California Kids Care (CKC)

QUALITY MANAGEMENT WORK PLAN
Fiscal Year 2020

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APPENDIXES

I. INTRODUCTION

A. Mission Statement of the California Kids Care QAPI Program

The mission of the California Kids Care (CKC) QM program is to ensure that strong and effective clinical quality, optimal service, and cost effective care is provided and excellent clinical outcomes are achieved for Members of the Rady Children's Hospital Population Specific Plan (PSP) 705, dba California Kids Care. We focus on the conversion of new knowledge into practical applications to improve care and PSP Member experience.

II. PURPOSE & ORGANZATIONAL STRUCTURE

A. Purpose

The purpose is to ensure that the CKC Quality Program is designed to optimize our ability to deliver high quality, safe, patient-focused, family-centered, and cost effective care, as well as to add value by improving patient outcomes and financial performance. The comprehensive plan is data driven and provides the framework, structure, and methodology to support the provision of care, the flow of information, performance improvement, and accountability for goal attainment.

The goals of the plan are to:

- Proactively identify and address potential quality issues and patient safety indicators.
- Improve the utilization of evidence-based Clinical Guidelines to reduce the variation in care delivery, improve health outcomes, reduce unnecessary use of resources and improve Member satisfaction.
- Identify service utilization that indicates a wide variation in utilization or cost and work to reduce variation and improve value.
- Determine appropriate use of resources to avoid any overuse, underuse or misuse of healthcare resources.
- Identify and address disparities in the delivery of healthcare services.
- Promote cultural and linguistic awareness and competencies among care delivery stakeholders.
- Facilitate improved continuity of care and care coordination among healthcare system provider types.
- Improve access to care.
- Implement effective mechanisms to improve patient safety and quality of processes.
- Ensure compliance with DHCS standards.
- Promote an environment focused on family centered care; ensuring the patient and family are an integral part of the CKC care team.

B. Organizational Structure

The CKC Clinical Advisory Committee (CKC CAC) monitors and evaluates the performance of the five CCS conditions: Acute Lymphocytic Leukemia (ALL), Cystic Fibrosis (CF), Diabetes Mellitus (DM), Hemophilia, and Sickle Cell Disease (SCD). The CKC Quality

Workgroup team will develop a system to measure all required metrics, develop, implement and evaluate performance improvement plans and provide reports on results to the CKC CAC for review and analysis.

This process is reported quarterly to the CKC CAC and annually to the Rady Children's Hospital Quality, Safety, and Medical Affairs Committee of the Board of Directors. RCHSD Quality, Safety and Medical Affairs Committee promotes, supports and has ultimate responsibility and authority to assure that quality of care is provided to CKC Members, as well as supports and approves a comprehensive and integrated Quality Improvement System.

The Quality of Care Committee (QOC) provides oversight on the monitoring, evaluation, and improvement of the clinical performance of CKC and its contracted Provider Network.

In addition, with respect to Utilization Management (UM) within the California Kids Care Population Specific Plan:

- The CKC Utilization Management Leadership Team and the CKC Quality Improvement workgroup of the CAC reports to the CKC CAC.
- The CKC UM Leadership Team will ensure all Utilization Management activities are being met and data is available for review and analysis.

C. Roles, Responsibilities, Structure, and Communication

The Quality Improvement System is comprised of the roles listed below to support operations. The Quality Improvement Program includes a multidisciplinary approach to establish structures and systems across the continuum of patient care that supports multidisciplinary performance improvement activities. (See attached Organizational Chart – Appendix III). To achieve the stated goals, the multidisciplinary team must establish and maintain mechanisms for assuring effective dialogue between primary care physicians, specialists, the hospital and other providers.

The multidisciplinary team includes, but is not limited to:

- Senior Vice President Care Redesign
- Senior Medical Director
- UM Medical Director
- Associate Director Member Services & UM Operations
- Director Care Redesign for Hospital and Network
- Director Clinical Care Redesign and Case Management
- Director Ambulatory Care Redesign
- Physician Specialists: Hematology/Oncology, Pulmonology and Endocrinology
- Social Workers
- Dietitians
- Pharmacists
- Quality Improvement Manager
- Quality Improvement Advisor
- Clinic Nursing staff and leadership: Hematology/Oncology, Pulmonology and Endocrinology

- Financial Counselors
- CKC RN Care Navigators
- CKC Patient Care Coordinators (PCC's)
- Customer Service Representative
- Systems Analyst
- Utilization Management Coordinator

The Medical Directors, and administrative directors are jointly responsible for oversight and management of the Quality Assessment PI (QAPI) plan, including reviewing and approving all indicators and performance improvement activities.

The CKC Leadership and Team stakeholders across the PSP and Rady Children's system of care/integrated delivery network collaborate with the Medical Directors on program organization, activities, and performance management.

The Medical Directors are active members of the CKC QAPI committees and are present and involved for quality presentations and reviews. The directors oversee the performance of the program's operations. They may delegate day-to-day operations to an administrator while maintaining overall responsibility.

Responsibilities of the CKC multidisciplinary teams include:

- Maintaining quality of care through monitoring of improvement mechanisms designed to provide opportunities to continuously improve. Measurements and metric such as patient/family satisfaction, patient outcomes, patient safety and financial performance will be tracked.
- Monitoring and ensuring that all quality requirements of licensing, regulatory and accrediting agencies are met.
- Ensuring that the QAPI Program will be coordinated with all aspects of managed care contracting to include but not limited to: UM, Credentialing, Member Complaints, Member satisfaction, and Medical Review/Site Review.
- Establishing benchmarks for the QAPI indicators and assisting in the analysis, development, implementation, and evaluation of the effectiveness of corrective action plans.
- Tracking and analyzing data. Reports to all required committees.
- Reviewing and updating policies with regard to DHCS regulations and policies and monitors for compliance.
- Assisting in development and implementation of quality improvement projects related to medication use.
- Assisting in development and implementation of quality improvement projects related to psychosocial issues and collaborates with the team to implement corrective action plans as appropriate.

- Providing oversite for the QAPI process and ensuring corrective action plan goals are met and reporting is timely.

- Reviewing the effectiveness of corrective actions with the team and CKC committees.

- Responsible to ensure initial and ongoing training of personnel caring for CKC patients in all related areas.

- Assisting in the process for community providers to receive data on their patient's care gaps from the EPIC system, Population Health module. Healthy Planet is an integrated portal that allows the community providers to participate in the QI process and improve their patient outcomes.

D. Quality Assessment

The QAPI Program monitors the quality indicators on the QAPI Dashboard as outlined in the attached Appendices (See Appendix I and II). The indicators are reviewed, tracked, and trended at the disease-specific/CCS condition subcommittees, CKC CAC, QOC, and the RCHSD Quality, Safety, and Medical Affairs Committee of the Rady Children's Hospital Board of Directors. Performance improvement initiatives are prioritized and selected with a focus on improving care. Benchmark measures are included and may be based on best practice, regulation compliance, national/industry standards, data outcomes of the analysis of adverse/sentinel events, participation in national registries/databases, or internal standards.

E. Communication

Performance, revisions, and approvals of the QM Plan are reviewed and presented annually to the disease specific subcommittees, the CKC CAC, QOC, RCHSD Quality, Safety and Medical Affairs Committee and other meetings as requested (see QAPI Org Chart, Appendix III).

F. CKC Family Advisory Committee (FAC)

The CKC FAC will provide ongoing input and evaluation of policies and procedures and the operations of the CKC program as outlined in policy and procedure of the California Kids Care Advisory and Family Subcommittee. Patient and family advisory feedback will be reviewed and included in the development, review and approval of the annual QM Plan.

G. CKC Quality Improvement Workgroup of the Clinical Advisory Committee

The CKC Operations Committee meets monthly and is responsible to direct, facilitate, and support the departments involved in all phases of CKC care to continually improve the quality and safety of care provided to its Members. Any new or revised policies and procedures are also discussed, and, where needed, a plan is developed and implemented to ensure competency and/or training of staff is determined. The CKC RN Care Navigators are a resource and a liaison between the CKC Quality Program and the clinic disease specific programs. Ancillary departments such as pharmacy, social services, nutrition, Homecare and IT attend as needed. Feedback from the Committee regarding safety, quality, and/or educational needs is

then provided back to CKC disease specific subcommittees or CKC Clinical Advisory Committee, as indicated.

H. CKC Clinical Advisory Committee

The CKC CAC is composed of the PSP's Chief Medical Officer or equivalent, the San Diego County CCS Medical Director, and at least four CCS paneled providers to advise on clinical issues related to the five CCS conditions in the Rady Children's Hospital PSP, California Kids Care. This Committee must maintain a working knowledge of clinical issues regarding safety and quality for improvement of overall care, outcomes and the PSP. The CKC CAC reviews data and trends to identify issues for improvement. The CAC utilizes evidence-based clinical literature and research in the development of pathways, guidelines and order sets. The Committee participates in the prioritization of organizational and departmental QAPI activities. Other key responsibilities include advocating for resources, and the revision and approval of the annual CKC Quality Management Plan. The CKC CAC meets quarterly.

I. Joint Quality Team

The Joint Quality Team (JQT) develops and reviews the CKC QM Plan in conjunction with the CKC Quality Improvement Workgroup of the Clinical Advisory Committee. The JQT ensures that DHCS quality deliverables are being met in a timely manner. The team ensures that all data is accurate and that systems are in place to provide and analyze data. Reporting structure process and outcomes are facilitated by this Joint Quality Team.

Membership consists of CKC Administrative, Clinical and UM leadership, analysts, Quality Improvement Advisors, CKC Senior UM Medical Director, and Rady Children's MSO key personnel. The JQT meets at least monthly, but no less than seven times per year.

J. Quality of Care Committee (QOC)

The QOC provides oversight on the monitoring, evaluation, and improvement of clinical performance of CKC and its contracted Provider Network. The QOC is comprised of both primary and specialty providers. The structure is designed to ensure that the system is guided by providers. The QOC meets quarterly; CKC must report quarterly. Key responsibilities include; review and approval of the CKC P&Ps, the annual QM Plan, and standardized utilization review criteria and protocols. They provide oversight of the physician/practitioner peer review process. The QOC provides feedback on QAPI identified trends and patterns, and makes recommendations for improving the quality of care delivered and /or enhancing CKC Member satisfaction.

K. Quality and Safety Operations Council (QSOC)

The QSOC strives to improve clinical care and services provided by RCHSD and CKC by coordinating, supporting, and leading clinical quality and safety efforts. Membership includes executive leadership of the hospital and Medical Practice Foundation, Quality Management leadership, Risk Management, Pharmacist in Chief, and the Emergency Department medical and clinical directors. QSOC reviews and approves the annual QM Plan, Policies and Procedures,

and QAPI initiatives, results, and trends. CKC will report quarterly. Written reports will be submitted to the RCHSD Quality, Safety, and Medical Affairs Board quarterly by QSOC. The reports will be sufficiently detailed to identify any significant or chronic quality of care issues. Reports correspondingly document all follow up action taken to address any needed improvements to quality of care to prevent the recurrence of issues.

L. RCHSD Quality, Safety, and Medical Affairs Committee

The RCHSD Quality, Safety, and Medical Affairs Committee of the Rady Children's Hospital Board of Directors promotes, supports and has ultimate responsibility and authority to assure that quality of care is provided to CKC Members, as well as supports a comprehensive, integrated Quality Improvement System. The Committee sets the mission, values and strategic direction. The Committee provides the leadership, and oversight of the quality activities provided by the CKC Program, and is responsible to ensure the optimal utilization of resources. This Committee also supervises the implementation and maintenance of the CKC QM plan. QAPI dashboards and outcomes, and related quality projects are reported annually. Written reports and minutes from QSOC following CKC quarterly presentations will be provided to the Board on a quarterly basis for review and approval. The committee also addresses any organizational, resource needs, and/or additional support to operate effectively and safely. Additionally, this committee leads, coordinates, and supports care redesign and population health initiatives.

M. Performance Improvement (PI)

Performance Improvement Projects are identified through a variety of mechanisms, including HEDIS results; Consumer Assessment of Health Providers and Systems (CAPHS) survey; utilization data; practice and provider performance data; Group Needs Assessment (when available); Member satisfaction; provider access and network adequacy; and recommendations from CKC stakeholders.

Criteria to be selected for a PI Project action plan may include but is not limited to the following:

1. Clinical or service area with significant variation;
2. Prioritized clinical or service needs as identified by Members and/or providers;
3. Opportunity for improving health outcomes through dissemination or implementation of evidence-based best practice, Guideline or protocol;
4. Interventions and metrics that have the potential to impact a significant portion of the Member patient population;
5. Metrics or areas that are mandated by regulatory agencies; and
6. Measures not meeting or exceeding QOC designated Minimum Performance Levels.

Performance Improvement activities are developed for each CCS/disease specific condition in the Rady Children's Hospital PSP, California Kids Care (See Appendix IV). Additional PI activities are also identified and plans are developed for Complex Case Management, Behavioral Health, and CKC Administrative Issues, (See Appendix V, VI, VII.)

Performance improvement projects are presented and approved at multidisciplinary team meetings. The data is tracked through audits and reported quarterly at quality and CAC meetings.

The performance improvement project format is:

- Background / problem statement
- Root cause analysis, if indicated by an adverse advent (in conjunction with RCHSD QM)
- Goals
- Interventions
- Team members involved
- Data
- Start date
- Estimated completion date
- Actual completion date
- Results
- Next steps if required

III. NETWORK PROVIDER AGREEMENT

CKC shall negotiate and administer contracts in accordance with applicable State and federal laws, regulations, and the California Department of Health Care Services guidance requirements, including CKC policy CPM 11-69 for Contract Management. The CKC Managed Care Contracting department is responsible for the negotiating, reviewing, and obtaining final approvals for all contracts, Memorandum of Understanding (MOU)/Memorandum of Agreement (MOA) and Letters of Agreement (LOA) as outlined in CKC Policy for Providers Contracts.

Any quality, safety, access, member satisfaction issues will be reported to the CKC CAC, along with an annual assessment of performance and quality improvement activities. An annual review will be completed for each contract with the recommendation to continue, amend or terminate the contract.

IV. PROCESS DEVELOPMENT & REVIEW

A. Methodology

CKC utilizes a patient-centered, system-focused approach for evaluating and improving processes in collaboration with the specialty care teams. The CKC team and QOC actively monitor, evaluate, and improve the clinical and financial performance of its CKC Plan. The model used to drive performance improvement is PDSA that includes the following steps:

- **Plan** the improvement and continued data collection
- **Do** improvement, data collection and analysis
- **Study** the results and determine if the actions were effective
- **Act** to spread improvements and maintain the improvements

CKC will submit a PDSA worksheet for each indicator with a rate that does not meet the Minimum Performance Level (MPL). CKC will participate in a minimum of two performance improvement plans (PIP) per year.

V. PERSONNEL QUALIFICATIONS, TRAINING & COMPETENCY

The Quality Improvement Program staff must have the required education, experience, and training for each position as outlined in CKC-26 policy and procedures: Quality Improvement System.

A. Job Descriptions

Job descriptions are located in the department's individual employee files. CKC, in conjunction with the RCHSD Human Resources Department, are responsible for providing support for preparing, maintaining, and updating job descriptions relevant to personnel hiring and selection.

Personnel requirements, Job Descriptions & Competency Assessment: Each staff member has a job description that delineates key job functions and qualifications required to perform the job. Personnel are qualified, trained, and meet the competency requirements as required by CKC and RCHSD. Each staff member is provided initial and ongoing training as required to perform their work. Initial and ongoing competencies are evaluated to ensure ability to perform required tasks. Qualifications to provide training are in the job description(s) of the personnel providing training.

B. Documentation

Qualifications, orientation, initial and ongoing training and competence are tracked and documented in the employee's personnel file.

C. Qualifications

All CKC personnel performing specific assigned tasks are qualified on the basis of appropriate education, training, and expertise. Job descriptions identify appropriate qualifications for each position that affects care and quality.

D. Orientation

New Employees attend the following:

- RCHSD New Employee Orientation; and
- CKC Population Specific Plan Program Departmental Orientation.

E. Initial Training & Re-training

Personnel training is planned, organized, documented and is consistent with individual job descriptions. Training activities include, but are not limited to: the use of preceptors, training check-off lists, reviewing policies and procedures (P&Ps), competencies, and in-services.

New P&Ps are reviewed by appropriate staff prior to implementation. In the case of revisions, re-training is completed and documented.

VI. OUTCOME ANALYSIS

A. Review

The CKC CAC and QOC Committees review patient outcomes semi-annually and on an as needed basis with ad hoc meetings as indicated. Outcomes are analyzed and allow the team to determine opportunities for improvement in care. Data is reviewed and analyzed at the CKC CAC, QOC, and RCHSD Board Quality, Safety, and Medical Affairs Committee. Wherever possible, other outcome measures/indicators are benchmarked against national standards. When there is not a national benchmark available, the team reviews the data and literature and determines a goal. The CKC CAC also analyzes outcomes from each program and looks for any trends or areas for further interventions and improvements.

Across the Rady Children's Health Network, an integrated delivery system, there are providers on a shared Electronic Health Record (EHR), EPIC, and providers not on EPIC users. Epic Healthy Planet at Rady Children's provides external community providers tools to review and resolve care gaps through a web-based management portal. These analytics allow CKC to inform all providers of QI activities and outcomes.

Reports are provided for the Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Health Care Providers and Systems (CAHPS), Provider Satisfaction Survey, Performance Improvement Plan (PIP) and any other QI studies conducted during the audit period. These reports will assist in identification of additional areas for improvement opportunities. These reports will be provided to CKC providers and other stakeholders. Quality Improvement activities are also reported to all appropriate staff and stakeholders in order to keep them informed of ongoing monitoring, evaluation activities and related outcomes. Upon request, CKC will make available to Members and providers information about its Quality Management Program, including a description of the PI program and a report on progress in meeting the PI Plan goals.

CKC will report to the External Quality Review Organization (EQRO) the results for each performance measures required.

VII. AUDITS

- Results of quality improvement activities are reviewed and approved by the CKC CAC Committee and Senior Medical Director.
- Audits are conducted by individuals with expertise but not solely responsible for the process being audited.
- Audit results are used to recognize problems and identify performance improvement activities and compliance. Chart audit results are presented to the CKC CAC Committee to detect trends and assess if improvement activities are effective. Additional members of the specialty clinics and or other departments are invited as needed.
- Order sets and policies are created and/or revised, and education is provided as necessary.

- The CKC CAC review errors and participates in PI activities as needed.
- CKC will participate in an annual onsite performance measures validation audit by the DHCS selected contractor.
- CKC performs annual EQRO member satisfaction survey using CAHPS.

VIII. DETECTION & REPORTING OF POTENTIAL QUALITY ISSUES, ERRORS, SAFETY & ADVERSE EVENTS

The QAPI Plan strives to ensure the commitment to prevention and early detection of quality, safety and adverse events. The systems implemented in the QAPI Plan are designed to improve patient safety, quality, and outcomes throughout the continuum of the patient experience through event detection, reporting, investigating, analysis, and improvement initiatives. The UM Coordinator may identify a potential quality issue, which can be defined as an unacceptable deviation from expected performance on recognized standards of care or acceptable community standards, that warrants further investigation to determine whether an actual quality of care issue or opportunity for improvement exists.

Potential quality issues are identified through multiple mechanisms, including:

1. Information gathered via concurrent, prospective and retrospective utilization review
2. Utilization reports and case review data
3. Encounter and claims data
4. Member satisfaction surveys
5. Provider satisfaction surveys
6. Member Appeals/Grievances
7. Member calls through the Customer Service Department
8. Authorization and denial reporting
9. Medical Record audits, including HEDIS medical record reviews
10. Provider sentinel or "never" events, such as adverse events that are serious and possibly preventable via review of Provider Preventable Condition reporting as required by the State of California
    a. Upon identification of a potential quality issue, the UM Coordinator follows the CKC Over/Under Utilization P&P CKC-39

Potential quality of care issues, once catalogued and investigated will undergo corrective actions and each instance will be reported to the Senior Medical Director. The Senior Medical Director will then report quarterly to QOC. Any material breach of quality of care that could jeopardize the care received by a CKC Member will require immediate action by the Senior Medical Director and reported to the QOC. It will also be reported to the appropriate authority in compliance with California Business and Professional Code Section 805(b).

In the case of deficiencies or performance issues among CKC Providers, CKC will implement a detailed Corrective Action Plan (CAP). If CKC becomes aware of a participating Provider's failure to comply with any CKC participation criteria, the Provider's file will be called to the attention of the CKC Administrator and senior Medical Director. The Procedure as outlined in CKC P&P –26; Quality Improvement System will be followed.

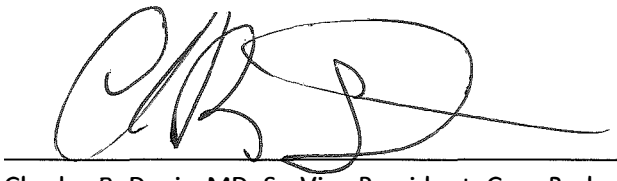
IX. DATA SUBMISSIONS

In accordance with Title 42, Code of Federal Regulations (CFR), sections 438.604 and 438.606 and contractual requirements, CKC shall certify data, information, and documentation submitted to DHCS.

Refer to:

- CKC P&P: Certification of Document and Data Submissions for California Kids Care

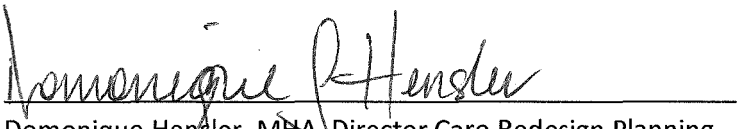
Signature Page



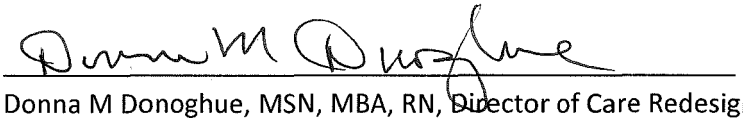
Charles B. Davis, MD, Sr. Vice President, Care Redesign and Managed Care — 7/17/2019 Date

Keri Carstairs, MD, Senior Medical Director — 7/17/2019 Date

Whitney Edwards, MD, Senior UM Medical Director — 7/17/2019 Date



Domonique Hensler, MHA, Director Care Redesign Planning For RCHSD and Network — 7/17/2019 Date



Donna M Donoghue, MSN, MBA, RN, Director of Care Redesign — 7/17/2019 Date

APPENDIX I
CLINICAL ENCOUNTER DATA

Comprehensive Whole Child Care

Indicator	Baseline	Goal	Source Data
Annual Comprehensive Clinic Visit	54.6%	60%	Chart Review
Annual Well Child Visit	54.9.%	60%	Cozeva
Annual Well Child Visit (internal measure)			Claims/EPIC
Annual Dental Screen	79.1.0%	90%	Chart Review
Annual Vision Screen	42.8%	60%	Chart Review
Depression Screening at minimum of annually	89.9.%	90%	EPIC
Food Security Screening	15.8%	30%	EPIC
Transportation Screening	20.9%	40%	EPIC
Up to date routine immunizations1	TBD	TBD	EPIC
Annual Influenza Vaccine	68.4%	80%	EPIC
My Chart Enrollment	61.76%	65%	EPIC
Increase Medication Possession Rate (MPR)	N/A	75%	Claims, Pharm D review
Decrease no show rate	TBD	TBD	EPIC

1Based on county immunization records comprehensive review

Growth and Development

Indicator	Baseline	Goal	Source Data
Improve BMI (25th-75th percentile)	37.43%	45%	EPIC
Annual Transition to Adult Screen (pts 12yrs and older)	N/A	70%	EPIC
Medical Insurance paperwork completed at 18yrs of age	N/A	100%	Chart Review
GHPP Insurance paperwork completed by 21 yrs. of age when applicable	N/A	100%	Chart Review

Utilization

Indicator	Baseline	Goal	Source Data
Maintain/decrease low acuity ED utilization	9.1%	10%	EPIC
Maintain/decrease unplanned readmissions within 30 days of discharge	TBD	TBD	EPIC
Reduction of ED visits for behavioral health concerns	TBD	TBD	EPIC

1Based on care provided at RCHSD only – Hospital Billing and Professional Billing

Satisfaction

Indicator	Baseline	Goal	Source Data
Client /Family Satisfaction	N/A	__	CAHPS data
Provider Satisfaction	N/A	__	CAHPS data

Acute Lymphoblastic Leukemia

Indicator	Baseline	Goal	Source Data
Comprehensive maintenance teaching	90%	90%	Chart Review
Physical Therapy Evaluation at initiation of maintenance	60%	70%	Chart Review
Return to school (if applicable) within 30 days of maintenance initiation	TBD	TBD	Chart Review
Comprehensive completion of maintenance/off therapy teaching	100%	90%	Chart Review

Cystic Fibrosis

Indicator	Baseline	Goal	Source Data
Upgrade to 50 PSI Pari-vios nebulizer at time of upgrade or replacement	0%	80%	EPIC Rx Chart Review

Diabetes Mellitus

Indicator	Baseline	Goal	Source Data
Maintain HbgA1c<7.5	23.1%	30%	EPIC
Comprehensive Annual Education	TBD	100%	Chart Review
High Risk pts as defined by Endocrinology will receive Homecare RN/SW visits as ordered	6%	30%	EPIC order Chart Review

Hemophilia

Indicator	Baseline	Goal	Source Data
Annual RN Home review and education, 6 months post comp visit via phone/Telemed encounter	70%	75%	Chart Review EPIC appt

Sickle Cell Disease

Indicator	Baseline	Goal	Source Data
Patients requiring compounded medications will be offered home delivery	TBD	90%	Pharm D review
Adherence to condition specific vaccinations	TBD	90%	EPIC

APPENDIX II
Medi-Cal 2020 Demonstration

Access to Care

Measure 1	Baseline	Goal	PI plan in place	Source
Percent members 12 months – 24 months with PCP visit	TBD*	50th Percentile	TBD	EZ CAP
Percent members 25 months – 6 years with PCP visit	TBD*	50th Percentile	TBD	EZ CAP
Percent members 7 years – 11 years with PCP visit	TBD*	50th Percentile	TBD	EZ CAP
Percent members 12 years – 20 years with PCP visit	TBD*	50th Percentile	TBD	EZ CAP
Percent members with PCP visit (aggregate)	TBD	50th Percentile	TBD	

Numerator: Number of unique members who had a visit with PCP during reporting period
Denominator: All members during reporting period
TBD*: retrospective data not "pure" enough to determine baseline numbers; post-implementation data required by State

Measure 2	Baseline	Goal	PI plan in place	Source
Percentage of members 12 years and older screened for clinical depression on encounter date and if positive, a follow-up plan documented	90.2%	90%	TBD	EPIC

Numerator: Unique members in appropriate age group screened for clinical depression and follow-up plan documented if positive
Denominator: All members 12 years and older during reporting period
Based upon Specialty Clinics

Measure 3	Baseline	Goal	PI plan in place	Source
OP Visits per 1,000 Member Months1	TBD*	TBD	TBD	EZ CAP
Prescriptions per 1,000 Member Months2	TBD*	TBD	TBD	MEDIMPACT
Mild to Moderate Mental Health Visits per 1,000 Member Months3	TBD*	TBD	TBD	EZ CAP

1Unique OP Visits
2NDC/Member/DOS
3Psychotherapy Services and Diagnostic Evaluations visits
TBD*: retrospective data not "pure" enough to determine baseline numbers

Satisfaction

Measures	Baseline	Goal	PI plan in place	Source
Satisfaction with both PCP and Subspecialty care access and quality	N/A	TBD	TBD	CAHPS
Provider Satisfaction	N/A	TBD	TBD	CAHPS

Quality of Care

Measure 1 – Childhood Immunization Status	Baseline	Goal	PI plan in place	Source
Percentage of Members 2 years of age who had appropriate childhood immunizations1	11.34%	TBD	TBD	EPIC

Numerator: Percentage of Members 2 years of age who had 4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 HepB, 1 VZV, 4 PCV, 1 HepA, 2 or 3 RV and 2 Flu Vaccines by age 2
Denominator: All members 2 years of age
1ALL patients excluded from measurement

Measure 2 – Controlling HbA1c Levels	Baseline	Goal	PI plan in place	Source
Percent members with type 1 or type 2 diabetes mellitus with a recent HbA1c > 8%	58.9%	65%	TBD	EPIC

Numerator: Number of members from denominator whose most recent HbA1c level during reporting period was > 8%
Denominator: All members with a Dx of type 1 or type 2 diabetes mellitus during reporting period

Care Coordination

Measure 1 – All-Cause Readmissions	Baseline	Goal	PI plan in place	Source
Number of acute inpatient stays followed by an unplanned acute readmission within 30 days; and predicted probability of an acute readmission for members 1 – 20 years	18.8%*	TBD	TBD	EPIC

Numerator: 1 acute readmission for any diagnosis within 30 days of Index Discharge Date
Denominator: All acute inpatient discharges for members 1 – 20 years as of the Index Discharge Date who had 1 or more discharges within a 12 month reporting period
*Baseline based on Epic data for members who received care at RCHSD; going forward data will be claims data

Measure 2 – Utilization of ER, OP, IP, Rx and Mild/Moderate Health Services	Baseline	Goal	PI plan in place	Source
ER Visits per 1000 Member Months	TBD	TBD	TBD	EZ CAP
ER Visits with an IP admission per 1000 Member Months	TBD	TBD	TBD	EZ CAP
IP Admissions per 1000 Member Months	TBD	TBD	TBD	EZ CAP

ER Visits per month
ER Visits that resulted in an inpatient admission per month
Inpatient admissions per month

Measure 3 – Special Care Center	Baseline	Goal	PI plan in place	Source
Special Care Center visit with 90 days of referral	100%	100%	TBD	EPIC

Numerator: Unique members with an initial visit to a SCC within 90 days of auth request
Denominator: Unique members with an initial request for auth to a SCC

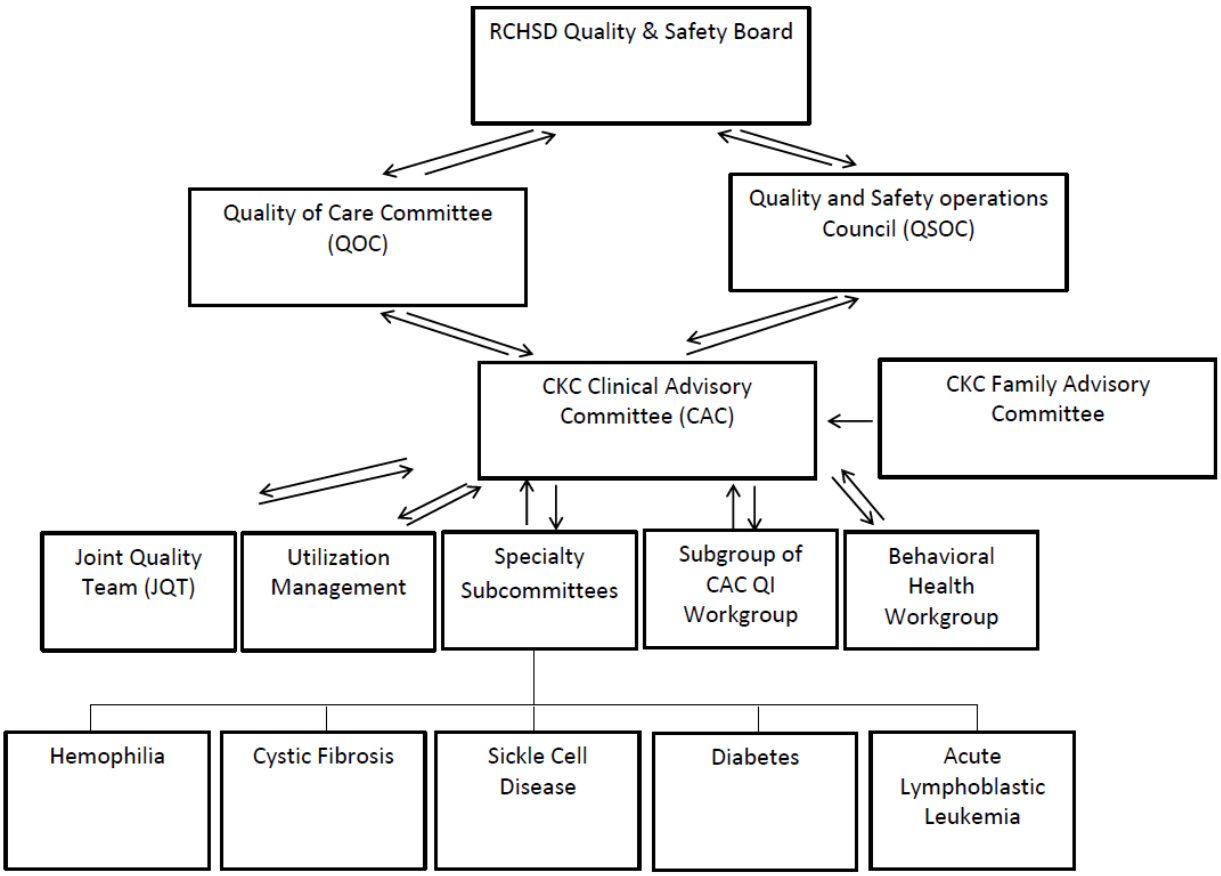
Total Cost of Care

Measure 1 – Total Cost of Care	Baseline	Goal	PI plan in place	Source
Total cost of care including all costs associated with treating members	TBD	TBD	TBD	EZ CAP

Total cost of care at RCHSD used actuarially to calculate rates at CCS pilot inception

APPENDIX III

California Kids Care (CKC) Quality Improvement System Flow Chart



APPENDIX IV
Specialty Clinical Performance Improvement Plan

I. GOALS:

Goal 1: 90% of patients over 12 year of age receive an annual transition to adult care assessment and visit

Action plan:

1. Finalize disease specific transition self-management education materials for A.L.L, Diabetes Mellitus, and Sickle Cell disease to be built into Epic
2. Discuss workflow issues with each team July, August Subcommittees with CKC team to finalize roles and responsibilities
3. Identify all patient over 12 years old with RN Care Navigators
4. Continue to enroll patients/families in MY Chart

Goal 2: Increase or maintain medication adherence as measured by Medication Possession Ratio (MPR) to goal of 0.8

Action plan:

1. CKC pharmacist to run monthly MPR reports
2. CKC RN Navigators to call families to provide additional education and comprehensive medication assessment
3. Telemedicine visit as indicated
4. Individualize patient medication adherence plan with tools such MedAction calendars, alerts and/or pillboxes as indicated
5. Incorporate Motivational Interviewing into patient assessments
6. Partner with care team to troubleshoot barriers to medication adherence

Goal 3: 90% of Acute Lymphoblastic Leukemia (A.L.L.) patients receive comprehensive teaching and additional support at maintenance initiation and 1 month after by CKC RN Navigator.

Action plan:

1. CKC RN to continue to schedule ALL pts starting maintenance therapy for 3 sessions of teaching by phone or telemedicine visit
2. Utilize Maintenance medication handouts
3. Utilize system to identify patients going onto maintenance treatment and coordinate with the specialty team at the monthly subcommittee meeting
4. Utilize Motivational Interviewing techniques and other interventions to support families

Goal 4: 90% of all A.L.L**.** patients receive Physical Therapy (P.T.) evaluation at the start of
Maintenance Therapy

Action plan:

1. Meeting scheduled with A.L.L CKC RN Navigator and P.T. Manager to discuss identified scheduling issues on July
2. Continue with Minnesota Stoplight P.T. program

3. CKC P.C.C's to continue to assist families with scheduling of evaluation and transportation as indicated

Goal 5: Patient Care Coordinator to partner with Thriving after Cancer (TAC) RN Care Coordinator to schedule follow-up appointments and diagnostics

Action plan:

1. Monthly meetings with TAC RN and A.L.L. P.C.C. to identify "lost to follow up" patients
2. P.C.C. to partner with RN Care Navigator to provide Care Coordination to both the Off therapy and TAC patients
3. Assist in scheduling TAC visits every 2 years, H/O follow up appointment on alternate year, and establish care with PCP.

Goal 6: Improve HgA1c scores >7.5 by 10%

Action Plan:

1. CKC Team to collaborate with Endocrinology D.M. team to identify best practice for education and placement of Continuous Glucose Monitors
2. Conduct chart review of adherence of patients on Continuous glucose monitors (CGM's) and report to D.M. team
3. Provide support groups, information fairs and telemedicine visits
4. Motivation interviewing to promote adherence
5. Partner with Endocrinologist to identify which high risk patients should receive RN/SW Homecare visit for additional assessment and education

Goal 7: 90% of all Cystic Fibrosis patients will receive calls at designated intervals

Action Plan:

1. C.F Respiratory Therapists to receive training on Telemedicine visits
2. Implementation of Phone scripts for C.F. patients.
3. Director of Respiratory Therapy to assist with R.T. support for calls for assessment and education
4. Pilot to start 7/19
5. Dispense Pari-vios in C.F. clinic to promote home adherence to regimens

Goal 8: Provide Hemophilia education annually (6 months post Comprehensive clinic visit)

Action Plan:

1. Promote My Chart so RN telemedicine visit can occur
2. Schedule call or RN telemedicine 6 months post Comprehensive Clinic visit to re-enforce education and incorporate into care plan
3. Ensure that family is aware of and understands Emergency Care Plan provided by Provider at HTC clinic visit

APPENDIX V
Complex Case Management (CCM) Quality Improvement Work Plan

II. GOALS:

Goal 1: Continue initial and ongoing training and competency program.

Action plan:

1. CKC Educator to review/revise training materials and competency check off consistent with NCQA guidelines and policy and procedures as indicated.
2. Each newly hired RN Care Navigator will receive individualized training and competency check off by the Educator.
3. Issues are reviewed at bimonthly CKC RN Navigator and PCC meetings with leadership and Educator.
4. Audit EPIC documentation and provide feedback to RN Care Navigators
5. Assess and review results of documentation of patient and family education
6. Finalize criteria specific to each diagnosis on what would require assignment to CCM vs Care Coordination by the Patient Care Coordinator (P.C.C.). Review with specialty care teams.

Goal 2: Continue enhancements with EPIC documentation screens/dashboards

Action plan:

1. Monthly meetings with CKC leadership, educator, and EPIC team to create screens for documentation of goals, interventions, and progress
2. CKC RN Care Navigators to receive initial and ongoing training from EPIC expert
3. CKC RN Care Navigators to provide feedback on ease of documentation and any improvements needed to accurately document
4. Ensure CKC RN Navigators are able to Individualize patient care plans
5. CPMG RN Care Navigators to "mentor" and provide tips on EPIC CCM documentation

Goal 3: 100% of CKC RN Care Navigator will utilize Motivational Interviewing sessions to assist with effective communication with members and their families/caregivers

Action plan:

1. CKC RN Navigators to discuss CCM issues, interventions, and results at bimonthly CKC team meetings
2. CKC leadership and CKC Medical Director to provide support and suggestions on complex members during CKC monthly CAC clinical subcommittee meeting
3. Host a Motivational Speaker at the Summer Back to School Event

Goal 4: Partner with CKC Specialty Interdisciplinary Care Team on goal setting

Action plan:

1. CKC Leadership, RN Care Navigator, and CKC Senior Medical Director to attend monthly Specialty team meetings to identify members with CCM needs and develop goals together
2. Incorporate Specialty teams feedback into goal setting and interventions

3. Identify additional resources, therapies, DME etc. that will assist in CCM of member
4. Evaluate effectiveness of plan with Specialty team

Goal 5: Improve flu vaccine rate to 80%

Action Plan:

1. Develop Health Education information on importance of flu vaccine administration
2. Distribute materials in the clinics and mail to the home starting early fall
3. RN Care Navigators and P.C.C's to include information and direct to Specialty clinic or PCP during calls
4. Specialty clinics to offer during visits

Goal 6: Decrease No Show/cancellation rate

Action Plan:

1. Provide disease management information during CCM or CC calls to educate families
2. Offer telemedicine visits for additional teaching sessions
3. Assist with arranging transportation
4. Provide pre-visit calls

Goal 7: Improve Self-management and Transitions of Care to Adult Care

Action Plan:

1. Finalize work with Rady Hospital Transition to Adult Care Committee to develop EPIC based readiness for transition assessments and goals
2. Work with each CKC Specialty team on development of content for each goal
3. Administer assessment annually for children 12 years and older
4. Re-enforce self-management education on subsequent CCM calls
5. Provide Transition Assessment results to the teams quarterly

Goal 8: Partner with Community Organization to Optimize Referral and Utilization Resources

Action Plan:

1. Continue to update list of community resources and educate staff
2. Host Back To School Summer Luau Event with Community partners for patients and families

APPENDIX VI
Behavioral Health Improvement Work Plan

III. GOALS:

Goal 1: Continue to develop CKC Behavioral Health Workflow

Action plan:

1. Continue meetings with CKC Leadership, UM and Customer Relations Leadership, contracting, CKC quality and clinical team, and Rady Children's Hospital Behavioral Health leadership, and community Behavioral health providers.
2. Finalize criteria, services, and responsibility for mild, moderate and severe mental health issues
3. Discuss preservation of continuity of care

Goal 2: Continue to develop Behavioral Health Provider Network

Action plan:

1. Senior Leadership and Behavioral Health Workgroup to continue to identify and meet with community Behavioral Health providers to discuss steps to develop a Behavioral Health Network
2. Continuity of Care and access issues to be considered
3. Providers must be Medical paneled
4. Pursue contracts for Mild to Moderate Behavioral Health
5. Provide education and updates on available CKC clinical and customer service teams

Goal 3: Ongoing training and education with Rady Specialty Clinic and Inpatient SW's

Action plan:

1. CKC leadership and CKC RN Navigators to meet with RCHSD Behavioral Health Manager to do patient case review
2. Behavioral Health Manager to educate SW's on CKC referral process updates
3. Joint clinical case review meetings with CKC clinical teams and specialty teams to develop patient care plans as indicated
4. Update Resource List as required

Goal 5: Establish Behavioral Health Contracts for Mild to Moderate Health

Action Plan:

1. CKC leadership and senior Medical Director to work with contracting to establish rates
2. Assess that services are meeting access needs in all geographic areas of SD

Goal 6: Identify Designated CKC Behavioral Health Care Provider for QI system

Action Plan:

1. Ad hoc member in Q.I.S to provide Senior UM Medical Director consultation

Note: Additional Goals to be developed first quarter FY 2020 for Behavioral Health

IV. GOALS:

Goal 1: Continue contract with Pharmacy Benefit Manager (PBM); MedImpact
Action Plan

1. Ongoing Formulary review by senior Medical Director and CKC Pharmacist
2. continue PBM work group; Senior Care Redesign VP, Senior Medical Director, Administrative and Clinical Care Redesign Directors, Rady Pharmacist in Chief, Care Redesign Pharmacist and MedImpact key personnel.
3. Senior Medical Director to review any formulary changes with the Specialty Clinic Medical Directors to receive approval for care
4. Create P.A form for mediations that frequently require Prior Authorizations for specialists

Goal 2: Improve/maintain number of CKC members that receive annual comprehensive clinic
Visit by the multidisciplinary team

Action Plan:

1. Perform chart audit to determine baseline, A.L.L., Hemo, and SCD has appointment type, D.M and C.F do not
2. Develop tracking system for all 5 clinics
3. Ensure that education plan is documented so CKC clinical team can reinforce
4. Review billing codes utilized for the Multidisciplinary team and run reports
5. Assess compliance with each team on annual comprehensive clinic visit completion rate
6. Inform Specialty clinics at Monthly Subcommittee meetings

Goal 3: Continue to develop plan and materials for the Health Education System
Action Plan

1. CKC Educator to coordinate with RCHSD Educator on Health Education topics and materials
2. Health Education steering committee to meet with Marketing July 2019 to develop plan
3. Discuss potential topics and delivery methods for health education materials for patients and families at the July CKC Family Advisory Committee meeting
4. Finalize Health Education Plan July 2019
5. Plan to complete and distribute First Comprehensive health Education member handbook for mailing by September 2019
6. Flu vaccine mailing October 2019
7. Develop web site
8. Distribute wellness information at Back to school event for CKC members 8/3/19

Goal 4: Continue ongoing education and distribution of CKC quality results to Providers

Action Plan

1. EPIC upgrade 8/19 by Rich White to enable providers to see quality results for their CKC members
2. Ongoing Provider newsletter to all Primary Care Providers with CKC information, quality updates, and education as indicated
3. Add as an agenda item to JQT meetings for FY 20