SECOND ANNUAL REPORT TO THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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Introduction

The Medi-Cal Quality Improvement Program (MCQuIP) was established on October 1, 2011 through a 5-year, $4.25 million Interagency Agreement (IAA) between the California Department of Health Care Services (DHCS) and the UC Davis Health System’s Institute for Population Health Improvement (IPHI). Under this agreement, IPHI, in close collaboration with DHCS, is charged with establishing a quality improvement (QI) program for the $63 billion per year California Medical Assistance Program (Medi-Cal); developing a systems-level quality management strategy and providing ongoing evaluation for the $3.3 billion, 5-year Delivery System Reform Incentive Payments (DSRIP) Program that is part of the state’s 1115 Medicaid Waiver; conducting a broad review of QI strategies and methods used by Medicaid and other relevant publicly funded health care programs; supporting the development and management of lifestyle programs and member communication approaches to optimize population health; and providing executive-level strategic advice, thought leadership, and organizational change management support within DHCS.

The MCQuIP yielded material results during the second year of the collaboration, October 1, 2012 through September 30, 2013. This report highlights the major accomplishments achieved for each deliverable in the IAA.

Accomplishments

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

DHCS Strategy for Quality Improvement in Health Care

In the first year of the IAA, IPHI’s Quality Improvement Expert Consultant (QIEC), Kenneth W. Kizer, MD, MPH, and Chief Prevention Officer (CPO), Desiree Backman, DrPH, MS, RD, worked with the DHCS Medical Director, Neal Kohatsu, MD, MPH, to develop the first DHCS Strategy for Quality Improvement in Health Care, 2012 (Quality Strategy). The Quality Strategy serves as the blueprint for the Department’s efforts to improve the health of all Californians; improve the quality of health care, including the patient care experience, in all DHCS programs; and reduce the rate of increase in the Department’s per capita health care costs. To accomplish these three linked goals, the Quality Strategy is supported by seven priorities, which include:

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

Following a statewide stakeholder input process that included both Departmental staff and some 5,000 external stakeholders, the CPO worked with the DHCS Medical Director and Research Scientist, Patricia Lee, PhD, in the second year of the IAA to synthesize and prioritize stakeholder feedback and revise the Quality Strategy, 2012 accordingly.
Accomplishments

The Quality Strategy was approved by DHCS Director, Toby Douglas, and it was published and uploaded onto the DHCS website in November 2012 (see Appendix A).

Soon after the release of Quality Strategy, 2012, the CPO and DHCS Medical Director began working on Quality Strategy, 2013. The latest version of the Quality Strategy was informed by the Baseline Assessment of Quality Improvement Activities in DHCS: Methods and Results (see Deliverable C) and fee-for-service (FFS) and encounter data analyzed by IPHI’s Quality Scientist (QS), Brian Paciotti, PhD, MS. New QI areas were added including: reducing provider-preventable conditions and potentially preventable events system-wide; reducing opiate overdose; improving data and management to drive decision-making; health care financing reform; improving care for super-utilizers; improving palliative and end-of-life care; improving physical and behavioral health coordination; reducing overweight and obesity, increasing breastfeeding, increasing immunization rates among Medi-Cal members; increasing screening of adults for alcohol misuse and providing brief counseling; and increasing CalFresh enrollment among Medi-Cal members who are eligible but not currently enrolled in the nutrition assistance program. IPHI’s Clinical Quality Officer (CQO), Ulfat Shaikh, MD, MPH, MS, provided input to DHCS leadership on potential nationally recognized measures that could be utilized to measure progress toward quality aims. See Appendix B for the draft Quality Strategy, 2013.

Using Data to Drive Quality Improvement

Data System Refinement

The QS worked with the DHCS Chief Medical Information Officer, Linette Scott, MD, MPH to: (1) evaluate how the MIS/DSS system can become the central data source for analytics within DHCS; (2) evaluate how to improve the data submitted to the Centers for Medicare and Medicaid Services (CMS) data repository (Medicaid Statistical Information System); (3) help the DHCS Data Research Committee map specific data fields to owners within the Medi-Cal organizational structure; and (4) create a secure folder within the MIS/DSS environment to enable the Research and Analytic Studies Branch to link to the Office of Statewide Health Planning and Development (OSHPD)/Medi-Cal dataset.

The QS also worked with the DHCS Data Research Committee to build the complex queries necessary to extract MIS/DSS data requested by external researchers, and helped define processes (e.g., privacy, security, forms) required to provide data to approved researchers. Specifically, the QS:

- Sent data to Dr. Todd Gilmer in August 2013 for the Medicaid utilization project;
- Created a preliminary dataset for Dr. Ushma Upadhyay to investigate the distance to receive a pregnancy termination procedure in Medi-Cal;
- Collaborated with the Medi-Cal Incentives to Quit Smoking (MIQS) team and the Research Triangle Institute (RTI) to identify data fields within MIS/DSS that will be required to support the evaluation of MIQS, and provided a list of fields related to encounter/claims data, eligibility, and providers that could be used to measure specific process and outcomes of interest to RTI.
- Worked with the DHCS Pharmacy Division to perform initial queries to evaluate the prevalence of smoking among Medi-Cal members; and
- Assisted in defining required fields and created SQL code to extract data, linking Cancer Registry data with Medi-Cal data.
**Data Queries and Analyses**

The QS performed ad hoc data queries and analyses using Medi-Cal FFS and encounter data to inform Quality Strategy, 2013. The QS extracted pre-aggregated results from the Data “Symmetry™ Grouper system” provided by Optum. The Symmetry™ Groupers aggregate complex medical, laboratory, and pharmacy claims into episodes of care. Three powerful analytic tools were used to support questions related to the Quality Strategy, including Episode Treatment Groups (groups raw claims into clinically meaningful episodes of care), Episode Risk Groups (scores risk of current and future high costs), and Evidence Based Medicine (nearly 600 pre-calculated quality measures such as the Health Care Effectiveness Data and Information Set).

The QS produced reports that included basic frequencies and descriptive statistics within the following domains: (1) hospice and palliative care; (2) breastfeeding; (3) immunizations; (4) health disparities using health indicators from the Let’s Get Healthy California Task Force Final Report; (5) evaluation of aid codes; and (6) eligibility counts for specific sub-populations. Under the direction of the QIEC, the QS also performed in-depth analyses and reports related to: (1) high-cost Medi-Cal members and their co-morbidities; (2) Agency for Healthcare Research & Quality (AHRQ) Prevention Quality Indicators (PQIs); and (3) AHRQ Patient Safety Indicators (PSIs). The following reports and analyses were produced:

- The QS developed preliminary reports to understand the Medi-Cal “super-utilizer” population. The goal of the project is to identify FFS Medi-Cal members with the highest costs, and then characterize the patterns associated with demographic traits, service utilization, and disease co-morbidities. In the first series of reports, the QS helped Allen Tong, MD, MPH (a DHSC intern) identify the highest cost Medi-Cal members, and then evaluate the degree to which health interventions could reduce costs and improve health among these members. This resulted in a Master’s of Public Health thesis that was presented by Dr. Tong at UC Davis, and Dr. Tong won an award for his poster that summarized this research. Beginning in late August 2013, the QS began working with a research scientist from Optum to refine the data queries and create more detailed reports.

- AHRQ produced two sets of quality indicators that could be useful for measuring the quality of care for Medi-Cal members—Prevention Quality Indicators (PQIs) and Patient Safety Indicators (PSIs). The PQIs are a set of measures that use hospital inpatient discharge data to identify conditions for which good outpatient care can potentially prevent the need for hospitalizations. PSIs identify rare, but dangerous and costly, adverse medical events. The QS produced the PQIs and PSIs using the relatively high-quality OSHPD Patient Discharge Data (PDD). In addition, the QS produced PQI rates using MIS/DSS claims data and the Symmetry™ grouper system, and evaluated the quality of managed care encounter data by comparing the results to the more reliable OSHPD PDD. The QS produced a preliminary report and handout, and delivered a presentation about the indicators during the April 22, 2013 Medical Performance Advisory Committee (MPAC) meeting (see deliverable F).

The CQO has been working with DHCS staff and UC Davis health services researchers to analyze data on pediatric access, quality, and outcomes within the California Health Interview Survey. One set of analyses currently in progress compares access to care for children enrolled in the Healthy Families Program and children enrolled in Medi-Cal. Given that approximately 800,000 children in the Healthy Families Program will eventually transition into Medi-Cal, this programmatic change could have potentially important implications on access to care.

Another set of analyses evaluate population health issues for pediatric asthma in California, including health care disparities, emergency department use, hospital admissions, medication use, and school absence. Our analysis, submitted as an abstract to the 2014 American College of Preventive Medicine conference, found that children enrolled in Medi-Cal had twice the number of emergency department visits compared to children with private or no
Accomplishments

We also found very low influenza immunization rates among children with asthma in California, which was unrelated to health care access. We are analyzing these results further with the goal of preparing a report that assesses potential causes and suggests population level interventions.

Finally, the CPO has been leading efforts with the QS and a DHCS Research Scientist, Patricia Lee, PhD, to complete a series of health disparities fact sheets, based upon the 39 health indicators in the Let’s Get Healthy California Task Force Final Report. The fact sheets are designed to highlight health disparities among Medi-Cal beneficiaries compared to California’s non-Medi-Cal population, and the data will help inform the development of QI initiatives for the seventh priority of the Quality Strategy—Eliminate Health Disparities. The team has focused on 24 of the 39 indicators initially, and plans are underway to address all indicators over time. The executive summary, introduction, fact sheets, and data sources and methods have been reviewed Department-wide and approved by the DHCS Medical Director, and the team is waiting for final approval from DHCS Director, Toby Douglas prior to publication on the DHCS website. See Appendix C for the executive summary, introduction, fact sheets, and data sources and methods section.

Building a Culture of Quality at DHCS

Quality Improvement Academy

As part of the DHCS Adult Medicaid Quality Grant funded in December 2012, IPHI’s CQO worked with the DHCS Medical Director to plan a series of QI trainings to advance quality competency at DHCS. The first QI training course is a one-day introduction to the core principles of QI for supervisors and managers. The objectives of the course include: (1) discuss the core principles of QI, (2) share QI tools that staff can use in their day-to-day activities, and (3) discuss team/group skills that can help staff play a more direct and effective role in the development and implementation of the Quality Strategy.

The second course is a nine-day longitudinal class in the application of QI methodology. The goal of this course is to increase the ability of DHCS clinicians and staff to apply QI methodology while improving health care delivery processes and outcomes. The training will be a practical, in-depth course for clinicians, analysts, administrators and other project staff at DHCS who will implement and evaluate two QI projects in the areas of diabetes management and early elective deliveries less than 39 weeks. The course will give participants the understanding and tools necessary to conduct state-of-the-art QI projects and to use QI methods to manage and effectively integrate interventions. In the longer term, the course will facilitate the development of skills and competencies needed by staff to actively lead, participate in, and direct the Quality Strategy. It will build on the experience of QI experts at IPHI and will bring project team members together to learn the theory and techniques of: (1) designing data systems, (2) outcome measurement and tracking, (3) methods for rapid improvement, (4) data management, (5) information synthesis, and (6) total quality management/continuous QI.

Project teams will apply QI principles to systematically develop and implement their improvement projects. As project teams develop and implement their projects they will increase their skills in establishing the magnitude of the problem, developing focused aims for improvement, identifying areas to change, utilizing QI tools, collecting data, and assessing if changes were successful. At the culmination of this course, each of the two project teams will complete and report on their improvement projects.

The CQO is in the process of developing the courses and plans to launch the first class in January 2014 with the DHCS Quality Officer, Julia Logan, MD, MPH.
Qualify Strategy and Quality Improvement Presentations

To further nurture the culture of quality at DHCS, the CPO presented the *Quality Strategy, 2012* and emerging areas in the *Quality Strategy, 2013* at the Drug Utilization Review Board meeting in February and the DHCS new employee orientation in March, June, July and August 2013. The CPO also presented the new elements of the *Quality Strategy, 2013* at the Managed Care Medical Directors meeting in April 2013, and received feedback and suggestions that were then incorporated into the draft 2013 strategy. The CPO and DHCS Medical Director presented the results of the baseline assessment of QI activities and new *Quality Strategy* ideas at the supervisors and above meeting in March. Finally, in August 2013, the CPO and DHCS Medical Director presented the *Quality Strategy, 2012* and lessons learned during a National Quality Strategy webinar hosted by the Agency for Healthcare Research and Quality. For the slides and a transcript of the presentation, go to [http://www.ahrq.gov/workingforquality/nqs/webinar080813/webinar2.htm](http://www.ahrq.gov/workingforquality/nqs/webinar080813/webinar2.htm).

In addition, the CQO developed the QI Capsule, a new learning opportunity for the DHCS Office of the Medical Director team. In succinct 15 to 20 minute sessions during team meetings, the CQO presented summaries on current national and state issues on health care quality. Past QI Capsule topics have included bundled payments, patient-centered medical homes, and medication adherence in chronic diseases. The CQO also presented at DHCS Learning Series sessions on the following topics: Introduction to QI and the Healthy Eating Active Living Telehealth Community of Practice, as well as facilitated a DHCS journal club session on Medicaid incentive programs to encourage healthy behavior.

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

**Baseline Assessment of QI Activities in DHCS**

At the request of the DHCS Director and IPHI QIEC, the CPO conducted a comprehensive baseline assessment of QI activities in DHCS from April-December 2012. The purpose of the assessment was to: (1) establish a Department-wide baseline of QI activities in three areas: clinical care, health promotion and disease prevention, and administration; (2) identify quality metrics that were being collected by the Department but which were not specifically linked to QI activities; (3) identify gaps in the Department’s QI activities; and (4) obtain recommendations for additional QI efforts.

The assessment team, led by the CPO, developed and pilot tested a Quality Improvement Survey (QIS) instrument that was then administered to all operational units within the Department. All units responded to the survey, with 18 Offices and Divisions providing detailed information and 20 other units reporting no activities.

A total of 20 clinical care, 4 health promotion and disease prevention, and 20 administrative QI activities were reported. Some examples included the DSRIP Program; reducing all-cause readmissions and health care acquired infections; improving the proportion of Medi-Cal members who get help in quitting smoking; waivers to help frail seniors and persons with mid- to late-stage HIV/AIDS or developmental disabilities remain in their homes and communities as an alternative to being placed in health care facilities; and enhancing fraud detection and deterrence.

Thirty metrics, including 13 Healthcare Effectiveness Data and Information Set (HEDIS) measures, were being collected by DHCS but were not specifically linked to statewide QI activities. In addition, survey respondents noted both broad gaps in current QI practices (e.g., lack of consistent measurement and translation of data into QI efforts Department-wide) and specific programmatic gaps (e.g., the absence of a comprehensive tobacco treatment plan). Respondents offered many suggestions for new QI activities involving multiple programmatic areas within the Department, including dental care; obesity, tobacco, and alcohol and substance abuse prevention; data, measurement, and modeling; business processes; and QI training. Multiple cross-cutting QI activities were noted.
Accomplishments

The baseline assessment report was reviewed and approved by the DHCS Director and Medical Director in January 2013, and it was published in August. The results of the assessment helped inform the development of the Quality Strategy, 2013. See Appendix D for the Baseline Assessment of Quality Improvement Activities in DHCS: Methods and Results.

QI Follow-Up Assessment System

After completing the baseline assessment of QI activities, the CPO and QS developed an evaluation system to assess the performance of existing DHCS QI activities and collect new QI activities annually. The system included detailed instructions to Department staff and templates to collect updates on existing and new QI activities. This new system was launched by the Office of the Medical Director in September 2013. See Appendix E for the instructions and evaluation templates.

Deliverables D and E: Develop a Systems-level Quality Management Strategy for DSRIP. Provide ongoing evaluation of DSRIP, including providing at least semi-annual reports that assess general and specific areas of improvement.

The CQO, with leadership support from the QIEC, has been providing ongoing technical support and specific recommendations to DHCS and the 21 participating designated public hospitals in order to optimize achievement of DSRIP Program milestones. This assistance has been provided in the form of face-to-face and telephone meetings as well as electronic communication. Examples of recommendations made include implementation and interpretation of Clinician and Group-Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) survey; selection of measures and target setting related to management of severe sepsis, central line associated blood stream infections, and surgical site infections; selection of measures for diabetes; and assessment of interventions implemented by hospitals based on published literature and national guidelines.

Semi-annual and annual reports from participating public hospitals, as well as aggregate reports from CAPH-SNI, were rigorously reviewed. Individual feedback to hospitals was provided in written format. These feedback reports assess implementation of milestones and address general as well as specific ways to improve reporting and implementation of milestones. Technical assistance and mentoring was provided to hospitals on best practices and strategies related to their QI initiatives. The CQO mentored the newly recruited DHCS Quality Officer on DSRIP report evaluation strategies. The CQO also worked with DHCS leadership and staff to develop data validation guidelines for hospitals to enable hospitals to put in place policies and procedures to ensure data integrity and validity.

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

Because of the scale and complexity of the scope of work undertaken by IPHI, the QIEC proposed and DHCS agreed that an external advisory group composed of experts in QI and population health would be very useful. The overarching purpose of MPAC is to advise IPHI and the Department on how to most effectively advance health, clinical quality, and outcomes. Specific goals for the MPAC members include:

1. Review and comment on the Department’s evolving Quality Strategy;
2. Review and comment on QI activities currently being pursued by Medi-Cal and identify where additional efforts may be needed;
3. Advise on building a culture of quality at DHCS and implementing large-scale, sustainable delivery system reforms;
[4] Review and comment on DSRIP status reports and advise on how to optimize achievement of QI targets; and
[5] Otherwise provide input on topics proposed by DHCS and the QIEC.

In the first year of the IAA, the QIEC recruited and secured seven MPAC and two Ex-Officio members, and convened one MPAC meeting. For a list of MPAC members, please visit: http://www.ucdmc.ucdavis.edu/iphi/Committees/MPAC/members.html. The QIEC chairs the MPAC and actively leads its deliberations.

In the second year of the IAA, the QIEC and CPO, in collaboration with the DHCS Medical Director, convened the second MPAC meeting on November 5, 2012. Topics included updates to the Quality Strategy; observations and discussion about DSRIP; review and discussion of the DHCS baseline assessment of QI activities; quality measurement; and quality of care in a managed care environment. MPAC members recommended the next meeting focus on proposed quality initiatives for Quality Strategy, 2013. See Appendix F for the MPAC meeting agenda.

On April 22, 2013 another MPAC meeting was convened. Topics included Quality Strategy, 2013, the managed care prevention assessment, health disparities report, DSRIP and Coordinated Care Initiative, Medi-Cal Adult Quality Care Improvement Grant, and Medi-Cal data strategy and intervention development. The QIEC facilitated the meeting. The CPO presented the managed care prevention assessment and health disparities report. The CQO presented an update on the DSRIP Program as well as quality improvement training for DHCS staff. The QS created and presented analyses related to the AHRQ PQIs and PSIs. See Appendix G for the MPAC meeting packet.

Additional MPAC meetings that were tentatively scheduled for later in the year were deferred per the request of DHCS.

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

**Increasing Food Availability for Medi-Cal Families**

The CPO, in partnership with the California Departments of Public Health (CDPH) and Social Services (CDSS), led efforts to increase CalFresh enrollment among the nearly 2 million Medi-Cal members who are eligible but not enrolled in the nutrition assistance program. The Departments recently agreed to establish a DHCS QI project to increase enrollment by: (1) including CalFresh in the Covered California Single Streamlined Application; (2) linking Medi-Cal members to CalFresh through DHCS social media and the IPHI population health website; (3) promoting CalFresh in Medi-Cal enrollment materials; (4) distributing CalFresh information through member mailings; and (5) delivering CalFresh enrollment training to Certified Application Assistants and health educators with the Medi-Cal Contracted Managed Care Plans (MCMCP). The CPO, QS, and DHCS analyst, Tianna Morgan worked with CDSS to set a target of increasing CalFresh enrollment by 5 percent from January 2014 through January 2015.

**Obesity Prevention**

To advance healthful eating, physical activity and obesity prevention in Medi-Cal, the CPO submitted a $533,000 grant proposal in July 2013 to the Network for a Healthy California (Network) as part of the Network’s annual plan to the United States Department of Agriculture Supplemental Nutrition Assistance Program-Education (SNAP-Ed). The proposal, titled Champions for Change Rx, featured formative research, including stakeholder key informant interviews and focus groups with Medi-Cal members, to inform the development and evaluation of an obesity prevention program linking health care and community interventions. The aims of the formative research are to: (1) identify feasible, sustainable, age and culturally-appropriate obesity prevention approaches in the health care setting that can be delivered to SNAP-Ed eligible Medi-Cal members; (2) identify tested Network/SNAP-Ed tools, resources, materials, and communication methods that can be applied to the health care setting; (3) identify efficient and effective
Accomplishments

ways to drive SNAP-Ed eligible Medi-Cal members to participate in Network community-based interventions where they live, work, learn, worship, play, make food and physical activity decisions, and become involved in community empowerment efforts; (4) develop and produce a pilot program and evaluation plan designed to reduce the risk and prevalence of overweight and obesity among SNAP-Ed eligible Medi-Cal members; and (5) develop the components of the pilot program and testing phase in preparation for pilot program implementation and evaluation in FFY 2015. The grant was funded in late September 2013, and plans are underway to begin the formative research phase in October 2013. See Appendix H for the obesity prevention proposal.

Tobacco Cessation

Archimedes Modeling

The QS supported DHCS staff in learning how to use Archimedes, a simulation modeling tool developed by Kaiser Permanente, to predict health outcomes for a variety of health interventions. To launch the first modeling project requested by the DHCS Medical Director in the spring/summer of 2013, a DHCS intern (Rachel Abbott), with support from the QS, used the Archimedes model to project various outcomes associated with smoking cessation programs. The smoking cessation project focused on how the MIQS Program might save lives and money under a variety of modeling assumptions. The DHCS intern and QS ran a number of Archimedes simulations that varied adherence rates (5%, 12%, and 17%) and included five subpopulations (hypertensive, female, diabetic, age between 18 and 34 years, and age between 35 and 65 years). Two populations were considered. First, the population was set at 25,000 to reflect the expected number of Medi-Cal smokers reached by the MIQS Program. Based on this population, Archimedes predicted that a 5% quit rate would result in $3.3 million of savings and a 17% quit rate could save $9.1 million. Second, the entire population of about 2.5 million adult non-senior Medi-Cal smokers was modeled. Based on a 17% quit rate and a 20-year time horizon, the model predicted: (1) $936 million in savings; (2) a 1.23% reduction in the Medi-Cal death rate; and (3) a 1.63% reduction in the Medi-Cal stroke rate. Overall, the simulations produced reasonable results that could help Medi-Cal shape policies related to smoking cessation programs.

Tobacco Summit to Advance Quit Attempts

The CPO was invited by the Center for Tobacco Cessation and California Smokers’ Helpline to attend a statewide tobacco summit in January 2013. The purpose of the summit was to strengthen messages and support to help Californians quit tobacco. At the end of the summit, the participants developed an action plan to increase the quit attempt rate in California from 60.7% to 66.8% by 2014. The CPO offered several DHCS tobacco cessation approaches to the plan, including the MIQS Program, promotion of MIQS through Welltopia by DHCS, and the establishment of a standard of care for treating tobacco use in the Medi-Cal managed care plans by implementing the recommendations included in the Treating Tobacco Use and Dependence: 2008 Update, Clinical Practice Guideline. As a follow up to the summit, the CPO has been collaborating with the MIQS Program Manager to provide updates on DHCS progress in these areas.

Alcohol Abuse

As noted in Deliverables H and I, the CPO conducted a baseline assessment of preventive health services among the MCMCP in the Winter of 2013. One of many areas assessed was the delivery of alcohol abuse prevention programs among Medi-Cal members. The survey revealed that out of 20 participating health plans, no plans identified a formal screening tool for alcohol abuse, 9 were unable to report any alcohol abuse prevention programming, and only 5 reported in-person counseling.
In response to these and other findings, the CPO enlisted the assistance of a DHCS intern, Natalie McGowan, RN, in July 2013 to conduct a literature review of the best evidence-based practice for alcohol screening, counseling, and referral to treatment. Natalie worked with staff in the newly-developed DHCS Substance Use Disorder Prevention, Treatment and Recovery Division to develop her recommendations. As shown in Appendix I, Natalie recommended Screening, Brief Intervention, and Referral to Treatment (SBIRT) as the gold standard technique for alcohol use screening. Plans are underway to determine the best way to advance this recommendation through the MCMCP.

The CPO also has been working with the Substance Use Disorder Prevention, Treatment and Recovery Division to identify QI activities for Quality Strategy, 2013. New QI activities, which will be incorporated into the final draft of the Quality Strategy in November 2013, will include substance use disorder prevention workforce training; improvements in statewide alcohol and other drug prevention outcomes; QI in the California Access to Recovery Effort (CARE) Program; SBIRT; improvements in Friday Night Live compliance; and an increase in the number of counties addressing underage drinking and excessive drinking by using evidence-based environmental prevention strategies such as retail availability, drinking and driving, and visibility of actions in the media.

**Baseline Assessment of Preventive Health Services**
Refer to Deliverable H and I.

**Prevention and Wellness Communication**
Refer to Deliverables J and K.

**Deliverables H and I**: Evaluate and analyze the delivery of clinical preventive services, and develop and implement strategies to improve network performance in quality measures in this domain. Identify and encourage adoption of effective population health strategies by DHCS contracted health plans.

After conducting the baseline assessment of QI activities in DHCS and learning there were few reported QI initiatives in the prevention area, the CPO worked with the DHCS Managed Care Division to understand the types of preventive services delivered by the MCMCP. The CPO learned that DHCS does not track or assess the type of preventive services and programs that are delivered through the MCMCP in a comprehensive way, despite contract specifications that address the delivery of preventive services (see Appendix J for a summary of prevention-related specifications in the MCMCP contracts).

To resolve this issue, the CPO assembled a team in November 2012, including Managed Care Division staff and a DHCS intern, Rachel Trusty, to conduct a baseline assessment of preventive health services among the MCMCP. The purpose of the assessment was to understand: (1) the types of prevention programs/services offered to Medi-Cal members; (2) methods used for program/service delivery; (3) measures of program/service effectiveness; and (4) how plans connect with community resources to address social determinants of health.

One health educator lead from each of the 21 MCMCP was recruited to complete the assessment, with support from his/her Medical Director. From November 2012 through February 2013, a 296-item survey was developed, pilot tested, and administered to the participants, yielding 20 responses (see Appendix K for the survey). Qualitative and quantitative measures and corresponding analytical methods were used to assess the four aims in the areas of healthful eating, physical activity, substance abuse, breastfeeding, and cardiovascular disease, type 2 diabetes, obesity, and asthma prevention and management. Tobacco cessation was excluded from the survey because a previous assessment had been conducted through the MIQS Program.
Accomplishments

With oversight from the CPO, the DHCS intern completed the initial analysis and drafted a report of the findings in May 2013 (see Appendix L for the report). The CPO, QS, and Research Assistant (RA), Jennifer Kilroy, have conducted additional analyses and are in the process of drafting a manuscript for publication. Both sets of analyses suggest that reported preventive services and descriptions of interventions with the “greatest impact” often did not conform to evidence-based practices. Few plans stratify members by risk, use incentives, measure performance, track enrollment, or offer intensive face-to-face interventions. Printed materials and in-person interactions were more common than social media and email. Prevention programs reached small populations and most focused on tertiary prevention. Finally, MCMCP varied with respect to referrals to community assistance programs and lifestyle-related community events that address the social determinants of health.

The results of the assessment will be used to: (1) set a minimum standard of preventive care that is consistent with evidence-based preventive medicine; and (2) establish a monitoring system to track the performance of preventive care services delivered by the MCMCP.

Deliverables J and K: Foster partner relationships between DHCS and members through strong bi-directional communication with respect to needs, responsibilities, and preferences related to healthy lifestyle. Design a strong member education, communication, and intervention platform that drives improvement in population health.

One of the priorities of the Quality Strategy is to engage persons and families in their health. During the first year of the IAA, the DHCS Medical Director and CPO explored the use of social media and other forms of communication to reach Medi-Cal members with information and resources about prevention and wellness. Recommendations from the exploratory period were used to inform the accomplishments noted below.

Welltopia by DHCS Facebook Page and Twitter

The CPO led efforts, with support from two DHCS analysts (Heidi Oliver and Tianna Morgan) and an intern (Hannah Robins), to build, pilot test, and implement a DHCS wellness Facebook page, titled Welltopia by DHCS (Welltopia). The primary target audience is Medi-Cal members, with an emphasis on Medi-Cal mothers. The purpose of Welltopia is to provide tips, information, and resources to help Medi-Cal members eat healthier foods, engage in adequate physical activity, reduce stress, quit smoking, connect with local resources that support the social determinants of health, and interact with the Facebook community.

During the development phase, the CPO and DHCS analysts worked with Marketing by Design to develop the Welltopia brand, logo, and Facebook design (Appendix M). Credible content was secured from the California Tobacco Control Program, Network for a Healthy California, Kaiser Permanente, CalFresh, California Certified Farmers’ Markets, Produce for Better Health Foundation, among others. The CPO and a DHCS analyst developed the first three months of content, which was approved by the DHCS Office of Public Affairs and Medical Director.

The Facebook page, located at www.facebook.com/DHCSWelltopia, was launched on April 24, 2013, with the goal of achieving 10,000 “likes” by December 31, 2013. New posts for the Facebook page are being developed by a DHCS intern, with oversight from the CPO and assistance from DHCS analysts. In addition, the posts have been converted into Tweets, and the Tweets are being shared through the DHCS Twitter account (@WelltopiaDHCS).

From July through August 2013, the CPO collaborated with the Sacramento Food Bank’s parenting education class to conduct one Spanish-language and two English-language focus groups with low-income women and men to receive feedback on Welltopia. A DHCS analyst (Heidi Oliver) scheduled the focus groups and worked with the CPO to facilitate and document the group discussions. Feedback from the focus group participants was generally positive. Some common areas for improvement included the following:
Accomplishments

- Develop a Welltopia website because not everyone is on Facebook
- Expand resources for stress management, parenting, fun family activities, goal setting, and social support
- Add information on alcohol and drug abuse prevention, treatment, and recovery
- Add a calendar of community events, such as health fairs, free activities for children, teens and families, and free health promotion classes
- Provide information in Spanish
- Add hotline numbers to address domestic violence, food access, shelter, and other urgent issues
- Market Welltopia to Medi-Cal members

Following the focus groups, the CPO and DHCS analysts implemented changes to Welltopia to reflect consumer feedback. For example, to increase the number of “likes” on Welltopia, the CPO led efforts with Marketing by Design in mid-September 2013 to develop, implement, and evaluate an inexpensive Facebook advertising campaign. Marketing by Design created the advertisements and the team used Facebook analytics to measure the performance of the campaign and messages. During the first two weeks of the campaign (September 11-30), the number of “likes” increased from 349 to 1,250, representing a gain of 901. See Appendix N for a report on the campaign’s performance as of September 30, 2013. Plans are underway to continue the advertising campaign and monitor its performance.

The team also produced 94,000 Welltopia fliers, which will be distributed to new Medi-Cal members in October as part of the beneficiary identification card mailers. Plans are underway to assess the effectiveness of the mailers to increase the number of Medi-Cal members who “like” Welltopia. New content in the areas of stress management, fun family activities, goal setting, social services, and social support were added. Finally, one of the Welltopia tobacco cessation infographics was used by the MIQS Program for their pilot transit advertising campaign. The advertisement, which promoted the $20 tobacco cessation gift card incentive, increased call volume to the California Smokers’ Helpline by over 35% in Sacramento County. The advertisement will also be running in Sutter and Yuba Counties at no cost to DHCS.

Population Health Improvement Website

In August 2013, the CPO and IPHI’s Chief Administrative Officer, Allyn Ami secured $50,000 from the California Health e-Quality Program to develop and implement a population health improvement website that will support Welltopia and enhance the availability of prevention and wellness resources for Medi-Cal members. The purpose of the website is to connect Californians, especially those with limited incomes, with credible resources for healthy personal, family and community development, starting with topics that address the leading causes of preventable morbidity (e.g., tobacco, diet, physical activity, and alcohol abuse) and the social determinants of health (e.g., education, employment, housing, health insurance, access to food, etc.).

In September 2013, the CPO assembled a website development team, including both IPHI and DHCS staff. The CPO and website team developed the website concept (Appendix O), as well as a draft site map (Appendix P). Plans are underway to launch the website in January 2014, create a strong interface between the site and Welltopia, and measure performance over time.

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

Deliverables A-C, F-K, and M demonstrate IPHI’s efforts to support a strong prevention focus across all DHCS programs. In addition, there has been steady growth in the amount and type of QI projects that address prevention. Specifically, when the baseline assessment of QI activities was conducted in 2012, four prevention-related QI projects were reported.
Accomplishments

in the areas of tobacco cessation, family planning, American Indian infant health promotion, and newborn hearing and screening. In addition to these areas, the draft Quality Strategy, 2013 now includes preventive dental services, breast and cervical cancer screening, chlamydia screening, breastfeeding promotion, overweight and obesity reduction, screening for alcohol misuse and brief counseling, and more (see Appendix B, Quality Strategy, 2013).

**Deliverable M:** Provide executive-level strategic advice, thought leadership, and technical assistance through in-person, teleconference, and other means.

**Strategic Advice, Thought Leaders, and Technical Assistance**

The IPHI team provided executive- and program-level strategic advice, thought leadership, and technical assistance in the following areas:

- The QIEC (Kenneth W. Kizer, MD, MPH) met with DHCS leadership and staff regularly to provide thought leadership on all aspects of the MCQuIP, and provided direction to the CPO, CQO, and QS.
- The CPO (Desiree Backman, DrPH, RD) met with DHCS leadership and staff on a daily basis to provide leadership and support on the Quality Strategy, QI and preventive services baseline assessments, partnership development, prevention and health promotion, member communication approaches, and IPHI administrative and contract matters. The CPO also provided staff oversight to the QS and RA.
- The QS (Brian Paciotti, PhD, MS) met with DHCS leadership and staff on a regular basis to provide technical assistance on data systems and data management, as well as conducted numerous analyses using Medi-Cal data. The QS also delivered the following presentations: How Community Culture Influences Group Outcomes such as Cooperation, DHCS Learning Series; How the SymmetryTM Groupers and Quality Indicators can be used to Facilitate Analytical Reporting and QI, MIS/DSS Users Group; and Use of AHRQ Prevention Quality Indicators, Encounter Data Improvement Project.
- The CQO (Ulfat Shaikh, MD, MPH) met with DHCS leadership and staff on a regular basis to provide technical assistance on the DSRIP program and QI, in general.
- The Program Manager (Allyn Fernandez-Ami, MPH) met with DHCS leadership to provide technical assistance and fiscal management for the IAA.
- The RA (Jennifer Kilroy) provided administrative support to the CPO, designed the Baseline Assessment of Quality Improvement Activities in DHCS: Methods and Results report, designed the health disparities fact sheets, finalized the population health website site map, contributed to the website concept paper, and gathered literature on the topics of preventive services and health care delivery models.

**Added-Value Deliverables:**

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

- The QIEC served as a member of the Governor’s Let’s Get Healthy California Task Force, and the CPO provided staff support on DHCS assignments related to the Task Force, including weekly meetings and health indicator development. The Let’s Get Healthy California Task Force Final Report was released December 19, 2012 [http://www.chhs.ca.gov/Documents/___Let%27s%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf]. As noted previously, the health indicators in the report served as the foundation for the DHCS health disparities fact sheets.
• The CPO served as a DHCS liaison for the California State Innovation Model (CalSIM) Workgroup—Living Well: Preventing and Managing Chronic Disease. The recommendations from this and four other workgroups are being used to inform the development of a State Health Care Innovation Plan proposal. Go to: http://www.chhs.ca.gov/Documents/CalSIM%20Work%20Group%20Recommendations%20Submitted%20to%20Date.pdf for a copy of the each workgroup’s recommendations.

• The QIEC serves as the senior scientific advisor for the CalSIM Planning Grant, and participated in various CalSIM discussion roundtables and in one-on-one and small group discussions with project staff, and in the review and critique of the state Healthcare Innovation Plan Proposal.

• The CPO worked with Health in All Policies staff, a local Community Supported Agriculture (CSA) group, and the DHCS Medical Director to improve the food environment at DHCS. In March 2013, the team conducted a survey to gauge interest by DHCS staff in a weekly delivery of farm-fresh produce to those that subscribe for the service. Of 356 respondents, 246 (69%) were interested in the service. The pilot service was launched on April 24, 2013, with nearly 100 DHCS employees participating. Customer satisfaction has been high, and other state agencies such as the California Departments of Education and Public Health have expressed interest in participating in the produce deliver service. Following completion of the pilot test service in July, it was determined that the service should continue. The service is now offered on an annual basis to both DHCS and the California Department of Public Health.

• The QIEC serves as a member of the External Advisory Panel for the Texas DSRIP program. On April 12, 2013, the QIEC made a presentation in Austin, TX, to the Texas DSRIP program staff and consultants on observations about and lessons learned in the California DSRIP program.
Appendix A

Toby Douglas, Director

Strategy for Quality Improvement in Health Care

November 2012
Introduction and Background

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

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

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

Development of the DHCS Quality Strategy

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

Three Linked Goals

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

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

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

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

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

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

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

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

**Examples of Patient Safety Initiatives**

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

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

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

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

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

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

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

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

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

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

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

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

- **Develop a Performance Outcome System for Early and Periodic Screening, Diagnosis, and Treatment in Mental Health Services.** DHCS, in collaboration with stakeholders, is designing a mental health services performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment as mandated by Senate Bill 1009 (Chapter 34, Statutes of 2012). The specific aims of the system are to: (1) ensure access of eligible children and youth to appropriate mental health services; (2) provide information that improves quality at the patient and system
levels; and (3) evaluate services, over time, for effectiveness and efficiency. While the focus of this system is on children, the Department plans to use what it learns from this process to similarly improve how it measures and continuously improves the mental health system’s performance and outcomes for adults.

- **Improve Health Outcomes for Members with Severe Mental Illness and Children with Serious Emotional Disorders.** DHCS is committed to providing safe, effective, efficient, patient-centered care to Medi-Cal members with chronic physical and mental health conditions. Through the California Mental Health Care Management Program (CalMEND) Pilot Collaborative, DHCS has partnered with six California counties to implement care management quality improvement processes at the local level to improve the integration of mental health care and primary care services to Medi-Cal members with severe mental illness (SMI) and children with serious emotional disorders (SED). Going forward, CalMEND hopes to continue its quality improvement efforts in promoting safe and effective use of pharmacotherapy treatment for the SMI and SED populations.

- **Improve Psychotropic Medication Use in Children and Youth in Foster Care.** Building on the experience from the CalMEND project, DHCS is working with the California Department of Social Services (CDSS) to develop a project that seeks to dramatically improve psychotropic medication use within this population by 2015. Abuse of psychotropic medication in children and youth is prevalent among those in foster care. Measures of system improvements will include: improving care coordination, removing barriers and improving the efficient use of a health and education passport, and improving care through strengthening partnerships with youth and families. Key elements of the project include: 1) strategies to engage providers to improve adherence to guidelines for prescribing and administering psychotropic medications; and 2) establishing an engaged partnership among youth and adults. Together, these elements will help to achieve success for the project.

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

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

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

Example of an Emerging Engagement Initiative

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

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

Examples of Communication and Coordination Initiatives

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

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

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

Examples of Prevention Initiatives

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

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

- **Support the Million Hearts Initiative.** Million Hearts™ (MHI) is a national public-private sector initiative that was launched by the United States Department of Health and Human Services (DHHS) in September 2011 to prevent 1 million heart attacks and strokes over five years. The initiative aims to help millions of Americans improve their heart health by preventing and treating high blood pressure, high cholesterol, and tobacco use. Working with our own public and private partners, DHCS will determine the best way to support MHI through its existing programs and emerging quality improvement initiatives.

*Foster healthy communities.* Approximately half of all preventable mortality is attributable to four lifestyle issues: smoking, poor nutrition, physical inactivity, and alcohol abuse. While these are often viewed as individual choice issues, the most effective means of improving these risk factors in populations is through fostering healthy communities. For example, creation of the social and physical environment in California where non-smoking became the social norm led to a 50% reduction in the smoking rate over 20 years. Therefore, it is essential that the state commit to creating healthier communities to address the obesity and diabetes epidemics (and other public health problems) that threaten to overwhelm the health care system in California. CDPH, voluntary health agencies, community-based organizations, and many other stakeholders play leadership roles in fostering healthy communities. DHCS will work to coordinate with these partners to support this important priority.

*Examples of Collaborations to Foster Healthy Communities*

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

*Eliminate health disparities.* Eliminating disparities in care is a key facet of health care quality according to the IOM, and it is a core principle of the NQS. Disparities in health care include, but are not limited

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to, those based on race, color, national origin, sex, age, disability, language, health literacy, sexual orientation and gender identity, source of payment, socioeconomic status, and geography. The National Health Care Disparities Report\(^4\) is a useful resource to better understand disparities linked to health care and will be used to provide context for the Department’s efforts to eliminating such disparities.

**Examples of Efforts to Eliminate Health Disparities**

2. **Continue to Increase DHCS’ Capacity to Eliminate Health Disparities and Support the Activities of the Office of Health Equity.** DHCS is committed to eliminating disparities in the full continuum of care delivered to its members. As part of this commitment, DHCS will work to both identify and address health disparities using effective intervention and policy. A key partner in this work will be the newly created Office of Health Equity (OHE) within CDPH. Established through legislative mandate, effective July 2012, OHE consolidates DHCS’ Office of Women’s Health, CDPH’s Office of Multicultural Health, Health in All Policies Task Force, the Healthy Places Team, and the Department of Mental Health’s Office of Multicultural Services. This reorganization was implemented to better identify and ameliorate health disparities for disadvantaged and underserved communities by examining these issues through a more integrated approach to public health, behavioral health, and health care issues. DHCS recognizes that significant health disparities continue to exist within health care. Working with OHE and other stakeholders, the Department will strive to eliminate disparities in health and health care and to ensure that culturally competent care is provided equitably to those we serve.

**Quality Strategy Guiding Principles**

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

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

2. **Science provides the foundation for policy.** Medicine and population health are rapidly evolving fields. New findings from research can reduce mortality and disability, improve health, and help to bend the cost curve. To accomplish these goals, the Department will use evidence-based approaches, including best practices in quality improvement. A valuable resource is the Quality and Patient Safety section within the Agency for Healthcare Research and Quality (AHRQ) website.\(^5\) The section provides extensive information on consumer assessment, standardized quality methods, quality metrics, the National Quality Measures Clearinghouse, patient safety, quality diagnostic tools for states, and other important topics. Other organizations providing useful resources for quality improvement include the National Committee for Quality Assurance, the National Quality Forum, the Joint Commission, the Institute for Healthcare Improvement, professional organizations, voluntary health organizations and many other public and private entities.

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

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

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

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

**Looking Forward**

**Initial Version of the Quality Strategy**

This version of the DHCS Quality Strategy is meant to provide an overview of the Department’s approach to quality, but will not have all of the detailed intervention methods and metrics that will be included in successive versions. The intent of releasing an overview was to engage stakeholders at the earliest stage of planning. The Department conducted a statewide webinar to introduce the Quality Strategy and administered a statewide stakeholder survey to obtain feedback from the health community. This version of the Quality Strategy includes feedback from DHCS staff and stakeholders.
To help inform future versions of the Quality Strategy, the Department recently conducted a comprehensive baseline assessment of its current quality improvement activities. The results of the baseline assessment will help inform the development of the next version of the Quality Strategy, which will incorporate specific aims, metrics, quality improvement strategies and initiatives, timelines, and evaluation reporting plans. We will focus on quality initiatives that meet the following criteria:

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

The Department will continue to work with stakeholders as the Quality Strategy evolves and DHCS lays the groundwork for the next, more specific Quality Strategy Implementation Plan.

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

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

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

Three Aims. The NQS will pursue three broad aims:

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

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

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

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

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

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Appendix A

community, and state-level activities that are responsive to local circumstances;

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

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

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

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

Other National Quality Initiatives

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2011 Baseline</th>
<th>2017 Goal</th>
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<tbody>
<tr>
<td>Aspirin use for people at high risk</td>
<td>47%</td>
<td>65%</td>
</tr>
<tr>
<td>Blood pressure control</td>
<td>46%</td>
<td>65%</td>
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<tr>
<td>Effective treatment of high cholesterol (LDL-C)</td>
<td>33%</td>
<td>65%</td>
</tr>
<tr>
<td>Smoking prevalence</td>
<td>19%</td>
<td>17%</td>
</tr>
<tr>
<td>Sodium intake (average)</td>
<td>3.5g/day</td>
<td>20% reduction</td>
</tr>
<tr>
<td>Artificial trans fat consumption (average)</td>
<td>1% of calories/day</td>
<td>50% reduction</td>
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Appendix B: *Quality Strategy, 2013*
Strategy for Quality Improvement in Health Care

Toby Douglas, Director

August 2013
Introduction and Background

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

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

Another driver is the Department’s five-year 1115 federal waiver, entitled Bridge to Reform, which is improving clinical quality through better coordination of care for vulnerable populations, care delivery redesign, population-focused interventions, and enhanced patient safety. By improving quality, these efforts will help to bend the health care cost curve. On May 3, 2012, Governor Brown also issued Executive Order B-19-12, establishing the Let’s Get Healthy California Task Force to “develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity.”1 In December 2012, the Task Force issued a report with recommendations for how the state can make progress toward becoming the healthiest state in the nation over the next decade, and health care system redesign was highlighted as an important goal in the report.2 Finally, the Affordable Care Act (ACA) (P.L. 111-148)3 addresses many important health care quality issues in domains such as prevention and health promotion, patient safety, coordinated and complex care, community health, and new care delivery models.

Development of the DHCS Quality Strategy, 2012

The initial version of the DHCS Quality Strategy was developed and produced, with statewide stakeholder input, in November 2012 using the National Strategy for Quality Improvement in Health Care (National Quality Strategy or NQS) as a foundation (see Appendix A for a summary of the NQS). Because QI is challenging and resource-intensive, it is important to look for areas of vertical alignment—meaning there is consensus at the federal, state, regional, and provider levels. The NQS used an extensive and broad stakeholder engagement process, making it a reasonable starting point for the Quality Strategy. The DHCS Quality Strategy, however, specifically addresses the needs of Californians and focuses on the Department’s programs.

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Appendix B

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

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

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

The Department’s Seven Priorities

The Department’s seven priorities of the Quality Strategy are to:

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

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

Development of the DHCS Quality Strategy, 2013

DHCS is committed to updating the Quality Strategy annually to reflect the best evidence, policy, and practice in health care. To inform the development of the Quality Strategy, 2013, we conducted an assessment to inventory the Department’s QI activities. The inventory sought to: 1) establish a Department-wide baseline of QI activities in three areas: clinical care, health promotion and disease prevention, and administration; 2) identify quality metrics that were being collected by the Department but which were not specifically linked to QI activities; 3) identify gaps in the Department’s QI activities; and 4) offer recommendations for future QI efforts. The baseline assessment was conducted as part of the Medi-Cal Quality Improvement Program (MCQuIP), which is supported through an Interagency Agreement with the Institute for Population Health Improvement at the UC Davis Health System. Visit www.dhcs.ca.gov/quality improvement/baseline assessment to view the report, entitled Baseline Assessment of Quality Improvement Activities in the California Department of Health Care Services: Methods and Results.
Table 1 provides a high-level synthesis of DHCS QI activities that were gathered during the baseline assessment. The QI activities were matched with each of the seven priorities within the Quality Strategy to identify areas with substantial QI activities and areas for future QI development and implementation. Some QI activities fit within one priority while others cut across two or more priorities. Table 1 also captures QI activities that are under development. These activities will become formal QI projects in the next 1-3 years. Many of these activities have a well-defined problem and intervention plan, but may require additional components such as: increased data collection and analytic capacity, augmented infrastructure and funding, or perhaps, changes in law or policy prior to being launched as formal QI projects.
## Table 1

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<thead>
<tr>
<th>Priority 1</th>
<th>Priority 2</th>
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<th>Priority 4</th>
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### California Children's Services

**Neonatal Quality Improvement Initiative**: Reduce the collaborative's Central Line Associated Blood Stream Infection rate by another 25% among participating Neonatal Intensive Care Units (NICUs).

**Payment Adjustment for Provider-Preventable Complications**, including Health Care-Acquired Conditions: Vascular Catheter-Associated/Central Line-Associated Bloodstream Infection in NICUs/Pediatric Intensive Care Units (PICUs). To implement best practices of central line insertion and maintenance resulting in a decrease in preventable infections, improvement in clinical outcomes, decreased length of stay, and decreased cost.

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

**Managed care all-cause readmissions (HEDIS, 2012)**: Reduce the number of all-cause readmissions within 30 days of an acute inpatient discharge for members 21 years and older.


**Member Roundtables, (Under Development)**: Conduct roundtable discussions with Medi-Cal members to understand the best ways to engage members and families in their health, with an emphasis on prevention.

**Managed Care Internal and Small Group Collaborative QI Project**: Improve communication to improve the patient care experience and percentage of members selecting the top rating for overall health care and personal MD in a patient satisfaction survey.

**Adoption of Electronic Health Records (EHRs)**: With increased adoption of EHRs, the focus is shifting to the use of EHRs and exchange of information among providers to improve care coordination for Medi-Cal members.

**Free the Data Initiative**: Improve the DHCS' use of data from internal and external data analytic processes to make information easier to find and more accessible to the public, staff, and stakeholders.


**DHCs Welltopia Facebook Page**: Maintain a DHCs Facebook Page, linking Medi-Cal members to prevention resources (e.g., nutrition, physical activity, smoking cessation, stress management, sexual services, and more).

**Managed Care Incentive to Quit Smoking**: Increase utilization of the Smokers' Helpline through the use of appropriate incentives; and implement a comprehensive tobacco cessation policy through the managed care plans.


**Member Roundtables, (Under Development)**: Conduct roundtable discussions with Medi-Cal members to understand the best ways to engage members and families in their health, with an emphasis on prevention.

**Managed Care Incentive to Quit Smoking**: Increase utilization of the Smokers' Helpline through the use of appropriate incentives; and implement a comprehensive tobacco cessation policy through the managed care plans.

**Free the Data Initiative**: Improve the DHCS' use of data from internal and external data analytic processes to make information easier to find and more accessible to the public, staff, and stakeholders.

**2011 Client Exit Interview**: Assess clients' perspective on the quality of provider/patient interaction: a) to increase the proportion of new clients who leave it with high efficacy contraception; and b) to increase the proportion of clients.

**Managed Care Internal and Small Group Collaborative QI Project**: Improve communication to improve the patient care experience and percentage of members selecting the top rating for overall health care and personal MD in a patient satisfaction survey.

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<p>| Priority 1 | Improve patient safety Use for Children and Youth in Foster Care: | [formula] Improve psychotropic medication use for children and youth in foster care by: 1) reducing the rate of antipsychotic polypharmacy and 2) improving the monitoring of antipsychotic use among children and youth in foster care. | Appendix B | 37 |</p>
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**Subsidized Housing**, as an alternative to long-term placement in a nursing facility.

**Home and Community-based Services Waiver for Californians with Developmental Disabilities (DD)***: Serve participants in their own homes and communities as an alternative to placing Medicaid-eligible individuals in hospitals, nursing facilities, or intermediate care facilities for persons with mental retardation.

**DHCS University**: Improve the knowledge, skills, and abilities of the Medi-Cal program managers, senior managers, and executives throughout the Department. (Related to All Priorities)

**DHCS Quality Improvement Training, Medi-Cal Adult Quality Care Improvement Project**: One-day training for DHCS supervisors and managers on the core principles of QI; and nine-day longitudinal course in the application of QI methodology among DHCS clinicians and staff conducting the diabetes management and maternal QI projects. (Related to All Priorities).

**Return on Investment (ROI) Manual**: Quantify the value/results of A&I by comparing cost recoveries, savings, and avoidance against the resources expended to complete the work.

**Fraud Detection and Deterrence: Field Audit Reviews**: 1) Ensure Medi-Cal providers are appropriately compensated based on: a) medical necessity; b) appropriateness of care; c) documentation of services rendered; d) qualifications of provider; e) Medi-Cal rules of billing; and f) statutes and regulations; and 2) to identify substandard care or behavior that puts patients at risk.

**Individual Provider Claims Analysis Report**: Increase the accuracy of billing levels for Evaluation and Management (E & M) procedure codes and reduce inappropriate and costly claims.

**timely and complete treatment initiated for cancers diagnosed; and**

**3) deliver breast and cervical cancer screening to priority populations.**

**Provider Profiles with Two Clinical Indicators**: 1) Improve clinical quality outcomes for chlamydia screening of female members age 25 years and younger; and 2) improve clinical quality outcomes for chlamydia targeted screening of female members over age 25 years.

**2011 Family Planning, Access, Care and Treatment (Family PACT) Medical Record Review**: 1) Assess whether family planning and reproductive health care services provided under Family PACT are consistent with program standards: a) to increase the use of effective contraceptive methods as a result of the Family PACT visit; b) increase the proportion of clients who receive education and counseling services; c) decrease the proportion of women who receive annual cervical cytology screening tests; and 2) determine whether the quality of
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**Medi-Cal Payment Error Study (MPES):**
Accurately measure the Medi-Cal paid claims error rate for eight different groups of provider/service types (each type is called a strata).

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

**Family PACT QI/Utilization Management Monitoring Activities:**
1) Identify inappropriate use of Family PACT services; and 2) identify areas where costs could be saved in the Family PACT program.

**Improve Critical Access Hospital’s (CAHs) Quality Reviews and Service Delivery through Multi-hospital Benchmarking (Under Refinement):**
1) Achieve at least 75% of CAHs use of the Kansas Hospital Association Foundation’s Quality Health Indicators (QHI) for benchmarking and report purposes; and 2) demonstrate improvement in at least one QHI per hospital.

**Improve CAHs Operational Performance through Support of Onsite Technical Assistance using the Lean Methodology (Under Refinement):**
1) Support at least 7 CAHs participation in at least one Lean project; and 2) demonstrate improvement in operational QI/Performance Improvement measures.

**CAH Participation in the Medicare Beneficiary Quality Improvement Project (MBQIP) using Selected Measures from the CMS Hospital Compare (HC) Data Reporting Program (Under Refinement):**
1) Identify areas for QI through the use of CAHs reporting of MBQIP outpatient 1-7 measures; and 2) demonstrate improvement in one or more outpatient MBQIP measures.

**Services delivered under the program improved over time.**

**Maternal Health Quality Improvement Project, Medi-Cal Adult Quality Care Improvement Project (Refer to Priority 1).**

**Reduce Overweight and Obesity Among Medi-Cal Members (Under Development)**

**Increase Breastfeeding Among Medi-Cal Mothers (Under Development)**

**Increase Immunization Rates among Medi-Cal Members (Under Development)**

**Increase Screening of Adults for Alcohol Misuse and Provide Brief Counseling (Under Development)**
### Emerging QI Focus Areas

The Quality Strategy, 2013 builds upon the 2012 version and incorporates the baseline assessment results. This version of the Quality Strategy and successive annual updates are intended to be aspirational. We are committed, as a Department, to provide those we serve with the best possible care, striving to achieve the highest levels of health and health outcomes.

To continue to make progress toward that vision, we appreciate the need for continued innovation in science and practice. We will be working on several important themes related to quality and outcomes. While these concepts are at different stages of development, we believe that it is important to identify areas requiring innovation and additional planning. The emerging focus areas are described within each of the Quality Strategy priority areas below.

#### Priority 1: Improve patient safety
- Reduce provider-preventable conditions through implementation of section 2702, ACA.
- Working closely with stakeholders, the Department will reduce preventable adverse events known at Provider-Preventable Conditions (PPCs). PPCs include events such as: a foreign object retained after surgery, advanced pressure ulcers, falls and trauma, and surgical site infections. They also include so-called never events involving surgery: wrong procedure, wrong site, and wrong patient.

#### Priority 2: Deliver effective, efficient, affordable care
- Improve data quality and systems, data management and analytic capacity.

#### Priority 3: Engage persons & families in their health
- Medi-Cal Specialty Mental Health Services for Children and Youth (Under Development): Develop a performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment of mental health services for eligible children and youth that will improve outcomes at the individual and system levels and will inform fiscal decision making related to the purchase of services.
- Improve Data Quality and Management to Drive Decision-making (Under Development)
- Health Care Financing Reform: State Innovation Models (Under Development)
- Reduce Overuse, Misuse and Waste (Under Development)

#### Priority 4: Enhance communication & coordination of care

#### Priority 5: Advance prevention

#### Priority 6: Foster healthy communities

#### Priority 7: Eliminate health disparities

Note: QI activities in italicized text represent projects that are under development.
Emerging QI Focus Areas

The *Quality Strategy, 2013* builds upon the 2012 version and incorporates the baseline assessment results. This version of the *Quality Strategy* and successive annual updates are intended to be aspirational. We are committed, as a Department, to provide those we serve with the best possible care, striving to achieve the highest levels of health and health outcomes.

To continue to make progress toward that vision, we appreciate the need for continued innovation in science and practice. We will be working on several important themes related to quality and outcomes. While these concepts are at different stages of development, we believe that it is important to identify areas requiring innovation and additional planning. The emerging focus areas are described within each of the *Quality Strategy* priority areas below.

**Improve Patient Safety**

*Reduce provider-preventable conditions through implementation of section 2702, ACA.* Working closely with stakeholders, the Department will reduce preventable adverse events known at Provider-Preventable Conditions (PPCs). PPCs include events such as: a foreign object retained after surgery, advanced pressure ulcers, falls and trauma, and surgical site infections. They also include so-called never events involving surgery: wrong procedure, wrong site, and wrong patient.

*Reduce Opiate-Related Morbidity and Mortality.* According to national data tracked by the Centers for Disease Control and Prevention, opiate-related morbidity and mortality has been increasing dramatically in the last few years. The problem is complex involving providers, patients, and the health care system, more broadly. Besides the human toll, economic costs attributable to medical care and society, in general, are substantial. Furthermore, the magnitude of opiate-related morbidity and mortality is reportedly greater in the Medicaid population in comparison with the private sector. In response, DHCS will be convening internal and external stakeholders to develop an effective action plan to address this critical health area. The plan will include collecting and analyzing the data and information to characterize the nature and magnitude of the problem in the Medi-Cal Program and developing effective policies and programs to reduce the adverse impact of opiates.

**Deliver Effective, Efficient, Affordable Care**

*Improve data quality and systems, data management and analytic capacity.* Data and information are the foundation for the entire *Quality Strategy*. To provide senior leadership in this area, DHCS appointed Linette Scott, MD, MPH as Chief Medical Information Officer. Substantial progress has been made to enhance the flow of data to drive health care and organizational decision-making. For example, in December 2012, DHCS was awarded a $2 million, two-year grant from CMS to improve the ability to collect, report, and advance adult quality metrics.
As part of the Cal MediConnect Program, the CMIO and Medi-Cal Managed Care Division have been leading a business process improvement project to improve the quality of encounter data received from managed care plans. Encounter data is necessary to support robust program evaluation and quality measurement. Additional organizational improvements to support information management in DHCS are being driven by requirements of the Medicaid Information Technology Architecture (MITA), which emphasizes use of national standards, automation, and improved efficiencies.

**Health care payment reform.** California was recently awarded a $2.7 M State Innovation Model (SIM) Design Grant from the Center for Medicare and Medicaid Innovation (CMMI). This grant will be used to develop a State Health Care Innovation Plan to improve health care quality and to reward value versus volume by changing payment structures. As a major component of the state’s health care system, DHCS is actively engaged in the policy work funded by the SIM grant, and views it as a tremendous opportunity to advance the linked goals of: 1) improving health; 2) improving care; 3) and reducing cost. The Department will be engaged with multiple external stakeholders in both the public and private sectors to implement the State Health Care Innovation Plan.

**Engage Persons and Families in their Health**

**Social media.** One of the promising ways to engage members, patients, and families in their care is through the use of social media. The availability of cell phones and smartphones is increasing rapidly in low-income populations and therefore represents an important channel of two-way information sharing and engagement. In addition, there are a growing number of applications that may have health-promoting uses including: Facebook, Twitter, Pinterest, text messaging, and others. In April 2013, the Department launched a prevention-focused Facebook page called “Welltopia by the California Department of Health Care Services.” Welltopia provides information, free applications, videos, and more on nutrition, physical activity, smoking cessation, and stress management. It also creates a space for community members to share their ideas about healthy living. Visit Welltopia at [https://www.facebook.com/DHCSWelltopia](https://www.facebook.com/DHCSWelltopia).

**Listen to the voices of members, patients, and families.** Central to the concept of member- and patient-centered care is the need to directly engage members, patients, and families to understand the care experience from their perspective, to assess their needs, to gather their recommendations, and to develop more effective programs and policies that best serve identified needs. A number of channels are being considered including focus groups and community roundtable discussions, advisory panels, and webinars. We are aware that partners and stakeholders have extensive experience in this area and hope to build on their successful approaches.

**Enhance Communication and Coordination of Care**

**Improve care for super utilizers.** Identifying so-called “super-utilizers” using “hot-spotting” techniques has garnered national attention through the work of Jeffrey Brenner, MD (Camden
Appendix B

Coalition of Health Care Providers) and others. It is well known, now, that health care utilization in Medicaid populations is typically skewed where 5% of members account for approximately 50% of health care expenditures. In Camden, NJ, Dr. Brenner observed that 1% of residents accounted for 30% of health care costs. The good news is that there is a growing body of experience from many different parts of the country, including California, demonstrating that effective models of intensive case management can show dramatic improvements in health and health outcomes accompanied by equally dramatic reductions in costs, achieving the Triple Aim. We intend to work closely with partners in academia and the community to explore this promising area that uses data to drive breakthrough improvements in quality.

*Improve palliative and end-of-life care.* One of the goals in the *Let’s Get Healthy California Task Force Report* is to maintain dignity and independence at the end-of-life. This goal speaks to the importance of quality of life in the provision of health care. In addition, engaging members, patients, and families to ensure that personal preferences and values are respected is very relevant to this goal. We will be exploring the indicators identified by the Let’s Get Healthy California Task Force to determine what can be done at DHCS to improve palliative and end-of-life care.

*Coordinate physical and behavioral health.* The prevalence of mental health and alcohol/drug concerns are high in many low-income populations. Many individuals have both physical and behavioral health needs that require coordinated care if improvements in overall health are to be achieved. The recent incorporation of mental health services and alcohol and drug treatment programs into DHCS provides an important opportunity to look at care delivery in a more comprehensive way. Using data and best evidence, we will be working to better bridge physical and behavioral health service delivery to improve clinical quality and population health.

*Advance adoption of health information technology (HIT) and health information exchange (HIE).* One of the five priorities for the EHR Incentive Program is to engage patients and families in their care. This has been seen across the state with increased adoption of personal health records and the use of the “Blue Button.” DHCS plans to follow the Medicare model and develop the “Blue Button” capacity so that members can view their personal health information represented by claims and other reporting mechanisms. Another priority for the EHR Incentive Program is care coordination. In partnership with other Health Information Technology for Economic and Clinical Health (HITECH) programs in California and nationally, DHCS has supported the development of health information exchange capacity in the state and recognizes the critical role technology will play in supporting payment reform efforts such as DSRIP and Cal MediConnect Program.

*Advance Prevention*

*Reduce smoking prevalence.* Effective prevention strategies call for a system-based approach. DHCS will ensure that prevention activities are scaled up to have a population-wide effect. For example, our five-year, $10 million Medi-Cal Incentives to Quit Smoking Program is an important component of a larger effort to significantly reduce the smoking prevalence among the approximately 700,000 Medi-Cal members who currently smoke. To achieve this reduction,
DHCS is working with its managed care plans to provide the best standard of care for tobacco cessation, including: the availability of all seven Food and Drug Administration-approved medications to treat tobacco use; eliminating barriers for tobacco treatment benefits (e.g., co-pays, cost sharing, utilization restrictions, and Treatment Authorization Requests); and ready access to individual, group, and telephone counseling. DHCS is also committed to providing physician education to ensure the system-wide use of “Ask, Advise, and Refer,” as well as helping long term care facilities, including mental health facilities, substance abuse centers, and nursing homes, to adopt smoke-free campus policies.

*Improve nutrition and physical activity.* The prevalence of overweight and obesity requires immediate attention. We are committed to working with partners in public health, such as the Network for a Healthy California, and health care to develop, test, and implement programs to address obesity in a systematic fashion. It is too complex a problem to address any other way.

*Other prevention activities.* We are committed to improving breastfeeding and immunization rates among Medi-Cal members, as well as using the scientific literature and examples from the field to identity high-value interventions that have been underutilized (e.g., aspirin prophylaxis for appropriate high-risk populations and alcohol screening and counseling). Because the great majority of Medi-Cal members will be served by managed care plans, we also will be conducting regular surveys aimed at assessing prevention efforts in nutrition, physical activity, smoking, behavioral health, among others.

*Fostering Healthy Communities*

*Strengthen the link between health care and public health.* There is a need to create a stronger bridge between health care and public health to transform our disease management, sick care system into a true health care system that addresses population health. This is especially critical given that merely four modifiable health behaviors—lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption—are responsible for much of the illness, suffering, and early death related to chronic disease. DHCS recognizes the importance of the collaboration between medicine and public health, acknowledging that behavioral patterns, social circumstances, and environmental exposures oftentimes have unfavorable effects on health outcomes. To that end, DHCS is investigating models of care and patient navigation approaches that connect the health care delivery system with community resources to address the social determinants of health, including access to food, housing, education, job placement, and other social factors.

The health care, public health interface is growing stronger through collaborations among DHCS, the California Department of Public Health (CDPH), and the California Department of Social Services (CDSS). As an example, DHCS is collaborating with CDPH and CDSS to increase CalFresh enrollment among the 1.2 million Medi-Cal members who are eligible but not currently enrolled. In addition, strong collaboration and coordination exists between CDPH’s Tobacco Control and Diabetes Programs and our Medi-Cal Incentives to Quit Smoking Program. Many public health and health care partners have also contributed content to the Department’s Welltopia Facebook page.
Eliminate Health Disparities

Increase understanding of health disparities. The Let’s Get Healthy California Task Force Report identified a number of specific priorities and indicators that could be used to help eliminate health disparities. The Department is currently developing a series of fact sheets using available metrics to begin to characterize identifiable health disparities in populations served by DHCS. Once identified, we will work with stakeholders and partners to develop aggressive intervention plans to eliminate addressable disparities. As part of this partnership work, we are developing an interagency agreement with the CDPH Office of Health Equity to optimize effectiveness and efficiency in our shared efforts to eliminate health disparities.

Quality Strategy Coordination

On behalf of DHCS senior leadership, Neal Kohatsu, MD, MPH, Medical Director, coordinates the development, implementation, and evaluation of the Quality Strategy in partnership with stakeholders. In addition, DHCS has developed an Interagency Agreement with the U.C. Davis (UCD) Institute for Population Health Improvement directed by Kenneth W. Kizer, MD, MPH, Distinguished Professor, UCD School of Medicine and the Betty Irene Moore School of Nursing.

Dr. Kizer and associates are providing thought leadership, technical assistance, consultation, and training for the Department, including advancing the DHCS Quality Strategy. IPHI support is provided using an integrated approach through the MCQuIP. Key associates within MCQuIP include: Desiree Backman, DrPH, MS, RD, Chief Prevention Officer; Ulfat Shaikh, MD, MPH, Clinical Quality Officer; and Brian Paciotti, PhD, Quality Scientist. Dr. Kizer has also established the Medi-Cal Performance Advisory Committee (MPAC), which is a multi-disciplinary group of prominent QI thought leaders from academia, health plans, hospitals, foundations, and local government. MPAC provides important perspectives to help IPHI provide the most useful, evidence-based recommendations to advance quality and health.

Summary

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

Summary of the National Quality Strategy

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

Three Aims. The NQS will pursue three broad aims:

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

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

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

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

1. Person-centeredness and family engagement, including understanding and valuing patient preferences, will guide all strategies, goals, and health care improvement efforts;
2. Specific health considerations will be addressed for patients of all ages, backgrounds, health needs, care locations, and sources of coverage;

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3. Eliminating disparities in care—including but not limited to those based on race, color, national origin, gender, age, disability, language, health literacy, sexual orientation and gender identity, source of payment, socioeconomic status, and geography—will be an integral part of all strategies, goals and health care improvement efforts;

4. Attention will be paid to aligning the efforts of the public and private sectors;

5. Quality improvement will be driven by supporting innovation, evaluating efforts around the country, rapid-cycle learning, and disseminating evidence about what works;

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

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

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

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

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

Related National Quality Initiatives

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

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

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

2. Help patients heal without complication. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased such that all hospital readmissions would be reduced by 20% compared to 2010. Achieving this goal would mean more than 1.6 million patients will recover from illnesses without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.
DHHS will be using $1 billion from the ACA to address these goals. It is anticipated that other entities from the public and private sectors also will be committing resources to PfP.

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2011 Baseline</th>
<th>2017 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin use for people at high risk</td>
<td>47%</td>
<td>65%</td>
</tr>
<tr>
<td>Blood pressure control</td>
<td>46%</td>
<td>65%</td>
</tr>
<tr>
<td>Effective treatment of high cholesterol (LDL-C)</td>
<td>33%</td>
<td>65%</td>
</tr>
<tr>
<td>Smoking prevalence</td>
<td>19%</td>
<td>17%</td>
</tr>
<tr>
<td>Sodium intake (average)</td>
<td>3.5g/day</td>
<td>20% reduction</td>
</tr>
<tr>
<td>Artificial trans fat consumption (average)</td>
<td>1% of calories/day</td>
<td>50% reduction</td>
</tr>
</tbody>
</table>
Appendix C: Health Disparities in the Medi-Cal Population Fact Sheets
The California Department of Health Care Services’ (DHCS) vision is to preserve and improve the physical and mental health of all Californians. DHCS works closely with health care providers, health plans, advocacy groups, and local government, among others, to ensure that health care services are available and accessible for low-income individuals and families and persons with disabilities. DHCS finances and administers a number of health care delivery programs, including the California Medical Assistance Program (Medi-Cal), California Children’s Medical Services Program, Child Health and Disability Prevention Program, and Genetically Handicapped Persons Program.¹ To achieve high-quality, equitable health care delivery within these programs, it is important to identify health disparities among the population served and work to eliminate such disparities. DHCS has made a strong commitment to eliminate health disparities, and this commitment is reflected in the Department’s newly-updated Strategic Plan and the DHCS Strategy for Quality Improvement in Health Care.²

DHCS has produced a set of fact sheets, titled Health Disparities in the Medi-Cal Population, to explore potential inequalities in various health indicators among Californians. The Department elected to use the 39 health indicators presented in the California Health and Human Services Agency’s Let’s Get Healthy California Task Force Final Report, as a starting point for the fact sheets.³ The report is a product of Governor Brown’s Executive Order B-19-12, establishing the Let’s Get Healthy California Task Force to “develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity.”⁴ The Executive Order directed the Task Force to issue a report in December 2012, with recommendations for how California can make progress toward becoming the healthiest state in the nation over the next decade.

Health Disparities in the Medi-Cal Population provides a snapshot of the health of Medi-Cal members from various backgrounds, compared to the state population, so that health organizations, government officials, policymakers, and advocates can better understand possible disparities. The initial suite of fact sheets includes 24 of the 39 indicators from the Let’s Get Healthy California Task Force Final Report. Click here to review the list of fact sheets. As you review the fact sheets, link to the Data Sources and Methods to understand how the data were gathered and analyzed, as well as any limitations about the data.

In the future, more health topics will be examined such as smoking among adolescents and adults, nonfatal child maltreatment, diabetes prevalence, and hospice enrollment. In addition, other social strata and groups will be explored.


Link to Data Sources and Methods

Fall 2013
THE DEPARTMENT OF HEALTH CARE SERVICES (DHCS) WOULD LIKE TO ACKNOWLEDGE THE AUTHORS OF HEALTH DISPARITIES IN THE MEDI-CAL POPULATION FOR THEIR EXCELLENT WORK IN DEVELOPING THESE FACT SHEETS AND THEIR DEDICATION TO IMPROVING THE HEALTH OF CALIFORNIANS.

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Link to Data Sources and Methods

**Fall 2013**
The Centers for Disease Control and Prevention define infant mortality as the death of a baby before his or her first birthday. About 25,000 infants die each year in the United States, and there are significant differences by age, race, and ethnicity. African American infants have twice the infant mortality rate as White infants.1

Of the 6 babies that die for every 1,000 births, most die as a result of serious birth defects, being born too small or early, Sudden Infant Death Syndrome, maternal complications, or are victims of injuries.1

In 2010, the infant mortality rate for the state of California was 4.7 per 1,000 births.2 The infant mortality rate for Medi-Cal members in 2010 was slightly higher at 5.5 per 1,000.3 Infant mortality rates varied by race/ethnicity with African Americans and people classified as “Other” or “Unknown” having substantially higher rates as compared to Whites, Latinos, and Asians/Pacific Islanders. For all of the racial/ethnic groups, infant mortality rates were higher among Medi-Cal members as compared to the non-Medi-Cal population. The differences, however, were largest among African Americans, Other/Unknown, and Whites.

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Link to Data Sources and Methods
The field of public health can be proud of its successes with vaccines—smallpox has been eradicated and other serious diseases are now much less of a threat. Indeed, vaccines may be our best defense against infectious diseases. The success story of vaccines also has some unintended side effects. With many infectious diseases becoming rare, many people see these as less of a threat and decide not to vaccinate their children. In addition, fears about side effects of vaccines have resulted in public protests about the dangers of vaccination, resulting in a growing number of parents not vaccinating their children.

The Let’s Get Healthy California Task Force Final Report showed that vaccination rates for all doses of recommended vaccines among California children aged 19 to 35 months was about 68%, slightly lower than the national rate of 70%. Medi-Cal claims and encounter data could not provide a directly comparable measure to the overall California rate, but it was possible to evaluate if racial/ethnic disparities might exist. The Figure shows that Asians/Pacific Islanders and Latinos were slightly more likely to be vaccinated as compared to African Americans and Whites. Although Medi-Cal quality reports have shown relatively low immunization rates among Medi-Cal members, it is likely that some of the low immunization rates shown in the Figure are at least partially related to incomplete claims and encounter data within this domain.

### Figure

#### Medi-Cal Patients’ Immunizations by Second Birthday, by Race/Ethnicity, 2011-2012

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>White</th>
<th>Latino</th>
<th>African American</th>
<th>Native American</th>
<th>Asian/PI</th>
<th>Other/Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella</td>
<td>60%</td>
<td>40%</td>
<td>20%</td>
<td>80%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td>80%</td>
<td>60%</td>
<td>40%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>MMR</td>
<td>80%</td>
<td>60%</td>
<td>40%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>DTaP</td>
<td>80%</td>
<td>60%</td>
<td>40%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>80%</td>
<td>60%</td>
<td>40%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Polio</td>
<td>80%</td>
<td>60%</td>
<td>40%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>80%</td>
<td>60%</td>
<td>40%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>80%</td>
<td>60%</td>
<td>40%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Influenza</td>
<td>80%</td>
<td>60%</td>
<td>40%</td>
<td>20%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Note: Members eligible for both Medicare and Medicaid were excluded; Patients 2 years old at the end of the report; PI= Pacific Islander; MMR = Measles, Mumps, and Rubella; DTaP = Diphtheria, Tetanus, and Pertussis.


Link to Data Sources and Methods

Fall 2013
Appendix C

Health Disparities in the Medi-Cal Population

Adverse Childhood Experience

Adverse Childhood Experiences (ACE) include psychological, physical and sexual abuse, neglect, and other family dysfunction experienced before the age of 18. Studies have shown a strong dose-response relationship between ACEs and negative health outcomes, including risky behaviors, mental disorders, physical illness, overall poor quality of life, and early death.1-3 Research has noted that ACEs are widely prevalent among California’s general adult population.4 It is therefore important to prevent ACEs.

Among adult Californians, Whites and Latinos reported higher rates of experiencing at least one type of ACE and Asians/Others reported the lowest rates (see Figure).

A similar pattern was found in the California adult Medi-Cal population with Whites and Latinos reporting higher rates of experiencing at least one type of ACE than African Americans and Asians/Others. With the exception of Whites, all race/ethnicity rates of ACEs were slightly higher for the statewide California population than in the Medi-Cal population.

Figure


Education in general is likely to be associated with health outcomes later in life. A recent meta-analysis found a clear association between education and health that cannot be explained by income, employment, or family background. Educational achievement in turn may be related to early success with reading. For example, reading proficiency at the end of third grade is associated with high school graduation.

Third grade may be a transition point when kids start to use reading as a tool for learning, and students with less proficiency may have a difficult time performing well across academic subjects.

In 2012, 48% of third graders were reading at an advanced or proficient level (boys 45%; girls 50%). Education data were not specific to the Medi-Cal population, but reports from the Standardized Testing and Reporting system were available for "economically disadvantaged" and "not economically disadvantaged" as well as by race/ethnicity. The California Department of Education classifies children as economically disadvantaged if they participate in the free or reduced price meal program, or if their parents’ education level was coded as "not high school graduate." All economically disadvantaged third graders, regardless of race/ethnicity, experienced much lower reading proficiency rates as compared to those who were not economically disadvantaged (see Figure). Asians had the highest proficiency rates, followed by Whites.

Figure

<table>
<thead>
<tr>
<th>Economic Status</th>
<th>Asian</th>
<th>White</th>
<th>Pacific Islander</th>
<th>Latino</th>
<th>African American</th>
<th>Native American</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economically Disadvantaged</td>
<td>60%</td>
<td>45%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Not Economically Disadvantaged</td>
<td>80%</td>
<td>50%</td>
<td>80%</td>
<td>60%</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>


Link to Data Sources and Methods

Asthma is the most prevalent condition among infants and children up to age 17. There are nearly 1.5 million children in California that have asthma, and the condition makes it difficult for this group to exercise, play, and attend school. The causes of asthma are complex, but there are risk factors such as exposure to air pollution that are at least partially modifiable.

There is evidence that children unable to manage their asthma tend to utilize emergency departments (ED) at increased rates. As such, better management of this chronic disease is critical to reducing ED visits and improving the quality of life for children with asthma.

The statewide ED visit rate for asthma was 73.0 per 10,000 children aged 0 to 17. This was similar to the rate for the Medi-Cal population of 72.6 per 10,000. As with Californians overall, there were strong racial/ethnic disparities among children in the Medi-Cal program. For example, African Americans were over eight times more likely than Asians/Pacific Islanders to visit the ED for asthma-related complications (see Figure below).

**Figure**

<table>
<thead>
<tr>
<th>Number of Visits per 10,000 Population</th>
<th>African American</th>
<th>White</th>
<th>Latino</th>
<th>Native American</th>
<th>Other</th>
<th>Asian/Pacific Islander</th>
</tr>
</thead>
</table>
| Source: Numerators: Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data, 2010; Denominators: Medi-Cal MIS/DSS, 2010. Note: Members eligible for both Medicare and Medicaid were excluded.

Link to Data Sources and Methods

Physical activity is associated with many positive health outcomes. For children, it is important to develop an active lifestyle in the early years of life, since habits from early childhood through adolescence may influence habits in adulthood. Moreover, the increasing prevalence of childhood obesity suggests that poor diet and physical inactivity need to be improved for immediate health impacts.

California students in grades five, seven, and nine receive a physical fitness test called the FITNESSGRAM®. The six-part test is used to evaluate levels of fitness that offer protection from diseases associated with inactivity. The test showed that children categorized as “economically disadvantaged” or “not economically disadvantaged” differ in their ability to complete all of the six fitness requirements. The California Department of Education classifies children as economically disadvantaged if they participate in the free or reduced price meal program, or if their parents’ education level was coded as “not high school graduate.”

As shown in the Figure below, economically disadvantaged children—those more likely to be in the Medi-Cal system—were less likely to complete all six of the fitness requirements. In addition, there were substantial disparities by race/ethnicity. Native Americans, Pacific Islanders, Latinos, and African Americans were less likely to meet all six fitness requirements as compared to Whites and Asians.

**Figure**

![2011-2012 California Physical Fitness Report](image)


In the 2008 Physical Activity Guidelines for Americans, the United States Department of Health and Human Services recommended that children and adolescents engage in at least one hour of moderate or vigorous physical activity each day. In fact, there is strong evidence that physical activity reduces the risk of chronic diseases (diabetes, cardiovascular disease, obesity, etc.), depression, and anxiety, and leads to favorable body composition in children and adolescents. Meeting this recommendation can lead to better health outcomes.

Among California adolescents, males were more likely to meet the physical activity guidelines for aerobic physical activity of at least one hour of moderate or vigorous physical activity each day compared to females (see Figure).

In the Medi-Cal population, there was a similar pattern with males being more likely to meet the physical activity guidelines for aerobic physical activity compared to females. Regardless of gender, the Medi-Cal population reported higher rates of physical activity than California adolescents as a whole.

**Figure**

<table>
<thead>
<tr>
<th>Proportion of Adolescents Who Meet Physical Activity Guidelines for Aerobic Physical Activity Among California and Medi-Cal Populations, by Gender, 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>30%</td>
</tr>
<tr>
<td>Medi-Cal</td>
</tr>
</tbody>
</table>

Source: AskCHIS, California Health Interview Survey, 2009.


**Link to Data Sources and Methods**

Fall 2013
Sugar-sweetened beverages (SSBs), like sodas and energy drinks, are the largest source of added sugar and are associated with increased rates of obesity and other chronic health conditions. Adolescents consume the most SSBs compared to other age groups. Research has noted that adolescents who drink more SSBs are more likely to eat high-calorie, low-nutrient foods. Some studies have shown that the intake of SSBs among California adolescents has increased in the past decade.

Among California adolescents, the Multiracial group and Latinos were most likely to consume two or more SSBs a day, while Whites and Asians/Others were the least likely (see Figure).

In the California Medi-Cal population, Latino adolescents were most likely to drink two or more SSBs a day as compared to White and African American adolescents. Except for African Americans, Medi-Cal adolescents reported higher rates of SSBs than the general California adolescent population. Due to small sample sizes, however, the percentages for Multiracial and Asian/Other adolescents were statistically unstable and un-reportable.

**Figure**

Percent of California and Medi-Cal Adolescents Who Reported Drinking 2 or More Sweetened Beverages a Day, by Race/Ethnicity, 2009

Source: AskCHIS, California Health Interview Survey, 2009.

*Statistically unstable

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Link to Data Sources and Methods
Appendix C

Health Disparities in the Medi-Cal Population

It is recommended that teens eat 3.5 to 6.5 cups of fruits and vegetables each day depending on their age, sex, and physical activity level.¹ Most vegetables and fruits are major contributors of certain nutrients that are under-consumed in the United States, including folate, magnesium, potassium, dietary fiber, and vitamins A, C, and K.² Consumption of vegetables and fruits is also associated with a reduced risk of many chronic diseases, may be protective against certain types of cancer, and may help teens achieve and maintain a healthy weight.¹ ²

Among Californians, adolescent males were more likely to report eating 5 or more servings of fruits and vegetables a day compared to females (see Figure).

Conversely, in the California Medi-Cal population, adolescent females were more likely to report eating 5 or more servings of fruits and vegetables a day compared to adolescent males. Regardless of gender, the Medi-Cal population reported less daily consumption of fruits and vegetables compared to the general California population.

Figure

Rate of Consuming 5 or More Servings of Fruits and Vegetables per Day Among California and Medi-Cal Adolescents, by Gender, 2009

<table>
<thead>
<tr>
<th></th>
<th>Females</th>
<th>Males</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>30%</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>California</td>
<td>25%</td>
<td>15%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: AskCHIS, California Health Interview Survey, 2009.


Link to Data Sources and Methods

Fall 2013
According to a 2012 Institute of Medicine report, obese youth are likely to be obese in adulthood. This report also stated that overweight youth were at greater risk for other health problems, including type 2 diabetes, hypertension, asthma, early maturation, and orthopedic problems.\(^1\) Recently, several chronic diseases which had originally been considered “adult onset” are now appearing at younger ages, including type 2 diabetes and elevated blood pressure.\(^1\)\(^2\) Lastly, research has noted that obesity can vary by gender.\(^3\)

Body Mass Index (BMI)-for-age charts are recommended to assess weight in relation to stature for children aged 2 to 20. Adolescents aged 12 to 17 were considered obese if they had a BMI equal to or greater than the 95th percentile. Among adolescent Californians, males reported higher rates of being obese than females (see Figure).

Among California Medi-Cal adolescents, females reported higher rates of being obese than males. In addition, the Medi-Cal adolescent population was more likely to be obese than California adolescents in general.

### Figure

<table>
<thead>
<tr>
<th>Proportion of Obesity Among Adolescents, by Age and Gender for California and Medi-Cal Recipients, 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Adolescents Aged 12-17</td>
</tr>
<tr>
<td>California Population</td>
</tr>
<tr>
<td>Adolescents Aged 12-17</td>
</tr>
<tr>
<td>Medi-Cal Population</td>
</tr>
<tr>
<td>Source: AskCHIS, California Health Interview Survey, 2009.</td>
</tr>
</tbody>
</table>


**Link to Data Sources and Methods**

Fall 2013
Overall health status is a self-reported measure of a person’s perceived health over time. Research has shown that health status is related to chronic diseases (e.g., vascular events, depression, and cancer) and the risk factors for chronic diseases (e.g., stress and physical activity). Analysis of health status can identify subgroups with poor perceived health, assist in guiding interventions to improve their situations, and avert more serious consequences.

In California, the Multiracial group was more likely to report that their overall health status was good, very good, or excellent (90.4%), followed by Whites (90.0%), Asians/Others (84.5%), African Americans (83.5%), and Latinos (77.3%) (see Figure).

In the California Medi-Cal population, the Multiracial group again was more likely to report that their overall health status was good, very good, or excellent (80.0%), followed by Latinos (78.6%), African Americans (74.7%), Whites (73.9%), and Asians/Others (60.3%). Regardless of race/ethnicity, the Medi-Cal population reported lower rates of overall health status than the general California population.

**Link to Data Sources and Methods**

Health Disparities in the Medi-Cal Population

Adult Physical Activity

In the 2008 Physical Activity Guidelines for Americans, the United States Department of Health and Human Services recommended that adults engage in at least 150 minutes of moderate-intensity physical activity each week or 75 minutes a week of vigorous-intensity aerobics. Research has shown that physical activity can lower the risk of early death, coronary heart disease, stroke, high blood pressure, type 2 diabetes, breast and colon cancer, depression, and cognitive impairment in older adults.1

Among California adults, Whites were most likely to report 150 or more minutes of physical activity each week, while Latinos were the least likely (see Figure).

In the Medi-Cal adult population, Asians/Others and Whites were more likely to report 150 or more minutes of physical activity each week as compared to African Americans and Latinos. For all race/ethnicity groups except Asian/Other, the Medi-Cal population reported lower rates of physical activity than the general California adult population.

Figure


Link to Data Sources and Methods
Sugar-sweetened beverages (SSBs), like sodas and energy drinks, are the largest source of added sugar and are associated with increased rates of obesity and other chronic health conditions such as high blood pressure.\(^1\)\(^2\) It has been noted that SSBs are associated with consumption of salty foods and fast foods.\(^5\) Lastly, research has shown a higher intake of SSBs in low-income populations than high-income populations.\(^6\)

Among California adults, Latinos and African Americans were the most likely to consume an estimated two or more SSBs a day, while Whites and Asians/Others were the least likely (see Figure).

In the California Medi-Cal population, Multiracial adults were most likely to drink an estimated two or more SSBs a day as compared to African American, White, Latino, and Asian/Other adults. Regardless of race/ethnicity, the Medi-Cal population reported higher rates of SSBs than the California population, in general.

**Figure**

Percent of Sweetened Beverages Consumed per Month (60 or More) Among California and Medi-Cal Adults, by Race/Ethnicity, 2009

![Bar chart showing percentage of sweetened beverages consumed per month among California and Medi-Cal adults by race/ethnicity.

Source: AskCHIS; California Health Interview Survey, 2009.

**Link to Data Sources and Methods**

Medi-Cal claims and encounter data suggested that about 7.23% of all members had an episode of care related to hypertension between July 1, 2011 and June 30, 2012. To identify possible disparities by race/ethnicity, the Figure below shows the percent of hypertensive Medi-Cal members adherent to four types of prescribed medications used to manage hypertension. Whites and Asians/Pacific Islanders were slightly more likely to adhere to ACE-Inhibitors, Beta-Blockers, and Calcium Channel Blockers, while Native Americans and Asians/Pacific Islanders were slightly more likely to adhere to Angiotensin II Receptor Antagonists.

Figure

Medi-Cal Hypertension Patients Adherent to Prescribed Medications, by Race/Ethnicity, 2011-12

ACE-Inhibitor

Angiotensin II Receptor Antagonist

Beta-Blocker

Calcium Channel Blocker

Note: Members eligible for both Medicare and Medicaid were excluded; ACE = angiotensin-converting enzyme; PI = Pacific Islander.


Link to Data Sources and Methods
According to a 2012 Institute of Medicine report, two-thirds of adults in the United States are overweight or obese and the proportion of those who are obese has more than doubled since 1976-1980. Some of the health consequences of obesity include high blood pressure, high cholesterol, cardiovascular disease, and diabetes.\(^1\) Many of the health care costs of these chronic diseases are paid for with public dollars. It has been estimated that total Medicare and Medicaid spending reductions would be 8.5% and 11.8%, respectively, in the absence of obesity.\(^2\)

Adults with a Body Mass Index (BMI) of 25 to 29.9 are defined as overweight and those with a BMI of 30 and above are classified as obese. Among adult Californians, Latinos and African Americans reported higher rates of being overweight and obese than Whites and Asians/Others (see Figure).

In the adult Medi-Cal population, Latinos and Asians/Others reported higher rates of being overweight than Whites and African Americans. The highest rates for obesity were among Whites and African Americans and the lowest was among Asians/Others. Medi-Cal adults were more likely to report being overweight than California adults only in the Asian/Other population. Regardless of race/ethnicity, however, Medi-Cal adults were more likely to report being obese compared to California adults. Due to the small number of Asian/Other adults in the sample, results for this group should be interpreted with caution.

Figure

**Rate of Being Overweight and Obese Among California and Medi-Cal Adults, by Race/Ethnicity, 2011**


Link to Data Sources and Methods

Fall 2013
Depression involves five or more symptoms such as sad mood or diminished interest that are continuously present for at least two weeks.\(^1\) Depression among adolescents is influenced by stressful events and changes associated with maturing, sex hormones, and interpersonal conflicts.\(^2\) Research has shown that adolescent girls are twice as likely as boys to experience depression.\(^3\)

The *Let's Get Healthy California Task Force Final Report* provided survey data that suggested about one-third of 7th, 9th, and 11th graders experienced sad or hopeless feelings in the past 12 months.\(^4\) In a national survey, 8.0% of 12 to 17 year olds reported a “major depressive episode.”\(^5\) Unfortunately, one report suggested that only 38.9% of adolescents who experienced at least one major depressive event in the last year received treatment for major depression.\(^6\)

Medi-Cal claims and encounter data suggested that about 1.7% of adolescents between the age of 12 and 17 received medical treatment for depression. Although possibly related to data quality problems such as incomplete reporting of managed care encounter data, there were racial/ethnic disparities associated with treatment of depression (see Figure). Native Americans and Whites were more likely than other groups to receive treatment for a major depression event. The rate for Asians and Pacific Islanders was substantially lower.

**Figure**

![Health Disparities in the Medi-Cal Population](Image)

**Medi-Cal Adolescents Aged 12-17 with Claims or Encounters Related to Major Depression, by Race/Ethnicity, 2010**

- **White**: 30 events per 1,000
- **Native American**: 20 events per 1,000
- **African American**: 10 events per 1,000
- **Latino**: 10 events per 1,000
- **Other/Unknown**: 5 events per 1,000
- **Asian/Pacific Islander**: 2 events per 1,000

Source: Medi-Cal MIS/DSS and Symmetry ETG Groupers, 2010 Ver. 8.0.

Note: Members eligible for both Medicare and Medicaid were excluded.

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5. National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration.
Depression involves five or more symptoms such as sad mood or diminished interest that are continuously present for at least two weeks. Major depression affects between 5% and 10% of patients in primary care settings, and often goes undiagnosed and untreated. Depression has negative impacts on interpersonal relationships and one's ability to perform in the workplace. In addition, depression is associated with suicide and other adverse health behaviors such as smoking, alcohol consumption, physical inactivity, and sleep disturbance.

The *Let's Get Healthy California Task Force Final Report* reported that 6% of California adults have experienced a Major Depressive Episode. Medi-Cal claims and encounter data suggested that about 4.9% of adults (aged 18-64) received some type of medical treatment for depression. Although possibly related to data quality problems such as incomplete reporting of managed care encounter records, there were racial/ethnic disparities associated with treatment of depression (see Figure). Whites and Native Americans were more likely than other groups to receive treatment for a major depression event. The rate for Asians and Pacific Islanders was substantially lower.

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**Health Disparities in the Medi-Cal Population**

**Adult Depression**

Depression involves five or more symptoms such as sad mood or diminished interest that are continuously present for at least two weeks. Major depression affects between 5% and 10% of patients in primary care settings, and often goes undiagnosed and untreated. Depression has negative impacts on interpersonal relationships and one’s ability to perform in the workplace. In addition, depression is associated with suicide and other adverse health behaviors such as smoking, alcohol consumption, physical inactivity, and sleep disturbance.

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**Figure**

![Figure](image.png)

*Medi-Cal Adults with Claims or Encounters Related to Major Depression, by Race/Ethnicity, 2010*

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Events per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>20</td>
</tr>
<tr>
<td>Native American</td>
<td>40</td>
</tr>
<tr>
<td>African American</td>
<td>60</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>80</td>
</tr>
<tr>
<td>Latino</td>
<td>100</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: Medi-Cal MIS/DSS and Symmetry ETG Groupers, 2010 Ver. 8.0. Members eligible for both Medicare and Medicaid were excluded.

**Link to Data Sources and Methods**

Colorectal cancer involves abnormal cell growth in the colon or rectum. Following lung cancer, colorectal cancer is the second leading cause of cancer death in the United States. Risk factors include age, presence of polyps, personal/family history, diet, exercise, and smoking.¹

Colorectal cancer screening includes sigmoidoscopy, colonoscopy, and fecal occult blood testing to detect problems before symptoms emerge.² There is evidence that colorectal cancer screening saves lives.¹,³ Given this evidence, the U.S. Preventive Services Task Force recommends colorectal cancer screening for men and women aged 50 to 75.¹

Claims and encounter data from the Medi-Cal data warehouse were used to create a Healthcare Effectiveness Data and Information Set (HEDIS) quality indicator to measure patients 50 to 75 years of age that received appropriate screening for colorectal cancer (see Figure). Screening rates were substantially higher for Asians/Pacific Islanders and Others. Whites and Latinos form a middle group, with Native Americans and African Americans having the lowest rates.

Figure

<table>
<thead>
<tr>
<th>Hospitalizations per 100,000 Population</th>
<th>African American</th>
<th>Asian/Pacific Islander</th>
<th>White</th>
<th>Latino</th>
<th>Native American</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Pacific Islander</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Other</td>
<td>15%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>White</td>
<td>25%</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
<td>0%</td>
</tr>
<tr>
<td>Latino</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Native American</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>African American</td>
<td>10%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>


Note: Members eligible for both Medicare and Medicaid were excluded.


Link to Data Sources and Methods

Fall 2013
Palliative care programs help people and their families manage the pain and stress of serious diseases rather than to treat or seek a cure. As a specialized type of medical care, palliative care can increase patients’ quality of life and in some instances extend life. It can also provide options about how and where to manage terminal illnesses.1 Studies showed that palliative care programs can reduce costs.1-3 Based on surveys of California hospitals, between 2007 and 2011, pediatric palliative care increased by 128% and adult palliative care increased by 24%. In 2011, 53% of California hospitals had some type of palliative care program.1

It is important to understand the degree to which Medi-Cal members have access to palliative care. One important initiative has led to a 3-fold increase in palliative care programs in California public hospitals (from 4 to 12).4 The Figure below shows the number of hospitals in three groups categorized by the number of Medi-Cal hospital discharges per year. The Figure then shows the proportion of the hospitals with palliative care programs.5 For example, there were 185 hospitals with between 500 and 5,000 Medi-Cal discharges per year, and within this group, 96 (48%) of the hospitals had a palliative care program. Hospitals that treat a large number of Medi-Cal members each year generally have palliative care programs.

Figure

<table>
<thead>
<tr>
<th>Number of Hospitals</th>
<th>Hospitals With Palliative Care Program</th>
<th>Hospitals Without Palliative Care Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>500 - 5,000</td>
<td>100</td>
<td>90</td>
</tr>
<tr>
<td>5,000 - 10,000</td>
<td>60</td>
<td>35</td>
</tr>
<tr>
<td>10,000+</td>
<td>40</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: UCSF Palliative Care Survey of California Hospitals; Office of Statewide Health Planning and Development (OSHPD) facility reports, 2011.

1. California Healthcare Foundation. When compassion is the cure: Progress and promise in hospital-based palliative care. 2012 Foundation, conducted by UCSF

Link to Data Sources and Methods

Fall 2013
Health Disparities in the Medi-Cal Population

Preventable Hospitalizations

When conditions like diabetes, congestive heart failure, and asthma are managed properly in ambulatory care settings, fewer people experience acute complications that require inpatient hospitalization. Thus, many hospitalizations are preventable as a result of better access to high-quality outpatient care.

The Let's Get Healthy California Task Force Final Report provided an overall California rate of 1,243 preventable hospitalizations per 100,000 people (age-sex adjusted). For the Medi-Cal population, however, the unadjusted preventable hospitalization rate was slightly higher at 1,290 per 100,000.

Preventable hospitalizations for the Medi-Cal population are presented by race/ethnicity in the Figure below. African Americans had the highest rates, followed by Whites, Asians/Pacific Islanders, Latinos, Native Americans, and Others.

![Figure: Preventable Hospitalizations per 100,000 Medi-Cal Members, by Race/Ethnicity, 2011]


Note: Rates produced from the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators Composite, Version 4.4. Members eligible for both Medicare and Medicaid were excluded.

4. Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data, 2011.

Link to Data Sources and Methods
Health Disparities in the Medi-Cal Population

A large proportion of hospital readmissions are attributed to people with chronic diseases such as congestive heart failure and diabetes.  

Research suggests that hospital readmissions are both costly and potentially dangerous to patients. Fortunately, there is evidence that hospital readmissions can be reduced through better coordination of care. For example, clear discharge instructions and post-discharge communication may help patients better manage their own health and prevent acute episodes that require re-hospitalization. Evidence is leading to policy changes. Medicare is reducing payment for specific readmissions and Medi-Cal has started a Statewide collaborative to reduce All-Cause Readmissions using quality improvement projects.

The Let’s Get Healthy California Task Force Final Report provided an overall California readmission rate of 14.1%. The hospital readmission rate for the Medi-Cal population was higher at 18.7%.

Readmission rates vary by race/ethnicity, yet the differences were the most striking for the Medi-Cal population. For example, although there was only a small difference between the Medi-Cal and non-Medical population among Native Americans, the readmission rates were substantially different for Whites. African Americans, Latinos, Asians/Pacific Islanders, and Others also had higher rates among the Medi-Cal population, yet the relative difference was not as extreme as among Whites.

**Figure**

![Figure: 30-Day All-Cause Unplanned Readmission Rate (Unadjusted) for Medi-Cal and non-Medi-Cal Adults, by Race/Ethnicity, 2011](image)

Source: Office of Statewide Health Planning and Development (OSHPD) Discharge Data, 2011.

7. Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data, 2011.
Hospital care offers people many opportunities for improved health. However, hospital care can be potentially dangerous with a possible 98,000 or more people dying each year in the United States from hospital-acquired conditions.¹ Hospital-acquired infections—one important category of hospital-acquired conditions—are expensive with an estimated national cost between $38 and $45 billion dollars each year.² Numerous initiatives at the state and federal levels are striving to reduce hospital-acquired infections, and quality improvement programs have shown great potential to reduce hospital-acquired conditions.³

Hospital-acquired conditions averaged 0.75 per 1,000 hospital discharges for the California non-Medi-Cal population and 0.84 per 1,000 discharges for Medi-Cal members.⁴ The rates among racial/ethnic groups for the non-Medi-Cal populations are relatively similar. Within the Medi-Cal population, however, there are larger differences between racial/ethnic groups. The racial/ethnic category Other, and to a lesser extent Native Americans, have relatively higher rates as compared to African Americans, Whites, Latinos, and Asians/Pacific Islanders.

**Figure**

**Incidence of Measurable Hospital-Acquired Conditions for Medi-Cal and non-Medi-Cal Adults, by Race/ Ethnicity, 2011**

- **Events per 1,000 Discharges**
  - Medi-Cal
  - non-Medi-Cal

**Source:** Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data, 2011.
**Note:** Rates produced from the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) Composite, Version 4.4.

4. Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data, 2011.
In the 2008 *Physical Activity Guidelines for Americans*, the United States Department of Health and Human Services recommended that children and adolescents engage in at least one hour of moderate or vigorous physical activity each day. Decreased physical activity and an increased sedentary lifestyle have led to increased obesity and chronic diseases (e.g., diabetes and hypertension) among youth. Walking and biking to and from school is one way for children and adolescents to meet this recommendation, and if followed, can lead to better health outcomes.¹

Among California youth, Latinos and African Americans were most likely to walk, bike, or skate to and from school in the past week, while Whites and Asians/Others were the least likely (see Figure).

In the Medi-Cal population, there was a similar pattern with Latino and African American youth being most likely to walk, bike, or skate to and from school in the past week as compared to Multiracial, White, and Asian/Other youth. Regardless of race/ethnicity, the Medi-Cal population reported higher rates of physical activity than the California youth population.

![Figure](image)

Source: AskCHIS, California Health Interview Survey, 2009.


Link to Data Sources and Methods
Poor neighborhood safety has been associated with poor health outcomes in adults. Research has shown that a lack of neighborhood safety is associated with obesity, low physical activity, increased tobacco use in pregnant women, depression in Korean adults, and decreased adherence to diabetes self-management among adult type 2 diabetics. Overall, adults who perceive their neighborhoods to be unsafe may be less able to participate in low-cost activities (i.e., walking) and may experience increased stress. These factors may in turn lead to maladaptive coping and an inability to manage their health.

In California, White adults were more likely to report feeling safe in their neighborhood all or most of the time (95.5%), followed by the Multiracial group (94.1%), Asians/Others (89.9%), African Americans (86.3%), and Latinos (84.9%) (see Figure).

In the California Medi-Cal population, White adults were more likely to report feeling safe in their neighborhood all or most of the time (88.4%), followed by African Americans (81.2%), the Multiracial group (80.4%), Asians/Others (79.9%), and Latinos (78.3%). Regardless of race/ethnicity, the Medi-Cal population reported lower rates of feeling safe in their neighborhood as compared to the general California population.

### Figure

**Perceived Neighborhood Safety among California and Medi-Cal Adults, by Race/Ethnicity, 2009**

Source: California Health Interview Survey, 2009.

### Link to Data Sources and Methods

Appendix C

This document provides a summary of the data sources and methods that were used for each of the Health Disparities in the Medi-Cal Population fact sheets. The first section provides details about the data sources and methods for fact sheets based on survey data. The second section describes the Medi-Cal Management Information System/Decision Support System (MIS/DSS) data warehouse and how indicators were constructed from fee-for-service claims and managed care encounter data. It also covers the remaining fact sheets that use data sources produced by California government agencies (i.e., Office of Statewide Health Planning and Development (OSHPD), California Department of Public Health (CDPH), and California Department of Education (CDE)). The last section provides details about defining race and ethnicity categories for the fact sheets.

The fact sheets replicate the Let’s Get Healthy California Task Force (LGHCTF) Final Report in the California Medi-Cal population. The methods and indicators used for the fact sheets have numerous similarities to those used in the LGHCTF Final Report. First, it was possible to replicate most of the fact sheets that were based on survey data given the availability of information about Medi-Cal members. Thus, for these indicators, direct comparisons were possible between the overall California rate and the Medi-Cal population. Second, with the exception of the Preventable Hospitalizations fact sheet, rates were not adjusted for age or sex. In addition to the similarities, there were a few notable differences between the fact sheets using non-survey data and some of the indicators in the LGHCTF Final Report. Specifically, some of the data were not available to create indicators for the Medi-Cal population. Thus, proxy indicators were created that were conceptually similar, albeit different than the original indicators published in the report. In addition, for some indicators, comparisons had to be made between Medi-Cal and non-Medi-Cal rates rather than the overall California population rate. Finally, in contrast to the survey data with known or limited data quality problems, some of the non-survey indicators had more uncertainty regarding data quality. Details about these issues are found in specific sections below.

Survey Data

Some of the data for these fact sheets were collected from two Computer-Assisted Telephone Interview (CATI) surveys with a similar methodology that allows generalizability to the California state population: 1) California Health Interview Survey (CHIS) and 2) Behavioral Risk Factor Surveillance Survey (BRFSS). Where appropriate, data from both BRFSS and CHIS were weighted to the 2000 Census. Because the age, race, and sex characteristics of respondents differ somewhat from the actual age, race, and sex characteristics of the California population, both surveys used weighting adjustment developed to improve the representativeness of their samples. CHIS was administered to youth aged 12 to 17 and adults over age 18. California BRFSS was administered to adults over the age of 18.

There are limitations when analyzing survey data. There is a certain amount of respondent bias inherent in any study; study participants are usually cooperative and wish to please the interviewer. Data from anonymous and confidential telephone surveys cannot be verified and may be imprecise, especially for more sensitive topics.

The cross-sectional designs of these two surveys also have some inherent limitations. Foremost of these is the inability to determine causation between variables, occurrences, and events. Additionally, while most of the survey scales, indices, and questions were previously validated, the surveys as a whole were not tested for validity or reliability. Following is a description of the surveys and other data sources used for these fact sheets.
California Health Interview Survey

CHIS is the largest state health survey and one of the largest health surveys in the United States. It is a random-digit dial (RDD) telephone survey of households drawn from every county in California. The survey collects information from approximately 50,000 households, and it has been administered every two years since 2001. The CHIS sample is representative of the state's non-institutionalized population living in households. CHIS interviews one sample adult in each household. In households with children, CHIS interviews one adolescent aged 12 to 17 and obtains information for one child under age 12 by interviewing the adult who is most knowledgeable about the child.

The sample size for the 2009 CHIS was 59,938 (47,614 Adults, 8,945 Children, and 3,379 Adolescents). The Medi-Cal sample for CHIS included people who reported having Medi-Cal only or Medi-Cal and Medicare. CHIS covers a wide range of topics, including health status, health conditions, health-related behaviors, health insurance coverage, access to and use of health care services, and the health and development of children and adolescents. To capture the rich diversity of the California population, interviews were conducted in five languages: English, Spanish, Chinese (Mandarin and Cantonese dialects), Vietnamese, and Korean. These languages were chosen based on analysis of 2000 Census data to identify the languages that would cover the largest number of Californians in the CHIS sample that either did not speak English or did not speak English well enough to otherwise participate.

CHIS is a collaborative project of the University of California, Los Angeles (UCLA) Center for Health Policy Research, CDPH, DHCS, and the Public Health Institute. CHIS is based at the UCLA Center for Health Policy Research in Los Angeles, California. Funding for CHIS comes from state and federal agencies and from several private foundations. Questions and topics in the surveys may vary, dependent on funders' interests. To obtain the data or further information about this survey, interested parties may call (866) 275-2447 or email chis@ucla.edu.

Adolescent Fruit and Vegetable Consumption, Adolescent Physical Activity, Adolescent Sugar Sweetened Beverages Consumption, Adult Soda and Sweetened Beverages Consumption, Adolescent Obesity, Overall Health Status, and Walking, Biking, and Skating to School Fact Sheets

Data from CHIS were drawn from the public AskCHIS website at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx.

Neighborhood Safety Fact Sheet

CHIS information was not available on the public website (AskCHIS) for the Neighborhood Safety and Overall Health fact sheets; therefore, data were analyzed using public use CHIS data sets.

California Behavioral Risk Factor Surveillance Survey

BRFSS is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors among adults over age 18 in the United States annually since 1984. BRFSS provides state-specific information about issues such as diabetes, obesity, cancer screening, nutrition, physical activity, tobacco use, and more.

BRFSS is a state-based system of health surveys that generate information about health risk behaviors, clinical preventive practices, and health care access and use primarily related to chronic diseases and injury. This survey is conducted by the 50 state health departments as well as those in the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands with support from the Centers for Disease Control and Prevention (CDC). BRFSS completes more than 400,000 adult interviews nationally and over 10,000 adult interviews in California each year. California BRFSS is administered in English and Spanish. Response rates measure how successful a survey has been in reaching selected respondents. Two rates are calculated for the BRFSS, an "upper-bound" rate and a CASRO (Council of American Survey Research Organizations) rate. The overall response rate for California BRFSS data used in these fact
sheets ranged from approximately 34% to 58%, depending on the type of response rate calculated (57% to 58% for the upper-bound and 34% to 43% for CASRO). Funding for California BRFSS comes from CDC, California state programs, and several private foundations. Questions and topics in the surveys may vary dependent on funders’ interests. To obtain the data or further information about this survey, interested parties may call (916) 779-2677 or email Marta Induni at minduni@s-r-g.org. For more technical information on these surveys, please refer to the BRFSS Documentation and Technical Report.²

Adverse Childhood Experiences, Adult Physical Activity, and Adult Obesity Fact Sheets
During the analyses for the Adverse Childhood Experiences, Adult Physical Activity, and Adult Obesity fact sheets, the California BRFSS was based at the Public Health Institute’s Survey Research Group in Sacramento, California. The Medi-Cal program is specific to California; therefore, there was not a Medi-Cal variable in the CDC BRFSS dataset. These fact sheets were focused on comparing the Medi-Cal population to the California population; therefore, the California BRFSS dataset, not the CDC BRFSS dataset, was used in these analyses.

Non Survey Data

Medi-Cal Management Information System/Decision Support System
To manage and store a vast amount of data, DHCS created a data warehouse and reporting system named the MIS/DSS. MIS/DSS contains 10 years of data (about 2.5 billion records) that are extracted from approximately 30 different sources (e.g., eligibility, fee-for-service paid and denied claims, mental health claims, dental claims, and managed care encounter data). In addition, the warehouse includes numerous reference data files to help users map codes to specific labels and descriptions. For example, there are reference tables to The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9) and other Medi-Cal specific codes. MIS/DSS allows DHCS analytical staff to query specific types of claims or encounters and create analytical reports.

Three main types of Medi-Cal data were used in the fact sheets. First, eligibility data contain records for each month that a potential Medi-Cal member is eligible for services. Dual eligible members (eligible for both Medi-Cal and Medicare) were excluded because Medicare is generally the first payer. These data show when individuals are eligible for Medi-Cal services and thus are useful to construct denominators for rates. Second, there are data related to fee-for-service claims. Fee-for-service claims are submitted by providers to Medi-Cal through a fiscal intermediary for reimbursement for services. Third, managed care encounter data are collected to identify visits and services. Managed care plans are paid on a per member per month basis. Although managed care plans are not paid for individual services, they are required to submit to Medi-Cal “encounter” data for each visit. Fee-for-service claims data are known to be of higher quality in comparison to managed care encounter data given that financial reimbursement is associated with the former. Programs have recently been started, however, to improve the quality of encounter data to ensure that all data are submitted (without duplicates), data elements are correctly coded, and the data represent real health care visits. Although important achievements have been made to improve the quality of encounter data, information derived from these data should be used with caution.

In addition to claims and encounter data, the MIS/DSS system includes numerous tables derived from a product called Symmetry® to “pre-aggregate” claims and encounters into both “episodes of care” and quality indicators. Episode Treatment Groups® (ETGs®), which became available in 1993, offer a powerful way of creating episodes of care by placing inpatient, outpatient, and ancillary services into mutually exclusive and exhaustive categories. For example, if a person receives care for a broken arm, the initial visit to treat the break is specified as the “anchor” visit. Then all subsequent follow-up visits and prescriptions are linked to the anchor record to form an episode of care. Although conceptually similar to Diagnosis Related Groups (DRGs), the ETGs identify an entire episode of care regardless of whether it was inpatient or outpatient care. A benefit of using ETGs is that a variety of codes other than diagnosis codes are used to define specific...
conditions. For example, many of the ETGs are defined using procedure and revenue codes along with drug codes for specific prescriptions. Given that Medi-Cal only receives two diagnoses as defined by ICD-9 codes, and few validity checks are performed on submitted datasets, it is advantageous that the ETGs define conditions using multiple code types. Concerning quality measurement, the Symmetry® Evidence Based Medicine Connect™ (EBM Connect™) product creates over 580 quality indicators based on the claims and encounter records. Many of the EBM Connect™ quality indicators are based on algorithms that have been validated by groups such as the National Quality Forum.

Adolescent and Adult Depression Fact Sheets
The Adolescent and Adult Depression fact sheets included both fee-for-service claims and managed care encounter data from the MIS/DSS system. The Episode Treatment Groups® system version 8.0 was used to select all claims and encounters associated with episodes of care categorized as “major depression.” The eligibility data from MIS/DSS was used to estimate the number of Medi-Cal members (for the specific age groups) that were at risk of this event.

Hypertension Management, Childhood Immunizations, and Colorectal Cancer Screening Fact Sheets
The three indicators in this group of fact sheets were created using the Symmetry® Evidence Based Medicine Connect™ version 8.0. The EBM Connect™ product implements all of the “business rules” or algorithms that define over 580 quality indicators. Some of the quality indicators are national standards, thus the algorithms copy as closely as possible all of the logic that is required to construct numerators and denominators for rates (e.g., inclusion and exclusion rules). For some of the indicators, EBM Connect™ creates the appropriate cohort of patients based on specific Episode Treatment Groups. For example, the hypertension indicator is generated by first selecting all patients that had an episode of care related to hypertension. There were a few limitations with the indicators in this category. First, since it was not possible to find data sources to replicate the LGHCTF Final Report indicators for the Medi-Cal population, results from EBM Connect™ were used to look at health indicators that were conceptually similar to the original indicators. Second, by using the MIS/DSS system for these indicators data were unavailable to report comparison rates for the non-Medi-Cal population. Third, all of the indicators described here used both fee-for-service claims and managed care encounter data. Given the known limitations of managed care encounter data, the results of these four fact sheets should be viewed as preliminary until additional validation has been performed or better data and associated indicators become available. Finally, the hypertension indicator has not been validated by expert panels.

Hypertension Management. There were four separate indicators in this fact sheet to evaluate if disparities existed with regards to how well Medi-Cal members from different racial/ethnic groups managed their hypertension. These medication adherence indicators relied on pharmacy claims data and were created to determine the degree to which a patient was adhering to a prescribed medication based on prescription filling patterns. Technical staff working on validating the encounter data has found that the pharmacy claims data were generally well reported and more reliable than the medical encounters.

Childhood Immunizations. The reported childhood immunization indicators from EBM Connect™ were similar but not identical to the national standard indicators on which they were based. These indicators could not be replicated exactly because the original indicators involved a hybrid methodology of both administrative and clinical data.

Colorectal Cancer Screening. The EBM Connect™ system used a nationally validated Healthcare Effectiveness Data and Information Set (HEDIS) measure to create this colorectal cancer screening indicator. HEDIS is a set of nationally recognized performance indicators used to evaluate health plans. HEDIS national standards are based on selected HEDIS indicators that assess compliance with chronic and acute conditions, as well as preventive care.
Office of Statewide Health Planning and Development

Two datasets available from OSHPD were used for specific fact sheets listed below. First, California licensed hospitals are required to submit data to OSHPD every six months about patients that are discharged from their facilities. The Patient Discharge Dataset (PDD) includes elements related to demographics (e.g., age, gender, race/ethnicity), diagnoses and procedures, expected source of payment, total charges, length-of-stay, and additional fields related to source of admission and place of discharge. The PDD is subjected to validation rules upon submission to OSHPD and has a reputation of being a useful and high-quality dataset. Second, beginning in 2005, OSHPD began collecting encounter records associated with patients who are treated in licensed California emergency departments. Similar to the Patient Discharge Data, the Emergency Department (ED) dataset contains data elements related to demographics, treatment information, patient disposition, and expected source of payment. More information can be found on the OSHPD website: http://www.oshpd.ca.gov/HID/Products.

Analytical staff in the OSHPD Healthcare Information Division and the CDPH California Breathing unit produced information for the fact sheets below.

Hospital-Acquired Conditions Fact Sheet
The Agency for Healthcare Research and Quality (AHRQ) releases software each year to produce a variety of quality indicators using administrative hospital data. The Patient Safety Indicators (PSIs) are a set of indicators that can be used to identify potential adverse events that occur after procedures and childbirth. More information about the indicators can be found on the AHRQ website: http://www.qualityindicators.ahrq.gov/modules/psi_overview.aspx.

OSHPD staff applied the SAS software version 4.4 of the PSIs to the 2011 Patient Discharge Data (PDD). Their analysis involved a few steps. First, the PDD was modified to conform to the data specifications required to produce the PSIs. Second, important parameters were set in the AHRQ SAS software to conform to the input data, and the PSI algorithms were applied to transform patient-level data into hospital observed and risk-adjusted rates. Third, a separate SAS program was run to produce a composite PSI indicator. The PSI composite combined 11 of the individual PSIs (using various weights) into one global measure of patient safety. Finally, using an “expected payer” field available in the PDD, the OSHPD researchers stratified the composite measure by Medi-Cal and non-Medi-Cal. It is important to note that the expected payer field is known to have data reliability issues, and thus the results should be compared to other data sources. For example, a preliminary file was used to link the OSHPD patient discharge dataset to the Medi-Cal eligibility file. Using only records that matched on Social Security Number, problems were identified with the expected payer field. Staff is currently working on a more sophisticated probabilistic linkage, and when complete, this file can be used to create an updated fact sheet. For the current fact sheet, however, it is likely that the “expected payer” field is robust enough to present preliminary results.

Preventable Hospitalizations Fact Sheet
In addition to the PSIs, AHRQ also produced a set of indicators to measure “ambulatory care sensitive conditions.” These conditions are chronic and acute conditions that if properly managed by patients and primary care physicians, are less likely to lead to acute complications that require hospitalizations. The AHRQ Prevention Quality Indicators (PQIs) are available to measure a number of chronic and acute conditions, and a global composite measure is provided to weight and aggregate a number of the individual indicators. OSHPD research staff followed similar steps as described above for the PSIs to produce PQI numerators.

The PQIs were created as “area” indicators—numerators for specific geographic areas such as counties were divided by population data to get rates per 100,000 people. For example, OSHPD produced county-level PQI reports that showed the likelihood that people from particular counties were hospitalized for chronic and acute conditions. To produce the PQI composite measure for the Medi-Cal population, staff could not rely on the published census data that were integrated into the AHRQ software. Thus, DHCS staff received

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the PQI numerator data (stratified by race/ethnicity) from OSHPD staff, and then relied on eligibility data from the Medi-Cal MIS/DSS system (described above) to produce the denominators. For each racial/ethnic group, DHCS staff excluded “dual eligible” members that were eligible for both Medi-Cal and Medicare. Since Medicare is the primary payer for this population, Medi-Cal has incomplete claims/encounter data for this group.

**Hospital Readmissions Fact Sheet**
OSHPD research staff received from the Centers for Medicare and Medicaid Services (CMS) a preliminary version of the SAS computer code used to produce hospital readmission rates (the same staff also produced the rate for the *LGHCTF Final Report*). Staff applied the algorithms to the PDD to identify numerators and denominators. Similar to other analyses using the PDD described above, staff used the “expected payer” field to identify Medi-Cal and non-Medical patients (see note above about data quality issues associated with this field).

**Childhood Asthma Emergency Department Visits Fact Sheet**
OSHPD ED and PDD data were used to create numerators for the childhood asthma rate. Researchers from CDPH counted ED visits among children and adolescents aged 0 to 17 with a principal diagnosis defined by the ICD-9 code 493. When an ED visit resulted in a hospital admission, the visit was only recorded in the Patient Discharge Dataset. Thus, it was necessary to add visits from the hospital discharge database to the counts of ED visits (inpatient discharges that did not include an ED visit were excluded). With this methodology, the numerator counts were based on the number of ED visits, and not the number of unique individuals. Finally, the expected payer field within the OSHPD ED dataset was used to identify Medi-Cal members.

After receiving the stratified counts by race/ethnicity, the Medi-Cal MIS/DSS system was used to estimate the specific denominators to construct the rates. Medi-Cal members who were eligible for both Medi-Cal and Medicare (“dual eligibles”) were excluded given that Medicare is the primary payer for this population and thus there are incomplete claims and encounter data for this group.

**Palliative Care Fact Sheet**
Using OSHPD Patient Discharge Data, researchers at the University of California, San Francisco identified 351 California acute care hospitals that they expected to have a palliative care program. They submitted a web-based survey with branching logic to each hospital to learn if they had a palliative care program. If any palliative care services were offered, a hospital was designated as a palliative care hospital. OSHPD publishes inpatient profiles on their website. These reports used the “expected payer” source from the Patient Discharge Data to count the number of hospital discharges with an expected payer of Medi-Cal. Looking at all of the general acute care hospitals in California, hospitals were categorized by the number of Medi-Cal members treated in 2011. Dr. Steven Z. Pantilat’s team at the University of California, San Francisco linked their palliative care survey data to the list of hospitals categorized by Medi-Cal patients to identify the degree to which hospitals with a larger proportion of Medi-Cal members had a palliative care program.

**California Department of Education**
CDE publishes two data sources important for two fact sheets. First, the California Education Code since 1996 has mandated educational agencies to administer a physical fitness test (PFT) to all fifth, seventh, and ninth graders. The State Board of Education selected a test called the Fitnessgram® to measure minimum fitness levels that are likely associated with characteristics that can prevent inactivity-related diseases. Second, each spring students in grades two through eleven must take a Standardized Testing and Reporting (STAR) test. The purpose of the STAR tests is to access how well students are doing in various subjects such as math, reading, writing, science, and history. Both the STAR test results and the PFT data can be queried from the DataQuest system on the CDE website: [http://data1.cde.ca.gov/dataquest/](http://data1.cde.ca.gov/dataquest/).
Reading Proficiency and Childhood Physical Fitness Fact Sheets
At the time of publication, there were no Medi-Cal specific data available to measure childhood physical fitness or reading proficiency. However, PFT and STAR data can be stratified by socio-economic status. Students were classified as “economically disadvantaged” if they participated in the free or reduced price meal program, or if their parent education level was coded as “not high school graduate.” Within the DataQuest query system, the economically disadvantaged variable was used as a proxy measure for the Medi-Cal population given that the vast majority of Medi-Cal members are near or below federal poverty boundaries. In addition, the data were stratified by race/ethnicity.

Birth Cohort File
Infant Mortality Fact Sheet
Each year, analytical staff from CDPH link vital statistics from birth and death files to create the Birth Cohort File. The file allows researchers to evaluate both infant deaths and birth outcomes, and represents all of the live births that occurred in California for the calendar year. In addition, death information is available for all infants born in the calendar year but who died within 12 months of birth. More information can be found on the CDPH website: http://www.cdph.ca.gov/data/dataresources/requests/Pages/BirthandFetalDeathFiles.aspx.

Using the Birth Cohort File, staff from CDPH created an infant mortality rate. The numerator was created by selecting infant deaths where the source of payment for prenatal care or delivery is indicated as Medi-Cal (or non-Medi-Cal). The denominator included all live births to California state residents where the source of payment for prenatal care or delivery is indicated as Medi-Cal (or non-Medi-Cal). Using the Birth Cohort File, the overall California infant mortality rate was 4.9 per 1,000 births. This is higher than the overall rate of 4.7 per 1,000 births that is reported on the CDPH website. The CDPH report has a lower infant mortality rate because this report used an unlinked death file that had fewer reported deaths than the Birth Cohort File. The Birth Cohort File is produced after the death file and thus is able to incorporate out-of-state deaths and any additional deaths not reported in the original death file.

To stratify by the Medi-Cal population, two variables from the Birth Cohort File were used. First, two data elements were selected from the data field labeled “principle source of payment for prenatal care or delivery is indicated as Medi-Cal (or non-Medi-Cal). The Hispanic field was re-labeled “Latino” and in some instances was used in conjunction with race to form an “Other/Non-Latino” category. The eligibility data from the (MIS/DSS) data warehouse have detailed racial/ethnic breakdowns (e.g., Hmong, Vietnamese). To maintain consistency with other fact sheets, Asian categories were aggregated and included with Pacific Islanders. Finally, the MIS/DSS has missing data for about 10% of the eligible members. These members were grouped with the “Other” category to form an “Other/Unknown” category. The vital statistics from CDPH included similar ethnic/racial categories. The fact sheet using these data also created an “Other/Unknown” category. The survey data sources have similar, yet slightly different categories. CHIS reported race/ethnicity categories for Latino, African American, White, Asian/Other, and Multiracial, while BRFSS only allowed race/ethnicity categories for four groups (Latino,
African American, White, and Asian/Other). In some instances, the survey sample size for the Medi-Cal population was too small to analyze race/ethnicity differences; therefore, in these cases, gender differences were examined.
Appendix D: Baseline Assessment of Quality Improvement Activities in the California Department of Health Care Services: Methods and Results
BASELINE ASSESSMENT OF QUALITY IMPROVEMENT ACTIVITIES
IN THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES: METHODS AND RESULTS

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LETTER FROM DIRECTOR DOUGLAS

Dear Colleagues:

I am very pleased with the release of this report, which was commissioned by the Department, to define a quality improvement baseline for the programs of the California Department of Health Care Services (DHCS). This baseline is an essential component of developing a detailed Quality Strategy in 2013 that will include specific clinical and population health initiatives designed to improve health and health outcomes for Californians.

I want to thank Kenneth W. Kizer, MD, MPH, Director, UC Davis Institute for Population Health Improvement (UCD/IPHI) for his ongoing leadership, through an Interagency Agreement (IA), to help DHCS achieve the highest levels of health and health care quality for the members we serve. This baseline assessment of quality improvement activities was one of the specific products delivered through the IA. I also express my appreciation to Desiree Backman, DrPH, MS, RD, an IPHI Scientist, for her great work as first author of the report. Desiree also serves as Chief Prevention Officer for DHCS, within the Office of the Medical Director.

Most importantly, this report would not be possible without the enthusiastic and dedicated participation by each Division and Office within the Department. I applaud the commitment of staff to provide the important data that are the essence of this baseline assessment. This work exemplifies our shared commitment to a “Culture of Quality” that spans all of our efforts in both clinical and administrative areas.

In the near future, we will be releasing the Department’s revised Strategic Plan. The Plan will provide the framework documenting how we will advance our mission to improve the health of Californians over the coming years. The Quality Strategy is subsumed under the Strategic Plan, and will provide specificity on a number of initiatives to improve health and health outcomes.

While this assessment is an important milestone in our efforts to advance quality, it is also, quite literally, a starting point. Using this report, I look forward to seeing us plan and implement the programs and policies that will significantly improve health and health outcomes for Medi-Cal members and all Californians.

Sincerely,

Toby Douglas
Director, California Department of Health Care Services
Many people contributed to this report. IPHI would like to especially thank Toby Douglas, Director, DHCS, for commissioning the report and for his vision of providing the highest possible quality care to all Californians.

Deep gratitude is also extended to the staff of the Office of the Medical Director at DHCS, for contributing to the development of the Quality Improvement Survey, coordinating receipt of the responses, and offering feedback on the report. IPHI further acknowledges staff in the Offices and Divisions throughout DHCS who offered their thoughtful responses to the baseline assessment and shared their stories of quality improvement. This report reflects much hard work and dedication to improving lives and transforming the health care delivery system.
EXECUTIVE SUMMARY

DHCS works closely with health care providers, health plans, advocacy groups, and local government, among others, throughout California to ensure that health care services are available and accessible for low-income individuals and families and persons with disabilities. DHCS is placing renewed emphasis on achieving optimal clinical outcomes by eliminating overuse, ineffective services and avoidable complications, and by advancing safe, cost-effective care.

In the late spring of 2012, a team functioning under the direction of the Chief Prevention Officer conducted an inventory of the Department’s Quality Improvement (QI) activities. The inventory sought to: 1) establish a Department-wide baseline of QI activities in three areas: clinical care, health promotion and disease prevention, and administration; 2) identify quality metrics that were being collected by the Department but which were not specifically linked to QI activities; 3) identify gaps in the Department’s QI activities; and 4) obtain recommendations for additional QI efforts.

The assessment team developed and pilot tested a Quality Improvement Survey (QIS) instrument that was then administered to all the operational units within the Department. All units responded to the survey, with 18 Offices and Divisions providing detailed information and 20 other units reporting no activities.

A total of 20 clinical care, 4 health promotion and disease prevention, and 20 administrative QI activities were reported. Some examples included California’s Delivery System Reform Incentive Payments (DSRIP) Program; reducing all-cause readmissions and health care acquired infections; improving the proportion of Medi-Cal members who get help in quitting smoking; waivers to help frail seniors and persons with mid- to late-stage HIV/AIDS or developmental disabilities remain in their homes and communities as an alternative to being placed in health care facilities; and enhancing fraud detection and deterrence.

Thirty metrics, including 13 Healthcare Effectiveness Data and Information Set (HEDIS) measures, were being collected by DHCS but were not specifically linked to statewide QI activities. In addition, survey respondents noted both broad gaps in current QI practices (e.g., lack of consistent measurement and translation of data into QI efforts Department-wide) and specific programmatic gaps (e.g., the absence of a comprehensive tobacco treatment plan). Respondents offered many suggestions for new QI activities involving multiple programmatic areas within the Department, including dental care; obesity, tobacco, and alcohol and substance abuse prevention; data, measurement, and modeling; business processes; and QI training. Multiple cross-cutting QI activities were noted.

The findings of this report will help inform the development of a multi-year Department-wide Quality Improvement Plan.
Background of the California Department of Health Care Services

The mission of DHCS is to preserve and improve the health of all Californians. DHCS works closely with health care providers, health plans, advocacy groups, local government, among others, to ensure that health care services are available and accessible for low-income individuals and families and persons with disabilities.\(^1\)

With an annual budget of over $60 billion, DHCS finances and administers a number of health care delivery programs, including the California Medical Assistance Program (Medi-Cal), Children’s Medical Services, and Primary and Rural Health Services (Figure 1).\(^2\) Through these public insurance programs, DHCS also helps to maintain the financial viability of critical specialized care services, such as burn centers, trauma centers, and children’s specialty hospitals. In addition, the Department provides funding to assist hospitals and clinics in medically underserved areas.

**Figure 1. DHCS Expenditures by Program Area, 2012-2013**

The largest and most far-reaching DHCS program is Medi-Cal, California’s Medicaid program. Supported by a combination of federal and state dollars, Medi-Cal serves some 8 million members annually—men, women, and children who otherwise could not afford critical and sometimes life-saving health care.\(^3\) More than 400 hospitals and approximately 130,000 doctors, pharmacists, dentists, and other health care providers participate in the Medi-Cal program.

In addition to the core services provided by DHCS, implementation of the Patient Protection and Affordable Care Act (ACA) is a Department priority. It will offer Californians increased access to affordable health care insurance, a consumer-friendly, more streamlined enrollment process, and opportunities to improve the quality of health care. DHCS’ 5-year Medicaid Section 1115 waiver, entitled *Bridge to Reform*, was granted by the federal government in 2011. It allows the Department to enroll hundreds of thousands more uninsured persons in advance of the full implementation of the ACA, transition the most vulnerable members into managed care, and invest hundreds of millions of dollars in strengthening California’s health care safety net.\(^3\)
Introduction

Quality Improvement in Health Care

Quality Improvement Imperative
DHCS places an emphasis on achieving optimal clinical outcomes in all departmental programs by eliminating overuse, ineffective services and avoidable complications, and by advancing safe, cost-effective care. The Department’s emphasis on health care quality is driven first and foremost by a moral obligation to provide the best possible health care and service to Californians and to be responsible stewards of limited public funds.

A confluence of other forces is catalyzing efforts to improve the quality of care. DHCS’ Medicaid Section 1115 waiver is providing funding to improve clinical quality through better coordination of care for vulnerable populations, redesign of care delivery, population-focused interventions, and enhanced patient safety. Likewise, the ACA addresses many important health care quality domains such as health promotion and disease prevention, patient safety, coordination of care for persons with complex conditions, community health, and new care delivery models. Overall, these quality improvement efforts should help bend the health care cost curve.

Quality Strategy and Quality Improvement Inventory
To accelerate advancements in quality of care, DHCS produced the Strategy for Quality Improvement in Health Care (aka the “Quality Strategy”). The Quality Strategy establishes QI goals, priorities, and guiding principles, and highlights existing and emerging DHCS QI initiatives to improve health and patient care and control the increase in health care costs. It aligns with the National Strategy for Quality Improvement in Health Care (the “National Quality Strategy”) and reflects the best evidence-based practice in the areas of patient safety, care delivery, person and family engagement, communication and coordination of care, prevention, healthy communities, and elimination of health disparities.

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

Survey Development
In April 2012, a multi-disciplinary team in the DHCS Office of the Medical Director (the “assessment team”) developed a Quality Improvement Survey (QIS) instrument to: 1) inventory the current QI activities within DHCS in the areas of clinical care, health promotion and disease prevention, and administration; 2) identify quality metrics that were being collected by DHCS but which were not specifically linked to QI activities; 3) determine gaps in existing QI activities; and 4) offer suggestions for new QI efforts.

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

Pilot Test
The assessment team invited a sample of 12 DHCS leaders, representing a cross-section of the organization, and one external QI expert to pilot test the QIS. The respondents were asked to review and critique the survey instrument. The assessment team revised the QIS based on the feedback.

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

Data Collection
The QIS, detailed instructions for completing it, and a sample of a completed QIS were emailed to the leaders of all 35 Offices and Divisions within DHCS. The Offices and Divisions support all major functions within the Department. Three other leaders representing special subgroups within the organization were also included in the survey distribution list to ensure the most comprehensive response possible (see Appendix B for the DHCS organization chart, and Appendix C for a list of the Offices, Divisions, and subgroups, and their respective functions within DHCS).
Appendix D

Methods

The respondents were given three weeks to complete the survey (April 27—May 18, 2012). To encourage responses and collect complete data for each response, the QIS data collection process was shared at selected staff meetings, multiple e-mail reminders were sent to respondents, and technical assistance was provided to those who had questions or required additional information.

Data Analysis

QI activities in the clinical care, health promotion and disease prevention, and administrative domains were tabulated and summarized in tables in an effort to capture key variables (i.e., the DHCS office or division, the QI activity title, its aims, baseline metrics, target metrics, and start date and end date). Nine reported QI activities did not meet the definition of QI and were excluded from the summary tables. In addition, four QI activities were consolidated into two separate activities to eliminate redundancy.

The quality metrics that were being collected by DHCS but which were not specifically linked to QI activities were compiled into a list and grouped by Departmental program or function. Perceived gaps in QI activities were grouped into categories, as appropriate, and a list of responses was compiled. A list of suggestions for new QI activities was also compiled and categorized into clinical care, health promotion and disease prevention, and administration, and a crosscutting category was included for those activities that likely represented all three domains.
Description of Respondents

All programmatic units responded to the survey. Eighteen Offices and Divisions (see below list) provided detailed responses, while 20 groups noted that they had nothing to report.

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

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

A total of 20 clinical care, 4 health promotion and disease prevention, and 20 administrative QI activities were described by 15 DHCS Offices and Divisions. Tables 1, 2, and 3 list the reported QI activities by domain. Some QI activities are complex and contain many baseline and target metrics. In those cases, a website link is provided to view additional metrics that are beyond the scope of the tables.

To provide the most complete picture, the assessment team elected to include all reported activities meeting the QI definition, regardless of whether they directly or indirectly impacted quality of care, ranging from those at an advanced planning stage to those that have been in place for many years. As a result, activities that had incomplete or empty response fields were accepted as long as there were definitive plans to fully implement them in the near term, and a few administrative activities were included that were small in scale and remote to service delivery.
## Results

### Table 1: Clinical QI Activities

<table>
<thead>
<tr>
<th>DHCS Office or Division</th>
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<th>Baseline Metric(s)</th>
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<tr>
<td>Benefits Division, Every Woman Counts</td>
<td>Core Program Performance Indicators (CPPI)</td>
<td>1. To ensure timely and complete diagnostic follow-up of abnormal breast and cervical cancer screening results.</td>
<td>CPPI set by the Centers for Disease Control and Prevention.</td>
<td>1. Breast/cervical diagnosis completed.</td>
<td>Start date: 10/09 End date: Ongoing</td>
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<td>2. To ensure timely and complete treatment initiated for cancers diagnosed.</td>
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<td>2. Breast/cervical diagnosis completed within 60 days.</td>
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<td>3. To deliver breast and cervical cancer screening to priority populations.</td>
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<td>3. Breast/cervical treatment initiated.</td>
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<td>4. Breast/cervical treatment initiated within 60 days.</td>
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<td>5. Women rarely/never screened for cervical cancer (&gt;20%).</td>
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<td>6. Mammography screening age 50 and older (&gt;75%).</td>
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<td>Director’s Office</td>
<td>California’s 1115 Waiver: Delivery System Reform Incentive Payments (DSRIP) Program</td>
<td>1. To support California’s designated public hospitals (DPH) in meaningfully enhancing the quality of care and health of the patients and families they serve by transforming their delivery system. The DPHs will transform their delivery systems to: provide integrated systems of care; offer timely, proactive, coordinated medical homes; provide patients with positive health care experiences; deliver proactive and planned prevention and primary care services for all patients; deliver high-quality care and drive quality, safety, and efficiency; and provide equitable care.</td>
<td>1. Baseline metrics vary by DPH. Baseline metrics for each DPH are under development.</td>
<td>1. Target metrics vary by DPH. Target metrics for each DPH are under development.</td>
<td>Start date: 11/20/10 End date: 10/20/15</td>
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| Director’s Office        | Coordinated Care Initiative  | 1. To coordinate Medi-Cal and Medicare benefits across health care settings and improve the continuity of care across acute care, long term care, behavioral health, including mental health and substance abuse disorder services, and home- and community-based service settings using a person-centered approach.  
2. To coordinate access to acute and long term care services for dual eligible members.  
3. To maximize the ability of dual eligible members to remain in their homes and communities with appropriate services and supports in lieu of institutional care.  
4. To increase the availability of and access to home- and community-based services.  
5. To coordinate access to necessary and appropriate behavioral health services, including mental health and substance use disorder services.  
6. To improve the quality of care for dual eligible members.  
7. To promote a system that is both sustainable and person- and family-centered by providing dual eligible members with timely access to appropriate, coordinated health care services and community resources that enable them to attain or maintain personal health goals. | 1–7. Under development in conjunction with Centers for Medicare and Medicaid Services (CMS) and stakeholder review. | 1–7. Under development in conjunction with CMS and stakeholder review. | Start date: 6/1/13  
End date: 12/31/16 (transition from a demonstration project to an ongoing program) |
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<td>Medi-Cal Dental Services Division</td>
<td>Increasing Children’s Use of Preventive Dental Services and Dental Sealants</td>
<td>1. To increase the rate of children, ages 1-20 years, enrolled in Medi-Cal who receive any preventive dental service by 10 percentage points over a 5-year period.</td>
<td>Rate of children, ages 1-20 years, enrolled in Medi-Cal in Federal Fiscal Year (FFY) 2011 who received any preventive dental services was 32.6% for children enrolled for any length of time, and 35.7% for children continuously enrolled for at least 90 days.</td>
<td>Rate of children, ages 1-20 years, enrolled in Medi-Cal who receive any preventive dental services will increase to 42.6% for children enrolled for any length of time, and 45.7% for children continuously enrolled for at least 90 days.</td>
<td>Start date: Goal 1: 10/1/11 Goal 2: To Be Determined (TBD) by CMS End date: Goal 1: 9/30/16 Goal 2: TBD by CMS</td>
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<td>2. To increase the rate of children, ages 6-9 years, enrolled in Medi-Cal who receive a dental sealant on a permanent molar by 10 percentage points over a 5-year period.</td>
<td>Rate of children, ages 6-9 years, enrolled in Medi-Cal in FFY 2012 who received a dental sealant on a permanent molar tooth was 15.2% for children enrolled for any length of time, and 16.3% for children continuously enrolled for at least 90 days.</td>
<td>Rate of children, ages 6-9 years, enrolled in Medi-Cal who receive a dental sealant on a permanent molar tooth will increase to 25.2% for children enrolled for any length of time, and 26.3% for children continuously enrolled for at least 90 days.</td>
<td>Start date: Goal 1: 10/1/11 Goal 2: TBD by CMS End date: Goal 1: 9/30/16 Goal 2: TBD by CMS</td>
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| Medi-Cal Dental Services Division | Dental Managed Care QI Project | 1. To improve performance by dental managed care plans on several dental quality measures over a one-year period. | 1. Baseline metrics on the following measures are under development for each Medi-Cal dental managed care plan:  
   a. Annual dental visit  
   b. Continuity of care  
   c. Use of preventive services  
   d. Use of sealants  
   e. Treatment/prevention of caries  
   f. Exams/oral health evaluation  
   g. Overall utilization of dental services  
   h. Usual source of care | 1. Target metrics on the following measures are under development for each Medi-Cal dental managed care plan:  
   a. Annual dental visit  
   b. Continuity of care  
   c. Use of preventive services  
   d. Use of sealants  
   e. Treatment/prevention of caries  
   f. Exams/oral health evaluation  
   g. Overall utilization of dental services  
   h. Usual source of care | Start date: TBD  
End date: TBD |
| Medi-Cal Managed Care Division | All-cause Readmissions (ACR) | 1. To reduce the number of all-cause readmissions within 30 days of an acute inpatient discharge for members 21 years and older. | 1. In September 2012, baseline data will be submitted for ACR rates in 3 populations enrolled in the plan for each county including:  
   a. Overall readmission rate  
   b. Seniors and persons with disabilities (SPDs) readmission rate  
   c. Non-SPD readmission rate | 1. Unknown until the baseline is established. | Start date: 7/1/11  
End date: 5/1/15 |
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<td>Medi-Cal Managed Care Division</td>
<td>Internal &amp; Small Group Collaborative QI Projects</td>
<td>1. To improve the quality of care delivered to Medi-Cal members by DHCS-contracted health plans. QI projects vary by health plan and include areas such as: increasing the number of advanced directives, HIV/AIDS viral load testing, BMI documentation for children and adolescents, rate of prenatal visits during the first trimester of pregnancy, percentage of controlled blood pressure, and communication to improve the patient care experience; improving the rate of postpartum care visits, comprehensive diabetes care, cervical cancer screening among women 21-64 years, and treatment of Chronic Obstructive Pulmonary Disease (COPD) among patients 40 years and older; and reducing health disparities in childhood obesity and rate of children and adolescents discharged to out-of-home placements.</td>
<td>1. Baseline metrics vary by health plan and QI project. View QI projects for each health plan at: <a href="http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2011-12_QIP_Qtr1-1to3-31-12_Report.pdf">http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2011-12_QIP_Qtr1-1to3-31-12_Report.pdf</a></td>
<td>1. Target metrics vary by health plan and QI project. View QI projects for each health plan at: <a href="http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2011-12_QIP_Qtr1-1to3-31-12_Report.pdf">http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2011-12_QIP_Qtr1-1to3-31-12_Report.pdf</a></td>
<td>Start date: Varies by health plan</td>
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| Office of Family Planning | Provider Profiles with Two Clinical Indicators                     | 1. To improve clinical quality outcomes for chlamydia screening of female members age 25 years and younger. | Private providers screen 69% of female clients and public providers screen 63% of female clients. | Increase member screening rate in targeted groups to 85%.                         | 1. Start date: 9/05  
                              |                                                                      | 2. To improve clinical quality outcomes for chlamydia-targeted screening of female members over age 25 years. | Private providers screen 64% of female clients and public providers screen 59% of female clients. | Ensure maximum screening rate does not exceed 50% of the targeted group.       | 2. Start date: 1/06  
<pre><code>                          |                                                                      |                                                                                             |                                                                                   | End date: Ongoing                                           |
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| Office of Family Planning | 2011 Family Planning, Access, Care, and Treatment (Family PACT) Medical Record Review (MRR) | 1. To assess whether family planning and reproductive health care services provided under Family PACT are consistent with program standards.   | a. 22% increase at the end of a visit compared to the beginning of a visit (2007 Family PACT MRR). | a. Increase the proportion of women using effective contraceptive methods as a result of a Family PACT visit to 25%. | Start date: 7/10  
                            |                                                                       | b. To increase the proportion of clients who receive education and counseling services.                                                 | b. 76% have documentation of receiving counseling (2007 Family PACT MRR).       | b. Increase the proportion of clients with documentation of counseling to greater than 76%. | End date: 6/13    |
|                         |                                                                       | c. To decrease the proportion of women who receive annual cervical cytology screening tests.                                               | c. 49% annual screening rate (2007 Family PACT MRR).                               | c. Decrease the rate of annual cervical cytology screening to 45%.               |                  |
|                         |                                                                       | 2. To determine whether the quality of services delivered under the program improved over time.                                           | 2. Baseline metrics vary by indicator.                                            | 2. Target metrics vary by indicator.                                           |                  |
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<td>Office of the Medical Director</td>
<td>Adoption of Electronic Health Records (EHRs)</td>
<td>1. To improve care coordination among Medi-Cal providers, as Medi-Cal providers and members will be able to use available electronic information to make informed health care decisions at the point of care. 2. To improve member engagement, as members will have electronic access to their Personal Health Records and self-management tools by 2015. 3. To improve population health, as member and population health data from EHRs will be shared between approved institutions.</td>
<td>1–3. No use of EHRs by Medi-Cal providers eligible for incentive payments.</td>
<td>1–3. 90% of Medi-Cal providers eligible for incentive payments adopted EHRs for meaningful use in their practices by 2015.</td>
<td>Start date: 10/3/11 End date: 12/31/15</td>
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<td>Pharmacy Benefits Division</td>
<td>Improve Psychotropic Medication Use for Children and Youth in Foster Care</td>
<td>To achieve improved psychotropic medication use for children and youth in foster care by:</td>
<td>1. Reducing the rate of antipsychotic polypharmacy.</td>
<td>1. Rate/proportion of polypharmacy of two or more antipsychotics: 20.4% (2009/2010 data).</td>
<td>Start date: 7/1/12 End date: 6/30/15</td>
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<td>2. Improving the antipsychotic dose prescribed to be within the recommended guidelines.</td>
<td>2. Rate/dose of antipsychotic dose within age-specific recommended guidelines: No baseline metric because the measure is new.</td>
<td>2. Improving the monitoring of metabolic risk associated with the use of antipsychotics.</td>
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<td>3. Improving the monitoring of metabolic risk associated with the use of antipsychotics.</td>
<td>3. Rate/proportion of children and youth in foster care prescribed with at least one psychotropic medication that will have an annual metabolic risk assessment: No baseline metric because the measure is new.</td>
<td>3. 80% of children and youth in foster care prescribed with at least one psychotropic medication will have an annual metabolic risk assessment and evaluation.</td>
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Each county specialty mental health service participating in the collaborative can also decide to include additional aims based on county-specific interventions. | 1. Rate/proportion of polypharmacy of two or more antipsychotics: 15.6% (2007 data). | Start date: 7/07  
End date: 6/12 |
| Primary and Rural Health Division          | Improve Critical Access Hospitals’ (CAHs) Quality Reviews and Service Delivery through Multi-hospital Benchmarking | 1. To achieve at least 75% of California CAHs’ use of the Kansas Hospital Association Foundation’s Quality Health Indicators (QHi) for benchmarking and reporting purposes.  
2. To demonstrate improvement in at least one QHi per hospital. | 1. Sixteen (51.6%) of 31 CAHs reported core measures using QHi from 9/1/11-5/1/12. The QHi project focuses on 8 of the 32 core measures.  
2. Baseline metrics vary by CAHs and their selected measures. | 1. At least twenty-three of 31 (75%) CAHs reporting core measures using QHi.  
2. Target metrics vary by CAHs and their selected measures. | Start date: 9/1/11  
End date: 8/31/15 |
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| Primary and Rural Health Division | Improve CAHs Operational Performance through Support of Onsite Technical Assistance using the Lean Methodology | 1. To support at least seven CAHs participation in at least one Lean project. Lean projects are designed specifically for each hospital.  
2. To demonstrate improvement in operational QI/Performance Improvement (PI) measures for each CAH-specific project (i.e., reduced patient wait times, reduced number of days for cash on hand). | 1. Number of CAHs participating in QI or PI activities using Lean methodology.  
2. Baseline metrics vary by CAH-specific projects. | 1. Seven CAHs completed QI or PI activities using Lean methodology.  
2. Target metrics vary by CAH-specific projects. | Start date: 9/1/11  
End date: 8/31/15 |
| Primary and Rural Health Division | CAH Participation in the Medicare Beneficiary Quality Improvement Project (MBQIP) using Selected Measures from the CMS Hospital Compare (HC) Data Reporting Program | 1. To identify areas for QI through the use of CAHs reporting of MBQIP outpatient 1-7 measures.  
2. To demonstrate improvement in one or more outpatient MBQIP measures. | 1. Five (16%) of 31 CAHs are reporting one or more MBQIP outpatient measures to HC. The indicators chosen include pneumonia, heart failure, inpatient and outpatient, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).  
2. Baseline metrics vary by CAH. | 1. Twenty-three (75%) of 31 CAHs are reporting all MBQIP measures to HC.  
2. Target metrics vary by CAH. | Start date: 9/1/11  
End date: 8/31/15 |
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| Systems of Care Division | California Children’s Services (CCS) Neonatal QI Initiative         | 1. To reduce the collaborative’s Central Line Associated Blood Stream Infection (CLABSI) rate by another 25% among the participating Neonatal Intensive Care Units (NICU).                                         | 1. CLABSI per 1,000 line days – 0.8. | 1. CLABSI per 1,000 line days – 0.6. | Start date: Began in 2008 and the current cycle began in 2011  
End date: Current cycle ends in 2013 |
| Systems of Care Division | Survey and Certification of CCS Medical Therapy Units (MTUs) as Outpatient Rehabilitation Centers (OPRCs) | 1. To assure that CCS MTUs meet and continue to meet all OPRC standards.                                                                                                                                                  | 1. The number of MTUs that were able to qualify initially as OPRC on their first survey compared to those that required plans of correction. | 1. The number of MTUs that were able to re-qualify as OPRC on their recertification survey compared to those that required a plan of correction. | Start date: 10/92  
End date: No projected end date |
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| Systems of Care Division | CCS/California Perinatal Quality Care Collaborative High Risk Infant Follow-up Quality Care Initiative (CCS/CPGCC HRIF QCI) | 1. To identify infants who might develop CCS-eligible conditions after discharge from a CCS-approved NICU.  
2. Improve the neurodevelopmental outcomes of infants served by the CCS HRIF Programs through collaboration between Children’s Medical Services/CCS and the CPGCC. | 1–2. Baseline metrics have not been developed due to the formative stage of this project, which includes the development, design, and implementation of the HRIF QCI.  
Basic demographics and descriptive information on the reported variables (i.e., special service needs, neurologic parameters, developmental testing, medication use, re-hospitalization, etc.) have been collected and are under review to develop baseline and target metrics. | 1–2. Target metrics are under development. | Start date: FFY 06  
End date: Ongoing |
## Table 1: Clinical QI Activities

<table>
<thead>
<tr>
<th>DHCS Office or Division</th>
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<th>Baseline Metric(s)</th>
<th>Target Metric(s)</th>
<th>Start &amp; End Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems of Care Division</td>
<td>Payment Adjustment for Provider-Preventable Complications, Including Health Care-Acquired Conditions: Vascular Catheter-associated/ Central Line-associated Bloodstream Infection (CLABSI) in Neonatal and Pediatric Intensive Care Units (NICU/PICU)</td>
<td>1. To implement best practices of central line (CL) insertion and maintenance resulting in decreased preventable infections, improved clinical outcomes, decreased length of stay, and decreased cost.</td>
<td>1. Explore the relationship between NICU and PICU CLABSI rate and participation in statewide QI targeting CLABSI prevention.</td>
<td>1. Decreasing number of NICUs and PICUs with greater than expected CLABSI rate. 2. Decreasing overall statewide NICU and PICU CLABSI rates. 3. Decreasing overall statewide NICU and PICU CL-days. 4. Narrower distribution of NICU/PICU CLABSI rates. 5. Increasingly strong relationship between application of best practices for CL care and NICU/PICU CLABSI rate.</td>
<td>Start date: 7/1/12 End date: Annual, anticipate multiple years</td>
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</tbody>
</table>
# Table 1: Clinical QI Activities

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<tbody>
<tr>
<td>Systems of Care Division</td>
<td>Payment Adjustment for Provider-Preventable Complications, Including Health Care-Acquired Conditions: Surgical Site Infection (SSI)</td>
<td>To decrease incidence of SSI in 2 conditions: 1. Mediastinitis following pediatric cardiac surgery, excluding hypoplastic heart syndrome, &lt; 30 days of age, and/or delayed sternal closure. 2. Deep wound infection following scoliosis repair in children who do not exhibit neuromuscular disease.</td>
<td>1-2. Published reports of these SSI and the first year of mandated reporting will provide baseline data. The new requirement for identification of all patients with such infections, not only those with death or serious disability as currently reported, limits validity of baseline data.</td>
<td>1-2. Decrease in the 2 SSIs, with improved clinical outcomes, including length of stay and decreased cost.</td>
<td>Start date: 7/1/12 End date: Annual, anticipate multiple years</td>
</tr>
</tbody>
</table>
## Results

### Table 2: Health Promotion and Disease Prevention QI Activities

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<thead>
<tr>
<th>DHCS Office or Division</th>
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</thead>
</table>
| Office of the Medical Director | Medi-Cal Incentives to Quit Smoking (MIQS) Project | 1. Increase utilization of the Smokers’ Helpline through the use of appropriate incentives.  
   a. To increase the proportion of new clients who leave a visit with high efficacy methods.  
   b. To increase the proportion of clients who report that the provider asked about their usual source of care. | 1. The Helpline receives an average of 17,500 Medi-Cal callers annually. | 1. Increase the number of Medi-Cal callers to the Helpline by 50% to approximately 25,000 calls by 12/31/15. | Start date: 9/13/11  
   End date: 9/12/16 |
   a. To increase the proportion of new clients who leave a visit with high efficacy contraception (49%).  
   b. To increase the proportion of clients who report that the provider asked about their usual source of care (25%). |  
|                         |                                                                        | a. Increase the proportion of new clients who leave a visit with high efficacy contraception to 55%.  
   b. Increase the proportion of clients who report that the provider asked about their usual source of care to 30%. |  
|                         |                                                                        | Start date: 7/10  
   End date: 6/13 |
Table 2: Health Promotion and Disease Prevention QI Activities

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<tbody>
<tr>
<td>Primary &amp; Rural Health Division</td>
<td>American Indian Infant Health Initiative (AIIHI)</td>
<td>1. To educate families on health promotion and disease prevention including: tobacco use, nutrition, alcohol and drug use, immunizations, teen pregnancy prevention, prenatal care, and sexually transmitted diseases.</td>
<td>1. 90% of AIIHI clinics document the provision of three educational topics as identified in the specific aim.</td>
<td>1. 100% of AIIHI clinics document the provision of three educational topics as identified in the specific aim.</td>
<td>Start date: 7/1/09 End date: 6/30/14</td>
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<tr>
<td>DHCS Office or Division</td>
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<td>Target Metric(s)</td>
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<tr>
<td>Systems of Care Division</td>
<td>Newborn Hearing and Screening Program QI Learning Collaborative</td>
<td>1. Complete hearing screening by 1 month of age.</td>
<td>1. Screening: No show rate for outpatient screens- 9%; no show rate for diagnostic evaluations- 9%.</td>
<td>1. Screening: Decrease regional no show rate for outpatient screening appointments and diagnostic audiologic appointments to 6%.</td>
<td>Start date: Project began in 2006. Latest aim developed in 2011. End date: No projected end date</td>
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<td>2. Complete diagnostic audiologic evaluation by 3 months of age.</td>
<td>2. Diagnostic: First diagnostic appointment by 3 months of age- 81%.</td>
<td>2. Diagnostic: Increase to 85% the percent of infants who have the first appointment for a diagnostic audiologic evaluation by 3 months of age.</td>
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<td>3. Enroll infants with hearing loss in early intervention services by 6 months of age.</td>
<td>3. Early Intervention: Survey data from the Los Angeles Unified School District Early Start Program and pilot project at the California School for the Deaf, Fremont (CSDF), Early Start Program-no initial data available.</td>
<td>3. Early Intervention: Identify the number and percent of children scoring at or above age level on the MacArthur language assessment at the Los Angeles Unified School District Early Start Program and at the CSDF Early Start Program.</td>
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### Table 3: Administrative QI Activities

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<tr>
<td>Administration Division: Human Resources Branch</td>
<td>Family and Medical Leave Act (FMLA) Request Process and Business Workflow Automation System</td>
<td>1. To revise the FMLA forms and procedures; eliminate the need for response letters; reduce the amount of time it takes to complete the response; and create an automated system for the submission of FMLA requests that will reduce paper and processing time.</td>
<td>1. The current FMLA request response turnaround time takes 4-7 working days.</td>
<td>1. Reduce turnaround time by 50% to 2-3 working days.</td>
<td>Start date: 4/1/12, End date: 3/30/13</td>
</tr>
<tr>
<td>Administration Division: Human Resources Branch</td>
<td>State Disability Insurance (SDI), Non-Industrial Disability Insurance (NDI), and Leave of Absence (LOA) Request Process</td>
<td>1. To revise the SDI/NDI/LOA forms and procedures; eliminate the need for response letters; and reduce the amount of time it takes to complete the response.</td>
<td>1. The current number of days from the date a SDI/NDI/LOA request is submitted to the date of the SDI/NDI/LOA response.</td>
<td>1. A 25% reduction in the number of days it takes to process responses to SDI/NDI/LOA requests.</td>
<td>Start date: 4/1/12, End date: 3/30/13</td>
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Table 3: Administrative QI Activities

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<tr>
<td>Administration Division: Workforce Planning and Development</td>
<td>DHCS University</td>
<td>1. To improve the knowledge, skills, and abilities of the Medical program managers, senior managers, and executives throughout the Department.</td>
<td>1. No current participants in the DHCS University.</td>
<td>1. Train 50 participants in the DHCS University within the first year of the program. Conduct training transfer surveys to ensure knowledge retention and create a training practicum to help participants demonstrate problem-solving skills.</td>
<td>Start date: 2/1/13 End date: Ongoing</td>
</tr>
<tr>
<td>Audits &amp; Investigations Division</td>
<td>Return on Investment (ROI) Manual</td>
<td>1. To quantify the value/results of A&amp;I by comparing cost recoveries, savings, and avoidance against the resources expended to complete the work.</td>
<td>1. Monthly ROI ratio of 1:1 as displayed in a dashboard.</td>
<td>1. Continually increase the ROI ratio and surpass the 1:1 break-even point. Current average ROI is 6:1 [i.e., for every dollar spent, A&amp;I brings back $6 in the form of cost recoveries, savings, and avoidance].</td>
<td>Start date: 2005 End date: Ongoing</td>
</tr>
<tr>
<td>Audits &amp; Investigations Division</td>
<td>Audits &amp; Investigations Case Development, Tracking, and Referral Flowcharts</td>
<td>1. To fully document the DHCS collective case development, tracking, and referral process.</td>
<td>1. The number of cases monthly leading to subsequent sanctions plus the number of cases monthly referred to the Department of Justice (DOJ) for criminal prosecution.</td>
<td>1. Increase in the number of quality cases developed for subsequent review, audit, and referral to DOJ.</td>
<td>Start date: 12/1/12 End date: Ongoing</td>
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### Table 3: Administrative QI Activities

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<tbody>
<tr>
<td>Audits &amp; Investigations Division: Medical Review Branch, Research Section</td>
<td>Fraud Detection and Deterrence: Field Audit Reviews</td>
<td>1. To ensure Medi-Cal providers are appropriately compensated based on:</td>
<td>1. Measurement of compliance with DHCS policies and procedures with respect to the application of established Field Audit Review standards, compliance of Medical Record review, consistency of conclusions with DHCS policy, and conformity of report findings and recommendations with program standards.</td>
<td>1. Specific review criteria based on:</td>
<td>Start date: 1999 Fraud Initiative End date: Ongoing</td>
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<td>a. Medical necessity</td>
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<td>a. Case sample select</td>
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<td></td>
<td>b. Appropriateness of care</td>
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<td>b. Review teams</td>
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<td></td>
<td></td>
<td>c. Documentation of services rendered</td>
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<td>c. Review criteria and elements</td>
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<td></td>
<td>d. Qualifications of provider</td>
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<td>d. Best practice questions and topic criteria</td>
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<td>e. Medi-Cal rules of billing</td>
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<td>f. Statutes and regulations</td>
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<td>2. To identify substandard care or behavior that puts patients at risk.</td>
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<tr>
<td>Audits &amp; Investigations Division: Medical Review Branch, Research Section</td>
<td>Individual Provider Claims Analysis Report</td>
<td>1. To increase the accuracy of billing levels for Evaluation and Management (E &amp; M) procedure codes and reduce inappropriate and costly claims.</td>
<td>1. Baseline metrics are the baseline percentages of paid claims by level (there are five different levels for each of the 3 different types of E &amp; M procedure codes).</td>
<td>1. Decrease in the most costly level 4 and 5 claims. A specific target has not been established.</td>
<td>Start date: First report in 1/10. Second report started in 8/11. End date: First report completed in 12/10. Second report will be completed in 7/12.</td>
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<tr>
<td>Audits &amp; Investigations Division: Medical Review Branch, Research Section</td>
<td>Medi-Cal Payment Error Study (MPES)</td>
<td>1. To accurately measure the Medi-Cal paid claims error rate for eight different groups of provider/service types (each type is called a strata).</td>
<td>1. Eight payment error rates for each strata expressed as a percentage of payments made in error.</td>
<td>1. There are no specific target metrics. Since the error is derived from a sample, there will be year-to-year fluctuations in the data.</td>
<td>Start date: 2005 and completed every two years End date: Ongoing</td>
</tr>
<tr>
<td>Benefits Division</td>
<td>Data Navigator Project</td>
<td>1. To improve the collection and documentation of screening and diagnostic results for women in Every Woman Counts.</td>
<td>1. Error type. 2. Error frequency. 3. CPPI performance. 4. Number of contacts with the primary care physician. 5. Persistent performance problems.</td>
<td>1–5. Complete follow-up on 90% of current records identified.</td>
<td>Start date: 7/08 End date: Ongoing</td>
</tr>
<tr>
<td>Director’s Office</td>
<td>Eligibility and Enrollment for Medi-Cal-eligible Californians: Meeting the Goals of the Affordable Care Act</td>
<td>1. To maximize the enrollment of Medi-Cal-eligible Californians.</td>
<td>1. 1.3 million Californians are currently eligible for Medi-Cal but are unenrolled. 2. 1.4 million Californians will be newly eligible to enroll in Medi-Cal as of 2014.</td>
<td>1. Increase Medi-Cal enrollment by 2.8 million by the end of 2014.</td>
<td>Start date: Open enrollment begins Fall 2013 End date: Ongoing</td>
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</table>
| Long Term Care Division| Assisted Living Waiver      | 1. To offer Medi-Cal-eligible members the choice of residing in an assisted living setting, either a Residential Care Facility for the Elderly or Publicly Subsidized Housing, as an alternative to long term placement in a nursing facility. | 1. Costs for comparable services in an institutional setting.  
Report Period Year: 2011  
Average cost per member in an institutional setting: $39,856 | 1. Demonstrate cost effectiveness by providing the same scope of services at a lower cost than the baseline metric.  
Report Period Year: 2011  
Average cost per member enrolled in the Assisted Living Waiver receiving home and community-based care: $20,951 | Start date: 3/1/09  
End date: Waiver renewal submission after 5 years |
| Long Term Care Division| HIV/AIDS Waiver             | 1. To provide services that allow persons with mid- to late-stage HIV/AIDS to remain in their homes, rather than hospitals or nursing facilities, by providing a continuum of care, resulting in improved quality of life and the stabilization and maintenance of optimal health. | 1. Costs for comparable services in an institutional setting.  
Report Period Year: 2010  
Average cost per member in an institutional setting: $144,011 | 1. Demonstrate cost effectiveness by providing the same scope of services at a lower cost than the baseline metric.  
Report Period Year: 2010  
Average cost per member enrolled in the HIV/AIDS Waiver receiving home and community-based care: $29,094 | Start date: 1/1/12  
End date: Waiver renewal submission after 5 years |
## Table 3: Administrative QI Activities

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| Long Term Care Division | Home and Community Based Services Waiver for Californians with Developmental Disabilities (DD) | 1. To serve participants in their own homes and communities as an alternative to placing Medicaid-eligible individuals in hospitals, nursing facilities, or intermediate care facilities for persons with mental retardation. | 1. Costs for comparable services in an institutional setting.  
Report Period Year: 2010  
Average cost per member in an institutional setting: $78,692 | 1. Demonstrate cost effectiveness by providing the same scope of services at a lower cost than the baseline metric.  
Report Period Year: 2010  
Average cost per member enrolled in the DD Waiver receiving home and community-based care: $36,771 | Start date: 3/29/12  
End date: Waiver renewal submission after 5 years |
| Long Term Care Division | Multipurpose Senior Services Program Waiver (MSSP)                      | 1. To foster and maintain independence and dignity in community settings for frail seniors by preventing or delaying their avoidable placement in a nursing facility.  
MSSP provides services to eligible clients and their families that enable clients to remain in their homes. | 1. Costs for comparable services in an institutional setting.  
Report Period Year: 2010  
Average cost per member in an institutional setting: $37,172 | 1. Demonstrate cost effectiveness by providing the same scope of services at a lower cost than the baseline metric.  
Report Period Year: 2010  
Average cost per member enrolled in the MSSP Waiver receiving home and community-based care: $19,763 | Start date: 7/1/09  
End date: Waiver renewal submission after 5 years |
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<td>Mental Health Services Division</td>
<td>Medi-Cal Specialty Mental Health Services for Children and Youth</td>
<td>1. To develop a performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment mental health services for eligible children and youth that will improve outcomes at the individual and system levels and will inform fiscal decision-making related to the purchase of services.</td>
<td>1. Baseline metrics are under development.</td>
<td>1. Target metrics are under development.</td>
<td>Start date: 9/1/12 End date: Ongoing</td>
</tr>
</tbody>
</table>
| Office of Family Planning       | Family PACT QI/Utilization Management Monitoring Activities           | 1. To identify inappropriate use of Family PACT services.  
2. To identify areas where costs could be saved in the Family PACT program.                                                                                                                                                                                                                                                                                                                                 | 1–2. Baseline metrics vary by indicator.                                          | 1–2. Target metrics vary by indicator.                                         | Start date: 7/99 End date: Ongoing                                             |
| Primary & Rural Health Division | DHCS Tribal Advisory Process Tracking                                 | 1. To ensure timely notification to tribes and designees of the Indian Health Program on proposed changes to the Medi-Cal program.                                                                                                                                                                                                                                                                                                                               | 1. Timeline for notifications on proposed changes to the Medi-Cal program is 35 days prior to submission to CMS. | 1. Complete notification process according to American Recovery and Reinvestment Act requirements and Service Provision Assessment measures to submit changes within 35 days. | Start date: 10/1/10 End date: Ongoing                                       |
Table 3: Administrative QI Activities

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<tr>
<td>Systems of Care Division</td>
<td>Pediatric Palliative Care Waiver</td>
<td>1. To provide pediatric palliative care services to allow children who have a CCS-eligible medical condition with a complex set of needs and their families the benefits of hospice-like services, in addition to state plan services during the course of an illness. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and family.</td>
<td>1. Costs for comparable services in an institutional setting.</td>
<td>1. Demonstrate cost effectiveness by providing the same scope of services at a lower cost than the baseline metric.</td>
<td>Start date: Proposed effective date of 4/1/12</td>
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<td>Pre-enrollment average per member per month cost: $16,819.78</td>
<td>Post enrollment average per member per month cost: $14,222.00</td>
<td>End date: Waiver renewal submission after 5 years</td>
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| Third Party Liability & Recovery Division | Improve the Accuracy of the Third Party Health Insurance Records in the Medi-Cal Eligibility Data System (Meds) | 1. To improve the accuracy of Meds Health Insurance System and other health coverage records.  
2. To provide verified Medicare/Medi-Cal (duals) eligibility to Medicare Advantage and Medicare Special Needs Plans (SNP). | 1. Prior to the implementation of the Trading Partner Agreements (now $0 contracts) and the associated data match process with DHCS’ 23 trading partners, the Other Coverage Unit employed approximately 50 staff. Their job was to enter data submitted through paper Health Insurance Questionnaires and remove the same data when contacted by county eligibility workers, Medi-Cal providers, or Medi-Cal members. There were no hard data available at that time to estimate the number of erroneous records being held in the system. | 1. Use only primary source information when cost avoiding Medi-Cal claims.  
2. Verify each month and update as needed commercial health insurance Meds records.  
3. Remove health insurance records that contradict commercial health insurance data.  
4. Provide monthly dual eligibility data to Medicare Advantage and SNP with California service area contracts. | Start date: 3/1/03                  
End date: Ongoing |
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| Utilization Management Division | Reduction in Contract Staff                | 1. To reduce the size of billable contract staff by consolidating key data entry functions between field offices.                                                                                           | 1. 11 Full Time Equivalent (FTE) contract staff.                                | 1. A shift in Treatment Authorization Request (TAR) processing from paper to e-TAR processing will allow for a reduction in contract staff of 5 FTE, effective July 1, 2012. Further planned improvements in processes will allow for the complete reduction of all contract staff in San Francisco by September 1, 2012, an additional 6.0 FTE. The change in processing and the elimination of contract staff in San Francisco will also result in a 50% reduction in needed lease space in San Francisco. | Start date: 3/1/12  
End date: 9/1/12 |
Appendix D

Quality Metrics Collected by DHCS but not Specifically Linked with QI Activities

A total of 30 quality metrics were collected by 8 DHCS Offices and Divisions, but these metrics were not linked to QI activities at the time of the survey.

- Fourteen Healthcare Effectiveness Data and Information Set (HEDIS) measures were gathered in 2012 from managed care plans serving Medi-Cal members. Only one measure (i.e., all-cause readmission) was part of a statewide QI effort.

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

- Six performance measures were reported as being collected annually by the local Child Health and Disability Prevention Programs (CHDPs). The measures were used to assist local programs and DHCS in monitoring compliance with specific scope-of-work requirements.

1. Care coordination—Degree to which the local CHDPs provided effective care coordination to CHDP-eligible children.
2. New provider orientation—Percentage of new CHDP providers with evidence of QI monitoring by the local CHDP through a new provider orientation.
3. Provider recertification—Percentage of CHDP providers who completed recertification within the past fiscal year.
4. Desktop review—Percentage of confidential screening/billing reports reviewed for compliance with the CHDP Periodicity Schedule for Health Assessment Requirements within the past fiscal year as evidenced by desktop review documentation.
5. Childhood obesity—Prevalence of overweight children in a “critical group” according to the Pediatric Nutrition Surveillance System (PedNSS) Annual Report, and description of local program utilization of PedNSS reports in health care and community venues. “Critical group” was defined as the age and/or race/ethnic group with the highest prevalence of overweight as indicated by Body Mass Index-for-Age at ≥95th percentile in County/City PedNSS reports.
Appendix D

Results

6. School entry exams (optional)—Percent of children entering first grade in public and private school by school district reporting a “Report of Health Examination for School Entry” or “Waiver of Health Examination for School Entry.”

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

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

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

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

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

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

• Three measures were collected to track DHCS administrative processes.

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

Gaps in Existing QI Activities

Four DHCS Divisions and one Office identified a total of eight gaps in existing QI activities. These included:

  1. A lack of consistent measurement and translation of data into QI projects Department-wide.
  2. The need for a clear definition of high-quality clinical services.
  3. The absence of any DHCS requirements for Federally Qualified Health Centers and Rural Health Clinics to report medical or dental procedures. This impairs the Department’s ability to fully implement QI activities that are dependent on the availability of such data.
4. A lack of administrative QI in the Medi-Cal dental program.
5. The absence of a comprehensive tobacco treatment plan, including recommended treatment options and clinical systems change to treat tobacco use. Currently, only two managed care health plans offer the comprehensive coverage recommended by the Agency for Health Care Research and Quality. Comprehensive coverage should include: 1) all seven of the FDA-approved medications for treating tobacco use, including bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and nicotine patch and varenicline; 2) individual, group, and telephone counseling; and 3) elimination of barriers to tobacco treatment benefits, such as co-pays and utilization restrictions.
6. A gap between the Department of Health and Human Services (DHHS) initial core set of pharmacy-related health care quality measures recommended for Medicaid-eligible adults and DHCS’ implementation of these measures. DHCS is in the process of reviewing the measurement gap and has commenced a process to prioritize the implementation of the DHHS measures.
7. The need to reduce the number of primary care physicians who submit claims without outcome data and who receive paid claims without corresponding data submission for the Every Woman Counts program.
8. The need to give greater consideration for how to select, gather, and measure behavioral health outcome measures that are valid, reliable, and improve the quality of services, especially given the recent addition of community behavioral health programs and Drug Medi-Cal to DHCS.

Suggestions for New QI Activities

Eleven DHCS Offices and Divisions offered a wide range of suggestions for new QI activities. Two new clinical care, 7 health promotion and disease prevention, and 12 administrative QI activities were recommended. Six cross-cutting QI activities were also suggested.

Proposed Clinical Care QI Activities

1. Develop and implement a QI activity to reduce morbidity and medical treatment expenditures from diabetes and cardiovascular disease by providing dental care to at-risk members.
2. Develop and implement a QI activity to track women referred to the Breast and Cervical Cancer Treatment Program who complete treatment, as well as monitor their survival.

Proposed Health Promotion and Disease Prevention QI Activities

1. Provide consistent and comprehensive screening, diagnosis, and treatment of overweight and obesity for all children, adolescents, and adults, including preconception care.
2. Implement a comprehensive tobacco use treatment plan.
3. Develop QI activities to reduce alcohol and substance abuse among Medi-Cal members.
4. Develop and implement a QI activity to support dental disease prevention.
5. Develop and implement a QI activity for maternal mortality prevention.
6. Provide screening for intimate partner violence.
7. Evaluate and improve, as needed, the implementation of new cervical cancer screening guidelines and the frequency of Pap tests for the Every Woman Counts program.
Appendix D

Results

Proposed Administrative QI Activities

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

Data and modeling
3. Collect data to monitor, evaluate, and improve new cost-saving proposals such as the physician visit cap and hearing aid limitation.
4. Enhance the quality of data in the Management Information System/Decision Support System. Expand the data elements in the system and ensure they match the values in the Surveillance Utility Review Subsystem.
5. Improve the quantity and quality of encounter data collected by Medi-Cal’s contracted managed care plans to enhance service monitoring.
6. Track the effectiveness of integrated behavioral health care; use External Quality Review Organizations and other data to measure Mental Health Program performance; and measure the effectiveness of processing mental health-related payments to counties.
7. Implement a system of predictive modeling in order to better identify potentially fraudulent claims and prevent payment of fraudulent providers.

Business Processes
8. Reduce the volume of paper claims that come to Medi-Cal FFS.
9. Develop and implement a plan to transition California’s designated public hospitals from the TAR process for inpatient hospital stays to a TAR-free process subject to DHCS oversight.
10. Assess customer satisfaction and opportunities for improvement in the DHCS Program Support Branch.
11. Improve the process for issuing state plan amendments, requests for additional information, informal letters, and informal comments.

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

Proposed Cross-cutting QI Activities
1. Develop and implement QI activities to improve medication adherence that related to the management of chronic conditions, such as diabetes and coronary artery disease, and health promotion.
2. Develop and implement QI activities that integrate behavioral health and physical health to promote whole health using patient-centered care approaches.
3. Assess process and outcomes of the patient-centered medical home model.
4. Measure quality for long term care.
5. Develop quality measures FFS.
6. Use statewide surveillance and Medi-Cal data to guide planning and implementation of future QI activities.
The QII described in this report is the first known effort to comprehensively identity the QI activities being conducted within DHCS. Thus, it provides an important baseline for expanding the Department’s QI activities. The findings in each of the four survey areas establish a foundation for implementing the Quality Strategy and highlight opportunities for the Department to further demonstrate its commitment to QI.

This baseline assessment shows that a wide range of QI activities are currently underway in DHCS, some being longstanding while others have been only recently introduced.

The vast majority of QI projects were within the clinical and administrative domains, which was not surprising given the Department’s relatively recent enhanced focus on prevention and population health. Some of the clinical QI projects were in keeping with the National Quality Strategy, including the reduction of all-cause readmissions and reduction of health care-acquired infections.7 Likewise, the Medi-Cal Incentive to Quit Smoking project complements the National Quality Strategy’s objective to improve the proportion of people trying to quit smoking who get help.7

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

This baseline assessment also showed that many metrics, including multiple HEDIS measures, are being collected by DHCS but are not specifically linked to any statewide QI activity. The list of these metrics provides an opportunity for the Department to consider implementing additional QI activities and raises questions about what additional measures should be collected in the future.

Finally, this survey provides valuable insight into the gaps in the Department’s QI portfolio, some of which represent systemic problems (e.g., the Department-wide lack of consistent measurement and translation of data into QI activities), while others are program specific (e.g., the absence of a comprehensive tobacco treatment plan). The many suggestions for additional QI activities underscore the broad-based interest in QI that exists within the Department and provide important guidance for advancing QI within DHCS.

These suggestions will be carefully reviewed within the context of everything that is currently being done, the Department’s strategic and programmatic priorities and its resources, and a multi-year QI plan will be developed. DHCS will invite feedback and counsel from its internal staff, stakeholders, and the newly-created Medi-Cal Performance Advisory Committee, as it moves forward in this regard.


Dear Colleagues,

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

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

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

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

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

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

As you respond to the questions in each part of the survey, we ask that you collaborate with your respective teams to obtain the most complete data possible, and coordinate a single survey package from your Division or Office. Please complete and hand-deliver your hardcopy survey and attachments to the Director’s Office, Attention: [Name], OR submit your completed survey via email to [Email].
Appendix D

Appendix A

Responses are due by **5:00pm, Monday, May 7, 2012**. To assist with administering the survey, the QI inventory team, within the Office of the Medical Director, will personally meet with division staff, as needed. You may contact [Adrienne Lowe](mailto:adrienne.lowe@dhcs.ca.gov) at 552-9607 to schedule a meeting time, or you can contact her if you have any questions for which a meeting is not required.

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

Survey Template

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

Part 1: Clinical QI Projects

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

a. Title

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

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

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

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

   ■ Other Metric(s), please describe.

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

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

e. Start date of the project

f. End date of the project

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

h. Project partners (include internal and external partners)

i. Funding source
   Who is funding the project?

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

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

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

Part II: Health Promotion and Disease Prevention QI Projects

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

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

- Smoking cessation and tobacco control
- Obesity prevention
- Nutrition and healthy eating
- Physical activity
- HIV/AIDS prevention
- Sexually transmitted disease prevention
- Motor vehicle and other injury prevention
- Violence prevention
Appendix A

• Alcohol and other substance abuse (including drug abuse)
• Prescription drug overdose
• Immunizations
• Teenage pregnancy prevention
• Preconception and prenatal care
• Screening and early detection of cancer
• Screening and early detection of cardiovascular disease
• Screening and early detection of diabetes
• Mental health
• Stress management
• Counseling (e.g., psychological counseling, weight management counseling)
• Health care associated infections, pressure ulcers, falls, and other preventable patient safety-related problems
• Complementary or alternative medicine (e.g., acupuncture)
• Referral to community services for prevention support

a. **Title**

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

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

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

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

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

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

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

e. **Start date of the project**

f. **End date of the project**
Appendix A

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

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

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

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

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

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

**Part III: Administrative QI Projects**

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

a.  **Title**

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

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

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

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

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

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

e. Start date of the project

f. End date of the project

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

i. Project partners (include internal and external partners)

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

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

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

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

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

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

Part V: Existing QI Gaps and Future Ideas

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

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

Thank you for completing the survey. The results of the survey will be available for review and discussion in June 2012.
Part 1: Clinical QI Projects

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

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

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

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

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

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

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

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

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

  e. Start date of the project
     July 1, 2012

  f. End date of the project
     June 30, 2015

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

  h. Project partners (include internal and external partners)

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

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

  k. Is performance tracked at the provider/practitioner level?
     - [x] Yes. If yes, describe how the performance is tracked.
     - [ ] No.
     - [ ] Don’t know.
Appendix A

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

Part II: Health Promotion and Disease Prevention QI Projects

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

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

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

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

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

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

Appendix A

**Baseline Metric(s) are the basis for measurement and calculation. They are the reference point(s) against which subsequent data are compared and evaluated over time.**
- The Helpline receives an average of 17,500 Medi-Cal callers annually.
- 22% of adult Medi-Cal members are smokers.

**Target Metrics(s) are values that have been pre-determined as indicators for success or failure. They are measurable improvements based on the baseline data.**
- CDP outreach will increase annual # of Medi-Cal callers to the Helpline by 50% to approximately 35,000 calls in calendar 2017.
- Reduce the smoking prevalence rate to 17% by December 2017.

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

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

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

**Start date of the project**
September 13, 2011

**End date of the project**
September 12, 2016

**Lead staff for the project (List up to 2)**
Who is the Project Director, Manager, or other key point of contact?
- MIQS Project Director: Neal Kohatsu, MD, MPH, Medical Director
- MIQS Project Manager: Gordon Sloss, MPA
Appendix A

Part III: Administrative QI Projects

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

a. **Title**
Reduction in time to hire DHCS civil service line staff.

b. **Specific Aim(s)**
*What are the desired outcome(s) for the project?*
Reduce the total time required from concept to start date to hire line staff.
Appendix D

Appendix A

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

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

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

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

- Site(s) (check all that apply):
  ☐ Emergency department
  ☐ Outpatient
  ☐ Inpatient
  ☐ Long-term care
  ☑ DHCS
  ☐ Other (please list): None.

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

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

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

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

- Executive Sponsor: Karen Johnson, Deputy Director
- Project Manager: Lisa Lassetter, Human Resources Branch Chief

h. Project partners (include internal and external partners)
i. **Funding source**  
*Who is funding the project?*  
No external or internal funding. Using existing staffing.

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

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

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

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

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

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

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

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

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**Part V: Existing QI Gaps and Future Ideas**

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

A comprehensive tobacco treatment plan, including recommended treatment options and clinical systems change to treat tobacco use, is not available. Currently, only two managed care health plans offer the comprehensive coverage recommended by AHRQ based on the Public Health Service-sponsored Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update. Comprehensive coverage would include:
Appendix A

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

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

Thank you for completing the survey. The results of the survey will be available for review and discussion in June 2012.
Administration Division (ADMIN)
ADMIN provides an array of central support services to achieve DHCS program and operations objectives. ADMIN streamlines policies and procedures, ensures fiscal accountability of programs by overseeing financial management, including budget development and oversight; provides responsive and reliable employee support and human resource management systems; provides guidance and consultation on contract and purchasing services; responsibly manages DHCS physical resources through facilities and telecommunications business services; supports the protection of DHCS employees through the Health and Safety office; and evaluates business processes with attention to improvements in other Department-wide support functions.

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

Benefits Division
The Benefits Division is responsible for managing and ensuring the uniform promulgation of federal and state laws and regulations regarding Medi-Cal benefits and policies affecting more than 150,000 providers of medical services to some 8 million Medi-Cal members. The division is a primary liaison with CMS for amendments to the State Medicaid Plan and coordinates with other divisions and state departments to ensure compliance with state and federal requirements under the State Plan. The division also has responsibility for the oversight and management of the Every Woman Counts (EWC) program, the largest breast cancer detection program in the nation, serving more than 260,000 women annually. EWC provides breast clinical services, such as mammograms, clinical breast exams, and diagnostic tests, to low-income California women ages 40 and over with inadequate or no health coverage. EWC also provides cervical clinical services, such as pap smears, HPV (Human Papilloma Virus) tests, and cervical diagnostic tests, for low-income, uninsured, and underinsured California women ages 25 and over. In addition, EWC carries out patient and provider education to increase awareness of the importance of screening and the availability of services for disparate high-risk populations, and it conducts required quality assurance and program evaluation activities. Through a process based upon published scientific, policy and practice evidence, the Benefits Division adds, limits, modifies, or eliminates targeted services to increase patient safety, reduce risk, and reduce cost of care. The division consists of the Policy and Benefits Branch and the Cancer Detection and Treatment Branch.

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

**Capitation Rates Development Division (CRDD)**

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

**Director’s Office**

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

Fee-For-Service Rates Development Division (FFSRDD)

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

Financial Management Branch (FMB)

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

Fiscal Forecasting Branch (FFB)

FFB serves as the Department’s local assistance fiscal expert and ensures the integrity of appropriation estimates. FFB is responsible for providing fiscal analysis of policy to the Director, California Health and Human Services Agency, Department of Finance, Governor’s Office, and Legislature. Twice each year, FFB prepares formal cost estimates for the over $60 billion Medi-Cal program and $350 million Family Health Program. The cost estimates include a fiscal analysis of policy changes, a projection of base program costs, and updated case load and utilization trends. The Administration and Legislature use the estimates to develop the annual budget and DHCS uses them to complete quarterly federal grant requests.

Information Technology Services Division (ITSD)

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

Legislative & Governmental Affairs Division (LGA)

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

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

Low-Income Health Program (LIHP) Division

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

Medi-Cal Dental Services Division (MDSD)

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

Medi-Cal Eligibility Division (MCED)

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

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

Mental Health Services Division (MHSD)

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

Office of Administrative Hearings and Appeals (OAHA)

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

Office of Civil Rights (OCR)

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

OFP is charged by the California Legislature “to make available to citizens of the state who are of childbearing age comprehensive medical knowledge, assistance, and services relating to the planning of families.” The purpose of family planning is to provide women and men a means by which they decide for themselves the number, timing, and spacing of their children. OFP administers the Family PACT program. Family PACT is California’s innovative approach to provide comprehensive family planning services to eligible low-income (under 200% of the federal poverty level) men and women. Family PACT serves 1.8 million income eligible men and women of childbearing age through a network of 2,400 public and private providers.

Office of Health Information Technology (OHIT)

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

Office of HIPAA Compliance (OHC)

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

Office of Legal Services (OLS)

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

Office of Medi-Cal Procurement (OMCP)

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

Office of Multicultural Health (OMH)

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

Office of Public Affairs (OPA)

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

Office of Selective Provider Contracting Program (OSPCP)

Through OSPCP, DHCS contracts on a competitive basis with those hospitals that desire to provide inpatient services to Medi-Cal members at a negotiated per diem rate for all hospital inpatient services. In utilizing
principles of competition and the negotiation process, OSPCP is able to optimize the availability of cost-effective hospital inpatient services under the Medi-Cal program. The California Medical Assistance Commission (CMAC) was the agency established to negotiate with hospitals on behalf of DHCS from 1983 until July 1, 2012. On July 1, 2012, CMAC was eliminated and the SPCP was transferred to DHCS for negotiation and administration until the SPCP is replaced by the implementation of the new discharge-based Diagnostic Related Group (DRG) hospital inpatient payment methodology, currently scheduled for July 1, 2013. The SPCP has operated successfully for more than 29 years, and the competitive contracting process has assured continued hospital access for Medi-Cal members. Since the inception of SPCP, the program has saved the General Fund $12.7 billion.

Office of Women’s Health (OWH)

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

Office of Workforce Planning & Development (OWPD)

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

Pharmacy Benefits Division (PBD)

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

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

Provider Enrollment Division (PED)

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

Research and Analytical Studies Branch (RASB)

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

Safety Net Financing Division (SNFD)

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

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

Systems of Care for Children and Adults Division (SCD)

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

Third Party Liability and Recovery Division (TPLRD)

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

Utilization Management Division (UMD)

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

Last summer you were invited to participate in the Department’s Quality Improvement Survey (QIS). The purpose of the QIS was to inventory all current Quality Improvement (QI) projects in the Department to help inform the development of the DHCS Strategy for Quality Improvement in Health Care, as well as advance QI in the Department’s newly-developed Strategic Plan. Your response to the QIS was outstanding, and we were able to gather nearly 50 QI projects Department-wide in the areas of clinical care, health promotion and disease prevention, and administration.

Now that a year has elapsed, we would like to learn how your existing QI projects have progressed or changed, and whether new QI projects have been developed. For the purpose of this update, QI is defined as a process designed to improve the delivery of preventive, diagnostic, therapeutic, rehabilitative, and administrative measures in order to improve health systems, and maintain, restore, or improve health or health outcomes of individuals and populations. QI projects are required, at a minimum, to have a specific aim(s), baseline metric(s), target metric(s), defined intervention(s), and timeline.

We have provided the attached Excel spreadsheet to collect your information, as well as a sample of a completed Excel spreadsheet to use as an example. Please follow the instructions below to complete your Excel spreadsheets, and submit your response to Leah Northrop, our new Quality Specialist, at leah.northrop@dhcs.ca.gov by COB Wednesday, October 16th. If you have any questions, or would like any assistance in developing or refining your QI project, please contact Leah directly via email or at (916) 440-7693.

Once we have collected and analyzed the QI project data Department-wide, we will send you a draft copy of what we gathered and your QI projects will be included in upcoming additions of the DHCS Strategy for Quality Improvement in Health Care. Thank you for taking the time to respond to our request and for being a QI champion at DHCS.

Best regards,

Neal Kohatsu, MD, MPH, Medical Director

Desiree Backman, DrPH, MS, RD, Chief Prevention Officer
INSTRUCTIONS
EXISTING QI PROJECTS:
Step 1: Update Existing QI Projects

1. Please “enable” the Excel spreadsheet so you can update your QI project(s). Please note that each Division/Office has its own sheet containing the existing QI projects. Simply click on the sheet with your Division/Office acronym/name to access your existing QI projects.

2. The top rows of the sheet include your existing QI projects. Please review each row to determine whether the information for your QI project(s) is accurate. Under “Project Status” please “click” the white cell that corresponds with your QI project, and then a drop down menu arrow will appear in the lower right corner. Choose the appropriate drop down for that QI project. Your selection of the drop down menu for each QI project will help guide you to complete the columns labeled “Explain Any Changes That Have Been Made,” “Performance Toward Target,” and “Additional Project Information.”

Drop down menu for “Project Status” and columns labeled “Explain Any Changes That Have Been Made,” “Performance Toward Target,” and Additional Project Information."

- **Project Status: Completed** = The QI project has been completed and is no longer active.
  - You do not need to include information in the column “Explain Changes That Have Been Made.”
  - In the column labeled “Performance Toward Target,” please describe the progress that has been made toward meeting the QI project target. Please refer to the sample form for examples.
  - In the column labeled “Additional Project Information,” please include a few sentences describing the successes, challenges, lessons learned or best practices resulting from your completed QI project.

- **Project Status: Ongoing—No Change** = The QI project is being implemented and there are no changes to the information provided in the Excel spreadsheet.
  - You do not need to place information under the column “Explain Changes That Have Been Made.”
  - In the column labeled “Performance Toward Target,” please describe the progress that has been made toward meeting the QI project target. Please refer to the sample form for examples.
  - In the column labeled “Additional Project Information,” please briefly describe any successes, challenges, lessons learned or best practices resulting so far from your QI project.

- **Project Status: Ongoing—with Modifications** = The QI project is being implemented, but there are changes to the information provided in the Excel spreadsheet.
Appendix E

- Under the column “Explain Changes That Have Been Made,” please describe the modifications that have been made to the QI project.
- In the column labeled “Performance Toward Target,” please describe the progress that has been made toward meeting the QI project target. Please refer to the sample form for examples.
- In the column labeled “Additional Project Information,” briefly describe any successes, challenges, lessons learned or best practices resulting from your QI activity and the modifications made.

**Project Status: On Hold** = The QI project is not being implemented because it is “on hold” for now. Please provide an explanation of the “on hold” status in the cell provided.

- Under the column “Explain Changes That Have Been Made,” please describe why the QI project has been placed “on hold.”
- You do not need to include information under the column “Performance Toward Target.”
- In the column labeled “Additional Project Information,” briefly describe any successes, challenges or lessons learned from your QI activity.

**Project Status: Cancelled** = The QI project is not being implemented because it has been cancelled.

- Under the column “Explain Changes That Have Been Made,” please explain why the QI project has been cancelled.
- You do not need to include information under the column “Performance Toward Target.”
- In the column labeled “Additional Project Information,” briefly describe any challenges or lessons learned from your QI project.

3. Please describe the data source(s) you are using to measure how each of your existing QI projects are meeting your designated target(s) (e.g., HEDIS, CAPHS, claims data, encounter data, etc.).
4. Please describe how often the data are collected and analyzed (e.g., monthly, quarterly, annually, etc.).

**NEW QI PROJECTS:**

**Step 2: Add New QI Projects**

1. Scroll down to the Excel Spreadsheet labeled “New QI Projects.”
2. If you do not have new QI projects to report, click “No” on the appropriate check box.
3. If you have new QI projects to report, click “Yes” on the appropriate check box and use a separate row of the Excel spreadsheet to describe each of your new QI projects.
4. Please complete all of the cells in the row. Below are definitions of each cell, with corresponding examples.

- **DHCS Office or Division** = Name of the Office or Division conducting the QI project.
  
  Example: Pharmacy Division

  - **Title and Aim(s)** = Title: Title of the QI project. Aim(s): What are the desired outcomes of the project?
    
    Example:
    
    **Title:** Improve Psychotropic Medication Use for Children and Youth in Foster Care
    **Aim:** To achieve improved psychotropic medication use in children and youth in foster care by reducing the rate of antipsychotic polypharmacy.

  - **Baseline** = Baseline metrics are the basis for measurement and calculation. They are the reference point(s) against which subsequent data are compared and evaluated over time.
    
    Example: Rate/proportion of polypharmacy of two or more antipsychotics 20.4% (2009/2010 data).

  - **Target** = Target metrics are values that have been pre-determined as indicators for success or failure. They are measurable improvements based on the baseline data.
    
    Example: Reduce the rate of antipsychotic polypharmacy to 15% by 6/30/15.

  - **Denominator** = Total number of people, things, days, processes, etc. potentially impacted by the QI project.
    
    Example: Number of foster care children with one or more antipsychotics: 4,930

  - **Start & End Dates** = The month/day/year of the start and end of your QI project.
    
    Example: Start date: 7/1/12; End date: 6/30/15

  - **Target Population** = The population reached by your QI project.
    
    Example: Medi-Cal members

  - **Data Source(s)** = Data Sources you use to measure how your QI project is meeting your designated target(s) (e.g., HEDIS, CAPHS, claims data, encounter data, etc.).
    

  - **Frequency of Data Collection** = How often the data are collected and analyzed. Some data sources may be available on a daily or weekly basis (e.g., number of phone calls, etc.), while some data sources may be updated on a monthly, quarterly or annual basis (surveys, vital statistics, etc.).
Example: The DHCS MIS/DSS system contains claim/encounter records, and data related to eligibility, providers and prescriptions. MIS/DSS loads or refreshes data on a monthly data release cycle, with some data available within a month, while the availability of other data can take 6 to 12 months. To account for this data lag, the MIS/DSS data is analyzed on a yearly basis.
### EXISTING QI ACTIVITIES:

<table>
<thead>
<tr>
<th>DHCS Office or Division</th>
<th>Title and Aim(s)</th>
<th>Baseline</th>
<th>Target</th>
<th>Denominator</th>
<th>Start &amp; End Dates</th>
<th>Target Population</th>
<th>Project Status (Select One Option from the Drop Down Box in Each Cell’s Lower Right Corner)</th>
<th>Explain Any Changes That Have Been Made</th>
<th>Performance Toward Target</th>
<th>Additional Project Information (Successes, Challenges, etc.)</th>
<th>Data Source(s)</th>
<th>Frequency of Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services Division</td>
<td><strong>Medi-Cal Specialty Mental Health Services for Children and Youth (Under Development):</strong> 1) To develop a performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment of mental health services for eligible children and youth that will improve outcomes at the individual and system levels and will inform fiscal decision making related to the purchase of services.</td>
<td>1) Baseline metrics under development</td>
<td>1) Target metrics under development</td>
<td>Unknown at this time</td>
<td>Start date: 9/1/12 End date: Ongoing</td>
<td>Medi-Cal and non-Medi-Cal patients</td>
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</tbody>
</table>
**NEW QI ACTIVITIES:**

*If YES, use this table for new QI activities that are not included in the "Existing Activities" section of the spreadsheet above. Insert additional rows, if necessary.*

<table>
<thead>
<tr>
<th>DHCS Office or Division</th>
<th>Title and Aim(s)</th>
<th>Baseline</th>
<th>Target</th>
<th>Denominator</th>
<th>Start &amp; End Dates</th>
<th>Target Population</th>
<th>Data Source(s)</th>
<th>Frequency of Data Collection</th>
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</table>
### EXISTING Q1 ACTIVITIES:

<table>
<thead>
<tr>
<th>DHCS Office or Division</th>
<th>Title and Aim(s)</th>
<th>Baseline</th>
<th>Target</th>
<th>Denominator</th>
<th>Start &amp; End Dates</th>
<th>Target Population</th>
<th>Project Status</th>
<th>Explain Any Changes That Have Been Made</th>
<th>Performance Toward Target</th>
<th>Additional Project Information (Successes, Challenges, etc.)</th>
<th>Data Source(s)</th>
<th>Frequency of Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office of the Medical Director</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity among Children and Adolescents: To increase the documentation rates of BMI percentile, counseling, or referral for nutrition and physical activity in 10 pilot community clinics.</td>
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<td>1) Average documentation rate of BMI percentile: 55%. Specific rates vary by clinic.</td>
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<td>2) Average rate of nutrition counseling: 56%. Specific rates vary by clinic.</td>
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<td>3) Average rate of physical activity counseling: 40%. Specific rates vary by clinic.</td>
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<td>1) Average documentation rate of BMI percentile: Increase to 80%. Specific rates vary by clinic.</td>
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<td>2) Average rate of nutrition counseling: Increase to 80%. Specific rates vary by clinic.</td>
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<td>3) Average rate of physical activity counseling: 75%. Specific rates vary by clinic.</td>
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<td>16,500 children and adolescents, aged 3 to 17 years, who had an outpatient visit with a primary care practitioner or OB/GYN in the pilot community clinics during the measurement year: March 2012-2013</td>
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<td>Start date: March 1, 2012</td>
<td>End date: March 1, 2014</td>
<td>Children and adolescents enrolled and not enrolled in Medi-Cal</td>
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<td>ON GOING - WITH MODIFICATION (Provide explanation on the next column)</td>
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<td>The number of pilot community clinics was reduced to 9 on June 21, 2012 due to workforce reductions.</td>
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<td>All other aspects of the Q1 project have remained the same.</td>
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<td>1) Average documentation rate of BMI percentile: 60%. Specific rates vary by clinic.</td>
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<td>2) Average rate of nutrition counseling: 62%. Specific rates vary by clinic.</td>
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<td>3) Average rate of physical activity counseling: 45%. Specific rates vary by clinic.</td>
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<td>Challenges: It was difficult to recruit the pilot community clinics initially due to concerns of extra workload. One community clinic also dropped out of the pilot due to workforce reductions. Successes: Despite the challenges, the pilot program is on track, within budget, and running efficiently.</td>
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<td>Healthcare Effectiveness Data and Information Set (HEDIS): Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, BMI Assessment, Nutrition Counseling, Physical Activity Counseling</td>
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<td>Data collected annually.</td>
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</table>
**NEW QI ACTIVITIES:**

*If YES, use this table for new QI activities that are not included in the "Existing Activities" section of the spreadsheet above. Insert additional rows, if necessary.*

<table>
<thead>
<tr>
<th>DHC's Office or Division</th>
<th>Title and Aim(s)</th>
<th>Baseline</th>
<th>Target</th>
<th>Denominator</th>
<th>Start &amp; End Dates</th>
<th>Target Population</th>
<th>Data Source(s)</th>
<th>Frequency of Data Collection</th>
</tr>
</thead>
</table>
| Pharmacy Division        | Improve Psychotropic Medication Use for Children and Youth in Foster Care: To achieve improved psychotropic medication use for children and youth in foster care by reducing the rate of antipsychotic polypharmacy. | Rate of polypharmacy of two or more antipsychotics: 20.4% (2009/2010 data). | Reduce the rate of antipsychotic polypharmacy to 15%. | Number of foster care children with one or more antipsychotics: 4,930. | Start date: 7/1/12  
End date: 6/30/15 | Medi-Cal members  
Note: Started collecting data as part of a 16-state study, and in the future, we may benefit by comparing CA data to national data as part of a larger effort to benefit people beyond Medi-Cal. | There are numerous technical specifications for this measure in a data dictionary; the numerator and denominator shown here provides a conceptual summary of the measure.  
**Numerator:** Number of Medi-Cal foster children with two or more antipsychotics found in claims/encounter data.  
**Denominator:** Number of Medi-Cal foster children with at least one antipsychotic found in claims/encounter data.  
**Data Source:** MIS/DSS claims and encounter data; eligibility data with specific aid codes for foster children. | Data analyzed on a yearly basis. While many eligibility, claims, and encounter data are loaded into MIS/DSS as these become available from the various data streams each month, some claims are not sent to DHC's for six months or up to a year. Thus, this measure uses data that are at least a year old to ensure all claims and encounter data are included in the analysis.
<table>
<thead>
<tr>
<th>DHCS Office or Division</th>
<th>Title and Aim(s)</th>
<th>Baseline</th>
<th>Target</th>
<th>Denominator</th>
<th>Start &amp; End Dates</th>
<th>Target Population</th>
<th>Data Source(s)</th>
<th>Frequency of Data Collection</th>
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<tbody>
<tr>
<td>Office of the Medical Director</td>
<td>Medi-Cal Incentive to Quit Smoking: To increase utilization of the Smokers’ Helpline through the use of appropriate incentives.</td>
<td>The Helpline receives an average of 17,500 Medi-Cal callers annually.</td>
<td>1) Increase the number of Medi-Cal callers to the Helpline by 50% to approximately 25,000 calls by 12/31/15.</td>
<td>681,247</td>
<td>Start date: 9/13/11</td>
<td>End date: 9/12/16</td>
<td>Medi-Cal members</td>
<td>Total number of Helpline calls (summed over year)</td>
</tr>
<tr>
<td>Administration Division: Workforce Planning and Development</td>
<td>DHCS University: To improve the knowledge, skills, and abilities of the Medi-Cal program managers, senior managers, and executives throughout the Department.</td>
<td>No current participants in the DHCS University.</td>
<td>1) Train 50 participants in the DHCS University within the first year of the program. 2) Conduct training transfer surveys to ensure knowledge retention and create a training practicum to help participants demonstrate problem solving skills.</td>
<td>594 program managers, senior managers, and executives</td>
<td>Start date: 2/1/13</td>
<td>End date: Ongoing</td>
<td>Staff serving Medi-Cal members</td>
<td>1) Total number of participants enrolled in DHCS University  2) Percent of enrolled DHCS University students who complete transfer surveys Data Source: Workforce Division administrative data</td>
</tr>
</tbody>
</table>
Appendix F: Medi-Cal Performance Advisory Committee Agenda, November 5, 2012
# MEDI-CAL PERFORMANCE ADVISORY COMMITTEE

Institute for Population Health Improvement  
Conference Room 2020  
UC Davis Health System  
4800 2nd Avenue  
Sacramento, CA 95817

## AGENDA

November 5, 2012

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter(s)</th>
</tr>
</thead>
</table>
| 10:00 – 10:20 | I.  Welcome and Opening Comments                                                               | Kenneth W. Kizer, MD, MPH, Director  
Institute for Population Health Improvement |
| 10:20 – 10:35 | II. DHCS Quality Strategy – Update and Revisions                                                 | Neal D. Kohatsu, MD, MPH, Medical Director  
California Department of Health Care Services |
| 10:35 – 11:05 | III. Delivery System Reform Incentive Payments (DSRIP) Program – Update, observations and discussion  \  
Ulfat Shaikh, MD, MPH, MS, Clinical Quality Officer  
California Department of Health Care Services  
Amber Kemp, MBA, Special Assistant to the Medical Director  
California Department of Health Care Services  
Kenneth W. Kizer, MD, MPH, Director  
Institute for Population Health Improvement |
| 11:05 – 11:20 | IV. Medi-Cal Adult Quality Care Improvement Grant and Data Management – Update                  | Linette Scott, MD, Chief Medical Information Officer  
California Dept. of Health Care Services |
| 11:20 – 12:30 | V. DHCS Quality Inventory – Update and review                                                     | Neal D. Kohatsu, MD, MPH, Medical Director  
California Department of Health Care Services  
Desiree Backman, DrPH, MS, RD  
Chief Prevention Officer  
California Department of Health Care Services |
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>1230 – 1:00 PM</td>
<td>Working Lunch</td>
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<tr>
<td>1:00 – 1:30 PM</td>
<td>I. <strong>DHCS Quality Inventory – Discussion</strong></td>
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<td>Neal D. Kohatsu, MD, MPH, Medical Director</td>
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<td>California Department of Health Care Services</td>
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<td>Desiree Backman, DrPH, MS, RD Chief Prevention Officer</td>
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<td>California Department of Health Care Services</td>
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<td>1:30 – 1:50 PM</td>
<td>II. <strong>Toby Douglas’ testimony to the Assembly Health Committee, October 25, 2012 – Review and Discussion</strong></td>
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<td>Toby Douglas, Director</td>
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<td>California Department of Health Care Services</td>
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<td>Neal D. Kohatsu, MD, MPH, Medical Director</td>
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<td>California Department of Health Care Services</td>
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<td>1:50 – 2:50 PM</td>
<td>III. ** Medi-Cal Quality Dashboard – Discussion about a construct, measures and other issues**</td>
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<td>Kenneth W. Kizer, MD, MPH, Director</td>
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<td>Institute for Population Health Improvement</td>
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<td>2:50 – 3:00 PM</td>
<td>Break</td>
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<tr>
<td>3:00 – 4:00 PM</td>
<td>IV. <strong>Assessing and Managing Medi-Cal quality of care in a managed care environment</strong></td>
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<td>Kenneth W. Kizer, MD, MPH, Director</td>
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<td>Institute for Population Health Improvement</td>
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<td>4:00 – 4:15 PM</td>
<td>V. <strong>Wrap Up</strong></td>
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<td>Kenneth W. Kizer, MD, MPH, Director</td>
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<td>Institute for Population Health Improvement</td>
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</tbody>
</table>
Appendix G: Medi-Cal Performance Advisory Committee
Agenda, April 22, 2013
# Medi-Cal Performance Advisory Committee Meeting

April 22, 2013

Institute for Population Health Improvement  
FSSB Classroom, room 2030  
UC Davis Medical Center  
4800 2nd Avenue  
Sacramento, CA 95817

## Agenda

<table>
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<tr>
<th>Time</th>
<th>Section</th>
<th>Presenter(s)</th>
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| 10:00 – 10:20 AM | I. Welcome and Opening Comments | Kenneth W. Kizer, MD, MPH, Director  
Institute for Population Health Improvement |
| 10:20 – 10:40 AM | II. DHCS Updates | Toby Douglas, Director  
California Department of Health Care Services |
| 10:40 – 11:10 AM | III. DHCS Quality Strategy: Prevention Assessment, Health Disparities Report, and Revisions – Update and Discussion | Neal D. Kohatsu, MD, MPH, Medical Director  
California Department of Health Care Services  
Desiree Backman, DrPH, RD, Chief Prevention Officer, DHCS  
Institute for Population Health Improvement |
| 11:10 – 12:00 PM | IV. Delivery System Reform Incentive Payments (DSRIP) Program & Coordinated Care Initiative Evaluation– Update and Discussion | Neal D. Kohatsu, MD, MPH  
Kenneth W. Kizer, MD, MPH  
Ulfat Shaikh, MD, MPH, MS, Clinical Quality Officer, DHCS  
Institute for Population Health Improvement |
| 12:00 – 12:30 PM | V. Medi-Cal Adult Quality Care Improvement Grant– Update and Discussion | Linette Scott, MD, MPH, Chief Medical Information Officer  
California Department of Health Care Services |
<table>
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<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>12:30 – 1:00 PM</td>
<td><strong>Working Lunch</strong></td>
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| 1:00 – 2:50 PM | **VI. Medi-Cal Data Strategy and Intervention Development: Patient Safety and Prevention Quality Indicators – Discussion and Recommendations**  
Neal D. Kohatsu, MD, MPH  
Kenneth W. Kizer, MD, MPH  
Linette Scott, MD, MPH  
Brian Paciotti, PhD, Quality Scientist  
Institute for Population Health Improvement |
| 2:50 – 3:10 PM | **Break**                                    |
| 3:10 – 3:30 PM | **VII. Medi-Cal Data Strategy and Intervention Development: Patient Safety and Prevention Quality Indicators (Continued) – Discussion and Recommendations**  
Neal D. Kohatsu, MD, MPH  
Kenneth W. Kizer, MD, MPH  
Linette Scott, MD, MPH  
Brian Paciotti, PhD |
| 3:30 – 4:00 PM | **VIII. Wrap Up**                            
Kenneth W. Kizer, MD, MPH |
Appendix H: Champions For Change Rx Proposal
STATE LEVEL PROJECT SUMMARY FORM

CHAMPIONS FOR CHANGE Rx: BUILDING A STRONG INTERFACE BETWEEN COMMUNITY AND HEALTH CARE INTERVENTIONS TO PREVENT AND REDUCE OBESITY AMONG LOW-INCOME CALIFORNIANS

FFY 2014

1. **Goals & Objectives** *(See State Level Objectives).*

2. **Project Title:** Champions for Change Rx: Building a Strong Interface between Community and Health Care Interventions to Prevent and Reduce Obesity among Low-income Californians

   a. **Related State Objectives:**
      Related State Objectives include 1, 2, 3, and 4

   b. **Audience**
      - Gender: Female and Male
      - Ethnicity: All races and ethnicities
      - Languages: English and Spanish
      - Ages: Adults, especially SNAP-Ed eligible women with children, and SNAP-Ed and Medi-Cal intermediaries who serve this audience

   c. **Focus on SNAP Eligibles**
      As described in the Narrative Summary below, a total of five roundtable discussions will be conducted in northern, central, and southern California with SNAP-eligible Medi-Cal members. Income eligibility will be verified by the roundtable discussion participants at the time of recruitment. In addition, key informant interviews will be conducted with representatives from Medi-Cal managed care plans and provider groups, as well as Network state and Local Health Department leaders. The Medi-Cal managed care plan representatives and provider groups will serve more than 50% SNAP-eligible Medi-Cal members in their practices and the Network state and Local Health Department leaders will serve SNAP-eligible Californians as part of their routine scope of work.

   d. **Project Description**
      - **Key Strategies:** Key strategies will be based upon the formative research results of this project. See the Narrative Summary below for a description of Champions for Change Rx.

      Key Educational Messages: Key educational messages will be based upon the formative research results of this project and will be consistent with Network messages (e.g., childhood obesity prevention, chronic disease and obesity prevention, dietary quality, fruits and vegetables, healthy beverage promotion, healthier eating (general), cooking skills, physical activity
promotion (integrated with nutrition education), food shopping/preparation, and CalFresh promotion (brief promotional message). See the Narrative Summary below for a description of Champions for Change Rx.

**Intervention Sites:**
Health care delivery organizations and community sites will be identified based upon the formative research. See the Narrative Summary below for a description of Champions for Change Rx.

**Projected Number of Contacts:**
Direct (unduplicated) Contacts: 40 SNAP-Ed eligible Medi-Cal members reached through 5 roundtable discussions in northern, central, and southern California. See the Narrative Summary below for additional details.

**Narrative Summary:**

**Problem Statement**
The California Department of Health Care Services’ (DHCS) mission is to preserve and improve the health of all Californians by operating and financing programs that deliver vital health care services to approximately 8.3 million individuals including low-income families and children, seniors and persons with disabilities, children in foster care, pregnant women, and those with certain diseases and conditions. These services include medical, mental health, substance use treatment, and long-term care.

As part of DHCS’ commitment to deliver high-quality care, an assessment was conducted from April-October 2012 to inventory all Departmental quality improvement (QI) efforts in the areas of clinical care, health promotion and disease prevention, and administration. Although a wide variety of QI activities was reported in the areas of clinical care and administration, little activity was noted in the area of health promotion and disease prevention. Most notably, there was an absence of QI activities in the areas of healthy eating, physical activity, and obesity prevention despite the high rates of overweight and obesity among children (29.6%), adolescents (35.2%), and adults (65.7%) enrolled in the Department’s largest program, Medi-Cal. The results of the assessment provided a call to action to develop, implement, evaluate, and sustain a comprehensive obesity prevention program that links the many facets of the health care system to the Network’s existing community-based efforts. At this time, unfortunately, there are no programmatic funds available for such a program.

**Background**
DHCS programs integrate a broad spectrum of care primarily via Medi-Cal, a federal/state partnership serving individuals and families who meet defined eligibility requirements. Medi-Cal services are delivered by more than 400 hospitals, approximately 130,000 doctors, pharmacists, dentists and other health care providers, and 21 managed care plans. Of the 8.3 million Medi-Cal members currently served by
DHCS, over 7.2 million (88%) have annual household incomes that are at or below 185% of the Federal Poverty Level. This income criterion is consistent with SNAP-Ed.

To accelerate advancements in care, DHCS recently produced the *Strategy for Quality Improvement in Health Care (Quality Strategy)*.\(^2\) The *Quality Strategy* establishes goals, priorities, and guiding principles, as well as highlights existing and emerging DHCS QI initiatives to improve health and patient care, and reduce costs. It aligns with the *National Strategy for Quality Improvement in Health Care*\(^3\) and reflects the best evidence-based practice known to date in the areas of patient safety, care delivery, person and family engagement, communication and coordination of care, prevention, healthy communities, and elimination of health disparities.

Given the large number of SNAP-Ed eligible individuals reached through Medi-Cal and DHCS’ newly-established commitment to QI in the areas of prevention and healthy communities, DHCS is interested in collaborating with the *Network* to conduct formative research, develop, and then pilot test a program to link obesity prevention efforts among SNAP-Ed eligible Medi-Cal members in the health care setting with the *Network’s* community-based interventions. The purpose of the program will be to reduce the risk and prevalence of overweight and obesity among SNAP-Ed eligible Medi-Cal members and reduce projected health care costs.

The initial phase of the project will be to conduct formative research and develop the components of the pilot program from October 1, 2013-September 30, 2014, in collaboration with the *Network*. The aims of the formative research and program development phase are to:

- Identify feasible, sustainable, age- and culturally-appropriate obesity prevention approaches in the health care setting that can be delivered to SNAP-Ed eligible Medi-Cal members;
- Identify tested *Network/SNAP-Ed* tools, resources, materials, and communication methods that can be applied to the health care setting;
- Identify efficient and effective ways to drive SNAP-Ed eligible Medi-Cal members to participate in *Network* community-based interventions where they live, work, learn, worship, play, make food and physical activity decisions, and become involved in community empowerment efforts.
- Develop and produce a pilot program and evaluation plan designed to reduce the risk and prevalence of overweight and obesity among SNAP-Ed eligible Medi-Cal members and reduce projected health care costs.
- Develop the components of the pilot program in preparation for pilot program implementation and formal evaluation in Federal Fiscal Year (FFY) 2015.

**Implementation Partners**
This proposal incorporates the complementary strengths of three partners: the California Department of Public Health (CDPH), DHCS, and the University of California, Davis,
Institute for Population Health Improvement (IPHI). In July 2007, the Department of Health Services split into DHCS and CDPH to enable each department to focus on health care and public health, respectively. However, both departments are dedicated to improving the health of all Californians and work closely on specific areas such as: chronic disease prevention and management; elimination of health disparities; advancing prevention; and building healthier communities.

In 2011, DHCS initiated a five-year, interagency agreement with IPHI to provide technical assistance, including on-site staffing, to help the Department advance the Triple Aim of: improved health, improved care, and reduced cost. IPHI is directed by Kenneth W. Kizer, MD, MPH, Distinguished Professor, UC Davis School of Medicine and the Betty Irene Moore School of Nursing. Dr. Kizer is an internationally-known expert in public health, health care quality, and system redesign and a member of the Institute of Medicine. He is credited with the transformation of the Veterans Administration Health Care System into one of the nation’s preeminent health systems. Prior to this work, Dr. Kizer served as Director of the California Department of Health Services where he fostered the development of the 5-a-Day Program and the internationally-known Tobacco Control Program. This proposal includes IPHI as the subcontractor with DHCS. Under Dr. Kizer’s leadership, IPHI staff are highly qualified to assist DHCS in carrying out the scope of work for this project, which requires expertise in population health, system redesign, program development, and evaluation.

**Scope of Activities**

**Task 1**
In collaboration with Network state and Local Health Department staff, identify and compile a list of tested Network, MyPlate, and other SNAP-Ed tools, materials, and community-based intervention approaches that could apply to the health care setting and be implemented widely with Medi-Cal members using DHCS distribution channels, including hospitals, clinics, pharmacists, and managed care plans.

Date: October-December 2013

**Task 2**
Conduct a minimum of 25 key informant interviews with representatives from Medi-Cal managed care plans and provider groups, as well as Network state and Local Health Department leaders to identify feasible, sustainable, age- and culturally-appropriate obesity prevention approaches in the health care setting and identify ways to link Medi-Cal members with the Network’s community-based approaches where they live, work, learn, worship, play, make food and physical activity decisions, and become involved in community empowerment efforts.

A broad array of health care, community-based, and technological approaches will be vetted with the key informants including, but not limited to: First Lady Michelle Obama’s *Let’s Move—Health Care Providers*,4 the American Medical Association expert
committee recommendations on the assessment, prevention, and treatment of child and adolescent overweight and obesity,\(^5\) the *Let’s Go! Childhood Obesity Resource Toolkit for Healthcare Professionals*,\(^6\) the California Medical Association Foundation’s Obesity Provider Toolkits,\(^7\)\(^8\) and various *Network*, MyPlate, and other SNAP-Ed resources. A variety of ways to link SNAP-Ed eligible Medi-Cal members to the *Network’s* community-based interventions will also be explored, including the use of targeted social media and web-based applications, referral by health care providers, and more.

After the key informant interviews have been conducted, the results will be analyzed and a report of the findings and recommendations will be produced.

**Date:** October 2013-March 2014

**Task 3**

Conduct a total of five roundtable discussions with SNAP-Ed eligible Medi-Cal members in northern, central, and southern California to identify obesity prevention approaches in the health care setting that would best meet their needs. In addition, identify ways to create an effective link between obesity prevention in the health care setting and *Network* community-based interventions. The roundtables will explore questions such as: What resources, assistance, or types of content related to nutrition and physical activity would most likely to be useful in the health care setting? What channels, formats, or delivery modes would be most effective (e.g., 1-on-1 counseling, classes, support groups)? What are specific ways the health care system could support community-based prevention activities? The results of the roundtable discussions will be analyzed and a report of the findings and recommendations will be produced.

This developmental work to better understand local differences is necessary for a number of reasons. First, the Medi-Cal population is quite diverse with respect to urban/rural residence, race/ethnicity, language and culture. Second, the Medi-Cal Program is the largest in the U.S. with 8.5 million members and is delivered through a health care network which varies, significantly, across the state. There are over 20 individual health plan contracts, a significant fee-for-service network, large multi-specialty medical groups, small practices, as well as federally qualified health centers. Third, there is a major expansion of Medi-Cal eligibility supported through the Affordable Care Act. One and one-half to two million more Medi-Cal members will be enrolled in the next few years. This expansion is driving significant redesign of the health care system including the rapid growth of patient-centered medical homes, improved chronic disease management, and enhanced working relationships between health care and community services.

The proposed roundtable discussions across the state will enable the development of programs for SNAP-Ed-eligible Medi-Cal members that are tailored to the varied needs and environments described above.

**Date:** October 2013-March 2014
Task 4
In collaboration with Network state and Local Health Department staff, identify and compile a list of communities in California that could serve as pilot test sites for future health care/community intervention testing. The pilot test sites should have: well-coordinated, evidence-based Network activities; campaigns, programs, and collaboratives that reach SNAP-Ed eligible families; a high prevalence of overweight and obesity; Medi-Cal managed care plans that support the implementation of prevention approaches in health care settings and community-based linkages; and Medi-Cal managed care plans that are able to efficiently and effectively provide aggregate health data to monitor the outcomes of the pilot test.

Date: October 2013-January 2014

Task 5
Based on Tasks 1-4, develop and produce a pilot intervention and evaluation plan aimed at reducing the risk and prevalence of overweight and obesity among SNAP-Ed eligible Medi-Cal members and reducing projected health care costs, with an emphasis on those that suffer the effects of overweight and obesity (e.g., Medi-Cal members with metabolic syndrome, type 2 diabetes, and cardiovascular disease). DHCS will collaborate with the Network’s Research and Evaluation Unit to develop the evaluation plan based upon the Western Region SNAP-Ed Nutrition, Physical Activity, and Obesity Prevention Outcomes Evaluation Framework, 2013. DHCS will submit the plan for Network approval and prepare for intervention and evaluation execution in FFY 2015.

In FFY 2015 and depending upon the availability of funds, DHCS plans to conduct an evaluation to determine the effects of health care and community interventions, which will be informed by the activities in this proposal, on selected measures among SNAP-Ed eligible Medi-Cal members. Anticipated measures for the FFY 2015 evaluation include diet and physical activity behaviors and behavioral predictors, Body Mass Index, hemoglobin A1C, lipid levels, blood pressure, patient satisfaction, quality of life, and projected health care cost estimates using a sophisticated modeling program known as Archimedes. Other measures may include: practice changes among health care organizations, improved access to obesity prevention interventions by SNAP-Ed eligible Medi-Cal members and their families, and commitment of resources in the health care sector for nutrition and physical activity.

If the project is able to demonstrate improvement in health behaviors and outcomes in a cost-effective fashion, the program will be broadly implemented across the Medi-Cal health care delivery system. Based on the experience of the implementation partners and the care with which the formative research will be conducted, we believe that the program will likely produce significant value for SNAP-Ed-eligible Medi-Cal members and for those organizations that deliver the program.

Date: March-May 2014
Task 6
Based on the Network-approved pilot intervention and evaluation plan, develop and assemble the following pilot program and evaluation components:

- Confirm health care and community pilot test sites and partners.
- Confirm logistics of participant recruitment for the pilot test.
- Assemble health care program intervention pieces and materials. DHCS is planning to use existing Network/My Plate/SNAP-Ed materials and health care obesity prevention tools to the greatest extent possible. Develop methods to motivate and drive SNAP-Ed eligible Medi-Cal members to Network interventions at the community level. The methods will be based upon the findings of the formative research.
- Develop draft evaluation instruments and methods to secure health data. As noted above, health data will include, but may not be limited to the following: diet and physical activity behaviors and behavioral predictors, Body Mass Index, hemoglobin A1C, lipid levels, blood pressure, patient satisfaction, quality of life, projected health care cost estimates using the Archimedes modeling program, practice changes among health care organizations, improved access to obesity prevention interventions by SNAP-Ed eligible Medi-Cal members and their families, and commitment of resources in the health care sector for nutrition and physical activity.
- Prepare for the launch of the pilot test in FFY 2015.

Date: June-September 2014

Reaching SNAP-Ed Consumers

The formative research phase of Champions for Change Rx is designed to inform the development of a health care/community pilot program that meets all USDA targeting criteria and specifically reaches the SNAP-Ed eligible population.

Maximizing SNAP-Ed’s Impact

The formative research phase of Champions for Change Rx is designed to inform the development of a health care/community pilot program that leverages and maximizes all possible connections between the Network and DHCS’ large-scale, statewide, population health system.

Strength through Collaboration

Champions for Change Rx is designed to stimulate synergy among CDPH, DHCS, Local Health Departments funded by the Network, the extensive Medi-Cal health care delivery system in California, and SNAP-Ed eligible Medi-Cal members.
e. **Summary of Research**

   The results from the key informant interviews and roundtable discussions will inform the
development of the Champions for Change Rx pilot program and evaluation plan.

f. **Modification of Project Methods/Strategies**

   Champions for Change Rx is a new project; as such, no modifications to the project
methods/strategies are requested.

g. **Use of Existing Educational Materials**

   As described in the Narrative Summary in Tasks 1 and 2, DHCS staff, in collaboration
with *Network* state and Local Health Department staff, will identify and compile a list of
tested *Network*, MyPlate, and other SNAP-Ed tools, materials, and community-based
intervention approaches that could apply to the health care setting and be implemented
widely with SNAP-Ed eligible Medi-Cal members using DHCS distribution channels,
including hospitals, clinics, pharmacists, and managed care plans.

   In addition, during the key informant interviews, a broad array of health care,
community-based, and technological approaches will be vetted with the key informants
including, but not limited to: First Lady Michelle Obama’s *Let’s Move—Health Care
Providers*, the American Medical Association expert committee recommendations on the
assessment, prevention, and treatment of child and adolescent overweight and obesity,
the *Let’s Go! Childhood Obesity Resource Toolkit for Healthcare Professionals*, the
California Medical Association Foundation’s Obesity Provider Toolkits, and various
*Network*, MyPlate, and other SNAP-Ed resources.

h. **Development of New Educational Materials**

   None planned.

i. **Key Performance Measures/Indicators**

   Formative research results for Champions for Change Rx will help inform the
development of the pilot program and evaluation plan.

   Key performance measures/indicators for the future pilot program evaluation in FFY
2015 may include, but are not limited to: diet and physical activity behaviors and
behavioral predictors, Body Mass Index, hemoglobin A1C, lipid levels, blood pressure,
patient satisfaction, quality of life, projected health care cost estimates using the
Archimedes modeling program, practice changes among health care organizations,
Improved access to obesity prevention interventions by SNAP-Ed eligible Medi-Cal
members and their families, and commitment of resources in the health care sector for
nutrition and physical activity.
3. Evaluation Plan
An evaluation plan will be developed based upon the formative research results for Champions for Change Rx.

As noted previously, in FFY 2015 and depending upon the availability of funds, DHCS plans to conduct an evaluation to determine the effects of health care and community interventions, which will be informed by the activities in this proposal, on selected measures among SNAP-Ed eligible Medi-Cal members. Anticipated measures for the FFY 2105 evaluation include diet and physical activity behaviors and behavioral predictors, Body Mass Index, hemoglobin A1C, lipid levels, blood pressure, patient satisfaction, quality of life, and projected health care cost estimates using the Archimedes modeling program. Other measures may include: practice changes among health care organizations, improved access to obesity prevention interventions by SNAP-Ed eligible Medi-Cal members and their families, and commitment of resources in the health care sector for nutrition and physical activity.

If the project is able to demonstrate improvement in health behaviors and outcomes in a cost-effective fashion, the program will be broadly implemented across the Medi-Cal health care delivery system. Based on the experience of the implementation partners and the care with which the formative research will be conducted, we believe that the program will likely produce significant value for SNAP-Ed-eligible Medi-Cal members and for those organizations that deliver the program.

4. Coordination Efforts
• Champions for Change Rx is designed to stimulate synergy among CDPH, DHCS, Local Health Departments funded by the Network, the extensive Medi-Cal health care delivery system in California, and SNAP-Ed eligible Medi-Cal members. To our knowledge, this is the first time that CDPH and DHCS have connected their large-scale program and health care systems to reduce the prevalence and risk of overweight and obesity among the low-income populations they serve. This new collaboration is consistent with other large-scale partnerships that DHCS has forged in the last year. For example, DHCS and CDSS have established a partnership to increase CalFresh enrollment among the 1.2 million Medi-Cal members who are eligible but not currently enrolled in the nutrition assistance program. CDSS and DHCS have identified and are implementing a variety of ways to promote CalFresh through Medi-Cal and connect the two systems at the time of health care enrollment and recertification.
References


EXHIBIT A
SCOPE OF WORK
Budget Justification
Champions for Change Rx:
Building a Strong Interface between Community and Health Care Interventions
to Prevent and Reduce Obesity among Low-Income Californians

Summary of Project:

<table>
<thead>
<tr>
<th>Description of Tasks and Activities</th>
<th>Start Date</th>
<th>End Date</th>
<th>Responsible Staff</th>
<th>Deliverable</th>
<th>Amount</th>
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<tbody>
<tr>
<td>1. In collaboration with Network and local staff, identify and compile a list of tested Network, MyPlate, and other SNAP-Ed tools, materials, and community-based intervention approaches that could apply to the health care setting and be implemented widely with Medi-Cal members using DHCS distribution channels, including hospitals, clinics, pharmacies, and managed care plans.</td>
<td>10/1/2013</td>
<td>12/31/2013</td>
<td>Program Manager (PM); Program Assistant (PA)</td>
<td>List of tested Network, MyPlate, and other SNAP-Ed tools, materials, and community-based intervention approaches that could apply to the health care setting</td>
<td>$42,142.33</td>
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<td>2. Conduct a minimum of 25 key informant interviews with representatives from Medi-Cal managed care plans and provider groups, as well as state and local Network leaders to identify feasible, sustainable, age- and culturally-appropriate obesity prevention approaches in the health care setting and identify ways to link Medi-Cal members with the Network’s community-based approach where they live, work, learn, worship, play, make food and physical activity decisions, and become involved in community empowerment efforts.</td>
<td>10/1/2013</td>
<td>3/31/2014</td>
<td>Program Manager; Program Assistant; Subcontractor</td>
<td>Prepare the key informant interview surveys; recruit participants; conduct the key informant interviews; analyze the data; and write a final report of the findings and recommendations.</td>
<td>$50,808.47</td>
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<td>3. Conduct a total of five roundtable discussions with SNAP-Ed eligible Medi-Cal members in northern, central, and southern California to identify obesity prevention approaches in the health care setting that would best meet their needs. In addition, identify ways to create an effective link between obesity prevention in the health care setting and Network community-based interventions. Analyze the results of the roundtable discussions and produce a report of the findings and recommendations for action.</td>
<td>10/1/2013</td>
<td>3/31/2014</td>
<td>Program Manager; Program Assistant; Subcontractor</td>
<td>Prepare the roundtable moderator’s guide; recruit participants; conduct the roundtable discussions; analyze the data; and write a final report of the findings and recommendations.</td>
<td>$80,308.47</td>
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Total Budget: $530,312.33
### EXHIBIT A

**SCOPE OF WORK**

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<tr>
<td>4 In collaboration with Network state and local staff, identify and compile a list of communities in California that could serve as pilot test sites for future health care/community intervention testing. The pilot test sites should have: well-coordinated, evidence-based Network activities; campaigns, programs, and collaboratives that reach sufficient numbers of SNAP-Ed eligible families; a high prevalence of overweight and obesity; Medi-Cal managed care plans that support the implementation of prevention approaches in health care settings and community-based sites; and Medi-Cal managed care plans that are able to efficiently and effectively provide aggregate health data to monitor the outcomes of the pilot test.</td>
<td>19/1/2013</td>
<td>1/31/2014</td>
<td>Program Manager; Program Assistant</td>
<td>Identify and provide recommendations for pilot test sites for future health care/community intervention testing; conduct site visits, as needed.</td>
<td>$46,983.87</td>
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<td>5 Based on Tasks 1-4, develop and produce a pilot intervention and evaluation plan aimed at reducing the risk and prevalence of overweight and obesity among SNAP-Ed eligible Medi-Cal members. Submit the plan for Network approval, and prepare for intervention and evaluation development.</td>
<td>3/1/2014</td>
<td>5/31/2014</td>
<td>Program Manager; Program Assistant; Subcontractor</td>
<td>Produce a pilot intervention and evaluation plan</td>
<td>$124,350.80</td>
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| 6 Based on the Network-approved pilot intervention and evaluation plan, develop and assemble the following pilot program and evaluation components:  
  - Confirm health care and community pilot test sites and partners.  
  - Confirm logistics of participant recruitment for the pilot test.  
  - Assemble health care program intervention pieces and materials. DHC5 is planning to use existing Network/My Plate/SNAP-Ed materials and health care obesity prevention tools to the greatest extent possible.  
  - Develop methods to motivate and drive SNAP-Ed eligible Medi-Cal members to Network interventions at the community level. The methods will be based upon the findings of the formative research.  
  - Develop and pilot test evaluation instruments and methods to secure health data.  
  - Prepare for the launch of the pilot test in Federal Fiscal Year 2015. | 6/1/2014 | 9/30/2014 | Program Manager; Program Assistant; Subcontractor | Secure health care and community pilot test sites and partners; finalize participant recruitment logistics; secure materials and intervention pieces; develop methods to motivate and drive members to Network interventions; develop and pilot test evaluation instruments and methods to secure health data. | $177,723.40 |

**TOTAL** | | | | | $530,319.33

**Notes:**

Task 1 represents 25% personnel costs (PM & PA) = $42,642
Task 2 represents 5% personnel costs (PM & PA) $8,868 + subcontractor costs $42,500 = $51,308
EXHIBIT A
SCOPE OF WORK

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<tr>
<td>Task 3 represents 5% personnel costs (PM &amp; PA) $8,808 + subcontractor costs $80,000 = $88,808</td>
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<td>Task 4 represents 29% personnel costs (PM &amp; PA) $35,434 + five (5) in-state site visits for two (2) representatives at $12,000 = $47,434 (In-state trip costs include mileage, lodging, parking, and per diem).</td>
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<td>Task 5 represents 30% personnel costs (PM &amp; PA) $44,851 + subcontractor costs $80,000 = $124,851</td>
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<td>Task 6 represents 15% personnel costs (PM &amp; PA) $23,225 + subcontractor costs $155,500 (including personnel costs, materials development and IT service) = $178,223</td>
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Appendix I: The Need for Mandatory Screening for Alcohol Abuse in Medi Cal
The Need for Mandatory Screening for Alcohol Abuse in Medi-Cal

August 30, 2013

Natalie McGowan BSN, RN

Healthcare professionals have the responsibility to provide care in a way that recognizes and treats illnesses and prevents harmful behaviors. They often do so through screening. One area of healthcare that fails adequate detection is alcohol abuse. Misuse of alcohol is a nation-wide problem of epidemic proportion, holding steady as the third leading cause of preventable death in the United States.1 In 2010 over 10,000 people died from drunk driving accidents. The yearly estimated national death toll caused by alcohol is 80,000 lives.2

Our healthcare community is greatly impacted by the injuries sustained from risky levels of alcoholic beverage consumption. In 2006, there were more than 1.2 million emergency room visits and 2.7 million physician office visits due to excessive drinking.3 Annually 2.3 million years of life are lost from alcohol.2

California Data Consistent with the National Epidemic

The state of California is noted to have the largest alcohol market and the highest rate of consumption totaling more than 14 billion drinks a year.4 The most recent evaluation of the state in 2010 found that excessive alcohol use caused 22,281 deaths.5 The estimated state cost in 2010 due to alcohol abuse is over $128 billion a year,5 which includes

- Impaired Driving
- Violent Crime
- Non-Violent Crime
- Child Maltreatment
- Other Mortality
- Medical Cost of Illness
- Substance Abuse Treatment
- Risky Youth Sex

In the 2007 report titled “Preventive Care: A National Profile on Use, Disparities, and Health Benefits,” screening adults for alcohol misuse and brief counseling is listed as one of the six most cost-effective preventive services.6 Despite evidence that alcohol abuse is costly, preventive efforts in Medi-Cal primary care are lacking. According to the report titled “A Formative Program Evaluation of California Managed Care Preventive Services” revealed that out of 20 participating health plans within Medi-Cal, none identified a formal screening tool for alcohol abuse.7 Seventeen plans did not have an intervention goal and only five reported in-person counseling.7 Furthermore, the most recent Strategy for Quality Improvement in Health Care acknowledges the need but does not contain
current measured initiatives reported for alcohol misuse screening and prevention. Even when accounting for the recent absorption of the Alcohol and Drug Program division, no mandatory alcohol screening protocols exist in California.

**Universal alcohol use screening is widely recommended**

The National Institute of Alcohol Abuse and Alcoholism\(^9\) defines hazardous alcohol use when a male exceeds more than four drinks on one occasion or more than 14 standard drinks per week. Women are defined to be at risk when they exceed more than three drinks per occasion and more than seven drinks per week.\(^9\) (see appendix 1) In May 2013 The U.S. Prevention Services Task Force released a B grade as their final recommendation for alcohol use screening.\(^10\) They urge that “primary care professionals ask all adults 18 years and older about their drinking habits and offer counseling to those who drink more than they should.” The World Health Organization (WHO),\(^11\) Substance Abuse and Mental Health Services Administration (SAMHSA),\(^12\) and the National Institute of Health (NIH)\(^13\) endorse this statement. In addition, Healthy People 2020 is striving to “increase primary care settings that implement evidence-based alcohol screening and brief intervention.”\(^14\) Furthermore, the Affordable Care Act requires alcohol misuse screening and counseling to be covered by non-grandfathered private plans without copayments or deductibles.\(^15\) To avoid health disparities between the privately insured and the Medicaid population,\(^16\) screening all Medi-Cal members is essential.

**Screening, Brief Intervention and Referral to Treatment (SBIRT) is golden standard technique for alcohol use screening**

"The data from SBIRT is not merely impressive; within the framework of most medical interventions, the impact of SBIRT is astounding, knock-your-socks-off, nearly too good to be true . . . ." Timmen Cermak, M.D.\(^17\)

Defining a golden standard for screening that has a strong evidence-base is a necessity for linking process performance and patient outcomes, along with accountability.\(^18\) **SBIRT**, short for screening, brief intervention, and referral to treatment, is a comprehensive approach that focuses on early intervention for people who suffer from or are at risk of developing alcohol or other substance use disorders.\(^12\) SBIRT has been declared effective by multiple sources\(^10,11,13\) since the landmark TREAT study released in the “Brief Physician Advice for Problem Alcohol Drinkers.”\(^19\) SBIRT is cost effective.\(^20\) It has been estimated to save healthcare costs ranging from 3 to 5-fold for every $1.00 spent,\(^21\) and decreases the risk of long-lasting physical and emotional trauma related to harmful drinking.\(^22\)

**How SBIRT works: Step 1: Screen for Use**

The first step in the SBIRT process is screening for presence of alcohol use and the quantity consumed. There are three situations in which screening should be performed:
SBIRT is a process that can be used with substance use disorders along with alcohol abuse. This is important to recognize especially in the sense that alcohol and other substances are often abused concurrently. In a patient assessment, the 10 question Drug Abuse Substance Test (DAST-10) screening tool, is the preferred method of measurement. However, for the purpose of this brief, alcohol is primarily discussed.

If a patient does not currently use alcohol, he/she should be applauded for maintaining abstinence. A low risk drinker who does not exceed recommended intake levels should receive brief education on drinking responsibly.

**Step 2: Brief Intervention**

Brief intervention (BI) is the second step of SBIRT. It consists of a short conversation, five to ten minutes to 20-30 minutes depending on severity of use and can be easily integrated into a primary care visit. It is billable to Medicaid by physicians, nurse specialists, and mental health counselors depending on state regulations. The primary care setting is preferable because it offers a lower cost alternative to more formal, specialist-led treatment which at this time is scarce in many areas.

The main focus of a brief intervention (BI) is to motivate at-risk drinkers to change their behavior and cut down on their consumption of alcohol. During a BI the health provider should:

1) Give information about patients’ substance use based on their assessment score
2) Advise in a clear, respectful way that the patient decrease or stop using alcohol
3) Encourage patient to set goals to decrease use and identify specific steps to reach these goals
4) Teach patient skills that will help him/her change harmful behaviors and reduce risk of negative outcomes from their use
5) Provide a referral to further screening and brief intervention has been proven to decrease alcohol use in at-risk drinkers, but it may be too late of an intervention for those with very heavy use or dependence and are diagnosed as having a substance use disorder. Therefore, the primary targets of early screening and counseling are patients identified as “at risk” drinkers. Preventing their progression to dependence is important for success.

**Step 3: Referral to Treatment**

Referral to Treatment is the last stage of SBIRT. One in four adults drinks above the recommended single-day or weekly levels and may have alcohol dependence or alcohol abuse problems. An estimated four percent of the population may drink at levels that require treatment that is beyond a brief intervention. In 2009 87.9 percent of the population that was perceived to qualify for
Alcohol treatment did not realize they needed it. Eight percent received treatment at a substance abuse treatment facility. Four and a half percent did not receive treatment but felt they needed it.31

### Recommendations for Implementation

Well-documented studies such as the Trial for Early Alcohol Treatment (TREAT) project19 have shown great success of SBIRT in the primary care environment.19,21 However, most of the grants from SAMHSA during 2003 and 2012 were conducted mainly in emergency departments. Although these grants were successful in reducing costs and readmissions due to alcohol misuse, 32,33,34 literature representing presence of SBIRT in primary care is inconsistent. In order to achieve this, recommendations in Medi-Cal primary care are as follows-

<table>
<thead>
<tr>
<th>Implement mandatory screening tools</th>
<th>Initiate SBIRT on the Staying Healthy Assessment (SHA)</th>
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<tr>
<td>The Alcohol Use Disorders Information Tool (AUDIT) has been recognized as the most widely used and effective tool.10 It is a billable tool23 that consists of ten questions and is estimated to take 2 to 5 minutes to administer and best determines a patients’ level of risk.9 Because AUDIT is a bit time consuming, SAMHSA recommends the first three questions as a short version, also called AUDIT-C (C for consumption) See appendix 4 to screen whether a patient drinks alcohol or not.12 This version takes only 1-2 minutes to administer and is accepted as having appropriate questions that detect alcohol misuse10,35,36. The National Institute of Alcohol Abuse and Alcoholism also endorses a one question option; “On any single occasion during the past 3 months, have you had more than 5 drinks containing alcohol?” as accurately identifying a patient who meets at-risk drinking criteria.9</td>
<td>Participating Medi-Cal primary care providers are provided an SHA37 that contains one question related to alcohol use; “Do you drink 2 or more alcoholic drinks per day?” This does not determine whether a man or woman is drinking above the recommended limits and is therefore inadequate. Changing the SHA to the approved one-question or the AUDIT-C would be more appropriate. If the patients’ answer flags concern, the 10 question AUDIT tool should be performed to determine level of risk and need for a Brief Intervention.</td>
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<tr>
<td>Make the SHA part of each Medi-Cal members’ Electronic Medical Record</td>
<td>Implementing SBIRT in electronic medical records has been proven to yield high success rates.38 The SHA at this time is only administered on paper and is not tracked and analyzed by Medi-Cal. It is unknown how often Medi-Cal members receive proper screening and intervention. To ensure</td>
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</table>
Appendix I

quality and accountability, the SHA needs to be updated, uploaded to participating systems, and administered electronically.

**Determine who is qualified to conduct screening and brief interventions**

SBIRT is billable through Medicaid by physicians, physician assistants, and nurse practitioners, depending on a state’s scope of practice. The current problem, however, is that it will be implemented on an already strained workforce that doesn’t necessarily feel comfortable with their abilities to address substance use disorders. One current initiative is training and integrating primary care and behavioral health into one discipline to improve feelings of competence.

**Decide on SBIRT training tool for providers**

Workforce training is a time-consuming process, but is necessary for consistency and competence among those performing the SBIRT process in health care settings. Sbirttraining.com is a low cost, time efficient evidence-based online training tool that has potential to make an impact on patient outcomes.47

**Develop plan on how to execute SBIRT and add it as a Quality Strategy**

"Implementing screening and brief intervention would be a revolution in 21st century medical practice. It would help reduce billions of dollars annually in lost productivity, injury and social costs associated with risky behaviors. It would also encourage those with chronic conditions to get the treatment they need. But medical practices are unlikely to take action without pressure from others who would benefit. The question is, when will society demand this change?"

John C. Higgins-Biddle, PhD

At this time there is no current quality strategy to address alcohol abuse prevention under the Advance Prevention priority. Using the recommendations of this brief, a template has been outlined for its’ addition. Alcohol or drug dependence treatment initiation is a measure by the Healthcare Effectiveness Data and Information Set for Medicare, but it is not a mandatory measure for Medical programs at this time. After suggested mandatory implementation and provider training is completed, measuring alcohol screening through HEDIS should be a requirement for all participating health plans to check for compliance.

**Supportive and self-help materials should be available to Medi-Cal members**

Welltopia, the Department of Health Care Services Facebook site, would be a great outlet for offering information to Medi-Cal members. With the recent integration of the Alcohol and Drug Programs (ADP), it was found that they also had a Facebook page.
Linking the two would create a powerful resource. Information to self-help sites such as www.alcoholscreening.org could be included. Also, the Resource Center at ADP has a plethora of resources and a helpline for members needing information about treatment programs. Tracking callers and checking their follow up is another step that can make a difference for those in need.

References


16. Guerrero EG. Enhancing access and retention in substance abuse treatment: The role of Medicaid payment acceptance and cultural competence. Drug and Alc Dep 2013


33. Desy PM, Howard PK, Perhats C, Li S. Alcohol screening, brief intervention, and referral to treatment conducted by emergency nurses: an impact evaluation. J of Emerg Nsg 2010; 36(6), 538-545.

34. State of California Health and Human Services Agency. Screening, Brief Intervention, Referral to Treatment Final Report, 2012. Department of Alcohol and Drug Programs,


37. Department of Health Care Services. Staying Healthy Assessment


47. Tanner TB, Wilhelm SE, Rossie KM, Metcalf MP. Web-based SBIRT skills training for health professional students and primary care providers. Substance Abuse 2012; 33(3), 316-320.


Appendix 1

Recommended Alcohol Consumption Amounts

NATIONAL INSTITUTES OF HEALTH
NIAAA | NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM
Understanding the impact of alcohol on human health and well-being

Risky or hazardous alcohol use means drinking more than the recommended daily, weekly, or per-occasion amounts resulting in increased risk for health consequences. USPSTF

To stay low risk, keep within BOTH the single-day AND weekly limits.
Appendix 2

DAST-10 Questionnaire – can be used with SBIRT for non-alcohol substance abuse

DRUG USE QUESTIONNAIRE (DAST-10)

NAME: ___________________________ Date: ________________

The following questions concern information about your potential involvement with drugs excluding alcohol and tobacco during the past 12 months. Carefully read each countynment and decide if your answer is "YES" or "NO". Then, check the appropriate box beside the question.

When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter medications used in excess of the directions and any non-medical use of any drugs. The various classes of drugs may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints etc…), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., Heroin). Remember that the questions do not include alcohol or tobacco.

Please answer every question. If you have difficulty with a countynment, then choose the response that is mostly right.

These questions refer to the past 12 months only. YES NO

1. Have you used drugs other than those required for medical reasons?.....

2. Do you abuse more than one drug at a time?.................................

3. Are you always able to stop using drugs when you want to?.............

4. Have you had “blackouts” or “flashbacks” as a result of drug use?......

5. Do you ever feel bad or guilty about your drug use?.........................

6. Does your spouse (or parent) ever complain about your involvement with drugs?.................................................................

7. Have you neglected your family because of your use of drugs?...........

8. Have you engaged in illegal activities in order to obtain drugs?..........  

9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?.......................................................

10. Have you had medical problems as a result of your drug use  
(e.g., memory loss, hepatitis, convulsions, bleeding etc…)?..............

*DAST Score........................................

*See scoring instructions for correct scoring procedure
Appendix 3

Estimated Percentages of the Population who will benefit from SBIRT

Office of National Drug Control Policy (ONDCP) July 2012
Appendix 4

AUDIT Tool – Recommended Screening Tool

AUDIT – C consists of the First 3 Questions of AUDIT

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying “Now I am going to ask you some questions about your use of alcoholic beverages during this past year.” Explain what is meant by “alcoholic beverages” by using local examples of beer, wine, vodka, etc. Code answers in terms of “standard drinks”. Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?
   (0) Never [Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 3 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
   Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

8. How often during the last year have you been unable to remember what happened the night before you had been drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   (0) No
   (1) Yes, but not in the last year
   (2) Yes, during the last year

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
   (0) No
   (1) Yes, but not in the last year
   (2) Yes, during the last year

If total is greater than recommended cut-off, consult User’s Manual.
Appendix J: Summary of prevention specifications in the MCMCP contracts
<table>
<thead>
<tr>
<th>Attachment Section Header</th>
<th>Subsection</th>
<th>COHS Plan Detail</th>
<th>GMC</th>
<th>Two Plan</th>
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<tbody>
<tr>
<td>Exhibit A, Attachment 10</td>
<td>4. Services for Members under Twenty-One (21) Years of Age</td>
<td>Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.</td>
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<td>Scope of Services</td>
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<tr>
<td>Exhibit A, Attachment 10</td>
<td>4. Services for Members under Twenty-One (21) Years of Age</td>
<td>Contractor shall provide preventive services for all Members under 21 years of age as specified by the most recent AAP periodicity schedule.</td>
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<tr>
<td>Scope of Services</td>
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<tr>
<td>Exhibit A, Attachment 10</td>
<td>4. Services for Members under Twenty-One (21) Years of Age</td>
<td>Contractor shall ensure that routine preventive health visits for Members under 21 years of age include the age appropriate IHEBA, as described in Exhibit A, Attachment 10, Provision 7, Paragraph A.</td>
<td></td>
<td>N/A</td>
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<td>Scope of Services</td>
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<tr>
<td>Exhibit A, Attachment 10</td>
<td>B. Adult Preventive Services</td>
<td>Contractor shall cover and ensure all preventive and Medically Necessary diagnostic and treatment services for adult Members. Contractor shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult Members [age 21 or older].</td>
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<tr>
<td>Scope of Services</td>
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<tr>
<td>Exhibit A, Attachment 10</td>
<td>A. Health Education</td>
<td>1) Contractor shall implement and maintain a health education system that provides the organized programs, services, functions, and resources necessary to deliver health education, health promotion and patient education to assist Members improve their health and manage illness. 2) Contractor shall ensure administrative oversight, direction, management, and supervision of the health education system by a qualified, full-time health educator. Contractor shall maintain the organization and staffing to ensure successful implementation and maintenance of an effective health education system. Health education program activities must be coordinated and integrated with the Contractor’s overall health care and quality improvement plan. 3) Contractor shall ensure the organized delivery of health education programs and services, at no charge for Members, using a variety of educational strategies, methods and materials that are appropriate for the Member population and effective in achieving behavioral change for improved health. Contractor shall ensure that all health education information and materials are provided to Members at no higher than a 6th grade reading level, unless otherwise approved by DHCS, and are provided in a manner and form that are easily understood and culturally and linguistically appropriate for the intended audience. 6) Contractor shall provide health education programs and services directly and/or through subcontractors that have expertise in delivery of health education.</td>
<td>1) Contractor shall implement and maintain a health education system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members. 2) Contractor shall ensure administrative oversight of the health education system by a qualified full-time health educator. 3) Contractor shall provide health education programs and services at no charge to Members directly and/or through Subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Member population. 4) Contractor shall ensure the</td>
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<td>Attachment Section Header</td>
<td>Subsection</td>
<td>COHS Plan Detail</td>
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<td>education programs and services. Contractor shall conduct targeted outreach to promote optimal program use and participation by Members.</td>
<td></td>
<td>organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health.</td>
</tr>
<tr>
<td>Exhibit A, Attachment 10 Scope of Services</td>
<td>A. Health Education</td>
<td>7) Contractors shall maintain a health education system that provides educational interventions addressing the following health categories and topics and ensure that these programs are available and accessible to Members upon referral by providers and also upon the Member’s request. a) Effective use of Managed Health Care Services: Educational interventions designed to assist Members to effectively use the managed health care system, preventive and primary healthcare services, obstetrical care, and health education services; and appropriately use complementary and alternative care. b) Risk-Reduction and Healthy Lifestyles: Educational interventions designed to assist Members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes, including programs for tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases, HIV/AIDS, and unintended pregnancy; nutrition, weight control, and physical activity; and parenting. c) Self-Care and Management of Health Conditions: Educational interventions designed to assist Members to learn and follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases or health conditions, including programs for pregnancy, asthma, diabetes, and hypertension.</td>
<td></td>
<td>6) Contractor shall maintain a health education system that provides educational interventions addressing the following health categories and topics: a) Appropriate use of health care services – managed health care; preventive and primary health care; obstetrical care; health education services; and, complementary and alternative care. b) Risk-reduction and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and, parenting. c) Self-care and management of health conditions – pregnancy; asthma; diabetes; and, hypertension.</td>
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<tr>
<td>Exhibit A, Attachment 11 Case Management and Coordination of Care</td>
<td>16. Women, Infants, and Children Supplemental Nutrition Program (WIC)</td>
<td>A. WIC services are not covered under this Contract. However, Contractor shall have procedures to identify and refer eligible Members for WIC services.</td>
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</table>
Appendix K: Medi-Cal Managed Care Plan Prevention Survey
The Department of Health Care Services (DHCS) recently released the Strategy for Quality Improvement in Health Care (Quality Strategy, http://www.dhcs.ca.gov/services/Documents/DHCSQualityStrategy81312.pdf ). The Quality Strategy is the Department’s blueprint to improve health, enhance quality, including the patient care experience, in all DHCS programs, and reduce health care costs. To inform the Quality Strategy, DHCS conducted a baseline assessment of its Quality Improvement (QI) efforts Department-wide. The baseline assessment results showed that DHCS needed to have a better understanding of the prevention and health promotion efforts that are being implemented by contracted health plans.

As a result of the baseline assessment, DHCS developed this prevention and health promotion survey to determine how the department can collaborate with managed care plans, and support their efforts to provide preventive services to Medi-Cal members. The purpose of the survey is to:

1. Obtain information about the administrative oversight of your health plan’s (Plan’s) health education system;
2. Identify the types of prevention and health promotion programs your Plan offers to Medi-Cal members;
3. Understand how your Plan communicates with Medi-Cal members and their families about prevention and health promotion;
4. Understand your Plan’s efforts to reduce health disparities through your prevention and health promotion programs; and
5. Understand your Plan’s activities to foster healthy communities.

The results of the survey will help DHCS identify ways to link to and support your prevention and health promotion efforts. As you complete the survey, please keep the following definitions in mind:

- **Prevention** encompasses primary, secondary, and tertiary prevention. Primary prevention prevents disease in healthy people. Secondary prevention prevents or reverses disease at an early or precursor stage. Tertiary prevention reduces mortality and morbidity in patients with established disease. (Katz & Ali, 2009)
- **Health promotion** is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. (World Health Organization, 2005)
- **Health education** is any combination of planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions. (Joint Committee on Terminology, 2001)

The due date for completing this survey is **February 12, 2013** The health educator responsible for administrative oversight of the Plan’s health education system should complete and submit the survey on behalf of the Plan. We suggest printing a PDF copy of the survey to get input from your Plan’s medical director and other appropriate staff before going online to complete and submit the survey. Please answer each question to the best of your ability, and remember that there are no right or wrong answers.
2013 DHCS Health Plan Prevention Survey

Thank you for your time and effort in completing this important survey.

References

Health Education Oversight

The following questions relate to the administrative oversight of your Plan's health education system.

1. Health Plan Name:

2. Please enter the following information regarding the Plan's full-time qualified health educator responsible for administrative oversight of the Plan's health education system.
   - Name:
   - Degree(s)/Specialty:
   - Title (current position):
   - Email Address:
   - Phone Number:

3. Please provide a brief description of the Plan's health education system/organization.

4. How many full-time equivalent employees does the Plan have dedicated to health education?

5. How many Medi-Cal members were enrolled with the Plan as of December 2012?

6. What percentage of the Plan's health education services are subcontracted with delegated entities?
   - None
   - Less than 25%
   - 25 - 49%
   - 50 - 74%
   - More than 75%
7. How does the Plan monitor subcontractor performance for health education services? (Check all that apply)

☐ All health education contract requirements are included in subcontract agreements
☐ Subcontractor reports
☐ Site visits
☐ Teleconference calls to check-in and provide updates
☐ Plan provides written updates regarding program updates/changes
☐ Other (please specify)

8. Please explain how the Plan ensures that all network providers and delegated providers receive provider training/education as specified in the contract:
## 2013 DHCS Health Plan Prevention Survey

### 9. How often does the Plan conduct provider training/education about Medi-Cal contract requirements for the following topics?

<table>
<thead>
<tr>
<th>Topic</th>
<th>More than once a year</th>
<th>Annually</th>
<th>Every 2 yrs.</th>
<th>Every 3-5 yrs.</th>
<th>New providers only</th>
<th>Never</th>
<th>Don't know</th>
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<td>Primary care provider point of service prevention requirements</td>
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<td>U.S. Preventive Services Task Force guidelines</td>
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<td>Other (name requirement and frequency of training)</td>
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</tbody>
</table>

**Prevention and Health Promotion Interventions**

The following questions relate to the healthy lifestyle interventions provided by your Plan.

**Promoting a Healthy Lifestyle:** *Program Delivery*
### 2013 DHCS Health Plan Prevention Survey

1. **How is the content delivered for the Plan's healthy lifestyle interventions? (Check all that apply)**

<table>
<thead>
<tr>
<th>Content Delivery Method</th>
<th>Healthy eating</th>
<th>Physical activity</th>
<th>Alcohol abuse</th>
<th>Drug abuse</th>
<th>Breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group class(es)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Nurse advice line</td>
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<tr>
<td>In-person counseling</td>
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<tr>
<td>Phone counseling</td>
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<tr>
<td>Medical appointment(s)</td>
<td></td>
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<tr>
<td>Printed material(s)</td>
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<tr>
<td>Email(s)</td>
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<tr>
<td>Plan website</td>
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<td></td>
</tr>
<tr>
<td>Other website(s)</td>
<td></td>
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<tr>
<td>Text message(s)</td>
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<td>Twitter</td>
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<tr>
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<tr>
<td>N/A</td>
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<tr>
<td>Other (please specify)</td>
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</tr>
</tbody>
</table>

2. **Who delivers the Plan’s healthy lifestyle interventions? (Check all that apply)**

<table>
<thead>
<tr>
<th>Delivery Method</th>
<th>Healthy eating</th>
<th>Physical activity</th>
<th>Alcohol abuse</th>
<th>Drug abuse</th>
<th>Breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third party vendor/subcontractor</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Collaboration with a community organization</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Health plan staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network provider office(s)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>N/A</td>
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<tr>
<td>Don’t know</td>
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<tr>
<td>Other</td>
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<tr>
<td>Other (please specify)</td>
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</tr>
</tbody>
</table>

---
### 3. Are Medi-Cal members required to obtain a referral to participate in the Plan's healthy lifestyle interventions?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy eating</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Physical activity</td>
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<tr>
<td>Alcohol abuse</td>
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<tr>
<td>Drug abuse</td>
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</tr>
<tr>
<td>Breastfeeding</td>
<td></td>
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</tr>
</tbody>
</table>

### 4. Does the Plan use incentives to encourage Medi-Cal members to participate in healthy lifestyle interventions?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy eating</td>
<td></td>
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<tr>
<td>Physical activity</td>
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<td>Alcohol abuse</td>
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<td>Drug abuse</td>
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<tr>
<td>Breastfeeding</td>
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</tbody>
</table>

If yes, please describe the incentive program.

### 5. Does the Plan limit the number of times Medi-Cal members can access healthy lifestyle interventions?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy eating</td>
<td></td>
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<tr>
<td>Physical activity</td>
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<tr>
<td>Alcohol abuse</td>
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<td>Drug abuse</td>
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<tr>
<td>Breastfeeding</td>
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</tbody>
</table>

If yes, what is the limit?
### 2013 DHCS Health Plan Prevention Survey

6. Please indicate method(s) used by the Plan to inform providers/health care professionals about the availability of healthy lifestyle interventions. (Check all that apply)

<table>
<thead>
<tr>
<th>Method</th>
<th>Healthy eating</th>
<th>Physical activity</th>
<th>Alcohol abuse</th>
<th>Drug abuse</th>
<th>Breastfeeding</th>
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<tbody>
<tr>
<td>Conferences</td>
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<td>Provider office site visits</td>
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<td>Webinars</td>
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<td>Phone calls</td>
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<td>Printed materials</td>
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<td>Newsletters</td>
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<td>N/A</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Other (please specify)

7. If you would like to provide a general overview/description of the Plan’s healthy lifestyle activities, or more detail on any of the answers you have provided above, please do so here. (optional)

(a) Healthy eating:

(b) Physical activity:
## 2013 DHCS Health Plan Prevention Survey

### (c) Alcohol abuse:

<p>| | |</p>
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<thead>
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### (d) Drug abuse:

<p>| | |</p>
<table>
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<th></th>
<th></th>
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</thead>
</table>

### (e) Breastfeeding:

<p>| | |</p>
<table>
<thead>
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</thead>
</table>

8. Please tell us what DHCS can do to complement the Plan’s healthy lifestyle interventions.

### Prevention and Health Promotion Interventions

The following questions are asking for more detailed information about the Plan’s most impactful healthy lifestyle interventions in each lifestyle area.

**Promoting a Healthy Lifestyle: Healthy Eating**

1. Does the Plan conduct an intervention to encourage Medi-Cal members to eat a healthy diet?

   - Yes
   - Yes, (but not directly)
   - No
   - Don’t know

2. Please provide the name for each healthy eating intervention offered to Medi-Cal members.
3. Please provide a description of the healthy eating intervention that has the greatest impact for Medi-Cal members. Note: If the intervention has been described in detail in another section of the survey, please refer to that section rather than re-entering the information.

   Intervention name:

   Intervention goals:

   List measurable objectives for the intervention:

   Intervention description:

4. How many hours of education does this intervention provide? (may include hours of coaching, counseling, support group participation, etc.)

5. Is this intervention tailored/customized for any of the following characteristics?

   (a) Age
   - Infants
   - Children
   - Teenagers
   - Young adults
   - Adults
   - Seniors
   - Don't know
   - N/A

   Other (please specify)

   (b) Gender
   - Male
   - Female
   - Don't know
   - N/A
## 2013 DHCS Health Plan Prevention Survey

### (c) Race/Ethnicity(s) (Check all that apply)

- [ ] African American
- [ ] Native American
- [ ] Don’t know
- [ ] Asian
- [ ] Pacific Islander
- [ ] N/A
- [ ] Latino / Hispanic
- [ ] White / Caucasian
- [ ] Other (please specify)

### (d) Language(s) (Check all that apply)

- [ ] Arabic
- [ ] Khmer
- [ ] Tagalog
- [ ] Armenian
- [ ] Korean
- [ ] Vietnamese
- [ ] Cantonese
- [ ] Mandarin
- [ ] Don’t know
- [ ] English
- [ ] Russian
- [ ] N/A
- [ ] Farsi
- [ ] Sign Language
- [ ] Spanish
- [ ] Other (please specify)

### (e) Disability (Please specify)


### (f) Other (Please specify)


### 6. How does the Plan measure the effectiveness of this healthy eating intervention?


### 7. What changes have been documented in Medi-Cal members who have participated in this intervention? (e.g., 30% of participants significantly reduced Body Mass Index, etc)


2013 DHCS Health Plan Prevention Survey

8. In the last two years, have you changed this intervention to improve outcomes?

☐ Yes
☐ No
☐ Don't know

If yes, please provide details.

9. Are there any changes you would like to make, that you haven't implemented already, to improve the outcomes of this intervention?

☐ Yes
☐ No
☐ Don't know

If yes, please provide details.

10. Are there any barriers, challenges, or limitations preventing you from implementing the changes described above in question nine?

☐ Yes
☐ No
☐ N/A
☐ Don't know

If yes, please provide details.
2013 DHCS Health Plan Prevention Survey

11. Please indicate which Plan members are eligible to participate in this healthy eating intervention:

- All Plan Members
- Medi-Cal Members Only
- All Plan Members who meet eligibility criteria. (specify criteria below)
- Medi-Cal Members who meet eligibility criteria. (specify criteria below)
- Other (specify criteria below)

Please specify eligibility criteria: (e.g., members with diabetes, cardiovascular disease, etc.)

12. How many Medi-Cal members participated in this healthy eating intervention in 2012?

Promoting a Healthy Lifestyle: Physical Activity

1. Does the Plan conduct an intervention to encourage Medi-Cal members to be physically active?

- Yes
- Yes, (but not directly)
- No
- Don't know

2. Please provide the name for each physical activity intervention offered to Medi-Cal members.

3. Please provide a description of the physical activity intervention that has the greatest impact for Medi-Cal members. Note: If the intervention has been described in detail in another section of the survey, please refer to that section rather than re-entering the information.

Intervention name:
**2013 DHCS Health Plan Prevention Survey**

**Intervention goals:**

**List measurable objectives for the intervention:**

**Intervention description:**

4. How many hours of education does this Intervention provide? (may include hours of coaching, counseling, support group participation, etc.)

5. Is this intervention tailored/customized for any of the following characteristics?

(a) Age

- [ ] Infants
- [ ] Children
- [ ] Teenagers
- [ ] Young adults
- [ ] Adults
- [ ] Seniors
- [ ] Don't know
- [ ] N/A

Other (please specify)

(b) Gender

- [ ] Male
- [ ] Female
- [ ] Don't know
- [ ] N/A
2013 DHCS Health Plan Prevention Survey

(c) Race/Ethnicity(s) (Check all that apply)

- [ ] African American
- [ ] Native American
- [ ] Don't know
- [ ] Asian
- [ ] Pacific Islander
- [ ] N/A
- [ ] Latino / Hispanic
- [ ] White / Caucasian
- Other (please specify)

(d) Language(s) (Check all that apply)

- [ ] Arabic
- [ ] Khmer
- [ ] Tagalog
- [ ] Armenian
- [ ] Korean
- [ ] Vietnamese
- [ ] Cantonese
- [ ] Mandarin
- [ ] Don't know
- [ ] English
- [ ] Russian
- [ ] N/A
- [ ] Farsi
- [ ] Sign Language
- [ ] Spanish
- Other (please specify)

(e) Disability (Please specify)


(f) Other (Please specify)


6. How does the Plan measure the effectiveness of this physical activity intervention?


7. What changes have been documented in Medi-Cal members who have participated in this intervention? (e.g., 30% of participants significantly increased daily activity, etc.)


2013 DHCS Health Plan Prevention Survey

8. In the last two years, have you changed this intervention to improve outcomes?
   - Yes
   - No
   - Don't know

If yes, please provide details.

9. Are there any changes you would like to make, that you haven't implemented already, to improve the outcomes of this intervention?
   - Yes
   - No
   - Don't know

If yes, please provide details.

10. Are there any barriers, challenges, or limitations preventing you from implementing the changes described above in question nine?
    - Yes
    - No
    - N/A
    - Don't know

If yes, please provide details.
2013 DHCS Health Plan Prevention Survey

11. Please indicate which Plan members are eligible to participate in the physical activity intervention:

- All Plan Members
- Medi-Cal Members Only
- All Plan Members who meet eligibility criteria. (specify criteria below)
- Medi-Cal Members who meet eligibility criteria. (specify criteria below)
- Other (specify criteria below)

Please specify eligibility criteria: (e.g., members with diabetes, cardiovascular disease, etc.)

12. How many Medi-Cal members participated in this physical activity intervention in 2012?

Promoting a Healthy Lifestyle: Alcohol Use

1. Does the Plan conduct an intervention for Medi-Cal members to prevent alcohol abuse?

- Yes
- Yes, (but not directly)
- No
- Don’t know

2. Please provide the program name for each alcohol abuse intervention offered to Medi-Cal members.

3. Please provide a description of the alcohol abuse intervention that has the greatest impact for Medi-Cal members.

   Intervention name:
2013 DHCS Health Plan Prevention Survey

**Intervention goals:**

**List measurable objectives for the intervention:**

**Intervention description:**

4. How many hours of education does this intervention provide? (may include hours of coaching, counseling, support group participation, etc.)

5. Is this intervention tailored/customized for any of the following characteristics?

(a) Age

- [ ] Infants
- [ ] Children
- [ ] Teenagers
- [ ] Young adults
- [ ] Adults
- [ ] Seniors
- [ ] Don't know
- [ ] N/A
- [ ] Other (please specify)

(b) Gender

- [ ] Male
- [ ] Female
- [ ] Don't know
- [ ] N/A
- [ ] N/A
2013 DHCS Health Plan Prevention Survey

(c) Race/Ethnicity(s) (Check all that apply)

- African American
- Asian
- Latino / Hispanic
- Native American
- Pacific Islander
- White / Caucasian
- Don’t know
- N/A

Other (please specify)

(d) Language(s) (Check all that apply)

- Arabic
- Armenian
- Cantonese
- English
- Farsi
- Hmong
- Khmer
- Korean
- Mandarin
- Russian
- Sign Language
- Spanish
- Tagalog
- Vietnamese
- Don’t know
- N/A

Other (please specify)

(e) Disability (Please specify)

(f) Other (Please specify)

6. How does the Plan measure the effectiveness of this alcohol abuse prevention intervention?

7. What changes have been documented in Medi-Cal members who have participated in this alcohol abuse intervention? (e.g., 30% of participants stopped drinking alcohol, etc.)
2013 DHCS Health Plan Prevention Survey

8. In the last two years, have you changed this intervention to improve outcomes?
   - Yes
   - No
   - Don't know

   If yes, please provide details.

9. Are there any changes you would like to make, that you haven't implemented already, to improve the outcomes of this intervention?
   - Yes
   - No
   - Don't know

   If yes, please provide details.

10. Are there any barriers, challenges, or limitations preventing you from implementing the changes described above in question nine?
    - Yes
    - No
    - N/A
    - Don't know

   If yes, please provide details.
2013 DHCS Health Plan Prevention Survey

11. Please indicate which Plan members are eligible to participate in this alcohol abuse prevention intervention:

- All Plan Members
- Medi-Cal Members Only
- All Plan Members who meet eligibility criteria. (specify criteria below)
- Medi-Cal Members who meet eligibility criteria. (specify criteria below)
- Other (specify criteria below)

Please specify eligibility criteria: (e.g., members with diabetes, cardiovascular disease, etc.)

12. How many Medi-Cal members participated in this alcohol abuse prevention intervention in 2012?

Promoting a Healthy Lifestyle: Drug Abuse

1. Does the Plan conduct an intervention for Medi-Cal members to prevent drug abuse?

- Yes
- Yes, (but not directly)
- No
- Don't know

2. Please provide the name for each drug abuse intervention offered to Medi-Cal members.

3. Please provide a description of the drug abuse intervention that has the greatest impact for Medi-Cal members.

   Intervention name:
2013 DHCS Health Plan Prevention Survey

Intervention goals:

List measurable objectives for the intervention:

Intervention description:

4. How many hours of education does this intervention provide? (may include hours of coaching, counseling, support group participation, etc.)

5. Is this intervention tailored/customized for any of the following characteristics?

(a) Age

- [ ] Infants
- [ ] Children
- [ ] Teenagers
- [ ] Young adults
- [ ] Adults
- [ ] Seniors
- [ ] Don't know
- [ ] N/A

Other (please specify)

(b) Gender

- [ ] Male
- [ ] Female
- [ ] Don't know
- [ ] N/A
### 2013 DHCS Health Plan Prevention Survey

**Appendix K**

**6. How does the Plan measure the effectiveness of this drug abuse prevention intervention?**

<table>
<thead>
<tr>
<th>Race/Ethnicity(s) (Check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Latino / Hispanic</td>
</tr>
</tbody>
</table>

**Other (please specify)**

<table>
<thead>
<tr>
<th>Language(s) (Check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic</td>
</tr>
<tr>
<td>Armenian</td>
</tr>
<tr>
<td>Cantonese</td>
</tr>
<tr>
<td>English</td>
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<tr>
<td>Farsi</td>
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<tr>
<td>Hmong</td>
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</tbody>
</table>

**Other (please specify)**
2013 DHCS Health Plan Prevention Survey

7. What changes have been documented in Medi-Cal members who have participated in this drug abuse intervention? (e.g., 15% of participants contacted their doctor about stopping the use of drugs, etc.)

8. In the last two years, have you changed this intervention to improve outcomes?
   - Yes
   - No
   - Don't know
   If yes, please provide details.

9. Are there any changes you would like to make, that you haven't implemented already, to improve the outcomes of this intervention?
   - Yes
   - No
   - Don't know
   If yes, please provide details.

10. Are there any barriers, challenges, or limitations preventing you from implementing the changes described above in question nine?
    - Yes
    - No
    - N/A
    - Don't know
    If yes, please provide details.
11. Please indicate which Plan members are eligible to participate in this drug abuse prevention intervention:

- [ ] All Plan Members
- [ ] Medi-Cal Members Only
- [ ] All Plan Members who meet eligibility criteria. (specify criteria below)
- [ ] Medi-Cal Members who meet eligibility criteria. (specify criteria below)
- [ ] Other (specify criteria below)

Please specify eligibility criteria: (e.g., members with diabetes, cardiovascular disease, etc.)

12. How many Medi-Cal members participated in this drug abuse prevention intervention in 2012?

Promoting a Healthy Lifestyle: Breastfeeding

1. Does the Plan conduct an intervention for Medi-Cal members to promote breastfeeding?

- [ ] Yes
- [ ] Yes, (but not directly)
- [ ] No
- [ ] Don't know

2. Please provide the program name for each breastfeeding intervention offered to Medi-Cal members.

3. Please provide a description of the breastfeeding intervention that has the greatest impact for Medi-Cal members.

   Intervention name:
2013 DHCS Health Plan Prevention Survey

What is the primary focus of the Plan’s breastfeeding intervention?

- Primarily promotes breastfeeding initiation
- Primarily promotes breastfeeding continuation
- Promotes breastfeeding initiation and continuation equally
- Other (please specify)

Intervention goals:

List measurable objectives for the intervention:

Intervention description:

4. How many hours of education does this intervention provide? (may include hours of coaching, counseling, support group participation, etc.)

5. Is this intervention tailored/customized for any of the following characteristics?

(a) Age

- Infants
- Children
- Teenagers
- Young adults
- Adults
- Seniors
- Don’t know
- N/A
- Other (please specify)
2013 DHCS Health Plan Prevention Survey

(b) Gender
- [] Male
- [] Female
- [ ] Don’t know
- [ ] N/A

(c) Race/Ethnicity(s) (Check all that apply)
- [ ] African American
- [ ] Native American
- [ ] Don’t know
- [ ] Asian
- [ ] Pacific Islander
- [ ] N/A
- [ ] Latino / Hispanic
- [ ] White / Caucasian

Other (please specify)

(d) Language(s) (Check all that apply)
- [ ] Arabic
- [ ] Khmer
- [ ] Tagalog
- [ ] Armenian
- [ ] Korean
- [ ] Vietnamese
- [ ] Cantonese
- [ ] Mandarin
- [ ] Don’t know
- [ ] English
- [ ] Russian
- [ ] N/A
- [ ] Farsi
- [ ] Sign Language
- [ ] Spanish
- [ ] Hmong
- [ ] Don’t know
- [ ] N/A

Other (please specify)

(e) Disability (Please specify)

(f) Other (Please specify)

6. How does the Plan measure the effectiveness of this breastfeeding intervention?
2013 DHCS Health Plan Prevention Survey

7. What changes have been documented in Medi-Cal members who have participated in this breastfeeding intervention? (e.g., 10% increase in new mothers initiating breastfeeding, etc.)

8. In the last two years, have you changed this intervention to improve outcomes?
   - Yes
   - No
   - Don't know
   If yes, please provide details.

9. Are there any changes you would like to make, that you haven't implemented already, to improve the outcomes of this intervention?
   - Yes
   - No
   - Don't know
   If yes, please provide details.

10. Are there any barriers, challenges, or limitations, preventing you from implementing the changes described above in question nine?
    - Yes
    - No
    - N/A
    - Don't know
    If yes, please provide details.
### 2013 DHCS Health Plan Prevention Survey

11. Please indicate which Plan members are eligible to participate in this breastfeeding intervention:

- [ ] All Plan Members who can breastfeed
- [ ] Medi-Cal Members Only who can breastfeed
- [ ] Other (please specify)

12. How many Medi-Cal members participated in this breastfeeding intervention in 2012?

---

### Preventing Chronic Diseases

The following questions relate to the chronic disease prevention interventions provided by your Plan.

**Disease Prevention Programs:** *Program Delivery*
### 1. How is the program content delivered for the Plan’s chronic disease prevention interventions? (Check all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Overweight/Obesity</th>
<th>Cardiovascular disease</th>
<th>Type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group class(es)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse advice line</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-person counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical appointment(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Printed material(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan website</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other website(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Text message(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facebook</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twitter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other (please specify)

### 2. Who delivers the Plan’s chronic disease prevention interventions? (Check all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Overweight/Obesity</th>
<th>Cardiovascular disease</th>
<th>Type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third party vendor/subcontractor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration with a community organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health plan staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network provider office(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other (please specify)
### 2013 DHCS Health Plan Prevention Survey

#### 3. Are Medi-Cal members required to obtain a referral to participate in the Plan's chronic disease prevention interventions?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight/Obesity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 2 diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 4. Does the Plan use incentives to encourage Medi-Cal members to participate in chronic disease prevention interventions?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight/Obesity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 2 diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, please describe the incentive program.

If yes, what is the limit?

#### 5. Does the Plan limit the number of times Medi-Cal members can access chronic disease prevention interventions?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overweight/Obesity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 2 diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, what is the limit?
2013 DHCS Health Plan Prevention Survey

6. Please indicate method(s) used by the Plan to inform providers/health care professionals about the availability of chronic disease prevention interventions. (Check all that apply)

<table>
<thead>
<tr>
<th>Method</th>
<th>Overweight/Obesity</th>
<th>Cardiovascular disease</th>
<th>Type 2 diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conferences</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Provider meetings</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Provider office site visits</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Webinars</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Phone calls</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Printed materials</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Newsletters</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Fax blasts</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Emails</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Plan website</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other websites</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Text messages</td>
<td>□</td>
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<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

7. If you would like to provide a general overview/description of the Plan’s chronic disease prevention activities, or more detail on any of the answers you have provided above, please do so here. (optional)

(a) Overweight/Obesity:

(b) Cardiovascular disease:
Preventing Chronic Diseases
The following questions are asking for more detailed information about the Plan’s most impactful chronic disease prevention intervention for each disease.

**Disease Prevention Intervention:** Overweight/Obesity
**NOTE:** The Centers for Disease Control and Prevention (CDC) defines overweight and obesity by age group as:

- **Adults (aged 20 and older):**
  - Overweight - BMI between 25 and 29.9.
  - Obese - BMI of 30 or higher.

- **Children and adolescents (aged 2—19 years):**
  - Overweight - A BMI at or above the 85th percentile and lower than the 95th percentile for children of the same age and sex.
  - Obese - A BMI at or above the 95th percentile for children of the same age and sex.

1. **Does the Plan conduct an intervention for Medi-Cal members to prevent overweight/obesity?**
   - Yes
   - Yes, (but not directly)
   - No
   - Don’t know

2. **Please provide the name for each overweight/obesity prevention intervention offered to Medi-Cal members.**
### 3. Please provide a description of the overweight/obesity prevention intervention that has the greatest impact for Medi-Cal members. Note: If the intervention has been described in detail in another section of the survey, please refer to that section rather than re-entering the information.

- **Intervention name:**

- **Intervention goals:**

- **List measurable objectives for the intervention:**

- **Intervention description:**

### 4. How many hours of education does this intervention provide? (may include hours of coaching, counseling, support group participation, etc.)

### 5. Is this intervention tailored/customized for any of the following characteristics?

#### (a) Age

- Infants
- Children
- Teenagers
- Young adults
- Adults
- Seniors
- Don't know
- N/A

**Other (please specify):**

#### (b) Gender

- Male
- Female
- Don't know
- N/A
### 2013 DHCS Health Plan Prevention Survey

**Appendix K**

#### (c) Race/Ethnicity(s) (Check all that apply)
- [ ] African American
- [ ] Native American
- [ ] Don't know
- [ ] Asian
- [ ] Pacific Islander
- [ ] N/A
- [ ] Latino / Hispanic
- [ ] White / Caucasian

Other (please specify)

<table>
<thead>
<tr>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

#### (d) Language(s) (Check all that apply)
- [ ] Arabic
- [ ] Khmer
- [ ] Tagalog
- [ ] Armenian
- [ ] Korean
- [ ] Vietnamese
- [ ] Cantonese
- [ ] Mandarin
- [ ] Don't know
- [ ] English
- [ ] Russian
- [ ] N/A
- [ ] Farsi
- [ ] Sign Language
- [ ] Other (please specify)

<table>
<thead>
<tr>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

#### (e) Disability (Please specify)

Other (please specify)

<table>
<thead>
<tr>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

#### (f) Other (Please specify)

Other (Please specify)

<table>
<thead>
<tr>
<th>Other (Please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

#### 6. How does the Plan measure the effectiveness of this overweight/obesity prevention intervention?

<table>
<thead>
<tr>
<th>How does the Plan measure the effectiveness of this overweight/obesity prevention intervention?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

245
7. What changes have been documented in Medi-Cal members who have participated in this overweight/obesity prevention intervention? (e.g., 30% of participants significantly reduced Body Mass Index, etc.)

8. In the last two years, have you changed this intervention to improve outcomes?

- Yes
- No
- Don't know

If yes, please provide details.

9. Are there any changes you would like to make, that you haven't implemented already, to improve the outcomes of this intervention?

- Yes
- No
- N/A
- Don't know

If yes, please provide details.

10. Are there any barriers, challenges, or limitations preventing you from implementing the changes described above in question nine?

- Yes
- No
- N/A
- Don't know

If yes, please provide details.
2013 DHCS Health Plan Prevention Survey

11. Please indicate which Plan members are eligible to participate in this overweight/obesity intervention:
   - [ ] All Plan Members
   - [ ] Medi-Cal Members Only
   - [ ] All Plan Members who meet eligibility criteria (specify criteria below)
   - [ ] Medi-Cal Members who meet eligibility criteria (specify criteria below)
   - [ ] Other (specify criteria below)

   Please specify eligibility criteria: (e.g., members who are obese/overweight, etc.)

12. How many Medi-Cal members participated in this overweight/obesity prevention intervention in 2012?

Disease Prevention Intervention: Cardiovascular Disease

1. Does the Plan conduct an intervention for Medi-Cal members to prevent cardiovascular disease?
   - [ ] Yes
   - [ ] Yes, (but not directly)
   - [ ] No
   - [ ] Don’t know

2. Please provide the name for each cardiovascular disease prevention intervention offered to Medi-Cal members.

3. Please provide a description of the cardiovascular disease prevention intervention that has the greatest impact for Medi-Cal members. Note: If the intervention has been described in detail in another section of the survey, please refer to that section rather than re-entering the information.

   Intervention name:
2013 DHCS Health Plan Prevention Survey

Intervention goals:

List measurable objectives for the intervention:

Intervention description:

4. How many hours of education does this intervention provide? (may include hours of coaching, counseling, support group participation, etc.)

5. Is this intervention tailored/customized for any of the following characteristics?

(a) Age

- Infants
- Children
- Teenagers
- Young adults
- Adults
- Seniors
- Don't know
- N/A

Other (please specify)

(b) Gender

- Male
- Female
- Don't know
- N/A
2013 DHCS Health Plan Prevention Survey

(c) Race/Ethnicity(s) (Check all that apply)

- African American
- Native American
- Don't know
- Asian
- Pacific Islander
- N/A
- Latino / Hispanic
- White / Caucasian
- Other (please specify)

(d) Language(s) (Check all that apply)

- Arabic
- Khmer
- Tagalog
- Armenian
- Korean
- Vietnamese
- Cantonese
- Mandarin
- Don't know
- English
- Russian
- N/A
- Farsi
- Sign Language
- Spanish
- Other (please specify)

(e) Disability (Please specify)

(f) Other (Please specify)

6. How does the Plan measure the effectiveness of this cardiovascular disease prevention intervention?
7. What changes have been documented in Medi-Cal members who have participated in this cardiovascular disease prevention intervention? (e.g., 90% of participants are getting 30 minutes or more of physical activity a day, etc.)

8. In the last two years, have you changed this intervention to improve outcomes?
   - Yes
   - No
   - Don’t know
   If yes, please provide details.

9. Are there any changes you would like to make, that you haven't implemented already, to improve the outcomes of this intervention?
   - Yes
   - No
   - Don’t know
   If yes, please provide details.

10. Are there any barriers, challenges, or limitations preventing you from implementing the changes described above in question nine?
    - Yes
    - No
    - N/A
    - Don’t know
    If yes, please provide details.
2013 DHCS Health Plan Prevention Survey

11. Please indicate which Plan members are eligible to participate in this cardiovascular disease prevention intervention:

- [ ] All Plan Members
- [ ] Medi-Cal Members Only
- [ ] All Plan Members who meet eligibility criteria. (specify criteria below)
- [ ] Medi-Cal Members who meet eligibility criteria. (specify criteria below)
- [ ] Other (specify criteria below)

Please specify eligibility criteria: (e.g., members with hypertension, etc.)

12. How many Medi-Cal members participated in this cardiovascular disease prevention intervention in 2012?

<table>
<thead>
<tr>
<th>Disease Prevention Intervention: Diabetes</th>
</tr>
</thead>
</table>

1. Does the Plan conduct an intervention for Medi-Cal members to prevent type 2 diabetes?

- [ ] Yes
- [ ] Yes, (but not directly)
- [ ] No
- [ ] Don't know

2. Please provide the name of every type 2 diabetes prevention intervention offered to Medi-Cal members.

3. Please provide a description of the type 2 diabetes prevention intervention that has the greatest impact for Medi-Cal members. Note: If the intervention has been described in detail in another section of the survey, please refer to that section rather than re-entering the information.

   Intervention name:
2013 DHCS Health Plan Prevention Survey

Intervention goals:

List measurable objectives for the intervention:

Intervention description:

4. How many hours of education does this intervention provide? (may include hours of coaching, counseling, support group participation, etc.)

5. Is this intervention tailored/customized for any of the following characteristics?

(a) Age

- Infants
- Children
- Teenagers
- Young adults
- Adults
- Seniors
- Don't know
- N/A

Other (please specify)

(b) Gender

- Male
- Female
- Don't know
- N/A
2013 DHCS Health Plan Prevention Survey

(c) Race/Ethnicity(s) (Check all that apply)

- [ ] African American
- [ ] Asian
- [ ] Latino / Hispanic
- [ ] Native American
- [ ] Pacific Islander
- [ ] White / Caucasian
- [ ] Don't know
- [ ] N/A

Other (please specify)

(d) Language(s) (Check all that apply)

- [ ] Arabic
- [ ] Armenian
- [ ] Cantonese
- [ ] English
- [ ] Farsi
- [ ] Hmong
- [ ] Khmer
- [ ] Korean
- [ ] Mandarin
- [ ] Russian
- [ ] Sign Language
- [ ] Spanish
- [ ] Tagalog
- [ ] Vietnamese
- [ ] Don't know
- [ ] N/A

Other (please specify)

(e) Disability (Please specify)

(f) Other (Please specify)

6. How does the Plan measure the effectiveness of this type 2 diabetes prevention intervention?

7. What changes have been documented in Medi-Cal members who have participated in this type 2 diabetes prevention intervention? (e.g., 50% of participants have a healthy weight, etc.)
8. In the last two years, have you changed this intervention to improve outcomes?

- Yes
- No
- Don't know

If yes, please provide details.

9. Are there any changes you would like to make, that you haven't implemented already, to improve the outcomes of this intervention?

- Yes
- No
- Don't know

If yes, please provide details.

10. Are there any barriers, challenges, or limitations preventing you from implementing the changes described above in question nine?

- Yes
- No
- N/A
- Don't know

If yes, please provide details.
2013 DHCS Health Plan Prevention Survey

11. Please indicate which Plan members are eligible to participate in this type 2 diabetes prevention intervention:

- All Plan Members
- Medi-Cal Members Only
- All Plan Members who meet eligibility criteria. (specify criteria below)
- Medi-Cal Members who meet eligibility criteria. (specify criteria below)
- Other (specify criteria below)

Please specify eligibility criteria: (e.g., members with high Body Mass Index, etc.)

12. How many Medi-Cal members participated in this type 2 diabetes prevention intervention in 2012?

Screenings

The following questions relate to screenings provided by your Plan.

Note: Some questions in this section may require clinical staff input.
## 2013 DHCS Health Plan Prevention Survey

1. Which race/ethnic groups receive targeted outreach to increase their participation in screenings?

<table>
<thead>
<tr>
<th></th>
<th>Cholesterol screening</th>
<th>Diabetes screening</th>
<th>Hypertension screening</th>
<th>Obesity screening</th>
<th>Overweight screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medi-Cal members regardless of race/ethnicity</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>African American</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Asian</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
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<td>❌</td>
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</tr>
<tr>
<td>Native American</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Pacific Islanders</td>
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<td>❌</td>
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<td>❌</td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Don’t know</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
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<td>Other</td>
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<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
</tbody>
</table>

Other (please specify)
### 2013 DHCS Health Plan Prevention Survey

#### 2. What methods are used by the Plan to communicate with Medi-Cal members about the importance of completing recommended screenings? (Check all that apply)

<table>
<thead>
<tr>
<th>Medical appointment(s)</th>
<th>Cholesterol screening</th>
<th>Diabetes screening</th>
<th>Hypertension screening</th>
<th>Obesity screening</th>
<th>Overweight screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone call(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email(s)</td>
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<tr>
<td>Brochure(s)</td>
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<tr>
<td>Poster(s)</td>
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<tr>
<td>Flyer(s)</td>
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<tr>
<td>Mail</td>
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<tr>
<td>Newsletter(s)</td>
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<td>Text message(s)</td>
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<td>N/A</td>
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<tr>
<td>Other</td>
<td></td>
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</tr>
</tbody>
</table>

Other (please specify)

#### 3. Does the Plan require providers to follow up at least once with Medi-Cal members who are overdue for screenings?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overweight screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 2013 DHCS Health Plan Prevention Survey

#### 4. Does the Plan use incentives to encourage Medi-Cal member participation in screenings?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes screening</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Hypertension screening</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Obesity screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overweight screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, please describe the incentive program.

#### 5. Please indicate how the Plan's providers follow up with Medi-Cal members whose screening results are outside normal/healthy limits? (Check all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Cholesterol screening</th>
<th>Diabetes screening</th>
<th>Hypertension screening</th>
<th>Obesity screening</th>
<th>Overweight screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule follow-up appointment</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Schedule diagnostic test(s)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Referral to specialist</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Contact Member by phone</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Contact Member by mail</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Email(s)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Refer to healthy lifestyle class(es)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Don't know</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>N/A</td>
<td>[ ]</td>
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</tr>
<tr>
<td>Other</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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</tr>
</tbody>
</table>

Other (please specify)

---

**Disease Management Interventions:** The following questions relate to the disease management interventions offered by your Plan.

These interventions are designed to reduce mortality and morbidity of Medi-Cal members by focusing on the effective self management of an established disease.

**Disease Management:** *Program Delivery*
### 2013 DHCS Health Plan Prevention Survey

#### 1. How does the Plan identify Medi-Cal members who qualify for disease management interventions? (Check all that apply)

<table>
<thead>
<tr>
<th>Weight management</th>
<th>Cardiovascular disease management</th>
<th>Diabetes management</th>
<th>Asthma management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease registry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmaceutical use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don't know</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other (please specify)

#### 2. When are Medi-Cal members referred to the Plan's disease management interventions? (Check all that apply)

<table>
<thead>
<tr>
<th>Weight management</th>
<th>Cardiovascular disease management</th>
<th>Diabetes management</th>
<th>Asthma management</th>
</tr>
</thead>
<tbody>
<tr>
<td>At diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual check up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient request</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Don't know</td>
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<td></td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Other (please specify)
### 3. How is the program content delivered for the Plan’s disease management interventions? (Check all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Weight management</th>
<th>Cardiovascular disease management</th>
<th>Diabetes management</th>
<th>Asthma management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group class(es)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse advice line</td>
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</tr>
<tr>
<td>In-person counseling</td>
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<tr>
<td>Phone counseling</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Medical appointment(s)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Printed material(s)</td>
<td></td>
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<tr>
<td>Email(s)</td>
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<td></td>
</tr>
<tr>
<td>Plan website</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other website(s)</td>
<td></td>
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<tr>
<td>Text message(s)</td>
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<tr>
<td>Facebook</td>
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<td>Twitter</td>
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<tr>
<td>Don’t know</td>
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<tr>
<td>Other</td>
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<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4. Who delivers the Plan’s disease management interventions? (Check all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Weight management</th>
<th>Cardiovascular disease management</th>
<th>Diabetes management</th>
<th>Asthma management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third party vendor/subcontractor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration with a community organization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health plan staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network provider office(s)</td>
<td></td>
<td></td>
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<tr>
<td>N/A</td>
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<tr>
<td>Don’t know</td>
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<tr>
<td>Other</td>
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</tr>
<tr>
<td>Other (please specify)</td>
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<td></td>
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</tr>
</tbody>
</table>
2013 DHCS Health Plan Prevention Survey

5. Does the Plan use incentives to encourage Medi-Cal members to participate in disease management interventions?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular disease management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes management</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Asthma management</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

If yes, please describe the incentive program.

6. Does the Plan limit the number of times Medi-Cal members can access disease management interventions?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular disease management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma management</td>
<td></td>
<td></td>
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</tbody>
</table>

If yes, what is the limit?
7. Please indicate method(s) used by the Plan to inform providers/health care professionals about the availability of disease management interventions. (Check all that apply)

<table>
<thead>
<tr>
<th>Method</th>
<th>Obesity</th>
<th>Cardiovascular disease</th>
<th>Diabetes</th>
<th>Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conferences</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>Provider meetings</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Provider office site visits</td>
<td>☐</td>
<td>☐</td>
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<td>Webinars</td>
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<tr>
<td>Phone calls</td>
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<tr>
<td>Printed materials</td>
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<tr>
<td>Newsletters</td>
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<tr>
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<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other websites</td>
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<td>Text message</td>
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<tr>
<td>Don't know</td>
<td>☐</td>
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<tr>
<td>N/A</td>
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<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Other (please specify)

8. If you would like to provide a general overview/description of the Plan's disease management activities, or more detail on any of the answers you have provided above, please do so here. (optional)

(a) Weight management:

(b) Cardiovascular disease management:
## 2013 DHCS Health Plan Prevention Survey

### (c) Diabetes management:

---

### (d) Asthma management:

---

9. Please tell us what DHCS can do to complement the Plan's disease management interventions.

---

### Disease Management Interventions: The following questions are asking for more detailed information about the Plan's most impactful disease management interventions.

**Disease Management Intervention: Weight Management**

1. Does the Plan conduct a weight management intervention for Medi-Cal members who are obese or overweight?

- Yes, for those who are obese
- Yes, for those who are overweight
- Yes, for those who are overweight or obese
- Yes, (but not directly), for those who are obese
- Yes, (but not directly), for those who are overweight
- Yes, (but not directly), for those who are overweight or obese
- No
- Don't know

2. Please provide the name for each weight management intervention offered to Medi-Cal members.

---


3. Please provide a description of the weight management prevention intervention that has the greatest impact for Medi-Cal members. Note: If the intervention has been described in detail in another section of the survey, please refer to that section rather than re-entering the information.

**Intervention name:**

<table>
<thead>
<tr>
<th>Intervention goals:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**List measurable objectives for the intervention:**

<table>
<thead>
<tr>
<th>Intervention description:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

4. How many hours of education does this intervention provide? (may include hours of coaching, counseling, support group participation, etc.)

<table>
<thead>
<tr>
<th>5. Is this intervention tailored/customized for any of the following characteristics?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Age</td>
</tr>
<tr>
<td>[ ] Infants                          [ ] Young adults                  [ ] Don't know</td>
</tr>
<tr>
<td>[ ] Children                        [ ] Adults                      [ ] N/A</td>
</tr>
<tr>
<td>[ ] Teenagers                       [ ] Seniors</td>
</tr>
<tr>
<td>Other (please specify)</td>
</tr>
<tr>
<td>(b) Gender</td>
</tr>
<tr>
<td>[ ] Male                            [ ] Don't know</td>
</tr>
<tr>
<td>[ ] Female                          [ ] N/A</td>
</tr>
</tbody>
</table>
### 2013 DHCS Health Plan Prevention Survey

#### (c) Race/Ethnicity(s) (Check all that apply)
- [ ] African American
- [ ] Native American
- [ ] Don't know
- [ ] Asian
- [ ] Pacific Islander
- [ ] N/A
- [ ] Latino / Hispanic
- [ ] White / Caucasian

Other (please specify)

#### (d) Language(s) (Check all that apply)
- [ ] Arabic
- [ ] Khmer
- [ ] Tagalog
- [ ] Armenian
- [ ] Korean
- [ ] Vietnamese
- [ ] Cantonese
- [ ] Mandarin
- [ ] Don't know
- [ ] English
- [ ] Russian
- [ ] N/A
- [ ] Farsi
- [ ] Sign Language
- [ ] Other
- [ ] Spanish
- [ ] Other

Other (please specify)

#### (e) Disability (Please specify)

#### (f) Other (Please specify)

6. How does the Plan measure the effectiveness of this weight management intervention?

7. What changes have been documented in Medi-Cal members who have participated in this weight management intervention? (e.g., 20% of participants decreased their Body Mass Index by 5% or more, etc.)
8. In the last two years, have you changed this intervention to improve outcomes?

- [ ] Yes
- [ ] No
- [ ] Don't know

If yes, please provide details.

9. Are there any changes you would like to make, that you haven't implemented already, to improve the outcomes of this intervention?

- [ ] Yes
- [ ] No
- [ ] Don't know

If yes, please provide details.

10. Are there any barriers, challenges, or limitations preventing you from implementing the changes described above in question nine?

- [ ] Yes
- [ ] No
- [ ] N/A
- [ ] Don't know

If yes, please provide details.
2013 DHCS Health Plan Prevention Survey

11. Please indicate which Plan members are eligible to participate in this weight management intervention:

- All Plan Members who are overweight/obese
- Medi-Cal Members Only who are overweight/obese
- Other (please specify)

12. How many Medi-Cal members participated in this weight management intervention in 2012?

Disease Management Intervention: Cardiovascular Disease

1. Does the Plan conduct a cardiovascular disease management intervention for Medi-Cal members who have cardiovascular disease?

- Yes
- Yes, (but not directly)
- No
- Don't know

2. Please provide the name for each cardiovascular disease management intervention offered to Medi-Cal members.

3. Please provide a description of the cardiovascular disease management intervention that has the greatest impact for Medi-Cal members. Note: If the intervention has been described in detail in another section of the survey, please refer to that section rather than re-entering the information.

   Intervention name:
2013 DHCS Health Plan Prevention Survey

**Intervention goals:**

**List measurable objectives for the intervention:**

**Intervention description:**

4. **How many hours of education does this intervention provide?** (may include hours of coaching, counseling, support group participation, etc.)

5. **Is this intervention tailored/customized for any of the following characteristics?**

   (a) **Age**
   - [ ] Infants
   - [ ] Children
   - [ ] Teenagers
   - [ ] Young adults
   - [ ] Adults
   - [ ] Seniors
   - [ ] Don’t know
   - [ ] N/A
   - [ ] Other (please specify)

   Other (please specify)

(b) **Gender**
- [ ] Male
- [ ] Female
- [ ] Don’t know
- [ ] N/A
2013 DHCS Health Plan Prevention Survey

(c) Race/Ethnicity(s) (Check all that apply)

- African American
- Asian
- Latino / Hispanic
- Native American
- Pacific Islander
- White / Caucasian
- Don't know
- N/A

Other (please specify)

(d) Language(s) (Check all that apply)

- Arabic
- Armenian
- Cantonese
- English
- Farsi
- Hmong
- Khmer
- Korean
- Mandarin
- Russian
- Sign Language
- Spanish
- Tagalog
- Vietnamese
- Don't know
- N/A

Other (please specify)

(e) Disability (Please specify)

(f) Other (Please specify)

6. How does the Plan measure the effectiveness of this cardiovascular disease management intervention?
2013 DHCS Health Plan Prevention Survey

7. What changes have been documented in Medi-Cal members who have participated in this cardiovascular disease management intervention? (e.g., 90% of participants have blood pressure within normal limits, etc.)

8. In the last two years, have you changed this intervention to improve outcomes?
   - Yes
   - No
   - Don't know

   If yes, please provide details.

9. Are there any changes you would like to make, that you haven't implemented already, to improve the outcomes of this intervention?
   - Yes
   - No
   - Don't know

   If yes, please provide details.

10. Are there any barriers, challenges, or limitations preventing you from implementing the changes described above in question nine?
    - Yes
    - No
    - N/A
    - Don't know

    If yes, please provide details.
11. Please indicate which Plan members are eligible to participate in this cardiovascular disease management intervention:

- All Plan Members with cardiovascular disease
- Medi-Cal Members Only with cardiovascular disease
- Other (please specify)

12. How many Medi-Cal members participated in this cardiovascular disease management intervention in 2012?

Disease Management Intervention: *Diabetes*

1. Does the Plan conduct a diabetes management intervention for Medi-Cal members who have diabetes?

- Yes
- Yes, (but not directly)
- No
- Don't know

2. Please provide the name for each diabetes management intervention offered to Medi-Cal members.

3. Please provide a description of the diabetes management intervention that has greatest impact for Medi-Cal members. Note: If the intervention has been described in detail in another section of the survey, please refer to that section rather than re-entering the information.

   Intervention name:
## 2013 DHCS Health Plan Prevention Survey

### Intervention goals:

- [ ]

### List measurable objectives for the intervention:

- [ ]

### Intervention description:

- [ ]

### 4. How many hours of education does this intervention provide? (may include hours of coaching, counseling, support group participation, etc.)

- [ ]

### 5. Is this intervention tailored/customized for any of the following characteristics?

#### (a) Age

- [ ] Infants
- [ ] Children
- [ ] Teenagers
- [ ] Young adults
- [ ] Adults
- [ ] Seniors
- [ ] Don't know
- [ ] N/A
- [ ] Other (please specify):

- [ ]

#### (b) Gender

- [ ] Male
- [ ] Female
- [ ] Don't know
- [ ] N/A
- [ ]
### 2013 DHCS Health Plan Prevention Survey

(c) **Race/Ethnicity(s) (Check all that apply)**

- [ ] African American
- [ ] Native American
- [ ] Don't know
- [ ] Asian
- [ ] Pacific Islander
- [ ] N/A
- [ ] Latino / Hispanic
- [ ] White / Caucasian
- Other (please specify)

(d) **Language(s) (Check all that apply)**

- [ ] Arabic
- [ ] Khmer
- [ ] Tagalog
- [ ] Armenian
- [ ] Korean
- [ ] Vietnamese
- [ ] Cantonese
- [ ] Mandarin
- [ ] Don't know
- [ ] English
- [ ] Russian
- [ ] N/A
- [ ] Farsi
- [ ] Sign Language
- [ ] Spanish
- Other (please specify)

(e) **Disability (Please specify)**

(f) **Other (Please specify)**

6. **How does the Plan measure the effectiveness of this diabetes management intervention?**
2013 DHCS Health Plan Prevention Survey

7. What changes have been documented in Medi-Cal members who have participated in this diabetes management intervention? (e.g., 90% of participants have blood glucose within normal limits, etc.)

8. In the last two years, have you changed this intervention to improve outcomes?
   - Yes
   - No
   - Don't know

If yes, please provide details.

9. Are there any changes you would like to make, that you haven't implemented already, to improve the outcomes of this intervention?
   - Yes
   - No
   - Don't know

If yes, please provide details.

10. Are there any barriers, challenges, or limitations preventing you from implementing the changes described above in question nine?
    - Yes
    - No
    - N/A
    - Don't know

If yes, please provide details.
2013 DHCS Health Plan Prevention Survey

11. Please indicate which Plan members are eligible to participate in this diabetes management intervention:
   - All Plan Members with diabetes
   - Medi-Cal Members Only with diabetes
   - Other (please specify)

12. How many Medi-Cal members participated in this diabetes management intervention in 2012?

Disease Management Education Intervention: Asthma

1. Does the Plan conduct an asthma management intervention for Medi-Cal members who have asthma?
   - Yes
   - Yes, (but not directly)
   - No
   - Don't know

2. Please provide the name for each asthma management intervention offered to Medi-Cal members.

3. Please provide a description of the asthma management intervention that has the greatest impact for Medi-Cal members. Note: If the intervention has been described in detail in another section of the survey, please refer to that section rather than re-entering the information.
   - Intervention name:
2013 DHCS Health Plan Prevention Survey

Intervention goals:

List measurable objectives for the intervention:

Intervention description:

4. How many hours of education does this intervention provide? (may include hours of coaching, counseling, support group participation, etc.)

5. Is this intervention tailored/customized for any of the following characteristics?

(a) Age

- [ ] Infants
- [ ] Children
- [ ] Teenagers
- [ ] Young adults
- [ ] Adults
- [ ] Seniors
- [ ] Don't know
- [ ] N/A

Other (please specify)

(b) Gender

- [ ] Male
- [ ] Female
- [ ] Don't know
- [ ] N/A
2013 DHCS Health Plan Prevention Survey

(c) Race/Ethnicity(s) (Check all that apply)

- African American
- Asian
- Latino / Hispanic
- Native American
- Pacific Islander
- White / Caucasian
- Don't know
- N/A

Other (please specify)

(d) Language(s) (Check all that apply)

- Arabic
- Armenian
- Cantonese
- English
- Farsi
- Hmong
- Khmer
- Korean
- Mandarin
- Russian
- Sign Language
- Spanish
- Tagalog
- Vietnamese
- Don't know
- N/A

Other (please specify)

(e) Disability (Please specify)

(f) Other (Please specify)

6. How does the Plan measure the effectiveness of this asthma management intervention?

7. What changes have been documented in Medi-Cal members who have participated in this asthma management intervention? (e.g., 70% of participants did not have an asthma attack for at least 6 months after this intervention, etc.)
### 2013 DHCS Health Plan Prevention Survey

8. In the last two years, have you changed this intervention to improve outcomes?

- Yes
- No
- Don't know

If yes, please provide details.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
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</table>

9. Are there any changes you would like to make, that you haven't implemented already, to improve the outcomes of this intervention?

- Yes
- No
- Don't know

If yes, please provide details.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
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</table>

10. Are there any barriers, challenges, or limitations preventing you from implementing the changes described above in question nine?

- Yes
- No
- N/A
- Don’t know

If yes, please provide details.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Don’t know</th>
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278
11. Please indicate which Plan members are eligible to participate in this asthma management intervention:

- All Plan Members with asthma
- Medi-Cal Members Only with asthma
- Other (please specify)

12. How many Medi-Cal members participated in this asthma management intervention in 2012?

Fostering Healthy Communities: The following questions relate to your Plan’s efforts to improve health outcomes by fostering healthy communities.

1. What activities does the Plan sponsor to foster healthy communities? (Check all that apply)

- Farmers’ markets
- Community gardens
- School gardens
- Other (please specify)

- Food pantries
- Walking clubs
- Walking or running events
- Physical activity events
- None

- Physical activity events
- None
2. Does the Plan refer Medi-Cal members to any of the following assistance programs? (Check all that apply)

- CalFresh (food stamp program)
- Food banks
- Women, Infants and Children Supplemental Nutrition Program (WIC)
- Childcare assistance
- Job training and placement
- Vocational education programs
- English proficiency programs
- Adult education/General Educational Development (GED) test preparation
- Utilities assistance (such as electricity, home heating, phone service)
- Temporary Aid for Needy Families (TANF/Welfare)
- Housing assistance
- Domestic violence shelters
- Homeless shelters
- Don't know
- None
- Other (please specify)

3. Does the Plan have a farm-to-health care program that provides locally grown food for hospital meals?

- Yes
- No
- Don't know

If yes, please describe this program
## 2013 DHCS Health Plan Prevention Survey

### 4. Does the Plan have a farm-to-health care program that provides locally grown food for employee wellness programs?

- [ ] Yes
- [ ] No
- [ ] The Plan does not have any employee wellness programs
- [ ] Don't know

If yes, please describe this program

---

### 5. Does the Plan use health navigators?

- [ ] Yes
- [ ] No
- [ ] Don't know

If yes, please describe their role and main functions

---

### 6. Does the Plan use community health workers/promotores?

- [ ] Yes
- [ ] No
- [ ] Don't know

If yes, please describe their role and main functions

---

### 7. Please tell us what DHCS can do to support and complement the Plan's efforts to foster healthy communities.

---

Thank you for taking the time to complete the DHCS prevention survey. We look forward to sharing the results with you once they become available.
Appendix L: A Report on the Formative Program Evaluation of California Managed Care Preventive Services
A Formative Program Evaluation of California Managed Care Preventive Services

By Rachel Trusty
For the California Department of Health Care Services
Disclaimer

This report has been prepared for the California Department of Health Care Services (DHCS) under the supervision of the Chief Prevention Officer, Desiree Backman. The author completed this report in partial fulfillment of the requirements for the master’s of Public Policy at Mills College. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Master of Public Policy Program at Mills College, the client organization, or any other agency.

The survey developed for this research project is available from the author upon request. Requests for access to the survey responses should be submitted directly to the California Department of Health Care Services, Sacramento, CA.
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Executive Summary

Medi-Cal provides health care coverage for over eight million Californians at a budgeted cost of $63 billion for fiscal year 2012-2013. A combination of increasing health care costs and enrollment has resulted in Medi-Cal costs growing over 10 percent annually since fiscal year 2006-2007. Anticipating the expansion of Medi-Cal coverage in 2014 due to the implementation of the Patient Protection and Affordable Care Act, the state has a clear interest in improving health outcomes and reducing, or at the very least containing, per capita health care costs.

With over 25 percent of recent health care spending growth attributed to preventable disease, providing interventions for members that have been shown to be effective at preventing disease from occurring, reversing disease at an early stage, or effectively managing disease can make a valuable contribution to improving individual health outcomes and reducing the growing burden of health care costs.

Managed health care plans, which provide coverage to an increasing proportion of the Medi-Cal population, have utilized the efficiencies of their integrated medical provider networks and coordinated health systems to provide a wide variety of disease prevention interventions to their members. This research project was designed to provide the California Department of Health Care Services (DHCS) with a better understanding of the preventive services provided to Medi-Cal members by the managed care plans, an overview of how services are designed and implemented, and insight into how effective the interventions are at engaging and educating Medi-Cal members about disease prevention.

The results provided clear evidence of a diverse array of prevention interventions being offered to Medi-Cal members by the managed care plans. The results also indicated that there is an opportunity for DHCS to work with the plans to: develop clear and shared definitions of what an intervention is; establish a common framework of prevention services based on member health status and willingness to participate in prevention interventions; and develop consistent measures of effectiveness and program utilization to more effectively evaluate intervention results and create a more consistent Medi-Cal member experience of prevention. The key benefits in investing resources in these strategic planning activities would be to:
build a common framework based on best-practices, be more efficient in targeting resources to specific prevention populations, have clear and realistic shared expectations about the role and contribution providers can make in promoting prevention with members, and create comparable measures with which to evaluate interventions and their impact on different populations. This investment will result in more effective prevention services being provided to Medi-Cal members, and therefore, will improve member health and reduce future medical costs associated with preventable disease.

This study recommends DHCS continue to work with the managed care health plans to: (1) develop a prevention program framework describing the members’ experience of prevention services based on health status and willingness to participate in prevention interventions, (2) develop consistent measures to track and evaluate member participation and intervention effectiveness, and (3) update the managed care contract language to establish clear and consistent program guidelines for preventive services.

Combined, these recommendations are designed to: maximize efficiencies and reduce health care costs by enhancing collaboration between the plans and DHCS; advance effective prevention interventions that are feasible to implement across a wide range of territories and communities; and develop consistent ways to evaluate interventions and their impact on improving the health outcomes of Medi-Cal members.
**Introduction**

Medicaid was established by the Social Security Act of 1965 to provide health care coverage for low-income people and persons with disabilities. Medicaid is jointly funded by state and federal governments and administered by the states. To participate, states are required to provide coverage to certain populations, called *mandatory eligibility groups*, which are established by the federal government, but may also elect to expand eligibility to other populations, called *optional eligibility groups*, with federal approval.

In California, the California Department of Health Care Services (DHCS) is responsible for administering the state’s Medicaid program, which is known as the California Medical Assistance Program (Medi-Cal). DHCS’s mission is to “preserve and improve the health status of all Californians” by operating and financing programs that deliver vital health care services to eligible individuals. Through the Medi-Cal program, DHCS provides health care coverage to approximately 8.3 million individuals, or more than 20 percent of California’s population, including: 33 percent of children, more than 10 percent of adults and over 46 percent of all births in the state. In addition, Medi-Cal provides health care coverage for most people living with AIDS, and covers expenses for two-thirds of all nursing home residents (California Healthcare Foundation, 2009).

According to the Governor’s 2013-2014 Health and Human Services budget summary, a combination of health care cost inflation, rate increases and caseload growth have resulted in Medi-Cal benefit costs growing 10.6 percent annually since fiscal year 2006-07. The Governor’s 2013-2014 proposed state budget includes $63 billion to support DHCS programs and services; of this, almost $16 billion will come from the state’s general fund, representing over 16 percent of the total general fund spending for the fiscal year (California Department of Finance, 2012). With per capita health care costs rising and considerable growth in enrollment projected due in large part to the federal Patient Protection and Affordable Care Act (PPACA) implementation scheduled for January 2014, the state has a clear interest in improving the health of Medi-Cal members and thereby reducing, or at the very least containing, health care costs.
The purpose of this study is to provide an assessment of the prevention interventions available to Medi-Cal members enrolled in contracted managed care plans. Effective healthy lifestyle, disease prevention and disease management programs not only improve quality of life by improving health outcomes, they also reduce health care costs by empowering members with the knowledge and skills to: increase their health, avoid the development of preventable disease and effectively manage existing conditions (Centers for Disease Control and Prevention, 2009). This study helps DHCS better understand the range of prevention interventions being offered by the contracted managed care plans, how these interventions are designed and delivered, and how effective they are at reaching and educating the Medi-Cal population.

Health Care and Prevention

DHCS coordinates and directs health care services for Medi-Cal members by contracting with local providers, health plans, and health professionals in each of the state’s 58 counties. Historically in California, health care services have been provided by independent doctors, clinics, and other health care providers using a fee-for-service model. In this model, Medi-Cal members seek medical services from any approved independent provider who is then compensated by DHCS on a per visit/treatment basis. The fee-for-service model allows members to receive services from the practitioners they prefer, and provides limited ways for DHCS to control the services rendered or the costs incurred beyond reducing the reimbursement rates per treatment it pays providers (California HealthCare Foundation (CHCF), 2005).

The fee-for-service model is a “sick care” model, focused on treating people once they are sick. With payments made for treating each presenting disease or condition, there is no coordinated network or financial incentive to encourage the provision of preventive services designed to help members avoid disease or chronic conditions. Indeed, many believe the fee-for-service model contributes to rising health care costs because it incents providers to recommend and ultimately charge for more treatment than may be necessary.

In contrast, health care providers in the managed care model are part of a network connected through membership to a plan. In this model, a Medi-Cal member selects a practitioners or clinic as their primary provider who is then responsible for coordinating care and referring
members to other in-plan providers for specialized services (CHCF, 2005). In the managed care model, the plan is paid a fixed monthly rate per patient regardless of the services used. These financial and organizational structures encourage cost-efficiencies through: better coordination of care between clinical practitioners; improved access to primary care; and an emphasis on disease prevention services as a way to increase healthy lifestyles, prevent disease, and improve disease self-management.

Currently, over 60 percent of Medi-Cal members receive their health services from one of the 30 contracted managed care providers (California Department of Health Care Services, 2012). To further increase managed care enrollment, DHCS is establishing new contracts in counties that previously did not have a managed care Medi-Cal provider, and has begun mandating managed care enrollment for Medi-Cal members. When the planned managed care conversion initiatives are complete, DHCS anticipates the vast majority of Medi-Cal members will be enrolled with managed care providers. With over 25 percent of recent health care spending growth attributed to increases in obesity, diabetes, high cholesterol and heart disease (Thorpe, Florence, & Joski, 2004), which are, in many cases, preventable conditions, managed care providers and DHCS have a shared incentive to promote health and disease management as a way to improve health outcomes and reduce health care costs.

**DHCS Quality Strategy**

As a leading payer for health care services in California, DHCS is working with others in the health care community to develop effective strategies to improve health outcomes and the health care delivery system. DHCS recently published the Strategy for Quality Improvement in Health Care (Quality Strategy) as its blueprint for improving health, enhancing quality and reducing health care costs (California Department of Health Care Services, 2012). There are seven priorities identified in the DHCS Quality Strategy:

1. Improve patient safety;
2. Deliver effective, efficient, affordable care;
3. Engage persons and families in their health;
4. Enhance communication and coordination of care;
5. Advance prevention;
6. Foster healthy communities; and
7. Eliminate health disparities.
To inform the Quality Strategy, DHCS conducted an internal baseline assessment of the department’s quality improvement projects and programs. However, an assessment of quality would not be complete without understanding the Medi-Cal member’s experience of prevention, engagement, and community initiatives at the plan level. To provide a more complete understanding of how DHCS can best support, complement, and develop policy to advance effective evidence-based prevention and health education interventions, the department first needed to increase its understanding of the breadth of prevention services the managed care health plans offer Medi-Cal members, how programs are adapted, accessed, and utilized by various populations, and how the plans evaluate the effectiveness of the interventions they offer.

**Purpose of the Study**

This study provides DHCS with an in-depth description and formative program evaluation of the preventive services available to the Medi-Cal members regarding the leading causes of preventable disease and death. This study evaluates and analyzes a subset of the survey results to provide DHCS with a summary of key findings regarding the availability and design of the prevention services provided by the contracted managed health care plans. This research, along with the Quality Strategy and inventory of quality improvement efforts Department-wide, can then be used to inform the development of a DHCS Quality Improvement Implementation Plan (California Department of Health Care Services, 2012).
Survey Development

DHCS contracts with 30 managed health care plans. Twenty-four of the plans provide services to the general Medi-Cal population; some of these plans are business units of a larger single health care organization with shared health education services. Once the separate business units are combined, they represented 21 unique health care organizations. The remaining six plans provide specialized services to targeted member populations, such as long-term care for the elderly and services for members diagnosed with AIDS. The prevention priorities of these six specialized providers are specific to the populations they serve, and were outside of the scope and purpose of this study.

Working under the direction of the DHCS Chief Prevention Officer, and in partnership with the Medi-Cal Managed Care Division and other DHCS staff, a survey was developed to assess the health education and prevention interventions offered to Medi-Cal members by the contracted managed care plans.

In the pre-design meeting with the health educators, it became clear that the survey scope needed to be focused and limited to remain manageable. The survey scope was narrowed to primarily target prevention interventions for some of the leading causes of preventable disease and death, including: heart disease, obesity, diabetes, lack of physical activity, poor nutrition and excessive alcohol consumption (Centers for Disease Control and Prevention, 2012). Tobacco cessation was excluded from this survey because it was the subject of a separate survey administered by the California Department of Public Health in January 2012. Additionally, breastfeeding was included in the survey from the onset because of its significance to DHCS as the largest single payer for births in California (California Department of Health Care Services, 2010).

At each stage of this four-month comprehensive design process, feedback was incorporated from a wide range of stakeholders. Feedback from the contracted plans’ health educators and medical directors about the impact of alcohol abuse, drug abuse and asthma disease management resulted in these topics being added to the survey. Feedback from the California Department of Public Health’s California Diabetes Program and California Heart Disease and Stroke Prevention Program helped inform the design and content of the intervention specific
questions. Finally, with approval from the DHCS Medical Director and DHCS Managed Care Division Chief, a pilot test was conducted with the managed care plans’ health educators to gather further input and feedback before the survey design was completed.

**Survey Questions**

The final survey consisted of 296 questions spanning five domains: health education oversight, healthy lifestyles, disease prevention, disease management and fostering healthy communities. The healthy lifestyle, disease prevention and disease management sections were further broken down by behavior or disease.

**Health Education Oversight** - This survey section consisted of nine questions. These questions measured how plans communicated with providers about available prevention services and how the services were delivered.

**Sample Questions** - “What percentage of the Plan's health education services are subcontracted with delegated entities?” and “How often does the Plan conduct provider training/education about Medi-Cal contract requirements for the following topics?”

**Healthy Lifestyles** –Healthy lifestyle interventions are designed to encourage healthful lifestyle behaviors to reduce the risk of poor health outcomes and improve overall quality of life. This survey section consisted of 113 questions. Twelve questions measured program delivery, including the range of content delivery methods used and whether plans provided incentives to members to participate or set limitations for member access. The remaining questions asked about specific interventions for healthy eating, physical activity, alcohol abuse prevention, drug abuse prevention and breastfeeding.

**Sample Questions** - “Please provide a description of the healthy eating intervention that has the greatest impact for Medi-Cal members.” and “How many hours of education does this intervention provide?” and “How does the Plan measure the effectiveness of this intervention?”
Note: The same intervention specific questions were repeated in the healthy lifestyle, disease preventions and disease management sections of the survey.

**Disease Prevention** – Disease prevention interventions are designed to help members prevent or reverse disease at an early stage, or for early detection of disease. This survey section consisted of 75 questions. Ten questions measured program delivery, including the range of content delivery methods used and whether plans provided incentives to members to participate or set limitations for member access. The remaining questions asked about specific interventions for obesity/overweight prevention, cardiovascular disease prevention, type 2 diabetes prevention and disease screening.

**Disease Management** - Disease management interventions are designed to help members who have an established disease improve their quality of life and improve self-management. This survey section consisted of 92 questions. Twelve questions measured program delivery, including the range of content delivery methods used and whether plans provided incentives to members to participate or set limitations for member access. The remaining questions asked about specific interventions for weight management, cardiovascular disease management, diabetes management and asthma management.

**Fostering Healthy Communities** - This survey section consisted of seven questions about the plans’ efforts to address the social determinants of health in the broader community including: supporting increased access to fresh fruit and vegetables by promoting or supporting farmers’ markets and community gardens, connecting members with county services that offer financial assistance for housing, and supporting the development of community organizations that promote walking or social support for disease management.

**Sample Questions** – “Does the Plan refer Medi-Cal members to any of the following assistance programs?” and “Does the Plan use community health workers/promotores?”
Data Collection

The survey distribution was limited to the 21 managed health care organizations described above that provide health care services to the general Medi-Cal population. “Appendix B. Managed Care Plan Overviews” provides a brief description of these managed health care plans, including the number of Medi-Cal members enrolled in each.

The survey was administered by the DHCS Medi-Cal Managed Care Division via an online tool and delivered to the managed care plans’ health educators in January 2013. The 21 health educators were given four weeks to complete the survey and submit their responses. Twenty plans submitted survey responses, and these were then downloaded to Microsoft Excel for analysis.

Methods of Analysis

The analysis of survey responses assessed the extent to which managed care plans provided prevention and disease management prevention interventions. The analysis also included an assessment of whether the interventions described by the plans in each of the prevention categories (healthy lifestyle, disease prevention and disease management) were aligned with the definition provided in the Research Design section of this report.

The assessment of the programs and interventions included a synthesis of common themes and program consistency, specifically concerning program availability, delivery, content, design and member utilization across plans and prevention area.
Results

The purpose of this section is to provide an accessible summary of data collected from the managed care plans by prevention topic. This section does not include an analysis or interpretation of the data. The findings, described later in this report, were derived from an evaluation of this data in addition to the intervention narrative descriptions provided by the plans found in Appendix D.

This section summarizes a subset of the responses from the healthy lifestyle, disease prevention and disease management sections of the survey: measures of participation, effectiveness, goals, target audience, delivery method and education hours. These results were selected because together, they were the responses most directly relevant to how the interventions were designed, delivered and measured by the plans.

The results excluded responses from the health education oversight and fostering healthy communities sections of the survey. Also excluded were responses about how interventions were customized for age, gender, race, language, disability or other; changes that have been made to interventions; changes that respondents would like to make to interventions; barriers to making intervention changes; and responses about referrals, incentives and limits to intervention access.

The health education oversight and fostering healthy communities responses were excluded because the scope of this report was limited to intervention design. The intervention customization elements were excluded because the survey results were unclear and needed further explanation and clarification. The responses regarding change were excluded because these were not directly related to the current intervention design. Finally, the responses regarding referrals, incentives and limits were excluded because the responses indicated little variation across plans.
Healthy Lifestyles Results

The healthy lifestyle interventions surveyed were healthy eating, physical activity, alcohol abuse prevention, drug abuse prevention and breastfeeding. Select results are provided below.

Intervention Delivery Overview

Plans were asked to check “all that apply” for how intervention content was delivered and who delivered content for each prevention topic. As shown in Table 1, printed materials, plan website and medical appointments were the responses most frequently checked for how content was delivered. Table 2 shows network provider offices and community collaboration were the most frequently checked for who delivered content.

Table 1. Healthy Lifestyle Interventions: Delivery Methods for the 20 Responding Plans

<table>
<thead>
<tr>
<th>Method</th>
<th>Healthy eating</th>
<th>Physical activity</th>
<th>Alcohol abuse</th>
<th>Drug abuse</th>
<th>Breast-feeding</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed material(s)</td>
<td>20</td>
<td>20</td>
<td>15</td>
<td>16</td>
<td>19</td>
<td>90</td>
</tr>
<tr>
<td>Plan website</td>
<td>20</td>
<td>19</td>
<td>10</td>
<td>12</td>
<td>14</td>
<td>75</td>
</tr>
<tr>
<td>Medical appointment(s)</td>
<td>18</td>
<td>17</td>
<td>10</td>
<td>11</td>
<td>14</td>
<td>70</td>
</tr>
<tr>
<td>Group class(es)</td>
<td>16</td>
<td>13</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>70</td>
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<td>Phone counseling</td>
<td>12</td>
<td>11</td>
<td>5</td>
<td>6</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>In-person counseling</td>
<td>12</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>12</td>
<td>43</td>
</tr>
<tr>
<td>Nurse advice line</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>18</td>
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<tr>
<td>Other website(s)</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Text message(s)</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>15</td>
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<td>Facebook</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Email(s)</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>N/A</td>
<td>2</td>
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<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Twitter</td>
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<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

Table 2. Healthy Lifestyle Interventions: Who Delivered for the 20 Responding Plans

<table>
<thead>
<tr>
<th>Who</th>
<th>Healthy eating</th>
<th>Physical activity</th>
<th>Alcohol abuse</th>
<th>Drug abuse</th>
<th>Breast-feeding</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network provider office(s)</td>
<td>17</td>
<td>16</td>
<td>10</td>
<td>9</td>
<td>14</td>
<td>66</td>
</tr>
<tr>
<td>Collaboration with a community org</td>
<td>12</td>
<td>14</td>
<td>10</td>
<td>9</td>
<td>16</td>
<td>61</td>
</tr>
<tr>
<td>Health plan staff</td>
<td>14</td>
<td>14</td>
<td>7</td>
<td>6</td>
<td>11</td>
<td>52</td>
</tr>
<tr>
<td>Third party vendor/subcontractor</td>
<td>12</td>
<td>9</td>
<td>1</td>
<td>3</td>
<td>8</td>
<td>33</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>
Healthy Lifestyle Interventions

Later in the survey, the plans were asked if they provided an intervention for each healthy lifestyle prevention topic, and, if so, to describe the most effective intervention they offered. The following results are a summary of the responses and descriptions provided by the plans.

**Intervention availability:** All plans provided interventions for healthy eating and physical activity, and 19 provided breastfeeding interventions. Alcohol abuse prevention interventions were provided by 11 plans and drug abuse prevention interventions were provided by 12 plans.

**Table 3. Healthy Lifestyle: Interventions Provided**

<table>
<thead>
<tr>
<th>Provided</th>
<th>Healthy Eating</th>
<th>Physical Activity</th>
<th>Alcohol abuse</th>
<th>Drug abuse</th>
<th>Breastfeeding</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>13</td>
<td>11</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>39</td>
</tr>
<tr>
<td>Yes, (but not directly)</td>
<td>7</td>
<td>9</td>
<td>9</td>
<td>7</td>
<td>11</td>
<td>43</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>8</td>
<td>1</td>
<td>18</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
<td><strong>20</strong></td>
<td><strong>20</strong></td>
<td><strong>20</strong></td>
<td><strong>20</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Healthy Eating**

- **Delivery Methods** – Nine plans’ interventions were delivered as a group class, five described 1:1 counseling and two utilized a community program. Of the remaining four plans, one used a provider toolkit, one used a direct mailing, one used a primary care appointment with follow-up phone call, and one used a newsletter.

- **Target Audience** - Eight interventions targeted all plan members, five targeted children who are overweight/obese, two targeted Medi-Cal members only, two targeted all children, one targeted overweight/obese members and one targeted the general public. One plan did not identify a target audience.

- **Hours** - Eleven plans quantified education hours provided. Six plans provided 1 - 3 hours, three plans provided five hours, one provided 10 hours and one provided 18.5 hours.

- **Goals** - Twelve plans identified healthy eating as the primary intervention goal, and three identified the goal as weight loss. Of the remaining plans, one used primary care physician awareness, one used member specific goals and one used referral to community program. One plan did not identify a goal, and another provided an answer that was unclear.
• **Effectiveness** - Six plans used increased member knowledge to measure effectiveness, four plans used member feedback, three plans used BMI/weight loss and one plan used community awareness. Five plans did not provide a measure of intervention effectiveness.

• **Medi-Cal Member Participation** - Thirteen plans provided participation data for 2012, ranging from eight to 973 participants. Four plans reported less than 100 participants, six plans reported between 100 and 200 participants, and three plans reported over 500 participants.

• **Documented Change** – Four plans identified behavior change reported by members, three plans identified increase in knowledge reported by members, one plan identified increase in BMI recording by providers and one identified decreased member BMI. Eleven plans did not identify documented changes.

**Physical Activity**

• **Delivery Methods** – Six plans delivered their intervention using 1:1 counseling, six plans used a community program/referral program, three plans delivered their program through a group class and two plans used newspaper articles. Of the remaining three plans, one used direct mailing, one used primary care appointments and one used primary care appointments with a follow-up phone call.

• **Target Audience** - Nine interventions targeted all plan members, four plans targeted children who are overweight/obese, two plans targeted Medi-Cal members only and two plans targeted all children. Four plans did not identify a target audience.

• **Hours** - Ten plans quantified education hours provided. Five plans provided 1 - 2 hours, two plans provided five hours, two plans provided 11 - 12 hours and one plan provided 19 hours.

• **Goals** - Eleven plans identified increasing physical activity as the primary intervention goal. Nine plans did not identify a goal.

• **Effectiveness** - Four plans used member feedback to measure effectiveness and three plans used participation. Of the remaining plans one plan used increase in physical activity, one plan member knowledge and one plan decreased BMI. Ten plans did not provide a measure of intervention effectiveness.
• **Medi-Cal Member Participation** - Eight plans provided participation data for 2012, ranging from 28 - 973 participants. Three plans reported less than 100 participants, two plans reported between 100 and 200 participants and three plans reported 400 or more participants.

• **Documented Change** – Three plans identified behavior change reported by members. Seventeen plans did not identify documented changes.

**Alcohol Abuse**

• **Delivery Methods** – Three plans’ interventions were delivered using printed material, three plans used newsletter articles and three plans used community referrals/programs. One plan used direct mailing and another plan used a group class as the delivery method. Nine plans did not identify an intervention delivery method.

• **Target Audience** - Five interventions targeted all plan members, one targeted pregnant women and new mothers, and one targeted the community. Thirteen plans did not identify a target audience.

• **Hours** - No plans quantified education hours provided.

• **Goals** - Two plans identified referral to resources as the primary intervention goal, and one identified member knowledge. Seventeen plans did not identify an intervention goal.

• **Effectiveness** - One plan used the timeliness of the mailing to measure effectiveness. Nineteen plans did not provide a measure of effectiveness.

• **Medi-Cal Member Participation** - Two plans provided participation data for 2012. One plan reported four members participated and the other reported 22,500 participants.

• **Documented Change** – No plans identify documented changes.

**Drug Abuse**

*(Note: These results do not include responses from two plans that described smoking cessation programs in this section.)*

• **Delivery Methods** – Three plans used printed material to deliver their intervention, three plans used newsletter articles, three plans used community referrals/programs and one plan used a group class. Eight plans did not provide information on an intervention delivery method.
• **Target Audience** – Five interventions targeted all plan members, two plans targeted the community and one plan targeted Medi-Cal members only. Ten plans did not identify a target audience.

• **Hours** – No plans quantified education hours provided.

• **Goals** - Two plans identified referral to community programs as the primary intervention goal. Sixteen plans did not identify goals.

• **Effectiveness** – No plans provided a measure of effectiveness.

• **Medi-Cal Member Participation** - One plan provided participation data for 2012; four members participated in the intervention.

• **Documented Change** – No plans identify documented changes.

**Breastfeeding**

• **Delivery Methods** – Six plans delivered the intervention using direct mailings, and five used community referrals/programs. Of the remaining plans, one used printed materials, one used 1:1 counseling, one used a group class, one used provider education and one used text messaging. One plan did not provide a delivery method and three provided descriptions that were unclear.

• **Target Audience** - Thirteen plans targeted all plan members who can breastfeed, and two plans targeted Medi-Cal members only who can breastfeed. Five plans did not identify a target audience.

• **Hours** – Eight plans quantified education hours provided. Six plans provided between 0.5 - 3 hours, one plan provided five hours and one plan provided 12 hours.

• **Goals** - Nine plans identified increased breastfeeding as the primary intervention goal, two identified increased knowledge of services, and one plan identified increased clinical staff knowledge as their goal. Eight plans did not identify an intervention goal.

• **Effectiveness** - Six plans used participation to measure effectiveness, three plans used data on breastfeeding practices and one plan used member feedback. Nine plans did not provide a measure of effectiveness.

• **Medi-Cal Member Participation** - Eight plans provided participation data for 2012, ranging from 29 - 22,518 participants. One plan reported 29 participants, three plans reported participation between 350 - 1,000 members, three plans reported participation between 1,900 - 4,300 members and one plan reported over 22,500 participants.
• **Documented Change** – One plan identified plan statistics for member breastfeeding behavior and one plan identified county statistics for breastfeeding. Eighteen plans did not identify documented changes.

**Disease Prevention Results**

The disease prevention programs surveyed were cardiovascular disease prevention, overweight/obesity prevention and type 2 diabetes prevention. Select results are provided below.

**Intervention Delivery Overview**

Plans were asked to check “all that apply” for how intervention content was delivered and who delivered content for each prevention topic. As shown in Table 4, printed materials, plan website and medical appointments were the responses most frequently checked for how content was delivered. Table 5 shows network staff, network provider offices and community collaboration were the most frequently checked for who delivered content.

### Table 4. Disease Prevention Intervention: Delivery Methods for the 20 Responding Plans

<table>
<thead>
<tr>
<th>Method</th>
<th>CDV disease</th>
<th>Overweight/Obesity</th>
<th>Type 2 diabetes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed material(s)</td>
<td>19</td>
<td>19</td>
<td>18</td>
<td>56</td>
</tr>
<tr>
<td>Plan website</td>
<td>18</td>
<td>18</td>
<td>19</td>
<td>55</td>
</tr>
<tr>
<td>Medical appt(s)</td>
<td>15</td>
<td>17</td>
<td>16</td>
<td>48</td>
</tr>
<tr>
<td>Phone counseling</td>
<td>12</td>
<td>15</td>
<td>15</td>
<td>42</td>
</tr>
<tr>
<td>Group class(es)</td>
<td>9</td>
<td>15</td>
<td>17</td>
<td>41</td>
</tr>
<tr>
<td>In-person counseling</td>
<td>8</td>
<td>11</td>
<td>11</td>
<td>30</td>
</tr>
<tr>
<td>Nurse advice line</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Other website(s)</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Facebook</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Text message(s)</td>
<td>1</td>
<td></td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Email(s)</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
### Table 5. Disease Prevention Intervention: Who Delivered for the 20 Responding Plans

<table>
<thead>
<tr>
<th>Who</th>
<th>CDV disease</th>
<th>Overweight/Obesity</th>
<th>Type 2 diabetes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health plan staff</td>
<td>15</td>
<td>16</td>
<td>18</td>
<td>49</td>
</tr>
<tr>
<td>Network provider office(s)</td>
<td>14</td>
<td>16</td>
<td>14</td>
<td>44</td>
</tr>
<tr>
<td>Collaboration with a community organization</td>
<td>7</td>
<td>16</td>
<td>14</td>
<td>36</td>
</tr>
<tr>
<td>Third party vendor/subcontractor</td>
<td>8</td>
<td>14</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>N/A</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

### Disease Prevention Interventions

Later in the survey, the plans were asked if they provided an intervention for each disease prevention topic, and if so, to describe the most effective intervention they offered. The following results are a summary of the responses and descriptions provided by the plans.

**Intervention availability:** Fifteen plans provided a cardiovascular disease prevention intervention, 19 plans provided an overweight/obesity prevention intervention and 16 plans provided a type 2 diabetes prevention intervention.

### Table 6. Disease Prevention Interventions Provided

<table>
<thead>
<tr>
<th>Offered</th>
<th>Cardiovascular disease prevention</th>
<th>Overweight/obesity prevention</th>
<th>Type 2 diabetes prevention</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>8</td>
<td>13</td>
<td>11</td>
<td>32</td>
</tr>
<tr>
<td>Yes, (but not directly)</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>18</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>60</td>
</tr>
</tbody>
</table>

### Overweight/Obesity Prevention

- **Delivery Methods** – Ten plans delivered content using a group class and four used 1:1 counseling of various lengths. Of the remaining four plans, one used dial-in phone support, one used automated outbound calls, one used direct mailing and one used gym access.

- **Target Audience** – Seven plans targeted all plan members, three plans targeted members who are overweight/obese, three plans targeted children who are overweight/obese and two plans targeted Medi-Cal members only. Of the remaining plans, one plan targeted Medi-Cal children who are overweight/obese, one plan targeted all plan children and one
plan targeted community teenagers through an intervention delivered through local high schools. Two plans did not identify a target audience.

- **Hours** – Twelve plans quantified education hours provided. Five plans provided 1 - 2.5 hours, two plans provided five hours, two plans provided approximately eight hours, one plan provided 18.5 hours and another up to 48 hours. Finally, one plan provided 1 - 5 hours of gym use per week, with no limit on annual usage.

- **Goals** – Six plans identified increased knowledge as the primary intervention goal, three plans identified change in member behavior, one plan identified increased screening and one identified weight loss as the program goal. Nine plans did not identify a goal.

- **Effectiveness** – Four plans used member feedback, four plans used encounter and participation data, and one plan used weight loss to measure effectiveness. Eleven plans did not provide a measure of effectiveness.

- **Medi-Cal Member Participation** – Thirteen plans provided participation data for 2012, ranging from 8 - 11,490 participants. Five plans reported less than 100 participants, four plans reported between 100 – 200 participants and four plans reported 500 or more participants.

- **Documented Change** – One plan documented increases in screening, one plan documented member knowledge, one plan documented member reported behavior change and one documented used weight loss. Sixteen plans did not identify documented changes.

**Cardiovascular Disease prevention**

- **Delivery Methods** – Five plans delivered content using a group class, two used 1:1 counseling and two provided services dependent on member need. Of the remaining plans, one plan used a provider incentive, one used a nurse advice line, one used a community referral, one used the plan website, one used direct mailing and one used a phone call. Five plans did not describe a delivery method.

- **Target Audience** – Nine plans targeted all plan members. Of the remaining plans, one targeted members with congestive heart failure, one targeted overweight/obese children, one targeted all adult members, one targeted Medi-Cal members only and one targeted adults with type 2 diabetes. Six plans did not identify a target audience.
• **Hours** – Six plans quantified education hours provided. Four plans provide 1.5 - 5 hours, one plan provided 10 hours and another approximately 48 hours.

• **Goals** – Four plans identified disease management as the primary goal, and two plans identified a decrease in risk factors. Of the remaining plans, one plan identified behavior change, one identified increased screening and one identified member needs. Eleven plans did not identify goals.

• **Effectiveness** – Four plans used member knowledge to measure effectiveness, two plans used clinical services usage and one plan used Healthcare Effectiveness Data and Information Set (HEDIS) measures. Thirteen plans did not provide a measure of effectiveness.

• **Medi-Cal Member Participation** – Nine plans provided participation data for 2012, ranging from 9 - 8,031 participants. Three plans reported less than 100 participants, four plans reported 100 - 350, one plan reported 1,776 and one plan reported 8,031 participants.

• **Documented Change** – One plan documented increases in screening, one documented member knowledge, one documented decreased hospitalization and one documented increased education delivered. Sixteen plans did not identify documented changes.

**Type 2 Diabetes Prevention**

• **Delivery Methods** – Six plans delivered content using a group class and two plans used direct mailings. Of the remaining plans, one plan used a provider incentive, one used a member incentive for screening compliance, one used a community referral and one used complex case management. Five plans did not describe a delivery method.

• **Target Audience** – Six plans targeted all plan members, three plans targeted adults with diabetes and two plans targeted all members with diabetes. One plan targeted adults with impaired glucose tolerance or diabetes and one plan targeted Medi-Cal members only. Seven plans did not identify a target audience.

• **Hours** – Nine plans quantified education hours provided. Four plans provided 1.5 - 5 hours, three between 10 - 12 hours, one plan provided up to 20 hours and another plan provided over 48 hours.

• **Goals** – Eight plans identified disease management as the primary intervention goal, three plans identified increasing screening compliance and two plans identified increased
member knowledge of healthy lifestyle behaviors as the primary goal. Seven plans did not identify a goal.

- **Effectiveness** – Six plans used member feedback to measure effectiveness. Of the remaining plans, one used HEDIS measures, one used decrease in hospitalizations and one used program participation. Ten plans did not provide a measure of intervention effectiveness, and one described a measure that was unclear.

- **Medi-Cal Member Participation** – Ten plans provided participation data for 2012, ranging from 35 - 4,025 members. Three plans reported less than 100 participants, three plans 100 -350 participants and four plans reported 2,400 - 4,025 participants.

- **Documented Change** – Two plans identified decreased hospitalization, two plans identified compliance with clinical measures, one plan identified increase in knowledge and one plan identified increased screenings completed. Fourteen plans did not identify documented changes.
Disease Management Results

The disease management programs surveyed were weight management, diabetes management, cardiovascular disease management and asthma management. Select results are provided below.

Intervention Delivery Overview

Plans were asked to check “all that apply” for how intervention content was delivered and who delivered content. As shown in Table 7, printed materials, medical appointments and plan websites were the responses most frequently checked for how content was delivered. Table 8 shows network staff, network provider offices and third party vendors were the most frequently checked for who delivered content.

Table 7. Disease Management Intervention: Delivery Methods for the 20 Responding Plans

<table>
<thead>
<tr>
<th>Method</th>
<th>Asthma management</th>
<th>Cardiovascular disease management</th>
<th>Diabetes management</th>
<th>Weight management</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed material(s)</td>
<td>17</td>
<td>11</td>
<td>18</td>
<td>16</td>
<td>62</td>
</tr>
<tr>
<td>Medical appointment(s)</td>
<td>14</td>
<td>10</td>
<td>15</td>
<td>14</td>
<td>53</td>
</tr>
<tr>
<td>Plan website</td>
<td>13</td>
<td>7</td>
<td>15</td>
<td>13</td>
<td>48</td>
</tr>
<tr>
<td>Phone counseling</td>
<td>13</td>
<td>7</td>
<td>14</td>
<td>12</td>
<td>46</td>
</tr>
<tr>
<td>Group class(es)</td>
<td>10</td>
<td>6</td>
<td>15</td>
<td>14</td>
<td>45</td>
</tr>
<tr>
<td>In-person counseling</td>
<td>8</td>
<td>4</td>
<td>9</td>
<td>8</td>
<td>29</td>
</tr>
<tr>
<td>Nurse advice line</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>N/A</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Other website(s)</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Text message(s)</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Email(s)</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 8. Disease Management Interventions: Who Delivered for the 20 Responding Plans

<table>
<thead>
<tr>
<th>Who</th>
<th>Asthma management</th>
<th>Cardiovascular disease management</th>
<th>Diabetes management</th>
<th>Weight management</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health plan staff</td>
<td>17</td>
<td>10</td>
<td>17</td>
<td>12</td>
<td>56</td>
</tr>
<tr>
<td>Network provider office(s)</td>
<td>14</td>
<td>13</td>
<td>14</td>
<td>13</td>
<td>54</td>
</tr>
<tr>
<td>Third party vendor/subcontractor</td>
<td>9</td>
<td>4</td>
<td>13</td>
<td>12</td>
<td>38</td>
</tr>
<tr>
<td>Collaboration with a community organization</td>
<td>11</td>
<td>4</td>
<td>12</td>
<td>9</td>
<td>36</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

Disease Management Interventions

Later in the survey, the plans were asked if they provided an intervention for each disease management topic, and if so, to describe the most effective intervention they offered. The following results are a summary of the responses and descriptions provided by the plans.

Intervention availability: Eighteen plans provided a diabetes and weight management intervention, 15 plans provided an asthma management intervention, and 11 plans provided a cardiovascular disease management intervention.

Table 9. Disease Management Interventions Provided

<table>
<thead>
<tr>
<th>Program Offered</th>
<th>Asthma management</th>
<th>Cardiovascular disease management</th>
<th>Diabetes management</th>
<th>Weight management</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>11</td>
<td>7</td>
<td>13</td>
<td>3</td>
<td>34</td>
</tr>
<tr>
<td>Yes, (but not directly)</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Yes, for overweight or obese</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, (but not directly), for overweight or obese</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, for obese</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Don't know</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
Weight Management

- **Delivery Methods** – Seven plans delivered content using 1:1 counseling of various lengths, six plans used a group class, two plans used community referrals and two plans used direct mailings. One plan used primary care appointments with follow up phone calls to deliver content. Two plans did not describe a method of delivery.

- **Target Audience** – Ten interventions targeted members who are overweight/obese. These include: four interventions targeting children, three targeting all members, two targeting Medi-Cal members only and one targeting children who are Medi-Cal members. Six interventions did not use member weight status as a target criteria for their weight management intervention. These included: four interventions targeting all members, one targeting Medi-Cal members only and one targeting all children. Four plans did not identify a target audience.

- **Hours** – Twelve plans quantified education hours provided. Six plans provided 1.5 - 5 hours, two plans provided approximately eight hours, two plans provided approximately 20 hours and two provided 40-48 hours.

- **Goals** – Four plans identified increased knowledge as the primary intervention goal, and one plan used a decrease in BMI. Fifteen plans did not identify a goal.

- **Effectiveness** – One plan used member feedback to measure effectiveness, one plan used decreased BMI and one plan used participation numbers. Seventeen plans did not provide a measure of intervention effectiveness.

- **Medi-Cal Member Participation** – Twelve plans provided participation data for 2012, ranging from 28 - 35,000 participants. Two plans reported less than 100 participants, five plans reported 100 – 200 participants, four plans reported 500 - 2,000 participants and one plan reported 35,000 participants.

- **Documented Change** – One plan documented increases in screening and one plan documented increases in member knowledge. Eighteen plans did not identify documented changes.
Diabetes Management

- **Delivery Methods** – Five plans delivered content using a direct mailing, four plans used 1:1 counseling of various lengths, three plans used group classes to deliver the intervention, two plans used member incentives and one plan used a community program. Four plans did not provide a delivery method and one description was unclear.

- **Target Audience** – Eight plans targeted all plan members with diabetes, two plans targeted Medi-Cal members with diabetes, and two plans targeted all adults with diabetes. One plan targeted all members and one targeted the attendees of a community clinic. Six plans did not identify a target audience.

- **Hours** – Seven plans quantified education hours provided. Two plans provided 1 - 2.5 hours, two plans provided up to 5 hours, two plans provided 8-10 hours and one plan provided 15 hours.

- **Goals** – Nine plans identified improving disease management as the primary goal and two plans identified increasing screening compliance behavior. Eight plans did not identify a goal and one description was unclear.

- **Effectiveness** – Six plans used member feedback to measure effectiveness, three plans used clinical test results, two plans used screening compliance data and one plan used program enrollment as a measure of effectiveness. Seven plans did not provide a measure of effectiveness and one was unclear.

- **Medi-Cal Member Participation** – Ten plans provided participation data for 2012, ranging from 9 - 21,520 participants. Three plans reported less than 100 participants, two plans reported 700 - 1,000 participants, three plans reported 2,400 - 4,300 participants and two plans reported over 17,500 participants.

- **Documented Change** – Three plans identified improved screening results, two plans identified increases in completed screenings, and one plan identified member feedback of improved disease management. Fourteen plans did not identify documented changes.
Cardiovascular Disease Management

- **Delivery Methods** – Three plans delivered content using a group class, three plans used direct mail and two plans used 1:1 counseling of various lengths. Of the remaining plans, one plan used case management, one used a nurse advice line and one used community programs. Nine plans did not describe a delivery method.

- **Target Audience** – Four plans targeted all plan members, two plans targeted members who have cardiovascular disease, one plan targeted Medi-Cal members with cardiovascular disease and one plan targeted all adult plan members. Twelve plans did not identify a target audience.

- **Hours** – Two plans quantified two hours of education hours each.

- **Goals** – One plan used increased support for members, one plan used decreased emergency services utilization, one plan used increased member knowledge and one plan used increased participation. Sixteen plans did not identify a goal.

- **Effectiveness** – One plan used member feedback, one plan used increased knowledge and one plan used changes in emergency services utilization data. Seventeen plans did not provide a measure of effectiveness.

- **Medi-Cal Member Participation** – Three plans provided participation data for 2012; the participation numbers reported were 135, 314 and 7,810.

- **Documented Change** – One plan identified decreased emergency room use. Nineteen plans did not identify documented changes.

Asthma Management

- **Delivery Methods** – Five plans delivered content using 1:1 counseling of various lengths, three plans used direct mail and two plans used group classes. Of the remaining plans, one plan individual tailored management, one used pharmaceutical and emergency use reports sent to primary care offices, and one used community referral. Five plans did not describe a delivery method.

- **Target Audience** – Ten plans targeted all plan members with asthma, three plans targeted Medi-Cal members with asthma and one plan targeted all members. Six plans did not identify a target audience.

- **Hours** – Seven plans quantified education hours provided. Three plans provided 1-2 hours, three plans provided 4 - 6 hours and one plan provided approximately 10 hours.
• **Goals** – Thirteen plans identified improving disease management as the primary intervention goal. Seven plans did not identify a goal.

• **Effectiveness** – Five plans used member feedback, two plans used pharmaceutical data, two plans used HEDIS measures and two plans used emergency services utilization data. Eight plans did not provide a measure of effectiveness.

• **Medi-Cal Member Participation** – Ten plans provided participation data ranging from 3 - 44,289. Two plans reported less than 100 participants, three plans reported 150 – 800 participants, four plans reported 1,800 - 7,100 participants and one plan reported over 44,000 participants.

• **Documented Change** – Three plans identified member feedback of improved disease management, three plans identified improved screening results, two plans identified improved HEDIS measures and one plan identified increased numbers of asthma action plans. Eleven plans did not identify documented changes.
Findings and Analysis

Finding 1: What defines a prevention intervention is inconsistent across plans.

When survey responses were compared, it became apparent that plans did not share a common definition of what constituted an intervention. Without a shared definition, the ability to compare interventions across plans is compromised, while also making it challenging for the plans to know if they are meeting DHCS’s expectations.

As described in the survey design section of this report, the “healthy lifestyle”, “disease prevention” and “disease management” survey sections started with questions about overall intervention delivery, and were followed by questions asking for more detailed descriptions of the most effective intervention provided for each topic area.

The overall intervention delivery questions included the questions “How is the content delivered for the Plan's (insert prevention topic name) interventions? (Check all that apply),” and “Who delivers the Plan’s (insert prevention topic name) interventions? (Check all that apply).” Answers provided to these questions shall be referred to as “Section One Questions.” Later in the survey, the plans were asked, “Does the Plan conduct an intervention for Medi-Cal members to (insert prevention topic name)?” and, if the plan responded “Yes”, the respondent was then asked to answer more detailed questions about what they considered the most effective interventions they offered to Medi-Cal members. Answers provided to these questions shall be referred to as “Section Two Questions.”

Using responses to questions for alcohol and drug abuse prevention interventions to illustrate this finding, the intervention descriptions provided in “Section Two Questions” by plans who said they did provide an intervention overwhelmingly described one or a combination of: newsletter articles, printed materials and referrals to community/county programs. The following are examples of descriptions provided in the “Section Two Questions:”

“Point of service provider education and community programs.”

“We refer to our County Behavior Health Department.”
“For the prevention of alcohol abuse, information is added to our member newsletter. As for alcohol abuse, members are sent to AOD services in our Public Health Department.”

“Printed Health Education Materials provided by the Plan and/or provider to the Medi-Cal Members. The intervention is a direct community referral to the National Clearinghouse for Alcohol and Drug Abuse Information Line.”

Comparing the intervention descriptions above to the “Section One Questions” responses provided by plans that indicated in the “Section Two Questions” that they did not provide an intervention showed many similarities in how plans delivered information to members about alcohol and drug abuse prevention. Table 10 shows the responses provided to “Section One Questions” by plans that indicated in “Section Two Questions” that no intervention was provided. This table shows that, while plans acknowledged that information was being delivered to members for alcohol and drug abuse prevention, using many of the same techniques as those who did describe an intervention, these plans did not consider these various activities to be formal prevention interventions.

Table 10. Alcohol and Drug Use Prevention Delivery Methods Checked In “Section One Questions” By Plans That Later Indicated In “Section Two Questions” That No Intervention Was Offered

<table>
<thead>
<tr>
<th>Respondent ID</th>
<th>Program</th>
<th>In-person counseling</th>
<th>Phone counseling</th>
<th>Group class(es)</th>
<th>Nurse advice line</th>
<th>Medical appt(s)</th>
<th>Other</th>
<th>Other website(s)</th>
<th>Plan website</th>
<th>Printed material(s)</th>
<th>Text msg(s)</th>
<th>Facebook</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>2454178521</td>
<td>Alcohol</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drug</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
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<td>2458547097</td>
<td>Alcohol</td>
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<td></td>
<td></td>
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<td></td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drug</td>
<td>1 1 1 1 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
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<td>1</td>
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<td>1</td>
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</tr>
<tr>
<td></td>
<td>Drug</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2479896345</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td></td>
<td>Drug</td>
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<td>1</td>
<td></td>
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<td>1</td>
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<td></td>
</tr>
<tr>
<td>2480462999</td>
<td>Alcohol</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>1</td>
<td>1</td>
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<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2480637655</td>
<td>Alcohol</td>
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<td>1</td>
<td>1</td>
<td>1</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2479896345</td>
<td>Drug</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>1</td>
<td></td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2480655848</td>
<td>Alcohol</td>
<td>1 1 1 1 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2480462999</td>
<td>Drug</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

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In addition, to further support this finding, one respondent raised this issue in two areas of the survey.

“It would be helpful if DHCS set guidelines as to what is expected from disease prevention interventions. Is having information on our website or newsletter a type of prevention intervention?”

“It would be helpful if DHCS was more specific as to the level of intervention required for the various topics in order to comply with the requirement. For example; would a simple mailer be suffice vs a class/support group.”

To achieve consistency in how plans define an intervention, it will be necessary to develop a common and clear understanding about whether delivery methods such as: newsletter articles, plan websites, nurse advise lines, medical appointments or collaborations with community providers constitute a prevention interventions alone or in combination with other activities, and whether the definition of an intervention can or should vary depending on prevention category or audience. Until consistency is achieved, it will be difficult to compare prevention intervention availability (much less effectiveness) across plans.

Finding 2. Significant variations exist in intervention delivery methods and education hours.

An analysis of the plans’ responses showed a significant variation in intervention delivery method and hours of education provided for each prevention topic.

Interventions for a prevention topic were delivered in a variety of ways by different plans; methods of delivery varied from articles in newsletters, to sending information to providers, to member 1:1 multi-session counseling, to referral to non-contracted community organizations, or, in many cases, no intervention was provided at all. In addition, the same delivery methods were also utilized with similar frequencies across prevention categories from healthy lifestyle to disease management. For example, for physical activity (a healthy lifestyle intervention) and cardiovascular disease management (a disease management intervention), two of the top intervention delivery methods were 1:1 counseling or a group class. This variation is consistent across all prevention topics covered by the survey.

In terms of education hours, there was also a wide variation provided by different plans within the same prevention topic, and little evidence of variation in the number of education
hours provided across prevention categories from healthy lifestyles to disease management. For example, for healthy eating (a healthy lifestyle intervention), nine plans did not indicate any quantified education hours, six plans provided 1 - 3 hours, three plans provided five hours, one provided 10 hours and one provided 18.5 hours. When these responses are compared to the hours of education offered to help members manage their diabetes (a disease management intervention), we see similar responses; thirteen plans did not quantified education hours, two plans provided 1 - 2.5 hours, two plans provided up to 5 hours, two plans provided 8-10 hours and one plan provided 15 hours. This pattern can be observed throughout the survey with any prevention topic.

Variations in delivery methods or education hours within a prevention topic is not, by default, a problem and, in fact, may be the result of interventions being refined to reflect the needs and uniqueness of the communities they serve. However, the degree of variation could also mean that some plans do not have easily accessible or effective interventions, while others may provide interventions that represent the optimal design for each area of prevention. Also, the similarity in hours and delivery methods offered to different populations was unexpected; the expectation was that interventions designed to help members with disease management would be, in general, more intensive in terms of delivery method and hours than those for healthy lifestyles.

The important consideration resulting from this finding is to what extent the level of variety offered by the plans within topics, and similarity in hours and delivery methods offered across prevention categories, represents a variety of effective and evidence based interventions, or whether it would be more effective to provide a framework of standard evidence-based criteria by prevention topic that is adaptable enough to be incorporated into a variety of interventions so as not to stifle innovation and adaptation to member needs.

**Finding 3. Audiences for many interventions are not delineated by disease management, disease prevention or healthy lifestyle.**

The practice of using interventions designed for one prevention category i.e., “disease management,” to delivery prevention services to members in another prevention category such as “health lifestyles” was unexpected because the priorities and objectives for each are different; however, the survey responses indicated that this is a common practice. This means
that regardless of the member’s current health status, they were provided with interventions primarily designed to address the needs and priorities of, in this example, “disease management.”

The survey categories “healthy lifestyle”, “disease prevention” and “disease management” were designed to provide evidence of how intervention design adapted to respond to the changes in member need based on current health status. The survey introduction provided the following description of the different prevention categories:

“Prevention encompasses primary, secondary, and tertiary prevention. Primary prevention prevents disease in healthy people. Secondary prevention prevents or reverses disease at an early or precursor stage. Tertiary prevention reduces mortality and morbidity in patients with established disease. (Katz & Ali, 2009)”

The survey category “healthy lifestyle” was expected to contain responses about interventions designed to address primary prevention, the category “disease prevention” was expected to contain responses about interventions designed to address secondary prevention and the category “disease management” was expected to contain responses about interventions designed to address tertiary prevention; the use of these categories, and the understanding of their meaning, was tested and validated with the plans during the survey design process.

Each plan was asked to describe in detail the most effective intervention they provided for each disease or behavior topic within the prevention categories of “healthy lifestyle,” “disease prevention” and “disease management”. Although the level of detail provided in the intervention descriptions varied across plans and programs, the descriptions provided clear evidence that plans frequently described interventions that emphasized “disease management” to address the needs of “disease prevention” and “healthy lifestyle” audiences.
The following are examples of interventions that were described by the respondents as the most effective for “healthy lifestyles”, yet the response described “disease management” as a primary goal.

**Physical Activity** – “Families with a pediatric member identified as obese/overweight is mailed information on simple things families can do to eat healthier and be more active. The parent completes an enrollment form where they indicate the healthy changes they want to make. Parents receive a free recipe book and Big 5 store discount coupons, and information they request about community programs and registered dietitians contracted with the health plan. An evaluation form is mailed 3-4 months later.”

**Healthy Eating** – “Medical providers refer members over the 95% BMI. Disease management nurse then screens and refers member and family to appropriate health education resources, encourages change, sets goals with family, and mails tip sheets.”

The following are examples of interventions that were described by the respondents as the most effective for “disease prevention”, yet the response described “disease management” as a primary goal.

**Type 2 diabetes prevention** – “Learn the basics of managing your type two diabetes so you can feel better and be active and healthy. In this class, we give you an overview of the five key areas of type 2 diabetes management: healthy eating, exercise, monitoring your blood sugar levels, proper use of medication, and managing stress. Bring your blood glucose monitor to class.”

**Overweight/Obesity prevention** – “Overweight/obese members ages 17 and over may self-refer or be referred by the provider for Weight Watcher’s for weight management. Members interested in participating in the program are mailed vouchers to utilize the program up to 6 months or 24 weeks as long as they show proof of 1/2-2lbs of weight loss per week.”

To demonstrate the degree to which this practice is common, an analysis of the interventions’ descriptions, which can be found in Appendix D, and responses to the target audience question, summarized in the results section of this paper, was completed to assess whether the interventions described were primarily designed to target the prevention population (“healthy lifestyle,” “disease prevention” or “disease management”) to which they were assigned. The “Plan Response” columns in Table 11 show the plans’ responses to the questions “Does the Plan conduct an intervention to encourage Medi-Cal members to (insert behavior/disease name)?” The Evaluation column in Table 11 represents the results of the
analysis of the survey responses, where only those interventions that primarily targeted the prevention category they were assigned to were counted as “Yes.”

Table 11. Does the Intervention Target the Prevention Category with which it is Assigned?

<table>
<thead>
<tr>
<th>Prevention Category</th>
<th>Intervention Topic</th>
<th>Plan Response</th>
<th>Intervention Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Healthy Lifestyle</td>
<td>Healthy eating</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Physical activity</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Alcohol abuse</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Drug abuse</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Breastfeeding</td>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td>Disease Prevention</td>
<td>Overweight/obesity prevention</td>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Cardiovascular Disease prevention</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Type 2 diabetes prevention</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Disease Management</td>
<td>Weight management</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Diabetes management</td>
<td>18</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Cardiovascular Disease management</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Asthma management</td>
<td>15</td>
<td>3</td>
</tr>
</tbody>
</table>

As the results in Table 11 show, many of the interventions, especially those described in the “healthy lifestyle” and “disease prevention” categories, were not primarily designed for the assigned audience; i.e., of the 20 plans that described a physical activity intervention, only 12 described interventions targeting members that would be described as fitting the primary prevention/healthy lifestyles category.

This finding raises an important question: to what extent does the literature and real-world experience suggest that using interventions designed for one prevention population are effective at changing behaviors and improving health outcomes in another population?
Finding 4. Plans used the same prevention intervention across prevention categories and topics.

Evaluation of the plans’ survey responses revealed many examples where individual plans described using the same intervention across different prevention categories. This practice was especially prevalent when prevention categories were clearly linked or represented progressive stages of a disease or behavior, i.e., obesity/overweight prevention and weight management, or type 2 diabetes prevention and diabetes management.

To illustrate this finding, Table 12 uses color to visually represent the frequency with which plans described the same program across four weight related prevention topics: physical activity, healthy eating, overweight/obesity prevention and weight management.

### Table 12. Interventions Used Across Topics

<table>
<thead>
<tr>
<th>Respondent ID (24+)</th>
<th>Health Eating</th>
<th>Physical Activity</th>
<th>Overweight/Obesity Prevention</th>
<th>Weight Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>71025175</td>
<td></td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>68881380</td>
<td></td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>65188372</td>
<td></td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>74384566</td>
<td></td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>78667591</td>
<td></td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>80655848</td>
<td>3</td>
<td>N/A</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>71033747</td>
<td></td>
<td>N/A</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>65827423</td>
<td></td>
<td>N/A</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>63187682</td>
<td>3</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>54178521</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>80391703</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>80637655</td>
<td>2</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>80462999</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>77739426</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>78658539</td>
<td>2</td>
<td>N/A</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>65629389</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>79896345</td>
<td></td>
<td></td>
<td>2</td>
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<tr>
<td>77725533</td>
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<td>2</td>
<td></td>
</tr>
<tr>
<td>58547097</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>71382406</td>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
Table 12 shows that the first five plans listed described the same intervention for all four prevention topics, the following five plans described the same intervention for three of the topics, and the next six plans described the same intervention at least twice for different prevention topics. N/A indicates the plan did not provide an intervention and a blank uncolored cell represents an unduplicated intervention. Only four plans described a different intervention in each prevention topic they offered.

There was no evidence found to indicate that these interventions were customized for each prevention population or topic, which would suggest the same content, delivery methods and education hours were provided to all populations that participated in these interventions. To provide an example, this would mean that the needs of a member who is currently thought to be healthy but wants to know how to improve their nutritional intake and activity levels are considered to be no different from a member who is already obese and needs help managing their weight. It would also suggest that a group class, which is a common intervention delivery method, included members at various health stages from “healthy lifestyle” to “disease management.”

Further discussion would be useful to help understand to what extent the literature and real world experience supports the effectiveness of this “one-size-fits-all” approach to prevention.

Finding 5. Plans saw a role for DHCS in facilitating the establishment and sharing of best practices, messaging and content for prevention interventions.

Within each of the survey sections “healthy lifestyle”, “disease prevention”, “disease management” and “fostering health communities”, plans were asked “Please tell us what DHCS can do to complement the Plan’s interventions.” The responses to these questions expressed the plans’ clear and consistent desire for DHCS to purposefully facilitate the sharing of best practices, messaging and materials. Fifteen plans provided responses that included at least one mention of best practices, messaging or materials; the following are examples of the plans’ suggestions:

“It will be helpful if DHCS would share other plans program work so we can complement each other's efforts.”
“Provide materials that are culturally appropriate in all the threshold languages at 6th grade or lower reading level on all topics.”

“As available, providing plans with information on new and existing resources for programs/interventions.”

“Whenver possible, provide health handouts and resources that meet readability guidelines and are translated and keep websites at state-level current with good resources.”

“Have a web site with health education materials in all state mandated topics and translated into multiple languages.”

“Implement a state-wide media campaign promoting healthy lifestyle.”

The consistency in responses indicated a desire and perceived benefit for a forum for plans to share best practices with each other, and for DHCS to provide a way to share effective prevention intervention resources. One frequently mentioned desire was for DHCS to develop a repository of intervention materials and resources translated into various languages; this was especially consistent in the healthy lifestyles and disease prevention program areas. In addition, there were specific requests for DHCS to provide guidelines for acceptable interventions or examples of approved materials in each prevention area.

**Finding 6. Limited data is provided for member participation, participant documented change and measures of intervention effectiveness.**

The survey responses showed that many plans were unable to provide data for member participation, documented change or intervention effectiveness. Measuring how many members participated in interventions, how effective the intervention was at changing behavior or health outcomes, and establishing measures of effectiveness are necessary tools to evaluate the impact of interventions. When present, these measures also allow comparison of the relative effectiveness of interventions in different communities and regional areas, and provide the evidence to drive program change to better meet the needs of specific populations.

As described in the survey design section of this report, the survey sections for “healthy lifestyle”, “disease prevention” and “disease management” started with questions about overall program delivery, and were followed by questions asking for more detailed descriptions of the most effective intervention provided for each topic area.
For each intervention described in detail, plans were specifically asked to provide information about the number of Medi-Cal members who had participated in the intervention in 2012, what changes had been documented in members who participated, and how the plan measured the effectiveness of the intervention.

Table 13 summarizes how many of the plans that provided an intervention were able to provide information for intervention participation, documented change and effectiveness. The results demonstrate a consistent lack of available data across the plans.

<table>
<thead>
<tr>
<th>Prevention Category</th>
<th>Prevention Topic</th>
<th>Intervention Provided</th>
<th>Participation Data was Provided</th>
<th>Effectiveness Measure was Provided</th>
<th>Documented Change was Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Lifestyle</td>
<td>Healthy eating</td>
<td>20</td>
<td>13</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Physical activity</td>
<td>20</td>
<td>8</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Alcohol abuse</td>
<td>11</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Drug abuse</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Breastfeeding</td>
<td>19</td>
<td>8</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Disease Prevention</td>
<td>Overweight/obesity prev.</td>
<td>19</td>
<td>13</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>CDV prev.</td>
<td>15</td>
<td>9</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Type 2 diabetes prev.</td>
<td>16</td>
<td>10</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Disease Mgmt.</td>
<td>Weight mgmt.</td>
<td>18</td>
<td>12</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Diabetes mgmt.</td>
<td>18</td>
<td>10</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>CDV mgmt.</td>
<td>11</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Asthma mgmt.</td>
<td>15</td>
<td>10</td>
<td>12</td>
<td>9</td>
</tr>
</tbody>
</table>

Some plans’ responses explained that data was unavailable due to the newness of the intervention; other plans indicated that data was unavailable or was unquantifiable for the intervention. Further discussion would be useful to help understand the challenges plans have experienced accessing quantifiable data, and whether best practices exist to effectively and feasibly measure participation, documented change, and effectiveness for each intervention type.
Finding 7. Estimated need for prevention interventions is high, yet prevention intervention participation was relatively low.

The results section of this paper provides detailed summaries of the intervention participation numbers provided by plans by prevention topic. Table 14 shows the total of all the participation numbers provided in this survey.

Table 14. Intervention Participation by Prevention Activity for the 20 Responding Plans

<table>
<thead>
<tr>
<th>Prevention Intervention</th>
<th>Participation Totals for Plans that Provided Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy eating</td>
<td>3,329</td>
</tr>
<tr>
<td>Physical activity</td>
<td>2,336</td>
</tr>
<tr>
<td>Drug abuse prevention</td>
<td>293</td>
</tr>
<tr>
<td>Alcohol abuse prevention</td>
<td>22,522</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>33,812</td>
</tr>
<tr>
<td>Type 2 diabetes prevention</td>
<td>13,933</td>
</tr>
<tr>
<td>Overweight/Obesity prevention</td>
<td>15,236</td>
</tr>
<tr>
<td>Cardiovascular disease prevention</td>
<td>10,633</td>
</tr>
<tr>
<td>Asthma management</td>
<td>66,026</td>
</tr>
<tr>
<td>Cardiovascular disease management</td>
<td>8,259</td>
</tr>
<tr>
<td>Diabetes management</td>
<td>50,552</td>
</tr>
<tr>
<td>Weight management</td>
<td>39,739</td>
</tr>
</tbody>
</table>

Although disease prevalence data for the Medi-Cal population was unavailable, by using DHCS membership data and disease prevalence estimates provided in Appendix A, a rough magnitude of disease prevalence for Medi-Cal members enrolled at the 20 plans could be calculated. The results of these calculations are summarized in Table 15.

While accepting that participation numbers were only provided for the described interventions and not all plans were able to provide data, comparing participation numbers to these disease prevalence estimates still raises important questions about whether the level of participation is appropriate based on the estimated disease/behavior prevalence.
Table 15. Medi-Cal Disease Prevalence Estimates for the 20 Responding Plans

<table>
<thead>
<tr>
<th>Category</th>
<th>Prevalence Rate Used</th>
<th>Estimated Prevalence at Responding Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Est. &lt; 21 Years</td>
<td>0.53</td>
<td>2,527,379</td>
</tr>
<tr>
<td>Population Est. 21 Years +</td>
<td>0.47</td>
<td>2,241,261</td>
</tr>
<tr>
<td>Fruit/Veg. Consumption &lt; recommended</td>
<td>0.72</td>
<td>3,433,421</td>
</tr>
<tr>
<td>Do not meet weekly physical activity levels.</td>
<td>0.32</td>
<td>1,525,965</td>
</tr>
<tr>
<td>Child w/Diabetes</td>
<td>0.002</td>
<td>4,600</td>
</tr>
<tr>
<td>Adults w/Diabetes</td>
<td>0.08</td>
<td>170,336</td>
</tr>
<tr>
<td>Adult w/Pre-Diabetes</td>
<td>0.29</td>
<td>649,966</td>
</tr>
<tr>
<td>Adult w/CDV Disease</td>
<td>0.01</td>
<td>31,378</td>
</tr>
<tr>
<td>Overweight/Obese Adults</td>
<td>0.60</td>
<td>1,344,756</td>
</tr>
<tr>
<td>Overweight/Obese Children</td>
<td>0.33</td>
<td>834,035</td>
</tr>
<tr>
<td>Adults w/Asthma</td>
<td>0.14</td>
<td>307,035</td>
</tr>
<tr>
<td>Children w/Asthma</td>
<td>0.13</td>
<td>336,141</td>
</tr>
<tr>
<td>2006 Managed Care Births*</td>
<td></td>
<td>58,685</td>
</tr>
</tbody>
</table>

* http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal%20Births%20-%20CY%202006.aspx

** If participation was provided as a range, the highest number was used. If participations data was provided as a multi-year number, an average was calculated.

Using these estimates, almost 2.2 million members enrolled with the 20 plans are overweight or obese, while just under 40,000, or 1.8 percent, participated in the described weight management interventions in 2012. In addition, it is estimated that nearly 3.5 million of Medi-Cal members enrolled with the 20 plans do not consume the recommended amount of fruit and vegetables, while just over 3,300, or less than 1 percent, participated in the described healthy eating interventions in 2012. These examples suggest that there is high population need for prevention interventions, yet relatively low annual prevention intervention participation.

Low participation may reflect a lack of demand or interest for prevention interventions, accessibility challenges caused by intervention delivery methods, a lack of knowledge of how prevention can improve health outcomes, program availability or any number of other barriers. Developing realistic and shared goals for participation, and a better understanding of which factors contribute to low participation, are important steps to help inform change designed to encourage increased participation in prevention interventions.
Limitations

There are several limitations to the overall study presented here, starting with limitations inherent to the data collection underlying it. First, the survey’s purpose was to develop a high level overview of the preventive services provided by the managed care plans. The questions used were designed to be consistent throughout the survey and general enough to be used across all the prevention topics surveyed. This decision did not allow for the specialization of questions to capture the nuances of prevention and disease management specific to individual behavior or disease topics. Therefore, caution should be used in interpreting results at the disease/behavior-specific level.

Second, the survey was not designed to provide a full inventory of all the prevention services provided by each plan, or as a tool to evaluate whether plans are compliant with contractual provisions for preventive services. Therefore, the results would not accurately address these research questions. Third, questions asking for respondents to “check all that apply” are not frequency weighted, therefore each check is valued equally and it is unable to be determined if, for example, a plan used a particular delivery method once or 1,000 times.

Fourth, participation numbers provided for interventions do not provide detail of which members received which component of the intervention for how long. Therefore, there is no sensitivity in the survey for how often a delivery method is used with how many members. Fifth, intervention delivery methods, goals and effectiveness data were, in part, derived from an analysis of open-ended responses. The detail and depth of these responses varied considerably across plans and prevention topics, and further research is recommended to validate those results.

Finally, although plans were asked to consider all prevention interventions as they completed this survey, including clinical and health education led interventions, the extent to which respondents had access to the resources necessary to do this may have varied by plan. With these limitations in mind, the survey responses and findings are a resource best suited to guide further research and discussion, and to inform overall program development and design.
Recommendations

The survey results and findings have provided information to increase DHCS’ knowledge of the breadth of prevention services offered by the contracted managed care health plans to Medi-Cal members. The managed care plans’ responses provided evidence of interventions designed to support many of the priorities DHCS identified in its quality strategy: advancing prevention, engaging persons and families in their health, and enhancing communication and coordination of care.

The survey responses also revealed a wide variety of prevention interventions in terms of delivery, design and availability. To the extent these variations are a result of, and foster, innovation and adaptations to account for differences in member demographics and need, they should be encouraged. However, the evidence suggests that increased cooperation and coordination between DHCS and the plans and a clearly defined framework of best practices would help create more consistent access to effective prevention services for Medi-Cal members.

Recommendation 1: Develop a “model” prevention program framework.

DHCS, in collaboration with the health plans, should develop a prevention program framework that describes its expectation of the Medi-Cal member’s prevention services experience, and clearly defines terminology and language. This framework development should include the voice and perspective of Medi-Cal members. To achieve this, DHCS should develop member focus groups to gain insight into the types of programs members believe would be most effective and accessible, and identify barriers to participation.

The program framework should establish a core set of expectations for prevention services for members in each prevention category using evidence-based best practices. DHCS should also consider further segmentation of members by engagement level within each prevention category, i.e., members who are practicing recommended behaviors, members who aren’t practicing recommended behaviors but are interested in changing behaviors, and members who aren’t practicing recommended behaviors and are currently not interested in changing. This segmentation will allow more effective messaging tailored to meet members where they are and allow the plans to target resources appropriately.
The framework should also identify messaging for healthy lifestyles and disease prevention that can be used by both the plans and DHCS. According to Lake Research Partners, a research firm specializing in issue advocacy, “Message discipline is critical to victory. Campaigns must focus on no more than three main messages that reinforce an overall campaign theme” (Mermin, 2013). Consistent, simple messages are not only more effective at reaching their intended audiences and, by extension, improving the health outcomes of Medi-Cal members; they will also help create efficiencies for DHCS and the managed care organizations, and reduce duplication of effort. The idea is not to dictate what plans say or how they deliver the message; rather the goal of this recommendation is to encourage collaboration of effort to create an established set of shared messages and strategies, based on widely accepted best-practices, that plans see a benefit in leveraging. If shared prevention themes are adopted by DHCS and the plans, the consistency of the messages members receive will maximize the effectiveness of prevention campaigns.

Finally, once a framework has been developed, a pilot test should be conducted in collaboration with the plans, including the modeling of data collection for the purposes of supporting evidence-based evaluation. Ideally, the pilot test will be completed with more than one managed care plan so the effectiveness and practicality of the framework can be tested in urban and rural settings, small and large managed care plans, and in commercial, non-profit and public plans. The purpose of the pilot program will be to test the feasibility and effectiveness of the framework, its adaptability to diverse settings and provide real-world feedback to inform program design.

**Recommendation 2: Develop consistent measures to track and evaluate member participation and intervention effectiveness.**

DHCS, working in collaboration with the managed care plans, should define consistent and meaningful measures of participation and program effectiveness to evaluate prevention interventions. Some examples of the types of data that might be useful to evaluate intervention effectiveness are: “How many people participated?”, “How many times was a web-page visited?”, “How many participants report increased fruit and vegetable consumption after three months?” and “How many members followed-up on community referrals?”. Where meaningful, quantifiable measures cannot be readily established or
reported, the rationale and supporting evidence for continuing the programs should be documented.

Once consistent measures are established, program effectiveness measures should be routinely collected and evaluated by the plans and DHCS to document successes and encourage continuous improvement.

**Recommendation 3: Change the managed care contract language to be more specific about what plans are expected to provide for preventive services.**

The current boilerplate contact language, excerpts of which are in Appendix C, lacks clear definition, making it difficult for plans to effectively assess their current level of compliance with prevention service requirements. Using the results of the work completed in Recommendations 1 and 2, DHCS should update the contract to include the language definitions, a core prevention framework and intervention effectiveness measurement guidelines. This recommendation is intended to establish a shared and clear understanding of the contract requirements and how they are fulfilled.

DHCS should also evaluate whether reducing the prevention topics required by the contract, or creating core prevention topics and secondary topics with less stringent requirements would be beneficial. The purpose of this work would be to evaluate if narrowing the focus of the limited resources available for prevention interventions into key topics would be a more effective strategy for improving overall member health outcomes.

**Conclusion**

If implemented, these recommendations would each constitute an important step towards resolving some of the main programmatic challenges identified in this report. Together, they would establish an evidence base for effective interventions by audience, define consistent language, improve coordination and sharing of best practices, increase member access to effective prevention services, and provide measurements of effectiveness to support continuous program improvement. If successfully implemented, these recommendations would improve Medi-Cal member health outcomes and the associated costs of preventable and manageable disease.
Acknowledgements

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I would also like to acknowledge my professor and advisor Sharyl Rabinovici from the Mills College Public Policy Program for her guidance and feedback during this process. Finally, I would like to thank my partner Julie Davis for her tireless reading and re-reading of this report, as well as Nicole Sowers, Mills MPP 2013 candidate, and my dear friends Crystal Gomez and Denise Piercy for their edits and feedback.
Appendix A. Disease/Behavior Impact and Relevance

As described in the survey development section of this report, the survey scope was limited to primarily target prevention interventions for the leading causes of preventable disease and death, with some additional areas of importance to the Medi-Cal population in terms of health care need and cost.

The following behavior and disease overviews provide a brief description of the impact the surveyed behaviors and diseases have on population health, and the connection between healthy lifestyles and disease.

Healthy Eating and Physical Activity

A healthful diet and regular physical activity reduce the of risk high blood pressure, high cholesterol, diabetes, heart disease, stroke, cancer, and obesity. However, despite the benefits, most Americans fail to achieve the recommended minimums for daily physical activity and fruit and vegetable consumption (Centers for Disease Control and Prevention, 2009). Currently, only 28 percent of Californians meet the recommended standard of eating fruits and vegetables five times a day (California Department of Health and Human Services, 2012), and while 68 percent report meeting the federal guidelines for weekly physical activity, over 22 percent reported participating in no physical activity (Karpilow, Reed, Chamberlain, & Shimada, 2011). Increases in population physical activity and healthy eating are expected to reduce the prevalence of serious disease and the associated increased health care costs.

Diabetes

The California Department of Public Health estimates that nearly three million people in California have diabetes, and almost another eight million have pre-diabetes. California reported a 38 percent increase in cases of diabetes between 1998-2007 (California Department of Public Health, 2009), and this number is expected to grow. Once rare, type 2 diabetes is also being diagnosed with increasing frequency in children, and is directly associated with increases in childhood obesity and physical inactivity. The incidence of diabetes in youth is estimated at approximately 1.82 cases per 1000 youth. (SEARCH for Diabetes in Youth Study Group, 2006).
Diabetes is a major cause of heart disease and stroke, and can lead to other serious complications, such as vision loss, kidney failure and amputations of legs or feet. It is estimated that average medical expenses are twice as high for a person with diabetes than for a person without. (Centers for Disease Control and Prevention, 2012)

Risk factors for diabetes include: impaired glucose tolerance and/or fasting glucose; a family history of diabetes; being overweight or obese, physical inactivity and high blood pressure (Centers for Disease Control and Prevention, 2009).

**Cardiovascular Disease**
Cardiovascular disease (CVD), which includes heart disease, heart failure and stroke, is the leading cause of death in California, accounting for more than one-third of deaths in 2004. Overall, it is estimated that 5.9% of Californians have CVD, however it is far more prevalent with age, ranging from 1.4 percent of the population 18-39 years of age to over 27 percent of those over 80 years of age (Reynen, Kamigaki, Pheatt, & Chaput, 2007).

Health care costs per capita for people with heart disease are, on average, five times higher than costs for the general adult population. California’s annual cost for heart disease and stroke was expected to exceed $48 billion in 2006 (California Department of Public Health, 2007), and was then expected to rise further due to increases in obesity, diabetes, improved survival rates and increased life expectancy. Nine percent of Californians with heart disease are insured through Medi-Cal, while another 56 percent are insured through Medicare (Anderson & Wilson, 2006).

Risk factors for CVD include: high blood pressure, high cholesterol, tobacco use, obesity and physical inactivity (Reynen, et al.).

**Overweight/Obesity**
Overweight and obesity are major risk factors for many of the diseases responsible for premature morbidity and mortality, including hypertension, cardiovascular disease, some cancers, stroke and diabetes (Institute of Medicine, 2012). In 2011, over 60 percent of California adults were overweight or obese, and while the percent overweight has remained
stable since 1995, rates of obesity have increased over 63 percent and with it, the risk of chronic disease (Centers for Disease Control, 2011).

California’s children are also increasingly overweight and obese, especially children in low-income households. In 2010, over 33 percent of 2-5 year olds and over 42 percent of 5-19 year olds were either overweight or obese (California Department of Health Care Services, 2012).

In 2006, the health care costs associated with obesity and overweight in California were estimated to be $12.8 billion (Chenoweth & Associates, Inc., 2009). If the current trends in population overweight/obesity continue, disease prevalence and the health care costs associated with these conditions are expected to rise.

Risk factors for overweight/obesity include: unhealthy diet, physical inactivity, poverty, food insecurity, unsafe neighborhoods and lack of sleep. (Karpilow, et al.)

**Asthma**

In 2007, 13.7% of adults and 13.3% of children in California reported being diagnosed with asthma in their lifetime (Milet, Tran, Eatherton, Flattery, & Kreutzer, 2007), and according to the CDC, the prevalence of asthma nationally has been rising and continues to be higher in children and people living below the poverty level (Akinbami, Moorman, Bailey, & et al., 2012). Although most people with asthma have mild or very mild symptoms, about 27 percent experience moderate to severe symptoms, and these rates are higher for older people and people living in low-income households (Milet, et al).

In 2005, the last year data are available, there were almost 145,000 emergency department visits for asthma attacks. Of these, Medi-Cal was the expected payer in over 31 percent of cases. In the same year there were also 36,060 asthma hospitalizations, 33 percent of which were covered by Medi-Cal. In 2005, the cost of asthma hospitalization, not including emergency visits, was $763 million (Milet, et al.).

Risk factors for asthma include: family history, cigarette smoke, indoor and outdoor air pollutants, and being overweight. (Milet, et al.)
Alcohol and Drug Abuse

The California Department of Alcohol and Drug Programs reported that in 2009, California had 30,639 alcohol-related and 25,783 drug-related hospitalizations, while emergency department visits were 90,203 and 39,741 respectively. They also estimated that 3 million Californians age 12 and older need, but are not receiving, treatment for alcohol and drug abuse (California Department of Alcohol and Drug Programs, 2011).

Nationally in 2008, Medicaid paid an average of 17.9 percent of alcohol treatment and 27.5 percent of illicit drug treatment costs for people 12 years and older (U.S. Department of Health and Human Services, 2009). In 2005, it was estimated the medical and mental health costs attributable to alcohol abuse in California were $5.9 billion (Rosen, Miller, & Simon, 2008).


Breastfeeding

Medi-Cal is the payee for 41 - 46 percent of all births in California (California Department of Health Care Services, 2010), making Medi-Cal the single largest health care provider for new babies and their mothers in the state. Breastfeeding is an important first step in disease prevention and decreases the child’s risk of many chronic diseases including asthma, obesity and type 2 diabetes. Breastfeeding is also linked to a lower risk of diabetes, breast and ovarian cancer and postpartum depression in new mothers (U.S. Department of Health and Human Services, 2010). Babies who are breastfed for the first six months post-partum are typically healthier and require fewer medical visits or prescriptions. The U.S. Department of Health and Human Services estimates potential annual health care savings of $13 billion nationally if 90 percent of new mothers breastfed for six months.

Barriers to breastfeeding: lack of knowledge, lack of accurate information, hospital practices such as formula discharge packets, lack of a support network, psychosocial barriers such as misconceptions, negative attitudes and cultural barriers (California Department of Public Health, 2008).
Appendix B. Managed Care Plan Overviews

The 21 contracted managed health care organization included in the survey vary in organizational structure, scope of services, geographic coverage and the percentage of their membership who are Medi-Cal members. A brief description of each managed care health plan and their Medi-Cal membership has been provided below to give flavor of the diversity of these plans organizational structures and scope.

Note: The short plan descriptions and total plan membership were retrieved from individual plan websites on February 13, 2013. The report author is able to provide source URLs upon request.

Alameda Alliance for Health

Established in January 1996, the Alliance was created by and for Alameda County residents. The Alliance is a public, not-for-profit managed care health plan committed to making health care services accessible to lower-income people in Alameda County. The network includes over 1,700 doctors, 15 hospitals, 29 community health centers and over 200 pharmacies.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership(^1)</th>
<th>Plan Medi-Cal Membership(^2)</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda</td>
<td>243,275</td>
<td>137,912</td>
<td>56.7%</td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: 140,000 as of February 2012
- Medi-Cal as a percent of total plan membership (approx.): 78.5 percent


Anthem Blue Cross Partnership Plan

Anthem Blue Cross is a not-for-profit health plan whose mission is to ensure all Californians have access to high-quality health care at an affordable price. Founded in 1939, the network includes over 114,000 physicians, 838 hospitals and more than 5,700 independent and chain pharmacies throughout the state.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda</td>
<td>243,275</td>
<td>35,349</td>
<td>14.5%</td>
</tr>
<tr>
<td>Contra Costa</td>
<td>131,952</td>
<td>13,654</td>
<td>10.3%</td>
</tr>
<tr>
<td>Fresno</td>
<td>299,363</td>
<td>72,602</td>
<td>24.3%</td>
</tr>
<tr>
<td>Kings</td>
<td>33,393</td>
<td>10,870</td>
<td>32.6%</td>
</tr>
<tr>
<td>Madera</td>
<td>42,230</td>
<td>10,596</td>
<td>25.1%</td>
</tr>
<tr>
<td>Sacramento</td>
<td>308,037</td>
<td>99,352</td>
<td>32.3%</td>
</tr>
<tr>
<td>San Francisco</td>
<td>134,579</td>
<td>15,157</td>
<td>11.3%</td>
</tr>
<tr>
<td>San Joaquin</td>
<td>170,765</td>
<td>303</td>
<td>0.2%</td>
</tr>
<tr>
<td>Santa Clara</td>
<td>261,699</td>
<td>40,421</td>
<td>15.4%</td>
</tr>
<tr>
<td>Stanislaus</td>
<td>128,318</td>
<td>861</td>
<td>0.7%</td>
</tr>
<tr>
<td>Tulare</td>
<td>160,183</td>
<td>68,037</td>
<td>42.5%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>367,202</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: over 3,400,000
- Medi-Cal as a percent of total plan membership (approx.): 10.7 percent

CalOptima

CalOptima was created in 1993 as a County Organized Health System. CalOptima is a public agency that manages programs funded by the state and federal government, but operates independently. The network includes 1,700 primary care providers and 4,400 specialists, 30 acute and rehab hospitals, 30 community health centers, 480 pharmacies and 113 long-term care facilities.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orange</td>
<td>467,937</td>
<td>416,798</td>
<td>89.1%</td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: 416,341 (February 2013)
- Medi-Cal as a percent of total plan membership (approx.): 100 percent
CalViva Health

CalViva Health is the Local Initiative Plan for Fresno, Kings and Madera Counties, created after the expansion of Medi-Cal managed care was authorized in 2005 and sponsored by the Regional Health Authority. The network includes over 1,600 provider including doctors, specialists, hospitals and pharmacies throughout the three counties.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresno</td>
<td>299,363</td>
<td>162,512</td>
<td>54.3%</td>
</tr>
<tr>
<td>Kings</td>
<td>33,393</td>
<td>14,062</td>
<td>42.1%</td>
</tr>
<tr>
<td>Madera</td>
<td>42,230</td>
<td>19,616</td>
<td>46.5%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>196,190</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: over 190,000
- Medi-Cal as a percent of total plan membership (approx.): 100 percent

Care1st Health Plan

Care1st Health Plan was created in 1994. Initially begun as a Medicaid Plan, today it is a full service health plan offering multiple health care options that include Medicare, Medi-Cal Health, Medi-Cal Dental, Healthy Families and commercial coverage. The network includes over 7,000 physicians, 52 Medical Groups/IPAs, 80 hospitals and numerous ancillary providers.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Diego</td>
<td>451,842</td>
<td>30,415</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: over 320,000
- Medi-Cal as a percent of total plan membership (approx.): 9.5 percent
CenCal Health

Created in 1983, CenCal Health administers several publicly-funded health care programs for low-income residents of Santa Barbara and San Luis Obispo counties. CenCal Health is a public entity that is governed by a 13-member board of directors appointed by the Santa Barbara and San Luis Obispo County Boards’ of Supervisors. The network includes over 260 primary care providers and 1,370 specialists.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Barbara</td>
<td>74,176</td>
<td>62,530</td>
<td>84.3%</td>
</tr>
<tr>
<td>San Luis Obispo</td>
<td>30,635</td>
<td>28,227</td>
<td>92.1%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>90,757</td>
<td></td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: 108,464
- Medi-Cal as a percent of total plan membership (approx.): 83.7 percent

Central California Alliance for Health

Since 1996 the Alliance has worked to improve health care locally for people living in the Central Coast region, expanding to provide services to Merced County in 2009. The Alliance is a publicly operated, locally governed non-profit health plan. The Alliance network includes over 2,110 providers.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merced</td>
<td>80,292</td>
<td>73,248</td>
<td>91.2%</td>
</tr>
<tr>
<td>Monterey</td>
<td>88,589</td>
<td>73,625</td>
<td>83.1%</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>38,508</td>
<td>34,560</td>
<td>89.7%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>181,433</td>
<td></td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: over 210,000
- Medi-Cal as a percent of total plan membership (approx.): 86.4 percent
Community Health Group

Community Health Group is a nonprofit health plan operating in San Diego County, providing health care services to San Diego County residents since 1982. The network includes a wide network of health care practitioners, hospitals and ancillary providers.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Diego</td>
<td>451,842</td>
<td>147,330</td>
<td>32.6%</td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: over 148,000
- Medi-Cal as a percent of total plan membership (approx.): 100 percent

Contra Costa Health Plan

In 1973, Contra Costa Health Plan became the first county sponsored health plan in California to offer Medi-Cal managed care coverage. The network consists of over 1,300 primary care providers and specialists.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contra Costa</td>
<td>131,952</td>
<td>78,676</td>
<td>59.6%</td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: over 100,000
- Medi-Cal as a percent of total plan membership (approx.): 78.7 percent

Gold Coast Health Plan

Gold Coast Health Plan is an independent public entity created by county ordinance to serve Medi-Cal members. In 2009, the Ventura County Board of Supervisors approved implementation of a County Organized Health System (COHS) model, transitioning from fee-for-service to Medi-Cal managed care. The network includes more than 3,600 doctors, 187 pharmacies and most of the local hospitals and long-term care facilities in Ventura County.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventura</td>
<td>111,492</td>
<td>99,595</td>
<td>89.3%</td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: over 100,000
- Medi-Cal as a percent of total plan membership (approx.): 100 percent
**Health Net**

Health Net, Inc. is a publicly traded managed care organization that delivers managed health care services through health plans and government-sponsored managed care plans. As one of the largest managed care plans in California, Health Net has an extensive network of providers, medical facilities and pharmacies.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kern</td>
<td>224,473</td>
<td>559</td>
<td>0.2%</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>2,250,353</td>
<td>494,555</td>
<td>22.0%</td>
</tr>
<tr>
<td>Sacramento</td>
<td>308,037</td>
<td>71,666</td>
<td>23.3%</td>
</tr>
<tr>
<td>San Diego</td>
<td>451,842</td>
<td>34,165</td>
<td>7.6%</td>
</tr>
<tr>
<td>San Joaquin</td>
<td>170,765</td>
<td>4,443</td>
<td>2.6%</td>
</tr>
<tr>
<td>Stanislaus</td>
<td>128,318</td>
<td>485</td>
<td>0.4%</td>
</tr>
<tr>
<td>Tulare</td>
<td>160,183</td>
<td>799</td>
<td>0.5%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>606,672</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: 2,226,000
- Medi-Cal as a percent of total plan membership (approx.): 27.1 percent

**Health Plan of San Joaquin**

Health Plan of San Joaquin (HPSJ) has offered Medi-Cal managed care in San Joaquin County since 1996. HPSJ is governed by an 11-member commission, which is appointed by the San Joaquin County Board of Supervisors. The network includes over 180 Primary Care Physicians with access to most hospitals and area clinics.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Joaquin</td>
<td>170,765</td>
<td>120,892</td>
<td>70.8%</td>
</tr>
<tr>
<td>Stanislaus</td>
<td>128,318</td>
<td>24,760</td>
<td>19.3%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>145,652</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: over 115,000
- Medi-Cal as a percent of total plan membership (approx.): 100 percent
Health Plan of San Mateo

The Health Plan of San Mateo (HPSM) is a local non-profit health care plan governed by the San Mateo Health Commission. HPSM contracts with a local mix of private and public hospitals, clinics and physicians. The network includes over 800 providers, more than 2,000 specialty care providers available by referral, 12 hospitals, 234 independent and chain pharmacies, and 115 long-term care facilities.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Mateo</td>
<td>77,027</td>
<td>66,154</td>
<td>85.9%</td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013
- Total plan California membership: 108,936
- Medi-Cal as a percent of total plan membership (approx.): 60.7 percent

Inland Empire Health Plan

Since September 1996, Inland Empire Health Plan (IEHP) has partnered with providers to deliver high-quality health care. IEHP is a local, not-for-profit, public health plan. The network includes over 750 primary care physicians, 1,500 specialists, 600 pharmacies and 29 major hospitals in the inland empire.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Riverside</td>
<td>409,328</td>
<td>268,309</td>
<td>65.5%</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>481,334</td>
<td>299,429</td>
<td>62.2%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>567,738</td>
<td></td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013
- Total plan California membership: over 579,434
- Medi-Cal as a percent of total plan membership (approx.): 98 percent
Kern Family Healthcare
The Kern County board of supervisors established Kern Health Systems (KHS) in April 1993 as a non-profit, public-benefit corporation to be the Kern County Local Initiative. The network includes over 800 Primary Care Practitioners, clinics and specialists, 5 hospitals and over 90 local pharmacies.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kern</td>
<td>224,473</td>
<td>116,161</td>
<td>51.7%</td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013
- Total plan California membership: over 100,000
- Medi-Cal as a percent of total plan membership (approx.): 100 percent

Kaiser Permanente
Founded in 1945, Kaiser Permanente is one of the nation’s largest not-for-profit health plans. Kaiser operates over 35 hospitals in California where members can access primary care, lab tests, X-rays, and pharmacy services.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sacramento</td>
<td>308,037</td>
<td>29,005</td>
<td>9.4%</td>
</tr>
<tr>
<td>San Diego</td>
<td>451,842</td>
<td>24,446</td>
<td>5.4%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>53,451</td>
<td></td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013
- Total plan California membership: 6,850,484
- Medi-Cal as a percent of total plan membership (approx.): less than 1 percent

LA Care
L.A. Care began serving Los Angeles County residents in 1998, and is now the nation’s largest public health plan. L.A. Care contracts directly with hospitals, physicians groups and other health care services to create a network that includes more than 10,000 providers.

<table>
<thead>
<tr>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
<th>County Medi-Cal Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>2,250,353</td>
<td>1,004,062</td>
<td>44.6%</td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013
- Total plan California membership: more than 1,000,000
- Medi-Cal as a percent of total plan membership (approx.): 100 percent
**Molina Healthcare**

Molina Healthcare, Inc., is a for-profit company that focuses exclusively on government-sponsored health care programs and the health care needs of low-income families and individuals served through these programs. The network includes thousands of physicians and hundreds of hospitals.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Riverside</td>
<td>409,328</td>
<td>40,676</td>
<td>9.9%</td>
</tr>
<tr>
<td>Sacramento</td>
<td>308,037</td>
<td>35,300</td>
<td>11.5%</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>481,334</td>
<td>55,520</td>
<td>11.5%</td>
</tr>
<tr>
<td>San Diego</td>
<td>451,842</td>
<td>85,535</td>
<td>18.9%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>217,031</strong></td>
<td></td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: 355,000
- Medi-Cal as a percent of total plan membership (approx.): 61.1 percent

**Partnership HealthPlan of California**

Founded in 1993 in Solano County, Partnership HealthPlan of California has since expanded into neighboring Napa, Yolo, Sonoma, Marin and Mendocino Counties. The health plan's commission is appointed by each of the covered County Boards’ of Supervisors.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marin</td>
<td>21,230</td>
<td>17,066</td>
<td>80.4%</td>
</tr>
<tr>
<td>Mendocino</td>
<td>21,783</td>
<td>20,029</td>
<td>91.9%</td>
</tr>
<tr>
<td>Napa</td>
<td>15,421</td>
<td>13,733</td>
<td>89.1%</td>
</tr>
<tr>
<td>Solano</td>
<td>62,999</td>
<td>60,310</td>
<td>95.7%</td>
</tr>
<tr>
<td>Sonoma</td>
<td>60,020</td>
<td>54,062</td>
<td>90.1%</td>
</tr>
<tr>
<td>Yolo</td>
<td>28,422</td>
<td>26,505</td>
<td>93.3%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>191,705</strong></td>
<td></td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013

- Total plan California membership: 205,000
- Medi-Cal as a percent of total plan membership (approx.): 93.5 percent
San Francisco Health Plan
In 1994, the City and County of San Francisco created the San Francisco Health Plan (SFHP). SFHP’s purpose is to provide affordable health care coverage to low and moderate-income families. The network includes over 2,300 primary care providers and specialists, six hospitals and 200 pharmacies.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Francisco</td>
<td>134,579</td>
<td>64,450</td>
<td>47.9%</td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013
- Total plan California membership: over 70,000
- Medi-Cal as a percent of total plan membership (approx.): 92.1 percent

Santa Clara Family Health
In 1995, the Santa Clara County Board of Supervisors established the Santa Clara County Health Authority (SCFHP). SCFHP is a public, not-for-profit health plan that operates solely in Santa Clara County. The network includes 919 primary care physicians, over 2,800 specialists, eight hospitals and over 250 pharmacies.

<table>
<thead>
<tr>
<th>County Name</th>
<th>County Medi-Cal Membership</th>
<th>Plan Medi-Cal Membership</th>
<th>Plan % of County Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Clara</td>
<td>261,699</td>
<td>136,586</td>
<td>52.2%</td>
</tr>
</tbody>
</table>

Note: Table data as of January 2013
- Total plan California membership: more than 136,000
- Medi-Cal as a percent of total plan membership (approx.): 100 percent
## Appendix C. DHCS Managed Care Boilerplate Contract Language for Prevention Services.

<table>
<thead>
<tr>
<th>Attachment Section Header</th>
<th>Subsection</th>
<th>COHS Plan Detail</th>
<th>GMC</th>
<th>Two Plan</th>
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</thead>
<tbody>
<tr>
<td>Exhibit A, Attachment 10 Scope of Services</td>
<td>4. Services for Members under Twenty-One (21) Years of Age</td>
<td>Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.</td>
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<tr>
<td>Exhibit A, Attachment 10 Scope of Services</td>
<td>4. Services for Members under Twenty-One (21) Years of Age</td>
<td>Contractor shall provide preventive services for all Members under 21 years of age as specified by the most recent AAP periodicity schedule.</td>
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<tr>
<td>Exhibit A, Attachment 10 Scope of Services</td>
<td>4. Services for Members under Twenty-One (21) Years of Age</td>
<td>Contractor shall ensure that routine preventive health visits for Members under 21 years of age include the age appropriate IHEBA, as described in Exhibit A, Attachment 10, Provision 7, Paragraph A.</td>
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<td>N/A</td>
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<tr>
<td>Exhibit A, Attachment 10 Scope of Services</td>
<td>B. Adult Preventive Services</td>
<td>Contractor shall cover and ensure all preventive and Medically Necessary diagnostic and treatment services for adult Members. Contractor shall ensure that the latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult Members [age 21 or older].</td>
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<tr>
<td>Exhibit A, Attachment 10 Scope of Services</td>
<td>A. Health Education</td>
<td>1) Contractor shall implement and maintain a health education system that provides the organized programs, services, functions, and resources</td>
<td>1) Contractor shall implement and maintain a health education system that provides the organized programs, services, functions, and resources</td>
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<td>necessary to deliver health education, health promotion and patient education to assist Members improve their health and manage illness. 2) Contractor shall ensure administrative oversight, direction, management, and supervision of the health education system by a qualified, full-time health educator. Contractor shall maintain the organization and staffing to ensure successful implementation and maintenance of an effective health education system. Health education program activities must be coordinated and integrated with the Contractor’s overall health care and quality improvement plan. 5) Contractor shall ensure the organized delivery of health education programs and services, at no charge for Members, using a variety of educational strategies, methods and materials that are appropriate for the Member population and effective in achieving behavioral change for improved health. Contractor shall ensure that all health education information and materials are provided to Members at no higher than a 6th grade reading level, unless otherwise approved by DHCS, and are provided in a manner and form that are easily understood and culturally and linguistically appropriate for the intended audience. 6) Contractor shall provide health education programs and services directly and/or through subcontractors that have expertise in delivery of health education programs and services. Contractor shall conduct system that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Members. 2) Contractor shall ensure administrative oversight of the health education system by a qualified full-time health educator. 3) Contractor shall provide health education programs and services at no charge to Members directly and/or through Subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Member population.</td>
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<td>targeted outreach to promote optimal program use and participation by Members.</td>
<td>4) Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for Members and effective in achieving behavioral change for improved health.</td>
<td></td>
</tr>
<tr>
<td>Exhibit A, Attachment 10</td>
<td>A. Health Education</td>
<td>7) Contractors shall maintain a health education system that provides educational interventions addressing the following health categories and topics and ensure that these programs are available and accessible to Members upon referral by providers and also upon the Member’s request. &lt;br&gt; a) Effective use of Managed Health Care Services: Educational interventions designed to assist Members to effectively use the managed health care system, preventive and primary healthcare services, obstetrical care, and health education services; and appropriately use complementary and alternative care. &lt;br&gt; b) Risk-Reduction and Healthy Lifestyles: Educational interventions designed to assist Members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes,</td>
<td>6) Contractor shall maintain a health education system that provides educational interventions addressing the following health categories and topics: &lt;br&gt; a) Appropriate use of health care services – managed health care; preventive and primary healthcare; obstetrical care; health education services; and, complimentary and alternative care.</td>
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<td>including programs for tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases, HIV/AIDS, and unintended pregnancy; nutrition, weight control, and physical activity; and parenting.</td>
<td>c) Self-Care and Management of Health Conditions: Educational interventions designed to assist Members to learn and follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases or health conditions, including programs for pregnancy, asthma, diabetes, and hypertension.</td>
<td>b) Risk-reduction and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and, parenting. c) Self-care and management of health conditions – pregnancy; asthma; diabetes; and, hypertension.</td>
</tr>
<tr>
<td>Exhibit A, Attachment 11 Case Management and Coordination of Care</td>
<td>16. Women, Infants, and Children Supplemental Nutrition Program (WIC)</td>
<td>A. WIC services are not covered under this Contract. However, Contractor shall have procedures to identify and refer eligible Members for WIC services.</td>
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</table>
### Appendix D. Survey Responses: Interventions Descriptions.

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<thead>
<tr>
<th>Program Type</th>
<th>Program Offered</th>
<th>All Interventions</th>
<th>Intervention Described</th>
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<tbody>
<tr>
<td>Alcohol abuse</td>
<td>No</td>
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<tr>
<td>Alcohol abuse</td>
<td>No</td>
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<tr>
<td>Alcohol abuse</td>
<td>No</td>
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<tr>
<td>Alcohol abuse</td>
<td>Yes, (but not directly)</td>
<td>There is no specific program (e.g. Fit Families for Life). The intervention provided is in the form of printed materials and a direct community referral.</td>
<td>Printed Materials</td>
<td>Printed Health Education Materials provided by the Plan and/or provider to the Medi-Cal Members. The intervention is a direct community referral to the National Clearinghouse for Alcohol and Drug Abuse Information Line.</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>Yes, (but not directly)</td>
<td>Point of Service education and community programs.</td>
<td>Point of service provider education and community programs.</td>
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<tr>
<td>Alcohol abuse</td>
<td>No</td>
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<tr>
<td>Alcohol abuse</td>
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<tr>
<td>Alcohol abuse</td>
<td>Yes, (but not directly)</td>
<td>For the prevention of alcohol abuse, information is added to our member newsletter. As for alcohol abuse, members are sent to AOD services in our Public Health Department</td>
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<tr>
<td>Alcohol abuse</td>
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<tr>
<td>Alcohol abuse</td>
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<tr>
<td>Alcohol abuse</td>
<td>Yes, (but not directly)</td>
<td>Members are referred to community programs providing alcohol abuse services, including Alanon and Alateen.</td>
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<tr>
<td>Alcohol abuse</td>
<td>Yes, (but not directly)</td>
<td>We refer to our County Behavior Health Department</td>
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<tr>
<td>Program Type</td>
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<tr>
<td>Alcohol abuse</td>
<td>Yes, (but not directly)</td>
<td>Healthy Babies program and Care Management member education.</td>
<td>Healthy Babies Program</td>
<td>Health Education mails out a Healthy Babies-Pregnancy booklet and Healthy Babies-Delivery booklet upon receipt of notice from various data sources. Information includes baby's stages of development, healthy eating &amp; exercise, breastfeeding, dangers of alcohol &amp; drug abuse, healthy weight gain, Sudden Infant Death Syndrome, Shaken Baby Syndrome, tips for new fathers, family planning, post-partum visits, etc.</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>Yes, (but not directly)</td>
<td>Carved out of GMC membership. Sac County provides drug and alcohol programs. Support groups and community referrals are made for GMC members</td>
<td>Alcohol Anonymous</td>
<td>AA offers hope, healing, discussion, and fellowship for alcohol recovery. This is a self-help program open to the community.</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>Yes</td>
<td>-Member Newsletter articles - Prenatal Educational Mailings</td>
<td>None available</td>
<td></td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>Yes, (but not directly)</td>
<td>Alcohol abuse prevention health education materials and case management services for members with substance abuse issues.</td>
<td>Case Management</td>
<td>L.A. Care Health Plan makes health education materials aimed at preventing alcohol abuse available for network providers to distribute to members. L.A. Care Health Plan's Case Managers and Social Workers provide counseling and referrals to treatment programs and sober living programs.</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>No</td>
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<tr>
<td>Alcohol abuse</td>
<td>Yes</td>
<td>PHC encourages its members to seek help for alcohol abuse by providing health articles in the member newsletter and PHC website. Information is provided on resources that are available for members that are seeking help for alcohol abuse. This information is listed on PHC website and in the member newsletter. PHC case managers provide telephonic education and resources as appropriate.</td>
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<tr>
<td>Alcohol abuse</td>
<td>Yes, (but not directly)</td>
<td>We offer a list of classes available at various clinic sites. Sites offer classes according to their patient populations. SFHP financially compensates clinics and providers who offer these services through the Health Education Compensation Program. The goal of HECP is to support ongoing and sustainable health education activities by rewarding efforts that help keep our members healthy.</td>
<td>Health Education Compensation Program</td>
<td>1. incentivize clinics and provider sites to offer group health classes to SFHP members. 2. support efforts by clinics/providers to keep members healthy. Health education classes on nutrition, healthy eating, etc.</td>
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<tr>
<td>Alcohol abuse</td>
<td>No</td>
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<tr>
<td>Asthma Management</td>
<td>No response</td>
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<tr>
<td>Asthma Management</td>
<td>Yes, (but not directly)</td>
<td>Participation in the Condition Care Program, each intervention is tailored to the individuals specific needs based on the individual assessment.</td>
<td>No Specific Interventions falls under Disease Management Program</td>
<td>As part of our efforts to better engage members, we utilize and strongly support an approach to care that is based on the precepts of health-behavior change. In particular, our programs are designed to support interventions that address individual situations, biases, and general barriers that prevent members from adopting healthier behaviors. We recognize that every member’s life experience with his or her condition is highly personal and that a “cookie cutter” approach does not address, let alone resolve, the complex factors that lead to optimal condition management.</td>
</tr>
<tr>
<td>Asthma Management</td>
<td>Yes</td>
<td>Phone Counseling, printed materials, plan website, Breathmobile</td>
<td>Breathmobile</td>
<td>Telephonic assessment, education and follow-up</td>
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<tr>
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<tr>
<td>Asthma Management</td>
<td>Yes</td>
<td>Asthma-Be In Charge disease management program</td>
<td>Asthma-Be In Charge disease management program</td>
<td>Using claims, pharmacy and encounter data, asthmatic members ages 5-64 are identified and invited to join the disease management program. Members are stratified into low and high risk based on how frequent they have visited the ER or inpatient in the last 12 months relating to their asthma. Low risk members get educational mailing and IVR twice a year and unlimited access to a disease management nurse. High risk members get nurse outbound calls and appropriate educational mailings to help them meet their action plan. Members also have unlimited inbound calls to a disease management nurse. Each member with asthma receives an asthma self-management instructional book and an asthma action plan that helps the member set target goals with his or her PCP for: • Asthma trigger modification • Controller and rescue medication usage • Peak flow meter home monitoring • Asthma symptom management</td>
</tr>
<tr>
<td>Asthma Management</td>
<td>Yes</td>
<td>Care1st Cares</td>
<td>Care1st Cares</td>
<td>1. Members receive regular nurse calls  2. Members can call nurses with questions  3. Members receive reminders to obtain preventive screenings  4. Members receive educational mailings  5. Education on how to use peak flow meters  6. Reports to primary care doctor</td>
</tr>
<tr>
<td>Asthma Management</td>
<td>Yes</td>
<td>Breathe SMART programs for members with Asthma/COPD -</td>
<td>Breathe SMART Reports for providers</td>
<td>Health plan sends quarterly reports to Primary Care Providers (PCP) that list members that meet criteria for Asthma/COPD and number of Rx fills to date of controller/rescue medications, as well as any ER or hospital visits noted.</td>
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<tr>
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<tr>
<td>Asthma Management</td>
<td>Yes</td>
<td>Healthy Breathing for Life program</td>
<td>Healthy Breathing for Life program</td>
<td>Members with asthma are stratified by risk level. All members with asthma receive a letter and educational materials about asthma management and asthma education benefits. High-risk members receive a phone call from Health Programs staff, during which staff assess members' level of understanding about asthma management and provide education as needed. Staff refer members to approved clinical asthma education providers, where they receive education and assessments, create an Asthma Action Plan (AAP), and learn to properly use medical equipment, such as inhalers, spacers, and peak flow meters. Members whose PCP submits an AAP are entered in a raffle for a chance to win a $50 gift card.</td>
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<tr>
<td>Asthma Management</td>
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<tr>
<td>Asthma Management</td>
<td>Don't know</td>
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<tr>
<td>Asthma Management</td>
<td>Yes</td>
<td>Asthma-Be In Charge disease management program Asthma community classes</td>
<td>Asthma-Be In Charge disease management program</td>
<td>using claims, pharmacy and encounter data, asthmatic members ages 5-64 are identified and invited to join the disease management program. Members are stratified into low and high risk based on how frequent they have visited the ER or inpatient in the last 12 months relating to their asthma. Low risk members get educational mailing and IVR twice a year and unlimited access to a disease management nurse. High risk members get nurse outbound calls and appropriate educational mailings to help them meet their action plan. Members also have unlimited inbound calls to a disease management nurse. Each member with asthma receives an asthma self-management instructional book and an asthma action plan that helps the member set target goals with his or her PCP for: • Asthma trigger modification • Controller and rescue medication usage • Peak flow meter home monitoring • Asthma symptom management</td>
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<tr>
<td>Asthma Management</td>
<td>Yes</td>
<td>HPSJ Pharmacy Department has coding in the claims system to identify members who are filling a high quantity of rescue medications, but a low quantity of controller medications. These members' information is transmitted to their PCP and Pharmacy for suggested intervention.</td>
<td>HPSJ Disease/Case Management Program</td>
<td>Disease prevention interventions are provided by HPSJ case managers, social workers and health navigators. The Pharmacy Department is also working with members, providers and pharmacies to encourage the appropriate use of medications.</td>
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<tr>
<td>Asthma Management</td>
<td>Yes, (but not directly)</td>
<td>Free resources in the county</td>
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<tr>
<td>Asthma Management</td>
<td>Yes</td>
<td>IEHP Health Management Program (Disease Management) - Asthma</td>
<td>IEHP Health Management Program (Disease Management) - Asthma</td>
<td>The IEHP Health Management Program is an over-arching structure that encompasses a variety of administrative, clinical, cognitive, functional needs, lifestyle, behavioral, depression and psychosocial services designated to improve Members’ health and prevent exacerbation and complications due to asthma.</td>
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<tr>
<td>Asthma Management</td>
<td>Yes</td>
<td>Understanding Your Asthma, Understanding Your Child's Asthma, Understanding Your Child's Asthma Video</td>
<td>Understanding Your Asthma</td>
<td>Learn what triggers can cause asthma flare-ups or reduce their impact. We also cover the different types of asthma medications and how and when to use them. Please bring your asthma medications, peak flow meter, and AeroChamber space to class.</td>
</tr>
<tr>
<td>Asthma Management</td>
<td>Yes</td>
<td>In home education visits (indirectly through 3rd party vendor) Health education mailings Member newsletter articles</td>
<td>In home education visits</td>
<td>Members diagnosed with asthma receive a home visit from a health educator to discuss asthma, triggers, and medication management.</td>
</tr>
<tr>
<td>Asthma Management</td>
<td>Yes, (but not directly)</td>
<td>L.A. Care's Asthma Disease Management Program addresses a range of interventions, including but not limited to condition monitoring, monitoring patient adherence to the program's treatment plans, medical and behavioral co-morbidities and other health conditions and health</td>
<td>LA Cares About Asthma (L.A. Care's Asthma Disease Management Program)</td>
<td>LA Cares About Asthma focuses on the development, implementation, and evaluation of a system of coordinated health care interventions and communications for members with asthma and the practitioners who care for them. The members of the multidisciplinary program team use their expertise in specific areas to develop and implement multi-faceted intervention programs that are culturally sensitive, linguistically appropriate and meet the unique needs of the</td>
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<tr>
<td>Asthma</td>
<td>Yes</td>
<td>Breathe with Ease asthma management program. The American Lung Association's home visitation asthma education program. The Long Beach asthma care program.</td>
<td>Breathe with Ease program.</td>
<td>Members identified with asthma are offered participation in the Breathe with Ease asthma program and those who participate are case managed by nurses with asthma management training. In San Bernardino and Long Beach, Molina Healthcare collaborates with the American Lung Association and the Long Beach Asthma care program in providing home visitation programs where members identified as having hospitalizations due to asthma flare ups are educated on proper medication management of asthma, identification and reduction of home triggers via a free home triggers assessment and the provision of asthma friendly cleaning products and bedding.</td>
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<tr>
<td>Asthma</td>
<td>No</td>
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<tr>
<td>Asthma</td>
<td>Yes, (but not directly)</td>
<td>We offer a list of classes available at various clinic sites. Sites offer classes according to their patient populations. SFHP financially compensates clinics and providers who offer these services through the Health Education Compensation Program. The goal of HECP is to support ongoing and sustainable health education activities by rewarding efforts that help keep our members healthy.</td>
<td>Health Education Compensation Program</td>
<td>1. incentivize clinics and provider sites to offer group health classes to SFHP members. 2. support efforts by clinics/providers to keep members healthy. Health education classes on nutrition, healthy eating, etc.</td>
</tr>
<tr>
<td>Asthma</td>
<td>Don’t know</td>
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<tr>
<td>Breastfeeding</td>
<td>Yes</td>
<td>Baby Steps Mailing Lactation Support</td>
<td>Baby Steps Mailing</td>
<td>All newly identified pregnant members receive a prenatal mailing with key health promotion messages on prenatal care, classes available, the importance of breastfeeding. The mailing includes offers for Text4Baby, the First 5 Parents Kit, a list of Alliance lactation consultants and immunization information. All newly delivered moms</td>
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<tr>
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<tr>
<td>Breastfeeding</td>
<td>Yes, (but not directly)</td>
<td>This is completed on all Medi-Cal members that enroll and engage in the Future Moms program.</td>
<td>The Future Moms program conducts breast-feeding education, but there is no specific intervention.</td>
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<tr>
<td>Breastfeeding</td>
<td>Yes, (but not directly)</td>
<td>Members are provided education on breastfeeding and referred to community resources.</td>
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<tr>
<td>Breastfeeding</td>
<td>Yes</td>
<td>1. Pregnancy Matters 2. Breastfeeding and Nutrition Support Line</td>
<td>Pregnancy Matters</td>
<td>Pregnant women are identified and invited to request an education Pregnancy Matters packet which includes breastfeeding information. Members are also invited to access the dedicated Breastfeeding and Nutrition Support Line as needed. The Plan also educates members of lactation consultant if needed.</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Yes, (but not directly)</td>
<td>Provider point of service education and community programs.</td>
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<tr>
<td>Breastfeeding</td>
<td>Yes, (but not directly)</td>
<td>Promotion of local breastfeeding services-through WIC, contracted lactation consultants, hospitals. Articles in member newsletter on breastfeeding on a regular basis. Promotion of text4baby for postpartum mothers.</td>
<td>No specific intervention or program to report.</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Yes</td>
<td>The Healthy Moms and Healthy Babies program includes a breastfeeding benefit component.</td>
<td>Healthy Moms and Healthy Babies program, which includes a</td>
<td>Members can receive up to 2 hours of lactation counseling after the birth of their child, provided by a pre-approved Internationally Board Certified Lactation Consultant (IBCLC). Only moms who are returning to work or school</td>
</tr>
<tr>
<td>Program Type</td>
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<tr>
<td>Breastfeeding</td>
<td>Yes, (but not directly)</td>
<td>Lactation consultants are available through the Public Health Department and WIC services. CCHP also has a CPSP direct services for our members. Breastfeeding services and support are continuously provided to our new moms through various avenues. This includes, clinic services, public health, and WIC services. CCHP actively participates in the county's breastfeeding task force.</td>
<td>breastfeeding benefit component.</td>
<td>or who have a medical reason why they can’t breastfeed are eligible for a breast pump.</td>
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<tr>
<td>Breastfeeding</td>
<td>No</td>
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<tr>
<td>Breastfeeding</td>
<td>Yes</td>
<td>Pregnancy Matters Program Breastfeeding and Nutrition Support Line Infant Nutrition Provider Guide and Training that promotes the use of breast pumps by Medi-Cal members</td>
<td>Pregnancy Matters educational packets</td>
<td>Pregnant women are identified and invited to request an education Pregnancy Matters packet which includes breastfeeding information. Invite members to access the dedicated Breastfeeding and Nutrition Support Line as needed. Educate members of lactation consultant if needed.</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Yes, (but not directly)</td>
<td>HPSJ works with 7 local hospitals who provide breastfeeding education/services to our members. We also work with the SJC Breastfeeding Consortium and the three local WIC agencies.</td>
<td>Established by each agency/program.</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Yes, (but not directly)</td>
<td>We refer to services offered by other community organizations</td>
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</tr>
<tr>
<td>Breastfeeding</td>
<td>Yes, (but not directly)</td>
<td>Healthy Babies Program and Care Management member education</td>
<td>Healthy Babies</td>
<td>Health Education mails out a Healthy Babies-Pregnancy booklet and Healthy Babies-Delivery booklet upon receipt of notice from various data sources. Information includes baby’s stages of development, healthy eating &amp; exercise, breastfeeding, healthy weight gain, Sudden Infant Death</td>
</tr>
<tr>
<td>Program Type</td>
<td>Program Offered</td>
<td>All Interventions</td>
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<tr>
<td>Breastfeeding</td>
<td>Yes</td>
<td>Breastfeeding Group Class, Newborn Group Class, Breastfeeding Advice Line, Lactation Clinic</td>
<td>Breastfeeding</td>
<td>Studies show that breastfeeding offers many health benefits for you and your baby. In the Breastfeeding class, you'll learn how to position your baby for nursing, how to tell if your baby is getting milk, and ways to prevent common breastfeeding discomforts and challenges. It is recommended this class should be taken during pregnancy.</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Yes</td>
<td>OB Case Management Calls, Perinatal educational packets, Member Newsletter articles</td>
<td>OB Case Management Calls</td>
<td>All pregnant and postpartum members are mailed educational packets which include information on the importance and benefits of breastfeeding. Additionally through the OB Case Management project, all pregnant and postpartum members are contacted to provide assistance and education including but not limited to the importance and benefits of breastfeeding.</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Yes, (but not directly)</td>
<td>Breastfeeding hospital mailing, prenatal mailing which includes breastfeeding educational materials.</td>
<td>Breastfeeding hospital mailing</td>
<td>L.A. Care Health Plan sends an annual mailing to contracted hospitals which includes information about MMCD Policy Letter 98-10, WIC, how to order educational materials promoting breastfeeding, and additional resources for breastfeeding assistance.</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Yes</td>
<td>Motherhood Matters program</td>
<td>Motherhood Matters</td>
<td>All pregnant members enrolled into the Motherhood Matters program are followed until 6 weeks postpartum and are educated on the importance and benefits of breastfeeding and provided support as needed through the 6 weeks post-partum check up. After that it is up to the member to follow up with the program educators as needed for support and further counseling as needed. All pregnant and postpartum members are offered encouraged and offered paperwork to sign up for the WIC.</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Yes</td>
<td>Growing Together Perinatal Program (GTPP)</td>
<td>GTPP Breast Pump Program</td>
<td>Encouragement and support through PHC annual train-the-trainer training in breastfeeding for providers. • Case management and referrals to community resources • Free breast pumps for breastfeeding are available to PHC members returning to work or school • Live phone information and support is available during pregnancy.</td>
</tr>
<tr>
<td>Program Type</td>
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<tr>
<td>Breastfeeding</td>
<td>Yes, (but not directly)</td>
<td>Health Education Compensation Program (HECP), SFHP’s Your Body Your Baby program, cross-promotion of classes not part of HECP but within our network</td>
<td>Your Body, Your Baby</td>
<td>SFHP staff member conducts live outreach calls to eligible women to inform them about the prenatal and postpartum incentives (for provider visits within specified timeframes). Member declines or accepts offer to receive health education packet (with prenatal and postpartum--including much info on breastfeeding) through mail as well as offer to receive more info on the incentive. SFHP staff tracks delivery of baby (if successful, staff mails packet to mother if she has not already received it). SFHP staff also directs member to SFHP website for more health education information.</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Yes, (but not directly)</td>
<td>Text for Babies</td>
<td>Text for Babies</td>
<td>None</td>
</tr>
<tr>
<td>Cardiovascular Disease Prevention</td>
<td>No</td>
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<tr>
<td>Cardiovascular Disease Prevention</td>
<td>Yes, (but not directly)</td>
<td>Participation in the Condition Care Program, each intervention is tailored to the individuals specific needs based on the individual assessment.</td>
<td>No Specific Interventions falls under Disease Management Program</td>
<td>As part of our efforts to better engage members, we utilize and strongly support an approach to care that is based on the precepts of health-behavior change. In particular, our programs are designed to support interventions that address individual situations, biases, and general barriers that prevent members from adopting healthier behaviors. We recognize that every member’s life experience with his or her condition is highly personal and that a “cookie cutter” approach does not address, let alone resolve, the complex factors that lead to optimal condition management.</td>
</tr>
<tr>
<td>Cardiovascular Disease Prevention</td>
<td>Yes</td>
<td>a). Provider and member lab reminder mailings to encourage members to get lab tests (ie. HbA1c and LDL)  b). Medi-Cal Provider Incentives for LDL screenings  c). Articles in member newsletters  d). Articles in mailed</td>
<td>Medi-Cal Provider Incentives for LDL Screening</td>
<td>Providers were given $100/screening (up to 2 screenings) for each member who was diagnosed with congestive heart failure and got an LDL screening.</td>
</tr>
<tr>
<td>Program Type</td>
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<tr>
<td>Cardiovascular Disease Prevention</td>
<td>Yes</td>
<td>member health guide e). Share clinical practice guidelines with providers</td>
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<td>There is not a specific program (e.g. Fit Families for Life), however, Medi-Cal members receive cardiovascular disease prevention intervention through the Nurse Advice Line and through their health care provider.</td>
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<td></td>
<td>Yes, (but not directly)</td>
<td>community programs</td>
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<td>No</td>
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<td>Yes, (but not directly)</td>
<td>Information is added to our Health Education website, and member newsletter</td>
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<td>Yes, (but not directly)</td>
<td>Fit Families for Life suite of programs  a. Home Edition  b. Coaching Program  c. Breastfeeding and Nutrition Support Line  d. Community Classes  e. Rethink Your Drink and Flex Your Health through T2X</td>
<td>Fit Families for Life-Coaching Program</td>
<td>Members ages 6-20 with a 95 BMI percentile are referred by their doctor into the Coaching program. Members will get up to five coaching calls with a nutrition nurse or dietitian to help members complete the Home Edition and address additional nutrition and/or physical activity concerns. Members have unlimited inbound calls to the nurse/dietitian. Knowledge, intentions and behaviors are recorded pre and post intervention. Note that other Fit Families for Life programs do not required a provider’s referral. Members can participate on their own will.</td>
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<tr>
<td>Cardiovascular Disease Prevention</td>
<td>Yes, (but not directly)</td>
<td>Disease prevention interventions are provided by HPSJ case managers, social workers and health navigators. Our Pharmacy Department also has a program to monitor and educate patients and physicians on anti-platelet therapy that has had positive outcomes on a population level.</td>
<td>Members identified at risk complete a health risk assessment (HRA) which allows HPSJ staff to address the individual member's needs.</td>
<td>HRAs identify members in need of services to address needs related to cardiovascular disease. Follow-up by case managers, social workers, health navigators, home visits by NP, etc.</td>
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<td>Cardiovascular Disease Prevention</td>
<td>No</td>
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<tr>
<td>Cardiovascular Disease Prevention</td>
<td>Yes</td>
<td>PCP clinical health education to members and the Healthy Heart Program</td>
<td>The Healthy Heart Program</td>
<td>The Healthy Heart Program is an at-home mailing program designed to educate members on the risk factors of heart disease and provide members with tools to implement lifestyle changes to reduce their risks. Members learn about different topics along with The Heart Family. Topics include building a heart-healthy kitchen, identifying various types of fats, reading food labels, incorporating physical activities daily, smoking cessation, hypertension, stress management, and women and heart disease. Members receive sequential education packets that they can complete at their own pace.</td>
</tr>
<tr>
<td>Cardiovascular Disease Prevention</td>
<td>Yes</td>
<td>Heart Health (Group Class) Cardiovascular Health: Preventing Heart Attacks and Strokes (Group Class) Congestive Heart Failure Self Care (Group Class)</td>
<td>Heart Health</td>
<td>Diet Plans a big role in management of cholesterol levels, congestive heart failure, and high blood pressure. If you have one or more of these conditions, this class is for you. Topics include learning how to eat more healthfully in a restaurant, adopt low-fat cooking techniques, read food labels.</td>
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<td>Program Type</td>
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<tr>
<td>Cardiovascular Disease Prevention</td>
<td>Yes</td>
<td>The Healthy Eating and Active Lifestyle Class provides hands-on and practical activities to help members identify ways to integrate healthy eating and physical activity into their daily lives. The class is intended to help members manage their weight. Participants are generally members who were referred by their PCP or self-referred themselves to the class. The topics of the class include: MyPlate and identifying examples of foods from all food groups, such as whole grains; Favorite recipe makeovers; Easy cooking demos, such as green smoothies and bean dip with vegetables; Short exercise routines, including Zumba moves; strength and yoga. Members receive incentives, such as measuring cups and recipe booklets by actively participating in the class activities. The class is evaluated with a brief post-class knowledge evaluation questionnaire and 3-month follow-up calls.</td>
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<tr>
<td>Cardiovascular Disease Prevention</td>
<td>Yes</td>
<td>Take Action Against Cholesterol</td>
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<td>A two-hour in-person group education session which teaches skills to prevent or manage high cholesterol. Instruction includes nutrition and physical activity education.</td>
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<td>Complex case management services are provided by the primary care provider, in collaboration with Molina's care management services, to manage acute and chronic illness, including emotional and social support issues by a multidisciplinary case management team, in coordination of resources to ensure member-regulated development or improved functionality, and the coordination of care plans specific to member needs. All case management activities are documented in a web-based member-management system.</td>
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<tr>
<td>Cardiovascular Disease Prevention</td>
<td>Yes</td>
<td>All members identified as having cardiovascular disease are notified of the CVD program. The general CVD educational materials mailed to members are targeted to heart disease prevention and management, and information related to heart disease management, lifestyle change, and the development of health management plans. Members identified as having chronic illness are contacted and offered complex case management services.</td>
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<tr>
<td>Cardiovascular Disease Prevention</td>
<td>Yes</td>
<td>Chronic Care Improvement Project - this project was launched in 2012 to reduce the morbidity and mortality with cardiovascular disease among PHC Advantage members with type 2 diabetes. Since uncontrolled diabetes is a leading risk factor for cardiovascular disease, controlling diabetes represent an excellent opportunity to improve outcomes across both chronic conditions.</td>
<td>Chronic Care Improvement Project (CCIP)</td>
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<td>We offer a list of classes available at various clinic sites. Sites offer classes according to their patient populations. SFHP financially compensates clinics and providers who offer these services through the Health Education Compensation Program. The goal of HECP is to support ongoing and sustainable health education activities by rewarding efforts that help keep our members healthy.</td>
<td>Health Education Compensation Program</td>
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<td>Self management group program</td>
<td>Health Trust</td>
<td>Not available for this survey</td>
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<td>No</td>
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<tr>
<td>Cardiovascular Disease</td>
<td>Yes, (but not</td>
<td>Participation in the Condition Care Program, each intervention is tailored to the</td>
<td>No Specific Interventions falls under Disease</td>
<td>As part of our efforts to better engage members, we utilize and strongly support an approach to care that is based on the precepts of health-behavior change. In particular, our programs are designed to support interventions that address individual situations, biases, and general barriers that prevent members from adopting healthier behaviors. We recognize that every member’s life experience with his or her condition is highly personal and that a “cookie cutter” approach does not address, let alone resolve, the complex factors that lead to optimal condition management.</td>
</tr>
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<td>Management</td>
<td>directly)</td>
<td>the individuals specific needs based on the individual assessment.</td>
<td>Management Program</td>
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<td>Heart Health Disease Management Program</td>
<td>Low risk members with heart disease will receive quarterly educational mailing and a list of self-management classes. Moderate risk members with heart disease will receive: biannual monitoring of lab tests and reminder letter mailings, targeted information on depression, tests, shots and on how to prevent further problems, quarterly educational mailings and a list of self-management classes. High risk members with heart disease will be contacted by a health coach/referral to case management and receive: targeted information on depression, tests shots and on how to prevent further problems, biannual monitoring of lab tests and reminder letter mailings, quarterly educational mailing and a list of self-management classes.</td>
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<td>Heart Health Disease Management Program is designed to improve the quality of life and improve health outcomes for our members with heart disease.</td>
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<td>Heart Health Disease Management Program</td>
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<td>There is not a specific program (e.g. Fit Families for Life), however, Medi-Cal members receive cardiovascular disease prevention intervention through the Nurse Advice Line and through their health care provider.</td>
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<td>We refer to community programs. Additionally, some members receive counseling if they are being case managed. Care 1st has a CHF disease management program.</td>
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<td>Program Type</td>
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<tr>
<td>Cardiovascular Disease Management</td>
<td>No</td>
<td>dietitian services, group appointments, and patient educators are all available.</td>
<td></td>
<td>services are provided by the contracting facility/provider</td>
</tr>
<tr>
<td>Cardiovascular Disease Management</td>
<td>No</td>
<td>Don't know</td>
<td></td>
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<tr>
<td>Cardiovascular Disease Management</td>
<td>Yes, (but not directly)</td>
<td>Cardiovascular disease management services are provided by HPSJ case managers, social workers and health navigators.</td>
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<tr>
<td>Cardiovascular Disease Management</td>
<td>No</td>
<td>Care Management, and Healthy Heart Program</td>
<td>The Healthy Heart Program is an at-home mailing program designed to educate members on the risk factors of heart disease and provide members with tools to implement lifestyle changes to reduce their risks. Members learn about different topics along with The Heart Family. Topics include building a heart-healthy kitchen, identifying various types of fats, reading food labels, incorporating physical activities daily, smoking cessation, hypertension, stress management, and women and heart disease. Members receive sequential education packets that they can complete at their own pace.</td>
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<tr>
<td>Cardiovascular Disease Management</td>
<td>Yes</td>
<td>Healthy Eating and Active Lifestyle Class</td>
<td>The Healthy Eating and Active Lifestyle Class provides members with hands-on and practical activities and discussions to help members identify ways to integrate healthy eating and physical activity into their lifestyle. This class is intended to help members manage their weight. Participants are generally members who were referred by their primary care physicians. The topics include: - MyPlate and identifying examples of foods from all food groups - How to read nutrition labels - How to be a whole grain detective and identify whole grains - Favorite recipe makeovers - Easy cooking demos, such as green smoothies and bean dip with vegetables - Short exercise routines, including Zumba moves, strength, and yoga. Members receive incentives, such as measuring cups, pedometers, and recipe booklets. The class is evaluated with a brief post-class knowledge evaluation questionnaire and 3-month follow-up calls.</td>
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<tr>
<td>Cardiovascular Disease Management</td>
<td>Yes</td>
<td>Cardiovascular disease management program</td>
<td>All members identified with having CVD are passively managed by the bi-annual mailing of Molina’s diabetes/cvd newsletters. Members identified with CVD are notified of the availability of this program and provided contact.</td>
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<tr>
<td>Cardiovascular Disease Management</td>
<td>No</td>
<td>We offer a list of classes available at various clinic sites. Sites offer classes according to their patient populations. SFHP financially compensates clinics and providers who offer these services through the Health Education Compensation Program. The goal of HECP is to support ongoing and sustainable health education activities by rewarding efforts that help keep our members healthy.</td>
<td>1. incentivize clinics and provider sites to offer group health classes to SFHP members. 2. support efforts by clinics/providers to keep members healthy. Health education classes on nutrition, healthy eating, etc.</td>
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</tr>
<tr>
<td>Diabetes Management</td>
<td>Don't know</td>
<td>Alameda County Diabetes Program Bay Area Diabetes &amp; Wellness Alliance Disease Management Program</td>
<td>One-on-one counseling to help member understand the disease, the doctor's plan and guidance in how to self-manage the disease.</td>
<td></td>
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<tr>
<td>Diabetes Management</td>
<td>Yes, (but not directly)</td>
<td>Part of the Chronic Disease Management (Condition Care Program) The 2013 diabetes incentive program for CA Medi-Cal will target noncompliant members with a planned launch 9/15/2013.</td>
<td>Diabetes incentive</td>
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Incentive letter offering $25 incentive gift card to each noncompliant member for getting A1C, LDL Cholesterol and Urine Microalbumin lab screening tests by 12/31/2013. This incentive letter instructs the member to call their doctor and schedule an appointment to get the lab tests. The member will be required to get all 3 lab tests to qualify for the gift card. The member’s PCP is required to attest that the lab screening tests were completed by 12/31/2013 by signing the return mail-in attestation form. A second $25 incentive offering will be sent to members who have not had a dilated retinal exam in 2013. The mailing will launch 9/15/2013. The member is instructed...
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<tr>
<td>Diabetes Management</td>
<td>Yes</td>
<td>Diabetes Disease Management</td>
<td>Diabetes Disease Management</td>
<td>Phone counseling: Provide assistance, encouragement and promote self-management among members with diabetes and coordinate access to care.</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>Yes</td>
<td>Diabetes-Be In Charge disease management program Diabetes community education classes</td>
<td>Diabetes-Be In Charge disease management program</td>
<td>Using claims, encounter and pharmacy data, members 21 and older who have type 2 diabetes are identified and invited to join the disease management program. Members are stratified into low and high risk based on how frequent they have visited the ER or inpatient in the last 12 months relating to their diabetes. Low risk members get educational mailing and IVR twice a year and unlimited access to a disease management nurse. High risk members get nurse outbound calls and appropriate educational mailings to help them meet their action plan. Members also have unlimited inbound calls to a disease management nurse.</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>Yes, (but not directly)</td>
<td>We work with community organization and refer to these programs. Additionally, if a member is being case managed, he or she will receive education from the case manager. We also refer member to Registered Dietitians.</td>
<td>We work with community organization and refer to these programs.</td>
<td>We work with community organization and refer to these programs. Additionally, if a member is being case managed, he or she will receive education from the case manager. We also refer member to Registered Dietitians.</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>Yes</td>
<td>Diabetes SMART Program - New Member mailing and monthly Provider reports. Diabetes articles in member newsletter, and diabetes resources and self-management tools.</td>
<td>Diabetes SMART New Member mailing.</td>
<td>Started in July 2012, newly identified members on our monthly Diabetes SMART enrollment lists are mailed a Diabetes Health Record and Diabetes Action Plan, along with a form to request other useful resources and referrals for diabetes education. New tools being offered to members include recipe books, DVD on diabetes, and</td>
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- to call and make an appointment with their eye doctor for a dilated retinal exam. The member is also instructed to tell their eye doctor that they have diabetes. The member has to complete the exam by 12/31/2013 to qualify for the gift card. The member’s eye care provider will be required to sign the return mail-in attestation form to confirm the exam was completed.
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<tr>
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</thead>
<tbody>
<tr>
<td>Diabetes Management</td>
<td>Yes</td>
<td>Live Better with Diabetes program</td>
<td>Live Better with Diabetes program</td>
<td>The Alliance offers a $50 gift certificate to members with diabetes for obtaining the following 4 screenings during the calendar year: HbA1c, LDL-C, Eye exam, and appropriate medical attention for nephropathy. All members with a diagnosis of diabetes receive a letter about the incentive program towards the beginning of the year, and a reminder notice goes out to members who have not yet gotten each of the 4 screenings towards the end of the year. Providers also receive a list of members who are due for screenings. Alliance staff refer members to approved clinical diabetes management education providers, where they receive education and assessments, and learn about self-care, healthy lifestyle changes, and avoiding hospitalization or complications.</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>Yes</td>
<td>Disease Management for Diabetics, Group Appointments, Health education, and Dietitian Services, Counseling/Motivational Interviewing</td>
<td>Disease Management Program for diabetics</td>
<td>Members receive a welcome packet with information about accessing disease management nurse assistance. DM nurse also helps with making appointments to resources such as classes i.e. group appointment, PCP, dietician services health education and/or community resource support. Encouragement toward calling DM RN for overall assessment, focus on goal setting, problem solving and behavioral modification</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>Yes, (but not directly)</td>
<td>Currently under development</td>
<td></td>
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<tr>
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<tr>
<td>Diabetes Management</td>
<td>Yes</td>
<td>Diabetes-Be In Charge disease management program Diabetes community education classes</td>
<td>Diabetes-Be In Charge disease management program</td>
<td>using claims, encounter and pharmacy data, members 21 and older who have type 2 diabetes are identified and invited to join the disease management program. Members are stratified into low and high risk based on how frequent they have visited the ER or inpatient in the last 12 months relating to their diabetes. Low risk members get educational mailing and IVR twice a year and unlimited access to a disease management nurse. High risk members get nurse outbound calls and appropriate educational mailings to help them meet their action plan. Members also have unlimited inbound calls to a disease management nurse.</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>Yes</td>
<td>HPSJ is licensed to provide the Stanford Chronic Disease Self-Management Program. We refer members to Community Partners/Agencies that provide Diabetes Management Classes. These include local hospitals and community-based organizations. We provide Community Wellness Grants to support Diabetes Management Programs. These providers include Golden Valley Health Centers, St. Mary's Interfaith Community, and California Medical Association Foundation.</td>
<td>St. Mary's Interfaith Community - Diabetes Education and Counseling Program</td>
<td>St. Mary's Interfaith Community Services Program includes the provision of Gluco-strips and meters to track client's blood levels, provide diabetes education which includes resource information on the importance of adjusting food intake, increasing physical activity and/or referring clients for pharmacologic therapy and respond appropriately to their blood glucose readings. Access to monitoring devices and supplies is a vital component towards encouraging self-monitoring and self-management practices, and ensuring an adequate supply of blood glucose monitors, test strips and lancets is equally as important.</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>Yes, (but not directly)</td>
<td>Subcontracted</td>
<td>IEHP Health Management Program (Disease Management) - Diabetes</td>
<td>The IEHP Health Management Program is an over-arching structure that encompasses a variety of administrative, clinical, cognitive, functional needs, lifestyle, behavioral, depression and psychosocial services designated to improve Members’ health and prevent exacerbation and</td>
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<tr>
<td>Diabetes Management</td>
<td>Yes</td>
<td>Diabetes Basics  Starting Insulin Insulin for Diabetes Video Series Living Well with Diabetes Diabetes Pattern Management Diabetes Care Management Program Diabetes Nutrition Meal Planning for Diabetes Diabetes Support Group Healthier Living with Ongoing Health Conditions</td>
<td>Diabetes Basics</td>
<td>Learn the basics of managing your type 2 diabetes so you can feel better and be active and healthy. In this class, we give you an overview of the five key areas of type 2 diabetes management: healthy eating, exercise, monitoring your blood sugar levels, proper use of medication, and managing stress. Bring your blood glucose monitor to class.</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>Yes</td>
<td>• Individual health education appointments with a health plan health educator or dietitian • Diabetes Education Classes (offered indirectly through a partner agency) • In home education visits (offered indirectly through a partner agency) • Health education materials mailed to members • Diabetes management text message pilot project • Disease Management care manager outreach calls • Diabetic Clinic</td>
<td>We work with community organization and refer to these programs. Additionally, if a member is being case managed, he or she will receive education from the case manager. We also refer member to Registered Dietitians.</td>
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</tr>
<tr>
<td>Diabetes Management</td>
<td>Yes</td>
<td>&quot;L.A. Cares About Diabetes&quot; Population identification processes Evidence based practice guidelines Education</td>
<td>L.A. Cares About Diabetes</td>
<td>Education on the disease process, symptoms and triggers. Review, evaluation, and support of medical and behavioral health co-morbidities, and other health conditions such as cognitive deficits and physical limitations. Education on preventive measures, and on identified health and psycho-social risks. Reinforcement of the importance of prescribed medication adherence.</td>
</tr>
<tr>
<td>Diabetes Management</td>
<td>Yes</td>
<td>Healthy Living with Diabetes.</td>
<td>Healthy Living with Diabetes</td>
<td>All members identified as having diabetes are passively managed by mailing bi-annual diabetes/cvd newsletters. The Healthy Living with Diabetes program is an opt in program. Members identified with diabetes are notified of the availability of this program and provided contact information. Members that wish to participate are assessed</td>
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<tr>
<td>Diabetes Management</td>
<td>No</td>
<td>HEC, Healthier Living, and DMTx (the health text messaging program)</td>
<td>not sure which has most impact yet. HL and DMTx are relatively new. Will describe Healthier Living below</td>
<td>This is an evidence-based 6-week self-management program. Workshop is facilitated by two trained leaders. Classes are highly interactive and participative, where mutual support and success build the participants' confidence in their ability to manage their health and maintain a quality of life.</td>
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<tr>
<td>Diabetes Management</td>
<td>Don't know</td>
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<tr>
<td>Drug abuse</td>
<td>No</td>
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<tr>
<td>Drug abuse</td>
<td>No</td>
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<tr>
<td>Drug abuse</td>
<td>Yes, (but not directly)</td>
<td>There is no specific program (e.g. Fit Families for Life). The intervention provided is in the form of printed materials and a direct community referral.</td>
<td>Printed Materials</td>
<td>Printed Health Education Materials provided by the Plan and/or provider to the Medi-Cal Members. The intervention is a direct community referral to the National Clearinghouse for Alcohol and Drug Abuse Information Line.</td>
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<tr>
<td>Drug abuse</td>
<td>Yes, (but not directly)</td>
<td>Point of service provider education and community programs.</td>
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<tr>
<td>Drug abuse</td>
<td>No</td>
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<tr>
<td>Drug abuse</td>
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<tr>
<td>Drug abuse</td>
<td>Yes, (but not directly)</td>
<td>For the prevention of drug abuse, information is added to our member newsletter. As for drug abuse, members are sent to AOD services in our Public Health Department</td>
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<tr>
<td>Drug abuse</td>
<td>No</td>
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<tr>
<td>Drug abuse</td>
<td>Yes, (but not directly)</td>
<td>Members are referred to community programs providing substance abuse services.</td>
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<tr>
<td>Drug abuse</td>
<td>Yes, (but not directly)</td>
<td>We refer to our county behavioral health department.</td>
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<tr>
<td>Drug abuse</td>
<td>Yes</td>
<td>Eradicator (Super Hero), care management member education, and the Healthy Babies Program</td>
<td>Eradicator</td>
<td>The Eradicator is another IEHP super hero. He fights villains who try to get children to start smoking or not to quit smoking. He has his own web page where members can view his comic book, get information about the harms of smoking, take a pledge not to start smoking, etc.</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>Yes</td>
<td>Drug abuse programs are not a covered benefit through Sacramento GMC Contract. However, we offer on-site support groups: Cocaine Anonymous, Marijuana Anonymous, and Narcotics Anonymous</td>
<td></td>
<td>Cocaine Anonymous - Join a group of individuals who have taken a pledge to remain drug free and to support each other along every stage of their recovery. This is a self-help program open to the community. Marijuana Anonymous - Group members share their experience, strength, and hope with each other to help others recover from marijuana addiction. This is a self-help program open to the community.</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>Yes</td>
<td>Member newsletter articles, prenatal educational mailings.</td>
<td>None available</td>
<td>L.A. Care Health Plan makes health education materials aimed at preventing alcohol abuse available for network providers to distribute to members. L.A. Care Health Plan's Case Managers and Social Workers provide counseling and referrals to treatment programs and sober living programs.</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>Yes, (but not directly)</td>
<td>Drug abuse prevention health education materials. Case management services for members with substance abuse issues.</td>
<td>Case management</td>
<td>California's Smokers Helpline - Offer smoking cessation support all members identified as smokers. If member is interested, refer to California's Smokers Help Line via a warm transfer and fulfill requests for Nicotine Replacement Therapy as requested by provider.</td>
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<tr>
<td>Drug abuse</td>
<td>Yes</td>
<td>PHC encourages its members to seek help for drug abuse by providing health articles in the member newsletter and PHC website. Information is provided on resources that are available for members that are seeking help for drug abuse. This information is listed on PHC website, member newsletter and through individual interaction between members and PHC case managers, as appropriate.</td>
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<tr>
<td>Drug abuse</td>
<td>Yes, (but not directly)</td>
<td>We offer a list of classes available at various clinic sites. Sites offer classes according to their patient populations. SFHP financially compensates clinics and providers who offer these services through the Health Education Compensation Program. The goal of HECP is to support ongoing and sustainable health education activities by rewarding efforts that help keep our members healthy.</td>
<td>Health Education Compensation Program</td>
<td>1. incentivize clinics and provider sites to offer group health classes to SFHP members. 2. support efforts by clinics/providers to keep members healthy. Health education classes on nutrition, healthy eating, etc.</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>No</td>
<td></td>
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<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>Your Ticket to Health - Alliance program Weight Watchers - indirect program Healthy Hearts - contracted program for children We pay for members to attend various healthy living (eating and exercise) classes at local clinics and hospitals.</td>
<td>Weight Watchers</td>
<td>Weight Watchers Program  At Weight Watchers meetings members will learn to follow the PointsPlus program. They receive guidance, strategies and tips plus: a leader who has lost weight on the program, a supportive and caring environment, helpful tools, guides and recipes. The 3 step PowerStart program will help set members up for success.</td>
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<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>Adult Obesity Prevention program (launched 2012), Childhood Obesity prevention program subject to approval), Preventive Care medicaid form ( created by Anthem Blue Cross) and used as a tool for providers to counsel members on nutrition. Get up Get moving Booklets; BMI Materials also promote healthy lifestyles.</td>
<td>BMI Materials - Provider Toolkits</td>
<td>Provider toolkits were distributed to provider offices along with face to face and online BMI training. The toolkits include brochures on healthy eating; physical activity; growth charts and BMI Wheels.</td>
</tr>
<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>Direct member nutritional education</td>
<td>Direct member nutritional education</td>
<td>Registered Dietitian provides counseling and completes assessment, goals &amp; objectives are identified. Registered Dietitian and member determine the length (number of sessions) that may be needed to accomplish goals.</td>
</tr>
<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>Fit Families for Life suite of programs a. Home Edition b. Coaching Program c. Breastfeeding and Nutrition Support Line d. Community Classes</td>
<td>Fit Families for Life-Coaching Program</td>
<td>Members ages 6-20 with a 95 BMI percentile are referred by their doctor into the Coaching program. Members will get up to five coaching calls with a nutrition nurse or dietitian to help members complete the Home Edition and address additional nutrition and/or physical activity concerns. Members have unlimited inbound calls to the nurse/dietitian. Knowledge, intentions and behaviors are recorded pre and post intervention. Note that other Fit Families for Life programs do not require a provider’s referral. Members can participate on their own will.</td>
</tr>
<tr>
<td>Healthy Eating</td>
<td>Yes, (but not directly)</td>
<td>1. Healthy Weight for a Lifetime 2. Community programs offered through hospitals and community organizations</td>
<td>Healthy Weight for a Lifetime</td>
<td>Discuss healthy eating using MyPlate models, fat tubes, labels, and food models. Encourage members to slowly change eating patterns to look like MyPlat. Teach members how to read and compare food labels. Show how portion sizes have increased over the years. Discuss good and bad fats. Encourage members to discuss the three types of exercise. Member who attend the class get a healthy eating cookbook and a pedometer.</td>
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<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>Live Better Make a Change program Eating to Feel Your Best booklet for adult members Nutrition education counseling with a contracted registered dietitian - up to 2 hours per month</td>
<td>Live Better - Make a Change (Viva Mejor - Haga un Cambio)</td>
<td>Families with a pediatric member identified as obese/overweight is mailed information on simple things families can do to eat healthier and be more active. The parent completes an enrollment form where they indicate the healthy changes they want to make. Parents receive a free recipe book and Big 5 store discount coupons, and information they request about community programs and registered dietitians contracted with the health plan. An evaluation form is mailed 3-4 months later.</td>
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<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>Weight Watchers Support program; Healthy Weight for Life program</td>
<td>Healthy Weight for Life program</td>
<td>Healthy Weight for Life (HWL) is a program designed to promote healthy lifestyles, self-care and the prevention of chronic disease. The goal is to assist members who are overweight or obese with improving their knowledge about eating healthy, being more active, and maintaining a healthy weight.</td>
</tr>
<tr>
<td>Healthy Eating</td>
<td>Yes, (but not directly)</td>
<td>Healthy eating information is added continuously on our member newsletter. Tip sheets encourage drinking water vs sugary drinks, and eating more fruits and vegetables. Healthy recipes are located directly on our website as well. We also provide a Disease Management Program and incentives for participating in healthy eating activities</td>
<td>Disease Management Program for Obese children ages 2-11 who are &gt;95% BMI</td>
<td>Medical providers refer members over the 95% BMI. Disease management nurse then screens and refers member and family to appropriate health education resources, encourages change, sets goals with family, and mails tip sheets.</td>
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<tr>
<td>Healthy Eating</td>
<td>Yes, (but not directly)</td>
<td>Member Newsletter</td>
<td>None Provided</td>
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<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>Fit Families for Life suite of programs a. Home Edition b. Coaching Program c. Breastfeeding and Nutrition Support Line d. Community Classes e. Rethink Your Drink and Flex Your Health through T2X</td>
<td>Fit Families for Life-Coaching Program</td>
<td>Members ages 6-20 with a 95 BMI percentile are referred by their doctor into the Coaching program. Members will get up to five coaching calls with a nutrition nurse or dietitian to help members complete the Home Edition and address additional nutrition and/or physical activity concerns. Members have unlimited inbound calls to the nurse/dietitian. Knowledge, intentions and behaviors are</td>
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<tr>
<td>Healthy Eating</td>
<td>Yes, (but not directly)</td>
<td>Community Wellness Grants to Delta Health Care, Emergency Food Bank &amp; Family Services, Boys and Girls Club of Tracy, Haven of Peace, and Puentes-Boggs Tract Community Farm Program.</td>
<td>recorded pre and post intervention. Note that other Fit Families for Life programs do not required a provider’s referral. Members can participate on their own will.</td>
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<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>Shapedown</td>
<td>Shapedown</td>
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<tr>
<td>Healthy Eating</td>
<td>Yes, (but not directly)</td>
<td>Super Nutricia</td>
<td>Super Nutricia</td>
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<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>Healthy Eating Active Living (3 different classes: Toddlers/Kids, Teens, and Adults) Nutrition Counseling (MD Referral) Nutrition Advice Line Nourish - Healthy Eating (Online) Onsite Farmer's Markets (6 locations) Health Education Resources available through the Health Education Centers</td>
<td>Healthy Eating, Active Living</td>
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1) Conduct 10 nutrition trainings for parents - at least 10 parents/sessions (8,000 total parents)  
2) Provide fresh produce to 20,000 underserved client families with 2 mobile vans  
3) Nutrition educators educate, raise awareness and induce behavioral change through nutrition  
4) Provide onsite cooking demonstrations with recipes using fresh produce and healthy cooking ingredients alternatives  

HPSM offers the Shapedown program for children 6-18. It is a family centered weight management program for children and their families. It is offered as a group class once a week for 2 hours for a total of 8 weeks. It also includes an initial assessment prior to participating in group and a one month individual follow-up.

IEHP created a Super Hero, Super Nutricia, who promotes healthy eating and being active to combat childhood obesity. She performs a skit at community events where she battles junk food villains and couch potato. She has her own website within the plan’s website. Members can receive her comic book, placemat, bookmarks, and other tools to promote healthy eating and physical activity.

Healthy eating and exercise habits begin at home. We're here to help you and your school-age children develop a healthy lifestyle together. We'll cover basic nutrition principles and strategies on how to increase energy and fitness with activities the whole family can enjoy.
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<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>• Healthy Eating and Active Lifestyle Classes • Individual health education appointments with a health plan health educator or dietitian • Heart Healthy Lifestyle Classes (offered indirectly through a partner agency) • Diabetes Education Classes (offered indirectly through a partner agency) • In home education visits (offered indirectly through a partner agency) • Health education materials mailed to members • Diabetes management text message pilot project</td>
<td>Healthy Eating and Active Lifestyle Class</td>
<td>The Healthy Eating and Active Lifestyle Class provides members with hands-on and practical activities and discussions to help members identify ways to integrate healthy eating and physical activity into their lifestyle. This class is intended to help members manage their weight. Participants are generally members who were referred by their PCP or self-referred themselves to the class. The topics of the class include: • MyPlate and identifying examples of food groups • Food portion size examples of foods from all of food groups • How to read nutrition labels • How to be a whole grain detective and identify whole grains • Favorite recipe makeovers • Easy cooking demos, such as green smoothies and bean dip with vegetables • Short exercise routines, including Zumba moves, strength, and yoga Members receive incentives, such as measuring cups, pedometers and recipe booklets by actively participating in the class activities. The class is evaluated with a brief post-class knowledge evaluation questionnaire, and 3-month follow-up calls.</td>
</tr>
<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>Weight Watchers, My Healthy Plate, Eat and Play in a Healthy Way, e.n.e.r.g.y., Snack Right!</td>
<td>Snack Right! Healthy Eating Wellness Workshop</td>
<td>A one-hour, one-session wellness workshop which discusses basic nutrition with emphasis on healthy snacking for children and the rest of the family.</td>
</tr>
<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>Medical visit assessment IHEBA; provides educational materials; referral for dietitian consults or weight management as needed; community outreach for healthy eating and prevention of obesity.</td>
<td>1:1 consultations by a Registered Dietitian, Health Educator or Nurse.</td>
<td>Access to healthy eating or dietary consultations are made available to all members. The services are promoted to members via through members welcome packets, website and through their providers. Members may self refer or providers may refer their members for this service.</td>
</tr>
<tr>
<td>Healthy Eating</td>
<td>Yes, (but not directly)</td>
<td>Take Off Pounds Sensibly (TOPS) Medical Nutrition Therapy</td>
<td>Take Off Pounds Sensibly (TOPS)</td>
<td>PHC offers this intervention by paying the enrollment fees for members up to age 65 with a BMI of 30 or greater. Members who are at risk may be considered for the program on a case-by-case basis with a BMI of 25 or greater and additional risk factors such as diabetes, family history of diabetes, high cholesterol, sleep apnea, etc. Members must have a certificate signed by their PCP</td>
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<td>Healthy Eating</td>
<td>Yes, (but not directly)</td>
<td>We offer a list of classes available at various clinic sites. Sites offer classes according to their patient populations. SFHP financially compensates clinics and providers who offer these services through the Health Education Compensation Program. The goal of HECP is to support ongoing and sustainable health education activities by rewarding efforts that help keep our members healthy.</td>
<td>1. incentivize clinics and provider sites to offer group health classes to SFHP members. 2. support efforts by clinics/providers to keep members healthy. Health education classes on nutrition, healthy eating, etc.</td>
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<tr>
<td>Healthy Eating</td>
<td>Yes</td>
<td>5 Keys Program</td>
<td>5 Keys Program</td>
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<tr>
<td>Overweight/obesity</td>
<td>Yes</td>
<td>Your Ticket to Health Weight Watchers Referral and payment for various classes/programs offered by local clinics and hospitals.</td>
<td>The Your Ticket to Health program provides support and incentives to Alliance members interested in taking steps toward a healthier lifestyle and managing or losing weight. This program will depend on the collaboration of community classes, meetings and facilities which are or will become part of our network of nutrition and exercise resources available to Alliance members. Participating Alliance members will receive phone support from our Health Coaches who will: • Discover what is the best first steps for them • Send health information and tools to help...</td>
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<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes</td>
<td>Adult Obesity prevention; childhood obesity Prevention (subject to approval); Obesity task Force with CA Health Collaborative (pending) Fresno and Madera Counties only.</td>
<td>Adult Obesity Prevention</td>
<td>Automated calls are delivered to members over 18 years of age who are identified as obese/over weight based on claims diagnosis. Messaging included in the calls focuses on healthy eating; annual check-ups; stress; sleep and physical activity.</td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes</td>
<td>Overweight/Obesity Prevention education</td>
<td>Overweight/Obesity Prevention education</td>
<td>Provide telephone and face-to-face counseling regarding how to prevent obesity. Mail targeted newsletters to members who are at risk for obesity, topics include: healthy eating, physical activity, healthy cooking and healthy habits.</td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes</td>
<td>Fit Families for Life suite of programs a. Home Edition  b. Coaching Program c. Breastfeeding and Nutrition Support Line d. Community Classes</td>
<td>Fit Families for Life-Coaching Program</td>
<td>Members ages 6-20 with a 95 BMI percentile are referred by their doctor into the Coaching program. Members will get up to five coaching calls with a nutrition nurse or dietitian to help members complete the Home Edition and address additional nutrition and/or physical activity concerns. Members have unlimited inbound calls to the nurse/dietitian. Knowledge, intentions and behaviors are recorded pre and post intervention. Note that other Fit Families for Life programs do not require a provider’s referral. Members can participate on their own will.</td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes, (but not directly)</td>
<td>Community programs, referral to Registered Dietitians and Health Plan Classes.</td>
<td>Healthy Weight for a Lifetime</td>
<td>Discuss healthy eating using MyPlate models, fat tubes, labels, and food models. Encourage members to slowly change eating patterns to look like MyPlate. Teach members how to read and compare food labels. Show how portion sizes have increased over the years. Discuss good and bad fats. Encourage members to discuss the three types of exercise. Member who attend the class get a healthy eating cookbook and a pedometer.</td>
</tr>
<tr>
<td>Program Type</td>
<td>Program Offered</td>
<td>All Interventions</td>
<td>Intervention Described</td>
<td>Intervention Description</td>
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<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes</td>
<td>Being Active to Feel Your Best booklet for adult members  Bike Safety - article in member newsletter, May 2012 ; free community bike maps Live Better Make a Change program and Big 5 discount coupons (for purchase of shoes/helmets, sporting equipment/clothes.</td>
<td>Live Better - Make a Change (Viva Mejor - Haga un Cambio)</td>
<td>Families with a pediatric member identified as obese/overweight is mailed information on simple things families can do to eat healthier and be more active. The parent completes an enrollment form where they indicate the healthy changes they want to make. Parents receive a free recipe book and Big 5 store discount coupons, and information they request about community programs and registered dietitians contracted with the health plan. An evaluation form is mailed 3-4 months later.</td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td>No</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes</td>
<td>For adults we mainly provide access to patient educators, dietician services, and group appointments For children we offer the same services but also provide a Quality Improvement Program targeting Obese children ages 2-11 who are &gt; the 95% BMI</td>
<td>Disease Management Program Obese children ages 2-11 who are &gt; the 95% BMI</td>
<td>Medical providers refer members over the 95% BMI. Disease management nurse then screens and refers member and family to appropriate health education resources, encourages change, sets goals with family, and mails tip sheets.</td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes (but not directly)</td>
<td>GCHP works with local community partners</td>
<td>None Provided</td>
<td>None Provided</td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes</td>
<td>Fit Families for Life suite of programs a. Home Edition b. Coaching Program c. Breastfeeding and Nutrition Support Line d. Community Classes e. Rethink Your Drink and Flex Your Health through T2X</td>
<td>Fit Families for Life - Coaching Program</td>
<td>Members ages 6-20 with a 95 BMI percentile are referred by their doctor into the Coaching program. Members will get up to five coaching calls with a nutrition nurse or dietitian to help members complete the Home Edition and address additional nutrition and/or physical activity concerns. Members have unlimited inbound calls to the nurse/dietitian. Knowledge, intentions and behaviors are recorded pre and post intervention. Note that other Fit Families for Life programs do not require a provider’s referral. Members can participate on their own will.</td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes (but not directly)</td>
<td>HPSJ provides a toolkit to providers to assess members’ risk of overweight/obesity. HPSJ also provides Community Wellness Grants</td>
<td>Delta Health Care - Healthy Teens/Smart Teens Program</td>
<td>Classroom presentations include education on nutrition, physical activity, and healthy weight. Clinic visits address weight as needed.</td>
</tr>
<tr>
<td>Program Type</td>
<td>All Interventions</td>
<td>Program Offered</td>
<td>Interventions Description</td>
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<tr>
<td>Overweight/obesity Prevention</td>
<td></td>
<td>Yes</td>
<td>shapes down</td>
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<tr>
<td>Overweight/obesity Prevention</td>
<td></td>
<td>Yes</td>
<td>PCP clinical health education to members before and after BMI assessment of members and education by PCPs.</td>
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<tr>
<td>Overweight/obesity Prevention</td>
<td></td>
<td>Yes</td>
<td>IEHP Weight Loss Programs</td>
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<tr>
<td>Overweight/obesity Prevention</td>
<td></td>
<td>Yes</td>
<td>Managing Your Weight (Group Class)</td>
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<tr>
<td>Overweight/obesity Prevention</td>
<td></td>
<td>Yes</td>
<td>Heart Healthy Lifestyle Classes (offered indirectly through a partner agency)</td>
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<tr>
<td>Overweight/obesity Prevention</td>
<td></td>
<td>Yes</td>
<td>Diabetes Education Classes (offered indirectly through a partner agency)</td>
<td></td>
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<tr>
<td>Overweight/obesity Prevention</td>
<td></td>
<td>Yes</td>
<td>In home education visits (offered indirectly through a partner agency)</td>
<td></td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td></td>
<td>Yes</td>
<td>Health education materials mailed to members</td>
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**Intervention Description:**

- **HPFS** offers the Shapedown program for children 6-18. It is a family-centered weight management program for children and their families. It is offered as a group class once a week for 2 hours for a total of 8 weeks. It also includes an initial assessment prior to participating in the group and a one-month follow-up visit to community partners/agencies providing education/services to prevent overweight/obesity.

- Some weight loss programs are time-limited - 6-8 weekly sessions - that provide education on reading food labels, and portion size control. Some programs are very-low-calorie, medically-supervised weight loss programs that help members lose weight at a quicker pace and then maintain the weight loss through healthy eating. There is also an ongoing weight loss program that can support members until they reach a healthy BMI.

- Losing weight and keeping it off requires more than just cutting calories. Learn the latest research on weight loss, how to get started, how to keep it off, and about various programs Kaiser Permanente offers that support healthy lifestyle choices for successful, long-term weight loss.

- The Healthy Eating and Active Lifestyle Class provides members with hands-on and practical activities and discussions to help members identify ways to integrate healthy eating and physical activity into their lifestyle. This class is intended to help members manage their weight. Participants are generally members who were referred by their PCP or self-referred themselves to the class. The topics of the class include: • MyPlate and identifying examples of foods from all of the food groups • How to read nutrition labels • How to be a whole grain detective • Easy recipe makeovers • Favorite recipe makeovers • Exercise and physical activity

- The Healthy Eating and Active Lifestyle Class provides individualized health education and lifestyle coaching. Participants receive dietitian appointmentswo and personalized nutrition and lifestyle coaching from a dietitian. The class also includes guided physical activity sessions and education sessions to promote healthy eating and physical activity.
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<tr>
<th>Program Type</th>
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<th>All Interventions</th>
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<tbody>
<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes</td>
<td>message pilot project</td>
<td></td>
<td>cooking demos, such as green smoothies and bean dip with vegetables • Short exercise routines, including Zumba moves, strength, and yoga Members receive incentives, such as measuring cups, pedometers and recipe booklets by actively participating in the class activities. The class is evaluated with a brief post-class knowledge evaluation questionnaire, and 3-month follow-up calls.</td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes</td>
<td>Weight Watchers, My Healthy Plate, Eat and Play in a Healthy Way, e.n.e.r.g.y., Snack Right!</td>
<td>Snack Right! Healthy Eating Wellness Workshop</td>
<td>A one-hour, one-session wellness workshop which discusses basic nutrition with emphasis on healthy snacking for children and the rest of the family.</td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes</td>
<td>Community classes in weight management; Health Educator consultations and RD consultations for children with BMI over 85th percentile.</td>
<td>Weight Watcher's</td>
<td>Overweight/obese members ages 17 and over may self-refer or be referred by the provider for Weight Watcher's for weight management. Members interested in participating in the program are mailed vouchers to utilize the program up to 6 months or 24 weeks as long as they show proof of 1/2-2lbs of weight loss per week.</td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes, (but not directly)</td>
<td>Take Off Pounds Sensibly (TOPS) Medical Nutrition Therapy</td>
<td>Take Off Pounds Sensibly (TOPS)</td>
<td>PHC offers this intervention by paying the enrollment fees for members up to age 65 with a BMI of 30 or greater. Members who are at risk may be considered for the program on a case-by-case basis with a BMI of 25 or greater and additional risk factors such as diabetes, family history of diabetes, high cholesterol, sleep apnea, etc. Members must have a certificate signed by their PCP stating that the member meets eligibility criteria and is appropriate for the program with the member's signature on the certificate. Members that enroll in the program attend weekly meetings to share tips on losing weight, exchange recipes, and lend encouragement and support.</td>
</tr>
<tr>
<td>Overweight/obesity Prevention</td>
<td>Yes, (but not directly)</td>
<td>We offer a list of classes available at various clinic sites. Sites offer classes according to their patient populations. SFHP financially compensates clinics and providers who offer these services through the Health Education Compensation Program. The goal of</td>
<td>Health Education Compensation Program</td>
<td>1. incentivize clinics and provider sites to offer group health classes to SFHP members. 2. support efforts by clinics/providers to keep members healthy. Health education classes on nutrition, healthy eating, etc.</td>
</tr>
<tr>
<td>Program Type</td>
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<tr>
<td>HECP</td>
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<td>HECIP is to support ongoing and sustainable health education activities by rewarding efforts that help keep our members healthy.</td>
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<tr>
<td>Overweight/obesity</td>
<td>Yes, (but not</td>
<td>Open Gym for members older than 13 years.</td>
<td>Open Gym for members older than 13 years.</td>
<td>Contract with gym with certified trainers. Members can access all week.</td>
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<tr>
<td>Prevention</td>
<td>directly)</td>
<td></td>
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<tr>
<td>Physical Activity</td>
<td>Yes</td>
<td>Your Ticket to Health Healthy Hearts - contracted program for children We pay for members to attend various healthy living (eating and exercise) classes at local clinics and hospitals.</td>
<td>Your Ticket to Health</td>
<td>The Your Ticket to Health program provides support and incentives to Alliance members interested in taking steps toward a healthier lifestyle and managing or losing weight. This program will depend on the collaboration of community classes, meetings and facilities which are or will become part of our network of nutrition and exercise resources available to Alliance members. Participating Alliance members will receive phone support from our Health Coaches who will: • Discover what is the best first steps for them • Send health information and tools to help them in their healthy lifestyle goals • Refer interested members to a clinic, school or community based activity or class • Discuss possible barriers to participation and how to overcome them • Track progress in the program</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Yes</td>
<td>Jump rope intervention (Northern CA); Get Up Get Active LA; Adult Obesity prevention; Childhood Obesity Prevention (subject to approval); Fit Family Program - LA</td>
<td>Get Up Get Active</td>
<td>Anthem cosponsored this initiative with California State University Northridge. Graduate level students in Kinesiology worked with residents on a regular basis to discuss activities people can participate in such as Zumba. Five hundred frisbees were given out to promote physical activity as well.</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Yes, (but not</td>
<td>Direct member counseling and make referrals to community resources</td>
<td>Member counseling provided on physical activity</td>
<td>counseling and make referrals to community resources</td>
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<td></td>
<td>directly)</td>
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<tr>
<td>Intervention Description</td>
<td>Program Type</td>
<td>Physical Activity</td>
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<tr>
<td>Fit Families for Life Coaching Program</td>
<td>Yes</td>
<td>(but not directly)</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Healthy Weight for a Lifetime</td>
<td>Yes, (but not directly)</td>
<td>Healthy Weight for a Lifetime 2</td>
<td>Yes</td>
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</tr>
<tr>
<td>Live Better - Make a Change (Viva Mejor - Haga un Cambio)</td>
<td>Yes</td>
<td>Live Better Make a Change program and Big 5 discount coupons</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Being Active to Feel Your Best book</td>
<td>Yes</td>
<td>Being Active to Feel Your Best book for adult members. Bike Safety - article in member newsletter, May 2012</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Weight Watchers Support program</td>
<td>Yes</td>
<td>Weight Watchers Support program, Healthy Weight for Life program</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Provider Counseling</td>
<td>Yes, (but not directly)</td>
<td>Provider Counseling</td>
<td>Yes</td>
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</tbody>
</table>

Members ages 6-20 with a 95 BMI percentile are referred by their doctor into the Coaching Program. Members will go through coaching calls with a nutrition nurse or dietitian. Members will address additional nutrition and physical activity concerns. Members have unlimited inbound calls to the nutrition nurse/dietitian. Knowledge, intentions and behaviors are recorded pre and post intervention. Note that all Fit Families for Life programs do not require a provider referral. Members can participate on their own will.

Program Type

- Physical Activity
- Provider Counseling

Intervention Description

1. Healthy Weight for a Lifetime
   - Discuss healthy eating using MyPlate models, fat tubes, labels, and food models. Encourage members to slowly change eating patterns to look like MyPlate. Teach members how to read and compare food labels. Show how portion sizes have increased over the years. Discuss good and bad fats. Encourage members to discuss the types of exercise. Members who attend the class get a healthy eating cookbook and a Pedometer.

2. Live Better Make a Change (Viva Mejor - Haga un Cambio)
   - Families with a pediatric member identified as obese/overweight are mailed information on simple things families can do to eat healthier and be more active. The parent completes an enrollment form where they indicate the healthy changes they want to make. Parents receive a free recipe book and Big 5 store discount coupons, and information about community programs and registered dietitians contracted with the health plan. An evaluation form is mailed 3-4 months later.

3. Healthy Weight for Life (HWL)
   - A program designed to promote healthy lifestyles, self-care, and the prevention of chronic disease. The goal is to assist members who are overweight or obese with improving their knowledge about eating healthy, being more active, and maintaining a healthy weight.

It would be helpful if DHCS set guidelines as to what is expected from disease prevention interventions. Is having expectations and goals for these interventions important?
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<tr>
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<tbody>
<tr>
<td>Physical Activity</td>
<td>Yes, (but not directly)</td>
<td>Member Newsletter</td>
<td>None Provided</td>
<td></td>
</tr>
</tbody>
</table>
| Physical Activity | Yes | Fit Families for Life suite of programs  
                      a. Home Edition  
                      b. Coaching Program  
                      c. Breastfeeding and Nutrition Support Line  
                      d. Community Classes  
                      e. Rethink Your Drink and Flex Your Health through T2X
| Fit Families for Life-Coaching Program | Members ages 6-20 with a 95 BMI percentile are referred by their doctor into the Coaching program. Members will get up to five coaching calls with a nutrition nurse or dietitian to help members complete the Home Edition and address additional nutrition and/or physical activity concerns. Members have unlimited inbound calls to the nurse/dietitian. Knowledge, intentions and behaviors are recorded pre and post intervention. Note that other Fit Families for Life programs do not require a provider’s referral. Members can participate on their own will. |
| Physical Activity | Yes, (but not directly) | HPSJ provides Community Wellness Grants to community partners to provide physical activity education/services to HPSJ members; i.e. Boys & Girls Club of Tracy, YMCA, Delta Health Care, and Give Every Child a Chance.  
<p>| Boys &amp; Girls Club of Tracy - Inclusion Program | HPSJ funding supports the Inclusion Program which provides families with high quality, after-school care for youth with physical, emotional and mental disabilities. |
| Physical Activity | Yes, (but not directly) | We refer to parks &amp; rec department and CBO | | |
| Physical Activity | Yes, (but not directly) | Super Nutricia | | IEHP created a Super Hero, Super Nutricia, who promotes healthy eating and being active to combat childhood obesity. She performs a skit at community events where she battles junk food villains and couch potato. She has her own website within the plan's website. Members can receive her comic book, placemat, bookmarks, and other tools to promote healthy eating and physical activity. |</p>
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<tbody>
<tr>
<td>Physical Activity</td>
<td>Yes</td>
<td>Online Health Coaching: Let's Get Physical Wellness Coaching (telephonic) 10,000 Steps</td>
<td>Wellness Coaching</td>
<td>Many of us need help when it comes to making healthy changes. We may want to do things differently but have a hard time actually doing what it takes. To help close the gap between &quot;thinking about change&quot; and &quot;taking action,&quot; Kaiser Permanente offered wellness coaching phone appointments and online wellness coaching at no additional fee to members.</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Yes</td>
<td>• Healthy Eating and Active Lifestyle Classes • Individual health education appointments with a health plan health educator or dietitian • Heart Healthy Lifestyle Classes (offered indirectly through a partner agency) • Diabetes Education Classes (offered indirectly through a partner agency) • In home education visits (offered indirectly through a partner agency) • Health education materials mailed to members • Diabetes management text message pilot project</td>
<td>Healthy Eating and Active Lifestyle Class</td>
<td>The Healthy Eating and Active Lifestyle Class provides members with hands-on and practical activities and discussions to help members identify ways to integrate healthy eating and physical activity into their lifestyle. This class is intended to help members manage their weight. Participants are generally members who were referred by their PCP or self-referred themselves to the class. The topics of the class include: • MyPlate and identifying examples of food groups • Food portion size examples of foods from all of food groups • How to read nutrition labels • How to be a whole grain detective and identify whole grains • Favorite recipe makeovers • Easy cooking demos, such as green smoothies and bean dip with vegetables • Short exercise routines, including Zumba moves, strength, and yoga Members receive incentives, such as measuring cups, pedometers and recipe booklets by actively participating in the class activities. The class is evaluated with a brief post-class knowledge evaluation questionnaire, and 3-month follow-up calls.</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Yes</td>
<td>e.n.e.r.g.y. (Eating nutritiously, exercising regularly, and growing &quot;Y&quot;-isely), Burn Rubber</td>
<td>e.n.e.r.g.y. (Eating nutritiously, exercising regularly, and growing &quot;Y&quot;-isely)</td>
<td>The program integrates an interactive, family-centered model. A team of highly-trained community health workers/health educators and a Registered Dietitian provide a behavior modification, culturally-sensitive, and age-appropriate approach to treatment of childhood obesity for 5 to 17 year olds. e.n.e.r.g.y. supports and educates not only the target child, but the whole family.</td>
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<tr>
<td>Program Type</td>
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<tr>
<td>Physical Activity</td>
<td>Yes, (but not directly)</td>
<td>Molina does not offer a formal physical activity program to its members. Molina's Health Education Department identifies free physical activity/exercise classes in the community and promotes them to the provider network for member referral.</td>
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<tr>
<td>Physical Activity</td>
<td>Yes</td>
<td>N/A</td>
<td>PHC encourages its members to be physically active by providing health articles in the member newsletter and PHC website. Health articles are also written in local newspapers.</td>
<td></td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Yes, (but not directly)</td>
<td>We offer a list of classes available at various clinic sites. Sites offer classes according to their patient populations. SFHP financially compensates clinics and providers who offer these services through the Health Education Compensation Program. The goal of HECP is to support ongoing and sustainable health education activities by rewarding efforts that help keep our members healthy.</td>
<td>1. incentivize clinics and provider sites to offer group health classes to SFHP members. 2. support efforts by clinics/providers to keep members healthy. Health education classes on nutrition, healthy eating, etc.</td>
<td></td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Yes</td>
<td>Summer Swimming Program</td>
<td>Using CHDP data SCFHP identified 135 members with BMI greater than 95% and 400 members with BMI greater than 85%, in the age range of 2 years to 21 years old. Outreach calls were made to each member/family the first week of May 2012. Followed by a letter to present to the City of San Jose for either a one week swim session or a pass for 11 free swims at the City pool.</td>
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<tr>
<td>Type 2 Diabetes Prevention</td>
<td>No</td>
<td></td>
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<tr>
<td>Program Type</td>
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<td>All Interventions</td>
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<tr>
<td>Type 2 Diabetes Prevention</td>
<td>Yes, (but not directly)</td>
<td>Part of the Chronic Disease Management (Condition Care Program). The 2013 diabetes incentive program for CA Medi-Cal will target noncompliant members with a planned launch 9/15/2013.</td>
<td>Diabetes incentive</td>
<td>Incentive letter offering $25 incentive gift card to each noncompliant member for getting A1C, LDL Cholesterol and Urine Microalbumin lab screening tests by 12/31/2013. This incentive letter instructs the member to call their doctor and schedule an appointment to get the lab tests. The member will be required to get all 3 lab tests to qualify for the gift card. The member's PCP is required to attest that the lab screening tests were completed by 12/31/2013 by signing the return mail-in attestation form. A second $25 incentive offering will be sent to members who have not had a dilated retinal exam in 2013. The mailing will launch 9/15/2013. The member is instructed to call and make an appointment with their eye doctor for a dilated retinal exam. The member is also instructed to tell their eye doctor that they have diabetes. The member has to complete the exam by 12/31/2013 to qualify for the gift card. The member's eye care provider will be required to sign the return mail-in attestation form to confirm the exam was completed.</td>
</tr>
<tr>
<td>Type 2 Diabetes Prevention</td>
<td>Yes</td>
<td>a). Provider and member lab reminder mailings to encourage members to get lab tests (ie, HbA1c and LDL) b). Medi-Cal Provider Incentives for HbA1c Screening c). Articles in member newsletters d). Articles in mailed member health guide e). Share clinical practice guidelines with providers</td>
<td>Medi-Cal Provider Incentives for HbA1c screening</td>
<td>Providers were given $100/screening (up to 2 screenings) for each member who was diagnosed with diabetes and got an HbA1c screening.</td>
</tr>
<tr>
<td>Type 2 Diabetes Prevention</td>
<td>Yes</td>
<td>Diabetes-Be In Charge disease management program Diabetes community education classes</td>
<td>Diabetes-Be In Charge disease management program</td>
<td>Using claims, encounter and pharmacy data, members 21 and older who have type 2 diabetes are identified and invited to join the disease management program. Members are stratified into low and high risk based on how frequent they have visited the ER or inpatient in the last 12 months relating to their diabetes. Low risk members get educational mailing and IVR twice a year and unlimited</td>
</tr>
<tr>
<td>Program Type</td>
<td>Program Offered</td>
<td>All Interventions</td>
<td>Intervention Described</td>
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</tr>
<tr>
<td>Type 2 Diabetes Prevention</td>
<td>Yes, (but not directly)</td>
<td>Community Programs</td>
<td></td>
<td>access to a disease management nurse. High risk members get nurse outbound calls and appropriate educational mailings to help them meet their action plan. Members also have unlimited inbound calls to a disease management nurse.</td>
</tr>
<tr>
<td>Type 2 Diabetes Prevention</td>
<td>No</td>
<td></td>
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<tr>
<td>Type 2 Diabetes Prevention</td>
<td>Yes</td>
<td>The Alliance offers a Clinical Health Education benefit, which covers impaired glucose tolerance.</td>
<td>Clinical Health Education benefit</td>
<td>Education is provided by a pre-approved Certified Diabetes Educator, Registered Dietician, or physician. Members receive up to 10 hours of a combination of one-on-one and group education in the initial 12-month period, plus 2 hours of education every year thereafter.</td>
</tr>
<tr>
<td>Type 2 Diabetes Prevention</td>
<td>Yes</td>
<td>Health information in our member newsletter, printed materials. Members have access to patient educators and dietitian services.</td>
<td>Dietitian services</td>
<td>Not familiar with the objective, services are directly from the provider</td>
</tr>
<tr>
<td>Type 2 Diabetes Prevention</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 2 Diabetes Prevention</td>
<td>Yes</td>
<td>Diabetes-Be In Charge disease management program Diabetes community education classes</td>
<td>Diabetes-Be In Charge disease management program</td>
<td>using claims, encounter and pharmacy data, members 21 and older who have type 2 diabetes are identified and invited to join the disease management program. Members are stratified into low and high risk based on how frequent they have visited the ER or inpatient in the last 12 months relating to their diabetes. Low risk members get educational mailing and IVR twice a year and unlimited access to a disease management nurse. High risk members get nurse outbound calls and appropriate educational mailings to help them meet their action plan. Members also have unlimited inbound calls to a disease management nurse.</td>
</tr>
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<thead>
<tr>
<th>Program Type</th>
<th>Program Offered</th>
<th>All Interventions</th>
<th>Intervention Described</th>
<th>Intervention Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2 Diabetes</td>
<td>Yes</td>
<td>Diabetes prevention/intervention services are provided by HPSJ case managers, social workers and health navigators. We provide member incentives for following Diabetes guidelines for testing and treatment, i.e. A1c, LDL, BP, eye, kidney, etc.</td>
<td>Members at risk of type 2 diabetes participate in a HRA which allows staff to address their needs.</td>
<td>Includes one on one education, community classes, educational materials and peer support groups.</td>
</tr>
<tr>
<td>Prevention</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Yes, (but not directly)</td>
<td>Various diabetes are subcontracted.</td>
<td></td>
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<tr>
<td></td>
<td>Yes</td>
<td>1) IEHP Diabetes Self-Management Program (classes)  2) IEHP Diabetes booklets series  3) IEHP Diabetes Self-Care Guide and Tip Sheets  4) PCP clinical health education to members</td>
<td>IEHP Diabetes Self-Management Program</td>
<td>Health Education Dept. contracts with Registered Dietitians, Certified Diabetes Educators, Registered Nurses, and Diabetes Treatment Centers to conduct the IEHP Diabetes Self-Management Program consisting of individual and/or group classes for adult members with diabetes. The Health Education Dept. also developed a series of diabetes booklets, a Diabetes Self-Care Guide and associated Tip Sheets for our classes and Care Management staff to assist them in educating members.</td>
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<tr>
<td></td>
<td>Yes</td>
<td>Prediabetes Diabetes Basics Living Well with Diabetes Diabetes Care Management Program Diabetes and Nutrition Meal Planning for Diabetes Diabetes Support Group</td>
<td>Diabetes Basics</td>
<td>Learn the basics of managing your type two diabetes so you can feel better and be active and healthy. In this class, we give you an overview of the five key areas of type 2 diabetes management: healthy eating, exercise, monitoring your blood sugar levels, proper use of medication, and managing stress. Bring your blood glucose monitor to class.</td>
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<tr>
<td></td>
<td>Yes</td>
<td>• Individual health education appointments with a health plan health educator or dietitian • Diabetes Education Classes (offered indirectly through a partner agency) • In home education visits (offered indirectly through a partner agency) • Health education materials mailed to</td>
<td>Diabetic Clinic</td>
<td>The diabetic clinic is designed to be a &quot;One Stop Shop&quot; providing comprehensive preventive and pharmacologic intervention including nutrition classes, PharmD counseling, foot and eye exams, and lab specimen acquisition. It should function as a specialty/ancillary clinic allowing PCP buy-in and collaboration.</td>
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<tr>
<td>Program Type</td>
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<tr>
<td></td>
<td></td>
<td>members • Diabetes management text message pilot project • Disease Management care manager outreach calls • Diabetic Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 2 Diabetes Prevention</td>
<td>Yes</td>
<td>Diabetes Basics &quot;Sugar in the Blood&quot;</td>
<td>Diabetes Basics &quot;Sugar in the Blood&quot;</td>
<td>A 1.5 hour in-person education session that teaches basic diabetes in easy-to-understand terms, risk factors for diabetes, symptoms of diabetes, the importance of knowing blood sugar numbers, and ways to prevent or control diabetes. The session is divided into three modules: 1) Health education/risk information, 2) Nutrition, and 3) Medication adherence.</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Healthy Living with Diabetes and Complex Case Management</td>
<td>Complex case management program</td>
<td>Complex case management services are provided by the primary care provider, in collaboration with Molina's Complex case manager and includes basic case management services, management of acute and chronic illness, including emotional and social support issues by a multidisciplinary case management team, intense coordination of resources to ensure member regains optimal health or improved functionality, and the development of care plans specific to member's needs with input from member and PCP, and updating these plans at least annually. All case management activities are conducted and documented in a web-based member-centric health management database which tracks activities and progress of a member throughout the course of case management in the CCM</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>We offer a list of classes available at various clinic sites. Sites offer classes according to their patient populations. SFHP financially compensates clinics and providers who offer these services through the Health Education Compensation Program. The goal of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 2 Diabetes Prevention</td>
<td>Yes, (but not directly)</td>
<td>Health Education Compensation Program</td>
<td></td>
<td>1. incentivize clinics and provider sites to offer group health classes to SFHP members. 2. support efforts by clinics/providers to keep members healthy. Health education classes on nutrition, healthy eating, etc.</td>
</tr>
<tr>
<td>Program Type</td>
<td>Program Offered</td>
<td>All Interventions</td>
<td>Intervention Described</td>
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<tr>
<td>HECP</td>
<td></td>
<td>HECP is to support ongoing and sustainable health education activities by rewarding efforts that help keep our members healthy.</td>
<td></td>
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</tr>
<tr>
<td>Type 2 Diabetes Prevention</td>
<td>Yes, (but not directly)</td>
<td>Contracted Diabetes Education Program</td>
<td>Indian Health Center Diabetic Program</td>
<td>Educate diabetic members on their disease process Teach disease self management</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes, for those who are overweight or obese</td>
<td>Your Ticket for Health Weight Watchers</td>
<td>Your Ticket to Health</td>
<td>The Your Ticket to Health program provides support and incentives to Alliance members interested in taking steps toward a healthier lifestyle and managing or losing weight. This program will depend on the collaboration of community classes, meetings and facilities which are or will become part of our network of nutrition and exercise resources available to Alliance members. Participating Alliance members will receive phone support from our Health Coaches who will: • Discover what is the best first steps for them • Send health information and tools to help them in their healthy lifestyle goals • Refer interested members to a clinic, school or community based activity or class • Discuss possible barriers to participation and how to overcome them • Track progress in the program</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes, for those who are overweight or obese</td>
<td>Your Ticket for Health Weight Watchers</td>
<td>Your Ticket to Health</td>
<td>Weight management information is available in some of the disease management programs such as diabetes and Future Moms. The Plan, however, does not have specific weight management program.</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes</td>
<td>Childhood Obesity Prevention &amp; Treatment Program</td>
<td>Childhood Obesity Prevention &amp; Treatment Program</td>
<td>CalOptima members are mailed targeted education on healthy eating, portion control, physical activity, healthy recipes, healthy habits, and why it is important to talk to their child's doctor about a healthy weight. CalOptima physicians are sent education on how to engage with the member when talking about Body Mass Index (BMI), screenings, and how to refer to weight management program or services. CalOptima members are also encouraged to call CalOptima's Health Education to</td>
</tr>
<tr>
<td>Program Type</td>
<td>Program Offered</td>
<td>All Interventions</td>
<td>Intervention Described</td>
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</tr>
<tr>
<td>Weight Management</td>
<td>Yes, for those who are overweight or obese</td>
<td>Fit Families for Life suite of programs a. Home Edition b. Coaching Program c. Breastfeeding and Nutrition Support Line d. Community Classes</td>
<td>Fit Families for Life-Coaching Program</td>
<td>Members ages 6-20 with a 95 BMI percentile are referred by their doctor into the Coaching program. Members will get up to five coaching calls with a nutrition nurse or dietitian to help members complete the Home Edition and address additional nutrition and/or physical activity concerns. Members have unlimited inbound calls to the nurse/dietitian. Knowledge, intentions and behaviors are recorded pre and post intervention. Note that other Fit Families for Life programs do not require a provider’s referral. Members can participate on their own will.</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes, (but not directly), for those who are overweight or obese</td>
<td>We refer to community programs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Management</td>
<td>No</td>
<td>Being Active to Feel Your Best booklet for adult members Bike Safety - article in member newsletter, May 2012; free community bike maps Live Better Make a Change program and Big 5 discount coupons (for purchase of shoes/helmets, sporting equipment/clothes.</td>
<td>Live Better - Make a Change (Viva Mejor - Haga un Cambio)</td>
<td>Families with a pediatric member identified as obese/overweight is mailed information on simple things families can do to eat healthier and be more active. The parent completes an enrollment form where they indicate the healthy changes they want to make. Parents receive a free recipe book and Big 5 store discount coupons, and information they request about community programs and registered dietitians contracted with the health plan. An evaluation form is mailed 3-4 months later.</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes, for those who are overweight or obese</td>
<td>Weight Watchers Support program; Healthy Weight for Life program</td>
<td>Healthy Weight for Life program</td>
<td>Healthy Weight for Life (HWL) is a program designed to promote healthy lifestyles, self-care and the prevention of chronic disease. The goal is to assist members who are overweight or obese with improving their knowledge about eating healthy, being more active, and maintaining a healthy weight.</td>
</tr>
<tr>
<td>Program Type</td>
<td>Program Offered</td>
<td>All Interventions</td>
<td>Intervention Described</td>
<td>Intervention Description</td>
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</tr>
<tr>
<td>Weight Management</td>
<td>Yes, for those who are obese</td>
<td>Disease management program for Obese children ages 2-11 who are &gt; the 95% BMI, dietitian services, group appointments, and patient educators are all available.</td>
<td>Disease Management Program Obese children ages 2-11 who are &gt; the 95% BMI</td>
<td>Medical providers refer members over the 95% BMI. Disease management nurse then screens and refers member and family to appropriate health education resources, encourages change, sets goals with family, and mails tip sheets.</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Don’t know</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes</td>
<td>Fit Families for Life suite of programs a. Home Edition b. Coaching Program c. Breastfeeding and Nutrition Support Line d. Community Classes e. Rethink Your Drink and Flex Your Health through T2X</td>
<td>Fit Families for Life-Coaching Program</td>
<td>Members ages 6-20 with a 95 BMI percentile are referred by their doctor into the Coaching program. Members will get up to five coaching calls with a nutrition nurse or dietitian to help members complete the Home Edition and address additional nutrition and/or physical activity concerns. Members have unlimited inbound calls to the nurse/dietitian. Knowledge, intentions and behaviors are recorded pre and post intervention. Note that other Fit Families for Life programs do not required a provider’s referral. Members can participate on their own will.</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes, (but not directly), for those who are overweight or obese</td>
<td>HPSJ members are referred to Community Resources that are available for nutrition and counseling, physical activity and recreation resources. SJC Public Health Services distributes a toolkit, “Tools and Resources for Collaboration” through their CHDP program. This is a resource directory for weight management resources in SJC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes, for those who are overweight or obese</td>
<td>Shapedown</td>
<td>Shapedown</td>
<td>HPSSM offers the Shapedown program for children 6-18. It is a family centered weight management program for children and their families. It is offered as a group class once a week for 2 hours for a total of 8 weeks. It also includes an initial assessment prior to participating in group and a one month individual follow-up.</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes, for those who are overweight or obese</td>
<td>PCP clinical health education to members; BMI assessment of</td>
<td>IEHP Weight Loss Programs</td>
<td>Some weight loss programs are time-limited - 6-8 weekly sessions - that provide education on reading food labels,</td>
</tr>
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*Note: Some programs may vary in availability and requirements based on specific health conditions and referrals.*
<table>
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<tr>
<th>Program Type</th>
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<th>All Interventions</th>
<th>Intervention Described</th>
<th>Intervention Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Management</td>
<td>Yes, for those who are overweight or obese</td>
<td>Healthy Eating and Label Reading In the Kitchen with Carole- Online program Online Health Coaching: S.M.A.R.T. Eating Weight Management Information Line Weight Management Support Group Managing Your Weight</td>
<td>Managing Your Weight</td>
<td>Losing weight and keeping it off requires more than just cutting calories. Learn the latest research on weight loss, how to get started, how to keep it off, and about various programs Kaiser Permanente offers that support healthy lifestyle choices for successful, long-term weight loss.</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes</td>
<td>• Healthy Eating and Active Lifestyle Classes • Individual health education appointments with a health plan health educator or dietitian • Heart Healthy Lifestyle Classes (offered indirectly through a partner agency) • Diabetes Education Classes (offered indirectly through a partner agency) • In home education visits (offered indirectly through a partner agency) • Health education materials mailed to members • Diabetes management text message pilot project</td>
<td>Healthy Eating and Active Lifestyle Class</td>
<td>The Healthy Eating and Active Lifestyle Class provides members with hands-on and practical activities and discussions to help members identify ways to integrate healthy eating and physical activity into their lifestyle. This class is intended to help members manage their weight. Participants are generally members who were referred by their PCP or self-referred themselves to the class. The topics of the class include: • MyPlate and identifying examples of food groups • Food portion size examples of foods from all of food groups • How to read nutrition labels • How to be a whole grain detective and identify whole grains • Favorite recipe makeovers • Easy cooking demos, such as green smoothies and bean dip with vegetables • Short exercise routines, including Zumba moves, strength, and yoga Members receive incentives, such as measuring cups, pedometers and recipe booklets by actively participating in the class activities. The class is evaluated with a brief post-class knowledge evaluation questionnaire, and 3-month follow-up calls.</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes</td>
<td>members and education by PCPs, IEHP Weight Loss Programs</td>
<td></td>
<td>portion size control, exercise, stress management, and family interventions. Some programs are very-low-calorie, medically-supervised weight loss programs that help members lose weight at a quicker pace and then maintain the weight loss through healthy eating. There is also an ongoing weight loss program that can support members until they reach a healthy BMI.</td>
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<tr>
<td>Program Type</td>
<td>Program Offered</td>
<td>All Interventions</td>
<td>Intervention Described</td>
<td>Intervention Description</td>
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</tr>
<tr>
<td>Weight Management</td>
<td>Yes, for those who are overweight or obese</td>
<td>Weight Watchers, e.n.e.r.g.y., My Health Plate, Eat and Play in a Healthy Way, Snack Right!</td>
<td>e.n.e.r.g.y. (Eating nutritiously, exercising regularly, and growing &quot;Y&quot;-isely)</td>
<td>The program integrates an interactive, family-centered model. A team of highly-trained community health workers/health educators and a Registered Dietitian provide a behavior modification, culturally-sensitive, and age-appropriate approach to treatment of childhood obesity for 5 to 17 year olds. e.n.e.r.g.y. supports and educates not only the target child, but the whole family.</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes, for those who are overweight or obese</td>
<td>Community classes in weight management; Health Educator consultations and RD consultations for children with BMI over 85th percentile.</td>
<td>Weight Watcher's</td>
<td>Overweight/obese members ages 17 and over may self-refeer or be referred by the provider for Weight Watcher's for weight management. Members interested in participating in the program are mailed vouchers to utilize the program up to 6 months or 24 weeks as long as they show proof of 1/2-2lbs of weight loss per week.</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes, (but not directly), for those who are overweight or obese</td>
<td>Medical Nutrition Services (MNS)</td>
<td>Medical Nutrition Services (MNS)</td>
<td>PHC provides an enhanced benefit Medical Nutrition Services (MNS) for children and adults. Children age 0-20 and adults 21 and older can receive this benefit under certain medical conditions, overweight and obesity being one of the criteria. This intervention also applies to members with chronic conditions, children that are underweight or failure to thrive, substance abuse with related nutritional deficiencies, malnutrition and or eating disorders and cancer to name a few. The MNS must be provided by a California licensed register dietitian or certified Diabetes Educator contracted with PHC.</td>
</tr>
<tr>
<td>Weight Management</td>
<td>Yes, (but not directly)</td>
<td>We offer a list of classes available at various clinic sites. Sites offer classes according to their patient populations. SFHP financially compensates clinics and providers who offer these services through the Health Education Compensation Program. The goal of HECP is to support ongoing and sustainable health education activities by rewarding efforts that help keep our members healthy.</td>
<td>Health Education Compensation Program</td>
<td>1. incentivize clinics and provider sites to offer group health classes to SFHP members. 2. support efforts by clinics/providers to keep members healthy. Health education classes on nutrition, healthy eating, etc.</td>
</tr>
<tr>
<td>Program Type</td>
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<td>Intervention Described</td>
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<tr>
<td>Weight Management</td>
<td>Yes, (but not directly), for those</td>
<td>Members meet with Physicians, R.D., and</td>
<td></td>
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<tr>
<td></td>
<td>who are overweight or obese</td>
<td>psychology to assist member in individual plan.</td>
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</tbody>
</table>

Stanford Hospital Weight Loss Program

Members meet with Physicians, R.D., and psychology to assist member in individual plan.
Works Cited


Appendix M: Welltopia by DHCS Facebook Page
Appendix M

Welltopia by DHCS

Government Organization
Find great tips about nutrition, physical activity, quitting smoking, melting away stress, and more!
Live Well and Be Well.

About – Suggest an Edit
Photos
Likes
Quit Smoking
Farmer's Market

Post
Write something...

Welltopia by DHCS shared a link.
October 22

#Fall harvest brings us lots of good #fruits & #veggies! This time of year, try any variety of squash, pears, brussels sprouts, apples, and sweet potatoes! Which is your favorite? http://ow.ly/p3yhz

Fall Farmers' Market Finds
ow.ly

Enjoy the season's best with these 10 fall fruit recipes.

Like · Comment · Share

3 people like this.
Appendix N: Welltopia by DHCS Facebook Report
Appendix N

Welltopia by DHCS - Facebook Ads - Report - Summary

A summary of the Facebook Ads campaign September 2013
Campaign launched on 9/11—this report covers 2 full weeks from 9/11-9/25

We began with 6 ads using images from our Welltopia by DHCS Facebook page

We chose to pay for ‘impressions’ and for every 1000 times our ad was seen, we would pay the value of the ad space on that day (determined by Facebook algorithms).

We optimized our audience (to increase our chances of Likes) using the Facebook Ad Manager. We targeted our audience based on their location, age, gender and precise interests.

At the end of Week 1, we had gained 425 Likes in our campaign

<table>
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<th>DAY</th>
<th>LIKES (actual)</th>
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<td>Weds</td>
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<tr>
<td>Thurs</td>
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<td>412</td>
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<tr>
<td>Fri</td>
<td>37</td>
<td>469</td>
</tr>
<tr>
<td>Sat</td>
<td>54</td>
<td>506</td>
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<tr>
<td>Sun</td>
<td>65</td>
<td>569</td>
</tr>
<tr>
<td>Mon</td>
<td>61</td>
<td>630</td>
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<tr>
<td>Tues</td>
<td>76</td>
<td>704</td>
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<tr>
<td>Weeks</td>
<td>252</td>
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We learned that 4 of our ads were not performing, and opted to pause them and allow the 2 successful ads to continue for Week 2.
We adjusted our audience based on Week 1 results—to further optimize our impressions.

At the end of Week 2, we had gained another 476 Likes in our campaign.

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<td>Tues</td>
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<td>1280</td>
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<tr>
<td>Wed</td>
<td>18</td>
<td>1340</td>
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<tr>
<td>Thurs</td>
<td>192</td>
<td>858</td>
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<tr>
<td>Fri</td>
<td>80</td>
<td>940</td>
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<tr>
<td>Sat</td>
<td>193</td>
<td>1043</td>
</tr>
<tr>
<td>Sun</td>
<td>66</td>
<td>1130</td>
</tr>
</tbody>
</table>

Our campaign demonstrated a gain in momentum, exactly as Facebook predicted.

The cost-per-like in $ began to decrease, from around $1 to around 90 cents, a further indication that our campaign was growing stronger.

Going into Week 3, one of our ads showed signs that it was beginning to plateau, so a new image was selected and lined up to keep the campaign fresh.

After a successful pilot week, followed by a gain in momentum in the second week, it was decided that the campaign should continue, and we would continue to respond to what the audience was, or was not, engaging with in our ads.

A prediction was made that we would reach 5000 Likes in 5 weeks.
Appendix O: Population Health Improvement Website Concept Paper
Population Health Improvement
Consumer Website Concept

Institute for Population Health Improvement | UC Davis Health System
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Background

The Medi-Cal Quality Improvement Program (MCQuIP) was established through a 5-year, $4.25 million Interagency Agreement (IA) between the California Department of Health Care Services (DHCS) and the UC Davis Health System’s Institute for Population Health Improvement (IPHI). Under this agreement, IPHI, in collaboration with DHCS, is charged with establishing a quality improvement program for the $63 billion per year California Medical Assistance Program (Medi-Cal). Two interrelated deliverables in the MCQuIP IA is for IPHI to: “foster partner relationships between DHCS and Medi-Cal members through strong bi-directional communication with respect to needs, responsibilities, and preferences related to healthy lifestyle” and “design a strong Medi-Cal member education, communication, and intervention platform that drives improvement in population health.”

To advance these deliverables, IPHI staff, in collaboration with DHCS, recently developed, pilot tested, and implemented a healthy lifestyle Facebook page for Medi-Cal members, with an emphasis on mother’s with school-aged children, titled Welltopia by DHCS. The Facebook page features credible information, free applications, and videos related to healthful eating, physical activity, smoking cessation, and stress management. There are also links to social and community services such as CalFresh, education, job placement, free or low-cost utilities, and other services and information. Plans are underway to feature new content in the areas of alcohol and drug abuse prevention, healthy relationships, reproductive health, among others. Daily Facebook posts have been converted into Tweets at the request of the DHCS Office of Public Affairs, and the Tweets are being disseminated through the Welltopia by DHCS Twitter account as another way to communicate healthy lifestyle information to the public.

While Facebook and Twitter communication channels are available, feedback from recent focus groups with low-income community members and published literature suggest that a consumer website is essential to support and ground the social media efforts (Medi-Cal Members Round Table Discussion, personal communication, July 17, 2013). As a result, IPHI has proposed, and DHCS has agreed, to develop, test, implement, and sustain a population health improvement website for consumers that complement the Welltopia by DHCS. In addition, the website will facilitate linkages among IPHI, DHCS, and other credible partner websites, and enables more content and links to be used by consumers, especially those who are not on Facebook and Twitter. IPHI and DHCS will collaborate on the design and content of the website, and the California Health eQuality Program will fund the development of the site. DHCS has agreed that University of California, Davis (UCD) and UCD Health System (UCDHS) policies and procedures will govern the development and execution of the website.

Following is a description of the purpose and goals of the consumer website, the primary target audience, the communication channel considerations, content and messages, evaluation, and sustainability.

- Free applications
- Surveys and polls
The website should include an interactive component that allows the audience to connect:

- Catalyze action at the community level
- Develop local resource connections
- Provide a platform for community advocacy and health empowerment (under consideration)
  - Blog(s)
  - Forum(s)
  - Open calendar
  - Tap into Vimeo links; offer people the opportunity to contribute their own video material and have it posted through the site

Given the nature of the target audience and the collaboration between the Institute and DHCS, there are special design attributes that should be taken into consideration when developing the website. The overall look and feel should embody the design characteristics of the Welltopia by DHCS Facebook page while abiding by UCD/UCDHS policies and procedures related to website design and style standards.

Specific characteristics from the Welltopia by DHCS Facebook page should be incorporated into the website including:

- Pictures that are close up, multi-cultural and feature adults, children, families, friends, and communities
- Depict mind, body, and spirit health habits, hopefulness, and empowerment

**Content and Messages**

The website will offer a constellation of health-related information in an organized and intuitive manner. Content and partnerships that are readily available are designated as Tier 1, and content, and partnerships that are under development are designated as Tier 2. At a minimum, Tier 1 content and the alcohol/drug abuse content in Tier 2 will be included in the initial development of the website.

**Healthy behaviors**

**Tier 1**

- Healthful eating (e.g., current dietary advice, tips and techniques, and benefits including tips for involving kids in food preparation; inexpensive and tasty recipes with correlated nutritional value; shopping and preparation advice; information about gardening and gleaning; brief food demonstrations; ways to improve the food environment at home, work and community; connections to local nutrition education resources such as free cooking classes; connection to local food resources such as farmers’ markets and food banks, CalFresh, Women, Infants and Children (WIC), Child and Adults Care Food Program (CACFP), and School Breakfast and Lunch Program enrollment; connections to hotlines for eating disorder; and, resources to set goals and action plans, etc.)
Credible resources and existing partners’ will include: Network for a Healthy California, USDA (SNAP-Ed Program, Farmer’s Market Nutrition Program (FMNP), Food and Nutrition Service (FNS)), Centers for Disease Control and Prevention, California Department of Social Services, Produce for Better Health Foundation, California Certified Farmers’ Markets, WIC, UC Davis Food Science and Technology Department, UC Davis Nutrition department, and UC Davis Human and Community Development

- Physical activity/play (e.g., current physical activity advice, tips and techniques, and benefits; inexpensive individual and family activities; ways to improve the physical activity environment at home, work and the community; connections to local physical activity resources such as free physical activity classes at local schools, calendar of community events, and locations of local parks/greenbelts; short fitness how-to videos; and more information on dancing, free or low-cost yoga classes; and, resources to set goals and action plans, etc.)

Credible resources and existing partners’ will include: Network for a Healthy California, Safe and Active Communities, USDA SNAP-Ed Program, Centers for Disease Control and Prevention, and Kaiser Permanente’s Every Body Walk! Campaign, and UC Davis School of Medicine

- Smoking Cessation (e.g., current quitting smoking advice, tips and techniques to quit; and resources to get counseling through the California Smokers’ Helpline; enrollment in the Medi-Cal Incentives to Quit Smoking Program; and, local advocacy for tobacco-free environments, etc.)

Credible resources and existing partners’ will include: California Tobacco Control Program, California Smokers’ Helpline, DHCS, and UC Davis Tobacco Control Evaluation Center

- Stress management (e.g., current stress management advice, tips and techniques including meditation; connections to local resources for support such as meditation/breathing classes; and, connections to hotlines for suicide, mental disorders, adolescent development, etc.)

Credible resources and existing partners’ will include: Kaiser Permanente, Centers for Disease Control and Prevention, DHCS, Substance Abuse and Mental Health Services Administration, UC Davis Student Health and Counseling Services Department, UC Davis Counseling and Psychological Services Department, UC Davis Academic and Staff Assistance Program, and the UC Davis Fitness and Wellness Center

Tier 2

- Alcohol and drug abuse: (e.g., tools for parents to talk to their teens about drugs and alcohol; resources for parents to understand the stages and warning signs of drug abuse; tools for helping and aiding recovery; information on motivating people to change; resources for Al-Anon
and Alcoholics Anonymous meetings; resources for drug rehabilitation centers and treatment facilities; and, classes, tools for understanding relapse, hotlines, etc.)

Potential resources and partners’ will include: National Institute on Alcohol Abuse & Alcoholism, National Alcohol and Substance Abuse Information Center, Substance Abuse and Mental Health Services Administration, DHCS, Drug Free Partnership, UC Davis Alcohol, UC Davis Academic and Staff Assistance Program, Tobacco and Other Drug Intervention Services Department, and others under investigation

• Healthy relationships and whole-hearted living: (e.g., Tools for taking care of infants; parenting and managing family crisis; educational pieces about starting and ending relationships; tools for parents to talk to their teens about friendship problems; resources for parents to learn how to discipline their children; resources to promote healthy relationships and communication; domestic/partner abuse information; marriage counseling resources; anger management resources; connections to hotlines for sexual assault, domestic abuse, child help, etc.)

Potential resources and partners’ will include: UC Davis Health System, UC Davis Sociology department, UC Davis Communication department, UC Davis Psychology and Psychiatry departments, UC Davis Women and Gender Studies department, and more potential resources and partners under investigation

• Safe sexual practices: (e.g., safe sex education materials; resources for birth control and sexually transmitted disease testing; and, women’s health, etc.)

Potential resources and partners’ will include: UC Davis Student Health and Counseling Services, UC Davis Women and Gender Studies department, TeenSource.org, and more potential resources and partners under investigation

• Signs, symptoms, and management of leading chronic diseases

Potential resources and partners’ will include: UC Davis Chronic Disease Management, and more potential resources and partners under investigation

Social determinants of health

The following are links to resources that address the social determinants of health. Additional links will be identified and used during the website development phase.

• Job placement resources: (e.g., interviewing tips; resume workshops; and job listings, etc.)
Potential resources and partners’ will include: UC Davis Internship and Career Center, California Work Opportunity and Responsibility for Kids (CalWORKS), California Employment Development Department (EDD), California Department of Fair Employment and Housing, CalJOBS, Career One Stop, and more potential resources and partners under investigation

- Education resources: (e.g., How to enroll in community college; scholarship information; how to get your children excited for school; information about benefits of after school programs, etc.)

Potential resources and partners’ will include: Free application for federal student aid (FASFA), California Community Colleges Chancellor’s Office, University of California, California State University, First 5 California, California Department of Education, California State Library, and more potential resources and partners under investigation

- Child care resources: (e.g., How to find childcare; rights related to childcare; financial assistance programs for childcare; resources for after school programs, etc.)

Potential resources and partners’ will include: National Resource Directory, State Children’s Health Insurance Program (SCHIP) and more potential resources and partners under investigation

- CalFresh enrollment resources: (e.g., What the program is, who is eligible, how to apply, local resources, etc.)

Potential resources and partners’ will include: California Department of Public Health, Department of Public Services, National Resource Directory, and more potential resources and partners under investigation

- WIC Enrollment resources: (e.g., Who is eligible, how to apply, local resources, etc.)

Potential resources and partners’ will include: USDA Food and Nutrition Services, California Department of Public Health, and more potential resources and partners under investigation

- Medi-Cal enrollment and Covered California resources: (e.g., How to enroll in Medi-Cal, qualifications for enrolling in Medi-Cal, explaining Health Maintenance Organization (HMO) insurance vs. Preferred Provider Organization (PPO) insurance, etc.)

Potential resources and partners’ will include: DHCS, Covered California, and more potential resources and partners under investigation

- Low-cost utility and housing resources: (e.g., Housing Opportunities for Persons with AIDS (HOPWA); Housing Choice Voucher Program Information (Section 8); Supportive Housing for
persons with Disabilities (section 811); Homeless Veterans Program and Continuum of Care Homeless Assistance Program (CoC); Temporary Assistance for Needy Families (TANF); Low Income Home Energy Assistance Program (LIHEAP); California LifeLine Program, etc.)

Potential resources and partners’ will include: National Resource Directory, Sacramento Housing Alliance, California Department of Housing and Community Development, and more potential resources and partners under investigation

• Citizenship resources: (e.g., English Language information, classes, and tutors; citizenship application and process explanation, etc.)

Potential resources and partners’ will include: United States Citizenship and Immigration Services Department, and more potential resources and partners under investigation

Marketing the Website

Prior to the website’s launch date, it will be beta-tested with focus groups from the target population. Once the website is ready for launch, the following marketing tactics will be developed to promote the website:

• Print collateral
  o Flyer/mailer to new Medi-Cal members
  o Branding on IPHI publication materials (annual reports, brochures, press releases)
  o UCD/UCDHS, DHCS, and partners’ public affairs offices

• Digital marketing
  o Development of an early landing page (Example: http://eatfresh.org)
  o E-blasts/e-newsletters
  o Social media updates (e.g., updates, events, photos, videos, etc. on the Welltopia by DHCS Facebook page and any other social media sites our partners have)

• Website displays at local events
• Media partnerships with popular radio and television stations

Evaluation

Given the nature of the breadth, scope, and reach of the website, we will conduct evaluations to measure user engagement, website traffic, brand development and recognition, in addition to measuring internal processes for maintaining the website. These measurements will allow the communication team to draw conclusions for the website’s next steps and inform DHCS of high traffic content areas.

Measurements of User Engagement and Website Traffic
Appendix O

- Incorporate outbound link tracking devices into content to measure user engagement and website traffic (e.g., Bitl.ly, ClickMeter, etc.)
- Incorporate inbound link tracking devices to measure website traffic and analyze to make recommendations for adjustments (e.g., SoloSeo, MajesticSEO, etc.)

Brand Development and Recognition
- Distribution of surveys to website users (e.g., Survey Monkey, Qualtrics, etc.)

Website Strategy
- Conduct strengths, weaknesses, opportunities, and threats (SWOT) analysis on a regular basis in order to provide feedback and recommendations
- Analyze maintenance systems for content quality, updates, etc.
- Analyze interactive website features user and staff response time

Sustainability

The Institute is a developing organization with limited resources. As a result, it is important that the website is resource and financially sustainable.

Initial content will be created by the IPHI communication team, in partnership with DHCS, and will take an estimated six months to complete. IPHI’s California Health eQuality Program has allocated $50,000 to support the development of the website through December 31, 2013. Two consultants will be hired to assist with website development. The first consultant, Bill Sykes, develops the website pages, widgets, and applications for the website to function. The second consultant, Marketing by Design, takes the information the IPHI communication team gathers and translates it into accessible and relatable language and pictures for our target audience.

After the website has been launched, content updates and website maintenance could be provided by the IPHI Executive Assistant assigned, in part, to MCQuIP. The Executive Assistant will also be involved in the evaluation of the website; ensuring systematic processes are established for website maintenance. In addition, the bi-directional communication aspects of the website, such as blog postings, will be designed and placed in a free cross-platform integration program that allows the content added to the website to be simultaneously distributed on social media websites without having to access those sites individually.
Appendix P: Population Health Improvement Site Map