MEDI-CAL QUALITY IMPROVEMENT PROGRAM

FIRST ANNUAL REPORT TO THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
FEBRUARY 2013

INSTITUTE FOR POPULATION HEALTH IMPROVEMENT

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Interagency Agreement #11–88141    October 1, 2011 – September 30, 2012
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Purpose

[INSERT TEXT HERE]
The Medi-Cal Quality Improvement Program (MCQuIP) is a new program established through a 5-year, $4.25 million interagency agreement (IAA) between the California Department of Health Care Services (DHCS) and the UC Davis Health System’s Institute for Population Health Improvement (IPHI). Under this agreement, IPHI, in collaboration with DHCS, is charged with establishing a quality improvement program for the $60 billion per year California Medical Assistance Program (Medi-Cal); developing a systems-level quality management strategy and on-going evaluation for the $3.3 billion, 5-year Delivery System Reform Incentive Payments (DSRIP) Program that is part of the state’s 1115 Medicaid Waiver; conducting a broad review of quality improvement (QI) strategies and methods used by Medicaid and other relevant publicly funded health care programs; supporting the development and management of lifestyle programs and member communication approaches to optimize population health; and providing executive-level strategic advice, thought leadership, and organizational change management within DHCS.

The MCQuIP yielded material results during the first year of the collaboration, October 1, 2011 through September 30, 2012. This report highlights the major accomplishments achieved for each deliverable in the IAA.
Accomplishments

Deliverables A and B
Develop a written QI plan whose aims and priorities reflect shared values and best practices, and which is consistent with the federal Department of Health and Human Services’ National Quality Strategy. Update the QI plan at least annually beginning one year after acceptance of the initial plan.

From April–September 2012, IPHI’s Quality Improvement Expert Consultant (QIEC) and Chief Prevention Officer (CPO) worked with the DHCS Medical Director to complete the first approved draft of the DHCS Strategy for Quality Improvement in Health Care (DHCS Quality Strategy) (Appendix A). The DHCS Quality Strategy, which is closely aligned with the National Strategy for Quality Improvement in Health Care, serves as the Department’s blueprint to improve the health of all Californians, improve quality, including the patient care experience, in all DHCS programs, and reduce the Department’s per capita health care costs. These three linked goals are supported by seven priorities, which include:

1. Improve patient safety;
2. Deliver effective, efficient, affordable care;
3. Engage persons and families in their health;
4. Enhance communication and coordination of care;
5. Advance prevention;
6. Foster healthy communities; and
7. Eliminate health disparities.

After the first approved draft of the DHCS Quality Strategy was completed in June 2012, the CPO worked with the DHCS Medical Director to:

- Develop an internal and external stakeholder input process;
- Develop and deliver PowerPoint presentations on the DHCS Quality Strategy to DHCS executive staff and interns, the statewide stakeholder workgroup, and selected Divisions; and
- Develop and implement a webinar to present the DHCS Quality Strategy to stakeholders statewide. Over 5,000 stakeholders were invited to participate in the webinar, and 181 attended.

Following the webinar, the CPO worked with a DHCS Research Scientist to develop and administer a stakeholder input survey and analyze the data. Plans are underway to use the survey results to guide revisions to the DHCS Quality Strategy.

Deliverable C
Conduct a broad review of QI strategies and methods used by Medicaid and other relevant publicly funded health care programs to the extent allowed by available resources.

Baseline Assessment of QI Activities in DHCS
At the request of the DHCS Director and IPHI QIEC, the CPO conducted a comprehensive baseline assessment of QI activities in DHCS from April–September 2012. The purpose of the assessment was to:
1) establish a Department-wide baseline of QI activities in the clinical, health promotion and disease prevention, and administrative domains;
2) identify quality metrics that were being collected by the Department but were not linked to current QI activities;
3) identify gaps in existing QI activities; and
4) offer recommendations for future QI efforts.
Prior to the assessment, the CPO worked with DHCS staff in the Office of the Medical Director to develop and pilot test a Quality Improvement Survey (QIS). The QIS was administered to 33 Offices and Divisions and 3 subgroups within the Department, representing all major organizational functions. All groups responded to the QIS, with 15 Offices and Divisions completing the survey and 21 groups noting that the QIS did not pertain to them.

A total of 15 clinical, 3 health promotion and disease prevention, and 16 administrative QI activities were identified. Some examples included DSRIP; reducing all-cause readmissions and health-care acquired infections; improving the proportion of Medi-Cal members who get help to quit smoking; and waivers to help those with mid- to late-stage HIV/AIDS, developmental disabilities, and frail seniors to remain in their homes and communities as an alternative to being placed in health care facilities.

Thirty-one metrics, including 14 Healthcare Effectiveness Data and Information Set (HEDIS) measures, were collected by DHCS but were not linked to specific statewide QI activities. In addition, broadly stated gaps in current QI practices (e.g., lack of consistent measurement and translation of data into QI efforts Department-wide) to very specific gaps (e.g., the absence of a comprehensive tobacco treatment plan) were noted.

Respondents also had many suggestions for new QI activities. New QI suggestions involved multiple areas within the Department, including dental care; obesity, tobacco, and alcohol and substance abuse prevention; data, measurement, and modeling; business processes; and QI training. Multiple cross-cutting QI activities were also noted.

A draft report of the assessment, entitled Baseline Assessment of Quality Improvement Activities in the California Department of Health Care Services: Methods and Results (Baseline Assessment), was approved by DHCS (Appendix B). The report will help inform the development of a multi-year DHCS QI implementation plan.

In addition to the findings of the report, the Baseline Assessment offered an opportunity to engage DHCS staff in a dialogue about the DHCS Quality Strategy and QI. During the initial phase of data collection, it was clear that many DHCS respondents either did not see their day-to-day work as QI-related or did not understand the fundamentals of QI. Over the course of working with each respondent and their respective teams, several additional QI activities were identified. Staff also gained an understanding of how their work supports the DHCS Quality Strategy and will contribute to the development of the QI implementation plan. This process has contributed to the foundation for establishing a culture of quality in DHCS.

Quality Improvement Map
Following completion of the preliminary Baseline Assessment report in September 2012, the CPO, with leadership support from the GIIEC, developed a draft QI map linking each of the seven priorities of the DHCS Quality Strategy with relevant DHCS QI activities, measures collected or used by DHCS, DHCS Data Research Committee approved research projects, and the Medicaid Information Technology Architecture. See Appendix C for the draft QI map. The QI map provides a critical foundation for developing the 2013 DHCS Quality Strategy, which will begin to detail specific implementation activities and timeframes during Year 2 of the IAA.
Deliverables D and E
Develop a Systems-level Quality Management Strategy for DSRIP. Provide on-going evaluation of DSRIP, including providing at least semi-annual reports that assess general and specific areas of improvement.

From May-September 2012, IPHI’s Clinical Quality Officer (CQO), with leadership support from the QIEC, provided ongoing technical support and specific recommendations to DHCS and the 21 participating designated public hospitals in order to optimize achievement of DSRIP Program milestones. This assistance was provided in the form of face-to-face and telephone meetings as well as electronic communication. Examples of recommendations made include clarification of issues related to the implementation and interpretation of Clinician and Group-Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) survey, selection of measures related to sepsis mortality and Central Line Blood Stream Infection bundle compliance, and clarification of appropriate measures to utilize for Surgical Site Infections.

The first semi-annual reports from participating public hospitals have been rigorously reviewed and a synthesis of the findings was produced (Appendix D). Individual as well as collective feedback has been provided to hospitals in written format. These feedback reports assess implementation of milestones and address general as well as specific ways to improve reporting and implementation of milestones. Technical assistance and mentoring was provided to hospitals on best practices and strategies to report QI initiatives. For example, a template based on tools from the Institute for Healthcare Improvement (Appendix E) was provided to enable hospitals to qualitatively report on their initiatives and communicate QI challenges, opportunities, and shared learning. The utilization of this template has mutually contributed to the richness of the most recent annual reports, compared to the previous semi-annual reports.

Deliverable F
Convene and lead a multi-disciplinary Medi-Cal Performance Advisory Committee (MPAC). MPAC shall routinely meet about quarterly, and more frequently if needed, and issue periodic reports memorializing its findings and recommendations.

The overarching purpose of MPAC is to advise IPHI and the Department on how to most effectively advance health, clinical quality, and outcomes. Specific goals for the MPAC members include:

1. Review and comment on the Department’s evolving DHCS Quality Strategy;
2. Review and comment on the QI activities currently being pursued by Medi-Cal and identify where additional efforts may be needed;
3. Provide guidance and feedback in the development and implementation of the multi-year QI implementation plan, with special consideration given to building a culture of quality at DHCS and implementing large-scale, sustainable delivery system reforms;
4. Review and comment on DSRIP status reports and advise on how to optimize achievement of QI targets; and
5. Advise on the evaluation and effective implementation of the California Coordinated Care Initiative (California’s Medicare-Medicaid Dual Eligible Demonstration Project), specifically in regards to the federal and state evaluations that are planned for this effort.

From October-May 2012, the QIEC recruited and secured seven members and two ex-officio members to
serve on MPAC, all of whom are known and respected leaders in health care in California (see Appendix F for a list of MPAC members and their biographies).

The first MPAC meeting was conducted on September 7, 2012. The purpose of the meeting was to orient members to the IPHI portfolio of population health and health care projects, and IPHI’s role with DHCS; review and offer feedback on the DHCS Quality Strategy and preliminary findings from the Baseline Assessment of Quality Improvement Activities in the California Department of Health Care Services: Methods and Results; become familiar with large-scale DHCS QI initiatives including DSRIP and the California Coordinated Care Initiative; learn how DHCS is working to improve data systems to drive QI; and discuss disclosures/conflict of interest and committee rules of engagement (see Appendix G for the MPAC agenda). IPHI, in collaboration with the DHCS Medical Director, developed fact sheets for MPAC members on the following DHCS Programs: DSRIP- Designated Public Hospitals, DSRIP-Non-designated Public Hospitals, and the Coordinated Care Initiative.

**Deliverable G**
Support the development and management of lifestyle programs to optimize population health with particular attention to: smoking cessation, nutrition, physical activity, and alcohol/substance abuse.

In advance of developing the DHCS QI implementation plan to improve prevention and foster healthy communities, the CPO began building partnerships and programmatic elements particularly in the areas of nutrition and physical activity. From April-September 2012, the CPO:

- Collaborated with the Department of Social Services (DSS) and the California Department of Public Health’s (CDPH) Network for a Healthy California to determine how DHCS could increase enrollment in the CalFresh food assistance program among the nearly 1.2 million Medi-Cal members who are eligible currently. Plans are underway to promote CalFresh on DHCS’ wellness Facebook page (see Deliverables J and K); link current CalFresh outreach and promotional efforts at DSS and CDPH with the Medi-Cal enrollment and renewal process; work with the managed care plans to promote CalFresh; and link CalFresh enrollment with California’s Health Benefit Exchange.
- Collaborated with two DHCS interns and the Medical Director to develop an obesity screening and counseling protocol for adults and children/adolescents for the Non-Designated Public Hospital DSRIP scope of work. This protocol is consistent with the US Preventive Services Task Force recommendations for obesity screening and counseling. In addition, an overweight screening and lifestyle prescription protocol for adults and children/adolescents was developed based on the First Lady’s Let’s Move Campaign. See Appendix H for a description of the protocols.
- Collaborated with the DHCS Medical Director to mentor a DHCS intern. The intern conducted a literature review on obesity prevention, with an emphasis on clinical prevention. A final report of the review was submitted to DHCS in August 2012.
- Participated in selected meetings for the $10 million, 5-year Medi-Cal Incentive to Quit Smoking Project.

These activities complement the other lifestyle- and prevention-related activities noted in Deliverables A-C, F, and H-M.
Deliverables H and I
Evaluate and analyze the delivery of clinical preventive services, and develop and implement strategies to improve network performance in quality measures in this domain. Identify and encourage adoption of effective population health strategies by DHCS contracted health plans.

From August-September 2012, the CPO led efforts to assess how DHCS contracted managed care plans deliver clinical preventive services. The CPO worked with a DHCS intern to:

2. Review DHCS managed care plan contracts to identify requirements for clinical preventive/health promotion services; and
3. Meet with the DHCS Managed Care Division to determine the extent to which clinical preventive/health promotion services are documented for each health plan.

The results of the assessment showed that there was not a consistent process in place to gather information on how the managed care plans deliver and evaluate their clinical preventive/health promotion services. Plans are underway to establish a system for the Managed Care Division to obtain this information. Specifically, the CPO is working with a DHCS intern, Managed Care Division staff, and the Medical Director to develop and administer a DHCS clinical preventive services/health promotion survey to the managed care plans. The purpose of the survey will be to:

1. Obtain information about administrative oversight of the plans’ health education system;
2. Identify the types of primary, secondary, and tertiary programs and services the plans deliver to Medi-Cal members and the effectiveness of the services;
3. Understand how the plans communicate with members and their families about prevention and health promotion; and
4. Understand how the plans foster healthy communities.

The survey will be administered in Year 2 of the IAA. The results will help DHCS:

- Identify areas for QI in three of the DHCS Quality Strategy priority areas, namely prevention, healthy communities, and engaging members and families in their health;
- Improve the delivery of clinical preventive/health promotion services among the managed care plans;
- Highlight and translate best practices; and
- Establish a system for the Managed Care Division to gather data on clinical preventive/health promotion services on a consistent basis.

Deliverables J and K
Foster partner relationships between DHCS and members through strong bi-directional communication with respect to needs, responsibilities, and preferences related to healthy lifestyle. Design a strong member education, communication, and intervention platform that drives improvement in population health.
One of the priorities of the DHCS Quality Strategy is to engage persons and families in their health. From April-September 2012, IPHI’s CPO and DHCS’ Medical Director began exploring ways to enhance the delivery of education and communication to Medi-Cal members from the state-level, with special attention to lifestyle-related messaging. Several formative steps were taken to inform the direction of a communication and education plan:

1. Social media is a rapidly growing communication channel, and DHCS wanted to understand the extent to which low-income audiences access information through social media websites such as Facebook, Twitter, and YouTube. To explore this topic, the CPO and Medical Director worked with a DHCS intern to conduct a literature review from April-August 2012. The results of the literature review suggested that low-income audiences increasingly use social media sites and access information from smartphones. It was recommended that DHCS create profiles on Facebook, Twitter, and YouTube; create a “follow us” section on the DHCS home page that contains all of the social media sites; create a free text messaging program to send health information to Medi-Cal members; and support social media messaging with community-based events. DHCS has recently made a commitment to support social media, and a workgroup is in the process of drafting DHCS policy on the use of social media Department-wide.

2. As a result of the social media literature review, the CPO has been leading efforts to build and pilot test a wellness Facebook page. Plans are underway to identify content areas, secure relevant and credible content from partner organizations, build a roll-out schedule, pilot test the page with Medi-Cal members, schedule a launch for the page, and develop an evaluation plan.

3. As noted in Deliverables H and I, the CPO is directing the development and administration of a prevention survey to the DHCS managed care plans. One area of assessment is to understand how the managed care plans communicate with Medi-Cal members and their families about prevention and health promotion. The results of the survey will help identify strategic areas of communication and education collaboration between DHCS and the health plans, as well as identify gaps and opportunities for new state-level interventions.

4. Plans are underway by the CPO and Medical Director to collaborate with a Sacramento-based Medi-Cal physician to conduct roundtable discussions with Medi-Cal members. The purpose of the roundtable discussions will be to: 1) identify ways in which DHCS can optimize member and family engagement in health; 2) test social media approaches to stimulate improvements in lifestyle behaviors and link members to community/public health resources; and 3) identify ways to enhance member involvement in shared decision making.

Deliverable L
Support a strong prevention focus across all DHCS programs.

Deliverables A-C, F-K, and M demonstrate IPHI’s efforts to support a strong prevention focus across all DHCS programs. In addition to these activities, the DHCS Medical Director began implementing a journal club to enhance the learning environment in the Department. The CPO worked with the Medical Director to facilitate the discussion of two lifestyle-related journal club topics including obesity and consumption of sugar-sweetened beverages. The discussion of these topics, in addition to the other deliverables noted in this report, has helped to elevate the role of prevention in DHCS programs and among its staff.
Deliverable M
Provide executive-level strategic advice, thought leadership, and technical assistance through in-person, teleconference, and other means.

Recruitment of IPHI Positions
From October 2011-September 2012, the QIEC began building the IPHI team to fulfill the deliverables of the IAA. IPHI:

- Recruited and secured the CPO (Start date: April 2012), Program Manager (Start date: May 2012), and CQO (Start date: May 2012).
- Began recruiting for the Chief Quality Officer, but recruitment was suspended when DHCS decided to secure the position through the State.
- Recruited and began the selection process for the Quality Scientist.

Strategic Advice, Thought Leaders, and Technical Assistance
The IPHI team provided executive- and program-level strategic advice, thought leadership, and technical assistance in the following areas:

- The QIEC (Kenneth W. Kizer, MD, MPH) met with DHCS leadership and staff regularly to provide thought leadership on all aspects of the MCQuIP, and provided direction to the CPO and CQO.
- The CPO (Desiree Backman, DrPH, RD) met with DHCS leadership and staff on a daily basis to provide leadership and support on the DHCS Quality Strategy, Baseline Assessment, QI map, partnership development, prevention and health promotion, member communication approaches, workforce planning and development in the Office of the Medical Director, and IPHI administrative matters. In addition, Dr. Backman contributed to the diabetes QI activity description and provided overarching comments/suggestions for the Adult Medicaid QI Grant proposal recently submitted by DHCS to the Centers for Medicare and Medicaid Services.
- The CQO (Ulfat Shaikh, MD, MPH) met with DHCS leadership and staff on a regular basis to provide technical assistance on the DSRIP program. In addition Dr. Shaikh wrote the “QI Education” section of the Adult Medicaid QI Grant proposal.
- The Program Manager (Allyn Fernandez-Ami, MPH) met with DHCS leadership to provide technical assistance and fiscal management for the IAA.

Added-Value Deliverables
IPHI provided added-value deliverables to meet the needs of DHCS, including the following:

- The QIEC served as a member of the Governor’s Let’s Get Healthy California Task Force, and the CPO provided staff support on DHCS assignments related to the Task Force. Support included weekly meetings, preparation of the National Quality Strategy webinar, and indicator development. The final report of the Task Force, to be released in December 2012, will be used to shape the QI implementation plan.
- The CPO served on a DHCS Strategic Planning subcommittee to review strategies and action plans for the following DHCS commitments: 1) improve the consumer experience so individuals can easily access high-quality health care when they need it, where they need it, at all stages of life;
2) treat the whole person by coordinating and integrating medical, dental, mental health, substance use treatment services, and long term care; 3) improve and maintain health and well-being through effective prevention and intervention; and 4) develop effective, efficient, and sustainable health care delivery systems. The subcommittee suggestions helped inform the refinement of the pending DHCS Strategic Plan.

- In collaboration with the DHCS Medical Director, the CPO provided counsel on DHCS workforce development and expansion, and conducted interviews and recommended candidates for the following positions: Staff Services Analyst, Associate Governmental Program Analyst, Staff Services Manager II, Chief Quality Officer (in process), and Chief Medical Information Officer.
### Medi-Cal Quality Improvement Program

**Interagency Agreement #11–88141**  
**Project Year:** October 1, 2011 – September 30, 2012

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<tr>
<th>Deliverables</th>
<th>Annual Approved Budget ($)</th>
<th>YTD Actual Expenses</th>
<th>*Under/Over Expenditure ($) (%)</th>
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| **Deliverables A and B:**  
Develop a written QI plan whose aims and priorities reflect shared values and best practices, and which is consistent with the federal Department of Health and Human Services’ National Quality Strategy. Update the QI plan at least annually beginning one year after acceptance of the initial plan. | $62,674 | $15,221 | 24% | $- | 0% | $47,453 | 76% |
| **Deliverable C:**  
Conduct a broad review of QI strategies and methods used by Medicaid and other relevant publicly funded health care programs to the extent allowed by available resources. | $32,766 | $15,221 | 46% | $- | 0% | $17,545 | 54% |
| **Deliverables D and E:**  
Develop a Systems-level Quality Management Strategy for DSRIP. Provide on-going evaluation of DSRIP, including providing at least semi-annual reports that assess general and specific areas of improvement. | $326,580 | $- | 0% | $59,331 | 18% | $267,249 | 82% |
| **Deliverable F:**  
Convene and lead a multi-disciplinary Medi-Cal Performance Advisory Committee (MPAC). MPAC shall routinely meet about quarterly, and more frequently if needed, and issue periodic reports memorializing its findings and recommendations. | $117,173 | $34,386 | 29% | $- | 0% | $82,787 | 71% |
| **Deliverable G:**  
Support the development and management of lifestyle programs to optimize population health with particular attention to: smoking cessation, nutrition, physical activity, and alcohol/substance abuse. | $32,766 | $15,221 | 46% | $- | 0% | $17,545 | 54% |
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<td>Deliverables J and K: Foster partner relationships between DHCS and members through strong bi-directional communication with respect to needs, responsibilities, and preferences related to healthy lifestyle. Design a strong member education, communication, and intervention platform that drives improvement in population health.</td>
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<td>Deliverable M: Provide executive-level strategic advice, thought leadership, and technical assistance through in-person, teleconference, and other means.</td>
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<td>$603,695 71%</td>
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*Under expenditure due to delay in hiring staff. Third Quarter start date for staff.

**All DSRIP funds support these deliverables
Appendix A

Strategy for Quality Improvement in Health Care

Toby Douglas, Director

August 2012
Introduction and Background
The Department of Health Care Services (DHCS) is placing a renewed emphasis on achieving high quality and optimal clinical outcomes in all departmental programs. This focus closely aligns with the Department’s mission: to preserve and improve the health of all Californians. To help achieve this mission, we are initiating the DHCS Strategy for Quality Improvement in Health Care (referred to hereafter as the Quality Strategy), which describes the aims, priorities, guiding principles and specific programs, projects, and metrics related to quality improvement.

Why the renewed emphasis on quality and outcomes in DHCS? Most importantly, we have an ethical obligation to provide the best possible care and service to Californians and to be responsible stewards of public funds. In addition, there is a confluence of other drivers. Addressing the issue of limited and declining health care resources, Donald Berwick, MD, former Administrator, Centers for Medicare and Medicaid Services (CMS) has noted on many occasions that the most effective and appropriate way to reduce health care costs is to do so by improving quality.

Another driver is the Department’s five-year 1115 federal waiver entitled, Bridge to Reform, which is improving clinical quality through better coordination of care for vulnerable populations, care delivery redesign, population-focused interventions, and enhanced patient safety. By improving quality, these efforts will help to bend the health care cost curve. Finally, the Affordable Care Act (ACA) (P.L. 111-148)\(^1\) addresses many important health care quality issues in domains such as prevention and health promotion, patient safety, coordinated and complex care, community health, and new care delivery models.

Development of the DHCS Quality Strategy
This initial version of the DHCS Quality Strategy was developed using the National Strategy for Quality Improvement in Health Care (National Quality Strategy or NQS) as a foundation (see Appendix for a summary of the NQS). Because quality improvement is challenging and resource-intensive, it is important to look for areas of vertical alignment—meaning there is consensus at the federal, state, regional, and provider levels. The NQS used an extensive and broad stakeholder engagement process, making it a reasonable starting point for the Quality Strategy. The DHCS Quality Strategy, however, specifically addresses the needs of Californians and focuses on the Department’s programs.

Three Linked Goals
Consistent with the Institute for Healthcare Improvement’s Triple Aim and the Three Aims of the NQS, DHCS’s Quality Strategy is anchored by Three Linked Goals:

1. Improve the health of all Californians;
2. Enhance quality, including the patient care experience, in all DHCS programs; and
3. Reduce the Department’s per capita health care program costs.

The Three Linked Goals are integral to the development, implementation, and ongoing updates of the Quality Strategy.

\(^1\)Patient Protection and Affordable Care Act, Public Law No. 111-148, enacted March 23, 2010.
The Department’s Seven Priorities
The Department’s seven priorities of the Quality Strategy are to:

1. Improve patient safety
2. Deliver effective, efficient, affordable care
3. Engage persons and families in their health
4. Enhance communication and coordination of care
5. Advance prevention
6. Foster healthy communities
7. Eliminate health disparities

The first six priorities are very similar to those in the NQS since they are relevant to public- and private-sector care delivery across many patient populations. The seventh priority, “Eliminate Health Disparities,” is particularly significant for the population served by DHCS programs, including Medi-Cal, and it is very similar to NQS Principle #3—which is a cross-cutting commitment to eliminate disparities due to race/ethnicity, gender, age, socioeconomic status, geography, and many other factors. The order of the seven priorities does not indicate prioritization. All seven domains are of high priority.

Additional commentary and specific examples associated with each priority is provided, below. The examples are not an inventory of current DHCS quality efforts, which are extensive. An inventory is being completed and will be released at a later date. Instead, the examples are intended to illustrate the types of efforts that will be developed fully within the Quality Strategy.

**Improve patient safety.** In spite of the national attention devoted to patient safety since the publication of the Institute of Medicine (IOM) report, To Err is Human: Building a Safer Health System, the burden of death and disability attributable to preventable medical error remains unacceptably high. It is essential that DHCS work closely with stakeholders to design policy and program interventions aimed at reducing health care-acquired conditions. Progress must also be tracked, quantitatively, to ensure the achievement of better health outcomes.

**Examples of Patient Safety Initiatives**

- **Reduce Provider-Preventable Conditions through Implementation of Section 2702, ACA.** Working closely with stakeholders, the Department will reduce preventable adverse events known as Provider-Preventable Conditions (PPCs). PPCs include events such as: a foreign object retained after surgery, advanced pressure ulcers, falls and trauma, and surgical site infections. They also include so-called never events involving surgery: wrong procedure, wrong site, and wrong patient. The State Plan Amendment to implement Section 2702 was recently approved by CMS with an effective date of July 1, 2012.

- **Advance Patient Safety in California’s Public Hospitals.** The Delivery System Reform Incentive Pool (DSRIP) Program is an important component of the 1115(a) Medicaid Demonstration program, “Bridge to Reform.” A significant portion of the DSRIP Program is devoted to patient safety. Details of this work can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/DSRIP1.aspx.

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Two areas of focus for all 17 designated public hospital systems are: (1) improved detection and management of sepsis (serious, life-threatening blood infections); and (2) central line-associated bloodstream infection prevention. In addition, each public hospital system will be implementing other quality improvement initiatives that are relevant to the individual institutions. Each quality improvement focus will: (1) specify a measurable impact on population health; (2) have a strong evidence base; and (3) have the potential to reduce morbidity, mortality, or both in the public hospital population. Beginning July 2013, many of the designated public hospital systems will be launching a program to advance the quality of care provided to HIV/AIDS patients. This quality improvement program is part of the Low-Income Health Program (a component of the 1115(a) waiver).

- **Enhance Maternal Quality of Care and Improve Obstetrical Outcomes.** With over 45% of births covered by Medi-Cal, DHCS is committed to improving maternal quality of care and reducing the rate of elective deliveries prior to 39 weeks of gestation. Research indicates that elective deliveries before 39 weeks increase the risk of significant complications for the mother and the baby, as well as long-term health problems. DHCS will monitor the recently announced federal Strong Start Initiative, a public-private partnership to reduce the rate of early elective deliveries, that will make available a funding opportunity for providers, states and other applicants to test the effectiveness of enhanced prenatal care approaches to reduce preterm births for women covered by Medicaid and at risk for preterm births. In addition, DHCS will partner with the California Maternal Quality of Care Collaborative on efforts to implement clinical best practices and quality improvement techniques to end preventable morbidity, mortality, and disparities in California maternity care.

- **Reduce Neonatal Nosocomial Infections.** Working with the California Perinatal Quality Care Collaborative (CPQCC), DHCS will reduce/eliminate catheter-associated bloodstream infections and other hospital-acquired infections in California Children’s Service (CCS)-approved Neonatal Intensive Care Units (NICUs). In addition to improving patient safety, the opportunity to share best practices with other NICUs will result in improved communication among hospitals and their staffs, and should also produce cost-savings for hospitals.

- **Identify Quality Improvement Opportunities for Neonatal Intensive Care Units.** Through the High Risk Infant Follow-up (HRIF) Quality of Care Initiative, DHCS, in collaboration with CPQCC, has developed a web-based HRIF Reporting System to collect data for the CCS HRIF Program. The reporting system will: 1) identify quality improvement opportunities for NICUs in the reduction of long-term morbidity; 2) allow programs to compare their activities with all sites throughout the state; and 3) allow the state to assess site-specific successes. The system, collecting data on high-risk infants up to their third birthday who are enrolled in the CCS HRIF Program, will add value to the current CPQCC data already collected.

- **Reduce Harm Caused in Hospitals.** DHCS will engage stakeholders to determine the best ways to support the National Partnership for Patients (PfP) Initiative, which aims to: 1) keep patients from getting injured or sicker, and 2) help patients heal without complication. The goals of this public-private partnership are to decrease hospital-acquired conditions by 40% and preventable readmissions by 20% by 2013.

- **Reduce Potentially Preventable Events.** DHCS is committed to improving all aspects of patient safety and the overall quality of care provided to its members. As such, DHCS will place an emphasis on reducing Potentially Preventable Admissions (PPAs), Potentially Preventable Readmissions (PPRs), Potentially Preventable Complications (PPCs), Potentially Preventable
Emergency Department Visits (PPVs), and Potentially Preventable Ancillary Services (PPSs). DHCS will work with its contracted managed care plans and contracted actuary, Mercer Health & Benefits LLC, to develop an evidence-based payment method focused on reducing PPAs as a first step. Development of this method is justified by the need to reduce the incidence of PPEs coupled with the strong evidence base that such reductions are achievable using readily available system change strategies.

**Deliver effective, efficient, affordable care.** It is no longer tenable to simply look at the effectiveness or cost of care in isolation. As embodied in the Department’s commitment to the Three Linked Goals, we must simultaneously consider the perspectives of population health, quality of care, and the per capita cost of care, given finite and shrinking budgets and the need to serve more Californians. The complexities of this challenge will require the development and testing of new models of care such as medical homes and accountable care organizations. Also included in this priority area is the need to eliminate ineffective care as well as fraud and abuse.

**Examples of Effective, Efficient, Affordable Care Initiatives**

- **Improve Care Coordination for Seniors and Persons with Disabilities.** The 1115 Waiver allows DHCS to achieve care coordination, better manage chronic conditions, and improve health outcomes by transitioning the Seniors and Persons with Disabilities (SPD) population into Medi-Cal Managed Care. Beginning June 2011, DHCS began enrolling the SPD population into managed care in 16 counties. The Governor’s 2012-13 budget proposes to expand Medi-Cal managed care statewide starting in June 2013. The proposal combines strong beneficiary protections with centralized responsibility for the broader continuum of care. This combination will promote accountability and coordination, align financial incentives and improve care continuity across medical services, long-term services, and behavioral health services.

- **Integrate Care for Dual Eligible Individuals.** DHCS is developing a pilot program to test innovative payment and person-centered delivery models that integrate the full range of acute, behavioral health, and long-term supports and services for members that are dually eligible for Medicare and Medi-Cal. DHCS will pursue newly available federal funding to support this work through the federal Coordinated Health Care Office. The pilot goals are to: 1) coordinate Medicare and Medi-Cal benefits across care settings; 2) maximize the ability of dually eligible individuals to remain in their homes and communities with appropriate services and supports in lieu of institutional care; and 3) minimize or eliminate cost-shifting between Medicare and Medicaid. DHCS aims to achieve significant efficiencies and improved care for members that are dually eligible.

- **Improve Health Outcomes for Members with Severe Mental Illness and Children with Serious Emotional Disorders.** DHCS is committed to providing safe, effective, efficient, patient-centered care to Medi-Cal members with chronic physical and mental health conditions. Through the California Mental Health Care Management Program (CalMEND) Pilot Collaborative, DHCS has partnered with six California counties to implement care management quality improvement processes at the local level to improve the integration of mental health care and primary care services to Medi-Cal members with severe mental illness (SMI) and children with serious emotional disorders (SED). Going forward, CalMEND hopes to continue its quality improvement efforts in promoting safe and effective use of pharmacotherapy treatment for the SMI and SED populations.
• **Improve Psychotropic Medication Use in Children and Youth in Foster Care.** Building on the experience from the CalMEND project, DHCS is working with the California Department of Social Services (CDSS) to develop a project that seeks to dramatically improve psychotropic medication use within this population by 2015. Abuse of psychotropic medication in children and youth is prevalent among those in foster care. Measures of system improvements will include: improving care coordination, removing barriers and improving the efficient use of a health and education passport, and improving care through strengthening partnerships with youth and families. Key elements of the project include: 1) strategies to engage providers to improve adherence to guidelines for prescribing and administering psychotropic medications; and 2) establishing an engaged partnership among youth and adults. Together, these elements will help to achieve success for the project.

• **Improve Care Coordination for Children with Special Health Care Needs.** DHCS will demonstrate improved care coordination for children with special health care needs through a Demonstration Project using four proposed pilot models: 1) Existing Managed Care Plans; 2) Enhanced Primary Care Case Management; 3) Specialty Health Care Plans; and 4) Provider-Based Accountable Care Organizations. Improved care coordination for this vulnerable population will result in improved health outcomes, improved cost-effectiveness and clearer accountability, improved satisfaction with care, and the promotion of timely access to family-centered care.

• **Control Rising Cost of Care and Improve Quality of Care Through Implementation of Diagnosis-Related Group-Based Hospital Reimbursement.** DHCS, in consultation with stakeholders, is developing a new method of paying for hospital inpatient services in the fee-for-service Medicaid program. Instead of paying hospitals on a cost or charge basis, effective January 1, 2013, hospitals will be paid prospectively on a fixed-price system based upon the diagnosis-related group (DRG) into which a patient is classified. By discouraging unnecessary and potentially harmful procedures, and by encouraging the concentration of complex procedures in facilities that conduct them frequently, DRGs have become widely recognized as one of the most important cost control and quality improvement tools that governments and private payers have implemented.

**Engage persons and families in their health.** There are many reasons why person and family engagement is important. Fundamentally, adult patients have the right to make informed decisions on all aspects of their care. Therefore, they must be engaged actively in health care decision-making. In addition, in many situations (e.g., when the patient is a minor), families must have an active role in health decisions and health management because adherence to lifestyle, medication, behavioral, and other medical recommendations can have a major impact on health.

**Example of an Emerging Engagement Initiative**

• **Leverage Social Media and Other Community Outreach Tools to Engage Members in their Health and Health Care.** Social media tools such as Facebook, Twitter, text messaging, and blogs have the potential to transform relationships between health care providers and their members, as these tools provide opportunities for bi-directional conversations to take place. DHCS recognizes the importance of members taking an active role in their health and health care and is committed to collaborating with partners, including health plans and hospitals, to use social media and other community outreach tools to: (1) enhance transparency; (2) engage
members to solicit their ideas, suggestions, and feedback; (3) connect members to health-promoting resources in their communities; and (4) foster health-promoting social networks.

**Enhance communication and coordination of care.** To achieve coordinated care, it is essential to have rapid, consistent communication of all necessary clinical information among providers. Such communication will help to reduce medical errors and duplicative care and to advance health care quality. Effective communication among providers is especially important for persons with one or more chronic conditions to achieve effective and efficient management of their complex care needs. Enhanced communication and coordination depends primarily on thoughtful system design, which ensures that clinical decision-making can occur with ready access to all necessary information. Technology, such as electronic health records, e-prescribing, and telehealth, can support and facilitate effective coordinated care but will not be effective unless underlying information flow is designed appropriately.

**Examples of Communication and Coordination Initiatives**

- **Increase the Adoption of Electronic Health Records.** Electronic Health Records (EHRs) are a key enabling technology for improving the quality, safety, and efficiency of the health care system. By administering the Medi-Cal EHR Incentive Program, which is part of the Health Information Technology for Economic and Clinical Health (HITECH) Act, it is DHCS’ goal that by 2015, 90% of Medi-Cal providers eligible for incentive payments will have adopted EHRs for meaningful use in their practices. EHR adoption will result in: 1) improved care coordination among Medi-Cal providers, as Medi-Cal providers and members will be able to use available electronic information to make informed health care decisions at the point of care; 2) greater member engagement, as members will have electronic access to their Personal Health Record and self-management tools by 2015; and 3) population health improvement, as member and population health data from EHRs will be shared bi-directionally between providers, DHCS, the California Department of Public Health (CDPH), the Office of Statewide Health Planning and Development, and other approved institutions. Such data sharing will support the essential functions of public health and assessment of the effectiveness, quality, accessibility, and cost of care.

- **Participate in and Contribute to the Development of the Health Information Exchange (HIE) in California.** The HITECH Act was passed nationally as part of the American Recovery and Reinvestment Act to provide the technology framework for care delivery transformation. DHCS is partnering with the other HITECH grantees and partners to develop and implement the policy framework, standards, and funding models for health information to be exchanged electronically to improve outcomes and reduce cost.

- **Optimize Clinical and Administrative Data and Information to Advance the Three Linked Goals.** To provide leadership and coordination for clinical data and information flows, the Department has recently appointed Linette Scott, MD, MPH as Chief Medical Information Officer (CMIO) to work with counterparts in health plans and health care environments to improve clinical and administrative data necessary to monitor success in this priority area. The CMIO will also work across DHCS programs to maximize the impact of initiatives affecting data availability, such as the Medicaid Information Technology Architecture (MITA), HITECH, and Health Insurance Portability and Accountability Act (HIPAA) 5010 and International Classification of Diseases (ICD)-10 conversions. DHCS recognizes the importance of both clinical and administrative data
to monitor progress throughout all aspects of the Quality Strategy.

**Advance prevention.** Advancing prevention encompasses primary, secondary, and tertiary prevention. Primary prevention prevents disease in healthy people. Secondary prevention prevents or reverses disease at an early or precursor stage. Tertiary prevention reduces mortality and morbidity in patients with established disease. Prevention interventions are usually not cost-saving. However, they are frequently cost-effective, meaning they are “good buys” when compared with other alternatives. More importantly, there is an ethical imperative that it is better to prevent rather than treat disease, where possible, because the goal of care at the individual and societal level is to preserve and enhance health.

**Examples of Prevention Initiatives**

- **Reduce the Smoking Rate Among Medi-Cal Members.** Although California has the second lowest smoking rate in the country at 12 percent, 3.6 million Californians are current smokers. Approximately 725,000 of these smokers are adult members in the Medi-Cal program. In addition, smoking rates are disturbingly high among certain subgroups such as low-income residents with diabetes and other chronic diseases. Through a coordinated, system-wide initiative, DHCS will promote adoption of the policy and systems-change strategies outlined in the Public Health Service-sponsored Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update* as recommended by the Agency for Healthcare Research and Quality (AHRQ). By making available the full complement of effective tobacco use treatments, adapting clinical systems to assess all patients for tobacco use, strongly advising those that smoke about the importance of quitting, referring smokers to evidence-based treatments, and training Medi-Cal providers on evidence-based tobacco use treatment strategies, DHCS will reasonably be able to reduce smoking prevalence by 25% among adult Medi-Cal members.

Through the Medicaid Incentives for the Prevention of Chronic Diseases (MIPCD) Program, authorized under section 4108 of the ACA, DHCS will test the effectiveness of providing incentives directly to Medicaid members who participate in the Medi-Cal Incentives to Quit Smoking (MIQS) Project and change their health risks and outcomes by adopting healthy behaviors. The MIQS Project will focus on offering incentives to Medi-Cal members for participation in tobacco cessation services through the nationally renowned California Smokers’ Helpline. MIQS is expected to demonstrate that tobacco cessation benefits, including both pharmacological and behavioral treatments, that are well promoted and barrier-free and that include modest incentives for utilization and retention, are effective in increasing attempts to quit smoking, reducing smoking prevalence, and lowering Medi-Cal health care costs. The MIQS Project term is September 2011 through September 2016.

- **Support the Million Hearts Initiative.** Million Hearts™ (MHI) is a national public-private sector initiative that was launched by the United States Department of Health and Human Services (DHHS) in September 2011 to prevent 1 million heart attacks and strokes over five years. The initiative aims to help millions of Americans improve their heart health by preventing and treating high blood pressure, high cholesterol, and tobacco use. Working with our own public and private partners, DHCS will determine the best way to support MHI through its existing programs and emerging quality improvement initiatives.
**Foster healthy communities.** Approximately half of all preventable mortality is attributable to four lifestyle issues: smoking, poor nutrition, physical inactivity, and alcohol abuse. While these are often viewed as individual choice issues, the most effective means of improving these risk factors in populations is through fostering healthy communities. For example, creation of the social and physical environment in California where non-smoking became the social norm led to a 50% reduction in the smoking rate over 20 years. Therefore, it is essential that the state commit to creating healthier communities to address the obesity and diabetes epidemics (and other public health problems) that threaten to overwhelm the health care system in California. CDPH, voluntary health agencies, community-based organizations, and many other stakeholders play leadership roles in fostering healthy communities. DHCS will work to coordinate with these partners to support this important priority.

**Examples of Collaborations to Foster Healthy Communities**

- **Strengthen DHCS’ Health Promotion Efforts.** DHCS recognizes the importance of the collaboration between medicine and public health, acknowledging that behavioral patterns, social circumstances and environmental exposures oftentimes have unfavorable effects on health outcomes. As such, DHCS remains committed to its continued collaboration with CDPH to bridge the gap between health care and community-based improvements that promote healthy choices and environments. In addition to this collaboration, DHCS has established an Interagency Agreement with the U.C. Davis Institute for Population Health Improvement (IPHI), led by Kenneth W. Kizer, MD, MPH to provide thought leadership and technical assistance. Emphasizing the close working relationship, the Department has designated an IPHI scientist, Desiree Backman, DrPH, RD as Chief Prevention Officer for DHCS, to improve population health by enhancing the link between health care and population health promotion.

**Eliminate health disparities.** Eliminating disparities in care is a key facet of health care quality according to the IOM, and it is a core principle of the NQS. Disparities in health care include, but are not limited to, those based on race, color, national origin, sex, age, disability, language, health literacy, sexual orientation and gender identity, source of payment, socioeconomic status, and geography. The National Health Care Disparities Report is a useful resource to better understand disparities linked to health care and will be used to provide context for the Department’s efforts to eliminating such disparities.

**Examples of Efforts to Eliminate Health Disparities**

- **Continue to Increase DHCS’ Capacity to Eliminate Health Disparities and Support the Activities of the Office of Health Equity.** DHCS is committed to eliminating disparities in the full continuum of care delivered to its members. As part of this commitment, DHCS will work to both identify and address health disparities using effective intervention and policy. A key partner in this work will be the newly created Office of Health Equity (OHE) within CDPH. Established through legislative mandate, effective July 2012, OHE consolidates DHCS’ Office of Women’s Health, CDPH’s Office of Multicultural Health, Health in All Policies Task Force, the Healthy

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Places Team, and the Department of Mental Health’s Office of Multicultural Services. This reorganization was implemented to better identify and ameliorate health disparities for disadvantaged and underserved communities by examining these issues through a more integrated approach to public health, behavioral health, and health care issues. DHCS recognizes that significant health disparities continue to exist within health care. Working with OHE and other stakeholders, the Department will strive to eliminate disparities in health and health care and to ensure that culturally competent care is provided equitably to those we serve.

**Quality Strategy Guiding Principles**

The DHCS Quality Strategy is anchored in a core set of guiding principles shared by stakeholders throughout California. These principles will guide the achievement of the Three Linked Aims and seven priorities of the Quality Strategy. The guiding principles include the following:

1. **Person-centeredness and family engagement are central to high-quality care.** Health outcomes and patient satisfaction can improve when: (1) patients’ needs, experiences, and preferences are taken into account; (2) they are supported by a strong social system at the provider, community and family levels; and (3) they receive clear, understandable information that enables them to actively participate in their own care. DHCS is committed to improving systems of care to ensure the “whole person” is supported throughout the care delivery process.

2. **Science provides the foundation for policy.** Medicine and population health are rapidly evolving fields. New findings from research can reduce mortality and disability, improve health, and help to bend the cost curve. To accomplish these goals, the Department will use evidence-based approaches, including best practices in quality improvement. A valuable resource is the Quality and Patient Safety section within the Agency for Healthcare Research and Quality (AHRQ) website. The section provides extensive information on consumer assessment, standardized quality methods, quality metrics, the National Quality Measures Clearinghouse, patient safety, quality diagnostic tools for states, and other important topics. Other organizations providing useful resources for quality improvement include the National Committee for Quality Assurance, the National Quality Forum, the Joint Commission, the Institute for Healthcare Improvement, professional organizations, voluntary health organizations and many other public and private entities.

In the area of clinical prevention, the United States Preventive Services Task Force (USPSTF) recommendations have been broadly adopted and are referenced in the ACA. Reflecting the constant advances in clinical sciences, the ACA mandates that the USPSTF provide an annual report to Congress that identifies gaps in the evidence base and recommends priority areas that deserve further examination. To bridge clinical practice and population health, with a focus on the social and environmental determinants of health, the National Prevention Strategy and the Guide to Community Preventive Services provide approaches that have been proven effective.

3. **Integration and coordination of services and systems within the Department and among its partners will accelerate.** Vertical and horizontal integration among the Department’s programs

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and services is essential to positively impact the rapidly changing health care environment. Leveraging the efforts of our partners is equally important in creating an effective, patient-centered, continuum of care for our members. For example, one of the biggest opportunities for improving health care and overall health is improving the way we treat and prevent chronic illnesses. Health care providers can offer recommendations on how to stay healthy, but making changes in diet, physical activity, tobacco use, and other lifestyle behaviors is often difficult without community supports and resources. The Department works to advance close coordination between health care providers and those working to improve the conditions in which people live.

4. **Policy, interventions, and new innovations are designed and implemented with substantive stakeholder engagement and collaboration.** As an entity of state government, DHCS exists to serve the people of California. Certainly patients and beneficiaries of the Department's programs are key stakeholders. Others include, but are not limited to the general public, other units of state government, local government, communities, the provider network, advocacy organizations, and others. DHCS values the voice of its stakeholders and appreciates that collaboration and engagement is necessary to drive innovation and system-wide advancements in care.

5. **Ongoing evaluation and updates of the Quality Strategy represent a commitment to strive for the highest quality and best possible outcomes.** DHCS will continually strive to provide the best possible care to Californians eligible for departmental services. This commitment to continuous quality improvement (CQI) includes:
   - Developing integrated, efficient data systems;
   - Using rapid-cycle learning and improvement;
   - Advancing workforce and organizational development in CQI; and
   - Disseminating quantitative and qualitative evidence.

**Looking Forward**

**Initial Version of the Quality Strategy**

This version of the DHCS *Quality Strategy* is meant to provide an overview of the Department's approach to quality, but will not have all of the detailed intervention methods and metrics that will be included in successive versions. The intent of releasing an overview is to engage stakeholders at the earliest stage of planning. The Department will use conference calls, in-person meetings and presentations, web postings, electronic communications, and other channels that may prove useful for engaging stakeholders.

Once the initial priorities are identified following public comment, the Department will continue to work with stakeholders to further develop the plan, incorporating specific aims, metrics, quality improvement strategies and initiatives, timelines, and evaluation and reporting plans. For the purposes of the *Quality Strategy*, we will focus on quality initiatives that meet the following criteria:

1. Addresses a significant population health issue;
2. There is good evidence that interventions, including program and policy, can improve outcomes and ideally reduce costs;
3. Specific aim(s), with timeframes, are clearly defined;
4. Valid and reliable metrics are employed;
5. Quality improvement management techniques are used; and
6. Ongoing evaluation and reporting are conducted.

To help inform future versions of the *Quality Strategy*, the Department is conducting a comprehensive inventory of its current quality improvement projects, identifying gaps, and developing recommendations for future improvement projects.

**Quality Strategy Coordination**
Neal Kohatsu, MD, MPH, DHCS Medical Director, with DHCS senior leadership, will coordinate the development and implementation of the *Quality Strategy* in close partnership with stakeholders. In addition, DHCS has developed a formal partnership with the U.C. Davis (UCD) IPHI directed by Kenneth W. Kizer, MD, MPH, Distinguished Professor, UCD School of Medicine and the Betty Irene Moore School of Nursing. Dr. Kizer and associates will provide thought leadership, technical assistance, consultation, and training for the Department and will support the development, implementation, and evaluation of the *Quality Strategy*. Dr. Kizer will also assemble and oversee a national caliber advisory group to provide advice on the *Quality Strategy*.

**Summary**
The *DHCS Quality Strategy* is a living document that describes aims, priorities, guiding principles and specific programs, projects, and metrics relating to quality improvement within the Department. The ultimate purpose of the *Quality Strategy* is to improve health, enhance quality, and reduce per capita health care costs. In partnership with stakeholders, we will use the *Quality Strategy* to build and sustain a culture of quality that benefits Medi-Cal members and all Californians.
APPENDIX

Summary of the National Quality Strategy

Overview. As required by the ACA, the Secretary of DHHS established the NQS, which was published in March 2011. The NQS was developed with the engagement of a broad range of stakeholders representing all health care sectors. It serves as a roadmap for improving the quality of care in both the public and private sectors. The NQS will be updated annually and enhanced to provide more detail related to goals, measures, and actions required for each component of the nation’s health care system.

Three Aims. The NQS will pursue three broad aims:

1. Better Care—Improve the overall quality, by making health care more patient-centered, accessible, and safe;
2. Healthy People/Healthy Communities—Improve the health of the United States population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care; and
3. Affordable Care—Reduce the cost of quality health care for individuals, families, employers, and government.

Six Priorities. To advance the three aims, the NQS will focus on six priorities:

1. Making care safer by reducing harm caused in the delivery of care;
2. Ensuring that each person and family are engaged as partners in their care;
3. Promoting effective communication and coordination of care;
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;
5. Working with communities to promote wide use of best practices to enable healthy living; and
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Ten Principles. The NQS is guided by ten principles (available at www.ahrq.gov/workingforquality) that were developed with extensive national stakeholder input. They are:

1. Person-centeredness and family engagement, including understanding and valuing patient preferences, will guide all strategies, goals, and health care improvement efforts;
2. Specific health considerations will be addressed for patients of all ages, backgrounds, health needs, care locations, and sources of coverage;
3. Eliminating disparities in care—including but not limited to those based on race, color, national origin, gender, age, disability, language, health literacy, sexual orientation and gender identity, source of payment, socioeconomic status, and geography—will be an integral part of all strategies, goals and health care improvement efforts;
4. Attention will be paid to aligning the efforts of the public and private sectors;
5. Quality improvement will be driven by supporting innovation, evaluating efforts around the country, rapid-cycle learning, and disseminating evidence about what works;

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6. Consistent national standards will be promoted, while maintaining support for local, community, and state-level activities that are responsive to local circumstances;

7. Primary care will become a bigger focus, with special attention towards the challenges faced by vulnerable populations, including children, older adults, and those with multiple health conditions;

8. Coordination among primary care, behavioral health, other specialty clinicians and health systems will be enhanced to ensure that these systems treat the “whole person;”

9. Integration of care delivery with community and public health planning will be promoted; and

10. Providing patients, providers, and payers with the clear information they need to make choices that are right for them, will be encouraged.

Other National Quality Initiatives

There are two national quality initiatives, both public-private partnerships supported by DHHS that dovetail with the NQS.

**Partnership for Patients (PfP).** The Partnership consists of a range of health care stakeholders (including hospitals, employers, physicians, nurses, patient advocates, state and federal government, and others) committed to developing improved models of care to achieve two goals:

1. Keep patients from getting injured or sicker. By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years.

2. Help patients heal without complication. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased such that all hospital readmissions would be reduced by 20% compared to 2010. Achieving this goal would mean more than 1.6 million patients will recover from illnesses without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

DHHS will be using $1 billion from the ACA to address these goals. It is anticipated that other entities from the public and private sectors also will be committing resources to PfP.

**Million Hearts Initiative (MHI).** The MHI sets the ambitious national goal of preventing 1 million heart attacks and strokes in five years. The interventions will involve public health efforts to encourage healthier nutritional choices as well as improved clinical management of risk factors (targeting the “ABCS”—Aspirin, Blood pressure, Cholesterol, and Smoking cessation) that has been proven to reduce cardiovascular disease mortality and morbidity. Specific goals are listed in the table below:

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<thead>
<tr>
<th>Indicator</th>
<th>2011 Baseline</th>
<th>2017 Goal</th>
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<tr>
<td>Aspirin use for people at high risk</td>
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<td>65%</td>
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<tr>
<td>Blood pressure control</td>
<td>46%</td>
<td>65%</td>
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<tr>
<td>Effective treatment of high cholesterol (LDL-C)</td>
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<td>65%</td>
</tr>
<tr>
<td>Smoking prevalence</td>
<td>19%</td>
<td>17%</td>
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<tr>
<td>Sodium intake (average)</td>
<td>3.5g/day</td>
<td>20% reduction</td>
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<tr>
<td>Artificial trans fat consumption (average)</td>
<td>1% of calories/day</td>
<td>50% reduction</td>
</tr>
</tbody>
</table>
BASELINE ASSESSMENT OF QUALITY IMPROVEMENT ACTIVITIES
IN THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES: METHODS AND RESULTS

Desiree Backman, DrPH, MS, RD
Chief Prevention Officer, Department of Health Care Services and
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Distinguished Professor, UC Davis School of Medicine and Betty Irene Moore School of Nursing and
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EXECUTIVE SUMMARY

The California Department of Health Care Services (DHCS) works closely with health care professionals, county governments, and health plans to provide a health care safety net for California’s low-income persons and families, and persons with disabilities. DHCS is placing an emphasis on achieving optimal clinical outcomes in all departmental programs by eliminating overuse, ineffective services and avoidable complications, and by advancing safe, effective care.

From April through May 2012, a DHCS assessment team conducted an inventory of the Department’s Quality Improvement (QI) activities. The purpose of the inventory was to: 1) establish a Department-wide baseline of QI activities in the clinical, health promotion and disease prevention, and administrative domains; 2) identify quality metrics that were being collected by the Department but were not linked to current QI activities; 3) identify gaps in existing QI activities; and 4) offer recommendations for future QI efforts.

The assessment team developed and pilot tested a Quality Improvement Survey (QIS). The QIS was administered to 33 Offices and Divisions and 3 subgroups within the Department, representing all major organizational functions. All groups responded to the QIS, with 15 Offices and Divisions completing the survey and 21 groups noting that the QIS did not pertain to them.

A total of 15 clinical, 3 health promotion and disease prevention, and 16 administrative QI activities were captured. Some examples included California’s Delivery System Reform Incentive Payments (DSRIP) Program; reducing all-cause readmissions and health-care acquired infections; improving the proportion of Medi-Cal members who get help to quit smoking; and waivers to help those with mid- to late-stage HIV/AIDS, developmental disabilities, and frail seniors to remain in their homes and communities as an alternative to being placed in health care facilities.

Thirty-one metrics, including 14 Healthcare Effectiveness Data and Information Set (HEDIS) measures, were collected by DHCS but were not linked to specific QI activities. In addition, broadly stated gaps in current QI practices (e.g., lack of consistent measurement and translation of data into QI efforts Department-wide) to very specific gaps (e.g., the absence of a comprehensive tobacco treatment plan) were noted. Many suggestions for new QI activities were offered. The new QI recommendations involved multiple areas within the Department, such as dental; obesity, tobacco, and alcohol and substance abuse prevention; data, measurement, and modeling; business processes; and QI training. Multiple cross-cutting QI activities were also noted.

The findings of this report will help inform the development of recommendations to improve the Department’s QI activities and result in a multi-year DHCS QI implementation plan.
INTRODUCTION

Background of the California Department of Health Care Services

The mission of DHCS is to preserve and improve the health status of all Californians. DHCS works closely with health care professionals, county governments, and health plans to provide a health care safety net for California’s low-income persons and families, and persons with disabilities.1

With an annual departmental budget of over $51 billion, DHCS finances and administers a number of health care delivery programs, including the California Medical Assistance Program (Medi-Cal), Children’s Medical Services, and Primary and Rural Health (Figure 1).2 Through its public insurance programs, DHCS also helps maintain the financial viability of critical specialized care services, such as burn centers, trauma centers and children’s specialty hospitals, as well as provides funding to assist hospitals and clinics located in underserved areas and those serving underserved populations.

The largest and most far-reaching DHCS program is Medi-Cal, California’s version of the national Medicaid program. Supported by a combination of federal and state dollars, Medi-Cal serves more than 7.5 million members annually—men, women, and children who otherwise could not afford critical and sometimes life-saving health care.3 More than 400 hospitals and approximately 130,000 doctors, pharmacists, dentists, and other health care providers participate in the Medi-Cal program to provide medically necessary services to Medi-Cal members.

In addition to the core services offered by DHCS, federal health care reform, implemented through the Patient Protection and Affordable Care Act (ACA), is a priority. It will offer Californians access to affordable health care insurance, a consumer-friendly, streamlined process for enrolling in coverage, and an opportunity to improve the quality of health care. DHCS’ 5-year Medicaid Section 1115 waiver, entitled Bridge to Reform, was granted by the federal government in 2011. It allows the Department to prepare in advance of the full implementation of health care reform by covering hundreds of thousands more uninsured people, transitioning the most vulnerable members into managed care, and investing in transforming California’s safety net delivery system.3
Quality Improvement in Health Care

Quality Improvement Imperative

DHCS is placing an emphasis on achieving optimal clinical outcomes in all departmental programs by eliminating overuse, ineffective services and avoidable complications, and by advancing safe, effective care. DHCS’ emphasis on health care quality is driven first and foremost by an ethical obligation to provide the best health care and service to Californians and to be responsible stewards of public funds.

There is also a confluence of other drivers that are catalyzing efforts in quality care. DHCS’ Medicaid Section 1115 waiver is improving clinical quality through better coordination of care for vulnerable populations, care delivery redesign, population-focused interventions, and enhanced patient safety. Likewise, the ACA addresses many important health care quality issues in domains such as prevention and health promotion, patient safety, coordinated and complex care, community health, and new care delivery models. By improving quality, these efforts will help bend the health care cost curve.

Quality Strategy and Quality Improvement Inventory

To accelerate advancements in care, DHCS has produced the Strategy for Quality Improvement in Health Care (Quality Strategy). The Quality Strategy establishes goals, priorities, and guiding principles, as well as highlights existing and emerging DHCS QI initiatives to improve health and patient care, and reduce cost. It aligns with the National Strategy for Quality Improvement in Health Care (National Quality Strategy) and reflects the best evidence-based practice known to date in the areas of patient safety, care delivery, person and family engagement, communication and coordination of care, prevention, healthy communities, and elimination of health disparities.

Prior to launching the Quality Strategy, DHCS conducted a Quality Improvement Inventory (QII) to: 1) establish a baseline of QI projects Department-wide; 2) inform future metrics and health care improvement projects to support the Quality Strategy; and 3) identify areas for improvement in the Department’s health care services and practice.

The report that follows describes the methods and results of the QII. A separate report, entitled Baseline Assessment of Quality Improvement Activities in the California Department of Health Care Services: Recommendations for Action, will provide recommendations for strengthening the Department’s QI efforts in the future. This report will be published subsequently.
METHODS

Quality Improvement Survey

Survey Development

In April 2012, an assessment team in the DHCS Office of the Medical Director developed the QIS to: 1) inventory the current QI activities within DHCS in the areas of clinical care, health promotion and disease prevention, and administration; 2) identify quality metrics that were being collected by DHCS but were not currently linked to QI activities; 3) determine gaps in existing QI activities; and 4) offer suggestions for new QI efforts.

QI was defined as a process designed to raise the standards for the delivery of preventive, diagnostic, therapeutic, and rehabilitative measures in order to maintain, restore, or improve health or health outcomes of individuals and populations. QI projects were required, at a minimum, to have a specific aim(s), baseline metric(s), target metric(s), defined intervention(s), including a specific site(s), and timeline.

Pilot Test

The assessment team invited a sample of 12 DHCS leaders, representing a cross-section of the organization, and one external quality improvement expert to pilot test the QIS. The respondents were asked to offer feedback on all aspects of the survey. The assessment team received feedback to make a few word changes and one pilot test respondent suggested that the QIS should be delivered in an electronic format. The assessment team made all of the recommended changes.

Final Survey

The final QIS consisted of three separate parts to capture the clinical, health promotion and disease prevention, and administrative QI activities. Within each part, respondents were asked to identify the title, aim(s), baseline metric(s), target metric(s), intervention site(s), start date, end date, lead staff, project partners, and funding source for each activity. They were also asked whether the activity was optional or mandatory, whether any reports were available, whether and how performance was tracked at the provider/practitioner or individual/worker level, and whether and how the patient-care experience or client/customer experience was tracked. In the remaining QIS, the respondents were asked to describe: quality metrics that were being collected but were not linked to current QI activities; gaps in the Department’s existing QI activities; and suggestions for future QI efforts (see Appendix A for the final QIS, including instructions, the survey, and a sample of a completed survey).

Data Collection

The QIS, detailed instructions, and a sample of a completed QIS were emailed to the leaders of all 33 Offices and Divisions within DHCS. The Offices and Divisions support all major functions within the Department. Three other leaders, which represented special subgroups within the organization, were also included in the survey distribution list to ensure the most comprehensive response possible (see Appendix B for the DHCS
organization chart, and Appendix C for a list of the Offices, Divisions, and subgroups, and their respective functions within DHCS).

The respondents were asked to work with their respective teams to complete the QIS from April 27—May 18, 2012. To encourage responses and collect complete data for each response, the QIS data collection process was shared at selected staff meetings, three emails were sent to respondents to remind them to complete the QIS, and technical assistance was provided to respondents who had questions about the QIS or required additional follow up to ensure their responses were complete.

**Data Analysis**

The QI activities in the clinical, health promotion and disease prevention, and administrative domains were each summarized into tables to capture key variables, namely the title, specific aims, baseline metrics, target metrics, start date, and end date. Nine QIS responses did not meet the requirements for QI and were therefore excluded from the summary tables. In addition, four QI projects were grouped into pairs and consolidated into two separate projects to eliminate redundancy.

The quality metrics that were being collected by DHCS but were not linked to QI activities were compiled into a list and grouped by program or area of organizational function. Perceived gaps in existing QI activities were grouped into like categories, as appropriate, and a list of responses was compiled. A list of suggestions for new QI activities was also synthesized, compiled and categorized into clinical, health promotion and disease prevention, and administrative domains, and a crosscutting category was included for those activities that likely represented all domains.
RESULTS

Description of Respondents

All 33 Offices and Divisions and 3 subgroups within DHCS responded to the QIS. Fifteen Offices and Divisions completed the survey and 21 groups noted that the QIS questions did not pertain to them. The following provides a list of groups that completed the QIS:

- Administration Division
- Audits & Investigations Division
- Benefits & Waiver Analysis Division
- Director’s Office
- Medi-Cal Dental Services Division
- Medi-Cal Managed Care Division
- Office of Civil Rights
- Office of HIPPA Compliance
- Office of the Medical Director
- Office of Women’s Health
- Pharmacy Benefits Division
- Primary and Rural Health Division
- Systems of Care for Children and Adults Division
- Third Party Liability and Recovery Division
- Utilization Management Division

Clinical, Health Promotion and Disease Prevention, and Administrative QI Activities

A total of 15 clinical, 3 health promotion and disease prevention, and 16 administrative QI activities were described by 12 DHCS Offices and Divisions. Tables 1, 2, and 3 show a description of the QI activities within each domain. Some QI activities are complex and contain many baseline and target metrics. In those cases, a website link is provided to view additional metrics that are beyond the scope of the tables.

To have the most complete picture of QI efforts at DHCS, the assessment team elected to include all activities across the spectrum of QI, from those at the advanced planning stage to others that have been in the field for multiple years. Likewise, activities that directly impacted quality of care and those that contributed distally were included. As a result, activities that had incomplete or empty response fields were accepted as long as there were definitive plans to fully implement them in the near term, and a few administrative activities were included that were smaller in scale and more remote to service delivery.
### Table 1: Clinical QI Activities

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<thead>
<tr>
<th>DHCS Office or Division</th>
<th>Title</th>
<th>Aim(s)</th>
<th>Baseline Metric(s)</th>
<th>Target Metric(s)</th>
<th>Start &amp; End Date</th>
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<tr>
<td>Medi-Cal Dental Services Division</td>
<td>Increasing Children’s Use of Preventive Dental Services and Dental Sealants</td>
<td>1. To increase the rate of children, ages 1-20 years, enrolled in Medi-Cal who receive any preventive dental service by 10 percentage points over a 5-year period.</td>
<td>Rate of children, ages 1-20 years, enrolled in Medi-Cal who received any preventive dental services was 32.6% for children enrolled for any length of time, and 35.7% for children continuously enrolled for at least 90 days.</td>
<td>1. Rate of children, ages 1-20 years, enrolled in Medi-Cal who receive any preventive dental services will increase to 42.6% for children enrolled for any length of time, and 45.7% for children continuously enrolled for at least 90 days.</td>
<td>Start date: Goal 1: 10/1/11 Goal 2: To Be Determined (TBD) by CMS</td>
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<td>End date: Goal 1: 9/30/16 Goal 2: TBD by CMS</td>
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<td>2. To increase the rate of children, ages 6-9 years, enrolled in Medi-Cal who receive a dental sealant on a permanent molar by 10 percentage points over a 5-year period.</td>
<td>Rate of children, ages 6-9 years, enrolled in Medi-Cal in FFY 2012 who received a dental sealant on a permanent molar tooth was 15.2% for children enrolled for any length of time, and 16.3% for children continuously enrolled for at least 90 days.</td>
<td>2. Rate of children, ages 6-9 years, enrolled in Medi-Cal who receive a dental sealant on a permanent molar tooth will increase to 25.2% for children enrolled for any length of time, and 26.3% for children continuously enrolled for at least 90 days.</td>
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<td>DHCS Office or Division</td>
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| Medi-Cal Dental Services Division | Dental Managed Care QI Project | 1. To improve performance by dental managed care plans on several dental quality measures over a one-year period. | 1. Baseline metrics on the following measures are available for each Medi-Cal dental managed care plan:  
   a. Annual dental visit  
   b. Continuity of care  
   c. Use of preventive services  
   d. Use of sealants  
   e. Treatment/prevention of caries  
   f. Exams/oral health evaluation  
   g. Overall utilization of dental services  
   h. Usual source of care | View baseline metrics for each dental managed care plan at www.dhcs.ca.gov. | Start date: TBD  
End date: TBD |
| | | | 1. Target metrics on the following measures are available for each Medi-Cal dental managed care plan:  
   a. Annual dental visit  
   b. Continuity of care  
   c. Use of preventive services  
   d. Use of sealants  
   e. Treatment/prevention of caries  
   f. Exams/oral health evaluation  
   g. Overall utilization of dental services  
   h. Usual source of care | View target metrics for each dental managed care plan at www.dhcs.ca.gov. | |
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<th>DHCS Office or Division</th>
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<th>Aim(s)</th>
<th>Baseline Metric(s)</th>
<th>Target Metric(s)</th>
<th>Start &amp; End Date</th>
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| Medi-Cal Managed Care Division | Internal & Small Group Collaborative QI Projects | 1. To improve the quality of care delivered to Medi-Cal members by DHCS-contracted health plans. QI projects vary by health plan and include areas such as: increasing the number of advanced directives, HIV/AIDS viral load testing, BMI documentation for children and adolescents, rate of prenatal visits during the first trimester of pregnancy, percentage of controlled blood pressure, and communication to improve the patient care experience; improving the rate of postpartum care visits, comprehensive diabetes care, cervical cancer screening among women 21-64 years, and treatment of COPD patients 40 years and older; and reducing health disparities in childhood obesity and rate of children and adolescents discharged to out-of-home placements. | 1. Baseline metrics vary by health plan and QI project. View baseline metrics for each health plan at www.dhcs.ca.gov. | 1. Target metrics vary by health plan and QI project. View target metrics for each health plan at www.dhcs.ca.gov. | Start date: Varies by health plan  
End date: Varies by health plan  
View start and end dates for each health plan at www.dhcs.ca.gov. |
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<th>DHCS Office or Division</th>
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<th>Target Metric(s)</th>
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| Medi-Cal Managed Care Division              | All-cause Readmissions (ACR)               | 1. To reduce the number of all-cause readmissions within 30 days of an acute inpatient discharge for members 21 years and older. | 1. In September 2012, baseline data will be submitted for ACR rates in 3 populations enrolled in the plan for each county including: b. Overall readmission rate c. Seniors and persons with disabilities (SPDs) readmission rate d. Non-SPD readmission rate | 1. Unknown until the baseline has been established. | Start date: 7/1/11  
End date: 5/1/15 |
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<th>DHCS Office or Division</th>
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<th>Baseline Metric(s)</th>
<th>Target Metric(s)</th>
<th>Start &amp; End Date</th>
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| Director’s Office      | California’s 1115 Waiver: Delivery System Reform Incentive Payments (DSRIP) Program | 1. To support California’s designated public hospitals (DPH) in meaningfully enhancing the quality of care and health of the patients and families they serve by transforming their delivery system.  
  
The DPHs will transform their delivery systems to: provide integrated systems of care; offer timely, proactive, coordinated medical homes; provide patients with positive health care experiences; deliver proactive and planned prevention and primary care services for all patients; deliver high-quality care and drive quality, safety, and efficiency; and provide equitable care. | 1. Baseline metrics vary by DPH.  
Baseline metrics for each DPH are under development. | 1. Target metrics vary by DPH.  
Target metrics for each DPH are under development. | Start date: 11/20/10  
End date: 10/20/15 |
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<th>DHCS Office or Division</th>
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<th>Aim(s)</th>
<th>Baseline Metric(s)</th>
<th>Target Metric(s)</th>
<th>Start &amp; End Date</th>
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| Pharmacy Benefits Division | Improve Psychotropic Medication Use for Children and Youth in Foster Care | To achieve improved psychotropic medication use for children and youth in foster care by: 1. Reducing the rate of antipsychotic polypharmacy. 2. Improving the antipsychotic dose prescribed to be within the recommended guidelines. 3. Improving the monitoring of metabolic risk associated with the use of antipsychotics. | 1. Rate/proportion of polypharmacy of two more antipsychotics: 20.4% (2009/2010 data). 2. Rate/dose of antipsychotic dose within age-specific recommended guidelines: No baseline metric because the measure is new. 3. Rate/proportion of children and youth in foster care prescribed with at least one psychotropic medication that will have an annual metabolic risk assessment: No baseline metric because the measure is new. | 1. Reduce the rate of antipsychotic polypharmacy to 15%. 2. 80% of psychotropic medications prescribed for children and youth in foster care will be within the recommended dose range for specified age group. 3. 80% of children and youth in foster care prescribed with at least one psychotropic medication will have an annual metabolic risk assessment and evaluation. | Start date: 7/1/12  
End date: 6/30/15 |
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<th>DHCS Office or Division</th>
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<th>Baseline Metric(s)</th>
<th>Target Metric(s)</th>
<th>Start &amp; End Date</th>
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<tr>
<td>Pharmacy Benefits Division</td>
<td>California Mental Health Care Management Program Collaborative’s Performance Improvement Plan: Improving Antipsychotic Medication Use in the Adult Population</td>
<td>To achieve improved psychotropic medication use in the adult population by: 1. Reducing the rate of antipsychotic polypharmacy. Each county specialty mental health service participating in the collaborative can also decide to include additional aims based on county-specific interventions.</td>
<td>1. Rate/proportion of polypharmacy of two or more antipsychotics: 15.6% (2007 data).</td>
<td>1. Reduce the rate of antipsychotic polypharmacy by 10% from baseline.</td>
<td>Start date: 7/2007  End date: 6/2012</td>
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<tr>
<td>Primary and Rural Health Division</td>
<td>Improve Critical Access Hospitals’ (CAHs) Quality Reviews and Service Delivery through Multi-hospital Benchmarking</td>
<td>1. To achieve at least 75% of California CAHs use of the Kansas Hospital Association Foundation’s Quality Health Indicators (QHi) for benchmarking and reporting purposes. 2. To demonstrate improvement in at least one QHi per hospital.</td>
<td>1. Sixteen (51.6%) of 31 CAHs reported core measures using QHi from 9/1/11-5/1/12. The QHi project focuses on 8 of the 32 core measures. 2. Baseline metrics vary by CAHs and their selected measures.</td>
<td>1. At least 23 of 31 (75%) CAHs reporting core measures using QHi. 2. Target metrics vary by CAHs and their selected measures.</td>
<td>Start date: 9/1/11  End date: 8/31/15</td>
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<td>DHCS Office or Division</td>
<td>Title</td>
<td>Aim(s)</td>
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| Primary and Rural Health Division | Improve CAHs Operational Performance through Support of Onsite Technical Assistance using the Lean Methodology | 1. To support at least seven CAHs participation in at least one Lean project. Lean projects are designed specifically for each hospital. 2. To demonstrate improvement in operational QI/Performance Improvement (PI) measures for each CAH-specific project (i.e., reduced patient wait times, reduced number of days for cash on hand). | 1. Number of CAHs participating in QI or Performance Improvement (PI) activities using Lean methodology. 2. Baseline metrics vary by CAH-specific projects. View baseline metrics for CAHs at www.dhcs.ca.gov. | 1. Seven CAHs completed QI or PI activities using Lean methodology. 2. Target metrics vary by CAH-specific projects. View target metrics for CAHs at www.dhcs.ca.gov. | Start date: 9/1/11  
End date: 8/31/15 |
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<th>DHCS Office or Division</th>
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<th>Baseline Metric(s)</th>
<th>Target Metric(s)</th>
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| Primary and Rural Health Division | CAH Participation in the Medicare Beneficiary Quality Improvement Project (MBQIP) using Selected Measures from the CMS Hospital Compare (HC) Data Reporting Program | 1. To identify areas for QI through the use of CAHs reporting of MBQIP outpatient 1-7 measures.  
2. To demonstrate improvement in one or more outpatient MBQIP measures. | 1. Five (16%) of 31 CAHs are reporting one or more MBQIP outpatient measures to HC. The indicators chosen include pneumonia, heart failure, inpatient and outpatient, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).  
2. Baseline metrics vary by CAH. View baseline metrics for CAHs at [www.dhcs.ca.gov](http://www.dhcs.ca.gov). | 1. Twenty-three (75%) of CAHs reporting all MBQIP measures to HC.  
2. Target metrics vary by CAH. View target metrics for CAHs at [www.dhcs.ca.gov](http://www.dhcs.ca.gov). | Start date: 9/1/11  
End date: 8/31/15 |
| Systems of Care Division | California Children’s Services (CCS) Neonatal Quality Improvement Initiative | 3. To reduce the collaborative’s Central Line Associated Blood Stream Infection (CLABSI) rate by another 25% among the participating Neonatal Intensive Care Units (NICU). | 1. CLABSI per 1,000 line days – 0.8. | 1. CLABSI per 1,000 line days – 0.6. | Start date: Began in 2008 and the current cycle began in 2011  
End date: Current cycle ends in 2013 |
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<th>DHCS Office or Division</th>
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<tr>
<td>Systems of Care Division</td>
<td>Survey and Certification of CCS Medical Therapy Units (MTUs) as Outpatient Rehabilitation Centers (OPRCs)</td>
<td>1. To assure that CCS MTUs meet and continue to meet all OPRC standards.</td>
<td>1. The number of MTUs that were able to qualify initially as OPRC on their first survey compared to those that required plans of correction.</td>
<td>1. The number of MTUs that were able to re-qualify as OPRC on their recertification survey compared to those that required a plan of correction.</td>
<td>Start date: 10/1992  End date: No projected end date</td>
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<tr>
<td>Systems of Care Division</td>
<td>CCS/California Perinatal Quality Care Collaborative High Risk Infant Follow-up Quality Care Initiative (CCS/CPQCC HRIF QCI)</td>
<td>1. To identify infants who might develop CCS-eligible conditions after discharge from a CCS-approved NICU. Improve the neurodevelopmental outcomes of infants served by the CCS HRIF Programs through collaboration between Children’s Medical Services/CCS and the CPQCC.</td>
<td>1-2. Baseline metrics have not been developed due to the formative stage of this project, which includes the development, design, and implementation of the HRIF QCI. Basic demographics and descriptive information on the reported variables (i.e., special service needs, neurologic parameters, developmental testing, medication use, re-hospitalization, etc.) have been collected and are under review to develop baseline and target metrics.</td>
<td>1-2. Target metrics are under development.</td>
<td>Start date: FFY 2006  End date: Ongoing</td>
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<td>DHCS Office or Division</td>
<td>Title</td>
<td>Aim(s)</td>
<td>Baseline Metric(s)</td>
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<td>Systems of Care Division</td>
<td>Payment Adjustment for Provider-Preventable Complications, Including Health Care-Acquired Conditions: Vascular Catheter-associated/ Central Line-associated Bloodstream Infection (CLABSI) in Neonatal and Pediatric Intensive Care Units (NICU/PICU)</td>
<td>1. To implement best practices of central line (CL) insertion and maintenance resulting in a decrease in preventable infections, improving clinical outcomes, decreasing length of stay, and decreasing cost.</td>
<td>1. Explore the relationship between NICU and PICU CLABSI rate and participation in statewide QI targeting CLABSI prevention.</td>
<td>1. Decreasing number of NICUs and PICUs with greater than expected CLABSI rate. 2. Decreasing overall statewide NICU and PICU CLABSI rates. 3. Decreasing overall statewide NICU and PICU CL-days. 4. Narrower distribution of NICU/PICU CLABSI rates. 5. Increasingly strong relationship between application of best practices for CL care and NICU/PICU CLABSI rate.</td>
<td>Start date: 7/1/12  End date: Annual, anticipate multiple years</td>
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<tr>
<td>DHCS Office or Division</td>
<td>Title</td>
<td>Aim(s)</td>
<td>Baseline Metric(s)</td>
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| Systems of Care Division | Payment Adjustment for Provider-Preventable Complications, Including Health Care-Acquired Conditions: Surgical Site Infection (SSI) | To decrease incidence of SSI in 2 conditions: 1. Mediastinitis following pediatric cardiac surgery, excluding hypoplastic heart syndrome, < 30 days of age, and/or delayed sternal closure. 2. Deep wound infection following scoliosis repair in children who do not exhibit neuromuscular disease. | 1-2. Published reports of these SSI and the first year of mandated reporting will provide baseline data. The new requirement for identification of all patients with such infections, not only those with death or serious disability as currently reported, limits validity of baseline data. | 1-2. Decrease in the 2 SSIs, with improved clinical outcomes, including length of stay and decreased cost. | Start date: 7/1/12  
End date: Annual, anticipate multiple years |
### Table 2: Health Promotion and Disease Prevention QI Activities

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<tr>
<th>DHCS Office or Division</th>
<th>Title</th>
<th>Aim(s)</th>
<th>Baseline Metric(s)</th>
<th>Target Metric(s)</th>
<th>Start &amp; End Date</th>
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<tr>
<td>Office of the Medical Director</td>
<td>Medi-Cal Incentives to Quit Smoking (MIQS) Project</td>
<td>1. Increase utilization of the Smokers’ Helpline through the use of appropriate incentives.</td>
<td>1. The Helpline receives an average of 17,500 Medi-Cal callers annually.</td>
<td>1. Increase the number of Medi-Cal callers to the Helpline by 50% to approximately 25,000 calls by 12/31/15.</td>
<td>Start date: 9/13/11 End date: 9/12/16</td>
</tr>
<tr>
<td>Primary &amp; Rural Health Division</td>
<td>American Indian Infant Health Initiative (AIHI)</td>
<td>1. To educate families on health promotion and disease prevention including: tobacco use, nutrition, alcohol and drug use, immunizations, teen pregnancy prevention, prenatal care, and sexually transmitted diseases.</td>
<td>1. 90% of AIHI clinics document the provision of three educational topics as identified in the specific aim.</td>
<td>1. 100% of AIHI clinics document the provision of three educational topics as identified in the specific aim.</td>
<td>Start date: 7/1/09 End date: 6/30/14</td>
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<td>DHCS Office or Division</td>
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<tr>
<td>Systems of Care Division</td>
<td>Newborn Hearing and Screening Program Quality Improvement Learning Collaborative</td>
<td>1. Complete hearing screening by 1 month of age.</td>
<td>1. Screening: No show rate for outpatient screens- 9%; no show rate for diagnostic evaluations- 9%.</td>
<td>1. Screening: Decrease regional no show rate for outpatient screening appointments and diagnostic audiologic appointments to 6%.</td>
<td>Start date: Project began in 2006. Latest aim developed in 2011. End date: No projected end date</td>
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<td>2. Complete diagnostic audiologic evaluation by 3 months of age.</td>
<td>2. Diagnostic: First diagnostic appointment by 3 months of age – 81%.</td>
<td>2. Diagnostic: Increase to 85% the percent of infants who have the first appointment for a diagnostic audiologic evaluation by 3 months of age.</td>
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<td>3. Enroll infants with hearing loss in early intervention services by 6 months of age.</td>
<td>3. Early Intervention: Survey data from the Los Angeles Unified School District Early Start Program and pilot project at the California School for the Deaf, Fremont (CSDF), Early Start Program – no initial data available.</td>
<td>3. Early Intervention: Identify the number and percent of children scoring at or above age level on the MacArthur language assessment at the Los Angeles Unified School District Early Start Program and at the CSDF Early Start Program.</td>
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### Table 3: Administrative QI Activities

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<th>DHCS Office or Division</th>
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<tr>
<td>Administration Division: Human Resources Branch</td>
<td>Family and Medical Leave Act (FMLA) Request Process and Business Workflow Automation System</td>
<td>1. To revise the FMLA forms and procedures; eliminate the need for response letters; reduce the amount of time it takes to complete the response; and create an automated system for the submission of FMLA requests that will reduce paper and processing time.</td>
<td>1. The current FMLA request response turnaround time takes 4-7 working days.</td>
<td>1. Reduce turnaround time by 50% to 2-3 working days.</td>
<td>Start date: 4/1/12</td>
</tr>
<tr>
<td>Administration Division: Human Resources Branch</td>
<td>State Disability Insurance (SDI), Non-Industrial Disability Insurance (NDI), and Leave of Absence (LOA) Request Process</td>
<td>1. To revise the SDI/NDI/LOA forms and procedures; eliminate the need for response letters; and reduce the amount of time it takes to complete the response.</td>
<td>1. The current number of days from the date a SDI/NDI/LOA request is submitted to the date of the SDI/NDI/LOA response.</td>
<td>1. A 25% reduction in the number of days it takes to process responses to SDI/NDI/LOA requests.</td>
<td>Start date: 4/1/12</td>
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End date: 3/30/13
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<th>DHCS Office or Division</th>
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<tr>
<td>Administration Division: Workforce Planning and Development</td>
<td>DHCS University</td>
<td>1. To improve the knowledge, skills, and abilities of the Medi-Cal program managers, senior managers, and executives throughout the Department.</td>
<td>1. No current participants in the DHCS University.</td>
<td>1. Train 50 participants in the DHCS University within the first year of the program. Conduct training transfer surveys to ensure knowledge retention and create a training practicum to help participants demonstrate problem solving skills.</td>
<td>Start date: 2/1/13 End date: Ongoing</td>
</tr>
<tr>
<td>Audits &amp; Investigations Division</td>
<td>Return on Investment (ROI) Manual</td>
<td>1. To quantify the value/results of A&amp;I by comparing cost recoveries, savings, and avoidance against the resources expended to complete the work.</td>
<td>1. Monthly ROI ratio of 1:1 as displayed in a dashboard.</td>
<td>1. Continually increase the ROI ratio and surpass the 1:1 break-even point. Current average ROI is 6:1 (i.e., for every dollar spent, A&amp;I brings back $6 in the form of cost recoveries, savings, and avoidance).</td>
<td>Start date: 2005 End date: Ongoing</td>
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<td>DHCS Office or Division</td>
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<tr>
<td>Audits &amp; Investigations Division</td>
<td>Audits &amp; Investigations Case Development, Tracking, and Referral Flowcharts</td>
<td>1. To fully document the DHCS collective case development, tracking, and referral process.</td>
<td>1. The number of cases monthly leading to subsequent sanctions plus the number of cases monthly referred to the Department of Justice (DOJ) for criminal prosecution.</td>
<td>1. Increase in the number of quality cases developed for subsequent review, audit, and referral to DOJ.</td>
<td>Start date: 12/1/12 End date: Ongoing</td>
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<tr>
<td>DHCS Office or Division</td>
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<tr>
<td>Audits &amp; Investigations Division: Medical Review Branch, Research Section</td>
<td>Individual Provider Claims Analysis Report</td>
<td>1. To increase the accuracy of billing levels for Evaluation and Management (E &amp; M) procedure codes and reduce inappropriate and costly claims.</td>
<td>1. Baseline metrics are the baseline percentages of paid claims by level (there are five different levels for each of the 3 different types of E &amp; M procedure codes).</td>
<td>1. Decrease in the most costly level 4 and 5 claims. A specific target has not been established.</td>
<td>Start date: First report in 1/2010. Second report started in 8/2011. End date: First report completed in 12/2010. Second report will be completed in 7/2012.</td>
</tr>
<tr>
<td>Audits &amp; Investigations Division: Medical Review Branch, Research Section</td>
<td>Medi-Cal Payment Error Study (MPES)</td>
<td>1. To accurately measure the Medi-Cal paid claims error rate for eight different groups of provider/service types (each type is called a strata).</td>
<td>1. Eight payment error rates for each strata expressed as a percentage of payments made in error.</td>
<td>1. There are no specific target metrics. Since the error is derived from a sample, there will be year-to-year fluctuations in the data.</td>
<td>Start date: 2005 and completed every two years End date: Ongoing</td>
</tr>
<tr>
<td>Benefits &amp; Waiver Analysis Division</td>
<td>HIV/AIDS Waiver</td>
<td>1. To provide services that allow persons with mid- to late-stage HIV/AIDS to remain in their homes, rather than hospitals or nursing facilities, by providing a continuum of care, resulting in improved quality of life and the stabilization and maintenance of optimal health.</td>
<td>1. Costs for comparable services in an institutional setting.</td>
<td>1. Demonstrate cost effectiveness by providing the same scope of services at a lower cost than the baseline metric.</td>
<td>Start date: 1/1/12 End date: Waiver renewal submissions after 5 years</td>
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**Report Period Year: 2010**
Average cost per beneficiary in an institutional setting: $144,011

**Report Period Year: 2010**
Average cost per beneficiary enrolled in the HIV/AIDS Waiver receiving home and community based care: $29,094
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<tr>
<td>Benefits &amp; Waiver Analysis Division</td>
<td>Home and Community Based Services Waiver for Californians with Developmental Disabilities (DD)</td>
<td>1. To serve participants in their own homes and communities as an alternative to placing Medicaid-eligible individuals in hospitals, nursing facilities, or intermediate care facilities for persons with mental retardation.</td>
<td>1. Costs for comparable services in an institutional setting.</td>
<td>1. Demonstrate cost effectiveness by providing the same scope of services at a lower cost than the baseline metric.</td>
<td>Start date: 3/29/12 End date: Waiver renewal submissions after 5 years</td>
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<tr>
<td>Benefits &amp; Waiver Analysis Division</td>
<td>Multipurpose Senior Services Program Waiver (MSSP)</td>
<td>1. To foster and maintain independence and dignity in community settings for frail seniors by preventing or delaying their avoidable placement in a nursing facility. MSSP provides services to eligible clients and their families that enable clients to remain in their homes.</td>
<td>1. Costs for comparable services in an institutional setting.</td>
<td>1. Demonstrate cost effectiveness by providing the same scope of services at a lower cost than the baseline metric.</td>
<td>Start date: 7/1/09 End date: Waiver renewal submissions after 5 years</td>
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<tr>
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| Benefits & Waiver Analysis Division     | Pediatric Palliative Care Waiver (PPC)                                | 1. To provide pediatric palliative care services to allow children who have a CCS-eligible medical condition with a complex set of needs and their families the benefits of hospice-like services, in addition to state plan services during the course of an illness. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and family. | 1. Costs for comparable services in an institutional setting. | 1. Demonstrate cost effectiveness by providing the same scope of services at a lower cost than the baseline metric. | Start date: Proposed effective date of 4/1/12  
End date: Waiver renewal submissions after 5 years |

| Director's Office                       | Eligibility and Enrollment for Medi-Cal eligible Californians: Meeting the Goals of the Affordable Care Act | 1. To maximize the enrollment of Medi-Cal eligible Californians. | 1. 1.3 million Californians are currently eligible for Medi-Cal but are unenrolled. | Increase Medi-Cal enrollment by 2.8 million by the end of 2014. | Start date: Open enrollment begins Fall 2013  
End date: Ongoing |
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<tr>
<td>Primary &amp; Rural Health Division</td>
<td>DHCS Tribal Advisory Process Tracking</td>
<td>1. To ensure timely notification to tribes and designees of the Indian Health Program on proposed changes to the Medi-Cal program.</td>
<td>1. Timeline for notifications on proposed changes to the Medi-Cal program is 35 days prior to submission to CMS.</td>
<td>1. Complete notification process according to American Recovery and Reinvestment Act requirements and Service Provision Assessment measures to submit changes within 35 days.</td>
<td>Start date: 10/1/10 End date: Ongoing</td>
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<td>Third Party Liability &amp; Recovery Division</td>
<td>Improve the Accuracy of the Third Party Health Insurance Records in the Medi-Cal Eligibility Data System (MEDS)</td>
<td>1. To improve the accuracy of MEDS Health Insurance System and other health coverage records. 2. To provide verified Medicare/Medi-Cal (duals) eligibility to Medicare Advantage and Medicare Special Needs Plans (SNP).</td>
<td>Prior to the implementation of the Trading Partner Agreements (now $0 contracts) and the associated data match process with DHCS’ 23 trading partners, the Other Coverage Unit employed approximately 50 staff. Their job was to enter data submitted through paper Health Insurance Questionnaires and remove the same data when contacted by county eligibility workers, Medi-Cal providers, or Medi-Cal beneficiaries.</td>
<td>1. Use only primary source information when cost avoiding Medi-Cal claims. 2. Verify each month and update as needed commercial health insurance MEDS records. 3. Remove health insurance records that contradict commercial health insurance data. 4. Provide monthly dual eligibility data to Medicare Advantage and Special Needs Plans with California service area contracts.</td>
<td>Start date: 3/1/03 End date: Ongoing</td>
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<td>Utilization Management Division</td>
<td>Reduction in Contract Staff</td>
<td>1. To reduce the size of billable contract staff by consolidating key data entry functions between field offices.</td>
<td>1. 11 Full Time Equivalent (FTE) contract staff.</td>
<td>1. A shift in Treatment Authorization Request (TAR) processing from paper to e-TAR processing will allow for a reduction in contract staff of 5 FTE, effective July 1, 2012. Further planned improvements in processes will allow for the complete reduction of all contract staff in San Francisco by September 1, 2012, an additional 6.0 FTE. The change in processing and the elimination of contract staff in San Francisco will also result in a 50% reduction in needed lease space in San Francisco.</td>
<td>Start date: 3/1/12 End date: 9/1/12</td>
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Quality Metrics Collected by DHCS but not Linked with QI Activities

A total of 31 quality metrics were collected by 8 DHCS Offices and Divisions, but these metrics were not linked to QI activities at the time of the survey.

- Fourteen Healthcare Effectiveness Data and Information Set (HEDIS) measures were gathered in 2012 from all managed care plans serving Medi-Cal members.
  1. Well-child visits in the 3rd, 4th, 5th, and 6th years of life
  2. Adolescent well-care visits
  3. Child immunization status
  4. Prenatal and postpartum care—Timeliness of prenatal care and postpartum care
  5. Use of imaging studies for low back pain
  6. Cervical cancer screening
  7. Weight assessment and counseling for nutrition and physical activity—Children and adolescents
  8. Comprehensive diabetes care—Eye exam (retinal); Low-density Lipoprotein Cholesterol (LDL-C) screening; LDL-C control (<100 mg/dl); Hemoglobin A1c (HbA1c) testing; HbA1c poor control (>9.0%); HbA1c control (<8.0%); medical attention for nephropathy; and blood pressure control (<140/90mm Hg)
  9. Avoidance of antibiotic treatment in adults with acute bronchitis
  10. Children and adolescents’ access to primary care practitioners
  11. Immunizations for adolescents
  12. Annual monitoring for patients on persistent medications (without anticonvulsant indicator)
  13. Ambulatory care—Outpatient visits and Emergency Department visits
  14. All-cause readmissions

- Six performance measures were collected and reported annually by the local Child Health and Disability Prevention Programs (CHDPs). The measures were used to assist local programs and DHCS in monitoring compliance with specific scope-of-work requirements.
  1. Care coordination—The degree to which the local CHDPs provided effective care coordination to CHDP-eligible children.
  2. New provider orientation—The percentage of new CHDP providers with evidence of QI monitoring by the local CHDP through a new provider orientation.
  3. Provider recertification—The percentage of CHDP providers who completed recertification within the past fiscal year.
  4. Desktop review—The percentage of confidential screening/billing reports reviewed for compliance with the CHDP Periodicity Schedule for Health Assessment Requirements within the past fiscal year as evidenced by desktop review documentation.
  5. Childhood obesity—Prevalence of overweight children in a “critical group” according to the Pediatric Nutrition Surveillance System (PedNSS) Annual Report, and description of local program utilization of PedNSS reports in health care and community venues. “Critical group” was defined as the age and/or race/ethnic group with the highest prevalence of overweight as indicated by Body Mass Index-for-Age at >95th percentile in County/City PedNSS reports.
6. School entry exams (optional)—The percent of children entering first grade in public and private school by school district reporting a “Report of Health Examination for School Entry” or “Waiver of Health Examination for School Entry.”

- Two performance measures were collected and reported annually by the local Health Care Program for Children in Foster Care (HCPCFC). The quality measures were used to assist local programs and DHCS in monitoring compliance with specified scope-of-work requirements.

  1. Care coordination—The degree to which the local HCPCFC provides effective care coordination to eligible children.
  2. Health and dental exams for children in out-of-home placement—The degree to which the local HCPCFC ensured access to health and dental care services for eligible children according to the CHDP Periodicity Schedule for Health Assessment Requirements.

- Five Treatment Authorization Request (TAR) measures were collected and reported regularly by DHCS.

  1. Number of TARs that all Field Offices received.
  2. Time period a TAR remains in the queue for review by a Nurse or Medical Consultant.
  3. Number of TARs that had been auto-adjudicated.
  4. Tracking monthly Pharmacy Consultant TAR reviews that were approved, denied, deferred, or modified.
  5. Quality assurance checks within the Service Utilization, Review, Guidance, and Evaluation application.

- One pharmacy-related measure was collected and tracked by the Drug Use Review Program.

  1. Persistence of beta-blocker treatment after myocardial infarction.

- Three measures were collected to track DHCS administrative processes.

  1. The time it takes to complete internal and external discrimination complaints. The current target is to have an average case processing time of 90 days.
  2. Monitoring the transition from the legacy California Medicaid Management Information Systems (CA-MMISs) to a new computer system that will accommodate new HIPAA health care transactions.
  3. The time it takes to receive, assign, and complete a variety of administrative tasks such as system development notices, operational instruction letters, bill analyses, fair hearing and re-hearing, issue papers, and health care communication procedure coding system reviews.

### Gaps in Existing QI Activities

Three DHCS Divisions and one Office identified five gaps in existing QI activities. These included:

1. A lack of consistent measurement and translation of data into QI projects Department-wide.
2. The absence of any DHCS requirements for Federally Qualified Health Centers and Rural Health Clinics to report medical or dental procedures. This impairs the Department’s ability to fully implement
QI activities that are dependent on the availability of such data.
3. A lack of administrative QI in the Medi-Cal dental program.
4. The absence of a comprehensive tobacco treatment plan, including recommended treatment options and clinical systems change to treat tobacco use. Currently, only two managed care health plans offer the comprehensive coverage recommended by the Agency for Health Care Research and Quality. Comprehensive coverage should include: 1) all seven of the FDA-approved medications for treating tobacco use, including bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and nicotine patch and varenicline; 2) individual, group, and telephone counseling; and 3) elimination of barriers to tobacco treatment benefits, such as co-pays and utilization restrictions.
5. A gap between the Department of Health and Human Services (DHHS) initial core set of pharmacy-related health care quality measures recommended for Medicaid-eligible adults and DHCS’ implementation of these measures. DHCS is in the process of reviewing the measurement gap, and has commenced a process to prioritize the implementation of the DHHS measures.

Suggestions for New QI Activities

A total of 10 DHCS Offices and Divisions offered a wide range of suggestions for new QI activities. One new clinical, 6 health promotion and disease prevention, and 11 administrative QI activities were recommended. There were also 6 QI suggestions that cut across each of the three domains.

Clinical QI Activities

1. Develop and implement a QI activity to reduce morbidity and medical treatment expenditures from diabetes and cardiovascular disease by providing dental care to at-risk members.

Health Promotion and Disease Prevention QI Activities

1. Provide consistent and comprehensive screening, diagnosis, and treatment of overweight and obesity for all children, adolescents, and adults, including preconception care.
2. Implement a comprehensive tobacco use treatment plan.
3. Develop QI activities to reduce alcohol and substance abuse among Medi-Cal members.
4. Develop and implement a QI activity to support dental disease prevention.
5. Develop and implement a QI activity for maternal mortality prevention.
6. Provide screening for intimate partner violence.

Administrative QI Activities

Dental QI
1. Require Federally Qualified Hospital Centers and Rural Health Clinics to report medical and dental procedures to improve the quality, comprehensiveness, and reliability of medical and dental QI.
2. Monitor Medi-Cal’s fee-for-service and managed care dental program.

Data and modeling
3. Collect data to monitor, evaluate, and improve new cost-saving proposals such as the physician visit cap and hearing aid limitation.
4. Enhance the quality of data in the Management Information System/Decision Support System. Expand the data elements in the system and ensure they match the values in the Surveillance Utility Review Subsystem.
5. Improve the quantity and quality of encounter data collected by Medi-Cal’s contracted managed care plans to enhance service monitoring.
6. Implement a system of predictive modeling in order to better identify potentially fraudulent claims and prevent payment of fraudulent providers.

Business Processes
7. Reduce the volume of paper claims that come to Medi-Cal fee-for-service.
8. Develop and implement a plan to transition California’s designated public hospitals from the TAR process for inpatient hospital stays to a TAR-free process subject to DHCS oversight.
10. Improve the process for issuing state plan amendments, requests for additional information, informal letters, and informal comments.

Training
11. Develop, implement, and maintain a QI training program to instill and maintain a culture of quality in DHCS.

Cross-cutting QI Projects
1. Develop and implement QI activities that relate to the management of chronic conditions, such as diabetes and coronary artery disease, and health promotion on improving medication adherence.
2. Develop and implement QI activities that integrate behavioral health and physical health to promote whole health using patient-centered care approaches.
3. Assess process and outcomes of the patient-centered medical home model.
4. Measure quality for long-term care.
5. Develop quality measures for fee-for-service.
6. Use statewide surveillance and Medi-Cal data to guide planning and implementation of future QI activities.
DISCUSSION

The QII is DHCS’ most comprehensive assessment of QI activities conducted to date, reflecting the steadfast commitment of the Department to support the delivery of quality health care to the most vulnerable populations in California. The QII provided an opportunity to: 1) establish a Department-wide baseline of QI activities in the clinical, health promotion and disease prevention, and administrative domains; 2) identify metrics that were being collected by the Department but were not linked to QI activities; 3) identify gaps in existing QI activities; and 4) offer recommendations for future QI efforts. The findings in each of these four areas will set the stage for the continued evolution of the DHCS Quality Strategy and the development of a subsequent Department-wide QI implementation plan.

The results of the QIS showed a wide range of basic to complex QI activities in current operation. Some of the QI projects are new to the Department, demonstrating the ever-growing commitment to quality health care. Conversely, other projects have been operational for multiple years.

The vast majority of QI projects were within the clinical and administrative domains, which was expected given the Department’s relatively recent emphasis on prevention and population health. Some of the clinical QI projects were in keeping with the National Quality Strategy, including the reduction of all-cause readmissions and reduction of health care-acquired infections.7 Likewise, the Medi-Cal Incentive to Quit Smoking project complements the National Quality Strategy’s objective to improve the proportion of people trying to quit smoking who get help.7

Large-scale, system-wide activities, supported by funds from the State and CMS, were also represented. Some examples included California’s DSRIP Program, and waivers to help those with mid- to late-stage HIV/AIDS, developmental disabilities, frail seniors, and children with CCS-eligible medical conditions to remain in their homes and communities as an alternative to being placed in health care facilities. These QI efforts demonstrate significant opportunities to fundamentally change the health care system to improve health, quality, value, and the patient care experience.

Multiple metrics, including selected HEDIS measures, were being collected by DHCS but were not linked to specific QI activities. The list of metrics provides an opportunity for the Department to consider whether QI activities should be developed to support these measures or a sub-set thereof, and whether additional measures should be considered for future collection.

Additional insight was gained by identifying gaps in existing QI activities. Broadly stated gaps, such a lack of consistent measurement and translation of data into QI activities Department-wide, to very specific gaps, such as the absence of a comprehensive tobacco treatment plan, were noted. In addition, many clinical, health promotion and disease prevention, and administrative suggestions for new QI efforts were offered. The new QI recommendations involved multiple areas within the Department, such as dental; obesity prevention; tobacco cessation; alcohol and substance abuse prevention; partner violence screening; data, measurement, and modeling; business processes; and QI training. Cross-cutting QI activities were also noted in the areas of pharmacy; chronic disease management and health promotion; integration of behavioral and physical health; evaluation of the patient-centered medical home model; quality measures for long-term care and fee-for-service; and use of state surveillance and Medi-Cal data to guide QI planning and implementation. Taken collectively, the gaps and suggestions for new QI activities offer fresh ideas on how to advance QI throughout DHCS.
NEXT STEPS

The QII has provided DHCS with an opportunity to understand comprehensively the QI activities that are in current operation, as well as identify areas for improvement, strategic integration, and innovative growth in quality care.

The next phase of the QII is to translate the findings highlighted in this report and develop a separate report, entitled *Baseline Assessment of Quality Improvement Activities in the California Department of Health Care Services: Recommendations for Action*. The report will provide recommendations for: 1) improving and advancing the Department’s QI activities; 2) translating existing measures into relevant QI efforts; and 3) establishing a Departmental system of QI throughout all functional areas of DHCS.

To help inform the development of the recommendations, DHCS will invite feedback and counsel from its internal staff, stakeholders, and the newly-created Medi-Cal Performance Advisory Committee, which was assembled by the Institute for Population Health Improvement at the University of California Davis Health System. The outcome of this process will be the recommendations publication, which will ultimately inform the *DHCS Quality Strategy* and future DHCS QI implementation plan.
References


Dear Colleagues,

Thank you for participating in the Department’s Quality Improvement Survey (QIS). The purpose of the QIS is to inventory all current Quality Improvement (QI) activities in the Department, including QI projects, ongoing programs, and processes within the clinical, health promotion and disease prevention, and administrative domains. We will also be capturing quality metrics that are not linked to QI projects but which are currently being collected by the Department, as well as existing QI gaps and future ideas.

As you are aware, DHCS is in the process of developing a Quality Strategy for Medi-Cal, using the National Quality Strategy and associated quality initiatives as a foundation. Before we can realize the full potential of the Quality Strategy and build well-informed tactics and metrics, we must first understand our existing QI efforts and identify areas for future improvement. Once the survey responses are collected and analyzed, the results will inform our strategy and help us all continue to build an outstanding, member-centered, cost-effective health network for the Medi-Cal members we serve.

Instructions
The survey is divided into five parts: 1) clinical projects; 2) health promotion and disease prevention projects; 3) administrative projects; 4) quality metrics not tied to a specific QI project; and 5) existing QI gaps and future ideas.

Attachment I provides a survey template that you will use to complete the portion of the assessment that reflects your area of QI responsibility. The survey elements are in **bold**. Definitions or explanatory text are in **bold italic**. Please place an X in the appropriate check boxes. In addition, cut and paste additional survey templates for each part as needed.

Attachment II provides an example for each of the five parts listed above, to assist you in completing the survey.

**PLEASE NOTE:** If you have existing reports, abstracts, grant applications, or QI project descriptions, you may simply reference these in your survey and attach them to your email response. *There is no need to transfer information to the survey if you have it in another document.* For example, Systems of Care has several, ongoing Quality of Care Collaboratives. Staff should provide the titles of those QI projects in the survey and write, “See attached QI project descriptions.”

As you respond to the questions in each part of the survey, we ask that you collaborate with your respective teams to obtain the most complete data possible, and coordinate a single survey package from your Division or Office. Please complete and hand-deliver your hardcopy survey and attachments to the Director’s Office, Attention: [redacted], OR submit your completed survey via email to [redacted].
Responses are due by **5:00pm, Monday, May 7, 2012**. To assist with administering the survey, the QI inventory team, within the Office of the Medical Director, will personally meet with division staff, as needed. You may contact [redacted] at [redacted] and [redacted] to schedule a meeting time, or you can contact [redacted] if you have any questions for which a meeting is not required.

We value and appreciate your efforts in completing this survey. Your thoughtful responses will serve as an important foundation for our collective QI efforts. We will provide a report of the results when they become available in June, and then begin the process of building the details around the Quality Strategy in collaboration with the UC Davis Institute for Population Health Improvement. Thank you again for your responses.
Part 1: Clinical QI Projects

Please describe existing clinical QI projects for which you and your team are responsible. A clinical QI project is typically implemented for a 1- to 3-year period. Also include “QI processes,” as well as “QI projects” that have become, in effect, “QI programs” because they are ongoing. QI projects have baseline metric(s), target metric(s), and defined intervention(s) to move from baseline to target.

a. **Title**

b. **Specific Aim(s)**

   What are the desired outcome(s) for the project?

c. **Metrics**

   A metric is a variable that can be quantified, tracked, and used to detect variation. Metrics include key process and outcome variables.

   - **Baseline Metric(s)** are the basis for measurement and calculation. They are the reference point(s) against which subsequent data are compared and evaluated over time.

   - **Target Metric(s)** are values that have been pre-determined as indicators for success or failure. They are measurable improvements based on the baseline data.

   - **Other Metric(s), please describe.**

   - **Intervention Site(s) (check all that apply):**

     - [ ] Emergency department
     - [ ] Outpatient
     - [ ] Inpatient
     - [ ] Long-term care
     - [ ] Other (please list):
Appendix B

(Please provide the relevant section of the document to be converted to natural text.)

d. Is the project optional or mandatory?
   ☐ Optional.
   ☐ Mandatory. If mandatory, what is the authority requiring it?

e. Start date of the project

f. End date of the project

g. Lead staff for the project (List up to 2)
   Who is the Project Director, Manager, or other key point of contact?

h. Project partners (include internal and external partners)

i. Funding source
   Who is funding the project?

j. Are there any reports available on this project?
   ☐ Yes. If yes, please list and indicate their frequency (e.g., quarterly, annually)
   ☐ No.

k. Is performance tracked at the provider/practitioner level?
   ☐ Yes. If yes, describe how the performance is tracked.
   ☐ No.
   ☐ Don’t know.

l. Is the quality of patient care experiences tracked for this project?
   ☐ Yes. If yes, describe how patient care experiences are tracked.
   ☐ No.
   ☐ Don’t know.

Part II: Health Promotion and Disease Prevention QI Projects

Please describe existing health promotion and disease prevention QI projects for which you and your team are responsible. A QI project is typically implemented for a 1- to 3-year period. Also include “QI processes,” as well as “QI projects” that have become, in effect, “QI programs” because they are ongoing. QI projects have baseline metric(s), target metric(s), and defined intervention(s) to move from baseline to target.

When you think about health promotion and disease prevention QI projects, please consider the following practice areas [These are “prompts” to ensure we don’t leave out any projects. You only need to respond if there is an active project in a domain]:

- Smoking cessation and tobacco control
- Obesity prevention
- HIV/AIDS prevention
- Sexually transmitted disease prevention
• Nutrition and healthy eating
• Physical activity
• Alcohol and other substance abuse (including drug abuse)
• Prescription drug overdose
• Immunizations
• Teenage pregnancy prevention
• Preconception and prenatal care
• Screening and early detection of cancer
• Screening and early detection of cardiovascular disease
• Screening and early detection of diabetes

• Motor vehicle and other injury prevention
• Violence prevention
• Mental health
• Stress management
• Counseling (e.g., psychological counseling, weight management counseling)
• Health care associated infections, pressure ulcers, falls, and other preventable patient safety-related problems
• Complementary or alternative medicine (e.g., acupuncture)
• Referral to community services for prevention support

a. Title

b. Specific Aim(s)
What are the desired outcome(s) for the project?

c. Metrics
A metric is a variable that can be quantified, tracked, and used to detect variation. Metrics include key process and outcome variables.

■ Baseline Metric(s) are the basis for measurement and calculation. They are the reference point(s) against which subsequent data are compared and evaluated over time.

■ Target Metric(s) are values that have been pre-determined as indicators for success or failure. They are measurable improvements based on the baseline data.

■ Other Metric(s), please describe.

■ Intervention Site(s) (check all that apply):
  □ Emergency department
  □ Outpatient
  □ Inpatient
  □ Long-term care
  □ Other (please list):

d. Is the project optional or mandatory?
  □ Optional.
  □ Mandatory. If mandatory, what is the authority requiring it?

e. Start date of the project
f. **End date of the project**

g. **Lead staff for the project (List up to 2)**
*Who is the Project Director, Manager, or other key point of contact?*

h. **Project partners (include internal and external partners)**

i. **Funding source**
*Who is funding the project?*

j. **Are there any reports available on this project?**
   - ☐ Yes. If yes, please list and indicate their frequency (e.g., quarterly, annually)
   - ☐ No.

k. **Is performance tracked at the provider/practitioner level?**
   - ☐ Yes. If yes, describe how the performance is tracked.
   - ☐ No.
   - ☐ Don’t know.

l. **Is the quality of patient care experiences tracked for this project?**
   - ☐ Yes. If yes, describe how patient care experiences are tracked.
   - ☐ No.
   - ☐ Don’t know.

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**Part III: Administrative QI Projects**

Please describe existing administrative QI projects for which you and your team are responsible. An administrative QI project is typically implemented over a 1- to 3-year period. Also include “QI processes,” as well as “QI projects” that have become, in effect, “QI programs” because they are ongoing. QI projects have baseline metric(s), target metric(s), and defined intervention(s) to move from baseline to target.

a. **Title**

b. **Specific Aim(s)**
*What are the desired outcome(s) for the project?*

c. **Metrics**
*A metric is a variable that can be quantified, tracked, and used to detect variation. Metrics include key process and outcome variables.*

   - Baseline Metric(s) are the basis for measurement and calculation. They are the reference point(s) against which subsequent data are compared and evaluated over time.
■ **Target Metrics(s)** are values that have been pre-determined as indicators for success or failure. They are measurable improvements based on the baseline data.

■ **Other Metric(s), please describe.**

■ **Site(s) (check all that apply):**
  □ Emergency department  
  □ Outpatient  
  □ Inpatient  
  □ Long-term care  
  □ DHCS  
  □ Other (please list):

  

  d. **Is the project optional or mandatory?**
    □ Optional.
    □ Mandatory. If mandatory, what is the authority requiring it?

  e. **Start date of the project**
  
  f. **End date of the project**
  
  g. **Lead staff for the project (List up to 2)**
    Who is the Project Director, Manager, or other key point of contact?
  
  h. **Project partners (include internal and external partners)**
  
  i. **Funding source**
    Who is funding the project?
  
  j. **Are there any reports available on this project?**
    □ Yes. If yes, please list and indicate their frequency (e.g., quarterly, annually)
    □ No.

  k. **Is performance tracked at the individual/worker level?**
    □ Yes. If yes, describe how the performance is tracked.
    □ No.
    □ Don’t know.

  l. **Is the quality of client/customer experiences tracked for this project?**
    □ Yes. If yes, describe how the client/customer experiences are tracked.
    □ No.
    □ Don’t know.
Part IV: Quality Metrics Collected but not Linked with a QI Project

a. Please list quality metrics that are currently being collected but which are not linked to a QI project. Briefly describe how the quality metric is being used.

A metric is a variable that can be quantified, tracked, and used to detect variation. Metrics include key process and outcome variables.

Part V: Existing QI Gaps and Future Ideas

a. Are there any gaps in the Department’s existing clinical, health promotion and disease prevention, and administrative QI projects?

b. What suggestions do you have for new clinical, health promotion and disease prevention, and administrative QI projects in the future?

Thank you for completing the survey. The results of the survey will be available for review and discussion in June 2012.
Example of Completed Survey

California Department of Health Care Services (DHCS)
Inventory of Quality Improvement Projects

Survey Template

Please complete the following Quality Improvement (QI) survey for 1) Clinical QI Projects; 2) Health Promotion and Disease Prevention QI Projects; 3) Administrative QI Projects; 4) Quality Metrics not Linked to a Specific Project; and 5) Existing QI Gaps and Future Ideas. Please cut and paste additional survey templates for each part as needed.

Part 1: Clinical QI Projects

Please describe existing clinical QI projects for which you and your team are responsible. A clinical QI project is typically implemented for a 1- to 3-year period. Also include “QI processes,” as well as “QI projects” that have become, in effect, “QI programs” because they are ongoing. QI projects have baseline metric(s), target metric(s), and defined intervention(s) to move from baseline to target.

a. Title
Reducing Intravenous Catheter-Associated Infection Rate in 10 Community Hospitals

b. Specific Aim(s)
What are the desired outcome(s) for the project?
To achieve a 66% reduction in the overall rate of catheter-associated infections in 10 community hospitals by June 30, 2014.

c. Metrics
A metric is a variable that can be quantified, tracked, and used to detect variation. Metrics include key process and outcome variables.

■ Baseline Metric(s) are the basis for measurement and calculation. They are the reference point(s) against which subsequent data are compared and evaluated over time.
Current overall intravenous catheter-associated infection rate is 3/1000 catheter-days measured 7/1/11-6/30/12.

■ Target Metric(s) are values that have been pre-determined as indicators for success or failure. They are measurable improvements based on the baseline data.
Reduce the intravenous catheter-associated infection rate to 1/1000 catheter-days or lower, measured 7/1/14-12/31/14.

■ Other Metric(s), please describe.
None
- **Intervention Site(s) (check all that apply):**
  - ☐ Emergency department
  - ☐ Outpatient
  - ☑ Inpatient
  - ☐ Long-term care
  - ☐ Other (please list):

  - d. **Is the project optional or mandatory?**
    - ☑ Optional.
    - ☐ Mandatory. If mandatory, what is the authority requiring it?

  - e. **Start date of the project**
    - July 1, 2012

  - f. **End date of the project**
    - June 30, 2015

  - g. **Lead staff for the project (List up to 2)**
    - *Who is the Project Director, Manager, or other key point of contact?*
    - Neal Kohatsu, MD, MPH, Project Director
    - Amber Kemp, Project Manager

  - h. **Project partners (include internal and external partners)**
    - Medi-Cal Managed Care Division
    - Acme Health Plan
    - I’m OK, You’re OK Health Plan
    - CDPH Licensing & Certification
    - 10 community hospital partners

  - i. **Funding source**
    - *Who is funding the project?*
    - Centers for Medicare and Medicaid, Center for Medicare and Medicaid Innovation

  - j. **Are there any reports available on this project?**
    - ☑ Yes. If yes, please list and indicate their frequency (e.g., quarterly, annually)
      - A final report will be produced by 6/30/15
    - ☐ No.

  - k. **Is performance tracked at the provider/practitioner level?**
    - ☐ Yes. If yes, describe how the performance is tracked.
    - ☑ No.
    - ☐ Don’t know.
I. **Is the quality of patient care experiences tracked for this project?**
   ☑ Yes. If yes, describe how patient care experiences are tracked.
   Focus group information will be collected at baseline and at the project midpoint on patient care experience.
   ☐ No.
   ☐ Don’t know.

Part II: Health Promotion and Disease Prevention QI Projects

Please describe existing health promotion and disease prevention QI projects for which you and your team are responsible. A QI project is typically implemented for a 1- to 3-year period. Also include “QI processes,” as well as “QI projects” that have become, in effect, “QI programs” because they are ongoing. QI projects have baseline metric(s), target metric(s), and defined intervention(s) to move from baseline to target.

When you think about health promotion and disease prevention QI projects, please consider the following practice areas [These are “prompts” to ensure we don’t leave out any projects. You only need to respond if there is an active project in a domain]:

- Smoking cessation and tobacco control
- Obesity prevention
- Nutrition and healthy eating
- Physical activity
- Alcohol and other substance abuse (including drug abuse)
- Prescription drug overdose
- Immunizations
- Teenage pregnancy prevention
- Preconception and prenatal care
- Screening and early detection of cancer
- Screening and early detection of cardiovascular disease
- Screening and early detection of diabetes
- HIV/AIDS prevention
- Sexually transmitted disease prevention
- Motor vehicle and other injury prevention
- Violence prevention
- Mental health
- Stress management
- Counseling (e.g., psychological counseling, weight management counseling)
- Health care associated infections, pressure ulcers, falls, and other preventable patient safety-related problems
- Complementary or alternative medicine (e.g., acupuncture)
- Referral to community services for prevention support

a. **Title**
   Medi-Cal Incentives to Quit Smoking (MIQS) Project

d. **Specific Aim(s)**
   What are the desired outcome(s) for the project?
   - Increase use of the Smokers’ Helpline through the use of appropriate incentives.
   - Reduce the Medi-Cal smoking prevalence.

c. **Metrics**
   A metric is a variable that can be quantified, tracked, and used to detect variation. Metrics include key process and outcome variables.
Baseline Metric(s) are the basis for measurement and calculation. They are the reference point(s) against which subsequent data are compared and evaluated over time.

- The Helpline receives an average of 17,500 Medi-Cal callers annually.
- 22% of adult Medi-Cal members are smokers.

Target Metrics(s) are values that have been pre-determined as indicators for success or failure. They are measurable improvements based on the baseline data.

- CDP outreach will increase annual # of Medi-Cal callers to the Helpline by 50% to approximately 35,000 calls in calendar 2017.
- Reduce the smoking prevalence rate to 17% by December 2017.

Other Metric(s), please describe.
- # of Counseling Sessions Completed
- # of Relapse Prevention Sessions Completed

Intervention Site(s) (check all that apply):
- Emergency department
- Outpatient
- Inpatient
- Long-term care
- Other (please list):
  - Statewide telephone counseling from the Helpline at UCSD.

Is the project optional or mandatory?
- Optional.
- Mandatory. If mandatory, what is the authority requiring it?

Start date of the project
September 13, 2011

End date of the project
September 12, 2016

Lead staff for the project (List up to 2)
Who is the Project Director, Manager, or other key point of contact?
h. **Project partners (include internal and external partners)**

California Tobacco Control Program (CDPH)
California Medicaid Research Institute (UCSF, multi-campus)
California Diabetes Program (UCSF, CDPH)
California Smokers' Helpline (UCSD)
Institute for Health & Aging (UCSF) health economists
Centers for Medicare & Medicaid Services (CMS)
All MMCD contracted health plans

i. **Funding source**

*Who is funding the project?*
Federal grant awarded to DHCS by CMS.

j. **Are there any reports available on this project?**

- Yes. If yes, please list and indicate their frequency (e.g., quarterly, annually)
  - Quarter 1 Report (9/13/11 – 12/31/11) submitted to CMS quarterly.
  - Operational Protocol (updated 12/1/11) revised on an ongoing basis.

- No.

k. **Is performance tracked at the provider/practitioner level?**

- Yes. If yes, describe how the performance is tracked.
- No.
- Don’t know.

l. **Is the quality of patient care experiences tracked for this project?**

- Yes. If yes, describe how patient care experiences are tracked.
- No.
- Don’t know.

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**Part III: Administrative QI Projects**

Please describe existing administrative QI projects for which you and your team are responsible. An administrative QI project is typically implemented over a 1- to 3-year period. Also include “QI processes,” as well as “QI projects” that have become, in effect, “QI programs” because they are ongoing. QI projects have baseline metric(s), target metric(s), and defined intervention(s) to move from baseline to target.

a. **Title**

Reduction in time to hire DHCS civil service line staff.

b. **Specific Aim(s)**

*What are the desired outcome(s) for the project?*

Reduce the total time required from concept to start date to hire line staff.

c. **Metrics**
A metric is a variable that can be quantified, tracked, and used to detect variation. Metrics include key process and outcome variables.

- **Baseline Metric(s) are the basis for measurement and calculation. They are the reference point(s) against which subsequent data are compared and evaluated over time.**
  
  In calendar year 2011, total time for hire (from submission of first draft duty statement to start date) was 4 months.

- **Target Metrics(s) are values that have been pre-determined as indicators for success or failure. They are measurable improvements based on the baseline data.**
  
  Total time for hire in calendar 2014 (using baseline definition) will be 2 months.

- **Other Metric(s), please describe.**
  
  None.

- **Site(s) (check all that apply):**
  
  - [ ] Emergency department
  - [ ] Outpatient
  - [ ] Inpatient
  - [ ] Long-term care
  - [ ] DHCS
  - [x] Other (please list):

- **d. Is the project optional or mandatory?**
  
  - [ ] Optional.
  - [x] Mandatory. If mandatory, what is the authority requiring it?

- **e. Start date of the project**
  
  7/1/12

- **f. End date of the project**
  
  12/31/14

- **g. Lead staff for the project (List up to 2)**

  Who is the Project Director, Manager, or other key point of contact?

  - [ ]

- **h. Project partners (include internal and external partners)**

  - [ ]

  - [ ]
i. Funding source
   Who is funding the project?
   No external or internal funding. Using existing staffing.

j. Are there any reports available on this project?
   ☐ Yes. If yes, please list and indicate their frequency (e.g., quarterly, annually)
   ☑ No.

k. Is performance tracked at the individual/worker level?
   ☑ Yes. If yes, describe how the performance is tracked.
   Track the process of concept to start date to hire line staff.
   ☐ No.
   ☐ Don’t know.

l. Is the quality of client/customer experiences tracked for this project?
   ☐ Yes. If yes, describe how the client/customer experiences are tracked.
   ☑ No.
   ☐ Don’t know.

Part IV: Quality Metrics Collected but not Linked with a QI Project

a. Please list quality metrics that are currently being collected but which are not linked to a QI project. Briefly describe how the quality metric is being used.

A metric is a variable that can be quantified, tracked, and used to detect variation. Metrics include key process and outcome variables.

Example 1
Metric: Time to complete bill analysis
Use: Compare responsiveness of various divisions

Example 2
Metric: Flu immunization rate among fee-for-service members
Use: Evaluate potential to minimize epidemic morbidity and mortality

Part V: Existing QI Gaps and Future Ideas

a. Are there any gaps in the Department’s existing clinical, health promotion and disease prevention, and administrative QI projects?
   A comprehensive tobacco treatment plan, including recommended treatment options and clinical systems change to treat tobacco use, is not available. Currently, only two managed care health plans offer the comprehensive coverage recommended by AHRQ based on the Public Health Service-sponsored Clinical Practice Guideline, Treating Tobacco Use and
Appendix B

Dependence: 2008 Update. Comprehensive coverage would include: 1) all seven of the FDA-approved medications for treating tobacco use: bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, the nicotine patch, and varenicline; 2) individual, group, and telephone counseling; and 3) elimination of barriers to tobacco treatment benefits (e.g., co-pays, utilization restrictions).

b. What suggestions do you have for new clinical, health promotion and disease prevention, and administrative QI projects in the future?
Implement a comprehensive tobacco use treatment plan.

Thank you for completing the survey. The results of the survey will be available for review and discussion in June 2012.
Administration Division (ADMIN)

ADMIN provides an array of central support services to achieve DHCS program and operations objectives. ADMIN streamlines policies and procedures, ensures fiscal accountability of programs by overseeing financial management, including budget development and oversight; provides responsive and reliable employee support and human resource management systems; provides guidance and consultation on contract and purchasing services; responsibly manages DHCS physical resources through facilities and telecommunications business services; supports the protection of DHCS employees through the Health and Safety office; and evaluates business processes with attention to improvements in other Department-wide support functions.

Audits & Investigations Division (A&I)

A&I works to protect and enhance the fiscal integrity of the health programs administered by DHCS and ensure a high quality of care is provided to the beneficiaries of these programs. The goal of A&I is to improve the efficiency, economy, and effectiveness of DHCS and the programs it administers by ensuring the accountability of state and federal health care funding as well as identifying funds for recovery, where appropriate. Program duties include: identifying and investigating Medi-Cal provider and beneficiary fraud, waste, and abuse; conducting financial and medical audits; reviewing post payment utilizations; auditing internal DHCS programs; and conducting special audits as needed by DHCS, the California Health and Human Services Agency, and the Governor’s Office.

Benefits & Waiver Analysis Division (BWAD)

BWAD is responsible for managing and ensuring the uniform application of federal and state laws and regulations regarding Medi-Cal benefits and waiver policies that affect more than 150,000 providers of medical services to Medi-Cal beneficiaries. BWAD is the primary liaison with the federal Centers for Medicare & Medicaid Services (CMS) for five waivers and coordinates with other DHCS divisions and state departments to ensure compliance with state and federal requirements under those waivers and the State Plan. The division consists of the Medi-Cal Policy Branch and the Benefits and Waiver Analysis Branch.

California Medicaid Management Information System (CA-MMIS) Division

The CA-MMIS Division is responsible for all activities associated with the use of California’s information technology system, which processes and pays approximately $19 billion a year in Medi-Cal fee-for-service (FFS) health care claims, as well as claims for other DHCS health care programs. CA-MMIS processes payments to providers for medical care provided to Medi-Cal beneficiaries in the state. Located within CA-MMIS is the Fiscal Intermediary Branch (FI), which operates and maintains the system that includes: the operation of a telephone service center and provider relations functions (publications, outreach and training); system operations; and processing eligibility inquiry transactions, treatment authorization requests, and service authority requests. FI is also responsible for planning, developing, testing, and implementing a new Medicaid Management Information System, which will provide current technology and support a service-oriented architecture, consistent with the Medicaid Information Technology Architecture.
Capitation Rates Development Division (CRDD)

CRDD is responsible for the accuracy and integrity of data used to calculate and implement capitation rates in compliance with contractual and regulatory requirements. Located within CRDD is the Actuary Unit, which calculates and sets the capitation rates for managed care organizations and performs calculations of budget estimates. The actuaries certify that capitation rates for managed care health plans are determined in compliance with federal requirements. The Financial Management Unit performs research and rate calculations on Medi-Cal eligibility data and costs for all Medi-Cal programs, as well as interprets and analyzes legislative impacts on managed care program costs. The Financial Analysis Unit (FAU), also part of CRDD, ensures correct application and payment of capitation rates with regard to contractual agreements and Departmental policy. The FAU also acts as the liaison between DHCS’ Fiscal Forecasting Division, CMS, Department of Finance (DOF), and the Legislative Analyst's Office. The Financial Review Unit ensures the timely reporting of financial and accounting data by managed care organizations and provides financial analyses to stakeholders.

Director’s Office (DO)

The Director’s Office is responsible for the day-to-day administration of the Department’s workforce and facilities, creation of policy, and operation of Medi-Cal and other Departmental programs. The work within the office includes the following areas: the Director oversees the operation of the entire Department and its programs. The Director acts as the Department’s executive contact with the California Health and Human Services Agency and Governor’s Office. In this capacity, the Director also serves as the state Medicaid director. The Chief Deputy Director is responsible for managing and directing the day-to-day operations, as well as implementing the Department’s policies and assisting in the formulation of policy to achieve the Department’s mission. In addition, the Chief Deputy Director oversees the Deputy Directors who manage a variety of offices within DHCS, including Administration, Fiscal Forecasting & Data Management, Medi-Cal Procurement, Legal Services, Administrative Hearings and Appeals, Audits and Investigations, Legislative & Governmental Affairs, Information Technology Services, Public Affairs, HIPAA Compliance, Provider Enrollment, Utilization Management, Third Party Liability and Recovery, and the Fiscal Intermediary Medicaid Management Information Systems. The Associate Director is responsible for ensuring the coordination of Departmental programs, and advising the Directorate on all matters of policy critical to the Administration’s development of publicly financed health care programs and health care reform. The Associate Director works as a supervisor in the implementation of national health care reform initiatives for publicly financed health programs under the Department. Additionally, the Associate Director engages in strategic planning, health care policy, and financing. The Office of the Medical Director, led by the Medical Director, works to improve the health of all Californians, enhance quality, including the patient care experience, in all DHCS programs, and reduce DHCS’ per capita health care program costs. These goals are achieved through a close working relationship with numerous internal and external partners. Because of the critical importance of both population health and clinical outcomes, the Medical Director works with a multidisciplinary leadership team consisting of a Chief Prevention Officer, Chief Quality Officer, and Chief Medical Information Officer.

Fee-For-Service Rates Development Division (FFSRDD)

FFSRDD is responsible for developing Medi-Cal reimbursement rates for non-institutional and long-term care services, performing analyses for General Fund cost savings/avoidance proposals and rate
methodologies and assisting the Office of Legal Services in defending DHCS in legal actions. FFSRDD serves as a point of contact on matters pertaining to Medi-Cal non-institutional and long-term care rate setting. FFSRDD crafts legislation and submits State Plan Amendments regarding changes to provider reimbursements. FFSRDD also administers a quality assurance fee program that collects more than $500 million annually.

Financial Management Branch (FMB)
FMB is responsible for the development, presentation, implementation, and monitoring of the Department’s expenditure plan. Additionally, FMB is responsible for certifying that all records and accounts are maintained in accordance with applicable laws, State and Federal regulations, and Departmental policy, which require that there are adequate internal controls to provide reasonable protection for State assets. This is accomplished by ensuring that fiscal resources are properly accounted for and that reliable financial information is available on a timely basis for use in decision-making, which will contribute to the effective and efficient attainment of the Department’s goals.

Fiscal Forecasting Branch (FFB)
FFB serves as the Department’s local assistance fiscal expert and ensures the integrity of appropriation estimates. FFB is responsible for providing fiscal analysis of policy to the Director, California Health and Human Services Agency, Department of Finance, Governor’s Office, and Legislature. Twice each year, FFB prepares formal cost estimates for the over $50 billion Medi-Cal program and $350 million Family Health Program. The cost estimates include a fiscal analysis of policy changes, a projection of base program costs, and updated caseload and utilization trends. The Administration and Legislature use the estimates to develop the annual budget and DHCS uses them to complete quarterly federal grant requests.

Information Technology Services Division (ITSD)
ITSD provides a secure, reliable information technology environment to support the program and administrative objectives of DHCS, Health and Human Services Agency, California Department of Public Health (CDPH), Office of Health Information Integrity, and the Health Benefit Exchange Board. ITSD is responsible for establishing information technology policy and standards and ensuring compliance with state and federal laws and regulations regarding the use of information technology and the safeguarding of electronic information. ITSD supports a complex portfolio of program applications, the largest of which is the Medi-Cal Eligibility Data System. ITSD duties include: providing quality application and data services to DHCS programs; facilitating successful completion of IT projects; and managing the design, installation, upgrade, and support of a complex technology infrastructure including network, servers, desktops, network devices, messaging systems, Web sites, Web applications, and databases.

Legislative & Governmental Affairs Division (LGA)
LGA facilitates, coordinates, and advocates for the development and enactment of legislation in the interest of public health and health care. As a key player in carrying out DHCS’ mission to protect and advance the health of all Californians, LGA assists in the development and refinement of the state’s health care laws.
Long-Term Care Division (LTCD)

LTCD is an integral component of California’s Olmstead Plan by ensuring the provision of long-term services and supports to Medi-Cal-eligible frail seniors and persons with disabilities. These services and supports allow this population to live in their own homes or community-based settings instead of facilities. LTCD directly operates and/or administers five home- and community-based services (HCBS) waivers on behalf of DHCS, as the single state Medicaid agency. LTCD also provides monitoring and oversight for four HCBS waivers and the In-Home Supportive Services state plan benefit operated by the Department of Social Services, Department of Aging, and Department of Developmental Services. In addition, LTCD operates two managed care programs, Program of All-Inclusive Care for the Elderly and Senior Care Action Network, and the California Partnership for Long-Term Care, a long-term care insurance program. LTCD administers a federal, Money Follows the Person grant, to transition Medi-Cal-eligible residents from long-term care facilities back to community living arrangements. LTCD works collaboratively with the Medi-Cal Managed Care Division to integrate long-term services and supports for seniors and persons with disabilities and Medicare/Medi-Cal dual eligible beneficiaries in a managed care delivery system.

Low-Income Health Program (LIHP) Division

Created through the implementation of the ACA, LIHP is responsible for administering and managing approximately $3 billion in federal funding to implement LIHP in California. The program will extend and expand the Health Care Coverage Initiative program to a statewide local program targeting the Medicaid expansion population and the low-income adult population eligible for participation in the Health Benefit Exchange. Division responsibilities include developing policies and procedures related to LIHP, reviewing and approving claiming invoices for federal reimbursement to local LIHPs, and providing technical assistance. The division also monitors program compliance with contracts, Special Terms and Conditions, and federal requirements; compiles program data for federal and state reporting requirements; and develops contracts and amendments. In addition, the division collaborates with program stakeholders and other divisions in planning program transition.

Medi-Cal Dental Services Division (MDSD)

MDSD is responsible for the provision of dental services to Medi-Cal members. Services are provided under fee-for-service (FFS) and managed care models. MDSD contracts with a dental fiscal intermediary for FFS and 13 managed care plans and prepaid health plans to provide dental care for Medi-Cal members. The FFS program is statewide, and the dental managed care plan/prepaid health plans are located in Sacramento and Los Angeles counties.

Medi-Cal Eligibility Division (MCED)

MCED is responsible for developing statewide policies, procedures, and regulations governing Medi-Cal eligibility and ensures eligibility is determined accurately and timely in accordance with state and federal requirements. Additional duties include performing Medi-Cal quality control reviews of county compliance with state and federal eligibility requirements; working with the county welfare department consortiums and ITSD in developing the business rules necessary to implement eligibility policy; and maintaining the records of beneficiaries in both the county eligibility systems and DHCS’ Medi-Cal Eligibility Data System. MCED provides county public social service agencies with policy direction via All County
Welfare Directors Letters and Medi-Cal Eligibility Information Letters that implement Medi-Cal eligibility policies and procedures.

**Medi-Cal Managed Care Division (MMCD)**

MMCD contracts with managed care organizations to arrange for the provision of health care services for approximately 4.4 million Medi-Cal beneficiaries in 30 counties. MMCD has three primary models: Two-Plan, which operates in 14 counties; County Organized Health Systems (COHS), which operate in 14 counties; and Geographic Managed Care, which operates in two counties. MMCD also contracts with a prepaid health plan in one additional county and with two specialty plans. In total, Medi-Cal managed care paid health plans approximately $10.6 billion for rate year 2010-11. MMCD has three branches: Plan Monitoring/Program Integrity, Policy and Financial Management, and Plan Management.

**Mental Health Services Division (MHSD)**

MHSD is responsible for developing, implementing, and overseeing policies and procedures related to the Specialty Mental Health Consolidation Program (1915 [b] Freedom of Choice Waiver) and non-waiver Medi-Cal mental health services. Additional duties include: interpreting policy and providing technical assistance to county mental health plans; overseeing the California Mental Health Care Management Program, the pilot collaborative to integrate primary care and mental health services; working to improve Medi-Cal member access and quality of care; and ensuring cost effective use of mental health care resources. MHSD collaborates with internal and external partners, including professional associations and community stakeholders, to assess and develop effective and efficient delivery systems that improve mental health care options and reduce mental and physical health care costs. MHSD is also a statewide advocate for mental health services, including services that address cultural disparities.

**Office of Administrative Hearings and Appeals (OAHA)**

Under delegated authority from the Director, OAHA conducts quasi-judicial hearings in accordance with the Administrative Procedure Act for nearly all program actions taken by the Department and, pursuant to interagency agreement, actions taken by other state agencies. Under the supervision of the Deputy Director and Chief Administrative Law Judge and the Chief Hearing Officer, OAHA is responsible for conducting conferences with parties, ruling on motions, presiding over hearings, and writing proposed and final decisions. The OAHA staff consider and adjudicate many sensitive and financially significant issues, including those that involve licensure and certification of nursing facilities and medical personnel, appropriate delivery of services for handicapped children, suspension of enrollment of Medi-Cal providers, funding of all institutional and non-institutional Medi-Cal providers, and implementation of and the rate setting for Medi-Cal managed care contracts.

**Office of Civil Rights (OCR)**

OCR is responsible for overseeing compliance with various federal and state civil rights laws and implementing regulations and executive orders pertaining to employment and services by DHCS and its contractors to ensure nondiscrimination in the access and delivery of health care services provided or administered by DHCS. OCR provides Departmental guidance, coordination, monitoring, training, and investigation of issues relating to DHCS employees through the Internal Equal Employment Opportunity Program (Title VII), External Civil Rights Compliance Program (Title VI), and Reasonable Accommodation
Program. Additionally, OCR coordinates and develops technical, prevention, and sensitivity awareness training that deals with Equal Employment Opportunity and disability issues, and resolves complaints of discrimination via counseling, informal reviews, investigations, and mediations filed by DHCS applicants and employees.

Office of Health Information Technology (OHIT)

OHIT is responsible for implementing the Medi-Cal Electronic Health Record Incentive Program. This incentive program will improve the quality, safety, and efficiency of health care by Medi-Cal hospitals and professionals through incentive payments to encourage the meaningful use of electronic health records. OHIT administers a new program that began making incentive payments in 2011 to qualified Medi-Cal health care providers who adopt and use electronic health records in accordance with the American Recovery and Reinvestment Act of 2009. OHIT sets the policies and procedures for the program, in addition to implementing systems to disburse, track, and report the incentive payments. It also develops goals and metrics for the program, including the impact of the program on quality, cost, and service.

Office of HIPAA Compliance (OHC)

OHC is responsible for leadership and oversight related to the implementation and maintenance efforts of a range of federally required initiatives to simplify and standardize the administration of health care while protecting the privacy of patients served by DHCS programs. Federal Health Information Portability and Accountability Act (HIPAA) legislation passed in 1996, which established national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data and was adopted to improve the efficiency and effectiveness of the nation’s health care system by encouraging the widespread use of electronic data interchange. HIPAA requirements continue to be updated, most recently through administrative simplification provisions included in the ACA. OHC also serves as the DHCS lead for measuring and monitoring progress against the Medicaid Information Technology Architecture (MITA) framework, a federal initiative that holds states accountable for federally funded health IT expenditures.

Office of Legal Services (OLS)

OLS provides comprehensive legal services to DHCS and its employees and legal support to all Departmental programs. OLS’s 50 attorneys and 9 paralegals are distributed among 5 large legal teams, each of which focuses on a particular area of Departmental legal work: the Administrative Litigation Unit represents DHCS in administrative hearings before the Office of Administrative Hearings and Appeals, the State Personnel Board and other state entities, and handles the bulk of DHCS’ legal personnel functions. The Medi-Cal House Counsel Team serves as DHCS’ primary provider of legal support for programmatic functions, including drafting and reviewing much of DHCS’ proposed legislation. The Medi-Cal Litigation Team provides programmatic legal support, but also serves as DHCS’ liaison to the California Attorney General’s Office and other external entities about litigation involving DHCS, and this team provides litigation support for active cases. The Special Projects Team handles legal assignments that emanate primarily from the Directorate, such as implementation projects related to the ACA. The newly created Medi-Cal Financing and Rates Team specialize in its namesake subject matter. OLS also contains two sub-specialty programs: the Privacy Office, staffed by attorneys dedicated to privacy legal compliance; and the Office of Regulations, which is responsible for ensuring the consistency and accuracy of all regulations that DHCS promulgates.
Office of Medi-Cal Procurement (OMCP)

OMCP is an internal consulting and advisory group within DHCS. OMCP’s function is to conduct major procurements. OMCP is responsible for the entire process including the development of procurement documents, evaluation of any proposals received in response to those documents, and development and approval of the contract documents. All Medi-Cal procurement and contracting procedures are conducted with the highest integrity, with the goal of producing procurement documents and contracts that are effective and cost-efficient for the Medi-Cal program.

Office of Multicultural Health (OMH)

OMH serves as the internal focal point for improved planning and coordination of activities and programs that serve California’s racial and ethnic populations. OMH’s mission is to increase the capacity of DHCS and CDPH, health care providers, and ethnic/racial communities to achieve equity, reduce health disparities, and improve access to quality care among racial/ethnic, lesbian, gay, bisexual and transgender (LGBT) and other underserved populations in California. OMH duties include informing and advocating for policies and practices to increase the effectiveness of programs and services toward reducing health disparities and inequities among diverse racial/ethnic, LGBT, and underserved populations; informing and advancing national, state and local discussions on multicultural and LGBT health, cultural and linguistic competence, workforce diversity, health equity, and the reduction of disparities in health and health care; advocating for and using federal, state and community level data to address the issues of health and health care disparities among racial/ethnic, LGBT, and underserved populations to monitor and evaluate health outcomes among these groups; creating and strengthening information networks among DHCS and CDPH programs and ethnic/racial, LGBT, and underserved communities for the inclusion of community participation in decision-making related to health issues; and building internal and external capacity to achieve equity and reduce health disparities through training, technical assistance, consultation, and strategic planning. On July 1, 2012, OMH became part of the Office of Health Equity at CDPH.

Office of Public Affairs (OPA)

OPA is responsible for overall communications and outreach activities associated with DHCS and serves as the central conduit of information for the Department. OPA is responsible for responding to inquiries, drafts, and finalizing approved responses and delivering responses to various stakeholders, the public, and media. OPA also assesses the impact of actions or situations involving the Department and provides guidance on the appropriate message and method of response. OPA crafts statements and press releases, conducts interviews and background briefings, and stages press conferences. OPA works to engage the general public and media with compelling, informative features on the home page of the DHCS website and communicates with internal staff primarily through the DHCS Times Department newsletter. OPA also assists with DHCS’ public education and outreach programs, such as the California Partnership for Long-Term Care.

Office of Women’s Health (OWH)

At the time of the survey, OWH was a shared program within DHCS and CDPH that guided women’s public health services in a positive, comprehensive way to promote health and well-being and reduce the burden of preventable disease and injury among women and girls in California. OWH was responsible
for setting and monitoring women’s health policies that promoted more comprehensive and effective approaches to improve women’s overall health, including quality assessment, monitoring and improvement, coordination of existing programs and resources, enhancing the visibility and prominence of women’s health problems, and developing cost-effective, innovative solutions to addressing those problems. OWH had five major functions: women’s health policy, women’s health research, program administration of the Gynecological Cancer Information Program, health education and health literacy, and outreach. OWH staffed the Women’s Health Council, and chaired the interagency California Women’s Health Survey and its interagency workgroup that researched women’s health and published annual reports and research findings. OWH was consolidated into the Office of Health Equity at CDPH on July 1, 2012.

Office of Workforce Planning & Development (OWPD)

OWPD leads the workforce planning and recruitment efforts for DHCS. OWPD ensures that divisions have a resource to better enhance their efforts to recruit, retain, train, and successfully prepare employees for the future. Duties include recruiting, researching, evaluating, and acting on opportunities to enhance DHCS’ efforts to decrease vacancy rates; working with divisions to develop systems to increase DHCS’ retention rates and employee satisfaction; and succession planning by identifying effective processes for knowledge transfer and providing opportunities for employees to matriculate successfully upward in DHCS.

Pharmacy Benefits Division (PBD)

PBD is responsible for DHCS’ Medi-Cal fee-for-service (FFS) drug program and the management of the Medi-Cal managed care pharmacy program. PBD is comprised of four branches: Pharmacy Policy, Enteral and Medical Supplies, Drug Contracting, and Drug Rebates. PBD also oversees the Vision Services program and the CalMEND program, which is charged with improving the health of Medi-Cal beneficiaries with mental illness. PBD has primary responsibility for ensuring that prescription drug coverage is provided to FFS Medi-Cal beneficiaries. PBD contracts with drug and medical supply manufacturers and providers to ensure they meet specific criteria, including safety, effectiveness and essential need, and to eliminate the potential for misuse. In exchange for the ability to contract with Medi-Cal, manufacturers provide rebates to the program, which is considered one of the most aggressive in the country.

Primary & Rural Health Division (PRHD)

PRHD works to improve the health status of diverse population groups living in medically underserved urban and rural areas. PRHD administers seven programs that seek to improve and make accessible comprehensive primary care services and other public health services for persons at risk, including the uninsured or indigent, and those who would otherwise have limited or no access to services due to geographical, cultural, or language barriers. The programs include: Rural Health Services Development (RHSD), Seasonal and Agricultural Workers (SAMW), Indian Health (IH), California State Office of Rural Health (CalSORH), Medicare Rural Hospital Flexibility/Critical Access Hospital (FLEX/CAH), Small Rural Hospital Improvement (SHIP) and J-1 Visa Waiver. PRHD functions as the primary liaison for providers and other stakeholders concerned with rural health, Indian health, and primary care clinics. PRHD works with rural health constituents to provide training and technical assistance to strengthen the rural health care infrastructure. PRHD has lead responsibility for ensuring that DHCS complies with federal requirements to
seek regular and ongoing advice from tribes and Indian health program designees on proposed changes to the Medi-Cal program that have a direct impact on Indians and Indian health providers. PRHD administers the American Indian Infant Health Initiative (AIIHI) and Federal Emergency Preparedness activities.

Provider Enrollment Division (PED)

PED is responsible for the review and action of FFS provider applications seeking to participate in the Medi-Cal program, including ensuring that all applicants meet licensure requirements and participation standards defined by federal and state statutes and regulations. PED also conducts re-enrollment functions of current providers to ensure continued compliance with program requirements and standards of participation. PED has responsibility for updating and maintaining the Provider Master File database that is used in the claims payment process. PED is actively involved in Medi-Cal anti-fraud efforts aimed at preventing fraud, waste, and abuse in the Medi-Cal program.

Research and Analytical Studies Branch (RASB)

RASB assumes the lead analytical and consultation research role for DHCS. RASB develops objective data summaries and reports, and conducts analytical studies that assist DHCS in achieving its mission and goals. RASB expands, enhances, and further develops an array of analytical products and content that are created to meet DHCS’ information and decision-making needs.

Safety Net Financing Division (SNFD)

SNFD administers supplemental payments in accordance with the Bridge to Reform, Section 1115 Medicaid Waiver and the Medicaid State Plan. Within SNFD, the Medi-Cal Supplemental Payment Section (MSPS) processes and monitors payments for hospitals and other types of providers for various supplemental programs and administers the Quality Assurance Fee (QAF) program. The Hospital/Uninsured Care Demonstration Section (HUCDS) evaluates designated public hospital costs and rates, oversees the development of California’s new comprehensive waiver, oversees the implementation of the Diagnostic Related Group (DRG) inpatient hospital’s reimbursement methodology, and administers the Subacute Care Program. The Administrative Claiming, Local and School Services Branch provides federal reimbursement to counties and school districts for administrative activities, targeted case management, and certain medically necessary school-based services. The Disproportionate Share Hospital Financing and Non-Contract Hospital Recoupment Branch reimburses eligible hospitals for uncompensated care costs for hospital services and recoups overpayments for inpatient hospital services provided by non-contract hospitals.

Substance Use Disorder Treatment Services Division (SUDTSD)

SUDTSD establishes and implements policies and procedures for the effective operation of the Drug Medi-Cal Treatment Program. Working with key federal partners and the other DHCS Deputy Directors, SUDTSD interprets policy and provides technical assistance to counties and other entities that provide Drug Medi-Cal Treatment Program services. In addition, SUDTSD works collaboratively with internal and external partners, including professional associations and community stakeholders, to assess and develop effective and efficient delivery systems that improve substance use treatment services and outcomes, and help to reduce health care costs. SUDTSD is also a statewide advocate for substance use disorder
services, including services that address cultural disparities.

Systems of Care for Children and Adults Division (SCD)

SCD is responsible for creating effective and efficient comprehensive systems of care for vulnerable populations with chronic conditions to better improve or maintain their health care status and reduce health care costs. SCD is comprised of two major branches: the Statewide Medical Services Branch (SMSB) and Program Operations Branch (POB). SMSB is comprised of medical professionals who have oversight of Children’s Medical Services. Children’s Medical Services includes several programs, including California Children’s Services (CCS) Programs (CCS Medical Therapy Programs, CCS High-Risk Infant Follow-Up Program/Quality Care Initiative, Partners for Children-Pediatric Palliative Care Home and Community Based Waiver, etc.), Child Health and Disability Prevention Program, Genetically Handicapped Persons Program, the Newborn Hearing Screening Program, and the Health Care Program for Children in Foster Care. The POB has administrative oversight of these programs. POB is also responsible for the development and implementation of the CCS demonstration pilot program as a component of DHCS’ Bridge to Reform, Section 1115 Medicaid Waiver.

Third Party Liability and Recovery Division (TPLRD)

TPLRD is responsible for ensuring that the Medi-Cal program complies with state and federal laws and regulations requiring that Medi-Cal be the payer of last resort. TPLRD duties include recovering Medi-Cal expenses from liable third parties and avoiding Medi-Cal cost by identifying or purchasing alternative health care coverage. TPLRD’s recovery programs, Estate Recovery, Personal Injury, and Overpayments, account for $300 million in annual revenue. TPLRD cost avoidance programs annually process more than 300 million commercial insurance records and pay Medicare premiums for 1.1 million dual eligible beneficiaries, avoiding more than $3 billion in Medi-Cal costs. In addition to the coordination of benefits programs, TPLRD is responsible for the collection of the provider Quality Assurance Fee, totaling approximately $4 billion annually.

Utilization Management Division (UMD)

UMD is comprised of five branches, two pharmacy sections, and an appeals and litigation section. UMD provides strong, cost-effective utilization controls by reviewing and adjudicating Treatment Authorization Requests (TARs) for certain medical procedures, services, and drugs for fee-for-service Medi-Cal beneficiaries prior to payment for services. UMD responds to all TAR appeals submitted by providers and offers program support to the Office of Legal Services for all litigation resulting from denied TAR appeals. UMD is also responsible for the Designated Public Hospital Project, which allows public hospitals in California to use an evidence-based standardized tool to determine medical necessity for hospital days and services for Medi-Cal beneficiaries in lieu of submitting a TAR to the field office.
DHCS Quality Strategy Priorities, Quality Improvement Activities, and Current Measures

GOALS:
1. Improve the health of all Californians.
2. Enhance quality, including the patient care experience, in all DHCS programs.
3. Reduce the Department’s per capita health care program costs.

<table>
<thead>
<tr>
<th>Priority 1: Improve Patient Safety</th>
<th>Current Quality Improvement Activities</th>
<th>Measures Collected/Used by DHCS</th>
<th>Data Research Committee Approved Projects</th>
<th>Medicaid Information Technology Architecture</th>
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<tbody>
<tr>
<td>California Children’s Services (CCS) Neonatal Quality Improvement Initiative:</td>
<td></td>
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<td>Care management: Perform screening and assessment</td>
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<tr>
<td>1. To reduce the collaborative’s Central Line Associated Blood Stream Infection rate by another 25% among participating NICUs.</td>
<td>Patient safety measures are under consideration, in collaboration with the Governor’s Let’s Get Healthy California Task Force</td>
<td>Not applicable</td>
<td>Care management: Manage treatment plan and outcomes.</td>
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<tr>
<td>Payment Adjustment for Provider-Preventable Complications, including Health Care-Acquired Conditions: Vascular Catheter-Associated/ Central Line-Associated Bloodstream Infections in NICUs/PICUs:</td>
<td></td>
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<td>Performance management</td>
</tr>
<tr>
<td>1. To implement best practices of central line insertion and maintenance resulting in a decrease in preventable infections, improvement in clinical outcomes, decreased length of stay, and decreased cost.</td>
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</table>
### Current Quality Improvement Activities

- **Payment Adjustment for Provider-Preventable Complications, including Health Care-Acquired Conditions: Surgical Site Infection (SSI):**
  1. To implement best practices of central line insertion and maintenance resulting in a decrease in preventable infections, improvement in clinical outcomes, decreased length of stay, and decreased cost.

- **Delivery System Reform Incentive Payments Program (DSRIP):**
  1. To support California’s designated public hospitals in meaningfully enhancing the quality of care and health of the patients and families they serve by transforming the delivery system. All public hospitals will improve severe sepsis detection and management, and increase prevention of central line-associated bloodstream infections. Areas outside of patient safety include expansion of medical homes, expansion of chronic care management models, and integration of physical and behavioral health care, among others. For more details, go to: [http://www.dhcs.ca.gov/provgovpart/Pages/DSRIP1.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/DSRIP1.aspx).

### Measures Collected/Used by DHCS

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<th>Current Quality Improvement Activities</th>
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<tbody>
<tr>
<td>Improve Psychotropic Medication Use for Children and Youth in Foster Care: To achieve improved psychotropic medication use for children and youth in foster care by: 1. Reducing the rate of antipsychotic polypharmacy; 2. Improving the antipsychotic dose prescribed to be within the recommended guidelines; and 3. Improving the monitoring of metabolic risk associated with the use of antipsychotics.</td>
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<tr>
<td>California Mental Health Care Management Program Collaborative’s Performance Improvement Plan: Improving Antipsychotic Medical Use in the Adult Population. 1. To achieve improved psychotropic medication use in the adult population by reducing the rate of antipsychotic polypharmacy.</td>
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### Priority 2: Deliver Effective, Efficient, Affordable Care

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</table>
| Managed Care Internal & Small Group Collaborative QI Projects:  
1. To improve the quality of care delivered to Medi-Cal members by DHCS-contracted managed care plans. Increase the number of advanced directives, HIV/AIDS viral load testing, weight assessment/counseling for nutrition and PA for children/adolescents, rate of prenatal visits during the first trimester of pregnancy, percentage of controlled blood pressure, communication to improve the patient care experience, percentage of members selecting the top rating for overall health care and personal MD on a patient satisfaction survey, rates for all submeasures (HEDIS and other) in care for older adults, and rate of school attendance; improve the rate of postpartum care visits, comprehensive diabetes care/rate of HbA1C testing-retinal exam screening, cervical cancer screening for seniors/persons with disabilities & women 21-64 years, and treatment of COPD; and reduce health disparities in childhood obesity, rate of children and adolescents discharged to out-of-home placement, and rate of ER admissions for members with persistent asthma. (See QIP reports at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2011-12_QIP_Qtr_1-1to3-31-12_Report.pdf). | Medi-Cal Adult Quality Care Improvement Project, Grant Pending:  
• Comprehensive diabetes care–LDL-C screening and HbA1C testing (HEDIS)  
• Diabetes short-term complications readmission rate (PQI)  
• Chronic Obstructive Pulmonary Disease admission rate (PQI)  
• Congestive Heart Failure admission rate (PQI)  
• Adult asthma admission rate (PQI)  
• Elective delivery (PC-01)  
• Antenatal Steroids (PC-03) | Medi-Cal Managed Care Program: CAHPS  
• Getting care quickly |
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<tr>
<td>Managed care all-cause readmissions (HEDIS, 2012)*:</td>
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<tr>
<td>1. To reduce the number of all-cause readmissions within 30 days of an acute inpatient discharge for members 21 years and older.</td>
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<tr>
<td>Improve Critical Access Hospital’s (CAHs) Quality Reviews and Service Delivery through Multi-hospital Benchmarking:</td>
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<tr>
<td>1. To achieve at least 75% of CAHs use of the Kansas Hospital Association Foundation’s Quality Health Indicators (QHi) for benchmarking and report purposes; and</td>
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<tr>
<td>2. To demonstrate improvement in at least one QHi per hospital.</td>
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<td>Improve CAHs Operational Performance through Support of Onsite Technical Assistance using the Lean Methodology:</td>
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<tr>
<td>1. To support at least 7 CAHs participation in at least one Lean project; and</td>
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<tr>
<td>2. To demonstrate improvement in operational QI/Performance Improvement measures.</td>
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| **CAH Participation in the Medicare Beneficiary Quality Improvement Project (MBQIP) using Selected Measures from the CMS Hospital Compare (HC) Data Reporting Program:**  
1. To identify areas for QI through the use of CAHs reporting of MBQIP outpatient 1-7 measures; and  
2. To demonstrate improvement in one or more outpatient MBQIP measures. | | | |
| **Survey and Certification of CCS Medical Therapy Units (MTUs) as Outpatient Rehabilitation Centers (OPRCs):**  
1. To assure that CCS MTUs meet and continue to meet all OPRC standards. | | | |
| **CCS/California Perinatal Quality Care Collaborative High Risk Infant Follow-up Quality Care Initiative (CCS/CPQCC HRIF QCI):**  
1. To identify infants who might develop CCS-eligible conditions after discharge from a CCS-approved NICU; and  
2. Improve the neurodevelopmental outcomes of infants served by CCS HRIF Programs through collaboration between CMS/CCS and the CPQCC. | | | |
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<tr>
<td>DHCS University:</td>
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<tr>
<td>1. To improve the knowledge, skills, and abilities of the Medi-Cal program managers, senior managers, and executives throughout the Department.</td>
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<tr>
<td>Return on Investment (ROI) Manual:</td>
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<tr>
<td>1. To quantify the value/results of A&amp;I by comparing cost recoveries, savings, and avoidance against the resources expended to complete the work.</td>
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<tr>
<td>Audits &amp; Investigations Care Development, Tracking, and Referral Flowcharts:</td>
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<tr>
<td>1. To fully document the DHCS collective case development, tracking, and referral process.</td>
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<tr>
<td>Fraud Detection and Deterrence: Field Audit Reviews:</td>
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<tr>
<td>1. To ensure Medi-Cal providers are appropriately compensated based on: a. Medical necessity; b. Appropriateness of care; c. Documentation of services rendered; d. Qualifications of provider; e. Medi-Cal rules of billing; and f. Statutes and regulations; and 2. To identify substandard care or behavior that puts patients at risk.</td>
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<tr>
<td>Individual Provider Claims Analysis Report:</td>
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<tr>
<td>1. To increase the accuracy of billing levels for Evaluation and Management (E &amp; M) procedure codes and reduce inappropriate and costly claims.</td>
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<tr>
<td>Medi-Cal Payment Error Study (MPES):</td>
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<tr>
<td>1. To accurately measure the Medi-Cal paid claims error rate for eight different groups of provider/service types (each type is called a strata).</td>
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<td>HIV/AIDS Waiver:</td>
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<tr>
<td>1. To provide services that allow persons with mid- to late-stage HIV/AIDS to remain in their homes, rather than hospitals or nursing facilities, by providing a continuum of care, resulting in improved quality of life and the stabilization and maintenance of optimal health.</td>
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<tr>
<td>Home and Community Based Services Waiver for Californians with Developmental Disabilities (DD):</td>
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<tr>
<td>1. To serve participants in their own homes and communities as an alternative to placing Medicaid-eligible individuals in hospitals, nursing facilities, or intermediate care facilities for persons with mental retardation.</td>
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</table>
### Multipurpose Senior Services Program Waiver (MSSP):
1. To foster and maintain independence and dignity in community settings for frail seniors by preventing or delaying their avoidable placement in a nursing facility. MSSP provides services to eligible clients and their families that enable clients to remain in their homes.

### Pediatric Palliative Care Waiver (PPC):
1. To provide pediatric palliative care services to allow children who have a CCS-eligible medical condition with a complex set of needs and their families the benefits of hospice-like services, in addition to state plan services during the course of an illness. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and family.

### Eligibility and Enrollment for Medi-Cal eligible Californians: Meeting the Goals of the Affordable Care Act:
1. To maximize the enrollment of Medi-Cal eligible Californians.
### DHCS Tribal Advisory Process Tracking:
1. To ensure timely notification to tribes and designees of the Indian Health Program on proposed changes to the Medi-Cal program.

### Improve the Accuracy of the Third Party Health Insurance Records in the Medi-Cal Eligibility Data System (MEDS):
1. To improve the accuracy of MEDS Health Insurance System and other health coverage records; and
2. To provide verified Medicare/Medi-Cal (duals) eligibility to Medicare Advantage and Medicare Special Needs Plans (SNP).

### DSRIP (see Priority 1).

### Coordinated Care Initiative:
1. To transition seniors and persons with disabilities into Medi-Cal Managed Care; and
2. Coordinate Medicare and Medi-Cal benefits across care settings, maximize the ability of dually eligible individuals to remain in their homes and communities with appropriate services and supports in lieu of institutional care, and minimize or eliminate cost-shifting between Medicare and Medicaid.
<table>
<thead>
<tr>
<th>Current Quality Improvement Activities</th>
<th>Measures Collected/Used by DHCS</th>
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</table>
| **Data Navigator Project:**  
1. To improve the collection and documentation of screening and diagnostic results from women in Every Woman Counts. | | | |
| **Medi-Cal Specialty Mental Health Services for Children and Youth:**  
1. To develop a performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment of mental health services for eligible children and youth that will improve outcomes at the individual and system levels and will inform fiscal decision making related to the purchase of services. | | | |
| **Family PACT QI/Utilization Management Monitoring Activities:**  
1. To identify inappropriate use of Family PACT services; and  
2. To identify areas where costs could be saved in the Family PACT program. | | | |
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<tr>
<td>Diabetes Quality Improvement Project, Medi-Cal Adult Quality Care Improvement Project, Grant Pending:</td>
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<tr>
<td>1. To improve overall diabetes management in the Medi-Cal Program by developing and implementing a two-pronged program including both provider education and patient outreach and engagement.</td>
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<tr>
<td>Maternal Health Quality Improvement Project, Medi-Cal Adult Quality Care Improvement Project, Grant Pending:</td>
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<tr>
<td>1. To reduce early (&lt;39 weeks) elective deliveries in the Medi-Cal Program and in California, in general.</td>
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<tr>
<td>DHCS Quality Improvement Training, Medi-Cal Adult Quality Care Improvement Project, Grant Pending:</td>
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<tr>
<td>One-day training for DHCS supervisors and managers on the core principles of QI; and nine-day longitudinal course in the application of QI methodology among DHCS clinicians and staff conducting the diabetes management and maternal QI projects.</td>
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## Priority 3: Engage Persons and Families in their Health

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</table>
| Member Roundtables, Pending: Collaborate with Debora Paterniti, PhD to conduct roundtable discussions with Medi-Cal members. The purpose of the roundtable discussions will be to understand the best ways to engage members and families in their health, with an emphasis on prevention. | Medi-Cal Managed Care Program: CAHPS  
- Health literacy questionnaire has section on disease self-management  
- Patient-Centered Medical Home (PCMH) - has questions on providers supporting patient taking care of their own health and discussing medication decision | Not applicable | Care management: Manage population health outreach |
| Planetree Collaboration, Pending: Collaborate with Planetree to improve the patient care experience. | Group Needs Assessment of Clients with Managed Care Plans: Language preference when talking to primary care provider; physician speaks client language; English proficiency of client; need for interpreter when talking to physician; provision of books, brochures or flyers about health; health topics of most interest; preferred ways to learn about health; actions taken to learn reasons for having difficulty to get information and support to stay healthy; satisfaction with health education classes and materials received from physician, office, clinic, hospital or health plan; frequency that beliefs conflict with the physician’s advice; use of the Internet; and preferred way to get health information from health plan | | Member management: Manage member information; manage applicant and member communication; manage member grievance and appeal; perform population and member outreach |
## Appendix C

### Priority 4: Enhance Communication and Coordination of Care

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<tr>
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</table>
| Internal and Small Group Collaborative QI Projects (see Priority 2): Increase communication to improve the patient care experience and percentage of members selecting the top rating for overall health care and personal MD in a patient satisfaction survey. | Medi-Cal Managed Care Program: CAHPS  
• Getting needed care; how well doctors communicate; customer service; shared decision making; health literacy (covers communication about medicine, test results, and forms)  
• Rating of health plan; rating of all health care; rating of personal doctor; rating of specialist seen most often | Not applicable | Care management: Manage case information  
Care management: Manage population health outreach  
Operations management: Manage data |
| Adoption of Electronic Health Records (EHRs):  
1. To improve care coordination among Medi-Cal providers;  
2. To improve member engagement; and  
3. To improve population health. | | | |
| 2011 Client Exit Interview:  
1. To assess clients' perspective on the quality of provider/patient interaction:  
a. To increase the proportion of new clients who leave a visit with high efficacy contraception; and  
b. To increase the proportion of clients who report that the provider asked about their usual source of care. | | | |
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<tr>
<td>California Health Interview Survey (CHIS): 2009 CHIS Adult Survey  • Is there anyone at your doctor’s office or clinic who helps coordinate your care with other doctors or services such as tests or treatments?  2009 CHIS Adult Survey (AskCHIS)  • When you get written information at a doctor’s office, would you say it is very easy, somewhat easy, somewhat difficult, or very difficult to understand?  2009 CHIS Adolescent Survey  • Is there anyone at your doctor’s office or clinic who helps coordinate your care with other doctors or services, such as tests or treatments?  2009 CHIS Child Survey  • Is there anyone at (CHILD’s) doctor’s office or clinic who helps coordinate (his/her) care with other doctors or services such as tests or treatments?</td>
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| Medi-Cal Incentive to Quit Smoking: Increase utilization of the Smokers’ Helpline through the use of appropriate incentives. | Medi-Cal Managed Care Program: HEDIS, 2012  
- Well-child visits in the 3rd, 4th, 5th, and 6th years  
- Adolescent well-care visits  
- Child immunization status  
- Immunizations for adolescents  
- Cervical cancer screening*  
- Weight assessment and counseling for nutrition and physical activity—children and adolescents | Not applicable | Care management: Manage registry |
| American Indian Infant Health Initiative: Educate families on health promotion and disease prevention including: tobacco use, nutrition, alcohol and drug use, immunizations, teen pregnancy prevention, prenatal care, and sexually transmitted diseases. | | | |
| Newborn Hearing and Screening Program Quality Improvement Learning Collaborative:  
1. To complete hearing screening by 1 month of age;  
2. To complete diagnostic audiologic evaluation by 3 months of age; and  
3. To enroll infants with hearing loss in early intervention services by 6 months of age. | | | |
| Internal & Small Group Collaborative QI Projects (see above): Increase weight assessment/counseling for nutrition and PA for children/adolescents; percentage of controlled blood pressure; comprehensive diabetes care/HbA1C testing/retinal exam screening; cervical cancer screening for seniors/persons with disabilities & women 21-64 years; prenatal and postpartum care visits. | | | |
## Increasing Children’s Use of Preventive Dental Services and Dental Sealants:

1. To increase the rate of children, ages 1-20 years, enrolled in Medi-Cal who receive any preventive dental service by 10 percentage points over a 5-year period; and
2. To increase the rate of children, ages 6-9 years, enrolled in Medi-Cal who receive a dental sealant on a permanent molar by 10 percentage points over a 5-year period.

### Core Program Performance Indicators for Every Woman Counts:

1. To ensure timely and complete diagnostic follow-up of abnormal breast and cervical cancer screening results;
2. To ensure timely and complete treatment initiated for cancers diagnosed; and
3. To deliver breast and cervical cancer screening to priority populations.

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<tbody>
<tr>
<td><strong>Increasing Children’s Use of Preventive Dental Services and Dental Sealants:</strong></td>
<td>CHIS 2011</td>
<td>• Cervical cancer screening • Mammography screening • Asthma control • Diabetes screening • Diabetes control • Medications to control HBP • Plan to take care of heart disease • Rate of flu vaccine • Colon cancer screening • HPV vaccination • Fall prevention • Fruit &amp; vegetable consumption &amp; physical activity • Mental health screening • Dental &amp; routine checkup info</td>
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<tr>
<td>Provider profiles with Two Clinical Indicators:</td>
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<tr>
<td>1. To improve clinical quality outcomes for chlamydia screening of female members age 25 years and younger; and</td>
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<tr>
<td>2. To improve clinical quality outcomes for chlamydia targeted screening of female members over age 25 years.</td>
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<td>2011 Family Planning, Access, Care and Treatment (Family PACT) Medical Record Review:</td>
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<tr>
<td>1. To assess whether family planning and reproductive health care services provided under Family PACT are consistent with program standards:</td>
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<tr>
<td>a. To increase the use of effective contraceptive methods as a result of the Family PACT visit;</td>
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<td>b. To increase the proportion of clients who receive education and counseling services;</td>
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<td>c. To decrease the proportion of women who receive annual cervical cytology screening tests; and</td>
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<td>2. To determine whether the quality of services delivered under the program improved over time.</td>
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## Priority 6: Foster Healthy Communities

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<tr>
<td>CalFresh Promotion, pending: Conduct a pilot project to increase CalFresh enrollment among eligible Medi-Cal members.</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
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## Priority 7: Eliminate Health Disparities

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<tr>
<th>Current Quality Improvement Activities</th>
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<tbody>
<tr>
<td>All quality improvement activities are designed to reduce health disparities among low-income Californians.</td>
<td>Descriptive epidemiology report to identify health disparities among Medi-Cal members, in progress.</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
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</table>

*Measures included in the Medi-Cal Adult Quality Care Improvement Project*
Appendix D

DSRIP DY7 Interim Report Feedback
(Clinical Quality Improvement)

Alameda County Medical Center

Improvement Plan

- Progress toward implementing panel management is excellent.
- Level of participation in learning collaboratives is impressive.
- Planned process for developing care coordination model is robust.
- Please include plan for ongoing staff training to account for staff turnover.
- Lean and Six Sigma initiative: In future reports please specify what processes were improved, mention how many and what kinds of staff were trained.
- Improving patient flow in ED: Intake nurse intervention as well as plan for testing is excellent.
- Severe sepsis detection and management bundle: Very good demonstration of evidence-based quality improvement strategies as well as electronic health record integration.
- Central line associated blood stream infection: Sound intervention and measurement plan.
- Surgical site infection prevention: Adequate progress.
- Hospital acquired pressure ulcer prevention: Adequate progress.
- Page 30, sepsis harm reduction improvement activities: Need description of activities.

Data and Milestones

- Participant training survey and resident practicum: Outline key results of your survey as well as how the success of resident training was evaluated.
- Need more details and outlines of training program, since these comprise a key component of your intervention.
- Implementing and expanding care transitions program: Process milestone is very modest relative to amount of incentive payment ($3,920,000 to pilot plan in one medical-surgical unit).
- Follow-up phone calls are only one aspect of a care transitions program. Recommend more multifaceted approaches.
- Patient and caregiver experience: Include process measures. Milestone and goal needs to be more ambitious to justify level of incentive ($3,327,750 to develop plan).
- In future reports provide data on current HCAHPS scores and quantitative progress toward goal.
- In future reports please include more detailed quantitative data for milestones.
- Per instructions on use of reporting form, for milestones not achieved or partially achieved, please include an assessment of actual and potential causes. Explanation must reflect understanding of systems level issues.

Arrowhead Regional Medical Center

Improvement Plan

- Those parts of report that have been filled are detailed and well-written. However, report has a large number of missing fields.
- Training of primary care workforce; sepsis training; Chronic Care Model; Medical Home training; central line bundle training; pressure ulcer prevention training: Include curricular outlines, frequency of training, and results of evaluation of training programs.
• Implement the Chronic Care Model for diabetes – The chronic care model has multiple components. Some sites choose to focus more on particular aspects of the chronic care model depending on their patient population. If this is so for your medical center, please specify what aspects of the Chronic Care Model you will focus on. Please provide sufficient detail on how the Chronic Care Model, or components of the Model, will be implemented to allow the reviewer to understand system level factors that could be barriers or facilitators of success.

• Expand chronic care management models: For goal of applying the Chronic Care Model to one targeted chronic disease (diabetes): Specify which diabetes performance measures were selected as well as prior performance on diabetes measures.

• Participation in the SNI Sepsis and CLABSI Collaborative is commendable. However, please report on specific practice changes made locally as a result of participation in these collaboratives, as well as challenges and successes.

• Pressure ulcer prevention, Implement hourly rounding- This is a major change to workflow and clinician practice. Please describe how this intervention was tested and improved upon following its implementation (rapid cycle testing).

Data and Milestones

- It is difficult to provide formative feedback on report and milestones due to insufficient information. For example, milestone is for at least 50% of new patients to the medical home to receive their first appointment in a timely manner. However, no data has been provided to support attainment of milestones. No information on what interventions were carried out has been provided.
- In future reports please include quantitative data so that reviewer is able to clearly assess progress toward milestones.
- Compliance with central line insertion practices: No data reported.
- At risk populations, care coordination, preventive health, sepsis, central line associated blood steam infection: Please provide baseline data and any follow-up data available.

Contra Costa Regional Medical Center Improvement Plan

• Enhance interpretation services and culturally competent care: Include results of gap analysis. Describe how interpreters were trained. Describe plans for sustainability in case of turn-over of interpreters.

• Expand medical home: A system for assignment of individuals to medical home is mentioned. Describe this process in more detail. Describe results – how process is being continually tested for effectiveness, how many patients were assigned to PCP after this process was implemented.

• Redesign to improve patient experience: Display quarterly patient experience data - Evaluation of how frequently data on hospital intranet site is accessed and if this information is helpful to stakeholders will be important information to evaluate.

• Redesign to improve patient experience: What did your patient and family focus group interviews show regarding gaps in communication?

• Patient care giver experience: Describe your specific aim statement for the collaborative and results of baseline gap analysis. Describe how CG-CAHPS data will be shared with clinicians to promote ongoing learning and improvement.

• Integrate physical and behavioral health care: A pilot conducted in one health center is mentioned. Describe how changes were piloted in more detail, as well as results of your tests of change to
evaluate if the pilot worked.

- Conduct medication management: Describe intervention that was piloted to improve medication refill process in more detail. How were pharmacists and other staff trained? Include training outline/materials. How was pilot evaluated and what were results of this evaluation?
- Patient/caregiver experience, undertake planning to implement CG-CAHPS: Describe your planning process in more detail.
- Severe sepsis, implement sepsis resuscitation bundle: Describe sepsis screening tool, process for implementation of changes, how stakeholders were engaged, how implementation was tested, and results of tests of change.
- Central line insertion protocol: Describe process for implementation.
- Hospital acquired pressure ulcers: Summarize results of your assessment of nurses’ knowledge. Describe how flow sheet was developed and tested. Regarding new processes developed, how are you testing compliance with the “4-eyed skin assessment”? How were nurses trained (include training outline), and what are plans for sustaining changes? How did nurses respond to this process change, e.g., rate of adoption of change or assessment of potential reasons for not adopting change.

Data and Milestones

- Expand primary care capacity: Current Third Next Available Appointment is 13.88 days. Improvement targets of 2% reduction per year (13.6 days -> 13.3 days -> 13.1 days) are much too low. With thoughtful implementation of meaningful and evidence based process changes, this measure can reasonably be expected to increase more sizably.
- Redesign to improve patient experience: Intervention involves implementing patient surveys. Report needs to include results of early implementation, e.g., what percentage of eligible patients ended up being surveyed and response rate.
- Care coordination and at-risk populations: Provide summary of data for diabetes measures. Describe measurement process and inclusion/exclusion criteria.
- Central Line Associated Blood Stream Infections: Include summary of baseline and follow-up data.

Kern Medical Center Improvement Plan

- Expand primary care capacity: Describe the nurse triage software that was selected, including how it is being tested locally.
- For your goal of providing timely appointments in clinic for patients who request urgent appointments: Provide baseline and follow-up data in description. For this particular aim, monthly data collection will most likely provide you with important information, since capacity to meet demand will be subject to seasonal patterns.
- Enhance interpretation services, training program to improve cultural competency: Provide outlines of training programs.
- Enhance urgent medical advice, patient-focused educational newsletters- This is an impressive commitment. It will be important to assess the helpfulness of these newsletters at an early stage to allow changes based on patient feedback. Do you have information on your patient population with respect to health literacy? If so, how has this information been utilized in the publication of newsletter? Are newsletters published in languages other than English?
- Expand specialty care capacity- Very impressive reductions in wait time following hiring of
endocrinologist.

- Sepsis and venous thromboembolism: Describe results of your gap analysis of current processes for detecting and treating severe sepsis. Provide outlines or summary of clinicians training programs for severe sepsis. Other than evaluation of number of clinicians completing educational program, how is success of this educational program being measured (e.g., change in knowledge, attitudes, skills, or behavior)?

**Data and Milestones**

- Provide more robust documentation of changes implemented and data analysis, especially regarding Medical Home Initiative. For example, for milestone regarding percentage of patients assigned to medical homes contacted for their first patient visit within 120 days, improvements in phone access, metrics on the primary care dashboard, provide baseline and follow-up data to demonstrate improvement.
- Increase patient engagement, by completing 5 patient engagement initiatives: How is patient engagement being measured to evaluate the success of these initiatives?
- Hospital acquired pressure ulcer prevention: Provide summary of baseline and follow-up data.

**Los Angeles County Department of Health Services Improvement Plan**

- Comprehensive risk-reduction program for patients with diabetes: Excellent use of electronic health record based decision support tools.
- Expand interaction types beyond one-to-one visits to include group visits, telephone visits, etc.: Exemplary level of commitment and innovation. Good demonstration of success of interventions.
- Enhance Performance Improvement and Reporting Capacity, quality dashboard: Provide more details on how access/use of the dashboard is being tracked, how the dashboard has been used to improve quality of care, feedback from end users on usefulness of this dashboard.
- Enhance Coding and Documentation for Quality Data, train staff on changes in work flow: Provide examples and outlines of training programs.
- Provider training on Medical Home model: Provide details of training and quantitative / qualitative results of evaluation of this training.
- Sepsis and central line infection: Describe barriers that you identified. Please also provide more details on tests of change noted in your report as well as the outcomes of these tests of change.
- Sepsis and central line infection curricula: Provide outlines of these curricula. In addition to tracking completion rate of modules, how will curricula be evaluated?
- Surgical site infection, address provider knowledge deficits- From the description in the report it is unclear what these knowledge deficits were and what exactly was done to address them.

**Data and Milestones**

- Co-locate mental health services with primary care: The report mentions that co-located services are more convenient for patients and allow increased clinician collaboration: How is this being objectively measured and what are the results of this evaluation?
- Track the number of referrals from primary care providers to on-site mental health professionals: Data needs to be included in reports to enable the reviewer to adequately assess the effectiveness of interventions.
- Many milestones have been easily met or exceeded. Milestones need to be reevaluated so that
they are more ambitious and show meaningful improvement with new quality improvement interventions. For examples: to enhance urgent medical advice, the DPH aimed to expand access to Nurse Advice Line (NAL) by 10% over baseline. The DPH has already increased calls by 7.5% over baseline due to increased enrollment in Healthy Way LA and marketing to Healthy Way LA members. For number of NAL patient contacts who reported intent to go to the ED for non-emergent conditions but were re-directed to non-ED resources, a goal of 10% was noted, and the DPH reported a 12% increase over the baseline year.

- Assignment of patients to medical home teams: How will patient-level improvements in care, such as patient satisfaction be evaluated?

Natividad Medical Center
Improvement Plan

- Redesign to improve patient experience, Develop regular organizational display of patient experience data and provide quarterly updates to employees: It will be important to assess if such displays are of value to the clinicians and staff or if this strategy is in fact improving patient experience.
- Redesign to improve patient experience, Develop a staff education plan to integrate the patient experience into employee orientation and training: Please provide more details of training program such as curricula and outlines. Please provide information on how this training program will be evaluated.
- Apply process improvement methodology to improve quality/efficiency, Convene training events conducted by designated process improvement trainers: Please provide details of this training program including curricula and how it will be evaluated.
- Central Line Insertion Practices: Provide details on how components of the bundle were introduced and tested (e.g., details of Plan-Do-Study-Act cycles), how buy-in was achieved among front-line clinicians and other stakeholders, as well as plans for sustaining changes.

Data and Milestones

- Expand primary care capacity: Process milestones in report (train 6 Touro University medical students, complete MOU with Stanford to serve as training site for PA students) are important initiatives in the longer term development of the clinical workforce. However, while each of these approaches has the potential to be beneficial, the benefit may not be large or immediate. Approaches that may be more consistent with the DSRIP timeframe might include strategies to link all patients to a medical home, hiring additional clinicians and support staff, adding primary care clinic sessions on weekday evenings and weekend days, and promoting more appropriate use of primary care services by implementing a centralized nurse telephone advice line and appointment scheduling service.
- Apply process improvement methodology to improve quality/efficiency, Target 1 specific process to improve utilizing the Model for Improvement framework (ventilator-associated-pneumonia): Please details of baseline and follow-up data to support the results of this intervention.
- Care coordination, preventive health: Please provide baseline and any follow-up data available for diabetes, mammography and influenza measures in report.
- Severe sepsis, hospital acquired pressure ulcer prevention: Please provide baseline and follow-up data in report.
- Most planned milestones achieved or at least on track to achieve.
Riverside County Regional Medical Center

Improvement Plan

• Expand primary care capacity: Very good set of interventions selected toward reaching goal. Regarding implementing the mobile health clinic, please include how success of this mobile clinic will be evaluated.
• Expand specialty care capacity, Launch a new CHF specialty clinic: Please provide information on how effectiveness of the clinic will be evaluated.
• The level of intervention (hiring 1 nurse practitioner under the supervision of a cardiologist for a CHF clinic) seems out of proportion to the relatively large incentive amount.
• Expand chronic care management models: Good descriptions of outpatient diabetic medication titration program and peri-operative glucose control program. Regarding milestone of increasing patients who select a self-management goal, seeking direct feedback from patients who do/do not end up selecting these goals, to investigate barriers/facilitators may be informative.
• Redesign primary care, Train 70% of relevant staff in the Family Care Clinic on methods for redesigning the clinic to improve efficiency: Please include details of this training, including curricular outlines and methods for evaluating the success of this training. Is there evidence in the literature that demonstrates that such training (“review and discussion of procedures that will improve patient flow and efficiency”) is indeed effective in changing and sustaining clinician and staff behavior? If so, please provide references.

Data and Milestones

• Virtually all planned milestones have been achieved and substantially exceeded. Reconsider milestones set in subsequent years to see if they need to be increased to ensure meaningful improvement.
• Implement and utilize disease management registry, Train at least five more staff on populating and/or using the diabetes and/or CHF registries: Describe results of training and how training will be reinforced. Include plans for sustainability, given staff turnover. Include plans to validate accuracy of entered data.
• Expand medical homes, Assign at least 25% of eligible patients to a medical home in the Family Care Clinic: Describe changes made in more detail, including how these changes were tested and modified (rapid cycle quality improvement).
• Severe sepsis, Compliance with sepsis resuscitation bundle: Please describe results of interventions to implement components of the bundle. Data should demonstrate continuous testing of interventions and incremental learning from data (rapid cycle quality improvement).
• Provide documentation/data that supports the milestones reported in the reporting form.

San Francisco General Hospital

Improvement Plan

• Increase training of primary care workforce, Develop and implement a curriculum for residents to utilize their practice data to demonstrate skills in quality assessment and improvement: Please provide outline of curriculum and assessment plan.
• Expand specialty care capacity, Increase the number of outpatient encounters by at least 5% in 2 targeted specialty clinics: Describe what changes were implemented to increase these outpatient encounters, how these changes were tested, and strategies to sustain changes.
• Enhance performance improvement and reporting capacity, Quality and Leadership Academy:
Appendix D

Provide details of curriculum, including curricular outlines and evaluation process.

• Severe sepsis detection and management, Compliance with sepsis resuscitation bundle: Describe specific changes implemented as a result of participation in collaboratives, how incremental learning occurred during implementation of changes, and strategies to sustain changes.

• Central Line Associated Blood Stream Infections: Describe how changes were implemented, tested, and how incremental learning occurred (rapid cycle quality improvement). Describe how buy-in was obtained from frontline clinicians and other stakeholders, and plans to ensure sustainability of changes.

Data and Milestones

• The DSRIP Plan identifies initiatives in all categories 1-4, but there was no reporting on most categories in Categories 1 and 2 outside of expanding specialty care, performance improvement, medical home, behavioral health, and specialty care access.

• Provide more complete milestone reporting and provide documentation to support milestones reported on form.

San Joaquin General Hospital
Improvement Plan

• Many descriptions of improvement activities are cut off on the submitted PDF document making it impossible to review. Please resubmit readable version.

• Central Line Associated Blood Stream Infection: Report mentions that “improvement efforts will be focusing on physician compliance. We have a difficult task of getting physicians buy-in on completing a form they consider unnecessary”. This is obviously a significant challenge. The report needs to describe how physicians are being engaged in this effort, and how barriers to change are going to be evaluated and addressed.

Data and Milestones

• Close to no documentation has been provided to support milestones on form. This report is therefore very difficult to review. Please provide documentation to support milestones reported on form.

• Expand primary care capacity: Milestone of adding 1.5 FTE primary care provider in clinic seems out of proportion to relatively large incentive amount.

San Mateo Medical Center
Improvement Plan

• Expand medical homes, At least 60 percent of eligible patients will be assigned to primary care provider teams: Please provide clear description of changes implemented, as well as changes are tested and modified on an increasing scale (small tests of change, rapid cycle improvement).

• Redesign primary care: Excellent set of evidence based interventions implemented. Please include details of how each change was tested on a smaller scale, modified based on learning from data, implemented on a larger scale, and how buy-in from stakeholders was achieved. What strategies are being use to increase the likelihood of sustaining changes.

• Redesign to improve patient experience: Please provide baseline data in report. Provide specific examples of how staff has utilized these data to test improvement strategies.

• Integrate physical and behavioral health care: Provide an outline of the implemented program, as well as information on barriers and facilitators to implementation and scaling up. Describe what
specifically was learnt from this pilot that will inform scaling up of the program.

**Data and Milestones**

- Please provide documentation/data to support the milestones reported in the reporting form.
- Good description of changes implemented to achieve Time to Next Available Appointment within 7 days and REAL data. However, it is difficult to appreciate the magnitude of change due to lack of data in report. Please provide baseline and follow-up data.

**Santa Clara Valley Medical Center**

**Improvement Plan**

- Expand primary care capacity: Very good interventions for panel management. However, please provide more outcome data. Also describe how changes were tested, modified, and scaled up (rapid cycle quality improvement).
- Implement and utilize disease management registry functionality, Conduct training on registry platform: Provide outlines of training programs and how effectiveness of training will be evaluated.
- Expand chronic care management models, Formalize multi-disciplinary teams: As currently described in report, teams consist only of pharmacist care managers and physicians. Please report how other stakeholders are engaged in teams, e.g., nurses, social workers, administrative staff, patients, caregivers, etc.
- Expand chronic care management models, Train relevant staff in the chronic care model: Include outlines of training programs, how effectiveness of training will be evaluated, and how learning will be sustained given staffing changes and knowledge attrition over time.
- Redesign to improve patient experience, Implement plans for regular organization-wide communication of patient experience data and efforts to improve patient/family experience: Describe how the effectiveness of such communication is being evaluated (such as specific examples of how communication of these data with employees improved care delivery).
- Redesign to improve patient experience: How are patients engaged as active members of the care delivery team (other than patient experience surveys); for example, including patients on performance improvement teams has been shown to accelerate improvement.
- Integrate physical and behavioral health care, 500 primary care patients will be provided behavioral health services by end of Year Two: What processes/systems were modified to enable this substantially increased volume? How were these changes piloted, tested, modified and scaled up. Please provide further aggregate information to show that such services improved care delivery or patient outcomes.

**Data and Milestones**

- Multiple missing data fields in reporting form.
- Expand chronic care management models, Apply the chronic care model to the management of glycemic control and dyslipidemia in diabetes: Please provide data to allow the reviewer to assess the effectiveness of interventions.
- Patient/care giver experience, CG-CAHPS planning: What is the sample size you are considering in order to conduct estimates at the provider level?
- Severe sepsis, Compliance with sepsis resuscitation bundle: Total Bundle Compliance July-December is reported. The DPH mentions that a sepsis Screening Tool was not in place for this time frame, and other criteria were used to obtain baseline values. Please clarify how follow-up data will be
measured and tracked using measures that are comparable to those used at baseline.

University of California, Davis Medical Center

Improvement Plan

• There is no description of improvement activities, changes made, how these changes were tested, scaled up etc. It is impossible to understand what processes were implemented or modified to achieve goals. Including such information is important, since it can be shared with other DPHs to allow for shared learning and collaborative improvement.
• Please include curricular outlines for training programs as well as a summary of results of the evaluation of these programs.
• Since all milestones have been reported as already been achieved, future milestones will need to be revisited to ensure meaningful improvement.

Data and Milestones

• No baseline/follow-up data has been provided. It is not possible to evaluate progression toward achieving goals. Please provide documentation that supports form milestone results.

University of California, Irvine Medical Center

Improvement Plan

• Expand primary care capacity: Please summarize baseline and follow-up data to illustrate this improved access.
• Increase training of primary care workforce, Create training program and materials for CHF coaches: provide outlines of training program curricula. Were these programs based on those used successfully at other organizations, or were they completely developed in-house. If the latter, how were they tested prior to implementation?
• Increase training of primary care workforce, Recruitment of learners across disciplines to begin engagement with project: provide details on these learners, how many, what type of clinicians?
• Increase training of primary care workforce, Develop the multidisciplinary team model for educating care providers in medical homes, IT, EHRs, and patient education: Describe how this training will be evaluated for effectiveness?
• Expand medical homes, Continue to assess readiness of the site being designated an NCQA: Please summarize your action plan.
• Expand chronic care management models, Educate providers to effectively involve patients: Please provide outlines of training curricula and how this training will be evaluated for effectiveness.
• Redesign to improve patient experience, Achieve compliance in the information being updated in patient charts: Your success is commendable. It will be very useful to learn about processes that were modified that you attribute to your success? What are your plans for sustaining these results?
• VTE prophylaxis, Redesign and implementation of electronic solutions: Summarize these interventions.
• VTE prophylaxis, Provide education program for staff: Include curricular outlines. How will training be evaluated for effectiveness?

Data and Milestone

• Very little documentation was provided in the form to support the milestones.
• Develop risk stratification capabilities/functionalities, Implement pilot protocol using diabetes as a
model: Provide more details on pilot, e.g., how many patients surveyed, how was work flow and process informed by pilot?

- Develop risk stratification capabilities/functionalities, Evaluate proportion of patients in each risk stratum: How were these analyses conducted? What were the results of these analyses?
- Redesign to improve patient experience, Pilot the tool: Please summarize data from these piloted surveys. What else did you learn from the pilot about your process?
- Establish/expand a patient care navigation program, Increase number of referrals/patients served: Please provide baseline and follow-up results of improvement initiatives.

University of California, Los Angeles Hospitals
Improvement Plan

- Increase training of primary care workforce, IMG program: provide curricular outline as well as information on how success of this program will be evaluated.
- Expand specialty care capacity, Train primary care providers, specialists and staff: How was the effectiveness of this training evaluated?
- Expand medical homes, Implement the adult and pediatric medical home model in primary care clinics as pilot: Provide data to show results of pilot. How did pilot inform modification and scaling up of interventions to other sites?
- Conduct Medication Management, Develop evidence-based decision rules that will be the clinical underpinning of each point of care decision support message: How were these electronic health record based changes pilot tested (small tests of change)?
- Compliance with Central Line Insertion Practices: Report mentions that many units in the hospital do not embrace the data. However, some units in the hospital do reach out and work one-on-one with Infection Control Department to complete a comprehensive unit based patient safety improvement project. Has the hospital examined change management strategies for the units that do not reach out? Also, it may be helpful to interview units that do reach out to understand characteristics of these units that might facilitate data driven improvement.
- Hospital-acquired pressure ulcers, Achieve hospital-acquired pressure ulcer prevalence of less than 2.5%: What strategies are in place to sustain improvements?

Data and Milestones

- Limited documentation has been provided in reporting form to support milestones.

University of California, San Diego Health System
Improvement Plan

- Implement and utilize disease management registry functionality, Conduct staff training on using registry: Please provide outlines of training program and how effectiveness of training will be evaluated.
- Introduce telemedicine: Provide more data on the pilot telemedicine program, e.g., what types and how many consulting providers, how is the volume of consultations, for what kinds of clinical services? How will service be evaluated? What was learnt from the pilot that will be used to inform scaling up of telemedicine services?
- Enhance coding and documentation for quality data: ICD-10/5010 conversion project is a mandatory initiative for future reimbursement and not an innovation as described by DSRIP. It is unclear from the description in the report how it differs from the mandate.
• Improve patient flow in the emergency department, Decrease the percent of patients who leave the ER without being seen by 5%, Reduce ED wait time for admitted patients by 5%: Summarize changes that were made that resulted in improvements, and how these changes were piloted, tested and scaled up.

• Conduct medication management, Implement program to improve continuity of medication management from acute to ambulatory setting: Please describe changes implemented as well as data to show rates of implementation of various components of the intervention. What were specific barriers and how were they evaluated and handled? How were stakeholders engaged? What were facilitators to success?

• Implement/expand care transitions program, Pilot care transitions process on 2 wards: Summarize key components of the intervention, success rate in implementing these components, how changes were tested, refined and re-implemented (small tests of change/rapid cycle quality improvement), and how stakeholders were engaged.

• Implement real-time hospital acquired infection system, Development of electronic system for real-time education on HAI prevention: How is this system being evaluated for helpfulness and effectiveness?

• Implement real-time hospital acquired infection system, Prompts for prevention and risk identification: Were these prompts tested prior to full implementation? If so, what did this evaluation show? How were front-line clinicians engaged in the design and implementation of these prompts?

Data and Milestones

• Please provide documentation of baseline and follow-up data to support milestones on the form.

University of California, San Francisco Medical Center Improvement Plan

• Implement and utilize disease management registry functionality: What were specific lessons learnt during implementation of registries? How were barriers overcome? What were facilitators to success?

• Enhance performance improvement and reporting capacity, Implement quality improvement data systems, collection and reporting capabilities: How are front line clinicians being engaged in these efforts? How are data dashboard and other reports used by clinicians?

• Expand medical homes, train MA’s/health workers in panel management and health coaching: Please provide summary/outline of training program.

• Severe sepsis detection and management, Implement sepsis resuscitation bundle: Report mentions that unit-based teams are using performance improvement methods, PDSA cycles, to pilot and test ways to implement and sustain new protocols: Please provide examples of these PDSA cycles and small tests of change, what was learnt and how interventions have been modified based on learning.

• Hospital-acquired pressure ulcer prevention: The report describes clinician education and retrospective incident reviews as the main interventions. Did the medical center implement any systems-level changes to current care processes, e.g., standardizing comprehensive skin assessments, and pressure ulcer risk assessment? If so, was performance on these process measures evaluated?

• Hospital-acquired pressure ulcer prevention, Clinician education: How was baseline and follow-up level of staff knowledge assessed? For example, the Pieper Pressure Ulcer Knowledge Test has been used in multiple urban and rural settings to examine pressure ulcer knowledge among nurses.
and other professionals.

Data and Milestones
- Please provide documentation to support milestones on reporting form.
- Report results of the Diabetes, short-term complications measure to the State - 2 patients in a 6-month period, Report results of the Uncontrolled Diabetes measure to the State (DY7-10) - 0 patients in a 6-month period. If these results are truly this low, perhaps another diagnosis for at-risk populations should be targeted?
- Multiple blank data fields, especially for Category 4.

Ventura County Medical Center Improvement Plan
- Report contains inadequate data. Much if the documentation is in the form of attachments such as PowerPoint presentations. These attachments do not contain information specific enough to permit meaningful feedback and are cumbersome to read. A summary of baseline data, performance improvement activities, tests of change and follow-up data contained within the main report will greatly help the reviewer assess progress toward milestones. This will also avoid the need to review additional attachments to search for relevant data.
- Integrate physical and behavioral health care, Adopt an evidence based treatment practice utilizing the IMPACT Collaborative Care Treatment Model: The data provided under this milestone (number of referrals) does not directly address of this milestone goal was reached.
- Use palliative care programs: How is this program being evaluated for its success? Please provide outlines of training programs for resident physicians on this topic. The report does not provide evidence that patient and family perspective on the helpfulness or effectiveness of the palliative care consulting service was assessed.
- Please send examples/outlines of training programs.
- Severe sepsis, Compliance with sepsis resuscitation bundle: How is the protocol being implemented? How have health care providers sued the feedback and dashboard to improve care delivery?
- Central Line Associated Blood Stream Infection, Compliance with CLIP: Please describe specific systems-level changes made to increase bundle compliance.
- Hospital Acquired Pressure Ulcer Prevention: Please provide outlines of education programs. How was baseline and follow-up level of staff knowledge assessed? For example, the Pieper Pressure Ulcer Knowledge Test has been used in multiple urban and rural settings to examine pressure ulcer knowledge among nurses and other professionals.

Data and Milestones
- Please provide data to support milestones.
Appendix E

Quality Improvement Tool

Project description must not exceed 600 words (not including the template text)
All information (including tables) must be included in a single document

1. **Context:** Where was this improvement work done? What sort of unit/department? What staff/patient groups were involved?

2. **Problem:** What was the specific problem or system dysfunction that you set out to address? How was it affecting patient care?

3. **Assessment of problem and analysis of its causes:** How did you quantify the problem? Did you involve your staff at this stage? How did you assess the causes of the problem? What solutions/changes were needed to make improvements?

4. **Intervention:** Describe the intervention used in sufficient detail so that others could reproduce it.

5. **Study design:** If your study was formal research, then describe the study design (for example, observational, quasi-experimental, experimental) chosen for measuring the impact of the intervention the outcomes.

6. **Strategy for change:** How did you implement the proposed change? What staff or other groups were involved? How did you disseminate the results of your analysis and your plans for change to the groups involved with/affected by the planned change? What was the timetable for change?

7. **Measurement of improvement:** How did you measure the effects of your planned changes? Describe the analytical methods used and the results obtained.

8. **Effects of changes:** What were the effects of your changes? How far did these changes resolve the problem that triggered your work? How did this improve patient care? What problems were encountered with the process of changes or with the changes?

9. **Lessons learnt:** What lessons have you learnt from this work? What would you do differently next time?

10. **Message for others:** What is the main message based on the experience that you describe here that you would like to convey to others? Discuss what your findings mean for patients and/or systems of care.

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Kenneth W. Kizer, M.D., M.P.H. - Chair
Distinguished Professor and Director
Institute for Population Health Improvement
UC Davis Health System

Dr. Kenneth W. Kizer is Director of the Institute for Population Health Improvement, UC Davis Health System, and a Distinguished Professor in the UC Davis School of Medicine (Department of Emergency Medicine) and the Betty Irene Moore School of Nursing.

Dr. Kizer’s professional experience includes positions in academia and the public and private sectors. His previous positions have included: President, CEO and Chairman of Medsphere Systems Corporation, the nation’s leading commercial provider of open source healthcare information technology; founding President and CEO, National Quality Forum, a Washington, DC-based quality improvement and consensus standards setting organization; Under Secretary for Health, U.S. Department of Veterans Affairs and chief executive officer of the nation’s largest healthcare system; Director, California Department of Health Services; and Director, Emergency Medical Services Authority, State of California. He has served on the U.S. Preventive Services Task Force and as Chairman of the Board of The California Wellness Foundation, the nation’s largest philanthropy devoted to health promotion and disease prevention, as well as on the governing boards of managed care and health IT companies, several foundations and various professional associations and non-profit organizations. He also has worked in various capacities over the years with numerous foreign countries on health-related matters.

Dr. Kizer is an honors graduate of Stanford University and UCLA, and the recipient of two honorary doctorates. He is board certified in six medical specialties and/or subspecialties, and has authored over 400 original articles, book chapters and other reports. He is a fellow or distinguished fellow of 11 professional societies and a member of Alpha Omega Alpha National Honor Medical Society, Delta Omega National Honorary Public Health Society, the Institute of Medicine of the National Academy of Sciences, and the National Academy of Public Administration. He is also a Fellow National of The Explorers Club, a founding member and past president of the international Wilderness Medical Society, a former U.S. Navy diver, and a nationally recognized expert on diving and aquatic sports medicine and the medical aspects of wilderness activities.

His accomplishments have been recognized with dozens of awards, including the Award of Excellence, American Public Health Association; Distinguished Service Medal, American Legion; Earnest A. Codman Award, The Joint Commission; Gustav O. Lienhard Medal and Award, Institute of Medicine; Justin Ford Kimball Innovator Award, American Hospital Association; Nathan Davis Award for Outstanding Public Service, American Medical Association; John D. Chase Award for Physician Executive Excellence, Association of Military Surgeons of the United States; Exceptional Service Award, U.S. Department of Veterans Affairs; Rodney T. West Literary Achievement Award, American College of Physician Executives; Special Recognition Award, March of Dimes; Rear Admiral William S. Parsens Award for Scientific Medi-Cal Performance Advisory Committee
Institute for Population Health Improvement
and Technical Progress, Navy League of the United States; Torch Award, Coalition to Protect All Californians from Tobacco; Founders’ Award, American College of Medical Quality; and the Award of Honor, American Society of Health-System Pharmacists.

He has been selected as one of the ‘100 Most Powerful People in Healthcare’ by Modern Healthcare magazine on several occasions, and his work has been featured in Time, Business Week, Fortune, The Wall Street Journal, The New York Times and numerous other magazines, newspapers and national television shows.

Sophia Chang, M.D., M.P.H.
Director
Better Chronic Disease Care Program, California Healthcare Foundation

Dr. Sophia Chang is director of the foundation’s Better Chronic Disease Care program, which focuses on improving clinical outcomes and quality of life for Californians with chronic diseases. The foundation’s work in this area includes strengthening safety-net systems of care, managing care for the most costly, leveraging health information technology, and promoting appropriate care toward the end of life.

Chang is the former director of the Veteran Health Administration’s Center for Quality Management in Public Health, which worked to improve patient care through the use of innovative quality management techniques and clinical information systems.

Chang’s previous positions include director of the HIV/AIDS program for the Henry J. Kaiser Family Foundation; medical director of the San Francisco Health Plan, a managed health care plan for Medicaid recipients; and director of AIDS Health Services for the San Francisco Department of Public Health, where she oversaw the Ryan White CARE Programs for the city. She also has worked as a medical researcher, examining health disparities in breast cancer care.

She recently served on the Managed Risk Medical Insurance Board, which oversees Healthy Families (the state’s Children’s Health Insurance Program) and California’s Pre-Existing Condition Insurance Plan (from September 2006 to May 2011). Chang continues to practice general internal medicine at San Francisco General Hospital as a UCSF faculty member. She holds a bachelor’s degree from Amherst College; a master of public health from the University of California, Berkeley; and a medical doctorate from Columbia University’s College of Physicians and Surgeons.

Bradley Gilbert, M.D.
Chief Executive Officer
Inland Empire Health Plan

Dr. Bradley Gilbert was appointed the IEHP Chief Executive Officer in October 2008. As one of the largest public not-for-profit health plans in California with over 568,000 members and a provider network with over 3,000 providers, Dr. Gilbert is leading IEHP into the healthcare reform era. Prior to being appointed CEO, Dr. Gilbert served as Chief Medical Officer for IEHP.

Under his leadership, IEHP was the first Medicaid-only plan in California to earn NCQA Accreditation in 2000. IEHP also earned a #1 Medicaid HMO ranking in California by U.S. News and World Report in 2008. In 2010, he lead IEHP to become one of only five health plans across the country to achieve a 5-star rating for Medicare Part D Quality and Performance. In May 2012 IEHP received a 100 percent score on the Standards portion of its NCQA review, with an overall Commendable Accreditation Level.
Dr. Gilbert is also a healthcare industry leader at the state and national level. He serves on the Boards of the national Association of Community Affiliated Plans, the California Association of Health Plans and the Local Health Plans of California.

Dr. Gilbert is Board Certified in General Preventive Medicine and has extensive experience in Public Health, health care delivery and health care policy development.

Marge Ginsburg, B.S.N., M.P.H.
Executive Director
Center for Healthcare Decisions

Marge is the founder and Executive Director of the Center for Healthcare Decisions (CHCD), a nonprofit, nonpartisan organization in California that seeks the public’s perspective on complex health policy issues. Through deliberative small-group processes, the lay public addresses difficult issues from the vantage point “what should we do as a society.”

Currently she is working with American Institutes for Research on an AHRQ-funded project, conducting national discussion groups on the use of medical evidence. She recently completed a project for California’s health benefit exchange on a fair model for cost-sharing and is now planning a state project to consider seniors’ priorities in addressing the cost of Medicare. Last year, CHCD began its Common Cents initiative, exploring ways that the public will support for efficient use of communal healthcare resources.

In 2011, she was one of 18 members of the Institute of Medicine’s Committee on Essential Health Benefits. She is a member of NCQA’s Committee on Performance Measurement and other committees to improve health care in California.

Marge received her nursing degree from the University of Maryland and a Masters in Public Health from UC Berkeley.

Sheldon Greenfield, M.D.
Donald Bren Professor of Medicine and Executive Co-Director
Health Policy Research Institute at the University of California, Irvine

Sheldon Greenfield, MD, an internationally recognized leader in quality of care and health services research, is the Donald Bren Professor of Medicine and Executive Co-Director of the Health Policy Research Institute at the University of California, Irvine. Dr. Greenfield’s research has focused on primary care outcomes, quality of chronic disease care, comparative effectiveness research and patient participation in care. He was the 1995 recipient of the PEW Health Professions Award for lifetime achievement in Primary Care Research.

Dr. Greenfield is a recipient of the Glaser Award of the Society of General Internal Medicine and the 1999 Novartis Global Outcomes Leadership Award. Dr. Greenfield was elected to the IOM in 1996. He was Chair of the IOM report Cancer Patient to Cancer Survivor: Lost in Transition and was also the Chair of the National Diabetes Quality Improvement Alliance. He was Co-Chair of the IOM Committee on setting National Priorities for Comparative Effectiveness Research. He was also Chair of a 2011 IOM Committee to standardize Clinical Practice Guidelines. He is current chair of the National Quality Forum Advisory Panel for Diabetes and Chronic Kidney Disease, and a member of the NQF Outcomes Steering Committee. He is also Co-Senior Editor of the new international Journal of Comparative Effectiveness Research.
Mitchell H. Katz, M.D.
Director
Los Angeles County Department of Health Services

Mitchell H. Katz, MD is the Director of the Los Angeles County Department of Health Services, the second largest health system in the nation. Previously, he was the Director of Health for the City and County of San Francisco for thirteen years. Prior to becoming the Director in San Francisco, he served the Department in a number of positions, including Director of the AIDS Office and Director of the Emergency Medical Services Agency. He practices medicine as a primary care doctor at Edward R. Roybal Comprehensive Health Center.

Elizabeth McGlynn, Ph.D.
Director
Center for Effectiveness & Safety Research, Kaiser Permanente

Elizabeth A. McGlynn, PhD, is the Director of Kaiser Permanente’s Center for Effectiveness and Safety Research (CESR). She is responsible for the strategic direction and scientific oversight of CESR, a virtual center designed to improve the health and well-being of Kaiser’s 9 million members and the public by conducting comparative effectiveness and safety research and implementing findings in policy and practice. Dr. McGlynn is an internationally known expert on methods for evaluating the appropriateness, quality and efficiency of health care delivery. She has conducted research in the U.S. and in other countries. Dr. McGlynn has also led major initiatives to evaluate health reform options under consideration at the federal and state levels.

Prior to joining Kaiser Permanente, Dr. McGlynn was the Associate Director of RAND Health and held the RAND Distinguished Chair in Health Care Quality. She was responsible for strategic development and oversight of the research portfolio, and external dissemination and communications of RAND Health research findings.

Dr. McGlynn is a member of the Institute of Medicine. She serves as the Secretary and Treasurer of the American Board of Internal Medicine Foundation Board of Trustees. She is on the Board of Academy Health and the Institute of Medicine Board of Health Care Services. She serves on the Scientific Advisory Group for the Institute for Healthcare Improvement. She co-chairs the Coordinating Committee for the National Quality Forum’s Measures Application Partnership. She serves on the editorial boards for Health Services Research and The Milbank Quarterly and is a regular reviewer for many leading journals.

Dr. McGlynn received her B.A. in international political economy from The Colorado College, her MPP from the University of Michigan’s Gerald R. Ford School of Public Policy, and her Ph.D. in public policy analysis from the Pardee RAND Graduate School.

Anna M Roth, R.N., M.S., M.P.H.
Chief Executive Officer
Contra Costa Regional Medical Center and Health Centers

Health Centers, a public hospital system in the San Francisco Bay Area. Ms. Roth spearheaded quality improvement efforts throughout her system including the introduction of The Model for Improvement and the Toyota Production System.

Committed to the engagement of frontline staff as leaders of change, Ms. Roth established the CCRMC Change Agent Fellowship to cultivate leaders from within her system as local improvement experts and
create a culture of continuous improvement. Ms. Roth also sees the inclusion of patients, families and the community as essential to transformation and includes them as full partners in delivery system redesign.

Ms. Roth was selected as an Institute for Health Care Improvement (IHI) Quality Improvement Fellow. She holds a master’s degree from the University of California, San Francisco and an MPH from Harvard University. She is a lecturer at the UC Berkeley School of Public Health and a member of the National Public Health and Hospital Institute’s Board of Directors, a past member of the National Association of Public Hospitals and Health Systems’ Quality Council and currently the Board Chair for the California Healthcare Safety Net Institute.

Ex-Officio

Neal D. Kohatsu, M.D., M.P.H.
Medical Director
California Department of Health Care Services

Dr. Kohatsu was appointed in March 2011 as Medical Director for the California Department of Health Care Services. He is charged with advancing population health and improving clinical quality and is coordinating the development and implementation of the Department’s Quality Strategy.

Dr. Kohatsu has held leadership positions in the public, private, and academic sectors related to prevention, chronic disease management, quality improvement, and patient safety. He has served as Acting State Health Officer and Associate Director for Medical Quality in the Department of Health Services. Later, he served as Medical Director for the Medical Board of California. Following his tenure at the Medical Board, Dr. Kohatsu was Associate Professor of Epidemiology at the University of Iowa.

Dr. Kohatsu is board-certified in Public Health and General Preventive Medicine. He is a past president of the American College of Preventive Medicine and is on the Editorial Board of the American Journal of Preventive Medicine.

Elliott Main, M.D.
Medical Director
California Maternal Quality Care Collaborative

Elliott Main, MD, has been the Director of the California Maternal Quality Care Collaborative (CMQCC) since its formation in 2005. He also chairs the California Maternal Mortality Review Committee and has authored two national Maternity Quality Improvement Toolkits on Obstetric hemorrhage and Elective Delivery <39 weeks gestation.

Dr. Main currently serves on multiple national committees on Maternal Quality Measurement including NQF, ACOG, PCPI/AMA (Co-Chair), The Joint Commission, NCQA and the RAND Corporation. He also co-chairs a national ACOG and NCHS project—“reVITALize” to standardize maternity definitions for quality measures and birth certificates. Dr Main has recently been asked to serve on the upcoming national CMS-CMCS (Center for Medicaid and CHIP Services) Expert Panel on Improving Maternal and Infant Health Outcomes.

Dr. Main trained in obstetrics and gynecology at Washington University School of Medicine and in Maternal-Fetal Medicine at the University of Pennsylvania. Dr Main is a Clinical Professor of Obstetrics and Gynecology at the University of California, San Francisco, and Visiting Professor of Obstetrics and Gynecology at Stanford University.

Since 1998, he has been the Chairman of the
Department of Obstetrics and Gynecology of California Pacific Medical Center in San Francisco. That department, with over 100 Ob/GYN’s and over 6,000 annual births is one of the largest in the US.
## Medi-Cal Performance Advisory Committee Agenda

**September 7, 2012**

**Medical Education Building**  
**UC Davis Health System**  
**4610 X Street**  
**Sacramento, CA 95817**  
**Deans Conference Room**  
**Room 3103**

<table>
<thead>
<tr>
<th>Time</th>
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| 1000 – 1025 | **Call to Order**  
Kenneth W. Kizer, MD, MPH, Director  
Institute for Population Health Improvement  

**Introductions**  
**Opening Comments**  
- UC Davis Health System  
  Federick J. Meyers, MD, MACP  
  Executive Associate Dean  
- Department of Health Care Services  
  Toby Douglas, Director  
  California Department of Health Care Services  
  Neal D. Kohatsu, MD, MPH, Medical Director  
  California Department of Health Care Services  

| 1025 – 1045 | **UCDHS Institute for Population Health Services – Overview**  
Kenneth W. Kizer, MD, MPH |
| 1045 – 1115 | **Disclosures & Conflict of Interest Discussion**  
**Committee Rules of Engagement**  
Kenneth W. Kizer, MD, MPH |
| 1115 – 1200 | **Medi-Cal Quality Improvement Program**  
Neal D. Kohatsu, MD, MPH  
Kenneth W. Kizer, MD, MPH  
Desiree Backman, DrPH, MS, RD; Chief Prevention Officer, IPHI and DHCS  
Ulfat Shaikh, MD, MPH; Clinical Quality Officer, IPHI and DHCS  
- Overview and Deliverables  
- DHCS Quality Improvement Activities Inventory |
<p>| 1200 – 1230 | <strong>Working Lunch</strong> |</p>
<table>
<thead>
<tr>
<th>Time</th>
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| 1230 – 1300 | Medi-Cal Quality Improvement Program (Continued)  
|           | • Delivery System Reform Incentive Program (DSRIP)                                  |
| 1300 – 1430 | Medi-Cal Quality Improvement Activities – Presentation and Discussion  
|           | Neal D. Kohatsu, MD, MPH  
|           | Kenneth W. Kizer, MD, MPH  
|           | Desiree Backman, DrPH, MS, RD  
|           | • DHCS Quality Strategy  
|           | • California Coordinated Care Initiative (Medicare-Medicaid Dual Eligible Project)  
|           | • Non-Designated Public Hospital Quality Improvement Program                        |
| 1430 – 1445 | Break                                                                             |
| 1445 – 1545 | Medi-Cal Quality Improvement Activities – Presentation and Discussion (Continued)  
|           | Neal D. Kohatsu, MD, MPH  
|           | Kenneth W. Kizer, MD, MPH  
|           | Linnette Scott, MD; Chief Medical Informatics Officer, DHCS  
|           | Ulfat Shaikh, MD, MPH  
|           | • Adult Medicaid Quality Grant (QI Training)  
|           | • Health Policy in Practice Fellowship  
|           | • Let’s Get Healthy California Task Force                                           |
| 1545 – 1600 | Wrap-up and Next Meeting                                                          |
BMI Screening and Obesity/Overweight Protocol

Introduce U.S. Preventive Services Task Force BMI Screening & Obesity Counseling

**Project Goal:** Develop the tools and processes to collect accurate patient Body Mass Index (BMI), BMI weight classification status data and trends in a structured format, to assist BMI weight classification diagnosis and provide appropriate weight management interventions. Increase prescriptions for healthy living for patients regardless of weight classification. Increase referrals of adults, adolescents, and children, diagnosed as obese, to in-house and/or community-based, counseling programs, as defined by the US Preventive Services Task Force (USPSTF).

**Potential Project Elements:**
- Collect accurate BMI data at the point of care for all adults, adolescents, and children.
- Improve and expand medical screening, diagnosis, and advice for weight management, including healthy living prescriptions.
- Improve and expand referral of adults, adolescents, and children, diagnosed as obese, to in-house and/or community-based, age appropriate counseling programs, as defined by the USPSTF.
- Analyze and report on quality outcomes.
- Develop improvement plans to address health outcome disparities.

**Key Measures:**

**Process Measures:**

**A. Measure (Screening Measure):** Develop patient weight management data template and integrate this template into the patient record database/data warehouse or electronic medical record (EMR/EHR).

**Metric:** Develop patient weight management template.

Documentation showing the development of weight management tools including weight, height, calculated BMI, and BMI weight classifications.

**Data Source:** Patient records database/data warehouse or EMR/EHR.

**Rationale/Evidence:** The USPSTF found good evidence that BMI is an acceptable measure for identifying children and adolescents with excess weight\(^1\), and is reliable and valid for identifying adults at increased risk for mortality and morbidity due to overweight and obesity\(^2\). Implementing BMI into EMR/EHR systems is supported by a number of studies that show EMR/EHRs increase the documentation of BMI weight screening\(^3\).

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Measure (Screening Measure): Develop weight management clinical support tool to track patient BMI over time.

Metric: BMI tracking tool that shows changes and trends in patient BMI over time.

Submission of print screen, report, printout or other documentation of BMI tracking too.

Data Source: Patient records database/data warehouse or EMR/EHR.

Rationale/Evidence: Patients should receive periodic monitoring of their BMI to identify weight gain at an early stage, and identifying an upward trend over time provides an opportunity for primary prevention.

Measure (Screening Measure): Develop weight management clinical decision-support tool that provides direct access to evidence-based intervention recommendations to clinical staff based on BMI weight classification.

Metric: Incorporate a clinical decision-support tool into the patient record system that provides clinical staff with evidence-based recommendations based on patient BMI weight classification. At a minimum the decision-support tool will include: (1) healthy living prescription led counseling for all patients, including goal setting as appropriate; and (2) counseling as defined by the USPSTF for adults/adolescents/children diagnosed as obese. These required tools/programs, and their rationale, are identified as individual measures and described below.

Note: Specifically identifying these required decision-support tools is not intended to limit the development and use of additional support tools.

Documentation of the recommended clinical advice built into the clinical decision-support tool to support BMI weight classification clinical interactions, including but not limited to, evidence of healthy living prescription led counseling tools for all patients and age-appropriate counseling resources and referral tools for obese patients.

Data Source: Patient records database/data warehouse or EMR/EHR.

Rationale/Evidence: If EHR vendors included data fields to capture pediatric and adult BMI, document nutrition and activity counseling, and identify resources on healthy lifestyles for physicians and patients, they would facilitate the delivery of individual care, as well as allow for better population health management at the practice level and surveillance and monitoring of public health data at the community, local government, and state levels.
D. **Measure (Counseling Measure):** As part of the BMI screening protocol, integrate nutrition and physical activity healthy living prescription counseling for all patients into the clinical decision-support tool to facilitate brief conversations about nutrition and physical activity, and assist in establishing patient goals for behavior change, where appropriate.

**Metric:** Utilize prescriptions for healthy living that include both nutrition and physical activity behavior assessment and goal setting; the prescription is designed and used to facilitate conversations with all patients about BMI, weight management, and making choices about healthier living. The “Let’s Move! Prescription for a healthier life” is the recommended model for this prescription.

The “Let’s Move! Prescription for a healthier life” guides physicians and patients in assessing current nutrition and activity behavior baselines for two nutrition and two physical activity behaviors, and provides an area for written goal setting. To support flexibility in adapting prescriptions for healthy living to meet local need, this measure does not define the number or specific behaviors to be included; however, it does require the healthy living prescription counseling tool include, at minimum, at least one physical activity AND one nutrition behavior.

Let’s Move! Prescription for a healthier life, behaviors:
- Eat at least 5 fruits and vegetables every day.
- Limit screen time (for example, TV, video games, computer) to 2 hours or less per day.
- Get 1 hour or more of physical activity every day.
- Drink fewer sugar-sweetened drinks.

Documentation of healthy living prescriptions in clinical support tools for review with all patients, including the ability for patients to establish and write/document goals for change.

Evidence of an increase in the number of brief behavioral interventions with patients discussing healthy living prescriptions and goals.

**Data Source:** Patient records database/data warehouse or EMR/EHR.

**Rationale/Evidence:** Written prescriptions are an effective tool in the clinical setting for assisting patients in setting goals for improving health behaviors. Prescriptions have been shown to positively affect counseling and preventive services in the clinical setting.7

E. **Measure (Counseling Measure):** Implement an age appropriate, in-house and/or referral network of community-based counseling programs, as defined by the USPSTF, for adults, adolescents, and children diagnosed as obese.

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Metric: Document and implement an age appropriate, in-house and/or referral network of community-based, counseling program, as defined by USPSTF, for adults, adolescents and children diagnosed as obese. Demonstrate and document a process for referring patients to these approved counseling programs.

F. USPSTF Adult Counseling Program Definition:

Intensive, multicomponent behavioral interventions for obese adults include the following components:

- Behavioral management activities, such as setting weight-loss goals
- Improving diet or nutrition and increasing physical activity
- Addressing barriers to change
- Self-monitoring
- Strategizing how to maintain lifestyle changes
- The USPSTF found that the most effective interventions were comprehensive and were of high intensity (12 to 26 sessions in a year).

Although the USPSTF could not determine the effectiveness of other specific intervention components, most of the higher-intensity behavioral interventions included multiple behavioral management activities, such as group sessions, individual sessions, setting weight-loss goals, improving diet or nutrition, physical activity sessions, addressing barriers to change, active use of self-monitoring, and strategizing how to maintain lifestyle changes. Although intensive interventions may be impractical within many primary care settings, patients may be referred from primary care to community-based programs for these interventions.

G. USPSTF Children and Adolescents Counseling Program Definition:

Comprehensive moderate- to high-intensity programs that include dietary, physical activity, and behavioral counseling components.

Interventions were deemed comprehensive if they included all of the following elements: (1) counseling for weight loss or healthy diet; (2) counseling for physical activity or a physical activity program; and (3) instruction in and support for the use of behavioral management techniques to help make and sustain changes in diet and physical activity. Behavioral management techniques included self-monitoring, stimulus control, eating management, contingency management, and cognitive-behavioral techniques.

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Hours of contact were used as a proxy for treatment intensity and categorized as very low (<10 hours), low (10-25 hours), moderate (26-75 hours), or high (>75 hours).

Documentation of age-appropriate counseling program referral network and the process for making a referral to these programs.

**Data source:** Policies and procedures documentation.

**Rationale/Evidence:** The recommendation of the USPSTF is that all obese adults, defined as people over the age of 18 with a BMI of 30 or higher, and all obese children, defined as 6 - 18 years having a BMI at ≥95th percentile for age and gender, should be referred to counseling programs that contain all of the USPSTF recommended components.

**Measure (Screening Measure):** Develop clinical team training addressing the evidence-based rationale for establishing BMI and BMI weight classification as a vital sign, how to record and track patient BMI and BMI weight classification in the medical record, the rationale and evidence-base for clinical interventions based on weight classification, and behavioral counseling techniques to increase self-efficacy in weight management counseling, advice and prescription.

**Metric:** Complete training of clinical staff on the weight management tools and rationale. Documentation of program curriculum and participation list.

**Data Source:** Training program database.

**Rationale/Evidence:** Although it is recommended that clinicians offer counseling and behavioral support to obese patients, studies have found that many health care providers do not feel prepared, competent, or comfortable in discussing weight with their patients and lack reliable models of treatment to guide their efforts. In order to address the reported lack of competence and comfort health care professionals report in discussing weight management with patients, and provide a model of treatment to guide their efforts, the Institute of Medicine recommends educational and quality improvement efforts to incorporate obesity care into clinical practice.

**I. Measure (Counseling Measure):** Develop/implement reporting of healthy living prescriptions for all patients and referrals made and/or referral status of obese patients, to appropriate in-house and/or community-based counseling programs.

**Metric:** Analysis of referral reporting.

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Appendix G

Documentation of brief counseling and healthy living prescription advice provided to the patient by clinical staff regarding their BMI weight classification, and the referral status of obese patients to appropriate in-house and/or community-based counseling programs.

**Data source:** Patient records database/data warehouse, or EMR/EHR.

**Rationale/Evidence:** The purpose of reporting for advice and referrals is to allow analysis of quality measures and programs, promote future inquiry and rapid-cycle continuous quality improvement efforts, and measure outcomes of different referral practices and programs.

**Improvement Measures:**

**J.** Measure (Screening Measure): Record and document accurate BMI and BMI weight classification for patients in a structured data format.

**Metric:** Increase the proportion and percent of patients with accurate BMI and BMI weight classification recorded in their patient health record.

**Numerator:** Number of patients with BMI recorded.

**Denominator:** Total number of patients registered.

**Data source:** Patient records database/data warehouse or EMR/EHR.

**Rationale/Evidence:** Weight screening using BMI as a measure is a widely recognized best practice and recommended as a standard practice in clinical settings by the USPSTF,13-14 Institute of Medicine,15 and the National Quality Forum.16

**K.** Measure (Screening Measure): Analyze and report on BMI, BMI weight classification, and referral status for the population of patients with a BMI weight classification of obese. Reports should also be developed by demographic sub-groups including gender, race/ethnicity, age, primary language, education and annual household income, where data is available, in order to identify disparities in service.

**Metric:** Weight management data analysis.

Documentation of weight management metrics by subgroups.

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Data source: Patient records database/data warehouse, or EMR/EHR.

Rationale/Evidence: Studies consistently show large racial/ethnic disparities in obesity among women, children, and adolescents in the United States. Some minority and low-socioeconomic status groups such as non-Hispanic Black women and children, Mexican-American women and children, low-socioeconomic status Black men and White women and children, Native Americans, and Pacific Islanders are disproportionately affected. The purpose of developing this reporting is to monitor and eliminate disparities through the continuous development of targeted quality improvement efforts.

Measure (Screening Measure): Clinical health care providers, using clinical decision support tools, provide patients with appropriate advice, counseling, prescriptions and referrals based on patient documented BMI weight classification.

Metric: Increase in the proportion of patients receiving advice, counseling, prescriptions and referrals based on their documented BMI weight classification.

Numerator: Number of patients receiving advice, counseling, prescriptions and referrals by BMI weight classification.

Denominator: Number of patient with each BMI weight classification.

Data Source: Patient records database/data warehouse or EMR/EHR.

Rationale/Evidence: The purpose of recording and documenting BMI and BMI weight classifications is to provide the appropriate advice and counseling to patients and to encourage them to engage in programs designed to help them reduce their BMI and improve their health outcomes.

Metric: Increase the proportion of patients with healthy living prescription goals who receive follow-up regarding their goals and their self-reported progress towards achieving those goals.

Numerator I: Number of patients with a follow up reminder in the EMR/ EHR for a review of healthy living goals in the next appointment/call or mediated intervention.

Denominator I: Number of patients who set healthy living prescription goals.

Numerator II: Where a follow up appointment/call has occurred progress towards goals has been recorded and/or barriers to progress discussed, and new goals set if appropriate.

Denominator II: Number of patients that received a healthy living prescription >6 months ago.

Data Source: Patient records database/data warehouse or EMR/EHR.

Rationale/Evidence: When behavioral goals have been established, inclusion of a follow-up plan, and continued counseling and encouragement, using a variety of health care team members, is an effective method to encourage and support behavioral change.\(^\text{18}\)

Measure (Counseling Measure): Increase the number of obese patients referred to an age-appropriate, in-house and/or community-based, counseling program, as defined by the USPSTF.

Metric: Number/percentage of obese patients referred to an appropriate age appropriate counseling program.

Numerator: Report/documentation of the number of referrals.

Denominator: Number of obese patients.

Data source: Patient records database/data warehouse, or EMR/EHR.

Rationale/Evidence: The recommendation of the USPSTF is that all obese adults, defined as people over the age of 18 with a BMI of 30 or higher,\(^\text{19}\) and all obese children, defined as 6 - 18 years having a BMI at ≥95th percentile for age and gender,\(^\text{20}\) should be referred to counseling programs that contain all of the USPSTF recommended components.

Measure (Counseling Measure): Analyze and report on the immediate and long-term effectiveness of selected counseling interventions on patient vital signs, including maintaining or reducing BMI, and maintaining or achieving healthy blood pressure. In addition to reporting on the overall population of referred patients, reports should also be available by demographic sub-groups including gender, race/ethnicity, age, primary language, education and annual household income, where data is available.

Metric: Referral Effectiveness Analysis.

Documentation of changes to vital signs for referred populations.

Data source: Patient records database/data warehouse, or EMR/EHR.


Rationale/Evidence: Studies show large racial/ethnic disparities in obesity among women, children, and adolescents in the United States. Some minority and low-socioeconomic status groups such as non-Hispanic Black women and children, Mexican-American women and children, low-socioeconomic status Black men and White women and children, Native Americans, and Pacific Islanders are disproportionately affected. The purpose of developing reporting to monitor ongoing disparities is to eventually eliminate them through a process of rapid-cycle continuous quality improvement efforts. This measure is designed to facilitate this analysis.
