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I) QUALITY IMPROVEMENT PROGRAM AND STRUCTURE

A) Work Plan Goals
- Review previous years QI Program and Work Plan to evaluate if the goals and objectives were met.
- Prepare the Evaluation and Work Plan with measurable goals and objectives.
- Document discussion and encourage a thoughtful process in the development of interventions to address areas for improvement.
- Demonstrate and document quantitative and qualitative analysis.
- Make revisions, to meet current standards and requirements including changes approved through committee action and analysis. Include signature pages, Work Plan, Evaluation, Policies and Procedures and attachments.
- Utilize the annual evaluation in the development of the Annual Work Plan for the upcoming year.
- Include a calendar of main project goals and due dates
- Review all standing policies and procedures and make revisions as needed to meet all regulatory requirements.
- Develop new policies and procedures for any areas not currently covered or to meet new/current regulatory requirements.

B) Key Findings
The 2009 program description, work plan, policies and procedures and the 2008 annual evaluation were presented to the Medical Services Committee on February 18, 2009. The committee reviewed all the documents and approved them without any revisions. After the Medical Services Committee approval, these documents were presented to the Board of Directors on February 18, 2009. The Board reviewed the documents and approved them without any revisions.

During the 4th quarter the Quality Improvement Department completed a review of all policies and procedures and identified several revisions. The QI Department transitioned Disease State Management to the Utilization Management Department in April 2009, which generated several policy and procedure revisions. These changes were made to initiate the process of bringing all DSM programs in-house and not use vendors. Our goal is to provide these services in an overall comprehensive and coordinated approach. Our evaluations revealed that we could provide these services directly rather than through a vendor. In addition, having DSM programs internally, allows us to improve program efficiencies and operationally better expedite patient needs.

The Quality Outreach Department and efforts were revised to include additional tools, which strengthened our outreach to providers’ offices. These tools are aimed at using data sources to empower physicians to better track their patients preventive and clinical needs. These changes were developed because the previous process, which was aimed at saving our staffing time, added additional work to the physician’s office staff. As Care1st Health Plan’s membership grows, it becomes more difficult to address these needs without hiring additional staffing that is outside our capability. Additionally, the change focused our efforts at the specific physician site and involves a very proactive effort to change behavior and processes at the point of care. With a focus on the physician sites it allows us to use our resources more efficiently in training the physician staff to track their members for these services and our data resources are working to help them meet these needs better. Through incentives to the physicians we have made significant steps forward in changing the behavior at the point of care.

C) Interventions
The QI Department presented the recommendation for moving DSM programs in-house and the additional tools added to Quality Outreach to our Medical Services Committee and through this committee to the Board of Directors for approval. The entire DSM program was reviewed by NCQA consultants to assure we met all requirements and all policies and procedures were approved.
D) Analysis of Findings/Progress
All policies and procedures were revised to a new formatting system, which is consistent company wide. It made policies easier to track and manage.

E) F/U Actions
The QI Department will continue to monitor these documents for any revisions on an ongoing basis.

II) CLINICAL IMPROVEMENT-HEDIS

A) WELL CHILD VISITS 3-6 YEARS OF AGE

1) Key Findings/Goals
We experienced a slight decrease in rate from 2008 (81.0%) as compared to our rate in 2009 (80.7%), which is seen as a sustained rate and is not a significant change but we identified the following contributing factors;
- Need additional proactive tracking mechanisms in-place to identify members needing services and notifying both the member and physician of these needs well in advance of the end of the year.
- Physician documentation was missing required components (i.e. anticipatory guidance) thus the visit could not be counted during the hybrid evaluation
- Submission of encounter data is very poor due to several reasons contributing to the issue; capitated contracts thus no claims data, submission of encounter data to medical groups then to health plan causing opportunities for data loss.

We set the following goal:
- Increase rate by at least 2.5%, which represents a 2.1 percentage point increase.

2) Interventions
We continued and initiated the following interventions to address the issues identified:
- Pay fee for service CHDP visits for Care1st Direct.
- Send birthday card reminders and articles within the member newsletters.
- Send monthly reports to providers requesting they contact members due for these services.
- Contact members assisting them to schedule these services.

3) Analysis of Findings/Progress
Quantitative Analysis;

<table>
<thead>
<tr>
<th>Year</th>
<th>Care1st</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>67.5%</td>
<td>59.8%</td>
</tr>
<tr>
<td>2008</td>
<td>66.7%</td>
<td>59.8%</td>
</tr>
<tr>
<td>2009</td>
<td>80.7%</td>
<td>59.8%</td>
</tr>
</tbody>
</table>

National Benchmarks for 2009
25th Percentile = 59.8%
50th Percentile = 68.2%
75th Percentile = 74.0%
90th Percentile = 78.9%

Sample Sizes
N for 2007 = 111
N for 2008 = 116
N for 2009 = 114
The benchmark in the graph represents the 25^th percentile of the National rate from the previous year. We have been able to meet and exceed the 90^th percentile of the National rate for 2009.

**Qualitative Analysis:**
Care1st has sustained our high performance level in this measure from the previous year, which reveals a solid trend of improvement over the last three years. Physicians obtained a report of members requiring services on two occasions during the year. There is evidence that the tracking of this population and contacting members assisting in scheduling visits contributed to the increase in rate.

**Barrier Analysis:**
- Documentation in the record revealed that several physicians are advising their members that a well child physical only needs to be completed every two or three years. The American Academy of Pediatrics (AAP) guidelines requires a well child visit annually.

4) F/U Actions
The Quality Improvement Department recommends the following improvement plan to address concerns identified and to continue to improve our rate:
- Continue our current interventions, which include paying fee for service CHDP for all Care1st Direct, sending birthday cards with reminders for all well child visits each year, sending list of members that require the services to physicians and continuing all HEDIS tracking outreach.
- Initiate new Quality Outreach Program, which pays physicians incentives for completing these services, through proactive visits to the office with an aim at education and change of behavior towards improvement.
- Distribution of our newly developed Quality Improvement Provider Profile report, including peer data comparisons of HEDIS rates, to each practitioner every six months.
- Added new medical record reminder sheets to be placed in the members record reminding of services due, in an effort to take advantage of opportunities during episodic visits.
- Distribution of the IPA/MG Profile Report, including medical group comparisons of HEDIS rates, to each IPA/MG quarterly.

B) ADOLESCENT WELL CARE VISITS

1) Key Findings/Goals
We experienced an improvement in rate from 2007 (23.4%) as compared to our rate in 2008 (34.1%), which was found to be a meaningful improvement (P= 0.0614) we identified the following contributing factors;
- We initiated strong proactive tracking mechanisms to identify members needing services and notifying both the member and physician of these needs well in advance of the end of the year.
- Documentation in records revealed physicians are advising members that a physical is needed physicals every two, three or even four years, which we provided education to the physicians during our outreach visits.
- Physician documentation often is missing required components (i.e. anticipatory guidance) thus the visit could not be counted during the hybrid evaluation, so we provided the physicians with medical record tools and education aimed at addressing these documentation concerns
- Submission of encounter data is very poor with several reasons contributing to the issue; capitated contracts thus no claims data, submission of encounter data to medical groups then to health plan causing opportunities for data loss. So we implemented an incentive program for physicians to submit specific encounter data directly to the plan.

We set the following goal;
- Increase our rate by 15%, which represents a 5.1 percentage point increase
2) **Interventions**

We continued and initiated the following interventions to address the issues identified;

- Paying fee for service CHDP visits for Care1st Direct.
- Sending member reports to providers requesting they contact members due to a Physical.
- Quality Outreach visits to physicians with strong education on requirements and tools to help them meet standards of documentation.
- Provider profiles giving physicians actual results of how they are doing compared to peers.

3) **Analysis of Findings/Progress**

**Quantitative Analysis:**

<table>
<thead>
<tr>
<th>Year</th>
<th>Care1st</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>33.4%</td>
<td>32.8%</td>
</tr>
<tr>
<td>2008</td>
<td>34.1%</td>
<td>35.3%</td>
</tr>
<tr>
<td>2009</td>
<td>43.2%</td>
<td>35.9%</td>
</tr>
</tbody>
</table>

**Qualitative Analysis:**

The rate increase from 2008 compared to 2009 was not statistically significant. Care1st has shown a three year trend of improvement in this measure and when comparing the 2007 rate to the 2009 rate the improvement is statistically significant (P= 0.0010). We have met our goal for improvement and also reached the 50th percentile of the National rate.

Our administrative rate has improved each of the past three years. We have identified many barriers to getting member to complete this examination, but one of the main barriers is that physicians are telling member they do not need a physical every year.

**Barrier Analysis:**

- Physicians continue to advise adolescent patients that a full physical is not necessary every year.
- Audit of the documentation in the record revealed that several members had a physical but the documentation was missing specific components.

4) **F/U Actions**

The Quality Improvement Department recommends the following improvement plan to address concerns identified and to continue to improve our rate:

- Continue our current interventions, which include paying fee for service CHDP for all Care1st Direct, sending list of members that require the services to physicians and continuing all HEDIS tracking outreach.
- Continue the proactive Quality Outreach Program, which pays physicians incentives for completing these services, through proactive visits to the office with an aim at education and change of behavior towards improvement.
- Continue the distribution of our Quality Improvement Provider Profile report, including peer data comparisons of HEDIS rates, to each practitioner every six months.
- Continue distribution of the IPA/MG Profile Report, including medical group comparisons of HEDIS rates, to each IPA/MG.
C) CHILDHOOD IMMUNIZATIONS

1) Key Findings/Goals
We experienced an increase in rate from 58.9% in 2007 compared to our 2008 rate of 75.7%, which is a significant improvement and we identified the following contributing factors:
- Contacting parents of members who require these services and assisting them in scheduling these services.
- We started collecting hospital records to identify the initial HepB vaccination, which is often given right after birth
We set the following goals:
Childhood Immunizations (Combination 3)
- Increase our rate by 5%, which represents a 3.8 percentage point increase

2) Interventions
We continued and initiated the following interventions to address the issues identified:
- Continue to mail out reminders to providers with members who are due for immunizations, mail reminders to members and pay fee for service CHDP for Care1st Direct members.
- Contact parents of member assisting them in scheduling required service.
- Initiate a pay for performance program with the physicians, which will be based from AAP guidelines.
- Pursue immunization registry data collection.

3) Analysis of Findings/Progress

Quantitative Analysis:

![Graph showing immunization rates]

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>58.9%</td>
<td>33.8%</td>
</tr>
<tr>
<td>2008</td>
<td>75.7%</td>
<td>54.3%</td>
</tr>
<tr>
<td>2009</td>
<td>83.9%</td>
<td>59.9%</td>
</tr>
</tbody>
</table>

National Benchmarks for 2009
25th Percentile = 59.9%
50th Percentile = 68.6%
75th Percentile = 74.3%
90th Percentile = 78.2%

Sample Sizes
N for 2007 = 411
N for 2008 = 411
N for 2009 = 411

Benchmark in the graphs represents the 25th percentile of the National rate. We have shown significant improvement trends for the past three years. We currently meet the 90th percentile of the National Rates.

Qualitative Analysis:
Care1st has shown an increase in rate in each of the past three years, which we attribute the improvement to proactive contacts and provider engagement. Our tracking systems have also contributed to an increase in our data collection processes. Physicians were provided reports listing their assigned members who require these services every six months. Most physicians had Quality Outreach visits with educational tools and profile reports giving the physician their rates compared to peers.
Barrier Analysis:
- Many members receive their first HepB vaccination right after birth in the hospital and sometimes PCPs are not documenting that this was given
- The most common vaccination that is non-compliant is the 4th PCV for combination 3

4) F/U Actions
The Quality Improvement Department recommends the following improvement plan to address concerns identified and to continue to improve our rate:
- Continue our current interventions, which include paying fee for service CHDP for all Care1st Direct, sending list of members that require the services to physicians and continuing all HEDIS tracking outreach.
- Continue the proactive Quality Outreach Program, which pays physicians incentives for completing these services, through proactive visits to the office with an aim at education and change of behavior towards improvement.
- Continue the distribution of our Quality Improvement Provider Profile report, including peer data comparisons of HEDIS rates, and to each practitioner every six months.
- Continue distribution of the IPA/MG Profile Report, including medical group comparisons of HEDIS rates, to each IPA/MG.
- Add specific medical record tools to the Outreach packet, including a medical record reminder sheet. This reminder sheet goes into the medical record and specifically requests these services be completed with specified timeframes. The language on these reminders is very specific.

D) TIMELINESS OF PRENATAL CARE

1) Key Findings/Goals
We experienced an increase in rate from 73.3% in 2007 compared to 78.4% in 2008, which was due to these identified factors:
- Identification of our pregnant members using prenatal vitamin reports, in addition to the other sources helped to identify pregnancies sooner.
- Submission of prenatal encounter data is very poor because: Global authorization for OB care does not support collection of encounter data, submission of encounter data to medical groups then to health plan is an opportunity for data loss, members can go anywhere without authorization so it is difficult to find out where they were seen.

We set the following goal:
- Increase our rate by 5%, which represents a 3.46 percentage point increase

2) Interventions
We continued and initiated the following interventions to address the issues identified;
- Identify pregnant members through aid code designation, authorizations and prenatal vitamins and contact them to enroll in the Healthy Start Program.
- Give incentive to pregnant members who attend all their prenatal appointments.
- Encourage members to have Comprehensive Prenatal Services Program (CPSP) services.
3) Analysis of Findings/Progress

Quantitative Analysis:

The benchmark in the graph represents the 25th percentile of the National rate. We have shown a meaningful improvement in rate from 2007 to 2008, which was sustained in 2009.

Qualitative Analysis:

Care1st has shown an increase in rate from 2007 compared to 2008, which was a meaningful improvement and this improvement was sustained in 2009.

Barrier Analysis:

- The Healthy Start Program is very labor intensive with several manual processes.
- There is no incentive for an OB physician to submit encounter data because they are paid using a global authorization.
- Identification of pregnant members early remains a significant challenge because they can go anywhere for OB care without authorization.

4) F/U Actions

The Quality Improvement Department recommends the following improvement plan to address concerns identified and to continue to improve our rate:

- Continue our Healthy Start Program but use the program to identify where care was provided and request records.
- Automate manual processes to streamline the program by making it less labor intensive.
- Initiate an incentive program for OB physicians for completing prenatal care, which will improve data collection.
- Contact all identified pregnant members and capture the name, address and contact information for their OB Physician.

E) POSTPARTUM CARE

1) Key Findings/Goals

We experienced a decrease in rate from 56.5% in 2007 compared to 64.7% in 2008, which was a statistically significant improvement (P= 0.0150) and we identified contributing factors:

- Difficulty in identification of where our member obtained prenatal and postpartum care was resolved by tracking proactively during the year where care took place.
- There is still strong evidence that members were non-compliant with appointments.
- Analysis revealed that most postpartum visits that did not meet the criteria were due to having the visit prior to the 21st day. In many cases this is because they had a c-section and needed to be checked sooner but never returned for the second follow-up visit. This was addressed by offering the member an incentive to go between these dates and the provider an incentive to perform the second visit.
- Submission of encounter data is very poor with several reasons contributing to the issue; Global authorization for OB care does not support collection of encounter data, submission of encounter data...
to medical groups then to health plan causing opportunities for data loss, members can go anywhere without authorization so it is difficult to find out where they were seen.

We set the following goal:
- Increase our rate by 10%, which represents a 5.77 percentage point increase

2) Interventions
We continued and initiated the following interventions to address the issues identified:
- Pay physicians $50 incentive for a postpartum visit within 21 – 56 days after delivery.
- Give member $10 gift certificate as incentive for completing a postpartum visit within the required dates.
- Contact all new mothers assisting them in scheduling this visit.
- Proactively collect all prenatal and postpartum records, and use the Healthy Start program to track data and information leading to where member accessed care

3) Analysis of Findings/Progress

Quantitative Analysis:

<table>
<thead>
<tr>
<th>Year</th>
<th>Care1st</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>56.5%</td>
<td>64.7%</td>
</tr>
<tr>
<td>2008</td>
<td>49.7%</td>
<td>54.3%</td>
</tr>
<tr>
<td>2009</td>
<td>77.6%</td>
<td>54.3%</td>
</tr>
</tbody>
</table>

The benchmark in the graph represents the 25th percentile of the National rate. We have seen an increase in our rate over the past year meeting the 50th percentile of the National Rate.

Qualitative Analysis:
Care1st has shown a statistically significant increase in rate over the past three years. For comparison of 2008 to 2009 rates the improvement was significant (P = 0.0001). Submission of encounter data and identification of where members obtained care remain the largest challenges to improvement.

Barrier Analysis:
- Many members had a postpartum visit but did not meet the HEDIS criteria because they had the visit prior to the 21st day.
- Member non-compliance in attending the postpartum visit is high, many schedule but are no-shows for the appointment.
- The tracking and interventions in place are labor intensive

4) F/U Actions
The Quality Improvement Department recommends the following improvement plan to address concerns identified and to improve our rate:
- Continue $10 gift certificate incentive to members for completing the postpartum visit within timeframes.
• Educate all OB and PCP physicians about the $50 incentive for completing the postpartum visit within timeframes and emphasize that if member had visit early they still need to complete a postpartum visit between 21-56 days post delivery.
• Automate manual processes to streamline our identification and intervention processes.
• Start reminder calls the day prior to a scheduled postpartum visit to limit no shows.
• Incorporate pharmacy and lab data to identify where members were seen for their postpartum visit.

F) CERVICAL CANCER SCREENING

1) Key Findings/Goals
We experienced a significant increase in rate from 59.9% in 2007 as compared to 69.3% in 2008, which we identified the following contributing factors:
• Proactive identification of where member had well woman care.
• Educational effort to physicians to document last pap smear with result on health history forms.
• Labs are an IPA responsibility and data often times is not getting to Care1st.

We set the following goals:
• Increase our rate by 10%, which represents a 5.9 percentage point increase

2) Interventions
We continued and initiated the following interventions to address the issues identified;
• Mail reminders to members who have not received a Pap Smear and educate them on the importance of obtaining this service.
• Mail listing of members who require this service to the PCP
• Place article in the member summer newsletter educating about the importance of this preventive service
• Contact members requiring this service and assist them in scheduling an appointment.
• Obtain lab data through the CALINX Standardized lab reporting format for our lab repository.

3) Analysis of Findings/Progress
Quantitative Analysis;

Benchmark in the graph represents the 25th percentile of the National rate. Our rate in 2008 compared to 2007 was a significant increase and we were able to sustain this increase in 2009.

Qualitative Analysis:
We experienced a slight decrease in rate from 69.6 to 69.3, which is not significant and demonstrates we were able to sustain our improvement from the previous year. Our tracking systems have shown improvement in our data collection processes, which is evidenced by an increase in our administrative rate.
Barrier Analysis:
- Quest Diagnostics submission of lab data through the CALIX format has incomplete, missing or inaccurate data. The issue stems from individual draw centers using multiple variations of ID numbers in the member ID field, which results in a loss of about 30% of the data because they are un-identifiable.

4) F/U Actions
The Quality Improvement Department recommends the following improvement plan to address concerns identified and to improve our rate:
- Continue to mail out reminders to members who have not received a Pap Smear and educate them on the importance of obtaining this preventive service.
- Initiate a Woman’s Health Program with a contact number for member to schedule services directly without authorization.
- Contact members who have not obtained screening and assist in scheduling service.
- Work with Quest Diagnostics to identify barriers and solutions to correct data quality issues.
- Initiate new Quality Outreach Program, which pays physicians incentives for completing these services, through proactive visits to the office with an aim at education and change of behavior towards improvement.
- Disseminate the Quality Improvement Profile Reports to all PCPs every six months.
- Disseminate the IPA/MG Profile Reports quarterly.
- Initiate the automated phone reminder system

G) BREAST CANCER SCREENING

1) Key Findings/Goals
We experienced an increase in rate from 47.8% in 2007 as compared to 49.2% in 2008, which was not significant. The following contributed to our increase in rate:
- The transition of members from UHP to Care1st had a significant effect taking into account this is a two year measure and we were able to assess this population and get them services during the measurement year.
- Effective HEDIS tracking assisted us in identification of members who had no documentation of screening and coordinators were able to collect copy of screening if service was found to have been completed (this measure is an administrative measure only).

We set the following goals:
- Increase our rate by 10%, which represents a 4.9 percentage point increase

2) Interventions
We continued and initiated the following interventions to address the issues identified:
- Mail out reminders to members who have not had a mammogram
- Mail out a list of members to the PCP who are due for the screening
- Contact member who have not had the screening and assist them in scheduling service
- Initiate automated phone reminder system
3) Analysis of Findings/Progress

**Quantitative Analysis:**

The benchmark in the graph represents the 25th percentile of the national rate. Our rate decreased, which was a significant decrease in rate (P= 0.0001). We did meet Minimum Performance Level and this year the UHP transition should have been a factor in the rate.

**Qualitative Analysis:**

Care1st has shown a decrease in rate from 49.2% in 2008 to 45.82% in 2009, which was significant. Review revealed that members are often times non-compliant with getting this service done, and providers are not recommending it as the documentation in the record does not address this often times.

**Barrier Analysis:**

- Documentation in the record reveals member who are referred to this service, often times do not show for the testing or refuse
- Providers are not documenting that the service is being discuss with the member.
- Claims for screenings are paid by the IPA/MG and this data is submitted to Care1st, leaving an opportunity for data loss.

**F/U Actions**

The QI Department recommends the following actions to address the barriers and increase our rate:

- Continue to mail out reminders to members who have not received the screening, educate members on the importance of preventive care, and mail list of members requiring services to PCPs.
- Initiate a Woman’s Health Program with a direct line for members to call and schedule these services without authorization.
- Educate members with an article in the summer issue of the member newsletter.
- Contact member who have not obtained the service and assist in scheduling screening.
- Continue Quality Outreach Program, which pays physicians incentives for completing these services, through proactive visits to the office with an aim at education and change of behavior towards improvement.
- Distribute our new Quality Improvement Profile Report to all PCP every six months.
- Distribute our new IPA/MG Profile Report to IPA/MGs quarterly.
- Use the automated phone reminder system as developed.

**APPROPRIATE TREATMENT FOR PEOPLE WITH ASTHMA**

**Key Findings/Goals**

We experienced an increase in rate from 85.0% in 2007 as compared to 85.6% in 2008. The following factors contributed to the increase in rate:

- Use of our asthma disease management program through an NCQA accredited vendor (Alere).
We set the following goals;
   • Increase our rate by 5%, which represents a 4.3 percentage point increase.

2) Interventions
We continued and initiated the following interventions to address the issues identified:
   • Refer all persistent asthmatics to our comprehensive asthma disease management program.
   • Review pharmacy data for persistent asthmatics not on controller medication and send correspondence to the PCP with suggestions to start controller medication.
   • Contact these members and assist them in scheduling an appointment with their PCP.
   • Educate members about the importance of asthma treatment with an article in our summer issue of our member newsletter.

3) Analysis of Findings/Progress
Quantitative Analysis:

The benchmark in the graph represents the 25th percentile of the national rate. We have been able to show a three year trend of improvement.

Qualitative Analysis:
Care1st has shown an increase in rate from 85.6% in 2008 to an 86.2% in 2009. There were no changes to the NCQA methodology this year. The use identification of member not meeting criteria and contacting the PCP to start controller medication has contributed to our increase.

Qualitative Analysis:
   • Review of the members records revealed that many members where prescribed controller medications but never filled the prescription.
   • There is an educational deficit with some members in understanding the use of controller medication because they do not feel they need to take it when they are not experiencing symptoms.

4) F/U Actions
The QI Department recommends the following actions to address barriers and increase our rate:
   • Continue with our comprehensive asthma disease management program aimed at improving controller medication use.
   • Review member pharmacy profiles and share this information with the PCP, so the physician can identify members not filling medications.
   • Educational newsletter article in the summer member newsletter.
   • Contact members out of compliance and assist them in scheduling an appointment.
   • Initiate new Quality Outreach Program, which pays physicians incentives for completing these services, through proactive visits to the office with an aim at education and change of behavior towards improvement.
I) COMPREHENSIVE DIABETES CARE

1) Key Findings/Goals
   a) HgbA1c Testing and Poor Control Measures
      Our HgbA1c testing rate in 2007 was 74.7%, which improved to 81.8% in 2008 exceeding the 50th percentile of the National rate.
   
   b) LDL Testing and level <100 Measures
      Our LDL testing rate in 2007 was 73.0%, which improved in 2008 to 74.7%, which was not a significant improvement. We did meet and exceed the 50th percentile of the National rate.
   
   c) Diabetic Eye Exam Measure
      Our diabetic eye exam rate in 2007 was 49.2%, which improved in 2008 to 54.5% and was not a significant improvement. We met and exceeded the 50th percentile of the National rate.
   
   d) Monitoring Nephropathy Measure
      Our diabetic nephropathy monitoring rate in 2007 was 77.6%, which decreased in 2008 to 74.2% but was not a significant change in rate. We met and exceeded to the 25th percentile of the National rate.

2) Interventions
   We initiated the following interventions to improve our rate:
   - Obtain lab data through the CALINX Standardized lab reporting format for our lab repository.
   - Contact members who have not had required labs completed and assist in scheduling these services.
   - Mail list of members who require this services to the PCP

3) Analysis of Findings/Progress
   Quantitative Analysis:

   ![HgbA1c Testing Chart]
   
   **National Benchmarks for 2009**
   - 25th Percentile = 74.2%
   - 50th Percentile = 79.6%
   - 75th Percentile = 85.6%
   - 90th Percentile = 88.8%
   
   **Sample Sizes**
   - N for 2007 = 411
   - N for 2008 = 411
   - N for 2009 = 411

   ![LDL Testing Chart]
   
   **National Benchmarks for 2009**
   - 25th Percentile = 66.7%
   - 50th Percentile = 73.2%
   - 75th Percentile = 78.6%
   - 90th Percentile = 81.8%
   
   **Sample Sizes**
   - N for 2007 = 411
   - N for 2008 = 411
   - N for 2009 = 411
The benchmarks in the above graphs represent the 25th percentile of the national rate. We improved our rate in two of the four key diabetic measures but none of the changes were statistically significant.

Qualitative Analysis:
Care1st has shown an improvement in all of the CDC measures. The Monitoring Nephropathy measure had a change in methodology so we have used the 2007 rate as our baseline going forward.

Barrier Analysis:
- Quest Diagnostics submission of lab data through the CALIX format has incomplete, missing or inaccurate data. The issue stems from individual draw centers using multiple variations of ID numbers in the member ID field, which results in a loss of about 30% of the data because they are unidentifiable.
- Our tracking of diabetic members only consisted of identification of diabetics that did not have the required service and did not identify those who had poor results and require follow-up.
- On record review many members are having testing done but following up on the results needs to improve.

4) F/U Actions
The QI Department recommends the following actions to improve our rates:
- Work with Quest Diagnostics to identify barriers and solutions to improve data quality issues.
- Contact members who have not obtained services and assist in scheduling service.
- Identify members with poor screening results and contact them to assure they understand the results and need for follow-up.
- Implement a new direct referral to our contracted eye care vendor to improve member access.
• Continue Quality Outreach Program, which pays physicians incentives for completing these services, through proactive visits to the office with an aim at education and change of behavior towards improvement.
• Disseminate the Quality Improvement Profile Reports to all PCPs every six months.
• Disseminate medical record reminder sheets to be placed in the record reminding of services due.
• Disseminate the IPA/MG Profile Reports quarterly.

III) DISEASE MANAGEMENT

A) ASTHMA DSM PROGRAM

1) Key Findings/Goals
   In April 2009 the Asthma Disease Management Program was brought in-house and the contract with Alere was terminated. The Asthma DSM programs responsibility is with a new Disease Management Department within the Utilization Management Department. All Disease management reporting will be through this department going forward.

B) CONGESTIVE HEART FAILURE (CHF) AND CORONARY ARTERY DISEASE (CAD) DSM PROGRAMS-HEALTHWAYS NCQA ACCREDITED VENDOR

1) Key Findings
   Care1st Health Plan initiated the Congestive Heart Failure and Coronary Artery Disease program in April of 2008. The Disease Management Programs were moved internally into a new Disease management Department within the Utilization Management Department. All reporting will be through this department going forward.
IV) POTENTIAL QUALITY ISSUE REVIEWS

A) REVIEW SUMMARY

1) Key Findings/Goals
In 2009 there were a total of 300 cases reviewed, which a majority were automatically identified through review of our claims, encounter and hospitalization reports. Members admitted with a primary chronic diagnosis are reviewed because they have a high potential that the admission could have been prevented with appropriate outpatient care. These cases are a majority of our reviews and asthma admissions are the highest case type reviewed. Of the 300 cases reviewed, there were only two total quality of care issues identified, which were addressed with a CAP.

During 2008 there were a total of 367 cases reviewed, with only three cases where a quality issue was identified.

2) Interventions
Because we have documented a so many reviews with very little quality issues being identified we have implemented the following interventions during 2009:
- Limit the amount of automated case identifications for review and train UM nurses to identify cases with a potential for quality related issues.
- Utilize Disease Management and Complex Case Management programs to identify high potential cases to review.
- Continue with some automated reviews such as readmissions for the same diagnosis within 30 days.
- Re-measure to document improvement.

3) Analysis of Findings/Progress

Quantitative Analysis:
There were only two quality related issues identified through these reviews in 2009, indicating that a changes in the identification process for cases needed to be made. These changes were made during 2009 and we will follow-up in 2010 to see if there is an increase in the identification of quality issues.

As a note we followed up on the high volume of re-admission cases that QI has reviewed and worked to limit case reviews to cases specifically with a high potential for quality issues to be identified. As a result, re-admission reviews significantly decreased in 2009.

4) F/U Actions
The QI Department recommends the following actions to improve the rate of readmission;
- Evaluate the changes made in case identification to measure improved identification of actual quality related issues.
- Utilize Disease Management and Complex Case Management programs to identify high potential cases to review.
A) **CLINICAL PRACTICE GUIDELINES**

1) **Key Findings**

The QI Department assures that all clinical and preventive health guidelines are taken through the committee and reviewed and approved annually. Care1st has the following Clinical Practice Guidelines approved:

- Diabetes - using the American Diabetes Association clinical practice guidelines
- Asthma - Using the American Heart, Lung and Blood Institutes guidelines
- Cardiac Disorders
- COPD
- Hypertension
- Treatment of Viral Upper respiratory Infection
- Treatment of Acute Pharyngitis
- Treatment of Uncomplicated Urinary Tract Infection in Women

Care1st has revised the asthma guidelines based on revisions made by the American Heart, Lung and Blood Institutes guidelines. Care1st has also revised the diabetes guidelines based on additions made to formulary. The Pharmacy Department presented these guidelines to the Pharmacy and Therapeutics Committee for approval and the committee made recommendations, which are currently pending.

Care1st uses nationally recognized preventive care guidelines, which are used to develop periodicity table preventive health guidance sheets for physicians and members. These guidelines were approved through the Medical Services Committee in January 2009. These guidelines are taken from National sources such as:

- American College of Obstetrics and Gynecology
- American Academy of Pediatrics
- United States Preventive Services Task Force Standards

Care1st uses nationally recognized utilization review guidelines to assist in making determinations, which were approved through our Medical Services Committee in January 2009. Our approved utilization guidelines are:

- Milliman Care Guidelines

2) **Goals**

The QI Department recommends setting the following goals for 2010:

- Review, revise and approve the following CPGs by the end of the 1st quarter of 2010:
  - Asthma
  - Diabetes
  - Treatment of Viral Upper Respiratory Infection
  - Treatment of Acute Pharyngitis
  - Treatment of Uncomplicated Urinary Tract Infection in Women
  - Hypertension
  - Cardiac Disorders
  - Chronic Obstructive Pulmonary Disease (COPD)
VI) CONTINUITY AND COORDINATION OF CARE

A) BETWEEN PCP AND DOCUMENTATION OF FOLLOW-UP OF LAB OR DIAGNOSTIC TEST RESULTS

1) Key Findings/Goals

The QI Department looked at a random sample of HEDIS files collected between January - December 2008 to assess the continuity of care between Lab and Radiology services ensuring that a provider had initialed the reports and consulted results with member.

2) Interventions

No initial interventions were implemented, since this is a new study.

3) Analysis/Findings

Our study included a review of 848 files, where 436 had lab and/or radiology reports. Of the 436, there were a total 416 that met compliance where the Radiology or Lab report results were communicated to the member, by the physician, based on documentation in the record. Of the 436, only 20 were not signed by Provider or the review was not documented in the medical record. Based on results, we have a 95.4% compliance rate.

Qualitative Analysis
Our evaluation evidenced that members are receiving their lab/radiology results from their provider. We will continue to evaluate this in the future.

4) Follow Up/Actions

The QI Department recommends the following actions to sustain rate:

- We will continue to evaluate this continuity measure for one more year to identify if any issues are present.
VII) ACCESSIBILITY TO CARE AND SERVICES

A) APPOINTMENT AVAILABILITY

1) Key Findings/Goals
Care1st Health Plan is required by LA Care to conduct our appointment availability and after hours access to care studies as a collaborative with other local health plans. This collaborative study is aimed at reducing the burden on practitioner offices and health plan resources because many of the physician’s offices are contracted with several health plans.

We set the following goals:
- Collaborate with LA Care and other Plan Partners on an annual access to care study. This is done through a vendor with LA Care.
- Meet the wait days requirement: Urgent within 48 hours, non-urgent within 10 business days, routine, IHA and CHDP within 30 days.
- Assure appropriate access to specialty practitioner within 30 days of authorization.

2) Interventions
We continued and initiated the following interventions to address the issues identified:
- Continue with the collaborative access to care study in 2009, which will be conducted through a vendor contracted by LA Care.
- Complete a corrective action plan that addresses all the areas we are not meeting compliance with standards.
- Educate practitioners about the requirements
- Educate members about the requirements

3) Analysis of Findings/Progress

Quantitative Analysis:
This graph below represents the average wait day-children 2-15 years of age
This graph below represents the average wait day for children 2-15 years of age for sensitive services.

This graph below represents the average wait day for adult 16 years of age and greater.

This graph below represents the average wait day for adults age 16 years and greater for sensitive services.

The rates were broken down by PCP specialty (GP, FP, IM, OBGYN and Peds) and Family Practice had higher timeframes in routine, IHA and CHDP visits then any other specialty comparing both adult and pediatric population in 2007 and 2008 but additional contracting in specific geographical areas showed significant improvement in 2009, but the timeframes were still well within standards for each year.
Review of the member grievances concerning access to care related issues revealed 8 total concerning access to the PCP and 10 total concerning access to the specialist. Review of these grievances did not identify quality related issues requiring correction. There were 19 grievances related to appointment availability as compared to 25 in 2008 and the graph below represents grievances related to appointment availability annualized per 1,000 members, which reveals meaningful improvement.

This table details the wait-day comparison of those specialties surveyed in 2007, 2008 and 2009. The standard Care1st has set is at least 90% compliance with the 30 days timeframe.

**Table 7-A**

<table>
<thead>
<tr>
<th>Specialty Type</th>
<th>Average # of Days</th>
<th>% in compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007</td>
<td>2008</td>
</tr>
<tr>
<td>Allergy</td>
<td>9.7</td>
<td>13.9</td>
</tr>
<tr>
<td>Cardiovascular Disease (MD Only)</td>
<td>17.1</td>
<td>21.7</td>
</tr>
<tr>
<td>Dermatology</td>
<td>17.2</td>
<td><strong>11.3</strong></td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>13.4</td>
<td>15.4</td>
</tr>
<tr>
<td>Hand Surgery</td>
<td>9.4</td>
<td><strong>8.3</strong></td>
</tr>
<tr>
<td>Nephrology</td>
<td>22.3</td>
<td><strong>17.6</strong></td>
</tr>
<tr>
<td>Neurology (MD Only)</td>
<td>17.1</td>
<td>20.2</td>
</tr>
<tr>
<td>Obstetrics-Gynecology (MD Only)</td>
<td>13.1</td>
<td><strong>10.4</strong></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>18.6</td>
<td>14.1</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>13.8</td>
<td>23.5</td>
</tr>
<tr>
<td>Pediatric Allergy</td>
<td>13.8</td>
<td><strong>11.3</strong></td>
</tr>
<tr>
<td>Pediatric Cardiology (MD Only)</td>
<td>30.6</td>
<td><strong>25.8</strong></td>
</tr>
<tr>
<td>Pediatric Endocrinology</td>
<td>47.0</td>
<td>16.5</td>
</tr>
<tr>
<td>Pediatric Gastroenterology</td>
<td>16.0</td>
<td>30.3</td>
</tr>
<tr>
<td>Pediatric Hematology-Oncology</td>
<td>8.5</td>
<td>17.3</td>
</tr>
<tr>
<td>Pediatric Neurology</td>
<td>18.5</td>
<td>35.5</td>
</tr>
<tr>
<td>Pediatric Orthopedics</td>
<td>14.5</td>
<td>9.0</td>
</tr>
<tr>
<td>Pulmonary Disease</td>
<td>12.8</td>
<td>14.5</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>21.5</td>
<td><strong>19.8</strong></td>
</tr>
<tr>
<td>Urology</td>
<td>15.8</td>
<td><strong>13.3</strong></td>
</tr>
</tbody>
</table>

**Bold** type represents an improvement in days or percentage of compliance. *Italics* represents sample sizes below 20 so placing a statistical significance is not possible.

**Analysis**

These rates were obtained by mystery shopper contact calls done by The Myers Group and involved 602 specialist provider offices that were contacted. For the PCP study each provider was sent a mail-in survey, which was sent to 2,186 PCPs (1,570 non-pediatric and 616 pediatric). From the survey 972 responded giving a 44.5% response rate. The PCP survey was validated through a mystery shopper sample that included both responding providers and non-responding providers.
Significance Testing
For compliance rate comparisons, the z test is used to determine significant differences. Significant differences are determined for mean wait days through a t-test. All significance testing was performed at the 99% confidence level.

There was no statistical difference identified as it relates to the PCP wait times for appointments. Care1st has seen an increase in the wait time related to prenatal care over a three year period.

Qualitative Analysis:
When comparing the Care1st Health Plan providers with the Non-Care1st providers there was a significantly shorter wait time with Care1st as it related to non-urgent, routine, preventative, IHA, pregnancy services and initial prenatal appointment. Care1st had a significantly longer wait time as it related to urgent, STD, and HIV related services. Care1st Health Plan had the highest compliance rate as it related to the specialist mystery shopper analysis at a 92.3%.

There were no trends found related to grievances and our rate per 1,000 members has decreased. There were many areas that revealed improvement in wait days as it related to specialty access for appointments. In addition, these decreases are not statistically significant due to the number of grievances concerning these issues are very low.

4) F/U Actions
The QI Department recommends the following actions to sustain and improve the rate:
- Continue our current interventions, which include annually educating our practitioner network and members on the access to care standards. This keeps members informed so when delays are found they can contact us. This also assures practitioners are informed of the standards that they will be audited on for compliance.
- Target specific practitioner that are not meeting standards and work to educate and support them in meeting requirements.
- Report results in the summer practitioner newsletter.
- Compare results with our geo access study to identify possible network gaps, such as remote areas that might have decreased access related issues.

B) AFTER HOURS AVAILABILITY

1) Key Findings/Goals
The criteria for compliance in this area requires that the physician or designated on-call physician be available to respond to and/or coordinate care for a patient’s medical needs beyond normal hours. To ensure after-hours health care access and availability, the physician may use a professional exchange service, automated answering /paging system with an option for connection to a live party, or be directly accessible by phone. It is also required that any after-hours system or service that a physician uses provide emergency instructions in the event that the patient is experiencing a life-threatening emergency.

We set the following goals:
- Assure all practitioner offices are available or have a covering physician available 24 hours a day 7 days a week.
- Assure all physicians that have an automated system to answer calls have emergency instructions.
- Educate all members and practitioners about access to care standards.

2) Interventions
We continued and initiated the following interventions to address the issues identified:
- Mail educational information to members and practitioners detailing access to care standards.
- Support and take part in all collaborative interventions.
- Complete a corrective action plan directly with each practitioner who fails to meet standards.
3) Analysis of Findings/Progress

Quantitative Analysis:
The 2009 analysis had a sample size of 1,972 for Care 1st Health Plan. Care1st had a compliance rate on every indicator in 2009 of 60.3%, which was second among the plan partners. This rate was a significant decrease from the previous year, which was 68.4% and all health plan experienced greater decreases than Care1st.

- A 78.8% compliance rate, where the provider was available for the after hours call and Care1st had, the highest rate of all plan partners.
- A 6.7% of the call the phone continued to ring with no answer.
- A 7.8% were a recorded message with no contact information.
- A 86.3% of the offices that had an answering service were able to connect with the PCP.
- A 96.2% had a way to reach the PCP or a covering provider. 87.6% had emergency contact information available for the member.

There were four total complaints during 2009 concerning after-hours availability, in which two were with the same provider. There were issues found with one practitioner and focused audits were completed and corrective action plan was completed. All follow-up evaluation revealed this issue improved and no further complaints have been received on this practitioner. Our CAHPS survey results revealed improvement in satisfaction concerning referral authorization process and timeliness, but the improvements were not statistically significant.

Qualitative Analysis:
Reasons for Non-Compliance: The primary reason for PCP after-hours non-compliance was use of an automated system that did not offer the patient an opportunity to speak with a live party. In addition to a no answer when calling on 6.7% of them.

4) F/U Actions
The QI Department recommends the following recommendations to improve our rate of compliance:
- Complete a summary write up and present to the physicians during the next Quality Outreach visits.
- Do an educational mailing to the entire network in the next newsletter.
- Continue the nurse advice line to assure members have clinical advice if provider is not available.
- Need to take actions to identify wrong information in our systems, such as wrong phone number or disconnected phone numbers, and immediately correct this information.

Our annual CAHPS survey had an overall 48.34% rating when asked if they are taken to the exam room within 15 minutes of their appointment. Review of our grievances annualized per 10,000 members as they relate to waiting time in the physicians office revealed a significant decrease in rate.

D) PCP GEOGRAPHICAL AVAILABILITY

1) Key Findings/Goals
We conducted our Geo Access study in October 2009, which was aimed at assuring we have sufficient coverage for our members. This study will be conducted every year so we can draw strong comparisons to measure improvement.

We set the following goals:
- Meet 95% compliance in having at least one PCP within 15 miles of members home.

2) Interventions
We continued and initiated the following interventions to address the issues identified:
- Provider Relations Department uses this analysis to identify areas of coverage gaps and attempts to contract physicians to fill the gaps.
• Provide free transportation

3) Analysis of Findings/Progress

Quantitative Analysis:

% of Members who have at least one PCP within 15 miles of home

<table>
<thead>
<tr>
<th>PCP Access All</th>
<th>PCP Access Child</th>
<th>PCP Access Adult</th>
<th>PCP Ob/Gyn</th>
</tr>
</thead>
<tbody>
<tr>
<td>99.50%</td>
<td>99.50%</td>
<td>99.50%</td>
<td>99.50%</td>
</tr>
</tbody>
</table>

The goal in policy is set at 95% compliance and we meet this with each PCP specialty.

Qualitative Analysis:
There are no problems identified as it relates to geographical distribution of PCP. The areas we can improve on coverage is Lancaster/Palmdale, which is a remote area with limited coverage. We address this by offering our members free transportation to all their appointments.

4) F/U Actions
The QI Department recommends the following actions to sustain the increase in rate and continue to improve the rate:
• Assure that Provider Relations has these geographical mappings to identify areas where additional contracting might be needed.
• Continue to offer free transportation to appointments.
• Re-measure annually

E) SPECIALIST GEOGRAPHICAL AVAILABILITY

1) Key Findings/Goals
We conducted our Geo Access study in October 2009, which was aimed at assuring we have sufficient coverage of specialists for our members. This study will be conducted every year so we can draw strong comparisons to measure improvement. We set the following goals;
• Improve member satisfaction of specialty network and access to care
• Increase the percentage of members who have a specialty within 0-15 miles
• Meet 95% or greater in all high volume specialists

2) Interventions
We continued and initiated the following interventions to address the issues identified;
• Work with Provider Relations on conducting this study by utilizing the geo access software program.
• Evaluate and report results to the Medical Services Committee and Board of Directors
• Collaboratively develop interventions and corrective action plans with other departments to measure improvements
3) **Analysis of Findings/Progress**

*Quantitative Analysis:*

The table below represents the rate of member who have at least one of the identified specialists within 15 miles of their home.

Table 7-E

<table>
<thead>
<tr>
<th>PCP ACCESSIBILITY (LOS ANGELES)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ancillary</td>
<td>99.5%</td>
</tr>
<tr>
<td>Hospital &amp; Emergency Facil.*</td>
<td>98.7%</td>
</tr>
<tr>
<td>Allergy</td>
<td>90.6%</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>90.0%</td>
</tr>
<tr>
<td>Audiology</td>
<td>37.4%</td>
</tr>
<tr>
<td><strong>Cardiology</strong></td>
<td>98.8%</td>
</tr>
<tr>
<td><strong>Dermatology</strong></td>
<td>99.3%</td>
</tr>
<tr>
<td><strong>ENT</strong></td>
<td>98.6%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>98.9%</td>
</tr>
<tr>
<td><strong>Gastroenterology</strong></td>
<td>98.8%</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>82.4%</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>98.8%</td>
</tr>
<tr>
<td>Hematology</td>
<td>34.7%</td>
</tr>
<tr>
<td>HIV Specialist</td>
<td>56.4%</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>99.3%</td>
</tr>
<tr>
<td>Medical Genetics</td>
<td>71.4%</td>
</tr>
<tr>
<td>Neonatology</td>
<td>89.9%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>99.1%</td>
</tr>
<tr>
<td>Neurology/Neuro Surgery</td>
<td>98.8%</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>88.4%</td>
</tr>
<tr>
<td><strong>OB/GYN (Specialists only)</strong></td>
<td>99.0%</td>
</tr>
<tr>
<td>Occupational Medicine</td>
<td>51.4%</td>
</tr>
<tr>
<td><strong>Ophthalmology</strong></td>
<td>99.0%</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>99.5%</td>
</tr>
<tr>
<td>Pathology</td>
<td>87.9%</td>
</tr>
<tr>
<td>Pediatric Allergy</td>
<td>67.0%</td>
</tr>
<tr>
<td>Pediatric Cardiology</td>
<td>99.0%</td>
</tr>
<tr>
<td>Pediatric Endocrinology</td>
<td>74.7%</td>
</tr>
<tr>
<td>Pediatric Gastroenterology</td>
<td>90.4%</td>
</tr>
<tr>
<td>Pediatric Hematology/Oncology</td>
<td>82.7%</td>
</tr>
<tr>
<td>Pediatric Infectious Disease</td>
<td>81.2%</td>
</tr>
<tr>
<td>Pediatric Nephrology</td>
<td>71.4%</td>
</tr>
<tr>
<td>Pediatric Neurology</td>
<td>76.6%</td>
</tr>
<tr>
<td>Pediatric Orthopedic Surgery</td>
<td>80.4%</td>
</tr>
<tr>
<td>Pediatric Surgery</td>
<td>90.3%</td>
</tr>
<tr>
<td>Pediatric Pulmonary</td>
<td>70.4%</td>
</tr>
<tr>
<td>Perinatology</td>
<td>95.5%</td>
</tr>
</tbody>
</table>
Care1st Health Plan  
Los Angeles County Medi-Cal  
2009 Annual Evaluation

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td>98.4%</td>
</tr>
<tr>
<td>Podiatry</td>
<td>99.2%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>90.1%</td>
</tr>
<tr>
<td>Pulmonary Medicine</td>
<td>98.8%</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>99.0%</td>
</tr>
<tr>
<td>Radiology</td>
<td>98.5%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>99.0%</td>
</tr>
<tr>
<td>Surgery</td>
<td>99.0%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>86.8%</td>
</tr>
<tr>
<td>Urology</td>
<td>99.1%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>80.3%</td>
</tr>
</tbody>
</table>

*Represents 199,583 Members*

Review of high volume specialty practitioners is determined by having greater than 2% of the referral volume, which we changed from 5% so we can focus on additional specialties. When we had it set at 5% we met the standards and this only identified three specialties to track. There were only a couple specialties that meet the high volume criteria and they are identified with Bold type. Our goal is to have appropriate coverage with at least a 95% compliance rate.

**Qualitative Analysis:**
Assessment of our Geo Access mappings revealed that Care1st has appropriate coverage to meet our membership needs. Because our membership in the Medi-Cal population tends to be a younger population we assessed the pediatric sub-specialty network. There was an issue two years ago identified that there was increased wait times in getting an appointment to a pediatric sub-specialty. Our efforts were to increase our network to address this issue, and PNO has been contracting additional pediatric sub-specialties. We are continuing to focus on contracting these sub-specialties. We have seen a dramatic improvement in our rate as it relates to members getting an appointment. In almost every specialty group there was lower coverage in Lancaster/Palmdale, which we assure there is free transportation offered to appointments.

4) **F/U Actions**
The QI Department recommends the following actions to sustain our improved rate:
- Continue our current interventions of disseminating this information to our PNO department to make attempts to contract specialty providers in lower coverage areas. We have referred every specialty area below 95% compliance to PNO during 2009 for intervention.
- Continue free transportation to our members to assure open access.
- Continue to seek pediatric sub-specialty contracts in areas with low coverage.

F) **HOSPITAL AND ANCILLARY GEOGRAPHICAL AVAILABILITY**

1) **Key Findings/Goals**
   We conducted our hospital and ancillary service Geo Access study in October 2008, which was aimed at assuring we have sufficient coverage of hospitals and ancillary services for our members. This study will be conducted every year so we can draw strong comparisons to measure improvement. We set the following goals:
   - Increase percentage of member with a hospital within 15 miles of their home
   - Increase the percentage of member with ancillary services within 15 miles of their home
   - Identify gaps in coverage

2) **Interventions**
   We are currently utilizing or planning the following interventions;
3) **Analysis of Findings/Progress**

**Quantitative Analysis:**

*Ancillary Providers*
We reviewed our ancillary providers using the Geo Access programs, for having at least one provider within 15 miles of the member’s home. For Medi-Cal Los Angeles we have met a 99.5% compliance rate for this measure. The area that has slight gaps is remote geographically but has shown improvement and currently meet standards of greater than 95%.

*Hospitals and Emergency Services*
We reviewed our contracted hospitals and emergency services using the Geo Access programs, for having at least one within 15 miles of the member’s home. For Medi-Cal Los Angeles we currently meet a 99.3% compliance rate. The area in Lancaster and Palmdale, which is a remote area the hospital coverage is 94% and will improve with a new hospital opening.

**Qualitative Analysis**
The opportunity to improve these rates are remote, because we have a high compliance rate coupled with the fact the only areas that do not have full 100% compliance are remote geographical regions without additional services to contract with. Care1st offers free transportation services to members to address any issues this might cause.

4) **F/U Actions**
The QI Department recommends the following actions to sustain or increase our compliance rate:

- Continue to offer free transportation to members; this assists the members who are in remote areas to have access to these services even if they do not have transportation.
- Forward results to Provider Relations Department to research the possibility of additional services Care1st can contract with.
- Assure these specific member are notified that transportation is available and the process for arranging this service.
- When new hospital in remote area is completed we will work to secure a contract.

### VIII) MEMBER AND PRACTITIONER SATISFACTION

#### A) MEMBER GREIVANCES

1) **Key Findings/Goals**
Care1st identifies grievances through written submissions from members, received in the provider office and mainly received through member calls to our Member Services Department. These calls are coded for the appropriate issue and reviewed by a nurse to be given a determination if a possible quality issue is present. We define a grievance as any show of dissatisfaction by the member or member’s family.

Historically delay in the authorization process is our highest complaint issue, which mainly involves delegated IPA/MGs. There were 406 total grievances reviewed by the QI Department for Medi-Cal Los Angeles in 2009. Delay in authorization complaints represented 49.7% of all our complaint issues in 2007, which increased to 61.3% in 2008 so we placed specific efforts on provider education concerning timely submission, IPA education about timely processing and staff education. In 2009 the rate has decreased to 49.8% of all grievance issues reviewed.

We set the following goals:

- Goal is to decrease the rate annualized per 1,000 members of delay in authorization grievances.
Goal is to decrease the rate for delay in authorization issues with identified IPAs
Improve member satisfaction rate for getting an authorization within 7 days

2) Interventions
We continued and initiated the following interventions to address the issues identified:
- Track and trend grievances to identify opportunities for improvement.
- Monitor the identified non-compliant IPA’s and complete corrective action plans.
- Chief Medical Officer will review all clinical issues. The Peer Review and/or Medical Services Committees will review all applicable cases.
- Resolution times will conform to regulatory requirements.
- Required reports will be made to regulatory agencies.

3) Analysis of Findings/Progress

Quantitative Analysis:

Delay in Authorization Complaint Annualized per 1,000 Members

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>2.9</td>
</tr>
<tr>
<td>2008</td>
<td>4.4</td>
</tr>
<tr>
<td>2009</td>
<td>1.0</td>
</tr>
</tbody>
</table>

The rate is based from an annualized per 1,000 member rate, which revealed a significant increase in complaint volume in 2008 but the corrective actions taken revealed a significant decrease in 2009 compared to both 2007 and 2008 rates.

Qualitative Analysis:
This complaint issue remains our highest percentage of complaints received, but focused education and intervention with providers and medical groups have significantly decreased the volume of these complaints from member when reviewing the annualized per 1000 rates. Although there is a significant improvement in the annualized number, the total amount of complaint issues decreased and delay in the authorization process still is the highest issue requiring improvement.

4) F/U Actions
The QI Department recommends the following actions to improve our rates:
- Work to initiate specific direct referral processes with our direct line of business.
- Develop stronger IPA/MG tracking of grievance related issues to add to profile reports and educate them during JOC meetings.
- Add additional educational components to the Quality Outreach packets addressing member complaint issues.
B) MEMBER SATISFACTION

1) Key Findings/Goals
Care1st conducts annual CAHPS survey and we analyze the results to develop corrective actions for improvement. Each year we measure the results compared from the previous year to assess success of interventions. We set the following goals based on the previous survey done:
- Goal to improve response rate and rates across the board.
- Goal to improve member satisfaction with primary care practitioner as it relates to appointment availability and communication about medical conditions with the member.
- Goal to improve member satisfaction with wait time for referrals and specialty appointments

2) Interventions
We continued and initiated the following interventions to address the issues identified:
- Proactively run contact calls to members and update contact information when a member calls Member Services to assure we have the most updated contact information.
- Oversight of CAHPS vendor process
- Obtain results from Vendor, which are much more detailed than the results submitted to NCQA
- Present results to the Medical Services Committee and Board of Directors with recommendations for improvements
- Conduct a short member survey when a member contacts our Member Services Department asking about specific issues they are having and use this information to develop changes in our processes proactively (not just wait for CAHPS). This will allow us to obtain valuable detailed information.
- Conduct a follow-up survey on all grievances to assure we resolved the member issue to their satisfaction.
- Send specific information to member through Newsletters, direct mailings and web site that addresses access to care requirements, waiting times, telephone access, grievance process and several additional subjects. In addition, the CAHPS survey covers asking member to contact us if they have any issue, so we can work to correct it proactively.

3) Analysis of Findings/Progress
Quantitative Analysis:
The graphs below detail the results of our child CAHPS survey for 2008 (blue) and 2009 (burgundy) and represents the percentage that answered with an 8, 9 or 10 on a scale of 1-10 with 10 being best.
The only two areas where we had a decrease in rate were appointment availability question and the decrease was not statistically significant.

The following graphs represent results from the Adult survey

1- Rating of all health care  
2- Rating of personal doctor  
3- Rating of specialist seen most often  
4- Rating of health plan
Qualitative Analysis:
We have shown an improvement across every question except for appointment availability, smoking cessation and easy to complete forms from the health plan. We contribute the improvement to specific targeted Quality Outreach efforts to the providers. With these Outreach visits we addressed specific CAHPS survey issues that pertained to how the practitioners communicate with members. These specific related questions had the highest improvement of any other questions.

4) F/U Actions
The QI Department recommends the following actions to improve our rates:
- Develop a member specific follow-up survey after they file a grievance to assure we resolved issues to their satisfaction
- Send educational mailing that addresses referral process, timelines and what to expect from this process. The goal is to answer questions in advance and give the member strong expectations. This mailing will go out annually.
- Provide educational efforts to practitioners through direct Quality Outreach visits, addressing specific areas of the CAHPS survey and discuss results.

D) PROVIDER SATISFACTION

1) Key Findings/Goals
We set the following goals:
- Improve response rate by 10%
- Improve provider satisfaction with Pharmacy by 5%
- Improve provider satisfaction with Utilization Management by 5%
- To have a 90% satisfaction rate in each area

2) Interventions
Interventions used to address issues identified in the 2007-2008 provider satisfaction survey were:
- Provide education to provider network concerning the following resources, to improve dissemination of information:
  - C&L Services and resources
  - Medi-Cal Claims guidelines
  - Pharmacy turn around times
Care1st Health Plan  
Los Angeles County Medi-Cal  
2009 Annual Evaluation

- Healthy Start Program
- Member and Provider grievance process
- QI activities and results
- Provider appeals process

- Evaluate the distribution of the provider manual and orientations to assure they are being completed
- Initiate direct mailing of QI reports to IPA provider networks

3) Analysis of Findings/Progress

**Quantitative Analysis of 2009 Provider Satisfaction Survey:** All rates are based on Satisfied and very satisfied responses to questions

**Provider Relations (PNO)**- Our goal was to improve the rate of practitioners obtaining an orientation and a provider manual. All other areas of the PNO section of the survey were well above 90% satisfaction

![Given with a Practitioner Orientation](chart)

![Received a Practitioner Manual](chart)

**Member Services**- Our goal was to better educate the Member Services Representatives so when practitioner offices call, their questions will be answered accurately. The Member Services Department has shown meaningful improvement in being able to assist the provider when calling. The only area that revealed a decrease in rate is timeliness, which is related to higher volume of calls. Member Services has implemented an automated eligibility system option for practitioners to check eligibility.

![Received a Practitioner Manual](chart)

1) My calls are answered courteously  
2) My calls are answered in a timely manner  
3) Member Services Representative was able to assist me
**Claims and Capitation** - There were significant improvements in claims timeliness and claims being processed according to contract agreement. All questions related to claims met the goal of 90% or higher.

**Utilization Management** - Referrals being processed timely and the appeals process being easy to follow fell below our goal. The appeals process being easy to follow had a significant decrease in rate. There was improvement in denial notifications that consistently provided denial reasons for Care1st Direct, however there was a significant decrease with the IPAs. We have a very comprehensive program to improve this with the IPA and a close monitoring system in place.

**Health Education** - Health Education was well above goal for providing useful information to practitioners and providing materials that were helpful to their members. There was a significant improvement in practitioner stating they use the monthly patient education classes for their patients, which increased by 22%.

**Culture and Linguistics** - C&L related questions revealed we are meeting goal in practitioners understanding of regulatory requirements and standards. We have shown improvement in practitioner stating they know how to access specific interpretation and cultural services, but these questions about knowing how to access remain below goal. We will add C&L specific educational materials to our next Quality Outreach packets in 2010.

**Quality Improvement** - Results have revealed a decrease in satisfaction concerning the grievance process, and practitioners feeling they have been kept informed about quality improvement activities. We have rolled out very comprehensive Quality Outreach program in 2008 and re-vamped it to include multiple QI related intervention programs and activities. We visited each provider giving them profiles of how their quality numbers look in comparison to their peers. We provided multiple tools aimed at helping practitioners meet these member goals and the visits were well received.

**Pharmacy Services** - There were some areas that scored below 90% satisfaction as detailed in the graph below:

<table>
<thead>
<tr>
<th></th>
<th>1) Care1st formulary meets my patients’ needs</th>
<th>2) Care1st Pharmacy staff are able to assist me</th>
<th>3) Care1st Pharmacy network is adequate for my patients’ needs</th>
<th>4) Prior authorization drug requests are processed in a timely manner</th>
<th>5) The Drug Denial process is consistent</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>91.8%</td>
<td>84.0%</td>
<td>89.4%</td>
<td>91.2%</td>
<td>90.9%</td>
</tr>
<tr>
<td>4</td>
<td>88.2%</td>
<td>84.5%</td>
<td>93.8%</td>
<td>90.0%</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>91.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>90.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>90.0%</td>
<td></td>
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</tr>
</tbody>
</table>

![Graph showing pharmacy service satisfaction with percentages]
Based on the results of this survey and other specific data collected the Pharmacy Department is making several changes to the formulary as it relates to specific edits and specific tier medications, which are aimed at improving satisfaction. These specific changes will limit specific prior authorization requirements. The Pharmacy Department has also implemented a Prior Authorization tracking system that identifies member taking prior authorization medications and works to re-new the annual prior authorization at least a month prior to expiration limiting any delay to the member or practitioner.

IX) FACILITY SITE REVIEW AND PATIENT SAFETY

A) FACILITY SITE REVIEW

1) Activity and Status
- 264 sites assigned
- 89 due in 2009
- 89 completed

We set the following goals:
- Ensure facility site reviews are being conducted in a timely manner
- Educate our contracted practitioners on the FSR process and increase the pass rate
- Address patient safety issues found during the FSR process
- Assure availability and accessibility for disabled patients

2) F/U Actions
The QI Department recommends the following actions to continue our strong FSR process:
- Revise our FSR Resource Manual, aimed at helping practitioners meet standards
- Update the FSR Resource Manual on the web for practitioners to access by June
- Hire and train new FSR nurse reviewer, to replace current Master Trainer who moved out of State.

B) PATIENT SAFETY

1) Key Findings/Goals
The QI Department did not focus on a specific patient safety related issues to develop interventions in 2009. We will focus on addressing a patient safety related issues in 2010.

X) CREDENTIALING

A) CREDENTIALING

1) Activity and Status
The Credentialing Committee actions for 2009 are as follows:
- 143 initial approved
- 241 Re-creds
- 10 Re-creds non-compliant
- 100 Inactivation’s
- 159 HDO’s (LA, SD, SB/Riverside, OC)
- We were audited by LA Care in June 2009 and passed with a small CAP that was completed.
- We have been able to meet all required timeframes during the year, by terming non-compliant practitioners. If a practitioner fails to complete the re-credentialing application by set timeframes they must complete the initial credentialing process again to stay within the network.
- We audited all the delegated IPA/MGs and completed a CAP for any deficiencies identified.
We set the following goals:
- Ensure the process is being completed in a timely manner.
- Goal to improve reporting of timeliness to the committee and board.

2) F/U Actions
The QI Department recommends the following actions to continue to improve the rate:
- Complete credentialing IPA oversight audits
- Conduct Credentialing Committee each month
- Conduct Credentialing and re-credentialing process in a timely manner
- Review all 2010 NCQA standards to assure we comply