L.A. Care HEALTH PLAN®

For All of L.A.

L.A. Care Health Plan

2024 Population Health Management Program Description

May 28, 2024

ACCREDITED NCQA HEALTH PLAN ACCREDITED

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Program Overview

L.A. Care's mission is to provide access to quality health care for Los Angeles County's vulnerable and low-income communities and residents and to support the safety net in any way required to achieve that purpose. Our vision is a healthy community in which all have access to the health care they need and can achieve health equity. Our goal is to provide value to our members, providers and internal staff. With more than 503 square miles of L.A. county to cover, more than 2 million total members, more than 13,000 physicians, over 20,000 specialist providers, and over 2,000 internal staff, the traditional methods of medical care management must be modified to use electronic and automated processes wherever possible and save as much time for quality personal contact when most beneficial.

The Population Health Management (PHM) Program strives to address health needs at all points along the continuum of health and wellbeing, through participation of, engagement with and targeted interventions for the member population across all lines of business. The integration of population health management consolidates and coordinates multiple program and service offerings into one seamless system, producing efficiencies that drive improved health outcomes, addressing social determinants of health, decrease disparities and reduce overall health care spending. L.A. Care's population health management services are provided by a team that includes medical, care management, social services, behavioral health and community resources together whose goal is to coordinate and ensure the right service at the right level for any sub-population. Rather than providing specific service categories into which individuals must fit, L.A. Care's population health management revolves around the individual's needs and adapts to their health status—providing support, access and education all along the continuum. Through a high tech, high touch, highly efficient workflow we can use the widest breadth of data sources with optimal process flow to achieve a holistic view of members and providers for ideal customer relationship management. The Population Health Management Program is conducted through coordination and collaboration with the following programs: Health Education (HE), Complex Case Management (CCM), Care Management (CM), Pharmacy, Social Services and Social Work, Utilization Management (UM), the Quality Improvement (QI), Enhanced Care Management (ECM), Community Supports and other internal and external programs.

The major components of the program are: 1) population identification; 2) assessment and risk stratification and segmentation through whole person care approaches addressing social determinants of health in addition to clinical indicators; 3) member enrollment, health appraisal (HA) and engagement; 4) interventions focused on: monitoring, health promotion and basic population health management, early detection, condition management, enhanced care management, complex care management, transition care services, community support programs and patient safety; 5) evaluating program outcomes. L.A. Care's PHM Program's foundation is built upon meeting the National Committee for Quality Assurance (NCQA) PHM Standards, L.A. Care's Enterprisewide goals and objectives as well as meeting the California Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal Program (CalAIM, which launched in 2022.

Organization Goals

The overarching purpose of L.A. Care's Population Health Management Program (PHMP) is to align with the quadruple aim in order to achieve better member outcomes, improved member experience, improved provider experience and lower healthcare costs. L.A. Care will be implementing the PHMP through CalAIM's 5-year waiver program and integrating the requirements throughout L.A. Care's overall PHMP to address the DHCS Bold Goals. Organizational, national and state goals are established to address:

1. Improving health status and quality of life by delivering population specific, equitable, quality care and services to members through an integrated comprehensive and ongoing system of monitoring, evaluation and improvement.
    a. Reducing racial and ethnic disparities and maternal care disparities
    b. Improving well-child visits, immunization rates, depression screening rates and follow-up care for mental health and substance abuse disorders.
2. Improving the member experience by creating a seamless system of care and services that reduce duplicative processes and are patient-centric, allowing for ongoing feedback and participation from members and families. This includes streamlining transitional care services (TCS) for members transferring from one setting or level of care to another.
3. Improving provider satisfaction and experience by creating well-structured programs and services, communicating program information in a timely and clear manner and working to support and become an integral partner with providers in managing their members participating in population health management program.
4. Reducing healthcare costs to the health system and members by effectively and efficiently managing health benefits, chronic conditions, and promoting healthy lifestyles through value-based initiatives, modernization of systems and payment reform.
5. Maintaining high standards of care and service by employing experienced registered nurses and other professionals such as License Social Workers (LCSW), who preferably hold the Certified Case Manager (CCM) designation, awarded by the Commission for Case Manager Certification. Additionally, all programs are administered using adopted evidence-based standards of care.
6. Integrating and collaborating with key stakeholders as part of a multi-disciplinary team. By integrating and collaborating with medical, care management, behavioral health, and community based resources, information flows are more efficient and

effective in managing patient populations. This results in less duplication of processes, less unnecessary contacts to the member, improved member experience and care is provided in a conscientious and cost-effective manner.

Note: Goals specific to each program category are addressed in **Attachment A**.

Objectives

- To promote population specific, optimal wellness while promoting self-care capabilities
- To increase coordination of care and services through multidisciplinary management principles
- To create and sustain an embedded care management and enhanced care management patient-centered medical home model for managing members with chronic and/or complex conditions
- To empower members and families to adopt and self-manage healthy lifestyles
- To enhance the quality of life for our members and families
- To consider social drivers of health and racial and ethnic disparities in order to ensure health equity, wellness and optimal health for all members
- To facilitate interventions that lead to improved health outcomes, increased member satisfaction, and reduce costs
- To identify members at risk for poor health outcomes (e.g., diagnosis of one or more targeted chronic conditions, non-adherence to recommended treatment, access barriers, social/environmental risks, etc.)
- To develop mutually set goals to foster member/family independence in making informed decisions about managing member's chronic condition(s)
- To emphasize member self-direction and involvement by teaching members to manage their own health care needs and utilizing available and appropriate community resources
- To facilitate shared access of information across the provider network
- To promote continuity of care by developing ongoing relationships between primary care providers, care managers, plan partners, community, and member/family and other multi-disciplinary team collaborators
- To facilitate the use of appropriate resources at the right time and in the right setting
- To collaborate with other local health plans and health departments to improve health outcomes for all of Los Angeles

Accountability and Support Resources

Authority and Accountability

Please see the Quality Improvement Program Description for full details of the enterprise wide Quality Assurance Programs.[1] The Population Health Management Program is led by the Chief Medical Officer and designees, including the Chief Quality and Information Executive and a Population Health Management Cross Functional Team (PHM CFT) which reports up to the Quality Oversight Committee (QOC). Member related regulatory requirements, reporting and program maintenance may be reported to the Member Quality Service Committee (MQSC) which also reports up to QOC to address NCQA and CalAIM requirements.

Population Health Management Cross Functional Team Committee

Role and Reporting Relationship: The PHM CFT is responsible for establishing a formal process to address gaps identified in the annual Population Assessment and to provide oversight, strategic guidance and input to PHM programs across L.A. Care and to meet the NCQA PHM standards and DHCS CalAIM standards. The committee serves as a platform for team and department leads to present current and prospective initiatives/interventions and programs for approval as well as provide updates regarding NCQA PHM results, Population Assessment findings and develop actions and initiative/interventions and programs to address gaps in care, address health disparities and to present results and evaluations. In addition, the PHM CFT promotes inter-departmental coordination and alignment of PHM related initiatives, improvement efforts, data/reporting requests and participation.

Member Quality Service Committee

Role and Reporting Relationship: The MQSC is responsible for improving and maintaining the L.A. Care member experience for all product lines. The scope of the committee includes, but is not limited to; analysis of the following sources to identify opportunities for improvement in member satisfaction as identified in the following: Member Satisfaction Surveys, Member Retention Reports, Access & Availability Surveys, Appeals & Grievances Data, and Interface of Provider Satisfaction with Member Satisfaction. The committee will also act as a steering committee for member quality service issues. The Member Quality Service Committee reports its findings and recommendations to the Quality Oversight Committee (QOC).

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Quality Oversight Committee

Role and Reporting Relationships: The QOC is an internal committee within L.A. Care which reports to the Board of Governors through the Compliance and Quality Committee. The QOC is charged with aligning organization-wide quality improvement goals and efforts prior to program implementation and monitoring the overall performance of L.A. Care quality improvement infrastructure.

Structure: The QOC membership is comprised of L.A. Care staff who are involved in improvement activities. A quorum is established when a minimum of 50% of the membership is in attendance. The Committee is chaired by the Medical Director, Quality Improvement or Senior Quality, Population Health and Informatics Executive. Voting members are managers and above.

Network related issues are reviewed through the Joint Performance Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC).

Quality Improvement and Health Equity Committee (QIHEC)

Role and Reporting Relationship: The QIHEC primary objective is to ensure practitioner participation in the Quality Improvement (QI) program through planning, design, and review of programs, quality improvement activities, interventions, and evidence based clinical practice guidelines designed to improve performance. The committee provides an opportunity to dialogue with the provider community and gather feedback on clinical and administrative initiatives. The committee reports through the Medical Director or designee, to the Quality Oversight Committee.

Chief Medical Officer: L.A. Care's Chief Medical Officer (CMO) is a physician, Board Certified in a primary care specialty, holding a current valid, unrestricted California Physician and Surgeon License. The CMO is an ex-officio member of the Board of Governors (BoG) and reports to the Chief Executive Officer (CEO). The CMO is the senior healthcare clinician and has the ultimate responsibility for the QI Program and assigns authority for aspects of the program to the Medical Director, Quality Improvement & Health Assessment.

- Ensuring that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management
- Ensuring that the medical care provided meets the community standards for acceptable medical care
- Ensuring that medical protocols and rules of conduct for plan medical personnel are followed
- Developing and implementing medical policy
- Ensuring that the Quality Improvement and Utilization Management Departments interface appropriately to maximize opportunities for quality improvement activities

Program Support Resources

Program support resources include the following:

1. Members: Executive Community Advisory Committee (ECAC) or Regional Community Advisory Committee (RCAC) members
2. Chief Quality and Information Executive
3. Medical Directors: Quality, Equity, Diversity and Inclusion, Utilization Management, Care Management, Behavioral Health
4. Personal Primary Care Provider (PCP)
5. Care Managers Administrative Support (including Enhanced Care Management and Community Supports)
6. Transitional Care Services (TCS)
7. Social Support (including Social Workers and Community Health Workers)
8. Health Education, Nutrition/Dietary Support
9. Behavioral Health Support
10. Management and Operations Management Support including Clinical Operations
11. Pharmacy Support
12. Information Technology Support (IT)
13. Health Information Management (HIM) Analytic Support

Personal Physician: Each member has an assigned Primary Care Provider (PCP) as their personal provider. The personal provider leads a care team who collectively takes responsibility for the initial visit and ongoing care to meet all required age-appropriate assessments and screenings. Day-to-day care team activities are focused on managing population-based outcomes and maximizing individual enrollee adherence to a distinct, customized self-care management program that leverages information technology.

Care Manager: Responsibilities of the Care Manager include but may not be limited to:

- Conduct initial and ongoing assessments of each member with respect to clinical condition, areas of need/risk, level of care and plan of care
- Engage the use of other disciplines including but not limited to Social Work, Transition of Care, Health Education, Behavioral Health, Pharmacy, Community Health Workers (CHW), etc. in care planning as appropriate and based on identified needs
- Apply decision support criteria appropriately according to evidence based clinical practice guidelines
- Partner with members and/or family members to assess, develop, implement, monitor actions to improve health status and quality of life which results in comprehensive, individualized care plans, using a multidisciplinary process
- Facilitate a learning environment with member and families to address self-management and/or educational needs
- Provide assistance with navigation and referrals, such as to CHWs or community-based social services.
- Document all aspects of care management services rendered in the clinical documentation system
- Maintain professional contact with other care management team members (physicians, health educators, nurses, social workers, community health workers, community service agencies, etc.) to promote quality care/education
- Ensure all basic population health requirements and NCQA care management standards are met
- Participate in community-based activities
- Stay current with new technologies and computer software utilized in member education and training
- Act as an advocate for the member and family
- Identify/report quality of care and risk management issues

Care Coordination Support: Responsibilities include direct support to the Care Manager in managing member and provider outreach, coordination with providers, and care management support of administrative tasks such as correspondence management and interdisciplinary care team meeting support.

Enhanced Care Management (ECM) Services: ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and nonclinical needs of high-cost and/or high-need members who meet ECM Populations of Focus eligibility criteria, through systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch, and person centered. ECM is a Medi-Cal benefit.

Community Supports: L.A. Care has implemented twelve of the fourteen (CalAIM) Community Supports (CS) services (formerly In-Lieu-of-Services). CS focus on addressing combined medical and social determinants of health needs to avoid higher levels of care or

other future health care costs. CS help to comprehensively address the needs of members, including homelessness, unstable and unsafe housing, food insecurity, and/or other social needs and support delivery of care for members enrolled in Enhanced Care Management (ECM). CalAIM CS include:

- Housing Transition Navigation Services
- Housing Tenancy and Support Services
- Housing Deposits
- Recuperative Care (Medical Respite)
- Respite (for Caregivers)
- Personal Care and Homemaker Services
- Nursing Facility Transition/Diversion to Assisted Living Facilities (such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF))
- Community Transition Services/Nursing Facility Transition to a Home
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

L.A. Care will launch the following additional CS by the end of 2024:

- Day Habilitation
- Short Term Post Hospitalization Housing

Field/Street Medicine: L.A. Care is slated in April 2024 to implement the L.A. County Field Medicine Program (LAC-FMP) to offer comprehensive health and social services to members experiencing homelessness in the members' lived environment (Street Medicine). The program will also include longitudinal primary and specialty care services through Street Medicine, mobile clinics, and in brick and mortar care settings. This program is intended to provide services and linkage to community resources to reduce barriers to care and support transition to permanent housing. Services may be provided to members living on the street, in shelters, or in temporary housing.

Transitional Care Services: Responsibilities include coordinating and verifying that members receive all appropriate transitional care services, regardless of setting and including but not limited to: inpatient facilities, discharging facilities, and community-based organizations.

Social Worker Support: The social worker or CHW participates in the development of the individualized care plan with focus on social needs, use of existing resources, coordination/facilitation of social service elements of the individualized care plan and assist in ensuring availability of needed resources.

Nutrition/Dietary Support: Dietary support is augmented by health education programs and services or individual hospital/community affiliated programs, when needed.

Behavioral Health Support: Care Management assessment tools include questions to determine the members' behavioral health needs and members are directed to appropriate programmatic levels accordingly. Based on DHCS' Adult & Youth Screening Tool for Medi-Cal Mental Health Services, such as Adverse Childhood Experiences (ACE) assessment, the members will be referred to Carelon or DMH as appropriate. Members' individualized care plans reflect these referrals and interventions as needed. Additionally, Medi-Cal members age 65 and above should receive an annual cognitive health assessment (ACHA).

Management and Operations Support: An interdisciplinary team made up of the Health Services departments providing member programs and services is responsible for the provision of management support for the program. This includes such things as management of funding sources to support program activities (staff salaries and benefits, program operational oversight, office space and equipment, etc.). Management support encompasses delivery of routine progress reports to L.A. Care's Quality Oversight Committee. The reports include program demographics and enrollment statistics as well as results of process and outcome measures. Primary care providers participating in the program are responsible for providing clinical guidance to members, program staff and other care team members in the management of chronic conditions, including basic population health management services (BPHM). The Health Services Directors will work closely with the Director of Communications and Community Outreach to address challenges and/or barriers to successfully managing members in the care management program.

Pharmacy Support: Pharmacy services provide assistance to the care team in developing strategies and programs to improve medication accessibility, appropriateness, and/or adherence. They provide monthly reporting across all lines of business regarding utilization and cost. Quarterly, the Pharmacy Quality Oversight Committee reviews medications for revision to the formulary as well as any pharmacy program related issues.

Health Information Management: Effective chronic condition care is virtually impossible without information systems that assure ready access to key data on individual members as well as populations of members. A comprehensive clinical information system can enhance the care of individual enrollees by providing timely reminders about needed services and summarized data to track and plan care. This also includes gathering, sharing and assessing timely and accurate data on member preferences and needs to identify efficient and effective opportunities for intervention through processes such as data-driven risk stratification, predictive analytics, identification of gaps in care, and standardized assessment processes. L.A. Care receives Admission, Discharge, Transfer (ADT) data

and utilizes data to coordinate member care. At the practice population level, they identify groups of members needing additional care as well as facilitate performance monitoring and quality improvement efforts. Additionally, L.A. Care tracks key performance indicators including Healthcare Effectiveness Data and Information Set (HEDIS), Enhanced Care Management (ECM), and Utilization Metrics to measure progress and report quarterly to DHCS for CalAIM, include the key performance indicators that are specific to PHMP.

System of Record – Clinical Care Advance (CCA) is used by the Care Managers, Social Workers, Health Educators, Behavioral Health, Community Health Workers and Care Coordinators to document all member communication and member's problems, progress toward meeting, goals, interventions and barriers within an individualized care plan. CCA automatically documents staff ID and data and time of action on the case and when interaction with the member occurred. Additionally, automated prompts can be set for follow-up.

- Quality Dashboards-L.A. Care will incorporate dashboards into appropriate staff's workflows
- Optum Impact Symmetry Suite-L.A. Care will utilize Optum customized reports to support L.A. Care's data needs and provide analytics to efficiently identify and stratify the population into different programmatic levels, programs and targeted campaigns.
- Impact Intelligence (I.I.)-is a tool that will give LA Care a retrospective view of member data and comprehensively show us trends in the member's care and the efficacy of implemented programs/decisions made for the member.
- Impact Pro (IPro)-is a tool geared towards a prospective view. Predictions into what could be the outcome if certain decisions are made or not, as members are identified.

Both Impact Intelligence (I.I.) and Impact Pro (IPro) will enable L.A. Care with the following capabilities:

- Enhance the quality and performance of our health plan as we move more to a managed care organization.
- Enhance the health and well-being of our members.
- Optimize facility and physician network.
- Promote our managed care organization and client relationship—value, efficiency, and quality, i.e., add value to our PCPs and SCPs.
- Detect cost utilization and quality trends.
- Integrate patient satisfaction data and HRA results to improve patient care and physician performance.
- Health Information Exchange – The ability to access member's necessary medical information through access to the electronic health record (EHR) systems enhances the continuity and coordination of care between the hospital, primary care provider office

and the Population Health Management Program team. L.A. Care's Population Health Management team and participating primary care providers will work together to develop and implement a plan to integrate data across settings. Initially data integration may require multiple system access while planning for data migration through interfaces or some other data sharing platform in the future.

Analytic Resources: The ability of the program to design statistically valid and reliable outcome metrics is provided through the analytical support of L.A. Care's Health Informatics resources and/or contracted resources. Data analytics evaluate the population and translates the data into understandable and actionable information that can be drilled down to an individual level. Data is evaluated by the health system and care team as appropriate, and utilized to generate actions that can best serve healthcare needs with a priority toward lowering overall healthcare spending. Analytic resources work closely with all organizations contributing to the program as part of the care team to develop appropriate data collection instruments, secure data storage sources, and generate reports as designated by program performance measures. DHCS will launch the PHM Service that will be applied statewide. The PHM Service will use a variety of data sources beyond claims and encounters to determine risk tiers to oversee the penetration rate of services, such as wellness and prevention services, transitional care services, and care management programs.

Programs/Services Overview

Current Programs

Keeping Members Healthy: L.A. Care has multiple programs that focus on keeping members healthy. The following programs and services are made available to all identified members.

- Fight the Flu Campaign
- Early Childhood Vaccines Campaign*
- Healthy Moms
- Health in Motion™
- Colorectal Cancer Screening
- Breast Cancer Screening
- Cervical Cancer Screening

Early Detection/Emerging Risk/ Prevention: L.A. Care has multiple programs that focus on early identification and mitigation of risk factors. The following programs and services are made available to all identified members.

- Basic Population Health Management (BPHM)

- Centers for Disease Control and Prevention (CDC)-recognized Diabetes Prevention Program*
- Child Health and Disability Prevention (CHDP)
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) Services

Chronic Condition Management: L.A. Care has multiple programs to focus on managing members with identified chronic conditions or multiple chronic conditions. The following programs and services are made available to all identified members.

Asthma

- Asthma Medication Ratio (AMR) Education Kit
- L.A. Cares About Asthma Program*

Diabetes

- Diabetes Self-Management Education and Support (DSME-S) program*
- L.A. Care Diabetes Quality Improvement Project (QIP)
- Diabetes Education Kit
- L.A. Cares About Diabetes*
- Diabetes Text Message Campaign*

Cardiovascular Disease

- L.A. Cares About Your Heart*

Care Management programmatic levels:

- Enhanced Care Management
- High Risk and Complex Case Management*
- Palliative Care

Social Determinants of Health

- Equity Council
- Doula Services
- Community Health Workers (CHWs)
- Community Support Services
- Field/ Street Medicine

Care Transitions (Outcomes Across Settings)

- Follow-up After Hospitalization Incentive Program for mental health related hospitalizations*
- MLTSS Care Coordination
- Transitional Care Services for all levels of care

Patient Safety

- Medication Therapy Management (MTM)*
- Pharmacy Home Program & Opioid Home Program- Opioid Abuse*
- Ambulatory Care Pharmacy Initiative*
- Community Pharmacy Value-based Program-California Right Meds Collaborative (CRMC)*

Programs with an interactive component with members. Members receive materials informing them they are enrolled in or eligible for a program.

Population Assessment

L.A. Care assesses its member population at least annually to identify needs and make adjustments in its population health management programs and/or services and resources to fit current needs. Data that is available and accessible is collected and analyzed as part of the assessment process. This includes demographic data such as gender, age and Regional Community Advisory Committee (RCAC) regions, members receiving Managed Long Term Services and Supports (MLTSS), Healthcare Effectiveness Data and Information Set (HEDIS) data, inpatient and outpatient utilization data and a homeless identification algorithm. Data across all age categories is included in the assessment with a specific sub-population age category of 2-19 years of age segmented out for a focused needs assessment of children. Information gathered includes at a minimum the following:

- Social determinants of health (SDoH) – This is identified using the University of Wisconsin Area Deprivation Index (ADI)[2], based on 17 markers of socio-economic status derived from zip-code and SDoH z-code claims as coded by providers. Additionally, within IPro the Social Vulnerability Index (SVI) from the Centers for Disease Control and Prevention (CDC) is included so staff can identify alerts for clinical indicators for sets of SDoH codes.
- Federal and state program eligibility for Medi-Cal (MCLA) – This is identified using Federal and State eligibility files received daily.
- Members with disabilities and serious and persistent mental illness (SPMI) – This is identified using the Current Procedural Terminology (CPT) and Diagnosis Codes included in claims and encounters data.
- Multiple chronic conditions or severe injuries – This is identified using the Current Procedural Terminology (CPT) and Diagnosis Codes included in claims and encounters data. Diagnosis data is grouped using the Agency for Healthcare Research and Quality Clinical Classifications Software Refined (AHRQ CCSR[3]) The AHRQ CCSR methodology allows for more clinical meaningful groups of diagnosis codes.
- At risk ethnic, language (including assessing members with limited English proficiency) or racial group – This is identified using Federal and State eligibility files received daily.

L.A. Care uses assessment results at least annually to review and update its population health management structure, and strategy including programs, services, activities and resources such as staffing ratios, clinical qualifications, job training, external resource needs, community resources, contacts, and cultural competency to meet member needs.

L.A. Care is working to integrate the following data sources in the Risk Stratification and Segmentation (RSS):

- Screenings and assessments;
- Managed care and fee-for-service (FFS) medical and dental claims and encounters;
- Social services reports (e.g., CalFresh; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); California Work Opportunity and Responsibility to Kids (CalWORKs); In-Home Services and Supports (IHSS));
- Electronic health records;
- Referrals and authorizations;

[2] **https://www.neighborhoodatlas.medicine.wisc.edu/**

[3] https://hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp

- MCP behavioral health Screenings, Brief Interventions, and Referral to Treatment (SBIRT), medications for addiction treatment (MTOUD, also known as Medications for Opioid Use Disorder), and other substance use disorders (SUD), and other non-specialty mental health services information;
- County behavioral health Drug Medi-Cal (DMC), Drug Medi-Cal Organized Delivery System (DMC-ODS), and Specialty Mental Health System (SMHS) information available through the Short-Doyle/Medi-Cal and California Medicaid Management Information Systems (CA-MMIS) claims system;
- Pharmacy claims and encounters;
- Disengaged member reports (e.g., assigned members who have not utilized any services);
- Laboratory test results;
- Admissions, discharge, and transfer (ADT) data;
- Race, ethnicity, and language information;
- Sexual orientation and gender identity (SOGI) information;
- Disability status;
- Justice-involved data;
- Housing reports (e.g., through the Homeless Data Integration System (HDIS),
- Homelessness Management Information System (HMIS), and/or Z-code claims or encounter data); and
- For members under 21, information on developmental and adverse childhood experiences (ACEs) screenings.

Every three years L.A. Care will be submitting a Population Needs Assessment (PNA) to DHCS that describes the needs of the population which is focusing on cultural, linguistic, health education needs and health disparities. Prior to the July 2022 submission the PNA submission was done annually.

The population is divided into meaningful subsets using the population assessment findings and risk stratified based on care needs at all levels and intensities. This process better facilitates L.A. Care's ability to determine appropriate resources and interventions needed to members who can most benefit from population health management programs and services. The segmentation table provides a break-down of the number of members eligible for each program in order to target inequities and gaps in care.

L.A. Care will be a part of the DHCS PHM Service when available which will use a single, statewide, open-source Risk Stratification and Segmentation (RSS) methodology with standardized risk tier criteria. RSS results in the categorization of all members according to their care and risk needs at all levels and intensities, the risk tier criteria will place all Medi-Cal members into high-, medium-rising, and low-risk tiers.

L.A. Care understands that the Optum IPro data reflects inequities that exist both in the healthcare system and society at large, from unequal treatment and outcomes within the system to unequal representation for those with limited access to the system. As a result, we annually conduct analyses to ensure there no biases in our risk stratification approaches. In addition, L.A. Care is vigilant in identifying bias by identifying disparities and focusing interventions to address these identified disparities.

L.A. Care collects and reviews data from multiple sources. The data sources are combined and used to identify eligible members for each program or services within the Population Health Management framework and implement interventions, including the use of telehealth, virtual visits and remote patient monitoring. Data integration may be used to identify populations to support members' care needs at the appropriate time and place. This may include high-care and high-touch needs such as, complex case management, enhanced care management or preventive care needs such as chronic care and health promotion programs. Data sources used for program identification include the following:

Data Integration and Segmentation of Member Cohorts

PHM Service: DHCS plans to launch a statewide PHM Service, which is a technology service designed to support PHM Program functions. The PHM Service will provide health plans, providers, counties, members, and other authorized users with access to comprehensive data on members' health history, needs, and risks, including historical administrative, medical, behavioral, dental, and social service data and other program information from disparate sources. The PHM Service will use these data to support risk stratification, segmentation and tiering, assessment and screening processes, and analytics and reporting functions.

Health Appraisal: HA data is used to identify and enroll members eligible for appropriate and meaningful L.A. Care programs (e.g., health coaching, nutrition and weight management services provided by Registered Dieticians). Members are encouraged to complete a HA annually through L.A. Care's online health and wellness portal, My Health In Motion™ (My HIM). See Health Appraisal section below for more details.

Health Information Exchange: Data is available for L.A. Care's clinical staff through the Los Angeles Network for Enhanced Services (LANES) from participants including Department of Health Services (DHS) and Department of Mental Health (DMH). L.A. Care also receives admission/discharge and transfer (ADT) data from in-network hospitals through e-Connect. L.A. Care also receives hospital data from PointClickCare (PCC) software to analyze population health in a variety of ways. Care Management, Behavioral Health,

Utilization Management, Quality Performance Management, Managed Long Term Support Services, Health Education, Enhanced Care Management (ECM) and Pharmacy within Health Services use PCC to examine near real-time admissions, discharges and transfers of our members from hospitals to improve quality of care provided to members through timely data exchange.

L.A. Care is currently building out its Health Information Exchange Ecosystem with the three HIEs mentioned above. Once implemented, data from each HIE will be appropriately incorporated into the whole of L.A. Care's health data for downstream uses. Eventually all data types will be ingested and processed through one common path and therefore optimized for volume and validity for those downstream uses. The key differences between HIE data and usual methods of obtaining data is timing and depth. The data is sent from provider electronic health records system (EHR) via HL7 XML transmission in near real time from when the encounter is processed in the source EHR directly to the recipient system. Acute care transition, medical records, lab and pharmacy may be sent in this manner.

Health Services Programs within L.A. Care: Hospital census data from UM as well as member referrals between health services programs, such as Care Management (CM) and Social Work and Behavioral Health occur within the system of record and are used to identify and stratify members.

Health Information Technology (HIT) Resources and Support – L.A. Care Health Plan receives data from multiple external sources and endeavors to make efficient use of all of them. These include but are not limited to various sources of claims and encounters data: Historical claims and Encounter files from the state (DHCS); Data through Electronic Data Interchange (EDI) which include claims, encounters from plan partners, Independent Physician Associations (IPAs), Management Services Organizations (MSOs) and Provider Offices and billing companies. Additionally, we receive pharmacy encounters that DHCS provides, since they own the contract with the Pharmacy Benefits Management organization.

Through the HEDIS process, L.A. Care receives Direct Data Submissions from Electronic Health Records that represent and fill gaps created by the EDI process for encounters above. L.A. Care also receives supplemental data files which may be a "standard data source" and not require Primary Source Validation (PSV) or Non-Standard which do require PSV audit and review. L.A. Care receives multiple types of assessments, from members, providers and those completed by the health plan. These could be available online with the potential of electronic transitions of responses and results, to within the operational system, to paper versions which must be converted, loaded and archived appropriately. There are various operational systems throughout the organization that create and store data, for example, the HEDIS engine, Cognizant Claimsphere, Cozeva, Risk Adjustment applications, and the medical management operational system of record.

Health Information Exchange (HIE) – L.A. Care is currently building out its Health Information Exchange Ecosystem with multiple HIEs for the breadth of data desired. Once implemented, data from each HIE will be appropriately incorporated into the whole of L.A. Care's

health data for downstream uses. Eventually all data types will be ingested and processed through one common path and therefore optimized for volume and validity for those downstream uses. The key differences between HIE data and usual methods of obtaining data is timing and depth. The data is sent from provider electronic health records system (EHR) via HL7 XML transmission in near real time from when the encounter is processed in the source EHR directly to the recipient system. Acute care transition, medical records, lab and pharmacy may be sent in this manner. L.A. Care currently works with “eConnect”, EDIE™ PreManage and “LANES”.

The Population Health Assessment (PHA) for NCQA and Population Needs Assessment (PNA) for DHCS are used to identify member health needs and health disparities and evaluate existing programs and implement programs to address unmet needs. The PHA and PNA use a variety of data sources including HEDIS results, CAHPS results and member stakeholder input from the Executive Community Advisory Committee (ECAC) and are separated out by inpatient, outpatient, emergency room and diagnoses. DHCS will implement a modified PNA process that will require L.A. Care to provide a more robust description of the population needs of members and the communities they live in, less frequent data collection, and more meaningful and systematic community engagement that will augment the data currently available to provide a fuller picture of the needs of members as well as the needs and strengths of the communities in which they live. L.A. Care is required to submit a PNA every three years to DHCS and will be required to develop the PNA in partnership and alignment with Local Health Jurisdictions’ Community Health Improvement Plans (CHIPs), and hospitals’ Community Health Needs Assessments (CHNAs) and processes. The next full PNA submission will be due in 2025.

Health Appraisal

Health Appraisal (HA) Administration and Disclosure

L.A. Care uses multiple tools to assess the patient population and identify members for appropriate population health management programs.

L.A. Care makes available a HA to all members across all lines of business. This tool is web-accessible and provides immediate results and recommendations based on the member’s identified risks. Members who do not have web access may request the HA be administered over the telephone or have a printed copy mailed to them. L.A. Care logs all telephonic or mail requests for the HA by members.

After completion, the member is offered additional education through various means including online support with a health coach. Completion of the HA is encouraged at least annually and members can also update their results at any time. Prior to members

completing the HA, information is provided in easy-to-understand language as to how the information is used, a list of organizations and individuals (physician and care team) who might receive the information and reasons for sharing of HA information, and how participants may consent or decline to have information used and disclosed. L.A. Care's NCQA-certified vendor for health and wellness portal services assesses member understanding of the HA disclosure language through a documented review of HA readability/understandability. This process encompasses readability and understandability of the HA disclaimer performed at least every three years via usability testing, and annually to ensure use of plain language principles, clear paragraph headings, common terms and concise sentences.

L.A. Care provides a Health Information Form (HIF) also known as the Member Evaluation Tool (MET) for all MCLA members. This is a 10 question mail-based tool included in new member packets that provides where the member/caregiver provides their own perspective on health in terms of having chronic conditions, treatment, health needs, language preference, and level of mobility. L.A. Care collects the information for new members, identifies needs and act on these needs, and disseminates the information as necessary for member's care through the pre-identified trigger responses. These are disseminated in the system of record, to the appropriate care management department (Care Management, Social Work, Social Services or Utilization Management) to further support the member's care and care coordination needs.

Health Risk Assessments (HRAs) are more detailed tools used to assess higher risk members from Dual Special Needs Program (DSNP) and MCLA SPDs. The assessment goes deeper into detail for risk stratification in the four domains of clinical, social, functional and economic concerns.

Health Appraisal Content

L.A. Care's HA includes the following components

- Demographic information (age, gender, ethnicity)
- Health history, including chronic illness and current treatment
- Self-perceived health status using validated questions
- Behavioral change strategies – questions to help guide changes in behavior and reduce risk.
- Hearing and vision needs –hearing and vision impairment assessment questions
- Language needs

In addition to the above components, specific areas are assessed. They include:

- Height and Weight
- Smoking and tobacco use
- Physical activity
- Healthy eating
- Stress
- Productivity or absenteeism
- Health prevention (breast cancer, cervical cancer screening colorectal screening and annual influenza vaccination)
- At-risk drinking
- Depressive symptoms
- Safety behaviors

Health Appraisal Summary Report and Format

HA results are shared with the member after they complete the form in an easy to understand format. Members receive an interactive, detailed personal health assessment report of their health risks (Low Risk, Moderate Risk or High Risk), overall Wellness Score, and evidence based health recommendations and health education targeted to their identified risks, including recommendations for self-management tools and workshops. The HA score gives members insight into healthy lifestyle habits and ways to improve their wellbeing related to nutrition, exercise, safety, preventive health, as well as other categories. With this well-coordinated online application, the member may learn more on targeted topics based on their responses, contact L.A. Care, or be connected with a health coach. Members are encouraged to complete the HA annually and can also update their results at any time. Members receive an updated personal health assessment report upon doing so comparing their results to previous Health Assessment results. The HA, personal health assessment report, risk advisor, and health library articles are available in English and Spanish via My Health In Motion™ (My HIM). Some, but not all of the self-management tools are available in Spanish.

HA that is required for SPD and D-SNP members is called the HRA. It is a longer, more clinically detailed assessment for higher risk individuals. It is offered as in-person first and if accepted is completed using external vendors from Multipurpose Senior Services Programs (MSSPs). Coordination and communication regarding this process is based on phone calls and faxes. The rest of the HRAs are completed as a phone conversation with L.A. Care's Customer Solutions Center (CSC) representatives. The timing and exact process of HRA completion is distinctly described by All Plan and Dual Plan letters from the Department of Health Care Services

(DHCS). CSC works within multiple applications in order to complete the contact and completion documentation. Beyond the HRA, all necessary assessments are coordinated in the operational system of record, with progression based on member need.

Initial Health Appointment (IHA)

A new Medi-Cal member also needs to have an Initial Health Appointment (IHA) by their provider. The IHA includes a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases within 120 days of enrollment. Prior the IHA also required an Individual Health Education Behavioral Assessment (IHEBA) and a Staying Healthy Assessment (SHA), but since 2023 is no longer a component for the IHA. Education is provided to Physician Provider Groups (PPGs) and the Direct Network providers and they are delegated the responsibility to complete the IHA.

In addition, to the review of the member's medical records, DHCS is looking additionally to MCAS measures as an indicator of compliance with the IHA.

Health Appraisal Review and Update Process

The HA is contracted through Oracle, an NCQA-certified vendor, and is reviewed and updated at least every two years and more frequently if new evidence is available.

Risk Stratification and Program Identification Methodology

L.A. Care's Population Health Management Program scope includes member segmentation, risk stratification and program identification. Members are identified for programs in health promotion and early detection, condition management or complex case management.

During pre-enrollment, L.A. Care receives external claims and encounters data and assesses members' risk level based on an algorithm to assign a high or low risk level to the member. For DSNP and SPD members the stratification determines the timing of the completion and contact activity for the HRA. Once the HRA is completed, the score of the HRA determines the member as complex, high or low risk. These stratifications determine if the member receives Care Coordination from internal L.A. Care staff (Complex and High Risk) or are delegated for management to the PPG to whom they are assigned (Low Risk).

Members are triaged to participate in L.A. Care's Cardiovascular Risk Reduction (CVD) program based on the output from algorithms designed to assess member appropriateness for the program monthly The algorithm identifies the members and stratifies the member into risk levels (low, medium or high).

Monthly, all L.A. Care member data is run through IPro for risk stratification of the entire population. Clinical risk stratification is based on evidence-based practice guidelines that are applied into risk stratification criteria, from which multiple L.A. Care programs prioritize interventions, including complex case management, end stage renal disease, and behavioral health. Social Determinants of Health (SDoH) are identified through ADI zip-code data in the annual Population Health Assessment and through z-code claims from providers. The Optum IPro data reflects inequities that exist both in the healthcare system and society at large, from unequal treatment and outcomes within the system to unequal representation for those with limited access to the system. In addition, L.A. Care is vigilant in identifying bias by identifying disparities and focusing interventions to address these identified disparities.

Specific criteria are used in multiple programs to identify members. These include community-based programs like Enhanced Care Management (ECM), and Community Support Services.

All risks identified during the enrollment and assessment process are incorporated into care planning activities to increase the likelihood of positive outcomes. Based on information gathered during the assessment, members are risk stratified and a self-management care plan is generated with the members, significant influencers, and members of the care team, as appropriate. Refer to each condition management program overview for risk stratification detail.

Enrollment - In addition to identifying members through data algorithms, members may also be identified and referred through many internal and external sources (e.g. Internal Departments such as Health Education, UM etc. or External Sources such as Providers, Nurse Advice Line, Discharge Planners, Caregivers, and Members etc.). Members are informed about available Population Health Management programs through L.A. Care's website and member newsletters and when a referral is received, administrative support staff in each program review member's eligibility and criteria for enrollment. Upon enrollment, a welcome letter is sent informing members how they were identified for the program, how to use program services, and how to opt in or out of the program at any time. For interactive programs, telephonic contact is made to engage the member into the appropriate program and intervention. Members may opt in or out of the program at any time.

Supporting the PHM roll out, DHCS will be launching a statewide PHM Service. The PHM Service will provide a wide-range of Medi-Cal stakeholders with data access and availability for Medi-Cal members' health history, needs, and risks, including historical administrative, medical, behavioral, dental, social service data, and other program information from current disparate sources. The PHM Service will utilize this data to support risk stratification, segmentation and tiering; assessment and screening processes; potential medical, behavioral, and social supports; and, analytics and reporting functions. The PHM Service will also improve data

accuracy and improve DHCS' ability to understand population health trends and the efficacy of various PHM interventions and strengthen oversight.

Key Programs and Services

Please refer to **Attachment A** for specific 2023 goals and interventions to track and improve rates. Below details programs and initiatives in each area of focus across the continuum of care. Interventions use a variety of modalities for communication with increased emphasis on utilizing technology, including robocalls, social media campaigns and virtual health such as Telehealth solutions such as: Teladoc, Nurse Advice Line and eConsults. This may not be fully inclusive of all initiatives, interventions and campaigns across L.A. Care, but represents programs, interventions and campaigns that Population Health Management focuses on and tracks year to year. This year L.A. Care has addressed DHCS's updated requirements for the PHM Strategy to align with the Comprehensive Quality Strategy (CQS) Clinical Focus Areas and Bold Goals and have more emphasis on community engagement, racial/ethnic disparities in well child visits and immunizatons; closing maternity care disparities for black and native American persons, improving maternal and adolescent depression screening, improving follow up for mental health and substance use disorder and ensuring addressing children's preventive care measures.

Health Promotion (Keeping Members Healthy) and Early Detection (Emerging Risk)

L.A. Care's health promotion and early detection programs promote healthy lifestyle choices to members through education, resources, health screenings and incentives. These programs exist as a vehicle to engage members in managing their health, overall wellness and improve member health status.

Annual Cognitive Health Assessment (ACHA)- Aims to ensure timely detection and early intervention for Alzheimer's disease or related dementias for eligible Medi-Cal members 65 and older. Providers are required to complete the Dementia Care Aware Cognitive Health Assessment training and conduct appropriate follow-up services based on the ACHA findings.

Antidepressant Medication Management (AMM) Member Letter – The AMM Member mailer is sent out to increase member knowledge around antidepressant medication treatment plans, including issues related to adherence and side effects. Additionally, the letter encourages any members who are also due for a care gap measure (Breast Cancer, Colorectal Cancer and Cervical Cancer Screening). The letter was disseminated in English and Spanish according to member demographic profiles for preferred language.

Attention Deficit Disorder (ADD) Provider Intervention – Distribution of notification letters to prescribing providers encouraging them to emphasize the importance of follow-up care with their child-aged patients diagnosed with ADD and prescribed medication-based treatment, in accordance with clinical practice guidelines and the relevant ADD HEDIS quality measure.

Blood Lead Screening – All Plan Letter (APL) 20-016 makes L.A. Care responsible for the provision of blood lead screening tests in children between the ages of 12 months to 6 years old who are enrolled in Medi-Cal. In response to the APL, a Lead Data report is available to providers on the provider portal and updated on a monthly basis. By posting these reports to the Provider Portal, we are ensuring that providers are informed of which Medi-Cal children are in need of a blood lead screening test in order to close their screening gap. Social Media posts go out annually to educate the community about the importance of lead screening.

Cancer Screening Programs:

- *Colorectal Cancer Screening Program* – Aims to improve colorectal cancer screening rates by increasing awareness among members due for colorectal cancer screening. Outreach efforts include automated reminder calls, social media posts encouraging colorectal cancer screening and educational mailers, at home test kids, text message campaign, member incentive (LACC only sent to members due for their screening.
- *Breast Cancer Screening Program* – Aims to improve breast cancer screening rates by increasing awareness among members due for a screening mammogram. Outreach efforts include reminder calls, educational mailers, and social media posts encouraging breast cancer screening.The educational mailer will be sent to members who have been compliant before in this measure but are currently no longer compliant. Reminder memos were sent to contracted PPGs to disseminate to providers, specialists and imaging centers in their network. This memo stated that prior authorizations were not needed for preventive screenings – including breast cancer and cervical cancer screening.
- *Cervical Cancer Screening Program* – Aims to improve cervical cancer screening rates by increasing awareness among members due for cervical cancer screening. Outreach efforts include automated reminder calls, an educational mailer targetingmembers who have been compliant before in this measure but are currently no longer compliant and a social media campaign (Facebook ads) encouraging women to go in for their Pap test.
- *Osteoporosis Management:* L.A. Care collaborates with Homebase Medical to administer in-home DEXA scans for DSNP women who have had a fracture. The goal is to close gaps in care and to prevent further fractures related to osteoporosis in women ages 67-85. Each Nurse or Specialist conducts outreach calls to members or member providers to ensure proper osteoporosis management for our members. This includes: in-home DEXA scans, DEXA scans at a facility, appointments with their Primary Care Physician (PCP), medication, and any SDOH related assistance.
- *Community Resource Centers (CRCs)*– As a benefit for both L.A. Care members and the overall community, all twelve (12) L.A. Care Community Resource Centers (CRCs) offer health education, physical activity classes, and social support services. Health education classes include self-management of chronic conditions such as diabetes, obesity, heart disease, and hypertension, CPR/First Aid, healthy living, and healthy cooking and eating. Exercise and physical fitness classes include aerobics,

strengthening, and stretching. CRCs also support with health promotion services like flu vaccine clinics, blood led screenings in collaboration with public health partners, and others. Monthly calendars with daily schedules for each CRC location may be found at communityresourcecenterla.org.

- *Early Childhood Vaccines Campaign* – Encourages parents/guardians to get their children's immunizations based on the recommended immunization schedule. Member initiatives include a paid social media campaign, robocalls, and postcards encouraging childhood immunizations well care visits. These member initiatives focus on the Childhood Immunization Combination10, which are the recommended vaccines for children to receive by their 2nd birthday. The Missing Vaccine report is a provider level report noting missing antigens for eligible members in Childhood Immunization 10 and Immunizations for Adolescents Combination 2. This report is available on the L.A. Care Provider Portal.

Fight the Flu and COVID Campaign - Encourages DSNP, MCLA, LACC/D, and PASC-SEIU members to obtain their annual flu and COVID vaccines as indicated. Campaign activities are a collaborative effort between the Health Education, Communications, Pharmacy, Community Resource Center (CRC), and Customer Solution Center Departments and run annually from September to May. Campaign activities include automated reminder calls, CSC pre-screen messaging, educational postcards, member and provider newsletter articles, email reminders, provider fax, a social media campaign, Flu Myths Buster video, a text messaging campaign, and end of call flu reminders. Messaging includes information about the importance of the flu and COVID vaccines, given the ongoing risk of COVID-19. Messages also include healthy habits to prevent the flu and COVID, and information about where to get both a flu and COVID shot including the doctor's office, local pharmacy, or community vaccine events. Members 65 and older also receive messaging about the importance of the pneumococcal vaccine. DSNP members who receive their flu shot receive a $25 incentive gift card. The Pharmacy department also conducts outbound medication adherence calls to DSNP members and includes a flu reminder directing members to receive their vaccine at local pharmacies. In addition, during inbound pharmacy calls, L.A. Care's Pharmacy department staff advertise any upcoming vaccine clinics being offered at Community Resource Centers (CRC) to members.

Health in Motion™ – Provided through L.A. Care's Health Education Department, various programs and services supplement population health management by providing robust and flexible health education programing. Members have access to a variety of in-person group appointments and individual telephonic or virtual consults with health educators or registered dietitians. Services are available at no cost to direct line of business members and are conducted in English and Spanish. Interpreters are available upon request for other languages, as needed. This program also includes accessibility to materials and tools to facilitate member/family/caregiver involvement in making informed decisions about their health. Members access Health Education services via health care provider referral, L.A. Care staff referral, targeted recruitment by diagnosis, or self-referral. The program is promoted to members and providers via multiple channels, including L.A. Care's website, member and provider newsletters and by collaborating with Physician Provider Groups (PPGs) to educate providers about available health education services and resources.

As an adjunct to *Health in Motion*™, L.A. Care makes available an on-line health and wellness portal, *My Health in Motion*™ which compliments in-person and telephonic health education services. It allows members to complete a Health Assessment, view a personalized report of their health risk and strengths, and utilize tailored self-management tools such as workshops, exercise how-to videos, and meal plans. Members can also work with a health coach, via a secure messaging platform.

Healthy Mom – The "Healthy Mom" Program includes MCLA, DSNP, and L.A. Care Covered (LACC) members who recently gave birth. The program seeks to improve HEDIS rates for timely postpartum visits through member and provider outreach and education. Members are identified weekly from hospital discharge data via eConnect, LANES and CMT platforms. Our postpartum text messaging campaign outreaches, to members identified as having recently delivered, informing them about the importance of having a postpartum visit as well as sharing relevant parenting resources. The L.A. Care Health Education Advocate conducts telephonic outreach calls to members identified by delivery data but have no postpartum encounter data. Members receive telephonic education on the importance of completing a postpartum visit within 7-84 days after delivery, scheduling assistance and help with arranging transportation and interpreting services as needed. Members whose postpartum visit has been confirmed by encounter data receive a $40 gift card for completing their postpartum visit.

Additionally, maternal mental health is an established benefit for L.A. Care members. This requires all licensed health care providers offering prenatal or postpartum care to screen for maternal mental health conditions during the prenatal period (during pregnancy before birth), postpartum period (up to 1 year after giving birth), or both. Providers connect members to behavioral health providers and other supportive community resources.

Additional prenatal resources for MCLA members include a general or targeted letter connecting them to educational materials and resources based on the availability of trimester information.

Medi-Cal and LACC members further receive doula service benefits. A doula is a birth worker who can be a source of comfort and encouragement during and after pregnancy, advocate for members birth plan, provide breastfeeding support, and connect families to needed resources. Planned promotion for the doula benefit and postpartum visits includes the following modalities: member flyer and mailer, text messaging campaign, provider webinar, information posted on L.A. Care's Maternity Care webpage (**www.lacare.org/pregnancy**), provider forms, and educating L.A. Care staff about the availability of this program. Doula care has been proven to show improved birth outcomes and L.A. Care looks forward to continued birth outcome improvements through the utilization of this program.

Healthy Pregnancy Program
To support enhanced data capture and timely identification of pregnant members, L.A. Care utilizes a prenatal report integrating prenatal identification sources such as HIE, CMT, prenatal data survey, HIF, LANES and others. The prenatal report helps in timely

identification of pregnant members and provides race/ethnicity information for targeted disparity interventions. Through this report, L.A. Care has the opportunity to reach additional pregnant members to educate them on the importance of prenatal care and connect them to additional educational materials and resources to initiate prenatal care.

MCLA pregnant members are mailed trimester specific pregnancy packets or a general letter when trimester information is not available. The mailing packets include educational materials about the importance of prenatal care, childhood immunizations, breastfeeding, postpartum depression, and resources such as a flyer for WIC and Text4baby programs. The mailing packets also includes contact information for L.A. Care's Health Education Advocate for assistance in the scheduling of prenatal appointments, transportation and interpreting services.

L.A. Care also conducts a prenatal text messaging campaign for MCLA Black/African American members and all LACC members to address maternal mortality disparities. The campaign emphasizes the importance of prenatal visits and informs members of valuable pregnancy resources such as the doula benefit for MCLA members

Initial Health Appointment (IHA) – L.A. Care aims to improve initial health appointment (IHA) rates through a training and monitoring program to ensure providers complete an IHA with newly enrolled members within the appropriate timeframes; 120 days. An IHA includes an assessment of the member's physical history, mental health history, identification of risks, assessment of need for preventive screens or services, health education and diagnosis and plan of treatment for diseases. Training and monthly IHAs reports are provided to Physician Provider Groups (PPGs) and the Direct Network providers and they are delegated the responsibility to complete the IHA. Delegation Oversight and Enterprise Performance Optimization (EPO) monitor the delegates' completion of this requirement. Quality Improvement has an IHA Dashboard to monitor IHA completion rates to track throughout the year. A provider incentive for completing the IHA was included in the Pay-For- Performance (P4P) program.

Condition/Disease Management Programs:

L.A. Care annually assesess top diagnoses across the membership and develops programs and initatives to target the most needed areas of focus for condition and disease management intiatives and programs. Disease Management focuses on emerging disease and the prevention of disease-related exacerbations and complications using evidence-based treatment guidelines and patient monitoring and education tools. Programs like these have been successful in helping patients suffering from chronic illness improve their health status over the entire course of the disease (Gillespie and Rossiter, 2003). Disease management supports the provider-patient relationship through collaborative care in the treatment plan while emphasizing prevention and patient self-management. Below details the programs and initiatives L.A. Care has in place to address asthma management, diabetes management, and cardiovascular disease management.

Asthma:

- L.A. Cares About Asthma – L.A. Care's Health Education Department launched an asthma support program January 2021. The program focuses on identification of newly diagnosed members with asthma offering them materials and resources as an "opt-in" program option. The program encourages members 18 years and older to create an online health and wellness portal account to access additional resources including self-paced workshops, videos and a chat feature. Promotional Interventions include monthly mailings, articles in Provider Progress Notes, Live Well/Be Well, and Stay Well for LACC.

L.A. Care's Pharmacy department has been collaborating with the Quality Improvement department and Chronic Care Workgroup to design and implement an intervention to help ensure adherence of controller medications and decrease overutilization of emergency rescue inhalers in our MCLA and LACC asthma member population. The AMR Education Kit is an informational packet that includes a magnetic postcard to remind the members to take their chronic medications, stickers to help the members differentiate between controller medications and quick-relief inhalers, an instruction handout on where and how to place the stickers, and an education handout to explain the importance of adherence. The program continues to send AMR Education Kits to MCLA and LACC members.

Community Supports services offered by L.A. Care include Asthma Remediation for members with poorly controlled asthma. Asthma Remediation services are environmental asthma trigger remediations which include physical modifications to a home environment necessary to ensure the health and safety of the member or enable the member to function in the home to avoid asthma-related hospitalizations.

Diabetes:

- *Diabetes Prevention Program (DPP)* – Seeks to prevent or delay the onset of type 2 diabetes in high-risk adult members through a year-long behavioral change program. High risk (pre-diabetic) members are identified through an integration of claims, encounters, and lab data. Adult members who meet the Centers for Disease Control and Prevention (CDC) DPP clinical criteria are eligible for the program. Key components of the program include a trained lifestyle coach and a CDC approved curriculum with group support over the course of the year. The program must comply with CDC DPP guidelines and be delivered by a CDC recognized provider.
- L.A. Care has a Quality Improvement Project (QIP) targeting Black or African American and American Indian Alaska Native L.A. Care Covered members with diabetes to improve A1c control. Intervention design includes several prioritized strategies for member, provider, system and community levels. Interventions for members include medically tailored meals for up to 8 weeks and the option to work with a L.A. Care Registered Dietician. A packet mailed to members contained information on mail order prescriptions, A1c levels, diabetes medications and a booklet with helpful phone numbers, resource center locations and

healthy lifestyle information. Members may be referred to the Health Education Department's *Diabetes Self-Management Education –Support Program (DSME-S)* that enables members to control and manage their condition, including A1c levels. The program is delivered through virtual group sessions, in person sessions or individually over the telephone.This program is recognized by the American Diabetes Association (ADA) and adheres to the 2022 National Standards for Diabetes Self-Management Education and Support.

- L.A. Cares About Diabetes – L.A Care's Health Education Department launched an enhanced support program in January 2021. Members newly diagnosed with diabetes are identified monthly and sent a welcome packet with educational materials and additional resources. Adult members are encouraged to "opt in" to the program by creating an online account through the health and wellness portal to access additional resources including self-paced work shops, videos and a chat feature. Members also have the opportunity to enroll in the comprehensive Diabetes Self-Management Education and Support Program (DSME-S). Members may enroll in the DSME-S program by member outreach and/or through a provider referral. The L.A. Cares About Diabetes program includes a subset of members alsodiagnosed with diabetes and chronic kidney disease. These members receive an additional brochure on kidney self-care with their mailing and are directed to the kidney self-care microsite in the health and wellness portal. In addition to the monthly mailings, articles for providers in Provider Progress Notes, articles for members in Live Well/Be Well, and Stay Well are published at least once per year.
- Diabetes Text Message Campaign is a text campaign of six messages sent bi-weekly educating members on how to self-manage their diabetes through lifestyle choices (diet and physical activity) and encourage diabetic doctor appointments, A1c lab testing, retinal eye-exams and daily feet checks.
- Diabetes Education Kit will include a 'Diabetes Magnet Mailer'. The Diabetes Magnet Mailer was designed by the pharmacy department and includes a white board magnet and dry erase marker encouraging members to record their most recent A1c, blood pressure reading, diabetic screenings (foot and eye) as well as a place to check off whether or not they have taken daily medications. This mailer will be sent to all non-compliant HbA1c <8% direct network members, Spanish speaking D-SNP and LACC members.
- L.A. Care Diabetes Medication Adherence program - The Comprehensive Adherence Solutions Program (CASP) actively engages non-adherent members and those at risk of non-adherence. L.A. Care's pharmacists and pharmacy technicians engage members in discussions about their adherence to non-insulin and other diabetes management medications, while proactively addressing any barriers identified. This multifaceted approach encompasses patient education, transportation services, mail order referrals, 100-day supply conversions, medication synchronization, referrals to our Medication Therapy Management (MTM) vendor, and vaccine education.

- Transform L.A. offers technical assistance to 20 Direct Network practices to support improving patient centered care. The practice coach/facilitators work with the practices to provide QI tools to improve results of the HbA1c Poor Control (>9%) HEDIS/ Clinical Quality Measure to improve care delivery and health outcomes for members. Tools include AMA Team Based Approach to Diabetes, Point of Care A1c testing, and Motivational Interviewing.

- The Equity and Quality at Independent Practices in L.A. County (EQuIP-LA) program is a two-year quality improvement collaborative supporting small, independent, primary care practices and independent physician associations (IPAs) serving Medi-Cal enrollees of color in Los Angeles County. Similarly to Transform L.A., the program offers technical assistance to 31 practices to improve the results of HbA1c Poor Control (>9%) while reducing related health disparities to improve care delivery and health outcomes for members.

Cardiovascular Disease

- L.A. Care's Health Education department offers heart health education and lifestyle modification coaching. Health care providers may request registered dietitian (RD) consults with one of our staff RDs by submitting a Medical Nutrition Therapy (MNT) referral for the more common heart related conditions such as hypertension and hyperlipidemias.
- Health Promoters Program and American Heart Association (AHA) have a partnership providing Blood Pressure Control Education, Blood Pressure cuffs, community resources and social support to members of the Support Circles.
- L.A. Care's Quality Improvement department manages a hypertension text campaign.
- *L.A. Cares About Your Heart (Chronic Care Improvement Program (CCIP)* – L.A. Care's Care Management team offers a cardiovascular disease management program. This program focuses on members with Hypertension (HTN) and is designed to address early issues in the disease to prevent complications. The program is focused on Black/African American members from MCLA, CMC, and LACC lines of business. Objectives for the program are to improve cardiovascular disease self-management through home monitoring and recording of blood pressure, identifying self-management goals for control of hypertension, providing health education on a heart-healthy lifestyle, and improving member engagement with their PCP regarding cardiovascular health.
- Transform L.A. offers technical assistance to 20 Direct Network provider practices to support improving patient centered care. The CBP (Controlling Blood Pressure) program offers providers QI tools to improve care delivery supported by practice facilitators. Tools include the Johns Hopkins MAP (Measure Accurately, Act Rapidly, and Partner with Patients Program), Outreach Workflow Redesign, and Teach Back.

- The Equity and Quality at Independent Practices in L.A. County (EQuIP-LA) program is a two-year quality improvement collaborative supporting small, independent, primary care practices and independent physician associations (IPAs) serving Medi-Cal enrollees of color in Los Angeles County. Similarly to Transform L.A., the program offers technical assistance to 31 practices to improve the results of Controlling Blood Pressure (CBP) while reducing related health disparities to improve care delivery and health outcomes for members.
- L.A. Care's Pharmacy Department has several programs to address hypertension and Cardiovascular Disease management.
    - L.A. Care Pharmacy's Community Pharmacy Value-based program - California Right Meds Collaborative (CRMC) targets members with diabetes and other chronic conditions like hypertension. Our CRMC pharmacists conduct high-level comprehensive medication management (CMM) services that include identifying medication-related problems, and consulting on diet/lifestyle recommendations, while also identifying barriers members may face at partner clinics and pharmacies. CRMC pharmacists educate members with poor blood pressure control and offer to assist the member with obtaining a blood pressure monitor. Pharmacy expanded the CRMC program in 2022 to add a Cardiovascular Disease (CVD) cohort for members with recent CVD-related inpatient admissions, focusing on preventing further inpatient admission and remaining adherent to cardiovascular disease medications after enrollment into CRMC. L.A. Care also provides an end of year adherence bonus incentive payment to participating CRMC pharmacies for all DSNP and LACC members enrolled in CRMC who successfully meet adherence measures for diabetes medications, hypertension medications (RAS-antagonists), and statin medications.
    - L.A. Care Hypertension Medication Adherence program - The Comprehensive Adherence Solutions Program (CASP) actively engages non-adherent members and those at risk of non-adherence. L.A. Care's pharmacists and pharmacy technicians engage members in discussions about their adherence to hypertension management medications, proactively addressing any barriers identified. This multifaceted approach encompasses patient education, transportation services, mail order referrals, 100-day supply conversions, medication synchronization, referrals to our Medication Therapy Management (MTM) vendor, and vaccine education.

Hypercholesterolemia

- L.A. Care Cholesterol Medication Adherence program - The Comprehensive Adherence Solutions Program (CASP) actively engages non-adherent members and those at risk of non-adherence. L.A. Care's pharmacists and pharmacy technicians engage members in discussions about their adherence to cholesterol management medications, proactively addressing any barriers identified. This multifaceted approach encompasses patient education, transportation services, mail order referrals, 100-day supply conversions, medication synchronization, referrals to our Medication Therapy Management (MTM) vendor, and vaccine education.

Care Management Program:

Definition of Care Management (CM):

L.A. Care's Care Management program has adopted the American Case Management Associations's (ACMA) definition of care management, expanding upon it to include all aspects of a member's biopsychosocial wellness, including behavioral health and social determinants of health.

"Care management is a dynamic process that assesses, plans, implements, coordinates, monitors, and evaluates to improve outcomes, experiences, and value. The practice of case management is professional and collaborative, occurring in a variety of settings where medical care, mental health care, and social supports are delivered. Services are facilitated by diverse disciplines in conjunction with the care recipient and their support system. In pursuit of health equity, priorities include identifying needs, ensuring appropriate access to resources/services, addressing social determinants of health, and facilitating safe care transitions. Professional case managers help navigate complex systems to achieve mutual goals, advocate for those they serve, and recognize personal dignity, autonomy, and the right to self-determination" (ACMA, 2022).

L.A. Care's Care Management program, which includes Low-Risk Care Management, Medium Risk Care Management, High-Risk Care Management and Complex Care Management, is part of the overarching Population Health Management strategy that looks at the whole person and provides appropriate services and care for the member. The program is aligned with the population health triple aim of providing the right care at the right time in the right place for our members with complex needs.

Mission of Care Management:

The mission of Care Management is to assist and empower members to understand and manage their health care needs across the care continuum by coordinating quality health care services through a member-centric value-based approach in development of a care plan. Including the use of best practices and designated quality indicators contribute to the optimal health, function, safety and satisfaction of the members.

L.A. Care's Care Management program is founded on a multi-disciplinary, integrated care model where:

- The assigned care manager assists the member to coordinate their care and address their biopsychosocial needs.
- Care Management activities revolve around the needs and preferences of the member.
- Multiple disciplines collaborate to support the member and the caregiver in the implementation of the member's care plan. These disciplines may include internal L.A. Care resources as well as the member's providers and external community-based organizations. These resources may include, but are not limited to, the member's primary care physician, community health workers (CHW), Social Services, Social Work (SW), Disease Management (DM), Managed Long Term Services and Supports

(MLTSS), Utilization Management (UM), Home & Community Based Services (HCBS), Pharmacy, and other supportive services as directed or needed by the member. Recommendations are shared the Primary Care Provider to assist in closing care gaps.

- Field-based services such as face-to-face meetings at one of the Community Resource Centers, are available through community health workers for members identified as the most vulnerable or at elevated risk of hospitalization or institutionalization.

The Care Management program is designed to:

1. Minimize the risk of exacerbations or deterioration of the medical conditions based on initial assessment of physical, behavioral, cognitive, functional status and social determinates completed within 30 days in Complex Care Management enrollment by the:

    a. Initial assessment of members' health status, including condition-specific issues.
    b. Documentation of clinical history, including medications and poly-pharmacy issues.
    c. Initial assessment of activities of daily living and early identification of rehabilitation needs.
    d. Initial assessment of mental/behavioral health status, including cognitive functions.
    e. Initial assessment of social determinants of health.
    f. Initial assessment of life-planning activities.
    g. Evaluation of cultural and linguistic needs, preferences or limitations.
    h. Evaluation of visual and hearing needs, preferences or limitations.
    i. Evaluation of caregiver resources and involvement and social support needs.
    j. Evaluation of available benefits.
    k. Evaluation of community resources.
    l. Assessment of life-planning activities.
    m. Development of a personalized care management plan within 30 calendar days of member eligibility for complex case management. Care plan includes prioritized goals and considers member/caregiver preferences and their desired level of involvement in the care management plan.
        i. Develop a schedule for follow-up and communication with members.

ii. Develop and communicate member's self-management plan.
iii. Assess member process against the case management plan.
iv. Facilitate member referrals to resources and follow-up processes.

2. Identify barriers to member meeting goals and provide solutions.
3. Identify and address safety issues.
4. Provide dedicated staff (licensed and support) to assist in coordinating care needs between multiple specialist, specialty centers, ancillary vendors and pharmacies.
5. Provide appropriate access to care in the right setting.

Members are identified for care management through:

- Health Risk Assessment (HRA)
- Health Information Form (HIF)
- Internal department referral (e.g. Utilization Management, Health Education, Nurse Advice Line etc)
- Hospital Discharge planner referral
- Member or caregiver referral
- Practitioner or Physician Provider Group (PPG) referral
- Predictive Modeling

The Case Management program is comprised of five programmatic levels based on member diagnosis and acuity: Enhanced Care Management, Complex, High Risk, Medium Risk and Low Risk. L.A. Care internally manages High Risk and Complex Case Management (CCM) for all lines of business . L.A. Care's Low Risk Case Management processes are delegated to PPGs except for the membership of the L.A. Care Direct LOB, which is managed by L.A. Care's internal Care Management Team.

Enhance Care Management providers and Care Managers are clinicians, nurses and social workers who are trained to assess members with complex medical and psychosocial needs. Case Managers provide disease-specific interventions that follow the guidance of evidence-based clinical guideposts which support the members in achieving their preferred health goals. The team also includes Care Coordinators and Community Health Workers that support Care Managers in delivering services and support to members. The program empowers members and gives them the necessary tools to be better managers of their own health and

needs to improve their overall health and quality of life. Collaboration with providers and other participants of the interdisciplinary care team improves the knowledge and effectiveness of our provider community and improves the quality of care provided to members. Additionally, collaboration with community partners expands the range of services available for members to improve their condition management and care.

Chronic Conditions Addressed through Care Management Programs:

L.A. Care's Care Management department addresses chronic conditions, including those members with multiple chronic conditions, within the context of L.A. Care's High Risk and Complex Case Management programs. Care Management addresses chronic conditions through two different approaches: Disease Management and Case Management.

Chronic Condition Management – Chronic condition management programs focus on mitigating the risk of chronic conditions. Members are assigned a Care Manager in the Case Management department to develop an Individualized Care Plan and are encouraged to set achievable goals in managing their multiple chronic conditions. Education is focused on lifestyle modifications, medication adherence, the importance of PCP engagement, and most importantly self-management. Interventions are standardized in accordance with nationally established clinical guidelines. Members are assisted in obtaining BP monitoring equipment through their plan benefit, taught how to use the equipment and the importance of sharing the results with their PCP.

"Whole person" orientation toward adherence – The care manager is responsible for coordinating and managing the member's health care needs and appropriately arranging care with other qualified professionals This includes acute care, chronic care, preventive services, and end-of-life care, with strong consideration for the individual's value system, personal preferences and level of engagement in decision making.

Care Coordination: L.A. Care makes every effort to coordinate care of members across settings, providers and levels of care to minimize multiple contacts within the organization. The Care Management program serves as a focal point of member care and the assigned Care Manager is the lead in developing the individualized care plan and coordinating member care. Only one Care Manager is assigned to a case, so if a member participates in L.A. Care's High Risk or Complex Care Management, the PPG is informed immediately so they can close any open care management cases on their end to avoid overlap. Care Managers will still work closely with PPGs to support members in receiving referrals and authorizations for needed services. Care Manager identifies additional needs and links members to other internal programs such as Behavioral Health (BH), Social Work (SW) or Managed Long Term Support Services (MLTSS), while maintaining the role of being the primary contact for the member. When appropriate, the Care Manager will also provide warm handoffs to external programs in Community Based Organizations (CBO) or at the PPG, thus ensuring seamless transitions.

This approach houses the primary responsibility of member contact and coordination under a Care Manager to reduce duplication of services and unnecessary member confusion as well as outreach from multiple entities. L.A. Care's electronic system of record Clinical Care Advance (CCA) is accessible not only to L.A. Care's Care Management team but other L.A. Care departments including Utilization Management, Behavioral Health, Health Education, and MLTSS so the assigned Care Manager is kept abreast of developments and interventions from other disciplines to effectively maintain the role of the primary contact with the member. While other clinical staff may become involved in the member's care plan and communicate directly with the member when necessary, the Care Manager will always be able to facilitate that coordination. If a member is enrolled in the Enhanced Care Management Program, the member is excluded from High Risk or Complex Case Management.

Measured and managed adherence to evidence-based practices by the care team and the member – Improved health outcomes are critical to the success and sustainability of the program. Evidence-based medicine, shared decision making aids, and clinical decision-support tools are used to develop care plans. Outcomes are measured by completing member care plan goals and by the graduation from the care management program. The care team accepts accountability for continuous quality improvement by voluntarily engaging in performance measurement and improvement. Members actively participate in decision-making, and feedback is sought to ensure member and health system expectations are being met. Information technology is used to appropriately support optimal care, performance measurement, education, and enhanced communication. Evidence-based Clinical Practice Guidelines (CPGs), which are adopted by Care Management and network providers, are reviewed and approved annually by L.A. Care's Quality Oversight Committee. A current list of CPGs is available on L.A. Care's website:

https://www.lacare.org/providers/provider-resources/tools-toolkits/clinical-practice-guidelines

Enhanced accessibility – Includes new communication options among members, their personal physician, care managers, community health workers, and the care team. Innovations such as group visits, telehealth, health portals, robust customized educational tools and self-monitoring devices are used when appropriate and available.

Condition Monitoring – Condition Management focuses on working with members to help them learn how to better self-manage their chronic and/or complex condition(s). It includes regular monitoring calls, monthly letters, reminders and alerts when recommended screenings and tests are due, and education and self-management tools.

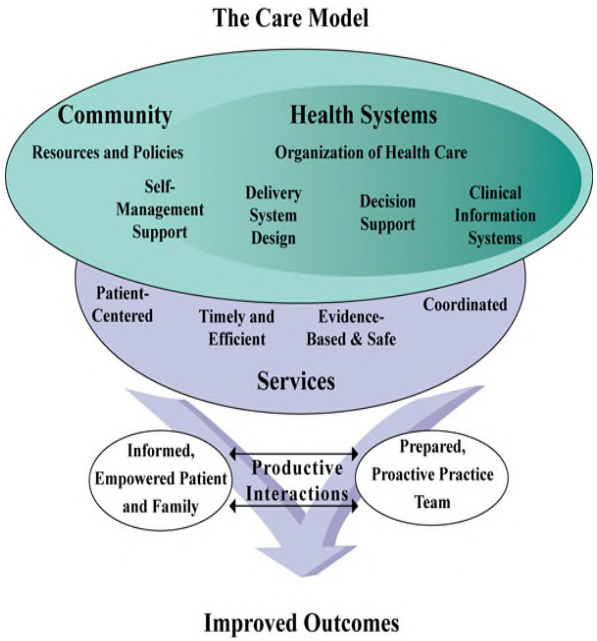
Self-Management Plan Adherence – Two primary methods are used to increase adherence to self-management plans:

1. Motivational Interviewing (MI) - MI is a "person-centered counseling method for addressing the common problem of ambivalence about behavior change. Care Team members are trained in motivational interviewing techniques as part of the education curriculum for all new hires and is reinforced throughout the year.

2. Self-Management Support (SMS) – plays a critical role in patient adherence to an enrollee's self-management plan. The program defines SMS as the systematic provision of education and supportive interventions by the healthcare system to increase member's skills and confidence in managing their health problems, including regular assessment of progress towards goals. SMS tools are made available digitally or by print or telephonically if requested.
   - *Self-Management Tools* – Help members determine risk factors, provide guidance on health issues, recommends ways to improve health or support reducing risk or maintaining low risk. Through L.A. Care's online health and wellness portal, My Health In Motion™ (My HIM), members have access to self-management tools like food logs and physical activity trackers. Upon completing the HA, members receive recommendations for self-management tools and workshops to complete based on the identified risks. The self-management tools available via My HIM cover: healthy weight (BMI maintenance), smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, avoiding at-risk drinking and identifying depressive symptoms. Tools are also available specific to identified self-management needs for certain conditions being managed by L.A. Care staff and members can be referred into appropriate care management programs. Self-Management Tools are available digitally and may be requested in print or telephonically.
   - *Self-Management Education* – Involves the interaction of the member with a multifaceted education instructional team and may be presented individually and/or in group settings. Care Team members must maintain current in health and wellness and condition management principles and practice as well as all appropriate evidence-based guidelines. Care Manager(s) obtain regular continuing education in the areas of chronic condition management, behavioral interventions, teaching and learning skills, and counseling skills. Educational methods will take into account health literacy and cultural aspects of the members in the program.
   - Self-Management Tools-Usability Testing – L.A. Care evaluates the understanding of self-management tools at least once every 36 months. Understanding assessment areas include ability to understand the language and special needs including vision and hearing. Self-Management Tools-Review and Update Process – L.A. Care reviews and updates self-management tools available for maintaining a healthy weight, healthy diet, and physical activity, smoking and tobacco cessation, alcohol consumption, managing stress and identifying depressive symptoms at least every two years. The assessment compares current tools with any new evidence based guidelines that may have been released since the last two-year review.
   - Health Risk Assessment Review – L.A. Care periodically reviews the tool and scoring and revises based on regulatory requirements and to optimize the tool for best member experience and results.
   - *Supportive Interventions* – L.A. Care works with members to make sure they have access to the services and supplies (including glucose testing supplies and blood pressure monitors) they need including access to medications, DME and services. Enrollees are assessed for any gaps and care management staff work with the benefits manager and/or local resources to fill any coverage gaps.

- Community Connections – Staff are familiar with community resources available and utilize them as appropriate to facilitate access to care and service needs by members. Staff can access Community Link, which uses Find Help, a social care network that provides the resources of thousands of nonprofits and social care providers serving the community. Connections include services to CalFresh, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), California Work Opportunity and Responsibility to Kids (CalWORKs) and In-Home Services and Supports (IHSS).Training is available for providers and staff.

- Assessment of Progress – Each member enrolled in the programs receives as part of the care plan a self-management goal customized to meet their needs. Documentation includes evidence of collaboration among other interdisciplinary care team members, providers and referral sources. Collaboratively, the patient and/or other support resources will set frequency of communication intervals in which to celebrate accomplishments, recognize barriers and challenges, and together work on interventions to resolve the things that "get in the way". L.A. Care's Care Management programs are conceptually and structurally based in industry standard models of care delivery such as the MacColl Institute's Care Model and Patient Centered Medical Home Model.



Patient-Centered Medical Home Model –The "medical home" is a term used to describe a health care model in which individuals use primary care practices as the basis for accessible, continuous, comprehensive and integrated care.
L.A. Care supports the goal of the medical home to provide a patient with a broad spectrum of care, both preventive and curative, over a period of time and to coordinate all of the care the patient receives. Integrated Care Managers and other team members support the physician in facilitating the coordination of care and services their patient needs.

Palliative care – In 2018, SB1004 was approved requiring all managed Medi-Cal plans to offer palliative care services. L.A. Care's palliative care program is administered by the MLTSS program. Members under the MCLA line of business have this benefit if they meet the clinical criteria. The services are provided by vendors specializing in this care with the goal to provide members and their caregivers an extra layer of support as they live with advanced illness. Services are aimed at prevention suffering by means of early identification, through assessment, treatment of pain and other burdensome symptoms and addressing the psychosocial and spiritual needs of individuals.

Transitional Care Services: L.A. Care works to ensure a safe care transition for all members.

The Care Management Program provides person-centered support to members in Care Management during care transitions for members transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings.. When members experience a care transition they are at a higher risk for being impacted by gaps in care and adverse health events. L.A. Care's Care Management Program intervenes during and after a care transition to ensure members in Care Management have the adequate supports to complete successful transitions. L.A. Care and its delegates monitor members in Care Management on a daily basis to determine if a hospital or facility admission has occurred. Interventions and other care management activities supporting the member's care transition, can include collatoration with the interdisciplinary care team (ICT) , to ensure the member is able to transition safely to the least restrictive environment. In the event of a care transition members in care management will be outreached by Care Management staff to:

  - Provide support for a safe discharge to the least restrictive environment, in collaboration with facility staff
  - Educate and refer the member to services and resources to support a safe transition.

- *Medication Reconciliation* - The L.A. Care Pharmacy team completes a medication reconciliation for a subset of members who are usually at high risk of readmission following discharge, based on a discharge risk assessment. In addition to completing a medication reconciliation, a pharmacist conducts outreach to the member to discuss medication concerns and the importance of the member following up with their PCP. The completed medication reconciliation is shared with the member's PCP to support the member's post-discharge needs.
- *TCS Field Visit Pilot*- Under Care Management, the TCS CHW team is in the process of developing a field visit pilot which will entail TCS CHWs conducting field visits to members' homes upon discharge home from a facility. The aim with these field visits will be to support members identified as at risk of having an adverse health outcome following discharge home. Members who will receive a post discharge field visit include, but are not limited to, member who have home safety concerns, have limited to no social support, and have barriers to completing paperwork tied to services and programs. During the field visit, the TCS CHWs will provide interventions including a home safety check, assistance with completing applications for programs, and education about resources and programs that will enhance the members safety and wellbeing at home and in the community.

Social Determinants of Health

Social Determinants of Health (SDOH) Data Collection Strategy: The 2023-2025 Health Equity and Disparities Mitigation Plan (HEDM) includes an objective to strengthen the collection and linkages of SDOH information on the need for food, housing, and transportation among L.A. Care members (Health Equity Zone 3). View HEDM **here**.

L.A. Care is taking a multipronged approach strategy that will focus on collecting SDOH, Z code data from providers to meet the SDOH needs of members. The collection of Z code data is a regulatory requirement by several regulatory agencies. The ICD-10-CM encounter Z codes are used to document SDOH data (e.g. housing, food insecurity, transportation, etc). L.A. Care has also added an SDOH metric to the Value Initiative for Independent Physician Associations Performance (VIIP), Los Angeles Covered California (LACC) VIIP, and Physician-4-Program (P4P) to continue to monitor and strengthen member data collection. The SDOH metric will inform providers of their performance, benchmarks, and an opportunity to improve performance. Additionally, the SDOH metric is being incentivized for Measurement Year 2023. Additionally, L.A. Care disseminates provider communications and offers provider training to support the collection of SDOH Z code data. This Z code data will improve the SDOH metrics in Optum's Area Deprivation and Social Vulnerability Indices.

Health Equity – Supporting vulnerable populations and addressing health disparities is a part of L.A. Care's mission. L.A. Care recruited and hired a new Chief Health Equity Officer (CHEO), Alexander Li, MD in February 2023. The CHEO leads the Health Equity Department and the health equity team recently published the 2023-25 L.A. Care Health Equity and Disparities Mitigation Plan (HEDMP) to guide the QI Health Equity program over the next two years. Additionally in 2024, L.A. Care achieved the Health Equity Accreditation (HEA) from the National Committee for Quality Assurance (NCQA).

Below is a brief overview of L.A. Care's four health equity zones and its respective focus. The four Health Equity Zones that will serve as areas of focus are:

1. **Address key health disparities:** close racial and ethnic gaps in health outcomes among members;
2. **Lead change**: provide leadership and be an ally for community partners to promote health equity and social justice;
3. **Move towards equitable care:** ensure that our members have access to care and services that are free of bias and that our providers are supported in delivering equitable, culturally tailored care;
4. **Embrace diversity, equity, and inclusion (DEI):** serve as a model in supporting an equitable and inclusive work environment, as reflected in our workforce and business practices.

For the purpose of the QI Health Equity Program as related to performance measures and goals, please access the HEDMP. The full HEDM can be found here.

Since this is the inaugural year where L.A Care has a HEDMP and seeks to create a sustainable health equity and DEI movement, L.A. Care Health Equity team developed an organized infrastructure to support and promote health equity and DEI initiatives and culture. L.A. Care Health Equity team created an Equity Council Structure that includes the Equity Council Steering Committee, Member Equity Council, Consumer Health Equity Council, Provider Equity Council and L.A. Care Team Council. Below are further details of the councils:

- The **Equity Council Steering Committee (ECSC)** is the governing committee that leads L.A. Care's efforts on equity and social justice with high visibility throughout the organization. It is composed of staff and senior leaders. ECSC will institutionalize accountability for equity at the member, network, and staff level. The ECSC is chaired by the CHEO and reports up to the CEO.
- The **Member Equity Council** recommends, expands and implements activities that promotes health equity and equity of services among our members. The Council will also align health equity efforts enterprise-wide and increase the awareness of health equity throughout L.A. Care. Health equity efforts are inclusive of modifiable and actionable social determinants of health efforts.
    - The purpose of the **Consumer Health Equity Council** provides a forum for consumer to advocate, discuss and offer their perspectives on important issues related to L.A. Care's activities. This council reports up to the Member Equity Council.
- The **Provider Equity Council** focuses on diversity among L.A. Care's participating providers and seeks to align our network and be responsive to the diversity of the members we serve.
- **L.A. Care Team Council** includes representation from different departments across L.A. Care. This Council provides a forum where DEI initiatives are discussed. Thereafter, the Team Council makes recommendations and supports the implementation of the recommendations.
- Additionally, L.A. Care's Health Equity and Quality Improvement Department created a new **Quality Improvement and Health Equity Committee (QIHEC).** The QIHEC is composed of L.A. Care staff, members and providers and will jointly review, offer feedback and provide recommendations on quality improvement and health equity initiatives. The new committee is co-chaired by the Quality Medical Director and Chief Health Equity Officer.

Community Supports – Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services – As part of CalAIM Community Supports, L.A. Care makes available Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services, which collectively form a continuum to help members who are experiencing homelessness or at risk for homelessness identify, secure, and maintain safe and stable housing. These services are intended for members who are

experiencing homelessness or at risk for homelessness with complex health, disability, and/or behavioral health conditions to facilitate access and retention in care and improved health.

Homeless Data Profile – The Community Health Department, in partnership with Advanced Analytics Lab and Health Information Management, completed a profile of L.A. Care's unhoused members, which includes demographics, provider relationships, clinical, utilization, and cost information. L.A. Care integrates this data into the annual Population Assessment in order to identify and stratify this population for interventions and population health management and safety net programs.

Find Help: Staff are familiar with community resources available and utilize them as appropriate to facilitate access to care and service needs by members. Staff can access Community Link, powered by Find Help, previously known as Aunt Bertha. Find Help is a social services network that provides a resource directory and offers information to thousands of nonprofits and social care providers serving the Los Angeles County community. Trough the Community Link, our staff also has access to country wide resources. Training on how to best use Community Link is available for providers and staff.

Care Transitions

L.A. Care improves members' outcomes across settings by focusing on continuity of care through coordinated care transitions. This is addressed through a variety of programs or initiatives.

- *Managed Long Term Care Services and Supports (MLTSS) Care Coordination* – Strives to ensure MCLA members' targeted population are receiving care coordination, by accessing unmet needs, reviewing care plans, assessments and telephonic outreach. Risk factors are assessed using an HRA tool and includes assessments in the categories of social determinants, functional capacity, medical conditions, and behavioral health conditions. Members are identified by the Community Based Adult Services (CBAS) Eligibility Determination Tool, HRA Stratification, and APL 17-012 Assessments.
- Utilization Management (UM) Care Coordination – Strives to ensure members' transitions of care are handled smoothly and timely. While our members are in house, concurrent review nurses are working with facility care managers to assess for discharge planning needs and/or referrals that may be beneficial, such as case management, palliative care, or community support services. When discharge planning requests are received from the hospital, they are processed within regulatory time frames to ensure there is no delay to the member's discharge from the facility
- *Behavioral Health* – L.A. Care Health Plan (L.A. Care) provides Mental Health and Substance Use Disorder Services through Primary Care Providers (PCP), Behavioral Health Specialty Providers through L.A. Care's behavioral health vendor, Carelon Behavioral Health (formerly known as Beacon Health Options), Los Angeles County Department of Mental Health (DMH), and Los Angeles County Department of Public Health (DPH). For members enrolled in Medi-Cal, including MCLA and D-SNP lines of

business (LOB), the delivery system in which members can access care is based on the type and severity of symptoms and impairment. For commercial LOBs, all services besides primary care (PCP) screenings are provided by Carelon Behavioral Health. The delivery system in which member accesses their care is the organization that completes utilization management reviews based on established State regulatory criteria. The bifurcated system complicates data sharing by creating separate entities with their own protocols and technologies, leading to challenges in exchanging information.

On January 1, 2023, as part of DHCS guidance, L.A. Care adopted the "Screening and Transition of Care Tools for Medi-Cal Mental Health Services" which is aimed to design a coherent plan to address members' service needs across Medi-Cal mental health delivery systems, ensure all Medi-Cal members receive coordinated services, and improve health outcomes. The goal is to ensure members have access to the right care, in the right place, at the right time. The Screening Tools help determine the appropriate delivery system where members can access care based on acuity of their symptoms and treatment needs. The Transition of Care Tool ensures that members who are receiving mental health services from one delivery system receive timely and coordinated care when their existing services need to be transitioned to the other delivery system, or when services need to be added to their existing mental health treatment from the other delivery system. It is required to be used by all mental health service providers except when mental health providers are contacted directly by members seeking mental health services.

Following a discharge of inpatient psychiatric admission for D-SNP, LACC and PASC LOBs, Carelon provides aftercare support to connect the member with a behavioral health provider within 30-days of discharge, facilitating continuity of care and ensuring a smooth transition from inpatient to outpatient services. Inpatient psychiatric admissions for MCLA LOB are managed by the Department of Mental Health (DMH). The transitions of care are supported and arranged by hospital staff. DMH provides hospitals with supportive services to transition members to lower levels of care.

Carelon Behavioral Health has implemented an intervention aimed to connect members who were admitted to the Emergency Department (ED) with a principal diagnosis of a mental illness or intentional self-harm with a practitioner within 30-days of ED visit. This initiative is designed to ensure that individuals receive timely follow-up care and support after their ED visit, helping to prevent future crises and promoting overall well-being to improve health outcomes.

Patient Safety

Medication Therapy Management (MTM) Program – To improve the safety of our members, L.A. Care has a Medication Therapy Management (MTM) Program that includes an annual comprehensive medication review (CMR) for D-SNP members who meet the following eligibility criteria: at least 3 chronic conditions (e.g., osteoporosis, chronic heart failure, diabetes, etc.), take at least 8 covered Part D medications, and medication costs of covered Part D medications more than $5,330/year. D-SNP members who are part of a Part D Drug Management Program for frequently abused drugs are also eligible for this program. As part of the Medication Therapy Management Program, pharmacists or other licensed professionals performed comprehensive medication reviews for D-SNP

members who are MTM-eligible. The program includes high touch telephonic outreaches by MTM providers from the contracted vendor, Navitus Clinical Engagement Center (CEC), to ensure optimum therapeutic outcomes through improved medication use by completing timely CMRs. Members in the MTM program will also receive a Targeted Medication Review (TMR) of medicaitions at least every 3 months. Any medication recommendations identified are sent to members' providers.

Pharmacy Home Program & Opioid Abuse – In an effort to reduce abuse and diversion of frequently abused drugs (FADs) L.A. Care Pharmacy department implemented a Part D Drug Management Program, the Opioid Home Program, as defined by CMS, in addition to the already established Pharmacy Home Program for LACC and PASC lines of business. L.A. Care may identify a member eligible for lock-in if pharmacy claims utilization reports flag at-risk members with overutilization of frequently abused drugs (opioids and/or benzodiazepines). For the D-SNP members, a recent history of opioid-related overdose and concurrent opioid utilization also qualifies the member for this program. The Pharmacy department at L.A. Care contacts the member's PCP, other prescribing specialists (e.g., pain specialists), and the dispensing pharmacy to ensure that the pharmacy and/or provider lock-in would be clinically appropriate. If it is agreed that the member should be locked in, they will be restricted to one pharmacy and/or one provider where they will receive all prescription opioids and benzodiazepines. Notices will be mailed out to the potential at-risk members informing them of their selected pharmacy and/or provider, information about the program, instructions on how to submit information for case review, and instructions on how to submit their preferences for a pharmacy and/or provider. At-risk members will be locked in for 12 months with an option to extend an additional 12 months after the initial year depending on clinical basis. To ensure the safe use of opioids, DSNP members who are enrolled in the Opioid Home Program are also eligible for the Medication Therapy Management (MTM) program, in which clinicians thoroughly review the member's medication regimen with the member or authorized representative. As of January 1, 2022, pharmacy benefits and services are carved out through the fee-for-service delivery system, titled Medi-Cal Rx, for all members of the MCLA line of business. Therefore the Department of Health Care Services (DHCS) will provide opioid management services for these members, but will not implement any lock-in programs.

Community Pharmacy Value-Based Program – California Right Meds Collaborative (CRMC) – L.A. Care Pharmacy Department partnered with the University of Southern California's (USC) California Right Meds Collaborative (CRMC) to expand access to healthcare for our most vulnerable high-risk patient populations. The goal is to develop a network of highly trained and experienced CRMC community pharmacies to manage chronic diseases and ease the burden on our strained primary care system. The program also develops partnerships with FQHCs to maximize effectiveness, resolve data gaps, and ensure close communication and collaboration with the members' providers. Open to all lines of business, CRMC targets members with various chronic diseases, such as diabetes and cardiovascular disease. Our CRMC pharmacists conduct high-level comprehensive medication management (CMM) services that include identifying medication-related problems, consulting on diet/lifestyle recommendations, and care coordination. Members are provided with individualized care plans and the pharmacists work with the provider and member to ensure the member

is making progress towards their health goals. CRMC was recognized by the Centers for Disease Control and Prevention as an innovative best practice for patient care and continues to be a valuable program to L.A. Care members.

Field/ Street Medicine Program – Slated to be implemented April 2024. This program is intended to provide medically necessary services and linkage to Community Supports to members who are experiencing homelessness in the field (lived environment) to reduce barriers to care.

Communication and Support

Members

L.A. Care distributes information about all Population Health Management (PHM) programs and services to member by mail and provides PHM program information on the member website. Information presented is also made available within each specific program or services using interactive contact such as telephone or home visits. The member portal includes the ability for members to live chat with a health coach within Health In Motion™. PHM program information provided includes but may not be limited to eligibility criteria and enrollment process, program services and how to use, and how to opt-in or opt-out of the program.

L.A. Care mails information to members who do not have access to fax, e-mail, telephone, mobile device, or internet access.

Practitioners and Plan Partners

L.A. Care supports network practitioners or providers achieve population health management goals by working collaboratively with the provider to achieve the best quality care for members. This includes:

- *Data and information sharing*
  - Provider Portal to communicate reports to providers (e.g. Initial Health Appointment).
  - Provider Opportunity Reports (POR) to encourage providers to help their members to close clinical gaps in care.
  - All HRA data is communicated to the PPG care team that manages the member. The completed HRA is posted digitally to the Provider Portal or can be requested by phone or mail. The member can also access a digital copy of the completed HRA through the Member Portal or receive a printed copy of the results by request by phone or mail.
  - Leveraging the 80:20 rule in focusing efforts on PCPs and PPGs that hold 80% or more of our membership.

- L.A. Care is prioritizing the collection and reporting of members' social determinants of health (SDOH), so their needs can be better identified and supported. Our goal is to collaborate with our network providers to reliably and consistently collect this data through screening and utilizing SDOH Z codes.

- *Evidence-based or certified decision-making aids*
  - L.A. Care Health Plan systematically reviews and adopts evidence-based Clinical Practice and Preventive Health Guidelines promulgated from peer-reviewed sources and from organizations like the National Guideline Clearinghouse and U.S. Preventive Services Task Force. Guidelines for diseases and health conditions identified as most salient to L.A. Care members for the provision of preventive, acute or chronic medical and behavioral health services are regularly reviewed by L.A. Care's Joint PICC and PQC to help improve the delivery of health care services to members. The most current list of Clinical Practice and Preventive Health Guidelines adopted by L.A. Care is available for download on L.A. Care's provider website.

- *Providing practice transformation support to primary care practitioners*
  - L.A. Care's Transform L.A. Program offers practice transformation support and technical assistance to Direct Network clinicians to transform their practice. Transformation is measured using the Practice Assessment Tool (PAT) with the aim to improve patient and family centered care design, build a culture of continuous data driven quality improvement and achieve sustainable business operations. Primary areas of technical assistance include electronic health record data reporting and population health management workflows.
  - The Equity and Quality at Independent Practices in L.A. County (EQuIP-LA) program is a two-year quality improvement collaborative for small, independent, primary care practices and independent physician associations (IPAs) serving Medi-Cal enrollees of color in Los Angeles County. It is a joint program of the California Health Foundation (CHCF), Community Partners, California Quality Collaborative (CQC), Health Net and L.A. Care Health Plan. The program focuses on building the quality improvement capacity and care delivery among the 31enrolled practices through a health equity lens.
  - The Equity and Practice Transformation (EPT) Payment Program is a one-time $140 million Department of Health Care Services (DHCS) initiative designed to improve primary care for Medi-Cal recipients by advancing equity, reducing COVID-19-driven care disparities, investing in up-stream care models/ partnerships to address health/wellness, and fund practice transformation aligned with value-based payment models. The 3-year program aligns with DHCS's: Comprehensive Quality Strategy, Equity Roadmap and "50 by 2025 Bold Goals" programs. EPT will provide Directed Payments to practices to invest in technology, infrastructure, staffing, technical assistance, and improvements in access to care with a focus on health equity. The program also includes a state-wide learning collaborative.

- The Help Me Grow L.A. program is a joint effort between L.A. Care and First 5 LA to provide a 3-year program/pilot to improve awareness of and increase developmental milestone screenings for children ages 0-5 years. This program is part of the Help Me Grow LA system to provide early identification and interventions for children who may not be on track with developmental milestones. The program follows the recommendations of the American Academy of Pediatrics (AAP) for screenings to be conducted at ages: 9 months, 18 months, and 24-30 months to identify any possible delays that children may be experiencing. Approximately 15% of children are estimated to have a development delay, and by conducting screenings at these ages, delays.
- The Integrated In-person and Virtual Speciality Care Program (V-SCP) is a model of care that incorporates the use of eConsults between PCP and Speciality Care Physican reviewers to address specialty care needs and coordinate access to speciality telehealth visits, and as needed, in-person specialty visits for L.A. Care Direct Network Medi-Cal patients.
- L.A. Care offers a Physician Leadership Program (PLP), a six-month program designed to equip physicians with tangible leadership and management skills necessary to effect transformational change within their health centers and improve patient care and health outcomes. The program includes in-person seminars, and webinars with expert faculty, personalized individualized leadership coaching. Topics include leading effective teams, improving clinic functioning, managing health care finances and developing a personal approach to leadership. Continuing Medical Education (CME) are offered to participants after attending all mandatory sessions.
- L.A. Care has a Community Health Investment Fund (CHIF) that awards grants to clinics and other nonprofit organizations to help meet the health and social needs of low-income and marginalized community members across Los Angeles County. Projects funded included clinical infrastructure support to hire and retain concordant mid-level staff, those advancing solutions for food, income, and housing security, interventions to end disparities in Black infant and maternal morbidity and mortality, and capacity building and leadership development for historically underfunded organizations that address inequities and structural racism through advocacy and civic engagement. Additionally, in 2024 an additional Accessible Equipment Fund will be launched to to expand access to care and accurate weight measurement for Seniors and People with Disabilities (SPD) and other differently abled individuals. This fund will provide approximately 40 accessible exam tables and weight scales for clinics serving this population.

- *Providing comparative quality and pricing information on selected specialties*
  - L.A. Care has developed the Value Initiative for Independent Practice Association (IPA) Performance (VIIP). VIIP measures five domains: access and availability; Healthcare Effectiveness Data and Information Set (HEDIS); member satisfaction; utilization; and encounter timeliness, providing practitioners comparative quality reports.

- L.A. Care provides each line of business' pharmacy formulary on the provider website, encouraging providers to prescribe based on recommended formulary.

- *Providing training on equity, cultural competency, bias, diversity and inclusion*
  - L.A. Care has developed trainings for practitioners (available to all practitioners in the network) on topics of health equity, including cultural competence, bias, diversity and inclusion. These trainings are delivered virtually and providers can access at any time, but are recommended to take annually.
- *Using Provider Satisfaction Survey results to inform our programs to support practices* and better understand providers' needs. Starting in 2020, Quality Improvement started leading Patient Experience Trainings. These trainings include topics such as: Telehealth, managing patient expectations, challenging situations with patients, time management, motivating patients, strategies to avoid burn-out in a busy practice, handling patient complaints and phone service. These trainings are open to all providers in the L.A. Care network.

- *Other activities to support practitioners or providers in achieving Population Health Management Goals*
  - L.A. Care offers a Managed Care Academy to strengthen and enhance the business operations of community clinic organizations. The goal is to assist clinics in becoming more familiar with L.A. Care benefits and services available to our members. Through a series of managed care trainings and staff education opportunities, we aim to ensure staff are abreast of managed care principles and healthcare policy that directly affect clinic operations and sustainability.
  - L.A. Care offers a variety of CME opportunities for network providers, including topics such as leadership training, improving quality health performance through Healthcare Effectiveness Data and Information Set (HEDIS) and clinical topics such as pediatric cycle of care and Women, Infants and Children (WIC).
  - L.A. Care's Elevating the Safety Net Scholarship Program has since 2018, awarded eight full-tuition scholarships annually for students who receive medical school admission at Charles R. Drew University of Medicine and Science or David Geffen School of Medicine at UCLA. This program supports students from underrepresented backgrounds in medicine and significantly reduces the educational debt burden for community-minded individuals who express a commitment to practicing in low-income areas of Los Angeles County.
  - L.A. Care builds robust partnerships

  - Internally among core and cross-functional teams (e.g. support offered through Health Homes CB-CMEs oversight and monitoring to improve their skills in care management, care coordination and longitudinally working toward progressive quality improvement).
  - Externally among trade associations, Department of Health Services, Foundations and Community Based Organizations (CBOs) and leverage our Advisory Committees (e.g. Children's Health Consultant Advisory Committee (CHCAC), Executive Community Advisory Committee (ECAC) and Technical Advisory Committee (TAC)

Performance Measurement

The following process and outcome measures are monitored and reported at specified frequencies. Key performance measurements include but may not be limited to:

(*)- indicates measure is part of the CalAIM Key Performance Indicators

- **Clinical Measures**
  - 33 HEDIS Measures*
- **Keeping Members Healthy**
  - Annual influenza vaccinations
  - Ambulatory or Preventative Care Visits for Adults and Children*
  - Annual primary care visits*
  - Follow-up ambulatory visits within 7 days post-hospital discharge*
- **Early Detection (Emerging Risk)**
  - Cancer Screening
    - Colorectal
    - Breast
  - Black/African American members receiving prenatal care

- **Chronic Condition Management**

  Diabetes

  - Black/ African American with A1c >8%
  - Black/African Americans with controlled blood pressure
  - Medication Adherence for Hypertension (RAS Antagonists)

  High-risk Chronic Conditions

  - Emergency Department visits for members 18 years and older with multiple high-risk chronic conditions with follow-up service within 7 days of the ED visit.
  - Depression Screenings for adolescents and adults*
  - Multiple emergency department visits within one year*
  - Rate of participation into Care Management after discharge*

- **Care Management**
  - Palliative Care Program Emergency Department and Inpatient Utilization (Baseline)
  - Eligible members enrolled in Care Management*
  - Rate of members receiving Community Health Worker (CHW) Benefits*
  - 16 Enhanced Care Management (ECM) Measures*

- **Care Transitions**
  - Behavioral Health Management
    - Follow up hospital incentive program
  - Transition of Care
    - Discharges:

a. Patient Engagement After Inpatient Discharge
b. Medication Reconciliation

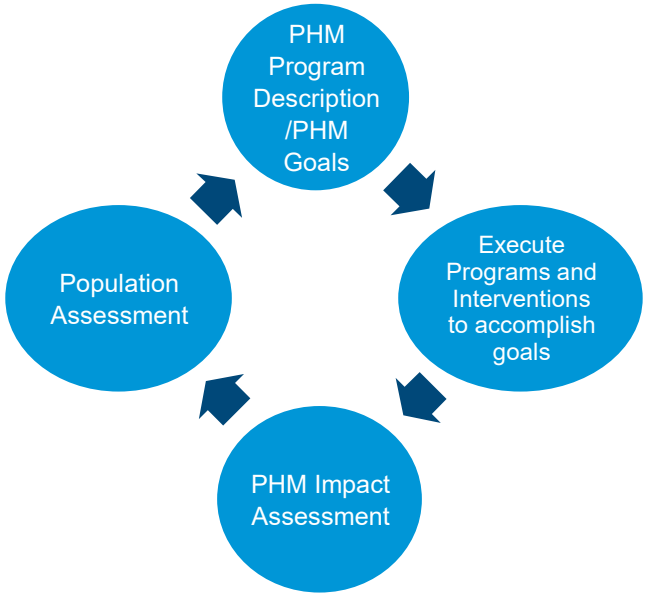
- **Patient Safety**
  - Readmission Rate or Ratio
- **Member & Provider Experience**
  - A member satisfaction survey administered at least annually:
    - MediCal and LACC: Getting care quickly
    - Getting needed care
  - Improve member unable to contact rates
  - Provider Information is up-to-date for those receiving Time Access Report (TAR)

  D-SNP:
  - Medication Therapy Management Program participants completing the Comprehensive Medication Review
- **Data**
  - Rate of Emergency Department Utilization*
  - Implement Admission, Discharge, and Transfer (ADT) pilot program for Fast Healthcare Interoperability Resources (FHIR)*
  - Rate of Admission, Discharge, and Transfer (ADT) notifications received from contracted acute care facilities
  - Rate of Admission, Discharge, and Transfer (ADT) notifications received from contracted skilled nursing facilities (SNFs)

Please see Attachment A for Performance Measure Specifics and Goals Established

Please see Attachment B for CalAIM Key Performance Indicators (KPI)

Annual Impact Evaluation



Annually, L.A. Care assesses all PHM programs and services to goals established to evaluate whether it has achieved its goals and to identify opportunities to improve. Each performance measure is reported for the calendar year with a trending analysis of previous performance in comparison to goals and/or benchmarks and trending results. Findings are presented in narrative and visual data display (charts, graphs, tables, etc.) with a full interpretation of results. Performance measures include relevant clinical, cost/utilization and experience measures. As opportunities are identified improvement actions are implemented. The impact evaluation is presented to the Member Quality Service Committee. Additionally, L.A. Care uses peer-reviewed evidence-based research available from the Center for Organizational Excellence to guide the development of interventions and programs based on current evidence-based research on health care as well as management and leadership. The diagram below describes the continuous cycle and process used to identify and target and segment members and evaluate and assess the effectiveness of Population Health Management programs. Each year's Program Description, which includes the PHM goals and interventions, are based on a combination of analyses of the prior year's impact assessment and population assessment in order to develop that year's PHM goals and interventions. The population assessment and impact evaluation inform the following year's activities and PHM goals. The Population Assessment is completed at the start of the Calendar Year (using encounters/claims to segment needs of the members) and the Impact Evaluation is done at end of the year to assess the effectiveness of programs and goals. The PHM Program Strategy with PHM Goals and Interventions will be reviewed and revised based on a combination of analyses from the Population Assessment and the program outcomes identified from the Impact Evaluation

L.A. Care Delegation Oversight and Monitoring: L.A. Care's Quality Improvement and Enterprise Performance Optimization (EPO) monitors and audits L.A. Care's Delegates. L.A. Care has written service agreements with delegated Plan Partners, Specialty Health Plans, and External Entities to provide specific health care services and perform other delegated functions. L.A. Care requires and ensures that each delegate is capable of managing the delegated activities and are in compliance with L.A. Care, current NCQA standards and state and federal regulatory requirements. Specific elements of the QI program may be delegated. However, L.A. Care remains responsible for and has appropriate structures and mechanisms to oversee all delegated QI activities. All components

of the QI process, maintained by delegates, will be made available to L.A. Care at the time of scheduled oversight audits as well as ongoing monitoring. On an annual basis, L.A. Care evaluates the delegates' performance against NCQA, DMHC/DHCS, and CMS standards for the delegated activities. L.A. Care also conducts ongoing monitoring through oversight reports, meetings, and collaboration to continually assess compliance with standards and requirements. Oversight audit and monitoring results are reviewed, opportunities for performance improvement are identified and reported to the delegate and corrective action plans are required to address deficiencies. Currently, the delegate has roughly 40 calendar days to implement the corrective action plan (CAP). After that period, L.A. Care may conduct CAP validation to ensure that substantial correction of deficiencies occurred and the CAP implemented was satisfactory.

L.A. Care is accountable for all quality improvement functions and responsibilities that are delegated and contracts with Delegates should at a minimum include:

- Quality improvement responsibilities, and specific delegated functions and activities
- L.A. Care's oversight, monitoring, and evaluation processes and Delegate's agreement to such processes.
- L.A. Care's reporting requirements and approval processes. The contract agreement shall include Delegate's responsibility to report quality improvement activities at least quarterly.
- L.A. Care's actions/remedies if Delegate's obligations are not met.

Attachments

Attachment A: Population Health Management Performance Management 2024 Goals and Segmentation (Total Goals=18)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
Percentage of adults and children seen for an ambulatory or preventive care visits.	Composite of Adult Access to Preventive/Ambulatory Health Services (AAP) (20 years+), Child and Adolescent Well Care Visits (WCV) (3-21 years) and Well Child Visits in the First 30 months of life (W30A) (0-30) months)	MCLA	>=61%	*Report, including last date of service and number of well child visit to date is used to assist target audience to close gaps in care for children from 0-30 months of age. *Provider Opportunity Reports (PORs) availalbe on provider portal *CPG posted on provider portol *QI Webinars	*Birthday cards with preventive health reminders *Preventive Health Guideline Mailing *Preventive health text messaging campaign *Preventive health Interactive Voice Response (IVR) campaign *Various outreaches (texting, IVR, robocalls, mailers, social media) for multiple domains encouraging members to see their providers	*Quality Improvement (Brigitte/Laura G.)
Percentage of adults and children seen for an ambulatory or preventive care visits.	Composite of Adult Access to Preventive/Ambulatory Health Services (AAP) (20 years+), Child and Adolescent Well Care Visits (WCV) (3-21 years) and Well Child Visits in the First 30 months of life (W30A) (0-30months)	LACC	>=68%	*Report, including last date of service and number of well child visit to date is used to assist target audience to close gaps in care for children from 0-30 months of age. *Provider Opportunity Reports (PORs) availalbe on provider portal *CPG posted on provider portol *QI Webinars	*Birthday cards with preventive health reminders *Preventive Health Guideline Mailing *Preventive health text messaging campaign *Preventive health Interactive Voice Response (IVR) campaign *Various outreaches (texting, IVR, robocalls, mailers, social media) for multiple domains encouraging members to see their providers	*Quality Improvement (Brigitte/Laura G.)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
Percentage of adults and children seen for an ambulatory or preventive care visits.	Composite of Adult Access to Preventive/Ambulatory Health Services (AAP) (20 years+), Child and Adolescent Well Care Visits (WCV) (3-21 years) and Well Child Visits in the First 30 months of life (W30A) (0-30months)	DSNP	>=90%	*Report, including last date of service and number of well child visit to date is used to assist target audience to close gaps in care for children from 0-30 months of age. *Provider Opportunity Reports (PORs) availalbe on provider portal *CPG posted on provider portol *QI Webinars	*Birthday cards with preventive health reminders *Preventive Health Guideline Mailing *Preventive health text messaging campaign *Preventive health Interactive Voice Response (IVR) campaign *Various outreaches (texting, IVR, robocalls, mailers, social media) for multiple domains encouraging members to see their providers	*Quality Improvement (Brigitte/Laura G.)
Percentage of members who received an annual influenza vaccination.	Adult Immunization Status (AIS): Flu Sub-measure	D-SNP	>=48%	*Tips for flu shot promotion sent to appropriate providers via fax.	*L.A. Care staff will send inbound/outbound calls with flu shot reminder during the flu season. *Thank you card sent to D-SNP members who have received the flu shot up until 12/31/22. *Flu shot reminder postcards with $25 incentive information mailed to members. *Automated call reminding members to get the annual flu shot. *Recorded reminder to get the flu shot included in pre-screen message members hear when calling into L.A. Care's Member Services. *Email reminding members to get the annual flu shot. *Facebook and Instagram campaign targeting high-risk groups promoting the annual flu vaccine and connecting individuals to additional educational resources.	*HECLS (Susan Alvarado)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
New: DISPARITY measure. Percentage of Black/African American members 2 years of age who have had the combination 10 vaccine by their 2nd birthday.	Childhood Immunization Status (CIS-10)	MCLA	>=13%			*QI (Brigitte/Laura G) *Health Equity (Marina)
Percentage of members receiving colorectal screening.	Colorectal Screening (COL)	LACC	>=63%	* Gaps in Care Reports - Once the prospective HEDIS data is up and running, around March, they go out starting in April every month. I believe the high level summary reports are emailed to PPGs and gaps posted to the provider portal. Solo doc lists are also posted to the portal. Naomi Lim is the Program Manager over that process and can provide more details	*Automated calls to members due for colorectal cancer screening. *Mailer to members due for colorectal cancer screening - cobranded with American Cancer Society. *At-home colorectal cancer screening FIT Kits. QI currently in RFP to acquire vendor. *Text messaging campaign. *Social media campaign in March for colorectal cancer awareness month.	*Quality Improvement (Xin L/Brigitte B)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
Percentage of members receiving colorectal screening.	Colorectal Screening (COL)	D-SNP	>=71%	* Gaps in Care Reports - Once the prospective HEDIS data is up and running, around March, they go out starting in April every month. I believe the high level summary reports are emailed to PPGs and gaps posted to the provider portal. Solo doc lists are also posted to the portal. Naomi Lim is the Program Manager over that process and can provide more details	*Automated calls to members due for colorectal cancer screening. *Mailer to members due for colorectal cancer screening - cobranded with American Cancer Society. *At-home colorectal cancer screening FIT Kits. QI currently in RFP to acquire vendor. *Text messaging campaign. *Social media campaign in March for colorectal cancer awareness month.	*Quality Improvement (Xin L/Brigitte B)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
New: Percentage of members receiving cervical cancer screening	Cervical Cancer Screening (CCS)	MCLA	>=58%	* Gaps in Care Reports - Once the prospective HEDIS data is up and running, around March, they go out starting in April every month. I believe the high level summary reports are emailed to PPGs and gaps posted to the provider portal. Solo doc lists are also posted to the portal. Naomi Lim is the Program Manager over that process and can provide more details	*Automated calls to members due for mammogram screening. *Mailer to members due for mammogram screening. *Social media posts encouraging breast cancer screening. *Looking into hosting a mammography event at a CRC or clinic.	*QI (Xin L/Brigitte B)
New: Percentage of members receiving cervical cancer screening	Cervical Cancer Screening (CCS)	LACC	>=53%	* Gaps in Care Reports - Once the prospective HEDIS data is up and running, around March, they go out starting in April every month. I believe the high level summary reports are emailed to PPGs and gaps posted to the provider portal. Solo doc lists are also posted to the portal. Naomi Lim is the Program Manager over that process and can provide more details	*Automated calls to members due for mammogram screening. *Mailer to members due for mammogram screening. *Social media posts encouraging breast cancer screening. *Looking into hosting a mammography event at a CRC or clinic.	*QI (Xin L/Brigitte B)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
Percentage of Black or African American members receiving prenatal care.	Prenatal and Postnatal Care (PPC): Prenatal Sub-measure	MCLA	>=70%	* Gaps in Care Reports - Once the prospective HEDIS data is up and running, around March, they go out starting in April every month. I believe the high level summary reports are emailed to PPGs and gaps posted to the provider portal. Solo doc lists are also posted to the portal. Naomi Lim is the Program Manager over that process and can provide more details	*Trimester specific health education materials are mailed to MCLA pregnant members only and a general prenatal letter is mailed to pregnant members, in all lines of business, without trimester information.	*Quality Improvement (Kristin Schlater) *Health Equity (Marina Acosta)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
Percentage of Black or African American members with diabetes control (HbA1c <8%).	Comprehensive Diabetes Care (CDC): <8 Sub-measure	MCLA	>=43%	* Gaps in Care Reports - Once the prospective HEDIS data is up and running, around March, they go out starting in April every month. I believe the high level summary reports are emailed to PPGs and gaps posted to the provider portal. Solo doc lists are also posted to the portal. Naomi Lim is the Program Manager over that process and can provide more details. Added race/ethnicity to report so providers can identify disparities.	*Text messages to educate members about Comprehensive Diabetes Care. *Letter for opt-in program directing members to access health education materials and resources through L.A. Care's My Health In Motion™ (MyHIM) health and wellness portal. *Diabetes 'white-board' magnet mailer including dry erase markers encouraging members to record their most recent A1c, blood pressure reading, diabetic screenings (foot/eye) and daily medication. (Direct Network Members) *At-home A1c Kits. QI currently in RFP to acquire vendor.	*Quality Imrovement (Alison/Brigitte)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
Percentage of Black or African American members with diabetes control (HbA1c <8%).	Comprehensive Diabetes Care (CDC): <8 Sub-measure	LACC	>=57%	* Gaps in Care Reports - Once the prospective HEDIS data is up and running, around March, they go out starting in April every month. I believe the high level summary reports are emailed to PPGs and gaps posted to the provider portal. Solo doc lists are also posted to the portal. Naomi Lim is the Program Manager over that process and can provide more details. Added race/ethnicity to report so providers can identify disparities.	*Text messages to educate members about Comprehensive Diabetes Care. *Letter for opt-in program directing members to access health education materials and resources through L.A. Care's My Health In Motion™ (MyHIM) health and wellness portal. *At-home A1c Kits. QI currently in RFP to acquire vendor. *Medically Tailored Meals provided via vendor GA Foods for Covered CA Quality Improvement Project. Outreach calls began in March 2023.	*Quality Improvement (Alison/Brigitte)

Performance Indicator	Measure Name	LOB	Goal 2022-2023	Provider Interventions	Member Interventions	Participating Department
Percentage of Black or African American members with diabetes control (HbA1c <8%).	Comprehensive Diabetes Care (CDC) <8%	D-SNP	>=65%	* Gaps in Care Reports - Once the prospective HEDIS data is up and running, around March, they go out starting in April every month. I believe the high level summary reports are emailed to PPGs and gaps posted to the provider portal. Solo doc lists are also posted to the portal. Naomi Lim is the Program Manager over that process and can provide more details. Added race/ethnicity to report so providers can identify disparities.	*Text messages to educate members about Comprehensive Diabetes Care. *Letter for opt-in program directing members to access health education materials and resources through L.A. Care's My Health In Motion™ (MyHIM) health and wellness portal. *At-home A1c Kits. QI currently in RFP to acquire vendor.	*Quality Improvement (Alison/Brigitte)
Percentage of members with BP controlled: Black or African American members.	Controlling Blood Pressure (CBP)	MCLA	>=33%	* Gaps in Care Reports - Once the prospective HEDIS data is up and running, around March, they go out starting in April every month. I believe the high level summary reports are emailed to PPGs and gaps posted to the provider portal. Solo doc lists are also posted to the portal. Naomi Lim is the Program Manager over that process and can provide more details. Added race/ethnicity to report so providers can identify disparities.	*Text messages to educate members about Controlling High Blood Pressure. *IVR outreach. One script to be culturally tailored to the BAA population for CBP.	*Quality Improvement (Alison/Brigitte)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
Percentage of members with BP controlled: Black or African American members.	Controlling Blood Pressure (CBP)	LACC	>=42%	* Gaps in Care Reports - Once the prospective HEDIS data is up and running, around March, they go out starting in April every month. I believe the high level summary reports are emailed to PPGs and gaps posted to the provider portal. Solo doc lists are also posted to the portal. Naomi Lim is the Program Manager over that process and can provide more details. Added race/ethnicity to report so providers can identify disparities.	*Text messages to educate members about Controlling High Blood Pressure. *IVR outreach. One script to be culturally tailored to the BAA population for CBP.	*Quality Improvement (Alison/Brigitte)
Percentage of members with BP controlled: Black or African American members.	Controlling Blood Pressure (CBP)	D-SNP	>=53%	* Gaps in Care Reports - Once the prospective HEDIS data is up and running, around March, they go out starting in April every month. I believe the high level summary reports are emailed to PPGs and gaps posted to the provider portal. Solo doc lists are also posted to the portal. Naomi Lim is the Program Manager over that process and can provide more details. Added race/ethnicity to report so providers can identify disparities.	*Text messages to educate members about Controlling High Blood Pressure. *IVR outreach. One script to be culturally tailored to the BAA population for CBP.	*Quality Improvement (Alison/Brigitte)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
Percentage of emergency department (ED) visits for members 18 years and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.	Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions (FMC)	D-SNP	>=54%			*STARS (Donna)/ Quality Improvement (Bettsy)
New: Percentage of members 6 years and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 30 days.	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	MCLA	>=35%			*QI (Bettsy/Brigitte) *BH (Rose)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
Percentage of members in the Medication Therapy Management (MTM) Program completing the Comprehensive Medication Review (CMR).	Part D Data Validation File Measure D11	D-SNP	>=61%	Comprehensive Medication Review telephonic outreaches to members and/or providers conducted by Navitus Clinical Engagement Center (CEC).	Comprehensive Medication Review telephonic outreaches to members and/or providers conducted by Navitus Clinical Engagement Center (CEC).	*Pharmacy (Andy/Ann)
NEW: Percentage of eligible members with depression screening for adolescents and adults	Depression Screening for Adolescents and Adults (DSF-E)	MCLA	>=8%	TBD	*Social Media *Health Education Materials	*Behavioral Health (Rose) *Quality Improvement (Bettsy)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
NEW: Percentage of eligible members with depression screening for adolescents and adults	Depression Screening for Adolescents and Adults (DSF-E)	D-SNP	>=49%	TBD	*Social Media *Health Education Materials	*Behavioral Health (Rose) *Quality Improvement (Bettsy)
Percentage of members completing patient engagement after inpatient discharge.	Transitions of Care (TRC): Patient Engagement After Inpatient Discharge Sub-measure	MCLA	>=62%	*Transition of Care Program (TCP) is a collaboration between Social Services and Pharmacy to reduce readmissions for high-risk members. TCP team engages with member to address social, clinical, and provider needs including, but not limited to, medication reconciliation and follow up appointments. *Development of TRC for all identified high risk members through either Enhanced Care Management (ECM), Complex Care Management (CCM) or PPGs.	*Transition of Care Program (TCP) is a collaboration between Social Services and Pharmacy to reduce readmissions for high-risk members. TCP team engages with member to address social, clinical, and provider needs including, but not limited to, medication reconciliation and follow up appointments. *Development of TRC for all identified high risk members through either Enhanced Care Management (ECM), Complex Care Management (CCM) or PPGs.	*STARS (Donna)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
Percentage of members completing patient engagement after inpatient discharge.	Transitions of Care (TRC): Patient Engagement After Inpatient Discharge Sub-measure	D-SNP	>=77%	Focus is on Medi-Cal per CalAIM, but will address D-SNP as well.	Focus is on Medi-Cal per CalAIM, but will address D-SNP as well.	*STARS (Donna)
Percentage of members with medication reconciliation discharge.	Transitions of Care (TRC): Medication Reconciliation Discharge Sub-measure	MCLA	>=9%	*Transition of Care Program (TCP) is a collaboration between Social Services and Pharmacy to reduce readmissions for high-risk members. TCP team engages with member to address social, clinical, and provider needs including, but not limited to, medication reconciliation and follow up appointments. *Development of TRC for all identified high risk members through either Enhanced Care Management (ECM), Complex Care Management (CCM) or PPGs.	*Transition of Care Program (TCP) is a collaboration between Social Services and Pharmacy to reduce readmissions for high-risk members. TCP team engages with member to address social, clinical, and provider needs including, but not limited to, medication reconciliation and follow up appointments. *Development of TRC for all identified high risk members through either Enhanced Care Management (ECM), Complex Care Management (CCM) or PPGs.	*STARS (Donna)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
Percentage of members with medication reconciliation discharge.	Transitions of Care (TRC): Medication Reconciliation Discharge Sub-measure	D-SNP	>=51%	Focus is on Medi-Cal per CalAIM, but will address D-SNP as well.	Focus is on Medi-Cal per CalAIM, but will address D-SNP as well.	*STARS (Donna)
NEW: Ingest ADT notifications from Health Information Exchanges (HIEs) in near real-time using Fast Healthcare Interoperability Resources (FHIR) Application Programming Interface (API) into the Clinical Data Repository (CDR) by September 30, 2024.	DHCS CalAIM Transitional Care Services Requirement by 1/1/2023. (FHIR ADT data)	All LOBs	Ingest ADT notifications from Health Information Exchanges (HIEs) in near real-time using Fast Healthcare Interoperability Resources (FHIR) Application Programming Interface (API) into the Clinical Data Repository (CDR) by September 30, 2024.			*HIT (Sai Vodela)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
Elevating Customer Experience Metric: Improvement of Member Unable to Contact (UTC) Rate: Improve UTC rate in the Individualized Care Plan (ICP) by 5% by August, 2024	Individualized Care Plan (ICP) Unable to Contact Rate	DSNP	Achieve 5% improvement over 2023 by August 2024.		An improvement to the DSNP Master Risk level report has been requested – the fix will include alternate contact information for members when data is available. The report is disseminated to PPGs on a monthly basis and will improve Care Manager access to alternate phone numbers for members.	*Care Management (Amanda Leigh Asmus) *CSC/VOICE *EPO (Jovi) *QI/Enhancing Customer Experience (ECE) (Brigitte-ECE)
NEW: Elevating Provider Experience Metric: Overall Provider Satisfaction for Direct Network Providers	Overall Provider Satisfaction for Direct Network Providers on Provider Satisfaction Survey	All LOBs	>=75%			*Customer Relationship Management (CRM) *Provider Network Management (PNM) (Angie and Raffie) *Provider Data Management (PDM) (Christine Salary) *QI/ECE (Brigitte -ECE)

Performance Indicator	Measure Name	LOB	Goal 2023-2024	Provider Interventions	Member Interventions	Participating Department
NEW: Improving CAHPS "Rating of Health Plan" measure.	Rating of Health Plan	MCLA - Adult	>=74%	*SullivanLuallin group patient experience trainings. L.A. Care hosts 2 series every year and works with various clinics and IPAs to host trainings for their staff. *Various interventions and efforts captured in ECE workplan from across the organization. Link to workplan in "Notes" column.	*Various interventions and efforts captured in ECE workplan from across the organization. Link to workplan in "Notes" column.	*ECE (Brigitte /Linda)
		MCLA - Child	>=60%	*SullivanLuallin group patient experience trainings. L.A. Care hosts 2 series every year and works with various clinics and IPAs to host trainings for their staff. *Various interventions and efforts captured in ECE workplan from across the organization. Link to workplan in "Notes" column.	*Various interventions and efforts captured in ECE workplan from across the organization. Link to workplan in "Notes" column.	*ECE (Brigitte /Linda)
		LACC	>=80%	*SullivanLuallin group patient experience trainings. L.A. Care hosts 2 series every year and works with various clinics and IPAs to host trainings for their staff. *Various interventions and efforts captured in ECE workplan from across the organization. Link to workplan in "Notes" column.	*Various interventions and efforts captured in ECE workplan from across the organization. Link to workplan in "Notes" column.	*ECE (Brigitte /Linda)
		D-SNP	>=75%	*SullivanLuallin group patient experience trainings. L.A. Care hosts 2 series every year and works with various clinics and IPAs to host trainings for their staff. *Various interventions and efforts captured in ECE workplan from across the organization. Link to workplan in "Notes" column.	*Various interventions and efforts captured in ECE workplan from across the organization. Link to workplan in "Notes" column.	*ECE (Brigitte /Linda)

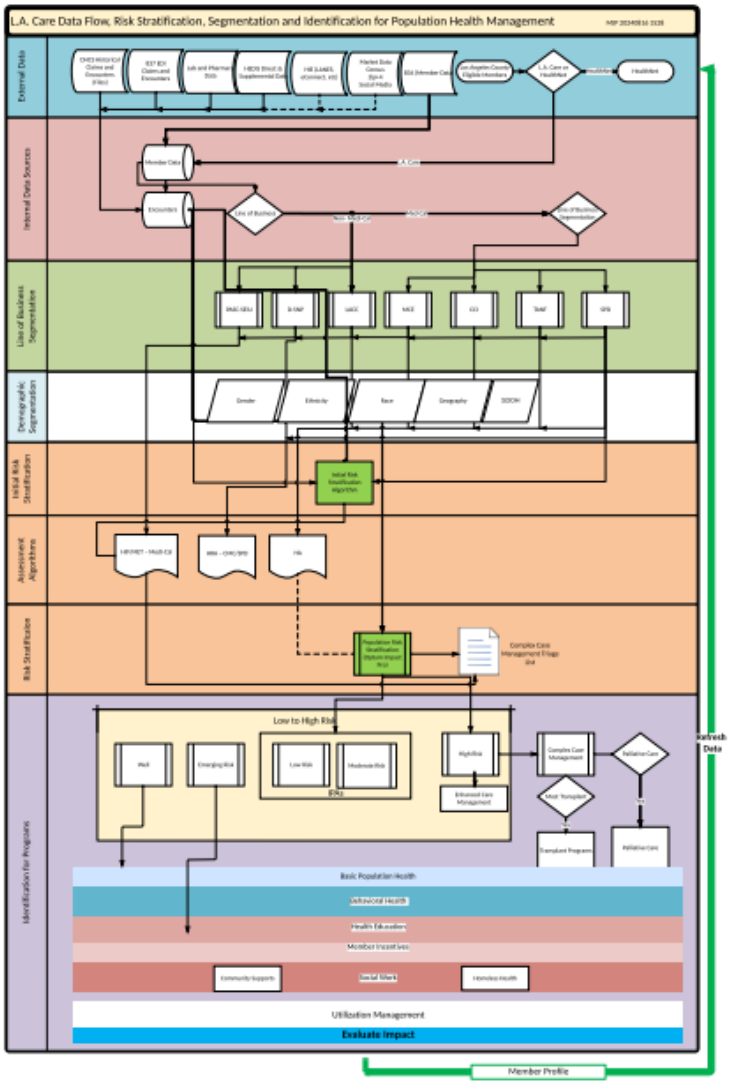
Attachment B: CalAIM Key Performance Indicators

KPI Indicator/ Source	KPI Measurement
Primary Care Engagement/Appropriate Utilization	Percentage of members who had more ED visits than primary care visits within a 12-month period.
Primary Care Engagement/Appropriate Utilization	Percentage of members who had at least one primary care visit within 12-month period.
Primary Care Engagement/Appropriate Utilization	Percentage of members with no ambulatory or preventive visit within a 12-month period.
Community Health Worker Benefit Integration	Percentage of members who received CHW benefit.
RSST	Percentage of medium-rising and high-risk members identified through the PHM Service RSS who are enrolled in CCM
RSST	Percentage of high-risk members identified through the PHM Service RSS who are enrolled in ECM
Complex Care Management (CCM)	Percentage of members eligible for CCM who are successfully enrolled in the CCM program.
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Individuals Experiencing Homelessness" Populations of Focus (POF)
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Individuals At Risk for Avoidable Hospital or ED Utilization" Populations of Focus (POF)
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Individuals with Serious Mental Health and/or Substance Use Disorder (SUD) needs" Populations of Focus (POF)
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Individuals Transitioning for Incarceration" Populations of Focus (POF)
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Adults Living in the Community and At Risk for LTC Institutionalization" Populations of Focus (POF)
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Adult Nursing Facility Residents Transitioning to the Community" Populations of Focus (POF)
Enhanced Care Management (ECM)	Percentage of members enrolled in all ECM Children and Youth" Populations of Focus (POFs)
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness" Populations of Focus (POF)
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Children and Youth At Risk for Avoidable Hospital or ED Utilization" Populations of Focus (POF)
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Children and Youth with Serious Mental Health and/or SUD Needs" Populations of Focus (POF)

KPI Indicator/ Source	KPI Measurement
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Children and Youth Transitioning from Incarceration" (POF)
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition" Populations of Focus (POF)
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Children and Youth Involved in Child Welfare" Populations of Focus (POF)
TCS	Percentage of contracted acute care facilities from which MCPs receive ADT notifications
TCS	Percentage of contracted skilled nursing facilities from which MCPs receive ADT notifications
Enhanced Care Management (ECM)	Percentage of transitions for high-risk members that had at least one interaction with their assigned care manager within 7-days post discharge.
HEDIS	Percentage of acute hospital stay discharges which had follow-up ambulatory visit within 7 days post hospital discharge
Enhanced Care Management (ECM)	Percentage of members enrolled in ECM "Adults Living in the Community and At Risk for LTC Institutionalization" Population of Focus (POF) and "Adult Nursing Facility Residents Transitioning to the Community" POF from referrals made by the member's assigned transitional care manager
HEDIS	Depression Screening and Follow-Up for Adolescents and Adults
HEDIS	Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits
HEDIS	Well-Child Visits in the First 30 Months of Life - 15 to 30 Months – Two or More Well-Child Visits
HEDIS	Child and Adolescent Well-Care Visits
HEDIS	Developmental Screening for the First Three Years of Life
HEDIS	Lead Screening for Children
HEDIS	Childhood Immunization Status: Combination 10
HEDIS	Immunizations for Adolescents: Combination 2
HEDIS	Topical Fluoride for Children
HEDIS	Prenatal Depression Screening and Follow Up
HEDIS	Postpartum Depression Screening and Follow Up
HEDIS	Colorectal Cancer Screening
HEDIS	Chlamydia Screening in Women
HEDIS	Breast Cancer Screening
HEDIS	Cervical Cancer Screening
HEDIS	Ambulatory Care: Emergency Department (ED) Visits
KPI Indicator/ Source	**KPI Measurement**

HEDIS	Adults' Access to Preventive/Ambulatory Health Services
HEDIS	CAHPS: Getting Needed Care
HEDIS	CAHPS: Getting Care Quickly
HEDIS	Depression Remission or Response for Adolescents and Adults
HEDIS	Asthma Medication Ratio
HEDIS	Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9%)
HEDIS	Controlling High Blood Pressure
HEDIS	Antidepressant Medication Management: Acute Phase Treatment
HEDIS	Antidepressant Medication Management: Continuation Phase Treatment
HEDIS	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase
HEDIS	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase
HEDIS	Pharmacotherapy for Opioid Use Disorder
HEDIS	Follow-Up after ED Visit for Mental Illness - 30 days
HEDIS	Follow-Up after ED Visit for Substance Use - 30 day
HEDIS	Plan All-Cause Readmissions
HEDIS	Potentially Preventable 30-day Post-Discharge Readmission
HEDIS	Prenatal and Postpartum Care: Postpartum Care
HEDIS	Prenatal and Postpartum Care: Timeliness of Prenatal Care
HEDIS	Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate

Attachment C: Data Flow



Attachment D: References

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