DHCS: Promoting Quality & Equity Through Bold Goals

April 27, 2023

Priya Motz, DO, MPH, Quality & Health Equity Transformation Branch Chief, *Quality & Population Health Management*

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

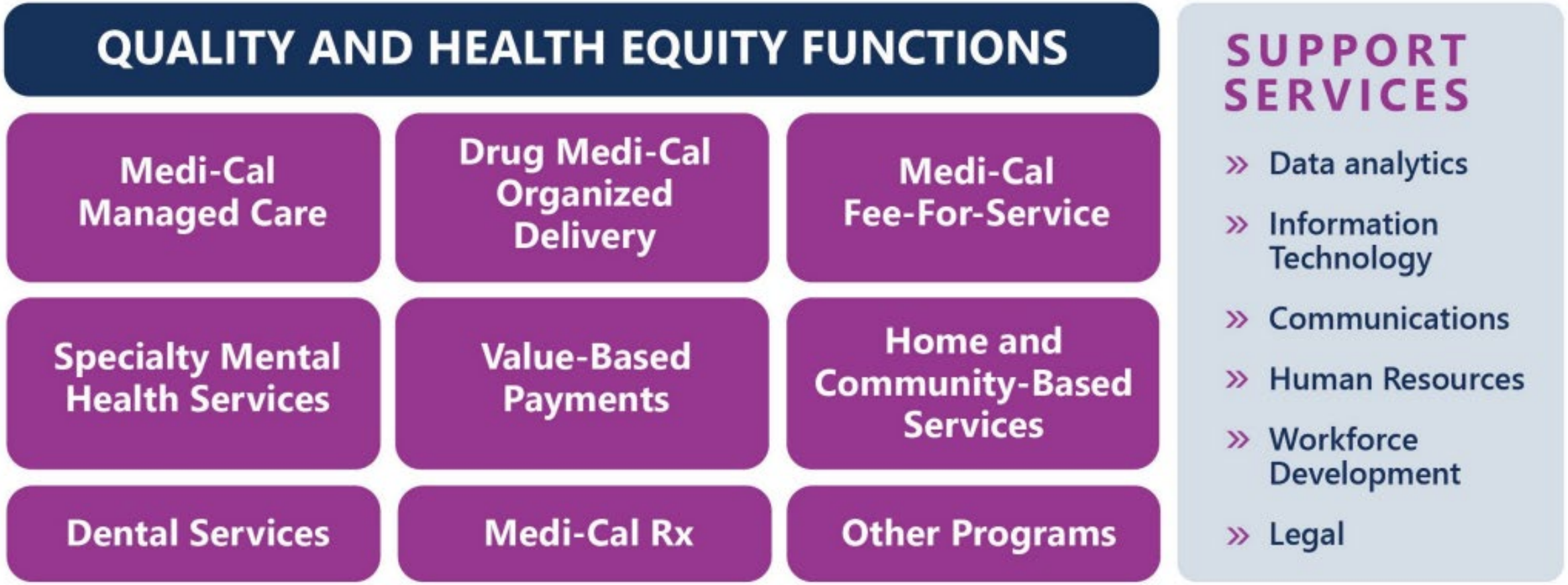
Objectives

- Comprehensive Quality Strategy Overview
- Bold Goals Breakdown
- Infrastructural Change
- Collaboration & Discussion Questions

Vision

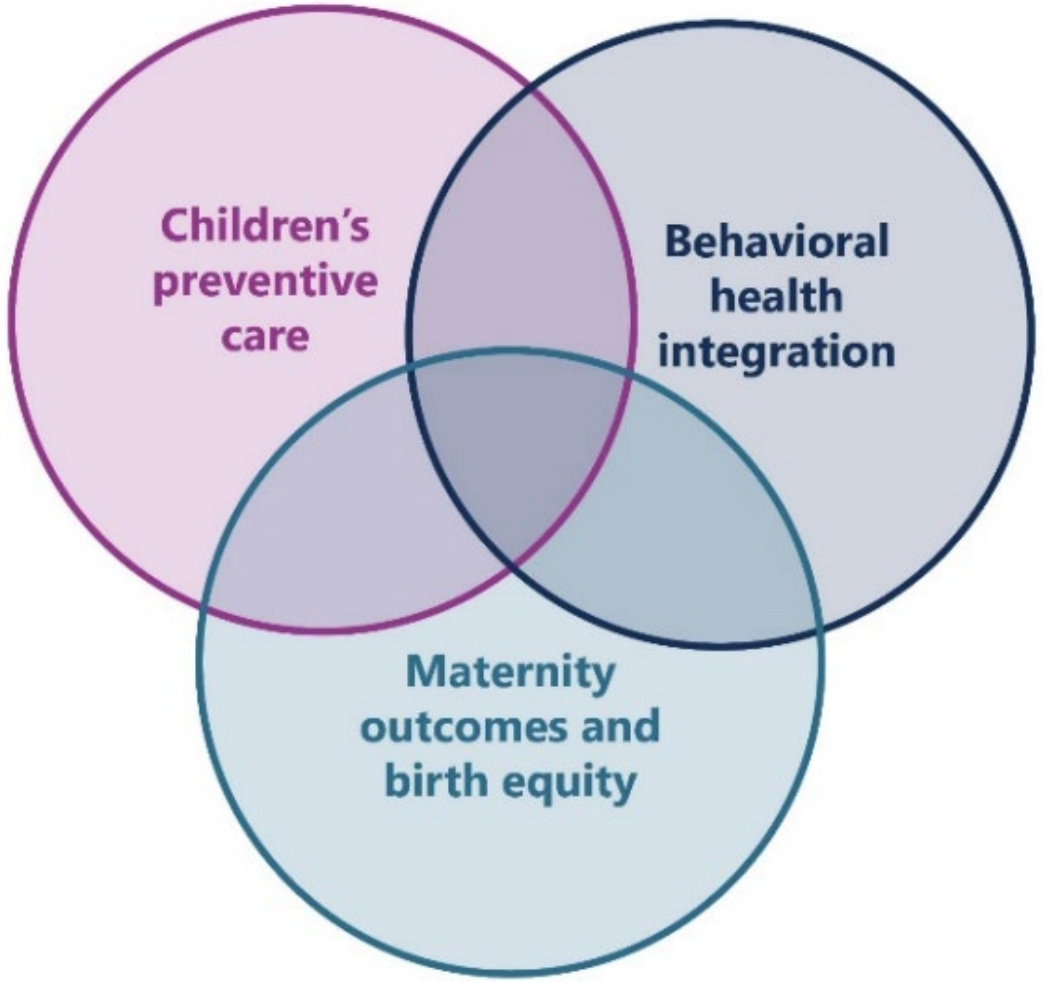

QUALITY STRATEGY GOALS
Engaging members as owners of their own care
Keeping families and communities healthy via prevention
Providing early interventions for rising risk and patient-centered chronic disease management
Providing whole person care for high-risk populations, addressing social drivers of health
QUALITY STRATEGY GUIDING PRINCIPLES
» Eliminating health disparities through anti-racism and community-based partnerships
» Data-driven improvements that address the whole person
» Transparency, accountability and member involvement

Bridging & Aligning Quality



Continuous Quality Improvement Cycle

Clinical Focus Areas



QUALITY/HEALTH EQUITY IMPROVEMENT FRAMEWORK

Driving Change

- Focused initiatives to drive transformation/innovation
- Innovative metrics, process measures, bundles
- Incentives if met (financial or otherwise)
- Example uses: CalAIM incentive programs, COVID19 vaccine incentive program, QIP optional metrics

Foundation:

- Creates a standard across programs/plans
- Fundamental outcome/access measures
- Minimum performance levels & improvement targets
- Penalties if not met
- Example uses: QIP required metrics, MCAS, auto-assignment algorithm

Specific Measures

Infant, child, and adolescent well-child visits
Childhood and adolescent vaccinations

Prenatal and postpartum visits
C-section rates

Prenatal and postpartum depression screening
Adolescent depression screening and follow up

Follow up after ED visit for SUD within 30 days
Depression screening and follow up for adults
Initiation and engagement of alcohol and SUD treatment

Infant, child, and adolescent well-child visits
Childhood and adolescent vaccinations
Blood lead and developmental screening
Chlamydia screening for adolescents

BOLD GOALS: 50x2025

STATE LEVEL

Close racial/ethnic disparities in well-child visits and immunizations by 50%

Close maternity care disparity for Black and Native American persons by 50%

Improve maternal and adolescent depression screening by 50%

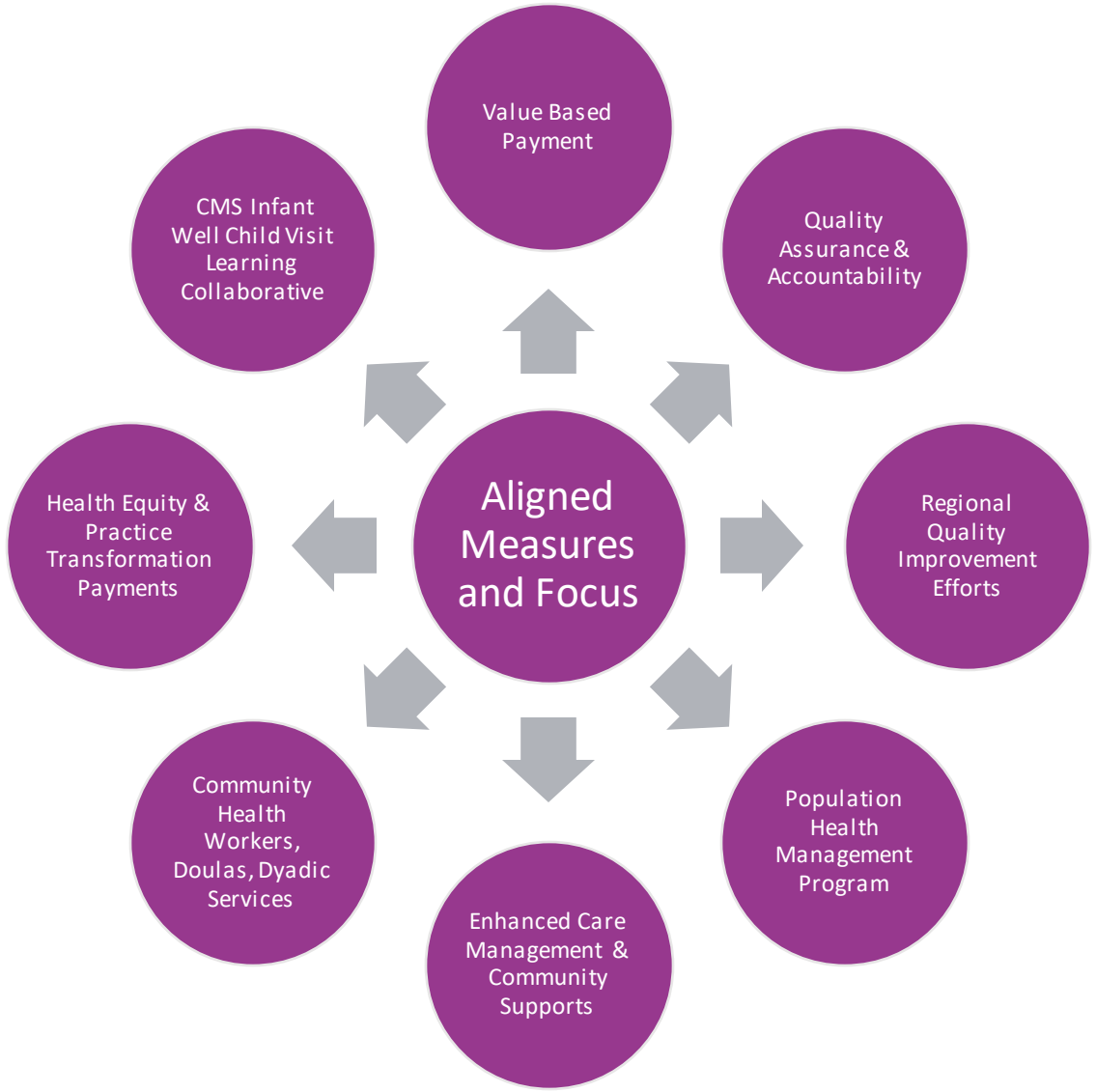
Improve follow up for mental health and substance use disorder by 50%

Ensure all health plans exceed the 50th percentile for all children's preventive care measures

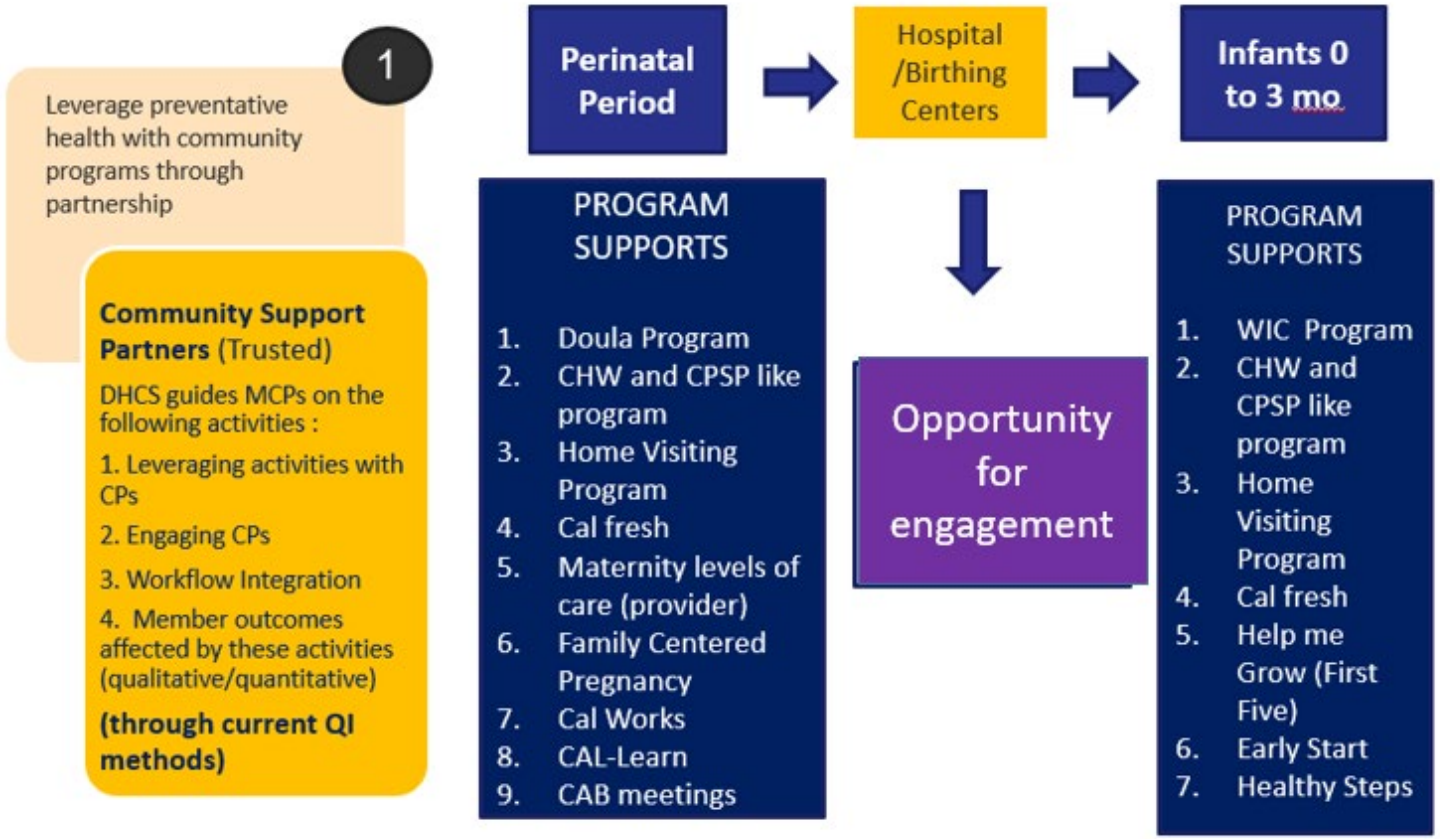
Domains	Measures (MY 2023)
Child & Adolescent Preventative Health	• Child and Adolescent Well-Care Visits (WCV)* • Childhood Immunization Status: Combination 10 (CIS-10)* • Developmental Screening in the First Three Years of Life (DEV) • Immunizations for Adolescents: Combination 2 (IMA-2)* • Lead screening in Children (LSC) • Topical Fluoride for Children (TFL-CH) • Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months (W30)* • Well-Child Visits in the First 30 Month of Life - Well-Child Visits for Age 15 Months - 30 Months (W30)*
Reproductive Health	• Chlamydia Screening in Women (CHL) • Prenatal and Postpartum Care: Postpartum Care (PPC-Pst)* • Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)* • Postpartum Depression Screening and Follow Up (PDS-E) • Prenatal Depression Screening and Follow Up (PND-E) • Prenatal Immunization Status (PRS-E)

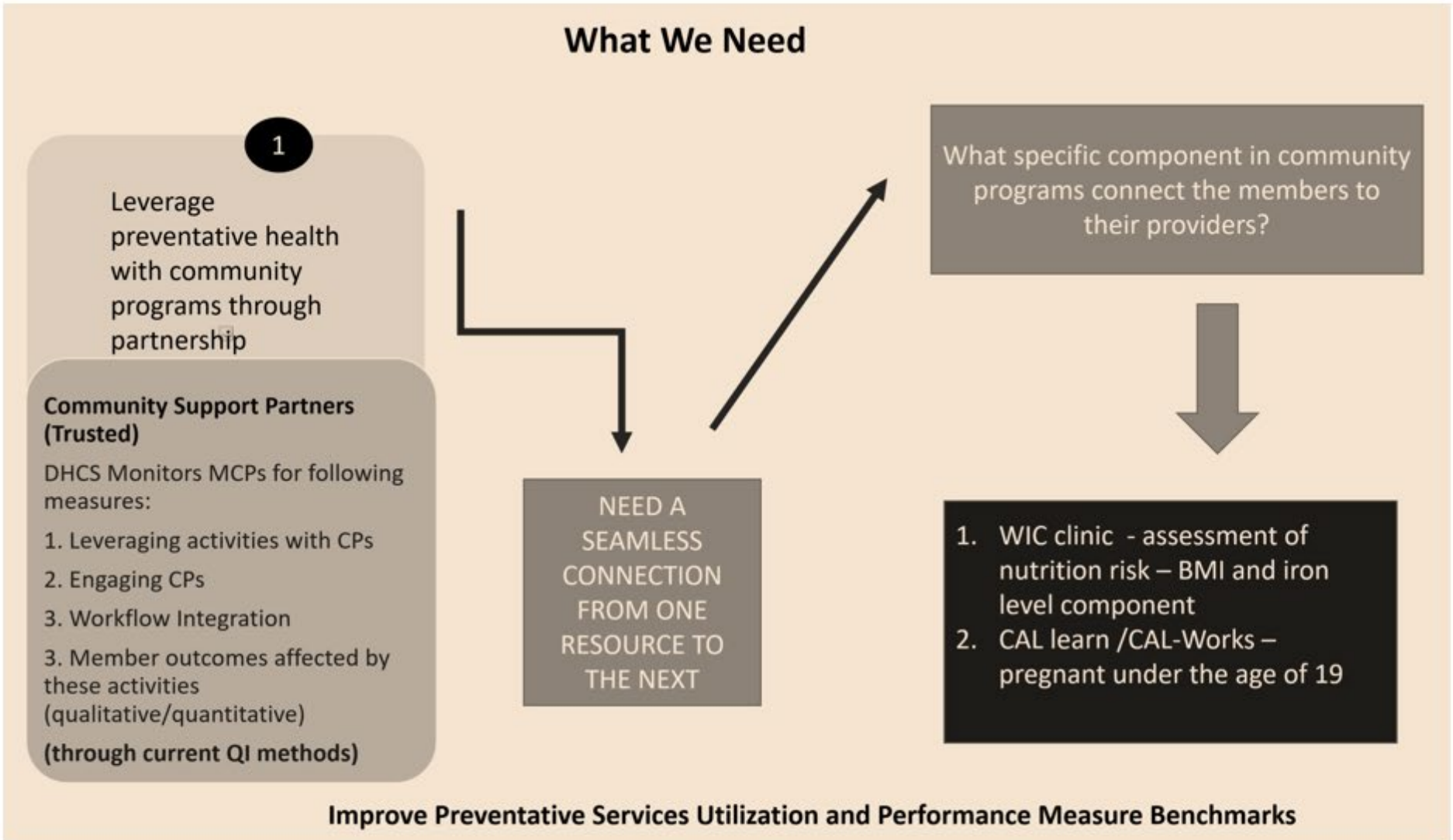
Domains	Measures (MY 2023)
Behavioral Health	• Follow-Up After Emergency Department (ED) Visit for Mental Illness – 30 days (FUM)* • Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)* • Depression Remission or Response for Adolescents and Adults (DRR-E) • Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)* • Pharmacotherapy for Opioid Use Disorder (POD)*
Chronic Diseases	• Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC-H9)* • Controlling High Blood Pressure (CBP)* • Asthma Medication Ratio (AMR)*
Cancer Prevention	• Breast Cancer Screening (BCS)*—ECDS/Admin • Cervical Cancer Screening (CCS) • Colorectal Cancer Screening (COL)*

Multi-Pronged Strategy



Improving Preventive Services Utilization & Performance Measures





Affects the following Domains:

1. Children
2. Reproductive
3. Maternal
4. Cancer Screening
5. Psychotropic and Opioid Management
6. Behavioral
7. Long Term

2

Family / Dyad- based activities/interventions

Family Unit Intervention (trusted)

DHCS monitors MCPs for the following measures:

1. Family unit engagement activities and progress

2. Improving Referral Structures for easy care access

3. Local preventative care and coordination activities

(through current QI methods)

Postpartum and Infants 0 to 3 mo

PROGRAM SUPPORTS

1. WIC Program
2. CHW and CPSP like program
3. Home Visiting Program
4. Cal Fresh
5. Help me Grow (First Five)
6. Early Start
7. Healthy Steps

Postpartum support lacking and only public health county based programs exist

PMAD blue dot program , Father Corps (Alameda county)

2

Family / Dyad- based activities/interventions

Family Unit Intervention (Trusted)

DHCS monitors MCPs for the following measures:

1. Family unit engagement activities and progress
2. Improving Referral Structures for easy care access
3. Preventative care and coordination activities

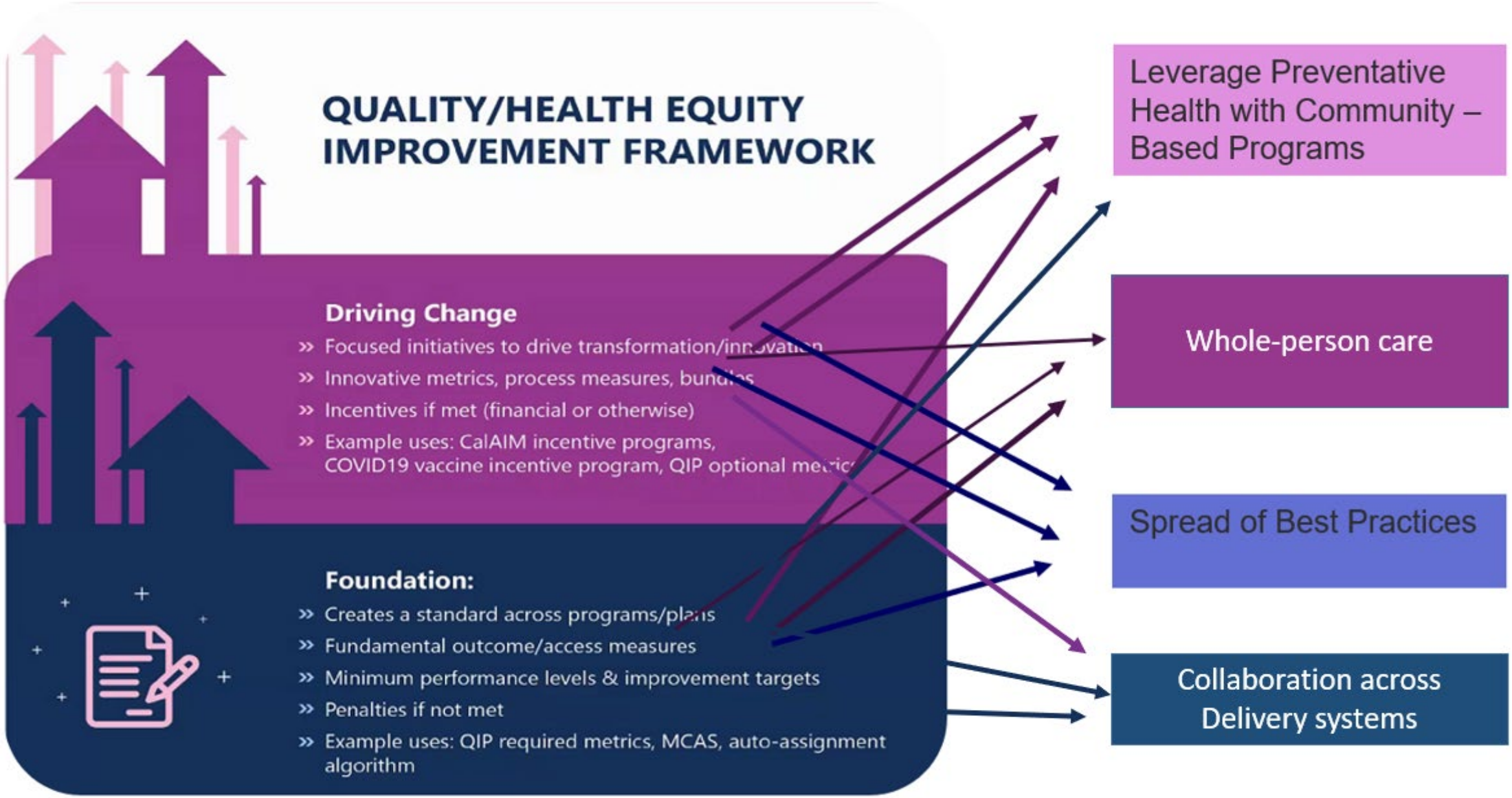
(through current QI methods)

Postpartum and 0 to 3 mo.

Data support: Are hard-to-reach members (frequent gap in care appearances) receiving ECM or CM?

CHW Utilization: Specific wrap around care approach

Bundling of measures: Orchestrated approaches that allow members to seek and receive preventative care


QUALITY/HEALTH EQUITY IMPROVEMENT FRAMEWORK
Driving Change
» Focused initiatives to drive transformation/innovation
» Innovative metrics, process measures, bundles
» Incentives if met (financial or otherwise)
» Example uses: CalAIM incentive programs, COVID19 vaccine incentive program, QIP optional metrics
Foundation:
» Creates a standard across programs/plans
» Fundamental outcome/access measures
» Minimum performance levels & improvement targets
» Penalties if not met
» Example uses: QIP required metrics, MCAS, auto-assignment algorithm
Leverage Preventative Health with Community – Based Programs
Whole-person care
Spread of Best Practices
Collaboration across Delivery systems

Discussion Questions

- How is your organization aligning efforts with the State's identified clinical focus areas and health equity goals?
- How are you driving whole-person care for Medi-Cal Members?
- What are some areas the State can focus to achieve the Bold Goals?
- How can we collaborate to align our focus areas with your organization's in promoting higher quality and equitable services?

Questions?

Priya.Motz@dhcs.ca.gov