Innovative ideas like coordinating and providing transportation, employing text messaging between Health Care Coordinators and patients, and connecting members to resources through community partnerships are among the standout solutions provided in this program.

As of October 2015, multiple callback attempts to new GMC members have resulted in a higher Initial Health Assessment (physical exam and Individual Health Education Behavioral Assessment) completion rate. The GMC Patient Day Rate (PDR) has decreased 6.5% and emergency department visits have decreased 8.7% (year over year Jan thru Aug). More importantly, several individual success stories have been reported since the inception of the program, citing extreme satisfaction among Medi-Cal patients.

2. Medi-Cal Data Repository (MCDR)

In Medi-Cal, health plans receive files with member specific information from the state and plan partners with varying schedules and formats. This makes it difficult for care delivery and health plan operations teams to obtain information when they need it on services, authorizations or benefits utilized by Medi-Cal beneficiaries without having to look through multiple sources. This impedes the care coordination process and might create unnecessary requests for services and/or authorizations which the members are already utilizing if information is not easily obtainable. Kaiser created the Medi-Cal Data Repository (MCDR), which is a centralized web-based system for care delivery and health plan operation teams at KP to obtain valuable data and information for Medi-Cal members at the point of request. This innovative system is programmed to integrate data files with information such as IHSS, CBAS, MSSP, LTC, MERs, METs, Regional Center, Claims, TARs, coverage and many more. Users can easily log on, enter member CIN, and within seconds obtain information on all the Medi-Cal services the member is utilizing or has been authorized that KP has obtained from the state and plan partners. The system has produced great outcomes such as: a streamlined care delivery process that allows access to care plan notes, IPCs, authorizations etc., which are only a few clicks away, improved quality of care and care coordination, quick and efficient access to information (users no longer have to browse through multiple sources), information obtained is specific to the member the user is seeking to obtain, and data flow and systems optimization so the departments no longer need to store files in their shared drives and file delivery schedules are tracked within the MCDR system.

Kern Health System (KHS)

Monthly HEDIS Trending and Compliance Report

KHS determined providers in their network did not have the information required to proactively identify deficiencies in their HEDIS rates. Because of this information gap, the providers did not have the ability to identify and engage members throughout the year with targeted outreach efforts and track the effectiveness of their outreach efforts. This new tool captures real-time information for the majority of the HEDIS measures using the same HEDIS methodology that is part of the yearly audit. The tool allows providers to identify deficiencies in their rates, create targeted outreach efforts to address the deficiencies and track the effectiveness of their outreach efforts. The report does this by providing monthly information related to their current HEDIS rates and prior year rates so they can track month-over-month and year-over-year changes. The report also contains actionable information by listing all of the members assigned to the provider, which measure(s) the member is part of, and if the member has or has not been successfully engaged during the calendar year. The feedback we have received from the providers so far is very positive. The providers have moved away from being reactive, after the official HEDIS rates are published, to now being proactive throughout the year in addressing identified deficiencies. We will have a better
idea if this new tool correlates into higher HEDIS rates for the providers and KHS after the 2017 HEDIS audit is completed, but initial results are positive.

### Partnership Health Plan of California (PHC)

1. **Partners in Palliative Care (PIPC) Pilot**

   In 2015, Partnership Health Plan of California (PHC) launched a pilot program offering community-based palliative care services. Each of the four pilot sites were required to have an interdisciplinary palliative care team to implement a service delivery model with a range of services (pain/symptom management, advance care planning, case management, round the clock telephonic support, caregiver assessment, spiritual support, etc.). Services were delivered in the patient’s home, over the phone, or through video conferencing. The pilot was designed to test a community-based palliative care model with a small number of provider sites. While hospice services provide some of the same services as palliative care, the pilot program addressed the gap between curative and hospice care for those patients with serious illnesses. The end goal aligned the provisions of care with members’ wishes, supporting better quality of life for members and their families, and improving the value of care provided by PHC. A Qualitative evaluation indicated that pilot site stakeholders found the service delivery model to be responsive to participant needs and that they were able to implement the delivery model components. The quantitative evaluation analyzed the financial viability of the model. Findings showed a decrease in hospital, emergency department, and total plan costs, indicating good financial outcomes for PHC and viability of continued services using this model.

2. **Expanding Diabetic Retinopathy Screening in Primary Clinics**

   Diabetic retinopathy is a highly preventable disease with potentially devastating outcomes if undiagnosed and untreated. Screening to detect the disease is traditionally completed through an exam with an eye care specialist. Despite the significant preventative benefits of screening, rates among diabetic members of Partnership Health Plan of California (PHC) were below identified HEDIS targets. In 2015, PHC launched a program to test the ability of supporting clinics to improve diabetic retinopathy screening (DRS) through the use of digital retinal cameras in the primary care setting and store-and-forward telemedicine. Six primary care clinics applied and were selected to receive retinal screening cameras (purchased and owned by PHC), and clinic staff received training for camera operation and image upload to a web-based, store-and-forward telemedicine platform (EyePACS, LLC). Participating providers contracted with UC Berkeley Digital Health for image interpretation completed by credentialed optometrists. While the use of store-and-forward telemedicine to improve retinal screening rates among diabetic populations in the safety net is not new, PHC enhanced its ability to reimburse providers who offer the screening service by de-limiting the CMS-designated allowable diagnoses code set to include the entire spectrum of ICD-10 diabetic diagnoses codes. To date, participating providers have completed six months of diabetic retinopathy screening. One of the six participating clinics has already demonstrated an overall trended increase in diabetic eye exam screening rate from baseline (La Clinica, North Vallejo). All six providers participating in the project have increased their efforts to accurately track and report diabetic patient data, which has resulted in increased efforts to coordinate patient care between clinics and local eye care specialists, and increased focus on panel management, electronic health record processes, and population health monitoring.