Fresno-Kings-Madera
Regional Health Authority

CalViva Health
QI/UM Committee
Meeting Minutes
March 21, 2013

Madera County Resource Management Agency
Conference Room A-7
2037 West Cleveland Avenue
Madera, CA 93637
Attachment A

Committee Members in Attendance		CalViva Health Staff in Attendance	
✓	**Patrick Marabella, M.D.**, CalViva Chief Medical Officer, Chair	✓	**Mary Beth Corrado**, Chief Compliance Officer (CCO)
✓	**Aftab Naz, M.D.**, At-large Appointee, Madera County	✓	**Amy Schneider, RN,** Director of Medical Management Services
✓	**David Glossbrenner**, M.D., Adventist Health		**Morgan Essenheimer**, Compliance Analyst
✓	**David Cardona, M.D.**, Fresno County At-large Appointee, Family Care Providers (arrived 11:07)	✓	**Alex Rocha**, Quality Specialist
✓	**Jonathan Forncrook, D.O.**, Camerena Health Center	✓	**Brandi Leyva**, Medical Administrative Coordinator
✓	**Conrad Chao, M.D.**, Fresno County At-large Appointee, UCSF/CCMG		
	David Hodge, M.D., Fresno County At-large Appointee, Chair of RHA **(Alternate)**		
Guests/Speakers			
	Maria Ortega, Health Net		
	Claudia Sicairos, Administrative Assistant, Health Net		

➢ = in attendance

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
#1 Call to Order Patrick Marabella, M.D, Chair	The meeting was called to order at 11:02 am.	
#2 Approve Consent Agenda Committee Minutes 1/17/13 Provider Updates - Medical Policies: Fourth Qtr 2012 - Pharmacy Recommended Drug List: First Qtr 2013 (Attachments A, B, C) **Action** Patrick Marabella, M.D, Chair	All items on the Consent Agenda were approved as submitted.	Motion: Approve Consent Agenda 4-0 (Forncrook/Naz)
#3 QI Business -2013 QIUM Committee Charter (Attachment D) **Action**	The QIUM Committee Charter was presented for approval with one edit on page 3, section V.A.4.(f) "For the purpose of meeting a quorum, the RHA Commission Chair may appoint an alternate member, who is also a provider member of the RHA Commission, to serve as a voting member of the committee." This will assist in assuring a quorum is met and committee business can be completed in a timely manner.	Motion: Approve 2013 QIUM Committee Charter 5-0 (Chao/Naz)

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Patrick Marabella, M.D		
#3 QI Business 2013 Quality Improvement Program Description (Attachment E) **Action** Patrick Marabella, M.D, Chair	*Dr. Marabella informed the committee that to facilitate discussion of the Annual Program Documents for QI and UMCM a Powerpoint presentation will be utilized. The full documents under discussion are included in the meeting packet. The Powerpoint presentation is not an official part of the committee's records but will be used only as a discussion tool. Approval of each official document is required.* 2013 Quality Improvement Program Description. <u>Major Changes for 2013</u>: ➢ Medi-Cal Complex Case Management transitioning from Alere to McKesson effective March 1st, 2013. ➢ QIUM Operational Workgroup was added. The members of this workgroup consist of CalViva Health and Health Net staff. The workgroup provides a forum for ongoing monitoring and evaluation of care and services. ➢ Access Workgroup added. The members of this workgroup consist of CalViva Health and Health Net staff. The workgroup reviews results of monitoring, identifies gaps and recommends improvements related to access and availability.	Motion: Approve 2013 QI Program Description 5-0 (Glossbrenner/ Forncrook)
#3 QI Business 2013 Quality Improvement Work Plan (Attachment F) **Action** Patrick Marabella, M.D, Chair	<u>Planned Activities and QI Focus for 2013</u>: 1. <u>Chronic Care/Disease Management</u> - Improve Asthma Patients Self-Management and improve outcomes for patients with Diabetes by utilizing the Disease Management Program and providing further education to the Asthma and Diabetes patients. 2. <u>Access to Care</u> - Improve Access to Care: The Access Workgroup was initiated in 2013, ongoing monitoring implemented through surveys and reports, and the Department of Managed Health Care (DMHC) requires a Timely Access Report due March 2013 to reflect efforts. - Improve Compliance with After Hours Access to Care: After Hours scripts in threshold languages have been provided to Providers, Provider Updates are distributed to providers for educational purposes. Ongoing monitoring is conducted along with annual surveys to assess improvement. - Improve Member Satisfaction with Access to Care by distributing the Patient Experience Toolkits to providers to assist in improving the patient experience by offering guidelines, tips, and other useful materials. Member Orientation classes are provided to educate members on Medi-Cal Managed Care and Health Plan options, process and procedure, and benefits. 3. <u>Quality of Care & Patient Safety Initiatives</u> - Meet or exceed Health Employment Data Information System (HEDIS) Minimum Performance levels for default enrollment measures. Provider compliance with the following standard metrics will be assessed and strategies for improvement implemented when needed. ▪ Well Child Visits every 3-6 years ▪ HbA1c testing	Motion: Approve 2013 Quality Improvement Work Plan 5-0 (Glossbrenner/ Forncrook)

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	▪ Cervical Cancer Screening ▪ Prenatal Care Visits - Dr. Glossbrenner reported that obtaining the medical records for HEDIS data gathering can be burdensome to providers with a large volume of members. He requested that high volume providers be notified in advance so they can ensure adequate resources to pull the records for the data samples. - Decrease the percent of members with multiple Narcotic Prescriptions. Dr. Glossbrenner reported that in Kings County there is an initiative focusing on preventing teenagers from abusing prescription medications. He recommended that CalViva communicate with Kings County to learn more about this program. Dr. Chao inquired regarding the availability of Pain Management services (including pharmacologic therapy) for CalViva members. At times member's need referral for these services and it is difficult to locate a provider. This is a challenging area that may require further review. - Wellness/Preventative Health: Breast Cancer Screenings to include: ▪ Well Woman Screening Notepad ▪ IVR Calls for Mammograms ▪ Members Newsletters 4. Quality Improvement Projects (QIPs) - Comprehensive Diabetes Care-Eye Exam Initiative: Data analysis and barrier analysis are in progress. Member Newsletters will be sent to diabetic members to educate them on the importance of scheduling an annual eye exam. Provider mailings and tools will be distributed. The Disease Management program focuses on the diabetic patient as well. - All Cause Hospital Readmissions-Statewide Collaborative ▪ The Barrier Analysis and proposed interventions were submitted to Department of Health Care Services (DHCS) and Health Services Advisory Group (HSAG) in January and were approved. Interventions will include: ▪ Health Plan Onsite Case Managers ▪ Ambulatory Case Management program modified ▪ Participate in MyHealthDirect pilot program for Primary Care Physician (PCP) appointment scheduling	CVH staff will follow up with the HEDIS department to inquire about provider notification of HEDIS file requests and report back to the committee.
#3 **QI Business** Oversight Audit Report for Health Net (Attachment G) **Information** Patrick Marabella, M.D, Chair	An Oversight Audit of the various functions and responsibilities delegated to Health Net Community Solutions was conducted to demonstrate evidence of compliance and adherence to CalViva Health's policies, procedures, regulatory and contractual requirements. Overall, Health Net performed well and complied with most requirements. Corrective Action Plans (CAPs) were required in some areas and Health Net submitted acceptable resolutions for each finding. Analysis/Findings: CalViva Health determined Health Net Community Solutions to have 100% compliance with all elements for the following Departments/Functions: Appeals and Grievances, Quality Improvement, Claims, Continuity of Care,	

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	Access and Availability, Call Center, Health Education, Provider Disputes and Credentialing. Deficiencies were found and Corrective Action Plans required in the following areas: ➢ Utilization Management ➢ Emergency Services ➢ Cultural and Linguistics ➢ Marketing ➢ Provider Network ➢ Member Rights Actions Taken: ➢ Health Net Community Solutions submitted CAPs and additional evidence to meet all deficient areas. After review, CalViva Health accepted CAPs for all areas. Utilization Management and Member Rights require ongoing monitoring of reports and proper use of policies and procedures throughout 2013. CalViva Health will continue to monitor all ongoing CAPs to ensure the use of correct policies and procedures while conducting CalViva Health business. Reports will be reviewed quarterly to determine accurate and necessary information is being reported.	
#3 **QI Business** Appeals and Grievances Executive Summary (Attachments H, I, J) **Information** Patrick Marabella, M.D, Chair	The 4th Quarter 2012 appeals and grievance case summary report was reviewed by the committee. Member Appeals and Grievances- - There were 23 appeals with the majority of appeal cases found in Fresno County. - There were 72 Grievances which is consistent with prior quarters. ▪ There were 7 Interpersonal cases against one provider in Fresno County. Information regarding these cases has been provided to the Credentialing Committee. ▪ After analysis, it was found that no cases were validated as quality of care issues. All other Quality of Care (QOC) grievance types were too low in volume to identify trends or patterns. Turnaround time and Volume- - There were a total of 95 cases received in the quarter and all closed within compliance. No actions necessary for Quarter 4, as 100% compliance was achieved. Access Related Grievances-(includes both Quality of Service and Quality of Care) - There were 9 Primary Care Physician Referral for Services grievances - There were 2 Availability of Appointment with Primary Care Physician grievances. - Case analysis was conducted and there were no trends identified. Appeals and Grievances Inter-rater Reliability Audit- For the audit period of October 1, 2012 through December 1, 2012, results for the appeals and grievances case reviews averaged an overall score of 98.7%. Results of audit are shared with staff. No further action required at this time.	
#3 **QI Business** Appeals and Grievances Dashboard	This report is current through January 2013 and is broken down into two major categories: Appeals and Grievances. This report provides monthly data to facilitate monitoring for trends in the number and types of	

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(Attachment K) **Information** Patrick Marabella, M.D, Chair	cases over time. There will be ongoing refinements to improve the information contained in this report. Grievances: ➢ The grievances are broken down into two categories: Expedited and Standard. ➢ Grievance metrics are reported according to cases received and cases resolved within the time period. There were 26 grievances received and 25 grievances resolved in the month of January 2013. ➢ Grievances are further broken down into two categories: Quality of Service QOS (Administrative), and Quality of Care QOC (Clinical). There were 21 QOS resolved grievances for January 2013. There were 4 QOC resolved grievances. ➢ Grievances are also broken down by county. ➢ No actionable trends identified. Appeals: ➢ The appeals are broken down into two categories: Expedited and Standard. ➢ Appeal metrics are reported by received date and resolved date. There were 8 appeals received in the month of January 2013 and 10 appeals were resolved in this month. Resolved appeals are broken down into two categories: Pre-service and Post service. All were pre-service appeals. No actionable trends were identified. Future Dashboards will include separate tabs to allow for tracking and trending of the following populations:: 1. Seniors and Persons with Disabilities (SPD) 2. Community Based Adult Services (CBAS) 3. Healthy Families (now called Targeted Low-Income Children-TLIC)	
#3 QI Business Disease Management & Nurse Advice Line (Attachment L) **Information** Patrick Marabella, M.D, Chair	This report provides a summary of the CalViva Health 2012 Disease Management and Nurse Advice Line Year-end Evaluation. Goals of the Asthma and Diabetes-*Be In Charge!* Disease Management Programs include: ➢ Improve knowledge of their primary disease and their co-morbidities ➢ Address barriers to care that influence health outcomes ➢ Lifestyle changes that could result in a positive impact on their health status ➢ Accessing health care resources as appropriate Data/Results: Disease Management ➢ From March 2011 through December 2012, over 10,000 CalViva Health members have been identified to participate in the *Be In Charge!* Disease Management Program. ➢ All five clinical asthma measures and nine out of twelve diabetes measures met the performance targets. Nurse Advice Line (NAL) ➢ From January through December 2012, majority of calls that came into the NAL from the CalViva Health counties were answered by a nurse and over 300 were routed to a Health Resource Coordinator for	

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	appropriate customer service assistance. ➢ The CalViva Health timely access reporting performance measure is 75% or more of calls to be answered in 45 seconds. This performance measure was met at 86% or above for all four quarters in 2012. Analysis/Findings: The Nurse Advice Line aided in reducing the number of unnecessary ER visits and encouraged calls to MD. Actions Taken: ➢ CalViva Health met with McKesson to identify opportunities for improvement and to increase promotion of the Nurse Advice Line. ➢ CalViva Health staff disseminated A1c testing posters for provider offices in all counties and implemented Diabetes Basics classes. CalViva Health will continue to implement improvement efforts with McKesson to enhance Asthma and Diabetes *Be In Charge!* Programs' clinical outcomes, and report updates and findings to QIUM Committee. Committee members discussed potential ways to make this data more useful and actionable including establishing provider specific rates, comparing these results to HEDIS results and communicating these results to providers. These recommendations will be shared with the Health Education department and follow up will occur in future meetings.	
#4 **UM Business** Key Indicator Report (Attachment M) **Information** Patrick Marabella, M.D, Chair	Key Indicator Report reflects data as of February 20th, 2013. New Features of Reports: 1. Categorized data broken down by "Seniors and Persons with Disabilities (SPDs)", and "Non-SPDs". 2. County specific targets – the county specific goals are currently being recalculated/updated. 3. A formula error was noted on the YTD for readmissions that will be corrected for the next report. No other trends identified.	
#4 **UM Business** Executive Summary 2012 UMCM Work Plan (Attachment N) **Information** Patrick Marabella, M.D, Chair	CalViva Health has delegated responsibility for utilization management and case management activities to Health Net Community Solutions. Staffing: The UM/CM staff includes a variety of individuals to support CalViva Health medical management activities including: - Medical Directors - Project Managers - Data Analysts - Utilization Management Coordinators - Provider Appeals RN's and support staff The staff was expanded to support SPD enrollment. Compliance with Regulatory Requirements: ➢ The year-long phased-in enrollment of SPDs that went into effect in June 2011 was completed. ➢ CBAS transition initiated 10/1/12 with 75 face-to-face assessments approved since transition	

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	➢ Special Continuity of Care (COC) benefit for SPDs was added. This program allows SPD members to continue ongoing care with a previous provider for up to 12 months. ➢ Inter-rater reliability testing completed Monitoring the UM Process: ➢ UM/CM activities in 2012 include attempting to improve appropriate inpatient utilization performance in the tri-county area: - Ambulatory Case Management (ACM) staff provides outreach to new members to ensure timely access to services and new members with complex or serious medical conditions receive RN assessment of health and related needs. - Focus populations are also identified through monthly review of claims data, triage and assessment of members. - In 2013, there will be a focus on transition initiatives to address high cost/high utilization membership. - The numbers of authorizations for service requests received are monitored on a monthly basis. Care Management: ➢ An ACM Program was initiated during 2011 with a focus on monthly CalViva health member outreach reports for case management assessment. ➢ High-risk pregnancy activity began in quarter 4 2011. The Perinatal Case Management Program was developed in 2012 with the following goals: - Ensure that pregnant women at high-risk of a poor pregnancy outcome are referred to appropriate specialists including perinatologists. - High-risk women receive care in facilities providing high-risk pregnancy care and services. - High-risk women receive appropriate perinatal risk screening to promote good birth outcomes. ➢ The "Be In Charge" Diabetes and Asthma Programs continue to support members with these diagnoses including identification, stratification, and management of low and high risk members. Over and Under Utilization: Under Utilization: ➢ PM-160 submission is measure and promoted: - PM-160 data is tracked through Health Net encounters department and presented to CalViva Health QI/UM Committee twice annually. - Compliance with this requirement has improved. Over Utilization: ➢ Interventions effective as of 2013 include: - Onsite complex discharge planning - Pharmacy Case Management – in home and telephonic pharmacist intervention for patients with frequent readmissions and complex and multiple medications impacting good outcomes. - MyHealthDirect- a web based method of booking appointments for patients with the PCP. - Complex Case Management- enhanced program to allow for additional patients to be under intensive	

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	case management. - Expanding Disease Management offerings including Diabetes, Asthma, COPD, CAD, CHF, and Chronic Pain.	
#4 UM Business 2012 UMCM Work Plan Evaluation (Attachment O) **Action** Patrick Marabella, M.D, Chair	2012 UMCM Work Plan Evaluation was reviewed. Dr.Chao suggested that the committee consider an evaluation of new prematurity metrics for future discussion/workplan development. Opportunities to improve the referral process and initiate early interventions could improve outcomes.	Motion: Approve 2012 UMCM Workplan Evaluation 5-0 (Glossbrenner/Chao)
#4 UM Business 2013 UMCM Program Description (Attachment P) **Action** Patrick Marabella, M.D, Chair	2013 UMCM Program Description. <u>Changes for 2013</u>: 1. Minor grammatical corrections, language clarification, and updated terminology throughout the document. 2. Updated the list of monitoring reports included in the document. The addition of Onsite Case Managers at acute care hospitals was discussed and felt to be a positive addition to the program. The committee members recommended distribution of a Provider Update to communicate this important enhancement to providers in the community.	CVH staff will recommend a Provider Update re: Onsite CM to Provider Communications Motion: Approve 2013 UMCM Program Description 5-0 (Glossbrenner/Chao)
#4 UM Business 2013 UMCM Work Plan (Attachment Q) **Action** Patrick Marabella, M.D, Chair	2013 UMCM Work Plan. <u>Areas of Attention</u>: 1. Compliance with Regulatory and Accreditation Requirements - Ensure qualified licensed health professionals assess the clinical information used to support UM decisions - Separation of Medical Decisions from Fiscal Considerations - Periodic audits for Compliance with NCQA standards 2. Monitor UM Process - Number of authorizations for service requests received - Timeliness of processing the authorizations request - Conduct annual Inter-rater Reliability testing for health care professionals involved in UM decision making 3. Monitoring Utilization Metrics	Motion: Approve 2013 UMCM Workplan 5-0 (Glossbrenner/Chao)

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	- Improve Medi-Cal shared risk and FFS UM acute in-patient performance - Over/under utilization including PM-160 submissions and Hospital readmissions 4. Monitoring Coordination with Other Programs and Vendor Oversight - Ambulatory Case Management Program Implementation - Referrals to Perinatal Case Management - Complex Case Management - Be In Charge Diabetes DSM Program 5. Monitoring Activities for Special Populations - Increase rate of CCS identification - Provide UM/CM Programs to support Seniors and Persons with Disabilities (SPD) mandatory managed care requirements - Support implementation of Community Based Adult Services (CBAS) for eligible members	
#4 UM Business Case Management Review Process Audit (Attachment R) **Information** Patrick Marabella, M.D, Chair	➢ InterQual Clinical Decision Support Criteria are used along with other evidence-based medical policies and technical assessment tools by UMCM staff to assist clinical reviewers with consistency in reviewing medical criteria. ➢ The goal of CM audits is to facilitate consistent, credible, timely medical management records that will result in accurate and timely UM decisions and claims payment. Data/Results: - An average of 32 CM cases were audited per month for the reporting period Sept 2012 to Feb 2013. - The overall average CM audit score was 98% exceeding the goal of 95%. Actions Taken: ➢ Focused audits were conducted to increase turnaround time compliance. ➢ Training on new prior authorization requirements was completed. Continue to monitor quarterly audit reports and provide focused training opportunities.	
#4 UM Business Physicians/Non Physicians Inter-rater Reliability Report (Attachment S) **Information** Patrick Marabella, M.D, Chair	Purpose of Activity: ➢ Implementation of annual training and testing using the InterQual IRR tool and asses the test results for user proficiency. Analysis/Findings: ➢ The scoring system for IQ IRR was changed to pass/fail as of September 2010. ➢ 27 Care Managers and 6 Medical Directors all passed the IQ IRR test ➢ The test results indicate that the Certified InterQual Trainers provided adequate training for all nurses and clinical users. All staff are proficient in using the InterQual program.	
#5 Pharmacy Executive Summary Pharmacy Reports (Attachments T, U, V, W) **Information**	The pharmacy quarterly reports on operational metrics, top medication prior authorization (PA) requests, quarterly Recommended Drug List (RDL) changes, and the annual report of pharmacist inter-rater reliability (IRR) allow the committee to assess for emerging patterns in authorization requests and compliance around prior authorization and call center metrics, and to formulate potential process improvements.	

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Patrick Marabella, M.D, Chair	Pharmacy Operations Metrics: ➢ All quarter 4 2012 prior authorization operational metrics were within 5% of standard ➢ All quarter 4 2012 provider call metrics were within standard Top Pharmacy Prior Authorizations: ➢ No barriers to medication access through PA process were identified. 4th Quarter 2012 RDL Provider Updates Highlights: ➢ Combivent will be discontinued mid-2013 ➢ Fluoxetine is now on the formulary without restrictions ➢ Qsymia has been added to the formulary with PA required ➢ Veramyst status has been changed to non-formulary Pharmacist Inter-rater Reliability The IRR results for 4th quarter 2011 through 3rd quarter 2012 show that the overall standard was met for both the QA Committee selected medications and the random review in each quarter. Some individual standards missed goal in the 2nd and 3rd quarters of 2012. Next Steps: No trend was detected in the errors reported, just an increase in the volume of random errors identified. For every finding, individual follow up education is done with the pharmacist who made the error. Continual pharmacist and departmental training is needed to improve consistency and accuracy with which pharmacists apply criteria in UM decision making, and how they communicate those decisions.	
#6 Compliance Update - Public Policy Committee - DMHC Medical Survey/DHCS Audit **Information** Mary Beth Corrado, CCO	MB Corrado provided a verbal Compliance Update for the committee regarding the Public Policy Committee and the status of various audits that CalViva Health is involved in. Public Policy Committee The Public Policy Committee met on March 6, 2013. The Committee reviewed the physical accessibility requirements, annual summary for appeals and grievances activities, and marketing activities for 2012. An update was provided for Healthy Families, Public Health Programs, and the Medical Survey Audit. No recommendations for improvement at this time. Audit Status Update CalViva Health is currently undergoing a joint audit by DMHC and DHCS. DMHC is performing a SPD Medical Survey Audit and DHCS is performing a Full Service Medical Survey. DHCS performs the Full Service Medical Survey every 2 years while DMHC performs the SPD Medical Survey Audit every 3 years. DHCS also performed a HEDIS Audit through Health Services Advisory Group (HSAG). HSAG audited both CalViva Health and Health Net at the same time looking at HEDIS data collection methodology, analysis, reporting, and storage of the data. The initial report was received on March 20, 2013. All issues have to be resolved prior to the final data submission to DHCS and HSAG on June 3, 2013. The report of the DHCS Member Rights & Program Integrity Review completed last year required no corrective actions. DHCS did give CalViva Health a follow up call regarding the implementation of DHCS's	Once the formal reports from DMHC and DHCS are received, an update will be provided to the Committee.

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	recommendations. In February 2013, DHCS requested CalViva Health provide a written report of the implementation of recommendations of improvement.	
#7 Policy/Procedure Review - Quality Improvement Summary -Utilization Management Summary (Attachment X) -Potential Quality Issues Policy (Attachment Y)	Quality Improvement Summary Quality Improvement Policies reviewed with changes: 1. Facility Site and Medical Record Review (QI-011) 2. Physical Accessibility Review (QI-012) Utilization Management Summary Utilization Management Policies reviewed with changes: 1. Standing Referral to Specialty Care (UM-003) 2. Second Opinion (UM-010) 3. Application of the Member Evaluation Tool (MET) (UM-015) 4. Communications and Accessibility to UM (UM-050) 5. Case Management Review Monitoring (UM-105) 6. Targeted Case Management (UM-110) 7. Medi-Cal Disease Management (UM-112) 8. Separation of Medical Management from Administrative and Financial Management (UM-118). Potential Quality Issues Policy (QI-014): This is a new policy developed to expand upon the process for monitoring and evaluating potential quality of care issues (PQI) involving CalViva Health members. Previously this process was included in the Appeals and Grievance policies. The intent of this process is to facilitate continuous improvements in care and service provided to CalViva members and to comply with federal and state regulations associated with quality and safety. A copy of all policies under consideration for review and approval were available at the meeting.	Motion: Approve Quality Improvement and Utilization Management Policies 5-0 (Glossbrenner/Chao)
#8 Old Business	None.	
#9 Announcements	None.	
#10 Public Comment	None.	
#11 Adjourn Patrick Marabella, M.D, Chair	Meeting was adjourned at 12:37pm.	

NEXT MEETING: May 16th, 2013

Submitted this Day: May 16, 2013

Submitted by: Amy B Schneider

Amy Schneider, RN, Director Medical Management

Acknowledgment of Committee Approval:

Patrick C. Marabella, MD Committee Chair