CalViva Health
2018
Quality Improvement
Work Plan

3/9/2018

CalViva Health 2018 Quality Improvement Work Plan

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CalViva Health 2018 Quality Improvement Work Plan

I. Purpose

The purpose of the CalViva Health's Quality Improvement Program Work Plan is to establish objectives for the QI Program and review clinical, service and safety related outcomes against the priorities and objectives established by the Program. An assessment of critical barriers is made when objectives have not been met.

II. CalViva Health Goals

1. We will anticipate, understand and respond to customer needs and be customer-driven in everything we do.
2. We will hire and retain the best people, create the best climate, provide the best tools to do the best job and build a spirit of warmth, friendliness and pride throughout the company.
3. We will dedicate ourselves to a standard of excellence in all of our customer relationships.
4. We will promote better outcomes for our customers through improved provider relationships and through the promotion of evidence-based health care.
5. We will provide efficient, simple and high quality administrative services that get things right the first time.
6. We will build excellent business systems and processes and demonstrate the highest degree of integrity in all aspects of the operation of our business.

III. Scope

The CalViva Health Quality Improvement Work Plan encompasses quality improvement activities for 2018. The development of this document requires resources of multiple departments.

CalViva Health 2018 Quality Improvement Work Plan

Glossary of Abbreviations/Acronyms

A&G:	Appeals and Grievances
A&I:	Audits and Investigation
AH:	After Hours
AWC:	Adolescent Well-Care
BH:	Behavioral Health
C&L:	Cultural and Linguistic
CAHPS:	Consumer Assessment of Healthcare Providers and Systems
CAP:	Corrective Action Plan
CDC:	Comprehensive Diabetes Care
CM:	Case Management
CP:	Clinical Pharmacist
CVH:	CalViva Health
DHCS:	Department of Health Care Services
DM:	Disease Management
DMHC:	Department of Managed Health Care
DN:	Direct Network
FFS:	Fee-for-Service
HE:	Health Education
HPL:	High Performance Level
HN:	Health Net
HSAG:	Health Services Advisory Group
IHA:	Initial Health Assessment
ICE:	Industry Collaborative Effort
IP:	Improvement Plan
IVR:	Interactive Voice Response
MCL:	Medi-Cal
MH:	Mental Health
MMCD:	Medi-Cal Managed Care Division
MPL:	Minimum Performance Level
PCP:	Primary Care Physician
PIP:	Performance Improvement Project
PMPM:	Per Member Per Month
PMPY:	Per Member Per Year
PNM:	Provider Network Management
PRR:	Provider Relations Representative
PTMPY:	Per Thousand Members Per Year
QI:	Quality Improvement
SPD:	Seniors and Persons with Disabilities
UM:	Utilization Management

I. ACCESS, AVAILABILITY, & SERVICE

Section A: Description of Intervention (due Q1)

1-1: Improve Access to Care- Timely Appointments to Primary Care Physicians, Specialist, Ancillary Providers and After Hours Access

☐ **New Initiative** ☒ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☒ **Quality of Service**	☐ **Safety Clinical Care**

Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Access to care is critical to a member's ability to get care in an appropriate timeframe and to the member's satisfaction. Assessing practitioner compliance with access standards and surveying members allows the identification of areas for improvement.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

Timely Appointment Access to Primary Care Physicians and Specialists is measured through seven metrics. The specific goal is 80% for all measures. Success will be evaluated at the end of the survey period. Timely Appointment Access is monitored using the DMHC PAAS Tool and the CVH PAAS Tool.

Timely Appointment Access to Ancillary Providers is measured through two metrics. The goal is 80% for all metrics. Timely Appointment Access is monitored using the DMHC PAAS Tool.

After-Hours (AH) Access is evaluated through an annual telephonic Provider After-Hours Access Survey. This survey is conducted to assess provider compliance with required after-hours emergency instructions for members and that members can expect to receive a call-back from a qualified health professional within 30 minutes when seeking urgent care/services by telephone. The results are made available to all applicable provider organizations through annual provider updates. When deficiencies are identified, improvement plans are requested of contracted providers and provider groups as described in CVH policy PV-100-007 Accessibility of Providers and Practitioners. These measures assess whether 90% of providers have appropriate emergency instructions whenever their offices are closed/after-hours, and if 90% of providers are available for members to contact them during after-hours for urgent issues within the 30-minute timeframe standard.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Implement Provider Appointment Access Survey (PAAS) to monitor appointment access at the provider level to comply with DMHC and continue conducting Medi-Cal Appointment Access Survey to comply with DHCS requirements	P	Q3-Q4	CVH/HN
Develop and distribute provider updates, as applicable, informing providers of upcoming surveys, survey results, and educational information for improvement.	P	Q1 - Q4	CVH/HN
Review and update the Appointment Access & Provider Availability P&P as needed to reflect all regulatory and accreditation requirements and submit for approval	P	Q1	CVH/HN
Complete all Provider Updates for informing CalViva Health providers of PAAS and PAHAS Survey results, with educational information for improvement (no later than 3 months after results survey have been finalized).	P	Q3 (for 2017 results)	CVH/HN
Implement Provider After-Hours Availability Survey (PAHAS) to monitor provider offices' after-hours urgent care instructions and physician availability.	P	Q3- Q4	CVH/HN
Complete a CAP as necessary – when CalViva providers are below standard; including additional interventions for providers not meeting standards two consecutive years.	P	Q3-Q4	CVH/HN
Annual review, update and distribution of Patient Experience Toolkit, After-Hours Script, Guidelines for compliance and Monitoring and Appointment Scheduling Tip sheet	P	Q1-Q4	CVH/HN

Conduct provider onsite office audits for all repeat noncompliant providers	P	Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)

Measure(s)	Specific Goal	RY 2017	RY 2018 Mid-year	Baseline Source	Baseline Value
Access to Non-Urgent Appointments for Primary Care – Appointment within 10 business days of request	80%	Overall=90.0% Fresno=89.6% Kings=91.3% Madera=92.3%	Overall: Fresno: Kings: Madera:	CVH Performance RY2016	Overall= 83.4% Fresno=82.3% Kings=93.1% Madera=82.9%
Access to Non-Urgent Appointments with Specialist – Appointment within 15 business days of request	80%	Overall=81.4% Fresno=84.0% Kings=60.0% Madera=81.8%	Overall: Fresno: Kings: Madera:	CVH Performance RY2016	Overall= 76.1% Fresno=87.6% Kings=80.9% Madera=60%
Access to Urgent Care Services that do not require prior authorization – Wait time not to exceed 48 hours	80%	Overall=76.8% Fresno=79.2% Kings=55.5% Madera=77.7%	Overall: Fresno: Kings: Madera:	CVH Performance RY2016	Overall= 72.5% Fresno=71.3% Kings=67.7% Madera=81.6%
Access to First Prenatal Visit – Within 10 business days of request	80%	Overall=94.2% Fresno=92.5% Kings=100% Madera=100%	Overall: Fresno: Kings: Madera:	CVH Performance RY2016	Overall= 84.2% Fresno=80.2% Kings=100% Madera=100%
Access to Well-Child Visit with PCP – within 10 business days of request	80%	Overall=84.3% Fresno=83.9% Kings=100% Madera=70.0%	Overall: Fresno: Kings: Madera:	CVH Performance RY2016	Overall= 77.3% Fresno=73.6% Kings=92.8% Madera=88%
Access to Physician Exams and Wellness Checks – within 30 calendar days of request	80%	Overall=82.2% Fresno=81.2% Kings=100% Madera=70.0%	Overall: Fresno: Kings: Madera:	CVH Performance RY2016	Overall= 90.4% Fresno=88.3% Kings=92.8% Madera=100%
Access to Non-Urgent Ancillary services for MRI/Mammogram/Physical Therapy – Appointment within 15 business days of request	80%	Overall=100% Fresno=100% Kings=100% Madera=N/A	Overall: Fresno: Kings: Madera:	CVH Performance RY2016	Overall= 90.9% Fresno=90.9% Kings=N/A Madera=N/A
Appropriate After-Hours (AH) emergency instructions	90%	Overall=94.1% Fresno=94.5% Kings=92.7% Madera=93.8%	Overall: Fresno: Kings: Madera:	CVH Performance RY2016	Overall= 92.3% Fresno=94.6% Kings=79.4% Madera=83.3%
Member informed to expect a call-back from a qualified health professional within 30 minutes	90%	Overall=83.1% Fresno=84.1%	Overall: Fresno:	CVH Performance RY2016	Overall= 86.5% Fresno=87.1%

		Kings=74.0% Madera=93.8%	Kings: Madera:		Kings=90.9% Madera=80%
Analysis: Intervention Effectiveness w Barrier Analysis					
Initiative Continuation Status	☐ **Closed**	☐ **Continue Initiative Unchanged**	☐**Continue Initiative with Modification**		

Section A: Description of Intervention (due Q1)

1-2: Improve Member Satisfaction

☐ New Initiative ☒ Ongoing Initiative from prior year

Initiative Type(s)	☒ Quality of Care	☒ Quality of Service	☒ Safety Clinical Care

Reporting Leader(s)	Primary:	CalViva Health Medical Management	Secondary:	Health Net QI Department

Rationale and Aim(s) of Initiative

Member Satisfaction by DHCS is evaluated every 2 years and was last evaluated in RY 2016. The results were aligned close to the Medicaid State Average. Member perception of quality of care and care coordination is multifaceted and affected by the provider, the plan, member demographics and individual health status and experience so evaluation and intervention are directed towards touchpoints by the member.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The following CAHPS Metrics will be used to evaluate the effectiveness of the interventions:

1. Getting Needed Care (Ease to get appointment with specialist, and ease to get care, tests, and treatment);
2. Getting Care Quickly (Getting care right away (urgent), getting appointment as soon as needed (routine) and see doctor within 30 minutes of apt. time
3. Rating of all health care
4. Rating of personal doctor
5. How well do doctors communicate (did your doctor explain things in a way that was easy to understand and did the doctor listen to the patient)

The goal for member satisfaction is to reach the Quality Compass 50th percentile.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Annually review, update, distribute and promote the 2018 Patient Experience(PE) Toolkit to providers	P	Q1-Q2	CVH/HN
Annually, review update and distribute Appointment Scheduling Tip Sheet and Quick Reference Guide	P	Q1-Q2	CVH/HN
Annually, review update and distribute the "Talking with my Doctor" agenda setting form as part of the PE Toolkit to educate and empower members and improve their overall experience	P/M	Q1-Q2	CVH/HN
Annually, review, update and enhance materials on Interpreter services 24/7 to remind providers of the availability of these services and how to access them	P	Q1-Q2	CVH/HN
Create article and distribute in Member newsletter highlighting access standards and interpreter services	M	Q2	CVH/HN
Annually, review and update and enhance materials on the Nurse Advice Line to encourage use of this service by members	P/M	Q1-Q2	CVH/HN
Update and conduct scaled-back member survey to assess effectiveness of interventions implemented	M	Q3	CVH/HN

Section B: Mid-Year Update on Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3 2018)

Measure(s)	Specific Goal	MY 2020	RY 2018	Baseline Source	Baseline Value
CAHPS metric: Getting Needed Care	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 81.35%			RY 2016 CVH results	77.65
CAHPS metric: Getting Care Quickly	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 81.55%			RY 2016 CVH results	73.56%
CAHPS metric: Rating of All Health Care	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 72.82%			RY 2016 CVH results	69.17%
CAHPS metric: Rating of Personal Doctor	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 80.00%			RY 2016 CVH results	77.26%
CAHPS metric: How well doctors communicate	Exceed RY2016 All Plans Medicaid Average 50th Nat'l = 90.70%			RY 2016 CVH results	89.97%
Analysis: Intervention Effectiveness w Barrier Analysis	DHCS CAHPS is surveyed only every two years so no data is available for RY2017				
Initiative Continuation Status	☐ **Closed**	☐ **Continue Initiative Unchanged**	☐ **Continue Initiative with Modification**		

II.QUALITY & SAFETY OF CARE

Section A: Description of Intervention (due Q1)

2-1: Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

☐ **New Initiative** ☒ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☒ **Safety Clinical Care**

Reporting Leader(s)	**Reporting Leader(s)**	**CalViva Health Medical Management**	**Reporting Leader(s)**	**Health Net QI Department and Health Net Health Education Department**

Rationale and Aim(s) of Initiative

Overall Aim: To reduce the number of prescriptions for antibiotics inappropriately prescribed to CalViva Health adult members diagnosed with acute bronchitis.

Rationale: Antibiotic resistance is both costly and a major public health issue, totaling up to $20 billion in direct healthcare costs.[1] Every year, at least 2 million people become infected with bacteria that are resistant to antibiotics, and at least 23,000 people die as a result.[2] In general, antibiotic-resistant infections result in longer and/or more expensive treatments, longer hospital stays, additional doctor visits, and increased disability and mortality risk.[1] According to the CDC, the use of antibiotics is "the single most important factor leading to antibiotic resistance around the world."[2]

Barriers to appropriate antibiotic prescribing include providers not ordering the appropriate laboratory tests to confirm if an antibiotic is needed, and patients demanding an antibiotic. [1] To help address these barriers, CalViva helps promote the Choosing Wisely® patient education materials and is also involved with the California Medical Foundation's Alliance Working for Antibiotic Resistance Education (AWARE) annual campaign to promote appropriate antibiotic use among providers and patients. According to a meta-analysis published in the British Medical Journal patients prescribed an antibiotic for a respiratory infection consistently developed bacterial resistance to that antibiotic; this effect was greatest in the first two months immediately after treatment [pooled odds ratio 2.37 (CI 1.42-3.95)] but could persist for up to 12 months. This contributes to an increased number of organisms resistant to first line antibiotics, which may lead to increased use of second line antibiotics.[3] Therefore, it is crucial that providers have updated tools and information to ensure that antibiotics are not prescribed inappropriately or overprescribed.

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[1]Centers for Disease Control and Prevention (CDC). Antibiotic Resistance Threats in the United States, 2013. April 2013. Available at http://www.cdc.gov/drugresistance/threat-report-2013/pdf/ar-threats-2013-508.pdf. Downloaded January 17, 2014.

[2]Centers for Disease Control and Prevention (CDC, Antibiotic/Antimicrobial Resistance. Accessed January 12, 2017 at /www.cdc.gov/drugresistance.

[3]Costelloe C, Metcalfe C, Lovering A, Mant D, Hay AD. 2010. Effect of antibiotic prescribing in primary care on antimicrobial resistance in individual patients: systematic review and meta-analysis. BMJ. 2010 May 18;340:c2096.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The HEDIS measure, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription (a higher rate indicates appropriate treatment of adults with acute bronchitis).. Madera county baseline HEDIS result for RY 2016 was 19.69% and RY2017 was 18.26% which was 3.86% below the MPL (188 numerator events out of the 230 in the denominator).

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Identify a high volume, low compliance provider in Madera County to drill down to identify physicians and mid-level providers for targeted interventions. (Submit QI Summaries)	P	Q1, Q2	CVH/HN

AAB Provider Tip Sheet will be available through the Provider Portal and hand-delivered by Provider Relations staff. The tip sheet covers HEDIS documentation, best practices, and recommended treatment guidelines.	P	Q1-Q2	CVH/HN
Mail 2018 AWARE toolkit containing provider and member educational resources on appropriate antibiotic use Mailed by AWARE offices(CMAF) to top 20% of antibiotic prescribers (MDs) identified in Fresno, Kings and Madera Counties.	P	Q1	CMAF/CVH/HN
Provider Relations to distribute provider education materials to targeted providers identified as high prescribing for two or more consecutive years. Materials will include the new AWARE toolkit and Tip Sheet, and Choosing Wisely® resources on the appropriate use of antibiotics and best practices to avoid overprescribing antibiotics.	P	Q2/Q3	CVH/HN
Participate in 2018-2019 AWARE toolkit revision planning.	P	Q3/Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3)

Measure(s)	Specific Goal	RY 2017	RY 2018	Baseline Source	Baseline Value
HEDIS Appropriate Treatment for Adults with Acute Bronchitis (AAB)	Directional improvement to meet or exceed the MPL 22.12% (RY 2017	Madera: 18.26%	Madera:	RY 2016 CVH results	Madera: 19.69%

Analysis: Intervention Effectiveness w Barrier Analysis	
Initiation Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

2-2: Annual Monitoring for Patients on Persistent Medications (MPM)

☐ **New Initiative** ☒ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☒ **Safety Clinical Care**

Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department and Health Net Health Education Department**

Rationale and Aim(s) of Initiative

Overall Aim: Reduce the occurrence of preventable adverse drug events for CalViva Health members on Persistent Medications (MPM).

Rationale: For patients managing chronic diseases, medication adherence is paramount in improving overall health benefits. However, there is still not enough information on how to improve adherence in a cost-effective manner (Seabury, 2014). The CDC estimates that approximately over one million individuals are seen in emergency departments for adverse drug events in which case many are preventable. (Centers for Disease Control and Prevention , 2017). As a patient advances in age, there is a likelihood that he/she will take more medications to care for their chronic diseases. It is even more likely that the older adult population (65 years and older) are twice as likely to visit emergency departments for adverse drug events (Centers for Disease Control and Prevention, 2012). Therefore, it is imperative that this population not only adhere to their medication but seek regular care with their provider to make sure that their current medication is correct for them or adjust as needed by conducting routine laboratory tests.

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Centers for Disease Control and Prevention. (2012, October 2). *Medicatin Safety Program*. Retrieved January 23, 2018, from Adults and Older Adults Adverse Drug Events: https://www.cdc.gov/medicationsafety/adult_adversedrugevents.html

Centers for Disease Control and Prevention . (2017, June 19). *Medication Safety Program.* Retrieved January 23, 2018, from Adverse Drug Event Monitoring: https://www.cdc.gov/medicationsafety/program_focus_activities.html

Seabury, S. G. (2014). Understanding and Overcomming Barriers to Medication Adherence: A Review of Research Priorities. *Journal of Managed Care and Speciality Pharmacy*, 775-783.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The HEDIS Measure, Annual Monitoring for Patients on Persistent Medications (MPM) will be used to evaluate the effectiveness of the interventions implemented for this measure. The measure evaluates the percentage of adults 18 years and older who have received at least 180 treatment days of ambulatory medication therapy of either ACE/ARBs or diuretics. Madera County's baseline HEDIS result for ACE/ARBs in RY 2016 was 83.98% and in RY 2017 was 82.64%. The baseline HEDIS results for diuretics in RY 2016 was 83.57% in RY 2017 was 82.20%. The SMART AIM goal is that 50% or more ot the members at the targeted high volume, low performing clinic will have completed their annual laboratory testing thereby meeting or exceeding the MPL.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Work with high volume, low compliance provider in Madera County to distribute a Provider Profile identifying members who need to complete their annual laboratory test in order to improve test completion rates.. (submit PDSAs)	P	Q1, Q2	CVH/HN
Conduct regular meetings with the Madera County provider to receive updates on improvement activities and status check on Test completions.	P	Q1, Q2	CVH/HN
Implement a $25 gift card member incentive to improve MPM laboratory test rates.	M	Q1, Q2	CVH/HN

Implement a member text (SMS) message to encourage and remind members: 1) to schedule an appointment to complete labs and 2) to attend already scheduled appointments.	M	Q2 to Q4	CVH/HN
Implement CVS “Health Tags” educational health message (with reminder from health tech) on members’ prescription pharmacy bag labels in Madera County.	M	Q3 and Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3)

Measure(s)	Specific Goal	RY 2017	RY 2018	Baseline Source	Baseline Value
HEDIS® Monitoring Persistent Medications: ACE/ARB	Meet or Exceed DHCS MPL update 85.63% (RY 2017)	Madera: 82.64%	: Madera:	RY 2016 CVH results	Madera: 83.98%
HEDIS® Monitoring Persistent Medications: Diuretics	Meet or Exceed DHCS MPL update 85.18% (RY 2017)	Madera: 82.20%	Madera:	RY 2016 CVH results	Madera: 83.57%

Analysis: Intervention Effectiveness w Barrier Analysis	
Initiative Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

2-3: Use of Imaging Studied for Low Back Pain (LBP)

☒ **New Initiative** ☐ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☒ **Safety Clinical Care**

Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: Reduce use of unnecessary imaging studies in CalViva Health adult members diagnosed with uncomplicated low back pain

Rationale: More than 80 percent of Americans will experience LBP in their lifetime. Imaging tests, such as plain X-rays, MRIs and CT scans, are commonly performed to diagnose the severity of the condition. There is a need to reduce the use of imaging studies for LBP since imaging tests do not provide useful information in cases of strained muscles and ligaments, can expose patients to unnecessary radiation and can be costly. Unnecessary imaging studies can also lead to the need for additional more invasive testing, which increases the risk for complications, such as infections.[1] Evidence-based studies do not recommend imaging for LBP during this time unless red flags are present, such as severe or progressive neurological signs or symptoms that suggest a serious or specific underlying condition. Patients with LBP usually feel better within a month and pain can be managed through self-help techniques.

[1]Integrated Healthcare Association – Smart Care California. LBP information retrieved from www.iha.org/our-work/insights/smart-care-california/focus-area-low-back-pain, October 31, 2017.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The HEDIS Measure, Use of Imaging Studies for Low Back Pain (LBP) will be used to evaluate the effectiveness of the interventions implemented for this measure. The measure evaluates the percentage of adults aged 18-50 years with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. Madera County's baseline HEDIS results in RY 2016 was 74.17% and in RY 2017 was 66.67%.The Smart Aim goal is to educate providers on the "Red Flag" symptoms for ordering an imaging studying, conservative treatment for treating LBP, the length of time needed to re-evaluate the condition, and the direct and indirect risks associated with imaging studies.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Implement provider training on best practices, recommended clinical guidelines, with a pre and post-test to assess knowledge gained from the presentation. Distribute member and provider education resources at the end of the training. (Submit PDSA)	P	Q1	CVH/HN
Work with a high volume, low compliance provider in Madera County to initiate targeted interventions to improve LBP rate (Submit PDSAs)	P	Q1, Q2	CVH/HN
Conduct regular meetings with the Madera County provider to share results and receive updates on improvement activities.	P	Q1, Q2	CVH/HN
LBP Provider Tip Sheet will be emailed to CVH providers and uploaded through the Provider Portal. The tip sheet covers HEDIS documentation, best practices, and recommended treatment guidelines.	P	Q1	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)

Section B: Analysis of Intervention Implementation (due end of Q4)

Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)

Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3) Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3)					
Measure(s)	**Specific Goal**	**RY 2017**	**RY 2018**	**Baseline Source**	**Baseline Value**
HEDIS® Low Back Pain	Meet or Exceed DHCS MPL RY2017 69.88%	Madera: insert result 66.67%	Madera:	RY 2016 CVH results	Fresno: 70.65% Kings: 75.50% Madera: 74.17%
Analysis: Intervention Effectiveness w Barrier Analysis					
Initiative Continuation Status	☐ **Closed**	☐ **Continue Initiative Unchanged**	☐ **Continue Initiative with Modification**		

III.PERFORMANCE IMPROVEMENT PROJECTS

Section A: Description of Intervention (due Q1)

3-1: Improving Childhood Immunizations (CIS-3)

☒ **New Initiative** ☐ **Ongoing Initiative from prior year**

Initiative Type(s)		☒ **Quality of Care**	☒ **Quality of Service**		☐ **Safety Clinical Care**
Reporting Leader(s)	**Primary:**	**CalViva Health Medical Management**	**Secondary:**		**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: To improve child health in Fresno County.

Rationale: Childhood immunizations are critical to community health, and favorably impact overall health outcomes. The increase in life expectancy during the 20th century is largely due to improvements in child survival. This increase is associated with reductions in infectious disease mortality due to immunizations. Childhood immunizations are proven to help a child stay healthy, protect them from serious illnesses such as polio, tetanus, and hepatitis, and avoid the potentially harmful effects of diseases like mumps and measles. According to HealthyPeople.gov, each birth cohort vaccinated with the routine immunization schedule saves 33,000 lives, prevents 14 million cases of disease, reduces direct health care costs by 9.9 billion, and saves 33.4 billion dollars in indirect costs.[1]

Therefore, CalViva Health has selected Childhood Immunizations Status – Combination 3 (CIS-3) in Fresno County for a Performance Improvement Project (PIP) topic. Childhood immunizations is a component of the seven priority focus areas (Foster Healthy Communities) identified by DHCS for the Medi-Cal Quality Strategy.[2] Although the CIS-3 measure in Fresno County is not under the MPL, the rate has declined by almost 3% in RY 2017, while both Madera and Kings Counties have demonstrated improved rates. The continued decline in immunization rates in Fresno County leave more children vulnerable to measles, pertussis, and other vaccine-preventable diseases.

[1] *HealthyPeople.gov.* (n.d.). Retrieved October 30, 2017, from Immunization and Infectious Diseases : https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases
[2] Kent, J. (2017). *2017 DHCS Strategy for Quality Improvement in Health Care (Quality Strategy).* California Department of Health Care Services (DHCS).

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The HEDIS measure, Childhood Immunization Status - Combination 3 (CIS-3), will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of members who turn 2 years old who have been identified for completing the following vaccinations: four diphtheria, tetanus, and pertussis (DTaP); three inactivated poliovirus (IPV); one measles, mumps, and rubella (MMR), three Haemophilus influenza type B (HiB); three hepatitis B, one varicella-zoster virus (chicken pox or VZV); and four pneumococcal conjugate vaccinations on or before their second birthday. The baseline rate of 62.5% was determined based on the RY 2017 HEDIS hybrid data for two high volume, low preforming clinics in Fresno County. The SMART Aim Goal for the targeted clinics is 71%; a statistically significant improvement. The performance improvement project will continue through June 2019.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Complete process mapping activity with high volume, low compliance clinic in Fresno County (Module 3).	P	Q1/Q2	CVH/HN
Complete a Failure Modes and Effects Analysis (FMEA) around clinic processes for improving CIS-3 rates (Module 3).	P	Q1/Q2	CVH/HN
Develop interventions with high volume, low compliance clinic, to address high priority gaps identified in FMEA (Module 4).	P	Q2	CVH/HN
Member newsletter article: Childhood Immunizations	M	Q3	CVH/HN
Continue direct member incentive for completion of childhood immunizations to improve rates	M	Q2, Q3, and Q4	CVH/HN
Childhood immunizations reminder campaign: IVR, email or SMS.	M	Q3, and Q4	CVH/HN
	M	Q3, and Q4	CVH/HN

Fotonovela booklet mailing to members and distribution to Provider Relations Team for them to take to physician offices. The booklets use storytelling to educate and address barriers to immunizations.	M	Q3, and Q4	CVH/HN
Provider level incentive for PCPs to close Care Gaps and improve HEDIS scores	P	Q1, Q2, Q3, and Q4	CVH/HN
Provider Tip Sheets will be hand-delivered to CVH provider groups.	P	Q2, Q3, and Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
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Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3)

Measure(s)	Specific Goal	RY 2018	RY 2019	Baseline Source	Baseline Value
Childhood Immunization Combo 3	Meet or Exceed SMART Aim Goal of 71%	Fresno:	Fresno:	RY 2017 CVH results	Fresno: 62.5%

Analysis: Intervention Effectiveness w Barrier Analysis	
Initiation Continuation Status	☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

Section A: Description of Intervention (due Q1)

3-2 Addressing Postpartum Visit Disparities

☒ **New Initiative** ☐ **Ongoing Initiative from prior year**

Initiative Type(s)	☒ **Quality of Care**	☐ **Quality of Service**	☐ **Safety Clinical Care**

Reporting Leaders	**Primary**	**CalViva Health Medical Management**	**Secondary**	**Health Net QI Department**

Rationale and Aim(s) of Initiative

Overall Aim: Improve maternal health in Fresno County.

Rationale: Postpartum care continues to be a priority in the 2017 DHCS Strategy for Quality Improvement in Health Care in the delivery of effective, efficient and affordable care under Medi-Cal Managed Care (Priority 2). DHCS has also adopted the strategy of eliminating health disparities in the Medi-Cal population (Priority 7).[1] The PIP proposed by CalViva Health addresses both priorities by aiming to develop interventions specifically for disparities within a population receiving postpartum care. Closing gaps in care due to disparity is also a priority for CalViva Health, which has developed a strategy to address disparities using the Robert Wood Johnson Foundation's definition of health equity:

Health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.[2]

The postpartum visit is important for support of breastfeeding, screening for postpartum mood and anxiety disorders, follow-up of conditions such as diabetes and hypertension, and family planning. It is also often the only time to incorporate the essentials of care between pregnancies, integrate all relevant clinical information and provide information to the patient. Given the disparate rates between the Kerman and Mendota Clinics in Fresno County, and the opportunities identified through barrier analysis and literature review, postpartum care is a critical PIP disparities topic for CalViva in rural Fresno County.

[1] Kent, J. (2017). *2017 DHCS Strategy for Quality Improvement in Health Care (Quality Strategy).* California Department of Health Care Services (DHCS).
[2]Braveman, P. E. (2017). What Is Health Equity? And What Difference Does a Definition Make? Princeton: Robert Wood Johnson Foundation.

Description of Outcome Measures Used To Evaluate Effectiveness of Interventions. Includes improvement goals and baseline & evaluation measurement periods.

The HEDIS measure, Postpartum Care (PPC), will be used to evaluate the effectiveness of interventions. The measure evaluates the percentage of women who completed a postpartum visit including a pelvic exam or postpartum care on or between 21-56 days after delivery, as documented through either administrative data or medical record review. The HEDIS timeframe for postpartum care is from November 6, 2017 to November 5, 2018. The baseline rate of 50% was determined based on the RY 2017 HEDIS data for the high volume, low preforming clinic. The SMART Aim Goal for the targeted clinic is 64%; a statistically significant improvement. The performance improvement project will continue through June 2019.

Planned Activities

Activities	Target of Intervention: Member (M) / Provider (P)	Timeframe for Completion	Responsible Party(s)
Work with a high volume, low compliance Clinic with identified disparity in Fresno County to map process for scheduling postpartum care visits with patients (Module 3).	P	Q1	CVH/HN
Complete FMEA with identified high volume, low compliance clinic, to prioritize gaps in processes and potential interventions (Module 3).	P	Q1	CVH/HN
Develop interventions with high volume, low compliance clinic, to address high priority gaps identified in FMEA (Module 4).	P	Q2	CVH/HN
Provider Tip Sheet on Postpartum Care will be hand-delivered to CVH provider groups	P	Q2	CVH/HN
Provider level incentive for PCPs to close Care Gaps and improve HEDIS scores	P	Q1, Q2, Q3 and Q4	CVH/HN
Implement Postpartum Member Incentive by sending a $25 gift card to members for whom we receive a correctly completed and timely Postpartum Care Notification Form from their provider in all CVH Counties	M	Q1, Q2, Q3 and Q4	CVH/HN

Section B: Mid-Year Update of Intervention Implementation (due Q3)	Section B: Analysis of Intervention Implementation (due end of Q4)
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Section C: Evaluation of Effectiveness of Interventions - Measure (s), Specific Goal (due Q1)
Section C: Evaluation of Effectiveness of Interventions - Baseline Source, Baseline Value (due Q3)
Section C: Evaluation of Effectiveness of Interventions – Evaluation Period, Analysis (due Q3)

Measure(s)	Specific Goal	RY 2018	RY 2019	Baseline Source	Baseline Value
Postpartum Care Visits	Meet or Exceed SMART Aim Goal of 64%	Fresno:	Fresno:	RY 2017 CVH results	Fresno: 50%

Analysis: Intervention Effectiveness w Barrier Analysis	

Initiative Continuation Status ☐ **Closed** ☐ **Continue Initiative Unchanged** ☐ **Continue Initiative with Modification**

IV. CROSSWALK OF ONGOING WORKPLAN ACTIVITIES

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
WELLNESS/ PREVENTIVE HEALTH					
1. Distribute Preventive Screening Guidelines (PSG) to Members	CVH/HN		☐		
2. Adopt, Disseminate Medical Clinical Practice Guidelines (CPG)	CVH/HN		☐		
CHRONIC CARE/ DISEASE MANAGEMENT					
1. Monitor Disease Management program For appropriate member outreach	CVH/HN		☐		
ACCESS, AVAILABILITY, SATISFACTION AND SERVICE					
1. C&L Report: Analyze and report Cultural and Linguistics (C&L)	CVH/HN		☐		
2. ACCESS SURVEY: Monitor and report access to care standards using telephonic surveys vendor(s) and/or California Cooperative Health Care Reporting Initiative.	CVH/HN		☐		
3. Complete and submit DMHC Timely Access Reporting (TAR) by March 31 filing due date	CVH/ HN		☐		
4. A&G REPORT: Identify opportunities to improve member service and satisfaction through appeals and grievances	CVH/HN		☐		
5. Group Needs Assessment Update– C&L, HE and QI work plans include activities designed to address last GNA findings (2016) as required by DHCS. Next full GNA due in 2021.	CVH/HN		☐		
6. GEO ACCESS: Assess and report on availability of network to identify opportunities for improvement: Analyze and inform Provider Network Management areas for increased contracting with a particular provider to improve availability. (bi-annual: next report 2018)	CVH/HN		☐		
7. Maintain compliance with DHCS Initial Health Assessment (IHA) 3-pronged outreach requirement: Annual IHA Compliance Monitoring Report	CVH/HN		☐		
QUALITY AND SAFETY OF CARE					
Integrated Case Management • Implement use of ImpactPro as the predictive modeling tool to identify high risk members for referral to ICM. • Evaluate the ICM Program based on the following measures:	/CVH/HN		☐		

Activity	Activity Leader	Mid-Year Update	Year End (YE) Complete?	Date	YE Update or Explanation *(if not complete)*
○ Readmission rates ○ ED utilization ○ Overall health care costs ○ Member Satisfaction					
CREDENTIALING / RECREDENTIALING					
1. Credentialing/Recredentialing Practitioners/Providers – Achieve and maintain a 100% timely compliance and 100% accuracy score	CVH/HN		☐		
DELEGATION OVERSIGHT/ BEHAVIORAL HEALTH					
1. Conduct oversight of Behavioral Health BH) through delegated reports on BH (may include member satisfaction surveys, provider surveys, etc.)	CVH/HN		☐		
QUALITY IMPROVEMENT					
1. Maintain Facility Site Review (FSR) and Medical Record (MRR) Compliance: To ensure practitioner offices and medical records comply with DHCS contracted requirements per MMCD Policy Letter 14-004 and Physical Accessibility Review Survey per MMCD Policy Letter 12-006 & 15-023	CVH/HN		☐		.
2. Evaluation of the QI program: Complete QI Work Plan evaluations annually.	CVH/HN		☐		
DEPRESSION SCREENING AND FOLLOW-UP					
3. Development and distribution of provider educational resources on screening for clinical depression and follow up (12 years and older)	CVH/HN		☐		