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 quality improvement assessment 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 2013 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

ACKNOWLEDGEMENTS

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.
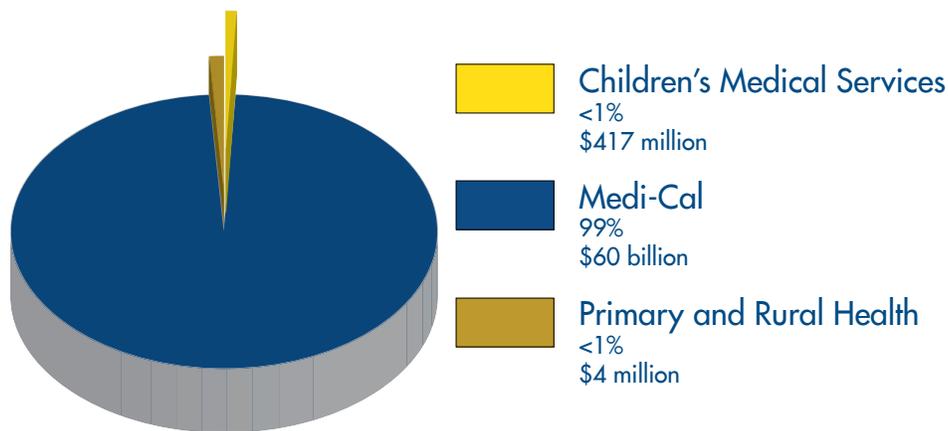
INTRODUCTION

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

Children's Medical Services
<1%
$417 million

Medi-Cal
99%
$60 billion

Primary and Rural Health
<1%
$4 million

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.[4] 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.[5] 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"*).[6] 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.[7]

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.

METHODS

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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.[8] 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).

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.

RESULTS

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

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Benefits Division, *Every Woman Counts*	Core Program Performance Indicators (CPPI)	1. To ensure timely and complete diagnostic follow-up of abnormal breast and cervical cancer screening results. 2. To ensure timely and complete treatment initiated for cancers diagnosed. 3. To deliver breast and cervical cancer screening to priority populations.	CPPI set by the Centers for Disease Control and Prevention.	1. Breast/cervical diagnosis completed. 2. Breast/cervical diagnosis completed within 60 days. 3. Breast/cervical treatment initiated. 4. Breast/cervical treatment initiated within 60 days. 5. Women rarely/never screened for cervical cancer (>20%). 6. Mammography screening age 50 and older (>75%).	Start date: 10/09 End date: Ongoing

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Director's Office	California's 1115 Waiver: Delivery System Reform Incentive Payments (DSRIP) Program	1. To support California's designated public hospitals (DPH) in meaningfully enhancing the quality of care and health of the patients and families they serve by transforming their delivery system. The DPHs will transform their delivery systems to: provide integrated systems of care; offer timely, proactive, coordinated medical homes; provide patients with positive health care experiences; deliver proactive and planned prevention and primary care services for all patients; deliver high-quality care and drive quality, safety, and efficiency; and provide equitable care.	1. Baseline metrics vary by DPH. Baseline metrics for each DPH are under development.	1. Target metrics vary by DPH. Target metrics for each DPH are under development.	Start date: 11/20/10 End date: 10/20/15

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
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)

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Medi-Cal Dental Services Division	Increasing Children's Use of Preventive Dental Services and Dental Sealants	1. To increase the rate of children, ages 1-20 years, enrolled in Medi-Cal who receive any preventive dental service by 10 percentage points over a 5-year period.	1. 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.	1. Rate of children, ages 1-20 years, enrolled in Medi-Cal who receive any preventive dental services will increase to 42.6% for children enrolled for any length of time, and 45.7% for children continuously enrolled for at least 90 days.	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 |
| | | 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. | 2. 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. | 2. Rate of children, ages 6-9 years, enrolled in Medi-Cal who receive a dental sealant on a permanent molar tooth will increase to 25.2% for children enrolled for any length of time, and 26.3% for children continuously enrolled for at least 90 days. | |

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
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

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Medi-Cal Managed Care Division	Internal & Small Group Collaborative QI Projects	1. To improve the quality of care delivered to Medi-Cal members by DHCS-contracted health plans. QI projects vary by health plan and include areas such as: increasing the number of advanced directives, HIV/AIDS viral load testing, BMI documentation for children and adolescents, rate of prenatal visits during the first trimester of pregnancy, percentage of controlled blood pressure, and communication to improve the patient care experience; improving the rate of postpartum care visits, comprehensive diabetes care, cervical cancer screening among women 21-64 years, and treatment of 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.	1. Baseline metrics vary by health plan and QI project. View QI projects for each health plan at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2011-12_QIP_Qtr_1-1to3-31-12_Report.pdf	1. Target metrics vary by health plan and QI project. View QI projects for each health plan at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2011-12_QIP_Qtr_1-1to3-31-12_Report.pdf	Start date: Varies by health plan End date: Varies by health plan

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
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. 2. To improve clinical quality outcomes for chlamydia-targeted screening of female members over age 25 years.	1. Private providers screen 69% of female clients and public providers screen 63% of female clients. 2. Private providers screen 64% of female clients and public providers screen 59% of female clients.	1. Increase member screening rate in targeted groups to 85%. 2. Ensure maximum screening rate does not exceed 50% of the targeted group.	1. Start date: 9/05 End date: Ongoing 2. Start date: 1/06 End date: Ongoing

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
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. To increase the use of effective contraceptive methods as a result of the Family PACT visit. b. To increase the proportion of clients who receive education and counseling services. c. To decrease the proportion of women who receive annual cervical cytology screening tests. 2. To determine whether the quality of services delivered under the program improved over time.	a. 22% increase at the end of a visit compared to the beginning of a visit (2007 Family PACT MRR). b. 76% have documentation of receiving counseling (2007 Family PACT MRR). c. 49% annual screening rate (2007 Family PACT MRR). 2. Baseline metrics vary by indicator.	a. Increase the proportion of women using effective contraceptive methods as a result of a Family PACT visit to 25%. b. Increase the proportion of clients with documentation of counseling to greater than 76%. c. Decrease the rate of annual cervical cytology screening to 45%. 2. Target metrics vary by indicator.	Start date: 7/10 End date: 6/13

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Office of the Medical Director	Adoption of Electronic Health Records (EHRs)	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.	1–3. No use of EHRs by Medi-Cal providers eligible for incentive payments.	1–3. 90% of Medi-Cal providers eligible for incentive payments adopted EHRs for meaningful use in their practices by 2015.	Start date: 10/3/11 End date: 12/31/15

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Pharmacy Benefits Division	Improve Psychotropic Medication Use for Children and Youth in Foster Care	To achieve improved psychotropic medication use for children and youth in foster care by: 1. Reducing the rate of antipsychotic polypharmacy. 2. Improving the antipsychotic dose prescribed to be within the recommended guidelines. 3. Improving the monitoring of metabolic risk associated with the use of antipsychotics.	1. Rate/ proportion of polypharmacy of two or more antipsychotics: 20.4% (2009/2010 data). 2. Rate/dose of antipsychotic dose within age-specific recommended guidelines: No baseline metric because the measure is new. 3. Rate/ proportion of children and youth in foster care prescribed with at least one psychotropic medication that will have an annual metabolic risk assessment: No baseline metric because the measure is new.	1. Reduce the rate of antipsychotic polypharmacy to 15%. 2. 80% of psychotropic medications prescribed for children and youth in foster care will be within the recommended dose range for specified age group. 3. 80% of children and youth in foster care prescribed with at least one psychotropic medication will have an annual metabolic risk assessment and evaluation.	Start date: 7/1/12 End date: 6/30/15

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Pharmacy Benefits Division	California Mental Health Care Management Program Collaborative's Performance Improvement Plan: Improving Antipsychotic Medication Use in the Adult Population	To achieve improved psychotropic medication use in the adult population by: 1. Reducing the rate of antipsychotic polypharmacy. Each county specialty mental health service participating in the collaborative can also decide to include additional aims based on county-specific interventions.	1. Rate/ proportion of polypharmacy of two or more antipsychotics: 15.6% (2007 data).	1. Reduce the rate of antipsychotic polypharmacy by 10% from baseline.	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

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
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

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
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

Table 1: Clinical QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Systems of Care Division	CCS/California Perinatal Quality Care Collaborative High Risk Infant Follow-up Quality Care Initiative (CCS/CPQCC HRIF QCI)	1. To identify infants who might develop CCS-eligible conditions after discharge from a CCS-approved NICU. 2. Improve the neurodevelopmental outcomes of infants served by the CCS HRIF Programs through collaboration between Children's Medical Services/CCS and the CPQCC.	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

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Systems of Care Division	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)	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.	1. Explore the relationship between NICU and PICU CLABSI rate and participation in statewide QI targeting CLABSI prevention.	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.	Start date: 7/1/12 End date: Annual, anticipate multiple years

Table 1: Clinical QI Activities

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

Results

Table 2: Health Promotion and Disease Prevention QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
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.	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
Office of Family Planning	2011 Client Exit Interview	1. To assess clients' perspective on the quality of provider/ patient interactions. 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.	a. Proportion of new clients who leave a visit with high efficacy contraception (49%). b. Proportion of clients who report that the provider asked about their usual source of care (25%).	a. Increase the proportion of new clients 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

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Primary & Rural Health Division	American Indian Infant Health Initiative (AIIHI)	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.	1. 90% of AIIHI clinics document the provision of three educational topics as identified in the specific aim.	1. 100% of AIIHI clinics document the provision of three educational topics as identified in the specific aim.	Start date: 7/1/09 End date: 6/30/14

Table 2: Health Promotion and Disease Prevention QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Systems of Care Division	Newborn Hearing and Screening Program QI Learning Collaborative	1. Complete hearing screening by 1 month of age.	1. Screening: No show rate for outpatient screens- 9%; no show rate for diagnostic evaluations- 9%.	1. Screening: Decrease regional no show rate for outpatient screening appointments and diagnostic audiologic appointments to 6%.	Start date: Project began in 2006. Latest aim developed in 2011. End date: No projected end date
		2. Complete diagnostic audiologic evaluation by 3 months of age.	2. Diagnostic: First diagnostic appointment by 3 months of age- 81%.	2. Diagnostic: Increase to 85% the percent of infants who have the first appointment for a diagnostic audiologic evaluation by 3 months of age.	
		3. Enroll infants with hearing loss in early intervention services by 6 months of age.	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.	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.	
			4. Parent Support: Accept referral to Parent Links- 27%.	4. Parent Support: Increase to 50% the percent of families in the Los Angeles Unified School District Early Start Program who accept a referral to Parent Links.	

Results

Table 3: Administrative QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Administration Division: Human Resources Branch	Family and Medical Leave Act (FMLA) Request Process and Business Workflow Automation System	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.	1. The current FMLA request response turnaround time takes 4-7 working days.	1. Reduce turnaround time by 50% to 2-3 working days.	Start date: 4/1/12 End date: 3/30/13
Administration Division: Human Resources Branch	State Disability Insurance (SDI), Non-Industrial Disability Insurance (NDI), and Leave of Absence (LOA) Request Process	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.	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.	1. A 25% reduction in the number of days it takes to process responses to SDI/NDI/LOA requests.	Start date: 4/1/12 End date: 3/30/13

Table 3: Administrative QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Administration Division: Workforce Planning and Development	DHCS University	1. To improve the knowledge, skills, and abilities of the Medi-Cal program managers, senior managers, and executives throughout the Department.	1. No current participants in the DHCS University.	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.	Start date: 2/1/13 End date: Ongoing
Audits & Investigations Division	Return on Investment (ROI) Manual	1. To quantify the value/results of A&I by comparing cost recoveries, savings, and avoidance against the resources expended to complete the work.	1. Monthly ROI ratio of 1:1 as displayed in a dashboard.	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&I brings back $6 in the form of cost recoveries, savings, and avoidance).	Start date: 2005 End date: Ongoing
Audits & Investigations Division	Audits & Investigations Case Development, Tracking, and Referral Flowcharts	1. To fully document the DHCS collective case development, tracking, and referral process.	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.	1. Increase in the number of quality cases developed for subsequent review, audit, and referral to DOJ.	Start date: 12/1/12 End date: Ongoing

Table 3: Administrative QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Audits & Investigations Division: Medical Review Branch, Research Section	Fraud Detection and Deterrence: Field Audit Reviews	1. To ensure Medi-Cal providers are appropriately compensated based on: a. Medical necessity b. Appropriateness of care c. Documentation of services rendered d. Qualifications of provider e. Medi-Cal rules of billing f. Statutes and regulations 2. To identify substandard care or behavior that puts patients at risk.	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 recom-mendations with program standards.	1. Specific review criteria based on: a. Case sample select b. Review teams c. Review criteria and elements d. Best practice questions and topic criteria	Start date: 1999 Fraud Initiative End date: Ongoing
Audits & Investigations Division: Medical Review Branch, Research Section	Individual Provider Claims Analysis Report	1. To increase the accuracy of billing levels for Evaluation and Management (E & M) procedure codes and reduce inappropriate and costly claims.	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 & M procedure codes).	1. Decrease in the most costly level 4 and 5 claims. A specific target has not been established.	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.

Table 3: Administrative QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Audits & Investigations Division: Medical Review Branch, Research Section	Medi-Cal Payment Error Study (MPES)	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).	1. Eight payment error rates for each strata expressed as a percentage of payments made in error.	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.	Start date: 2005 and completed every two years End date: Ongoing
Benefits Division	Data Navigator Project	1. To improve the collection and documentation of screening and diagnostic results for women in *Every Woman Counts*.	1. Error type. 2. Error frequency. 3. CPPI performance. 4. Number of contacts with the primary care physician. 5. Persistent performance problems.	1–5. Complete follow-up on 90% of current records identified.	Start date: 7/08 End date: Ongoing
Director's Office	Eligibility and Enrollment for Medi-Cal-eligible Californians: Meeting the Goals of the Affordable Care Act	1. To maximize the enrollment of Medi-Cal-eligible Californians.	1. 1.3 million Californians are currently eligible for Medi-Cal but are unenrolled. 2. 1.4 million Californians will be newly eligible to enroll in Medi-Cal as of 2014.	1. Increase Medi-Cal enrollment by 2.8 million by the end of 2014.	Start date: Open enrollment begins Fall 2013 End date: Ongoing

Table 3: Administrative QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
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. Reporting 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

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
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

Table 3: Administrative QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Mental Health Services Division	Medi-Cal Specialty Mental Health Services for Children and Youth	1. To develop a performance outcome system for Early and Periodic Screening, Diagnosis, and Treatment 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.	1. Baseline metrics are under development.	1. Target metrics are under development.	Start date: 9/1/12 End date: Ongoing
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

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
Systems of Care Division	Pediatric Palliative Care Waiver	1. To provide pediatric palliative care services to allow children who have a CCS-eligible medical condition with a complex set of needs and their families the benefits of hospice-like services, in addition to state plan services during the course of an illness. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and family.	1. Costs for comparable services in an institutional setting. Pre-enrollment average per member per month cost: $16,819.78	1. Demonstrate cost effectiveness by providing the same scope of services at a lower cost than the baseline metric. Post enrollment average per member per month cost: $14,222.00	Start date: Proposed effective date of 4/1/12 End date: Waiver renewal submission after 5 years

Table 3: Administrative QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
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

Table 3: Administrative QI Activities

DHCS Office or Division	Title	Aim(s)	Baseline Metric(s)	Target Metric(s)	Start & End Dates
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

Results

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.

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.

Results

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.

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.

DISCUSSION

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.

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APPENDICES

Appendix A: QIS Email Instructions, Survey Template, and Example of Completed Survey

Email Instructions

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: ▮▮▮▮▮▮▮▮, OR submit your completed survey via email to ▮▮▮▮▮▮▮▮▮▮.

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 ███████████ at ███████ and ███████████████████ to schedule a meeting time, or you can contact █████████ 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 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**

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

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

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

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

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

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

Part II: Health Promotion and Disease Prevention QI Projects

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

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

- Smoking cessation and tobacco control
- Obesity prevention

- HIV/AIDS prevention
- Sexually transmitted disease prevention

Appendix A

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

a. **Title**

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

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

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

■ *Target 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**

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**

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

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

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

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

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

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

Appendix A

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.

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.

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

Survey Template

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

Part 1: Clinical QI Projects

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

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

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

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

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

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

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

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

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

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

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

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

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?**
   - ☒ **Yes. If yes, please list and indicate their frequency (e.g., quarterly, annually)**
     A final report will be produced by 6/30/15
   - ☐ **No.**

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

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.

- *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.

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

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

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

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?
    Federal grant awarded to DHCS by CMS.

j. **Are there any reports available on this project?**
    ☒ **Yes. If yes, please list and indicate their frequency (e.g., quarterly, annually)**
    ■ Quarter 1 Report (9/13/11 – 12/31/11) submitted to CMS quarterly.
    ■ Operational Protocol (updated 12/1/11) revised on an ongoing basis.
    ☐ **No.**

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

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

Part III: Administrative QI Projects

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

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

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

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

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

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

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

- *Site(s) (check all that apply):*
  ☐ **Emergency department**
  ☐ **Outpatient**
  ☐ **Inpatient**
  ☐ **Long-term care**
  ☒ **DHCS**
  ☐ **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**
7/1/12

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

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

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

Appendix A

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

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

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

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

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

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

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

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

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

Part V: Existing QI Gaps and Future Ideas

a. **Are there any gaps in the Department's existing clinical, health promotion and disease prevention, and administrative QI projects?**
   A comprehensive tobacco treatment plan, including recommended treatment options and clinical systems change to treat tobacco use, is not available. Currently, only two managed care health plans offer the comprehensive coverage recommended by AHRQ based on the Public Health Service-sponsored Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update. Comprehensive coverage would include:

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

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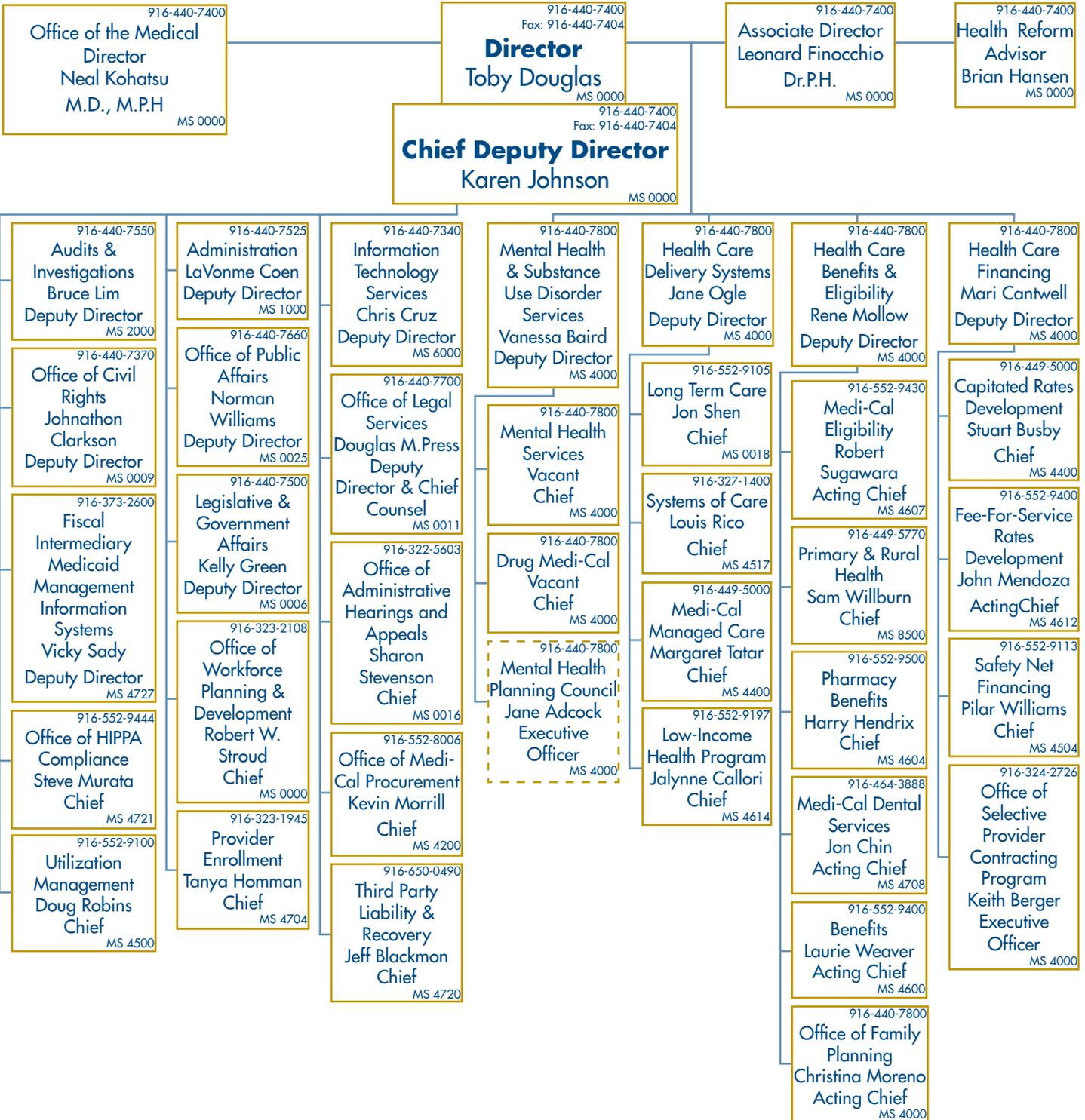Implement a comprehensive tobacco use treatment plan.

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

Department of Health Care Services
August 1, 2012

DHCS
California Department of
HealthCareServices

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916-552-9100
Utilization Management
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Chief
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916-440-7525
Administration
LaVonme Coen
Deputy Director
MS 1000

916-440-7660
Office of Public Affairs
Norman Williams
Deputy Director
MS 0025

916-440-7500
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Kelly Green
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MS 0006

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Robert W. Stroud
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Tanya Homman
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MS 4704

916-440-7340
Information Technology Services
Chris Cruz
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MS 6000

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916-322-5603
Office of Administrative Hearings and Appeals
Sharon Stevenson
Chief
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916-552-8006
Office of Medi-Cal Procurement
Kevin Morrill
Chief
MS 4200

916-650-0490
Third Party Liability & Recovery
Jeff Blackmon
Chief
MS 4720

916-440-7800
Mental Health & Substance Use Disorder Services
Vanessa Baird
Deputy Director
MS 4000

916-440-7800
Mental Health Services
Vacant
Chief
MS 4000

916-440-7800
Drug Medi-Cal
Vacant
Chief
MS 4000

916-440-7800
Mental Health Planning Council
Jane Adcock
Executive Officer
MS 4000

916-440-7800
Health Care Delivery Systems
Jane Ogle
Deputy Director
MS 4000

916-552-9105
Long Term Care
Jon Shen
Chief
MS 0018

916-327-1400
Systems of Care
Louis Rico
Chief
MS 4517

916-449-5000
Medi-Cal Managed Care
Margaret Tatar
Chief
MS 4400

916-552-9197
Low-Income Health Program
Jalynne Callori
Chief
MS 4614

916-440-7800
Health Care Benefits & Eligibility
Rene Mollow
Deputy Director
MS 4000

916-552-9430
Medi-Cal Eligibility
Robert Sugawara
Acting Chief
MS 4607

916-449-5770
Primary & Rural Health
Sam Willburn
Chief
MS 8500

916-552-9500
Pharmacy Benefits
Harry Hendrix
Chief
MS 4604

916-464-3888
Medi-Cal Dental Services
Jon Chin
Acting Chief
MS 4708

916-552-9400
Benefits
Laurie Weaver
Acting Chief
MS 4600

916-440-7800
Office of Family Planning
Christina Moreno
Acting Chief
MS 4000

916-440-7800
Health Care Financing
Mari Cantwell
Deputy Director
MS 4000

916-449-5000
Capitated Rates Development
Stuart Busby
Chief
MS 4400

916-552-9400
Fee-For-Service Rates Development
John Mendoza
ActingChief
MS 4612

916-552-9113
Safety Net Financing
Pilar Williams
Chief
MS 4504

916-324-2726
Office of Selective Provider Contracting Program
Keith Berger
Executive Officer
MS 4000

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

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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.

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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.

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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.

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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.

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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 racial/ethnic, LGBT, and underserved populations to monitor and evaluate health outcomes among these groups; creating and strengthening information networks among DHCS and CDPH programs and ethnic/racial, LGBT, and underserved communities for the inclusion of community participation in decision-making related to health issues; and building internal and external capacity to achieve equity and reduce health disparities through training, technical assistance, consultation, and strategic planning. On July 1, 2012, OMH became part of the Office of Health Equity at CDPH.

Office of Public Affairs (OPA)

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

Office of 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.

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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.

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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.

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